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CHRONIC PSYCHOSOMATIC PAIN ALLEVIATED BY BRIEF THERAPY

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Abstract

A case is presented of a male patient with intractable pain that responded very rapidly to the therapeutic release of a suppressed negative emotion (anger) and a re-vivification of a previously experienced successful use of acupuncture for pain relief. The case demonstrates the mind–body link found in somatization or psychosomatic disorders and shows how this was used in its resolution. The interventions involved seeding, anchoring, utilization and re-vivification, silent abreaction and imagery. During hypnosis the patient no longer complained of his pain, a state which continued after hypnosis had been reversed. Clinical outcome in routine evaluation (CORE) forms were used both before and two weeks after the therapeutic session and showed a dramatic change to normalization, which was maintained at a four-month follow-up. The treatment, which consisted of 15 minutes in surgery and a therapy session of one hour, demonstrates that sometimes very brief therapy can be very productive.

Key words: hypnosis, imagery, mind–body links, pain, re-vivification, seeding

Introduction

There is much in the literature on mind–body interaction and the way emotional conflicts and distress can evince physical symptoms, giving rise to psychosomatic disorder or somatization (Pert, Dreher and Ruff, 1998; Fara and Sonino, 2000; McWhinney, Epstein and Freeman, 2001). Constant pain syndrome, which is included under the DSM-IV criteria for 'pain disorder', is a problem that many general practitioners and those working in pain clinics have to treat as best they can (Wise, 1977). The diagnostic criteria of pain disorder, as defined in the DSM-IV, are as follows:

- Pain in one or more anatomical sites is the predominant focus of the clinical presentation and is of sufficient severity to warrant clinical attention.
- The pain causes clinically significant distress or impairment in social, occupational or other important areas of functioning.
- Psychological factors are judged to have an important role in the onset, severity, exacerbation, or maintenance of the pain.
- The symptom or deficit is not intentionally produced or feigned.
- The pain is not better accounted for by a mood, anxiety or psychotic disorder and does not meet criteria for dyspareunia.

The case presented fulfils all of these criteria and is one of constant pain syndrome which provides a prime example of mind–body links — both in its inception and in its treatment.

Presentation and history

M presented in surgery asking for a repeat of his analgesic medication, Kapake, which is a fairly strong opiate analgesic, one step down from morphine. He was currently taking six to eight tablets daily. His usual doctor was away on holiday and the following history was obtained.

M had had problems with his right knee since 1964, when he had suffered a twisting knee injury. This occurred whilst he was in the Forces and meant that he was invalided out. He had had a further injury to the same knee a few years later whilst working for the police and had not worked since. M had had a considerable amount of surgical intervention, including a number of arthroscopies, culminating in a right knee replacement and had recently been told that there was no physical reason for his level of pain. He was married, had no children and his father had died the previous year. He had 'tried everything' to help his knee problems but to no avail. This included acupuncture. M described how he had become aware of a feeling of warmth, relaxation and well-being as he had had acupuncture for a pain in his left hip. He talked about how a feeling of heat had spread up from his foot and how pleasant it had been. The pain in his left hip had gone following this treatment but when he tried acupuncture again for his knee pain it had not been effective.

M complained of continuous pain from his knee, which on a 10-point scale, where 10 was most extreme pain and zero was no pain, he gave a rating of eight. M said it had been like that as long as he could remember, it never varied and nothing eased it or made it worse. Patients can be quite accurate when using a visual analogue scale to assess pain in order to monitor progress (Miller and Ferris, 1993; Mantyselka, Kumpusalo, Ahoven and Takala, 2001).

M complained that his pain was preventing him from doing many of the things he enjoyed, such as mending old cars in his garage, and that his relationship was suffering generally from his depression, irritability and bad temper. He was also experiencing some sleep difficulties and felt this was contributing to his depression and irritability. He had seen various consultants who recently had told him there was nothing wrong with his knee and the pain was 'all in his head'. M felt angry that he was being disbelieved and labelled a fraud. The clinical impression was one of frustration and depression in that he felt tired all the time, lacked motivation and enjoyment, was very irritable and bad-tempered and had sleep disturbance, all of which matched well with his clinical outcomes in routine evaluation (CORE) scores (Core System Group, 1988).

CORE was developed by the Psychological Therapies Research Centre at the University of Leeds for use in both the primary and secondary care sectors, and is an assessment tool that comprises a 34-point questionnaire that assesses a patient's feelings of well-being, functioning, level of perceived problems and risk of self-harm or harm to others. The measure is problem-scored, that is, the higher the score the more problems the individual is reporting and/or the more distressed he or she is. The normative data were based on three non-clinical studies from students on a variety of courses at two different universities ($n = 1106$). Clinical data were obtained at 21 sites, mostly within the NHS, from users waiting for or receiving a wide variety of psychological interventions from counsellors, psychotherapists and clinical psychologists ($n = 890$).

As may be seen in Figure 1, which shows CORE ratings before and after therapy, with non-clinical norms, M scored well above the non-clinical mean and standard deviation in all domains except risk of self harm/harm to others.

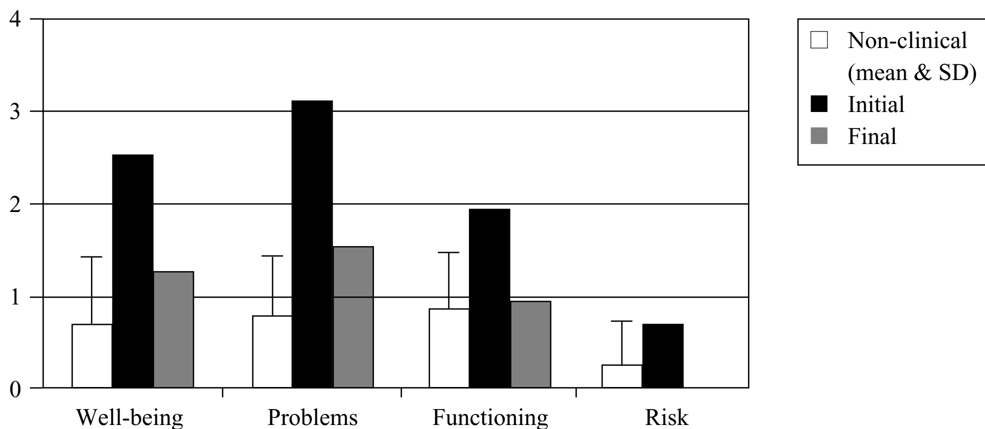

Figure 1. CORE values before and after therapy, and normative values.

Plan and rationale of treatment

From M's explanation of why he needed the analgesia both his language and his non-verbal behaviour suggested suppressed anger. This had built up over time and was directed towards various institutions, such as the army, the police and the medical profession, and also his father, who had died recently. Following Hilgard and Hilgard's (1994) description of the distress of chronic pain as sensory pain, suffering and mental anguish, the reduction of suffering and mental anguish may have a significant effect on the experience of pain. Negative affect may have a positive feedback on negative symptoms by disturbing the natural homeostasis of the system (Capra, 1997). Fernandez and Turk (1995) have shown how anger can contribute to an experience of pain. Accordingly, if rapport was established, release of anger might benefit M — both in terms of his emotional well-being and also with his level of pain.

When M talked about his successful experience using acupuncture in the past there were minimal cues that this appeared to have been an important and very pleasant experience. The intention was to use a re-vivification of this (Kroger and Fezler, 1976) as a hypnotic induction to help him access his unconscious resources for change. Having established a suitable calmness or safety anchor (Bandler and Grinder, 1979) the plan was to use a 'silent abreaction' (Watkins, 1980) to help M to release his anger, followed by client-generated imagery to deal more directly with the knee pain.

Therapeutic interventions

Validation, re-framing and seeding

I convinced M that I believed he had real pain, even though I wondered whether his anger and emotional distress might be affecting it. Pain was explained as a signal of emotional distress as well as of physical injury; we are inextricably interlinked organisms of mind *and* body where each affects the other in many different ways. Our emotional state can affect our physical feelings and we can develop a physical pain with an emotional cause, such as a tension headache or 'butterflies' in the stomach. Our unconscious mind has resources that we can tap into by the use of hypnosis as the path. Our

conscious and unconscious minds are useful constructs and models that help us to explain how things happen. Our conscious mind is only aware of a small part of our reality at any one time. When we learn a skill, such as driving a car, at the start it is a very conscious activity but as we become more familiar with it, we do it unconsciously, leaving our conscious mind room to deal with other things. Our unconscious mind already knows in many ways how to heal, for instance whenever we cut or burn ourselves.

Here, the idea was seeded that M could do things 'unconsciously' which would have an effect on his physical well-being. Most importantly, rapport was established, acknowledging M's experience of painful sensations. I paced M's experience and began to lead him to re-frame his pain as possibly having an emotional component. Seeds were sown for future therapeutic intervention and an expectation of change. After about 10 minutes M was given a leaflet explaining a little about hypnosis, an appointment made for the following week, and he filled in a CORE form.

Calmness or 'safety' anchor

At the start of the main therapeutic session M was instructed to close his eyes and to focus on feelings of calmness and relaxation, and was asked what words or pictures came into his mind as he did so. M was instructed to access a time when he felt really calm and relaxed. He described fishing on the local river with his father as a young boy. I asked M to really be there again, seeing, hearing, smelling and feeling whatever he had experienced at the time (Bandler and Grinder, 1979). M then opened his eyes and we discussed how he had felt. He described seeing a kingfisher and the feel of the water as he trailed his fingers over the side of the boat. It was then suggested that whenever M wanted to access those pleasant feelings of calmness all he needed to do was to close his eyes and be there again.

It was suggested to M that anger was only useful in so far as it alerts us to injustice and gives us energy to right a wrong. Otherwise, anger only festers and hurts ourselves, not those people with whom we are angry. M agreed that he felt intense anger and that it was not doing him any good. He said he would like to find a way to get rid of it safely, without hurting anyone. We discussed hypnosis in terms of the following model (Figure 2).

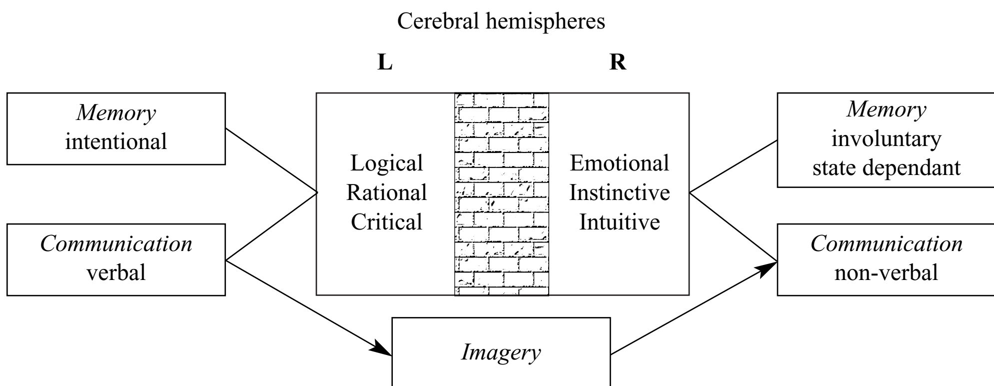

Figure 2. Hypnosis in terms of a brain hemisphere model. (Reproduced with the kind permission of Dr Leslie Brann.)

Imagery may be seen as the bridge between conscious and unconscious processing, and whereas talking about emotions often does not affect them, the use of imagery often does. Imagery, symbol and metaphor may be seen as the language of the unconscious (Kopp, 1995). M might be able to use imagery to help himself get rid of his anger.

Induction using re-vivification

As an hypnotic induction, M was asked to close his eyes and recall the feeling that he had described when he had had the successful session of acupuncture — 'that lovely warm, relaxing feeling' — and spread it all down his body. When he did so, M noticeably relaxed into his chair as his breathing slowed and his facial muscles softened.

Silent abreaction

M was instructed to look at his anger and to allow his unconscious mind to make whatever learning and understanding it needed so that he could let go of his feelings of anger, and to nod when he felt that it would be all right to let the anger go.

When, after a few moments, M nodded, he was asked to take himself, in his imagination, far away from anywhere to a rocky place, maybe a cliff or a quarry. There he was to select a boulder or rock that was to become his anger and project all the anger that he wished to be rid of into it and mark it in some way so that he knew what the rock represented. He was then to look around and find some way of smashing up the rock, maybe a pickaxe, maybe a hammer and chisel, a pneumatic drill or some dynamite. He was then to really enjoy smashing up the rock into tiny pieces and to give a nod when he was finished.

When M nodded, he was asked what he wished to do with the little pieces left. He wanted to sweep them away, which he then did. The suggestion was given that M should go back to the relaxing time when he was fishing on the river and gather up the calm feelings that that gave him.

Hypnotic analgesia

The following instructions were given:

- To focus M's attention on his knee and see what he needed to do to allow it to feel more comfortable; to which he said that it was fine and that it did not feel any different from his other knee, and rated it zero.
- To thank his 'unconscious mind' for helping him so well with the suggestion that all he need do was to notice change. Pain can be a message, but then it would only need to be at one or two on his scale so long as he noticed it and took any appropriate action needed. It would only need to 'shout' at him if he ignored it and exercised his knee inadvisedly.

It was suggested that M could keep the comfort that he was currently experiencing when he came out of trance, whether he was resting or active.

Outcome and follow-up

When M came out of trance he still rated his knee pain at zero. At follow-up, two and eight weeks later, his pain had not returned. A final CORE score was done at the eight-week follow-up. M had ceased all analgesic medication during the week following our

work and, when seen four months and ten months later, M's knee was still not causing him any problems and he was still off medication.

Discussion

Acknowledging the reality of M's pain, which built good rapport, and getting him to agree that all the anger he was feeling was contributing to his pain, appeared to be the keys to this intervention (Lindal, 1990). The timing of the intervention was also likely to be important, in that M was ready, for whatever reason, to make changes (Rogers, 1957; Kirsch, 1990).

Validation of patients' symptoms is of supreme importance, as too often doctors convey the impression that something that is not obviously physically pathological is merely imaginary. A pain is a pain whatever the cause! 'It is all in the mind', as was said or implied by the surgeon out of rapport with this patient, only served to increase M's emotional distress and anger. The unvarying nature of the pain was a definite pointer to its 'psychosomatic' origins. I know of no pain caused by physical pathology, apart from that due to bony metastases, that is unremitting, and even this latter has some variability in intensity.

By describing the intervention (silent abreaction) and discussing it beforehand, the idea of resolution was seeded as a pre-hypnotic suggestion (Rosen, 1984), both at a conscious and at an unconscious level; it also reduced apprehension towards the unknown. By accessing M's previous successful use of acupuncture to remove pain, the indirect suggestion was given that it could happen again. (M's unconscious mind already knew how to help him). M's body language as he described the feelings he had experienced had made it obvious that it was a very significant episode. Going with those feelings and re-accessing them was a powerful link to his unconscious resources. The use of imagery (silent abreaction) gave M a way of safely releasing pent-up feelings of frustration and aggression, and of letting go his anger. The use of the word *when* rather than *if* when asking about M's readiness to release his anger created a useful bind. M was also asked to project into the rock the anger 'that he wished to get rid of' not 'all his anger' as there might be anger that he wished to retain.

Although there was the intention to use some client-generated imagery to help M with his pain following the silent abreaction, it appeared that he had already resolved his problem and I had to mask my surprise at the result. Had disbelief been expressed it may have broken the rapport and sabotaged the good work done.

Conclusions

The story or model used allowed room for manoeuvre so that the pain could be let go at this time without loss of Ego. The 'story' that M's mind–body links had helped to generate the pain as an expression of his emotional distress, and then allowed resolution as he acknowledged and dissipated his anger and re-accessed a 'healing state' that he had previously experienced, was a device that worked extremely effectively in this case.

By paying attention to minimal cues, building rapport, releasing negative affect and connecting with patients' healing resources, change may be effected in cases where traditional medical methods often fail, such as those with psychosomatic pain. In constant pain syndrome the pain is there for some unconscious psychological reason, and if the patient is ready to work on it then hypnosis can provide the key to unconscious

processes that can resolve it. Or, as in this case, if it is no longer serving a purpose hypnosis may be used to facilitate the process of its resolution.

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