THE USE OF HYPNOSIS IN THE MANAGEMENT OF PATIENTS WITH CANCER

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Hippocrates: *Nothing should be ommitted in an art which interests the whole world, one which may be beneficial to suffering humanity and which does not risk human life or comfort.*

(14) *GUERIR QUELQUEFOIS, SOULANGER SOUVENT, CONSOLER TOUJOURS. meaning: "To cure sometimes, To help often, To comfort always."*

INTRODUCTION

The management of the cancer patients is one of the most challenging medical problems of our time (13). The doctor's ability to carry these patients through their travail taxes not only his therapeutic resourcefulness but also his general ability to deal with human suffering.

The use of hypnosis in the management of the cancer patients has received increasing attention in recent years (1, 3-4, 6-7, 9-10, 12-14, 16-17, 20-26). In 1954 Butler (1) published a detailed report on the use of hypnosis in 12 advanced cancer patients, and concluded that pain, anxiety and organ dysfunction in the cancer patients could be effectively treated by hypnotherapy. Quite penetrating, too, were his observations concerning the psychodynamic basis for pain, most especially the influence of a sense of guilt, of a need to expiate and suffer, as a retribution for unconscious death wishes or for other immoral, antisocial, or antireligious acts, real or fancied. In 1959, in a paper on "Hypnosis in Painful Terminal Illness" Erickson (9) pointed out: The use of psychological measures in the treatment of human illness, whether organic or psychological or a combination of both, is as old as human history. In fact, he stated, the psychological aspect of medicine constitutes the art of medicine and transforms the physician from a skillful mechanic or technician into a needed human source of faith, hope, assistance, and, most importantly, of motivation for the patient toward physical and mental health and well-being. He also pointed out that in terminal painful disease, sedatives, analgesics and narcotics are employed that may deprive the patient of the privilege of knowing that he is alive and of enjoying what pleasures yet remain; also, they deprive his relatives of adequate contacts with the patient. Erickson advocated hypnosis not as an absolute answer to all medical problems involved, but rather as one of the possible approaches in the handling of the patient's problems that possesses special and highly significant values at both psychological and physiological levels. Lea and colleagues (1960) reported favourable results of 20 unselected patients (mostly cancer patients) with chronic intractable pain referred for treatment by hypnotherapy. Cangello, 1961, (3) reported using hypnosis on 22 advanced cancer patients who had reached the point where narcotic medication every four hours had become necessary (in some cases for over a year), with the following results: 59% showed partial or total decrease in narcotic requirements, while the remaining 41% did not appear to have been influenced. Morphis (17) assisted cancer patients in accepting the diagnosis through the use of hypnosis. As a radiologist and radium therapist he helped his patients to tolerate better the radium needles inserted in the malignant area through the use of hypnosis. He also used hypnosis to help control the nausea and vomiting associated with radiation therapy. Conn (6) found hypnotherapy substantially reduced the need for narcotics and kept the patient comfortable and free from anxiety. Uzer and colleagues (28) in a double blind study with iproniazide in advanced cancer found that "there was no significant difference in performance, mental status, appetite or weight gain in well-matched patients who were receiving the test drug and those receiving the placebo," indicating at least equal effectiveness of the drug and of psychological forces.

PERSONAL EXPERIENCE

My own experience in the use of hypnosis in this field coincides mostly with the results obtained by most workers. Though Butler in his experience felt that only subjects capable of reaching deep trances were able to reap some benefit, Erickson, Sacerdote, Lea and others achieved lasting results in just only one session

of very light hypnosis. I tend to agree with the latter that success does not depend upon the depth of hypnosis. My impression is that better results are obtained when the patient seeks hypnosis himself and when his consultant refers the case. Good rapport is half of the treatment. I feel that hypnosis may contribute to the patient's comfort, not only in the terminal stages of the disease but also during any time starting at the point when the patient is informed of his malignancy. Hypnosis can be used to assist the patient in accepting the diagnosis, to change his attitude from one of complete despair to hopeful toleration, to facilitate surgery and minimise post-operative discomfort, to relieve the distress of the patient, to relieve pain, to reduce the need for narcotics, to lessen the ill effects of radiation therapy. The following cases will serve to illustrate some of these points.

Case 1. A 40-year-old man had pain and swelling of his inguinal gland. Biopsy revealed a malignant metastasis from an unknown malignant melanoma. He was given 5 weeks deep X-ray therapy and followed by chemotherapy with no results. The gland became larger and ulcerated and his thigh became swollen. He suffered from severe intractable pain radiating down his whole leg. He also had headaches, vomiting and insomnia. Three attempts of subarachnoid injections of alcohol failed to give him any relief. For many weeks preceding hypnosis, he had been kept in a narcotic semi-stupor, since this was the only way to control his pain, to enable him to sleep, and to enable him to eat without extensive nausea and vomiting. The actual diagnosis was withheld from him by his surgeon though he suspected himself suffering from cancer; and this is not a wise thing to do with cancer patients. The patient was taught autohypnosis, hallucinations, analgesia and anesthesia, time distortion, body disorientation and dissociation. His narcotic requirement became dramatically reduced. Although bedridden for the last few weeks, he continued quite comfortably with minimum narcotics with a complacency and acceptance rarely seen except in the well conditioned hypnotic subject.

Case 2. A 44-year-old woman underwent a radical mastectomy for cancer of the breast. After operation she complained of insomnia, epigastric discomfort, irritating cough and was very low spirted. Hypnotherapy relieved all these symptoms. She was then conditioned for the deep X-ray therapy which she was going to have the following week and which she was doubtful, fearful and reluctant to undergo. Hypnotherapy removed her doubt and fear, and suggestions were given that she would tolerate the deep X-ray well and would have no blisters or discomfort. She went through a successful 20 times deep X-ray therapy with no discomfort, blisters or burns.

Case 3. A 29 year-old Chinese School unmarried teacher underwent above-knee amputation for osteoclastoma of tibia, and suffered from phantom limb, insomnia and depression. A year ago she had turned down the amputation to seek other forms of treatment. Though the amputation was successful and stump had healed well, she suffered from phantom limb insomnia and depression. She regretted having wasted a year and feared that the amputation might be too late. Hypnotherapy successfully removed all her symptoms, and motivated her for physiotherapy with more keenness and enthusiasm. She did her exercises faithfully, learned to use the clutches very well before the artificial limb was ready, and soon she walked with agility on her artificial leg.

Case 4. A 32-year-old horsewife had above-knee amputation for Synovial Sarcoma. Soon after operation she had phantom limb. She was depressed having only one leg, and also feared recurrence of the cancer. Hypnotherapy successfully removed her phantom limb, and instilled confident hope in her. Hypnosis was also used to make her get used to one limb, to be able to stand on one leg without falling, and also motivated her to physiotherapy exercises.

Case 5. A 72-year-old woman with a bronchogenic carcinoma suffered from a racking cough, chest pain, dyspnea and orthopnea, anorexia and insomnia. Though patient attained only a light trance, she was relieved of most of all this distressing symptomatology without resorting to much drug medication until her death 6 months later.

Case 6. A 37-year-old man was very much distressed when he was diagnosed having carcinoma of his stomach and required surgery. He was very depressed, fearful and unable to sleep. Two hypnotic sessions turned him from a state of complete dispair to one of confident hope. His surgery was also much facilitated; he required no night's sedation before surgery, amount of thiopentone used was much reduced, he needed only one single injection of omnopon after operation, and his post-operative convalescence was remarkable. He is still well and alive.

Case 7. A 55-year-old man was admitted for partial gastrectomy for carcinoma of the stomach. He was given two hypnotic conditioning for the surgery. He was a good hypnotic subject. He had no night's sedation before surgery, no premedication, amount of thiopentone used for induction was only 100 mgm., and after the operation he had only a single dose of gr. 1/3 omnopon. He was able to get out of bed the next day after operation after the drip was off. His post-operative convalescence was remarkable (5).

Case 8. A 37-year-old housewife was referred by the physician for excision of thyroid adenoma suspecting malignancy. Two hypnotic sessions were given to condition her for surgery. At operation the malignancy was evident and a bilateral excision of thyroid was done. She had no night's sedation before surgery, no premedication, amount of thiopentone for induction was 125 mgm. and she had no pain after the operation. Histological examination confirmed the diagnosis, but the surgeons were afraid to let her know the truth. She was re-hypnotised again during the post-operative period and tactfully informed of the diagnosis under a trance. She accepted the diagnosis very well and made a rapid recovery (5).

Case 9. A 52-year-old woman was histologically proved to have Post-Nasal-Space carcinoma and was advised deep X-ray therapy. She was very much shaken, fearful and depressed, because she said "she had seen the horrible condition of people after DXT." Hypnotherapy was used to persuade her to accept the DXT, and was also used to lessen the ill effects of radiation therapy and to help her go through the complete course of deep X-ray treatment without much complication.

Case 10. A 33-year-old man was referred for hypnotherapy because of a severe pain in his right arm radiating down from the shoulder. He had a big shadow in his right lung and a swelling in his right supra-clavicular fossa, and suspected of having lung cancer. Though a good hypnotic subject repeated effort of hypnotherapy failed to give him any benefit. He died few months later in agonising pain.

DISCUSSION

Pain states are the most difficult problems to manage in the cancer patients. Though everybody knows what is meant by pain and suffering, yet pain has never been satisfactorily defined. Sir Thomas Lewis wrote: "Reflection tells me that I am so far from being able satisfactory to define pain, that the attempt would serve no useful purpose. Pain, like similar subjective things, is known to us by experience and described by illustration." (19) Sherrington defined pain as "the psychical adjunct of an imperative protective reflex (27). However, severe protracted pain in advanced cancer has lost any quality it may have had as a protective reflex; instead it is capable of sapping the strength and the will-to-live of the patient. Engel in a brilliant paper on psychogenic pain and painprone patient remarked: "When we examine the full gamut of circumstances, from the simple peripheral stimulus to the complex psychological components, we must acknowledge that pain in final analysis is a psychic phenomenon. The two-component concept of pain, which speaks of pain sensation and the reaction of pain, is misleading because it implies that pain can originate only from a "pain receptor". (8). Gooddy goes so far as to say: "There can be no pathways nor nerve endings for pain. The notion of pathways for pain is but a figment of the observer's mind." (11)

The pain in cancer is usually a formidable motivation to the patient for accepting hypnosis. However, in spite of this, many conscious and subconscious forces are often working to prevent either successful induction or satisfactory exploitation of the state of hypnosis. As Sarcerdote (21) had pointed out: "hypnosis may be useless in patients for whom the prolonged suffering is a necessary psychological expiatory experience whether they are aware of this consciously or not. There are some who need a painful crippling illness as a solution from hard work to various life problems. Cangello (2) also remarked: "At first it was confusing to find that an individual who entered a deep trance state might be unable to obtain relief of pain while another who was at best in a hypnoidal or light state experienced complete pain relief. When it is realised, however, that an individual may believe that this disease is a form of punishment from God; that this suffering may reward him or her with eternal life; then one can realised that such patients cannot and will not accept pain-relieving suggestions." Sacerdote (24) classified analgesic agents into three groups: (i) Drugs that modify the peripheral pain receptor sites; (ii) Drugs that modify the central perception of pain; and (iii) Drugs that change the reaction of the individual to the pain experience. He said hypnosis

could be classified among the third group of pain-relieving durgs—those that change the reaction of the individual to the pain experience. Beecher brings on the fact that morphine and all related narcotics, synthetic or not, while they are assumed to act mostly by changing the central perception of pain, are actually, to a great extend, modifying the psychic reaction to pain (2).

Petrie and colleagues (18) pointed out the characteristic changes produced by prefrontal lobotomies are not explained either by changes at the source of pain which is evident, or by changes in the threshold for pain, but by a significant change in the personality of the patient. Hypnosis relieves pain by what is generally termed "a psychological lobotomy".

CONCLUSION: Hypnosis offers an approach to the problem of the cancer patients and may well prove to be the only really practical approach toward solving many of the difficulties encountered in the total care of the cancer patients. Heroic measures of neuro-surgical intervention such as alcohol block, cordotomy, prefrontal lobotomy, hypophysectomy, etc. are rarely useful or necessary.

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