

CLINICAL HYPNOTHERAPY

# Collaborative Care & Referral Guide

For Doctors and Healthcare Professionals

A concise guide to when Clinical Hypnotherapy may offer useful complementary support alongside appropriate medical and psychological care.



## Healing Mind CY (HMCY)

Charles Eleftheriou | Clinical Hypnotherapist & NLP Practitioner/Coach

Online worldwide • In person in Cyprus

# 1. Purpose of this guide

This guide is intended to support appropriate professional referrals and collaborative care. It explains where Clinical Hypnotherapy may be considered as an adjunctive intervention, where medical assessment or collaboration is important, and where referral to another service is more appropriate.

## **Core principle**

Clinical Hypnotherapy can support psychological, behavioural, emotional and learned responses that may influence a patient's symptoms, distress, coping or quality of life. It does not replace medical diagnosis, prescribed medication, psychiatric assessment, emergency care or treatment that requires another regulated professional.

## **What Clinical Hypnotherapy is**

Clinical Hypnotherapy uses focused attention, therapeutic communication, imagery and suggestion to support learning and change. The patient remains involved in the process throughout; hypnosis does not override free will or give the practitioner control over the patient.

## **What it may help a patient do**

- reduce competing distractions and excessive arousal
- engage imagination more effectively
- rehearse new responses before using them in everyday situations
- strengthen useful emotional and coping resources
- change conditioned or automatic responses
- reinforce health-supportive behaviour and self-management skills

## **HMCY approach**

HMCY uses a personalised, client-centred and solution-focused approach. Interventions are selected according to the person's desired outcome, formulation, readiness, ecology, safety and professional scope rather than applied as a fixed protocol.

## 2. Referral overview

The table below is a practical screening guide, not a diagnostic tool. Final suitability is assessed individually.

| Referral status                           | Presentation                                                           | Potential HMCY role                                                                                                                                             |
|-------------------------------------------|------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>CONSIDER REFERRAL</b>                  | <b>Stress / chronic over-arousal</b>                                   | Stress regulation, coping, conditioned responses and behavioural patterns.                                                                                      |
| <b>CONSIDER REFERRAL</b>                  | <b>Fears and specific phobias</b>                                      | Conditioned fear responses, desensitisation, rehearsal and resource building.                                                                                   |
| <b>CONSIDER REFERRAL</b>                  | <b>Medical, dental or procedure anxiety</b>                            | Anticipatory anxiety, fear reduction, preparation and coping.                                                                                                   |
| <b>CONSIDER REFERRAL</b>                  | <b>Grief and adjustment</b>                                            | Support for emotional processing, coping, guilt and adjustment where there is no urgent risk or specialist need.                                                |
| <b>CONSIDER REFERRAL</b>                  | <b>Health-related habits / behaviour change</b>                        | Triggers, automatic habits, motivation, beliefs and reinforcement.                                                                                              |
| <b>MEDICAL ASSESSMENT / COLLABORATION</b> | <b>Persistent or chronic pain</b>                                      | Psychological and behavioural components of pain after physical assessment and appropriate diagnostic investigation.                                            |
| <b>MEDICAL ASSESSMENT / COLLABORATION</b> | <b>Panic symptoms / panic disorder</b>                                 | Work only after appropriate medical assessment/diagnosis because similar symptoms may have physical causes.                                                     |
| <b>MEDICAL ASSESSMENT / COLLABORATION</b> | <b>IBS / functional gastrointestinal symptoms</b>                      | Adjunctive work where a medical diagnosis has been established and treatment remains coordinated appropriately.                                                 |
| <b>MEDICAL ASSESSMENT / COLLABORATION</b> | <b>Mild depressive symptoms / low mood</b>                             | Adjunctive support only when appropriate medical or mental-health oversight is in place. Not presented as a standalone treatment for major depressive disorder. |
| <b>MEDICAL ASSESSMENT / COLLABORATION</b> | <b>Psychosexual difficulties / fertility-related stress</b>            | Psychological or performance-related factors may be supported after relevant medical causes have been assessed and alongside appropriate healthcare.            |
| <b>REFER / URGENT CARE</b>                | <b>Suicidal intent, immediate risk, severe psychiatric disturbance</b> | Emergency or appropriately qualified medical/mental-health care takes priority.                                                                                 |
| <b>REFER / INVESTIGATE FIRST</b>          | <b>Unexplained physical symptoms</b>                                   | Medical investigation first; HMCY does not assume that a physical symptom is psychological.                                                                     |

### 3. Common collaborative applications



#### **Pain & symptom coping**

May support pain perception, fear, tension, expectancy and self-management after appropriate medical investigation. Hypnosis is used as an adjunct, not to mask new or unexplained pathology.



#### **Medical / dental procedures**

May support anticipatory anxiety, fear, preparation, coping and rehearsal before appropriate procedures. Medical treatment and anaesthesia remain under the healthcare team.



#### **IBS**

Gut-directed and symptom-focused hypnotherapy may be considered where IBS has been medically diagnosed. NICE includes hypnotherapy among psychological interventions that may be considered for refractory IBS.



#### **Anxiety / panic**

May support excessive arousal, fear, avoidance and conditioned responses. Panic-like symptoms that have not been medically assessed require appropriate evaluation first.

#### **Important clinical distinction**

The aim is not to tell a patient that symptoms are “all in the mind”. The aim is to work with modifiable psychological and behavioural factors while medical causes and treatment remain appropriately managed.

## 4. Additional areas where referral may be useful

### **Stress and chronic over-arousal**

Work may focus on physiological arousal, sleep-disrupting stress patterns, coping, boundaries, emotional regulation and learned responses.

### **Grief and adjustment**

Support may help the person process emotions, guilt, change and continuing bonds while recognising that grief varies greatly between individuals.

### **Health-related behaviour change**

Hypnotherapy and behavioural work may support motivation, habits, smoking cessation, adherence-related behaviours, confidence and reinforcement of desired choices.

### **Weight and eating-related behaviour**

Work may be appropriate for emotional, conditioned or automatic eating and motivation. Suspected or diagnosed eating disorders require specialist assessment and coordinated care.

### **Psychosexual difficulties**

Where a doctor has excluded or managed relevant physical causes, work may focus on performance anxiety, fear, confidence and conditioned responses. Specialist presentations remain outside scope unless specifically trained and competent.

### **Fertility-related stress**

HMCY may support stress, anxiety, coping and emotional wellbeing alongside fertility care. Hypnotherapy is not presented as a treatment for infertility or as a means of guaranteeing conception.

### **Alcohol / substance-related behaviour**

Psychological patterns and motivation may sometimes be addressed as part of multidisciplinary care. HMCY does not diagnose dependence, manage detoxification or advise abrupt cessation where withdrawal may be medically dangerous.

### **Low mood / mild depressive symptoms**

ICCH training supports carefully bounded work with mild presentations and medical involvement. Current research does not justify presenting hypnosis as a standalone treatment for major depressive disorder.

## 5. Working alongside medical care

### HMCY does not change medication

HMCY does not advise patients to stop, reduce, increase or otherwise alter prescribed medication. Medication questions are referred back to the prescriber or appropriate healthcare professional.

### Professional collaboration

- Where another professional is providing essential care, the objective is to complement that care rather than compete with it.
- With the patient's informed consent, relevant information may be shared with the referring healthcare professional where this supports safe and coordinated care.
- Only information that is necessary and relevant should be exchanged.
- If a presentation falls outside HMCY's training, competence or professional scope, the patient is referred to a more appropriate professional.
- Physical symptoms, significant changes in mental state or possible medical conditions are referred for appropriate assessment.

### A useful referral question

**“Is there a psychological, behavioural, fear-related or learned component that is continuing to affect this patient's distress, coping, symptom experience or health behaviour?”**

If yes - and the patient is medically stable and suitable - Clinical Hypnotherapy may provide a complementary avenue of support.

### Informed consent and autonomy

Patients receive clear information about the purpose of the work, methods that may be used, limitations, confidentiality, their right to ask questions, decline an intervention or stop the process. Consent is treated as ongoing rather than as a one-off signature.

## 6. Safety, limitations and referral boundaries

### Urgent or specialist referral takes priority when there is:

- immediate danger to self or another person
- suicidal intent or serious self-harm risk
- severe psychiatric disturbance or marked deterioration in mental state
- urgent medical need or new unexplained physical symptoms
- a presentation outside the practitioner's competence or insurance scope
- a need for medical detoxification or management of potentially dangerous withdrawal
- an eating disorder or other condition requiring specialist multidisciplinary management

### Specific safeguards drawn from ICCH training

- Depression: ICCH training advises medical involvement and restricts hypnotherapy work to mild presentations; suicidal intent requires immediate referral.
- Panic: ICCH training states that panic attack/panic disorder should be medically diagnosed before hypnotherapy, because symptoms can overlap with serious physical conditions.
- Pain: ICCH training requires physical examination and appropriate diagnostic studies before psychological intervention for pain.
- Alcohol-related problems: ICCH training states that diagnosis belongs to a qualified medical practitioner; abrupt withdrawal in dependent drinkers can be medically dangerous.

#### **No guarantees**

Clinical Hypnotherapy is not presented as a cure and outcomes cannot be guaranteed. Suitability, likely benefit, alternatives and limitations are discussed individually.

## 7. Referral pathway and patient experience

|          |                                         |                                                                                                                                                           |
|----------|-----------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>1</b> | <b>Referral or signposting</b>          | The doctor or healthcare professional recommends that the patient explore Clinical Hypnotherapy, or provides the patient leaflet.                         |
| <b>2</b> | <b>Initial suitability conversation</b> | The patient arranges a free discovery call. This is an initial discussion, not a therapy session.                                                         |
| <b>3</b> | <b>Assessment and contracting</b>       | HMCY clarifies the presenting difficulty, desired outcome, relevant history, current care, safety considerations and whether hypnotherapy is appropriate. |
| <b>4</b> | <b>Personalised therapeutic work</b>    | Interventions are selected according to the individual rather than following a fixed script. Progress and response are reviewed throughout.               |
| <b>5</b> | <b>Collaboration where appropriate</b>  | With the patient's consent, relevant updates or questions can be communicated to the referring professional.                                              |
| <b>6</b> | <b>Review / discharge / referral</b>    | Work ends when appropriate, or the patient is referred onward if another form of care becomes more suitable.                                              |

### What the patient can expect in hypnosis

- focused attention rather than unconsciousness
- the ability to speak, ask questions and remain involved
- collaborative suggestions rather than control
- a clear therapeutic purpose linked to the patient's goals
- review and future-pacing so learning can be applied in everyday life

## 8. Evidence, professional standards and contact

### Evidence-informed positioning

The evidence for hypnosis varies by clinical application. A 20-year overview of 49 meta-analyses found the most robust evidence in patients undergoing medical procedures and in pain populations. NICE recommends considering hypnotherapy among psychological interventions for adults with refractory IBS. Evidence for major depressive disorder is currently insufficient to recommend hypnosis as a standalone treatment, which is why HMCY positions any low-mood/depression work as adjunctive and medically coordinated.

### Selected references and standards

- Rosendahl J, Alldredge CT, Haddenhorst A. Meta-analytic evidence on the efficacy of hypnosis for mental and somatic health issues: a 20-year perspective. *Frontiers in Psychology*. 2024;14:1330238. doi:10.3389/fpsyg.2023.1330238.
- NICE. Irritable bowel syndrome in adults: diagnosis and management (CG61), recommendation 1.2.3.1: psychological interventions including hypnotherapy for refractory IBS.
- National Center for Complementary and Integrative Health (NCCIH). Hypnosis - current evidence summary.
- Souza FL et al. Hypnosis for depression: systematic review of randomized clinical trials with meta-analysis. *Complementary Therapies in Clinical Practice*. 2024;57:101913.
- International College of Clinical Hypnotherapy (ICCH) training manuals: Depression; Anxieties, Fears & Phobias; Hypnotic Anaesthesia/Pain; Grief; Weight & Food Issues; Addictions; Psychosexual Disorders & Fertility.
- Cyprus Hypnotherapy Association. Code of Ethics.
- Healing Mind CY. HMCY AI Knowledge Base & Content Strategy - scope, professional boundaries, referral and informed-consent standards.

#### Healing Mind CY

Charles Eleftheriou

Clinical Hypnotherapist & NLP Practitioner/Coach

info@hmcy.org

+357 99 331689

www.hmcy.org

Online worldwide • In person in Cyprus



**Free Discovery Call**

www.hmcy.org/book-online