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MAIN PAPER

USING HYPNOSIS WITH PATIENTS UNDERGOING CHEMOTHERAPY

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ABSTRACT

Chemotherapy is a procedure many cancer patients have to undergo. For some patients the trauma of chemotherapy can be so great that they cannot cope with it. This paper explores areas where hypnosis as part of a psychological intervention can be of great assistance. However, one should not lose sight of the need to prevent, rather than to treat, psychological problems.

INTRODUCTION

Nowadays, there is increasing recognition that patients suffering from cancer may require psychological assistance. The diagnosis of cancer can result in significant psychopathology in addition to the trauma of the procedures that patients have to undergo. Details of such problems and a number of treatment approaches including cognitive behavioural therapy (referred to as adjuvant psychological therapy), are amply covered in Moorey and Greer (1989), Watson (1991) and Greer, Moorey, Baruch, Watson, Robertson, Mason, Rowden, Law and Bliss (1992). Group approaches including the use of self-hypnosis training have been described by Spiegel (1993) and Spiegel, Bloom, Kraemer and Gottheim (1989).

The journal *Psycho-Oncology* regularly publishes studies demonstrating the value of many psychological interventions. Indeed, working with cancer patients is a growing area.

This paper is concerned with the use of hypnosis with patients receiving chemotherapy, a treatment that cancer patients frequently have to undergo. Nowadays, it is increasingly becoming more or less routine to offer it to patients with breast or other forms of cancer as a part of treatment even when there are no direct indications that cancer is actively still present as trials have shown that it does seem to increase survival time. Most patients would agree that it is not a pleasant procedure. It involves venipunctures and it is particularly important that the needle is securely in the vein as leakage into tissue can be extremely destructive, so the process of establishing a suitable vein can require several punctures (one patient with whom I was involved required five attempts on one occasion).

In addition to the stresses of the procedure itself, chemotherapy can have many distressing side-effects. These include nausea and vomiting, debilitating fatigue, hair loss, alteration of skin quality, etc. Although nausea and vomiting can be reasonably

well controlled by drugs, this is not guaranteed. The drugs themselves can cause disruption, Steroids can alter mood, do cause weight gain, and can cause sleep disturbance. Understandably, then, prior to receiving chemotherapy, many patients become anxious having heard 'horror stories'. However, faced with the decision most patients will, even reluctantly and with dread, accept it as part of their 'fight' against cancer.

CASE ILLUSTRATIONS

Despite the good service provided by Grimsby Hospital as regards well-trained specialist nurses and a sensitive oncologist, there remain a number of patients who require the services of a psychologist.

Bejenke (1996) has clearly demonstrated the effects of both hypnosis and waking suggestion on chemotherapy side effects, pain following surgery and anxiety. This paper illustrates the use of hypnosis with oncology patients at Grimsby Hospital in the areas described below:

1. Needle phobia
2. Nausea and vomiting
3. Anxiety
4. The experience of chemotherapy itself
5. Beliefs about chemotherapy

Needle phobia

Needle phobias are far from being simple phobic problems.* As part of assessment, it is very important to establish just what it is that 'drives' the fear, that is, to elicit the 'bottom line' cognition and belief, otherwise therapy could be inappropriately targeted. Standard behavioural treatments involve desensitization or exposure, which is appropriate if the problem centres on avoidance through a fear of discomfort, or a belief that one cannot cope. However, if the fear is more related to 'invasiveness/violation' a more exploratory/cognitive approach may be necessary. Some examples of common 'drivers' include 'fear of pain' — catastrophic beliefs about pain, 'invasiveness', and 'the needle *is* the chemotherapy'. The latter is illustrated in Case 3 where the patient apparently developed a needle phobia in order to 'avoid' having chemotherapy, which she clearly did not want to have, but felt under pressure to comply for her husband's sake.

In view of this complexity, therapy can involve cognitive challenges, distraction techniques, hypnotic analgesia, dissociation, reframing and the restructuring of early trauma.

Case 1

Mrs T. was so phobic she delayed 7 months before going to her doctor with a breast lump. Her phobia centred on (1) a fear of pain, and (2) denial of her condition. She responded well to a desensitization programme with hypnosis for confidence building, relaxation and ego-strengthening, so that after only three sessions she could successfully cope with blood testing. However, her anxiety over chemotherapy remained very high and in order to deal with this, she taught herself to 'dissociate' from the situation, spending her chemotherapy time in imagery 'far away on a tropical island',

*Despite a fairly comprehensive literature search, I could not find any references to controlled trials using hypnosis to treat needle phobias but only some unhelpful anecdotal papers.

with a total lack of awareness of the procedure, and symbolically, her cancer. The technique permitted her to complete her treatment and her difficulties in coping with cancer were addressed at a later date.

Case 2

Mrs H. refused to have chemotherapy because of her fear of being 'invaded'. This required exploration using ideomotor signalling and a 'video recall' technique. She enhanced a memory of being in hospital as a young child and being held down by several nurses who were unresponsive to her screams. No-one seemed to have offered any comfort. In trance, she restructured the experience, sending her 'adult self' into the situation to rescue, comfort and reassure the child. After this, she was able to cope.

Case 3

Mrs L., a 65-year-old lady with liver secondaries claimed to be needle phobic and therefore to be unable to accept chemotherapy. However, the oncologist suspected that she really did not wish chemotherapy but was going along with the idea for her husband's sake. On assessment, she insisted that she really wanted to undergo chemotherapy, but that she was too frightened of the procedure. She requested help with this through hypnotherapy. She stated that if she could be 'so deep in trance that she was "unaware" of what was going on' she would be able to cope.

Although avoidance is not the treatment of choice, it was more important to help this woman cope with a procedure than to worry about helping her to face her fear. However, it was suggested to her that she did express some doubts about chemotherapy, but if she could overcome her fear of not coping, she could then make a proper informed choice.

She was a good hypnotic subject, and readily became so involved in imagery that she could detach herself from her surroundings. Ideomotor responses were employed to check that she had indeed succeeded in reaching a suitably 'deep' state. At that point, she burst into tears and admitted that the real problem was that she did not want to have chemotherapy, but felt she had had enough.

Her husband accepted this, and the consultant reinforced her choice. It would appear that the use of hypnosis helped her to reach her preferred decision.

Nausea and vomiting

Treatment for nausea and vomiting during a chemotherapy programme is well documented in the literature. Walker, for example, has developed a technique he calls 'Nausea Management Training' (Walker, 1984; Walker, Dawson, Pollet, Ratcliffe & Hamilton, 1988), which involves hypnotic desensitization via exposure to the stimuli of nausea combined with relaxation techniques. However, I would like to report one interesting case involving a lady who developed a nausea and vomiting problem *after* her chemotherapy was complete.

Case 4

Mrs L., a 44 year-old-lady whose primary breast cancer and its recurrence had been successfully treated and who had had some vomiting during chemotherapy, developed severe symptoms of sickness after treatment had ceased, which resulted in persistent nausea and daily bouts of sickness. No obvious medical cause could be determined and the oncologist queried anxiety, which again was not immediately apparent apart from apparently normal levels of concern about her condition. Using

ideomotor signalling, it emerged that her symptoms were related to anxiety about recurrence and were functional in that they maintained the consultant's attention. Using reframing, her 'unconscious' revealed that 90% of her symptoms were anxiety, and agreed to reduce the symptoms in exchange for monthly checks at the GP surgery. As this lady had had one recurrence of her cancer, this seemed reasonable, and her symptoms reduced from daily bouts of sickness to some nausea once a week.

Anxiety

Many patients are so anxious about receiving chemotherapy, and its side effects that they have been referred for psychological assistance. Their problem is by no means simple as the anxiety is almost always intertwined with fears about cancer itself, recurrences, death and similar themes. As regards chemotherapy, often sound education and reassurance that if symptoms occur they can be controlled is enough. However, for some, hypnosis used simply as a relaxation and supportive technique can be of immense benefit. An approach to anxiety that I have used I call 'Anxiety Limitation'. Patients are encouraged to learn self-talk strategies to challenge their anxiety, such as 'Yes! Recurrences can happen, but what is the point of worrying when it isn't happening now? It might never happen, so all this worrying would be a waste', and to combine this with 'posting their worries into a very safe, strong locked box or drawer where they can remain 'til needed'. Again, the general emphasis is on the use of hypnosis in a cognitive-behavioural context including the eliciting and challenging of negative cognitions, relaxation/self-hypnosis, and the anchoring of comfort.

As part of the process of using hypnosis with these patients, I include rehearsal, that is, the patients imagine themselves coping, experiencing the chemotherapy with minimal side-effects and calmness, and also, if appropriate, future pacing, with patients seeing themselves at the end of the treatment programme, their recovery complete.

Case 5

Mr B., aged 37 and receiving chemotherapy for Hodgkins lymphoma, developed panic attacks on entry to the chemotherapy unit. He experienced catastrophic thoughts concerning his ability to cope and 'survive' the procedure. He used self-hypnosis with positive self-talk and images of himself having successfully completed his treatment.

The experience of chemotherapy itself

For many patients, having to undergo chemotherapy, even if they are not needle phobic, can bring problems such as those mentioned above. These patients tend to catastrophize about their ability to cope. Standard cognitive-behavioural techniques, such as rehearsal and exposure with hypnosis as an adjunct can normally be effective.

However, there are patients who find the *sensations* produced by the chemotherapy agents travelling along a vein and circulating through the vascular system so discomforting and distressing that they may stop attending, or certainly find excuses to avoid treatment.

Case 6

Mrs R., a lady with non-Hodgkins lymphoma, was referred as she had refused two treatment sessions. She cancelled both at the last minute, causing irritation to the chemotherapy department staff as her medication had already been drawn up in

anticipation. As her prognosis was potentially very good, there was concern also for her future well-being. She reported that she could not stand the 'itching, burning, creeping feeling' of the agent once it entered her vein. It made her feel like 'getting up and running'. Hypnosis was used to help her alter the sensations to a 'warm, comfortable pink glowing feeling flowing round the body'. She also used relaxation during the procedure.

Beliefs about chemotherapy

Relating to the points just made, it is always important to investigate a patient's beliefs about what chemotherapy does and how it works. For example, I recently saw a woman receiving aggressive chemotherapy who was very anxious about being sick, despite receiving good medical and psychological help. Her worries centred on her belief that if she was sick, she would vomit up her chemotherapy drugs and stop them working. In this instance, she was given appropriate information on how chemotherapy operated in her body, and why it would not be affected by any vomiting was enough to alleviate her anxieties. However, for another patient, Case 7, a hypnotic approach was adopted.

Case 7

Mrs V., a 36-year-old woman, was undergoing chemotherapy for Hodgkin's Disease. She was terrified of chemotherapy, but could not identify any reasons for her fear. Even being asked to picture having chemotherapy, and then to focus on what thoughts or images were 'going through her mind' revealed nothing. She could not identify any relevant thoughts or images. She was a good hypnotic subject, which enabled her to put 'undergoing chemotherapy' on an imaginary television screen. Picturing the process of chemotherapy, she discovered that she viewed it as an 'evil, destructive monster', which she believed would kill her. Having recognized this, she was then able to go on and challenge her thinking and generate new, more positive imagery.

COMMENT

Patients often produce vivid imagery of their chemotherapy, which can potentially enhance its discomfort and distress. There is often a frighteningly destructive element to these images, as with Case 7, and one can only speculate on their possible harmful effects. On the other hand, as with Case 6, imagery can be manipulated to alter the experience, permitting the experience to be more comfortable. Imagery is not, of course, a phenomenon linked exclusively to hypnosis. It is something that most individuals routinely enjoy as part of their 'inner experience'. Many therapists, who do not employ hypnosis as such, *do* work with relaxation and guided imagery techniques. Within a hypnotic context, however, it does seem to take on a more vivid and 'realistic' quality, which often enhances its 'power' as experienced by the patient. Again with reference to Case 6, the manipulation of imagery within a hypnotic context would certainly seem to have improved her experience of chemotherapy.

The effects of imagery on health, both in and out of formal hypnosis, remain unproven; although many, such as Simonton (Simonton, Matthews-Simonton & Chrighton, 1978), emphasize the importance of healing visualization, it has not been submitted to satisfactory scientific testing. Indeed, Simonton and others have been criticized for making excessive, exaggerated and unscientific claims for visualization, which have caused many cancer sufferers much distress and guilt, believing that when

these techniques do not work it is their fault. However, it can still be argued that anything that can help a patient to *feel* better, can only be beneficial. In addition, controlling and using imagery as in Case 6 above can facilitate a sense of control and self-efficacy in patients who, when diagnosed and being treated for cancer, often feel disenpowered and helpless, and in the control of the medical profession and the disease itself.

DISCUSSION

Spiegel (1993) and Ratcliffe, Dawson and Walker (1995) have commented that there may be some support for the hypothesis that teaching patients to use self-hypnosis may have a positive effect on survival. However, unlike approaches based on 'healing power of visualization', which have caused many cancer sufferers much distress and guilt through their belief that when these techniques do not work that it is their fault, self-hypnosis does not place a heavy burden of responsibility on the patient as they are not put under pressure. Certainly research in the area of psychoneuroimmunology, (e.g., Walker, 1997; Walker, Johnson & Eremin,1993) does suggest that the immune system is affected by stress and relaxation, so it may be that the interventions described above are doing more than just helping the patient get through their treatment.

Whilst it is all very well to treat the problems that arise in chemotherapy, how much better it would be if they could be prevented by appropriate prophylactic psychological interventions to reduce treatment trauma and psychopathology. Though Walker, Lolley, Dawson and Ratcliffe (1991) make the point that such interventions as 'Nausea Management Training' are not useful *unless* the patient has experienced side effects, they do emphasize the importance of good information and preparation as a feature of prevention. One cannot help but consider how many of the problems described above, with the possible exception of needle phobia, could have been prevented, the patients consequently spared distress and the number of sessions needed to help them drastically reduced.

Whilst the primary goal in the treatment of cancer is to ensure that patients get whatever treatment can be given to save life, and more than that, to prolong good quality of life, it is clearly important in doing this to take into consideration a patient's psychological adjustment to their illness, its treatment and their coping strategies. In helping patients to deal with the problems described above, and others not within the scope of this paper, one is not only facilitating well-being during treatment, but enhancing a patient's sense of control and self-efficacy.

Hopefully, with growing awareness of all these issues, psychological care from the moment a patient presents — even before the diagnosis is made — will eventually become as routine as a blood test with the focus on prevention rather than on cure.

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