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The director of this dissertation is:

Alice Rose

Professor:

Signature of Author

Department:

Psychology

School:

Arts and Sciences
Georgia State University
University Plaza
Atlanta, Georgia 30303

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The author of this dissertation is:

Name: Alice Watkins Rose

Street Address: 2350 Dabney Terrace

City And State: East Point, Georgia 30344

The director of this dissertation is:

Professor: Pauline Clance, Ph. D.

Department: Psychology

School: Arts and Sciences
Georgia State University
University Plaza
Atlanta, Georgia 30303

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CANCER: THE SILENT SCREAM

A DISSERTATION

Presented in Partial Fulfillment of Requirements for the Degree
Doctor of Philosophy in the Division of
Graduate Studies, School of Arts and Sciences,
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1979

By

Alice Rose

Pauline Powell Vance

Director

John G. Monas

Dean

School of Arts and Sciences

Committee:

Richard E. Felder

Ray A. Cassick

D. Rouzen

Robert H. Hankla

Director of Graduate Division

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Chapter 1

INTRODUCTION

Experimental studies on the psychological characteristics of cancer patients are just beginning to emerge, although writings reporting on the behavior and personality of cancer patients have existed for centuries (Goldfarb, Driesen, & Cole, 1967). Of the many theories appearing in the literature, none comprehensively integrates the great diversity of findings, explains the possible underlying psychological dynamics, and offers a suggestion for psychotherapeutic treatment. The present theoretical study has set about that task.

The basic format of the discussion will be a step-by-step presentation of the author's model for the possible psychogenesis of human cancer. As each hypothesis is offered, the literature from which it has been generated will be reviewed.

This dissertation documents that cancer patients differ from other people specifically in their emotional expressiveness. It further shows that cancer patients generally tend to suppress their feelings more than people without cancer who constitute several control groups. Moreover, this dissertation integrates the literature on behavioral characteristics of cancer patients with the findings about emotional expression in order to elaborate three central theses. First, by exploring the evidence linking emotional expressiveness and cancer, this dissertation lays to rest doubts that the relationship may be unimportant or spurious. Second, by elaborating the pivotal role played by poor or incomplete expression of emotions in the development of the cancer-prone personality, the dissertation proposes a

hypothetical mechanism to explain why some people develop cancer while others presumably exposed to similar environmental stresses do not. Third, having detailed what seems to be the crucial role of emotional dynamics in the development of cancer, the dissertation explores the implications of these findings for developing a psychotherapeutic treatment for cancer based on encouraging the expression of emotions.

The order of the chapters has a special significance in that each represents, as far as possible, a sequence in time in the developmental history of the typical cancer patient's life. "Helplessness and Hopelessness," the second chapter, describes the underlying dynamics of the cancer patient's early life. The third chapter, "Socialization and Emotions," describes some of the most frequently reported findings about the emotional characteristics of cancer patients and discusses the developmental environment that would foster these characteristics. The fourth chapter, "Limitlessness and the Controlling Persona," integrates the interaction of early dynamics, emotional characteristics, and the developmental environment of cancer patients. Although no single "cancer personality" results from this interaction, there are still certain dynamics common to the personalities of most cancer patients. They are discussed in this fourth chapter. Chapter Five, "The Precipitating Event," describes what happens to the cancer patient just before he develops cancer. These five chapters conclude the part of the theory which explains how cancer might develop psychodynamically.

The sixth chapter includes a proposal for psychotherapy with cancer patients that would interrupt the personality structures associated with cancer development, possibly leading to a change in the progress of the cancer itself. While there are many therapists who are interested in helping cancer patients to die, or helping the cancer patient's family to adjust to

their circumstances, the three psychotherapists discussed in the final chapter are special in that they, as I, work to change the course of cancer through psychotherapy. Chapter Seven, the final chapter, summarizes the theory and presents a metaphorical description of cancer derived from the psychodynamics presented in the theory.

Chapter 2

HELPLESSNESS AND HOPELESSNESS

Literature suggests that cancer patients often experience helplessness to a profound degree, sometimes even before the cancer develops; but no less important, literature describes cancer patients as helpless. This chapter discusses helplessness as a learned response (Seligman, 1975) which may be important in the psychodynamic development of cancer. Seligman's (1975) research suggests that helplessness is often associated with depression, passivity, and the feeling that there is no way out of situations. Furthermore, this chapter applies Seligman's theory to cancer patients who experience depression and passivity frequently in their lives before developing cancer. The last part of this chapter presents a theoretical discussion explaining helplessness and hopelessness in a developmental and dynamic way in connection with cancer patients. This discussion constitutes the underpinnings of the major theoretical workings of the theory.

Hopelessness in Cancer Patients

In a review of the writings of eighteenth and nineteenth century physicians describing cancer patients, Kowal (1955) wrote: "Out of the whole range of human emotions they [the physicians] all, more or less, tended to select for emphasis those which reflected despair or hopelessness as the precursor of the neoplastic state. Of this relation between despair and cancer they were convinced" (pp. 226-227). Modern writers have followed the lead of these earlier writers in reporting a period of despair and hopelessness preceding the onset of cancer (Goldfarb et al., 1967). For instance, Greene

(1966) found in 32 females with leukemia and lymphoma certain affects associated with the period prior to the onset of cancer: sadness (23 Ss); weeping (15 Ss); helplessness and hopelessness including the feelings of "too much," "given up," "lost," and "no future" (14 Ss); anxiety (3 Ss); anger (3 Ss); apathy (2 Ss). The onset of these affects occurred as long as four years before cancer was detected, with a median time of one year. In the same study, Greene (1966) found similar states of despair and hopelessness preceding the onset of leukemia and lymphoma in 57 out of 61 males. Unfortunately, Greene did not use control groups, so while his results lend weight to the theory which this dissertation explores, we can only view them as indicators and not as experimentally verified evidence.

Indeed it seems that hopelessness may be an antecedent of not only cancer, but life-threatening diseases in general (Engel, 1965; Brown, 1966). Engel (1965) identifies what he calls a "conservation-withdrawal" pattern in seriously ill patients. He interviewed patients with ulcerative colitis and leukemia, apparently comparing them to a group of general medical patients not selected for diagnosis. In more than 80 percent of all patients, the manifest disease was preceded by a psychological condition which ultimately he came to formulate as "giving up."

From open-ended interviews with patients on medical wards, Schmale (1958) determined that a hopelessness factor immediately precedes the onset of disease: "A feeling of 'despair,' 'nothing left,' or 'it's the end,' perceived as coming from a change in relationship [s], resulting in a self-directed desire to do absolutely nothing. Even as the object came closer . . . the patient was unable to relate" (p. 266).

Certain concepts from the Bahnsons' (Bahnson, 1970) theory of psychosomatic disease can be used to account for the fact that hopelessness

and despair precede the onset of cancer as well as other life-threatening diseases. According to the Bahnsons (Bahnson, 1970), people choose whether their customary reaction to unresolvable stress will be psychiatric or somatic. Just as psychiatric diseases can be classified in terms of degree of psychic regression, so can physical diseases in terms of "somatic regression." Cancer represents the most extreme somatic regression. Furthermore, for the Bahnsons, similar psychodynamics occur in all physical diseases, but in cancer they are the most extreme.

In the case of hopelessness specifically, I propose that while hopelessness may precede many diseases, in cancer patients it is at its most extreme. Indeed, Schmale and Iker (1966) looked for a "special kind of hopelessness" involving "total giving up," extreme self-blame, and frustration in a group of women suspected of but not yet conclusively diagnosed as having cancer of the cervix. Using open-ended taped interviews and certain scales on the Minnesota Multiphasic Personality Inventory (MMPI), they predicted outcomes of the diagnoses. While none of the MMPI measures reached the .05 level of significance as predictors, good results were obtained with the interviews from which estimates of the presence of this special hopelessness were made. In a later publication, Schmale and Iker (1971) reported that out of a total of 68 patients interviewed they correctly predicted 19 patients to have cancer, whereas 28 actually did have cancer. Thirty-one patients were predicted correctly to have no cancer, whereas 40 actually had no cancer. The percentage of correct predictions overall based on hopelessness determined from interviews equals 50/68, or 73.6 percent.

To explain their misses, Schmale and Iker (1971) theorize that for cancer to develop, two factors must be present: a predisposition to cancer on the cellular level and the development of hopelessness. The cellular

predisposition is the initiator, and hopelessness is the promotor; one without the other will not lead to cancer. So people who manifest hopelessness may not develop cancer because they lack the cellular tendency, and people with the cellular tendency may not develop cancer because they do not become hopeless.

Nevertheless, Schmale and Iker's theory does not account for the presence of cancer in those who do not evidence signs of hopelessness. These people may belong to a special type of cancer patient the Simontons call "Super Stars" (Achterberg, 1976), who never show signs of hopelessness or helplessness. Others have encountered these "atypical" non-hopeless cancer patients. Using the Differential Diagnostic Technique (North, 1953; Stennet, 1955), a projective method similar to the Bender Gestalt, Stavraký (1968) found that cancer patients who lived longest were frequently hostile and more emotionally controlled than those that die sooner. She sees these characteristics as the antithesis of the "hopelessness" or "giving up" reaction.

While the Simontons regard their non-hopeless cancer patients as special cases outside the typically described "hopeless" cancer personality, so far no one has proposed a theory which explains how people with seemingly antithetical personalities could share the same psychological dynamics. In the chapter "Limitlessness and the Controlling Persona," this dissertation establishes the common thread between them.

Thus far, we have discussed experimental evidence of hopelessness which occurs just prior to the development of cancer and which might be thought of as resulting from the physical changes that accompany cancer. However, many theorists suggest that hopelessness may not be solely a reaction to one life event, but may be a lifelong way of being, present long before cancer develops (Reich, 1948; Abse, Wilkins, Van de Castle, Buxton, Demars, Brown, and Kirschner, 1974).

Schmale and Iker (1971) noted that many of their cancer patients reported experiencing hopelessness on other occasions in their pasts. LeShan's studies (1966, 1977; LeShan & Gassman, 1958; LeShan & Reznikoff, 1960; LeShan & Worthington, 1956c) support the findings that hopelessness (and helplessness) is a lifelong pattern with cancer patients. In 42 out of 45 cancer therapy cases and in only one out of 30 control cases, LeShan (1966) found: "The pattern [of hopelessness] seems to have three major parts. The first is the childhood and adolescence marked by feelings of isolation; a sense that intense and meaningful relationships are dangerous and bring pain and rejection; and a sense of deep hopelessness and despair" (p. 783). Following adolescence, the patients achieved some temporary satisfactions in life but then returned to their previous state, resulting in:

... a sense of utter despair, and a conviction that life held nothing more for them... The depth and intensity of this orientation is so great that it is difficult to describe. Basically it is a bleak hopelessness about ever achieving any real feelings or meaning or enjoyment in life... [The patient] feels condemned to make tremendous efforts to share the zest, the enthusiasm, the feeling of belonging that he senses in others, but deeply believes that these efforts will ultimately fail (p. 783).

The hopelessness that LeShan describes became apparent primarily in intensive psychotherapy and was not reflected in the projective tests he gave, although, as Schmale and Iker report (1966), it emerged occasionally in interviews. In all but three cases, patients did not consciously verbalize their hopelessness at the beginning of therapy, but when they became conscious of it later in therapy, they said that they had always felt that way. One patient's description is especially poignant:

"I go on and I'm very efficient and I function very adequately, but this has nothing to do with the real me. Inside, none of this matters. All I've ever really wanted is just to be left alone, and since you never really can have that, all I wanted is to be dead" (LeShan, 1966, p. 783).

In 1976 H. M. Voth published his findings on one of the only longitudinal and therefore most valuable studies of personality variables in human cancer. In the early 1960's, H. M. Voth administered his perceptual test for autokinesis (the perception of movement of a stationary light in a dark room). In the test for autokinesis, the observer is seated at a table seven feet away from a pinpoint of white light in a normally lighted room. He is told that the room will be darkened except for a light, and that light may or may not appear to move. Should it move, he is to trace its path with a pencil on paper. The measure of autokinesis is the logarithm of the length in inches of the line drawn (H. M. Voth & Mayman, 1968). Those who see little or no movement are said to have low autokinesis, while those who see a great deal of movement have high autokinesis. Certain personality characteristics are associated with low or high autokinesis.

During the course of his 15 years of work on autokinesis, H. M. Voth (1976) obtained tests of hundreds of subjects. Over the years it came to his attention that 17 women and 14 men who had been given the test later developed cancer of the cervix, bowel, breast, thyroid, lymph tissue, or skin. Using the chi square test, Voth found that the 31 cancer patients demonstrated less autokinesis than other hospitalized psychiatric patients ($X^2 = 6.82, p < .025$), and much less than normals ($X^2 = 171.42, p < .005$). While hospitalized psychiatric patients experience less autokinesis than normals ($X^2 = 171.42, p < .005$), cancer patients demonstrate extremely low autokinesis, lower than both psychiatric patients and normals.

Low autokinesis has been associated with depression (A.C. Voth, 1974; A. C. Voth & H. M. Voth, 1971), tendencies toward suicide (H. M. Voth, A. C. Voth, & Cancro, 1969), and the inclination to require hospitalization (H. M. Voth, 1976). H. M. Voth (1976) believes that the common element among

depression, need for hospitalization, and suicide is a sense of defeat and hopelessness.

H. M. Voth's 1976 study is one of primary importance because it supports the hypothesis that there are enduring psychological factors in cancer patients that precede the development of the tumor. Because Voth collected his data long before cancer developed, it seems that the hopelessness associated with low autokinesis existed as well long before cancer developed.

In the only other retrospective study of cancer patients, Hagnell (1966) re-examined a Swedish population given the Sjobring method of personality description in 1947. This method is based on a theory of personality variation that assumes the existence of four independent "constitutionally" determined dimensions of personality function: 1) intellectual ability, 2) the degree of lability and suggestibility in intellectual as well as emotional life, 3) the amount of energy supply in nervous system functioning, and most important for the present discussion, 4) a factor called, "Stability." Stability is defined by Hagnell as relating to "emotional control in the sense of coolness" and to "degree of abstract thinking and of precision and elegance of thought" (p. 847). On each factor, people can score in the normal range (Medio), low (Sub), or high (Super). A Substable score indicates tendencies toward inertia and inhibition, and in Hagnell's words, is related to a "melancholic" approach to life.

Out of 2,550 adults assessed, 20 men and 22 women were identified as having developed cancer during the ten years between July 1947 and June 1957. For the most part, diagnosis was obtained through operation, biopsy, or autopsy. No associations were observed between cancer incidence and the four personality ratings for the men. But there was a marked excess of

observed cases of cancer among Substable women, when age-specific incidence rates of cancer for all women were used to calculate the expected number of cases among women measured for Stability. Eight controls matched for sex and birth date were drawn for each of these female cancer cases. More cancer patients were Substable than were noncancerous controls ($p < .005$).

Like the H. M. Voth (1976) research, the importance of this study lies in the fact that the personality factors were in evidence long before the cancer developed, in some cases as many as ten years. Of all the current research in cancer, these two studies lend the most support to the hypothesis that there are psychological factors that predate cancer development.

The foregoing review suggests that cancer patients and others suffer from hopelessness not only at the time of disease onset, but also at other times in their lives. In some of the literature, the word "helplessness" is sometimes used interchangeably with hopelessness. The confusion calls for clarification. Hopelessness is a feeling state of despairing, when the person has no expectation of good or success. Helplessness is a behavioral and psychological state of "doing nothing" that occurs when events are perceived as beyond the control of the person experiencing them (Seligman, 1975). Hopelessness is the larger category in that if one feels hopeless, he will be helpless. However, one can be helpless without feeling hopeless. This distinction is particularly important to the present theory because Seligman's recent research on the developmental dynamics of learned helplessness may shed some light on the possible developmental dynamics of cancer patients.

Helplessness in Cancer Patients and Learned Helplessness

Seligman and his co-workers (Miller & Seligman, 1973; Overmeier & Seligman, 1967; Seligman, 1968; Seligman, 1975; Seligman & Maier, 1967)

conducted the definitive work on helplessness as a behavioral style. They placed dogs in well-designed experimental situations to maximize the dogs' actual helplessness. Dogs which had not experienced helplessness quickly learned to jump a barrier to avoid shock in a shuttle box. When a light preceded the shock, these dogs learned to avoid the shock entirely by jumping to a safe compartment. However, if a dog had previously been placed in a situation where shocks were unavoidable and inescapable, where nothing the dog did ended the shock, then when placed in the shuttle box where he could avoid the shock, he would not jump to safety. In fact, this "learned helplessness" is very difficult to extinguish. Even when the experimenter "showed" the dog how to escape by dragging him across the barrier, almost all of the dogs never learned to jump to safety. The dogs sat and took the shock.

Studies with humans under various unavoidable painful situations, some involving shock, have resulted in the same findings as those with the dogs (Hiroto, 1974; Hiroto & Seligman, 1975). People learned helplessness when placed in situations in which nothing they did could control their discomfort.

According to Seligman (1975), some of the side effects of learned helplessness are depression, passivity (making no attempts to avoid discomfort when escape is possible), decreased appetite, loss of sexual potency, and a lack of normal aggressiveness (the dogs do not fight back when attacked). If helplessness is a factor in the psychological dynamics of cancer patients, then we might expect characteristics of cancer patients to include some of these side effects.

The following discussion draws parallels between the side effects of helplessness that Seligman noted and characteristics of cancer patients. A gradual decline in sexual potency, starting as long as ten years prior to the

development of cancer, was present in the patients Reich (1948) treated for cancer. Seligman's "failure to fight back when attacked" is similar to an inability to express anger or hostility on one's own behalf, which has frequently been observed in cancer patients (Bacon, Renneker, & Cutler, 1952; Bahnson & Bahnson, 1966; Butler, 1954; Cobb, 1953; LeShan, 1977; Nemeth & Mezei, 1964; Roland & Snyder, 1977; Simonton & Simonton, 1975). Anorexia, or loss of appetite, almost always accompanies cancer (Butler, 1954; Greene, Young, & Swisher, 1956). Of course, anorexia may be a result of metabolic changes brought about by the tumor itself; however, no one seems to know conclusively why the anorexia appears. These characteristics of cancer patients which parallel the side effects of learned helplessness are not discussed in the literature as often as are depression and passivity. The section which follows is a review of studies which suggest depression and passivity are associated with the development of cancer.

Passivity and Depression

Passivity in cancer patients has been noted by several writers (Blumberg, West, & Ellis, 1954; Greene, 1954, 1966; Greene & Miller, 1958; Greene, Young, & Swisher, 1956). In comparing the Rorschach responses of a group of cancer patients with those of a group of benign tumor patients, Nemeth and Mezei (1964) found that although there is no significant difference in the total hostility score, when this score is broken up into active and passive scores, the difference appears. Namely, the malignant group scores high on passive hostility (wound, broken or decayed objects, smashed creatures), whereas the benign group is high on active hostility (fighting, quarreling, devouring creatures). Also, the benign group seems to defend themselves against their dependency needs while the cancer subjects

submit to them. Fighting appears to be the benign group's style, while passivity and helplessness are the cancer group's style.

Researchers argue whether depression is a response to having cancer or is a psychodynamic trait of cancer patients. Depression has been reported to occur long before the onset of cancer, in both patients in psychoanalysis (Abse, 1964; Inman, 1964; Renneker, 1957) and those not in psychotherapy (Miller & Jones, 1948). In most cases, psychoanalysis had been ongoing for several years prior to the development of cancer, with depression being one of the patient's presenting complaints. Voth's (1976) retrospective study also suggests a life history of depression in cancer patients, since they scored low in autokinesis long before cancer developed. Low autokinesis is associated with depression and suicidal tendencies.

Still, it is not conclusively clear from the literature whether depression occurs before the development of cancer. Chevens reported in 1931 that while death from cancer was relatively rare among hospitalized mental patients, when it did occur it was more than twice as frequent in paranoid than in melancholic (depressed) patients (Chevens, 1931). On the other hand, death from cancer seems to be associated with affective psychosis, which includes severe depression. According to Bratfos and Haug (1968), patients with affective psychosis have a three-fold death rate compared to the general population, with cancer being one of the most frequent causes of death.

In a retrospective study, Kerr, Schapira, and Roth (1969) used a sample of 135 patients with affective disorders who were admitted to psychiatric hospitals over a two-year period (1963-1965). Of 28 males with depressive illnesses, five died from carcinoma and seven died from other physical diseases. The difference between the expected number of deaths

from carcinoma based on the age of the sample and national death rates in 1965, and the observed rate using the exact Poisson probabilities test was highly significant ($p = .0001$). These patients apparently had no previous history of depressive illness, and the onset of this depression was insidious and without apparent cause. The time intervals in years between the onset of depression and death for five patients were 1, 1.1, 2.7, 3, and 4.2. Kerr et al. conclude that depressive illness may be an early manifestation of cancer.

In a seemingly contradictory study, Evans, Baldwin, and Gath (1974) used a larger sample, 823 psychiatric inpatients who were diagnosed as having affective disorders. Diagnosis was made by clinicians and coded according to the standard international code. Expected mortality rates from cancer were based on local figures for the site of the experiment. The cancer rate among patients with affective disorders did not exceed the rate typical for that area.

The foregoing two studies seem to contradict each other unless we examine their methods more closely. In the Kerr et al. study, patients were diagnosed as having cancer before they were found to be depressed. From this study we can only say that people having cancer are likely to be depressed. On the other hand, Evans et al. tried to predict contraction of and death from cancer in a group of depressives. That the cancer rate is no higher for this depressed group than it is in a local control group shows only that people who get depressed do not necessarily get cancer.

Craig and Abeloff (1974) in administering a questionnaire to cancer patients which assesses self-rating of psychiatric symptoms found that depression was one of the two factors chosen, while anxiety and hostility were not. Unfortunately, no control group was used so all that can be said of this study is that cancer patients describe themselves as depressed rather than as anxious or hostile.

On the one hand, Shands, Finesinger, Cobb, and Abrams (1951) argue that depression develops secondarily to the cancer and to being treated for cancer. They consider this depression to be one approach to handling hostilities, an alternative approach being paranoia. For these researchers then, the depression noted in cancer patients 1) occurs after cancer develops and 2) is only one of several routes the cancer patient might take to express his reaction to having cancer and being treated for it.

On the other hand, Bacon, Renneker, and Cutler (1952) hold that depression is not a reaction to having cancer but is a factor in its development. According to their study, depression was a frequent personality factor in 40 breast cancer patients prior to the diagnosis of cancer. The depression was both acute and chronic, with the patients experiencing vague feelings of anxiety, guilt, and self-blame. Indeed, for Bacon et al., depression plays a major role in the ontology of cancer: "Separation traumas and depressions should be viewed as establishing a favorable internal climate for disease. This state of decreased host resistance is what is alluded to in such phrases as 'passive suicide' or 'host acquiescence'" (p. 121).

If depression is dynamically important in the cancer process, then we would expect that patients who undergo therapy for depression might experience a change in the course of their cancers. Goldfarb, Driesen, and Cole (1967) report giving chemotherapy and electro shock therapy, a treatment used almost exclusively in depression, to three depressed cancer patients. After 17 months, one patient showed no evidence of her breast tumor, one died of cancer, and the third died much later of pneumonitis with the relationship to malignancy unknown to the author. Goldfarb et al. speculate that the physical agent in these somewhat favorable results could have been the reduction of free fatty acids brought about by the administration of electro shock therapy. Thus, they associate the reduction of free

fatty acids with both a resolution of depression and a reduction in cancer growth.

In support of this theory Goldfarb et al. cite two cases of cancer treated by Koroljow (1962) using insulin shock (coma), which not only dispels depression but also reduces free fatty acid levels. In the first case, Koroljow administered insulin shock to two patients, one with cancer of the leg and the other with cancer of the cervix, both severely depressed. Following insulin shock, not only was their depression dispelled, but they were apparently free of cancer for at least two years. Koroljow lost contact with them after two years. The second case, reported in a personal communication to Goldfarb, concerns the successful treatment of two patients with carcinoma to whom Koroljow gave oral insulin (tolbutamide), which also reduces free fatty acids. They remained free of carcinoma for more than two years. Thus, Goldfarb et al. conclude: "It appears that cancer patients and depressed patients share psychodynamic characteristics (difficulty with object loss, feelings of despair, and inability to express anger) as well as biochemical (elevated free fatty acid level) features" (p. 1550).

Other observers do not find depression associated with cancer. Schmale and Iker (1966) report that depression as shown on the MMPI is not a good predictor of whether a patient suspected of cancer indeed turns out to be diagnosed as having cancer. Bahnson and Bahnson (1964b) report that there are indices on the Rorschach that contraindicate depression: "1) the low number of (K, k, and C') percepts, especially the lack of dysphoric C', 2) the high W% and low Dd%, and 3) finding that (H + A) (Hd + Ad). These indicators should be reversed in order to suggest depression" (p. 47).

The best explanation of these seemingly contradictory findings on depression is that the factor being traced by researchers is not really depression but is some other product of learned helplessness such as apathy or inhibition. While some of the cancer patients who have this special apathy born of helplessness may also be depressed, others may not be. Bahnson and Bahnson (1964b) are two of the few writers who recognize apathy without depression in cancer patients. They write that it is not depression per se that characterizes the cancer patient:

Their personality picture, then, became characterized by bleakness, depletion, and lack of emotional meaning. In other studies, this barrenness has been interpreted as depression, grief, or despair; in other words, as the manifestation of an affective reaction or a mood state Here we have wished to present an alternative hypothesis: that the observed flattening and emptiness of the cancer personality is not necessarily related to depression (p. 61).

Helplessness and Inhibition

More meaningful for the understanding of the psychodynamics of cancer patients than simple observations that they frequently experience mood states such as hopelessness and depression is considering descriptions of cancer patients in the context of what we know about helplessness. Only a few writers actually use the word "helpless" in describing cancer patients. One is Schmale (1958). Using open-ended interviews with patients admitted to medical wards, many of whom had cancer, he found a factor he called helplessness, which occurred prior to the onset of disease. These patients experienced: "A feeling of being 'discouraged,' 'let down,' and 'left out' perceived as coming from a change in relationship [s], leading to an object-directed desire to be taken care of and protected. The patient was unable, however, to act on the desire to bring the object close" (p. 264).

While not exactly emphasizing the helplessness of their cancer patients, Nemeth and Mezei (1964) observed clear instances of it in psychological testing. They developed a malignity score based on the Rorschach, for distinguishing benign tumor patients from cancer patients. Nemeth and Mezei found only four responses which distinguished the two groups. Of importance to us here was the finding that cancer patients asked for help in taking the test, while benign patients tended not to do so. Since testing situations are commonly viewed as microcosms of the client's behavioral style, these patients are probably helpless in other aspects of their lives. As an indicator of helplessness, this study provides clinical data for observable, behavioral helplessness which occurs frequently in cancer patients and which does not occur in patients with benign tumors.

Two aspects of helplessness described in the above research are the feelings that 1) nothing one does can change his situation, and 2) one needs to be taken care of by others. Other aspects of helplessness are: 3) the feeling that one is trapped in a situation from which there is no escape, and 4) the sense that "doing nothing," or inhibiting oneself, is the best response in most situations (Seligman, 1975). While actual helplessness is not often mentioned in descriptions of cancer patients, one or several of these aspects of helplessness may be. For example, LeShan and Gassman (1958) found that all but one of their cancer patients in psychotherapy reported that at some time in their lives before the onset of cancer, "they had reached a point of despair about ever being able to obtain any real satisfaction in life. They felt themselves to be in a mental trap, a situation in which their creative energies could not function, and from which there was no escape" (p. 729). Even the "special kind of hopelessness" described earlier in this chapter and discovered by Schmale and Iker (1971) seems to be a facet of helplessness in that it

involves a sense of no escape, a giving up, a sense of frustration for which the person feels there is no resolution.

One chilling bit of information in the cancer literature indirectly points to a helplessness factor associated with cancer. American prisoners of war detained in Japanese prison camps died from cancer at a rate which exceeded that of the general population of comparable age by a factor of more than two to one (Federal Security Agency, 1940-1955). One limitation of this study is that no information was provided as to whether the prisoners of war were unduly exposed to radiation. Perhaps the horror of prison camp life is not that one might die or be tortured, but that one is entirely helpless to influence his fate. Furthermore, in order to maintain a modicum of safety, one must inhibit himself in every way.

When Seligman (1975) describes how helpless people "do nothing" in the face of stress or threat, one gets the sense that they employ pervasive inhibition. Different kinds of inhibition have been connected with cancer patients. For instance, Grinker (1966) mentions inhibition of certain functions of organs or organ systems which leads to "extinction of internal vegetative activities." Actually, this idea is not new with Grinker, although he might not be aware of it. In the 1940's Wilhelm Reich (1948) described this same inhibition of vegetative functioning as a precursor to cancer in the patients he was treating. Perhaps this is an example of inhibition born of helplessness; inhibition that is so pervasive it is expressed on a visceral level.

A second kind of inhibition, parasympathetic dominance of the autonomic nervous system, may be characteristic of cancer patients. Alexander (1950) identified parasympathetic dominance as a characteristic of certain individuals, and as an indication of chronic states of inhibition as opposed to excitation. He theorized that parasympathetic dominance charac-

opposed to excitation. He theorized that parasympathetic dominance characterizes people with various psychosomatic diseases, while sympathetic dominance characterizes people with diseases related to overexcited states, such as heart conditions. Reich (1948) was first to suggest that cancer is among the diseases of people with parasympathetic dominance. Recent research supports these theories. Kissen, Brown, and Kissen (1969) gave a new eleven-item scale of the Awareness of Autonomic Activity (AAA) to 120 lung cancer patients and 157 cancer-free controls. Low scores indicate a lack of awareness of autonomic activity, a factor associated with parasympathetic dominance. That cancer patients scored significantly lower than controls suggests they are parasympathetically dominant. Kissen cites Mandler as reporting that people who experience less autonomic activity as measured by the AAA actually have less. "To be more specific yet, inspection of the items of the AAA scale suggests that high scorers probably experience much activity of the sympathetic nervous system . . . the lung cancer patients may have low arousal . . . they may be parasympathetically dominant" (p. 542).

If cancer patients are parasympathetically dominant, it follows that they might respond to stress not with physiological responses associated with preparation for fight or flight, but with physiological signs of slowed responses. For example, Katz, Weiner, and Gallagher (1970) found that the steroid rate of cancer patients who had just been told that they had breast cancer was very low, a paradoxical occurrence because the commonly assumed reaction to stress is an increased steroid rate (Selye, 1946). To explain this curious phenomenon, Katz et al. speculate that cancer patients and depressives may have been physiologically immobilized (inhibited) over many years.

We also wonder whether certain chronically depressed people may even appear to respond with "paradoxical" steroid rates in the face of a new threat. These are frequently people who have become psychologically immobilized over many years; conceivably there is an associated "damping down" of physiological responsiveness as well (p. 141).

A third kind of inhibition which may be associated with cancer is inhibition of the Central Nervous System (CNS). In controlled experiments with rats, Kavetsky, Turkevich, and Balitsky (1966) reported that there is evidence suggesting that inhibition of the CNS favors tumor development while excitation hinders it. Specifically sodium amytal, a CNS inhibitor, leads to marked invasiveness of the cancer while excitation of the CNS with caffeine, strychnine, or amphetamine inhibits the spread of cancer. In this case then, CNS inhibition is associated with cancer growth, while its opposite, excitation, is associated with a retardation in growth.

Cancer patients also show signs of "cortical inhibition," according to George (1970). George hypothesized that low reversal rates on the Necker Cube signify cortical inhibition. The Necker Cube is a drawing of a three-dimensional figure which gives the illusion of reversing the top with the bottom. Reversal rates, which differ for different populations, are calculated by counting how many reversals are reported by subjects within a given time period. Testing 31 cancer patients and 39 control patients with miscellaneous disorders at a veteran's hospital, George found the cancer patients to have a significantly lower rate of reversal ($p < .01$), indicating the cancer patients manifested more cortical inhibition than did the control group.

Finally, perhaps inhibition in the nervous system is correlated with inhibition in general behavior. Cancer patients have often been described as inhibited in terms of different aspects of their personality, or as "inhibited" people (Butler, 1954; B. Cobb, 1953; Nemeth & Mezei, 1963; Renneker et al., 1963).

Inhibition, whether physiological or behavioral, impedes free activity, expression, or functioning. The issue here is not so much what functions are inhibited but why. In the helplessness paradigm, the animals and humans keep themselves from making any responses; they inhibit themselves. From the literature on physiological and behavioral inhibition in cancer patients; on depression, passivity, decreased sexual functioning, and decreased aggression (all side effects of helplessness); and on observed hopelessness and instances of helplessness in a testing situation, I suggest that helplessness may be an important, indeed central dynamic in the psychological development of cancer patients.

Helplessness and Hopelessness, the Underlying Emotional Dynamic of the Cancer Patient's Personality Style

Evidence has been presented here that implies that cancer patients have been subjected to developmental environments that foster the helplessness and hopelessness found in adults. No one has attempted to construct a model of the early lives of cancer patients which reflects these observed characteristics in adults, perhaps because few researchers have accepted the possibility that cancer could be psychogenic. In the remainder of this chapter, I offer the following theoretical reconstruction of the developmental factors that foster helplessness and hopelessness as a model of the early lives of cancer patients.

One can readily imagine childhood situations, especially in infancy, in which the parents construct the environment so that the child's actions have no influence on his fate. Indeed, childrearing techniques practiced by many American parents do just that. For example, parents let children "cry it out" in the crib, because responding to their cries would either reinforce crying behavior or the child's expectation of gratification (thereby "spoiling" the child). As Bell and Ainsworth (1972) report:

Because it is disagreeable to adults, however, crying is generally considered a changeworthy behavior. The issue of infant crying and the effect of maternal responsiveness to it has prompted pronouncements on infant care and is at the center of the controversy between "strict" versus "permissive" practices. A review of U.S. Children's Bureau "Infant Care" pamphlets shows that, in the period between 1920 and 1940, mothers were admonished not to pick up a baby between feedings, lest he learn "that crying will get him what he wants, sufficient to make a spoiled, fussy baby, and a household tyrant whose continual demands make a slave of the mother" (1924, p. 44). Although more recent advice of the bureau encourages mothers to follow their natural impulse to respond to crying, the belief that this may result in increased crying persists, supported by untested or perhaps naive extrapolations from learning theory which assume that to respond to a cry will reinforce crying behavior (p. 117).

Not responding to the infant's cries, the parent sets up the helplessness paradigm. The infant's crying is his only way of doing something about his situation: call for help. Ignoring the cry leaves the infant with the sense that nothing he does changes his situation; in other words, with the sense that he is helpless.

This childrearing technique may result in what Engle (1965) identified as a "Depression-Withdrawal-Response." He discusses a case in which a two-year-old had been left unattended for long periods during which no one responded to her crying. In contrast to most children who respond to threat with crying and moving away, this child responded by "abrupt cessation of all motor activity, loss of muscle tone, inattention, and ultimately, sleep" (p. 851). Her response corresponds perfectly to the parasympathetic response identified as helplessness, and proposed earlier as part of the cancer patient's style.

While one important element in Seligman's helplessness paradigm is that nothing the person does changes his situation, there is another element

that stands out as particularly horrifying: the subjects had no way to escape from continuous pain in the form of electroshock. It is no simple accident that continuous pain was an integral part of the experimental design. Not being able to stop pain would leave anyone experiencing it with an acute sense of helplessness and hopelessness. This very element in the paradigm is what the potential cancer patient probably suffers from most in his childhood, continual psychologically-generated pain from which he cannot escape.

One can readily imagine childhood situations in which parents inadvertently construct the environment so that the child's actions do not influence his fate, but one has difficulty imagining situations in which parents cause the child continuous pain. Yet, this is exactly what I propose here: in addition to maximizing situational helplessness as described above, what I will term the "carcinogenic" parent causes his child continuous pain from which he cannot escape. The following theory of pain accumulation and storage, derived from Primal Theory (Janov, 1970), explains how this childhood dilemma can come about. In order to fully present this particular form of pathology, I will first describe the situations that mediate against it and then the conditions which cause it.

When children are unhampered and emotionally healthy, they express their feelings, pain, anger, fear, and joyousness in lively, active, and even loud ways. They express their needs and the helplessness that is a natural condition of infancy. Healthy parents welcome the expression of the child's full range of emotions, from joy to rage; they also recognize the child's needs and feel good about satisfying them. But healthy parents know that there are needs of the child that they cannot remedy. For example, they cannot stop the pain which a colicky baby goes through. Yet they do not feel helpless as parents, for they recognize that there are many experiences in

life over which no one has any control. They hold their baby and tell him, "I know it hurts. We'll go through this together. Just cry it out." They know intuitively that crying is the infant's means of discharging pain. Healthy parents then are not threatened by their own or their infant's helplessness.

In contrast, I hypothesize that the carcinogenic parents neither meet the child's needs¹ nor tolerate his expression of pain (crying). The following hypotheses about carcinogenic parents are offered as a theoretical reconstruction of the way they interact with their children. Research is needed to test them. Carcinogenic parents work under several premises: By (1) being perfect parents, they (2) are in complete control of their child's actions and well-being, and so (3) their child need never cry.² When the child cries for no apparent reason, the carcinogenic parents find themselves with no other recourse than to shut him up.

I hypothesize that the carcinogenic parents invest themselves in the perfection of their role and are therefore blinded to the real needs of their child. This failure to meet the needs of their child inflicts great physical and emotional pain. But as the child of carcinogenic parents, he cannot express his pain through crying, and so he has no other choice but to trap the pain inside, causing tremendous internal stress. As the child matures, he continues to hold in his pain and emotions and never develops an adequate outlet for them. Because he cannot discharge them outwardly, his only choice is to store them and discharge them inwardly on his own tissues.

The above account of the onset of disease is but one major consequence of the inability to express pain and emotions outwardly. There are many indications that cancer patients discharge emotions ineffectively or not at all (see Chapter 3). A second crucial consequence is that the individual develops an unreal self, in a desperate attempt to become a person

his parents can love: quiet, obedient, subservient, or high achieving (Janov, 1970). Janov (1970) reports that the unreal self develops when the child has to shut himself off to the intolerable internal pain in order to survive. But there is a price to pay for surviving this way: By shutting off his awareness of pain, the child shuts himself off from totally experiencing any of his feelings, positive or negative, and he is no longer fully living his life.

Shutting off from emotions and pain is called "the split" (Janov, 1970) because the child splits away from his real self which is his feeling, expressive, needing self. Instead of realizing his parents will never love him for his real self, he takes up the false hope that maybe they will love him if he complies with their demands to be something other than his real self; that is, the parent-pleasing unreal self.

Thus, the cancer patient invests in the unreal self to the exclusion of his real, expressive self.³ For example, cancer patients are described as controlled, well-behaved, acquiescent, and overly socially adjusted (see Chapter 3), in other words, parent pleasing. But the cancer patient is indeed "split": on the outside, he may appear even serene and happy, but underneath his entrenched social facade lies unbearable psychic pain all the more unbearable because it has never been relieved through discharge.

By assuming an unreal nonexpressive self, the cancer patient becomes constricted and leads a "barren" (Bahnson & Bahnson, 1964c) and emotionally dead life. Furthermore, over the years he becomes so out of touch with his real self that he is no longer aware of his own needs.⁴

A third consequence of poor emotional discharge is that the stored pain and emotions never let up. They are constant, continuous, and inescapable. Because he cannot discharge them, the person is trapped with his pain and emotions. Nothing he does enables him to escape from or

adequately rid himself of his psychic pain. In other words, he is helpless to change his internal state. Such is the case with cancer patients: they carry with them a constant source of psychic pain, which they are helpless to discharge. In combination with a childhood in which learned helplessness (Seligman, 1975) is maximized, this last consequence of poor emotional expression means that helplessness and being trapped are the cancer patient's major issues. The cancer patient learns early not only that he is helpless to influence his situation, but also that he is helpless to rid himself of trapped internal pain and emotions. The consequences of this situation have a direct bearing on the personality characteristics of cancer patients, their major life issues, and the time at which cancer will develop. These ideas will be presented in their entirety in the following chapters.

NOTES TO CHAPTER 2

¹Booth (1969) suspected that carcinogenic parents do not fully meet the needs of their children. For example, he linked the increase in mortality from cancer to the childrearing technique of bottle feeding which frustrates some very basic needs: "The risk for the bottle-fed infant is created by the fact that it can be done in a completely mechanical way, and all display of affection is the result of either instinct or of conscious intention. Not so long ago, the prevailing medical attitude even deliberately discouraged the cuddling of babies as 'unhygienic' or as bad for the development of a sound character That [the predisposition] for cancer results partly from modern childrearing practices is most strongly suggested by the fact that, within the last 25 years, childhood cancer, formerly a rare event, has become the second-ranking cause of death in childhood" (p. 57).

²It is difficult to reconcile cancer patients' accounts of being ignored, abused, or neglected as children with a desire on their parents' part to be perfect. While the neglect is very real, the carcinogenic parent still presents himself to the world and to his child as having fulfilled his role as a parent perfectly.

³Bahnsen and Bahnsen (1964c) report that cancer patients have on the one hand a "conscious self which is socially adequate, but empty and meaningless" . . . and on the other, an "unconscious self which is explosive, tragic, and tormented By discharging the bio-physical correlates of inhibited psychic drive along primitive and regressive physiological channels, the person kills himself [with cancer]. The two 'selves' have remained strangers to each other" (p. 61).

⁴As LeShan (1977) comments on cancer patients in psychotherapy: "Frequently, I found, the cancer patient's own desires and wishes had been so completely repressed, and the self-alienation was so total that when at the start of therapy I asked the question, 'What do you really want out of life?' the response would be a blank and astonished stare. That question had never been seen as valid" (LeShan, 1977, p. 34).

Chapter 3

EMOTIONS, SOCIALIZATION, AND THE RELATIONSHIP TO PARENTS

As demonstrated in the previous chapter, the cancer patient's difficulty with expressing his feelings is the central dynamic in the development of the behavioral style of the majority of cancer patients, characterized as overly polite, acquiescent, and obedient, or in other words, as excessively socialized. I believe that poor emotional expression and excessive socialization go hand in hand. For example, a typically overly-polite person does not show anger; indeed, he is "in control of himself," meaning in control of his emotions, most of the time.

Even more central than the role of excessive socialization in the ontogeny of cancer is inadequate or abortive expression of emotions; therefore, the second part of this chapter reviews the literature which suggests that cancer patients demonstrate those traits. Later in this second section we discuss the premise that denial and repression are the defense mechanisms most likely to be associated with emotional suppression. Then, literature which addresses this issue in terms of cancer patients is reviewed. The incapacity to adequately discharge emotions and the tendency toward over-socialization may be regarded as only a mild form of psychopathology, if considered pathological at all by many conventional psychotherapists. However, it is the thesis of this chapter that when these factors exist in the extreme, as they seem to do in cancer patients, they indicate great, if hidden and subtle, early psychological damage. When one's means of emotional expression have been damaged, one has little chance for healing or psychological growth later in life, and one is even less likely to heal or change than

one who is excessively "expressive." For example, the psychotic, whom we accept as having been severely damaged in early life, achieves expression of sorts in his pathology. If allowed a safe environment in which to express his pathology fully, he will often heal himself through expression (Laing, 1967). The cancer patient, however, by means of massive denial and repression possesses no such outlet, and I propose here that 1) without extensive psychotherapeutic intervention, growth and change is very unlikely, and 2) early deprivation of a particularly severe, hidden, and subtle nature occurred, perhaps equal to the deprivation suffered by psychotics.

Since the possibility that cancer is psychogenic has only recently re-emerged in the literature, few studies exist on the early lives of cancer patients. These few studies will be reviewed in the final section of this chapter. It is hoped that such a discussion will generate interest in the early childhoods of cancer patients so that practices that seem to encourage the development of cancer might be examined in the interests of prevention.

The Cancer Patient's Social Style: Excessively Socialized

The cancer patient behaves in a manner that suggests obedience to cultural proscriptions. The literature on cancer patients repeatedly describes them as possessing culturally valued traits. The most frequently mentioned trait is a facade of excessive pleasantness and cheerfulness (Bacon, Renneker, & Cutler, 1952; O. B. Inman, 1964; Renneker, Cutler, Hora, Bacon, Bradley, & Kearney, 1963). Cancer patients have always been described as being: "universally tractable with an eagerness to please" (Trunnell, 1952); compliant (Bacon et al., 1952; Miller & Jones, 1948); nice (Blumberg, West, & Ellis, 1954; Trunnell, 1952); having benign goodness (Butler, 1954; LeShan & Gassman, 1958); agreeable (LeShan & Gassman, 1958); polite, apologetic,

almost painfully acquiescent, overcooperative (Blumberg et al., 1954); consistently serious (Bahnson & Bahnson, 1966; Blumberg et al., 1954), overly conscientious (Schmale & Iker, 1966). In fact, the literature consistently shows that cancer patients are unable to express hostility in particular (Bacon et al., 1952; Bahnson & Bahnson, 1966; Butler, 1954; Cobb, 1953; Cutler, 1954; Greene, Young, & Swisher, 1956; LeShan, 1966; LeShan & Worthington, 1965b, 1956c; Renneker et al., 1963; Stavrazy et al., 1966;), and even deny that they are hostile (Craig & Abeloff, 1974), another mark of well-behaved good people.

Kissen (1963a, 1964a) found that lung cancer patients report much lower incidence of childhood behavioral disorders such as bedwetting, temper tantrums, and trouble with authority than people with other chest problems. Kissen interprets this as indicating a reduced outlet for emotions in childhood, which also suggests a history of obedience to cultural and parental proscriptions. Ruderman (1977), a recovered cancer patient turned psychotherapist, describes himself and his cancer patients as having led lives of social adjustment. On paper and pencil tests, cancer patients also report themselves socially adjusted (Huggan, 1968b).

Indeed, cancer patients appear the model of sanity and adjustment, in that they are anchored in day-to-day existence and are not likely to be flighty or overly imaginative. For example, researchers note cancer patients have a most "practical" approach to life (Bahnson & Bahnson, 1964b) or what others call a "reality orientation" (Abse et al., 1972; Blumberg et al., 1954; Evans, 1926; LeShan, 1966). In two experimental studies (reviewed in detail in Chapter 2) using extensively validated instruments and conducted years before the populations tested developed cancer, Hagnell (1966) found that future cancer patients "effectively engaged in everyday happenings," as

opposed to having an "abstract or idea orientation"; and Voth (1976) found future cancer patients clinging to current, reality-oriented problem-solving. In Voth's test the future cancer patients were remarkably anchored in the actual reality of the test situation and were not at all focused on subjective experiences, an unusual occurrence in his testing situation.

The focus on day-to-day experience, which contributes to the sense that the cancer patient is highly normal and adjusted, may instead be a manifestation of what Evans (1926) terms extraversion. The cancer patient avoids, at all costs, looking inward. Later in this chapter the cancer patient's avoidance of emotional catharsis will be discussed in detail. One prerequisite of cathartic emotional expression is a willingness to reveal internal states, which the cancer patient seems unwilling to do. In fact, the unusually strong focus on external reality interferes with the focus on internal emotional states necessary for full emotional expression.

That cancer patients seem overly polite and acquiescent, reality-oriented, and externally focused may seem mild problems, if they can be termed problems at all. However, some authors feel that such descriptions graze only the surface of a deeper dynamic, that of severe constriction and rigidity. First reporting on the rigidity of cancer patients in her Jungian analysis of 100 cancer patients, Evans (1926) describes them as having an "inflexible nature" (p. 122), or as being "unyielding, obstinate, set-in-his-way" people (p. 113). The ground is prepared for the development of cancer when "The cancer patient is forced toward a compensation which is only obtained by a sacrifice of a one-sided attitude. This they will not do" (p. 119).

Subsequent researchers and psychotherapists have continued to describe cancer patients as rigid and conventional (Blumberg et al., 1954; Booth, 1965; Grisson, Weiner, & Weiner, 1975; Stavrakys, 1968). Reich (1948)

and the Bahnsons (1964a, 1966) view the rigidity of the cancer patient with alarm. Reich's entire book is devoted to a description of the extreme rigidity in the cancer patient's life, which results in constricting every aspect of living. According to Reich, the constriction occurs not only in the social and sexual realms, but also in the physical body itself. Although Reich was often able to loosen muscular constriction in most of his noncancerous patients, he sometimes found the task impossible with his cancer patients. He regards this rigidity and constriction as the primary cause of cancer development.

The Bahnsons (1966), outspoken about the all-pervasive rigidity and conventionality in the cancer patient, consider this a pathological constriction in living. First, in unstructured interviews, they found that cancer patients led continually constricted, rigid, and barren lives, and that they existed in a narrow day-to-day routine. "It was as if they then lived two lives: one formal, realistic, and common-sense oriented, filling a social role with near perfection, but with another wounded and despairing self existing independently and unrelated to the conscious and social self . . ." (p. 831). Elsewhere, the Bahnsons (1964b) describe a fomenting unconscious level and "on the other hand, a shell of schematic and appropriate social behavior, conscious and related to the 'social self,' which is carried out in a rigid and perseverative fashion" (p. 61).

Second, on the Rorschach the Bahnsons (1964b) found indications that, compared to a group of normal subjects, the cancer patient is "a rigid, constricted, practically-oriented person who cannot utilize his inner potentials in his relationship with the environment Thus they become robotlike, but retain the skills and reactions necessary to operate successfully and acceptably within the social structure" (1964b, p. 46). The Bahnsons (1964b) further describe the cancer patient as leading an emotionally bleak

life with a severe lack of self-communication, reduced access to emotional resources, a diminished ability for empathic contact, and a lack of what Rorschach (1953) termed the "inner reworking" of external reality. Similarly, Beatrix Cobb (1953) found that cancer patients show higher levels of constriction, passivity, and emotional immaturity on the Rorschach than do noncancerous controls.

Much of the foregoing discussion presents cancer patients as well-mannered, pacific, "good" persons who are cheerful in the face of adversity and, in conventional terms, well-adjusted (socialized). But Reich, the Bahnsons, and Cobb suggest that this surface adjustment might be masking a type of constriction that is devastating to the cancer patient's real inner self. The constriction mentioned most prevalently in the cancer literature is the inability to express emotions. I assume that such a constriction can indeed be devastating and, of itself, can act as a primary dynamic in the cancer process.

Diminished Outlet for Emotional Expression

This dissertation devotes much attention to emotions for three primary reasons. First, most authors writing cancer literature have noted that cancer patients have trouble expressing either one or several different emotions. Second, when researchers have discovered that cancer patients do not express their emotions, they have underestimated, and often failed to realize, the importance of their discovery. Third, I believe that there is a culturally supported tendency in most people to avoid feeling painful or negative emotions. This is particularly strong in cancer patients. The final chapter of this dissertation proposes a method of psychotherapy which puts cancer patients in touch with their long-suppressed painful emotions.

As a group, cancer patients have been repeatedly described as suppressing emotions, or expressing emotions unsatisfactorily. Simonton and Simonton (1975) note the frequency of reports linking emotions to cancer:

There are over 200 articles in the medical literature covering different aspects of the relationship between the emotions and stress to malignancy, as well as other very serious diseases. The interesting thing about the literature is that in all these articles the conclusion is that there is a relationship. None (to my knowledge) conclude that there is no relationship. The question is one of degree of importance and how to influence it, not whether or not the emotions are a factor (p. 29).

Furthermore, Simmons (1966) came to the same conclusion in his book, The Psychogenic Theory of Cancer: a wide variety of literature seems to implicate emotional variables in the psychogenesis of cancer. In addition, LeShan and Worthington (1956b), in reviewing approximately 40 articles on cancer, conclude:

As one examines these papers, one is struck by the fact that there are consistent factors reported in the studies which gathered their material in different ways. There appear to be some separate threads which run through the entire literature . . . the cancer patient's inability successfully to express hostile feelings and emotions . . . (p. 55).

Early studies also report a link between emotions and cancer. Elida Evans (1926) noted that a loss of some kind often preceded the development of cancer and that cancer patients were unable to secure any effective outlet for psychic energy. Perhaps Evans was observing the results of blocked emotional expression in the face of loss.

According to Kowal (1955), eighteenth and nineteenth century physicians were aware of the relationship between emotions and cancer. These physicians mention the following emotional states as primary or contributing causes of cancer: grief, disappointment, bereavement, despair, hopelessness, and mental depression. I propose, however, that linking the presence of these emotions with the cause of cancer is misleading. After all,

many people encounter these emotions throughout life and do not develop cancer. Rather, it is the failure to encounter them completely, to express them fully and actively when they occur, that I believe is linked with cancer growth. By full or active expression, I mean crying, sobbing, uttering sounds like moaning, wailing, or screaming, and moving such as flailing the arms and legs, or tossing and turning. Furthermore, in full expression, the emotional experience continues until one reaches some form of resolution and relaxation. When one does not reach this state of resolution and relaxation, the expression has been aborted (Rose, 1978). Not crying in the face of a loss because the loss is totally denied and repressed, "keeping a stiff upper lip" when strong sad feelings have been stirred, or holding an emotion vaguely in awareness and crying occasionally but never reaching a sense of resolution and completion, all connote abortive expression.

Greene, Young, and Swisher (1956) describe abortive expression in their female patients with lymphoma or leukemia:

All patients showed appreciable inability to express anger Generally all the patients had used motor activity and work as a means of expressing and relieving emotional tension Separations had been dealt with in a variety of ways In twelve patients [out of 32] there had occurred a prolonged unresolved grief response still manifest . . . years or decades after the loss (pp. 286-287).

In addition, they note that some of their patients reacted to loss or separation with "identification with and introjection of the lost object, accompanied by denial of affect." In the above description, these observers offer examples of a range of abortive expression from failure to express to sublimation of expression in motor activity to an apparent expression aborted in the sense that no resolution or end of the emotion was reached.

While several observers have noted the idea of a diminished outlet for emotions (Bacon et al., 1952; Stephenson & Grace, 1954), Kissen (1963a,

1964a, 1964b, 1964c, 1966; Kissen, Brown, & Kissen, 1969; Kissen & Eysenck, 1962; Kissen & Rao, 1969) has conducted the most carefully controlled research in the literature on psychological variables in human cancer. Kissen most frequently employed the Maudsley Personality Inventory (MPI), designed by Eysenck to measure Neuroticism. Eysenck postulated that the Neuroticism (N) Score measures certain aspects of neurosis, but Kissen made a creditable case that the N Score actually measures emotional lability or the ability to discharge emotions. Thus, if high N Scores reflect excessive emotionality, low N Scores might reflect emotional unresponsiveness.

In a typically well-designed experiment, Kissen¹ (Kissen & Eysenck, 1962) compared N Scores of cancer patients with those of patients with other chest diseases. The scores of the cancer group were well below the scores of both the control groups and Eysenck's standardization sample. Kissen therefore concluded that male lung cancer patients seem to have "a diminished outlet for emotions" compared to that of males with other chest diseases, and that the level of emotional lability of male lung cancer patients is well below that of normals used to standardize the MPI.

In a similarly designed study (Kissen, 1963a), two measures of emotionality were used: 1) the MPI and 2) a frequency count of childhood behavioral disorders such as bedwetting, phobias, trouble with authority, stammering, and temper tantrums. Since childhood behavioral disorders represent emotional outlets, Kissen predicted that cancer patients would recall and report significantly fewer of them than would noncancerous controls. Furthermore, if cancer patients did not report childhood disorders which had actually occurred, then the failure to remember would indicate denial or repression of emotional experiences. As predicted, lung cancer patients showed a diminished outlet for emotions compared to their non-

cancerous controls which was reflected in a significantly lower incidence of childhood behavioral disorders and lower N Scores on the MPI. In addition, there was a strong statistical correlation between the two measures.

Kissen (1964c), in a later study, was dismayed to find a very high mean N Score in cancer patients which indicated high emotional lability, the opposite results from those he had predicted. He could account for these findings only when he divided patients in a before-surgery and an after-surgery group. The presurgical cancer patients scored very low on N, figures which indicated the expected characteristic of poor emotional discharge and supported the previous studies. The postsurgical cancerous groups, however, which included patients with lung cancer and cancer of other sites, scored extremely high on N Scores, indicating high emotional lability ($p < .01$). Kissen was now sure that surgery was the intervening variable.

For noncancerous groups selected from surgical wards to match cancer patients for age, social class, and operation status (including appendectomy, amputation, and repair of inguinal hernia), findings were similar. Emotional lability was significantly higher after surgery than before for the controls. The major difference between the two groups was that before surgery emotional lability fell in the normal range for the controls, but in the abnormally low range for the cancer patients. After surgery emotional lability was abnormally and extremely high for both cancer and control groups. Surgery, therefore, was the variable accounting for high N Scores, not cancer. Kissen offered no explanation for these interesting findings and indicated that further research might be needed to explain the results.

How is it that the seemingly enduring life pattern of diminished capacity for emotional expression could be completely and quickly reversed by the single event of surgery? One possible explanation comes from Reich's

(1948) theory of defense mechanisms. According to Reich, the body's muscular armoring parallels ego defense mechanisms. The stronger and more rigid the ego defenses, the more rigid the bodily defenses. Surgery, then, may physically interrupt muscular defenses, causing a parallel breakdown in ego defenses. If we assume that ego defenses work against emotional expression, what can we expect to result from the physical disruption of a psychic defense but greater emotional lability, as found by Kissen (1964c).²

It seems that the "emotional lability" variable is related to cancer development regardless of culture or nationality. Rae & McCall (1973) correlated the national ratings of N Scores on the MPI with mortality rate from lung cancer and cervical cancer $-.71$, with cervical cancer $-.30$, suggesting the inverse relationship between cancer and emotional lability originally proposed by Kissen.³

Extreme Suppressors and Extreme Expressors

Earlier in this chapter we described several examples of abortive expression of emotions by cancer patients ranging from total suppression to apparent expression. Following Kissen's findings, the few researchers who have investigated cancer patients in terms of their emotional expression have expected to find mainly the inability to express emotions (or emotional suppression). Using self ratings by cancer patients and reports from close relatives of cancer patients, Greer and Morris (1975) found that the majority of their cancer patients were extreme suppressors of emotions, as expected. However they were surprised to find that a very few cancer patients were extreme expressors. Furthermore, for the present analysis, it is significant that almost none of their cancer patients fell into what Greer and Morris determined was a normal range of emotional expression.

A case can be made that both extreme suppression and extreme expression characterize those who are unable to follow their emotional expressions to a point of resolution and relaxation. People able to express complete emotional expression go through four stages: Tension, Charge, Discharge, and Relaxation (Rose, 1978). In the Tension stage, the person experiences the sensation that a feeling is coming into awareness. He recognizes it as his own and welcomes it. He allows the feeling to increase in intensity until it builds up to a point where there is no turning back from full expression: the Charge stage. Discharge happens when there is total cathartic emotional expression. In this stage the person "loses himself," or loses self control. Discharge involves motor activity as well as the usual forms of emotional expression. For example, the person may sob, wail, or scream; he may kick, flail his arms and legs, or even toss and roll on the floor. Full expression occurs in a wave-like surge. Like a wave, it subsides naturally, leaving the person with a sensation of deep relaxation and resolution accompanied by a sense of being at peace with himself and the world. This final stage of total peace and well-being is the Relaxation stage.

According to Rose (1978) emotional expression can be permanently interrupted or frozen at any juncture in the cycle, to the detriment of the person's homeostatic balance (see Rose 1978 for a complete explanation). Furthermore, people get stuck in a reverberating circuit which prevents them from experiencing the cycle in a complete, healthy way. Pertinent to the present discussion is being stuck in one particular reverberating circuit: "Charge-Discharge," where the person continually expresses anger to an extreme degree but does not seem to reach any resolution (come to the Relaxation stage).

Interestingly enough, Greer and Morris (1975) found that cancer patients who were extreme expressors described themselves and were described by others as often expressing anger to an extreme degree. In terms of Rose's theory (1978), a few cancer patients are false "Dischargers" who express anger continually and in a way that does not lead to resolution or relaxation. Although these people can obviously express emotion, they fail to express emotions in a way that is healthy and complete. Earlier I reported that Greer and Morris (1975) found that almost none of their cancer patients fell into the normal range of emotional expression; rather they fell at either extreme. In the light of this research and Rose's theory, I conclude that although the cancer patient's particular difficulty with emotions may take various forms, all reveal a breakdown in the ability to express emotions in a way that leads to completion and relaxation. The extreme suppressor never expresses his emotions because he refuses to allow the emotional charge to build sufficiently for discharge, while the extreme expressor is caught in an aberrant discharge that never leads to relaxation and resolution.

Anger and Hostility

While we are proposing here that the cancer patient's difficulties with expressing emotions may take various forms, many reports in the literature focus on the inability to express anger. Researchers have used various methods to investigate this inability, including psychotherapeutic interviews and therapy (Bacon et al., 1952; LeShan, 1977; Roland & Snyder, 1977; Simonton & Simonton, 1975); observations of cancer patients in hypnotherapy (Butler, 1954); questionnaires (Bahnon & Bahnon, 1966); the Rorschach (Nemeth & Mezei, 1964); interviews together with projective tests and questionnaires (LeShan & Worthington, 1956c); and a combination of projective tests, questionnaires, and interviews (Cobb, 1953). While it is

infeasible to discuss each of these investigations here, I will review three of the pertinent reports.

Bahnson and Bahnson (1966) gave cancer patients a forced-choice questionnaire to assess their behavior when very angry, and found that cancer patients did not "strike back," did not "curse and swear" or "kick and throw things," did not feel "like giving up, or feel depressed," did not feel "tense and restless," did not "get excited and keyed up," and especially did not "get angry with everyone or with themselves." They denied getting mixed up or confused and did not feel "burned up or boiling inside." They stated, on the contrary, that they felt "like keeping close to and friendly with people," spent their time "thinking about how to clarify their problems," and tried to think about "more pleasant things" (1963, p. 832).

Of particular interest to us here are two inferences from Bahnson and Bahnson's research. First, the cancer patients they investigated seem never to have experienced any of the assertive body movements associated with the normal expression of anger. Earlier in this chapter I discussed these assertive body movements as necessary components of full emotional expression (see page 42 above). Second, the anger-expressing behaviors which these cancer patients did report appear to be incongruent with their true feelings.

A second study worthy of our attention is that of LeShan and Worthington (1956c) who administered the Worthington Personal History, a projective device, to 250 cancer patients and 150 controls with no known illness. Clinical interviews were additionally given to 80 cancer patients. Sixty-four percent of the cancer patients as compared to only 32 percent of the controls exhibited inhibition of hostility in their test protocols. The cancer patients were unable to express anger, resentment, or aggression

toward other people in defense of themselves, although they could express these feelings in defense of other people or ideals. Although the test protocols could not determine whether this difficulty with anger was a life-long pattern, the hour interview clearly indicated that it was, and that this pattern had been established long before the appearance of the tumor.

The LeShan and Worthington study (1965c) supports our model in two ways. First, it demonstrates concretely once again that cancer patients are socially developed and more intensely focused on the world about them than on their inner lives. Second, the interviews have led both LeShan and Worthington and me to conclude that a cancer patient's problems with full expression of anger is life-long.

A third study presents a startling example of the significance of suppressed rage in the dynamics of cancer development. Giovacchini and Muslin (1965) report one case of a patient in psychotherapy who evidenced dramatic changes in the expression of her anger. At the outset of psychotherapy she was able to express briefly her long-suppressed rage. However, she was not able to sustain her expression and soon turned the anger inward. Shortly afterward she developed feelings of helplessness, and a cancer was found. This study illustrates a major premise of our theory: that cancer-prone individuals are likely to suppress anger.

Ruderman (1977) puts the issue of the expression of anger into the larger perspective of the cancer patient's generalized difficulties in expressing all of his emotions and impulses:

What has gotten into the literature is mainly the part about anger, which is true—cancer patients do hold in anger. But calling it held in anger is really not sufficient. It is really just holding in, in general. And holding in, in general, also means holding in a lot of life or, in other words, impulses. So in cancer patients you've basically got constricted personalities in which the nutrients and everything else are not flowing.

Feelings About Feelings

The above discussion on anger presents us with several telling questions:

1) Are cancer patients aware that they repress emotions? While most are probably unaware, Shands et al. (1951) quote one cancer patient as saying she and all the other patients on the ward knew cancer was the manifestation of "old, strong, repressed hatreds" (p. 1161).

2) Once aware, how do cancer patients feel about this fact? The following excerpt from a newspaper interview with a cancer patient illustrates not only the patient's difficulty in expressing emotions and impulses, but also her equanimity at living her life in that manner. She tells the reporter that she is disturbed by what she has read about a cancer-prone character type who is unemotional, inhibited, and repressed":

I immediately thought, "I'm exactly the type," she says with a laugh. You look back on your life and think, "I was married eight years, why did I stay married that long; why was I a good student in school, maybe I was repressing my delinquent impulses; I repress my emotions!" And then I realized, "Who doesn't?" That's also being called civilized. I don't know a single person who doesn't repress emotions. How can you not, if you're educated and involved in mental activity that requires control, planning, routine? ("Fantastic Knowing You're Going to Die," 1978).

3) Do cancer patients exhibit a common attitude about emotional expression? Some cancer patients report a distaste for being emotionally aroused. For example, Shands et al. (1951) discuss a patient who had warmed up emotionally to a therapist during a session. The next day she recoiled from the contact, saying to the therapist, "Go away. I don't want to see you. You stirred me all up yesterday, and I was very unhappy after you left" (p. 1168).

Other cancer patients are ashamed of their feelings and make efforts to conceal them. Greene, Young, and Swisher (1956) reported that 16 out of 32 women cancer patients had complained of sadness for either weeks or months before their leukemia was detected. For the ten patients who experienced recurrent weeping, the weeping was the most distressing manifestation of illness, more distressing than the lump itself, the bleeding, or the knowledge of diagnosis. In nearly all instances, the authors reported that the patients had not expressed their sadness to others and that they had wept only when alone. In a similar manner, Abrams and Finesinger's (1953) patient experienced shame over having feelings. While she acknowledged the presence of despair over her physical deterioration, she expressed the injunction that it must be concealed: "I'm so discouraged. If only I could eat or walk. I can't stay in bed all the time. I must pull myself together. I must not show anyone how I feel" (p. 480).

In summary, then, some cancer patients do know that they suppress their feelings, and they choose to go on doing so. It is this point which makes up yet another premise of our theory: By continuing to suppress emotions, cancer patients feed their disease process.

Denial and Repression

In order to continually hold emotions in, it seems likely that cancer patients would more often use ego defenses associated with holding in, such as denial and repression, than would others who do not prevent self-expression. One major premise of the Bahnsons' theory (1969) regarding the etiology of cancer is that a person's characteristic ego-defensive style determines whether or not he will somatize his conflicts, as in cancer, or express them interpersonally, as in psychosis. Because the typical cancer patient is overly-socialized (i.e., he is polite, acquiescent, and over-

cooperative), he does not express his conflicts intra-personally. Instead, the cancer patient would be expected to employ defenses that suppress conflict, such as denial and repression. The following section will review the literature on denial and repression in the cancer patient.

Several kinds of denial and repression have been reported. The most commonly reported is the patient's denial that he has something the matter with him when he first detects symptoms. In these instances, patients delay seeking medical diagnosis and treatment after first noticing symptoms, even when they know early treatment could prevent death (Abrams & Finesinger, 1963). If patients deny their symptoms to reduce their anxiety, we would expect that they would experience less anxiety on discovery of their symptoms than those who seek diagnosis promptly. Cameron and Hinton (1968) found that patients who reported little anxiety over discovering a lump in their breasts had delayed more than patients who reported greater anxiety.⁴

Once diagnosed, cancer patients sometimes use massive denial in response to news of their illness. For some patients, being told by their doctors that they had cancer had no bearing on whether they believed they had cancer (Moses & Cividali, 1966).

At later stages in the disease process, the patient often shows a third kind of denial: he denies that he is seriously ill at all, or that his physical symptoms have to do with cancer. Blumberg et al. (1954) report that many patients maintained the attitude that they had nothing to worry about, even though their cancers were advanced and moribund. Many of these patients denied that their illnesses were seriously incapacitating or that their symptoms were even due to cancer. I offer the following incident as an example of denial in the later stages of cancer: Not long ago an acquaintance diagnosed as having severely metastacized breast cancer called to say

she believed she was cancer-free. However she reported: "I tried to walk today, but my knees gave in. You know how weak you are after a fever." When she died, we found that the cancer had metastasized to her spinal cord and had interfered with her motor activity. Similarly, Rosner (1966) presented case histories of patients reporting "problems" with living, for example, housewife fatigue, insomnia, or depression, when in fact they had carcinomas that they knew about and were being treated for. Some of these patients mentioned their cancers, but only as an afterthought.

One might argue that patients facing any fatal and debilitating disease, not just cancer, would experience similar forms of denial. Denial of the impact of illness and the limitations it imposes on the bearer were researched by Levine and Zigler (1975), who hypothesized that the extent of denial would be proportionate to the devastation of the disease to one's self-image. They hypothesized that stroke, which impairs self-image most, would be the most devastating disease, followed by lung cancer and heart disease. Levine and Zigler reasoned that if patients deny the impact of their illnesses, the disparity between an assessment of their real and ideal selves would be no greater than in nonsick controls. Such disparity then would gauge the person's degree of satisfaction with himself. On the other hand, if patients were "as satisfied with themselves" as were the well controls, then they were using denial. On both instruments, all three patient groups showed no more dissatisfaction with themselves than did well controls, which indicates that they were using denial.

In order to see if denial seems different for patients before they are sick compared to after they are sick, Levine and Zigler asked patients to rate their real and ideal selves before getting sick. Controls were asked to rate

themselves "a year ago" and "now". As expected, the ratings of control groups were consistent over time, but all three patient groups revealed greater dissatisfaction with themselves "now" than "before," a disparity which indicated that they were not totally denying the presence of their disease. The "before-now" disparities changed least for the stroke patients (indicating greater denial), next for the cancer patients, and most for the heart patients.

This experiment brings up several questions. If denial emerges at the onset of life-threatening diseases other than cancer, is it that the denial we observe in cancer patients is due to a "threat" factor common to all serious illness and not specific to cancer? If so, can we then say that denial is not part of the psychological dynamics preceding the development of cancer?

There are two ways to address this issue. One is to suggest that the psychological dynamics in cancer development are common to other life-threatening diseases. The Bahnsons (1964a), for instance, theorize that people with psychogenic physical diseases (cancer, heart disease, and stroke) have psychological dynamics in common which are very different from those of the mentally ill. People with "physical" diseases have chosen denial and repression as life-long defenses, serving to internalize stress and prevent emotional expression. The body absorbs the stress and eventually breaks down. Denial and repression must be maintained then by all people with psychogenic diseases in order to maintain the dynamics of the disease process. Cancer is just one of those diseases in which denial and repression play a central role.

A second way to consider the issue raised by the Levine and Zigler experiment is to search for instances where denial or repression is a defense

used by cancer patients long before their disease developed. The strongest support for this hypothesis is Voth's (1976) research on autokinesis (summarized on pages 9-10 above). Voth (1976) found that as long as ten years before the development of cancer, cancer patients scored extremely low on autokinesis compared either to normals or to a psychiatric population. And in other research, low autokinesis has been associated with repression as a defense mechanism (Voth & Mayman, 1966, 1968). As almost all other research of defense mechanisms has been done when cancer was suspected or known, this study is especially important because it supports the hypothesis that repression was operating long before the cancer developed.

Other research supports the hypothesis of a denial-repression style in cancer patients when they use denial in areas of their lives not associated with the cancer. Renneker et al. (1963) report that cancer patients seem to deny there is anything wrong with them psychiatrically. In this study of 67 women with breast cancer, 52 (78 percent) were considered to have disturbing neurotic symptoms and were advised to take psychotherapy then. The only three who accepted were described by Renneker as using denial excessively as a defense during their psychotherapy.

Bard and Waxenberg (1957) found that postoperative breast cancer patients had little appreciation of the severity of trauma associated with their surgery. Immediately following radical mastectomy, they replied on a questionnaire that they had never had a serious operation. Although this might be taken as another example of denial associated with the onset of cancer, it could also be interpreted as a part of a more generalized life-long pattern of denial—the cancer patient denying the occurrence of any previous trauma.

In one study (Kissen, 1966), cancer patients reported significantly fewer deprivations before the age of 15 than did cancer-free controls. Kissen suspected that repression (forgetting) might account for his findings until he inadvertently found that cancer patients did remember instances of early trauma. In interviews focused on other life events, the cancer patients mentioned severe early adversities, such as the death of a parent or sibling, quite casually, as if they were not adversities at all. Like the cancer patients who denied that they had had serious surgery, Kissen's patients denied the seriousness of their early losses, and by doing so indicated that denial was part of a life-long pattern rather than the result of the onset of threatening disease.

While others have noticed that denial seems a life-long defense mechanism for cancer patients (Blumberg et al., 1954), Bahnson and Bahnson (1969) have carried out some of the best research on this hypothesis. They used the Bahnson Rhythmical Apperception Test (BRAT) to detect projection and denial in a group of cancer patients and a group of cancer-free or "normal" controls. Projection is a defense which allows for the expression of conflict interpersonally, while denial and repression help internalize the conflict. Because any degree of somatization requires internalization of the conflict, the cancer patient would be expected to show less projection and more denial and repression than do cancer-free controls.

On the BRAT, subjects were asked to fill out an adjective check list describing their own moods. They then filled out the same checklist describing feelings which neutral auditory stimuli convey. Bahnson and Bahnson measured projection as the extent to which the subject attributes to the neutral auditory stimuli the same emotional qualities he describes himself as experiencing. The two checklists describe mood in terms of five bipolar

dimensions: Anxiety (anxiety+, secureness-), Guilt (guilt+, self-acceptance-), Hedonic Level (depression+, elation-), Hostility (hostility+, friendliness-), and Social Interaction (dominance+, submission-).

Bahnson and Bahnson administered the BRAT to fifteen males undergoing cancer treatment and 38 normal males not in any treatment. They then compared mean measures of projection on the adjective checklists by t-tests. All mean differences considered separately were in the predicted direction with cancer patients scoring below the normal group in projection of anxiety ($p < .01$), depression ($p < .005$), hostility ($p < .02$), guilt ($p < .025$), and dominance ($p < .12$). When all measures of projection were combined, cancer patients used projection significantly less than did normals ($p < .001$).⁵

The Bahnsons unexpectedly found that cancer patients described the environment positively, using adjectives such as clean, gentle, peaceful, pure, and trustful, more frequently than did normals. The normals tended to assign opposite qualities to the environment, such as dirty, frail, nervous, rude, and ugly. Cancer patients seemed to deny unpleasantness in the world around them, seeing it as a benign place in which all happens for the best. The Bahnsons thought this an indication of repression of unpleasant past events.

One problem with the Bahnsons' research, however, is that their test, the BRAT, has not been subjected to any tests of reliability or validity. The Bahnsons call for further refinement of their instrument, without which their findings must remain tentative.

I have pursued this discussion of denial and repression because these defenses, more than others, prohibit the cancer patient from expressing his emotions in a cathartic manner. Perhaps something in the early experience of cancer patients encourages poor emotional expression and sets up the life-long pattern of denial and repression.

Childhood Experiences and Relationship to Parents⁶

In light of the observations reported at the beginning of this chapter which suggest that cancer patients are well-behaved, pacific, and overly socialized, and the preceding observations that suggest cancer patients show deference to authority and manifest a lifelong pattern of denial, I first hypothesized that the early lives of cancer patients might have been governed by rigid social discipline. One cancer patient I interviewed described her life with her parents as follows:

I remember how awful Sundays were. My mother and father had the rule that you couldn't talk until after church was over. We would get up in silence and eat in silence. My brother and I could not even read the funnies Waiting for the service to be over was an agony. It seemed like forever

I was constantly being taught how to behave properly I could not even go to the football games in college like the rest of my friends. No, my mother would go to the games with me. I could not even have a date by myself.

A second cancer patient described a similar focus on proper behavior:

Th: Can you say a little more about what their (your parents') philosophy of child rearing was?

Pt: Well, my father was one of the last of the old Southern gentlemen. And he thought I should be raised like a lady: I should know how to embroider; I should know enough about sports to discuss them intelligently; I should have a good seat on a horse . . . (all said in a sing-song voice, as if reciting a catechism).

Similarly, the following excerpt from a therapy session points out the rigid childhood discipline under which the patient grew up. The patient recalled an incident from her childhood, visualized it in great detail. At the end of the incident, she realized that she was crying alone in her room. The therapist asked her to imagine herself as she was in that room and to, "Enter, as you are now, the room in which little Arlene is crying on the bed. You walk into the room. She looks up at you. What do you do?" Patient: "I would hit her" (LeShan, 1964, p. 116). The patient's response implies how her

parents treated her: they would hit her to stop her from crying. Such treatment goes beyond mere discipline or insistence on proper behavior. In this situation the parent causes pain and then punishes the child for expressing and releasing that pain (see Chapter 2 for a more detailed discussion).

In considering these case histories, I began to reason that parents who do not validate feelings might be emotionally distant themselves. They might lack affection and warmth, and they might be negligent of their children's needs. What I had first viewed as rigid discipline, I came to see as a symptom of the parents' need to maintain a socially acceptable role model of "parent." The parent focuses his attention on his external behavior and the child's external behavior rather than fostering a true meeting between himself and his child. From psychotherapeutic work with five women with cancer in intensive analysis, Renneker et al. (1963) found that these women underwent instances of severe punishment, distance from their parents, and coldness and criticality on the part of their parents during their childhoods.

Simmons (1966) reported a lack of affection and warmth in the early lives of cancer patients. He surveyed the lives of eight famous people who died of cancer, focusing on their childhoods. Simmons concluded:

Each had a deprived childhood with very little normal parental affection. They had never received love, nor could in turn give love. Few of the persons considered had friends and devoted families. Only Grant and Taft had well-established families of their own. Stein and Gershwin never married, and Runyan and Napoleon were noted for their lack of contribution to family life (p. 186).

Simmons' conclusions must be viewed with caution because he made his hypothesis and searched for examples to prove it. Nevertheless, Thomas and Duszynsky (1974), who conducted one of the only longitudinal studies on psychological variables in cancer, report findings which indicate emotional

distance between the cancer patient and his parents, in other words, Simmons' hypothesis. Over a twenty-year period, they noted occurrences of five diseases: malignant tumor, suicide, mental illness, hypertension, and coronary occlusion, among medical doctors who had been students at Johns Hopkins University. Thomas and Duszynsky recorded complete life histories and administered comprehensive test batteries to the students. After graduation, the doctors were retested at regular intervals. The authors correlated the occurrence of the five target diseases with various personality variables in their testing.

While differing markedly from the profiles of people with coronary occlusion or hypertension, the profiles of the cancer group often resembled those of the suicide and mental illness groups. "Every negative or unfavorable family attitude was more frequently found in suicide, mental illness, and malignant tumor groups than in the other two groups, while the reverse was true for every positive or 'favorable' relationship" (p. 259).⁷

Thomas and Duszynsky (1974) determined whether their subjects had had uncomfortable relationships by noting what words they did not use to describe them on the Family Attitude Questionnaire. Thomas and Duszynsky found that while 9.5 percent of the total control population did not choose the words "steady," "companionable," "understanding," or "warm," to describe their fathers, 31 percent of the cancer patients, 28 percent of the suicides, 29 percent of the people with mental illness, 5.9 percent of the hypertensives, and 14.3 percent of those with coronary occlusion did not choose them to describe their fathers. We expect poor relationships with parents for people with mental problems as was found, but here cancer patients also seem to have poor relationships with their fathers. How is it that the responses of people with cancer, a physical disease, are not like the responses

of others with physical diseases (hypertension and coronary occlusion), but are in fact much like the responses of those with emotional problems? If we follow the argument that I put forth here, it is easy to resolve this paradox. Emotional damage in the form of hurtful relationships to parents is as powerful a variable in bringing about the development of cancer as it is in the development of mental illness.

Some cancer patients perceive their parents as neglecting. Using the Roe-Siegelman Parent Child Relationship Questionnaire, Bahnson and Bahnson (1970) found that cancer patients perceived their parents as "More neglecting, barren, and cold than did [myocardial infarction] patients or normal control subjects" (p. 63). In terms of statistically significant differences between cancer patients and controls, cancer patients reported their mothers to be less protective ($p < .05$), less punishing ($p < .06$), less rejecting ($p < .03$), less casual ($p < .01$), less "Rewarding, Symbolic Love" ($p < .03$), and less demanding ($p < .02$). It is not clear what "Rewarding, Symbolic Love" means, since the Bahnsons do not explain the term. We may infer from these findings that cancer patients may have experienced neglect from and poor contact with their parents. For example, cancer patients perceived both their parents as being less protective, with the mother described as not loving. We may surmise that a child who does not feel protected may lack a sense of safety in his life. Maslow (1968) theorized that the need for safety is second only to the very basic physiological needs. Thus, not having these needs met may be a form of neglect.

In the Bahnson and Bahnson study, cancer patients describe their mothers as less loving but less rejecting. This paradox lends itself to two interpretations. First, it may be a sign of poor contact. For example, although the mother may not openly reject or be angry with the child, she

does not love him. Even open anger and rejection are forms of contact, clear communication between parent and child. But in the childhood experience of these cancer patients, perhaps no clear communication as to the status of the child with the mother exists. Second, by not rejecting the child the mother is fulfilling her social role as a "good" mother. At the same time, however, by not loving him, she neglects her intrinsic role. No clear relationship exists between mother and child. The child is left not with anger or hatred, but with no emotion (nothing) on which to build a healthy relationship with his mother.

Many studies report that women cancer patients have had a pathological relationship with their mothers (Bacon et al., 1952; Greene, Young, & Swisher, 1956; Renneker et al., 1963; Reznikoff, 1955). Bacon et al. (1952) describe case reports of women with breast cancer:

We will describe the major behavioral characteristics observed as . . . unresolved hostile conflict with the mother, handled through denial and unrealistic sacrifice Almost all of the women had had a pathological relationship with their own mother. This was commonly reflected in a conscious sense of extreme obligation which led them to go to high degrees of self-sacrifice for the sake of their mother. The underlying hostility was almost always unconscious but was clearly evident in the obvious reaction formation involved. Very few were able to vent their rage toward the mother This unresolved attachment with masochistic devotion to the mother was seen in 30 patients (p. 354).

Similarly, in their 1963 study, Renneker et al. report:

All five (women cancer) patients were deprived of oral-dependent gratifications and frustrated through unsatisfactory relationships with their mothers. Fathers provided some gratifications. The result was vulnerability to depression. Fearing mother's retaliation, they blocked men as available sources of security and gratification. They identified with their mother's masochistic personality and showed chronic oral dependent, passive needs (p. 110).

Neglect of the cancer patient's dependency needs in childhood is further indicated by many reports that cancer patients had to take care of

others at an early age (Greene, Young, & Swisher, 1956; Renneker et al., 1963; Reznikoff, 1955). In caring for others while still children themselves, they were forced to parent others as well as themselves, and had no means for satisfying their own dependency needs.

Research by LeShan and Reznikoff (1960) indirectly indicates that dependency needs may have been neglected early in cancer patients' lives. Hypothesizing that the birth of the next sibling is a psychological blow to a child when it occurs in close proximity to his own birth, LeShan and Reznikoff (1960) found that the birth of the next youngest sibling occurred earlier in the lives of cancer patients than in the lives of controls. Since the new sibling would make increasing demands on the mother's time and attention, we may guess that the cancer patient suffered some neglect of his needs.

From the studies noted above, then, little emotional support or nurturance seems to characterize the mother-child relationship for cancer patients, a relationship which formulates how much closeness and support the person can ask for and receive from others later in life. Just as the mother is treated in her childhood, so will she treat her offspring. In observing the mothers of leukemic children, Greene and Miller (1958) concur with Orbach, Sutherland, and Bozeman (1955):

We agree with their observations that the mothers of these children do not turn to their own mothers for tangible or emotional support during their child's illness. Most of these mothers, however, had apparent difficulty in turning to anyone for support for themselves during the illness of the child (p. 137).

Of further interest here is LeShan and Worthington's (1956c) report that cancer patients are dominated from childhood by the feeling that their opportunities for satisfactory relationships are strictly limited. Similarly, the Bahnsons (1966) report that the severe difficulty cancer patients experiences in childhood in establishing their relationships extended into adulthood.

In unstructured interviews they found that many cancer patients have been unable to resolve unsatisfying attachments to their parents early in life. These patients continued to have strong unresolved dependency needs in adult life, and prior to the onset of cancer their means of compensating for these needs had collapsed. According to the Bahnsons (1970):

Our own clinical investigations of 80 cancer patients showed that . . . cancer patients appear to have had primitive but unsatisfying relationships to their parents, particularly to the mother of a pregenital and most often oral character with ambivalence and rage. Only with the greatest effort could these children maintain an uncertain relationship to the significant parent. Their adolescent separation from the parent had been painful and was perceived as a severe deprivation against which they continued to struggle in their adult years by attempting to establish a close relationship with a mate or spouse . . . which proved difficult . . . because the child's mistrust and hostility often were transferred to the adult partner (p. 62).

When one considers that the female cancer patient seems deprived of mothering as a child, was forced to mother others at an early age, and became inhibited in her own maternal instincts (Bacon et al., 1952), it seems paradoxical that many cancer patients consider themselves to be ideal mothers. While many of Bacon and his colleagues' (1952) cancer patients showed maternal inhibition (of 20 wives without children, only one consciously wanted to have children, and of 20 mothers with children, three consciously wanted them), the ones that were mothers prided themselves on providing excellent care for their offspring. Apparently this "excellent care" extends in some cases to the husband. Reznikoff's (1955) patients viewed themselves as mothering their husbands, complying with their husbands' every want and whim.

Idealized motherhood may be passed from generation to generation in families where cancer occurs, so that the psychological dynamics that

appear in the offspring who get cancer manifest similarly in the mothers. While no researcher to date has investigated this possibility, Greene and Miller (1958) describe mothers of leukemic children as preoccupied with "ideals of being model mothers well beyond their physical and psychological capabilities" (p. 135).⁸ They seemed bent on "out-mothering their own mothers according to some social ideal of good mothering which they seem to have internalized presumably as a result of their own childhood experiences of being mothered" (p. 137). One wonders if the leukemic children might have grown up to be "ideal" mothers themselves.

A common theme of idealizing motherhood expresses the situation of both carcinogenic mothers and cancer patients. In the case of the carcinogenic mother, she calls herself an "ideal" parent, trying to "out-mother" her own mother. Yet, she will not call on her own mother for loving support in a time of crisis, implying that her experience at her mother's hands was not one of loving support. The mothers with cancer all pride themselves on being "ideal" mothers, yet they report they did not consciously want to have children. Women with cancer seem to have mothered others when they were children themselves, and in some cases have developed extremes of self-denial especially directed toward their own mothers (Bacon et al., 1952).

An unconscious masquerade occurs in these women with cancer and in their mothers that spans generations, a masquerade that preserves at all costs the appearance of being loving and socially perfect. However, anger and resentment at having to take care of a child, when one has not been properly loved and taken care of oneself, is not expressed and resolved. Instead, these women invest much energy in behaving as ideal mothers should, and we return to the Bahnsons' (1966) model of the cancer patient filling social roles to perfection, while feeling devastated internally. If we accept

the psychogenic view of cancer, it is not surprising that such a way of being seems to exist for the mothers of cancer patients as well as for cancer patients themselves, for the deepest, unconscious psychological aspects of the mother-child relationship are often passed from generation to generation.

Summary

This chapter has explored one of the major hypotheses of the theory that cancer patients show aberrations in their capacity for emotional expression, especially not being able to complete emotional experiences and arrive at resolution. One concomitant of aberrations in emotional expression is an investment in the external, or what might be called the social, self. Thus, being well behaved, "sane" and adjusted, is a primary focus of the cancer patient. It is as if he equates emotional expression with misbehavior or madness.

The cancer patient pays for his loss of emotional expression in a sacrifice of the internal self for external appearances, probably occurring early in life when self-relationships are being established. To verify this hypothesis, then, I reviewed studies on the relationship of cancer patients to their parents. The literature revealed that in their childhoods, cancer patients experienced the non-validation of their emotions, impairment of emotional contact and warmth, and subtle neglect. By not validating the child's emotions, carcinogenic parents bring about the very patterns in behavior which typify the cancer patient: self-control, suppression of emotions, an investment in serenity at all costs, the devaluation of self-expression, an inability to know what one needs or wants.

NOTES TO CHAPTER 3

¹Kissen's research was extremely well-designed from several stand-points: First, in a typical study, Kissen and Eysenck (1962) observed patients admitted to three chest units for diagnosis and treatment, 116 experimental subjects with lung cancer and 123 controls with other lung diseases. All subjects had either chest cancer or other chest diseases. If Kissen had used a nonsick group as controls, he might have been measuring a "sickness" factor or a chest disorder factor, rather than factors due to the presence of cancer.

Second, Kissen and Eysenck assigned subjects to experimental or control groups post hoc, with subjects diagnosed through biopsy as cancerous or noncancerous after they were tested psychologically. This design has two advantages: It eliminates experimenter bias because no one knows to which group the patient will be assigned at the time of testing, and both patient groups were undergoing similar experiences at the same stage in their hospitalization. That is, both were experiencing the stress of not knowing their diagnoses and the stress of being diagnosed, and none had undergone treatment. Kissen suspected and later demonstrated (1964c) that treatment for cancer alters scores on the MPI.

Third, Kissen further divided his groups into those with a previous history of psychosomatic diseases and those without, so that he would not be measuring effects due to the presence of psychosomatic disease rather than cancer. He was careful to have the control group checked for cancer elsewhere in their bodies, a refinement that has seldom appeared in other research.

Nonetheless, two minor criticisms of design can be made. Because Kissen used only male subjects, it is not certain whether his findings apply also to women. Furthermore, we cannot gauge the ages of subjects from the range he gives in his report. Kissen divided the subjects into age groups listed as "up to 54, 55 through 64, and 65 and over," two open-ended groups, and a group with a nine-year age span. Such a comparison is of questionable advisability in controlling for the age variable.

²Following Reich's theory, psychotherapists working with cancer patients can use Kissen's findings to help structure the time to initiate psychotherapy. For example, the therapist interested in helping the cancer patient express emotions should initiate psychotherapy as soon after surgery as possible, while the cancer patient is relatively undefended. Furthermore, if the psychotherapist waits until long after surgery is over, the cancer patient might have reverted to earlier states where he was far less emotionally labile. Re-testing cancer patients with the MPI long after they have recovered from surgery might reveal this to be the case.

³If inability to express emotions is a primary factor in the development of cancer, how then do we address the issue of carcinogenic substances? For instance, it may be suggested that the rise in cancer rates among children (Ariel & Pack, 1960) is not due to emotional factors so much as it is

to the increase in carcinogens in the environment. Research by Kissen (1964a, 1964b) addresses that issue.

In Kissen's research (1964a, 1964b) we will consider cigarette smoke the carcinogen. He gauged the exposure to smoke in terms of the amount of smoke suffusing into internal tissue, in other words, in terms of whether or not the person inhaled. Lung cancer patients and a control group of patients with other chest diseases served as subjects. Kissen covaried a measure of emotional expressiveness (N Scores on the MPI) with amount of cigarettes smoked by inhalers and noninhalers. Heavy smokers had more than 25 cigarettes a day while light smokers had less than 25. Included was a group of nonsmokers.

As Kissen found in his earlier research, when compared to noncancer patients, cancer patients had significantly lower N Scores indicating poor emotional discharge. When he examined the smoking variable, Kissen found that within the cancer group, mean N Scores on the MPI fell into a gradient based on amount of exposure of lung tissue to cigarette smoke: Heavy Inhalers 4.0; Light Inhalers 3.8; Heavy Noninhalers 3.5; Light Noninhalers 2.2; Nonsmokers 2.0. The group as a whole had scores indicating poor emotional discharge, but heavy smokers had better emotional discharge than did light noninhalers or nonsmokers who had the poorest emotional discharge. This gradient did not emerge for the noncancer patients.

Kissen's findings indicate that those with the poorest outlet for emotions contracted cancer in the presence of the least amount of carcinogen (none), and the variable of emotional discharge seems more important than the amount of carcinogen one is exposed to. Thus, when addressing the issue of carcinogens, we must consider the interplay of variables: the poorer the outlet for emotional discharge, the less the exposure to carcinogens required to induce cancer. Since these findings apply to cigarette smoking, more research is needed to see if the same interplay of variables applies to other carcinogens.

⁴A study by Katz, Gallagher, and Hellman (1970) may be reinterpreted to clarify the relationship between denial and delay. They confronted hospitalized women, as yet undiagnosed for cancer, with the possibility of biopsy, loss of a breast, and death from cancer, and systematically recorded their affects, assuming that emotional expression in this situation indicated "defensive failure," immaturity, and lack of adjustment. Women who showed pleasant affect in the face of impending mutilation or death were considered admirable and, by implication, in better psychological health than those who cried or expressed dismay. Katz et al. were amazed to find that their "healthy" women, those who showed pleasant affect, delayed seeking treatment to a greater extent than those who were upset. What they interpreted as maturity and adjustment was instead denial of affect, denial which is associated with a pathological lack of anxiety in the face of dire threat.

We propose here that there are many times in life when it is quite appropriate to feel anxiety and even panic. Experiencing these powerful feelings often moves one to immediate action. It is no surprise that the women open to these feelings just before surgery acted faster (did not delay getting help) than those who remained calm.

This study is important from another standpoint: It crystalizes the culturally supported assumption that being emotional and anxious is indicative of psychiatric pathology, or is a sign that one's defenses have failed when they should not have. Katz et al. provide us with a clear example of the

belief that when faced with dire threat and loss, healthy people remain calm. This is the very assumption that cancer patients live by and is, I propose here, indicative of psychological problems.

⁵The Bahnsons' patients in this study were already under treatment for cancer, and Kissen (1964c) indicated that treatment may cause patients to be more emotionally labile. As a consequence of their increased level of emotionality, they would be expected to project more, if projection facilitates emotional expression while denial and repression do not. The findings that these supposedly more emotionally labile cancer patients projected negative feelings less than did normals strengthens the Bahnsons' hypotheses.

⁶I have reviewed here almost every published piece of research related to the childhood experiences of cancer patients. Research on the childhood experiences of cancer patients is so limited that I have included information culled from other research which was not originally designed to investigate this issue.

⁷Two other well-controlled studies report similar results. On tests and questionnaires, Cobb (1953) found more and stronger negative reaction to their families among cancer patients than either in the general population or in an equated group of colitis patients. Reznikoff (1955) used a battery of tests on well controls, benign controls, and patients with breast cancer (the latter groups were determined post hoc). The cancer patients were less positive with regard to their feelings about their fathers and their families compared to either control group.

⁸Greene and Miller's study is the only one to my knowledge that mentions characteristics of the mothers of cancer patients from first-hand observation.

Chapter 4

LIMITLESSNESS AND THE CONTROLLING PERSONA

In the previous chapter, I discussed the cancer patient's inability to discharge emotions and pain. In this chapter I will discuss a powerful manifestation of that undischarged emotion and pain which I call limitlessness. Furthermore, I will review the personality traits which typify or characterize the cancer patient (lack of self-awareness, perfectionism, self-sacrifice, isolation, self-hate, and extraversion) and which occur concurrently with limitlessness. Finally, I postulate an underlying dynamic common to very different personality types among cancer patients.

As I described earlier, pain and emotions are stored.¹ As the person grows older, he must maintain powerful defenses, such as denial and repression, to keep his pain and emotions from emerging to consciousness. Eventually this repressed, undischarged pain becomes encapsulated, feeding upon itself in a reverberating circuit which cannot be penetrated or interrupted. Precisely because the cancer patient has no way at his disposal to interrupt this circuit, the pain becomes limitless.

When in cathartic psychotherapy the pain circuit is interrupted (through emotional expression), the patient perceives the vastness and depth of his pain for the first time, and he reports it to be limitless. For example, Janov (1970) calls the limitless pain the "Primal Pool of Pain." In response to this, one patient is reported to have shouted out in group therapy, "Primal Pool? Hell, it's an Ocean!" Because of the split between the real feeling self and the unreal social self which prevents awareness of feelings, by the time the person reaches adulthood, he is neither aware of his pain nor aware of the

sensation that it is limitless. Only in deep cathartic therapy when the person begins to encounter his emotions and pain for perhaps the first time, does the awareness emerge.

Limitlessness manifests in yet a second way in the cancer patient. The presence of limitless pain, accompanied by a gross lack of awareness of the pain, leads to a distortion of the person's perception of his physical limitations in life. Perhaps the distortion results from a total lack of contact with the real self, a contact which if present makes the person aware of his own vulnerability, his humanness, and thus his limitations. Perhaps there is some strange identification of the person's self with the limitlessness of the pain at some point. Although this seems far-fetched, I have witnessed this very process in a Primal session, during which a patient, regressed to infancy, reported exactly such an identification or confusion of the self with the limitlessness of his own pain. While I cannot explain this phenomenon, I propose that those who carry limitless pain manifest distortions of their perception about physical limitations.

The distortion takes many different forms in cancer patients. For example, some feel they have an infinite capacity to work and cope; others think they can put up with any and all disagreeable situations; others feel that even when utterly exhausted they can push on. Common to all of these different approaches to living is that despite all odds, cancer patients will themselves to endure.

Although cancer researchers have up to now not specifically measured this sense of limitlessness, it is possible for us to derive indices of limitlessness from current findings. The primary index, the one from which others proceed, is the cancer patient's lack of self-awareness.

Lack of Self-Awareness

Self-awareness, by which I mean contact with emotions, needs and stored pain, is the mechanism that keeps a person aware of his own vulnerability and of his physical limitations. Several indices that cancer patients are not in touch with their internal selves appear in the literature (Bahnson & Bahnson, 1964b, 1966, 1969; Jacobs, 1954; Valadares, 1969). Descriptions include poor introspective capacity (Abse et al., 1972), a lack of self-communication (Bahnson & Bahnson, 1964b), a lack of insight by cancer patients into their own personality patterns (Abrams & Finesinger, 1953),² and a sense that cancer patients are in "utter despair of being themselves" (LeShan, 1977).

Alienation. When self-awareness is poor, parts of the self are hidden and may be said to become encapsulated and isolated from contact with the whole person. Bennette (1969) calls this isolation "alienation," drawing an analogy between self-alienation (and social alienation) and cellular isolation. According to Bennette, at the cellular level alienation involves a loss of communication of information which is essential to organizational control of the entire organism. It is not a failure of the immunological system in battle against recognized cancer cells which allows the cancer to grow, but an incapacity of the normal cells to perceive the presence of the isolated, unnatural, cancerous cells. Bennette describes the cancer cell as "anonymous," a part of the self not recognized because it is isolated from awareness.

In support of his cellular theory of alienation, Bennette cites Shelton, Evans, and Parker (1963), who changed normal tissue into cancerous tissue by isolating it from contact with other normal cells:

They demonstrated malignant transformations of normal cells in the situation of isolation within semi-permeable capsules implanted into the peritoneal cavities of animals These sealed chambers of Millipore filter material allowed the passage of body fluids but not of cells, so that the contained normal cells were isolated from contact with other cells but were otherwise environmentally situated, with access to humoral homeostatic influences. The experiments strongly suggest that the loss of cell contact is an essential quality of the alienation (p. 357).

Bennette further cites Goldhaber (1961) as showing that it is the isolation of normal cells from other normal cells that constitute the carcinogenic influence. Goldhaber demonstrated this by varying the size of the pores in the Millipore filter material implanted into the body cavities of animals. If the pores were big enough, cells could make contact with other cells and tumors did not develop. But when the pores were too small for cells to make contact with other cells, tumors did develop.³

Bennette draws a parallel between isolation and alienation at the somatic level and alienation and poor internal communication on the psychic level in cancer patients:

A similar situation may exist at the psychic level We could develop the idea that invasive cancer results from an internalization of disturbances of identity and communication that cannot find psychic expression because of the strength of well-differentiated psychic controlling functions, that is, a strongly developed . . . ego, coupled with inadequate bodily homeostatic control. On the other hand, where the ego and other psychic controls are poorly developed, but there is a competent bodily homeostasis, a similar disturbance of deep identity would lead to psychotic regression Malignant diseases and regressive psychoses could be seen as alternative biographical expressions . . . of the same underlying pathology, a pathology of alienation" (Bennette, 1969, p. 361).

Thus, Bennette proposes that the lack of internal communication in the cancer patient is a dynamic instrumental in causing cancer.

Similarly, Booth (1964a) theorizes that the behavior of the cancer cell parallels the social behavior of the cancer patient. He calls cancer cells "autistic": they multiply in defiance of other organs and have a metabolism independent of oxygen; they do not express relatedness; they are only "in touch" with themselves.

If cancer patients are alienated from themselves on the cellular and psychological levels, they are also alienated from others in the sense of not developing deep emotional relationships. Of her fast-dying patients Shrifte (1962) reports:

They showed little tendency to receive richly and warmly from others or to give out their own riches and warmth to others. They did not seem to have personal, alive contact with the outside world. It was as though the outside world served primarily as stimulus for internal production, not particularly as a source of lively transactional relationship (p. 393).

According to Shrifte, fast-dying cancer patients are forced to become interpersonal isolates in order to protect themselves from being drained by contact with other people, but by doing so they also cut off any possibility of psychological nourishment from others.

While many psychotherapists have clinically observed that cancer patients feel lonely, isolated, and unloved (LeShan, 1969; Renneker, 1957; Roland & Snyder, 1977; Ruderman, 1977), Spinetta, Rigler, and Karon (1973) developed a method for measuring the feeling of being alone and/or of wanting to be alone in hospitalized leukemic children. A full-scale model of the hospital room was constructed. It included a bed with a child doll in it which was referred to as the subject's "friend who was sick in the hospital." The subject was then given dolls representing father, mother, doctor, nurse, with instructions to place one doll at a time where it usually goes. In their 1974 study, they asked 25 leukemic and 25 chronically but not fatally ill children ages six to ten to place the dolls where they would like them to be.

The leukemic children placed the figures at significantly greater distances from the bed than did the chronically ill children. Spinetta and his colleagues' findings seem to reveal the leukemic children's desire to put distance between themselves and others.

To describe the difference between how the healthy person and the cancer-prone individual interact with others, Ruderman (1977) created the following metaphor in an interview:

And it feels like you have a social body, a lot of people huddling around a campfire and then some people drift off and away and are getting cold because they're very far from the fire. And they do not know or they don't have initiative or whatever it is to get back to the fire where the main body is. These are people [cancer patients] who are getting colder and colder and eventually die because they are not getting nourished by us. I see cancer patients dying basically because they feel alone. And cancer is the technical way they manipulate their bodies to accomplish that They want out because it's too cold out there.

LeShan (1969, p. 849), too, documents the cancer patient's sense of isolation in this exchange with a patient:

Th: Sometimes one's job is to cultivate one's garden.
The garden in one's back yard, in the front, or
the one in one's heart.

Pa: What's the use of cultivating a little patch of
rocks surrounded by high thick hedges?

Th: That's how you see your heart?

Pa: Yes.

Perceived limitless energy. The individual who lacks self-awareness does not look inward. Not looking inward could well be the link between limitless pain and perceived limitless energy. Pain storage (limitless pain) is perpetuated by not looking inward, since looking inward is the first step toward discharge. And, only awareness of the internal self and its needs can tell a person that he has stretched himself too far, that he has extended

beyond his resources, or even that he has certain needs that must be fulfilled. Thus, without self-awareness, two things happen to people: they do not discharge pain, and they have no natural "governor" on the expenditure of their resources, no way of knowing that resources are limited. Shrifte (1962) noticed that rapidly dying cancer patients expend their own internal resources without replenishing them from the nourishment of others. Such a person treats himself as if he were limitless. For example, he might work until exhausted or sick, take on too many jobs to do in too short a time, require of himself standards of achievement that are unattainable.

Shrifte (1962) gave the Rorschach to cancer patients whom she later divided into a long-lived (15 Ss) and a fast-dying (seven Ss) group. She found that the two groups differed significantly in the way they responded to the Rorschach. The long-lived group gave more responses that indicated they could be "moved by" the environment than did the fast-dying group, who on the other hand gave responses that indicated they were primarily interested in trying to affect the world.⁴ One could say that the long-lived group had a greater capacity to be touched by qualities in the outside world,⁵ or more especially by contact with other people who might provide psychological nourishment. But the fast-dying group seemed to expend their own energies without ever getting nourished. Shrifte described this fast-dying group as having an "expenditure style":

The [fast-dying group] demonstrated a tendency to utilize more frequently and more profligately their own inner substance than to interact with the world outside themselves Outside stimuli would provoke them to productivity. Their reaction to the outside stimulus would be a drawing upon their inner storehouse and a striving to conceptualize from their own stock of feelings, ideas, etc. (p. 393)

A friend of mine with cancer amazed me with the extent to which she was incapable of responding to a loving statement from her grandchild.

When her grandson told her how sad he had felt when "they almost lost her," she reported feeling indignant. Similarly, one of the Simontons' patients inadvertently recounted an instance in which he was not moved by a fellow cancer patient who made a feeling statement to him:

When we checked into the room . . . my roommate, who had acute leukemia, looked at me and said, and I shall never forget this, "I'm glad to have a young healthy roommate, for a change. I've lost four in the last year, and I'm long past my life expectancy." And I said, "Hey, baby, that's your problem. You work on that one; I'm going to work on mine" (See Achtergerb, 1976).

The above two instances demonstrate the cancer patient's inability to take psychological nourishment from those near them. In the former case, the grandson was offering love and remorse. In the latter case, the roommate was inviting the Simontons' patient into his community. Both patients demonstrate the "I'd rather go it alone" attitude which will use up their inner resources and not allow them to be replenished through emotional contact with others. I call this phenomenon "perceived limitlessness." By denying a need for others, and by not being moved by others, cancer patients reinforce their sense that they have limitless resources from which to draw.

Extraversion. When Elida Evans (1926) described cancer patients as "extraverts," she may have been reporting on a characteristic similar to Shrifte's "expenditure style." Evans saw 100 cancer patients in Jungian analysis and described them as focusing on the external world in the extreme. Evans' view of extraversion differs from the conventional view and from the one apparently measured by most psychological inventories.⁶ Evans writes:

Extraversion is an outward turning energy Every extraverted personality thinks, feels, and acts in relation to the object, and this condition we observe in the cancer patients and in such direct and noticeable fashion that no one can doubt the patient's dependence upon the object. If the person is . . . a feeling extravert then the subject "feels himself into" the object. This feeling into is a condition we find in the cancer patients, and with such an intensity it results in a state of

feeling accompanied by appreciable bodily enervation (p.49). . . . The extravert, with an outflowing libido, cannot use it [the libido] alone; it would go to waste or sink into himself and make trouble. He must attach it to someone or something . . . find a home for it, as it were (p. 52).

In the passage quoted above, Evans described the kind of outpouring of libidinal energy that is similar to Shrift's "expenditure style" and her descriptions of movement from the individual onto the outside world. So intense is this movement of energy toward the world that the cancer patient experiences "appreciable bodily enervation," or an exhaustion of inner resources. The cancer patient, then, treats himself as if he had limitless energy to expend.

Self-Sacrifice

While cancer patients have often been described as self-sacrificing (Renneker & Cutler, 1952; Booth, 1965; Cutler, 1954; LeShan, 1966; Renneker et al., 1963; Schmale & Iker, 1966; Valadares, 1969) and masochistic (Bacon, Renneker, & Cutler, 1952; Butler, 1954; Greene, Young, & Swisher, 1956; Renneker et al., 1963), I believe the terms describe external behavior but do not adequately reflect what is going on internally. Furthermore, these descriptions lead the therapist to take a certain approach with the cancer patient that might not take into account all aspects of the behavior. A more useful way of interpreting behaviors of cancer patients which are normally described as self-sacrificing would be to call them manifestations of perceived limitlessness.

Once again, perceived limitlessness is the individual's sense that he has unlimited capacities and energy. A therapist who calls the observed behavior self-sacrifice and masochism might search for resentment or reaction formation to anger in his patients, since these are often considered part of the dynamics of masochism and self-sacrifice. While this gives the

therapist one handle on some of the patient's experiences, without the concept of limitlessness the therapist may not focus the patient on his perceived limitlessness and eventually on the limitless pain which is linked to it.

For example, Evans' (1926) description of cancer patients can be better interpreted in terms of perceived limitlessness than in terms of self-sacrifice. After stating that the cancer patient "puts himself into the object," she wrote:

If the object of his attachment has sorrow, the patient feels it, and so much so that we find that cancer victim neglecting his own needs. Families of such patients tell you: "He is so foolish in taking care of himself She will do nothing for herself; we have to watch her all the time. If she has a cold coming on, she will do nothing to stop it We have told her what to do . . . or at least to tell us [about the cold]. She never says a word" (p. 136).

Not being in touch with his own emotions and pain, and focusing on the external world, the cancer patient "feels for others," rather than "for himself." Furthermore, he appears to "give himself away" or give all his energy to others. The important dynamic is not that he is self-sacrificing, but that he has no sense of his own limitations. Without this sense, he has no way to stop expending his energy.

Perfectionism

The cancer patient's perceived limitlessness manifests itself in his self-expectations of perfection. Demanding perfection of oneself is really a request for limitless expenditure of energy, because perfection can rarely be attained. The Bahnsons (1966) write of the cancer patient's filling social and family roles with "near perfection." I take this as no accident of wording, for the cancer patient strives for perfection in many ways. For example, Grisson, Weiner, and Weiner (1975) found that cancer patients showed an

unexplained high view of their "moral ethical" selves, when compared to a cancer-free control group. Perhaps they were striving for moral perfection. Similarly, Schmale and Iker (1971) reported both "high ideals" and a "desire to be perfect" in their cancer patients. Furthermore, if we look again at Levine and Zigler's (1975) study, we find that stroke patients lower their ideal self estimates and hence their levels of aspiration once they find out the severity of their disease. In contrast, cancer patients maintain their high ideal self estimates and lower their estimates of their "real functioning," indicating that they continue to set unrealistically high levels of aspiration for themselves. In effect, they create a no-win situation by continuing to have high levels of aspiration in the face of deteriorating physical conditions. Under the circumstances, the most likely course is to try harder to reach an ideal that can never be reached, which is the perfectionist's dilemma.

Perhaps the cancer patient has been given what Kaylor (1975) calls a "try harder script" early in life. One of the Simontons' patients who, as a young boy, suffered an injury that made him unable to make the baseball team, reports that by his senior year he had become the "number one pitcher." Apparently he received "try harder" messages early in life: "I've been very goal oriented my entire life My favorite story as a child was 'the little train that thought he could' I remember my mother's saying to me, 'If anybody else can do it, you can do it'" (See Achterberg, 1976).

Ruderman (1977), a cured cancer patient who became a cancer psychotherapist, implied in a personal interview that by dropping his own perfectionism he was able to modify his rigid character structure, a change which was responsible for his cure. Although he does not use the word "perfectionism" *per se*, he implies it was a pervasive part of his character structure. When he was near death, an insight occurred to him which gave

him an opening into the belief systems which were the foundation of his personality. Ruderman reported that his most emotionally moving moment came when: "I looked around me and saw that other people were making mistakes." He realized for the first time that he could give himself permission to be less than perfect. The insight was apparently his first psychotherapeutic breakthrough because, after having the insight, he opened up to many emotional experiences that eventually led to the "spontaneous" remission of his cancer.

Perfectionism tampers with the ending, the limits, of endeavors. Because perfection is seldom reached, the perfectionist keeps himself in a perpetual struggle where he must never quit trying harder for a goal that will never be attained. Under the demands of perfection, expenditure of the self can become limitless. Ruderman's comments imply that the cancer patient's need for perfection is a central part of his personality and that when he became more self-aware, he no longer was compelled to continue to make limitless demands upon himself.

Self-Hate

The final topic to be discussed on limitlessness is self-hate, which is often mentioned in conjunction with self-sacrifice in cancer patients (Reneker et al., 1963) and which Booth (1961) implied may be the cause of cancer growth. Self-hate derives from an individual's lack of an external object on which to direct his feelings of anger. The process may be illustrated as follows.

A child feels unloved and unlovable when his feelings are not validated, because feelings come from the true inner self. When the child's feelings are not appreciated, he feels deeply that he is not loved for his true self (Janov, 1970). The feeling of not being loved sets off a chain reaction

leading to self-hate. It is as if the child said to himself, "They don't love me. Something must be wrong with me. I am despicable." The parent who too often leaves the child to his own devices leaves him helpless. The child thus has no object for his feelings. Frustration and rage often result. Again, no one is there to receive (validate) the rage. Pessó (1973) asserts that rage must have an object. When it does not, the child "eats his rage," using himself as the object. Acting together, all of these dynamics cause rage to be imploded within rather than to be expressed. Once rage is imploded, a vicious cycle, or closed circuit, is set up which is seldom interrupted because the individual allows no input from the outside to affect it. When an individual uses himself as the hated object, he has no inclination to check with external reality. The "fight" going on within is exclusive and all-absorbing. It does not involve others, so others are never drawn into it. In fact, cancer patients do not get angry with others. They have isolated their anger and fighting from external reality and others, in order to maintain their social stances as polite, acquiescent individuals. Thus the anger is contained inside, and it can be directed at no one, then, but oneself. In this regard, the cancer patient is helpless, just as the child whose parent has left him to his own devices is helpless.⁷ Because the cancer patient does not check with external reality, he again stops or blocks movement from the external to the internal. Thus, as LeShan (1977) reports, no amount of assurance of worth or love from others penetrates the self-hate of the cancer patient.

Self-hate, then, is the exposed tip of the iceberg that is limitless rage within the cancer patient, apparent to both the patient and to those who are close to him. LeShan (1977) wrote that the self-hate of the cancer patient could be compared to that of neurotics, but that it is even more remarkable and pervasive:

One new factor was a marked amount of self-dislike and self-distrust observed in these cancer patients. These individuals did not respect their own accomplishments; they did not like themselves or the attributes they perceived in themselves. In a majority of cases, they had basically accepted (and often over-compensated for) self-perceptions such as "stupid," "lazy," "mediocre," "destructive," etc. Other people responded to them much more positively than they did to themselves, but this, of course, took none of the sting out of their belief about themselves (p. 32).

While the patient may be aware of his hatred toward himself, he is in most cases unaware of the vast mountain of limitless rage that underlies self-hatred. The accumulated rage is the individual's reaction to having been left helpless with no outlet for his feelings. Self-hatred, then, is limitless rage which has found an outlet—the self. Because the outlet is the self, the rage remains entrapped and self-perpetuating.

Cancer patients rarely tap their rage, even in psychotherapy. When they do, they become aware of its vastness. For example, Giovacchini and Muslin (1965) reported on a patient who through psychoanalysis came in touch with her limitless rage. They wrote that she was "terrified of losing control and being overwhelmed and destroyed by her inner rage" (p. 526).

Limitless is manifested in the cancer patient in many guises: lack of self-awareness, alienation, perceived limitless energy, extraversion, self-sacrifice, perfectionism, and self-hate. It is limitlessness, both a result and a cause of helplessness, which underlies all of the cancer personality styles that have been identified by earlier researchers and therapists. In the following section, I will take this underlying dynamic one step further by showing how it manifests itself in a behavioral style common to cancer patients: the controlling persona.

The Controlling Persona

I began this chapter with the statement that while cancer patients may be characterized as having many different personality types, all cancer patients manifest a common mode of behavior that governs both their external and internal ways of being. This dynamic common to all cancer patients I call the Controlling Persona. Here I refer to personality types as external ways of being and the Controlling Persona as the dynamic from which all of these personality types of cancer patients may spring.

Control

The major underlying dynamic that influences personality development in the cancer patient can be surmised from one quote from the literature on helplessness. Having repeatedly experienced helplessness,

Henceforth, the individual learns to perceive himself as having no control over the stimulus situation and either gives up altogether or attempts to arrange his environment in a manner that maximizes his control over the stimulus situation. However, if he fails to rearrange his environment and to exert control over the consequences, this might later interfere with his capacity to foresee, challenge, and later search for alternatives, although alternatives may be available (Valle, 1977, p. 7).

The essential concept Valle is mentioning is control. It is proposed here that control is the obsession, conscious or unconscious, of the cancer personality. The cancer patient's early life experiences have amounted to being tormented over not being in control of his situation and of his own pain. This accumulated pain itself seems to be without controls. And the only escape he has had in such a hopeless situation has been to control himself, control his own emotions, so that he does not have to feel the pain. The control of his emotions can be said to spread and pervade his entire personality so that much of him seems to be controlled. The cancer victim treats not only himself as an object to be controlled, but others. Elida Evans (1926) was one of the first to note the excessive control of others manifested by her

patients. "For the sake of the [cancer patient] it is essential that the independence of the object be not too manifest, for a separation or being cast aside by the object, which he [the object] must oftentimes do in defense of his own individuality, is fatal to the [cancer] patient" (p. 135). Evans sees the control of the cancer patient's object to be a matter of life and death to him. There could be no stronger a motivation to control than that.

Similar to Evans, Booth recognizes the cancer patient's concern with control: the cancer victim treats not only himself as an object to be controlled, but others:

In cancer one finds that the patient has originally been concerned with the establishment of control over objects, in the broadest sense of the word object . . . not mutuality and partnership . . . This trait does not imply that these patients have been selfish or possessive, nor that they have necessarily been aggressive in their attitudes toward others Psychoanalysis has defined this personality type as the anal character In the psychological development of these individuals the dynamic pattern of the anal function, that is, the earliest infantile experience of controlling an inanimate object, retains particular importance (Booth, 1965, p. 16).

That Booth describes cancer patients as anal characters is significant when we realize that the anal personality type, who of all the psychoanalytic characters is obsessed with control, has been thought to be rare. Booth believes that the anal personality type is emerging as the dominant personality type of technological man. Here Booth alludes to the dramatic rise in cancer that is occurring in this century.

Most cancer patients are oblivious of their desire to control others. However, my associate and I interviewed one aware patient who was cured of her cancer in one week through a combination of spiritual and psychotherapy. She presented her world view, represented by a triangle, one of the

angles of which is control. She described how her triangle, her life, became unbalanced:

Int: Do you feel that when you got cancer that triangle got unbalanced?

Pa: Yes, definitely.

Int: In which direction?

Pa: (Laughs) Every which way, I think.

Int: Was it more on one side of it than the other?

Pa: I would say it was more of the excess control power. Controlling too much that was not mine to control. Trying to control others rather than myself, and getting that control into other people's business instead of my own. I was trying to manipulate my husband, I was trying to manipulate all kinds of things. My house, my finances. You know, I was into control (Rose & Schlosser, 1978).

Not only are cancer patients concerned with controlling others, but if we accept the helplessness paradigm as part of the cancer patient's early life, they would also be touchy about being controlled by others. An individual who experiences helplessness has only one way to keep himself from feeling helplessness, and that is by maintaining his control of others. By allowing someone else to control him, he finds himself once more lost in what he sees as the repetition of his childhood helplessness. What Booth (1964) describes as "resistant to outside influences" may in fact be a manifestation of not wanting to be controlled by others. "Cancer patients strive for independent self-expression and to avoid emotional involvements on the level of equality. This makes them resistant to outside influences" (Booth, 1964, p. 44). Similarly, Shrifte's (1962) concept of the cancer patient's investment in

"moving the world" rather than "being moved by it" can actually be called an investment in controlling others while not being controlled by them.⁹

Other researchers (Booth, 1964; E. Evans, 1926) have noted the characteristic of obstinacy in cancer patients. Obstinacy is a refusal to be influenced or controlled by others. An anecdote given by one of the Simontons' patients illustrates obstinacy: Upon detecting no cancer on this patient's X-rays, the radiologist made sure he had identified the patient correctly to the oncologist by asking, "Is your guy an ornery son of a bitch who does what he wants to instead of what I tell him?"

The following excerpt from a lecture given by the same patient about the remission of his cancer illustrates his concern with control and his vacillation between giving up control to a higher authority and keeping it for himself. In speaking of his search for a healer, he says: "It was important to me that this not be an Oral Roberts or Kathryn Kuhlman [faith healers] or whoever. It was important to me that it be an oncologist, someone who understood my problem, this disease. Somehow it had to be somebody who would help me to get the power from inside and not from him or or her." In other words, he wanted to be in control of his own cure. Yet in the introduction to his speech, he reveals what is perhaps a giving away of power (and control) to his oncologist, Carl Simonton: "I've been thinking a lot about this talk and I've been thinking about a name for it. Maybe you could help me with this. I boiled it down to two. One is 'How I Was Snatched from the Jaws of Death by Ultra Doctor,' and then the other is 'My Life After Meeting Baba Ram Carl.'" While the Simontons' patient states that he wishes to maintain control of his healing process, the introduction to his speech indicates that perhaps unconsciously he turned over the responsibility for having been healed to an outside authority. Basically, what the patient described here is

an investment in the authority of his doctor. In fact, it may be that cancer patients in general tend toward authoritarianism.

Authoritarianism

If control is a major issue to the cancer patient, we might expect cancer patients to manifest a belief that an obedience-oriented way of childrearing is best. They may want to keep firm control of their children. Bahnson and Bahnson (1966) administered tests to cancer patients which included a question about child-rearing philosophy. Twenty-four cancer patients answered the Connecticut Health Study which included a number of forced choice items, some drawn from the MMPI, the F Scale, and other current personality inventories. On the question, "Obedience and respect for authority are the most important virtues children should have," 22 cancer patients marked "agree," two marked "disagree." The Bahnsons suggest that cancer patients are authoritarian, rigid, and socially conforming people.

Authoritarianism is a belief in blind submission to the authority of others. People with an authoritarian orientation might be concerned with the control of people as opposed to, for instance, trusting that people do not have to be controlled. To date, Kennedy, Tellegan, Kennedy, & Havernick, (1976) have conducted the only study on cancer and authoritarianism. Twenty-two cured cancer patients, free of cancer from five to 21 years, were compared to a group of college students, a group of non-diseased persons over 40 years old examined at a cancer detection center, and a group of diabetes mellitus patients. The cancer group and the group at the detection center scored substantially higher on authoritarianism as measured by the Differential Personality Questionnaire, an unpublished instrument. On this test, high scorers describe themselves as endorsing traditional values, such as strict

child-rearing practices, good manners, stern law enforcement, a religious faith, and respect for authority.

As Kennedy et al. suggest, it may be that age is the primary factor, since older people are more likely to develop cancer and score higher on tests of authoritarianism than younger people.¹⁰ While Kennedy's findings do not stand up to rigorous scrutiny, the possibility that cancer patients are authoritarian deserves further investigation.

Divergent "Cancer Personalities"

Researchers have identified several divergent personality styles in cancer patients, so that on the surface there appears to be no single personality style which fits all cancer patients. A review of the significant personality styles follows.

Among the first researchers to recognize that cancer patients exhibit various personality styles were Greene, Young, and Swisher (1956). They classified 32 women cancer patients they observed into four groups: Mothering Women, Manly Women, Clingingly Dependent Women, and Isolated Dependent Women. Of the 32 women seen, 37 percent were mothering, overly pleasant, altruistic, good patients who behaved like ideal mothers. They lived through many objects and were relatively self-sufficient. Five patients (16 percent) were "manly" (with men's jobs such as foreman, machinist, and airplane pilot), self-sufficient, denying of any need for anyone except one individual. Toward everyone they were demeaning and belittling. They were least restricted of the group in their ability to express anger. Fifteen (47 percent) were dependent. Six were clingingly dependent, living off many different people in parasitic relationships with no attempt to deny their dependency needs. Nine were dependent but isolated, having a close relationship with one person.

Helpless-Hopeless. By far the most frequently reported cancer personality, that which I have classified as the Helpless-Hopeless Style, was described by Blumberg, West, and Ellis (1954) as belonging to a "fast-dying" group: "We also were impressed by the polite, apologetic, almost painful acquiescence of the patients with rapidly progressing disease, as contrasted with the more expressive and sometimes bizarre personalities of those who responded brilliantly to therapy with long remissions and long survival" (p. 277). Furthermore, Schmale and Iker (1971) accurately predicted the development of cancer in patients who exhibited a special kind of hopelessness that they defined as "a total giving up."

Perhaps a factor in maintaining the Helpless-Hopeless Style is the patient's masochism and his inability to discharge anger. Bacon, Renneker, and Cutler (1952) studied 40 women with carcinoma of the breast. Thirty-five of the subjects were observed as having the following major behavioral characteristics: masochistic character structure; inhibited sexuality; inhibited motherhood; a facade of pleasantness covering an inability to discharge or deal appropriately with hostility or aggressiveness; unresolved conflict with the mother handled through denial; a frequent picture prior to clinical diagnosis of cancer of acute or chronic depression with vague feelings of anxiety, guilt, self-criticism, and self-condemnation. Thirty of the 40 denied ever having been angry, and most presented a facade of pleasantness. While the inability to discharge anger in people with the Helpless-Hopeless Style is most noticeable, perhaps these people cannot find an outlet for emotions in general. Blumberg, West, and Ellis (1954) found their fast-dying group to be highly defensive, depressed or anxious, and unable to discharge these affects.

Extreme Suppressors - Extreme Expressors. Greer and Morris (1975) identified two major classes of cancer patients: Extreme Suppressors (those who have never or not more than twice in their adult lives shown anger) and Extreme Expressors (those who had a history of frequent outbursts of anger and had never or rarely concealed their feelings). Greer and Morris chose as their sample patients admitted to the hospital for breast tumor biopsy. The experimental group became those with positive biopsies for cancer, and the control group were those who had lumps which were non-cancerous.¹¹

The methods of assessing emotional functioning included structured psychiatric interviews done by a psychiatrist and two research assistants and the Mill Hill Test of Verbal Intelligence, the Eysenck Personality Inventory (a form of the MPI), and the Caine and Foulds Hostility and Direction of Hostility Questionnaire. Among other data gathered in the interview was information about the patients' degree of concealment of anger and other emotions. The patients' husbands or close relatives were interviewed separately to verify the patients' accounts.

Greer and Morris observed 69 cancer patients and 91 controls. They found that when they considered anger apart from other emotions, 47.8 percent (33) of the cancer patients and 15.4 percent (14) of the controls fell into the extreme suppressors' group. The significance of difference between these proportions was $p < .00001$. Only 29 percent (20) of the cancer patients were apparently normal as opposed to 72.5 percent of the controls ($p < .00001$). Fourteen of the cancer patients (20.03 percent) and nine of the controls (9.9 percent) were extreme expressors ($p < .02$). When feelings other than anger were considered, more cancer than control patients occurred in the extreme suppressor group, and more control than cancer patients occurred in the apparently normal group in proportions very similar to those

reported for anger. There was a non-significant trend for more cancer than control patients to be extreme expressors. Thus, almost two thirds of the cancer patients fell into the extreme categories, either extreme suppressors or extreme expressors, with more of them being extreme suppressors. The finding that cancer patients are extreme expressors was totally unexpected.¹²

Thus Greer and Morris identify two distinctive personality types in cancer patients which parallel the two I propose here. The extreme suppressor group may well fall into the Helpless-Hopeless category, while the extreme expressors may belong to the Super Star (long-lived) category. Greer and Morris do not give enough information to allow the reader to interpret Extreme Expressors as being long-lived patients. Nevertheless, I believe Extreme Expressors closely resemble the Long-Lived and Super Star groups which will be discussed next.

Long-Lived. While most of the cancer research identifies patients as belonging to what I call the Helpless-Hopeless group, a number of other studies point to the existence of yet another markedly different personality style. In many studies, this group is referred to as "long-lived." What seems to characterize this group other than their tendency to live longer than most other cancer patients is their ability to discharge anger and their free access to hostility (Stavraky, 1968; Blumberg et al., 1954). Bacon et al. (1952) report on an unusual group of cancer patients who are able to discharge affects and who do not show signs of the Helpless-Hopeless Style: "We are impressed by the different personality formations of the 55-70 age group. Many of these women had better channels for affect discharge, were not masochistic, were generally emancipated from the mother or else had more active neurotic techniques for discharging energy" (p. 460). This, too, was a

longer-lived group. They lived five to ten years with unoperable and relatively untreated carcinomas, an unusual length of time with cancer of the breast.

Super Stars. Achterberg (1976), a colleague of the Simontons, speaks of a small group (two to five percent) of special patients who were unlike other patients. Not only are these people not helpless, but they are expressive of anger and long-lived (Achterberg, Matthews-Simonton, & Simonton; 1977). Extremely capable individuals, they will their cancer into remission. In a taped lecture Achterberg (1976) said:

Emerging among our patient population is a group of people that we call Super Stars They have lived at least two years beyond a diagnosis of incurable disease. Our impressions of them are that they are first of all highly motivated; they are generally successful professionally. They are bright; they are verbal; they're compulsive; sometimes they are scrappy. But they are never, never meek or obsequious. They have the most monumental, magnificent egos you've ever seen in your life. When you have more than two Super Stars in a room together, the air is thick with their contention. [From various psychological tests] we have found that first of all we can discriminate between that group and the group of patients who die within a year after diagnosis on the basis of ego strength, their belief in themselves, flexibility, non-conformity, the ability to see both sides of the issue, and the tendency to maintain personality integration under stress Interestingly enough, they are not interested in what other people think of them. They are totally self-reliant and believe that they and only they are in control of their lives.

The Simontons have effected remarkable remissions in cancer patients through visualization techniques combined with a behavior modification program. They were particularly successful in bringing about remission in those patients belonging to the Super Star category. These individuals are for the most part achievers who are highly motivated and strong-willed. They contrast markedly with those cancer patients whom the Simontons were unable to help control their cancers, a group which fits into the Helpless-Hopeless style.

Even though the cancers of the Super Stars went into remission, the kernel of the cancer persona remains: Super Stars still exert control over themselves and others, and they still manifest signs of limitlessness. For example, in the following passage one of the Simontons' Super Star personalities verbally recounts his seemingly limitless prowess on the racquetball court:

I began to play racquetball, which I'm addicted to, and I would play . . . [speaking rapidly] you know it's a very exhausting sport, about three times as strenuous as singles tennis, I . . . I from what I'm told, and, um, I played a half game and then a game. [Wife's name] and I went to Israel about a month later, and we climbed hills that most of the people couldn't get up and down . . . I came back . . . and six months after the date I was disease-free, I beat the state champion of [home state] in racquetball, who was 15 years my junior By the way [undertone] I've beat both my doctors in racquetball now I'm going to play them sometime in a tournament, two on one. Me the one and them the two (See Achterberg, 1976).

The Controlling Persona: Shared Dynamics

The personality styles of cancer patients that appear on the surface differ so markedly from each other that there may be no one cancer personality style. This theory suggests that while the styles differ, the dynamics common to all the personality styles (called the Controlling Persona) do not. The shared dynamics which constitute the controlling persona are limitlessness, hopelessness, and control.

Limitlessness has two meanings in the present theory. First, limitlessness describes the pain that occurs early in life and that is the necessary factor in the development of stored helplessness. This limitlessness is not normally visible and can only be detected in tests that tap deep psychological levels. Second, on the personality or behavioral level, limitlessness refers to the drive of the "Super Star" who feels he or she can beat all comers in competition, or refers to the degree of self-sacrifice to

which some cancer patients commit themselves. No matter how it is expressed, limitlessness is an underlying dynamic of all cancer patients.

Just as limitlessness has two meanings, so does helplessness. There is the profound feeling of helplessness experienced by the infant that most people avoid re-experiencing except in deep psychotherapy. This feeling state is stored in perhaps greater quantities in cancer patients than in the general population because it has never been released, even in earliest childhood.

The second kind of helplessness is the helplessness that manifests behaviorally. On the behavioral level, the person either acts out helplessness and is thus somewhat aware of this underlying feeling state because he "lives" it, or he shows a reaction formation to it and is totally unaware of it. The person confronted with the helplessness paradigm makes extreme attempts to control his life situations (Valle, 1977); if he fails, he remains helpless. In my theory, he develops the Helpless-Hopeless style. If he succeeds, he exhibits a reaction formation to helplessness. Characteristically, such a person would be frightened of ever being controlled by others and would, in addition, constantly deny ever having been helpless or the possibility that he might need help. In other words, their control of the world is desperate. In my theory, this person develops a Super Star style, and, as will be shown in Chapter 5, "The Precipitating Event," if control is lost, cancer and death ensue. Both the Helpless-Hopeless and the Super Star types do succeed in some kind of control, although the Super Star controls on a grander scale.¹³

While the above discussion of cancer personality seems to revolve around expression of emotions, it is not merely the ability to express emotions which releases a cancer patient from his limitless stored pain. Recall that a small group of cancer patients excessively expressed anger.

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While these individuals can express anger, they may not express the full range of emotions, particularly neediness or helplessness. For this reason, then, their capacity to discharge emotions is limited. Furthermore, their discharge of anger does not seem to be the deep discharge of anger that leads to a satisfying end, the kind that one experiences in deep therapy. And, as such, it is not a health-restoring discharge of anger. Despite an outburst of anger, the expressive cancer patient remains characteristically overly expressive, whereas in healthy discharge the anger is spent and the person does not remain overly expressive. However, it does seem that one's chances for survival of cancer are better if one is able to discharge anger than if one does not discharge emotions at all.

In this chapter I have proposed that although cancer patients exhibit varied personalities, they are alike in that they all experience the same underlying dynamics of limitlessness, helplessness, and control. This theory leads us to a possible cure of cancer through a type of psychotherapy through which patients are helped to discharge limitless pain and even helplessness. Before I discuss this psychotherapy, I turn to a discussion of an event in many cancer patients' lives which immediately precedes the onset of detectable cancer.

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¹To my knowledge, no one else has suggested that cancer patients have stored psychic pain, nor has anyone tried to measure it. Support for this hypothesis, however, comes from Shrifte's (1962) findings that cancer patients have a greater degree of "accumulated underlying unpleasant feeling tensions," as measured by the Rorschach, than is usually found in the general public. These "feeling tensions" are not physical pain suffered from the cancer, because Shrifte's group included cancer patients who were actually cured at the time she tested them (which she found out several years later). More likely, Shrifte is reporting a manifestation of stored psychic pain which has been buried from awareness. Furthermore, her descriptions of the variable she measured coincide with some concepts in the present theory, leading me to believe that she was observing signs of psychic pain while not fully recognizing all the possible implications. For example, "feeling tensions" might refer to the emotional quality of the psychic pain, "accumulated" suggests that it is stored, "underlying" implies that the pain is out of awareness but ever present, and "unpleasant" describes the nature of pain. Thus, Shrifte's variable has many characteristics of the stored psychic pain I refer to in the present theory.

²Even though cancer patients give answers on tests that imply they are suffering from psychological distress, still they do not own that they have psychological problems (Bahnon & Bahnon, 1966). Even when psychotherapists discover disturbing neurotic symptoms in cancer patients and have advised them to enter psychotherapy, nearly all have declined (Renneker et al., 1963). Thus, the psychological distress is present in cancer patients, but they lack the introspection necessary to fully perceive it.

³Jonas (1966) proposes that the cancer cell's alienation must occur in the midst of awareness. "Only when there is an awareness potential can one become alienated" (p. 1043). As evidence he suggests that cancer never develops where the central nervous system is cut off in injury. In support of his argument, I have noticed one report that a metastatic melanoma disappeared after a lobotomy (West, 1954). Interesting though this theory may be, it should be viewed with caution for Kavetski (1958) reported that tumors develop more rapidly in animals that are decerebrated.

⁴In Shrifte's conceptualization, form, color, and shading responses are indices of being "moved" by the world, and movement and vitality responses are indices of wanting to "move" the world.

⁵When one is in touch with his inner self, only then can external stimuli trigger emotional responses. "Not being moved" is not allowing oneself to be touched or reached, a particular awareness not unlike that described by Maslow (1968) as "being cognition."

⁶It may be that cancer patients are not extraverts in the sense of being outgoing, or having uninhibited social proclivities. Kissen (1963) suggests that Extraversion on the MPI measures these proclivities. Early in his work, Kissen found that male lung cancer patients scored higher on Extraversion than controls (Kissen & Eyesenck, 1962) and when Coppen and Metcalfe (1963) replicated the study with women, they found that women with cancer scored significantly higher on Extraversion than either a hospitalized or a non-hospitalized cancer-free group. Later research did not bear these findings out. While a tendency for extraversion was found in male lung cancer patients, it was not statistically significant (1963, 1964). In 1969 Kissen repeated his research on male lung cancer patients using the newer Eyesenck Personality Inventory, which superseded the MPI and has a lie scale that corrects for socially desirable responses. Whether controlled or not controlled for social desirability, the differences between cancerous and non-cancerous male patients on extraversion were negligible. Perhaps this type of extraversion is present only in women.

Kennedy, Tellegen, Kennedy, and Havernick (1976) compared responses from medically-treated patients free of cancer for up to 20 years to responses from students, diabetics, and disease-free patients at a detection center for cancer. Female cured cancer patients were significantly higher on social closeness on the Personality Differential Questionnaire than all others. High scores on "social closeness" means they describe themselves as gregarious and inclined to seek relationships with others. These findings were not true for the males tested. Similarly, Hagnell (1966) found that "an interest in people rather than ideas, meanings, or implications" was characteristic of women who later developed cancer, but not of men.

It seems that the extraversion being measured by all of these researchers refers to a desire for social contact rather than an external orientation to life. Sex-role stereotyping may account for the fact that female cancer patients but not male cancer patients are extraverts.

⁷It is interesting to note that Nemeth and Mezei (1964) link helplessness with self-hate in their discussion of the behavior of cancer patients in a testing situation. Only cancer patients asked for help when tested, while benign and normal subjects did not. Nemeth and Mezei interpreted the reason for calling for help as a result of the cancer patient "having no solid ground to stand on" in the face of "total self-annihilation" born of self-hate.

⁸Similarly, Roland and Snyder (1977) consider the cancer patient's "self-directed beliefs and emotions" about himself, especially self-hate, to constitute the most important avenue for the psychotherapist in dealing with the problems of cancer patients.

⁹It is interesting to note that both researchers maintain that in order for cancer patients to resist outside influences, they must keep emotional distance from others. Shrifte writes that one consequence of the expenditure style is: "When moving the external world is present without being moved, the individual would need to maintain emotional distance in order to protect himself in relationships" (p. 394).

¹⁰Kennedy et al. (1976) attribute the finding that cancer patients score higher on authoritarianism to the age variable. Both the former cancer patients and the people at the detection center are older than the others. Older people tend to score higher on authoritarianism. Kennedy et al. report neither numerical data nor statistical manipulations of the data on these two groups. Thus it is impossible to tell if the two groups differ from each other in degree of authoritarianism, high scoring though they both may be, and there is no report of whether differences are statistically significant. Furthermore, conclusions about the age variable are difficult to assess because the groups were not age-matched. In this study they are just called "similar" in age.

A possibility not considered by these researchers may account for their findings: people who go to cancer detection centers may be more authoritarian than others. Behaviorally they are following current recommendations from medical authorities to undergo periodic examinations for cancer. High authoritarianism in this group, and not age, may account for Kennedy's findings. However, the findings about authoritarianism can be questioned because the instrument has not been validated. It would be good to repeat Kennedy and his colleagues' study using more popular measures of authoritarianism.

¹¹Two good aspects of Greer and Morris' research design which I would like to point out are: first, they used the double blind method, and second, they verified the presence of cancer in their experimental group through tissue examination.

¹²Although inter-rater reliability was not determined, these researchers statistically compared each of the three raters' findings with findings from the pooled ratings of all three. Each rater's findings appeared to be consistent with the findings of the raters as a whole. This is not as tight a method of assessing reliability as establishing inter-rater reliability, but often, due to the incapacitating nature of their illnesses, cancer patients cannot tolerate being tested several times over the same material.

¹³The Helpless-Hopeless type gains control through self-sacrifice and manipulation of others.

Chapter 5

THE PRECIPITATING EVENT

Much of the literature on cancer suggests that the onset of disease is brought about by the disruption of the cancer patient's control of a specific object, for example, a relationship, a socioeconomic career, an avocation, or other endeavor (Booth, 1973). The object attachment of the cancer patient is so intense and so exclusive that once the tie has been established between the cancer patient and his object of attachment, it is unlikely to be severed easily. When the cancer patient loses his object of attachment--for instance, a loved one, a job, status, or whatever he may have invested himself in--cancer sometimes ensues. The first part of this chapter will review articles which note the intensity of the cancer patient's object attachments. The second part will examine the growing evidence that cancer patients typically experience a traumatic loss approximately six to 18 months prior to the discovery of their cancer. In the light of these circumstances, the third section explains how cancer could develop in terms of the psychological dynamics proposed in the present theory.

Object Attachment

Elida Evans (1926) was the first to describe the intense attachment of the cancer patient to his object. She wrote that the object may be either a person or an endeavor, but that, whatever it is, his attachment to it is unyielding and rigid. In different parts of her 1926 book, Evans explains:

They have tried to put their entire selves into their objectives, their stock of libido has rushed out, or tried to, with strong current (p. 115). . . . He transfers a part of himself, his being, into the object, whether it is a human being, or human interest, as business for instance, or any outlet for his energy. When this energy flows into the object there is an identification with the

object. This "introjection," identification, of one's self into the object in an attempt to compensate for what is missing in the life energy of the one who "feels" himself into the object (p. 120) For the sake of the [cancer patient] it is essential that the independence of the object be not too manifest, for a separation or being cast aside by the object, which he [the object] must oftentimes do in defense of his own individuality, is fatal to the patient (p. 135).

Evans describes how the cancer patient is so set in his ways, so obstinate and unyielding, that he cannot choose a new object into which to pour energies, once he has lost the old object.

They are inadequate for the everyday demands of adjustment to changing conditions, and give the impression of their being . . . unyielding, obstinate, set-in-[their]-ways people . . . They [cancer patients] are forced toward a compensation which can be obtained only by a sacrifice of the hitherto onesided attitude. This they cannot or will not do (p. 119).

Thus, when the object leaves the cancer patient, or when he loses the object, as in a business loss, Evans describes:

Like a vine torn off from its supports, the cancer patient does not and cannot start a new growth. It is no self will of the patient, for his life depends upon the continuity of his relation with the object. It is the inflexibility of his nature which creates another kind of self will to cling to an idea which in the end destroys him (p. 121).

Such a fixedness of an object attachment is described by one of LeShan and Gassman's (1958) patients who said, "If I go on with this [psychotherapy], I'll look at my marriage, and if I look at it, I'll break it up. If it is a choice between my life and my marriage, I'd rather lose my life" (p. 728). Booth (1965), too, echoes Evans in his view of the intensity of object attachment:

Loss of an important object represents a particularly traumatic experience for [the cancer patient]. Mastery over the object is a dominant need for the subject, and the obstinate sticking to a position once taken makes it difficult to find a substitute object (Booth, 1965, p. 48).

Later Booth (1969) theorized that in cancer, part of the body has been turned into the lost object. Furthermore, the organ which was involved

biologically or symbolically in the lost object relationship is chosen for the cancer site. For example, a mother who has lost her daughter's dependence upon her for psychological nourishment might get breast cancer. Booth explains the inability of the cancer patient to form a new object attachment in terms of the old "object" being firmly implanted inside the body in the form of the tumor. With his "object" inside, the patient need no longer search among external objects for the satisfaction of his needs.

I propose that what these therapists report as an inability to form a new object attachment is actually a concomitant of the deep and deadly helplessness the cancer patient experienced early in life. In his experiments on learned helplessness, where nothing the person does can influence his fate, Seligman (1975) reports that helplessness interferes with the person's motivation to initiate and learn new responses. Also, even when once-helpless people are led through new responses, they cannot perform these new responses when tested again. In light of Seligman's findings, we believe that cancer patients who have been subjected early in life to helplessness will perceive that new object attachments are not possible once they lose an old relationship. The cancer patient will be unable to recognize other options. A more thorough integration of the literature on object attachment and loss and the current theory follows at the end of this chapter. First, however, I will review evidence that cancer patients have experienced a great loss prior to the onset of disease.

Loss Preceding the Development of Cancer

Greene, Young, and Swisher (1956) noted that 24 out of 32 women with lymphomas and leukemias had experienced losses prior to the development of cancer, including death, divorce, or separation of a parent or

husband. When they added to their list the advent of menopause in the patient (considered the end to the ability to replace certain love objects), the loss of work, and/or a change of home, they found that 30 of the 32 patients had experienced losses. Later, Greene and Miller (1958) reported on a group of 33 children and adolescents with reticulo-endothelial disease. Thirty-one of the 33 children had experienced a real or a symbolic loss prior to the onset of disease including the birth of a sibling rival who now received the full attention of the mother which had once been his; a change of home; the beginning of school; and the separation or threat of separation from a significant person. Unfortunately, neither study used a control group or raters to judge and compare judgments of what constitutes loss.

Greene and Swisher (1969) presented findings of loss in three sets of twins, one of whom developed leukemia while the other did not. They searched the past histories of the twins and found losses to have occurred for the leukemic but not the healthy twins. For example, the leukemic twins suffered: loss in competition with the healthy twin caused by the birth of a female second child rather than a male; the loss of land assigned to the sick twin, but not the healthy twin, when an expressway was run through the family farm; the loss of the father through divorce when the sick twin was more attached to him than the healthy twin; and loss in competition when the healthy twin acquired a girl friend when the sick twin did not have one. In each case the healthy twin possessed something the leukemic twin either had never had or had had to give up. It appears that resentment over losses in competition with the well twin might have been the precipitating factor more than generalized loss. However, any interpretation of these data is risky because the method is open to experimenter bias, since there was no use of inter-rater reliability in judging what constituted loss.

In a study that used a control group (150 Ss), LeShan and Worthington (1956c) assessed the personalities of 250 patients with malignant tumors by means of the Worthington Personality History. Seventy-one percent of the cancer group as compared to 14 percent of the control group had undergone the loss of a vital relationship followed by great tension. From this study, LeShan and Worthington (1956a) hypothesized that cancer rates should be related to marital status of the four marital classes; i.e., cancer rates should be highest for the widowed, lower for the divorced, lower still for the married, and lowest for single women. LeShan and Worthington believed that these groups would experience descending degrees of loss. Using statistical data from several sources and over several years, they found their hypothesis supported. The major objection to this study is that both cancer and the order of the marital status variables are age-graded, e.g., an older person is both more likely to get cancer and to be widowed. What they claim to measure as an effect of loss, then, may well be an effect of age. Nevertheless, loss has been noted by psychotherapists to precede the development of cancer from as much as two years to a matter of months (Roland & Snyder, 1977; Ruderman, 1977; Simonton & Simonton, 1975). Most often the patients have lost the one relationship that they treasured most in life. Furthermore, cancer patients seem to have attached all their hopes for gratification and satisfaction in life to this single relationship. Once they lose the relationship, many of them give up their reasons for living. For example, LeShan (1977) writes:

The strongest clue in the search for a pattern in the lives of cancer patients concerned the loss of the patient's raison d'etre. This loss of their sense of purpose in life had occurred at some point in the past, apparently pre-dating the first noted symptoms of cancer For these patients there had once been a period when they had participated much more fully in life. At that time they had had a relationship with a person or group that was of great and deep meaning to them. All other

relationships had been comparatively superficial. The single central relationship satisfied their needs to express their creativity, to relate to others, to be a member of a group For these people, the loss of the central relationship can be catastrophic (pp. 22-23).

Furthermore, the present loss may awaken in the cancer patient all the grief he has stored inside of him from early losses in life. Given his inability to discharge emotions, he is unable to discharge either his present grief or the grief from the old losses he knew earlier in life. In this case, I would expect signs of early losses in cancer patients.

In a further analysis of 250 cancer patients and 150 controls, LeShan and Worthington (1956c) found that 62 percent of the cancer patients and 10 percent of the controls showed unresolved guilt and anxiety over the death or psychological loss of a parent or sibling. It seems that in the first seven years of life, a trauma occurred which deeply affected the child's ability to relate to others, like the loss or death of a parent. Similarly, Reznikoff (1955), in a study of 50 women attending a clinic for diagnosis of early breast cancer, found that those that turned out to have cancer reported significantly more sibling death in childhood than those with benign lumps.

Smith and Sebastian (1976) interviewed 44 cancer and 44 non-cancer patients to determine the number of critical incidents experienced in their lifetimes. Patients were requested to list "events that have occurred in your life which have made you feel very concerned, emotional, stressed." Intensity of the incident was rated by the first interviewer on a 15-point scale and evaluated by the other interviewer by tape (reliability ranged from .89 to .91). The cancer group had 107 critical incidents that were high in emotional implications, while the non-cancer group recorded only 40.

The findings about loss and early loss appear to be contradictory, however. Muslin, Gyarfas, and Pieper (1966) compared the number of early

separations, recent separations, and combination of early and recent separations, of malignant vs. benign tumor patients matched for race, age, marital and socio-economic status. Diagnosis was not known to anyone before the experimental procedure began. A panel of judges who decided whether or not something constituted a loss, found no difference in the number of childhood separations, no difference in the number of recent separations, and no difference in the combined number of separations between the two groups.

At first glance, this study, so well-controlled, casts doubts on the hypothesis that cancer patients have experienced losses either immediately prior to the development of cancer or at other times in their lives. However, as Muslin et al. (1966) suggest, a panel of judges, not the cancer patients themselves, decided what constituted a loss. Sometimes what is considered meaningless to an outside observer is perceived as a devastating loss by the person experiencing it. Schmale (1958) reported that, immediately preceding the onset of illness, hospitalized medical patients experienced a deep sense of loss over events that might appear insignificant to others: "These symbolic losses related to such events as a failing grade on a report card; patient finding daughter dating boy her husband forbade her to see; friend forgetting dinner engagement with patient; and another teacher criticizing patient's pupils" (p. 270). Schmale theorizes that the loss "initiated or reawakened conscious conflict over actual or fantasized past losses." In terms of Muslin's et al. (1966) experiment, the judges could well have missed events in the cancer patients' lives considered extremely stressful to them but not recognized as such by outside observers. Unfortunately, Muslin et al. looked only at separations. Perhaps the "objects of attachment" for these cancer patients were something in life other than people, such as a job or other endeavor. Interpretation of stressful loss is part of each person's unique experience.

Indeed, stress or loss per se may not be linked to the development of cancer. It is not, for instance, grief that causes cancer. If grief did cause cancer, all of mankind who grieved would develop cancer. Rather, it is the burying of emotion, the "refusal to mourn," that causes the cancer patient to fail to process grief and loss when it is encountered. By "processing stress and loss," I do not mean showing adjustment in the face of it. In fact, that is exactly what the cancer patient might do, with disastrous consequences. I mean owning the loss or stress by embracing the grief. The more intensely an individual expresses his grief, the more he processes his loss and recovers from it. But because the cancer patient values his appearance of adjustment over surrender to emotions, he is unable to express his grief fully.

Failure to Process Loss and Introjection

When Greene, Young, and Swisher (1956) investigated loss in cancer patients, they were most impressed that the majority of the cancer patients they observed did not experience grief. Instead, the cancer patients projected both the grief and the significance of the loss onto another person who had experienced the same loss. For example, the patient would say, "'I feel sorry for Mother who lost Father.' At the same time, the patient would identify with the person who experienced the same loss and by comforting him or her, achieve some relief" (p. 287). When acknowledging another's feelings, the patient does not discharge his own. Here the cancer patient "feels himself into" another person, as Evans (1926) described, and is "sad for" the other person, not for himself.

When the cancer patient acknowledges the feelings of others, he does not claim his own grief, but the grief exists and must be dealt with in some way. One way in which the cancer patient might deal with this grief is

by introjecting his lost object (See also Evans, 1926; Greene et al., 1956; Booth, 1964b, 1965; Nemeth & Mezei, 1964). According to Perls (1969), introjection is the "swallowing whole" of beliefs and attitudes without examining them and "digesting" them thoroughly. Furthermore, not only are beliefs and attitudes introjected, but sometimes entire persons. As "introjects," the person or material "remains intact, isolated as a foreign body in the system" (Perls, 1969, p. 130). So encapsulated are the introjects that they are not very likely ever to be examined. While introjects are created when others' beliefs and personhoods are "swallowed whole," still they are the creation of the person who has them. In other words, an introject is created by the person regardless of the characteristics of the actual person who is introjected.

Booth (1965) hypothesizes that the tumor itself symbolizes the lost object. Like an "introject," the tumor is isolated from the cancer patient's awareness. Furthermore, cancer is not a foreign invader, like a virus, but like the introject is a creation by the cancer patient to represent the lost object:

A cancer can be understood as a symbolic substitute for the lost object. In the earlier life of the cancer patient, the object has played the role of an extension of the self, even when it has been another individual. The tumor, as an outgrowth of the body symbolized the lost object Thus even on the cellular level cancer symbolizes the autonomy which has been the predominant aim of the patient in his days of health" (Booth, 1964b, p. 17).

In another article, Booth (1965) hypothesizes that cancer patients delay treatment for their disease because they have come to value their tumors as lost objects of attachment:

The unconscious meaning of the tumor as substitute for a highly valued realistic object explains certain baffling observations about the behavior of cancer patients, most specifically the fact that they so often delay diagnosis and therapy long after outsiders have suspected the truth. They are reluctant to

surrender the substitute object to the surgeon" (Booth, 1965, p. 48).

Similarly, Nemeth and Mezei (1964) theorize that cancer is the internalization of broken interpersonal relations over which the person is conflicted. In research using the Rorschach, they found that "criticizing or withdrawing anatomy responses" and making vain attempts to find certain body parts or organs in the blots constituted one of three variables that successfully distinguished cancer patients from non-cancer patients. For example, a cancer patient might say, "The heart ought to be here, but it is not." Nemeth and Mezei view the preponderance of anatomy responses in cancer patients as a sign of withdrawal of an external interpersonal conflict into the body. Here they seem to be describing a kind of introjection of an external conflict. Unlike Booth, though, Nemeth and Mezei imply that cancer can occur when the introjection is unsuccessful, e.g., they interpret the "withdrawal of anatomy responses" to represent a failure to reorient the conflict "within the body":

The interpersonal conflict is withdrawn into the body scheme and the object relations are replaced by a narcissistic occupation with the body. This process finds expression in the Rorschach test through the great number of anatomy responses While patients are unable to find their way in the outside world, they make an attempt at reorientation within the body scheme Our assumption is that when withdrawal is unsuccessful, when a subject is unable to find his or her way in the body scheme, malignity is present. Namely, we have found that a great number of the cancer patients criticize or withdraw their anatomy responses" (pp. 12-13).

While Booth and Nemeth and Mezei may not be describing the same phenomenon, an observation from my experiences in Gestalt therapy may explain their similarity. In Gestalt therapy, when an object of attachment is "introjected," many of the emotions associated with that object are kept out of awareness. Only when the introjection is brought into awareness and is worked through in therapy are the emotions experienced by the patient. In

the case of the cancer patient who is described as having introjected a lost object of attachment, I would say that the introjection serves to keep the emotions associated with the loss encapsulated, isolated, and out of awareness. Once introjected, the loss will not be experienced as such by the cancer patient. For Booth, cancer represents the internalization of a lost object; for Nemeth and Mezei, when cancer is present, external "conflict is withdrawn into the body scheme," but the cancer patient fails to reorient the conflict into the "body scheme." However, both might agree that the cancer patient does not work through his conflicts or process his losses, but seeks to internalize and encapsulate them in a way that is devastating to the integrity of his organism. By externalizing his emotions, by acknowledging the losses of others but not owning these same losses in himself, the cancer patient fails to discharge his own grief. These undischarged emotions, this unexorcized, as it were, object of attachment takes on a new form inside himself. The cancer patient unknowingly introjects the object and all his feelings surrounding his loss of it.

The cancer patient, then, maintains control over his object of attachment whether it be the object itself or the feelings about his loss which he incorporates and encapsulates inside himself as the tumor. In this sense, it is the reaction to the loss itself which brings on the cancer. Thus, the cancer patient's need to control (see Booth, 1965) and his refusal to express his loss which creates the environment for the development of cancer.

Chapter 6

SOLUTIONS: PSYCHOTHERAPY WITH CANCER PATIENTS

In the preceding chapters I have postulated that the most potent force in the psychodynamics of cancer development is the individual's inability to express and discharge emotions. If this is true, it follows that psychotherapy may enable cancer patients to get in touch with their emotions and thereby release from their tissues the physical manifestation of stored pain, helplessness, grief, and emotions. In this chapter I will examine those therapies currently being used to alter the course of disease in cancer patients. Not all of the therapies focus on the expression of feelings. However, all focus on change and psychological growth. Before we can discuss these different types of psychotherapy we must understand the concept of stasis, which incorporates several ways by which cancer patients stop themselves from changing and growing.

Stasis

For the present theory, stasis means anything that keeps a person locked in stereotyped ways of being, feeling, or behaving, so that he keeps himself from changing and growing psychologically.¹ While anyone may experience stasis at some point in life, the cancer patient experiences stasis throughout life. Stasis in the cancer patient takes many different forms: "doing nothing," isolation, having a "closed circuit" to the outside, control of others and of the self, extraversion, denial, repression, and self-hate. If psychotherapy were to interrupt stasis in the cancer patient, we would expect changes in the course of the cancer.

Doing Nothing

In childhood situations where helplessness is maximized, the best response is to do nothing (Seligman, 1975). This special form of "doing nothing," born of despair, permeates the lives of the helpless. In terms of the present theory, the behavioral "doing nothing" is the external manifestation of a deeply-felt internal despair which invokes an internal kind of stasis, a "doing nothing" for the internal self, a giving up, a not caring about the self, a willingness to "die" inside. In effect, the individual caught up in "doing nothing" says to himself, "What's the use of living? Nothing I do, nothing I feel, nothing, will ever change this situation. I may as well be dead." Thus, the nature of despair stops the cancer patient from seeking psychotherapy which might help him grow and change.

Behaviorally, "doing nothing" is a kind of stasis, a lack of movement in the physical sense of the word. Muhlbock (1951) and Newton (1964) have noted that lack of exercise is associated with the development of cancer in laboratory animals.

Isolation

A second kind of stasis experienced by cancer patients is isolation. Often noted in cancer patients (Bennette, 1966), isolation may be a result of maximized helplessness. Evidence for this hypothesis comes from reports on prisoners of war who show symptoms of maximized helplessness: listlessness and apathy (Strassman, Thaler, and Schein, 1956). Bettelheim (1979) observed that listless and apathetic inmates become emotionally isolated from other inmates.

In cancer patients, isolation may be explained in terms of learned helplessness. One of the lessons of helplessness is not only that one cannot help himself in getting what he needs, but that no one else will help either. Because he was not helped by his parents, the cancer patient learned early

never to depend on others. He becomes remote, even isolated, from others in adulthood. The cancer patient feels that he can go to no one for warmth and support. Therefore he is unable to take in anything from others; he cannot be psychically "fed."

"Closed Circuit" and Limitlessness

Isolation leads to another form of stasis: the cancer patient does not keep an open "circuit" to the outside. He becomes self-contained (see Evans, 1926; Shrifte, 1962 for support for this hypothesis). The cancer patient cannot accept the strength, love, energy which others could give him, and so he "feeds" upon himself for support and nourishment. But he cannot feed upon himself forever. He soon begins to starve internally. Because of his refusal to allow the nourishment from others to enter, the cancer patient expends himself in living, and because stasis prevents change, he continues to expend himself, treating himself as if he were limitless.

Control of Others and of the Self

If the adult cancer patient were made fully aware of the tragedy of his childhood helplessness, he might be plunged into cathartic emotional expression. But the adult cancer patient spends much of his energy defending himself from awareness of his childhood experiences which created helplessness in him. He does this primarily by controlling others and situations in which he finds himself. Recall that trying to control the situation is one of the responses a child might make to maximized helplessness. Indeed, trying to control the situation is a last effort to fight off the despair of helplessness.

Having once experienced helplessness, the adult cancer patient tries to prevent himself from experiencing this intolerable state again by trying to

control at least one person or situation in his life. To give up control would bring about movement of the stored emotional material. To maintain control keeps the material static, stifled, not moving, and out of awareness.

Extraversion, Denial, and Repression

Extraversion, denial, and repression help to keep emotional material from moving to expression; in other words, they keep the material static. The cancer patient is not aware of his internal pain for two reasons. First, he tends to be an extravert who refuses to look inward, and second, he is prone to use the defenses denial and repression. He focuses on the external world to avoid what is deepest within him. On the other hand, a look inside might bring awareness. It is impossible for anyone to express emotions and pain without first focusing on his internal state. By totally avoiding the first step toward expression, an internal focus and awareness, the cancer patient prevents expression at its inception.

Denial and repression are defenses that serve to keep internal states such as pain from awareness. The cancer patient is so thoroughly successful in his battle to repress and deny his own pain and emotions that he often appears to have little anxiety and little easily recognized psychopathology.

Self-Hate

Self-hate is a particularly virulent type of stasis, for once rage is imploded, the cancer patient begins an all-absorbing, exclusive fight with himself and allows nothing or no one to interrupt it. Cancer patients seldom get angry at others; the majority of them express only self-anger.

The above discussion of stases illustrates some forms readily inferred from the dynamics described in the present theory. However, the list is by no means complete, for others could easily be generated.

Solutions: Psychotherapy with Cancer Patients

Given the proposed psychodynamic of cancer development, psychotherapy can offer the cancer patient a means for changing the outcome of his disease by interrupting one or more of the stases outlined above. Interrupting stasis in the cancer patient is not a simple task. Much skill, understanding, and patience are required of the therapist. The three psychotherapies described below have employed one or more of the following techniques for interrupting stasis:

1. Help the patient to relinquish self-control, especially that involving emotional expression. Such an accomplishment interrupts stasis in a major way, since the breakdown of emotional expression is one of the primal contributors to the cancer dynamic. Emotional expression interrupts stases of all kinds.
2. Interrupt the self-hate cycle, for instance, by helping the patient get angry at others.
3. Encourage the cancer patient to become active in his own defense against disease, a difficult step because it amounts to breaking the helplessness-learning set for which "doing nothing" is the "best" response (Seligman, 1975).
4. Guide the patient toward looking inward.
5. Foster the patient's acceptance of responsibility for creating cancer.

Cured cancer patients report that this is the hardest step of all (Rose & Schlosser, 1978). The difficulty may result from the following: (a) helplessness convinces one that things just happen to him, not that he is a causing agent in his own fate; (b) taking responsibility requires that one focus inwardly, which the cancer

patient does not willingly do; (c) taking responsibility means one must admit that things have run amok internally at one's own instigation, an admission that one is out of control on some level.

6. Interrupt the facade of social perfection.
7. Interrupt perfectionism.
8. Help him go deeply into the despair and helplessness of his childhood. Only when emotional expression is fully restored, when there are adequate internal and therapeutic supports, can this be done safely.
9. Open the "closed circuit" so that psychic nourishment enters the system, a difficult step because the cancer patient learned early in life that reaching out to others was dangerous and painful.

As psychotherapy with cancer patients becomes more prevalent, other points where stasis can be interrupted should emerge. Psychotherapy aimed at affecting the course of cancer is very new. The best known group is Simonton and Simonton, who started publishing in 1977. Three other therapists—Ruderman (himself a cured cancer patient), and Roland and Snyder, a team who focus on cancer patients' "self-directed beliefs and emotions," have contributed greatly to the psychotherapeutic treatment of the cancer patient.

The Simontons

Carl and Stephanie Simonton, an oncologist and a therapist who have worked together to develop an innovative and unique method of treating cancer patients, combine traditional medical techniques such as surgery, chemotherapy, and radiation, with visual imaging (which they call meditation), behavior modification, self-help methods, such as using workbooks, and group meetings.

The Simontons and their associates have been prolific in their contributions to information about cancer patients in the few short years they have been working. First, based on data gathered from cancer patients using the imaging technique, Achterberg and Lawlis (1978), the Simontons' associates, have developed a projective technique (IMAGE-CA) for evaluating not only where the patient is in his disease process but also his prognosis should he use the imaging technique in an attempt to change the course of his cancer. Secondly, Achterberg and Lawlis (1977, 1979) have done the most extensive psychological testing of cancer patients to date. Testing 126 patients, they used the MMPI, Levenson's adaptation of locus of control (Levenson, 1973), Fundamental Interpersonal Relations Orientation-Behavior (Schutz, 1975), and the BEM Sex Role Inventory (Bem, 1974). Finally, the Simontons and their associates have set up one of the best publicized clinics for the psychological treatment of cancer patients. Before their clinic, treatment centers were relatively obscure, so that patients seeking help might not know where to turn. Because of the Simontons' efforts to get their discoveries known to the public, more patients than ever before will get psychotherapeutic help, and we can look to the Simontons to continue to increase our information about cancer patients.

Most of what we know about the success rate of the Simontons' work comes from Achterberg's (1976) taped comments. She reported that, at the time of the taping, the Simontons had treated 100 patients, some for only one session, others for the entire program. Achterberg provides statistics on 40 patients with whom the Simontons had had recent contact. All had been diagnosed as having incurable cancer which had widely metastasized (Stage 4). After treatment (length of treatment not specified), the cancer in 31 percent of the patients was no longer evident, in 31 percent the cancer was

stable, in 20 percent the cancer had grown, and in 17 percent the cancer was regressing. Achterburg states that the quality of life for all patients had improved; that is, they had restructured their lives so that they would say they were living in a way that they had always wanted to live. Eighty-two percent were fully active and employed, and few required pain medication.

Underlying the Simontons' treatment are two major premises: the patient is personally responsible for developing and for combatting cancer, and his attitudes toward that responsibility determine whether he will survive. Consequently, much of the Simontons' work consists of getting patients to take responsibility for the development of their cancer. One method the Simontons (1975) use is to urge patients to identify the "secondary gains of illness," outcomes or results of disease which please the patient, such as love and attention. Once a patient identifies the secondary gains of his cancer, then he is one step closer to accepting the theory that he has taken on the cancer in order to bring about the secondary gains.

After the patient accepts his responsibility, the Simontons give him techniques for recognizing his capacity to fight off the disease. The patient is led through progressive relaxation and told to visualize his disease, the medical treatment he is undergoing—chemotherapy or radiation, and his body's own immunity mechanisms (which for simplicity they term white blood cells) attacking the cancer. At the close of an orientation session in which the Simontons take the patient through these visualization techniques, they give the patient a tape of the process to play at home three times a day. Apparently, some cancer patients with whom the Simontons have worked do not readily visualize active treatment or defense against cancer. In my work, I have encountered cancer patients who visualize their own bodies' immunological mechanisms as impotent. For example, one of my patients visualized

the following: the cancer was a beehive, the X-ray was a light, and the white blood cells were a coil six inches long:

Th: "What do the white blood cells do?"

Pt: "They lie next to the bee hive."

Th: "Describe what the X-ray does."

Pt: "Just a light, shines on my chest."

In his imagination he not only symbolizes the passivity of his immunological defenses and the ineffectiveness of his treatment, but tells us that the cancer is powerful. Beehives not only bustle with activity and threaten intruders with pain, but they can send emissaries to distant regions (metastasize?). Some of the Simontons' cancer patients have produced similar symbolizations (Achterberg & Lawlis, 1978).

The Simontons work in groups with patients who do not perceive their ability to control the growth of cancer. The patients are encouraged to change their imagery to make the cancer vulnerable and the defenses and the treatment strong. They are also helped to follow their visualization schedules, which many of them are reluctant to do (Simonton & Simonton, 1975).

The Simontons are well aware of the passivity and the feelings of helplessness of many cancer patients. They work to change these attitudes not only by encouraging the patient to combat the cancer himself, but also by modifying his behavior to resemble that of patients who are successful in the program. Although they do not write directly of using behavior modification, the Simontons do hint that they do so:

The work by Blumberg and Klopfer [Blumberg, 1954; Klopfer, 1957] . . . substantiates the notion that attitudes, the emotions, and personality characteristics are indeed related to treatment responses, and it further offers some guidelines for structuring psychotherapy to allow patients to adopt those personality characteristics that have been found to relate to retardation of

tumor growth Training in these attributes . . . serves as a starting point for developing a psychotherapeutic intervention model (1978, p. 21).

The Simontons, then, direct cancer patients to emulate the behavior of their "Super Stars," the two percent of their patients who recover quickly from cancer. Achterberg's (Achterberg, Matthews-Simonton, & Simonton, 1977) descriptions of these Super Stars and how they differ from the more typical cancer patients are recorded in Chapter 4.

In terms of the present theory, the Simontons interrupt two kinds of stasis, the helplessness learning set and the focus on the external. They try to counteract helplessness in several ways. First, by having their patients accept responsibility for developing the cancer, they force him to see that he was indeed the agent in this process and not the passive recipient of some external force. Second, by encouraging the patient's activity in defending against the cancer, they place the responsibility for his cure upon him. Third, they modify the patient's behavior so that he does not act helpless at any time, for instance, when he interacts with others.

The Simontons interrupt their patients' external focus in two ways. First, they force the patient to look to himself rather than to external agents for responsibility in developing cancer. Second, they force the patient to look inward through the visualization process itself, in which the patient must visualize parts of his body and concentrate on what is going on inside him.

Ruderman

Ruderman uses his own experiences as a former cancer patient in his psychotherapeutic treatment of cancer patients. His experiences while deathly ill have influenced his goals in psychotherapy. By all odds, Ruderman reports, he should have died, either from his widely metastasized cancer or from the excessive doses of radiation he received. Close to death, he

perceived himself as floating at the top of the room, looking down upon his own body (an out-of-body experience). But he did not die; he reentered his body with the thoughts that he could fight the cancer, he did have something to make life worth living (the birth of an infant son), and he did not always have to strive for perfection. Ruderman suffers neither from cancer nor from the effects of radiation.

Ruderman's techniques reflect his experiences in several ways. First, when he had cancer, he felt life was not worth living and was without pleasure, so the major thrust of his therapy is toward mobilizing the patient's commitment to living a pleasurable, meaningful life. According to Ruderman, simply not wanting to die will not keep the cancer patient alive. He must "make a commitment toward living" and work hard to change how he lives. For example, Ruderman (1977) helps patients "to identify those things that make you feel good and do them, not matter how hard it is to do; and to stop taking all those toxic messages about how it is unrealistic to do this." Second, Ruderman's patients actively fight their own cancers by using a visualization technique much like that of the Simontons combined with meditation. Third, Ruderman works on a wide range of the cancer patient's social style, including his perfectionism (discussed in Chapter 4), conventionality, and investment in appearing adjusted and rational. Two examples Ruderman gives illustrate his techniques. He often asks patients to rebel a little by doing things they would never have done before, such as not paying a bill. In this example, Ruderman loosens the patient's belief in always being well-behaved and adjusted. Second, Ruderman describes an example of a recurrent interaction between him and his patients:

If I ask them, "Tell me the last irrational feeling that you have had, a feeling you have had that is not rational," they're quite confused. They will say, "What do you mean?" "Some feeling that didn't make sense." "What do you mean, 'that doesn't make

sense'?" "Did you ever see someone that walks in a store and that you feel like dumping a kettle of water on them even if you never saw them before?" "Well, why would you feel like dumping a kettle of water on them if you never saw them before?" That's it. That's a typical cancer patient. He is adamant that what he feels has to make sense in terms he understands. If it doesn't make sense, he won't admit to feeling it (1977).

Ruderman realizes that some emotions are "irrational," but his patients are so invested in being rational that they cannot imagine experiencing such emotions, so Ruderman tries to change that investment.

Lastly, Ruderman's awareness of the cancer patient's isolation from others (described in Chapter 4) leads Ruderman to reach out to the cancer patient and encourage him to take warmth from others. To this end, Ruderman has recently started touching his patients and encouraging them to touch others in their lives:

These people feel cold inside. They don't always say it that way, but that's what, if you listen with that in mind, you'll hear For instance, I see a married couple together for the first time; one of them's got cancer, and in about 45 minutes into the session, I'll say, "When's the last time you two physically held each other?" And it's like I'm pressing a button, and a lot of times tears flow almost automatically, especially on the woman's part. But you begin to feel that these are people who have had very little physical contact. They're starving from that.

I had a lady here who I see once a week . . . and she's supposed to die . . . in three months, and she's obviously in very bad shape. But she was sitting here a couple of weeks ago, and she has a lot of pain; she takes pain pills, and we were going through a meditation and in the middle of the meditation she broke down. The pain was so strong that she couldn't keep it up, and she was doubled over I just went around to the back of her chair and was just massaging the back of her neck and the side of her face I didn't say anything. I kept it up for several minutes, just massaging her neck. In about three minutes she calmed down [and finished the session] . . . She told me that she had never let anybody touch her like that in a nonsexual situation. And the feelings induced by it she has never confronted for years, but they were obviously so good that the next week when I saw her she told me that after she left the office that day, she had less pain all week than she's had (1977).

Thus Ruderman reduces his patients' isolation by interrupting the "closed circuits" to the outside that prevents their getting psychological nourishment from others.

In terms of my view of cancer dynamics, Ruderman interrupts stasis in the cancer patient at several points. For example, he works toward having patients become active in their defense against cancer, interrupting the helplessness learning set; he encourages the patient to get warmth from others, interrupting the "closed circuit" to psychological nourishment; and he suggests the patient rebel against some of his typical overly-socialized behaviors. Furthermore, Ruderman offers the kind of support, nourishment, and attention to the patient's psychologically-starved condition that encourages self-exploration and emotional expression.

Emotional Expression as the Primary Goal in Psychotherapy

Ruderman's work introduces a concept in psychotherapy that the Simontons do not address: emotional expression. While surveying psychological literature on cancer, I noticed several reports that led me to believe that encouraging emotional expression in cancer patients might be crucial. For example, LeShan and Gassman (1963) document one case which demonstrates the effects of intense expression on cancer. Their 32-year-old male patient, who had extensive metastases of a malignant melanoma, revealed in psychotherapy that he had had a tense relationship with his father. He began to have difficulty in swallowing because a palpable lump, diagnosed as a rapidly growing metastasis, had begun growing in this throat. His primary cancer had been diagnosed earlier, but the means of that diagnosis was not specified in this report. The surgeon diagnosed the new lump by examining the growth visually, as part of it extended onto the tongue. Surgery was scheduled to remove the tumor so that the patient could eat.

In a psychotherapy session, the patient recalled a heretofore totally repressed scene from his adolescence:

... when he witnessed his father prepare to murder the only adult who had ever been warm and kind to him. The murder was committed... Later, he repressed the entire scene and consciously believed that his father was innocent and "framed".... During the course of psychotherapy, recurrent dreams and associations indicated that tension over his relationship to his father's guilt in the murder was mobilized. [The pain in his throat increased]. In a psychotherapy session on the day before surgery was scheduled, he recalled the entire incident with all the emotion he had felt at the time. He recounted it in detail, weeping and trembling (p. 731).

Immediately after this experience, the cancer decreased markedly, finally disappearing:

Four hours later, he told the therapist that he had just finished the first meal he had been able to eat in a week without pain in his throat. Twenty-four hours later, the mass was markedly reduced; 48 hours later, it was even smaller; and within four days it had disappeared. The surgical procedure was not carried out (p. 731).

In my way of thinking, the cancer was metaphorically expressing the unfelt and stored pain centering around the incident. The important issue is not that this patient "recalled the incident with all the emotion he had felt at the time," but rather that he felt all the emotions for the first time which he was unable to feel when the incident occurred. His therapy session was no ordinary session in which material is recalled from the past, but one in which he actively and fully expressed those stored emotions. Once he had expressed the emotions, the metastasis in that particular place no longer had a "reason for being," and disappeared.

What is particularly valuable about this study for the current theory is that the patient was examined by a surgeon before and after his emotional discharge. The surgeon reported:

6-23-55. Ears negative. Uvula adematous. There is a mass about 3 cm in diameter occupying lateral part of the right glosso-epiglottic fossa and extending on to the anterior pillar on the right. A right subdiaphragmatic node is palpable, the mass on tongue had a deep red to purplish color and is slightly tender. He complains of pain radiating to the right ear and some pain on continual swallowing.

7-3-55. No pain in right ear on swallowing. Uvula has normal appearance. Mass seen previously and described on 6-23-55, which was 3 cm in diameter, has disappeared. The glosso-epiglottic fossa is entirely clean (p. 731).

LeShan and Gassman seem not to have continued encouraging emotional expression in patients. Their work was done in 1955, and since then they have not written anything more on this issue (LeShan, 1977). Perhaps this incident was an isolated experience, for had LeShan and Gassman recognized that emotional expression occurred shortly before the remission of disease, I believe they would have invested more time in researching this issue or applying it in psychotherapy.

LeShan and Gassman (1955) account for what happened in the above incident by suggesting only that "Psychologically stressful events in the patient's life" or in his therapy "relate to changes in tumor growth rate" (p. 730). While this is true, I think it is incomplete, because it is the fact that this patient fully encountered and expressed his stressful event and stored emotions that led to a change in the cancer. Because LeShan and Gassman's explanation links stress with cancer growth, they might suggest that past events which are stressful should not be worked with in psychotherapy. Indeed, LeShan and Gassman caution that such work may lead to an increase in cancer growth.

Without an adequate theory to explain why recalled experiences sometimes are associated with an increase in cancer growth, such a finding might suggest that expressive therapy may do more harm than good. The present theory, however, offers an explanation: the extent to which the patient fully expresses original stored pain and childhood experiences is the extent to which the cancer growth will be reduced; the extent to which the stressful event is reinvoked but not actively and releasefully expressed is the extent to which the cancer growth will increase.

The following case illustrates my point. Cancer disappeared when the patient expressed his stored emotions in a releaseful manner but reappeared when he invoked more stored pain but was unable to express it releasefully. Roland and Snyder (1977) report on a 48-year-old male with a tumor in his neck. This patient had had an unfeeling relationship with his father and a need to prove himself for love. "Being himself was not enough" (p. 10). Six months after the death of his oldest son, he began to feel hopelessness and despair. Cancer was diagnosed. He moved to California "to die" and entered group therapy "accidentally." After several sessions:

He realized he had a choice. He could start to share these deep feelings of alienation and self-denial. He brought himself back to the pain of his son's death The more he shared himself in the groups, the more he wanted to share with his daughter. After four months of sharing his pain, and feeling acceptance . . . the tumor disappeared (p. 10).

Elated, this patient returned to the East, saw his daughter and tried to share his feelings with her. She refused. Feelings of despair and hopelessness returned, and the tumor came back. Although he returned to the West, he refused to rejoin the group. Apparently, then, when the patient releases his despair and hopelessness, the cancer recedes. When he once again reinvokes the feelings but does not or cannot discharge them, cancer returns or increases.

This case signals psychotherapists who wish to do expressive therapy with cancer patients to provide therapy that does not foster an invoking of old pain without full discharge. For example, therapists must help their cancer patients become aware of the risk of invoking despair in situations in which full discharge is not available to them or in which they are dependent on receptivity of others to discharge their pain.

One example where full discharge of rage was apparently not available to a patient being treated in psychoanalysis is a case reported by Giovacchini and Muslin (1965). The patient's presenting problems were of a severe psychological nature: "identity diffusion syndrome" (not knowing who she was) with almost total incapacity to function as a housewife. In her case, her psychological symptoms served to express and release deep, stored rage. In fact, this patient was aware of some level that she had stored rage, that it was limitless, and that it was beginning to surface. Giovacchini and Muslin report that she had dreams which revealed fears "of being swallowed by a threatening unknown outside force. She was also terrified of losing control and being overwhelmed and destroyed by her inner rage" (p. 526). Apparently nothing was done to encourage the expression of this limitless rage, for later in therapy the theme of losing control and being inundated remained. The patient suddenly shed her psychiatric symptoms and developed cancer. This case warns psychotherapists that when stored emotions of great magnitude are invoked, there are risks for the patient who does not discharge them (in this case, the development of cancer). Renneker et al. (1963) describe other cases in which emotional expression in therapy has been linked to a shrinkage in cancer growth and apparent cure.² For example, the first patient had been given several months to live after cancer was diagnosed. A young, "naive" therapist initiated aggressive therapy, using early deep interpretations of the

patient's hostile impulses toward her mother in competition for her father. After 15 hours of therapy, the patient became violently angry at the therapist and terminated. Fortunately, she went to another therapist and has continued with him. In this second therapy, she was allowed to vent her anger in the presence of supportive listening. Her cancer has disappeared and she remained cancer-free at the time of writing.

In this case the mobilization of rage seems to have been the most important factor in curing the patient. In contrast to LeShan and Gassman's (1955) patient who regressed to the past and expressed his stored emotion in conjunction with the original object, his father, this patient's object of rage seems to have remained the naive therapist and not the original objects, presumably her parents. The active expression of emotions alone, not regression to original events when emotions were first stored, brought about remission. This case brings up the interesting issue of whether there is a need for regression to original events and a need for the emotions to be expressed in conjunction with original objects. In this case, deep expression at any object seemed to suffice.

The second patient has been followed for ten years and has had no recurrence of her cancer following psychotherapy. Her case is similar to the first, in that the expression of anger was central:

The removal of the patient's resistances against expression of her anger, with realistic ventilation in appropriate circumstances, was one of the important changes Bella achieved through therapy. Behind her attitude of selflessness and sacrifice there lurked a deep feeling of hostility toward her parents and the world for not having taken care of her (p. 112).

The third patient was said to have "gained freedom of emotional expression," but her cancer continued until her death. However, an interesting incident was reported to have happened when she first became cancerous.

Her husband had been paying attention to her sister, and was singularly unloving toward the patient:

Her rage toward her husband mounted, and one night after a trivial incident she suddenly attacked him in a blind rage. In spite of his large size, she "tried to kill him, to scratch his eyes out--if I'd a gun I would have murdered." She stopped abruptly in the midst of her fury and lapsed into a profound depression which lasted for four months (p. 115).

The patient reported that after this experience she expected to develop cancer, and it did occur. This case is an excellent example of a stored feeling coming to the fore to be expressed, but not being discharged and instead manifesting as cancer.

Renneker et al. reported that this patient did achieve expression, although the cancer failed to be affected. This failure casts some doubt on the present proposal for therapy. However, one cannot tell from reading the report just how much and what kind of emotional expression was achieved.

Renneker's et al. fourth patient was not cured of cancer and seems not to have undergone any kind of emotional expression in therapy. From what Renneker et al. report about this case, we may conclude that the assistant therapist may have unknowingly cut off the patient's emotional expression. For example, when she asked the therapist to "curse at" her, he suggested that she "need not cling to the masochistic way of gaining love." The patient was experiencing a need for an emotional exchange, but the therapist's response was to label her as "masochistic." Such a response does not encourage expression but is more a request for her to change her beliefs. The therapist also reports that "her therapy was overwhelmed with need feelings" when her father died during treatment. Thus the therapist seems to regard her feelings of need as an obstruction to the therapeutic process rather than as a feeling state to be welcomed, worked with, and discharged in therapy. (See Janov, 1970, for a description of how certain feelings of need

can be discharged in the same manner as are emotions.) It is particularly ironic that while the Renneker et al. patients who achieved remission of their cancers got out some sort of feelings, this therapist termed her feelings of need to be a hindrance to the therapy.

Renneker et al.'s fifth patient recovered from cancer with neither much of an investment in therapy nor any apparent emotional expression. Instead, she seems to have found a love object she did not have before. She may be one of the exceptional cancer patients who is flexible enough to replace a lost love object with a new one. In doing so, she has not changed psychologically (interrupted stasis) but has maintained her controlling persona.

In many of these case histories, a remission or decrease in cancer growth follows deep emotional expression. In my way of thinking, psychotherapy with cancer patients should have as its primary goal the expression of emotions on any level the patient can manage. No matter if the patient cannot regress to the past and express his emotions and pain in the context of scenes where original pain was first stored, because expression on this level plunges one into the deepest and most cathartic release. Because total catharsis is the ideal, I assumed that only this method would work. However, in considering the above cases, deep emotional expression of any kind on a continuing basis moves the emotional mass of stored pain.

Roland and Snyder

Although Roland and Snyder explore cancer patients' "self-directed beliefs and emotions" and consequently do not focus primarily on the expression of emotions, Roland and Snyder set up a loving and supportive environment where emotional expression is allowed. Because they have only recently started psychotherapy with cancer patients, Roland and Snyder have

not yet published. Information about their work comes from three sources: my interview with Snyder, a talk given by Roland and Snyder at the 1978 meeting of the Association of Humanistic Psychology, and the "Chrysalis Report," an unpublished report on their work with 15 patients. Because there are so few cases of expressive therapy used with cancer patients, I review all eleven cancer cases in the report. Four of the cancer patients who achieved emotional expression showed either improvement or remission in their cancers; the outcome of a fifth expressive patient is not yet known. The six who did not experience emotional release showed either no improvement or a worsening of their disease. Because reports that detail emotional expression in cancer patients are so rare, each case is discussed below (Roland & Snyder, 1977).

Case 1. 32-year-old female, cancer of the cervix, one interview.

Shortly after she learned she had cancer, she went through deep emotional "letting go" during which she shared with two close friends much of the early pain and alienation of her childhood. This period of mourning went on for two or three months during which she had no follow-up checks on her cancer. A few months later, a check-up revealed that her cancer had undergone a complete remission.

Case 8. 31-year-old female, cancer of hip, six months in self-healing group. While she was in her late twenties, a school program to which she had devoted herself was suddenly discontinued; she fell into a state of hopelessness and despair. The loss seemed to reinforce her earlier childhood feelings of unworthiness, and a few months later she developed cancer. She joined the self-healing group. "Discoloration and pain in her hip completely subsided in

almost direct relationship to the expression and exploration of her long-suppressed feelings of unworthiness and rejection" (p. 9).

Case 9. This case was reviewed above. 48-year-old male, tumor in neck, larynx removed, four months in self-healing group. His tumor disappeared when he shared his feelings in the group, but reappeared when the feelings were reinvoked with his daughter but not discharged.

Case 12. 32-year-old female, cancer of the cervix, two months in self-healing group. She had a troubled childhood in which she never felt loved for being herself. Her father left when she was 14 years old, and she reports consciously giving up on herself at that time. Cancer appeared shortly after her first husband left her, seeming to reinforce all the feelings of unworthiness she experienced as a child. "Through the expression and understanding of her deep feelings of unworthiness and fear of rejection, she is gaining faith in herself. It appears that her cancer is improving" (p. 13).

Case 15. 66-year-old male, cancer of the pancreas, diagnosed terminal, two months in self-healing group. From his childhood he recalls seeking love from an unloving father and never believing that he deserved to be loved or that being himself was ever enough. "This man wants to change and is willing to go through any fears in order to finally like and appreciate himself. It is too early to tell what effect this . . . is having on his cancer" (p. 16).

While improvement in cancer followed the expression of emotions in four of these five cases, in the cases where cancer did not improve, there was also a failure to reach emotional expression:

Case 2. 35-year-old male, cancer of lymph nodes, two interviews. He does not trust his deepest feelings, mainly because as a child they were never validated. The cancer appears to be somewhat under control, but he is displaying little interest in exploring his emotional insecurities. He is using radiation and Simonton's visualization techniques.

Case 3. 45-year-old female, breast cancer, two months of self-healing group. "Deeply insecure as a child and tended to keep feelings to herself. Saw herself as cold, reserved, aloof, controlled by fears Both occurrences of her cancer came within two months after her husband threatened to . . . divorce her" (p. 4). Her tumors have been removed, but she lives in fear of recurrence. Snyder and Roland do not comment any further on the state of her cancer, but they suggest that the outcome for her is questionable.

Case 5. 50-year-old female, brain tumor, one interview. She remembers making a conscious decision as a child not to cry or be vulnerable, and will not deal with her long-suppressed feelings in group. Using Simonton's visualization techniques, the tumor appears to be under control, but the outcome for her is thought questionable.

Case 7. 45-year-old female, breast cancer, mastectomy, two interviews. She has a recurring dream throughout her life of being hopelessly crushed by an enormous force with only a thin sliver of light representing hope and survival. A former childhood friend, by whom she felt deeply betrayed, visited her two years ago. "She became extremely upset with this friend . . . (S)he flew into an uncontrollable rage, ordering her to leave her home . . . (S)he fell into a sustained state of depression and despair. Less than six months

later, she developed breast cancer" (p. 8). This patient had a mastectomy with little concern over her loss. Her feelings of unworthiness and low self-esteem remain unexpressed and unresolved. Now there is the possibility of a tumor in her other breast.

Case 10. 50-year-old female, breast cancer with metastases to hip and neck, mastectomy, three interviews. Extremely alienated childhood where she decided at an early age to keep her feelings to herself and not allow anyone to hurt her again. Since childhood she has always prided herself on being able to take care of herself, and does not need anyone else. She still has not dealt with her deep feeling of insecurity, aloneness, and despair. "It is almost as if she is willing to try anything before dealing with those deep nagging feelings which she cannot control and won't go away" (p. 11). Her cancer continues to rapidly metastasize.

Case 11. 22-year-old female, identical twin, malignant melanoma, last stage. Two months in self-healing group. In childhood her feelings and emotions were never openly validated. She was extremely resistant to expressing her emotions in group, telling her therapist that she had actually prayed in the groups not to cry. She died of cancer.

The preceding case histories support not only my recommendation that expressive therapy be used with cancer patients, but also several of my hypotheses about the psychological dynamics of cancer development. Among these hypotheses are that cancer patients have childhoods which lacked warmth, that as children they were expected to be something other than their real, expressive selves, that their feelings were not validated as children, and

that at an early age they "decided" to stop expressing their emotions. While Roland and Snyder view the dynamics of cancer development in much the same way I do, we differ in our degree of focus on self-directed beliefs and emotions, or self-hate.

Roland and Snyder (1977) outline several hypotheses in the Chrysalis Report which are paraphrased here. First, people participate in the onset, development, and outcome of their diseases through their self-directed beliefs and emotions. The cancer patient sends self-hating and negative messages and emotions to himself about himself (self-directed beliefs and emotions). Unresolved stress and these negative feelings about himself persist from childhood and are constantly reinforced. As Roland and Snyder have said, "Just as rats will persist in pain and not move away from it, so will cancer patients." They will dwell on painful memories and not remember joyful ones.

According to Roland and Snyder, energy used in ego-defense against psychic and interpersonal pain impairs the natural immunological system of the body. "Through the exploration, expression, and assimilation of self-directed beliefs and emotions, the energy required for ego-defense is constructively assimilated or rerouted, and restoration of the natural immunological system of the body should follow" (Roland & Snyder, 1978, p. v).

Part of the therapy process is that patients recognize their personal responsibility in creating their disease and the role of their self-directed beliefs and emotions in the onset of the disease. In Roland and Snyder's view, when the self-directed beliefs and emotions are fully explored, self-love and acceptance replace self-hate and negation.

When Roland and Snyder addressed the Association of Humanistic Psychology, they maintained that cancer patients have lost touch with

lovingness, of which all people are a part. Instead, cancer patients are isolated and lonely, alienated. After a major loss, the pain of feeling unloved and alone is so awesome that the cancer patient turns his immunological mechanism off and gives up hope of living. In therapy, Roland and Snyder help the patient to yield to his sadness and despair in order to reach what lies beyond those feelings: love, self-acceptance, and a sense of belonging to the loving plan. When all of these things happen, the cancer goes into remission.

The difference between Roland and Snyder's approach and mine is subtle, because some of the psychotherapeutic interventions such as the encouragement of emotional expression are the same. Whereas Roland and Snyder focus on the expression of self-directed beliefs and emotions, I hold that the expression of any type of held-in emotions, not necessarily self-directed ones, will induce remission. In order to clarify Roland and Snyder's position, I asked the following questions in an interview with Snyder:

AR: "So you're very definitely working very strongly toward getting them to feel?"

RS: "We don't start out with the idea that you've got to feel something. We start out with the idea that probably the reason you have cancer has to do with how you feel about yourself."

And at another time in the same interview:

RS: "That's how we work with how people think about themselves. We see them coming in, triggered by something. What gets triggered is feelings around the event. Like, 'My husband just died,' or 'My wife just died,' or 'My husband and I just split.' There's [sic] feelings around that event. But there are deeper feelings that go deeper into the individual about how they feel about themselves, and how they have always felt about themselves, and that's what we get into."

AR: "You'd say that's the primary focus of your therapy? That deeper feeling?"

RS: "Yes, absolutely."

In the dialogue above, the distinction is subtle, but there is indeed a difference in the presuppositions. I work toward having the patient discharge any feeling, whereas Roland and Snyder do not do so. Snyder calls the self-directed emotions the deeper ones, whereas I believe that stored pain and other emotions are deeper than self-directed feelings. Feelings of hate for the self, though potent, derive from accumulated, stored pain and rage. For example, it has been my experience that when pain and stored feelings of any kind are fully discharged, such as the feelings of loss Snyder describes in the second example, the patient sheds his self-hate without ever directly working on that issue.

Evaluation of the Interruption of Stases in These Treatments

Each of the therapists described above has been successful in changing the course of cancer by bringing about the interruption of stasis. Stasis is that immobile, entrenched part of the cancer patient's character structure that prevents growth or change. I wish to look at the ways in which these three groups of therapists go about interrupting stasis.

As noted above, Simonton and Simonton appear to use behavior modification with patients. I have found nothing in their tapes or in their published work that indicates they are working with patients to bring about emotional expression. Indeed, Simonton and Simonton spend their time working with patients to reinforce greater self-control in the cancer patient. I described the cancer persona as the individual who maintains a constant willful control over himself and his environment by focusing on his external

image and on self-control. He prevents himself from experiencing and expressing his internal pain and emotions which brought the controlling persona in the first place. I consider the Simontons admirable in coming to the end that is desired--remission of cancer--but a little off the mark, for they appear to be reinforcing the cancer persona as I have described it, rather than effecting a change in the cancer patient's character structure. One change, for example, might be a loosening of control on others and on one's own feelings. Simonton and Simonton, however, focus the patient's attention on simulating the very strong, forceful, willful personality traits of their Super Stars, those few individuals who respond quickly to visualization techniques. In effect, Simonton and Simonton are removing their patients one step further from fully encountering their underlying feelings of helplessness, need, and pain.

Ruderman (1977), who has long been in touch with the cancer patient's emotional starvation and isolation, works with patients to help them become aware of needing warmth from others. He interrupts stasis by encouraging the patient to take in emotional nourishment and, in so doing, open the "closed circuit" to the outside. Unlike the Simontons, Ruderman does not reinforce the "try harder" scripts (perfectionism) cancer patients tend to live out. I see Ruderman's methods of interrupting stasis as being closer to an ideal method than the Simontons' method because the psychotherapeutic environment he describes would be more likely to invite the expression of emotions and needs.

Of all therapists who are conducting psychotherapy with cancer patients, Roland and Snyder come closest to an ideal approach because they not only strive for emotional expression in their patients, but also give genuine support to patients who express their feelings. Roland and Snyder

focus on dispelling the cancer patient's self-hate, one type of stasis. On the other hand, I view self-hate as a symptom of limitlessness, entrapped rage, pain, and emotions. While Roland and Snyder achieve the results I hope to bring about, they have not discovered what I believe to be a more complete picture of the psychodynamics of the cancer patient. For example, Roland and Snyder do not account for the patient (Renneker et al., 1963) who expressed rage toward her therapist and brought about remission of her cancer. She focused not on her self-directed beliefs, but on discharging anger. In my view, if the patient can fully express any feeling, e.g., rage, helplessness, pain, fear, need, that patient has a chance of sending her cancer into remission.

Based on my extensive review of cancer literature and the treatments that have successfully brought about remissions in cancer patients, I propose an ideal psychotherapy for cancer patients. Like Simonton and Simonton's therapy, it involves helping the cancer patient accept responsibility for his cancer. Like Ruderman's therapy, it recognizes the cancer patient's starved internal state and sets up an environment of support. Like Roland and Snyder's therapy, it encourages the exploration of feelings. Unlike these three therapy groups, I propose that the catalyst in the remission of cancer is the deep release of any stored emotions: pain, helplessness, need, fear, or rage. At the outset of my research, I hypothesized that remission would only come about when the patient had relived parts of his early past when he first encountered loss, and relived the pain and emotions he had stored for a lifetime. But two considerations changed that hypothesis.

First, there is the example of the patient (Renneker et al., 1963) who expressed her stored rage toward her therapist and not toward her

parents, the original objects. This case illustrates that cancer can go into remission without the patient's having to relive events which led to the storage of emotions in the first place. Second, in applying concepts from this theory to a cancer patient, my associate Schlosser (1979) brought about rapid remission of breast cancer metastasized to the lung by getting the patient to cry.³ The patient cried about her present life experiences but did not experience the deep emotional expression that occurs when people express intense, stored childhood pain. Thus, I concluded that it is not necessarily the reliving of stored pain from childhood, but it is the undergoing of any kind of emotional release which will move the emotional mass.

Once emotion has been released, I cannot stress strongly enough that care must be taken by the therapist to help the patient continue expressing emotions. Roland and Snyder's patient who opened up to his emotions, visited his daughter, was unable to continue crying, and experienced recurrence of his cancer signals us that the patient must be made fully aware of the risks he undertakes in therapy. The cancer patient's powerful character structure, which has self-control as its foundation, constantly works against him. Cancer patients must be warned that emotional expression must be continued indefinitely. Otherwise, the patient risks recurrence of the cancer. In other words, once open, the cancer patient must remain feeling and expressive in order to stay free of cancer.

By interrupting stasis in the cancer patient, the psychotherapist may help facilitate a remission of cancer, but to combat the tendency toward recurrence, the therapist should encourage emotional expression. Emotional expression not only interrupts all kinds of stasis, but it loosens the controlling persona at its foundation.

NOTES TO CHAPTER 6

¹Reich (1974) first named and noticed the special stasis of the cancer patient, describing it in terms of the free flow of sexual energy being stopped throughout the body. Although many neurotics experience sexual stasis, the stasis in cancer patients is remarkably pronounced. Corresponding to sexual stasis are certain rigid personality traits. In the present theory, neither sexual stasis nor the sexual behavior of cancer patients will be discussed, since Reich covered those aspects thoroughly. Instead, Reich's term is used, and is given new meaning.

²Of the five breast cancer patients they treated in psychotherapy, some were free of cancer for as long as ten years after therapy.

³While the patient never relived past pain, she conveyed to me her sense that her crying could go on forever. She was thus in touch with the limitlessness of her stored pain without regressing to the past to relive it.

Chapter 7

SUMMARY AND CONCLUSIONS

The Roots of Helplessness

The child of the carcinogenic parent lives in a situation where his helplessness is maximized, where he has no control over his fate. Many childrearing practices which often seem to be diametrically opposite to each other contribute to maximized helplessness. For example, a mother might "smother" her child, never letting him learn to do things for himself. Thus, he would find that he is helpless in getting himself what he wants. Or, parents might leave their child crying in his crib, since picking him up too often is said to "spoil" him. Actually, this practice teaches the child that he is helpless, unable to get help from his parents when he needs it. The latter example seems to be opposite to the former, suggesting neglect rather than excessive attention. The ways to foster helplessness are myriad. However, the result is the same: the child has no control over his own fate.

There are two possible paths a helpless child could take. His first response might be to exert control of some kind over the situation. If the child should fail, or be forced to fail, in his efforts at control, he might plunge into the second reaction to maximized helplessness: utter despair and hopelessness, a giving up, a feeling that all is futile.

Adult cancer patients made helpless as children will similarly plunge into despair if they lose control of important objects. But if the adult cancer patient can feel that he is in control of at least one person or a situation, he will not have to feel the helplessness and despair from his childhood and, as

Evans (1926) notes, the control will be a matter of life or death for the cancer patient. It will be desperate. Thus, the cancer patient's investment in control is rigid and unbending. To give up control would bring about movement of the stored emotional material (despair and helplessness). To maintain control keeps the material static, stifled, not moving, and out of awareness.

Control is not restricted to the control of others. It is applied with a heavy hand to the cancer patient's own emotions, causing the appearance of the second control dynamic early in life: the breakdown of emotional expression. Through emotional expression, the impact of painful situations and the accumulation of tensions are discharged. Emotional expression, natural to all healthy people and to healthy children, prevents illnesses, both mental and physical, but early in life the cancer patient's natural emotional expression breaks down. Many different experiences cause a child to stop expressing his feelings. For example, his parents may not acknowledge (validate) his feelings. Feelings must be "heard" and accepted as real by someone in early life, or the child learns to stop expressing them. As a second example, parents can literally force the child to stop feeling by demanding that he stop on pain of punishment. As a third example, the child can experience an event so traumatic that he is overwhelmed with pain. His natural protective defenses cause him to shut his massive pain out of awareness. If no one is there to validate his pain, the traumatic experience or accumulated pain will not be expressed, often resulting in a refusal to continue expressing all pain as well as other emotions. Whatever the specific mechanisms that cause the child to stop feeling, the general childhood situation is one where he gets little support for emotional expression, suggesting an atmosphere of subtle neglect and emotional coldness (an

atmosphere found in the childhoods of cancer patients by Thomas and Duszynski, 1974).

Left without a means of expression, the child can only choose to keep the feelings to himself and store them within his system. Unbearable tension mounts within him; however, instead of living forever in intolerable pain and tension, he shuts himself off to it, dying inside, losing his zest for living. The child's inner dying is not loud and expressive; it occurs quietly and without protest. In fact, the death is hardly noticeable to others around the child, who appears to them to be well-behaved, unobtrusive, quiet, and "mature for his years."

Nonetheless, the "good" behavior, the social adjustment, the lack of rage of the cancer patient is actually the aftermath of the death of his internal, real, self. He lives life like an automaton, going through the motions and the roles expected of him while feeling dead inside. He becomes the true technological man, causing no problems to his society, not even protesting his own internal death.

Stasis and the Controlling Persona

While mild-mannered, obsequious, overly-polite as adults, and generally over-socialized, cancer patients yet maintain a willful, rigid character structure (the Controlling Persona) that prevents change and psychological growth. We cannot identify a single "cancer personality," so great are the varieties of people who develop cancer, but underlying dynamics are the same. Two contrasting types of cancer patient, the "Helpless-Hopeless" and the "Super Star," though different in outward appearances, share the same dynamics born of childhood helplessness.

Super Stars develop from the child whose response to imposed helplessness was to exert and gain rigid control. The Super Star controls

people and situations around him with a desperate fervor; he pushes himself on to greater and greater achievement, holding out perfection as his never-ending goal; and he scorns helplessness with a vengeance. Apparently, these cancer patients anger easily and have no problem expressing the anger.

Helpless-Hopeless cancer patients, on the other hand, were children who attempted control and failed. As adults, they remain parent-pleasing, intimidated, obsequious, non-expressive, and socially "adjusted." Full of self-hate, they are unable to express anger. However mild-mannered, the Helpless-Hopeless cancer patient controls with an iron hand, but not on as grand a scale as the Super Star. Helpless-Hopeless cancer patients control themselves in that they seldom express emotions, and they control others through various techniques such as self-sacrifice. Common to both these types of patients is the Controlling Persona, the rigid character structure demanding control of the self and others.

Cancer patients maintain the Controlling Persona by remaining static in many ways. I call these means of preventing change stasis. The overriding form of stasis that prevents psychological change in the cancer patient's adulthood is the continued refusal or inability to express emotions in ways that lead to release and resolution. Closely related forms of stasis include refusal to look inward and denial and repression of feelings. Refusal to look inward prevents emotional expression at its inception, for we can express our feelings only by becoming aware that they are indeed inside of us. Such awareness requires looking inward. Denial and repression similarly defend cancer patients from contact with internal material. Many other forms of stasis are outlined in Chapter 6.

Once stasis is interrupted, cancer goes into remission in many cases. I recommend that psychotherapists adopt the goal of emotional expression in

psychotherapy with cancer patients, because expression interrupts the Controlling Persona at its foundation--control--and expression discharges stored pain and emotions. Chapter 6 documents the successful application of this kind of psychotherapy to cancer patients.

The Interaction of Helplessness and Emotional Expression

Returning to the discussion of the two early dynamics in cancer, helplessness and emotional suppression, the two dynamics interact. Helplessness brings on the refusal to express emotions because the resignation, the "doing nothing" of maximized helplessness, applies to emotional expression as well as behavior. The cancer patient "does nothing" as far as expressing emotions is concerned. It is as if he says to himself, "What's the use of expressing my feelings? There is no one to hear them (validate them). There is no resolution for them. It will just hurt more to experience my pain and emotions fully. I am better off to shut them off before I hurt too much."

When a person stops expressing his emotions and pain, he has no way to discharge them. Eventually, he even loses the awareness that expression will relieve him. He becomes literally helpless to do anything about the way he feels. He knows that he does not feel good, but there is nothing he can do to feel better. Thus, the refusal to express emotions increases helplessness in the sense that the person becomes helpless to stop his pain.

Interacting with each other, the two dynamics trap the cancer patient. Helplessness in childhood contributes to stopping the expression of his emotions and pain. Not expressing pain increases helplessness to do anything about how he feels. The person is trapped in continuous helplessness and pain accumulation. Without outlets the pain becomes limitless, without end.

Isolation

One of the lessons of helplessness is not only that one cannot help himself in getting what he needs, but that no one else will help either. Because cancer patients have lived in childhood situations where helplessness is maximized, they learn early never to depend on others and live in continued isolation in adulthood. The cancer patient can go to no one else for warmth and support. He cannot take in anything from others, cannot be "fed" psychically. In other words, he does not keep an open "circuit" to the outside. He becomes self-contained so that movement is literally stopped from the outside (others) to the inside, causing the cancer patient to "feed" upon himself for support and nourishment.

One cannot feed upon himself forever without starving internally. The cancer patient expends himself in living because he refuses to allow movement of nourishment from others to the inside. Because of the change-preventing nature of his character structure, nothing will end his expenditure. He treats himself as if he were limitless. For example, he might work until exhausted or sick, take on too many jobs to do in too short a time, or require of himself standards of achievement that are unattainable.

Limitlessness

Could there be a link between limitless pain and a perception of the self as limitless? Perhaps it lies in the cancer patient's refusal to look inward. Pain storage (limitless pain) is perpetuated by the refusal to look inward, since looking inward is the first step toward discharge. Only awareness of the internal self and its needs can tell a person that he has stretched himself too far, that he has extended beyond his resources, or even that he has certain needs that must be fulfilled. Thus, without self-

awareness, two things happen: people store pain, and they have no natural "governor" on the expenditure of their resources, no way of knowing the limits of their resources.

The concept of limitlessness sheds light on two characteristics of the cancer patient: his perfectionism and his total attachment to a person, object, situation, or endeavor (object attachment).

Perfectionism tampers with the ending, the limits, of endeavors. Because perfection is seldom reached, the perfectionist keeps himself in a perpetual struggle where he must never quit trying harder for a goal that will never be attained. Under the demands of perfection, expenditure of the self can become limitless. Because the perfectionist sees himself as limitless, he may recklessly give his all to one other person, to a situation, or to an endeavor. In other words, he expends himself as if he were infinite. This limitless self-investment directly influences the development of cancer when the perfectionist loses the object of his attachment. Other people experience losses in life, yet they do not develop cancer. How could loss have such catastrophic consequences for the cancer patient?

Loss has a special meaning for the cancer patient for two reasons. It involves loss of the object in which he has invested all of himself, and it means the loss of "control" of a situation that was used to stave off feelings of helplessness from childhood. When the object is lost, the cancer patient briefly begins to re-experience all the futility, despair, helplessness, and hopelessness (stored limitless pain) from his childhood.

Exactly what pain from childhood is held off by his investment in the object varies with the individual. For instance, the situation he once controlled might reassure him that he is not helpless but thoroughly in control; that he is not alone in life; that he is indeed cared for; that there is

at least one person to focus emotions upon even if the emotion be smoldering resentment. Whatever individual and private form the reassurance takes, when loss occurs he is no longer reassured. Now there is nothing to prevent contact with his stored feelings and pain.

The loss of control of the object of attachment is especially significant given the unique personality characteristics of the cancer patient. The cancer growth begins shortly after his uniquely personal loss when the cancer patient characteristically clamps down on his feelings and refuses or is unable to discharge the tremendous store of feelings now centered on this event. The traumatic loss has such extremely severe impact on the cancer patient precisely because it evokes and unleashes the potent unresolved feelings from his childhood which he has long since "successfully" forgotten, given his defensive style of denial and repression.

If the cancer patient were to find a new object on which to attach his hopes, he might not develop cancer (Evans, 1926). However, it is not in his nature to seek alternatives, given his early helplessness. Consequently, he remains one-sided, feeling that he has no other choice. In other situations, the cancer patient might be flexible, but in this one situation which involves his object of attachment and is inextricably tied to helplessness, he cannot be flexible. Instead of allowing his old pain to surface and be processed or instead of fully experiencing his new loss, the cancer patient labors to perfect his social persona and invests much energy in the appearance or facade of social control. It is not at all surprising that he denies or refuses to acknowledge the impact of the traumatic loss. Given his style, he concerns himself not with his feelings and well-being, but rather with his outward functioning. Thus we might expect him to attend to issues such as whether he continues to look as if he is functioning adequately, is in control, is

respectable, is admirable or competent, or seems to know what he's doing, but almost never to attend to his feelings. For a person who disowns his needs, feelings, and limitations, it is hardly surprising that when he has suffered a loss he would cling even more strongly to his social self, by which he has achieved his identity and in which he has put most of his energy for his entire life. Thus, the turning to the social self places the cancer patient one step further away from an awareness which would allow him to process his loss as an adult.

Booth (1965) implies that cancer is the introjection of the lost object. I believe that the loss of the object is a catalyst that opens up the wellspring of limitless pain which is the source, the cause, of cancer, even though this loss might appear quite insignificant. Earlier I gave examples of seemingly insignificant losses cited by physicians at the outset of cancer: for example, Greene and Swisher (1969) found a leukemic twin who developed cancer after the birth of a daughter, when he had wanted a son like the boy his twin had fathered. In another case, Greene and Swisher (1969) described twins, one of whom had no girlfriend and developed leukemia after his healthy twin acquired a girlfriend. In each of these cases we cannot say that the loss in sibling competition would seem particularly significant to an outside observer, or that it was directly responsible for the cancer, but I propose that the one loss opened up a whirlpool of emotions the cancer patient had refused to experience throughout his lifetime. The patient encapsulated emotions exposed by such precipitating events, and they became internalized as cancer.

The moment of silent catastrophe begins; the cancer grows, alienated from awareness. What might be the meaning of the cancer, then, the message of the cancer to the organism?

The Metaphorical Meaning of Cancer

Cancer expresses the limitless pain and feelings the patient has isolated from his experience, has refused to contact. In this way, cancer may be said to personify limitlessness; it is limitless growth. And it is this limitlessness that frightens us most about cancer--it is uncontrollable, evergrowing, careening on outside the normal limits that other healthy cells have. Stored emotions which are not allowed expression behave in the same way. Like cancer, their existence is isolated from awareness, tucked away, not to be contacted. Like cancer, they take on the quality of being limitless.

If the cancer were to dialogue with the organism, it might say, "I am your limitless feelings. You refuse to feel me; you hide me from your awareness. But I shall gain expression in spite of you. I shall be the very limitlessness you have isolated and ignored."

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