A CASE OF POST-HERPETIC NEURALGIA TREATED WITH SELF-HYPNOSIS AND IMAGERY

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Abstract

This is a study of a case of post-herpetic neuralgia treated successfully with the use of self-hypnosis and client generated imagery in three sessions, the total treatment time being two hours. Paramount in the resolution was an acceptance of the symptom.

Key words: imagery, mini-trance, self-hypnosis

Background

Post-herpetic neuralgia is defined as pain persisting for more than two months after shingles (Herpes Zoster). The Oxford Textbook of Medicine states that 10% of untreated Herpes Zoster sufferers go on to develop post-herpetic neuralgia and that this incidence rises with age, being 50% at over 60 years of age and rising to 75% at over 70 years.

Post-herpetic neuralgia is classically a difficult condition to treat and many patients suffer for many years from intractable pain. Opiate analgesics are often ineffective and drugs such as Gabapentin and Amitriptylene are commonly used in pain clinics with varying efficacy. Psychological approaches (Haythornthwaite and Benrud-Larson, 2001) and hypnotic techniques have been reported in the literature to be effective in the treatment of post-herpetic neuralgia (King, 1988; Dane and Rowlingson, 1988).

It is also thought that post-herpetic neuralgia may arise from posthypnotic type suggestion at a time of vulnerability by an authoritative figure giving the negative suggestion that the patient will experience pain in the future (Rossi and Cheek, 1988)

Case presentation

David was a 65-year-old man who presented with ‘unbearable’ neuralgia pain around the right side of his trunk that had been present for 18 months. He had never been ill before and felt that his pain had ‘taken over his life’. It was ‘always there’ and he scored its intensity as 70 out of 100 most of the time. It was very touch sensitive and he described the sensation to be as though he had ‘taken the skin off and was rubbing salt in’. Analgesic medication helped a little but he had to take such a high dose that he felt doped and drowsy and therefore wanted to discontinue it. On further questioning he stated that he was pain free when riding his horse. Hypnosis was discussed and he expressed a keen desire to proceed. He had no relevant past psychological history, was happily married and enjoying his retirement.
Post-herpetic neuralgia treated with self-hypnosis and imagery

During the first session of one hour, a revivification of a time when he was horse riding was used to induce hypnosis (Kroger and Fezler, 1976) and a self-hypnotic trigger was taught. It was suggested that he sit or lie down, decide how long he was to do his hypnosis for and take a deep breath in. As he breathed out he was to count to three in his head. On the count of one his eyelids would feel heavy, on the count of two they would close and on the count of three he would instantly slip into a deeply relaxed state of hypnosis. It was further suggested that he develop imagery of his pain and begin to find a way to heal it.

Ideomotor signalling (Cheek and LeCron, 1968) was set up with a ‘yes’ and ‘no’ finger and his ‘unconscious’ mind was asked if there was any imprint involved in the development of his neuralgia and whether it continued to serve any purpose. A negative response was obtained to both of these questions. On re-alerting he reported that he had been pain free in trance but that as he moved the pain recurred.

A technique that was developed from Professor Harry Stanton of Tasmania (from a one-day workshop at the Royal Society of Medicine in 1997) was then taught where the intention is set and ideomotor (or unconscious) movement is used to monitor progress of the process.

The method is as follows:

1. The hands are held 10–12cm apart and the ‘unconscious mind’ is asked if it is prepared to work on ‘x’ now. If ‘yes’ then the hands gradually come together as the unconscious mind reviews the problem and its antecedents. If ‘no’ then the hands will move apart. This must be respected, and the technique perhaps tried again later.
2. One hand is then instructed to drift down to the lap as the unconscious mind mobilizes the resources it needs to deal with the problem.
3. The other hand is then instructed to move down to the lap as the unconscious mind starts to use these resources to help with the problem.

Throughout, it is important to remind the patient that he should not try to move his hand or try to stop it moving but just to allow it to happen.

It was suggested that David do his self-hypnosis regularly and also do the hand exercise daily. A suitable time when he could do this was agreed.

He was seen again for half an hour two weeks later and reported that he had successfully used self-hypnosis to keep himself pain free for as long as two hours at a time. The pain relief lasted for about ten minutes after he came out of hypnosis but then recurred. It was suggested that he take himself back into hypnosis and whilst he was in hypnosis various suggestions were given. It was suggested that the nerve endings had become super sensitive and that, like a faulty smoke alarm, were firing off impulses when the toast was burning rather than the kitchen catching fire. It was further suggested that he could begin to reduce the oversensitivity by resetting his smoke alarm and that he could perhaps pour soothing, healing fluid down the affected nerves to help them. The comfort that he was experiencing in hypnosis was matched across in his daily activities and it was suggested that he could use mini-trances to reactivate his comfort whenever he felt he needed it. It was suggested that he anchor the comfort he was experiencing with a visual or auditory cue. He was then re-alerted and he reported that he had developed the phrase ‘Go away’ as an auditory anchor to the comfort.

At the third session two weeks later (also half an hour in length) he reported that he was doing his self-hypnosis easily, even with his eyes open, but that the pain still recurred on movement apart from the times when he was horse riding.
Whilst in the consulting room it was suggested that he practise going into hypnosis and then bring his head out of trance so that he could hold a conversation whilst keeping comfort in his body. He was then asked to close his eyes and go deeper inside himself and visualize the problem. He reported that it was like a black jellyfish clinging to his side. It was then suggested that as what he was doing hadn’t been working, maybe telling the pain to ‘go away’ was not the best way to deal with it. The analogy of a child, clamouring for attention and becoming more and more insistent if it was ignored, was used. It was suggested that he welcome it in and ask what it wanted. There was a marked physiological response as he did this and he reported that the image had changed to a ball of soft blue wool that needed unravelling. He was asked to give a nod to indicate when he had done whatever he needed to do.

When he indicated with a nod that he was ready to proceed, one arm was lifted into the air. When catalepsy was observed it was suggested that the part of his mind that knew how to keep him comfortable whilst moving certain muscles (such as those used when he talked, whilst horse riding and whilst lowering his arm back down to his lap) could begin to learn to keep that same comfort during other muscle movements. It was further suggested that in the same way that his body formed a scab over a wound to protect it as it healed he could do the same thing with his oversensitive nerve endings as the soothing fluid he poured down the nerves healed them. He was then re-alerted and reported that he was surprised at the change he felt when he stopped fighting against the pain and asked what it wanted. At a conscious level he had no idea of what he had done to effect the change.

An appointment was made for four weeks later but he telephoned to cancel saying that he no longer needed it as he was fine. He was doing self-hypnosis regularly and the neuralgia was no longer bothersome. He discontinued his analgesia and has not restarted to date, which is now six months from the hypnosis sessions.

Discussion

At the first session David stated that the pain was ‘always’ there. It is always useful to challenge these all or nothing statements and find exceptions (Cade and O’Hanlon, 1993) and indeed, on further questioning, he revealed that he felt comfortable horse riding. This then informed the choice of induction. Horse riding could be seen as a type of naturalistic trance. Indeed he reported being pain free during hypnosis as well as during riding.

A self-hypnotic trigger was used as a more rapid induction for when he wanted to do his self-hypnosis. It was also important to emphasize his control as this had been indicated as a problem in the history when he reported that the pain had ‘taken over his life’. Stanton’s Hands technique was a useful way of allowing the patient to generate and utilize unconscious resources to help solve a problem. It can also be useful to emphasize to a patient that they are in control and not the therapist.

It has been reported that post-herpetic neuralgia can follow an imprint given at the time of the acute attack of herpes zoster so that this needed to be explored as well as any secondary purpose that the neuralgia might be serving. As the response was negative, further exploration was not deemed necessary.

At the second session David’s expertise in self-hypnosis was acknowledged and utilized as an induction method. This is also a good way of ego strengthening. The use of a metaphor such as the smoke alarm communicates at a more ‘right-brained’ level. Various images can be suggested as ideas to the patient – he had expressed that healing fluid bathing the nerves had appealed to him so this was the basis for the suggested
imagery. David’s production of the internal auditory anchor ‘go away’ may be thought to be an unresourceful way of communicating with himself internally but it had to be respected until such time as he found out for himself that it was not such a good idea and was ready to try a different approach.

Utilizing a mini-trance is often effective with pain as the pain-free interval persists for some time after trance has been reversed and it can be suggested that this will lengthen. In a way it is utilizing anchoring, as the comfort has been linked to the feeling of being in trance. Utilizing trance in the body and bringing the head out of trance in order to see and communicate whilst keeping comfort can also be useful in obstetric cases.

Acceptance of his symptom and communication with it via imagery was central to the resolution of his pain. The marked physiological response (flushing) to this suggestion indicated that significant change had occurred.

Client-generated imagery and the subsequent changing of the image indicated that resolution was progressing (Kopp, 1995). Arm catalepsy and a reversal of the arm levitation was utilized as David was already familiar and comfortable with the concept of ideo-motor movement. It could be argued that this was unnecessary as he had already resolved the problem but reinforcement is always useful.

In this case the client can be seen to have all the resources he needed for change (Thompson, Weyandt and Irwin, 1964) and that by accepting the symptom and working with it rather than against it (O’Hanlon, 2003) resolution was obtained. Neither myself as the therapist nor the client had any idea consciously as to what unconscious problems underpinned his pain, but imagery and ideo-motor movement were used very successfully to access and work with this at an unconscious level.

References


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