Büntig WE:
Learning from Cancer Patients.
Ventling CD (ed): Body Psychotherapy in Progressive and Chronic Disorders.
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Carl Simonton[1], as a radio-oncologist, wondered why some patients thrived under his radiation therapy while others with the same diagnosis, the same progression and the same prognosis wilted. He asked his patients and found out that those who got well had something meaningful to do in their lives that they wanted to finish before they died.

An example comes to mind: A 40 year old woman with a poor prognosis as a consequence of an uterine cancer prayed to live until her twin daughters would go to their first Holy Communion. When she realized that praying obviously had helped, she resolved to keep up the practice, and lived until she died at age 72 from an ileus wrongly diagnosed as an intestinal infection.

It pays to listen carefully to our patients instead of imagining that we always know better than they do.

I have worked with cancer patients for 20 years. Before getting to know Carl Simonton, from whom I have learned a lot, I learned most of what I know about cancer from my patients. I believe the potential to healing is not to be found in our medicine but in the nature of our patients. *Natura sanat, medicus curat* - nature heals, the doctor takes care, that this can happen. We cut, we sew, and we apply radiation and medicine. (Some of us still take the time to talk to their patients, and very few know how to listen – at least that's what the patients tell me). The wound as a rule heals better after being stitched, however never ever has a doctor healed anybody; it is always the wound, the natural organism itself that does the healing.

I call my workshops for ill people 'disease as chance'. The title suggests that I consider disease to be a chance. Many people observe that their crisis served them as a trigger for personal development.

This thought is as old as the one that we hear from a variety of spiritual teachers. We are told to take the narrow, stony path, not the wide road (Jesus Christ); we are challenged to "climb a mountain of a thousand swords" (Zen); a Sufi Saint prays "Lord, send me a thousand foes calling me a heretic", and a Persian proverb says "A solved problem is as useful for the development of the human spirit as a broken sword on the battlefield". We seem to need problems to develop our humanity.

What I have to say about dealing with psychosomatic disease I've learned working with cancer patients but I think it applies to all psychosomatic disease.

Patients know - consciously or unconsciously - best what they need and what they want to be healed of, or for. Some of them have goals different from ours. Some of them e.g. would rather be healed toward a dignified dying than for a prolongation of a life that, in their view, seems purposeless and miserable. Accordingly, the prolongation of survival is not my highest goal in the work with these patients, but the improvement of the quality of their lives of which their dying is an important part.

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[1] Simonton OS, Simonton-Matthews S, Achterberg J: Wieder gesund werden. Rowohlt, Verlag. Hamburg 19□□

In my workshops, my work is not medical but educational. The advantage of this is demystification. When I work as a teacher and not as a healer or doctor, it is more difficult for patients to believe that I could heal them. People going to the doctor tend to believe that the doctor can heal them, and cancer patients believe that even more. One of the personal tendencies connected to cancer is the lack of autonomy called *anomia*, the ignorance of our own inner law, including the ignorance about their own inner healing capacities. Saying that I am not working as a doctor is applying an indirect suggestion: I'm a teacher, and if you come to a teacher it means that there is something to be learned. This way it is easier for patients to get used to the thought that the healing power is within themselves, and that, in co-operation with the doctor, they can learn to support this healing power.

I want to share with you how I got to work with cancer patients, not because my personal story is so important, but rather to tell you the lessons I have learned from my patients in the course of the years.

Cancer is a psychosomatic disease

More than twenty years ago I was a psychotherapist in private practice, working with Gestalt therapy and Bioenergetic analysis. A young woman from a southern European country – very attractive, elegantly dressed, very sophisticated and very verbal – comes to the session and reports that a year ago she had had a carcinoma of the thyroid which had been removed and radiated. She now had a recurrence at the same spot that likewise had been removed and radiated. She had refused the total operation that had been recommended because that would have rendered her extremely unattractive. "They would have taken half of my neck, and I would rather die than be disfigured or mutilated to that extent", she said. As a media person, she was identified with prettiness, attractiveness, and perfection.

I asked the woman what I could do for her. She answered that she had two years to live, and she wanted to use the time to find out what kind of a person she was that she allowed something like that to grow in her, and she wanted my support in that exploration.

Throughout my medical carrier, I had always been interested in psychosomatic questions. I was convinced that the common cold, the migraine attack, the ulcer of the stomach, asthma, and coronary disease etc. were psychosomatic diseases. Now I was confronted with a patient who told me that she saw her cancer as an expression of the way she lived. I was stunned. Today I'm stunned that I did not wake up then, because as a Bioenergetic therapist I knew the literature of Wilhelm Reich[2]. I should have known that there are people who consider their cancer a psychosomatic disease, but I had forgotten. This patient now made a connection between her disease and her way of living. That was my first lesson: cancer is a psychosomatic disease.

The tumor is not the disease, only its symptom.

In Bioenergetics we work with the body: we mobilize the body, we suggest expressive movements, we encourage discharge. That may lead to much crying and chat-

[2] Büntig WE: Das Werk von Wilhelm Reich und seinen Nachfolgern. In 'Die Psychologie des XX. Jahrhunderts'. Kindler Verlag. Zürich, 1977.

tering teeth which already in the bible was considered to be healing or re-incarnating. One day our patient is standing in the room, her whole body vibrating, quietly crying and with chattering teeth. She calms down, smiles a fine smile emerging from within, saying quietly, and very clearly "Wolf, my cancer is gone". When I ask her "what do you mean - did they not cut out the last metastasis a year and a half ago?" she says: "That was not the cancer, that was only the tumor". When I ask her, what her cancer was, if not the tumor, she answered: "Cancer is how I live". That was the second lesson. The patient saw her tumor only as a symptom while her disease was the way she lived.

Hopelessness

The patient hates me every session, because in the regression she remembers things she prefers not to know, not to talk about letting anybody else know. She begins to feel a truth that she doesn't want to feel, e.g. her lack of grounding, her sense of not standing in life. But she returns again and again, because after each session she feels better – somehow more real.

Only after developing a sense of presence she realizes how much she depends on feedback by others for the confirmation of her self-image. She follows the rules of others, submits to norms not her own, and feels alienated from herself. The patient recognizes her *normopathy*[3] as the cause of her cancer. She talks about the permanent stress – or strain[4] – due to her habit of always having to pretend that she is different from what she is beneath her pretty façade, trying to find out what people might expect from her, and looking for approval. Who she is is not a direct experience of her individual presence in the moment, but is an image constructed as a reaction to her fear of what others may think of her.

Many of us were traumatized very early on. The process of birth already was terrible – suffocation by disconnection of the source of oxygen as our first experience in the new world, being hung at the legs and hit on our backs, acid in our eyes – all kinds of good reasons for not wanting to be here at all. Early experiences like that may trigger the basic feeling "I don't want to be here, this is wrong", but being identified with the world at that time, we experience ourselves as wrong, and as incompetent. Already, at that early time, we are quite capable of letting the world know through our emotions what we need. But since most people at our time and in our part of the world are well in their minds but completely out of touch, we find ourselves at the hands of people who don't understand our signals. In this basic experience of incompetence – "whatever I do doesn't lead to anything" – I see the deepest root of our inferiority feeling – a first occasion to develop a distrust of our competence and doubt of our own worth.

Humans born in narcosis, not seeing shining eyes welcoming them on this world; babies fed according to the clock, not in response to their personal needs; children raised according to parental expectations rather than their own potential; humans who, as a consequence, never really felt accepted and perceived – humans like that may learn to think they have to earn their right to exist by being good and nice, by submitting and performing.

However, existence is a given, you cannot earn the right to exist. Trying to earn a given, rather than to take the given as a gift, is a deep source of hopelessness.

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3 Büntig WE: Normopathy and Autonomy (unpublished manuscript)

4 Zander W: Neurotische Körpersymptomatik. Springer Verlag.

The attempt to earn love in the sense of unconditional acceptance by exaggerated adoption to norms, i.e. trough self-denial, is hopeless. If my basic experience is that mother loves me only when I'm nice, and I therefore do everything to be seen that way, I will not believe that she loves me as I am, because she does not love me for what I am but for what I pretend to be. If she cannot love me for what I am ... Here we have a vicious circle.

LeShan, the pioneer of psycho-oncology who as a trained psychoanalyst had worked all his life with cancer patients, defines the hopelessness of those who develop cancer this way: "Hopelessness is trying to be who you are not."[5] This insight into the psycho-dynamics of the hopelessness underlying cancer was the third lesson, in connection with the fourth.

Self denial means permanent stress

The medical sociologist Grossarth-Maticek showed in repeated prospective studies with great populations that people showing the psychological factors 'rational and anti-emotional behavior', 'latent despair' and 'denial' run a much higher risk to die of cancer within the next ten years in comparison to a control group.[6] These observations correspond to older retrospective studies of which most see the suppression of emotional reactions as a common factor disposing to cancer.

Thanks to Freud we know about the defense mechanisms: denial, suppression, repression, transference, etc. Thanks to Wilhelm Reich we know that these defense mechanisms are work done with muscles.

The baby screaming for hours for milk or attention, being torn between the pain of the hunger and the pain of the screaming, deals with it finally by contracting. The child screaming from the pain of physical abuse, threatened by more abuse in reaction to his or her screaming, contracts. Like the ameba that expands toward what is nursing and shrinks away from what is threatening, humans open up to love, and shrink away from what does not promise love and pleasure.

If our needs in early childhood are not appropriately met, if the corresponding emotions are answered by the threat of annihilation, neglect, demands, expectations, manipulation, seduction, suppression, contempt, allegations etc., the child learns first to suppress the emotional expression, soon the perception of the need and finally even the impulse itself by contracting the corresponding musculature. To get what they need, children learn to hold their breath, to grind their teeth, to throttle their throat, to pull their shoulders up and their bellies in, to lock their knees, to squeeze their buttocks etc.

Humans, like all living beings, develop in movement. We move in relation to objects (aggression); we move towards them, away from them or against them, as Karen Horney pointed out. Moving, we perceive inner movement (sensing), we give these inner movements personal meaning (feeling), and we express them (emotion). If we are holding a lot, we move less; then there is less inner movement to be sensed, we feel and learn less, and develop a diminished felt sense of self. With a weakened sense of

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5 LeShan L: Diagnose Krebs – Wendepunkt und Neubeginn. Klett-Cotta. Stuttgart 19□□.

6 Grossarth-Maticek R: Systemische Epidemiologie und präventive Verhaltensmedizin chronischer Erkrankungen. Walter de Gruyter. Berlin, New York 1999

self, we learn to rely on an abstract self-image which we need to have recognized and confirmed by other people.

The defense mechanisms described above are embodied as conditioned reflexes to past experience that can be triggered by minimal, unspecific stimuli, and diminish the perception of possibilities of satisfaction in present time. This way, given a certain character structure, even a friendly approach can trigger a reflex of pulling up shoulders, holding breath and grinding teeth, and this way may be experienced as a threat. If you, dear reader, pull up your shoulders a little and grind your teeth, you will automatically experience your environment as distant or even hostile; and with locked knees you most likely loose your contact to the ground, and to reality.

Exposed to these reflexes, the whole organism shrinks – Wilhelm Reich saw cancer as a 'shrinking biopathy'[7]. The person imprinted this way feels unloved, and as a consequence tries to obtain love through submission. The paranoia corresponding to the defensive stance, i.e. the expected rejection or hostility projected into the environment, means permanent stress. And stress weakens the immune system. This was shown in so many experiments in animals and clinical situations in humans that this fact cannot be doubted any longer.

Loss as a trigger

A t a certain point in therapy, a woman with breast cancer understands that her divorce – today one would say psychoanalytically: the loss of a meaningful object – was the trigger of her disease. She sees that whatever she did, and how hard she tried, she could not get her husband to love her the way she needed him to love her. In many years of a marriage concerned about harmony, she had strained to please him, to do everything right for him, always in the secret hope that "one day he will see what I do for him, and he will have to love me". The husband, of course, loved her the way he understood loving, but she could not perceive that, so he finally gave up.

LeShan[8] describes a pattern of life characteristic for cancer patients: The early loss of an important close relative in early childhood (I would add: the failure of early bonding) weakens the ability to relate of the young person. Deep and close relationships are experienced as dangerous. (An example from the literature: Fritz Zorn dying from cancer describes in his book 'Mars'[9] in which he levels with the Zurich 'gold coast' how he was part of many groups, but never had a real friend.) Somewhere along the line this person commits to a relationship to another person, an important cause, a profession, even an illusionary hope (a purpose giving object) on whom he or she becomes overdependent for establishing security, self-worth, meaning, etc. in his or her life. As long as this relationship lasts, and as long as the person can believe that he or she, by doing everything to the point of self-denial, can secure affirmation of the right to exist, early despair can be repressed. When, however, at a certain point the availability of the purpose giving object cannot be controlled any longer, cancer develops. In LeShan's study 72 % of his cancer patients showed this pattern.

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[7] Reich W: The function of the orgasm. German edition: Die Funktion des Orgasmus. Kiepenheuer und Witsch. Köln 1969) (Für Englische Referenz 7)

[8] LeShan L: Diagnose Krebs – Wendepunkt und Neubeginn. Klett-Cotta. Stuttgart 19□□

[9] Zorn F: Mars. □□□□□□ (wie 7)

In one of the earliest statistical investigations of psychological factors in relation to cancer about 150 years ago, bereavement was shown to be one trigger of cancer.[10] Today there are corresponding investigations in the laboratory showing that in a high percentage of recently bereaved men of a certain age group, the immune system collapses in the first six weeks after the loss of the partner.[11] That doesn't mean that cancer will occur in every case of bereavement, but we may say that this study affirms the earliest statistical investigation of psychosocial factors facilitating the development of cancer.

The most plausible hypothesis is that in persons who depend on objects for meaning in life, and are strained by latent despair, as a consequence of the loss of an object the intensified stress necessary to suppress the actualized despair may cause the collapse of the immune system.

Cancer as suicide

This patient said that when she saw that she would not be able to salvage her marriage through her persistent attempts at adaptation, she did not want to live any longer. She now understood her cancer as a socially acceptable attempt at suicide. I was reminded of the 17th century poet John Donne who, dying of cancer, said that he had done nothing with purpose and perversely against himself, and yet he was his own executioner.

Another patient expressed that connection directly. Since her young years, she had attempted to find recognition of her worth as a woman in many changing sexual relationships; however, every time a man was ready to commit to a relationship with her, she ran as fast as she could – into the bed of the next one. When, at age 35, she recognized this pattern, she resolved: "If I don't have a man and a child in a years time, I will kill myself." Exactly one year later she had the diagnosis of breast cancer. The first thing she said in the initial interview was: "I guess I didn't dare do it directly, so I did it this way."

Motivation to live – a healing factor

The next lesson – again from my first cancer patient – was that the motivation to live had a great influence on the course of disease. The motivation is increased when you have a good reason to live.

That woman with thyroid cancer reacts positively to all kinds of treatment as far as well-being is concerned; e.g. she has hardly any side-effects from the treatment. In spite of intensive radiation she blossoms. Quite obviously, falling in love with the doctor of the ward boosts her motivation to live. However, her whole belief system gets turned upside down. Remember: She is identified with being attractive, has to be dressed and behave always properly, smell good, be clever etc. Because of the circumstances of radiation, according to her own standards, she is anything else but attractive. She is "painted like an Indian", she does not always smell fresh, she must not wash her hair, she finds herself ugly and feels miserable – and just in that moment a man falls in love with her whom she herself finds marvelous. She gets married to him, and she has two – now grown – children with him.

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[10] Quoted in Simonton OS, Simonton-Matthews S, Achterberg J: Wieder gesund werden. Rowohlt, Verlag. Hamburg 19□□

[11] Riethmüller G (Keine Ahnung wo ich das finde)

The marriage lasted 15 years. The woman went through her divorce without a recurrence, and has lived well up to now for more then 20 years.

Spiritual forces – miracles are possible

The next lesson came from a colleague who jumped to my rescue when, after my first public lecture on psychological factors involved in cancer, the doctors in the dark suits with a bow in the second last row bombarded me with questions about statistical proof of my observations and hypothesis. She told us that she was a pathologist, and had just returned from a conference where for several days they had discussed the evidence for the role of the immune functions in relationship to morbidity and outcome of different kinds of cancer. She shared that she was very impressed by the accumulated knowledge, but was questioning how this all could be applied clinically.

She tells the audience how, on her way back, in the train compartment, she has a thought provoking encounter with a middle aged man, a carpenter, sitting opposite her, who started sharing with her his own story of a spontaneous remission from (if I remember correctly) colon cancer. He tells her that he is just going home with the diagnosis of health from the very same university clinic from which he had been sent home to die 3 years ago. After exhausting all common therapies like operation, radiation and chemotherapy, they had told him that medicine could not do anything anymore for him. At that moment he knew that if no human being could help him anymore, only a miracle could, and that he had to rely on his spiritual forces. She finishes her contribution by saying that it would be absolutely unscientific to deny phenomena like spontaneous remission only because we do not understand them. The least that we could do would be to not stop wondering... Today the idea that a man could heal from cancer by relying on his spiritual forces is not so alien to me anymore, but then I found it very remarkable. This was the eighth, and the most important lesson: miracles are possible.

Miracles are not very probable, but they are possible. The probability, according to scientific and statistical observation, of so many life-supporting factors coming together in this minute speck of dust in the galaxies is extremely low. Life on earth is quite unlikely, but obviously possible.

We commit a grave medical mistake if we rely only on probability to the exclusion of the possible. E.g., if we tell a patient with a carcinoma of the pancreas only that according to statistics he has a chance of 2 % to live five years, and do not stress that he has chances, and can do something, to belong to these 2 %, we participate in something like VooDoo-Killing. We support his hopelessness instead of reminding him that what is possible is always more than what is probable.

Probability (as the German word 'Wahrscheinlichkeit' indicates) only covers what seems true. Even if it is highly unlikely that somebody heals from this or that disease, we must not lose sight of the possibility of healing. This is a more correct dealing with reality than denying the possibility of 2 %. It does not mean that we raise falls hope when we say that there are things that are possible even if they are not very probable. So we have to do both, get the patient acquainted with the statistical probabilites around his disease AND keep is mind open for what is possible.

Being a product of this culture and of medical training, and therefore always tempted to confuse the calculations of probability of the statisticians with truth, even af-

ter witnessing a number of unlikely cures, I need to remind myself again and again of the possibilities of miracles. I never get tired of inviting patients to the miracle of life. I tell them to look out of the window, to see the sun rise and go down, to watch the moon wax and wane, to discover fragile flowers pushing through snow, to see the trees grow new buds before shedding their leaves, to feel their pulse and their breathing, to remember a child being born – even if our mind has explanations for some of these phenomena we can open ourselves to the miracle of Life behind it all.

People opening to this miracle of life live a more meaningful life and die a more meaningful death even if they don't live longer. That also I call healing.

The power of imagination

In the lecture mentioned above, there was a man in the audience whose wife suffered from a metastasing carcinoma of the breast. He had collected much of the important literature available at that time about psychosocial factors in relation to cancer, and he gave it to me. What a great gift! This way I learned about the work of Carl Simonton and Jeanne Achterberg and their way of working with imagery, and all the other things they made their patients do in order to stimulate self healing, and I felt confirmed in many of my own observations.

His wife comes for treatment. Like many she knows next to nothing of her self beyond the reflections from her environment. Through body-work, she starts to realize, and to enjoy, that one can sense oneself. She spontaneously discovers that she can feel her own pulse. When she realizes that there is something happening in her body she cannot control, she is scared, even angry. (Later, after observing similar reactions in many other patients, I recognize the inclination to control life as a common characteristic of the character fixation disposing to cancer which I call 'normopathy').

I reframe the pulse that she experiences as dangerous as a sign of life within herself. She gets so fascinated that she continues to practice sensing her pulse at home, and when she comes back to the next session, she reports that she can sense the wave of the pulse and to follow it to where-ever this leads her in her body. The patient realizes that she can follow the pulse, and with it the felt sense of self, to where-ever she wants except the areas where she has tumors. Despite her fear of dissolving in this diffuse feeling of soft pulsing, she learns to focus her consciousness on the metastases, and to direct the wave of life there whereupon she senses that the spots that she hat experienced as absent or cool become hot all of a sudden.

Around that time she discovers in my practice a book about anatomy for artists, and when she asks me I confirm that her rib cage looks the same as in the book. When she asks what metastasis look like – she had about 20 in her ribs at that time – I recommend that she looks at her X-rays, which she gets from the clinic to find out that in metastasis the bone structure looks washed out. She remembers an old passion of hers, and with a painted pencil she starts to draw rib cages. Where-ever she has a metastasis, she smears the fine bone structure and says: "This is how it is". Then she takes a sharp eraser, erases all the metastasis and draws fine bone structure, and says "and this is how it should be". A few weeks later the oncologist calls me saying "a miracle is happening; finally, the hormone treatment is working – the metastases are melting like butter in a stove."

Today I believe that we can influence the course of disease by imagination, by informing or, better, reminding our organism of what is possible. In the case of our patient this does not mean to deny the metastases that are there. It means that she reminds herself through imagination of the possibility of healthy bone structure, and her bone tissue heals. I know many other instances in which the persistent imagination of desirable outcome, against all probability, was connected with the manifestation of possible health.

Tumors come and go

The same patient has other metastases later on, which all, except for one, disappear again, especially after physical activity. First, the metastases in the vertebrae start to shrink after an autonomous decision, revival of the marriage and much exercise.

One day, the patient asks me for advice if she should go on a canoe trip to Norway with her husband. At the hospital she had been told that she shouldn't because she was risking a collapse of her vertebra in which she had developed a cherry-sized metastasis. I tell her firmly that no way could she get me to intervene in this struggle. There is only one she can ask for advice, and that is her own self. She looks inside, sees herself paddle in one of the fjords, and says "I go". When she returns after four weeks, she is tanned, looks back on a period of closeness and peace and joy with her husband, and the metastasis has shrunken to the size of a pea.

Then follows a long phase of ambivalence toward her husband. She develops the belief that only through separation can she get independent of him. On the other hand, she feels she cannot leave him without guilt feelings because of what she perceives as his helplessness. She develops new metastases that now become the cause of much pain. She turns to folk dancing, falls in love with a young man, and the metastases disappear. When the young man leaves her for another woman, she develops a large metastasis in the left shoulder involving the joint. In her fighting spirit, she answers this by starting to play tennis – she is left-handed- and the metastasis disappears.

Since then, I do not believe anymore what I learned in school, that cancer is the mathematical process: One cell today, two cells tomorrow, then four, eight, sixteen, etc. Today I know from the observation of many similar cases that cancer is a very dynamic process.

Another woman comes to mind. I don't know her, really. She, however, remembers me from a long time ago when she once saw me as a young man. Many years later she writes me. She has heard that I am concerned with cancer, and in her letter tells me her story. She has been given up by medicine a long time ago. There are times when she can literally watch the metastases grow in her lymph nodes. Then she disappears in the woods and, living in a primitive cottage, starts to paint "like mad". Like Breughel, she paints the devils always lurking underneath her façade. She paints what to the normopathic mind seems like pornography, blasphemy and saintliness at the same time. She paints "the devil out of her body" as we would say in German – and the tumors shrink again. For a numbers of years I have not heard of her. She may have died. She may, still, be alive.

Freedom from complaints - or health?

Back to the before-mentioned patient, the one who went on a boating trip in spite of all medical advice to the contrary. We worked together for a few years, and for a long time, the metastasis in the vertebrae was the only one that remained. Then I hear from Carl Simonton about the work with the secondary gain of disease, and tell her about it. She remembers that, before coming to therapy, she once had thought "It would be good to always have a little bit of cancer; that way I will never again have to do this stupid work I'm doing". She hates her job but, because of her age, she doesn't believe she could learn something else.

She stays in this ambivalence for a long time. The urge to do something useful gets stronger, her existence as an unused pensioner becomes more and more intolerable; but she doesn't find anything that she wants to commit to, and she doesn't engage in a new relationship, despite good chances, after finally separating from her husband. In therapy she talks about the things she does, how she feels, and what she feels driven by, she describes her inner suffering, but she doesn't change anything. I remember how Carl Simonton once warned me: "Most people want to get better – they don't want to get well".

Transference

The tenth lesson helped me to understand more deeply the psycho-dynamics around transference in cancer. One day I go on vacation for a month without preparing the patient sufficiently, without giving her enough exercises to do in the meantime, and without helping her to integrate into a system of support. Her marriage was over and her new affair at limbo. I have become her *intimus*, and a safety valve. And all of the sudden I'm gone. Her early history is marked by great abandonment, and by massive denial of her (female) identity (her 80 year old father still calls his 50 year old daughter 'Peter'). And now she is abandoned again. The enthusiasm about the disappearance of the metastases in her chest and her shoulder is followed by disillusionment and disappointment. When I come back from my holiday, the metastasis in the vertebrae has grown again, from the size of a cherry to that of a large cherry, threatening to collapse.

I had become the purpose-giving object for this patient, and she had directed all her hopes to be accepted, recognized, and cared for on to me. She experiences my sudden disappearance as devastating as a newly born must experience the disappearance of mother.

(This occurrence taught me to beware of too much transference with cancer patients, in order to avoid this kind of 'malign regression' into dependency outside of the therapeutic situation. This is the reason why, with cancer patients, I almost exclusively work in experiential groups, and not in individual therapy. The group is a much more consistent mother than an individual can ever be.)

When I confronted the patient with the fact that I had become her or the central figure in her life, and that years ago she had admitted the wish to always keep a little bit of cancer, it was one confrontation to many. She broke off therapy immediately. Not much later she had a recurrence, as I heard from the female therapist to whom she had turned. Two years later she died. However, she agreed to her dying, and she died in peace of mind. Towards the end of her life she had become sort of a teacher for many other people with cancer by handing on what she had developed internally. She must

have undergone a substantial spiritual development in her last years, and must have encouraged others through her presence.

This brings us to the topic 'disease as chance, or the suffering of human beings as a trigger of personal development'.

Gain of Disease

The work with secondary gain of disease is described extensively by Carl Simonton[12]. There is a gain to every disease, if you are open for the idea. Of course, there are people who say that their disease is only a disaster, they are its victim, and others – or the cosmos – are to blame. Why me? I have given up trying to convince people of something that doesn't fit for them. The work with the gain of disease is only one tool of many, and an intervention that doesn't work is more a burden than a helpful tool.

However, one could at least ask patients what they mean with their question "Why me?" Even from the point of view of a victim one could usefully ask the question, meaning "Why did that happen to me?", "How did I deserve it?", or "What does this disease say about me? What can I learn from it for my life?"

Sometimes I tell people that as a psychotherapist I am a specialist in life-style. You go to the surgeon, when you need something to be cut out, and you go to the psychotherapist if you want to learn about yourself, if you are interested in your way of living. Most of the people who come to my groups can make use of questions like these, they even have come because of these questions, after reading them in our brochure. If you want to, you can make work easier for the patients by explaining the concept of gain of disease with your own examples.

As a rule, patients identify four categories of gain of disease:

1. relief, or escape from a situation experienced as hopeless;
2. attention or a similar need confirming existence;
3. the question of purpose of life, and finally:
4. autonomy.

Disease as relief or escape

The first gain of disease is relief from a burden or an escape from a situation perceived as hopeless. Not infrequently, a patient will say: "I knew that I could not go on like this. For a long time I was afraid that I could not keep up with the situation - that I would fail. When I got the diagnosis, my first reaction was relief."

A woman in her fifties with breast cancer comes to a counseling session. We talk about the basic assumptions of the work. When she asks "Does that mean I would have to inquire into my marriage?", I answer "Not necessarily, but since you are asking, maybe yes". She gets very quiet, bows her head, sheds a few tears, and says "I would rather die". Then she explains that she doesn't really want to know what she allowed in this marriage, and what she did to herself in that marriage. She would rather live out the prognosis of two years as good as she could, and leave everything "under the rug". To think of separation or even divorce was not conceivable; the way she had been

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[12] Simonton OS, Simonton-Matthews S, Achterberg J: Wieder gesund werden. Rowohlt, Verlag. Hamburg 19□□...

brought up, changing her mind would be more stress than going on with repressing what she did not want to know. She assumed that if she would confront all that, she would die faster, and therefore she wanted to leave everything as it was. I believe this was a wise decision. Some researchers believe that denial and repression is the second best strategy for survival in cancer, next to active tackling with the disease.

Attention

In the beginning, especially with those who statistically have very little chance of survival and who therefore don't have much time to change a lot of things in their life, the work with the need for attention is central. On the lists that patients make of gains of disease, the attention factor is rarely missing. "My husband all of a sudden realizes that I am still there", "My wife takes good care of me since I have been so sick", "Suddenly, I have become interesting for people", "I am very surprised how many people come to visit – I always thought they would only come because I am so pretty, attractive, interesting, intelligent, brave, etc.. I am none of these and yet they come. They must mean me".

Let me give you an example for attention as a gain of disease: Henry, a patient with a carcinoma of the lung with hopeless prognosis, has de-compensated and needs to be transferred to the intensive-care unit. Nobody understands why he starts to flourish again until I visit him one evening. The reason is very simple. In the intensive-care unit there are seven beds, one is empty, three are occupied by unconscious people – and there are three night nurses. Who has worked in intensive-care units knows that the nurses there are of the category if angels. Very dedicated, very committed people are working there. At home, his wife made him cook his own tea as long as he could, and I considered that the right decision, even if it was difficult for her. Here in the intensive-care unit he was being pampered. There was always somebody there ready to hold his hand, to rub his back, and to listen to him discussing his marriage problems – a lot of touch, a lot of attention. Of course, Henry blossoms. He is only afraid of being sent to back the regular ward.

Back in the regular ward, Henry de-compensates again. He doesn't practice, he doesn't meditate, it is impossible to reach him with words, and he hardly responds to touch. He is full of codeine to suppress the coughing, and it is not possible for him to talk. Christmas is coming, and in one of my visits I tell him I want to say goodbye because I anticipate that we will not see each other again. No reaction. I try again, in vain. The third time around I talk with more emphasis about saying goodbye – it's the last time that I can visit him before Christmas. I talk about the good times that we had together, the love that was there and the good work that we did. I talk about his wife and his daughter, and I give him a survey of all the understanding and relating that he had developed in the time of this disease. Suddenly this man whom I had perceived as unconscious sits up in his bed, looks at me and says: "Man, leave me alone with your ... dying", whereupon I say "Yes, of course." I give him the codeine into one hand, I hand him the paper basket, and although I say nothing he understands the symbolic gesture. He looks at me somewhat pitiful, but then he throws the codeine into the basket, asks for his cassette recorder, and continues to practice his imagery and meditations.

When I come back after Christmas, his bed is empty. I shed a few tears, but the night nurse, seeing me, comforts me "He went home today". He had waken up and become active. He finds out that in the United States an apparatus has been developed that he could produce oxygen with in his own bathtub. He convinces his health insurance that it would be worthwhile to buy the machine for him because it was cheaper than ten days in the hospital, and he had resolved to live longer. At home, I find him sitting with a guitar in his hands. With the little breath that is left to him, he is teaching his little daughter a few songs. Henry lives three more months. In his last weeks he cleans up his relationship with his wife, and finally dies in the arms of his wife, in the presence of their little daughter, and with a few friends that he had gotten close to in the group around his bed – without choking, in meditation, and in peace. I take it to be useful work to teach people to live well and to die well.

Attention confirms existence. The need for the confirmation of existence through attention has been neglected in psychotherapy for a long time in favor of Freud's hobby, the sex-drive. The most reasonable material on attention that I have found in this area comes from the Sufi philosopher Idries Shah'13. He observes that everything that people do with each other – be it buying or selling, teaching or learning, talking or listening, preaching or praying, leading or following – just everything people do with each other is at least stained, if not determined, by the need for attention.

There is an easy test of how you go about your need for attention. Just imagine, here and now, that you say into the face of a person whom you consider a friend, "Please look at me, please listen to me! Please hold me!" How do you react to this fantasy? Do you get warm, or do you shrink? There is a great number of people who have a hard time asking these things of an other, and there are people who would rather grind her teeth into their jaws or bite their tongue then get a request like that over their lips. The need is so great, and the emotional reaction they fear is so overwhelming, that true to an old habit, they shrink.

In the beginning, we are completely dependent on mother for both food and attention. By experiencing getting hungry and being fed again and again, we've learned that the rhythmic cycle of getting hungry and being fed is part of life. We have no doubt in our minds that it is agreeable to get hungry, and we have learned to expect that there is food.

We need attention as much as we need food. But if mother doesn't know how to attend to her child as a unique human being in a personal way, we learn to believe that we are not worth being paid attention to, and finally find our most basic need annoying, if not disagreeable. Some of us even believe it would be better if they were not there at all.

Before we do anything else, we should pay attention to our patients, and we should teach them pay attention to themselves. This way, over time, they may become independent of the attention of others, and of unconscious and coincidental sources of attention like fashion, status symbols, keeping up with the Jones's, what people think of them – and finally: disease. We become independent in dealing with a need only by recognition of the need, not by denial. We can suppress the need for attention as little as that for hunger for food, or thirst for fluid.

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[13] Idries Shah: Learning How to Learn.

Those who are ambivalent about attention, and hence are not used to paying attention to themselves as well as to life around them, easily get lost in their grudges about the past as well as their fears about the future. When existence is jeopardized by a life-threatening disease - which may have been invited by the constant stress of having to prove the right to exist - then practicing attention is of utmost importance at least for the quality of live, if not for survival.

Attention in itself is healing, and the therapist who really gives attention to his patients is already doing a lot for them – and sometimes he can do more. He can teach patients to pay attention to themselves, to their feelings, to their needs, and to their dreams.

Careful work with this as well as with other basic needs if of central importance for the course of disease, and recovery. If the person learns to experience or to except that he is welcome, accepted, taken serious, appreciated and respected just the way he or she is, then they can also learn to accept themselves, to take themselves seriously, to appreciate and to respect themselves. As a rule this is a prerequisite for learning to perceive the call of the inner voice saying what their life should be about.

Autonomy

We can learn a lot about secondary gain of disease from Heidi, a woman suffering of a rapidly growing malignant non-Hodgkin lymphoma. I had first met her in an open four-week intensive. In the opening round, after others had weakly and timidly said what they had come for, Heidi said with a clear voice: "I'm here because I have cancer, and I want to do something for my life". That changed immediately the tenor of the group for the rest of the month. From the beginning on this woman became a teacher for the other members of the group, and later for other people around her in her life. During the break of one of the first days she handed me a little piece of paper saying: "I don't dare say it in the group – it's to crazy, but I am grateful for having gotten this disease". When I asked her to explain she said she had never believed that she would ever question, or even find out, who she is.

Heidi was completely defined by others. Her identity was unknown to her as she identified her self with roles she had developed in relation to others. She was the loving wife of a depressive man, the caring mother of two spoiled teenagers, the colleague of teachers who used her as a leader because she could best verbalize their own political dreams, and more than anything else she was the patient daughter of an alcoholic mother. She had no idea of who she was as an independent human being.

She learned in big steps. In no time, she became the most successful practitioner of imagery I have met so far. She was treated with aggressive chemotherapy and had to go to the clinic regularly for a blood count. One day the professor wanted to keep her in intensive care immediately, because the white blood cells had gone down so dramatically. She refused to stay, telling him to wait for three days, and see. After three days she came back with normal blood count. Not only did she imagine her immune system as really strong, but also she had discovered sexuality – for herself and for her white blood cells. Vividly and with zest she imagined the multiplication of white blood cells as mice copulating and having babies all the time.

When I first saw her, her prognosis was a few weeks. When she called me three and a half years later to say goodbye she had had three complete remissions, and three recurrences. There were times when she could watch the knots on her neck grow, and others when she could watch them disappear.

Under therapy, Heidi became a very independent woman. That doesn't mean she became asocial, quite to the contrary. She just knew more and more of herself and her own inner law. She became clearer in relations to others, she learned to say no where necessary, to take care of her own boundaries, and thereby had much more time to open for contacts with her fellow human beings and to give them what she really had – an open ear. She knew how to listen. She became more and more beautiful in the sense that the soul she was came through her eyes more and more; her eyes became more and more open, more and more unguarded. People she looked at knew they were being seen.

Heidi also learned to see her death. She had gone to a Greek island for a few weeks to look at her life, past and present. One day she had a conversation with a screech owl sitting on the roof of the little chapel nearby from where she camped, and she knew her time had come. The night she died she called me. She told me she didn't want to go, she was fighting like a lioness but her strength was used up. She knew she was going this very night. She said that she was grateful that in these three and a half years with cancer she had learned more than in the thirty years before, and that she had learned a lot.

She had learned to tell her fellow teachers to find a new ringleader for their rebellion. She learned to tell her husband to shape up. She told him she had cancer, and he was depressed; that she was his wife, not his mother, that she could not carry him any longer, and that if he preferred to stay put at home that was okay, but she was going to the pottery shop. She liked the pottery shop. There she could kick the wheel and make angry sounds. She learned to tell her teenage daughters to clean up their rooms and to do the dishes half of the week. And, what was most difficult, she learned to send her mother away. When she came, drunk as usual and ready to dump her misery on her, she said: "Mom, I love you – sober! Come back tomorrow when you have slept it off, and we will talk." Heidi had become rather autonomous.

Let me give you another example of the development of autonomy triggered by falling ill with cancer. When Ursula heard me talk, in the group, about gain of disease, she knocked her fist on the floor, saying "Exactly, doctor, that's it! – The disease was my alarm clock". When I asked her what she meant she said: "Well, up to recently I did not exist at all. I was always there for other people, trying to please them, and to do everything right. I ironed my husband's shirts and polished my sons' shoes, but I myself didn't occur. That has changed radically at the point of diagnosis. Today, I go first". When I thought, secretly "That sounds a little selfish, that's not what it is all about", she said loudly "that may sound a little selfish, but that's not what it is. I love being there for others!" – here we see a radical turn in consciousness: where before she had to be there for others to prove her right to exist, now she loves being there for them – "and, of course, I iron the shirts of my husband and I polish the shoes of my sons; but it is me who is doing that". She had radically put herself at the center of her life and taken charge of anything she did. It was she herself, doing what she did, thinking what she thought, feeling what she felt, letting go of what she was letting go at that moment. No-

body else was responsible for, or guilty of, what happened in her life. The one who is doing what I am doing, that's me.

Autonomy seems to be one of the most important psychosocial factors in the struggle with any disease. People demonstrate autonomy in the way they deal with their disease. Some people developing the ability to say "This is my disease. It is up to me to make sense of that disease, to understand the lessons it is telling me, and to change the circumstances of my life in a way that supports healing". They give up seeing themselves as victims, and become autonomous. That's hard work, even stressful work, but it is also the most meaningful way of dealing with the disease.

Feeling

Feeling is a way of paying attention to one-self. Feeling is a conscious, purposeful activity that helps us to know ourselves.

The activity of feeling is a completely different matter than having feelings. Usually, it is not us who have feelings and think thoughts; rather the feelings and reactions have us. The feelings we have, as well as our habitual thoughts, are automatic reactions, reflexes conditioned to automatically protect us, to help us to defend against hurt and pain, to isolate us from unwanted intrusion, to secure attention, closeness and belonging etc. In the present, these usually more or less inappropriate reactions are triggered by unspecific stimuli. Real feeling, in contrast, requires an open mind and an open heart, a sensing of the fine movements of the body and the soul, a listening to the flow of relatedness.

There are only two main causes of misery and disease: too much of what hurts and harms, and too little of what is nourishing and healing. The more we replace the art of feeling with the science of measuring, the more we get habituated to swallow what hurts and harms, and to avoid what is nourishing and healing. In order to distinguish what harms from what helps, to recognize and to defend against what hurts us and to find and take in what we want, to recognize what corresponds to our needs, what nourishes and strengthens our bodies and souls, and what not, we must learn to feel.

Having feelings is an impulsive reaction to something that reminds us of what was, and what we never, or always, want to experience again, depending on whether the conditioning experience was pleasurable or painful. Real feeling, however, takes time. When we take the time to feel, we may outgrow engrained patterns of reaction, go beyond habits of experience, and start to really experience what is.

A man talks to me about his experience watching, on television, the Twin Towers in New York come down after the terrorist attack of September 11, 2001. The more often he sees the frequent repetitions of the scene, the more he comes in contact with the terror around living through the bomber attacks every night in the last weeks of World War II in Berlin when, at age seven, he lost most of the people he loved. He talks about how he got callous, even cynical, in defense against the horror, and how witnessing the terror in New York – full of compassion with the children witnessing on television the burial of their mothers under an enormous pile of debris – helps him to uncover old fear, sadness, and despair, allows him to open to buried feelings, and makes it possible for him to start mourning the loved ones he lost more than half a century ago. Then he concludes: "I can allow the feeling, both the helplessness and the rage. When I feel deeper without reacting, I may reach to where I can feel that there is no difference be-

tween 'me' and 'you', 'us' and 'them', 'ours' and 'theirs'. I may realize that we are a multitude of ONE, and that by feeding each other – with food as well as with compassion and respect and love – we feed ourselves so that we may develop what is our shared birthright: our True Human Nature".

Spirituality

Up to now I've described gains of disease concerning psychological and emotional factors as well as the way people organize their lives up to the point of autonomy. Most important, however, seems to be not to block the spiritual awakening of some patients where it happens through the shock of disease. In many cases people experience at the moment of diagnosis, or shortly thereafter, what Maslow[14] called peak experiences: experiences of being free of any conditioned reality, of sheer being and, paradoxically, of unreasonable happiness, even bliss, of contentment, of freedom, of oneness with their lives. Some people feel in the light all of sudden, some completely free of fear. We know that a lot of personal development is needed to maintain the connection to this spiritual realm. For me it has become a criterion for the good life more than anything else – more than survival times or the satisfaction of emotional needs: whether patients can maintain the access to this realm of Being.

I remember an unhappy example of a colleague with a very rare cancer. There were only sixty cases like him in the whole republic, a fact he kept repeating as if becoming special by that co-incidence. He suffered great pain from a large metastasis in the liver. He did not talk, and he did not seem interested in my explanations of what the work could be about. Therefore, I turned to the topic of dying. He complained, sourly, that I talked about dying in a matter of fact way, not giving him all the attention he thought he deserved for his near death, and asked angrily whether I knew anything about it. I told him about a few occasions when I had been close to death, and added that one day I almost drowned. When he heard me say "drowned", he got all excited and lively, saying that he had experienced drowning himself. He became luminous while telling me how, going under during a wild water trip, he had gone through a peak-experience. He had experienced complete freedom of consciousness, and felt free of any fear of dying. He experienced himself as absolutely present and utterly curious. He consented to dying which turned out to be the same as being utterly present in a different space. He had watched himself drowning in this river, seeing the leaves dancing around him, seeing air bubbles rising up from the ground, hearing the stones grinding at the ground of the river, and described the fascination with watching himself in clear consciousness how he was losing consciousness. When he had finished the story, there was a deep silence in the room, and he was obviously free of pain.

Unfortunately I could not interest and motivate him to invest energy and dedication into the development of the capacity to remember the qualities of this unique experience.

Sometimes, however, people succeed in developing something like a philosophical stance towards their disease, and a meditative praxis that prevents them from becoming victims of their pain, and even their dying.

Conclusion

I have described a few cases that didn't have a 'good' outcome seen from the perspective of medical statistics. But seen that way, our life never turns out good. On the other hand, I consider good quality of dying to be a good result of therapy. Most of us die. Mulla Nasrudin once said "I would be very surprised if I survived this life". Well, it looks like he survived until now – didn't he?[15]

Spontaneous remission does occur. In the meantime – since medical science has discovered psychoneuroimmunology, apoptosis and other mechanisms that may explain the phenomenon – one can openly talk about it in the mainstream medical community without risking being ridiculed. In a recent conference addressing the topic, I overheard some of the old gentlemen murmur "Maybe one in a hundred thousand". When I made a list in my mind of people I knew who had experienced spontaneous remission and had survived a hopeless prognosis, without checking my files I came up with 15 out of about 750 persons I have worked with. That's one out of fifty.

Group psychotherapy helps. In a study of the four most common kinds of cancer, Simonton's finding of a doubled median survival following psychosocial intervention could be discounted as unscientific because he compared his results not with a matched control group but with the results of the best clinics of the country. Spiegel[16], however, in a study of advanced breast cancer, and Fawszy[17] in a study of melanoma, later came up with very similar results.

Back to the beginning: Healing is a natural capacity of any living organism. It is happening all the time. Health and disease are not opposites, but poles of a wide spectrum. Whether the scales incline to one or the other side depends, among other things, on how we live our life.

There is a lot you can do to support your natural healing powers. You can learn how to be present, to feel, and to reduce stress. You can learn to fight, to play, and to free your emotions; eat better, move and sleep more, and avoid alimentary as well as psychological poisoning; and most important than anything else: learn to say 'No' when you feel no, and 'Yes' when there is a yes inside.

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[15] one can find a large selction of these wonderful teaching stories in Idries Shah: The Sufis. □□

[16] Spiegel □□□

[17] Fawszy □ and Fawszy, □□□

Patients with hematologic cancer, lung cancer, or with metastatic cancer (stage IV) had the highest frequency of severe events. Patients with nonmetastatic cancer experienced similar frequencies of severe conditions to those observed in patients without cancer. Patients who received surgery had higher risks of having severe events, whereas patients who underwent only radiotherapy did not demonstrate significant differences in severe events when compared with patients without cancer. These findings indicate that patients with cancer appear more vulnerable to SARS-CoV-2 outbreak. SIGNIFICANCE: Because this is the first large cohort study on this topic, our report will provide much-needed information that will benefit patients with cancer globally. I am a patient, I live â€“ and I use that word very specifically â€“ I live with metastatic bowel cancer. So, in terms of my background, I was an educator. I was a deputy head teacher of a secondary school, passionate about education. I was training to be a head teacher, about to take on my headship, and then I got totally and utterly blindsided at the age of 35, being told that I had metastatic cancer.Â Well, I learned that it could happen to me, and it can happen to anyone. And more than that, I realized that actually, thereâ€™s a massive need for educating, just on a different level, about cancer. Especially for colorectal or bowel cancer, because, as Dr. Michel Coleman said in our discussion, around one-third of bowel cancer diagnoses in the UK are classified as an emergency. 80% of patients with lung cancer died during first five years of diagnosis. Lung cancer screening includes the use of low-dose computed tomography (CT) scans, focused on high-risk groups such as smokers and people with preexisting lung disease. The National Lung Screening Trial (NLST), the largest randomized clinical trial demostrated a 20% reduction in death in current or former smokers.