COMPLEX REGIONAL PAIN SYNDROME: A CASE REPORT OF THE USE OF HYPNOTHERAPY TO CONTROL THE PAIN OF COMPLEX REGIONAL PAIN SYNDROME TYPE 1

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ABSTRACT

This case report describes the use of hypnotherapy in a general medical practice setting to help control the pain of complex regional pain syndrome for a 67 year-old woman who had had the condition for five years, with previously inadequate pain control despite maximum tolerated doses of analgesic medication and input from specialists in the local Pain Clinic and Orthopaedic Clinic.

Keywords: hypnotherapy, complex regional pain syndrome

BACKGROUND

Mrs A presented to me last year at the age of 67 in connection with complex regional pain syndrome type 1 (Birklein, 2005) affecting her right ankle (with pain radiating up to her mid-calf, and down to her forefoot) for which she has been under the care of the local pain clinic. She expressed an interest in the possibility of hypnotherapy to help the pain, as she wasn't keen on the other options that had been suggested at the pain clinic (e.g. lumbar plexus block) and also because she appeared to be on the maximum tolerated doses of analgesic medication, without adequate control of the pain. (Higher doses of amitriptyline had sedated her excessively, and higher doses of gabapentin increased her appetite unmanageably, despite helping the pain.)

PAST MEDICAL HISTORY

1990 cervical spondylosis, treated by physio.
1993 arthroscopy left knee – chondromalacia patellae.
1998 arthroscopy right knee – grade 4 degenerative change noted.
2000 right tibial tubercle advancement.
2003 left total knee replacement.
2006 onset of pain in right ankle – no obvious precipitant, no injury recalled – she just woke up one morning with pain and swelling, which was initially attributed to gout. X-ray showed marked soft-tissue swelling but no definite bony abnormality.
2009 right calcaneal osteotomy, right tibialis posterior reconstruction, and flexor digitorum longus transfer. Complex regional pain syndrome diagnosed later the same year.
2012 right subtalar injection; unfortunately not helpful in relieving the pain, so offered a triple fusion by her orthopaedic surgeon, but Mrs A was reluctant to commit to this

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unless there was nothing else that could be done to relieve the pain (particularly as there was no guarantee that even this would do so).

PAST PSYCHIATRIC HISTORY

Nil.

DRUG HISTORY

Gabapentin 400mg capsules three times daily.
Dihydrocodeine 60mg modified release tablets twice daily.
Morphine 10mg tablets 1–2 four hourly as required.
(Intolerant of NSAIDs – heartburn.)

SOCIAL HISTORY

She has lived alone since her husband died four years ago. She works two days a week as a cook at a nursery. She has never smoked, and has a modest alcohol intake.

FIRST SESSION (JUNE 2013 – 55 MINUTES)

I began by exploring the problem and checking her other past medical and psychiatric history. We discussed the nature of hypnosis and other potential applications for hypnotherapy, and in particular its use for pain control. (She hadn't had any personal experience of hypnosis, and hadn't seen anything other than TV shows.) As I have with other patients, I used a computer metaphor to explain the facility of the human mind to use hypnosis, likening it to a piece of software which comes pre-loaded on a computer, but may not be used until some time after purchase, when a friend shows us how to use it and then we realize how useful it can be. We discussed models of pain perception, including the example of phantom limb pains in amputees, to illustrate how pain is appreciated centrally, and thus is amenable to treatment with psychological approaches such as hypnotherapy. I went on to outline my suggested treatment plan, and proceeded with her agreement.

I used a standard induction, using fixation of attention (a point on the ceiling, above and slightly behind where she was sitting) with distraction (asking her to count down from 300 in her head) then suggestions of blurring of vision, eyelid heaviness, and eye closure, after which I went on to deepen the trance using progressive relaxation of all her muscle groups (starting from around the eyes and working down to the feet) followed by an abbreviated adaptation of Greggs' cycle of progress suggestions (Hammond, 1990: 150–1). Next, I suggested mechanisms to utilize unconscious resources, using a computer metaphor, whereby the unconscious part of her mind would work like a search program in the background, sorting through all her memories and experiences for resources to help her with her current problem, which could then be made available to her conscious mind at some convenient time. Subsequently I deepened the trance further using one of Beata Jencks' breathing exercises (Hammond, 1990: 162–5) – visualization of inhaling through the fingertips and up through the arms, then exhaling down through the trunk and legs and out through the tips of the toes – then arm heaviness and lightness exercises (Waxman, 1989: 72–5), before asking her to visualize herself in some calm and tranquil surroundings (having checked before induction for a suitable image – she had

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chosen to think of herself sitting in her garden) leading into a control room metaphor (walking down some steps from the garden to a securely locked control room, to which only she had the key) in order to adjust the settings for her pain downwards to manageable levels. After this, I gave some suggestions to facilitate future sessions, then set up an autohypnosis template and finally woke her up by counting from one to ten. She was very positive about the experience, and was interested in trying autohypnosis at home. We agreed to meet again in a fortnight, and she said she would try to practise autohypnosis every day until then.

SECOND SESSION (15 MINUTES)

She had been practising autohypnosis with reasonable success, using the visualization exercise (without the control room) but didn't feel she had been able to replicate the relaxation achieved last time. Unfortunately this time, her leg was too painful (burning pain with sharp twinges) to manage induction, so we agreed to postpone the session until the following week.

THIRD SESSION (30 MINUTES)

She had continued to use autohypnosis at home, and had swapped one of her working days from Thursday to Friday so as to be able to rest her leg, which felt better as a result. We discussed a treatment plan, and with her agreement, proceeded to induction (fixation on a point on the ceiling, with a count down from ten to one) followed by progressive relaxation, a diaphragmatic breathing exercise, suggestions to encourage utilization of unconscious resources, then further deepening using arm heaviness and lightness, this time with the suggestion of transferring the lightness sensation to her right ankle. Also, I offered the option of localizing the discomfort to one tiny spot, possibly a fingernail or toenail, which could then be trimmed off. Subsequently I went on to a visualization exercise (her garden) with visualization of putting on a cool stocking from a cool-box, then reinforcement of the control room metaphor and the concept of central control of sensation, using phantom limb pain as an example. Next I set up an anchor, so that she would have the ability to tap into a calm and relaxed state of mind when needed, then reinforced the autohypnosis template and woke her up by counting from one to ten. We arranged to meet again for follow-up (in a normal 10-minute surgery slot) five weeks later.

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When reviewed five weeks later, she was continuing to use autohypnosis daily (generally after her evening bath) and found it effective in reducing the pain, so that she didn't need additional analgesia. The pain continued to fluctuate, and she still had some bad days, but in general it was significantly better than it had been. She hadn't found the stocking image particularly effective, but had developed her own – she visualized peeling back the skin over her ankle, and pulling out the painful spot from within it. She was keen to carry on and develop this, and I encouraged her to do so. We arranged further follow-up in five weeks.

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At the next follow-up, her improvement had been maintained. She was still getting some bad days (two that week, which was unusual) but had been using less medication than before. She had stopped morphine tablets quite a few months previously, and was taking dihydrocodeine

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60mg MR intermittently rather than regularly. (I thought that she would be better having a supply of quick-acting dihydrocodeine for flare-ups, so issued a prescription for this.) She continued to take gabapentin regularly. She was practising autohypnosis four times a week, and continued to find it helpful, particularly when she used the imagery described last time. I didn't arrange any further formal follow-up, but advised her to continue regular autohypnosis, and to try the faster-acting formulation of dihydrocodeine as required whilst slowly reducing her intake of the slow release formulation. (I also offered the option of a booster session in future, if she felt the need.)

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I saw her next in February 2014, when she attended in connection with pain in her right knee, due to moderately severe osteoarthritis (confirmed on X-ray) which fortunately was generally manageable with paracetamol as required. I also asked her about her ankle pain, which remained under control with on-going autohypnosis.

I contacted her again in April 2014, to ask her permission to write this case report, and to review her analgesic usage. She continued to take gabapentin 400mg twice daily on a regular basis, with paracetamol as required along with an occasional dihydrocodeine 30mg tablet, more commonly on the days on which she works, but she had only needed to take six of these over the previous two and a half weeks. I also asked her to write a short account of her experience to accompany this case report, and I have transcribed this in full as follows:

> Thanks for suggesting hypnotherapy. It really turned my life around. After I learned how to relax, and how to use this to control the pain, I found I didn't need so many painkillers. Sometimes if the pain is bad, nothing really works, and I do have to turn to the strong painkillers, but this is not that often. I take 400mg gabapentin three times a day. Being able to relax has helped me in many other ways. I must say after so many years of injections, physio, and mixtures of pills, just a short time of hypnotherapy has really turned my life around for the better. Thank you so much.

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