Cancer, the Mind, and the Problem of Self-blame

Keith I. Block, MD, Roger Dafter, PhD, and Howard P. Greenwald, PhD

"Why me?" This question of causal attribution is pervasive among cancer patients—so pervasive, in fact, that it is the basis for the name of the largest national breast cancer patient support network. As work in the field of psychooncology has advanced, the emotional aspects of cancer have been publicized and have entered the minds of lay audiences everywhere. A 2001 survey by Stewart and colleagues of Canadian breast cancer survivors, recurrence free for an average of nearly 9 years, found that 42% of them believed that stress caused breast cancer—a belief that is without scientific foundation—while only 27% felt that genetics and 15% felt that diet were involved in causing breast cancer.[1] Remarkably, 60% of the women attributed their lack of recurrence to having a positive attitude and only 4% to use of tamoxifen.

While there has been much publicity on lifestyle factors that can cause cancer, from excessive sun exposure to smoking, there clearly is a substantial part of the public who are predisposed to believe that emotional factors are a cause of cancer. Integrative practitioners, who emphasize lifestyle adaptations in treatment of cancer, not to mention causation, are invariably familiar with patients who react to their awareness of cancer's lifestyle connections with paralyzing self-blame and guilt. "Blame the victim" scenarios, or statements that cancer has been caused or progressed because of emotional stress, frustration of significant needs in life, or negative thoughts or emotions, appear to have been prominent in interactions with some alternative practitioners working with cancer patients. In addition, research studies have raised the possibility that psychosocial interventions might improve cancer survival, suggesting to many that psychosocial factors might also cause cancer. To explore the role that both alternative psychologies and research on psychosocial oncology may play in such self-blame, we have asked 2 insightful researchers to participate in this Point-Counterpoint. The 2 respondents have different assessments of the question of whether psychosocial factors might influence cancer causation or survival. Roger Dafter, PhD, is the associate director of the Mind-Body Medicine Group at the UCLA Division of Head and Neck Surgery and assistant clinical professor of Surgery and Psychiatry at UCLA Geffin School of Medicine. He is generally receptive toward the idea of psychosocial factors playing a role in cancer. Howard P. Greenwald, PhD, is a professor of management and policy at the University of Southern California School of Policy Planning and Development. He is the author of *Who Survives Cancer?*[2] and has generally felt that there is no solid evidence to support the relevance of psychological factors in cancer. Both Dafter and Greenwald responded to questions posed by *Integrative Cancer Therapies* staff in telephone interviews, slightly edited for publication. I, as the first author, provide a general perspective following their responses.

Excessive self-blame and guilt are, in one sense, a potential side effect of psychooncology and integrative medicine. The typical interventions of integrative medicine might threaten the psychological well-being of patients who find support groups irritating, who do not want to undertake exercise programs or low-fat diets, or who are most comfortable leaving medical decisions to their doctors. In this article, we will explore chiefly the question of whether psychooncology contributes to excessive self-blame among cancer patients, and, if so, what could be done about it. This is an important question for those of us in the integrative care community and one that is worth consideration by all who work with cancer patients.

Question 1.

How real and how prevalent is the problem of cancer patients blaming themselves for their illness or decline?

KIB is at the Block Center for Integrative Cancer Care, Evanston, Illinois. RD is in the Division of Head and Neck Surgery, UCLA Geffin School of Medicine. HPG is in the School of Planning, Policy and Development, University of Southern California, Los Angeles.

Correspondence: Keith I. Block, Block Center for Integrative Cancer Care, 1800 Sherman, Suite 350, Evanston, IL 60201. Geffin School of Medicine. E-mail: drblock@blockmedical.com.

DOI: 10.1177/1534735406289106

Dafter: I wish we had systematic empirical data to address that issue, but I am not aware of a survey that answers this specific question. However, my colleagues and I at the UCLA Medical Center, in the head and neck division, have been researching patients since about 1985, and I would estimate that 50% of patients report some self-blame.

I have also observed certain trends in working with these patients over the past 25 years. During this time, cancer has come out of the closet and become more normalized, and as a result, I have seen less self-blame over time. But it's still a common problem. The prevalence of blame also depends on the severity of the cancer, which does not progress as a unitary disease, because its course varies according to tumor cell type, site, immunocompetency, and genetic factors. Cancer acts as if it were many different diseases with a smaller percentage becoming lethal actors as medical treatments progress. An important factor is how catastrophic the disease is, regarding chances of survival and the intensity of the surgical, chemotherapy, and radiation treatments required. The more catastrophic, obviously, the greater the shock and the more severe the emotional reactions. I have been working with head and neck cancer patients for more than 10 years, and these patients often face the sacrifice of the voice, the larynx, loss of hearing, facial paralyses, and so forth. This shock is quite natural, and the patient often tries to ascertain blame as a kind of natural response, even an adaptive one. "What could I have done to bring this on?" Sometimes this helps mobilize the person as he or she tries to find a sense of empowerment. But self-blame can persist as a maladjustment in which the person becomes paralyzed, helpless. Also, patients susceptible to this problem are those for whom self-blame resonates with their psychosocial history—those who have had early traumas, previous cancers, a childhood history of self-deprecation, or who already have psychiatric conditions. The shock of diagnosis can stir up anxiety disorders, and a host of feelings are triggered or compressed.

Also, my clinical experience in the UCLA Division of Head and Neck Surgery has been illustrative because responses will depend on environmental or behavioral factors that contribute to the cancer. For head and neck cancer, especially of the throat, smoking and drinking alcohol are major contributors, often overlapping ones. For alcoholics or chronic smokers, their head and neck cancers are [usually] related to their addictive behaviors. So interestingly enough, one of the mechanisms of addiction is frequently a denial of one's personal role and externalization of blame. A number of these patients will find ways to assign blame to other factors rather than their high risk behaviors. They need to be treated the way other addictive individuals would be treated. To sum up, all sorts of factors contribute to the appearance of self-blame, including how severe or catastrophic the cancer, whether addictive behaviors are involved as causes, what kind of personality variables you are dealing with—whether, for example, the person has an addictive personality prone to externalize blame or whether he or she has an earlier history of anxiety or depression and is therefore prone to self-blame. And it's also important to recognize that some people's self-blame is transient—part of a normal shock reaction in which the individual searches for personal responsibility.

Greenwald: Blame among cancer patients is a very important problem. It has been widely reported that many cancer patients experience self-blame, and it has been researched since the 1970s. We have gotten clues from an ongoing research collaboration with colleagues at the Yale University School of Nursing. In this study, we interviewed long-term survivors of cervical cancer in the state of Connecticut. We were interested in the experience of long-term survival, which I later wrote about in my book *Who Survives Cancer?* Most studies of quality-of-life and other factors in cancer survival look at only the first few years postdiagnosis since it can be hard to find subjects many years later. But we put a lot of effort toward finding a sample of women who had been diagnosed, in this case, with cervical cancer as far back as the 1970s. I recently reviewed some of our data from this Yale study. We asked the patients if they had ever asked themselves, "Why me?" which is often the first opening to self-blame. More than 50% of them answered yes, they had asked themselves that question. Now with heart disease, you would not get that same level of self-doubt. Heart disease patients cite all kinds of specific reasons for getting heart disease, mostly involving behaviors such as smoking and diet. We also asked the patients whether they had concerns about how others view cervical cancer, and roughly one third of them said yes, they did. At least in this recent study of this type of cancer, people do go through self-doubts and recriminations regarding the view others have of their disease.

The problem of blame pivots on knowledge of cancer risk factors, and for many types of cancer, there are no known risk factors.* For lung cancer, there are the known risk factors of smoking and asbestos. Smoking and alcohol predispose one to head and neck cancers. Skin cancers are associated with sun exposure. Certain cancers have strong inherited genetic linkages, including some forms of colon cancer, a minority of breast cancers, retinoblastoma, and a few others. But for many cancers, there are no known risk factors of overwhelming importance. This opens up the issue of self-blame. These are the people who wonder, "Why me? Why did *I* get it?" This can lead directly to, "I've always had bad luck. Maybe I'm just a cancer-prone person-

*In the case of cervical cancer, many of the patients in Dr Greenwald's collaboration with Yale researchers were diagnosed in the 1970s, long before it was proven that infection with certain strains of the human papilloma virus are a major cause of the disease.

ality. Perhaps I have suppressed desires and passions that are causing this."

Question 2.

To what extent is this idea—that psychological factors can contribute to the onset or progression of cancer—a direct cause of blame?

Dafter: It's a complex question, especially with little data to draw from. But I do think that patients are more likely to blame themselves during the early period of shock after diagnosis. They often erroneously exaggerate the lethality of their cancer, based on common misconceptions of cancer being a unitary disease with a likely death sentence. In my experience, roughly 60% to 70% of patients consider stress or emotional problems as a real factor in their cancers. Then, as they acquire more facts about the distinct etiologies, courses of treatment, and prognosis for *their* cancer from their doctors, the Internet, and other sources, they move out of shock, lowering their tendency to self-blame. Of course, my own estimates are skewed by demographics—I live and work in Los Angeles.

But socioeconomic factors play a role because higher status is associated with higher levels of education as well. And more well-educated and well-read groups will be more exposed to ideas about the role of stress or mind-body factors in health. So during this early shock, when the mind looks for explanations, that is when people exposed by popular media to the idea of psychological factors in cancer are most likely to blame themselves. But after the shock, this wanes. Yet it will stick for some individuals. People with a history of depression or anxiety disorder will be more susceptible for it to stick. If they experienced child abuse or early trauma, they will be more prone to self-blame that persists. Patients who typically respond to stress by beating themselves up, or laying awake at night with anxiety, or who compulsively get fixated on a negative thought—these are the ones with self-blame that is more likely to stick.

People with less education, those less exposed to sophisticated ideas about mind and body, may also blame themselves but in a different way. They can be vulnerable to older cultural stigmas about cancer or to what Susan Sontag writes about in her book *Illness as Metaphor* regarding the early metaphors from the 1930s, 1940s, and 1950s about cancer as something contagious, like an infection, or something that comes from bad living or a dirty environment.[3] With less education, they might not get more enlightened views that have helped to destigmatize cancer. Combine this with a predisposition to psychological distress and self-blame, and the person will feel that they somehow brought the cancer on themselves. If they are then exposed by the media to simplified ideas about the mind or stress bringing on cancer, the problem gets worse.

Greenwald: I have no doubt that ideas about psychological causes of cancer contribute to self-blame. Not for everyone, but for those who come to believe popular notions of the science behind this. At the root of this problem is the popularization of science. The belief that emotional factors contribute to cancer or cancer survival does have a basis in science, but it's overinterpreted. For example, I reviewed the recent medical literature and came across a recent study in the *Journal of the National Cancer Institute* that illustrates this.[4] It involved 35 nude mice, which have weakened immune systems. [The researchers] wanted to see what would happen when these mice were exposed to ultraviolet (UV) light, a known risk for skin cancer. One group of the [UV-light exposed] mice were also exposed to stressful conditions. The question was, would stressing these mice increase their proneness to skin cancer? And by golly, it did.[4] So there's evidence on the laboratory level that stress makes mice prone to cancer. You can't dispute this. It's a well-written article published in a leading journal. On the other hand, to what degree can you generalize from the experience of these mice, and the kind of stress they are subjected to, to the human experience, with its complicated emotions? Also, the study deals with predisposition to cancer. How much can you extrapolate these findings to cancer survival? It's a very big leap from animals to humans. Not only that, but the study was of nude mice, specially bred to have deficient immune systems so they can grow tumors. These mice don't exist in nature—they are highly cancer prone. You see how overinterpretation and popularization feeds this problem.

Question 3.

Does the idea that psychosocial or mind-body factors can contribute to cancer risk or decline lead inevitably to "blaming the victim?" Or is it more a matter of how these factors are understood and articulated?

Dafter: I do think it's how the mind's role is explained to people. But it's also the preexisting predisposition to self-blame of the people listening to the explanations, whether from the media, doctors, or psychotherapists. As far as how it is explained and articulated, a key problem is what I call the unicausal theory of cancer: when any one factor is seen as omnipotent. When mind-body is presented to patients as a one-cause, one-cure approach—this can be harmful.

Saying that your emotions or stress levels absolutely cause cancer is unicausal. Older psychosomatic theories of cancer seemed to make this mistake, viewing the mind as overriding ecological factors and biomedical realities. You see the same problem in certain new age ideas about cancer, including those of Louise Hays. If psyche or spiritual factors are seen as responsible for 80% to 90% of the variance in cancer, it does get pernicious. [When patients hold these ideas] it must be

addressed during the early shock stage after diagnosis, or they may even avoid medical treatment. These patients run off to one-cause cancer cures or healers who rely strictly on mind-body or spiritual [treatments] and avoid biomedical treatment. It becomes very tragic. We see concrete cases like this on a regular basis. Patients have, say, a 70% 5-year survival rate, but then they avoid biomedical treatments. Then they come back 18 months later with an essentially terminal condition.

We can avoid this problem by explaining the multicausal model of cancer and other diseases. Treatment must include an educational process that explains the multicausal model, which takes the onus of complete responsibility for the disease or for recovery off the patient and his or her psyche.

Greenwald: I don't yet accept that psychosocial factors have any direct impact on cancer, but for the sake of argument, if this were proven, I would not say that blame (by others or the self) was inevitable. So many conditions that caused self-blame in the past are today viewed through our medical model. The best example is alcoholism and other addictions, which are now strictly seen as medical conditions. They are no longer stigmatized as terrible character flaws, at least by most of the country. The whole thrust of interpreting disorders once considered character flaws has changed; even criminal behavior has become medicalized. Depressed patients who go to a psychiatrist might blame themselves for being depressed. Then they discover that they have a biochemical imbalance in the brain, and this relieves their self-blame. They have a disease, and it's not their fault. The same should occur if it were ever shown definitively that emotions or traits contributed to cancer or cancer mortality.

Question 4.

In her classic book* Illness as Metaphor, *Susan Sontag wrote that metaphors for cancer were a major cause of self-blame. What popular metaphors, or ideas about the mind's putative role in cancer, contribute most to self-blame? How can we change these metaphors and ideas?

Dafter: Today there is a new kind of metaphor, the idea of the positive personality who won't get cancer. Or who survives cancer. If you're a negative person, or you express negative emotions—anger, fear, despair—you are going to get cancer or succumb to cancer. This metaphor is off base, as I showed in an article I published in 1996, "Why 'Negative Emotions' Can Sometime Be Positive."[5] So-called negative emotions, including fear, anger, and grief, are a natural part of reactions to cancer, and there is evidence that not being aware of these emotions can have negative consequences in terms of health and even cancer progression. It's a real problem when cancer patients feel they must stay positive, an example of a metaphor that causes more self-blame. When patients can't stay positive, they think this will worsen their recovery, so their despair gets even worse.

People who care for cancer patients must change this metaphor, and this includes oncologists. We want oncologists to also get out the facts about positive feelings and negative feelings: the whole spectrum is normal. This normalization could help patients to stop worrying that their natural emotions are harmful. That's why at UCLA, we are training our surgical residents to understand the emotional reactions of patients. If our surgical residents can learn this, for goodness sake, other doctors and providers can do this as well.

Greenwald: In tracing the cultural roots of blame, I can't do any better than Susan Sontag did 30 years ago in *Illness as Metaphor*.[3] While things have changed for the better, a certain mystique about cancer still persists. And it's not a favorable mystique. Consider the bodily areas afflicted with cancer. Heart disease afflicts the heart, which is viewed as a noble organ. But people get colon and rectal cancers. They get testicular, cervical, and prostate cancers. The disease can hit people in all these emotionally sensitive areas of the body. We conducted our cancer study at the Yale School of Nursing, and some groups working with us conducted similar studies in other parts of the country. One of them was New Mexico, which has a large Latino population, including some very traditional segments of the society, and they observed a great deal of stigmatization of women with cervical cancer because it's a sexually pertinent organ system.

Sontag also discusses tuberculosis and how back in the 19th century, people thought that tuberculosis was an illness of the soul. A prime example was the poet Keats, who died of tuberculosis in his 20s. The idea was that patients pined away because they were frustrated, often romantically. They could never reach the lover on that Grecian urn, and their bodies reacted to this, and they'd end up with tuberculosis. It wasn't many decades before scientists discovered the specific bacteria that caused tuberculosis and eventually found a cure with antibiotics. Tuberculosis had nothing whatsoever to do with an illness of the soul. Sontag, who herself had breast cancer and lived for 30 years, speculated, I think wisely, that one day we'll find out even more about cancer and these myths about the mind's role will disappear. And patients will stop asking, "What did I do wrong?"

I do need a disclaimer, however. Since I made similar points in my book *Who Survives Cancer?* I have learned a great deal, and I think it's important to realize that people's emotions and attitudes do contribute to their survival. But the relationship involves behavior. For example, people often smoke because there's something missing in their lives. Education and economic levels have an impact. Drugs and alcohol are more common among the poor and disadvantaged, partly to ease frustrations related to economic status.

These behaviors expose people to all varieties of illnesses, including cancer. Another factor is that an individual's behavior when he gets a disease can either extend or shorten his life. This includes medical compliance; if you show up for your chemotherapy, you are more likely to survive. There are many things cancer patients must do to survive that are attitude related. Whole categories of psychopathology, and also rational personal decisions, will affect survival in cancer and other diseases. But these interactions are not taking place on the level of immunology, affecting a person's biological cancer defenses. They take place on the level of human behavior.

Question 5.

Is there any intellectual and moral framework for understanding the role of the mind in cancer risk or recovery that does not blame the patient? If so, could you describe this framework?

Dafter: A way to get rid of blame is to counter the current myths. Perhaps the most common myth cancer patients embrace from the start is that they must keep up positive emotions and thoughts to cure their cancer. As a result, they become mortified by their own natural shock, fear, or reactions featuring some symptoms of major depression during challenging periods. If patients aren't blaming themselves to begin with, as soon as they have normal reactions—grief, anger, and anxiety—they start blaming themselves at that point.

To reduce or avoid blame, we must alter the myth that all negative emotions are negative. In fact, many are positive because they tell the patient what he or she needs at this crucial time. Negative emotions can help mobilize behavior change to lower cancer risks and comply with medical treatments. If you present a sound mind-body model, it normalizes these emotions, so patients know that their reactions are part of an innate survival response. These feelings focus them on what the doctors are saying. Fear and sadness guide them toward what they need to do—get help, get information, get emotional support, and find the best doctors. Anger means that something is wrong and must be righted. Whether it's in the medical system or their system. This mind-body model can reframe the blame.

In our department [UCLA's Division of Head and Neck Surgery], we train the head and neck surgical and radiation oncology residents. All of these doctors are getting it. This should be a regular part of oncology training, to teach young medical and surgical oncologists how to normalize their patients' psychological distress. They can help patients to mobilize their emotions toward fighting their illness, rather than emotions based on the myth that they shouldn't be feeling anything negative.

We have hard evidence that distress, anger, fear, sorrow, and shock are all normal responses in the aftermath of a cancer diagnosis. Data from a range of studies suggest that acknowledging these emotions and sharing them with trusted individuals are more likely to do psychological and physiological good rather than harm. This information immediately liberates cancer patients. They have permission to feel their authentic feelings. Often I encourage the family to talk openly with their loved one and to cry together and share negative reactions, which can deepen the bonds. Evidence from emotional expression studies and intervention trials suggests that this helps patients psychologically and medically.[6] Even if it doesn't help them physically, we surely know it will help them to feel a hell of a lot better and improve their quality of life.

Greenwald: There is literature showing 2 kinds of self-blame associated with cancer. One is behavioral self-blame, and the other is characterological self-blame. Behavioral self-blame refers to behaviors that caused me to get sick, such as smoking, while characterological self-blame suggests that I'm just the kind of person who gets sick.

In a recent study, published in 2005 in the *Journal of Behavioral Medicine*, researchers [from Indiana State University] looked at self-blame in women with breast cancer.[7] The investigators speculated that characterological self-blame would be more destructive than behavioral self-blame. This had been suggested by earlier psychosocial research. In other words, at least with behavioral self-blame, the patient says, "I've never taken care of myself, and now I have this disease, so I'm going to start taking care of myself." Whereas with characterological self-blame, the problem is your very character, which is not something you can easily change, if at all. [Unpublished] findings from our Yale study tend to support this distinction.

The study itself, "Blame and Distress Among Women With Newly Diagnosed Breast Cancer," doesn't deal with predictions of mortality. It doesn't deal with carcinogenesis. It explores only these 2 dimensions of self-blame and how they affect psychological outcomes. What they found was no difference in the psychological impact of characterological self-blame versus behavioral self-blame. Both were highly correlated with negative emotional states such as depression and anxiety. The researchers could not support the hypothesis that there is a good form of self-blame versus a harmful one. In the precincts of academic research, this is interesting. It suggests that any form of self-blame is bad for recently diagnosed cancer patients.

One approach would be to not focus on the role of the mind in cancer, which has not yet been well proven in any event. I am also not convinced that psychological interventions can affect survival of cancer patients. But I do think that they can be useful, absolutely. And perhaps they can help reduce self-blame. Your whole outlook—what else do you really have? Even if it's your dying day, if you have a favorable outlook, it's not the worst day of your life. And

if you believe in salvation and that you are among the saved, it could be the best day of your life. I have a close friend who died of cancer a couple of years ago, who was a devout Christian, and he was completely convinced of his salvation. He wasn't looking toward death with any trepidation at all.

You can use illness to contemplate how you've lived your life and how you want to live it differently. If you are cured, great. If you're not cured, you can still live the rest of your life differently. The sick role you have been thrust into, whether it's temporary or permanent, can have its advantages. People take care of you. You get out of some of your day-to-day responsibilities, which are eclipsed by the medical issues in any case.

For a lot of people, it's a time to think things over and make some new decisions, and good can come of it hopefully. There's easier, less perilous ways to achieve the same outcomes, but a lot of people with life-threatening illness do seem to change their lives in a favorable manner. You can also review your past and feel good about the life you've lived. That would certainly alleviate self-blame, I would think.

Responses: Dr Block

Question 1.

How real and how prevalent is the problem of cancer patients blaming themselves for their illness or decline?

Although they arrive at their figures in quite different ways, both Drs Dafter and Greenwald arrive at a figure of about 50% of cancer patients experiencing some degree of self-blame. Dafter estimates his figure based on extensive clinical experience, while Greenwald reports that more than 50% of patients in his cervical cancer survivor group reported asking themselves the question, "Why me?" With 2 such different means of estimation arriving at the same figure, I suppose it could even be accurate! It is, nevertheless, extraordinary how much emotional energy can be drained from a cancer patient who becomes caught in this pattern of self-blame. As Greenwald points out, heart patients do not express such self-doubt and discuss the contribution of lifestyle factors to their disease without overwhelming guilt.

Will self-blame disappear from the scene or at least decrease in incidence when the causes of cancer are clarified, as Dafter and Greenwald as well as Susan Sontag speculate? One would hope so. It is interesting, though, and of some concern, that the study on characterological and behavioral self-blame cited by Greenwald found that both types of blame were highly correlated with depression and anxiety. Could both the self-blame and the cancer have their roots in depression? It is still questionable whether cancer patients have higher rates of depression than patients with other chronic diseases. An intriguing study in Japan, however, recently found that depressed persons (without cancer) had higher levels of DNA damage than nondepressed persons did, which would theoretically increase their susceptibility to cancer.[8] Such DNA damage would likely arise from long-term poor lifestyle habits associated with depression. One could speculate that this susceptibility to preoccupation with self-blame is to some extent a manifestation of depressive tendencies that are associated with carcinogenesis.

Greenwald discusses the difference in cancers that have and those that do not have established risk factors. One could certainly understand why a lung cancer patient might believe that his or her long-term smoking brought about cancer. Even in situations with clear lifestyle antecedents, though, the physician caring for such a patient should attempt to defuse excessive self-blame. For one thing, it is neither helpful nor humane to allow patients to remain paralyzed by guilt. For another, at the time when many of today's lung cancer patients began smoking, little was known by the public about the dangers of smoking. Furthermore, tobacco—a drug that is highly addictive as well as carcinogenic—received government price supports for decades, only to be sold to a susceptible public, including young teenagers, with sophisticated advertising. Quitting once one becomes addicted to tobacco is notoriously difficult. The extent to which the lung cancer patient was actually physically able to control his or her cravings, and thus accomplish the task of quitting, may be very small. Guilt is only occasionally of value in motivating patients to break an unhealthy habit; it's known that lung cancer patients who stop smoking have a better outcome than those who do not. For most patients, however, guilt is counterproductive.

Question 2.

To what extent is this idea—that psychological factors can contribute to the onset or progression of cancer—a direct cause of blame?

Drs Dafter and Greenwald raise different issues in response to this question. Dafter points out that patients with high socioeconomic status may be more aware of the links between stress and cancer, while those with less education may be more susceptible to older stigmas, such as cancer as a product of bad living. Either the well-educated or the poorly educated can then be susceptible to oversimplified discussion of stress-cancer connections in the media, a topic that Greenwald discusses.

My own clinical observation is that people with various types of backgrounds can be susceptible to self-blame based on the idea that psychological factors could contribute to cancer. In the population that presents at our integrative cancer clinic, it is not unusual to see patients who have picked up this idea from alternative practitioners. In one recent case (of which I have changed potentially identifying details), a businessman in his 30s who suffered from a sarcoma arrived at our clinic after working for some time with an alternative practitioner on a detoxification regimen. The regimen itself did not appear to have done any harm, but the patient was feeling very vulnerable from the psychological effects of the treatment. After learning that the businessman had previously had to delay starting a long-anticipated new company because of various life circumstances, the alternative practitioner exclaimed, "You got cancer because you gave up your dream!" The businessman, still unable to start his company, became preoccupied with guilt stemming from buying into this statement. Extensive discussion and counseling revealed that his dream had not been given up but only delayed. This helped convince the patient that his concern had no basis in reality as a cause of his cancer.

In this case, not only was the practitioner—whose training should have equipped him to know better—talking without benefit of scientific data, he had not even listened well to what the patient said in the first place. There is no evidence that I am familiar with that indicates that this type of alternative psychology could actually contribute to healing, while substantial experience points out its potential for harm. That this psychology still exists in the integrative and CAM communities is distressing.

Question 3.

Does the idea that psychosocial or mind-body factors can contribute to cancer risk or decline lead inevitably to "blaming the victim?" Or is it more a matter of how these factors are understood and articulated?

In response to this question, Dr Dafter, who does see a role for mind-body factors in cancer, emphasizes the need to place emotions and stress into a proper context as only one of many factors in a multifactorial model of cancer causation, while Dr Greenwald, who does not yet accept any role for psychosocial factors in the origins of cancer, points out the medical causes of diseases that were formerly considered character flaws. As a physician who works from a psychobiological perspective, I see stress and emotional factors as agents that can promote carcinogenesis through their effects on stress and other hormones (eg, melatonin), as well as their contribution to poor eating and other risky lifestyle choices. Just as the foods and many of the lifestyle factors involved in cancer risk are, in essence, determined by the patient's culture and not their own conscious choice, stress and emotional upset may be reactions to external factors and societal inequities beyond the patient's capacity to control. And as long as there are mutated oncogenes that trigger malignant processes, there is no reason that either psychosocial factors or poor lifestyle choices should be recruited to play roles in "blame-the-victim" scenarios.

Question 4.

In her classic book* Illness as Metaphor, *Susan Sontag wrote that metaphors for cancer were a major cause of self-blame. What popular metaphors, or ideas about the mind's putative role in cancer, contribute most to self-blame? How can we change these metaphors and ideas?

Dr Dafter, I think, puts his finger on one of the more destructive current metaphors in cancer care: the "positive" cancer patient who does not allow herself or himself to succumb to negative emotions and thus conquers cancer. This metaphor may be at work in the study on breast cancer patients by Stewart mentioned above,[1] 60% of whom attributed their lack of recurrence to positive attitudes. It is not clear to me where this idea came from, but it seems possible that it is an aspect of the alternative psychology mentioned above, as well as the general approval of positive thinking in contemporary culture. We grapple with this attitude in the clinic almost daily, as do Dafter and his colleagues at UCLA, and I am glad to read that he is training residents there to encourage patients to express both positive and negative emotions. Expression and exploration of both positive and so-called negative emotions are critical to the emotional well-being of cancer patients, especially for those with advancing disease who may encounter worsening scans or blood tests. In these situations especially, there is nothing at all to be gained by suppressing negative emotions. Working through them, resolving them where possible, and readjusting the patient's hopes and expectations in a way that is helpful, rather than traumatic, is an important skill for oncologists and integrative practitioners alike.

Dr Greenwald discusses the impact that psychosocial factors can have on cancer survival, not through internal or immune mechanisms but through behavioral mechanisms. Patients' choices to take chemotherapy treatment and pursue healthful lifestyles can positively affect survival. Conversely, and especially among people who are under economic or other disadvantages,

unhealthful coping mechanisms such as resorting to drugs, tobacco, or alcohol threaten survival. The 2 approaches to the question of whether psychological factors contribute to cancer risk or survival unite in this aspect of psychosocial oncology.

I think, however, that there is more to be explored in the potential benefits of psychosocial interventions than research has investigated to date. Alastair Cunningham, in an earlier article in this journal, described a group of patients who were highly involved in a psychotherapy-assisted group self-help study, to the extent of doing daily journaling, mental imaging, meditation, cognitive monitoring, or relaxation, sometimes for hours each day.[9] These patients had longer survival and better quality of life than patients who attended the program but had little or no involvement. There may be ways to structure psychooncology programs that engage patients more thoroughly while helping them to mobilize their physical and psychological resources more effectively. Such belief and engagement in a program may be the difference in an effective outcome or an ineffective one.

Question 5.

Is there any intellectual and moral framework for understanding the role of the mind in cancer risk or recovery that does not blame the patient? If so, could you describe this framework?

Dr Dafter is on target in his assessment of this question. The "positive cancer patient" metaphor is simply a maladaptive myth, and to counter it, we must teach doctors and patients alike the true value of "negative" emotions. Anger, fear, and depression, as Dafter points out, are not only natural reactions to shocking situations but are, in fact, critical to our survival, allowing us to mobilize our resources to cope with the threats of disease. Giving patients permission to experience their real feelings and to communicate with their family members and significant others opens up these times of crisis and benefits both patients and families. Dr Greenwald, on the other hand, expands the role of the mind in cancer in a different direction, rejecting self-blame in favor of reflecting on your life, changing directions if relevant, or just feeling good about what you have accomplished, gaining an outlook that is positive not in the sense of denying any negative feelings but in a wider, more holistic, or even spiritual sense.

The 2 approaches of Dafter and Greenwald point out that no matter what the ultimate role of the mind in causing or curing cancer, it is not something to be used as a cause of guilt or blame. Many cancer patients may fall prey to such feelings during times of shock, such as at initial diagnosis, especially those with certain predisposing conditions. It is the responsibility of the health professional to guide such patients to a constructive understanding of the meaning of their emotional responses. If blame and guilt are in some cases side effects of psychooncology and integrative cancer care, it is because these have been misunderstood or misapplied, not because blaming the victim is a natural consequence of these areas of study.

References

1. Stewart DE, Cheung AM, Duff S, et al. Attributions of cause and recurrence in long-term breast cancer survivors. *Psychooncology.* 2001;10:179-183.
2. Greenwald H. *Who Survives Cancer?* Berkeley: University of California Press; 1992.
3. Sontag S. *Illness as Metaphor.* New York, NY: Farrar, Straus and Giroux; 1978.
4. Saul AN, Oberyszyn TM, Daugherty C, et al. Chronic stress and susceptibility to skin cancer. *J Natl Cancer Inst.* 2005;97: 1760-1767.
5. Dafter RE. Why "negative" emotions can sometimes be positive: the spectrum model of emotions and their role in mind-body healing. *Advances: The Journal of Mind-Body Medicine.* 1996;12:6-19.
6. Temoshok L, Dreher H. *The Type C Connection: The Behavioral Links to Cancer and Your Health.* New York, NY: Random House; 1992.
7. Bennett KK, Compas BE, Beckjord E, Glinder JG. Self-blame and distress among women with newly diagnosed breast cancer. *J Behav Med.* 2005;28:313-323.
8. Irie M, Miyata M, Kasai H. Depression and possible cancer risk due to oxidative DNA damage. *J Psychiatr Res.* 2005;39:553-560.
9. Cunningham AJ, Phillips C, Stephen J, Edmonds C. Fighting for life: a qualitative analysis of the process of psychotherapy-assisted self-help in patients with metastatic cancer. *Integr Cancer Ther.* 2002;1:146-161.