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The Use of Hypnosis in the Treatment of Pain
A story of technique and collaboration

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THE USE OF HYPNOSIS IN THE TREATMENT OF PAIN A STORY OF TECHNIQUE AND COLLABORATION

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Erickson-Klein begins

"Do you mind if I ask you a personal question?" The familiar preamble accompanied by an apprehensive look heralds the crossing of an unseen social barrier. My siblings and I already know what is to follow. "What was it like to live with Milton Erickson?" Frequently the questioner follows with an eager look and sigh of relief. The gesture silently adds " Now the question is asked, I await a magical answer."

The unanswerable question is asked, not on a few occasions, but with regularity that numbers in thousands. Occasionally the questioning goes deeper "How was Milton Erickson different from others in his everyday life?" "How did his actions and temperament affect those around him?" "Was he a good father?" And often the questions extend to "Are you the genius that he was?" Another unasked question lingers in the background: "Can you help me to go beyond my own limits so I can become the genius he was? " That question remains unanswered and unanswerable.

What is salient about my father is how hard he worked and his openness for ongoing exploration. From the moment of awakening, his mind was working even as he relaxed. His interests exceeded intellectual curiosity and encompassed a broad tolerance for ambiguity; discoveries made everyday embraced an outlook of flexibility.

Early in his career, Erickson practiced at the Eloise State Hospital in Detroit Michigan while his young family resided on-site. Failing health brought our family to Phoenix, Arizona in 1948 where my parents chose to continue proximity of personal and professional lives by converting a bedroom of our small home into an office. The shared space of the front entrance, living room, and the single bathroom brought together the children, patients, colleagues, pets and neighbors; the home/office became a seamless integration of problem solving, creative ideas and professional exploration. The varied interactions of eight siblings are always complex. Our lives involved role-modeling of healthy behaviors including collaborating and compromising for resolution of needs or differences. Our space was a home / office where love and respect were bolstered by the opportunity of healthy engagement with other human beings.

The combined perspectives of family, students, and patients in participatory roles gave depth to the richness of life. Family members enjoyed the unique texture of the unexpected and were often rewarded with lasting appreciation for unique gifts that each person who entered our home brought with them. Hyonosis was common topic of shared conversations. Discussions between Dad and colleagues or patients often carried over to the living room or dinner table. While none of my seven siblings nor I aspired to be "like" Dad, each of us found hypnosis central to everyday life. We all share a powerful belief in the positive potential of the unconscious mind and the viewpoint that wisdom is multiplied through interactions with others.

Pain Management in My Professional Practice

Today, subjective reports are considered to be the standard measure of pain. I begin with the patients' concerns and quickly seek to contextualize experiences within a larger picture: functionality, quality of life, and ability to participate in desired activities. Evaluation of discomfort from a stance of how it interferes with enjoyment of life is more relevant than the commonly used numeric distress scale.

Interview: I begin treatment with a patient telling "the story of my pain". Stories link suffering to various life events that may or may not make sense from a medical perspective. A personal story provides a potent resource, and often gives direction leading to diminishment of pain. While confrontation with pain risks hesitancy, fear, and discomfort, expectation and nourishment of hope can often displace limitations. Encouraging the patient to turn towards the pain, I ask direct questions to explore about how discomfort impacts life. I ask the patient to pause and reflect, and to describe the pain in as much detail as is available. Occasionally, the mere act of looking for details objectifies and de-potentiates the distress. Descriptions reveal

the patients' internal resources, creativity and use of imagination. Word choices reveal individual beliefs of how change occurs, perception of time, triggers, and responses to sensory stimuli. Integrated into the listening phase, I inquire about "has this been tried-- or that?" seeding possibilities for exploration and expectation of success. As the conversation develops, I elicit descriptions from patients of experiential discovery for what is effective. Limits of beneficial effects are addressed with curiosity. Hope and expectation are brought in to enhance possibilities of new discoveries. Harvested from the discussion is a collection of meaningful words that can be used for positive suggestions.

Goal Setting: The next phase is to facilitate the patients' identification of realistic goals and criteria to measure progress. Typically goals do not involve making the pain totally go away, rather put the sensations in a different context with less interference with participation in life. Concrete measureable objectives are agreed upon. I express the expectation that the patient will evaluate their progress regularly.

Self -review: Acceptance of self-responsibility provides a foundation essential for all psychotherapy. The phrase Give yourself a check-up is how I formalize self-review. The locus of control is handed to the patient. Along with self-reflection come the burdens and privileges of responsibility to continue on a useful path or to alter direction to find a useful path. Many times patients feel unprepared and inadequate for this process, yet quickly recognize the necessity. For many, it is as if they have been lost in the woods and I begin to speak about working with a compass.

Hypnotic Suggestion: Throughout the interview, goal setting, and nourishment of self-review, I use a combination of direct and indirect suggestion. For example I seek the details of pain as it recedes, I question the prospect of separation of pain from fear, I ask about the times when pain is not an issue. I encourage active awareness of adjustments, changes, re-balance of movement or other factors that impact a sense of well-being. In these ways hypnotic suggestion is already integrated into the sessions informally from the first encounter, and more formally after the basic groundwork is established. Hypnotic suggestion offers an opportunity to cultivate flexibility; a broadening of perspective. Hypnosis is a tool that is at once vast yet specific, as vague as it is incisive. Collaboration offers a greater opportunity for discovery, redirection of energy, and sets a platform for looking from a new direction. Pain robs a person of their own locus of control; the act of reclamation opens the door to meaningful adaptations. Most of the time, these strategies work. My expectation that a direction will be found to offer freedom from the shackles of pain and permit re-entry into a meaningful lifestyle allows me to guide long suffering patients to success most of the time. Yet, on some occasions, relief is not forthcoming. Even with Erickson, there were a few of his patients who were forced to make significant compromises of lifestyle for unwelcome chronic painful conditions. Some found successful relief from pain and later recurrence of discomfort. For some, therapy lasted longer than the brief interval in which hypnotic pain management was the focus. Some conditions require re-evaluation, re-focus, and even acceptance of ongoing losses.

Application of Hypnotic Intervention to Cases: For further discussion, I have selected three cases from my work with patients who presented seeking relief from pain. Of the three cases, I consider one to be a full success and the second a partial success. In the third I had very little impact in the relief of symptoms. I have asked my colleague to comment on her perceptions about my choice of hypnosis as the primary therapeutic tool.

Successful Treatment

Several years ago a 66 year-old retired physician sought hypnotherapy for chronic back pain following an injury resulting from a rock climbing accident. He asked for hypnotherapy to augment a series of traditional medical interventions that had proved ineffective in restoring his flexibility and comfort. He was specifically interested in returning to the active outdoor life he had previously enjoyed. In listening to his story, it became quickly apparent that part of his unresolved distress stemmed from relationship issues. His fiancé had not attended to him in the way he needed during his many months of acute care. The injury was compounded with uncertainty of potential for full recovery, questions about lifestyle compromises and the disappointment of not being able to count on a loved one. While he acknowledged that the relationship added to his distress, he sought only hypnotic techniques to minimize the experience of physical pain. I accepted this without question. For hypnotherapeutic interventions, I began with a Jacobson progressive relaxation transitioning into a suggestive guided imagery with visuals the patient provided. I facilitated his imaginary experience of walking strongly and comfortably in a location that I described in a most vague and permissive manner. I incorporated many suggestions of physical awareness with the imagery then began to interject suggestions of becoming "more independent" "appreciative of himself" "confident in his own abilities" "filled with the expectation

of new discoveries" "finding new comfort within himself". As with most of my patients who are in the process of re-adjustment to physical changes, I generously offered suggestions related to finding an inner sense of alignment and balance. I then encouraged him to become attuned to the sense of healing and progress and to any lifestyle changes needed to accommodate a healthy sense of self. My suggestions were specifically intended to address the relationship with himself, but intentionally ambiguous enough to carry the expectation that he would discover relationship with others was also relevant.

Over a two-month period I saw him for six sessions and within that time, while apprehensive about "potential discomfort", he had found comfort and had resumed a level of function that brought back his joy of living. Six months later, he returned. By then he admitted he recognized that interpersonal relationships were contributing to residual pain and was ready to be more flexible in his conversations. I listened to his concerns, and saw him for two sessions. Each session involved hypnotic trancework in which the patient imagined going to a time and place of feeling his feet solidly on the ground, moving comfortably, feeling appreciated for all of his inner strength and beauty. The work was very broad and open. A year later, he reported that he had broken up with his fiancé, was free of pain and was fully active in outdoor adventures. He attributed his healing to finding a balance of comfort within himself.

Limited Success

A second case involved a matriarch in her mid-sixties who had been diagnosed with end- stage cervical cancer. While in radiation treatment her bladder had been damaged; every time she urinated she experienced "intense, overwhelming and excruciating burning". Referred by her oncologist to hospice, pharmacologic remedies had been abundantly explored but none reduced the searing pain each time she voided. She had reached a point of expressing that "God wants me to suffer" and self described her time on earth as one of suffering. She anticipated comfort after death, and had even "begged the Lord to take me". She lived with her daughters who treasured each day with her; all agreed that the Lord was not yet ready. The patient would have to wait until the time was right.

On a home visit, I offered hypnosis as a way of relaxing and finding a "new way" of feeling the sensations that occurred when she urinated. The hypnotic inductions I used connected to her expressed spiritual beliefs of joining Jesus in heaven -- when the time is right. I questioned the possibility "previewing" the comfort that awaits. I proposed an imaginary visit ascending to the heavens, for a short while, and then returning to the "here and now" to share the joys with her family. Both she and her daughters rapidly embraced the possibility. Beginning with a guided imagery, hypnotic suggestions were given for her to feel the comfort, through and through, and to bring the comfort with her "for a visit" to her earthly presence. Within three short sessions she reported that she had learned to access the comfort, to connect with it, and to bring the "billowing clouds and caress of Jesus" down to her bed. Thus she was able to ease suffering when it struck her. Functionally, she improved markedly and began to be more interactive and participatory within the household. She resumed ambulation with her walker, supervising in the kitchen and once even answered the door. I followed her for the next eight months until her death, sometimes just listening to her describe her imaginary visits to heaven, sometimes offering my own suggestions for imagery. I consider this to be a partial success in that the patient continued to refer to her pain as a ten on a scale of one to ten, but it had given her tools and a context for a life of value.

Unsuccessful Hypnotic Work

A third case involves a 45 year-old female who was referred by a physician for treatment of pain related to trigeminal neuralgia. The patient had been appropriately examined and diagnosed, but had never established a stable patient-physician relationship due in part to her unwillingness to take medication. She described increasingly severe symptoms over an interval of about five years during which she had visited a variety of physicians and other resources. Each time medications were offered, she researched potential side effects and made the decision not to take the risks. A married factory worker in generally good health, she described herself as "never having been sick in any way prior to the onset of facial pain". Deeply religious, she used prayer and Biblical readings to help her, but had not found relief for this condition. She described the pain as unpredictable, varying day-to-day, and growing in frequency of intensity over time. Unaware of pain as she slept, morning awakening brought uncertainty. She began each day with prayer that "today is the day the Lord heals me" coupled with apprehension of not knowing what the day would bring. By early morning, she experienced the presence of pain, sometimes mild and sometimes fully debilitating, and each day the pain remained constant through the day. She described, some days are two, and some days are ten, but once it hits, it is there all day long. Initially she was able to re-direct herself with prayer or distraction techniques. She had learned to use an imaginary gesture of "pushing" the pain to a smaller area to make it more tolerable. Today she tearfully describes the unpredictability, intensity and increasing debilitation to be intolerable.

Hypnosis is incompatible with some regional religious orientations. This was asked about in the context of her faith on the initial visit. She reasoned that the Lord had sent her resources and she must

try to learn to use them. In addition to encouraging her to find a physician with whom she could have an ongoing relationship, I referred her to her pastor, but she responded that she belongs to a huge mega-church in which personal attention by the pastor is not practiced.

An exhaustive variety of hypnotic approaches were used. She seemed, in many ways, to be a responsive subject though she struggled with giving herself freedom to feel change. With each hypnotic exercise, she returned to discussion of the cognitive process and to her religion. Suggestions offered both in cognitive sessions and in hypnotic sessions ranged from exploring new perceptions to trusting your unconscious ability to adapt. Despite her seeming motivation, and what seemed to be genuine efforts to learn, she failed to find significant relief from anything offered.

In the next year and a half, she stopped coming when her husband experienced a serious illness but once he stabilized she resumed treatment. A total of 20 visits with me, and visits to various other physicians and services all proved unsuccessful at symptom reduction. Today she reports "a claw-like presence grabbing and pinching my face." While the patient is willing to continue ongoing visits and I am available for a broader therapeutic approach than focus on her pain, her expressed sole purpose for therapy is to find relief from her facial pain.

Despite the persistence of symptoms her participation in life appears to be generally well-balanced. Secondary gain appears minimal. She has managed remarkably well in conducting her life "as if" she does not suffer. Office visits provide her with a forum for verbalizing the discomfort that minimizes the need to alter personal friendships or burden her family. Her focus remains fixed on Biblical readings and expectations of spiritual healing. Those expectations remain unfulfilled. I am at a loss of how to offer her genuine guidance.

Bluntzer offers a collegial viewpoint

In the realm of medicine, few areas are more controversial and more confounding than somatization and psychosomatic symptoms.

The three cases serve as useful examples of the complexities and hardships of addressing the combined affective and somatic elements of psychosomatic illness. Whether working with pain in which underlying diagnosis explains the symptoms, or in working with conditions that are unexplained, the challenge remains the same-- how to facilitate the quest for comfort.

For better understanding of useful ways to address subjective symptoms, it is of value to clarify the current practice of psychosomatic medicine. I have tried to address shortcomings of current approaches with the proposal of a "Self Model" that can maximize resources for clinicians and patients.

Treatment of pain with hypnotherapy is useful in the presence of subjective distress in the absence of objective findings. Once the physician has made that determination the physician-patient conversation has effectively ended. Medical literature implicitly informs the doctor that the patient is no longer a reliable source of information. In other words, the physician shifts from the collaborative to the somewhat coercive partner. This influences the relationship in one or more of these three directions:

(1) The patient is viewed as impaired (burdened with alexithymia -- difficulty in identifying and describing feelings)
(2) The patient is viewed as neurotic (emotionally unstable, and with propensity for negative affect)
(3) The patient is deemed a victim of misperception.

Correspondingly, the physician is condemned to being the person who defines the true patient. The task becomes how to rescue the patient: how to convince the patient of the physician's reality or how to help the patient lead a meaningful life despite their impairment, neuroses or misperceptions.

Milton Erickson's methods of hypnotherapy are an alternative to this imbalance. The patient is viewed as the resource of solutions. The practitioner is only a partner or guide. The patient's reality is not questioned; they remain the authority on their experiences. The patient is not viewed as impaired, weak or dishonest. The utility of this method is unquestionable given current medical horizons of research.

The task of remodeling the relationship into a duet of effort is without defined methods. The physician and patient are required to muster substantial curiosity, flexibility and tolerance of ambiguity in an area where "objective, scientific fact" trumps all subjective experience. To my knowledge this task is not recognized in medical literature. The topic is only skirted in the mind-body pursuits of various researchers as Herbert Benson, John Kabat-Zinn and others. While this is a fascinating and lively area of scientific exploration, its discoveries are not common knowledge. How these discoveries will assist the physician or the patient with psychosomatic symptoms is unclear.

It is the loss of a previously equal partnership that is most dissatisfying. The moment a symptom is deemed psychosomatic the physician's option of mobilizing the patient's internal resources becomes severely impoverished or non-existent. It is this frustration that has crippled many a physician-patient effort. "Just send them to a psychiatrist" has been the recommendation of my peers. While sometimes this is a necessary choice, it leaves the physician in the position of rescuer, definer of truth and the one who determines the patient is impaired or dishonest or weak.

What has troubled me throughout my career is the element of dishonesty or deception by the doctor that is sanctioned when adopting this customary

method. After all, the physician lacks years of intimate information about the patient's inner life. While psychiatric intervention may result in a patient's relief, most patients will not pursue that option. If they do, it may be a lengthy, costly pursuit with a possibility of failure. Regardless, the patient is designated a victim of misperception, delusion, misattribution or misinformation. The problem is the patient's mind, not their body.

An impasse occurs at the moment the physician refuses to openly acknowledge the areas of thought where the patient disagrees with scientific evidence. If confrontation occurs, it often is interpreted as an effort to "convert" the patient to the "scientific" viewpoint. Manipulation is named and the future of the relationship impaired.

In order to address this dynamic inherent in the practice of medicine I have designed a model that accounts for the patients' vast unknown resources in a way that does not dispute science, that does not demand that the patient be labeled a victim. The model must sustain the authority of the patient about him/her self. In order to achieve that, my patients and I have sometimes agreed to entertain a different definition of self. This work has resulted in a more holistic model that promotes curiosity, flexibility and tolerance of ambiguity without loss of the merits of science. This restores the collaborative relationship between the two parties and sustains honest communication.

In collaboration with my patients I begin by drawing a simple diagram of a model of "Self" that is easily communicated and negotiated. It avoids any disputes about what is 'real' and what is 'not real'. The self is imagined as three continuous functions, each with a unique form of communication that may or may not be logical. The model describes three realms, and all three can be imagined connecting to a universal consciousness.

Higher Self:
Communicates using creativity and intuition.
Common Self:
Communicates using logic and cause-effect.
Deep Self:
Communicates illogically with symbols and metaphors.

While for some patients the word hypnosis may threaten loss of control, discussion of a Self Model does not carry burdensome associations. The introduction of Higher Self, Common Self and Deep Self creates space for the logical as well as the illogical, the real as well as the unreal. This opening of perspective shifts formerly conflicted ideas into complementary elements, and adds formerly discarded resources. Introduction of this model stimulates curiosity and requires some minimal flexibility and tolerance of ambiguity.

The concept of Higher Self welcomes the beauty and power of the inexplicably numinous and embraces the patient's spiritual orientation. The patient and I usually agree that religion has been designated by society as the authority in this realm. None of the patient's religious beliefs need be challenged.

When presenting the model I am careful to acknowledge that science has concerned itself primarily with the realm of Common Self and has made innumerable useful discoveries there. The authority of medicine in this area is affirmed.

The Deep Self provides a designated territory for irrational thoughts and feelings. The illogical becomes recognized as a resource to be located and used. This acknowledgment shifts the relationship from victim/rescuer to a duet of collaboration. It is this partnership that made Erickson so effective and which explains the popularity of many therapies that lack scientific validation.

Fundamental tenets of constantly engendered curiosity, flexibility and tolerance of ambiguity create a context that maximizes the opportunity for change without invalidating the patient's authority. It releases the physician from dishonest and deceptive pursuits. The patient no longer risks humiliation by scientific findings. By acceptance of all three levels, all experiences can be viewed as contributions to health and well-being. Thus, the essential element of honesty is restored to the patient-physician relationship.

The Model as is Relates to Three Cases

Three cases of using hypnosis for pain management with varying degrees of success have been described. These examples are re-visited with the Self Model. The partnership of the clinician and the patient engaging the key elements of curiosity, flexibility and tolerance of ambiguity become apparent in the context of case examples.

Successful Treatment: The 66 year-old physician with the back injury did not envision his relationship as a component of his pain. This division conflicts with current scientific evidence that pain is both affective and somatic. However, the Self Model permits integration of the relationship component into the Deep Self. Upon claiming it as such, it now becomes a resource. Although this model was not formally introduced, the hypnotic work done invited the patient to connect to a sense of Deep Self in a symbolic manner. The permission inherent in Deep Self allowed the patient to eventually examine relationship issues that had formerly been excluded. In addition it allowed him to work without risking invalidation, humiliation by science and without endangering the supportive relationship with the clinician. Equally important, the clinician was able to maintain internal integrity that supplied a reliable springboard for creativity. The patient, a physician, was fully competent in the realm of Common Self. His own knowledge of the limits of scientific treatment moved his Higher

Self to seek help by exploring hypnosis, a methodology that had not been part of his recognized resources. Using this model every element of his experience had utility and value.

Limited Success: The case of the woman with advanced cancer began after interventions reasoned to be useful by the Common Self had already been exhausted. This case elegantly demonstrates the advantageous use of Higher Self resources without embarking on a theological debate. The clinician is not required to adopt or question the religious point of view embraced by the patient. Instead religious ways are used as rich resources to empower the patient. The clinician's use of these beliefs is ethical and honest. In addition, adopting the Self Model prevents the clinician from over-investment in the science/ logic/ cause-effect discussion of the Common Self, or confusion with the symbols or metaphors that emerge from the Deep Self. There is an economy of energy that is created from the Higher Self which is utilized in the patient as a major source of growth and change. While the somatic component of pain remained a ten, the affective component of pain was diminished as evidence by her expanded behaviors.

Unsuccessful Hypnotic Work: The patient with trigeminal neuralgia was also religious. Her faith is so strong as to give her the strength to face each day in the presence of daily torture indicating the presence of Higher Self resources. Disconnection from Higher Self resources including the pastor and the religious community impaired her ability to use the Higher Self in service of her expressed needs. In addition she rejected assistance from the realm of medicine, the Common Self. Her limitations in using hypnosis reflected a mistrust of her Deep Self, even prohibiting her from using her own metaphor for pain as a claw on her face. The inability to identify a Self of maximum resource created an impasse that prevented progress. Perhaps a discussion of the Self Model might have loosened the conversation and allowed her to claim internal resources that could have then been strengthened by the clinician's creativity. However even though efforts to stimulate curiosity were met with some success, the clinician was unable to augment the patient's limited flexibility and tolerance for ambiguity.

Conclusion by Both Authors

At the time of this writing, the Self Model has proven highly successful for both authors. Work with hypnosis can be enhanced by exploration of the Higher Self, the Common Self and the Deep Self. It offers a method of being maximally inclusive of all available resources, and as Erickson taught, promotes a partnership with the patient in which there is an integrity of information, spirit and direction. Recognition and effective use of curiosity, flexibility, and tolerance of ambiguity maximizes opportunity for successful hypnotherapy. These three elements and the Self Model provide a framework from which a clinician can examine and modify their own work both the successful cases and those with less than optimal outcomes. Additionally, it facilitates critique among colleagues.

Openly reporting cases in which the outcome was less than optimal reveals not only the weaknesses of the patient but the limitations of the clinician. Having a resource base of colleagues with whom to discuss outcomes, both good and bad, helps to advance the field. Erickson lived that principle, inviting contributions from all available parties

What Milton Erickson sought in life was no different from most of us -- to be the best we can, to help others to become the best they can, and to share the wisdom that we all contain within. What he taught us was to work hard, to adapt when needed and to remain open to discovery