Cancer Pain: Psychological Management Using Hypnosis

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Psychological approaches are important in the management of cancer pain, and hypnosis is an especially useful technique that can be integrated into the total care of the patient. Although a major application of hypnosis to cancer patients is the direct relief of pain,[1,2] there are wider psychotherapeutic benefits as well: inner strength or will to live can be increased and directed to the patient's development of greater personal responsibility for his or her well-being. Hypnosis can be learned and skillfully employed by the physician, by consulting psychologists or psychiatrists, and by the nursing staff.

Hypnosis has been used throughout this century, both as a medical technique (for analgesia, muscle relaxation, and in some cases, to facilitate healing) and as a psychotherapeutic tool (to alleviate symptoms, uncover forgotten material, and facilitate behavioral change). Historically, it has been associated with mysticism. However, the current scientific understanding of hypnosis is rooted in rational, demonstrable psychological principles. Hypnosis is a natural human ability, not an aberration or neurotic symptom, as once was believed; it is an altered state of consciousness characterized by changes in perception (i.e., analgesia) or memory (i.e., amnesia or hypermnesia).

Although individuals differ in the facility with which they can be hypnotized, we find that the degree of "hypnotic susceptibility" is not critical to the clinical result. Controversy surrounds this issue, but there is evidence that even persons of low hypnotic susceptibility can achieve clinical hypnotic success.[3-10] In the clinical context, we suggest that the issue of susceptibility be ignored. Every patient should be presumed capable of attaining a clinically useful hypnotic state.[5]

A "clinically useful" hypnotic state simply means that quality or degree or level of hypnosis that facilitates therapeutic progress. Like other states of consciousness (including the normal waking state), the state of hypnosis varies over time and circumstance. Although it is not clear what determines the "depth" that a particular patient will achieve at a given time, depth is partly dependent on the trust felt by the patient in the situation, how much time is allowed, and to some extent, on hypnotic technique. A discussion of the techniques of hypnosis is beyond the scope of this paper. However, clinical training in the use of hypnosis includes training in certain techniques used to promote adequate clinical depth.

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Although it was once thought that the ability to develop hypnotic analgesia was dependent on significant hypnotic depth, our experience suggests, to the contrary, that significant analgesia can be achieved in only a "light" state of hypnosis. For purposes of analgesia, then, depth is not necessarily an important consideration.

In the psychological management of cancer pain, we view hypnosis as one component to be appropriately integrated into the wider therapeutic context —in contrast to the view that hypnosis is, by itself, a complete and adequate intervention. The incorporation of hypnosis into a treatment plan to control cancer pain has three principal advantages:

- Hypnosis can alleviate pain without unpleasant or destructive side effects. The degree of pain relief achieved can range from moderate control to total analgesia.
- Hypnosis does not reduce normal functioning and does not mentally incapacitate the patient in any way, nor does the patient develop tolerance to its effects.
- Hypnosis can be used to promote life-enhancing attitudes in the patient, and the attitude toward the cancer can be altered in beneficial ways.

Hypnosis, then, can help the cancer patient when medication or surgery cannot, and has none of the disadvantages sometimes associated with medication and surgery. Further, hypnosis can accelerate the psychological processes that must be activated in the effective management of chronic illness. For reasons not yet understood, the development of such an altered state of consciousness in conjunction with appropriate therapeutic guidance can rapidly reduce obsessional, destructive thoughts, and can nourish a patient's self-esteem by helping him or her to focus on personal capabilities and active participation in the therapy. This supports the patient's capacity to function and reduces the otherwise inevitable sense of helplessness. Through hypnosis a patient may be freed from anxieties associated with pain, disease, or death. This can lead to increased chances of adaptive rehabilitation and/or greater acceptance of discomfort and premature death.

Such use of hypnosis assumes a wider psychotherapeutic context, however. By this we mean that a psychological approach to a patient is intended to foster a patient's own resources: to support the patient's self-esteem and to explore ways of increasing it; to expand the patient's awareness of his or her inner life and awareness of the extent to which this can affect the patient's experience of self, family, work, and the illness. We are impressed with the value of gestalt techniques[11] in providing a model of psychological intervention. While affording the patient an opportunity to experience insight, the gestalt approach also suggests concrete behavioral changes to facilitate therapeutic goals. It is important, then, that the use of hypnotic techniques be a part of other psychological treatment. While this fact does not preclude the use of hypnosis by psychologically untrained clinicians, it is necessary to understand the importance of taking the patient's psychological needs into consideration when formulating a treatment plan.

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Behavioral techniques are significant concomitants when hypnosis is used to manage pain. The use of psychological techniques assumes, of course, that patients are motivated and committed to work on their own outside the therapeutic setting. It is important to formulate realistic goals for the therapist and patient, and a specific time in which behavioral assignments will be performed. For instance, one goal in managing cancer pain is to develop self-control over pain and its associated anxieties. It is important that a patient spend a certain amount of time daily to initiate and prac-

tice self-hypnosis. This strategy requires that a patient participate in his or her own care.

Involving family members is also important when hypnosis is used as a therapeutic modality, and it is helpful for them to actually learn how to participate in the patient's hypnosis. This not only diminishes the experience of helplessness on the part of the patient and family members, but also facilitates meaningful communication that otherwise is often compromised as the disease progresses and medical treatment becomes more intrusive.

Six hypnotic strategies may be used to control cancer pain:

- directly blocking awareness of pain through the suggestion of anesthesia or analgesia;
- substituting another feeling (such as pressure) for the pain;
- moving the perception of the pain to a smaller or less vulnerable area of the body;
- altering the meaning of the pain so it becomes less important and less debilitating;
- increasing tolerance for the pain; and
- in extreme cases, dissociating perception of the body from the patient's awareness.

The following case reports describe patients with pain secondary to malignant disease who used clinical hypnosis:

Case 1. Lynn, a 47-year-old, recently married woman diagnosed with acute myelogenous leukemia, complained of pain in the pelvic and lower back areas. Physical findings did not explain such discomfort. After six months of remission, Lynn was rehospitalized to begin an intensive course of chemotherapy. It was noted by her physicians and nurses that she was becoming despondent and passive about her treatment, characteristics not evident during prior hospitalizations. In addition, she was becoming increasingly dependent on her husband and physicians and reported a growing sense of fear and helplessness when they were not available. Paranoid obsessional thinking developed, and she began to accuse her husband of seeking lovers.

Hypnosis was employed to help reduce her escalating anxiety and depression and to enable her to use her own capabilities to relieve discomfort and obsessional thinking. Additional psychotherapy sessions in conjunction with hypnosis enabled Lynn to become aware that she was using pain as a means of securing her husband's attention and maintaining her doctors' interest in her.

Two different techniques were used in Lynn's case. First, structured guided imagery enabled her to focus on emotional issues in an indirect manner by creating mental images associated with a relaxed setting. Second, deeper hypnotic inductions were employed to reduce her pain and to begin the process of accepting the terminal nature of her illness.

The value of hypnosis was its positive effect in increasing Lynn's sense of inner strength and enhancing self-directed efforts at relaxation and pain reduction. In addition, changes in her attitude developed that helped her to face her impending death and separation from her husband.

Case 2. Mark, a 42-year-old pharmaceutical company representative, was diagnosed with testicular cancer. He had intense pain in his pelvic area and was fearful of becoming addicted to the narcotics used to treat the pain. Mark was unable to face his physicians' reports that his cancer was progressing rapidly and refused to accept the fact that his illness could not be cured. He insisted that there must be a drug to help him and began to make plans to travel to Mexico for laetrile treatments.

Mark presented doctors and nurses with difficulties because he would not comply with instructions and attempted to plan his own treatment. Psychological consultation was requested because he was assessed as being depressed and defiant, showing inappropriate denial, and making unrealistic plans for marriage in spite of the unfavorable prognosis.

Hypnosis was indicated at first as a means of helping Mark to relax and to

reduce his anxiety. Resistance to this form of intervention was resolved when Mark was taught techniques to hypnotize the therapist (as a means of increasing his trust). Once he began to feel he was not being "used as a guinea pig," he became amenable to hypnotic inductions. Suggestions to relax and develop better communication with the hospital staff helped relieve some of his feelings of helplessness. With a growing sense of ability to communicate his needs to the hospital staff, Mark became less defensive when presented with test results.

The treatment plan for hypnotherapy had three components. Initial efforts were focused on helping the patient relax and interact cooperatively with the medical and nursing staff. Relaxation suggestions were given, and the patient began to experience less anxiety. Second, the patient learned self-hypnosis to help counteract pain in his pelvic area.

The third phase of treatment involved the patient working on psychological issues relating to the progress of his disease and the inevitability of separation from his loved ones. As a result of the successful results of the previous two phases of treatment, Mark became increasingly involved in assessing his relationship with his girlfriend and gradually accepted the physicians' reports about his future. Using a hypnotic technique that allowed him to visually project himself and his girlfriend onto a hallucinated movie screen, he was able to distance himself from his own psychological conflicts about separation. Some resolution was achieved in acknowledging the limitations of his treatment and the reality that he would die within a few weeks.

As he became more willing to face death, Mark was determined to reconcile family differences. Age regression was employed when he felt ready to explore painful childhood memories. Mark requested his parents and brother to fly from the East Coast to be with him while he was still conscious. He was able to spend a week before his death talking, laughing, and crying with his family in a way that was impossible prior to hypnotherapy.

Pain control was maintained without narcotics until two weeks prior to his death. Even then, narcotic dosages were minimal, thus allowing cognitive functioning during the reunion with his family and the process of separation from his girlfriend. Psychological distress was decreased with self-hypnosis, and he was less anxious in the hospital than he had been prior to hypnotherapy. It was to the credit of the medical and nursing staff that practical issues could be attended to: with their help, it was possible to avoid frequent interruptions and thus ensure time for the patient to engage in self-hypnosis. This was made possible by administering medication at regular intervals and posting signs on his door during prearranged 20-minute periods for self-hypnosis.

"Pain control was maintained without narcotics until two weeks prior to (the patient's) death."

Case 3. Debra, a 27-year-old single woman with breast cancer, suffered severe phantom pain following mastectomy. Although she was enrolled in graduate school prior to her surgery, she dropped out because pain interfered with her concentration. For seven years prior to her illness, she had lived alone or with her boyfriend, but during her recovery from surgery she returned home to be cared for by her parents. Debra's physicians were optimistic about her chances for rehabilitation and a full life. However, she began to regress psychologically, depending on her parents to help her with such tasks as dressing and cooking, which she realistically could perform herself. She was referred for hypnotherapy by her physicians when efforts at rehabilitation failed, causes and treatment for prolonged pain remained unclear, and she became despondent and prepared to die.

Debra presented as a passive, withdrawn woman, reportedly different from

the woman she was prior to mastectomy. She admitted feeling that she had lost her femininity and was no longer attractive to males. Recently, she had broken up with her boyfriend and felt she would not pursue relationships with other males. Hypnotherapy centered on relieving her anxiety and increasing her feelings of self-esteem. She was asked to visualize the woman she was prior to her diagnosis and the woman she was after surgery. She made her own connections and associations regarding the changes that had occurred. In fact, she was surprised at how much she had regressed and acknowledged that complaints of pain kept her family and friends attentive to her because they felt sorry for her.

Under hypnotic suggestion, Debra had conversations with her former self and then with the dependent, pain-ridden woman she had become. Suggestions were made about her becoming increasingly active and more oriented toward living. Self-hypnosis was initiated as a means to help Debra relax, to enjoy physical contact with her boyfriend, and to become less aware of physical pain. Her poor self-image and fear of rejection were overcome as she slowly became desensitized to her surgical scar. In this process she was able to tolerate the pain until it was significantly relieved.

Within a year, Debra was attending school full time and was no longer afraid to date. Although still involved with her boyfriend, she expressed a desire to remain single for a longer period of time to avoid rushing into marriage with the first person who had accepted her as somebody who had had a mastectomy. Continued use of self-hypnosis took the form of daily meditation. In addition, she reported developing greater self-confidence, increasing relief from physical discomfort, and an ability to distance herself from fears of dying.

Case 4. This case is included to illustrate that although hypnosis is often helpful in the management of cancer pain, it is not always entirely successful. Lois was a 73-year-old woman with pain from bone cancer. She had had a full career as an elementary school administrator and for the past 25 years had operated her own private school. She was angry about developing cancer and frustrated that the pain was interfering with her ability to work. She found narcotic analgesics ineffective. Hypnosis was suggested as a means to help her gain control over the pain and to deal with her anger and sense of helplessness. Although Lois seemed willing to engage in hypnotherapy, she was unable to significantly reduce the pain outside of the therapeutic setting.

Lois had been in a position of authority most of her adult life and had difficulty accepting suggestions to relax and to alter her cognitions to develop a sense of control over her pain. As she struggled against the awareness of her poor prognosis, she may have generalized her defenses to fight off all outside forces, including therapeutic ones. Lois experienced frustration when progress was slow, and she prematurely terminated therapy.

It is unfortunate that Lois left therapy without the opportunity to explore psychological issues impinging on her pain and illness (such as the issue of control by others), because it may be that further therapy would have enabled her to be open to pain relief that might have lasted beyond the office sessions.

In the three successful cases described, hypnosis was used for immediate relief, with suggestions to reduce anxiety and to promote analgesia and relaxation. This phase was followed by the teaching of self-hypnosis to significantly increase the patient's sense of self-control. And finally, therapy was broadened to deal with the psychological issues related to pain, disease, separation, and death. These cases illustrate that hypnosis is beneficial as part of the total treatment plan in managing patients with cancer pain. Hypnosis is not always successful, however, and should not be perceived as either a panacea or a "last resort."

Although hypnotherapy has been successful in reducing pain and anxiety, it is not magical. Patients must be informed about its nature, benefits, and

TABLE 1
PRINCIPAL ADVANTAGES OF HYPNOSIS IN CANCER PAIN CONTROL

1. Alleviation of pain without destructive or unpleasant side effects. (Relief ranges from moderate control to total analgesia.)
2. No reduction of normal functioning or mental capacity; no development of tolerance to hypnotic effect.
3. Promotion of life-enhancing attitudes in patient; beneficial change in attitudes toward cancer.

TABLE 2
SIX HYPNOTIC STRATEGIES TO CONTROL CANCER PAIN

1. Block pain awareness through suggestion of anesthesia or analgesia.
2. Substitute another feeling for the pain.
3. Move pain perception to smaller or less vulnerable area.
4. Alter meaning of pain to make it less painful, debilitating.
5. Increase tolerance of pain.
6. Dissociate perception of body from patient's awareness (in extreme cases).

limitations, and it is imperative that they be receptive and motivated to accept the services of the clinician for psychotherapy or hypnotherapy. To facilitate treatment success, the clinician must evaluate the patient's needs and motivations and apply this knowledge in choosing hypnosis and/or other psychological strategies. Expectations of instant improvements can lead to frustration and disappointment for both therapist and patient, and tend to result in abortive treatment. Patients must be willing to actively engage in therapy; they face treatment failure if they expect to be passive recipients. Short but structured periods of time, especially in the initial phases of therapy, must be allotted, and an effort to practice self-hypnosis must be part of the patient's commitment to treatment.

Summary

In the treatment of cancer, particularly when pain is a serious symptom, psychological support of a patient is important and can, in fact, facilitate ongoing oncologic treatment. Hypnosis represents a psychological technique of great potency for reducing pain, increasing patients' life-enhancing attitudes, and helping patients deal with death and separation.

Ultimately, the value of hypnosis lies in enabling an individual to potentiate inner capacities for creating psychological quiescence and physical comfort. For a suffering cancer patient, relief that comes from within can provide a much-needed experience of personal efficacy and strength.

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WAR AND PEACE

It is the greatest tragedy of the scientific community that so large a proportion of its activity is devoted to the learning of war and so little to the learning of peace. It could well be that because of this the overall long-run impact of science is to bring closer the day of human extinction.

Nevertheless, science is also the greatest hope of the human race.

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