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SEDUCTIVE SYMBOLISM

Psychoanalysis in the Context of Oncology

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Beliefs about what caused their cancer are a central facet of patients' experience of illness. These beliefs make up the patient's theory of etiology, which derives from various sources, including conscious and unconscious fantasy. This paper highlights this dimension of patients' experience, and the possible interaction between patients' psychogenic theories of etiology and their therapists' potentially generated psychogenic theories regarding patients' disease. It is suggested that a countertransferential pull for therapists exists to generate psychogenic theory regarding patients' cancer in the face of the threat of impotency it presents. This is discussed as a seductive pull into symbolism-based understanding of patients' cancer etiology—a pull this paper aims to characterize. It is suggested that the seductive pull results from the influence of psychoanalytic psychosomatic theory in the context of the dynamic between the ill patient and the therapist. Some psychoanalytic psychosomatic theory posits symbolism-based linear psychogenesis and the possible correction of soma via psyche in a great variety of illnesses and conditions, including cancer, and the hypothetical effect of this literature on the clinician's mindset and clinical work is considered. Specifically, it is suggested that this portion of our literature might serve a psychological function for clinicians, as it can help to shore up an omnipotence defense against the undertow of chaos inherent in cancer-related bodily dysfunction. More generally, it is argued that the context of existing psychoanalytic psychosomatic theory characterized by a focus on symbolism-based linear psychogenesis is potentially influential, and that this influence needs to be examined.

Keywords: fantasy, oncology, psychoanalytic psychosomatic theory, psychogenesis, psychological function of theory

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> "I'm living on a razor's edge. Cancer is maddening. It will drive you mad. I'm a floater. I'm out there in outer space. I'm in a void. They offered a cure but now . . . well, they don't know what to tell me. The people who are most supposed to help me don't have anything to offer me." Mr. Y, 26 years old

> "We denied the uncontrollability of cancer with the belief in our therapeutic powers. *This is exactly the most common reaction of cancer patients when confronted with cancer.*" (Renneker, 1957, p. 411, italics in original)

> "Efforts to avoid theories lead to conflicts and self-deception, and favor the unrecognized unconscious operation of such preconceptions. It is the willingness to reflect on our necessarily theory-laden observations that offers the opportunity to arrive at novel observations and conclusions, to recognize what may go beyond our expectations." (Grossman, 1995, p. 896)

Despite advances in medical knowledge linking behaviors to certain cancers (e.g., smoking and lung cancer, or sun exposure and melanoma) and ones linking particular testable genes to specific cancers (e.g., the link between the BRCA1 and BRCA2 genes and breast and ovarian cancer), most cancers are far from understood. Even in the presence of known links, much remains unknown—why one smoker develops lung cancer and others don't, why some nonsmokers do—leaving plenty of room for personal theorizing about why one person has the disease and another does not (see Linn, Linn & Stein, 1982, for an interesting study of personalized theorizing about the causes of cancer among lung cancer patients with a history of heavy smoking.) Theories about the etiology of cancer abound in our culture, reflecting a mix of scant, and often-changing information, popular mythology, and personal fantasy.

Beliefs about what caused their own cancer are a central facet of patients' experience of illness. These fantasy-based beliefs (Britton, 1995) about the root of the disease are multilayered and partly unconscious; they can be thought of as the patient's theory of etiology. This theory can be quite pointedly specific—I got cancer because I absorbed my wife's negativity—and is sometimes the source, along with fears of death and disfigurement, of the psychic suffering that accompanies grave physical disease. Most powerfully, as will be demonstrated below via case material, a patient might experience cancer as the actualization or completion of a crucial fantasy about his or herself (Bergner, 2009).

Given its focus on unconscious fantasy and dynamics, psychoanalytic psychotherapy—more than the existential and cognitive approaches typically utilized in the setting of oncology—can potentially deeply engage this dimension of patients' experience. However, such an engagement is complex and challenging. In this paper, I will try to characterize this challenge.

I will discuss and flesh out the following interrelated points. (a) Patients' theories are layered, multiply determined, and possess conscious and shared, conscious and secret, as well as unconscious, fantasy-based parts. (b) Because of their nature—they involve unconscious dynamics related to archaic takes on the self—patients' fantasies often confer a sense of certainty or conviction about the roots of the cancer, even when such certainty and conviction are not warranted given medical research's findings or their lack. (c) Tolerance for the psychic experience of cancer partly hinges upon the capacity to live with uncertainty, and to simultaneously utilize several strategies—such as medicine and faith, traditional and alternative medicine, emotional reckoning and denial—and contain several emotional states that are in some sense contradictory. Psychotherapy with cancer patients often reflects the tension between uncertainty and the anxieties it arouses, and the theories that aim to combat it. (d) Therapists, made vulnerable by the uncertainty and chaos

inherent in their cancer patients' disease, might also be pulled to make sense by making theories about the etiology of the cancer, and might at times be specifically pulled toward a certain kind of psychogenic theorizing. This is certainly not inevitable, nor always operating, but it is a potentially seductive pull, which might be more or less conscious and fully articulated in the mind of the clinician. This pull derives from a mix of sources and, when it is operating and unexplored, could exert an influence upon the clinical process, in part by affecting the therapist's stance toward the patient's own psychogenic theories. Certain portions of psychoanalytic psychosomatic theorizing make this pull more likely. (e) It is important to examine and reconsider psychoanalytic psychosomatic theory that addresses cancer per se, as well as writings that address other diseases and physical dysfunctions that are presently insufficiently understood by medicine (Apfel & Keylor, 2002, e.g., discuss this in relation to infertility, and Gerson, 2002, in relation to colitis and Crohn's disease.) We are, to varying degrees, embedded in our theoretical context, and should examine its overt as well as potentially unconscious, preconscious, subtle effects upon and sufficiency for our clinical work.

The Importance of Examining Our Theories

The inevitable, necessary, yet complex influences of psychoanalytic theories of pathogenesis, the mind, development, and clinical process on clinical practice have been explored by many authors (Arlow, 1981; Almond, 2003; Fonagy, 2002; Gilmore, 2008; Grossman, 1995; Michels, 2003; Sandler, 1983; Smith, 2003; Wilson, 2004.) Fonagy (2002) views the process of clinicians turning to theory to guide practice as costly to the field of psychoanalysis. The tight and direct connection presumed between theory and practice—the assumed appropriateness of being guided by theory when making choices regarding which actions to take in one's practice—places unjustified constraints upon practice due to the unacknowledged limitations of the theory. Addressing clinicians' powerful relationship to theory and explicating what he offers as a psychological view of theories, Grossman (1995) emphasizes the transformation of the meanings of theoretical concepts, which come to represent unconscious fantasies. In his discussion of the unconscious vicissitudes of psychoanalytic theories, Grossman concentrates in particular on the enduring unconscious relationship of theory to authority. This contributes to adherence to or usage of the theory, or to the championing of an (impossible) antitheoretical (and manifestly rejecting of authority) attitude. Grossman writes that the various fates of theory in the mind of the clinician depend on whether we use the theories deliberately or whether they influence us preconsciously or unconsciously. Along this vein, Wilson (2004) reiterates that the hold of theories on an analyst is akin to that of unconscious fantasies, which intermittently come and go in consciousness. Theories become internal objects, imbued with the transferences that characterize our professional psychoanalytic context. Additionally, theories are understood through the filter of the analyst's compromise formations, and thus are invariably rendered idiosyncratic.

Almond (2003), focusing upon the holding and thus in a sense comforting function of theory, views theory as providing a psychological presence, a sense of conviction, and affective stability, which make effective analytic work possible for the analyst. Writing about developmental theory, Gilmore (2008) states that every psychoanalyst's implicit developmental theory—even when the analyst ascribes to an ostensibly a-developmental theoretical persuasion such as is characteristic of postmodern positions that more or less discard the genetic viewpoint—is woven into his or her listening and exploration of every

clinical presentation. This is so, Gilmore suggests, because an analyst orients toward particular aspects of each clinical moment by his or her conviction of how the mind develops. Clinicians' understanding of the significance of real events in patients' histories, of the transformative nature of development, of the nature of experience during various times in life, and so on, guide their inquiry into patients' history, current life, and transferential dynamics, whether or not clinicians avow that they are operating with an explicit developmental theory in mind.

The intent in the present paper is to concentrate upon a certain sector of psychoanalytic psychosomatic theory—which espouses notions of symbolism-based linear psychogenesis—and explore its potential psychological function for the clinician and thus its (more or less recognized) contribution to clinical work. My sense that the pull I wish to characterize—a pull toward certain kinds of psychogenic theorizing—does sometimes exert influence in the consulting room is based on clinical experience and conversations over some years with colleagues and students treating patients with cancer, and my reading of some of our literature. One clinical case– Joyce McDougal's (2000), will be discussed in detail below, and used as an example to spell out the potential nature of the presence of some core aspects of psychoanalytic psychosomatic theory in clinical practice in the context of oncology. The extent to which individual clinicians actually are impacted by the literature in the way that I am addressing here is an empirical question that can and ought to be investigated. However, my point here is that such an influence could potentially exist and at least sometimes does—as McDougal's case demonstrates, because of the interaction between the kind of knowledge—limited and changing—that is available in the context of oncology, the anxiety it generates, the anxiety-reducing psychological function of our theories, and the nature of the transference-countertransference matrix in which our work is embedded. The intent here is not to critique individual clinicians, but rather to: (a) scrutinize and work to bring out ways in which our psychosomatic literature, because of its complex psychological function—including its holding, comforting dimension, as well as its relation to authority and to both superego- and ego-ideal-related transferences—matters, and could at times be influential in shaping our work even in subtle ways we might not readily recognize, and (b) point to a reexamination of some of our literature.

Preliminary Sketch of the Issue

The literature about psychoanalytic psychotherapy with cancer patients is sparse, but the existing writings vividly capture the challenge of working in the presence of physical suffering and threat to the patient's life and bodily integrity. Therapists typically feel painful feelings in such a setting, deriving from their identifications with and feelings about their patient, and from knowledge, anxiety, and fantasy about disease, as well as personal vulnerabilities linked to experiences with and fantasies about the body. (Adler, 1984; Renneker, 1957) Searles (1990) thought that psychotherapeutic work with cancer patients revives the therapist's sense of omnipotence and its limits and requires him or her to come to terms with it anew. In his account of efforts to identify intrapsychic antecedents of breast cancer in analysands as part of the program of psychoanalytic research into psychosomatic processes undertaken by the Chicago Institute for Psychoanalysis Research Project, Renneker (1957) describes his group's driven search for psychogenic explanations for the etiology of the cancer, and attributes the determined nature of this search to

the threat of impotency presented by patients' cancer. (I will discuss the particulars of this group's theorizing later in the paper.)

Psychoanalytic clinicians possess both articulated and unarticulated theories about the link between mind and body in disease generally (Seidenberg, 1963), and in cancer in particular, and about the possible effect of psychoanalytic treatment on physical illness (Renneker, 1957). These theories derive from a blend of clinicians' personal, idiosyncratic beliefs and fantasies about mind-body links, and psychoanalytic psychosomatic thinking. To the extent that clinicians' theories are rooted in and consistent with the context of the presently available psychoanalytic psychosomatic literature, the theories are likely to be experienced as comfortingly coherent with, and a part and parcel of, clinicians' sense of professional identity and psychoanalytic ego ideal.

Psychoanalytic psychosomatic theory has held that unconscious conflicts are symbolically and causally linked to somatic dysfunction (Alexander, 1950; Groddeck, 1917/1977, Sperling, 1964), and that the body speaks for the mind, expressing archaic, flooding conflict or emotional overstimulation that cannot be verbally and maturely represented and expressed, via bodily dysfunction. (See Gottlieb, 2003, for a review of these views, of which McDougal, 1989, is a champion). For decades, a diverse variety of physical symptoms, syndromes, and diseases (from migraine headaches, to colitis, ulcer, asthma, or infertility) had been understood as expressive of psychic content (Apfel & Keylor, 2002; Gerson, 2002). Physical symptoms were viewed, sometimes rather inclusively, as stand-ins for psychological ones. The method applied to psychological material, psychoanalysis, was considered similarly appropriate for an array of physical symptoms, since these were seen as signifiers in the chain of signification leading from past psychic reality to present phenomena.

Groddeck (1917/1977) wrote about the unconscious "choice" of certain parts of the body for the expression of symbolic representation of meaning as the process that leads to disposition to particular kinds of illness. Although he wrote almost a century ago, this view about the symbolic choice of disease can be found to reverberate in McDougal's (1989) contemporary and highly influential writings (to be discussed below), as well as quite often in patients' fantasies. Sperling (1964), too, stated that somatic symptoms (e.g., migraine headaches) represented the expression of specific pregenital impulses and fantasies, with the somatic symptom being a form of pregential conversion neurosis. More recently, some authors writing about infertility have protested the denial of psychogenesis brought about by the ascendancy of medical intervention (Allison, 1997). They have offered psychoanalytic psychotherapy as the tool for uncovering the unconscious fantasies and conflicts that underlie infertility and, via insight into these, as a tool, as well, for its cure (Ferber, 2002).

Since its earliest days, the psychoanalytic psychosomatic literature has evolved and become more differentiated so that it now contains more than one model for explaining the psyche-soma link (Gottlieb, 2003, and Taylor, 2003, helpfully discuss and differentiate conversion-based and somatization-based models). Nevertheless, one basic tenet of more classical psychoanalytic psychosomatic theory—that underlying some manifest symptomatic soma there is primary, symbolically related, generating psyche—remains. Its underpinnings and implications are consistent with those inherent to the basic tenets of general psychoanalytic thought, namely, that unconscious material is potent and creates symptoms, that present-day symptoms express iterations of the past and of psychic reality to which they ought to be traced, and that the alleviation of symptoms entails reconstructing their unconscious source.

This theoretical mindset, and the assumptions about the psyche-soma relationship that are embedded in it, might contribute, sometimes subtly, to the way psychoanalytically-based clinicians make sense of some of patients' physical disease or dysfunction, and of patients' own theorizing about it, just as psychoanalytic developmental theory shapes our understanding of developmentally salient themes in patients' material.[1] In situations of great uncertainty and the unknown, such as prevail in many cases of cancer (and some other diseases and conditions, including some forms of infertility), there may be a greater, more or less conscious and explicit pull toward the kind of psychogenic theorizing that is the focus of this paper, because of a need to counteract an acute sense of helplessness and great anxiety, which can arouse—in the manner articulated earlier regarding the psychological function of theories—unconscious appeals to the authority and knowledge, and thus power, that are vested in the theory. (A detailed example of the use of symbolism-based theorizing regarding a patient's cancer is to be found in the McDougal case mentioned earlier, and will be discussed below.)

To flesh out the idea of patients' multidetermined construction of a psychogenic theory to explain their cancer, and the potential interaction between their theories and the ones clinicians might be pulled to construct, I will begin with a case vignette. I will address hypothetical ways in which the clinician's and the patient's theories might converge, and the potential effect of such a hypothetical convergence. The point here is not to suggest that all clinicians would always construct the kind of theory sketched here, but rather that there is a pull toward and therefore potential for some (more or less conscious) version of this kind of thinking. Next, I will discuss some pervasive to our culture views of and efforts to explain cancer as a somatic disease with underlying psychic dimensions. Then, narrowing the focus, I will critically examine both explicit, articulated psychoanalytic writings about cancer, as well as the overall psychoanalytic psychosomatic theoretical context within which such thinking is embedded. Third, I will look briefly into psychoanalytic psychotherapy with cancer patients, and closely read a case of Joyce McDougal's in order to examine the effect of her well known and highly influential psychosomatic theorizing on the clinical material. Finally, using a long vignette from a case of mine, I will trace the vicissitudes of a patient's shifting theories about his cancer and discuss the challenges these presented in his psychotherapy.

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[1] This isn't to say, of course, that all clinicians indiscriminately make sense of every single instance of physical dysfunction using theory in the way I am describing, that is aiming for reconstruction of unconscious symbolic meaning that is viewed as having a causal relationship to the bodily symptoms and their alleviation. Common sense suggests that in some cases—the presence of appendicitis or conjunctivitis, for example, this would be less likely. However, some contemporary authors do causally link a diverse array of physical changes to psychoanalytic work and view as mutative the reconstruction of the symbolic link between the symptom and its meaning; for example, Knafo (2009) describes the treatment of a man whose (actual) vision improved remarkably during the course of his psychoanalytic treatment, and states that insight may have a direct effect upon sight. While calling attention to the presence of such positions towards symbolic psyche-to-soma links in our literature as indicators of the meaningfulness and effect of our theoretical context upon clinical thinking, I am in no way suggesting that there exist no psyche-to-soma influences and links. Rather, as stated elsewhere (Bergner, 2009), I am calling into question the effect of the particular nature of the characterization of the psyche-soma relationship—as linear and symbolism-based—that can be found in some of our literature, as well as our complex psychological relationship to this literature.

How Theory Might Color Practice: Mr. X, for Whom "the Punishment Fits the Crime"

Mr. X, a 53-year-old, married, Catholic man was hospitalized for chemotherapeutic treatment for a recurrence of testicular cancer. During his hospital stay, he interacted little with nurses or doctors, confining his remarks to polite requests for antiemetic and sleep medications and for newspapers, which he read for most of the day behind his closed hospital room door. The nursing staff asked that Mr. X be seen for an evaluation by the psychiatry service, because he was requesting sleeping pills each night, and the staff felt concerned about his mood. They found him highly anxious, and yet, they also found him aloof, odd, and unemotional and therefore difficult to empathize with or get to know.

Mr. X's medical chart described that he had a recurrent nonseminomatous germ cell tumor, having initially been treated for cancer nearly 30 years earlier, in his midtwenties. At that time, he had had a testicular mass with nodal involvement, and was treated with an orchiectomy (the surgical removal of his testicle) and several rounds of chemotherapy. Recently, Mr. X suffered back pain, and after numerous false leads, was found to have a recurrence in some of his lymph nodes.

Testicular cancer, made famous by champion cyclist Lance Armstrong, is the most common cancer in young American men between the ages of 20 and 34. The causes of this cancer are not well understood, but one known risk factor is cryptorchidism, the congenital failure of testes to descend into the scrotal sac. This risk factor is overcome if surgical repair of the condition is performed before age 6. Associative factors suggested but not confirmed in the medical literature have been: infections of testicular tissue; unusual bleeding during mothers' pregnancy; exposure of mothers to exogenous estrogen, alcohol, or X-rays during pregnancy; and familial history of the disease. Men who discover a lump or an enlarged testicle, fluid, or unusual pain usually detect the disease. The most common symptom of metastatic disease is back pain. Cure rates for the various forms of testicular cancer are very high, by some estimates exceeding 95% for one common type of the disease, and close to that for others (Roth & Scher, 1998).

Although unilateral orchiectomy in itself does not necessarily cause infertility or sexual dysfunction (ibid) the effects of treatment with chemotherapy and radiotherapy, or surgical complications, may contribute to problems in sexual experience (e.g., erectile dysfunction and reduced rates of and pleasure in orgasm). It is thought that some of these difficulties derive from men's anxiety, feelings, and fantasies regarding sexuality and fertility. Couples' therapists working with testicular cancer patients suggest that organic and psychological factors must be investigated together, as sexual anxieties in this setting are caused by multiple, interacting factors (Schover & Eschenbach, 1984). Treatments for more advanced forms of the disease can lead to (sometimes temporary) infertility, which can contribute to sexual avoidance and fears about sexual functioning (Roth & Scher, 1998; Schover & Eschenbach, 1984).

The oncologist described the particular recurrence of Mr. X's disease, following a roughly two-decade-long remission, as exceedingly rare and linked to poor prognosis. He also concluded that the recurrence was secondary to the early surgery's failure to completely remove all cancerous cells.

In his hospital room, dressed in a short, flimsy, hospital gown and a loosely tied bathrobe, Mr. X initially appeared overly exposed, in a way that was starkly different from the staff's sense of him as a guarded, closed, and aloof man. He cordially accepted the consultation, saying: "I have been lying there at night thinking silly thoughts over and over

again in my head and I cannot fall asleep." Regarding his "silly" thoughts, Mr. X said: "I see myself as broken, imperfect, and incomplete." However, he also said he was a survivor, and there was a calm, eerily peaceful feeling to his remarks. When probed about the difference between the content of his words and his almost pleased affect, Mr. X smiled. He then said: "I am a sexual addict, a compulsive masturbator. I have been since I was very young, maybe 13 or 14. I always used to masturbate when I was nervous, it was a self-soothing thing." He then related that he had first married in his 20s, before the initial diagnosis of cancer, and that he "failed to consummate the marriage" because of sexual impotence. He had his first successful sexual intercourse, with a prostitute, some years after his initial cancer treatment. In all the years since that first marriage, and continuing through the years of his current marriage, Mr. X engaged in masturbation several times a day, using pornographic materials. He hid this activity from his current wife until she discovered him masturbating. Since then, the two had been attending a couple's therapy group, and Mr. X had also been attending a self-help group for compulsive masturbators, both of which he said he found helpful.

I thought that Mr. X viewed his cancer as punishment for years of secret masturbation, with all its meanings to him, and cancer treatment as an actualization of castration fantasies. Mr. X said that he obtained relief from the diagnosis of recurrence, as he felt it was a "punishment perfectly fitting with the crime." He said there was relief in being discovered by his wife, and that the diagnosis took care of the problem of "always waiting for the other shoe to drop." It seemed that the diagnosis and the treatment felt like concretizations of unconsciously felt need for punishment, related to Mr. X's complex sexual guilt. This guilt was linked, in his conscious experience, to the secrecy of his masturbatory practices, which represented betrayal of his wife. However, it seemed he was also suffering from complex guilt related to the content of his masturbatory fantasies, to his frequent sexual arousal and pleasure, and to his many transgressions against inhibitions laid down in early life through the intertwining of religious and familial dynamics.

Mr. X was suffering (evident through sleeplessness and anxiety), yet he also felt peaceful and, ironically, more in control than he had in years, as his both conscious and unconscious guilt had been plaguing him, and as he, unconsciously had continued to beg fate for punishment.

A psychoanalytic perspective offered much food for thought with respect to the multidetermined nature of Mr. X's sexuality, guilt, and the possible death wishes embedded in his relieved feelings about his perceived punishment. He interpreted his illness as linked directly to his sexual and relational compromises, believing that underlying wishes and conflicts caused his physical disease—a disease that is both deserved and in some way apt and "chosen" specifically (recall Groddeck) to address his particular sexual conflict and its behavioral expression. These ideas circumvented the oncologist's conclusion that the recurrence was caused by problems in the early surgery, and the currently existing knowledge—and its limits—about his disease. Supporting the links the patient was making, even implicitly, ran the risk of colluding with his guilt, his sense of responsibility for his disease. While the links he believed in led to his stated relief, they also underlay his suffering, some of which, I expected, was only just beginning to arise. On the other hand, the links he saw provided a sense of meaning, coherence, and a fantasized measure of control. Deconstructing them would entail a confrontation with randomness and having been failed by others (as in the case of a poorly executed early surgery). Was Mr. X's belief about his disease providing surface level relief that masked or compounded intense underlying anxiety? Or was his relief deep and enduring?

And what about the therapist's view of Mr. X's illness? As described above, psychoanalytic psychosomatic theory has held that unconscious conflicts are causally linked to somatic dysfunction, and that via various forms of bodily dysfunction, the body speaks for the archaically-conflicted or overwhelmed mind (McDougal, 1989). Further, some of our theories articulate a symbolic connection between the particular physical symptom or disease and the underlying unconscious conflict—as mentioned above, according to this view, the physical symptom is apt and chosen because it expresses a meaning directly deriving from the conflict (Apfel & Keylor, 2002; Groddeck, 1977/1917, Sperling, 1964; McDougal, 1989). This has remained a core part of our theoretical context, our psychoanalytic-psychosomatic worldview. How might it color our work with Mr. X? In what way does it contribute to our understanding of him? We may hypothesize that his multiply determined sexual guilt led him to unconsciously wish for a punishing castration. Might we go an extra step and view the removal of his testicle, his treatment-caused impotence as a motivated outcome or resolution of conflict? Would we, then, in a sense, "agree with" Mr. X's fantasy—that, via some kind of conversion of symbolically related psychic to somatic reality, his cancer was caused by unconscious sexual conflicts?

While clinicians' reactions to such a psychogenic theory regarding Mr. X inevitably vary (some might wholly reject it), it is important to recognize that some of our literature, if applied to Mr. X, may well lead to the suggestion that Mr. X's unconscious sexual conflicts, guilt, and wish for a castrating punishment have resulted in and are expressed through his cancer. It also may suggest that Mr. X's cancer could have been prevented had he been able to make a different, more mature psychic compromise, and thus choose a different, more mature—nonsomatic—symptom, in the face of his sexual conflicts. If we were to follow some core aspects of our theory and think this way—and I will soon articulate in further detail where we would be getting such thinking—then our understanding would jive with the patient's own theory: that his cancer is traceable to potent, symbolic psychic content. In such a hypothetical instance, in which the patient's theory would be consistent with the analyst's, the possibility for real consideration of the function of the patient's theory, its multiply determined nature—reflective of self-hatred, masochistic submission, and identification with an internalized, persecuting aggressor—would be limited. The potential space required for such exploratory work would have been flattened. Therapist and patient would now be colluding, perhaps subtly and not necessarily explicitly, in the fantasy that something real—the root, the actual presence of psychic reality and the psychological past in the present body—has been uncovered (Bergner, 2009).

That not every clinician always or ever thinks this way, or would, with a patient such as Mr. X is, of course, true. However, we need to investigate whether, when, or how we might be pulled to think along such lines, more or less consciously—because of our anxiety and impotence in the face of patients' threatening disease, and because of the psychological function of our literature and our reliance upon it. To underscore, the extent to which this pull operates is a researchable question. However, before this question can be asked in an operationalizable manner, we must first recognize that because theory does color clinical practice, the potential contribution to clinical thinking of the kind of theory of psychogenesis I am highlighting here (of symbolism based linear psychogenesis) needs investigating, as this kind of theory does continue to characterize sometimes influential portions of our contemporary literature.

Our Culture's Beliefs and Theories About the Psychogenic Etiology of Cancer

In her polemic against prevailing ways of thinking about cancer, cultural critic Susan Sontag, herself a cancer patient at the time of her writing, stated that "disease is just disease" (p. 22). and metaphors or symbolic thinking about cancer have nothing but destructive power, because they prevent people from seeking aggressive medical care, and imbue physical suffering with emotional and spiritual pain that is unjustified. Sontag wrote that according to the "mythology of cancer," (p. 22) people get cancer because of repressed feelings. In earlier times, sexual feelings were believed to have been the culprit; however, angry ones are now in center stage (see also Frank, 2002). Sontag was opposed to what she called the psychologizing of disease. She wrote: "Psychologizing seems to provide control over the experiences and events [like grave illnesses] over which people have in fact little or no control. Psychological understanding undermines the 'reality' of a disease" (p. 55, brackets in original).

A decade later, Sontag (1988/1990) reflected upon her earlier essay and noted that its purpose had been to "calm the imagination, not to incite it. Not to confer meaning, but to deprive something of meaning . . . To regard cancer as if it were just a disease—a very serious one, but just a disease. Not a curse, not a punishment, not an embarrassment. Without 'meaning'" (p. 102).[2]

Sontag represents the polar opposite response to beliefs in the psychogenesis of cancer, which are common in both popular and scholarly writings. In the 1980s, physician and bestselling author Bernie Siegel popularized the view that cancer can be caused by psychosocial factors (repression of feelings, a response to loss) and that it is curable via changes in the person's psychological way of being in the world. (See Saplosky, 2004, for a discussion of Siegel's book, and see Harrington, 2008, for a discussion of shifting cultural narratives about the power of medical science and the potency of patients' perception of their disease for its ultimate outcome.)

As early as 1959, Perrin and Pierce, writing in the leading journal *Psychosomatic Medicine*, critically reviewed research that investigated psychosomatic aspects of cancer. The authors addressed influential studies, which examined the two ideas that persist in more contemporary writings: namely that cancer occurs following psychological trauma especially involving loss, and that cancer develops in certain kinds of personalities. Most of the reviewed studies used psychoanalytic evaluations of patient life stories, anecdotal or demographic methods, or psychological testing. Perrin and Pierce discuss enormous methodological flaws in all aspects of the research, from selection of cancer patients after disease onset, to the absence of appropriate controls, from problematic measuring instruments to flawed statistical design and analyses. They write: ". . . as one views the chronological literature in this area, it becomes apparent that successive writers tended to draw their hunches directly from their predecessors who often used faulty sampling, inadequate statistical treatment, and so forth. The danger of building up a mass of data on such a weak foundation cannot be overestimated." (p. 417)

More recent efforts to identify psychogenic factors related to cancer include: those that seek to identify psychological factors predisposing to the onset of disease, and those that

[2] In her total belief in medical science's capability ultimately to find the cause of and thereby cure cancer, Sontag represents a pole as exclusionary of uncertainty as the other pole she rejects—of meaning-focused discourse. See Rieff, 2008, for an account of Sontag's final battle with cancer, from which she ultimately died, and of the effect on her of her conviction in medicine's power to cure.

seek to assess psychological interventions with cancer patients. Most predisposition studies focus on personality. Some attempt to link a personality profile termed Type C, which designates a characteristic coping pattern marked by denial of negative emotions, to the development of cancer (see Taylor, Bagby, & Parker, 1997 for a description of such studies). While more sophisticated than the earlier efforts, disturbingly, these studies continue to suffer from crucial flaws. Primarily, they study personalities in people already sick with cancer, rather than prospectively, or build in supposed controls (like studying women awaiting breast biopsy, rather than ones already diagnosed) that do not, in fact effectively control for the effect of subjects' knowing or suspecting they have the disease (Sapolsky, 2004). Even Temoshok, a highly prolific researcher employing the Type C construct, has recently elaborated upon the enormous complexity of characterizing cancer onset or causality, which she differentiated from what she viewed as the more manageable, though still daunting task, of linking the Type C coping pattern with disease progression (Temoshok, 1997, and see also her 2008 article about HIV progression).

Intervention studies focusing on therapeutic modalities (e.g., support groups) with cancer patients can further be divided into two subgroups. One group assesses improvement in patients' quality of life due to better coping following intervention. The other asks whether psychological interventions might affect disease progression, either via their impact upon patients' health-promoting behaviors (including compliance with cancer treatments) or via a direct psychophysiological route (involving a beneficial effect of reduced stress upon immune system functioning). The latter studies have yielded mixed results. Well-publicized positive findings have been exceedingly hard to replicate in subsequent studies because of the tremendous heterogeneity of cancer, the variable and tumor-specific nature of the link between immune system activity and the disease, and the immense complexity of isolating effects, as well as building in controls (Sapolsky, 2004). As a result, the database on whatever psychophysiological pathways may be involved in affecting disease outcome following psychological intervention is at present sparse (Andersen, 2002).

The search for idiosyncratic and/or psychogenic causes among patients has been studied by psycho-oncologists. The earlier-mentioned study of beliefs about the causes of cancer in end-stage lung cancer patients with a history of smoking (Linn, Linn & Stein, 1982) found that these patients' search for a reason for their disease is personal; the lung cancer patient who is a heavy smoker uses personally meaningful explanations to make sense of why he got cancer when his older neighbor who smokes more heavily did not. Another study found that patients typically spontaneously discuss causality first when asked open-endedly about their illness; causal explanations can change over time for individuals; most patients offer more than one causal explanation, and these may appear incongruent, especially when the cancer is less well understood by the scientific community; and, importantly, patients may cling to their causal explanations ambivalently and in secrecy (Taylor, 1995).

Psychoanalytic Views of Cancer as Psychogenic

Psychoanalytic formulations of cancer have been consistent with the overall psychoanalytic psychosomatic theoretical context described earlier, in which, historically, many bodily symptoms were viewed as linked to and deriving from psychic sources (Alexander, 1950; Groddeck, 1917/1977). A series of papers appeared in the 1950s and 1960s in the journal *Psychosomatic Medicine*, (and were summarized shortly thereafter in *Psychoan-*

alytic Quarterly), discussing the findings generated by the earlier-mentioned Chicago Institute for Psychoanalysis Research Project, which investigated "psychosomatic correlations" in women with breast cancer (Bacon, Renneker, & Cutler, 1952; Renneker, 1957; Renneker et al., 1963). Describing the personality development and psychotherapies or psychoanalyses of 5 women with breast cancer, Renneker et al. (1963) focused on the emotional situation prior to the manifestation of cancer, stating that depressive reactions decrease "host resistance" to the disease. Speculating that carcinogenic trends are related to disturbances in sexuality and in the maternal drive, the authors identified a particular conflictual, intrapsychic constellation, and postulated that this constellation constitutes a force, which would upset the normal hormonal balance. (They did not test this hypothesis, which provides a nucleus of an idea about a mechanism by which psyche and soma are linked.) Here is a partial statement of their formulation:

> All 5 of our patients were deprived of oral-dependent gratifications and frustrated through unsatisfactory relationships with their mothers. As the fathers occasionally provided some gratification, they were associated through experience as the source of oral-dependent gratification. This presence of the nucleus of the depressive constellation . . . made our patients particularly vulnerable to the development of depressive reactions later in life. The dynamic constellation was complicated by the partial blocking of men as available sources of satisfaction and security . . . out of their guilt toward or fear of mother . . . the conflicts between the guilt or fear of mother and the chronic oral-dependent, passive needs in relation to men were handled by identification with the mothers' masochistic personality structure. (Renneker et al., 1963, pp. 118–119)

To understand how this conceptualization reflects, derives from, and further contributes to the overall context of psychoanalytic psychosomatic theory, it is instructive to compare it with a formulation about infertility, offered by Marie Langer at around the same time, in 1958. She wrote:

> One common factor in their family constellation [of eight infertile women she had studied through psychoanalysis] was a predominating mother figure while the father was weak, rejecting or absent. Another factor shared by these patients consisted of their having suffered severe oral frustrations . . . owing to a new pregnancy of the mother [and/or] . . . in seven of the cases . . . unusual tragic events had occurred in . . . infancy, for instance, the mother's death during delivery, an outbreak of puerperal psychosis in the mother, the death of a younger and rival sibling, all accidents connected with maternity. The infancy of only one out of eight patients was free from serious external traumata; but she was the youngest child, and as we know, the fantasies which are frequent in such cases refer to having magically prevented the mother from having another baby . . . Hence they all carried within them the representation of a destroyed mother which the facts of external reality seemed to confirm. (Langer, 1958, p. 1)

Note the similarities in the types of thinking offered in these formulations of breast cancer and infertility. Both sets of ideas were derived from the psychoanalyses of a small number of women, both clearly describe dynamics and events that are common in childhood, and that were especially commonly encountered in the childhood experience of the patients under discussion (as these women grew up in the 1920s and 1930s, or even earlier). In other words, if we take a step back from these formulations and try to separate them from infertility and cancer, we see that they capture dynamics commonly found in the analyses of women of childbearing years, understood in the terms derived from a particular social and psychoanalytic era. Langer asserted, "the understanding of early anxieties together with the conception of envy enables us to grasp the meaning *and the*

psychosomatic mechanisms of many fertility disorders" (1958, p. 5, italics added). It is important to realize that while Langer offered what might be a compelling depiction of the experience of infertile women she encountered in her practice, she thereby claimed to have also offered an explanation of cause and mechanism, solely because the explanation made coherent sense according to psychoanalytic ideas. Room was even made for the patient whose story did not fit the pattern and was said to have destroyed mother only in fantasy—and the theory, viewed as discovered mechanism, stood.[3] Future writings about infertility worked with similar so-called explanations in the absence of confirmatory research findings (Apfel & Keylor, 2002).

Writing in the 1970s, Booth (1973, 1977) concluded, on the basis of his own psychoanalytic work with patients and his reading of available literature, that

> 1. As infants, cancer patients experienced traumatic frustration in their mother relationship. Their personalities bear the imprint of dominant pregential fixation; 2. The life histories . . . are characterized by a desperate need for control of a specific object which may be a personal relationship, a socioeconomic career, or a vocation . . .; 3. The neoplastic process began when the patient experienced the irreparable loss of control over his idiosyncratic object. The loss could be caused by external events, by declining vitality, or by both factors; 4. The neoplastic process is localized in the organ whose function dominated in the genetic makeup of the patient, and consequently determined the nature of the object to be controlled; 5. The tumor represents the internalized lost object . . .; 6. The course of the disease depends upon the balance of power between the unconscious satisfaction derived from the neoplastic process, and the satisfactions derived from the remaining object relationships. (1973, p. 1)

In defining the nature of the relevant object and the circumstances of its loss in so inclusive a manner—a relationship, career, vocation, lost through events or just mere aging—Booth was casting a very wide net that could seem to be describing the cancer of a great many, if not most, people. (Booth uses these ideas to explain the roots of Freud's cancer). This author's position, like Langer's about infertility, is both that cancer is psychogenic, caused by unconscious dynamics, and that it is understandable through the psychoanalytic method; further, the psychoanalytic method is viewed as possessing the tools not only to identify etiology but also—because the course of the disease depends upon an object relational balance—to contribute to cure.

Goldberg (1990) states that adequate coping in the face of loss of a loved object does not inevitably lead to cancer, but rather to mourning without lengthy regression and melancholia. But, she adds: "Where cancer is the end result in melancholia, the indication is of inadequate resolution of early conflicts" (p. 9). Using circular reasoning, she adds that clinicians have described cancer patients as poor in producing fantasy when they are in psychoanalytic treatment, and that therefore it may be hypothesized that the "somatic symptom of cancer is a biological acting out of the fantasy, and thus replaces the fantasy" (p. 10). Note the kind of thinking utilized here—a somatic symptom is equivalent to a psychological one, psyche generates soma, the psychoanalytic process can account for and explain physical reality, and so on. Note, also, the absence of considerations of cause and effect. Even if cancer patients (a massively heterogeneous group) were to be poor fantasy-producers (an unsupported assertion), this certainly would not tell us anything about the relation between the presence of the disease and the absence of fantasy. Fearful,

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[3] Langer's writings were taught recently, in 2007, in the femininity portion of a class on gender offered at a prominent psychoanalytic training institute; they were received with interest and appreciation by candidates, which is to say that they remain a visible part of our literature.

anxious, ill, or physically compromised—as well as often medicated—patients may be constricted in their verbal production of fantasy as a result of their experience of illness. And, even knowing that a given patient may have been a poor fantasy producer before the onset of cancer does not in itself tell us anything about what links may or may not exist between the psychological characteristic and the physical disease (see Taylor, Bagby & Parker, 1997, for in depth discussion of research about the relevant construct of alexithymia).

In his earlier-mentioned 1957 article, Renneker wrote:

> We were biased researchers. Biased in the sense that we *believed*, on the basis of our preliminary study of cancer of the breast, that there *was* a psychological trigger factor in some cases. Our disregard of cancer knowledge was appalling . . . . [T]he therapeutic goal was clearly the prevention of cancer recurrence, or the abolition of active cancer, through the successful, thorough analysis of the total personality . . . We hoped to prevent or cure a disease whose etiology, development, and treatment are still shrouded in ignorance and uncertainties. We were convinced that it could be a psychosomatic disease, but we had little idea how or why this came about. This need to believe the psychosomatic connections in cancer and its vulnerability to psychoanalytic treatment was an early universal reaction designed to avoid facing the idea that our therapeutic efforts might be in vain (p. 411).

Psychotherapy and Psychoanalysis With Cancer Patients

Writings about psychoanalysis and psychoanalytic psychotherapy with cancer patients frequently focus upon the therapist's countertransference (Adams-Silvan, 1994; Adler, 1984; Hans, 1988; Hulsey & Frost, 1995; Minerbo, 1998; Norton, 1963; Postone, 1998; Renneker, 1957; Searles, 1990; Sourkes, Massie, & Holland, 1998; Straker, 1998). Psycho-oncology authors such as Sourkes, Massie and Holland (1998) write that the therapist must possess a high level of tolerance for ambiguity in working with patients whose lives are predicated on uncertainty. Adler (1984) uses Winnicott's concept of hate in the countertransference to address hate in the treatment of the medically ill, who remind therapists of their own potential physical helplessness and of ultimate death. According to Adler, hate with a wish to destroy or rid ourselves of the person who confronts us with such painful fantasies is inevitable, as is the therapist's magical wish that physical illness be reversible by psychological means.

Particular concerns that often arise in the psychotherapy are usefully covered in the psycho-oncology literature. Postone (1998) discusses the illness triggering an intensification of intrapsychic conflict. He states that the meaning patients attribute to their illness and treatment often intensifies suffering, and must be explored, as I have been suggesting. Such attribution, in all of its conscious and unconscious layers, colors all aspects of the patient's experience, including the sense of loss linked to the threatened integrity of the body, loss of a sense of control, increased dependency, fears of abandonment, loss of identity, and fear of death (Dreiffus-Katan, 1994; Postone, 1998; Sourkes, Massie, & Holland, 1998).

And what about the therapist's response to a cancer patient's particular attribution of meaning to the disease? I have been discussing the potential role of the theoretical context in influencing how therapists understand and work with patients' psychogenic theories. In some instances, patients consciously and explicitly interpret their disease as psychogenic and also potentially treated through psychological means, thus exerting enormous pressure upon therapists to confront their own understanding of the patient's disease and come to

terms with the limits to their power to rescue and cure. Hans' (1988) patient accused him of not having done his job, thereby causing her cancer's recurrence. In a description of a fantastical seeming case of factitious cancer in a patient, Kupfermann (1998) writes that she asked herself whether she had perhaps caused the patient to develop her cancer (which ultimately was found not to exist!) by prematurely introducing the idea of the termination of therapy. Hulsey and Frost (1995) write of the psychotherapy of an anxious, schizoid man agitated by physical complaints, who was eventually diagnosed with advanced stage intestinal cancer. The patient became convinced that he had developed his cancer through his anxieties. (While stating that the case demonstrates disease symbolically representing repressed psychic material, the authors do not address the effect of the interaction between the patient's theory of etiology and his therapist's on the therapeutic process.) Lloyd-Mayer's (1994) patient had the fantasy that psychoanalysis would be a panacea, even perhaps a cure for her cancer, a fantasy challenged by her analyst.

Attention is paid in the literature to the question of how much to interpret when working with very ill or dying patients. Some (Norton, 1963) emphasize the regressive aspects of the therapeutic relationship, and advocate facilitation of this, eschewing confrontation with aggressive dynamics. Adams-Silvan (1994) felt reluctant to undo a suppression that was important to her patient, and thus did not address the patient's miscarriages and perception of her body as producing cancer instead of babies. Other authors (Lloyd-Mayer, 1994; Minerbo, 1998) advocate using positive and negative, regressive and aggressive aspects of the therapeutic relationship. Toward the end of her patient's life, Minerbo (1998) struggled to contain and interpret the horror of her patient's dying, in order to make it possible for the patient to speak of coming death and voice her fear of it. All of these authors work to remain sensitively close to the patients' experience of illness. They do not focus upon their own, or the patients', theories or fantasies of etiology.

In contradistinction, an explicit effort to address the etiology of the patient's disease is exemplified by McDougal's (2000) paper about the analytic treatment of a 40-year-old woman who had breast cancer. While McDougal manifestly works to analyze the patient's potent fantasies about the process linking her psyche and soma, a close reading reveals the significant reverberations of McDougal's own well-known position about the links between psyche and soma in the analytic material. I will now detour for a moment to explicate McDougal's highly influential, frequently cited view of psychosomatic processes in some detail, in order to examine the effects of this view in her approach to her patient.

In her book *Theaters of the Body* (1989) McDougal formulates her view that somatic dysfunction represents a symptom through which the psyche sends its message when the psyche is unable to achieve mental representation of this message. In a statement that exemplifies psychoanalytic thinking about the symbolic function of symptoms, she writes:

> An individual's body might act as if it were trying to 'get rid of' something poisonous (as in ulcerative colitis in which the body contents are brutally ejected), or as though it were trying to 'hold onto' something (as in bronchial asthma, in which the patient frequently cannot expel his breath). Why would the bowel continue to empty its contents in the absence of any organic pathology? And why would anyone hold his breath, in fact almost stop breathing, *without a physical reason for doing so*? (Italics added, 1989, p. 55)

Assumptions such as McDougal's, that there are no "physical *reasons*" for these illnesses, (when it is always possible that there is a complex, interconnected mass of physical reasons that is as yet unknown to us) buttress the leap to psychogenic explana-

tions that appear to supply causality and meaningful, because intuitively appealing, mechanisms.

McDougal's approach is fleshed out in her discussion of the case of Sophie, a young woman who suffered from, among other complaints, eczema. The eczema first manifested in adolescence, when the patient experienced an irruption on her right hand, and it usually recurred on this hand as well. Sophie linked her first outbreak to an illicit sexual incident, and interpreted it as somatic punishment for sexual guilt. But McDougal continues to investigate what she thinks is more likely to be the key to this eczema, because it appeared to irrupt not only following sexual contact. In other words, she continued searching for the "truer" cause, rather than viewing the patient's belief about the cause as, in itself, the primarily salient material. She states:

> the fact that the eczema occurred only on her hands suggests *symbolism of a primitive pregenital kind . . . It seems probable that if Sophie had access to her aggressive and violent fantasies at the level of verbal thought, she would not have suffered from this symptom.* (Italics added, 1989, p. 87)

I will now spell out the kind of clinical thinking articulated here in McDougal's case of Sophie, as applied to Mr. X, the testicular cancer patient described earlier. To recall, Mr. X had a cancer that specifically implicates his sexuality, one whose treatment bears directly on themes of castration and emasculation. Along the lines of McDougal's Sophie, one might feel pulled to believe, more or less consciously and explicitly, that it seems probable that had Mr. X had access to his sexual/aggressive fantasies at the level of symbolic verbal thought, and therefore could have expressed them in a different kind of sexual-relational context—a more mature genital one—than the one in which he expressed his sexuality, he would not have suffered from his particular kind of disease, as he would not have unconsciously needed to create a somatic symptom and bring upon his castration.

McDougal begins her (2000) paper about her treatment of a cancer patient with a quote from The Dalai Lama, which says "the Tibetan medical system holds that the origins of illness are rooted in 'Ignorance, Desire or Hatred . . . provided these are kept in a state of equilibrium the body remains healthy.'"(p. 45) Although she states that it is obvious the psychoanalyst cannot cure cancer, her opening quote resonates in the reader's mind throughout the reading of the paper, as it sets the stage for causally linking psychic material with physical disease. She later states: ". . . I have learned from working with several breast cancer patients that the nature of their tie to their own mothers frequently reveals a highly disturbed relationship" (p. 47). Again, this statement implies etiology, a linking of psychic content with symbolically related disease—of the breast, an organ of maternal identification—and I think this implication remains despite McDougal's following remark that ostensibly addresses only the patient's fantasy about the cancer once it is already found. She writes: "[s]ince cancer is envisioned as a deathlike enemy in the interior of one's body, it is readily equated with a fantasized 'internal mother' who is attacking her daughter from within" (p. 47). To my reading, there is an uneasy cohabitation in McDougal's writing about this patient, of humility about the psychoanalyst's curative powers and about the notion that etiology is traceable to psychic content, together with just such an implication—that symbolic structures not only follow or coexist with the discovery of disease, but also cause its development.

McDougal's patient presents vivid fantasies of her cancer's origins and its link to her mother. The patient wrote what McDougal characterizes as a reconstruction of her infancy, in which she said:

> [A]nd so the fear became a black mass, invading every pore of the little baby . . . the black mass that is invading every centimeter of the baby's body—and slowly it becomes a crab—a cancer—except that the baby has no name for it. (p. 55)

This powerful image, and others like it, clearly indicate the patient's fantasies about the origin of her cancer, and reveal the kind of idiosyncratic meaning saturated with fantasy, which patients attribute to their disease. They raise the vexing clinical question about the meaning of the analyst's acceptance of such fantasies as reconstructions or discoveries of a truth, as opposed to her exploration or analysis of the function of such multilayered fantasies for the patient.

McDougal's patient used to pummel her breasts in her checks for breast cancer, and following her insight that she had been intending to mutilate her breasts as part of her frightened reaction to her femininity, she asked: "What does this have to do with my cancer?" And McDougal replied: "Is cancer another way of attacking your womanhood?" (p. 58). This exchange, again, reveals the slippery dance around the notion that symbolic structures caused the patient's cancer, or led her to will it and collude with its creation, that cancer is a motivated compromise formation. The patient makes the startling remark that her disease is psychic reality transformed into real reality and that the two must be separated (p. 60), but the psychoanalytic framework that provides a backdrop for her treatment actually encourages a particular kind of—symbolic, linear, and unidirectional—linking of psychic and physical reality.

Love and Food: Vicissitudes in a Patient's Beliefs About the Roots of his Cancer and in the Related Countertransference

I will now describe two phases in the treatment of my patient Mr. Y, which capture a shift in his fantasies and beliefs regarding the etiology of his disease, and related shifts in his experience of himself in relation to others in his internal world. Like with Mr. X, as this patient held onto his fantasies tightly—since they served an important function—I grappled constantly with the question of what my own stance toward them ought to be. Neutrality with respect to the dynamics embedded in these fantasies proved to be especially challenging to maintain, or to achieve, because the fantasies influenced the patient's decisions about his medical treatments. Thus, this case is being brought in order to trace the process of engaging with theories of etiology and uncertainty in the course of a treatment, rather than in order to claim some kind of resolution or cure which were not, as will soon become clear, achieved.

Mr. Y, a 26-year-old sculptor with Hodgkin's disease, was referred for psychotherapy by his oncologist, who described the patient as "angry and having a hard time coping with his incurable disease." This initial referring remark continued to resonate in my mind despite some hopeful vicissitudes in the patient's medical situation and health. From the start, I wondered if I had been made privy to something important about the patient, which he himself may or may not have been told, or have believed, whatever its ultimate truthfulness might be. This is not an uncommon situation when treating patients referred by physicians, but in this instance, given the severity and certitude of the oncologist's remark, and the patient's evolving conflicted relationship with the field of medicine and his physicians, the presence of the word incurable in my mind gave rise to particularly complex countertransferential challenges.

Diagnosed in his early 20s, Mr. Y went through exhaustive, grueling treatments of many kinds, including a double stem cell transplant, several surgeries, and multiple rounds

of experimental chemotherapy and radiation. To his shock, and possibly that of his physicians, he did not go into remission. Instead, his disease stalled; it occasionally progressed, but rounds of further treatment stalled it again, leading his oncologists to describe it as "stable." This state of affairs was maddeningly frustrating and painful for Mr. Y and his family, especially considering that Hodgkin's disease is generally considered to be highly treatable. Mr. Y, like other Hodgkin's disease patients I have treated, often remarked with bitter sarcasm that his is supposed to be the good kind of lymphoma to have.

Hodgkin's disease is a subtype of lymphoma. Hodgkin's lymphoma has a bimodal age incidence, with peaks between the ages of 15 and 34, and after age 50. Survival in the younger group is usually better, with 80% of patients under 35 with this disease living five years or more after treatment. The causes of lymph node tumors are unknown, though recent evidence suggests a viral or infectious origin. The effects of chemotherapeutic agents and radiation are many. Of particular relevance for Mr. Y, young men who undergo chemotherapy and pelvic irradiation for Hodgkin's disease frequently become aspermic and sterile (Lesko, 1998).

Mr. Y is the younger of two siblings. His brother is three years older and a highly acclaimed promising painter who studied at premier institutions and was, from early childhood, celebrated for his talent. Mr. Y, on the other hand, was viewed as somewhat of a problem child. There were minor birth complications, leading to an overnight stay in the neonatal intensive care unit. His mother told him that this made her bonding with him slower than her bonding with his older brother. He was somewhat hyperactive and inattentive in early elementary school, and an evaluation is reported to have yielded a diagnosis of mild attention-deficit hyperactivity disorder. He was also an unhappy young boy who told his mother at the age of 4 that he wanted to die. It is impossible to assess, in hindsight, whether depressive feelings may have manifested as or exacerbated inattentiveness or hyperactivity.

Mr. Y attributes his unhappiness in childhood to feeling sure and clear that his parents, especially his mother, preferred his older brother because she found him easier to love and be proud of. Mr. Y's parents were highly invested in the older brother's talent, and he was given special art training from early on, whereas Mr. Y's artistic aspirations and talent only emerged in early adolescence. Mr. Y describes his mother as judgmental, not accepting of him, and highly intrusive and inappropriate in that she revealed too much of her own emotional troubles to him. Mr. Y's father often traveled for very extensive periods, and it was this that led mother to use her younger son for solace; she often revealed the extent of her loneliness and insecurities to her son, including her doubts and fears about father's possible infidelities. When father was present, he often teased and humiliated Mr. Y, seemingly playfully at times, but at other times the sadistic flavor of his attacks was clear. Growing up, Mr. Y was often angry with both parents for the many ways in which he felt they failed him. In his more forgiving moods, he saw them as driven by anxiety, and as overly conformist because of their fear of thinking for themselves.

During his first few sessions with me, Mr. Y described his medical treatment in detail. He had been diagnosed after he discovered a lump. He knew right away that something was very wrong because he had been feeling extremely unwell. After listing all of the procedures and interventions he had had to endure, he said that he had just concluded a year long round of chemotherapy, only to be told that his disease is "stable! Not in remission, not gone, just stable! What kind of word is that?" He became angry, and when I spoke about his anger—his feeling of having been failed by the doctors, and his anger at them, he began to pound the wall with his fist, yelling "you better believe I'm angry!

I'm beyond angry! At the doctors? Yes, at God, whatever that means, at the universe! I am so beyond angry." Soon after this session, he began describing his early life. He said: "I always felt I was not meant to be, so in a way I've struggled for survival my whole life, against this sense, ever since whatever happened at birth, when my mother couldn't just love me for who I was." It wasn't long before his anger at the oncologists and the universe linked up with his sense of his early life as filled with stress and sadness from being unloved, or only loved conditionally. He began to speak about his mother's way of loving him as toxic, his father's absence as not buffering mother's suffocating nature, and his father's presence as further fuel for the toxic fire. He believed his cancer was a result of his emotional experiences with his parents. "All that toxic stuff, after a while, that poison really seeps into you and it does things," he said.

For several months, Mr. Y grappled with searing anger at his parents and his conviction that their way of loving him caused his disease. He was able to see his rage at the doctors for not saving him as linked to and reflective of his rage at his parents for not having rescued him from the pain and struggles of his childhood. In fact, he found it liberating to discover that his anger at the doctors for "pumping [him] full of this poison" [chemotherapy] and for what? For their own reasons, because of their own needs," [to further a research agenda and financial profit] was reflective of feelings about his parents. (He had referred to what his parents had given him as toxic poison, and he was initially surprised and then interested by the reverberation of words in both contexts.) There was something liberating about this, because it freed him from some of the paranoid, persecutory feelings he had toward an oncologist he had initially, and for a while, genuinely liked, and whom he came to describe as "a really good guy, I know he is doing the best for me that he can, but he, like all the rest of them, just doesn't know much." This realization was immensely complex to embrace. Confrontation with his parents' shortcomings and insecurities, which underlay their failings, was intertwined with confrontation with the oncologists' ineffectualness and the lacks of power and knowledge that underlay their failings. So, there was sadness to contend with now, but less of a sense of persecution, a prospect of loss less suffused with violence.

Throughout this period, I was often explicitly called upon to affirm Mr. Y's theory about the origin of his disease. At times he'd challenge: "you don't believe me, do you?" This was, of course, a loaded question, because beyond its content, the very taunt or challenge of it paralleled his aggressive opposition to his mother, which was designed to mask and ward off threatening neediness, vulnerability, and wishes for a rescuing union. I interpreted this questioning as Mr. Y's own projected doubt and lurking feeling of not knowing what to believe. And I spoke to him about his need to feel that he knows for sure, as that mitigates the feeling of being hit by lightning. He was terrified at the feeling of not being in control; knowing, even if what he believed he knew caused him pain, felt less frightening than not knowing. Not knowing was linked to the terror of what lay ahead, which was, Mr. Y sensed, truly unknown at this time. We were also able to link the state of not knowing to a painful sense of being out of sync as a child, not knowing in which way he needed to be different, but sensing that to receive the kind of love and acceptance he craved, he needed to be a way that he didn't know how to be.

At times I focused on the dilemma of whether to know something that is so painful to contend with exacts a more or less bearable price than to consider truly not knowing. The cost of believing there was a known psychological cause included guilt and self-recrimination about not undoing or combating it. I said: "and what if there is no way of knowing ultimately. How to live with that?" This work, which we cycled back into and through time and again, re-established the collaborative quality of sessions, and led to a

softening of Mr. Y's anger. It placed us, together, in the position of being on the brink of not knowing. This differed from what he had expected and worked to defend against: the feeling of being alone with a sense of confusion, and shunned or not accepted in his out of sync experience, or, on the other hand, the feeling of being relied upon to know and understand prematurely.

While Mr. Y's belief of this time—that his early parenting experiences caused his cancer—was conscious, he was not yet consciously aware of the revenge component of his fantasy about this chain of causality. That is, at the height of his anger, Mr. Y was powered by the fantasy that his cancer was the ultimate revenge. Here he was, getting back at his parents for what they had done to him; he could see how pained they were by his illness, and felt little patience for his mother's worry and expression of concern. There was an omnipotent fantasy embedded here—the other side of which was the excruciating pain of impotence in the face of the disease—that the cancer is, in a sense, under his control, as it is the tool with which he triumphed over his parents by causing their suffering. This triumph was, of course, the other side of feeling defeated and guilty. "This is finally showing them what pain is," he said, loudly and in an accusatory tone, at the height of this period.

Exploration of this revenge fantasy led us to the understanding that Mr. Y's sense of being stalled in his life, his lack of motivation for pursuing his sculpting, was multidetermined. We had previously discussed it in relation to fear of investing in an unknown future, and a self-protective retreat from trying to "have a life" in the face of so much uncertainty, and this line of thinking remained central. Now, however, Mr. Y came to understand his stalled stance as, also motivated by the wish to compound his parents' pain by making them see his life as "ruined." Later still, oedipal dynamics that underlay his inhibited competitiveness and self-assertion related to the motivation to stall his development also came to the fore. This perspective—seeing his stalled life as partially motivated—freed Mr. Y to consider parts of his life as involving choice, and not only destiny. He began to see himself as more separate from, and less desperate to revive, a fantasy of omnipotent others who will shape him. For the first time since the conclusion of his latest chemotherapy, which brought loss of accuracy of sensation in his hands, he began to sculpt again. He also began to date, and to explore sex, which brought up longstanding difficulties with integrating affection and sexuality, in the context of a new reality of being aspermic and feeling his orgasms changed. Because both sculpting and sex physically bore the mark of his treatments, he was forced to work to integrate some version of his changed body into his sense of self.

I felt very hopeful for my patient. I was hopeful about the prospect of his resumed development, his reactivation of living life despite the disease. Yet I also feared a worsening or a more active return of his disease. In a maternal countertransferential position, I found myself acutely attentive to his physical presence and to his reports about minute physical shifts. For example, when he complained of feeling tired one day, I silently noted to myself that he was scratching the skin of his arms and shins a lot, and aware that itchy skin of a kind is a symptom of Hodgkin's disease. I found it difficult to remain openly engaged with his expressed optimism. And then one day, Mr. Y. experienced sharp, unbearable pain in his back. A visit to the emergency room led to radiation treatments, which targeted lymph nodes that had grown and were exerting pressure. His disease was no longer definitively stable. Further testing led his oncologists to recommend a particularly risky and grueling form of transplant from an unrelated donor. He was told that, while there are some more chemotherapeutic options for him, these are very toxic, considered to be of last resort, and are not expected to yield full remission. The transplant,

one physician reportedly told him, is his only real hope. At the same time, he said he was told that the transplant had an 80% likelihood of failing for various reasons, and that catastrophic complications, and death, were distinctly possible in the course or as an immediate consequence of the transplant. Also, the transplant would need to be done at a particular location, in a hospital in a faraway state, and, in the best of circumstances, would involve a hospital stay of well over a month.

This news was devastating, and the effect on Mr. Y was profound. He became enraged, and was initially focused upon what he called "the absurdity of what they are offering me." He said he had lost all faith in doctors and in allopathic medicine, and considered them "bankrupt, corrupt and peddling in poison even though they don't have any idea what they're doing." As his rage grew, he began to discuss elaborate theories linking the drug companies and the oncologists in a web of financial profit-driven manipulation and deceit. Some of his theories were by no means original, and, to some degree, reflected a common critique of the corrupting influence of the marriage of medicine and money. But there was still an unmistakable paranoid, persecuted quality to his thinking, which was reminiscent of, but more fragmented than, the initial stance in which he had blamed his parents.

At this time, my efforts to interpret Mr. Y's disappointment and anxiety, his sadness and fear, fell on deaf ears. He angrily challenged me to "prove" which side I was on. Was I, too, corrupt or brainwashed like his oncologists and his parents, who only knew allopathic medicine and failed to see it for the sham that it was, or was I with him, daring to cross over to a more liberated, alternative place and perspective? Greatly intensifying his thus far only passing, occasional involvement with an alternative healer, he drastically altered his eating habits, and adopted a number of practices, including some involving the injection of substances into his body. He followed the advice of this guru very closely, and soon came to develop a close relationship with him, in which Mr. Y functioned like a devout disciple. Our sessions were filled with descriptions of his changed approach to eating and cleansing of his body. At times he'd initially withhold some details, until it would emerge that he didn't know if he could trust me to "listen to me with an open, respectful mind, instead of taking the safe but bankrupt approach of siding with the doctors and their empty threats."

I inquired in detail about his experience, the taste of his food, what pleasure he may have derived from eating, and the pressure and yet empowerment he now felt. Eventually, I interpreted his questioning of me—whether I was on the side of his oncologists or his healer—as a projection of his own conflict, the part of him that was reluctant to give up all allegiance to allopathic medicine being relegated to me. Our understanding of this dynamic crystallized when a pattern emerged in which, in the weeks preceding medical diagnostic tests, he'd talk about wishing to leave therapy, or at least to take a break. When it became clear that he tried to avoid sessions preceding medical appointments he claimed he had no interest in keeping, I suggested to Mr. Y that he was trying to evade his own conflict, the part of him that did wish to keep his appointments, if not out of fear solely, then at least partly out of hope that he'd find his disease had again stalled. Following this work, Mr. Y returned to keeping his diagnostic medical appointments. He prepared for them by adhering very strictly to the alternative regimen he was following in the weeks preceding them. The diagnostic procedures then came to feel like tests of his endurance and his power to save himself, and he felt driven to "show them," (the oncologists), that he was "taking care of myself in a way they know nothing about, a way they are completely ignorant of." He was filled with fantasies of an auto-rebirth of sorts, a new beginning not derived from his parents. With the guidance of his healer, he developed

an explanatory scheme that linked his disease to food. Cancer was caused, in this view, by too much of certain ways of eating, which he associated with the general mainstream public's ignorance, and with his parents' conformism, and which involved being cut off from one's body and "abusing it instead of having self-worth and respect for one's body."

Mr. Y's physical experience improved greatly. He stopped using the pain medication he had relied upon in the weeks following his emergency radiation treatments. He began to exercise, and reported feeling stronger, less fatigued, and more alive. He felt certain that he had found an approach that would help him fight his disease while living his life, and proudly triumphant when his diagnostic medical tests showed no further progression in his disease, despite the earlier predictions that without further treatment he'd be in imminent danger. What did I think? Were these improvements produced by the alternative regimen he had adopted? Were some of them—the pain relief, perhaps—caused or aided by his belief that he was finally being healed, which led to a changed interpretation of pain, or to relaxation of muscular tension that had previously compounded his pain? Would the stalling of his disease have happened anyway as a result of a delayed effect of the medical treatment he had already received, as it had before, without any alternative intervention? There was no way to know.

Mr. Y's optimism was infused with a sense of triumph, which was at moments infectious, but also bore the clear mark of a manic defense that was, inherently, worryingly fragile. In response to a comment of mine about his cancer during one session from this phase, Mr. Y yelled: "Oh, I don't have cancer! I don't." "What do you mean?" I asked. "I don't have this disease," he said. "I'm cured of this whole paradigm." He went on to elaborate his belief that he was making radical systemic changes in his body, which were antithetical to the kind of imbalance represented by a disease such as cancer.

My internal response at this time was conflicted and uneasy. I felt dared and challenged to wonder if perhaps Mr. Y was now on the verge of curing himself via the alternative route he had found. Yet I feared his threatened complete retreat from engagement with allopathic medicine. I did not know, and asked myself whether it was my task to know, whether it was possible for me to know, or whether the position I was being placed in was the very one from which my patient was fleeing—that of acknowledging the possibilities and the unknowns together, without arriving at a meaningfully coherent resolution of the question. I began to interpret Mr. Y's transferential relationship to his alternative healer as idealizing, and involving a longed for merger and loss of self, in flight from the feared, persecutory relationship with the oncologists. Thus, we began to focus on the nature of Mr. Y's relationship to his guru, rather than on the system of thought he represented, and to link it to longed for states of early life. I also linked his fantasized inhabiting of a cleansed, reborn body with flight from the internally persecuting body he associated with his disease. This captured a profound fantasy of replacing the toxic introjects of childhood with new nourishing ones. Mr. Y's manic, yelling demeanor—which had often included statements about leaving therapy—calmed considerably. He began acknowledging the cost inherent in his health regimen—the loss of pleasure, and thus to consider his choices as complex, involving gains and losses. He wondered about the other parts of life he had again shoved aside. We stopped therapy when he was able to obtain a promising apprenticeship with a sculptor in another country. This represented a resumption of his noncancer life, and was therefore very positive, even as it clearly also indicated a need to close the door, for the time being at least—without clarity about causality on either of our parts—on the challenges raised by the therapy.

Psychoanalytic Psychosomatics in the Context of Oncology—Closing Thoughts

Although cancer has not been addressed as one of the paradigmatic psychosomatic diseases in mainstream psychoanalytic writings, the overall context of psychoanalytic psychosomatic theorizing could affect clinical thinking about cancer, via the clinician's theories—public and private, unconscious, preconscious, and consciously articulated—about the psychogenesis of disease. Traditional psychoanalytic theories about the psyche-soma offered psychoanalytic thinking both as a tool for hypothesizing about the origin of some physical disease and dysfunction, as well as, at times, as a contributor, via a psychoanalytic psychotherapeutic process, to the cure of such physical problems. A contemporary version of such ideas may be most clearly evident in McDougal's (1989) influential writings about psychosomatosis—the expression via psychosomatic processes of material unable to be expressed via neurotic, verbally available channels. Variants of propositions such as McDougal's are common in contemporary writings about a variety of somatic experiences and presentations. These propositions are consonant with the broad context of the psychoanalytic mindset, which emphasizes effecting change via reconstruction of the past and of psychic reality through examination of its embeddedness in present reality via symptoms. In portions of our core psychoanalytic psychosomatic theory, some physical disease or dysfunction (sometimes rather inclusively) has been and still is considered a symptom generated by the psyche and functioning like other symptoms—as a symbolic structure produced because of conflict or deficit in order to be a carrier of meaning.

As psychotherapists working with cancer patients who are overwhelmed by the anxiety of uncertainty, we often feel our own anxiety, as well as acute impotence, which in the context of our relationship with our patient and all of its transferential and countertransferential dynamics, has the potential to activate conflict involving omnipotence, and an omnipotence defense. Such a threatening, anxiety-generating conflictual psychic position has the potential to lead us to turn to and utilize, in a more or less articulated manner, the kind of psychoanalytic psychosomatic theory that serves a holding function, that is comforting, that restores our sense of potency, that dovetails with our need to identify with psyche—versus soma—and to feel that the former can have power over the latter. Some of our theories posit symbolism-based linear psychogenesis and the potential correction of soma via psyche, and these theories may exert a seductive pull because of the role that such theories unconsciously play in our minds, in a manner akin to the one articulated by Grossman (1995) in his writings about the psychological vicissitudes of theory in clinical work, specifically the transformation of theoretical ideas as these come to represent unconscious fantasies. Such a pull is most likely to be operating when the disease or dysfunction we are seeking to understand is complex and poorly understood—as is the case in cancer, some infertility, and other syndromes and conditions that remain thus far poorly understood by medicine.

I hope to have made it clear that I am not suggesting that all or most clinicians endorse and explicitly utilize the theory I have been discussing in the manner described here. As Wilson (2004) emphasizes, clinicians operate with idiosyncratic versions of psychoanalytic theories, which reflect individual variants of the theories that are infused with unconscious fantasy. Additionally, as Grossman (1995) explains, theories that are consciously applied present a somewhat different issue than ones appealed to preconsciously or unconsciously.

Clinicians possess their own not necessarily articulated or examined, multiply determined theories about the link between psyche and soma and about psychotherapy's

potential to affect it, reflecting a blend of each clinician's own dynamics and his or her particular variant of relating to the professional context of psychoanalytic theory, and to the broader cultural context with which this professional one interacts.

Psychoanalytic theorizing about the psyche-soma matrix is in need of update. There have been new inroads in psychoneuroimmunology and other psychobiological research that attempt to examine the basic axioms of our culture's evolving take on the psyche-soma relationship (See Sapolsky, 2004, for a friendly guide through some of these endeavors.) I have been discussing the need to examine the ways in which core sections of our theory that continue to be embedded in models of symbolism-based linear psychogenesis might influence our practice. In addition, it is worth considering to what degree or in which way such models might affect our profession's relation to the broader academic and cultural context. It is worth considering, for example, whether to the extent that we remain attached to the kind of psychogenic theorizing characterized here, rather than participating in the discourse of nonlinear complexity that posits a different kind of mixing of psychic and somatic factors in accounting for physical outcomes (Bergner, 2009), we risk isolation from our intellectual and cultural environment at cost to the ongoing development of our field.

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