Teaching Self-Hypnosis to Patients with Chronic Pain

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For the past twenty years hypnotherapy and self-hypnosis have been utilized as valid tools for the successful management of severe protracted pain. Control often has been achieved in cases where other modalities of pain management had been inadequate. Hypnosis properly applied can bring some degree of improvement to 90 percent of patients. More remarkable degree of pain relief is achievable in the 25 percent of patients who have high hypnotic "talent," and with very limited expenditure of time and effort. The author discusses basic theories of pain, pain-control and hypnosis, and he clarifies the effects of physiological, biochemical, and psychological variables which can affect the procedures and the results. Presentation of a clinical case with quoted excerpts of verbalization serves to illustrate the most important points.

During more than 20 years of clinical experience I have found hypnosis to be useful as a principal or a subsidiary tool in managing chronic pain. Eclectic approaches which take into account the complex biochemical and neurophysiological realities, as well as the cognitive and psychological background, have been especially effective. Also, I have always conveyed to my patients my belief that their pain is real, even when etiology and pathology can not be ascertained and demonstrated. This attitude is useful in eliminating from our minds and from the minds of the patients any artificial distinctions between real pain and psychogenic pain. As a consequence, even in those instances where hypnotherapy seems to bring about almost miraculous relief, no doubt will arise about the reality of the preexisting pain. This does not exclude the causative roles that hysterical conversions, verging on malingering, depressive reactions, psychotic equivalents, consciously or subconsciously motivated, can play in the origin and persistence of pain.

The subjective experience of pain is indeed the result of many interacting variables, sensory, motor, cognitive, motivational and emotional. They do not occur in a vacuum, rather they are based upon the functions of the infinitely complex microscopic anatomical substratum of the central and peripheral nervous systems. Essential biochemical interactions involving various neurotransmitters and specific chemical receptor sites are activated or inhibited at cellular, intercellular and molecular levels. Pain, especially intractable pain of a chronic and recurrent nature, creates intense physiological and psychological stress which is often insufficiently relieved by analgesic, narcotic, and psychothropic drugs and by neurosurgical interventions.

From a practical viewpoint it is important to keep in mind that at least one out of five persons suffering
from severe chronic pain is probably an excellent potential hypnotic subject who can learn to utilize hetero- and self-hypnosis in two or three hours of intelligent training. It then becomes possible to spare these patients long periods of suffering and hospitalization, to eliminate the need for neurosurgical interventions, to reduce the use of narcotic drugs and to improve the quality of life. At the same time, precious hours of physicians' and nurses' time can be saved. It is probable that in some cases of malignancy, lengths of comfortable survival are prolonged.

In all of these cases where pain has lost (if it ever had had them) the characteristics of being "the psychical adjunct of an imperative protective reflex,"' hypnosis permits function without unnecessary suffering.

The gate-control theory of pain modulation introduced by Melzak and Wall, the discovery of prostaglandins and other naturally occurring chemicals in the production of pain, the related understanding of the "modus operandi" of antirheumatic and other anti-inflammatory agents, the recent exciting discoveries of specific receptor sites for narcotics and their relationship to naturally occurring narcotic-like polypeptides, (endorphins and enkephalins) has brought us closer to an understanding of pain and "pain-killers." But at the same time these discoveries have brought us nearer a logical explanation for the success of hypnosis and other "psychological" approaches to the modification of pain.

Pain, even more than sight, hearing, smell, taste and touch, is the result of an integration and abstraction by the central nervous system of various peripheral stimuli acting upon specific structures, and of preexisting memories and experiences stored and catalogued in biochemical language in various cells and centers of the central nervous system.6

Similar ideas are expressed by Sternbach, in the context of learning theory to explain pain persisting in the face of apparent "organic recovery" and to suggest different approaches to pain control, including biofeedback models.7 Hilgard and Hilgard7 have noted that, even when chemical or hypnotic analgesia or anesthesia does eliminate the pain experience, certain physiological correlates of pain do persist. The concept of a "hidden observer," a dissociated entity reporting the existence of pain while the subject himself consciously experiences no pain, somehow conveys the idea that chemical and hypnotic anesthesia and analgesia alter the quality rather than the totality of the pain experience.

Since readers of this article probably have little familiarity with the theories, techniques and applications of the complex phenomena of hypnosis, I shall illustrate as clearly as possible some of the induction techniques and applications to severe chronic pain by reporting in detail the conduct of hypnotherapy with a patient of mine. I shall explain the rationale for what I am doing or saying. I shall interpret step by step the patient's physical, emotional and intellectual responses to my verbal and nonverbal activities and indicate how the resulting modulation and elimination of chronic pain is achieved and maintained.

Insofar as I generally attempt to make the patient self-sufficient through self-hypnosis, I must at least give an operational definition of self-hypnosis: It is a state of hypnosis achieved, maintained, and utilized without the immediate direct assistance and guidance of the physician or psychologist. The methodologies for teaching self-hypnosis include:

1. Written instructions.
2. Oral instructions administered in person or by audiotapes and videotapes.
3. Observation of other subjects who are learning or have learned self-hypnosis.

The instructions may be received by the learner while he is in individual or in group hypnosis, or before any formal hypnosis is induced. I have utilized all of the above modalities; but my personal preference has been for individual teaching of the patient while he is in hypnosis according to the model of hypnotherapy illustrated by the following:

**CASE REPORT**

Mrs. I.M.T., age 59, had been in chronic pain since twisting her back two years previously. Repeated investigations by competent orthopedists and neurologists had concluded that the pathology consisted of multiple osteoarthritic hypertrophic spurs of her vertebral column which impinged especially upon the posterior roots. The main area of her pain and consequent disability was the one innervated by the left sciatic nerve. For two years all therapeutic interventions, including traction and acupuncture and hospitalizations, had been unsuccessful, and she had been advised by her physicians "to learn to live with it." She had been forced to
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abandon the majority of her activities.

When seen by me, the pain and disability which had continued for over two years consisted of frequently recurring pain in the neck radiating to the ears, shoulders and upper extremities, moderate backache, and almost constant intolerable burning head from right to left would indicate further developing hypnosis.

Additional deepening was achieved with the instruction that, as I counted down from 10 to 1, she would visualize each number in bright colors against a background of her choice. Simultaneously with each lower number there would ensue deeper levels of relaxation in every muscle.

I then explained that, with the progressive relaxation, her neck and back muscles would become free of spasms, thus decreasing the pressure that the bone spurs had been exerting upon the nerve roots. I also gave a simplified version of the gate-control theory: “Your brain is now sending messages to the gate-control stations to tune down the intensity and quality of the pain signals, so that you will feel less and less discomfort . . . your brain will produce a sufficient amount of your own morphine . . . in the next six months the spurs in your spine may even become smaller and less sharp . . . you have been a good person, I believe you have suffered enough, you have been punished more than enough . . . ” She was then deepened by “fractionation”: “You mentally count from 1 to 10 visualizing again each number until your eyes reopen; they then look at the leaves of the large houseplant behind my desk, enjoying the leaves until your eyes close again and sleep begins; you may just enjoy the sleep or you may have a dream — which you can keep from me and possibly even from yourself until an appropriate time.” (This is an approach to developing amnesia.) “You will maintain the learning and the improvement between successive visits to me. During nighttime sleep you will gain experience pleasant and useful dreams.” After dehypnotization she practiced self-hypnosis by simply lifting her hand and looking at it in the way she had done before. Following these instructions: “Then the same sequence will occur automatically from the moment you first look at your hand.” the experiences of hetero-hypnosis were promptly reproduced in self-hypnosis.

Four days later she reported being very relaxed, having slept better and having been able to take a walk. The second visit was dedicated to further rehearsing of the experiences of the previous visit.

In the following week, having continued to practice self-hypnosis at home for periods of 10 minutes (during which she heard my voice as if she were in
my office) she began to function in a more normal way, almost free of pain. The dream that she had had in my office during hypnosis had involved reexperiencing lovemaking with her husband, an activity which had been impossible for over two years. More practice of hetero- and self-hypnosis was conducted during the third hour, with suggestions of age regression to a much younger and much healthier period of her life. The hour was concluded with suggestions that her body was becoming stronger and her joints regaining full range of motion, and that the healing professions from a routine, systematic utilization of hypnosis in the relief of pain.

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one out of five have so much innate capability for hypnosis that excellent results can be achieved with limited expenditure of effort and time. Only lack of information and distorted views are still preventing the healing professions from a routine, systematic utilization of hypnosis in the relief of pain.

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**REFERENCES**