

## BELIEF SYSTEMS AND MANAGEMENT OF THE EMOTIONAL ASPECTS OF MALIGNANCY

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*The following lecture was delivered at the University of Florida, Gainesville, Florida. The symposium, June 14 & 15, 1974, was entitled "New Dimensions of Habilitation for the Handicapped" and was presented by the State of Florida, Department of Health and Rehabilitation Services.*

*This talk is one example of pioneering efforts in the application of transpersonal techniques as an adjunct to standard medical treatment. According to Dr. Elmer Green of the Menninger Foundation, "Carl and Stephanie Simonton are pioneering in the domain of mind-body communication and are getting remarkable results in cancer control by coupling visualization for physiological self-regulation with traditional radiology." -Editor*

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 of these articles the conclusion is that there is a relationship between the two. 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 emotions are a factor. So I'd like to begin with a quotation that has had a profound effect on my own thinking, and this is by a cancer specialist who was past president of the American Cancer Society in 1959, Dr. Eugene P. Pendergrass. I'm quoting from his presidential address, and these are his concluding remarks:

Anyone who has had an extensive experience in the treatment of cancer is aware that there are great differences among patients....

*relationship  
of  
emotion  
and stress  
to  
malignancy*

*treatment  
of  
patient  
as a  
whole*

I personally have observed cancer patients who have undergone successful treatment and were living and well for years. Then an emotional stress such as the death of a son in World War II, the infidelity of a daughter-in-law, or the burden of long unemployment seem to have been precipitating factors in the reactivation of their disease which resulted in death.... There is solid evidence that the course of disease in general is affected by emotional distress... Thus, we as doctors may begin to emphasize *treatment of the patient as a whole* as well as *the* disease from which the patient is suffering. We may learn how to influence general body systems and through them modify the neoplasm which resides within the body.

As we go forward... searching for new means of controlling growth both within the cell and through systemic influences it is my sincere hope that we can widen the quest to include the distinct possibility that within one's mind is a power capable of exerting forces which can either enhance or inhibit the progress of this disease,

To summarize what I consider the salient points from the literature and my own experience in working in these areas for four years now, the biggest single factor that I can find as a predisposing factor to the actual development of the disease is the loss of a serious love object, occurring six to eighteen months prior to the diagnosis. This is well documented in several long-term studies. Now the significant thing about this is that obviously not everyone who undergoes a serious loss, such as loss of a spouse or a child, develops a malignancy or any other serious disease. That's only one factor. The loss, whether real or imagined, has to be very significant; and even more important is the feeling that it engenders in the patient. The loss has to be such, and the response to the loss such, that it engenders the feeling of helplessness and hopelessness. Therefore, it's more than a loss-it's the culmination of the life history pattern of the patient. And this also is well-defined in the literature.

*personality  
of  
cancer  
patient*

When we look at what constitutes the personality of the cancer patient, we find that there are many reputed authorities claiming there is no cancer personality. I can't see how one could be familiar with the literature and make this statement. I believe the work that has come out in *Type A Behavior and Your Heart* (Friedman & Rosenman, 1974) shows clearly that there is a life-history pattern in the development of heart diseases, and I believe that if we continue to look, we will find predisposing psychological factors in the development of all disease. Those predisposing factors most agreed upon as (negative) personality characteristics of the cancer patient are: (1)

a great tendency to hold resentment and a marked inability to forgive, (2) a tendency towards self-pity, (3) a poor ability to develop and maintain meaningful, long-term relationships, (4) a very poor self-image.

I believe one of the big underlying factors behind all of the more superficial personality characteristics is basic rejection. The patient usually feels that he has been rejected by either one or both of his parents, and consequently develops the life-history pattern that we see so commonly in the cancer patient. All of us have a certain amount of this in our own personality. I probably have more than many. Of course, I developed cancer when I was 17, so I should have more than many. Just as Dr. Friedman, in *Type A Behavior and Your Heart*, points out the problems of personality in heart disease, he shows that they are very changeable. I strongly feel-and I certainly hope-that the cancer personality is changeable. Otherwise, I'm in a difficult spot. But if we don't bring it to the level of awareness, it is difficult to change. And just as Friedman and Rosenman point out in their book, the patient is very resistant to looking at the basic problem. That is, one very large factor contributing to heart disease is the person's response to stress. Supposing this same thing is true in cancer, which seems very strongly to be so, then as surely as the heart patient resists the fact that he has this type of personality, the cancer patient resists even more strongly. The heart disease personality is basically a much more socially acceptable personality than the cancer personality.

So how do we do anything about this? How do we go about changing this life history pattern? As I have stated before, this is a very difficult and responsible business in my experience. You're questioning things that so many people never consciously question. But let's look at some of the more pertinent factors that influence how patients present themselves and how they progress throughout the course of treatment. I believe there are three extremely important factors that need to be recognized and brought to light. One is the belief system of the patient. The second is the belief system of the family and those people who surround the patient and are meaningful to him. The third is the belief system of the physician. I'm going to elaborate on all of these and the role that I feel they play.

*important  
factors  
in  
patient's  
progress*

Let's begin with the belief system of the patient. I feel his beliefs about his disease, his treatment and himself are very big factors, having a significant role in the course that his body takes during and after treatment. If we look at cancer as a disease, most patients see it as synonymous with death and

*belief  
system  
of  
patient*

something from without that there is almost no hope of controlling. Most patients have very negative feelings about treatment, whether it's radiation therapy, chemotherapy or surgery. From the extensive psychological experimentation in expectancy, I can't see how any thinking person can help but see the relationship between what a person believes will happen as far as his treatment and disease are concerned and the eventual outcome. The psychological experimentation concerning expectancy points strongly toward this.

The last part, as far as the patient is concerned, is his set of beliefs about himself. Now I previously outlined the basic negative personality characteristics of the cancer patient. I said he had a very poor self-image. You see, he's got three strikes against him already! His belief about himself influences the course of his disease and his response to treatment. Therefore, this is an area where it is mandatory to modify early if you're going to modify the course of this disease significantly. Most patients see themselves as victims of the disease and not as having participated in the development of it. They also can see almost nothing that they personally can do to help themselves get well. Or at least this is the belief system that most of my patients present to me.

*belief  
system  
of  
family*

The belief system of the family is also vital, because we communicate what we believe to those around us. The patient is with the health-care personnel a small part of the time compared with how much of the time he is with his family. So you see, education of the family and changing their beliefs about the parameters of the disease are also vitally important in influencing the course of the patient.

*belief  
system  
of  
physician*

The last area is the belief system of the physician. Most physicians are not aware of the fact that their thoughts about the treatment and the patient's own ability influence the outcome, but they most definitely do. It has been pointed out by several different speakers already today how this works, starting with Dr. Rhine this morning. Expectancy of teachers influences children, and on down the line. You see, where the real problem comes in is when the physician's belief system parallels that of the initial belief system of the patient, namely, that the disease comes from without, that it's synonymous with death, that the treatment is bad, and the patient has little or nothing that he can do to fight the disease. This is all too common a belief among physicians. I know, because I have a large number of acquaintances who are cancer specialists, and I've heard them make statements like, "There is nothing that can be done." This, to me, indicates how they really feel about what a

person can individually do to heal himself much more strongly than what they might intellectually tell me.

When we look at spontaneous remission or at unexpectedly good responses and try to figure out what happens in common, we find the same spontaneous occurrence of visualizing oneself being well. You analyze these people, you sit down with them and you find out what their thoughts are during that period of time, from the time they were given their diagnosis to the time that they were over their disease with no medical treatment: I have not found any patient that did not go through a similar visualizing process. It might be a spiritual process, God healing them, up and down the whole spectrum. But the important thing was what they pictured and the way they saw things. They were very positive, regardless of the source, and their picture was very positive. I find that the converse is true of my patients. Whenever I have a person visualizing, and I ask him to go through his visualization with me, how he pictures things tells me a tremendous amount about how he pictures his disease, his treatment, and his own ability to fight it. If I had nothing but one tool to use in looking at my patient's attitude, it would be how regularly he is relaxing and what his imagery is. This tells me so much more than he could tell me consciously, because he isn't even aware of what he's telling me. Too often in his visualization he sees the cancer as some big powerful thing, and the treatment as some little weak something that doesn't do much. He sees his white blood cells, his own immune mechanism, as really nonexistent, and he's trying to coax it into working. These are to me very unhealthy signs. I say they are unhealthy signs because patients who verbalize these things are, in general, doing very poorly at the time they tell me this. Then we begin to take a different approach, not just using behavior modifications, but looking at the reasons behind why the person has these images of the disease, the treatment and himself. We begin to work with him in a conscious way, to modify these images to the point that they will be more meaningful in his body's ability to fight the disease.

*spontaneous  
remission  
and  
visualization*

One of the things that I do early is to show the patient visually some of the best responses that I have ever seen, with some of the least side effects to the treatment. I do this so that he can have a very powerful image of what is possible. I show him a series of slides, not typical responses, but among the best I've ever seen. This is so he might see what the potential of the body is, both in getting rid of the disease and in the minimal reaction to treatment. When I arrived at Travis Air Force Base, I decided to duplicate two studies that had previously been done,

*correlation  
of  
attitude  
and response  
to  
treatment*

correlating the patient's response with different personality characteristics and attitudes. I set up a study in which, at the completion of treatment, five staff members assessed each patient on their attitudes, from doubly positive to doubly negative, based on each one's clinical experience. I also had each staff member independently vote on what the clinical response had been, again based on their own experience, grading these responses from excellent to poor. Then when we averaged these together, giving one score for each patient, we found essentially a one-to-one correlation, which was similar to what Dr. Stavraký had found in her work in Canada. Those patients with positive attitudes had good responses, those with negative attitudes had poor responses, and out of 152 patients over an 18-month period, only two did not fall into the predicted categories (*see table below*).

|                      |                    | ATTITUDE |    |    |    |    | Response<br>Totals |
|----------------------|--------------------|----------|----|----|----|----|--------------------|
|                      |                    | +        | +  | ++ | ++ | ++ |                    |
| CLINICAL<br>RESPONSE | Excellent          | 0        | 0  | 0  | 11 | 9  | 20                 |
|                      | Good               | 0        | 2  | 34 | 31 | 0  | 67                 |
|                      | Fair               | 0        | 14 | 29 | 0  | 0  | 43                 |
|                      | Poor               | 2        | 17 | 3  | 0  | 0  | 22                 |
|                      | Attitude<br>Totals | 2        | 33 | 66 | 42 | 9  | 152                |

These were 152 consecutive cases as they presented themselves in the department. Now out of the 20 patients who had excellent responses, 11 of them positive and 9 of them doubly positive, 14 had less than a 50% chance of a five-year cure, and only 6 of them had better than a 50% chance for a five-year cure. We found that the correlation was with attitudes and not with severity of their illness.

Now it should be strongly stressed that this was a very artificial environment, in a very protective atmosphere-ithat of a treatment center. These statistics did not last after they were out of that environment. Many patients who were very negative and had very poor responses changed after this study was over. In talking about it they said they didn't like the positivity, trying to see themselves getting well. After they got through treatment, there was a turn-around. They gained some degree of perspective, were much more pleasant to be with, and their health changed. Many of the patients with severe diseases had

been very positive in this protective environment, but, when they got back to their home situation, they changed attitudinally, and we saw their diseases change correspondingly. So to try to extrapolate from this or draw any far-ranging conclusions is foolish, because the study was designed to look at patients under very controlled conditions. I did this study to see how our responses would correspond with the work done in Canada and UCLA, and found a very comparable correlation. I also learned many other things as a result of doing this study.

I've asked my partner, Stephanie, who also happens to be my wife, to go into some of the specifics of what we do in beginning to allow the patient to see the role he's played in the development of his disease, and bring these things to his awareness so he can participate in the course of his disease. Stephanie will discuss the specific aspects of this portion of the therapy, since she coordinates this in our office.

*Stephanie Simonton:* In order to explain the specifics of what our psychotherapy consists of, I think it would be best if [ give you an overview of the type of practice we have and the type of patients we deal with. The treatment varies from patient to patient. We have to assess the patients' belief structures when we first see them and try to fit our treatment to their needs. We find that if we get into a conflict with their beliefs, they constantly fight us, and will almost get worse in spite of us, or to spite us.

*type  
of practice  
and  
type  
of patients*

We have a private practice 'with another radiation therapist in Fort Worth. The large majority of our patients come to us through normal referral channels from other physicians in our community, as most other cancer specialists receive their patients. These are about 80-90% of the patients we treat. We treat them with both medical treatment (radiation therapy or chemotherapy or whatever is appropriate) and psychotherapy. Most of them come to us not knowing that they are going to receive psychotherapy with their regular radiation therapy. It should be pointed out that of the patients that we receive through normal medical channels, who come to us with no preconceived ideas about what our treatment is, or any mental concept, over half of them will not participate in any form of psychotherapy. They will not attend group therapy. They will not use the relaxation and visualization techniques we prescribe. Many of them not only will not talk about, or allow us to talk to their families about, the psychological aspects of their disease, but they might even go back to their physician and ask to be referred to another doctor. That was a shock to me, yet as I continue to work with the patients, I am beginning to un-

derstand more of this. So let's begin with an understanding of where the consciousness of most of our patients is.

One of the other types of patients we are beginning to receive from our local community do not have active disease currently. They may be patients who have been free of disease for a year or two or three, but are coming to us for help in dealing with what we now know is one of the real residuals of cancer, and that is fear ... the fear of recurrence, fear of reactivation-are they going to die? It is interesting to note that before a person has cancer, he may have a tennis elbow that aches occasionally. However, once he has had cancer, that aching tennis elbow suddenly represents the fear of metastases. Every time it hurts he thinks, "Is that a new cancer growing in there?" These patients need concrete techniques they can use to deal with aches and pains. Particularly after knowing that the mind participates in our becoming ill, it certainly doesn't help to worry and visualize cancer growing in new places.

The other type of patient that we have is generally referred from out-of-town and out-of-state. They are very few in number and we're extremely selective, but we are accepting some patients who come to us just for psychotherapy. They're usually receiving medical treatment from their local physician in their own community, or there may be no appropriate medical treatment for their case. They come to us believing there is a psychological component to their disease, and asking for help in understanding how to participate more positively in their future prognosis. These are extremely rewarding patients. They're probably the ones that we learn the most from, because they already have grasped so many concepts concerning their own disease process. Basically I think the biggest thing we do for these patients is give them reassurance and a greater awareness of themselves.

*concepts  
underlying  
treatment*

Now let me go over some of the concepts underlying our treatment, and then I'll get into the specifics of it. The first concept, and probably the hardest one for our patients to deal with, is our general concept of disease-the idea of personal responsibility. It's a difficult one. I think I can best refer to it as a double-edged sword. The idea that we have no participation in disease, that it's an outside agent acting on our body and we have nothing to do with its getting there, may be comforting in its denial. On the other hand, if you believe that concept, it doesn't make sense that you then can have any control in the progression of your disease. There's a double-edged sword there. In order to really grasp the concept that they can men-

tally influence their body's immune mechanism, they must eventually realize that their mind and emotions and body act as a unit and can't be separated. There is a mental and psychological participation, as well as a physical one, in the development of their disease. Once they can understand the psychological as well as physical reasons underlying their disease, they seem to get a better grasp on the future and how to deal with that. If you want to understand-and it took me a while to grasp it-how difficult psychotherapy is when you're ill, try an experiment. The next time you have the flu or a cold, ask yourself that very difficult question, "Why did I need this? What purpose does it serve?" It's a strange thing that happens to those of us, the staff, who work with the patients. If you're talking to a person who has cancer about his mentally participating in both the development and the progress of his disease, and suddenly you develop a cold, you have to get in touch with that. You can't continue to talk to them about influencing their cancer when you can't influence your own cold. So it causes aU of us to do a great deal of self-discovery, which is not easy.

For some reason we have a conception of responsibility being the same as blame. This is one reason for our inability as a society to deal with the emotional aspects of our diseases. We feel that if we accept responsibility that we are to blame, should feel guilty, or have done something wrong. We try to convey the idea to the patient that it's just as if you were to deny your body food for too long; we know that you would eventually die. The same thing is true emotionally. A human being doesn't survive just by food, clothing and shelter. We have emotional needs that are very real and very concrete, and if these are denied, life loses its meaning. We will begin to seek the end of our life. We stress not that they should feel guilty, but that they have emotional needs that are not being met.

We do this in the beginning by trying to get patients to see what we call the 'secondary gains of illness'. One of the things we try to get them to do is to see how much different their life is now than before they developed the disease. This is the clue to what we call the secondary gains. Let me give you an example of a woman who has breast cancer. Typically, a couple of years prior to the development of her disease, her children were suddenly growing up, graduating from school and beginning to enter their own lives. Her husband had become very preoccupied in his business and she had suddenly felt unneeded. Since the development of her disease, her husband is now showing her attention that he has not shown her in years. Now that's fine. It's good that he's giving her affection because she

*"secondary  
gains  
of  
illness"*

needs that. But what we try to get her to see is that if the disease is the only way she can get that, then the disease must continue in order for her to get that secondary gain, this affection. We don't try to get her to cut off that affection, but rather, we help her develop healthier ways of getting the support she needs emotionally. In essence the concept we use is not that one regains health first and then goes back to living a normal life, but that patients do better when they do both simultaneously.

I'm reminded of an unusual situation we had recently in one of our group therapy sessions, where we had two patients who had almost identical diseases. They were within a few years of age of each other, and both men had lung cancer that had spread to their brain. One man had had the disease for over a year, but had not missed work other than a few hours each time he had a treatment. Early in the development of his disease he had gotten in touch with a lot of things that were causing life to lose meaning for him. He started to spend more time with his family, taking his family with him on business trips. I remember him saying One day, "You know, I'd forgotten that I didn't look at the trees. I hadn't been looking at the trees and the grass and the flowers for a long time. And now I do that." It was interesting to watch *him*, every week he improved, getting stronger, healthier .

The other man who had lung cancer which had spread to his brain stopped working practically the day he received his diagnosis. He had gone home to sit in front of the television set all day. His wife said that what he did every day was to watch the clock to make sure she gave him his pain medication on *time*. He was in constant pain. He could not even bring himself to go fishing, which is something he liked to do, He died in a short period of time. The other man is still getting healthier day after day. This is the kind of thing that we try to show our patients. The treatment for both patients was the same medically, the diagnosis was the same, the patients' ages and physical conditions were almost identical. *The* difference was in attitude, the way the patients reacted once they knew the diagnosis.

When we began our psychotherapy, based on Dr. LeShan's findings that cancer patients have an emotional trauma 6-18 months prior to the development of the disease, we found ourselves trying to get patients in touch with the event, and to change certain things about their lives so that life could gain more meaning. In essence, we were trying to accomplish in a period of four to five weeks, in once-a-week group therapy

sessions, what it takes years of psychoanalysis to do-if it's ever accomplished. As you can imagine, that became very frustrating. We then began to realize that not every woman who goes through a divorce develops cancer, not every man who retires from work develops cancer, not every person who experiences an unhappy marriage develops cancer as a result. And these are some of the common stresses we see. The difference, then, was not the stress: that was not the problem. The problem was the person's *reaction* to that stress. We try to get them to see that here is something they do have control over. They may not be able to control their husband when he makes them angry or their children when they frustrate them, but they can control how they choose to react to that situation. And I stress the word *choose*.

*Significance  
of  
choice  
in reaction  
to  
stress*

Now let me describe the actual tools we use. During the first week a patient comes to our office, he attends what we call an orientation session. He attends with as many family members and close friends as he would like to bring. We know that a person doesn't become sick in a vacuum nor does he get well in a vacuum. We do best when we mobilize all the forces within the person's environment. So early on, we try to educate the entire family. Many times the patient never brings his family back again after the first session. But we do generally get him to bring some of his family with him, at least his spouse. During the orientation session, we explain our concept of disease, how the mind interacts with the body, and how attitude plays a major role. We teach our patients a technique which we call relaxation and visualization. You might call it biofeedback without a machine, meditation, autogenic training. There are lots of names for it, but it is a basic relaxation technique in which the patients are told to visualize their disease, their treatment and their body's own immune mechanisms (we call them white blood cells to make it simple) acting on that disease. We tell them to do this three times a day, every day.

*relaxation  
and  
visualization  
technique*

At that orientation, they are given a tape recording of the relaxation process that they can take home with them and listen to. All they have to do is put it on a cassette tape player and turn it on. We also give them the book, *The Will to Live*, a short paperback by Dr. Arnold Hutschnecker that more fully elaborates the principles of the mind-body concept. They are told at that session that they may attend what we call group classes or group therapy sessions once a week. Again, I estimate that over 50% of them will not come back at that point. Many of their families come to us and say they understand the psychological component in their relative's disease, but can't get him or her back to the group sessions.

In the group sessions, on a twice-a-week basis, we talk primarily about the relaxation and mental imagery process and how many times they are doing it. Again, we find that the majority of the patients, if they ever use the technique, use it *rarely*, once a day instead of three times a day, or maybe three times a week. We talk about why they are not using the technique. And very often the things that are preventing them from quieting themselves, from listening to themselves and mentally picturing their own disease process, are the very things that are causing life to lose its meaning. In the group we tend to discover those things that are preventing them from getting well.

Let me give you an example of the kinds of things we talk about in groups. Remember the man I described to you who had lung cancer that had spread to his brain, the one who was doing poorly? He kept insisting that he was using the meditation or the relaxation technique three times a day. His wife said she **did** turn on the tape recorder and he was listening to it. So one day we had him describe to us what he visualized. We asked him what his cancer looked like to him and he said, "It looks like a big black rat." When we asked what his treatment looked like (he was receiving chemotherapy in the form of little yellow pills), he replied, "They look like little yellow pills and they go into my bloodstream and they look like tiny pills." We also asked what happened between the pills and the rat. He said, "Once in a while eats one of the pills." We asked what happened when he did and he said, "Well, he's sick for awhile, but he always gets better and he bites me all the harder." When we asked about his white blood cells, he replied, "They look like an incubator. You know how eggs sit under the warm light? Well, they're incubating in there and one day they're going to hatch." That was his visualization, three times a day, which gives you a good idea of the way he visualized his disease.

*current  
studies*

**I'll** conclude by describing some of the studies we presently are engaged in. We instigated a control study with another radiation therapist in Fort Worth five months ago. Between his office and ours we treat approximately three-fourths of the patients given radiation therapy in the city. Both offices administer standard doses of radiation therapy, and our patients are treated on the same equipment, by the same technicians. The difference between the two *is* the psychotherapy administered to our patients. This study should show some interesting statistics, as to whether we can change both the quality and quantity of the patient's survival time by influencing his attitude. In addition to this, we are cooperating in a study with

the Carl Jung Institute of Los Angeles, using Jungian analytical techniques to more fully study the psychological aspects of our patients.

A good deal of research has been done on the personality of the cancer patient. One of the most intriguing aspects of this work is the suggestion that the behavior pattern of the patient can even be correlated to the exact location of the malignancy. For instance, the breast cancer patient has a behavior pattern different from the lung cancer patient, etc. We are currently quantitating this in our patients.

I recently finished reading the book, *Type A Behavior and Your Heart*, and was very excited by the possible implications it could have on medicine in the future. The similarities between their work and ours has led me to hope that we will begin to look at disease in a new way, that instead of being entirely concerned with the disease process itself, we will also take into account the patient and his environment as a whole, and see disease as a symptom of the general and total well-being of the patient.

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