

Clinical Applications of Hypnosis for Brief and Efficient Pain Management Psychotherapy

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This paper describes four specific clinical applications of hypnosis that can make psychotherapy for pain management briefer, more goal-oriented, and more efficient: (1) the assessment of hypnotizability; (2) the induction of hypnotic analgesia and development of individualized pain coping strategies; (3) direct suggestion, cognitive reframing, hypnotic metaphors, and pain relief imagery; and (4) brief psychodynamic reprocessing during the trance state of emotional factors in the patient's experience of chronic pain. Important theoretical and clinical issues regarding the relationship of hypnotizability to the induction of hypnotic analgesia are presented, and attempts to individualize pain treatment strategies on the basis of assessed differences in hypnotizability and patients' preferred coping strategies are described. Some ways are also presented of integrating direct hypnotic suggestion, cognitive reframing, hypnotic metaphors and imagery for alleviating the sensory and affective components of pain with an exploratory, insight-oriented, and brief psychodynamic reprocessing approach during trance for resolving unconscious sources of resistance to treatment and reducing the emotional overlay associated with chronic pain. Some basic assumptions underlying the use of this approach are discussed, and a brief step-by-step protocol is outlined.

Facilitating Brief and Efficient Pain Management Psychotherapy

In their recent clinical handbook, Eimer and Freeman (1998) define *Pain Management Psychotherapy* as "the clinical application of behavioral and psychological methods, in a professional context, for alleviating emotional suffering, improving pain relief, and promoting pain management" (p. vii). They list its seven fundamental components and therapeutic goals: (1) contextually appropriate initial and ongoing assessments of psychological, personality, and pain status; (2) individualized psycho-educational teaching to provide the patient with an understandable model of pain mechanisms and rationale for the therapy; (3)

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Cognitive Therapy and imagery modification for modifying negative thinking patterns and images that maintain suffering, and building a functional repertoire of thoughts and images that promote pain relief; (4) Behavioral Reactivation Therapy for increasing positively reinforcing activities and assisting in the patient's physical rehabilitation; (5) training in pain coping skills; (6) teaching of relaxation skills; and (7) cognitive-emotive reprocessing of upsetting or traumatic memories associated with pain, the ill role, and pain treatment.

The above assessment and treatment components and goals of Pain Management Psychotherapy can be facilitated through the appropriate clinical utilization of hypnosis. This can make it feasible to keep the therapy program brief—meaning short-term, time-limited, goal-oriented, and efficient.

In my practice of Brief Cognitive Psychotherapy and Hypnosis, after the initial assessment/intake evaluation session with a chronic pain patient, I typically contract with the patient to commit to five meetings so that we can address the specific goals formulated in the intake. At the fifth meeting, we review the patient's progress relative to these goals, and jointly decide whether to continue meeting. If a collaborative therapeutic relationship has been formed, and the patient feels the meetings have been valuable, a contract is frequently made for another five sessions to continue the therapeutic work we have agreed to do.

In line with this practical way of working, this paper will describe four specific clinical applications of hypnosis that can facilitate the efficient delivery of Brief Pain Management Psychotherapy: (1) the assessment of hypnotizability; (2) the induction of hypnotic analgesia and development of individualized pain coping strategies; (3) the utilization of direct suggestion, cognitive reframing, hypnotic metaphors, and pain relief imagery; and (4) brief psychodynamic reprocessing during the trance state of emotional factors in the patient's experience of chronic pain.

Hypnotizability or hypnotic suggestibility assessment can provide useful information to the clinician in designing appropriate individualized pain management and coping strategies by making efficient use of the patient's capacity for experiencing hypnotic analgesia (Council, 1999; Eimer & Freeman, 1998; Hilgard & Hilgard, 1994; Holroyd, 1996; Spiegel & Spiegel, 1978/1987). In this paper, I use the terms hypnotizability, hypnotic ability, hypnotic responsiveness, and hypnotic suggestibility interchangeably as they all refer to the same thing—that is, individual differences in responding to hypnotic suggestions (Council, 1999).

The induction of hypnotic analgesia, or hypnotically induced pain reduction, can make it possible for a patient to experience a respite from the pain's intensity. A welcome experience of pain relief that is not induced by drugs, even if it only lasts briefly, can often make a significant positive impression that may be utilized therapeutically. It may provide an inroad for beginning to change pain perceptions and helping a patient become more receptive to learning psychological methods of coping with and managing the pain experience.

The utilization of direct suggestion, cognitive reframing, hypnotic metaphors, and pain relief imagery can provide the primary means for helping pain patients change the ways they think and feel about their pain and helping them develop more effective coping strategies.

Brief psychodynamic reprocessing of pain-related emotional material during trance is an exploratory and insight-oriented, short-term treatment that includes age regression and ideomotor communication. It can often be helpful for uncovering, reprocessing and alleviating some of the unconscious cognitive and emotional factors underlying the extreme emotional distress and suffering frequently associated with and usually worsening persistent

pain states (Cheek, 1994; Cheek & LeCron, 1968; Eimer & Freeman, 1998; Ewin, 1978; 1986; 1992; Rossi & Cheek, 1988).

Hypnosis as a Key Tool for Pain Control

Definitions of Hypnosis Terms and Concepts

From my cognitive perspective, the purpose of a hypnotic induction is to make the patient responsive to suggestions. The hypnotic state is a state of heightened suggestibility, and hypnotizability is defined as the patient's degree of responsiveness to the therapist's suggestions. Defining these concepts in this way allows us to incorporate what are, in my view, the essential reasons for using hypnosis as a key clinical tool in Brief Pain Management Psychotherapy. These are: (a) to induce through the appropriate utilization of suggestion, an experiential transformation in a patient's pain sensations and perceptions; (b) to reframe dysfunctional pain cognitions, beliefs, and feelings, and (c) to facilitate the change of dysfunctional pain behavior (Eimer & Freeman, 1998; Zarren & Eimer, in preparation).

As I see it, hypnosis, or the hypnotic state, is a continuum from the moment the therapeutic relationship is established, through the conclusion of the trance experience and beyond (Zarren & Eimer, in preparation). In clinical practice, good therapeutic rapport is usually associated with a patient's increased suggestibility. Good therapeutic rapport may be at least partly determined by the therapist's having an accurate understanding of what can best promote a patient's positive responsiveness to the therapist's input, communications, and suggestions—in other words, understanding the patient's hypnotizability. Thus, it makes good sense to assess a patient's hypnotizability in the clinical situation where the overarching goal is to influence the patient positively through one's verbal and non-verbal communications.

Whether or not a given patient would score equally as hypnotizable in other situational contexts is another matter. The patient may not, given the influence of context and expectancy variables on measures of hypnotizability (Barber, 1996; Chaves, 1999; Coe, 1993; Council, 1999; Evans, 1974; Kirsch, 1999; Kirsch & Council, 1992; Lynn & Sivec, 1992; Woody, Bowers, & Oakman, 1992), and of the particular hypnotizability measures used (Perry, Nadon, & Button, 1992). However, I consider the point moot because the therapist's goals are to maximally influence the patient's responsiveness in a positive direction in that clinical situation for a specific mutually agreed purpose, and to promote generalization of the positive experience and responses across relevant situations and stability across time in a way that adequately serves that mutually agreed purpose.

With good therapeutic rapport, even during the waking state, before the performance of any formal hypnotic induction ceremony or ritual, patients often will have already entered or shifted spontaneously into an altered state of awareness with increased suggestibility (Zarren, 1996a). Trance, or the trance state, is defined and identified as what follows after the patient's eyes close during and after the hypnotic induction ceremony (Zarren & Eimer, in preparation).

As aptly stated by Spiegel and Spiegel (1978/1987, p. 34), "In the formal induction of a trance, an individual enters a state of sustained, attentive-receptive concentration, either in response to an inner signal or to a signal from another person which activates this capacity for a shift of awareness and permits more intensive concentration in a designated direction."

During the trance state, trance logic often allows receptive patients to accept direct therapeutic suggestions uncritically (Orne, 1959; Weitzenhoffer, 1989; Zarren, personal communication,

September, 1999). Therefore, following earlier work by Zarren (1996a), I often say to the patient in trance at the end of the hypnotic induction ceremony: “As you go deeper and deeper into relaxation and hypnosis, the doorway to your unconscious opens and with your permission I have the opportunity to talk directly to your unconscious and give it the information it needs to have to help you make the changes you want to make.” (Zarren & Eimer, 1999, in press).

Hypnotic suggestions, delivered both in the waking state and during trance, have the potential to profoundly alter a patient’s subjective experience. Therefore, it is important to ask: What does the patient experience subjectively when he or she responds to the therapist’s suggestions? Given the often unpredictable nature of pain, it may be desirable that patients experience hypnotic pain relief occurring as automatically, spontaneously, unconsciously, and unpredictably as their subjective experience of pain worsening (Barber, 1996).

The Trance State. In trance, the hypnotized individual usually experiences some degree of involuntariness or automaticity in his or her responses to hypnotic suggestions (Bowers, 1992; Cheek, 1994; Crawford, 1990; Eastwood, Gaskowski, & Bowers, 1998; Evans, 1991; Hilgard, 1986, 1991; Spiegel & Spiegel, 1978/1987). Trance, or the trance state, may also be understood and conceptualized as a state of parallel awareness in which the individual is able to process information effortlessly on a number of levels simultaneously (Spiegel & Spiegel, 1978/1987). This altered state of consciousness may also be conceptualized as a “controlled form of dissociation in the service of the therapy” (Bowers, 1992; Evans, 1991; Hilgard, 1986, 1991). It seems to include “the ability to be both here and there at the same time” (H. Spiegel, personal communication, 1996)—for example to be aware of pain on one level, but yet to remain unbothered by it.

These attributes of both the trance state and the hypnotic state can make hypnosis a useful tool for inducing increased responsiveness and receptivity to pain management strategies and interventions. However, in the clinical setting, the clinician’s conceptualization of the patient and diagnostic understanding of the patient’s pain constitute the basis for designing hypnotic and non-hypnotic treatment strategies. The degree of automaticity of the patient’s responses to the therapist’s suggestions, and the quality of the patient’s subjective experience of trance can be related to the constructs of hypnotizability, hypnotic suggestibility, and hypnotic responsiveness

Initial Evaluation of the Pain Patient

In my view, the initial work-up should assess pain history, medical and psychiatric history, mental status, the patient’s personality style, and the patient’s hypnotizability. It should yield an adequate understanding of the patient’s pain experience and coping strategies (Eimer & Allen, 1995/1997; Eimer & Freeman, 1998; Turk & Melzack, 1992). It is important to learn about the pain’s physical, temporal and spatial qualities—what it feels like, if it is constant or intermittent, and if it is physically localized, or experienced as diffuse, radiating, or spreading. If psychological testing is performed, it usually should be kept brief, as most chronic pain patients often are too impatient to take tests that they may experience as irrelevant to their pain problems (Eimer & Allen, 1995/1997; Eimer & Freeman, 1998).

It is also important to determine whether or not a chronic pain patient suffers from what Ewin (1986, 1992) has termed Constant Pain Syndrome. This condition is characterized by the patient experiencing the pain as always being there. It is identified by the patient’s answering no to two essential questions: (1) “Since your pain started, has there ever been a

time when you were completely free of pain?” and (2) “Are you pain-free when you are asleep?” (Ewin, 1986, p. 283).

Ewin hypothesizes that on an unconscious emotional level, patients with constant pain may equate their pain with being alive, and therefore by implication, that they may unconsciously equate the pain’s removal with death. This hypothesis ought to be considered when clinical history-taking reveals that there has been a simultaneous occurrence of three things at the time of the pain’s onset: (1) mental disorientation, as in a concussion, stroke, or drug overdose; (2) fear of dying; and (3) significant pain (“Ewin’s triad”: Ewin, 1986). Ewin postulates that such a coincidence of events can imprint (meaning fix in place) in the patient’s unconscious the idea that the pain equals life. If this is in fact so, then reframing this idea may be an important goal of Brief Pain Management Psychotherapy.

Assessing Hypnotizability for Hypnotic Analgesia

Given that the subjective experience of pain includes sensory-discriminative, affective-motivational, and cognitive-evaluative components (Melzack & Wall, 1965; 1982), it is important when evaluating the effectiveness of hypnotic interventions for pain management to specify which of these components were addressed. Holroyd (1996) points out that, at least in experimental settings, hypnosis has generally been more effective in reducing pain’s affective component (distress and suffering) than in inducing analgesia to pain’s sensory component. However, this general conclusion needs to be qualified by the patient variable of hypnotizability. For example, in an experimental study by Price and Barber (1987) as discussed by Barber (1996), highly responsive subjects were better able to reduce pain’s sensory component than were less hypnotically responsive subjects. Both groups of subjects, however, were equally effective in reducing the affective or suffering component of the pain.

Hypnotic Analgesia

Pure pain reduction, or analgesia, is a psychological treatment goal that is more frequently associated with hypnotic interventions than with other psychological and behavioral interventions such as Cognitive-Behavior Therapy and biofeedback (Brown & Fromm, 1987; Eimer & Freeman, 1998; Holroyd, 1996). Typically, with an adequately prepared patient, clinicians can help that patient experience a significant amelioration of pain intensity through the use of hypnosis with appropriately designed suggestions for hypnotic analgesia, pain coping, and relaxation (Brown & Fromm, 1987; Eimer & Freeman, 1998).

Following Crawford et al. (1998), hypnotic analgesia is understood to be attention-based “in that persons inhibit incoming sensations from awareness while often simultaneously deploying their attention elsewhere” (p. 1). Highly hypnotizable persons in contrast to low hypnotizables appear to have a greater ability to: (1) sustain focused attention; (2) become absorbed in either positive or negative experiences; (3) actively inhibit their attention to incoming stimuli, and (4) learn to flexibly shift their focus of attention, coping strategy, or state of consciousness (Bates, 1993; Crawford, 1990, 1994; Crawford et al., 1998; Eimer & Freeman, 1998; Evans, 1991; Hilgard & Hilgard, 1994; Lynn & Sivec, 1992; Spiegel & Spiegel, 1978/1987; Woody, Bowers, & Oakman, 1992). To the extent to which a clinician is able to draw on these abilities in a highly hypnotizable patient, or teach low hypnotizables how to do these things, the clinician is more likely to be effective in inducing relief from pain through the use of hypnosis.

The Hypnotic Induction Profile (HIP)

Based on the above as guiding assumptions, it is my view that it is often desirable to administer a brief portable assessment of hypnotizability at the outset of one's clinical work with most pain patients. Spiegel and Spiegel's (1978/1987) Hypnotic Induction Profile (HIP) typically serves this purpose well. This procedure is brief, taking anywhere from 5 to 10 minutes, and places few performance demands on the patient, while at the same time getting the patient to actively do something. When the HIP is administered as part of a patient's introduction to hypnosis, it can provide the patient with a firsthand experience of what hypnosis is like, while at the same time inform the clinician about the patient's hypnotic response capabilities and personality style.

Introducing the HIP. The HIP is administered in such a way as to establish a flow and minimize performance anxiety. One item in the scale should flow into the next so that the patient experiences the whole procedure in a smooth and continuous manner (H. Spiegel, personal communication, 1996). The HIP is introduced to the patient as a method of seeing how quickly the patient can get relaxed (Wain, 1998).

This is how I introduce the HIP to patients in the waking state before inducing trance or deep relaxation:

You are here in the office today for help in coping with pain. Pressure, stress, and tension worsen pain. Relaxation helps everyone lessen pressure, stress, and tension because relaxation is the opposite of stress and tension. The two are not compatible. When you are deeply relaxed, you cannot feel pressure, tension and stress. One of the ways I may be able to help you cope better with your pain is to teach you a method of going into deep relaxation. So, with your permission, I would like to use a brief procedure to see how quickly you can get relaxed. Is that alright with you? Then, with your permission, I would like to teach you a way to improve your ability to get deeply relaxed whenever you want to. Is that alright with you?

Hypnotic Phenomena Assessed with the HIP. The HIP tests the patient's motivation and willingness to comply with the clinician's directives and suggestions as part of the hypnotic induction ritual. It also assesses the patient's capacity to experience a number of hypnotic phenomena relevant to inducing hypnotic analgesia. These phenomena include speed and automaticity of responsiveness to hypnotic suggestions; imagination capabilities; and the ability to: enter a relaxed state; suspend voluntary control; experience an altered state of consciousness; feel floating sensations; produce a signalled arm levitation; perceive physical dissociation; respond to post-hypnotic suggestion; and experience spontaneous amnesia.

Based on a patient's quantitative Induction Score and qualitative Profile Pattern on the HIP, that patient may be classified as being either a Non-Hypnotizable, Low Hypnotizable, Mid-Range (Moderate) Hypnotizable, or High Hypnotizable. This information, interpreted along with that patient's pattern of responses on the Spiegel Apollonian-Odyssean-Dionysian Personality Style Questionnaire (AOD: Spiegel & Spiegel, 1978/1987, pp. 152-153), can enable the clinician to make some predictions about that patient's ability to benefit from specific pain management strategies, which can be useful for treatment planning. Criteria for sorting patients into these hypnotizability categories are summarized below along with recommended hypnotic and non-hypnotic pain management strategies. For detailed

guidelines and instructions explaining how to score each item on the HIP, tabulate and interpret these scores, and compute a patient's Induction Score and Profile Pattern, the reader is referred to the original source, Spiegel and Spiegel (1978/1987).

Irrespective of hypnotizability level, with acute pain states anxiety is the predominant affect that usually needs to be addressed and reframed. With chronic pain states, the predominant affects tend to be depression, anger and anxiety.

Hypnotic Strategies for High Hypnotizables. Based on the HIP, patients are classified as highly hypnotizable if their total Induction Score sums to anywhere between 14 and 16. These patients generally evidence a Grade 3 to 4 eye roll and Regular Intact HIP Profile Patterns. Some show the Grade 5 syndrome (Spiegel & Spiegel, 1978/1987). Their responses on the Spiegels' AOD Personality Style Questionnaire often cluster in what the Spiegels term the Dionysian category (named after the Greek god Dionysus). Dionysian responses reflect a high capacity for absorption and intense and focused concentration, good imagination capabilities, a present versus past or future time orientation, a tendency to be trusting, an excellent memory, and a willingness to go with one's feelings and suspend critical judgment in different situations.

Highly hypnotizable chronic pain patients are most likely to benefit from direct hypnotic suggestions for alleviating and altering their pain. A brief induction is usually all that is necessary to induce an adequate trance for the hypnotic work. High hypnotizables typically show high automaticity in their hypnotic responses. Specific pain relief strategies that high hypnotizables are often capable of utilizing effectively include: direct suggestions for turning down the pain; induction of numbness; transfer of glove anesthesia; symptom substitution and transformation; displacement of pain sensations; physical dissociation of and from painful areas of the body; induction of amnesia; time distortion; age regression to times of comfort before the pain; and post-hypnotic suggestions associating instant analgesia with specific cues or behaviors. They also frequently respond favorably to brief psychodynamic reprocessing of emotional material uncovered during trance utilizing exploratory age regression and ideomotor communication methods described by Cheek (1994), Cheek and LeCron (1968), Ewin (1986, 1992), and Rossi and Cheek (1988).

When the pain is reported as constant, or when a Constant Pain Syndrome is diagnosed based on Ewin's (1992) criteria, the clinical use of Cheek's and Ewin's methods can often prove to be helpful and productive. When the pain is intermittent or episodic, high hypnotizables may benefit from posthypnotic suggestions anchored to prepain cues. When the pain is continuous, they may be more likely to benefit from posthypnotic suggestions anchored to frequent situational cues and habit behaviors.

Hypnotic Strategies for Low Hypnotizables. Based on the HIP, patients are classified as low in hypnotic responsiveness if their total Induction Score sums to anywhere between 6 and 9. These patients typically show a Grade 0 to 2 eye roll, and may have Regular Intact, Special Zero, or Nonintact Soft HIP Profile Patterns (Spiegel & Spiegel, 1978/1987). Their responses on the AOD Personality Style Questionnaire often cluster in what the Spiegels label as the Apollonian category (after the Greek god Apollo). According to the Spiegels' personality typology, Apollonian characteristics include being more cognitively oriented, organized, critical, and logical. It is more difficult for them to withdraw their peripheral awareness, and hence they have the least ability for intense focused concentration and absorption. Apollonians tend to value reason, intellectual understanding, and the retention of control over passion, feelings, emotion, heartfelt intuition, trust and letting go.

Chronic pain patients who score in the low range of hypnotizability tend to have the most difficulty ignoring a painful stimulus. Therefore, pain control for these patients is likely to require more effort from them. They are most likely to benefit from direct suggestions for redirecting their attention away from the pain onto something else. However, it can also often be helpful to intersperse therapeutic suggestions conversationally in an indirect but subtle manner.

An emphasis on hypnotic induction procedures is often contraindicated. If an induction is utilized at all, it should be short so as to avoid confronting patient resistance due to issues such as performance anxiety, doubts about the ability to be hypnotized, need to retain control, and so on. In fact, it often may be more effective to avoid using the term hypnosis and instead, to refer to the protocol as coping strategy training or relaxation training.

Specific pain control strategies that low hypnotizables tend to be most capable of utilizing include: redirection of attention to other body parts, competing sensations, or something external (e.g., a marble: Zarren, 1996a, 1996b, Zarren & Eimer, 1999, in preparation); reminders of things that the patient actually does that give pain relief; learning an effective relaxation method; breathing work; biofeedback training; cognitive reframing of catastrophic thoughts and images (Eimer & Freeman, 1998; Zarren & Eimer, in preparation); instruction in the use of positive coping self-talk (Hanson & Gerber, 1990; Turk, Meichenbaum, & Genest, 1983); self-instructional and stress inoculation training (Meichenbaum, 1985); coaching in thought interruption; designating coping cues based on a stimulus control model (Fordyce, 1988; Turk, Meichenbaum, & Genest, 1983); building pain tolerance through gradual increases in exposure time to pain through direct focus on pain sensations (Eimer & Freeman, 1998); imaginary transformation of the pain's context (Turk, Meichenbaum, & Genest, 1983); and age progression or time projection into a pain-free or less painful and more comfortable positive future (Erickson, 1980).

It also tends to be beneficial to guide these patients in relabeling pain on a comfort-discomfort continuum. Patient motivation to get well and contextual placebo effects should be exploited (Evans, 1974, 1990, in press). Patients' perceptions of self-efficacy can be built up through a process of guiding them to try out and assess the effectiveness of different coping strategies. Brown and Fromm's (1987) protocol for building self-efficacy and progressive task mastery involves guiding the patient through a hierarchy of pain control tasks graded according to their difficulty and degree of psychological baggage, beginning with an easy task. The patient is helped to achieve success in using strategies to control neutral, artificially induced, temporary, non-clinical types of pain first (e.g., pain produced by pinching the webbing between thumb and index finger, or by the cold pressor method). Then, the patient is guided on to less distressing clinical pain, and only gradually worked up to addressing the worst pain last.

When the pain is intermittent or episodic, low hypnotizables are likely to benefit from the suggestion to implement a coping strategy previously found to be effective at the first sign of the pain. When the pain is continuous, they are likely to benefit from the suggestion to employ the chosen coping strategy at fixed intervals which are tied to the duration of pain relief experienced.

All of the above make it clear that there is a large selection of pain coping strategies from which to choose for patients with low hypnotic responsiveness. One of the most important considerations is assessing which coping strategies work best for whom by giving these patients the opportunity to test out different strategies while reframing negative beliefs that fuel performance anxiety, pessimistic thinking, doubtfulness, and discouragement. Also,

with these patients, it is useful to redirect the focus towards reducing affective distress and suffering as opposed to focusing exclusively on altering or alleviating the sensory aspects of the pain. In this regard, it is usually helpful to focus on reframing the pain's meaning, and changing the patient's attitude, with the goals of building acceptance of the pain, faith and hope.

Hypnotic Strategies for Mid-Range Hypnotizables. Based on the HIP, patients are classified as mid-range or moderate in hypnotic responsiveness if their total Induction Score sums to anywhere between 10 and 13. These patients usually show a Grade 2 to 3 eye roll, and may have Regular Intact or Special (Incremental) Intact HIP Profile Patterns (Spiegel & Spiegel, 1978/1987). Their responses on the AOD Personality Style Questionnaire often cluster in both the Apollonian and Dionysian categories. According to the Spiegels' personality typology, for these individuals who are termed Odysseans (named after the Greek tragic hero and wanderer, Odysseus), there exists a perennial tension between reason and feeling which often leaves them feeling less settled and the effects of conflicting pressures.

Chronic pain patients who score in the mid-range of hypnotizability are likely to benefit from indirect as well as direct hypnotic suggestions for avoiding and altering their pain. In some cases, a longer induction may be necessary to induce an adequate trance for hypnotically working with the pain. In other cases, a short induction may be more indicated in order to bypass patient resistance. Mid-range hypnotizables typically show a moderate and variable degree of automaticity in their hypnotic responses.

Specific pain control strategies that mid-range hypnotizables tend to be most capable of utilizing include: building pain replacement images (e.g., tingling, cooling, lightness, floating); redirecting attention to other body parts, competing sensations, or something external (e.g., a marble: Zarren, 1996a, 1996b; Zarren & Eimer, 1999, in preparation); reminders of things that the patient actually does that give pain relief; arm levitation; transfer of glove anesthesia, cognitive reframing of catastrophic thoughts and images; and post-hypnotic suggestions marking specific cues as reminders to do self-hypnosis or instant relaxation. They also often respond favorably to brief psychodynamic reprocessing of emotional material uncovered during trance utilizing the exploratory age regression and ideomotor communication methods described by Cheek (1994) and Ewin (1986, 1992).

When the pain is episodic, mid-range patients may benefit from suggestions to do self-hypnosis at the first sign of pain. When the pain is continuous, they are more likely to benefit from suggestions to do self-hypnosis at fixed intervals that are tied to the duration of pain relief experienced.

Strategies for Non-Hypnotizable Patients. Patients whose total Induction Score sums to anywhere between 0 and 5, and who evidence Regular Zero and Nonintact Decrement Profile Patterns on the HIP are considered non-hypnotizable. Regular Zeros evidence no inherent potential for hypnosis based on a zero eye-roll sign and an inability to experience any of the central hypnotic phenomena on the HIP (Spiegel & Spiegel, 1978/1987). Nonintact Decrements show some inherent potential to experience trance (as evidenced by a positive eye-roll sign), but they cannot express this potential because of an inability to sustain the necessary concentration and focus. Patients who show these profile patterns can nevertheless be helped non-hypnotically in controlling their pain utilizing many of the same strategies applicable to low hypnotizables. Waking State Reframing (Zarren, 1996a; Zarren & Eimer, 1999, in preparation) of negative beliefs fuelling depression, anger, and anxiety, the suffering component of the pain, is especially applicable.

The problems of non-hypnotizability and patient resistance to the label hypnosis also may be circumvented frequently by utilizing a brief relaxation procedure that does not present any performance demands or hypnotic challenges. The patient is first helped to feel comfortable in a relaxed state in the office. Then, the patient is taught to do self-relaxation based on the office experience. Following earlier work by Zarren (1996a, 1996b), direct suggestions such as the following are made with the patient in a comfortable state of relaxation:

Today, you are learning what it feels like to be comfortably relaxed. You are building a memory of deep relaxation that you can borrow back to relax yourself . . . You don't have to talk to yourself, or give yourself suggestions. The very act of relaxing yourself in this way automatically reinforces the things that I have said to you today during the relaxation experience and the things I may say to you in the future, when you are comfortably relaxed (Zarren & Eimer, 1999, in preparation).

In this way, the patient is helped to transfer the memory of deep relaxation experienced in the office over the course of several sessions to his or her own self-relaxation practice.

During their own self-relaxation practice, patients usually are instructed just to relax, and not to talk to themselves (Zarren, 1996b). After patients feel successful doing self-relaxation, they are often given the homework assignment of writing out their pain control goals as specifically as possible in terms of what they want to accomplish. These goals are gone over in the following meeting and transformed into appropriate, short and simple positive suggestions that are written down and given to the patient to take home. Patients from then on are instructed to read these pain control suggestions several times to themselves a few minutes before doing their self-relaxation at home.

The Induction of Hypnotic Analgesia and Development of Individualized Pain Coping Strategies

Capacity to Experience Hypnotic Analgesia and Individualizing Pain Coping Strategies

Pain is usually experienced by the chronic pain patient as nonvolitional and out of control. Likewise, successful hypnotic analgesia is typically marked by effortless or automatic reduction in pain. In fact, one of the distinguishing features of hypnosis is the experience of nonvolition that typically accompanies hypnotic responding (Eastwood, Gaskowski & Bowers, 1998). This is what may make it especially well suited for pain control.

A study by Eastwood, Gaskowski & Bowers (1998) provided support for the notion that hypnotic analgesia differs qualitatively from cognitive-behavioral pain coping strategies in that the former does not appear to require as much active attentional effort as does the latter. These investigators found that levels of reported pain were affected by an interaction between frequency of requested pain report, pain control strategy used, and level of hypnotizability. More frequent pain reporting was associated with less pain reduction for high hypnotizables using cognitive coping strategies as opposed to hypnotic analgesia; for low hypnotizables, more frequent pain reporting was associated with less pain reduction regardless of strategy utilized.

The clinical implications of these findings are that more frequent pain reporting (as is promoted through the use of pain diaries, or frequently requesting patients to report their pain levels) may ironically serve to reinforce some patients' (low and medium hypnotizables)

preoccupation with their pain and hence increase their pain. For low hypnotizables, hypnotic analgesia apparently requires a substantial amount of attentional effort, and their concentration may in fact be interrupted by having to rate their pain. However, for high hypnotizables, hypnotic analgesia does not appear to require as much attentional effort. Given their apparent ability to process information effortlessly on a number of levels simultaneously, frequent pain reporting under hypnotic analgesia apparently is not as disruptive of high hypnotizables' analgesic state as it is for low hypnotizables. These findings underscore the clinical importance of assessing patients' hypnotic abilities in order to match appropriate pain treatment and coping strategies with patient characteristics.

Expectancy and Placebo Effects. Another important clinical issue has to do with the fact that there appears to be a strong expectancy, relational, and contextual placebo component operating in the hypnotic context (Barber, 1996; Chaves, 1999; Coe, 1993; Evans, 1974; Kirsch, 1999; Kirsch & Council, 1992; Woody, Bowers, & Oakman, 1992). That is, the expectation that hypnosis will work to reduce pain can become a therapeutically exploitable self-fulfilling prophecy. The importance of manipulating a patient's expectancies in the service of the therapy should not be minimized, especially with patients of low hypnotizability. Hypnosis and suggestion may be facilitative of other cognitive strategies in reducing pain in so far as they promote positive expectancy effects (Chaves, 1993, 1999; Eimer & Freeman, 1998; Evans, in press; Kirsch & Council, 1992).

The major clinical implication is that the assessment of hypnotizability is best not construed as a pass/fail or trait phenomenon that exists irrespective of the situational context. To do so, could ignore the very important role that situational influences have on hypnotic performances (Council, 1999; Kirsch, 1999; Kirsch & Council, 1992), and on patients' subjective experiences of hypnosis. It seems that a good strategy for introducing a hypnotizability test such as the HIP is to explain to the patient that the procedure is a way of seeing how quickly the patient can get relaxed, of discovering the best way to teach that patient how to relax, and of determining the best pain management strategy for that patient. This is likely to keep any unnecessary performance anxiety or negative feelings about hypnosis to a minimum. This approach may also serve to prime the patient for further exploration of hypnotic phenomena that might be useful for pain management and for the development of appropriate individualized pain coping strategies.

Pain Coping Strategies, Hypnosis, and Pain Treatment Outcomes

Pain coping strategies are the things that individuals do to handle or deal with their pain. Pain coping strategy utilization is associated with patients' adequacy of adjustment to their condition and pain treatment outcomes (Eimer & Allen, 1995; Hill, Niven, & Knussen, 1995; Jensen & Karoly, 1991; Keefe et al., 1990; Revenson & Felton, 1989; Rosenstiel & Keefe, 1983; Turner & Clancy, 1986). Various classificatory schemes have been developed for sorting pain coping strategies, and research has revealed that certain ones predict positive adjustment and others predict maladjustment and disability (Eimer & Freeman, 1998; Keefe et al., 1990; Rosenstiel & Keefe, 1983; Turner & Clancy, 1986).

Many of the positive coping strategies can be taught, and coping strategy training can be conducted both with and without hypnosis. However, appropriate clinical utilization of hypnosis can often enhance patients' learning of appropriate positive coping strategies. For example, hypnotic rehearsal of functional pain coping and relaxation skills can help many patients feel more comfortable using them in actuality. In addition, hypnotic rehearsal of positively reinforcing activities and other techniques borrowed from sports medicine can

be useful for reactivating dormant action potentials and facilitating a patient's physical rehabilitation (Evans, 1990; in press).

Classifying Pain Coping Strategies

The 4 A's of Pain Management. Brown and Fromm (1987) have conceptually sorted hypnotic and cognitive pain coping and self-control strategies into four non-mutually exclusive categories. These are *Avoidance*, *Alteration*, *Alleviation*, and *Awareness* (the 4 A's). They advocate assessing the patient's ability to benefit from the use of different strategies within each of these categories by first introducing and testing the strategies during successive trials with a self-induced, controlled, and neutral pain (e.g., pinching the webbing between thumb and index finger) in the waking state. The goal is to compile an individualized hierarchy of strategies in terms of their effectiveness for each patient. After the patient experiences some self-efficacy, suggestions are gradually given for transfer of the pain control and analgesia to the patient's clinical pain.

Coping strategies for avoiding pain would include: internal and external distraction, shifting the focus of attention to something else, displacement to another part of the body, focusing on breathing, time distortion, hypnotic dreaming to discover inner and external resources, recalling a pleasant memory or imagining a pleasant fantasy, and age regression and progression.

Strategies for altering the pain experience which comprise the largest category would include: inducing amnesia, reframing the pain's meaning, relabeling terms that take the focus off of pain as pain (such as relabeling pain as discomfort), cognitive modification of catastrophic interpretations and ideation, imaginal rehearsal of stress inoculation techniques for different pain trigger situations, self-image modification, sensory transformation and symptom substitution, pain displacement to another bodily location, transferring numbness or comfort from another part of the body to the painful body part (as in "glove anesthesia"), eliciting pain relief imagery, imaginal transformation of the pain context, relaxation, breathwork, and physical dissociation from the pain.

Alleviation strategies would include: direct suggestion for reduction in the pain's intensity, frequency, and duration, and the induction of numbness and hypnotic analgesia.

Finally, awareness strategies would include: dispassionately and passively watching the pain, objectively describing it and freely associating to how it feels, pain diary keeping, and rating the pain's magnitude and intensity. Directly focusing on and describing the pain in detail can be a useful induction strategy for patients who have difficulty going into trance (Barr, 1998). This "hard work" can set the stage for giving the suggestion to the tired patient to just let go, drift off, and relax.

Which Cognitive Coping Strategies Work Best for Whom?

Based on the voluminous research on pain coping strategies (Anderson & Rehm, 1984; Eimer & Allen, 1995/1997; Eimer & Freeman, 1998; Fernandez & Turk, 1989; Hanson & Gerber, 1990; Hill, Niven, & Knussen, 1995; Holmes & Stevenson, 1990; Keefe et al., 1990) and my clinical experience, we need to match our coping strategy interventions with patients' preferred modes of coping and personality styles, levels of hypnotizability, and the type, intensity, duration, and chronicity of the target pain. Some coping strategies are more learnable and useful for high as opposed to low hypnotizables (Eimer & Freeman, 1998; Evans, 1991; Hilgard & Hilgard, 1994; Holroyd, 1996; Price & Barber, 1987; Spiegel

& Spiegel, 1978/1987). For example, high hypnotizables often are more capable of successfully employing coping strategies that involve the use of imagination and imagery to alleviate, alter, and avoid the sensory experience of pain.

Nevertheless, for patients at all levels of hypnotizability, reducing the tendency to catastrophize and make habitual negative cognitive appraisals appears to be a key positive change mechanism because patients' beliefs and thought processes mediate their use of coping strategies (Anderson & Rehm, 1984; Eimer & Allen, 1995/1997; Eimer & Freeman, 1998; Fernandez & Turk, 1989; Jensen & Karoly, 1991; Lefebvre, 1981; Shutty, DeGood, & Tuttle, 1990; Williams & Keefe, 1991). Negative, maladaptive beliefs and appraisals are related to dysfunctional coping behavior. Therefore, the delivery of direct suggestions to the patient to cognitively reframe maladaptive beliefs is a key component of Brief Pain Management Psychotherapy.

Direct Suggestion, Cognitive Reframing, Hypnotic Metaphors, and Pain Relief Imagery

Waking State and Trance State Reframing

Cognitive reframing of negative beliefs may be most effective when it is done both before the induction of trance and during the trance experience. Utilizing change language (Watzlawick, 1978; Zarren, 1996a; Zarren & Eimer, in preparation) to communicate with the patient's Conscious and Unconscious at the same time in a waking, non-trance state, the patient is prepared for the trance experience. This process can be called *Waking State Reframing* and is conceptualized as the entre to the trance experience. It constitutes the basis for establishing the therapeutic relationship, changing the way the patient thinks about the target issues, and seeding therapeutic ideas.

As the patient goes through the process of relating to the therapist, and begins to feel more relaxed, the patient's suggestibility frequently increases. After the hypnotic induction ceremony, during the trance experience, the appropriate positive therapeutic suggestions seeded earlier during the waking state may be repeated using somewhat different phrasing to reinforce the cognitive reframes presented prior to trance. This phase of the therapy can be termed *Trance State Reframing*.

According to the cognitive working model underlying the protocol I employ, the trance state is conceptualized as an altered state of awareness that involves increased absorption and concentration, increased receptivity to suggestion, and very often relaxation. It is understood as an altered state, but one that is an exaggeration of an altered state that has already been developed during the waking state reframing phase of the therapeutic relationship during which the patient's suggestibility has been primed (Zarren, 1996a; Zarren & Eimer, 1999, in preparation).

Waking State Reframing followed by relaxation, trance induction, direct suggestion, utilization of hypnotic metaphors, and imagery work, are often successful in fixing information in place in the patient's Conscious and Unconscious, and in helping the patient change dysfunctional beliefs, feelings, and behavior.

Hypnotic Metaphors and Pain Relief Imagery

Hypnotic Metaphors. Hypnotic metaphors combined with suggestions for pain relief imagery can often be employed for: teaching useful concepts; uncovering, exploring,

reframing, and changing the meaning of the patient's pain experience; helping the patient remember to employ adaptive pain coping strategies; and building a functional repertoire of thoughts and images that may promote pain relief (Eimer & Freeman, 1998; Evans, 1990, in press; Ewin, 1978, 1986, 1992). They can also provide the patient with an understandable model of pain mechanisms, a convincing rationale for the therapy, and assist in modifying negative thinking patterns and images that may be maintaining suffering and continuing distress.

Pain Management Metaphors. Some useful conceptual metaphors that may provide fertile seeds for elaborating appropriate pain management suggestions are:

(1) You can learn to "filter the hurt out of the pain" (Spiegel & Spiegel, 1978/1987, pp. 254-256).

(2a) "When suffering is removed, pure pain does not hurt as much" (Ewin, 1978, p. 87, 1986, p. 285).

(2b) Would it be all right for you to experience a small amount of pure pain as long as it is at a tolerable level? (Ewin, 1978, p. 87, 1986, p. 285).

(2c) Now that you know you are alive because you know that all of the usual signs of life are present, wouldn't it be preferable to be alive without pain than to be alive with it? (Ewin, 1978, p. 88, 1986, pp. 284-285).

(2d) "No pain lasts forever" (Ewin, 1978, p. 89, 1986, p. 286).

(2e) Perhaps you have already suffered more than enough to make up for your faults and mistakes (Ewin, 1978, p. 89, personal communication, March, 1997);

(2f) You are the one who is suffering, miserable, and disabled, not the object of your anger (Ewin, 1986, p. 286).

(2g) Is it fair for you to be both your own judge and jury? (Ewin, personal communication, March, 1997).

(3) "Is there any possible good that can come out of all this?" (Ewin, 1986, p. 286);

(4) Pain may be mandatory but suffering is optional.

(5) The master control room panel, pain dimmer switch, or pain intensity rheostat resides in your brain (Mutter, 1998).

(6) You can learn to control unwanted and unnecessary pain. Your alarm system will remain intact so that you will notice and experience any new sensations (Barr, 1998).

The ABC's Model of Cognitive Pain Management. I frequently find it useful to integrate the assumptions underlying Melzack and Wall's (1965, 1982) Gate-Control Model with Albert Ellis's (1993) ABC cognitive approach as a framework for reframing patients' beliefs about the factors that may make their pain worse (Eimer & Freeman, 1998). For example during Waking State Reframing, I often say the following to patients:

Persistent pain is a real adversity to have to deal with. Let's give it the letter A for the moment because A is the first letter in the word adversity. Now, the emotional consequences of having persistent pain may be that you get into moods where you feel mad, scared, sad, or depressed. For the moment, let's give these emotional consequences the letter C because C is the first letter in the word consequences.

Now there is something that begins with the letter B that lives between the A and the C, between the adversity of having persistent pain and the emotional consequences of this unfortunate reality which colors your experience and brings on your negative moods. This letter B is the first letter in the word beliefs. Your beliefs live between the adversity of persistent pain and the emotional consequences which color your experience. Your beliefs include everything you tell yourself when you are in pain, all the thoughts you have and judgments you make about yourself, your pain, your condition, other people, the treatments you have gone through, and so on. This B-factor or belief factor affects how you perceive and experience the adversity of the pure physical sensations that make up your pain. So these are the ABC's of the pain experience.

Now this idea is important because it provides a possible solution that may help you to feel better and cope better. The solution is to recognize and take responsibility for your thoughts, feelings, and behaviors. Recognize what you are telling yourself at point B, your beliefs, when you are in pain and in a bad mood, and then think and do something different.

Remember that at point A you have pain, at point B, you have some thoughts or beliefs about the pain, or about how somebody has treated you, and at point C, you may feel mad, scared, sad, or some other bad feeling or mood. Unfortunately, these feelings may be making you suffer more than you have to. So, if we can somehow remove this suffering part of the pain, you may not have to hurt quite as much. You may feel more comfortable. That is the point of this whole ABC idea.

So, when you recognize that you are in a bad mood, recognize that your bad mood is the emotional consequence of being in pain. Then, recognize what you are thinking or believing at that moment, or what you are doing at that moment—we can add the letter D which is the first letter in doing. Then change what you are thinking or believing, do something different, and you will feel less upset, less hurt, suffer less, and feel more comfortable.

A Movie Theater Metaphor. Following Chapman & Nakamura (1998), a movie theater metaphor can be suggested during waking state reframing to change a chronic pain patient's perceptions of the immediacy, urgency, and importance of pain signals. For example:

Imagine that you are sitting in a theater watching a movie. If you should suddenly hear alarming shouts of smoke and fire, you would respond appropriately. An unexpected shout of "Fire!" will command attention because it is important to survival. But, if you knew that the shouting was from kids fooling around, which in your experience does not signal

an impending blaze, you would know that you need not pay it any attention. You might want the volume on the movie turned up, or more activity to go on on the screen, so that the shouting could be drowned out or reduced in clarity. The more you can remain absorbed and interested in the movie, the less distracting and bothersome the shouts of false alarm will be.

Hypnoprojective Techniques. Brown and Fromm (1986) describe a variety of hypnoprojective techniques for helping patients in hypnosis or trance produce imagery or fantasies to symbolically represent the unconscious meaning of their symptom or problem. For example, invoking the movie theater metaphor again, the therapist may suggest that the patient imagine watching the screen as a movie begins that is about the target problem or symptom. One step removed from the problem, the patient can then be guided permissively to explore the problem symbolically, and to discover feelings, thoughts, and solutions to the problem that may come up while continuing to imagine watching the movie unfold.

Spiegel and Spiegel (1978/1987) also describe a visual imagery split screen technique for projecting and partitioning negative and positive thoughts and feelings about a problem, reprocessing them, and finally integrating them into a constructive resolution.

Imaginal Mental Rehearsal. In the imagery modality, visual or another individually appropriate mode of mental rehearsal may often prove helpful for stimulating action potentials for pain coping strategy utilization (Evans, 1990, in press). For example, Evans (1990, in press) describes a useful visual mental rehearsal strategy for patients who wake up feeling stiff and in pain. The patient is taught to practice imagining getting out of bed easily, effortlessly, and energetically for 30 to 60 seconds before actually arising in the morning. This coping strategy can also be mentally rehearsed just before or during the patient's self-hypnosis or self-relaxation practice.

Pain Relief and Healing Imagery. In hypnosis and trance, guided imagery may be employed for facilitating a patient's mental representations of inner healing forces, sources of pain relief, and resources (Barr, 1998; Bresler, 1979; Brigham, 1994; Eimer & Freeman, 1998; Ford, 1994; Mutter, 1998; Rossi & Cheek, 1988; Syrjala & Abrams, 1996). Once the patient's attention is directed inward in the hypnotic state and in trance, it can be suggested that the patient imagine and form a mental representation of the underlying cause of the pain. The patient can then be helped to construct a mental representation of healing and pain relief processes such as drug mechanisms, surgical procedures, physical therapy, therapeutic exercise, palliative procedures (e.g., applying ice or heat to areas that hurt), and the body's own processes of physical healing and repair. Finally, the therapist can help the patient to tailor these mental representations of healing and pain relief to overcome the patient's illness representations. Emphasizing the mind-body connection, the direct suggestion may be offered that this will actually stimulate the physical healing process. It may also be indicated to suggest that the patient practice doing the above pain relief imagery work several times a day before or during self-relaxation or self-hypnosis practice sessions.

Inner Parts Work. Hypnotic metaphors invoking the ideas of working with ego states (Watkins & Watkins, 1997), negotiating among unconscious parts of the personality, and consulting with inner sources of wisdom such as an inner advisor (Bresler, 1979), can also be utilized to help a patient uncover and reprocess thoughts and feelings associated with pain symptoms and the body. The process of dialoguing with inner parts of the self may also prove helpful for negotiating acceptable alternative solutions to psychological conflicts that meet the individual's needs in a more functional manner.

Often, uncovering, exploration, review, and reprocessing of previously unconscious emotional material associated with past experiences and pain is also desirable. In such cases, I utilize a brief insight-oriented psychotherapy and hypnosis protocol derived from the pioneering work of Ewin (1978, 1986, 1992) and Cheek (Cheek, 1994; Cheek & LeCron, 1968; Rossi & Cheek, 1988), and also described in Hammond (1990).

Brief Psychodynamic Reprocessing of Emotional Factors Associated with Chronic Pain

Following Cheek (1994) and Ewin (1978, 1986, 1992), the protocol I employ entails the use of age regression and ideomotor communication during trance to help the patient uncover, explore, review, and psychodynamically reprocess dysfunctional thoughts and feelings related to that patient's persistent pain state and continued suffering. The material uncovered in the trance state is reviewed by the patient with the therapist's guidance and supervision. The therapist then helps the patient to rationally reframe the material in order to promote more functional thoughts and feelings, and reduce the negative emotional overlay that can worsen pain (Cheek, 1994; Cheek & LeCron, 1968; Eimer & Freeman, 1998; Ewin, 1978, 1984, 1986, 1992; Hammond, 1990; Rossi & Cheek, 1988; Zarren & Eimer, in preparation).

Basic Assumptions Underlying the Use of Brief Psychodynamic Reprocessing

As I see it, this insight-oriented psychodynamic reprocessing protocol is predicated on the following set of basic assumptions. (1) At one time in the past, the patient's now chronic pain was acute. (2) When that acute pain first began to appear significant to the patient, and unresolvable or unexplainable, the patient began to wonder if it would ever go away, and significant anxiety probably resulted. (3) This anxiety, along with whatever other intense emotional feelings were generated at that time, became associated with the pain. (4) The pain as a message from the body signifying that something was wrong, along with these intense emotional feelings, became fixed (or one might use the term imprinted) in the patient's Unconscious along with some specific negative and dysfunctional thoughts. (5) As the pain continued to remain, it created further unresolved stress which intensified the patient's negative emotional experience and strengthened the patient's negative and dysfunctional beliefs. (6) For the patient to feel better, these cognitive and emotional factors need to be uncovered and reviewed, and the negative, dysfunctional thoughts and beliefs need to be reframed so that the patient thinks and feels differently about the material and the meaning of his or her pain.

The Step-By-Step Psychodynamic Reprocessing Protocol

What follows is a summary of the essential steps of the protocol modelled from the work of Cheek (Cheek, 1994, personal communication, 1995; Cheek & LeCron, 1968; Rossi & Cheek, 1988) and Ewin (1978, 1986, 1992, personal communication, March, 1997). While I have organized the steps in this way for ease of learning, teaching, and following them, the therapist needs to be flexible in their application. The procedure should flow naturally because one can never be sure in advance where the process will lead. The therapist needs to be prepared to handle new material as it is comes up. Every patient is different even though there are commonalities and patterns.

(1) After having performed an adequate work-up (Eimer & Freeman, 1998), during Waking State Reframing, four ways of communicating with the Unconscious Mind are explained to the patient (Cheek, 1998; Zarren, 1996a; Zarren & Eimer, in preparation): (a) Repetition of a behavior can

turn it into an unconsciously controlled habit; (b) A trauma or crisis can fix in place or imprint in the Unconscious Mind a powerful, usually negative emotion and accompanying cognition or belief; (c) When an individual is in a state of deep relaxation or hypnosis, the doorway to the Unconscious opens, and with the individual's permission, direct suggestions can be given directly to the Unconscious in a language it will accept, to help the individual change behavior he or she wants to change (Zarren, 1996a; Zarren & Eimer, in preparation); and (d) It is possible to communicate directly through the body by means of ideomotor signals. Information that has been stored on an unconscious or physiological level is first converted to a pre-verbal musculo-skeletal level through the utilization of ideomotor or ideosensory signals. Then, these signals from the Unconscious can be utilized to bring that information to a conscious verbal level (Cheek, 1994; Rossi & Cheek, 1988).

(2) Further appropriate Waking State Reframing is done, followed by an appropriate trance induction, and Trance State Reframing (Zarren & Eimer, in preparation).

(3) Ideomotor finger signals are set up following Cheek's methods (Cheek, 1994; Eimer & Freeman, 1998; Hammond, 1990; Rossi & Cheek, 1988).

(4) The patient is regressed back to the first moment the target pain was felt to be important and the patient is asked to review the incident.

(5) The signal value and functional necessity of the pain at that time is affirmed empathically.

(6) Utilizing ideomotor finger signals, the patient's Unconscious Mind is then asked if the pain still has the same functional necessity now as it did then. The patient is asked: "Does your Unconscious Mind know now that your pain has already served its purpose?" and "Since your pain was the best way your body knew to protect itself from further injury at that time, it was very important then. But now you have other ways to protect yourself from further injury. Isn't this true?" A "no" answer requires exploration. A "yes" answer calls for enumeration of these alternative ways by the patient.

(7) The patient is then asked: "Now that you have other ways to prevent further injury, do you still need that pain to protect you from further injury?" A "yes" answer requires further exploration which often uncovers fears and concerns that need to be reframed. A "no" answer calls for asking: "Since you don't need that pain any more and you are here to get rid of it, would it be alright to let it go?" A "yes" answer calls for utilizing Cheek's method for ideomotor turn-off of the pain at an unconscious level (Cheek, 1994, Hammond, 1990; Rossi & Cheek, 1988). A "no" answer calls for asking the patient if it is alright to share what purpose it still serves.

(8) The therapist asks: "Knowing that it still serves an important purpose, do you still need all of it to serve that purpose?" A "yes" response requires further exploration and again usually elicits important material for

reframing. A “no” response calls for asking: “Knowing that all of it is not needed, would it be alright to diminish it to a minimum, more comfortable, tolerable level?” and “Would it be alright to let some of it go?” A “yes” answer again leads to Cheek’s ideomotor turn-off protocol. It is summarized below in steps 9 through 13.

The unconscious pain turn-off procedure is begun only if the patient signals that it feels alright to be more comfortable. In the above steps, this would be either at steps 7 or 8.

(9) The next step is to instruct the Unconscious to turn off the pain on an inner unconscious level and to signal with the yes finger when this has been accomplished.

(10) The patient is then told that it will take a minute or more until he or she becomes consciously aware of the comfort, and to signal as soon as this is noticed.

(11) Following the signal, the patient is told to ask his or her Unconscious for a commitment to maintain this comfort for a specified time period. The patient is asked to signal when this is accomplished and to tell the therapist how long the commitment is for.

(12) This commitment is then reinforced by the therapist through post-hypnotic suggestion.

(13) Finally, the patient is taught to employ these steps in his or her own self-hypnosis.

Ewin (1986) astutely points out that very often the pain returns later that day or the next day with a vengeance because the patient usually has second thoughts fueled by unconscious fears of having relinquished something functionally necessary that in Constant Pain Syndrome cases, is held on to as if it were a life support system! Therefore, it is generally a good idea to be available to see the patient within a day or two of the session in which all of the above work was done. I also tell my patients that if for any reason they feel the need, they should call me. Often, the issue can be reframed over the telephone. As Ewin points out, if the patient complains that the pain has become significantly worse (which is further evidence that the pain had active psychogenic components), this is a good opportunity to paradoxically point out that the patient was able to take control of the pain and make it worse, and therefore, that the patient can also make it better whenever he or she chooses. Then the patient is asked if he or she would like to “cut it in half right now?”

At this point, if the patient answers “yes”, the therapist can lead in one of two directions. One is to repeat Cheek’s ideomotor turn-off protocol. A second is to follow Ewin’s fractionation protocol in cases of Constant Pain Syndrome (Ewin, 1986). This involves inducing trance and instructing the patient to signal when the pain is half as intense as it was when the patient arrived in the office. The next step is key. The therapist asks, “Would it be alright for you to have one minute completely free of pain, realizing it is better to live without pain than to live with pain?” A “yes” response calls for an ideomotor signal when this is accomplished. Following the fractionation or graduation principle of starting with a relatively undaunting task and proceeding up the ladder gradually, it is suggested that if the patient can do it for one minute, then the patient can do it whenever he or she is ready, for two, four, six, eight minutes, a half-hour, an hour, and so on.

It is also essential to emphasize the patient's self-efficacy by suggesting that it is the patient and not the therapist who owns the control. In cases of secondary gain, such as litigation and disability, the patient needs to know that he or she can choose when to exercise that control—that there are times when it is adaptive to perceive the pain, and times when it is adaptive not to.

Summary and Conclusion

This paper described four specific clinical applications of hypnosis that can make psychotherapy for pain management briefer and more efficient. First, important hypnosis terms and concepts were defined from a cognitive perspective. This was followed by a detailed discussion of hypnotizability assessment. As part of the patient's initial work-up, hypnotizability assessment can provide information for developing individualized pain management and coping strategies based on the patient's assessed capacity to experience hypnotic analgesia and related hypnotic phenomena.

While demonstrating the clinical utility of assessing hypnotizability, the importance of being mindful of the effects that patients' expectancies and beliefs have in the clinical context was also discussed. It was shown that these variables can be utilized to reinforce the positive effects of hypnotizability assessment in priming a patient's suggestibility.

Then, a model for Waking State and Trance State Reframing was presented. Ways to employ this model for increasing the effectiveness of direct suggestion, cognitive reframing, hypnotic metaphors, and pain relief imagery were described. Finally, a protocol for brief psychodynamic reprocessing of emotional factors associated with patients' experiences of chronic and persistent pain was described. It was shown how this protocol can be employed as a way of clearing away emotional overlay factors so that the patient can be helped to be more receptive to utilizing sound pain management strategies.

References

- Anderson, L.P., & Rehm, L.P. (1984). The relationship between strategies of coping and perceptions of pain in three chronic pain groups. *Journal of Clinical Psychology, 40*, 1170-1177.
- Barber, J. (1996). *Hypnosis and suggestion in the treatment of pain*. New York: W.W. Norton.
- Barr, T.J. (1998). *Integrating hypnosis into behavioral medicine*. Workshop presented at the Annual Meeting of the American Society of Clinical hypnosis, Ft. Worth, Texas.
- Bates, B.L. (1993). Individual differences in response to hypnosis. In J.W. Rhue, S.J. Lynn & I. Kirsch (Eds.), *Handbook of clinical hypnosis* (pp. 23-54). Washington, DC: APA.
- Bowers, K.S. (1992). Imagination and dissociation in hypnotic responding. *International Journal of Clinical and Experimental hypnosis, 40*, 253-275.
- Bresler, D. (1979). *Free yourself from pain*. New York: Simon and Schuster.
- Brigham, D.D. (1994). *Imagery for getting well: Clinical applications of behavioral medicine*. New York: W.W. Norton & Company.
- Brown, D.P. & Fromm, E. (1986). *Hypnotherapy and hypnoanalysis*. Hillsdale, NJ: Lawrence Erlbaum.

- Brown, D.P. & Fromm, E. (1987). *Hypnosis and behavioral medicine*. Hillsdale, NJ: Lawrence Erlbaum.
- Chapman, C. R. & Nakamura, Y. (1998). Hypnotic analgesia: A constructivist framework. *International Journal of Clinical and Experimental hypnosis*, Vol. XLVI, No. 1, 6-27.
- Chaves, J.F. (1993). Hypnosis in pain management. In J.W. Rhue, S.J. Lynn & I. Kirsch (Eds.), *Handbook of clinical hypnosis*, (pp. 511-532). Washington, DC: APA.
- Chaves, J.F. (1999). Applying hypnosis in pain management: Implications of alternative theoretical perspectives. In I. Kirsch, A. Capafons, E. Cardena, & S. Amigo (Eds.), *Clinical hypnosis and self-regulation: Cognitive-behavioral perspectives* (pp. 227-247). Washington, D.C.: American Psychological Association.
- Cheek, D.B. (1994). *Hypnosis: The application of ideomotor procedures*. Boston: Allyn & Bacon.
- Cheek, D.B., & LeCron, L.M. (1968). *Clinical hypnotherapy*. New York: Grune & Stratton.
- Coe, W.C. (1993). Expectations and hypnotherapy. In J.W. Rhue, S.J. Lynn & I. Kirsch (Eds.), *Handbook of clinical hypnosis*, (pp. 73-94). Washington, DC: APA.
- Council, J.R. (1999). Measures of hypnotic responding. In I. Kirsch, A. Capafons, E. Cardena, & S. Amigo (Eds.), *Clinical hypnosis and self-regulation: Cognitive-behavioral perspectives* (pp. 119-140). Washington, D.C.: American Psychological Association.
- Crawford, H.J. (1990). Cognitive and psychophysiological correlates of hypnotic responsiveness and hypnosis. In M.L. Fass & D.P. Brown (Eds.), *Creative mastery in hypnosis and hypnoanalysis: A festschrift for Erika Fromm* (pp. 47-54). Hillsdale, NJ: Erlbaum.
- Crawford, H.J. (1994). Brain systems involved in attention and disattention (hypnotic analgesia) to pain. In K.H. Pribram (Ed.), *Origins: Brain and self-organization* (pp. 661-679). Hillsdale, Erlbaum.
- Crawford, H.J., Knebel, T., Kaplan, L., Vendemia, J.M.C., Xie, M., Jamison, S., & Pribram, K.H. (1998). Hypnotic analgesia: 1. Somatosensory event-related potential changes to noxious stimuli and 2. Transfer learning to reduce chronic low back pain. *International Journal of Clinical and Experimental hypnosis*, Vol. XLVI, No. 1, 92-132.
- Eastwood, J.D., Gaskowski, P., & Bowers, K.S. (1998). The folly of effort: Ironic effects in the mental control of pain. *International Journal of Clinical and Experimental hypnosis*, Vol. XLVI, 1, 77-91.
- Eimer, B.N. & Allen, L. (1995/1997). *Psychological assessment of chronic pain and disability: User's guide to the Pain Assessment Battery*. Durham, NC: CogniSyst, Inc.
- Eimer, B.N. & Freeman, A. (1998). *Pain management psychotherapy: A practical guide*. New York: John Wiley & Sons, Inc.
- Ellis, A. (1993). Rational-emotive therapy and hypnosis. In J.W. Rhue, S.J. Lynn & I. Kirsch (Eds.), *Handbook of clinical hypnosis*, (pp. 173-186). Washington, DC: APA.
- Erickson, M.H. (1980). Pseudo-orientation in time as a hypnotherapeutic procedure. In E.L. Rossi (Ed.), *Innovative hypnotherapy: The collected papers of Milton H. Erickson on*

hypnosis—Volume IV (pp. 397-423). New York: Irvington.

Evans, F.J. (1974). The placebo response in pain reduction. *Advances in Neurology*, *Vol. 4*, 289-296.

Evans, F.J. (1990). Hypnosis and pain control. *Australian Journal of Clinical hypnosis*, *Vol. 18*, 1, 21-33.

Evans, F.J. (1991). Hypnotizability: Individual differences in dissociation and the flexible control of cognitive processes. In S.J. Lynn & J.W. Rhue (Eds.), *Theories of hypnosis*. New York: Guilford.

Evans, F.J. (in press). Hypnosis in chronic pain management. In G.D. Burrows, R.O. Stanley, & P.B. Bloom (Eds.), *Advances in clinical hypnosis*. New York: John Wiley.

Ewin, D.M. (1978). Relieving suffering and pain with hypnosis. *Geriatrics*, *33*(6), 87-89.

Ewin, D.M. (1984). Hypnosis in surgery and anesthesia. In W.C. Wester II & A.H. Smith, Jr. (Eds.), *Clinical hypnosis: A multidisciplinary approach* (pp. 210-235). Philadelphia, PA: J.B. Lippincott.

Ewin, D.M. (1986). Hypnosis and pain management. In B. Zilbergeld, M.G. Edelstien, & D.L. Araoz (Eds.), *Hypnosis: Questions & answers* (pp. 282-288). New York: W.W. Norton & Company.

Ewin, D.M. (1992). Constant pain syndrome: Its psychological meaning and cure using hypnoanalysis. *Hypnos*, *XIX*(1), 57-62.

Fernandez, E., & Turk, D.C. (1989). The utility of cognitive coping strategies for altering pain perception: A meta-analysis. *Pain*, *38*, 123-135.

Ford, N.D. (1994). *Painstoppers: The magic of all-natural pain relief*. West Nyack, New York: Parker Publishing Company.

Fordyce, W.E. (1988). Pain and suffering. *American Psychologist*, *43*, 276-283.

Hammond, D.C. (Ed.). (1990). *Handbook of hypnotic suggestions and metaphors*. NY: W.W. Norton.

Hanson, R.W., & Gerber, K.E. (1990). *Coping with chronic pain: A guide to patient self-management*. New York: The Guilford Press.

Hilgard, E.R. (1986). *Divided consciousness: Multiple controls in human thought and action*. New York: John Wiley.

Hilgard, E.R. (1991). A neodissociation interpretation of hypnosis. In S.J. Lynn & J.W. Rhue (Eds.), *Theories of hypnosis: Current models and perspectives* (pp. 83-104). NY: Guilford.

Hilgard, E.R., & Hilgard, J.R. (1994). *Hypnosis in the relief of pain* (Rev. ed.). New York: Brunner/Mazel.

Hill, A., Niven, C.A., & Knussen, C. (1995). The role of coping in adjustment to phantom limb pain. *Pain*, *62*, 79-86.

Holmes, J.A., & Stevenson, C.A.Z. (1990). Differential effects of avoidant and attentional coping strategies on adaptation to chronic and recent-onset pain. *Health Psychology*, *9*,

577-584.

Holroyd, J. (1996). Hypnosis treatment of clinical pain: Understanding why hypnosis is useful. *International Journal of Clinical and Experimental hypnosis, Vol. XLIV*, No. 1, 33-51.

Jensen, M.P. & Karoly, P. (1991). Control beliefs, coping efforts and adjustment to chronic pain. *Journal of Consulting and Clinical Psychology, 59*, 431-438.

Keefe, F.J., Crisson, J.E., Urban, B.J., & Williams, D.A. (1990). Analyzing chronic low back pain: The relative contribution of pain coping strategies. *Pain, 40*, 293-301.

Kirsch, I. (1999). Clinical hypnosis as a nondeceptive placebo. In I. Kirsch, A. Capafons, E. Cardena, & S. Amigo (Eds.), *Clinical hypnosis and self-regulation: Cognitive-behavioral perspectives* (pp. 211-226). Washington, D.C.: American Psychological Association.

Kirsch, I. & Council, J.R. (1992). Situational and personality correlates of hypnotic responsiveness. In E. Fromm & M.R. Nash (Eds.), *Contemporary hypnosis research* (pp. 267-291). NY: Guilford.

Lefebvre, M.F. (1981). Cognitive distortion and cognitive errors in depressed psychiatric and low back pain patients. *Journal of Consulting and Clinical Psychology, 49*, 517-525.

Lynn, S.J., & Sivec, H. (1992). The hypnotizable subject as creative problem-solving agent. In E. Fromm & M.R. Nash (Eds.), *Contemporary hypnosis research* (pp. 292-333). New York: Guilford Press.

Meichenbaum, D. (1985). *Stress inoculation training*. New York: Pergamon Press.

Melzack, R., & Wall, P. (1965). Pain mechanisms: A new theory. *Science, 50*, 971-979.

Melzack, R., & Wall, P. (1982). *The challenge of pain*. New York: Basic Books.

Mutter, C. (1998). Hypnotic treatment of psychosomatic disorders. Workshop presented at the Annual Meeting of the American Society of Clinical hypnosis, Ft. Worth, Texas.

Orne, M.T. (1959). The nature of hypnosis: Artifact and essence. *Journal of Abnormal and Social Science, 58*, 277-299.

Perry, C., Nadon, R., & Button, J. (1992). The measurement of hypnotic ability. In E. Fromm & M.R. Nash (Eds.), *Contemporary hypnosis research* (pp. 459-490). New York: The Guilford Press.

Price, D.D. & Barber, J. (1987). A quantitative analysis of factors that contribute to the efficacy of hypnotic analgesia. *Journal of Abnormal Psychology, 96*, 46-51.

Revenson, T.A., & Felton, B.J. (1989). Disability and coping as predictors of psychological adjustment to rheumatoid arthritis. *Journal of Consulting and Clinical Psychology, 57*, 344-348.

Rosenstiel, A.K., & Keefe, F.J. (1983). The use of coping strategies in low-back patients: Relationship to patient characteristics and current adjustment. *Pain, 17*, 33-40.

Rossi, E.L., & Cheek, D.B. (1988). *Mind-body therapy: Methods of ideodynamic healing in hypnosis*. New York: W.W. Norton & Company.

Shutty, M.S., DeGood, D.E., & Tuttle, D.H. (1990). Chronic pain patients' beliefs about

their pain and treatment outcomes. *Archives of Physical Medicine and Rehabilitation*, 71, 128-132.

Spiegel, H., & Spiegel, D. (1978/1987). *Trance and treatment: Clinical uses of hypnosis*. Washington, DC: American Psychiatric Press, Inc.

Syrjala, K.L., & Abrams, J.R. (1996). Hypnosis and imagery in the treatment of pain. In R.J. Gatchel & D.C. Turk (Eds.), *Psychological approaches to pain management* (pp. 231-258). New York: Guilford.

Turk, D.C., Meichenbaum, D. & Genest, M. (1983). *Pain and behavioral medicine: A cognitive-behavioral perspective*. New York: The Guilford Press.

Turk, D.C., & Melzack, R. (Eds.). (1992). *Handbook of pain assessment*. New York: Guilford Press.

Turner, J.A., & Clancy, S. (1986). Strategies for coping with chronic low back pain: Relationship to pain and disability. *Pain*, 24, 355-364.

Wain, H. (1998). Treatment of conversion disorders. Workshop presented at the Annual Meeting of the American Society of Clinical Hypnosis, Ft. Worth, Texas.

Watkins, J.G., & Watkins, H.H. (1997). *Ego states: Theory and therapy*. New York: W.W. Norton.

Watzlawick, P. (1978). *The language of change: Elements of therapeutic communication*. New York: W.W. Norton.

Weitzenhoffer, A.M. (1989). *The practice of hypnosis—Volume One: Traditional and semi-traditional techniques and phenomenology*. New York: John Wiley & Sons.

Williams, D.A., & Keefe, F.J. (1991). Pain beliefs and the use of cognitive-behavioral coping strategies. *Pain*, 46, 185-190.

Woody, E.Z., Bowers, K.S., & Oakman, J.M. (1992). A conceptual analysis of hypnotic responsiveness: Experience, individual differences, and context. In E. Fromm & M.R. Nash (Eds.), *Contemporary hypnosis research* (pp. 3-33). New York: The Guilford Press.

Zarren, J.I. (1996a). *Cognitive hypnosis for behavior change*. Unpublished manuscript.

Zarren, J.I. (1996b). *Self-hypnosis in clinical practice*. Introductory workshop presented at the Annual Meeting of the American Society of Clinical Hypnosis, Miami, FL.

Zarren, J.I. & Eimer, B.N. (1999). *Brief cognitive hypnosis*. Advanced workshop presented at the Annual Meeting of the American Society of Clinical Hypnosis, Atlanta, GA.

Zarren, J.I. & Eimer, B.N. (book in preparation). *Brief cognitive hypnosis: Facilitating the change of dysfunctional behavior*. New York: Springer Publishing Company.