

THE THERAPIST AS A TRAVELLING COMPANION TO THE CHRONICALLY ILL: HYPNOSIS AND CANCER RELATED SYMPTOMS

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Abstract

The complex interaction of pain, other symptoms and suffering in cancer patients requires a treatment approach that integrates psychological as well as pharmacological interventions. The supplementation of a pharmacological pain treatment concept based on WHO-guidelines by the use of self hypnosis was examined in a controlled clinical follow up study: 61 of 342 patients with cancer related pain referred to the Interdisciplinary Pain Unit of Munich University Clinic were included. In a cross-over design they were randomly assigned to two different successions of treatments after a 2-week period of establishing optimal medication: either AB (A: using self- hypnosis and analgesics, followed by B: pharmacological treatment alone, 4 weeks each) or BA (B: continuing pharmacological treatment alone and then A: using additional self-hypnosis). Patients themselves evaluated therapeutic effectiveness with the help of visual analogue scales (VAS) in a 'pain diary' for a total of 10 weeks. On account of a carryover-effect caused by the beneficial effects of self-hypnosis the 'cross-over' did not show statistical significance. Using a parallel design we found a statistically significant reduction of pain and suffering after the first four weeks for treatment A (with self-hypnosis) in comparison to treatment B (without self-hypnosis). The utilization of hypnosis requires an intensive subjective exchange over a period of time between the patient and the therapist, who embark as travelling companions on a journey through uncharted territory. Three case reports serve as an example for three different 'time windows' of this travelling companionship of therapists and patients: short term/crisis intervention, cooperation for several weeks/coping enhancement, and long term/psychotherapy. Copyright © 2008 British Society of Experimental & Clinical Hypnosis. Published by John Wiley & Sons, Ltd.

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Chronic illness

Recuperating from illness or suffering due to pain is a spontaneous experience that is enhanced sometimes by medical measures. However, what if the chosen intervention is unable to cure, promote healing or alleviate pain? Severe limitations due to chronic illness require a high degree of diagnostic and therapeutic competence, combined with psychosomatic understanding und communication skills. It is a major challenge for therapists to localize the measures that will promote a personal and emancipatory development in patients, rather than drawing them even deeper into chronicity and frustration.

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To this end, the subjective experience of 'being sick' and 'suffering' ('*Kranksein*') must be considered as equally important as the objective classification of a 'sickness' and its 'symptoms' ('*Krankheit*'). Psychotherapeutic support is often necessary in order to overcome wishful thinking and discover those changes that will prove potentially decisive; both patients and therapists have to build on a therapeutic alliance that subsists on creativity, endurance and patience in order to succeed. Within this alliance the perspectives of both participants as 'experts' are needed to localize those experiences or symptoms that might be susceptible to modification. What can patients discover that they are able to do all by themselves? What can be done for the patients through measures based on scientific evidence?

I consider hypnosis and self-hypnosis to be invaluable tools for dealing with symptoms of chronic illness (especially cancer), as well as diverse psychological issues related to medical care (Ebell and Beyer, 1993; Ebell, 2002). This understanding has evolved pragmatically since 1976 through my daily work in anesthesiology, intensive care medicine and interdisciplinary pain therapy at Munich University clinic. Since 1992 my work has focused on psychotherapeutic practice with the chronically ill (Ebell, 2001).

I regard the therapeutic alliance as a joint venture, i.e. a journey in which therapist and patient join in a cooperative effort to search for potential changes. The client examines his or her resources, as well as relevant obstacles and conflicts. The therapist offers personal and professional experience by helping out with 'objective' knowledge about chronic illness. In my position as a travelling companion to a patient who is chronically ill, the onset of the journey is paying careful attention to the patient's explanation of his or her subjective experience with suffering. It is, on the other hand, essential while listening to also relate what is being said to objective criteria in order to interpret the patient's description as the 'symptoms' of a defined sickness. In the practice of hypnosis, encouraging patients to reexamine their experiences and explanations can, in itself, prove instrumental in the promotion of change.

This presentation will focus on pain as exemplary of these two perspectives: pain as the subjective experience of the patient and pain, as seen from the perspective of the therapist, as a major symptom that often requires diagnostic and therapeutic medical measures.

Cancer related pain

The complex interaction of pain and suffering in cancer patients requires a treatment approach that integrates psychological as well as pharmacological interventions (Larbig and Tschuschke, 2000; Sellschopp, Fegg, Frick, Gruber, Pouget-Schors, Thöml, Vodermaier and Vollmer, 2005; Herrschbach, Heußner and Sellschopp, 2006). Although symptomatic pain relief according to WHO guidelines for medication is undoubtedly effective, chronic pain and side effects of therapy related to cancer still represent a severe disturbance of personal coping processes and psychosocial adjustment. Furthermore it is not unusual that the cancer patient is, through pain, communicating the emotional experience of suffering, anxiety and/or depression. Therefore the reduction of nociceptive sensory information input (e.g. through pharmacological treatments, neurolytic blocks, etc.) should be supplemented by the therapist providing psychosocial coping strategies (Ebell and Beyer, 1995; Aulbert, Nauck, and Radbruch, 2007).

The experience of pain involves complex behavioural patterns as well as emotional and cognitive components (Nakamura and Chapman, 2002). These are mediated by the central nervous system and sustained by memory. It is consequently instrumental to pain

relief and symptom control through hypnosis that the 'here and now' trance experience also addresses the representation of past experience and the construction of the future. Is this approach effective? Can self-hypnosis as a supplement to a pharmacological treatment concept for cancer related pain mobilize inherent coping abilities?

Self-hypnosis and cancer related pain

In 1988 to 1991 (funded by the German Cancer Society), in a *controlled clinical follow-up study*, pharmacological pain treatment (WHO guidelines: three step 'ladder' of analgesic medication, mounting up to morphine and/or other strong opioids) was supplemented by the use of self-hypnosis for pain control. This clinical trial (Ebell and Beyer, 1993) examined the following three questions:

- 1 Are 'routine' cancer patients of the Interdisciplinary Pain Unit (IPU) willing to accept instructions in self-hypnosis as part of a complete treatment concept?
- 2 Do standardized instructions for self-hypnosis recorded on audiotape sufficiently activate individual resources and capabilities to experience and utilize hypnotic phenomena (analgesia, dissociation, time distortion, etc.) in order to reduce pain and suffering?
- 3 Does this approach enhance pain control more effectively than a purely pharmacological treatment concept following WHO guidelines?

Entry and exclusion criteria

All patients with pain related to cancer referred to the IPU were eligible for entry into the study. The exclusion criteria were 'withdrawal of consent', 'rapidly progressing disease making data collection impossible', 'large differences between reported and actual use of analgesics' and 'more than a total of 10 and/or more than 3 consecutive days missing in the pain diary'. Informed consent of each study patient was obtained.

Over a period of 15 consecutive months 342 cancer patients were referred to the IPU. One hundred and three of these patients met the entry criteria and were interested to participate in the study. A total of 61 signed 'informed consent'. Eight patients withdrew consent, 2 were excluded due to a lack of data in the pain diary and the study was discontinued for 19 patients on account of rapidly progressing disease. Thirty-two patients met all requirements of the study.

Randomization and treatment plan

The trial was conducted according to a '2x2-crossover-design' (see Figure 1). After a baseline period of at least 2 weeks each patient received 2 different treatments: A, treatment with instructions for self-hypnosis in addition to the pharmacologic treatment, or B, pharmacologic treatment alone. Half of the patients received A first and B after a period of 4 weeks, the remaining patients were treated at first with B and then with A. After entering the study each patient was assigned by block randomization to one of the two treatment sequences (AB or BA).

Outcome variable

The patients logged their conditions every day in a 'pain diary', in which they were required to assess the amount of 'continuous pain', 'pain attacks', 'suffering from pain', 'well being', 'coping expectation', and 'experienced self control' with the help of visual analogue scales (0–100). The patients were also asked to report on the 'use of analgesics'

2-Periods - Crossover - Study with two treatments (A und B)

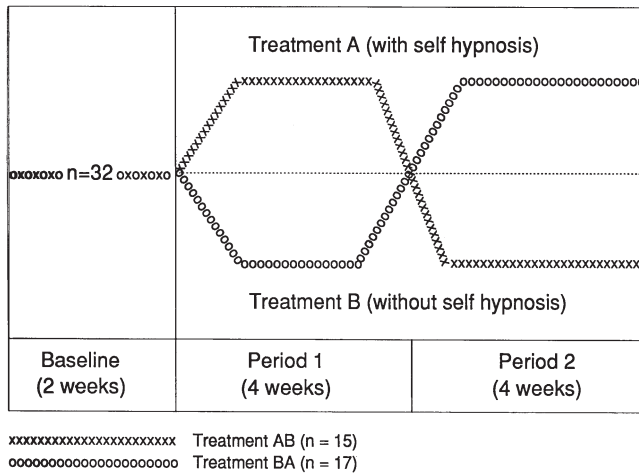


Figure 1: 2 × 2 - crossover - design

and ‘number and character of self- hypnosis exercises’. An objective assessment of the patients’ symptoms was done by a physician.

The Stanford Hypnotic Clinical Scale for Adults/SHCS-A (Morgan and Hilgard, 1978/79) was applied. The patients were informed that the results of this test would not influence our offer of self-hypnosis. Team members having therapeutic contact with a patient had no access to Stanford scores until the end of the study, thus avoiding bias. Before knowing patients’ scoring on the Stanford scale, all patients were classified as ‘responsive’ or ‘unresponsive’ to self-hypnosis in intensive team workups, under the guidance of two supervisors experienced in the field of clinical hypnosis.

Results

The two major outcome variables ‘pain intensity’ (Figure 2) and ‘suffering from pain’ (Figure 3) showed an amelioration from baseline to period 1 in those patients treated with self-hypnosis first (AB) and a worsening in the patients first getting pharmacological treatment alone (BA). Although treatment was changed to analgesics alone, the amelioration in period 1 (AB) remained constant in period 2 (B). The worsening of symptoms (BA) could not be reversed by changing the treatment to self-hypnosis (A).

The *statistical evaluation* (variance analysis) of the crossover did not show significance (p-values: ‘pain’: 0.6496 for periods, 0.5955 for treatment; ‘suffering’: 0.7211 for periods, 0.8290 for treatment), since patients, who successfully applied self-hypnosis for pain control did not – of course! – dismiss this strategy in the second period of four weeks, although they were compliant to the requirement not to use the tape recorded exercise. When discussing the methodological and clinical implications of various possible study designs, we had, unfortunately, not taken this learning effect into consideration.

Another reason may have been the rapid progression of cancer disease in all patients: 28 patients died within 6 months (6 study patients who completed, 22 who discontinued), 14 patients during the following 6 months (10 who completed and 4 who discontinued),

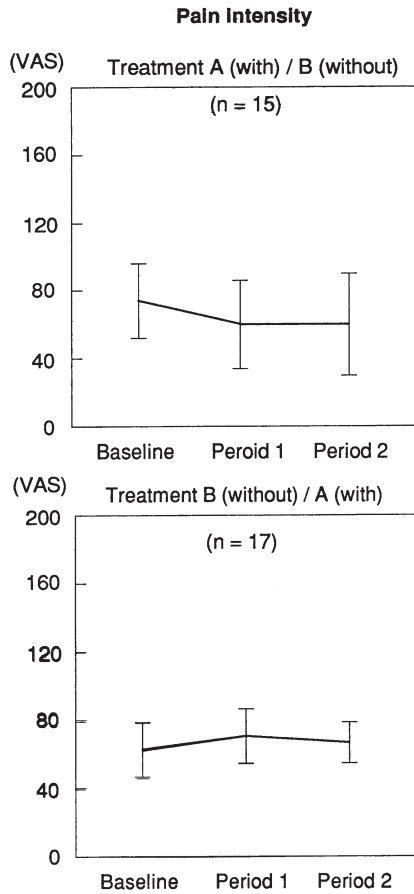


Figure 2: pain intensity

summing up to a total of 42 of the 61 study patients dead after 1 year since beginning the pain diary documentation.

Why then did we choose the *cross-over design* approved in pharmacological research studies? Aside from the idea that it would control inter-individual differences as far as highly subjective outcome variables were measurable and only a small number of patients was expected to take part in the study, another major reason was the patients' motivation: without benefiting from learning self-hypnosis during the trial, no patient would have done the detailed logging in the pain diary.

To test and prove the assumption that this 'disappointing' result was due to the therapeutically intended 'carry over effect' we did an exploratory data analysis using a normal two-arm parallel design, i.e. comparison of the treatment periods with self-hypnosis (A) and the treatment periods with analgesics alone (B). Here we found a clear (p-values 0.05) statistically significant reduction of 'pain' (0.0114) and 'suffering' (0.0164).

Clinical evaluation

Eleven patients reported achieving pain control; 12 other patients reported benefits of rest, relaxation and sleep; 9 patients reported neither improved pain control nor any other benefits (mostly patients with psychological comorbidity and complicated contextual

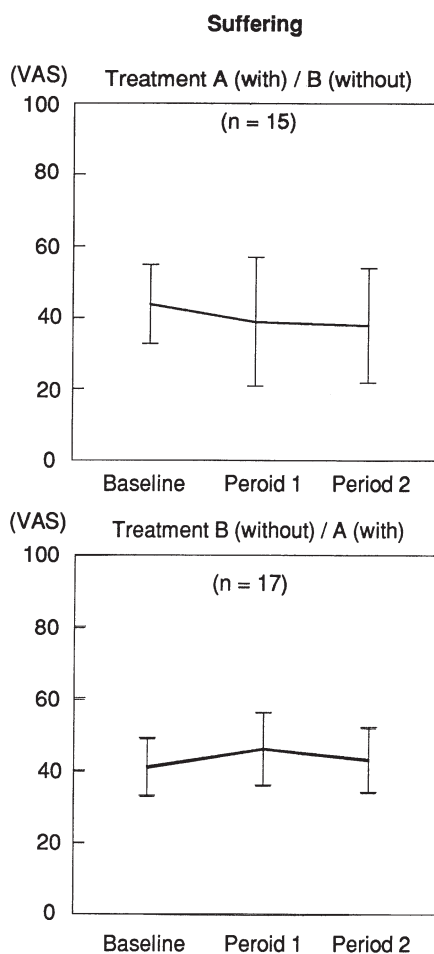


Figure 3: suffering from pain

conditions, such as marital and family difficulties) through self-hypnosis. On the basis of these rough clinical estimates, we correlated the occurrence of beneficial clinical effects through self-hypnosis with the Stanford scores (SHCS-A: maximum of 5 points). The Stanford score clearly corroborates the team's evaluation only for 6 patients: 3 scoring highest ('5') and 3 scoring lowest ('0'). One patient rejected the test procedure and two tests were, for organizational reasons, not carried out. The Stanford scale scores of the remaining 23 patients seemed of no value in predicting the clinical effect of self-hypnosis. Had we based our selection of patients on the Stanford scoring results, our choice would indeed have been very questionable (Ebell, 1994).

Self hypnosis – a worthwhile support with cancer related pain

Answering the three questions above we conclude:

- 1 About 30% of the routine cancer patients referred to the IPU appreciated the chance to learn self-hypnosis as a 'support for self efficacy' ('Hilfe zur Selbsthilfe') to achieve pain control in a framework of conventional therapy.

- 2 Standardized audiotaped instructions seemed able to serve as an individual tool for the effective supplementation of pharmacological treatment. The additional reduction of pain and suffering could be due to mobilizing inherent coping abilities (see case report 2 below). Supplementary individual counseling should be mandatory. This accompaniment requires attention for all factors involved: physical changes (e.g. side effects of oncological therapy, progression of disease), psychotherapeutic aspects (e.g. stress, anxiety, depression), and social issues (e.g. spouse's reactions, family situation, conflicts within hospital ward). Continuous reassessment of the suggested parts of such a treatment puzzle is necessary.
- 3 Up until the present time we have had to deal with the historical prejudice against hypnosis as being unacceptable because of the fear of 'loss of control' and/or 'having to succumb to another person's will'. Well founded, its renaissance in the medical and psychotherapeutic field paradoxically goes with the idea of 'enhancement of control' and/or 'discovery of individual resources and strength'. This holds true not only for self-hypnosis in the medical field but for contemporary conceptions of human relationship in hypnotherapy, too.

Ideomotor signalling

My own work with pain patients has been greatly influenced by the work of David B. Cheek (1994). Above all, ideomotor signalling (Damsbo, 1987), with or without formal trance induction, has proved itself to be an invaluable clinical tool. The numerous experiences with patients using this approach have enriched and shaped my personal understanding of hypnosis. As a doctor I had been basically focused on a list of direct or indirect suggestions applicable as interventions aimed at pain relief (Erickson, 1967). However, when I started to notice entirely unexpected positive physio-psychological changes evolving all by themselves out of spontaneous and/or induced trance states, I became more and more convinced that many other factors, such as intersubjective exchange, existential needs, motivation, etc., have a decisive influence on which trance phenomena can be brought about and when they occur (Ebell, 1994). I found myself relying more and more on implicit memories and knowledge as potential resources – i.e. on the principle of an underlying primary homeostatic regulation of the patient. The latter implies after all that any effective solution must draw on the immanent potential of the patient's own regulatory resources.

Case reports

Leaving now these clinical trial data that have pointed up the efficiency of self-hypnosis for patients with cancer related pain syndromes, I will present three case reports of individuals who experienced decisive changes through hypnosis and self-hypnosis. These are examples for three different 'time windows' regarding my 'travelling companionship' (1 short term, 2 cooperation for several weeks, 3 long term) and respectively three main approaches for therapeutic support (1 crisis intervention, 2 coping enhancement, 3 psychotherapy).

1 Short term travelling companionship – crisis intervention

Ideomotor signalling enables decisive modification of morphine side effects and relief of suffering

Mr S (69 years old) suffered from cancer of the kidney with progressive bone and lung metastases. He experienced good pain relief through morphine. However, under this medication his dreams actualized his horrifying experiences in World War II as a young soldier. For weeks he had been caught in a 'lose-lose' situation: whether to suffer from his pain or his past. I told him that I knew how trapped he felt in a situation seemingly without any good options. Then I induced catalepsy in one hand in order to approach his 'unconscious' mind for help by asking whether it would be possible to find 'just a little modification for this dilemma'. Were the unconscious to agree to the proposition of change, then the consent should be made noticeable by a movement of one of the fingers of the cataleptic hand. The patient, who was sitting quietly with his eyes closed, focused his attention on the image of a good place to be. After a while, his little finger made a slow and hesitating movement. I reported this to him, declared this signal to be sufficient feedback and promised to come back the next morning to find out how he was feeling and what the finger movement possibly could have meant. From this night on, morphine medication continued to be completely effective as a pain relief, and, during the remaining six months the patient was to live, no longer caused the unwanted side effects. I assume there must have been a causal relationship between my presence, our exchange, the induction of hypnosis, the ideomotor signal and this relevant subjective and clinical change.

2 Cooperation for several weeks – self-hypnosis as a major coping enhancement

Relief of suffering from neuropathic pain, dyspnoea and side effects of chemotherapy

Mrs L (45 years old) suffered from neurogenic pain due to breast carcinoma with invasive growth into the brachial plexus including additional nerve damage through radiation. This patient continuously experienced the sensation that her arm 'was constantly rubbing against the thorns of a large cactus'. With the help of the fantasy that she had wrapped her arm in ice cubes of 'just the right size and just the right temperature to make it feel comfortable' she achieved complete analgesia that lasted for several hours. Within several weeks of this practice, this quality of pain ceased and the ongoing morphine therapy simultaneously became completely effective. Some months later – and all by herself – she applied self-hypnosis in order to relieve breathing difficulties that were caused by lung metastases. This time she utilized an image she had seen in a film of the Canadian plains depicting huge, yellow wheat fields that stretched from horizon to horizon. As a third form of creative application of her special abilities she reported that she experienced almost no negative side effects of her rather aggressive chemotherapy, because it assisted her in fighting for each day of her life, in order to fulfill her loving responsibility to remain as long as possible with her son and her husband.

3 Long term psychotherapeutic cooperation – various therapeutic objectives

Therapeutic relationship and goals were shaped decisively by hypnosis and self-hypnosis

After being hospitalized for four months because of premature labour, Mrs R (35 years old) gave birth to a baby girl. Since the required medication against contractions of the uterus had caused partial liver failure, she had been confined to strict bed rest. She had been additionally under stress due to weekly ultrasound controls of a growing ovarian tumor with suspected malignancy. Immediately after giving birth the tumor was removed. It turned out to be clearly malignant. Since malignant cells might have entered the abdominal cavity through accidental opening of the ovarian cystical structure, chemotherapy was required. This resulted in severe side effects, which elicited even more stress and the desire to abandon therapy altogether.

In this phase of medical therapy the psycho-oncologist recommended psychotherapeutic support. Compared to the outset of our journey as travelling companions, this phase of our collaboration turned out to be unexpectedly efficient. Thanks to the help of hypnosis and self-hypnosis, the second chemotherapy cycle caused many fewer side effects than the first. During the third cycle of chemotherapy, which completely contradicted the expectations and unintentionally given 'suggestions' of the concerned medical staff, the patient experienced even fewer side effects. By this time she experienced all interventions as helpful in her struggle to regain normal living.

In a further phase of treatment, traumatizing aspects (events, suggestions, interactions, etc.) of the hospital stay were revisited, partially neutralized, integrated, and reframed. According to a list of challenges the patient had formulated for her 'life after treatment' (for example: overcoming feelings of guilt toward her daughter, whom she could not care for over a longer period of time; when and how to return to her job which required the maintenance of high management qualifications, etc.), strategies were discussed and the possibilities of their realization were often validated through hypnosis. Our mutual psychotherapeutic journey lasted for about a year and it traversed many short-term therapeutic goals.

A second phase of the journey followed two years later, when the patient had become pregnant again and was suffering from hyperemesis gravidarum (vomiting 25 times a day at the beginning of the pregnancy). After eight sessions the pregnancy normalized and the patient gave birth at term to a healthy boy.

Why therapeutic hypnosis?

It is important here that there be no misunderstanding. These vignettes do not portray the rule and it would do hypnosis a disservice to be portrayed as a procedure tantamount to a cure-all. We all know too well that cure-alls do not exist. Still, extraordinary case histories like the ones reported here help by calling inquisitive attention to the invaluable potentials of our patients. In a book *Why Therapeutic Hypnosis* which I recently edited (Ebell and Schuckall, 2004) many colleagues report and discuss similar astonishing experiences in their particular fields. It was not an easy task, persuading all the authors to describe exactly what they did, spoke, thought, observed, rather than letting them merely declare: I used hypnosis. All these interesting case histories issuing from the practice of medicine, dentistry and psychotherapy illustrate the profound potential of the state and techniques of what we contemporarily call hypnosis. I assume that they prob-

ably document an access to physio-psychological homeostatic capacities that have stood the test of time over millions of years of evolution and many thousands of years of human relations (Brown, 1991).

In my own work I proceed on the hypothesis that any experience represents some kind of adequate response to issues that I, as an outsider, am, of course, unable to oversee at the onset of therapy – especially if the response seems contradictory when considered from the objective perspective of typical symptoms of a defined illness. If there is any real chance for decisive modifications, these must originate within the immanent potential of the patients themselves as unique living ‘systems’, with their own experiences, values, resources and hindrances.

The therapist as a travelling companion

Utilizing hypnosis techniques and hypnotic phenomena for treatment of the chronically ill requires an intensive subjective exchange over a period of time. Patient and therapist embark as travelling companions on a journey together through entirely uncharted territory. This journey of mutual experience and learning cannot be substituted by mere suggestion. Hypnosis and especially self-hypnosis work because they seek to promote well-being by drawing on the intrinsic resources of the patient. Even though it cannot be foreseen whether the ensuing changes in the patient’s experience will be decisive or not, there are indeed reasons to proceed with optimism. Within this treatment context the patient is enrolled as co-planner and decision maker. The active participation of patients in determining treatment steps is of the utmost necessity, simply because all the information necessary to achieve symptom relief or healing is carried within the patients themselves. This information is the result of an absolutely individual code of life experiences and conflicts. The patient alone has the capacity to decipher his or her own code, reformulate it or create a new one. Within the context of this singular reality, the patient is accompanied by the therapist as a travelling companion who functions as well as a scout in the uncharted territory.

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