

Treating the Cognitive and Emotional Components of Persistent Pain

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Physicians only have partial success in helping patients with chronic pain obtain relief (Eimer, 2000, 2002; Eimer & Freeman, 1998). Pain relieving drugs have unpleasant side effects and often don't diminish the pain enough. Furthermore, the psychosocial ramifications of persistent pain are not amenable to a medical solution. However well meaning, the physician cannot repair the narcissistic wounds the patient sustains through loss of his social and vocational role status. Thus, the physician who must deal with such painful conditions as arthritis, fibromyalgia, chronic fatigue syndrome, low back problems, chronic headaches, reflex sympathetic dystrophy, thalamic pain syndrome, interstitial cystitis, post-herpetic neuralgia, idiopathic pelvic pain, and chronic dental pain, is sometimes at a loss as to how to lessen the suffering.

Pain AND Suffering

Study after study emphasizes the need to separate the word "pain" into two words – "pain", meaning the objective, measurable, neurophysiological signal, and "suffering", meaning the subjective, emotional, and evaluative response (Ewin, 1978, 1992). In fact, as far back as the 1960's, before Pain Medicine became a medical board specialty, Melzack and Wall (1965) posited a multidimensional system for classifying pain: the sensory-discriminative dimension, the motivational-emotional dimension, and the cognitive-evaluative dimension. These dimensions, or components, of the pain experience guided the development of Melzack and Wall's "Gate Control Model" of pain, and the development of Melzack's famous McGill Pain Questionnaire (Melzack,

1975).

The major motivational and emotional challenge that many people with chronic pain confront is coping with the permanence of their underlying physical injuries. Given the nature of pain as a survival-oriented, signaling system between body and brain, this permanence, and the emotional overlay, sets up a reverberating pain circuit between the brain and the rest of the body (Melzack, 1996; Melzack & Wall, 1982).

The Challenge

On one level, there is habituation. The patient adaptively learns to function amidst ongoing nociception. On another level however, there develops a hypersensitivity (and pre-occupation with) to pain sensations (i.e. nociception), which is only adaptive if the pain changes, possibly indicating a worsening of the existing injury, or the emergence of a new one.

The net result, in many cases, is adaptive dysfunction and disability, which is often worsened by a system that frequently rewards suffering and dysfunction, and punishes getting well, through monetary incentives. The combination of the survival value of pain as a signal that something is physically and/or emotionally wrong, along with its psychosocial benefits, creates a formidable obstacle to getting well.

Despite the enormity of the challenges, there is a whole body of work in the psychological literature that has demonstrated that these obstacles can be removed, and that the motivated, persistent pain patient can be helped to obtain greater pain relief without more drugs (Eimer & Freeman, 1998; Gatchel, 2005; Turk, 2002).

Fear, dread, helplessness, and powerlessness are emotions commonly stirred by persistent pain, and these emotions color the patient's perceptions, very often increasing

the patient's suffering immeasurably. However, the negative emotional and imaginative aspects of pain are often amenable to good hypnotherapy (Cheek, 1994; Cheek & LeCron, 1968; Crasilneck & Hall, 1975; Ewin, 1978, 1992; Hilgard & Hilgard, 1975; Zarren & Eimer, 2002).

Good hypnotherapy can relieve suffering because hypnosis deals with imagination, instincts, emotions, and value judgments. The insights cultivated from experience with hypnotherapy can provide valuable information for helping the patient cope with persistent pain. The person who is disappointed when he sees his proverbial glass as half empty can be elated by realizing that the glass is half full.

Inducing Positive Feelings and Expectations

When anxiety and suffering are removed, it appears that pure pain does not hurt as much (Ewin, 1978). For example, when a needle pierces the skin to draw blood, the skin is being injured, the pain receptors are stimulated, and pure pain is produced. However, the patient may or may not suffer. Whether or not he does, is determined by how he feels about needles, drawing blood, white coats, the doctor's office, the circumstances for which blood is being drawn, and so forth. The same principle applies to visits to the dentist.

How many people dread going to a dentist who habitually either does not talk with his patients, or says, "Brace yourself, this will hurt"? On the other hand, the dentist who had made it a habit of talking with his patients and saying things like, "You are going to feel pressure [pure sensation absent the emotional and suffering component]. It will go away soon" [lack of permanence], probably has more comfortable and happier patients!

Hypnosis Is a Natural remedy for Pain AND Suffering

These facts are what make hypnosis so effective for relieving persistent pain. Pain is involuntary. It comes without effort, and a good hypnotic state is also involuntary (achieved without effort). As with many things in life (e.g., falling asleep, swallowing, urinating, having an orgasm), effort is counter-productive when it comes to entering hypnosis. It is also counter-productive when it comes to coping with the experience of physical pain. Note that we are not referring to the necessary effort that needs to be put into rehabilitative endeavors, such as reversing de-conditioning through a graded exercise program, improving endurance and so forth.

Pain is made worse by negative daydreams and the imagination. Hypnosis is a state of controlled positive daydreaming, and as Hilgard (1991) pointed out, “believed-in imagination”.

Pain is made worse by negative attention and over-preoccupation with it as the focus of attention. Hypnosis involves the redirection of attention.

Pain is associated with tension and stress. Hypnosis is associated with relaxation and comfort, the emotional and physical opposites of the former.

Persistent pain is associated with feeling helpless and out of control. Hypnosis can give the patient a greater measure of control of his feelings and thoughts. This can translate into a different experience of the pain symptoms and a greater feeling of control over them—i.e., better coping.

In the hypnotic relationship, when the hypnotherapist asks the patient in trance, “Would it be all right for you to experience a small amount of pure pain as long as it is at a tolerable level?”, he opens up a new doorway of possibility. That is that it is possible to

hurt less. Nothing objective may have changed, but the patient who grants this permission feels he has regained some control in the moment. He can then be helped to extend that control over time to keeping the pain at a tolerable level.

No More Wild Imaginings

All human beings are capable of imagining the worst, and early in the evaluation of a pain problem, the clinician should comment on this universal human tendency and advise the patient of the harmful effects of harboring, nurturing, and hiding these fears. The more laboratory tests and consultations that are undertaken in search of “the cause” of the pain, the more time the patient has to wonder about himself and let his imagination and fears take over. Chronic fear of the unknown is a debilitating emotion, and unabated, it often leads to depression.

In a good trance, a patient will let down his defenses and be more open to dealing with his hidden fears. The patient’s suffering is alleviated not only by removing his unreasonable fears but also by analyzing his problem (Remember the first intake question: “Tell me about your problem.”) and demonstrating how much suffering unbridled emotion can cause. Just making a diagnosis of emotional overlay and teaching the patient how to deal with his emotions takes away much of the mysteriousness of the condition, and gives the patient hope that, with practice, he can regain control of himself.

Conviction of Benefit Blocks Suffering

The conviction of benefit blocks harmful emotions and consequent suffering. Harold Beecher’s (1946) often quoted battlefield studies illustrate his conclusion that “there is no simple direct relationship between the wound per se and the pain (suffering) experienced. The pain is in very large part determined by other factors, and of great

importance here is the significance of the wound In the wounded soldier [the response to injury] was relief, thankfulness at his escape alive from the battlefield, even euphoria: to the civilian, his major surgery was a depressing, calamitous event.”

Constant Pain

The *Constant Pain Syndrome* can be diagnosed readily, and may not be amenable to any treatment other than hypnoanalysis. The patient will say the pain is constant, NEVER goes away, and “I live with it”. The therapist should show skepticism and challenge the patient with “What about when you’re asleep?” If the patient insists that he falls asleep in spite of the pain, and is aware of it immediately on arising, he is asked, “Since this started, has there ever been any time when you were *completely* free of pain?” If the patient answers “NO” to this, it’s unlikely that the pain is physical.

Physical pain is rarely, if ever, constant. Cancer pain can be completely relieved for several hours by opiates. Arthritis has remissions, or is relieved temporarily by treatment. Even the pain of a ruptured disc will relent for a short time by resting in certain positions.

“I live with it” implies that I cannot be alive without it, or more literally, the pain equates with life itself. No one can be without life for five minutes, and having this idea means that the patient cannot be without pain (i.e. life) for five minutes. The therapist who proposes to end this type of pain (life) is a threat to the patient, and the intuitive therapist can see that an attack on the pain with direct suggestions will be rejected even in deep trance. The patient needs hypnoanalysis.

The *constant pain syndrome* is characterized by the simultaneous occurrence of three things (Ewin’s triad): (1) *mental disorientation* in which the patient may have had a

concussion, a drug overdose, a stroke, an anesthetic, or even a lucid dream causing him to be unable to think clearly and respond in a normal way; (2) *fear of death* in which the experience is perceived as life threatening; and (3) *pain*.

Being mentally unable to deal with the perceived threat of death, the presence of pain is reassuring to the subconscious mind that he can't have died yet. When such a triad has occurred, and the patient has recovered normal waking mentation, the subconscious still clings tenaciously to the deeply imprinted idea that pain equals life. Therapy involves regression to the incident and accepting that it was a good idea at the time, but that it is no longer helpful.

Pain Reframe

We regress the patient to the time of the pain's onset and affirm the patient's perception that at the time when other signs of life were lacking, it WAS reassuring to feel the pain. We emphasize that this was only temporary. We suggest in trance, that *now that all the usual signs of life are present, and continue to be present, you can be alive without the pain rather than live with it. The pain had value at the time it began, but now there are all of the usual ways of knowing that you are alive. Wouldn't it be nice to experience a few minutes in trance of being pain-free and still alive?* An IM YES answer to this question is a point of entry in helping the patient relinquish unnecessary pain.

No Pain Lasts Forever

Patients who have persistent pain, especially if its cause is obscure, tend to ask themselves. "When will I ever get relief?" and "Can I stand it indefinitely?" With the patient in trance, it is helpful to give the simple direct suggestion that "no pain lasts

forever”. Repeating this suggestion at each visit plants the thought that the pain is NOT interminable, and this gradually becomes comforting for the motivated patient.

Other Negative Emotions Need To Be Let Go

If while in trance the patient reveals that guilt is a problem, the remark that *perhaps you have suffered enough to make up for the fault*, often will suffice as a start in terminating the self-punishment.

The cure for resentment and blame is an old one: FORGIVENESS. We point out to the patient that he is the one who is suffering, miserable and disabled, not the object of his anger. We may also take the strategy of assuming the role of spokesman for the patient’s adversary, apologize for the physical injury and hurt feelings, and ask for forgiveness. Patients are often not ready to forgive immediately, but when they do, their suffering is greatly relieved and their ego is boosted. They feel that they are somehow a better person for it.

In sum, it is helpful to reframe pain as being a subjective experience consisting of two separate but interacting entities: the physical (nociceptive) pain sensations and the emotional suffering. The physical, anatomic, and electrochemical aspects of pain are treated as medically indicated by physical therapy, medicines, nerve blocks, electrical stimulators, and surgery. The suffering component involves the patient’s (1) non-acceptance of the pain, (2) fear of the unknown, (3) pessimistic evaluation of the meaning of the pain, (4) feeling of no time limit on the suffering, and (5) often self-destructive feelings of guilt, resentment and anger. These emotions and imaginings are amenable to good hypnotherapy. When suffering is removed, pain tends to become tolerable, and it may even disappear.

Case Examples

A.G. was a 42 year-old white female, Ph.D. psychologist seen by DME. She complained of a constant headache “as long as I can remember”. She had extensive medical work-ups and was diagnosed with “nervous headache”. She had undergone psychoanalysis in seeking a cure. Both she and her analyst believed that there was significance in a recurring dream she had had since age 4 or 5 years, in which she is looking out the window watching her father bury something. She experienced anxiety just by talking about this dream. She admitted that somehow she felt that she was the thing that her father was burying. However, this insight did not yield a cure.

The patient went into trance easily and IMs were set up. She was first asked to review on a subconscious level her memories of what caused the headaches and what it meant to her, giving an IM signal with her thumb when she had completed this task.

Questioning proceeded as follows:

DME: Would it be all right for you to go back and relive the experience again just as though you were there?

IM: NO. [Comment: This is usual with a death experience as no one wants to go back and die again!]

DME: Would it be all right for your fingers to answer some questions about it?

IM: YES.

DME: Yes. Okay. Did this happen before you were one year old?

IM: YES.

DME: Yes. Did this happen after your birth experience?

IM: YES.

[Comment: The retrograde search led to her tenth day of life, which was established as the date.]

DME: Does what is happening make your head hurt? [Comment: DME has shifted to the present tense.]

IM: YES.

DME: Yes, it makes your head hurt. Are you sick?

IM: NO.

DME: No you are not sick. Have you been injured?

IM: YES.

DME: Yes you have been injured. Are you afraid you are going to die?

IM: [No IM response.]

DME: Is your father there?

IM: YES.

DME: Yes, your father is there. Does he say something that affects you?

IM: YES.

DME: Yes he does. Is it all right to know what he is saying?

IM: [Patient begins to cry.] “She is going to die. . .she is dead.” [continues to cry and tremble.]

DME: But you survived. It is [date] and you are here, safe with us at this symposium.

You got well. You are all right. Come back through the years, back to the present, to today [date] here with us. Safe. Now, you can look back through the years and know in the deepest part of your mind and being that you did NOT really die and you are quite intact and okay. You have earned an advanced

degree, you are working regularly, you are successful, and you run a household.

When you know this on a feeling level, your yes finger will lift.

IM: YES.

DME: Yes. Good. When this happened, was the pain the only way you knew you were alive?

IM: YES.

DME: Yes. At the deepest levels of your subconscious mind, does the headache give you a sense, some sense of reassurance that you have not died yet?

IM: YES.

DME: Yes. Okay. Since the pain was the only way you knew then that you were alive, when it happened, it must have been very reassuring then.

IM: YES.

DME: Okay. Yes. But do you really need it now that you have so many other ways to know that you are still alive?

IM: NO.

DME: No. You no longer need it. That's wonderful! Since you don't need it any longer, why don't you just let it go?

IM: [None. Patient shows some agitation and spontaneously roused from her trance without answering. She then commented:]

P: This has been a very moving experience. [But she still had a headache.]

The foregoing took place at a pain symposium where the patient had volunteered for a

demonstration of hypnoanalysis. Significantly, on the preceding day, she had watched a

movie
showing an African healer treating a native by incising the scalp and scraping the skull to
let out
the demons. The native patient in the movie was wide awake in a trance-like state
throughout the
procedure and showed no signs of pain. The psychologist patient watching the film
became so ill
that she had to get up and leave the theater. The film somehow had stirred up her
memory of the
traumatic event that had happened on the tenth day of her life, that made her father say,
“she is
going to die”.

On the evening of her first trance, the patient had an exacerbation of her head pain
and
she got very little sleep. Apparently, her instinctive sense of self-preservation could not
lay aside
a symptom that for so long functioned as a marker for life itself. The next day I
(DME) hypnotized her privately.

In trance, I reassured her that there was no hurry and that even though she knew
she did
not need the headache any longer, no one could make her give it up until she was ready to
do so. This was reassuring and reestablished her sense of control.

DME: Would be all right with your feeling mind to be completely free of the pain for

five minutes, knowing that you can resume it instantly if you choose to do so?

IM: YES.

DME: Yes. Great. Your yes finger will lift when you are completely free of the pain.

IM: A few seconds later, her yes finger lifts, and she spontaneously smiles.

DME: Yes. Great. Now, <Name>, enjoy 5 minutes of complete comfort.

[Before the five minutes are up, DME continues . . .]

DME: Now <Name>, because you can be free of that pain for 5 minutes, I wonder if you can extend this relief to 10 minutes? Answer with your fingers.

IM: YES.

DME: Yes, you can. That is great. Now enjoy a few more minutes of complete comfort.

[Silence]

DME: How do you feel? Speak to me.

P: Good.

DME: How comfortable are you now?

P: Very comfortable. I haven't felt this way, so relaxed in a long time.

DME: You haven't felt this relaxed in a long time. That's great. When you are in hypnosis and deeply relaxed, you cannot also be in discomfort or tense. That is because relaxation and those other negative feelings are physical and emotional opposites of each other. So, continue to remain in hypnosis and relaxation for a little while longer, and in a little while, when I rouse you up, some or all of that comfort will last after you are alert and back here in your waking state.

DME: I want you to relax daily and practice what we have done here together. Just take a few minutes when you can be by yourself and undisturbed, and rest back

comfortably with your eyes closed and relax. If your mind wanders, that is okay. Hypnosis is just another way to daydream. Perhaps your mind will wander into a pleasant memory, or to your “laughing place”, where you can enjoy yourself and not be bothered or disturbed by anyone or anything. And you can enjoy being in your laughing place for a little while until you are ready to rouse yourself up and come back to the present. Would that be all right with you? Let your feelings answer.

IM: YES.

DME: At first, perhaps you can be comfortable in your laughing place for 5 minutes.

Then, when you are ready, you can extend this comfort to 10 minutes.

Eventually, you'll feel ready to extend your comfort and freedom from discomfort in your head to 20 minutes, and eventually, to one hour, one day, and eventually, when you are ready, extend that relief permanently. I'd like to ask your feeling mind if that feels all right, if that feels yes, agreeable. Answer with your fingers.

IM: [After about a minute and a half . . .] YES.

The patient was alerted and they discussed the experience. Within three days, she reported that she was free of pain. Follow-up 11 months later revealed that she had been free of her headache since treatment (Ewin, 1992).

Handling “Slip-Backs”

As happened in the aforementioned case, very often, patients who experience significant relief from the pain in trance, experience an exacerbation, or “slip-back” of the pain later in the day or the next day. They typically have second and third thoughts about giving up

a “life support system” they have relied on for months or years. This frequently results in their experiencing a paradoxical *increase* in the pain on the evening of the visit. If the patient calls in an anxious state, we see the patient that day as an emergency reassuring the patient on the telephone that his reaction is normal, and that he will feel much better by the end of the day. In the office:

P: What the hell did you do to me?

Therapist: So, you were able to make it worse?

P: I didn’t make it worse! It just got worse.

Therapist: Your subconscious mind took control and made it worse. That’s wonderful! It means that you’ve taken control of your pain. If you can make it worse, you can make it better whenever you choose.

P: Hmmm.

Therapist: Would you like to cut it in half right now?

[Comment: The patient is in a win-win double bind because he just complained about the pain,

so we put him right into trance and say:]

Therapist: When your pain is half as intense as it was on coming into my office, your yes finger will rise. (Wait for the finger signal.)

IM: YES.

Therapist: Good. Would it be all right to have one minute of being completely free of pain again, realizing that it is better to be alive *without* pain than to be alive *with* pain?

IM: YES.

Therapist: Yes. Good. Okay. When you are completely free of pain, your yes finger will rise.

IM: YES.

Therapist: Good. Okay. Now, I am going to time one minute. (Time the minute.) Okay, it has been a minute. Has it been a surprisingly comfortable minute?

IM: YES.

Therapist: Good. Now <Name>, because you can do it for one minute, then, whenever you're ready, you can do it for two minutes. Signal me when you are ready to do it, to be completely free of pain for two minutes.

[Comment: Keep suggesting increasing spans of time as is appropriate. For example, four, and

then eight, and then twelve minutes, and then give the posthypnotic suggestion that

Eventually,

you will feel ready to extend your comfort to 20 minutes, and eventually to . . . and so on.]

Therapist: I'd like to ask your feeling mind if that feels all right, if that feels yes, agreeable.

Answer with your fingers.

What about Secondary Gain from Pain?

Some patients have so much secondary gain involved from disability payments, pensions,

liability litigation, family manipulation, etc., that a sudden and miraculous cure would be self-

defeating and make them lose face. So, we mustn't overtreat to satisfy our own egos.

These patients require a suggestion such as: "Knowing now that you can control your pain, whenever you are ready, you will be able to diminish your pain to a minimal and tolerable level, or turn it off completely at will."

Since pain is an emotional feeling and a sensation, pure pain without emotional overlay or conditioning is experimentally quite tolerable (Melzack & Wall, 1982). Other feelings that increase suffering require exploration, since they create overlay that can be moderated (Ewin, 1986).

Dealing with Nonacceptance

Nonacceptance is a problem because the patient didn't ask for the pain. It is involuntary. So, pain patients often ask the question almost like a mantra, "Why me?" This often stands as an obstacle to successful treatment as the patient refuses to move on until the question is answered.

Since there is no satisfactory answer, we bypass it in trance and intersperse the suggestion that

“pure pain doesn’t really hurt that much”. Later, we ask for an ideomotor answer to the question, “Would it be all right for you to experience a small amount of pure pain as long as it is at a tolerable level?” The patient who gives his permission feels that he has regained some control and will extend that control to keeping the pain “pure” and at a tolerable level (Eimer, 2000; Ewin, 1986).

Removing Negative Suggestions

A common and significant problem with many pain patients we have seen is the negative suggestion they have been given by doctors to the effect that “You have to learn to live with it.”

This is translated by the patient’s subconscious to mean that the only way to get rid of it is to die!

Obviously, this is not a good idea and it obstructs treatment. In trance, we remove this bad idea

and replace it with something like, “You will find you can cope with it.”

Glove Analgesia for Trance Ratification

When we feel we need to do trance ratification with a skeptical chronic pain patient, we’ll do a rapid induction, set up ideomotor signals, and then proceed to induce glove analgesia in the hand being used for IM signaling. The cortical representation of the

hand occupies approximately one-third of the sensory and motor strips in the contra-lateral hemisphere of the cerebral cortex (Penfield, 1974). We speculate that this may explain the well known observation that glove analgesia is easier to induce than direct analgesia in other parts of the body.

Anesthesia is not feeling anything. Analgesia is not feeling pain. It's much easier to hypnotically produce the latter, so that's what we aim for. Glove analgesia involves suggestions of numbness in the hand and wrist, as might be experienced if the patient put on a thick glove. Once this sensory feeling is induced, further suggestions can be given for the patient to transfer (or displace, or rub, or send) the induced numbness and diminution of sensory feeling to any part of the body that hurts.

The patient can be directed to place the numbed hand directly on the painful body part, and then to rub that body part with the numbed hand, while visualizing the numbness flowing from the hand into the painful body part. If the patient cannot reach the painful body part, this is not a problem. The patient is told to place the numbed hand on an accessible body part, and it is suggested that the numbness will flow into the targeted painful area.

We induce glove analgesia in the hand that's doing IM signaling. The hand is positioned with the wrist flexed, forearm upright, and the elbow resting on the armrest of the chair, or the bent arm floating in the air.

T: Would it be all right with your subconscious mind for you to let your hand
 and wrist get

numb and unfeeling?

IM: (Often) NO.

T: Nothing happens for no reason. Speak to me and tell me why not?

P: Because I don't think I can do it. I'm hurting too much. (Translation: He's
 already tried

as hard as he can and failed.)

T: It's true that you are hurting a lot, but I didn't ask if you COULD do it, I
 asked if you

would give permission to let it happen. I'll tell you what to do. If you feel you would be
interested in what can happen, your YES finger will rise.

IM: YES.

T: And we want to produce Glove Analgesia. So, the next question, yes or no, is are
you willing at a deep subconscious level, to let this happen effortlessly without even
trying? To just give it permission to happen?

IM: Yes.

T: Okay. That's good. Way, way, way down deep. Some part of your mind knows
how to do this. To just let this entire wrist and hand begin to become numb. To begin to
lose sensation so that I could pinch your skin and it wouldn't even bother you.

 And I don't know just how you'll do this.

 Some people picture themselves just wearing a magic numb glove over their
whole hand and wrist. Some picture themselves wearing a big thick electrician's glove,
so that nothing can bother it, nothing can hurt it.

 Some make it cold and numb. People who have been in snow country know what
it's like to go out and play in the snow until your hand gets so numb you'll hardly be
aware of anything.

 Some people have been on picnics where there's a big ice chest full of ice water,

and a whole lot of different cans and drinks in there, and you reach and hunt and hunt for the one Budweiser that you want, and by the time you find it, that hand is just as numb as if it had been in the snow.

Some people even visualize it as dissociated, just unhooked from the rest of the body, so that they don't feel anything in the hand.

I don't know how you'll do this. But you just gave it permission, and it'll begin to happen. This whole area will get more and more numb with each breath you take [Gently stroke the entire hand and wrist.] as you go deeper and deeper. And when it has become nice and numb, you'll let me know because your yes finger will rise.

[Comment: The therapist and patient must have patience.]

T: It happens without effort. Each breath you take, you go deeper and deeper. The deeper you go, the more numb it gets.

[Comment: As the therapist watches and waits, he gently validates and encourages the patient.]

T: That's right . . . Deeper and deeper . . . Hmmn. Hmmn . . . All right . . .

T: Something will change. More and more numb. Time for you to move on. All right. [If nothing happens after several minutes, stroke the yes and no finger and ask:] Is it still all right to let it happen?

IM: Yes finger rises.

T: Okay. There's no hurry. Take all the time that it takes to go as deep as you need to go. [Comment: If appropriate, you can interweave the comment and question that "We tend to do it when we need it. Answer with your fingers. Yes or no, don't you really need to know how to do this?"]

IM: Yes.

T: Yes. More and more numb. Notice that something is really changing . . . Now we got a “yes” signal. Keep it there. Keep it numb.

[Comment: For this kind of testing, we use a surgical instrument called an Allis clamp. This will grasp tightly but not penetrate the skin. It makes a measured, reproducible amount of pressure so that the patient can later compare the same pressure in the waking state. At this point, we take our Allis clamp and begin to gently and gradually pinch the skin tighter and tighter on the outer aspect of the wrist without setting the clamp at first. This is a form of gradual conditioning to the suggestion we are going to make. As long as the patient shows no signs of discomfort, we gradually squeeze the clamp tighter and tighter].

T: You may feel some pressure, but the more pressure you feel, the more comfortably relaxed you will become. [By using the word “pressure” we are telling the subconscious how to interpret any feeling that is there. A person doesn’t mind “pressure” but doesn’t want “pain”]. Now we set the clamp.

T: Now <Name>, stay deeply relaxed and open your eyes, and look at what you can accomplish.

P: Opens eyes and sees the clamp hanging from his wrist.

T: Now close your eyes and stay deeply relaxed and go twice as deep. (We remove the clamp as soon as the patient closes his eyes because seeing it may startle him enough to start left brain logical processing and lighten the trance.). I’m taking the clamp off and you’ll be pleased with yourself and proud of yourself for what you’re able to do. You never know when it may be useful to know that you can turn off discomfort.

[Comment: Be sure to remove the suggested sensations of analgesia before alerting the patient.]

T: Okay. Let your sensations all come back to normal. Let your whole wrist and hand come back to normal. (Then alert the patient.)

After alerting, we hand the clamp to the patient, and say: “Here try this yourself in the waking state and see if you notice any difference.” The difference is obvious. This ratifies to the patient that something new has happened. He has been in a trance and is capable of controlling his pain.

Case Example of Transfer of Glove Analgesia to Painful Body Part

Therapist: In your deepest mind, just visualize a change taking place in this hand and wrist (stroking the signaling hand and wrist). Just like in a day dream – I don’t know how you will do it – some people remember getting the hand very cold and numb in the snow, or reaching into the ice chest for a cold drink. Some people can picture it like it had turned into a piece of wood. Some visualize wearing a magic numbing glove or a thick electrician’s glove. Some even picture it for awhile as not even attached to the body, so no sensation can be felt. Whatever you choose to picture will work for you, and when it’s numb enough so that I can pinch the skin without even bothering you, your YES finger will rise.

IM: (After 1 or 2 minutes) YES.

Therapist: Okay. Keep that feeling. You may feel a little pressure now, and the more pressure you feel, the more deeply relaxed you will become. (Here we use a surgical instrument called an Allis clamp to squeeze the wrist skin gently

at first, then to lock in place.) Stay deeply relaxed, open your eyes, and see what you can do. How does it feel?

Patient: Wow. I don't really feel very much at all in that hand.

Therapist: See what your mind can do? Now close your eyes. Experience how powerful your mind is, the power of the mind over the body. (Remove the clamp.) Now, make that hand twice as numb, and when you feel that the hand is twice as numb, your yes finger will rise.

IM: YES.

Therapist: Yes. Good. Twice as numb. Twice as unfeeling. Twice as numb. Twice as unfeeling. Now take a deep deep breath and go twice as deep.

IM: Patient takes a deep breath and then yes finger rises.

Therapist: Very good. Wasn't that easy?

IM: YES.

Therapist: I'm only asking you to do the exact opposite of what you've invested so much energy into; that is, if something isn't working, you need to try harder and harder. The truth is that "bad ideas come without effort". So, how do you think good ideas need to come?

IM: Head nod . . . YES finger rises.

Therapist: That's right, without effort. Good. Now take that hand and place it on your abdomen, and I wonder if you can just imagine this; the numbness in this hand (stroke back of hand) flowing like cool running water through your abdomen and into your back. The numbness just flowing, like a trickle of Novacain to where it is most needed, in your back, making your

back feel cool and numb, cool and numb, like it has been lying on ice.

Like you're lying in the cold snow. Do you know what cold snow feels like?

IM: YES.

Therapist: Good. It's just what your back needs now. It makes your back feel nice and numb. Without much feeling. Nice and numb and without much feeling at all. You might feel some touch sensations, but you want to have it like it doesn't feel any discomfort at all. Your yes finger will rise when your back feels nice and numb, nice and numb.

IM: YES.

Therapist: Great. Now I want you to stay deeply relaxed and tell me how your back feels. Speak to me.

Patient: Nice and numb.

Therapist: Good. Your back is nice and numb. Now let your hand be normal again, and keep the numbness and the comfort and the protection in your back. It will last for several hours after I rouse you up.

A Direct Approach to Pain Reduction

We often have clinical success using the following direct approach with the patient in trance.

T: On a scale from 0 to 10, with 0 being "no pain" and 10 being "the worst you can imagine", tell me where it is now.

P: 6.

T: 6. Okay. Now, tell me what number would be tolerable. Possible to ignore.

P: Hmmm. Uh, 2.

T: Okay. Two. Now you said that right now it's a 6. Is that so?

P: Yes.

T: Six. Okay. I wonder if you can make it an "8". Just for a minute. Make it an 8.

And when you've gotten it up to an 8, your yes finger will rise.

IM: YES.

P: I'm at an 8 now and I don't like it!

T: You made it an 8. Now, since you were able to increase it to an 8, you can decrease it back down to a 6, where it was a minute ago. Go ahead and do that now and let me know by lifting your yes finger when it's back at a 6.

IM: Yes.

T: Great. Okay. It's now a 6. So, <Name>, if you can turn it up to 8, then perhaps you have the ability to control it better than you knew. Since you now know you have some control, would it be all right to turn it down to a 5 right now? Answer with you fingers.

IM: Yes.

T: Yes. Turn it down to a 5 and your yes finger will rise when it's a 5.

IM: Yes finger rises.

The therapist works gradually over a period of visits to have the patient get it down to a tolerable number. If you go too fast, the patient may not be able to do it. You want to avoid another "try and fail". Every success leads to more success.

Indirect Approaches

Laughing Place Technique

[The therapist begins by stating the following:]

Laughter is a natural antidote to suffering. Everybody's got a place and a time where they feel like laughing. Where nothing can bother you and nothing can disturb you.

T: Would it be all right with your feeling mind for you to find your laughing place now?

IM: Yes.

T: Yes. Good. Go ahead and find your laughing place and when you are there, your yes finger will rise.

IM: Yes.

T: Good. You are there. Would it be all right with your feeling mind to bring it up to a conscious level and tell me all about it?

IM: Yes.

T: Yes. Good. Go ahead and tell me about your laughing place.

P: [Tells therapist about his laughing place.]

T: Would it be all right for you to enjoy being there for a little while, experiencing it with all five senses, consciously and subconsciously, just as if you are really there?

IM: Yes.

T: Yes. Good. Enjoy it with all five senses. What you see. What you hear. What you smell. What you taste. And what you touch. Get into being there, and when you feel it and enjoy being there with all five senses, your yes finger will rise.

IM: Yes.

T: When you know that you are feeling more comfortable, your yes finger will rise.

IM: Yes.

T: Everyone experiences pain on both a subconscious and conscious level.

Sometimes, pain is just subconscious, beneath our awareness. We may be unaware of what happened to make the pain break through into conscious awareness. When we are in our laughing place, and the subconscious pain goes away, we may not even be aware of it. That's because it's subconscious.

T: <Name>, when you know that the subconscious element of the pain is totally gone, your yes finger will rise.

IM: Yes.

T: Great. Now <Name>, would it be all right with your feeling mind to make some of that subconscious relief conscious? Answer with your fingers.

IM: Yes.

T: Yes. Good. Go ahead then, and when you know that your conscious pain is diminished by 25%, your yes finger will rise.

IM: Yes.

[Comment: The therapist keeps on helping the patient chip away as much pain as possible until he gets a NO, or an objection, which then needs to be addressed. At the end of the procedure, say:]

T: Take a mental snapshot of your Laughing Place so that at any time, while we're doing therapy, we can shift to that instantly no matter what else is going on. When you learn self-hypnosis, you can also find your laughing place is a very pleasant daydream to drive out stress and pain, because it doesn't hurt at your laughing place.

Rossi and Cheek's "Body Lights" Imagery

I (BNE) often employ Rossi and Cheek's (1988) rapid hypnoanalytic imagery technique for helping patients experience relief from pain. Cheek (1994) classified this method as an "indirect" approach to ideomotor search for causal events. After inducing trance and setting up IM signals:

Therapist: Imagine you are standing in front of a full-length mirror. Look at yourself in the mirror and see tiny colored lights in different parts of your body. These colored lights represent different physical sensations. There is a different color for every sensation including pain. In fact, there are even different colors for different types of pain. The more intense the sensation is, the more intense, the brighter, the color is. When you see the total picture, your yes finger will slowly lift.

IM: YES finger eventually lifts.

Therapist: Now that you see the total picture, would it be all right with your feeling mind for you to scan the entire picture and tell me what sensations the colors of each light represent?

IM: Wait for a YES.

Therapist: Would it be all right with your feeling mind to choose the least uncomfortable part of the body to do some therapeutic work? Answer with your fingers.

IM: Wait for a YES.

Therapist: Yes. Let your feeling mind go back to a time when that body light stood for some other comfortable sensation. Your yes finger will lift when you are

back at that time.

IM: Wait for YES finger to lift.

Therapist: Now, orient forward in time to the first moment when that body light that now stands for discomfort took the place of the light that stood for comfort. Your yes finger will lift when you arrive at that moment. When you are there, please tell me your age and what is going on.

IM: Wait for YES finger signal and for the patient to verbally respond.

Therapist: Yes. You are . . . years old and [repeat in the present tense the when, what, where and with whom of what the patient relates].

Therapist: Is there any good reason now, why you have to continue having discomfort in that body part?

IM: Wait for an IM or verbal response.

Therapist: [If the patient answers “yes”, it is important to explore the patient's felt reasons. If the patient answers “no”, ask:] Now that you are aware of what is happening, is your feeling mind willing to let you turn off that discomfort and continue the healing process so that you can get well?

IM: Wait for a response. If the response is NO . . .

Therapist: [The therapist should explore with the patient’s permission the factors that stand in the way of turning off the discomfort. The therapist should also ask:] Answer with your fingers. Is your feeling mind willing to let you turn down the dial on that discomfort so that you can continue to heal?

IM: Wait for a response. If the response is YES . . .

Therapist: Yes. Okay good. Now I’d like you to imagine a future time when you will

no longer be suffering from discomfort in that body part. When it feels more comfortable. When you are there, your YES finger will lift and you will see the month, day, and year as though written on a chalkboard right in front of you.

IM: Wait for a response.

Therapist: Okay. Great! Tell me what you see.

IM: Wait for a verbal response.

Therapist: Thank you. Now lock in on that with every cell in your mind, and body and feelings. Want it to happen, let it happen, and it will happen.

It is suggested that the patient practice orienting to that future time and rehearse imagining the associated more comfortable sensations. The above steps are repeated for other more painful body parts so that the patient gradually works his or her way up a hierarchy of increasingly painful body parts.

Cheek and LeCron's Method

I (BNE) have been using Cheek and LeCron's (1968) ideomotor analysis protocol for years with good success. Their protocol is employed as illustrated in the following case:

A 48 year-old single, white male college professor (R.) consulted BNE for hypnosis for pain management after being referred by his HMO primary care physician. He said that his doctor told him that I (BNE) helped people manage their pain better using hypnosis. Although skeptical, he made the call and booked an appointment. An hour and a half was devoted to the intake.

I learned that R. was diagnosed with spinal stenosis, fibromyalgia and chronic fatigue syndrome, and that he had undergone back surgery three years previously, which

entailed laminectomies at L3-4, L4-5, and L5-S1 vertebral levels. The surgery had eliminated his leg pain, but his symptoms of fibromyalgia and chronic fatigue worsened after the surgery. At this point, he was thinking of taking early retirement on long-term disability.

At the end of the first visit, after the intake and history-taking, he was hypnotized using a rapid trance induction, and ideomotor signals were established. He was seen for a second visit three days later. The second visit lasted about one hour and ideomotor analysis was conducted. The following is a summary of that session:

T: Is it all right for me to help you with this problem?

IM: YES

T: Would it be all right to let your subconscious mind orient back in time to the first moment in your life when pain of this sort first became important to you?

IM: YES

T: Yes. Okay. Let the subconscious part of your mind orient back in time to the first moment in your life when pain of this sort first became important to you. When you're there, your "yes" finger will lift. As it lifts, please bring these memories up to a level where you can tell about them.

IM: YES

T: Is it all right to tell me what's come to your mind?

IM: YES

T: Yes. Tell me what's come to your mind.

IM: I remember being in my apartment and realizing that I had this "yuppie disease", this chronic fatigue syndrome they'd been talking about.

T: Tell me what the date is.

P: It's December of 1992.

T: It's December 1992 and you realize you have this "yuppie disease". What leads you to realize this?

P: I'm not getting better.

T: You're not getting better. Does anything happen, or does anyone say something to you that makes the pain and fatigue you're having seem very important?

P: Hmmm. Yeh. This chiropractor said he cannot do anything for me, and that my back is like that of a 70 year old.

T: (Repeats P's last statement.) Did anything happen before this, at an earlier time, which made what the chiropractor said seem very important?

P: Huh hmm. I kept having like these flues and back attacks. And after each flu, I'd be drained and washed out for weeks.

T: Answer with your fingers, yes or no. Did what that chiropractor said make you feel that you could not get well?

IM: YES

T: Knowing what you know today, on Tuesday, October 6th, 1998, yes or no, answer with your feelings, is it possible that that chiropractor was not very knowledgeable about pain and rehabilitation?

IM: YES

T: Sure. That chiropractor was not very knowledgeable about how to get people with your problem well. Yes or no, didn't you see another doctor who had a better treatment plan?

IM: YES

T: Sure you did. And tell me what he said.

P: He said I don't need surgery. He said I need physical therapy.

T: Uh huh. He was a respected neurosurgeon and he said you need physical therapy.

Did you go for the physical therapy?

IM: NO.

T: No. You didn't go for it. Tell me why you didn't go for it.

P: Because I was depressed.

T: So you didn't follow that doctor's advice because you were depressed. Okay. You were depressed then. And eventually you needed to have surgery, and it was a successful operation, wasn't it?

IM: YES

T: Now, here you are today, on Tuesday, October 6th, 1998. Knowing what you know now, answer with your fingers, yes or no, does your inner mind feel willing to let me help you get well?

IM: YES

T: Yes. Great! Okay. Project forward to the time when you are completely over this trouble and are no longer afraid of it recurring. When you're there, your "yes" finger will slowly rise, and tell me the date that pops into your mind.

IM: YES

P: It's Saturday, December 26th, 1998.

T: (Repeats date.) Okay. Yes or no. Is there anything else we need to know before we start working toward this goal?

IM: NO

T: Would you like to learn self-hypnosis?

IM: YES

I (BNE) taught the patient a brief self-hypnosis exercise. I instructed him to practice it for 2 to 3 minute periods ten times a day. We rehearsed it to make sure he got it and could do it. We then rehearsed turning the pain ON and OFF, and making it WORSE and then BETTER as described earlier.

The patient called the following day and complained that his pain and fatigue had somehow gotten worse. I saw the patient that evening as an emergency. IM analysis revealed that the patient had dreamt about conversations he'd had with his mother who was a very anxious woman and very overprotective. We uncovered the fixed idea (that he had gotten from her) that he worked too hard and didn't relax enough (this was not so.). As a result of this fixed idea, he believed that he was a very fragile person and vulnerable to getting sick if he overexerted himself, mentally or physically. In trance, I removed this suggestion.

We also practiced turning the pain ON and OFF, and making it WORSE and then BETTER, first on a subconscious level, and then on a conscious level. I also reframed and removed the fixed idea that HE had caused all of his physical problems through careless weight lifting several years before his pain problem started.

IM signaling revealed that, on a feeling level, he felt that now that he knew these things, he could get better. The patient was seen for one more visit two weeks later. He reported that he was practicing his self-hypnosis, and that he was feeling hopeful, and had more energy.

The patient came back for another visit in January of 1999, after his visualized recovery date. He was dating someone and feared that his medical problems would scare the woman off. In both waking and hypnotic states, these fears were reframed in light of the overall improvement in his functionality, improved energy level, diminished medication use, and overall greater comfort.

The “White Light”

This is a guided imagery technique for helping a patient finish some “unfinished business” with a deceased loved one. It’s also useful for helping a patient gain self-esteem. It is a useful tool in grief or bereavement therapy as well as in pain management psychotherapy (Eimer & Freeman, 1998).

Summary

We begin by seeding in the waking state, that the White Light is part of the near death experience for us all, no matter what our religion (even for atheists). We suggest that it is possible to safely visit the White Light to make contact with an important person who has passed, and communicate with that person.

We start by agreeing to go together to the White Light. Trance is induced and IM signals are set up. If it’s appropriate, with the patient’s permission, we either hold hands, or we put our hand on the patient’s. We then begin by setting the scene -- that it's twilight, and way off in the distance we can see a little twinkling light like a small star, pure white and brilliant, even though it's so far away.

Together, we, and the patient, start walking towards it, and we notice that it is coming towards us, getting larger and brighter all the time. Soon we become aware that it has no form -- it's not a mist, it's not a cloud, it's not a person, but there is an awesome

energy, warm and bright, and as it envelopes us, we realize that it IS energy, and that energy is LOVE. We can inhale it, and feel it spread through every cell in our bodies, making us know that we're precious - not perfect, but precious.

And the White Light brings with it an important person who has gone before, and we suggest that the patient can have a private conversation with that person to clarify any unfinished business. This is a time when one can ask for forgiveness, give forgiveness, share love, and reassure each other. We state that we'll be quiet while the patient takes all the time he needs to complete his conversation, and that when he feels content, he can just nod his head to let us know. (5 to 10 minutes of silence, perhaps some tears).

After the nod, we suggest that it's time now for us to say goodbye and return to our office, but we take with us the reassurance that we experienced that all of us are precious -- not perfect, but precious. We turn away and know that the White Light is going back, getting smaller and smaller, until it's just like a little, twinkly star that disappears, and we come back to TODAY . . . (We state the exact day, and date, because "today" may still be a regression back to the day the patient's loved one died).

Case Example

The journey is begun with the patient in trance, and after IM signals have been set up. The case of one patient who had longstanding, ongoing issues with his stern father (who was now deceased), went like this:

T: Do you know what the "White Light" is?

IM: Yes.

T: Yes. Raymond Moody wrote a book called "Life After Life". He interviewed people who had "near death experiences" and had recovered and come back alive. No

matter who he interviewed, or what religion they had, if they had a “near death experience”, they all saw the “White Light”. It’s an energy concept. Light is a form of energy and the energy they reported in the White Light was love. But it didn’t have to be deserved, or earned. It was love that was given because it was needed. It engulfed them. They experienced an awesome love, and it was so wonderful that when they came back, they didn’t care about whether or not they actually died! Almost universally, they said “There’s something important I have to do before I can go back. I have to love more here, and be a better person, because I want to go back and experience the White Light again”. A lot of them said that the White Light brought somebody with it. In particular somebody they had unfinished business with.

Now, I’m going to ask you <Name>, “yes” or “no”, if I go with you, would you like to go visit the White Light right now?

IM: Yes.

T: Yes. I wonder if the White Light will bring your father. Maybe he has something to say to you and you have something to say to him. But let’s just see ourselves in the twilight. Walking together. Maybe holding hands. And way off in the distance, we see a bright pinpoint of light, like a twinkling star. It’s coming toward us, and as it does, it gets bigger and brighter, and brighter and bigger. Pure, brilliant white light. It has no form, no shape. It’s not a mist, it’s not a cloud, but we experience it as a warm loving energy as we bask in its comfort. It makes us feel precious, absolutely precious.

And your father has gone before you . . . Look around and see, “yes” or “no”, does he know you’re here?

IM: YES

T: Does he come back? Does he have something to say to you?

IM: YES

T: Does he think you're precious too, now that he's experienced the White Light?

IM: YES

T: Oh, I think that he needs to pass this on to you. In spite of his toughness, he's followed you all this time. And he's very proud that a part of him is still here, helping people, teaching, growing. I'll be quiet while you and he communicate in this atmosphere of comfort. When you have completed saying what's really important, your "yes" finger will rise.

(Silence for 2 or 3 minutes).

IM: Yes.

T: Does he ask you to forgive him for letting you feel so bad for so long?

IM: YES

T: Does the White Light communicate to you that all of God's children are precious and they're entitled to feel lovable, just because they've been made, and you're one of God's children?

IM: YES

T: We all ought to do the best we can with what we've got, but we don't have to prove we're lovable, because that comes with the territory. It's a freebie. We may not act lovable all the time, or even feel loving all the time. But the issue is whether or not we're willing to accept love when it knocks. When the White Light comes and it engulfs us, are we going to hold our breath and NOT inhale it? Yes or no?

IM: NO

T: That would be our stubbornness.

T: This gift is a special kind of love we know as charitable love.. It doesn't ask for payback. It's what the White Light brings, and when someone says "I don't accept charity," they're rejecting feeling precious. Perhaps your dad didn't think that he was precious until he got to the White Light. But he knows now, and he knows that he was precious, and that you are precious. You wanted to please him. Didn't you?

IM: YES

T: And has he just told you that you really do please him?

IM: YES

T: Each breath you take, feel this energy. Feel this unconditional love. Just loving <Patient's Name> because he's <Name>. Breathe it in. Let it go through your lungs and into your bloodstream. Circulate it through your heart and to your brain. Your liver, your muscles, your skin. And if you can accept a gift, a gift of love, that makes you vulnerable, but it also makes you stronger. Can you feel it making you stronger?

IM: YES

T: You will be able to continue to process this. I wonder if your father is there in your presence, if you are aware of a message from him in the form of the White Light?

IM: YES

T: It's been there all along. All you have to do is inhale it. You're just as precious to your father, your mother, your wife and your children. And your peers. It's all there for you. Accept it.

IM: YES

T: Now it's time for us to come on back. The White Light begins to move away and

get smaller and smaller and smaller, and we can look way off in the distance and finally it's like a tiny blinking star, and it goes out. And we look around and here we are back in . . . on [Date: Month/Day/Year]. And when you're ready, just open your eyes and come back, fully alert, sound in mind, sound in body, and in control of your feelings.

Comment. Later this patient reported that he felt a decrease in tension, and more satisfaction and self-esteem since his visit to the White Light.