Chapter 8: Medical Hypnosis and the Anodyne Imagery Technique

"Someday, after mastering the winds, the waves, the tides and gravity we shall harness for God the energies of love and then, for a second time in the history of the world, man will have discovered fire." - Pierre Teilhard de Chardin

During my last year in Virginia, I met X-Ray tech turned hypnotherapist Donna Hamilton at the A. R. E. She told me was in the process of publishing an article with interventional radiologist Elvira Lang about the work she was doing at the Palo Alto VA Hospital applying neurolinguistic programming (NLP) techniques to procedures in the Radiology Department. NLP is a model of interpersonal communication for creating successful behavior change derived from hypnosis theory.

Donna described a patient with severe chronic pain who needed a jejunostomy tube changed through a tract in his abdominal wall. She asked him first to come up with an image that represented his pain. He said it was like a raw red piece of meat with a butcher knife stuck in it. She asked him to change the image to make it more comfortable. He turned it into a toy knife and removed it, which gave him a sense of control over his pain for the first time and reduced his need for medication.

One of the most intriguing examples she shared with me was of a claustrophobic patient undergoing MRI whose images were degraded by motion artifacts. She showed me MRI scans before and after her NLP intervention which demonstrated a marked improvement in image quality. I was intrigued because claustrophobia was a challenging issue for the MRI Safety Committee. One patient even published an “Ode to the MRI scanner” describing it as a “coffin that makes noise.”

The standard approach at that time when there was no such thing as a wide bore or open magnet was to give patients who were concerned about the confining atmosphere of the scanner Valium by mouth.
Let Magic Happen: Synchronicities, Healing Stories and Techniques of a Holistic Radiologist

which unfortunately yielded inconsistent results. Intravenous Valium worked quite well except for the potential side effect of patients forgetting to breathe when they were in the scanner. Occasional breathing is definitely recommended during a scan that may last up to an hour.

After I arrived at Duke, she sent me a copy of her paper, “Anodyne Imagery: An Alternative to IV Sedation in Interventional Radiology,” which was published in the *American Journal of Roentgenology* in May 1994. It was a good choice of title as anodyne meant “no pain” and imagery was a more marketable term than NLP or hypnosis at the time. I immediately invited her to visit me at Duke with the intention of making this unique approach available to our patients.

Thanks to our open-minded Chairman Carl Ravin, I arranged for her to give a Radiology Grand Rounds presentation and to spend a week working with patients in the Department to demonstrate Anodyne Imagery to the staff. It was pretty much unprecedented for an X-Ray tech to give such a presentation, but then it was also unusual for a tech to be co-author of a paper in a prestigious journal. Working with patients also required her to be granted temporary hospital credentialing privileges.

**First Duke Anodyne Imagery Patients**

The 2 most memorable patients she worked with that week were serendipitously referred by interventional radiologist Cynthia Payne (no pun intended) and neuroradiologist Linda Gray. The first one was a classic North Carolina patient, an elderly woman with lung cancer who was the wife of a local tobacco farmer. She half jokingly said her only allergy was to pain during her intake interview for the procedure making her the ideal candidate to assess the effectiveness of Anodyne Imagery.

Cynthia was doing a Port-A-Cath placement for her intravenous chemotherapy which involved threading a catheter into the subclavian vein in the chest followed by minor surgery to create a subcutaneous pouch to hold the reservoir. The process included multiple forceful passes with
progressively larger needles under the clavicle to dilate the track for the catheter. The procedure usually required a considerable amount of sedation with IV Versed for anxiety and Fentanyl for pain.

Donna introduced herself and asked the lady if she had a favorite vacation spot. She immediately responded that she had just been on a wonderful trip to Hawaii, so Donna suggested that she could take a free imagery trip there during the procedure. She taught her some relaxation breathing and then incorporated different facets of the experience on the X-Ray table into the beach imagery. The lady quickly got very involved in her internal experience of lying on the warm sand under the sun.

Even Cynthia got into the act when she needed to irrigate the wound with copious amounts of saline that ran over the woman’s chest by saying, “Here comes another wave.” At the end of the case, she was amazed to discover that no Versed had been used and only half as much Fentanyl as usual. She expressed concern about the patient’s comfort during the procedure, but the lady said “It was wonderful.” She was the first of many satisfied Anodyne Imagery customers at Duke.

The Grand Rounds presentation went exceptionally well including a review of the impressive scientific results from the 21 patients described in the paper and a group imagery experience for the entire staff in attendance. Ultrasound specialist Mark Kliewer went right from the talk to his next procedure, used the technique on his own without further instruction and got excellent results. There was much discussion about bringing her back to do a formal training for the staff.

The grand finale of the week came the next day when Terry Alport, a local architect, arrived for a special angiographic procedure by Linda Gray. There had already been much hype during the week regarding the case as he was very anxious about having been diagnosed with a brain aneurysm that Linda needed to do a test occlusion on before he could be scheduled for surgery. He would need to be awake and alert during the procedure, so they could monitor the results.

Donna arrived to find him in the waiting room fully dressed in a big overcoat with arms folded tightly across his chest giving off very negative body language. However, using rapport skills derived
from NLP that subtly mirror a patient’s mannerisms, Donna soon put him at ease by starting with her arms crossed and gradually shifting to an open position. She then found that he was actually very skilled at visual imagery due to his professional background.

He wound up sitting on the porch of his condo at Bald Head Island, NC, watching the sunset while geese flew over as the procedure started. It had to be done without sedation due to the risk of stroke during the test occlusion of the vertebral artery feeding the aneurysm. She also taught him a method during the procedure to lower his blood pressure to normal for the first time in months. He subsequently quit taking his blood pressure medicine altogether using the techniques he learned from Donna.

Terry and his wife Nancy Lane were ecstatic about the results after the case was over, but Donna had to rush to the airport to catch her plane back to California later that afternoon. They immediately arranged to fly her back the next week to work with Terry during the delicate aneurysm surgery. Chief of Neurosurgery Alan Friedman was open-minded enough to support the process, and Terry sailed through the surgery making a quick recovery out of the Neuro ICU in record time afterwards.

Duke Radiology Department Anodyne Imagery Training

I got funding from Carl Ravin to bring Donna back to do a 2 week training for the radiology staff including nurses, techs and physicians. A few months later an adventurous group of us spent two consecutive weekends learning and experiencing Anodyne Imagery. During the week in between Donna and her partner John Pateros were available for consultation around the Department to supervise our fledgling attempts at applying what we had learned, and we had daily group debriefing sessions.

Melissa Holbrook, RN, reported accompanying an anxious patient to the CT scanner who was extremely short of breath. A pneumothorax with a partially collapsed lung was detected, and a surgeon was called to put in a chest tube and reinflate the lung. Melissa began stroking the patient’s forehead at
the same rate as the rapid breathing and then gradually slowed down using an NLP technique known as pacing. Amazingly, by the time the surgeon arrived the patient was breathing at a normal rate.

MRI tech Ann Charles had a patient with an unusual breathing problem due to a rare condition known as relapsing polychondritis where the cartilage throughout the body starts to dissolve and collapse. His trachea would spontaneously collapse when he laid down flat making him panic due to air hunger. She had him image his trachea as a rigid tube in his chest, and his breathing immediately improved to the point where he could lay down long enough to complete the study.

Another of Ann’s MRI patients was a skeptical engineering professor with severe shoulder pain who also could not lie down comfortably in the magnet. He wasn’t really interested in any “California woo-woo stuff,” but was motivated to find out what was wrong with his shoulder. She had him imagine having manually operated digital pain meters in each hand and gradually got him to dial down the meter readings first on one side then on the other until he was able to become pain free during the study.

I had a non-English speaking, Hispanic patient for an ankle arthrogram who had severe reflex sympathetic dystrophy, a painful syndrome that makes the lightest touch to the skin intolerable. I asked the interpreter to find out where he would rather be than on the X-ray table having this procedure. He immediately said he would rather be at his favorite restaurant eating a sumptuous dinner. While he ate a five course meal, I put a big needle into his ankle, injected iodine contrast and took films without pain.

The results were quite remarkable considering our lack of background in such approaches. My longtime friend Chuck Spritzer took the training also and found it to be particularly useful in dealing with claustrophobic patients. The other techs would often call him to assist when Ann wasn’t available. Patients were particularly pleased with being empowered to handle their own fears without drugs enabling them to drive home right away afterwards without having to wait hours for the Valium to wear off.

Mammography specialist Ruth Walsh, MD, found it useful for breast biopsies, but also encountered one of the few Anodyne Imagery pitfalls in the process. She suggested that a patient might
find it relaxing to imagine going to the beach during a biopsy rather than asking her where she wanted to go. She soon started crying, and Ruth skillfully asked “What are you experiencing?” She recalled her husband dying at the beach, so chose the mountains instead and relaxed for the rest of the biopsy.

During the week that Donna was at Duke, I took her to meet key faculty members in other departments in the hospital to lay the foundation for a future hospital-wide training. She wound up doing a bronchoscopy with pulmonologist Peter Kussin without any sedation and an endoscopy with gastroenterologist Paul Jowell at the VA hospital also without sedation. These unprecedented experiences were instrumental in assisting us in getting funding for additional Duke trainings.

**Duke Hospital Anodyne Imagery Training**

Donna and John returned later in 1995 to teach another 2 week training that was open to staff from the entire Medical Center. We had 25 nurses, techs and physicians from throughout the hospital in that training which created magical synergistic possibilities for healing. The most interesting result was the discovery of patients arriving in the Radiology Department for a procedure who had already learned Anodyne Imagery from another practitioner in a different part of the hospital.

My most dramatic example of that phenomenon came as a result of a request I got from Duke Trustee Edwin Jones, Jr., to visit his friend who had been admitted for prostate cancer treatment. I went to see him up in his hospital room, and I taught him Anodyne Imagery to use on a minor skin biopsy he has having that afternoon. He picked a sacred temple in Japan that he had visited years before as his preferred place to go during the procedure.

It turned out that he was naturally talented at the imagery work. When I came back to see him a few days later, he said he had just returned from the Radiology Department after an interventional procedure on his kidneys. He had surprised the radiology staff by announcing that he had just learned an
imagery method that he could use to go through the procedure without medication. That kind of magic started happening all around the hospital in unexpected ways.

The most surprising results came from the least likely participant in the training, urologist John Weinerth, one of the most experienced senior surgeons in the hospital. John and his wife, Peggy Bridges, who worked as his urology nurse, took the training together and then applied Anodyne Imagery as a team during urology procedures. For those of you who have never had or seen one, a cystoscopy is considered a scary experience with a large tube inserted into the small urethral orifice.

John has a rather gruff demeanor like a Marine-drill sergeant with a low growling voice, and most of his patients were anxious and hyper prior to the cystoscopies. During the training he learned rapport skills that allowed him to shift the tone of his voice to match and pace the high pitched anxiety in his patients’ voices, and then lower it again to lead them to a more relaxed state. Working in tandem with Peggy, they were able to do the procedures quickly and safely with less medication.

One of John’s patients had a history of multiple outpatient surgeries for kidney stone removal and would always have to be admitted to the hospital afterwards for nausea from the anesthetic medications. Using an Anodyne Imagery technique derived from hypnosis, he gave the patient preoperative suggestions that she would become hungry for her favorite food right after the procedure. Afterwards, she wanted her nasogastric tube removed right away and recovered quickly without any nausea.

**Impact of Anodyne Imagery Trainings at Duke**

After the training, I did a survey of the practitioners to see what impact Anodyne Imagery had on their practices. John responded that he had spent a few thousand dollars travelling across the country to learn a new urological surgical technique that he had only used on a couple patients since that trip. In comparison, he used Anodyne Imagery that he learned for free on every patient every day as an integral part of his practice, so the difference in value was several orders of magnitude.
Nurse practitioner Laura Blue, the patient coordinator for the heart transplant program, used Anodyne Imagery with dozens of anxious patients waiting for heart transplants each day. A lot of her interactions were over the phone which worked just as well as in person. When a major TV news station did a story on Anodyne Imagery at Duke in 1996, she gave an interview in which she said in her Southern drawl, “I used to dread those encounters with anxious patients, and now, I don’t.”

Suzie Crater, RN, from the Durham VA Hospital also participated in the training which lead to incorporation of Anodyne Imagery into the MANTRA Project that she and cardiologist Mitch Krucoff did at the VA. These successes led to an additional training at the VA in 1996 which included members of the Duke Anesthesiology Department. We later estimated that Anodyne Imagery in both hospitals positively impacted more than 1000 patient interactions per week.

Terry Alford’s imagery experience of geese flying into the setting sun eventually became the inspiration for the picture on the cover of the April 29, 1996 Inside Duke University Medical Center publication that featured his story and many others in an article entitled “Anodyne Imagery: Getting Away From Anxiety.” The possibilities in 1996 seemed limitless, and we began developing a plan to create an Anodyne Imagery training center based at Duke.

I wrote an article for the *Radiology Administrative Journal* entitled “New Vistas for Anodyne Imagery” and presented a paper on “Anodyne Imagery for Musculoskeletal Radiologic Procedures” at the Society of Skeletal Radiology. Ann Charles and I created a research project to study the impact of Anodyne Imagery on claustrophobic patients in MRI as a randomized controlled trial versus standard sedation which finally got approved by the Institutional Review Board after months of revisions.

Melissa Holbrook, RN, did her Nursing Master’s thesis on Anodyne Imagery, and one of my medical students did a cost-effectiveness analysis project which showed the possibility for saving thousands of dollars on medical and surgical procedures by training additional practitioners in the
Let Magic Happen: Synchronicities, Healing Stories and Techniques of a Holistic Radiologist

Medical Center. We even had the support of Duke Medical Center Chancellor Ralph Snyderman who was impressed by the many positive reports from practitioners and patients.

Unfortunately, in 1997, the entire Anodyne Imagery vision completely fell apart in a short period of time. Ann did one patient in the research project, then seriously injured her shoulder and went out on disability. Donna and John presented a business plan for a training center at Duke to the administration which was rejected during a period of budget cutbacks. They dissolved their partnership shortly afterwards, so it is sad to say that there is no longer a way to be officially trained in Anodyne Imagery.

The good news however, is that Elvira Lang, MD, the original radiologist that Donna collaborated with on her first paper, went on to Harvard to do extensive research on what she renamed “non-pharmacological analgesia” or “self-hypnotic relaxation” which started out as Anodyne Imagery at the Palo Alto VA Hospital in 1994. Her work with psychologist Eleanor Laser is summarized in a 2009 book, *Patient Sedation Without Medication: Rapid rapport and quick hypnotic techniques.*

**Anodyne Imagery Technique**

Although there is no formal training in Anodyne Imagery anymore, I can teach you some basics that you can use for yourself or with someone else. The basic steps are establishing rapport, using language skillfully, teaching relaxation breathing, choosing a preferred place, and changing components of the images. Combined together these methods can completely transform an experience from one of pain to one of comfort.

Establishing rapport can be accomplished by subtly mirroring a patient’s gestures, words, voice quality or behavior in a way that communicates acceptance on a subconscious level. This process can be distinguished from mimicry as it occurs without exaggeration beneath the level of conscious awareness. As a general rule, if you pace a person 3 times in this fashion by matching them in 3 ways, it is then possible to lead them in a mutually beneficial manner to a shared goal.
The skillful use of language is derived from hypnosis theory with the emphasis being placed on positive or neutral phrases. For example, the typical language used during a radiology procedure includes the description of the initial injection of local anesthetic as like a “little bee sting that burns.” Since most people don’t consider any bee sting as little, it has the effect of creating a painful response. Changing the words to “notice the sensation from the numbing medication” creates a more comfortable experience.

Relaxation breathing in Anodyne Imagery is presented slightly differently from a normal breath to create a hypnotic anchor for relaxation. The first step is breathing out to empty the lungs of anxiety, followed by taking a deep breath in of relaxation. The subsequent expiration completes the relaxation process by letting go of any remaining tension. This breathing sequence can be used at any time during a procedure as a reminder to go deeper into relaxation.

Choosing a preferred place is best done in a non-specific way, as distinguished from guided imagery where the practitioner tells the patient what images to use. The question, “Where would you rather be?” turns over complete control of the process to the imager. That approach avoids the pitfall of giving someone a suggestion to go somewhere or do something that might bring up unexpected emotionally charged material with a less satisfactory result.

Changing components of the images during the experience can shift the emotional content in a powerful way. Asking “What are you experiencing?” is an open-ended question that does not plant additional leading suggestions. If a disturbing image is elicited, the next step is to give instructions on how to modify the image in a way to make it more comfortable by shrinking it, changing its color, moving it further away or simply asking “What would make it more comfortable?”

The steps are as follows:

1) Establish rapport by subtly mirroring 3 aspects of behavior such as spoken words, voice quality, gestures, posture or body language to communicate a sense of acceptance.
2) Eliminate negative language from the dialogue and consciously use positive or neutral language
to create confidence, trust and relaxation.

3) Teach relaxation breathing by beginning with a complete expiration, followed by a deep
inspiration of relaxation and another expiration to let go of all tension.

4) Elicit non-specific preferred place imagery by asking “Do you have a favorite place to imagine
going that would be safe, secure and relaxing?”

5) Guide management of specific symptoms by asking “Can you think of an image that represents
that symptom?” and giving suggestions for modification of the components of the image.

6) For unexpected issues that arise ask “What are you experiencing?” and then give empowering
suggestions about transforming the images into more comfortable ones.

7) Learn to trust your intuition in combination with the proper healing intention to come up with the
appropriate images, words and suggestions at just the right time.

Web Resources

Elvira Lang, MD, [www.hypnalgesics.com](http://www.hypnalgesics.com)

---

1 Elvira V. Lang and Donna Hamilton., “Anodyne Imagery: An Alternative to IV Sedation in
3 D. L. Burk, Jr., “Anodyne imagery for musculoskeletal radiologic procedures,” Program of the 19th
Annual Scientific Session, Society of Skeletal Radiology, Tucson, AZ, March 6-9, 1996.