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From Subconscious Entrapment to Emotional Freedom: The Role of Dehypnosis in Psychosomatic Healing

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Abstract

Trauma and fear can trigger negative emotions that harm a person's mental health and often show up physically as psychosomatic pain. Both positive and negative feelings can create harmful neural patterns, called pathological neural networks (PNNs), which become deeply embedded in the subconscious and keep psychosomatic pain ongoing. Treatments like extinction learning, cognitive behavioral therapy (CBT), regression hypnotherapy, and traditional hypnosis are commonly used to ease psychosomatic pain. These methods mainly help people reach a calm state, but calmness doesn't always mean the pain or negative feelings are gone—they can still resurface. To fully overcome psychosomatic pain and emotional distress, it's necessary to go beyond just feeling calm and instead reach a state of complete emotional emptiness. Mindchat therapy, a type of de-hypnosis, works by altering brain patterns and breaking down the harmful neural networks that cause pain and negative emotions. This therapy alone may successfully remove both psychosomatic pain and negative emotions by going deeper than what traditional therapies achieve. This article explores how negative emotions relate to psychosomatic pain through the functioning of PNNs from a neuropsychological perspective.

Keywords: Psychosomatic pain, Hypnotherapy, Dehypnotherapy, Chronic pain, Symptoms, De-hypnosis

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Introduction

Psychosomatic disorders are conditions where psychological stress negatively impacts bodily functions, often without a clear medical diagnosis or sometimes being misdiagnosed. Doctors may believe the diagnosis is correct when patients show some improvement, but this relief is usually incomplete and unstable. Studies estimate that around 80% of people worldwide experience at least one symptom related to psychosomatic pain or similar issues within a month [1]. The terms psychosomatic pain, somatic pain, and chronic pain are frequently used interchangeably, so this article discusses research involving any individuals experiencing symptoms under these categories. Additionally, psychosomatic pain often occurs alongside other diagnosed medical conditions like diabetes, infections, cancer, anxiety, or depression. This paper considers these overlaps, especially focusing on negative emotions tied to anxiety and depression, which are common in those suffering from psychosomatic pain and worsen health outcomes globally in a two-way relationship [2].

Psychosomatic, somatic, and chronic pain arise from a complex interplay of biological, neurological, psychological, and social factors. Research supports the idea that both negative and positive emotions contribute to these types of pain by fueling pathological neural networks (PNNs) [3]. Emotions act as energy sources, essentially driving the activity within these neural pathways.

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Among these pain types, psychosomatic pain is most frequently overlooked, misdiagnosed, or inadequately treated (Kroenke, 2003). This is partly because the scientific and medical communities lack a unified definition, face challenges in identifying causes, often fail to connect physical symptoms with psychological and neurological processes, and have limited treatment options. While all these factors prolong the suffering caused by psychosomatic pain, this article primarily focuses on: a) the two-way link between neuropathology and negative emotions, and b) why Mindchat Therapy represents a promising modern treatment capable of relieving this condition.

Many treatments for psychosomatic pain aim to help patients reach a state of calmness and then consider them "cured," "relieved," or "healed." However, these approaches often overlook the critical connection between psychosomatic pain and its underlying negative emotions, which can result in continued or even worsening suffering, potentially leading to additional psychosomatic conditions. In essence, such methods act as temporary fixes rather than true cures. From a neurological standpoint, these therapies (which will be discussed in detail later) fail to address the pathological neural networks (PNNs) that harbor the negative emotions. While patients may experience some relief, it tends to be partial and short-lived. When the negative emotions fueling the PNN are reactivated, the symptoms often return, leaving the patient stuck in a recurring cycle.

In contrast, Mindchat Therapy works by dismantling the PNN(s), preventing them from being triggered again unexpectedly. It stands out as the only therapy currently that understands that achieving calmness is not the ultimate goal—because merely disengaging from a PNN does not mean it has been destroyed. By using this calm state strategically to confront negative emotions, Mindchat Therapy breaks the self-reinforcing feedback loop of PNNs, ultimately eradicating psychosomatic pain.

To begin this review, we draw on clinical data concerning psychosomatic, somatic, and chronic pain to define and differentiate these conditions, focusing particularly on the findings and significance of the study *Patients Presenting with Somatic Complaints: Epidemiology, Psychiatric Comorbidity, and Management* by Dr. Kurt Kroenke and colleagues. Dr. Kroenke's research supports the definition of psychosomatic pain used here and highlights its common comorbidity with other disorders. Moreover, the study emphasizes that many existing therapies neglect the crucial bidirectional relationships among neurological, psychological, and social factors—an understanding that is essential for effective treatment [1].

Following this, we review various existing therapies for psychosomatic, somatic, and chronic pain, identifying their limitations. We then examine neurobiological evidence to better comprehend the connections between these pain types and their associated self-sustaining PNNs from a neurological perspective. Lastly, we introduce Mindchat Therapy as an innovative approach aimed at eliminating negative emotions and psychosomatic pain altogether.

Materials and Methods

To gather relevant information, databases such as ResearchGate and PubMed were searched for peer-reviewed articles. Sources included journals like *Southern Medical Journal*, *The American Journal of Medicine*, *Encyclopedia Britannica*, and others focused on psychiatry, neuroscience, and clinical hypnosis. Statistical facts were collected from trusted organizations including the CDC, Mayo Clinic, Psychology Today, and the National Center for PTSD.

The main search terms used were hypnotherapy, chronic pain, psychosomatic pain, neuropathology, somatic pain, and negative emotions. The review's scope was refined as new findings on the neurological basis of psychosomatic pain emerged.

Key terms

Psychosomatic, somatic, and chronic pain

Understanding psychosomatic pain requires clear definitions, yet current classifications like ICD-10 and DSM-5 mainly list symptoms without explaining their causes. This gap makes it difficult to standardize diagnoses for psychosomatic disorders.

Somatic pain covers physical symptoms such as dizziness, palpitations, fatigue, and pain, often diagnosed as mental health-related disorders by professionals. People with chronic illnesses like diabetes, cancer, or heart disease face a higher risk of depression and anxiety. Around 80% of people report some somatic symptoms monthly, many of which have no clear medical cause.

Chronic pain is defined as pain lasting longer than three months without a definite diagnosis. Unlike normal pain, which protects the body, chronic pain offers no benefit and arises when nerve signals and unconscious threat awareness fail to be blocked. These pain signals start in nerve cells under the skin or in organs and travel to the brain through nerves and the spinal cord. Emotional reactions like fear and anxiety often make the pain worse. Over time, brain circuits involved in processing pain can become independent and self-reinforcing, creating a loop of persistent pain linked to pathological neural networks (PNNs).

Chronic, somatic, and psychosomatic pain

Pain is a natural bodily reaction to injury or trauma, often felt as tenderness, bruises, or muscle tightness. This pain serves a protective role by signaling the body to avoid further damage. However, when pain persists for longer than three months even after the initial injury has healed, it is usually considered chronic pain by medical professionals. Chronic pain develops because

the body is unable to properly reduce or block the transmission of pain signals and subconscious threat responses to the brain. These signals originate in nerve endings beneath the skin and within organs and travel through nerve pathways to the spinal cord and brain [4]. Experiencing pain can cause emotional distress, such as anxiety or fear, which often worsens the perception of pain. Over time, brain regions responsible for processing pain may become disconnected from normal regulatory mechanisms, leading to persistent pain maintained by pathological neural circuits known as PNNs.

In contrast, psychosomatic disorders lack a clear, universally accepted definition, which makes them difficult to diagnose and treat effectively. While classification systems like the ICD-10 and DSM-5 list symptoms related to psychosomatic conditions, they do not fully explain the underlying causes [5–7]. This gap contributes to inconsistent identification and classification of psychosomatic disorders [8].

An overview of various chronic, somatic, and psychosomatic pain disorders, along with their descriptions, is provided in **Table 1** [9].

Below is a paraphrased version of the table and its description, rephrased to be distinct from the original while maintaining the same meaning and structure. The table is provided in a plain text format directly in the chatbox for easy copying.

Table 1. Chronic, Somatic, and Psychosomatic Pain Conditions and Their Characteristics

Condition	Characteristics/Description
Hypertension	Elevated blood pressure (140/90 mmHg or higher), intense headaches, vision problems, breathing difficulties, irregular heart rhythm
Respiratory Conditions: (1) Asthma (2) Chronic Obstructive Pulmonary Disease (COPD) (3) Chronic Bronchitis	Trouble breathing, shortness of breath, persistent cough, ongoing chest discomfort, excessive mucus production
Gastrointestinal Issues: (1) Irritable Bowel Syndrome (IBS) (2) Gastroesophageal Reflux Disease (GERD)	Bloating, gas, constipation, acid reflux, indigestion, pelvic discomfort
Migraine/Tension Headaches	Severe, throbbing head pain, sensitivity to light or noise, nausea, vomiting
Sexual Dysfunction: (1) Erectile Dysfunction (ED) (2) Frigidity	Difficulty achieving or maintaining an erection, inability to reach orgasm
Atopic Dermatitis	Skin irritation, itchiness, dryness, rashes, blistering
Post-Traumatic Stress Disorder (PTSD)	Recurring unwanted memories or flashbacks, avoidance behaviors, changes in mood or cognition, difficulty recalling traumatic events, heightened arousal or reactivity
Fibromyalgia	Widespread body pain, exhaustion, cognitive challenges
Stomach Ulcers (Peptic, Duodenal, Gastric)	Sores on the esophagus, stomach, or small intestine, abdominal pain
Alexithymia	Challenges identifying or expressing emotions in oneself or others, lack of drive, unpredictable physical symptoms (e.g., rapid heartbeat, breathing issues, headaches)

Sources:[10–23]

Description: **Table 1** lists chronic, somatic, and psychosomatic pain conditions along with their associated symptoms and descriptions. The conditions include hypertension, respiratory issues, gastrointestinal problems, migraines, sexual dysfunction, dermatitis, PTSD, fibromyalgia, stomach ulcers, and alexithymia. Each condition is accompanied by a detailed explanation of its primary symptoms or characteristics, highlighting their physical and psychological impacts.

Psychosomatic pain and comorbidity

Dr. Kroenke's research highlights that a significant majority of individuals with depression or anxiety also experience somatic symptoms, with estimates ranging from 70% to 90%. Additionally, among patients who present with medically unexplained symptoms, approximately 50-75% have a depressive disorder, while 40-50% suffer from an anxiety disorder. One of the crucial findings from Dr. Kroenke's work is that the total number of somatic symptoms a patient reports strongly correlates with the likelihood of having a psychological disorder such as depression or anxiety. Although this symptom count is not specific to any single diagnosis, it acts as an important marker suggesting the presence of psychopathological processes. Essentially, the greater the number of somatic complaints, the higher the probability that the patient also has a mood or anxiety disorder. **Table 2** below summarizes this relationship based on Dr. Kroenke's data from primary care populations [1].

Table 2. Correlation Between Number of Somatic Symptoms and Probability of Depressive or Anxiety Disorder

Number of Somatic Symptoms*	Study A (N=1000)	Mood Disorder (%)	Anxiety Disorder (%)	Study B (N=499)	Mood or Anxiety Disorder (%)
0–1	215	1%	2%	106	4%
2–3	225	7%	12%	131	18%
4–5	191	13%	23%	129	31%
6–8	230	30%	44%	96	52%
≥ 9	139	48%	60%	37	78%

*Number of symptoms reported as "bothered a lot" in the past month based on the PRIME-MD checklist.

These findings reinforce the idea that psychosomatic pain and negative emotions are closely linked through pathological neural networks (PNNs), which can both influence and be influenced by one another in a self-perpetuating cycle. While negative emotions are central in maintaining these networks, emerging perspectives like MindChat Therapy suggest that positive emotions can also contribute to pain experiences.

Pathological neural networks

When a person experiences acute pain from a direct stimulus—such as a sudden movement or injury—this unconditioned stimulus (US) sends signals to the lateral nucleus of the amygdala (LA). The LA then communicates with the central nucleus (CE) of the amygdala, which orchestrates fear responses through behavioral changes, autonomic nervous system activity, and hormone release. This system plays a vital role in helping individuals avoid future harm by learning to fear potentially injurious stimuli [24].

Neuroanatomy of psychosomatic pain: the self-sustaining feedback loop

Psychosomatic pain develops when pain persists even in the absence of an actual painful stimulus (US). For instance, if a person's arm was once injured by a particular movement, simply anticipating or thinking about that movement later can trigger real physical and emotional pain. Another example is a person who suffered an assault from someone with a distinct feature, like a mustache, during childhood. Later in life, seeing someone else with a mustache—even if harmless—can activate the pathological neural network responsible for that traumatic association. This fear-driven pain occurs subconsciously and despite no real threat being present.

In these cases, the original unconditioned stimulus (US) has become a conditioned stimulus (CS) because of fear-learning processes. The CS can trigger pain when the person:

- Encounters the trigger,
- Thinks about it,
- Or anticipates the pain associated with it.

Neuropathologically, the key distinction between pain caused directly by the US and pain caused by the CS involves pathways projecting from the hippocampus (which processes contextual memories) to the basal nucleus of the amygdala.

Summary of pain, psychosomatic transformation, and neural mechanisms

Pain naturally arises as part of the body's healing process, initially triggered by a harmful or unconditioned stimulus (US) and accompanied by heightened activity in the amygdala. However, when the original stimulus is no longer harmful but continues to be perceived as threatening, it becomes a conditioned stimulus (CS). This mistaken perception of danger involves additional input from the hippocampus and eventually leads to the development of psychosomatic pain.

Over time, this ongoing process changes the individual's perception, causing the brain to turn what was once a healing response into an automatic and generalized reaction. In effect, the neural network involved becomes the brain's default response to the trigger—even when no real threat exists [24]. This mechanism supports the concept that psychosomatic pain is maintained by pathological neural networks (PNNs), which form through the association of the initial trauma or movement, the expectation of harm, and negative emotions linked to fear conditioning. When the CS is wrongly perceived as dangerous, and the person fails to accept that pain may no longer be justified, this leads to hypervigilance, muscle tension, avoidance behaviors, and protective guarding. These threat responses not only worsen the pain experience but also contribute to disability and deepen emotional distress. Thus, psychosomatic pain becomes a self-reinforcing, bidirectional cycle.

Why traditional therapies that promote calmness often fall short

Once fear conditioning has become an automatic generalized response, it becomes very challenging to treat because the brain resists changing these ingrained reactions. Many therapeutic approaches use extinction learning (EL), which involves safely exposing patients to the CS rather than avoiding it. This process helps individuals reframe their misinterpretations and reduce reliance on avoidance or safety behaviors.

Neuropathologically, EL works through the following pathways [24]:

- Exposure to the CS activates the ventromedial prefrontal cortex (vmPFC), which forms inhibitory connections (IC) that send signals to the intercalated cell masses (ITC).
- These IC signals then suppress fear expression by acting on the central nucleus (CE) of the amygdala.
- The vmPFC also projects to the lateral amygdala (LA) to further regulate fear.
- The hippocampus sends signals to both the vmPFC and LA to provide contextual information that modulates extinction.

Unlike fear learning, extinction learning involves increased vmPFC activity and reduced amygdala response. Therapeutic techniques such as cognitive behavioral therapy (CBT) and regression hypnotherapy incorporate EL principles. For instance, regression therapy guides patients through recalling traumatic memories under hypnosis to reduce fear responses [25].

However, unless the therapy specifically addresses the negative emotions fueling the PNN, the pathological neural network is rarely fully dismantled—and when it is, the process tends to be slow and prolonged.

The challenge of fully resolving psychosomatic pain

Most treatment methods help patients feel more relaxed by partially disengaging certain emotions or states within the PNN that cause discomfort. But since the psychosomatic pain stems from negative emotions feeding the PNN, complete resolution requires addressing all such emotions connected to the triggering event. Without this comprehensive emotional work, the PNN persists.

The author, after years of clinical experience with classical hypnosis, gestalt therapy, psychoanalysis, and various CBT methods, chose to leave traditional practice due to the time-consuming nature of uncovering multiple traumatic events. In contrast, MindChat presents a streamlined, practical approach that efficiently identifies all key drivers of a pathological neural network.

Summary: the development of psychosomatic pain and challenges in treatment

Pain naturally arises as part of the body's healing process, initially triggered by a harmful or unconditioned stimulus (US) and involving increased activity in the amygdala. However, when the original stimulus is no longer actually harmful but continues to be perceived as such, it becomes a conditioned stimulus (CS). This mistaken perception is influenced by additional signals from the hippocampus and can develop into psychosomatic pain.

As this cycle repeats, the individual's perception shifts, and their brain begins to treat what was once a healing response as an automatic, generalized reaction. Essentially, this neural pathway becomes the default response to the trigger, even if no real threat exists [24]. This supports the idea that psychosomatic pain is maintained by pathological neural networks (PNNs), which form through the association of the initial trauma or injury, anticipation of danger, and negative emotions tied to fear learning. When a person continues to see the CS as threatening and doesn't accept that it may no longer cause pain, they develop hypervigilance, muscle tension, avoidance, and protective guarding behaviors. This is how pain and its anticipation turn psychosomatic and bidirectional. These threat responses worsen pain, increase disability, and deepen psychological distress.

Limitations of traditional calmness-focused therapies

Treating fear learning once it has become an automatic generalized response is difficult because the brain resists changing its ingrained patterns. Many therapies use extinction learning (EL), which involves safely exposing patients to the CS rather than avoiding it. This approach challenges patients to reframe their misinterpretations and stop relying on safety behaviors.

The neuropathological process of EL, which runs alongside fear learning, includes [24]:

- Exposure to the CS activates the ventromedial prefrontal cortex (vmPFC), which creates inhibitory connections (IC) that send signals to the intercalated cell masses (ITC).
- The IC then inhibit fear responses by acting on the central nucleus of the amygdala (CE).
- The vmPFC also projects IC signals to the lateral amygdala (LA) to further control fear expression.
- The hippocampus projects to both the vmPFC and LA to help modulate extinction based on context.

The main difference between fear learning and extinction learning lies in increased vmPFC activity and decreased amygdala activity. Therapies such as cognitive behavioral therapy (CBT) and regression hypnotherapy incorporate EL principles. In regression therapy, for example, a hypnotist guides the patient through traumatic memories to reduce fear [25].

However, unless therapy explicitly addresses the negative emotions fueling the PNN, the pathological neural network rarely fully dissolves—and when it does, this process is often slow and prolonged.

The need for comprehensive emotional processing

Most treatments help patients by temporarily reducing certain negative emotions or states within the PNN, easing psychosomatic discomfort. But because psychosomatic pain originates from the negative emotions maintaining the PNN, full healing requires uncovering and resolving all such emotions linked to the original trigger. Without this thorough emotional work, the PNN remains intact.

The author eventually left traditional practice—despite experience in hypnosis, gestalt therapy, psychoanalysis, and most CBT—due to the time-consuming nature of locating multiple traumatic memories. MindChat presents a practical and efficient alternative that can identify all core elements driving a PNN.

Results and Discussion

The interaction of fear and pain culminates in the formation of pathological neural networks (PNNs) that sustain psychosomatic pain. Many current treatments for chronic and psychosomatic pain focus on extinction learning (EL) by exposing patients to the triggering stimulus—whether it's a movement, traumatic memory, or any sensory element (VAKOG). This exposure typically induces a state of calmness, as mentioned earlier. While some therapies encourage patients to disengage from these neural pathways, Mindchat Therapy aims to eliminate these pathways entirely.

Although PNNs may weaken over time when not actively engaged, traditional approaches often overlook the core driver of the pain: the negative emotions tied both to the initial stimulus and to the anticipation of pain. Simply put, EL suppresses the outward expression of fear, but does not eradicate fear itself.

This distinction sets Mindchat Therapy apart. It leverages the induced calmness—not as a mere therapeutic goal, but as a signal representing a negative emotional byproduct entrenched within the same PNN sustaining the psychosomatic pain. In other words, the calmness may be a defensive mechanism produced by the PNN to protect itself from being dismantled by conventional psychotherapy. The PNN essentially conceals itself, deceiving therapists into thinking the treatment is complete [26, 27].

Moreover, many conventional therapies show limited effectiveness when applied alone, with success rates under 50%, often requiring combination with other treatments by trained professionals. In contrast, Mindchat Therapy demonstrates an efficacy exceeding 80% and can be effectively applied as a standalone treatment.

By utilizing this hypnotic state of calmness, Mindchat Therapy guides individuals through a process of "de-hypnotization" — eliciting and removing the underlying negative emotions fueling the PNN. Mindchat acts as a tool to awaken patients from the trance-like calm produced by trauma, which perpetuates negative emotions, PNN formation, and psychosomatic discomfort. Achieving a state of "nothingness" signals successful awakening from this trance, marking the desired therapeutic outcome.

For these reasons, Mindchat Therapy holds transformative potential not only within hypnosis and hypnotherapy but also across medicine, psychology, and psychotherapy [28].

Conclusion

For many psychosomatic conditions, medication and traditional therapies often provide little to no lasting relief—at best offering temporary or partial reduction in pain. This happens because these treatments fail to target the core issue: the pathological neural network (PNN) linked to the pain. Without eliminating both the negative emotions and the PNN itself, symptoms persist in duration, frequency, and intensity.

Conventional therapies typically focus on achieving a state of calmness but do not fully address the root causes of psychosomatic pain. In contrast, Mindchat Therapy harnesses this calm state as a tool to remove the driving forces behind PNNs, including their related mental states. This is critical because PNNs can generate not only pain but also a wide spectrum of symptoms.

Mindchat Therapy introduces a novel approach known as DeHypnosis, a form of therapy and self-therapy developed by MindChat. Notably, this method does not require professional training, making it accessible for self-application, typically effective for individuals from around five years old and up.

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