Australian Hypnotherapists Association

Submission to

Department of Health and Ageing

Prepared for the

Review of the Australian Government Rebate on

Private Health Insurance for Natural Therapies

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CONTENTS

ABOUT THE AUSTRALIAN HYPNOTHERAPISTS ASSOCIATION

With over 1000 members the Australian Hypnotherapists' Association (AHA) forms the largest group of professional clinical hypnotherapists in Australia. Its members practice in both the private and public sectors complementing other modalities, with many members working closely with doctors, dentists, psychologists, psychiatrists and other health service providers.

Formed in 1949 and incorporated in 1956 the AHA is seen as the premier professional body for professional clinical hypnotherapists in Australia. In 1999 the association published the second edition of its standards book titled "A Set of Competency and Proficiency Standards for Australian Professional Clinical Hypnotherapists". This work is in the National Library in Canberra as well as in a number of university libraries around the world. Consequently it has been recognised throughout the profession in Australian and internationally as a de-facto standard for the training of clinical hypnotherapists.

Since 1956 the AHA has been representing individual practitioners in Australia as the peak body and professional voice for hypnotherapy. The AHA has maintained its independence and is not aligned with any training organisation.

The AHA has worked toward uniform standards of practice, raising training standards and encouraging registration of the profession for more than 65 years and provides on-going professional development around the practice of hypnotherapy, supervision and accountability for its members.

The AHA also maintains a national public register, the National Hypnotherapists Register of Australia (NHRA), of qualified hypnotherapists that meet AHA national standards. This online register is a public resource enabling members of the public to choose a fully qualified specialist hypnotherapist with confidence.

SECTION ONE - ABOUT THIS SUBMISSION

The AHA welcomes the opportunity to comment on *"The Review of the Australian Government Rebate of Private Health Insurance for Natural Therapies".*

The AHA has for many years worked with other bodies within the profession with a view to addressing inconsistent recognition of the hypnotherapy profession by health bodies as well as state and federal governments. The mission of the AHA includes:

- Promoting the hypnotherapy profession and the services provided by well trained qualified hypnotherapists,
- Setting national standards, providing accreditation, supervision and ongoing professional development for professional hypnotherapists and;
- Initiating and coordinating ongoing research into the benefits provided by the clinical and economic benefits of hypnotherapy.

SECTION TWO – EXECUTIVE SUMMARY

Over the past 30 years the hypnotherapy profession has grown in recognition around the world, particularly in the UK where hypnotherapist form part of the Complementary and Alternative Medicine (CAM) of NHS hospitals. Hypnotherapists in these teams deliver treatment relating to habits, phobias, anxiety, panic attacks, fear, stress, pain management, sleeping problems, concerns with chemotherapy treatment and palliative care. In the USA and Australia, hypnotherapy is now widely recognised as a valuable tool in improving health outcomes.

Hypnotherapy is in the process of defining its place within the context of the health sector and has begun to do so by developing nationally recognised qualifications, voluntary self-regulation, national standards and national codes of conduct and ethics. As the largest and oldest hypnotherapy association in Australia the AHA has, and continues to be the initiator of such standards and codes.

This submission discusses the clinical efficacy of hypnotherapy, its cost effectiveness, and quality and safety within the Australian context. Using published research, the submission will demonstrate that hypnotherapy has clinical efficacy, is cost effective when compared to many other treatment options and has a record of safety and quality in its delivery.

SECTION THREE – DEFINING HYPNOTHERAPY

The definition of hypnosis as adopted by Division 30 of the American Psychological Association is as follows:

> "Hypnosis typically involves an introduction to the procedure during which the subject is told that suggestions for imaginative experiences will be presented. The hypnotic induction is an extended initial suggestion for using one's imagination, and may contain further elaborations of the introduction. A hypnotic procedure is used to encourage and evaluate responses to suggestions. When using hypnosis, one person (the subject) is guided by another (the hypnotist) to respond to suggestions for changes in subjective experience, alterations in perception, sensation, emotion, thought or behaviour. Persons can also learn self-hypnosis, which is the act of administering hypnotic procedures on one's own. If the subject responds to hypnotic suggestions, it is generally inferred that hypnosis has been induced. Many believe that hypnotic responses and experiences are characteristic of a hypnotic state. While some think that it is not necessary to use the word "hypnosis" as part of the hypnotic induction, others view it as essential.
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> "Details of hypnotic procedures and suggestions will differ depending on the goals of the practitioner and the purposes of the clinical or research endeavour. Procedures traditionally involve suggestions to relax, though relaxation is not necessary for hypnosis and a wide variety of suggestions can be used including those to become more alert. Suggestions that permit the extent of hypnosis to be assessed by comparing responses to standardized scales can be used in both clinical and research settings. While the majority of individuals are responsive to at least some suggestions, scores on standardized scales range from high to negligible. Traditionally, scores are grouped into low, medium, and high categories. As is the case with other positively-scaled measures of psychological constructs such as

attention and awareness, the salience of evidence for having achieved hypnosis increases with the individual's score" (Green et al 2003.)

SECTION THREE - THE EFFICACY OF HYPNOTHERAPY

Clinical Hypnotherapy is a developing profession and as such, is still developing its capacity for scholarly research. However, as can be seen from the evidence below there is a strong body of contemporary research being conducted around the world into the efficacy of hypnotherapy. This research demonstrates the efficacy of hypnotherapy as an adjunct or complementary modality when used to treat the following conditions:

Irritable Bowel Syndrome / Gastrointestinal disorders

Hypnosis has seen a resurgence recently in the clinical treatment of gastric problems (Benham and Younger 2012). Tan et al (2005) reviewed the empirical literature on hypnotherapy for Irritable Bowel Syndrome (IBS), including six published studies with a control group, and concluded that the approach met the highest qualifications of efficacy and specificity, according to the efficacy guidelines of the Clinical Psychology Division of the American Psychological Association.

In a major review for the European Journal of Gastroenterology & Hepatology, Gonsalkorale and Whorwell (2005) found "accumulating and compelling evidence that hypnotherapy is an effective treatment for irritable bowel syndrome." They concluded: "Recently, studies have shown that hypnotherapy has beneficial effects that are long lasting, with most patients maintaining improvement, and with decreased consultation and medication needs in the long term."

In a special issue of the International Journal of Clinical and Experimental Hypnosis, Whitehead (2006) reviewed 11 clinical studies, four of which were randomized trials. He found that "this body of research consistently shows hypnosis to have a substantial therapeutic impact on IBS, even for patients unresponsive to standard medical interventions. The median response rate to hypnosis treatment is 87%, bowel symptoms can generally be expected to improve by about half, psychological symptoms and life functioning improve after treatment, and therapeutic gains are well maintained for most patients for years after the end of treatment."

In a long-term follow-up study, Lindfors et al (2012) concluded that "gut-directed hypnotherapy in refractory IBS is an effective treatment option with long-lasting effects, also when given outside highly specialized hypnotherapy centres. Apart from the clinical benefits, the reduction in health-care utilization has the potential to reduce the health-care costs."

Chronic and Acute Pain Management

Hypnosis has long been recognised as effective in the treatment of chronic pain. Montgomery (2000) conducted a meta-analysis of 18 studies and found a "moderate to large hypnoanalgesic effect, supporting the efficacy of hypnotic techniques for pain management."

Benham and Younger (2012) state “hypnotically induced analgesia is arguably the area in which hypnosis has proved itself most adequately, providing reduction of both chronic (eg cancer) and acute (eg surgical) pain.” They cite a National Institute of Health report (1999) finding “strong evidence for the use of hypnosis in alleviating the pain associated with cancer” and other data “suggesting the effectiveness of hypnosis in other chronic pain conditions, which include irritable bowel syndrome, oral mucositis, temporomandibular disorders, and tension headaches.”

Jensen and Patterson (2006) reviewed controlled trials of hypnotic treatment for chronic pain and concluded that “hypnotic analgesia produces significantly greater decreases in pain relative to no-treatment and to some non-hypnotic interventions such as medication management, physical therapy, and education/advice.”

Schnur (2008a) conducted a meta-analysis of 26 randomized controlled trials of hypnosis interventions to manage distress related to medical procedures, and concluded that “[T]he data strongly support the use of hypnosis as a non-pharmacologic intervention to reduce emotional distress associated with medical procedures, and suggest that the more widespread adoption of hypnosis could improve the quality of life of millions of patients undergoing medical procedures.”

Uman et al (2008) reported the results of a systematic review of 28 randomized controlled trials of 1,039 participants in treatment conditions and 951 in control conditions in psychological interventions for children and adolescents undergoing needle-related procedures. They concluded that the largest effect sizes for treatment improvement over control conditions were found for distraction, combined cognitive-behavioural interventions and hypnosis, with hypnosis producing the most positive evidence of all the interventions assessed.

Obstetrics

Brown et al (2007) reviewed the benefits and effectiveness of hypnosis in obstetrics and labour and delivery, demonstrating significant reductions in the use of analgesics and anaesthesia and in shorter Stages 1 and 2 labors; and found that hypnosis was beneficial in relation to labour length, pain levels, and the enjoyment of labour, as well as its effectiveness in preterm labour in randomized controlled trials and in a meta-analysis.

Julie Phillips-Moore (2012) surveyed 145 couples from Sydney who had undertaken a HypnoBirthing program and found results similar to previous studies: reduction in pain or discomfort during birth, a reduction in pain medication, fewer deliveries by caesarean section, shorter labours, high Apgar scores and less post-partum depression.

Asthma

Hackman and Gershwin (2000) conducted a critical review of hypnosis as a treatment for asthma and concluded that, “significant data suggest that hypnosis may be an effective treatment for asthma… Studies conducted to date have consistently demonstrated an effect of hypnosis with asthma… Children in particular appear to respond well to hypnosis as a tool for improving asthma symptoms.”

Hypertension

According to Benham and Younger (2012), "the literature suggests that hypnosis is one technique that can be used to lower blood pressure. The use of hypnosis may be most effective in lowering the blood pressure of individuals who are hypertensive."

Obesity and Weight Management

Elkins et al (2007) concluded that a "more intensive approach to hypnosis can result in biologically confirmed abstinence rates of 40 percent or higher," cited in Nash and Barnier (2012).

In a meta-analysis of five studies adding hypnosis to cognitive-behavioral treatments for weight reduction, Kirsch (1996) found a mean weight loss at the final assessment of 2.74kg (6.03lbs) without hypnosis and 6.75kg (14.88lbs) with hypnosis. The effect size for this difference was 0.98 SD. Correlational analyses indicated that the benefits of hypnosis increased substantially over time (r = .74). "The addition of hypnosis," concluded the study, "appears to have a significant and substantial effect on the outcome of cognitive-behavioral treatment for weight reduction, and this effect increases over time." The mean weight loss reported in the five studies indicates that hypnosis can "more than double the effects of cognitive-behavioral treatment." The data also indicates that "the impact of hypnosis increases over time, suggesting that it is especially useful for long-term maintenance of weight loss."

In 2007 Sapp et al reviewed the research on hypnosis and obesity over the previous 25 years – including Kirsch's meta-analysis – and concluded that "[o]verall it has been found that hypnosis as a treatment of obesity, whether alone or in combination with other treatments, is effective at producing weight loss… In addition, many studies have indicated that the gains are maintained, if not increased, in the long-term… Overall, hypnosis is a promising treatment in treating individuals with obesity."

Anxiety, Depression, Phobias and Fears

Hypnosis in the treatment of depression is a relatively new application, with the result that controlled research on ways hypnosis can be applied in the treatment of depression has been under-studied (Yapko 2012). Alladin and Alibhai (2007) examined the effectiveness of hypnotherapy combined with cognitive-behavioral therapy (CBT), the first (and so far only) controlled comparison of hypnotherapy with a well-established psychotherapy for depression, meeting the APA criteria for a "probably efficacious" treatment for depression. Patients receiving cognitive hypnotherapy produced significantly larger changes in Beck Depression Inventory, Beck Anxiety Inventory, and Beck Hopelessness Scale: the effect was maintained at 6-month and 12-month follow-ups.

A meta-analysis of 18 studies by Kirsch et al (1995) compared treatment of a range of psychological disorders (including anxiety) using CBT alone or CBT combined with hypnosis and found that CBT supplemented by hypnosis led to more clinical gains than CBT alone (cited in Bryant 2012).

Psychotherapy costs less than anti-depressants. As summarized by Kirsch (2011), "About nine months after the beginning of treatment, the costs of continuing antidepressant treatment catch up to the costs of brief psychotherapy, and after

that, the cumulative costs of medication continue to rise, whereas those of psychotherapy do not" (citing Dobson et al 2008).

Bryant et al (2005) undertook the first controlled treatment study of hypnosis and cognitive behavioral therapy (CBT) of acute stress disorder (ASD). They found that in terms of treatment completers (n _ 69), fewer participants in the CBT and CBT hypnosis groups met criteria for post-traumatic stress disorder at post treatment and 6-month follow-up than those in the SC group. CBT-hypnosis resulted in greater reduction in re-experiencing symptoms at post treatment than CBT. These findings suggest that hypnosis may have use in facilitating the treatment effects of CBT for post-traumatic stress.

The following year Bryant et al (2006) published the results of a long-term study of the benefits of cognitive behavior therapy, which included CBT combined with hypnosis. They found that "[p]atients who received CBT and CBT/hypnosis reported less re-experiencing and less avoidance symptoms than patients who received SC [supportive counselling]."

Stress

A review by Hammond (2010) demonstrated that the inclusion of hypnosis with other treatment modalities (e.g., CBT or acupuncture) commonly improves the outcomes obtained by the other therapeutic modalities alone. Hammond also states that:

- Hypnosis has been shown to be effective in reducing state anxiety associated with cancer, surgery, burns and a variety of medical/dental procedures.
- Self-hypnosis training has also been demonstrated to effectively treat anxiety-related disorders, such as tension headaches, migraines and irritable bowel syndrome.
- Six studies have demonstrated changes in trait anxiety from self-hypnosis training, but further randomized controlled outcome studies would be desirable on the hypnotic treatment of generalized anxiety disorder and in further documenting changes in trait anxiety.
- Self-hypnosis training has been demonstrated to be a rapid, cost-effective, non-addictive, side effect free and safe alternative to medication for the treatment of anxiety-related conditions, and the public has been shown to be open to hypnosis treatment. In patients with more severe problems, self-hypnosis training may very easily be combined with other forms of treatment.

Insomnia

Abramowitz et al (2008) evaluated the benefits of add-on hypnotherapy for patients experiencing chronic PTSD. Thirty-two PTSD patients treated by SSRI antidepressants and supportive psychotherapy were randomized to 2 groups: 15 patients in the first group received Zolpidem 10 mg nightly for 14 nights, and 17 patient in the hypnotherapy group were treated by symptom-oriented hypnotherapy, twice-a-week 1.5-hour sessions for 2 weeks. There was a significant main effect of the hypnotherapy treatment with PTSD symptoms as measured by the Posttraumatic Disorder Scale. This effect was preserved at follow-up 1 month later. Additional

benefits for the hypnotherapy group were decreases in intrusion and avoidance reactions and improvement in all sleep variables assessed.

Nicotine Dependency

Carmody et al (2008) conducted a randomized trial of 286 smokers and used biochemical confirmation to compare hypnosis with standard behavioural counselling where both interventions were combined with nicotine patches. Based on biochemical or proxy confirmation, 26% of the individuals in the hypnosis group were abstinent at 6 months compared with 18% of the behavioural group; at 12 months, based on biochemical or proxy confirmation, the quit rate was 20% for the hypnosis participants compared with 14% of the behavioural group.

In 2010 Lynn et al considered the current state of knowledge of hypnosis and smoking cessation, including the Carmody study mentioned above, and concluded "hypnosis is one of a number of treatments that can play a valuable role in smoking cessation." They state that, while there is still much to learn, "for now, clinicians can accurately inform patients that 20-35% of individuals will benefit, long-term, from hypnotically assisted smoking interventions."

Additionally, Elkins and Perfect (2012) argue that "effective hypnosis intervention for smoking cessation may need to be intensified in some way to achieve better results. In fact, reports of more individualized and intensive approaches to hypnosis for smoking cessation have indeed suggested that higher rates of smoking cessation might be achieved." Elkins et al (2007) concluded that a "more intensive approach to hypnosis can result in biologically confirmed abstinence rates of 40 percent or higher" cited in Nash and Barnier (2012).

Breast Cancer Surgery

A randomised controlled trial demonstrated that a brief hypnosis intervention before breast cancer surgery statistically significantly reduced intraoperative use of the analgesic lidocaine and the sedative propofol. Filshie (2008) noted that 'The hypnosis intervention also reduced patient-reported postsurgical pain (intensity and unpleasantness), nausea, fatigue, discomfort, and emotional upset to an extent that was consistent with benchmarks for clinically meaningful differences. The present brief hypnosis intervention appears to be one of the rare clinical interventions that can simultaneously reduce both symptom burden and costs.'

SECTION FOUR - THE COST EFFECTIVENESS OF CLINICAL HYPNOTHERAPY

There is no recommended fee structure for clinical hypnotherapists in Australia. However, the industry-recognised practice is for clinical hypnotherapists in private practice to adopt a fee structure comparable to that of psychologists in similar practices, although many hypnotherapists' fees are in fact lower.

Due to its suitability as a brief intervention solution focused therapy, hypnotherapy has proved extremely cost effective both in and out of the hospital environment. Rapkin et al (1998) observed that patients trained with hypnosis before surgery had significantly shorter stays in hospital. Research shows that hypnosis methods have been used successfully for anxiety associated with medical procedures, (Spiegel 1998).

Furthermore, a 2002 cost analysis by radiologists Elvira Lang, MD and Max Rosen, MD, that compared intravenous conscious sedation with hypnotic sedation during radiology treatment found that the cost of the hypnotic intervention was twice as inexpensive as was the cost for the standard sedation procedure, (Lang, E. V., & Rosen, M. P. 2002)

SECTION FIVE - THE SAFETY AND QUALITY OF CLINICAL HYPNOTHERAPY

During its review of psychological practices legislation in 2009, the Parliament of South Australia reviewed the practice of hypnotherapy as an entity in its own right. The hypnotherapy profession was subjected to rigorous examination with a view to assessing whether the profession should be deregulated. The South Australian reviewers were expressly required to determine the level of risk or harm, if any, posed by the practice of hypnotherapy.

After conducting a literature review and examining industry codes of conduct and ethics relating to unregistered practitioners, a The Report to the Department of Health Into Hypnosis (2008) concluded, "the evidence of a high risk to the public does not appear sufficient to warrant a prohibition on practice".

The 2008 report also notes that in the mid 1990s, the Australian Health Ministers' Advisory Council (AHMAC) established a process for determining whether unregulated health profession should be subject to regulation. A number of criteria were established by AHMAC for assessing whether a profession should be regulated by legislation, one of these being 'Do the activities of the occupation pose a significant risk of harm to the health and safety of the public?' In 1996, AHMAC determined that the practice of hypnosis should not be regulated, as there was no evidence of demonstrable harm.

The report to the Department of Health noted that, some harms are known, but these can be remedied or prevented if;

- Practitioner training covers these issues;
- National standards of competency are developed; and
- A national voluntary self-regulation scheme is established.

The South Australian Parliament reviewed this 2008 report and supported the 1996 Australian Health Ministers' Advisory Council decision (cited in Parliament of South

Australian, 2009d)) that there was no need to regulate hypnosis as there was no evidence of harm.

The hypnotherapy profession has addressed these concerns in the following ways:

- The Hypnotherapy Council of Australia (HCA) was established to ensure self-regulation. The AHA was instrumental in forming this peak body.
- AHA and HCA have published National Standards and a Code of Conduct and Practice. The AHA standards and Code of Conduct are more extensive than those of HCA.
- Requirement of professional indemnity insurance for hypnotherapists,
- Government accredited qualifications in hypnotherapy have been in place since 1998 and;
- National associations exist to provide minimum standards, accreditation, on-going professional training, professional, operational and clinical supervision to member hypnotherapists.

SECTION SIX - CONCLUSION

This submission has demonstrated the clinical efficacy, the cost effectiveness and the safety and quality of clinical hypnotherapy as practiced in Australia. It has also outlined some of the positive changes that have helped professionalise this modality over the last 30 years. These include government-accredited training, the development of national standards of competency, the development of professional associations and an industry peak body, self-regulation and the safeguarding of the public by the instituting of minimum standards and clinical supervision.

Having demonstrated the efficacy, value and quality of contemporary hypnotherapy it is important that hypnotherapy continue to be part of the Australian Government Rebate on private health insurance.

REFERENCES

Alladin, A. and Alibhai, A. (2007). Cognitive hypnotherapy for depression: an empirical investigation. *International Journal of Clinical and Experimental Hypnosis,* 55: 147–166.

Benham, G. and Younger, J. (2012) Hypnosis and mind-body interactions. In Nash and Barnier (2012).

Brown, D. and Hammond D. (2007) Evidence-based clinical hypnosis for obstetrics, labor and delivery, and preterm labor. *International Journal of Clinical and Experimental Hypnosis,* 55: 355-371.

Bryant, R., Moulds, M. and Guthrie R. (2005) The additive benefit of hypnosis and cognitive-behavioral therapy in treating acute stress disorder. *Journal of Consulting and Clinical Psychology,* 73: 334-340.

Bryant, R., Moulds, M., Nixon, R., Mastrodomenico, J., Felmingham, K. and Hopwood, S. (2006) Hypnotherapy and cognitive behaviour therapy of acute stress disorder: a 3 year follow-up. *Behaviour Research and Therapy,* 44: 1331-1335.

Bryant, R. (2012) Hypnosis and anxiety: early interventions. In Nash and Barnier (2012).

Dobson, Keith S., Hollon, S. D., Dimidjian, S., Schmaling, K., Kohlenburg R., Gallop, R., Rizvi, S., Gollan, J., Dunner, D., and Jacobson, N. (2008) Randomized trial of behavioral activation, cognitive therapy, and anti-depressant medication in the prevention of relapse and recurrence in major depression. *Journal of Consulting and Clinical Psychology* 76: 468-477.

Elkins, G. R., Marcus, J. D., Rajab, M. H., Bates, J. D. and Cook, T. (2007) A pilot study of intensive hypnotherapy for smoking cessation. *International Journal of Clinical and Experimental Hypnosis,* 54: 303-315.

Gonsalkorale, W. and Whorwell, P. (2005) Hypnotherapy in the treatment of irritable bowel syndrome. *European Journal of Gastroenterology & Hepatology* 17: 15-20.

Green, J., Barabasz, A., Barrett, D., and Montgomery, G. (2005) Forging ahead: The 2003 APA Division 30 definition of hypnosis. *International Journal of Clinical and Experimental Hypnosis,* 53: 259-264.

Hackman, R., Stern J. and Gershwin, M. (2000) Hypnosis and asthma: a critical review. *Journal of Asthma* 37: 1-15.

Hammond, D. C. (2010). Hypnosis in the treatment of anxiety- and stress-relate ed disorders. *Expert Review of Neurotherapeutics, 10*(2), 263-273. doi: 10.1586/ern.09.140

Integration of Behavioral and Relaxation Approaches into the Treatment of Chronic Pain and Insomnia. NIH Technol Assess Statement 1995 Oct 16-18:1-34.

Jensen, M. and Patterson, D. (2006) Hypnotic treatment of chronic pain. *Journal of Behavioral Medicine* 29: 95-124.

Kirsch, I., Montgomery, G and Sapirstein, G. (1995) Hypnosis as an adjunct to cognitive behavioral psychotherapy: a meta-analysis. *Journal of Consulting and Clinical Psychology,* 63: 214-220.

Kirsch, I. (1996) Hypnotic enhancement of cognitive-behavioral weight loss treatments – another meta-reanalysis. *Journal of Consulting and Clinical Psychology* 64, 517-519.

Kirsch, I. (2010). *The emperor's new drugs: exploding the antidepressant myth.* Random House: London.

Lang, E., Benotsch, E., Fick, L., Lutgendorf, S., Berbaum, M., Berbaum, K.,*et al.* (2000). Adjunctive non-pharmacologic analgesia for invasive medical procedures: a randomized trial. *Lancet* 355: 1486-1490.

Lang, E. and Rosen, M. (2002) Cost analysis of adjunct hypnosis for sedation during outpatient interventional procedures. *Radiology* 222: 375–382.

Lindfors, P., Unge, P., Nyhlin, H., Ljótsson, B., Björnsson, E. S., Abrahamsson, H., & Simrén, M. (2012). Long-term effects of hypnotherapy in patients with refractory irritable bowel syndrome. *Scandinavian Journal of Gastroenterology, 47*, 414-421.
Lynn, S. Green, J., Accardi, M., and Cleere, C. (2010) Hypnosis and smoking cessation: the state of the science. *American Journal of Clinical Hypnosis* 52, 177-181.
Mauer, M., Burnett, K., Oullette, E., Ironson, G. and Dandes, H. (1999) Medical hyposis and orthopedic hand surgery: pain perception, postoperative recovery, and therapeutic comfort. *International Journal of Clinical and Experimental Hypnosis,* 47: 144-61.
Montgomery, G., DuHamel, K. and Redd, W. (2000) A meta-analysis of hypnotically induced analgesia: how effective is hypnosis? *International Journal of Clinical and Experimental Hypnosis* 48: 138-153.
Nash, M. R. and Barnier, A. J. (ed) (2012) *The Oxford Handbook of Hypnosis: Theory, Research, and Practice.* Oxford University Press, Oxford.
Phillips-Moore, J. (2012) Birthing outcomes from an Australian HypnoBirthing programme. *British Journal of Midwifery* 20, 558-564.
Rapkin, D.A., Straubing, M., Singh, A. & Holroyd, J.C. (1988). *Guided Imagery and Hypnosis: Effect on Acute Recovery from Head and Neck Cancer Surgery*. Paper presented at the Annual Meeting of the Society for Clinical and Experimental Hypnosis, Asheville, N.C.
Sapp, M., Obiakor, F., Scholze, S., and Gregas, A. (2007) Confidence intervals and hypnosis in the treatment of obesity. *Australian Journal of Clinical Hypnotherapy and Hypnosis* 28: 25-33.
Schnur, J. Kafer, I., Marcus, C. and Montgomery, G. (2008a). Hypnosis to manage distress related to medical procedures: a meta-analysis. *Contemporary Hypnosis* 25: 114-128.
Schnur, J., Bovbjerg, D., David, D., Tatrow, K., Goldfarb, A., Silverstein, J., Weltz, C. and Montgomery, G. (2008b) Hypnosis decreases presurgical distress in excisional breast biopsy patients. *Anaesthesia and Analgesia* 106: 440-444.
Spiegel, D, (1998). *Report in the Harvard Mental Health Letter,* September 1998, vol. 15, p. 5-6.
Stewart, James. (2005) Hypnosis in contemporary medicine. *Mayo Clin Proc.* 80: 511-524.
Tan, G., Hammond, D. and Joseph, G. (2005) Hypnosis and irritable bowel syndrome: a review of efficacy and mechanism of action. *American Journal of Clinical Hypnosis,* 47: 161-178.
Uman, L., Chambers, C., McGrath, P., & Kisely, S. (2008). A systematic review of randomized controlled trials examining psychological interventions for needle-related procedural pain and distress in children and adolescents: an abbreviated Cochrane review. *Journal of Pediatric Psychology,* 33: 842-854.
Whitehead, W. (2006) Hypnosis for irritable bowel syndrome: the empirical evidence of therapeutic effects. *International Journal of Clinical and Experimental Hypnosis,* 54:7-20.
Yapko, M. (2012). Hypnotic approaches in treating depression, in Nash and Barnier (2012).

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The AHA is a professional association and would like to be informed of the outcome of the consultation. The AHA would also attend relevant forums in any capital city should these take place.