HYPNOSIS AND PAIN MANAGEMENT

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Introduction:

Hypnosis is a process involving a hypnotist and a subject who agrees to be hypnotized. Being hypnotized is usually characterized by intense concentration, extreme relaxation, and high suggestibility. Hypnosis has long been understood to produce varied effects in subjects. Although the public at large tends to associate hypnosis with stage performances and bad sit-com episodes, the health community has approached the topic in a different way. Originally viewed as a magical cure-all, hypnosis has undergone tremendous amounts of scientific testing in modern times. When used in an appropriate manner, hypnosis has proven itself to be an effective tool in the management of pain and pain perception.

Summary: Nurses have used complementary therapies for many years to relieve anxiety, promote comfort, and reduce or alleviate pain. Physical therapies are most commonly used in our scenario but behavioral approach had been less customary, since familiarity of health personnel is very less (36%) with these techniques (Zaza et al, 1999). Hypnosis is empirically proved best therapy for pain management. Hypnosis is a process involving a hypnotist and a subject who agrees to be hypnotized. Being hypnotized is usually characterized by intense concentration, extreme relaxation and high suggestibility. This paper initially address hypnosis from an historical perspective to give the reader a decent background in which to view current trends in research in the field. Then will explain how hypnosis worked followed by the empirical evidences and problems encountered in use of hypnosis when used for pain management.

Historical Perspective Of Hypnosis

- Hypnosis was discovered by a Viennese physician, Friederich Anton Mesmer, in the late 1700’s. He used hypnosis and called Mesmerism.
- In 1784, Louis XVI formed a commission to investigate Mesmer’s Findings about hypnosis, unfortunately, there after Mesmerism fell from popularity (Hall, 1986).
- In England around 1843, the surgeon James Braid revisited the phenomenon of Mesmerism and renamed it hypnosis, after the Greek god of sleep, Hypnosis. He was the first person to attribute the phenomenon to psychological rather than physical variables. His findings renewed interest in the subject, especially in France, where hypnosis gained popularity again as a form of pain reduction during surgery. Eventually, Braid’s technique was found to be unsatisfactory, and hypnosis drifted out of favor once again (Hall, 1986).
- In the late 1800’s Benheim and Liebneut came upon hypnosis as a treatment for physical and functional diseases.
- Later once again the scientific method has been applied to hypnosis, it has been shown to be increasingly effective in a wider variety of maladies than anyone had ever thought possible but still the health care community continue to ignore a relatively easy and effective form of pain management, although hypnosis proponents are growing in numbers.

HOW HYPNOSIS WORKS:

Unfortunately, there is no one on Earth who can conclusively explain the mechanisms by which hypnosis works. There is, however, scattered literature which attempts to describe the mechanism for hypnosis’s effectiveness. The most common psychological explanation for how hypnosis works is based upon a dissociation model. This model has been seen in patients with multiple personality disorder. Dissociation eliminates pain by placing it in a sort of psychological storage area, away from the primary consciousness of the patient. This model of dissociation is commonly referred to as the “hidden observer” model of cognition. Watkins and Watkins (1990) suggested that the dissociation which occurs in multiple personality patients can be analogously induced in normal hypnosis patients. They referred to the dissociation as the use of an “ego state”, and that in a normal person this state is malleable, as seen in varying mood states. In some moods, we are susceptible to do things which in other moods we are not. It is when this ego state is faulty that it breaks off into the “hidden observer” model. But hypnosis can induce placement of pain into a...
"covert" ego state which is hidden away. Because of this model, it is noted that the pain is still there, it is simply tucked away so that it is not dealt with. The pain, however may resurface later in an undesirable form, such as a nervous habit or fear. So far, no support to this resurfacing theory has been shown.

Unfortunately, this model of hypnosis mechanism is not very satisfying. Although it may explain where the pain goes to, it does not provide a definite road map for explaining the effectiveness of hypnosis. Why can't an awake patient simply "bury" the pain into a covert ego state? Why is hypnosis necessary to access such an ego state? Watkins and Watkins acknowledge these limitations, and claim that further research is required, especially in regard to their resurfacing theory.

Another interesting study compared the use of biofeedback with hypnosis to reduce test anxiety. Because both groups scored similarly, there may be a similar underlying mechanism responsible for their effectiveness. These results were compared to uses of desensitization and relaxation training, and were all found to be similar. Because all of those methods involve a form of a relaxation technique, that may be the underlying key to understanding hypnosis's effectiveness (Spies, 1979). Comprehension of relaxation may lead to a better understanding of all these techniques, including hypnosis. Once hypnosis is understood in regards to relaxation, it may yield the clues needed to explain its pain management capabilities. Once again, further research is required.

The physiological explanations for the mechanism by which hypnosis controls pain management are even less understood than the psychological models. This avenue of study has not been pursued by many researchers, and almost nothing is known in this area.

Weinstein and Au (1991) noticed that norepinephrine levels were significantly higher during angioplasty of hypnotized patients in comparison to non-hypnotized controls. Because norepinephrine has an effect on sleep states, it is therefore possible that hypnosis increases these levels due to its similarity to an REM state of sleep. This would imply that hypnosis provides a measurable chemical inhibitory effect on pain conduction. This shows that psychological and physiological mechanisms by which hypnosis operates are not well characterized nor understood. Therefore further research is required before any definite conclusions can be drawn.

**EMPIRICAL EVIDENCES ABOUT HYPNOSIS:**
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**Is hypnosis alleviative of pain?** The body of literature which has investigated whether hypnosis can reduce pain sensitivity has been overwhelmingly supportive. An example of the many instances in which hypnosis has reduced pain sensitivity is in the Hajek et al. (1990) study of cutaneous pain threshold. In the study, eczemic subjects under hypnosis reported a higher amount of applied pressure before pain was experienced than non-hypnotized subjects. In fact, hypnosis was shown to cure the patients quicker than those without! In 1990, Evans investigated the possible ways in which hypnosis effectiveness varies according to different types of pain. He determined that the style of hypnosis was more important than the type of pain. For acute pain, he suggested hypnotic suggestions focusing on anxiety-reduction and emphasis on minimizing the importance of the pain. For chronic pain, Evans suggested directly confronting the pain under hypnosis, dealing with both the pain's physical and psychological effects on the patient.

**Where to use hypnosis?**

In investigations of what type of pain hypnosis is effective at which types are not, most seem to indicate that hypnosis is universal successful in pain management. Hypnosis has been shown effective management of many varied types of pain, including pain associated with childbirth, angioplasty (Weinstein Au, 1991), leukemia, and even headaches (VanDyck, et al, 1991). Is hypnosis curative or analgesic or both?

There is controversy involving the discrepancy between a curative and analgesic approach to hypnosis. At present this issue may be debatable. In a case study Morris (1987) described a young girl attempting to get liquid nitrogen, curettage, an electro-escission to remove the warts on her hands, she used a hypnotic technique involving visualization of a wart-free hand. Within three months, the warts on her hand were completely eliminated, and continue to be gone for up to four months following her last treatment. This surprising case illustrates how hypnosis can do it, in fact, it may be possible but one can only say after further research in this direction.

**Problems Encountered With Hypnosis Therapy:**

A main difficulty in the widespread use of hypnosis involves the problem of hypnotizability ratings in patients. (VanDyck, et al, 1991). In the case of subjects who do not know language which spoken by the therapist will cause a great problem.

Regardless of the problem mentioned, hypnosis has been shown to be a useful tool for pain management in many situations. Most of the problems presented are surmountable, provided that the therapist is careful to avoid the pit
ials of incorrect imagery and low hypnotizability in patients.

Conclusion: Even though exact mechanisms of action about hypnosis is unknown but still it has merit. Fortunately, the body of knowledge regarding hypnosis continues to grow, and hopefully will one day address these issues. The trend will hopefully lead to an examination of the neurochemical basis for hypnosis in pain management. Understanding of this mechanism can also lead to advances in comprehension of other relaxation and dissociative states. Obviously, the use of pain management via hypnosis should be rigorously examined, so that it can be available to patients, nurses and system as a useful and safe alternative tool for pain management.

Recommendation: Extensive large experimental trails are needed to explore various dimensions and effectiveness of hypnosis as an pain management therapy.

References: