CHAPTER 12

Resonance Based Medicine: A Systems Perspective for Managing Chronic Pain

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Hansjörg Ebell considers the implementation of hypnosis and self-hypnosis to be both fitting and invaluable when dealing with chronic illness (especially chronic pain and cancer) in the context of medical care. This conviction evolved pragmatically over years through his studied application of hypnotic phenomena in anesthesiology (1976-80), intensive care medicine (1980-83), interdisciplinary pain therapy at Munich University Clinic (1983-92), and, since 1992, in his psychotherapeutic practice. Dr. Ebell's publications on clinical issues regarding pain therapy and psycho-oncology include a controlled clinical study: Self-hypnosis as adjunct to pain therapy according to WHO guidelines with cancer patients, 1988-91. Further papers on psychotherapeutic support of chronically ill patients, most of them written in German, can be found on his website (www.doktorebell.de).

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Chronic Pain and Medical Practice

Acute pain can be resolved when the cause has been treated sufficiently and/or its inherent homeostatic regulation has been addressed. However, what can be done when pain and disability persist, either with or without knowledge of the

underlying cause? What if medical interventions prove themselves unable to cure, promote healing, or alleviate pain? What if therapeutic interventions themselves, i.e., treatments that are meant to help, make the condition worse? In recent decades, the suffering associated with chronic pain has been presented more and more as a "symptom," to be acknowledged and treated in the medical system as a discrete "disease." The predominant biomedical approach of "find it and fix it" needs to undertake a shift towards a more complex bio-psycho-social model in order to effectively support adaptive coping and self-management.

Adequate treatment of chronic pain requires a high degree of diagnostic and therapeutic competency to be able to identify the underlying pathophysiological factors and psycho-social issues. Clinicians must be able to both identify treatments that facilitate pain relief and to determine how to empower patients to learn to independently manage their pain more effectively. At the same time, clinicians need to be aware of the danger of promoting a patient's helplessness and dependence. This can be prevented through recognition of the simple fact that the patient's subjective experience of "*being* ill" (German: Krank*sein*) is of no less importance than the therapist's objective classification of "ill*ness*" (German: Krank*heit*; see Sauerbruch & Wenke, 1936, p. 76).

Both perspectives refer to the same condition. They are comparable to the perspective on a landscape in and of itself, and to the perspective of a map that illustrates certain aspects of the landscape, such as roads, population, and/or vegetation. If clinicians and patients work together in a *therapeutic alliance in resonance,* each with the expertise that stems from their specific point of view, they can collaboratively develop the most effective treatment plan. Putting this interventional *and* inter-relational approach into

practice must be rooted in *patient-centered communication*: *"resonance based medicine."*

"Pain as an emotion..."

Nakamura and Chapman (2002) present a constructivist view on pain and suffering; that is, on "how pain hurts." "Classical thinking in neuroscience has characterized pain as a predominantly sensory experience... current knowledge would justify construing *pain as an emotion with sensory features as opposed to the older notion of a sensory experience with emotional sequela* [emphasis added]" (Nakamura & Chapman, 2002, p. 202). The authors summarize, "The constructivist model of pain can go beyond classical pain theory to account for the following problems: pain reflects top-down influences as well as bottom-up signaling of tissue damage; pain can exist with or without tissue damage; *pain is mainly an affective phenomenon; pain acts like an attractor in dynamical systems theory* [emphasis added]" (Nakamura & Chapman, 2002, p. 202).

The experience of pain triggers a complex set of avoidance behaviors as well as a search for assistance. Jensen (2016) thoroughly discusses the implications of two distinct neural networks—the Behavioral Activation System (BAS) and the Behavioral Inhibition System (BIS)—in trying to understand and treat chronic pain. Under the guidance of the BIS, pain is frequently used as an "admission ticket" to the interventional medical system which has a primary goal of fighting (i.e., reducing or eliminating) the pain, most often via analgesic medications ("pain killers") and/or even surgery. After years of chronification, this approach often makes the problem worse, for despite brief periods of relief achieved with biomedically focused treatments, the risk of even greater suffering and helplessness due to dependency may increase.

Neuroplasticity, i.e., changes in neural networks through learning processes on multiple levels, stabilizes an

interdependent system of interacting biological, psychological, social, and spiritual factors. Such a system resists efforts to induce quick and radical changes, especially when only biological factors, such as suspected underlying nerve damage and/or tissue inflammation, are addressed. Reducing the suffering and improving the overall quality of life of the patient requires more complex bio-psycho-social interventions. Changes are needed that can provide *new* experiences. Such experiences aim at *"more of this is needed"* (i.e., treatments that activate the BAS) rather than focusing on pain as the *"only thing to get rid of"* (i.e. driving the BIS).

The conventional biomedical approach that sees the patient as a passive receiver of treatment does not allow him to cope effectively with pain, stress, and/or other related life challenges. What can be done to help patients help themselves? The important questions that arise here are: What resources are available to the patient that can help him to reduce suffering? *"What instead?"* should and could be the center of awareness, of cognition, or of behavior in order to promote self-competence, self-efficacy, and well-being? Any and all encounters of the two approaches—i.e., the one for *being* ill and the other for ill*ness*—must proceed within the context of *interactive resonance*. The character of these encounters must heighten acceptance of the fact that handing over any painful part of the body for repair is not an option.

Among other approaches, Jensen (2016) finds hypnosis appropriate, since it "could have a direct effect on creating new associations in either the BIS or BAS (depending on the specific suggestions offered) which then would facilitate the establishment of new automatic responses to pain or other stimuli" (Jensen, 2016, p. 529.e11). David Spiegel (1985), a recognized expert in the field of psycho-oncology, found hypnosis to be especially useful to "filter the hurt out of the pain," not only with cancer patients.

The Core Element of Hypnosis and "Resonance Based Medicine" is Therapeutic Communication

Communicating with the patient *in resonance* supports required changes. *Patient-centered therapeutic communication* (see Figure 1) corresponds to a pyramid of layers, one on top of the other. Translated into clinical practice, the layers of communication are, of course, not distinct. They refer here to the key aspects in communication that guide the treatment. Their effective application requires mindfulness for the fundamental law of interpersonal communication in which the *receiver's* interpretation of the communicated message, rather than the *sender's*, is considered to be decisive.

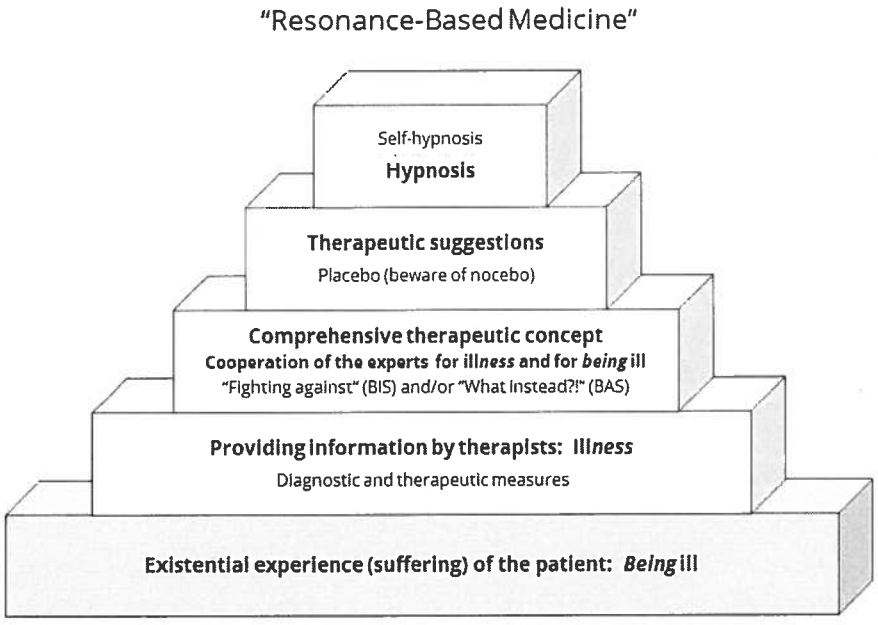

Figure 12-1. Levels of communication in resonance based medicine

The patient's existential experience of *being* ill, with the concomitant suffering that necessitates medical treatment and/or therapeutic support, serves as the basis of any therapeutic communication.

With respect to the first layer, all patients need to be provided with necessary information about their ill*ness* (fulfilling the legal duty to inform and ask for consent for any treatment) in a manner that facilitates anxiety reduction (i.e., addressing the underlying question, "What's wrong with me?") and that can transmit confidence for a good outcome.

Second, and especially when dealing with chronic pain, the therapist must present himself as a collaborator who is contributing his knowledge (e.g., state-of-the-art treatment guidelines based on "evidence based medicine", Sackett et al., 1996) as an expert on ill*ness*. The patient is contributing his expertise of *being* ill, and thus is capable of determining if and when treatment goals have been or are being achieved. By taking both perspectives into account all clinical decisions can evolve *in resonance*: *"shared decision making."*

The critical role of the third layer, that approaches hypnosis, is often underestimated. Broadly based clinical research (Varga, 2011; Kekecs & Varga, 2013, Cyna et al., 2011) illustrates the power and efficacy of suggestions provided in treatment settings without formal trance induction. Clinicians can, and for the benefit of their patients indeed should in the clinical setting, make use of positive suggestions, better known as the placebo response. The clinician must be aware of a patient's readiness to accept a suggestion in order to avoid negative suggestions that may well make things worse (e.g., a surgeon making a statement such as, "You will hurt like hell when you wake up in the recovery room."; Bejenke, 1996, p. 214).

Hypnosis and self-hypnosis are not separate tools but are self-evident procedural steps in the continuity of interdependent aspects or layers of this pyramid model of *patient-centered therapeutic communication*. Positioned on top of

the pyramid, as sequential measures of a development, they appear neither exotic, nor extraordinary—even when combined with a formal ritual of hypnotic induction, or when using hand levitation or other peculiar hypnotic phenomena. *Therapeutic communication* is the core element both of hypnosis itself and of a medical practice based on *intersubjective exchange in resonance*: *"resonance based medicine."*

Hypnosis and Self-Hypnosis are at the Pinnacle of a "Resonance Based Medicine" Approach to Dealing with Chronic Pain

When applied to the treatment of chronic pain, *resonance* implies using the authority of medical expertise in order to transmit the key notion to the patient that *he or she alone is the expert in regards to changes that are necessary and possible*. The clinician-patient relationship can best be seen as a joint venture that aims at catalyzing the processes of personal change, rather than delivering ready-made solutions. Its aim is to "restore or maintain the patient's sense of competence, increase the patient's sense of control, foster self-mastery and independence, enable the patient to retain dignity, include the patient as an integral and active participant in his care instead of a passive recipient" (Bejenke, 1996, p. 211). Although interventional and directive hypnotic techniques can be effective in an acute setting for pain control, chronic pain requires a cooperative effort. *Hypnosis offers a way of teaching the patient how to use self-hypnosis*.

It is of central importance to enable the patient to make a decisive transition from the problem-oriented search to fight or reduce pain (BIS), toward a solution-oriented BAS approach. Here, questions such as "How would you like to feel?" and "How should it feel instead?" invite the individual responses from the patient to answer personally with a

multitude of desirable perceptions. Within the context of an atmosphere of trust, not too many steps are required to test these options by relaxing and imagining a "favorite place" where these qualities *can be experienced as real to the extent that it makes a difference to the patient.* The advantage of this approach is that any improvement referring to a valued "What instead?" goal can be perceived as progress and rewarding and is an impulse into the BAS; while a reduction of pain (as source of the suffering, BIS) is unlikely to be experienced as progress unless it gets very close to zero, which is indeed unlikely for most chronic pain patients.

It would, however, be naïve to view this approach as the simplistic proposal that in order for chronic pain to go away patients just need to think positively and practice self-hypnosis. Without an understanding and therapeutic processing of related bio-psycho-social and spiritual issues, years of suffering will allow for only limited progress. The stability of the system—i.e., the missing predisposition for easy change—is anchored in an unconscious conditioning of implicit biographical memories, helplessness, pain, physical, and/or perhaps sexual abuse. These converge in a sort of glow that generates the heat and smoke of chronic pain and suffering. Since hypnosis is conceptualized as an *intersubjective, relational exchange* (Erickson, 2013; Haley, 2015) *rather than the mere application of (yet another) powerful (but invasive) technique* it is particularly effective in addressing these supplementary and yet influential aspects of chronic pain. The intimacy of a present-day relationship that is intensely protective and trustworthy encourages in and of itself relief and overall stress reduction. Its characteristic quality of *"attunement"* (Bonshtein, 2012) that enables an adequate understanding of the patient's past experiences is a

prerequisite for addressing chronic pain suffering and for exploring the patient's options for a better future.

Hypnosis can offer access to "rooms for change" (McClintock, 1999) in which associative fields containing painful memories can be processed, resolved, and/or integrated in such a way that previous experiences are no longer able to function unconsciously as "triggers" for stress and pain. When past incidents are no longer the designated problem, today's peace can be made with what happened in the past. Even if the traces left by such incidents in the patient's memories are the cause of trouble, what happened in the past cannot be changed. The memory of the past, however, can be changed; neuroplasticity is gospel for the rehabilitation of chronic pain patients, even though, paradoxically, it acts as the basis of chronification as well.

Hypnotic and self-hypnotic imagination of an adaptive "What instead?" and being in a "safe place" (visual, auditory, kinesthetic, olfactory, gustatory) can facilitate the experience of feeling comfortably and entirely secure—especially when there are many reasons for feeling bad and endangered by conditions that may not disappear "just like that" (e.g., cancer treatment or being chronically ill). The experiences of feeling secure within oneself serve as a sort of power station; where the batteries of personal confidence can be recharged in order to be able to meet up with and to fulfill the requirements and the challenges of everyday life.

The patience, confidence, and nurturing quality of a patient-therapist relationship *in resonance* encourage the patient to make his or her own choices. This benign *intersubjective resonance* between persons serves as a model and as a source of induction for the restoration of a better *intrapersonal resonance* of the individual patient that emanates

from homeostatic regulation (Brown, 1991). This too facilitates change in the patient's relationship with pain.

Change and Healing: A Hypnosystemic Approach to Chronification and Rehabilitation

Resonance (Rosa, 2016; Ebell, 2017) indicates a professionally shaped sphere of relatedness as a process of mutual influence during a collaborative effort to identify possibilities of change. Seen from a systems perspective, even a problem depicted as the *worst*—including the subjective experience of pain and suffering—represents the best possible solution for the individual *under the given conditions*. Any therapeutic impulse to target a better solution requires a "comprehensive treatment concept operating on three major operational levels simultaneously: intrapersonal, interactional, and contextual" (Ebell, 1995, p. 4).

In terms of its function according to systems theory, chronic pain acts as an "attractor," as well as an "attention-getter," in its ability to invoke the conscious awareness of the person concerned. This insures the high intrinsic stability of the system. In contrast, the subjective experience of pain invokes an absolute need for change and a maximum activation of the BIS. Chapman et al. (2008) explain that, "the nervous-endocrine-immune ensemble constitutes a single overarching system, or supersystem, that responds as a whole to tissue trauma and contributes to the multidimensional subjective experience of pain. This leads to the hypothesis that supersystem dysregulation contributes significantly to chronic pain and related multisymptom disorders" (Chapman et al., p. 123). They go on to say, "Supersystem dysregulation (is) prolonged dysfunction in the ability of a system to recover its

normal relationship to other systems and its normal level of operation after perturbation" (Chapman et al., p. 135).

The primary task and challenge is thus to *constructively destabilize the status quo of the system in order to induce change for the better.* This goal is achieved by (1) identifying the patient's resources for experimentation with something that could open a door to positive experiences and by (2) identifying (auto-) suggestions that by continuously activating the BAS augment a personal counterbalance to pain and suffering. The aim here is not only to induce *"first order" quantitative* changes (e.g., reduction of pain intensity and/or quality) but *"second order" qualitative* changes in the patient's perception and overall quality of life as well. Progress (healing) is tantamount to the emergence of a complex system and cannot be fabricated and/or controlled completely in the therapeutic exchange of the partners. Change happens.

Any search for appropriate hypnotic (auto-)suggestions is facilitated by ideomotor signaling (Cheek, 1994). This technique allows the clinician and the patient to determine if proposed suggestions are consistent with the patient's inner values and experiences, and for the patient to disclose ambivalence and/or a variety of different views. Just like a traffic light that provides the driver with a green (go!), red (stop!), or orange (proceed with caution!) guidance, ideomotor signaling indicates how to best proceed, especially when discussions on a cognitive level tend to confuse and cause uncertainty.

Case Report: Complex Regional Pain Syndrome

My treatment of a patient with a 10-year history of Complex Regional Pain Syndrome (CRPS) can serve here as an illustration of *collaborating in resonance* within the

framework of a *comprehensive therapeutic concept*. This syndrome is characterized by a high degree of suffering due to pain and the disabled state of the involved extremity and its dramatic tendency toward deterioration. Exacerbations can be triggered by normal physical activities and by emotional stress. This very special dysregulation of a normally reliable healing process (underlying an overreaction and/or lacking inhibition of inflammatory cascades in the neuro-endocrine system) was first described in the beginning of the last century by the surgeon Paul Sudeck, and, until recently, CRPS was also labeled "Sudeck's dystrophy"(Agarwal-Kozlowski et al., 2011; Sudeck, 1900).

Looking back on her "career" of being a chronic pain patient, Mrs. T, 55 years old, is convinced that psychotherapy, hypnosis, and self-hypnosis helped her to learn to live decisively with her pain in general, to reduce her suffering, and to become an appreciated and equal decision-making partner. All of this was done in order to optimize her medical treatment in regards to the quality and intensity of rehabilitation exercises, the handling of analgesic opiate-medication, and the use of invasive medical procedures like botox-injections, infusions, etc. from time to time.

A Small Path of Worrying Develops into a Highway of Pain and Suffering

Mrs. T's problem began after an arthroscopy of the right elbow joint and the suture of a tendon. She developed typical CRPS symptoms in her right hand, which, despite immediate recognition and treatment of the syndrome, not only persisted but changed for the worse; this was disastrous for the right-handed homemaker who also worked as a secretary. It was only after three years of deterioration that she was adequately treated in an interdisciplinary and multimodal hospital

setting with a clear recommendation for continuous ambulatory psychotherapeutic treatment of the concomitant depressive reaction.

In a first phase of collaboration we focused on identifying those factors that induced feelings of emotional overload in her relationships at home and at work, and we explored how these feelings could be managed more effectively. Emotional reactions, (mostly feelings of being "moved") and tears, surprised her, as did her cognitive associations to traumatizing past events.

The working hypothesis for our collaborative research as experts for ill*ness* and *being* ill was the following personification of "Mr. Sudeck," i.e., her pain-problem. What if he were an extremely demanding and rigid teacher rather than the cruel torturer she experienced at the outset of treatment. As a teacher, he uses draconian punishment and offers no explanation as to "why" he overreacts to any level of physical or emotional stress. What if a part of herself (i.e., her own strictness) is as judgmental and merciless as Mr. Sudeck is? This is an old fashioned, fundamentalist, educational method of disciplinary punishment that does not allow for a single mistake and prohibits normalcy and healing.

Mr. Sudeck's pedagogic style is, without the slightest doubt, unacceptable, and it maximally activates her BIS. There is, however, a big "but," for he might in fact be well-meaning. If she is able to receive the messages he is trying to convey and she can make progress in developing more effective coping strategies, he may turn out to be just a strict teacher who does not accept cheating. Given Mrs. T's strong sense of duty and discipline, Mr. Sudeck is in truth aware of stressors long before Mrs. T, herself, would notice. Actually, Mr. Sudeck might, in the long run, help her discover how to

reduce her overall stress, which could eventually help her to achieve a better quality of life in general.

The most difficult part for us both as experts for ill*ness* and *being* ill was to not put blame on anyone or anything, but instead to use her insights pragmatically in order to strengthen her BAS. From this point of view, Mr. Sudeck proved to be a reliable and knowledgeable investigator who evaluated intrapersonal, interpersonal, and contextual changes thoroughly.

On the other hand, his tendency to overreact and to use pain intensity as punishment was not useful feedback. A more gentle reaction on his side would help her to experiment more with the "what instead" approach and to generate more and more positive experiences (BAS); achieving a better quality of life or even healing. Mr. Sudeck's retirement became our shared goal, i.e., that Mrs. T could be more accepting and more merciful with herself. If she were to acquire the self-competence and self-efficacy needed in order to take care of herself, well, Mr. Sudeck would no longer have to be so fiercely vigilant and suspicious of her anymore.

Within two years a certain level of acceptance was attained. Mrs. T understood that Mr. Sudeck (i.e., the pain), other symptoms, and specific reactions represented only one of many aspects of herself as a complex system and that her CRPS was not a weird, external, malevolent energy that was bullying her. A vital part of this learning process was the need to work through and finally overcome her own attitude that her right arm was the *only* problem ("If I didn't have this d#&! CRPS, everything would be alright!"). Her first coping strategy had been the attempt to ignore it ("The right hand does not belong to me"). However, since her arm hurt so much the strategy was ineffective and proved useless. As a

consequence, she cursed her "f&%!ing hand," and for some months even searched for a surgeon who would be willing to amputate it. We eventually found the following "what instead": "*My hand belongs to me, and it is my duty and job to care for it, even when or especially, because it is such a trouble maker.*"

Mrs. T reduced her work hours, practiced saying "No," and gave the requests of her family members and her colleagues careful thought before automatically answering "Yes, I'll take care of that." Her ongoing opiate medication regimen, which, prior to psychotherapeutic treatment had not resulted in adequate palliation, began to provide sufficient pain relief. She learned to take time to care for herself through rest, sports activities, and relaxation in self-hypnosis. After 22 treatment sessions Mrs. T decided it was no longer necessary to continue her psychotherapy.

Two-and-a-half years later I received an email with an update on her medical status and her ups and downs. Just before she wrote she had, all by herself, withdrawn from a regimen of very high dose fentanyl. In her email she posed the following question: "I was able to control my pain pretty well until recently, but now the muscle tonus in my arm is so high that I am unable to open my hand any more. I have been wearing a brace on the hand for about a year, but it feels as if my hand and forearm are torn apart. I think that that's why my pain is getting worse and harder to control. Do you think it would make sense to try self-hypnosis?" My immediate answer was, "Yes, I do." She then came back to see me for self-hypnosis training.

Transcript (Hypnosis Session)

After an in-depth review of the course of her pain therapy and her coping strategies in the time since our last session two

years ago, and after discussing relevant changes in her personal and professional relationship systems, we focused on Mrs. T's formulation of her primary treatment goal. Although proud of having been able to maintain her pain in general to a level of about 4 (measured by a numerical rating scale from 0 to 10), she hoped to learn the necessary skills in order to effectively relax her affected arm and shoulder and to reestablish an awareness of the forearm as the natural anatomic connection between the elbow and the hand.

Clinician: Mrs. T, we have talked in detail about your problems for about an hour. So let's turn to an in-depth discussion of a suitable "What instead?" Let's concentrate on developing ideas that could help you to be better able to relax your arm and your shoulder, and especially, what could be an alternative sensation for your hand and forearm, which have felt somehow torn apart for quite a while now.

[I use her own wording of the problem while I turn to consideration of a possible solution, i.e., her personal alternative and individual "What instead?"]

What would be your number-one wish on your priority wishlist today if your unconscious mind would be able to fulfill it, just like that?

Patient: I want to regain a feeling that the arm is, in itself complete, so that I'll be able to let go and relax it more easily as a whole. I remember something a doctor in Sri Lanka said last year. I contacted him during a vacation there, and he told me that I am blocked, that there are many blockades, and that it is necessary to achieve a flow again.

Clinician: Do you feel a blockade right now? And if so, where?

Patient: When I turn my attention to my right shoulder and arm now—I usually try to avoid being aware of them at all, much less to focus on how they feel—my perception ends at the elbow. Then there is a gap, and my perception starts again in my fingers.

Clinician: Would you mind closing your eyes and telling me what you see between your elbow and your fingers?

[More a suggestion than a question.]

Patient: *[After a pause.]* **I see something like the image from an accident. Something anatomical. Just bone and flesh; each end torn apart and frayed.**

Clinician: Sounds like an understandable reason for feeling pain and for suffering.

Patient: That picture scares me. It looks icky, disgusting.

Clinician: Remember how we successfully collaborated years ago on overcoming your fantasy of tearing the arm out? You had developed that fantasy as an attempt to get rid of the pain and the other problems in your hand.

If you had torn out the arm back then, it might have looked like that. But focus *now* on what might be the alternative to such an icky and disgusting picture of an arm torn into pieces with frayed ends. What comes to your mind, when you concentrate *now* on an image and/or a feeling of how it should and could look and feel like instead?

Maybe you have to think about it... or maybe it'll develop just by itself and get clearer and clearer... just take your time, lean back with your head resting on your shoulders, and your arms resting on your thighs.... Take a few deep

breaths, and relax... and just wait a little for what is going to happen.

Patient: *[After some minutes.]* **A thought, a sentence comes up: "It is going to be whole again!"**

Clinician: *[Assuring.]* **This seems perfect. If it is fitting for you and your unconscious mind, you can relax deeper and deeper... and feel more and more comfortable... to discover what your arm needs. What *you* need, and what may help the *two ends to start to come together and to heal and to become a whole again*, and what is necessary and helpful *to let them grow together again and heal to become a whole again.***

The *deeper* you float into a feeling of deep confidence... that this might not only be possible but that it will happen—even after so many years of pain and suffering—the *lighter* the other hand will feel. Your left hand will show you and me that your unconscious is willing... will cooperate... to support this project of yours of healing, by feeling lighter and lighter.

The signal may be to lift just a little bit from its position of lying comfortably on your thigh because it feels lighter and lighter, whereas the rest of your body feels comfortably heavy and relaxed. If this is going to happen, if your number-one wish is going to be answered and fulfilled, then *it'll happen all by itself, just like the healing of tissue is something happening all by itself.* If there is flow again where there have been blockades, these blockades can and will be resolved.

[With minimal hesitating, jerky movements her left hand rises several inches, as if it were driven by a geared wheel, typical of ideomotor movements. To my surprise there is a

similar movement in the fingers of her right hand too. They spread a little and lift up from the brace, visible, since the tape on the brace only covers the knuckles. Mrs. T seems calm, her breathing is deep and regular, her eyes are moving behind her eyelids.]

If you are feeling alright now, I suppose you are taking the first steps on your new path to healing. Maybe an experience will emerge that can lead you along this path, an experience made up of what you feel, see, hear, and maybe even taste. Ideally, it will consist of all of the elements you need for healing, and it may become an ideal basis for your self-hypnosis exercises, the reason why you contacted me again, after years of very successfully coping with the strain of pain and stress of your everyday pressure and challenges.

Patient: I can see and feel a pipe, much like my brace. It is round and it encloses my forearm, protecting it, from the elbow to the knuckles of my hand. I can't look through it; because it is sort of metallic. I can't see what happens in there.

Clinician: Could there be something else in there other than your arm, in the pipe, something helpful that will *optimize the healing of both ends and help to connect them to become a whole again*?

Patient: Chamomile flowers, something natural to support healing.

Clinician: A powerful remedy, well known since ancient times. ... Is something else in there, in the pipe, to support healing?

Patient: *[Reporting with eyelids still closed.]* **That's interesting; the metal pipe is changing into something else. Now it's a**

kind of bark, the bark of a tree; a bark that has many outer and inner layers. The inner layers are responsible for growth and nurturing of the trunk, the outer for protecting it. ... I think it is a birch tree. I love birch trees. I see them very often when I go for a walk where I live. It is surrounded by a marsh.

Clinician: That sounds perfect. Just sink into this experience *as deeply as possible now* by taking another deep breath. You and your unconscious, I think, are doing a great job. Just watch now, if anything else is going to happen to help you to generate the ideal idea of regeneration. You have all the time you need—*[Voice lowered, to emphasize the post-hypnotic suggestion]***—*to store this strong healing image in your memory, so you can call on it again, ask it to appear again during your self-hypnosis practice as vividly as it is right now to support you and your healing project—*[Voice as before]* although it'll be just a few minutes in real time.**

As long as your left hand is still floating, I suppose that this is the time you need for letting everything that is helpful sink into your memory, into the archives. In these archives there are memories that might be waiting, ready to show up, when they are needed, and some parts are better sealed, so that they don't bother you anymore. And there is a wise archivist who knows what belongs to which part of the archive.

> *[Indirect suggestion for amnesia for the feeling of the arm as if torn apart and for a quick recall of her pipe of birch bark imagination of healing.]*

Healing makes a difference right from the beginning... and especially in the long run. You certainly know and remember the potential of the body to heal wounds; such as

a cut in the skin. It happens all by itself, sometimes with scars that are difficult to see, even if you look for them with a magnifying lens.

Patient: *[Appearing very calm, facial muscles relaxed, breathing regularly, her left hand lowering very slowly, inch by inch, as if driven by a geared wheel.]*

Clinician: *[Reorientation.]* **As soon as the fingertips of your left hand touch your thigh again, your hand will come to rest. It'll feel normal again and it doesn't have to signal anything to anybody anymore. It's just your left hand with its own weight; it can function normally and as needed. The contact of hand and thigh will be the starting point for you to count back silently from 10 to 0, number by number, step by step, to say goodbye to the inner world, your healing image, and to promise to return from time to time during self-hypnosis as discussed. ... At about 5, half-way back to the here and now of sitting comfortably in this chair here in my office, you take a deep breath... and when you arrive at 0, you'll open your eyes, look around, stretch your arms and legs and be fully oriented.**

Patient: *[After a while, smiling.]* **I didn't expect that. The last thing that I saw was a normal elbow and forearm as a whole; no torn ends anymore!**

Clinician: Congratulations. Looks like a good start. We'll discuss your experiences with self-hypnosis by mail and soon we can have another session to support your healing project. You may use your familiar relaxation ritual for inducing self-hypnosis to focus on the image of the pipe of birch bark around your forearm. Maybe some additional images with the same healing quality will emerge, having

the quality of a distinct "What instead?" compared with where we started today at the beginning of our session.

Follow-up

Starting with this session, and for the past three years, we have remained in contact. We have had several sessions, often with months in between them; during this time, Mrs. T had ups and downs. For about half a year after the described hypnosis experience she intensively practiced the healing image of a pipe of birch bark around her right forearm. Her ability to use this imagery depended on her overall stress level, but she continued to use self-hypnosis regularly for relaxation and recovery. Mrs. T is still wearing her brace for protection, and her right hand is still completely unusable for household chores. Her hand reacts with growing pain in any active exercise treatment that is necessary to prevent further deficits.

She ultimately quit her job and retired. This, as well as the death of her father the same year and the concomitant neediness of her elderly mother, induced a crisis. Her supportive husband is a continuous and present resource; they spend as much time together as possible. Pain has not ceased and it remains her major challenge. Nonetheless, in my view, the hypnotic experience described above signified a decisive step and was a turning point in the right direction; that is, to *awaken her empathy and accept her responsibility for taking care of her poor arm and hand*. Mrs. T had been an active partner as the decisive expert for her *being* ill to cooperate with professional CRPS experts in the context of a *comprehensive therapeutic concept*. Self-hypnosis serves her as reliable source of support in dealing with multiple aspects of coping with stress, pain, and with her handicapped arm.

Summary and Conclusion

To treat and manage chronic illness, especially chronic pain, *therapists and patients must join forces in a collaborative effort to seek out potential changes* in the context of an *interdisciplinary and multimodal comprehensive therapeutic concept*. This joint venture corresponds to a process of mutual learning. It is conducted in an atmosphere of *intersubjective resonance*—that is, the relatedness of two individual human beings in the roles of therapist and patient. Both act as experts of their respective perspectives; the professional for the diagnosed ill*ness* and patient for *being* ill. A prerequisite for a *therapeutic alliance* requires that their exchange be shaped professionally as a *patient-centered therapeutic communication*. Although objective and subjective limitations exist, both experts learn together where those limitations are. Well-established medical interventions based on empirical evidence ("evidence based medicine") need to be supplemented by this approach of *resonance based medicine*.

Hypnosis may offer access to resources for change and hidden potentials, and self-hypnosis may become a decisive coping strategy. Optimally tailored (auto-)suggestions are identified by analyzing the problem mutually (i.e., the patient's symptoms that act as trigger of the *Behavioral Inhibition System*) and then guiding the patient towards individual solutions that have a distinct *"What instead?!"* quality. *Ideomotor signaling* may assist this process, helping to identify appropriate goals that strengthen the *Behavioral Activation System*.

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