***P*arts *T*herapy *H*ypnosis (PTH) for Pain Management**

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***PAIN* is a *noxious* or unpleasant *sensory* and *emotional* experience** associated with actual or potential tissue damage to one or more parts of the body. Note that this definition includes both sensory-physical and emotional-affective components or "parts".

Pain also has a cognitive-evaluative or interpretive part. That means that when we are in pain, we naturally have a need to make sense of why we are in pain.

For ease of remembering the sensory, cognitive and emotional parts, we can parse the word *PAIN* into a mnemonic:

P*hysical* – ***A****ffective* – ***I****nterpretive* – ***N****oxious.* And if we add the word ***S****timulus* to this apt mnemonic, we get P-A-I-N-S. Clearly pain has "parts".

A basic law of physics is that *for every action there is an "equal" and "opposite" reaction*. In the realm of mental and behavioral psychology, this principle must be slightly modified.

A basic law of psychology is that *for every behavior, thought, feeling, personality trait, and mental state there is an opposite behavior, thought, feeling, personality trait, and mental state, which may or may not be "equal" in its strength, complexity, duration, or implications, to the former.* This is because, just as Freud had said, all psychological responses have multiple determinants, or "parts".

A basic assumption of most psychotherapies is that every behavior, thought, feeling, personality trait, and mental state has a *duality*. For example, *aggression* cannot exist without an opposite such as *passivity* as a potential behavior, and *angry* cannot exist without an opposite such as *forgiving* as a potential feeling state, and *tense* cannot exist without an opposite such as *calm* as a physical state. But…

Because psychological responses are motivated by multiple determinants, the opposite of a behavior or feeling for one person is often different from the opposite of the same behavior or feeling for someone else.

These dualities often shift over time within the same individual given the situational context, the person's mood state, mental state, role being assumed, and/or the "part" of the person's personality that has been activated at any given point in time.

A basic assumption of Parts Therapy is that everyone has different parts of what we call their "personality". The parts that are relevant to the work of most therapies, and more specifically for our purposes here, Parts Therapy, are those personality parts that are fairly well formed and consistently patterned in relation to the presenting symptom or presenting problem. But going back to "duality" for the moment…

Given that we humans think in terms of dualities or opposites, that it is a way of knowing the world around us, it is natural to think in terms of "mind" vs. "body". Therefore…

It is also natural to separate the emotional from the physical or the physical from the emotional parts of the pain experience. But…

While we can think about the mind and the body as separate, one cannot realistically separate the mind from the body because mind and body are really two sides of the same coin. Only a guillotine can separate the mind from the body, and that is certainly not in the realm of therapy!

But the mind is really just a metaphor for consciousness. One can talk about various types of mind or mental consciousness which of course fits into our concept of multiplicity.

There is the brain or "head mind" and the "heart mind". The former is associated with logical, critical, analytical thinking and the latter is associated with intuition and feelings. Some people have much more of one type of mind than the other. For some people, these two minds co-exist without much or even any awareness of the existence of the other. And for some people, these two types of mind are well integrated. But…

The center of it all is the central processor that runs a person's conscious and unconscious mental and physical functions. That central processor is that major bodily organ called the human brain.

Unconscious mental and physical functions include habit patterns as well as the involuntary or autonomic physiological processes that keep us alive, such as breathing, heart rate, blood pressure, digestion, body temperature, blood flow, etc.

The strain of pain is felt mainly in the brain. Even though a person may feel noxious sensations, that is, physical hurt or pain in his/her back, neck, or other body location, irrespective of the body part that hurts, all pain is felt in the brain. This is because without a brain, there would be no pain. There would also be no life! And…

Without pain as a protective signal and warning of danger to the body, a person would likely get into a lot of physical trouble and end up gravely injured or dead! So…

Both the brain and pain are essential and necessary "evils". But sometimes too much of a good thing can be a bad thing!

Pain as a signal. Pain is a signal that something is wrong somewhere in the body. It can be a life saver.

Physiologically speaking, sensory pain signals are transmitted as electrical nerve impulses from a part of the body up the dorsal horn of the spino-thalamic tract of the spinal cord to certain areas of the brain where those nerve signals are interpreted for meaning and perceptions are created.

In chronic pain syndromes, the pain signal functions like a broken fire alarm with highly amplified speakers that are activated every time the temperature in the hallway rises above 85 degrees. Or, it can be likened to a submachine gun discharging an endless supply of .45 caliber rounds. In other words…

The alarm activation threshold is low and the alarm response is high volume and continual.

The same tissue injury often has different effects on different people. It could create a great deal of pain, strain and stress for one person and a lot less pain, strain and stress, or even no pain or stress at all in another person.

Whether chronic pain is an outcome depends on the situational context, the person's pre-existing vulnerability, and the meaning the person assigns to the injury and the acute pain.

The degree of pain and degree of injury are not always correlated. Furthermore, there are certain types of pain that actually have no sensory equivalent. A prime example would be "phantom limb pain" where the actual amputated limb or portion of the limb that is no longer there is still perceived as hurting. That is, the painful sensations continue to be felt in the area where the absent limb or part of the limb used to be. No sensory signals are being sent from that absent portion of the limb. Yet, the pain perception is real and the person in pain is really in pain. Why?

The Pain Gate Control Model. Based on the seminal work of the research team of Melzack and Wall in the 1960's, we now know that chronic and persistent pain is modulated through a Neuro-Endocrine Matrix (NEM) of electrical signals. And the key point here is that conscious and subconscious brain patterns and perceptions are the central modulating factors.

Some perceptions (i.e., thoughts, feelings, behaviors) open the *"pain gate"* and others close it. In other words, the degree of hurt and suffering and the quality, intensity, strength, and duration of pain, acute or chronic, are influenced by what a person thinks and does. And…

In chronic pain syndromes, this NEM has become highly sensitized. As with the fire alarm/firearm analogy, it is either always on, or shooting, or it takes little to trigger its activation.

Severe psychological and physical trauma, chronic anxiety and chronic depression can make people vulnerable, or sensitized, to developing chronic pain in response to one or more injuries, which can be like the "straw that breaks the camel's back". Conversely, persistent physical pain often causes persistent anxiety and depression.

Anxiety and depression have specific causal factors. Anxiety results from the belief that one's resources and inner strength are not strong enough to handle a perceived threat. In other words, the threat exceeds one's resources.

Depression results when anxiety persists unabated and wears a person down to the point of learned helplessness and eventually, hopelessness. Unabated anxiety and depression drive a person physio-psychologically into a state of exhaustion.

Exhaustion lowers a person's immunity and resilience to stress. Here again, the exhausted person is physio-psychologically weakened and more prone to injury. The person's threshold for activation of pain as a signaling function also may be lowered. And if the alarm switch is overly sensitized to pain and stress, any degree of pain and stress will function as a pain activation or pain intensification trigger. And the alarm stays on…

Pain affects and is affected by a pain sufferer's expectations, beliefs, perceptions, attitude, motivations, emotional reactions, and evaluations. All of these factors fall under the realm of psychology. Thus, chronic pain is both a psycho-physiological phenomenon as well as a physio-psychological phenomenon.

The Gate Control Model and the pain sensitization effect partially explain why there are so many cases of (a) persistent pain associated with no objectively measurable tissue damage, and (b) chronic pain that persists long after the tissue that was damaged has healed.

Unexplainably persistent pain is a "dissociated part" of a person's mind and body. This appears to be an end result of all of the above phenomena. If the pain is a "dissociated part", then Parts Therapy Hypnosis could be a sensible and natural way to treat that persistent pain from a psychological perspective.

The effective use of Parts Therapy Hypnosis (PTH) to help a client manage persistent pain and get lasting pain relief depends on the hypnotherapist being competent at facilitating the client's journey through the following ten (10) steps. The hypnotherapist must help the client:

1. **Become adequately prepared** for the hypnotherapy through the hypnotherapist's artful use of waking state reframing and waking suggestions.
2. **Uncover**, through the artful use of *Parts Therapy Hypnosis*, in combination with *hypnotic regression* techniques if necessary, the underlying problem/s which constitute the source and origin of his/her anxieties and depression.
3. **Cooperate in inviting those parts** of the client to come forward that have something to do or say about the client's excessive pain and suffering.
4. **Host and participate in a mediation session** with the "involved parts" to generate an acceptable and more comfortable solution to the identified underlying problem which gave rise to the persistent pain as a *disharmonious* and "painful solution".
5. **Invite and assist any "involved parts" who need to re-experience**, relive, and release painful feelings associated with the originating events (i.e., the original problem) to do so safely.
6. **Assist all "involved parts" involved to re-learn** a more appropriate, healthy and less painful/more comfortable solution which would make the continuation of the same level of pain unnecessary—because after all, pain is a signal.
7. **Assist all "involved parts" in learning new more comfortable ways** of thinking about and dealing with the old problem, or the changed problem, in the present.
8. **Make sure all "involved parts"** have an acceptable role to play.
9. **Assist all "involved parts" to co-participate in:**
    a. **Reaching an acceptable agreement for a harmonious solution** to the original problem; a solution which does not necessitate so much pain…
    b. **Sealing the deal that will heal the disharmony** which had resulted in excessive pain...
    c. **Test and confirm** that excessive pain is in fact no longer necessary.
10. **Thank all of the involved parts** for coming forward and participating in the healing process.