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SOME IMPLICATIONS OF SELECTED STUDIES OF PSYCHOSOMATIC MEDICINE
FOR THE PASTORAL MINISTRY

A Thesis Presented to the Faculty
of Concordia Seminary, St. Louis,
Department of Practical Theology
in partial fulfillment of the
requirements for the degree of
Master of Sacred Theology

by

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CHAPTER I

INTRODUCTION

During the 1965 convention of the Lutheran Church--Missouri Synod held in Detroit, Michigan, the Synod resolved:

Whereas the Scriptures teach us that God's love reaches out to the whole man, for God the Father lovingly creates and preserves man; the Son redeemed him in body, soul, and mind; the Holy Spirit brings him to faith and moves him to use body, soul, and mind in God's great mission; and

Our Lord became a man and ministered to the needs of the whole man, forgiving sins, healing the sick, feeding the hungry, and even providing wine for a marriage feast; and

Our Lord at His return will solemnly report whether or not we fed, clothed, and visited Him in the least of His hungry, naked, and forsaken brethren;

Therefore be it resolved that we affirm that the church is God's mission to the whole man. Wherever a Christian as God's witness encounters the man to whom God sends him, he meets someone whose body, soul, and mind are related in one totality. Therefore Christians, individually and corporately, prayerfully seek to serve the needs of the total man. Christians bring the Good News of the living Christ to dying men. They bring instruction in all useful knowledge. They help and befriend their neighbor on our small planet in every bodily need. They help their neighbor to improve and protect his property and business by bringing him economic help and enabling him to earn his daily bread in dignity and self-respect. Christians minister to the needs of the whole man not because they have forgotten the witness of the Gospel, but because they remember it. They know that the demonstration of their faith in Christ adds power to its proclamation.¹

If indeed the church is to minister to the needs of the whole man it must understand the "whole man." Understanding the "whole man"

¹The Lutheran Church--Missouri Synod, "Affirmations on God's Mission," adopted by the Synod in convention at Detroit, Michigan, June 16-25, 1965.

presupposes baptizing the research which is done about man in the secular fields for use by the church in its ministry. As the Chicago Area Study Group, held in anticipation of the consultation on Health and Salvation meeting during September of 1967 under the auspices of the World Council of Churches, said:

Not only in regard to faith healing, but on many other problems in the area of the relationship between religion and health there is need for much research and study. This research needs to have an empirical base and to be grounded in modern methods of analysis and interpretation. There are large areas in the relationship between religion, health, and illness, or between salvation and healing which need [to be] explored. Research is a method of the modern secular world which needs to be baptized in the service of the church.²

This thesis is an attempt to provide such a base, not with original research, but with an analysis of the research which has been done in a specific area.

The methodology which this thesis employs is fully as important as the actual specific results demonstrated in this thesis. This study is not confined to, nor is even its principle interest in, the biblical or theological understanding of man. This biblical understanding of man is the framework out of which a pastor operates. Some studies are available on this topic.³ But the Bible does not deal with psychosomatic

²Chicago Area Study Group, "Health and Salvation," prepared for the consultation on Health and Salvation of the World Council of Churches. Available from the Department of Ministry of the National Council of Churches, p. 26.

³Two books of this sort are, What Then Is Man? (St. Louis: Concordia Publishing House, 1958) and Herman Preus and Edmund Smits, Editors, The Doctrine of Man in Classical Lutheran Theology (Minneapolis: Augsburg Publishing House, 1962).

illness per se. Therefore, to minister to a patient whose illness has psychosomatic overtones requires more than a general theoretical understanding of the biblical understanding of man, illness, and health.

Ministry also involves more than a general theoretical understanding of psychological principles, or principles built up through common sense over years of ministry. Two additional items are required: (1) Hard-nosed facts established by theoretical frameworks and specific research, and (2) The ability to be open to the human personality and to be able to read the human document. The basic methodology of this paper is the following: Out of the basic biblical understanding of man flows a concern for the total man. This concern is put into practice in ministry. Ministry must, out of necessity, take into consideration what is discovered about the nature and characteristics of man through scientific research and secular theory.

This thesis will concentrate on selected aspects of the work of the field of psychosomatic medicine. Chapters II through IV will attempt to clarify the general and accepted usage of the term "psychosomatic" and some of the theoretical formulations of what "psychosomatic" really means. The fifth chapter will specialize in the area of research done on the psychosomatic aspects of cancer. Most of the research material is found in the journal Psychosomatic Medicine, although it is not confined to that journal exclusively. The sixth chapter will deal briefly with the nature of the healing ministry of Jesus and His concern for the whole man. This chapter will provide the biblical basis for a ministry of the church and its pastors which is helpful in affairs of this world. The seventh chapter will explore ways in which the pastor can utilize some of

the tentative conclusions reached by an examination of the research. Also included in this chapter is a discussion of the goals and philosophy of pastoral care itself. Basic to a concept of pastoral care is the research of Dr. Carroll A. Wise, a pioneer in the field of pastoral counseling in America. Doctor Wise has also read and made helpful suggestions for the first five chapters of this thesis.

A special thanks goes to the library staff at Saint Louis State Hospital, St. Louis, Missouri, for their patience and invaluable assistance in finding and utilizing the research done in this area.

CHAPTER II

TOWARD A DEFINITION OF "PSYCHOSOMATIC"

"Psychosomatic" is a term which may have a number of general meanings to different people. For the sake of consistency, the term will be defined. In this paper, the word "psychosomatic" will reflect an approach to the human organism which recognizes that the distinction between "functional" and "organic" diseases, that is, a clear distinction between a given number of illnesses caused by organic breakdown only and a given number of illnesses caused by a psychic breakdown only, is an arbitrary distinction which does not take into consideration the individual as a whole.

Franz Alexander notes that the principle accomplishment of the rise of the scientific era since the mid-seventeenth century was a "deanimation of nature"¹ which substituted physical causality for a psychic causality. The laws of physics replaced the concept of evil or benign spirits. Physical causality replaced the explanation of phenomena from a psychological perspective. Primitive man knew what prompted his own actions (in terms of his basic emotions) and attributed similar motivations to the forces of nature, according to Alexander's view. Scientific man learned the laws of physics; he no longer needed to project his own emotions onto the forces of nature. In the nineteenth century, the fields of biology and medicine also came under the influence of "deanimation."

¹Franz Alexander, "The Development of Psychosomatic Medicine," Psychosomatic Medicine, XXIV (January-February 1962), 14.

Scientists hoped that all the mysteries of life, just as those of the inanimate nature, could be solved by applying to them the laws of physics and chemistry. The modern physician more and more thought of himself as a mechanic, a glorified repairman of that complex physico-chemical apparatus--the human organism.²

According to this view, man has "deanimated" himself, so that all disease and illness must have its roots in a mechanical or physical phenomenon. Yet the physical cause of certain diseases, especially those that were generally called mental diseases, could not be discovered. A modern compartmentalization of man occurred which, according to Alexander, split the consideration of human illnesses into functional and organic illnesses.

As used in this paper, psychosomatic medicine is not a continued attempt to perpetuate the division of man's illnesses into two categories: Those which have an organic causality and those which have a psychogenic causality. In fact, this paper stands as a reaction against this mechanistic conception of man. Already in 1948, J. L. Halliday defined a psychosomatic affection as

A bodily disorder whose nature can be appreciated only when emotional disturbances, that is, psychological happenings, are investigated in addition to physical disturbances, that is, somatic happenings.³

Paul Tillich speaks of a developing multidimensional view of man which does not consist in layers that can be studied separately. Health, for Tillich, is a proper functioning of man in all areas of his

²Ibid.

³David Kissen, "A Scientific Approach to Clinical Research in Psychosomatic Medicine," Psychosomatic Medicine, XXII (March-April 1960), 121. The quotation is from J. L. Halliday, Psychosocial Medicine (New York: W. W. Norton and Company, Inc., 1948).

experience, in the physical, chemical, and biological dimensions, all of which relate man to himself and to his environment.⁴ Carroll Wise attempted to catch this emphasis.

The basic difference between the new and the old conception of illness lies in their view of the nature of man. The older point of view was materialistic in its approach and divided the body into many parts, attempting to understand each part as a separate unit without considering its relationships to other parts or to the whole. There was no consideration of man-as-a-whole. This is the essence of the new conception. Man, according to the new viewpoint, is to be thought of as an organism which functions as a whole and which possesses an organic unity which makes the whole more than the sum of its parts.⁵

Man stands as a whole organism who must also relate to his environment. Thus, another aspect to man is the environment in which the person has lived.⁶ Indeed, any problem with which a man is faced involves both the relation of the man to himself and his relationship to his environment. A person's environment, that is the human problems which surround him, are not apart from a person's illness, but can be an important component of it.⁷ It is the whole functioning of the individual, both in his relationship to himself and to his environment, which gains for that individual a state of health.⁸ Any approach to

⁴Aarne Siirala, The Voice of Illness (Philadelphia: Fortress Press, 1964), p. 145. The quotation is from Paul Tillich, "The Meaning of Health," an essay delivered before the New York Society for Clinical Psychiatry in January of 1960.

⁵Carroll A. Wise, Religion in Illness and Health (New York: Harper and Brothers, c.1942), p. 8.

⁶Ibid., p. 9.

⁷G. Canby Robinson, The Patient As A Person (New York: Commonwealth Fund, 1946), p. x.

⁸Wise, p. 79.

man's illness must acknowledge the total functioning of the individual, according to this point of view.

Emotions, such as fear, anger, or guilt, can have a definite physical effect. The best-known examples are weeping, laughing, blushing, and losing bowel or bladder control under the influence of fear. All these examples are, however, "transitory processes occurring in everyday life in all healthy persons."⁹ According to Alexander's view, what can be said about transitory processes can also be said about chronic disturbances of physiological functions. Emotional factors in all illness are one category of factors, therefore, which must be taken into consideration when treating a patient. "Emotional factors represent merely a category of factors which, only in combination with certain nonemotional factors, produce organic diseases."¹⁰

Even though there may be much difference of opinion about the relative worth of the contributions of Sigmund Freud in this area, it must be conceded that the psychoanalytic movement, originating with some romantic precursors of Freud like J. C. Heinroth¹¹ and K. G. Carus,¹²

⁹Franz Alexander, "Present Trends in Psychiatry and the Future Outlook," in Studies in Psychosomatic Medicine (New York: Ronald Press, 1946), p. 26.

¹⁰Franz Alexander, "Training Principles in Psychosomatic Medicine," in Studies in Psychosomatic Medicine (New York: Ronald Press, 1948), p. 35.

¹¹Franz Alexander isolates Heinroth's book, Lehrbuch der Stoerungen des Seelenlebens, first published in 1818, as the first instance of the use of the word "psychosomatic." See Alexander, "The Development of Psychosomatic Medicine," XXIV, 18.

¹²In Alexander's article referred to in the above footnote, he cites Carus' book Psyche as building a philosophy based on the concept of the unconscious.

made a major contribution to the study of man's illnesses, including his "organic" ones. Pedro Entralgo isolates five major contributions of psychoanalysis to medicine.

1. The discovery of the absolute necessity of dialogue with the patient, both for the diagnosis and for the treatment of the ailment. . . .
2. The diagnostic and therapeutic appreciation of instinct as a component of human life. . . .
3. The discovery of the existence and the significance of the different forms of psychological consciousness in the life of man.
4. Freud's decisive contribution to a full understanding of the influence that mental life exerts upon bodily movements and the latter upon the former.
5. The successful attempt to assign to its proper place, in the overall biography of the patient, the event of the illness.¹³

Louis Linn isolates (1) the concept of the unconscious mental processes, (2) the psychological relationship between the experimenter and the experimental subject, (3) the function of the ego in research, (4) techniques for exploring the unconscious, (5) psychosomatic studies of infants and children, and (6) the theoretical foundation of psychoanalysis as a frame of reference for research, as the major contributions of the psychoanalytically-oriented school to psychosomatic medicine.¹⁴ It is from a development which begins in modern times with the psychoanalytical movement that increased amount of emphasis on

¹³Pedro Lain Entralgo, Mind and Body, Psychosomatic Pathology (New York: P. J. Kenedy, 1956), pp. 128-31.

¹⁴Louis Linn, "Psychoanalytic Contributions to Psychosomatic Research," Psychosomatic Medicine, XX (March-April 1958), 88-95.

psychological factors in illness may be traced.¹⁵ This influence will be shown with increased clarity in the following chapters.

In its development, the psychosomatic movement within medicine has not attempted to become, generally, another field of specialization within the medical profession. Its attempt is to permeate all of medicine. It is a reaction against a mechanical or "de-animated" view of man. Psychosomatic medicine might just as well be called comprehensive or holistic medicine. It represents a point of view, studying and treating the individual as such instead of localizing pathology within, for instance, one affected organ. Psychosomatic medicine, according to Carl Binger, "is a point of view toward the study of illness and disease and an approach toward research. It includes the individual's reactions to his illness and its implications for his personal and social life as well as the effects of these upon the functioning of his body."¹⁶ If this definition of psychosomatic medicine is valid, Binger continues, then "all disease can be looked at from this point of view."¹⁷ The proper future of psychosomatic medicine is to work itself out of a job, in that all medicine should take a holistic approach to the human being. Therefore, the term "psychosomatic" does not in this paper have the connotation of a speciality field within medicine which postulates a psychogenic aetiology for all

¹⁵ Entralgo, pp. 140-42.

¹⁶ Carl Binger, "Editorial Notes," Psychosomatic Medicine, XXII (July-August 1960), 249.

¹⁷ Ibid.

or certain illnesses. Psychosomatic, even as its derivation from the Greek words would indicate, refers to a complex process of interaction of "emotional" and "physical" factors within one given individual. As Millet observes:

The significance of the illness to the patient, the pressures under which he has lived, the attitudes of those nearest him, his economic and social situation, and the outstanding traits in his personality--all these, and perhaps other special factors, must be evaluated, and their contribution to the total picture of disability must be correctly estimated. If this is not done the adrenalin may check the asthma, the ointment relieve the eczema, and the diet heal the ulcer, but the whole patient is little altered and the same break in his adaptive efficiency may well occur again.¹⁸

This particular view of the nature of psychosomatic medicine and research is the general view espoused by those medical men who form the American Psychosomatic Society. There is also an apparent trend, however, toward making psychosomatic medicine into a scientific discipline, complete with specialization.¹⁹ Those who favor this trend have organized into the Academy of Psychosomatic Medicine. This movement, from the point of view established in this chapter, can be seen as a further compartmentalization of the study of man and his illnesses, rather than a movement toward a greater view of man as a whole, functioning unit.

A working definition of psychosomatic medicine and research has been developed, evolving as it did out of a historical context. It is

¹⁸John A. P. Millet, "Body, Mind, and Spirit," in Religion and Health (New York: Association Press, 1958), p. 35.

¹⁹F. D. Wittkower and Z. J. Lipowski, "Recent Developments in Psychosomatic Medicine," Psychosomatic Medicine, XXVIII (September-October 1966), 724.

the attempt to view all disease as a result of a complex set of factors which include the individual's relationship to himself (both bodily functions and attitudes toward "self"), his relationship to his environment (including bodily reactions both of a "physical" and "emotional" nature), and his relationships to other people, which is in fact, only a special category of a person's relationship to his environment. If this concept of medicine takes into consideration the interdependence of body, mind, and spirit, that is, relates to the whole man at all levels of his total functioning, then there should be certain skills which the clergyman may bring to bear in the eventual treatment of a patient.²⁰ The contributions of a clergyman in this total process will be developed in a later chapter.

²⁰Clergy-Doctor Cooperation (London: Church Information Office, 1963), p. 9.

CHAPTER III

"SPECIFICITY THEORY" APPROACHES TO PSYCHOSOMATIC ILLNESS

Introduction

There would seem to be general agreement that all illnesses have some kind of psychosomatic aspect, that is, that any illness has psychological manifestations either in a causal or resultant relationship. This general agreement does not mean, however, that there is agreement on the nature or the extent of the causal psychic factors in an illness. The importance of psychological factors in physiological functioning is beyond question.¹ The problem in agreement arises when the question of the specific interrelations of physiological and psychological function is raised. Precisely how are the emotional and bodily functions related? The purpose of this chapter is to review one of the major categories of theories of the interrelation of the psychological and physiological functions. This set of theories is called "specificity theory." This school of thought has been most influenced by the work of Sigmund Freud and his followers in the psychoanalytical tradition.

Flandars Dunbar

A specificity theory of psychosomatic illness attempts to show that there are specific psychological events which cause a specific illness.

¹Russell E. Mason, Internal Perception and Bodily Functioning (New York: International Universities Press, 1961), p. 113.

One of the more well-known of the specificity theories is that of Flandars Dunbar, who suggested that "various personality constellations are etiologically associated with specific diseases."² About people who suffer from a psychogenic illness, Dunbar writes

They select symptoms in much the same way that healthy people select clothes, choosing carefully for style, fit and the effect upon others. Yet many do not know they have done it. The selection is done quite independently of the individual's will. It is the work of emotional conflicts which have continued long enough and sharply enough to have a physical effect. The exact form of the bodily ailment is chosen by an emotional system which is groping for some benefit. It is seeking to save something from its own wreckage.³

The particular symptom is, for Dunbar, a product of the intrapsychic workings of the self, attempting to do the best possible job of adjustment under the circumstances. For instance, Dunbar studied for five years the emotional factors of cardio-vascular disease. She concluded: "It is the characteristic of people who suffer from heart disease that they are hard workers, driving themselves without mercy and apparently enjoying it. It is typical of them to say: 'I have to keep doing something useful.'"⁴

While searching for a control group, necessary for statistical analysis of her study, Dunbar chose fracture patients in a general hospital as her control, "acting on the supposition that accidents are

²Harold I. Kaplan and Helen S. Kaplan, "Current Theoretical Concepts in Psychosomatic Medicine," The American Journal of Psychiatry, CXV (June 1959), 1092.

³Helen Flandars Dunbar, Mind and Body (New enlarged edition; New York: Random House, 1955), p. 34.

⁴Ibid., p. 126.

accidents and can and do happen to anybody."⁵ She found, however, that there were certain psychological characteristics common to the whole group which were afflicted with what she called "accidentitis." She found that they were decisive to the point of impulsiveness, that they concentrated upon immediate need-fulfillment rather than long-term goals, and that they took good care of their health.⁶ In addition, "the frequency with which the patient described his upbringing as strict was surprising."⁷ Later Dunbar found this to be a general resentment of any authority.

Dunbar finds the ulcer patient to be one torn between dependence and the desire for independence, arising from the tension implicit in the basic mother-child relationship.⁸ The asthma and hay fever patient is involved in a conflict "about longing for mother-care and mother-love."⁹ "There may be a feeling of frustration as a result of too little love or a fear of being smothered by too much."¹⁰ Dunbar has, thereby, developed what she calls "personality profiles," isolating personality characteristics of those suffering from specific illnesses. According to Kaplan and Kaplan, Dunbar's theories are "historically

⁵Ibid., p. 106.

⁶Ibid., p. 109.

⁷Ibid.

⁸Ibid., p. 169.

⁹Ibid., p. 185.

¹⁰Ibid.

important but no longer accepted."¹¹ While Dunbar's theories may be criticised as being oversimplifications, it is important to remember that Dunbar's theories developed directly from her clinical observations and research on the wards of a general hospital. Inasmuch as they were accurate clinical observations in her day, their value is more than a mere historical one. Her theories can be tested in clinical experimentation today.

Sigmund Freud and Classical Psychoanalysis

Another whole series of specificity theories derive from the work of Sigmund Freud. Freud held that certain hysterical somatic functions could be caused by inner psychological conflicts that were transformed into a symbolically significant functional symptom. For instance (acknowledging the didactic value of Freud's work with Anna O., but preferring a more modern example), Berblinger cites the case of a thirty-five year old male physician who learned that his fifty-eight year old mother in Europe had undergone a left mastectomy for cancer. He could not return to Europe to see her, since this was during World War Two. This doctor, several weeks after hearing of his mother's operation, developed a burning sensation and soreness of his left nipple. Berblinger reports that his symptoms disappeared when another physician gave him an opportunity to talk about his sick mother.¹² Here is an

¹¹Kaplan and Kaplan, CXV, 1092.

¹²Klaus W. Berblinger, "The Functional Symptom in Psychiatric Perspective," Psychosomatics, VII (July-August 1966), 207.

example, according to Berblinger, of an internal emotional conflict finding direct, symbolic representation through somatic symptoms.

In classical Freudian terminology, conversion "signifies the symbolic expression by means of physical manifestations (motor and sensory) of both repressed instinctual wishes and the defense set up against them."¹³ Conversion is typical in hysteria since "hysterical symptoms mean that repression has been unsuccessful."¹⁴ The means by which the inner tension moves to physiological manifestations is somatic compliance, that is, "the symptom becomes located in some particular organ because of what Ferenczi calls 'A special suitability or tendency of the organ concerned to combine with the excitation masses liberated from the repressed material.'"¹⁵ An example of the somatic compliance of an organ would be the paralysis of an arm, if the arm signified for the person intended aggression against which other mechanisms in the personality were struggling.¹⁶ The energy for the impulsive expression of the hostility by aggression was blocked from direct gratification. This blocking included, in this theoretical example, the paralysis of the arm. A paralyzed arm cannot strike out in anger.

¹³William Healy, Augusta Bronner, and Anna Bowers, The Structure and Meaning of Psychoanalysis (New York: Alfred Knopf, 1930), p. 236.

¹⁴Ibid.

¹⁵Ibid., p. 238.

¹⁶Ibid.

Freudian-influenced Religious Thinkers

Showing this Freudian influence, men who move in theological as well as psychological circles have attempted to construct a theory of the psychosomatic nature of illness. Carroll Wise, for instance, believes that there is one basic psychological fact behind many physical symptoms: "The person has attempted to deal with his conflict by the process of repression."¹⁷ The aim of an illness is to maintain psychological equilibrium so that conscious anxiety is not felt. Therefore, Wise agrees with the classical Freudian idea that symptoms which are symbolically significant, that is, those that are maintained by the process of conversion, are a result of repressed material which is too powerful for the normal ego defenses. Therefore the ego must go to another line of defense: physical symptoms.

Gotthard Booth believes, like Wise, that illness serves as the expression of the personality of the person. "The symptoms of illness serve only as self-expression."¹⁸ In some form or another the particular illness takes the form of alienation from a particular bodily function.¹⁹ For instance, the epileptic would be a person with a strong tendency toward aggression, but who ordinarily has the power to control this aggression. (Aggression is a product of alienation from the object

¹⁷Carroll A. Wise, Religion in Illness and Health (3rd Edition; New York: Harper and Brothers, c.1942), p. 25.

¹⁸Gotthard Booth, "The Voice of the Body," in The Voice of Illness (Philadelphia: Fortress Press, 1964), p. 7.

¹⁹Ibid., p. 3.

toward which the aggression is directed.) Only an overwhelming amount of aggressive tension can bring about the necessity of release by a functional symptom. When this aggressive tension becomes too great, a "seizure" occurs. By and large, however, the actual aggression is still controlled because the aggression is released in the form of "socially harmless fits."²⁰

In another series of articles, Booth attempts to apply Freud's original approach to all organs of the body. "The mouth expresses psychological receptiveness; the anus, possessiveness; the sex organs, desire for union with another individual. It seems logical that other organs also express specific needs and are subject to specific injuries."²¹ Booth argues that both the physical form of the organism and the environment express the unique way of life of the individual.

The macroscopic and the microscopic forms of the organism express the psychological situation of the given subject. . . . Within certain limits, individual will and the influence of the environment can steer the way in which the "organism pursues its individual path toward death," but it is evident that the influence can be effective only when it concentrates on strengthening or weakening certain patterns inherent in the genetic equipment.²²

Organic diseases are symbolic expressions of personality tendencies, within the limitation of what the organism "has" on the basis of its heredity, according to the Booth position.

²⁰Ibid., p. 4.

²¹Gotthard Booth, "The Role of Physical Form in Psychodynamics," Psychoanalysis and the Psychoanalytic Review, XLVII (Spring 1960), 52.

²²Ibid., XLVII, 59.

Booth has done a great deal of work with Parkinson's disease. According to Booth, the Parkinsonian is a person who must act to be successful. Stemming from a constitutional predisposition toward action and domination plus later emotional features of a moralizing parent and his own weak position among his brothers and sisters, the Parkinsonian's major concern is to succeed "because he is anxious to improve his performance and his position."²³ The point at which the disease process begins is the critical point where success meets defeat. The essence of the disease process is that "the personality regresses from realistic satisfactions to a level of merely symbolic satisfactions."²⁴ Free action gives place to a biological necessity to act. "The kind of activity into which he is forced must be considered a caricature of his original personality; his muscles are in a constant state of tension, and hands and legs are shaking."²⁵ The disease process retains the muscles in a constant state of action and maintains them in the center of the personality orientation. "The function finds satisfaction symbolically, although its satisfaction means practical defeat."²⁶

²³Gotthard Booth, "Basic Concepts of Psychosomatic Medicine," in Healing: Human and Divine (New York: Association Press, 1957), p. 45.

²⁴Ibid., p. 46.

²⁵Ibid.

²⁶Ibid., p. 51.

Substitution of Symbolically Equivalent Symptoms by Hypnosis

The majority of the theoretical presentations on the symbolic nature of psychosomatic symptoms proceed from a clinical rather than an experimental approach. This means that, like Freud, certain theories are constructed which seem to explain the phenomenon as the doctor sees it in his patients. Some experiments which would tend to support some of these theoretical foundations have been carried on. An example of this is a study by P. F. D. Seitz who attempted to replace symptoms by means of hypnosis. Seitz concludes: "Psychodynamically equivalent symptoms may replace original conversion reactions, but nonequivalent symptoms cannot be substituted in this way."²⁷ Thus, hysterical trauma of the hands and forearms could be replaced by torticollis, gagging-choking-vomiting, headache, and dissociated acting out of an impulse to strangle.²⁸ The theory would hold that the shaking of the hands and forearms represents a repressed aggressive impulse to kill, specifically by strangulation. Since the substituted symptoms were equivalent in symbolic meaning to the original symptom, they could be interchanged by means of hypnosis. Pedophilia, according to Seitz's studies, could be replaced by "an obsessive preoccupation with thoughts of injuring a child."²⁹ Symptoms which were not equivalent symptoms could not be interchanged by means of hypnosis.

²⁷ Philip F. D. Seitz, "Experiments in the Substitution of Symptoms by Hypnosis:11," Psychosomatic Medicine, XV (September-October 1953), 421.

²⁸ Ibid.

²⁹ Ibid.

Franz Alexander

Franz Alexander combines Freudian psychoanalytic insights with Walter Cannon's classic animal studies of the "adaptive bodily responses to fear and rage."³⁰ He offers a multi-causal explanation of psychodynamic patterns in disease. Alexander dealt specifically with duodenal ulcers, ulcerative colitis, asthma, essential hypertension, rheumatoid arthritis, thyrotoxicosis, and neurodermatitis.³¹ He postulates that an individual who has a specific organic vulnerability which either was inherited or acquired early in life "will develop organic symptoms under the influence of specific emotional stress situations. I called this specific organ vulnerability the 'X' factor."³² Thus the onset situation is one which combines this emotional vulnerability toward certain stress situations and a specific organic vulnerability. When the emotional stress is high enough the individual will respond with specific organic symptoms.

For instance, if the craving for love and care can be felt as if it were a need for food (roughly resembling the satisfaction of the oral stage of development, intake both of affection and nourishment, according to Freudian theory), then the body can react with a kind of chronic hunger. The stomach is kept in a state of being emotionally prepared for

³⁰ Franz Alexander, "The Development of Psychosomatic Medicine," Psychosomatic Medicine, XXIV (January-February 1962), 19.

³¹ Ibid., XXIV, 20.

³² Ibid.

food which does not come. In this situation perhaps an ulcer will develop.³³ Although there is much controversy over Alexander's theories, he has received some support from the experimental studies of I. A. Mirsky.³⁴ Alexander, as did both Wise and Booth, has moved at least one step forward from the classical Freudian theory. He postulates both organ vulnerability (either inherited or learned early in the development of the child) and a specific emotional stress vulnerability. This is not synonymous with a classical conversion reaction.

Karl Menninger

Karl Menninger uses as his theoretical starting point Freud's hypothesis of a death instinct. He feels that "the destructiveness in the world cannot all be ascribed to fate and the forces of nature, but must in part be laid at the door of man himself."³⁵ The destructiveness appears to Menninger to include a great deal of self-destructiveness. The best theory to account for what is known, especially what he has observed in years of clinical practice, is "Freud's hypothesis of a death instinct, or primary impulses of destructiveness opposed by a life instinct, or primary impulses of creativeness and constructiveness."³⁶ Life is interaction between these two forces, constituting both the psychological and biological basis for life. Chronic invalidism, for

³³Carl A. Binger, The Doctor's Job (New York: W. W. Norton, 1945), p. 111.

³⁴Alexander, "The Development of Psychosomatic Medicine," XXIV, 24.

³⁵Karl A. Menninger, Man Against Himself (New York: Harcourt, Brace, and Company, c.1938), p. 81.

³⁶Ibid.

instance, represents a battle between the forces of destruction--the will to die and the forces of erotization--the will to live.

Were the death instinct a little stronger or the defense a little weaker, the patient would die of his disease. Were the erotic capacities a little greater, they would overcome the destructive tendencies and the patient would find other techniques for living and loving without the involuntary martyrdom of invalidism which, costly as it is, remains his only satisfaction in life.³⁷

Basic to an onset of illness is a temporary ascendancy of the destructive impulse, which may take the form of a need for punishment as well as the form of self-destruction.³⁸

In a study of heart patients Menninger found that heart symptoms were sometimes a reflection or expression of strong aggressive tendencies which had been totally repressed. He found them to occur in men who were strongly attached to their fathers and often hostile to their mothers. "The conscious affection for the father usually completely obliterated the deeply buried hostilities for him."³⁹ Menninger's central thesis is that some forms of organic disease, like these heart symptoms, represent an attempt to solve unconscious, that is, repressed conflicts, "the nature of these conflicts being related to the opposition and interaction of aggressive, self-punitive, and erotic components of the self-destructive tendency."⁴⁰ Menninger recognizes the possibility of coincidence that

³⁷ Ibid., p. 158.

³⁸ Ibid., p. 362.

³⁹ Ibid., p. 375.

⁴⁰ Ibid., p. 415.

does cast a long shadow over his theoretical framework, but he is confident that at least these relationships occur repeatedly in many of the patients that he has seen.⁴¹

Jergen Ruesch

Jergen Ruesch believes that the common denominator which exists in a majority of the patients whom he has studied has been that "symptomatology, personality structure, as well as social techniques of these patients pointed to a rather primitive level of psychological organization."⁴² The common denominator, according to Ruesch, is arrested maturation. The somatic symptoms are a means of infantile self-expression. This infantile personality has experienced trauma at a very early age which has resulted in a lack of integration in all of the following stages.⁴³ The infantile person cannot express himself by means of mature interpersonal communications, so he must express his communications through his organs.⁴⁴ Ruesch's approach toward cure is a modified psychotherapy for children, except with chronologically adult patients.⁴⁵ Ruesch reflects an approach which attempts to find a common denominator in psychosomatic symptomatology. Whether it is possible to find such a common denominator remains to be documented.

⁴¹Ibid., p. 390.

⁴²Jergen Ruesch, "The Infantile Personality: The Core Problem in Psychosomatic Medicine," Psychosomatic Medicine, X (May-June 1948), 134.

⁴³Ibid., X, 139.

⁴⁴Ibid., X, 142.

⁴⁵Ibid.

Summary

In the field of psychosomatic studies these men and women, all psychiatrists except for Wise, who is an ordained clergyman (Dunbar also received a theological degree), form one basic theoretical group which postulates some form of specific functional impairment which is associated with a specific personality type or combination of personality factors. Dunbar represents an attempt to construct a general personality profile on the basis of personality characteristics of patients with a specific disease or illness. Freud saw some disturbances of the somatic function as an ego defense, lest suppressed material become conscious. He calls this mechanism conversion; the ultimate result is conversion hysteria. Wise and Booth postulate a symbolic meaning for sickness. Somatic symptoms can be an attempt of the individual to deal with repressed material. Many functional disorders, therefore, have a symbolic meaning, many times unconscious, to the patient. The illness is used as an attempt to maintain emotional homeostasis, that is, equilibrium. Alexander postulates a certain organ vulnerability, an "X" factor, which causes a symptom at a particular organ because of an inherited or learned weakness at that organ and the onsetting factor of emotional stress. Menninger postulates many organic symptoms resulting from a conflict between the life and death instincts within the individual. Ruesch believes that many somatic problems result from individuals who have not progressed past the most basic stages of development and, therefore, have not been able to integrate any of the later stages. Therefore they tend to express themselves in an infantile manner, by somatic symptoms, rather than by inter-personal communication.

These theorists have, in one form or another, relied on Freud. Yet in most instances their contribution represents an additional block or two on the original Freudian structure. Basically these theoretical constructs are largely unproven by empirical or statistical experimentation, although some experimental support does exist. The basic methodology with these men is a clinical or case approach, descriptive of the mechanisms at work in individual cases. There is no doubt that the Freudian foundation has given much stimulus to research and thought in the area of psychosomatic symptoms and illnesses.

CHAPTER IV

MULTI-DISCIPLINARY APPROACHES TO PSYCHOSOMATIC ILLNESS

Introduction

Fundamentally, the specificity theories have been attempts to postulate a unified theory of psychosomatic illness. They have been attempts to find a theoretical construction which will account for most of the observed phenomena as these theorists have found it in their clinical experience. All of the research and theorizing has not been done by those who are so oriented, however. The field of psychosomatic studies has not been left exclusively to the researchers or theorists of the Freudian persuasion or of an advanced form of a specificity theory, although there is little question that the psychoanalytical base has been a very productive starting point for much of the research. The purpose of this chapter is to examine work done by theorists who advocate a broader base of causality. This chapter will show that there is at least a small trend toward expanding the possibilities of the causality of psychosomatic symptoms. In general, these approaches might be called multi-disciplinary approaches, following the categorization of Kaplan and Kaplan.¹

¹Harold I. Kaplan and Helen S. Kaplan, "Current Theoretical Concepts in Psychosomatic Medicine," The American Journal of Psychiatry, CXV (June 1959), 1095.

Biosocial Concept

J. Groen, in an article in the Journal of Psychosomatic Research, maintains that man must be regarded as both a biological and social mammal. This obvious fact requires little explanation, but its significance is, perhaps, sometimes not understood in the field of medicine. For example, man, biologically, has a very long period during which he is dependent upon his parents. This is a biological fact. Because of this fact man has developed a number of social customs to regulate this dependency period. Thus, an infant must be toilet-trained because settled life makes necessary excretory control by the infant and the adult. Every man, therefore

is restricted in the possibilities to live out his natural tendencies not only by the physical (geographical, climatic, etc.) limitations of his environment, but also, and even to a higher degree, by the behaviour of his fellow men. The society in which the human being is born and in which he has to live is not only a physical or biological environment. It is a culture, a community where patterns of life are regulated only partly by the biological nature of man and the environmental, climatic, and geographical conditions, but mostly by social, i.e., economic, national, and religious conditions, customs, and laws, written and unwritten.²

Every culture can be seen as a compromise between natural drives and socialization. Because compromise is necessary, a certain amount of frustration of man is also apparently necessary. Groen's central thesis at this point is that man adapts to a partially satisfying and, at the

²J. Groen, "Psychosomatic Disturbances as a Form of Substituted Behavior," Journal of Psychosomatic Research, II (April-June 1957), 86.

same time, partially frustrating environment, by means of a process of substitution, whereby drives are satisfied by being discharged, either partially or completely.³

Groen isolates four categories of human behavior. If the individual is able to find adequate substitutions for the gratification of his drives, "within the framework of behavior patterns which are required and permissible within the culture in which he is placed"⁴ the individual is said to have "adequate, normal, or healthy patterns of behavior."⁵ If the individual acts out his drives in a manner which brings him into conflict with the culture, his behavior is termed psychopathic or sociopathic and is considered abnormal behavior.⁶ If an individual remains within the cultural norms but does not find gratification of his drives by his behavior, he may develop severe internal conflicts, called neuroses. The behavior of this individual is called psychoneurotic behavior.⁷ The individual's behavior brings him into conflict with himself rather than, in the case of the psychopath, into conflict with society.

The fourth category of human behavior Groen calls "psychosomatic patterns of abnormal behavior, (that is, psychogenic bodily disease)."⁸

³Ibid., II, 87.

⁴Ibid., II, 86.

⁵Ibid., II, 87.

⁶Ibid., II, 88.

⁷Ibid., II, 89

⁸Ibid., II, 90.

When an individual, according to Groen, attempts to conform to the rule of society (and therefore rejects the role of the sociopath or psychopath), but does not find gratification of his basic drives and rejects the behavior pattern of the neurotic, "somatic reaction patterns are substituted in an increasing intensity and duration, so that they are called diseased, and thus bring the individual to the family doctor or the specialist."⁹ Groen sees some evidence to indicate that this fourth form of behavior may be more popular in our Western culture than the other two non-normal behavior patterns, because somatic symptomatology is met "with sincere sympathy and care,"¹⁰ while there is more condemnation which results to the individual from sociopathic or neurotic behavior. In order to study the disturbance, investigation must be made into all areas of the individual's life-space. The inborn properties of the central nervous system, basic hereditary factors, individual personality patterns, and environmental factors must be studied.¹¹ Thus, study is needed by personnel who are trained medically, sociologically, anthropologically, and psychologically. For instance, Groen feels that somatic "acting out" is on the increase because our Western civilization continues to restrict more and more other forms of "acting out," like weeping, and continues to encourage self-control. This is a problem not only for a psychologist, but for many personnel trained in various fields.

⁹Ibid., II, 91.

¹⁰Ibid.

¹¹Ibid., II, 92.

The control of neuromuscular discharges which western man must master to live adequately in this culture is, at least for individuals, both an educative and potentially pathogenic factor, leading to the appearance of psychosomatic disease. This insight into the social root of disease, for long recognized in the aetiology of the various forms of mental illness, now appears to be also responsible for the psychosomatic disturbances.¹²

A Field Theory

Groen's approach seems to approximate the kind of "field theory" approach in psychosomatic medicine advocated by Roy Grinker and his followers.¹³ A field theory simply indicates that all factors--historic and contemporary, external and internal--which influence a patient must be studied. Grinker feels that investigators of different disciplines should study the same disease at the same time within their own frame of reference.¹⁴ Then, perhaps, a complete picture of the place of the total illness might be seen.

For instance, Grinker feels that no scientific discipline can speak alone, considering the complexities of human existence. Each discipline has a particular method by which it observes the workings of the human being. But any method has an inherent limit on it by its very nature. Any method is restricted by its own frame of reference; it cannot describe outside of this framework. The only possible solution to this problem of specialized disciplines is to work in an interdisciplinary group which

¹²Ibid., II, 95.

¹³Kaplan and Kaplan, CXV, 1096.

¹⁴Ibid., CXV, 1095.

is "molded together by common conceptual schemes and scientific approaches."¹⁵ Grinker feels that the infantile organism begins its existence in a state of "unification, undifferentiation, or wholeness."¹⁶ Even though many processes become differentiated as the organism matures, yet there remains a basic unity. A multi-disciplinary field approach is the best available means for Grinker to study the now differentiated processes in order to find the underlying unity which does exist. Grinker recognizes the difficulties of the formation of such interdisciplinary groups, yet he believes that the implications of the fact that the organism reflects a conceptual unity forces such a multi-disciplinary approach. "We cannot operate alone anymore in a single field, whether this be biochemistry, physiology, psychology, neurology, internal medicine, or psychoanalysis."¹⁷ The thrust of this thesis is to show that pastors cannot operate alone in pastoral care either.

Multi-Descriptive Theory

Another approach to psychosomatic illness is one which does not attempt to fit the symptoms of an illness into any theoretical construction whatsoever, but attempts to describe the various encountered possibilities. Klaus W. Berblinger lists eight criteria for what he calls a functional symptom.

¹⁵Roy Grinker, "Some Current Trends and Hypotheses of Psychosomatic Research," in The Psychosomatic Concept in Psychoanalysis (New York: International Universities Press, 1953), p. 61.

¹⁶Roy Grinker and Fred Robbins, Psychosomatic Case Book (New York: Blakiston Company, 1954), p. 33.

¹⁷Grinker, p. 60.

1. Absence or relative insignificance of organic impairment with regard to the predominant complaint.
2. Onset, periodicity, and absence of major changes in the present dysfunction.
3. Positive history of similar disabilities in the past.
4. Demonstrable correlation between the onset, exacerbation, or chronicity and social or emotional stress.
5. Modification of symptomatology through ventilation and correlation during the psychiatric interview or other forms of patient-centered history-taking.
6. The presence of personality traits that can be considered susceptible to stress and have a psychopathological connotation.
7. The meaning of the disability in psychological and interpersonal terms.
8. A possible history of iatrogenic and social aggravation of the symptom.¹⁸

The functional symptom, once described, can have many causes.

There can be, for instance, a symptom which has obvious symbolic overtones, clear to everyone but the patient. Here Berblinger describes the classic conversion reaction, where "the emotional difficulty or conflict found initial and direct representation through somatic symptoms."¹⁹ The thirty-five year old male physician described in Chapter III is an excellent example of this category. But unlike the theorists who would attempt to place all psychosomatic symptoms into this category or some category like it, Berblinger proceeds to describe

¹⁸Klaus Berblinger, "The Functional Symptom in Psychiatric Perspective," Psychosomatics, VII (July-August 1966), 206.

¹⁹Ibid., VII, 207.

"the functional symptom without apparent symbolism."²⁰ He discusses a case where "the functional symptoms are not recognizable or related to ideational content and affect. Organ choice and types of symptoms do not serve as a defense against specific anxiety and tension."²¹

Another category Berblinger labels "post-traumatic neuroses and functional overlay" by which he sees the patient's symptoms completely out of proportion to the actual organic pathology involved.²² Another type he calls the "post-traumatic neuroses." He uses the accident process to clarify this concept. Berblinger isolates the following elements to this process.

1. The actual accident and the immediate incapacitation.
2. The patient's general reaction to sickness and his capacity to deal with the immediate disablement.
3. Time factors, like emergency care and the length of litigation.
4. Clarification of responsibility and compensation.
5. Attitudes exhibited by those who are in direct contact with the accidental happening and of those who determine aftercare and restitution.
6. The ultimate physical and psychological state of the patient. In other words, a comparison between pre- and post-morbid functioning by the patient, his doctors, and insurance carriers.²³

²⁰Ibid., VII, 208.

²¹Ibid.

²²Ibid., VII, 209.

²³Ibid., VII, 210.

Thus Berblinger attempts to describe different forms of psychosomatic symptomatology as he has found them without constructing one single theoretical framework. He limits himself to a description of the different kinds and functions of the symptoms and causes. He uses these descriptions to show that the patient must be seen in what Berblinger calls his "psycho-bio-social existence and the organism's need for homeostasis."²⁴ Effective therapy, therefore, is concerned always with multiple factors of stress, "be these genetic, traumatic, infectious, metabolic, catabolic, social, or psychological in nature."²⁵

Reflections

Perhaps the most obvious alternative to the specificity-theory-oriented research is simply research which is conducted outside of the realm of any grand theoretical formulation. There is a great deal of this type of research being conducted, although it is not so readily available to this writer, nor has it been so popularly noted among religious or theological writers. The best summary of much of the independent research that has been done from a primarily medically-oriented research base is Russell W. Mason's Internal Perception and Bodily Functioning.²⁶ This represents the contribution of one field, the experimental-medical man. Contributions of this sort would be awaited from other fields.

²⁴Ibid., VII, 205.

²⁵Ibid.

²⁶Russell E. Mason, Internal Perception and Bodily Functioning (New York: International Universities Press, 1961).

The point is that increasingly it is thought that a uni-causal explanation for psychosomatic symptoms is an oversimplification. Much study must be made before one theory can come forward which will really command the incomplete data in the field. Three examples of this larger field or descriptive theory have been presented in the persons of Groen, Grinker, and Berblinger.²⁷ The following chapter will survey the research that has been done with one type of disease process: cancer.

²⁷In response to reading this chapter, Dr. Carroll A. Wise asked: "Do the approaches in this chapter rule out the approaches in Chapter III?" Even though it is the propensity of this author to attempt to categorize theorists for a better understanding of the trends in the field, the author does not wish to imply that the approaches are exclusive of each other. One can hold to a specificity theory and still be concerned about the multi-causal factors, some of which come from the environment. Another theorist might be most interested in the environmental factors, but also be sensitive to the intra-psychic conflicts. Chapters III and IV discuss emphases rather than mutually exclusive positions.

CHAPTER V

RESEARCH INTO THE PSYCHOSOMATIC ASPECTS OF CARCINOMA

Introduction

In an article published in 1954, George Engel noted: "We repeatedly affirm our belief that all diseases are 'psychosomatic,' in the sense that psychological processes are always involved."¹ Yet he notes that over eighty percent of the articles which appeared in Psychosomatic Medicine, the Journal of the American Psychosomatic Society, were devoted to the "circulatory system, skin, gastrointestinal tract, respiratory system, pain, and metabolic disturbances."² He laments the fact that more research has not been done in the area of the psychological study of cancer patients. Among other reasons for studying such persons, he indicates (1) that the cancer patient is a human being whose disease process will be reflected in his psychological processes; (2) that a psychological study may give information about the conditions, both internal and external, which would be necessary for the development of cancer (and its location in a particular organ); (3) that psychological material may provide information to help explain the cancer process itself; (4) that information may be gained to help understand the effect the cancer patient has on those around him; and (5) that this psychological knowledge of the cancer patient will contribute

¹George L. Engel, "Selection of Clinical Material in Psychosomatic Medicine," Psychosomatic Medicine, XVI (September-October 1954), 368.

²Ibid.

to better care, both of the patient and those who are emotionally involved with the patient, as his family and close friends.³ Since the time of Engel's article, and to a limited extent before it, research articles have appeared studying the psychosomatic aspects of cancer.

Lawrence LeShan puts forward the case for the necessity of research in this area by using an analogous picture.

Even theoretically, the existence of a correlation between emotional stresses and cancer does not mean that easing of these stresses will halt the cancerous process. One does not put out a forest fire by extinguishing the match that started it. It is nevertheless true that it may be necessary, after putting out the fire with other means, i.e., surgery, radiation, or chemotherapy, to extinguish the match in order to prevent a new fire.⁴

The purpose of this chapter is to explore some of the many research experiments and clinical evaluations which have been made of the psychological factors implicit in the cancer process. Of course, research has been done with patients suffering from many other diseases, as Chapters III and IV of this paper have intimated. Yet the cancer research will illustrate the type of research and theorization which is being done, as well as give some indication of the results which have come as an outgrowth of the research projects. The conclusions which are drawn as a result of the research are most tentative--in fact, many are still very much in dispute. But the trends of the research will become reasonably clear.

³Ibid., XVI, 371-72.

⁴Lawrence LeShan, "Psychological States as Factors in the Development of Malignant Disease: A Critical Review," Journal of the National Cancer Institute, LXII (January 1959), 14.

Research and Theory Until 1900

Lawrence LeShan has summarized the psychosomatic concept of the development of malignant disease in the period from 1400 to 1900. He notes that cancer was often associated in the late middle ages with the humoral theory.⁵ Galen, LeShan feels, "believed that melancholic women were more prone to cancer than those of sanguine temperament."⁶ Based on the humoral theory, W. A. Walsche writes in 1846: "Women of high color and sanguinous temperament are more subject to mammary cancer than are those of different constitution."⁷ As a result of this emphasis upon personality and cancer, D. Gendron, in 1701, noted a case of the onset of cancer.

Mrs. Emerson, upon the death of her daughter, underwent great affliction, and perceived her breast to swell, which soon after grew painful; at last broke out in a most inveterate cancer, which consumed a great part of it in a short time. She had always enjoyed a perfect state of health.⁸

Willard Parker, in a study of ninety-seven cases of breast cancer, relates that he felt that grief was associated with cancer.

⁵The humoral theory of the middle ages was an attempt to categorize mankind into "types." There were four temperaments, two active and two passive. The active temperaments were choleric (quickly and easily excited; tends to react immediately and the impression remains deeply rooted) and sanguine (speedily excited, yet impression soon fades away). The passive temperaments were melancholic (slow to excitement yet the impressions remains deeply rooted) and phlegmatic (slow to excitement, little inclination to react, and the impression vanishes quickly). These are innate temperaments.

⁶LeShan, LXII, 1.

⁷Ibid., LXII, 2.

⁸Ibid.

It is a fact that grief is especially associated with the disease. If cancer patients were as a rule cheerful before the malignant development made its appearance, the psychological theory, no matter how logical, must fall: but it is otherwise. The fact substantiates what reason points out.⁹

The same kind of conclusions about the research and theory developed during this time is reached by Samuel Kowal. He found the following on the basis of the evidence.

The 18th and 19th century physicians were impressed by the frequency with which certain life situations tended to occur prior to the development of a neoplasm.¹⁰

These situations most often were either the loss of a significant figure who was in a meaningful relationship with the patient or the frustration of a significant life goal. "The common denominator which appeared to underlie these diverse situations was the reaction of despair and hopelessness."¹¹ This raises a question for Kowal: perhaps the human organism dies when all reasons for survival--"the goals of life"--have disappeared.¹²

In both of these historical surveys, LeShan and Kowal are both impressed with the fact that the physicians sought out the connection between the life situation of the patient and the disease which was found to be in progress. If there was a connection, then they felt a causal connection might exist. Both LeShan and Kowal find the majority

⁹Ibid., LXII, 3.

¹⁰Samuel J. Kowal, "Emotions as a Cause of Cancer: 18th and 19th Century Contributions," The Psychoanalytic Review, XLII (July 1955), 218.

¹¹Ibid.

¹²Ibid., XLII, 226.

of the psychological explanations of this time period centering around the development of despair, anxiety, frustration, and hopelessness in the patient, prior to the onset of cancer.

Specificity Theory-Oriented Research--Loss of a Love Object

Gotthard Booth, following the major uni-causal theory which was explored in Chapter III, develops the theoretical approach that cancer represents a symbolic substitute for a lost love object. He found that the cancer patient has generally attempted to establish a definite control over objects. Thus, "not mutuality and partnership but the security of the particular relationship valued by this individual is needed."¹³ He finds that disease strikes "when their particular object seems to have been irretrievably lost."¹⁴ In this basic theoretical approach, Booth finds himself in agreement with the conclusions reached by a number of eighteen and nineteenth century physicians. Booth's theory is supported, in addition, by his understanding of Freudian theory. The person who attempts to gain control over objects desires the external object to become an extension of himself. Thus, when the object is lost, something must be found to replace it. Symbolically, the neoplasm within the person replaces the lost love object.

The tumor, as an outgrowth of the body, symbolizes the lost object. The cells of the tumor do not interact with other living organisms as is the case in bacterial infection. They react to inanimate substances which become part of the cell chemistry, chaining the cell's metabolism

¹³ Gotthard Booth, "The Voice of the Body," in The Voice of Illness (Philadelphia: Fortress Press, 1964), p. 15.

¹⁴ Ibid.

so that the cancer becomes independent of oxygen. Thus even on the cellular level cancer symbolizes the autonomy which has been the predominant aim of the patient in the days of health.¹⁵

A number of studies have been made to test, to some extent, this hypothesis. LeShan and Worthington studied twenty-eight case histories of patients, fifteen who had cancer and thirteen controls who had no malignant disease. They were given unidentified to a group of analysts. The analysts were to pick those with cancer and those with no cancer on the basis of the examination of the protocols. This examination was a check on a previous project which found the following factors arising more frequently in the protocols of patients with malignant cancer.

1. Loss of an important relationship before the diagnosis of the tumor;
2. Inability to express hostile feelings toward other people; and
3. Tension over the death of a parent, often an event that had occurred far in the past.¹⁶

Using these three factors to sort the twenty-eight protocols, correct predictions were made in twenty-four of the twenty-eight cases. In other words, in 86 per cent of the cases a correct prediction as to a person having cancer or not having cancer was made by these judges on the basis of the presence or absence of the three factors listed.

¹⁵Ibid., p. 17.

¹⁶Lawrence LeShan and Richard Worthington, "Some Psychologic Correlates of Neoplastic Disease: A Preliminary Report," Journal of Clinical and Experimental Psychopathology and Quarterly Review of Psychiatry and Neurology, XVI (December 1955), 282.

Of the four incorrectly placed, three noncancerous patients were predicted as having cancer and one cancerous patient (cancer of the skin) was predicted to be a non-cancerous patient. "Statistically, that this number of correct predictions would occur by chance is less than one in a thousand ($P = .0001$)."¹⁷ Thus, LeShan and Worthington, while recognizing the small number of patients in this survey, still feel that this data would tend to support the listed emotional factors and external happenings as occurring more frequently in cancerous than non-cancerous patients.

Renneker and his group studied five women who had cancer of the breast. The study lasted over a period of six years. They found that a crisis occurred in the lives of their patients, "when the selected object abandoned the patient, provided inadequate, lost warmth or the ability to feed, or died."¹⁸ This loss precipitated a depression which, Renneker postulates, is "responsible for a decrease in host resistance"¹⁹ in these patients. This group of experimenters postulated, on the basis of this study of five women, that the cancer process itself is a complex reaction which may be precipitated or encouraged by this emotional circle: "Oral frustration destructive rage turning against self depression oral frustration and the like."²⁰

¹⁷ Ibid., XVI, 283.

¹⁸ Richard Renneker, Robert Cutler, Jerome Hora, Catherine Bacon, Garnet Bradley, John Kearney, and Max Cutler, "Psychoanalytic Exploration of Emotional Correlates of Cancer of the Breast," Psychosomatic Medicine, XXV (March-April 1963), 119.

¹⁹ Ibid., XXV, 122.

²⁰ Ibid., XXV, 119.

Renneker has taken the general idea of cancer developing after the loss of a love object and combined with this emotional factor "the multiple organic and environmental factors which are a part of the multi-causal process of cancer."²¹ This research postulates the loss of an important love object plus other environmental and constitutional factors as comprising the process of carcinoma.

Schmale and Iker attempted to measure one result of the loss of a love object: hopelessness. They define high hopelessness potential:

[It is] revealed by the subject's report of reactions to life events in general, especially by a history of long-standing hyper-activity and devotion to causes with little or no feeling of success or pleasure, irrespective of actual accomplishment. Such an individual rarely feels he achieves what he desires to achieve and assumes most of the responsibility for what he considers evidence of failure.²²

The effect of hopelessness is expressed by feelings of "doom," "the end," or "finished."²³ The individual can do nothing, in effect, to reclaim the gratifications which were felt in the past. Schmale and Iker studied forty women who were discovered upon routine examination to have a cell structure in the cervix which caused a suspicion of cancer. Psychological tests were given to these patients; the high hopelessness potential as defined previously was isolated. Of the forty women who were studied, the interview prediction "correctly

²¹Ibid., XXV, 106.

²²Arthur Schmale and Howard Iker, "The Effect of Hopelessness and the Development of Cancer," Psychosomatic Medicine, XXVIII (September-October 1966), 715.

²³Ibid.

identified 8 of the 14 that had cancer and 23 of 26 that did not. Thus, there were 31 correct predictions and 9 incorrect predictions."²⁴ This result would happen, according to statistical analysis, in only seven of one thousand chances.

Our criteria (high hopelessness potential and/or recent feelings of hopelessness) for predicting the presence or absence of cervical cancer in women with repeated evidence of Class-III cytology as found on cervical smear appeared to be validated.²⁵

This study would appear to give additional support to the general thesis that psychologically, cancer patients have generally experienced some sort of object-loss on which emotional energy was spent. As a result these patients have experienced and are experiencing feelings of loss, including depression and hopelessness.

In a study of fifty women who were attending a breast tumor clinic for the first time, clinical questionnaires and projective techniques were used to determine personality patterns. A group of twenty-five women who were examined and found to be free completely of breast cancer served as the control group. Comparisons between that group and the group of women who were found to have breast cancer were made. Some differences between the groups are listed below.

1. Women with malignant tumors reported a far greater number of sibling deaths at birth or in infancy.
2. The childhood of the cancer patients seemed to be characterized by excessive responsibilities predominately associated with caring for younger children. As adults their marriages appeared less successful.

²⁴Ibid., XXVIII, 716.

²⁵Ibid.

3. The cancer group expressed more negative feelings toward pregnancy and birth and evidenced specific disturbances in feminine identification.²⁶

Of special interest is that the women reported a greater number of sibling deaths, indicating an early loss of what would be considered a primary emotional relationship. This is an early loss of a love object.

Of interest to any specificity theorist is why the cancer develops at a particular site. Fisher and Cleveland attempted to determine if an individual's body image might have any relationship to the development of cancer at a particular site. They used as their sample eighty-nine patients, fifty-nine with body-exterior cancer and thirty with body-interior cancer.

This viewpoint is based on the idea that all phases of an individual's functioning, whether "physiological" or "psychological" or "biochemical," are intimately linked and can be meaningfully conceptualized as exerting mutually determining types and effects.²⁷

Fisher and Cleveland found that to a statistically significant degree, "the patient with body-exterior cancer has a greater tendency to conceive of his body as enclosed by an impenetrable boundary than does the patient with interior cancer."²⁸ Perhaps, therefore, the unconscious fantasy of a body-image, learned over a long period of time, may play a significant role in the site of the development of cancer in a patient.

²⁶Marvin Reznikoff, "Psychological Factors in Breast Cancer," Psychosomatic Medicine, XVIII (July-August 1956), 308.

²⁷Seymour Fisher and Sidney Cleveland, "Relationship of Body Image to Site of Cancer," Psychosomatic Medicine, XVIII (July-August 1956), 308.

²⁸Ibid., XVIII, 309.

As a check on this study, the researchers took the personal data of ten patients, five exterior and five interior cancer patients, and removed all identifying data. Then they sorted the records according to where the psychological tests indicated the cancer would develop. "Of the 10 records . . . psychologist sorted them all correctly, the other 2 misplaced 2 of the 10."²⁹ The sample is small; therefore any conclusions are highly tentative. However, the data would indicate a possible relationship between the body-image of a patient and the site where the cancer would develop.

Diminished Emotional Discharge as a Characteristic of a Cancer Patient

"Everyone carries the cancer potential with him. . . . It is simply a matter of whether you die of something else before you die of cancer."³⁰ Perhaps there is a psychological factor in the activation of the cancer potential. This was the underlying supposition and question in an experiment by Bacon, Renneker, and Cutler, studying forty patients with cancer of the breast. This was a clinical study, that is, it utilized the personal remembrances of the patients and the personal observations of the interviewers. As a result of their studies, the following positive characteristics of these patients were isolated.

1. The masochistic character structure;
2. Inhibited sexuality;

²⁹ Ibid., XVIII, 304.

³⁰ C. L. Bacon, R. Renneker, and M. Cutler, "A Psychosomatic Survey of Cancer of the Breast," Psychosomatic Medicine, XIV (November-December 1952), 453.

3. Inhibited motherhood;
4. The inability to discharge or deal appropriately with anger, aggressiveness, or hostility, covered over by a facade of pleasantness;
5. The unresolved hostile conflict with mother, handled through denial and unrealistic sacrifice; and
6. Delay in securing treatment.³¹

Practically all of the characteristics listed may be understood as a lack of ability to express or discharge internal emotions. For instance, masochism directs the emotions against the person. The emotional conflict remains internalized. The sexual drive remains internalized; it is inhibited in its outward expression. The desire to "mother" finds difficulty in being expressed in outward manifestations of motherhood. Anger, aggression, or hostility cannot be dealt with or discharged, which means that the emotion cannot dissipate or be directed at a meaningful object, but must remain internalized. The researchers found that of the forty women, only five could handle anger appropriately, five could handle anger partially appropriately, and thirty (75 per cent) had no ability to handle anger at all appropriately.³²

With a number of these women the conflict with mother had never been resolved. The basic emotion has been covered by its exact opposite emotion (reaction formation), indicating a poor resolution of the emotional conflict.

³¹Ibid., XIV, 454.

³²Ibid., XIV, 456.

Almost all the women had had a pathological relationship with their own mothers. This was commonly reflected in a conscious sense of extreme obligation which led them to go to high degrees of self-sacrifice for the sake of the mother. The underlying hostility was almost always unconscious but was clearly evident in the obvious reaction formation involved. Very few were able to vent their rage toward the mother.³³

A self-sacrificing attitude as a character trait was found in thirty-five (87½ per cent) of the patients. This self-sacrificing attitude is interpreted as reaction formation, that is, "there is only apparent conformity to the reality principle,"³⁴ while in actuality the very opposite emotion is at least unconsciously being felt.

David Kissen attempted to study the relationship between lung cancer and peptic ulcer in males. He studied 458 males, 212 suffering from lung cancer and 216 serving as a control group. This study is included here on the supposition that a case seems to have been developed in other research for the association of the development of an ulcer with internalized stress (or diminished emotional discharge opportunities). Kissen found: "The chief difference between the lung-cancer patients and the main controls was the occurrence of a significantly more frequent peptic ulcer history among the lung cancer patients in the age groups 45 and 64, especially 45-54."³⁵ He very cautiously asserted that there may be some kind of a relationship

³³Ibid.

³⁴William Healy, Augusta Bronner, and Anna Mae Bowers, The Structure and Meaning of Psychoanalysis (New York: Alfred Knopf 1930), p. 228.

³⁵David Kissen, "Relationship Between Primary Lung Cancer and Peptic Ulcer in Males," Psychosomatic Medicine, XXIV (March-April 1962), 135.

between the two diseases, although "there was no suggestive difference in the age groups 25-44 and 65 and older."³⁶

In another article, Kissen relates that after he had seen some one hundred fifty lung-cancer patients and about the same number of controls (non-cancerous patients), the clinical material which he gathered offered certain generalizations which he wished to test statistically. He hypothesized that as opposed to the non-cancer patient, the lung-cancer patient would "(1) have a significantly diminished outlet for emotional discharge, and (2) tend to bottle up or conceal their emotional difficulties."³⁷ He used the M.P.I. (Maudsley Personality Inventory) and a clinical questionnaire to study the patients. One of the means of comparison in the clinical questionnaire was an investigation into childhood behavior disorders, such as bed wetting, fears, phobias, anxieties, sleep disturbances, stammering, trouble with authority because of absence from school, and temper tantrums. It was hypothesized that the lung-cancer patients would have experienced less of these behavior disorders because they would have less capacity for emotional discharge.³⁸ Kissen found: "Even excluding bed wedding, significantly fewer lung-cancer patients than controls had had childhood behavior disorders."³⁹ Thus Kissen believes that the data

³⁶Ibid.

³⁷David Kissen, "Personality Characteristics in Males Conducive to Lung Cancer," The British Journal of Medical Psychology, XXXVI (January-March 1963), 27.

³⁸Ibid., XXXVI, 38.

³⁹Ibid., XXXVI, 29.

support his original hypothesis. The lower incidence of childhood behavior disorders indicate a poor outlet for emotional discharge. In addition, in response to questioning, the lung-cancer group stated that they tended to conceal or bottle up emotional problems. Therefore, he found, in support of his second hypothesis, that there seemed to be a greater tendency on the part of the cancer patients to conceal their difficulties.

In yet another study Kissen and Eysenck found in 116 male lung cancer patients and 123 male non-cancerous controls, that the cancer group had a low rate for neuroticism.⁴⁰ Neuroticism is defined as "the individual's general emotional liability, emotional over-responsiveness and liability to breakdown under stress."⁴¹ Neurotic actions give an opportunity for internal emotions to be discharged, even in ways that may be unacceptable to society. A low neuroticism score, as interpreted by Kissen and Eysenck, would tend to indicate that the emotions remained internalized and not expressed. In short, there was no ability, even on a neurotic level, to express or discharge inner tension.

Blumberg, West, and Ellis postulated:

The very development of cancer in man might conceivably result from the physiological effects of long-continued inner stress which has remained unresolved by either outward action or successful adaptation. In other words,

⁴⁰David Kissen and H. J. Eysenck, "Personality in Male Lung Cancer Patients," Journal of Psychosomatic Research, VI (April-June 1962), 126.

⁴¹Kissen, "Personality Characteristics in Males Conducive to Lung Cancer," XXXVI, 30.

it seems that human cancer could represent, at least in many instances, a non-adaption syndrome.⁴²

The concept of inner stress which would not be able to find sufficient channels for outlet would closely parallel the concepts of lack of the ability for emotional discharge and the concept of emotions forced to remain internalized. Blumberg and his group analyzed fifty cancer patients, dividing them into two groups of twenty-five patients with rapidly progressing cancer and another twenty-five patients with slowly progressing cancer. The attempt of the investigation was to see if there would be any significant personality differences between the groups in which the carcinoma was progressing rapidly and that group in which it was progressing slowly and could be easily controlled. Blumberg, West, and Ellis found that the profiles of the patients with rapidly progressing cancers generally showed two or more of these three following characteristics on the M.M.P.I. (Minnesota Multiphasic Personality Inventory).

1. Highly negative "F-K" values (-12 or more negative), considered indicative of high defensiveness or strong tendency to present the appearance of serenity in the presence of deep inner stress.
2. "D" values of 55 and over without accompanying increase of neurotic factors "Hs" and "Hy," considered indicative of anxiety or depression unrelieved through neurotic or normal channels of discharge.
3. Low "Ma" scores (under 60) suggesting an abnormal lack of ability to decrease anxiety through usual outward corrective action.⁴³

⁴²Eugene Blumberg, Philip West, and Frank Ellis, "A Possible Relationship Between Psychological Factors and Human Cancer," Psychosomatic Medicine, XVI (July-August 1954), 277.

⁴³Ibid., XVI, 278.

These results indicated that generally there was little ability on the part of the cancer patients with rapidly progressing cancers to discharge internal emotional feelings into external channels.

Blumberg, West, and Ellis found that the cancer patients who had strong resistance to the growth of the cancer cells were able to reduce their internal emotional stress by means of normal outward activity, psychopathic activity, neurotic activity which operated successfully, and psychotic activity.⁴⁴ Those patients with rapidly progressing cancers do not have this ability, they found.

The ability to effectively utilize any of these well-known mechanisms appears to be singularly lacking in the average cancer patient and particularly in those with rapid growth. They were noted to be consistently serious, over-cooperative, over-nice, over-anxious, painfully sensitive, passive, apologetic personalities, and, as far as could be ascertained from family records, they had suffered from this pitiful lack of self-expression and self-realization all their lives.⁴⁵

These researchers discovered that the psychological differences between the two groups were easily detectable through the results of the Minnesota Multiphasic Personality Inventory. They hypothesize: "Long-standing, intense emotional stress may exert a profoundly stimulating effect on the growth rate of an established cancer in man."⁴⁶

Tarlau and Smallheiser studied twenty-two married women, eleven of whom had breast cancer and eleven of whom had cancer of the cervix.

⁴⁴Ibid., XVI, 285.

⁴⁵Ibid.

⁴⁶Ibid.

They wanted to compare the two groups to see if there were statistically significant differences in personality between the two groups, thereby establishing a psychic reason for the development of the carcinoma at a particular spot. They tested these women by means of a personal interview for one to two hours, the Rorschach test, and a test utilizing the drawing of the human figure. Significant differences were found between the two groups, although these differences are expressed in psychoanalytic terminology. The breast group was found to be fixated at the oral level of development, while the cervix group was found to be fixated at the genital level of development.⁴⁷ This would tend to support a symbolic or specificity-theory explanation of the development of cancer at these respective sites. Both groups, however, scored lower-than-average on the "M" score of the Rorschach test. "M is interpreted as the ability of an individual to accept himself, to accept his inner wishes and desires."⁴⁸ The breast patients especially were found to have severe repressive mechanism which they used to "inhibit their emotional reactivity and contact with their inner life."⁴⁹ In this early study (1951), the beginning ideas of the concept of a diminished outlet for emotional discharge are found.

The implications of this section of reported research is that the process of cancer might seem to be an attempt of the organism to deal

⁴⁷Milton Tarlau and Irwin Smalheiser, "Personality Patterns in Patients with Malignant Tumors of the Breast and Cervix," Psychosomatic Medicine, XIII (March-April 1951), 120.

⁴⁸Ibid., XIII, 119.

⁴⁹Ibid., XIII, 120.

with the emotion which cannot be discharged by some other form of activity. This research seems to be saying, in line with Freud's concept of a psychic energy system, that the emotional energy of an individual must be used somewhere. If it does not get discharged externally, it remains internally within the system, within the organism. This energy may be used in a non-adaptive way, that is, by the development of carcinoma. This general implication comes rather close to the theoretical presentation of J. Groen, where the development of a disease process is initiated only after other forms of behavior adaptation have been tried and found unsuccessful.⁵⁰ The basic mechanism described by these researchers is the inability to release by some form of behavior or action, the internal emotional stress, tension, or problem. This, they are saying, is a general characteristic of cancer patients, although all the researchers discussed here admit the tentativeness of their conclusions and the need for further study and documentation.

Research on the Rate of the Progression of Cancer in Animals

There is no indisputable theory explaining the physiological process in the development of cancer. It is thought by some, including Otto Warburg, that cancer cells originate from the normal body cells in two distinct phases. "The first phase is the irreversible injuring of respiration,"⁵¹ that is, the injuring of the ability to absorb oxygen

⁵⁰ See the presentation of Groen's position in Chapter IV of this thesis.

⁵¹ Otto Warburg, "On the Origin of Cancer Cells," Science, CXXIII (February 24, 1956), 312.

and give off the produce. But cancer cells do not immediately result once the respiration of body cells has been irreversibly damaged.⁵²

The injured cells must pass through a second phase before the cancer process is in full swing. The second phase of the formation of the carcinoma is a struggle for continued existence on the part of the injured cells. Part of the cells die, but some of their number succeed in reproducing, by means of what Warburg calls fermentation energy.

"Because of the morphological inferiority of fermentation energy, the highly differentiated body cells are converted by this into undifferentiated cells that grow wildly--the cancer cells."⁵³ The actual mechanism

may be in dispute, but there does seem to be some two-phase cycle in the development of cancer, as well as in the onset of most diseases so that they become an illness. Warburg is saying that there are two phases to the growth of cancer in an organism: (1) the initial phase at the beginning, and (2) the time when the cancer cells have survived and begin to dominate. The fact that the development of cancer is not to be seen as a once-started, never-to-be-reversed process, but as a long struggle within the body during which the cancer cells may be destroyed or, at least, controlled, has given rise to research into the psychological factors which may impede or aid the development of the cancer cells. One such study was reported in the previous section by Blumberg, West, and Ellis. Some laboratory experimentation has been done with animals.

⁵²Ibid., CXXIII, 310.

⁵³Ibid.

Reznikoff and Martin "endeavored to determine the influence of a stress situation on the incidence of mammary tumors in mice and also on the age of the animals at the time the tumor occurs."⁵⁴ Two groups of mice were used, one group having a predisposition to mammary cancer, and one group which did not. One half of the mice in each group were stressed "by administering daily intermittent electric shocks to them for periods ranging from about six months to well over a year. The remaining mice served as controls."⁵⁵ The mice which did not have a predisposition to mammary cancer did not develop that cancer, even when stressed. This indicates, perhaps, that continued stress alone is not a causative factor in the development of mammary cancer in mice. About seventy-five per cent of both the stressed and unstressed mice in the group with the predisposition to mammary cancer developed it. However, the tumors tended to appear earlier in the mice which were stressed than in the non-stressed mice.

On the average, tumors appeared 37 days earlier in the CC₂⁵⁶ stressed mice than they did in the CC₂ nonstressed animals. The mean ages of the onset of the tumors were 284 days and 321 days for the CC₂ stressed and non-stressed groups, respectively. This difference is not statistically significant.⁵⁷

⁵⁴Marvin Reznikoff and David Martin, "The Influence of Stress in Mammary Cancer in Mice," Journal of Psychosomatic Research, II (January-March 1957), 60.

⁵⁵Ibid.

⁵⁶CC₂ means the group of mice which had a tendency toward the development of mammary cancer, called by Reznikoff and Martin a "milk factor."

⁵⁷Reznikoff and Martin, II, 58.

The last sentence means that this research shows only a tendency, and does not represent a statistically significant result. The tendency is that stress combined with a predisposition to cancer produces a faster growth of the cancer cells than does the predisposition alone.

Ader and Friedman worked with twelve litters of Sprague-Dawley rats. They randomly chose seven litters which they separated from their mothers at fifteen days of age. The five remaining litters were separated from their mothers at the end of twenty-one days. At that point all the animals were weighed, marked, and housed. At the end of forty-five days all the animals were inoculated with a suspension of the Walker 256 (a specific strain of carcinoma). The inoculation was made subcutaneously into the back of each animal. This experiment was designed to study whether an early separation from the mother, to be interpreted as an early trauma, inhibits or accelerates or makes no difference in the growth of the cancer in the animals, and to determine whether this factor made any difference in the body weight of the animals. There was no significant difference between the two groups in the maintenance of body weight. However, Ader and Friedman did find "a significant difference in the rate at which the animals died."⁵⁸ They found that that group of rats which were separated from their mothers after fifteen days died a median of twenty-one days after they were inoculated with the Walker 256. The animals who remained with their mothers through twenty-one days died a median of twenty-five days

⁵⁸Robert Ader and Stanford Friedman, "Social Factors Affecting Emotionality and Resistance to Disease in Animals," Psychosomatic Medicine, XXVIII (March-April 1965), 121.

after they were inoculated with the Walker 256. Statistically, this could happen by chance in only sixteen of every one thousand cases.⁵⁹

Ader and Friedman could not offer any explanation for these facts, since they believed the mortality rate to be a function of many factors.

Yet they could state:

Whatever the mechanisms mediating tumor growth or eventual mortality, it is assumed that the differences obtained are, in part, a result of an as yet unspecified chronic alteration in the psychophysiologic function effected by the early separation experience.⁶⁰

In a study by Friedman, Ader, and Glasgow, which does not deal directly with the growth of cancer cells, the researchers subjected adult mice to an environmental stress. Those who were stressed, one group of twelve mice, maintained their body weight on a level with the controls, an other group of twelve mice. A third group of twelve was inoculated with Cocksachie B-2 virus, which had no adverse effects on the maintenance of body weight. But, when a fourth group of twelve mice was inoculated with the Cocksachie B-2 virus and given the environmental stress, there was a significant weight loss.⁶¹ They feel that this gives some evidence for a multi-causal view of the etiology of disease, since "neither the stress nor the pathogenic agent, acting independently, was sufficient to cause disease."⁶² In a likewise

⁵⁹Ibid.

⁶⁰Ibid.

⁶¹Stanford Friedman, Robert Ader, and Lowell Glasgow, "Effects of Psychological Stress in Adult Mice Inoculated with Cocksachie B Viruses," Psychosomatic Medicine, XXVII (July-August 1965), 367.

⁶²Ibid.

manner, it might seem in light of the research discussed in this chapter, that there may be a multi-causal etiology involved in the beginning and/or continuation of the cancer process.

Criticism of the Research

Although it does not lie within the competence of this writer to evaluate the statistical methodology and experimental design of the research, it must be noted that some of the results of the studies reviewed in this chapter have been challenged. Perhaps the most over-all general criticisms about the majority of the studies were that the samples were too small, the controls were not adequate, and that the statistical tests did not reflect advancing statistical techniques.⁶³ Perrin and Pierce note that most techniques used (especially in studies like Bacon, Renneker, and Culter), were "relatively unsophisticated techniques."⁶⁴ Perrin and Pierce believe that many of the supposed implications of the research represent theories which are constructed with a lack of hard evidence for them. For instance, they state that much theory is based upon anecdotal methods which allow nothing more than suggestion. When psychological tests were used, Perrin and Pierce are kinder, but still dubious, in their evaluation. In short, while they seem to be gratified for some of the pioneering work up to the writing of their article (1959), Perrin and Pierce believe that greater

⁶³George Perrin and Irene Pierce, "Psychosomatic Aspects of Cancer," Psychosomatic Medicine, XXI (September-October 1959), 411.

⁶⁴Ibid., XXI, 410.

statistical care should be taken in the formation of theories and results of research. Since the time of their article, much more research has been done. It should be noted that many of the studies reviewed in this chapter are products of the post-1959 period and indicate a greater degree of statistical sophistication than some of the earlier studies do.

In some instances, the original experiments have been duplicated and the results the second time have not been as significant as when the study was first done. For instance, Krasnoff attempted to validate the study by Blumberg, West and Ellis. In addition, however, Krasnoff used a sample of men and women with one kind of cancer, malignant melanoma, instead of Blumberg's sample of male patients with various different types of cancer.⁶⁵ Krasnoff found that in only eight of the twenty-two classifications did the criteria of the Minnesota Multiphasic Personality Inventory and the classifications of the Rorschach match the medical predictions of life expectancy. "Thus, the present investigation failed to confirm the previously reported findings."⁶⁶

Wheeler and Caldwell attempted to substantiate the findings of Tarlau and Smalheiser and found their generalizations to be too broad for their statistics. But these same researchers tend to confirm the general trends reported by Bacon, Renneker, and Cutler.⁶⁷ A study by

⁶⁵ Alan Krasnoff, "Psychological Variables and Human Cancer: A Cross-validation Study," Psychosomatic Medicine, XXI (July-August, 1959), 292.

⁶⁶ Ibid., XXI, 295.

⁶⁷ John Wheeler and Bettye Caldwell, "Psychological Evaluation of Women with Cancer of the Breast and of the Cervix," Psychosomatic Medicine, XVII (July-August 1955), 260.

Shrifte found the following: "Neither extent nor quality of underlying unpleasant feeling tension was a discriminator between those whose cancer was arrested and those whose cancer had continued."⁶⁸ Yet Shrifte himself is not too clear in his own statistical analysis. The point of this section is to show that there has been research which does not confirm some of the findings reported. There has also been criticism of the experimental methodology. The themes presented in this chapter are not to be considered as anything approaching the final word, but they are about all that is available in the area of studies of the psychological factors in the development of carcinoma. These studies represent the beginnings of an attempt at understanding, not the final dogma about cancer patients.

Discussion

Assuming the tentative nature of the research which has been presented in this chapter, the question still remains about how to interpret the general themes. It appears to this writer that there are at least four ways to interpret the data. The first alternative is to present the available data as the psychogenic cause for cancer. Given a sufficiently strong loss of an object, for instance, it might be theorized that cancer would develop as a non-adaptive symptom. Thus there would be postulated a psychogenic causality for the cancer process. A second alternative is reflected by Giovacchini and Muslin. They

⁶⁸Mirian Shrifte, "Toward Identification of a Psychological Variable in Host Resistance to Cancer," Psychological Medicine, XXIV (July-August 1962), 390.

postulate that the psychological characteristics of cancer patients are a result of an unconscious perception of the fact that something is wrong internally, that is, the growth of a malignant neoplasm. Thus the psychological characteristics, especially those reported in the section of this chapter about the lack of emotional discharge, are a result of the response of the personality to the cancer, not a cause of the cancer. "We are postulating, therefore, that at some level the patient was aware that something threatening was occurring inside of her and that the disruptive ego state was a reaction to the beginning carcinoma."⁶⁹ The authors do admit, however, that an alternative hypothesis is "that the emotional state is in some way implicated in the genesis of the neoplasm."⁷⁰

The third alternative is to assume a multiple causality of the disease, and to postulate therefore that there are both emotional and physiological causes in the development and progression of the cancer process. This would seem to be the general trend which the results of the animal experiments are taking. In short, there may be some sort of a propensity in the organism to cancer, but this cancer process is not set off until an emotional trauma or series of traumas begins the process.

A fourth alternative is to ignore the data, that is, to assume across-the-board statistical and psychoanalytic bias on the part of

⁶⁹Peter Giovacchini and Hyman Muslin, "Ego Equilibrium and Cancer of the Breast," Psychosomatic Medicine, XXVII (November-December 1965), 528.

⁷⁰Ibid., XXVII, 529.

the researchers. In this case, the cancer patient would be treated in a completely physiological way.

In any case, according to the researchers themselves, these results are only tentative. They reflect a beginning of study into the field and do not represent hard and fast results. At very best it could be said that there seems to be some relationship between the loss of a love object, the lack of ability to discharge emotions, a state of inner psychic tension in the development and continuation of the neoplastic condition, and that some psychological factors might be involved in the rate of growth of the cancer cells.

CHAPTER VI

JESUS, THE CHURCH, AND THE MINISTRY TO THE WHOLE MAN

Introduction

Of what use is the material found in Chapters I to V of this thesis to the Christian Church and its pastors? It is the purpose of this chapter to document the thesis that the ministry of Jesus was a ministry concerned with the total man, including man's bodily pathologies and his pathological relationship to God. The saving work of Jesus the Christ includes overcoming the results of the basic relationship to God which has been ruptured by man's sin. As the relationship to God is restored, so the symptoms of that broken relationship may be overcome and conquered. The Church in its ministry seeks to live-out and proclaim the victory which was won by Jesus the Christ. Therefore the Church is to follow the example of its Lord, both in proclamation and healing. The Church must be concerned with the total man, a physical-spiritual unity.

Disease and Illness in the Old Testament

The Chicago Area Study Group, in preparing their paper for the Consultation on Health and Salvation of the World Council of Churches, distinguished between "illness" and "disease." Illness was defined as "the experience of a person who has a disease."¹ This experience can

¹Chicago Area Study Group, "Health and Salvation," prepared for the Consultation on Health and Salvation of the World Council of Churches. Available from the Department of Ministry, National Council of Churches, p. 8.

be either beneficial or damaging. It can be either growth-producing or stifling. Disease, on the other hand, "is a derangement of structure or function, physical, mental, or social, which may be due to various kinds of causes."² Illness is the reaction of the person; disease is the pathological process itself. "Disease is always seen as evil, something destructive of human values, as something to be overcome."³

Basic to the concept of disease in the Old Testament is the story of the fall in Genesis 3. In Gen. 2:17, Yahweh gave man the freedom to eat of every tree in the garden except the tree of the knowledge of good and evil, "for in the day that you eat of it you shall die." When Adam and Eve ate from the tree, however, they did not die immediately. But the process which leads to death was begun.

In the sweat of your face you shall eat bread till you return to the ground, for out of it you were taken. You are dust and to dust you shall return.⁴

The process which leads to death, of which disease is a part, is a result of disobedience to God. In a pre-fall world, there was no disease. In the post-fall world, disease stands as a sign of the broken relationship of the creation with the creator.

Disease can also be a direct punishment for sin, in the thought of the Old Testament.

If you spurn my statutes, and if your soul abhors my ordinances, so that you will not do all my commandments, but break my covenant, I will do this to you: I will

²Ibid.

³Ibid., p. 9.

⁴Gen. 3:19.

appoint over you sudden terror, consumption, and fever that waste the eyes and cause life to pine away.⁵

Yahweh promises health, instead of the diseases which he inflicted upon the Egyptians, "if you will diligently harken to the voice of the Lord your God, and do that which is right in his eyes, and give heed to his commandments, and keep all his statutes."⁶ Even though Yahweh can send disease and Yahweh can cure disease, the theological assertion about disease throughout most of the Hexateuch is, "all the disturbances in our natural life have their roots in a disturbed relationship to God."⁷

Disease, and the individual experience of disease in illness, is a result--a symptom--of a broken relationship between man and God. Sometimes Yahweh inflicted the disease process upon people for their disobedience to him. The book of Job, however, brings into question any generalizations about the retributive idea of sickness. "There is no answer here as to why a good man suffers. Instead, there is the experience of the redemptive presence of God in the midst of the suffering."⁸

Man is sick in his relationship to God because of the fall and because of man's constant disobedience to God. Man is sick in body

⁵Lev. 26:15-16.

⁶Ex. 15:26.

⁷Gerhard von Rad, Old Testament Theology (Edinburgh: Oliver and Boyd, 1962), I, 275.

⁸Chicago Area Study Group, p. 10.

because the whole cosmos is "out of kilter."⁹ The process of death began with the fall, a form of this process being disease. Disease, then, is a result of a basic malady. It is a symptom of the sin that needs healing. Therefore the Psalmist could write: "O Lord, be gracious unto me; heal me, for I have sinned against Thee."¹⁰ Because disease is a symptom of the gulf in the relationship between man and God, it would be expected that Jesus would deal with disease in this light.

Jesus, the Healer

It is obvious from the biblical accounts of Jesus' life that he was interested in the alleviation of "this-world" pathologies as well as "saving souls" for the next world. He is interested in both the root cause of man's malady and the results of that root cause. Healing is so much a part of the ministry of Jesus that Matthew mentions healing miracles in a parallel position to the actual preaching of the Gospel.

Jesus went all over Galilee, teaching in their meeting houses, preaching the Good News of the Kingdom, and healing people from every kind of disease and sickness.¹¹

Practically the same sentence structure is found in Matt. 9:35. Jesus' career is described in terms of teaching, preaching, and healing. In addition to the two instances of the dead being raised by Jesus, there

⁹Meinert H. Grumm, "Biblical Study Toward a Theology of Healing," Selected Papers of Interest to Participants in Medical Mission Study Program (Chicago: Wheat Ridge Foundation, n.d.), p. 64.

¹⁰Ps. 41:4.

¹¹Matt. 4:23.

are twenty-six instances of healing by Jesus reported in the Gospels, "three of these involving more than one person."¹² All of the Gospels speak of Jesus as a healer. He is the great physician, as Luke records that "the power of the Lord was present for Jesus to heal the sick."¹³ He also states that people came to hear him and to be healed of their diseases. "All the people tried to touch him, for power was going out from him and healing them all."¹⁴ Luke even has Peter say: "He went everywhere, doing good and healing all who were under the power of the devil, for God was with him."¹⁵ At least in part, therefore, the work of Jesus the Christ included the healing of physical and/or mental illness and disease.

The manifestation of healing through Jesus' ministry is seen as the demonstration of the coming of the Kingdom of God. Healing represents the sign that once the basic malady has been healed, the results of that malady may also be healed. Healing is the sign of the Messianic age. According to Luke, Jesus proclaimed: "This passage of scripture has come true today, as you heard it being read,"¹⁶ after he had read from the prophet Isaiah.

¹²United Presbyterian Church in the USA--Board of National Missions, The Relation of the Christian Faith to Health (New York: Presbyterian General Assembly, 1960), p. 13.

¹³Luke 5:17b.

¹⁴Luke 6:19.

¹⁵Acts 10:38b.

¹⁶Luke 4:29.

The Spirit of the Lord is upon me. He has anointed me to preach the Good News to the poor, He has sent me to proclaim liberty to the captives, and recovery of sight to the blind, to set free the oppressed, and to announce the year when the Lord will save his people.¹⁷

Jesus again alludes to the prophet Isaiah when he replies to the questions which were posed to him by the disciples of John the Baptizer.

Go back and tell John what you have seen and heard; the blind can see, the lame can walk, the lepers are made clean, the deaf can hear, the dead are raised to life, and the Good News is preached to the poor.¹⁸

Matthew points out especially that Jesus "healed all who were sick" on a given evening, "to make true what the prophet Isaiah said, 'He himself took our illnesses and carried away our diseases.'"¹⁹

As Meinert Grumm observes, "This wide-ranging ministry of healing and deliverance was the fulfillment of the promise that the son of righteousness would arise with healing in its wings, that the age of the Messiah had come."²⁰ Grumm also notes that so central are the works of healing to the ministry of Jesus, that there are found in the first chapter of Mark more miracles of healing than are found in the entire Old Testament.²¹ With the demonstrations of the power of Jesus to heal,

¹⁷Luke 4:18-19.

¹⁸Luke 7:22.

¹⁹Matt. 8:17.

²⁰Grumm, p. 6.

²¹Ibid., p. 7.

the Gospel writers make it plain that "with Him the kingdom of God has broken into this suffering world."²²

While healing is to be considered an integral part of Jesus' ministry, it is not to be considered the only part of his ministry. Jesus refused to continue his healing ministry in Capernaum, for instance, because he had to go to other cities. "I must preach the Good News of the Kingdom of God in other towns also, for that is what God sent me to do."²³ At times Jesus would retreat to a "lonely place" in order to pray, despite the fact that as his fame increased, "the crowds of people came to hear him and be healed from their diseases."²⁴ At times, when there is individual need, Jesus helps, apparently out of his love and mercy, not necessarily as a response to the faith of the people. Matthew records instances like this when he states: "Jesus got out of the boat, and when he saw the large crowd his heart was filled with pity for them, and he healed their sick."²⁵ In mercy he heals as a sign of the coming of the Kingdom of God. It is a sign that the basic malady of man, his relationship to God which has been broken, is being overcome. The sign--healing--is not, however, his total ministry.

In addition to the healing miracles being a sign of the coming Kingdom, Luke also records that at least one incidence of healing was

²²H. M. Beyer, "Therapeia, therapeo, therapon," Theological Dictionary of the New Testament (Grand Rapids, Michigan: Wm. B. Eerdmans Publishing Company, 1965), III, 131.

²³Luke 4:43.

²⁴Luke 5:15.

²⁵Matt. 14:14.

used by Jesus as a sign that he could forgive sins. "'I will prove to you, then, that the Son of Man has authority on earth to forgive sins.' So he said to the paralyzed man, 'I tell you, get up, pick up your bed, and go home.'"²⁶ Physical healing becomes a sign here for an invisible healing, the forgiveness of sins. This immediately puts the emphasis on the restoration of a right relationship with God through the forgiveness of sins, rather than placing the emphasis on the healing itself. In attempting to make clear this distinction, both Grumm and Scharlemann cite the example of Jesus curing the ten lepers. All ten were "healed" (iaomai); yet only one was "made well" or "saved" (sodzo). This was the one who returned to Jesus "praising God with a loud voice."²⁷ Jesus apparently wanted gratitude to God shown for healing "in order that the physical benefit may not be unaccompanied by spiritual blessing."²⁸

Since Jesus is called "Jesus," according to Matthew, because the name means that "he will save his people from their sins";²⁹ since Jesus states that the Son of God was not sent "into the world to be its judge, but to be its Savior";³⁰ and since Jesus' initial proclamation was: "The right time has come . . . and the Kingdom of God is near! Turn away from your sins and believe the Good News!"³¹--the ultimate purpose

²⁶Luke 5:24.

²⁷Luke 17:15b.

²⁸Albrecht Oepke, "iaomai, iasis, iara, iatros," Theological Dictionary of the New Testament, III, 208.

²⁹Matt. 1:21b.

³⁰John 3:17.

³¹Mark 1:15.

of Jesus' ministry was to effect a reconciliation between God and man, through the forgiveness of sins. If the main cause is cured, then the results, or symptoms, are also cured. Healing becomes a pen-ultimate sign of the ultimate healing of the relationship between God and man.

Physical cure is one item among many that belongs to a syndrome of values less than ultimate. A cure does not necessarily result in healing understood and restoration into a working relationship with one's God as creator and redeemer.³²

Healing can be the beginning or a continuation of a process which culminates in a total right relationship with God, that is, salvation. Although "almost a third of the New Testament references to salvation are to restored functions of body, mind, or spirit,"³³ the majority of the New Testament references to "salvation" (soteria) have to do with deliverance from sin and death, especially in Paul who always conceives of salvation as being only partly realized with its full impact still in the future.³⁴

From the Christian standpoint, man's fundamental need is not merely health as described in the classic ideal of "a sound mind in a sound body." Man's need is deliverance from divine condemnation and acceptance into divine fellowship.³⁵

Physical cure, healing, can become an opportunity, not only to be

³²Martin H. Schlaremann, "Salvation," prepared for the Consultation on Health and Salvation of the World Council of Churches, held in Chicago on April 3-4, 1967. Available from the Department of Ministry, National Council of Churches, p. 1.

³³United Presbyterian Church, p. 14.

³⁴1 Cor. 5:5; 10:33.

³⁵United Presbyterian Church, p. 14.

restored to physical health, but to begin a process which culminates in wholeness or health which is possible only with a right relationship to God.

The Church and the Task of the Pastor

The concern for healing did not end with the end of Jesus' ministry, according to the biblical writers. While he was yet living, Jesus sent out disciples to do the same three things that he had been doing: teaching, preaching, and healing. "So they went out and preached that people should turn away from their sins. They drove out many demons, and poured oil on many sick people and healed them."³⁶ The church continued a ministry to the whole man as it continued to perform healing miracles. Peter attracted many people "bringing their sick and those who had evil spirits in them; and they were all healed."³⁷ In all, "seven individual healings by the apostles are mentioned."³⁸ Apparently healing was a part of the work of preaching for the apostles, since they decided to devote themselves full-time to "prayer and the work of preaching."³⁹ That the apostles did heal bodily disease reflects, first of all, that they too were participating in the healing that comes through a restored relationship to God and which has as its possible effect the healing of bodily disease. Secondly, the apostle's healing reflects

³⁶Mark 6:12-13.

³⁷Acts 5:16.

³⁸United Presbyterian Church, p. 25.

³⁹Acts 6:4.

their attempt to follow in the steps which Jesus followed, preaching, teaching, and healing.

It is the biblical understanding which has been demonstrated which makes the first five chapters of this thesis relevant to the Church and its pastors. The Church follows its master in its functions and its activities; it preaches, teaches, and heals. In its healing function it knows that just as disease came as a sign of the degeneration of creation as a result of man's sin, so healing of disease comes as a sign of the restoration of creation as a result of the obedience of Jesus the Christ. Bodily healing is a pen-ultimate concern, in that it serves as a sign of the ultimate concern, reconciliation with God. Yet as Jesus' ministry was to the whole man, so the church's ministry is to the whole man. The church, in carrying out Jesus' commission and in witnessing to the action of God in Jesus, has a place in healing.

On the one hand, the church expresses its concern for the whole man in its ministries of healing, including medical missions, social work agencies, and pastoral counseling. It expresses its concern for man who experiences manifestations of evil and sin and expressions of the demonic powers in the form of disease which is destructive of human values and potentials. Yet, on the other hand, all forms of physical healing and restoration of bodily wholeness eventually fail, for death comes to all. In Jesus' ministry there is always an added ultimate dimension. Healing, insofar as it exists, is a "this-worldly" function, a sign which points to an ultimate reality. Healings exist here and now. Salvation, the restoration of a right relationship to God, extends past the "here-and-now" into an eternal dimension. This

is especially clear in Paul's writings. Healing, in a Christian context, is not true healing or wholeness unless it takes in the added dimension of "salvation."

As the church and its pastors use the theory and research developed in the first five chapters, it will do so with a dual emphasis: (1) It simply wishes to follow its teacher in his concern and compassion for the whole man, and (2) it wishes to point beyond the individual action of healing to the full healing or salvation that takes place as a result of God's love in Jesus the Christ. Therefore the full healing of the man-God relationship is termed "salvation." Physical healing is a prototype or sign of the ultimate healing of a ruptured relationship to God effected by Jesus the Christ.

The Coonoor Conference

In March of 1967, forty men and women met in Coonoor, South India, "to re-examine the church's involvement in healing."⁴⁰ This meeting was sponsored by the Lutheran Church--Missouri Synod and the Wheat Ridge Foundation. The conclusions of this conference are parallel conclusions to those of this chapter. The summary statement of this conference substantially agrees with the thesis of this sixth chapter.

The whole creation groans in its need for deliverance. A study of the biblical view of illness and of Christ's ministry of healing forces us to see this need in the broadest of terms. This was the basic insight of the

⁴⁰Thomas A. Droege, "The Healing Mission of the Church: A Report on the Findings of the Coonoor Conference," Concordia Theological Monthly, Occasional Papers Number 2 (St. Louis: Concordia Publishing House, May 1968), p. 5.

conference on this topic. All other findings of the conference were rooted in a broad and inclusive definition of illness. Sickness, brokenness, and death--all are linked together as symptoms of the common need for deliverance.

Distortions which pervade every level of man's being and everything in the world are all aspects of the same sickness. This fact is sometimes clouded by a sharp dualism people have been drawing between material and spiritual reality. This dualism agrees neither with the biblical nor the contemporary view of illness and healing. The church has often divorced man's spiritual sickness from his physical suffering and social ills. Sometimes the church has been concerned about the physical only to get at the spiritual. In this event, the church shows less than total concern.⁴¹

In this paper, this author has placed the emphasis on disease in body as a sign of the greater disharmony, a broken relationship between man and God. The former is a type of the latter. The former is penultimate; the latter is ultimate. The Coonor Conference sees all distortions as aspects of the same sickness: man's misuse of "his freedom to cut himself off from God."⁴²

In discussing healing, the Coonor Conference concluded:

Not only the ministry of Christ but also His death points to the unitary nature of His healing. Christ's death not only healed and atoned; it reconciled. All reconciliation and healing flows from His reconciliation. The Lord of all creation participated in our agony, sickness, and death. He gained victory for the whole of creation.⁴³

Once again, the emphasis in this paper is a healing in body as a sign of the greater healing--a reconciliation between man and God. The former

⁴¹Ibid., p. 8.

⁴²Ibid., p. 9.

⁴³Ibid., p. 11.

is penultimate; the latter is ultimate. A true sign, however, participates in the reality of that to which it points. The unity of the healing process is affirmed by both the Coonoor Conference and this author.

Read in the light of the theology of the cross, "the continuous and victorious encounters with the powers that deny the existence and goodness of God" must be of a piece with the victorious encounter of Christ with the powers of evil, an encounter that cannot be understood apart from the willingness to take up the burden of the other. Thus Christ's command to heal becomes for the Christian the imperative to work for the restoration of true wholeness for every sort and condition of men. The Tübingen definition of health will not let us subsume all human virtues under "health" or place health at the top of the whole ladder of human virtues. To regard harmony as the goal of the healing mission is, at best, to be shortsighted and unchristian. At worst, it is to foster irresponsibility, egocentricity, and self-satisfied complacency.⁴⁴

Healing is not equivalent to salvation. Yet, "whether manifested corporately or individually, healing is a first fruit of that ultimate perfect health and restoration in the resurrection life."⁴⁵

The conclusions of the Coonoor Conference are parallel to the conclusions of this chapter. Now that the theological basis has been established for the use of the data found in the first five chapters in the healing work of the pastor, the question remains: How can the pastor use this data to best fulfill his healing and proclaiming function as he ministers to the cancer patient (or, in a broader context, the "psychosomatic" patient)? This will be the burden of the next chapter.

⁴⁴Ibid., p. 15.

⁴⁵Ibid., p. 25.

CHAPTER VII

THE PASTOR AND THE DATA

Introduction

The theoretical formulations which have been examined earlier in this paper have given rise to the following hypotheses, all of which have some empirical support: (1) By definition, since a Christian pastor's ministry as well as the total ministry of the church are ministries which follow the example of Jesus Christ, ministry concerns itself with serving here and now, even if only in pen-ultimate terms. Bodily or psychological healing is a sign of the greater healing of the relationship between God and man, yet the church has a legitimate concern in this area for its own sake, not just for the sake of the reality to which healing points; (2) By the very nature of the word "psychosomatic," it is realized that every illness has certain psychological effects, regardless of how "organic" the aetiology of the illness may be; (3) It is possible that there are psychological factors in the aetiology of disease, including carcinoma. One attempt to explain the development of cancer is that it is an attempt to replace a lost love object on an unconscious, symbolic level. In addition, one characteristic of a cancer patient is that he has difficulty expressing and discharging emotional feelings; (4) There is some empirical support to suggesting a combination of factors, including family and vocational environment, contribute to the development and progression of the disease process of cancer.

This chapter will attempt to draw out some implications of the previous chapters for the ministry of the parish pastor. As such, this is not a research chapter, but represents some logical steps for the pastor to take with the data. This chapter is not designed to be exhaustive. It expresses a beginning in the process of using "secular" research in the service of the church and its ministry to people.

The Goal of Pastoral Care

Carroll A. Wise is an early pioneer in exploring the meaning of pastoral care to a person suffering from an illness. His book, Religion in Illness and Health (published in 1942) was already discussed in Chapter III. In a new book, published in 1966, The Meaning of Pastoral Care, Wise elaborates upon the place of the pastor as a "medium of healing rather than of condemnation."¹ For Wise, "pastoral care is the art of communicating the inner meaning of the Gospel to persons at the point of their need."² Several words in this sentence need close scrutiny. What is the Gospel?

The Gospel, then, is a Person and through this Person, a living relationship with God. The Gospel was embodied in a Person whose relationships with men have been taken to reveal the redemptive, reconciling relationship which God offers all men. . . . This new relationship results in a new sense of being which enables them to move toward discovering and becoming the persons they are potentially. The suffering of Christ speaks of an aspect of the nature of God which reaches out to man on the level of his own

¹Carroll A. Wise, The Meaning of Pastoral Care (New York: Harper and Row, 1966), p. 9.

²Ibid., p. 8.

deepest suffering, the anxiety caused by alienation from God. The Gospel is Christ himself and the power of the new relationship that God has offered to men through Christ.³

What is "the point of need" for Wise? Wherever there is something which defeats man's purpose; wherever there is something which robs man of his privacy, uniqueness, awareness, and autonomy;⁴ whatever keeps man from fulfilling himself as a child of God made in the image of God; from all these man seeks deliverance. He finds this deliverance in the inner meaning of the Gospel, as he becomes more truly and fully what he was intended by God to be. The central need of a person is that he "become himself, to fulfill the image of God within him, to give actuality to the potential for which he was created."⁵

Within a Lutheran context, this author would place all those forces which keep man from a right relationship to God, himself, and his neighbor, as potential proclamations of the "Law." That which speaks to man to inform him that creation is not in a harmonious relationship to God (and therefore that he is not in a right relationship to God either) is "Law." That which overcomes the disharmony and creates wholeness, beginning with a reestablished relationship to God, is "Gospel." That which keeps man from this wholeness is an evil from which he has been delivered by the action of God in Jesus the Christ.

On a human level, if a man's need is that he is (and feels!) guilty before God for his offenses against God's ordinances, the Gospel heals

³Ibid., p. 10.

⁴Ibid., p. 53.

⁵Ibid., p. 38.

the guilt and restores a harmonious relationship between God and man. In theological terminology, this is the forgiveness of sins. There are other basic needs, however. There is a deep need for community and fellowship--a genuine communion of man to man. Christian community established in the name and for the sake of Jesus overcomes alienation and loneliness. The Gospel here could be a reconciling person or community which can, in the name of Jesus, establish a genuine relationship and communion with this person. In theological terms, this is the working-out of the doctrine of the body of Christ. Thus, pastoral care is aid to a person in overcoming all those things which bind him and keep him in subjection, which keep him from becoming what God in Christ would have him be.

The goal of pastoral care is that the person become a more fully-functioning person. This implies establishment of a right relationship with God, dealing with the fact of an illness and death, and seeking to restore wholeness through healing. In the case of cancer, the pastor needs to be sensitive to the possible causes of the illness within the intrapsychic conflicts of the patient and within his environmental structure, to the necessity of facing the illness in terms of its possible terminal aspects, and to the patient's personal relationship to God. In order to mediate the ability to become a more fully-functioning person, the pastor needs certain qualities in his pastoral care.

R. A. Lambourne adds some insight into this process of pastoral care when he isolates the order of events of an illness. For the purposes of this thesis, the onset of cancer is assumed.

- A. The crisis occurs. The bare historical event.
The bare clinical event.
- B. God proclaims, through conscience, priest, prophet, wise man or representative head, that the crisis is a symptom of wrong relations between men, and between God and men.
- C. God calls for response, for insight, repentance, and putting right what has gone wrong, and he makes it plain that good responses will lead to a mature relation with Him, and that bad responses will lead to alienation or breakdown.
- D. The immediate symptoms of the present cosmic disorder, the specific evil, the disease, or whatever we like to call the crisis, are not necessarily rectified by a good response, but the cosmic disorder is always lessened, and history moves towards God's end for it, towards man's salvation.⁶

Of course, this progression of events must remain on a dynamic level, and is not to be treated as a course of events to be imposed on the patient. The basic goal of pastoral care, however, remains clear. Postulating a unitary concept of man, that a man become a more fully-functioning person means that he become whole--in relationship to God, to himself, and to his neighbor.

The goal of this type of pastoral care which is proposed is not always healing, in the sense of the cure of a particular illness. Perhaps the cancer has progressed beyond the point of reversability. In this case, to be a fully-functioning person means to deal with the question of death and eternal life. If the cancer has a psychological cause, the goal would include overcoming the destructive causes of the carcinoma to effect a reversal of the process, probably combined with a

⁶R. A. Lambourne, "What is Healing?" Selected Papers of Interest to Participants in Medical Mission Study Program (Chicago: Wheat Ridge Foundation, n.d.), p. 30.

surgical operation to remove the malignant cells. The specific goal of this pastoral care is different with each case. Once again, the broad goal is clear: that a person become a more fully-functioning person, dealing with the realities of his situation in relationship to God, himself and his neighbor.

General Principles for Pastoral Care of a Cancer Patient

According to the development of this thesis, for a pastor to assume that when he ministers to a patient with cancer he is dealing with a person who has only an organic disease which bears no relation to his own personhood, is a false assumption. The cancer process is not simply an "attack" of something external to the individual. At the very least the cancer is having an effect on the person. Perhaps its aetiology is a psychological one. In short, the pastor recognizes that he is dealing with a person in whom the disease process of cancer may be symbolizing a deeper psychological process or in whom the growth of the cancer is effected by the patient's environment. The first general principle for the pastor who wishes to minister is that he develop a sensitivity for listening to the actual communications of the patient. Consider Pastor A. making this call on a cancer patient.

Pastor A.: Good afternoon, Mrs. C. How are you?

Mrs. C.: Oh, not very good today. I've been depressed a lot. But that's not unusual. Ever since my son died I haven't felt right.

Pastor A.: You really shouldn't feel depressed about your son's death. After all, he was killed fighting for his country in Viet Nam. He died for his country and you should be proud of him.

Mrs. C.: Yet, I suppose I should be.

Pastor A.: For your comfort, today I would like to read a section from scripture which tells about Christ being the resurrection and the life. . . .

Pastor A., in this brief capsule interview, missed the communication of the patient. Somehow the depression which Mrs. C felt was not proper, according to Pastor A.'s responses. He told her how she should be feeling; he did not examine how she was feeling. Pastor A missed the element of "loss." Having developed a certain amount of sensitivity in listening, the conversation might have gone in a different direction.

Pastor A.: Good afternoon, Mrs. C. How are you?

Mrs. C.: Oh, not very good today. I've been depressed a lot. But that's not really unusual. Ever since my son died I haven't felt right.

Pastor A.: You have felt down in the dumps for awhile.

Mrs. C.: I certainly have. You can't understand what it means to a mother--to me, when my son was killed in Viet Nam.

Pastor A.: You being a mother who has lost a son--makes you feel kind of empty inside.

Mrs. C.: Yes, all of a sudden it hits you that you will never see him again.

Here Pastor A.'s recognition of Mrs. C.'s feelings, and his willingness to deal with them, enabled her to ventilate her feelings. He was sensitive to her communications and responded to them. Perhaps this interview, or subsequent ones, could then be used to explore Mrs. C.'s feelings of loss concerning her son.

Related to the development of sensitivity to listen to the real communications of the patient is an ability to accept the feelings of the patient. The development of carcinoma, according to some theorists, can be related to the loss of a significant love object. This feeling of loss can extend to all personal relationships, since "loss" can be generalized to many other relationships. Even in areas where the pastor might have strong feelings himself, it is the patient's feelings which are important and need to be understood.

- Mrs. C.: It seems that I am all alone, even though there are many people around me. I feel sometimes that even God has left me.
- Pastor A.: There is no need to feel that God has left you, since he has promised, "Lo, I will be with you, even unto the end of the world." God is always with you, so you don't have to feel alone.
- Mrs. C.: I suppose that I shouldn't feel that God has left me, but I do.
- Pastor A.: Well, God doesn't leave you, regardless of how you may feel. Let us pray that you might realize the true presence of God with you even here in this hospital room today.

Pastor A. was more concerned about defending God's promise than he was to listen and to accept Mrs. C.'s feelings of loss which extended to her relationships to others, even to God. Being able to accept Mrs. C.'s feelings about even God deserting her, thereby not feeling it necessary to defend God, Pastor A. might have been able to explore her feelings concerning the loss of her son.

- Mrs. C.: It seems that I am all alone, even though there are many people around me. I feel sometimes that even God has left me.
- Pastor A.: Sometimes you feel alone, even feel that God has left you alone.
- Mrs. C.: It's terrible to feel alone. It doesn't seem like I really have anybody to turn to that is really concerned about me.
- Pastor A.: When you think people don't care, that makes you feel more alone than ever.
- Mrs. C.: Oh yes. It is something like I felt first when my son died in Viet Nam.

By being able to accept the patient's communications, even when they were directed negatively at God, Pastor A. might be able to explore the feelings of loneliness which at present Mrs. C. is experiencing. Acceptance is available for both the positive and the negative feelings.

It is easy for the pastor or anyone to accept positive feelings, such as high resolutions about how the patient will live life once he is well. It is difficult for pastors as well as others to accept negative feelings, such

as resentment against God for an illness. However, if sick persons are encouraged to discuss these negative feelings, then there is a greater chance of altering them.⁷

An emphasis upon "acceptance" of a patient's feelings has been emphasized in psychological circles by Carl Rogers, among others. There have been recent attempts by some theologians to give acceptance, which is a therapeutic necessity for the pastor, a theological undergirding in the doctrine of the atonement. Thomas C. Oden offers a syllogism which is central to this school of thought.

(A) If, in order to be effective, psychotherapy must mediate an accepting reality which is grounded in being itself; (B) if the accepting reality in being itself has disclosed itself in an event to which the Christian proclamation explicitly witnesses; then (C) the implicit ontological assumption of all effective psychotherapy is made explicit in the Christian proclamation.⁸

The accepting reality already exists; it has been revealed in the action of God in Jesus the Christ. Thus, an illness is a sign of the greater illness in the relationship between man and God, so the acceptance which a person finds in an accepting counselor "only points to an acceptance that has its source beyond himself."⁹ According to Oden's position, acceptance of the patient's feelings and an "unconditional positive regard"¹⁰ for the patient are not just good therapeutic techniques,

⁷United Presbyterian Church in the USA: Board of National Missions, The Relation of Christian Faith to Health (New York: Presbyterian General Assembly, 1960), p. 47.

⁸Thomas C. Oden, Kerygma and Counseling (Philadelphia: Westminster Press, 1966), p. 24.

⁹Ibid., p. 22.

¹⁰This phrase was introduced by Carl Rogers.

but they are grounded in the basic reality of God who, in an act of unconditional positive regard, disclosed himself in Jesus the Christ.

A similar position is postulated by Don Browning. For Browning, the therapeutic relationship contains two aspects: (1) unconditional positive regard, which is an active process of "positively caring for what the client is feeling,"¹¹ and (2) empathy, which is a passive process of participating in the feelings of the client. These together form "unconditional emphatic acceptance."¹² The relationship of a therapist to a client is "an active relationship in that it conveys a positive regard or caring for the feelings of the other. Yet it is a passive relationship in that it conveys this caring by receiving or feeling the feelings of the other as the other feels them."¹³

When the pastor who is ministering to a cancer patient conveys these attitudes toward his patient, he is doing two things. He is providing an atmosphere in which the feelings of the person can be confronted and discussed. Secondly, he is pointing to the reality of God who manifests these characteristics on an ultimate level. It is God's reception of all of man's feelings, even negative ones, "that makes it possible for man to realize that there are no conditions placed on his worth."¹⁴

Listening is important in pastoral counseling to a cancer patient in order to understand accurately the feelings of the patient. Listening,

¹¹Don S. Browning, Atonement and Psychotherapy (Philadelphia: Westminster Press, 1966), p. 127.

¹²Ibid.

¹³Ibid., p. 175.

¹⁴Ibid., p. 204.

therefore, implies a sensitivity to both verbal and non-verbal communications. Listening and acceptance are mutually necessary so that the pastor might truly "hear" the communications of his patient that he might by this stance of unconditional emphatic acceptance, provide a good therapeutic environment and communicate the ultimate acceptance of God. A pastor can develop a sensitivity to listen and an ability to accept both positive and negative feelings to the extent that he himself is a total person, that is, one who has matured in his own personality. As he has understood and recognized his own emotions, and dealt with them, the pastor can communicate real feelings as he receives them from his patient. Fundamental to any ministry to a cancer patient are these qualities.

There are many vocations which aid a person in becoming a more fully functioning person. A nurse may aid in promoting maximum use of the facilities available in the hospital; a doctor may serve to remove the cancerous growth; an orderly might help facilitate normal physiological functions. What is the unique task of the clergyman as he ministers to the cancer patient? That the pastor points to the reality of the spiritual has already been discussed above. As a follower of Jesus the Christ he points to the symbolic nature of illness and healing, in relationship to their cosmic dimensions, while facilitating this-worldly healing. The pastor, by his unconditional emphatic acceptance, points to the ultimate form of acceptance as an attribute of God. In this atmosphere emotional feelings, long repressed or suppressed, might be expressed. The pastor aids growth, so that the individual might be more fully what God in the Christ would have him to be.

In this manner the pastor represents to the patient a world-view which does place healing and sickness in a total, theological perspective. He also is in a position, by his knowledge of the whole man, to minister effectively to the needs of the whole man. How, specifically, the theoretical and experimental studies related in Chapters III to IV can be used by the pastor in his ministry will be the subject of the next two sections.

Principles from the Specificity Theories

Central to the working of most specificity theories, especially those which have a Freudian base, is the concept of repression. Important emotional conflicts and feelings may be repressed, that is, pushed into the unconscious. Out of the unconscious these repressed emotions find expression in somatic pathology. In his ministry to the patient, a pastor can be aware of the possible existence of such repressed feelings. The pastoral ministry which consists exclusively of devotion and prayer does not give opportunity for the expression of some of these feelings. Listening and accepting are necessary before a patient will gain the "courage" to deal with some of those underlying conflicts. An obvious implication of this theoretical construct, therefore, is that the pastor is alert to the possibilities of repressed emotional conflicts in his patient who is experiencing an illness.

Repressed feelings still determine behavior, except they, unlike conscious feelings, are not perceived on a level of conscious awareness. The person is being motivated by forces within his own personality of which he is unaware. The problem is, therefore, that the patient does

not consciously perceive the causes of some of his behavior, perhaps even the causes of his illness. There are ways of helping unconscious material become conscious. Freud called dreams the royal road to the unconscious. The meaning of dreams can be a valuable aid.¹⁵ Free association is a psychoanalytic-therapeutic tool for discovery of the unconscious processes. An illness, including development of a cancer, could be a symbolic communication of an unconscious process, centered in a series of repressed feelings and drives. Sensitivity to this symbolic communication might enable the pastor to help the patient recognize his communication (insight) and deal with the processes involved (adaptation and change).

Men like Alexander, Menninger, and Ruesch represent elaborations on the theme of the organization of the repressed material. Alexander postulates organ vulnerability which develops in a stress situation. The pastor is alert, thereby, to the possibility of an emotional crisis previous to the onset of the cancer. Given an environment which is accepting, as the pastor in his relationship with the patient gives, the emotional crisis may be worked through. According to Menninger's system, the erotic or creative impulses must be aided to overcome the destructive impulses. The pastor, being on the side of creativity, is in a position to aid this. For Ruesch, the infant personality must grow to an adult personality, for healing to result. In all these systems, the pastor remains on the side of the development of the ego, aiding a person to

¹⁵ See Eric Fromm, The Forgotten Language (New York: Grove Press, Inc., 1951).

overcome the conflicts and deal with them, making an acceptable solution both to himself and to society.

Some research with cancer patients has pointed out that there is a great deal of repressed material which the cancer patient is incapable of expressing. This characteristic is called "diminished emotional discharge." The pastor, perhaps more than anyone else in the hospital, has the opportunity to sit with the patient for a long enough time that the patient may have time to begin to express his feelings, given an open enough environment with a pastor who allows this kind of communication. The pastor can encourage the patient to express what he feels, in addition to aiding him in clarifying his emotional conflicts.

This task may be illustrated by the following interview. After some time in counseling, the patient, Mrs. C., makes the following statement:

Mrs. C.: You know, it suddenly strikes me--I really don't know how to put it--that sometimes my husband really makes me angry. Like the way that he came to visit me today. He acts like I am some sort of a child.

If this statement by Mrs. C. were an attempt to see if emotions could be expressed freely, then a response which accepts the emotional feeling is crucial for any further ability of Mrs. C. to express emotion.

Pastor A.: When your husband pampers you and treats you like a baby, you feel angry.

This response would catch Mrs. C.'s feeling, having the effect of being an understanding response which encourages her to express more of her feeling. A quick way to stop any more attempts at communication of feelings would be the following:

Pastor A.: I am sure that your husband was only trying to be helpful.

Mrs. C. would have discovered once again that it does not pay to express an emotional feeling. Her characteristic inter-personal patterns once again are repeated with the pastor. She dares not express what she is really feeling. If, however, the pastor allows the emotion to stand, that is, to accept it emphatically, then the patient will come to feel that emotions can be expressed. This changes the pattern to a more growth-producing one.

A theological concept which might be helpful is the "forgiveness of sins," whereby the church understands that there is no emotional feeling which is not forgivable. Emotional feelings can be expressed freely and dealt with, under the forgiving grace of Jesus the Christ. Forgiveness of sins is not an abstract doctrinal formulation, within this definition. It is not the mere verbal confession of wrong-doing and the verbal pronouncement of forgiveness. In order to meet the need, the forgiveness must reach the basic point of the origin of the guilt. This may, in Freudian terms, stem from an unresolved oedipal conflict or from an earlier unresolved conflict or fixation at some other developmental point. Forgiveness is a dynamic concept which reaches to the core of the problem. The pastor is not content with the superficial recital of forgiveness. Even within the theological formulation of the "forgiveness of sins," it could be the pastor's ability to accept all kinds of emotions which may be the crucial factor in whether or not the patient actually feels forgiven. A pastor may not be able to act forgiving, thereby mediating the forgiveness of God, if he is not able to be an accepting and emphatic person. After the mediation of forgiveness

the pastor may be able to explore with the patient appropriate ways that the patient's emotional energy could be discharged effectively. Among these ways are various avenues which serve to sublimate and/or gratify the basic needs involved.

One aetiological consideration for the development of cancer is that cancer is a symbolic manifestation of the attempt to regain a lost love-object. Examples of the beginning stages of handling this are included in the previous section dealing with acceptance. The implications of this theory include the fact that the pastor is sensitive to this possibility with his patient who has developed cancer. As he is sensitive to this he might be able to help the patient to deal with his fact of loss and substitute another real object for the lost one. Among the theological concepts that might be helpful are the idea of the resurrection of the dead, thereby indicating that the one "lost," in the case of death, is not "lost" forever, and the priesthood of all believers, whereby the patient might redirect his activities, his psychic energy, for the benefit of those who might need his help.

For a theorist like Booth, the fundamental problem in connection with the loss of a love-object is the basic personality of the individual. The patient desires to control persons so that they become an extension of himself. This indicates, something like Reusch's theory, that the patient is operating on a very infantile level. Therefore, a doctrine which is proclaimed, such as the resurrection of the dead, may be used pathologically by the patient in the hopes that in eternity he will regain control over his lost love-object. The stance of the pastor could not be to foster this way of thinking by a straight proclamation

of the resurrection of the dead. In that case a good theological doctrine would contribute to the pathology of the patient. The pastor would desire to deal with the inner core issue, that of the desire to control people. Depending on the amount of time available, he may do this by being a person who will not play the "game" with the patient. The pastor will not submit to being controlled. If the pattern of the patient's behavior is that he desires to control people, he will also attempt to do the same with the pastor, probably operating on an unconscious level. The pastor responds by not following this pattern. Hopefully, the patient will be able to deal with his inability to control and the reasons why control is a necessity for him. In this case, growth will be the result.

Renneker postulated the emotional circle: oral frustration destructive rage → turning against self → depression → oral frustration. The frustration comes from an inability to control the desired love-object. The task of the pastor is to explore with the patient the causes of the frustration, in the hopes that a better way will be found to deal with the frustration.

Other words used to describe the emotional states of cancer patients include the words despair, anxiety, frustration, and hopelessness. There is no pastoral anecdote for negative emotional feelings. The "theology of hope" is not meaningful, for instance, if it is simply proclaimed apart from the genuine emotions of the situation, contrary to the position of a man like Eduard Thurneysen.¹⁶ Dealing with the

¹⁶ Eduard Thurneysen, A Theology of Pastoral Care (Richmond, Virginia: John Knox Press, 1962). Translated from the German by Jack A. Worthington and Thomas Wieser.

emotional states of the cancer patient implies a genuine confrontation with the emotion, rather than a superficial acknowledgment of it.

Basic to the pastoral care developed in this thesis is that the pastor be aware of the possible emotional causes and factors in the cancer patient and be prepared to deal with them in a genuine, emphatic manner. For a patient to be able to share a feeling of hopelessness with a person who understands might give the patient courage to deal with the issue of hopelessness in his life. The emphasis in this approach is not surface concepts, but dynamic feelings and emotions, causes and relationships.

There has been some speculation among the specificity theorists that the site of a given disease may express symbolically some "communication" of the personality of the patient. It is an important implication for the pastor's ministry that he be able to explore the meaning of the illness with the patient. The meaning of an illness, according to these theorists, can be an important factor in its development. This implies that the pastor remain open to whatever the patient communicates about his illness, not disregarding its possible symbolic meaning.¹⁷

¹⁷In the author's own ministry, there was an eighty year-old woman who had cataract surgery two years previous to the time that the author visited her. During the entire time after her operation, she had not left her house. In the course of some pastoral conversation, the author prodded her to get out of the house, indicating that he would be willing to drive her to a friend's house a few blocks away. She stated that she would think about it. Two weeks later, the author returned to her home to find that she had an arm in a cast, having tripped on a "crack" in the pavement in the back yard of her house. Her statement was as follows: "You see, I told you that I wasn't ready to leave the house yet. Now you know that I have to stay inside." Her accident seemed to be a symbolic way of telling me that I was pushing her to do something that she was not ready to do.

In all this a pastor will be able to gauge how deep-seated a given emotional problem is in his patient. If its depth is too deep for the pastor to handle competently, he may then suggest some additional consultations for the patient, perhaps with the staff psychiatrist or psychologist. It is possible that the pastor is in the best position to handle such a referral, since he has had a number of previous relationships already established with the patient and his family.

Principles from the Multi-Disciplinary Theories

An underlying principle of the specificity theorist is their conviction that the problem in psychosomatic illness is an intra-psychic problem. To postulate a death-instinct, repression, substitution for a lost love-object, an infantile personality, or an inability to discharge emotion, locates the problem area within the individual. The problem or conflict is one which needs to be dealt with on an individual level, within the personality processes of the patient. The multi-disciplinary approach does not exclude dealing with the intra-psychic conflict. It does, however, emphasize multiple factors influencing the patient, including environmental and field factors. The general principles of ministry to a patient experiencing an illness which were discussed as listening and acceptance, are principles within the multi-disciplinary approach also. Listening and acceptance are important in order to determine where the external influences are and how the patient perceives the things and the people external to himself.

Groen's bio-social approach emphasizes a psychosomatic pattern of abnormal behavior as a form of adaptation to society. The individual has

tried to find gratification for his needs within the framework of his society and failed; he has attempted to operate against the society in a psychopathic manner and failed, perhaps because of the threats and executions of punishment; he has come into conflict within himself, remaining in conflict. But the internal conflict does not aid in the gratification of the person's needs. Finally, the individual adopts bodily pathology as a way of gratifying his needs. Central to Groen's structure of pathology is that the person has learned by his attempts at living with society to obtain gratifications by other-than-normal means. The problem is not only within the individual. The patient has learned his behavior pattern by reacting with society.¹⁸ The pastor must learn to function on two fronts: (1) He must recognize the existence of the intra-psychic conflicts; and (2) He must help the patient deal with the realities of the societal situation by which he learned this method of gratification by use of bodily pathology.

The stress situation could be, for instance, that the patient has problems in his marital relationship. He had attempted a "normal" interaction early in the marriage, but it did not provide the necessary gratifications. He rejected anti-social acting out against his wife, because of the laws in society against beating and assaulting his wife.

¹⁸It is clear that specificity theorists and multi-causal theorists are not mutually exclusive categories. Alexander's emotional stress which causes the vulnerable organ to break down could very well be stress caused by a person external to the patient. Even classical Freudian theory recognizes that behavior traits are learned from inter-personal interaction. The difference as this author sees it is a difference in therapeutic emphasis. The Freudian works primarily with the intra-psychic conflict; the multi-causal theorist works as much with the total environment as he does with the intra-psychic conflict.

He also rejected the development of severe neurotic pathology. (This rejection was done on an unconscious level.) He found that he receives the most gratification from his wife when he experiences an illness. The pastor, sensitive to this development, not only aids the patient in clarifying his internal conflicts, but also encourages marital counseling. In this manner the pastor aids the patient in dealing with the conflict at both levels of its existence: intra-psychically and environmentally. Once the couple begins marriage counseling, the pastor can represent the healing forces which may enable the marital conflict to be resolved. Of course, this was only one hypothetical example of the many external conflicts which may be involved in any illness.

The reactions and attitudes of the family and social environment are important in a multi-disciplinary approach. The pastor has, perhaps, unique access to the family and may have the best comprehensive view of the family dynamics because of his previous contacts in different situations with the family unit. The pastor has the opportunity to work in the dimension of the family structure to attempt to foster healthy attitudes toward the patient. For instance, it is possible that the growth rate of cancer is linked to the amount of stress an individual experiences. If the pastor knows that part of this stress comes from within the family unit, he may be able, by emphatic and accepting counseling of the family members, to alleviate a part of the stress situation. What place the person occupies within this family constellation may be vital. Many families need a scapegoat through which the inter-personal problems of the family are buried. The problems of the

one become the center around which the family is organized. The pastor from his vantage point can see possible family influences on the patient and attempt to deal with them.

Central to Berblinger's approach is the attempt to describe the use of the symptoms of the illness. His approach is valuable especially for its openness. Of what purpose is the illness? What does it mean in the total life-space of the patient? What does the illness accomplish? Once the function of an illness is described, therapy consists of dealing with whatever factors are involved. Here sensitivity in listening is vital, as is an openness to deal with whatever might come to light, regardless of the personal theoretical orientation of the pastor.

Crucial to any multi-causal approach is the concept of the pastor as a member of a working team, one of many experts in their own specific area or areas. Especially with the patient whose religious attitudes are a significant part of his personality, the pastor functions as a member of this team. He needs to keep in close contact with the doctors, nurses, social work staff, therapists, psychologists, and so forth, who are in their own way ministering to the patient. If causes of illness as well as the rate of the progression of the illness are multiple, the pastor should take his place in a multiple staff. His relationships to the members of the medical and associated professions can be energetically improved and a close cooperation established.

The pastor, as a minister to the whole man, perceives a specific illness in both its theological and personal perspectives. The doctor may perceive the illness in a different way. Both doctor and pastor, however, are concerned with the same patient. They are also both

concerned with healing. The first level of a working team approach that can be expanded is that level of the relationship of the doctor and the pastor. The Chicago Area Study Group listed three levels of doctor-pastor relationships that can be improved.

One of these would be the teaching relationship where each is seen as having something to teach the other. Many physicians today are seeking guidance from the theologian in regard to the moral problems involved in certain illnesses and new forms of treatment. Another level of relationship would be as colleagues. This would be more of a person to person relationship with a common concern for the patient. And the third would be more professional--the clergyman may need the services of the physician, and the physician may need the services of the pastor.¹⁹

Other medical personnel make up the therapeutic team. The United Presbyterian Church lists eight areas in which this multiple-staff relationship to the patient may be encouraged.

1. Interchange at the formal level of lectures and panels given by pastors to medical groups and by physicians to ministerial groups;
2. Consultation between pastors and physicians at more informal levels regarding the theoretical relationship of faith and health and the practical approaches by which pastors and physicians seek to prevent illness and to facilitate recovery from it;
3. Better understanding on the part of the parishioner-patients of the relationship between faith and health by means of sermons, addresses, articles, and books;
4. Extension or post-graduate courses for pastors and/or physicians for the purpose of increasing their knowledge and their skill in this field;

¹⁹Chicago Area Study Group, "Health and Salvation," prepared for the Consultation on Health and Salvation of the World Council of Churches. Available from the Department of Ministry of the National Council of Churches, p. 18.

5. Cooperation and support by pastors and physicians of institutional chaplains and their work in general and mental hospitals;
6. Instruction of medical students in the value of cooperation between ministers and physicians, in the role of the minister in the sick-room and in the relevance of the Christian Faith to the moral and ethical decisions facing the physician in his work;
7. Instruction of nurses in training concerning the importance of compassion in all nurse-patient relationships and their opportunities for natural Christian witness to faith;
8. Discussion groups which deal with some of the subjects of mutual interest to pastors and physicians.²⁰

Such a multi-disciplinary approach, somewhat allied to that of Grinker's, implies that there be a confrontation of disciplines in the service of the patient. The pastor neither has all the answers in some theological cliché, nor does he take a professional back-seat to a member of any other profession.

Conclusion

This chapter represents only the beginning of the possible use of the data of this thesis. The responsibility for the use of the data rests with the pastor who confronts the individual patient and begins to minister to him. Data is always general; the important specific is the patient and his life.

²⁰United Presbyterian Church, pp. 54-55.

CHAPTER VIII

CONCLUSION

This thesis has attempted to deal with the question of the pastoral ministry in relationship to people who experience an illness which is of psychosomatic origin or which has psychosomatic implications. The question raised is, How can the pastor best minister to this kind of a patient within the theological context in which both he and his patient stand? The answer of this thesis is clear. The pastor uses all of the available material which aids him to understand the personality dynamics of his patient in order to minister effectively to him in the name of Jesus the Christ. This methodology implies a number of considerations: (1) The pastor is aware of the theological suppositions and the theological perspectives in illness and health; (2) the pastor is aware of the basic techniques of counseling which enable the establishment of a genuine relationship with the patient. The pastor operates in a listening and accepting framework; (3) The pastor is aware of the nature of psychosomatic illness in general; and (4) The pastor is aware of the nature of the research carried out in the fields of psychosomatic illness in the specific disease areas in which he is working. In the case of this thesis, the specific area which occupied most of the attention was the disease of cancer.

Many theoretical constructs were examined which dealt with the nature of psychosomatic illness. They were grouped into two general areas, specificity theories and multi-causal theories, although these categories are not mutually exclusive. With these two general theories

as background, the research into the psychosomatic nature of the cancer process was examined. After a discussion of the healing ministry of Jesus and the Church and the relationship of illness and health to salvation, specific suggestions were made to help the pastor in his ministry to the whole man. Basic to these suggestions were the qualities of listening and acceptance which were seen as fundamental to any pastoral work involving ministry to a person, including the person who is ill.

The study of man continues in many areas, among them in the area of psychosomatic medicine. If a pastor is to minister effectively to the hypothetical man, he must know something about the man. The purpose of this study was to present the theories and research and suggest some implications. The assumption is that the pastor must know more than theology to minister to man. He must also have more than a "common-sense" approach to psychological and personal problems. He must be able to read the human document.

Many questions remain to be answered. Much more needs to be done within the field of psychosomatic medicine itself. The Freudian model has been a source of much fruitful experimentation. Freudian concepts, such as repression and super-ego, unconscious motivation and id, are hard to define and extremely difficult, if not impossible, to measure. Perhaps a new model with more operationally definable terms is necessary? This raises the further and more basic question: How is the man to be studied? Must statistical methodology along a mathematical model be used to study man and prove probabilities? Or is clinical observation the best method? In either case more must be done to study man. Certainly,

for a pastor, studies in the biblical view of man are necessary. Yet it is not the biblical man who is met in the hospital. An individual and unique man is met in the hospital. "Man" must be studied, but it is the individual man to whom ministry must come.

The study of the relationships of psychological variables to the onset and progression of cancer is just in its infancy. Many more questions need to be asked; many more studies need to be carried out. With the new studies the pastor needs to cultivate an openness to what the studies might suggest, regardless of his present theological or psychological perspective, that his ministry to the whole man might be most effective.

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