The Role of Relationship Building in Palliative Care: Utilization in Service of Healing When Cure is Not Possible

(Daniel Handel, MD)
"Just in Time Approaches"

Dan Handel, MD

I have no financial relationships to disclose and I will not discuss off label use or investigational use of drugs or procedures in my presentation.

However, we will label and investigate distinguishing attributes of chronic and terminal pain from acute pain, tailor suggestions to individual patient preferences and beliefs, and develop layered, interwoven relevant hypnotic strategies to ease existential and soul anguish, promote self-management of pain associated with illness or medical procedures, and facilitate the reinterpretation of loss into legacy.

The Qualitative Nature of Suffering

- Profoundly personal and part of human nature
- Results from a threat to the integrity of our personhood; the physical and psychological self, and our relationship with others
- Endurable when meaningful
- Philosophic stance influenced by personal topography
- Cannot be identified/measured by scientific methods
Advanced Illness: What is the human experience?
Cancer as a Model....

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of energy</td>
<td>74.2%</td>
</tr>
<tr>
<td>Worrying</td>
<td>70.9%</td>
</tr>
<tr>
<td>Feeling sad</td>
<td>66.1%</td>
</tr>
<tr>
<td>Pain</td>
<td>62.7%</td>
</tr>
<tr>
<td>Feeling nervous</td>
<td>61.9%</td>
</tr>
<tr>
<td>Drowsiness</td>
<td>61.0%</td>
</tr>
<tr>
<td>Dry mouth</td>
<td>56.5%</td>
</tr>
<tr>
<td>Difficulty sleeping</td>
<td>53.7%</td>
</tr>
<tr>
<td>Feeling irritable</td>
<td>48.3%</td>
</tr>
</tbody>
</table>

Using a Bio-Psychosocial model

- Understanding the medical history & issues
  - The nature of the injury and resultant disability caused by medical problem
  - The nature of that part of the disability caused by compensatory behaviors
  - Effects of present treatment regimen
  - Effects of past treatment regimen

- What is the history of the presenting problem?
- Watch for the rehearsal of the problem's history; What is said?
- What kind of impression does the person want to leave you with?

- Appearance
- Affect
- Motor behavior & movement patterns
- Attending behaviors & focus of awareness
- Phenomenological experience of problem
- Nature of suffering - response to problem
Beliefs
Internal dialogue
Sources of pleasure
Sources of meaning
History of past medical/surgical experiences
Challenges brought by those experiences
What has patient learned?
How does that inform this problem’s solution?
Patient’s story...identity...self-view...world-view

Environmental influences
home & work physical environments
home & work social environments
Relationships
Financial factors

Treatment Planning

Restoration of Homeostasis
• sleep
• physical health
• mood
Self-regulation training
• sensory
• affective
• cognitive

Fostering hope
• being able to respond
• switching goals from pain relief to alleviation of suffering
Threshold management
Performance enhancement

Important Questions...
What am I teaching by what I say and do?
• healing can be automatic and rapid
• hurt is not always harm.
• challenge and pain are sometimes necessary...
• we define ourselves by how we meet these challenges...
• sometimes success comes through redefining our goals

What is my patient learning?
•
Psycho-education:

Getting better is determined by what you (THE PATIENT) do and how well you use your body to recover.

Educate proper →
- Awareness
- Thoughts and Beliefs
- Feelings
- Actions

Treatment- universally helpful approaches

- Psycho-education
- Relaxation and self-soothing techniques
- Self-regulation strategies for decreasing sensory discomfort
- Pacing and desensitization
- Modifying movement and increasing natural movement
- Enhancing performance

Assessment-- Developing a Philosophy of Treatment: Determining The What and The How

Assumptions:
1. There is a disturbance in the body-mind which is leading to a lack of harmony between the different manifestations of being.
2. There is experience that is out of conscious awareness or not attended to.
3. The person is suffering.
Referrals:
Is the patient’s view of the problem the same as that of the referring physician?
• Eg pain vs function
• Fear vs ability to undergo testing or procedure
• Use of medication vs pain/anxiety/bothersome symptom

Must negotiate this thoroughly...map a strategy that adequately addresses PATIENT’s ISSUES...while also adequately managing the referrers’ concerns

A deeper understanding of hypnosis: Its secrets, its nature, its essence.

Barber TX, Am J Clin Hypnos 42 (3-4): 208. 2000

3 highly responsive types of hypnotic subjects:
(a) fantasy-prone: vivid internal imagination, strongly internally directed
(b) amnesia-prone: mental repression and compartmentalizing undesired memories, thoughts, and emotions
(c) positively set: maximally ready to cooperate, think-with, and imagine what is suggested while letting go of contrary thoughts-- cooperative & willing, go-with, think-with, co-directed

Structural Aspects of Hypnosis
**Induction**

- Narrowing focus of attention
- Intensifying self-awareness
- Creating positive expectancy
- Examples
  - favorite place: "Where would you rather be...?"
  - progressive relaxation: "Begin to notice..."
  - hypnotic phenomena: “experiments”
  - biofeedback: “Starting with your body”

**Intensification**

- Progressive focus on induction effects
- Facilitating patient ownership
  - "Moving the hypnosis"
- Methods
  - Notice conscious/non-conscious split
  - Intensify sensory aspects
  - Wonder...how this might help...and whatever else comes to mind

**Therapeutic Changes**

- Metaphors for symptom/physiological change
- Utilize information from the introductory interviews
- Awareness of the trance experience
- Non-consciously directed ideas
- Ego-strengthening suggestions about “doing it right”
- “Seeding” = post-hypnotic “gifts”
Post-Hypnotic Suggestions

• “Hypnotic Triad”
• The bridge extending into daily consciousness
• Anchoring signals: intero- and exteroceptive
• Reinforcement of therapeutic goals, often SH
• Can be framed explicitly as a self-selected “souvenir”

Classic Suggestion Effect

• A sense of involuntariness (lack of self-agency)...seems “automatic”
• It was ‘like magic’...or ‘by itself’...
• Unconscious response
• May not recall the hypnotic session...amnesia

Ending Trance

• Review of experience in trance
• Ego-strengthening self-congratulations
• Permissive return to “usual” awareness
• “And you might notice what comes to interesting and uniquely helpful thoughts come to mind when I stop talking...as you return to full orientation to this space and time...”
• Be patient, check on re-orientation...finish your work
Ratification & Reflection

- Establish state of awareness
- Review experience
  - “What would you like to tell me about what you have just done?”
- Ratify effectiveness
  - “That was the shot?”
  - time distortion
  - activate post-hypnotic suggestions

Self-Hypnosis

Plan... timing... of self-hypnosis
“Go ahead... I’ll be quiet.”
“Teach me how you do it.”
Discuss doubts and obstacles
More ego-strengthening
“What happens the more you practice?”

Feedback

“How did this visit go?”
“Will this help you so far?”
“Did I do anything that bothered you?”
“Is there anything you want me to do differently next time?”
Why not do this in every encounter?
Susceptibility, Suggestibility, Hypnotizability, Hypnotic Ability

- Involves varying talents or skills, including imaginative involvement, dissociation, and capacity to be “absorbed” or “engaged” in an experience.
- Involves varying capacities to achieve degrees of “depth” or “intensity”
- Involves alterations in states of consciousness or willingness to enter into social contract.

When and for what?

A RCT of a Brief Hypnosis Intervention to Control Side Effects in Breast Surgery Patients

356 screened
200 Women for excisional breast tumor surgery
Randomized
105 Hypnosis
15 minutes training
Empathic listening 15 min with psychologist
95 Attention/Time Control
Advised practice
H Trainer present at surgery

POSITIVE OUTCOMES IN ALL:
1. Patient-reported post surgical pain
2. Reduced use of propofol and lidocaine
3. Other side effects
4. Institutional costs of surgery

A RCT of a Brief Hypnosis Intervention to Control Side Effects in Breast Surgery Patients

A Systematic Review of Randomized Controlled Trials Examining Psychological Interventions for Needle-related Procedural Pain and Distress in Children and Adolescents: An Abbreviated Cochrane Review


• 28 trials met criteria
• 1039 treatment participants, 951 controls
  • Lumbar punctures, bone marrow aspirations, vascular access
• Largest effect sizes for treatment improvement over control conditions were found for
  • hypnosis,
  • distraction, and
  • combined CBT (CBT plus a mind-body approach)
Hypnosis reduces distress and duration of an invasive medical procedure for children.

- **N=44, VCUG randomized to hypnosis (n=21), standard care (n=23)** while undergoing procedure.
- **Mean prior VCUGs = 2.95**
  - 1 hour training hypnosis procedure- self-hypnotic visual imagery, trained therapist.
  - Home practice encouraged
  - Therapist present during procedure
  - SC= relaxation and breath work training, education about the procedure.

**RESULTS:**
Significant benefits for HYPNOSIS group
- Observer rated distress less than past VCUGs and less than SC group
- Med Staff reported more cooperation than SC
- Total procedure time shorter (by 14 minutes)
- Moderate to large effect sizes for each of four outcomes

Hypnosis for procedure-related pain and distress in pediatric cancer patients:

- **Conclusions:** 8 major in pediatric cancer studies:
  1. Pain reductions and anxiety/distress - statistically significant.
  2. Procedure-related pain and distress.
  3. Methodological limitations
  4. Adjunctive use of hypnosis as for LP's, BMA's.
Clinical hypnosis in the alleviation of procedure-related pain in pediatric oncology patients.


Prospective RCT of efficacy of manual-based hypnosis for pain in 80 pediatric cancer patients undergoing regular LPs. Randomized to four groups:

1. **DH + SC**: (Direct hypnosis + standard medical treatment)
2. **IH + SC**: (Indirect hypnosis + standard medical treatment)
3. **AC + SC**: (Attention control + standard medical treatment)
4. **SC**: (Standard medical treatment)

Hypnosis is effective for procedural pain. The presence of a therapist is important.

Can Medical Hypnosis Accelerate Post-Surgical Wound Healing?
Results of a Clinical Trial

Results of this preliminary trial indicate that use of a targeted hypnotic intervention can accelerate postoperative wound healing and suggest that further tests of using hypnosis to augment physical healing are warranted.
Anxiousness- a common companion in medical settings...

normal...pathological...
DSM criteria for disorder...

Dan Handel MD

Anxiety
Kessler, Chiu, Demler, & Walters 2005

Disorders-
- Onset = 11yrs; Women = 60% more prevalent (Kessler 2005)
- Presentation:
  - fearfulness, tension, uncertainty, and irrational perception of threat
- Physical symptoms can include:
  - Tachycardia, dizziness, sweaty palms, jitteriness, muscle tightness, elevated BP, nausea
Evidence-based interventions for Anxiety

- All effective interventions, whether psychological or pharmacological, => induce state of relaxation, => core mediator
- Hypnosis - can be used to
  - Teach relaxation
  - Reinforce coping skills
  - Provide therapeutic experiences at unconscious or experiential level of awareness
- CBT approaches

Assessment

Consider physical, social, psychological contributing factors—
- Physical
  - Thyroid problems, TIA, hyperventilation, Vitamin B12 deficiency, hypoglycemia
- Social
  - Social supports
  - Social stress related to social interaction
- Psychological
  - Beliefs and cognitions related to fears and symptoms: 'every time I go there something bad happens…'

- Tell me about the first time you noticed this anxiety?
- …got better or worse over time?
- …kinds of thoughts…?
- …what do you do when…?
- …do you avoid any situations because of this?
- …do you do anything to try to reduce this anxiety? (avoidant behaviors, alcohol and other medicating…)
- …how easily do you relax?
- …what symptoms indicate you have a problem with anxiety?

…best suggestions derive from these answers…utilize idioms and language
**DESIGN HYPNOTIC LANGUAGE:**

- Better over time... time to feel better?
- Thoughts that are helpful? Harmful?
- Does your body do something to feel better?
- Do you feel better doing something?
- Does doing make feeling better easier sometimes?
- Does relaxing come easily... or have you had to work to relax in the past?

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**Anxiety always relates to perception of threat**

- Conscious vs symbolic threat
- Conscious: patient can easily relate
  - first time...
  - thoughts preceding...
  - Formulation of source of threat
- Preconscious/symbolic
  - May need exploratory work to identify source
  - Can still treat with CBT/hypnosis
  - 'heading into threat... conflict... trouble'...back to a first time these feeling appeared... (affect bridge... only after safe place imagery established)

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**Hypnotizability and Anxiety**

- Anxiety prevalence higher in highly hypnotizable subjects
  (Orne and Frankel 1976; Wickramasakura, W 1977)

- More phobias (neurotic) in more highly hypnotizable populations

- Multiple replications of this strong association
  (Foenander, Burrows, Gerschman, Home 1980; Gerschman, Burrows, & Reade, 1987; John, Hollander, & Perry, 1983; Kelly, 1984)
Hypnosis and CBT

- CBT - strong evidence for efficacy in treating anxiety, phobias
  (Barlow, 2002; Chambless & Ollendick, 2001)
  CBT > insight oriented or medical approaches alone
  - Meta-analyses (Barlow, 1984; Chambless, 1998; Otto, 1997; Westen & Morrison, 2001)

- CBT effective for social phobias (Federoff, 2001; Feske & Chambless 1995)

- CBT effective for panic attacks (Deacon & Abramovitz, 2004)

Goals

**CBT -**
- Change underlying cognitions
- Relaxation-based interventions
- Exposure therapy
- +/- Imagery

**Hypnosis -**
Positive experiential changes (Epstein, 1994):
1. Rational thinking system
2. Real life experiences (exposure) within the therapeutic relationship can alter unconscious, experiential processing
3. Communication that uses fantasy, imagery, or narrative...imaginative exposure, hypnotic suggestion...hypnotic inductions
Evidence-based interventions

**Anxiety**
- CBT approaches used in order to -
  - Produce and train therapeutic self-regulation - with goal of relaxation
  - Stop or alter unhelpful thoughts
  - Improve self-image and confidence ➔ improve coping
  - Reinforce positive strategies

**PTSD**
- As above + safe place + self-modulation
- Exposure
- Desensitization

**Evidence-based interventions**
All effective interventions (psychological or pharmacological):
relaxation as core mediator of effectiveness

**Hypnosis**
- Teach relaxation
- Reinforce coping skills
- Provide therapeutic experiences at unconscious or experiential level of awareness

**CBT**
- Train therapeutic self-regulation - with goal of relaxation
- Stop / alter thoughts (unhelpful)
- Improve self-image and confidence ➔ improve coping
- Similar skill-building!

**Assessment**

- Physical, social, psychological contributing factors—
  - **Physical factors**—
    - Thyroid problems, TIA's, hyperventilation, Vit B2 deficiency, hypoglycemia
  - **Social factors**—
    - Social supports
    - Social stresses related to social interaction
  - **Psychological factors**—
    - Beliefs and cognitions related to fears and symptoms...‘every time I go there something bad happens...’
Assessment

... first time you noticed this (anxiety)?
... when and how has it changed?
... kinds of thoughts accompany it?
... kinds of thoughts do you notice when you have this anxiety?
... what do you do when...

Assessment

... do you avoid any situations because of this?
... do you do anything to try to reduce this anxiety?
   (avoidant behaviors, alcohol and other medicating...)
... how easily do you relax?
... what symptoms indicate you have a problem with anxiety?
... what do you notice when this is happening?
... what does it feel like when it starts?
... how does your body feel when it happens?

Hypnotizability and Anxiety

Higher prevalence in highly hypnotizable subjects

Ome and Frankel 1976; Wiltronsavikur, W. 1977

More Phobias → more Highly Hypnotizable

Multiple replications of this strong association

Fennel, Barlow, Gershman, Horne 1982; Gershman, Barlow, 1987; John, Hollander, 1982; Kelly, 1984
Hypnotic suggestions

- Hypnosis can enhance CBT
  - Public speaking anxiety...RCT
  1. CBT – cognitive restructuring (CR), exposure (ET), and relaxation training (RT)
  2. CBT + (H) induction and suggestions
  3. No treatment (NT)

  ➔ CBT, CBT + H >>> NT
  ➔ CBT + H improved more quickly than CBT alone

Schoenberger, Kirsch, Montgomery 1997

Jack- head and neck radiation
Emergency situations- "Keep It Simple..."

"") just can't relax...
I feel like I...Just can't breathe ..."
I hurt all over after each treatment..."
...That mask makes me feel like my
mouth just can't let my breath out
anymore...then I just have to get out!

Deepening instructions...relaxation
Darlene - fear of flying

Cancer research...
must fly from SLC, Utah to NIH in Bethesda MD
Mormon, Avenue... holds her hand throughout the four hour flight
Nearly canceled her ‘last hope’ medical visit at NIH

Visualization, Exposure, & Ego Strengthening

Sleep as metaphor for change...
Start with a more easily and quickly treated symptom...

Fears and anxiety...Mindful suggestions

• Notice your thoughts
• Without trying...
• Just observing...
• Floating by...
• Notice them...
• Flow more and more...
• Accept each thought... for what it is...
Fears and anxiety...Cognitive Restructuring

Fears and anxiety...Visualization & Exposure Therapy
1. ‘Rehearse success’ (imagery)
2. Ego strengthening suggestions
3. Anchoring suggestions
4. Bound-contingent suggestions...
   • When...then
   • After...you will
   • If...then
   • You will find yourself settling...as you move forward better and better...
   • More comfortably...more fluidly...

Fears and anxiety...Post hypnotic
• Anchoring suggestions
• Positive PHS suggestions
• Ease of practice
• Future positive expectancy
Introduction and full practice...
...where does the hypnosis begin?

PTSD in Medical Settings

Is the cause the threat?
...our process of care?
...or something else?

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<table>
<thead>
<tr>
<th>Traumatic event</th>
<th>No. of studies</th>
<th>Range of prevalence estimates</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rape [56, 57]</td>
<td>&gt;50</td>
<td>14%–60%</td>
<td>Completed rape is associated with the greatest risk of PTSD.</td>
</tr>
<tr>
<td>Man-made disaster [58]</td>
<td>106</td>
<td>25%–75%</td>
<td>Studies with highest prevalence estimates were conducted on subjects exposed to extreme trauma shortly after the event.</td>
</tr>
<tr>
<td>ICU</td>
<td>16</td>
<td>5%–63%</td>
<td>Prevalence rates are extremely high relative to other medical populations.</td>
</tr>
<tr>
<td>Natural disaster [59]</td>
<td>80</td>
<td>5%–80%</td>
<td>Most studies report rates in the lower half of the 5%–60% range.</td>
</tr>
</tbody>
</table>
PTSD Symptoms

**Re-Experiencing** (intrusion):
- upset by things that remind you of what happened
- nightmares, vivid memories, or flashbacks of the event (flashbacks)
- dread or panic... of imminent danger, anxiety, irritability...
- labile mood... low mood

**Avoidance and Numbing:**
- emotionally cut off... numb... lost interest in things and relationships previously important to you
  - Relationship difficulties.
- sleep and concentration difficulties

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ICU-Related PTSD Risk Factors

**RISK FACTORS**
- ICU length of stay (longer duration)
- Hospital stay (longer duration)
- Length of mechanical ventilation (longer duration)
- Greater levels of sedation
- Female gender, younger age, psychiatric history
- # traumatic memories/frightening recollections
- Delusional memories

---

Risk of PTSD Symptoms in Family Members of ICU Patients.


PTSD risk of ICU patients' family members:
- @ 90 days after ICU discharge / death from 21 ICUs:
  1. IES (Impact of Event Scale) = PTSD symptoms
  2. SF-36
  3. HADS (Hospital Anxiety and Depression scale)

- clinically meaningful PTS reaction was common
- the strongest risk factor = sharing in end-of-life decisions for relative in the ICU.
PTSD SYMPTOMS LINGER AFTER INTENSIVE CARE

(Johns Hopkins Univ.)

IF mechanical ventilation → 33% to 50% develop PTSD!

• Impairs quality of life
• Slower recovery from critical illness,
• Interferes with RTW or usual ADL.

Post-intensive care syndrome

75% ICU patients → delirium →
1. Reduced survival and
2. Increased long-term mortality
→ 25% w PTSD symptoms @ 2 years.

Levels of sedation → delirium

PREVENTION STRATEGIES:
1. Less sedation, more exercise,
2. Day – Night orientation: dark, quiet rooms at night to encourage
more normal sleep

1 Million / year on ventilator in ICUs

Rattray et al. 2005

• > 50% ICU survivors → impaired basic living activities @ 1 yr from PTSD
(intrusive thoughts, persistent fears, low mood, anxiety)
• 55% had cognitive impairment and
36% had MDD at one year
• Worsened by heavy sedation
(common during ventilation)
Studies that report the prevalence of PTSD in medical ICU patients

<table>
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<tr>
<th>Reference</th>
<th>Study Design</th>
<th>Sample Size</th>
<th>Follow-up</th>
<th>PTSD Prevalence</th>
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<tr>
<td>Rattray et al., 2005</td>
<td>Prospective cohort</td>
<td>N=109</td>
<td>@ discharge, @ 6 months, @ 12 months</td>
<td>20% with high avoidance scores and 18% with high intrusion scores</td>
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<tr>
<td>Capuzzo et al., 2005</td>
<td>Prospective cohort</td>
<td>N=84</td>
<td>1 week and 3 months</td>
<td>5% with PTSS</td>
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<td>Cuthbertson et al., 2004</td>
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<td>N=111</td>
<td>3 months</td>
<td>14% with PTSD</td>
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<td>Nickel et al., 2004</td>
<td>Cross-sectional</td>
<td>N=41</td>
<td>percentage lost to follow-up not recorded</td>
<td>17% with PTSS; 9.76% PTSD + psychiatric history</td>
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<td>Jones et al., 2003</td>
<td>RCT</td>
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<td>N=105</td>
<td>~1 year</td>
<td>18.5% PTSD; + delusional memories (-) sedative interruption --&gt; less PTSD</td>
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<td>Schelling et al., 2001</td>
<td>Retrospective cohort</td>
<td>N=24</td>
<td>21 to 49 months</td>
<td>40% PTSD (-) hydrocortisone --&gt; less PTSD</td>
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Intensive care diaries reduce new onset post traumatic stress disorder following critical illness: a randomised, controlled trial

Christina Jones1, Carl Blickman1, Markia Capozzi2, Impala Epcroft3, Hans Reuten4, Cristina Genna1, Christian Hylander5, Richard O Gaffey6, the RACH group

Abstract

Introduction: Patients recovering from critical illness have been shown to be at risk of developing Post Traumatic Stress Disorder (PTSD). This study was to evaluate whether a prospectively collected diary of a patient’s intensive care unit (ICU) day when used during convalescence following critical illness will reduce the development of new onset PTSD.

Methods: Intensive care patients with an ICU stay of more than 72 hours were recruited to a randomised controlled trial examining the effect of a diary on the details of the patients ICU stay on the development of acute PTSD. The intervention patients received their ICU diary at 1 month following critical care discharge and the true assessment of the development of acute PTSD was made at 3 months.

Results: 322 patients were randomised to the study at 1 month. The incidence of new cases of PTSD was reduced by: 1 in 500 patients receiving intensive care.

Conclusions: The provision of an ICU diary is effective in aiding psychological recovery and reducing the incidence of new PTSD.
ICU diaries reduce new onset PTSD following critical illness: an RCT

- Diary of a patient's ICU stay (prospectively collected)
  - Used during convalescence
  - Reduced new onset PTSD.
- ICU > 72 hours, RCT, n=352
  - Diary of details of the patient's ICU stay (daily events)
  - Effect on incidence of post ICU PTSD.
- INTERVENTION:
  - Patient received diary at ICU discharge + 1 month
  - PTSD assessment at 3 months.

Results:
- ICU diary reduces PTSD: \( p = 0.02 \)

Evidence-based interventions for Anxiety, PTSD

All effective interventions induce a state of relaxation as a core mediator of effectiveness

- **Hypnosis** can be used to:
  - Induce relaxation
  - Enhance coping skills
  - **PTSD** - Therapeutic experiences at unconscious or experiential level of awareness
  - Desensitize from intrusive thoughts and feelings
  - *Repair* the "narrative" (meaning) that is contributing to PTSD/anxiety

- **CBT** approaches used in order to:
  - Train therapeutic self-regulation - with goal of relaxation
  - Stop or alter unhelpful thoughts
  - Improve self-image and confidence → improve coping

Similar skill-building!

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<tr>
<th>Anxiety</th>
<th>N=50</th>
<th>42% @ enrollment</th>
<th>( 15% @ 6 \text{ months} )</th>
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<td>Depression</td>
<td>16% @ enrollment</td>
<td>( 0% @ 6 \text{ months} )</td>
<td></td>
</tr>
<tr>
<td>PTSD</td>
<td>( 35% \text{ PTSD} @ 6 \text{ months} )</td>
<td></td>
<td></td>
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<tr>
<td>PTSD bereaved</td>
<td>PTSD non-bereaved</td>
<td>( 46% @ 6 \text{ months} )</td>
<td></td>
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<table>
<thead>
<tr>
<th>Assessment time</th>
<th>Anxiety*</th>
<th>Depression*</th>
<th>Posttraumatic stress</th>
<th>Complicated grief</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enrollment</td>
<td>42 (29-50)</td>
<td>6 (5-8)</td>
<td>20 (15-30)</td>
<td>6 (5-10)</td>
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<tr>
<td>3 months</td>
<td>31 (20-43)</td>
<td>8 (6-12)</td>
<td>10 (8-20)</td>
<td>4 (3-7)</td>
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<tr>
<td>Baseline</td>
<td>56 (38-72)</td>
<td>10 (8-15)</td>
<td>25 (20-30)</td>
<td>10 (8-15)</td>
</tr>
</tbody>
</table>

*Comparisons made using Wilcoxon signed-rank test.
Conclusions

Hospital ICU experiences can harm the mental health of patients AND families
1. The LOS and severe illness is linked to mental health danger
2. ICU care routinely produces PTSD symptoms
3. ICU deaths are commonly linked to complicated, prolonged grief

*Narrative-Based Therapy can be helpful (Meaning – Based)*

*Mindfulness and Hypnosis can aid resilience and restoration of balance*

Interventions

**Primary Prevention of ICU Delirium, PTSD, Anxiety**

1. Ventilated: mind-body approaches for anxiety
2. Sleep management approaches: environment of care, CBT, meditation, hypnosis, relaxation training
3. Specific hypnotic tasks:
   a. Ego-strengthening
   b. Rehearsal/techniques: proper breathing, decanulation...
   c. Time projection, repression, distortion
   d. Construct a helpful narrative

**Secondary treatment of ICU delirium, PTSD, anxiety**

1. Medications
2. Non-pharm approaches: day/night, reorientation, environment of care
3. Calming approaches: hypnosis, relaxation training, meditation, touch based therapies (massage, Reiki, healing touch)
4. ICU diaries: ‘creating a narrative’
5. Hypnotic narrative...
   safety, containment, support, purpose, legacy...
Hypnotic Strategy: matching style and purpose

- establish appropriate goals
- distinguish trance from attaining of therapeutic goal (to minimize opportunity for resistance)

"Would it be OK with you if you/we"...or...
"Would you prefer to put yourself in trance with eyes open or closed?" — contract for success

Developing Strategy

1. expectations
2. ‘yes set’
3. shift focus
4. instruct on trance behavior
5. provide analog for expected change
6. intensify process
7. image future goal achievement
8. closure & realerting

Expectations from Trance

often helpful to separate success in trance from therapeutic goals...
“learn how to relax and pay close attention to my voice”
...invite GREATER self-control
Frequent praise when appropriate...
PHS (hidden instructions) to enhance hypnotic response...

• LISTEN...for clues to hidden feelings or beliefs
Establish the “Set”

“Set set”
• Use of truisms
  everyone... often... it's not uncommon for... it is a very common experience to... most people... you already know...
  Would you like to go into trance, as many do, by focusing your eyes on a spot on the wall, or would you like to just allow your eyes to close naturally as you go into trance?
• Focus on motor, sensory, affective, or cognitive processes (spheres of ‘being’)

Shift Focus

Interspersal: words or phrases that “seed” ideas and focus attention (often used in naturalistic inductions)
• Shifting your attention...to your breathing...its depth...its pace...your attention deepens as your breaths focus...invites you to inwardly notice...
• your deepening attention...to your relaxation...
• allowing your absorption within...within the sound of my voice...you can notice whatever your current experience IS...in your breathing...in your MUSCLES...inward relaxed in your deeper focus...
• Accomplished by ‘pairing’ an observation with a suggested change in focus... (bound-contingent suggestions)

Instruct in Trance Behavior

• allow sufficient freedom for success...
• covering all possibilities of response...
  And you may notice that hand beginning to feel differently...in some interesting ways...you may notice a different feeling...a buzzing...or tingling feeling...somewhere in that hand... BEFORE it feels heavy... or it may feel lighter... as you notice a change... in its feeling... it may be interesting for you to notice how you first notice the change in feeling... as your relaxation deepens... your attention deepens... you notice more here and now... hearing all there is to hear... of my voice... as your inward thoughts guide you deeper and deeper relaxed... until it just feels automatic to feel this deeper feeling of spreading relaxation...inner calm...confident calm...deeper into infinite possibilities for successful changes within...
• focuses patient responsiveness in a certain direction ('fail-safe' approach)
Analog or Metaphor for Change

• “as you better learn this method of deeper relaxation... you may find less room for mental tension... and that old neck pain.”

• “by learning hand-warming you will have greater control over your autonomic system... and notice how much less intense... and less frequent... those migraines seem bother... less to notice of that bother... less often noticing as much bother... more noticing your longer periods without nearly as much bother... so that your confidence in feeling better will eventually feel inevitable... won’t it?”

Intensification

1. fractionation for deepening.
2. implied directives... “as soon as...”
3. implied suggestion for an internal response that will take place inside the patient... “then...”
4. contingent behavioral response to signal when suggested response has been accomplished:
   - “... your arm will float comfortably down... to your lap... signaling your successful reduction in that burning discomfort... that has bothered that leg... so long... so that touch... on your lap... can remind you of the power of your internal mind... allowing you to remember... how that started... that feeling of comfort... started to change the burning... to something less than that... so your mind remembers this... your confident comfort can grow... allowing better calm and comfort...”

Goal Achievement

• image the success
• look forward to the time when...

‘Final Gift’

1. anchor positive suggestions... relapse prevention suggestions...
2. Prepare to realert... Then...
3. Most valued... important... useful suggestion
4. Then REALERT

Notice muscle tone return on each inhalation

“With yourself, of the way back... into the room”

Mind in another with your tone and pace of speech
Realerting

Increase vocal volume with each suggestion
Utilization - comment on changes in posture, limbs moving, stretching, etc.
Direct suggestion (e.g., "Bring yourself up into the room") or "Now be alert" or permissive "You may find that you are alerting" as you wish
Check with subject to mark transition from trance to "normal": e.g., "What was that like for you?" "Are completely back yet?"
First question: "And what are you noticing now?" (Gary Ellis, PhD)

Reverse any suggestion used for induction or deepening
Notice muscle tone return on each inhalation
Increase vocal volume with each suggestion
Utilization - comment on changes in posture, limbs moving, stretching, etc.
Just prior to realerting - important suggestions...covertly (confusion) or quietly...less resistance

Induction:
- attention
- motivation
- confidence in...hypnotist...procedure

Suggestions:
- Indirect
- Double-bind
- Repetition
- Engage imagination
- Enhance/invite emotional content to suggestions
- Positive suggestions

Laws of Suggestion
- Law of Concentrated Attention-
  - The principle of repetition: when attention is concentrated on an idea, that idea tends to realize itself.
- Law of Dominant Effect
  - A strong emotion counteracts and takes precedence over a weaker one.
- Law of Reversed Effect (Emile Coué)
  - The harder one tries, the less chance of success.
  - However... "Any idea exclusively occupies the mind turns into reality"
  - Coué attributes his success in curing people to the basic principle that to get cured by suggestion one must do away with one's will power (Conscious) and instead use one's imagination or idea (Unconscious).
  - The imagination(Unconscious) is the only controlling force. The use of Will Power (Conscious) unfailingly sets in the "Law of Reversed Effort"
Therapeutic Suggestion

• No research to suggest the superiority of any suggestion style.
• ‘Automatic’ suggestions...lack of agency...

**Direct**

“You are going to have a dream...”
“You are getting more and more comfortable...”
“Go deeper... and deeper still...”
“You are going back into the past...you are becoming much younger and smaller...”

Efficient/parsimonious—for patients with low resistance who feel positive retransference/rappor
Crisis; speed required

Therapeutic Suggestion

**Implication**

“Have you been hypnotized before?”
“Would you like to put yourself in trance with your eyes open or closed?”
“Let yourself be curious about just how deep you will go...”
Useful as “pre-hypnotic” suggestion; deepening; problem solving...sets positive expectancy

Therapeutic Suggestion

**Not knowing/Not doing**

“Pay close attention to what I tell you, and think about the things I suggest. Then let happen whatever you find is happening, even if it surprises you a little. Just let it happen by itself. Just watch yourself go deeper... and deeper... just let it happen”

• For clients with performance anxiety about being hypnotic subject... for oppositional / resistant behaviors
Therapeutic Suggestion

Contingent

“In a moment, when I stop talking, (then) you will begin to dream. When I speak to you again in a minute or as you will stop dreaming, if you still are dreaming… and you will listen to me just as you have been doing… and respond as you hear my count… backwards from 10 to 1. When you hear “5”, (then) your eyes will naturally open… but you will not be fully alert… Until you hear the count of “1”… (then) you will be entirely returned to usual alertness… to your surroundings… confidently returned, all the way, awake as usually you are.”

Rapport… utilization… ratification … pacing
… create positive expectancy

Truisms

“People experience hypnotic depth in different ways at different times… Not everyone can have the same experiences or produce the same effects when hypnotized… It is common to notice… how attention comes… and goes… even for those who respond best… to healing suggestions… as their mind learns… new ways that feeling different… can be the new ways… to think and feel… and its OK if you are one of these… but its OK also if you are one of the others… who just notice those comfortable changes… most naturally… as they go deeper… into your meaning… of my words… and their own thoughts… as each passing breath… each moment of deeper calm… washes over their experience. OK?”

Imagery/Metaphor

“… imagine a force pulling your hands together… perhaps rubber bands around the back of the hands… or magnets held in each hand… pulling them together…
… as you exhale… imagine yourself going down [up] steps… (elevator, escalator)…”

“… like ever so gently letting the air all the way out of a balloon…”

imaging overrides willing… reduce performance anxiety

PAIN:

Strategies and Goals

• Reframing understanding of Pain
• Reinterpretation of signals
• Relaxation, self regulation & self soothing
• Awareness training & Dis-identification
• Associating and conditioning
• Dissociation
Deepening

**Use an induction technique**

- Progressive relaxation
- Naturalistic method
- Spiegel eye roll
- Chiasson method
- Contingent suggestion...
- Eye-fixation method
- Hand-levitation, hand reverse-levitation

---

**Deepening¹**

**Direct suggestion:**

Go deeper into this state of focused attention...count down

**Imagery:**

Escalator...floating on a cloud
Floating deeper into a cloud...to the very center...insulated from outside noise and thoughts and bother...
Drifting through color into a safe and special place

---

**Deepening²**

**Suggestions:**

Or...as your subconscious hears and responds to my voice, settling into a special and safe state...noting nothing in particular...except the feeling of deeper calm...deeper comfort...just that special feeling of going safely deeper...

Imagine yourself going into this state of deep relaxation...at home...or some other safe place...where you will notice all of your attention focused on your relaxing muscles...on your breath coming deeply and easily...and with each exhalation your face grows more and more relaxed...and as your muscles choose to let go, you notice your eye muscles relax and and your eyes close...your swallow muscles go smooth and relaxed...as your mind hears the words 'relax...relax...' and your whole being settles into a peaceful calm...deeply, hypnotically involved...
Deepening

- Post-hypnotic suggestions
- Talking techniques:
  - Deeper and deeper
  - Down an escalator
  - Counting deeper
- Resting (silence)
- Subtle methods—rehearsal technique
- Confusional methods

Fractionation

1. counting down (deeper), up (lighter), then down
2. closing, opening, closing eyes...(seeing an anesthetized hand...or a levitated arm)
3. realerting just one’s head or eyes (ostensibly to answer a question)...opening eyes...then going back deeply into hypnosis...returning just as deep...or deeper...

Test of Depth

Tart Scale—self report (1970)

0. Awake and alert
1. Borderline between sleep and awake
2. Lightly hypnotized
3. Quite strongly, deeply hypnotized
4. Really very hypnotized
5. Very deeply hypnotized

10. Very deeply hypnotized
**Depth Exercise**

1. Do Induction (see next slide)
2. Test depth using Tart Scale—the first number that comes to mind when asked to give 'state'
3. Deepen... using examples
4. Test depth again... repeat
5. Realert

---

A. Use an induction technique (any of your choice)

- Contingent suggestions. In moments when I keep talking, when you find deeper relaxation, other, you're more relaxed you're warmer, when you find it...when you find it... when you find it... when you find it... when you find it... when you find it... when you find it...

- Progressive relaxation or Spiegel eye roll

- Contingent suggestion... In a moment, when I speak to you again in a moment or so you will stop dreaming. If you are still dreaming, you will stop dreaming. If you are still dreaming, you will stop dreaming. If you are still dreaming, you will stop dreaming. If you are still dreaming, you will stop dreaming. If you are still dreaming, you will stop dreaming. If you are still dreaming, you will stop dreaming. If you are still dreaming, you will stop dreaming.

- Deepen... using examples... using examples...

- Test depth again... repeat...

- Realert

---

B. Test Depth: TART SCALE 0 to 10, with zero being usual alertness and ten being very deeply hypnotized...

C. Deepening suggestions: (choose one)

- Fractionation (count down, up, down; close, open, close eyelids... going deeper with each close... and... open your eyes... respond... then going back deep... even deeper... as your eyes close... returning just as deep or deeper...)

- Direct suggestion: (go deeper into this state of focused attention)

- Imagery (escalator; floating on a cloud; Nature scene... smell, taste, feel, hear, see)

D. Retest Depth

E. Realert

---

**Next step: Self-hypnosis**

- Reinforces self care
- Reinforces that hypnosis is an internal process
- Models self-care
- Onus of practice on patient (performance analogy)
- Can be strengthened at subsequent office visits
Teaching Self-Hypnosis

- Definitions
  - (Hilgard 1977) “All hypnosis is self-hypnosis”
  - (Fromm and Kahn 1990) True self-hypnosis is client-controlled
  - (Sanders 1991) Clinical self-hypnosis is a carefully taught skill

Summary
- Client can be taught to enter and control hypnosis by oneself
- Clinician may start and monitor effect
- Hypnosis in its essence may be self-hypnosis.

How are self and hetero hypnosis different?

Phenomenology

<table>
<thead>
<tr>
<th>Self Hypnosis</th>
<th>Heterohypnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>awareness of what is going on</td>
<td>unaware (AWARENESS)</td>
</tr>
<tr>
<td>feeling of mental activity</td>
<td>passivity (ACTIVATION)</td>
</tr>
<tr>
<td>feeling of being in control</td>
<td>being controlled (AGENCY)</td>
</tr>
<tr>
<td>time distortion</td>
<td>time congruence (TEMPORAL)</td>
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Summary: self hypnosis feels subjectively different.

Self vs Hetero hypnosis


Process and function differences
1. Cognitive process effects
2. Attention can alternate between focused and free floating
3. Major focus is on internal state vs external stimulation
4. Images in trance are richer and more vivid
5. Sense of trance depth fluctuates
6. More aware of own internal images & states: More ego-receptive
How are self and hetero hypnosis different?

Johnson and Weight 1976

Differences are subjective
Behavioral Similarities—
• catalepsy
• levitation
• perceptual illusions - temperature

General expectations about self hypnosis

Can direct self into and out of hypnosis
First experience “lighter” than in the office experience
Repeat suggestions...to get effect...& pair with images or sensations
Common misattribution to the therapist
Eventual sense of mastery over self-hypnosis

Medical applications of self hypnosis

Headache and low back pain (Spinohon and Linssen 1989).
Severe hemophilia. Those who used self-hypnosis reduced coagulant deficiency. (Swirsky-Sacchetti and Margolis 1986).
Cancer pain- Self hypnosis and group therapy - pain (Spiegel and Bloom 1983, 1989).
Increase white cell count by imagery (Achterberg 1985)
Shift awareness of chronic pain (Large and James 1988)
Sickle Cell Pain- Dinges, Bloom.
Educational Applications - S.H.

- Improving reading comprehension in college (Wark and LaPlante 1991)
- Creativity in story telling and writing (Bowers 1979)
- Reducing writing block (Stanton 1986)
- Alert self hypnosis to improve grades (Wark 1989) (Wark 1996)

Sports

Gymnastics and life training (Uneståhl 1983)

Are all hypnotic phenomena available in self-hypnosis?
- Deep anesthesia for gall bladder surgery (Rausch 1980)
- Negative hallucination for tinnitus (Vingoe 1968)
- Age regression (Fromm and Eisen 1982)
- Self administered liposuction (Botta 1999)

Demonstration of self hypnosis

- Induction
- Deepen
- Safe place
- Suggestion
- Post hypnotic suggestion

HINT:
1) demonstrate SH
2) do exercise together...
3) then observe patient doing exercise in SH
Types of clients who do well with self-hypnosis

- Internal locus of control vs external locus of control
- Autonomous vs therapist dependent
- Risk takers vs guidance seekers
- Enjoy fantasy vs enjoy reality
- Ego Receptive [open to information from unconscious, independent, self reliant] vs Ego Active [decision making, seeking structure, certainty and control]

Modified Six Step Self-Hypnosis Protocol
Garver, 1978 AJCH

1. Formulate suggestion
2. Starting cue
3. Induction protocol...100-95
4. Suggestion
5. Deepening...94-90
6. Realerting cue

Sleep Rehearsal

- As the time for sleep approaches
- As you prepare for bed...
  Passive language
  - Observe the image in the mirror (invites dissociation)
  - Lead suggestions with movements in mirror
  - The feeling of the feet moving toward bed...
  - The touch of sheets brings a wave of relaxation...
Sleep Rehearsal

As you move toward bed (deepening)
As your head finds its position of sleep...another DEEP breath, hold it...and as it
lets go you drift deeply, deeply through relaxation into sleep...
As (sensations in bed), then...suggestions for readiness and for sleep (ANCHOR
sleep).
• Suggestions for restorative sleep and instructions if any awakenings
(recidivism)
• Ego strengthening suggestions.
• Positive expectancy

Hypnotic Pain Coping Strategies

• Methods which:
  • achieve neurophysiological alterations
  • change or reorganize the cognitive-emotional understanding
  • improve behavioral patterns
  • promote new useful perceptions of time and space

Pain Coping Strategies

• direct suggestion for alleviation
  • suggestion for alleviation of pain
• distraction and avoidance
• alteration of pain experience
• awareness of pain experience
Distraction & Avoidance

- fantasy
  - involvement in pleasurable fantasy/memory
- time distortion (e.g. "road hypnosis")
  - make duration of pain seem shorter...
  - or interval between pains seem longer (OB)
- displacement... to some other part of body
- internal distraction... mental work
- external distraction... shift to external focus

Alteration of Pain Experience

- Cognitive change... altering meaning of the pain...less bothersome
- Perceptual change- Reinterpretation
  - amnesia for the pain (lessens dread)
  - altered meaning
  - altered anticipation
- Dissociation
  - dissociate painful body part... temporal dissociation...distance oneself from pain

Awareness of Pain Experience

- Sensory information
  - preparation to avoid catastrophizing
- Sensory awareness
  - (Meares- full awareness to pain experience to gain insight into nature of pain perception)
- Reactivity to pain sensations
Hypnosis

• Purposeful altered state of consciousness
  1. Focus of attention, Absorption
  2. Dissociation
  3. Heightened responsiveness to suggestion

Ability to accomplish psycho physiologic changes which are otherwise more difficult to accomplish
Often accompanied by relaxation (in adults)

Robert

• Chronic pain - esophageal cancer
• Radiation to chest
• Chemotherapy
• Near-death experiences x2
• Severe pain, lack of energy and appetite, disturbed sleep, isolating behavior
• Military background...highly successful, disciplined, athletic

Counting Deepening
Imagery experience (wellness)
Split screens:
• Current state screen
• Past, premorbid screen
• Future desired state screen
Second skin technique (into desired state)
Sensory-rich Immersion technique
"Be" in that state...completeness

John F. Kihlstrom, PhD

“To be blunt, hypnotic analgesia is efficacious and specific:
• Its efficacy is supported by a large number of methodologically sophisticated studies conducted by many independent investigators;
• It is not merely a placebo - in those who are hypnotizable, it is superior to both placebo and alternative psychological treatments such as stress inoculation.
• Based on the available evidence, approximately 50% of unselected patients can obtain significant pain relief from hypnosis” (NNT=2)
• Hypnotic analgesia is not mediated solely by:
  • stress inoculation
  • and other consciously deployed cognitive strategies,
  • nor is it mediated by stimulating the flow of endogenous opiates
Responsiveness to Hypnosis

- Migraine: good prophylaxis, less for acute
- Burns, Acute Pain: excellent
- Procedural pain: very helpful
- Cancer pain: AHCPR (effective adjunct, 1995 NIH Consensus Statement)
- Sudden incident pain: difficult
- Neuralgia: lancinating: mod. helpful
  neuropathy: difficult
  some studies find efficacy

Perioperative Hypnosis

- Preoperative Direct Suggestions:
  - relaxation and comfort... Dis-attention to or reinterpretation of operatory noises... relaxed muscles inside and out... feel safe and contented in a pleasant dream during your procedure...
  - Meaning—noises remind you of all of the attention from caring professionals who are here to help you...

Postoperative Suggestions:

you will...
- feel yourself recover quickly and completely...
- feel comfortably hungry as your bowel and bladder rapidly return to normal function...
- feel comforted by your deep breathing...
- savor the time and caring of the staff to help you get better quickly... and this will help you in your own healing efforts...
Postoperative Suggestions:
You may...

- notice a slight pulling or tugging which reminds you of the healing in this repaired area...
- a slight cramping or heaviness or tingling can remind you of the healing that is already beginning...
- healing is already underway... your condition is taken care of... you are better now
- you can look forward to good food and the hunger that allows us to enjoy it

Elbow surgery/Physician
No medications prior or during surgery
No postop pain medications
3 prep sessions
High hypnotizable
Goals:
Control
Lack of side effects
Reinterpretation...
sensory-rich experience
Team... trust... together
In touch with universe

Direct Suggestion:
suggestion for alleviation of pain

Symptom substitution
less noxious than presenting pain

Anesthesia (numbness)
decreased sensation of pain in involved area

Analgesia
imagined application of analgesic substance

Preparation for Procedures

- Direct Suggestion:
  - suggestion for alleviation of pain
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  - less noxious than presenting pain
- Anesthesia (numbness)
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- or interval between pains seem longer (OB)
- displacement... to some other part of body
- internal distraction... mental work
- external distraction... shift to external focus

Distraction

- Mental work
- Mental play

Dissociation

- Dissociate from pain
- Dissociate the pain

Alteration of Pain Experience

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  some studies find efficacy

Let’s take and allow you to image that part of your back that has become sore from activity. Notice how it has size and shape, and notice that tingling, numbing, feeling beginning to move toward that feeling.

And as you feel that flow, that comfortable sensation, on your own, allow that flow to the area. Some of that flow is sensory to the area, some of that flow is sensory to your parts flow speeding like a magnet, like the former part of a laminating stream, mixing budding, swelling, flowing with quickness to that area, mixing with it, calming, quelling that area.

And you can trace wires that go down... down from your brain... to the right side of your body... you can follow those down through your spinal cord. Down through the vertebrae, down to the pelvis, down to the right leg area, and so on. Notice which wires are ending at that stump, notice those that used to go to that leg that is now there. Follow those up, up through the pelvis... up through the lumbar spine and the cord... crossing over to the fast moving lane... up through the red brain... through the thalamus, all the way up to the control room... right to the switch... the sets of dials, dials in front...

And you can begin to touch... to turn down... that dial... and as that dial down... the notice that sensation that was to that missing leg... begins to gain more transparency... gaining more and more transparency... until you can begin to see it as a shadow of its prior self... with less substance to the sensation... noticing it less, and less... and as you continue to dial down, one notch at a time, turning down that sensation, turning down that dial... NOW... down and noticing... as with each turn down, you notice a calming, quelling feeling all over... that reminds you that your master control room, is that part of you that joins your mind and your body together with your spirit, the part that continues to gain in strength, that controls your inner system, including your inner autonomic system, that calms your inside, quiets your inside just right...
Poor Pain Prognostic Factors

- Blaming and anger issues
- Litigation ongoing
- External locus of perceived control
  - External medical treatment is necessary for improvement (see below)
  - No perceived rehabilitation goal
  - Passive attitude
- Entrenched belief in medical cure for pain

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• a slight cramping or heaviness or tingling can remind you of the healing that is already beginning...

• healing is already underway... your condition is taken care of... you are better now

• you can look forward to good food and the hunger that allows us to enjoy it

Josh-
sarcoma with invasion of brain and multiple pathologic rib fractures
**Depth Exercise**

Dan Handel MD

A. **Use an induction technique (any of your choice)**

- Progressive relaxation OR Spiegel eye roll
- Contingent suggestion... In a moment, *when* I stop talking, (then) you will slip into a hypnotic dream that will carry you deeper relaxed...deeper you’re your own experience...and *when* I speak to you again in a moment or so you will stop dreaming...if you are still deeply dreaming...and as you hear my voice, you will listen to me just as you have been doing...slipping more deeply involved in your own safe and comfortable inner experience...so that will each sound of my voice you will feel and respond to your own inner suggestion to go more soundly and deeply relaxed...more into that safe experience where you can effortlessly respond to your own inner experience...staying safely linked to my voice
- Pay close attention to what I tell you, and think about those things I suggest...then just let happen whatever you find is happening, even if you feel a little surprised...just let it happen...by itself...and as you observe this... you will go deeper...and deeper...just let it happen. *(Not knowing...not doing...open to all possibilities)*

B. **Test Depth: TART SCALE 0 to 10, with zero being usual alertness...and ten being very deeply hypnotized........then DEEPEN ... RETEST DEPTH**

C. **Deepening suggestions: (choose one)**

- **Fractionation** (count down, up, down; close, open, close eyelids...going deeper with each close...; and realert just one’s head or eyes (ostensibly to answer a question)...open your eyes...and respond...then going back deep and even deeper...as your eyes close...returning just as deep or deeper...)
- **Direct suggestion:** *(Go deeper into this state of focused attention)*
- **Imagery:** *(escalator; floating on a cloud; Nature scene...smell, taste, feel, hear, see)*

D. **Retest Depth TART SCALE**

Realert

Think of this as ‘training’ in ‘present mindful awareness’... of current conscious state...moment by moment...

This is useful tool when training to stay present, which invites less rumination in anxious patient or in chronic pain patient...