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THE USE OF HYPNOSIS FOR A PATIENT WITH CHRONIC PAIN

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Abstract

To protect confidentiality, the patient will be referred to as Alice. Alice was a 58-year-old woman who had been experiencing chronic pain in her right arm since an operation two years previously for syringomyelia. The referral, from an anaesthetist, requested psychological input for Alice to help her cope better with her pain, and adjust better to pain-related losses, particularly the loss of her ability to engage in creative pursuits, and her vocational loss, having to leave her job as an art teacher. Hypnosis was used throughout six treatment sessions. She learned self-hypnosis and used a tape which she eventually returned. She was able to use hypnosis to create complex visual images as if she were painting a picture. She thus regained some ability to imaginally enjoy her work again. She also learned to lower her pain levels through displacement and psychologically induced analgesia. Her general morale was lifted and a 6-month follow-up showed that the benefit of therapy was maintained despite significant family stress. She was no longer using painkillers or sleeping pills.

Extracts from the transcripts are included to illustrate therapeutic technique and progress.

Key words: hypnosis, chronic pain, analgesia, psychotherapy, imagery, relaxation

Description of problem

Alice's operation left her arm numb, with very little movement. Over a period of months she regained some useful function but then developed a painful tingling sensation and sometimes a shooting pain. She then had a diagnostic stellate ganglious block which produced a warm sensation but did not modify her pain. She described her pain as 'moving about' her arm and sometimes into her chest, shoulders and neck. By the time she came to see me she had been given a TENS machine which provided some relief. There had been no sexual dysfunction, although she and her husband had slept separately since her operation as she was unable to tolerate his movements. Her pain was exacerbated by both gross and very fine movement. She had noticed that cold weather, stress and worry also made it worse but that it was eased by distraction, for example, reading, gardening, socializing and gentle walks.

Background information

Alice was a sophisticated, intelligent and articulate woman. She was always elegantly dressed and carefully made up. She enjoyed a good, mutually supportive relationship with her husband, although their marriage had gone through a crisis 10 years previously when he had an affair. They had two grown-up sons who lived away. She expressed concern over their welfare and wished they were back home.

Alice was an only child, born when her mother was 42. She recalled a lonely existence as a young child as all seven of her aunts and uncles were childless. Her escape from an adult world was to use her imagination and to observe closely what was around her. She attributes her artistic talents and visual perceptual skills to these early experiences. She had significant stress in childhood with an undiagnosed lung condition. This had disrupted her schoolwork significantly as it did her relationships with other children and teachers. Growing up, she realized that having a family and being around people were important to her. In her professional experience she was greatly disturbed by the sight of spinster teachers whom she described as 'lonely, grey people'. She lived in a small village that was very active in its committees and local events, describing it as her extended family.

Assessment and formulation

There were definite organic explanations for Alice's chronic pain. The prognosis was poor in that her condition was not likely to improve. With respect to her mental well-being she presented as a frustrated, unhappy person, although there was no evidence of clinical depression or abnormal anxiety, and this was confirmed by psychometric screening (Hospital Anxiety and Depression Scale, Zigmond and Snaith, 1983). The McGill Pain Questionnaire (Melzack, 1975) was used to assess the sensory and affective dimensions of her pain experience. Her scoring indicated mild-to-moderate psychological distress associated with her pain. Pain intensity was rated 2 out of a possible 5 at the time of assessment (discomforting). At its worst her pain was 5 (excruciating) and was worse than other types of pain she had experienced. She had experienced significant pain-related losses, particularly vocational loss and the loss of artistic pastimes. The pain also disrupted her sleep. She coped by using distraction and was aware of what exacerbated her pain, namely certain movements and stress. Sources of stress included the aforementioned losses and the sense of loss of her former self. She also worried about her sons. Her own psychological defence system included rationalization and intellectualization of her problems and I suspected that she projected her own vulnerability on to her sons. She tended to mask her own vulnerability by presenting herself as a sophisticated intellectual. Only when she spoke about her sons did this persona alter.

Unconscious memories of her childhood illness were also likely to be resonating with her perception of her present circumstances. She felt, then, that she had no one to turn to and, in her present circumstances, although she described a good relationship with her husband, she felt that she was moaning and becoming a burden. There also seemed to be a gap in her emotional life that she needed to have filled, wishing in particular for her sons to return home.

Plan and description of therapy

Alice was a woman clearly with a creative, artistic imagination. I concluded, therefore,

that she would be a good candidate for hypnosis. Her obvious talents at visual imagery indicated that her visual modality would be useful in altering distressing images associated with her pain and in increasing her relaxation and stress control. Beneath her assertive front, Alice was a vulnerable, frightened woman. She feared being a burden and there were half-hidden fears about being left alone. I concluded that if she could gain some control over her pain, her self-efficacy would improve and thus her self-esteem. I believed that, apart from teaching her self-hypnosis, she should also have some space to work through her concerns in a safe counselling environment. I planned some basic educational input on the psychology of pain and its link with worry and stress. She received information on 'gate control theory' (Melzack and Wall, 1965) and pacing her activities. Although I was aware of conflict and difficulties going on beneath the surface, it was not my intention to offer longer-term psychotherapy. I hoped that providing her with coping strategies to raise her self-confidence and self-control would preclude the need for this, although I was aware that I may have to keep it in mind. Each of the six treatment sessions involved hypnosis. They began weekly for three weeks then two fortnightly sessions plus a follow-up session.

Hypnotic treatment

Session 1

The initial session was used for Alice to get used to hypnosis. I explained that she would be very relaxed and that she would be able to use this to help her imagine a pleasant scene. She was fascinated by the thought of hypnosis and had been looking forward to it since the assessment a few weeks previously. At the beginning of the session she described the pain in her arm as being at number 6 out of a possible 10 and that it felt like 'tight Velcro'. I hoped that we would reach a stage when I would be able to use this image to her advantage. Because of her difficulties with her arm and neck I used an eye-fixation induction rather than arm levitation. Suggestions of comfort and bodily relaxation were used for deepening. She looked very relaxed and ideomotor signalling was used to determine this. The latter is an exploratory technique to elicit information non-verbally, for example by finger movements for 'yes' and 'no'.

In trance Alice imagined a cottage that she had etched. What was immediately noticeable in exploring the scene was that she was unable to stay with one part of the 'picture' for very long. She was always adding to it and giving the most incredible detail about surfaces, textures, light and shade, as if she were painting a picture. She was unable to say which was her favourite part of the scene, saying that the whole of the scene was what she enjoyed. She did, however, enjoy the smooth surfaces of things such as the stone wall and the bark of some beech trees. Her visual modality took priority, although there was some auditory and kinaesthetic ability. Using what she provided, I invited her to lightly touch the smooth bark of the trees, associating this with deep relaxation. She signalled that she was much more relaxed and then I invited her to think about her arm and what the 'Velcro' felt like now:

> *Alice*: 'it isn't Velcro any more ... it's more like loose elastic ... it's nice and loose and comfortable....'

Alice reported pain reduction from 6 to 3. I reinforced this, emphasizing her control and her increasing relaxation.

> *Therapist*: '... that is very good ... you have managed to bring your number down from 6 to 3. See what control you have over this number ... just by being relaxed and imagining your special place ... and letting the Velcro go soft just like loose elastic ... each time you consciously relax like this you will be able to lower your number ... each time you think of your special place ... in all its detail, the more you will relax and be able to lower your number ... now think about the comfort you have right now and double it....'

On questioning, Alice informed me that she was now very comfortable and she was given post-hypnotic suggestions:

> *Therapist*: 'The next time you go into your trance you will find you will go into it more quickly, more easily and more deeply than before ... you will keep hold of the comfort from your trance as long as you need to ... you will become more and more able to control your number ... more and more confident in your ability to control your number ... more and more able to paint that beautiful picture in your mind's eye and be in it as long and as often as you want to ... as you become more relaxed and confident you will find that you can loosen the Velcro whenever you need to.…'

This was followed by some ego-strengthening suggestions before returning once more to her scene. When she did so, it was as though she were giving me an art lesson in how to observe. I instructed her to allow the scene to fade and alerted her by counting backwards.

The hypnosis had taken up most of the session and Alice was shocked that it had taken so much time. She said, smiling, that she did not think that she had been hypnotized but that it had been *very* interesting, saying 'It really was a distraction wasn't it', but added that it had worked and that she felt very good and was looking forward to her next session. In the counter-transference I felt that she had given me a 'good mark' for my efforts.

Session 2

I had made a tape for her to practise with at home. She had a reasonable week and was sleeping better. Her pain number was 4. In this session I concentrated on how she could control her pain by use of an anchor. In trance she reduced her pain number to 2. I praised her and suggested that she even had the ability to return to number 4. She looked uncomfortable but achieved this. I again praised her, emphasizing her increased control. On suggestion, she returned again to her special place, doing so with relish. As before, I made suggestions for increased comfort: the more details she explored, the more relaxed she would feel; the more relaxed she felt, the lower her number was, and so on. She reduced her number back down to 2, signalling when she had done so. I then invited her to make a movement with her left hand and at the same time feel the comfort and see her special place. She let her hand rest on her thigh. This was to be her anchor.

> *Therapist*: 'Good ... as your hand rests on your thigh you can feel the comfort more and more and all those good feelings from your special place.'

After reinforcement and post-hypnotic suggestions to practise her anchor and listen to her tape daily, she was alerted.

Alice described this session as fascinating and that she really did experience the pain increasing and decreasing. She must have been struck by my praise because she

then told me she always used praise when a pupil did something right and that she could not understand those teachers who only told pupils off for doing the wrong thing. Clearly, she wanted to praise me for being a 'good teacher'.

Sessions 3 and 4

Alice was making good progress. She was sleeping well and using the tape well. She was not so sure about the anchor. In trance she changed it to cupping her cheek and chin in her left hand. At the end of the session I gave her a sheet to go with the tape and post-hypnotic suggestion included using the tape less and referring to the sheet if necessary.

By session 4 Alice was using the tape less but was unsure of managing without it totally.

Session 5 (sessions now fortnightly)

She had had a difficult two weeks because of the onset of severely cold weather which affected her pain. I was also conscious that the sessions were nearing their end, and she was able to acknowledge sadness because of her feelings of attachment. In addition, in hypnosis, she was showing someone how to paint again and would miss that. In discussing her creativity she was now able to enjoy planting up her garden, saying '... I know it's not painting, but it's a start....'

Focusing on her problem with the cold she said she needed a lovely old-fashioned Victorian shawl to keep her warm. I used this in the session and asked her to visualize such a shawl, which had special properties. In hypnosis she created it, examined it and told me about every detail of the design and texture and how she could wrap it around herself in layers.

> *Therapist*: '... now just feel the shawl and drape it around yourself ... feel the snugness and how it is protecting you against the wind, keeping it out, feeling warm and snug trapping all the warm air. You can see yourself outside and the weather is cold and windy but this beautiful shawl is keeping you very very warm ... you can only feel a little bit of the wind ... but it doesn't bother you ... your shawl is protecting you ... and you can add the layers as you need them.'

Alice said that the pain had gone from her neck and arms and that it seemed to be draining into her hand. Using this, I suggested that it was draining down into her hand and into the chair. She was partly able to achieve this, saying that she could not get rid of it from her fingers. Nevertheless it was less discomforting there and she was able to reduce her pain number from 7 to 3. Post-hypnotic suggestions included her ability to move any discomfort from her neck into her arm whenever she needed to. In addition, she would always have her shawl close by should she need it and she would become very skilled at using it, as with her special place.

In post-hypnotic discussion Alice described a recovery in confidence after quite a nasty relapse. Her ability to visualize and to experience the feeling of warmth in trance had been of great help. She was surprised at the displacement of her pain, which was continuing to happen. Commonly with pain patients, Alice felt that the nearer her pain got to her head, the more distressing it became, so the ability to displace it had been very useful for her. She did not feel ready to give the tape back, even though she was now using it infrequently.

Session 6 (following a Christmas break of three weeks)
Alice returned the tape. She had been experiencing severe family problems, with her younger son developing schizophrenia. The emotional upset and resulting physical and mental tension had affected her pain but she was continuing to use self-hypnosis. Her new anchor was working well, her sleep continued to be good and she said that her husband had noticed she wasn't 'moaning' so much. Her activity levels were still higher than previously and she and her husband were planning a holiday.

In this session she consolidated what she had achieved and strengthened her anchor. Post-hypnotic suggestions were of her continuing regular practice of self-hypnosis, and of finding new ways of being creative as with her gardening.

Follow up – four months later
Alice had maintained progress. Work on her pain problem had made any further counselling unnecessary. She was particularly gratified that even after continuing difficulties with her son, she still felt in control, was coping well and was still enjoying self-hypnosis. She expressed gratitude for my help, especially after her 'initial scepticism'.

Discussion and conclusions

The price of chronic pain can be high. Unlike acute pain it generally serves no useful purpose, and it can be destructive and incapacitating in its psychological sequelae. Hilgard and Hilgard (1994) describe a triad of distress: sensory pain, suffering and mental anguish. It can involve bereavement regarding pain-related losses and learned helplessness, both of which can be precursors to depression.

Alice's experience is a case in point. She succeeded in being able to use hypnosis to lower her perceived pain to more acceptable levels. She attained control over her pain and suddenly had the opportunity to use her creativity, which was a secondary but very important beneficial 'side-effect' of her treatment. It is frequently noted in the clinical literature how hypnotic subjects can be creative in their use of hypnosis and it was interesting to observe how Alice was able to displace her pain spontaneously without prompting and was using hypnosis to 'paint'. The benefit of controlling her pain and using her creativity enhanced her self-efficacy and self-esteem and this was reflected in her general activity level and her relationship with her husband. The hypnotic experience itself was relaxing for her and no doubt helped her cope better with stresses and hassles that she reported, and to some extent it broke any pain-tension cycle. However, the analgesia was produced by direct suggestion, and no doubt her own assessment of it, namely that it worked by distraction, was a key component. Recent neurophysiological research supports this and suggests that hypnotic analgesia is an active inhibitory process involving the anterior frontal system. This interacts with other cortical and subcortical regions to inhibit incoming noxious stimuli (Crawford, Knebel and Vendemia, 1998).

With hindsight, I would have made more use of suggestions relevant to a possible unexplored need to hold on to some of her pain, as it seemed important for her not to let all of the pain drain out of her fingers. In addition, it may have been helpful to make use of the episodic pain she experienced in cold weather. Erickson (1959) describes this as being a construct of past remembered pain, a present pain experience and the future anticipated pain. The immediate pain is compounded thus. Erickson suggests that hypnotically suggested total or partial amnesia for the past

pain episodes would dull or eliminate anticipatory pain and render the present pain as transient and unexpected. Certainly, Alice dreaded the cold winds, expecting pain. Although I made the correct assumption that because of her artistic background, she would be a good hypnotic subject, I believe that the use of a hypnotizability scale such as the 'Is It Possible' protocol (Margolin, Byrne and Holst-Goltra, 1992) would have been of benefit. Although her 'initial scepticism' did not get in the way, it might have done and therefore a test would have indicated to her at an early stage that she was in control of her bodily sensations. As a clinician, I enjoy thinking on my feet and using what the patient brings to a session, but perhaps it would have been better practice to have these potentially helpful suggestions already tried and tested and ready in my mind to use.

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