

Hypnosis and Existential Psychotherapy with End-Stage Terminally Ill Patients

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Existential Psychological Theory was employed as a conceptual and theoretical foundation for the use of hypnotically facilitated therapy in the management of intractable pain, nausea, and vomiting in 3 end-stage, terminally ill cancer patients. The existential principles of death anxiety, existential isolation, and existential meaninglessness were addressed with a combination of classic and Ericksonian techniques. The intractable nature of the presenting physical symptoms was conceptualized as a possible manifestation of the impact of the terminal prognosis. Direct hypnotic suggestions for the management of pain, nausea and vomiting were avoided. It was hypothesized that, as the existential conflicts associated with the patients' terminal status resolved, the physiological symptoms would become responsive to medication. After 6 sessions grounded in the principles of Existential Psychotherapy, the intractable status of the physical symptomatology remitted, and the patients responded to medical management. This paper addresses the usefulness of Existential Psychotherapy in hypnotic interventions for mediating somatic and psychosomatic symptomatology.

Keywords: End-stage, existential, hypnosis, terminally ill, palliative care, psycho-oncology

Introduction

The Psycho-Oncology Perspective

There are many possible uses of hypnosis with patients who are terminally ill with cancer. The psycho-oncology perspective includes work that affects both life extension and improvement in the quality of life (QOL). Hypnosis with the terminally ill has been useful in facilitating internal changes within certain patients who recover completely or who experience desirable life extension (Greer, 1992; LeShan, 1989; Sheikh, 1983, 1986; Simonton, Matthews-Simonton & Creighton, 1978; Spiegel, Bloom & Yalom, 1981), as well as with work that fosters psychological development and spiritual growth (Frederick, 1997, 1998). There are reports of its having been involved in the modification of the disease process itself (Olness, 1980; Rossi, 1986).

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Hypnosis and the End-Stage Population

The role of hypnosis in the care of the physical and emotional needs of end-stage terminally ill cancer patients, individuals who are very close to death's door, has also been addressed in the literature (Newton, 1982-1983a, 1982-1983b; Margolis, 1982-1983; Sacerdote, 1968). A major application of hypnosis with this most needy population has been the management of pain (Willard, 1974; Sacerdote, 1962, 1968; Harper, 1999). Another significant focus has been the management of untoward side effects of chemotherapy and radiation: nausea and vomiting (Hoffman, 1983; Redd, Rosenberger, & Hendler, 1983; Cangelo, 1962; Redd, Anderson, & Minagawa, 1982; Lyles, Burish, Knozely, & Oldham, 1982). Additional studies have addressed the use of hypnosis with distressing psychological features associated with end-stage cancer such as depression and anxiety (Carcappa, 1963; Harper, 1999; Kaye, 1984). These can be outgrowths of the patient's need to complete some real life task or resolve some interpersonal difficulty (Kubler-Ross, 1969) before he/she can die.

Existential Psychological Theory and Existential Psychotherapy

Existential Psychological Theory and Existential Psychotherapy have not been directly cited in the literature of hypnosis with the terminally ill; however, several authors have reported efficacious results when the focus of hypnotherapy has centered on principles of Existential Psychological Theory. Levitan (1985) developed a hypnotic procedure called "hypnotic death rehearsal" that was designed to address and resolve the sequelae attributable to the existential principle of death anxiety. Rosenberg (1983) employed revivification of past accomplishments in the lives of terminally ill cancer patients as a vehicle with which to approach and resolve the existential sense of meaninglessness. Kaye (1984) demonstrated the value of using hypnosis and family therapy to effectively deal with existential isolation in a cancer patient.

Care of the Dying

The majority of Americans do not die in their own homes as envisioned in hospice philosophy (Craven & Wald, 1976). Instead, they die in hospitals. Unfortunately, dying in these highly technological institutions requires having to deal with endemic shortcomings in the end-of-life care that they provide. Pantilat (2002) pointed out that too often patients die alone and in pain, with their concerns and fears unattended by physicians. Moreover, advances in medicine and medical technology have had a marked impact on the process of dying. Lamentably, as Feifel (1977) reminds us, the prolongation of dying has also exacerbated the problems of loss of personal dignity and the stripping of empowerment for the dying patient. It has compounded pain, depression, dehumanization, and the loss of self-esteem. This brings to the forefront the urgent need for physicians to be able to recognize and address suffering in the dying.

Cassell (1999), in an examination of the issue of suffering in the terminally ill, admonished physicians to recognize that suffering is subjective and involves personal definitions of symptoms. Even if two patients have the same symptoms, their suffering can be expected to be different. Further, the complex methods and technologies employed to make diagnoses are aimed at the body rather than the person (Cassell, 1999). This is unfortunate because we realize more and more that dying is not just a biological process. Death is characterized by psychosocial (Feifel, 1959, 1977), interpersonal and intrapsychic

(Kubler-Ross, 1969), and developmental and spiritual (Frederick, 1997, 1998) dimensions.

Feifel's (1977) perspective is reassuring. He believes that as dying patients' emotional needs are met, untapped potentials for responsible behaviors are uncovered. This allows these patients to become less depressed, to feel that they are more in control and less inadequate. Spiegel, Bloom, and Yalom (1981) provided empirical evidence supportive of Feifel's (1977) prognostications regarding the benefits of meeting the emotional needs of the terminally ill. Their study of the effects of group support for terminally ill cancer patients demonstrated benefits in patients' self-esteem, mood and affect, overall efficacy of coping capacities and enhancement of the patients' quality of life.

The Emergence of Palliative Care Philosophy

The palliative care philosophy originated as an effort to address suffering in the terminally ill. Aulbert (1998) defined palliative care as the active total care of patients whose disease is not (or has ceased to be) responsive to curative treatment. He broadened the definition of palliative care to encompass the total care of the patient including body, mind, and spirit. The primary function of palliative care is the prevention and control of distressing symptoms. Aulbert (1998) asserted that emancipating dying patients from pain and suffering is the foremost treatment objective because it allows these patients to live their remaining time as fully as possible.

Pain in End-stage Patients

The occurrence of significant pain in the terminally ill is surprisingly frequent and encountered in more than one in three cases of cancer at the time of diagnosis and in two of three cases in advanced stages of cancer, and still significant in more than one of every four cases at or near the time of death (Cleeland, Gonin, Hatfield, Edmonson, Blum, Stewart, & Pandya, 1994). Pain is inadequately treated in these patients despite published guidelines for pain management (Cleeland et al., 1994). Mortimer and Bartlett (1997) discovered that only 5% of medical school trainees were able to calculate correctly the conversion of a parenteral dose of morphine to an equivalent dose of a controlled-release preparation. Most of the trainees were also unfamiliar with the palliative benefits of radiation therapy. Similarly (Doyle, 1997; Foley, 1997; Levy, 1996), physicians themselves have attested to their lack of confidence and competence in most aspects of palliative care. This is also true of German (Aulbert, 1988), Japanese (Takeda & Uki, 1994), French (Larue, Colleau, Fontaine, & Brasseur, 1995), and Norwegian physicians (Skauge, Borchgrevink, & Kaasa, 1996). Ruddick (1997) made it clear that the proposed objective of the philosophy of palliative care is not being met. The solution (Cassell, 1999) is adequate training geared towards humanizing the physicians and helping them acquire empathic attentiveness and active listening skills.

This article addresses the effectiveness of a humanized, hypnotically facilitated Existential Psychotherapy approach on the mediation of somatic and psychosomatic symptomatology in three terminally ill cancer patients.

Existential Psychological Theory

Existential Psychological Theory has its seeds in the philosophical movement called Existentialism, which originated in continental Europe circa the era between the

two World Wars. Ideologically, Existentialism became a conceptual and philosophically vigorous and passionate attack against the classic views and main objectives of Western philosophy (Barrett, 1964; Benda, 1960). Existentialism directed its focus away from the essence of things, which at one time was the exclusive direction of philosophy, into the individual existence of humans. Existentialism opposed and attacked the rationalism of Kant, Newtonian precepts, and launched an assault on scientism that treated the individual as a mere cog in a wheel of cause and effect (Roubiczek, 1966).

The movement sprang up in different parts of Europe and among different schools of thought (May, 1958). One of its vital roots was a school of philosophy known as Phenomenology and defined by Husserl as an approach that “bracketed” reality and took into account only the *phenomena* (McCormick & Elliston, 1981).

The Existential movement took on comprehensive dimensions and became manifest in literature, theater, art, and in general, all forms of cultural expression such as Kafka’s (1957/1946) *The Trial* and Camus’ (1946/1988) *The Stranger*. Camus’ protagonist left his position of depersonalization and meaninglessness to become completely alive for the first time on the morning of his scheduled execution. Existential philosophy has influenced numerous psychotherapists who became enamored with the perspective that humans are the architects of their existence.

Perhaps the earliest treatise on Existential Psychotherapy was Sartre’s (1956/1943, 1962) *Existential Psychoanalysis* in which freedom is conceptualized as the quintessential element of human nature:

Human freedom precedes essence in man and makes it possible; the essence of the human being is suspended in its freedom. What we call freedom is impossible to distinguish from the being of “human reality” (p. 25).

In more recent times, the theorists and authors Laing, (1965, 1983), Strauss (1958), and May (1958, 1967, 1969a, 1969b, 1972, 1977) have been associated with Existential Psychological Theory and psychotherapy.

The monumental distinction between Existential Psychological Theory and other theoretical orientations is the assumption that one is free to choose his/her own attitude towards life (Tillich, 1952; Binswanger, 1956; May, 1958). The individual has the inherent freedom to choose and create his/her own existence and to structure his/her destiny and his/her reaction to life’s predicaments, including his/her own death. What matters, according to Frankl (1988), is that one is free to shape one’s own character and is responsible for the stand one takes towards the circumstances his/her life offers. The capacity to take such stand is what makes us human.

Existentialism and Death

The principle of death is central to the understanding of man, and the existentialist position states that life and death are interdependent; they exist simultaneously and not consecutively. Yalom (1980) further adds “death whirls continuously beneath the membrane of life and exerts a vast influence upon experience and conduct”(p.29). Death, in the existentialist tradition, is considered a primordial source of anxiety and, as such, is the primary fount of psychopathology (Yalom, 1980). Death is inextricably a part of life, and, according to the existentialist writers, it must be

acknowledged and addressed in therapy. Otherwise it erects psychological defenses (Frankl, 1988; Bugental, 1965; Moustakas, 1961). Death, when properly confronted, can alter a patient's life perspective and promote a truly authentic immersion in life (Kafka, 1956/1943).

The opposite premise states that, to the degree that the prospect of death is denied and repressed, the satisfaction that life has to offer is diminished and death anxiety develops and permeates the individual (Becker, 1973). Death anxiety can then manifest psychosomatically and through other behavioral presentations. The existentialist position states that the reality and inevitability of death must be confronted, especially in the dying patient, and that a multiplicity of the psychological and medical challenges that these patients face are a product of repressed anxiety related to their imminent mortality (Yalom, 1980).

Existential Psychological Theory places great importance on the unequivocal truism that man is inexorably alone. Existential isolation and aloneness refers to an unbridgeable gulf between oneself and any other being. A confrontation with one's death and finiteness will inevitably lead to existential isolation as it promotes awareness that no one can die with one or for one. Heidegger (1962) stated that no one could take the other's death away from him. Dying, at its most fundamental level, is the loneliest human experience and as such it can be expected to engender, in the terminally ill, a profound sense of existential isolation and aloneness. Left unchallenged, existential isolation can repress and produce a host of psychosomatic traits (Sharby, 1975).

Meaninglessness is also a pivotal principle in existential theory and is associated with playing a crucial role in the etiology of neurosis. Wolman (1975) defines existential neurosis as failure to find meaning in life, the feeling that one has nothing to live for, nothing to struggle for, and nothing to hope for. To find oneself without meaning leads to considerable distress; in its severe form it may lead to suicide. The Nazi concentration camp literature has indicated that inmates devoid of a sense of meaning were unlikely to survive (Frankl, 1963; Bettelheim, 1979). The role of meaning and its importance in survival was demonstrated in a study of inmates of a communist concentration camp (Iglesias, 1984). In this study, inmates were found to have survived unimaginable tortures and indignities by ascribing meaning to their suffering.

The Fear of Death and Defenses Against the Fear of Death

Herman Feifel (1959, 1977), posited that fear of death itself can assume many disguises and hide in multiple behaviors not ordinarily associated or usually associated with it. He included insomnia, differing psychosomatic symptoms, and even certain aspects of psychotic processes as pathological presentations of death anxiety (Feifel, 1977). Psychotic defenses magically "hold back" or "undo" the possibility of death. The defensive posture of denial has also been associated with maladaptive, total denial of physical illness or disease process (Strauss, Spitzer, & Muskin, 1990); with non-compliance in late stage cancer patients (Kunkel, Woods, Rodgers, & Myers, 1997); and with total denial of diagnosis or implications of cancer (Greer, 1992). This type of presentation is apparently not infrequent, and consequently a cadre of diagnosticians is lobbying to have the diagnosis of Maladaptive Denial of Physical Illness included in the DSM-IV (American Psychiatric Association, 1994) as a subtype of Adjustment Disorder (Strauss, Spitzer, & Muskin, 1990; Muskin, Feldhammer, Gelfand, & Strauss, 1998).

Davidhizar, Poole, Giger, and Henderson (1998) and Kreitler (1999) have urged caution to clinicians dealing with terminal patients who employ denial and other complicated mechanisms of defense. They stress the importance of carefully evaluating the possibility of secondary gain from these complicated, pathological defense systems (Schoen, 1993).

Clinical Case Material

Methods Used

Work with three patients with end-stage cancer who were referred for hypnotherapy for the relief of intractable pain, nausea and vomiting is presented here. Existential Psychological Theory was utilized as a conceptual base and included the existential principles of death anxiety, existential isolation, and existential meaninglessness. There were no direct attempts to address the physical symptoms of pain, nausea, and vomiting, as these were hypothesized to serve a defensive psychological function including the purpose of obscuring the reality of the terminal status. This working hypothesis was supported by the theoretical work of Feifel (1959, 1977).

Hypnotic approaches with the three cases presented consisted of mixtures of classic inductions, classic hypnotic suggestions, and indirect Ericksonian methods (Zeig, 1980), including metaphorical stories directed at resolving existential death anxiety (Harper, 1999). Re-framing techniques (Hammond, 1990) were used to address existential meaninglessness. Life review strategies, by regression with revivification (Greenleaf, 1969; Erickson & Rossi, 1979) were also employed to address existential meaninglessness by reviewing and reliving successes in these patients' lives. Time progression strategies (Rosen, 1985) allowed the patients to have glimpses of their perpetual influence on their families. Existential aloneness and isolation were addressed by means of hypnotic hints, indirect cues, and by an adaptation of the "my-friend-John" approach (Bakal, 1981) for continued communality and connectedness with significant others. Hypnosis was induced, in all three cases by a classic eye fixation technique followed by the elevator technique for deepening (Crasilneck & Hall, 1985).

Clinical Case I

The patient, age 70, was in the terminal stage of prostate cancer with bone metastases and suffered from intractable pain. He had been referred by hospice for a trial of hypnotherapy because he was virtually unresponsive to prescribed pain management narcotics. His pain levels were consistently in the very high to excruciating range. Efforts to increase the levels of the narcotics produced a comatose-like effect.

This patient had had an illustrious career as a CEO of several companies and as a presidential consultant. His life had been focused on business, wealth, politics, and success. He had devoted his life to his career at the expense of his family. He was estranged from his three sons. He did not have friends, only associates. Now that he was ill and unable to work he was forgotten and alone.

The patient's psychological treatment was theoretically based on principles of Existential Psychotherapy. The lack of responsiveness to pain medication was conceptualized as an unconscious reaction to his terminal status. The lack of the ordinary resource of closeness to his family now haunted him and magnified his existential

aloneness. Moreover, it created fears associated with death. His life-long source of meaning, his career, was no longer viable, and he found himself in a state of existential meaninglessness.

Our hypnotic work included indirect methods that addressed his need to forgive himself for his perceived failures with his sons. Since there were three grandsons, the prospect of redeeming himself through involvement with these boys was considered. With that goal in mind, the following metaphorical insinuation was made: "Life sometimes offers second chances."

Meaninglessness was addressed with metaphorical, indirect efforts, and hypnotic hints that shed light on the importance, value, and meaning of mentoring his grandchildren. The intractable pain was not addressed directly. It was hypothesized that the pain picture would improve as the existential challenges resolved. After five home visits, this patient's medical pain management regimen became effective and complaints of pain diminished. The patient sought the company of his grandchildren and became their after school sitter. During the last six months of his life, he devoted his afternoons to teaching his grandchildren "valuable lessons that they will need to succeed in life." At follow-up, in his last week of life, he asked the following rhetorical question: "Why did I have to be dying to learn how to live?"

Clinical Case II

A retired airline pilot, diagnosed with carcinoma of the liver, was given a terminal prognosis of less than six months. The hospice staff recognized his intransigent insistence that he was going to "beat this illness" as denial. He complained of intractable abdominal pain that was unresponsive to narcotics. As the dosages were increased, the patient retreated into an unconscious, vegetative state. The intractable pain was conceptualized as an unconscious effort to hang on to life (Ewin, 1980) and the pain became a tether to which he clung tenaciously. As long as he experienced pain, he was alive and could compel his physicians to treat him aggressively. He assuaged his existential death anxiety by obsessing over the medical treatments, denying the prognosis, and deluding himself that the cancer was remitting. Ewin (1980) has contributed towards the understanding, manifestation, and the functional nature of this pain syndrome that has been coined "Constant Pain Syndrome."

The patient, referred by hospice for psychological care, was treated with hypnotically facilitated psychotherapy. This included dissociation that was produced by imagery of his flying to remote places. It was suggested that as he flew further and further away, all suffering would diminish. No other suggestions of pain reduction were provided. Time distortion was provided to create the experience that his flying excursions could last an eternity and could provide him with respite from all his anxieties and fears. A life review, conducted while he was in hypnotic age regression (with accompanying revivification), was provided for the purpose of helping him to acknowledge his successes and accomplishments. It also served as a vehicle for him to attribute significance and meaningfulness to his life. He was seen at home for six visits during a two-month period. His intractable pain rapidly responded to minimum dosages of pain medications. He attributed the flying jaunts with somehow providing him with relief from all symptoms. He died a peaceful death free of pain and fears.

Clinical Case III

A young family man, diagnosed with an aggressive pancreatic carcinoma was given a terminal prognosis of two months or less and was referred to hospice. His behavior towards hospice staff immediately turned combative, threatening, and violent. He refused to address the reality of his condition and prognosis and overcompensated by giving the impression that he was untouched by the ominous and inevitable course of his illness. The medical staff diagnosed the reaction as a recalcitrant form of denial and was literally unable to treat him.

The patient's presentation within the privacy of his home was dramatically different. He was depressed, despondent, and in total despair. His wife confided to the hospice staff that he was stockpiling medications to commit suicide. He was free of pain but suffered from intractable, chronic, and debilitating nausea and vomiting: vestiges of the aggressive chemotherapy regimen that had obviously been unsuccessful. Intractable nausea is also a primary symptom of this cancer and is often recalcitrant to pharmacologic approaches. This patient accepted hypnosis and therapy on the condition that all direct references to death be avoided. He asked for assistance in managing the nausea and vomiting.

The patient's violent behavior was conceptualized as a manifestation of existential death anxiety. The sudden, aggressive and fulminating impact of the carcinoma had rendered him incapable of continuing his responsibilities as father to his daughters. This deprived him of a profound source of meaning and significance. The defensive stance he adopted was furthering his existential aloneness as he either presented a facade of immutable steel, which was followed by violent and explosive tirades and outbursts. His presentation at home alienated the members of his family by an impenetrable depressive stupor, which furthered his existential aloneness.

Hypnotherapy involved a dissociative technique with his retreating into a healing place, a sanctuary where the healing of troubling, challenging, and upsetting concerns could be achieved. An allegorical story was narrated of a parent, who was away on an indefinite trip and was granted a wish to see his children grow up. The man was away from home indefinitely but was given the means to project ahead in time and witness his family's milestones. Attention was focused on how much the children resembled their father and how it seemed that, although away, his presence and influence were significantly reflected in his kids. He was told that being able to project ahead in time reassured the man, comforted him, and provided him with a sense of peace and tranquility.

Hypnotically visualizing the imaginal products of his influence gave the patient's life meaning. He was seen in his home for a total of six sessions. No direct references to nausea and vomiting were made; however, these symptoms became responsive to medications. The violent and combative behaviors dissipated, and the private depressive stupor accompanied by suicidal ideations resolved. He was seen for follow-up 3 weeks before his death and was observed to be involved with his family. He died quietly and peacefully in his home.

Discussion

Standard medical practice is insufficiently equipped to address the complex psychological factors inherent in the care of the terminally ill patient (Margolis, 1982-1983). Under such circumstances, hypnotic intervention, with its legacy of intimate,

individualized, and personal applications of care, can address the myriad of tormenting and anguishing complaints faced by these patients. Both pain and the side effects of medical treatments become part of a life that many dying patients refer to as purgatory. Hypnosis can help alleviate these symptoms and offer these patients some dignity in the final stage of life. Hypnotic approaches emphasizing dissociative techniques, pain management strategies, and methods for alleviating the side effects of chemotherapy have been found efficacious in alleviating suffering in the terminally ill (Genuis, 1995). Levitan (1992) has also documented the value of hypnotic approaches in the management of pain and symptom control (nausea, anticipatory emesis, learned food aversions and adverse treatment effects) in the dying patient

However, standardized symptom relief with hypnosis is not sufficient to meet these patients' needs (Margolis, 1982-1983). Terminally ill patients must often overcome phenomenological challenges if they are to live out their final days and die with dignity. Their being-in-the-world may be expressed through the symptoms of pain, nausea, vomiting, and so forth. Existential Psychotherapy offers a beacon that illuminates their path to surmounting the challenges of existential meaninglessness, existential isolation and existential death anxiety. Hypnosis can elegantly and powerfully facilitate Existential Psychotherapy to help patients meet these challenges by directly helping patients live meaningfully and as fully as possible until the end. The patients described experienced dramatic alleviation of pain, nausea, and vomiting when treated with hypnotically facilitated Existential Psychotherapy.

As a rule of thumb in all case studies, it is incumbent to recognize their limitations. It must be acknowledged that unknown and unidentified anatomical and physiologic changes within the patient could possibly have reflected themselves in an alleviation of the pain, nausea, and vomiting had there been no therapeutic interventions. It also is possible that there were therapeutic roles inherent in the collateral methods above and beyond the primary foci of treatment. For instance, how important a role did teaching the patients dissociative methods play and to what degree were the obtained results influenced by these strategies? These methods acted to remove the individual from the immediate perception of the symptom by movement through some other conceptual and experiential dimension such as time and space. One patient's self-attribution of benefit to his "flying jaunts" offered support for this interpretation.

Another element and possible contributory agent of change in the three cases herein presented, may have been transference factors and the need of some dying patients to have a "witness" to the value of their lives before they can let go (Frederick, personal communication). Were these patients more treatable because of the power of the transference to the author? Or was the healing influence of the ego-strengthening features inherent in the compassionate and empathic efforts employed (Frederick & McNeal, 1993) significant? The hypnosis and Existential Psychotherapies described here were probably helpful on a number of levels. The question of efficacy for the combination described here awaits controlled studies. It may be that such studies will be difficult, perhaps essentially impossible, for compassionate, empathic caregivers to conduct.

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