Clinical Integrative Hypnosis (CIH)

Clinical Overview and Referral Guide

Sebastian Kristof, M.D.

1. Abstract

Clinical Integrative Hypnosis (CIH) is a structured, evidence-informed mind–body framework designed to complement medical and psychological treatment. It helps patients improve physiological regulation, emotional resilience, and adherence to medical care by addressing subconscious processes that influence stress, immune, and endocrine function. Grounded in psycho-neuro-immunology and clinical hypnosis research, CIH offers practical collaboration models for healthcare providers seeking to integrate supportive mind–body methods into practice. This guide outlines its theoretical rationale, mechanisms, clinical applications across body systems, referral criteria, practical information, and measurable outcomes. CIH bridges the gap between conventional medicine and the subconscious dimension of healing, offering an accessible, research-based pathway to whole-person care.

Keywords: `hypnosis`, `clinical hypnotherapy`, `integrative medicine`, `mind–body`, `psychoneuroimmunology`, `psychosomatic`, `stress regulation`, `medical hypnosis`, `cancer care`, `pain management`, `IBS`, `autonomic balance`, `emotional resilience`

2. Overview

Clinical Integrative Hypnosis (CIH) offers a structured, research-informed mind–body intervention that complements medical and psychological care for patients with **medical conditions where mind-body approaches have been shown to complement standard treatment**. It supports physiological regulation, emotional resilience, and adaptation.

CIH does not claim to treat or cure disease, but can be highly beneficial in reducing symptoms, improving treatment adherence, and supporting the body's natural healing capacity.

This guide outlines applications, mechanisms, and collaboration models for physicians, healthcare providers, and integrative medicine practitioners across a range of medical conditions.

3. What Hypnosis Is and Is Not

Clinical hypnosis is a state of focused attention and heightened suggestibility that allows access to subconscious processes. It is a natural, research-supported state similar to deep concentration or meditation. CIH uses this state to help patients access their own inner resources, reframe limiting beliefs, and support physiological regulation.

Hypnosis is not sleep, unconsciousness, or loss of control. Patients remain aware, can hear and respond, and cannot be made to do anything against their will. Hypnosis is not mind control or a mystical trance. It is a collaborative process requiring patient participation and motivation, not a passive treatment.

Key differentiator: Unlike traditional talk therapy that primarily engages conscious cognition, CIH works directly with *subconscious patterns and automatic programs* that can block healing even when patients have conscious insight. By addressing these deeper layers, CIH helps shift the patient's psychological state where conscious understanding alone has not been sufficient. This shift often increases the likelihood of better medical outcomes.

4. Rationale for CIH

The psycho-neuro-immunological model demonstrates that **chronic stress, emotional suppression, and unresolved trauma** can impair immune surveillance, hormonal balance, and autonomic regulation, influencing disease progression and quality of life across multiple body systems.

Key Supporting Evidence (full references in bibliography):

- Spiegel D. et al. (1989). **Lancet** — Group hypnosis improved survival and quality of life in metastatic breast cancer.
- Andersen BL. et al. (2008). **Cancer** — Psychological intervention enhanced immune parameters and reduced recurrence.
- Epel ES & Blackburn EH. (2004). **PNAS** — Chronic stress shortens telomeres, accelerating cellular aging.

- Montgomery GH. et al. (2002). **Int J Clin Exp Hypn** — Hypnosis reduced pain, nausea, and fatigue during treatment.
- Palsson OS et al. (2016). **Am J Gastroenterol** — Hypnosis treatment for functional gastrointestinal disorders.
- Faymonville ME et al. (2000). **J Neurosci** — Neuroimaging demonstrates hypnotic suggestion modulates anterior cingulate cortex and insula.
- Flammer E & Alladin A (2007). **Int J Clin Exp Hypn** — Meta-analyses confirm efficacy in managing psychosomatic symptoms.
- Jensen MP et al. (2015). **Int J Clin Exp Hypn** — Hypnosis for chronic pain management: meta-analysis.

Clinical Implication: CIH modulates autonomic and endocrine pathways, fosters emotional regulation, and restores agency across diverse medical conditions.

5. Core Clinical Applications

5.1. Whole-Person Foundations (Primary Care & Mental Health)

CIH equips patients with foundational regulation skills that support general medical care, behavioral health, and day-to-day resilience.

5.1.1. Stress Regulation & Autonomic Balance

Indications: Hypertension, palpitations, functional neurological symptoms, dysautonomia, stress-driven somatic complaints.

Mechanism: Chronic hypervigilance, emotional suppression, and unresolved threat perception maintain sympathetic dominance and destabilize homeostasis.

CIH approach:
- Autonomic reset via subconscious safety cues.
- Symbolic desensitization of threat triggers.
- Installation of rapid relaxation anchors for daily use.

5.1.2. Sleep & Fatigue Recovery

Indications: Insomnia, chronic fatigue, non-restorative sleep, burnout.

Mechanism: Incomplete emotional closure and vigilance prevent parasympathetic dominance and restorative rest.

CIH approach:

- Installing subconscious safety.
- Structured closure of unfinished cognitive loops.
- Sleep anchors and restorative imagery.

Clinical Example: 41-year-old executive with chronic insomnia for 3 years, taking zolpidem 10mg nightly with diminishing effectiveness. Sleep onset delayed 1-2 hours, frequent nocturnal awakenings, daytime fatigue affecting work performance. Sleep hygiene optimization and CBT-I provided minimal benefit. Five CIH sessions over 7 weeks uncovered subconscious belief that "letting go means losing control" rooted in early family instability where vigilance equaled safety. Resolved this pattern and installed new program allowing nervous system to distinguish present safety from past threat. At 6-week follow-up, sleep onset reduced to 15-20 minutes, sleeping through the night 5-6 nights per week, tapered zolpidem to 5mg twice weekly with plan to discontinue.

5.1.3. Chronic Pain & Tension Disorders

Indications: Fibromyalgia, neuropathic pain, migraines, TMJ, back pain without structural pathology.

Mechanism: Learned neural circuits and emotional associations perpetuate nociceptive signaling and catastrophizing.

CIH approach:
- Disidentification from pain identity.
- Reprogramming predictive coding.
- Converting pain into emotional communication.

Clinical Example: 44-year-old woman with chronic migraines, 12-15 episodes per month for 6 years despite prophylactic topiramate and acute triptan therapy. Neurological workup unremarkable. Migraines typically triggered by stress, disrupting work and family life. Six CIH sessions over 8 weeks uncovered subconscious program: "I must be perfect or I'll be rejected," with migraines functioning as the body's only acceptable way to stop and rest. Resolved this pattern by creating permission for self-care before physiological

breakdown and reprogramming early warning signals. At 3-month follow-up, migraine frequency reduced to 3-4 per month, intensity decreased from 8/10 to 5/10, able to abort most episodes with early intervention and minimal medication.

5.1.4. Anxiety, Mood, and Trauma Integration

Indications: Generalized anxiety, adjustment disorder, trauma sequelae, depressive rumination, health anxiety.

Mechanism: Dysregulated limbic-somatic feedback loops reinforce intrusive imagery, anticipatory threat, and helplessness narratives.

CIH approach:

- Resource state installation for emotional regulation.
- Regression and reframing of core threat scripts.
- Future rehearsal to anchor agency and optimism.

Clinical Example: 38-year-old man with panic disorder, experiencing 8-12 panic attacks per month for 2 years. Taking escitalopram 20mg with partial benefit. Avoiding driving, crowded spaces, and business travel due to fear of attacks. Emergency room visits 3 times in past year for cardiac workup, all negative. Five CIH sessions over 7 weeks uncovered childhood pattern of hypervigilance linked to unpredictable parental anger; worked on desensitizing panic sensations, reframing physiological arousal as information rather than threat, and installing rapid self-regulation anchors. At 2-month follow-up, panic attacks reduced to 1-2 per month and described as "manageable," resumed driving and travel, discontinued ER visits, planning SSRI taper with psychiatrist.

5.1.5. Grief & Loss Processing

Indications: Bereavement, complicated grief, ambiguous loss, medical trauma grief, caregiver grief spillover.

Mechanism: Attachment ruptures and unresolved meaning conflicts anchor the nervous system in oscillating numbness and overwhelm, inhibiting adaptive mourning and self-care.

CIH approach:

- Guided dialogue with lost or changing attachments to facilitate completion.
- Structured hypnotic process for acknowledging pain while installing safe containment.
- Future pacing new roles and connections to reinvest in life.

5.2. Specialty Medicine Integrations

For specialty referrals, CIH addresses the mind–body mechanisms that commonly aggravate organ-specific conditions and treatment courses.

5.2.1. Digestive & Gut–Brain Conditions

Indications: IBS, functional dyspepsia, reflux, functional bloating, chronic constipation, emotional eating.

Mechanism: Gut–brain axis dysregulation linked to stress, impaired vagal tone, and conditioned visceral fear responses.

CIH approach:

- Regression to control-based fear patterns.
- Parasympathetic retraining via hypnotic imagery.
- Self-trust restoration and mindful eating anchors.

5.2.2. Hormonal & Reproductive Health

Indications: Perimenopausal and menopausal symptoms, PMS, sexual dysfunction, infertility of unexplained origin.

Mechanism: Cortisol–gonadal axis disruption, guilt or control conflicts around reproduction and sexuality, and intergenerational narratives of shame.

CIH approach:

- Regression to early conditioning around identity and worthiness.
- Processing and updating inherited family beliefs and patterns.
- Permission to receive, embodied compassion, and sensual reintegration.

5.2.3. Immune & Inflammatory Dermatology

Indications: Seasonal allergies, autoimmune fatigue, rheumatoid arthritis, lupus, IBD, eczema, psoriasis, acne, urticaria.

Mechanism: Chronic sympathetic dominance, internalized hostility, and boundary conflicts sustain immune overactivation and inflammatory cascades.

CIH approach:

- Resolving mind-body conflict patterns and self-attack narratives.
- Regression to early self-blame or boundary trauma.
- Installation of protective self-image and body-calming anchors.

Clinical Example: 29-year-old woman with severe seasonal allergic rhinitis, requiring daily cetirizine and fluticasone nasal spray for 6 months yearly, with breakthrough symptoms during peak pollen season causing fatigue and brain fog. Four CIH sessions in early spring uncovered subconscious pattern of immune hypervigilance linked to early boundary violations where she couldn't control what "came into her space." Reprogrammed immune system's threat-detection threshold and resolved association between environmental triggers and emotional overwhelm. During peak allergy season, reported 70% reduction in symptoms, reduced antihistamine use to as-needed only, maintained energy and focus at work. Sustained improvement in subsequent allergy seasons with occasional booster sessions.

5.3. Oncology & Life-Threatening Illness

CIH provides structured support across the oncology journey, addressing the psychological, physiological, and relational challenges inherent to life-threatening diagnoses.

5.3.1. Diagnosis & Treatment Adaptation

Indications: Shock, denial, anger, depression, decisional paralysis, anticipatory anxiety prior to interventions.

Mechanism: Identity destabilization, ego-body disconnect, and perceived loss of agency amplify stress biomarkers and hinder collaboration with care teams.

CIH approach:

- Emotional reframing and meaning-oriented regression work.
- Future projection imagery for procedure readiness and recovery.
- Anchoring agency through collaborative hypnotic rehearsal.

5.3.2. Symptom Management & Treatment Adherence

Indications: Treatment-related anxiety, anticipatory nausea, sleep disruption, fatigue, procedural pain, adherence challenges.

Mechanism: Fear-conditioned autonomic responses and helplessness narratives magnify symptom perception and undermine compliance.

CIH approach:
- Breathing and imagery anchors for symptom modulation.
- Subconscious resolution of helplessness and catastrophic imagery.
- Resource state installation to reinforce adherence and self-advocacy.

> **Clinical Example:** 48-year-old woman with stage II breast cancer experiencing severe anticipatory nausea before each chemotherapy cycle despite optimal antiemetic regimen. Anxiety disrupting sleep 3-4 nights before treatment. Referred for CIH one week before cycle 3 of 6. Three pre-emptive sessions uncovered subconscious program associating chemotherapy with "poison attacking me" rather than treatment. Resolved fear-conditioning and reprogrammed treatment as targeted healing working with her body. Installed autonomic regulation anchors and rehearsed feeling safe during infusion. For cycles 3-6, reported minimal nausea, maintained appetite, slept well before treatments, and felt more collaborative with care team. Oncologist noted improved treatment tolerance and completion of full protocol without delays.

5.3.3. Caregiver & Family Support

Indications: Emotional exhaustion, anticipatory grief, caregiver burnout, communication strain.

Mechanism: Vicarious trauma, boundary collapse, and chronic sympathetic activation erode resilience and caregiving capacity.

CIH approach:
- Resource retrieval and compassionate detachment practices.

- Strengthening boundaries while preserving connection.
- Restorative trance experiences for sustainable presence.

5.4. Existential & Meaning-Centered Care

Beyond symptom relief, CIH guides patients in integrating illness into their life story, uncovering meaning, and navigating identity transformation and values realignment.

5.4.1. Identity Reconstruction & Life Reorientation

Indications: Chronic illness identity disruption, loss of role function, fear of future limitations.

Mechanism: Narrative collapse and internalized stigma sustain despair and disengagement from healing behaviors.

CIH approach:
- Re-authoring subconscious identity scripts toward resilience.
- Imaginal dialogues with the body to rebuild trust.
- Anchoring adaptive self-concepts that honor limitations and strengths.

5.4.2. Meaning, Spirituality, and Growth

Indications: Search for purpose, existential questioning, values disconnection, desire to transform illness into growth.

Mechanism: Unresolved moral injury and values incongruence perpetuate distress and inhibit recovery-oriented behaviors.

CIH approach:
- Guided imagery for purpose discovery and value alignment.
- Structured release of guilt, shame, or self-punishment.
- Installation of growth-oriented metaphors that sustain hope.

5.4.3. End-of-Life and Legacy Work

Indications: Terminal diagnosis, fear of death, unresolved guilt, desire for closure, legacy planning.

Mechanism: Existential overwhelm and unfinished emotional business amplify suffering and complicate palliative care goals.

CIH approach:

- Forgiveness and closure rituals.
- Guided peaceful transition imagery.
- Legacy mapping to support dignity, meaning, and relational repair.

5.5. Cross-Cutting Clinical Support

Certain CIH protocols apply across specialties to bolster medical collaboration, procedural success, and long-term behavior change.

5.5.1. Procedural Preparation & Recovery

Indications: Surgical anxiety, pain, anesthesia sensitivity, rehabilitation hesitancy.

Mechanism: Anticipatory stress and threat imagery increase perioperative complications and prolong recovery trajectories.

CIH approach:
- Pre-surgery trance rehearsal and sensory desensitization.
- Postoperative healing imagery and analgesia modulation.
- Resource state installation for confidence and rehabilitation engagement.

> **Clinical Example:** 58-year-old woman scheduled for total knee replacement, extremely anxious about anesthesia and post-op pain based on traumatic previous surgery experience. Three pre-operative CIH sessions conducted over 3 weeks prior to surgery uncovered implicit memory of waking during prior surgery feeling helpless and voiceless. Resolved this traumatic imprint and reprogrammed subconscious associations with surgical environment from "danger/helplessness" to "collaborative healing." Installed somatic anchors for calm and trust. Patient entered surgery calm, required 40% less post-operative opioid analgesia than predicted by anesthesia team, participated actively in physical therapy from day 1, and achieved discharge goals one day earlier than average. Surgeon noted exceptional cooperation and recovery trajectory.

5.5.2. Treatment Adherence & Self-Management

Indications: Medication nonadherence, lifestyle change resistance, complex care plans, self-monitoring fatigue.

Mechanism: Subconscious belief conflicts, secondary gains, and overwhelm undermine follow-through despite conscious intent.

CIH approach:
- Uncovering and neutralizing competing subconscious commitments.
- Future pacing daily routines with embodied success states.
- Installing cues for accountability, reward, and self-compassion.

5.5.3. Resilience Coaching Across Care Pathways

Indications: Multimorbidity, frequent hospitalizations, caregiver-clinician communication gaps, burnout among long-term patients.

Mechanism: Fragmented care narratives and chronic stress erode motivation, clarity, and therapeutic alliance.

CIH approach:
- Narrative coherence work to integrate medical milestones.
- Rapid self-regulation tools for clinical encounters.
- Collaborative hypnosis to align patient, caregiver, and clinician goals.

6. Patient Selection & Referral Guidance

CIH functions best as a collaborative adjunct for patients who are motivated to participate in mind–body care and who have conditions influenced by stress physiology, emotional processing, or subconscious beliefs.

6.1. Ideal Candidates

- Medically managed patients whose symptoms are amplified by stress, fear, or dysregulation.
- Individuals open to experiential or imaginative interventions and willing to engage actively.
- Patients experiencing adherence challenges rooted in overwhelm, avoidance, or self-trust issues.
- Caregivers seeking tools to sustain presence, boundaries, and calm.

6.2. Readiness Signals

- Expressed desire to improve coping, regulation, or self-management skills.

- Curiosity about mind–body approaches or prior benefit from meditation, mindfulness, or therapy.
- Ability to reflect on internal experiences and articulate goals with coaching support.

6.3. When to Reconsider or Delay

- Acute psychiatric instability, untreated psychosis, or severe cognitive impairment.
- Active substance dependence without concurrent stabilization plan.
- Patients seeking a passive or purely "done to me" intervention rather than collaborative work.
- Situations where medical clearance is pending or where mind–body work may interfere with urgent procedures.

6.4. Referral Triggers & Use Cases

Consider CIH Referral When:

Medical Symptoms with Stress Component:

- Symptoms persist or fluctuate with stress despite appropriate medical management.
- Objective findings do not explain symptom severity, variability, or chronicity.
- Patterns suggest autonomic dysregulation (hypervigilance, startle, sleep disruption).
- Symptom relief correlates with relaxation, attention shift, or perceived safety.

Treatment-Related Challenges:

- Anticipatory stress reactions likely to compromise preparation, procedure tolerance, recovery, or adherence.
- Side effects or symptom flares are amplified by fear-conditioning or catastrophic imagery.
- Complex care plans trigger overwhelm, avoidance, or competing beliefs that impede follow-through.
- Sleep dysregulation undermines daytime function, coping, or medical recovery.

Psychosocial Factors Impacting Outcomes:

- Persistent fear, guilt, shame, grief, or caregiver strain erodes engagement and self-care.
- Identity or role disruption reduces agency and adherence to health behaviors.
- Patient seeks meaning-making to sustain motivation in the context of serious illness.

CIH vs. Traditional Psychotherapy:

CIH is particularly suited when:
- There is a clear mind–body/physiological component or autonomic involvement.
- Rapid symptom relief or regulation skills are needed alongside medical treatment.
- Patient is medically stable but emotionally dysregulated in ways that affect physiology.
- Previous talk therapy helped but didn't address somatic or subconscious patterns.

Traditional therapy (CBT, psychodynamic, EMDR) may be preferable when:
- Primary presentation is psychiatric without medical comorbidity (pure depression, PTSD, personality disorders).
- Patient needs long-term depth work on relational patterns or complex trauma.
- Cognitive restructuring alone is likely sufficient.

Sequential vs. Concurrent Treatment:

CIH and traditional therapy work differently and are best used *sequentially rather than concurrently*:

CIH Approach:
- Deep subconscious intervention targeting root patterns and physiological regulation.
- Typically 4-8 focused sessions over several weeks to months.
- Creates rapid, transformative shifts that often persist without ongoing sessions.
- Works at the level of automatic responses, nervous system regulation, and implicit beliefs.

Traditional Therapy Approach:
- Conscious cognitive work building coping skills and behavioral strategies.
- Long-term process (months to years) with regular ongoing sessions.

- Focuses on developing awareness, processing emotions, and modifying thought patterns.
- Works at the level of insight, skill-building, and relational patterns.

Timing Guidance:
- *Refer early* for procedural preparation (2-4 weeks before surgery) or when symptoms first become refractory.
- *Refer concurrently* with standard care for chronic conditions (CIH enhances, doesn't replace).
- *Refer when stuck*: if patient is doing "everything right" medically but outcomes plateau, psychosomatic factors may be limiting progress.

7. Collaboration Model

Clinical Integrative Hypnosis is **complementary**, not a replacement for medical care. CIH supports:
- Stress reduction and autonomic balance.
- Emotional integration and adherence.
- Reintegration of meaning and identity.

Referral Pathway:
1. Physician identifies appropriate patients.
2. Hypnotherapist performs intake and consent.
3. Optional feedback loop.
4. Documented outcomes.

Outcome Metrics:
- Lower anxiety and insomnia scores.
- Reduced analgesic/sedative use.
- Improved treatment adherence and appetite.
- Higher quality-of-life indices.
- Improved sleep quality and heart-rate variability.
- Reduced pain or symptom frequency.
- Decreased stress biomarkers.

8. Practical Information for Referring Physicians

Treatment Structure: CIH is a time-limited intervention, typically 4-8 focused sessions over several weeks to months, depending on condition complexity. Unlike ongoing therapy, CIH creates rapid subconscious shifts that often persist without continued sessions.

Timeline for Results:

- *Immediate:* Many patients experience noticeable relaxation and symptom relief during or immediately after the first session.
- *Short-term (1-3 sessions):* Improvements in sleep, anxiety levels, procedural tolerance, and physiological regulation become evident.
- *Medium-term (4-8 sessions):* Sustained symptom reduction, behavioral changes, and shifts in automatic stress responses consolidate.
- *Long-term:* Changes tend to persist months to years after completion due to the subconscious nature of the intervention.

Accessibility: CIH can be delivered effectively via secure video conferencing, making it accessible regardless of geographic location or mobility limitations. Clinical experience and emerging research indicate comparable outcomes between online and in-person sessions.

Value Proposition: The focused, time-limited nature of CIH (4-8 sessions vs. months/years of traditional therapy) often results in lower total treatment costs despite higher per-session fees, particularly when considering reduced medication use and improved medical outcomes.

Physician Communication: With patient consent, referring physicians receive intake summaries, progress updates, and completion reports focused on measurable outcomes and clinically relevant observations. The hypnotherapist views the referring physician as the primary clinical authority and aims to enhance, not complicate, the existing treatment plan.

9. Ethical and Clinical Safeguards

- CIH is supportive, not curative.
- Collaboration is encouraged but optional.
- Contraindications: severe cognitive impairment, untreated psychosis.

10. Summary for Referring Clinicians

Referring patients for CIH allows physicians to extend the reach of medicine into the emotional and behavioral dimensions of illness. CIH offers:

- Structured support for stress and emotion regulation during treatment.
- Safe, non-invasive enhancement of treatment adherence and resilience.
- Tools for trauma processing and restoration of agency.
- Assistance in navigating existential and spiritual aspects of illness.
- Caregiver support for compassion fatigue and grief.

By integrating CIH, clinicians become leaders in a holistic, patient-centered model of care that addresses physical, psychological, and emotional dimensions of healing.

11. Practice Benefits

CIH doesn't just help patients—it makes your practice more effective and efficient:

Better Patient Outcomes: Patients with reduced anxiety and better stress management show improved adherence to treatment plans, fewer complications, and better overall outcomes.

Easier Patient Visits: Patients who manage anxiety and stress through CIH are more engaged, better prepared, and easier to work with during appointments.

Practice Differentiation: Offering CIH referrals positions you as a forward-thinking physician who addresses the full spectrum of patient needs, not just symptoms.

Time Savings: Patients who better manage their stress and anxiety require less time during visits addressing emotional concerns, allowing you to focus on medical care.

Improved Patient Satisfaction: Patients who feel supported holistically report higher satisfaction scores and are more likely to refer others to your practice.

Reduced Medication Needs: CIH can help reduce reliance on anxiolytics, sleep aids, and pain medications in some patients, minimizing polypharmacy concerns.

12. Conclusion

Clinical Integrative Hypnosis bridges a critical gap in modern medicine: addressing the mind-body-emotional dimensions of illness while remaining grounded in research and clinical evidence. Unlike overly rigid clinical approaches that ignore these aspects, CIH addresses them systematically. Unlike alternative approaches that lack scientific backing, CIH is rooted in peer-reviewed research and designed for medical collaboration.

By integrating CIH into your practice, you gain an evidence-based tool that supports patients holistically while improving outcomes, efficiency, and patient satisfaction. CIH complements standard medical care, enhancing rather than replacing conventional treatment protocols.

13. References

1. Spiegel D, Bloom JR, Kraemer HC, Gottheil E. Effect of psychosocial treatment on survival of patients with metastatic breast cancer. Lancet. 1989;334(8668):888–891.
2. Andersen BL, Yang HC, Farrar WB, Golden-Kreutz D, Emery CF, Carson WE. Psychological intervention improves survival for breast cancer patients. Cancer. 2008;113(12):3450–3458.
3. Epel ES, Blackburn EH, Lin J, Dhabhar FS, Adler NE, Morrow JD. Accelerated telomere shortening in response to life stress. Proc Natl Acad Sci U S A. 2004;101(49):17312–17315.
4. Montgomery GH, Schnur JB, Kravits K. Hypnosis as an adjunct to cognitive-behavioral psychotherapy for cancer pain, nausea, and fatigue. Int J Clin Exp Hypn. 2002;50(4):347–365.
5. Faymonville ME, Laureys S, Degueldre C, Del Fiore G, Luxen A, Franck G. Neural mechanisms of hypnotic analgesia. J Neurosci. 2000;20(10):4375–4380.
6. Palsson OS, Whitehead WE, van Tilburg MAL, Turner M, Feld AD, Levy RL. Hypnosis treatment for functional gastrointestinal disorders. Am J Gastroenterol. 2016;111(2):221–237.
7. Jensen MP, Adachi T, Hakimian S. Hypnosis for chronic pain management: A meta-analytic review. Int J Clin Exp Hypn. 2015;63(2):144–165.

8. Flammer E, Alladin A. Evidence-based hypnotherapy for the treatment of psychosomatic disorders: A meta-analysis. Int J Clin Exp Hypn. 2007;55(3):251–274.
9. Kissane DW. The relief of existential suffering. Psychooncology. 2012;21(8):873–877.
10. Block SD, Billings JA. Patient requests for hastened death: Clinical evaluations and responses. N Engl J Med. 2006;354(25):2513–2517.
11. Northouse L, Williams AL, Given B, McCorkle R. Psychosocial care for family caregivers of patients with cancer. CA Cancer J Clin. 2012;62(2):118–146.
12. Shenefelt PD. Hypnosis in dermatology. Am J Clin Hypn. 2018;61(1):4–17.
13. Gruzelier J. A review of the impact of hypnosis, relaxation, guided imagery and individual differences on aspects of immunity and health. Contemp Hypn Integr Ther. 2002;19(2):45–63.
14. Gay MC, Philippot P, Luminet O. Differential effectiveness of hypnosis, relaxation, and self-hypnosis for stress management in students. Int J Clin Exp Hypn. 2014;62(1):1–20.
15. Faymonville ME, Fissette J, Mbo G, Roediger L, Del Fiore G, Albert A. Hypnosis as adjunct therapy in conscious sedation for plastic surgery. Lancet. 2000;355(9205):1415.
16. Elkins G, Marcus J, Rajab MH, Durgam S. Brief hypnotic intervention for chronic insomnia: A randomized clinical trial. Sleep. 2014;37(3):511–520.
17. Domar AD, Clapp D, Slawsby EA, Kessel B, Orav J, Freizinger M. The impact of group psychological interventions on pregnancy rates in infertile women. Fertil Steril. 2011;95(7):2269–2273.
18. Maher-Loughnan GP. Hypnosis in bronchial asthma. Br Med J. 1962;2(5302):371–376.

—

Author: Dr. Sebastian Kristof, M.D.

Certified Hypnotherapist | Former Research Fellow, Yale & UC San Diego | Former Principal Research Clinician, WCG (Mental Health)

www.DrKristof.com | info@drkristof.com