

A Method for using Hypnotism with Persons Living with Cancer

Examination for Fellow of the National Guild of Hypnotists

The Rev. C. Scot Giles, D.Min.
Board Certified Chaplain, Association of Professional Chaplains
Board Certified Hypnotist, Certified Instructor, National Guild of Hypnotists
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Introduction

This essay is an overview of the model of Complementary Medical Hypnotism I employ in my professional work. As I have come to be well-known as a hospital and medically-based practitioner I frequently receive requests for information about my work, especially research findings that support it. This essay submitted for my Fellow examination in the National Guild of Hypnotists contains that information, and I hope the Guild will feel free to distribute it..

The specific hypnotic techniques I employ are described in the official certification curriculum for medical hypnotism that I wrote for the National Guild of Hypnotists. This curriculum has been revised several times in the light of new research and I plan to keep it current. This essay is a more personal account of the assumptions that lie behind this curriculum and a further elaboration of how I use these methods in practical hypnotic work and the overall theory that guides the hypnotism. While I see many clients in individual sessions each week, much of my work is done in a group setting. This essay explains the design of my group programs and shares the outcomes data for the program based at La Grange Memorial Hospital since 1991. This program is called I Can Act Now (ICAN) and was the first medically approved, hospital based program in American for the hypnotic treatment of cancer.¹

My private medical hypnotism work is based on a model similar to the one described here, although the design of a private session is necessarily different from the design of a group program. I also offer several free clinics for cancer patients. These clinics use the format described in this essay, although they are larger groups with an attendance of twenty-five participants each, and meet monthly.

Much of my approach is rooted in the thinking of Bernie Siegel, MD. This approach is often called the Exceptional Cancer Patients Model. While Dr. Siegel does not practice hypnotism, his philosophical approach colors my own thinking.

In the early 1980s, when I was struggling with a life-changing medical condition, Dr. Siegel's thinking was the key to my own recovery. I suffer from an inherited cardio-vascular condition and I have a relatively severe case of it. Two decades ago the medication I needed to take for this condition began to cause debilitating cluster migraine headaches. My own physicians could find no alternative, but in his 1978 best selling book, Love, Medicine and Miracles, Dr. Siegel had suggested that it might be possible to use the power of the mind to enhance the effect of medication

¹ A copy of the brochure used to hold this program out to the public is attached to this essay as an appendix.

so that less would be needed. I corresponded with him and he encouraged me to try the technique, which has since come to be known as “hypnotic medication potentiation” in the Guild Medical Curriculum. Using self-hypnosis I was able to increase my body’s utilization of the necessary drug so that I achieved the same effect I had received, but from a lower dose. This reduction in dosage was sufficient to drop below the threshold that triggered the headaches.

Encouraged by this success, and having already been trained in hypnotism, I began to look for other opportunities to use the hypnotic arts and sciences to enhance healing. I was a parish minister at the time, and nine women in my congregation with breast cancer came to me to ask if I would help them with the side-effects of their treatment. All their physicians approved and I did the work, very much making the techniques up as I went along. All nine did much better than anyone expected them to do, and the physicians wanted to send other patients. In time Counseling Ministries, Incorporated, a Chicago-area group practice in pastoral care and counseling, learned of my work and invited me to join and practice medical hypnotism on a full-time basis.

The Origins of the ECaP Model

The Exceptional Cancer Patient's model of interpersonal helping, usually referred to by the acronym "ECaP," was developed by Bernie Siegel, M.D., in 1978. Since then ECaP has grown into an integrated model of psycho-social intervention that until recently was overseen by a national nonprofit organization with headquarters on the campus of Yale University. ECaP maintained a Health Professionals Training Program for practitioners of various disciplines, and sponsored on-going workshops on themes relevant to the model. The training program was international in scope, and practitioners from all over the world were trained, including me.

The development of the ECaP model cannot be separated from the idiosyncratic personality of the man who created it and who has acted as its primary advocate for the past 25 years. Dr. Siegel is a charismatic individual who often expresses his opinions with the stridency of total conviction. It can be argued that this style has not helped the ECaP model gain acceptance by the wider medical community. However, similar personality features can be readily found in the biographies of the founders of most systems of psychotherapy or medicine. Such characteristics may be necessary to bring a new system of intervention into the mainstream. The ECaP model has withstood the test of time and is clearly a practical philosophy that has helped a great many people.

According to personal conversation, in the early 1970s Dr. Siegel, after more than a decade as a practicing surgeon, found himself in a melancholy state of mind with gradually deteriorating physical vitality. On New Years Day in 1974 he began a process of introspection which led him to conclude his dysthymia was caused by the emotional distance he was holding from his patients. While other physicians may surely react differently, Dr. Siegel found such distance robbed him of the joy he had formerly found in his profession. He tried to find ways to learn about his patients on a personal level.

After training in psychotherapy with a medical colleague, Dr. Siegel sent letters to hundreds of his patients. He proposed forming a group to explore the emotional side of cancer. His idea was to talk with patients who seemed to be "beating the odds" living with cancer, hoping to find common

psychological characteristics among them. Such commonalities were found. Additional work showed that these qualities could be learned. The ECaP model was designed to teach these characteristics to persons who are struggling with illness. Since the founding of the first ECaP group, Dr. Siegel has published several best-selling popular books of which Love, Medicine & Miracles,² and Peace, Love & Healing,³ are probably the best known.

The Structure my ECaP-oriented Program

As the program attracts patients to the hospital and produces referrals into the hospital system for medical care, hospitals were eager to host the program. After interviewing several hospitals, I decided to base my hospital clinic at La Grange Memorial Hospital in La Grange, Illinois. The program was initiated in 1990 and began work with cancer patients in 1991. It has met continuously since that time. The program is called ICAN, an acronym for “I Can Act Now.” While the ownership of the hospital has changed several times, the program remains affiliated with the Cancer Survivor’s Program of the University of Chicago Medical Center.

Helping people living with life changing illness in my program is done as group work. Participants are screened prior to entry into the group to insure a basic personal stability and to verify that they have sufficient comfort with the methodology of the program to be able to use it readily. While individuals can benefit from this sort of intervention at any stage in their illness, experience has taught that those who start soon after diagnosis have the best experience in a group setting. Consequently, the intake process screens to insure that group participants are well enough to participate in the process effectively. Individual work is recommended for patients in the advanced stages of their disease. Once admitted, participants may stay in the program for as long as they wish.

The ICAN group meets weekly, for two hours at a time. The group begins with an ordered “check-in” where an object is passed among the participants and when it comes to a participant it is that person’s time to speak. This method insures that all present will participate and helps prevent the tendency of those persons with the loudest voices or the strongest needs to dominate the group.

The group ends with a hypnotic experience lasting approximately thirty minutes. As part of this experience, participants are guided into a state of deep relaxation using techniques drawn from classical and Ericksonian hypnotism. Once relaxation is achieved, participants are invited to use their imagination to vividly create in their minds various images. These images are constructed by the hypnotist with the intent to elevate mood, to create mental distance from painful experiences and to mobilize whatever healing resources the patient may have under unconscious control.

Participants may obtain a recorded copy of the hypnotic work each week for home reinforcement. While this is discretionary, most participants have developed a regular discipline of auto-hypnosis using the recordings.

² Siegel, Bernie S., Love, Medicine & Miracles (Harper and Row, Publishers Inc., New York, 1986).

³ Siegel, Bernie S., Peace, Love & Healing (Harper and Row Publishers Inc., New York, 1989).

The meeting format provides time for group members to talk about their experiences and feelings. The group does celebrate, within limits, the recovery or improvement of one of its members, and mourns the passing of a member who dies.

Finally, participants engage in experiential activities intended to probe their feelings about their illness and related themes. These experiences are constructed so as to relate to the philosophical principles of the ECaP model, which are described below.

In the implementation of the ICAN program at LaGrange Memorial Hospital, we require the consent of a patient's physician before a person may enter the ICAN group. There are two reasons for this requirement.

First, medical referral before working with a medical condition using hypnotism is a requirement both of Illinois law and the Code of Ethics of the National Guild of Hypnotists.

Second, we wish to make clear to the patient what the order of precedence should be in the management of their care. Requiring physician consent for participation in the group reminds the patient to look to his or her chosen physician as the primary designated authority to oversee care. There is much published opinion suggesting a patient is poorly served if anything is allowed to affect the integrity of the physician-patient relationship.⁴ The current situation in health care generally requires a patient wishing ECaP-oriented help, or anything similar, to seek it outside of the physician-patient bond. We provide an alternative. We make such help available on physician recommendation, in exactly the same way a physician might choose to make physical therapy, or any other adjunctive service, available to a patient undergoing care.

The Goals of ICAN

The primary goal of ECaP-oriented care is to provide support and tools for self-improvement to patients with life-changing illness. When I began to do work with medical cases in the early 1980s, this was the only goal of the method. It was enough. However, in the years that have followed, a secondary goal has been added, as research strongly suggests that a system of supportive care and self-improvement does affect physical health. The mechanism for this is not understood, but empirical data demonstrate significant medical improvement in treatment groups over control groups.

The best such study is "Effect of Psychosocial Treatment on Survival of Patients with Metastatic Breast Cancer," by David Spiegel, H.C. Kraemer, J.R. Bloom and E. Gottheil, published in The Lancet in 1989.⁵ In this study patients with breast cancer were randomly divided into intervention

⁴ See in this context: Frank, Jerome D., Persuasion and Healing (Schocken Books, New York, 1974), pp. 136-151. Also see: Foster, Daniel W., "Religion and Medicine: The Physician's Perspective," in Marty, Martin and Vaux, Kenneth, editors, Health/Medicine and the Faith Traditions (Fortress Press, Philadelphia, 1982), pp. 245-270

⁵ Spiegel, D., Kraemer, H.C., Bloom, J.R., and Gottheil, E., "Effect of Psychosocial Treatment on Survival of Patients with Metastatic Breast Cancer," The Lancet 1989, II, 888-891.

and control groups. Both groups received appropriate medical care. The intervention group also received supportive psychotherapy, including hypnotic experiences.⁶ Participants were tracked for ten years. The results were startling: "the intervention group lived on average twice as long as did controls."⁷ The statistical analysis in this study is lengthy and persuasive. While many studies have suggested such an outcome, this particular study, funded by grants from the National Cancer Institute and the American Cancer Research Fund, was conducted with an exceptional degree of rigor.

The published abstract for this study that appears in its heading is as follows:

The effect of psychosocial intervention on time of survival of 86 patients with metastatic breast cancer was studied prospectively. The 1-year intervention consisted of weekly supportive group therapy with self-hypnosis for pain. Both the treatment (n = 50) and control groups (n = 36) had routine oncological care. At 10-year follow-up, only 3 of the patients were alive, and death records were obtained for the other 83. Survival from time of randomisation and onset of intervention was a mean 36.6 (SD 37.6) months in the intervention group compared with 18.9 (10.8) months in the control group, a significant difference. Survival plots indicated that divergence in survival began at 20 months after entry, or 8 months after intervention ended.

A mind-body connection of this sort has been suspected for many years. In 1988, Ernest Rossi, Ph.D., and David Cheek, M.D., published an authoritative volume detailing the results of their work in psychosomatic theory.⁸ Rossi and Cheek hypothesize a direct connection between psychological states and specific illness. Their hypothesis is that "information substances" in the body, such as neuropeptides, hormones, and immunotransmitters, are generated by characteristic thought processes. These substances are believed to travel to specific organs and nodal areas of the central nervous system, causing somatic change. Rossi and Cheek stop short of proposing that psychological conflicts cause physical illness, but do propose that the resolution of those conflicts facilitates healing. A similar theory is advanced by Spiegel, Bloom, Kraemer and Gottheil.⁹

There has been a recent challenge to the claim the hypnotic and supportive intervention with persons living with cancer affects survival. In a recent study published in the New England Journal of Medicine¹⁰, Pamela J. Goodwin, M.D., argues on the basis of a comprehensive metastudy that

⁶ The intervention group used self-hypnosis techniques designed by David Spiegel, M.D., which differ in method from the techniques usually employed in an ECaP-oriented program. The ICAN program at LaGrange Memorial Hospital uses both guided imagery and the hypnotic techniques used by the intervention group in the 1989 Lancet study.

⁷ *Ibid.*, p. 889.

⁸ Ernest L., and Cheek, David B., Mind-Body Therapy (W.W. Norton & Company, New York, 1988).

⁹ Spiegel, Bloom, Kraemer and Gottheil, "Effect of Psychosocial Treatment on Survival of Patients with Metastatic Breast Cancer," The Lancet, p. 891.

¹⁰ Goodwin, M.D., Pamela J., Molynd Leszcz, M.D., Marguerite Ennis, Ph.D., Jan Koopmans, M.S.W., Leslie Vincent, R.N., Helaine Guther, M.S.W., Elaine Drysdale, M.D., Marilyn Hundley, Ph.D., Harvey M. Chochinov, M.D., Ph.D., Margaret Navarro, M.D., Michael Speca, Psy.D., Julia Masterson, M.D., Liz Dohan, M.S.W., Rami Sela, Ph.D., Barbara Warren, R.N., M.S.N., Alexander Paterson, M.D., Kathleen I. Pritchard, M.D., Andrew Arnold, M.B., B.S., Richard Doll, M.S.W., Susan E. O'Reilly, M.D., Gail Quirt, R.N., B.A.A., Nicky Hood, R.N., and Jonathan Hunter,

there is no evidence the psychosocial interventions increase survival in cancer patients. While quality of life does improve with participation in a support groups, there is no change in actual survival. This study has been widely reported as a refutation of the conclusion of Dr. Spiegel that such work would have a positive effect on survival. As stated in the study abstract:

Background Supportive–expressive group therapy has been reported to prolong survival among women with metastatic breast cancer. However, in recent studies, various psychosocial interventions have not prolonged survival.

Methods In a multicenter trial, we randomly assigned 235 women with metastatic breast cancer who were expected to survive at least three months in a 2:1 ratio to an intervention group that participated in weekly supportive–expressive group therapy (158 women) or to a control group that received no such intervention (77 women). All the women received educational materials and any medical or psychosocial care that was deemed necessary. The primary outcome was survival; psychosocial function was assessed by self-reported questionnaires.

Results Women assigned to supportive–expressive therapy had greater improvement in psychological symptoms and reported less pain ($P=0.04$) than women in the control group. A significant interaction of treatment–group assignment with base-line psychological score was found ($P\leq 0.003$ for the comparison of mood variables; $P=0.04$ for the comparison of pain); women who were more distressed benefited, whereas those who were less distressed did not. The psychological intervention did not prolong survival (median survival, 17.9 months in the intervention group and 17.6 months in the control group; hazard ratio for death according to the univariate analysis, 1.06 [95 percent confidence interval, 0.78 to 1.45]; hazard ratio according to the multivariate analysis, 1.23 [95 percent confidence interval, 0.88 to 1.72]).

Conclusions Supportive–expressive group therapy does not prolong survival in women with metastatic breast cancer. It improves mood and the perception of pain, particularly in women who are initially more distressed.

Mt. Sinai Hospital states the following about this study on its website:

There have been several randomized and non-randomized studies of the survival effects of psychological interventions in cancer patients. In a 1989 report in the Lancet, Dr. David Spiegel reported an unexpected survival benefit that women who participated in support groups lived, on average, twice as long as women who didn't. The BEST study was designed to replicate these results.¹¹

However, the comparison of the Spiegel study which did show extension of life in cancer patients to the study by Dr. Goodwin which does not show extension of life appears to be fatally flawed; although this flaw seems to be seldom noticed. As can be seen from the relevant abstracts, the 1989 Spiegel study employed two methodologies with the patients in the treatment group: group support *and* instruction in self-hypnosis. The 2001 metastudy by Dr. Goodwin compared the effect of survival on patients undergoing group support *only*. As the Spiegel study employed two methods of intervention and the Goodwin study employed only one, there is a formal confound in the data and the results cannot be compared. Indeed, an equally valid reading of this research would be that

M.D., “*The Effect of Group Psychosocial Support on Survival in Metastatic Breast Cancer*,” The New England Journal of Medicine, December 13, 2001, Volume 345, Number 24, pp, 1719-1726.

¹¹ <http://www.mtsinai.on.ca/MediaAndNews/SinaiNews/2001/20011212.htm>

while group support activities appear to improve quality of life in cancer patients, the addition of hypnosis is critical in achieving life extension.¹²

Because of findings such as these, our ICAN program offers a subordinate goal of helping people create the personal circumstances most favorable to recovery or medical improvement. There is a great danger of overstatement here. While ECaP-oriented therapy may help a patient's physical condition, the real arena of healing remains the medical arena, and my work is an adjunct to medical work, not a replacement for it.

Most importantly, if medical improvement does not result, this does not mean the patient has failed in their hypnotic work. The primary goal of the method remains self-improvement. To improve oneself is to have succeeded at the task of life, even if the reward is not more life.

At the present time there is a six-month waiting list for admission to the program.

Objective Results

There are intrinsic challenges to tabulating the objective results of a program such as ICAN.

First, the program was not created as a research study with the resources to followup with participants once they left the program.¹³ Therefore, we know that certain members have died because they died while part of the program or were able to confirm their death with obituaries or family members. Similarly, we know the active members are alive, as are those past members we were able to track down and contact by telephone. Some persons who have left the program and who have moved can be reasonably classified as "Believed Alive" based upon the existence of active telephone or voice mail accounts. However, there will always be some softness in the data of a program that was not originally conceived as research.

¹² [March 2004] Since the original publication of this paper word has reached me through third parties that Dr. Goodwin has stated that the use of hypnotism was included in her study. While no mention of this appears in the abstract or in the published protocol of the study, I am more than willing to take her at her word. It should be noted the hypnosis is indeed mentioned in one sentence in the discussion section of her paper. However, given this relative lack of emphasis on hypnotic technology I feel my comments remain appropriate. The use of hypnotism is the core of my ICAN program and is the axis around which everything turns. It is not something done in passing that barely merits mention as would seem to be the case with the Goodwin study. Given that hypnotism is as much the induction of conviction on the part of the subject as it is the induction of trance, if the hypnotism is not held up as being important it will not be effective. For this reason it does not appear to have been effective for Dr. Goodwin and her colleagues.

However, were I to write this paper now I would reframe the discussion of the Goodwin study to be a comparison between a program where hypnotism is central and important and a program where it was included as an add-on, hardly mentioned and not deemed of great consequence.

¹³ At the inception of the program hospital administration identified privacy concerns about participants. Therefore, Social Security Numbers of the group members were not recorded, making it impossible for us to track survival by the national SSN death index. However, I have faithfully tracked obituary notices and used the telephone to determine outcome as much as possible.

Second, when the program began in 1991, physician cooperation was not as thorough as might have been wished. Therefore, in 5 cases we have no record of the particular stage of the cancer and the participant him or herself did not know, although the general perception was that the disease was progressed.

Third, as the program is on-going with new members added as older members leave, it is not possible to quantify intervention v. survival at a statistical break point. Some members have participated in the program for approximately a year before withdrawing. However, two of the present members have been continuously in the program for 9 years. Most participants have stayed in the program for extended periods of time. On average the present participants have been in the program for five years.

Finally, there is no control group to insure validity, and so we must compare the actual results to statistical norms for survival to gain a sense of the effectiveness of the program. Unfortunately, there is no exactly comparable statistical standard. According to calculations (attached as an appendix to this essay¹⁴) created by the National Cancer Institute and recorded in the SEER (Surveillance, Epidemiology and End Results) database, the 5-year relative survival rate for all types of cancer among all races, gender, cancer stage and sites is 53.9% at the 1990 census, the most recent year for which the tabulation is available.¹⁵

As noted on the SEER tabulation, this survival rate has steadily increased over the years from 49.3% in 1970, in large part because of improvements in early detection of specific cancers with correspondingly higher survival rates, and this data is included in the SEER tabulation.

Tabulations of cancer survival at the 10-year point are usually not done for all cancers as a group because cancer outcomes tend to diverge at this point. However, 10-year survival estimates for specific cancers are always less than the estimate for 5-year survival, often dramatically less and some having virtually no 10-year survival at all. For example, the American Cancer Society puts the 5-year survival rate for prostate cancer at 97% with the 10-year survival at 79%,¹⁶ while the estimation for survival with pancreatic cancer is 5% at 5 years and survival at 10 years is so negligible that the rate is not even computed.¹⁷

¹⁴ Also available on-line at <http://seer.cancer.gov/publications/raterisk/rates28.html>

¹⁵ The SEER tabulation uses the commonly accepted cohort method for reporting results. Some experts argue that a period analysis is more appropriate to tabulate cancer survival as it takes into account recent medical advances by giving more weight to recent cases. However, as the data from the ICAN Program is data gathered over more than a decade, the traditional cohort method used by the National Cancer Institute seems more appropriate.

¹⁶ American Cancer Society, "What are the Key Statistics about Prostate Cancer?" American Cancer Society 2003. This essay is included as an appendix in this essay and is available on the web at http://www.cancer.org/docroot/CRI/content/CRI_2_4_1X_What_are_the_key_statistics_for_prostate_cancer_36.asp?sitearea=&level=

¹⁷ American Cancer Society, "What are the Key Statistics about Pancreatic Cancer?" American Cancer Society 2003. This essay is included as an appendix in this essay and is available on the web at http://www.cancer.org/docroot/CRI/content/CRI_2_4_1X_What_are_the_key_statistics_for_pancreatic_cancer_34.asp?sitearea=

Clearly, the participants in the ICAN Program do not represent a random sample of the patient population inclusive of early stage cancers where good outcome can be expected. The tabulated de-identified outcome census of participants is attached to this essay as an appendix. As a glance at the participant census shows, early detection played virtually no role in the lives of participants. All but 5 participants in the study group are known to have been admitted to the program with progressed metastatic disease or disease in reoccurrence, where survival would be expected to be far less than 53.9% at the five year point. Of the 5 participants whose disease was of unknown stage, it is believed that their disease was also progressed disease.

Still, some calculations are possible and they are provocative.

In the 13 years of the ICAN Program, 44 persons have participated. Of these, there were three participants who were admitted to the program on compassionate grounds in end-stage disease and were not expected to survive more than a few weeks. Therefore, they were never considered part of the “study group.” They were persons admitted with end stage lung cancer, end stage breast cancer with lung metastasis, and advanced angiosarcoma complicated by recent liver and kidney transplants, both of which were failing. These individuals each participated in the program for less than four weeks.

In addition, one person withdrew from the program after only one week due to time conflicts, and her data has been removed from the study group. Two persons could not be tracked at all and have moved on leaving no contact information whatsoever. Accordingly, their data has been removed from the study group as we have no data about their outcome.

As not all persons contacted responded, we must make educated guesses about their status. This has the effect of “softening” the data from a research perspective but I feel confident that the classifications are reasonable. These persons are classified as “Believed Alive” or “Believed Deceased.”

We were able to classify 5 individuals as “Believed Alive.” For 4 of these persons we were able to determine active telephone numbers or voice mail accounts, even though they did not respond to our follow-up call. One person in this classification, who had shown great resiliency to his illness throughout his years of participation in the program, had remained in contact until he retired to a distant state where we lost track of him. At our last contact with him he was continuing to do well. I felt given that he was already a long-term cancer survivor who was in hale condition at retirement he should plausibly be included in the “Believed Alive” classification even though we were not able to reach him to confirm his status.

Finally, two persons could not be tracked but I felt should be classified as “Believed Deceased” based upon their medical condition when they departed the program.¹⁸

Therefore, the study group consists of 38 persons who participated in the program, with many participating for several years.

¹⁸ I have classified these persons as “Believed Deceased” in an effort to keep the data as reasonable and clean as possible. However, it must be noted that several people I had initially classified as “Believed Deceased” on the same criteria were found to be very much alive when I did the telephone contacts to verify their outcome.

Although it did not, if the study group had consisted of persons with a range of cancer stages, early through progressed, 53.9%, or 20 persons, would have been expected to survive 5 years on average in accordance with the SEER database. We would expect a considerably lesser number to survive to the 10-year point or beyond.

At the 13-year point, far beyond the 5-year comparison point, 22 members of the ICAN program (57.9%) were alive or believed alive despite the progressed nature of their disease at admission to the program.

It is also instructive to note that when the participant data is sorted by date of enrollment in the program it becomes evident that the survival of participants is distributed throughout the timeline of the program. That is, it is not the case that the participants who are still alive are those admitted to the program recently while those who are deceased are those who were admitted at earlier times. For example, of the 6 persons admitted at the beginning of the program in 1991, 4 are still alive. Similarly, of the 6 persons admitted in 1994, 4 are still alive, while of the 4 persons admitted in 1995, 3 are still alive. It seems to me that this finding supports the method used in this comparison. As the survival of participants is distributed throughout the timeline of the program, comparison of results on the basis of the average of survival v. death throughout the timeline of the program is meaningful. The tabulated de-identified enrollment date census of participants is attached to this essay as an appendix.

Because of the limitations and relative softness of the data, no major conclusions can be drawn from the survival experience of the ICAN participants. However, the participants in our program appear to have experienced an average survival at more than 10 years that compares very favorably with the national average for survival at only 5 years for all stages of cancer. This improved survival is especially remarkable as the national average survival statistic includes data from persons detected with early stage disease, while our group participants almost uniformly had progressed disease.

Even allowing for medical advances since the 1990 SEER tabulation, it would be reasonable to see the objective outcome of the ICAN program as support for the finding of the Spiegel study that the combination of group support and hypnotism produces increased survival for persons living with cancer.

Basic Concepts of the ICAN Program

As I analyze the model, there are three philosophical principles that form its theoretical basis. These are explanatory style, unconscious awareness and the understanding of illness as metaphor. The purpose of the program is to help participants modify their explanatory style, come into touch with unconscious awareness, and discover a level of meaning in their illness. Accomplishing these tasks results in self-understanding and self-improvement. It may also, as mentioned above, help create circumstances favorable to medical improvement. These concepts are described below.

Explanatory Style

Perhaps the most basic concept in my work is the notion of "explanatory style." "Explanatory style" is the characteristic way in which individuals explain the world to themselves. The assumption is that all persons maintain an inner dialogue with themselves. As we conduct this dialogue we use idiosyncratic principles, rooted in our earliest learning experiences, to account for why things happen as they do. For example, a person might explain an example of dishonesty to him or herself by saying that "everyone cheats." Or, a person might explain an unfortunate romantic experience by thinking that "all men (or women) are untrustworthy."

The set of principles a person uses to make understandable his or her experience of the world constitutes the explanatory style for that individual. Generally, explanatory styles can be typified as positive and encouraging or as negative and cynical.

The term "explanatory style" was coined by Martin E.P. Seligman, Ph.D., a professor of psychology and Director of Clinical Training at the University of Pennsylvania. The concept is based on Dr. Seligman's research with "learned helplessness."¹⁹ Seligman's studies strongly suggest a connection between a sense of personal helplessness, manifested as a negative and misanthropic explanatory style, and general malaise and ill health. In two key experiments, one charting illness in a test population of undergraduates and another predicting survival in patients with malignant melanoma, the characteristics of a subject's explanatory style were more predictive of health than any other measure. Recently Dr. Seligman has published a major book on his research.²⁰

Within the ECaP model, considerable effort is expended to help a participant analyze his or her explanatory style and assess the early learning experiences that created it. Using social reinforcement as well as insight, participants learn to modify their characteristic patterns of self-talk and explanation so their explanatory style moves toward one that is hopeful, tolerant and forgiving. These are the characteristics Seligman found most conducive to physical and mental health.

The ICAN program has been spoken of as a program that "teaches people how to love." One way to understand this statement is that the program helps a person explain the world to him or herself in a compassionate and tender way. As participants develop an explanatory style that is consistent with compassion and tenderness, and inconsistent with distrust and pessimism, they experience a general improvement of mood and a sense of well-being. This is the reality behind the motto of Bernie Siegel, "Love Heals."

Hypnotically this agenda is advanced by direct and indirect hypnotic suggestion that teaches reframing of childhood learning and beliefs and ego-strengthening. Time-Line interventions, future pacing, age regression to initial sensitizing events or to times of strength, Heartland techniques,

¹⁹ Seligman, M.E.P. and Maier, S.F., "*Failure to Escape Traumatic Shock*," Journal of Experimental Psychology, 74, 1967: 1-9.

Also see: Abramson, L.Y., Seligman, M.E.P. and Teasdale, J.D., "*Learned Helplessness in Humans*," Journal of Abnormal Psychology, 87 (1), 1978:49-74.

²⁰ Seligman, Martin, E.P., Learned Optimism (Alfred A. Knopf, New York, 1991).

forgiveness and releasing are common metaphors that are employed in hypnotism intended to address this issue.

Unconscious Awareness

Probably the greatest single break between the view of the mind advocated by the hypnotic arts and sciences and traditional psychoanalysis is in the role assigned to the unconscious mind. In psychoanalytic theory the unconscious mind is a force which needs repression and mastery by the will if a person is to live well. Most hypnotists propose a different role for the unconscious mind. Similarly, drawing on the work of Carl Jung, Milton Erickson, and other clinicians, Dr. Siegel advances the notion that our unconscious mind is far more in touch with our inner needs and goals than our conscious mind.²¹

The theory is that while the unconscious mind struggles to communicate the awareness of what we need to be happy, healthy and whole, our conscious mind listens imperfectly. Therefore, the unconscious mind must use the language of symbol, metaphor, parapraxis (slips of the tongue) and dream to circumvent the conscious censor. One of the goals of the hypnotist is to help a client come into touch with whatever themes are emerging from unconscious processes.

Accordingly, the ICAN program takes seriously insights gained from dreams, fantasy and the interpretation of drawings. In each case a permissive system of interpretation is used. That is, a drawing or dream is understood to be correctly interpreted when its creator agrees that the interpretation is correct.

Hypnotic interventions aimed at this theme are exploratory in nature: hyperempria, inner guide work, programmed dreaming and spiritual imagery.

Illness as Metaphor

The most controversial and misunderstood feature of my ECaP-oriented approach is the use of illness as a metaphor for psychological and spiritual process. At some point in treatment, a participant will be invited to reflect upon whether there is a level at which their illness can be understood as symbolic of conflicts within the psyche. Almost always such an understanding can be found, and the participant will begin lifestyle changes intended to resolve those conflicts. This has given rise to enormous misunderstandings in the health care community about the intent of this sort of helping.

The typical critique offered of Bernie Siegel's work is that he can be read as encouraging people to believe they are responsible for getting sick and are at fault if they do not get well. People reading Dr. Siegel's books may conclude that if their cancer does not go into remission it is because they were not able to be "loving enough." Nothing could be farther from the truth, although the

²¹ I strongly suspect an influence on Dr. Siegel by the thinking of M. Scott Peck, M.D., whose popular book The Road Less Traveled proposes a parallel theory of unconscious processes.

misreading is understandable. This problem is magnified by therapists who have not been trained in the ECaP model, misunderstand it on this particular point, but attempt to use it.

While the Dr. Siegel's model does not ignore the role stress may have in depressing the immune system of a patient, there is no direct causal relationship hypothesized between psychic state and illness.²² Rather, a heuristic connection is proposed. That is, it can be evocative and psychologically rewarding to consider how the characteristics of one's illness might find parallels in one's personality--even if there is no actual causal link.

An example makes this concept clearer. A patient suffering from cardiovascular disease might be asked to consider whether there are areas in their emotional life where they feel "heartbroken." The actual etiology of the disease may have nothing to do with the mental state of the patient. However, asking the patient to reflect on the areas of heartbreak in his or her life offers the patient the opportunity to make the time of medical treatment a time of self-knowledge and improvement. While the arena of psychological endeavor might be selected on other grounds, selecting one that has a symbolic connection with one's physical condition gives it an existential importance not otherwise obtainable. We have seen participants undergo startling positive transformations as they have worked through understanding their illness as a metaphor.

The benefits of this approach are many. Perhaps the greatest is that patients are given something they can do to structure the time of treatment. While engaged in medical care they can also try to improve themselves personally. While concomitant medical improvement may be hoped for, even if it does not materialize, most people are happier if they achieve a moral victory or two. Such people report themselves feeling fulfilled, and typically their relationships with others deepen. Additionally, most clinicians find that patients who are happy with themselves are more compliant with treatment, philosophical about discomfort, and seem to enjoy greater vitality.

Hypnotism organized around this theme is intended to enhance boundaries and limits in relationships as a way of removing any secondary gain (the use of illness to solve relationship problems) and increasing assertiveness. Additionally, imagery is focused on changing whatever metaphor the participant's unconscious mind is employing into a healthier vein.

Specific Hypnotic Considerations

The ICAN program makes robust use of the hypnotic arts and sciences. In the opinion of this writer the use of hypnotism makes it especially effective and accounts for the long-term character of the program. While the original group in the Spiegel study met for one year, the ICAN program has participants who have been in the program for many years, with an average retention of five years for the current participants. This is an unusually long retention of participants in a group program.

Support group work, helpful though it may be, eventually becomes boring. There is only so much one has to say about one's medical condition and only so much one needs to learn before the condition is reasonably well understood and some sort of peace is made with it. Irvin D. Yalom,

²² Siegel, Bernie, Peace, Love & Healing, p. 47.

M.D., possibly one of the world's greatest experts on group psychotherapy, estimates that average retention in a group is one to two years.²³

While one might argue that increasing retention in a support group is not necessarily a good thing, the goal of the ICAN program is not personal transformation but medical improvement and maintenance with a disease condition that is, by definition, long-term and reoccurring. The belief is that the long-term characteristic of the program may lead to survival results that exceed all expectations. Participants in the Spiegel study experienced an improvement of survival at ten year follow-up after one year of group participation; however, all eventually died of their disease. I am hopeful of a better long-term outcome, and hypothesize that the long-term nature of our intervention will be the reason.

The key to retention of members in the long term has been the nature of the hypnotic work. Each week a different hypnotic experience is offered, varying in technique, nature and focus. Participants have come to consider this rich tapestry of hypnotism to be a kind of special treat, and it is very much looked forward to each week and eliminates the element of sameness and boredom that often corrupts support group work. At those weeks where sessions have gone overtime because of extended dialogue among the participants, the group members have been offered the choice of ending on time without the hypnotism or staying later into the evening to allow the hypnosis to take place. At no time in the past five years has the group elected to end on time by skipping the hypnotic work.

Summary

The ICAN program of La Grange Memorial Hospital developed by the writer of this essay is a program of group support and hypnotism. It is based on the Exceptional Cancer Patients model developed by Bernie Siegel, M.D. The program has been in continuous session since 1991.

The program features a combination of hypnotism and group support and can be a useful adjunct in the treatment of a patient with a life-changing illness. The primary goal of the ICAN method is supportive care for the patient, with a special orientation toward making the time of medical treatment also a time of self-improvement. A subordinate goal is to help the patient create the personal circumstances most favorable to medical improvement. There is limited, but good, empirical support for this subordinate goal. However, the primary goal of the ICAN program remains the task of self-improvement, and this can be achieved by any patient, regardless of medical outcome.

The unique feature of the ICAN program is the robust use of hypnotism. All participants undergo a weekly hypnotic experience and they may obtain a recorded copy for home reinforcement. The hypnotic techniques used are those detailed in the Complementary Medical Hypnotism Certification Curriculum of the National Guild of Hypnotists, also written by this author. The use of hypnotism has had the effect of extended member retention in the program by providing widely varying experiences each week, eliminating boredom. This retention is believed to be a key factor

²³ Yalom, Irvin, The Theory and Practice of Group Psychotherapy, Third Edition (Basic Books, New York, 1985), p. 368.

in the program and it is hoped it will have a long-term impact on both the quantity and quality of life of the participants.



Cancer Survival Rates

Changes in the 5-Year Relative Survival Rates by Primary Cancer Site, All Races

The overall 5-year relative survival rate for all cancer sites combined increased slightly from 49.3 percent in 1974-76 to 53.9 percent in 1983-90. Early data from 1960-63 and 1970-73 were not available for all races combined. Survival rates vary by primary site from less than 3 percent for cancer of the pancreas to more than 90 percent for cancer of the thyroid.

Part of the recent increase in breast cancer survival may be due to early detection; a higher percentage of the more recent cases were diagnosed with smaller tumors. Survival increases for prostate cancer may also in part be the result of early detection and the inclusion of occult disease in asymptomatic men.

5-Year Relative Survival Rates^a for Selected Cancer Sites, All Races

ALL RACES						
Cancer Site	1960-63	1970-73	1974-76	1977-79	1980-82	1983-90
Brain & Other Nervous			22.3	24.4	25.0	27.3
Breast (females)			74.3	74.5	76.2	80.4
Cervix Uteri			68.5	67.7	66.9	67.4
Colon & Rectum			49.5	51.7	54.2	59.2
Corpus & Uterus, NOS			87.7	84.9	81.4	83.2
Esophagus			4.7	5.1	6.7	9.2
Hodgkin's Disease			71.1	73.0	74.3	78.9
Kidney & Renal Pelvis			51.3	50.8	51.4	56.3
Larynx			65.4	66.8	68.0	67.0
Leukemias			34.2	36.6	37.4	38.3
Liver & Intrahep			3.8	3.7	3.4	6.0
Lung & Bronchus			12.3	13.3	13.3	13.4
Melanoma of Skin			79.7	81.5	82.1	85.1
Multiple Myeloma			24.4	26.1	28.0	27.7
Non-Hodgkin's Lymphoma			47.1	48.1	51.1	52.0
Oral Cavity & Pharynx			53.2	52.4	52.4	52.3
Ovary			36.5	38.1	38.9	41.8
Pancreas			2.6	2.5	3.1	3.2
Prostate			66.7	70.9	73.1	79.6

Stomach			15.1	16.7	17.5	18.5
Testis			78.6	87.2	91.7	93.3
Thyroid			91.9	92.5	94.2	94.6
Urinary Bladder			72.4	74.8	77.9	79.8
All Sites			49.3	49.8	50.6	53.9

[continue](#)

^a Data for 1960-63 and 1970-73 are from three hospital registries and one state registry and appear in *Cancer Patient Survival Experience, 1980*. Data for 1974-90 are from SEER, and represent approximately 10 percent of the U.S. population. Thus, the earlier data and the SEER data are not strictly comparable, but each represents the best available data for the period covered.

- Statistics could not be calculated.

Analysis of ICAN data Showing Date of Enrollment, Sorted by Outcome

#	Client	Sex	cancer and stage	status as of 6/2003	Enrolled
19		F	Breast Cancer, Stage 2	Active Member	1994
15		M	Prostate Cancer, Stage 1+, Hot Margins to Surgical Site	Active Member	1994
21		F	Breast Cancer, Stage 3, in Reoccurrence	Active Member	1998
18		F	Breast Cancer, Stage 3b	Active Member	1999
16		F	Breast Cancer, Stage 2	Active Member	2000
14		F	Multiple Myeloma, Stage 3	Active Member	2001
20		F	Multiple Myeloma, Stage 3b	Active Member	2001
17		F	Malignant Carcinoid Tumor	Active Member	2003
39		F	Breast Cancer, Stage Uncertain	Believed Alive (has current phone number)	1994
42		F	Breast Cancer, Stage Uncertain	Believed Alive (has current voice mail)	1991
27		F	Cervical and Uterine Cancer	Believed Alive (has current voice mail)	1995
30		F	Breast Cancer, Stage 2	Believed Alive (has current voice mail)	1995
33		M	Prostate Cancer, Stage 4	Believed Alive (known to have relocated)	1991
29		F	Breast Cancer, Stage 4	Believed Deceased	1991
25		F	Ovarian Cancer, Stage 3	Believed Deceased	1993
23		F	Breast Cancer, End Stage, Metastatic to Lungs	Compassionate Admission (died within 1 month)	1991*
22		F	Lung Cancer, End Stage	Compassionate Admission (died within 1 month)	1991*
24		M	Angiosarcoma, Stage 3, Kidney Liver Transplants	Compassionate Admission (died within 1 month)	2001*
38		F	Lymphoma, Stage 4	Confirmed Alive	1991
43		F	Breast Cancer, Stage 2	Confirmed Alive	1991
36		F	Breast Cancer, Stage 2	Confirmed Alive	1992
40		F	Breast Cancer, Stage 2	Confirmed Alive	1992
26		F	Lymphoma, Stage 4	Confirmed Alive	1994
34		F	Breast Cancer, Stage 1	Confirmed Alive	1995
35		F	Neurofibro Sarcoma and Malignant Melanoma	Confirmed Alive	1997
32		F	Breast Cancer, Stage 2	Confirmed Alive	1998
37		F	Breast Cancer, Stage 3	Confirmed Alive	2001
7		F	Rectal Cancer, Metastatic to Lungs and Lymph Nodes	Deceased	1991
10		F	Leiomyosarcoma, in Reoccurrence	Deceased	1992
11		F	Breast Cancer, Stage 4	Deceased	1992
12		F	Malignant Melanoma, Stage 3	Deceased	1992
28		M	Esophageal Cancer, Stage Uncertain	Deceased	1992
8		F	Breast Cancer, Stage 4, Metastatic to Lungs	Deceased	1993
13		F	Ovarian Cancer, Stage 3c	Deceased	1993

9	M	Colon Cancer, Extensive Metastatic Disease to Liver	Deceased	1993
3	F	Breast Cancer, Stage 2, Brain Lesion	Deceased	1994
5	F	Breast Cancer, Stage 4	Deceased	1994
6	F	Breast Cancer, Stage 3b	Deceased	1995
1	M	Hodgkin's Disease, Late Stage, Refractory	Deceased	1997
2	F	Pancreatic Cancer with Metastatic Liver Spread	Deceased	1999
4	F	Ovarian Cancer, Stage 3c	Deceased	1999
44	F	Breast Cancer, Stage 2	Unable to Track	1991*
41	F	Lymphoma, Stage Uncertain	Unable to Track	1991*
31	F	Breast Cancer, Stage Uncertain	Withdrew (attended 1 session)	1991*

Analysis of ICAN data Showing Date of Enrollment, Sorted by Enrollment Date

#	Client	Sex	cancer and stage	status as of 6/2003	Enrolled
42		F	Breast Cancer, Stage Uncertain	Believed Alive (has current voice mail)	1991
33		M	Prostate Cancer, Stage 4	Believed Alive (known to have relocated)	1991
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34		F	Breast Cancer, Stage 1	Confirmed Alive	1995
6		F	Breast Cancer, Stage 3b	Deceased	1995
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1		M	Hodgkin's Disease, Late Stage, Refractory	Deceased	1997
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44	F	Breast Cancer, Stage 2	Unable to Track	1991*
41	F	Lymphoma, Stage Uncertain	Unable to Track	1991*
31	F	Breast Cancer, Stage Uncertain	Withdrew (attended 1 session)	1991*
24	M	Angiosarcomia, Stage 3, Kidney Liver Transplants	Compassionate Admission (died within 1 month)	2001*



Cancer Reference Information

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What Are the Key Statistics About Prostate Cancer?

Prostate cancer is the most common cancer, excluding skin cancers, in American men. The American Cancer Society estimates that during 2003 about 220,900 new cases of prostate cancer will be diagnosed in the United States. One man in six will be diagnosed with prostate cancer during his lifetime, but only 1 man in 32 will die of this disease. African-American men are more likely both to have prostate cancer and to die from it than are white or Asian men. The reasons for this are still not known.

Prostate cancer is the second leading cause of cancer death in men in the United States, exceeded only by lung cancer. The American Cancer Society estimates that 28,900 men in the United States will die of prostate cancer during 2003. Prostate cancer accounts for about 10% of male cancer-related deaths.

- Among men diagnosed with prostate cancer, 97% survive at least 5 years, 79% survive at least 10 years, and 57% survive at least 15 years. These figures include all stages and grades of prostate cancer but do not account for men who die from other causes.
- At least 70% of all prostate cancers are found while they are still *localized* (confined to the prostate), and at least 85% have not spread beyond the surrounding tissues or lymph nodes. The 5-year relative survival rate for all of these men is nearly 100%.
- Of the roughly 6% of men whose prostate cancers have already spread to distant parts of the body at the time of diagnosis, 34% will survive at least 5 years.

Five-year and 10-year survival rates refer to the percentage of men who live *at least* 5 or 10 years after their prostate cancer is first diagnosed. *Relative* (also known as *disease-specific*) survival rates exclude patients dying of other diseases. This means that anyone who died of another cause, such as heart disease, is not counted. Because prostate cancer usually occurs in older men who often have other health problems, relative survival rates are generally used to produce a standard way of discussing prognosis (outlook for survival).

Unfortunately, it is impossible to have completely up-to-date survival figures. To realistically measure 10-year survival rates, we must have records of patients diagnosed at least 13 years ago. We need 10 years of follow-up plus the time it takes to assemble the data.

The death rate from prostate cancer has been decreasing, and men are being diagnosed earlier. This means that if you are diagnosed this year,

your prognosis is probably better than the numbers above.



Cancer Reference Information

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What Are The Key Statistics About Pancreatic Cancer?

The American Cancer Society estimates that 30,700 Americans (14,900 men and 15,800 women) will be diagnosed with cancer of the pancreas during 2003. Over the past 20 years, the rate of pancreatic cancer has declined slightly in men. The rate among women has remained stable, but may also be beginning to decline.

An estimated 30,000 Americans (14,700 men and 15,300 women) will die of pancreatic cancer in 2003, making this type of cancer the fourth leading cause of cancer death in men and in women. Approximately 21% of patients with cancer of the exocrine pancreas survive at least 1 year after diagnosis. About 5% survive 5 years after diagnosis.

Only about 10% of cancers of the pancreas appear to be contained entirely within the pancreas at the time they are diagnosed. Attempts to remove the entire cancer by surgery may be successful in some of these patients. But, even when no spread beyond the pancreas is apparent at the time of surgery, a small number of cancer cells may already have spread to other parts of the body but have not formed tumors large enough to be detected in their new location. Even for those people diagnosed with local-stage disease the 5-year survival rate is only 17%.

The 5-year survival rate refers to the percentage of patients who live at least 5 years after their cancer is diagnosed. Many of these patients live much longer than 5 years after diagnosis, and 5-year rates are used to produce a standard way of discussing prognosis. Five-year relative survival rates exclude from the calculations patients dying of other diseases, and are considered to be a more accurate way to describe the prognosis for patients with a particular type and stage of cancer. Of course, 5-year survival rates are based on patients diagnosed and initially treated more than 5 years ago. Improvements in treatment often result in a more favorable outlook for recently diagnosed patients.

The Cancer Wellness Doctrine

This Doctrine was created by the Cancer Support Team at La Grange Memorial Hospital in 1991. It communicates the powerful role that you play in your own treatment and healing. We hope you will embrace this doctrine as we do, share it with friends and loved ones, and find hope and inspiration in its message.



Cancer Wellness Doctrine

1. Cancer has changed my life, but that does not mean my life has been changed for the worse. I will decide how my life has been changed.
2. While there may be moments of uncertainty, there will always be reasons for hope.
3. I am the most important member of my healthcare team. The more active and curious I am about my treatment, the better my outlook will be.
4. I have the power to make a difference in my treatment and care.
5. Physical healing is not the only goal of my treatment. I can also use this time to heal my spirit, relationships and heart.



Directions

La Grange Memorial Hospital is located South of Ogden Avenue (Route 34).

Approaching from the North: From 294, take Ogden Avenue East to Gilbert, then turn right. Follow Gilbert until it becomes Willow Springs Road. La Grange Memorial Hospital is located on Willow Springs Road between 47th Street and 55th Street in La Grange.

Approaching from the South: From the Tri-State Expressway (294), exit at Plainfield Road. Go East to Willow Springs Road and turn left. Proceed North on Willow Springs Road until you arrive at the hospital.

From the Stevenson Expressway (55), exit at Willow Springs Road and proceed North to the hospital campus.

A Joint Program Between

LA GRANGE MEMORIAL HOSPITAL
5105 SOUTH WILLOW SPRINGS ROAD
LA GRANGE, ILLINOIS 60525

&

COUNSELING MINISTRIES, INC.
WHEATON OFFICE
1211 EAST PERSHING AVENUE
WHEATON, ILLINOIS 60187

**FOR MORE INFORMATION, CALL
(630) 668-1141**

I CAN



I
CAN
ACT
NOW

A hospital based,
medically
approved program
using hypnosis
as an adjunct for
the treatment of
cancer.

The I CAN Program is for persons facing the life-changing illness of cancer, and is an intermediate level of care on our menu of professional services. By teaching patients how to use the power of the mind to control discomfort, elevate mood and directly participate in the healing process, our program improves the overall quality of a patient's life, and can promote positive improvement in a patient's medical condition as well.

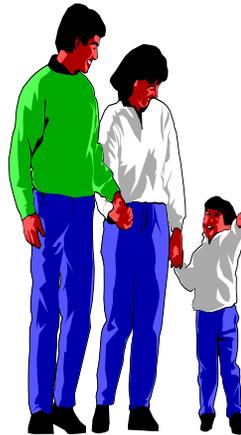
The I CAN Program merges self-help techniques with instruction in self-hypnosis. Based on the finding that state of mind has a significant effect on medical outcome, people who are engaged in healthy-minded living simply do better medically, even if they have a life-changing disease.

The leader of the I CAN program, Dr. Giles, has studied with leaders in the field of psycho-social oncology. He is a Board Certified Chaplain in our Department of Pastoral Care and one of the foremost practitioners of the hypnotic sciences in America.

Patients attend weekly two-hour group sessions at La Grange Memorial Hospital where they learn the techniques necessary to use the power of the mind to facilitate healing.

I CAN — I Can Act Now!

A hospital based, medically approved program for hypnotic intervention in the treatment of cancer. Call Dr. Giles at (630) 668-1141 for information.



How Hypnotism Can Help

All hypnosis is really self-hypnosis. Our work is an educational process that teaches you how to master an ability you already have. Once you have learned how to enter and use your trance state, you can use it to control aspects of your behavior that may have been outside of your control. For example, you can learn to improve mood, to put yourself in touch with more effective frames of mind, to move beyond pain and discomfort, and adjust your eating or other habits. Hypnotism was approved as a valid treatment modality by the American Medical Association in 1958.

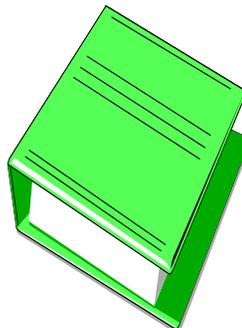
The hypnotism done as part of the I CAN Program is electronically enhanced and participants can obtain self-hypnotic tapes at little cost.

Payment



Participation in the I CAN program is provided on a modest fee-for-service basis. While policies vary, most insurance companies will not reimburse you for this work. However, our nonprofit rates are low, as neither La Grange Memorial Hospital nor Counseling Ministries attempts to earn a profit from this program. Participants pay only a small weekly fee, which is used to offset the cost of space, refreshments and other overhead costs.

How to Apply



If you wish to consider participation in the I CAN program, contact Dr. Giles directly at the number given in this brochure. He will schedule an Intake Assessment. There is a fee for the assessment, but that can be waived in cases of hardship. Your physician must prescribe the program for you. However, we will arrange for this after the intake session is complete.

Participation in the I CAN program is restricted by group size limits. The program may have a waiting list.
