

HYPNOSIS IN THE TREATMENT OF BACK PAIN

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Pain is the number one complaint and reason for seeking medical intervention (Erickson, 1968; Hilgard, 1975). The two major categories of pain are acute and chronic. Pratt et al. (1984), points out that according to the National Safety Council (1980), low back pain is the second largest cause of missed work days in the United States. In an overview of chronic back pain Chapman Smith (1991), points out while the U.S. population rose by 12.5% the number of individuals with disabling back pain rose by 168%, (Hazard, 1989), and that 85% of all people will experience disabling back pain during their lives.

In the U.S. from 1954 to 1981 the number of episodes of incapacity per 1,000 rose from 21.7 to 58.2 for men and from 8 to 44.7 for women (Waddell, 1987). Ten to fifteen years ago the estimate for monies spent on pain control and lost wages for chronic low back pain was over \$50 billion dollars a year in the United States (Bonica, 1977; Bressler, 1979) and 1,000 million pounds in the United Kingdom (Waddell, 1982). It is estimated that double the amount per year is currently being spent on pain control.

The Arthritis Association estimates that over 10% of the American population suffers from arthritic pain (Waters, 1982), afflicting over fifty million Americans and accounting for over 1.5 billion hours of "reduced efficiency" (Blau, 1974).

Migraine headaches alone affect 6.5% of the population (Litt, 1986) and are the number one most common complaint (Ryan, 1978), affecting over 42 million Americans (Diamond, 1979). Of these headaches, 80% are of a muscle contraction mixed migraine nature (Friedman, 1964). Currently the Ad Hoc Committee's (1982) definition of muscle contraction headaches assumes a skeletal-muscle basis. Beatty and Haynes (1979) suggests that muscle contraction headaches may be a result of other factors in addition to muscle-tension in the head and neck region. Two of these factors that they specifically indicate are the individual's pain threshold and pain tolerance. Hypnosis has been shown to have a direct affect on raising both the patient's pain threshold, and tolerance, (Stacher et al, 1975; Bassman * Wester, 1984).

The third factor is the individual's coping strategies. Teaching relaxation training and stress coping training had a significant positive effect on reducing migraines (Sorbi & Tellengen, 1988; Holroyd et al, 1988).

Hypnosis is the treatment of pain has demonstrated its ability in the fields of medicine, dentistry and psychology. In dentistry it has been used to reduce dental phobia and anxiety, control blood flow, salivation, and as an analgesic (Finkelstein 1984; Finkelstein, 1991). The use of hypnosis applied adjunctively as an anaesthetic to other modalities of treatment is well illustrated (DiBona, 1979; Morse & Wilcko, 1979; Carnow, 1991) and has proven its effectiveness with post-operative pain control (Wolf & Millet, 1960).

Within the medical field hypnosis has been utilized adjunctively to treat pain associated with psychiatric disorders (Werner, 1984; Murray Jobsis, 1991) cancer (Gardner 1976; Simonton, et al., 1978; Dash 1980; Hilgard & LeBaron, 1982; Hockenberry-Eaton & Contanch, 1989), sickle cell anemia (Zelter, et al., 1979), surgical procedures (Densen, 1971; Jones, 1977; Ewin, 1986; Blankfield, 1991), in lieu of anesthesia (Gravits, 1988; Esdaile, 1957), migraine headaches (Milne, 1983), gastrointestinal disorders (William & Singh, 1976), burn victims (Dahinterova, 1967; Wakeman & Kaplan, 1978), and Raynaud's Disease (Braun, 1979) to mention but a few of its applications.

Perhaps the most prevalent and commonly accepted application of hypnosis lies within the field of psychology. As an adjunctive tool in psychotherapy its applications are diverse. For many individuals back pain appears to show a reactivity to stress. Psychotherapists have utilized hypnosis as a primary intervention (Mott, 1982), in family counseling (Araoz & Negly-Parker, 1988), for pain control (Burte, 1988), in trauma (Edelstein, 1981; Peebles-Kleiger, 1989), with habit disorders (Reaney, 1984), in child psychotherapy (Klauber, 1984), chronic terminal illness (Kraft, 1990), psychosexual disorders (Araoz, 1982; Burte & Araoz, 1994), phobic and anxiety disorders (Burte & Araoz, 1986), as well as in forensic cases (Labelle et al., 1990; Orne, 1979), litigation cases (Udolf, 1981; Perry & Laurence, 1990), insomnia (Stanton, 1989) and onversion disorders (Van Dyke & Hoogduin, 1989).

In a study by Deyo and Bass (1989) a significant correlation was found between individuals manifesting an unhealthy lifestyle (illustrated by obesity and smoking habits), and the frequency and severity of low back pain. In addition, recovery rates and chronicity were also positively correlated. They suggest that programs for low back pain prevention may include interventions for these lifestyle related factors.

Therefore, of ancillary relevance to the caregiver is the application of hypnosis for treating habit disorders such as smoking (Frischolz & Spiegel, 1986; Mawhiney, 1981) and in treating obesity and eating disorders (Cochrane & Friesen, 1986). It has demonstrated its utility in stress related conditions as part of a low back pain/stress management program (Strasser, 1984), in habit formation and promotion of positive self conditioning (Dintenfass, 1975; Burte, 1987; Burte, 1988; Bernie, 1989; Burte, 1990), and in helping patients who may be feeling bored and apathetic about their lives, yet not clinically depressed (Burte & Araoz, 1987).

However, its most important applications with back pain patients is in its utility in mediating skeleton-muscular interactions with emotions (Kimmell, 1989), pain control (Wells, 1982; Evans, 1988), somatopsychic disorders (Ford, 1989), psychosomatic disorders (Crasilneck, 1980) and in psychoneuroimmunology (Hall, 1983; Kiocolt-Glaser et al., 1987; Bernie, 1989).

Hypnosis may also prove effective when the back pain specialist (i.e., chiropractor, orthopedist or physical therapist) is the entry point, primary care physician for patients who may be experiencing emotional duress and consequent skeletomuscular reactions secondary to accident, injury or lifestyle related trauma or stress (Burte, 1990).

A patient complaining of physical pain resulting in significant disability may be evidencing significant emotional overlays. In this instance the specialist communicates with the patient in relation to their pain and emotional overlay (suffering). Hypnosis has demonstrated its efficacy in such initial assessment, and treatment settings. Harold Wain (1986), states "Hypnosis is one treatment approach that appears to bridge the gap between physiological and psychological conceptualizations of pain".

For the specialist making such an assessment, the ability to evaluate both physiological pain and psychological pain (suffering) may be essential in making an accurate determination of impairment and prognosis.

CHRONIC VERSUS ACUTE PAIN

Of significant relevance to the caregiver is an understanding of the psychological correlates of chronic versus acute pain in low back pain patients. In a review of the literature addressing these psychological correlates to low back pain, (Burte, 1990), suggests that the acute patient is distinguished by the prevalent use of "sensory experiences" in describing their pain (i.e. "It feels like a sharp knife"), seeks a neurophysiological explanation for the basis of the pain (Sternbach, 1974; Sternback, 1978), more frequently requesting relief of "somatic" discomfort, and the symptoms are acute with minimal affective behaviors such as worry, anxiety or depression being presented.

Treatment of acute pain would appear to be best focused on addressing the symptomological distress (i.e. pain). In addition to conventional medical and chiropractic care, progressive muscle relaxation, biofeedback, meditation, and hypnosis have been reviewed as effective in the reduction of acute pain (Channon, 1986; Blanchard et al., 1987).

The patient with chronic pain is a more complex configuration of psychosocial, emotional, and physical disabilities. For identification purposes their language is much more “sensory affective” (i.e. “I can’t stand it anymore”), they demonstrate greater “suffering” in that they address profound fears of the immediate and distant future. The chronicity of the condition, and perhaps a history of repeated treatment failures cause them to be more skeptical about treatment promises and seek to obtain information in evaluating treatment modalities (i.e. “Nothing else has helped, what makes you think this will?”).

Chronic pain patients often demonstrate elevated levels of state anxiety, depression and affective discomfort (Sternback, 1974). However, other profiles on psychological measures suggest that the psychological conditions are “not always” secondary to the pain (Leavitt & Garron, 1982). From these mixed findings in the literature, one may need to assume a more complex interaction of correlations and causation between the physical and psychological states of the individual.

Further, profiles suggest that chronic pain patients “catastrophize” more and that the introduction of coping self-statements, controllability, and self efficacy statements improve the chronic pain patients ability to reduce “pain and suffering”. In addition, chronic low back pain patients may demonstrate greater degrees of “perfectionism and self-downing” (Forman et al., 1987). With such patients a combination of hypnotic analgesia and stress inoculation may be effective (Miller & Bowers, 1986).

TOWARD AN UNDERSTANDING OF PAIN AND SUFFERING

Burke (1989) points out that there is an absence in correlation between pain behavior and tissue damage. He suggests that nociception (the physiological input of pain through the nervous system) as stimulated by tissue damage is a separate entity from suffering (the subjective perception of pain which is mediated by cognitive and emotional factors). Fordyce (1986) furthers this point by suggesting that suffering occurs when the person anticipates that the present pain will in the foreseeable future threaten or encumber his/her way of life. It is, therefore, incumbent upon the caregiver, at this point, to not only seek ways to reduce their patient’s “pain” but also to seek means to ameliorate their “suffering”.

Seres (1977) suggests that in many people, 1) injury or illness serves to convert a non-acceptable problem into one which is justifiable by virtue of the accident or illness and 2) the illness now offers an acceptable way (symptomology) for the patient to dis-empower themselves, eliminate responsibility for their condition and remain uninvolved in their therapy. Based on this, it becomes essential for the caregiver of such individuals to return responsibility to the patient, and to uncover and address the underlying motivation for the continued dysfunction. Of primary importance here is that the actual suffering of the patient is quite real. In the situations described the patient is not consciously utilizing the “excuse” of discomfort or pain as a rationale for avoiding addressing specific problems, but rather is experiencing pain and suffering.

Spinhoven (1987), points out that the presence of psychopathology or interpersonal problems in the absence of organic pathology in low back pain patients has in the past constituted a contradiction of using hypnotic pain control. He argues that the dichotomy of organic versus psychogenic low back pain is obsolete and should be replaced by a more comprehensive biopsychological perspective. He sites the utility of hypnosis with such patients, providing certain therapy rationales and patient selections are observed.

In addition to the alleviation of pain through direct suggestion of analgesia, back and neck pain may be adjunctively aided through suggestion for deep muscle relaxation, (Jacobson, 1938; Jacobson, 1955), and therapeutic touch (Chaitow, 1981; Wells, 1982). There is little doubt that muscle contraction, spasticity or weakness resulting from either chronic fatigue or injury are major focuses in low back pain intervention (Trog et al., 1987). Adjunctive treatments such as galvanic, interferential, massage, and diathermy are modalities specifically focused on addressing these concerns (Langilott, 1985).

The use of hypnosis in achieving deep muscle relaxation in these patients serves two major purposes. First it returns to the patient responsibility for their recovery and secondly, can reduce spasticity and improve tonality to muscles in the low back region. Howatt and Weiss (1989), state that low back pain resulting from facet deviation as caused by various anatomical/psychological factors can be improved. Burke (1989), states that "treatment must be geared to return responsibility back to the patient. Once you have determined that the diagnosis is chronic pain behavior, passive therapies (manipulations, PT modalities, Tens units and massage) must be discontinued."

Based on this, the importance of patient education becomes clear. Chapman Smith (1990), suggests that "there is a compelling logic to the principle of having patients understand more about their problems and know how to take personal control of management as far as possible". He cites the research of Cherkin and MacCormack (1989), in which back pain patients reported being "very satisfied" three times as often (66% vs. 22%) after chiropractic care versus care for low back pain provided by their family physicians. The study showed "large inconsistent differences between patients reported they received about their back problems". Specifically chiropractic patients reported they received more information about the cause of pain, the period of recovery and how to care for their backs themselves.

In essence the chiropractic patients had more responsibility returned to them, approximate time limits were established for recovery and re-empowering (through instruction in exercise, posture and lifestyle). The role of "back school" in the chiropractic practice is well established (Zachrisson-Forsell, 1981). In addition to providing an education on physiology and function, and the importance of ergonomics and exercise, back schools often teach relaxation, breathing and cognitive distraction (i.e. hypnotic techniques) (Back Pain Monitor, 1990).

Current trends appear to suggest the effectiveness of approaches which utilize the increased interdisciplinary treatment of chronic low back pain, incorporating psychotherapy to focus on the somatic, emotional and social factors of chronic back pain and disability, (Maqwhiney, 1979; Tyler, 1984).

Based on this, education of the low back pain patient should include a psychological understanding of pain, pain mechanisms and the role of dysfunctional cognitive processes, muscle reactivity and tension in response to cognitive mediators and the operant training of the soma to cognitive and environmental stressors.

HYPNOSIS AND LOW BACK PAIN

Whereas relaxation training and biofeedback have demonstrated their utility in pain control (Blanchard et al., 1987) and cognitive restructuring and coping techniques have also demonstrated their utility, (Haley, 1967; Kroger, 1977) only hypnosis offers the combined benefits of all these techniques (Bassman & Wester, 1984). Hypnosis as a treatment approach provides the patient the opportunity to develop self-efficacy while developing the ability to engage in muscle relaxation, correction of dysfunctional cognitive processes and identification of maladaptive cognitive/physiological interactions.

An approach of particular comparability to hypnosis is described by Kimmel (1989), who suggests that tension is stored within the muscles as a result of earlier traumas and stress. Through the release of deep muscle tension (muscular relaxation) the patient is able to realize "in

the here and now, emotional tensions which were originally too painful to accept.” Kimmel further suggests that, “tensions and rigidity can be responsible for distortions and subluxation with all the neurological aberrations with which we are familiar...Whether the holding muscles can be relaxed or strain will determine the eventual long-term success with that condition. To attain deep muscular relaxation, the once painful memories associated with muscular tensions must be realized, dealt with and successfully handled by the patient.”

From the 1930's to the fifties, Jacobson demonstrated that disturbed thoughts and emotions are accompanied by electrically measurable heightened muscle tension and that relaxing these tightened muscles can lead to a reduction of unpleasant thoughts, emotions and affect (Jacobson, 1921; Jacobson, 1927; Jacobson, 1928; Jacobson, 1930; Jacobson, 1932; Jacobson, 1938; Jacobson, 1941; Jacobson, 1943; Jacobson, 1946; Jacobson, 1946; Jacobson, 1955). His work laid a foundation for much of the work on relaxation therapies which were to follow (Jacobson, 1970; Jacobson, 1970).

The idea that emotional distress and trauma can be released through touch and focused awareness on the area of physical discomfort is expressed by Ford (1989). He suggests that for proper alleviation of a spasm occurring as a result of trauma (emotional or physical) the “release of both the physical and psychological aspects of the injury” need to be addressed. He further suggests that addressing “either condition alone can recreate the other.”

Releasing only the muscle spasm leaves the underlying fear, which may well recreate the original spasm. Similarly, releasing the fear alone, leaves a painful spasm which has every potential to recreate the original fear. He refers to this process as “somatosyntheses”.

In relation to the correlation of the spasm and genesis of unpleasant thoughts and emotions Lowe (1989) suggests that sustained myofascial constrictions are likely to activate type C and type A delta sensory nerve fibers. The action potential pathways of these fibers induce generalized physiological arousal which gives rise to behaviors whose aim is to remove the aversive stimuli. The psychological arousal and behavioral activation are accompanied by unpleasant cognitions and emotions. He further suggest that “when the myofascial constrictions and their trigger points are relieved, the unpleasant thoughts and emotions subside”.

The use of hypnotic imagery for self diagnosis is an ancient art dating back twenty-five hundred years to an active healing center in Epidaurus. Modern exercises designed to contact a person's “internal body wisdom”, in order to provide information about physical problems and their solutions were developed and implemented by Wilensky (1988) with interesting results. He found that subjects received “information” about their physical condition through kinesthetic and symbolic forms. Follow up medical validation for this “information” provided validity for the subject's experiences.

Melzack and Perry (1975), utilized a direct suggestion hypnotic approach with 24 subjects experiencing chronic back pain, peripheral nerve injury, cancer, arthritis, phantom limb pain, stump pain, post traumatic and head pain. They found that 33 per cent of these patients demonstrated marked relief through hypnosis.

Spinhoven and Linssen (1989) , compared a 6 session self-hypnosis procedure to six patient education classes presented by a rehabilitation physician, an anesthesiologist, a physiotherapist and two psychologists. They found no significant difference between the groups on outcome measures of pain diaries, reports of pain intensity and on Symptom Checklist-90 (SLC-90) measurements (a self report symptom inventory).

However, pre to post measures for both treatment groups demonstrated significant improvements on pain diary measures, reduction of pain medications (33%) and improvements on scales of psychoneuroticism and depression on the SLC-90. The only outcome which did not demonstrate a significant reduction was reported pain intensity. They conclude that the self-hypnosis training yielded comparable results to those of the treatment package. It would appear that self-hypnosis may offer a more parsimonious treatment approach.

This finding may further suggest the utility of hypnosis as an adjunct to spinal manipulation and other physical interventions. The use of self hypnosis may be useful in the development of re-empowering the patient and developing coping skills which reduce “suffering” while actual physical interventions are directed at the neuro skeletal muscular aspects of “pain reduction”. Through the use of hypnosis a somatic bridge between the soma and the cognitive processes can be attained.

Whereas more “traditional models” of hypnosis often seek direct reduction of pain or suffering through relaxation, dissociation, analgesia, suggestion or distraction (Deahrs, 1977; Wain, 1980; Mawhiney). The “New Hypnosis” approach focuses on the physical discomfort (pain) as the “pathway” or “somatic bridge” to the source of the emotional discomfort (suffering) (Araoz, 1983). As such it reduces the need for lengthy and formal inductions utilizing instead the patients natural ability to go into a trance or trance-like state (Araoz, 1985a; Araoz 1985b).

It has been suggested that attaining a deep trance may not be necessary for therapeutic change or reduction of somatic discomfort. In fact, it may prove a hindrance to the patient by increasing reliance upon the person administering the induction, (thereby reducing self-efficacy and/or enhancing attributions of the severity of their illness.)

Barber & Hahn (1982), spanos, Kennedy and Gwynn (1984), found that a hypnotic induction was not necessary to attain pain control whereas other studies have found that a hypnotic induction significantly facilitates pain reduction (Crasilneck, 1975; Stacher et al., 1975; Brown & Fromm, 1987). Waking suggestion, as it is often referred to, utilizes no prior induction and dismisses the notion of hypnosis as an alternate state (Spanos et al., 1984).

The New Hypnosis suggests that through a reinterpretation of pain or the use of metaphorical language, psychsemantics and imagery pain can be dissociated away or reinterpreted clinically into a more comfortable experience. Distraction and reinterpretation of noxious stimuli as a means of pain reduction without induction was demonstrated by Spanos, Radtke-Bodorik, Ferguson and Jones (1979).

Interestingly, it may not be the presence or absence of an induction which determines pain reduction. Tenenbaum, Kurtz and Bienias (1990), found no difference between subjects who reported pain reduction under hypnotic or waking conditions. However, differences were found when susceptibility to hypnosis was introduced with high susceptibles reporting significantly lower pain ratings.

Watkins and Watkins (1990), offer an alternative theory of pain reduction suggesting that pain is dissociated to a covert “cognitive structural system” as a coping mechanism. The pain may be stored up to be expressed at a later date, in a sense storing up future “ouches”. They further suggest that through the sue of hypnosis to release the stored up pain in a “controlled” manner greater pain reduction for chronic patients can be obtained. Offering the sue of “alters” as an explanation of pain control is not, however, without question as to its validity (Barber, 1990; Evans, 1990) and will require further investigation even as it raises many new questions (Wain, 1990).

Hypnosis has for some time demonstrated its utility within the physical medicine, occupational and rehabilitation setting (Decker, 1960). Appel (1990), more recently reported on the use of hypnosis in developing self-esteem and self-efficacy with patients requiring varying degrees of physical rehabilitation.

Hypnosis was effectively utilized to help patients deal with frustration related to disabilities, overcome fears of falling and re-injury (often seen in industrial accident and geriatric cases) and applied to facilitate compliance with rehabilitative regimes. Appel further points out that hypnosis has been used in neuromuscular re-education. (Shires et al., 1954), neuromotor facilitation” (Garver, 1977), hypnotically hallucinated physical therapy (McCord, 1988) and mental practice (Warner and McNeil, 1988) to enhance the performance and outcome of physical tasks and objectives. The rehabilitative and pain concerns of these patients are equally common to those found in the chiropractic patient.

For many low back pain patients this equates with reduced emotional and physical “suffering” and potential reduced “pain” due to a more rapid rehabilitation and return to normal life styles.

Similarly, the New Hypnosis, an approach developed by Daniel Araoz (1985a) attempts to form a “somatic bridge” to help the patient understand the interaction between their somata and their emotional states. The individual is encouraged to focus in on the area of discomfort (i.e. low back pain) and to experience what thoughts, feelings, images, and sensations come up (Burte, 1989). They are encouraged to allow their rational mind to stand aside and allow “whatever” is there to “come up”. Often memories, psychosomatic expressions or unusual images appear, (as will be described in one case vignette). By talking through, revivifying or reframing these experiences, the patient can often release much of the “suffering” associated with the pain.

Another way this technique is used is to utilize the patient’s own ability to create analgesia upon suggesting. Though the use of guided imagery the patient is “led” to a less painful reframing of their discomfort. The creation of subconscious bandages or a cast like enclosure may with encouragement allow the patient to relax the muscles in their back, abdomen, chest, etc., thus reducing spasticity. It may also allow them to shift their focus back to normal activities of daily living.

Pain or discomfort is not, however, by any means necessary for “induction”. Trance can be achieved by utilizing the Ericksonian approach of redirecting the individual’s attention inward to their own immediate experiences (Lankton and Lankton, 1983). A most common beginning for the average low back pain patient might be through the use of “relaxation chatter”. Directing the patient’s attention to their breathing, noticing how the feelings of relaxation and tension changes with exhalation and inhalation, respectively, and having them just achieve a simple state of inward directedness and openness to whatever “come up” for them spontaneously.

The low back pain specialist must not be afraid of opening a “can of worms”. If “worms” come up, then they were there before the can was opened. The patient now has the opportunity to resolve these issues with the caregiver, or through a referral, with a mental health counselor.

Often, at this point the caregiver may only need to offer guidance into self-help, utilizing the patient’s ability to find a solution. Trained psychotherapists are aware that often it is the patient who generates the best solution to their problems. The tendency to be an advisor should be repressed so as to allow the patient’s “inner advisor” to help them. Erickson above all else stressed the importance of trusting the patient’s unconscious.

The non-mental health caregiver’s role is not to be a psychotherapist, but rather to help the patient increase their awareness of their inner experience and how it may relate to their physical expression of these difficulties. This technique offers a non-invasive supportive approach which helps the patient achieve a greater sense of self-efficacy while often reducing emotional and physical suffering.

Most therapists would agree that therapy begins in the waiting room. It is important that even the casual dialogue which transpires between the office staff or doctor with the patient incorporate a heightened awareness of psychosemantics. For example, the use of metaphorical language in casual conversation may offer insight into a patient’s problems. Comments such as “my back is killing me” or “my husband makes me sick” or “I can’t stand it anymore” often go unattended or sometimes are even inadvertently reinforced during dialogues with the patient.

The caregiver should always be alert to the opportunity to spontaneously reframe or alter these “negative self-hypnotic statements” into “constructive self-statements” (statements which empower the patient to correct problems in their lives) or address them later with the patient for the purposes of uncovering significant emotional issues which may be contributing to their “suffering” (Araoz, 1981).

The use of hypnotic psychosemantics offers caregivers an effective adjunctive tool requiring no additional time or effort, while providing potentially significant gains to their

patients, as well as to themselves. In the New Hypnosis, as in many Ericksonian approaches, no formal induction is used, rarely is the word “hypnosis” stated.

HYPNOTIC AUDIO TAPES

The use of self-hypnotic audio tapes and subliminal tapes appears to be well promoted within the back pain literature.

Self-hypnotic audio tapes have been effectively utilized in waiting rooms (Finkelstein, 1984) presurgically (Field, 1974) and to augment other forms of hypnotic pain control (Davidson, 1987). The practice of making an audio tape for the patient to take home and use is common in hypnotherapy. Pre-recorded tapes are also available and offer guided support and imagery exercises which have demonstrated their efficacy with diverse patient populations (Barber, 1979; Araoz, 1984). Dentists, physicians, chiropractors and physical therapists often need a rapid means of placing their patients into hypnosis when desired. Many of the formal techniques of rapid induction currently being employed are reviewed by Smith & Wester (161). Techniques which are frequently employed in dentistry (162), are especially modifiable to fit the needs of the back pain patient. It has been suggested that pain or trauma triggers self-hypnosis, and that often patients enter into a self-induced trance like state upon entering a doctor’s office or directly prior to an invasive procedure (Edelstein, 1981). This being the case then leading patients towards the positive utilization of this state is quite attainable.

Another way in which rapid induction is achieved is through the use of a post hypnotically placed cue (or signals) which returns the patient to a hypnotic state previously attained. The cue can be of a physical or verbal nature with the initial induction having been performed by either the caregiver or someone else. A simple example of this might be to ask your patient to take a deep breath and as they breathe out think the word “calm” and allow themselves to return to a memory of when their body was “very comfortable”, “feeling peaceful and calm, loose, limp and relaxed”. A few more moments of “relaxation chatter” is often enough to help the person turn inward and begin a hypnotic experience. A physical cue might consist of touching their thumb and forefinger together.

A rapid induction might also be initiated by combining relaxation and somatic awareness. For example, “when I hold your head like this, in the comfortable safety of this office you can let your body relax and notice a slight sinking and rising feeling as you breathe in and out... Good. Notice the feeling of relaxation in your neck as it is comfortably supported, let that feeling flow down through your shoulders, arms, upper back, lower back, etc. Good...Now as you relax twice as deeply as before notice how the body can just continue to relax as you imagine a peaceful, calm, warm, gentle day. Notice all the beautiful things around you. You are surrounded by serene delight knowing that nothing will harm you and nothing can bother you. Eventually, merely the physical contact may trigger a relaxation response.

A comparison of hetero-hypnosis, rapid induction, “hypnotic” audio tapes privately listened to while seated in the waiting room and a no hypnosis control group, Burte and Burte (1990) examined the efficacy of hypnosis applied adjunctively in pain control in a limited clinical setting.

A summary of findings from the patient population studied suggests a number of general trends. It does appear that the utilization of hypnotic and relaxation procedures offer some beneficial effect for (1) developing the patient’s ability to develop effective means of relaxing muscles and reducing reported discomfort on cue (2) enhancing the patient’s ability to develop improved coping skills in response to physical discomfort (3) increasing the patient’s ability to generate analgesic relief to reduce pain on cue, between appointments and reduce compensatory behaviors. However, no difference was found between the groups on patient compliance to therapy regimes through increased beliefs of self-efficacy.

It should be noted that the dependent measures relied upon the subjective reporting of pain. The utilization of subjective reporting of pain has been represented and supported in the pain literature (Scott & Huskisson, 1976; Gracely et al., 1978). Both the SP-Image (Selby, 1981) and the Psychosocial Pain Inventory (Getto & Heaton, 1985) demonstrate high reliability and validity with other measures (Cailliet, 1984; McCoy et al., 1984). It is important to acknowledge that in general within the clinical setting, it is often the "subjective report" of pain which initially guides the clinicians' investigation toward forming a clinical diagnosis.

Brief subjective measures were chosen specifically for their applicability and ease of utilization. They proved to be a non-intrusive and practical form of information acquisition which easily fit into a "history taking" and "ongoing evaluation" within a modest private practice. For more in depth evaluation process utilizing psychological measures in guiding physical functional restoration the reader is directed to Gatchel et al., (1986). For scales more focused specifically on the measurement of low back pain, and its impact on behavior, Deyo et al (1986) and Lawlis et al., (1977), respectively, provide additional support.

No attempt to evaluate "hypnotic susceptibility" of the patients was conducted. As Barber has shown the traditional scales of hypnotizability are not necessarily unquestionably reliable (Barber & Wilson, 1977). Finally, since the purpose of this paper is not to address the correlation of "susceptibility" to pain control the use of an untested subject population appeared more representative of the actual clinical population. Further, since formal inductions were rarely used, and no tests of "trance depth" were conducted, "susceptibility tests" seemed an unnecessary intrusion. To the extent that subjects were assigned to hypnotic treatment groups randomly, some generalization can be made. For the purposes of description and representation of the population involved, case vignettes will be presented followed by a summary of findings from the overall population studied.

VIGNETTE #1

Mrs. A. was under care for chronic lumbar myalgia with acute fibrositis, (chronic low back pain). She received spinal manipulation and hydrocolator therapy. Utilizing hypnosis the patient was directed to focus her attention on her low back pain. She was asked simply, as she lay on the adjusting table to imagine how the pain felt. She described the pain as a "sharp pain". The patient was asked to relax but become more and more aware of the sensations she was feeling as she focused on the "sharp pain" and to see if she could imagine how that pain would "look". She described that she imagined a knife in her back.

The patient was encouraged to stay with the imagery to see what the knife looked like. Was it large or small, fancy or plain? As the patient continued to focus on the image she spontaneously described that the knife's blade was fancy and that it was "sort of moving around, like someone was twisting it". She was asked if she could follow the blade to the handle to see if she saw anything. She reported that "a woman's hand was twisting the blade". She was asked to follow the hand up the arm to the shoulder, neck and head and see who was twisting the knife. The patient became tearful and reported that she saw her mother's face. She then indicated that she and her mother were not getting along. She felt that her mother was acting vindictively toward her and her husband due to recent marital problems. She further reported that she had always had a good relationship with her mother, even though at times her mother could be controlling.

The patient was asked to see if she could visualize her mother. She was then encouraged to begin a dialogue with her mother in which an understanding was eventually reached. She then rehearsed in imagery one more time how she would dialogue with her mother. She was then instructed to return her attention to her lower back and "see" how it now looked. She reported that the pain was significantly less and the knife was gone. She was encouraged to visualize her back as relaxed, smooth and comfortable. Her attention was directed to the warmth and relaxing effect

of the hydrocolators as they encouraged her back to enjoy the enriched feeling of relaxation, and to allow stress and tension to flow off her body. After a few minutes the hydrocolators were removed and a standard adjustment was applied.

VIGNETTE #2

Mrs. B. was seen for recurrent cervical myofascitis with cervical radiculopathy (pain in the upper cervical region). Prior to each adjustment she demonstrated significant muscle rigidity and tension. It was believed that a hypnotic relaxation procedure prior to entering the treatment room would facilitate the adjustment.

Mrs. B. was given a 12 minute hypnotic relaxation tape in which she first was guided through a brief breathing awareness exercise, followed by a muscle relaxation exercise, finally she was guided into an imagery exercise where she was to see herself in a safe place where nothing could harm her and nothing would bother her.

She was to notice how peaceful her body felt and how easily it could do whatever she asked of it. She was encouraged to visualize her muscles “however they appeared to her” but to notice how the uncomfortable parts of her seemed different from the comfortable parts. She was to imagine how her unconscious mind, which controlled all her muscles, could allow when it was ready, the uncomfortable parts to begin to become more like the comfortable ones. Upon completion of the tape she could rest comfortably becoming more and more deeply relaxed with each breath until her name was called, whereupon she could then continue to feel this comfortable, peaceful, relaxed feeling throughout the adjustment.

VIGNETTE #3

Mrs. C. was seen for cervical nerve root compression with thoracic myalgia (cervical, shoulder and upper back pain). She presented with a history of chronic pain. After examination it was determined that hypnoanalgesia would be effective in reducing pain to the cervical regions between adjustments. Mrs. C. was taught simple glove analgesia (the numbing of sensation in her hand) and then taught how she could transfer this to her neck and shoulder. There was concern that she would manifest symptom substitution, however, none was reported. Mrs. C. continued to use the glove analgesia “when needed”. She reported that she could work more effectively and for longer periods. Because of her increased ability to work and complete activities she reported an increased sense of control over her life. She appeared less depressed and engaged in less negative language while in the office.

VIGNETTE #4

Mrs. E. was under care for treatment of thoracic intersegmental dysarthria with associate myospasm (pain in the upper back region). In addition, her voice was weak and halting. She evidenced difficulty making eye contact and her posture was hunched. Chiropractic treatment involved spinal manipulation with adjunctive physiotherapy. In addition, Mrs. E was given the self-hypnosis tape to listen to prior to each treatment session.

She requested a copy to take home and utilize. It was suggested that she could have a copy following the completion on the study. During the four weeks, Mrs. E. began to demonstrate both postural and vocal changes. She indicated that she used the tape to imagine herself as a powerful, graceful, catlike creature. She described an increased awareness of her posture and felt that she could “let out” how she felt. Her physical pain demonstrated a marked rate of improvement.

VIGNETTE #5

Mr. F. was seen for chronic lumbar myalgia and myofascitis with concomitant sciatica (chronic low back pain with pain also reported in the lower limbs and intermittently in the shoulder and neck region). A rapid induction was utilized to demonstrate to the patient that he could control his pain and enhance self efficacy. He expressed repeated concern that “he would never get past this pain,” he expressed concern about permanent disability. Mrs. F. was asked if he would like to see if he could “turn off” the pain for a while. He agreed. After a rapid induction a distraction technique was used to demonstrate how he could reduce his “suffering” by focusing away from the pain and his worry about the future.

In a later session, rapid induction was used to help Mr. F. create spontaneous images of his body free of pain by turning down a “pain threshold dial” (an image he spontaneously offered during the end of the second session). Mr. F. stated that he had begun to utilize the technique at home on a daily basis between sessions and that he now felt that he would be able to return to work in the near future. During treatment sessions Mr. F. was instructed to allow himself to “feel” any discomfort he felt necessary to reassure himself that his doctor was aware of any pain he was having and that his “condition” was being addressed. As a result his affect improved and his physical muscular spasticity and tenderness did as well.

VIGNETTE #6

Mrs. G. was under care for lumbosacral nerve root compression and cervical myalgia, (low back, shoulder, neck and leg pain) following a recent accident. Mrs. C.’s primary complaint was that obsessive worry about her “new pain” was preventing her from falling asleep. The resulting lack of sleep was leaving her feeling weak and tired. She attributed much of her physical discomfort to chronic fatigue and worry. It was suggested that she might improve her sleep onset insomnia by learning analgesia as well as relaxation and distraction techniques to practice at night.

An imagery exercise was employed in which she was to enter a room which she had created and see how her body had for forth-three years enabled her to fall asleep. She was encouraged to “see” that her body knew how to fall asleep, and that she could by merely entering the room let her body do for her what it had always known how to do before. A post hypnotic suggestion was offered that she could practice this at home. Mrs. C. reported that following the session she felt “more rested than (she) could remember”. She also reported that she felt “less physically uncomfortable” than she could recall feeling for a long time.

By the end of the four sessions she reported that her sleep had improved. Her pain reports also indicated a reduction in discomfort. The largest change was in her reported feelings of increased self efficacy, reduction of “pain behaviors”, and increased “energy levels”.

VIGNETTE #7

Mrs. H. was seen reporting significant lumbar myalgia, cervical dysarthria with concomitant tension headaches (low back pain and recurrent headaches). Prior to an adjustment she asked if she could speak to the psychologist about her headaches. Upon beginning to describe her discomfort she was encouraged to close her eyes and “see what came to her mind first” as she focused on the discomfort of the headache. She described an image of herself “without money and being forced to leave her home”. (Mrs. H. was in the midst of a rather bad divorce.) She was afraid that she would not be able to take care of herself and her adolescent and teenage sons.

After she vented her anxiety, she was asked to focus on the “negative self-hypnotic statements” she was making to herself. She stated that, she was an “ACOA” (adult child of an alcoholic) and that she was often told as a child that she was “no good” and would “never be able to take care of herself”. As we examined the latter two statements it became clear to Mrs. H. that

they were the claims of her irrational parents and that in fact, she was the one who had always taken care of herself and her current family.

She was encouraged to focus on how she had taken care of her family (her husband being abusive and providing minimal to no support) and how she could continue to do so. Finally, she was instructed to “listen” for a voice as she imagined herself taking care of herself and her sons. She indicated she could “see and hear” her grandmother, telling her she was “good” and that she was “doing the right thing” and that she would be “alright”. Mrs. H. cried for a moment or two, then opened her eyes. By the end of the session she reported that her back pain and headache had somewhat diminished. Additional counseling was recommended.

In this instance, no formal induction was used and yet the patient had a very strong emotional and physiological reaction resulting in pain reduction. The total time of the session was approximately 16 minutes. Mrs. H. was then seen for her standard chiropractic adjustment and adjunctive treatment.

Hypnosis does appear to offer some treatment benefits over its absence within a general back pain population. Further, the effectiveness of any health professional will in the future rely upon their ability to treat not only the specific presenting condition but also depend largely upon their perception of the individual as an integration of mind, body and spirit. This is especially true for conditions which are affected by stress and psychoneuroimmunological functioning. Rossi (1988) states that “many types of chronic pain and recurrent symptoms and problems are actually information transducers that amplify the minimal stress signals of the mind/body”.

And finally, Borysenko (1988) suggests that “we are entering a new level in the scientific understanding of mechanisms by which faith, belief and imagination can actually unlock the secrets of healing”. She points out the importance of the mind/body connection and presents both vignettes and exercises useful to patients and practitioners alike.

It is hoped that this very preliminary paper will raise many more questions than it attempts to answer about the role of hypnosis in the treatment of low back pain.

The scope of this paper has been limited to the use of hypnosis in the treatment of back pain and suffering, however, the average back pain patient’s needs usually exceed pain and suffering reduction. As mentioned earlier, hypnosis has been utilized for other health related conditions including smoking, with loss, habit control, anxiety, stress management and improvement in immune system functioning.

As the emphasis of treatment shifts from “merely identifying pain and physical etiology” to an emphasis on the “total functioning” of the individual, hypnosis will play an increasingly important role. However, psychopathological involvement is often concomitantly involved. Lifestyle changes must be approached with caution and with full knowledge of the potential abreactions and “inner psychic” turmoil of the patient. The purpose of this paper has been toward broadening the understanding and investigation of hypnosis and exploring its practical utility in treating back pain patients.

The current research suggests that hypnosis may be an effective adjunctive modality which should be considered within the scope of the back pain specialist. In this paper the efficacy of hypnosis was not compared to other more traditional techniques of pain control such as biofeedback, progressive relaxation, acupuncture and acupressure. Previous research has made many of these comparisons.

The vignettes presented in this paper reflect individual cases from a previous study which offers support to the hypothesis that hypnosis and self-hypnosis are an effective tool in pain control and in reducing patient “suffering”.

Hypnosis may open many doorways into the deeper needs of our patients, but we must be prepared and equipped to step through.

