

Studio IASP sull'ipnosi nel trattamento del Dolore (2010 - 2012)

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Lo studio è stato presentato al 13° Congresso della IASP a Montreal, nel workshop del 31 agosto 2010 e si è concluso a luglio 2012. Lo scopo prefissato è fare il punto della situazione, su come l'ipnosi è percepita e utilizzata oggi, nel trattamento del dolore. Questo lavoro è il risultato della rielaborazione delle risposte ricevute dai membri della IASP (psichiatri / psicologi, anestesisti), dagli autori di articoli sul dolore e l'ipnosi pubblicati su Pub-Med, e dai centri o cliniche del dolore.

METHOD

E-mail invitation was sent from January to April, 2010 to IASP members (psychiatrist/psychologist, anesthesiologist), authors of papers on pain and hypnosis publicized in Pub-Med, and pain centers and pain clinic searched in internet, which totaled 2302. Ninety six clinicians participated from 35 countries (a response rate of 4.5 %). Among them, 32% were from North America and 52% were from Europe (Table 1).

Table 1. The number of facilities with a “hypnotist” by countries

USA	11	Australia	2
France	8	Ukraine	1
Canada	6	UK	1
Sweden	3	Repubblica di San Marino	1
Italy	3	Poland	1
Germany	3	Philippines	1
Switzerland	2	New Zealand	1
Spain	2	Japan	1
Netherlands	2	Israel	1
Brazil	2	Cuba	1
Austria	2	Belgium	1
total			54

The responses were divided into two groups; the facility with a hypnotist and the facility without a hypnotist. The facilities with a hypnotist totaled 54 in 22 countries. The number of facility without a hypnotist was 40 in 22 countries. The word “hypnotist” here means the specialist who practices hypnosis in their facilities as simply described in the question.

Facilities are different in scale (Table 2). The facility with the number of new patients between 250 and 500 is largest in number, whether it is with a hypnotist or without. The number of responses from facilities without a hypnotist might mean the growing interest in hypnosis or objection to handle this issue in this way. Some responders answered the questions about hypnotic intervention such as frame, techniques and so forth, though they stated that no specialist practices hypnosis.

Table 2. Scale of facility

New patient per year	Facility with psychological intervention with a hypnotist	Facility with psychological intervention without a hypnotist	Total
1~99	7	4	11
100~	4	3	7
250~	14	8	22
500~	9	5	14
1000~	5	6	11
2000~	5	3	8
5000~	1	1	2
unknown	8	3	11
	53	33	86

RESULTS

Each number indicated in parentheses on each issue is based on the number of responses to each question. The number on the left side of the slash indicates the number of clinicians who selected the items and on the right side is that of responses. They are not always the same. In the question where multiple answers are accepted, the difference between the facility with a hypnotist and without a hypnotist is evaluated by Fisher's exact test. Mean scores are tested by non-paired t-test. The analyses are performed with a statistical package (SPSS Ver.11.0). P values<0.10 are considered statistically significant.

1. Psychological intervention in pain treatment

1-1. Decision process for psychological intervention (Table 3)

In the decision process to introduce patients into psychological intervention, patient's wish (23/53), decision at a conference (22/53) and decision by a non-psychiatrist medical specialist in the facility (20/53) are more regarded than decision by psychiatrists or psychologists (13/53). "Patient's wish" is seen as more important in the facilities with a

hypnotist (7/39) than in that without hypnotist($P=0.012$). Facilities with a hypnotist place more emphasis on patients' motivation for psychological intervention.

Table 3. Decision process for psychological intervention

	Facilities with a hypnotists(N=53)	Facilities without a hypnotists(N=39)
Patient's wish	23	7
Decision at a conference	22	12
Decision by a physical doctor in the facility	20	19
Decision by psychiatrists or psychologists	13	8
Letter of referral from other facilities	8	4

1-2. *Used criteria for psychological intervention (Table 4)*

The top three criteria used for psychological interventions are, psychosomatic symptoms (31/49), history of unsuccessful medical treatments (30/49), and pain behavior (29/49), followed by severe distress in patients (26/49) and psychological response to intervention (25/49). Severe distress in patients is more regarded in the facilities without hypnotist (27/37) with significance ($P=0.067$). One comment includes the situation where pharmacological treatment is not available because of its side-effects.

Table 4. Used criteria for psychological intervention

	Facility with a hypnotist(N=49)	Facility without a hypnotist(N=37)
Psychosomatic symptom	31	22
History of unsuccessful medical treatments	30	20
Pain behavior	29	23
Severe distress in patients	26	27
Psychological response to intervention	25	14
Disease, symptom or syndrome specified in facility	9	3
All patients	6	2

1-3. *Psychological interventions offered besides hypnosis (Table 5)*

Psychological interventions offered besides hypnosis can be divided into four categories, just for this survey (Table 6). Cognitive approaches are most common (40), followed by general approach (18) and inner oriented approach (12), which contains biofeedback and hypnotic elements. Third generation CBT also contains hypnotic elements, however it is included in “cognitive approaches”. Dynamic uncovering approach is small in number (4).

Psychological intervention as a whole is more aggressively practiced in the facilities with a hypnotist. The total number of listed psychological intervention is 77 in 36 facilities with a hypnotist and 46 in 27 facilities without a hypnotist. Hypnosis seems not to replace other psychological interventions but to add a specific element to pain treatment of today

Table 5. Number of psychological interventions offered beside hypnosis

	Facilities with a hypnotist(n=36)	Facilities without a hypnotist(n=27)
Cognitive approach	40	19
General approach	18	12
Inner oriented approach	12	9
Dynamic uncovering approach	4	1
Others	3	5

Table 6. Four categories of psychological interventions in pain treatment

Category in this survey	Response
General approach	supportive humanistic counseling, MD counseling, motivational interviewing/psychotherapy
Cognitive approach 1	CBT, BT, self management, coping strategies, education
2	mindfulness, meditation, ACT, REBT*
Dynamic uncovering approach	psychoanalysis, dynamic counseling
Inner oriented approach	biofeedback, relaxation training, AT, distraction, psychophysiological self regulation
Others	art therapy (dance, music), couple-family therapy, systemic therapy, pain group, psychotherapy

* ACT; Acceptance and commitment therapy, REBT; Rational Emotive Behavior Therapy

1-4. *Psychological intervention rate in pain treatment (Table 7)*

The percentage of psychological interventions among the total new patients is different from one facility to another. In 35.0% of the facilities with a hypnotist (17/48), psychological intervention is applied to more than 51% of patients. The highest intervention rate (76%~100%) is 22.9% and related to the insurance systems which require and/or pay for multidisciplinary pain treatment, the academic initiative by the professor in university hospital or pain clinic, and needless to say, the psychological intervention facility.

Table 7. Percentage of psychological intervention among total new patients

	Facility with a hypnotist(N=48)	Facility without a hypnotist(N=38)
~100%	11	4
~75%	6	0
~50%	7	4
~25%	8	9
~5%	8	11
unknown %	8	5
none	0	5

2. *Target of hypnosis*

2-1. *Target generation (Table 8)*

Pain treatment with hypnosis targets all generations. The facilities specialized for children and/or adolescent are 19.0% (8/42).

Table 8. Target generation (N=42)

child	9
adolescent	8
adult	33
senior	11

2-2. Target of symptom and disease (Table9)

Hypnosis is applied to a variety of specific pain and other chronic pain in general. Target symptom/disease might almost depend on the facility where clinicians work. Among responders, 72.7%(32/44) had experience in treating chronic pain in general and 27.3% (12/44) had experience only in restricted targets such as phantom limb pain, headache, cancer, fibromyalgia, musculoskeletal pain, functional gastrointestinal pain, neuropathic pain, orofacial pain, burn pain, and so forth. Those titles are not so different whether the intervention is for individual or for group, in the facilities with hypnotist or without. Persistent post surgical pain, persistent pain associated with chronic disease like cystic fibrosis or sickle cell anemia, and acute pain with needle phobia were added by some responders.

Table 9. Target symptom and disease

	Facility with a hypnotist		Facility without a hypnotist	
	Individual intervention (n=45)	Group intervention (n=20)	Individual intervention (n=4)	Group intervention (n=13)
Phantom limb pain	19	5	1	3
Headache	19	7	2	3
Fibromyalgia	18	8	1	2
Cancer pain	18	5	1	3
Musculoskeletal pain	18	6	0	1
Functional gastrointestinal pain	17	5	2	3
Neuropathic pain	16	5	1	1
Orofacial pain	14	6	1	3
Burn pain	13	4	1	0
Chest pain	12	3	1	1
Traumatic injury	12	2	0	2
Arthritis	11	2	0	1
CRPS	11	4	2	3
Genitourinary pain	10	3	1	2
Chronic pain in general	32	15	3	12

2-3. Targets of hypnosis as a viable treatment (Table 10)

Successful outcomes in interventions underlie the “viability” evaluated. Clinicians regard persistent pain, followed by psychogenic aspect of pain, somatic pain and complicated difficult pain as the most viable targets for hypnosis. Clinicians in facilities with a hypnotist regard that hypnosis is a significantly more “viable” treatment for recurrent pain ($P=0.068$), somatic pain ($P=0.036$), preparation for transient/acute pain expected ($P=0.041$) than do those in facilities without a hypnotist. It implies that the effect of hypnosis on the somatic aspect is overlooked in those facilities without a hypnotist.

But “viability” in hypnosis has two implications, as pointed out in some comments. If it means rapid effectiveness, “preparation for transient/acute pain expected is easiest to obtain quick results”. If it means therapeutic potential, “hypnosis is effective for any pain”. But practically, “other fields of pain than transient/acute pain require more time and work and the results are more modest”. And for any pain, “its outcome is highly dependent on patient’s capacity and engagement”.

Two comments pointed out unspecific aspect of hypnosis as intervention. “Hypnosis is not effective”. “Hypnosis seems to work best if the hypnotist is enthusiastic about the technique. If one has repeated the same technique and words many many times, it can get too routine.”

Table 10. “Viable” pain for hypnosis

	Facility with a hypnotist(N=53)	Facility without a hypnotist(N=26)
Persistent pain	34	19
Psychogenic aspect of pain	30	15
Somatic pain	27	7
Complicated difficult pain	27	15
Preparation for transient/acute pain expected	26	8
Recurrent pain	25	7
Prevention of chronic pain	23	8
Acute pain	3	1
Chronic pain	2	0

3. Practice of hypnosis in pain treatment

In this and the next sections, percentages of patient for each issue are often described, because pain and pain patients are different among facilities and clinicians. The tables present the differences, and response is summarized in explanation, sometimes from a broader point of view.

3-1. Hypnosis on group basis or on individual basis (Table 11)

Hypnosis is utilized on an individual basis in a larger number of facilities than on a group basis. Independent use on individual basis is 59.3% (32/55), while that on group basis is 1.9% (1/55) and parallel or integrated use is 31.5% (17/55). Totally, Individual intervention is offered in 98% (49/55) of facilities.

As an example, the Auckland Regional Pain Service (New Zealand) has intensive 3-week group, brief group, or individual intervention. Intensive group intervention is funded by health board and Accident Compensation Corporation (ACC). All patients will have a psychosocial assessment. A careful application interview process chose 90 patients (about 10% of new patients per year) with motivation and readiness (accepted that they have chronic pain and that they need to learn self-management strategies) to learn self-management intensive program as chronic pain patient. The rest will go on to briefer group or individual interventions. Some patients in group are further introduced to individual intervention.

Table 11. Individual and group intervention

	Facility with a hypnotist(N=51)	Facility without a hypnotist(N=34)
Individual only	32	1
Parallel	7	0
Integrated	10	1
Group only	1	1
No intervention with hypnosis	1	31

3-2. Individual hypnosis among total psychological intervention (Table 12)

In 41.7% of the facilities with a hypnotist (21/51), individual hypnosis is applied to less than 5% of the total psychological interventions. The higher percentage of individual

hypnosis among total psychological intervention is related to the specific target such as child/adolescent, or the specific pain such as orofacial pain or fibromyalgia.

Table 12. Percentage of individual hypnosis among total psychological intervention

	Facility with a hypnotist(n=51)	Facility without a hypnotist(N=34)
76~100%	5	0
51~75%	7	0
26~50%	3	0
6~25%	11	0
~5%	21	4
None	4	30

3-3. Treatment frame of individual intervention in facility with hypnotist (Table 13)

Most commonly used frame of individual session is 60 minutes, every week, totaling less than 20 sessions. For relief of acute pain (3), the frame is quite different from that for chronic pain and the session number is brief one or two. Hypnosis in pain treatment is practiced in a limited frame as “a brief psychotherapy, not in theoretical view, but in pragmatic view. “

The same comment says “it is impossible to know the necessary session number for the patient from the beginning, but if both the clinician and the patient know they will have 5 times hypnosis for example, the internal process of healing is modulated in accordance with this limitation. The length can be shortened by technical ability as well as special genius (see Milton H. Erickson) but I think that the therapeutic alliance is most important”. But “sometime it takes time to change the patients’ disturbed somatic response to stress (one year or more).”

Table 13. Treatment frame of individual hypnosis

Session time (N=46)	
~30min.	7
~60min.	31
~90min.	4
~120min.	1
121min~	0
Unfixed	3

Session interval (N=46)	
No interval(single only)	1
Two sessions per week	9
Every week	17
Every two or three weeks	9
Every month	4
Unfixed	6

Number of sessions (N=43)	
Single session	1
2~5	13
6~10	20
11~20	7
20~	1
open	1

3-4. How hypnosis is utilized in individual intervention? (Table 14)

Hypnosis is utilized solely as hypnotic procedure incorporated in other psychotherapy such as CBT by 23.4% of responders (11/47), solely as a part of physical intervention by 12.8% of responders (6/47), solely as hypnotic intervention alone by 12.8% of responders (6/47). And 44.7% of responders (21/47) utilize hypnosis, depending on clinical situations differently.

Hypnosis is not utilized in 2 facilities though the facility included “hypnotist”. In these facilities, “hypnosis is not offered by clinician and is not asked for by patients”, the reason of which is not known.

Table 14. Utilization of hypnosis (N=47)

As hypnotic procedure	31
As hypnosis	26
As a part of physical intervention	17
hypnosis is not utilized	2

3-5. Most frequently used technique (Table 15)

The average number of frequently used technique in individual intervention is 5.6(SD 3.55). Needless to say, this does not necessarily mean they employ five or six techniques for one patient. It depends on the pain situation for each patient, clinical setting and treatment plan, which technique is to be employed. In group interventions where patients' needs are assessed in a more generalized manner, the average number is 4.2 (SD 2.62). In facilities without a hypnotist, it is 2.6 (SD 2.13).

The more frequently used technique might be applicable and effective for the larger population of pain patients. The top five are sensory focusing, imagery, sensory substitution, interspersal technique/metaphors and diminution of pain. Those excepting interspersal techniques/metaphors are employed also in the facilities without a hypnotist.

Table 15. Frequently used techniques

Intervention	Individual		Group	
	Hypnotist	with (N=44)	with (N=18)	without (N=9)
Sensory focusing and alteration		36	12	9
Imagery		35	13	3
Sensory substitution		29	6	1
Interspersal technique and use of metaphors		26	8	0
Diminution of pain		24	5	4
Body dissociation		22	10	3
Displacement		15	5	1
Abolition of pain		14	3	1
Motor response		13	2	1
Time distortion		13	3	0
Catalepsy		12	3	0
Amnesia		9	1	0

3-6. Tailoring and protocol in individual intervention

In individual intervention, 58.5% (24/41) of responders tailor their intervention according to patients' responses for more than 76% of patients. Two comments mentioned the individualized co-development of hypnotic strategy between client and therapist. Among clinicians who utilize hypnosis as hypnotic procedure incorporated in other psychotherapy such as CBT, and among those who utilize hypnosis as hypnotic intervention alone, the percentage of tailoring is diverse. And it is less than 5 % or more than 76% in case of clinician who utilize hypnosis as a part of physical intervention alone (Table 16).

Table 16. *For how many patients the intervention had to be tailored to their response? (N=41)*

76~100%	24
51~75%	4
26~50%	5
6~25%	2
~5%	5
None	1

Protocols may either quite powerful or quite inadequate, depending on pain situation. 55.0% (22/40) employ regular protocol or scripts constructed for each patient for less than 5% or none of patients (Table17). A comment says, “Fundamental respect of others, the acceptance of the nature of the patient, who is not required to change or assimilate a new neurobiological programming” leads to tailoring.

Table 17. *How many patients among those for hypnotic intervention were applied with regular use of protocol or scripts constructed for each individual patient? (N=40)*

76~100%	6
51~75%	5
26~50%	3
6~25%	4
~5%	7
Unknown %	1
None	14

3-7. *Teaching self hypnosis (Table18)*

Half of clinicians teach self hypnosis for more than 76% of patients. All clinicians employ teaching self hypnosis and 70.7% of them provide some audio-recordings.

Table 18. Self hypnosis and audio-recordings

	Teaching self hypnosis(N=44)	Providing audio-recordings (N=41)
76~100%	22	7
51~75%	8	2
26~50%	5	7
6~25%	5	3
~5%	3	9
Unknown %	1	1
None	0	12

3-8. Clinical setting of group intervention (Table 19)

Group interventions are practiced in 41.3% of facilities with hypnotists (19/46). Mostly the session is closed or semi-closed, every week and less than 20 sessions. Group interventions include two types. One is for outpatients and another is as a part of intensive full-time pain management program.

Even among in 13 facilities without a hypnotist, hypnosis is utilized as a procedure or as a part of physical intervention in two facilities.

Table 19. Group intervention

Session type	With a hypnotist(N=19)	Without a hypnotist(N=12)
Closed	11	8
Open	4	3
Semi-closed	3	1

Session time	With a hypnotist(N=19)	Without a hypnotist(N=13)
~30min.	3	1
~60min.	7	5
~90min.	4	3
~120min.	3	1
121min~	1	2
Unfixed	1	1

Session interval	With a hypnotist(N=19)	Without a hypnotist(N=14)
Two sessions per week	3	2
Every week	12	9
Every two or three weeks	4	1
Every month	0	1
Every two months~	0	0
Unfixed	0	1

Number of sessions	With a hypnotist(N=18)	Without a hypnotist(N=14)
~5	4	3
6~10	6	8
11~20	6	2
20~	0	0
open	2	1

Utilization of hypnosis	With a hypnotist(N=16)	Without a hypnotist(N=14)
As hypnotic procedure	14	1
As hypnosis	5	0
As a part of physical intervention	3	1
Hypnosis is not utilized	1	12

Intervention includes.	With a hypnotist(N=16)	Without a hypnotist(N=14)
Regular use of scripts for specific pain or state	10	5
Teaching self hypnosis	13	3
Providing audio-recordings	11	2

4. Observations and interventions on the way to hypnotic analgesia

In individual intervention, clinicians have a chance to observe pain and patients closely. Through the process of helping patients enter trance and create hypnotic analgesia, various factors are observed to influence patients' pain experience and clinicians' plan/process of intervention. The Survey asked three issues. Needless to say, these are only a part of factors. Stressful life event is added by comments.

4-1. Somatic tension related to pain (Table 20)

Some pain is causally associated with somatic tension. And some psychological tension creates somatic tension, predisposing to pain or dysfunction. Among responders, 58.1% of clinicians (25/43) observe somatic tension related to pain in more than 51% of patients. Only a part of them is intervened with regular use of protocol or scripts formulated for relaxation etc.

Table 20. “How many patients were found to have somatic tension related to their pain?” (N=43)

	Patients with Somatic tension(N=43)	Patients applied with regular use of protocol or scripts formulated for relaxation etc.(N=41)
76~100%	10	6
51~75%	15	5
26~50%	7	5
6~25%	2	3
~5%	0	5
Unknown %	9	1
0	0	16

4-2. Unconscious conflict underlying pain (Table 21)

The survey asked “how many patients were conclusively found to have psychological unconscious conflict underlying pain?” Logically, clinicians cannot conclude that certain patients have certain unconscious conflicts underlying pain. So mostly, it is concluded by patients themselves, usually at the ending stage of intervention. The answer “0%” accompanied comment reading “there are no such 'conclusive' findings”. The wording in the survey might be insufficient. A comment reads “we don't need to be worried about this as soon as hypnosis is chosen”.

Ten clinicians (23.3%) observe psychological unconscious conflict underlying pain in more than 51% of patients. Type of utilization does not make difference in this observation. Its incidence depends on nature of pain, patients and clinicians. But as a whole, it was much less frequently observed than “somatic tension related to pain”.

Table 21. How many patients were conclusively found to have psychological unconscious conflicts underlying pain? (N=43)

76~100%	1
51~75%	9
26~50%	9
6~25%	6
~5%	4
Unknown %	13
0	1

4-3. Intervention to “unconscious” element (Table 22)

“How many patients among those for hypnotic intervention were applied with the following sets of intervention?” “Symbolic process to deal with somatic and unconscious conflict at the same time” is employed by 87.5% of clinicians (35/40). “Dynamic uncovering approach for pain which is related to unconscious conflict” is employed by 71.8% of clinicians (28/39).

As a whole, in pain treatment, symbolic process might be more often employed than uncovering approach. 12 responders (30%) utilize symbolic for more than 51% of patients. 3 responders (7.7%) utilize dynamic uncovering approach for more than 51% of patients.

Table 22. Symbolic process and uncovering approach

	Utilizing symbolic process to deal with somatic and unconscious conflict at the same time (N=40)	Dynamic uncovering approach for pain which is related to unconscious conflict (N=39)
76~100%	7	1
51~75%	5	2
26~50%	9	8
6~25%	11	6
~5%	3	9
Unknown %	0	2
None	5	11

4-4. Pervasive developmental disorder (PDD) (s/o) underlying pain (Table 23)

It is asked “How many patients were found to have pervasive developmental disorder underlying pain?” At least, 52.4% of clinicians (22/42) observe some. Some hypersensitivity and/or adherence to stimulus are dealt with in hypnosis.

Table 23. “How many patients were found to have pervasive developmental disorder underlying pain?” (N=42)

76~100%	0
51~75%	2
26~50%	3
6~25%	5
~5%	12
Unknown %	16
0	4

5. Clinicians engaged in hypnotic pain treatment

5-1 “hypnotist” in pain treatment (Table 24)

Adding the number in the responses together, 104 clinicians practice hypnosis in 54 facilities, mainly in multidisciplinary pain center(MPC)/pain center (35; 64.8%), pain clinic (9; 16.7%), department of anesthesiology (4; 7.4%), department of psychosomatic medicine/psychiatry (3), and private practice of psychology (3).

Mostly, they work solely (29; 53.7%), or by 2 (17; 31.5%) in each facilities. The largest number in one facility was 10, followed by 5 or 3. Those facilities are MPC or pain clinic, 4 in France, others each in Israel, Sweden, Belgium and in New Zealand. In these facilities, hypnosis is more substantially and more stably utilized to help pain patients. The number of new patients per one hypnotist is quite roughly from 50 to 2000. But in the above mentioned facilities, it is roughly between 50 and 350

Table 24. Number of hypnotist and new patients per year

New patient per year	Number of hypnotist in one facility					Total
	1	2	3	5	10	
1~99	4	4	0	0	0	8
100~	2	2	0	0	0	4
250~	9	2	0	1	0	12
500~	1	3	4	0	1	9
1000~	3	1	0	1	0	5
2000~	2	2	1	0	0	5
5000~	1	0	0	0	0	1
unknown	2	3	0	0	0	5
	24	17	5	2	1	49

5-2. Specialty and experience years in pain treatment and in hypnosis

Among clinicians who practice hypnosis, medical doctors and psychologists were equal in number (Table 25). And it is worth noting that the mean experience years in pain treatment is 16.6years (SD 10.12), which is significantly longer than 11.4years (SD 11.87) in hypnosis. It implies that years of experience in pain treatment prepared them to learn and practice hypnosis. They realized the necessity to add new element to their pain treatment (Table 26).

Table 25. Specialty of "hypnotist"

Specialty	"Hypnotist"(N=45)
Physical medicine	4
Psychiatry	5
Psychology	20
Anesthesiologist	9
Pediatrician	2
Dentist	1
Nurse	2
Others	1

Table 26. Experience years in pain treatment and hypnosis

Years of experience	In pain treatment	In hypnosis
0	1	0
1~4	2	6
5~9	9	14
10~19	19	11
20~29	6	6
30~39	5	5
40~	1	1
50~	1	1

5-3. Number of patients for one clinician in the previous one year and describing outcome

The number of patients one “hypnotist” can help individually for a year is rather limited. Its mode is “30~49” (Table 27). The clinicians who track outcomes systematically for individual intervention is 29.7% (11/37), which does not depend on years of experience or number of patients for a year (Table 28).

Table 27. The number of pain patients individually intervened with hypnosis for the last one year (N=37)

0	2	20~29	3	60	2	100	2
1~9	9	30~49	8	70	2	250 patients	1
10~19	4	50	3	80	1		

Table 28. Do you track outcomes systematically?

Intervention	Hypnotist		Non hypnotist(N=11)
	individual(N=44)	group(N=20)	group
yes	14	10	5
no	28	10	6

5-5. *Barriers to the more wide spread use of hypnosis in pain treatment (Table29)*

Unfamiliarity among clinicians/patients and misconception among clinicians/academics are the top two chosen barriers. Attributes associated with hypnosis, such as multimodal nature of hypnosis, individuality of treatment plan/relationship, lack of specific/effective training, emotional involvement/hard work and nature of hypnosis contradicting accountability are chosen much less frequently than misconception and unfamiliarity. Added in responses are long engagement for therapy, lack of funding bodies, recruit/finding therapist and poor outcome study.

Table 29..Barriers to the more wide spread use of hypnosis in pain treatment

	With a hypnotist (N=55)	Without a hypnotist (N=33)
unfamiliarity among clinicians/patients	41	25
misconception among clinicians/academics	38	12
multimodal nature of hypnosis	15	8
individuality of treatment plan/relationship	13	4
lack of specific/effective training	11	10
emotional involvement/hard work	10	4
long engagement for therapy*	5	2
lack of funding bodies*	4	2
nature of hypnosis contradicting accountability	4	3
recruit/finding therapist*	1	2
poor outcome study*	1	1

TO CLOSE THIS FEEDBACK

We are in the closing part of this feedback. What is assumed to be “hypnosis” is evidently so diverse, as to frame, techniques and utilization, depending on target pains, target patients (Large, 1980) and facilities. The diversity makes it difficult to find a common language to describe hypnosis at present. Clinicians and patients are puzzled about what hypnosis is. But actually, it is substantially and stably utilized as a unique intervention modality in a certain number of facilities.

As a matter of fact, diversity is an advantage of hypnosis. Each pain situation has unique somatic, psychological and social aspects, which is more often true in chronic pain and influences techniques, strategies, length, frequency and number of sessions. The diversity of pain requires diversity in shaping interventions. Some experienced hypnotists answered that hypnosis is effective for all kinds of pain. So, interventions are tailored by almost all hypnotists. Some experienced clinicians tailor their intervention for all patients while the others tailor and regularly use protocol. The range of hypnosis is from full-fledged hypnosis to protocols or hypnotic elements in conversations.

By nature, pain experience is a result of automatic bio-psycho-social modulation of sensations or nociceptions. And Hypnotic analgesia is an innate brain function of humans, which is demonstrated in brain imaging studies (Faymonville et al., 2003; Boly et al., 2007; Vanhaudenhuyse, 2009; Vanhaudenhuyse et al., 2011). Therefore hypnotic analgesia is experienced as automatic and needs to be felt as patients' own ability. In the survey, all clinicians utilized self-hypnosis, which might be unique among other clinical situations applied with hypnosis. Hypnosis is neither to suggest nor to program patients specifically to change sensation and cognition. Hypnosis helps patients to facilitate innate pain modulation and respond to physical treatment. The “fundamental respect of others” in clinicians (Antonelli C. et al., 2010) secures patients to do their own works. The patient's innate therapeutic resources can be neglected or even undermined when pharmacological treatments are over-emphasized.

This survey did not ask about the success rate, which is influenced by the characteristics of facilities and the patients' selection. However for an example, more than half of the chronic pain patients could benefit from hypnotic intervention for their better coping with chronic pain (Large, 1980).

Coping with "barriers to the more spread use of hypnosis" and towards science of hypnosis, it seems necessary to specify the possible differences in pain besides acute/chronic in response to hypnosis and some influencing factors, as well as methods of induction. In general, the number of sessions is practically limited and the number of patients one clinician can treat is limited. In order to accumulate and to share our clinical experiences, we need to have a common set of descriptors for the different pain situations and factors limiting therapeutic progress. We also need to improve the reproducibility of hypnosis and clarify its safety and potential harm.

Many clinicians consider that something needs to be added to present pain treatment. Evidence-based practice (Patterson, DR, 2010, etc.) have helped clinicians/patients in pain treatment. More and more clinicians need to be interested in hypnosis and learn. May hypnosis be delivered to patients in need.

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