HYPNOTHERAPY OF A PAIN DISORDER:
A Clinical Case Study

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Abstract: Hypnotherapy’s effectiveness in improving and controlling chronic pain of various etiologies has been demonstrated by studies; the mechanism by which hypnosis does this is more complex than a simple induction of muscle relaxation. This study reveals, in addition to this mechanism, a deeper dimension of hypnotherapy from the vantage of a patient with a medical-surgical background, diagnosed with a pain disorder and major severe depressive disorder in addition to incurable painful symptoms, through treatment associated with hypnoanalysis. Following psychotherapy, which included some elements of cognitive-behavioral therapy, a complete remission of the anxious-depressive mood and the painful symptoms was achieved.

The purpose of this article is to present the role of hypnosis in the treatment of a patient suffering from chronic pain and who developed over time a severe depressive disorder in addition to the pain symptoms. The therapy methods used were mainly Ericksonian hypnosis and hypnoanalysis, in association with cognitive-behavioral therapy elements.

Medical Background

The subject is a 53-year-old female with no psychiatric history but a high medical-surgical background due to her chronic pain symptoms. These started in October 2006 with stabbing and stinging pain in the left shoulder, radiating down the left arm to the elbow, increasing with movement but with no numbness. It seems the pain started because of a psycho-physical overload (her daughter’s wedding, for which she cooked for a week for 30 guests, and her work at her firm where she was in charge of accounting, which she disliked). After onset came a long series of medical investigations and treatments, of which I mention the most important:

Address correspondence to Henrieta Mihaela Artimon, C. F. General Hospital, 21 Constantin Noica Street, Sibiu, 550357, Romania. E-mail: mihaela_artimon@yahoo.com
• A functional Magnetic Resonance Imaging (fMRI) of the cervical spine (March 2007); early changes of the cervical spondyloarthrosis and polydyschondroplasia, most evident at C5-C6.

• Surgery for cervical spinal stenosis (July 2007, Neurosurgery Clinic, Cluj, Romania); no improvement of the symptoms postsurgery.

• Electromyogram for paravertebral muscles (March 2008); it appears unlikely that it's a brachial plexus injury; it's possibly C6 or C7 radiculopathy aspect of the outbreak of local demyelination.

• Doppler ultrasound (March 2008); normal movement in the common carotid artery and its branches and in the subclavian artery. No significant adenopathy or tumor at the later-cervical subclavian overlapping level; no changes of brachial plexus roots.

• Cervical fMRI (March 2008); C5-C6 spinal block with no brachial plexus injury and no compressive cervical disc lesions.

• Hospitalization in the Rehabilitation Clinics of Cluj (May 2008), where they recommended anti-inflammatory medical treatment and physiotherapy, with no alleviation of symptoms; shoulder ultrasound performed in the hospital showed minimum acromioclavicular joint effusion and scapular-humeral joint.

• Seen at a neurology practice in Munich, Germany (January 2009); possibly a cervical radicular syndrome with no myographic disturbance.

• Seen at a rehabilitative medicine practice in Munich (January 2009); generalized tendomyotic syndrome; they recommended Amitriptyline retard 25 mg/day; the patient followed the treatment only sporadically.

• Surgery (July 2009, Sibiu, Romania) for subacromial impingement syndrome of the left shoulder; postsurgery there was no symptomatic improvement.

• Left subacromial synovectomy with decompression (November 2009) in a private clinic in Vienna, Austria, followed by physical rehabilitation and physiotherapy, also with no symptomatic improvement.

Despite the recommended treatments, the pain in the left shoulder and arm persisted, aggravated by even minimal movements and, in certain body positions, and becoming quasi-permanent and disabling. The patient’s mental state devolved into depression and anxiety with an obsessive fixation on the symptoms and fears of incurability, feelings of despair, and a desire for death. She had her first psychiatric appointment in April 2011, on the recommendation of a friend who attended psychotherapy meetings for a depressive episode. Psychological tests revealed high scores on depression and anxiety scales: a 37 on the Hamilton Depression scale and 33 on the Hamilton Anxiety scale.

Colligating the interview, the psychological tests, and the clinical and lab data led to the diagnosis of major severe depressive episode without psychotic symptoms and somatoform pain disorder.
PERSONAL AND FAMILY BACKGROUND

The patient belongs to a peasant family that focused a lot on working without giving any importance to relaxation; they had practically no notion of spare time. The patient was inculcated with these values at a very early age; her childhood was marked by responsibility. At the age of 8, her mother charged her with the care of her younger brother, a few months old, and in 2 years she also had to take care of her newborn brother. Her mother had a marked lack of affection toward the patient. Her mother always had a critical attitude toward the patient, often physically assaulted her (pulling her hair), and gave her household and agricultural tasks, as if she was an adult. The patient graduated from high school, got married (her marital relationship is very good) and gave birth to a daughter, now aged 30 and married. In 7 months, the patient is to become a grandmother, and she realizes she will not be able to help her daughter because of her health problems. In the last several years, she and one of her brothers had a small family business, but she stopped working there about 2 years ago due to her health. She has a good financial situation, and there were no identifiable recent psychiatric trauma or extremely stressful factors.

Treatment and Evolution

It was agreed, jointly, on a treatment plan that included anxiolytic treatment (Alprazolam 1 mg/day) and hypnosis, initially for 4 to 6 weeks (for controlling anxiety and to enable the psychotherapeutic approach) and psychotherapy, which included mainly Ericksonian hypnosis and hypnoanalysis in combination with cognitive-behavioral techniques.

The original goals of psychotherapy were to improve her general mood, eventually the remission of anxiety and depressive mood, and to control her pain symptoms in the first stage. The awareness of the pain’s psychogenic nature, improvement, and even disappearance of the pain were the objectives proposed to the patient for the second stage of the psychotherapy.

The therapy was conducted over 1 year and 3 months, with sessions twice a week in the first month, then once a week, with a break of about 1 month approximately 1 year after initiating therapy, when the patient was abroad to visit her daughter (a total of 65 sessions). The first 10 sessions were aimed at anchoring her resources and strengthening the self of the patient by influencing the unconscious through Ericksonian hypnosis, by experiencing the relaxation, by offering explanations on the connection between mind and body, through prescribing some behaviors (avoid focusing attention on symptoms), and by offering some direct suggestions, such as “I can control the pain, influencing
my thoughts and behavior." After the first 10 sessions, the patient’s mood improved significantly and even the painful symptoms became less frequent.

The next eight sessions aimed at transforming the pain’s unpleasant, unbearable sensations into ones that were more tolerable and even pleasant, both in the case of hypnosis scenarios and of prescriptions of guided imagery for at home (self-hypnosis). Also, it was suggested that she release the repressed emotions of the symptoms. Examples of some suggestions used in during hypnotherapy were the following:

Be aware of the unpleasant sensations, knowing that each cell of your body contains a piece of information, emotion . . . the history of your current symptoms. As you realize the sensations of the tensest part of your body, your unconscious mind can choose to convert them into more agreeable, more restful sensations . . . And as your unconscious mind transforms your body sensations, you can rewrite the history of your current symptoms . . . Because the mind affects the physical body, and the physical body influences mind.

The evolution was extremely positive, with the patient achieving good control of her symptoms and becoming aware of the connection between her mental status (irritability, anxiety) and her symptoms’ intensity, a fact that initially scared her because she believed it would be hard to treat. But reconsidering this as a positive and useful thing in therapy calmed her very much. It also changed the pain’s character; from intense and sharp, it became more diffuse and stinging. It was also explained to the patient how, over time, she consciously maintained her pain through all the attention she gave it with medical investigations, treatments, and diagnostic labels, so that her somatic illness became reality.

The next several meetings focused primarily on the deeper significance of the pain’s correlation with the patient’s life background and with her personality traits. The use of subpersonality technique in hypnoanalysis revealed this link between the current symptoms and the patient’s relationship with her mother; the patient had a catharsis during the hypnotic trance. This meeting was followed by a significant dream: The patient dreamed that her mother was having a baby, and she (the patient) was looking at her while she was holding a kind of jellyfish, which she said was “a mixture of ovule and sperm.” The dream was interpreted as a regression to her own conception and birth. During the sessions focused on past events that might be responsible for her current problems, the patient recalled, while in trance, a series of traumatic experiences from childhood and adolescence, which I discussed with her afterward and stressed the importance of their role in shaping her adult personality. The patient recorded high scores on the scales of dysfunctional attitudes (she is a perfectionist with a strong superego, even
tyrannical, but she does not trust herself, generally having the feeling that she does not do “enough” or she does not do things “quite well”; she wants to please everybody and to leave a good impression thus she cannot say “no”).

I encouraged her to talk about her feelings for her mother, and she admitted that she cannot love her, she just respects her, and she feels guilty for this but also for “speaking badly about her mother.” I reframed these feeling to make them acceptable explaining to her that this is human nature and how we are built, and it is natural that, if she did not receive her mother’s love, she could not feel it too. Following this approach in therapy, the patient visited her mother and told her: “You never told me that you love me, you only criticized me, I never felt your love.” Her mother replied: “I had to work, I had no time for this.” After this dialogue with her mother, the patient had an anxious-depressive relapse with increased pain intensity. She said: “I got mad that she does not realize even now.” Next followed a hypnotherapy approach of the resources of acceptance and forgiveness, as well as self-building techniques. I also used hypnotherapeutic scenarios suggesting acceptance, love, and self-worth (e.g., “Embrace yourself every time you see you again”).

The hypnoanalysis sessions alternated with hypnosis sessions aimed at restructuring the patient’s cognitions that were used to predict consciously, but automatically, the symptom and its manifestation. Moreover, we pursued acceptance of the pain, when it occurred, and its reframing as a barometer of her mental state and irrational behaviors (she noticed that when doing certain household activities or receiving guests, she usually has a “sense of urgency” and the feeling that someone is criticizing her—internalization of the maternal criticism—and, in such cases, the symptoms reappear).

In one of the hypnoanalysis sessions she remembered, as a child, that her mother used to wake her up early in the morning and send her to work in the field. She was never able to sleep as much as she would have liked. In trance, I administered the following suggestion:

I would like to tell the little girl in you that tonight she will sleep and have dreams, and in the morning she will wake up whenever she wants, she will open her eyes for a while and then she will close them back, or maybe she will stretch before getting out of bed, staying relaxed and quiet.

Two days after this meeting, the patient dreamed her mother died. She cried in her sleep and suffered a lot. When she woke up, she was glad it was just a dream, and she realized that she actually loved her mother; this awareness had the function of releasing her feelings of guilt about the failure to love her. The dream may have represented her unconscious desire for her mother to die, a symbolic death, liberating her from the conflict, itself unconscious, between the intense need for her
mother’s affection and the failure to receive it (this interpretation was not communicated to the patient, so as to not induce further feelings of guilt). After this dream, there was a significant improvement in the patient’s pain symptoms.

The behavioral prescriptions were aimed, in addition to symptom control, at changes in her daily activities: to have more time for herself for relaxing activities (she started to ride a bike in the park, where she lingered in a favorite place and experienced self-hypnosis techniques) and to educate herself to put off household activities she usually hurried to complete immediately (trance suggestion: “Take from the hypnosis’ time as much as you need, whenever you need time”). Moreover, I wanted the patient to be aware of her own limits and not to let them be violated. In terms of cognitive requirements, I recommended that the patient recognize the automatic thoughts that anticipated her painful symptoms and be aware of their irrationality, replacing them with positive autosuggestions, such as “I’m more relaxed” or “I can feel increasingly better.” Also, I worked with her dysfunctional attitudes, focusing on replacing “have to” with “I’d rather.”

The patient’s progress was extremely favorable, with complete disappearance of her depressive and anxious mood, with good social and family functioning, with significant behavioral changes (she became more assertive, she set better limits, and blamed herself less), and I noticed significant improvements in pain complaints; thus, at some point (after the forty-sixth session), she said that the pain did not reappear unless she thought about it. After the fiftieth session, the patient said she was not afraid of the pain’s recurrence and reported a complete remission for 3 weeks! However, after this, a minor and unexpected event happened: a visit announced only with 2 to 3 hours prior from some relatives from a different town, which induced in her again the performance anxiety related to their arrival. She stated that she perceived their visit as a considerable mental stress, and, during the night that followed the visit, she dreamed that she was in her parents’ home as a child, then a young unmarried lady, and that she was telling her parents that she must go to see a doctor, and she was repeating in her thoughts what she was going to tell him, how to describe her symptoms so he could understand her. The next morning she woke up again with the painful sensations in her shoulder and arm. I worked with this emotional and residual cognitive material in hypnotherapy with the complete resolution of the symptoms during the trance. This remission was maintained for about a week, after which the painful sensations reappeared sporadically (especially when she anticipated them) as local embarrassment, mild contracture or stinging, controllable symptoms by the patient through self-hypnosis or different cognitive-behavioral methods. After another four sessions, the pain disappeared completely;
this remission correlated with changes in the patient’s personality structure with reconciliation with traumatic childhood experiences and their integration in a new perspective.

**Results**

This study presented the case of a patient suffering from somatoform pain disorder that had multiple investigations and medical and surgical treatments with no results. The patient subsequently developed a severe depressive disorder and evolved extremely favorably under hypnotherapeutic and cognitive-behavioral interventions. The therapy goals were achieved entirely, resulting in a complete resolution of the anxious-depressive mood and of painful symptoms. At follow-ups made at 3 and 6 months posttreatment, it was found that these results were maintained; the patient no longer had any somatoform rebound and continued to have a good social and family functioning.

**Discussion**

The muscle pain symptoms were interpreted as an expression of the unconscious conflict between the need for approval, appreciation, and love from the mother and the impossibility of having this need met, generating guilt and feelings of inferiority. Her unconscious cognition was “If my mother did not love me/does not love me, it is probably because I do not deserve love (I’m a bad girl/a worthless human being/ineffective).” Consequently, the patient developed perfectionist behavior and performance anxiety, as well as a suppression of aggression, culminating in painful somatization. The factors that contributed to the success of the therapy were the patient’s motivation, a very good therapeutic relationship, and some psychological characteristics of the patient, such as the ability of self-analysis, self-mobilization in applying the therapeutic prescriptions, and good hypnotizability. These factors are common factors of success of hypnotherapy in general; good hypnotizability (Barabasz & Watkins, 2011) and the practice of self-hypnosis can be related to increased self-control of pain to “reduce anxiety, improve sleep and enhanced quality of life” (Elkins, Jensen, & Patterson, 2007, p. 286).

The hypnosis was the basic therapeutic modality in approaching this patient. The hypnotherapy has been extremely useful in the following:

1. Inclusion of body in the therapy and patient’s different perception of the body, due to the following:
a. Hypnotically experienced sensations, including dissociation of body experience;
b. Direct suggestions for changing the painful sensations into others that are more agreeable;
c. Self-hypnosis as a modality of self-control of emotions and painful symptoms. In this case, the Jacobson relaxation has not been proven, because it focused the patient on the symptom; instead, symptom dissociation guided by imaging was particularly useful for pain management, but without its repression in a hidden state of the ego (Watkins & Watkins, 1990), the pain itself being an expression of repressed ego-state of patient.

2. Anchoring individual resources for change.
3. Exploring the unconscious conflicts and release of the repressed emotional material through hypnoanalysis.

Studies in the literature confirm the effectiveness of hypnosis as well as of the cognitive-behavioral procedures in the treatment of chronic pain treatment of various etiologies (Elkins et al., 2007; Morley, Eccleston, & Williams, 1999). Some studies (Kirsch, Montgomery, & Sapirstein, 1995) observed a significant increase in the efficiency of cognitive-behavioral therapy when the hypnosis was associated with the treatment of a variety of mental and somatic disorders, including chronic pain. Others (Gay, Philippot, & Luminet, 2002), comparing the effectiveness of Ericksonian hypnosis with Jacobson relaxation on patients with osteoarthritis pain, reported that the benefits occur faster in the group treated with hypnosis. These observations are complementary to the study of Miller, Barabasz, and Barabasz (1991), concluding with observations of pain perception of subjects undergoing suggestions for relaxation or an active-alert hypnotic induction and that the relaxation is not necessary to obtain hypnotic analgesia. There are also controlled trials (Freeman, Barabasz, Barabasz, & Warner, 2000; Smith, Barabasz, & Barabasz, 1996) indicating that the hypnotic analgesia mechanism is not a distraction but dissociation, according to Hilgard's theory. Hypnosis produces an attenuated brain response to painful stimuli, confirmed by EEG potentials studies in correlation with hypnotic analgesia (Barabasz, 2000; Ray & De Pascalis, 2003; Spiegel, Bierre, & Rootenberg, 1989).

Positron emission tomography (PET) studies on modulation of pain perception by hypnosis show that hypnotic modulation of pain is mediated by the anterior cingulate cortex, and perception of the noxious stimuli are reduced during the hypnotic state (Faymonville et al., 2000). Also, the hypnotic state enhanced the functional modulation between the midcingulate cortex and a large neural network involved in sensory, affective, cognitive and behavioral aspects of nociception (Faymonville, Boly, & Laureys, 2006).
The clinical case I presented offers, in addition to highlighting the role of relaxation and hypnotic analgesia in relieving and controlling pain symptom, a deeper dimension to the usefulness of hypnotherapy in the treatment of pain by exploring unconscious conflicts and through suggestions for change that favored and enhanced the related cognitive-behavioral interventions. I used pain as a gateway to the unconscious conflicts with painful symptoms being an expression of the patient’s child ego-state. Reassurance and encouragement of this ego-state by means of hypnotic scenarios were a basic therapeutic modality in this case (according to Watkins’s ego-state therapy). In this way, the hypnotherapy has accelerated the positive progress of the case by means of patient experimentation of previously unknown facts. The literature confirms the high efficiency of hypnoanalysis in treating various neurotic disorders in comparison to psychoanalysis, which would require a much larger number of sessions (Barabasz & Watkins, 2011; Watkins, 1995), and also in comparison to cognitive-behavioral therapy in accessing trauma memories, which are encoded in the subcortical-subconscious brain regions (Barabasz, Barabasz, & Watkins, 2011). “Coexperience” (Watkins, 1995) is essential in this process with the therapeutic relationship thus becoming the strength of hypnoanalysis.

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REFERENCES


**Hypnotherapie bei Chronischem Schmerzsyndrom: Eine klinische Fallstudie**

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**Stephanie Reigel, MD**
L’hypnothérapie pour le soulagement de la douleur: Une étude de cas clinique

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Résumé: Des études ont montré l’efficacité de l’hypnothérapie pour soulager et maîtriser la douleur chronique associée à diverses maladies et qu’il ne s’agit pas d’une simple relaxation musculaire. La présente étude révèle de plus, grâce à des traitements liés à l’hypnoanalyse, une dimension plus approfondie de l’hypnothérapie pour les patients ayant des antécédents médicaux et chirurgicaux et qui souffrent de douleurs et d’une dépression grave associée à l’incapacité de soulager la douleur. Après une psychothérapie comprenant des éléments liés au comportement cognitif, l’hypnothérapie a donné lieu à une guérison complète du trouble anxieux dépressif et à l’élimination de la douleur.

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Hipnoterapia para el trastorno de dolor: Un estudio de caso clínico

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Resumen: La investigación ha demostrado la eficacia de la hipnoterapia para el mejoramiento y control de dolor crónico de varias etiologías; el mecanismo mediante el cual la hipnosis produce estos efectos es más complejo que una simple inducción de relajación muscular. Este estudio revela, además de este mecanismo, una dimensión más profunda sobre la hipnoterapia desde la perspectiva de un paciente con un antecedente médico-quirúrgico, diagnosticado con un trastorno de dolor y un trastorno depresivo mayor reactivo a los síntomas de dolor incurables, a través de un tratamiento asociado con hipnoterapia. Después de la psicoterapia, que incluyó algunos elementos de la terapia cognitivo-conductual, se logró una completa remisión del estado de ánimo ansioso-depresivo y de los síntomas de dolor.

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