Behavioral Aspects of Remission

Behavioral Aspects of Remission

Appendix Two, "Behavioral Aspects of Remission," contains reports, primarily case histories, from the medical and psychological literature where psychosocial variables or interventions are associated with remission of cancer. Many of the reports in this chapter appear elsewhere in this book.

The relationship between behavioral variables and cancer remission or survival is controversial. There is convincing evidence that psychological, social and spiritual support is important in coping with the disease. Still more study is needed to determine the effect the mind has on disease remission or survival.

It has been observed that case reports in the psychological literature contain little or no medical diagnostic information, and reports in the medical literature contain little or no personal information. Clearly both detailed diagnostic and personal information are needed to present a complete case history. The creation of a standard for case report presentations could add much to the understanding of what roles both biological and psychospiritual processes have on remission and survival from life-threatening diseases.

The references in this chapter are divided into two sections. A section of psychological and spiritual reports contains 16 annotated references with full text of 21 case reports.

A second section with reports of the influence of hypnosis and meditation on cancer remission contains 13 annotated and 24 supplemental references, and 8 case reports. In this section, an overview of the work of the Australian psychiatrist Dr. Ainslie Meares, who reported remissions from cancer in people who used his technique of meditation, is presented. Seven of the 8 case reports in this section were reported by Dr. Meares. Also in this section an 1846 case report in which hypnosis was associated with the remission of cancer is presented.

Psychological and Spiritual Reports

Psychological Variables in Human Cancer

Klopfer B

Journal of Projective Techniques and Personality Assessment 21: 1957; 331-340

Extracted Summary

The author presents his views on the psychological variables in cancer based upon his experience with cancer patients. He asks whether there is a connection between either the ego organization or the personality organization of the patient and the rate of cancer growth, and, if so, the author suggests that it is a symbiotic relationship which exists between the patient and his cancer. He speculates that if a good deal of the patient's vital energy is used up in the defense of an insecure ego then the organism does not seem to have the vital energy necessary to fight the cancer and the cancer can proliferate. If, however, a minimum of vital energy is consumed in ego defensiveness, then the cancer has a hard time making headway.

He presents a case report that he received as a personal communication from Dr. Philip West as an example of the psychological aspects of cancer regression.

Selected Case Report

Mr. Wright had a generalized far-advanced malignancy involving the lymph nodes, lymphosarcoma. Eventually the day came when he developed resistance to all known palliative treatments. Also, his increasing anemia precluded any intensive efforts with x-rays or nitrogen mustard, which might otherwise have been attempted. Huge tumor masses, the size of oranges, were in the neck, axillas, groin, chest and abdomen. The spleen and liver were enormous. The thoracic duct was obstructed, and between 1 and 2 liters of milky fluid had to be drawn from his chest every other day. He was taking oxygen by mask frequently, and our impression was that he was in a terminal state, untreatable, other than to give sedatives to ease him on his way.

In spite of all this, Mr. Wright was not without hope, even though his doctors most certainly were. The reason for this was that the new drug that he had expected to come along and save the day had already been reported in the newspapers! Its name was "Krebiozen" (subsequently shown to be a useless, inert preparation).

Then he heard in some way, that our clinic was to be one of a hundred places chosen by the Medical Association for evaluation of this treatment. We were allotted supplies of the drug sufficient for treating twelve selected cases. Mr. Wright was not considered eligible, since one stipulation was that the patient must not only be beyond the point where standard therapies could benefit, but also must have a life expectancy of at least 3, and preferably 6 months. He certainly didn't qualify on the latter point, and to give him a prognosis of more than 2 weeks seemed to be stretching things.

However, a few days later, the drug arrived, and we began setting up our testing program which, of course, did not include Mr. Wright. When he heard we were going to begin treatment with Krebiozen, his enthusiasm knew no bounds, and as much as I tried to dissuade him, he begged so hard for this "golden opportunity," that against my better judgment, and against the rules of the Krebiozen committee, I decided I would have to include him.

Injections were to be given three times weekly, and I remember he received his first one on a Friday. I didn't see him again until Monday and thought as I came to the hospital he might be moribund or dead by that time, and his supply of the drug could then be transferred to another case. What a surprise was in store for me! I had left him febrile, gasping for air, completely bedridden. Now, here he was, walking around the ward, chatting happily with the nurses, and spreading his message of good cheer to any who would listen. Immediately I hastened to see the others who had received their first injection at the same time. No change, or change for the worse was noted. Only in Mr. Wright was there brilliant improvement. The tumor masses had melted like snow balls on a hot stove, and in only these few days, they were half their original size! This is, of course, far more rapid regression than the most radiosensitive tumor could display under heavy x-ray given every day. And we already knew his tumor was no longer sensitive to irradiation. Also, he had had no other treatment outside of the single useless "shot."

This phenomenon demanded an explanation, but not only that, it almost insisted that we open our minds to learn, rather than try to explain. So, the injections were given 3 times weekly as planned, much to the joy of the patient, but much to our bewilderment. Within 10 days he was able to be discharged from his "death-bed," practically all signs of his disease having vanished in this short time.

Incredible as it sounds, this "terminal" patient, gasping his last breath through an oxygen mask, was now not only breathing normally, and fully active, he took off in his plane and flew at 12,000 feet, with no discomfort!

This unbelievable situation occurred at the beginning of the "Krebiozen" evaluation, but within two months, conflicting reports began to appear in the news, all of the testing clinics reporting no results. At the same time, the originators of the treatment were still blindly contradicting the discouraging facts that were beginning to emerge.

This disturbed our Mr. Wright considerably as the weeks wore on. Although he had no special training, he was, at times, reasonably logical and scientific in his thinking. He began to lose faith in his last hope which so far had been life-saving and left nothing to be desired. As the reported results became increasingly dismal, his faith waned, and after two months of practically perfect health, he relapsed to his original state, and became very gloomy and miserable. But here I saw the opportunity to double-check the drug and maybe to find out how the quacks can accomplish the results that they claim (and many of their claims are well substantiated). Knowing something of my patient's innate optimism by this time, I deliberately took advantage of him. This was for purely scientific reasons, in order to perform the perfect control experiment which could answer all the perplexing questions he had brought up. Furthermore, this scheme could not harm him in any way, I felt sure, and there was nothing I knew anyway that could help him.

When Mr. Wright had all but given up in despair with the recrudescence of his disease, in spite of the "wonder drug" which had worked so well at first, I decided to take the chance and play the quack. So deliberately lying, I told him not to believe what he read in the papers, the drug was really most promising after all. "What then," he asked, "was the reason for his relapse?" "Just because the substance deteriorates on standing," I replied, "a new super-refined, double-strength product is due to arrive tomorrow which can more than reproduce the great benefits derived from the original injections."

This news came as a great revelation to him, and Mr. Wright, ill as he was, became his optimistic self again, eager to start over. By delaying a couple of days before the "shipment" arrived, his anticipation of salvation had reached a tremendous pitch. When I announced that the new series of injections were about to begin, he was almost ecstatic and his faith was very strong.

With much fanfare, and putting on quite an act (which I deemed permissible under the circumstances), I administered the first injection of the doubly potent, fresh preparation, consisting of fresh water and nothing more. The results of this experiment were quite unbelievable to us at the time, although we must have had some suspicion of the remotely possible outcome to have even attempted it at all.

Recovery from his second near-terminal state was even more dramatic than the first. Tumor masses melted, chest fluid vanished, he became ambulatory, and even went back to flying again. At this time he was certainly the picture of health. The water injections were continued, since they worked such wonders. He then remained symptom-free for over two months. At this time the final AMA announcement appeared in the press, "nationwide tests show Krebiozen to be a worthless drug in treatment of cancer."

Within a few days of this report Mr. Wright was readmitted to the hospital in extremis. His faith was now gone, his last hope vanished, and he succumbed in less than two days.

Some Observations on Psychotherapy with Patients with Neoplastic Disease

LeShan LL; Gassmann ML

American Journal of Psychotherapy 12: 1958; 723-734

Extracted Summary

Ten patients with malignant neoplasms were studied in over 1,400 hours of intensive depth psychotherapy. This led to the recognition of a number of special problems arising during the psychotherapeutic treatment of cancer patients. Some tentative methods of handling these problems are presented and it is hoped that they will prove useful to others working in the same field.

The special problems were divided into four areas: (1) The anxieties of the cancer patient. These are predominantly realistic in nature and have to be accepted as such. More support is needed in this form of treatment than is generally given during psychotherapy. (2) The anxieties of the therapist. The therapist must be clear about the goals and values of working with patients who are likely to die in the course of the process. A control therapist is necessary in order that the stress, when one patient dies, does not affect the therapist's relationships with the other cancer patients. (3) The personality of cancer patients. Certain personality factors which have implications

for therapy appear with a good deal of consistency in individuals with cancer. These include an unusual amount of deeply repressed hostility, marked feeling of psychological isolation, and despair about having been unable to achieve real satisfactions in life. (4) Special psychosomatic aspects. There is some reason to believe that psychotherapy may under certain circumstances affect the growth rate and development of neoplasms. Therefore a good deal of caution is recommended in deciding how much guilt and hostility may be mobilized during the therapeutic process.

Selected Case Reports

A 34-year-old female, with a markedly anaplastic carcinoma of the breast, had visible metastatic growths in the right shoulder region. These had slowly and steadily increased in size over a three-month period. This woman had never accepted her hostility toward her husband and children, and had guilt feelings over the fact that she sometimes wished she were free of them. After approximately 45 hours of psychotherapy, she was able to accept and ventilate some of her hostility toward her children, and to accept the reassurance of the therapist that these were normal and valid emotions, and that they would not cause her to hurt or desert her family. In the following three days, there was a temporary but definite shrinkage of the visible tumor growths.

A 32-year-old male had extensive metastases of a malignant melanoma. In his early adolescence he had undergone an unusually traumatic experience when he witnessed his father prepare to murder the only adult who had ever been warm and kind to him. The murder was committed and, for a long time, he had been overwhelmed by the fear that he would be called to court during one of his father's repeated trials, and would be unable to keep from testifying against him. Later, he repressed the entire scene and consciously believed that his father was innocent and "framed."

During the course of psychotherapy, recurrent dreams and associations indicated that tension over his relationship to his father's guilt in the murder was mobilized. At the same time, he began to complain of pain in his throat and increasing difficulty in swallowing. Examination revealed a rapidly growing neoplasm in the right tonsillar and right glosso-epiglottic area. Preparations were made to remove it surgically so that he could continue to eat. In a psychotherapy session on the day before the operation was scheduled, he recalled the entire incident with all the emotion he had felt at the time. He recounted it in detail, weeping and trembling. Four hours later, he told the therapist that he had just finished the first meal he had been able to eat in a week without pain in his throat. Twenty-four hours later, the mass was markedly reduced; 48 hours later, it was even smaller; and within four days, it had disappeared. The surgical procedure was not carried out.

The reports of the surgeon who was called in consultation on this man are given: June 23, 1955. Ears negative. Uvula ademato us. There is a mass about 3 centimeters in diameter occupying lateral part of the right glosso-epiglottic fossa and extending on to the anterior pillar on the right. A right subdigastric node is palpable, the mass on tongue has a deep red to purplish color and is slightly tender. He complains of pain radiating to the right ear and some pain on continual swallowing.

July 3, 1955. No pain in right ear on swallowing. Uvula has normal appearance. Mass seen previously and described on June 23, 1955, which was 3 centimeters in diameter, has disappeared. The glosso-epiglottic fossa is entirely clean. On the right lateral pharyngeal wall there is a nodule one quarter inch in diameter (lymphatic tissue?). This does not appear to be part of the original picture. The pyriform sinuses are both clear. The right subdagastric nodes are not palpable. A left subdigastric node is questionably palpable. (B. Welt, M. D.)

Spontaneous Regression of Cancer

Shapiro SL

Eye Ear Nose Throat Monthly 46(10): Oct 1967; 1306-1310

Extracted Summary

Near the end of the thirteenth century a zealous, young priest of the order of Servites fell ill with a painful cancer of the foot. He bore his trial without a murmur and, when it was decided that amputation should be performed, spent the night preceding the operation in prayer before his crucifix. He then sank into a light slumber from which he awoke completely cured, to the amazement of the doctors who could no longer detect any trace of the disease. The holy man lived to the age of eighty and died in the odor of sanctity. He became known as St. Peregrinus, the patron saint of cancer.

The author begins his investigation of spontaneous regression of cancer with the above anecdote, and then presents brief synopses of cases that he has personally observed as well as those reported by others.

The author reviews Spontaneous Regression of Cancer, the book by Drs. Everson and Cole. Possible factors that may influence spontaneous regression are discussed. Some of the tantalizing reports regarding the successful use of imunology in cancer are also presented.

Selected Case Report

Sister Gertrude of the Sisters of Charity in New Orleans was admitted as a patient to the Hotel-Dieu Hospital in New Orleans on December 27, 1934. Her health had been failing rapidly for some months. On admission to the hospital, she was jaundiced and suffered from severe pain, nausea, chills, and a high fever. She was under the care of Dr. James T. Nix, who had previously operated on her for a gallbladder condition.

A preoperative diagnosis of cancer of the pancreas was made, and an exploratory laparatomy performed on January 5, 1935. The head of the pancreas was found to be enlarged to three times its normal size. The process appeared to be inoperable and the prognosis hopeless. A biopsy of the tumor was done and the wound closed. A diagnosis of carcinoma of the pancreas was made by three pathologists.

The sisters of the order interceded with Mother Seton, deceased founder of the order, in a series of novenas to spare the life of Sister Gertrude so that she might continue in service. She began to improve in health and made rapid progress. She was discharged from the hospital on February 1 and returned to her duties on March 1.

For seven and a half years after the operation she performed her arduous duties. She died suddenly on August 20, 1942. An autopsy was performed 36 hours after death in the laboratory of the DePaul Hospital in St. Louis, Missouri, by Dr. Walter J. Siebert. The immediate cause of death was ascertained to be massive pulmonary embolism. There was no evidence of carcinoma of the pancreas.

Psychobiological Aspects of Spontaneous Regressions of Cancer

Booth G

American Academy of Psychoanalysis. Journal 1(3): 1973; 303-317

Extracted Summary

In this paper it is proposed that psychological trauma is an antecedent to the development of cancer during a lifetime. It is suggested that as infants, cancer patients experience traumatic frustration in their mother relationship, and their subsequent life histories are characterized by a desperate need for control of a specific object. The neoplastic process begins when the patient experiences the irreparable loss of control over his idiosyncratic object. The tumor represents the internalized lost object and the course of the disease depends on the balance of power between the unconscious satisfaction derived from the neoplastic process, and the satisfactions derived from the remaining object relationships.

Cases of so-called spontaneous regression of cancer are of great practical importance because they prove that the psychosocial process between patient and environment can cure neoplasia without any physical attack on the tumor itself.

The dynamics of cancer therapy include (a) response on the part of friends and relatives similar to that produced by a suicidal attempt, and (b) the capacity of the patient to replace the lost object relationship by a new one. Rational cancer therapy thus requires that the patient be encouraged to accept the responsibility of resolving the existential crisis of which the neoplasia is the somatic expression.

In summary, the author concludes that sometimes cancer regresses in the absence of physical manipulation aimed at destroying the cancer cells. Such regressions of cancer are not spontaneous but responses of the organism to a favorable change in the psychosocial situation of the patient. So-called spontaneous cases of regression agree with the concept that cancer is the reaction of a pregenitally fixated personality against the loss of a vitally important object relationship. Healing

is mediated by the defense reaction of the cerebral cortex against cancerous tissue. The healing potential can be aided by physicians who utilize the plasticity of the brain function in a state of crisis.

The capacity of patients for cooperation with the therapist is limited by their intrinsic secretiveness and guilt feelings, compounded by the pervasive aura of pessimism surrounding cancer. These limitations make the psychotherapeutic approach difficult, but not impossible. Physicians, confronted with these difficult patients, are often reluctant to invest the necessary time in view of the uncertainty of the results. This negative approach is rationalized in terms of the prevailing prejudice that cancer is a disease of cellular origin. This prejudice is based upon the fantasy that animate nature can be manipulated by methods which have proved successful in controlling inanimate matter.

The growing evidence of the unpredictable results of purely somatic therapy gives reason for hope that the emphasis of cancer therapy will shift from physical destruction of the tumor to reconstruction of the patient's relationship with his human environment.

Selected Case Reports

A woman in her sixties was found to have an inoperable cancer of the pancreas. She returned to her home expecting to die. At this point her daughter, a devout Catholic, prayed for the recovery of her mother with whom she had been on bad terms for as long as she could remember. She finally wanted a reconciliation and her mother responded with what seemed to be a complete recovery. After 14 months of a harmonious relationship, the mother's health suddenly declined and a new operation was performed. It was found that the original tumor had regressed so much that it could have been removed if a small part of the tumor had not entered the bile duct (personal observation).

At the age of 63, composer Bela Bartok was found to be in what seemed to be the terminal stage of leukemia. He had been very depressed by the lack of response to his work in America. Unexpectedly, Serge Koussevitzky visited him in the hospital and commissioned him to write a work for the Boston Symphony Orchestra. It immediately became apparent that Bartok had taken a new lease on life. He returned to the South and wrote the most successful of his 106 works: the "Concerto for Orchestra" which had its premiere in the following year. He then composed his "Third Piano Concerto" and finished all but the last 17 bars when the final recurrence of leukemia killed him 27 months after the visit of Koussevitzky (Heinsheimer 1968).

Spontaneous Regressions: Scientific Documentation as a Basis for the Declaration of Miracles

Garner J

Canadian Medical Association Journal 111: Dec 7 1974; 1254-1264

Extracted Summary

The author presents an overview of the history and miraculous healings which have been reported at Lourdes. The story began in February, 1858 when 14-year-old Bernadette Soubirous was gathering firewood where the river runs beneath a rocky cliff. She heard a roaring, like the wind, and turned to see a lady wearing a white garment with a blue sash standing in a cave-like area part-way up the rocky cliff. The lady spoke in the local patois saying "would you do for me the grace of returning for 15 days?" No one else saw the lady, and the Church, after careful scrutiny, determined that Bernadette saw the lady 18 times. The lady said that she was the Immaculate Conception and requested that a spring be dug and that people should come and pray at that spot. The spring was dug and still flows.

In order for a healing to be classified as miraculous, five criteria must be met. First, it must be proved that the illness existed, and a diagnosis established. Second, it must be shown that the prognosis, with or without treatment, was poor; third, that the illness was serious and incurable; fourth, that the cure happened without convalescence, that it was virtually instantaneous, and, finally, that the cure was permanent. These criteria must be met by the Medical Bureau of Lourdes, the Church, and the diocese in which the "miraculée" lives.

At Lourdes, each case presented is reviewed by three panels of physicians. Since 1947, only 75 cases have been accepted at this first level. Of these, 52 were accepted by the second level, and only 27 were pronounced as scientifically inexplicable by the third level. After the panels of physicians have made their decision concerning the miraculous healing, the Church then makes a judgement as to whether these inexplicable cases are the result of divine intervention. The case is then sent to the local diocese where the local bishop sets up a commission to examine the evidence. These commissions are frequently more stringent than the medical panel at Lourdes since out of the 27 cases mentioned above, only 17 were pronounced miracles by the local diocese. To date, there have been 62 healings accepted as miracles.

Psychosomatic Consideration on Cancer Patients Who Have Made A Narrow Escape from Death

Ikemi Y; Nakagawa S; Nakagawa T; Mineyasu S
Dynamische Psychiatrie 31: 1975; 77-92

Extracted Summary

Clinical histories of five cases of spontaneous regression of cancer (SRC) have been analyzed from the psychosomatic point of view. As a result, some common features have been observed in their psychophysiological conditions. In all five cases, the absence of anxious and depressive reactions and the dramatic change of outlook on life seemed to have led to the full activation of their innate self-recuperative potentials and to have helped them to make a narrow escape from death. Such an extraordinary psychological achievement was supported and encouraged by their religious faith or favorable change of human environment. Furthermore, the authors feel that the background of Oriental thought also might help them reach such a blessed state of mind. As one of somatic conditions which might contribute to SRC in them, the unchanged or rather elevated immunological capacity which was usually lowered in cancer patients has been confirmed in three of them.

Selected Case Reports

Case 1: Y. H., a male church worker, died in November 1964, at the age of seventy-five. Clinical History: The patient was 64 years old when he noted sudden nasal bleeding and nasal obstruction while at work in March 1950. Dr. F., an otorhinolaryngologist, after having examined the patient, suspected malignant cancer and sent him to the department of otorhinolaryngology of the Kyushu University Hospital. An exploratory excision was conducted from a polyp on the right maxilla. Through the histological examination, a diagnosis of "cancer of the upper jaw (right side)" was made. The resection of the tumor was conducted on April 14, 1950.

He complained of hoarseness in January, 1951 when he thought he had caught a cold. At first he was treated under the diagnosis of chronic laryngitis, but the hoarseness was aggravated. Because of increased dry feeling in the laryngeal region as well as of hoarseness, the patient was examined again at the university hospital (age 66). A new growth of a tumor was discovered in the left side of the vocal cord. A record of this has been preserved on the chart at the university hospital. An exploratory excision followed by the microscopic histological examination revealed cancroid (squamonocell carcinoma).

Prof. S. of the department of otorhinolaryngology recommended that the patient be operated upon, but the patient declined it. He lived for the next thirteen years without receiving any regular treatment including radiotherapy, anti-cancer drug therapy, to say nothing of an operation. He died at the age of 78 when he received a bruise on the back which eventually caused his general deterioration.

Life History: The patient was born on a farm in 1886. At the age of eighteen, he became a member of a religious organization (Shinto sect). He was appointed teacher of a church when he was twenty-one. He then became a district leader of the organization and devoted himself to church work throughout his life.

He was a taciturn and self-punitive person by nature. After the end of the Second World War, his religious organization was exposed to a great crisis. During the war he was asked to take over important business in the administration of his town. With the end of the war, he had a very difficult time carrying out his responsibilities for his neighbors as well as for his church work. Under these circumstances, he suffered from maxilla cancer in 1950.

Course of Illness: Ten days after "the sentence of cancer," he visited the president of the religious organi-

zation, who said to him: "Remember that you are an invaluable asset for our church." This made him feel very happy and he shed tears of joy all the way back home. Since this moving experience, his hoarseness began to improve and he began to give a short speech at his church four months later (July, 1952). At this time his voice was still hoarse. Six months later, however, he spoke thirty minutes in the church and this time his voice was quite clear (this sermon was tape recorded).

In the literature concerning psychosomatic aspects of cancer, it has been noted that cancer patients, after having become aware of their cancer, often show a tendency of repression and are apt to lapse into depression with lack of motivation toward life and fear of death. This patient, however, did not demonstrate these characteristics at all. Today Dr. F. says: "The cancer of this patient seemed to be practically cured. When I looked into the vocal cord through laryngoscopy, the tumor was gone..."

Case 3: K. A., a 39-year-old housewife. Clinical History: She had an intermittent dull ache in the epigastrium in 1963 and was seen by Dr. S. in March 1966 because of continuous epigastralgia, lumbago, anaemia, general malaise and weight loss. Extensive examinations confirmed her stomach cancer with marked metastatic lesion. Dr. O., who operated on her, says: "When I opened the abdomen, I saw many thumb apex size metastases in the lessor curvature of the stomach and in lymph nodes of the mesentery leading to the transverse colon. Also the metastases in the mesocolon lymph nodes were certain, which were later histologically confirmed as adenocarcinoma. As I thought the recurrence was sure to come, I could not help performing gastrectomy which was a palliative operation (2/3 resection–Billroth I method). I sutured the abdomen leaving metastases of cancer as they were. I told her family that cancer metastases were so bad that she would live one month or three months at best..."

The patient, however, began to improve three months after the operation. She has been in good health for nine years ever since.

Life History: The patient was born on a farm in 1935. When she was in high school, her friend's mother invited her to become a member of a religious organization. She married her present husband at the age of twenty-four and they are running a drug store in Fukuoka City and have a 14-year-old son.

For several years prior to the onset of her cancer, her husband used to go out on his business till late at night, often attending drinking parties. Her self-centered and repressive personality contributed to repressing her aggression toward her husband. She had not consulted a doctor until March, 1966. At that time, she thought it was due to stomach ulcer and tried to endure stomach ache. How did she feel when the diagnosis of stomach cancer was confirmed? In response to our question, she stated:

"Frankly speaking, I was not afraid of cancer. That was because I had my religious faith. But without it, I would have given in to the fear of cancer. I am now very grateful to my friend's mother who persuaded me to have this faith."

She continued: "I suffered from cancer much earlier before reaching what is called 'the cancer age.' Because of this, I was forced to an early mental awakening. I had been a stubborn person and I feel I had my corners rounded off by having cancer. Faith to me is not the attachment to life just wishing to be saved, but it is gratitude to God who saved my spirit. I had begun to live a real life since that time."

Course of Illness: She has been in excellent condition nine years after the operation (Fig. 6). X-ray examinations of the residual stomach conducted in October, 1969 and July, 1971 revealed that the gastric wall was smooth with no evidence of irregular shaped region. No sign of metastasis was observed.

Case 4: K. K., a 77-year-old man. Clinical History: The patient noted anal bleeding and difficulty in defecation when he was forty-seven years old. At that time he thought he had hemorrhoids and was seen at the department of surgery of the Kyushu University Hospital. On examination, the growth of cancer tissue was detected in the fore wall of the rectum ampulla perforating there in a ring shape.

The doctor in charge recommended an operation, but the patient declined it for economic reasons. For some time, he had frequent episodes of abdominal pain, lumbago, tenesmus as well as emaciation. However, these symptoms gradually disappeared. For the past thirty years, he has had no symptoms of rectal cancer.

About three years ago, however, he had the feeling of fullness in the stomach which was accompanied by abdominal discharge and dull ache. He was seen by Dr. K. in May, 1973. Results of x-ray examination and gastrocamera led him to suspect gastric cancer. Biopsy material from the stomach revealed "poorly differentiated adenocarcinoma". However, the patient did not receive any regular treatment including an operation, x-ray treatment or anticancer drug therapy. Today he is alive and well.

Life History: The patient was born on a farm in 1896. At the age of sixteen, he became a believer in the Nichiren Sect of Buddhism. For some time he taught at a grade school and married his present wife when he was twenty-eight. They lived in Northern China during the World War II. After returning to Japan, they found it hard to make a living. While he raised rice on the farm, his wife had to peddle dry goods about the country while carrying their baby. They simply lived a hand-to-mouth living. This must have been a big frustration, as he had no one to turn to for help. It was at this time when he had the onset of rectal cancer.

As to the recent psychological stress, he has been living with his son's family who support him economically. He has had some emotional conflict with his son around 1970.

Course of Illness: When he was diagnosed as having cancer of the rectum at the Kyushu University Hospital

in 1949, he was not shocked, he says. As the Comprehensive Social Insurance System had not yet been established by that time, he learned that he had to pay 100,000 for the surgery from his own pocket. He had no one to turn to to borrow that amount of money, so he decided that he would work hard as long as he could live even if it meant a year or two. He says that his Buddhist faith served as a big support during these trying years.

He has been unconcerned about worldly ambitions. About three years ago he began to notice the aforementioned stomach symptoms, for which a diagnosis of stomach cancer was confirmed. He received occasional symptomatic treatment, but no anti-cancer agent therapy.

Notes on "Spontaneous" Regression of Cancer

Weinstock C

American Society of Psychosomatic Dentistry and Medicine. Journal 24(4): 1977; 106-110

Extracted Summary

The author describes 12 cases of spontaneous regression in cancer patients, i.e., improvement not attributable to conventional medical treatment. It is thought that depression causes decreased efficiency of the body's immune response. Therefore, if the patient's situation changes so that depression is relieved, the restored immune response will have a better chance to fight the malignancy. Some of the favorable emotional and social changes that occurred for these 12 patients involved marriage, birth of a grandchild, religious conversion, writing a book, and death of a despised husband. Interventions that alleviate depression, such as placebos and ECT, may also be effective in rallying the body's physical defenses. There is strong resistance in the health professions to recognizing cases of spontaneous regression.

Selected Case Reports

An aunt of mine was operated upon for carcinoma of the colon twenty years ago. It was widespread throughout the abdominal organs and cavity, and she was closed up and sent home to die. However, this woman of forty (who had lost both parents after long caring for them in their old age) met a man who interested her just before the cancer symptoms began. She was never told she had cancer, and recovered rapidly as wedding plans proceeded. She is fine today after a rather good marriage.

Dr. Maurice Green, as an intern, observed the treatment of a physician with glioblastoma multiforme. The operation was unsuccessful. The patient, however, had a regression rather than progression of symptoms and signs. Eventually he left the hospital completely well, indicating only that he felt differently about life after facing death.

A woman in her forties with a very traumatic childhood (much being shifted around, etc.) and an adult series of unfortunate love affairs and business disappointments developed depression, then breast cancer with metastases to many bones. She had a hystero-oophorectomy in July, 1975 and through September the usual progressive relief of bone pain. Then the pain became stable. I began to see her free of charge in November 1975 in supportive psychotherapy. By January, 1976, encouraged, she was again seeing her original psychotherapist from years ago, Dr. Martin Symonds. She was experiencing a reawakening of some former interests and had once more progressive diminution of bone pain and marked reduction of the metastases on bone x-rays. This, too, is a "spontaneous" regression since breast cancer bone metastases do not show symptomatic or radiological regression beyond the first 8-10 weeks following oophorectomy. Her improvement still continues, and there is no bone pain except under stress.

A woman of 51 had cancer of the bladder. This was unsuccessfully operated on. She had a religious conversion subsequently, and has been well for 10 years now.

A woman of 55 with terminal cancer of the colon was given two weeks to live. She was in skeletal condition. A grandchild was born. She gained much weight, lost all symptoms, and lived 14 months, helping much with the baby.

A woman of 52 had carcinoma of the uterus (originating near or in the cervix). It had spread to the intestine and death was expected within weeks. But her much-hated husband suddenly died. Today a year and a half later she is entirely well.

A Case of Healing in Malignancy

Bowers MK; Weinstock C

American Academy of Psychoanalysis. Journal 6(3): 1978; 393-402

Extracted Summary

The case of a young man who, during the course of psychotherapy, developed cancer and subsequently recovered from it is presented. The psychodynamics of the case are discussed in the context of experimental and clinical studies demonstrating a relationship between affect and the body's immunological system. A 19-year follow-up is presented.

Selected Case Report

This is the first published case of "spontaneous" recovery from cancer where the psychodynamics were known before, during, and after the incident. Daniel was first seen, at age 21, by Dr. Gotthard Booth. A seminarian (Episcopalian), Daniel experienced a powerful conflict between his preoccupation with sex and his ideal of celibacy. Rorschach and interview data show Dan as rebellious, frightened, rigid, and anxious. He was guilt-ridden over masturbation and insecure in social relationships, particularly with girls. Rigidly and anxiously preoccupied with Catholic-like forms of worship, he was deeply conflicted about his life goals. Booth noted, however, that Daniel was flexible in thinking and imagination, emotionally responsive, capable of differentiated introspection, and likely to benefit from psychological counselling. Shortly after seeing Booth, Daniel began psychotherapy with T.J.B., a well-trained pastoral counselor. Despite dedicated psychotherapy by T.J.B. Dan's seminary years were a walking nightmare. Upon graduation he refused ordination, choosing seclusion and a bare livelihood as a librarian. His therapy bogged down in a dependent and rather overtly hostile transference, with long silences or symbolic language only. In 1957, Dan developed a relationship with Constance, which he rigidly overcontrolled.

In August, 1958, T.J.B. insisted that Dan transfer to M. K. B., a female therapist, who placed him in a strong, cohesive therapy group as well as seeing him individually. Dan seemed almost too sick to be in the group, seldom speaking and appearing not to listen. M.K.B. arranged additional hours with a male therapist and occasional hours with T.J.B. and, with this therapeutic team and cohesive group, Dan began to move. He became aware of his great anxiety over impinging intimacy with Constance. His fear of object-loss, based on mother's abandonment of him in infancy, was enormous.

On approximately January 27, 1959 (at age 26), Dan noticed the first symptom of cancer, an increased hardness in his left testicle. Diagnosis was embryonal cell carcinoma of the testis. Operated on in February, 1959, Dan felt very well psychologically. He was sure for the first time that he loved Constance and wanted to marry her. Decisions to set one's life straight and come to terms with Fate following first knowledge of cancer often auger well.

After a visit from his mother, in which his mother insisted that Dan's cancer was her punishment by God for her sexual sins and Dan tried to convince her it was his cancer not hers, Dan experienced a psychoticlike episode, believing his cancer was God's punishment for his sins. In radiotherapy, he felt crucified, abandoned, and desolate under an implacable machine

After the postoperative period a deep suicidal depression set in. Because he had been too weak to work for months, he experienced money problems. However, during this period, he found a significant friend, a capuchin monkey, which he fought hard to get. To poor to buy it, he turned to M.K.B. and convinced her of his great need to cuddle and care for something or someone. M.K.B. intervened through a donor and bought the monkey.

Less than four months after the operation (June, 1959), Dan's anger broke through. Hitting the wall to keep from hitting Constance, he injured his hand. In the treatment of this injury, enlarged lymph nodes were found in the neck and axilla, and metastases in the chest wall and lung. Node biopsy showed cancer identical to the original embryonal cell carcinoma. Daniel's chances of one-year survival were zero. His case was considered 100% hopeless, and cobalt and nitrogen mustard therapy were instituted for purely palliative reasons. During this period his grandfather died. His grandmother caused Dan deep concern and the tumors on his neck grew so large he had to hold his head nearly touching one shoulder.

When Dan asked M.K.B. how serious his physical illness was, she told him he had less than three months, possibly a few weeks to live. "What do you want to do before you die?" she asked. "I want to get married and be ordained," Dan replied without hesitation. He was encouraged in the thought that only in living life intensely was there any hope for survival. Dan asked Constance to marry him and she agreed. Arrangements were made for Dan's ordination. Members of Dan's group arranged for a communion service in the group.

Hospitalization was difficult and by the time of the wedding, July 13, Dan looked like a walking ghost. The large neck tumors, however, had almost completely regressed. By July 20 x-ray showed almost complete resolution of pulmonary metastases, but this information did not penetrate the focal awareness of either M.K.B. or the somatic physicians. Age-regression hypnosis was used to

help Dan relive the feeling of his great grandmother's love; and after the vivid and meaningful experience, Dan continued to have a consciousness of a very real, warm relatedness to the great grandmother who loved him so deeply. (Dan named this hypnotic intervention an important part of his recovery.)

By July 31, x-rays showed complete disappearance of the pulmonary metastases (the information still not penetrating the clinical milieu), and on August 1, Dan was ordained deacon. On August 8, 1959, Dan was told there was no longer any evidence of cancer anywhere, and that he was now completely well. This sudden shift from the expectation of dying to the reality of living was a difficult one. A few hours later Dan was seized by a wrenching spasm of every muscle in his body, which he experienced as a literal tearing apart of body. He wanted desperately to die, and desperately to live. This ordeal seems to be what Spitz (1964-1965) calls a total "coenesthetic" experience, the "sensing" of the newborn infant.

Dan and Constance faced an enormous number of problems from which they grew. Finding the parish ministry restricting, Dan entered graduate school in architecture. Dan had five years of growing, unfolding life before disaster occurred again. His grandmother developed cancer and was hospitalized. Dan accepted custody of her small property in order to care for her after her insurance ran out. Dan's mother, visiting the hospital, discovered the arrangement and reacted with intense paranoid rage. The next day she took an overdose of drugs and killed herself, leaving a vindictive note. Dan's grandmother died a short time later. Dan finished architectural school with honors and finished his course as a city planner. For a long time he took little joy in it; he also began to manifest both grief and anger over his radiation-induced sterility, anger especially directed at M.K.B. that no frozen semen had been obtained and kept. The therapeutic relationship became too strained, and Dan returned to psychotherapy with W.S.F., a previous therapist. Dan and Constance adopted children, asking M.K.B. to be the godmother of their first child.

Today (1978), Daniel continues to grow. His work as a city planner is very successful. His relationship with Constance, though not without continued difficulty, grows in mutuality and reciprocity; and there is no trace of cancer. He is well into his nineteenth year of complete recovery. His primary physician was and still is Dr. Hector Perrone of Manhattan.

A Psychosomatic Study of Spontaneous Regression of Cancer on Local Lymphocyte Infiltration of Long Survival Cases of Cancer Patients, Mainly Digestive Cancer Patients, and Their Psychological Aspects

Nakagawa S; Yoshimura M; Nagata C; Matsuoka S; Ikemi Y
Japanese Journal of Psychosomatic Medicine 21(3): 1981; 217-227

Extracted Summary

Spontaneous regression of cancer (SRC) was classified according to the definition by Everson and Cole in 1966, and it was decided to recognize as proper cases those which met the following requirements: the reduction of a cancer which has been pathohistologically confirmed; reduction of a cancer in spite of unsatisfactory therapy or in the absence of any anti-cancer therapy; the long survival of the host body due to extremely delayed progress or prolonged arrest of cancer with no rapid growth of a malignant tumor; the long survival of the host body with no cachectic change of cancer in the presence of some anti-cancer therapy or the death of the host body after long survival due to some cause other than cancer.

Psychological evaluation revealed that the patients who experienced spontaneous regression had a marked tendency to repress their feelings. But after they knew they had cancer, they stopped their bad habits completely and started to live a meaningful life on a day-to-day basis by doing service for their surroundings. This can be called (according to Booth) an existential shift. It was characteristic of these cases that the patient showed no sign of depression, fear of death or loss of meaning of life after cancer was diagnosed.

Psychosomatic Elements in 18 Consecutive Cancer Regressions Positively Not Due to Somatic Therapy

Weinstock C

American Society of Psychosomatic Dentistry and Medicine. Journal 30(4): 1983; 151-155

Extracted Summary

This article contends that, on the basis of a review of the literature and clinical experience in 18 cancer regressions, some patients had a marked favorable psychosocial change 1-8 weeks before the shrinkage in their tumors was noticeable. These patients were depressed before the favorable change and all found life worth living afterward.

Somatic therapies are vital but the mood of cancer patients and their functional lymphocyte activity should be checked (especially after surgery), with referral to a psychiatrist or other psychotherapist if either good mood or adequate lymphocyte activity is missing.

Eighteen consecutive cases of marked cancer regression (wherein somatic treatment could not possibly have been the cause and wherein even minimal psychosocial data were known about the peri-regression status) were all found to have a marked favorable psychosocial change 1 to 8 weeks before the shrinkage was not noticeable. The changes ranged from religious conversion, to reconciliation with a long-hated mother, to a sudden marriage, and the death of a long-hated husband. We have never heard of it being otherwise in any cancer regression in the world. All 18 definitely did not have anything for which to live before the favorable psychosocial change, and all found life very much worth living afterwards.

Other major favorable psychosocial changes just preceding cancer regression (unexplained somatically) included the following: the unblocking of a career; the unblocking of the ordination of a seminarian; (the placebo effect and "religion" in Laetrile); finding of an important book to write; birth of a grandchild; happy hospitalization with ward and staff friendships of a previously nomadic alcoholic; and the growing of young children to school age so that a brilliant young woman could finally return to her highly intellectual career.

Lourdes Cures and Their Medical Assessment

Dowling SJ

Journal of the Royal Society of Medicine 77: Aug 1984; 634-638

Extracted Summary

In 1858 a 14-year-old girl claimed that a lady had appeared to her at the cliff of Massabielle, just outside the town of Lourdes in the French Pyrenees. The child's reports of their conversations led to the conclusion that this lady was the Blessed Virgin Mary, mother of Jesus Christ, and Lourdes rapidly became a place of pilgrimage. Although the healing of the sick did not feature in the statements made by the lady, sick people seeking a cure that could not be given to them by their doctors soon became prominent among the pilgrims: A few of them found what they sought. The local authorities, both Church and State, were suspicious and disapproving. The State eventually decided to leave the matter to the Church. The Bishop set up a commission to investigate the problem.

Following their report 4 years later he declared that 'it is our verdict that the Immaculate Mary, Mother of God, did really appear to Bernadette Soubirous...Our conviction is based on the testimony of Bernadette but more especially on the events which have occurred and which have no explanation save in the intervention of God.'

The Catholic Church is well used to claims of miraculous cure and to evaluating them by means of a set of criteria devised in 1735 by Cardinal Lambertini (afterwards Pope Benedict 14th). The rules are: (1) The disease must be serious, incurable or unlikely to respond to treatment. (2) The disease which disappeared must not have reached a stage at which it would have resolved by itself. (3) No medication should have been given, or if some medicines were prescribed then they

must have had only unimportant effects. (It is most unusual nowadays to find a case completely untreated and this rule is interpreted as excluding any patient who has had potentially curative treatment unless that treatment can be demonstrated to have failed.) (4) The cure must be sudden and reached instantaneously. (This is now extended to include cures developing over a period of days.) (5) The cure must be complete, not partial or incomplete.

The latest cure to be passed by the CMIL [International Medical Committee of Lourdes] as medically inexplicable is that of Delizia Cirolli, in September, 1982, a child from a village on the slopes of Mount Etna in Sicily. In 1976 when she was 12 years old she presented with a painful swollen right knee. The CMIL studied the case in 1980 and 1981 and at their meeting in 1982 they decided that Ewing's tumour was the correct diagnosis and concluded that the cure was scientifically inexplicable.

At the present time more than 4 million pilgrims visit the shrine every year and about 65,000 of them are registered and documented as sick. The Medical Bureau estimates that over 2 million sick pilgrims have come to Lourdes since 1858 and about 6,000 persons claiming to be cured have been examined by the doctors there: a total of 64 have been recognized as miraculous cures by the Catholic Church.

The Scientific Study of So-called Miracle Cures

Van Kalmthout MA

Paper presented at the Second European Conference on Psychotherapy Research; Louvain-la-Neuve, Belgium, September 3-7, 1985; 17 pgs

Extracted Summary

The question posed in this paper is whether the concept of miracle cures refers to an empirically observable event (thus one that can be approached in a scientific way). Also addressed are the characteristics of this phenomenon.

The author concludes that a miracle cure can be defined as the sudden, permanent and complete cure of a long-lasting serious condition (more or less organic in nature), for which no adequate treatment can be held responsible. The author cites two examples of miracle cures falling under this definition, namely the cures taking place at Lourdes and spontaneous regressions of cancer. A review of some possible promising psychological approaches to this phenomenon was presented. He argued that a systematic psychological investigation is necessary (and possible) in order to elucidate the eventual psychological processes involved in miracle cures.

Good examples of how such a study could be set up are the study of Tuchfeld on spontaneous remission in alcoholics (Tuchfeld, 1981) and the study of Ring (1980) on near-death experiences. Especially, the latter study shows that it is possible to study exceptional cases in a systematic way enabling specific questions to be answered.

The author states that the spontaneous cure of cancer seems an excellent phenomenon to use to study miracle cures in such a way. It is to be expected that such a study will increase our understanding of the fundamental processes of healing and change, which form the permanent core of all forms of psychotherapy and mental healing.

Psychosocial Correlates of "Spontaneous" Regression of Cancer

Van Baalen DC; De Vries MJ; Gondrie MT

Humane Medicine : Apr 1987; 14 pages

Extracted Summary

The behavioral characteristics of 6 cases of "spontaneous" regression of cancer (SRC) in advanced stages are described and compared with those of 6 patients with advanced progressive cancer (PRC). All patients, and in some cases their relatives, were subjected to a pre-structured open,

in-depth interview, transcripts of which were scored independently by 6 raters for 8 different characteristics. The aim of the study was to investigate whether the SRC patients shared certain psychological characteristics and/or changes in behavior and relationship toward the enviroment and whether their behavior differed from those of patients not having had an SRC. It appears that all SRC patients presented a relatively sudden change toward (increased) autonomous behavior and/or in their attitudes toward their illness, treatment and environment. Of the 8 behavioral criteria, 7 appear to discriminate between the 2 groups.

These findings are discussed in the light of clinical, epidemiological and experimental data, suggesting that a state of hopelessness, helplessness, mental depression, and social stress may lead to a depression of a variety of immune functions and may enhance the growth of malignant tumors. It is hypothesized that stimulation of the patient's autonomy and improving their relationship towards their environment, inside and outside the clinical situation, will improve the effectiveness of cancer treatment. Future intervention studies are needed to test this hypothesis.

"Spontaneous" Regression of Cancer

A Report of Seven Cases

Van Baalen DC; De Vries MJ

Humane Medicine : Apr 1987; 10 pages

Extracted Summary

The clinical history and course of illness of 7 cases of "spontaneous" regression of cancer (SRC) in advanced stages are described. SRC was determined according to the generally accepted criteria and after reviewing the histopathologic, roentgenologic and other relevant data. The relative ease with which 7 cases were collected in a period of about 2 years raises the question whether the phenomenon of SRC is as rare as is reported in the literature. Possible reasons for this seeming discrepancy are discussed. In order to learn more about some of the erratic aspects of cancer behaviour and host resistance through such "experiments of nature," it is recommended that registration of cases of SRC is actively undertaken by the national cancer registries.

Surveillance as a Possible Option for Management of Metastatic Renal Cell Carcinoma

Oliver RTD

Seminars in Urology 7(3): Aug 1989; 149-152

Extracted Summary

Ten years ago this department, prompted initially by the experience of apparent acceleration of tumor growth in a patient receiving chemotherapy for metastatic renal cell carcinoma and the experience of using surveillance as a management option for patients with stage I malignant teratoma and more recently for seminoma, set out to investigate the incidence of unexplained "spontaneous" regression in patients with metastatic renal cell carcinoma, using a surveillance protocol similar to that used to monitor stage I testis tumors.

Between 1977 and 1986, 73 patients were recruited into the study. Initially it was decided that a 25% increase in metastatic size would be considered a justification to go off surveillance protocol. This was changed when a patient, whose single lung metastasis progressed, was treated with BCG to which she had no response. She became progressively anemic due to alcohol abuse, was admitted to hospital, and after alcohol and BCG withdrawal, went into complete remission which continues today, 86 months later.

It is the aim of this report to update the results of this study and assess its significance in the light of more recent experience in the use of IL-2. At the time of the initial report three patients had achieved complete disappearance of measurable disease, two had partial responses, and

four had periods of prolonged stable disease for longer than excess of 12 months. Seven of these nine patients (i.e., 10% of the total group) remained progression-free at 12 months. One progressed at 14, two at 30, one at 52, and one at 120 months. One of the three patients achieving CR remains so at 72 months, and one of the four patients with stable disease remains off treatment at 58 months with slowly progressing (by 55%) but asymptomatic lung disease. At present, one of these nine patients remains continuously free of disease, although three others after late relapse are now in a further complete remission, giving an overall survival rate at 5 years of 6%.

Of perhaps more scientific interest is the observation that three of the nine patients having prolonged unexplained survival did so after relief of a psychologically distressing problem. The increasing number of similar observations are fueling reinterest in the longstanding idea that there might be neuropsychic interactions influencing antitumour immune responses.

Selected Case Reports

The first patient has been mentioned briefly already and showed complete disappearance of a lung metastasis after resolution of a marital problem associated with chronic alcohol abuse, having failed to respond to BCG.

The second patient was a 79-year-old man who, 4 years after nephrectomy, presented with lung metastases shortly after the death of his wife, which caused him considerable grief. When interviewed in depth after having been on surveillance for 3 years with slowly growing metastases and asked to what he attributed his good survival, he volunteered that for the last 3 years he had been attending a spiritual medium who had enabled him to make contact with his wife who told him that all was well.

The third patient is perhaps the most interesting. She had presented with metastases that had progressed after surgery and medroxyprogesterone treatment. At this stage she had been referred for interferon treatment. Before starting, medroxyprogesterone was stopped and she was entered on surveillance. She immediately felt better and over 6 months her lung metastases began to shrink. At this stage her cough returned and the residual shadowing began to increase. During the course of the interview at this time she volunteered that she was not legally married but that her common-law husband was an alcoholic who often was physically violent. This had temporarily stopped when she had been initially referred, but he had now returned to his violent behavior. Following counseling of both parties her lungs began to clear again, though they never totally cleared. Fifty months after diagnosis a single lesion began to enlarge and the patient became polycythemic. It transpired that her alcoholic partner had returned to his previous behavior and was also stealing from her to pay for his alcohol. She was admitted to hospital and the single chest lesion was excised and shown to contain clear cell carcinoma. Her hemoglobin decreased to normal and for the last 20 months she has remained well, living with her sister and free of disease, having moved out from her previous unsatisfactory domestic environment.

Psychospiritual Dimensions of Extraordinary Survival

Roud PC

Journal of Humanistic Psychology 29(1): Winter 1989; 59-83

Extracted Summary

Nine individuals who survived their medically confirmed diagnoses of "terminal cancer" were interviewed.

The patients' physicians were contacted and asked to confirm or not confirm the exceptionality of these patients. To qualify as an interviewee, the patient's physician needed to substantiate that when the diagnosis was verified the consensus of medical opinion would suggest that the likelihood of survival for as long as the person had lived already was 0.25. In actuality, all except one significantly exceeded these minimum requirements.

The survivors' self-reports were another method to establish their exceptionality. They all report being told (by one or more physicians) that they would die from their cancer in the near future. Because the purpose was to learn the survivors' stories, the interviews were open-ended. They were asked to discuss their experience and indicate why they thought their course of illness was so much more successful than predicted.

These people offered personal theories to account for the extraordinary results and discussed the nature of their life changes following the terminal prognoses. The similarity of responses was compelling. Survivors assumed responsibility for contracting cancer, disease outcome, and the quality of their lives. They believed that their attitudes and actions significantly influenced their illnesses. Survivors were leading fuller, freer, more meaningful lives following cancer onset. Fear and worry were greatly reduced, or even eliminated according to some. The author suggests that these profound changes may be related to their encounters with impending death. They reported an intense desire to stay alive. Life was viewed as a gift, far too precious to abandon prematurely. Survivors indicated that they cannot offer prescriptive healing formulas. They believe that seriously ill patients must discover for themselves what will be life-giving. Excerpts from interviews with three of the survivors are included.

Selected Case Histories of Cures Accepted as Miraculous by the International Medical Commission at Lourdes, Dr. Roger Pilon, Medical Director

Delizia Cirolli (born November 17, 1964) [from St. John Dowling, 1984]

The latest cure to be passed by the CMIL as medically inexplicable is that of Delizia Cirolli, in September, 1982–a child from a village on the slopes of Mount Etna in Sicily.

In 1976 when she was 12 years old she presented with a painful swollen right knee. An X-ray showed bone change, so she was referred to Professor Mollica at the Orthopaedic Clinic of the University of Catania. After further x-rays he did a biopsy which Professor Cordaro reported as showing a bony metastasis of a neuroblastoma. The surgeon advised amputation; the family refused. He then advised cobalt irradiation and she was transferred to the Radiotherapy Unit where she was so unhappy that her parents took her home the next day, before she had had any treatment. She went for a further consultation at the University of Turin but returned home without treatment. Her teacher suggested that Delizia be taken to Lourdes, and a collection made locally enabled her to go with her mother in August, 1976.

There she spent 4 days attending the ceremonies, praying at the Grotto and bathing in the water. There was no improvement and X-rays in September showed extension of the growth. The child went downhill and her mother began to prepare for her funeral. Nonetheless, the villagers continued to pray to Our Lady of Lourdes for her cure and her mother regularly gave her Lourdes water.

Shortly before Christmas she suddenly said that she wanted to get up and go out, which she did without pain but she was not able to get very far owing to weakness; at this time she weighed only 22 kilograms. Her knee swelling disappeared, leaving her with a degree of genu valgum, and her general condition returned to normal. X-rays showed repair of the bone.

The following July she returned to Lourdes to present herself to the Medical Bureau and did so again in 1978/79/80. X-rays of the thorax and abdomen showed no sign of the calcification often seen in neuroblastoma. There was no doubt that she had been cured but the exact diagnosis proved more difficult. The histological opinion of Professor Cordaro of Catania was a metastasis from a neuroblastoma. He sent the biopsy slides to the Medical Bureau and they were submitted to French histologists eminent in the field of bone tumours. Professor Payan of Marseilles considered that a metastasis from an undifferentiated neuroblastoma was a possibility, but gave his opinion that it was a Ewing's tumour. Professor Nezelof of Paris agreed that the diagnosis of a metastasis from a neuroblastoma could not be absolutely excluded, but concluded that Ewing's tumour was the most likely diagnosis. Dr. Mazabraud and his colleagues at the Curie Institute reached the same conclusion. Spontaneous remission of neuroblastoma has been reported, but very rarely and never after the age of 5 years. Spontaneous remission of Ewing's tumour has not been recorded.

The CMIL studied the case in 1980 and 1981 and at their meeting in 1982 they decided that Ewing's tumour was the correct diagnosis and concluded that the cure was scientifically inexplicable. The fact that the moment of cure was at home in Sicily and not in Lourdes was irrelevant to the work of the Committee. The child's family claimed that she had been cured by Our Lady of Lourdes, therefore the Lourdes system of medical scrutiny was set in motion. It is for the Church to decide whether or not the cure was miraculous and to be attributed to Our Lady of Lourdes; a year later no decision had been reached.

From the Communique from the Medical Bureau of Lourdes: At their meeting on 26th September 1982 the members of the International Medical Committee, after taking full cognizance of: the findings of a diocesan medical commission composed of all the doctors who treated

the patient (their assessment of the cure was voted by a two-thirds majority to be similar to that of the Medical Bureau); the report produced by the French doctor, M. A. Trifaud, and the Scottish doctor, Mr. B. Colivn; and after discussing it in a thoroughly exhaustive way, decided, with an almost unanimous vote that: "after six years, and without any treatment, this cure of a spreading malignant tumour in the upper extremity of the right tibia which young D.C. suffered, constitutes a quite exceptional phenomenon in the strictest sense of the words, contrary to all observations and expectations in medical experience and, what is more, inexplicable."

Vittorio Micheli (born February 6, 1940) [from Jim Garner, 1974]

Vittorio Micheli was inducted into the Italian army in November, 1961, being pronounced physically fit, albeit he had noticed minor pains in March of that year. In April, 1962 he presented to the Verona military hospital complaining of pains in the region of the left ischium and haunch. Extensive clinical examination, x-ray investigations and biopsies led to the diagnosis of sarcoma of the left pelvis.

By June, the condition had worsened and x-rays in August showed "almost complete destruction of the left pelvis" according to army records. Micheli was put into a hip-to-toe cast, with which he was able to stand and move around. In August, the army medical service sent him for radiological treatment but after three days concluded the case was not treatable by irradiation. The treatment was switched to chemotherapy but after two months no improvement was discerned and it was discontinued. In November, x-rays showed luxation of the femoral head and by January the femur had lost connection with the pelvis.

The following May, Micheli decided to go to Lourdes. His cast was exchanged for a stronger one and examination then showed the left hip to be deformed. The patient had totally lost control of his left leg. Pain was severe and continuous, requiring analgesics. He could no longer stand. The patient also suffered loss of appetite and digestive problems.

At Lourdes Micheli, still wearing his cast, was plunged into the baths. Immediately he felt hungry, a characteristic of Lourdes cures. His pains disappeared and he said later, under intensive examination, that he had the feeling his left leg had reattached itself to the pelvis. He felt well.

But he didn't jump straight out of the bath and run off to the grotto. His cast was still enclosing him. Indeed, although Micheli believed he had received a cure, the army doctors didn't. They kept the cast on him. But within a month Micheli was walking, still with the cast. In August, radiographs showed the sarcoma had regressed and the bone of the pelvis was regenerating. The improvement continued and today, although there is some distortion, the sarcoma has disappeared. Micheli works in a factory, standing for eight to ten hours a day. Articulation of his left hip and leg is "the same as normal" according to bureau records.

The Medical Bureau watched the case for five years and eventually decided it should be taken to the final stage, the bureau's international medical committee. In 1969 after lengthy discussion the latter voted 12-0 with six abstentions that Micheli's cure was inexplicable.

The six abstainers suggested the case be referred to a third professor of pathology, and this was done. In 1971 the voting was 12-0 with three abstentions that the case should be submitted to a canonical commission for asessment as a miracle. Finally, on May 26, 1976, a Diocesan Committee, nominated by the Archbishop of Trente, recognized the case of Vittorio Micheli as scientifically inexplicable; a miraculous cure.

The records have been sent to a large number of orthopedic surgeons, in particular those with experience of cancer of the bone. All replied that they never have encountered a case of spontaneous cure of a malignant tumour of the bone.

Dissociative States: Hypnosis and Meditation

Regression of Cancer after Intensive Meditation

Meares A
Medical Journal of Australia 2: 1976; 184

Extracted Summary

There is evidence to suggest that some cancers are influenced by immunological reactions. There is some similarity between immunological reactions and allergic reactions. Some allergic reactions can be modified by meditative experience. Furthermore, some cancers are influenced by endocrine reactions, and some endocrine reactions can be modified by meditative experience. With these ideas in mind I wrote to your correspondence column (Medical Journal of Australia, October 25) seeking referral of suitable cancer patients to conduct a small private experiment to see if the progress of their condition could be influenced by intensive meditation. Only three patients made themselves available and two of them soon dropped out of the experiment.

A case report of a patient with pathologically proven carcinomas in both breasts is reported. The patient experienced regression of metastases following intensive meditation.

Selected Case Report

The third patient, a single woman aged 49 years, has continued steadfastly in the experiment for the past six months. She had pathologically proven carcinomas of both breasts. She had been given radical radiotherapy to both breasts, with initial regression of the tumours. However, they soon recurred and she developed radiologically proven metastases in the spine. She underwent oophorectomy. There was a remission of symptoms, but she relapsed again and had treatment with Laetril (an extract of the apricot kernel) in Mexico. Her condition deteriorated and she required a blood transfusion. Treatment with cytotoxic drugs had been strongly advised, but for reasons of her own the patient kept putting off the decision to accept the treatment.

When I first saw the patient six months ago she was frail, debilitated, and in pain. Her left breast was wooden and immovable on the chest wall and the skin over it was so tight that it appeared in danger of rupture. The right breast had large, wooden lumps in it and the nipple was retracted. Her general condition continued to deteriorate for the first six weeks in which I saw her. Her weakness became greater and she had severe pain in the back. Her condition necessitated two more transfusions. She developed ascites which had to be tapped on two occasions. After six weeks further deterioration gradually ceased. Strength began to return. After the second paracentesis her abdomen started to refill, but the fluid has been reabsorbed. Three months ago the patient was barely able to keep down any food at all, whereas now she says she had enjoyed steak and onions. Initially she barely had the strength to come to my rooms and now she has been swimming in a friend's pool. She has had no analgesic treatment at all for the past ten weeks. The left breast is still hard, but there are definite soft patches developing in the under surface. It is now freely movable on the chest wall, and the skin is still tight, but very much less so than when the patient first presented. The nipple of the right breast is no longer retracted. Her abdomen is now soft to palpation. Her face has filled out, but there is still very marked loss of flesh above and below the clavicles. In spite of the loss of fluid from her abdomen, in the last seven weeks she had gained 9 pounds in weight.

In the six months the patient has attended more than 100 sessions of intensive meditation in a small group under my guidance. She has also practised what I have shown her for many hours, both in my rooms and at her home.

Atavistic Regression as a Factor in the Remission of Cancer

Meares A

Medical Journal of Australia 2(4): July 23 1977; 132-133

Extracted Summary

It is suggested that the atavistic regression of the mind in intensive meditation is accompanied by a similar physiological regression, and that this may involve the immune system and so influence the patient's defences against cancer. A case of a patient with carcinoma of the breast is reported in which regression of metastases occurred after intensive meditation.

Selected Case Report

Last year I reported a case of regression of advanced cancer after intensive meditation. (A Meares Medical Journal of Australia 2 (197); 184).

The significant episode in the patient's recovery is that after the publication of the report, she had a serious relapse. I went overseas for 3 1/2 weeks and the patient was left to continue her meditation unaided. She soon relapsed. Her breast became hard again and the skin over it became tense and discoloured. Her physical condition had clearly deteriorated.

On my return, I inquired in some detail about the way she had been meditating. It gradually became clear that she had changed the pattern of her meditation. With her initial success she had become very confident. Her recovery was hailed as a kind of miracle. Her photograph was in the papers. She gave television and radio interviews and was invited to give talks on how she "beat" cancer. In this burst of confidence, she departed from the extreme simplicity of the meditation she had been taught. She improved upon it. She would tell her cancer to get better. She would will it to get better. "I will make you get better." And of her own initiative she came upon the way of visualizing her cancer getting better. In this form of meditation there was clearly little atavistic regression.

However, when she returned to the extreme simplicity of the meditation in which she was originally instructed, her breast softened again, she put on weight, and strength returned. She had continued well for the nine months since this episode. From this it would seem that the atavistic regression, the going back to a simple and more primitive pattern of functioning was an essential factor in the patient's recovery.

Regression of Cancer after Intensive Meditation Followed by Death

Meares A

Medical Journal of Australia 2: 1977; 374-375

Extracted Summary

The author reports the follow-up of a case reported in an earlier article (Medical Journal of Australia 2(4) (July 23 1977) 132-133) in which a patient with carcinoma of the breast experienced regression of metastases following intensive meditation. After seeking treatment by Dr. Brych in the Cook Islands, the patient experienced a relapse and has since died.

Selected Case Report

In a recent article (Medical Journal of Australia 2 (1977) 132) I referred to a patient with advanced cancer who made a dramatic remission following intensive meditation who relapsed, and who made a second remission when her faulty style of meditation was corrected. At the time of submission of the article, the patient was well, strong, active and free of pain. Owing to the considerable professional interest in the subject, I now wish to report that the patient has since died. She developed ascites, was admitted to hospital for paracentesis, elected to have chemotherapy, and died within a few days.

In a strange, indirect, and negative fashion, her death tends to give further support to the idea that cancer growth can be influenced by intensive meditation. A few weeks ago, in Melbourne, considerable publicity was given to the treatment of advanced cancer by Dr. Brych in the Cook Islands. Without my knowledge, the patient concerned and a small coterie of cancer patients who were attending me for meditation became emotionally involved in the matter, and two of them left to seek treatment in the Cook Islands. It was at this time that the patient relapsed. She told my secretary that, if she had the money, she, too,

would seek further treatment in the Cook Islands. My interpretation of these events is that this situation caused doubts in her mind, and caused her to lose her ability for effective meditation and the still-dormant cancer became active. Her ready acceptance of the chemotherapy, when 18 months previously, in similar circumstances, she had steadfastly rejected offers of such help, seems to have been an outward expression of her new-found doubts about the meditation which had helped her so much in the past.

The Quality of Meditation Effective in the Regression of Cancer

Meares A

American Society of Psychosomatic Dentistry and Medicine. Journal 25: 1978; 129-132

Extracted Summary

The work of the Simontons at Fort Worth, U.S.A. and my own work here in Melbourne, Australia, show that cancer growth can be influenced by meditation. The purpose of this article is to describe that particular type of meditation which in my experience is most successful in its effect on cancer growth. Although my work has shown that cancer can be influenced by intensive meditation so that there has been clear evidence of regression of the growth and patients have lived far beyond the life expectancy estimated by experienced oncologists, it must be emphasized that it has not yet been fully established that it can be influenced to the point of cure.

Vivid Visualization and Dim Visual Awareness in the Regression of Cancer in Meditation

Meares A

American Society of Psychosomatic Dentistry and Medicine. Journal 25: 1978; 85-88

Extracted Summary

The use of intensive meditation by a patient with advanced cancer was followed by remission of the disease. A relapse occurred when she accompanied the meditation with vivid visualization of healthy cells eating the cancer cells. The alertness caused by the visualization interfered with the state of regression needed for the therapeutic effect (activation of the immune system) of the meditation to occur.

Selected Case Report

A single woman of 49 persisted in the experiment and made an extraordinary remission. She had a history of pathologically proven carcinomas of both breasts. She had been given radical radiotherapy with initial regression of the tumors. However they soon recurred and she developed radiologically proven metastases in the spine. She underwent oophorectomy. There was a remission of symptoms, but she relapsed again and had treatment with Laetril in Mexico. Her condition deteriorated and she required blood transfusions. Treatment with cytotoxic drugs had been strongly advised but the patient for reasons of her own declined treatment.

When I first saw her she was frail, debilitated, in pain and unable to keep down her food. Her left breast was wooden and immoveable on the chest wall, and the skin over it was so tight that it appeared in danger of rupture. The right breast had large wooden lumps in it and the nipple was retracted and discharging. She was started on a program of intensive meditation. Her general condition continued to deteriorate for the first six weeks of her seeing me. She developed ascites which produced subacute obstruction of the bowel, and had to be tapped on two occasions. After the second paracentesis her abdomen started to refill, but the fluid was reabsorbed. Appetite and strength returned. She put on weight and had no need of analgesics. The left breast became soft and the discharge from the right breast ceased.

At this stage I went overseas for three and a half weeks and she changed the pattern of the meditation, and she almost immediately relapsed. The left breast became wooden-hard again and the skin over it tense and discolored. However, when she was brought to return to the extremely simple and profound form of meditation in which she was originally instructed, the breast began to soften, her general condition improved again, and she gained 25 pounds in weight.

When first seen by me the patient was a humble little woman facing pain and death. As strength returned and it was clear that she was recovering from the cancer her whole lifestyle changed. She gave interviews on television, radio and to the press. Her photograph was in the newspapers and she gave talks on how she beat cancer. In this burst of overconfidence she departed from the profound simplicity of the type of meditation she had been taught. She improved upon it. She started to will the cancer to go away, so that she could clearly see the lump in her breasts getting smaller, and at other times she would bring herself to visualize the good cells eating away the bad cancer cells. In fact the patient herself had come to the idea of vivid visualization as a technique in meditation. She relapsed, but recovered again when she resumed the meditation of profound simplicity.

Regression of Osteogenic Sarcoma Metastases Associated with Intensive Meditation

Meares A

Medical Journal of Australia 2: Oct 21 1978; 433

Extracted Summary

The patient described showed marked regression of metastases associated with intensive meditation. It would seem that the patient has let the effects of the intense and prolonged meditation enter into his whole experience of life. His extraordinarily low level of anxiety is obvious to the most casual observer. It is suggested that this has enhanced the activity of his immune system by reducing his level of cortisone.

Selected Case Report

The patient, aged 25, underwent a mid-thigh amputation for osteogenic sarcoma 11 months before he first saw me 2 1/2 years ago. He had visible bony lumps of about 2 centimeters in diameter growing from the ribs, sternum and the crest of the ilium, and was coughing up small quantities of blood in which, he said, he could feel small spicules of bone. There were gross opacities in the x-ray films of his lungs. The patient had been told by a specialist that he had only two or three weeks to live, but in virtue of his profession he was already well aware of the pathology and prognosis of his condition. Now, 2 1/2 years later, he has moved to another State to resume his former occupation.

This young man has an extraordinary will to live, and has sought help from all the alternatives to orthodox medicine which were available to him. These have included acupuncture, massage, several sessions with Philippine faith healers, laying on of hands and yoga in an Indian ashram. He had short sessions of radiation therapy, and chemotherapy, but declined to continue treatment. He has also persisted with the dietary and enema treatment described by Max Gerson, the German physician, who gained some notoriety for this type of treatment in America in the 1940s. However, in addition to all these measures to gain relief, the patient has consistently maintained a rigorous discipline of intensive meditation as described previously. He has, in fact, consistently meditated from one to three hours daily.

Two other factors seem to be important. He has had extraordinary help and support from his girl friend, who more recently became his wife. She is extremely sensitive to his feelings and needs, and has spent hours in aiding his meditation and healing with massage and laying on of hands.

The other important factor would seem to be the patient's own state of mind. He has developed a degree of calm about him which I have rarely observed in anyone, even in oriental mystics with whom I have had some considerable experience. When asked to what he attributes the regression of metastases, he answers in some such terms as: "I really think it as our life, the way we experience our life." In other words, it would seem that the patient has let the effects of the intense and prolonged meditation enter into his whole experience of life. His extraordinarily low level of anxiety is obvious to the most casual observer. It is suggested that this has enhanced the activity of his immune system by reducing his level of cortisone.

The Psychological Treatment of Cancer: The Patient's Confusion of the Time for Living with the Time for Dying

Meares A
Australian Family Physician 8: 1979; 801-805

Extracted Summary

It has been shown that it is possible to influence cancer growth by a form of intensive meditation, although it is not yet established whether it can be influenced to the point of cure. In working with these patients it has been observed that the course of the illness has often been influenced by the patient's confusion of the biologically appropriate time for living and the time for dying. Without recourse to any formal psychotherapy, the family physician aware of this reaction may be able to enhance the immune defences and increase the quality of life of such patients.

Selected Case Reports

Case 2: A 34-year-old man with lymphosarcoma had been following a downhill course for four years in spite of massive treatment with chemotherapy. He was told he should get his affairs in order as at best his expectation of life was 12 months. He discontinued all orthodox treatment and sought help solely through intensive meditation. He improved, gained strength and seven months after first seeing me was told there was no clinical evidence of the disease. Two months later his brother-in-law had a psychotic episode.

The patient is an idealistic, socially conscious individual who felt that he should be able to do something to help. The brother-in-law's psychiatrist had a conference with the patient and his wife. In discussing this with me he used the expression, "It gives a feeling of hopelessness." He relapsed and had to have some more chemotherapy.

However, with the help of his wife and myself he was able to resolve the double-bind situation on a philosophical basis, and now, more than two years since first seeing me he is well and working, and continues with his meditation for some two hours daily.

Case 3: Fifteen months before seeing me a 40-year-old man had had a hemicolectomy for cancer, and two weeks before our initial consultation laparatomy disclosed miliary spread throughout the peritoneal cavity. He was advised by the surgeon that neither chemotherapy nor radiation held out any real help, and he elected to seek my assistance through intensive meditation. He had separated from his wife but after the laparotomy returned to her only to come to physical violence. His girl friend tearfully rejected him on the grounds that she was not strong enough to witness his decline and disintegration. He was truly in the double-bind of hopelessness. His condition deteriorated. He spoke of extreme anergy and lethargy in a way as if it were the precursor of death. However, by seeing his wife and by helping him achieve a more philosophical attitude of mind, I have in part freed him from the double-bind situation with quite dramatic improvement in his clinical condition.

Regression of Cancer of the Rectum After Intensive Meditation

Meares A
Medical Journal of Australia 2: Nov 17 1979; 539-540

Extracted Summary

Strangely enough, at present there is no clear indication that one type of neoplasm is more susceptible to intensive meditation than another. This probably means that host resistance and the effect of a profound and sustained reduction of anxiety on the immune system are more important in this work than is the nature of the tumour itself. It may well be that the extreme reduction of anxiety in these patients triggers off the mechanism which becomes active in the rare spontaneous remissions. This would be consistent with the observation that spontaneous remissions are often associated with some kind of religious experience or profound psychological reaction.

Before the commencement of treatment, it is explained to all cancer patients and, if possible, to a relative that this approach is at present purely experimental. If the patient says that he has been advised to have chemotherapy, and asks for my opinion, he is always told that this is the orthodox treatment.

My data have not yet reached a stage at which they can be effectively subjected to statistical analysis, and my own advancing years make any prolonged trial impracticable. In these circumstances, the publication of case reports may bring others to consider this approach as a possible alternative treatment of cancer.

Selected Case Report

The patient is a 64-year-old man, himself a professional in psychological healing. At the time when he first consulted me, over 12 months ago, he was scarcely able to use his bowels at all and was having an enema each day. He had to get up six or eight times each night to pass urine. His general health and strength were deteriorating. A surgeon had diagnosed carcinoma of the rectum, and this had been proved by biopsy taken per anum. The photomicrograph shows an adenocarcinoma infiltrating tissues beneath the muscularis mucosae. Immediate operation was advised; he was adamant that he would not submit to it. He had heard of the regression of cancer of the breast in one of my patients and sought my help. He was led into intensive meditation, which he captured quite readily through the help of his own professional experience. In addition to seeing me daily, he was required to meditate by himself for one to two hours each day. In two weeks he reported the first signs of improvement. In six weeks he was able to discontinue the use of the enema, and had regained the use of his bowels to the extent of passing stools which he described as like a pencil. In two months he was sleeping the night through without getting up. At this stage he was extremely confident that he had beaten the growth, and he went for a month's holiday to another State.

While he was away, a friend persuaded him to consult an iridologist, one who claims to diagnose bodily ailments by examining the iris. The iridologist spoke vaguely of both prostate trouble and cancer. This upset the patient, and he lost his ability to meditate. He consulted a leading surgeon, who told him the cancer was still there and advised immediate operation. He returned to me looking ill and shaken. I was able to restore his ability for intensive meditation. In two weeks much of his former strength had returned. In six months he had reasonably easy use of his bowels, passing stools of near-normal diameter. Now, over 12 months after first consulting me, he looks well and feels well. He is working at his profession as formerly, except that he allows himself three hours a day for meditation, an hour when he first gets up, ten minutes between patients, and an hour in the afternoon. He enjoys the meditation, and says that it adds to the quality of his life far beyond the relief of his cancer.

The patient is a sensitive man of thoughtful disposition, and quite venturesome by nature. He ponders the problems of his professional work, he writes poetry, and he is an expert hang-glider. This is a sport demanding the utmost courage, in which the glider jumps off a cliff edge into a strong wind while suspended from a kite-like contraption, and is carried upward by air currents. His sensitivity and professional background have made the meditation easier for him, and his courage has helped in yet another skirmish with death.

Remission of Massive Metastasis from Undifferentiated Carcinoma of the Lung Associated with Intensive Meditation

Meares A

American Society of Psychosomatic Dentistry and Medicine. Journal 27: 1980; 40-41

Extracted Summary

The therapeutic process in the present case is confused by the patient's subsequent physical treatment, but the case is reported in order to record the initial seven months remission from this highly malignant condition in the absence of any treatment at all except intensive meditation.

Selected Case Report

The patient aged 34 years first consulted me just two and a half years ago on account of a large swelling on the left side of his neck. He stated that he had been told at a leading oncology clinic that with treatment he might have 2-3 months to live but without treatment it would be a matter of 2-3 weeks. The patient declined

treatment, but continued to attend the clinic for observation. He had heard of the dramatic regression of a breast cancer following intensive meditation and he sought my help. He was breathless in ordinary conversation and troubled by persistent cough. He had a biopsy of the tumor in his neck, and the clinic reported that he had a classic Pancoast tumor of the lung (histology: anaplastic carcinoma) with recurrent laryngeal nerve involvement, a left Horner's syndrome and symptoms of C8, T1 root/plexus involvement.

Treatment by meditation was complicated by lack of any cooperation from the oncology clinic. The patient had been drinking quite heavily and this of course would greatly reduce his chances of effective meditation. He was actually encouraged in his drinking at the clinic apparently in the belief that if he had only a very short time to live he might as well do what he liked. However, in spite of minor bouts of drinking, he mastered the meditative procedure, at first seeing me daily and then less frequently, and practicing by himself at home. After seven months the mass in his neck showed little change and his physical strength was well maintained. At this stage he was told that the tumor in his neck could press on his "wind-pipe" and so cause him to suffocate. The patient panicked at this suggestion and immediately sought physical treatment. He has had a considerable amount of radiation and the swelling in his neck has subsided. Now two and a half years after first seeing me he is still able to get about in reasonable comfort.

What Can the Cancer Patient Expect from Intensive Meditation?

Meares A
Australian Family Physician 9: May 1980; 322-323

Extracted Summary

The results of treatment of 73 patients with advanced cancer who have been able to attend at least 20 sessions of intensive meditation indicate that nearly all such patients should expect significant reduction of anxiety and depression, together with much less discomfort and pain. There is reason to expect a ten percent chance of quite remarkable slowing of the rate of growth of the tumour, and a ten percent chance of less marked but still significant slowing. The results indicate that patients with advanced cancer have a ten percent chance of regression of the growth. There is a fifty percent chance of greatly improved quality of life and for those who die, a ninety percent chance of death with dignity.

Regression of Recurrence of Carcinoma of the Breast at Mastectomy Site Associated with Intensive Meditation

Meares A
Australian Family Physician 10: 1981; 218-219

Extracted Summary

The patient attended each weekday for a month for intensive meditation. By this time there was clear evidence of healing. It was arranged that the patient should return to her home in another State, and come back for further treatment in a month's time. However, by then the ulcer had nearly healed, the patient said she was well and felt it was unnecessary to return for further treatment. Figure 2 shows the ulcer completely healed, and the hard raised nodules have disappeared. She has, however, recently developed a bony metastasis for which she has had cobalt radiation.

Selected Case Report

The patient is a 54-year-old married woman with two adult children, the proprietress of a fashion shop. Fourteen months prior to seeing me she developed a mass around her left nipple. She had a radical mastectomy, with the pathologist reporting a cellular scirrhus carcinoma with involvement of the axillary nodes. Postoperatively she had telecobalt therapy. Four months later skin nodules appeared. These were treated with radiation without effect on the nodules. Tamoxifen was tried without effect and the patient was advised to have chemother-

apy. She refused this advice, as she had nursed her sister with cancer three years before she herself developed the disease. She stated she would never have chemotherapy after seeing what it did to her sister.

The patient then went to Germany where she says she was given injections, and has since continued the regime with weekly injections of Masterid (an anabolic steroid) and 42 tablets a day which she imports from Germany, and which she has been told contain an enzyme from pineapple. For several months she has been receiving help through relaxation from her family doctor.

She stated that two weeks prior to seeing me she had read one of my books and started to practise the mental exercises described in it; she stated that she thought the edges of the large ulcer had already started to heal. The size of the ulcer can be gauged from the tape measure around her chest. The marks at the side of the ulcer are hard, raised nodules.

The patient attended each weekday for a month for intensive meditation. By this time there was clear evidence of healing. It was arranged that the patient should return to her home in another State, and come back for further treatment in a month's time. However, by then the ulcer had nearly healed, the patient said she was well and felt it was unnecessary to return for further treatment. She has, however, recently developed a bony metastasis for which she has had cobalt radiation.

Psychological Mechanisms in the Regression of Cancer

Meares A

Medical Journal of Australia: June 11 1983; 583-584

Extracted Summary

Psychological regression is an essential feature of deep hypnosis, and also of intensive meditation. The important factor from the point of view of the present discussion is that psychological regression initiates physiological regression. This is well exemplified in the loss of colour vision in intensive meditation. So, in intensive meditation there is a mechanism which can initiate the physiological regression necessary to re-establish the healing process. Age regression is another well-established factor of deep hypnosis. Patients with cancer whose treatment is intensive meditation have reported a similar phenomenon. This is an ontological regression. It seems possible that, at a functional level, the ontological regression may initiate something akin to phylogenetic regression. Besides functioning at a regressed age level, the organism may, in fact, come to function in such a way that the physiological activity of the tissues is carried out at a simpler, more primitive biological level. Such a concept is relevant to the healing process in general, as the greater propensity for healing in lower forms of life (such as reptiles, crabs, starfish) is a matter of common observation.

Some cancers have regressed after intensive meditation in the absence of any orthodox treatment. I have discussed a number of psychological processes, any one of which might possibly be the effective mechanism in bringing about these regressions. We have now grown beyond the idea of seeking single causes of disease, and have generally come to believe that disease results from the interaction of a number of factors, both organic and psychological. If this applies to the cause of cancer, may it not also apply to the cure of cancer? In view of the remarkable propensity of the body for self-healing, perhaps we should return to an earlier medical orientation, and reexamine the healing process as an entitiy. From such an orientation, we may come to have a better understanding of the healing effect of intensive meditation.

An 1846 Report of Tumor Remission Associated with Hypnosis

Gravitz MA

American Journal of Clinical Hypnosis 28(1): July 1985; 16-19

Extracted Summary

It is now recognized that psychological factors may play a significant role in the etiology and progress of neoplastic disease, and in recent years hypnosis has been utilized as a therapeutic agent against the illness. This paper discusses an 1846 report of what may be the first association of hypnosis with the remission of a medically diagnosed breast tumor in a young female patient. Several possible explanations for this development are considered, including misdiagnosis, spontaneous remission, and mechanisms within the body's immune system.

Selected Case Report

The clinical case in point occurred in 1846, while he [La Roy Sunderland–1804-1885] was presenting a series of lectures in Boston shortly before the introduction of ether anesthesia. Sunderland was asked to render insensitive to surgical pain a young woman who was to have excised "a cancer (a tumour bigger than a hen's egg)" from her breast (Harte, 1903, Hypnotism and the Doctors Vol. II. [London: Fowler, 211]). The exact nature and diagnosis of this large growth is unclear from the published account, as the term tumour generally refers to a mass which can be either inflammatory, cystic, traumatic, benign, or malignant: the last is the condition most properly described as cancer. By 1846 the use of hypnotic anesthesia in surgery had already been described for several decades, and a painless mastectomy had been undertaken in 1829 in France.

Sunderland stipulated that the subject had to attend his lectures nightly, so that she could come fully under the influence of his treatment. This preparatory process resulted in the development of self-induction, as intended. Although no information was provided as to the actual time interval which elapsed between preparation and the scheduled surgery, the account indicated that it was only several days. Sunderland accompanied the patient to the operating room, and he subsequently reported the following: "At the appointed moment I had Mrs. Nichols spell-bound in the position directed by the surgeon. Her whole muscular system was in a state of cold rigidity resembling the sleep of death. Four surgeons were waiting below, and now, upon notice which I gave them that all was ready, they came up into the room where the patient was intranced. They instantly spread their surgical instruments upon the table, which was supplied with water, sponges, and all the implements necessary on such occasions. The first thing Dr. Walker did was to search for the location of the cancer. After manipulation for some minutes, he turned to the surgeon who stood nearest to him, and said, 'The bounds of the tumour do not seem to be well defined.' He then left, and the second surgeon tried to find the tumour; but in a few moments he gave it up, and was succeeded by the third and the fourth. Then Dr. Walker examined the patient once more, and began to look somewhat embarrassed. Each one of the surgeons now examined the patient over again, and twenty minutes more they spent in searching for the tumour, for which one of them had been treating that same lady for a year and a half. The surgeons now left the patient, and putting their heads together in a corner of the room, they whispered something I could not hear; when Dr. Walker said to me, 'We have concluded it best not to operate,' I asked, 'Why not?' and he replied, 'We do not find that there is any tumour there.' With this statement, the sticking plaster, the scalpel, and other instruments disappeared, and now my attention was given to the restoration of the patient...

During the few days she had been Pathetised, the tumour and the pain had disappeared as if by magic, and as they have now been gone for fourteen years the presumption is that she may be considered cured...I give this as a remarkable case of self-induction, and the self-healing energies of the human organism..."(Harte, 1903, p.212).

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