Chapter 8 – Prevention of Cancer During Rapid Growth Periods

Trying to avoid external carcinogens is like an old deer trying to outrun a wolf pack. A burst of speed may help for a while, but then the pack encircles its victim and moves in. There is no escape.

It is clear that we cannot successfully avoid all contact with external irritants. This is not to say we should not work to minimize contact with them or to clean up the environment. But until our society is truly committed to cleaning up its technological act, attempting to avoid carcinogens is equivalent to whistling in the very polluted wind! Obviously no one should expose himself to these agents any more than necessary, but some exposure is unavoidable.

Obsession with the problem is in itself a stimulator of internal irritants. Worrying is a trait of the precancerous personality. It only serves to pollute an individual from the inside. If we can minimize the production of these internal pollutants, we will not add to the external ones.

There are four categories of life events that are significant in the evolution of cancer. They have similar biological and psychological processes taking place at the same time. Biologically, the cells are dividing rapidly and new cellular growth is taking place, not only replacement of worn-out cells. Elevated hormone levels trigger the reaction.

Psychologically, what is particularly striking about these four categories is the preponderance of autistic residuals. In all of them, the individuals involved share a lower level of emotional defenses, a tendency to be self-contained, a drifting in and out of contact with the world at large, a hypersensitivity to irritation, and the possibility of depression.

The four categories are:

1. Infancy
2. Pregnancy
3. Adolescence
4. Sickness or injury

In all of these categories, mitosis (cell division) is largely modulated by elevated hormone levels and we are dealing with either the newborn psyche directly or its residuals. Emotionally, autistic functioning appears to be tied into this biological growth and/or healing process. All of these categories have an intrinsic potential for emotional and biological danger.

This union of emotional regression with rapid cell division we will call psychoplasia. It

is not known which causes which, but they must occur together to facilitate efficient growth and healing. Psychoplasia is a universal human experience. We all go through it at various points in our lives.

Again, let us start at the beginning. The baby is the human being at its most sensitive and thus most vulnerable point in life. His sensory systems are more like those of lower animals at this stage than any other. Sensitivity to chemical and physical irritants is extremely high. The baby is highly cooperative in letting us know when he has had too much stimulation. His discomfort at being overstimulated, either internally or externally, is obvious. The internal irritations of growth have a limited number of discharge mechanisms. He can use his voluntary muscles in random movements for the purpose of dissipation, but the effective discharge through the fusional relationship of mother and baby is better still. All of this was discussed earlier. What remains to be explored are the means of lowering irritation for the newborn.

Most important, no one should worry about spoiling a newborn baby. This is a psychological absurdity. This tiny human has no concept of cause and effect. His connections with the world can be made most powerfully through the autonomic areas of his nervous system. Any learning or conditioning that takes place at this time will be within this system. This is the time when he needs the most protection from irritation.

The newborn should be fed on demand as his system requires. If not, the first psychological message that he receives in life will be is that he was born to meet the needs of others. This evolves into the basic anxiety so many of us suffer from. Anxiety in new parents can result in finding comfort in rigidity. However, scheduled feedings for the newborn are an invitation to hyperirritation and instabilities in the developing digestive tract and related systems.

The only mothers who can let their newborns continue to scream in pain are those whose pediatricians have told them, “This is what is best for the kid. Let him cry himself to sleep. If you let him do it a couple of times, he will stop carrying on.”

I am sure the doctor is correct. The baby will eventually stop carrying on. But at what price? The price may be a dynamic for cancer.

Hospital procedures in this regard are highly questionable. In some instances, newborns are not fed for eight, ten, or even twelve hours while nurses wait for the first bowel movement to ascertain that the digestive tract is unblocked.

Any adult going that long without food would certainly protest. Just listen to yourself or friends who are dieting. For a baby, this is a horrendous amount of irritation immediately after birth.

Whenever I hear the term overstimulation being applied to the newborn, I immediately think in terms of hyperirritation. Overstimulation is overloading the capacity of the baby’s

nervous system by stimulation that seems, at times, unrelenting. Usually, the overstimulation occurs because the baby's needs are subordinated to those of the parents. An extreme example is a young father insisting that it is all right to take his two-week-old daughter into a smoky poolroom bar. A more common example is awakening the baby to entertain the grandparents or other relatives.

Internal stimuli can be dealt with in overstimulating ways as well. If a parent goes over-board trying to soothe a crying baby, patting and jiggling and bouncing him around with no success, he may be surprised to find that when he gives up in despair and puts the baby down, the baby goes right to sleep.

The baby can recover from other errors but not from being left alone or being ignored during times of hyperirritation. Parents must be flexible in trying to find new ways to soothe the baby. If it is not food that he wants, perhaps he needs changing. Or the baby may be too hot or too cold. Or he may simply need to be held and cuddled. The baby may also respond to soothing words or a lullaby. Above all, the parent should respond to the baby in a relaxed and sympathetic way. A frantic reaction just adds irritation to the irritation the baby already is suffering from. Remember, crying is the primary way a baby has of communicating.

Mistakes in caring for the baby physically within reasonable limits are of almost no significance if a fusion is taking place. If, however, there is minimal entropy, then even minor physical errors in infant care may be experienced as gross irritations. The mother (or mother substitute) must be capable of loving the newborn or serious consequences ensue. Love is not optional in childrearing. It is vitally necessary for survival as documented in a study done by Rene Spitz in 1947 (see Chapter 12). The baby's resistance to accepting love after being taught to fear this closeness is very similar to the cancer patient's dynamic.

The second category is pregnancy, including the months immediately following. For our purposes, we should think of pregnancy as lasting at least a year. To protect the health of both baby and mother, it is essential to provide proper care and emotional feeding of the expectant and new mother in order to facilitate her emotional regression, which necessary for fusion with the baby.

Pregnancy and the early mothering experience necessitates the shifting back and forth from autistic functioning (hypersensitivity, mood swings, dissociation, etc.) to more adult functioning. At the same time, the pregnant woman is undergoing rapid mitotic growth. Like the newborn, she experiences intense autistic feelings as she undergoes rapid cell division. She also is undergoing psychoplasia.

Unfortunately, it is easy for a husband, friends, and relatives to dismiss or become angry with the strange behavior of an adult expressing infantile feelings. A husband should never say to his pregnant wife, "You're only feeling this way because you're pregnant." She

does not care why she is feeling what she is feeling. She needs to have her feelings respected and soothe.

When autistic residuals are activated in the expectant or new mother, they limit the importance of words in the expression of caring. Close physical contact and gestures of unsolicited giving are far more soothing. How one says something, the tone, the feeling behind it, is far more important than the words themselves.

Women need to feel protected and cared for at this vulnerable time, but some have extremely powerful defenses against such feelings. They can find them too frightening and therefore deny them. They can be offended by the idea that they should have such feelings.

As a defensive new mother asserts her need for total self-control, one should avoid any confrontation. Instead, husband and family should be particularly considerate and complimentary while trying to persuade the mother to allow them to share in the care of the new baby.

When the new mother is experiencing infantile feelings, and perhaps acting on some of them, it is vitally important that the husband not add to any upset. His task is to minimize irritation, not make it worse. But merely not adding irritation to the hyperirritated state is not enough. The intensity must be lowered. The most effective way is through an entropic relationship**.** *The key to cancer prevention is the minimizing of any and all irritations at all stages of life.* This is best done through the processes of emotional entropy and fusion.

An area of special consideration is adoption. Adoptive mothers can regress to permit a fusion or they can resist. If the regression does take place, it is a sudden shock to the system. This new mother feels all the feelings of the biological mother, but far more powerfully and abruptly. It is an overnight condensation of what should have taken nine months. Cancer is not related to adoption. It is related to the fusion or lack of it between *any* mother and her newborn baby.

Marilyn is a thirty-two-year-old who has adhesions in both fallopian tubes, probably due to some earlier undetected infection. She remains infertile despite surgical attempts to remove the adhesions. She and her husband applied for adoption through a church facility. Three and a half years later, they were notified suddenly that a baby was available for them. Two days later, little Eric was brought home.

Marilyn reported what seemed like bizarre feelings, but actually fit into the concept of maternal regression to autism. She said, “I had almost four years to prepare for Eric’s arrival. I wanted this baby more than anything in my life. John, my husband, had expressed similar feelings and was very sympathic to my need for a baby. Can you imagine his reaction when, on the way to the adoption agency, I told him that I just could not do it, that I was terrified and I did not know why. He parked the car and tried to reason with me. Then he just hugged me and

said we could wait a day or so and make up our minds. I began to cry hysterically. I couldn't stop. I told him that I really felt totally wacko because now I could go through with it.

"When the nun handed me the baby, I had the strangest sensation that he was melting into me and vice versa. It was such a delicious sensation. He nestled right into my arms and chest. It was love at first sight. At home, I was a real character. I wouldn't let anyone, not even John, feed the baby for two days. He somehow seemed to understand. He stayed home from work and took care of me. When I finally collapsed, he was right there for both of us. I continued to have some really strange reactions.

"I developed a rash because of the soap I had been using. As soon as I switched to another brand, the rash went away. For several weeks after Eric's birth, I could not have sexual intercourse. It made me very uncomfortable, but I managed to satisfy John in other ways. What was strange was that I behaved like a seductive kitten, but I could not tolerate being penetrated. At times, I cried for no reason. Everything seemed to upset me. I really thought I was losing it!"

Marilyn's reactions are understandable if we put them in the context of the primary maternal regression and fusion with her son Eric. Her husband, John, was intuitively excellent at meeting her primitive needs. Not once did he attack her throughout her adjustment to the regression. He knew somehow that what she was going through could not be dealt with through reasoning. Instead of being antagonistic, he supported her whatever feelings she experienced.

John said that he was really frightened for Marilyn, that he felt totally inadequate and did not know what to do. He may not have *known* what to do, but he had all the right feelings to help mother his wife at this critical time. Eric is now six years old. He is a delightful child, quite capable of having and appropriately expressing all of his feelings.

Adoption should occur as soon after birth as possible. Agencies that require a waiting period can be assisting in the development of, at the least, genetic instabilities. The consequences can be far more severe. Any policy that interferes with the immediate fusion of a newborn and its mother, biological or adoptive, should be abolished.

Unfortunately, Marilyn's reaction to Eric is not the usual reaction of adoptive mothers. The adoption agency typically tells the adoptive mother that she and her husband have been selected because of their maturity. No one has told her that part of being mature is accepting all of one's feelings, even the infantile emotions. If she begins to feel the discomfort of a sudden regression, she immediately turns it off. If she has other significant pressures, such as an immature, withholding husband or a need to return to work at the earliest possible date, she is in no position to accept a regression.

Child custody cases can raise serious problems for babies and small children. Children should never suffer the abrupt termination of a fusion. Even in cases of abuse, the only reason to

separate a mother and a small child is if the abuse is life-threatening. What may appear to be a terrible relationship is, in most instances, better than the shock of an abrupt end to even a limited emotional entropic system. The most important consideration in child abuse, in general, is that the mother's sense of isolation breeds the abuse.

The next category that experiences intermittent emotional regression to autism coupled with increased hormone levels and rapid mitotic growth is adolescence. Adolescence is a period of psychoplasia in everyone's life. As an individual approaches and passes puberty, a significant increase in hormones of many kinds results in a general growth spurt and the development of secondary sexual characteristics. Overnight, the eleven- or twelve-year-old may appear to change into a semi-adult. Boys develop increased muscle bulk, broadened shoulders, body hair, and enlargement of sexual organs. Girls develop their breasts and hips and begin their menstrual cycle.

Volumes have been written about the teenager, who is perhaps one of the least understood individuals in the world. Temper tantrums and depressions, infatuations and promiscuity, delinquency and righteousness are all part of the same beast. Teenagers can be space cadets. We talk to them and two minutes notice later that they have heard nothing we said. They can spend long hours in isolation pursuing hobbies, studying, or looking out the window. They switch dramatically from extroversion to introversion. They are moody; feelings are intense, extreme, and, at times, overwhelming.

Teenagers can do things that seem absurdly provocative and have no explanation whatsoever. Bodily sensations can seem overpowering. Hyperactivity is characteristic of the adolescent, and he can eat enormous quantities of food without becoming obese. This unbounded energy and activity level is vitally important, for it allows the dissipation of autistic level irritations through the voluntary musculature. It may very well be life-preserving.

Athletic pursuits are vital to teenagers, but so is walking into town with friends and hanging out. This need for activity is a lifesaving defense for the hyperirritated baby in a somewhat adult body.

Adolescents are often clumsy, and go through periods of immature levels of motor coordination. Usually, we blame this on rapid growth, but it is similar to the lack of coordination and clumsiness observed in schizophrenics. Both the teenager and the schizophrenic at the autistic level are clumsy at times, because their mental and biological regressions bring them to infantile levels of coordination.

The teenager's other major defense against the evolution of cancer is first love. A pressing need for emotional entropy is activated by the adolescent's psychobiological regression to autism. But parents are no longer suitable for such intense fusion. The more mature parts of both teenagers and parents cannot tolerate the overstimulation of two sexually adult people being

intimate when sex is a taboo. So, first love steps in as a replacement for the parental intimacy from the infantile stage of life.

The teenager needs this fusion in order to deal with his hyperirritation, as the emotional pressures of adolescence create an overabundance of endogenous carcinogens.

If parents realize what is happening to the teenager, they need not feel injured by normal lack of connection or consideration of parents on the part of teenagers.

If an adequate fusion did not take place in infancy, certain problems may develop in adolescence. Alcohol, marijuana, cocaine, barbiturates, etc., all assist in dulling the senses to overwhelming irritaton from the inside or the outside. Unfortunately, most teenagers do experiment with drugs, but continuous and excessive indulgence indicates a pressing need to turn off the hypersensitivity of autism.

The disturbed teenager can endure the endogenous carcinogen factory of a competitive and pressurized school situation if he has smoked a joint. Without it,he will climb the walls.

Superficially, drugs seem to be facilitators of social interaction. In reality, the result is greater self-containment. Excessive drug use is a symptom of an inability to fuse, which can relate to subsequent cancer.

Sexual promiscuity, which is very common in adolescence, is another result of inadequate fusion in infancy.

Union with one individual is one mechanism for fusion. The teenager also has an avid need to belong in general. Special groups form to meet such needs. This explains the importance of athletic teams, sororities and fraternities, and high school and college clubs. As with the Mormons, belonging is the dominant theme. If a teenager does not or cannot experience first love or intense, sometimes fanatic, group membership, it may indicate an inability to fuse, and, thus, an aberrant emotional entropic system.

The inability to relate on such a level frequently results in moderate to dangerously severe depression. These depressions are an attempt to ward off hyperirritation. Increased hormone levels are irritants or internal carcinogens. An anaclitic depression (see Chapter 12) serves to minimize outside emotional irritants in order to avoid a repetition of the hyperirritability of early infancy. But, at the same time, it maximizes endogenous carcinogens.

Like the anaclitically depressed baby or cancer patient, the adolescent will push the concerned individual away. Concern is viewed as intrusive. How many times have parents heard, “You just don’t understand me. I can’t talk to you.” This translates to: “You don’t love me, and I cannot tolerate your intrusions!”

This pushing away eventually can lead to totally self-contained hyperirritation, which can be fatal. In adolescence, it leads to suicide, which can be either conscious and direct (pills, guns,

hanging, etc.) or unconscious and indirect (auto accidents, overdoses, provoked homicide, leukemia, etc.).

As the adolescent's cells reproduce, there is a risk of additional instabilities in the organ systems forming new tissue. This is true of any neoplasia. But unlike the newborn, adolescents, pregnant women, and the sick or injured do have psychological defenses that are thought to help process irritation. The more mature individual can escape or defend against these powerful irritations, so it is not new instabilities that are the predominant issue here. It is the hyperirritability that stems from the increase in hormone levels and the discomforts of rapid mitotic growth ("growing pains"). The psychoplasia of more advanced life stages is not nearly as severe as in the first two months of life, but it does make an individual more vulnerable to the elevated irritation levels tripping a landmine laid in infancy.

Thus, the adolescent needs to be protected from the physical damage to which the anaclitic depression is related. At this time, the wise parent or teacher will not add irritation to pre-existing irritation. He will not put the baby down, although the baby is now thirteen, sixteen, or eighteen years of age.

However, this time around it is even more difficult. This baby can be devastating in his ability to push away obnoxiously. He can get his parents and teachers to want, not only to put him down, bu to kill him at times!

If the anaclitic depression cannot be resolved by the parents (if they cannot make contact with the teenager), then professional help is a necessity. Permitting long term isolation is a repetition of the infantile dynamic of self-containment. It can be fatal.

Less severe, but very significant, is the basic parent-teenager conflict. Anytime you attempt to coerce an adolescent, you are probably adding to irritation. This is not to suggest that limits should not be set to adolescent behavior. They indicate a love and concern that adolescents can sense. If, however, they are set as part of a power play, they become unbearable irritants that result in rebellion. Teenagers cannot be told to do something lacking an adequate explanation without having them develop powerful resentments. It is far better to work toward cooperation.

The following is an example of how not to add irritation to pre-existing adolescent irritation.

Robert is a thirty-eight-year-old dentist with a private practice and an office in his home. His daughter, Judy, is a fifteen-year-old high school student. On Wednesdays and Fridays, Robert gives Judy a ride home from school since he has ten minutes free between patients. Judy is usually five minutes late, which throws her father's schedule off slightly. In the past, he always attacked her for her seemingly nonchalant attitude toward being late. She appeared to

ignore him, which only made him angrier. On Wednesdays and Fridays, Judy became an unruly monster at home, picking on her little brother and/or retreating to her room.

Patient: Last Friday, I tried what you suggested with Judy. Instead of attacking her right off for being late, I asked her about it. She told me her last period teacher always keeps the class late. So I asked her if she ever explained the problem of my schedule. She told me she did, but her teacher did not seem to care. I then told her that this must create a lot of anxiety for her, being caught in the middle. She said it did. She told me at times she was nauseated by her Wednesday and Friday afternoons.

Analyst: Did you join her?

Patient: Did I ever! I told her that her teacher was being terrible to her and to me. I said I would write a note or speak to the principal. Then I added that the rotten so-and-so should be kicked out of the profession. I explained that by now this teacher knew the predicament she was in. I told her that it must be awful being made to sit for the five minutes and know she would be late. She told me it actually made her sick. I told her that I would talk to the school administration if need be. The amazing thing is what happened next. For the entire trip home Judy let loose with a stream of invectives about this teacher and some of the others. The more she complained about them, the happier she got. By the time we got home, it was not my Wednesday-Friday Judy. She actually played with her brother and then offered to help him with his homework. Her stomachache disappeared in the car. She's been talking to me this week more than in the past year. She actually asked my opinion about some things. I couldn't believe my ears.

Analyst: What would have happened if you had continued with the usual position of attacking her for her lateness?

Patient: She would have been bitchy all night and feeling sick. When I think of the aggravation I caused her! I mean this teacher was busting her chops enough without me adding to it. It was miraculous what happened as soon as I did not add to it. I learned a lesson. I should say she taught me a lesson. Just think what she has been internalizing every Wednesday and Friday since September! Thanks for the advice. And I'm sure Judy's insides thank you, too.

What Robert did not realize was how profoundly inside his daughter's physiology the internalization took place. The genetic material of the nuclei of her cells was the possible degree of "insideness."

The final category at high risk for tripping a genetic landmine is convalescence. During

convalescence, the body is repairing itself (growing) through rapid cell division, which is largely under the influence of irritating chemical agents. At the same time, the activation of autistic residuals is taking place emotionally. An anaclitic depression may appear to be a defense against the overwhelming intensity of autistic feelings. The patient may, at times, push caring people away. He may be in and out of a coma-like sleep. He may appear totally self-involved. He knows he should be interested in the life events of the friends and family who come to visit. But we all can recall visiting people we care about and suffering the discomfort of their forced involvement with our daily affairs, which seem mundane in the face of a coronary occlusion, for example.

Even with less severe injury or illness, most of us regress to self-involvement. The definitive indicator of the regression to autism induced by physical trauma is the emotional symptom of being dissociated. The sick or injured are, at times, thoroughly spaced out. Medication cannot account for all of these reactions, psychoplasia can.

One frequently hears it said in the waiting rooms of intensive care units, "Don't say anything to upset him!" In other words, do not add irritation to pre-existing irritation.

When we visit a sick or injured person, we naturally are more tolerant of inappropriate comments coming from him. We put up with feeling rejected and pushed away by rationalizing that "Old Jim is just not himself." It is Old Jim, but it is also a very *Young* Jim with whom we are dealing. This is why he seems unfamiliar.

Emotional entropy will assist healing as it assists growth. Healing can be viewed as new growth. Therefore, self-containment is to be avoided, except for the periods of infant-like need for rest that accompany healing.

In most cases of healing and illness, the difficulty is in getting past infantile depression. We must be prepared to soothe the baby within the adult while these powerful feelings are laid bare.

Chapter 9 – Prevention of Cancer in Everyday Life

This chapter is especially for those of you who have been reading this book and saying, "But I did many of those awful things to my babies." Don't worry. You can make amends.

This chapter and the previous one will help you to recognize that internal levels of carcinogens in your loved ones and yourself are, to a great extent, under your control. The mechanisms of processing irritation can be relearned more easily in the young, but even the old can learn new tricks.

This chapter is about those new tricks.

Prevention in Childhood

The most carcinogenic statement that can be made to a child is, "Keep crying, and I'll give you something to cry about." This is the epitome of adding irritation to an already irritated human being. If you have been in the habit of saying things like this to your children, break the habit.

Normally, the degree of a parent's anger at a child relates to the seriousness of the child's transgression, but nothing deserves this degree of upset. The child already is sufficiently disturbed. What he needs is comforting and soothing; he does not need to be placed in an acutely hyperirritated state. If the child cannot expect love and soothing from his parents at these times, from whom can he expect it?

In a supermarket, a child's temper tantrum may seem like a public indictment to a parent; it can be very embarrassing. It is even more embarrassing if the tantrum has been caused by something the parent has said or done. How should such situations be handled?

The most commonly accepted advice is to walk away and leave the child alone. Eventually, he will calm down. That is probably true. Just as the newborn will eventually cry himself to sleep if no one picks him up. Ignoring the toddler with a tantrum is just as harmful.

Pick up the kicking, screaming toddler (he's a lot smaller than you are), hold him firmly, and speak to him soothingly, and eventually the screaming will turn to crying, the crying will turn to soft moaning, and the end result will be a peaceful child. There is no way to prevent all childhood upsets. Inevitably, they will occur, and the only cure is love.

Parents' threats can certainly cause the overt symptoms of an upset to be buried – just think how far! It is this kind of induced hyperirritation that must be avoided. The parent's rage must be controlled or the child will have internal scars for life.

Have you ever said to your child, "Keep crying, and you will have to go to your room until you settle down?" This is not hyperirritation, it is true, but it teaches self-containment. Most of us are guilty of this carcinogenic communication. It is the equivalent of leaving the baby to cry himself to sleep. The child needs his parents, even if his crying is upsetting them. A temporarily irritated parent is better than an emotionally exiled child.

Although separation is undesirable because it means self-containment and isolation for the child, it is better than the cumulative addition of irritation from the parent on the already irritated child.

Consider another situation. Imagine being a three-year-old who is afraid of the dark because of the lurking monsters, witches, and goblins. Where were yours? Perhaps in the closet, so those doors had to be shut each night. Maybe they hid under your bed or were just outside the window.

Shadows conceal evil somethings for most of us. When you admitted your fears to your mother and father, the conversation may have gone something like this:

Child: Daddy, I'm scared of the dark. I don't want you to go. Please don't.
Father: What are you afraid of in the dark?
Child: There's a green thing that is over there (pointing to the closet). I'm scared of it. It's ugly.
Father: (Laughing) There are no such things. That's all make-believe. There's nothing to be afraid of. Now, you just get into bed and go to sleep. I'll be downstairs, so don't worry.
Child: Please, Daddy, don't go!
Father: It's all make-believe. Now, you stop it and go to sleep. I'll leave the hallway light on.

Don't be scared.

This father did not take into account the importance of magic in the development of all children. Magical thinking is a major part of the preschooler's existence. When you ignore it for fear of encouraging it, you are inadvertently giving a communication that could be carcinogenic.

When the father walked away from his child, he left the youngster in a state of terror. He also left the child alone in a hyperirritated state, thus reinforcing self-containment.

How could this be handled better?

Child: Daddy, I'm scared of the dark! I don't want you to go. Please don't!

Father: What are you afraid of in the dark? When I was your age I was afraid of monsters and witches. Mine were blue with red eyes and red teeth. What are yours like?

Child: Mine are green with big hands. They come out of my closet at night. I'm scared of them, Daddy!

Father: Let me teach you some secret words. Whenever you see a monster, say these words and the monster will turn into a nice fairy. The words are boo, boo, who. Say them back to me.

Child: Boo, boo, who. Boo, boo, who. Boo, boo, who.

Father: Now, remember them. The monsters change right away. I'll check the closet before I leave. Remember, the magic words are boo, boo, who. If you need me, call. I'll be right here. But I know that boo, boo, who always work.

Child: Daddy, please tuck me in.

A couple reported to me that their two-year-old was frightened by the imaginary spiders in her room, and every night there was a battle to get the child to go to bed. I suggested the use of the Tasmanian devil, a character from the Bugs Bunny cartoons who viciously devours anything in sight that has carbon atoms in it. They bought a stuffed animal version of the devil and told their daughter that this evil-looking creature would take care of her. While she slept, the Tasmanian devil would eat all the spiders in her room.

The couple reported that they had total success with the devil, with one interesting side effect. Little Samantha is an angelic-looking blonde-haired, green-eyed child. She has grown so attached to "Tassie", as she calls her protector, that this ugly monster has replaced her teddy bear. She takes the creature everywhere with her and gets tremendous attention from people who are unable to reconcile the contrast between the beautiful Samantha and her Tassie. Using magic in the face of magical thinking reduces hyperirritated states. It provides protection by the parent in the form of magical phrases or protective stuffed animals. Most parents are afraid that this will convince their children that magic is true. That will not happen. To children at certain

stages, magic is the only truth in the face of fear of annihilation. However, children outgrow it. But in a stressful situation, we can all regress to it later in life.

For example, imagine yourself in the Battle of the Bulge with a Panzer tank coming at you. If you are like many people, you very well might call for your mother in the face of such terror. The magical part would be ascribing omnipotence to her. After all, how good is she with a bazooka or grenades? During such regressive fear, the need is to seek a magical savior. The farther back the regression, the more likely that mother will be called for.

The child encounters his Panzer tank every night. Do not desert him when he faces such terror. He will abandon the need for a magical savior with age. That is not the issue. What is important is what you are teaching him throughout this stage: the choice between self-containment, which can be carcinogenic, and fusion, which is not.

When introducing a child to any recreational activity that you enjoy, there is a secret to success that prevents both of you from becoming hyperirritated. The first time, the parent is not there to enjoy it. The parent's sole function, if he or she wants the child to become a companion in this activity, is to be there to comfort and encourage the child. If the parent is deluded into thinking that he or she is there to enjoy the activity, conflicts will arise.

A man told me how, at first, he turned off his daughter to the fishing he so much enjoyed but, eventually, wound up with a fishing buddy. On the first visit to the lake, he quickly showed the girl where the bass would most likely be, the proper way to cast, and what bait to use. He was in a hurry to get this over with so that he could go after the monster fish that stole his favorite lure the previous week. After about ten minutes of fishing, he saw his daughter sitting down, moping. He told her to keep trying, that it takes patience. She refused. He got angry, and the day ended with neither of them speaking to the other.

The next time out, he put the tackle on the ground, and they sat on the shore. He began skipping pebbles on the lake, and his daughter joined in the game. When she got bored, they hiked around the lake. He never mentioned fishing, but to his amazement, she asked to try the pretty lure with all the bright colors. He knew it was the wrong choice, but tied it on for her anyway. When she made her first catch, both she and the fish were hooked. Best of all, only the fish was hyperirritated.

To teach a new behavior pattern requires many repetitions of stimulus-response groups. You cannot expect a child to learn anything based upon one or two episodes. If you are guilty of isolated incidents of encouraging your child to learn self-containment, remember that it is only Hollywood that makes singular traumas into the significant parts of learning. In reality, you must repeat and repeat. If your baby was conditioned into fusion, occasional mistakes will be of little consequence.

What if you recognize now that your child was conditioned into self-containment in the face of hyperirritation? Reconditioning can provide a possible way out. If you stop reinforcing the self-containment, you will gradually take away the motivation, and the child's behavior can change.

Mary's usual behavior was to withdraw to her room whenever her father tried to offer constructive criticism of her behavior. Her father was afraid that if he tried to persuade her to stay with him to talk the matter over, she would not take his criticism seriously. However, rather than worry about sending mixed messages to his daughter, he should have encouraged her to remain with him to communicate about the feelings they each were experiencing.

If a parent's interactions with his child have been predominantly carcinogenic, it takes only occasional intermittent reinforcement to keep it carcinogenic. It is important to work to avoid these episodes. The parent must learn to respond to hyperirritation without adding to it, and to self-containment in such a way as to encourage communication. The child must not be allowed to retreat into himself.

Consider this common situation. The playroom is always a mess. Charles habitually leaves all of his toys on the floor, sometimes in dangerous locations. His parents have tried punishment and threats to get him to pick up and put his toys where they belong. Typically, Charles refuses to cooperate or does it so slowly that his mother is reduced to vindictive attacks on her ten-year-old.

A better way to handle this situation would go something like this:

Mother: It isn't going to work anymore.

Charles: What isn't going to work anymore?

Mother: You think that if you leave these toys around I am going to keep screaming at you about it. Well, I am not. I want you to tell me why you want me to scream at you.

Charles: I never want you to scream at me.

Mother: If you don't want me to scream at you, it takes about three to five minutes to pick up all your toys. It is just not going to work anymore. There will be no screaming over this sort of situation. If you cooperate with me, I will cooperate with you. You want to go to the movies this weekend. I am certain I will be more likely to do what you want if you can do a little bit of what I want. If not, that is okay. We don't have to go to the movies.

No matter what, the mother is not going to allow herself to lose her temper. She is now aware that, for some reason, this is what Charles wants of her, and she is going to ruin his game.

Help remove some hyperirritated states, and your child will seek you out. This is reconditioning. Many positive repetitions are necessary to effect relearning. On the other hand,

few are necessary to reinforce what already has been negatively learned. It all boils down to stopping the negative episodes and beginning a positive re-education at the same time.

I was sitting in a family restaurant on Long Island, and a rather nice-looking, affluent young family was at the next table. Their adorable child was busy being a four-year-old.

Four is a transitional age, like eleven or twelve. These are ages between important stages. They bridge the gaps in childhood development. For this reason, they can be difficult times for the child and the parents. The striving for maturity and independence is coupled with earlier, less mature patterns. There is confusion on everyone's part. Experts and laymen alike tend to see these stages as developmental no-man's-lands.

This particular four-year-old was busily playing with his food and having a wonderful time. His mother kept telling him to stop playing and sit quietly. She warned him that if he kept fooling around with food in his mouth he would choke. It was almost as if she had ordained it.

The next instant the child was trying to clear his throat of the food he was choking on. The father, who, I later found out, was a physician, smacked the little boy's back and the food came up. The mother reacted in what seemed like an inexcusable manner: as the child was crying, frightened, and gasping for air, she screamed and shook him violently.

This is the epitome of adding irritation to irritation. It also conditions the child not to show feelings nor expect or want comfort when hyperirritated.

However, one swallow does not a summer make. If the mother normally reacted this way, this child certainly would be damaged. But if we take into consideration how terrified *she* was, we can understand and forgive this isolated transgression. She should also forgive herself.

On the other hand, if this child's autistic-stage conditioning was precancerous, then intermittent episodes like this would reinforce the conditioning. For the mother to counteract the earlier conditioning, she must learn to offer comfort in the face of hyperirritation.

After the child settles down and is gently hugged and stroked, she can tell him: "I was frightened when you choked. Please don't play with food like that anymore. This is what can happen. I bet it scared you, too!" The child would probably react by talking about how frightened he was while describing his hyperirritated state. The internal irritants would subside immediately as his mother caressed him and wiped away his tears. She will have dissipated their effect.

Perhaps the more subtle continuation of negative early-stage learning occurs in hostile or negligent marital situations. Either parent can be guilty. If your marriage is hard to tolerate at times, ask yourself if you have been using your children to meet the emotional needs your spouse should be meeting. If a spouse is absent because of death or divorce, the risk of doing this is even greater.

In this situation, the child may be pushed into the position of assuming the adult emotional role in place of the absent parent. The child not only learns to delight in taking care of the parent's needs, but also gets rewarded for it. The child begins to feel responsible for any upsets the parent experiences. The child sits and listens to mother's or father's complaints and rarely gets to express his or her own. When the parent becomes depressed, the child may not feel responsible for the cause but can feel guilt over not being able to remove the depression.

In this kind of situation, parents will express pride in the fact that their child is ten years old going on thirty – a most depressing thing to hear about any child. It indicates the possibility that the child is not only being conditioned for self-containment, but is also being denied childhood. Anyone brought up this way will have the idea that being mature means denying all infantile or childish feelings, whereas genuine maturity is based upon acknowledging all of one's thoughts and feelings but acting upon them selectively. The child of a parent who becomes emotionally dependent upon him fears that childlike behavior will result in estrangement from the parent who needs his care.

Usually, the child cares for only one parent, and identifies with this parent's resentment of the other. The rejected parent then may resort to distancing himself or herself from the child. A father may see the child as belonging to the mother and have nothing more to do with him.

The situation can become very difficult to correct, but both parents should make every attempt to do so, however great the emotional strain. The parent who is reversing roles with the child must find a new emotional support system. The distancing parent must draw closer and let the child know that he or she is always there.

Not every bad marriage or divorce evolves into a subtly destructive situation that refreshens precancerous conditioning. But it is something to be seriously considered by any parent in this unhappy life circumstance.

On the other hand, do not overcompensate by never allowing your children to do anything for you. It is the direction of the emotional entropy that counts. Children need the parent to absorb their irritation, not vice versa. Immature parents are always a problem for the development of healthy children. Occasional immature behavior (inappropriate venting of rage, asking a child's opinion about matters with which he should not be concerned, etc.) is insignificant, if the autistic-stage conditioning has the emotional entropic system going in the right direction. But the child who has always had to worry about a parent's reaction will, in later life, generally be hyperirritated internally by worrying about everyone's potential reactions. As an adult, he will be overly concerned about doing the right thing and making the right impression. What an enormous strain this is on anyone unfortunate enough to have been so conditioned!

In discussing childrearing, the matter of corporal punishment cannot be avoided. Is it ever appropriate to strike a child? Many say absolutely not. Others say that sometimes it is the only way to get your message across. Both positions are wrong. Hitting a child should be reserved only for one of two reasons:

1. To be protective in life-threatening situations. A two-year-old does not have the thought development to know that his mother does not want him in the street because a truck could run over him without the driver knowing it. He cannot understand that apartment windowsills are not for climbing. He cannot know that abusing the family Doberman can get him killed. He *can* know that Mommy will smack his rear if he does any of those things. Inflict just enough pain to cause discomfort and fear of your reaction to any of the child's life-threatening pursuits. In these situations, the child should fear the parent. He cannot fear the real dangers until it is too late.

It is true, to some degree, that hitting the child could result in hyperirritation. But if your two-year-old does wind up under the truck or car or face down in the swimming pool, we do not have to worry about subsequent cancer, do we? In addition, the child who is transgressing in life-endangering ways is not usually in a pre-existing state of hyperirritation. The added irritation is sudden and pronounced, but it is not added to a hyperirritated mind or body. The child will understand that he is being protected not punished.

Many people believe that allowing a child to touch a hot stove or radiator, even if it results in blistered skin, teaches a beneficial lifetime lesson. In addition to the excruciating pain inflicted on the child, it carries the terrible message that the mother, who is responsible for his protection, let this happen. A child must never be allowed to hurt himself deliberately.

2. If you tend to lose control and are physically and emotionally abusive. In this situation, the intent is to avoid resorting to significant emotional and physical abuse. If you know that you can and usually do lose control, consider this: Before you are so out of control that abuse will follow, give the child a less severe smack on the backside. This can help put the brakes on for both of you. Telling anyone who is overly severe with a child to just stop is a waste of time. Venting some rage, but in a controlled way, is far more likely to work. Everyone wants to abuse their children at times, and almost everyone does, to some degree.

Hitting can be viewed as a medicine, and all medicines have some potentially negative side effects. It is important to weigh the risks versus the benefits, much like a physician must do in treating any disease or disorder.

The two most important points to remember in raising children are:

1. Avoid adding irritation to pre-existing irritation.
2. Avoid self-containment of irritation.

If you follow these rules, you very likely will avoid interactions related to cancer.

And you most certainly will provide the child with an orientation in life that will assist him or her in maturing and relating to others in a constructive manner.

Do not expect to be able to do a perfect job. But the more you try, the more benefits you will see.

Prevention during Marriage

If there is one basic tenet to follow for a marriage to be an efficient emotional entropic system, it is this: Feelings take precedence over facts.

In troubled marriages, someone is always wrong and someone is always right. The need to prove this indicates an investment in power plays and dominance. *There is no right or wrong in a marriage.* The only significant aspect of conflict is the feeling surrounding it. If feelings are dealt with first, the facts almost always are more easily resolved. If, however, one partner *needs* to be right all the time, the relationship can easily become disastrous. When one spouse denigrates or ignores the other's feelings, the conditioning for self-containment is activated. A husband may dismiss his wife's hurt feelings as ridiculous and not worth discussing. A wife may ignore a husband's needs as unimportant. Whatever the mechanism for wiping out feelings in a relationship, a relationship without feelings is wiped out!

You may consider your partner's position on an issue absurd. In reality, it may be absurd. But reality has nothing to do with the feelings involved. If you resort to *inflicting* your reality upon the situation, you are encouraging hyperirritation and self-containment in your partner.

If your partner has to be overly concerned about your reactions to different issues, then the emotional entropy is going in one direction. The partner who is more mature and in better control of himself or herself will be the one more likely to get cancer.

The marital relationship should ideally permit comfortable expression of feelings and thoughts from both partners. If a great disparity of maturity exists, then the more mature partner will be continually looking out for the other's feelings. The fragility and vulnerability of the immature partner will necessitate such care. This repeats the early infantile-maternal relationship. If this repetition occurs for one partner only, the other will have no means within the relationship to have his or her emotional irritation dealt with. He or she will remain self-contained as it becomes obvious over a period of time that the immature partner cannot deal with these feelings.

Precancerous individuals are excellent at caring for others but cannot accept unconditional caring directed toward them. Such a marriage may be comfortable. The partners may have selected each other to fulfill these unconscious needs.

Sandra is fifty-two years old. She is a very proper woman who compulsively does everything right. Her husband, Ned, is a fifty-four-year-old stockbroker. His business is successful in spite of his obvious immaturity. At work he, traffics in sexual byplay with his female staff. One secretary resigned because of his obnoxious behavior.

Whenever Sandra and Ned are out with friends, he is humorously seductive to any and all females, with the *exception* of his wife (mother). Sandra has repeatedly asked him to stop behaving this way, but he dismisses her feelings, saying, "You're so uptight! Can't you see I'm only kidding? I like to be lighthearted and have fun. You're such a stick-in-the-mud."

Although his wife has pointed this out on many occasions, Ned refuses to see that his behavior is felt by her as a hostile rejection. He insists that her perceptions are ridiculous. She can feel her insides knot up as she is coerced into ending the discussion.

Ned is an avid sports fan, but prefers to worship his athletic heroes in the presence of men. Sandra has tried to be included. She knows major league statistics better than most men, and she can name players in the NFL based on numbers. But Ned claims that his friends tease him about his wife's attendance at games by asking if he always has his *mother* along.

Money is a constant source of conflict. Although Sandra pays all the bills, she has learned to get Ned's permission before buying anything for herself. If she does not, he flies into a rage.

It is easy to see that Sandra is at risk. Ned continually denigrates her, but he denies it if she points it out to him. He refuses to discuss any matter that is important to his wife. On the other hand, she never refuses his need to communicate. In fact she welcomes having any time to talk.

This marriage is carcinogenic because the emotional entropy is such that the irritation flows constantly from the husband to the wife. She absorbs it and contains it all within herself. Sandra would not dream of discussing her marital difficulties with anyone. On the surface, her excuse is embarrassment. Beneath the surface, she suffers from a fear of intimacy. A marriage like this fits in perfectly with her with her autistic-stage conditioning. All irritation flows from him to her, and she must contain it or risk his elevated level of irritation being added to the irritation she already feels. Ned is her early mother. He will live to a ripe old age, while Sandra will probably succumb to cancer years earlier.

Whatever the problems are, no matter how absurd they appear to be, it is very important that a spouse always consider his or her mate's upset as the first order of business. The nature of the problem does not matter in the long run. It is how the two of them *process* marital irritation that does matter.

The following is another example of a couple in trouble:

Steven says that his wife, Helen, is totally lacking in passion. He feels unwanted because she shows no enthusiasm. He reports that she seems only to tolerate sexual contact. "She's so immature about it," Steven says, "that I feel like I am molesting a child." When he attempts to discuss this with Helen, it always turns out to be a monologue. She has nothing to say and remains unresponsive to any such discussions. If she does say anything at all, it is merely to say that she doesn't know why she can't respond. She feels attacked and belittled. Steven feels rejected and undesirable, but, for the most part, he tolerates and absorbs the irritation caused by her seeming lack of interest in a sexual relationship with her husband.

Helen never expresses closeness through sexual overtures. She cooks his favorite meals and tells him that is proof that she cares for him. At such moments, Steven feels like choking on the food.

Of the two, Steven is the far greater cancer risk. He admits that many of the women he dated prior to Helen were terrific sexually. He then adds, appearing totally perplexed, that the more they made it clear they genuinely cared about him and the more they took the sexual initiative to express love and devotion, the more he had a need to run. He even felt anger and disgust (a cover feeling for fear) at their expressions of love. Helen never behaved like this.

When they lie in bed at night, with Steven carrying on a monologue in his head about his problems and what he can do about them, he is once again a deserted, hyperirritated baby. He probably feels this way at the same time of night that he used to be left to cry himself to sleep.

Marriage can help reduce or add to our internal irritations, but marriage requires work to be anti-cancerous. Anti-cancerous marriage depends upon relative mutuality. If one spouse is the chronic giver and the other the receiver, a negative entropic system exists. Whether this centers on sex, the expression of feelings, or anything else, the system is one-directional. After a time, the receiver may learn to resent the giver's inability to receive. It comes across as a lack of desire for whatever this person has to offer. More important, it induces guilt, which turns into a feeling of resentment, and then both partners become self-contained.

Patient: I'm married to the original Earth Mother. She does everything, and she does it right. I've never known anyone so giving and caring. The trouble is that she's zero at receiving. I mean she does not know how to make me feel appreciated or wanted.

Analyst: Most men would be content to have all their needs met.

Patient: You don't understand. She is great at meeting all my needs *but one*. I have a need to be appreciated and accepted for what I can do, for what I can express! You know something? In a sense, she's very selfish. She deprives me of one of the most important aspects of my life, and *I* feel guilty about it. I know she had a rough time growing up. She was always performing, the top of her class in high school. She

keeps on performing and no one can get into her act. When I do something for her or give her a gift, I get the feeling that she is already trying to figure out how to outdo me! She cannot receive, and it is driving me crazy!

Anyone looking at this man's marriage superficially would assume that the wife is the giving, more mature partner. In reality she is a "performance anxiety" baby. The husband's constant acceptance, with no mutuality, is necessary for her to feel valued. She thinks of herself as a very giving person. Little does she know that she is overwhelmingly demanding. The husband is at risk in this marriage.

The first step toward achieving an anti-cancer marriage rests upon communication, but, unfortunately, words are not enough. When it comes to avoiding cancer, feelings and actions are far more important. Cancer stems from that time in life when we could not talk or understand language. All we could do was tune in to the feelings behind the words. In marriage, words can be cheap. But if the feelings and behavior do not change, all the talking in the world will not do any good.

Anti-cancer marriages are based upon feeling, behavior, and words. If a picture is worth a thousand words, a giving gesture in marriage is beyond value. When things are mutual and partners are equally mature, a great deal can be accomplished to assist each other in processing irritation through sharing. Sharing minimizes irritation; self-containment maximizes it.

If you do not have an anti-cancer marriage, work at it. If your spouse is uncooperative, you do not have to play the game by his or her rules. Your responses can help deal with the lack of cooperation. To begin with, do the opposite of what is expected. When he wants you distant and rejecting, be loving. Expect him to push you away. Do not fall for it! A reconditioning can happen if you do not respond as predicted. Throw the occasional curve ball. It can work wonders. Consider Paula and John:

John is the type of man who retreats into himself when upset about business or any other significant matter in his life. For years, Paula interpreted this to mean that he did not want to communicate with her, and she felt unwanted and rejected. She decided that something had to be done.

Rather than try to discuss the matter with him, something she often tried unsuccessfully, she managed to get past the symptoms and make physical contact with him when he was in his withdrawn moods. After several such significant preverbal and nonverbal exchanges, John almost miraculously began to talk about the problems that had caused his previous withdrawal and distancing.

The ideal anti-cancer marriage should have the following elements:

1. A shifting back and forth of the caring parental role.

2. Only one member of the couple can be angry at a time.
3. A desire to deal with and respect feelings as having priority over facts.

Shifting of parental roles in a marital relationship means that at different times irritation will be absorbed in different directions. Both genuinely will want to soothe each other with whatever works: talk, a hug, a giving gesture. Most important, both members of this team will provide this intimate caring when the other is hyperirritated. They will not permit retreat into self-containment.

Ideally only one partner in a marriage should get angry at a time so that the other can deal with the upset. If both are bordering on loss of control, then two hyperirritated babies are adding irritation to each other.

If facts dominate feelings, then at least one partner will be more correct all the way to the divorce court. When you can stop and say that nothing is worth this pain and conflict, you are on your way to an anti-cancer marriage. When each of you, at different times and together, can put the brakes on and ask, "What are we really fighting over? What is worth such an upset?" you are in a very positive relationship.

All three elements relate to the basic anti-cancer premise of not adding irritation to irritation while combating self-containment. All three necessitate emotional entropy and fusion.

But even if a marriage fails to meet these needs, it is better, in most cases, than having nothing. Remember that divorced and widowed women have significantly higher incidences of breast and cervical cancer.

If remarriage occurs and is successful, a carcinogenic situation can be avoided. The success of the remarriage may indicate that the need for a fusional relationship has finally been met. However, serial marriages suggest a strong possibility that an individual is unconsciously seeking fusionless relationships. It is a means of deceiving oneself. It is important to remember that we do what is familiar, not necessarily what is best for us. If this is your story, stop trying to fool yourself and recognize that you are avoiding intimacy.

Not everyone in a carcinogenic relationship will get or induce cancer. It is part of a constellation of dynamics that originates in infancy.

If your spouse develops cancer, it does not mean that you are the ogre who induced it. You are not responsible for establishing the autistic-stage instabilities. You did not teach your spouse how to maximize irritants.

But guilt is always present when a loved one is seriously ill, injured, or dies. No two people can live together without having some hostile thoughts for each other. Do not give yourself so much credit or power as to assume you could induce cancer in anyone who was not set up for it years ago.

On a more superficial level, guilt and the reasons for it are destructive to any marriage.

Prevention in Other Sexuality

Anything that is sexually pleasurable and agreeable to both parties, without causing pain, is potentially anti-cancer. However, recreational sex is just that, a recreation. It has little or nothing to do with emotional fusion, which only loving sexuality can promote. Orgasms can result in brief but powerful regressions to the intense, unfocused state comparable to that of the autistic-stage child. They can facilitate fusion or fight against it. They can become an object unto themselves, an end rather than a means, with potentially disastrous effects.

Patient: I don't know what to do anymore. Most guys would be ecstatic to be in my shoes. Almost every night, I can go to bed with a different woman. Three cheers for sexual freedom. The trouble is that I'm damned if I do and damned if I don't.

Analyst: Explain.

Patient: Well, before I make it with a woman, there is an excitement, the thrill of the hunt. I don't know. But if she tries to touch me after we have sex, my skin bristles! If she lights up a cigarette, I choke. I feel disgust at the touch and smells of her body. I never feel this way before or during, just after. But the worst is that while she's telling me I was the *greatest*, I'm feeling really depressed. I mean *depressed* – empty, hollow, like my insides fell out. The feeling is so unbearable that I commit the ultimate sin of the dating world over and over: I screw and run. Sex for me is like fast food for most people. It is valueless nutritionally, it just fills you up. After a few weeks of heavy contact, I can't stand the depression anymore. I stop looking for new conquests. It hurts too much. I can't remember the last time I stayed overnight with anyone. I am never going to meet someone I can marry, not like this. I'll probably die young, single, alone.

This man is exhibiting the typical anaclitic depressive reaction as it pertains to sex. Sexual intimacy for him is superficial. He is thoroughly, although unconsciously, afraid of genuine emotional attachment, but he realizes that his reactions are wrong somehow.

What we think of as old-fashioned romance most likely developed out of human infantile conditioning for fusion. Romance can be viewed as a repetition of the mother and child falling in love and getting used to each other. In the adolescent and adult versions, the mother and newborn roles switch back and forth between the partners. When people get to know each other before they go to bed together, they have a much better chance of developing emotional entropy. Control and placing feelings above sexuality indicate a mature degree of self-respect as well as a

desire to find a "workable" relationship. Sex is the final point in human development that permits an intense fusion.

Hypersexuality indicates a need for fusion that is not being met. Sex for sex's sake is indicative of an individual who denies his need to push people away by overcompensating with superficial closeness.

Devotees of sexual freedom maintain that a romantic attitude toward sexuality is antiquated. The sexually promiscuous would have us believe that sex is *just* a natural, biological function - as natural and therefore unrestricted an act as eating or eliminating. However, it is possible to survive without sex. Try that with eating or elimination.

The similarity is valid in another sense. The baby's earliest mechanism to reduce irritation is through the process of eating and elimination. Freud saw this removal of irritation as pleasurable for the infant. According to Freudian drive theories, the concept of pleasure and sexuality are interchangeable. This is an unfortunate choice in terminology. The feeding infant experiences pleasure as the hunger pain is removed. The organ systems involved with eating are the areas of the body that experience the pleasure - that is, they experience a significant reduction of irritation.

Pleasure easily can be seen as a sexual concept. Reduction of irritation entropically cannot be viewed this way so easily. Most of us are unaware that our sexual behavior is motivated by a desire to reduce all tension, not just sexual tension. If we view sex on a simplistic, superficial level, we are not taking this into account. After all, how can we trust our deepest feelings or show our vulnerability to relative strangers or people we know are only pursuing their own gratification? Promiscuous sex provides only self-contained release of tension.

The appeal of promiscuity can center, at first, upon a need to rebel against authority. Doing something that is questionable in society is appealing to the adolescent residuals of rebellion. However, its continued practice also can indicate that an individual is too frightened to let someone in.

One important symptom of self-containment is an obsessive need for orgasms. Masturbation is the bottom line of self-containment. As early as the Kinsey study, it was clear that almost everyone did it, and the rest probably lied about doing it. When masturbation becomes obsessional, however, it is symptomatic of self-containment and a need to modulate hyperirritability internally. Masturbation is an asexual act. It is the search for the soothing that mother should have provided, acted out through fantasies of her substitutes. It can be followed easily by anaclitic depressive reactions. Masturbation emphasizes, rather than reduces, isolation.

Extramarital sex and promiscuity are one step up from masturbation. You are almost certainly lying to yourself if you claim that you indulge in extramarital sex because of a

horrendous marriage and that you must seek fusion outside of it. "My wife doesn't understand me" can be a doubled-edged lie. She may not, but you probably do not understand her and/or yourself either. How will casual sex with someone else help you understand either? If she does not understand you, perhaps her own need to fuse clouds the issues. Perhaps, your need to resist fusion clouds your understanding.

If you truly want the opportunity to fuse, you either will try to make your marriage work or get out of it. Then you can begin the search for someone to whom you can freely and openly fuse. However, you will not find such a person on the next stool in a singles bar. Stop kidding yourself. The joke can be lethal in the long run.

I still believe in motherhood and apple pie, and even eat an occasional hot dog, nitrates and all. But when it comes to sex, my position is not based on morality or religion. Sexuality is one of the personality factors that contribute to an individual being precancerous or relatively immune. I advocate behavior that, I believe, will assist in developing immunity.

Prevention in Old Age

Old age is a high-risk time for cancer. Biologically, the degeneration of cellular material, particular chromosomes, and genetic materials can be said to be the obvious cause. After all, a woman over thirty-five is at greater risk of giving birth to a genetically-defective child than a twenty- or thirty-year-old. By age forty, the odds increase astronomically. This is caused by the shifting of genetic material on the chromosomes. These instabilities occur in the nucleus of the ovum. *Body* cells undergo the same type of degeneration. But this degeneration alone does not cause cancer. Age, as it relates to cancer, leads us back to the realm of external and internal carcinogens. People in the Caucases and Peru frequently live to be over 100 and free of cancer. Aging is not an answer in itself.

One person works in an asbestos factory for a brief time and then finds new employment; another person works there for years. Statistically, the long-time employee will run a much greater risk of cancer because the chemical irritation is cumulative. It builds up over time.

Two recent medical school graduates decided to specialize in treating and researching cancer. After a couple of years, Dr. A. found dealing with such patients depressing, and he completed a residency in another specialty. Dr. B. developed all sorts of defenses to guard against the emotional irritation of his practice of oncology. He had a reputation for being detached from his patients' feelings but highly competent medically. Twenty-two years later, Dr. B. died from a soft body-tissue cancer.

The emotional irritations caused by Dr. B.'s specialization were cumulative. Eventually, an instability was reached and the landmine went off. The greater the depth of the placement, the more it is protected and the longer it can take for the cumulative effects of irritation to reach the site.

Whether the irritation is external (asbestos) or internal (the strain of being an oncologist), the effects will accumulate over time. It can take until the person is sixty-five or eighty-two.

Other aspects of aging and cancer are based upon the intangibles, life events and the feelings surrounding them. A sudden and abrupt end to a significant emotional entropic system is a cause of cancer. The elderly have lost most of their close relationships through death. Previously, I pointed out that most of us know someone who lost a spouse and died of cancer soon afterward. Losing parents usually correlates to cancer only for the very young. Losing a husband or wife, a child, a sibling, or even a job, correlates to cancer in adults. In certain age categories, friends and relatives can die within close time intervals. If this happens to young adults, as in war, the incidence of cancer also is elevated. Repeated losses can be biologically and emotionally intolerable for many individuals if they had the necessary infantile conditioning and instabilities.

If you have a parent who has suffered a loss, there are important matters to consider to assist in his or her survival. If the marital relationship was loving, people can adjust more easily. If it was not, guilt over the death of the spouse can be pronounced and the need for punishment fulfilled by social isolation.

Help your parent to be in situations in which his or her contemporaries are present. If socializing is not permitted because of mourning traditions, be there for your parent. Have the grandchildren accessible. And, regardless of *your* feelings of disloyalty, encourage remarriage if at all feasible. Allow your parent appropriate time for grief, but try to help to keep it from continuing for more than six months. Even that relatively short period of time is risky in that malignancies can develop in the bodily cauldron of internal carcinogens from the reaction to grief.

Another part of aging is the regressive aspect of growing old. The individual becomes more and more dependent as physical limitations set in. Older people need help but may be "too proud" to admit it. Often, they are too anaclitically depressed to admit it. A great deal of what is commonly referred to as senility has remarkable similarities to an autistic-stage regression. Grandpa may be lost in his own thoughts a great deal of the time. Grandma may not hear what is said because of autistic residual rather than a hearing loss.

Thus, in old age, the accumulation of internal and external carcinogens can be coupled with a clear regression with marked autistic qualities. This corresponds to rapid cell growth at any age. The body is vulnerable to this growth – to cancer.

Always treat the elderly as older adults, not infants, in order to help combat the autistic regression or residuals that are a necessary part of cancer development,. Ask for their opinions, engage them in conversation and physical activity, and have them do whatever they can for themselves. *Do not infantilize the elderly.*

If they can work, they should be permitted and encouraged to do so. But they should not work in or around chemically or physically carcinogenic situations. No one should - but because of the accumulations of carcinogens throughout the years, these irritants can be more hazardous with age. Work can help keep self-esteem high. For some people, retirement is equivalent to a death sentence.

Prevention During Stress

During the 1980s and 1990s, a new mental health field opened up. Originally, its purpose was to help top-level executives cope with "stress." After several years and a lot of money, it became obvious that top-level executives did not need, nor did they benefit significantly from, workshops or counseling on stress management. As a matter of fact, they seemed to thrive in high-stress environments. It was when the stress was removed that they became vulnerable to psychosomatic disorders.

Freud pointed out that preoccupation with external problems prevents the emergence of *internal* conflicts into the conscious mind. Top executives often are obsessive-compulsives who show signs of tunnel vision and total emersion in challenging problems. Perhaps their internal conflicts are far more dangerous than any external stress. The drive or need for success can be an enormous defensive structure, preventing the awareness of internal conflicts.

The dominant internal issue is anxiety. Anxiety is not based upon reality. It is a residual from the past that can permeate all aspects of the being. Perceptions become distorted, making situations that are not anxiety-provoking for most people highly threatening for the person suffering from chronic anxiety. Stress is not the equivalent of anxiety. It is based upon reality and would be perceived as threatening by most people.

For a top-level executive, stress is manipulative, anxiety is not. Stress helps control anxiety for these people. As long as they can manipulate the variables leading up to stress, they love it; they thrive on it.

Seeking out stress is an anti-cancer defense for anyone whose anxiety reactions would produce overwhelming levels of internal carcinogens. As paradoxical as it may seem, stress apparently reduces the internal irritation of personalities prone to anxiety. However, this stress is based upon matters that can be influenced by the individual. Top-level executives have a say in what stressful issues they will deal with. They make the decisions that result in success or failure for entire organizations. One would think this enormous responsibility would be extremely harmful. Not to these men and women. They have ways out that are directly under their control.

Carcinogenic stress occurs when an individual does not *need* stress as a defense or when the variables of stress are not under the victim's control. The stress-management people made an important discovery when they found that middle-management personnel were subject to many kinds of psychomatic disorders, including cancer, when under stress. Why?

Middle-management personnel are in positions that can stimulate easily a reactivation of early conditioning for anxiety. For them, the causes of stress are often beyond their ability to manipulate. They are at the mercy of both the top-level executives and the people they supervise. They must meet the needs of these executives. In a sense, they must "baby" them, be concerned for their feelings and reactions. But middle-management must also meet the needs of the people working for them. At times, they must choose between cajoling and coercing to get them to produce.

Middle-management personnel are the business world's negotiators. They are the parents to both sides. They absorb everyone's irritation. They are the implementers of executive decisions. They are the recipients of negative morale, corporate malingering, and even conscious and unconscious sabotage. No one is there to absorb their irritation. Emotional entropy is not part of their work situation. Self-containment is far more likely to be the enforced psychological position. Stress for middle-management executives translates to coping with upsets and irritation from everyone. They cannot readily manipulate the variables or dissipate their own irritation.

Any stress that allows an individual to defend against anxiety and overwhelming internal carcinogens is anti-cancer. Any stress that places the individual in high performance anxiety situations in which the variables cannot be manipulated will produce high levels of internal carcinogens. Any stress that chronically places a person in the parental role while allowing for minimal dissipation of hyperirritation is highly carcinogenic. Middle-management personnel *must* turn to other areas of life for fusion and emotional entropy. Unfortunately, their upsets frequently result in anaclitic depressions. They can take out their frustrations on the people who care most about them, making it very difficult for them to receive what they really need: verbal

communication with a supportive loved one or, better yet, physical affection. A hug makes irritation leave the body as muscles relax and tensions fade. In the extreme, weakness can be felt as the entropic system is activated and working.

Three rules for the middle-manager:

1. Do not be stoic.
2. Do not be macho.
3. Do not be self-contained.

Prevention Through Exercise

> "I run 3-4 miles every evening after work. My dog runs alongside of me and is good, quiet company. I notice some strange things happen when I run. My mind drifts through everything from Aristotle to business. It is strange that if I think of upsetting things when I am running, they don't seem so bad. I can't stay miserable about anything. When I think of bad things, I notice I exert myself a little bit more. It's as if I throw whatever it is off.
>
> I notice my senses change. I know that sounds really way out, but listen to this. I figured this out because of my dog. On the way to the park where I run, my dog always urinates and defecates in the same area. Lots of other dogs use the same spot. I never notice the smell on the way to the park. I always notice it on the way back. I know you think it is because I'm breathing hard, but that's not the case. By the time I walk past that spot on my return, my senses really feel fine tuned. A rough towel after my shower can feel like sandpaper. I feel sexier and younger. I'm burning more calories, but I'm not as hungry. That I don't understand.
>
> It has become like a drug. I feel really bummed out if, for some reason, I can't run. I'm nervous and tense. I even have to control snapping at people. I need the discharge running provides."

This man was one of a number of athletes I interviewed: runners, weightlifters, aerobic dancers, tennis players, and golfers. The joggers and weightlifters had the same reaction as the runner. This reaction can be anti-cancerous. Social contact, music, and competition prevent this phenomenon.

As a person runs or lifts weights, the voluntary muscles are being used, with little mental involvement for successful completion of the task. Skill requirements are minimal. This permits the mental drifting that our runner describes. If your mind drifts like this while playing competitive sports or trying to keep in step with the aerobic dance class, you will lose miserably or stick out like a sore thumb. These activities require mental commitment. Running, bicycling, and weightlifting, in noncompetitive ways, do not. Simply stated, they permit a temporary regression to autism. As your mind drifts, you go in and out of this state. Coincidental with this regression is a powerful discharge of irritation through the voluntary muscles. Exercise on this level can be preventive and possibly somewhat curative with regard to cancer. The sensory vulnerabilities of infancy get reactivated. At the same time, an efficient dissipation of irritation is taking place emotionally and physiologically.

Studies indicate that people feel increased sexual desire after jogging or running. This relates more to a desire for fusion than elevated hormone levels.

The entire process is a repetition from early infancy. Every day that exercise on this level takes place is another day of emotional re-education if these guidelines are followed:

1. Exercise in isolation.
2. Do exercise that does not require concentration.
3. Avoid becoming competitive or training for competitive events.
4. Exercise without any distraction, such as music or conversation.

If these principles are adhered to, this is, perhaps, the only individualized program of anti-cancer dissipation of irritation. But it is not an adequate anti-cancer program by itself. The necessary reconditioning for processing of irritation cannot occur through exercise alone. It is best to view exercise of this nature as a stopgap, almost emergency, measure. It should be part of a daily routine for high-carcinogenic-stress individuals, but it is equivalent to putting a dressing on an unsutured wound. It is not enough, but it is better than nothing.

Prevention of cancer, with the exception of exercise, is never a do-it-yourself proposition. “Do it yourself” is, in itself, a carcinogenic concept. Prevention of cancer requires fusion to another human being. It requires an emotional entropic system to dissipate or minimize irritation.

Cancer prevention is a “do-it-yourselves” proposition.

Chapter 10 - Spontaneous Cures: How They Relate to All Cancer Patients

A semantic difficulty arises in medicine and psychology when we discuss people who recover from cancer without medical or psychotherapeutic intervention. The common medical term for such an occurrence is *spontaneous recovery*. In psychology, spontaneous recovery means the natural propensity to return to earlier patterns of conditioning. It is the return of previous learning following attempts (either conscious or unconscious) to extinguish or turn off this learning.

If you have not ridden a bicycle in ten years, we might consider the ten-year interval as extinguishing the previous learning. The old adage that once you learn to ride you never forget is an example of spontaneous recovery. With very little effort, you fall back on the previous conditioning.

Psychologically, spontaneous recovery would mean a return to the precancer symptoms or conditioning of emotional and physical responses to irritation, which would logically lead to another cancer flare-up. Medical people call this a reoccurrence.

Therefore, for the sake of clarity, any reference to recovery from cancer with little or no medical or psychotherapeutic treatment will be referred to as a *spontaneous cure* from this point forward.

Most of us have heard about cases of people with cancer who had little or no medical treatment, or whose treatment was stopped because their cases were considered hopeless, yet apparently were cured. Perhaps, they decided to trust in God rather than the medical establishment. Maybe the cancer was so advanced that their medical teams felt there was not enough likelihood of success to warrant the discomfort and dangers of treatment. Perhaps there were pre-existing medical problems that precluded full-blown chemotherapy, radiation, or surgery. Whatever the reason for not receiving full treatment or any treatment, these people got better. Why? The experts appear to be baffled. "These things happen with cancer. We don't know why, but we do know it happens."

These cases require very careful investigation, both medically and psychologically, in order to shed some light upon possible means for the prevention and cure of cancer. Who does not get cancer can be as important as who does. Who recovers and why is more important to investigate than who does not. Therefore, spontaneous cures should not be dismissed as oddball medical curiosities. They can hold significant answers to which we have been paying little attention.

What we do observe in many, if not most, cancer patients is a medical process referred to as *cachexia*. This is the term for the sudden and shocking weight loss, weakness, excruciating pain, and general wasting away of the victim of this disorder. If you have ever cared for a terminally-ill cancer patient, you have seen these horrors and cannot easily forget their extremes. Many, if not most, terminal cancer patients die from the effects of cachexia rather than from the cancer itself. Pneumonia, failure of the heart or other organ systems, infections, and metabolic poisoning are, perhaps, the most common side effects of the *process* of cachexia.

This process has received little attention in the United States as opposed to the Russia, for example. We appear to be obsessed with the tumor and/or the neoplastic cells of cancer, when we should be considering cancer to be a *process*.

Cancer cells or tumors drain nutrients and therefore energy that normally would be distributed to the cells that are still doing their metabolic jobs. Cancer cells just reproduce and rob other cells of their life-support systems. Rob may be an understatement. They commit monumental grand larceny – more like the Brink's job than shoplifting. Energy sources and reserves are depleted. Cachexia is the biological representation of the psychological phrase

"eating yourself up alive." The process accelerates as the cancer cells reproduce and spread. Even if the victim could consume a great deal more food than usual, the tumor would drain the energy provided so that consumption would become a losing battle. Typically, cachexia is somewhat accelerated by an aversion to food.**

Chemotherapy for most cancer results in nausea and diarrhea, thus causing loss of appetite and hastening cachexia. The lining of the digestive tract is rapidly reproducing

** The act of eating has tremendous psychological value, however. For the cancer-ridden, it means accepting food from someone else in order to sustain life. This may be the value of coaxing the victim to keep eating regardless of discomfort. The patient must feel the caring of the nutrient provider.

tissue and being attacked by the poisons oriented toward any rapidly reproducing cells in the body. Cancer patients frequently stop almost all eating, just as the cancer puts its most intense drain on the energy reserves of the body. The body starts to consume itself.

In every case of spontaneous cure that I have studied, the apparently doomed individual decided cachexia was not going to defeat him. In order to fight this process three elements were common to all:

1. Spontaneously cured patients forced themselves to eat.
2. They developed an obsessional drive for physical activity.
3. They resisted the regressive aspects of the disorder.

In other words, they refused to stay alone, they occupied their minds, they fought depression with feelings of anger and determination to overcome the situation.

These spontaneously cured patients suffered from leukemia, pancreatic, lung, metastasized breast, and colorectal cancer. Medical experts agreed in all cases that these people were doomed. They all survived more than seven years.

The first step is self-inflicted forced feeding. The patient must eat! And he must eat well-balanced meals to avoid carcinogenic irritation from eating predominantly one kind of food.

One person I spoke with explained that, at first, he threw up almost everything he ate. He would rest just long enough to end the urge to regurgitate, and then eat some more. It was

almost as if he were telling his stomach and esophagus that he was not going to let them give control to the cancer. Eventually, the regurgitation stopped.

He followed none of the more learned approaches to nutrition and cancer. *He just plain ate!* He knew nothing of the technicalities of what to eat. He did know that if he gave in to the impulse to refuse food, he would die.

This man's cancer was pancreatic. Only two percent of pancreatic cancer victims live for five years beyond their diagnosis. His pancreatic cancer was diagnosed over twenty years ago!

For this man, and for many others, the act of eating can be just as important as the nutrients consumed. In a weakened condition, the *apparently* terminal cancer victim is placed in a dependent role. He certainly cannot prepare his own meals and may even have to be fed. Being fed is a return to an early infantile position. Food represents the nurturance necessary to sustain life. Thus, it can be used as a means of communicating that the caring individual genuinely wants the cancer patient to survive.

Spontaneously cured people eat. It is as simple as that.

They also move. Within the guidelines set by medical experts or totally on their own, they get up and move. Those of us who have convalesced from any illness know that if we stay in bed "resting," we really are staying in bed weakening.

Cancer puts a drain on one's energy reserves, so it seems that conserving energy would be wise. However, this does not seem to be the case. In all the spontaneous cures I have studied, the people moved.

Sometimes, the effort involved was staggering. Mrs. A. spent over an hour getting from her bedroom to the kitchen table. She associated eating in bed with dying in bed. Her parents had died this way, and she was not going to let herself follow suit. After eating, she would sit and talk with her family for a while, then spend the next hour working her way back to her bedroom.

This fifty-one-year-old woman had undergone many medical interventions. Surgically, she had had a radical mastectomy and a hysterectomy. Chemotherapy had been used, but seemed only to weaken her. Radiation also had been used postoperatively. But the cancer kept spreading, in spite of all these efforts.

It was obvious to Mrs. A that nothing was working, and so she said, "No more." She took over. Her doctor told her family that, at most, she had a year to live.

When she took charge, her condition appeared hopeless. She had lost almost 20 percent of her body weight. Her skin was ashen, and her hair was almost completely gone. To keep her comfortable, her physician had prescribed pain medication, which left her feeling tired and out of touch with the world. Somehow she knew that this would destroy her if she continued it. On her own, she gradually withdrew from the pain medication. She grew to fear it as if it represented death itself. She may have been right.

If, as I have theorized, rapid cell reproduction is often tied into an autistic regression, then pain medication may facilitate both. The weakness it causes will help keep the person spaced out and isolated. The use of depressants in cancer treatment promotes the emergence of autistic residuals while repeating the original conditioning of self-containment of irritation. These drugs do not encourage meaningful relating. Instead, the user looks, sounds, and, in most ways, acts extremely self-contained.**

Mrs. A. had welcomed the relief from pain, but the isolation and feeling of loss of control were terrifying. She knew they spelled doom, which gave her the strength to go against everyone's advice and gradually stop the pain drugs. In so doing, she may have affected the rate of cell reproduction. In other words, she may have interfered with the process of negative psychoplasia.

Her methods were based upon her unconscious awareness that she must do everything to contradict what the cancer seemed to dictate. If she was nauseated, she ate anyway. If she was weak and tired, she forced herself to move. The more she wanted to be left alone, the more she forced herself to relate to loved ones. She even explained to them that they should not fall for her occasional nasty anger. She told them not to let themselves be pushed away, no matter what. Fortunately, her family understood and tolerated the abuse she occasionally heaped on them.

She was a potter by avocation and had her wheel in the basement. She retured to this hobby as soon as she could. Her only concession to her disorder was to replace her pedaled wheel with an electric one. She could not work at her former speed. What used to take two hours now required eight, but she stuck with it and created some beautiful pottery.

When she worked on her pottery, she planned the pieces as gifts for her family and friends. Thus, although she was alone and isolated while pursuing her hobby, she had others in mind. She also was discharging irritation through her voluntary musculature.

Her cachexia stopped, and color returned to her skin. She began to look more like one foot was out of the grave. Within a few months, she even looked like both feet were out. There

was no adequate medical explanation for her recovery, although her doctor sent her to a number of specialists hoping to get one. They either suggested that the standard procedures had finally worked, or they candidly admitted not knowing.

**If such medication seems necessary for the cancer patient, it should be used only to take the edge off, not remove, the pain. Lamaze techniques of childbirth are based on a counterconditioning that shows remarkable ability to reduce pain. Similar techniques might be of use to the cancer patient. Most important, they would require that the cancer patient relate to a coach, not a drug, for entropic removal of irritation (pain).

As a young graduate student, Professor W. developed colon cancer. He had surgery performed, as well as radiation and chemotherapy. When a reoccurrence of the disorder took place, he was told that nothing more could be done. But he was determined to defeat the cancer.

At about this time, he met a young woman whom he subsequently married. He was totally candid with her about the frightening facts of his cancer, but, remarkably, she accepted him regardless and remained consistently supportive. When he became depressed and wanted to give up, his fiancée threatened to leave him if he did not continue his fight against cancer. The two of them researched nutrition, other medical techniques, and different kinds of alternative approaches, and came to the conclusion that very little was making sense. They put together their own program for his rehabilitation. It included six to eight meals a day, plenty of movement and vigorous exercise, and a refusal to permit him to give up the music, art, and athletics that he had so much enjoyed in his precancerous existence. The program worked. Professor W. has been happily married for ten years now, is the father of two children, and has shown no signs of reoccurrence of cancer.

All of these people recovered from cancer that "should" have killed them. They interfered with the psychological connections to the biological symptoms. They moved and discharged irritation through the voluntary musculature, much in the manner of the newborn. They resisted the cancerous conditioning of refusing caring from others. They refused to permit the self-containment of the autistic stage. The negative psychoplasia was replaced with emotional entropy in which irritation was shared by the family. It is this interference with negative psychoplasia, along with reconditioning to process irritation entropically with others, that forms the basis of my recommended psychotherapeutic treatment plan.

All of these people have that certain spirit that makes them fight harder in the face of overwhelming odds. They are highly focused and can persevere when many others would give up. They almost appear to enjoy their defiance of cancer! They are proud of their victories, and they are entitled to this pride.

The three steps previously stated work because they buy time and/or a cure in itself. My suggestions are not intended to assist the individual to deal with death and dying. This approach is designed to promote life. There is too much to be accomplished and too little time to waste it on preparing for failure.

The next chapters deal with psychoanalytic treatment of cancerous and precancerous individuals. We cannot correct instabilities, but we can re-educate individuals to process internal and external irritation differently. When this happens, the body's defenses can stop fighting a losing battle and start to win.

It is very important to remember that relying upon one's ability to achieve a spontaneous cure alone is hazardous and usually fatal. But what we can learn from spontaneous cures can greatly help cancer treatment.

The following chapters are for both the professional and the layman. I apologize to the layman for some necessary technical language in Chapters 11 and 12. I do want to make the point that understanding a psychotherapeutic treatment plan will not affect anyone's ability to be treated. If my approach makes sense, perhaps I can motivate some victims and potential victims to consider seriously such a course of action. After all, why would anyone leave any reasonable stone unturned?

Chapter 11 – Treatment

We shall not cease from exploration and the end of all our exploring will be to arrive where we started, and know the place for the first time.

T. S. Eliot

In a sense, diagnosis of a precancerous personality, or even the awareness that one is treating a cancer patient, is irrelevant. Any psychoanalysis that integrates learning theory and drive theory should have the emotional re-education of the patient as its aim. A complete emotional re-education for any patient implies that access to autistic-stage feelings has been achieved. To do this, the patient must regress through the anaclitic depression.

Our greatest ally in gaining access to the autistic stage for the cancer patient is the *cancer itself.*

The Autistic-Stage Cancer Patient

With patients who do not respond to medical treatment, deterioration is hastened by cachexia and medical intervention. Medication, pain, and fear have these patients in a thoroughly regressed state prior to entering psychoanalytic treatment. Often, they are so weak and depleted that family and friends must help them into the analyst's office. Once there, they seem childlike in their lack of defensiveness. At the first session, they will show obvious signs of autistic-stage functioning. They will be in and out of awareness; they will even doze and then suddenly awake. Their mental activity is far away; their eyes have a distant look. Perhaps, if they are very near death, they will report seeing spots or lines of light. There is a peacefulness and longing in their expression that hides the overwhelming irritation to which they have been subjected.

The analyst usually will see improvement in such patients almost immediately, if he or she acts promptly and firmly. In order to comprehend this, a simple fact must be understood about the anaclitically-depressed children Rene Spitz studied (see Chapter 12). Their recovery was prompt, if a loving mother returned before it was too late. The analyst who works to replicate a loving, autistic-stage, mother-baby fusion will be the mother returning in time.

With advanced cancer patients who are functioning on an autistic-stage level, the analyst must intervene powerfully and convincingly to begin the recovery, as in the following example:

Analyst: What is cancer? What have you been told and/or read?
Patient: Cancer is the most horrible disease anyone can get. It is an unmerciful killer with pain

and suffering every step of the way!

Analyst: You're wrong. Stop thinking of cancer as a disease – it isn't. Cancer is a process in which your own cells are reproducing at an infantile rate. There is no good reason for this rapid cell division, such as healing or growth. It's your own cells regressing to infancy, when cells reproduced this fast normally. Most processes in the human body that go one way also can go other ways.

Patient: What do you mean it is a process and not a disease?

Analyst: There are no pathogens, no germs connected to it. Some viruses can irritate like any other irritants or carcinogens. No germs, no bugs, no bacteria, really no viruses, so I do not want to hear the word disease, sickness, or illness anymore. You have a disorder, a process going on, and if you work with me, it is my job to reverse this process. You just have to cooperate.

Patient: How will talking with you, or anyone else for that matter, reverse this process?

Analyst: You have two major systems in your body to protect you from external and internal threats. Do you know what they are?

Patient: Well, you have adrenaline to fight or flee from bad guys or attacking animals.

Analyst: What about inside threats like bad bacteria, viruses, or cancer.

Patient: You have white blood cells for that. Aren't they supposed to eat up the inside bad guys?

Analyst: Yes, they are. But sometimes we have a failure of our immune systems. If we produce too much flight or fight adrenaline, all or most of the time our immune system slows down. This is not a theory; it has been demonstrated from blood studies. So, it is my job to slow down this chronic adrenaline and speed up the good-guy white cells in your blood to kill cancer cells unmercifully.

Patient: I read somewhere that everyone has cancer cells in them 24/7. That it is stupid to think our cells are always reproducing the right way. So what you are saying makes sense.

Analyst: If you agree to treatment now, I want you aware of the fact that you are stuck with me. There will be no leaving me until you are better. Any important decisions must be discussed here first.

Patient: OK (Smiling broadly)

Analyst: I'm taking over. You're mine now.

Patient: Everyone else was so "iffy." I know you won't believe this, but I feel better already.

Analyst: I'm glad, but there will be ups and downs. The important thing to remember is that you and I will see this through *together*.

Patient: (Laughing) I don't want to leave. When can I see you again?

The analyst must replicate immediately the autistic-stage mother-baby relationship. He should not be cautious or exploratory with such a patient. Such caution will place the analyst in the same category as the other medical professionals who state probabilities and statistics about survival. They say things that make the patient aware of his fears and doubts about his recovery. They express hope reluctantly because of a desire to avoid fake optimism. The analyst, on the other hand, cannot be protecting himself from possible failure, considering the medical realities of his new patient. Fusion must be worked toward immediately; hope must be reinforced immediately; responsibility must be assumed immediately.

To anyone but an autistic-stage cancer patient facing death, such an intervention would be viewed as absurd and bizarre. The precancerous or optimistic cancer patient would think that such an analyst has a problem with omnipotence and a desire to own a condo on Mount Olympus. The cancer patient who has abandoned adult functioning under the pressure of the disorder and its treatment will view the analyst simply as unlike everyone else.

For this desperate patient, there is no anaclitic depression to be reached through psychoanalytic regression. It has been reached and passed through because of the severe effects of the cancer. Years of building safety in the traditional therapeutic relationship before a patient will allow access to the autistic stage have been brutally stripped away by the cancer. It is almost as if, in its arrogance, the cancer has exposed its Achilles' heel.

The analyst must take this opportunity before it is too late. If there is life and an ability to communicate in any manner, there is hope!

After the initial contact during which the deeply-regressed cancer patient is "adopted," the analyst must periodically reinforce the maternal role:

Patient: Everyone is saying I'm looking better. I do feel better and I'm eating again. But they all think it is because the chemo is finally working. I don't think so. I haven't had any in months. When I tell them it is because I'm coming to you, they pooh-pooh it. And it gets me upset.

Analyst: They don't have to approve. You and I know what is going on. Everything between us is special. They wouldn't understand. Don't upset yourself trying to convince anyone. It's our secret.

Patient: They all think I'm talking to you to learn how to accept what's happening. When I say that I hear your voice saying that you will work with me only for a cure, they don't believe it. No one has said that to me in two years. When you first said it, it was like a breath of fresh air. It's like my mantra now. Only a cure, only a cure.

The patient continued to express a desire to get better. But, at times, he was fusing by trying to please the analyst with claims of miraculous improvements, which represented a reverse

entropy. The analyst told him that he was expected to feel discomfort at times and even to be upset and depressed again. With this permission granted, the patient was able to report feeling overwhelming bodily sensations and being out of touch with his environment. When the analyst was aware of such stages, he had the patient close his eyes to facilitate the regression, and the autistic sensations became even more powerful.

The cancer patient should be instructed to use the couch as soon as possible. Eye contact is fusional in the original autistic stage. We all have witnessed the intensity of a mother and her baby's eyes meeting together in a fusional gaze. But eye contact for any adult, even an autistic-stage patient, can cause discomfort and confusion. The patient may feel embarrassed at being stared at or misunderstand the analyst's facial expression.** Although infants can experience fusion through eye contact, adults have had too many unpleasant experiences being forced to look perceived tormentors in the eye for this to happen. You can recall your own discomfort when a parent or teacher forced you not to look away while verbally attacking you.

Another reason I recommend the use of the couch is to facilitate repetition of the bodily sensations of the newborn stage. The bodily position of the newborn is one of reclining and looking up. However, the analyst should instruct these reclining adults to close their eyes, which permits patients to get lost in themselves. This is the nature of autism. Thus, closed eyes are the regressive partner of the reclining position.

As the patient goes deeper into the autistic state, he will report feeling strange bodily sensations. Extreme fluctuations may occur. For instance, the patient may report that his limbs

** Freud eventually admitted he had patients use the couch to avoid eye contact, which he found intolerable. Interestingly, Freud died from cancer. He also was, in my opinion, anaclitically depressed. Eye contact would not have been his forte.

feel heavy and then light, or perhaps they tingle. Some patients say that they feel crazy at these times. They are correct in that they are passing through the developmental stage that relates to the psychotic defenses. Observation of the patient's movements is of utmost importance as he undergoes the reactivation of the neonatal stage. When he is experiencing hyperirritation, he will attempt to discharge it through fidgety movements. If this defense remains purely autistic, feet or hands can shake, arms or legs can move, knees alternately can be drawn up to a bent position. This is the newborn's means of discharge through the voluntary musculature. With the adult

autistic-stage cancer patient, this movement appears involuntary and is quite similar to that of the overstimulated newborn.

The patient may resort to higher-level defenses if he is fluctuating between autism and symbiosis (awareness of an inside and an outside). In this case, movement will be the same, but the patient also will intermittently cross his arms or legs, intertwine his fingers, or touch his abdomen, head, or chest.

In both instances, the analyst should instruct the patient to remain still and not permit him to hold onto himself. In other words, he should not permit a closed, self-contained system. Taking this defense away will result in further verbal expression of primitive sensations.

The first time an analyst witnesses such a physical reaction can be startling. He can fear the patient is evolving into permanent psychosis. In order to stop this phenomenon, all the analyst has to do is ask the patient several successive questions or instruct him to sit up. The reaction disappears immediately as the regression is terminated abruptly. However, the analyst should allow at least five minutes for the patient to compose himself before he leaves.

This state of hyperirritation provides the opportunity to recondition toward fusion. But the patient will not demonstrate these raw feelings unless the analyst is calm and dedicated to soothing. The patient always anticipates that the involuntary reactions of the analyst will be similar to the autonomic reactions of the maternal figure. He must feel secure in order to be able to tolerate the discomfort of the hyperirritated stage in the presence of another person. The analyst should intervene minimally while the patient is functioning primarily on an autistic level, keeping in mind that the purpose is to establish the appropriate emotional entropy that should have been learned the first time around. The analyst should remain silent unless he is needed to foster the re-education. Remember that he is dealing with a *totally* preverbal conditioning.

The analyst merely has to be there with a genuine desire to cure the patient. Words do not matter to autistic-stage people (infants or adults). The tone and the feeling of a communication is, without a doubt, far more important than the content of what is said. At times, words actually can cause an interference and be viewed as grating irritations to a patient at this stage. The analyst is there to meet the patient's emotional needs; therefore, he should wait for the patient to speak first. If the patient is being asked to respond to the analyst, it is a reversal of emotional entropy. The analyst instructs the patient to speak at the beginning of treatment. That is all the instruction that is necessary. Merely saying, "Talk to me," is enough to establish whether the patient is resistant to communicating charged thoughts or feelings. With an autistic-stage cancer patient, any words beyond those that contribute to the fusion are superfluous and potentially irritating.

As the patient begins to improve, his family can become a problem for the successful continuation of treatment. Just a few weeks ago, they were contemplating funeral plans. They

had become afraid to hope; they had been preparing for the loss of a loved one. The physicians had made it clear that there was little, but more likely no, hope. They speak in terms of how much longer the loved one has left. They can believe that the analyst is perpetrating a cruel hoax. They are afraid of what they do not understand. At times, family members will attack the treatment and become reluctant to cooperate.

Regardless of how tempting it would be to bring the family together to help manage such resistance, the analyst would be wise to exclude them. Any other person present when the patient and analyst are together will be viewed by the patient as an interference with the fusion. Any other person present also will interfere with the expression of autistic-stage sensations. It also is important not to see the family separately from the patient, for this could make the patient feel betrayed.

The analyst should keep the family away, and rely on the patient's urgent need for contact with the analyst to resolve family resistance to cooperation. Even if the family is resistant, the patient's need will not be denied. Above all, the purity of the fusional relationship must be maintained.

For this reason, the analyst should not begin treating such patients unless he is as certain as possible that he will not have to leave the patient for at least several months. A vacation or even a medical emergency for the analyst could prove to be a separation of disastrous consequences. Analysts should plan as carefully as possible for such contingencies.

As the patient progresses through the autistic stage and into symbiosis (the beginning of object relations), he no longer will need the defense of the infantile, or anaclitic, depression. If the autistic-stage issues were dealt with to promote fusion, the patient will not have to defend against contact with the outside world because the analyst is viewed as safe to relate to. When the patient was hyperirritated during treatment, the analyst was soothing and comforting. Emotional entropy dissipated the patient's irritations. His involuntary nervous system was being reconditioned to seek soothing and comfort from another human being. The biochemistry that contributed to the activation of the unstable genetic material was being changed. The addiction to fight or flight chemical reactions was being cured. And his body's natural defenses were no longer fighting this inner-directed attack. Instead of chronic depletion by the cachexia and medical treatment, patients can reconstitute themselves and help repair the previous damage.

The patient wants to rid himself of this ultimate irritation called cancer. Since the mechanism is to permit the analyst to function as the absorbing early mother, the analyst will be subjected to emotional and, therefore, biochemical irritation. He must protect himself. He will be most fortunate if he has an anti-cancer marriage. He must have had a thorough, personal analysis. He must be "innoculated" prior to working with hyperirritated patients. In addition, no analyst should see more than one such patient a day. And a new patient will have to be seen

twice a week. The autistic-stage patient must also have access to the analyst via the phone at any time. Babies do wake up at 2 a.m. for a feeding! The analyst would be well-advised to plan mindless exercise activities for a time period immediately after these scheduled sessions. He should have no contact with his children, and perhaps no other patients, until he has dissipated the absorbed irritation.

It is most important that the patient avoid specialists who primarily treat cancer patients. If an analyst sees many such hyperirritated patients, treatment cannot be successful. In the first place, his patients will most likely outlive him; and, in the second place, he will be unable to do an adequate job. The need to defend against being overwhelmed will result in the analyst's resistance to absorbing irritation, which will diminish his effectiveness with his cancer patients.

Oncologists have significantly higher cancer rates than physicians in any other specialty. Analysts who *specialize* in treating cancers most likely will have even higher cancer rates.

The Optimistic Cancer Patient and the Precancerous Personality

It is paradoxical that precancerous and optimistic cancer patients are much more difficult to treat than the extremely regressed patient. The dynamics of cancer are not an ally in fostering regression in these people. Instead, cancer conditioning functions as a fifth columnist fighting against reconditioning. These patients are functioning on far more mature defensive levels than the person facing immediate death. It is these mature defenses that create obstacle after obstacle to the regression process in that they deny direct access to the autistic stage. Layer after layer of this onion must be peeled away to get to the center.

Regression is the mechanism that permits this access. The regression is facilitated by permitting and encouraging the patient to say whatever he wishes to communicate. The analyst's role is to accept unconditionally any and all communication, particularly that fraught with emotional significance. As the patient learns to trust the safety of the situation and the analyst, two things of great importance occur. First, the analyst comes to be seen as the parental figure who should have treated the patient in this fashion. Second, emotionally overwhelming conflicts are desensitized.

As the patient is encouraged to say everything, the emotional impact of the past is greatly reduced. The analyst's acceptance of verbal communication replicates what should have transpired originally when the patient/child was overwhelmed with feeling. The state of being overwhelmed translates to biochemical reactions regardless of the dominant developmental stage.

Whether the patient is an egocentric attention-seeker, shy and withdrawn, or somewhere in between, he will assume an omnipotent position. He can react to *anything* negative with a

why-does-this-happen-to-me attitude. He will use his sense of omnipotence to maximize his upsets. After all, it only happens because of him. He feels the pressure of believing he should be able to do something about it. He attacks himself when he cannot, although no one else could.

The optimistic cancer patient can be recognized simply from his medical history of a malignancy. His prognosis is good, and he wishes typically to deny fears of the likelihood of reoccurrences.

For the precancerous personality, proper diagnosis is more difficult but equally as important. A premature termination of treatment may result in greater likelihood of the development of cancer. The following should be looked for:

1. A history of hypersensitivity to chemical and physical irritants
2. A heightened sensory sensitivity
3. A need to care for others while refusing to permit the reverse
4. An inability to relate in moments of hyperirritation
5. An inability to tolerate closeness without conspicuous discomfort

For cancer patients who experienced spontaneous cures without medical or psychoanalytic intervention, the cancer itself facilitated a regression to autism. In all of these cases, there was "someone there" for the patient who got past the anaclitic depression and permitted a fusion. The analyst's task is to be that "someone there" as well as to help the patient regress through the anaclitic depression to the autistic stage.

The task is a difficult one because the mature defenses of the precancerous and optimistic cancer patient are on the alert to prevent access to the autistic sensations. If the neonatal stage was the scene of a conditioning for later cancer and self-containment in the face of hyperirritation, why would anyone want to risk confronting the autistic-stage fears of marasmus that cancer delays? Perhaps the only thing that permits the patient to seek and stay in treatment is the rational denial of his fear of confronting these sensations, although it is these very sensations from which he seeks relief. The analyst is unconsciously viewed as an overwhelming other. *But until the patient approaches the anaclitic depression, he will feel it would be irrational to be frightened of the analyst or the analytic process. Thus, these more mature defenses, while establishing obstacles, permit the patient to stay in treatment.*

The analyst's initial task is to help the patient avoid direct confrontation of the autistic-stage feelings. He does this to prevent immediate termination of treatment.

For most patients with this diagnosis, initial treatment can be like treating anyone else. They can be anxious but pleasant as they test the waters. However, some of these patients may be reluctant, passively-aggressive individuals for the first few meetings. If the analyst suggests that the patient tell him the story of his life, the patient may cover fifty-two years in ten minutes, and not know what to talk about next. For a month or more, the patient may spend all his time

objecting to being in the analyst's office. He will say that he does not feel comfortable with the treatment or that he does not believe in this "stuff." If the analyst joins or reflects the patient's fears, the defenses may be suspended long enough for the patient to discover that he does not have to deal immediately with the fear of annihilation that he experienced as a newborn.

As treatment progresses, patients in both categories will report fears of exploding from overwhelming irritation. The cancer patient will express this in terms of fear of reocurring cancer. The precancerous individual will describe feeling as if he will die from the continuation of such torment. He seems to know that he is at risk. He even can express a genuine chronic fear of cancer.

Telling a patient who has had cancer (or is precancerous) not to worry about his condition or situation is an attack on his defenses. The patient will feel, perhaps rightly so, that the analyst does not understand him. If the analyst goes along with the patient's fears, it allows the patient the opportunity to see the analyst as similar to himself. If the analyst wishes to lessen the impact of worry, he should tell the patient that he cannot be expected to do anything else but worry and that, perhaps, he does not worry enough. This feeds the conditioned response of worrying and, thus, provides temporary relief.

The analyst may have to interpret a resistance in order to permit the patient the opportunity to become aware of his investment in being irritated. This often makes so much sense to the adult parts of the patient that it helps reinforce the continuation of treatment.

In general, the treatment for the optimistic cancer patient and the precancer patient is the same as for anyone else. The analyst works to foster a relationship that permits the verbal expression of any and all thoughts and feelings. The more powerful the emotional impact of what is being said, the closer one gets to the anaclitic depression and, thus, the autistic stage.

One patient found it safer to talk about his medical treatment and its side effects than about his feelings and human relationships:

Patient: I don't want to come here any longer. It's not going to help.

Analyst: That may be true, but how do you know that already?

Patient: I just feel that way. This talking isn't going to do any good.

Analyst: You're probably right that talking about your cancer isn't going to do any good. We both know it's terrifying and depressing. What more can be said about it?

Patient: Nothing, you're right. But how will talking about anything make any difference?

Analyst: It might not, and it's already been three sessions.

Patient: Okay, I get the message. But each time I am preparing to come here, I feel as if my body is suddenly empty inside. The only other times I felt that way was when I first was told I had cancer and when they put me in that huge radiation machine.

Analyst: Why do you insist upon discussing cancer and how terrifying it can be? That's a fact

we are both aware of.

Patient: You're right. This morning I couldn't eat a thing. I felt really nauseated. But the doctor said that will subside in time. All right, no more cancer. How come I can't stop with it here and at other times I can't mention it?

Analyst: Is it possible that you already know it's okay to say anything here?

Patient: Yes, but I can't stop talking about cancer here, and I can't even tolerate hearing the word anywhere else.

Analyst: Then you had better tell me any thoughts or feelings you have ever had in regard to cancer. (The analyst is joining the resistance of being able to talk only of cancer as a means of avoiding feelings, so the patient no longer has to maintain this obsession.)

Patient: When I first got married, my mother died of cancer. She was very sick for almost a year with lung cancer. She died a month after I got married.

Analyst: Tell me about her. What was she like?

Patient: She was short and sort of chunky until she got sick. She was always there when I needed her. I wouldn't call her affectionate but she wasn't an iceberg either. If I needed her, she was there for me.

The patient continued a moving description of a young mother who took care of illness, injuries, and failures. But it was revealed later that she was incapable of giving any physical affection and never came near unconditional love. Gradually, the patient came to realize painfully that he always pushed others away and felt disgust at any demonstration of physical closeness.

In order to keep an optimistic patient or precancerous individual in treatment long enough to make any difference in terms of reconditioning, a full knowledge of the technique of psychological reflection is necessary. Confrontational, insightful, and interpretative approaches are contraindicated. Anyone who doubts this should try talking a paranoid schizophrenic out of his delusions. He will either attack or withdraw into himself.

The essence of reflective psychological technique is to strengthen defenses enough so that the patient is no longer invested in their maintainance. The analysts accomplishes this by providing a mirror of the patient's emotional state. At the same time his defenses are being strengthened, the patient learns to perceive the analyst as being just like himself, thereby replicating the mother-baby bonding, which also lacks boundaries of the self.)

Eventually, this will permit the safety to allow a regression to the anaclitic depression. After the patient passes through the anaclitic depression, which will be discussed in the next chapter, arrival at the autistic stage can be recognized from the feelings that the patient will describe: drifting, strange bodily sensations, oceanic feelings, heaviness in different parts of the

body, tingling sensations in the limbs - particularly fingers and toes, the sensation of floating around the room, dizziness, and so forth. It is the same experience as the autistic-stage cancer patient who is facing death in the near future. The patient finds it frightening because there is no conscious cause or explanation for these sensations.

Again, these patients also will feel that they are going insane, and the analyst should encourage them to feel just that. The analyst must let the patient know that the analytic session is a safe place to experience such powerful feelings and that no explanation or excuse is necessary. Feelings and thoughts are just there, no matter how extreme. It is what one does with them that counts. No one has ever been committed to a psychiatric hospital for feeling crazy. It is necessary to act crazy first. Patients need to be reassured about this as they experience such intense feelings.

Analysts also need to be reassured. The greater the capacity the analyst has to accept his own feelings, the greater the capacity to tolerate the patient's intense feelings.

If treatment fails, it can be due to the human inadequacy of the analyst. The powerful feelings that all cancer patients and precancerous personalities can induce are intolerable for the unanalyzed practitioner. At times, they are barely tolerable for the most aware analyst. The analyst can come to experience various feelings that the patient's parenting agent felt during different stages of his development. These feelings may prevent a desire for fusion on the *analyst's* part. The analyst periodically can become detached, irritated, or anxious. The patient is experiencing similar feelings. As the analyst works to control his own level of irritation, he can be working unconsciously to stifle the patient's expression of irritation.

It is reasonable to assume that, at times, the analyst can be replicating the mother's periodic inability to fuse with the infant during the autistic stage. At other times during the treatment, the analyst can experience other feelings the actual mother had. If the patient is both provocative and defiant, it is safe to speculate that the analyst is experiencing the feelings of parenting a toddler through the "terrible twos" or a teenager through the autistic residuals of adolescence. If the practitioner yields to the desire to shut the kid up, he will confirm the original toxic learning and harm the patient.

The outbursts of the autistic-stage patient may be whimpers or shouts with no *rational* explanation behind them. The analyst may feel that this is an intolerable amount of abuse to endure and work to cut off its expression. If the analyst loses sight of the patient's rage as merely a demonstration of infantile hyperirritation, he will feel attacked and injured by it. This will leave the patient with no alternative but to return to a self-contained emotional entropy, as the analyst replicates the original toxic response of the mother.

The entire purpose of analysis is to recondition the processing of irritation that occurred originally in the autistic stage. In order to accomplish this, the analyst must be placed in the

early maternal role. This transference of an earlier relationship onto the present therapeutic one is a natural phenomenon. All the analyst has to do to accomplish the development of such a relationship is to avoid getting in the way of its natural evolution. We all respond to life's stimulation based upon previous conditioning.

When the autistic-stage issues are dealt with, this surrogate mother will be viewed as the original, inconsistent maternal figure. If the baby was irritated then, the patient will be irritated now. *The irritation that was added to the pre-existing irritation was the first emotional and biological conditioning of this person. Cancer is the fulfillment of this conditioning. Thus, the surrogate, the analyst, is viewed as the ultimate irritator, the cancer itself!*

No artificial symbols are needed. The patient is plagued by symbols of cancer while asleep and awake. The analyst is the most workable symbol. This is due to the analyst's ability to change the response. The analyst does not add irritation to the system at the patient's vulnerable points. The analyst soothes and comforts in the way an ideal mother should have behaved. But this soothing and comforting will not result in a reconditioning unless the autistic-stage issues are reached and the analyst comes to be viewed as the overwhelming irritator - the cancer or the predisposition for it.

Once the hyperirritations of the autistic stage are reached, the analyst and patient will go through periods of what appear to be rage and love (more accurately called hyperirritation and homeostasis) that make each feel fused to the other. The feelings on both sides of the couch can be peaceful or agitated, but they are conspicuously thoughtless. Cognition can be absent in the analyst at this point. How then can he know what to do or say? The truth is that after the rage has been expressed, he does not have to know. His positive feelings for the patient are the only guidelines he needs.

The only exception to this is the patient's desire for physical contact. The analytic rule of no physical contact almost always must be maintained. More mature feelings can easily return, and physical contact can be destructive to treatment as the therapeutic relationship rapidly leaves autism and seeks eroticism. Both the analyst and the patient can have powerful, compulsive feelings to hold and be held. These must be refused, or the regression can be rapidly reversed.

It is the resolution of the expression of rage (hyperirritation) that is, ultimately, the path to autistic fusion. If this does not happen, then regression will be halted due to the patient's feeling a lack of safety in the relationship. The patient's desire to destroy the analyst then will be projected, and fear will preclude the expression of anger and dissatisfaction.

Many analysts can experience autistic fusion with patients but not recognize it as such. In response to rage directed at them, they can have extremely powerful feelings of wanting to comfort and soothe the patient. If the opposite occurs, however, the analyst must explore his reactions. If the analyst cannot comfortably love the patient at this point, the analyst should

avoid autistic issues with all patients. He needs to experience the correction of his own neonatal defense system. If he does not, the dangers to the analyst and the patient can be greatly increased.

If the analyst insists upon not permitting self-containment and is dedicated to the survival of his patient, he can be working toward fusion without any conscious intent. However, being unaware is a dangerous state for both the analyst as well as the patient, who cannot be expected to be aware of anything but feelings during autistic regression. Proper care for the patient rests in the analyst's hands. It is not the baby's responsibility to know anything. The analyst must take all the responsibility on his own shoulders.

Group therapy or analysis for optimistic cancer or precancerous patients is contraindicated. It is altogether impossible for autistic-stage cancer patients. Dealing with superficialities in a group will have little or no beneficial effect. If causal issues are dealt with in a group setting, there is serious risk of repeating the original toxic conditioning, particularly if one patient ascribes the surrogate maternal role to another group member. No one who is unprepared to do so can be expected to respond therapeutically to another's vigorous and possibly bizarre expression of hyperirritation. Patients who themselves are undergoing infantile hyperirritation emotionally and biologically cannot possibly react appropriately to another patient. This type of therapy actually produces a group of upset babies.

Group therapy is fine for more superficial life-management problems. No one can be expected to suspend enough defenses to express openly the strange and frightening feelings of autism in a group setting, nor would it be possible for a group leader to deal appropriately with such feelings.

Imminent Death and Resistance to Autism

Many people will resist autism until death has almost claimed them. From apparently mature but irritated levels of functioning, they will suddenly enter a coma-like sleep and expire. These individuals are maintaining the anaclitic depression position to the very end. They push away and get others to leave them in isolation. The next chapter is largely devoted to them, as it addresses the management of the anaclitic depression. At this point, I would like to present a case that illustrates the use of reflective psychoanalytic techniques in gaining access to the autistic stage:

A student of mine was involved in the treatment of an eighty-two-year-old woman who was suffering from metastasized cancer that originated in her breast. The student was a nurse on the medical team that had decided to treat only the patient's pain as she was too weak and the cancer had spread too far to do anything else. The nurse received permission to attempt

psychotherapeutic treatment, claiming that all she wanted to do was offer help in preparing the woman for death.

When the nurse first entered the patient's room, she saw a small, frail, emaciated-looking, older woman in a slightly raised bed. Her food tray was untouched. The staff had reported that Mrs. K., a widow with no visitors, only occasionally drank some water. Cachexia already had overwhelmed her system. Her skin was pale, the dull color of victims of starvation.

Student Analyst: Do you mind if I come in here and hide out for a while? (Exactly what Mrs. K was doing.)

Patient: (A grunt)

Student Analyst: (Taking off her nurse's hat and putting her feet up on the window sill) I can't take it any longer, all the sickness, the misery. I hate being a nurse. If I go out into the hallway, they will make me do some more work. I just want to hide. I can't go on with this anymore.

Patient: Why are you bothering me with this?

Student Analyst: The others told me that I wouldn't be disturbed in your room. They said you almost never talk and that you get almost no visitors. That sounds perfect to me. I need a place where I won't be disturbed. Do you mind if I turn on the TV?

Patient: (Angrily) Yes, I mind! What do you mean using my room as a hangout? Get out of here right now or I will report you. I am very sick and just want to be left alone.

Student Analyst: I just want to be left alone also. Face it, no one will bother to check up on you for at least a half hour, maybe longer.

Patient: (Shouting) Get out of here. Who are you? Why are you bothering me? What kind of nurse, a person, are you. You are not fit to be a nurse! Now get out or I'll have you fired!

Student Analyst: Well, then, hit the buzzer and turn me in. I'm not moving. I am the worst nurse you ever met, and I can't stand being any kind of nurse. So, go ahead, hit the buzzer.

Patient: I can't reach it. Hand it to me, you young bitch!

Student Analyst: Get it yourself or just be quiet.

This sort of thing went on for several more days. Finally, the patient began to give up her depression.

Patient: (Looking more alert and even somewhat groomed) It's you again. Can't you find some dying child to harass? Maybe a mother whose kid was just born

with no arms? Just leave me alone.

Student Analyst: Listen, I know an easy setup when I see it, and you are it. You still don't talk to anyone except to complain about me. They don't care. They even think you're lying. I've got them convinced.

Patient: You're a sadistic bitch! (With a slight smile) Would you just hand me that cup over there on the shelf?

Student Analyst: Get it yourself. I'm only here to goof off, not to work.

Patient: You're a monster. I hate you with every ounce of strength in me.

Student Analyst: That isn't much now is it.

Patient: (Crying) I'm so scared. Please stop torturing me. I need someone to care about me. It's crazy, but I know that someone is you. (Crying uncontrollably)

Student Analyst: You're right. That someone is me. We'll see this through together.

Patient: I really need you. You're such a bitch, and I really need you. I must be crazy.

The patient turned eighty-five last year. Her weight gain has become a problem. She has had to cut back on how much she eats. As far as the medical team is concerned, no cancer is observable. This case demonstrates that fusion can be achieved, even with a patient who desperately works to push away, and how therapeutic emotional entropy can be. It is but one of many cases that turned around at stages that seemed utterly hopeless.

Most important, this woman's situation shows how immediately accessible autism is when the anaclitic depression is present. The immediacy of death strips away the defenses that conceal the infantile feelings.

In summary, the only patients who do not require a resolution of the anaclitic depression are those so thoroughly regressed by the effects of cancer and its treatment that they are already functioning on an autistic level prior to entering analysis. They have nowhere to regress. The optimistic cancer patient and the precancerous individual are far from an intense anaclitic depression. However, residuals of it and the autistic stage can be observed in their inadequate ability to relate to others. This inadequacy lies in not being able to accept love and caring. The optimistic cancer patient who is at the anaclitic depression level of functioning will, as with the first category, be confronting death. But this individual knows unconsciously that autism represents the ultimate vulnerability. The desperation in pushing away is remarkable. The next chapter deals with this problem of managing this pushing away. All three categories, autistic-stage cancer, optimistic cancer, and precancerous, share aspects of autism and the anaclitic depression. The predominance of one level or the other determines the treatment plan. They must all undergo an autistic reconditioning.

What is curative for all is the emotional re-education that takes place through fusion and emotional entropy. Involuntary areas of the nervous system are harnessed to support life rather than kill the patient. The processing of irritation is relearned to permit the individual to minimize internal carcinogens while no longer seeking external ones. The immune system now can work to aid in recovery rather than merely containing the effects of internal irritants.

Chapter 12 – Infantile Depression

It was 1947, in postwar Switzerland, when Rene Spitz, M.D., first studied foundlinghome infants. His book, *The First Year of Life,* attempted to answer some of the questions about psychologically-deviant development in babies. The study was limited to infants chronologically past the autistic stage. The babies studied had been separated from their mothers at some point after this stage. While their physical needs were well-provided for by nuns, who performed their caring tasks efficiently, the babies' emotional needs were all but ignored. There was no time for play or cuddling. There was no understanding of the significance of the baby's need to fuse. Studies in neo-natal hospital units have shown that even premature babies who are held and talked to will take more nourishment per feeding session than if they are just fed "efficiently".

Of 123 children observed by Spitz, 19 displayed a clear-cut syndrome which Spitz referred to as *anaclitic depression*. In the second half of their brief lives, these babies changed from relatively happy individuals to weepy, withdrawn, immobile creatures, who even averted their faces to avoid interaction with anyone. If the approach of an outsider was "insistent," that is, the outsider would not be put off by the baby's avoidance mechanisms, crying and, occasionally, screaming would follow. The babies lost weight. Their insomnia was so bad that they had to be separated to prevent them from keeping each other awake. They all were prone to colds.

After three months in a loveless environment, the babies' pathetic weepiness subsided. It was replaced by a "frozen rigidity of expression." Spitz described them as lying or sitting with "wide-open, expressionless eyes, frozen immobile faces, and faraway looks, as if in a daze, apparently not seeing what went on around them." The babies were regressing to the autistic stage, characterized by a self-contained entropic system. They were going back to the first emotional stage of life.

The babies had been separated from their mothers between the sixth and eighth month of life for a three-month period. If the mother returned after the three-month period, but prior to the end of the fifth month, most of them recovered. Spitz stated that "in anaclitic depression, recovery is prompt when the love object is returned to the child within a period of three to five months. If there are any emotional disturbances of lasting consequence, these are not readily apparent at that time." Spitz speculated, however, that although he was not able to determine consequences, he felt that, in the long run, "scars" would show up later in life.

If similar emotional conditions surround any newborn, almost all of the *scars* that show up later in life will *cancers*.

After the fifth month of separation from the mother, symptoms become more severe. The prognosis is poor. The anaclitic-depressive reaction is not comparable to adult depression, which was viewed by Spitz as the result of a "sadistically cruel superego under whose relentless persecution the ego breaks down." At this stage of infancy, the precursors of guilt and conscience are not present.

Spitz observed that babies whose early relationships with their mothers were negative did not experience the same severity of suffering in the anaclitic depression as did babies who had positive maternal influences. Infants with a background of "bad" mothering were seen as having experienced relatively negative nurturing. Spitz described these babies as suffering from "mild depression" and believed that the syndrome masked deviant problems of a qualitative nature. Perhaps what Spitz was observing was a *fixation* at the autistic stage. The babies from negative backgrounds would not have entered a well-defined symbiosis with another person. At the least, a predominance of autistic residuals would characterize their immature personalities.

Spitz felt that good mothering prior to separation resulted in a powerful trauma to the abandoned infant with severe consequences. In other words, it was more upsetting to dissolve a viable entropic system than a weak, negative one.

The anaclitic depression that Spitz described can be viewed as the first interstage regression in life. The baby has entered a symbiosis with the mother, which is the next stage up from autism. The baby is still powerfully attached to the mother, but is beginning to see her as something outside of himself when the symbiosis is abruptly suspended. The child has no choice

but to attach his drives to something else. If the self is all that is available, the attachment is self-contained – there is a clear return to the self-contained entropy of a negative autistic experience.

What Spitz observed was a tremendous shift of entropy back to the self-contained system of an emotionally neglected newborn. *In the babies who were already emotionally neglected or abused, there was little shift of entropic factors*. Some irritation had to be siphoned off, but, to a large extent, irritation lodged within the body and mind of the baby. Damage had already begun in terms of negative *emotional* conditioning. Spitz was observing *prepsychotic* etiology (causation) in these "mildly depressed" infants.

The anaclitic depression is the regression to autism from a symbiotic stage. It is an autistic self-contained entropic system, characterized by an autistic management of emotionality coupled with the developing physical and mental abilities of the symbiotic stage. The baby in symbiosis can better communicate his emotional state; thought is evolving more clearly. When these factors are united with the autistic elements, the communication of self-containment is more easily discerned. The baby averts his eyes and face, cries, and even screams when contact is forced. He pushes away rigidly when held. Spitz's descriptions of these babies are overwhelmingly powerful. The terror and anguish in confronting the assumed aggressive maternal agent is enormous. These autistic residuals can remain throughout life.

The anaclitic depression can be the key to severe psychosomatic disorders. Cancer, the most primitive biological disorder, demonstrates this in the most powerful way. To appreciate its significance, I offer an analogy. When we approach birds on a beach, deer in a country setting, or even a strange dog on the street, they all have the same reaction. Up to a certain predetermined distance, they will permit our approach. As soon as we step over the line, they flee or, at least, back up to re-establish that original distance. On occasion, they may even make threatening gestures. The anaclitic depression is this mechanism on a human level. The human infant cannot flee and the human adult chooses not to because maturity has taught his intellect that there is no *real* danger. But their feelings may be the same as that of the sandpiper or the deer. (Equivalent brain areas in both the human and the lower animal worlds relate to this phenomenon.) However, without the ability for flight or fight, we are left to express the anaclitic depression in terms of our biochemical reaction and personality traits (as previously described).

Foresters have told me that forcing deer into crowded, enclosed areas results in high mortality rates. When I asked what they died from, the reply was that "cancer frequently seemed to be the culprit."

With patience and caring, we can train birds and other wild animals to allow us to be comfortably close. We can get past the primitive brain functions of lower animals through repetitive conditioning. Man is harder to deal with because of his intelligence. But once this more advanced defense is suspended, we gain access to these primitive brain functions.

The anaclitic depression is one of the first clear symptoms of a precancerous personality. Later in life, difficulty in accepting love and feeling connected to others can add to a precancerous diagnosis. The precancerous person will push others away, either subtly or overtly. He will be hypersensitive to irritation or impingements from others. Psychosexual errogenous zones will function as repositories for irritation, rather than centers of pleasure, within his self-contained entropic system and, thus, be highly vulnerable to cancer.

Whatever his defenses, they will be used to reinforce his original autistic conditioning, which is encapsulated within the defenses of more mature levels of development. It is only when this encapsulation is removed and the autism is laid bare that the basic drives are accessible for emotional re-education through conditioning toward fusion. Prior to this, the analyst will be dealing with more advanced levels of defense. It is only when all the defenses are temporarily suspended that the correction of the negative entropic system can occur. It is at this point that the basic drives (hyperirritation and homeostasis) can exist simultaneously for the patient through a fusion with the analyst.

It is this fusion, which was discussed earlier, that provides the precancerous or cancer patient with the opportunity to experience both irritation and homeostasis within a singular system. When the analyst can be viewed as the source of hyperirritation (the cancer), the signal for fusion is present. If the analyst responds with a communication of caring in the the face of the patient's irritaton, corrective reconditioning will take place. If the fusion is based upon the analyst adding his own irritation to the patient's, this union will be carcinogenic.

Suspension of the defenses against the expression of autistic irritation within the therapeutic relationship is the first step in treatment. At each developmental level, various defenses will be activated to prevent autistic-stage annihilation (marasmus). The patient's anticipation is that his expression of irritation will be met with the analyst's irritation. Prior to access to the basic drives, the patient must learn, through a suspension of more advanced stages of defenses, that the expression of rage within the analysis will result in the acceptance of his feelings by the analyst. If this does not occur, the patient will become guarded. Superficial granting of permission to express rage will not work. Superficial explanation of the defense and its causal factors will not work. What does work is reflective psychoanalytic techniques properly administered at the correct times.

Suspicion of the defenses of the anaclitic depression requires an understanding of the diagnosis and its dynamics. The anaclitic depression is the the cancer patient's last line of defense prior to reaching the rawness of autistic feelings, or prior to death. In *On Death and Dying,* Elisabeth Kubler-Ross points out that the more advanced stages of defense precede the depressive stage prior to the acceptance of death. It is my contention that after the other defenses are suspended, after the anaclitic depression is suspended, the patient has the opportunity to deal

with *the acceptance of life*! Death will be inevitable if the irritation and homeostasis are not reconditioned into a fused state. The depression that Kubler-Ross observed is a signal for optimism that perhaps something can be done. Kubler-Ross' depressive stage is an *adult* depression. Her clinical error is not connecting acceptance to the anaclitic depression. There is overlap, but the quiet, sedate, and "peaceful" person, perhaps dying from cancer, may be turning away from others in an anaclitic depressive reaction.

The analyst must take into account the nature of the defenses observed by Spitz in the anaclitically depressed infants. They turn away, reject, become rigid, scream, and cry pathetically to get the maternal agent to put them down. The analyst must understand any resentment of attack that this behavior generates in him. If he can remember that he is dealing with a terrified baby who believes he is going to be killed, then the analyst cannot, and will not, put the baby down! He will hold on long enough to allow the rigidity to subside. He will gently insist upon being connected and involved in spite of the patient's need for "space," distance, and isolation. *He will not put the baby down!*

Defenses against the therapeutic relationship and in the service of depression will manifest themselves in many ways, but the predominant defense will be to exclude the analyst. The patient will talk of other people in his life, significantly excluding this surrogate mother.

Patient: I was thinking about all the men I've known in my life who really amounted to nothing yet I continued the relationships until I got them to leave.

Analyst: What did these men have that I don't have?

Patient: They were bastards. Since my divorce, I've known only bastards. My ex-husband is a bastard.

Analyst: What did they have that I don't?

Patient: You're not a bastard. You're nice to me.

Analyst: Are you saying you be more involved in a relationship with me if I were a bastard?

Patient: I guess that's what happened. First, it was my husband, and now, Peter has been the worst yet. I still can't end it. I'm afraid to tell him how sick the doctors say I really am. He'd cut out on me. (The patient continued for ten minutes complaining about the sadistic men with whom she had had relationships.)

Analyst: What would it take for you to be interested in me?

Patient: Why do you keep butting in? You're not my type and you never will be.

Analyst: You'd better help me to be your type because when it comes down to it, it's just you and me anyway.

Patient: Then I'm in a lot of trouble.

Analyst: Is this your first awareness of being in a lot of trouble? You have cancer. Can

there be more trouble?

Patient: Why do you do this to me? You're a sadistic, egocentric son of a bitch. You think you're the only one who can help. What about my chemotherapist and the surgeon and all of them?

Analyst: When it comes down to it, it's just you and me.

Patient: Then what happens if something happens to you? (Negative wish for the analyst to die.)

Analyst: You'd better hope nothing does. (A deliberate replication of the earliest autistic relationship.)

Patient: You know, sometimes I don't know if you're for real, but I do know how much I hate you. I just want to be left alone. I want you to stop suffocating me. Leave me alone!

Analyst: Give it up. You know I'll never leave you alone. You're stuck with me. You can't leave and I can't go. We have to see this through.

Patient: I know I can't quit, but I feel like I really want to when you pull this shit! It's not fair. I'm a prisoner.

Analyst: You're right. It's not fair. (Addressing the unconscious cancerous aspects of the therapeutic relationship.) What does that have to do with anything?

Patient: (In a rage) I hate you. I really hate you. I hate you so much! (Crying) Please be nice to me. Stop doing this. I want you to care about me. (She was sobbing uncontrollably at this point.)

Analyst: When you can express yourself this honestly, anyone, even I, could have loving, caring feelings about you. (Said very gently)

Patient: I don't understand what is happening.

Analyst: You don't have to.

This was not the final resolution of the anaclitic depression, but it was a beginning. The patient, a forty-two-year-old woman, oscillated from the depressive need for isolation to the expression of raw autistic feelings. Once the anaclitic depression was being dealt with, she frequently reported powerful bodily sensations. In some sessions, all the analyst did was repeat the patient's communications back to her. This was usually the precursor to the baby's need to push away actively. The analyst's response would be to hang on verbally and then offer communications of caring. Once the patient (baby) realized she could not succeed in overpowering the analyst (mother), she was able to relinquish the rigid rejection and accept love. One suspension of the anaclitic depression is not enough. Many repetitions will have to occur.

It is very important that the analyst not use psychological reflection of this resistance, which would only help to maintain the defense, when the object is to suspend it in order to allow brief doses of love into the system.

Overwhelming doses of positive regard (love, affection, understanding) are contraindicated. One does not feed a victim of starvation a ten-course meal. The intake must be gradual and carefully metered or the very nurturance being offered may kill. When appropriately done, each additional input of caring from the analyst in the face of the patient's irritation within the therapeutic relationship replaces autistic-level conditioning with new life-supporting structures.

Misdiagnosis of the anaclitic depression can lead to further internalization and exacerbation of the precancerous or cancerous conditioning. The difficulty is to differentiate between depressive reactions on a more mature level and the anaclitic depression. The person suffering from a mature depression will be disturbed by severe feelings of guilt and fears of castration. The more advanced stages of defense observed by Kubler-Ross, such as denial, bargaining, and anger are permeated by elements of this depression. The person is either fleeing from despondent feelings or he is using their components to lessen the impact. Making a deal with God to prevent death indicates the need to utilize guilt in order to lessen feelings of total depression.

The symbolic castration aspects of surgery and other medical techniques also assist in the development of this more mature depression. After disfigurement, the patient feels that certainly enough of a price in suffering has been paid. He may react as if he is almost pleased, without tremendous feelings of loss for the missing body part, because the mastectomy or colostomy means he will survive. The depressive reaction to this symbolic castration has little connection to the anaclitic depression.

Patients report feelings of optimism if the surgery was a "success." They feel that if one suffers enough, gives up enough, endures enough, one deserves to be rewarded with a "cure." The patient will either see himself or God as the omnipotent entity in this cruel bartering.

For far too many, however, the cruelty does not stop with the offering of sacrifices. The depression that follows can be anaclitic in nature. It does not appeal in any way to adult logic and is their medium of passage into the realm of autistic-drive reactions.

The more mature depression can be suspended to foster regression to the less mature reaction. Psychological reflective techniques are highly applicable to the more mature depression. However, if this more mature reaction is mistaken for an anaclitic reaction, the risk of further internalization of rage and irritation is present. Comfort and solace are usually contraindicated for more mature depressive reactions. They foster internalization rather than

permit a venting of anger within the analysis. The result is continued self-containment, which is a carcinogenic irritant.

The anaclitic stage of depression also can be diagnosed when a relatively sudden shift occurs within the therapeutic relationship. With more mature defenses, the patient's inability to express certain problems within the therapeutic relationship may be viewed as a "transference resistance." It is the anticipation of the analyst's reaction to what the patient says that inhibits the expression of feelings.

Most people are not raised in an emotional environment that permits them to express all feelings freely. Children are taught that certain things are not permissible in an exchange with parents. The more primitive the feeling, the closer the feeling brings the child to hate or sex, the more inhibitions are placed upon the communication of them. This occurs within the initial emotional training as well as in the surrogate relationship of analysis. A major aspect of the analyst's task is to suspend the defenses that surround the expression of sexual or murderous feelings within the analysis. These are part of the constellation of defenses that compose the repetition compulsion, that is, the need to repeat that in which we are emotionally invested and with which we are familiar. Once the analytic relationship forms, defenses against the expression of forbidden feelings toward the analyst are termed *transference resistances*. Transference resistances are a frequent occurrence in the course of any analysis.

Another form of defense related to the surrogate maternal relationship is called "resistance to transference." Usually is encountered first in a therapeutic relationship with a patient who appears disconnected and out of touch with his surroundings. It is as if the patient does not want any relationship to develop, yet he maintains his appointments and follows the analytic rules.

The analyst will need to guard against feelings of disinterest in such an individual. He may be bored, sleepy, or annoyed during sessions. It may appear to him that the patient could just as well be talking to a tape recorder as another human being. If the patient asks questions, they are either rhetorical or the patient will answer them himself, often as the analyst is about to respond. To deal with this seemingly pointless situation, the analyst may investigate the patterns of defense by asking the patient why he does not ask real questions. He can ask the patient how he perceives the analyst. The purpose of such gentle questioning is to grant permission subtly to the patient to relate to the surrogate mother.

Other patients can appear confident and highly verbal. They will describe life events as if the sun rises and sets only upon them. But all of their narcissistic, egocentric defenses are compensations. They cover the insecurities and self-hate of the person too frightened to relate to others. Fragility will be sensed by the experienced, sensitive analyst. *The fear of relating is what is dominant.*

In dealing with the precancerous and many cancerous individuals, treatment can progress through understandable elements of transference resistance. One of the most significant symptoms of regression to an anaclitic depression will be a shift in feelings within the relationship. From, perhaps, moderate feelings of hatred and love, the patient suddenly seems to stop the process. It may seem as if the treatment is just beginning with regard to building a relationship, when an apparent resistance to transference (resistance to relating) suddenly develops.

The patient may use adult rationalizations like "I've outgrown you" or "You're just another person like everyone else." The analyst actually can feel hurt by this lack of involvement after some time of dealing with moderated feelings. However, he should stop and examine thoroughly the process of treatment up to this point. *Did he provoke such a reaction within his patient by not allowing the emergence of primitive feelings?* If he can find no evidence of this counterdefense, then he should suspect the evolution of the anaclitic depression within the analytic relationship. It will appear to be a sudden shift from "transference resistance" to "resistance to transference." In other words, it will appear to be a shift from fear of expressing feelings that exist to fear of relating at all.

This marks the beginning of regression to the infantile depression that serves as the lastt line of defense against the primitive feelings of raw irritation and homeostasis. This shift marks the point in treatment at which the analyst must stop using psychological reflective techniques. The rage of the anaclitic depression is used to defend against the impending annihilation of the negative autistic stage. Once the pushing away and objections to impingements stop, the expression of rage and then irritation must be welcomed and accepted by the analyst. Integrating the expression of autistic-stage homeostasis and irritation can be experienced by the analyst as one of the genuine rewards of his work. No one will thank him for it, certainly not the precancerous or cancer patients he treats. But the analyst now can enjoy the increased probability of the survival of his patient. As he meets raw irritation with acceptance and caring, he conditions a fusion. He also is conditioning a new mechanism to deal with all irritation.

The genetic damage to precancerous or cancer patients seems unlikely to be reversed once a genetic instability has taken place. What the analyst accomplishes is a reconditioning of the handling of irritation. From inner-directed, the patient becomes outer-directed. From hypersensitive, the patient becomes capable of modulating feelings. Events that would have had his endocrine system in overdrive are now accepted as the foibles of life.

The analyst has provided a mechanism to lessen the impact of the internalized irritations of the autistic stage. Love has been demonstrated to heighten the efficiency of the immunological system.

Physicians and laymen alike are aware of the importance of psychological states in susceptibility and resistance to disease. To a certain extent, people can learn to deal with stress and anxiety on their own. However, for a reversal of the cancerous process to occur, another human being must play a part in the recovery of health. It is not easy to convince the cancer patient of this. The beginning stages of psychoanalytic treatment of the cancer patient often will be marked by a defense against relating to others that can come much later for a precancerous patient. In both cases, however, this is a defense against immediate annihilation at the autistic level. There is a genuine fear of coming into contact with primitive feelings. Because of his original conditioning, the patient's expectation is that his irritations will be met by overwhelming irritation.

Although analysis is the least toxic approach to cancer, with the fewest side effects and minimal risk when compared to chemotherapy, radiation, and surgery, the reaction of the patient to the analyst can seem hard to understand. From direct accusations of charlatanism to stating quietly, "It's just not for me," a concerned friend or relative can be surprised at the patient's lack of desire for and obstinate avoidance of the analytic process. A typical conversation might go something like this:

Relative: What did you think of your first visit?
Patient: I thought she was a nice lady, but it's not for me.
Relative: Why not?
Patient: It's just not for me. Analysis is for crazy people. I'm not crazy. I have cancer. She can't help. It's not for me.
Relative: She sees a lot of people who aren't crazy, and she helps them a lot in their lives. Why not give it a try?
Patient: Look, I really appreciate your concern, but I'm not a candidate for that. It's too late for me anyway. You know that.

Arguing with the patient usually is to no avail because of the patient's unconscious need to repeat the anaclitic depressive position. The fear of dealing with the feelings that this infantile depression guards against is equivalent to a fear of immediate annihilation.

How then can someone with cancer be motivated to face his fears of emotional death prior to a real physical death? The physician can help. The patient already trusts him to carry out potentially hazardous procedures. If he genuinely believes that cancer can have a significant emotional basis, the cancer specialist will be able to demonstrate his caring by making such a referral. The patient, like the infant, will sense the unspoken feelings.

Another way to motivate the cancer patient to seek out a competent psychoanalyst is to have him read this book. A cancer patient will see himself in these pages. The adult, logical part of his mind will be able to use all of this information to face his fears of the feelings behind the infantile depression.

In summary, the psychoanalytic treatment plan for a precancerous or cancer patient is direct and simple to understand. First, a suspension of more advanced defenses must take place so that the anaclitic depressive position is reached. If cancer already exists, it will assist in facilitating this regression. As the individual is overwhelmed by his fears, the more advanced stages of defense will no longer work effectively. In order to get past these more advanced stages of defense, an implementation of reflective techniques is strongly recommended. The analyst should avoid using interpretation or insight therapies or artificial gestalt-like conjuring of images. Instead, he should work to build an early surrogate maternal relationship.

The second stage can take quite some time, as in the case of a precancerous condition, or it may be reached quickly, as in the case of an active cancer. Once the regression reaches the anaclitic depression, the patient will desperately push away from the analyst. Destruction of treatment is a great risk. If the analyst ignores, or is unaware of, the fact that the patient is trying to avoid the feelings behind the cancer, the patient will have to flee. If the analyst ignores the fact that he, the analyst, represents the cancer in the patient's unconscious, then the patient will have to flee. And if the analyst continues psychological reflection after the patient has reached autism, the cancer will worsen. If the analyst first can be viewed as the ultimate carcinogen, irritant, or cancer itself, and then can offer love and caring when the patient wants to flee from or destroy the analyst, a reconditioning can occur. A fusion of basic psychological forces will ensue as the patient learns to dissipate irritation through emotional entropy.

Chapter 13 – Karen

Und wie dein Wille ihren Sinn begreift,
lassen sie deine Augen zartlich los.

From Eingang (Initiation) by R. M. Rilke

When you have grasped its meaning with your will,
then tenderly your eyes will let it go.

Translated by C. F. MacIntyre in *Rilke, Selected Poems*

For me she was where this all began over thirty-five years ago. At the time we met, all the trite descriptions of a person wasting away fit her. Her skin was pale grey, with a clammy look to it. The dark semicircles under her eyes made her appear exhausted and terribly depressed. Her eyes bulged from her face and appeared glazed, dull, almost lifeless. She stared off into space, lost in her solitude. It did not take me long to realize that when she looked at me, she saw nothing.

Chemotherapy had caused most of Karen's hair to fall out. But the most shocking aspect of her appearance was her emaciation. She looked as if she very recently had been liberated from Auschwitz. Her skin clung to her skeleton. Her cheeks were concave. Both feet seemed to be already in the grave. All that remained was for her to lie down and be still.

When she first entered my office, she needed her husband's and mother's moral and physical support. She could barely walk.

Two days earlier, I had received a call from Dr. G., who works at one of the most famous cancer centers on the East Coast. He asked if I had had any success with treating drug abusers. Of course, I answered yes. I was the clinical director of a drug abuse agency.

He asked me if I would help a patient of his cut down on pain medication. He explained that Karen was a twenty-six-year old cancer patient who had had all the possible medical treatments, with no beneficial results. She had had a colostomy, but another malignant tumor had developed ten months later. She had had radiation and chemotherapy to the limit. And she had begun using Percodan more for emotional problems than for pain, so that when the time came that she would really need it, it would have no effect.

I asked Dr. G. for her prognosis. He replied with one word: "Hopeless." When I asked about how much time she had to live, Dr. G. assured me that Karen had, at the most, three to six months, but he believed she would die within the next three months.

At this point, I restrained myself. I did not want to tell Dr. G. that I had never "cured" anyone of drug abuse within a few weeks of the beginning of treatment. And I did not want to ask him the ultimate question: Why bother, if she had only a relatively rapid and certain death to look forward to? Most of all, I did not want to say no I will not or cannot do it. I still do not know why.

Karen's mother and husband left the office after they had helped seat her comfortably. She asked me what she should talk about. I told her that she could tell me everything and that her job was simply to talk.

What did I mean by everything, she wanted to know. I explained that she should say anything that she wanted to say. She could tell me the story of her life, if she wished. For the next ten minutes, she talked about how depressed she was over having to leave her children. They were six and three and a half years old. The older was a boy, the younger a girl.

Death was portrayed first by Karen as a separation. She described her cancer in a cool, clinical manner, talking of her pain and discomfort as if she were speaking of someone else. But when it came to her two small children being left without her, her voice quaked and she fought back the tears. In adult language, she spoke for them, for their inability to understand, and for their sadness and anger over her leaving them.

I felt like crying at several points, but worked to control myself and to remain relatively quiet. I asked three or four neutral questions to distract her from the powerful feelings she was expressing. My fear was that she would reveal too much too soon, and then be too embarrassed to continue treatment.

By the time the first session ended, we had agreed to meet twice a week. She seemed slightly more energetic at the conclusion of the session. She extended her hand, and I shook it. Then I asked her what the handshake meant in words. "Thanks" was all she said, and left.

I was completely exhausted emotionally. On very few occasions have I felt so depressed. I knew that *I* could not handle this alone. I had just begun my training at a psychoanalytic institute where Mrs. Yonata Feldman was on the faculty and decided to ask her to be my case supervisor. Perhaps her forty years of experience could make up for my deficiency in this regard. Fortunately, she agreed. Supervision was on a group level, and Karen's case was selected to be presented each week.

After my first presentation of the little I knew about Karen, Mrs. Feldman sat quietly listening to the irrelevant questions and comments of this group of novices. When they finally finished, she leaned forward slightly and asked, "Can he do it?" Her usual benevolent, grandmotherly smile was gone. She sat impassively, her mouth a straight line bridging her round cheeks, emphasizing her seriousness.

The first student to speak, a middle-aged man with the classic look of an analyst – goatee, glasses, and elbow-patched Harris-tweed jacket – said he felt Mrs. Feldman was asking if I could cure my young patient of cancer. He also said that if this was the meaning of her question, she was being cruel and unfair to me. After all, the physician had said that Karen certainly would be dead within six months at the most.

Mrs. Feldman's only comment was that his interpretation of the original question was correct. She was asking if I could cure the cancer. One by one, the students, all seven of them, agreed it was hopeless. A doctor with a central European accent offered me an out. "Perhaps," she said, "a cure could have been possible, but this cancer obviously is too far advanced."

Mrs. Feldman looked down at the desktop, remaining silent for what seemed liked hours but was only moments. She was reflecting upon something. I was studying her hands. At first, they were clasped tightly together. Suddenly, she leaned farther forward, unclasped her hands, placed them squarely on the desk, and stared into my eyes. "Can you do it, young man?" she asked. "Can you cure this woman's cancer?" Her eyes continued to look into mine. For a moment, I could not speak. I wanted to say yes, unequivocally, but I did not feel it. I knew that was what she wanted, but the best I could offer was an inane, nondescript "maybe."

She looked down at her hands. The gleam left her eyes. I felt as though I had deeply wounded and hurt her. I regrouped my forces. "Yes, I can, with your help. I can do it."

Mrs. Feldman's mouth turned up into a huge contagious smile. That is, it was contagious for me – no one else in the class smiled. They did not understand that I needed hope. They did not understand that my patient needed hope. They did not understand that Yonata Feldman knew there was always hope, if life and feeling were within reach. At that point, I loved her for the gift that was to take thirteen years to cultivate and mature. When Yonata Feldman died, I suffered a great loss. So did you.

The next session with Karen brought more surprises. She entered my office smartly attired, wearing a high-fashion wig and makeup. This was quite a shock for me. No matter how meticulously a "terminal" cancer patient attends to her grooming, her appearance will reflect the effects of cancer and cachexia. There was something Felliniesque about the way Karen looked. Her denial of death seemed almost absurd.

The real absurdity, however, was my denial. It took Mrs. Feldman by surprise that I did not recognize Karen's behavior as an attempt at *seduction*. For months, the patient had let her appearance deteriorate. All of a sudden, she was working desperately to look as good as she possibly could, and all I saw was that the rouge on her sunken gray cheeks made her look like a sickly, pathetic clown.

When Mrs. Feldman used the word seduction to explain this to me, I felt like the proverbial Missouri mule. First, you have to get his attention; then he can learn anything. The best attention-getter for a Missouri mule is a two-by-four between the ears. This tunes him in. When Mrs. Feldman used the word seduction, I felt as if I had been hit with a two-by-four.

At this point in my training analysis and education, I did not recognize that I was resistant to seeing this obvious communication for what it was. I was not ready to know that fusion with Karen would be necessary for her cure. I was not ready to recognize that being relatively

unanalyzed myself put me in danger of cancer. However, it took only this one smack with the two-by-four to open my eyes.

The courtship continued until the end of Karen's treatment. Let me hasten to add that behavior suggesting courting never took place. The thoughts and, more important, the feelings were sufficient. Karen was a very proper, very Catholic, parochial school graduate. She had also attended a Catholic women's college. Acting out was never a risk to her treatment. No statements of wanting such intimacy were directly or consciously made. When she had dreams of a fusional relationship with her analyst, the fusion always precluded genital sexuality. In the dream, I would be holding her, walking someplace with her, touching her face - or I would be a swarm of vicious insects invading her body and devouring her from the inside. The fusion was there, but it was extreme in terms of hyperirritation or homeostasis. I was either the mother who cared for her feelings through emotional entropy, or the mother who added irritation to pre-existing irritation. I was the mother who comforted or soothed, or I was her cancer. I knew nothing of this at the time.

When Karen asked if we could go for a walk one fine spring afternoon, I was tempted. But I realized that in order to do, so I would have to support her physically and used this as my rationalization for not going along with her wish. Instead, I told her how great I felt that she wanted to do this with me. I talked about where we would walk, whether we would rest along the way, and what she would want to see and share with me.

When Karen told me she wanted to see the buds on the trees and show me her favorite Japanese maple, my eyes misted over. Could Yonata Feldman have been right? When I reported Karen's wish in class, Mrs. Feldman's eyes seemed to fill with tears. I do not think this was my projection; I think the tears were real.

Half-jokingly, Karen had said, "Springtime and death just simply don't go together." I asked her what does go well with springtime, and she answered, "Babies, flowers, lovers, and mostly romance, but not in that order."

She described her husband's courtship and how wonderful he had been. She repeatedly emphasized what a wonderful man he was, so sensitive and vulnerable. She described him as playful, almost mischievous, at times. However, as she continued her description of him and the marital relationship, it became clear that she was consistently in the maternal role, soothing and comforting him. She was completely unaware of how little her husband gave her emotionally. She saw her task in life as caring for the needs of others. This obviously included her two children; what was not so obvious was her third baby, her husband.

The fact that Hal, her husband, was a Protestant added to the problem. Karen's parents almost disowned her when she married him. When she refused to have her children baptized, all communication stopped. She was an abandoned child, and remained an abandoned child until

she was diagnosed with cancer. She would not have contacted her parents even then, but Hal called them. In the face of such horror, they suspended their rejecton of their daughter. They felt guilty, and they admitted this to Karen. She, on the other hand, hated them for what had transpired. On some level, she realized that they had treated her as if she were a leper – or as if she had died. Was she now living up to the role they had prescribed?

Karen described her mother as cold and unaffectionate. As a child, she could recall the peck on the cheek, the lack of hugs, and the rare verbal communication. Every Christmas, the perfect gift was left under the tree, but never with a meaningful card. "Mom considered that stuff corny," she said. "It was simply 'To Karen, From Mom'." More often, there was no "to" or "from" on any emotional level. While Karen could not recall her early infancy, it was a safe bet that her mother was only intermittently emotionally responsive. She behaved properly more from guilt or concern for doing the right thing than from love and caring.

In the course of Karen's treatment, I had the opportunity to meet with her family members. Karen's mother lived up to her daughter's description. She was bright, affable, extremely proper, and egocentric. She kept referring to her daughter's death as a certainty, but that she, the mother, could not accept it. She spoke of the burden of caring for her dying daughter. And she spoke of the future burden of caring for her grandchildren. At least, she recognized that her son-in-law could not possibly cope.

In the few sessions I had with her, she never once referred to her daughter's feelings or pain except in terms of their effect on her. For example, she would say, "I really can't deal with Karen's suffering. It makes *me* feel sick to have to see a child of mine suffer so."

After several weeks, Karen's coloring changed. The grayish, clammy hue was replaced by a paleness that many fair-skinned redheads or blondes have. I called Dr. G. to tell him about it, and he asked whether she was reporting any change in appetite and eating habits. At the next session, I asked Karen about this.

She replied, "I guess I have been eating a little more. Come to think of it, I am eating maybe six or seven little meals each day. And you know what? I am not throwing it up like when I was on chemo or afterward. You know, I didn't even realize this was happening. How did you know to ask me that?"

I told her that she was looking much better to me. Strangely, this compliment seemed almost to startle her. She immediately began to describe her never-ending pain. She sounded almost defensive and somewhat angry. Apparently, she was not ready to give up any of her symptoms consciously. I inadvertently had attacked her defenses with my mild compliment.

After the shock wore off, I told her that she looked better only because of her new skin color. I quickly added that it might not mean anything. Again, I was surprised by her reaction, this time to my pessimism. She blushed and looked down in an almost coquettish manner. To

put it as succinctly as possible: *I was totally confused!* When I complimented her, she felt attacked, and when I told her she probably was not getting better, she became a little girl, flirting with me!

Mrs. Feldman explained that I was reflecting the defense (resistance) when I expressed pessimism. That freed the feelings beneath the surface. The blush came from Karen's feeling understood and getting in touch with her desire for caring and loving.

But it may have been too soon. It may have been an intuitive joining on my part, but the premature release of such powerful feelings could destroy the treatment. The feelings could scare the little baby Karen was concealing within her, and she would have to flee or be overwhelmed.

Mrs. Feldman told me to limit myself to two to five neutral questions per session. She warned me against making statements of any kind, particularly any that so easily could be misconstrued as a compliment. Any need to gratify Dr. G.'s or my curiosity would have to be controlled. It was not in Karen's best interest, and potentially too risky.

After several months of treatment, Karen began to gain weight for the first time in over a year, and she continued to gain weight as she passed the six-month survival limit of Dr. G.'s prognosis. She actually appeared to be getting better. Remission, an unexplainable remission, is what the doctors called it.

Yonata Feldman pointed out to me that the defense of self-destruction was no longer operating. In hindsight, I would say that the conditioned response of cancer had been extinguished. But why? No one had an adequate explanation. Mrs. Feldman's interpretation told me only what was obvious. Karen was telling me through her dreams and fantasies. All I had to do was listen to her words. Her unconscious was rich in vivid imagery that portrayed her struggle against a totally regressive death.

It was the winter of the first year of her new life. She walked into my office under her own steam, looking vibrant and alive. Her eyes had a twinkle in them, and she looked as if she could model for *Vogue*. Her hair was growing back, and she wore it in a stylish, short cut. She was dressed in a lacy white blouse with a black skirt and patterned stockings. For the first time, I was able to see how really attractive she was.

Karen: I went to a PTA meeting. Can you believe that? I actually felt good enough to get out of the house and go. Some people I know just as acquaintances did not recognize me. A few who did complimented me on my weight loss and new hair style. They said I looked great. I told them to just keep talking and not to stop. (Pause) What do you think?

Analyst: Would that matter?

Karen: Yes it would, or I wouldn't ask.

Analyst: What if I thought you looked horrendous? (I was trying to follow what I thought was my analytic role.)

Karen: I'd be crushed. But just answer me. Cut the questions and answer me!

Analyst: You look wonderful. (I was afraid to continue frustrating her, and I also was afraid to be complimentary. I hoped my supervisor could help me pick up the pieces in the aftermath of the compliment.)

Karen: You answered! Do you really think I look good?

Analyst: No, I think you're a pretty ugly person. I always tell ugly people they look great. It's one of my eccentricities.

Karen: You are a character. But you're right. I should know if I look good. I just wanted to hear it from you.

Analyst: What makes my opinion important?

Karen: Oh, cut it out! You know I care what you think about everything. (A repetition of the early maternal relationship.) You're very important to me. Maybe, sometimes, I think you are too important. But enough of that. Let me tell you a weird dream I had.

It started off with Hal and me going on a vacation to Florida. He's a nut about fishing, and when we're there, he goes out on a boat every day. I stay on some quiet beach and read a novel. Anyway, in the dream I went out in this little boat with him. The water was beautiful. The colors were all in pastel blues and greens. Islands dotted the stillness of the flats, as Hal calls this fishing area. I was in a bikini, baking in the sun. He was wearing cutoffs and a silly fishing hat as he was casting from the front of the boat. It was all very sensual.

Two dolphins suddenly appeared next to the boat. At first, I thought they were sharks because of the dorsal fins, but then they stuck their faces out of the water and chattered away with us. I threw them some bait fish, and they squealed with delight. Then, suddenly, they turned and swam away to join other dolphins off in the distance. They were gone. Maybe they represent the kids. I don't know.

But, anyway, Hal hooked in a big fish. His rod was almost bent in half when he flipped it into the boat. It almost landed on me. It was silvery, with a big mouth. But when it hit the deck right next to me, it sort of shattered into pieces. The pieces became little silvery fish with ugly mouths and sharp teeth. They went for me. I saw them going for my stomach. They were like vermin attached to me with needlelike teeth. If I tried to pull them off, I tore my flesh. I was bleeding.

Out of nowhere, this handsome, muscular guy appeared. He grabbed each fish and crushed it as it hung on me. After he killed them, he opened their mouths by pressing on the sides of the jaws. The teeth came out of me. He threw them back in the water. But they turned back into the big silver fish that Hal had caught. I looked up to see this guy's face, but the sun blinded me so that I had to look away. He put some kind of lotion or medicine on each wound. His hands and arms looked powerful and rough, but his touch was gentle, even tender. No one said a word.

He climbed onto a platform at the back of the boat. In real life, guides usually do this and push the boats along with a long pole from back there. He was doing that. I realized that Hal had just disappeared from the scene. Again, I tried to see this guy's face, and again the sun was in my eyes. I looked down at his feet and worked my way up his legs; they were gorgeous. Tanned skin with powerful muscles. Veins showed through, and normally that turns me off, but not this time. The hair on his legs was blondish. I kept looking up, but as soon as I saw *his* tight-fitting cutoffs, I woke up.

I tried to get back to sleep in order to continue the dream, but I couldn't, or if I did, I don't remember it. I guess I woke up because I was getting to forbidden feelings about someone other than my husband. I also was upset when I thought that all the dead little fish turned back into that big one, and it just swam away. I had the thought that it swam away to be caught another day. I don't know why, but that made me feel empty inside.

When I told Mrs. Feldman about this, she emphasized that Karen was getting in touch with issues of closeness in the treatment. She said that this was the critical issue. She must not be allowed to use sexuality as an excuse to avoid real maternal closeness. I was advised to avoid any questions or comments that, even tangentially, could bring us to the issue of adult sexuality.

Karen's symbols for cancer and her detached relationship with her husband were connected to the fish her husband caught and the predatory little fish that began to consume her. The class joked about all the Freudian symbols of waving a "rod" around until Mrs. Feldman pointed out that Hal's lack of involvement with his wife might be related to her cancer.

The guide was viewed generally as a representative of me, the analyst. One woman asked, jokingly, how I looked in cutoffs. I told her I had knobby knees.

The blinding sun was seen as Karen's defense against being consciously aware of sexual feelings toward me. Everyone in the class, myself included, related this to her strict religious upbringing and a desire for treatment to continue. If she realized that her "guide" represented her analyst, she might have to destroy treatment out of false guilt at being unfaithful in her marriage. Unfortunately, Karen believed that a thought was equivalent to a deed.

Looking back over the years at this dream, I became aware of the screen that the macho guide provided to prevent Karen from knowing that she desired maternal fusion and emotional entropy. Sex was a superficial issue. This "guide" saved her life and then continued to steer the course. Had she been able to see his face and desire his body, things might have been very different.

I believe now that these matters should have been explored. In some way, Karen should have been made to understand that *feelings* of adultery do not get anyone into divorce court. The big fish that got away to be caught another day might *not* have if her feelings had been dealt with as they evolved. The potential destruction of the treatment came from not teaching her how to tolerate such emotions.

This dream demonstrates that cancer patients do not have to conjure up artificially images of their disorder or their protectors. They do it quite spontaneously and naturally.

After the second year of Karen's treatment, an unanticipated question arose in class. How come the treatment was continuing? Dr. G. had asked only for assistance in lowering her drug intake which had been accomplished within several months of the start of her therapy. Now she was totally drug-free.

Karen had never raised the question of not terminating, and it never occurred to me. A relationship had developed in which drugs and even cancer were secondary to feelings of connection. The process of her treatment seemed so natural that no one had questioned it until this point.

The fact that at this point Karen had no sign of cancer anywhere in her body added to this. It just seemed to have happened. Some of the medical people said that, perhaps, all the techniques they had utilized finally were working. Dr. G. said he had no explanation. He had seen people outlive their prognosis, but Karen was more than just holding on. He had heard of spontaneous cures, but he had witnessed none in his career. He said jokingly that I should "bottle" whatever I was doing with Karen.

I still had a very limited knowledge of what I actually was doing. Mrs. Feldman, however, was enjoying every minute of the case presentation. She, at least, seemed to know something the rest of us were in the dark about.

Karen continued to tell me the story of her life and, eventually, began to see that Hal was inadequate at meeting her emotional needs. She described him as basically immature and more interested in his friends than his wife. She had always been impressed with his ability to play with the children until she became aware that he was playing as a peer, not a father. He even had trouble letting the children win at games. She complained that although they had resumed their sex life, nothing had really changed. Gratification was often unilateral, and afterward, there was no holding, talking, or tenderness. He just went to sleep.

For weeks prior to the return of their sexual relations, Karen had expressed her fear of being repulsive to Hal because of the scars left by surgery and radiation. She was afraid that he would not be able to be aroused by someone so disfigured. But the real, crushing blow came when she realized that he did not even seem to notice.

At first, she thought he was just protecting her feelings by saying nothing and appearing oblivious. However, when she commented on it to him, he sort of shrugged and said it was "no big deal."

To Karen, this was an intolerable negation of her feelings. "Why couldn't he have said he loved me so much that it was no big deal?" she asked. "Or maybe that I was such a turn-on, it was no big deal. The way he said it, it sounded like my feelings and fears of rejection were unimportant. I was genuinely shocked by the way he reacted. I don't know if I can ever forgive him for that!"

Karen continued to complain about Hal's insensitivity. She came to realize that he was, in many ways, far more like her mother than her father. The more she complained about him, the more interested she became in me. Why wasn't I wearing a wedding ring? How old was I anyway? Where did I go to school? The questions were a part of almost every session. I explored all of them with her, rather than answering directly. When she asked about my age, for example, rather than simply answer, the matter was explored.

When she asked about my marital status, she told me that because she preferred to think of me as single, I would be single in her mind. This conversation evolved into what type of woman I would be interested in. She speculated that my choice would be bright, well-educated, and voluptuous in appearance. Interestingly, this was a good description of Karen, although she did not see herself as such. Karen was thinking of my hypothetical ideal female as someone other than herself. This may have been an attempt to create distance and deny her feelings.

As she denigrated her husband and became more and more interested in her analyst, the little girl coquettishness disappeared. She began to share the intimacies of her *secret* past: episodes of cheating in school, experimenting with drugs and sex. She was a child of the sixties and had been caught between religious influences and the liberated atmosphere that surrounded her generation. Hesitantly, she revealed that she and Hal had participated in peace demonstrations, although her priest and parents supported the war in Vietnam. This placed her in yet another conflict, for she admitted that her peace activities were as much about socializing and fun as for any real convictions about the war. She now condemned herself for lack of purity of purpose.

A sense of propriety permeated her existence. When things were not right in her small world, or the world at large as she saw it, it genuinely irritated her. From the minute to the enormous, everything had its place or an upset resulted. The apparent lack of reason or cause for

the Vietnam war made it a tremendous irritant to Karen. When she permitted herself to belong, to feel part of, and to enjoy the peace movement, she was in touch with the intimacy of fusion. Thus, her guilt about not taking it seriously enough can be viewed as an attempt to dilute the feelings of belonging.

As Karen became aware that even subtle seduction would not work, she became less interested in me. The less interested she appeared to be in me as a significant entity in her life, the more she revealed her most intimate thoughts and feelings. When I could be trusted with such important aspects of her life, I was placed in what seemed like a less important and less intense role. At least, it appeared to me that I was less significant emotionally. And as I became less significantly emotionally, Karen became more and more depressed. I did not know it at the time, but now believe that this strange paradox indicated that she was entering an anaclitic depression.

She began to speak in philosophical terms about the meaning of life. Love and hate were discussed as vague, uncertain feelings. Karen attacked herself for doubting her love for her husband, even her children, at times. She admitted not knowing what love was. Although she had all the acceptable responses, she felt that they were shallow and empty. She cried when she said that maybe she never really experienced such closeness. Her inadequate mother, once again, became a topic, and then, for the first time, Karen tied her husband to her mother.

I asked where *I* fit in. She said she did not know, but I was slipping away. Karen seemed saddened when she said she did not understand why, but that I was not nearly as significant a part of her life as I had been.

Instead of recognizing this shift to the anaclitic depression, I felt rejected and hurt. Mrs. Feldman, and now the class seemed to think that I probably was responsible for Karen's recovery. Even if I really did not believe I had done anything to help, I certainly wanted to. This made Karen's confusion seem like an attack upon me. I was wounded narcissistically. I cared more about my feelings than hers. In my mind, she became an ingrate.

What I did not realize was that she was becoming a small baby whose fears centered upon closeness, a closeness that meant annihilation. She had to reduce the intimacy in order to avoid the annihilation she was taught to fear. At one point, she told me I was talking too much. I looked back on the session and realized I had said almost nothing, but the little I did say was perceived as an enormous irritation. Karen reacted to whatever I said as if my voice grated upon her. Instead of recognizing the hypersensitive baby, I saw an adult woman showing me I was unsatisfactory. In my ignorance, I was vulnerable. In hindsight, it is all too clear what had happened. My lack of understanding led to the inevitable, premature end of Karen's treatment.

At this point in my training and Karen's analysis, we both suffered a tremendous loss. Mrs. Feldman's health was deteriorating, and she was in and out of hospitals. Her mysticism and

twinkle were no longer there for us. She had a way of getting all of us to do the right things with our patients. No one else has had such a powerful effect upon my education. Yonata Feldman's internal little girl was insistent upon not being disappointed or denied. At the same time, she was totally supportive in the way she made recommendations. Now, she was unavailable. I felt like a little boy cast out into a tough world long before he was ready. I was angry with Mrs. Feldman for getting sick, but I pushed this out of my mind and clung to superficial realities. I would have to make do with someone else.

I am sure that the loss of Mrs. Feldman as my supervisor was far more important than the competence of the man who took her place. I had felt that I was in over my head right from the first session with Karen, but Mrs. Feldman repeatedly had thrown me a life preserver. I listened to my highly competent, new supervisor, but I did not hear him.

Karen continued to demean our relationship. She told me that I was becoming real, that my magic was leaving. "You are like everyone else," she said. "I see you as smart but not all knowing. Cute maybe, but you'd never be a movie star. Something is gone. I feel the loss, but I'm afraid it will never be back."

My new supervisor told me to give her space and, in effect, allow the dilution. This made sense if the best treatment plan was to continue to be non-confrontational. What neither one of us saw was the suicide lurking behind Karen's pushing away. Like the foundling home baby, she should not have been put down. I put her down. I allowed her to push away. I did not take advantage of the fact that, at this point, she was still ambivalent.

Karen: I don't know why we are continuing. The last test series at the hospital showed that no active cancer exists anywhere in my body. So, why are we continuing? I'm not taking any medication either.

Analyst: Maybe we should consider stopping.

Karen: When you say that my body feels weird. I sort of float from my stomach, and I tingle all over. My arms and legs are heavy and light at the same time. I don't think I could walk if I had to. All this happened as soon as you said maybe we should stop. I'd be too scared to stop. Leaving you frightens me. But I hate being so dependent!

I received all kinds of advice from my new supervisor. None of it made sense or seemed applicable. I, too, was a baby who had been put down. I felt toward my new supervisor what Karen felt toward me. We were getting nowhere, but I was afraid to leave him. And then it happened.

Karen had another dream. This was the last dream Karen ever shared with me. It sealed the fate of her treatment and, indirectly, her entire fate. She used this dream to destroy our

relationship. My supervisor and I did not know how to stop it, nor did we know what the horrible consequences would be.

Karen: I had a very upsetting dream last night. It made me feel horrible, even though I knew it was entirely absurd.

Analyst: The more absurd, the better.

Karen: I was being chased by a huge red lobster. The claws kept snapping shut with the loudness of a gunshot. All of a sudden, Hal appeared and was holding my hand, and we both ran as fast as we could. I got the feeling that he was slowing me down, that I could get caught in the lobster's claws. The scene ends, and just as suddenly, I'm in a new scene.

I am with you and Hal. The lobster is gone, and we are just walking somewhere. You are on my right, and Hal is on my left. Hal disappears, and it is just you and me. We stop and hug. That's when I woke up. As soon as I woke up, I thought that the dream meant I want you and not Hal. Hal is the father of my children. He has seen me through all sorts of difficulties. It's absurd that I would reject him for anyone.

Of course, I pointed out that this was only a dream. I told her that dreams do not simply mean what the surface story tells. I asked her why having the feelings was so objectionable when there were no actions. She nervously dismissed everything I said as analytic poppycock. At the same time, she said she was confused and did not understand what I said.

The worst happened. She was recognizing unconsciously her marriage's contribution to her cancer (the lobster). And she was recognizing the powerful need to replace those dynamics with something better. The trouble was that she still equated the feeling with the deed. The thought of ending her marriage was overwhelmingly frightening to her.

Karen started missing sessions. Several weeks later, she decided to end her analysis. I offered many good reasons to continue. She seemed to agree with all of them, and then dismissed them as meaningless. Two years and ten months after we first met, Karen's treatment ended. As far as the medical experts were concerned, there was no sign of active cancer in her body at that time. Three years and three months after our first meeting, Karen was dead from cancer.

Within one month after treatment stopped, Karen was diagnosed with widespread cancer, similar to but more pervasive than what she had when her analysis began. Four months later, she died. I was devastated when Hal called and told me what had happened.

Dr. G. told me that it was an unusual reoccurrence, both in the degree of spreading and the rapidity of tumor growth. He said that the cancer must have been just below the surface the entire time.

I believe that Karen died because I mistakenly put the baby down.

Karen provided the impetus for the evolution of my theory of the causes and prevention of cancer. My ultimate failure in treating her was based upon my ignorance. The strangeness of her death helped open my eyes. I hope it has opened yours as well.

But, most important, I hope that now some of the mystery of cancer is a little less mysterious. Perhaps now you can view the inevitability of this disorder as within your power to influence significantly.

Chapter 14 – Conclusions

I could have waited. The ghost of the ancient Greek physician, Galen, is still waiting. It was in 2nd Century B.C. – that's right, 2nd Century B.C. – that he noticed that internalizing, melancholy women were more prone to breast cancer than outgoing, cheerful women. In 1926, Dr. Elida Evans studied one hundred cancer patients and found that the loss of a significant relationship was the most common predisposing factor. Of five hundred cancer patients studied by Dr. L. LeShan, seventy-two percent demonstrated the following:

1. A childhood marked by depression and isolation.
2. Poor parental relationships.
3. A return to feelings similar to the isolation and despair of their childhoods.
4. Within six to eight months after the loss of a job or relationship that had strong emotions attached, cancer appeared.

Only ten percent of the noncancer control group had this history.

Doctors Evans and LeShan are waiting still for a theory that integrates their observations with the facts of carcinogen theory, virology, nutrition, and dynamic psychology. I believe my theory succeeds at this integration. It fills in the blanks and appears to address all aspects of cancer.

The logic behind it provides answers to why certain areas of our bodies are relatively immune to cancer. It solves the mystery of spontaneous cures. It explains the phenomenon intrinsic to medical treatment. It provides an orientation for prevention and cure. At this point, we have observable fact coupled with theoretical causation. If we stop worshipping minutia, we will be able to see the entire patient in his life space. If we do not, we will continue to spend millions on useless studies that only demonstrate the obvious.

But some readers of this book will continue to wait. Wait for what, you might ask. Wait for more proof? Some people will demand that I cure a few hundred cases the doctors have given up on before they utilize this theory. After all, this is the type of proof modern science demands.

My question is, why wait - when none of the recommendations that come from this theory can harm anyone? Why are we resistant to acknowledging that we really can have input into the evolution of our own potential cancer and that of our loved ones. The input is not as simplistic as avoiding hot dogs and cigarettes. It is based upon a soul-searching frankness most people prefer to avoid. It is based upon taking the risk of possibly being rejected and hurt emotionally as things get rearranged.

Studies in England and America point out that cancer has a multistage development. Biologists now state that the first stage might very well occur *early* in life. More and more, the researchers are demonstrating molecular biological evidence of the instability of nucleic material as it relates to cancer. And those stubborn folks who refuse to get cancers while immersed in carcinogens and ignoring anti-cancer nutrition remain an enigma to the research scientist.

Recently, cancer has been blamed on a new culprit: survival and aging. We all know that the elderly in America are more prone to malignancies. But what of the ninety-year-old gentleman who sold us yogurt on TV and had his mother come out of their home in the Crimea to confirm his claim that this dairy product was responsible for their longevity, as well as that of their neighbors. A friend of mine returned from fieldwork in the mountains of Peru to report that the Indians there frequently live well past one hundred. In fact, one hundred is not unusual. This book explains why the elderly in America are more vulnerable. It also offers answers as to why survival in other societies, in itself, does not cause cancer.

The risk in pursuing a narrow frame of reference with regard to cancer is that you will wind up in blind alleys. While addressing the American Cancer Society's 25th Annual Science Writers' Seminar, noted cancer researcher and molecular biologist, Dr. H. Rubin of the University of California at Berkeley, pointed out that an obsessional "euphoria" with oncogenes (the minutia of the cell nucleus) eventually will prove to be another blind alley in this field. He stated that a *new* medical biology will be needed to solve the mystery of cancer. I agree with this respected scientist, but would add that obsession with specifics such as oncogenes, nutrition, and carcinogens is an obstacle to integrating what is already known. My theory accomplishes that integration.

I believe that the ideas I have put forth can affect the disorder we call cancer. Their only side effect is cure.

Years ago, C. D. Darlington, addressing the First Oxford Chromosome Conference (1964), presented an adaptive hierarchy that also supports my theory. Basically, he stated that

the physical hierarchy of molecule-gene-chromosome-organism-community corresponds to a living hierarchy. In my opinion, significant irritation at any point along this continuum will result in significant negative change. In acknowledging the instability of genetic material, we acknowledge molecular biology's contribution. But can we see now that *irritation* to the community can work its way down to the individual, and then to the final point, the chemical nature of genetic material?

We started with a reference to a notorious president – Richard M. Nixon. He was vice president to a far more respected man, warrior, and president – Dwight D. Eisenhower. "Ike" led the Allied Forces in Europe against the hideously ugly Nazis of Adolph Hitler. He returned home a hero and subsequently was elected president. Eisenhower was a military man from top to bottom. It was Eisenhower who warned America of corporate interests getting into bed with the military. He called it the "military industrial complex." Ike was right – the costs of simple equipment, billed to the American taxpayer, were at levels the General Accounting Office and the public could not believe. Hammers, screwdrivers, and ashtrays on transport planes cost thousands of dollars each. The corruption was, and perhaps still is, rampant.

But no one talks about the real danger to this country. No one sees it as a duplication of the military industrial complex. There actually is a *medical* industrial complex that is contributing not only to the economic destruction of America, but to the poor care and deaths of innumerable people. The medical industrial complex is composed of the pharmaceutical industry, the giant hospital conglomerates, and the insurance companies. It is so large that average physicians do not stop to consider that can be duped by these evil people. The studies they rely upon in prescribing drugs are conducted under the influence of the drug companies. We know they have lied many times before. Entire law firms have been established to sue them for the damages their drugs cause. We see the ads on TV all the time.

Recent studies on chemotherapy for cancer clearly indicate that it shortens life and destroys the quality of life that remains. When people die from complications of cancer, what they really die from are the medical treatments. Many times, when people get better after exposure to chemotherapies, it remains unclear whether they got better due to chemotherapy or in spite of it. We all pay for this abuse, and with our lifestyle increasing our cancer rates, we simply cannot afford to offer treatments that do not work. Medical insurance costs continue to escalate, Medicare and Medicaid are in jeopardy, and we pay for treatments that are likely to kill us.

Let us once and for all get to the truth. Do coffee enemas, Laetril, Vitamin C, my form of psychotherapy, chemotherapy, radiotherapy, or surgery have any efficacy? Are we being exposed to quackery that defies our standards of human decency? Am I as much of a quack as

the medical industrial complex? Let us find out what works and what does not. Let us stop torturing people to death.

We need an impartial means of evaluating all known cancer treatments. We need these impartial evaluations to be conducted by totally objective, non-medical, non-institutional, non-herbal, non-psychological research experts. We need truly wealthy people who are not "connected" to fund this research. The computer and/or entertainment industries can help us here. No doctors will be allowed to conduct this research. Let us find out where lies are being foisted on the public. Let us end the unending costs of useless treatment. From the highest echelons of society, we need an organization that can be objective and dedicated to cutting through the deliberate distortions. We need these people as spokesmen to present these truths to the world.

Be aware that the medical industrial complex will fight back. They will attempt to discredit any and all of this research. Their usual way is with personal attacks on the characters of those they see as enemies. They have made false claims about these people many times. So, now I will admit candidly that I am a drug dealer, a gun runner, a whore monger, and a child molester. Let us see if they can top that. The fact that I have been married but once in my life, have three children, and pursue my hobbies with zest will not be of interest to them. They will want to discredit me and anyone who questions their often incompetent and downright evil ways.

I have one last suggestion for those of you who still doubt that cancer is a psychological and biological regression to infancy: visit your local hospital's oncology (cancer) unit and *see for yourself*. The most seriously regressed patients will be in diapers. They will have to be fed by others. Their physical coordination will be severely impaired. Outbursts of upset or quiet withdrawal will mark their reaction to being overstimulated by irritants, often provided by staff or relatives.

If this fails to convince you, do one thing more: ask any of the physicians there what characterizes the hormone levels of most tumors. They will say that they are elevated. Ask them by how much. They will tell you that the *hormone levels are the same as in normally developing fetuses and newborns.*

So, you see, I could not have waited.