



Hypnosis as an Adjunct in Management of Pain

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ABSTRACT: Hypnosis in the management of intractable pain is a valuable but frequently overlooked tool for the practicing physician. Two cases are presented which illustrate some of the benefits and limitations of hypnosis in pain management. Hypnosis is most effective when the patient is motivated, and pain is a strong motivating force. Secondary gain from the pain and underlying psychiatric illness must be considered when seemingly routine pain problems do not respond to hypnosis. Hypnosis may be equally effective for pain of organic or psychogenic origin. Ancillary benefits from hypnosis may include a diminution of secondary anxiety and depression. The technic is impractical for some patients because of the time requirements, but proper patient selection can obviate much of this objection. Self-hypnosis and/or the supervised use of a relative as a substitute for the physician enhances effectiveness. Training in hypnosis for adjunctive use in the management of pain is available to primary care physicians.

HYPNOSIS is one of the oldest tools of medicine. There is evidence that it was used by ancient Egyptians and the Persians, but the first publicized use of hypnosis in Western culture was by Franz Mesmer in France. He achieved some dramatic "cures," but the flamboyant methods and his unsupported theories of "animal magnetism" led the French Academy to discredit him in 1784. Unfortunately, "the baby was thrown out with the bath water," and the technic of hypnosis fell into general disrepute.

John Elliotson, the first to introduce the stethoscope into England, also experimented with hypnotism in the 19th Century, but he was severely criticized and ridiculed for his interest in it.

Jean Charcot, the neurologist, attracted many students, including Sigmund Freud, by his interest in hypnosis. He erroneously concluded that the hypnotic phenomena were the result of a deterioration of the central nervous system. Freud took Charcot's technic back to Vienna, but later rejected the use of hypnosis in favor of the psychoanalytic technics which he was developing at that time.

Medical hypnosis surfaced again during World War I and World War II, with demonstrated effectiveness

in the treatment of traumatic war neuroses. The psychiatric interest in hypnosis declined with the ascendancy of psychoanalytic influences in the 1950s, and it was not until 1958 that the American Medical Association issued a policy statement recognizing hypnosis as a legitimate method of treatment in both medicine and dentistry.

The ability of modern medical technology to prolong life inevitably has led to an increased interest in the quality of that life in chronic and terminal illnesses. A natural outgrowth of this change in focus has been a reconsideration of pain management in chronically and terminally ill patients. Many patients with chronic pain dislike the physical and psychologic dependence on narcotics which so frequently develops, as well as the dulling of the senses and the other mind-altering side effects of these drugs which adversely affect the quality of life.

Cases in which the available analgesic medications are ineffective are known to all physicians.¹ Frequent readmissions to the hospital for uncontrollable pain are both a financial and an emotional strain on terminally ill patients and their families. These facts lead to the inevitable conclusion that many patients with chronic, physically induced pain deserve an evaluation of the effectiveness of hypnosis, since one of the first and most enduring uses of medical hypnosis has been the alleviation of physical discomfort.²

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The following two cases will illustrate the benefits and the limitations of this treatment modality.

CASE REPORTS

Case 1. A 54-year-old man with a diagnosis of malignant mesothelioma involving the left lung and pleura had severe pain which had been relieved on the left side of the chest by a right percutaneous cordotomy, but he later had severe pain on the right side of the chest and in the abdomen. He was unable to sleep for more than a few minutes at a time because of the pain. Because intravenous morphine not only gave little relief from the pain but also produced mental confusion and hallucinations, he was referred for possible hypnosis.

On examination he was withdrawn, irritable, and obviously in pain. After the patient's common misconceptions about hypnosis were cleared up, he readily agreed to the procedure.

While under hypnosis, he was given the suggestion that the pain would seem far away as though it were not in his own body, and he was told that he could "tune down" his pain to a level that was perceptible but not bothersome. The chest pain was unchanged but his abdominal pain was relieved for approximately four hours after the hypnosis.

The patient's wife had observed the procedure, and when he awakened during that night in severe pain, rather than calling the nurse for medication, his wife imitated the hypnotic induction procedure, enabling him to return to sleep without medication. Subsequently, the patient and his wife were given some basic instructions in hypnosis and self-hypnosis to be used specifically for relieving pain and inducing sleep.

After three hypnotic sessions over a period of 24 hours, the patient no longer had abdominal pain, and though he had some discomfort in the chest at four- to six-hour intervals, the intensity was much less severe. He was discharged with good pain control by hypnosis and an occasional dose of 30 mg of codeine.

The patient lived approximately three months after discharge, and follow-up information indicated that he had continued to use self-hypnosis periodically and had become pain-free.

Case 2. A 62-year-old white man with oat cell carcinoma of the left lung had chronic pain in the thoracotomy incision site, relieved by a T3-36 rhizotomy, but he soon developed pain in the rhizotomy incision site and high in the left axilla, for which he was referred for possible hypnosis. He appeared to be acutely anxious and depressed and complained of burning pain in the neck. He related to his wife in a dependent manner, making frequent demands for attention in a querulous tone of voice.

Although he expressed little interest in hypnosis, he passively agreed to the procedure. After the first session, he reported a slight improvement in the pain while in hypnosis, but the pain relief did not extend into the posthypnotic state.

During the second session the patient's wife was in the room, and he was unable to achieve a state of hypnosis. He was asked to practice techniques of self-hypnosis several times during the next 24 hours. His wife was told that she might be able to help him, but she did not wish to participate.

A final trial with hypnosis was attempted the following day, with his wife out of the room, from which he appeared to achieve a light hypnotic state but without relief from pain.

Additional history from the patient revealed that he had been having frequent crying spells and felt depressed most of the time. He was treated with amitriptyline, 150 mg per day, and over the next several weeks his mood improved and the pain disappeared. Follow-up information five months later showed he had remained in good spirits and free of pain.

DISCUSSION

Experience has shown that hypnosis is most effective with a well motivated patient, whether the object is to modify a hysterical conversion symptom or to relieve pain. Pain is generally a strong motivating force.³ Both of the patients reported here seemed to be having similar degrees of pain from somewhat similar causes,

but their response to hypnosis was drastically different.

Additional history and a different type of treatment showed the pain of the second patient represented a "depressive equivalent"⁴ and required that the underlying depressive illness be treated rather than simply addressing the somatic symptom. In addition, the secondary gain from his pain in the increased attention from his wife interfered with the hypnotic process. Since the first patient's uncontrolled pain tended to isolate him from his family, secondary gain was not present.

The first patient's personality favored a good outcome with hypnosis, while in the second case, emotional and personality influences were the overriding consideration in determining an unfavorable outcome. An underlying psychiatric disorder may make hypnosis an impractical approach for certain patients and will indicate other treatment.⁵

A positive effect of hypnosis in many cases is the restoration of a sense of hopefulness and a diminution in secondary anxiety and depression.⁶ A lessening of tension and of fears associated with death is certainly related to pain relief, but it is probably an independent effect of hypnosis, since feelings of serenity and equanimity have been reported by patients even when their pain relief has only been partial. Mental clarity may also be improved by hypnosis and the decreased need for narcotics.

The patients in this report were given three hypnotic sessions each to determine the practicality of the technic. This involved a total expended time of about two hours in each case, indicating that a moderate investment of time will usually enable the physician to select the patients most likely to benefit from hypnosis.

Instructions for self-hypnosis should be given routinely to patients with intractable pain because it enables them to reinforce the pain-relieving suggestions when the need arises and decreases the frequency of reinforcement sessions with the physician.

The use of a family member as a surrogate therapist has not been previously reported in the literature. The practice requires certain precautions. The relative must be able to tolerate that type of intense relationship with the patient without undue distress and should also be cautioned against variations from the technic as prescribed by the physician. The benefits of a spouse helping with the hypnotic treatment are also apparent. Participation in the hypnosis can offer the spouse or relative a unique way to help a loved one. In Case 1, the frustration and sense of helplessness experienced by the patient's wife contributed to his readmission to the hospital. By acquiring a skill which enabled her to help relieve her husband's discomfort, she was able to share in a meaningful way the last few months of their lives together.

On the other hand, it would be improper and unwise to insist that a relative learn the mechanics of hypnosis. The technic should be offered in cases in which a healthy, close relationship already exists and when both people express an interest. The instructions should be restricted to the specific goals of relaxation, pain relief, and/or induction of sleep. The relative's application of hypnosis should be supervised by the physician just as other home care and treatments are monitored.

Interestingly, the period of pain relief from hypnosis is from four to six hours, essentially the same as with most narcotics, but the first case report and others in the literature⁷ illustrate that the time of pain relief is extended with repeated hypnotic reinforcement. Crasilneck and Hall⁷ have stated that the first few hypnotic inductions may produce a period of post-hypnotic pain relief which is longer for psychogenic pain than for organic pain. With subsequent reinforcement sessions, the period of pain relief may tend to equalize for pain of both types.

Many physicians continue to see hypnosis as a nonscientific instrument. Perhaps this is so first because scientific explanations for the hypnotic phenomenon admittedly are inadequate, and alterations of cerebral physiology mediated by hypnosis remain theoretical.⁸ Second, physicians tend to see an unsuccessful attempt at hypnosis as a personal failure rather than as a failure of a particular treatment mo-

ality. Much of this objection to hypnosis can be removed by more rational patient selection, as exemplified in Case 2.

Methods of inducing hypnosis can be learned in a few hours, and basic therapeutic technics can be learned with a few days of instruction. Two respected organizations in the United States offer annual workshops in medical hypnosis for physicians.*

Hypnosis provides a viable, noninvasive adjunct to the management of many patients with pain by helping to restore and maintain an improved level of physical and emotional functioning. Perhaps it should be tried in most cases before more drastic neurosurgical procedures.

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