# Psychological Factors in Cancer

Gerald Schoenewolf PhD

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By Gerald Schoenewolf Ph.D.

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## *About the Author*

Gerald Schoenewolf, Ph.D. is a New York State licensed psychologist who has practiced psychotherapy for over 33 years. He has authored 25 professional articles and 13 books on psychoanalysis and psychotherapy. His books include *101 Common Therapeutic Blunders, The Art of Hating,Counterresistance* and *Psychotherapy with People in the Arts*. He has also written and directed two feature films— *Therapy* and *Brooklyn Nights*. He lives in the Pennsylvania Poconos with his wife, Julia.

# Psychological Factors in Cancer

Recent research has shown a link between childhood abuse and adult cancer. This does not mean that cancer is necessarily caused by environmental stress, but stress does seem to be a factor in the etiology of some forms of cancer. For example, symptoms of depression and anxiety are linked to patients with cancer of the pancreas. The following case about a man who developed testicular cancer illustrates one instance in which childhood trauma seems to be a factor in the later development of cancer.

## Introduction

A while back I analyzed a young man who had developed cancer in one of his testicles—the right one, to be exact. In reconstructing his history, we were able to trace the etiology of the cancer, at least in part, to psychological factors. Since this case is one of the most clear and striking examples of a possible psychological etiology of cancer that I have encountered either directly or in the literature, I have decided to put the case on record.

Peter (the pseudonym for the patient) began treatment when he was in his early twenties. He was a tall, muscular man with a nervous constitution. The symptoms he presented were insomnia, impotence and anxiety, with occasional bouts of agoraphobia. He was functioning poorly on both social and professional levels, unable to assert himself in either area due to a strong fear of castration. He defended against this fear through repression, reaction

formation, denial and avoidance: he was a great procrastinator. He presented a mixed bag of often conflicting personality features, including masochism, passivity, hysteria and obsessive-compulsion.

Even though he was a large man—around six feet and eight inches tall, with a broad chest and broad shoulders—who towered almost a foot above me, he was quite submissive toward me from the beginning, as though he feared I might at any moment give him a good thrashing. Seemingly in constant terror, he would sit up in his chair and keep me under surveillance at all times with his large brown eyes. I had the impression that if I made any sudden move or said anything that might be construed as threatening he would be out of the door in a second.

Our initial dialogues were not notably fruitful. “I don’t know,” came out of his mouth again and again. This was his favorite phrase, often the first and last thing he would utter during a session.

“What don’t you know?” I asked him on one occasion.

“I don’t know.”

“You don’t know what you don’t know?”

“Yes, I don’t know.”

“Try saying, ‘I don’t want to know.’”

“I don’t want to know.”

“How does that feel? Does that feel right?”

“I don’t know.”

“You don’t know if you don’t want to know?”

“Right, I don’t know.”

We would go around and around like that. For a month or two it was difficult to get straight answers from him, and only bits and pieces of his history fell through the cracks of his character armor. It became evident that he felt he needed to be very defensive with me to the point where he ended up negating both himself and me, preventing anything meaningful from happening during the sessions. Little by little I managed to find out that he had recently had an operation to remove his right testicle. It had become malignant soon after he had left college and moved to New York—puffed up with a tumor that had doubled the size of the gland itself. Fortunately, the left testicle was not impaired and— oddly—he did not present any concerns about losing it.

I also found out that he had undergone this operation in secret. He had never told his family or his friends about the cancer or the surgery, due to feelings of shame and fear. In particular, he feared that his father would be enraged at him. He was terrified of his father and protective of both parents, whom he still saw regularly on weekends at their home in Queens, New York.

As far as he was concerned, his parents had done the best they could. “I don’t want to blame my parents,” he said, repeating one of the most common statements of patients at the beginning of therapy.

> “Is that why you didn’t tell them about the operation?” I asked nonchalantly.
>
> “I don’t know.”
>
> “You don’t know why you didn’t tell them?”
>
> “Yes, I don’t know.”

Eventually we were able to work through the “I-don’t-know” and “I-don’t-want-to-blame-my-parents” resistances and began to piece together the details of his history. As we did, we began to understand the psychological meaning of his cancer.

## The History

The major trauma of Peter’s childhood centered around bed-wetting. He had wet his bed from the ages of three to eight—by which time he was in the second year of elementary school. This was a dark age for him, enshrouded in childhood amnesia, and he did not at first clearly recall it. He knew the bed-wetting had happened because his mother talked about it and it had become a part of the family history. But he was only able to reconstruct a detailed

memory of it through dream analysis. Upon recalling the period, he began to let go of some of his debilitating repression.

During most of his childhood years he had suffered from night terrors, in which he would wake up with a start, his heart beating wildly, and scream out, “No! No! No!” at the top of his lungs as he broke into a cold sweat. He would never be able to recall the content of these terrors, despite the fact that he would be semiconscious when he had them. During his adult years he continued to have recurring nightmares covering the same theme and was again able to recall very little of their content.

Slowly, during the course of therapy, he began to remember and bring forward fragments of these nightmares to the treatment. He would dream about being attacked on the street by strange men; about thieves coming into his apartment and stealing his clothing or his computer; about walking in the woods and stepping in a steel trap and being stalked by a bear; about being trampled by a herd of Buffalo. All these fragments had fierce men or animals in them and he would always note a certain look in the eyes of the attackers. The looks said that they had something on him, they knew his dirty secret, and they knew he was going to have to pay for his “crimes” in a way that meant losing his manhood.

After about a year, he brought in his first dream in which his father

appeared. His father was standing in the background as two men attacked him. In this dream his father was but a silhouette and it took a while before the patient recognized him. He brought in another dream in which his father was more clearly recognizable; he was on the phone talking to his mother while a rabid dog with foaming mouth tore off his right arm. He brought in still another in which his father watched as a gang of black teenagers cornered him in an alley and kicked him in the testicles. This last dream proved the turning point in the reconstruction. The image of being kicked in the testicles by black men reawakened the fantasies that were attached to the original traumatic period.

> “You know, I used to have fantasies all the time of being kicked in the balls,” he said. “In fact, now that I think of it, I used to have fantasies that black men were kicking me in the balls. I also had fantasies of my father kicking me.”
>
> “Why black men?” I wondered.
>
> “I don’t know.”
>
> “What color is your father’s skin?”
>
> “Hmmmmm. I never thought of that. His skin is dark. I take after my mother. My skin and her skin is lighter than my father’s. She’s Irish. My father’s got half Columbian and half Indian blood.”

From that session on he began to remember his early childhood more and more clearly. Basically, he had gotten caught up in a crossfire. His father,

he said, was a “Spartan”: his mother an “Athenian.” His father was a macho man whose manners were crude and temper on the edge. His mother was a meek woman who attempted to appease her husband by indulging him in every way. Clinically, the father was obsessive-compulsive with sadistic features. He was obsessed with order and discipline. The mother was oral-impulsive with masochistic and passive-aggressive features. She utilized a martyr attitude to guilt-trip her husband and indirectly act out her anger. When Peter was born, he was drawn into the center of their conflicting characters and became the focus of their war of ideology. She indulged the boy and was critical of what she called the “physical abuse” by her husband. He was strict and punitive with the boy and critical of what he called the “spoiling” by the mother.

During the toilet-training stage the mother’s tendency was to go easy on Peter. If he didn’t want to go to the potty, that was all right. Let him enjoy being a child as long as he could. After all, he would be called upon to meet life’s many responsibilities soon enough. The father, on the other hand, would insist that the boy sit on the potty as long as it took for him to make a deposit of his valuable feces. Hence, the boy was caught between the indulgent, emotionally incestuous day world of his mother and the harsh, threatening, jealous, disciplinarian night world of his father. Consequently, the boy clung to his mother and dreaded the father’s homecoming each night, and his toilet training became flawed.

I use that word “flawed” deliberately to denote that a fixation developed at that stage. Just as the flaws underneath the earth’s crust which developed in its early formation portend future quakes, so also the flaw in Peter’s toilet training (his early formation) would lead to a future breakdown of his socialization. In specific, this pregenital fixation predisposed Peter to the bed-wetting that began to occur during at around the age of three. The bed-wetting was, at the same time, a symptom that was directly related to, and induced by, the war of ideology (liberal vs. conservative ideas) between his parents. He became the conduit through which that war was funneled.

When the bed-wetting began his mother was indulgent toward the habit and his father was antagonistic. It soon became a family ritual that pitted the mother and son against the father, and one that was symbolic of the oedipal nature of the mother-son and father-son relationship. The mother’s indulgence of the bed-wetting had an erotic undertone; each time it occurred, she would whisk the boy out of his bed and gently bath him, taking care to clean his private parts, speaking to him softly and conspiratorially so as not to wake the father. “Quiet, let’s not wake the old bear,” she would say. She would then put a clean sheet on his bed and hold his hand until he went back to sleep. Little wonder then that the habit, being thus reinforced, not only continued but intensified.

However, in time the father found out about the nighttime clandestine

activities. Once he did, he insisted on taking over the handling of the bed-wetting. “It’s your fault he pisses in his bed, because of your spoiling,” he said to the mother. “I’ll cure him of the habit, pronto!” He began to stay up nights and wait just outside the boy’s room at the time when he usually soaked his bed. Peering around the doorway, he would wait until he saw or heard a movement (such as Peter’s hand moving toward his genitals) or began to smell urine. Then he would pounce on the boy, throw back the covers, and yell at him. “Stop it! Stop it right now! Stop it, I said!” The boy would awaken with a start, his father’s huge body on top of him, his father’s dark eyes glaring at him, and begin to shiver and sob. His mother would rush in and scream at the father. His father would scream at the mother. She would clean him under the father’s scrutiny and he would say, “That’s right, pamper his little pecker so he’ll turn out to be a fairy.”

This ritual continued from the age of three to eight. For the first two years the struggle between the son and father, and between the mother and father, grew more intense. The son’s bed-wetting came to be an insult to the father’s pride, or, to put it more clinically, it was experienced as a narcissistic injury, as something shameful and unmanly that reflected on his own manhood. Moreover, to a fellow who grew up in the macho culture of South America, the son’s closeness with his mother smacked of male treason. Finally, the son’s continued enuresis was perceived as an act of deliberate defiance of the father’s authority; this too was a threat to his male pride.

Narcissism was also involved in the mother-son relationship; the son became a self-object to the mother. Her indulgence had strings attached—or perhaps we should say it had an umbilical cord attached; he was expected to mirror her as she wanted to be mirrored—as the loving, warm, long-suffering wife, who did not harbor a shred of ill-will, who did not get the credit she deserved and had to put up with the abusive treatment of her brute of a husband. The son was expected to mirror her by being her ally against the father and playing the role of the long-suffering son beside the long-suffering wife.

With regard to the act of wetting itself, Peter recalled with fondness the euphoric sensation of urinating, the gentle warmth as the urine trickled between his legs and surrounded his crotch and backside, and the sweet smell of the urine hovering about the nighttime air. Later, of course, when the urine had cooled and become sticky and the smell had turned bitter, he would experience discomfort. Then would come the terror of his father's wrath, mixed with the anticipation of his mother's loving touch. In fact, the enuresis had the unconscious meaning of an ejaculation (this came out in his associations), and since it was an act that allied him with his mother against his father, it also meant intercourse with her and murder of him.

The fact that it had this unconscious meaning made the boy all the more fearful of the father's Oedipal rage. The talion principle (projecting that his

father wanted to murder him) was ever-present in his relationship with his father, and it was predominant in shaping his character. The father, for his part, seemed to be the very epitome of the jealous oedipal father. He made it his mission to pry the boy loose from his close bonding with his mother.

As the second year passed, father and son became locked in a mighty battle of the bed. The father stepped up his terrorist attack on the son, growling now as he threw on the lights at the slightest sign of enuresis, jumping on the bed, pulling the boy's pants down and yelling, "Ah ha! What did I tell you? What did I tell you?" He would glare at the son, smiling maniacally, grinning as if he knew everything about the boy, everything about his dirty secret (his incestuous love for his mother). "Didn't I tell you not to do that? Didn't I? You don't listen, do you? I guess I'll have to teach you a lesson." Sometimes he would shake the boy until Peter thought that his head was going to rattle off of his shoulders. Sometimes he would turn the boy around and spank him. During these times, Peter would fear that his father was going to hit his genitals and injure them, so he would hold onto them with both hands. On one occasion he recalled his father saying something like, "You'd better hold on to your balls, because if you keep pissing in your bed I may just rip 'em off! How'd you like that? How'd you like it if I ripped 'em off? Then you'd just have a little nub of a dick and no balls! Ha, ha, ha, ha!"

The more the father terrorized him, the more the habit became stubbornly

entrenched. In fact, the habit now took on a compulsive quality. Peter recalled that despite his mounting fears of his father and his craving to stop the habit and thereby avoid his father's attacks, he could do nothing about it. He would go to bed determined not to do it, but do it all the same and at about the same time. Nor did he experience the pleasurable sensations that had once been linked with the wetting. The more the father attacked the habit, the more the habit became reflexive, like some awful hiccoughs of the groin that would not be calmed, despite its incurring the mad dog of the night.

Eventually the mother and son won this battle. The father, seeing that the habit was getting worse rather than better, finally threw up his hands in disgust and told his wife, "You can have him. You caused the problem. You deal with it. He's no son of mine anymore." The son was an oedipal conqueror, but he had a heavy price to pay. From then on, the father was hostile and distant to the boy, treating him as one might treat the worst kind of traitor. Without the father's active resistance to it, the habit lost part of its purpose; it continued for a few more years and then fizzled out. It stopped not because of anything the father or mother had done, but because Peter began to be shamed by his peers at school. The main cause of this shaming was that some little friends of his found out about the habit when he slept over and his bed was soaked in the morning. His two mates teased him for months at school, telling everyone else about it.

By the end of the second grade the bed-wetting had stopped completely. Just as the habit stopped, he began to have the night terrors. The night terrors came almost every night during the latency period. While the bed-wetting itself appeared to be a compulsive, ritualistic enactment of his incestuous cravings for his mother and oedipal struggle with his father, the drama associated with the bed-wetting seemed designed to master the flood of anxiety produced by the years of trauma, as well as to gain sympathy from his mother and appease his father. That drama and connected trauma led to the night terrors. Whereas during the earlier time he had awakened with a wet bed, now he awakened with a wet body, sweating profusely, and screaming. Almost every night he would wake up screaming and his mother would come to his bed to calm him. He didn't remember what he was screaming about, but his mother told him later he often had a begging tone: "No, no, please don't!" It was not until the dawning of adolescence that he began to have the fantasies of his father kicking his testicles that were to plague him throughout his teen years and early twenties.

He had these fantasies almost daily, sometimes after an interaction with his father, sometimes after interactions with teachers or boys at school. He imagined his father storming into his bedroom, throwing him onto the floor, and kicking at his crotch with his pointed Italian shoes. Or he would be taking a shower and imagine that his father might break into the bathroom and tear away the shower curtain, push him down into the tub, and stand over him,

kicking and laughing. Or he would be coming home at night and would imagine that his father was lurking in the bushes around the house and would jump him before he got to the porch, tackling him and kicking him hard between the legs. These fantasies were interspersed with those of black men kicking him.

Along with these fantasies, he began to become aware of a constant tension in his testicles, especially the right one. We speculated that because of his daily fantasies of being kicked in the testicles, he had unconsciously began to tense up this part of his body in anticipation of such an assault. After years of this kind of chronic tension in his right testicle, he became aware of a soreness there. Eventually he became aware that the size of his right testicle seemed larger than that of his left testicle. By his early twenties, his right testicle had grown to about twice the size of the left one, and it had an odd shape. By then, it felt sore all of the time.

He had put off going to see a physician, afraid of what he might find out. When he finally did, the cancer had invaded his testicle to a point where it could no longer be saved. The years of chronic tension had taken their toll.

## Related Research

Cancer has not generally been considered to be a psychosomatic disease, although there have been scattered speculations about the psychological component of cancer over the years. Kolb (1977) notes that

symptoms of depression, anxiety, and a premonition of serious illness are among the most frequent presenting complaints of patients with cancer of the pancreas. Such patients tend to suppress their rage responses and have often suffered a significant loss in their object relations in the preceding months. Monroe (1972) and Coles (1977) assume a psychological component to all diseases, including cancer. “All physical disorders may, in some degree, be precipitated by nonbiological, nonphysical factors” (Coles, p. 204). Among psychoanalysts, Reich (1933, 1948) made the most extensive study of cancer. He calls it a “living putrefaction of the tissue” that is associated with an individual’s unconscious damming up of energy through muscular contraction, or what he calls “biopathic shrinking.” Baker (1957) elaborated on Reich’s work, noting that cancer is the last stage in an ongoing process of organ deterioration, and it is most prevalent in “the most armored places”—that is, in the sexual regions of males and females, where tensions of unconscious sexual conflicts become localized and somatized.

A recent study by researchers at the University of Toronto showed that physical abuse in childhood was linked with the development of cancer in later life. The findings were based on a 2005 Canadian Community Health Survey focusing on the provinces of Manitoba and Saskatchewan and showed a 49% link between childhood abuse and adult cancer. Of the 13,092 respondents, 7.4 per cent stated that they had been physically abused as children by someone close to them, and 5.7 per cent said they had later been diagnosed with

cancer. The odds ratio diminished only slightly to 47 per cent when the numbers were adjusted to take in unhealthy behaviors such as drinking or smoking. Fuller-Thomson said there might be many reasons for this link. She speculated that chronic stress a child abuse victim would be under might elevate levels of cortisol (the stress hormone). The chronic release of cortisol is known to weaken the immune system, which would then interfere with the immune system's ability to detect and get rid of cancer cells.

The gist of these theories is that an individual suffering from chronic stress in any organ will eventually develop cancer in that organ. Such long-term stress causes biochemical changes that hamper the body's metabolism. Chronic sufferers of ulcers of the stomach or colon, for example, are prone to developing cancer in these organs. This has been medically documented: what has not been well-enough documented is the psychological aspects of this development. (It is perhaps ironic that the psychoanalyst who provided the deepest exploration of the psychology of cancer was himself a victim of it; Reich died of cancer soon after being imprisoned during the 1950s for obstruction of justice.)

While he did not explore the connection between psychology and cancer, Alexander (1950) nevertheless provided an explanation of the psychological etiology of many ailments as well as the personality conflicts of those prone to them. Among them was the ulcer patient. He sees ulcer-prone individuals as

oral characters whose sympathetic nervous systems are always switched on and whose stomachs are continuously producing acid in anticipation of taking in food. He traces this phenomenon back to fixations during the oral phase of development, when the child's oral needs are in some way deprived or over-stimulated. Hence, as an adult, the ulcer patient has an inadequate stimulus barrier and constantly needs soothing. Reflexively, he readies his stomach to take in food (an act of self-soothing) in order to calm the stress. However, by constantly flooding the stomach with acids, an ulcer develops. Over a period of years, if not treated, the ulcer may become cancerous.

It should be noted that recent medical research by Marshall and Warren (1983), for which they won the 2005 Nobel Prize, has dismissed the notion that ulcers are not caused by stress, and instead points to a stomach infection with the bacterium Helicobacter pylori. This bacterium is said to be the culprit in nearly 80% of stomach ulcers and in more than 90% of ulcers in the duodenum, the first portion of the small intestine. However, since their research was done it was discovered that a great number of people have this bacteria in their stomach but do not develop ulcers. So, even though a bacteria may be involved, this does not dismiss stress as an accompanying factor, as stress will weaken the immune system's ability to deal with the bacteria.

Following the same line of reasoning, a woman might develop breast or ovarian cancer or a man prostate cancer (three of the most prevalent forms of

malignancy) in a similar way: through chronic stress in those particular organs. As is now commonly known, not all women who have the gene related to breast cancer develop breast cancer; stress would seem to be the crucial factor. One of my patients developed a tumor in her breast about a year after having an abortion, during which time she had felt an ongoing tension in her breasts. She expressed a great deal of resentment about the abortion, related to the frustrated desire to nurse and nurture a baby. This strong desire harked back to the apparent frustration of her infantile oral needs by a mother whose husband (the patient's father), abandoned her when the patient was still an infant. This event caused the mother to lapse into depression and abandon her infant daughter, thereby seemingly fixating her daughter at this stage of orality.

Hess (1955) studied a case of breast cancer that developed after a patient lost her father to cancer. He interpreted that the patient's cancer stemmed partly from guilt feelings about his death, an over-identification with him, and a wish to avoid her depressive pain. A young male patient of mine developed prostatitis in his twenties and early signs of cancer; fortunately he was able to work through a lot of his formerly repressed thoughts and feelings in therapy and the prostatitis eventually subsided. He had experienced constant tension in his prostate glands since his early adolescence, and revealed a history of conflicts about his homosexual impulses.

Faller (1993), studying 120 lung cancer patients found that certain causal

attributions of the disease appeared to be a result of a specific way of coping. Using an interview and questionnaire, the study focused on the patient's emotional state and coping mode before and during the onset of cancer. Faller found a connection between emotional distress and the specific coping mechanisms of these patients which were of a deficient nature. However, he was not sure whether subjective causal attributions were determinants or epiphenomena of coping with the disease.

## Conclusion

To understand the specifics of one case of cancer is perhaps to highlight something about all cases. Peter's case, while perhaps not typical, is not atypical. It began with a pregenital fixation, produced by inadequate object relations, which in turn seemed to lead to the development of strong oedipal and castration complexes. His oedipal guilt and incestuous fantasies about his mother and his terror of his father aroused both complexes. The same object relations that produced them also prevented either complex from ever being resolved. To overcompensate for these complexes (or flaws), he had to chronically tense up (Reich's "biopathic shrinking") a part of his body—namely, the right testicle. Why the right testicle? I would speculate that "right" had for Peter an unconscious symbolic connection with "male" and "father," while left had a similar connection with "female" and "mother." In addition, our patient was from a Catholic background and therefore one can speculate that his

familiarity with a litany which states that Jesus (God's son) sat at the right side of his Father, may have had an impact on his development as well. Hence, his right testicle belonged to his father, his left to his mother.

The chronic tension in his right testicle ebbed and waned according to the events of his life. Generally, any interactions with his father, even the most perfunctory exchange of glances, would bring about a rise of tension. Interactions with other male authority figures, and with other males in general, would likewise produce more tension. At the same time, relationships with the opposite sex were also threatening, for they signified a reactivation of incestuous thoughts toward his mother and the associated castration fears.

The development of the malignant tumor came after he had graduated from college and was on his own in the city. Perhaps it had been developing all along, or perhaps there was something about being on his own that contributed to the process. Sometimes freedom itself can be threatening to one who has been enmeshed in the throes of a dysfunctional family system. Selye (1971) observed that the conversion of chronic stress into organic ailments often occurs not while the object producing the stress is present, but after the stressor is removed and the body no longer has to immunize (defend) itself against it. At this point the body runs out of resources and becomes exhausted. Without anything to defend against, reaching the stage of exhaustion, the body relaxes and becomes susceptible to illness.

It would seem from this case history and others that at times cancer may have a psychological component which precedes or coincides with the biological. At other times, as when a toxic chemical invades the body, the cancer may have primarily a physical origin. Soldiers who are exposed to chemical warfare come to mind. In addition, there is a relationship between chronic stress, the immune system, and biochemical changes in the body. Due to humankind's general resistance to looking at psychological trends, about which I have commented elsewhere (1991, 1997), the psychology of cancer has remained largely ignored and uncharted. A recent text on psychosomatic disorders, for example, does not even mention cancer (Wilson and Mintz, 1989). If just a fraction of the funds spent on cancer research were devoted to psychological components of cancer, we might make more headway in curing this disease.

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