Urodynamics, Neurourology and Pelvic Floor Dysfunctions

Alessandro Giammò
Antonella Biroli *Editors*

Chronic Pelvic Pain and Pelvic Dysfunctions

Assessment and Multidisciplinary Approach

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Editors
Alessandro Giammò
Neuro-Urology Department, CTO-Spinal Unit Hospital
Citta' Della Salute e della Scienza
Turin, Italy

Antonella Biroli
Autonomic Dysfunctions Center - Rehabilitation Unit
S. Giovanni Bosco Hospital - ASL Città di Torino
Turin, Italy

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Walter Comello

> We cannot solve our problems with the same thinking we used when we created them.
> —Albert Einstein

Saint Augustine wrote: "*There is a myself inside me that is much more myself than I am*". Nobody better than him has summarized so simply a truth that can explain the extraordinary, though often difficult and conflicting, relationship between an individual—or what he acknowledges as himself—and a part unseen by his conscience. This second part was subsequently called the unconscious by Freud. It has an apparently untameable instinct, but it is often united to a reasoning that is difficult to decipher. Yet it is a logic, indeed Machiavelli would have called it a *reason of state*, which becomes a very powerful and incontrollable action on the rational conscience. And this action is responsible for 95% of the potential for action and thus for behavioural decisions, but it can also influence the individual's somatic aspects. The part we all identify with, the *I* with its cognitive rational functions, is left with very little power when it clashes with it. So, the educational and cultural actions—that, at times, the individual pursues for an entire lifetime in order to achieve self-control—don't succeed unless there is a meeting, a secret attempt to compromise that can lead to a fragile and temporary acceptance. It would be better for the meeting to be an encounter in which to familiarize and find the best solution. It is from this relationship or absence of one that behaviours stem from, and even the attitudes and words that can caress or wound. It is difficult to acknowledge the power of what we are to them, yet they are the containers of meaning that mostly invisibly and silently over time form that *myself inside me that is much more myself than I am.* Not necessarily objectively, but on the basis of the mind's attributing dynamics which give meaning to those words. There are words that hurt and words that heal, however none will be indifferent to the individual's experience. The only

W. Comello (✉)
Psychè Study Centre, Turin, Italy
e-mail: studio@waltercomello.it

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ones to be acknowledged by the conscience for their effects are those that caress or cut like a scalpel. Words are conventional codes among individuals who speak a shared language, but they get translated by the mind into images based on subjective experience. Previous experiences provide a short-term or long-term memory tank which the mind refers to for subsequent attributions. Therefore, the individual becomes and is the result of personal history by sum or subtraction of events. Culture worldwide, in the many diverse forms of languages and traditions, both vertically over time and horizontally geographically, has always used and still uses rituals and metaphors for its most powerful pedagogic, educational, management and thaumaturgic actions. A metaphor transforms words into images, it is carefully, strategically and powerfully chosen, never by chance, so that the mind can receive it easily by penetrating the cerebral cortex or activating the limbic system directly. A metaphor is the parable, the history, the fairy tale, the aphorism. A metaphor is a place, a gesture, an object, a white coat. Western culture over the last centuries has wrongly believed that all this together with individual life experience could *perhaps* be related to human behaviour, but not to the body. Not long-ago, medicine students during their exams would discuss neurons as being typical brain cells which, once degenerated, could not be revitalized. However, we now know that there are 500 million neuronal cells in the intestine. This is the enteric nervous system, also known as *second brain*, as defined by the Columbia University scholar Michal D. Gershon. The intestine contains millions of cells and neuronal fibres that constitute a real and true autonomous nervous system. It is independent of the central nervous system and promotes intestinal contractions as well as releasing digestive enzymes. The enteric nervous system can integrate and process both external and internal stimuli received from the body by interacting with the central nervous system through an exchange of information mediated by the psycho-neuro-endocrine-immune system, the release of hormones, the vagus nerve and the immune system. Consequently, the two brains influence each other and determine our state of psycho-physical well-being. In fact, mental stress and negative thoughts activate the circuits of anxiety and fear, thus provoking an increase of intestinal motility, the release of cytokine as well as increased sensitivity and inflammation of the intestinal lining. This can lead to, for example, the onset of the irritable bowel syndrome or of an intestinal inflammatory disease. On the other hand, states of intestinal phlogosis determine an increase in the production of serotonin, the good mood hormone, and consequently of the enzyme in charge of its demolition. Under these conditions, there can be a lack of serotonin at central nervous system level and an onset of depression.

The enteric nervous system uses more than 30 neurotransmitters, many of which are identical to those present in the central nervous system, like acetylcholine, dopamine and serotonin. More than 90% of the body's serotonin is located in the stomach, which contains also 50% of the dopamine—currently being studied to better understand its use in the brain. Therefore, there is a correlation between the *two brains* also within processes that are functions of the central nervous system, where the latter becomes an *influencer* of the first. Actually, it is more appropriate to state that there is a reciprocal exchange in which the vagus nerve acts as a bridge and

distributes the information to the body. This means that an individual's experience doesn't remain only within behavioural areas of competence, but somewhere in some way it acts on the body, certainly not randomly. And what happens in the body has an important effect on the individual's psyche.

All of the above, which could be much further expanded, is necessary to better understand and assess **the effectiveness of psychotherapy with the aid of hypnosis in the treatment of the pain symptom in patients suffering from chronic pelvic pain** (CPP). In this chapter preconditions, protocol and results of treatment of CPP with *a specific psychotherapy method, which uses hypnosis* for a 6-month period, will be discussed.

10.1 Study Preconditions

There is a known correlation between CPP and the psychological condition experienced by the patient. On the other side, clinical hypnosis is recognized as having a role in the treatment of pain

10.2 Materials and Methods

Thirty-two patients (26 women, 6 men), average age 36.2 (21–52), affected by CPP clinically diagnosed and already treated with conventional therapies following the guidelines were selected. All shared the persistence of the pain symptom regardless of the conventional treatment (lifestyle, oral therapies, intravesicular therapies).

Before psychotherapy began, all patients underwent a standardized set of tests validated on the Italian population.

Tests administered:

- Cognitive Behavioural Assessment (CBA)—The test aims to collect all the data required to identify appropriate modalities of psychological activity for the symptoms described by the patient. It includes ten sections, each containing homogeneous items that investigate a specific aspect of the subject. The questionnaire collects and processes all the information including it in a wide-ranging assessment of the person's past and recent history. It thus produces a general personality profile.
  - Sexual Evaluation Schedule Assessment Monitoring (SESAMO)—A psychodiagnostic test which explores sexual and relational aspects, both normative and dysfunctional, in subjects that are single and not. It produces a psychosexual and socio-affective profile of the person as an idiographic image. It also formulates hypotheses on the causes and the dysfunctional aspects within the individual's and couple's sexuality. The investigation regards essentially the areas involving remote and current sexuality, but at the same time it also considers those connections that, even though indirectly, may have influenced

the formation and expression of the personality, of the affectivity and relational style.
- Minnesota Multiphase Personality Inventory 2 (MMPI-2)—One of the most widespread wide-range tests used to evaluate the main structural personality characteristics and emotional disorders. It is composed of 567 items, grouped in validity scales. The basic ones investigate the most significant personality aspects, the supplementary ones help to better understand any difficulties or disorders that emerged. In this version, more validity indicators have been added as well as additional scales. Also, norm standards more representative of the Italian population have been included. And the items have been formulated to eliminate ambiguity and gender discrimination.
- Stanford scale of hypnotic suggestibility—It's the most well-known scale of hypnotic suggestibility and consists of some suggestion-tests that are administered together with a standard hypnotic induction process. It is useful to assess the individual tendency/susceptibility towards the hypnotic process and highlights different responses to treatment.
- Quality of Life Index (QL index)—A very simple and short tool (5 items) designed to evaluate the outcome of treatment for cancer patients. However, as it's very general, it can be used also for other pathologies. It explores activities, daily routines, health, support and emotional states as well as providing a global assessment of the evaluator on the accuracy and reliability of his evaluation. The test offers a valid reference point for assessing treatment risks and benefits.
- Visual Analogic Scale (VAS) before and after treatment—This tool measures the subjective characteristics of the pain experienced by patients. The guidelines on pain treatment in the traumatized highlight how this symptom is often relegated to being second class and confirm the opportunity of adopting scales and tools that measure patients' subjective perception of pain in order to treat it more adequately.

Patients attended a 6-month therapeutic treatment with weekly appointments.

10.2.1 Phases of the Psychotherapy Process

- Search for a remote cause-effect diagnosis previous to the clinical diagnosis
- Evaluation of how the cause-effect relations identified concern the time of symptom onset or its current existence, for a current diagnosis.

These diagnostic phases are also part of the therapeutic process for the patient.

- Approach and training for the use of hypnosis based on a specific non-inductive method that aims to overcome unconscious patient resistance.
- Therapy using hypnosis with a body orientation to intervene on symptoms and symbolic implication to dematerialize the cause-effect relation.

10.2.2 Outline of the Psychotherapy Process

- *The body district is explored with its functions and meanings in a psychosomatic perspective*
- *Symptoms' time of onset*
- *Patient experience of the symptoms' onset*
- *Patient's subjective interpretation of the symptom–pathology*
- *Symptom structuring dynamics*
- *Hypnotic therapy*

10.2.3 The Body District Involved in the Psychosomatic Perspective

The urogenital apparatus is a complex system that oversees the excretory and reproductive functions. It refers to identity, male or female, to sexuality and related experiences, to the meaning of maternity. The excretory functions relate to the subject's dynamics concerning *acceptance or non-acceptance*. Additional meanings stemming from culture, education and life experiences may also be involved.

A subject not always welcomed, but of great interest when desiring to understand the reasons for a pathology's onset in a specific area of the body, is that of what organs symbolize. The world's culture, over time and across geography, seems to have a shared and recurring vision. This is what rituals from far away worlds and languages with their slang or local idiomatic expressions refer to. So, for example, organs like the heart and the liver seem to be always and everywhere considered, from the most archaic cultures to the skyscrapers of New York, one the centre of goodness and love and the other the centre of courage.

In an isolated Benin village in Africa, hundreds of miles away from the Guinea Gulf, a king had died. To celebrate his funeral hundreds of people from all the nearby village had come, with their kings and *fetisher* or shamans, who represent and at the same time interpret the religious and thaumaturgic power, as well as magical beliefs. The king had seven children and for this reason seven cows had been butchered and their meat distributed to the population. The carcasses were brought to a sacred spot near the village where only the kings and *fetishers* gathered. The dead king was renowned for his goodness and courage, and therefore for this specific ritual, the hearts and livers of the cows had been extracted. The kings and *fetishers* shared and ate the organs, so that by bringing them inside themselves they could also share the goodness and courage of the dead king.

Therefore, courage seems to have a location, a specific organ, the same of anger that is at times so difficult to contain. The heart instead appears to be the centre for goodness and love. For a long time, we've known that a healthy sentimental life is a base for the body's healthy functioning, starting from the immune system, and how much it affects cardiovascular diseases. This is true also when, in the absence of a partner or children, affective emotional needs are met by a pet. Probably science will soon be able to relate the more recent discovery of 50 million neurons in the

heart with the influence that our sentimental life has on the central nervous system's decisional processes.

Body organs have physiological functions but also symbolic ones. Indeed, their symbolism derives directly from their physiology. This mind body relationship is at the origin of well-being or pathology. Just like life quality is subjectively—and not objectively—an important condition for the organism's health, its negation can prepare for the onset of an illness that can be physical, psychic or both. So the arrival of a disease should not be interpreted as a casual or unlucky condition, but as the specific expression of an experience not casually referred to a target organ exactly because of its specific functions. Therefore, chronic pelvic pain is not only expression of a body that by chance—and for unknown reasons that there is no point in searching for—at a given point in life manifests itself. On the contrary, it is the clear symptom of a lifetime that for a specific reason represents itself in that body district and exactly with those modalities. The pathologies examined within chronic pelvic pain will presumably have a series of possible foreseeable origins, always and only related to the patient's subjective, and not objective, experience. The different diseases will differentiate in terms of symptoms and original causes, but with shared denominators. Interstitial cystitis will have shared roots, like endometriosis and pudendal neuralgia. A remote diagnosis within the patient's experience, in coherence with contemporary clinical diagnosis, is the essential condition for planning psychotherapy and for symptom resolution.

10.2.4 Chronic Pelvic Pain, a Different Interpretation

Chinese medicine defines the bladder as the soul's mirror.

A pathogenic agent acts on a terrain that has been predisposed by a specific psychological conflict, recent or remote. Possible consequences are *the pain and burning as an expression of an unhealed* wound, necessary at the time and that must continue to perform its sanctioning, avoiding and/or attentional function. It can then be interesting to discover fairly often a different meaning of the pain with respect to the burning within the patient's experience. The prior occurs more often in patients who seem to have sanctioning motivations related to past experiences that no longer exist in this somatic expression. Pain redeems from faults, indeed in the Bible Christ died on the cross to save humanity from the original sin, in other religions pain is a direct route for a certain Paradise. Burning instead relates to internal judgemental and guilt inducing dynamics where the burning is the means used to stop oneself, a tool for avoiding behaviours considered inadequate. This is the result of the *frequent urinary urgency that forces social isolation and justifies both with oneself and others the non-action.* The dynamics of control and non-control are definitely important, but they're subordinate to an unconscious and unaware need to yield to the seduction of fragility. Fragility absolves and creates *safe harbours* even where healing appears and is affirmed as a need. Often words, exhausting requests for help and at times even tears are not a priority compared to unconscious or veiled awareness of keeping the problem alive. Therefore, the reasons for maintaining the symptoms in this case risk being stronger than those for healing them.

10.2.5 Time of Symptomatology's Onset

The initial sessions with a patient aim to search for the onset of the first symptom over time and within memory, as precisely as possible: year, month, day and moment. Often repression processes and previous patient interpretations can compromise this search. The symptoms could have multiple forms at the time of inquiry or could have had them over time. It will be necessary to define the evolution of each symptom and to place it at a precise moment of the patient's history. It is important to return to the first symptom and to the time of its initial occurrence. From here an analysis of the patient's feelings related to the symptom's onset and the remote diagnosis begins.

10.2.6 Patient Experience in Relation to the Symptomatology's Onset

A single event, or episodes that repeated or spread over a timespan that can even be years, or is existent in the patient's current life is sought for. It will be an event emotionally important, in a nearby moment or at a time occurring at the most within the last year. A year is a conventional measurement unit in which past moments that could be at the origin of the symptomatology recur or are evoked. It is more likely that the causal relation will be of weeks or a few months. The event to look for isn't necessarily traumatic, even though patients often tend to concentrate their search on this kind of situation. It is an emotionally important event and, in the absence of trauma, it has the force to recall a remote trauma. This occurs unconsciously, but with a strategy aiming for the target organ. The unconscious will act similarly to a *magician* facing his audience: it will create a suggestion, a presumed different reality protecting the hidden truth. The goal is the effect, the symptom that precisely with its characteristics expresses its aim. *The magician* will be able to act successfully for years, but will stop being effective once *his trick* is understood. His effectiveness will increasingly lose power as the patient understands and accepts the cause and effect dynamics. It will then be important to observe the changing characteristics of that specific set of feelings over time. This is the purpose of psychotherapy: producing awareness, a new awareness as a basis for change.

10.2.7 Patient's Interpretative Subjectivity of the Symptom–Pathology

The patient's pathology can be diagnosed as a *post-traumatic stress disorder* in which, as widely shown by many studies, what counts is the subjectivity of events and not their objectivity. Albert Einstein affirmed that *a new way of thinking is necessary to solve the problems created by a previous way of thinking*. Before starting this specific psychotherapy, the patient has walked different therapeutic roads and

each one has surely conditioned and influenced his attitude and his willingness to finding a solution or even searching for one. The longer he or she has suffered, the less trust in finding a solution there will be. The longer the person has thought there not to be a causal connection in his symptoms, but only an unfortunate organic coincidence, the longer it will take him to accept its existence. The more traditional therapies have been the only option considered, the more it will be difficult to believe in a possible solution, although he can't do without one with his symptoms protracting over time. In some cases, patients have tried alternative solutions that were alternative only in the modality and brought no results. In other cases, patients for their culture or experience consider cause and effect relationships that have no foundation and thus are useless for healing.

The initial psychotherapy sessions will aim at building trust in its being a new and valid tool that is based on concrete principles, science and results. A new way of thinking prepares the patient to trust the therapeutic process. He will discover a causal and non-causal relation in which he identifies authentically and this will lead him to fully understand the therapeutic process. It is important to understand but it isn't the solution. After a few integrative and strengthening therapeutic settings, the patient will be willing to make what he has understood into his understanding. There is a fundamental difference: understanding means to take within and what you bring inside has the force for transformation. The dynamics that led to the illness had it, with similar competence the healing dynamics will have it too. If for some reason by now clear in the patient's experience the mind created his symptomatology, if there are no longer any reasons for it, the mind will gradually influence not creating the symptoms anymore. Hypnosis will be the tool able to access that competence area surgically, and from that time on will be perceived by the patient as relieving of responsibility in respect to the solution. It is essential to observe if the causal relation is maintained during psychotherapy by symptom structuring dynamics such as sanction, avoidance and attention. In this case, the following psychotherapy sessions will investigate them further in order to extinguish them. Until this condition is fulfilled, there will be no solution and even hypnosis will be useless.

The problems arise from *devaluing circumstances occurring over time or never realized* in the patient's evolutionary process.

They can be traced back to:

- *Sexuality experienced as guilt-inducing or accomplice* following child abuse often within the family
- *Homosexuality* not accepted or experienced conflictingly
- *Gender identity conflicts* and corresponding difficulties with cultural acceptance
- *Paraphilia* causing non-acceptance and conflicts
- *Emotional abandonment* causing devaluing conditions of the gender identity
- *Unresolved conditions relating to motherhood* following abortions, difficulty to procreate, severe unease in the relationship with one's mother in an identification-projection mechanism of a daughter.

10.2.8 Symptom Structuring Dynamics

Often the remote diagnosis in its cause-symptom relationship, together with the absence of prejudice, is the premise for the awaited use of hypnosis. This will lead the patient to recognize himself concretely in his results. In other cases, the analysis of the symptom's structuring can be the most difficult part for the patient. Acknowledging that there is a resistance towards healing isn't easy to accept and for this reason it is also hard to understand. But psychotherapy will proceed quickly reminding the patient of Hippocrates's phrase: *before healing someone it is necessary to ask if they are prepared to let go of what made them sick.* The patient will be able to recognize the reasons of his resistance and will then be prepared to face them. Psychotherapy will provide the tools or will suggest replacement alternatives if necessary. Both the onset and maintenance over time of the symptom–pathology serve for one or more of the following conditions: *sanction, avoidance and attention*.

- *Sanction—in guilt-inducing experiences where the pain or pathology are the means for atonement, precisely in the body area considered target organ deserving the specific sanction.*

The invalidity brought by the urinary frequency, the social unease caused by interstitial cystitis, the pain of pudendal neuralgia and endometriosis all refer to men or women who, for reasons buried over time, believe they are guilty of actions, or accomplices of others' actions, for which they deserve sanctioning. Their actions are always evaluated by a sort of *inner judge* that speaks using the inner voice, a severe *prosecutor* gripping a sacred text that contains values, culture, education, ethics, in other words what Freud would have called the *Super ego.* His only goal is to highlight faults and request the maximum possible penalty. The penalty can be physical pain, unhappiness or both. Depending on the assumed severity of facts the judge will sentence *the defendant* to atone by targeting the specific guilty organ for a timespan considered right and proportional. This period may last years or an entire lifetime, and in the most severe cases can lead to death. Death can occur either when a more serious life-threatening illness develops or with the person's suicide. Pain becomes a constant daily experience that has no respite. Sometimes the pain is only in the body, often invalidating the person in many aspects of his life quality and even undermining it completely. The target organ is subjected to a kind of *law of retaliation*. Cultures in which this is standing legislation derive it from a profound feeling of individuals: the kleptomaniac will attribute the whole responsibility of thefts to his hand, thus absolving his conscience and even lucidly recognizing it as correctly behaving. There are people responsible for serious crimes who seek their acquittal—or facilitated treatment—when approaching a real judge's sentence by attributing to an alter ego, a foggy state of conscience, the entire responsibility of that terrible gesture. They claim that those behaviours would never have been committed lucidly. There are subjects who in life attempt to escape their responsibilities and

others that through their symptoms or pathology acknowledge or even enlarge them, or take them on without guilt. However, the attribution of blame—whether real or not—is an unconscious process, and their somatization originates from here. All this will hold even more when rationality tends to attribute the origin of the disease, of all symptoms and their consequences entirely to organic causes. The cognitive rational mind enacts defence mechanisms that free from responsibility and entrust exclusively the medical specialist for the solution. From a psychotherapeutic perspective, the solution lies in the use of metaphor suggesting a sort of *therapeutic appeal court* in which to search for a sentence that differs from the first instance one. The psychotherapist will resemble a *defence lawyer*, but will most of all be a new *expert consultant* which provides the judge with a new version of the facts. So, therapy sessions will see a confrontation between on the one hand the new *defence approach* and on the other the patient in the roles of defendant, prosecutor and judge. *A different trial result will come from the re-examination of facts, from general or specific mitigating circumstances that will lead to acquittal.* Consequently, the body will no longer receive the sanction because the subject is rendered free of guilt. From that moment onwards, unless the patient has other reasons for structuring the symptom, hypnosis can be used to gradually reduce or totally heal the symptomatology.

- *Avoidance—as a tool to subtract oneself from the what is undesired, feared or towards which one feels inadequate or considers to be above personal abilities*

While the prevailing symptom of sanctioning is pain, in avoidance it is burning, and in the case of interstitial cystitis it is the urinary urgency. Within the avoidance dynamics of CPP patients, symptoms become functional to prevent or justify a condition. They are functional in an unaccepted—though desired—behaviour enacted by the subject or by others towards him. In other cases, it serves to avoid or restrict the undesired behaviour of others towards the patient. It often comes from a sexuality experienced as unacceptable, though perceived with a strong feeling of attraction. The strongest transgressions, like desires at times unconfessed even to oneself or fantasies that must be stopped before they turn into action, find a management tool in pain. A true *hell inside the body* flames that inhibit pleasure. As usual it is the subjectivity and not necessarily the objectivity that activates this symptom. The burning will be functional to avoid a sexuality perceived as guilty or accomplice, gender identity conflicts, paraphilia. A conflict between instincts and ethics, between the Id and the Super Ego that compromises the ego. In other cases, the burning serves to protect the subject from an emotional investment which appears risky or strongly destabilizing of psychic stability. The patient will tend to deny, to obstinately hide his condition to himself, often declaring in opposition the sincere desire for a new bond. It will be easy to find within the subject's history a significant pain caused by abandonment or betrayal. A truly *burning* disappointment that becomes *fire* like his symptom. If sexuality is often the engine in building a couple, the burning in that specific area becomes the best inhibitor. The same symptom appears also

as the negation of behaviours others enact towards the subject, in those cases where a fragile personality cannot prevent them and is forced to endure the action of an undesired partner. In this case, the symptom is actually a request to the subject to find the courage, the force to deny himself and thus remedy the situation. In every case the avoidance mechanism is functional to those who consider themselves unable to refuse. The psychotherapy process will have to find a solution, first of all acknowledging the issues at stake and then finding alternative strategies. Subsequently, hypnosis will play an important role, but only once the patient is authentically motivated to resolve.

- *Attention—in those subjects who discover the effectiveness of their symptoms for attracting the interest of family members or loved ones considered inadequately attentive.*

Attention is the measurement unit of love. It's one of the first learning experiences in life, the same that one risks to use in every occasion for the rest of one's life. When a baby is newborn, he discovers that his intense crying is irresistible for the mother who will soon arrive and take him in her arms. The mother will behave in this way believing that she is responding to her baby's need and the baby will discover that the mother's body is warm and soft and her milk is sweet. In that moment, he discovers that his crying is an effective tool for obtaining those conditions, and every subsequent time will confirm this. He doesn't fully understand the process, but he perceives the well-being which derives. His tears obtain attention which leads to well-being and his understanding is that it is an act of love. From that moment onwards every child, and subsequently every adult, will be aware of this and be able to use it throughout life. Tears will become the means for the somatization of discomfort, and both produce attention. There will be many occasions to manifest that discomfort to initially attract the mother and then, in the future, a partner. At times in the absence of a partner, or even when there is one, the search extends to the patient's social life: to doctors or whoever performs health supporting actions, psychologists and so on. The invalidity and pain produced by the urinary urgency are often associated and they reinforce each other precisely when they take on parallel effectiveness: the former as attention seeking and the latter as avoidance. At times the need for attention isn't characteristic solely of subjects who've made it their way of life, in any case it will seduce those who've always taken care of others' needs. Sometimes attention seeking is a need that is addressed to oneself, particularly in those people who need to remove it from the too many responsibilities or commitments they've undertaken in their lifetime. Psychotherapy will have to lead the patient to acknowledge this need and this often-unaware functional action. An essential condition for the patient to stop using this mechanism is a therapeutic strategy, which can include compensatory dynamics, that will conduct the patient to realize that merit rather than need will bring that attention—love.

The solution of symptoms and pathology requires the extinction of whatever maintains in being all three conditions.

10.2.9 State of the Art of the Psychotherapeutic Work

The patient's therapeutic process has so far included:

- *The search for a* ***remote cause-effect diagnosis*** *previous to the* ***clinical diagnosis****.*
- *An assessment of how the cause-effect relations identified within the problems are related to the time of symptom onset, and of its current presence, for a* ***current diagnosis***
- *An analysis, recognition and extinction of the causes maintaining active the* ***symptom's structuring dynamics***

From this time onwards, the patient has *a new awareness* of himself, of his current condition, and also of the causal experiences that have determined his symptom–pathology. He recognizes the symptom's structuring dynamics, understands and shares the responsibility for a solution, a partial solution or a non-solution. *The solution* will be available to those patients who, after understanding the cause-effect relations, will not maintain them or the symptom's structuring dynamics alive. *The partial solution* will be for those patients who, after understanding the causal connections of their experience, will maintain the symptoms with a different frequency and/or reduced intensity, by not giving up completely the benefits deriving from their structuring dynamics. *The non-solution* will be for those patients who will not identify with the causal links between clinical diagnosis and remote diagnosis and will continue to believe their pathology to be exclusively organic. It will also be for those who, while acknowledging the causal links, consider the pathology functional to their life, see their illness as an alternative to relational choices believed to be impossible or that in any case they aren't prepared to make. At this point of the psychotherapeutic process the patient is already able to recognize a partial result or a non-result of his symptoms with respect to three parameters: *frequency, intensity and duration*. From now on the patient is ready to begin the final important part of his therapeutic process with the use of hypnosis. This will put him in a special mind-body relation that will enable him to measure weekly *his results*, in respect to the reference parameters, until the symptom's extinction or its important reduction. Once these results are reached, they remain irreversible even after the completion of the 6-month psychotherapy.

10.2.10 Hypnosis in Short

Hypnosis is a specific state of consciousness in which the natural analytic functions are sufficiently reduced to consent the use of deeper unconscious levels for the individual's well-being. It is an extraordinary medical and psychological tool increasingly used in different contexts. Every human being provided with normal psychic activity can access them and the use of this technique for therapeutic purposes has no side-effects whatsoever. CLINICAL HYPNOSIS does not envisage loss of

consciousness or memory, nor can it act in any case against values or models of the subject.

How it works: The level of consciousness passes from the state of vigilance to an apparent sleep state through an imaginative phase, going from a lighter trance to a deeper one. The borders between these states are not well defined. The person experiencing hypnosis always perceives a pleasant sensation of peace and relaxation, is aware of what happens and will remember everything once he reopens his eyes. Hypnosis is achieved with a monoideism, by maintaining an idea that transforms into psychic and physical condition during the experience and in a subsequent time following the trance. It is an extremely natural psychosomatic phenomenon.

What it's for: It is effective for problems based on emotional states and habits considered inadequate, it values individual skills, stimulates the immune system, intervenes evidently and in a clinically measurable manner in physical therapies.

Medical uses: alleviates or eliminates any kind of pain, to the point of being, in many cases, an incredible natural alternative to pain killers. Greatly effective in sexual therapies, it intervenes in a targeted way on every form of organic pathology by stimulating the immune system and working on the specific area psychosomatically.

Psychological uses: it eliminates anxiety, depression, phobias and compulsive behaviours. It overcomes dependencies such as smoking, alcoholism and drug addiction when there is true motivation. Hypnosis can also induce positive feelings, regulate eating behaviour and is very important in post-traumatic stress disorders. It always solves in harmonizing processes of self-esteem.

Creative uses: It is useful in the artistic and sports fields. It improves artistic performance by favouring greater attention and concentration, it increases muscular resistance and permits peak performance. It unblocks hidden potential, stimulates creativity and helps the anamnestic activity when studying.

Legislation: Hypnosis is an authorized and experimentally verified therapeutic method in use for over a century. In Italy, it is fully legitimated by the principle of therapeutic freedom and in the recognition by the scientific community. Hypnosis can only be practiced by those authorized to practice a health profession. In other words, the hypnotist must be a qualified doctor or psychologist or, when used for pain therapy, a dentist. In some states, it may be practiced by health staff adequately trained in managing specific protocols. Any other use with clinical, diagnostic or therapeutic goals by unauthorized people implies the crime of unauthorized medical practice, envisaged and sanctioned by the criminal code.

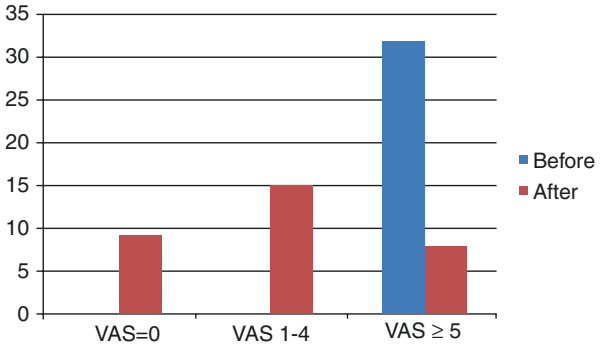
10.2.11 Hypnosis Therapy within a Specific Intervention Protocol

Hypnosis is taught to patients as a technique and tool for accessing a level of conscience useful for the goal planned and determined by a modular process and not using inductive techniques.

- Patients maintain a state of conscience and play an active and integrative role in the therapeutic process.
- Patients gain competence and awareness of their psychosomatic potential and from then onwards also in relation to the onset and the resolution of their problem.
- The contents of the psychotherapist's language are the essential key for the solution

Hypnosis is achieved through a psychosomatic phenomenon which deeply and authentically changes the patient's condition. The mind with its daily experiences is directly or passively responsible of our problems. The opportunity of understanding its reasons and extinguishing its cause-effect relations creates the necessary premises for the healing process. *When appropriately guided, the mind knows how to orient itself. It knows how to work on the body and heal it where necessary*. Those same skills that made it ill will know how to remedy to what was created once. It is a special state of conscience in which the patient conserves memory of what happens, it is not mind conditioning but removal of the obstacles that lie between disease and healing. It intervenes on the symptom- pathology, annuls pain and every session is a step forward, measurable and concrete, towards healing. Results are stable and irreversible because they are expression of a profound process of change achieved with a brief, silent and invisible process. These results are measurable by the patient first and consequently by the specialist through three evaluation parameters, *frequency, intensity and duration*. As the weeks of hypnotic treatment progress, the patient will gradually observe a reduced frequency of the pain or burning symptom, or of the urinary urgency. The patient will refer with satisfaction the progressive reduction of the symptom's intensity and notice that when the symptom does arise, it lasts less and less than before. Once these conditions have been reached (the remote diagnosis showing the causal relation between patient experience and illness onset, the removal of the symptom's structuring dynamics that kept it alive) by the psychotherapy, there are no insurmountable limits to the mind's ability to act on itself and on the body. The hypnotist's voice accompanies and teaches the mind to do what it already can do. His words are weighed and measured, surgical, like the precise action of a scalpel. So, they will be seeds that sprout a new condition. From the very first session, patients are accompanied by forms which measure results and variations in hypnotic suggestibility, by a protocol developed on the specific person and by forty-two parameters purposely studied. Time and clinical tests will then provide confirmation to patients of their results.

10.3 Results



10.3.1 Wh

Mean VAS score at the baseline was 8.15 (7–10), after 6 months 2.69 (0–8).

After 6 months VAS score was 0 in nine patients (28%), 1–4 in 15 patients (47%), >5 in eight patients (25%)

Mean QL index at the baseline was 3.31 (2–5), after 6 months 8.13 (4–10)

Improvement in standardized tests (domains of daily activity, sleep quality, social interaction, subjective perception of well-being) was also seen.

The results can be considered stable and without relapse or aggravation risks in that they have been produced through a gradual process of change induced by the psychotherapy's action. For the same reasons, they may be considered improvable even without psychotherapy. Two new interesting projects could be the follow up after a given timespan in absence of therapies (both conventional and psychotherapeutic), and a statistical analysis, based on conventional diagnostic parameters, of the personality types characterizing CPP patients—diversified for the three reference pathologies: interstitial cystitis, pudendal neuralgia and endometriosis.

10.4 Conclusions

This work shows how psychotherapeutic treatment with the aid of clinical hypnosis, within a specific intervention protocol, is an interesting research field for pain therapy in CPP patients.

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