

“TYPE-C”:  
EMPOWERMENT, BLAME, AND GENDER  
IN THE CREATION OF A CARCINOGENIC PERSONALITY

By

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## **ABSTRACT**

### **“TYPE-C”: EMPOWERMENT, BLAME, AND GENDER IN THE CREATION OF A CARCINOGENIC PERSONALITY**

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The belief that mind-set and emotional well-being can improve cancer survival time has become something of a truism in the United States. Despite claims that this is a commonsense and consistent belief which stretches back to Galen, mind-body approaches to cancer have varied radically in response to changing social and cultural contexts. This dissertation tracks shifting meanings of this claim and the varying institutional acceptance of it from the rise of psychosomatic medicine in the 1930s and 40s to the embrace of Contemporary and Alternative Therapies (CAM) in the 1990s. Through the 1950s and 60s, claims of a connection between mind, carcinogenesis, and survival were shaped by psychoanalytic theory and case narratives which reinforced a restrictive view of femininity. However, by the 1970s, mind-body medicine reflected newer gender roles and more eclectic beliefs about psychology. Of the cancer patients depicted in these later case narratives, women were often seen as over-reliant on family for personal fulfillment and lacking in opportunities for personal growth. Men with cancer were often depicted as caught within pathological versions of masculinity. Fixed gender roles came to be seen as potentially carcinogenic. Despite the increasingly feminist tone of these case narratives, there were growing disagreements about whether or not mind-body approaches were empowering or blame-ridden which stretched from feminist collectives to medical journals.

In order to show these shifts, I analyze debates within medical journals, the shifting claims in popular self-help books, news reports, the notes and drafts of the Boston Women's

Health Book Collective, the papers of the Office of Technology Assessment, tobacco industry documents, and Norman Cousins' papers. In these sources, it is possible to see the diverse motivations that encouraged people to advocate for mind-body cancer care. Many doctors were motivated by their insecurities about the growing interest in alternative medicine. Feminists adapted these ideas in ways that more closely matched their beliefs and goals. The tobacco industry had a clear financial incentive to find explanations for cancer that did not point to the carcinogens in cigarettes. Mind-body cancer literature is also an exceptionally useful lens for understanding changing ideas about emotional well-being, particularly as they tie to gender. Case narratives distill key beliefs about what it means to be healthy and well-adjusted, making it possible to see how gender roles change over time and what people believe the consequences might be for failing to conform. This literature also helps to show changing assumptions about the responsibility of the individual patient for healing, and changing beliefs about whether or not the natural world is inherently fair, just, or good.

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Dedicated to my mother, Elizabeth Pratt

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## KEY TO ABBREVIATIONS

ACT UP	AIDS Coalition to Unleash Power
AMA	American Medical Association
APS	American Psychosomatic Society
BWHBC	Boston Women's Health Book Collective
CANAH	Coalition for Alternatives in Nutrition and Healthcare
CECS	Courtauld Emotional Control Scale
DSM	<i>Diagnostic and Statistical Manual of Mental Disorders</i>
ECaP	Exceptional Cancer Patients
FDA	Federal Drug Administration
IAT	Immuno-Augmentative Therapy
JAMA	<i>Journal of the American Medical Association</i>
MMPI	Minnesota Multiphasic Personality Inventory
NEJM	<i>New England Journal of Medicine</i>
OBOS	<i>Our Bodies, Ourselves</i>
OTA	Office of Technology Assessment
PNI	Psychoneuroimmunology
TAB	Technology Assessment Board
TAT	Thematic Apperception Test
TIRC	Tobacco Industry Research Council

## INTRODUCTION

In December 1976, three weeks after my grandmother's exploratory surgery, her children only knew that the surgeon had found a tumor and removed it. She had been sick for more than three years and previously (mis)diagnosed with diverticulitis. Someone mentioned cancer in hushed tones, but with no details. As in many families, speaking of cancer was difficult and instead of discussing the diagnosis those who knew maintained a silence that permitted optimism or perhaps denial. Seeking answers, my mother and aunt arranged to meet her doctor in the lobby of St. Luke's Hospital in Kansas City, Missouri.

The doctor quickly realized no one had told the two young women sitting in front of him that their mother was dying. Furious that this job had been left to him, he explained that her ovarian cancer had metastasized throughout her abdomen and answered any questions about possible treatments, anti-cancer diets, and last hopes. Trying to explain that it was in fact fatal, he told them that, "usually people with ovarian cancer live between six months and four years, but because of your mother's personality I think it will be closer to six months."

Thirty-six years passed before my mother told me this story. I had already begun researching discourses surrounding cancer when she asked what the doctor might have meant when he said her personality would hasten her death. What was he seeing in Erna Belle Hull that made this believable to him? Were his ideas widely accepted? How could he blame her personality for killing her more quickly when she did survive with the disease for four years (at least three years prior to diagnosis and approximately six months after the surgery)?

In fact, the doctor's ideas were not unusual. Just a few months before, newspapers had covered an ongoing Johns Hopkins study. An article in the *Baltimore Sun* explained that

“[s]tudies have confirmed what medical authorities have been saying for centuries. That is, human emotions can be a factor in the development of cancer.”<sup>1</sup> The idea that personality and emotional patterns could both cause cancer and determine survival appeared in the *New York Times*, popular medical writing, psychological literature, and medical journals including *The Lancet*, *The New England Journal of Medicine*, and the *Journal of the American Medical Association*. Generally, the articles argued that depression, hopelessness, and emotional repression would lead to cancer or prevent recovery. Buoyed by beliefs about heart attacks and personality type as well as a growing interest in alternative medicine, by the 1970s, the link between personality and cancer seemed relatively uncontroversial.

These beliefs about emotion, carcinogenesis, and survival remained strong. In the late eighties, 42 Members of Congress asked the Office of Technology Assessment (OTA) to complete an evaluation of unconventional cancer treatments. The report’s conclusions about the lack of evidence for other unconventional treatments infuriated alternative practitioners and patients, creating so much tension that OTA staff feared violent demonstrations and had the police on hand for any public discussions. However, the report’s discussion of connections between psychology and survival drew envy from alternative practitioners who wished that their own ideas were met with the same acceptance. Though the study’s authors concluded that “[w]hether psychological and behavioral methods may influence the onset or progression of cancer is still an open question”<sup>2</sup> they noted that further studies were “clearly warranted.”<sup>3</sup> The acceptance of these ideas remains widespread and visible in both offhand comments about

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<sup>1</sup> Associated Press, “Emotions Can Cause Cancer, 30-year Study at Hopkins Indicates,” *The Sun* (Baltimore, MD), Jun 7, 1976.

<sup>2</sup> U.S. Congress, Office of Technology Assessment, *Unconventional Cancer Treatments*, OTA-H-405 (Washington, DC: U.S. Government Printing Office, September 1990, 36.

<sup>3</sup> U.S. Congress, Office of Technology Assessment, *Unconventional Cancer Treatments*, 37.

“fighting spirit” or “healthy mindset” and more direct warnings to patients about the dangers of unhealthy emotions.

In 2002, Stanford psychiatrist David Spiegel published an article in *Nature Reviews Cancer* claiming that even if only half of studies on the impact of psychological interventions on cancer survival found an improvement, “[i]f nothing else, these studies have made the examination of the relationship of quality and quantity of life among cancer patients a legitimate scientific question.”<sup>4</sup> Spiegel was correct to note the growing scientific interest in connections between psychology and tumor growth; his own 1989 *Lancet* article has already been cited 1364 times.<sup>5</sup> The articles he reviewed tapped into a series of widely held beliefs that emotions, personality, and attitude could cause cancer or determine the length of survival.

Spanning from psychoanalysts’ theories of cancer as the physical expression of repressed emotion in the 1920s to present-day ideas about cancer, depression, and positivity, this dissertation covers the history of the belief that emotions and personality shape carcinogenesis and healing. I argue that despite a seemingly continuous claim that emotional repression and depression cause cancer and hamper recovery, psychosomatic beliefs about cancer have shifted dramatically in response to social movements, cultural beliefs, and research paradigms. Researchers studying psychosomatic factors in cancer used gendered and racialized language to explain what a “carcinogenic personality” might look like. The terminology used to describe cancer patients remained constant in writing on the topic, but meanings did not. Emotional repression, depression, hopelessness, and helplessness appeared repeatedly in articles both in

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<sup>4</sup> David Spiegel, “Effects of Psychotherapy on Cancer Survival,” *Nature Reviews Cancer*, 2 no. 5 (2002): 6.

<sup>5</sup> David Spiegel, H.C. Kraemer, J.R. Bloom, and E. Gottheil, “Effect of Psychosocial Treatment on Survival of Patients with Metastatic Breast-Cancer” *Lancet*, 2 no. 8688 (1989): 888-891. Citation count from Web of Science, accessed June 22, 2018.

professional journals and the popular press. However, each of those terms has been redefined within different social contexts.

Psychosomatic theories of cancer are driven in large part by beliefs about gender roles and the majority of studies look at women's cancers. The belief that psychosomatic factors were more important in treating medical conditions in women than in men was widely acknowledged. Women have long been characterized as fragile, emotional, less capable of reason, and more subject to whims, vanities, and passions. Fragility and emotionality were seen as interconnected parts of femininity.<sup>6</sup> In consequence, psychosomatic disorders were (and remain) more frequently perceived as feminine, particularly in the discourse on cancer psychology. The popular guide to psychosomatic medicine, *Emotions and Bodily Changes*, noted, "[t]he literature concerning the psychosomatic problem in gynecology is so voluminous that a monograph would be required to cover it even cursorily."<sup>7</sup> Hypotheses on the associations between cancer, repressed emotion and hopelessness made sense for female patients because emotions were considered a more essential part of feminine nature than rationality. In effect, this body of literature naturalized men's rationality by taking repressed emotion off the table for investigation as a potentially carcinogenic trait in men.

As advocates of mind-body medicine illustrated the traits that they considered least healthy, they presumably drew from their perceptions of patients who were most likely to be diagnosed with particular types of cancer. For example, uterine (corpus and cervix), breast, and

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<sup>6</sup> Elaine Showalter, *The Female Malady: Women, Madness, and English Culture: 1830-1980* (New York: Pantheon Books, 1985). Phyllis Chesler, *Women and Madness* (Garden City: Doubleday, 1972).

<sup>7</sup> Helen Flanders Dunbar, *Emotions and Bodily Change* (New York: Columbia University Press, 1938), 330.



stomach cancer were the three most common types of cancer among women in 1930.<sup>8</sup> A major risk factor in both breast and corpus uterine cancer is nulliparity, never having had children. Not breast feeding further increases the risk of breast cancer. Age is an additional risk factor.

Psychoanalysts and physicians could easily see older, childless women as sexually repressed or emotionally stunted. Stereotypes about the types of people who were most likely to be diagnosed with specific types of cancer shaped hypotheses about how emotion could cause cancer and impact survival time.

In addition to drawing out stereotypes of patient groups, psychosomatic ideas frequently reinforce the types of behaviors that make cancer patients palatable to their healthy acquaintances. By pointing to positive thinking and hopefulness, friends and relations of cancer patients can discourage discussion of the all things unpleasant in the name of health. The anger, sadness, or pain of a diagnosis and continuing health consequences could be more justifiably swept under the rug. Further, a clear explanation for why another person got cancer and, more to the point, an explanation that lay entirely within the character of an individual patient, makes people feel safer. If they do not feel threatened by the risk of disease, spending time with cancer patients feels less like confronting mortality. The valorization of positivity also provided a way for patients to discuss cancer as a more meaningful part of their life narratives. In addition to helping some to make sense of their experiences, integrating cancer into a patient's life story could help to maintain social ties by discouraging others from running from what might seem unbearably depressing or frightening. They could describe (to borrow a book title from Lawrence LeShan) "Cancer as a Turning Point" not just because it made them confront their mortality and

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<sup>8</sup> American Cancer Society, "Cancer Statistics 2018: A Presentation from the American Cancer Society," <https://www.cancer.org/research/cancer-facts-statistics/all-cancer-facts-figures/cancer-facts-figures-2018.html>

focus on things that mattered, but because through cancer their body sent them specific messages about the types of behaviors they needed to change to live.<sup>9</sup>

Chapter one of this dissertation covers the rise of psychoanalytic explanations for cancer in psychology and medical journals from the 1920s through the 1960s. Freudian explanations of physical problems as hysterical symptoms of subconscious distress provided a framework for understanding cancer that grew slowly in popularity through the 1960s as psychoanalysis became dominant within psychiatry and psychology. Freudian theories focused heavily on women's cancers and argued that women needed to stay within clear emotional, sexual, and behavioral norms in order to avoid sickness. By finding contentment in a monogamous relationship, pursuing motherhood, accepting moderate dependence on men, and developing the right kind of sexuality, women would be able to preserve their health. Women who did not fit this pattern were described as emotionally repressed and hopeless, the key traits of cancer prone women. These descriptions of cancer patients were also racialized. Studies of pathological sexual adjustment often focused on black women. They used stereotypes about black personality and behavior to account for different rates of cancer by race, especially rates of cervical cancer.

Chapter one also explores published studies from the 1950s and 60s on cancer in men. Depression and emotional repression held less cultural relevance in the scientific literature evaluating the role of emotion in cancer for men. Except for a few studies on the personalities of male smokers and a handful of other assorted studies there has been little research on male patients. Papers from the Truth, Tobacco Industry Documents Library show how research on tobacco use, cancer, and personality was intended to distract from a growing consensus on the

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<sup>9</sup> Anne Harrington "The Body that Speaks" in *The Cure Within*, (New York: W. W. Norton & Company, 2008).

connection between smoking and lung cancer. These studies used male patients because the majority of smokers at the time were men. Other researchers focused on male patients because of the availability of employment or military records. This literature differed substantially from the research on female patients. Case narratives of male patients were rarely included and studies generally did not attempt to prescribe a healthy masculinity. For those attempting to divert attention from tobacco, defining healthy behavior was unimportant. For those analyzing convenient data on male patients, the scope of the data available encouraged a different type of analysis lacking personal detail.

Chapter two uses psychology texts, research on mind-body cancer treatment, and literature on stress to explore the effect of changing theoretical models for therapy and research. In the 1960s and 70s, psychoanalytic theory became less central and psychoanalysts faced challenges to their research methodology, their focus on sex, and their belief that the unconscious could ever be known or measured. Conflicts within psychology changed the way researchers and therapists approached their patients, studied psychosomatic medicine, and formulated conclusions. The descriptions of cancer patients who suffered from problems with sexual adjustment or early childhood events seemed increasingly outdated. The research methods of studies from the 50s and 60s which often relied on psychoanalytically informed projective testing like the Rorschach inkblot test also came under fire. However, despite the risk that these shifting research standards could invalidate older research, the belief that cancer was tied to emotion remained popular and culturally relevant.

An increasingly eclectic approach to therapy allowed for greater flexibility in clinical encounters and case narrative construction. Moreover, the wide acceptance of a growing body of literature on the health effects of stress, connections between the immune, endocrine, and

nervous systems, and biofeedback helped to legitimize mind-body medicine more generally. Despite a dramatic shift in content and methodology, advocates for mind-body care continued to use some of the same language as Freudian psychologists, referring to cancer patients as emotionally repressed and hopeless. These terms gained new meanings when they were taken out of a Freudian context. Emotional repression and depression were no longer tied as strongly to repression of early childhood memories or sexual desires. The move away from Freud opened a path for psychologists to define emotional repression in light of their own concerns and those of their patients including career, life purpose, and family pressures.

Chapter three uses popular books on cancer and therapy from the 1970s and 80s to show the effect of changing economic and social realities on the ways psychologists, doctors, and various other mind-body champions defined healthy and pathological personalities. Second wave feminism changed case narratives substantially. Many psychologists switched from describing emotionally repressed female patients as asexual, insufficiently maternal women to describing them as women who had not pursued their own dreams or careers outside the home. Some began to include more case studies of male patients. Strict gender roles were often described as unhealthy for both male and female cancer patients. Most advocates of mind-body cancer care stopped writing about race entirely. In addition to these changes in case narratives, in this chapter I argue that increased public interest in structural rather than individual explanations for problems like poverty and illness created a challenge to mind-body care. Terms like “victim blaming” which grew out of an analysis of racial inequalities were applied to holistic medicine. People increasingly accused mind-body advocates of blaming patients for their cancer, and of characterizing death as an individual failure on the part of the patient. Increasingly, writers challenged this by arguing that they empowered rather than blamed their patients. They also

claimed that empowered patients who worked past their anxieties might have more peaceful deaths.

Chapter four is a case study showing how one feminist group tried to adapt mind-body cancer care in light of their beliefs and health needs. Empowerment and rejection of gender roles were both appealing as feminist strategies to fight cancer. However, the individual changes which promised good health frequently ignored the broader social problems which could create stress and lead to cancer or hamper recovery. Moreover, issues of blame were particularly problematic. This chapter uses the papers of the Boston Women's Health Book Collective in order to see how they negotiated these challenges. Between 1973 and 1984, the members of the collective moved from rejecting psychosomatic medicine to encouraging patients to fight cancer by managing stress, using visualization, and embracing holistic approaches alongside standard care. Making this dramatic change required formulating ideas about emotional health which dealt with collective action and interpersonal support instead of individual positive thinking or adjustment.

Chapter five looks at how mind-body approaches to cancer became regular complements to standard care, embraced by doctors and occasionally offered through hospitals. On some level, mind-body medicine has a timeless psychological benefit for physicians who struggle to explain the deaths of their patients. But in the late 1970s and 80s mind-body cancer care had a specific appeal as a middle ground between physicians and patients who had a growing interest in alternative and holistic therapies. Physicians were increasingly concerned about the state of their profession. Mind-body cancer treatment offered a way for doctors to rebuild their relationship with patients and to justify the time spent doing that as medically necessary to hospitals and health management organizations. Furthermore, this allowed them to prioritize the intuitive,

personal side of medicine over laboratory testing and statistics. Moreover, these therapies were promoted specifically as complementary treatments which would enhance rather than replace physicians and standard treatment. In part because of these factors, by 1990 psychological approaches were considered the most promising of all unconventional cancer treatments. This chapter uses published books, journal articles, and correspondence in addition to archival material including the papers of Norman Cousins at the University of California Los Angeles and the papers of the Office of Technology Assessment from the National Archives.

In terms of secondary literature, I rely on Susan Sontag's *Illness as Metaphor* as my starting point for this dissertation. Published in 1978, *Illness as Metaphor* drew attention to the layers of meaning given to cancer, the assumptions about cancer patients' psychology and mental wellbeing, and the blame and guilt that accompanied them.<sup>10</sup> Sontag's work has encouraged many writing about the history of cancer care to include something about mind-body approaches, though many of those only briefly touch upon the subject as they are primarily interested in other areas of cancer treatment. *The Dread Disease: Cancer and Modern American Culture* by James Patterson, the first major academic history of cancer, largely followed Sontag's critique. But in addition to Sontag's argument that psychological theories were used to explain diseases only in the absence of scientific explanations, Patterson added more historical context. He drew attention to the growing interest in holistic medicine and frustration with orthodox care, particularly in the 1970s.<sup>11</sup> Both Patterson, and in much greater detail Keith Wailoo (in *How Cancer Crossed the Color Line*) have analyzed the belief that cancer was a "disease of civilization," which tied to

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<sup>10</sup> Susan Sontag, *Illness as Metaphor* (New York: Farrar, Straus and Giroux, 1978).

<sup>11</sup> James Patterson, *The Dread Disease: Cancer and Modern American Culture* (Cambridge: Harvard University Press, 1988), 272-276.

beliefs about psychology, race, and emotional depth.<sup>12</sup> In his 2005 book, *Bathsheba's Breast*, historian James S. Olson dismissively tied mind-body cancer care to “the narcissistic culture of the 1960s and 70s.” This, he argued, had allowed “psychological seeds [to] spread like weeds.”<sup>13</sup> Many others have chosen only to make brief reference to the idea. Barron Lerner’s *The Breast Cancer Wars* and Siddhartha Mukherjee’s *The Emperor of all Maladies* both focused instead on Sontag’s discussion of metaphors of contamination or of military determination in both individual patient care and in the “war on cancer.”<sup>14</sup> A number of books on the history of the tobacco industry have covered psychosomatic theories of cancer etiology, but from the perspective of industry representatives whose motives were both clear and atypical.<sup>15</sup> Between these books, there has been minimal discussion of the reasons that patients and orthodox physicians adopted these ideas, and minimal discussion of the ways in which mind-body depictions of cancer have changed.

In contrast, two authors have written more in-depth pieces specifically devoted to understanding mind-body therapy. I am particularly indebted to the work of Patricia Jasen and Anne Harrington. Jasen’s 2003 article, “Malignant Histories: Psychosomatic Medicine and the Female Cancer Patient in the Postwar Era,” focuses particularly on psychoanalytic cancer care. “Malignant Histories” outlines the rise of psychosomatic medicine which gave a professional

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<sup>12</sup> James Patterson, *The Dread Disease*, 79. Keith Wailoo, *How Cancer Crossed the Color Line*, (Oxford: Oxford University Press, 2011).

<sup>13</sup> James S. Olson, *Bathsheba's Breast: Women, Cancer, and History* (Baltimore: John Hopkins University Press, 2005), 161.

<sup>14</sup> Barron Lerner, *The Breast Cancer Wars: Fear, Hope, and the Pursuit of a Cure in Twentieth-Century America* (Oxford: Oxford University Press, 2001), 268. Siddhartha Mukherjee, *The Emperor of all Maladies: A Biography of Cancer* (New York: Scribner, 2010).

<sup>15</sup> Naomi Oreskes and Erik M. Conway, *Merchants of Doubt: How a Handful of Scientists Obscured the Truth on Issues from Tobacco Smoke to Global Warming* (New York, Bloomsbury Press, 2010): 16. David Michaels, *Doubt is Their Product: How Industry's Assault on Science Threatens Your Health* (Oxford: Oxford University Press, 2008).

framework for mind-body cancer theories and lays out the gendered pathologies which they believed caused cancer or fueled its growth.<sup>16</sup> Her work provides a starting point from which later formulations of mind-body cancer beliefs can be charted. Anne Harrington's 2008 book *The Cure Within* traces the wider history of mind-body medicine. Outlining the history of beliefs about mind-body connections to cancer specifically instead of mind-body medicine more generally allows me to add a more focused study of shifts in mind-body medicine, to see how the particular disease patterns and cultural baggage impacted beliefs. *The Cure Within* shows the general terrain of mind-body medicine, and the types of stories that people tell about disease. She covers stories about the power of suggestion to heal, stories where illnesses contain hidden meaning for our lives, beliefs about the health effects of positive thinking, and ideas about how modern life can pose a danger to our health. She further separates out stories about love as a healing emotional force, and stories that focus on the East as a repository for mind-body wisdom. Each of these narrative archetypes, she acknowledges, overlaps in significant ways. While I do not always map the case narratives in this dissertation onto Harrington's categorization of stories of healing and disease, her histories of each story pattern are useful for untangling the factors which are at play. I also draw heavily from secondary literature on health care systems, unorthodox medicine, psychology, and gender.

Often, the sources used in this dissertation do not fully distinguish between question of risk factors for developing cancer and factors which might impede recovery. For many of the advocates of mind-body cancer care, failure to address the purported emotional causes of carcinogenesis would lead to tumor growth and death. For example, where some hypothesized

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<sup>16</sup> Patricia Jasen, "Malignant Histories: Psychosomatic Medicine and the Female Cancer Patient in the Postwar Era," *Canadian Bulletin of Medical History*, Vol 20, Issue 2 (2003): 265-297.



that stress is a carcinogen, many also argued that stress would impede recovery. Similarly, if a lack of will to live is given as the cause of cancer, regaining a desire to live might encourage healing, immune function and tumor regression. Because my sources often blur these causal factors or operate on the assumption that they are the same at every stage in the disease process, occasionally these issues blur in the dissertation as well. Where research design and writers clearly separate factors in cancer etiology from factors tied to survival time, I have tried to make that clear.

There are a variety of sources that this dissertation will not attempt to cover. First, because I attempt to focus on beliefs that cancer is intrinsic to a person's mindset, not to their circumstances, I do not focus on literature on the health effects of negative life events or grief. Loss of jobs, spouses, or family members (often termed object loss) is not necessarily reflective of an inherently unhealthy personality. Thus articles claiming that loss causes cancer do not suggest personalities that one might aspire to for health. I do, however, include literature that addresses responses to grief as healthy or pathological. Second, I do not address Christian traditions of faith healing. There are, I think, close links between some variations of psychosomatic medicine and faith healing. Both call on individuals to adjust their perspectives and make right their own lives (whether in the eyes of God or a self-help book) in order to heal. Giving worry into God's hands is functionally similar to attempting to let go of stress in order to heal the body. Moreover, there are connections, at times between the gender roles women might encounter in the church and those recommended by psychoanalysts. Despite these similarities, faith healing operates with radically different perspectives on causal mechanisms for disease and healing. Proponents of faith healing, even when they believe that the worthy are rewarded with health, attribute healing to an all-powerful God while those in psychosomatic medicine were

more likely look to unchanging natural laws. Instead of seeing healing as a direct result of the divine, psychosomatic medicine relied on sometimes mechanisms, which while occasionally vague, were assumed to be physical, rooted in hormones and immune function. I do occasionally include religious figures who focus on these natural laws as laws of God, notably Norman Vincent Peale, in this dissertation.

Finally, it is not my goal in this dissertation to either evaluate all scientific claims of mind-body cancer healing or to make those who study them seem small or unkind. Setting aside questions of whether or not mind-body medicine can encourage self-blame on the part of patients who do not recover, many advocates of mind-body medicine mean well. While the doctor who met with my mother in the lobby of St. Luke's was callous, many mind-body cancer therapists orient their practice towards patients with terminal prognoses. Some continue to invest themselves in the lives of their patients, staying involved at a time when it is tempting for many to turn away. Trying to find ways that patients can live their best lives at a time when it seems little life is left, though this can often be clumsy and out of touch with the new reality patients face, demands commitment. The expectations they held for these patients changed, but in many cases, it seems clear that those expectations were shaped by the times they lived in. How some have characterized these patients has at times been callous, but generally serves as a reflection of the same callous ideas that were widespread at the time; they displayed the same racism, misogyny, and homophobia.

What I do aim to accomplish in this dissertation is twofold. First, historicizing mind-body cancer care helps to make it clear that the belief that cancer, mindset, personality, and emotion are connected is not timeless or universal. It is therefore not undeniable commonsense. Rather, the theoretical framework and justifications for why this makes sense change. Examples from the

writing of ancient physicians, nineteenth-century novelists, twentieth century- psychoanalysts, and stress-researchers and holistic alternative practitioners from the 1970s are frequently thrown together as if their claims and meanings are the same. They are not. Furthermore, the archetypical patients who populate these stories have changed to reflect the ideals and cautionary tales of their times, from frigid or promiscuous patients to the self-denying housewife. Understanding the variation in what physicians meant when they described patients with terms like “hopeless” helps to answer the initial question for this dissertation. Second, given these changes, I attempt to explore some of the factors that made these ideas appealing to specific groups at specific times. There are general reasons that mind-body cancer care is appealing including the sense of control and safety it provides patients, and the psychological benefit it provides to physicians trying to make sense of patient outcomes, and motivation for personal growth. However, many of the reasons for the ascendance of mind-body care shift with time. The cultural relevance of case narratives, patients’ specific frustrations with the medical system, doctors’ insecurity about their profession, and cultural ideas about empowerment, emotionality, and fairness also played into patterns of acceptance for mind-body theories.

## CHAPTER ONE: Psychoanalytic Approaches to Cancer and Postwar Life

The suburban housewife—she was the dream image of the young American women and the envy, it was said, of women all over the world. The American housewife—freed by science and labor-saving appliances from the drudgery, the dangers of childbirth and the illnesses of her grandmother... As a housewife and mother, she was respected as a full and equal partner to man in his world.<sup>17</sup>

-Betty Friedan

In 1961, psychoanalysts asked fifty female patients at Mount Sinai Hospital to draw a house, a tree, a man, and a woman while they waited for their examinations in the cancer detection clinic. To evaluate the drawings, “A list of ‘flaw’ items was compiled for each drawing (omissions, misplacements, distortions, etc.)”<sup>18</sup> This carefully made list of “flaws” in the drawings helped to identify issues of role adjustment and personality patterns that might have caused cancer. The researchers compared patient drawings with those of student nurses, psychiatric outpatients, and tumor clinic patients. The women at the detection clinic and the tumor clinic patients were found to have “a disturbed sexual identification,” “guilt feelings,” and “defective interpersonal relationships” among other things. For these psychoanalysts, failure to either achieve or fully appreciate the American dream of a loving heterosexual couple in a single-family home was evidence of a life-threatening pathology. American concerns about gender roles, the acceptance of psychoanalytic theory, and post-war faith in the capacity of any

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<sup>17</sup> Betty Friedan. *The Feminine Mystique* (New York, W.W. Norton & Company, 2001), 60-61. Originally published 1961.

<sup>18</sup> Fred Brown, “The Relationship Between Cancer and Personality,” *Annals of the New York Academy of Sciences*, 125, no. 3 (1966): 869.

individual who believed in him or herself to control their fate, came together to promote psychosomatic explanations of cancer.

In her 2003 article, “Malignant Histories: Psychosomatic Medicine and the Female Cancer Patient in the Postwar Era,” Patricia Jasen has thoroughly laid out the main psychoanalytic beliefs about cancer from 1920-1960.<sup>19</sup> Her work demonstrates the gendered assumptions held by researchers working in the field. In this chapter, I aim to build on her work by further exploring the post-war social and political context that allowed these ideas to flourish, adding material showing the degree to which other medical professionals accepted these ideas, and creating a comparison between the ways in which psychosomatic carcinogenesis was described in men and women.

Jasen shows that psychoanalytic beliefs about personality development provided the contours of psychosomatic theories of carcinogenesis in the interwar years and through the 1960s. At the heart of psychoanalytic beliefs about cancer were beliefs about healthy femininity. The majority of studies looked at women’s cancers and psychoanalysts called on women to accept their true natures including: moderate dependence on men, sexual desire kept safely within the bounds of marriage, and genuine maternal feelings. Emotional repression, in these cases interpreted as the repression or stunted development of natural feminine desires, was the key threat to women’s health. Hopelessness, in many cases defined as the inability to obtain sexual satisfaction, could also cause cancer. Within these definitions of carcinogenic womanhood, there were clear divisions between races built on assumptions about the sexual behaviors and personality patterns of black women.

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<sup>19</sup> Patricia Jasen, “Malignant Histories: Psychosomatic Medicine and the Female Cancer Patient in the Postwar Era,” *Canadian Bulletin of Medical History*, Vol 20, Issue 2 (2003): 265-297.

This chapter covers the growth of psychoanalytic arguments for psychosomatic carcinogenesis and the social order that maintained them. In the 1920s and 1930s a growing tradition of psychosomatic medicine laid the foundation for psychoanalytic theories of cancer. Psychoanalysts created a space for psychoanalysis in medicine and popularized the ideas of Freud. Following the Second World War, they cemented their place in the medical establishment. Their perceived ability to treat the problems of returning soldiers and the relevance of their ideas about gender and sexuality to the post-war social order gave them cultural authority and provided greater legitimacy for psychoanalytic research on cancer. Their work fit into a militant push for domesticity that drew on postwar economics, fears about race, Cold War understandings of American morality, and a fierce rejection of deviance. In addition, the post-war belief that individuals could make their own success and decide their own fate encouraged the belief that one's psychology could even determine health. The way in which they reinforced broader cultural ideals improved their own legitimacy. Maintaining women's roles was essential to American cultural life, ideas about raising young citizens, and even to Cold War efforts. Psychoanalytic approaches to cancer reinforced those ideals. As I look at the impact of these trends, I draw on Elaine Tyler May's work on postwar gender roles, Keith Wailoo's *How Cancer Crossed the Color Line*, Thomas Sugrue's work on suburban racial segregation, Hale's history of Freud in America, and Anne Harrington's *The Cure Within*.

This chapter also aims to begin an investigation of the extent to which these ideas spread among doctors. Many of the psychoanalysts writing on the topic have mentioned the reluctance of doctors to accept their arguments, positioning themselves as reformers providing a scientific basis for forgotten common knowledge. However, assumptions about the roles of personality in health were widespread, even among doctors, but they often remained unspoken. In order to

begin identifying the extent of these beliefs, I have included book reviews from major American medical journals as well as British journals such as *Nature* and *The British Medical Journal* that were widely read and respected in the United States. While it is difficult to know how doctors felt about their patients' personalities, many seem to have accepted as a truism the idea that positive and well-adjusted patients were more likely to recover from disease. Moreover, there were some theories that physiological mechanisms connected the mind and body in carcinogenesis. They argued that emotional repression and hopelessness prevented the immune system from stopping runaway cell growth and that regularly occurring cancerous mutations could usually be handled by the immune systems of psychologically healthy individuals. This explanation left room to view cancer as a biological process, but one mediated by psychology.

Finally, I hope to complement the accepted historical narrative about women's roles in psychosomatic theories of cancer by exploring the psychosomatic studies of cancer in men which were done at the same time. These studies have often been addressed only in more limited ways because they fit so poorly with the literature on women: the case narratives read differently, the categorization of patients was different, and frequently the authors wrote with other goals- like distracting from the role of tobacco in lung cancer. Comparing these sets of articles can help further understand the ways in which psychiatrists, psychologists, and medical professionals approached both their male and female patients in the 1950s and 60s.

Because ideas of cancer and personality have often been described as if they are uniform and consistent in content, this chapter serves to create a baseline to understand radical changes to psychosomatic cancer case narratives and studies that would appear in the 1970s. Despite dramatic methodological and theoretical shifts, the idea that emotions determine the onset and course of cancer remains pervasive. To understand this staying power, we must understand three

things that helped make claims about psychological determinants of cancer relevant and plausible: first, the history of mind-body medicine which stretched back to Galen; second, the impact of psychoanalytic theory on the rise of psychosomatic medicine starting in the 1920s; and third, the particular salience of gender roles in the 1950s and 60s—roles which psychosomatic medicine accepted and reinforced. This chapter will explore each of these driving forces before looking in more detail at how they shaped the gendered nature of psychosomatic explanations of cancer.

### **The Rise of Psychosomatic Medicine**

From the 1920s to the 1940s, American psychoanalysts laid a foundation for psychosomatic medicine as a subfield. Building on the work of Sigmund Freud, they carved a space within modern medicine. In order to do this, they combined a variety of strategies. First, they pointed to a longer history of psychosomatic thought that made mind-body connections seem like recovered common sense. Second, they highlighted the limitations of modern medicine in addressing or explaining many diseases. Zeroing in on areas where little was known allowed them to work in areas where doctors found research unproductive and were less defensive of their “turf.” Third, they embraced some of the patterns of medical science, by doing things like searching for specific causes for specific diseases. Finally, they established a professional society (The American Psychosomatic Society) with a journal (*The Journal of Psychosomatic Medicine*) in the late 1930s.<sup>20</sup> With one main exception, these early proponents of psychosomatic medicine did not address cancer, but they laid the intellectual groundwork for future connections and

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<sup>20</sup> “About APS: History of APS,” *American Psychosomatic Society*, accessed January 17, 2018. <http://www.psychosomatic.org/about/index.cfm>



gained substantial respect from orthodox doctors. The limited writing that focused specifically on cancer reflected widely-held beliefs about women's roles and responsibilities and tapped into early twentieth-century anxieties about population politics, specifically the fear that the white race might fail to reproduce as quickly as other races leading to a racial shift in the U.S. and eventual "race suicide."

A central tenet of Freudian psychology was that repressed desires and emotions could become lodged in the unconscious and find expression as physical symptoms. Famously, for example, Freud explained physical symptoms of his patient Dora—ranging from the bedwetting of her childhood, to the coughs she developed in her adolescence, and the loss of her voice—to Dora's repressed desires for her father, her father's friend, and his friend's wife.<sup>21</sup> Unresolved sexual tensions, stunted sexual development, and early childhood experiences could cause physical problems in the form of hysterical symptoms, he concluded. Though Freud never discussed cancer as a hysterical symptom, he laid a framework in which others could make intellectually respectable claims.

Psychoanalysts who built on this legacy did not create theories of personality and cancer out of whole cloth. Rather, they drew on a millennium-long tradition of connecting emotional patterns with cancer, putting old connections into their own analytical framework. Those who argued that personality could cause cancer proudly connected themselves to this longer history, typically beginning with Claudius Galen, a second-century physician and surgeon, whose system of humoral medicine connected excesses in one of the four humors to bilious, choleric, sanguine, or melancholic character profiles. They noted that: "in 'De tumoribus' [Galen] had observed that

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<sup>21</sup> Sigmund Freud, *Dora: An Analysis of a Case of Hysteria*, (New York: Macmillan Publishing Company, 1993).

melancholic women were more prone to cancer than were women of a sanguine temperament.”<sup>22</sup>

Claiming a connection to ancient physicians allowed advocates of psychosomatic medicine to make their ideas seem commonsense and timeless. A later proponent claimed that, “[t]he belief that personality contributes to the etiology of disease is as old as the history of human thought.”<sup>23</sup>

In addition to drawing connections to ancient medicine, they cited a wealth of more recent physicians who blamed cancer on mindset. In *The Dread Disease*, the historian James Patterson listed a number of nineteenth-century claims. For example, in 1826 Sir Astley Cooper claimed to have found a connection between rectal cancer and mental distress and between breast cancer, grief, and anxiety. Patterson also pointed to Walter Walsh who made similar claims, “that cancer often derived from the ‘influence of mental misery, sudden reverses of fortune, and habitual gloominess of the temper on the disposition of carcinomatous matter’”<sup>24</sup> Willard Parker also found that “great mental depression, particularly grief induces, a predisposition to such a disease as cancer, or becomes an exciting cause under circumstances where the predisposition had already been acquired.”<sup>25</sup> Sir Herbert Snow argued that grief and stress were key in breast and uterine cancer and used this to explain the higher disease incidence that he noticed in older women and in the city. When President Grant developed cancer of the mouth, even his physician, John Hancock Douglas ignored the idea that it might have been caused by smoking, instead

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<sup>22</sup> Karen Hagen Liste, “Breast Cancer, Personality, and the Feminine Role,” *Patient Education and Counseling*, 36, no. 1 (1999): 33.

<sup>23</sup> R. Fernandez-Ballesteros, “Cancer-prone Personality, Type C,” *International Encyclopedia of the Social & Behavioral Sciences*. (Amsterdam: Elsevier, 2001) 1439.

<sup>24</sup> James Patterson, *The Dread Disease: Cancer and Modern American Culture* (Cambridge: Harvard University Press, 1987), 24.

<sup>25</sup> James Patterson, *The Dread Disease*, 25.

pointing to Grant's financial problems and arguing that: "Depression and distress of mind was a more important factor."<sup>26</sup>

Psychoanalysts supplemented these medical descriptions of temperaments that were supposedly typical of cancer patients, with a long history of literary representations of depressed or repressed cancer patients. For example, many quoted English poet W. H. Auden's 1937 poem "Miss Gee," which depicts a prudish spinster passing through the years unloved while she represses her sexual desires. Praying not to be led into temptation,

She bicycled to the evening service  
With her clothes buttoned up to her neck.

She passed by the loving couples,  
She turned her head away;  
She passed by the loving couples,  
And they didn't ask her to stay.

When she finally sees a doctor, it is too late. Repressed sexual desires have destroyed her health and Miss Gee becomes just another cadaver for medical students, her body unclaimed and uncared for. The doctor in the poem explains to his wife:

Childless women get it [cancer].  
And men when they retire;  
It's as if there had to be some outlet  
For their foiled creative fire.<sup>27</sup>

Little explanation was needed; this was an old story that Auden could assume readers would recognize.

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<sup>26</sup> James Patterson, *The Dread Disease*, 3.

<sup>27</sup> W. H. Auden edited by Edward Mendelson, *Collected Poems*, (New York: Modern Library, 2007), 169-152. Quoted for example by Lawrence LeShan in *Cancer as a Turning Point: A Handbook for People with Cancer, Their Families, and Health Professionals* (New York: E. P. Dutton, 1989), 67.

Almost all published literary depictions of cancer patients focused on white patients. The writers they cited, who were usually if not always white, assumed that repression required an inner life and self-awareness that was not typically attributed to other races. Connecting their ideas to the observations of novelists, poets, and ancient physicians made their claims seem like obvious conclusions that physicians had simply forgotten in their obsession with modern science. While exceedingly valuable, they implied, advances in germ theory, chemistry, and surgical technique had not provided all the answers; some wisdom resided in existing intellectual traditions.

From the 1920s through the 1940s, psychoanalysts made this longer tradition of psychosomatic medicine their own. American psychosomatic medicine worked to gain legitimacy by building not only on their Freudian background, but by embracing key ideas in modern medicine and working around the edges of medical knowledge to build their legitimacy. The phenomena other sciences could not yet explain were fertile ground for psychosomatic explanations. Sometimes this might be diseases with unexplained causality or cancers whose risk factors had not yet been identified. In particular, writers zeroed in on ulcers and asthma as unexplained diseases that might reflect personality disturbances.

Even when there were accepted causes for specific diseases, the existence of probabilities instead of certainties left room for psychosomatic explanations. They were able to point to anecdotes or exceptions to demonstrate that personality could protect some people. For example, psychoanalysts could point to the comparative speed at which people recovered from the common cold or how long it took someone to succumb to tuberculosis.<sup>28</sup> Germ theory did not

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<sup>28</sup> See for example: Franz Alexander, *The Medical Value of Psychoanalysis*. (London: George Allen & Unwin LTD, 1931), 164.

eliminate all space for psychosomatic explanations, rather personality provided a way to explain host responses to bacteria. In particular, they built on the tenet of germ theory that specific diseases had specific causes. This required that they not only identify harmful personality traits, but that they identify specific problems in specific patient groups. Many psychoanalysts thus pointed not just to a broadly defined cancerous personality, but also to personality traits that might cause cervical, uterine, or lung cancer. In so doing they revealed a detailed array of stereotypes. Focusing on just breast cancer patients, for example, encouraged stereotypes about a more specific group of patients. They knew that breast cancer was increasingly common as women aged and that it disproportionately affected nuns. While we now know that having children and breastfeeding has a protective effect against breast cancer, researchers at the time did not. Instead of looking at these events, they identified risky personality traits through their perceptions of at-risk groups.<sup>29</sup>

Focusing on individual diseases and small groups of patients allowed them to maintain a place within the broader medical world by focusing primarily on diseases that doctors could not treat or explain while slowly expanding their reach. Many of the books and articles about personality and disease did not address cancer, but psychoanalysts gradually attempted to tackle more diseases as smaller successes made their ideas more respectable. The popularity of psychosomatic medicine was fueled by the widespread acceptance of psychosomatic arguments about gastric ulcers, asthma, and other diseases, several highly successful publications, and the growing acceptance of psychoanalysis more broadly.

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<sup>29</sup> For more on the doctrine of specificity see Patricia Jasen, “Malignant Histories: Psychosomatic Medicine and the Female Cancer Patient in the Postwar Era,” *Canadian Bulletin of Medical History*, Vol 20, Issue 2 (2003).

Ulcers were at the center of justifications for the utility of psychosomatic medicine. Until recent work on H. Pylori, ulcers were viewed almost entirely as psychosomatic health problems. Much of this literature built on Franz Alexander's work (discussed later) as well as Hans Selye's 1936 paper in *Nature*, "A Syndrome Produced by Diverse Nocuous Agents."<sup>30</sup> Selye exposed rats to a variety of abuses and found that this produced a common pattern of symptoms including "formation of acute erosions in the digestive tract."<sup>31</sup> *The Journal of the American Medical Association (JAMA)* published an article in 1942 which described patients with ulcers as nervous, high-strung people who tended to overcompensate.<sup>32</sup> They did not view this as a minor pattern, but rather claimed that "often the nervous symptoms overshadow the actual organic disease. Interestingly, enough, these patients are often of the type who live and work under tension; many of them are of the so called executive type."<sup>33</sup> The author was explicit that the lack of clearly understood causal mechanism encouraged his current psychosomatic understanding. "Since no adequate explanation of the etiology of ulcer has yet appeared," he argued, "there is no harm" in proposing a psychosomatic origin.<sup>34</sup> A variety of other publications concurred. Robert A. Katz published a book titled *Peptic Ulcer: Psychosomatic and Medical Aspects* which even included a story about "Wolf and Wolff" who "produced peptic ulcer in a patient with gastric fistula by

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<sup>30</sup> Hans Selye, "A Syndrome Produced by Diverse Nocuous Agents," *Nature*, Vol. 138, Issue 3479 (1936): 32.

<sup>31</sup> These included: "cold, surgical injury, production of spinal shock (transcision of the cord), excessive muscular exercise, or intoxications with sublethal doses of diverse drugs." Hans Selye, "A Syndrome Produced by Diverse Nocuous Agents," *Nature*, Vol. 138, Issue 3479 (1936): 32.

<sup>32</sup> Samuel Morrison and Maurice Feldman, "Psychosomatic Correlations of Duodenal Ulcer: A Statistical Study," *Journal of the American Medical Association*, Vol. 120 Issue 10 (1942): 738-739.

<sup>33</sup> Samuel Morrison and Maurice Feldman, "Psychosomatic Correlations of Duodenal Ulcer: A Statistical Study," *Journal of the American Medical Association*, Vol. 120 Issue 10 (1942): 739.

<sup>34</sup> Samuel Morrison and Maurice Feldman, "Psychosomatic Correlations of Duodenal Ulcer: A Statistical Study," *Journal of the American Medical Association*, Vol. 120 Issue 10 (1942): 739.

stimuli calculated to act on the emotions of the subject.”<sup>35</sup> Beliefs about personality and ulcers continue and patients are still regularly asked about stress when diagnosed even if *Helicobacter Pylori* is present.<sup>36</sup> In the majority of cases, *H. Pylori* remains asymptomatic and this uncertainty about who will be affected again leaves room for psychosomatic explanations.

While asthma is now only rarely discussed as a psychosomatic disease, in the 1950s the dominant belief was that it was emotionally driven. In 1958, Robert T. Long and his co-authors published “A Psychosomatic Study of Allergic and Emotional Factors in Children with Asthma” in the *American Journal of Psychiatry*. Asthmatic children had, the authors thought, “a need for closeness... which is expressed here as a regressive wish.” Moreover, in “the mothers of asthmatic children, [they] found evidence of the mother’s wish to maintain the child in an infantile dependent state. Further, that this way of dealing with the asthmatic child stemmed from mother’s own early unresolved conflicts.”<sup>37</sup> As usual, articles published in more generalist medical journals, as opposed to psychiatric or psychosomatic specialty journals, were somewhat more conservative with their conclusions. A 1959 article in *JAMA* found correlations between “the [MMPI] scales for hypochondriasis, depression, and hysteria” and asthma. However, they noted that some symptoms might contribute to MMPI scores and that some anxiety might be caused by the symptoms rather than the reverse.<sup>38</sup>

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<sup>35</sup> “Author’s Abstract” for Robert A. Katz, *Peptic Ulcer: Psychosomatic and Medical Aspects* (New Orleans, M.&S.J., 1944) published in *The Journal of Nervous and Mental Disease*, Vol. 102, Issue 1 (1945): 92.

<sup>36</sup> Recently, J Bruce Overmier and Robert Murison have argued of a need to build a more nuanced understanding of the role of psychology in determining the impact of *H. Pylori*. J. Bruce Overmier and Robert Murison, “Restoring Psychology’s Role in Peptic Ulcer,” *Applied Psychology Health and Well-Being*, Vol. 5, Issue 1 (2013).

<sup>37</sup> Robert T. Long et al, “A Psychosomatic Study of Allergic and Emotional Factors in Children with Asthma,” *The American Journal of Psychiatry*, Vol. 114, Issue 10 (1958): 898.

<sup>38</sup> Charles L. Heiskell et al, “Some Psychosomatic Aspects of Asthma,” *Journal of the American Medical Association*, Vol. 170, Issue 15 (1959): 1767.

The first book to attempt to explain cancer through psychoanalytic theory was *A Psychological Study of Cancer*, written by Carl Jung's student Elida Evans in 1926. Her fundamental claim was that cancer was a disease of extroverts. It occurred in those who had poured themselves into someone or something else and then lost their outlet. Capable of dealing with their feelings and finding meaning internally, introverts were protected.<sup>39</sup> Within this broader framework, her explanations of specific forms of cancer and individual case narratives were emblematic of later attempts to associate specific diseases with specific personality problems, explanations of racial divisions, and gendered differences in cancer causality. Women who longed for children but could not or chose not to have them risked breast or uterine cancer. This corresponded with observations that women without children were at greater risk of these forms of cancer. Female frigidity could even endanger husbands. For example, Evans claimed that "[men] denied their natural functions either from a frigid wife, or some really legitimate reason, seek satisfaction for existence and pleasure in food, and cancer of the stomach is most common with them."<sup>40</sup>

Evans built on assumptions which were widespread in the early decades of the twentieth century that white women risked the health of the entire race by failing to have children. Wailoo argues that cancer was seen as "one face of white race suicide – a particular preoccupation of American nativists in the 1910s, '20s, and '30s."<sup>41</sup> As they fell prey to false modesty, embraced the more selfish goals of career and social engagement, or tried to maintain a higher standard of living by having fewer children, white women risked cancer. In this view, failing to reproduce

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<sup>39</sup> Elida Evans, *A Psychological Study of Cancer* (New York: Vail-Ballou Press, 1926).

<sup>40</sup> Elida Evans, *A Psychological Study of Cancer* quoted by Keith Wailoo, *How Cancer Crossed the Color Line* (Oxford: Oxford University Press, 2011), 32.

<sup>41</sup> Keith Wailoo, *How Cancer Crossed the Color Line* (Oxford: Oxford University Press, 2011), 15.



the race was viewed as a danger to the nation, but also as a more personal tragedy for white women who might fall ill or endanger their husbands' health. Racists claimed that "primitives" who did not deny their urges would reproduce to outnumber whites while also protecting themselves from the psychological drivers of cancer. Evans drew on these beliefs, pointing to "doctors living and practicing in the wilds of Africa and Asia" who say "that carcinoma is rarely found among primitive tribes."<sup>42</sup> She explained that "Born in the collective unconscious as we all are, they never leave it, while we are supposed to educate ourselves out of its power."<sup>43</sup> At this time, many whites presumed that rural black Americans fit in this pattern, untouched by civilization. Willy Meyer, a New York surgeon from Westphalia, claimed that among this group "prolonged worry is almost unknown."<sup>44</sup> Stereotypes of the "Sambo" as a comic figure implied a contentedness with the racial order. Racist tropes frequently depicted rural black Americans through this figure as carefree, childish, and grinning; and this lack of worry protected them from disease. Leaving their rural environment or pushing their status could threaten this relative safety. This understanding of cancer as a disease of civilization was accepted so widely that it even impacted insurance premiums. In 1937 the chief statistician from Prudential Life Insurance claimed that "when uncivilized peoples (Arabs, Negroes) become civilized, the death rate from cancer reaches the average for civilized people."<sup>45</sup>

Again laying out a pattern for later work, Elida Evans positioned her book as a source for information that filled glaring holes in what doctors could explain about cancer. Jung began his

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<sup>42</sup> Elida Evans, *A Psychological Study of Cancer* quoted by Keith Wailoo, *How Cancer Crossed the Color Line*, 22.

<sup>43</sup> Elida Evans, *A Psychological Study of Cancer* quoted by Keith Wailoo, *How Cancer Crossed the Color Line*, 33.

<sup>44</sup> Keith Wailoo, *How Cancer Crossed the Color Line*, 41.

<sup>45</sup> Frederick Hoffman (1937) quoted in Keith Wailoo, *How Cancer Crossed the Color Line* (Oxford: Oxford University Press, 2011), 36.

introduction to Evan's book by pointing out the derision that Pasteur received and the early suspicion of smallpox vaccinations. The failure to accept the truth of psychology and to admit health advantages it could provide would later seem as absurd as the inability to recognize the value of germ theory. Jung continued by listing questions about cancer that modern science could not answer:

Why does not cancer always run a straightforward course? Why is recurrence delayed sometimes as long as twenty years? Why, more strangely still, does the patient sometimes remain free after one or two recurrences, from any further manifestations? Why does a husband and wife each have a cancerous growth at almost the same time, sometimes, both dying, sometimes only one of them? Why is it a disease of civilized races? Why does it always begin in one spot and not all over the body?

The sheer number of unanswered questions about cancer opened it to psychological explanations. Without much concern about the ambition of the project, Jung claimed "[t]hese questions are all answered in the following pages."<sup>46</sup>

Many psychoanalysts agreed. *The Psychoanalytic Review* said that, "The author of this book demonstrates beyond the shadow of a doubt that normal cancer cases have unique psychological makeups in common."<sup>47</sup> The reviewer continued on to explain that women who want "children and are unable, for various reasons, to acquire them, not infrequently develop cancer of the breast or less often of the uterus." The primary critique, in typical Freudian fashion, was that Evans spent too much time describing life events, and not enough time focused on early childhood development and the unconscious. In her case narratives, there was a sense that disease occurred largely in response to events in a person's life, rather than directly from

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<sup>46</sup> Carl G. Jung, "Introduction" in Elida Evans, *A Psychological Study of Cancer* (New York: Vail-Ballou Press, 1926), vi-vii.

<sup>47</sup> "Book Reviews: A Psychological Study of Cancer." *The Psychoanalytic Review* (New York: Vol. 15, 1928), 109.

unconscious drives. Despite the book's positive reception among psychoanalysts, it was largely ignored in major medical journals. However, as other areas of psychosomatic medicine grew more reputable, the idea reached broader audiences.

Two of the people who most effectively furthered the growth of psychosomatic medicine were Franz Alexander and Helen Flanders Dunbar. Franz Alexander, a Hungarian-born and German-trained psychoanalyst, spent most of his career in the United States. In 1932 he became the first director of the Chicago Institute for Psychoanalysis, where he worked with Karen Horney and Karl Menninger, among other influential psychoanalysts. His 1932 volume *The Medical Value of Psychoanalysis* did not address cancer, but it made a strong case for the importance of psychogenic factors in organic disease as well as for the inclusion of courses on psychoanalysis in medical curriculum, laying the groundwork for later psychosomatic cancer research. Alexander's key example of a disease with psychogenic origins was gastric ulcers. The book's other examples covered a wide variety of health problems, from the melancholia-driven gallbladder disturbance of a character in nineteenth-century French novelist Honoré de Balzac's *Le Cousin Pons* to one young wife's severe case of constipation stemming from her repressed desire for children and frustration with her inattentive husband.<sup>48</sup> Alexander even claimed that, while Koch's discovery of the tuberculosis bacillus had brought undeniable advances, it had led people to forget that psychology played a role even in how people respond to exposure. He claimed that if tuberculosis bacillus seemed to be everywhere in large centers, new explanations of "the variable factors responsible for the fact that only fraction of the persons infected becomes actually sick." He proposed that "In addition to constitution and acquired immunity, it has been

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<sup>48</sup> Alexander also diagnosed Cousin Pons with an oral fixation. Franz Alexander, *The Medical Value of Psychoanalysis*. (London: George Allen & Unwin LTD, 1931), 167-169.

necessary to assume that the psychological state of the individual exposed to infection is also a factor in his resistance to the disease.”<sup>49</sup>

Though Alexander did claim to address diseases like tuberculosis that seemed well understood, he was most effective at establishing his legitimacy when he addressed poorly understood problems like ulcers. *Helicobacter Pylori* would not be shown to survive in the stomach until 1982. Psychosomatic medicine filled this gap in causal explanations. While stress later became the key explanatory factor in ulcers, for Alexander lack of love and infantilization could cause ulcers. “Thus, in one of my cases,” he wrote, “a strong desire for dependence on others, the wish to be loved and taken care of, was present but repressed by the conscious ego, which was dominated by the masculine ideas of independence, success and activity.”<sup>50</sup> Because nursing, eating, and feelings of being loved and are cared for are so closely connected, “The stomach, exposed to a permanent psychic stimulus (unconscious phantasies of being fed), behaves even when it is empty as if it were in a state of digestion and thus is exposed all the time to the influence of the gastric juice.”<sup>51</sup> Alexander continued to model these specific causes for specific diseases. He posited that “repressed fears or unconscious apprehensions may produce heart symptoms... Another typical connection is between spite and extreme desire for independence and chronic constipation.”<sup>52</sup>

Reviews of Alexander’s work appeared in a variety of prestigious publications including *JAMA*, *Nature*, and *The British Medical Journal*. *The British Medical Journal* called the book “a particularly lucid exposition of his subject” and claimed that “it has given a concrete content to

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<sup>49</sup> Franz Alexander, *The Medical Value of Psychoanalysis*. (London: George Allen & Unwin LTD, 1931), 164.

<sup>50</sup> Franz Alexander, *The Medical Value of Psychoanalysis*, 190-191.

<sup>51</sup> Franz Alexander, *The Medical Value of Psychoanalysis*, 192-193.

<sup>52</sup> Franz Alexander, *The Medical Value of Psychoanalysis*, 196-197.

the philosophic postulate that living beings are psycho-biological entities, by investigating in detail the interrelation of physiological and psychological processes.”<sup>53</sup> *Nature*’s review was even more positive. The reviewer noted “Dr. Franz Alexander has dedicated his book... to his master, Sigmund Freud, and it must be admitted that the pupil has proved worthy of the master,” and concluded, “the great value of psychoanalysis to medicine can no longer be denied.”<sup>54</sup> Not only did the writer endorse Alexander’s work, but his review points to a significant respect for Freud and psychoanalysis within the medical profession. *JAMA*’s review, while a bit more cautious, highlighted the shared beliefs of psychoanalysts and organicists. The author wrote, “No modern physician, whether he agrees with Alexander or not, will deny the psychogenic factor in the causation of many organic conditions,” but continued on to “quarrel with the limited approach of psychoanalysis, even to a determination of only the psychogenic factors of disease; life phenomena cannot all be fitted into so little or so rigid a framework.”<sup>55</sup> While maintaining a reluctance to accept psychoanalysis as an all-encompassing theory, the review acknowledged that beliefs that the mind could affect health were so widely held in medicine as to be unremarkable. Later, as Freudian ideas became more dominant, other medical professionals became more comfortable fitting their older ideas into a psychoanalytic framework.

Helen Flanders Dunbar, a practicing psychiatrist in New York City who completed her Ph.D. and M.D. at Columbia before studying further in Vienna, also helped to drive the growth of psychosomatic medicine.<sup>56</sup> Her highly popular 1935 guide to psychosomatic medicine, *Emotions and Bodily Changes*, went through four editions. Dunbar briefly covered the diverse

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<sup>53</sup> “Review: The Medical Value of Psychoanalysis,” *British Medical Journal* Vol. 1, No. 3766 (Mar. 11, 1933): 416. <http://www.jstor.org/stable/25350829>

<sup>54</sup> “Review,” *Nature*, Vol. 131, Issue 3311 (1933): 532.

<sup>55</sup> “Review,” *Journal of the American Medical Association*, Vol 92, Issue 22 (1932): 1936.

<sup>56</sup> “Obituary: Helen Flanders Dunbar,” *British Medical Journal*, Vol. 5151, No. 2 (1959): 584.

research on psychosomatic medicine and created a book that functioned in large part as bibliography. *Emotions and Bodily Changes* not only served to highlight the amount of work being done, but it drew attention to the focus on women in psychosomatic medicine. In her chapter on gynecology she noted, “[t]he literature concerning the psychosomatic problem in gynecology is so voluminous that a monograph would be required to cover it even cursorily.”<sup>57</sup> There was no indication that this was problematic.

Like Alexander’s, Dunbar’s work gained a wide readership and positive feedback. *JAMA*’s review accepted that psychoanalysts were capable of “relieving sufferers from gastric ulcer” and praised “psychiatrists [for] furnishing some of the theory for treating asthma and *functional* heart disease.” These popularly accepted connections helped provide evidence that psychosomatic medicine could address a broader variety of problems. Overall, the reviewer agreed with Dunbar’s claim that “Psychiatry... is finding its place within medicine on the same basis as any other specialty” and believed it might “well serve as a crystallizing influence in the field of mental medicine.”<sup>58</sup>

Dunbar and Alexander both remained at the center of psychosomatic research. In 1939, Dunbar became the first editor of *Psychosomatic Medicine*, a position she held for ten years.<sup>59</sup> The journal was supported by the Josiah Macy, Jr. Foundation, as well as the National Research Council's Division of Anthropology and Psychology.<sup>60</sup> In addition to the formation of the journal, “in December 1942, the advisory board of the Journal voted to establish the ‘American

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<sup>57</sup> Helen Flanders Dunbar, *Emotions and Bodily Change* (New York: Columbia University Press, 1938), 330.

<sup>58</sup> “Emotions and Bodily Changes: A Survey of Literature on Psychosomatic Interrelationships,” *Journal of the American Medical Association*, Vol. 105, No. 10 (1935): 822.

<sup>59</sup> <http://www.bmj.com.proxy1.cl.msu.edu/content/2/5151/584.3>

<sup>60</sup> “About APS: History of APS,” *American Psychosomatic Society*, accessed January 17, 2018. <http://www.psychosomatic.org/about/index.cfm>

Society for Research in Psychosomatic Problems’.” Franz Alexander became the fifth president of the society in 1947.<sup>61</sup> While the membership was more heavily composed of psychiatrists, the leadership had a “mixture of scientists from several subspecialties of psychology and the social sciences and a variety of clinical specialties that included internal medicine, pediatrics (especially child development), neurology, and others.”<sup>62</sup> This work helped psychosomatic medicine gain a strong place in American thought by the end of the 1930s and gave a new framework to age old claims about health and wellness. While doctors had yet to accept Freudian thought as a complete explanation for psychology and psychosomatic disorders, many did take it seriously.

### **The Triumph of Psychoanalysis**

By the 1950s, psychoanalysis had become dominant and psychosomatic medicine had a platform within orthodox medical spaces. During the 50s and 60s Freudianism became so accepted that psychoanalysts held chairs in major psychiatry departments and directed the structure and content of DSM-1.<sup>63</sup> This allowed psychosomatic theories of cancer to flourish. After the Second World War, two main historical processes helped cement the place of Freud in the U.S. First, returning soldiers required new types of care and psychoanalysis was widely viewed as a successful way of treating them. Second, Freudian thought justified the family order that lay at the center of American social and political life in the early years of the Cold War and

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<sup>61</sup> “About APS: History of APS,” *American Psychosomatic Society*, accessed January 17, 2018. <http://www.psychosomatic.org/about/index.cfm>

<sup>62</sup> Donald Oken and Ann Maxwell Eward, “A Brief Report on the History and Role of the American Psychosomatic Society,” *Journal of Psychosomatic Research*, Vol. 42, Iss. 3 (1997): 308.

<sup>63</sup> Jonathan Metzl, *Prozac on the Couch: Prescribing Gender in the Era of Wonder Drugs*, (Durham: Duke University Press, 2003), 1.

provided systems to help women adjust to it. For both returning soldiers and new housewives, psychoanalysis promised successful adjustment to a gendered order. Soldiers became family men and providers; women became sexually fulfilled wives and caring mothers.

Returning from war, American soldiers, like those returning from World War I, struggled to reintegrate. They displayed patterns of behavior and symptoms that were troubling to ideas of manhood. However, in a trend growing from theories developed during World War I, there was a greater push to understand these men and rehabilitate them instead of writing them off as cowards or punishing them back into fighting shape.<sup>64</sup> When General Patton slapped a soldier who took shelter in an Army Hospital without visible wounds, the public was incensed.<sup>65</sup> Psychic wounds came to be treated more seriously and psychoanalysis seemed to help. Articles in popular magazines like *Time* and *Newsweek* touted the recoveries of soldiers through psychoanalysis and catharsis. One soldier recalled his experiences dealing with psychosomatic problems after the war: “They explained things to me, clear. At first I thought it was the bunk. But after a couple of days when I had these sessions with the doctors and when I talked to my buddies—it was a funny thing; my head stopped hurting.”<sup>66</sup> Put simply, “Once they got it off their chests, half their battle is won.”<sup>67</sup> By making convincing arguments that wounds could be both psychological and real, and by demonstrating that talking could cure them, psychoanalysis had carved out a real place within the medical establishment and in wider culture: they could treat war wounds and ease symptoms of soldiers that had previously seemed emasculating.

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<sup>64</sup> George L. Mosse, “Shell-Shock as a Social Disease,” *Journal of Contemporary History*, Vol. 35, No. 1 (2000): 101-108.

<sup>65</sup> “To Extend Inquiry into Patton Affair, Senate Group Will Look for Similar Army Episodes,” *New York Times*, November 29, 1923: 2.

<sup>66</sup> Nathan J. Hale Jr., *The Rise and Crisis of Psychoanalysis in the United States: Freud and the Americans, 1917-1985* (New York: Oxford University Press, 1995), 278.

<sup>67</sup> Nathan J. Hale Jr., *The Rise and Crisis of Psychoanalysis in the United States*, 278.



While psychoanalysis helped returning soldiers maintain their sense of manliness, Freudian ideals of femininity also held deep resonance. They built on anxieties of the times about the American family, domesticity, and race by pathologizing women who were insufficiently maternal, excessively masculine, or who failed to enjoy sex within the appropriate context. The version of femininity proposed by psychoanalysts was directly relevant to social needs following the Second World War. Americans were increasingly focused on their domestic lives after the Second World War. Elaine Tyler May has shown that following World War II young people rushed to create domestic safe havens. Reacting against war, depression, and the threat of Communist immorality, they formed new “traditional” families.<sup>68</sup> They aimed to create marriages that promoted and provided boundaries for an active sex life and to build perfect nuclear families with a committed mother in the home. Any nagging discontent with this arrangement or failure to meet this standard required an explanation and a solution. People turned to therapy for help. Psychoanalysts met this need by trying to help women accept their sexuality and channel it into reproductive and monogamous heterosexual relationships. They encouraged women to allow themselves to depend on men by becoming contented wives and mothers. Psychoanalysis both provided expert approval for the creation of normative families and promised to help women adjust to them.

The focus on domesticity was not a theoretical one. Median ages at first marriages dropped from 24.3 for men and 21.5 for women in 1940 to 22.8 for men and 20.3 for women by 1950. They did not exceed earlier levels until the late 70s.<sup>69</sup> Though immigration led to faster

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<sup>68</sup> Elaine Tyler May, *Homeward Bound: American Families in the Cold War Era*, (New York: Basic Books, 1988).

<sup>69</sup> US Census Bureau, “Table MS-2. Estimated Median Age at First Marriage: 1890 to present.” Accessed August 10, 2018. <https://www.census.gov/data/tables/time-series/demo/families/marital.html>

population growth from 1900-1910, the 1950s had the second highest percentage population increase of any decade in the twentieth century. Instead of immigration, this was the result of the baby boom following the war.<sup>70</sup> After World War II, men and women chose to marry younger and have more children, reversing longstanding trends.

Having the financial security to settle down after the Depression helped make this creation of single-family domestic havens possible for many Americans. Vastly increased expendable income and a market free from wartime restrictions led to increased consumer spending- much of which went into housing. Data from the Bureau of Economic Analysis shows a slow increase in investment in housing units from .3 billion dollars in 1933 at the nadir of the depression. This increase was followed by another collapse as war efforts prevented spending on construction. From another low of .7 billion dollars in 1944, spending shot up to 11.4 billion by 1948.<sup>71</sup> This corresponded with an increase in homeownership rates from 43.6% in 1940 to 55% in 1950.<sup>72</sup> Suburbs marched out from cities to accommodate demand for single-family homes.

While improved economic realities made it possible for many families to have more children, marry earlier, and live out a certain kind of domesticity, this is more than a story of rising prosperity. Increased social and political commitment both encouraged these behaviors and, for white families, incentivized them. Cold War ideology highlighted differences between the modern American woman and sexless Communists. The “modern American woman” was

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<sup>70</sup> Frank Hobbs and Nicole Stoops, U.S. Census Bureau, Census 2000 Special Reports, Series CENSR-4, *Demographic Trends in the 20<sup>th</sup> Century*, U.S. Government Printing Office, Washington, DC, 2002, 12-13.

<sup>71</sup> US Bureau of Economic Analysis, “Table 2.7. Investment in Private Fixed Assets, Equipment, Structures, and Intellectual Property Products by Type.” Accessed August 10, 2018. <https://www.bea.gov/iTable/iTable.cfm?ReqID=10&step=1#reqid=10&step=3&isuri=1&1003=51&1004=1929&1005=1969&1006=a&1011=0&1010=x>

<sup>72</sup> United States Census Bureau, “Historical Census of Housing Tables,” *census.gov*, accessed January 12, 2018, <http://www.census.gov/housing/census/data>

liberated from repressive Victorian sexual standards and able to find joy within her marriage. She raised her children as moral citizens within a loving home, free to follow the dictates of her religion, and she lived with the comforts of science that helped her to run her home efficiently. While Communist women were seen as sexless beings forced to become something other than women, American women were supposed to be free to follow their true nature. Liberation allowed them to be natural women who lived in comfort. Cold War debates promoted a limited view of female liberation. Historian Elaine Tyler May argues that women “hoped that the home would become not a confining place of drudgery, but a liberating arena of fulfillment through professional homemaking, meaningful childrearing, and satisfying sexuality.”<sup>73</sup>

The Kitchen Debates in 1959 brought these comparisons into focus. Richard Nixon and Nikita Khrushchev faced off over a model home in an American exhibition. Nixon showed Khrushchev the kitchen pointing out the washing machine in particular. “This is our newest model,” he said, “This is the kind which is built in thousands of units for direct installations in the houses. In America, we like to make life easier for women...” After Khrushchev interjected to point out the capitalist attitude towards women, Nixon continued, “I think that this attitude towards women is universal. What we want to do, is make life more easy for our housewives.”<sup>74</sup> Together, science and capitalism, Nixon believed, made women more comfortable and freed them from the most laborious housework without pushing women out of their “natural” environment.

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<sup>73</sup> Elaine Tyler May, *Homeward Bound: American Families in the Cold War Era*, (New York: Basic Books, 1988), 22.

<sup>74</sup> Richard Nixon and Nikita Khrushchev, “The Kitchen Debate—Transcript,” July 24, 1959. Central Intelligence Agency Library. <https://www.cia.gov/library/readingroom/docs/1959-07-24.pdf>

While technology liberated women who could afford it from the most taxing forms of housework, American freedom liberated them from Victorian standards of sexual reticence. Sexual liberation, within marriage, became an essential characteristic of the modern woman. May explains that, where Victorian women were expected to only begrudgingly tolerate sex for reproduction, “wives in the postwar era were recognized as sexual enthusiasts whose insistence on conjugal satisfaction would contribute to erotically charged marriages.” Marriages would serve to contain rather than repress sexuality. This “would enhance family togetherness, which would keep both men and women happy at home and would, in turn, foster wholesome childrearing.”<sup>75</sup> This move to greater sexual openness was reflected in fashion and after the war full skirts returned into fashion as “exaggerated bust lines and curves that created the aura of untouchable eroticism... the body itself was protected in a fortress of undergarments, warding off sexual contact but promising erotic excitements in the marital bed.”<sup>76</sup> Feminine freedoms were contained within marriage and a single family suburban home that provided comfort and privacy. American suburbs became feminine spaces of retreat, protected from the outside world, those of other races as well as various other threats. Through neighborhood associations and political advocacy, many white suburban women worked to protect their neighborhoods, themselves and their children from perceived black sexual aggression and immorality.<sup>77</sup>

The United States actively promoted family structures and lifestyles that reflected this vision of femininity and family. Through generous home loans, the GI Bill, and the creation of

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<sup>75</sup> Elaine Tyler May, *Homeward Bound: American Families in the Cold War Era*, (New York: Basic Books, 1988), 102-103.

<sup>76</sup> Elaine Tyler May, *Homeward Bound: American Families in the Cold War Era*, (New York: Basic Books, 1988), 112.

<sup>77</sup> Thomas Sugrue, *The Origins of the Urban Crisis: Race and Inequality in Postwar Detroit*, (Princeton: Princeton University Press, 2005), 250-252.

major highways into and through cities, the federal government drove the expansion of suburbs. And through discriminatory lending, city planning that demolished black neighborhoods, and the acceptance of racially restrictive covenants that prohibited selling to non-whites, the federal government maintained these suburbs as white spaces, protective of white womanhood.<sup>78</sup> In these wholesome, white, family spaces, women could raise the future generation of morally upstanding citizens.

Female satisfaction with the promises of American life—homes, comforts, husbands, sex, and happy families—was politically essential. Women who deviated from this vision were seen as threats to both the moral and the political order. In addition to facing social exile, feminists, lesbians, and various other kinds of deviants risked being seen as likely fellow travelers or Communists. Proper gender and sexual performance was necessary. Psychoanalysis promised to help deviants and women who felt nagging discomfort with this arrangement to adapt to their roles. In *The Feminine Mystique* and in interviews, Betty Friedan frequently referenced the way housewives sought help from psychoanalysts, approaching what Friedan saw as a reasonable reaction to oppressive gender roles as a personal failing related to sex or childhood development. Friedan explained that “When a woman went to a psychiatrist for help, as many women did, she would say, ‘I’m so ashamed,’ or ‘I must be hopelessly neurotic.’”<sup>79</sup> After all, “What kind of a woman was she if she did not feel this mysterious fulfillment waxing the kitchen floor?”<sup>80</sup> And psychoanalysts worked to meet these needs. Friedan noted that, “No month went by without a

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<sup>78</sup> Thomas Sugrue, *The Origins of the Urban Crisis: Race and Inequality in Postwar Detroit*.

<sup>79</sup> Betty Friedan. *The Feminine Mystique* (New York, W.W. Norton & Company, 2001), 62.

<sup>80</sup> Betty Friedan. *The Feminine Mystique* (New York, W.W. Norton & Company, 2001), 62.

new book by a psychiatrist or sexologist offering technical advice on finding greater fulfillment through sex.”<sup>81</sup>

The perceived success of psychoanalysis in meeting both the needs of women who did not adjust to or could not obtain the ideal family and the needs of returning soldiers helped give psychoanalysis relevance in daily life and a respected place in medicine. This success and integration into the establishment gave psychoanalysts freedom to expand the diseases they claimed to treat or prevent. Instead of focusing on the neglected diseases of medicine, ulcers and asthma, they felt freer to reiterate boldest claim of psychosomatic medicine: that they could explain carcinogenesis.

### **Carcinogenic Deviance**

Psychoanalytic theories of cancer were well suited to these limited views of sexual liberation and freedom to raise children in joyful homes. Psychosomatic studies of cancer among women identified sexual repression and frigidity as cancer risks while also maintaining boundaries on this sexuality by also pointing to risks in traits that might encourage sex outside of a heterosexual, marital context. Further risk factors included insufficiently maternal feelings. Failure to meet the standards of American womanhood jeopardized health, well-adjusted women were safe, and psychoanalysts could help guide women towards acceptance of their true natures, thus saving them from cancer.

Freudians writing about cancer constantly defined gender, but the way in which they believed identity developed encouraged them to focus on issues besides careers or intellectual and public engagement. Psychologists attempted to understand sexuality and relationships with

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<sup>81</sup> Betty Friedan. *The Feminine Mystique* (New York, W.W. Norton & Company, 2001), 67.

parents that unconsciously determined patients' actions and identities. Careers in this paradigm were largely irrelevant. In their studies they reinforced a picture of well-adjusted women as sexual and moderately dependent on men. Healthy sexuality was to be expressed through heterosexual, monogamous, reproductive sex. Women were to accept their maternal drives and their weakness in comparison to men.

Sexual repression emerged as a key risk factor for both breast cancer and cervical cancer. In order to make these arguments, psychologists reinterpreted sexual experiences as the direct result of personality and individual psychology instead of viewing them as specific behaviors or events. This allowed them to reinterpret data about sexual partners and cancer within a psychosomatic framework. In the 1950s, doctors were unaware of the role of human papillomavirus (HPV) but they were exploring the connection between race, sexuality, and cervical cancer.<sup>82</sup> "Personality Patterns in Patients with Malignant Tumors of the Breast and Cervix: An Exploratory Study" was published in a 1951 issue of *Psychosomatic Medicine*. Milton Tarlau, M.D. and Irwin Smalheiser, M.A. conducted interviews, Rorschach tests, and figure drawing tests with patients at New York City Cancer Institute on Welfare Island. They determined that both breast and cervical cancer patients had poor sexual adjustment and experienced difficulty conforming to the feminine role because of their dominating mothers. Women with breast cancer, "adapted by denying their sexuality, while the cervix patients have histories of a much more active early sex life and maladjustment reflected in the high incidence

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<sup>82</sup> For more on race, sexuality and the study of cervical cancer see Keith Wailoo "How the Other Half Dies" in *How Cancer Crossed the Color Line*, (Oxford; New York: Oxford University Press, 2011), 92-119.

of overt marital discord.”<sup>83</sup> Because they did not recognize women’s forms in the ink blots and drew women as stronger than men, both groups of patients were characterized as excessively masculine.<sup>84</sup> Lack of physical pleasure in cervical cancer patients encouraged them to leave current partners and drift from man to man while breast cancer patients simply pretended their sexuality did not exist. Both groups of patients failed to find the middle ground that psychiatrists considered healthiest: contented monogamy. While they did not explain how this played out in women’s lives, viewing women as stronger than men was considered self-evidently pathological.

The claim that cervical cancer patients failed to enjoy sex was consistent with one exception. Jasen points out that even research which contradicted earlier work still pointed back to problems of sexual maladjustment. For example, a study of sixty women, forty with cancer and twenty without, failed to replicate or verify earlier conclusions. Rather, they found “that the sweeping statements made by Bacon, Cutler and Renneker regarding the life experiences or personality characteristics of women with breast cancer” could not be justified. Their new observations still fit a pattern of focus on sexual fulfillment in cancer patients. Those in the study were more negative about sex and saw less “human movement” in ink blot tests. Jasen also noted that in accepting these differences as potentially causal, they failed to take into account the impact of radical mastectomies on women’s body image and sexuality.<sup>85</sup>

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<sup>83</sup> M. Tarlau and I. Smalheiser, “Personality Pattern in Patients with Malignant Tumors of the Breast and Cervix: An Exploratory Study,” *Journal of Psychosomatic Medicine* 13 No. 2 (1951): 118.

<sup>84</sup> M. Tarlau and I. Smalheiser “Personality Pattern in Patients with Malignant Tumors of the Breast and Cervix: An Exploratory Study,” *Journal of Psychosomatic Medicine* 13 No. 2 (1951): 119-120.

<sup>85</sup> John I. Wheeler, Jr. and Bettye McDonald Caldwell, “Psychological Evaluation of Women with Cancer of the Breast and of the Cervix,” *Psychosomatic Medicine*, 17 (1955): 256-68. Cited in Patricia Jasen, “Malignant Histories: Psychosomatic Medicine and the Female Cancer Patient in the Postwar Era,” *Canadian Bulletin of Medical History*, Vol 20, Issue 2 (2003): 279.



A 1954 study by doctors at the New York Hospital-Cornell Medical Center pointed also to “lower incidence of orgasm,” “dislike for sexual intercourse,” and “poor marital adjustment as indicated by the high incidence of divorce, desertion, and separation.”<sup>86</sup> Like the disease, marital discord was seen as emerging from personality problems in women, not as a result of circumstances or men’s actions. With the exception of object loss as a cause for psychosomatic cancer, psychosomatic theories of cancer depended on the ability to understand patients’ life histories as dependent on their personality.<sup>87</sup> Thus, regardless of the circumstances of divorce or desertion, events were characterized as resulting from individual problems: in this case as the result of a dislike for sexual intercourse. If events merely happened to patients, they could not serve to define cancerous personality patterns.

Studies of personality in cancer had to explain not just disease in individuals, but also had to reflect epidemiological patterns of disease within larger populations. Racial differences in incidence and mortality rates needed the support of stereotypes about racial differences in personality. And so the authors relied on their view of black women’s relationships to explain the higher rate of cervical cancer among black women. The authors pointed out that this pattern of marital discord was “particularly true of the Negroes.”<sup>88</sup> And their mention of “dominating mothers” fit within longstanding stereotypes of black family life. They considered the pathologies of black women obvious and used their view of black relationships to explain the higher rate of cervical cancer. Their attempt to extend the connection between personality and

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<sup>86</sup> James H. Stephenson and William J. Grace, “Life Stress and Cancer of the Cervix,” *Journal of Psychosomatic Medicine*, 16 No. 4 (1954): 292.

<sup>87</sup> Object loss, the loss of an important person or facet of one’s life, did not necessarily imply a personality trait in the patient. For example, spousal death was treated as an event. However, responses to negative events were frequently attributed to intrinsic personality characteristics.

<sup>88</sup> James H. Stephenson and William J. Grace, “Life Stress and Cancer of the Cervix,” *Journal of Psychosomatic Medicine*, 16 No. 4 (1954): 292.

cancer to explain all epidemiological trends provided an opportunity for them to draw on their racial as well as gendered stereotypes. In short, the landscape of cancer required a landscape of personality.

Research on emotion and breast cancer also focused on appropriate gender roles and sexuality. A 1962 article coauthored by seven psychoanalysts at the Chicago Institute for Psychoanalysis provided a clear explanation of how cancer patients in psychoanalysis were perceived. The authors explained that in prior research on “cancer of the breast, others have described disturbances in the assumption of the feminine role.”<sup>89</sup> They expanded on this not only by listing seven factors they considered important for carcinogenesis, but also by laying out the case stories of each of the study participants. The personality traits included:

- (1) masochistic character structure,
- (2) inhibited sexuality,
- (3) inhibited motherhood
- (4) a façade of pleasantness covering an inability to discharge or deal appropriately with hostility or aggressiveness.
- (5) unresolved conflict with the mother handled through denial and unrealistic sacrifices,
- (6) delay in securing treatment,
- (7) a frequent picture prior to clinical diagnosis of cancer of acute or chronic depression, with vague feelings of anxiety, guilt, strong self criticism, and self condemnation.<sup>90</sup>

In the five case narratives, the authors emphasized the patients’ depression and hopelessness.

They argued that depression and emotional conflict “should be viewed as establishing a favorable internal climate for disease. This state of decreased host resistance is what is alluded to

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<sup>89</sup> Richard E. Renneker et al., “Psychoanalytical Explorations of Emotional Correlates of Cancer of the Breast,” *Journal of Psychosomatic Medicine* 25 no. 2 (1963): 106.

<sup>90</sup> Richard E. Renneker et al., “Psychoanalytical Explorations of Emotional Correlates of Cancer of the Breast,” 106.

in such phrases as ‘passive suicide’ or ‘host acquiescence.’”<sup>91</sup> The stories supported these claims through their focus on the failed relationships of the women, their early negative sexual encounters, parental traumas, and losses. Some of the patients challenged the psychotherapists’ interpretations of their lives and one “rationalized her hostility toward the therapist with the accusation that he had taken away her ‘will to live,’ although it patently had been nonexistent prior to psychotherapy.”<sup>92</sup> In their effort to tie patients’ depression not to the events in women’s lives but rather to their underlying personality characteristics, the authors interpreted many of the events as the result of patients’ unconscious action. For example, early and abusive sexual experiences were repeatedly explained as the result of “unconscious seduction” by the patient.<sup>93</sup> This generated many of the conflicts with patients over interpretation.

Anne Harrington notes that Freud initially viewed these hysterical symptoms as the result of repressed memories, but moved to seeing them as the result of repressed fantasy. This switch meant that the analyst needed to more actively reinterpret patients’ stories and that patient memories were not to be trusted.<sup>94</sup> Identifying fantasies helped psychoanalysts feel they could ignore patient explanations of events and recategorize information from patients as reflective of disordered sexual development. While the women included in the case narratives above expressed frustration with the interpretations of their lives, many others opted not to participate. Renneker’s team saw this as a sign of “disturbing neurotic symptoms and ... accordingly advised

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<sup>91</sup> Richard E. Renneker et al., “Psychoanalytical Explorations of Emotional Correlates of Cancer of the Breast,” 120.

<sup>92</sup> Richard E. Renneker et al., “Psychoanalytical Explorations of Emotional Correlates of Cancer of the Breast,” 111.

<sup>93</sup> Richard E. Renneker et al., “Psychoanalytical Explorations of Emotional Correlates of Cancer of the Breast,” 109, 113, 120, 121.

<sup>94</sup> Anne Harrington, *The Cure Within*, 76.

[them] to have psychoanalytical therapy.” Jasen identified this as “A healthy skepticism” which “prevailed among most of the patients”<sup>95</sup>

William A. Greene conducted a series of studies on patients with lymphomas and leukemia, the first of which he published in 1954. This first and his remaining articles were published in *Psychosomatic Medicine*. While that first article covered psychology in male patients, the second article (written with coauthors Lawrence Young and Scott Swisher) addressed psychology in white women. The authors were each in psychiatry or medical departments at the University of Rochester, Rochester Municipal Hospital, or the Strong Memorial Hospital.<sup>96</sup> In support of their work, they received grants from the National Institute of Mental Health, National Institute of Health, Public Health Service, and the Foundations Fund for Research in Psychiatry.<sup>97</sup> Greene echoed many of the same fears about flawed femininity that his peers shared. Patients were interviewed, and in the majority of cases observed on a number of cases either at home or in the hospital. Some interviews with family members were also gathered.<sup>98</sup> They then divided their patients into four categories: mothering, clinging, isolated, and manly.<sup>99</sup>

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<sup>95</sup> Richard Renneker et al., “Psychoanalytical Explorations of Emotional Correlates of Cancer of the Breast,” *Psychosomatic Medicine*, 25 (1963): 122. Cited in Patricia Jasen, “Malignant Histories: Psychosomatic Medicine and the Female Cancer Patient in the Postwar Era,” *Canadian Bulletin of Medical History*, Vol 20, Issue 2 (2003): 282.

<sup>96</sup> William A. Greene, Lawrence E. Young, and Scott N. Swisher, “Psychological Factors and Reticuloendothelial Disease,” *Psychosomatic Medicine*, Volume 16, Issue 3 (1954):284.

<sup>97</sup> William A. Greene, Lawrence E. Young, and Scott N. Swisher, “Psychological Factors and Reticuloendothelial Disease,” 284.

<sup>98</sup> William A. Greene, Lawrence E. Young, and Scott N. Swisher, “Psychological Factors and Reticuloendothelial Disease,” 285.

<sup>99</sup> William A. Greene, Lawrence E. Young, and Scott N. Swisher, “Psychological Factors and Reticuloendothelial Disease,” 286.

The manly patients, they said, “showed obvious extreme masculine identification and included on machinist, one physical-education instructor, one court secretary, one ‘foreman’ in a bakery, and one airline pilot.” This group “comprised women denying any need for anyone except perhaps one individual. Toward everyone they were demeaning and belittling. To these women there was one person more insignificant than a man and that was any other woman.”<sup>100</sup> They described the clinging women as “chronically sad, whining women who cried for attention and made little attempt to deny this need.” The isolated group “usually had had a close relationship with one key person, a parent, husband, or child and had been unable to risk anything but a distant tentative relation with others.”<sup>101</sup> While these descriptions were not surprising in their negativity and gendered stereotypes. Despite describing the ‘mothering’ women as pleasant, they were still remarkably pathologized. These women, they wrote, were “pleasant, ‘good’ patients who had behaved like ideal mothers and whom we had come to describe as ‘trying to out-mother the mother.’” The “mothering” study participants took care of their own children, “other adults, and the sick. Three of this group had multiple foster children... Two of these women were described by their families as ‘always taking in strays,’ meaning various lone persons.”<sup>102</sup> As with the other patients, it was “inferred that all of these women had had an unresolved attachment to their mother.”<sup>103</sup> For all four groups, they determined “that one of the multiple conditions determining development of lymphoma and leukemia in adults may be

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<sup>100</sup> William A. Greene, Lawrence E. Young, and Scott N. Swisher, “Psychological Factors and Reticuloendothelial Disease,” 286.

<sup>101</sup> William A. Greene, Lawrence E. Young, and Scott N. Swisher, “Psychological Factors and Reticuloendothelial Disease,” 286.

<sup>102</sup> William A. Greene, Lawrence E. Young, and Scott N. Swisher, “Psychological Factors and Reticuloendothelial Disease,” 285.

<sup>103</sup> William A. Greene, Lawrence E. Young, and Scott N. Swisher, “Psychological Factors and Reticuloendothelial Disease,” 302.

separation from a key object or goal with ensuing depression.”<sup>104</sup> They were clear that this object loss was shaped in large part by the flawed relationships to objects of their various patient groups: from smothering to avoidant.

Psychoanalytic studies pointed to hopelessness and emotional repression as the cause of cancer, but their focus on sexuality shaped their interpretation of those terms. Inhibited sexuality and repressed emotion became synonymous and hopelessness became an inability to be satisfied by a monogamous heterosexual relationship. Discussion of career goals and conscious concerns was largely absent from psychoanalytic studies. The acknowledgement of larger goals most likely would have been interpreted as excessive masculinity, but careers rarely appear in the literature because they were not a part of analysts’ questions or primary clinical interests.

The main outlier for each of these trends was Wilhelm Reich. Reich worked closely with Freud at his clinic and taught the seminar on psychoanalytic therapy there until 1930. However, as his politics grew increasingly radical and his interest in “orgastic potency” and what he termed “orgone” increased, he went his own way.<sup>105</sup> Reich’s intense focus on sexuality went beyond that of orthodox psychoanalysts and offended sensibilities. Moreover, Reich was a Marxist, argued for sexual liberation and easy access to abortion, and explained fascism as the result of sexual repression.<sup>106</sup> Cancer too, he argued, grew out of sexual dysfunction. In the 1940s, Reich began building orgone accumulators (large boxes with a chair inside), which he believed would promote health. In 1948, he published *The Cancer Biopathy* which argued that “The many

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<sup>104</sup> William A. Greene, Lawrence E. Young, and Scott N. Swisher, “Psychological Factors and Reticuloendothelial Disease,” 303.

<sup>105</sup> James S. Olson, *Bathsheba’s Breast: Women, Cancer, and History* (Baltimore: John Hopkins University Press, 2005), 158.

<sup>106</sup> Dagmar Herzog, *Cold War Freud: Psychoanalysis in an Age of Catastrophes* (Cambridge: Cambridge University Press, 2017), 131-132, 3.

manifestations of cancer, like the multiplicities of neuroses and psychoses, conceal a single common denominator: sexual stasis.”<sup>107</sup> He used his book to further argue that his orgone accumulators could be used to treat this imbalance and the resulting cancer. But where other psychoanalysts manage to tap into cultural beliefs and gain institutional success. Reich was kicked out of the Communist party, had to come to the United States to flee from Nazis, was later disowned by his colleagues and faced prosecution for his claims. His work shows the limits of psychosomatic claims. In order to maintain institutional success, their therapies had to operate alongside standard therapies, their claims for curative potential had to be limited, and they had to fit within broader cultural beliefs. Wilhelm Reich died in prison.

### **Cancer in Men**

Studies of cancer in men did exist, but there was never the same incentive to identify particular kinds of pathological masculinity or deviancy as the cause of cancer in men. Depression and emotional repression held less cultural relevance in understandings of men, and accordingly, there was slightly less research on male patients during this period. Those articles which were published, often served different purposes. Research on tobacco use, cancer, and personality was intended to distract from growing consensus on the connection between smoking and lung cancer. These studies used male patients because the majority of smokers at the time were men. Other researchers focused on male patients because of the availability of employment or military records. Because of these differences in goals and available material, studies of cancer in men from the 1950s and 60s had a radically different tone than studies of cancer and

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<sup>107</sup> Wilhelm Reich, *The Cancer Biopathy: Volume II of the Discovery of the Orgone*, Andrew White with Mary Higgins and Chester M. Raphael, (New York: Farrar, Straus and Giroux: 1973), 153.

emotion in women. Case narratives were more rarely included and little effort was made to contextualize data within an interpretive framework that guided men into a healthier masculinity. For those attempting to divert attention from tobacco, interpretive frameworks were unimportant. For those analyzing convenient data on male patients, the scope of the data available encouraged a different type of analysis lacking personal detail. Often, the descriptions of male cancer patients were even complimentary, with patients described as more intelligent or outgoing than controls.

Lawrence LeShan's work fit clearly within these patterns of writing about men. LeShan was a prominent early researcher and popularizer in the field of psychosomatic medicine working at the Institute of Applied Biology in New York with funding from the Frederick Ayer Foundation.<sup>108</sup> Despite LeShan's side interests in topics including the paranormal, his work was highly influential. His 1959 literature review in the *Journal of the National Cancer Institute* has been cited 169 times.<sup>109110</sup> LeShan published one of the first of a series of articles about Hodgkin's disease in 1957. "A Psychosomatic Hypothesis Concerning the Etiology of Hodgkins' Disease" laid out three stages leading up to the development of the disease, with diagnosis occurring in the third stage. He also included three case narratives, two of which were for male patients, an unusual inclusion at this time. Hodgkin's patients had a difficult childhood according

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<sup>108</sup> Lawrence LeShan, *You Can Fight For Your Life: Emotional Factors in the Causation of Cancer* (New York: M. Evans and Company Inc., 1977), ix-x.

<sup>109</sup> Lawrence LeShan, "Psychological States as Factors in the Development of Malignant Disease—A Critical Review," *Journal of the National Cancer Institute*, 22 no. 1 (1959): 1-18. Citation count from [webofknowledge.com](http://webofknowledge.com) accessed June 22, 2018.

<sup>110</sup> Frederick Ayer Jr., heir of a family fortune, helped to support LeShan's research. "Mr. Ayer became a research physicist in energy production. But he used his wealth to further his interests in travel, orchids and the arts, and to fund research on DNA, cancer and human sexuality... He also contributed to research on UFOs." Carole Beers. "Frederick Ayer II, Scientist, Traveler." *Seattle Times*, October 22, 1998.



to LeShan and this childhood phase included “early psychological trauma [which]made the establishment of intense relationships difficult.” These children did, however, have “a rich fantasy life.” Later, in stage two, their lives were changed by the “discovery of a peer group with similar goals and orientations. This group provided a focus for the individual’s relationship needs. After a period of cautious testing, he felt accepted.”<sup>111</sup> Finally, “[t]he third phase of this pattern began with the loss of the relationship to this group for reasons beyond the individual’s control, such as, graduation from school and induction into the armed services.” This created a sense of isolation “in spite of the existence of many objective interpersonal relationships, a strong feeling of anomie was present.”<sup>112</sup> In a footnote, LeShan commented, “It is the writer’s strong impression that all the Hodgkin’s patients studied were people of superior intellectual endowment. In Phase 3, their ability and high energy level potential were blocked leaving open no channels of expression.”<sup>113</sup>

LeShan’s argument is dramatically different for this article than for the majority of other descriptions of cancer patients in the psychosomatic literature. Most obviously, LeShan makes clear that these patients share something valuable (intelligence) instead of just a similar form of maladjustment. But in addition, LeShan specified that the loss of the peer group was “for reasons beyond the individual’s control.” This blamelessness is in marked contrast to the description of negative events befalling women in the writing of researchers like Renneker who explained away

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<sup>111</sup> Lawrence LeShan, “A Psychosomatic Hypothesis Concerning the Etiology of Hodgkins’ Disease” *Psychological Reports*, Vol. 3 (1957): 566.

<sup>112</sup> Lawrence LeShan, “A Psychosomatic Hypothesis Concerning the Etiology of Hodgkins’ Disease” *Psychological Reports*, Vol. 3 (1957): 567.

<sup>113</sup> Lawrence LeShan, “A Psychosomatic Hypothesis Concerning the Etiology of Hodgkins’ Disease” *Psychological Reports*, Vol. 3 (1957): footnote 4, 567.

abusive sexual experiences of breast cancer patients as “unconscious seduction.” When cancer happened to men, bad luck dominated even psychosomatic narratives.

The case studies continued this trend. The first case narrative described a young man who did not fit in on the farm where he grew up. His family worried he would not amount to anything and could not help the family as a farmer. They sent him to business school with the hopes he would be able to support himself after. In college, he found joy and a new talent singing in the choir. When he tried to pursue music as his career and did not find his hoped-for success, he eventually fell ill. The second case narrative described the life of a young man whose father died when he was five. He suffered from guilt at the death of his father as well as the burden on his mother. As a child, he took an interest in science and studied to be an engineer in college but took a well-paying job as a truck driver instead to support his family.<sup>114</sup> His boredom grew and he developed cancer. The final case narrative described a woman with “an intellectually driven mother [and] a submissive and dominated father.” While her sister was the pretty one, the patient still managed to find meaning in piano and developed serious talent, moving to the city to study. Eventually her father pushed her to move back away from the “immoral city” and she came back, married, and languished.<sup>115</sup> While pathologization of gender roles still (particularly of the role reversed parents) appeared in the case narrative of the one female patient, it was still understood that women needed to have something to occupy them, that this might be outside of a family, and that controlling family members could be harmful. For men, the need to find a career and support a family was accepted in the case narratives.

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<sup>114</sup> Lawrence LeShan, “A Psychosomatic Hypothesis Concerning the Etiology of Hodgkins’ Disease” *Psychological Reports*, Vol. 3 (1957): 568.

<sup>115</sup> Lawrence LeShan, “A Psychosomatic Hypothesis Concerning the Etiology of Hodgkins’ Disease” *Psychological Reports*, Vol. 3 (1957): 569.

In 1959 Lawrence LeShan, Sidney Marvin from the Psychosomatic Laboratory of the Walter Reed Army Institute of Research, and Olga Lyster published an article in the *AMA Archives of General Psychiatry*. Their article, “Some Evidence of a Relationship Between Hodgkin’s Disease and Intelligence” argued that more intelligent people were more likely to develop Hodgkin’s Lymphoma. “It has been a recurring impression that patients with a diagnosis of Hodgkin’s disease seem to be more intelligent than average...” they said, citing LeShan’s 1957 article as well as occupational mortality records. Noting the lack of former data for this claim, they took, “408 partial or complete clinical records of Army personnel who had received the diagnosis of Hodgkin’s disease during the period from 1942 to 1945” and evaluated them “for evidence of the general intelligence level of this group.”<sup>116</sup> Many of these records included results from the Army General Classification Test and prewar occupation listings. “The mean AGCT score for 97 white enlisted men with proved cases of Hodgkin’s disease was 110, as compared with the Army population mean of 100 (standard deviation, 20).”

These studies fit with LeShan’s interest in psychosomatic medicine, but they were also shaped by his work with the Army. He later wrote that his work on cancer began after a friend told him “that he had been looking at personality tests of several people with cancer” and “felt that their emotional life history somehow played a part in the development of their illness, and that this should be investigated.” LeShan said that he “tucked the idea away in the back of my mind for future exploration. Two years later I was back in the army. Working in a very depressing job in an army mental hygiene clinic in Arkansas, I needed something interesting to

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<sup>116</sup> Lawrence LeShan, Sidney Marvin, and Olga Lyster, “Some Evidence of a Relationship Between Hodgkin’s Disease and Intelligence,” (*AMA Archives of General Psychiatry*, Vol. 1, 1959): 45/477.

fill my mind.”<sup>117</sup> Though LeShan was no longer employed by the Army (he worked at the Applied Institute of Biology), the Army still shaped the quality of his research on men. The availability of these larger data sets allowed researchers to follow the medical history of groups with previously collected psychological data to create a type of pre-made prospective study. This type of study lacked the focus on individuals and their psychological patterns that characterized studies looking at the same issues in women.<sup>118</sup>

Returning to William Greene, M.D., who authored the study on leukemia and lymphoma mentioned earlier in this chapter, can offer another clear comparison of how the same author might discuss male and female cancer patients. Greene did not sort his male patients into categories as he did with his female patients (mothering, clingy, manly, and isolated). Instead, while operating with the same ideas about object loss, he offered a single case narrative for each patient. While some of these were quite negative in their description of the patients, they were still presented as individually distinct except for the object loss common to most narratives. For example, while one “44-year-old man had a history of alcoholism,” and “behavior [which] indicated he had a very angry, immature personality, with a lifelong ambivalent dependence on his mother and wives,” there was no category of dependent or angry patients.<sup>119</sup> Greene noted

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<sup>117</sup> Lawrence LeShan, *Cancer as a Turning Point* (New York: Penguin Group, 1994): 6.

<sup>118</sup> LeShan also conducted a study with Marvin Reznikoff which attempted to use larger data sets instead of case narratives to demonstrate psychosomatic involvement in cancer. They looked to see if the interval between the birth of a cancer patient and the next youngest sibling was shorter than averaged because “The birth of a younger sibling, with the consequent perceived loss of parental energy and time, is a traumatic event. Other things being equal, the earlier this occurs, the more severe the trauma.” Lawrence LeShan and Marvin Reznikoff, “A Psychological Factor Apparently Associated with Neoplastic Disease,” *Journal of Abnormal and Social Psychology*, Vol. 60, No. 3 (1960): 439.

<sup>119</sup> William A. Greene, Lawrence E. Young, and Scott N. Swisher, “Psychological Factors and Reticuloendothelial Disease,” *Psychosomatic Medicine*, Volume 16, Issue 3 (1954): 226.

that “No common personality type of characteristic conflict situation for these patients as a group can be described from the data so far obtained.”<sup>120</sup>

The other reason for the disparity in this research was that it served other functions. Research on personality and cancer in men was funded by the tobacco industry in order to distract from the reality that tobacco causes cancer. After the 1953 publication of a study showing that tobacco tar painted on the skin of mice would cause cancer, industry representatives began working closely with public relations firms to disprove or more accurately to distract from this fact. Historians Naomi Oreskes and Erik M. Conway show that in order to create doubt in accepted science tobacco companies funded scientists whose work might draw attention to other risk factors of cancer or point to yet unanswered questions about how tobacco affected various individuals differently- especially why some smokers develop cancer and some do not. Established shortly after, the Tobacco Industry Research Committee worked largely under the direction of public relations expert and founder of Hill and Knowlton, John Hill, who said that “scientific doubts must remain.”<sup>121</sup> With prominent scientists such as Clarence Cook Little, who held a strong preference for genetically deterministic explanations of disease enlisted to distribute grant funding to independent scientists at accredited institutions, the committee would be able to fund research that would maintain the public perception that they promoted scientific rigor instead of pure obfuscation.<sup>122</sup> Similar groups were developed in Britain.

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<sup>120</sup> William A. Greene, Lawrence E. Young, and Scott N. Swisher, “Psychological Factors and Reticuloendothelial Disease,” *Psychosomatic Medicine*, Volume 16, Issue 3 (1954): 221.

<sup>121</sup> Naomi Oreskes and Erik M. Conway, *Merchants of Doubt: How a Handful of Scientists Obscured the Truth on Issues from Tobacco Smoke to Global Warming* (New York, Bloomsbury Press, 2010): 16.

<sup>122</sup> Naomi Oreskes and Erik M. Conway, *Merchants of Doubt: How a Handful of Scientists Obscured the Truth on Issues from Tobacco Smoke to Global Warming* (New York, Bloomsbury Press, 2010): 17.

Hans J. Eysenck was one of the most prominent beneficiaries of British tobacco industry money, and later of American tobacco industry money as well. Eysenck fled Germany in the 1930s, studied psychology at University College London, and later became head of the psychology department at the Institute of Psychiatry, “a training and research facility to be associated with Maudsley and Bethlem Hospitals.”<sup>123</sup> In 2002, he was still the third most cited psychologist in professional journal literature after Freud and Piaget.<sup>124</sup> His work on neuroticism, extroversion, personality scales, intelligence, and inheritance made him famous. Throughout his career he would take many contrarian, controversial, or racist positions. For example, he argued that there are innate differences in intelligence with strong racial disparities and that women were naturally suited to the home and would regret their careers. These positions and their connections to his later arguments on cancer are covered in more detail in chapter three. His iconoclastic position on psychoanalysis is discussed in chapter two. Amongst this diverse range of interests, Eysenck studied the personalities of smokers and of those with lung cancer and claimed that the data showed that the apparent connection between smoking and lung cancer could still be the result of correlation rather than causation. Eysenck instead posited the existence of a more neurotic and extroverted personality type that both encouraged cigarette smoking and was more likely to lead to lung cancer. Eysenck’s work on cancer was not aimed at pathologizing a particular personality pattern or changing it. Rather, it served simply to provide alternate explanations of lung cancer that would create public doubt in the scientifically accepted narrative.

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<sup>123</sup> Roderick D. Buchanan, *Playing with Fire: The Controversial Career of Hans J. Eysenck*. (New York: Oxford University Press, 2010), 3.

<sup>124</sup> Steven J. Haggbloom, “The 100 Most Eminent Psychologists of the 20<sup>th</sup> Century,” *Review of General Psychology*, Vol 6 No. 2 (2002): 142.

In addition to the different goals—discouraging regulation instead of promoting psychosomatic medicine—Eysenck’s work also approached his subjects differently in part because of his opposition to popular theories of the time. Eysenck was an iconoclast who argued firmly against taking Freud as gospel, insisting instead on experimental evaluations. In part because of this, the focus on early childhood experience, the subconscious, and even case narratives are absent from his articles. Eysenck’s relationship to psychoanalytic thought will be discussed more thoroughly in the next chapter.

Already a highly respected psychologist for his insistence on evidence based psychology, his work on introversion and extraversion, and his development of various personality scales, in 1960 Eysenck began publishing articles about the psychology of lung cancer patients and smokers. The first of these articles, published in 1960 with coauthors Mollie Tarrant, Myra Woolf, and L. England in the *British Medical Journal*, set out to evaluate claims that a separate factor, genotype, might characterize smokers, thus causing both smoking and lung cancer. “The main hypothesis,” they wrote, is “that both rate of smoking and proneness to lung cancer are due to some third variable underlying both... In other words, innate personality features determine our behavior with respect to smoking, at least in part, and they also determine our proneness to lung cancer.” The study was presented as if open-mindedness required it. “In spite of the fact that there is no real evidence in favour of this hypothesis, it cannot be dismissed out of hand,” they wrote. Eysenck and his coauthors “hypothesized that cigarette smokers would be (1) more extraverted, (2) less rigid, and (3) more neurotic than non-smokers.” Their study included 2,360 men who were “stratified according to age, social class, and smoking habits.” They found personality differences between pipe smokers and cigarette smokers, who were less introverted. “On the whole,” they said, “the data confirm the view that *genotypic differences exist between*

*smokers and non-smokers, and between cigarette smokers and pipe smokers.*”<sup>125</sup> While Freud may have said that “Sometimes a cigar is just a cigar”<sup>126</sup>, for Eysenck, cigars, cigarettes, and pipes all said something different about the smoker’s personality, though perhaps not about their relationship to phallic symbols.

Eysenck’s claims met with considerable mockery. The *British Medical Journal* published letters pointing to the absurdity of arguing that the relationship between lung cancer and cigarettes was merely correlation by identifying a weaker correlation and suggesting it was causal. Anthony Ryle likened Eysenck’s argument to “[a] comparison between the personalities of motor-racing drivers and tiddly-wink champions.” This, he argued, “would doubtless show different ratings, probably in part genetically determined; the death rate in car accidents of the former group would still be reduced if they stopped driving...” Ryle gave clear guidelines for what would be required to believe Eysenck: “Only if a group of non-smokers showing the extraversion and non-rigidity of the heavy smoker were shown to suffer the same incidence of lung cancer as their smoking brethren would the tobacco manufacturers have the right to set their consciences at rest.”<sup>127</sup> Correspondence from R.E.W. Fisher, published in the same issue, was yet more sarcastic. “This [research],” he wrote, “of course, goes a long way towards explaining the association between smoking and lung cancer and discrediting the unproved hypothesis that smoking causes lung cancer. We can now await with interest their demonstration that women who associate with men also tend to share certain personality characteristics (e.g., a liking for

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<sup>125</sup> H. J. Eysenck, Mollie Tarrant, Myra Woolf, and L. England, “Smoking and Personality,” *British Medical Journal*, Vol. 1 No. 5184 (1960): 1460. (Emphasis in original).

<sup>126</sup> Alan C. Elms searched to find the source this quotation but could not locate any reliable evidence that Freud actual said it. “Apocryphal Freud: Sigmund Freud’s Most Famous “Quotations” and Their Actual Sources,” *Annual of Psychoanalysis*, Volume 29 (2001): 83-104.

<sup>127</sup> Anthony Ryle, “Correspondence: Smoking and Personality,” *British Medical Journal*, Vol. 1, No. 5186 (1960): 1652.



social life). This will, of course, help to discredit the hypothesis that there is a causal connexion between association with men and maternity.”<sup>128</sup> Perhaps, they each argued, certain personality types might be more likely to make people smoke, but that did not change the fact that cigarettes rather than the personality type that encouraged their use, caused the disease.

That these responses to Eysenck were much more negative than responses to other literature on personality and cancer and even mocking helps to further understand the position of psychosomatic medicine within the medical establishment. Psychosomatic medicine could gain acceptance where it was assumed to be one factor in the development of disease without challenging the existence of other agreed upon risk factors. Moreover, when the personality traits were culturally irrelevant to standards of behavior, there was little motivation to embrace the results. Despite the responses, Eysenck continued to publish on the topic, including a number of articles and a book.

A 1962 article published with David M. Kissen, the founder and director of the Psychosomatic Research Unit at the University of Glasgow, included preliminary findings “that lung cancer patients are somewhat extraverted and markedly lower in neuroticism.” They also argued “that there may be interaction effects with psychosomatic disorders.” The “available evidence,” they claimed, “suggests that lung cancer patients have personality features distinct from (1) the general cigarette smoking population, (2) non-cancer patients with a history of commonly accepted psychosomatic disorders, and possibly (3) patients with cancer in other sites.”<sup>129</sup> His 1963 study in the *Journal of Psychosomatic Research* “found that cigarette

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<sup>128</sup> R.E.W. Fisher, “Correspondence: Smoking and Personality,” *British Medical Journal*, Vol. 1, No. 5186 (1960): 1652.

<sup>129</sup> David M. Kissen and H. J. Eysenck, “Personality in Male Lung Cancer Patients,” *Journal of Psychosomatic Research*, vol. 6 (1962): 127.

smoking was related to extraversion, pipe smoking to introversion; neuroticism was not related to smoking but the more neurotic inhaled more.”<sup>130</sup>

When Eysenck published his book *Smoking, Health, and Personality* in 1965, historian Roderick Buchanan says that, “his cautiously dissenting message provoked little response because scientific debate was largely seen as settled while the anti-smoking public health campaign had barely gotten off the ground.”<sup>131</sup> British tobacco industries “continued to fund Eysenck’s research, such as that on the positive, stimulating effects of nicotine, until the summer of 1970.”<sup>132</sup> However, slightly before that stopped, American tobacco companies began to fund Eysenck in the late 1960s with a grant of 10,000 dollars in 1969. His funding never stopped because he “took many proposals to the American tobacco industry during the 1970s and early 1980s” and “many, if not most, were accepted and supported.”<sup>133</sup> Eysenck’s work on cancer continued into the 1990s as a collaboration with Ronald Grossarth-Maticek. He also wrote substantially about psychological correlates of race and gender. His later work on cancer as well as his other politically charged work is covered in chapter three.

While Eysenck’s work was directly funded by the tobacco industry, the industry closely followed other studies of psychosomatic studies of cancer. Studies by Gotthard D. Booth, LeShan, and Perrin were all in their archives, even when they did not focus on lung cancer, because their focus on emotions over carcinogens provided the basis to argue that personality as

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<sup>130</sup> Hans J. Eysenck, “Smoking, Personality and Psychosomatic Disorders,” *Journal of Psychosomatic Research*, Vol. 7 (1963): 122.

<sup>131</sup> Roderick D. Buchanan, *Playing with Fire: The Controversial Career of Hans J. Eysenck*. (New York: Oxford University Press, 2010), 368.

<sup>132</sup> Roderick D. Buchanan, *Playing with Fire: The Controversial Career of Hans J. Eysenck*. (New York: Oxford University Press, 2010), 368.

<sup>133</sup> Roderick D. Buchanan, *Playing with Fire: The Controversial Career of Hans J. Eysenck*. (New York: Oxford University Press, 2010), 371.

opposed to cigarettes could cause cancer. Researchers who were not funded were still each evaluated as potential witnesses either in litigation or as experts to speak against regulation. Philip Morris' outside legal counsel made notes about LeShan and others. Of LeShan, they wrote: "He is a close friend of DM Kissen has been active in the Int'l Psychosomatic Cancer Institutes. He has concentrated on treatment of cancer patients rather than causation, but is probably friendly." They rated him as a "favorable" prospect to be a future witness.<sup>134</sup> Of Gotthard Booth they wrote: "He has been active in International Psychosomatic Cancer Assoc. He is not very Personable." Dr. Booth's rating as a potential witness was "neutral."<sup>135</sup> Hans Selye was also listed as "neutral" in the same evaluation. But they mentioned that he was a "Big name in stress + hormone effects. Long history of EVO studies in relation to "stress."<sup>136</sup> Selye first accepted \$1,000 in tobacco money in 1959 to author an unnamed memo (no longer available).<sup>137</sup> However, the larger grants did not come to Selye until after contact was reestablished in 1966, a process covered in the next chapter.<sup>138</sup>

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<sup>134</sup> Dr. Hardy, "Notes Regarding Profile of Different Doctors: Report from Philip Morris Outside Litigation Counsel to Philip Morris Counsel Regarding Potential Witness Development and Evaluation of Each Witness by Joint Defense Members, page 14." Undated. Philip Morris Records; Congressman Bliley Philip Morris Collection. UCSF Truth Tobacco Industry Documents. <https://www.industrydocumentslibrary.ucsf.edu/tobacco/docs/#id=jnvy0101>

<sup>135</sup> Dr. Hardy, "Notes Regarding Profile of Different Doctors: Report from Philip Morris Outside Litigation Counsel to Philip Morris Counsel Regarding Potential Witness Development and Evaluation of Each Witness by Joint Defense Members, page 2." Undated. Philip Morris Records; Congressman Bliley Philip Morris Collection. UCSF Truth Tobacco Industry Documents. <https://www.industrydocumentslibrary.ucsf.edu/tobacco/docs/#id=jnvy0101>

<sup>136</sup> Dr. Hardy, "Notes Regarding Profile of Different Doctors: Report from Philip Morris Outside Litigation Counsel to Philip Morris Counsel Regarding Potential Witness Development and Evaluation of Each Witness by Joint Defense Members, page 23." Undated. Philip Morris Records; Congressman Bliley Philip Morris Collection. UCSF Truth Tobacco Industry Documents. <https://www.industrydocumentslibrary.ucsf.edu/tobacco/docs/#id=jnvy0101>

<sup>137</sup> Mark P. Petticrew and Kelley Lee, "The 'Father of Stress' Meets 'Big Tobacco': Hans Selye and the Tobacco Industry," *Health Policy and Ethics*, 101, 3 (2011): 412.

<sup>138</sup> Mark P. Petticrew and Kelley Lee, "The 'Father of Stress' Meets 'Big Tobacco': Hans Selye and the Tobacco Industry," 412.

Despite the use of psychosomatic research to distract from the role of cigarette smoke, at least one member of the scientific advisory board for the Tobacco Industry Research Committee (TIRC) was highly skeptical of the research. An internal review of several articles, including one of LeShan's, was sent to Dr. Hockett, the Research director for the TIRC. Of the articles, advisory board member Edwin B. Wilson said that "there may be something in them and there may be nothing." Despite this apparent openness to the idea, he pointed out a variety of reasons it was likely wrong. First, he said, "Cancer comes at an advanced age... an age when one is more likely to have had a loss and perhaps less likely to adjust to it." Second, he pointed out the need to explain cancer in other species. "If cancer is a biological process, as it appears to be, because of attacking pretty much every old animal and many a plant and not a few insects, fish, etc.," he began, it would be odd, "that the mouse or rat or dog which has it (illegible) [should be] one which has lost a dear friend and is psychoneurotic about it." Finally, he noted the slow development of cancer following a slow development of pre-cancerous changes and suggested that early stage cancer might be as likely to cause changes in one's mood as the reverse.<sup>139</sup> It would clearly be a mistake to assume that tobacco funding for psychosomatic studies of disease or use of their data implied acceptance of those ideas.

### **Popularization Through Positive Thinking**

While psychoanalysts' power and legitimacy (outside of explanations for lung cancer) increased, another post-war trend buoyed ideas about health and psychology. Positive thinking, championed by the Methodist minister Norman Vincent Peale, was preached across the United

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<sup>139</sup> EB Wilson, "Letter to Doctor Hockett." March 12, 1959. Council for Tobacco Research Records. Unknown. <https://www.industrydocumentslibrary.ucsf.edu/tobacco.docs/fjgw0216>

States. Peale's 1952 bestseller *The Power of Positive Thinking* called each American to "BELIEVE IN YOURSELF! Have faith in your abilities! Without a humble but reasonable confidence in your own powers you cannot be successful or happy." Through confidence and positive thinking, people could improve their relationships, their health, their careers, and their sense of well-being. "It is appalling," Peale said, "to realize the number of pathetic people who are hampered and made miserable by the malady popularly called the inferiority complex." Peale believed that "in illness of any kind, from the common cold to cancer, emotional stress plays a part." And he further claimed that "only the person who wants to remain ill because of some subconscious will-to-fail attitude will ignore his possibilities for health."<sup>140</sup> The optimism of "positive thinking" was built upon gendered ideas of success- and its wide widespread availability. Men could find wealth and fulfilling jobs, women could find happy home lives, and everyone could reach health- if they believed.

Peale's ideas made sense against the background of white, middle-class Americans' growing prosperity. Those who were left behind must have approached the problem wrong, it seemed. If psychologically healthy, they would be able to work towards success. Moreover, Peale's ideas reinforced American beliefs that hard work and individual merit would be rewarded by explaining problems as the result of psychological maladjustment. Success in this narrative reflected not privilege or social structures, but personal enterprise and faith in oneself. The American dream was available to everyone- some groups just believed more strongly in their ability to obtain it.

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<sup>140</sup> Norman Vincent Peale, *The Power of Positive Thinking* (New York: Prentice-Hall, Inc, 1952), 1.

Peale combined post-war optimism with old ideas about faith healing, New Thought and Christian Science teachings, and popular psychoanalysis. Freud's influence was clear in the way Peale invoked inferiority complexes and the unconscious. Even sin, Peale later explained, was "a splinter in the unconscious mind" that could damage one's health.<sup>141</sup> In the 1930s, Peale had worked with a psychoanalyst to create a clinic in his New York church.<sup>142</sup> While Psychoanalysis had, in its early days, seemed a threat to American morality, for Peale it was just a part of how God had made the world. For Peale, all the ways one could improve their situation through positive thinking reflected the power of God. And spiritual wellness (positivity), health, psychoanalysis, and success came together. He set aside his fear that these claims made God a servant of individual desires:

There was a time when I acquiesced in the silly idea that there is no relationship between faith and prosperity; that when one talked about religion he should never relate it to achievement, that it dealt only with ethics and morals or social values. But now I realize that such a view point limits the power of God and the development of the individual.<sup>143</sup>

Carefully maintaining the importance of God over the role of the individual, Peale reminded his readers they could always heal themselves "...if it is the plan of God for the patient to live."<sup>144</sup>

While some saw this as "not faith in God, but 'faith in faith', which means in your capacities,"<sup>145</sup>

Billy Graham, a Baptist minister and evangelist whose sermons were aired on radio and television, and who served as advisor to many American presidents on matters of faith, said in

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<sup>141</sup> Anne Harrington, *The Cure Within: A History of Mind-Body Medicine*, (New York: WW. Norton & Company, 2008), 120.

<sup>142</sup> Anne Harrington, *The Cure Within: A History of Mind-Body Medicine*, (New York: WW. Norton & Company, 2008), 119.

<sup>143</sup> Norman Vincent Peale, *The Power of Positive Thinking* (New York: Fireside, 1952), 173.

<sup>144</sup> Norman Vincent Peale, *The Power of Positive Thinking* (New York: Fireside, 1952), 146.

<sup>145</sup> Anne Harrington, *The Cure Within: A History of Mind-Body Medicine*, (New York: WW. Norton & Company, 2008), 121.

1966 that he didn't "know anyone who has done more for the kingdom of God than Norman and Ruth Peale."<sup>146</sup> Peale had made psychosomatic medicine, or at least a version of it, an ordinary part of American faith.

Without the focus on religion, Dr. Arnold A. Hutschnecker, a psychiatrist from Austria who studied in Germany and fled Berlin in 1936 to come to the U.S., captured the same moment to further popularize the medical effects of positive thinking. Positive thinking could bring you health, long life, and beauty. Published in 1951, Hutschnecker's book, *The Will to Live*, was so widely read that President Nixon later sought him out to treat his back pain and *Vogue* published his articles.<sup>147</sup> Hutschnecker claimed that with a positive and healthy attitude one could avoid and overcome all disease: "we ourselves choose the time of illness, the kind of illness, the course of illness, and its gravity... We can and do change our minds. We can and do reverse our course, and turn back from illness to health."<sup>148</sup> These sweeping claims included cancer.

Hutschnecker believed that in addition to externally imposed conditions like hunger, cold, or exhaustion, "We must also deal with our ambitions and our fears, with jealousy, with grief, with feelings of inferiority, with defeats as well as victories, and with the inevitable acceptance of aging." For him, "Health depends on how well the individual as a whole can maintain balance through all these changes."<sup>149</sup> People who managed their emotions well could handle threats outside of their control, even cancer. "Cancer," he explained, "is considered a most deadly disease. Yet when live cancer tissue was implanted in human volunteers their

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<sup>146</sup> Anne Harrington, *The Cure Within: A History of Mind-Body Medicine*, (New York: WW. Norton & Company, 2008), 122.

<sup>147</sup> Erica Goode, "Arnold Hutschnecker, 102, Therapist to Nixon," *New York Times*, January 3, 2001.

<sup>148</sup> Arnold A. Hutschnecker, *The Will to Live*, (New York: Thomas Y. Crowell Company, 1951), 108.

<sup>149</sup> Arnold A. Hutschnecker, *The Will to Live*, 17.

healthy bodies responded with a ‘most vigorous inflammatory reaction.’ The invader was intensely fought off. The transplants were ‘promptly rejected and disappeared.’”<sup>150</sup> Hutschnecker believed that positive thinking could help maintain such strong immune function that even cancer could not hurt someone. Hutschnecker and Peale portrayed disease as the result of individual failure to think positively and to recognize one’s power to control a situation, not a result of bad luck.

Taken together, psychoanalytic theories of cancer and positive thinking reinforced cultural beliefs about how women should behave. They should be positive, trusting in their ability to find husbands, mother children, and find joy in sexuality within marriage. They should take responsibility for any inability to find the American dream or to be happy within it. Failure to do so could mean death.

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<sup>150</sup> Arnold A. Hutschnecker, *The Will to Live*, 18.



## **CHAPTER TWO:**

### **Changing Paradigms in Psychology: 1960-1980**

Psychosomatic studies of cancer in the 50s and 60s had largely relied on psychoanalytic theory as a framework for their work, and psychoanalytically informed tests as their research methods. During the 60s and 70s, psychoanalysis fell from favor as it faced both social and scientific challenges. The declining fortunes of Freud threatened to undermine psychosomatic explanations of cancer. Older research seemed increasingly outdated, both in method and content. This chapter addresses the changes which allowed mind-body cancer treatments and theories to stay relevant. I argue there are two primary explanations. First, the declining fortunes of Freud undermined older literature while opening the way for new, eclectic approaches. The decline in psychoanalytic dogma meant that descriptions of cancer patients could be rewritten to remain culturally relevant in a time of rapid social change. Second, stress, biofeedback, and psychoneuroimmunology research helped to provide new physiological evidence of a connection between mind and various bodily functions. This evidence was in turn stretched into generalizations about the ability of the mind to fight various diseases including cancer. Stress and personality research even led directly into the addition of a “Type C” or cancer-prone personality pattern to go alongside the more commonly recognized Type A and B personalities. Through all of these changes, old language about emotional repression and hopelessness survived the gradual dismantling of the credibility of Freudian psychoanalysis and its embedded assumptions about gender and disease.

## The Fall of Freud

In order to understand changing ideas about psychosomatic medicine and cancer, it is necessary to understand what happened to the psychoanalytic approach to psychosomatic research described in chapter one. During the 1960s and 70s, psychoanalysts faced challenges from all corners. Internal developments in mental health included the advent of psychopharmaceuticals. This turned psychiatry's focus from the unconscious to chemical brain changes as they searched for the causes of mental illness. Meanwhile, early research on the efficacy of various forms of mental health care failed to find an advantage for psychoanalysis. And, in the midst of this, the most famous philosopher of science positioned psychoanalysis and its research methods as pseudo-scientific. Even the claim of psychoanalysis to be the guardian of knowledge about sex was challenged by developments from researchers like Kinsey, Masters and Johnson. This destabilization of psychoanalysts' claims to understand sex was accelerated by changing social mores. As sexual and gendered behavior was challenged, Freud seemed outdated. Feminist critics from within psychoanalytic circles pushed back on concepts like "penis envy." Furthermore, the anti-psychiatry movement saw mental health care as coercive, pushing patients to fit societal norms. Moreover, drugs seemed far more cost effective than long-term therapy and perhaps kinder than extended hospitalization.

Philosopher of science Karl Popper's 1963 essay "Science as Falsification" attempted "*to distinguish between science and pseudo-science*; knowing very well that science often errs, and that pseudoscience may happen to stumble on the truth."<sup>151</sup> Popper, an admirer of psychoanalysis, nonetheless positioned the work of Marx, Freud, and Adler as key examples of

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<sup>151</sup> Italics in original. Karl Popper, "Science: Conjectures and Refutations," in *Conjectures and Refutations: The Growth of Scientific Knowledge* (London: Routledge and Kegan Paul, 1963), 33.

pseudoscience. Popper noticed that he "could not think of any human behavior which could not be interpreted in terms of either theory. It was precisely this fact -- that they always fitted, that they were always confirmed -- which in the eyes of their admirers constituted the strongest argument in favor of these theories. It began to dawn on me that this apparent strength was in fact their weakness."<sup>152</sup> If any fact could be reinterpreted to fit within the framework of psychoanalysis, it could not be falsified or proven wrong. While he acknowledged psychoanalysis might be correct on some points and could provide valuable insights, it could not generate bold hypotheses that could then be tested and potentially proven wrong. Eysenck too, argued that psychoanalysis was pseudoscience. He quoted Freud's dismissal of the need for experimental validation of his work, "because the wealth of reliable observations on which these assertions rest makes them independent of experimental verification."<sup>153</sup> Popper's and Eysenck's appraisal of psychoanalysis' scientific value fit within a broad series of challenges that the field faced.

Questions about whether or not psychoanalysis was a science were made more relevant by the availability of less expensive and time demanding care, particularly medication. The availability of new psychoactive drugs made extended treatment, whether it was psychoanalysis or hospitalization seem unnecessary. New medications developed in the 1950s and available by 1960 included: Librium (a benzodiazapine), Haldol (haloperidol), and phenothiazine antipsychotics like Thorazine. Especially in the face of the exposés of asylum conditions and concerns about the expense and accessibility of psychoanalysis, the idea that medication could provide an alternative to other forms of care, and allow patients to rapidly return to their normal

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<sup>152</sup> Karl Popper, "Science: Conjectures and Refutations," 35.

<sup>153</sup> Cited in Hans J. Eysenck and Glenn D. Wilson, eds., *Experimental Study of Freudian Theories*. (London: Routledge, 2013), xi.

lives was appealing. Though a few psychoanalysts tried to weave the impact of drugs into the theoretical outline of psychoanalysis, the trend towards medication led away from psychoanalysis. In July 1961, *The Atlantic* included a “Special Supplement on Psychiatry in American Life” which showcased the wide-ranging impact of psychoanalysis at its zenith in American culture: in medicine, religion, schools, and other areas. One of the submissions covered the impact of these new drugs. “The tranquilizers,” the author, a psychoanalyst from Montefiore Hospital in New York, claimed, “reduce the ego’s libido content.” The place of the libido and ego again, characterized the drugs he called “psychic energizers” which “not only relieve melancholia but, in general, reverse the changes that are brought about by tranquilizing medication.”<sup>154</sup> Despite attempts to connect psychoanalysis and medication through diagnosis, theory, and treatment, the development of psycho-pharmaceuticals created spaces for schools of psychiatry that prioritized biological understandings of mental disorders.

Some, including psychoanalysts, began to believe that, given the increasing therapeutic options, experimental verification for the superiority of psychoanalysis was needed. A series of studies showed equivalent results for different types of therapy. Rather than conclude that all therapies were equally ineffective, they decided that each worked in its own way. Nathan Hale compared this conclusion to “the Dodo bird’s verdict in *Alice in Wonderland*: ‘everybody has won and all must have prizes.’”<sup>155</sup> Many of these studies—at least those that provided data showing comparable results from different schools of psychoanalysis or lengths of treatment—came from psychoanalysts. Clarence Oberndorf was one those who looked at his own profession seeking proof. In 1942, he argued that “numerous and violent controversies in psychoanalytic

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<sup>154</sup> Mortimer Ostow, “The New Drugs,” *Atlantic*, July 1961: 94.

<sup>155</sup> Nathan J. Hale Jr., *The Rise and Crisis of Psychoanalysis in the United States: Freud and the Americans, 1917-1985* (New York: Oxford University Press, 1995), 314.

groups... and the frequent attempts to introduce new systems” came from “‘discomfiture and incertitude’ about ‘theory, methodology and results’”<sup>156</sup> Oberndorf claimed 60% recovery rates regardless of the treatment method or “rigorous psychoanalytic training.”<sup>157</sup> He also claimed good results from shorter treatments, sparing the patient the necessity of multi-year analyses which had become common. In 1946, Peter Denker, “a neuropsychiatrist from Bellevue Hospital in New York... argued that in 500 cases of neuroses treated by general practitioners with ‘sedatives, tonics, suggestion and reassurance, 72 percent recovered within two years.’”<sup>158</sup> A “disillusioned former Freudian therapist,” Joseph Wolpe from South Africa claimed 90% improvement with behavior therapy in the 1950s, though later data would not support these claims.<sup>159</sup> In 1952, Hans J. Eysenck claimed that “insight therapies...were no more effective than no treatment at all.”<sup>160</sup> A 1980 meta-analysis of the literature drew a conclusion which reflects these results well: “Researchers who claim superior efficacy of their approach to others without having actually demonstrated it in controlled comparative studies are guilty of chicanery or ignorance.”<sup>161</sup> The combination of shifts in patient groups, availability of cheaper and less time intensive, but equally effective treatment options, and options for medication for many of the sickest patients made psychoanalysis seem unnecessary.

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<sup>156</sup> C.P. Oberndorf, “Results with Psychoanalytic Therapy,” AP 99 (Nov. 1942): 381, Quoted in Nathan J. Hale Jr., *The Rise and Crisis of Psychoanalysis the United States*, 305.

<sup>157</sup> Nathan J. Hale Jr., *The Rise and Crisis of Psychoanalysis the United States*, 305.

<sup>158</sup> Peter G. Denker, “Results of treatment of Psychoneuroses by the General Practitioner,” presented to the Section of Neurology and Psychiatry of the Academy of Medicine and the New York Neurological Society, April 9, 1946, NYSJM 46:2 (1946): 2164-66, quoted in Nathan J. Hale Jr., *The Rise and Crisis of Psychoanalysis the United States*, 306.

<sup>159</sup> Nathan J. Hale Jr., *The Rise and Crisis of Psychoanalysis the United States*, 311.

<sup>160</sup> Nathan J. Hale Jr., *The Rise and Crisis of Psychoanalysis the United States*, 309.

<sup>161</sup> Smith, Glass, and Miller, *Benefits of Psychotherapy*, 183-84, Quoted in Nathan J. Hale Jr., *The Rise and Crisis of Psychoanalysis the United States*, 318.

If psychoanalytic therapy was more expensive, more time consuming, and no more effective than alternatives, psychoanalysts may have thought they could at least claim superiority when it came to understanding issues of sex. That too was challenged. In *Cold War Freud*, Dagmar Herzog argues that changing approaches to sex both in popular culture and science helped to dethrone psychoanalysis. New approaches to sex were especially problematic for Freudians because “sex was both the topic analysts thought they were experts on *and* they were deeply anxious about being associated too strongly with it.”<sup>162</sup> The work of Kinsey and Masters and Johnson made it clear that psychoanalysis was not the only way to study sex and suggested that Freudian approaches might even be wrong. Kinsey’s work showed that many of the behaviors and desires which psychoanalysts saw as pathological were quite common. For example, he noted in his 1948 report on sexual behavior in American men that 37 percent of men had participated in at least one homosexual encounter.<sup>163</sup> While psychoanalysts could easily counter that just because a behavior was common it was not necessarily right or healthy, Kinsey’s study made it more difficult to suggest that only men with deep psychological problems had sex with other men. This was in marked contrast to the homophobia of American psychoanalysis. Though homophobia was nearly universal in the profession, explanations for homosexual behavior were not. Herzog argues that Freudians could see it “as a way of attempting to avoid castration by the father—or as a way to unite with the father. It signaled over identification with a seductive or domineering mother—or it was a sign of profound fear of the female genitals. It functioned as a hapless way to repair one’s sense of inadequacy as a male—or

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<sup>162</sup> Dagmar Herzog, *Cold War Freud: Psychoanalysis in an Age of Catastrophes* (Cambridge: Cambridge University Press, 2017), 64.

<sup>163</sup> Alfred Kinsey, Wardell B. Pomeroy, and Clyde E. Martin, *Sexual Behavior in the Human Male* (Bloomington: Indiana University Press, 1975), 623.

it was a powerful sexual compulsion that required better control.”<sup>164</sup> In response to Kinsey, psychoanalysts could at least resort to accusations that he “treated humans ‘zoologically’” and “was an ignoramus about *love*.”<sup>165</sup> With the entrenchment of homophobia in psychoanalysis, it wasn’t until 1991 that the American Psychoanalytical association adopted a nondiscrimination policy for homosexuality, and it would take another eleven years for the International Psychoanalytical Association to adopt one.<sup>166</sup> Those in other schools had more freedom to determine their own approaches. The work of Masters and Johnson was even more damning. In 1966, they reported finding no physiological difference between clitoral or vaginal orgasms. All female orgasms, they claimed, were caused by clitoral stimulation.<sup>167</sup> Freud’s categories of sexual maturity, culminating for women in the ability to experience vaginal orgasms, seemed irrelevant. Put simply, Freud was proven wrong about sex.

Beyond the scientific challenges, Herzog argues that loosening sexual mores made sexual repression seem less relevant to explanations of neuroses and anxiety. If taboos about discussing and experiencing sexuality lifted and yet people continued to face mental health problems, something psychoanalysis may have been wrong.<sup>168</sup> The cache which psychoanalysis gained from providing a space to discuss sex and fantasy when that was not acceptable elsewhere declined. Cultural changes thus made psychoanalysis both less relevant and less necessary. Perhaps recognizing this, psychoanalyst Christopher Lasch wrote in his 1979 book, *The Culture of Narcissism*, about what he considered to be the unhealthy consequences of the social changes

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<sup>164</sup> Dagmar Herzog, *Cold War Freud*, 63.

<sup>165</sup> Dagmar Herzog, *Cold War Freud*, 65.

<sup>166</sup> Dagmar Herzog, *Cold War Freud*, 76.

<sup>167</sup> William H. Masters and Virginia E. Johnson, *Human Sexual Response*, (Boston: Little, Brown and Company, 1966), 66.

<sup>168</sup> Dagmar Herzog, *Cold War Freud*, 70-71.

he witnessed, including both feminism and the sexual revolution. He claimed that though their frustrations with restrictive roles might be understandable, “feminists forfeited the privileges of sex and middle-class origin when they campaigned for women’s rights” and in his summary of the “benefits of ‘liberation,’” the only accomplishment was that “men no longer treat women as ladies.”<sup>169</sup> He referred to the “pseudoliberated woman of Cosmopolitan” as “calculating” in her use of sex.<sup>170</sup>

While not aimed specifically at psychoanalysts, the 1960s and 70s anti-psychiatry movement undermined the basic idea that people needed to be returned to some kind of normalcy or “adjustment.” The work of Thomas Szasz, R.D. Laing, former patients, and others popularized a vision of psychiatry as repressive. Szasz argued against the biological basis of any mental illness. He saw therapy as oppressive, considering it “cognitively more accurate, and morally more dignified, to regard [the unconscious] as a lie rather than a mistake.”<sup>171</sup> Psychiatry, and the methods and concepts which were part of it, were seen as techniques of social control. Szasz and others even used imagery and metaphors to compare psychiatry to the Holocaust and the Vietnam War. One 1978 cartoon from *Madness News Network* depicted pills as bombs falling on bodies below as flames shot up around them.<sup>172</sup> This view of psychiatry and therapy was easier for many to accept because of the awareness of the murder of psychiatric patients in the holocaust and, closer to home, a growing number of news stories about overcrowded

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<sup>169</sup> Christopher Lasch, *The Culture of Narcissism: American Life in an Age of Diminishing Expectations* (New York: W.W. Norton & Company, 1979), 191.

<sup>170</sup> Christopher Lasch, *The Culture of Narcissism: American Life in an Age of Diminishing Expectations*, 194.

<sup>171</sup> Richard Vatz and Lee Weinberg, eds., *Thomas Szasz: Primary Values and Major Contentions* (Buffalo: Prometheus Books, 1961), 78. Cited in Jonathan Engel, *American Therapy*, 185-186.

<sup>172</sup> Heather Murray, “‘My Place Was Set At The Terrible Feast’: The Meanings of the ‘Anti-Psychiatry’ Movement and Responses in the United States, 1970s-1990s,” *The Journal of American Culture*, 37 no. 1 (2014): 37-51.



American asylums, lobotomies, and electro-shock therapy. The 1962 book by Ken Kesey and 1975 movie *One Flew Over the Cuckoo's Nest* further popularized these views as Nurse Ratchet's tyrannical rule over patients who while perhaps odd were not ill came to characterize psychiatry for many. The anti-psychiatry claim that psychiatry functioned as a form of social control overlapped in part with feminist critiques of mental health care for mistreating women and enforcing their position in society. Phyllis Chesler, for example, argued in 1972 that women were over-diagnosed and that many of their "problems" were simply failures to conform to gender norms. Chesler, however, put herself in opposition to the extremes of anti-psychiatry. She maintained that it was never her goal to romanticize mental illness because madness and its treatments were painful. Moreover, she said, "[m]ost weeping, depressed women, most anxious and terrified women are neither about to seize the means of production and reproduction, nor are they any more creatively involved with problems of cosmic powerlessness, evil and love than is the rest of the human race."<sup>173</sup>

The fall of Freud had two-pronged consequences for psychosomatic cancer care. The first of these consequences was that psychoanalysis was no longer the dominant mode of, and theoretical model for, therapy. The absence of a clear theoretical framework gave clinical psychologists and other therapists greater leeway to adopt less misogynistic or homophobic approaches. In addition, theoretical flexibility gave them freedom to put focus somewhere other than early childhood trauma and sexual development. These changes meant that therapists *could* occasionally take patients' concerns at face value, draw different conclusions from their interactions, and create case narratives and anecdotal evidence that reflected other aspects of their patients' lives. The second consequence was that projective testing came to be seen as more

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<sup>173</sup> Phyllis Chesler, *Women and Madness*, (Garden City: Doubleday & Company, 1972), xxiii.

outdated. This threatened to undermine past studies of cancer as they had often been conducted using projective methods such as the Rorschach Blot Test and the Thematic Apperception Test (TAT) which were based on psychoanalytic theory.

### **New Approaches to Therapy and Cancer Patients**

Both psychologists and psychiatrists began to diversify their approaches to include somatic, behavioral, and eclectic styles. Nathan Hale has shown that a consistent and marked decline of psychoanalysis began in the early 1960s.<sup>174</sup> Among UCLA psychiatric residents, the percentage who chose to train in psychoanalytic institutes dropped from 50 to 17 percent between 1966 and 1975. Leadership as department chairs in psychiatry changed more gradually. In 1990, three of ten chairmen at ten top medical schools still had membership in psychoanalytic organizations. This stretched into clinical psychology as well. Hale notes that “where 41 percent saw themselves as ‘psychodynamic’ in 1961, by 1976 this had dropped to 19 percent with over half describing themselves as ‘eclectic.’ By 1982, some 91 percent thought that the future lay with eclecticism.”<sup>175</sup> By the mid 1990s even those who remained in psychoanalysis had to adapt their theories substantially, or risk becoming a punchline. In 1994, Ruth Mattazaro, Ph.D. reviewed a book for the *NEJM* and argued that the its “inclusion [of psychoanalytic theory] could be compared to presenting, without critique, the Ptolemaic view of the universe in a physics books [sic].”<sup>176</sup>

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<sup>174</sup> Nathan J. Hale Jr., *The Rise and Crisis of Psychoanalysis the United States*, 302.

<sup>175</sup> Nathan J. Hale Jr., *The Rise and Crisis of Psychoanalysis the United States*, 302.

<sup>176</sup> Matarazzo, Ruth G. “Book Review,” *New England Journal of Medicine* 330, no. 7 (1994): 515. doi:10.1056/NEJM199402173300723.

Eclectics thought that the best approach to therapy was to draw from a wide variety of approaches and theoretical standpoints to achieve the best outcome for patients. In his book *American Therapy: The Rise of Psychotherapy in the United States*, Jonathon Engel briefly discusses this rise of eclecticism, explaining that shifting expectations of therapy had created a demand for a wider variety of treatment types. “Mental health practitioners,” Engel says, “were being called upon not simply to treat illness, but to ‘remove distress,’ in the words of Gerald Klerman of the National Institute of Mental Health. Psychiatrists and psychologists not only healed but eased ‘emotional discomfort’ and helped patients to ‘cope with life’s vicissitudes and social change.’”<sup>177</sup> Slightly vague descriptions of a therapist’s orientation like “eclecticism” or “person-centered” allowed for incorporation of different techniques from cognitive behavioral approaches to primal scream therapy as they seemed relevant to a particular patient. One psychiatrist from Illinois said, “The buzzword in our profession these days is ‘pragmatic eclecticism.’”<sup>178</sup> This diversification of therapies and theories gave room for a wider variety of ways of approaching and describing cancer patients. No longer theoretically bound to write about sexuality, early childhood development, or relationships to parents, psychologists could explore their own perception of patients and even take patients’ perceptions more seriously. Moreover, without the fixed expectations of Freudian orthodoxy, therapists were incentivized to reinforce and validate their patients’ world views. The decline of psychoanalysis could have created chaos for psychosomatic medicine by undermining its theoretical basis, but instead it allowed

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<sup>177</sup>Jonathan Engel, *American Therapy: The Rise of Psychotherapy in the United States*, (New York: Gotham Books, 2008), 184.

<sup>178</sup>David Gelman and Mary Hager, “Psychotherapy in the ‘80s,” *Newsweek*, 11/30/81, 70, quoted in Engel, *American Therapy*, Page 231.

proponents of mind-body medicine to be more responsive to new cultural conditions which are explored more fully in chapter three.

In addition to allowing therapists to reassess their more constricted ideas of healthy behavior, the decline in psychoanalytic dogma allowed therapists to more directly listen to patient concerns, without (as aggressively) reinterpreting their statements. Looking at Freud's famous case narratives of patients like Dora and Anna O. can show how the immediate concerns of patients were often rejected. Freud's *Dora* provides his analysis and narrative of psychoanalytical sessions with an eighteen-year-old girl. In the extended case history, he walks the reader through his process of decoding Dora's life from when her father first contacted him until he decided that Dora's symptoms were caused by her struggle to deal with her love for her father, her father's friend, and his wife, her governess, and finally Freud himself. As he interpreted her dreams, Freud found symbols of her sexuality, masturbation, and bed-wetting in each object and action. Dora herself expressed concern about inappropriate sexual contact from her father's friend.<sup>179</sup> He reinterpreted each of her responses including direct disagreement and silence as evidence of her denial and refusal to acknowledge what she knew on a subconscious level. His responses to professional challenges to his focus on sexuality were similar. Freud suggested other doctors were just unwilling to admit that they were personally jealous of the fact

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<sup>179</sup> After arranging for his wife and clerks to be elsewhere, "He then came back, and, instead of going out by the open door, suddenly clasped the girl to him and pressed a kiss upon her lips. This was surely just the situation to call up a distinct feeling of sexual excitement of a girl of fourteen who had never before been approached. But Dora had at that moment a violent feeling of disgust, tore herself free from the man, and hurried past him to the staircase and from there to the street door... the behavior of this child of fourteen was already entirely and completely hysterical. I should without question consider a person hysterical in whom an occasion for sexual excitement elicited feelings that were preponderantly or exclusively unpleasurable." Sigmund Freud, *Dora: An Analysis of a Case of Hysteria*, (New York: Macmillan Publishing Company, 1993), 21.

that he was able to discuss sexuality with his patients. When even direct disagreement and refusal to participate provided evidence of Freud's theories, one can understand Popper's point: no hypothesis of psychoanalysis could be falsified. More importantly, Dora's and other patients' worries could not be fully addressed.

Lawrence LeShan's work provides a clear example of what these transitions away from Freud looked like in therapy for cancer patients. By the time he wrote his 1977 book, *You Can Fight For Your Life*, LeShan had abandoned Freudian orthodoxy like so many others. He criticized earlier attempts to uncover the unconscious as leading to the "'Oho phenomenon': whenever the patient says something, the therapist responds with an inward, 'Oho, I know what that means.'" Quoting another psychiatrist, he noted that in Freudian psychoanalysis "[t]he individual's conscious report is rejected as untrustworthy and the contemporary thrust of his motives is disregarded in favor of a backward-tracing to earlier formative stages."<sup>180</sup> This type of objection to Freudian psychoanalysis encouraged listening to patients and the inclusion of rational aspects of life including careers and goals. LeShan claimed that through his practice he realized the limitations of Freudianism to capture the experiences of each of his patient's individual experiences. LeShan's theoretical influences and sources for methodological influences broadened to theater, novels, films, and philosophy. He abandoned the attempt to work within a single theory- and even stopped trying to fit patient meetings within a standard schedule. LeShan's shift fit within a broader trend towards eclecticism and away from theoretical constraints.

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<sup>180</sup> Lawrence LeShan, *You Can Fight For Your Life: Emotional Factors in the Causation of Cancer* (New York: M. Evans and Company Inc., 1977), 105.

As he moved away from psychoanalytic theory and language, LeShan developed his own system called crisis therapy specifically for cancer patients. This approach reflected broader trends towards eclecticism and toward accepting patient narratives. He framed crisis therapy in direct opposition to Freudianism which he believed had specific limitations for cancer patients, though acknowledging that he was potentially caricaturing Freud. Cancer patients, he said, “believe their lives to be fully determined.” Because he believed cancer patients experienced despair, an inability to feel that they could direct their lives and be themselves, he argued that any understanding of life which did not emphasize self-determination was particularly harmful. LeShan believed that both psychoanalysis and behaviorism reinforced the idea that life simply unfolded as a series of cause and effect actions upon the individual. He argued this only reinforced the fears of cancer patients that they were helpless to change their lives. Moreover, LeShan argued that the way in which psychoanalysis prevented patients from interpreting their own challenges and problems was particularly harmful for people who needed to learn to respect themselves, their talents, and wishes. Crisis therapy required helping people recognize when they had rejected part of their own desires and allowing them to recognize the validity of their own beliefs and desires, while working past the idea that if they embraced all of it people would reject them for it. This meant that LeShan had to support his patients’ goals when they were clear and help them find their own goals when they were not. In helping his patients identify what made life worth living for them personally becoming “well adjusted” simply was not a sufficient motivation. Rather he thought they had their own individual ways of finding what described as their “zest,” “*Lebensgefühl*,” and “feistiness.” He described his work as “akin to that of the gardener who wants his iris to become the best possible iris and the peony the best possible peony.” Each person had the individuality of a different type of bloom and “For each individual

in crisis psychotherapy, the goal is different.”<sup>181</sup> Recognizing this would require listening to his patients. Quoting Samuel Beckett, he asked: “Where would I go, if I could go, who would I be, if I could be, what would I say if I had a voice, who says this, saying it’s me?”<sup>182</sup> Learning these things in a partnership with his patients, he tried to help them develop realistic goals. None of this is to say that all therapists who used other practical or theoretical approaches accepted their patients’ interpretations of their concerns, or disavowed sexism and homophobia. They simply had more freedom to do so.

### **The Fall of Projective Testing**

In addition to changing therapeutic approaches, challenges to psychoanalysis discredited earlier psychosomatic cancer research relying on psychoanalytically informed projective testing. Emphasis on testing for what lay within the unconscious waned. Projective testing, most importantly the Rorschach, was challenged for a variety of reasons. First, increasing interest in psychology made it more difficult for test administrators to gain “unguarded” access to the unconscious. Second, varied scoring methods, test administration standards, and interpretative frameworks limited replicability and made tests seem unscientific. Third, there was concern that although the tests might help build a clinical picture, taken alone they over-pathologized test takers. Most importantly, as explained above, people were simply less interested in the contents of the unconscious. As with changes in clinical practice, changes in psychological testing were gradual and never complete. Many of the fiercest responses to projective testing came as it was being used in unquestioned ways in cancer research.

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<sup>181</sup>Lawrence LeShan, *You Can Fight For Your Life*, 108.

<sup>182</sup>Lawrence LeShan, *You Can Fight For Your Life*, 122.

Projective testing had allegedly helped psychoanalysts to investigate the unconscious. What might be slowly explored on an individual basis through dream analysis and extended conversations with an analyst was systematized in projective tests. Researchers believed they needed to access the unconscious (quantitatively if possible) and minimize personal bias. They were explicit about the potential influence of personal preferences and study design on the outcome of the study. Studies often addressed, if only in passing, the impact of hospital settings, interviewer bias, retrospective design, and selection bias. They attempted to counteract some of their own biases and those of their patients by shaping experimental conditions they believed could access the unconscious quantitatively and more directly. Their use of Rorschach blot tests, figure drawing, and storytelling, although later criticized as overly dependent on the interpretation of the psychiatrist, was intended to standardize the material to which test takers responded and to systematize classification of responses. By limiting patients' understanding of their methods, researchers believed they prevented patients from giving seemingly desirable but false responses. Requiring participants to answer questions without clear answers provided psychiatrists not with flawed data but rather with the direct overflow of the unconscious. Researchers specifically defended their methods on these grounds. One 1964 paper about the "cancer problem" argued that the Rorschach was the ideal tool for cancer research because:

It is obvious that the emotional complexity of personality research in the field of organic medicine demands specific precautions in order to secure objective and verifiable psychological data. Such material is provided by the... inkblot pictures of the Rorschach: the objective stimulus is clearly defined, the type of response depends on the subject, its content is expressed in visual form. Rorschach records are also much less subject to voluntary or involuntary distortion which enters in many ways all communications relying primarily on verbalization...This procedure separates the psychological research material from the interpretation, the subjective theories and the idiosyncratic use of language by the psychiatrist.<sup>183</sup>

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<sup>183</sup> Gotthard Booth, "Irrational Complications of the Cancer Problem," *American Journal of*



The supposedly objective responses to these tests could then be placed into categories and quantified. Patterns of responses were then placed within medical narratives linked back to the type of questions researchers chose to include within their interviews, which were almost exclusively aimed at uncovering issues related to sexuality.

The widespread adoption of projective testing led to its own problems. Increased cultural familiarity with Freud and particularly with the Rorschach undermined the goals of testing. Lawrence LeShan began his career by using the Rorschach and the Thematic Apperception Test,<sup>184</sup> but chose not to use either in the late 50s because "he realized both these approaches were too obviously psychological in nature. The patients were anxious lest the tests reveal personality flaws. They reacted in a defensive manner, constricting the answers and invalidating the results."<sup>185</sup> In 1957 LeShan switched to using the Worthington Personality History, a test "[d]esigned to allow the patients to tell their own life stories in their own words..."<sup>186</sup> At this point it seems LeShan was not concerned that his tests disregarded his patient's stories, but that patients were aware of the nature of the tests. The very acceptance of Freud and Rorschach in popular culture made it difficult for psychoanalysts to gain unguarded access to the unconscious.

It is easy to understand why LeShan would see the Rorschach as too transparent and its audiences as too aware of the test's function. In *Dark Mirror*, a 1946 noir, Olivia de Havilland played twins, one a murderer. The psychiatrist in the film used Rorschach responses to determine whether Ruth or Terry was the "evil twin." While Ruth sees maypole dancers, figure skaters, old

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*Psychoanalysis* 25 no. 1 (1965): 43.

<sup>184</sup> These are described as the two quintessentially psychoanalytical tests. Robert J. Gregory, *Psychological testing: History Principals, and Applications* (Boston: Allyn and Bacon, 1992), 437.

<sup>185</sup> Gregory McQuerter, "Cancer: Clues in the Mind," *Science News* 113, no. 3 (1978): 44.

<sup>186</sup> Gregory McQuerter, "Cancer: Clues in the Mind," *Science News* 113, no. 3 (1978): 44.

women on public transport, and a drum majorette, the murderous Terry first sees a mask with “black slanting holes for eyes, heavy eyebrows and pursed lips [which] give it a fixed expression.” Turning the image, she sees “the face of a white lamb with a black nose. It’s got a mark on its forehead. It looks like a moth spreading its wings over a butterfly. Beneath its front paws are two men face down with their arms outstretched. It all seems symbolic of something. The lamb looks so innocent but it has two men under its paws.” When asked what it seems symbolic of, she answers: “The lamb of death?”<sup>187</sup> Beyond the test’s use in detecting obvious psychopathological responses, the public quickly became aware of its connection to perhaps risqué undercurrents in their thought processes. In 1957, the year LeShan switched testing methods, Lowell Toy Manufacturing even released PERSON-ALYSIS: “a revealing psychological game for adults based on the latest psycho-scientific testing techniques.”<sup>188</sup> Advertisements in the *New Yorker* promised that the inkblot game would give “participants hilarious, exciting, intimate and revealing ‘peeks’ into the private lives of friends and family... even themselves.”<sup>189</sup>

In addition to the challenges of testing a more psychologically self-aware population, failure to create or adhere to a universal scoring system undermined claims of scientific objectivity for the test. Damion Searls, in his book *The Inkblots: Hermann Rorschach, His Iconic Test, and the Power of Seeing*, has laid out fundamental challenges faced by the Rorschach. He points to, among other factors, conflicting attempts to focus on different components of the test: its relationship to psychoanalytic theory and its scientific potential as a standardized test.

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<sup>187</sup> *The Dark Mirror*, directed by Robert Siodmak, (1946; International Pictures).

<sup>188</sup> PERSON-ALYSIS Instruction booklet quoted in Damion Searls, *The Inkblots: Hermann Rorschach, His Iconic Test, and the Power of Seeing*, (New York: Crown Publishers, 2017): location 4049.

<sup>189</sup> Quoted in Damion Searls, *The Inkblots*, location 4049.

Rorschach himself noted that this would be a challenge for many. “It comes out of two different approaches: psychoanalysis and academic research psychology,” he wrote in 1921. Because of this, he claimed: “the research psychologists find it too psychoanalytical, and the analysts often don’t understand it because they stay clinging to the content of the interpretations, with no sense for the formal aspect. What matters, though, is that it works: it gives amazingly correct diagnoses. And so they hate it all the more.”<sup>190</sup> Klopfer and Beck, two of the most prominent writers about the test in the U.S., both agreed about the value of the dual focus of the test. Both then continued to focus each on expansion of work with the Rorschach in ways that privileged half of that equation, however. According to Klopfer, Rorschach “combined, to a marked degree, the sound empirical realism of a clinician with the speculative acumen of an intuitive thinker.” While Beck pointed out that Rorschach “knew the value of free association. Fortunately, too, he possessed an experimental bent, appreciated the advantages of objectivity, and was gifted also with creative insight.”<sup>191</sup> Unlike Beck who maintained an “emphasis on objectivity,” Klopfer was more interested in the psychoanalytic aspects and “felt free to change the test and develop new techniques based on clinical experience and instinct, not necessarily empirical research.”<sup>192</sup> They thus developed different scoring systems and different understandings of what could be concluded from the data. Variations of the work of each were used nationwide. The resulting lack of comparability and difficulty replicating studies would help undermine ideas about the science behind the test even as use of the test expanded substantially. Differences in scoring were further complicated by those who saw the content of responses to the test as useful for analysis;

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<sup>190</sup> Hermann Rorschach, quoted in Damion Searls, *The Inkblots*, Location 3256.

<sup>191</sup> Beck, review of Klopfer, *Rorschach Technique*, 583, quoted in Damion Searls, *The Inkblots*, Location 3322.

<sup>192</sup> Damion Searls, *The Inkblots*, Locations 3402, 3322.

not through scoring systems but as material for psychoanalysis. Searls called this a type of “ham-fisted Freudianism” in which “one of the Rorschach inkblots was the ‘Father Card,’ another the ‘Mother Card,’ ... any responses to them were especially significant for the person’s family psychodrama. If a woman said the arms on the Father Card looked ‘skinny and weak,’ that was an ominous sign for her love life.”<sup>193</sup>

After facing sporadic earlier attacks, by the 1960s tests like the Rorschach were losing ground and by 1965 use of the Rorschach as acceptable evidence was frequently challenged.<sup>194</sup> While it was still being used in some cancer research, in 1965 Arthur Jansen wrote in *The Mental Measurements Yearbook* that: “Put frankly, the consensus of qualified judgment is that the Rorschach is a very poor test and has no practical worth for any of the purposes for which it is recommended by its devotees.”<sup>195</sup> For Jansen, a professor of psychology at University of California Berkley, the most damning thing was not the lack of efficacy, but that the test might “lead to harmful consequences in non-psychiatric settings, such as in schools and in industry” because of its tendency to over pathologize.”<sup>196</sup> For example, Virginia Ives, Marguerite Grant, and Jane Ranzoni found in a 1953 study that “More than one-third of a group of 145 18-year-olds would be diagnosed as neurotic” by the test and that younger populations showed even higher rates of some measures of neuroses.<sup>197</sup>

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<sup>193</sup> Damion Searls, *The Inkblots*, location 4099.

<sup>194</sup> For more information on challenges to the Rorschach see James M. Wood, M. Teresa Nezowski, Scott O. Lilienfeld, and Howard N. Garb, *What's Wrong with the Rorschach? Science Confronts the Controversial Inkblot Test* (San Francisco: Jossey-Bass, 2003). And Roderick D Buchanan, "Ink Blots or Profile Plots: The Rorschach Versus the MMPI as the Right Tool for a Science-Based Profession," *Science, Technology & Human Values* 22, no. 2 (April 1, 1997): 168–206. doi:10.1177/016224399702200202.

<sup>195</sup> Damion Searls, *The Inkblots*, Location 4694.

<sup>196</sup> Damion Searls, *The Inkblots*, Location 4694.

<sup>197</sup> Virginia Ives, Marguerite Grant, and Jane Ranzoni, “The ‘Neurotic’ Rorschachs of Normal Adolescents,” *Journal of Genetic Psychology*, Vol. 83 (1953): 56.

Finally, reduced interest in the unconscious motivations of individuals led to a decline in use of the Rorschach. Moreover, Searls claimed that “With the rise of community-based mental health treatment focusing on external socioeconomic and cultural forces, and the return to prominence here too of behavior-based theories, it started to seem relatively pointless to pay attention to the mind or to inner motivations....”<sup>198</sup> Like psychoanalytic therapy, psychoanalytically informed testing seemed like a lot of effort (particularly the painstaking scoring of the Rorschach) for minimal returns in discovering childhood maladjustments, when perhaps it would be easier and more cost effective to address immediate problems, and use therapies directly aimed at treating symptoms. Again, the same frustration with failure to listen to patients in therapy applied to projective testing. Some of these concerns grew most vocally out of anthropological work using projective testing to discover “national personalities.”

“Anthropologists,” Searls shows, “had promised that projective tests could give voice to the people being tested, but it was increasingly hard to ignore that, in Lemov’s words, such tests purported to ‘provide a kind of instamatic psychic X-ray that, by its very workings, allocated to the expert the task of discerning the true meaning of what was being said, what the native was thinking.’ It was the same ethical dilemma raised by any notion of the unconscious: If you claim there are things about people that they are unaware of, you are claiming to speak for them better than they can speak for themselves, usurping their right to their own life stories.”<sup>199</sup> The problems with the unconscious in therapy, turned out to be much the same as problems in testing: uncovering motivations that the patient was unaware of and which stretched to childhood

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<sup>198</sup> Damion Searls, *The Inkblots*, Location 4697.

<sup>199</sup> Damion Searls, *The Inkblots*, Location 4683.

was expensive, time consuming, and disregarded both the patient's voice and the reality of their immediate concerns.

Even most psychologists who continued to use the Rorschach recognized the critiques and limitations of projective testing. Boris Semeonoff, a reader in psychology at the University of Edinburgh, wrote in his 1976 textbook that "Projective techniques are notorious as a focus of controversy in present-day psychology. By some they are regarded as a dead letter," however, he pointed to regular reviews of "Projective Methodologies," especially in high ranking publications, as evidence that many still found value in them.<sup>200</sup> For Semeonoff the value of projective methodologies could be defended in part by viewing them as "techniques" rather than "tests." Semeonoff pointed out that, "When we talk about a 'test', the question immediately follows, 'What does it test?', with the implication, as already hinted, of 'What does it measure?'. If there is no simple answer, clearly we should use some other word than 'test'; hence the projectionists' preference for the term 'techniques'."<sup>201</sup> Classing the Rorschach as a technique preserved a place for it in a clinical setting as a preliminary method to begin understanding individual patients, but gave it little role as a research tool. Positioning projective testing as an art remained one of the last unassailable defenses for its champions. In the foreword to 1968's *Diagnostic Psychological Testing*, Robert Holt claimed that the decline in use of diagnostic testing, particularly of the Rorschach and TAT, was because "There were not enough testers of sufficient skill, experience, and ability to communicate what they knew to teach all the new students..."<sup>202</sup> As a result, testers had declined in quality. Holt characterized the true tester as

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<sup>200</sup> Boris Semeonoff, *Projective Techniques*, (London: John Wiley & Sons, 1976), 1.

<sup>201</sup> Boris Semeonoff, *Projective Techniques*, 5.

<sup>202</sup> David Rapaport, Merton M. Gill, and Roy Schafer, ed. By Robert R. Holt, *Diagnostic Psychological Testing* (New York: International Universities Press, 1968), 24.

gifted: "much of what the expert [tester] achieves is a matter of art, the exercise of intuition and craft in a way that is difficult to verbalize."<sup>203</sup> He believed that less skilled and undertrained testers oversold the tests and tarnished the reputations of truly talented analysts. No longer able to claim it as a science with replicable experiments, he too claimed it as a technique or art.

While projective research methods became less defensible, this did not undermine all the cancer research that had relied upon it. Review articles covering prior research on psychosomatic carcinogenesis pointed explicitly to the problems of earlier studies. They claimed that individual interviews and Rorschach blot tests relied too much on the interpretation of individual psychiatrists, preventing statistical comparison and replication. In addition, they faulted earlier studies for their retrospective organization and failure to control for stage at diagnosis. For example, at a conference on psychosomatic aspects of cancer, one of the papers critiqued the work of Gotthard Booth (described in the previous chapter) for "the apparently arbitrary significance he assigns to types of Rorschach responses, [and] the lack of conventional statistical treatment of the data." While the author of the paper did not reject all use of the test he did point to the unevenness of how it was applied.<sup>204</sup> In what would become a familiar refrain, in 1966 David Kissen acknowledged some of the shortcomings of past psychosomatic cancer research, but said "Methodology that may be open to criticism does not necessarily invalidate the findings. It does, however, imply an imperative need for careful corroboration which may be found by integrating the several reports of different observers as well as by improved techniques."<sup>205</sup>

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<sup>203</sup> David Rapaport, Merton M. Gill, and Roy Schafer, ed. By Robert R. Holt, *Diagnostic Psychological Testing*, 25.

<sup>204</sup> See for example: Fred Brown, "Relationship Between Cancer and Personality," *Annals of the New York Academy of Sciences* 125 no. A3 (1966): 869.

<sup>205</sup> David M. Kissen, "The Value of a Psychosomatic Approach to Cancer," *Annals of the New York Academy of Sciences*, Vol 125, (1966): 777.

Going forward, many researchers would choose to rely on tests like the Minnesota Multiphasic Personality Inventory (MMPI) which came to be favored over projective tests. Despite attempts to construct personality inventories as atheoretical tests, gender norms were still incorporated into their scoring. Moreover, personality inventories, in their earlier versions, introduced specific problems for studies on ill populations. In his work on changing trends in psychological testing, Roderick Buchanan found that "By 1969, the MMPI had surpassed the TAT and closely trailed the Rorschach in terms of clinical usage. A little over a decade later, it had become the most widely used test of personality in American Psychology."<sup>206</sup> Items for the MMPI were selected out of a large stock of questions, ranging from personal interests and career possibilities to health concerns and sexuality. Each had three possible answers: "True", "False", and "Cannot Say". By administering the test to groups of previously diagnosed and normal individuals and selecting questions that differentiated between these groups the developers created ten personality trait scales, twenty-six content areas, and four validity scales.<sup>207</sup> It is in the selection of test subjects that the effect of gender norms on the test become apparent. In the early 1940s, psychologists built a masculinity-femininity scale into the MMPI by administering the test to soldiers and effeminate gay men. Further studies used normative gender groups such as male business administration students and female stewardesses.<sup>208</sup>

General questionnaires like the MMPI had substantial problems when applied to cancer patients. The MMPI was not designed to be used on those with physical illnesses. Symptoms, of

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<sup>206</sup> Roderick D. Buchanan "Ink Blots or Profile Plots: The Rorschach Versus the MMPI as the Right Tool for a Science-Based Profession," *Science, Technology & Human Values* 22, no. 2 (April 1, 1997): 193. doi:10.1177/016224399702200202.

<sup>207</sup> W. Grant Dahlstrom, George S. Walsh, and Leona E. Dahlstrom, *An MMPI Handbook Volume I: Clinical Interpretation* (Minneapolis: University of Minnesota Press, 1972), 4-5.

<sup>208</sup> Hale Martin and Stephen E. Finn, *Masculinity and Femininity in the MMPI-2 and MMPI-A* (Minneapolis: University of Minnesota Press, 2010), 60-63.



even undiagnosed cancers often appeared as symptoms of depression. Fatigue, weight gain or loss, excessive sleep or insomnia could all be symptoms of either depression or other health problems. Moreover, the physical effects of cancer and the emotional impact of diagnosis can all lead to depression and anxiety. Researchers at Memorial Sloan-Kettering published an overview of emotion and cancer in *Cancer* and pointed out that many measurements of depression were "developed [for] psychiatric settings... it is questionable whether this scale correctly evaluates a cancer patient's state of mind, because the scale contains questions about fatigue, appetite and weight loss which are ordinary somatic symptoms for many cancer patients."<sup>209</sup> Questions about health on depression scales created a measurement bias. Cancer patients in poor health automatically scored higher in depression, validating the hypotheses of researchers. This methodological concern decreased use of the MMPI in psychosomatic research.<sup>210</sup>

### **Stress, Personality Typing, and Cancer Research**

Though the influence of psychoanalysis in psychiatry declined, new methodologies and interpretive frameworks provided new ways of connecting femininity, personality, and cancer. In the midst of a sea change in psychology that could have undermined psychosomatic medicine as a whole, stress research guided in large part by Hans Selye and a new fascination with "Type-A" personality provided fertile new grounds for research and new conceptual frameworks. The blow that could have come to psychosomatic cancer research from this shift in theoretical frameworks and research methodology was softened by the contemporaneous acceptance of beliefs about

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<sup>209</sup> W. H. Redd, and P. B. Jacobsen. "Emotions and Cancer: New Perspectives on an Old Question," *Cancer* 62, no. 8 (October 15, 1988): 1871–1879.

<sup>210</sup> Questions that measured health were also present in other inventories. The Bell Adjustment Inventory included the question "Are you subject to attacks of influenza?" Lee Cronbach, *Essentials of Psychological Testing*, (New York: Harper & Row,)521.

stress and heart disease which were then used as a model for looking at cancer patients. The “father of stress research,” Hans Selye, was born in Vienna, moved to Rome and then to Prague where received a doctorate in chemistry and a medical degree. After completing his degrees in 1931, he moved to the U.S. where he worked briefly at Johns Hopkins before moving to Montreal to work at McGill University. He stayed at McGill until 1945 when he took a position at the University of Montreal as the director of the Institute of Experimental Medicine and Surgery.<sup>211</sup> When he died in 1982, his eulogy in the *New York Times* emphasized the importance of his legacy in studying stress, pointing to his prolific work as “the author of 33 books and 1,600 articles on the subject. His book, *Stress Without Distress*, was translated into more than a dozen languages.”<sup>212</sup> Selye’s early animal studies and identification of general patterns of responses in rats to a variety of stressors, mentioned in the discussion of ulcers in chapter one, also pointed to a pattern of heart disease. This “Stress Syndrome”—a pattern of general responses in people to diverse stimuli—became the basis for a variety of work. The pattern of heart disease in animal stress studies was extended quickly to understanding the stresses of men’s working lives, particularly executive men.<sup>213</sup>

Meyer Friedman and Ray Rosenman created the ‘Type A’ behavior pattern in order to study the impact of stress on heart disease in humans. They surveyed “lay executives and physicians of their opinion of major causes of clinical coronary heart disease. The majority of both groups believed that chronic exposure to emotional trauma resulting from excessive ‘drive,’

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<sup>211</sup> David Bird, “Dr. Hans Selye Dies in Montreal; Studied Effect of Stress on Body,” *New York Times*, October 22 1982, B10.

<sup>212</sup> David Bird, “Dr. Hans Selye Dies in Montreal; Studied Effect of Stress on Body,” *New York Times*, October 22 1982, B10.

<sup>213</sup> For more on the history of Stress see: Mark Jackson, *The Age of Stress: Science and the Search for Stability* (Oxford: Oxford University Press, 2013).

competition, meeting ‘deadlines,’ and economic frustration was the major cause.”<sup>214</sup> Rosenman and Friedman then tested this in a variety of ways including by following accountants and measuring their serum cholesterol and type A behavior- finding elevations in both around April (tax season) followed by a decline.<sup>215</sup> They then attempted to establish a more formal definition of type A behavior. It included:

(1) an intense, sustained drive to achieve self-selected but usually poorly defined goals, (2) profound inclination and eagerness to compete, (3) persistent desire for recognition and advancement, (4) continuous involvement in multiple and diverse functions constantly subject to time restrictions (deadlines), (5) habitual propensity to accelerate the rate of execution of many physical and mental functions, and (6) extraordinary mental and physical alertness. A second overt behavior pattern (pattern B) then was formulated. Essentially the converse of pattern A...

They also included a “pattern C” which was like B “but also included a chronic state of anxiety or insecurity.”<sup>216</sup> Pattern A test subjects were selected by speaking with non-medical professionals from “various corporations, independent companies, and newspaper organizations,” describing the pattern, and having them recommend “associates most closely fitting this pattern.” Similar recommendation processes were used to collect the pattern B sample. Type C was composed of unemployed blind men.<sup>217</sup> Comparison of the groups found that men with pattern A behavior had higher serum cholesterol levels, faster blood clotting times, higher frequency of arcus senilis, and

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<sup>214</sup> Meyer Friedman and Ray H. Rosenman, “Association of Specific Overt Behavior Pattern with Blood and Cardiovascular Findings: Blood Cholesterol Level, Blood Clotting Time, Incidence of Arcus Senilis, and Clinical Coronary Artery Disease.” *JAMA*, 169 no 12 (1959): 1286.

<sup>215</sup> Meyer Friedman, Ray H. Rosenman, and Vernice Carroll “Changes in Serum Cholesterol and Blood Clotting Time in Men Subjected to Cyclic Variation of Occupational Stress,” *Circulation*, 17 (1958): 852-861.

<sup>216</sup> Meyer Friedman and Ray H. Rosenman, “Association of Specific Overt Behavior Pattern with Blood and Cardiovascular Findings,” 1286.

<sup>217</sup> Meyer Friedman and Ray H. Rosenman, “Association of Specific Overt Behavior Pattern with Blood and Cardiovascular Findings,” 1287.

higher rates of coronary disease: “23 group A men (28%) exhibited either clear-cut signs of clinical coronary disease, findings noted in only 3 of the 93 men of group B and in only 2 of the 46 men of group C.”<sup>218</sup> While type C (according to this definition) did not enter popular culture, type A and B were whole heartedly adopted. The work on stress or stress prone personalities of Selye as well as Friedman and Rosenman was different from psychosomatic research on cancer because it tied together animal models with data on physiological responses in addition to psychological data and disease rates. This increased the appearance of reliability for their work in ways that reflected well on claims about mind-body interactions more generally.

Their findings were dramatic and, like the work on cancer, tended to be reported in ways that pathologized women instead of men. In her book *The Hearts of Men: American Dreams and the Flight from Commitment*, Barbara Ehrenreich shows that the development of Type-A/Type-B personality dichotomy served to identify unhealthy personality traits for men, but it was created in a way that did not so much pathologize Type-A men as provide reasons for them to pause from work, escape commitment, and, once married, critique their wives for failing to provide the rest that would counterbalance their personality types.<sup>219</sup> Popular magazines told stories of men pushed to their breaking point by their wives. *McCall's* published a piece in 1964, “Five Husbands Who Might Have Lived,” which exemplified this sense that wives were to blame when their husbands fell prey to their ambitions and stress. In one of the article’s examples, Mr. Langdon, pushed to eat healthier by his doctor, asked how he could “eat grass for dinner when she has a steak with béarnaise sauce?” Not only did his wife fail to participate in the changes

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<sup>218</sup> Meyer Friedman and Ray H. Rosenman, “Association of Specific Overt Behavior Pattern with Blood and Cardiovascular Findings,” 1291.

<sup>219</sup> Barbara Ehrenreich, “Reasons of the Heart: Cardiology Rewrites the Masculine Script” in *Hearts of Men: American Dreams and the Flight from Commitment*.

necessary for his health, she also failed to curb her spending thus fueling his stress levels: “Mrs. Langdon showed her husband the leopard coat she had just purchased. He upbraided her for being extravagant. They both yelled. In the middle of a cutting remark, he sat down hard in a chair. He never got up.”<sup>220</sup>

This danger coming from the emotional pressures to earn sufficient money, though turned into a personality type, was frequently blamed on women like Mrs. Langdon. Women were blamed for failing to take on their share of the burden or earning, but also warned that, should they enter the work force, they would face the same fate. The *Reader's Digest* quoted cardiologist Herman Sobol advising women to “try to shield her husband from any added frenzy” and suggesting they “live within your husband's means.”<sup>221</sup> Dr. Edward Newman echoed the sentiment in *McCall's*: “A woman can be the dominating force in controlling the longevity of her husband.”<sup>222</sup> When women did enter the workforce, however they were threatened with heart attacks. “As more women abandon their protected roles and enter the competitive mainstream, [their] rate of coronaries is increasing,” the *New York Daily News* quoted Dr. Edward Schiemann.<sup>223</sup> Hans Selye weighed in: “The more the ‘Women's Liberation’ movement permits women to take what have usually been considered male jobs, the more women are subject to so-called male diseases, such as cardiac infarctions, gastric ulcers, and hypertension. They get the same satisfactions, too, of course, but at a price.”<sup>224</sup>

Selye also wrote about stress and cancer, work which had deeply personal motivations. After Selye was diagnosed with cancer, his interest in connecting stress and the disease

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<sup>220</sup> Barbara Ehrenreich, *Hearts of Men*, Location 1398.

<sup>221</sup> Barbara Ehrenreich, *Hearts of Men*, Location 1542.

<sup>222</sup> Barbara Ehrenreich, *Hearts of Men*, Location 1531.

<sup>223</sup> Barbara Ehrenreich, *Hearts of Men*, Location 1409.

<sup>224</sup> Barbara Ehrenreich, *Hearts of Men*, 78.

skyrocketed. For Selye, the concept of eustress was vital to understanding his own cancer recovery. Distress is the negative type of stress that Selye had earlier described, stressors that one did not feel empowered to change. Eustress, as opposed to distress, is the positive type of stress that comes from facing challenges and engaging with new possibilities. In 1977, Selye spoke with “great pride” in surviving “a normally fatal cancer, a histiocytic reticulosarcoma.” He believed it gave him a “unique qualification” to “deliver the keynote address at [the] 1977 symposium on Cancer, Stress, and Death in Montreal.” For Selye, his survival reflected the approach to life he had adopted after diagnosis. In the face of a dire situation, his bravery, stoicism, and continued dedication to work was instrumental. “Faced with the physical and emotional realities of this situation,” he said, “I refused to retreat from life in desperation. I immediately underwent surgery and cobalt therapy, but insisted on knowing my chances for a lasting recovery, which at that time seemed far from encouraging.” In the face of this, “Although I knew it would take tremendous self-discipline,” he said, “I was determined to continue living and working without worrying about the outcome. I suppressed any thoughts of my ostensibly imminent death, but rewrote my will, including in it several suggestions for the continuation of my work by my colleagues. Having taken care of that business, I promptly forced myself to disregard the whole calamity. I immersed myself in my work- and I survived!”<sup>225</sup>

Selye did not see this as a formula just for himself. He laid out a theoretical framework for the connection between stress and cancer in a paper he presented at the symposium. Titled “Stress, Cancer, and the Mind,” Selye’s paper argued that: “Stress and cancer are related essentially in three ways: (1) cancer can produce considerable stress in patients; (2) stress can

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<sup>225</sup> Hans Selye, “Foreword,” in *Cancer, Stress, and Death* ed. Jean Taché, Hans Selye, and Stacey B. Day (New York: Plenum Medical Book Company), xi.

cause or aggravate cancer; and (3) stress can inhibit or even prevent cancer.”<sup>226</sup> Still, Selye acknowledged the ambiguity of animal studies, and the limitations of past literature.<sup>227</sup> He called interpretation of psychosomatic data “extremely difficult and subject to doubt,” and said that there “is little tangible evidence” of “regression of malignancies as a consequence of the patient’s strong will to survive.”<sup>228</sup> Nevertheless, as psychoanalytically informed researchers had before him, Selye claimed the legacy of eighteenth and nineteenth-century physicians. He pointed in particular to Sir Richard Guy, Willard Parker, Ephraim Cutter, Amussat, and Piaget.<sup>229</sup> Diverse theoretical frameworks continue to claim the same history as evidence of the staying power, and therefore truth, of ideas about cancer and emotion.

Another presenter at the same symposium began to explain the difficulties in finding conclusive data by stressing the individuality of responses to stress and the many factors that effected those responses. Jean D. Tache, the Director of the Center for Applied Stress Studies in Pointe-Claire, Quebec, argued that “Quite a few misunderstandings about the nature of stress arise from the fact that all people do not react to stressors equally or in the exactly the same way.” Stress was an individually specific process “since there are no two identical individuals: each of us is conditioned by *endogenous* factors, i.e., genetically inherited traits such as familial

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<sup>226</sup> Hans Selye, “Stress, Cancer, and the Mind,” in *Cancer, Stress, and Death* ed. Jean Taché, Hans Selye, and Stacey B. Day (New York: Plenum Medical Book Company), 13.

<sup>227</sup> “In leukemic strains of mice, fighting among males allegedly tends to delay the development of the disease, presumably through increased glucocorticoid production. However, these claims have been contradicted by other investigators and in any event, not all types of neoplastic tissue react the same way. Indeed, according to certain authors, stress enhances the development of metastases in experimental tumor-bearing animals.” Hans Selye, “Stress, Cancer, and the Mind,” in *Cancer, Stress, and Death* ed. Jean Taché, Hans Selye, and Stacey B. Day (New York: Plenum Medical Book Company), 14.

<sup>228</sup> Hans Selye, “Stress, Cancer, and the Mind,” in *Cancer, Stress, and Death* ed. Jean Taché, Hans Selye, and Stacey B. Day (New York: Plenum Medical Book Company), 15-16.

<sup>229</sup> Hans Selye, “Stress, Cancer, and the Mind,” in *Cancer, Stress, and Death* ed. Jean Taché, Hans Selye, and Stacey B. Day (New York: Plenum Medical Book Company), 13.

diseases, proneness to certain maladies and weaknesses of specific organs, and *exogenous* factors, which include not only various physical conditions but also social, intellectual, and psychological elements are experienced.”<sup>230</sup> This individuality could explain the difficulty in finding coherent personality patterns or specific stressors that caused cancer. The type of stressor and the individual failed coping strategy could vary.

### **Adding a Personality Type**

Research on Type A and B personalities and heart disease made two primary contributions to ideas about personality and cancer. First, in its ubiquity and “common sense” approach, it kept the idea of a mind-body connection in health at the center of attention and legitimized it. Second, it provided another model for psychosomatic cancer research. Beginning in the late 70s and early 80s a few researchers explicitly tried to expand the A/B dichotomy to include a type C personality. Type C literature was not a break from other writing about cancer and personality. Rather, it fit other theories about cancer into a label that worked with ideas about type A and B. Perhaps the only substantive difference, was the move away from specificity by type of cancer that had characterized other work. Notably, this group included Steven Greer, from the Department of Psychological Medicine and Faith Courtauld Unit for Human Studies in Cancer at King’s College Hospital, and Lydia Temoshok from the Department of Psychiatry at the University of California, San Francisco. Steven Greer worked to create personality scales for “emotional control” for use in study of breast cancer patients- based in part on inverted measures of Type-A personality. Lydia Temoshok and her colleagues at the University of California- San

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<sup>230</sup> Jean Taché, “Introduction: Stress as a Cause of Disease,” in *Cancer, Stress, and Death* ed. Jean Taché, Hans Selye, and Stacey B. Day (New York: Plenum Medical Book Company), 6-7.



Francisco defined the type C or cancer prone personality in 1981 around the same traits proposed by other researchers in connection to cancer. The researchers “[u]sed the Term ‘Type C’ to refer to a cancer-prone personality as the opposite of the Type A pattern... or to a helpless-hopeless personality with depressive tendencies.”<sup>231</sup> A perhaps artificial “niceness” was at the key of their descriptions of patients. This definition of “Type C” stayed in use, however, it never reached the level of popular use or acceptance as Type A and B.

Greer had worked on psychology and cancer for some time, writing about methodological challenges and using patients at the stage of breast biopsy (prior to knowing the diagnosis or experiencing major disease symptoms) to evaluate common hypotheses about cancer and personality- finding correlations primarily for emotional suppression. As he continued to evaluate traits for breast cancer patients, in 1983 Greer and his colleague Maggie Watson published a new questionnaire to be used in research with breast cancer patients. It measured “the extent to which individuals report controlling anger, anxiety and depressed mood.”<sup>232</sup> The Courtauld Emotional Control Scale (CECS) was built “from the responses given by breast biopsy patients in semi-structured interviews.” These responses were then selected for their predictive values for suppression of anger, depression, and anxiety, and questions regarding the suppression of each emotion were arranged into three scales. The clear ties to Type A research came as they tested the scale for validity. Watson and Greer administered the test to “a consecutive series of 32 heart patients (30 males, 2 females), awaiting surgery for coronary

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<sup>231</sup> Lydia Temoshok, Bruce W. Heller, Richard W. Sagebiel, Mardsen S. Blois, David M. Sweet, Ralph J. DiClemente, and Marc L. Gold. “The Relationship of Psychosocial Factors to Prognostic Indicators in Cutaneous Malignant Melanoma.” *Journal of Psychosomatic Research* 29, no. 2 (1985): 141. doi:10.1016/0022-3999(85)90035-2.

<sup>232</sup> Maggie Watson and Steven Greer, “Development of a Questionnaire Measure of Emotional Control” *Journal of Psychosomatic Research*, Vol 27, No. 4, (1983): 299.

artery by-pass graft.” They explained that “The evidence on type ‘A’ behaviour suggests that an inability to control emotional reactions, particularly anger, is characteristic of patients at high risk to heart disease.”<sup>233</sup> Using primarily male heart disease patients, they tested to find an inverse correlation between the Bortner Type ‘A’ Behavior Scale and the CECS.<sup>234</sup> Just as heart disease patients became models for reactivity, breast cancer patients became the basis for new ways of studying emotional control; they intentionally positioned (feminine) cancer patients as mirror images of (masculine) heart disease patients. While Watson and Greer were developing their scale of what would be called ‘Type C’, Lydia Temoshok was establishing the term. Beginning in 1981 with a presentation she gave with B.W. Heller at the 89<sup>th</sup> Annual Convention of the American Psychological Association, Temoshok incorporated ‘Type C’ or cancer prone personality into the A/B scales and popularized the term.<sup>235</sup> According to Temoshok, the “‘Type C’ individual is cooperative, unassertive, patient... suppresses negative emotions (particularly anger) and ... accepts/complies with external authorities. This description is the polar opposite of the Type A behavior pattern which has been demonstrated to be predictive of coronary heart disease.”<sup>236</sup>

The term was quickly adopted and debated in the popular press. *Redbook* published an article in 1988 “Do You Have a Type-C (Cancer Prone) Personality?” which drew primarily on

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<sup>233</sup> Maggie Watson and Steven Greer, “Development of a Questionnaire Measure of Emotional Control” *Journal of Psychosomatic Research*, Vol 27, No. 4, (1983): 303.

<sup>234</sup> Maggie Watson and Steven Greer, “Development of a Questionnaire Measure of Emotional Control” *Journal of Psychosomatic Research*, Vol 27, No. 4, (1983): 304.

<sup>235</sup> Their paper “Stress and ‘Type C’ Versus Epidemiological Risk Factors in Melanoma” is cited in Lydia Temoshok “Biopsychosocial Studies on Cutaneous Malignant Melanoma: Psychosocial Factors Associated with Prognostic Indicators, Progression, Psychophysiology and Tumor-Host Response,” *Social Science & Medicine*, Vol 20 Issue 8 (1985): 833-840.

<sup>236</sup> Lydia Temoshok “Biopsychosocial Studies on Cutaneous Malignant Melanoma: Psychosocial Factors Associated with Prognostic Indicators, Progression, Psychophysiology and Tumor-Host Response,” *Social Science & Medicine*, Vol 20 Issue 8 (1985): 833-834.

the work of Greer, Temoshok, and LeShan. The article created an image of shared belief between these researchers, nurses, and doctors. Opening with an anecdote about a cancer patient named Jim whose nurse told him ‘there are people who believe it’s the nice guy’s disease.’ The patient “was struck by the comment. Extremely polite and unassertive, he’d always considered himself a ‘nice guy.’ Was there any truth to the nurse’s statement? Current scientific findings indicate there is.”<sup>237</sup> In addition to the nurses and patients, the author claimed:

Every experienced oncologist and cancer nurse well understands the meaning of the phrases “too good to live” and “too mean to die.” Expressing emotions—especially anger, loneliness and fear—results in a more complete recovery. The sense that one has some control over one’s body and can fight for one’s own recovery is not only a basic tenet of Dr. LeShan’s work but also of more and more researcher’s findings as further studies are completed. The bitching and agonizing, they say, are often healthy signs of the patient’s struggling for control.<sup>238</sup>

The Type-C stereotype of cancer patients was not new (except perhaps the published call for bitching), but rather part of the broader 1970s and 80s narrative about cancer patients. Patients were encouraged to spend some time thinking about their own psychological profile and were offered a quiz developed by LeShan in order to help them assess. The seven yes or no questions revolved around depression, dreams of a different life, and suppressed anger, like LeShan’s case narratives in other books. They asked:

1. Am I able to express anger when I feel it most strongly?
2. Do I try to make the best of things, no matter what happens, without ever complaining?
3. Do I think of myself as a lovable and worthwhile person most of the time?
4. Do I often feel lonely, rejected or isolated from other people?
5. Am I doing what I want to do with my life? Do I feel reasonably optimistic about ever fulfilling myself?
6. If I were told right now that I had only six months to live, would I go on

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<sup>237</sup> Dreher, Henry. “Do you have a Type-C (Cancer Prone) Personality?” *Redbook*; New York Vol. 171, Iss. 1, (May 1988): 108.

<sup>238</sup> Dreher, Henry. “Do you have a Type-C (Cancer Prone) Personality?” *Redbook*; New York Vol. 171, Iss. 1, (May 1988): 109, 158.

doing what I am doing right now? (Or do I have secret unfulfilled dreams, ambitions, and desires that I am ashamed of, some of which have plagued me all my life?)

7. If I were told I had a terminal illness, would I experience some sense of relief?<sup>239</sup>

*The New York Times* was a harder sell. The paper treated the connection between Type A and heart disease alternately as common knowledge or as a controversial claim.<sup>240</sup> However, when Temoshok published her 1992 book *The Type C Connection: The Behavioral Links to Cancer and Your Health*, coauthored by Henry Dreher (the author of the 1988 *Redbook* article), *The New York Times* published a scathing review. Noting that Type A research “remains hotly disputed,” Natalie Angier, the author of the review complained, “Now we are presented with the opposite of the A’s, the Type C’s: emotionally repressed people who almost never get angry or sad, who devote themselves to others while sacrificing their personal growth, and who shrug indifferently at any trouble that life lobs their way.”<sup>241</sup> This was personal for Angier whose father had been an “emotional firecracker, prone to violent outbursts of fury and ever in search of love and passion” yet had died of cancer at the age of 51. She said they used “unpersuasive patient anecdotes to make their case” and that “Ms. Temoshok includes little scientific data to support her thesis.”<sup>242</sup> With this failure, she railed against their willingness to propose “all sorts of ways that you, the emotionally limp individual at grave risk of an early death, can learn to

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<sup>239</sup> Dreher, Henry. “Do you have a Type-C (Cancer Prone) Personality?” *Redbook*; New York Vol. 171, Iss. 1, (May 1988): 109.

<sup>240</sup> For example, in the same year that the Times published the review, they also published an article about preschoolers who have Type-A traits claiming that they “show heart and blood vessel reactions that could eventually lead to coronary heart disease, according to a new study” and another piece claiming that type-a men were more likely to survive following a heart attack and calling for a reevaluation of the concept. “Science Watch; Type A Preschoolers,” *New York Times*, June 7, 1988: C7. Jane E. Brody, “‘Type A’ Men Fare Better in Heart Attack Study,” *New York Times*, January 14, 1988: B7.

<sup>241</sup> Natalie Angier, “Taking Illness Personally” *New York Times*, August 2, 1992.

<sup>242</sup> Natalie Angier, “Taking Illness Personally” *New York Times*, August 2, 1992.

express your rage, focus your anger, cry and laugh your way to healing.” *The Los Angeles Times* similarly called Temoshok’s book “chatty, anecdotal and proselytizing.”<sup>243</sup>

However, when physicians and oncologists were interviewed about their own attitudes to the material, they often suggested that while Temoshok’s argument was controversial and unproven, there was some level of underlying truth. In 1992 the Worcester, Massachusetts *Telegram & Gazette* also covered her book, but without the vitriolic tone of the *New York Times* review. As part of the review, they interviewed two oncologists. Both expressed doubt at the extent of Temoshok’s claims and a desire to see more research while also acknowledging that they considered it a promising area of study. Jack Ansel, a hematologist/oncologist from the University of Massachusetts Medical Center believed that the way in which patients respond to disease was “dependent in part on his attitude and emotional state.” However, he said, “this book takes it a step further and looks at the onset of disease and tries to link that to a personality type. That, in my mind, is more controversial.” After acknowledging the historical staying power of this idea, “Dr. Andrew I. Cederbaum, chief of the hematology/oncology division at The Medical Center of Central Massachusetts” concisely explained his take on the study: it was “an interesting concept [that] clearly needs a whole lot more work.”<sup>244</sup>

### **Biofeedback and Psychoneuroimmunology**

Two other scientific fields, biofeedback and psychoneuroimmunology (PNI), would help to cement the belief in a connection between the mind and body. In his 1975 attempt to condition rats to associate saccharine water with nausea, Robert Ader, a psychologist at the University of

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<sup>243</sup> Wingerson, Lois. “Book Review” *Los Angeles Times*, October 25, 1992: 2.

<sup>244</sup> Courtemanche, Dolores. “Link cited between personality, cancer ; Doctor warns of risk in “Type C behavior”” *Telegram & Gazette*; Worcester, Mass. [Worcester, Mass]20 July 1992: D1.

Rochester, unintentionally discovered that he could suppress the immune systems of rats through classical conditioning. The drug he had added to the saccharine water to induce nausea had suppressed the rats' immune systems, an effect that continued even after he stopped adding the drug.<sup>245</sup> This challenged the belief that the brain and immune system were unconnected. Scientists had believed these systems were separate because immune cells had been able to function outside of the body in petri dishes.<sup>246</sup> Additional ties between psychosocial factors, hormones, and immune function were subsequently observed including "alterations in immunologic reactivity among bereaved subjects" and changes in immune responses stemming from neurotransmitters.<sup>247</sup> In 1980, Ader proposed calling the study of the ties between these systems psychoneuroimmunology. Meanwhile, research in biofeedback also began to show a variety of ways in which people could practice awareness and conscious control of some bodily functions, through technology which used sound or light cues to keep subjects aware of tension in a specific muscle, blood pressure, or other measurements. This allowed them to more effectively recognize and consciously enter into desirable states of relaxation. Studies showed that biofeedback could be used to reduce tension headaches or create a reduction in blood pressure.<sup>248</sup> *The New York Times Magazine* covered initial reports that biofeedback could treat hypertension and expressed hope that this "marked the beginning of a new treatment for a wide variety of diseases, from psychiatric complaints to stress ailments like colitis and gastric ulcers, that will rely for its efficacy on the education of the nervous system."<sup>249</sup>

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<sup>245</sup> Anne Harrington, *The Cure Within*, 126-127.

<sup>246</sup> Anne Harrington, *The Cure Within*, 170-171.

<sup>247</sup> Robert Ader, "Presidential Address—1980: Psychosomatic and Psychoimmunological Research," *Psychosomatic Medicine*, Vol. 42, No. 3 (1980): 313.

<sup>248</sup> Anne Harrington, *The Cure Within*, 166-167, 214-215.

<sup>249</sup> Gay Luce and Ebik Peper, "Mind Over Body, Mind Over Mind," *New York Times Magazine*, September 12, 1971: 34.

From the belief that the nervous and immune systems were connected and the belief that bodily functions could be controlled at will, many rushed to find potential implications for disease treatment. If immune function could be conditioned, perhaps it could be conditioned to reach levels of function which would cause tumor regression. Perhaps through will and training, they argued, cancer could be controlled. Robert Ader suggested in 1980 that perhaps they could condition for higher immune function as well, and speculated that this might become part of cancer care because “the immune system mediates the predisposition to and the precipitation and perpetuation of a variety of organic disease states including, perhaps, some cancers.”<sup>250</sup> Another early proponent of PNI, George Solomon also expressed hope that it would be relevant in the treatment of cancer patients.<sup>251</sup> Again, despite the fact that biofeedback clinics made no claims about cancer, many who looked to defend mind-body cancer treatments saw all new, demonstrable connections between the brain and body as indications that their approach was correct. In *Getting Well Again*, the Simontons summarized biofeedback as evidence that “mind, body, and emotions are a unitary system—affect one and you affect the others.”<sup>252</sup>

### **Conceptual Continuity**

Older ways of conducting mind-body cancer research through projective tests had largely been undermined. Psychoanalytic emphases in describing cancer patients seemed outdated. However, this created an opening for newer, more culturally relevant ways of writing about patients. Despite the changing theoretical basis for psychosomatic research, the existence of a

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<sup>250</sup> Robert Ader, “Presidential Address—1980: Psychosomatic and Psychoimmunological Research,” *Psychosomatic Medicine*, Vol. 42, No. 3 (1980): 317.

<sup>251</sup> George F. Solomon and Alfred A. Amkraut, “Psychoneuroendocrinological Effects on the Immune Response,” *Annual Review of Microbiology*, Iss. 35: 155-184.

<sup>252</sup> O. Carl Simonton, Stephanie Simonton, and James Creighton, *Getting Well Again*, 31.

connection between personality and cancer remained widely accepted. By 1978 the research on psychosomatic carcinogenesis had increased in volume and become respectable enough that *Science News* felt it necessary to publish a literature review evaluating the research to date. The author considered the research credible and came to the conclusion that “the silent storm of cancer flourishes best in an ambience of despair.”<sup>253</sup> Even *JAMA* occasionally treated it as a relatively uncontroversial idea. One 1975 medical news bulletin discussed an animal study on the link between stress and cancer. Rather than stopping there, the authors quickly jumped to discussing humans. “Basically,” the author explained, “the possible mechanisms [for emotional carcinogenesis] revolve around loss or separation from a loved one (or from another important aspect of life), with subsequent feelings of hopelessness and despair, or a tendency to repress one’s emotions while leading a life characterized by endurance and order.”<sup>254</sup> The same language of emotional repression and hopelessness continued to dominate the discussion. The popularity of these theories would continue to increase among physicians throughout the 1980s for reasons covered in chapter five.

In addition to maintaining the same descriptive words used to describe cancer patients in earlier literature (depressed, hopeless, repressed), stress research often fell back to similar causal explanations for a variety of life events: personality. While fewer people were likely to write of unconscious seduction, stressors as things that occurred randomly were not considered the cause of cancer, responses to them and the personalities that created stressful situations were. This is evident in each of the sources above, from the way in which Selye attributed his recovery to his personal responses to stressors- not stressors themselves, to the *New York Times* description of

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<sup>253</sup> Gregory McQuerter, “Cancer: Clues in the Mind,” *Science News* 113, no. 3 (1978): 45.

<sup>254</sup> “Medical News: Animal Study Shows Intriguing Link Between Chronic Stress, Cancer,” *JAMA*, 1975 233 (7) 757-763, 757.



executives who create crises in order to resolve them- rather than just encountering crises, but Eysenck was perhaps most explicit in explaining this. “The first problem [in understanding stress research] arises,” he said, “from the fact that while we treat stress and personality as distinct and

separate concepts, they are really closely related. As I have postulated elsewhere, when we say ‘stress’ we usually mean ‘strain’, i.e., not the events perceived as stressors, but the individual reactions of the persons so stressed. Stress may be regarded as an objective concatenation of circumstances, e.g., dismissal from one’s job; divorce; death of one’s parents. But these objective events may produce quite different emotions in the person so afflicted, depending on his or her *personality*. ... In addition, it has been shown that life events are themselves a function of personality differences.<sup>255</sup>

The location of the cancer-causing problem within the individual remained. What had changed was the methodological approach, the framework for understanding personality development, and a few of the buzzwords—from inhibited motherhood to Type-C. While this change in framework was occurring, simultaneous changes to the ideas of what a hopeless, helpless, and repressed man or woman might look like were occurring—with substantial consequences for the types of advice and cautionary tales included in books and articles.

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<sup>255</sup> Emphasis in original. Hans J. Eysenck, “Cancer, Personality, and Stress: Prediction and Prevention,” *Advances in Behaviour Research and Therapy*, 16, 3, (1994): 169.

### **CHAPTER THREE: Feminism, Blame, and Popular Mind-Body Literature**

In the 1970s, popular writers with academic credentials began to guide the conversation about mind-body cancer care. Their work reached a broad audience as it was discussed in newspaper articles and entertained in medical journals. Exploring this body of literature highlights two key trends in mind-body medicine in the 70s and 80s. First, popular writers generally rejected the misogynistic idea that stunted femininity was a driver of cancer. This came as a result of both feminist changes in beliefs about gender roles and changing realities of women's work. In place of older ideas about carcinogenic femininity, they adapted ideas about helplessness, repression, and hopelessness to fit a new context where healthy femininity might include a career and interests beyond the family. They also began to include more case narratives addressing toxic aspects of masculinity. Second, there was a growing concern about victim blaming, which advocates of mind-body medicine tried to rebuff by focusing on the potential of their work to empower cancer patients. Social movements challenged the belief that people get what they deserve, succeed insofar as they are hard-working, and can pull themselves forward with positive thinking. In short, this undermined the idea that patients had individual control over whether they lived or died.

Little has been written about this shift in mind-body cancer care from the misogyny of many psychoanalytic case narratives described in chapter one to the case narratives described below which often read like feminist parables. Anne Harrington has argued that psychosomatic medicine was in decline by the 1970s, but that the field's key ideas about illness as an expression of the need for change, a bodily reflection of emotional problems, was adopted by "alternative,

feminist and holistic medicine.”<sup>256</sup> She characterized some of the literature from the 1980s as trying “to help, rather than implicitly condemn” those whose emotional repression stunted their ability to form relationships.<sup>257</sup> In this chapter I show that this literature came, in some cases, from the same people who were publishing before, not people who emerged from outside the field and suddenly shifted to trying to help. I also add to her work by giving a clearer picture of the gender roles in case narratives which would help make this literature appealing to feminists. Issues of blame in mind-body cancer treatments have been addressed repeatedly in the historiography, but almost always with the focus on Susan Sontag.<sup>258</sup> I aim to put Sontag into a broader context of cultural concerns about victim blaming and to put her arguments back into conversation with the responses of advocates for mind-body medicine, who argued that this was about empowerment to live and perhaps even making peace with death, not blame.

### **Feminism Changes the Literature**

In this section, I argue that by the 1970s, second wave feminism and changing employment patterns had dramatically changed the research on personality and cancer. Feminists challenged Freudian psychology directly. They brought different concerns to their therapists, and psychologists encountered feminist ideas in their daily and professional lives. As feminists questioned the reality of natural differences in gender roles and intellectual capabilities, they provided a wider array of possibilities for an expanding definition of femininity. Outside of these challenges, psychologists were more likely to have female patients who worked. Because of the

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<sup>256</sup> Ann Harrington, *The Cure Within*, (New York: W. W. Norton & Company, 2008), 94-95.

<sup>257</sup> Ann Harrington, *The Cure Within*, 196.

<sup>258</sup> Ann Harrington, *The Cure Within*, 97, James Patterson, *The Dread Disease: Cancer and Modern American Culture*, 275.

methodological and theoretical changes discussed in the previous chapter, psychologists were newly equipped to consider patients' conscious concerns about careers. They began writing case narratives and crafting research questions which engaged with feminist concerns in addition to their older questions of sexuality. Despite the changing factors that were included in understanding cancer, the basic premise remained the same: emotional repression and hopelessness caused cancer. In this context, emotional repression took on a greater array of meanings. For those most directly influenced by second wave feminism, emotionally repressed women were frequently depicted as housewives stuck catering to the needs of others.

Doctors' and therapists' encounters with female patients in their practices made the impact of feminism clear. Though a sizable minority of married women in 1950 worked outside the home (25 percent), women who could afford therapy were more likely to be able to afford to stay at home.<sup>259</sup> These women in many cases subscribed to ideals about gender that corresponded with their actual roles. By 1970 the portion of married women participating in the labor force had risen to 46%.<sup>260</sup> As more women chose to work or wanted to begin careers, psychologists' analysis may have changed to reflect the new desires of their patients and the reality that a growing number of female patients successfully held outside jobs and high-powered positions. The concerns of women in therapy had changed or, perhaps women were getting better at recognizing that their concerns did not fit the categories offered by psychoanalysts. Betty Friedan asked, "What need, what part of themselves, could so many women today be repressing? In this age after Freud, sex is immediately suspect. But this new stirring in women does not seem to be

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<sup>259</sup> Claudia Goldin, "The Quiet Revolution that Transformed Women's Employment, Education, and Family," *The American Economic Review*, 96, no. 2 (2006): 5.

<sup>260</sup> Claudia Goldin, "The Quiet Revolution that Transformed Women's Employment, Education, and Family," *The American Economic Review*, 96, no. 2 (2006): 6.

sex; it is, in fact, much harder for women to talk about than sex. Could there be another need, a part of themselves they have buried as deeply as the Victorian women buried sex?”<sup>261</sup>

The success of the feminist movement in the 1970s changed each group of participants in psychotherapy, both patients and doctors. Doctors were not only exposed to new gender ideals in their daily lives, they faced direct feminist opposition to both ongoing sexism in medicine and psychosomatic medicine in particular from other doctors. For example, a 1973 article in the *New England Journal of Medicine (NEJM)*, “Alleged Psychogenic Disorders in Women: A Possible Manifestation of Sexual Prejudice,” addressed the gendered stereotypes that led physicians to turn to psychosomatic explanations for women’s problems, but rarely for men’s.<sup>262</sup> Another *NEJM* article published the next year examined the attitude to women which was taught in medical schools at the time. One student quoted a lecturer who said: “The only significant difference between a woman and a cow is that a cow has more spigots.”<sup>263</sup> Others described the way their professors classified women: “Mothers are ‘complaining,’ young women are ‘cute tricks,’ and age-peers are ‘demanding and bitchy.’”<sup>264</sup> Again, the author noted the role of sexism in psychosomatic medicine. Apparently, many professors only used female pronouns when describing patients with psychosomatic problems.<sup>265</sup> These articles came shortly after the passage of Title IX, and the author noted that while female students in medical school could use

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<sup>261</sup> Betty Friedan, *The Feminine Mystique* (New York: Norton, 2001), 80.

<sup>262</sup> Lennane, K. Jean, and R. John Lennane. “Alleged Psychogenic Disorders in Women — A Possible Manifestation of Sexual Prejudice,” *New England Journal of Medicine* 288, no. 6 (1973): 288–292. doi:10.1056/NEJM197302082880605.

<sup>263</sup> Mary C. Howell, “What Medical Schools Teach about Women,” *New England Journal of Medicine*, 291, no. 6 (1974): 305.

<sup>264</sup> Mary C. Howell, “What Medical Schools Teach about Women,” 305.

<sup>265</sup> Mary C. Howell, “What Medical Schools Teach about Women,” 305.

this to challenge sexism, female patients could not.<sup>266</sup> Faced with direct professional challenges to their use of psychosomatic explanations of disease in women, newer descriptions of cancer patients were necessary.

Even where psychologists and therapists may not have thought of themselves as influenced by feminism or guilty of sexism in their past work, wide-ranging economic and cultural changes meant that they were confronted by women with different backgrounds. In her article, “The Quiet Revolution that Transformed Women’s Employment, Education, and Family,” Claudia Goldin, a professor of economics at Harvard argues that the period from the late 1800s until the late 1970s was a period of gradual evolution shaped by the removal of barriers against the employment of married women, changing work conditions and types of employment (especially clerical work), and other factors.<sup>267</sup> She shows that women’s roles changed dramatically as the result of a “quiet revolution” which took place in the late 70s and is still continuing in women’s workforce participation. The slow changes in women’s employment meant that women born after 1950 were more aware of the increased likelihood of extended labor force participation, were able to obtain oral contraception, and marry later, allowing them to envision a career rather than just a job and plan for higher education. For example, when asked about where they would be at age 35, women who were in their late teens in 1970 predicted a much lower rate of labor force participation (33%) than young women in 1978, 80% of whom expected to work at 35.<sup>268</sup> Whereas earlier generations of women had married younger and did not have a chance to define themselves prior to marriage in the same way, more of these

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<sup>266</sup> Mary C. Howell, “What Medical Schools Teach about Women,” 307.

<sup>267</sup> Claudia Goldin, “The Quiet Revolution that Transformed Women’s Employment, Education, and Family,” *The American Economic Review*, 96, no. 2 (2006): 1-21.

<sup>268</sup> Claudia Goldin, “The Quiet Revolution that Transformed Women’s Employment, Education, and Family,” *The American Economic Review*, 96, no. 2 (2006): 9.

women were able to finish college or even post-graduate programs at higher rates before marriage and child bearing. Instead of seeing work as something they might do temporarily if necessary when their partners were unable to finance their families, they saw work as a career and a part of their identity. This trend included women of all income and educational brackets. This connected to an increased focus for women on the meaning of their work and greater frustration in the face of lower recognition for their effort and training. Moreover, the pursuit of careers instead of shifting jobs combined with later childbirth meant that more women were raising small children while also being in positions of comparatively greater responsibility in their 30s.<sup>269</sup> Therapists thus saw women with radically different employment realities, expectations, and goals.

O. Carl Simonton provides a good example of how mind-body advocates began to learn from the concerns of their patients, and of how gender norms began to change in their case narratives. Radiation oncologist O. Carl Simonton and psychologist Stephanie Simonton worked together to develop a program from his observations of his patients who survived beyond their doctors' prognosis while he was working on his residency at the University of Oregon Medical School. Together they created the Cancer Counseling and Research Center in Dallas where Stephanie Simonton served as the director of counseling. The Center hosted six-day workshops for patients and their support person. In 1978, they published a book with James Creighton entitled *Getting Well Again: A Step-by Step, Self Help Guide to Overcoming Cancer for Patients and their Families*. The book included the Simonton's program of visualization and self-reflection, a combination of ideas about mind and body health from Galenic ideas, through stress

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<sup>269</sup> Claudia Goldin, "The Quiet Revolution that Transformed Women's Employment, Education, and Family," 1-21.

research and psycho-neuro immunology, and citations from Selye, LeShan, Eysenck, and many of the others covered so far in this dissertation. Visualization was the most distinctive contribution of the Simontons. In this process, cancer patients were instructed to relax and picture their immune systems and medications working to destroy weak cancer cells while the rest of their body remained strong. They also focused substantially on unconscious causes of disease, from the hopelessness described by LeShan to ideas of disease as an unconscious need to receive love and permission to express personal needs. One of Simonton's case studies tells the story of a woman who developed cancer shortly after her last child moved out of the home: "Jane's primary identity had been tied up in her children. When thrown back on her own resources she discovered that most of her skills were for nurturing others rather than for meeting her own needs."<sup>270</sup> His case narratives show that Simonton also thought women needed an identity outside of their families. He implied that women could take control of their own lives, but that doing so might require an expansion of their gender roles. Other case narratives described men who had put their "energy into developing primarily those parts of himself related to his work."<sup>271</sup> Men could find themselves "unable to permit... close relationships."<sup>272</sup> Women in turn who identified marital problems like affairs, could not heal them, but also did not believe in divorce were also likely to struggle to heal from cancer.<sup>273</sup> The book does not explore any further the social conditions that would lead to these types of problems, focusing instead on personal ability to change, but it did recognize the challenges caused by limiting one's self according to gendered expectations. "It is a particularly sad course of events," Simonton said,

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<sup>270</sup> O. Carl Simonton, Stephanie Simonton, and James Creighton, *Getting Well Again*, 66.

<sup>271</sup> O. Carl Simonton, Stephanie Simonton, and James Creighton, *Getting Well Again*, 118.

<sup>272</sup> O. Carl Simonton, Stephanie Simonton, and James Creighton, *Getting Well Again*, 73.

<sup>273</sup> O. Carl Simonton, Stephanie Simonton, and James Creighton, *Getting Well Again*, 70.



“that many times those people who most steadfastly and responsibly attempt to live up to cultural rules develop the most serious illnesses.”<sup>274</sup>

In another 1978 book, *And a Time to Live: Toward Emotional Well-Being During the Crisis of Cancer*, University of California, San Francisco-based oncologist Robert Chernin Cantor explicitly connected patients’ experiences to gender roles and the women’s movement. Strict gender roles, according to Cantor, could limit emotional expression, thus encouraging cancer growth and preventing patients from coping with cancer in loved ones. He argued, “Our culture usually demands strength, decisive action and dependability in men; nurturance, emotion and dependence in women. These sexual roles often persist despite the dramatic successes of the women’s movement.”<sup>275</sup> Cantor went on to describe the impact these assumptions have on men who are “expected to be ‘strong’ and thereby deprived of the privilege of being emotional.” When one’s wife or children fell ill, the necessary tasks of a man could change adding to the emotional turmoil. Though he noted that women face similar stresses, Cantor focused primarily on the impact of masculine stereotypes on grieving and ill men. “Family roles that have become overly rigid” according to Cantor “trap one area of our personality and, like a nightmare or a broken record, keep replaying the theme over and over again. We get to know the theme well, others learn what to expect, there is security in the familiar patterns. But the burdens and limitations are obvious.”<sup>276</sup> Cantor’s work showed that feminism not only changed the way some therapists viewed women but provided a space to reevaluate the effect of gender roles on men.

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<sup>274</sup> O. Carl Simonton, Stephanie Simonton, and James Creighton, *Getting Well Again: A Step-by-Step, Self Help Guide to Overcoming Cancer for Patients and their Families*, (Los Angeles: J.P. Tarcher, Inc., 1978), 125.

<sup>275</sup> Robert Chernin Cantor, *And a Time to Live: Toward Emotional Well-Being During the Crisis of Cancer*, (New York: Harper & Row, 1978), 144.

<sup>276</sup> Robert Chernin Cantor, *And a Time to Live*, 145.

Where the studies of cancer risk and personality in men described in chapter one were often studies of convenience or deflection, new ideas about gender and sex allowed room for more in-depth discussions of men's emotional lives.

In addition to his move away from psychoanalytic testing described in chapter two, Lawrence LeShan continued to serve as an indicator of trends in mind-body medicine. In the 1970s and 80s, LeShan's books were among the most popular about cancer and the mind. His 1977 book, *You Can Fight for Your Life*, and his 1989 book, *Cancer as a Turning Point*, were published by Dutton, part of the Penguin Publishing Group. Both books went through multiple editions. However, with the field of psychosomatic medicine attached to a Freudian orthodoxy in decline, LeShan's work was more successful in reaching lay audiences than in gaining the endorsement of the medical establishment.<sup>277</sup> He was regularly mentioned in newspaper and magazine articles on the connection between mind and cancer.<sup>278</sup> In both books he discussed a series of case studies reflecting his belief in women's capabilities, and his conviction that men needed to be able express their emotional sides. One patient named Emily, a poet, "had married a writer named Tom." She was talented and "her abilities were far greater than anything Tom could expect of his own potential."<sup>279</sup> He saw this as a threat and withdrew emotionally; she gave up her poetry and developed cancer. LeShan did not say whether she recovered. His 1989 book,

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<sup>277</sup> For examples of the ways in which LeShan was challenged as a "quack" see James Patterson, *The Dread Disease*, 273.

<sup>278</sup> See for example: "The Link Between Illness and Emotion" *Washington Post*, September 28, 1985: C5. Caroline Sperling, "Cancer Counseling: A Prescription of Hope," *Washington Post*, October 28, 1986: HE6. Eda Leshan, "Can Your Emotions Help You Resist Cancer?" *Woman's Day*, March 1975: 64-65, 98, 101-102, 104. Henry Dreher, "Do You Have a Type-C Cancer-Prone Personality?: Do You Fit the Profile?" *Redbook*, Vol. 171 Iss. 1 (May 1988): 108-109, 158, 160. Junius Adams, "How Well Do You Handle Stress?" *Cosmopolitan*, Vol. 194 Iss 1 (Jan 1983): 102, 108, 110.

<sup>279</sup> Lawrence LeShan, *You Can Fight for Your Life*, (Lanham: M. Evans, 2014), 42-43.

*Cancer as a Turning Point*, continued to illustrate what women with fulfilling lives looked like to LeShan. Written as a book for patients, their families, oncologists, and psychiatrists, the book was accessible and contained advice directly aimed at each group. His case stories included many women who needed fulfilling experiences outside of the home. Some of these women were already pursuing careers in which they were not content; others had raised their children and begun to feel aimless. One group of stories included women who had redirected or ended their careers for the sake of their husbands. Harriet, a skilled composer, married an artist whom she loved deeply. More talented than her husband, she taught piano lessons instead of producing and submitting her own work in order to protect his self-respect. LeShan urged her to pursue her own creative genius but she refused for fear it would destroy her husband and their marriage. Harriet died shortly thereafter. LeShan's disdain for her husband was palpable in the text and his understanding of the possibilities women should have within marriage was clear.<sup>280</sup> LeShan believed women needed to be able to use their talents and he believed those talents were often as great or greater than those of their husbands. Furthermore, he believed men needed to be in touch with characteristics that were widely considered feminine.

Like Cantor, LeShan also addressed the negative impact of gender roles on men. He included a number of stories of male cancer patients, some of whose marriages encouraged their cancer growth. Tom's marriage was simply a mismatch; after the divorce both spouses found fulfilling lives and his cancer disappeared.<sup>281</sup> For Charles, the story was different. He supported his family well by producing formulaic novels but always wanted to write more original work.

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<sup>280</sup> Lawrence LeShan, *Cancer as a Turning Point: A Handbook for People with Cancer, Their Families, and Health Professionals* (New York: E. P. Dutton, 1989), 66-68. For another example of this storyline see pages 102-103.

<sup>281</sup> Lawrence LeShan, *Cancer as a Turning Point*, 116-122.

LeShan claimed the patient used his belief that his wife needed to be supported at their current income level as an excuse not to risk the rejection that could come with change. As Charles worked with LeShan he eventually grew deeply fulfilled writing novels far more original than his earlier work. He died later of non-cancer related causes.<sup>282</sup> Another of LeShan's patients, Stephen, saw his "strength, competence, dominance and independence" as "the central parts, the bone structure, of his individuality."<sup>283</sup> He rejected his own impulses for passivity and dependency and could not approach love except through control. This view of manhood, though LeShan did not specifically address the gendered context of this patient, confined his emotional experiences and, in LeShan's eyes, served as a carcinogen. Strict gender roles could, in LeShan's view, stifle the creativity of both men and women. Cancer resulted from the pressure men felt to provide economic support or maintain a particular degree of control and the pressure women felt to remain within backstage roles providing emotional support.

Throughout his book, LeShan consistently referred back to W.H. Auden's description of cancer as a "foiled creative fire" in his 1937 poem, "Miss Gee".<sup>284</sup> Initially this seems to fit LeShan's case studies and his beliefs about the creative capabilities of women. However, reading the whole of Auden's poem one can see that Miss Gee dies of cancer because she represses her desires, never marries, never has children and is effectively an old maid. According to Auden:

Childless women get it [cancer],  
And men when they retire.  
It's as if they need some outlet  
For their foiled creative fire.<sup>285</sup>

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<sup>282</sup> Lawrence LeShan, *Cancer as a Turning Point*, 195-200.

<sup>283</sup> Lawrence LeShan, *You Can Fight for Your Life*, (Lanham: M. Evans, 2014), 42.

<sup>284</sup> See for example Lawrence LeShan, *Cancer as a Turning Point*, 67.

<sup>285</sup> W. H. Auden edited by Edward Mendelson, *Collected Poems*, (New York: Modern Library, 2007), 169-152. Also quoted in Anne Harrington, *The Cure Within: A History of Mind-Body Medicine* (New York: W. W. Norton and Co., 2008): 90 and Susan Sontag, *Illness as Metaphor and AIDS and Its Metaphors* (New York: Picador, 2001): 48.

LeShan's reading of Auden shows a substantial change from earlier views of cancer patients. Adopting a definition of "creative fire" that included more than reproduction, LeShan pushed women to find creative outlets through careers, self-discovery, and artistic expression. Whereas Auden generalized men as expressing creativity through work and risking cancer after retirement, LeShan pointed to fulfilling marriages and emotional depth in addition to employment. While claiming the same intellectual tradition as Auden and espousing ideas that appear similar at first glance, by the 1970s LeShan defined emotional repression and gender in a radically different way.

For many researchers, these newer ideas about gender began to seem self-explanatory. In 1981 *The Journal of Psychosomatic Research* published a paper on cancer which opened with a quotation of Bernard Shaw's definition of a lady as "a person trained to the utmost attainable degree in the art and habit of concealing her feelings and maintaining an imperturbable composure under the most trying circumstances." Despite the strong implications that ladylike behavior caused cancer the authors felt no need to expand on how gender norms encouraged emotional repression in the remainder of their paper.<sup>286</sup> Stephanie Matthews Simonton, who continues to work to meet the psychological needs of cancer patients, wrote *The Healing Family* and included both housewives and career women in her descriptions of cancer patients without suggesting that either path might be preferable.<sup>287</sup> The idea that careers could be healthful or gender norms harmful seemed no longer to require detailed exposition.

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<sup>286</sup> Correspondence of Ellen Terry and Bernard Shaw Cited in Tina Morris, Steven Greer, Keith W. Pettingale, and Margaret Watson, "Patterns of Expression of Anger and Their Psychological Correlates in Women with Breast Cancer." *Journal of Psychosomatic Research* 25, no. 2 (1981): 111. doi:10.1016/0022-3999(81)90098-2.

<sup>287</sup> Stephanie Simonton, and Robert L Shook. *The Healing Family: The Simonton Approach for Families Facing Illness*. Toronto; New York: Bantam Books, 1984.

Bernie Siegel, the founder of ECap (Exceptional Cancer Patients), a support group, was frank about the effect of gender roles on cancer rates. Spiegel was a surgeon at Yale who participated in a seminar in 1978 led by the Simontons. He used the insights he gained there to develop his new program for cancer patients.<sup>288</sup> Anne Harrington identifies Siegel as the most influential of those who wrote about relationships, mind, and cancer.<sup>289</sup> Siegel's 1983 book, *Love, Medicine, and Miracles* was published in paperback in 1986, and remained on the *New York Times* paperback best sellers list from 1990 to 1994. He referenced a variety of studies, unfortunately without clear citations, that drew out these patterns. Siegel claimed that housewives developed cancer 54 percent more often than others. "Little thought has been given to the possibility that the housewife's high risk of cancer may be due to her feeling trapped and the fact that often she is not living the life she wants but a performance," he said.<sup>290</sup> Like LeShan, he then went on to cite Auden's "Ms. Gee." Unlike LeShan, Siegel included the bit about how "childless women get [cancer]," but he it was still clear that he thought the definition of "creative fire" needed to go beyond that.<sup>291</sup> Siegel's approach to gender came up again when he said that "Compared with patients who did well, those whose disease progressed fastest were more conformist to sex-role stereotypes and developed images that were more concrete and less creative or symbolic."<sup>292</sup>

In addition to his generalizations, Siegel's case narratives showed the way he thought gender roles could be harmful. One example he gave, "A cancer patient named Sandy" had

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<sup>288</sup> Bernie S. Siegel, *Love, Medicine, And Miracles*, (New York: Harper Perrenial, 1998), 18-22.

<sup>289</sup> Anne Harrington, *The Cure Within*, 196.

<sup>290</sup> Bernie S. Siegel, *Love, Medicine, And Miracles*, 82.

<sup>291</sup> Bernie S. Siegel, *Love, Medicine, And Miracles*, 82.

<sup>292</sup> Bernie S. Siegel, *Love, Medicine, And Miracles*, 116.

written to Siegel with her story. She had been “conditioned to be a ‘doormat’” by her mother emotionally abused her and mocked her weight. Her first husband had “started staying out all night, then coming home drunk and beating her.” When she brought up divorce he had threatened to drive their whole family off a cliff. Simonton said that “During a second marriage in which she again took a subordinate role, Sandy developed breast cancer. At that time, she redirected her life and is well today.”<sup>293</sup> He referenced another woman who was a “flower child” but tried to fulfil her parents’ wishes and “grow up.” But after cancer, she felt she had the permission to go “back to her authentic loving self and is well today.”<sup>294</sup> More of his patients would say that they would “do anything to get well” but then worried that the schedule of activities would keep them from getting dinner on the table on time.<sup>295</sup> These examples show that he thought strict expectations about how women should behave, serve their families and their husbands got in the way of who they were authentically and squashed their dreams.

Even some doctors who argued that women’s changing lifestyles increased the incidence of disease suggested implementing social changes which furthered feminist goals in order to protect women’s health. Paul J. Rosch was the founder and president of the American Institute of Stress in Yonkers New York. He maintained ties with key figures in stress and psychosomatic research through a fellowship with Hans Selye in Montreal and “co-authored works with Dr. Selye as well as Dr. Flanders Dunbar.”<sup>296</sup> In 1986, he argued that feminism may have increased breast cancer by encouraging women to pursue careers where type A behavior was encouraged

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<sup>293</sup> Bernie S. Siegel, *Love, Medicine, And Miracles*, 78-79.

<sup>294</sup> Bernie S. Siegel, *Love, Medicine, And Miracles*, 93.

<sup>295</sup> Bernie S. Siegel, *Love, Medicine, And Miracles*, 96.

<sup>296</sup> “About AIS: History,” The American Institute of Stress, Accessed June 14, 2018, Stress.org

and where they would encounter more work stress.<sup>297</sup> The delay in marriage and childbirth for education and career further increased breast cancer risk, he noted. Rosch carefully pointed out that he did not advocate reversing the gains of feminism or changing demographic patterns. Instead he argued that the ill health effects of stress required greater attention to creating less stressful work environments for both men and women. Rosch continued his attempt to balance his understanding of stressors in women. For example, he pointed out that “[s]ingle working women have fourteen times the average risk of ovarian cancer than a matched group of homemakers.” Rosch went on to blame job stress but then suggested that this stress is “sometimes because of overt and covert sexual harassment... In addition, [women] find that despite equal or superior training, experience and ability, they are paid less than their male counterparts, and usually reach a dead end when they try to reach the upper rungs of the corporate ladder.”<sup>298</sup> Career stress was not healthful, he claimed, but his explanations pushed for a general reformulation of the American workplace, a more equal distribution of work by gender, and more respectful treatment of women.

## **Holdovers**

A few people did continue to make arguments which echoed the racial and gender politics researchers in the 50s and 60s. However, these were either increasingly fringe voices or contrarians within their fields. The clearest examples of arguments reprising older ideas about gender roles and race came from J. I. Rodale, a self-published health writer, and Hans Eysenck,

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<sup>297</sup> Paul J. Rosch, “Job Stress May Explain Rise in Breast Cancer,” *New York Times*. December 30, 1986, A18.

<sup>298</sup> Paul J. Rosch, “Stress and Cancer: As explained by Dr. Paul Rosch...” The American Institute of Stress, <http://www.stress.org/stress-and-cancer/> Accessed July 15, 2013.



whose other research kept him at the top of his field, but whose work on cancer was increasingly out of touch and ignored and whose writing on race and gender was often inflammatory. In their work, women devoted to their families or in caring professions were considered emotionally fulfilled and women without that outlet [typically maiden aunts and career women] were considered emotionally repressed. Emotional and creative outlets were considered necessary for both men and women. But those outlets were clearly defined: for women it was family life and for men it was labor. It is important to note that researchers who leaned most heavily in this direction were, by the 80s and 90s, largely seen as cranks. The isolation of these researchers and writers is indicative of the strengths of trends towards more critical view of gender roles in mind-body medicine.

Hans Eysenck continued to publish papers on cancer which further reinforced gender norms. In the early 80s he began working with Grossarth-Maticek, a sociologist from the University of Heidelberg, to study personality and health.<sup>299</sup> Grossarth-Maticek had collected data between 1966 and 1976 in the Yugoslavian town of Crevenka. His data included personality data, cholesterol levels, major health events, and prevalence and mortality statistics over this ten-year span.<sup>300</sup> This data set provided the basis for the papers they wrote together.<sup>301</sup> Eysenck carried his existing frustration with the feminist movement into his research. After publishing his ideas on the relationship between the biological fixity of intelligence and race in his 1965 book, *Race, Intelligence and Education*, he proceeded to argue for the biological fixity of gender

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<sup>299</sup> Roderick D. Buchanan, *Playing with Fire: The Controversial Career of Hans J. Eysenck*. (New York: Oxford University Press, 2010.), 361.

<sup>300</sup> Ronald Grossarth-Maticek et al., "The specific action of different personality risk factors on cancer of the breast, cervix, corpus uteri and other types of cancer: A prospective investigation," *Personality and Individual Differences* 23, no. 6 (1997): 951.

<sup>301</sup> Roderick D. Buchanan, *Playing with Fire: The Controversial Career of Hans J. Eysenck*. (New York: Oxford University Press, 2010.), 380.

norms.<sup>302</sup> While he did allow for exceptions, Eysenck claimed that many women who chose to pursue radical equality with men “would regret bitterly not having lived a complete family life, and enjoyed adornment, romantic love and role fulfillment.”<sup>303</sup> Unable to find a publisher for his book on sex in the United States, he continued to include his ideas on biologically appropriate gender behavior in his cancer research.

In one 1997 study, Grossarth-Maticek, Eysenck and their coauthors attempted to test ten hypotheses about the personalities of women who developed specific forms of cancer. One of the hypotheses is striking in the extent that it implies the healthfulness of traditional femininity. They hypothesized that “[t]hose women who later develop cancer of the corpus uteri tend to have a more ambivalent attitude toward the mother role than other women.”<sup>304</sup> Though it was a widely accepted risk factor for uterine cancer, the authors did not mention nulliparity, or having fewer children. Rather, they created a personality trait that categorized women with few or no children as inherently different and made an etiological claim based on personality rather than life history. In doing this they pathologized the personalities of women without children. This clearly reflected Eysenck’s belief that feminists chose career over family, and that they would regret this decision. The claims of this study echo the arguments of Freudian psychiatrists from fifty years before. However, despite the similarity of their hypotheses about ambivalence to motherhood,

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<sup>302</sup> Eysenck “suggested African Americans were a non-random subset of native African populations whose forebears were selected for dullness by slave traders... Likewise, Eysenck attributed other ethnic and national differentials in measured intelligence to similar mechanisms—explaining low Irish IQs, for example, by suggesting their best and brightest were the first to emigrate.” Roderick D. Buchanan, *Playing with Fire: The Controversial Career of Hans J. Eysenck*. (New York: Oxford University Press, 2010.), 290-291.

<sup>303</sup> Hans Jürgen Eysenck, *Rebel With a Cause: The Autobiography of Hans Eysenck* (New Brunswick: Transaction Publishers, 1997), 226.

<sup>304</sup> Ronald Grossarth-Maticek et al., “The specific action of different personality risk factors on cancer of the breast, cervix, corpus uteri and other types of cancer: A prospective investigation,” *Personality and Individual Differences* 23, no. 6 (1997): 950.

disturbed sexuality, and relationships with parents, Eysenck remained committed in his arguments against psychoanalysis. But he was just as committed in his beliefs about the biological reality of gender roles.

Despite the civil rights movement, far less was done to reevaluate the racial aspects of psychological descriptions of cancer patients. The descriptions of black women with cervical cancer that we saw in chapter one no longer appeared in the writing of popular authors like Simonton and LeShan, or in the work on stress from those like Rosch. Unlike the transformation of case narratives for women, there was no serious attempt to reformulate explanations for racially disparate rates of cancer. Instead the topic was mostly ignored. However, a few writers did continue this line of questioning. Unsurprisingly, Eysenck continued to use racialized descriptions of cervical cancer patients. Far across the spectrum of academic respectability from Eysenck, J.I. Rodale, editor of the magazines *Prevention* and *Organic Farming and Gardening* and early proponent of organic farming, wrote about his fears that the anger of blacks (now more visible to whites) might cause an increase in cancer rates among African Americans.

Eysenck and Grossarth-Maticek's treatment of cervical cancer was similar to their work on uterine cancer, but relied specifically on stereotypes of black women. Without mentioning HPV, they claimed to test four different hypotheses about women with cervical cancer. One was that "[t]hose women who later develop cervical cancer have more quick-changing relationships whereby their needs and expectations are more frustrated than other women."<sup>305</sup> The remaining three traits included idolization of the father, dominating mothers, and higher sadomasochistic tendencies. Each of these traits implied a connection with the promiscuous behaviors described

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<sup>305</sup> Ronald Grossarth-Maticek et al., "The specific action of different personality risk factors on cancer of the breast, cervix, corpus uteri and other types of cancer: A prospective investigation," *Personality and Individual Differences* 23, no. 6 (1997): 950.

by the first hypothesis. As they did with uterine cancer, the authors created personality traits that they believed partially overlapped with an accepted risk factor. HPV had been identified as a cause of cervical cancer by 1985, when the *New York Times* reported that multiple labs had identified the connection.<sup>306</sup> In the end, Eysenck and Grossarth-Maticek had to admit that they could not predict cervical cancer particularly well. Lack of fully conclusive data or perfect study design is something they, like many other researchers, were willing to admit. And like many others, Grossarth-Maticek and Eysenck made the claim that the evidence so far, though incomplete, at least demonstrated that they needed to conduct the larger, better planned, better-funded trials that would prove conclusively that they had been right all along. The authors' conclusions did not mention race. However, given the earlier attempts to explain racial differences in cervical cancer rates through personality and Eysenck's earlier work on race, it is necessary to understand the racial implications of their claims about cervical cancer. In 1975, while Grossarth-Maticek was completing his data collection, cervical cancer was 2.5 times more prevalent among black women than white women. Mortality rates were 2.8 times higher for blacks than for whites.<sup>307</sup> The personality traits hypothesized as relevant for cervical cancer echo stereotypes of black women, particularly the researchers' search for dominating mothers and instability in relationships.

Through his personal press, J.I. Rodale published *Happy People Rarely Get Cancer* in 1970 and tried to address the connection of the civil rights and Black Power movements to

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<sup>306</sup>Harold M. Schmeck, "Common Virus Linked to Cancer," *New York Times*, Feb. 12, 1985: C1, C6.

<sup>307</sup> "Age-Adjusted SEER Incidence Rates by Race/Ethnicity Cervix Uteri, All Ages, Female 1975-2015 (SEER 9)" and "Age-Adjusted U.S. Mortality Rates by Race/Ethnicity, Cervix Uteri, All Ages, Female 1975-2015," Survey Epidemiology and End Results. <https://seer.cancer.gov/faststats/selections.php?#Output>

cancer in an attempt to define and channel a healthful black masculinity. Rodale argued that proper nutrition and exercise would promote happiness and happiness would, in turn, prevent cancer. Rodale demonstrated this connection between nutrition, exercise, health, happiness, and cancer largely by relying on stereotypes of different racial and ethnic groups. For his chapter on the “The Happy Hunzas”, he drew on the work of an earlier anthropologist; for his ideas about differing cancer rates within the U.S. he used a few articles about Italian Americans in Roseto, but he primarily relied on his own prejudices. He explained how his thought process on this began in 1964:

the thought struck me, that if happy people don't get cancer, or get less cancer, then Negroes should get less cancer than whites, for the Negro race is a happy race. True, there is their problem of segregation, but the Negro nature being what it is, I think a Negro sings just the same, and is not going to let segregation dampen his spirits as much as a similar problem would do to a white person.<sup>308</sup>

While Rodale began to acknowledge the pain of segregation, he used racist tropes to minimize its effect and categorically separated whites and blacks by pointing to “the Negro nature.” Relying on “happy Sambo” stereotypes of blacks as happy on the farm, resistant to pain, and unfazed by the experiences of racism, Rodale continued his analysis with his understanding of changing black temperament. The conclusion of his books seems addressed to his understandings of black power and urban rebellion of the late 1960s. Rodale asked:

Will the present day demonstrating and violent activities of students and Negroes give them more cancer? A young Negro fellow about 25 passed me on Madison Avenue in New York City, a few weeks ago, his face distorted with hate. He said, “Man, you're on my land” and kept on moving... There is no question about it- the tensions are increasing, and we may expect this to further increase the incidence of cancer.”<sup>309</sup>

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<sup>308</sup> J.I. Rodale, *Happy People Rarely Get Cancer*, (Emmaus: Rodale Press, 1970), 6.

<sup>309</sup> J.I. Rodale, *Happy People Rarely Get Cancer*, 208.

Rodale's implication that it was better for blacks to await change and embrace their happy "nature" devalued all resistance. Hatred was what he saw in blacks, not something he could recognize in his fellow white Americans. Perceiving black emotionality and rage as a threat to black health did, however, require some recognition of black emotional life and ability to experience pain. Where cancer was seen as a disease of civilization, this meant recognizing a kind of internal life, even if they did not believe these feelings conveyed any of the depth or complexity that white women and men might experience.<sup>310, 311</sup> Despite the fact that this book strayed from trends toward ignoring race in mind-body cancer writing, and the fact that this was a self-published book, Rodale was regularly cited in other mind-body literature on cancer (even occasionally in academic work), but without his emphasis on race. For example, *Happy People*

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<sup>310</sup> For more on cancer and perceived level of "civilization" and for more on the assumption that cancer implied an emotional life too sophisticated for blacks see: Keith Wailoo, *How Cancer Crossed the Color Line*, (Oxford: Oxford University Press, 2011).

<sup>311</sup> Dr. Martin Luther King, Jr. also thought that conditions in the 60s might lead to deteriorating health for black Americans. King, however, saw the slow pace of change as a threat to emotional and physical health. He believed that shattered hopes and denied justice could push people to fall into unhealthy personality patterns. Without clear acceptance of the problems one faced and a "radiant hope" in the face of unjust conditions, people would crumble. In his book of sermons, *Strength to Love* (first published in 63), King wrote that, "One possible reaction [to shattered dreams] is to distill all of our frustrations into a core of bitterness and resentment. The person who pursues this path is likely to develop a callous attitude, a cold heart, and a bitter hatred toward God, toward those with whom he lives, and toward himself. Because he cannot corner God or life, he releases his pent-up vindictiveness in hostility toward other people." Not accepting God's peace and love and instead clinging to these angers and resentments, "poisons the soul and scars the personality, always harming the person who harbors this feeling more than anyone else. Medical science reveals that such physical ailments as arthritis, gastric ulcer, and asthma have on occasion been encouraged by bitter resentments. Psychosomatic medicine, dealing with bodily sicknesses which come from mental illnesses, shows how deep resentment may result in physical deterioration." Medical science and psychosomatic medicine were one and the same to King. While he used psychosomatic medicine to make different arguments— that love must drive responses to conflict and that racism could destroy health— his comfort with arguments about arthritis, ulcers, and asthma show the extent to which psychosomatic medicine had permeated popular culture. Martin Luther King, *Strength to Love*, (New York: Pocket Book, 1964).

*Rarely Get Cancer* was even mentioned positively alongside the work of LeShan, the Simontons, and Norman Cousins in an essay by Paul Rosch which was published in a volume edited by Hans Selye.<sup>312</sup>

### **Acknowledging Structures, Addressing Blame**

The second major change in the literature on mind-body medicine to occur in the late 1970s and 80s was the development of a conversation about blame, guilt, and cancer. I argue that this grew out of increasing interest in structural problems and inequality which challenged older notions about personality, individual responsibility, and disease. While it was psychoanalysts in the 50s and 60s who most clearly connected psychopathology with carcinogenesis, it was those in the 1970s and 80s whose research was most directly challenged for improperly placing blame on cancer patients. This conversation paralleled larger discussions about whether or not America really was a place of equal opportunity or whether structural problems shaped how far people made it in life. Recognizing the impact of environment, poverty, race, and gender made it harder to believe that America was a place where people got what they deserved, or that positive thinking and hard work were cure-alls. Americans began having conversations about “victim blaming” more generally and these filtered into conversations about disease. While feminism reshaped the case narratives and depictions of emotionally repressed cancer patients—providing new relevance for theories of emotion and disease—social movements were also influential in shaping critiques of mind-body medicine. Both the civil rights movement and second wave feminism encouraged a reappraisal of older beliefs about equal opportunity, meritocracy, and the

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<sup>312</sup> Paul J. Rosch, “Stress and Cancer: A Disease of Adaptation,” in *Cancer, Stress and Death* ed. Jean Tache', Hans Selye, and Stacey B. Day, (New York: Plenum Medical Book Company, 1979), 204.

American Dream. Myths of fairness in the United States had bolstered psychosomatic medicine, particularly the positive thinking varieties described in chapter one. As the nation forcefully confronted the reality that opportunities were not shared and many Americans did not get what they deserved, many turned these observations to healthcare and disease. Feminists specifically challenged the labeling of women's diseases as psychosomatic complaints. They saw this as simultaneously trivializing women's bodily experiences, and obstructing their access to necessary medical care. From civil rights advocates came the specific language of "blaming the victim" and an analysis of the ways in which psychology was used to explain away the difficulties black Americans faced in accessing healthcare, securing an education, and finding jobs and housing—all without discussing racial discrimination or structural problems. These broader critiques of psychology, healthcare, and psychosomatic medicine fueled arguments that mind-body theories about cancer blamed patients for their disease.

Despite increasingly patient-driven interpretations of events and disease narratives, questions about blame increased dramatically in the late 1970s and 80s. From the pages of the *NEJM* to the *New York Review of Books*, blame became an inescapable question in mind-body cancer care. When Susan Sontag, a novelist, playwright, and essayist, and the winner of a MacArthur Genius Grant, an American Book Award, and a National Book Critics Circle Award, published her multipart 1978 essay "Illness as Metaphor" in the *New York Review of Books*, the question of blame came to the forefront.<sup>313</sup> She persuasively argued in this widely read piece (which was quickly turned into a book) that all attempts to explain cancer through personality factors or character traits were the result of our lack of knowledge about cancer and they created

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<sup>313</sup>Margalit Fox, "Susan Sontag, Social Critic with Verve, Dies at 71," *New York Times*, Dec. 29, 2004.



only blame for those with illness. This forced a response from practitioners. The Simontons and LeShan both began writing about why their own theories were not blame driven, but rather about finding opportunities to reshape one's life in the face of cancer.

During the 1970s feminist critiques of psychosomatic medicine began to gain ground. From the Boston Women's Health Book Collective (covered in the next chapter) to articles published in medical journals and popular magazines, these critiques were ubiquitous. They argued that psychosomatic diagnoses were most frequently used for women's "complaints" and, moreover, that the descriptions of these patients were often unflattering. It seemed as if "psychosomatic" was simply a label used to mark difficult female patients, clearing doctors of responsibility for their care. The 1973 article in the *NEJM* mentioned earlier in this chapter claimed "[a]n erroneous belief in psychogenesis is damaging to the patient in many ways, though possibly convenient for the doctor."<sup>314</sup> The author worried that this would allow "irrational and ineffective treatment of prolonged and severe pain to continue in the otherwise analgesia-oriented 20th century."<sup>315</sup> Another article in *Social Science & Medicine* argued that "Contemporary physicians are similarly accused of arbitrarily defining women's complaints as psychosomatic, and using mood-modifying drugs, as they earlier used gynecological surgery, to calm their unruly patients."<sup>316</sup> Popular magazines echoed these points. Even the less radical magazine *Redbook*, printed an article titled "It's Your Body... Not Your Doctor's" in which the

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<sup>314</sup> Lennane, K. J., & Lennane, R. J., "Alleged Psychogenic Disorders in Women — A Possible Manifestation of Sexual Prejudice," *New England Journal of Medicine* 288, no. 6 (1973): 288-292.

<sup>315</sup> Lennane, K. J., & Lennane, R. J., "Alleged Psychogenic Disorders in Women — A Possible Manifestation of Sexual Prejudice," *New England Journal of Medicine* 288, no. 6 (1973): 288-292.

<sup>316</sup> Constance Nathanson, "Sex, Illness, and Medical Care: A Review of Data, Theory and Method," *Social Science & Medicine*, Vol 11, 1 (1977): 22.

author mentioned knowing “doctors who are authoritarian, condescending, paternalistic and sexist; who assume that women are ignorant and passive and want to be told what to do; who feel that most ‘ladies’ problems’ are psychosomatic, simply a manifestation of women’s assumed hyperactive emotions.”<sup>317</sup> The author characterized this as a “kind of psychological abuse” and believed it was “passed along from one generation of gynecologists to the next by way of research traditionally conducted by men and textbooks written by men.”<sup>318</sup>

While feminist critiques of psychosomatic medicine focused on the trivialization of women’s experiences and excuses for failing to provide proper care, other critiques drew together issues of blame in psychological explanations of various phenomena. Examining the origins of the phrase, “blaming the victim,” shows how this fit into the ideology of social movements. The phrase comes from the title of a 1971 book that became “one of the all-time academic best sellers.”<sup>319</sup> The author of *Blaming the Victim*, William Ryan, was a sociology professor with a Ph.D. in psychology. The book was largely a response to the Moynihan Report. Published in 1965, “The Negro Family: The Case for National Action” (frequently referred to as the Moynihan Report), covered the state of racial inequality in the United states. Written by Patrick Moynihan, the Department of Labor Secretary, the report was meant to argue that Civil Rights legislation on its own, without addressing economic inequality, would be insufficient because Civil Rights was “a movement for equality as well as for liberty.”<sup>320</sup> Without providing

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<sup>317</sup> Evalyn Gendel and Dalma Heyn, “It’s Your Body... Not Your Doctor’s,” *Redbook*, Vol. 142, 5 (March 1974): 89.

<sup>318</sup> Evalyn Gendel and Dalma Heyn, “It’s Your Body... Not Your Doctor’s,” *Redbook*, Vol. 142, 5 (March 1974): 89.

<sup>319</sup> Associated Press, “William J. Ryan, 78, Sociologist; Explored the Blaming of Victims,” *New York Times*, June 13, 2002.

<sup>320</sup> U.S. Department of Labor Office of Policy, Planning and Research, “The Negro Family: The Case for National Action,” (1965), 2.

jobs, Moynihan argued, equality would be difficult if not impossible to achieve because of both ongoing racism and what he perceived as problems within black families that developed in the face of slavery, racism and segregation, leading to a “cycle of poverty.” He referred to this as “the tangle of pathology” and argued that it was “capable of perpetuating itself without assistance from the white world.”<sup>321</sup> Ryan argued that victim blaming was a type of ideological response that allowed people (particularly white, middle class liberals) to hold the contradictory beliefs that the system in which they have succeeded is just and while also being “acutely aware of poverty, racial discrimination, exploitation and deprivation, and, moreover, [wanting] to do something concrete [about it].”<sup>322</sup> Identifying problems with the victims’ upbringing, family structure, or psychology, perhaps stemming from years of discrimination, and responding to those problems instead of acknowledging ongoing inequities allows people to have it both ways. Ryan noted that it could be hard to spot victim blaming because “those who practice this art display a deep concern that is quite genuine.”<sup>323</sup> He identified the process of victim blaming in American liberal concern about “matriarchy” in black families, writing about a culture of poverty, and the focus on psychological problems with black children as a cause of achievement gaps instead of focus on problems with educational institutions, curriculum, underfunding, and segregation.

With Ryan’s background in psychology, his book was really about the invention or identification of psychological traits to explain away racial disparities. He turned (though not to psychosomatic medicine as covered in this dissertation) also to the ways that psychology was

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<sup>321</sup> U.S. Department of Labor Office of Policy, Planning and Research, “The Negro Family: The Case for National Action,” 47.

<sup>322</sup> William Ryan, *Blaming the Victim* (New York: Pantheon Books, 1971), 27.

<sup>323</sup> William Ryan, *Blaming the Victim*, 6.

used to blame the victims of health inequalities. He pointed out that “the dominant style in American social welfare and health activities” was “to treat what we call social problems, such as poverty, disease, and mental illness, in terms of the individual deviance of the special unusual groups of persons who had those problems.”<sup>324</sup> The use of the term “victim blaming” stuck.

Figure 1 below shows both the rise of this term, as well as a general increase in concern about blame being misplaced on individuals. The use of “victim blaming” filtered from concerns about structural racism, to health to specific discussions of mind-body cancer theories.



**Figure 1. Changing use of “victim blaming” and related language: Percentage of books available on Google Books which use “blame the victim,” “victim blaming,” and “self blame.”<sup>325</sup>**

Ryan’s concepts were explicitly used to re-evaluate approaches to disease. For example, Susan Reverby directly tied together victim blaming with public health. In a 1972 article in the *American Journal of Public Health*, Reverby argued that the view of disease as evidence of “maladjustment of the host to the existing environment” was “symptomatic of what William Ryan has called the American ‘blaming the victim’ syndrome.” She believed that this

<sup>324</sup> William Ryan, *Blaming the Victim*, 15.

<sup>325</sup> Graph from Google Ngrams. <https://books.google.com/ngrams>

interpretation of disease as an individual failing was closely related to beliefs about “laissez-faire” economics and “Horatio Alger” types of stories. Instead, she argued that we should view disease “in a completely opposite way; that is the maladjustment of the existing environment to the host.”<sup>326</sup> The 1984 edition of *Our Bodies, Ourselves*, despite a strong interest in mind-body approaches, included a brief section titled “Blaming the Victim.” “This kind of thinking,” they warned, “again disregards political and social factors. And sometimes, no matter how much we try to stay healthy, we become ill. It is both cruel and useless to blame ourselves or let others blame us for getting sick.”<sup>327</sup>

The Simontons were among the first to respond to this discourse in their work. In *Getting Well Again*, they acknowledged that some patients would “feel guilty about their actions in the past” after they saw “how their beliefs and behaviors in response to stress may have contributed” to the disease.<sup>328</sup> But they urged their readers to take the same advice they gave their own patients: to remember that is not useful or accurate for them to blame themselves, because they argued that there was a difference between “being ‘to blame’ for something and having ‘participated’ in it.”<sup>329</sup> People are only to blame for something, they argued, if they choose it consciously, and their patients did not choose cancer. Second, they believed that to the extent that they participated in their disease, they did so because of the shape of our culture. This was not about blame, rather they argued people “who begin to accept responsibility for influencing the state of their health deserve the greatest of congratulations.” They deserved congratulations

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<sup>326</sup> Susan Reverby, “A Perspective on the Root Causes of Illness,” *American Journal of Public Health*, 72, no. 8 (1972): 1140.

<sup>327</sup> The Boston Women’s Health Book Collective, *The New Our Bodies Ourselves* (New York, Simon & Schuster, 1984), 57.

<sup>328</sup> O. Carl Simonton, Stephanie Simonton, and James Creighton, *Getting Well Again*, 124.

<sup>329</sup> O. Carl Simonton, Stephanie Simonton, and James Creighton, *Getting Well Again*, 124.

because looking at your “own attitudes, emotions, and feelings” is hard, but moreover because it is challenging to “[find] the courage to stand up to the cultural rules” and “to reject those that are not conducive to health.”<sup>330</sup> They said it made “no sense to blame persons living in this society for becoming ill in light of the rules they were taught for dealing with their emotions and feelings.”<sup>331</sup> Their program then offered a way of responding to a society wide failure to develop healthy emotional patterns. This cultural failure caused cancer, but individuals were empowered to break out of that cycle through personal change.

LeShan also made it clear that he saw this as a chance for empowerment, but did not (yet) directly engage with questions of blame in *You Can Fight for Your Life*. However, he was careful about how he wrote about patients who died. His book was dedicated to these patients, “the brave companions, the pioneers, who trusted me and helped me learn; who struggled with courage and passion beyond describing.”<sup>332</sup> He also spent part of the book writing about the successes of his patients who died, noting that for many “it has been possible to help them achieve a sense of personal fulfillment they had never previously enjoyed.”<sup>333</sup> They may not have survived, he argued, but they lived deeper. This focus on living deeply rather than surviving helped to pivot away from blaming patients who died. It acknowledged the limitations of the mind and of therapy, and reminded the reader that dying was a normal process.

Susan Sontag’s book *Illness as Metaphor* focused on cancer to argue that “[p]sychological theories of illness are a powerful means of placing the blame on the ill.”<sup>334</sup> She

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<sup>330</sup> O. Carl Simonton, Stephanie Simonton, and James Creighton, *Getting Well Again*, 125.

<sup>331</sup> O. Carl Simonton, Stephanie Simonton, and James Creighton, *Getting Well Again*, 124.

<sup>332</sup> Dedication from Lawrence LeShan, *You Can Fight for Your Life*, (Lanham: M. Evans, 2014).

<sup>333</sup> Lawrence LeShan, *You Can Fight for Your Life*, (Lanham: M. Evans, 2014), 67.

<sup>334</sup> Susan Sontag, *Illness as Metaphor* (New York: Farrar, Straus and Giroux, 1978), 57.

compared the metaphoric use of cancer with that of tuberculosis prior to a discovery of cause and treatment. Sontag carefully laid out the emotional stereotypes about people with tuberculosis or consumption: that they felt too much, or perhaps were too good for the world. Tuberculosis, she notes, was considered a romantic disease. Sontag then drew the comparison to perceptions of cancer patients. “Cancer,” she said, “is generally thought an inappropriate disease for a romantic character, in contrast to tuberculosis, perhaps because unromantic depression has supplanted the romantic notion of melancholy.” Melancholy, like that of someone with tuberculosis would, in the words of Poe, “ever be found inseparable from the perfection of the beautiful.” For Sontag, the depression of a cancer patient was “melancholy minus its charms—the animation, the fits.”<sup>335</sup> She continued to describe the depression and emotional repression described in cancer studies and the “prescriptions for self-expression, from talking it out to the primal scream.”<sup>336</sup> Finally, Sontag looked at the use of cancer as a metaphor for social problems. Cancer, as a disease of uncontrolled growth with extreme treatment modalities, became a metaphor for social evils of all kinds. Sontag gave examples ranging from general uses of disease as metaphors for problems of the “body politic” to more specific uses of cancer.<sup>337</sup> For example “Trotsky called Stalinism the cancer of Marxism” and Sontag noted that she herself had once written that “the white race is the cancer of human history.”<sup>338</sup> The ways in which cancer was described, she argued, could blame patients for their disease, paint a picture of cancer as a stain on the patient, justify more harmful therapies, and cement a picture of cancer as invariably fatal.

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<sup>335</sup> Susan Sontag, *Illness as Metaphor*, 50.

<sup>336</sup> Susan Sontag, *Illness as Metaphor*, 53.

<sup>337</sup> Susan Sontag, *Illness as Metaphor*, 72.

<sup>338</sup> Susan Sontag, *Illness as Metaphor*, 84-85.

At the core of Sontag's arguments against cancer metaphors in public life, battle language, and attempts to fill gaps in knowledge with psychological explanations was her belief that these things led to blame. "Nothing," she argued, "is more punitive than to give a disease a meaning—that meaning being invariably a moralistic one."<sup>339</sup> In addition to the fact that these theories made people responsible for the onset of disease, the explanation of their failings was often, according to Sontag, individual and moral. Moreover, she said that "Ostensibly," when someone loses a battle to cancer, "the illness is the culprit. But it is also the cancer patient who is made culpable."<sup>340</sup> Those who develop cancer, the group Sontag calls the "luckless ill" are given "the ultimate responsibility for falling ill and for getting well." Ultimately Sontag believed these theories blamed patients for carcinogenesis, failure to respond to treatment, coming out of remission, metastases, and death. More than identifying "responsibility" or providing hope in the face of disease, this was a way, she argued, that patients were "made to feel that they have deserved it."<sup>341</sup>

This debate moved into the *New England Journal of Medicine* after they published an article by Neil Fiore, a psychologist at the University of California Berkley Counseling Center, in 1979 describing his experience with cancer and his choice to use the Simonton visualization technique.<sup>342</sup> [Other aspects of the ongoing *NEJM* debate about mind-body medicine and cancer are covered in chapter five]. In support of using this technique, Fiore pointed to the physiological work of Hans Selye on stress, the psychological work of David Kissen, and PNI studies. He argued that psychological care and visualization training should be provided by hospitals. The

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<sup>339</sup> Susan Sontag, *Illness as Metaphor*, 58.

<sup>340</sup> Susan Sontag, *Illness as Metaphor*, 57

<sup>341</sup> Susan Sontag, *Illness as Metaphor*, 57.

<sup>342</sup> Neil Fiore, "Fighting Cancer—One Patient's Perspective," *New England Journal of Medicine*, 300, no. 6, (1979): 284-289.



correspondence sent to *NEJM* about Fiore's article was divided around questions of blame, guilt, and hope. Negative responses to visualization and other psychologically driven approaches to cancer focused on guilt, while positive responses argued that patients often engaged in self-blame regardless of psychological care, which could instead be seen as an empowered response. Responses to issues of blame always accompanied questions of efficacy in the correspondence. One doctor wrote a letter to editor saying that "No convincing evidence exists that mental attitude influences the course of cancer." He worried about the guilt in patients who did not recover, but noted that "hope and cheerfulness are valuable, whether or not they contribute to remission or cure."<sup>343</sup> Another doctor, citing Sontag, wrote that the type of article that Fiore made had "the potential for causing great harm to the patient who believes that some behavioral trait or moral flaw, e.g., depression or helplessness, is actually causing his or her disease." And referred to this as a "punitive myth of cancer."<sup>344</sup> Fiore responded: "A patient who takes an active part in his treatment may feel less guilt, knowing that he has done all that he can, while recognizing that there are things he cannot change or control. Guilt, in fact, can be an expression of an exaggerated sense of control and denial of human vulnerability and mortality."<sup>345</sup> Guilt, they argued, was something many people had an existing talent for regardless of ideas about personality, stress, or visualization- after all "Why me?" questions are not unique to psychosomatic medicine. These techniques could offer a way for people to turn nagging guilt into productive action.

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<sup>343</sup> Lewis Glickman, "Correspondence: Fighting Cancer: The Patient's Perspective," *New England Journal of Medicine*, 300, no 21, (1979): 1219.

<sup>344</sup> Aaron Manson "Correspondence: Fighting Cancer: The Patient's Perspective," *New England Journal of Medicine*, 300, no 21, (1979): 1219-1220.

<sup>345</sup> Neil Fiore, "Correspondence: Fighting Cancer: The Patient's Perspective," *New England Journal of Medicine*, 300, no 21, (1979): 1220.

This debate flared again in the *NEJM* in 1985 when Barrie Cassileth and a group of researchers from the University of Pennsylvania Cancer Center published a study titled “Psychosocial Correlates of Survival in Advanced Malignant Disease?”<sup>346</sup> The special article had a null result, finding no correlation between disease and a variety of psychological traits. It was published alongside an editorial by Dr. Marcia Angell, the deputy editor of the *New England Journal of Medicine*. Where Cassileth’s claims (described in greater detail in chapter five) were limited to the scope of the study, Angell’s article, “Disease as a Reflection of the Psyche” was a broader statement about research on mindset and health. Angell argued that the evidence on mindset and health showed no clear relationship and no useful role in helping patients. Moreover, Angell saw issues of blame in psychosomatic medicine not just as risks to be carefully avoided, but as inherent to that way of thinking. “After all,” she said, “a view that attaches credit to patients for controlling their disease also implies blame for the progression of the disease.”<sup>347</sup>

Beginning by establishing the prevalence of commonly held ideas about personality and health, the editorial pointed to “Books, magazines, and talk shows [which] abound in highly specific advice about achieving the necessary changes, as well as in explanations about how they work.” Angell focused on Norman Cousins and Carl and Stephanie Simonton: Cousins for his explanation of “how he managed to achieve a remission of his ankylosing spondylitis by means of laughter and Vitamin C,” and the Simontons for their work on imagery. Angell poked fun at the simplistic nature of these explanations for health as well as the tired gender tropes at the heart of them. “The connection,” she wrote, “between mental state and disease would seem to be direct

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<sup>346</sup> Barrie R. Cassileth, Edward J. Lust, David S. Miller, Lorraine L. Brown, and Clifford Miller, “Psychosocial Correlates of Survival in Advanced Malignant Disease?” *New England Journal of Medicine*, 312 No.24 (1985): 1551-1555.

<sup>347</sup> Marcia Angell, “Disease as a Reflection of the Psyche,” *New England Journal of Medicine*, 312 No.24 (1985): 1571.

and overriding. The hard-driving executive has a heart attack *because* he is pushing for a promotion, the middle-aged housewife gets breast cancer *because* she is brooding about her empty nest.” Throughout this, Angell showed a clear intellectual connection with Susan Sontag and cited her book *Illness as Metaphor* in her comparison between current ideas about personality and health and earlier explanations of Tuberculosis as a romantic disease of consuming passion. She saw little to no improvement in the amount of evidence supporting current claims.

Angell’s status with the journal prompted concern that hers was the position of the Journal’s whole editorial board. Readers pushed back strongly. The Journal published five letters to the editor in response to her article which, among other things, accused Angell of choosing straw man arguments by focusing on rebutting controversial public figures like Norman Cousins and the Simontons, of ignoring better designed current research that established biological pathways and worked with animal models, and of stifling research by cutting off what they considered a fruitful area of investigation that had many unanswered questions. Doctors from Duke University Medical Center, Beth Israel Hospital, Rice University, and other centers wrote in to emphasize existing evidence of a connection between mind and body. They mentioned hypertension, type A personality, biofeedback, and asthma as conditions which illustrated these relationships.<sup>348</sup> In addition, the past president, president, and president elect of the Society of Behavioral Medicine wrote in to share their worries about Angell’s article.<sup>349</sup> Only one of the

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<sup>348</sup> John O. Brooks III, “Correspondence: Disease as a Reflection of the Psyche,” *New England Journal of Medicine*, 313 no. 21 (1985): 1357-1358. Redford B. Williams, Herbert Benson, and Michael Follick, “Correspondence: Disease as a Reflection of the Psyche,” *New England Journal of Medicine*, 313 no. 21 (1985): 1356-1357.

<sup>349</sup> Redford B. Williams, Herbert Benson, and Michael Follick, “Correspondence: Disease as a Reflection of the Psyche,” *New England Journal of Medicine*, 313 no. 21 (1985): 1356-1357.

five challenged her position on issues of blame, the rest ignored it. The only comment on guilt expressed agreement with Angell's claim that "knowledge of a certain coping style that favors health or prevention of relapse of disease is a burden *when [a patient] is unable to achieve it.*"<sup>350</sup> Nonetheless, the author argued that it was still worth it if these coping styles were medically useful. Angell's position on guilt was again tentatively supported by Neil Fiore in his response to the study from Cassileth et al. Fiore said he was "generally in support of Dr. Angell's stance regarding the dangers of speculating about psychosocial factors contributing to cancer or its cure. More than ever before, it must be stated emphatically that cancer is not a punishment for wrong thinking, a weak will to live, or a loser mentality. We are all vulnerable to illness and death."<sup>351</sup> Fiore then continued to write about the values of Simonton's approach and improved psychological care. This position on blame shows the limited effect of this discourse in challenging the commitment of who argued for a continued role for mind-body medicine. For many, there were obvious ways that psychological explanations of disease could be seen as blame-driven, but they mostly saw that as a concern when psychology was used as a single variable explanation of disease, the personality changes that doctors asked for were excessive, or the development of harmful coping styles was viewed as an individual moral failing instead of as a socially conditioned trait.

The work of Sontag also forced questions of blame to come up more directly in the work of Siegel and LeShan. Bernie Siegel had perhaps one of the more tactless ways of explaining away issues of blame, and one that most directly entered into simultaneously occurring

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<sup>350</sup> Rolf Adler, "Correspondence: Disease as a Reflection of the Psyche," *New England Journal of Medicine*, 313 no. 21 (1985): 1358. Emphasis mine.

<sup>351</sup> Neil Fiore, "Correspondence: Disease as a Reflection of the Psyche," *New England Journal of Medicine*, 313 no. 21 (1985): 1354-1355.

discussions of victim-blaming in other areas. Noting that some patients do feel a sense of guilt or self-blame, “just as many children who get sick think their illness is a punishment for being bad.” Acknowledging that this was “not ideal” he nonetheless said that “this attitude is not entirely destructive.” Siegel argued that “those [people who’ve suffered catastrophe] who feel they’ve contributed to it (even if they did not) tend to get over the trauma more easily than those who feel totally helpless.” He explained that this was not just about cancer, but would hold “true for such tragedies as rape, earthquakes, and floods, as well as sickness.” For example,” he argued, “if a woman who has been raped can think, no matter what the circumstances, ‘It wouldn’t have happened if I’d been more careful, if I had learned to protect myself,’ she can reduce her sense of powerlessness and plan to make herself less vulnerable in the future.”<sup>352</sup> Where the Simontons had said that feelings of guilt were more of a misunderstanding, Siegel saw them as valuable; Where others focused solely on responsibility in disease, Siegel stretched his argument to taking responsibility for earthquakes and rape. In short, Siegel argued that self-blame in the face of rape, cancer, or natural disaster could be helpful. Self-blame was still, in Siegel’s mind, a poor replacement for responsibility and self-care. The tone of the conversation, he believed, could help people to take a healthier approach. When he asked: “Why did you need this illness?” he thought it needed to be done “constructively, not as a way of saying ‘look what a mess you’ve made of your life.’” Rather, he “intended to help patients realize that the emotional needs met by illness are all valid.”<sup>353</sup> Like LeShan, Siegel also believed that focusing on mindset did not blame the victim, because death was not a failure of the program. Rather, it was a reality for all people and they could in fact find themselves and their inner peace and still die, but almost as a choice.

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<sup>352</sup> Bernie S. Siegel, *Love, Medicine, And Miracles*, 104.

<sup>353</sup> Bernie S. Siegel, *Love, Medicine, And Miracles*, 111.

After all, he argued, “All people eventually die even when they’ve done beautiful things.”<sup>354</sup>

Counseling and finding peace could be palliative, allowing patients peace as they died. “Today,” he said, “I see that even death can be a form of healing. When patients whose bodies are tired and sore are at peace with themselves and their loved ones, they can choose death as their next treatment.”<sup>355</sup>

It was LeShan who, when he did directly address the question of blame in his 1989 book *Cancer as a Turning Point*, was most strident in his response. He wrote in the preface that:

I believe a serious problem has arisen in recent years. Despite professional background in associated areas, some individuals have a very limited knowledge of the field and have interpreted this approach as one that blames the patient for the illness... These critics talk complete nonsense. Thoughts and feelings do not cause cancer and cannot cure cancer. But they are one factor, and an important one, in the total ecology that makes up a human being.<sup>356</sup>

He not only rejected the arguments of those who would (in his interpretation) mischaracterize his work as blaming the patients, but derided those who would stretch his arguments in ways that did blame the patient. “Anyone,” he said, “who even hints that the person with cancer is responsible for getting it and/or for not getting better is not only the rankest amateur and should be completely ignored, but is setting in motion confusion, anxiety, and anger at the self.”<sup>357</sup>

This conversation about blame, empowerment, hope, and meaning continued among medical and lay people. Discussions of empowerment and blame provided some of the contours of feminist discourse about mind-body cancer care that are explored in chapter four. Meanwhile, the argument that patients could find success through mind-body medicine in the form of either more fulfilling final months and years or a more peaceful death continued to appear. This was not

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<sup>354</sup> Bernie S. Siegel, *Love, Medicine, And Miracles*, 111.

<sup>355</sup> Bernie S. Siegel, *Love, Medicine, And Miracles*, 207.

<sup>356</sup> Lawrence LeShan, *Cancer as a Turning Point*, (New York: Plume, 1994), xiii.

<sup>357</sup> Lawrence LeShan, *Cancer as a Turning Point*, (New York: Plume, 1994), xiv.

just as a way of including those who died as successes in a broader program aimed at survival, but as a justification for mind-body efforts when they proved irrelevant to survival. These arguments about finding new meaning enabled a continued focus on psychological care, support groups, and therapy, even when no measurable connection was found, a trend explored in chapter five.

## **Conclusion**

By the mid 1970s, mind-body approaches to cancer had made a dramatic change from the psychosomatic, psychoanalytic writing of the 1950s and 60s. In place of misogynistic depictions of cancerous women who failed to live out a conventional version of femininity, the new cautionary tales were of men and women who were trapped in repressive gender roles. LeShan, Cantor, Siegel, and the Simontons started to include stories of women who repressed their talents to protect their marriages and their husbands' egos and of men who were trapped by expectations that they be silent, strong, and support their families on a single income. Strict gender roles were explicitly described as dangerous to the health of those caught within them. This was a radical change from the psychoanalytic descriptions of women with cancer.

Meanwhile, a growing discussion of the structural causes of inequality, particularly of health inequality, raised questions about whether or not attempting to fix health by changing individual behavior instead of social conditions led to increased blame. In 1995, Bruce Link and Jo Phelan's highly influential article, "Social Conditions as Fundamental Causes of Disease," continued to draw attention to the limitations of focusing on "individually-based risk factors" without looking at the context and social factors which shape individual behaviors and exposures. They still saw "value and belief systems" as driving the failure of researchers to

evaluate the role of social conditions and structural factors. Like Susan Reverby and William Ryan, they pointed to the belief in the power “of the individual to control his or her personal fate.”<sup>358</sup>

Mind-body medicine in particular was subject to questions about whether its focus on the individual led to empowerment or blame as people for cancer patients. Debates about whether mind-body medicine empowers patients, blames them, or provides hope continue. Mind-body medicine can give the individual a sense of control, and provide a logic to their narrative that helps make sense of disease. However, if the implication is that survival is solely dependent on the patient’s choices, this can serve to blame those who die. Both of these changes grew from both progressive social movements and from shifting economic realities. Going forward, the changes outlined in this chapter would create challenges for those would try to incorporate ideas about mind-body healing into a radical view of healing.

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<sup>358</sup> Bruce G. Link and Jo Phelan, “Social Conditions as Fundamental Causes of Disease,” *Journal of Health and Social Behavior*, Supplemental Issue (1995): 80.



## **CHAPTER FOUR:**

### **Feminists Assess the New Mind-Body Medicine**

During the 1970s and 80s feminists began to reevaluate alternative medicine, and particularly mind-body cancer care. This chapter uses the writing, drafts, and research material of the Boston Women's Health Book Collective (BWHBC), as a way of outlining the terms of this debate. Formed by a group of women who began meeting in 1969, the Boston Women's Health Book Collective aimed to bring women knowledge about their own bodies and allow them to participate in the medical decision-making process. Their primary publication, *Our Bodies, Ourselves* (first published as *Women and Their Bodies: A Course*), has gone through many editions from the first 1970 version to the current professionally edited, textbook length volumes. Between the publication of the first commercial version of *Our Bodies, Ourselves* in 1973 and the major rewrite published in 1984, the collective dramatically changed its position on psychosomatic medicine. The 1973 version almost completely rejected psychosomatic medicine, at least as it was practiced in modern medicine. In 1984, they expressed cautious openness to mind-body cancer care, while warning about issues of blame. Their internal drafts and conversations, however, show that by 1984 most members of the collective agreed that though it should never be a single factor explanation or the only solution, the mind was involved in both carcinogenesis and survival.

This chapter will look at the difficulties presented to the collective by an idea that had the potential to both empower and to promote self-blame. I argue that, in addition to the fact that newer case narratives were sometimes written like feminist parables, there were a variety of other factors which allowed some feminists to embrace mind-body cancer treatments. First, though members initially rejected psychosomatic medicine, they had an existing focus on the

emotional health and personal development of women. Arguing that the emotional changes the collective advocated could promote physical health allowed them to further its existing goals. Second, stripped of its Freudian, misogynistic connotations, mind-body care seemed less like a dismissal and more like care. Third, the Collective developed a greater willingness to explore alternative medicine, which grew in part from developments in feminist theory. Finally, they found new ways of framing solutions for mind-body problems in terms of collective action instead of individual personal growth. In making these arguments, I build on the work of Amy Sue Bix, who showed some of the factors encouraging the BWHBC to embrace alternative medicine more generally, as well as the work of Kathy Davis, who has written about the history of the collective, the ways in which they engaged with broader communities of women, and their legacy of creating engaged readers.

### **About the Collective**

That first book by the Boston Women's Health Book Collective was the product of a small group who were mostly "young, white, [and] college-educated women, many of whom were raising small children."<sup>359</sup> They began working together after meeting at a workshop on "Women and Their Bodies" in 1969 which was held as part of a women's liberation conference at Emmanuel College in Boston. At their gatherings, they talked about their own experiences with "male physicians who were paternalistic, judgmental, or simply unable to provide the information that women needed."<sup>360</sup> The group covered issues relating to sexuality, birth control, and childbirth. Participants began bringing their friends and sisters, expanding the group through

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<sup>359</sup> Kathy Davis, *The Making of Our Bodies, Ourselves: How Feminism Travels Across Borders*, (Durham: Duke University Press, 2007), Location 303.

<sup>360</sup> Kathy Davis, *The Making of Our Bodies, Ourselves*, Location 274.

their personal networks. Initially, the group aimed to develop a list of supportive doctors. But, finding so few that they could agree on, the group began to study medical issues themselves, meeting weekly to share both their research and their own stories in a consciousness raising group type of format. Believing that “the personal is political” they looked to how their experiences were shaped by social, economic, and political factors.<sup>361</sup> They took the papers that they wrote to share with the group, added their individual stories, and took them to the New England Free Press. The book directly invited feedback and stories from other women, with specific notes about chapters they wanted to add where they would need anecdotes.<sup>362</sup> In its first year, *Women and Their Bodies: A Course* sold 250,000 copies.<sup>363</sup> Readers engaged with the material by sending letters and writing to tell their own stories.<sup>364</sup> After the initial success of this book, the collective moved to Simon and Schuster in order to reach a larger group of readers, putting aside their fears of “selling out.” At the point of getting this book contract, they formed a twelve-member core group that would continue the project.<sup>365</sup>

The Boston Women’s Health Book Collective was not a diverse group of women. Despite the way they understood themselves as part of a broader sisterhood of all women, they faced challenges from readers who did not identify with their descriptions of supposedly common experiences and members of their own staff challenged them on issues of racial inclusion. Many women (including nuns, people with mental illness, etc...) wrote in to say that while they loved the book they could not find either their own experiences there or the

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<sup>361</sup> Kathy Davis, *The Making of Our Bodies, Ourselves*, Location 278-292.

<sup>362</sup> Kathy Davis, *The Making of Our Bodies, Ourselves*, Location 303.

<sup>363</sup> Kathy Davis, *The Making of Our Bodies, Ourselves*, Location 300.

<sup>364</sup> Kathy Davis, *The Making of Our Bodies, Ourselves*, Location 292.

<sup>365</sup> Kathy Davis, *The Making of Our Bodies, Ourselves*, Location 303.

information which they needed.<sup>366</sup> Nevertheless, the Collective is still useful as a way to see fault-lines within feminist approaches to health because of the discussions it spurred. Members saved letters, chapter drafts, notes from their conversations, and records of the materials they read. They also evaluated a diverse range of materials as they constructed their chapters. Taking their documents alongside the material that they read, one can begin to see the fault lines and challenges of mind-body approaches to cancer for feminists who to varying degrees saw personal empowerment, environmentalism (particularly with concerns about carcinogens), access to affordable care, personal growth, and issues of blame as central to their understandings of both feminism and health.

The impact of the Collective was farther reaching than its members and its readership, and the lessons imparted were deeper than the information included in the book. Kathy Davis's book, *The Making of Our Bodies, Ourselves: How Feminism Travels Across Borders*, shows how looking at this less than diverse group of women can be useful for understanding the basic terms of a debate to which others then responded. Davis argues that the Boston Women's Health Book Collective is historically important, not just because of the particularly radical content in the books or their relevance to American feminist history. Rather the Collective matters because its publications created empowered readers who learned to see their own embodied experiences as grounds to engage with scientific literature as participants in creating knowledge. Moreover, she argues that the books contribute to feminist epistemology and "body theory." The writing style

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<sup>366</sup> "You have provided for a diversity in women's experience by your chapter on and by women in *Gay Lib*. Why not a parallel chapter on and by nuns?... For the sake of women's liberation it is crucial, I believe, that celibate chastity be shown as a valid and normal way of fulfillment." Boston Women's Health Book Collective Records, 1905-2003; Letter dated October 13, 1973. MC 503, Box 52 Folder 17. Schlesinger Library, Radcliffe Institute, Harvard university, Cambridge Mass.

allowed women to envision themselves in the text and develop their knowledge. From direct invitations to get a speculum and mirror to see and feel their own anatomy to the use of second person pronouns, readers were invited in and then given frameworks for identifying their unique concerns. Moreover, the inclusion of individual women's descriptions of their experiences and decision-making processes, illustrated how people could choose, in their own ways, their medical paths. Readers then could identify where their experiences differed as individuals, where their bodies were different, and challenge the book if it did not include them. Many women wrote in to do just that. Through this process, Davis argues that the book created empowered readers who drew on their own bodies and personal narratives.

Through this openness to challenge and context, the books established a feminist epistemology that could be used by other groups to create culturally specific understandings and approaches to disease. The book was not just translated, it was recreated and adapted in different cultural contexts where women faced different challenges, different public health problems, and different care systems. When other groups started this process, they adopted this belief in their own experiences and engagement, not the specific conclusions or priorities of the Boston Collective. While seeing cultural context as relevant to illness, the Collective's approaches to illness, sexuality, and health never lost sight of the bodily, grounded nature of personal experience, a problem that Davis identifies in the works of theorists like Donna Haraway and Judith Butler who focus on culturally driven explanations. For example, she suggests that for a woman with breast cancer, gender performance and cyborg bodies may help to understand the ways in which people choose to present themselves, and their bodies, and some of the medical decisions they make, but the reality that cancer could kill and may come with severe pain is not reflected in their descriptions. In its attempts to dismantle the idea that women's bodies came

with natural social constraints, Davis argues that feminist theory and history has failed to reconcile the physical realities of bodies or accept the limitations that they can impose for the sick or disabled.<sup>367</sup> Looking at the Boston Women's Health Book Collective's attempt to evaluate mind-body approaches to cancer shows how this particular group waded through competing ideas about psychological, biological, and cultural drivers of illness, and how they tried to weigh and balance them. Kathy Davis' arguments about the function of the books remind us that by writing about this the Collective did not create a uniform stance for all feminists, but rather laid out a series of responses and invited others to challenge them from their own experiences. Their body of work provides a case study to evaluate the conflicts that arose as feminists tried to grapple with the issues of blame and empowerment that are covered in chapter three.

### **Psychosomatic Medicine in the Early Books**

Initially, the Collective was skeptical of all psychosomatic medicine. The first commercial edition of *Our Bodies, Ourselves*, published in 1973, did not focus on either chronic health issues, therapy, or alternative medicine. Rather, these books took standard health advice about common medical problems and made it accessible so that women could make their own decisions. When they did go to doctors, Collective members wanted to be heard and to be taken seriously. They saw psychosomatic medicine as a way of dismissing their medical problems. They referred to it as an "insidious myth" and thought that doctors would only acknowledge the emotions of a patient when they felt "personally attacked and threatened" by their inability to

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<sup>367</sup> Davis, Kathy. *The Making of Our Bodies, Ourselves: How Feminism Travels across Borders*. Reprint. Duke University Press Books, 2007.

“find any physical cause for the symptoms you report.”<sup>368</sup> Despite this overall dismissal of psychosomatic medicine, they noted that “psychiatrists in many medical-education programs do try to help other specialists to see the ‘emotional component’ in the patient’s problems and illnesses” but failure to take this seriously meant doctors only addressed emotion as a last resort or a “weapon” they could use to avoid dealing with patients they saw as nuisances.<sup>369</sup> Their rejection of psychosomatic medicine stemmed not from a belief that emotions and health could not be connected, but frustration with how doctors addressed that connection and used it to dismiss female patients. Moreover, the type of psychosomatic medicine that they described was the use of psychosomatic medicine when the physician could not find a diagnosis, rather than psychosomatic approaches to already diagnosed, severe conditions.

Contemporaneous writing from outside the collective can help to show the types of medical problems which were routinely dismissed as psychosomatic. A 1973 article “Alleged Psychogenic Disorders in Women: A Possible Manifestation of Sexual Prejudice,” in the *New England Journal of Medicine* laid out common assumptions about women’s health and the effect of these assumptions on treatment. With the exception of the author’s discussion of psychosomatic explanations of “Disturbance in Young Babies,” the remainder of the article focused on sensations experienced only by women: primary dysmenorrhea, nausea of pregnancy, and pain in labor.<sup>370</sup> Of the cramps, doctors had said: “The pain is always secondary to an

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<sup>368</sup> The Boston Women’s Health Book Collective, *Our Bodies, Ourselves: A Book by and For Women*, (New York: Simon & Schuster, 1973), 246.

<sup>369</sup> The Boston Women’s Health Book Collective, *Our Bodies, Ourselves*, 246.

<sup>370</sup> The article looked at pain levels which were elevated when compared to a small percentage of women who only experience milder discomfort during labor. Lennane, K. Jean, and R. John Lennane. “Alleged Psychogenic Disorders in Women — A Possible Manifestation of Sexual Prejudice,” *New England Journal of Medicine* 288, no. 6 (1973): 288–292. doi:10.1056/NEJM197302082880605.

emotional problem.”<sup>371</sup> Nausea was, some doctors argued, the result of “irrationally exaggerated fear of the obstetric hazards confronting her, especially that of producing an abnormal child.”<sup>372</sup> Pain in labor was seen not just as psychosomatic, but as contagious by way of suggestion. “One shrieking woman,” some argued, “can ruin a dozen labours.”<sup>373</sup> These beliefs the author says: cause an “inadequate, even derisory, approach” to treatment.<sup>374</sup> Even with an obviously identifiable cause (pain in child birth), these were not problems male doctors would have experienced themselves, making it easier to dismiss them. And unlike untreated cancer, it is worth noting that these were not, in the majority of cases, fatal problems. This allowed doctors, once they had marked a problem as “in the mind,” to leave it untreated or undertreated. A psychosomatic diagnosis could, in these cases, mean a patient’s problems were unreal, undeserving of care. Patients were therefore left invalidated and un-medicated.

The 1973 version included substantial discussion of emotion and personal growth, often including the same depictions of personal growth that were becoming more common in popular writing about emotion and cancer. Repressed emotion was a key concern of the Collective. This repression was at the start of the book and overcoming it was necessary, they thought, to not only personal development, but to developing the personal resources and confidence necessary to engage in their healthcare. The book opens with lyrics to the song “Our Faces Belong to our Bodies” from the *It’s All Right to Be a Woman Theatre*: “Our faces are blunted. Our bodies are

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<sup>371</sup> Lennane, K. Jean, and R. John Lennane. “Alleged Psychogenic Disorders in Women — A Possible Manifestation of Sexual Prejudice,” 288.

<sup>372</sup> Lennane, K. Jean, and R. John Lennane. “Alleged Psychogenic Disorders in Women — A Possible Manifestation of Sexual Prejudice,” 289.

<sup>373</sup> Lennane, K. Jean, and R. John Lennane. “Alleged Psychogenic Disorders in Women — A Possible Manifestation of Sexual Prejudice,” 290.

<sup>374</sup> Lennane, K. Jean, and R. John Lennane. “Alleged Psychogenic Disorders in Women — A Possible Manifestation of Sexual Prejudice,” 288.



stunted. We cover our anger with smiles.”<sup>375</sup> Members of the Collective continued to describe the impact of discovering their own anger. They found that they had been taught “to be nice to everyone, to please everyone” and that they had managed this “by learning to conform to the feminine role, while suppressing qualities within us inappropriate to that role—independence, activity, anger, and pride.”<sup>376</sup> In addition to suppressing anger, they found that learned helplessness and dependence were common to their experiences and they fought to move past helplessness while accepting that perhaps relationships required some kind of mutual, healthier dependence. “It is hard,” they wrote, but they were “forever fighting a constant, inner struggle to give up and become weak, dependent, and hopeless again.”<sup>377</sup> They wanted to be able to accept all sides of themselves, those traits considered both male and female. And they called for this same freedom for men, “to create a cultural environment where all qualities can come out in all people.”<sup>378</sup> In short, they accepted many of the ideas about what a healthy personality might look like while expressing serious doubt about its relationship to physical health and the misogynistic ways in which it was applied by doctors.

### **Forcing a Reevaluation**

The position of the Collective with regard to mind-body treatment for cancer patients would have to be substantially fleshed out by the time the book was rewritten as *The New Our Bodies Ourselves* in 1984. Between the growing awareness of the work of LeShan and the Simontons, the changing moral lessons in case narratives which seemed to correspond to

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<sup>375</sup> The Boston Women’s Health Book Collective, *Our Bodies, Ourselves*, 4.

<sup>376</sup> The Boston Women’s Health Book Collective, *Our Bodies, Ourselves*, 6.

<sup>377</sup> The Boston Women’s Health Book Collective, *Our Bodies, Ourselves*, 10.

<sup>378</sup> The Boston Women’s Health Book Collective, *Our Bodies, Ourselves*, 6.

feminist ideas of personal growth and emotional health, and the criticism from Susan Sontag (discussed in the previous chapter), the material was harder to ignore. Where the 1973 version depicted psychosomatic medicine as an attempt to dismiss women's illnesses as trivial, the 1984 version included mind-body cancer care as a reasonable option to use alongside standard medicine. In private, members of the collective expressed the belief that neglecting mind-body care was foolish. This dramatic shift in the Collective's position was driven not just by the changing tone of popular mind-body literature. It was also driven by a demand from readers for more information about both cancer care and alternative medicine, the writing of Susan Sontag and Audre Lorde, and shifts in feminist theory which encouraged holism and the reclamation of older, traditionally female forms of healing.

In her book chapter "Engendering Alternatives: Women's Health Care Choices and Feminist Medical Rebellions," Amy Sue Bix shows how the Boston Women's Health Book Collective was moving more generally towards alternative medicine at this time. She explores historical connections between feminism, women's empowerment, and alternative medicine. Bix argued that the ways in which women used alternative medicine were gendered and aimed at empowerment. For Bix, alternative care is "a vehicle through which people dissatisfied with conventional treatment may seek to empower themselves" in ways may combine with "the agendas of oppositional political movements."<sup>379</sup> The motivating factors driving a feminist move towards alternative medicine were according to Bix, condescension and patriarchal approaches of doctors, "the twin disasters of diethylstilbestrol treatment and the Dalkon Shield," and the sense that holism had a greater "sensitivity to gender, race, class, and environmental concerns"

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<sup>379</sup> Amy Sue Bix, "Engendering Alternatives," in *The Politics of Healing: Histories of Alternative Medicine in Twentieth-Century North America* ed. Robert D. Johnson, (New York: Routledge, 2004), 153.

than allopathic medicine.<sup>380</sup> As the collective wrote later versions of their books, these factors increasingly came to direct their attention to alternative medicine.

Part of the growing discussion of mind-body medicine came simply because the scope of the book was growing. Requests from readers to include topics relevant to them poured in. Women wanted to learn about breast cancer, and mental health care, among other topics. One woman wrote in asking for “some information on Cancer, and Health and older women.”<sup>381</sup> She had been working with older women who shared common misconceptions which were not addressed in the book. Another letter writer offered “to prepare some materials on the health problems that women workers face.”<sup>382</sup> One reader challenged the lack of attention to mental health. She said: “You never go into mental health... many of us feel completely cut off from each other as women when we are going through the throws (sic) of a nervous breakdown, afraid and alone.”<sup>383</sup> Another asked for information on anorexia.<sup>384</sup> In a letter exchange with a woman who wanted “more information about diseases which specifically affect women—such as breast cancer” and an index, the Collective responded that “We will have more on women’s medical

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<sup>380</sup> Amy Sue Bix, “Engendering Alternatives,” 153.

<sup>381</sup> Boston Women’s Health Book Collective Records, 1905-2003; Undated Letter. MC 503, Box 53 Folder 7. Schlesinger Library, Radcliffe Institute, Harvard university, Cambridge Mass.

<sup>382</sup> Boston Women’s Health Book Collective Records, 1905-2003; Letter dated Nov. 9, 1973. MC 503, Box 52 Folder 17. Schlesinger Library, Radcliffe Institute, Harvard university, Cambridge Mass.

<sup>383</sup> Boston Women’s Health Book Collective Records, 1905-2003; Undated Letter. MC 503, Box 53 Folder 12. Schlesinger Library, Radcliffe Institute, Harvard university, Cambridge Mass.

<sup>384</sup> Boston Women’s Health Book Collective Records, 1905-2003; Letter dated April 6, 1975. MC 503, Box 53 Folder 7. Schlesinger Library, Radcliffe Institute, Harvard university, Cambridge Mass.

problems and procedures in the revised book. Unfortunately, that is one of many topics that there seems to be no end of information necessary to get to people.”<sup>385</sup>

As the Collective moved to include more about cancer (and cancer-specific alternative care), it changed the way it wrote about mind-body care. Initially, their concerns had centered around the ways in which psychosomatic medicine could be used to dismiss women’s medical concerns. In their experience, psychosomatic explanations were only employed when doctors could not find diagnoses or for health problems specific to women like menstrual cramps. When told that a problem was psychosomatic, the patient might be sent to a psychiatrist, and the search for a medical solution would stop. Psychosomatic medicine, it seemed, was a way of saying illness was illusory, all in the patient’s head. The Collective acknowledged that this was not the intention of psychosomatic medicine, but that it was the way doctors frequently used it with their patients. However, even with recommendations for therapy, a diagnosis of cancer could make it clear that doctors saw the patients’ health problems as valid and important. Cancer, psychosomatic in origin or not, was not an illusion. As the Collective spent more time both with specific mind-body medical writing, and more time studying cancer, their responses moved away from their initial impression of psychosomatic medicine as a method of brushing off and trivializing women’s “complaints.”

On top of this changing subject matter, members of the collective were reading work by Susan Sontag and Audre Lorde. Sontag and Lorde each wrote influential books that dealt with their own experiences with cancer- and evaluated how beliefs about personality, visualization, and emotional well-being had impacted their own journeys with cancer. Susan Sontag’s

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<sup>385</sup> Boston Women’s Health Book Collective Records, 1905-2003; Undated Letter to the collective and response letter dated April 23, 1972. MC 503, Box 52 Folder 15. Schlesinger Library, Radcliffe Institute, Harvard university, Cambridge Mass.

argument that mind-body explanations for disease caused blame, covered in the last chapter, reached into the medical community and to a wide, popular readership. Her criticism, in line with the earlier positions of the Collective on psychosomatic medicine more generally, encouraged further writing specifically about the consequences of mind-body cancer care. Audre Lorde was a self-described “Black feminist lesbian warrior poet,”<sup>386</sup> an English professor at Hunter College, a member of the Combahee River Collective, and the poet laureate of New York in 1991. She received multiple honorary doctorates for her work.<sup>387</sup> She published *The Cancer Journals* in 1980, a book which combined journal entries with essays in a narrative of her experience with breast cancer and mastectomy, particularly those things that made that experience different for a black lesbian. In discussing her treatment decisions as well as the life decisions she made after surgery, Lorde explored issues of mindset and cancer recovery. Both Sontag and Lorde were interested in the political implications of the ways in which we talk or fail to talk about cancer. And both of their books were read and referenced in *The New Our Bodies Ourselves*.

Audre Lorde’s *The Cancer Journals* was more selective about which ideas about cancer, personality, and mindset to reject. Though it was not entirely clear which other books about cancer and mindset Lorde had read, she did pick up *Getting Well Again* by Simonton and seems to have encountered others. Lorde’s rejection of ideas about happiness and cancer respond (though it seems this was not what she was reading) to Rodale’s argument about race, politics, and cancer. Where Rodale suggested that blacks eschew anger and fall back on what he saw as their natural capacity to be cheery in the face of hardship and discrimination, Lorde pointed to all

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<sup>386</sup> Audre Lorde, “Commencement Address: Oberlin College May 29, 1989” in *I am Your Sister: Collected and Unpublished Writings of Audre Lorde* ed. Rudolph P. Byrd, Johnetta Betsch Cole, and Beverly Guy Sheftall, (Oxford: Oxford University Press, 2009), 214.

<sup>387</sup> “Audre Lorde, 58, A Poet, Memoirist and Lecturer, Dies,” *New York Times*, November 20, 1992.

of the things she would have to ignore in order to be “happy in this best of all possible infernos.”<sup>388</sup> To be “happy” in the sense of accepting life as it was would mean ignoring the social issues which surrounded her and shutting her eyes on the world. Lorde considered this a kind of escapist way to deal with cancer; “It is easier to demand happiness than to clean up the environment.”<sup>389</sup> And she half-jokingly asked if she “was wrong to be working so hard against the oppressions afflicting women and Black people?”<sup>390</sup> Though she rejected the idea that unhappiness caused cancer, Lorde combined visualization, the healing power of a loving community, determination to live, and to an extent made clear in a later book, a search for a fulfilling life, as part of her battle to remain cancer free. She believed that she and all other women had “a militant responsibility to involve herself actively with her own health.”<sup>391</sup> Part of that was maintaining emotional wellness in order to “repair past, and minimize future damage to [her] body” and she decided that “battling despair [did] not mean closing [her] eyes to the enormity of the tasks of effecting change, nor ignoring the strength and the barbarity of the forces aligned against us.” For her it meant “taking joy in that battle.”<sup>392</sup> For Lorde, the fight for survival was always consciously framed as a battle, and this battle was always part of a larger narrative of fighting for survival against forces that would wish for her silence and destruction: racism, sexism, homophobia. For Lorde, self-care “is not self-indulgence, it is self-preservation, and that is an act of political warfare.”<sup>393</sup>

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<sup>388</sup> Audre Lorde, *The Cancer Journals*, (San Francisco: Aunt Lute Books, 1980), 74.

<sup>389</sup> Audre Lorde, *The Cancer Journals*, 74.

<sup>390</sup> Audre Lorde, *The Cancer Journals*, 74.

<sup>391</sup> Audre Lorde, *The Cancer Journals*, 73.

<sup>392</sup> Audre Lorde, *The Cancer Journals*, 16-17.

<sup>393</sup> Audre Lorde, “Epilogue, A Burst of Light: Living with Cancer” in *A Burst of Light: Essays by Audre Lorde* (Ithaca: Firebrand Books, 1988), 131.

Where Sontag saw political uses of cancer as a metaphor as harmful, Lorde wove them deeply into her recovery through her version of visualization. Though she wrote that Simonton's "smugness infuriates me" she found his book *Getting Well Again* useful.<sup>394</sup> In later writing, Lorde described how she adapted the ideas of Simonton to make them relevant. Her daily visualization was steeped in what overcoming and survival meant to her: defeating her "most implacable enemies." The cancer cells in her vision were "Bull Connor and his police dogs" or "P.W. Botha's bloated face of apartheid." Defeating these cancers were "a mighty avalanche of young, determined Black marchers," "the slow rhythmic advance of furious Blackness," "Black South African women moving through [her] blood destroying passbooks," and "Fireburn Mary."<sup>395</sup> Perhaps it varied, but on occasion the soundtrack was Bob Marley's "Redemption Song."<sup>396</sup> Nothing about this was fanciful for Lorde. Her battle against cancer was directly tied in her understanding to battling the forces of racism: "*When I speak out against the cynical U.S. intervention in Central America, I am working to save my life in every sense. Government research grants to the National Cancer Institute were cut in 1986 by the exact amount illegally turned over to the contras in Nicaragua. One hundred and five million dollars.*"<sup>397</sup>

Lorde also used the idea that a supportive community, particularly the love of women, and a personal drive to live would help her heal. Again, Lorde's position within broader struggles shaped the way she understood healing. She acknowledged the "tremendous amount of love" she received from the women she was close to, saying "it felt like being bathed in a

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<sup>394</sup> Audre Lorde, *The Cancer Journals*, 14.

<sup>395</sup> Audre Lorde, "Epilogue, A Burst of Light: Living with Cancer" in *A Burst of Light: Essays by Audre Lorde* (Ithaca: Firebrand Books, 1988), 132-133.

<sup>396</sup> Audre Lorde, "September 21, 1986, A Burst of Light: Living with Cancer" in *A Burst of Light: Essays by Audre Lorde* (Ithaca: Firebrand Books, 1988), 109-110.

<sup>397</sup> Emphasis in original. Audre Lorde, "Epilogue, A Burst of Light: Living with Cancer" in *A Burst of Light: Essays by Audre Lorde* (Ithaca: Firebrand Books, 1988), 133.

continuous tide of positive energies.” This love created “tangible floods of energy” which she “converted into power to heal.” Put simply, she said: “the love of women healed me.”<sup>398</sup> Women could cooperatively heal, could respond to the devastation of cancer not as individuals but as groups who fought together, she thought. But Lorde never thought that love alone could heal her, rather, she felt that she needed to have positive energy to absorb that love, “that there must have been an answering energy within myself that allowed me to connect to the power flowing.”<sup>399</sup> In addition to her answering energy, Lorde described a determination and “rage to live,” and credited her work with keeping her alive. She wondered if she “was strong enough to sustain that determination [to live].”<sup>400</sup> Rage, fear, and work came together in how she defined herself going forward. Lorde saw her writing and speaking as an antidote to the silence that fear had driven her to before. Cancer, by making her recognize her mortality, lessened the weight of fears while simultaneously making her fear losing the chance to say what she wanted. This awareness of her mortality, forced a recognition of what she “wished and wanted” for the remainder of her life and “priorities and omissions became strongly etched in a merciless light, and what I most regretted were my silences.” Of the fear driven motivations for these silences, now that she knew she might die anyway, she asked: “Of what had I ever been afraid?”<sup>401</sup>

While the Collective was directly exposed to contradictory material on mind-body medicine in their reading, they were also part of a shift in the zeitgeist. Feminist theorists, historians, and activists were engaged in a variety of projects that challenged dualistic splits between mind and body, nature and culture, intuition and reason; reclaimed discarded women

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<sup>398</sup> Audre Lorde, *The Cancer Journals*, 39.

<sup>399</sup> Audre Lorde, *The Cancer Journals*, 39-40.

<sup>400</sup> Audre Lorde, *The Cancer Journals*, 33.

<sup>401</sup> Audre Lorde, *The Cancer Journals*, 20.



from history (herstory) including midwives and witches; and opened a new space for feminist ways of knowing and healing. These projects encouraged the use of alternative medicine and particularly the use of healing traditions that reinforced traits typically coded as feminine.

Linda Alcoff and Alice Echols have tried to identify a different feminist trajectory which grew in the 1970s and 80s. Where feminists had worked to break down social constructions of gender, some tried to redefine women, to find some real truth. In this search, they often highlighted aspects of femininity that aligned more easily with alternative and mind-body medicine. Linda Alcoff defined cultural feminism as “the ideology of a female nature or female essence appropriated by feminists themselves in an effort to revalidate undervalued female attributes.”<sup>402</sup> Instead of allowing men to define what it meant to be a woman, cultural feminists began to build their own definitions which gave value to typically feminine traits. Alcoff argued that this process “construe[d] woman’s passivity as her peacefulness, her sentimentality as her proclivity to nurture, her subjectiveness as her advanced self-awareness, and so forth.”<sup>403</sup> Where early radical feminists “had sought the abolition of gender as a meaningful category,” Alice Echols argued in 1983 that “Today’s radical feminists, however, are more likely to discuss gender differences as though they reflect deep truths about the intractability of maleness and femaleness.”<sup>404</sup> Echols and Alcoff gave Adrienne Rich and Mary Daly as examples. Alcoff and Echols also argued that cultural feminism was a corrective for societal rejection of feminine characteristics, but were concerned that instead of just revaluing those things, cultural feminists

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<sup>402</sup> Linda Alcoff, “Cultural Feminism versus Post-Structuralism: The Identity Crisis in Feminist Theory,” *Signs: Journal of Women in Culture and Society*, 13 No. 3 (1988): 408.

<sup>403</sup> Linda Alcoff, “Cultural Feminism versus Post-Structuralism,” 407.

<sup>404</sup> Alice Echols, “The New Feminism of Yin and Yang,” in *Powers of Desire: The Politics of Sexuality* ed. Ann Snitow, Christine Stansell, and Sharon Thompson (New York: Monthly Review Press, 1983), 440.

essentialized them. These values at the core: peacefulness, proclivity to nurture, intuition, and self-awareness, could all be construed as ways in which women were inclined to heal--outside of the regulated medical profession. The connection between essentialized views of femininity, healing, and female empowerment can be seen as a resurgence of a longer tradition. Anne Harrington notes that the mind-cure movement in the United States was always more popular among women than men, in part because it gave them a sense of power. Where had been seen as frail and sickly, women could use their faith and intuition to recover and find strength. Moreover, Harrington says, "The minds of women were supposed to be more intuitive than rational, but mind-cure taught that these intuitive qualities were the very ones that opened the door to divine power."<sup>405</sup> In short, "their femininity was—or could be—a source of strength rather than weakness."<sup>406</sup> the idea that there was an essential female nature, nurturing and intuitive, made mind-body healing for women seem logical.

Despite accusations of essentialization, Daly, Rich, and other cultural feminists shared in the project of breaking down dualistic splits and challenging patriarchal ways of knowing. Opposition to dualism made mind-body theories more appealing and challenging epistemologies encouraged an embrace of alternative medicine. In her book *Gyn/Ecology: The Metaethics of Radical Feminism*, Mary Daly listed the "Eight Deadly Sins of the Fathers," one of which was "Professions." In this sin, she argued, "Deadly pride is epitomized in patriarchal professions, which condense the process of knowing into an inert and mystifying thing ('body of knowledge')."<sup>407</sup> She called women to recover another approach, that of "the original Athena,

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<sup>405</sup> Anne Harrington, *The Cure Within: A History of Mind-Body Medicine* (New York: W. W. Norton and Co., 2008): 111.

<sup>406</sup> Anne Harrington, *The Cure Within*, 111-112.

<sup>407</sup> Mary Daly, *Gyn/Ecology: The Metaethics of Radical Feminism*, (Boston: Beacon Press, 1978), 30.

whose loyalty is to her own kind, whose science/wisdom is of woman kind.”<sup>408</sup> Daly believed that “life-loving feminists have the power to affirm the basic Gyn/Ecological principle that everything is connected to everything else.” She referred to this as a “holistic process of knowing.”<sup>409</sup> Collapsing disciplinary boundaries and aiming for holism in a new feminist way of knowing did not, of course mean that Daly would ever have accepted the work of LeShan and the Simontons. In fact, despite the fact that she accepted mental health care might be necessary in some acute situations, Daly was quite clear about her dislike for both psychiatry (“mind-gynecology”) and therapists (“the/rapists”).<sup>410</sup>

Eco-feminism, particularly the work of Carolyn Merchant, also pushed against Cartesian Dualism. Merchant’s 1980 book *The Death of Nature: Women, Ecology and the Scientific Revolution* argued that the view of the earth matter as inert and subject to the use of men for gain and scientific exploration was metaphorically tied to descriptions of women. Merchant argued that “From an active teacher and parent, she [nature] has become a mindless, submissive body.”<sup>411</sup> Once views of nature became mechanistic and could be “viewed as a system of dead inert particles moved by external, rather than inherent forces, the mechanical framework itself could legitimate the manipulation of nature.”<sup>412</sup> Old limits on mining, agriculture, or use of the land disappeared as the earth became something to be used. Obtaining a balanced use of land, and a sense of human’s place within it required undoing this sense that nature could be cut down to isolated variables and consumed, and thus revaluing the metaphors of passive female bodies

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<sup>408</sup> Mary Daly, *Gyn/Ecology*, 13. This version of Athena would not be reborn through Zeus or separated from her mother and sisters as in myth.

<sup>409</sup> Mary Daly, *Gyn/Ecology*, 11.

<sup>410</sup> Mary Daly, *Gyn/Ecology*, 24, 228.

<sup>411</sup> Carolyn Merchant, *The Death of Nature: Women, Ecology, and the Scientific Revolution*, (New York: Harper One, 1990), 190.

<sup>412</sup> Carolyn Merchant, *The Death of Nature*, 193.

that supported this view. This focus on holism and interconnectedness again reinforced the idea that emotional and physical health would be intertwined. Bix shows how some came to explicitly connect this ecofeminist view of the environment and science with healing. Kathleen F. Phalen, for example, said in 1998 that “the earth will not be able to heal until women reclaim their power as healers.”<sup>413</sup>

A trend towards reclaiming the work of women as healers included a process of reimagining what feminist healthcare might look like and encouraged reclaiming treatments that might otherwise be considered superstitious. Mind-body care was framed as one of these traditional female healing techniques. Both Mary Daly and Carolyn Merchant participated in this recovery and embrace of the work of women as healers, including midwives and witches. They not only worked to rewrite history to include women, but also to identify the historical values that had forced their exclusion. The best example of this came in 1973, when Barbara Ehrenreich and Deirdre English published *Witches, Midwives and Nurses: A History of Women Healers*. The book credited witches with creating a more empirical approach to bodies and disease. Witches, they argued, “developed an extensive understanding of bones and muscles, herbs and drugs, while physicians were still deriving their prognoses from astrology and alchemists were trying to turn lead into gold.”<sup>414</sup> “Undoubtedly,” they acknowledged, “many of the witches’ other remedies were purely magical, and owed their effectiveness—if they had any—to their reputation.”<sup>415</sup> Ehrenreich and English took the idea that the work of witches and midwives was

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<sup>413</sup> Kathleen F. Phalen, *Integrative Medicine: Achieving Wellness through the Best of Eastern and Western Medical Practices* (Boston: Journey Editions, 1998), 136. Quoted in Amy Sue Bix, “Engendering Alternatives,” 164.

<sup>414</sup> Barbara Ehrenreich and Deirdre English, *Witches, Midwives and Nurses, Second Edition*, (New York: The Feminist Press at CUNY, 2010), 20.

<sup>415</sup> Barbara Ehrenreich and Deirdre English, *Witches, Midwives and Nurses*, 48.

rejected because it was superstitious, and argued instead that this work was destroyed (either through witch hunting or professionalization) because it was economically competitive with medicine. This argument showed that women's historical work was integral to the development of science and challenged ideas about "old wives' tales" and other folk wisdom.<sup>416</sup> Similarly, the 1981 book *Old Wives' Tales: The History of Remedies, Charms, and Spells* by Mary Chamberlain, argued that contrary to our ideas of women's medicine as superstitious, old wives "were consulted for their wisdom and experience, for their acquired skills or knowledge. They achieved what local reputation they had from their successes in the area of health care."<sup>417</sup>

*The New Our Bodies, Ourselves* brought together both this increasing interest in holism and the revived interest in older, discounted forms of care to begin sketching a feminist ethic of healing and history that tied together many of the collective's frustrations with medicine. Sections on healing in history and alternative healing drew particularly on the work of Ehrenreich, English, and Chamberlain. "The history of women as healers," they argued, "is our history... it puts us in touch with a power that has rightfully belonged to women throughout the ages and which we rightly now reclaim."<sup>418</sup> After identifying healing as an art of women (or at least an art which women were equally qualified) they began to identify the values that created a "vast difference between healing and medicine."<sup>419</sup> Key to this difference were ideas about holism and neighborly caring. From Ehrenreich, English, and Chamberlain, they picked up on the argument that healing (in contrast to medicine) was a community function which involved

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<sup>416</sup> It is worth noting that Ehrenreich was explicit that she did not encourage rejecting science, but objected to the hoarding of it.

<sup>417</sup> Mary Chamberlain, *Old Wives' Tales: Their History Remedies and Spells*, (London: Virago Press, 1981), 3.

<sup>418</sup> The Boston Women's Health Book Collective, *The New Our Bodies, Ourselves*, 589.

<sup>419</sup> The Boston Women's Health Book Collective, *The New Our Bodies, Ourselves*, 589.

sharing instead of economic gain. They quoted Ehrenreich and English, “Healing was female when it was a neighborly service, based in stable communities, where skills could be passed on for generations and where the healer knew her patients and their families. When the attempt to heal is detached from personal relationships to... become a commodity and a source of wealth in itself—then does the business of healing become a male enterprise.”<sup>420</sup> Similarly they quoted Chamberlain saying that the “knowledge [of old wives] was free and freely given. With little or no money at stake there was no need to preserve a ‘closed’ profession in terms of entry, training and dissemination of knowledge.”<sup>421</sup> This ethic of sharing as well as the idea that alternative medicine had its roots in the old practices of women filtered into the chapter on health and healing. The collective identified “massage, herbal medicine and visualization” as examples of “traditional female healing practices which had been in use for centuries.” They said that women had used these strategies to care “for members of their families and communities.”<sup>422</sup> In addition to bringing in specific ideas about healing as a historically female strength and of alternative medicine as a feminist, anti-capitalist space of sharing, the collective incorporated the belief that mind-body divisions might not be real. The same chapter said that “Wholistic health is based both on the idea that the body, mind and spirit form an integrated whole and on an understanding of the connectedness of the individual to her environment, her community and her world.”<sup>423</sup> Their adoption of a distinction between healing and medicine helped to prioritize the work of healers who looked at the whole patient, knew her story and contextualized her illness. Healing could also be a way of coming to terms when medicine did not work. One of the arguments that

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<sup>420</sup> The Boston Women’s Health Book Collective, *The New Our Bodies, Ourselves*, 593.

<sup>421</sup> The Boston Women’s Health Book Collective, *The New Our Bodies, Ourselves*, 590.

<sup>422</sup> The Boston Women’s Health Book Collective, *The New Our Bodies, Ourselves*, 54.

<sup>423</sup> The Boston Women’s Health Book Collective, *The New Our Bodies, Ourselves*, 55.

repeatedly came up in cancer discussions was that understanding mindset and disease was about knowing a patient's whole story, and if it did not prolong life, it still healed. Finally, if healing were a community activity, and counseling for cancer patients could be a form of healing, then this helped to avoid the idea that addressing mind-set for cancer was about focusing on the individual instead of society. Instead, healing/ counseling cancer patients could be an example of a feminist ethic of care.

In this period between the first publication of *Our Bodies, Ourselves* and the publication of *The New Our Bodies, Ourselves* in 1984, the Collective absorbed these influences. With growing confidence in their own ability to challenge doctors, but also affected by the feminist zeitgeist towards alternative medicine, they moved to include more alternative medicine. This included a full reevaluation of psychological approaches to cancer. The Collective acknowledged feeling more capable of challenging not just the practitioners but the knowledge base they operated on and explained in a draft that "In OBOS previously we relied on a world view that was less critical of technological, mechanistic means than we are now."<sup>424</sup> The combined distrust of medical professionals and trust in their own experiences made some Collective members argue that they should not "discount that which is not perceptible through measly scientific means."<sup>425</sup> The Collective was rediscovering women who had worked in alternative health care historically, from witches to wise women and midwives.<sup>426</sup>

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<sup>424</sup> Boston Women's Health Book Collective Additional Records, 1966-2010; Draft dated October 20, no year given. MC 667, Box 37 Folder 8. Schlesinger Library, Radcliffe Institute, Harvard University, Cambridge, Mass.

<sup>425</sup> Boston Women's Health Book Collective Additional Records, 1966-2010; Draft dated October 20, no year given. MC 667, Box 37 Folder 8. Schlesinger Library, Radcliffe Institute, Harvard University, Cambridge, Mass.

<sup>426</sup> The Boston Women's Health Book Collective, *The New Our Bodies, Ourselves*, 590-591.

## **Mind-Body Medicine in *The New Our Bodies, Ourselves***

This new openness to alternative medicine created a space for debate that shows different ways that feminists tried to evaluate what it meant to have a feminist approach to health. For some, identifying mental well-being as preventative medicine justified necessary self-care and provided an empowering alternative to the over-medicalized experience of womanhood. Others saw it as part of a continuing pattern of blaming women for their problems and failing to take them seriously. Perhaps, some argued, regardless of whether it seemed empowering or blame-filled, the empowering choice was to include it and let the reader decide whether it was personally meaningful. With more health writers like LeShan making arguments that fulfilling careers might protect health and Susan Sontag's argument that all metaphorical approaches to disease were damaging, ignoring beliefs about cancer and mindset no longer seemed to be an option. While members of the collective tried to address Sontag's arguments, newer ideas about cancer and emotion were appealing because they provided seemingly scientific proof of the truth of feminist arguments, showing that embracing strictly gendered behavior was not just unnecessary but fatal. The idea that repressed anger was cancerous reflected the discussions the collection had been having since the beginning about developing as whole individuals (with both masculine and feminine traits) and learning to express anger.

In the 1984 rewrite, the Collective tried to balance these perspectives. Even as the book recommended working to relieve stress and using psychological therapies to help with health and well-being, it cautioned against alternative practitioners who "place too much emphasis on the individual's responsibility." They included ideas about both "lack of will" and the "cancer personality" as examples of when people leaned too far in this direction. They cautioned that, by focusing on personal responsibility for healing, women could risk ignoring "political and social



factors.” If, for example, environmentalism and health justice are feminist values, then turning inward to find a cause and cure for health problems ignores other responsibilities. More importantly, they noted “sometimes, no matter how much we try to stay healthy, we become ill. It is both cruel and useless to blame ourselves or let others blame us for getting sick.” Nonetheless, they saw “trust in our capacity for self-healing” as “a welcome change from medicine’s dependence upon outside intervention.”<sup>427</sup> Alternative medicine, they believed, including psychological approaches to disease, could empower an individual if they learned to avoid self-blame and worked with others to do things like reduce stress. Specifically about cancer, they warned against the temptation to say things like: “she brought it on herself, all that repressed anger,” or “she just isn’t strong enough; she doesn’t really want to get well; she doesn’t have enough faith.”<sup>428</sup> Despite the specific rejection of ideas about cancer personalities the book recommended readings by LeShan and the Simontons, leaning heavily on LeShan’s work both for ideas about healthy approaches to disease and for his understandings of the relationships between responsibility and blame.

This careful balance around issues of blame in the published book hides internal embrace of ideas about cancer and emotional patterns. It is in the early conversations and drafts that the depth to which these ideas had entered the Collective comes through. Handwritten notes recording pre-draft comments provide records of how members addressed the issue, and how they modified their ideas for print. For example, in notes from an early conversation between the authors of the chapter on health and healing and Pamela Pacelli, who was acknowledged as providing particular help with the chapter, one woman asked: “What does alternative health care

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<sup>427</sup> The Boston Women’s Health Book Collective, *The New Our Bodies, Ourselves*, 57.

<sup>428</sup> The Boston Women’s Health Book Collective, *The New Our Bodies, Ourselves*, 529.

& alternative psychologies have that regular health care does not?” Perhaps, they thought, it “Helps [a] person to really evaluate for themselves how far they can go.”<sup>429</sup> From being described as a weapon in the first book, suddenly this promised personal growth and self-determination. They also addressed issues of blame and responsibility and found Sontag’s argument unconvincing at best. “Fact is,” they added, “by asking people to look at ways they take responsibility for their health [we are] not blaming people... we are brought up to think that responsibility is the blameful way.”<sup>430</sup>

They did not simply suggest that Sontag was wrong to make generalized arguments that blame and metaphor went hand in hand. Later in the same conversation they suggested Sontag was in denial about her own illness. “Perhaps,” one said, “Susan Sontag can’t face in herself that she had something to do with her illness.” She quickly added, “I’m not judging her ... She’s saying that’s a hunk of shit. I’m saying [Susan Sontag], if you feel happy and satisfied with the way you’ve dealt with your cancer and you don’t believe it’s a metaphor for anything then say that. Make your personal statement but don’t impose it on other people.”<sup>431</sup> The idea that Sontag could not “face in herself” her own responsibility for disease and therefore classed the whole idea as a “hunk of shit” reduced Sontag’s argument into an emotionally driven denial. This characterization of Sontag’s work (while probably not shared by the whole Collective), is

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<sup>429</sup> Hand written notes use a number of abbreviated words. I have expanded these for clarity whenever the meaning in the original is clear. Boston Women's Health Book Collective Additional records, 1966-2010; Notes from interview with Pamela Pacelli, page 1, undated. MC 667, Carton 6 Folder 8. Schlesinger Library, Radcliffe Institute, Harvard University, Cambridge, Mass.

<sup>430</sup> Boston Women's Health Book Collective Additional records, 1966-2010; Notes from interview with Pamela Pacelli, page 10, undated. MC 667, Carton 6 Folder 8. Schlesinger Library, Radcliffe Institute, Harvard University, Cambridge, Mass.

<sup>431</sup> Boston Women's Health Book Collective Additional records, 1966-2010; Notes from interview with Pamela Pacelli, page 11, undated. MC 667, Carton 6 Folder 8. Schlesinger Library, Radcliffe Institute, Harvard University, Cambridge, Mass.

remarkably reminiscent of psychoanalytic patterns of characterizing disagreement as “denial” and finding in it proof of the truth of an argument. Nevertheless, the position of the published version was that “classical psychoanalytic theory has been the source of most of the distorted ideas about women that pervade all medical training” and recommended finding a therapist who “accepted the way I presented issues and didn’t alter them to fit some theory.”<sup>432</sup>

Even as they embraced psychological explanations of cancer, they maintained the expectation that people who subscribed to psychological understandings also use allopathic medicine. A Collective member admitted she got “just as angry” at women who failed to do this.<sup>433</sup> One woman jumped in with an anecdote about a woman who had skin cancer and “wasn’t going to do anything about it medically. She wasn’t going to get tags checked out. She was just going to go to her ashram and sit and think about how she had lived her life.”<sup>434</sup> Reducing cancer to the psychological would, they argued, be “just as dumb” as focusing in on just one of the other explanations for disease.<sup>435</sup> The published version from 1984 noted that LeShan required his patients to also see a physician.<sup>436</sup> “One noted psychic healer,” they said, “warns people to be wary of healers who charge money and or promise a cure, and he cautions against the sleight-of-hand tricks some ‘healers’ use to reinforce their clients’ belief in them. He also requires that all

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<sup>432</sup> The Boston Women’s Health Book Collective, *The New Our Bodies, Ourselves*, 75.

<sup>433</sup> Boston Women's Health Book Collective Additional records, 1966-2010; Notes from interview with Pamela Pacelli, page 11, undated. MC 667, Carton 6 Folder 8. Schlesinger Library, Radcliffe Institute, Harvard University, Cambridge, Mass.

<sup>434</sup> Boston Women's Health Book Collective Additional records, 1966-2010; Notes from interview with Pamela Pacelli, page 12, undated. MC 667, Carton 6 Folder 8. Schlesinger Library, Radcliffe Institute, Harvard University, Cambridge, Mass.

<sup>435</sup> Boston Women's Health Book Collective Additional records, 1966-2010; Notes from interview with Pamela Pacelli, page 12, undated. MC 667, Carton 6 Folder 8. Schlesinger Library, Radcliffe Institute, Harvard University, Cambridge, Mass.

<sup>436</sup> The Boston Women’s Health Book Collective, *The New Our Bodies, Ourselves*, 69.

his clients be in consultation with a physician.”<sup>437</sup> This belief that therapy for cancer was an adjuvant instead of an alternative, helped justify it for many, a theme explored more in the next chapter.

Despite a clear preference that cancer patients use both psychological resources and medical care for their survival, one of the Collective’s main ways of viewing psychological care as empowering was by focusing on choice. In preparations for the 1984 published volume, they noted that the “Chapter needs to address that there are two ends of the spectrum and each individual person (with their therapist or health care practitioner) needs to find where they fall on that spectrum.”<sup>438</sup> This process of deciding which tools to use involved asking a series of questions: “How much has to do with congenital stuff, with pre-disposition, how much with the environment, and how much can they realistically do towards health.”<sup>439</sup> Answering these questions (both after diagnosis and in assessing risk factors for developing cancer) was necessary, they thought even for women living in Love Canal. “If,” for instance, “you live in a cancer area and you have a predisposition towards depression,” they argued, “then your practitioner has some responsibility to tell you these are some factors and you can choose whether or not to pay attention to those.”<sup>440</sup> The responsible thing for doctors and therapists to do was to lay out the possible factors and let individuals sort it out. If possible, to do so without

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<sup>437</sup> The Boston Women’s Health Book Collective, *The New Our Bodies, Ourselves*, 69.

<sup>438</sup> Boston Women’s Health Book Collective Additional records, 1966-2010; Notes from interview with Pamela Pacelli, page 9, undated. MC 667, Carton 6 Folder 8. Schlesinger Library, Radcliffe Institute, Harvard University, Cambridge, Mass.

<sup>439</sup> Boston Women’s Health Book Collective Additional records, 1966-2010; Notes from interview with Pamela Pacelli, page 9, undated. MC 667, Carton 6 Folder 8. Schlesinger Library, Radcliffe Institute, Harvard University, Cambridge, Mass.

<sup>440</sup> Boston Women’s Health Book Collective Additional records, 1966-2010; Notes from interview with Pamela Pacelli, page 9, undated. MC 667, Carton 6 Folder 8. Schlesinger Library, Radcliffe Institute, Harvard University, Cambridge, Mass.

being prescriptive. They concluded: “you can’t give people guidelines about who is healthy and who is not. You can only give them factors about how to evaluate your health, your responsibility or the environment’s responsibility, or society’s, or families’, and let them go about doing it.”<sup>441</sup> This logic extended to the Collective’s own responsibility towards readers. “It’s important,” they said, “if you are writing a book on empowerment to lay it out and let people who are reading it empower themselves.”<sup>442</sup>

The question for the Collective then was why so many women, like Sontag, rejected this opportunity to use their apparent psychological resources to heal themselves. They thought that perhaps conditioning, in this case a cultural tendency for women to beat themselves up, meant that women were more likely to see this either as judgment and blame (thus reacting negatively) or as an accurate indictment of their personality (thus reacting with an unhealthy sense of self-blame). This was why people had such unhealthy responses if, for example, someone was to say they were “neurotic.” They would reject it or succumb to guilt, “instead of saying alright, I have these things I’m not dealing with in my life and I have ... energy to look at myself dispassionately and do something about it.” The tendency to respond either by saying “Oh my God I can never be healed. I’m such a mess,” or to respond with anger and resentment, getting “angry at their practitioners.” They characterized these patterns as “a real problem in healthcare.”<sup>443</sup>

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<sup>441</sup> Boston Women's Health Book Collective Additional records, 1966-2010; Notes from interview with Pamela Pacelli, page 10, undated. MC 667, Carton 6 Folder 8. Schlesinger Library, Radcliffe Institute, Harvard University, Cambridge, Mass.

<sup>442</sup> Boston Women's Health Book Collective Additional records, 1966-2010; Notes from interview with Pamela Pacelli, page 13, undated. MC 667, Carton 6 Folder 8. Schlesinger Library, Radcliffe Institute, Harvard University, Cambridge, Mass.

<sup>443</sup> Boston Women's Health Book Collective Additional records, 1966-2010; Notes from interview with Pamela Pacelli, page 9, undated. MC 667, Carton 6 Folder 8. Schlesinger Library, Radcliffe Institute, Harvard University, Cambridge, Mass.

The struggle of balancing the belief that one needed to be emotionally invested in healing with the sense that patients needed and deserved standard care both from physicians and their community is obvious in the early drafts of the chapter on health and healing. One version included a scratched-out paragraph on the self as healer. “Others can help,” the Collective member wrote, “but no one but you can be responsible for your health.” As they tried to avoid turning this to blame they added: “This is not a new form of rugged individualism after many of us learned in the women’s movement how to care for rather than compete always with one another. We recognize that self and other are inseparable in that we are necessary to one another.”<sup>444</sup> Perhaps, women could work together to change their approach to healing and psychological processes, “But even with all the loving care and attention, with all the medicine in whatever form, we have to choose to use that energy or not... why is it that some people have the will to live stronger than others?”<sup>445</sup> Torn between the idea that very little could be solved on an individual level and her own belief in variable levels of the “will to live” the author saw collective action and help-seeking as necessary but useless without personal attempts to channel the will to live. While this didn’t survive even the author’s own first edits, she left in this: “We as individuals have to learn how to ask for help, how to accept it when it’s given, how to give when it’s needed. An essential skill to develop in a fragmented society that doesn’t generally foster attitudes that make this easy. With information and knowledge that we can get help from others,

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<sup>444</sup> Boston Women's Health Book Collective Additional records, 1966-2010; Typewritten draft, October 22, page 1. MC 667, Carton 37 Folder 11. Schlesinger Library, Radcliffe Institute, Harvard University, Cambridge, Mass.

<sup>445</sup> Boston Women's Health Book Collective Additional records, 1966-2010; Typewritten draft, October 22, page 1. MC 667, Carton 37 Folder 11. Schlesinger Library, Radcliffe Institute, Harvard University, Cambridge, Mass.

we still need to choose to focus our intention/will/energy on healing ourselves of dis-ease in any/all parts of our lives.”<sup>446</sup>

This tension between collective action and an inward turn, between group reflection and self-care, came out in discussions of psychosomatic medicine. Some worried that therapy was inherently apolitical, or at least not the heart of a mass movement. Those with the resources to participate in therapy might be better able to individually face and name their challenges and be able to make bolder decisions defined in their own terms as a result. However, systematic problems would not be directly challenged. By leaving each woman to meet the impact of discrimination and disadvantage with her own time and emotional resources, therapy required greater emotional labor without helping those who lacked access. Even for those who might participate and value these opportunities, these could be seen as severe limitations for a form of feminist praxis. The transformations would be individual rather than societal. These frustrations tinged how some feminists responded to claims that psychology or self-care (no matter how feminist) could be used as treatment of disease. The 1984 book gave as an example “a practitioner [who] might prescribe rest, exercise and change in diet, and not attend to the fact that the problem is caused by a dangerous on-the-job situation” and pointed to “poverty and racism as major sources of ill health.”<sup>447</sup>

The Collective adapted ideas about stress to mediate between social explanations for disease and ideas about personality and health. Where others studying stress had frequently focused on responses to stress as potentially dangerous (thereby studying personality), the

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<sup>446</sup> Boston Women's Health Book Collective Additional records, 1966-2010; Typewritten draft, October 22, page 1. MC 667, Carton 37 Folder 11. Schlesinger Library, Radcliffe Institute, Harvard University, Cambridge, Mass.

<sup>447</sup> The Boston Women's Health Book Collective, *The New Our Bodies, Ourselves: A Book by and For Women*, (New York: Simon & Schuster, 1984), 56.

Collective chose to focus on stressors, particularly those shaped by inequalities. This shift allowed them to focus on social environment rather than individuals. The section on stress (which they listed as a potential cause of cancer) included a list of potential stressors which echoed those mentioned by Rosch at the beginning of the chapter: “financial insecurity,” “job loss,” or “being discriminated against because of race, class, age, looks, sexual preference, or physical disability ... [or] an illness for which we can find no appropriate care.”<sup>448</sup> Thus they could argue that if responding to stress was necessary for your health, women *needed* to challenge hierarchical structures. And if perhaps therapy was an individualized response to disease, consciousness raising and support groups offered another feminist model. They said that “The following chapters seek to distinguish carefully between what we can do as individuals and the social factors which we must change by working together.”<sup>449</sup> Lorde would also return to this idea of stress as a health threat. She tried to minimize stress in her “practical everyday living.” Nonetheless, like the BWHBC, she considered it “nonsense” to believe she could remove all stress on her own “without becoming psychically deaf, mute, and blind.”<sup>450</sup> The toll of racism, sexism, and homophobia was just too high. For both Lorde and the BWHBC, removing stressors was about changing society as a whole. Alternative medicine and beliefs about mindset could either be a way to avoid looking at social problems, or a framework for addressing them.

Mind-body medicine also came up in other publications by the Boston Women’s Health Book Collective including *Ourselves Growing Older*. Founding members Paula Doress-Worters and Diana Siegel published the expansive volume in 1987 by expanding their previous chapter

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<sup>448</sup> The Boston Women’s Health Book Collective, *The New Our Bodies, Ourselves*, 4.

<sup>449</sup> The Boston Women’s Health Book Collective, *The New Our Bodies, Ourselves*, 4.

<sup>450</sup> Audre Lorde, “Nov 17, 1986, A Burst of Light: Living with Cancer” in *A Burst of Light: Essays by Audre Lorde* (Ithaca: Firebrand Books, 1988), 125.



on aging. *Ourselves Growing Older* focused on the health issues of older women who may no longer need information about contraception or childbirth. Like *Our Bodies, Our Selves*, the book has mixed approaches to psychosomatic healing and like various editions of OBOS, it draws on quotations from many individual women to help readers maintain a connection to the book, see the relevance to their own lives, and picture women like themselves as part of the knowledge making process. But unlike other books by the Collective, the attitude to connections between personality and cancer in this book were unequivocally negative. Nonetheless, the authors cited Norman Cousins, author of *Anatomy of an Illness*, a book about creating a remission from Ankylosing Spondylitis through laughter and high doses of vitamin C. Despite their comfort with mind-body medicine more generally, the book directly rejected it when it came to cancer. Not only did they say that these theories could cause guilt and victim blaming, they also saw them as false and concluded that “Periods of anger, fear, grumpiness, depression, hopelessness, and passivity are common, as you can discover by talking with others who have experiences with cancer. The success or failure of any treatment is not caused by the strength or weakness of your faith in it, by living right, or being a happy person.”<sup>451</sup> The comparison between the way in which “personality traits have been attributed to persons with cancer” with those “attributed in the last century to persons with tuberculosis”<sup>452</sup> showed that some members of the collective not only acknowledged the work of Sontag, but actively agreed with her.

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<sup>451</sup> Paula Brown Doress, Diana Laskin Siegal, and the Midlife and Older Women Book Project, in cooperation with the Boston Women’s Health Book Collective, *Ourselves, Growing Older: Women Aging with Knowledge and Power*, (New York: Simon & Schuster, 1987), 330.

<sup>452</sup> Paula Brown Doress, Diana Laskin Siegal, and the Midlife and Older Women Book Project, in cooperation with the Boston Women’s Health Book Collective, *Ourselves, Growing Older*, 330.

Despite the rejection of mind-body cancer care, many of the personal narratives in the book described ways in which women had worked on their own emotional health and personal growth in order to improve general physical health. One 74-year-old woman acknowledged that, “Whether I am healthy because I can be busy and happy or whether I can be busy and happy because I am healthy is a question.”<sup>453</sup> She did not provide an answer. Another woman described a search for ways of reaching her wellness and health goals she:

tried meditation, but my suppressed rage was so intense that nothing seemed to alleviate my health problems. When I was forty-seven, I finally woke up to the fact that I had been a doormat. I read that Tae Kwon Do [a Korean martial art] was good for assertiveness training for submissive women. To my surprise, yelling, hitting, and kicking at an imaginary opponent for an hour did wonders for my mind and body. My stress-related health problems began to disappear one by one. Today, at age fifty-nine, I have no pills in my medicine cabinet.<sup>454</sup>

Even when members of the collective made arguments against mind-body cancer care that were in full agreement with Sontag, they were invested in promoting a vision of health that was driven by personal fulfillment, emotional well-being, and empowerment. Directed by a different subset of the Collective, *Ourselves, Growing Older* more strongly emphasized the ways in which mind-body medicine could create blame for cancer, but still turned to it for other conditions.

## Conclusion and Epilogue

The BWHBC’s work showed a fraught relationship with psychological approaches to disease, and specifically to cancer. As they tried to identify what an empowered medical response might be they worked to balance ideas about the self as a healer with ideas about

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<sup>453</sup> Paula Brown Doress, Diana Laskin Siegal, and the Midlife and Older Women Book Project, in cooperation with the Boston Women’s Health Book Collective, *Ourselves, Growing Older*, 3.

<sup>454</sup> Paula Brown Doress, Diana Laskin Siegal, and the Midlife and Older Women Book Project, in cooperation with the Boston Women’s Health Book Collective, *Ourselves, Growing Older*, 13.

community responses, responsibility with blame, and freedom of choice in healing method with their idea of what was most rational. Moreover, they tried to see connections between personality, life experiences, and cancer as evidence of the danger of a patriarchal, racist and classist system. Throughout this process, they pushed up against the work of Susan Sontag. In the end, while they pointed out Sontag's arguments to readers, warning against blame, a "cancer personality," and political use of cancer as a metaphor, they leaned towards acceptance of the writing of LeShan, Simonton, and Lorde. This was in large part because new conceptions of cancer and emotion fit within their existing beliefs about repression of anger and stunted personal development among women.

Going forward, these ideas about emotional and physical healing as connected parts of women's empowerment would be separated from the radical politics of the collective. Varieties of these ideas, for example, were later incorporated into the world view of Oprah and the doctors and promoters of alternative medicine whose work she amplified through her media empire. These less radical visions nearly abandoned the focus on social, collective change and shifted away from the realities of patriarchy, racism, poverty, and environmental degradation as politically created sources of stress. Oprah called her viewers to watch *The Secret* (a movie which taught viewers how to use the "law of attraction" to heal and improve their lives through positive thinking) or read the book by Rhonda Byrne. This made it seem as if the only change needed was an individual shift in mindset, regardless of if the problem was with finances or health. Empowerment and gender roles still mattered to many of Oprah's guests, but it was personal empowerment through individual change. Frequent guests on Oprah's shows, Christianne Northrup and Caroline Myss both saw ovarian and breast cancer as tied to pathological relationships with men, but the cure was personal empowerment and escape from

bad marriages, not overthrowing the patriarchy. Northrop described ovarian cancer as “related to an extreme need for male authority or approval, as she gives her own emotional needs last priority.”<sup>455</sup> Myss described a patient with “serious ovarian and breast cancer” who “wanted to heal her cancer, but she lived with a man who treated her with total contempt.”<sup>456</sup> In both cases, the pathological dependence on men was presented as an individual problem with faulty gender roles, more akin to LeShan’s, Simonton’s, and Siegel’s calls for individual change than to the calls for collective action and social change that came from Lorde and the Boston Women’s Health Book Collective. As Bix concluded about the general acceptance of alternative care, “Feminist medical rebels had made the personal into the political, and in turn, modern alternative medicine had made the political into the personal.”<sup>457</sup>

Both Audre Lorde and Susan Sontag died of cancer, Lorde of metastatic liver cancer in 1992 and Sontag of Myelodysplastic Syndrome in 2004. In the late 80s, both Sontag and Lorde revisited their ideas about mind and illness. In 1989, Sontag expanded her analysis of the effect of metaphor on experiences with disease to AIDS, maintaining her position that psychological explanations of disease, metaphorical approaches to illness were cruel and blame-ridden. Her ideas about cancer would recur in arguments about the relevance of psychological factors to disease in popular publications and medical journals. With the knowledge that she was dying, Lorde published another piece on cancer, *A Burst of Light* in which she re-evaluated her attempts to fight cancer with visualization and self-actualization. She maintained the political drive to her approach. Her conclusions, which are worth quoting at length, fall in line with arguments that are

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<sup>455</sup> Christiane Northrup, *Women’s Bodies, Women’s Wisdom: Creating Physical and Emotional Health and Healing*, (New York: Bantam Books, 1998), 215.

<sup>456</sup> Caroline Myss, *Anatomy of the Spirit: The Seven Stages of Power and Healing*, (New York: Three Rivers Press, 1996), 53.

<sup>457</sup> Amy Sue Bix, “Engendering Alternatives,” 180.

continuously used in defense of psychotherapeutic approaches to cancer: evaluating psychological causes of cancer provides an impetus for growth that is unparalleled, and even if it doesn't work to extend your life, it might change your life for the better.

But my worst rage was the rage at myself. For a brief time I felt like a total failure. What had I been busting my ass doing these past six years if it wasn't living and loving and working to my utmost potential? And wasn't that all a guarantee supposed to keep exactly this kind of thing from ever happening again? So what had I done wrong and what was I going to have to pay for it and WHY ME?

But finally a little voice inside me said sharply, "Now really, is there any other way you would have preferred living the past six years that would have been more satisfying? And be that as it may, *should or shouldn't* isn't even the question. How do you want to live the rest of your life from now on and what are you going to do about it?" Time's a-wasting!

But there is a terrible clarity that comes from living with cancer that can be empowering if we do not turn aside from it. What more can they do to me? My time is limited, and this is so for each one of us. So how will the opposition reward me for my silences? For the pretense that this is in fact the best of all possible worlds? What will they give me for lying? A lifelong Safe Conduct Pass for everyone I love? Another lifetime for me? The end to racism? Sexism? Homophobia? Cruelty? The common cold?

It is the bread of art and the water of my spiritual life that remind me always to reach for what is highest within my capacities and in my demands of myself and others. Not for what is perfect but for what is the best possible. And I orchestrate my daily anticancer campaign with an intensity intrinsic to who I am, the intensity of making a poem. It is the same intensity with which I experience poetry, a student's first breakthrough, the loving energy of women I do not even know, the posted photograph of a sunrise taken from my winter dawn window, the intensity of loving.<sup>458</sup>

This defense of mind-body treatments for cancer, that they improved life even if they did not extend survival, provided an easy way to justify their use when patients did not survive and to

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<sup>458</sup> Audre Lorde, "Nov 15, 1986, A Burst of Light: Living with Cancer" in *A Burst of Light: Essays by Audre Lorde* (Ithaca: Firebrand Books, 1988), 122-123.

sidestep the prickly issues of victim-blaming. Like the Simontons, LeShan, and Siegel, Lorde argued that even patients who died gained by finding reasons to live.

## **CHAPTER FIVE:**

### **Mind-body Therapy as a Middle Ground**

It's a real hot potato.

-Senator Ted Kennedy<sup>459</sup>

On May 10, 1990, Senator Ted Kennedy, the chair of the Technology Assessment Board (TAB) met with the other members and the director of the Office of Technology Assessment (OTA), Dr. John H. Gibbons, to discuss the state of a controversial federal project begun three years before to review unconventional cancer treatments. They had all been previously updated on the struggles agency staff had faced in writing the report including calls and letters, negative press, and accusations of bias or worse from practitioners or promoters of various alternative treatments. Gibbons described the depth of patients' and family members' emotional investments in these treatments. Many wrote to say that they were worried they would no longer have "access to what they see as heroic measures." Doctors worried about patients who had discontinued potentially helpful conventional therapy in favor of unproven strategies, and others wrote about their desire to use both alternative and unconventional strategies together.<sup>460</sup> The senators and representatives clearly sympathized with Gibbons and the project director, and complimented

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<sup>459</sup> "Transcript of Proceedings: Congress of the United States Office of Technology Assessment Board Meeting May 10, 1990," page 19; Folder: TAB Meeting 5/10/90; Box 29/38 Meetings March-July 1990 Box 29/38; 1.6 Congressional Advisory Boards (TAB/TAAC); Records of the Office of Technology Assessment, ca. 1970-1995, Record Group 444 Office of Technology Assessment; National Archives Building, Washington, DC.

<sup>460</sup> "Transcript of Proceedings: Congress of the United States Office of Technology Assessment Board Meeting May 10, 1990," page 13; Folder: TAB Meeting 5/10/90; Box 29/38 Meetings March-July 1990 Box 29/38; 1.6 Congressional Advisory Boards (TAB/TAAC); Records of the Office of Technology Assessment, ca. 1970-1995, Record Group 444 Office of Technology Assessment; National Archives Building, Washington, DC.

them on the lengths they had gone to reach consensus, listen to critics, and move forward with the report. Nonetheless, Representative Houghton from New York expressed concern that the science could change before they finally released the report. “I hope you don’t have to get engulfed in this thing year after year after year,” he told Gibbons before acknowledging that, “I bet you feel that way, too.”<sup>461</sup>

In the ambitiously broad 1990 report, the main point of agreement between OTA staff, advisory board members, and critics was that mind-body cancer care was a promising form of complementary care. The controversy surrounding the report provides an opportunity to understand the place of psychotherapy in both alternative and conventional medicine. The controversy which delayed the report was indicative of a crisis in medical care as interest in alternative medicine grew. Advocates objected to the choice of project manager, the selection of the advisory committee, and the conclusions. As various drafts of the report were sent out, yet more complaints were registered. Before a hearing scheduled to listen to critics, the agency was in correspondence with police, ensuring that there would be precautions in place in case of rowdier protests.<sup>462</sup> However, even alternative practitioners who railed against the rest of the report’s claims generally agreed with its conclusions on psychological care as a part of cancer treatment. A joint letter from members of the report’s advisory panel critiqued the overall “tone

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<sup>461</sup> “Transcript of Proceedings: Congress of the United States Office of Technology Assessment Board Meeting May 10, 1990,” page 20; Folder: TAB Meeting 5/10/90; Box 29/38 Meetings March-July 1990 Box 29/38; 1.6 Congressional Advisory Boards (TAB/TAAC); Records of the Office of Technology Assessment, ca. 1970-1995, Record Group 444 Office of Technology Assessment; National Archives Building, Washington, DC.

<sup>462</sup> Letter from John H. Gibbons to Technology Assessment Board, March 6, 1990 “Re: Advisory Panel Meeting on Unconventional Cancer Treatments and Related Activities at OTA. Friday March 9 (9-5).” Unconventional Cancer Treatments; Box No. 31/40 August 1990; 3.1 Press Information Files; Records of the Office of Technology Assessment, ca. 1970-1995, Record Group 444; National Archives Building, Washington, DC.



and selection of facts,” but complimented “the psychological chapter,” because, “while flawed,” they believed it was “the best chapter in the report.”<sup>463</sup> Overall many critics believed this section had found a “middle ground” that was missing in the others.

This chapter shows that starting in the late 1970s, psychological approaches were adopted by medical professionals as a middle ground in broad conflicts over alternative medicine. While there is no single factor explaining this, I argue that mind-body cancer care appealed to doctors because it responded to many of their insecurities about their profession. Physicians were losing some of the deference to which they had become accustomed. Their conditions of employment were reshaping their clinical encounters, and they increasingly had to justify the utility of their treatments. Doctors faced growing criticism for alleged coldness, harsh treatments, and greed. Where they worried about the strength of their relationship with patients, mind-body medicine offered a way for doctors to show that they could listen and care. If they worried that patients would abandon conventional treatment in favor of alternative care, advocates promised that visualization, counseling, and hope would encourage compliance. Those who felt that their individual clinical judgment was undervalued by managed care and that their personal expertise was replaced by technology could use their insight to identify patients who needed additional psychological support. Finally, for those who resented that changes in the health care industry such as managed care limited the time they could spend with patients, the promise that emotional support could extend life helped to justify getting to know patients as a medical necessity.

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<sup>463</sup> Joint Letter from Selected OTA Advisory Panel Members, March 25, 1990, signed by Jeanne Achterberg, Ph.D. Institute of Transpersonal Psychology, Keith Block, M.D., Jonathon Collin, M.D., John Fink, Gar Hildebrand, Gerson Institute, Michael Lerner, Ph.D. Commonweal, Brendan O'Regan Vice President for Research Institute of Noetic Sciences, Andrew Weil, M.D, page 1; Folder: April, Box 18/32; Series 1.4 Correspondence Logs; Records of the Office of Technology Assessment, ca. 1970-1995, Record Group 444 Office of Technology Assessment; National Archives Building, Washington, DC.

Finally, the lack of risks from these treatments combined with the potential that even ineffective therapies might encourage psychologically and physically healthy behaviors limited the objections of doctors and other medical professionals.

In order to show these trends, I look at four key moments: Norman Cousins's career in health, the acceptance of the Simontons' work on guided imagery, debates over the meaning of a 1985 study in the *New England Journal of Medicine* (NEJM), and the 1990 Office of Technology Assessment report. My source material for this chapter includes mind-body literature, journal articles and responses, the papers of Norman Cousins which are held in the UCLA libraries, and OTA papers from the National Archives. This builds on a substantial literature addressing challenges to the prestige of doctors and the rising interest in alternative medicine. In particular, I use the work of Paul Starr, Jill Quadagno, Stanley Reiser, and Norman Gevitz. My argument that doctors' resulting insecurities encouraged them to embrace mind-body medicine builds on observations from Harrington. She argues that Norman Cousins' mind-body work "looked like a lifeline to many in the medical profession" because he framed holistic medicine as a partnership with physicians and demonstrated what that might look like with his own doctor.<sup>464</sup> I show that this partnership with physicians and careful alignment with their goals and preferred methods of care was key, not just to the embrace of Norman Cousins, but of mind-body cancer care more generally.

### **Physicians' Insecurities**

Many doctors during the 1970s and 80s were sensitive to a perceived decline in their prestige. "By the 1970s," historian John Burnham has noted, "statesmen of medicine were

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<sup>464</sup> Anne Harrington, *The Cure Within*, 124-125.

writing unhappily about being ‘deprofessionalized’ in the wake of attacks by articulate and knowledgeable critics.”<sup>465</sup> Skyrocketing costs created growing demand for either government regulation or attempts to encourage market competition through managed care. Campaigns addressing both the right to and rights within healthcare repositioned the physician’s role in society, and their reputation. Americans’ increasing distrust of authority coupled with frustration at the seemingly slow progress in medicine (particularly in cancer care) and high profile medical disasters combined to increase the perception that medicine was an industry bent on profit rather than a vocation driven by concern for patients. Meanwhile, changing financial incentives and growing corporatization of medicine made it increasingly difficult for doctors to develop a relationship with each of their patients. These changes made many physicians feel as if they had lost something in their roles and that they needed to regain the trust of a public that was ever more inclined to rely on alternative treatments instead of their own. Understanding physicians’ sense of their shifting place in society and medicine can help in understanding the appeal of mind-body medicine among this group.

According to Paul Starr, in the 1970s “[t]he economic and moral problems of medicine displaced scientific progress at the center of public attention.”<sup>466</sup> In 1970, a survey showed that three quarters of heads of families believed that the United States faced a crisis in health care.<sup>467</sup> Rising costs were at the center of this belief. Between 1960 and 1970 per capita health costs rose from \$142 to \$336 and total federal and state expenditures rose from 10.8 billion in 1965 to 27.8

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<sup>465</sup> John Burnham, “American Medicine’s Golden Age: What Happened to It?” *Science*, 215 no. 19 (1982): 1474.

<sup>466</sup> Paul Starr, *The Social Transformation of American Medicine: The Rise of a Sovereign Profession and the Making of a Vast Industry* (Basic Books, 1982), 379.

<sup>467</sup> Paul Starr, *The Social Transformation of American Medicine*, 381.

in 1970.<sup>468</sup> Third-party fee for service payment systems built without cost controls drove this increase. This payment model also shaped the type of services provided. Doctors were incentivized to have hospital visits instead of office visits, to increase the volume of procedures and testing, and to minimize the time they spent doing more difficult to bill things like talking to patients. In addition, this encouraged specialization over general practice.<sup>469</sup> Meanwhile, Americans increasingly resented the AMA's earlier campaigns to prevent socialized medicine.<sup>470</sup>

As health care costs increased and many were left out of entitlement programs, advocacy for the right to health care increased. Simultaneously, many like those in the Boston Women's Health Book Collective (as discussed in chapter four) pushed for rights within healthcare such as "Informed consent, the right to refuse treatment, the right to see one's own medical records, the right to participate in therapeutic decisions, and the right to due process in any proceeding for involuntary commitment to a mental institution."<sup>471</sup> Each of these claims operated on the assumption that doctors would not always act in the best interest of their patients. In 1977 one surgeon said that one thing he did "resent and resent very deeply is the idea that has been prevalent for the past seven years that patients have to be protected from physicians. This is a terrible thought to me. The best guardian that you can have of your welfare when you are ill with anything is your physician."<sup>472</sup> But Americans had a growing skepticism about doctors and suspicion of their profit motives.

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<sup>468</sup> Paul Starr, *The Social Transformation of American Medicine*, 384.

<sup>469</sup> Paul Starr, *The Social Transformation of American Medicine*, 386.

<sup>470</sup> See Paul Starr, *The Social Transformation of American Medicine*, Jill Quadagno, *One Nation Uninsured: Why the U.S. Has No National Health Insurance* (Oxford: Oxford University Press, 2005), and John Burnham, "American Medicine's Golden Age: What Happened to It?"

<sup>471</sup> Paul Starr, *The Social Transformation of American Medicine*, 389.

<sup>472</sup> Paul Starr, *The Social Transformation of American Medicine*, 390.

This distrust of medicine was easy to see in popular books and movies, news stories, high-profile medical disasters, and of course the resulting lawsuits. In popular culture, both the book and movie versions of *One Flew Over the Cuckoo's Nest* echoed the claims of the anti-psychiatry movement. The publication of *Medical Nemesis* by Ivan Illich drew attention to iatrogenic health problems and argued that risks from healthcare outweighed the benefits. These claims seemed real enough to many in the face of stories which undermined claims of both medical professionals and drug companies that they served the interest of patients. The exposure of Dalkon Shield's risks, its withdrawal from the market, and resulting lawsuits made many fear distrust the safety of medical processes which might seem routine. Use of Diethylstilbestrol for pregnant women was discontinued in 1971, with lawsuits for the cancers that it caused stretching into the 1980s. These cases made treatment options seem dangerous and understudied. Meanwhile, the revelation of the Tuskegee Syphilis Study drew into question whether doctors cared about treating patients at all. Other high-profile lawsuits challenged the previously assumed dominance and infallibility of MDs. The American Medical Association faced an antitrust suit from chiropractors.<sup>473</sup> Wyatt v. Stickney challenged the ability to indefinitely hold psychiatric patients against their will without providing what courts decided was adequate treatment. But mostly, physicians worried about facing malpractice suits. Doctor Louis Lasagna wrote in 1982 that "Lawyers and the courts seem every day to increase their meddling in our lives. The stress on 'patients' rights' sometimes seems to transmute itself into a symbol of

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<sup>473</sup> For more on this see Walter I Wardwell "Chiropracotors: Evolution to Acceptance" in *Other Healers: Unorthodox Medicine in America* ed. Norman Gevitz (Baltimore: Johns Hopkins University Press, 1988).

distrust. ‘Defensive medicine’ is the inevitably wasteful consequence of a society that grows more litigious all the time.”<sup>474</sup>

While these broad trajectories shaped doctor-patient relationships more generally, the combination of increased cost, seemingly slow progress, and failure to recognize the humanity of the patient was particularly powerful in cancer treatment. The 1970s saw both a public commitment to the war on cancer with increases in funding as well as promises of rapid cures. The failure to realize those cures led to increased frustration even as the costs of orthodox cancer care skyrocketed. Nixon’s “War on Cancer” began with the signing of the National Cancer Act in 1971 and promised quick cures with the scientific man power that had put a man on the moon in under a decade. The scientific optimism of penicillin, the polio vaccine, and space travel poured into cancer research. In his 1971 state of the union address, President Nixon called for “an appropriation of an extra \$100 million to launch an intensive campaign to find a cure for cancer” because “[t]he time has come in America when the same kind of concentrated effort that split the atom and took man to the moon should be turned toward conquering this dread disease. Let us make a total national commitment to achieve this goal.”<sup>475</sup> The next year while speaking to a National Cancer Conference in LA, he was slightly more circumspect in his hopes. “But perhaps more likely, from what I have learned in my rather brief acquaintance with the intricacy of this problem,” he said, “there will not be any single cure, it will not come suddenly. It may be that many people will each contribute partial cures-progress for various forms of this dread disease. But whenever and wherever the answers come, what they are going to represent is the

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<sup>474</sup> Louis Lasagna, “Review: Lipp, Martin R. *The Bitter Pill: Doctors, Patients and Failed Expectations*,” *Journal of Nervous and Mental Disease*, 170 no. 7 (1982): 440-441.

<sup>475</sup> Richard Nixon, “Annual Message to the Congress on the State of the Union,” January 22, 1971. Online by Gerhard Peters and John T. Woolley, *The American Presidency Project*. <http://www.presidency.ucsb.edu/ws/?pid=3110>.

final steps of a long journey, a journey that many of you in this room have been on for many, many years.”<sup>476</sup>

Nevertheless, the optimism and potential for unfulfilled hopes in the war on cancer drew wide-ranging criticism. The *New York Times* published an article several months after Nixon’s state of the union speech, but before the National Cancer Act passed that December. The article warned that “No general cure for cancer is in sight.” And little hope was given that this could “quickly be changed,” regardless of if spending were as high as “the country’s entire yearly military budget.” Despite the general optimism about scientific progress in the US, the author said:

the cancer problem can be equated with neither the Manhattan Project, which produced the atom bomb, nor the Apollo Project, which first put men on the moon. Both of these great efforts were primarily engineering tasks, which attained full momentum after the basic scientific principles were understood. Unfortunately, there is still colossal ignorance about the origin of cancer in all its myriad forms, even though some encouraging progress has been made.<sup>477</sup>

The optimism of rhetoric from the war on cancer and of spokespeople from the American Cancer Society was used by people like Ralph Moss, the assistant director of public relations at Memorial Sloan-Kettering Hospital who was fired following his accusations of a cover up of Laetrile data, to frame discussions of the continued challenges of orthodox medical care. Moss’ 1980 book, *The Cancer Syndrome*, drew on these issues of distrust in the government as well as hopes for a rapid cure together. “‘A medical Vietnam’ is how Food and Drug Administrator Donald Kennedy, Ph.D., succinctly described the war on cancer,” he wrote. Moss accused the government of hiding evidence of the efficacy of alternative cancer treatments while

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<sup>476</sup> Richard Nixon, “Remarks to a National Cancer Conference in Los Angeles, California,” September 28, 1972. Online by Gerhard Peters and John T. Woolley, *The American Presidency Project*. <http://www.presidency.ucsb.edu/ws/?pid=3610>.

<sup>477</sup> “War on Cancer,” *New York Times*, May 31, 1971: L17.

simultaneously avoiding discussion of the limitations of their own programs and orthodox care. Rising distrust in government agencies and in experts undermined attempts to regulate cancer treatments like Laetrile or Immuno-Augmentive Therapy and the rates at which people sought alternative treatment rose.

In 1984, a study of the characteristics of patients who used unorthodox medicine was framed in part as “an inquiry into the reasons for the sustained and apparently growing appeal of anti-medicine, non-medicinal, lifestyle-oriented alternatives during a period of technologic advance in orthodox medical care.”<sup>478</sup> The study included 304 inpatients at the University of Philadelphia Cancer Center, of whom 13% had once or still used alternative treatments, and 380 patients who were contacted through alternative practitioners.<sup>479</sup> Patients who used alternative treatments were more likely to be white and more likely to be well educated.<sup>480</sup> Use of alternative medicine was negatively correlated with positive views of the medical profession, and also with positive views of the government. “More than half of all patients,” according to the study, “regardless of treatment, felt that the government and the medical establishment attempt to deny freedom of choice in cancer treatment.” But their beliefs about the reasons were closely tied to their choice of treatment. Those “receiving conventional care were more likely to ascribe benevolent motives to this effort, such as the government's desire to protect the public or its maintenance of an overly conservative or cautious stance. Patients who used alternative therapies were more likely to interpret establishment efforts in terms of vested economic interests.”<sup>481</sup>

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<sup>478</sup> Barrie R. Cassileth, Edward J. Lusk, Thomas B. Strouse, and Brenda Bodenheimer, “Contemporary Unorthodox Treatments in Cancer Medicine: A Study of Patients, Treatments, and Practitioners,” *Annals of Internal Medicine*, 101 no. 1 (1984): 105.

<sup>479</sup> Barrie R. Cassileth et al. “Contemporary Unorthodox Treatments in Cancer Medicine,” 105-106.

<sup>480</sup> Barrie R. Cassileth et al. “Contemporary Unorthodox Treatments in Cancer Medicine,” 107.

<sup>481</sup> Barrie R. Cassileth et al. “Contemporary Unorthodox Treatments in Cancer Medicine,” 110.



Even some of the clear advances in cancer care were seen as the result of “mavericks in the cancer field, who had to buck the establishment to get their position heard,” not as successes of “the war on cancer.”<sup>482</sup> The development and acceptance of more limited breast cancer surgeries such as lumpectomy and simple mastectomy were considered examples of progress in spite of rather than because of the medical establishment. The one-step radical mastectomy (a procedure which combined surgical biopsy with a Halsted radical mastectomy, the removal of the affected breast, all underarm lymph nodes, and both chest wall muscles, in the case that the tumor was malignant) had been the unquestioned surgical option (except when surgeons opted for super-radical or extended radical procedures which removed extra lymph nodes and occasionally ribs).<sup>483</sup> Patients typically learned of their diagnosis only after waking up without a breast. George “Barney” Crile Jr., a surgeon at the Cleveland Clinic, began to argue that radical

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<sup>482</sup> Ralph Moss, *The Cancer Industry: Unravelling the Politics* (New York: Paragon House, 1989), 7. Originally published in 1980 as *The Cancer Syndrome*.

<sup>483</sup> The one-step radical was considered gospel- in part because of the reputation of its creator, Halsted, but also because it had made greater logical sense given earlier theories of cancer spread and patterns of late stage diagnosis, and because it fit into gendered understandings of surgical “bravery.” At a time when many cases of breast cancer were not diagnosed until there were not only easily palpable tumors but even after ulcerating skin lesions began to appear, extensive surgery was often required. However, as more cases were diagnosed at earlier stages, the need for this was limited. But by this time it was entrenched and many surgeons considered removing less tissues as less safe. For them, more surgery was self-evidently more. In *The Breast Cancer Wars*, Barron Lerner shows the impact of masculine standards on surgeons by pointing out the military metaphors that dominated surgical practice after World War Two. Surgeons returning from the war emphasized their bravery by performing ever more extensive radical surgeries. George Pack, nicknamed Pack the Knife, treated breast cancer as well as many other conditions and consistently pushed beyond standard procedures. When treating breast cancer patients, he often removed several ribs in order to reach more lymph nodes including those behind the clavicle in addition to the pectoral muscles. Lerner quotes Pack as saying “We shall have to wrestle with it often and fiercely before the final conquest. For today, the victory must lie in the struggle itself.” According to Lerner, masculinity ranked alongside factors such as hope, individualism and self-esteem to promote ‘wars’ on cancer. He demonstrated that like Pack, many considered “insufficiently radical surgery” as “nothing less than surgical cowardice.” Barron Lerner, *The Breast Cancer Wars: Fear, Hope, and the Pursuit of a Cure in Twentieth-Century America* (Oxford: Oxford University Press, 2001).

mastectomies were unnecessary in most cases, and stopped performing them in 1955. A group of surgeons including Oliver Cope from Massachusetts General Hospital and William Nolen who practiced in Minnesota, argued alongside him.<sup>484</sup> But many other surgeons saw simple mastectomies and lumpectomies as tantamount to a death sentence for patients. As the argument grew increasingly heated Crile published articles in the popular press, several books (*Cancer and Common Sense*, 1955; *What Women Should Know About the Breast Cancer Controversy*, 1973), appeared on TV, and even accused colleagues of preferring more extensive surgeries because of cost, drawing censure from colleagues who felt that the debate should remain internal. In 1975, Arthur Holleb complained that “women are marching on clinics and private offices waving copies of *McCall’s*, *Good Housekeeping*, *Ms.*, *Playgirl* or the supplement from their local newspaper.”<sup>485</sup> Crile was even censured in the same year by the Cleveland Academy of Medicine “for airing his views to the public instead of the medical profession.”<sup>486</sup>

While some doctors resented implications from patients that their treatment decisions were not infallible, they also faced technological developments that seemed to make their personal clinical wisdom less important, coupled with new controls on their work and pay. In 1978, Stanley Reiser, the director of Harvard Medical School’s Program in the History of Medicine, wrote that “modern medicine has now evolved to a point where diagnostic judgments based on ‘subjective evidence—the patient’s sensations and the physician’s own observations of the patient—are being supplanted by judgments based on ‘objective’ evidence, provided by

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<sup>484</sup> Many others, like Babette Rosamond and Rose Kushner, began to argue that the one-step procedure limited their choice. Despite officially giving their consent, in this case they gave a kind of surgical blank check.

<sup>485</sup> Barron Lerner, *The Breast Cancer Wars*, 164.

<sup>486</sup> Barron Lerner, *The Breast Cancer Wars*, 167

laboratory procedures and by mechanical and electronic devices.”<sup>487</sup> This was not without consequences. Doctors found that because “many of these instruments seemed to run themselves... the physician [became] in a sense more steward than master.”<sup>488</sup> The individual wisdom and intuition of the physician became less important. Technology also seemed to make it more difficult for doctors to listen to patients, whose verbal descriptions of symptoms could be discounted in favor of numerical representations. The physician, Reiser said, “must accept the patient as a human being, and regain and reassert his faith in his own medical judgment.”<sup>489</sup> In addition to doctors’ sense that their personal abilities were being sidelined in favor of technological judgments, many felt like they were losing their autonomy because of changing employment situations and cost control mechanisms.

Fee for service models in the US, paid by insurance agencies or intermediaries for the government had mostly signed off on all expenses. But in the 1970s and 80s, both attempts to control rising costs through regulation and conservative attempts to control costs through corporatization and private market competition led to decreased autonomy for physicians. Regulation attempted to curb unnecessary treatment or costs. Despite physician authorization for a procedure or expense, reimbursement could now be denied to hospitals by Professional Standard Review Organizations. Treatment had to be demonstrably useful. This encouraged hospitals to monitor and manage the work of physicians. Meanwhile, increasing numbers of doctors, rising costs of lawsuits, and the attempt to shift cost control to the private market led to an employment shift for doctors as many became employees instead of private practitioners. In

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<sup>487</sup> Stanley Joel Reiser, *Medicine and the Reign of Technology* (Cambridge: Cambridge University Press, 1978), ix.

<sup>488</sup> Stanley Joel Reiser, *Medicine and the Reign of Technology*, 229.

<sup>489</sup> Stanley Joel Reiser, *Medicine and the Reign of Technology*, 231.

*The Transformation of American Medicine*, Paul Starr identified this trend, noted that it was a buyer's market for employers, and highlighted concerns that it would continue. His expectation that the trend in employment conditions would continue proved correct. It was later found that "[a]mong newly practicing doctors (0 to 5 years in practice), the proportion who were salaried employees increased from 37 to 66 percent between 1983 and 1997."<sup>490</sup> Between funding checks and direct employment, doctors were increasingly answering to others. Many resented this intrusion on their autonomy and worried that it would limit their ability to provide care. In his 1980 book, *Bitter Pill: Doctors, Patients, and Failed Expectations*, Dr. Martin Lipp concluded that "The next several decades are going to be brutalizing for conscientious physicians who wish to be complete physicians to patients they want to see as whole human beings, who try to do it all."<sup>491</sup> Dr. Louis Lasagna, a physician who advocated for randomized clinical trials and wrote the 1964 version of the Hippocratic Oath now used in one third of American medical schools, reviewed the book. He said that it "expresses, in compelling style, the anxieties and concerns of a physician who is justifiably worried about what is happening to his profession." For Lasagna, a fight to change the terms of medicine, the policies and politics was necessary, "but," he said, "the right to practice good medicine is worth fighting for."<sup>492</sup>

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<sup>490</sup> Paul Starr, "The Coming of the Corporation," in *The Social Transformation of American Medicine*.

<sup>491</sup> Martin Lipp, *Bitter Pill: Doctors, Patients and Failed Expectations* (New York: Harper & Row, 1980). Cited in Matthew Ross, "Book Review," *General Hospital Psychiatry*, Vol. 4, Iss. 2 (1982): 161.

<sup>492</sup> Louis Lasagna, "Review: Lipp, Martin R. *The Bitter Pill: Doctors, Patients and Failed Expectations*," *Journal of Nervous and Mental Disease*, 170 no. 7 (1982): 441. Perhaps Lasagna was more sensitive than the average physician to changes to the doctor-patient relationship. His version of the oath includes a promise to treat not "a fever chart, a cancerous growth, but a sick human being" and a vow to "remember that there is art to medicine as well as science, and that warmth, sympathy, and understanding may outweigh the surgeon's knife or the chemist's drug."

## Creating Common Ground

Against this background of distrust in “the system” more generally and in medicine and cancer care specifically, patients faced the personal reality that despite expectations of silver bullets and rapid medical breakthroughs, many diseases remained untreatable. Even for those patients whose cancers were treatable, the protocols were often harsh, and they continued to live with the uncertainty of chronic illness. Mind-body care was appealing because it humanized cold hospital settings and provided hope. And most importantly, doctors remained open to it. Mind-body cancer care was presented to oncologists in ways that explicitly tied it to standard medicine. Norman Cousins argued that it was about a return to values that had traditionally shaped the doctor patient relationship. Strengthening that relationship, he argued, gave doctors a way to help even when their available medications were not of use. Those who taught visualization to cancer patients structured the visualizations around the role of the medications and treatments their oncologists prescribed. This was supposed to strengthen, not replace medical care. Placebo and evidence based medications could, they argued, be harnessed together. Repeatedly, advocates of mind-body care warned that if hope and patient involvement were not fostered through hospital programs, patients would turn to types of care that would replace or interfere with treatment. It seemed to provide evidence of a direct medical benefit for improving doctor-patient relationships and taking time with individual patients. In effect, mind-body care strengthened doctors’ hands. These arguments were so effective in securing medical acceptance for mind-body medicine that questioning its scientific validity became hugely controversial and proponents of other alternative treatments came to envy the status of mind-body approaches to medicine.

Norman Cousins, former editor-in-chief of the *New York Evening Post* and peace advocate, was one of the most effective advocates for mind-body medicine. Cousins was able to

position himself as someone who could help to repair the doctor-patient relationship and use this relationship to build up patients' ability to contribute to healing. Cousins' arguments stemmed from critiques that modern medicine was cold, often unnecessarily brutal in its treatments, disconnected from the individual, and rather prone to missing the point. Norman Cousins' most famous writing was not primarily about cancer, but rather about mind-body approaches to illnesses which he had personally faced: Ankylosing Spondylitis and heart disease. However, he supported the careers and research of those who studied the relationship between mind and cancer. In his books, articles and speeches he was clear about his belief in a role for therapy in healing from cancer. Cousins' name was cited in nearly every scientific and popular discussion of psychological approaches to cancer.<sup>493</sup> His work positioned mind-body medicine as a middle ground between conventional care and the general push towards alternative medicine. He did not propose replacing conventional techniques; rather, he thought doctors should simply get to know their patients better, work with them to understand the context of their disease, and help provide hope. This relationship between hope and healing could then continue even if the standard medical arsenal ran out of options.

Cousins' transition from journalism and advocacy into the world of healthcare began in the late seventies. In 1976, he published an article in the *New England Journal of Medicine*.<sup>494</sup> In a departure for the journal, this was a case narrative Cousins wrote about his own illness. Cousins recounted how he had (with the aid of large doses of Vitamin C and Marx Brothers movies) laughed himself into a remission of severe Ankylosing Spondylitis. He believed positive

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<sup>493</sup> This includes Angell's editorial discussed below, *Unconventional Cancer Treatments* (the report produced by the OTA), popular books, and news articles.

<sup>494</sup> Norman Cousins, "Anatomy of an Illness (As Perceived by the Patient)," *New England Journal of Medicine*, 295 No. 26 (1976): 1458-1463.

thoughts – in his case humor – helped reduce the impact of adrenal fatigue. In 1979, he expanded the narrative into a book titled *Anatomy of an Illness*. Both the book and the article set off a storm of responses, almost entirely positive. By the time the book was published, Cousins said that he had received about 3,000 letters about the article.<sup>495</sup> Physicians wrote initially to *NEJM* with a wide variety of responses, from standard letters to jokes and verse, all encouraging other doctors to take a more thorough look at the role of patients, and the doctor's relationship with them, in healing.

Some of this correspondence came from doctors who resented the idea that their personal judgments and clinical intuitions were not taken as valid observations. They believed that an overreliance on technology, statistics, and laboratories was harming medicine. Dr. Hunter H. McGuire Jr. of the Medical College of Virginia wrote that science had “become falsely equated with its tools: with oscilloscopes, computers, graphs, P values and reference lists.”<sup>496</sup> In addition to complimenting Cousins on his writing, Derrick Lonsdale from the Cleveland Clinic wrote to encourage his colleagues “in the medical profession” to “take it very seriously to heart and consider the deep implications behind these words of wisdom.” Lonsdale lamented changes in modern medical culture which might make it easy to disregard case narratives or anecdotes like Cousins’ instead of learning from them. “We have become saturated,” he claimed, “with the idea that ‘anecdotal’ clinical observation is a figment of an individual imagination and therefore to be ignored because it cannot be proved in the test tube.”<sup>497</sup> Even Sir William Osler could not, he

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<sup>495</sup> Norman Cousins, *Anatomy of an Illness: Reflections on Healing and Regeneration* (New York: W.W. Norton & Company, 1979), 125.

<sup>496</sup> Hunter H. McGuire, “Letter to the Editor,” *New England Journal of Medicine*, 296 no. 13, (1977): 762.

<sup>497</sup> Derrick Lonsdale, “Letter to the Editor,” *New England Journal of Medicine*, 296 no. 13, (1977): 762.

thought, be published in the contemporary climate of overreliance on the laboratory instead of observation and communication with patients. In effect, Lonsdale considered the truths of Cousins' work so clear as to be a justification for anecdotal evidence from clinical observation. Mind-body approaches to medicine were, in his mind, nearly self-evident. For both Lonsdale and McGuire, Cousins seemed to give power back to the individual physician by providing value to their observations over what they seemed to view as the rote application of best practices and lab tests. Others submitted responses that were more playful in their embrace of Cousins. Milton Chatton, a doctor who worked in a department of rehabilitation in Los Altos, CA, wrote in verse:

[Cousins] showed the 'truly wondrous' pow'r  
Of human cerebration,  
Placebo and bright laughter,  
Upon his inflammation.<sup>498</sup>

Riffs on this theme continued. Two years later, a doctor from Spain wrote in a with a terser summary of Cousins' argument, stating simply that "the surly bird gets the germ."<sup>499</sup>

In his own response to the correspondence published in the *NEJM*, Cousins stressed again the doctor-patient relationship, and the power to heal that it provided the doctor. He wrote that he had personally "received some 500 communications and requests for reprints" and he characterized the letters as "supportive and gratifying."<sup>500</sup> Initially, he said, he had feared the responses, but "it is now clear to me that a substantial number of physicians are now open and responsive to new ideas, who attach the highest importance to doctor-patient relations and who, while maintaining full respect for the scientific method, nonetheless are imbued with the idea

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<sup>498</sup> Milton J. Chatton, "Letter to the Editor," *New England Journal of Medicine*, 296 no. 13, (1977): 763.

<sup>499</sup> Daniel Shindler, "Laughter Therapy: The Surly Bird Gets the Germ, Letter to the Editor," *New England Journal of Medicine*, 300 no. 22 (1979): 1283.

<sup>500</sup> Norman Cousins, "Letter to the Editor, Response," *New England Journal of Medicine*, 296 no. 13, (1977): 763.



that the practice of medicine also belongs to the creative arts.”<sup>501</sup> While Cousins predicted that new discoveries would reshape all other facets of medicine, he believed “the sensitivity of the physician to the fragility of life, and to the resources within the patient that can be mobilized in an atmosphere of confidence and rapport” would never lose their importance.<sup>502</sup> His arguments about the personal characteristics of the physician and the power of personal relationships were embraced.

The book version of the article again managed to create a focus not on what patients could achieve outside of the medical profession, but on the importance of working with a physician. Cousins clearly credited his own physician, Dr. William Hitzig, as a support in his healing. They had, he said, “been close friends for more than twenty years...[and] had often discussed articles in the medical press.” Cousins considered himself fortunate to have a doctor who could be candid and “was able to put himself in the position of the patient.”<sup>503</sup> Cousins developed his plan for using Vitamin C and laughter in a non-hospital setting only after discussion with his physician about possible causes, and determined the specifics and the evaluated the risks in consultation with Hitzig. He credited his doctor with “listening carefully as [he] told him of [his] speculations” and said that Hitzig “shared [his] excitement about the possibilities of a recovery and liked the idea of a partnership.”<sup>504</sup> The physician, if not always the protagonist, always remained an important and valued position in this story. In 1980, JAMA published a review by Peter Horse, a doctor at the University of Chicago Medical Center. He wrote about the “kind of partnership” that Cousins developed with his physician to achieve his

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<sup>501</sup> Norman Cousins, “Letter to the Editor, Response,” 763.

<sup>502</sup> Norman Cousins, “Letter to the Editor, Response,” 763.

<sup>503</sup> Norman Cousins, *Anatomy of an Illness*, 30.

<sup>504</sup> Norman Cousins, *Anatomy of an Illness*, 38-39.

cure, again recognizing that this did not abrogate or threaten the doctor's role. The most negative thing the reviewer mentioned was that he was unsure how much the book added "to the original journal article" which he pointed out, "has been used repeatedly for medical teaching and discussion for nearly three years."<sup>505</sup> Cousins' work had clearly made an impact. His calls for physicians to help patients take responsibility, to involve themselves in care, and to foster hope had become a common part of medical education.

Cousins' work had touched a nerve. The article helped him as he started his second career in 1978 as a professor at UCLA. Housed in the department of psychiatry and behavioral sciences, Cousins' institutional affiliation further strengthened his legitimacy as a commentator on medicine in the U.S. His books on medicine written while at UCLA were widely read. In addition to *Anatomy of an Illness* and *Head First*, these included *The Healing Heart* and *The Physician in Literature*. He remained in high demand as a speaker, and gave talks at American Cancer Society events, medical school graduations, cancer support groups, public events, and professional association meetings. In addition to this work advocating for mind-body medicine, Cousins was able to develop an institutional home for it at UCLA. He was an effective fundraiser and developed a Task Force in Psycho-Neuro-Immunology (PNI) at UCLA which helped fund research. He was also instrumental in creating a new program in PNI at UCLA. In his career, Cousins was fundamental in tying mind-body medicine to the idea of a renewed doctor-patient relationship.

Ten years after the publication of *Anatomy of an Illness*, when Cousins published his book *Head First: The Biology of Hope*, doctors were still writing about how Cousins had

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<sup>505</sup> Peter H Morse, "Book Review," *Journal of the American Medical Association*, Vol. 243, No. 14 (1980): 1471.

involved physicians and worked to communicate with people in the medical profession. They praised him for recognizing that doctors tended to think differently than journalists. A reviewer in *NEJM* noted that “[o]ther ‘holistic’ practitioners have avoided the struggle [of trying to work with and understand the perspective of doctors] and resorted to polemic, personal influence and the appeal to desperate or dissatisfied patients for permission to act.” However, he praised Cousins because, “by contrast, [he] has chosen to join forces with traditional medicine, an eminently more productive credible endeavor.”<sup>506</sup> In this book, Norman Cousins had continued to depict what he saw as the ideal patient-physician relationship. After beginning his medical career at UCLA, Cousins said that a popular misconception arose that he had been appointed “as a medical ombudsman.”<sup>507</sup> He included three full pages of brief descriptions of patients who called or wrote to share stories of problems they had faced with their physicians. He claimed that the pattern in most of these stories “was that the patients felt they had not been treated with adequate respect or sensitivity.”<sup>508</sup> Often, he said, “poor communication rather than poor treatment served as the basis for these complains.” From these and other experiences with patients and doctors, Cousins concluded that “full communication between patient and physician is indispensable not just in arriving at an accurate diagnosis but in devising an effective strategy for treatment.” More importantly he added that, without clarification from physicians and compassion, “fear can exaggerate a negative diagnosis” while the reversal could “create nature’s own bypass.”<sup>509</sup> The investment of a doctor’s time and emotional energy could heal. Much of the failure to build these relationships was, Cousins believed, the fault of medical payment

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<sup>506</sup> Matthew A Budd, “Review: Head First: The Biology of Hope,” *NEJM*, April 26, 1990, 332: 1240.

<sup>507</sup> Norman Cousins, *Head First: The Biology of Hope* (New York: E.P. Dutton, 1989), 44.

<sup>508</sup> Norman Cousins, *Head First*, 47.

<sup>509</sup> Norman Cousins, *Head First*, 55.

structures. Because the “medical economy [was] dominated by third-party paymasters—insurance companies, the government, health plans, etc.—the harsh reality [was] that doctors get paid mostly for tests and procedures.”<sup>510</sup> In effect, Cousins tactfully communicated patient complaints and reconciled their frustrations with doctors’ anger about the constraints on their funding, control over their work, and reliance on technology that minimized their role. Mind-body medicine and hope became the medical justifications for fixing both what patients and what doctors saw as the problems with the modern medical system.

The task force began in 1984 when Joan Kroc expressed an interest in endowing a chair at UCLA in Cousins’ name. After some discussion, they decided instead that her \$2,000,000 donation could be put toward “advancing research in mind-body studies,” with half kept aside to support mind-body research projects at other institutions.<sup>511</sup> Cousins built a task force of researchers who could help to share their ideas, brainstorm new projects, identify existing research programs, and decide which to fund. Of the eight members who eventually joined, not including Cousins, two focused primarily on cancer.<sup>512</sup> Dr. Claus B. Bahnson was a psychologist at University of California, San Francisco. He had first published on emotion and cancer in a 1964 volume edited by Kissen and LeShan, but his first publications were on psychosomatic approaches to coronaries.<sup>513</sup> Later the task force added Dr. Fawzy I. Fawzy who worked on the health effects of positive attitudes on cancer and AIDS. Other members focused on medical

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<sup>510</sup> Norman Cousins, *Head First*, 55.

<sup>511</sup> Norman Cousins, *Head First*, 196-197.

<sup>512</sup> Norman Cousins, *Head First*, 198.

<sup>513</sup> C.B. Bahnson and M.B. Bahnson, “Denial and Repression of Primitive Impulses and of Disturbing Emotions in Patients with Malignant Neoplasms,” in *Psychosomatic Aspects of Neoplastic Disease* ed. By D.M. Kissen and L.L. LeShan. Cited in Claus B. Bahnson, “C.V., Numbered Reprint List.” Box 1750, Folder: Cancer, Norman Cousins Papers (Collection 1385). Department of Special Collections, Charles E. Young Research Library, University of California, Los Angeles.

ethics, behavioral aspects of health, or psychoneuroimmunology (PNI).<sup>514</sup> In addition to funding research and sharing their work, the task force and the donation supported “a series of programs at UCLA itself—lectures at the medical school, a postdoctoral program, a research award program, an international conference, and courses in psychoneuroimmunology.”<sup>515</sup> Cousins’ work with the task force would continue to receive substantial donor support including five million from Burton Bettinger and an additional three million from Joan Kroc.<sup>516</sup> The activities of the task force served to legitimize the connection between emotion and cancer.

The task force’s work on PNI was part of a larger trend that was particularly effective in providing a scientific basis for connections between the mind, carcinogenesis, and survival.<sup>517</sup> Members of the task force worked on a number of basic research questions on topics including “immune functions and interactions” and “the biology of pain.” Dr. George F. Solomon, a pioneer in PNI also served on the panel.<sup>518</sup> The 1980s had seen a sharp increase in PNI articles. The field started to be able to demonstrate connections between normal, temporary stressors like examinations, measurable levels of immune function, and infections and wound healing.<sup>519</sup> Even when existing evidence that cancer and emotions were connected was found to be inconclusive, evidence that immune function was connected to mood and stress encouraged a willingness to entertain the idea. In her 1987 book, *Cancer and Emotion: Psychological Preludes and Reactions to Cancer*, Jennifer Hughes wrote that because of “laboratory evidence that

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<sup>514</sup> Norman Cousins, *Head First*, 198-199.

<sup>515</sup> Norman Cousins, *Head First*, 209.

<sup>516</sup> Norman Cousins, *Head First*, 226-228.

<sup>517</sup> More on psychoneuroimmunology in chapter two.

<sup>518</sup> Norman Cousins, *Head First*, 198.

<sup>519</sup> Janice K Kiecolt-Glaser, Lynanne McGuire, and Theodore Robles, “Psychoneuroimmunology and Psychosomatic Medicine: Back to the Future,” *Psychosomatic Medicine*, 64 no. 1, 2002, 15-28.

psychological factors contribute to the strength of the body's 'immune defenses,'" mind-body "theories concerned with psychological contributions to cancer growth must be taken seriously."<sup>520</sup>

The Simontons were also highly effective at arguing that visualization, imagery, and mind-body medicine could improve the efficacy of modern medicine, rather than challenge its dominance. The Simontons, a radiation oncologist and psychologist team who built the Cancer Counseling and Research Center in Dallas, published influential books including *Getting Well Again* and *The Healing Family*. Their work exemplified the ways in which psychological treatments could become intertwined with orthodox medicine. Stephanie and O. Carl Simonton's systems of guided imagery were built specifically around minimizing the side effects from, and amplifying the effect of, standard therapies. The visualization processes they taught involved picturing chemotherapy and radiation devouring or destroying cancer cells, seeing cancer cells as weak and confused, imagining the immune system as powerful, and visualizing normal tissue as strong and unaffected by medication. In effect, they aimed to build an intentionally created placebo effect around evidence-based therapies patients were already using. The Simontons' academic backgrounds – his as a radiation oncologist, hers as a psychologist – further tied their work to orthodox medical practice. Visualization offered doctors a way of building alternative approaches into their own practice, and offered patients a way of feeling in control of, or at least hopeful about, their disease without adding additional medicines from alternative practitioners. Out of mind-body approaches to cancer, the Simontons' was the most positively received in medical journals.

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<sup>520</sup> Jennifer Hughes, *Cancer and Emotion: Psychological Preludes and Reactions to Cancer* (Chichester: John Wiley & Sons, 1987), 4.

Academic acceptance of Simontons' visualization programs and other ideas about psychological care for cancer patients grew largely out of this belief that it would support standard care. The *NEJM* published two patient narratives from medical professionals with cancer (one from a surgeon and one from a psychologist) both describing use of visual imagery and citing the Simontons. In 1979, psychologist Neil Fiore published the first of these. His article, discussed briefly in chapter three, described using a Simonton audiotape with instructions for how "patients can more completely co-operate with their treatment by visualizing the radiation or chemotherapy entering the body." This visualization was supposed to involve viewing cancer cells as weak and confused, immune systems and other cells as strong and capable of recovery. Fiore's "own "healthy imagining" involved relabeling the "toxic drugs" as "powerful allies."<sup>521</sup> Visualization did not substitute for or invalidate chemotherapy, it helped justify it to the patient. Visualization as Simonton presented it integrated standard therapies, placebo effects, and ideas about mindset. Fiore brought together a variety of past research in his general argument for the utility of psychological care for cancer patients. In addition to the Simontons, Fiore also cited Selye, Kissen (a coauthor of Eysenck's who took a more psychoanalytic approach), and a growing body of PNI research as evidence of the efficacy of psychological approaches.

Fiore argued that mind-body approaches should be standard parts of cancer care. Moreover, he argued that this should be done through hospitals and that adding these services would strengthen rather than weaken the ability of oncologists to provide orthodox treatments. He called doctors to recognize "the patient's mind and body [as] powerful factors in this fight."

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<sup>521</sup> Neil Fiore, "Fighting Cancer—One Patient's Perspective," *New England Journal of Medicine*, Vol. 300, No. 6 (1979): 287-288.

And he warned that “[f]ailure to use these potential allies can mean losing them to the ‘enemy’ through patient resistance to treatment, depression, and loss of a will to live.”<sup>522</sup> Therapy he believed could “prevent premature termination of treatment.”<sup>523</sup> He also called on hospitals to add teams of “ancillary personnel... to offer patients comprehensive therapy.”<sup>524</sup> As covered in chapter three, the responses to this article focused on issues of hope and blame. Fiore was accused by some of contributing to the “punitive myth of cancer.” However, for others, this understanding of guilt failed to recognize one of Fiore’s points: that patients would seek out hope, regardless of whether oncologists authorized it. If they could not participate in their own healing process with their physician, they would turn elsewhere and potentially stop necessary treatment. This meant that oncologists could either offer hope in the form of psychology based therapies or patients would seek alternative providers, abandoning standard care. The coordinator of a 1978 NCI retrospective study of Laetrile took this approach. He wrote in response to Fiore, not of guilt, but of hope. In the process of finding patients for his own study, he had noticed that most of those in the study had been “told by a physician that the patient had a ‘terminal disease’” and that “Nothing else can be done.” This, he believed, led to the desperation and a “blind dependence on any treatment offering cure, palliation or the faintest glimmer of optimism.”<sup>525</sup> In other words, hopelessness drove patients to quacks. Much of the value he saw in Fiore’s article was that it offered a way for physicians to communicate hope for their patients, and for patients to invest themselves in that treatment even when it might otherwise seem bleak. He wrote that doctors should never say “terminal” or “nothing else can be done” when dealing

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<sup>522</sup> Neil Fiore, “Fighting Cancer—One Patient’s Perspective,” 285.

<sup>523</sup> Neil Fiore, “Fighting Cancer—One Patient’s Perspective,” 286.

<sup>524</sup> Neil Fiore, “Fighting Cancer—One Patient’s Perspective,” 285.

<sup>525</sup> Neil M. Ellison, “Letter to the Editor,” *New England Journal of Medicine*, Vol. 300, No. 21 (1979): 1220.



with cancer patients or those with other chronic disease, believing that this would keep patients from going “to quackery or charlatans for care.”<sup>526</sup> Setting aside questions of the efficacy of psychological treatment as an effective intervention, he thought the language of hope built into these forms of care would keep patients from trading chemotherapy, surgery, or radiation for herbal or quack remedies. If patients did not find hope in their ability to personally contribute to their care, they would find another form of care. In short, psychological therapy for cancer patients reinforced standard care by protecting patients from harmful but seductive alternatives.

Another article in *NEJM*, “Lessons from Living with Cancer” by Dr. Robert Mack was published five years later. While focusing on his own use of visualization instead of offering proscriptions for others, Mack echoed the idea that this was about hope rather than blame. A self-described “successful 50-year-old surgeon, hard-driving and competitive,” he was diagnosed with early stage lung cancer.<sup>527</sup> For him, the work of the Simontons made sense in part because of how he understood the cause of his disease. In addition to acknowledging that he had been a smoker, he said he “repeatedly heard warnings about the stress levels in [his] life and the likelihood of an associated major illness.” Nonetheless, prior to diagnosis he had not made any changes because he “felt helpless to alter my life substantially or to be a different kind of person — to cope differently with life's stresses.”<sup>528</sup> At this point, Mack started doing visualization exercises from *Getting Well Again* and started exercising, but did not make drastic changes to his life. It was not until testing revealed the cancer had spread to his bones and realizing that he had

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<sup>526</sup> Neil M. Ellison, “Letter to the Editor,” *New England Journal of Medicine*, Vol. 300, No. 21 (1979): 1220.

<sup>527</sup> Robert M. Mack, “Lessons from Living with Cancer,” *New England Journal of Medicine*, 311 no. 25 (1984): 1640.

<sup>528</sup> Robert M. Mack, “Lessons from Living with Cancer,” *New England Journal of Medicine*, 311 no. 25 (1984): 1640.

“virtually no chances of living for five years,” a prognosis he found “intolerable,” that he began to incorporate deeper changes.<sup>529</sup> Because he “was not yet ready to be finished,” he began working with a counselor trained by the Simontons. In addition to helping him process all of the changes, stresses, and fears that came with cancer, she helped him see cancer as a “real time of choice.” Mack wrote about how he had reprioritized his life, and “become a different sort of person.” He was convinced that in this way he could “participate more in [his] survival with cancer.” While he acknowledged that no changes would guarantee his survival, he credited his counselor as “a major factor in my still being alive, and well, and functioning.” Visualization and counseling had given him hope to do things like plant tulip bulbs with the expectation that he might see them bloom in the spring even as he made realistic preparations for the possibility of death.<sup>530</sup> In addition to questions of standard medical care, blame and hope, these articles in the *NEJM* also highlight that acceptance of visualization was generally connected to belief in wide ranging ideas about stress, personality and cancer. While he learned the basics of visualization on his own, it was the Simonton trained counselor who helped Mack to develop broader changes to his life which he believed were necessary to survival. Both Fiore and Mack wrote about stress, connecting negative life events and poor responses to them with illness.

### **“Identifying the low point”**

The *NEJM* continued to publish articles dealing with hope, patient mindset, and survival, one of which would create a crisis for advocates of mind-body medicine. Norman Cousins wrote

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<sup>529</sup> Robert M. Mack, “Lessons from Living with Cancer,” *New England Journal of Medicine*, 311 no. 25 (1984): 1641.

<sup>530</sup> Robert M. Mack, “Lessons from Living with Cancer,” *New England Journal of Medicine*, 311 no. 25 (1984): 1641-1644.

that “If I can look back on my ‘highs’ during the years at the medical school, I have no difficulty in identifying the low point. It came in June 1985.”<sup>531</sup> He referred to the fallout from a 1985 study by Barrie Cassileth and a group of researchers from the University of Pennsylvania Cancer Center titled “Psychosocial Correlates of Survival in Advanced Malignant Disease?” in the *New England Journal of Medicine*. The study used a “self-report questionnaire... composed of questions concerning seven variables found to predict longevity or survival in previous investigations, social ties and marital history, job satisfaction, use of psychotropic drugs, general life evaluation/satisfaction, subjective view of adult health, degree of hopelessness/helplessness, and perception of the amount of adjustment required to cope with the new diagnosis.”<sup>532</sup> In order to study these variables, 204 “patients with unresectable cancer were followed to determine the length of survival.” They also evaluated time to relapse for 155 “patients with Stage I or II melanoma or Stage II breast cancer.”<sup>533</sup> While they found no relationship between their variables either individually or as a factor analysis, they were measured in their conclusion, allowing that there might be a relationship at other stages of cancer or perhaps other relevant variables. “Although,” they said, “These factors may contribute to the initiation of morbidity, the biology of the disease appears to predominate and to override the potential influence of life-style and psychological variables once the disease process is established.”<sup>534</sup> They provided considerable room for psychosomatic explanations of cancer etiology, but not for miraculous seeming cures

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<sup>531</sup> Norman Cousins, *Head First*, 210.

<sup>532</sup> Barrie R. Cassileth, Edward J. Lusk, David S. Miller, Lorraine L. Brown, and Clifford Miller, “Psychosocial Correlates of Survival in Advanced Malignant Disease?” *New England Journal of Medicine*, 312 No. 24 (1985): 1552.

<sup>533</sup> “Barrie R. Cassileth, Edward J. Lusk, David S. Miller, Lorraine L. Brown, and Clifford Miller, “Psychosocial Correlates of Survival in Advanced Malignant Disease?” 1551.

<sup>534</sup> Barrie R. Cassileth, Edward J. Lusk, David S. Miller, Lorraine L. Brown, and Clifford Miller, “Psychosocial Correlates of Survival in Advanced Malignant Disease?” 1551.

driven by psychological healing or even general small scale increases in life span as a result of overall well-being. Despite both a null result and limited conclusions, this study was still news. It drew the ire of other researchers and public figures. This study, an editorial published with it, and the correspondence show how difficult it was to reject the idea that emotions and survival were connected. In the face of null results, many maintained that claims and hypotheses about mind and cancer should be modified or limited, not rejected.

The *NEJM* added to the impact of the article's findings by publishing a piece by Dr. Marcia Angell (described in more detail in chapter three) in the same issue. Angell, the deputy editor of the *New England Journal of Medicine*, argued passionately against claims that psychology could cause or cure disease. Her paper titled "Disease as a Reflection of the Psyche" was not so limited in its conclusions as the Cassileth study. From Cassileth's study, Angell moved to summarize the state of psychosomatic research more generally. She concluded that "it is time to acknowledge that our belief in disease as a direct reflection of mental state is largely folklore."<sup>535</sup> Taken together the two pieces seemed to signal a rejection by the journal of not only these forms of psychosomatic oncology as evidence based medicine, but psychosomatic medicine more generally. It did not go unnoticed.

Responses from regular readers of the *NEJM* expressed serious frustration with the Cassileth article. The *NEJM* published a series of responses in a following issue. Peter Vitaliano, Ph.D., Patricia Lipscomb, M.D., Ph.D., and John Carr, Ph.D. From the University of Washington School of Medicine wrote that "In their belief that psychosocial factors can be adequately represented by seven poor measures, the authors ignore the dynamic richness and variety of

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<sup>535</sup> Marcia Angell, "Disease as a Reflection of the Psyche," *New England Journal of Medicine*, 312 No.24 (1985): 1572.

human experience.” In addition to the limitations they saw in the choice of variables, they claimed there was insufficient data available to support the validity of the measures used in the study.<sup>536</sup> These concerns about variables can be broken into two related challenges: first that the authors may not have used well studied scales to measure their variables and second that perhaps life and well-being is too complicated to measure with questionnaires or scales. To this first concern, Cassileth et al. simply noted that they had chosen instruments that “had been found valid and reliable by others.”<sup>537</sup> The second concern, about the “dynamic richness and variety of human experience”, did not offer a specific path forward. While they said that these were poor measures, there was no clear list of what a comprehensive set of variables might be or if this “dynamic richness” could in fact be measured. Cassileth pointed to “the absence of a methodologically acceptable means of quantifying the dynamic richness and variety of human experience.” If it could not be condensed into simple measures, there would be no way to disprove theories about the impact of well-being on cancer, rather researchers might be forced back to case narratives and anecdotal evidence. The intuitions of oncologists, doctors, and therapists would be the best available evidence. Judging by responses to Cousins’ initial case narrative, however, many did not see this as a problem. Theories about mindset and disease repeatedly celebrated the clinical judgment and personal intuition of the physician or counselor.

Another set of critiques helped to highlight a key question in mind-body medicine. At what stage does it cease to be reasonable to expect that patients can influence their health through mindset? A group of doctors and researchers from the University of Pittsburgh and

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<sup>536</sup> Peter P. Vitaliano, Patricia A. Lipscomb, and John E. Carr, “Correspondence: Psychosocial Variables and the Course of Cancer,” *New England Journal of Medicine*, Vol. 313, No. 21 (1985): 1355.

<sup>537</sup> Barrie R. Cassileth et al., “Response to Correspondence,” *New England Journal of Medicine*, Vol. 313, No. 21 (1985): 1356.

Carnegie Mellon University wrote in to question the choice of participants for the study. They said that, “in our view it would be most appropriate to study a homogenous group of patients in whom the disease was not so aggressive or so far advanced that the disease process itself would not override any role that behavior might have.”<sup>538</sup> For Levy and her coauthors, this request to focus on early stage disease was driven by what they believed were the limits of reasonable claims. They claimed that “no one questions that the major determinant of outcome in cancer is the biology of the tumor. But we and other investigators are asking whether behavior is also a biologic-response modifier to be investigated in carefully selected tumor systems.”<sup>539</sup> However, Cassileth and her coauthors designed the study partially to evaluate claims of late stage remission and cure. After all, the possibility of these apparent miracles was part and parcel of claims from the Simontons, LeShan, Cousins, Siegel, and others. For Siegel, no biological factor or cancer stage was so severe as to preclude survival. He believed, “There are no incurable diseases, only incurable people.”<sup>540</sup>

The articles were also widely covered in the news, precisely because they could be placed in conversation with the most popular advocates of positive emotions as healing strategies. *Time* directly tied the 1985 study to Cousins’ work, suggesting that the study undermined arguments which, the author claimed, were at the heart of Cousins’ “amateur foray into medicine.” Leon Jaroff, the author of the article, wrote that “Last week the New England Medical Journal

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<sup>538</sup> Sandra Levy, Alan Winkelstein, Bruce S. Rabin, Marc Lippman, and Sheldon Cohen, “Correspondence: Psychosocial Variables and the Course of Cancer,” *New England Journal of Medicine*, Vol. 313, No. 21 (1985): 1355.

<sup>539</sup> Sandra Levy, Alan Winkelstein, Bruce S. Rabin, Marc Lippman, and Sheldon Cohen, “Correspondence: Psychosocial Variables and the Course of Cancer,” *New England Journal of Medicine*, Vol. 313, No. 21 (1985): 1356.

<sup>540</sup> Bernie S. Siegel, *Love, Medicine & Miracles: Lessons Learned about Self-Healing from a Surgeon’s Experience with Exceptional Patients* (New York: Harper Perennial, 1990), 99.

published a study and an editorial that cast doubt on that popular view and stirred a tempest in the medical teapot.”<sup>541</sup> While later noting caveats, the *New York Times* characterized the study’s conclusions without mentioning that they applied in this case only to later stages, saying that patients’ “ways of life, social backgrounds and personalities had no bearing on whether they got better or died,” and all final outcomes were attributed to “the biology of the disease.”<sup>542</sup> *The New York Times* continued following this controversy. It quoted Angell as saying that she had “been astonished by the intensity of the debate,” and that it was as if she “had attacked motherhood and happiness. People seem to want to believe that how we think matters for our health—that we have the power to control things that are powerful and frightening—but it’s like doing a rain dance.”<sup>543</sup> She also added that her contribution received nearly as many replies as the journal had ever received on an article, most of it critical. *The Los Angeles Times*, meanwhile, reported simply that “A positive attitude is not likely to increase the chances of recovering from advanced cancer, contrary to popular belief, although it may make the disease more bearable.” Regardless of how the findings were framed, the study was big news.

Norman Cousins was deeply perturbed by the interpretation of the article as a refutation of his work. He raised it at a meeting of the task force and later wrote that, “members of the group were quick to point out that the conclusion of the study overlooked decades of scientific evidence showing that psychological factors play a role in the initiation and progression of

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<sup>541</sup> Leon Jaroff “Medicine: Can Attitudes Affect Cancer? A New Study Casts Doubt on the Power of Positive Thinking.” *Time*, June 24, 1985.

<sup>542</sup> Associated Press, “Study Disputes Idea on Cancer Patients Attitudes,” *New York Times*, June 13, 1985: A17.

<sup>543</sup> Daniel Goleman, “Debate Intensifies on Attitude and Health,” *New York Times*, October 29, 1985: C1, C7.

cancer.”<sup>544</sup> Cousins was further reassured that people would not be so easily swayed into dropping the idea when, “after a day or two, [he] began to receive calls and letters from physicians and medical researchers strongly supporting the idea that strong will to live and... positive emotions in general could make a difference in the patient’s total situation.”<sup>545</sup> Cassileth also expressed concern about interpretations of her article. *The Boston Globe* interviewed her for another article and she reaffirmed that “the message to patients has to be that we do not know the effect in an individual patient of any of these factors—and this is not the end of all studies.” Cassileth was very clear about her disappointment at the findings. “We had hoped very much,” she said, “we would find a factor or two that did influence survival or time to relapse.” She roughly summarized the study: “You’re not kidding, it’s discouraging.”<sup>546</sup>

This shared concern about what both Cassileth and Cousins saw as a misunderstanding of the study and its claims prompted them to co-write an article in response. Published in *The Los Angeles Times* on October 3, 1987 the article began, “We hope the following points will clarify our points of view. Rather than being diametrically opposed we share a common understanding and perspective.” They reminded patients who might be trying to participate in their healing that, “Physicians have always believed that a strong will to live helps a patient’s chances in combatting serious disease.” Together, they outlined four primary ideas on which they agreed. First, they said that “emotions and health are closely related.” Negative emotions, they claimed,

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<sup>544</sup> Draft of *Head First*, page 201, Box 1633, Folder: Cassileth/ Oncologist Survey. Norman Cousins Papers (Collection 1385). Department of Special Collections, Charles E. Young Library, University of California, Los Angeles.

<sup>545</sup> Draft of *Head First*, page 200, Box 1633, Folder: Cassileth/ Oncologist Survey. Norman Cousins Papers (Collection 1385). Department of Special Collections, Charles E. Young Library, University of California, Los Angeles.

<sup>546</sup> Judy Foreman, “Study Says Psychological Factors Have No Impact on Cancer,” *Boston Globe*, June 13, 1985: 5.



were clearly bad for health and could interfere with medical care. This, they said, has been ‘known for many years.’ The healing effect of positive emotions, they acknowledged, was still more open to question and research. Second, they agreed that health is complicated and that “there is no single, simple factor that causes or cures cancer and other major illnesses.”<sup>547</sup> Third, they emphasized that even if positive emotions were not curative, they are important for quality of life. Despite their importance, they stressed that positive emotions could never replace medical care. Finally, they agreed that doctors needed to work together with patients to avoid panic, “which is itself destructive and can interfere with effective treatment. These were, they seemed to believe, the basic, acceptable range of beliefs about mind-body cancer care that “reasonable” people could hold. For both Cassileth and Cousins, it was reasonable to debate and question the extent to which emotions could affect health in general and cancer in particular, but the connection was unquestionable.

Cousins confirmed that this was the common belief among doctors when his task force conducted a national survey of oncologists. Unfortunately, Cousins did not include a discussion of methods in his book so sampling strategies are not clear and the results should be taken with a grain of salt. Of the 649 responses, “more than 90% of the physicians said they attached the highest value to attitudes of hope and optimism.”<sup>548</sup> 79% listed a “strong will to live” as very or moderately important in “contributing to increased longevity” with similar importance attached to “positive approach to a challenge of the illness.”<sup>549</sup> In respondents’ additional written comments, Cousins noted that, “Forty-two physicians offered the opinion that psychosocial

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<sup>547</sup> Barrie R. Cassileth and Norman Cousins, “Fighting Illness, the Mind Has Both Power and Limits,” *Los Angeles Times*, October 3, 1985: B7.

<sup>548</sup> Norman Cousins, *Head First*, 217.

<sup>549</sup> Norman Cousins, *Head First*, 219

factors have some effect on longevity.” A small subset of nine added that “patients with a negative attitude (depressed, bitter, frustrated, despairing, recently retired or recently failed in a life endeavor) generally experienced a rapid progression of their disease.”<sup>550</sup>

This impassioned disagreement between the journal’s readers, researchers, popular writers, and editors is telling. It shows how tightly many medical professionals held to these ideas about cancer and personality, and how sincerely they expected undeniable evidence of a connection to be found. The attempt to create a more moderate interpretation of the data and outline a common ground is also illustrative. The alliance between Cassileth and Cousins to clarify what they saw as the terms of the debate, and more importantly, the extent of their agreement, illustrated the ubiquity of these ideas. They also showed how difficult it could be to challenge the belief of a mind-body cancer connection, even when the data did not serve their purposes. The role of mind-body medicine in cancer longevity could not be challenged lightly. The common ground emerging from this controversy was clear: mindset might not be able to save all patients, but its relevance could not be questioned. This agreement or middle ground would emerge clearly again in national debates about alternative medicine and regulation. Cassileth and Angell both became recurring characters in later debates, Cassileth as a mediating presence (for example as an advisor in the Office of Technology Assessment’s report on alternative cancer treatments), and Angell as an outspoken critic of unregulated alternative medicine.

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<sup>550</sup> Norman Cousins, *Head First*, 221.

## Under Congressional Review

While responses to these 1985 articles are indicative of the strength of responses to challenges of mind-body medicine, responses to the 1990 OTA report illustrate the position mind-body medicine held between alternative and conventional medicine. As every other alternative therapy included in the report created controversy, mind-body therapies were largely accepted by all sides. The OTA research process began in 1986 when Congressman Molinari of New York and numerous co-signers requested a report from the Office of Technology Assessment (OTA) on the value of Immuno-Augmentive Therapy (IAT).<sup>551</sup> Others quickly sent in letters of support for a study. They were responding to an FDA import ban passed in 1986. The ban remained unenforced, and cancer patients could still seek treatment at one of the IAT clinics maintained by Dr. Burton in the Bahamas and later in West Berlin and Mexico. Concerned that conducting a full study of IAT was “beyond the OTA’s role and mission,” the director of the agency, John Gibbons, proposed instead that they should instead do a “broader assessment of nontraditional methods of cancer treatment, using IAT as a case study.” He mentioned that the Energy and Commerce Committee was interested in “science and policy issues related to the methodologies and the current status of unproven and nontraditional cancer treatments.”<sup>552</sup>

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<sup>551</sup> U.S. Congress, Office of Technology Assessment, “Introduction” in *Unconventional Cancer Treatments*, OTA-H-405 (Washington, DC: U.S. Government Printing Office, September 1990).

<sup>552</sup> Letter from John H Gibbons to Technology Assessment Board dated September 23 1986 “Subject: Proposed Assessment on ‘Nontraditional Methods of Cancer Treatment: Science and Policy Issues.’” Folder: Nontraditional Methods, Box 18; 3.3 Project Series; Records of the Office of Technology Assessment, ca. 1970-1995, Record Group 444; National Archives Building, Washington, DC.

Initially, the project was due to be finished in June 1988, with a case study on IAT to be delivered earlier.<sup>553</sup> “

Those with an interest in IAT continued to pressure the agency. IAT clinics encouraged constituents to contact their representatives. Pre-printed postcards rolled in. “As one of your constituents and a potential cancer victim,” the post cards asked the representatives to encourage the study. The senders hoped that IAT might “save thousands of lives and end immeasurable suffering.” Representative Robert W. Kastenmeier from Wisconsin and others sent a sample of the postcards they received to the OTA with a request to “review the issues they raise and provide me with a complete report so that I might respond to them?”<sup>554</sup> Despite initially encouraging the OTA to complete the study, the correspondence quickly shifted to questioning the bias of the advisory panel and project staff. Citizens wrote letters trying to encourage the completion of the report (particularly for a fair evaluation of I.A.T.) and, after the Office of Technology Assessment assembled a team they began receiving a continued stream of letters and postcards disputing their choice of members, often with a flawed understanding of what role each person had and their power to decide the report’s final content and conclusions. The advisory board was composed of a mix of people from both hospitals and orthodox medical research programs as well as alternative medical practitioners. The report was also to be sent to an additional group of reviewers prior to publication. However, none of these individuals wrote the report or decided its content. This was done by OTA staff. Led by “Hellen Gelband, an

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<sup>553</sup> Project Proposal dated September 8; Folder: Nontraditional Methods, Box 18; 3.3 Project Series; Records of the Office of Technology Assessment, ca. 1970-1995, Record Group 444; National Archives Building, Washington, DC.

<sup>554</sup> Letter from Robert W. Kastenmeier to John H Gibbons, June 16, 1987; Folder: Nontraditional Methods of Cancer TMNT: Science and Policy Issues, Box 18; Series 3.3 Project Series; Records of the Office of Technology Assessment, ca. 1970-1995, Record Group 444; National Archives Building, Washington, DC.

epidemiologist in the [OTA's] health program," with the assistance of "two technically trained analysts, and a research assistant."<sup>555</sup> This confusion between people whose viewpoints were consulted and people who would write the report exacerbated concerns about the neutrality of advisory board members. In one letter, John Gibbons wrote that he needed to clarify that "project staff are not actually evaluating particular unorthodox cancer treatments for safety or efficacy, since OTA is not in a position to conduct clinical trials (and this is not what we were asked to do)."<sup>556</sup>

Catherine Frompovich, President and Legislative Advocate for the Coalition for Alternatives in Nutrition and Healthcare (CANAH), began an extended correspondence with a request to reshape the panel and include members of her suggestion including Linus Pauling, Frank Wiewel, Marie S. Steinmeyer, D.Sc., and Glen L. Rutherford. Frompovich wound up her letter with a veiled warning that if the OTA failed to "balance" the panel she and CANAH would push for an investigation. "Please accept these recommendations," she wrote, "as our way of letting you know that we feel a foul play has occurred. We should not like to see this assessment wind up being questioned by a Congressional committee."<sup>557</sup> Frompovich's letters seemed muted compared with those of others. Again, pre-printed postcards rolled in. On one side they asked:

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<sup>555</sup> Letter from John Gibbons to Mr. Murray A. Swanson, November 18, 1987; Folder: Nontraditional Methods of Cancer TMNT: Science and Policy Issues, Box 18; 3.3 Project Series; Records of the Office of Technology Assessment, ca. 1970-1995, Record Group 444; National Archives Building, Washington, DC.

<sup>556</sup> John Gibbons to Kenneth Kern, December 3, 1987. Letters and Responses January-December 1987, Box 9/20; Series 1.2 General Correspondence; Records of the Office of Technology Assessment, ca. 1970-1995, Record Group 444; National Archives Building, Washington, DC.

<sup>557</sup> Letter from Catherine Frompovich to John Gibbons and Clyde J. Behney cc to Linus Pauling, OTA Congressional Committee members, and other recommended panel members, September 14, 1987. Folder: Nontraditional Methods of Cancer TMNT: Science and Policy Issues, Box 18; 3.3 Project Series; Records of the Office of Technology Assessment, ca. 1970-1995, Record Group 444; National Archives Building, Washington, DC.

“Will the ‘Cancer Establishment’ get away with rigging the test results... AGAIN?!!” The back issued a call for senators and members of the House to monitor the investigation. “Dear Congressman,” the postcards read, “[a]s you may be aware, the OTA has begun its evaluations of several “alternative” methods of cancer treatment including Lawrence Burton’s Immuno-Augmentive Therapy (IAT). In the past the American Cancer Society, the American Medical Association and the large pharmaceutical companies have conspired to rig the results of such tests to discredit any and every type of cancer treatment they do not control. With literally *billions* of dollars at stake, I am concerned they will try to rig the OTA evaluations as well.”

Faced with this consistent outrage, which OTA director John Gibbons noted “has exceeded the normal clash of opinions accompanying our studies—even those on the strategic defense initiative and alternatives to the use of animals in research,” they determined a new plan to make critics feel heard.<sup>558</sup> They scheduled a full day meeting of the project Advisory Board on March 9, 1990 and invited the report’s toughest critics. The Technology Assessment Board and others were warned in advance that they should expect additional visits to their offices and that many critics were “also planning to attend the Advisory Panel meeting and possibly stage a demonstration outside the OTA building.” The memo noted that “The Capitol Police and the Metropolitan Police have been alerted and are taking appropriate precautions to make sure that the meeting runs as smoothly as possible.”<sup>559</sup> While it is unclear if the police had to escort

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<sup>558</sup> Letter from John H. Gibbons to Dr. Rosemary, undated; Folder: TAAC Feb 27-29, 89, Box 26/38; Series 1.6 Congressional Advisory Boards (TAB/TAAC) Meetings; Records of the Office of Technology Assessment, ca. 1970-1995, Record Group 444; National Archives Building, Washington, DC.

<sup>559</sup> Letter from John H. Gibbons to Technology Assessment Board, March 6, 1990 “Re: Advisory Panel Meeting on Unconventional Cancer Treatments and Related Activities at OTA. Friday March 9 (9-5);” Folder: Unorthodox Cancer Treatments, Box no. 31/40 August 1990; Series 3.1 Press Information Files; Records of the Office of Technology Assessment, ca. 1970-1995, Record Group 444; National Archives Building, Washington, DC.

anyone out of the meeting or intervene in any way, the OTA did write to thank police for their help.<sup>560</sup> Michael S. Evers, the director of Project Cure, wrote that if the OTA, “had provided us the draft report earlier, as originally promised, we could have had hundreds of angry critics jammed into your conference room.” He added that they would have “needed several more paddy wagons out back, too!”<sup>561</sup>

Threats of mass protests leading to mass arrests were not easily dismissed. ACT UP (AIDS Coalition to Unleash Power) staged their largest protest in 1988 to challenge the slow development and release of medications. Over 1200 people protested at the FDA headquarters, 176 people were arrested and the FDA was forced to shut down for the day.<sup>562</sup> These events were clearly still close to the surface in how staff and elected officials interpreted responses to the Study on Unconventional Cancer Treatments. Senator Kennedy spoke about the connection in a Technology Assessment Board Meeting. “We’re getting similar kinds of things in the AIDS area,” he said, and explained that people were frustrated with “the apparent slowness in the FDA in developing new drugs.”<sup>563</sup>

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<sup>560</sup> Letter from Frank Kerrigan, Chief of Police, to Mr. John H. Gibbons Dated March 26, 1990; Folder: April, Box 18/32; Series 1.4 Correspondence Logs; Records of the Office of Technology Assessment, ca. 1970-1995, Record Group 444; National Archives Building, Washington, DC.

<sup>561</sup> Michael S. Evers, Director of Project Cure, March 15, 1990, “RE: Draft Report on Unconventional Cancer Treatments;” Folder: March, Box 18/32; Series 1.4 Correspondence Logs; Records of the Office of Technology Assessment, ca. 1970-1995, Record Group 444; National Archives Building, Washington, DC.

<sup>562</sup> Warren Leary and David Binder, “Washington Talk: Briefing; Making Amends,” *New York Times*, November 3, 1988: 52.

<sup>563</sup> Transcript of Proceedings: Congress of the United States Office of Technology Assessment Board Meeting, May 10, 1990, page 18; Folder: TAB Meeting 5/10/90; Box 29/38 Meetings March-July 1990 Box 29/38; 1.6 Congressional Advisory Boards (TAB/TAAC); Records of the Office of Technology Assessment, ca. 1970-1995, Record Group 444 Office of Technology Assessment; National Archives Building, Washington, DC.

The drafts of the report and the transcripts of Advisory Panel meetings were unfortunately missing from the OTA papers in the National Archives; however, one copy of the transcript has been made available on the website of the Gerson Research Organization. The meeting was contentious. For example, Ralph Moss, saw the initial drafts as the result of callousness and disregard for cancer victims. Moss, the author of *The Cancer Industry* and the assistant director of public relations at Memorial Sloan-Kettering Hospital had been fired following his accusations that the hospital had hidden data proving the efficacy of Laetrile, a substance processed from fruit pits and falsely promoted as a cancer cure. His work had effectively tapped into fears that pharmaceutical companies wanted to profit from patients more than they wanted to heal them. “You people,” he said, “don't seem to have the right spirit to conduct this whole report. People are dying of cancer in this country.”<sup>564</sup> Patrick McGrady, the director of CanHelp (an alternative treatment referral center for cancer patients), furiously compared chemotherapy with alternative treatments. Chemotherapies, he claimed, “kill hundreds and thousands of patients every year and this is well documented. And you point to hypothetical adverse effects of the alternative therapies? HOW DARE YOU!”<sup>565</sup> Even members of the advisory panel had serious complaints about the way the material was handled. After this event, eight members of the advisory panel submitted a letter carefully detailing these problems. “In short,” they wrote, “we commend the scope of the effort and much of the work done but are

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<sup>564</sup> “Unconventional Cancer Treatments—Advisory Panel Meeting Transcript,” Gerson Research Organization, accessed April 1, 2018, <http://gerson-research.org/research/unconventional-cancer-treatments-advisory-panel-meeting-transcript/>

<sup>565</sup> Caps lock in original. “Unconventional Cancer Treatments—Advisory Panel Meeting Transcript,” Gerson Research Organization, accessed April 1, 2018, <http://gerson-research.org/research/unconventional-cancer-treatments-advisory-panel-meeting-transcript/>



concerned with tone and selection of facts.”<sup>566</sup> They agreed however that the chapter on psychological therapies was “the best chapter in the report as it stands.”<sup>567</sup>

Proponents of alternative therapy repeatedly accused the report and its authors of bias and subjectivity, but they drew attention to the “middle ground” in the way OTA handled psycho-oncology. They believed that OTA staff had created a middle ground by acknowledging the arguments for the plausibility of psychological approaches even as they drew attention to the lack of conclusive evidence. They also noted a moment of agreement about the non-curative potential. Michael Lerner served as a special consultant for the project. His background as the co-founder of Commonweal (a center in Bolinas, CA with a focus on “healing people and healing the earth”) put him in serious conflict with early drafts. Commonweal offered retreats for people who had been diagnosed with cancer to discuss the variety of healing options available, and to work on personal growth, relaxation, and healing in the face of disease. Lerner believed that with the exception of the chapter on psychotherapy, the report draft lacked “context... which... makes the plausibility of those therapies more apparent.” This explanation of plausibility in the absence of clear evidence, he said, “does come forward in the section on

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<sup>566</sup> Joint Letter from Selected OTA Advisory Panel Members, March 25, 1990, signed by Jeanne Achterberg, Ph.D. Institute of Transpersonal Psychology, Keith Block, M.D., Jonathon Collin, M.D., John Fink, Gar Hildebrand, Gerson Institute, Michael Lerner, Ph.D. Commonweal, Brendan O’Regan Vice President for Research Institute of Noetic Sciences, Andrew Weil, M.D, page 1; Folder: April, Box 18/32; Series 1.4 Correspondence Logs; Records of the Office of Technology Assessment, ca. 1970-1995, Record Group 444 Office of Technology Assessment; National Archives Building, Washington, DC.

<sup>567</sup> Joint Letter from Selected OTA Advisory Panel Members, March 25, 1990, signed by Jeanne Achterberg, Ph.D. Institute of Transpersonal Psychology, Keith Block, M.D., Jonathon Collin, M.D., John Fink, Gar Hildebrand, Gerson Institute, Michael Lerner, Ph.D. Commonweal, Brendan O’Regan Vice President for Research Institute of Noetic Sciences, Andrew Weil, M.D, page 10; Folder: April, Box 18/32; Series 1.4 Correspondence Logs; Records of the Office of Technology Assessment, ca. 1970-1995, Record Group 444 Office of Technology Assessment; National Archives Building, Washington, DC.

psychological approaches.” One participant in the discussion whose full name is missing called the information on spiritual approaches to healing “basically a mockery” while saying that the “counterbalance” was in the chapter on psychooncology. Similarly, Jeanne Achterberg, the director of research at the Institute of Transpersonal Psychology in Menlo Park, further described what this middle ground might look like. For Achterberg, finding the middle ground meant “understanding that curing is not the only endpoint in the treatment of disease, and if we come to that then a lot of the focus in the document starts to shift in terms of the way we look at the data.”<sup>568</sup> A letter from members of the advisory panel further explained what they meant by “middle ground.” It consisted of those who “seek to supplement judicious use of conventional therapies with spiritual, psychological, and nutritional approaches that they hope will improve quality of life and possibly contribute to life extension.”<sup>569</sup> They noted that as one dietary approach gained more traction, they expected it would “ ‘follow’ psychosocial interventions up the ladder into clinical respectability as adjunctive and complementary approaches to the treatment of cancer.”<sup>570</sup> Establishing a middle ground meant building therapies that worked with

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<sup>568</sup> “Unconventional Cancer Treatments—Advisory Panel Meeting Transcript,” Gerson Research Organization, accessed April 1, 2018, <http://gerson-research.org/research/unconventional-cancer-treatments-advisory-panel-meeting-transcript/>

<sup>569</sup> Joint Letter from Selected OTA Advisory Panel Members, March 25, 1990, signed by Jeanne Achterberg, Ph.D. Institute of Transpersonal Psychology, Keith BLcok, M.D., Jonathon Collin, M.D., John Fink, Gar Hildebrand, Gerson Institute, Michael Lerner, Ph.D. Commonweal, Brendan O’Regan Vice President for Research Institute of Noetic Sciences, Andrew Weil, M.D, page 2; Folder: April, Box 18/32; Series 1.4 Correspondence Logs; Records of the Office of Technology Assessment, ca. 1970-1995, Record Group 444 Office of Technology Assessment; National Archives Building, Washington, DC.

<sup>570</sup> Joint Letter from Selected OTA Advisory Panel Members, March 25, 1990, signed by Jeanne Achterberg, Ph.D. Institute of Transpersonal Psychology, Keith BLcok, M.D., Jonathon Collin, M.D., John Fink, Gar Hildebrand, Gerson Institute, Michael Lerner, Ph.D. Commonweal, Brendan O’Regan Vice President for Research Institute of Noetic Sciences, Andrew Weil, M.D, page 11; Folder: April, Box 18/32; Series 1.4 Correspondence Logs; Records of the Office of Technology Assessment, ca. 1970-1995, Record Group 444 Office of Technology Assessment; National Archives Building, Washington, DC.

conventional treatment, and psychosocial approaches were considered the example of therapies that had successfully managed that goal.

It is unsurprising that critics who rejected the remainder of the report embraced this section. Even in the early drafts, the project staff and advisory panel took a position embracing psychological therapies. The draft findings written in February 1989 singled out psychological therapies as likely to “eventually find a place in conventional medicine.” They called it “the one area of unconventional cancer treatment that is gaining acceptance by orthodox medical oncologists.” However, the preliminary findings did note that this acceptance was clearer for the use of psychological therapy as a pain control strategy and that life-saving claims of psychological therapies “continued unproven.” The draft findings also laid out what many patients who used unconventional therapies shared in common, a search for “an optimistic prognosis, treatment perceived as more humane, and psychological support” which they thought they could not find through their oncologists.<sup>571</sup>

While the 1989 preliminary findings from the report were already positively inclined towards psychological and behavioral cancer therapies, later that year a study in the *Lancet* by David Spiegel made it even easier for OTA staff to be open to these ideas.<sup>572</sup> A professor in psychiatry in the Stanford Medical School, Spiegel had begun studying the effect of cancer support groups and hypnosis in the late 1970s. His study assigned patients to either a treatment group consisting of 90-minute group psychotherapy sessions and hypnosis for pain. The

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<sup>571</sup> Discussion Paper: Draft Findings of the OTA Study on Unconventional Cancer Treatments February 27, 1989; Folder: TAAC Feb27-28, 89, Box 26/38; Series 1.6 Congressional Advisory Boards (TAB/TAAC); Records of the Office of Technology Assessment, ca. 1970-1995, Record Group 444 Office of Technology Assessment; National Archives Building, Washington, DC.

<sup>572</sup> David Spiegel, H.C. Kraemer, J.R. Bloom, and E. Gottheil, “Effect of Psychosocial Treatment on Survival of Patients with Metastatic Breast-Cancer” *Lancet*, 2 no. 8688 (1989): 888-891.

psychotherapy sessions were led by either a psychiatrist or a social worker who teamed with a therapist who had survived breast cancer. For Spiegel, the goal of the intervention was not increased survival, but improved adjustment, reduced anxiety around death, and increased ability to enjoy life. He had resented what he saw as crude ways of blaming patients and told a story of a woman who “had gone to a cancer support group to talk about her desperately ill son. The members of the group had looked at her and told her she needed first of all to realize that ‘every child with cancer is an unloved child.’”<sup>573</sup> Spiegel was surprised to note that in addition to psychological benefits, there was an increase in survival time among participants who were assigned to support group interventions. From the time of randomization, patients who received group therapy lived an average of 36.6 months while patients in the control group lived only 18.9 months. The three remaining survivors were all in the intervention group. As with the Cassileth study from 1985, Spiegel’s team found no correlation in psychological measures from before the treatment and survival time. The distinction followed from psychotherapy and disparities in survival began to appear eight months after the intervention concluded.

The final report maintained its positive attitude towards behavioral and psychological therapies. While still not claiming that psychological interventions had been proven to extend life, it wrote that a “larger randomized study” was “clearly warranted by Spiegel’s conclusions.”<sup>574</sup> Based on a study by Michael Lerner they said that approximately 10% of patients used programs designed to channel their mindset into healing, but they suggest that “[i]t is possible that more cancer patients will choose to pursue these approaches if they become more widely known and readily accessible (e.g., through oncologists or hospitals).” This process, they

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<sup>573</sup> Anne Harrington, *The Cure Within*, 199.

<sup>574</sup> U.S. Congress, Office of Technology Assessment, *Unconventional Cancer Treatments*, OTA-H-405 (Washington, DC: U.S. Government Printing Office, September 1990), 37.

said, was already happening as “psychological and behavioral methods are becoming a regular part of cancer treatment.”<sup>575</sup> While most of these programs focused on quality of life, others aimed to increase survival. One of the programs they highlighted, The Wellness Community in Santa Monica, “explicitly states that its approach to patient care is in support of, not a substitute for, mainstream medical care. Many cancer patients are reportedly referred to the program by their oncologists. Oncologists also serve on the center’s Professional Advisory Boards.”<sup>576</sup> The relationship to standard medicine was repeatedly mentioned. The description of Commonweal, a retreat center for cancer patients, again mentioned that many participants were referred by their physicians. Both the descriptions of Commonweal and of Spiegel’s study stressed that participants were also receiving standard therapy. They again noted that the Simonton “regimen was presented as an adjunctive approach to conventional cancer treatment.” They also repeated the claims of members of their advisory panel that this was part of a “‘middle ground’ (mainly psychological, behavioral, and dietary approaches used along with mainstream treatment).”<sup>577</sup>

## Conclusion

In 1985, press overstatement of the conclusions from Cassileth and her co-authors’ led to an appearance of crisis in mind-body cancer theories. Reports in some major newspapers treated the study as evidence that mind-set could not change the risk of disease and could never influence survival, regardless of the stage of cancer. However, the responses to these articles

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<sup>575</sup> U.S. Congress, Office of Technology Assessment, *Unconventional Cancer Treatments*, OTA-H-405 (Washington, DC: U.S. Government Printing Office, September 1990), 29.

<sup>576</sup> U.S. Congress, Office of Technology Assessment, *Unconventional Cancer Treatments*, OTA-H-405 (Washington, DC: U.S. Government Printing Office, September 1990), 30.

<sup>577</sup> U.S. Congress, Office of Technology Assessment, *Unconventional Cancer Treatments*, OTA-H-405 (Washington, DC: U.S. Government Printing Office, September 1990), 20.

served instead to underscore a substantial level of agreement about the importance of mind in cancer. To challenge this agreement was to risk substantial backlash. As Angell put it, disputing the role of mind in cancer survival was tantamount to attacking “motherhood and happiness.”

By 1990 psychological cancer treatments had become palatable to the majority of medical professionals. While other alternative forms of healing were widely used by patients with cancer, they were largely rejected by doctors. Advocates for psychological treatment modeled ways of reaching physicians. Psychological therapies were explicitly marketed as adjuvant and complementary. Moreover, where other therapies like Laetrile or Immuno-Augmentative Therapy threatened to replace the treatments of oncologists, psychological strategies seemed to strengthen their role. Recognizing patients who would benefit from psychological support relied on the clinical judgment of the physician. This gave physicians who felt their job relied more on lab results and impersonal diagnostics than on their own wisdom a sense that their personal characteristics and intuition helped patients survive. Proponents also promised that through psychological interventions they could encourage treatment compliance by giving patients faith and hope in its utility. With its easy compatibility with standard medicine, these theories seemed to also offer a common-sense explanation to doctors about why some of their patients died, a suggestion that the fault was not with the doctor’s medical care, and a set of resources to use when disease was no longer treatable.

It has remains clear just how hard it is to challenge beliefs about mind-body medicine. A 2001 study in *NEJM* again failed to show a significant connection between psychological intervention through support groups and survival time. The study attempted but failed to replicate Spiegel’s results. *NEJM* included an editorial by Spiegel in the issue. Rather than arguing with the study design or results, Spiegel suggested that his work was simply not

replicable because cultural attitudes to, and social support for, cancer patients had changed substantially. Control groups in the 1990s and 2000s no longer lacked support in the ways patients in the 1970s had. Group therapy, social support, and frameworks for seeing cancer as a turning point had become so common and easily available, he believed, that the control group no longer served as a proper control. The emotional isolation and despair that might have made things worse for patients was declining and hospitals had learned to provide psychological support. For many people, variations of the idea that emotional health could promote survival, tumor regression, or good health seemed simply too good to be false.

## CONCLUSION

It is the law of attraction. It says that the energy, that the thoughts, and the feelings that you put out into the world, both good and bad, are exactly what is always coming back to you. So you have the life that *you* have created. I've been talking about this for years on my show, I just never called it "the secret." But it's what this show is all about and has been about for 21 years: taking responsibility for your life, knowing that every choice that you have made has led you to where you are right now. Well the good news is that everybody has the power, no matter where you are in your life, to start changing it today.<sup>578</sup>

-Oprah Winfrey

The failure to replicate David Spiegel's study and to find consistent survival benefits of specific personality traits has made it more difficult to make serious academic claims that cancer etiology or survival is driven by mindset. However, beliefs about mind and cancer remain ubiquitous. For many doctors, there persists an unspoken and vague belief that patients who live the longest are in some way different, more determined to live, more hopeful, better. But the most influential supporter of mind-body medicine in recent years has perhaps been Oprah Winfrey. Her media empire shaped popular ideas about mind and health through the guests she invited, the programs she sponsored on her network, and the books she promoted. *The Oprah Winfrey Show* went national in 1986. At its peak, the show had 46 million viewers in 134 different countries.<sup>579</sup> In addition to her work on the show, Oprah maintained a magazine, *O*, a website, and a book club that can shoot any book she recommends to the top of the bestseller list.

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<sup>578</sup> "One Week Later: The Reaction to the Secret," *The Oprah Winfrey Show*, February 16, 2007.

<sup>579</sup> Kimberly Springer, "Introduction: Delineating the Contours of the Oprah Culture Industry," in *Stories of Oprah: The Oprahfication of American Culture* (Jackson: University Press of Mississippi, 2009), x, <http://ebookcentral.proquest.com/lib/michstate-ebooks/detail.action?docID=515546>.



She has supported the careers of people who made these types of claims about cancer including: Rhonda Byrne, Mehmet Oz, Deepak Chopra, Christianne Northrup, Christine Horner, Jack Canfield, and Caroline Myss. For example, on her show, Oprah promoted Rhonda Byrnes' 2006 book and 2009 movie, *The Secret*. The movie promised that viewers could have what they believe in, what they focus on, and what they direct their energy to through the law of attraction. This would bring both wealth and health. One of the women in the movie explained how she had cured her own breast cancer in under three months without chemotherapy or radiation. She simply believed she was already cured, repeated her gratitude for that as a mantra, and focused on the joy in her life. "Our physiology gives us feedback," another speaker in the movie claimed, "to let us know we have an imbalanced perspective."<sup>580</sup> Disease grew out of a lack of gratitude and love; the natural world in its goodness provided a sign to right one's life and to heal.

Oprah has crafted a view of health, cancer, and emotion which focuses on individual empowerment and studiously avoids acknowledgment of structural issues. In total, she promoted a concept of health and wealth that functioned as a secular version of the prosperity gospel mixed with a preference for "natural" health care and new age ideas. Oprah's vision of empowerment for her viewers operates on the assumption that anything was possible for any individual – cures, status, relationships, and wealth. She acknowledged obstacles including her own setbacks in processing her experiences as a victim of sexual assault and frequently discussed her progress or regression in her relationship with food and weight. Nevertheless, her own rise from rural Mississippi farm girl to media tycoon gave her reason to argue that obstacles were illusory. In a 1998 interview, Oprah said she believed the biggest problem facing African-Americans was "the loss of the spiritual self." All social problems she argued grew from this. And, she said, black

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<sup>580</sup> Drew Heriot, *The Secret* (TS Production LLC, 2007).

people who worried about their bills needed to find faith to believe that “The same God that can move planets can move your light bill.”<sup>581</sup> She had little interest in thinking about the structural causes of poverty and racism. In describing her experience at an HBCU, Oprah said that she “refused to conform to the militant thinking of time.” Her fellow students “resented” her because of her failure to go along with what she saw as a fad: “it was in to be angry.”<sup>582</sup> Oprah’s frank disavowal of anger over racism and the way in which she negated claims about structural racism and economic inequality by placing all responsibility on the individual and their faith allowed white women to feel safe from the need to confront issues that might provoke white guilt. In order to be as publicly successful and gain the viewership among white women that Oprah did, this distancing from black anger and failure to address structural racism was effective. Similarly, Oprah believed in the power of women to make their own choices and change their lives, and in particular she fought to make it possible for women to escape violence. But change, she always believed, operated on an individual level. Empowerment, to Oprah, meant not focusing on obstacles and not being a victim.

The ways in which Oprah’s guests and health gurus described proper approaches to cancer fit this model. Caroline Myss, the author of *Anatomy of the Spirit*, for example, was a repeat guest on The Oprah Winfrey Show. She described a woman who developed ovarian and breast cancer (supposedly) because of her dependence on a husband who showed only contempt for her. For Myss, the key problem was not that she was trapped in this marriage, but that she did not believe she could leave, she “could not see herself as having any personal power because she

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<sup>581</sup> Eric Stringfellow, “Oprah: I was Once Young, Poor, and From Mississippi,” *Clarion Ledger* (Jackson, MS), November 17, 1998. Cited in John Howard, “Beginnings with O” in *Stories of Oprah: The Oprahfication of American Culture* ed. Trystan Cotten and Kimberly Springer, (Jackson: University Press of Mississippi, 2009), 8.

<sup>582</sup> John Howard, “Beginnings with O,” 10 in Cotten and Springer, *Stories of Oprah*.

saw her husband as the source of her security; her biology was constantly receiving powerlessness signals.”<sup>583</sup> Myss saw her quick decline and death as evidence of the woman’s failure to recognize her own power. Christianne Northrup, who published her bestselling book *Women’s Bodies Women’s Wisdom* in 1994, echoed this. Ovarian cancer, she wrote, was, “related to an extreme need for male authority or approval.” In addition to appearing on *The Oprah Winfrey Show*, Northrup was a guest on “*The Today Show*, *NBC Nightly News*, *The View*, *Rachael Ray*, *Good Morning America*, *20/20*, and *The Dr. Oz Show*.”<sup>584</sup> Deepak Chopra, the author of many books including *Creating Health* and *Quantum Healing*, similarly saw a false belief about individual powerlessness as part of the explanation for disease. He claimed that he did not blame people for ill health, however he does argue that patients should “feel that [they] are not separate from these diseases; in fact, being an active participant is what saves [them] from being helpless victims.”<sup>585</sup> He cited stories of people who refused to believe in the reality of their cancer and therefore healed. The commonality between unexplained remissions, Chopra argued was a complete knowledge that they would recover, “as if the disease were merely a mirage, and the patient suddenly passed beyond it into a space where fear and despair and all sickness were nonexistent.”<sup>585</sup> Achieving health required that patients stop focusing on the external or systemic causes of their problems and disavow the status of “victim”; they could only look inward. The political analysis of the Boston Women’s Health Book Collective disappears in this version of empowerment. Oprah has untethered empowerment from the feminist movement. And she does not describe herself as a feminist. Instead, Oprah’s vision of empowerment and

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<sup>583</sup> Caroline M Myss, *Anatomy of the Spirit: The Seven Stages of Power and Healing*, 1996, 53–55.

<sup>584</sup> Deepak Chopra, *Perfect Health: The Complete Mind Body Guide*, Rev. ed (New York: Three Rivers Press, 2000), 97.

<sup>585</sup> Deepak Chopra, *Perfect Health*, 29.

health owes more to positive thinking, the belief that equality of opportunity already existed, and to new age medicine. The national run of *The Oprah Winfrey Show* spanned from the middle of Reagan's presidency to 2011. It reinforced the belief that token success meant that barriers were gone, color-blindness was the way to address racism, and perhaps we had reached a post-feminist world. Even as Oprah promoted people who tied their work to ancient medical systems like Ayurveda, the examples they used were closely tailored to the culture of the times.

Where empowerment, personal growth, and health are intimately connected in Oprah's world view, Lance Armstrong's cancer illustrates some of the ambiguities in how we talk about mind-body connection. Armstrong recovered from testicular cancer that had spread to his brain and lungs. He endured chemotherapy, brain surgery, and the removal of his right testicle.<sup>586</sup> After his treatment was complete, Armstrong returned to cycling, gaining far more success than he had before cancer, and won the Tour de France seven times. While he was rising to fame within the cycling world and popularizing distance cycling within the United States, Armstrong founded the Lance Armstrong Foundation, now called the Livestrong Foundation which supports cancer research and treatment. He was a national hero until the doping scandal broke. Armstrong was removed from the board of his foundation, lost his titles, and lost his endorsements. As he struggled to rebuild his tarnished reputation, Armstrong agreed to be interviewed by Oprah and articulated a different view of cancer and personality.

For Armstrong, personality did not change his biology; at most it changed his medical care. He believed that his personality had played a small part in saving him, but the traits that were most useful were his characteristic determination, stubbornness, and competitive spirit.

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<sup>586</sup> Lance Armstrong and Sally Jenkins, *It's Not about the Bike: My Journey Back to Life* (New York: Putnam, 2000).

These traits, he argued, were essential to identifying aggressive treatments, seeking second opinions and forcing himself to keep undergoing grueling medical care at a time when it might have seemed unproductive at best and detrimental at worst. In addition to the role of “blind luck” he gave some credit for survival to his “tough constitution” and to the fact that he knew “how to compete against long odds and big obstacles,” he explained in his book, *It’s Not About the Bike*. But, he refused to believe his character was the main factor because he knew that “Good, strong people get cancer, and they do all the right things to beat it, and they still die.”<sup>587</sup> But when he was interviewed by Oprah, he returned to a discussion of these traits, arguing that in his battle to defeat cancer, they became hardened. These personality traits were useful in competitive biking but they made him a worse person. He believed his diagnosis “turned [him] into a fighter.” And while he thought that was good, he “took that ruthless win-at-all-costs attitude into cycling which was bad.” In the face of cancer his “win at all costs” attitude made sense. In cycling it meant that he would do anything to win and to cover up his drug use. He became, in his own words “a bully.”<sup>588</sup> The traits that provided survival in one context led to ruthlessness and bullying in another. Survival was not buoyed by a general state of psychological health and personal well-being, but by obsessive single-mindedness. Armstrong used ideas about fighting spirit, in an attempt to rewrite his scandal as part of a survival story.

The ambiguity of ideas about “fighting spirit” and “positive thinking” allow us to sidestep harder conversations about guilt and blame for cancer patients. The ambiguity makes it possible not to recognize the number of people who believe that they can control their health through their mindset. Fighting spirit can be either admirable or dangerous. It can be used to

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<sup>587</sup> Lance Armstrong and Sally Jenkins, *It’s Not about the Bike*, 3.

<sup>588</sup> “Lance Armstrong & Oprah Winfrey: Interview Transcript,” BBC Sport, January 18, 2013, <https://www.bbc.com/sport/cycling/21065539>

mean that a person is capable of creating health even in the absence of medical care, or it can be used to describe the personal resources someone might need to navigate a confusing and overwhelming medical care system. Positive thinking can, again, refer to the ability to heal through thought alone, or it can mean that a patient sees value in life even while desperately ill, and that we should help them to do so. If, as this dissertation does, we wade through this sometimes ambiguous discourse to find the arguments that mindset directly contributes to healing and disease formation there are some constant themes.

Each variation of the argument that cancer is directly affected by personal characteristics and personality traits is intimately connected to the belief that the natural world is just or can be made to be so. In some cases, this is simply a sense that positive thinking on an individual scale will be rewarded, and socially maladaptive behavior will be punished. However, for most of those who advocate for mind-body medicine, cancer forms a part of a just and good world not as a one-to-one form of karmic revenge, but as a teacher of sorts. In most of the psychoanalytic explanations of cancer covered in chapter one, disease did not strike randomly. Rather it affected those who refused or failed to meet the standards of a post-war social order. Positive thinking as promoted by people like Norman Vincent Peale also reinforced a belief in the fairness of the natural world. Health and wealth, he claimed, were available to all with the proper mindset. Social inequalities and even bad luck ceased to be explanations for problems facing any individual. The implication was that there was something wrong with the lives of those with cancer. However, disease in both the ideology of positive thinking and in psychoanalytic thought could help patients to identify what was being repressed, find a more positive life, readjust and heal. As social expectations for what a good life looked like changed, the stock images of cancer patients did too, but the implication that this was the reflection of some underlying bit of

goodness and justice in the natural world stayed. LeShan, Simonton, and Siegel all started writing about men and women who were trapped in harmful gender roles which led to cancer. Still, they argued, the disease was a force for good in their lives. It showed how to reprioritize the things in their lives, move past the expectations that they tried to conform to, and reclaim their futures. In this formulation, social expectations may have been at fault, but the responsibility to move forward and change fell most squarely on the individual patient. Through this type of individual change, society would improve.

For others, the justice in mind-body medicine did not work on an individual level. Rather, social ills could lead to unfair disease burdens. However, the connection between mind and cancer still helped to identify social problems and inequalities. Remedying those problems would help to move simultaneously towards healthier lives for individuals and a more just society. Understanding disease meant that one could understand and remedy injustice. Take for example the work of the Boston Women's Health Book Collective and that of Paul Rosch. Both argued that sexism could cause cancer by leading to undue stress in the workplace. The BWHBC focused on how women were trained to minimize and doubt their feelings. Individual responses to these things were necessary, but they saw these as social problems. Preventing harassment in the work place could, they thought, prevent cancer. Engaging in social movements could lessen the sense of powerlessness and provide a space for emotional engagement, while also making sure that future generations of women did not face the same problems- and the resulting cancer. Whether we rectify the traits that can cause cancer individually or socially, what these arguments share is a belief that an understanding of how to fight cancer is an understanding of how to become better people and how to build a better society.

The reverse is also true. Those who argue against the belief that mind can cause or cure cancer tend to see the natural world as value neutral or potentially unfair. Those with cancer have not done something to deserve it, and it does not make them better people, they argue. The idea that cancer has some deeper meaning or lesson serves only, as Sontag argued, to blame patients and find a sense of control. This argument continues to be popular. After developing cancer, Barbara Ehrenreich began writing about the pressures to remain positive, feminine, and grateful. For her, these were reflections of both denial and a pathological need to explain everything as the result of individual actions. “Breast Cancer,” she said, “did not make me prettier or stronger, more feminine or spiritual. What it gave me, if you want to call this a ‘gift’, was a very personal, agonizing encounter with an ideological force in American culture that I had not been aware of before – one that encourages us to deny reality, submit cheerfully to misfortune and blame only ourselves for our fate.”<sup>589</sup> After posting about her anger at her experience with cancer on a support group website, Ehrenreich faced exhortations from other women with cancer to maintain a cheerful attitude and find a silver lining. This, she believed, could only cause patients to blame themselves if they did not recover. Ehrenreich has further argued that we should reevaluate our sense that we have full control over our minds and bodies and should fight the processes of aging and death indefinitely. The body and world, Ehrenreich believes are not in a simple natural harmony where each piece works towards goodness. Rather, even within the body the self-interest of individual cells can wreak havoc. Not just the rogue cells of cancer, but she draws attention to the ways in which macrophages will, instead of hunting cancer cells, safeguard them. The immune system, which advocates of mind-body medicine claim will defeat cancer if

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<sup>589</sup> Barbara Ehrenreich, *Bright-Sided: How Positive Thinking Is Undermining America* (New York: Picador, 2010), 44.



supported with good thoughts, seems to assist in its spread. Ehrenreich jokingly suggests that perhaps cancer is best fought by fostering negativity. Cancer, she believes, is not a gift; defeating it does not require positivity and a better self. The belief that it does is simply a reflection of a desire for control which can only serve to create blame. Moreover, she believes, this is a failure to recognize the basic nature of the world: that “the arc of history is long, but it bends toward catastrophic annihilation.”<sup>590</sup> The world in her mind is alive, fascinating, beautiful perhaps, but not necessarily good. Ehrenreich hopes that people will recognize that we live in an unfair world, that we have not caused disease, that disease is instead morally meaningless. This realization, she expects, will allow people to go on living their lives without worrying about what future calamities they can prevent and without becoming mired in self-blame.

Beliefs that encourage complete denial of disease like those in *The Secret* and claims that place all responsibility on patients, certainly do blame patients for their disease. If you believe that power to recover lies completely with the patient, and that there are “no incurable patients” then blame is inevitable for those develop cancer and those who die of it. But, for many, the belief that one can battle disease by changing one’s mindset is not a guarantee that doing so will lead to survival. It simply improves the odds. Death then does not have to be seen as the result of individual failure. When Sontag writes about the battle metaphors, she sees in them an implication that those who died had lost their battle, that they did not meet the emotional standards for proper healing. But if this is a matter of doing what one can to “fight” without a promise of survival, then those who do make it appear that they have reached emotional health

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<sup>590</sup> Barbara Ehrenreich, *Natural Causes: An Epidemic of Wellness, the Certainty of Dying, and Killing Ourselves to Live Longer*, First edition (New York: Twelve, 2018), 196.

prior to dying can receive the moral sheen of the fallen soldier. Blame can still play a part in these narratives, but not all deaths will be seen as the result of individual failure.

In addition, the claims that cancer is part of an ultimately good world which is driving us to do better, can be useful for many. While the pressure to remain positive can be relentless, that can provide a framework for patients to explain their situations in ways that do not cause people to recoil. This threatens to silence the pain of cancer victims but shapes a language that is easier to consume and which can be useful for activism. Where a more complete view of emotional wellness beyond just positivity is seen as key to healing, it can allow people to talk about their disease and perhaps can provide a rationale for cancer patients as they ask for the emotional support that they need and make life changes that they wish to. If the general assumption is that emotional wellbeing is essential health, patients may feel more justified in asking for help. Their social networks might find themselves more motivated to be supportive. Serious disease can prompt reevaluation and reprioritization. The belief that these reevaluations have therapeutic value can encourage patients to act on their insights. Through asking for emotional support, reevaluating their lives, and making change, those with cancer can give the disease meaning in their own lives, making it an important part of their life story instead of just an interruption.

The potential benefits of being able to integrate cancer into your life story, to use these theories to provide validation for setting a new life course, are not equally available to all of those with cancer. This story, like many others is telling for its omissions and silences. With a few notable exceptions like Audre Lorde, most of the narratives of patients overcoming cancer through personal growth and mental “battle” are white. Most are patients with means. The suggestion that men and women with cancer should recreate their lives and follow their dreams assumes the privileges necessary to do so. Robert Mack, the physician who wrote in to the *New*

*England Journal of Medicine* about his experience with visualization, spoke of reducing the hours he spent at work. Many of the case narratives involve travel, leaving a career for one that is more fulfilling, or walking away from a marriage. It would be a mistake to see these choices as equally available to all patients. While many of those who worked with LeShan or the Simontons knew their diagnoses to be terminal, the choices they made about career, love, family, and travel also imply that these patients were not yet so constrained by their symptoms that these activities were fully curtailed. Black cancer patients, poor and uneducated cancer patients, and cancer patients with debilitating symptoms have little space in these stories of miraculous recovery. This lack of representation in case narratives is further compounded in personal narratives and memoirs. Without the resources and time to write, many patients are not able to record their experiences or to gain an audience. Those who die soon after diagnosis, for example, rarely get to tell their own stories. These absences can lead us to forget that many of lifestyles changes suggested as supplementary treatments for cancer are not feasible for many, not because of their personality but because of their circumstances. Moreover, we can forget that many of those who died, but had little chance to write, lived fulfilling lives.

## BIBLIOGRAPHY

## BIBLIOGRAPHY

- Aaron Manson. "Correspondence: Fighting Cancer: The Patient's Perspective." *New England Journal of Medicine* 300, no. 21 (1979).
- "About APS: History." American Psychosomatic Society. Accessed August 12, 2018. <http://www.psychosomatic.org/about/index.cfm>.
- Adams, Junius. "How Well Do You Handle Stress." *Cosmopolitan*, January 1983.
- Ader, Robert. "Presidential Address-1980: Psychosomatic and Psychoimmunological Research." *Psychosomatic Medicine* 42, no. 3 (1980).
- Adler, Rolf. "Correspondence: Disease as a Reflection of the Psyche." *New England Journal of Medicine* 313, no. 21 (1985).
- "Age-Adjusted SEER Incidence Rates by Race/Ethnicity Cervix Uteri, All Ages, Female 1975-2015 (SEER 9)' and 'Age-Adjusted U.S. Mortality Rates by Race/Ethnicity, Cervix Uteri, All Ages, Female 1975-2015,' Survey Epidemiology and End Results." National Cancer Institute. Accessed August 12, 2018. <https://seer.cancer.gov/faststats/selections.php?#Output>.
- Alan C. Elms. "Apocryphal Freud: Sigmund Freud's Most Famous 'Quotations' and Their Actual Sources." *Annual of Psychoanalysis* 29 (2001): 83-104.
- Alcoff, Linda. "Cultural Feminism versus Post-Structuralism: The Identity Crisis in Feminist Theory." *Signs* 13, no. 3 (1988): 405.
- Alexander, Franz. *The Medical Value of Psychoanalysis*. London: George Allen & Unwin, 1931.
- Angell, Marcia. "Disease as a Reflection of the Psyche." *New England Journal of Medicine* 312, no. 24 (June 13, 1985): 1570-72. <https://doi.org/10.1056/NEJM198506133122411>.
- Angier, Natalie. "Taking Illness Personally." *New York Times*, August 2, 1992.
- Armstrong, Lance, and Sally Jenkins. *It's Not about the Bike: My Journey Back to Life*. New York: Putnam, 2000.
- Associated Press. "Emotions Can Cause Cancer, 30-Year Study at Hopkins Indicates." *The Sun*. June 7, 1976.
- Auden, W. H., and Edward Mendelson. *Collected Poems*. London: Faber, 1994.
- "Audre Lorde, 58, A Poet, Memoirist and Lecturer, Dies." *New York Times*, November 20, 1992.

- Batson, Joseph. "About AIS." *The American Institute of Stress* (blog), August 29, 2011. <https://www.stress.org/about/>.
- Beers, Carole. "Frederick Ayer II, Scientist, Traveler." *Seattle Times*, October 22, 1998.
- Bird, David. "Dr. Hans Selye Dies in Montreal; Studied Effect of Stress on Body." *New York Times*, October 22, 1982.
- Bix, Amy Sue. "Engendering Alternatives." In *The Politics of Healing: Histories of Alternative Medicine in Twentieth-Century North America*, edited by Robert D. Johnston. New York: Routledge, 2004.
- "Book Reviews: A Psychological Study of Cancer." *The Psychoanalytic Review* 15 (1928).
- Booth, G. "Irrational Complications of the Cancer Problem." *American Journal of Psychoanalysis* 25 (1965): 41.
- Boston Women's Health Book Collective. *Our Bodies, Ourselves*. New York: Simon & Schuster, 1973.
- Boston Women's Health Book Collective. *The New Our Bodies, Ourselves: A Book by and for Women*. New York: Simon & Schuster, 1984.
- Boston Women's Health Book Collective Records, MC 503. Schlesinger Library, Radcliffe Institute, Harvard University, Cambridge Mass.
- Boston Women's Health Book Collective Records, MC 667. Schlesinger Library, Radcliffe Institute, Harvard University, Cambridge Mass.
- Brody, Jane E. "Type A Men Fare Better in Heart Attack Study." *New York Times*, January 14, 1988.
- Brooks, John O. "Correspondence: Disease as a Reflection of the Psyche." *New England Journal of Medicine* 313, no. 21 (1985).
- Brown, Fred. "The Relationship Between Cancer and Personality." *Annals of the New York Academy of Sciences* 125, no. 3 (1966).
- Buchanan, R. D. "Ink Blots or Profile Plots: The Rorschach versus the MMPI as the Right Tool for a Science-Based Profession." *Science, Technology & Human Values* 22, no. 2 (1997): 168–206.
- Buchanan, Roderick D. *Playing with Fire: The Controversial Career of Hans J. Eysenck*. Oxford: Oxford University Press, 2010.

- Budd, Matthew A. "Review: Head First: The Biology of Hope." *New England Journal of Medicine* 332 (April 1990): 1240.
- Burnham, John C. "American Medicine's Golden Age: What Happened to It?" *Science* 215, no. 4539 (1982): 1474–79.
- "Cancer Facts & Figures 2018 | American Cancer Society." Accessed August 12, 2018. <https://www.cancer.org/research/cancer-facts-statistics/all-cancer-facts-figures/cancer-facts-figures-2018.html>.
- Cantor, Robert Chernin. *And a Time to Live: Toward Emotional Well-Being During the Crisis of Cancer*. New York: Harper & Row, 1978.
- Cassileth, Barrie R., and Norman Cousins. "Fighting Illness, the Mind Has Both Power and Limits." *Los Angeles Times*, October 3, 1985.
- Cassileth, Barrie R., and et al. "Response to Correspondence." *New England Journal of Medicine* 313, no. 21 (1985): 1356.
- Cassileth, Barrie R., Edward J. Lusk, David S. Miller, and Lorraine L. Brown. "Psychosocial Correlates of Survival in Advanced Malignant Disease?" *The New England Journal of Medicine* 312, no. 24 (June 13, 1985): 1551. <https://doi.org/10.1056/NEJM198506133122406>.
- Cassileth, Barrie R., Edward J. Lusk, Thomas B. Strouse, and Brenda J. Bodenheimer. "Contemporary Unorthodox Treatments in Cancer Medicine." *Annals of Internal Medicine* 101, no. 1 (July 1984): 105. <https://doi.org/10.1059/0003-4819-101-1-105>.
- Chamberlain, Mary. *Old Wives' Tales: The History of Remedies, Charms and Spells*. Stroud: Tempus, 2006.
- Chatton, Milton J. "Letter to the Editor." *New England Journal of Medicine* 296, no. 13 (1977): 763.
- Chesler, Phyllis. *Women and Madness*. New York: Palgrave Macmillan, 2005.
- Chopra, Deepak. *Perfect Health: The Complete Mind Body Guide*. New York: Three Rivers Press, 2000.
- Cotten, Trystan, and Kimberly Springer. *Stories of Oprah: The Oprahfication of American Culture*. Jackson, MS: University Press of Mississippi, 2009. <http://ebookcentral.proquest.com/lib/michstate-ebooks/detail.action?docID=515546>.
- Courtemanche, Dolores. "Link Cited Between Personality, Cancer; Doctor Warns of Risk in 'Type C Behavior.'" *Telegram & Gazette*. July 20, 1992.

- Cousins, Norman. "Anatomy of an Illness (as Perceived by the Patient)." *The New England Journal of Medicine* 295, no. 26 (December 1976): 1458–63. <https://doi.org/10.1056/NEJM197612232952605>.
- . *Anatomy of an Illness as Perceived by the Patient: Reflections on Healing and Regeneration*. New York: Norton, 1979.
- . *Head First: The Biology of Hope and the Healing Power of the Human Spirit*. New York: Penguin, 1990.
- . "Letter to the Editor: Response." *New England Journal of Medicine* 296, no. 13 (1977): 763.
- Cronbach, Lee J. *Essentials of Psychological Testing*. New York: Harper & Row, 1990.
- . *Essentials of Psychological Testing*. 5th ed. New York: Harper & Row, 1990.
- Dahlstrom, W. Grant, George Schlager Welsh, and Leona E. Dahlstrom. *An MMPI Handbook*. Minneapolis: University of Minnesota Press, 1972.
- Daly, Mary. *Gyn/Ecology: The Metaethics of Radical Feminism*. Boston: Beacon Press, 1978.
- Davis, Kathy. *The Making of Our Bodies, Ourselves: How Feminism Travels across Borders*. Next Wave. Durham, NC: Duke University Press, 2007.
- Doress-Worters, Paula B., and Diana Laskin Siegal. *Ourselves, Growing Older: Women Aging with Knowledge and Power*. New York: Simon & Schuster, 1987.
- Dreher, Henry. "Do You Have a Type-C (Cancer Prone) Personality?: Do You Fit the Profile?" *Redbook*, May 1988.
- Dunbar, Helen Flanders. *Emotions and Bodily Changes: A Survey of Literature on Psychosomatic Interrelationships, 1910-1933*. New York: Columbia University Press, 1938.
- Echols, Alice. "The New Feminism of Yin and Yang." In *Powers of Desire: The Politics of Sexuality*, edited by Ann Snitow, Christine Stansell, and Sharon Thompson, 440. New York: Monthly Review Press, 1983.
- Ehrenreich, Barbara. *Bright-Sided: How Positive Thinking Is Undermining America*. New York: Picador, 2010.
- . *Natural Causes: An Epidemic of Wellness, the Certainty of Dying, and Killing Ourselves to Live Longer*. New York: Twelve, 2018.



- . *The Hearts of Men: American Dreams and the Flight from Commitment*. The Anchor Library of Sociology. Garden City, N.J.: Anchor Press, 1983.
- Ehrenreich, Barbara, and Deirdre English. *Witches, Midwives, and Nurses: A History of Women Healers*. New York City: Feminist Press at the City University of New York, 2010.
- Ellison, Neil M. "Letter to the Editor." *New England Journal of Medicine* 300, no. 21 (1979): 1220.
- "Emotions and Bodily Changes: A Survey of Literature on Psychosomatic Interrelationships." *Journal of the American Medical Association* 105, no. 10 (1935).
- Engel, Jonathan. *American Therapy: The Rise of Psychotherapy in the United States*. New York: Gotham Books, 2009. <http://www.myilibrary.com?id=716180>.
- Evans, Elida. *A Psychological Study of Cancer*. New York: Vail-Ballou Press, 1926.
- Eysenck, H. J. "Cancer, Personality and Stress: Prediction and Prevention." *Advances in Behaviour Research and Therapy* 16, no. 3 (1994): 167–215. [https://doi.org/10.1016/0146-6402\(94\)00001-8](https://doi.org/10.1016/0146-6402(94)00001-8).
- . *Rebel with a Cause: The Autobiography of Hans Eysenck*. New Brunswick, N.J.: Transaction Publishers, 1997.
- . "Smoking, Personality and Psychosomatic Disorders." *Journal of Psychosomatic Research* 7 (1963).
- Eysenck, H. J., and Glenn D. Wilson, eds. *Experimental Study of Freudian Theories*. London: Routledge, 2013.
- Eysenck, H. J., Mollie Tarrant, Myra Woolf, and L. England. "Smoking And Personality." *The British Medical Journal* 1, no. 5184 (May 14, 1960): 1456–60.
- Fernandez-Ballesteros, R. "Cancer-Prone Personality, Type C." *International Encyclopedia of the Social & Behavioral Sciences*. Amsterdam: Elsevier, 2001.
- Fiore, Neil. "Correspondence: Disease as a Reflection of the Psyche." *New England Journal of Medicine* 313, no. 21 (1985).
- . "Correspondence: Fighting Cancer: The Patient's Perspective." *New England Journal of Medicine* 300, no. 21 (1979).
- . "Fighting Cancer — One Patient's Perspective." *The New England Journal of Medicine* 300, no. 6 (February 1979): 284–89. <https://doi.org/10.1056/NEJM197902083000604>.

- Foreman, Judy. "Study Says Psychological Factors Have No Impact on Cancer." *Boston Globe*, June 13, 1985.
- Fox, Margalit. "Susan Sontag, Social Critic with Verve, Dies at 71." *New York Times*, December 29, 2004.
- Freud, Sigmund, Anthea Bell, and Ritchie Robertson. *A Case of Hysteria: Dora*. London: Oxford Univ Press, 2013.
- Friedan, Betty. *The Feminine Mystique*. New York: Norton, 2001.
- Friedman, M., and R. H. Rosenman. "Association of Specific Overt Behavior Pattern with Blood and Cardiovascular Findings; Blood Cholesterol Level, Blood Clotting Time, Incidence of Arcus Senilis, and Clinical Coronary Artery Disease." *Journal of the American Medical Association* 169, no. 12 (March 1959): 1286.
- Friedman, M., R.H. Rosenman, and V. Carroll. "Changes in the Serum Cholesterol and Blood Clotting Time in Men Subjected to Cyclic Variation of Occupational Stress." *Circulation* 17, no. 5 (1958): 852–61.
- Gelman, David and Mary Hager. "Psychotherapy in the '80s." *Newsweek*, November 30, 1981.
- Gendel, Evalyn and Dalma Heyn. "It's Your Body... Not Your Doctor's." *Redbook*, March 1974.
- Gevitz, Norman, ed. *Other Healers: Unorthodox Medicine in America*. Baltimore: Johns Hopkins University Press, 1988.
- Glickman, Lewis. "Correspondence: Fighting Cancer: The Patient's Perspective." *New England Journal of Medicine* 300, no. 21 (1979).
- Goldin, Claudia. "The Quiet Revolution That Transformed Women's Employment, Education, and Family." *American Economic Review* 96, no. 2 (April 2006): 1–21. <https://doi.org/10.1257/000282806777212350>.
- Goode, Erica. "Arnold Hutschnecker, 102, Therapist to Nixon." *New York Times*, January 3, 2001.
- "Google Ngram Viewer." Accessed August 12, 2018. <https://books.google.com/ngrams>.
- Greene, William A., Lawrence E. Young, and Scott N. Swisher. "Psychological Factors and Reticuloendothelial Disease." *Psychosomatic Medicine* 18, no. 4 (1956): 284–303. <https://doi.org/10.1097/00006842-195607000-00003>.
- Greenwald, Howard P. *Who Survives Cancer?* Berkeley: University of California Press, 1992.

- Gregory, Robert J. *Psychological Testing: History, Principles, and Applications*. Boston: Pearson, 2014.
- Grossarth-Maticek, R., H. J. Eysenck, A. Pfeifer, and P. Schmidt. "The Specific Action of Different Personality Risk Factors on Cancer of the Breast, Cervix, Corpus Uteri and Other Types of Cancer: A Prospective Investigation." *Personality and Individual Differences* 23, no. 6 (1997): 949–60. [https://doi.org/10.1016/S0191-8869\(97\)00099-8](https://doi.org/10.1016/S0191-8869(97)00099-8).
- Haggbloom, Steven J., Renee Warnick, Jason E. Warnick, and Vinessa K. Jones. "The 100 Most Eminent Psychologists of the 20th Century." *Review of General Psychology* 6, no. 2 (2002): 139–52. <https://doi.org/10.1037//1089-2680.6.2.139>.
- Hale, Nathan G. *The Rise and Crisis of Psychoanalysis in the United States: Freud and the Americans 1917-1985*. Bridgewater, N.J.: Replica Books, 2000.
- Harrington, Anne. *The Cure Within: A History of Mind-Body Medicine*. New York: W.W. Norton & Company, 2009.
- Heiskell, Charles A. "Some Psychosomatic Aspects of Asthma." *Journal of the American Medical Association* 170, no. 15 (1959).
- Heriot, Drew. *The Secret*. TS Production LLC, 2007.
- Herzog, Dagmar. *Cold War Freud: Psychoanalysis in an Age of Catastrophes*. Cambridge: Cambridge University Press, 2017.
- Hobbs, Frank and Nicole Stoops, U.S. Census Bureau, Census 2000 Special Reports, Series CENSR-4, *Demographic Trends in the 20<sup>th</sup> Century*, U.S. Government Printing Office, Washington, DC, 2002.
- Howard, John. "Beginnings with O." In *Stories of Oprah: The Oprahfication of American Culture*. Jackson, MS: University Press of Mississippi, 2009. <http://ebookcentral.proquest.com/lib/michstate-ebooks/detail.action?docID=515546>.
- Howell, Mary C. "What Medical Schools Teach about Women." *New England Journal of Medicine* 291, no. 6 (August 1974). <https://doi.org/10.1056/NEJM197408082910612>.
- Hughes, Jennifer. *Cancer and Emotion: Psychological Preludes and Reactions to Cancer*. Chichester: Wiley, 1987.
- Hutschnecker, Arnold A. *The Will to Live*. New York: Thomas Y. Crowell Company, 1951.
- Ives, V., MQ Grant, and JH Ranzoni. "The Neurotic Rorschachs of Normal Adolescents." *Journal of Genetic Psychology* 83, no. 1 (January 1, 1953): 31–61.

- Jackson, Mark. *The Age of Stress: Science and the Search for Stability*. Oxford: Oxford University Press, 2013.
- Jaroff, Leon. "Medicine: Can Attitudes Affect Cancer?" *Time*, June 24, 1985. <http://content.time.com/time/magazine/article/0,9171,959465,00.html>.
- Jasen, Patricia. "Malignant Histories: Psychosomatic Medicine and the Female Cancer Patient in the Postwar Era." *Canadian Bulletin of Medical History* 20, no. 2 (2003): 265–97.
- Johnston, Robert D., ed. *The Politics of Healing: Histories of Alternative Medicine in Twentieth-Century North America*. New York: Routledge, 2004.
- Katz, Robert A. *Peptic Ulcer: Psychosomatic and Medical Aspects*. New Orleans: M. & S.J., 1944.
- Kiecolt-Glaser, Janice K., Lynanne McGuire, Theodore F. Robles, and Ronald Glaser. "Psychoneuroimmunology and Psychosomatic Medicine: Back to the Future." *Psychosomatic Medicine* 64, no. 1 (January 2002): 15.
- King, Martin Luther. *Strength to Love*. New York: Pocket Book, 1964.
- Kinsey, Alfred C., Wardell Baxter Pomeroy, and Clyde E. Martin. *Sexual Behavior in the Human Male*. Bloomington: Indiana University Press, 1975.
- Kissen, D. M. "The Value of a Psychosomatic Approach to Cancer." *Annals of the New York Academy of Sciences* 125, no. 3 (January 1966): 777.
- Kissen, David M., and H. J. Eysenck. "Personality in Male Lung Cancer Patients." *Journal of Psychosomatic Research* 6, no. 2 (1962): 123–27. [https://doi.org/10.1016/0022-3999\(62\)90062-4](https://doi.org/10.1016/0022-3999(62)90062-4).
- "Lance Armstrong & Oprah Winfrey: Interview Transcript." *BBC Sport*, January 8, 2013. <https://www.bbc.com/sport/cycling/21065539>.
- Lasagna, Louis. "Review: Lipp, Martin R. The Bitter Pill: Doctors, Patients and Failed Expectations." *Journal of Nervous and Mental Disease* 170, no. 7 (1982): 440–41.
- Lasch, Christopher. *The Culture of Narcissism: American Life in an Age of Diminishing Expectations*. New York: Norton & Company, 1991.
- Leary, Warren, and David Binder. "Washington Talk: Briefing; Making Amends." *The New York Times*. November 3, 1988, sec. U.S. <https://www.nytimes.com/1988/11/03/us/washington-talk-briefing-making-amends.html>.

- Lennane, K. Jean, and R. John Lennane. "Alleged Psychogenic Disorders in Women — A Possible Manifestation of Sexual Prejudice." *New England Journal of Medicine* 288, no. 6 (February 1973): 288–92. <https://doi.org/10.1056/NEJM197302082880605>.
- Lerner, Barron H. *The Breast Cancer Wars: Hope, Fear, and the Pursuit of a Cure in Twentieth-Century America*. Oxford: Oxford University Press, 2003.
- LeShan, Eda. "Can Your Emotions Help You Resist Cancer?" *Woman's Day*, March 1975.
- LeShan, Lawrence. "A Psychosomatic Hypothesis Concerning the Etiology of Hodgkins' Disease." *Psychological Reports* 3, no. 3 (June 1957): 565–75. <https://doi.org/10.2466/pr0.1957.3.3.565>.
- . *Cancer as a Turning Point: A Handbook for People with Cancer, Their Families, and Health Professionals*. New York: E. P. Dutton, 1989.
- . "Psychological States as Factors in the Development of Malignant Disease: A Critical Review." *Journal of the National Cancer Institute* 22, no. 1 (January 1959): 1.
- . *You Can Fight for Your Life: Emotional Factors in the Causation of Cancer*. New York: M. Evans & Company Inc., 1977.
- LeShan, Lawrence L., Sidney Marvin, and Olga Lyerly. "Some Evidence of a Relationship Between Hodgkin's Disease and Intelligence." *A.M.A. Archives of General Psychiatry* 1, no. 5 (1959): 477–79. <https://doi.org/10.1001/archpsyc.1959.03590050045005>.
- LeShan, Lawrence, and Marvin Reznikoff. "A Psychological Factor Apparently Associated with Neoplastic Disease." *The Journal of Abnormal and Social Psychology* 60, no. 3 (1960): 439–40. <https://doi.org/10.1037/h0047074>.
- Levy, Shandra, Alan Winkelstein, Bruce S. Rabin, Marc Lippman, and Sheldon Cohen. "Correspondence: Psychosocial Variables and the Course of Cancer." *New England Journal of Medicine* 313, no. 21 (1985).
- Link, Bruce G. and Jo Phelan, "Social Conditions as Fundamental Causes of Disease," *Journal of Health and Social Behavior*, Supplemental Issue (1995).
- Lipp, Martin R. *The Bitter Pill: Doctors, Patients, and Failed Expectations*. New York: Harper & Row, 1980.
- Liste, Karen Hagen. "Breast Cancer, Personality, and the Feminine Role." *Patient Education and Counseling* 36, no. 1 (1999).
- Wingerson, Lois. "Book Review." *Los Angeles Times*, October 25, 1992.

- Long, Robert T. "A Psychosomatic Study of Allergic and Emotional Factors in Children with Asthma." *The American Journal of Psychiatry* 114, no. 10 (1958).
- Lonsdale, Derrick. "Letter to the Editor." *New England Journal of Medicine* 296, no. 13 (1977): 762.
- Lorde, Audre. *A Burst of Light: Essays*. Ithaca, N.Y: Firebrand Books, 1988.
- . *I Am Your Sister: Collected and Unpublished Writings of Audre Lorde*. Edited by Rudolph P. Byrd. Transgressing Boundaries. Oxford New York: Oxford University Press, 2009.
- . *The Cancer Journals*. San Francisco: Aunt Lute Books, 1980.
- Luce, Gay, and Ebik Peper. "Mind Over Body, Mind Over Mind." *New York Times Magazine*, September 12, 1971.
- Mack, Robert M. "Lessons from Living with Cancer." *New England Journal of Medicine* 311, no. 25 (December 1984): 1640–44. <https://doi.org/10.1056/NEJM198412203112520>.
- Marksberry, Kellie. "Stress and Cancer." *The American Institute of Stress* (blog), October 24, 2011. <https://www.stress.org/stress-and-cancer/>.
- Martin, Hale and Stephen E. Finn. *Masculinity and Femininity in the MMPI-2 and MMPI-A*. Minneapolis: University of Minnesota Press, 2010.
- Masters, William H., and Virginia E. Johnson. *Human Sexual Response*. New York: Ishi Press International, 2010.
- Matarazzo, Ruth G. "Book Review." *The New England Journal of Medicine* 330, no. 7 (February 1994): 514–15. <https://doi.org/10.1056/NEJM199402173300723>.
- May, Elaine Tyler. *Homeward Bound: American Families in the Cold War Era*. New York: Basic Books, 1988.
- McGuire, Hunter H. "Letter to the Editor." *New England Journal of Medicine* 296, no. 13 (1977): 762.
- McQuerter, Gregory. "Cancer: Clues in the Mind." *Science News* 113 (January 1978): 44.
- "Medical News: Animal Study Shows Intriguing Link Between Chronic Stress, Cancer." *Journal of the American Medical Association* 233, no. 7 (1975).
- Merchant, Carolyn. *The Death of Nature: Women, Ecology, and the Scientific Revolution*. New York: Harper One, 1990.

- Metzl, Jonathan Michel. *Prozac on the Couch*. Durham, NC: Duke University Press, 2005.
- Michaels, David. *Doubt Is Their Product: How Industry's Assault on Science Threatens Your Health*. Oxford: Oxford University Press, 2008. <http://site.ebrary.com/id/10215788>.
- Morris, Tina, Steven Greer, Keith W. Pettingale, and Margaret Watson. "Patterns of Expression of Anger and Their Psychological Correlates in Women with Breast Cancer." *Journal of Psychosomatic Research* 25, no. 2 (January 1981): 111–17. [https://doi.org/10.1016/0022-3999\(81\)90098-2](https://doi.org/10.1016/0022-3999(81)90098-2).
- Morrison, Samuel, and Maurice Feldman. "Psychosomatic Correlations of Duodenal Ulcer: A Statistical Study." *Journal of the American Medical Association* 120, no. 10 (1942).
- Morse, Peter H. "Book Review." *Journal of the American Medical Association* 243, no. 14 (1980): 1471.
- Moss, Ralph W. *The Cancer Industry: The Classic Exposé on the Cancer Establishment*. New York: Equinox Press, 1996.
- Mosse, George. "Shell-Shock as a Social Disease." *Journal of Contemporary History* 35, no. 1 (2000).
- Mukherjee, Siddhartha. *The Emperor of All Maladies: A Biography of Cancer*. New York: Scribner, 2011.
- Murray, Heather. "'My Place Was Set at the Terrible Feast': The Meanings of the 'Anti-Psychiatry' Movement and Responses in the United States, 1970s-1990s." *Journal of American Culture* 37, no. 1 (2014): 37.
- Myss, Caroline M. *Anatomy of the Spirit: The Seven Stages of Power and Healing*. New York: Three Rivers Press, 1996.
- Nathanson, Constance A. "Sex, Illness, and Medical Care: A Review of Data, Theory, and Method." *Social Science and Medicine* 11, no. 1 (1977): 13–25. [https://doi.org/10.1016/0037-7856\(77\)90141-X](https://doi.org/10.1016/0037-7856(77)90141-X).
- Nixon, Richard. "Annual Message to the Congress on the State of the Union." Edited by Gerhard Peters and John T. Woolley, January 22, 1971. The American Presidency Project. <http://www.presidency.ucsb.edu/ws/?pid=3110>.
- . "Remarks to a National Cancer Conference in Los Angeles, California." Edited by Gerhard Peters and John T. Woolley, September 28, 1972. The American Presidency Project.

- Nixon, Richard, and Nikita Khrushchev. "The Kitchen Debate—Transcript," July 24, 1959. Central Intelligence Agency Library. <https://www.cia.gov/library/readingroom/docs/1959-07-24.pdf>.
- Norman Cousins Papers (Collection 1385). Department of Special Collections, Charles E. Young Research Library, University of California, Los Angeles.
- Northrup, Christiane. *Women's Bodies, Women's Wisdom: Creating Physical and Emotional Health and Healing*. New York: Bantam Books, 2010.
- Oberndorf, C. P. "Consideration of Results with Psychoanalytic Therapy." *American Journal of Psychiatry* 99, no. 3 (1942): 374–81. <https://doi.org/10.1176/ajp.99.3.374>.
- "Obituary: Helen Flanders Dunbar." *British Medical Journal* 5151, no. 2 (1959).
- Oken, Donald, and Ann Maxwell Eward. "A Brief Report on the History and Role of the American Psychosomatic Society." *Journal of Psychosomatic Research* 42, no. 3 (March 1997): 307–10. [https://doi.org/10.1016/S0022-3999\(96\)00326-1](https://doi.org/10.1016/S0022-3999(96)00326-1).
- Olson, James Stuart. *Bathsheba's Breast: Women, Cancer, and History*. Baltimore, MD: Johns Hopkins University Press, 2002.
- Oreskes, Naomi, and Erik M. Conway. *Merchants of Doubt: How a Handful of Scientists Obscured the Truth on Issues from Tobacco Smoke to Global Warming*. New York: Bloomsbury Press, 2010.
- Ostow, Mortimer. "The New Drugs." *Atlantic*, July 1961.
- Overmier, J. Bruce, and Robert Murison. "Restoring Psychology's Role in Peptic Ulcer." *Applied Psychology Health and Well-Being* 5, no. 1 (2013).
- Patterson, James T. *The Dread Disease: Cancer and Modern American Culture*. Cambridge: Harvard University Press, 1989.
- Paul J. Rosch. "Job Stress May Explain Rise in Breast Cancer." *New York Times*, December 30, 1986.
- Peale, Norman Vincent. *The Power of Positive Thinking*. New York: Prentice-Hall, Inc., 1952.
- Petticrew, Mark P., and Kelley Lee. "The 'Father of Stress' Meets 'Big Tobacco': Hans Selye and the Tobacco Industry." *American Journal of Public Health* 101, no. 3 (March 2011): 411.
- Phalen, Kathleen F. *Integrative Medicine: Achieving Wellness through the Best of Eastern and Western Medical Practices*. Boston: Journey Editions, 1998.



- Philip Morris Records; Congressman Bliley Philip Morris Collection. UCSF Truth Tobacco Industry Documents.
- Popper, Karl R. *Conjectures and Refutations: The Growth of Scientific Knowledge*. London: Routledge, 2002.
- Quadagno, Jill S. *One Nation, Uninsured: Why the U.S. Has No National Health Insurance*. Oxford: Oxford University Press, 2006.
- Rapaport, David, Merton M. Gill, and Robert R. Holt, eds. *Diagnostic Psychological Testing*. New York: International Universities Press, 1968.
- Records of the Office of Technology Assessment, ca. 1970-1995, Record Group 444 Office of Technology Assessment; National Archives Building, Washington, DC.
- Redd, William H., and Paul B. Jacobsen. "Emotions and Cancer. New Perspectives on an Old Question." *Cancer* 62, no. S1 (October 1988): 1871–79. [https://doi.org/10.1002/1097-0142\(19881015\)62:1<1871::AID-CNCR2820621331>3.0.CO;2-D](https://doi.org/10.1002/1097-0142(19881015)62:1<1871::AID-CNCR2820621331>3.0.CO;2-D).
- Reich, Wilhelm. *The Cancer Biopathy*. New York: Farrar, Straus and Giroux, 1973.
- Reiser, Stanley J. *Medicine and the Reign of Technology*. Cambridge: Cambridge University Press, 1988.
- Renneker, R. E., R. Cutler, J. Hora, and C. Bacon. "Psychoanalytical Explorations of Emotional Correlates of Cancer of the Breast." *Journal of Psychosomatic Medicine* 25, no. 2 (1963).
- Reverby, S. "A Perspective on the Root Causes of Illness." *American Journal of Public Health* 62, no. 8 (August 1972): 1140–42.
- "Review." *Nature* 131, no. 3311 (1933).
- "Review: The Medical Value of Psychoanalysis." *British Medical Journal* 1, no. 3766 (1933).
- Rodale, J. I. *Happy People Rarely Get Cancer*. Emmaus, PA: Rodale Press, 1970.
- Rosenberg, Steven A, and John M Barry. *The Transformed Cell: Unlocking the Mysteries of Cancer*. New York: Avon, 1993. <https://archive.org/details/transformedcellu00roserich>.
- Ross, Matthew. "Book Review." *General Hospital Psychiatry* 4, no. 2 (1982): 161.
- Ryan, William. *Blaming the Victim*. New York: Vintage Books, 1976.
- Ryle, Anthony, and R. E. W. Fisher. "Smoking and Personality." *The British Medical Journal* 1, no. 5186 (May 1960): 1652.

- Schindler, Daniel. "Laughter Therapy: The Surly Bird Gets the Germ." *New England Journal of Medicine* 300, no. 22 (May 31, 1979): 1283–1283. <https://doi.org/10.1056/NEJM197905313002235>.
- "Science Watch; Type A Preschoolers." *New York Times*, June 7, 1988.
- Schmeck, Harold M. "Common Virus Linked to Cancer." *New York Times*, February 12, 1985.
- Searls, Damion. *The Inkblots: Hermann Rorschach, His Iconic Test, and the Power of Seeing*. New York: Crown, 2017.
- Selye, Hans. "A Syndrome Produced by Diverse Nocuous Agents." *Nature* 138, no. 3479 (1936).
- Semeonoff, Boris. *Projective Techniques*. London: Wiley, 1976.
- Showalter, Elaine. *The Female Malady: Women, Madness, and English Culture, 1830-1980*. London: Virago, 2009.
- Siegel, Bernie S. *Love, Medicine & Miracles: Lessons Learned about Self-Healing from a Surgeon's Experience with Exceptional Patients*. New York: HarperPerennial, 1990.
- Simonton, O. Carl, Stephanie Simonton, and James L Creighton. *Getting Well Again: A Step-by-Step, Self-Help Guide to Overcoming Cancer for Patients and Their Families*. New York: Random House, 2009.
- Siodmak, Robert. *The Dark Mirror*. Noir. International Pictures, 1946.
- Smelser, Neil J., and Paul B. Baltes, eds. *International Encyclopedia of the Social & Behavioral Sciences*. Amsterdam: Elsevier, 2001.
- Smith, Mary Lee, Gene V. Glass, and Thomas I. Miller. *The Benefits of Psychotherapy*. Baltimore, MD: Johns Hopkins University Press, 1980.
- Snitow, Ann Barr, Christine Stansell, and Sharon Thompson, eds. *Powers of Desire: The Politics of Sexuality*. New York: Monthly Review Press, 1983.
- Solomon, George F. and Alfred A. Amkraut. "Psychoneuroendocrinological Effects on the Immune Response." *Annual Review of Microbiology* 35 (1981).
- Sontag, Susan. *Illness as Metaphor & AIDS and Its Metaphors*. New York: Picador, 2001.
- Sperling, Caroline. "Cancer Counseling: A Prescription of Hope." *Washington Post*, October 28, 1986.
- Spiegel, David. "Effects of Psychotherapy on Cancer Survival." *Nature Reviews Cancer* 2, no. 5 (2002).

- Spiegel, David, H.C. Kraemer, J.R. Bloom, and E. Gottheil. "Effect of Psychosocial Treatment on Survival of Patients with Metastatic Breast-Cancer." *Lancet* 2, no. 8688 (1989).
- Springer, Kimberly. "Introduction: Delineating the Contours of the Oprah Culture Industry." In *Stories of Oprah: The Oprahfication of American Culture*. Jackson, MS: University Press of Mississippi, 2009. <http://ebookcentral.proquest.com/lib/michstate-ebooks/detail.action?docID=515546>.
- Starr, Paul. *The Social Transformation of American Medicine*. New York: Basic Books, 2017.
- Stephenson, James H., and William J. Grace. "Life Stress and Cancer of the Cervix." *Psychosomatic Medicine* 16, no. 4 (1954).
- Stringfellow, Eric. "Oprah: I Was Once Young, Poor, and From Mississippi." *Clarion Ledger*. November 17, 1998.
- Sugrue, Thomas J. *The Origins of the Urban Crisis: Race and Inequality in Postwar Detroit: With a New Preface by the Author*. 1st Princeton Classic ed. Princeton Studies in American Politics. Princeton: Princeton University Press, 2005.
- Szasz, Thomas, Richard E. Vatz, and Lee S. Weinberg. *Thomas Szasz, Primary Values and Major Contentions*. Buffalo, N.Y: Prometheus Books, 1983.
- Tache, Jean, Hans Selye, and Stacey B Day, eds. *Cancer, Stress, and Death*. New York: Plenum, 1979. <http://public.eblib.com/choice/publicfullrecord.aspx?p=3085319>.
- Tarlau, M., and I. Smalheiser. "Personality Patterns in Patients with Malignant Tumors of the Breast and Cervix - An Exploratory Study." *Psychosomatic Medicine* 13, no. 2 (1951): 117–21.
- Temoshok, Lydia. "Biopsychosocial Studies on Cutaneous Malignant Melanoma: Psychosocial Factors Associated with Prognostic Indicators, Progression, Psychophysiology and Tumor-Host Response." *Social Science & Medicine* 20, no. 8 (1985): 833–40. [https://doi.org/10.1016/0277-9536\(85\)90338-7](https://doi.org/10.1016/0277-9536(85)90338-7).
- Temoshok, Lydia, and Henry Dreher. *The Type C Connection: The Behavioral Links to Cancer and Your Health*. New York: Random House, 1992.
- Temoshok, Lydia, Bruce W. Heller, Richard W. Sagebiel, Mardsen S. Blois, David M. Sweet, Ralph J. DiClemente, and Marc L. Gold. "The Relationship of Psychosocial Factors to Prognostic Indicators in Cutaneous Malignant Melanoma." *Journal of Psychosomatic Research* 29, no. 2 (January 1985): 139–53. [https://doi.org/10.1016/0022-3999\(85\)90035-2](https://doi.org/10.1016/0022-3999(85)90035-2).
- "The Link Between Illness and Emotion." *Washington Post*, September 28, 1985.

- “To Extend Inquiry into Patton Affair, Senate Group Will Look for Similar Army Episodes.” *New York Times*, November 29, 1923.
- U. S. Census Bureau. “Data.” Census of Housing. Accessed August 12, 2018. <https://www.census.gov/housing/census/data/>.
- U.S. Census Bureau. “Historical Marital Status Tables.” Accessed August 12, 2018. <https://www.census.gov/data/tables/time-series/demo/families/marital.html>.
- U.S. Congress, Office of Technology Assessment, *Unconventional Cancer Treatments*, OTA-H-405 (Washington, DC: U.S. Government Printing Office, September 1990).
- US Department of Commerce. “Table 2.7. Investment in Private Fixed Assets, Equipment, Structures, and Intellectual Property Products by Type.” Bureau of Economic Analysis. Accessed August 12, 2018. <https://www.bea.gov/iTable/iTable.cfm?ReqID=10&step=1#reqid=10&step=1&isuri=1&1003=51&1004=1929&1005=1969&1006=a&1011=0&1010=x>.
- U.S. Department of Labor Office of Policy, Planning and Research, “The Negro Family: The Case for National Action,” 1965.
- Vitaliano, Peter P., Patricia A. Lipscomb, and John E. Carr. “Correspondence: Psychosocial Variables and the Course of Cancer.” *New England Journal of Medicine* 313, no. 21 (1985): 1355.
- Wailoo, Keith. *How Cancer Crossed the Color Line*. Oxford: Oxford University Press, 2011.
- “War on Cancer.” *New York Times*, May 31, 1971.
- Watson, M., and S. Greer. “Development of a Questionnaire Measure of Emotional Control.” *Journal of Psychosomatic Research* 27, no. 4 (1983): 299.
- Wheeler, John I., and Betty McDonald Caldwell. “Psychological Evaluation of Women with Cancer of the Breast and of the Cervix.” *Psychosomatic Medicine* 17, no. 4 (1955): 256–68.
- William, RB, H. Benson, and MJ Follick. “Disease as a Reflection of the Psyche.” *New England Journal of Medicine* 313, no. 21 (1985): 1356–57.
- Williams, Redford B., Herbert Benson, and Michael Follick. “Correspondence: Disease as a Reflection of the Psyche.” *New England Journal of Medicine* 313, no. 21 (1985).
- Winfrey, Oprah. “One Week Later: The Reaction to the Secret,” *The Oprah Winfrey Show*, February 16, 2007.

Wood, Jim, ed. *What's Wrong with the Rorschach? Science Confronts the Controversial Inkblot Test*. San Francisco: Jossey-Bass, 2003.