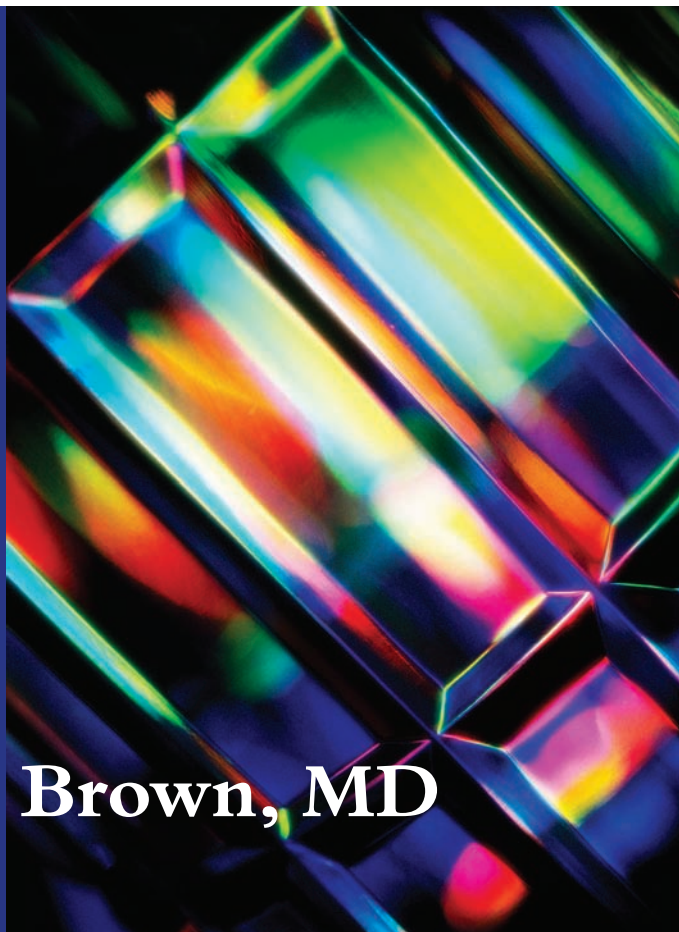
ADVANCES in the Use of HYPNOSIS for MEDICINE, DENTISTRY and PAIN PREVENTION/ MANAGEMENT

An up-to-date compendium of hypnosis research and clinical experience that will serve as a clarion call to the health care professional. It can serve as an outline for teaching, or as a guide to new applications of hypnosis within medicine and dentistry.

Julie H. Linden, PhD,
Past President, American Society of Clinical Hypnosis



Edited by **Donald C Brown, MD**

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Preface

The most important five minutes of life are the first five minutes after birth. How soon we breathe after being born may determine how quick we are the rest of our lives.

I started doing hypnosis in my family practice after a patient asked me to show her how to use hypnosis for her second labor and delivery. She'd had a prolonged and difficult delivery the first time around, and she did not want to go through the experience again. She did so well with the second birth that she said she would use hypnosis again if she decided to have any more children.

That was more than 44 years ago, and that early lesson stayed with me throughout my career. There were years when I have delivered more than 100 babies, and over half of my obstetrical patients chose to use hypnosis for labor and delivery. As a busy practitioner, their choice saved me a great deal of time because labors were shorter, with fewer examinations needed, and few medications prescribed. Over 50 percent of my patients required nothing more than hypnosis – that is, no anesthetics or analgesics.

That is a little of my specific experience, but the inspiration for this book came out of the many profound perspectives presented at the 6th Frontiers of Hypnosis Assembly in Halifax, Nova Scotia in 2003. The bulk of the present material was culled from 11 of the groundbreaking workshops that were presented there. All the material has been rewritten and updated by the authors.

The goal of the book is to feature the work of those who are expert in the use of hypnosis across a spectrum of settings and applications so that clinicians who wish to use it – or who already do – have access to the most in-depth information available on the biology of hypnosis as it pertains to medicine, dentistry, and pain prevention and management.

Because I believe that hypnosis is a much underutilized modality, this book has several purposes: to encourage more clinicians to start using hypnosis in their practices; to offer solid information on the biology of hypnosis and advances of clinical uses of hypnosis and self-hypnosis; and to present an overview of the big picture – the breadth and depth of clinical hypnosis for those who use it in their practices. A very useful feature of this book is the reference sections at the end of each chapter for those who wish to find further information on the topic. Additional general hypnosis books are suggested in the reference section at the end of Chapter 8.

Under Medical Hypnosis you will find chapters on the biology of hypnosis, mind–body communication, and psychosomatic medicine, among others. Under Dental Hypnosis, there are discussions of the practical management of pre-op anxiety, validating the use of hypnosis, and dealing with pain and anxiety in adults and children. In the section on Pain Prevention and Management, the authors address the use of hypnosis in anesthesiology, resolving traumatic and key decision memories in the treatment of pain and treating pain, anxiety, and sleep disorders in children and adolescents.

The final chapter of the book is a research report that will provide readers with a current view on findings that clarify the significance of the central role of hypnosis in obstetrics, labor, and delivery, including the use of self-hypnosis to prevent pain and premature childbirth. Prenatal hypnosis has been shown to positively affect the health of the newborn infant on a number of levels. This chapter emphasizes the importance of clinicians doing hypnosis research in their practices and publishing their findings.

Every chapter in this book focuses on an important application for the use of hypnosis, beginning at the beginning…the most important five minutes of life are the first five minutes after being born.

Chapter 2

*The Biology of Hypnosis**

Bruce H. Lipton

In 1952, a young British physician made a mistake. It was a mistake that was to bring short-lived scientific glory to Dr. Albert Mason. Mason tried to treat a 15-year-old boy's warts using hypnosis. Mason and other doctors had previously successfully used hypnosis to get rid of warts, but this was an especially tough case. The boy's leathery skin looked more like an elephant's hide than a human's, except for his chest, which had normal skin.

Mason's first hypnosis session focused on one arm. When the boy was in a hypnotic trance, Mason told him that the skin on that arm would heal and turn into healthy, pink skin. When the boy came back a week later, Mason was gratified to see that the arm looked healthy. But when Mason brought the boy to the referring surgeon, who had unsuccessfully tried to help the boy with skin grafts, he learned that he had made a medical error. The surgeon's eyes were wide with astonishment when he saw the boy's arm. It was then that he told Mason that the boy was suffering, not from warts, but from a lethal genetic disease called congenital ichthyosis. By reversing the symptoms using "only" the power of the mind, Mason and the boy had accomplished what had until that time been considered impossible. Mason continued the hypnosis sessions, with the stunning result that most of the boy's skin came to look like the healthy, pink arm after the first hypnosis session. The boy, who had been mercilessly teased in school because of his grotesque-looking skin, went on to lead a normal life.

When Mason wrote about his startling treatment for ichthyosis in the *British Medical Journal* in 1952, his article created a sensation (Mason, 1952). Mason was touted in the media and became a magnet for patients suffering from the rare, lethal disease that no one before had ever cured. But hypnosis was in the end not a cure-all. Mason tried it on a number of other ichthyosis patients, but he was never able to replicate the results he had had with the young boy. Mason attributes his failure to his own *belief* about the treatment. When Mason treated

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*This chapter is updated and adapted, by permission, from Chapter 5 of *Biology of Belief: Unleashing the Power of Consciousness, Matter and Miracles* (Lipton, 2005), Mountain of Love/Elite Books.

the new patients he couldn't replicate his cocky attitude as a young physician thinking he was treating a bad case of warts. After that first patient, Mason was fully aware that he was treating what everyone in the medical establishment knew to be a congenital, "incurable" disease. Mason tried to pretend that he was upbeat about the prognosis, but he told the Discovery Health Channel, "I was acting" (Discovery, 2003).

How is it possible that hypnosis can override genetic programming, as it did in the case above? And how could Mason's *belief* about that treatment affect its outcome? Exciting insights from the leading edge of biology provide some answers to the perennial questions concerning mind and body.

In the seventeenth century, René Descartes dismissed the idea that the mind influences the physical character of the body. Descartes' notion was that the physical body was made out of matter and the mind was made out of an unidentified, but clearly immaterial substance. Because he couldn't identify the nature of the mind, Descartes left behind an irresolvable philosophical conundrum: since only matter can affect matter, how can an immaterial mind be "connected" to a material body? The non-physical mind envisioned by Descartes was popularly defined as the "Ghost in the Machine" by Gilbert Ryle 50 years ago in his book *The Concept of Mind* (Ryle, 1949). Traditional biomedicine, whose science is based on a Newtonian matter-only universe, embraced Descartes' separation of mind and body. Medically speaking, it would be far easier to fix a mechanical body without having to deal with its meddling "ghost."

In contrast to the worldview of the matter-only Newtonian universe ascribed to by most life scientists, the reality of an energy-based quantum universe defined by physicists reconnects what Descartes took apart. Yes, the mind (energy) arises from the physical body, just as Descartes thought. However, our new understanding of quantum physics, the universe's mechanics, shows us how the physical body can be affected by the immaterial mind.

Biologists in the main have still not recognized the importance of quantum physics, but research suggests that sooner or later they will have to because the weight of scientific evidence is toppling the old materialist paradigm. An article by V. Pophristic and L. Goodman in the journal *Nature* in 2000 revealed that the laws of quantum physics, not Newtonian laws, control the life-generating movements of biologic molecules.

Reviewing this ground-breaking study for *Nature*, biophysicist F. Weinhold concluded: "When will chemistry textbooks begin to serve as aids, rather than barriers, to this enriched quantum-mechanic perspective on how molecular turnstiles work?" He further emphasized: "What are the forces that control the twisting and folding of molecules into complex shapes? Don't look for the answers in

Chapter 5

Psychosomatic Medicine

Marlene E. Hunter

What is "psychosomatic medicine"?

For hundreds of years, in the Western world, we have thought of medical problems as being distinct from emotional problems. One of the pioneers in challenging this concept was Hans Selye, a Canadian physician, who spoke openly about his belief that stress was a significant factor in many of our physical problems.

However, it was with the publication of *Psychoneuroimmunology*, edited by Robert Ader in 1981, that the medical world began to give real credence to what we now consider indisputable: that mind and body are irrevocably linked and our health, in every respect, depends on both healthy minds and healthy bodies.

Earlier in this medical revolution, Franz Alexander had related seven conditions as belonging to this new concept: essential hypertension, peptic ulcer, ulcerative colitis, hyperthyroidism, regional enteritis, rheumatoid arthritis and bronchial asthma (Alexander, 1950). I have always found it amusing that three of the seven are connected to the digestive system – what one might call a "gut reaction." I apologize for the bad pun, but not for the awareness of the link.

The word *psychosomatic* comes from the two roots, "psyche," meaning mind, and "soma," meaning body. When it first came into medical jargon, it was considered just that – jargon: another way of implying "imaginary." However, Ader's book brought clearer focus, and the dawning realization that we are never disconnected at the neck and that what happens in our emotional world has an impact on our physiological world, and vice versa.

We could easily think of various contributions from the psyche:

Anger, fear, trust/distrust, anxiety, love/hate

Just as easily can we think of the role of the soma:

The neuroendophysiological and biochemical responses to the emotions

What is "behavioral medicine"?

This term implies that we can help people improve their health by showing them ways to modify their behavior.

Implicit in this concept is that the person wants to and is ready to work to effect those changes. As clinicians, that is a factor that we must never ignore.

Viewed from these perspectives, it is easy to acknowledge that *everything* is psychosomatic. True, some things are more psyche and some are more soma, but "you can't have one without the other," as the old song says.

Examples of conditions with psychogenic roots:

- Insomnia
- Panic attacks
- Being "stressed out"
- Inability to concentrate
- Nightmares

Examples of conditions with somatogenic roots:

- Biochemical imbalance
- Hormonal deficiencies or excesses
- Infections
- Neoplasms
- Degenerative diseases: of the body and of the brain

How do psychosomatic and behavioral concepts and approaches work together?

When we acknowledge that *everything is psychosomatic,* we are already in the realm of behavioral medicine. When we help people to shift or change their thinking and emotional response by changing their behavior, for example, this addresses the "psyche" directly, and therefore, secondly, affects the soma also.

Chapter 10

Resolving Traumatic Memories Related to Persistent and Recurring Pain

James H. Straub and Vicki W. Straub

Traumatic memories and post-traumatic stress disorder (PTSD) are often related to persistent pain, anxiety and other difficulties seen in medical, surgical and dental procedures and treatment. In addition to physical injuries resulting from trauma, a variety of pain-related syndromes are significantly correlated with a history of PTSD (Shipherd, Keyes, et al., 2007; Villano, Rosenblum, et al., 2007; Andreski, Chilcoat, & Breslau, 1998; Asmundson & Taylor, 2006; Geisser, Roth, et al., 1996; Otis, Pincus, et al., 2006; Santos, 1997). A significant number of women with chronic pelvic pain have experienced sexual or physical abuse (Heim, Ehlert, et al., 1998; Lampe, Solder, et al., 2000). Engel (2003) looked at the relationship between multiple idiopathic physical symptoms (MIPS) and PTSD. He suggests: "MIPS may also represent the physical manifestation of an anxiety or depressive disorder, including PTSD. In a significant proportion of individuals with MIPS, there is no adequate psychosocial or biomedical explanation for the symptoms" (p. 199).

The trauma and traumatic memories can be the basis of the pain or serve to exacerbate the pain related to injuries or disease. Beckham, Crawford, et al. (1997) found veterans who had an increase in PTSD re-experiencing symptoms also experienced increased pain levels, pain and disability. The most common source of PTSD is motor vehicle accidents (Blanchard & Hickling, 2003b). According to their research, 15 to 45% of persons in serious motor vehicle accidents may develop PTSD. However, childhood physical and sexual abuse and war are also much too common sources and are significantly correlated with a variety of pain and medical disorders as mentioned above.

There are several models that have been developed to explain the high correlation between PTSD and persistent pain. These include the Mutual Maintenance model (Sharp & Harvey, 2001). Friedman, McEwen, et al. (2003) discuss the

relationship of PTSD, allostatic load and medical illness, including pain disorders. Other models include shared vulnerability and fear–avoidance (Otis, Keane, & Kerns, 2003) Further, the shared neurological processes of PTSD and persistent pain may exacerbate each other (Asmundson, Coons, et al., 2002; Schnurr, et al., 2003; Friedman, McEwen, et al., 2003; Meagher & Kendall-Tackett, 2003; Schnurr & Green, 2003; Sharp & Harvey, 2001).

Flashbacks and the re-experiencing of symptoms are a common characteristic of PTSD where the person re-experiences all or part of a traumatic memory. Somatosensory flashbacks can result in the re-experiencing of the sensations of the original trauma. Salomons, Osterman, et al. (2004) studied pain flashbacks related to surgery and found significant similarity in the revivification and the original experience. In addition, the treatment and reduction of PTSD may result in the reduction of pain (Shipherd, Keyes, et al., 2007). Beckham, Crawford, et al. (1997) reported a significant association of increased pain levels with increased re-experiencing of symptoms.

In this chapter, we focus primarily on dealing with specific traumatic memories that may be related to the experience of persistent pain or triggered during procedures. However, underlying traumatic memories that are not specifically related to the expression of pain can also be resolved by these techniques.

Case Examples

A young African-American woman being treated for severe recurring rectal pain without resolution was referred to me (JHS). With the use of an affective bridge during light hypnosis she remembered being anally raped with a Coke bottle by several male cousins when she was about 8 years old. She was embarrassed and uncomfortable going into any details about the episode. I explained a version of the movie theater technique to her and how she would not need to talk about any of the details of what happened in order to heal the memory. (While sometimes it is valuable for the patient to have someone hear his or her story, accepting the patient as a person while acknowledging the trauma of the experience, it is often more comfortable for them to be able to process the memory without having to share the details. This is especially true with memories that involve sexual abuse and degradation.) The total process with this woman took about 45 minutes. Twenty-five years later she reported no recurrence of the pain.

A 37-year-old Caucasian woman had been stabbed multiple times during a robbery of the store in which she was working and was still experiencing pain from the area of the wounds as well as anxiety more than a year after the event. With the resolution of the traumatic memories, she no longer experienced the pain and there was a significant reduction in her anxiety levels.

A middle-aged Caucasian woman was experiencing significant pain in her chest area two years after open heart surgery. While she did not have the initial conscious memory of experience, with the use of an affective/kinesthetic bridge she recalled awakening when she was in ice following the surgery. When this memory was resolved, so was the pain.

Sometimes, beliefs anchored to key decisions result in behavior patterns that lead to behavioral patterns that exacerbate existing problems. A middle-aged Caucasian farmer with significant back problems kept reinjuring himself by not restricting his activities. He was referred due to his non-compliance. He held a strong belief that he was not a "real man" (gaining his father's love and acceptance) if he gave into the pain, which would mean he could no longer do much of the physical labor required to run his farm. His key decision memory that was at the basis of his belief was identified and reworked. This resulted in his willingness to comply with the physician's guidelines and still feel like a whole acceptable man.

It is important to consider the possibility of prior trauma when the patient is not responding well to traditional treatment even when the history of related trauma is not obvious. Further, studies suggest a significantly higher history of abuse incidence and PTSD in patients with pelvic pain, IBS and other gastrointestinal problems, fibromyalgia and facial pain. Veterans wounded in combat with a prior history of PTSD report, on average, more significant pain and disability (Aaron, Herrell, et al., 2001; Asmundson, Wright, et al., 2003; Beckham, Crawford, et al., 1997; DeCarvalho, 2004; Howard, 1996; Lampe, Solder, et al., 2000; Longstreth, 1994; Martinez-Lavin, 2001; Namenek, 2006, Roy-Byrne, Smith, et al., 2004; Sherman, 1998).

Dentistry

As many dentists and oral surgeons are aware, people who have experienced sexual abuse, particularly oral abuse, often avoid dental treatment and can be easily triggered during the procedures. Some patients do not want to discuss their past traumatic experiences and some patients are not consciously aware of their abuse background, especially childhood sexual abuse, and have not figured out their pattern of avoidance (Santos, 1997). It is still helpful to screen patients for any history of oral sexual abuse or trauma.

What is most helpful for patients with trauma histories is having an empathic and understanding dentist who is willing to listen to their concerns. Further, the ability to control how their dental treatment proceeds with a way to stop the procedures eases anxiety. While these are common steps for most patients, they are even more important and may require more detailed and explicit

This landmark book explores the biology of hypnosis and its applications in medicine, dentistry, pain prevention and management. Drawing from presentations at the 6th Annual Frontiers of Hypnosis Assembly held in Halifax, Nova Scotia, Dr. Brown has edited a volume that will be of interest to a broad swathe of clinicians. The chapters will inform and stimulate the thinking and practice of clinicians who already use hypnosis and those who are interested in knowing more about its efficacy and potential. Contents include:

- Hypnosis in Medicine by David Spiegel, MD and Jose Maldonado, MD
- The Biology of Hypnosis by Bruce Lipton, PhD
- Hypnotic Induction Profile by David Spiegel, MD and George Fraser, MD
- Mind/Body Communication by Marlene Hunter MD
- Psychosomatic Medicine by Marlene Hunter MD
- Rapid Relaxation: The Practical Management of Pre-Op Anxiety by John G. Lovas, DDS and David A. Lovas, MD
- A Validation for Hypnosis in Dental Practice by Gabor Filo, DDS
- Pain, Anxiety and Dental Gagging in Adults and Children by Ashley A. Goodman, DDS and Donald C. Brown, MD
- The Use of Hypnosis in Anesthesiology and Pain by A. Max Chaumette, Jr., MD
- Resolving Traumatic and Key Decision Memories in the Treatment of Persistent Pain by James Straub, EdD and Vicki Straub, PhD, MBA
- Treating Pain, Anxiety and Sleep Disorders in Children and Adolescents by Leora Kuttner, PhD
- Evidence Based Hypnosis for Obstetrics, Labor and Delivery and Preterm Labor by Donald C. Brown, MD

The original material presented at the conference has been significantly updated and expanded and now provides one of the most important collections of literature on this subject available in this area.

"This book should be in every hypnosis practitioner's library. Dr. Brown has compiled the clinical and scholarly wisdom of the most prominent clinicians and academicians in the fields of hypnosis, medicine, dentistry and pain management. This book will be a desk-top reference for me for many years to come."

Bruce N. Eimer, PhD, ABPP, Co-author of *Pain Management Psychotherapy: A Practical Guide*

"The contributors to this book have provided interesting, comprehensive and thought-provoking insight into the art and science of clinical hypnosis. With examples, references for future exploration, and postulates of possible theories dealing with the mechanisms and biology of hypnosis, the reader is given important practical information highlighting the value and power of the mind/body connection, to which clinical hypnosis is the key. This book is written for the curious neophyte as well as the experienced 'hypnotist'. I highly recommend it."

V. Rausch, DDS, hypnotherapist and retired dental surgeon

"Clinical hypnosis has benefited countless individuals faced with a variety of medical and dental problems. Health care providers can no longer ignore the important applications for hypnosis in health care. This book offers readers at all levels understandable current evidence for important advances in hypnosis in the hope that many readers will be encouraged to utilize hypnosis [in their practice]."

Philip Klemka, MD, practicing psychotherapist

Donald Corey Brown, BSc, MD, CCFP, FCFP, ABFP, is an approved consultant in Medical Hypnosis by the American Society of Clinical Hypnosis. Dr. Brown was Founding Director, Department of Family Medicine, Dalhousie University Medical School. He is licensed to practice family medicine and medical hypnosis therapy in Nova Scotia, Canada. Dr. Brown is currently involved in full-time private practice as a consultant in medical hypnosis.

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