

## **CLINICAL REPORT**

### **A SINGLE-CASE STUDY OF GENERALIZED DYSTONIA AND HYPNOSIS, WITH UNEXPECTED IMMOBILITY AND AN UNTOWARD EFFECT**

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#### **Abstract**

A middle-aged male patient with generalized dystonia of childhood onset sought counselling for anxiety and depression. He also sought hypnotherapy to ease muscle pains and control the ceaseless spasmodic movements affecting most of his body. Relaxation under hypnosis produced near immobility. Anxiety and pain became negligible, but only during hypnosis. There was no permanent reduction in pain and only slight reduction in tension. His attempt to move both arms during hypnosis precipitated unpleasant internal sensations, and sensory-motor effects of dystonia ascending through the whole body.

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**Key words:** generalized dystonia, counselling, hypnosis, immobility, shock

#### **Introduction**

Dystonia is a neurological disorder causing repetitive spasms to muscles. The onset occurs typically around the fifth decade, often affecting only a small number of adjacent muscles. About 50% of patients are affected in the neck, eyes or face. Chronic spasms are usually painful, and are most effectively relieved by injections of the botulinum neurotoxin which relaxes the muscle and often stops the pain. Medication brings variable help to some forms of dystonia.

#### **James – a case study**

Within the context of counselling, James requested hypnotherapy for his symptoms. A machine engineer now in his forties, he showed the first signs of dystonia during childhood. By middle age, it had progressively affected his whole body. Gross movement of all large muscles was uneven, and fine co-ordination was difficult. Spasms of the large muscles in the trunk had not resulted in torsion, but still interfered with walking and bending. James had special difficulty in achieving clarity of diction because constant spasms affected all muscles except those controlling his vocal cords themselves. Sitting at rest, James's entire body was perceptibly in a state of constant limited movement. He reported that this state ceased only after perhaps 30 minutes' lying down at night. On waking in the morning, the troubles have recommenced.

James's list of 'everyday actions that cause intense pain' included all personal activities and using household and work appliances. At rest, he felt continuous pain,

most noticeably in the shoulders and upper arms where repetitive muscle contractions over decades had produced wasting and stiffness in several muscles. To sit composedly in a chair, James crossed his legs and folded his arms tightly up high to control the spasmodic movements. He held his chin down against his left fist to keep his head still. Surprisingly, but importantly for him, James is still working.

Having initially sought counselling for anxiety and depression, James asked, on an experimental basis, to try hypnotherapy to reduce the muscle pains, and help to control unwanted movements. For hypnotic induction, a simplified version of Miller's Endogenic Method (Miller, 1979) was used, the author calculated it would suit James's technical background and his biological frame of reference.

### Attempted therapeutic interventions

James's chief goal in receiving hypnosis was relaxation. At his first session, an experimental relaxation, achieved solely by focusing on breathing, produced some signs of relaxing. Before the relaxation, James was asked to rate his pain and anxiety on a scale of 0–5, in which 0 represented comfort and 5 the worst experienced. On this first use of scaling, both pain and anxiety were rated 3. After the relaxation, James was asked to rate his experience during relaxation; again he rated both pain and anxiety at 3.

At the second counselling session, it was clear that James's pain was very consistently uncomfortable, and it was decided not to ask him to rate it again for the moment. He now felt more confident about being hypnotized. The induction was soon effective and James relaxed deeply. The suggestions used on this occasion were *'Be still, be at rest'*.

When hypnotized, James's entire body became almost motionless. There remained only an occasional slight flicker to one cheek and a small movement in one muscle in the left forearm. It was suggested that James might feel himself to be within a bubble of safety in which more and more comfort would ease the pains away. This was linked verbally to a post-hypnotic suggestion that he could help himself to *'Be still'*.

After hypnosis, James expressed great amazement and happiness at the degree of stillness he had experienced, and felt that it had been complete. Before hypnosis, he had rated his current anxiety and (involuntary) movement at 4 and 4, respectively. During hypnosis he rated anxiety at 1 and movement at 0. After the hypnosis, the movements returned, but he felt much calmer.

The third session's discussion concentrated on the fact that James had not been free of anxiety for about 10 years. In recent months, his most distressing experience had been to see himself for the first time on a medical training video recording, which had caused him to feel severely depressed.

A week later, at the fourth counselling session, James talked about his pain. Across his shoulders, he described it as 'burning'. Down the arms it was a 'muscular sharp pain'. Of his face and jaw, James said, *'It aches and aches'*. Of his total state of pain, he added, *'Especially in the evenings, there's an intensity then...'*. On this particular day, James rated his pain at 3, and his anxiety and unwanted movement both at 4.

At his third hypnosis session, the same degree of deep relaxation and immobility was again achieved, during which the agreed therapy work was done. After hypnosis, James exclaimed, *'It's so peaceful. I know I'm not moving!'*

He wanted a rationale for the effects which so amazed him so the author sketched in the existence of different theories, and used the word 'unconscious', which James quickly seized upon. He then asked, *'If this is what you can have from the unconscious, why can't you have it all the time?'*

Over the next six months James was seen on an irregular basis, and mostly for counselling. Great changes had taken place in his life, which he had had some difficulty in assimilating. Hypnotherapy was used another ten times during this period, proving mostly helpful for relaxing at night when preparing for sleep, a little less useful for relaxing in evenings, and unsuccessful with reducing pain or improving coordination. A little optimism began to appear.

### **An untoward and cautionary experience**

The twentieth counselling session took place at the end of a 17-day trial with co-careldopa, a drug used to treat Parkinson's disease. In the latter, it normally eases muscular rigidity. With James, it did not provide any help, but added a mild side-effect of further tremor. The programme was planned for the thirteenth use of hypnosis. It had seemed a natural next step, after achieving and enjoying the periods of immobility under hypnosis, to attempt to carry over some of this relaxed muscular state into the realm of conscious movement. The author had imagined using ideomotor signalling, involving perhaps just one finger. James was more optimistic. We settled on his lowering his clasped hands from the level of his chin down to rest upon his lap while hypnotized. James then asked if there was a risk he would 'wake up' while he was lowering his hands in this way. To reassure him, it was proposed that a suggestion for deeper relaxation would be added during the movement.

The programme was to induce hypnosis, suggest extra relaxation to accompany the action of lowering his hands, allow James's face to relax without the physical reassurance of his hand's contact, and to reinforce the post-hypnotic suggestion for relaxation for use at home. The programme was begun.

At the moment of lowering his hands to his lap, physical agitation appeared. James screwed up his face, and his left foot (with the left leg crossed over the right) wagged furiously. The experiment was aborted and suggestions of calmness were given, and it was suggested that there would surely be an easier way for James to make his discovery. After a minute's rest, the hypnosis session was ended with the suggestion that there might be some understanding James could bring back during the final count from ten to one on reassuming his usual alertness.

James's subjective report of the episode described massive discomfort. After the induction, he had felt calm. Then, on starting to move, tension arose from within, which he graphically demonstrated with an upward sweep of his right hand. The tension then faded.

James described this tension as starting in his legs, rising up in disturbance through the abdomen and the chest, and finally into the arms. It therefore covered the whole body. At its worst, he could actually *feel* the dystonia come down his arms like a wave. His imagery was that of a liquid, as if someone had 'opened a tap'. He added, '*That sort of experience should start at . [touching the base of his skull] and not here,*' [pointing to his foot]. As a knowledgeable man, he felt the cause-and-effect order was illogical.

The physical shock had subsided within minutes; the emotional surprise continued for hours; and his sense of intellectual puzzlement lasted many days. The uncomplicated matter of hypnosis had suddenly ceased, for him, to be an unmitigated blessing and source of wonder.

James and the author continue to meet according to circumstances. He has continued to avail himself of hypnotherapy, most recently concerning a needle anxiety, and we assume that he suffers from no long-term negative effects from the untoward event. He has still no better understanding of it either.

## **Conclusion**

For most patients, the symptoms of dystonia are exacerbated by stress. Relaxation reduces the involuntary movements in most patients with dystonia (Jahanshahi and Marsden, 1989), as it does with most movement disorders (Wain et al., 1990), and hypnosis may reduce or almost abolish them (Friedman, 1965; Scheiderman et al., 1987; Medd, 1997).

James's untoward experience caused him sudden, great distress. In previous work with dystonia patients the author had met no similar negative effects, nor had any been found in the neurological literature.

[James amended the final wording of this report.]

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