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**Psychosis of the Body, Cancer of the Mind: The Isomorphic
Relation Between Cancer and Schizophrenia***

Jane G. Goldberg, Ph.D. 

*Although there are finer creations of the spirit than perversion
and psychosis, in the long run it is better to be mad than dead.*

Joyce McDougall

In observing the ways in which the process of differentiation between self and not-self can be thwarted on the level of the mind, Freud identified the disease of pathological narcissism. Parallel scientific research on the level of the body revealed that the equivalent somatic dysfunction led to the disease of cancer. Each of these two conditions reflects a state of dedifferentiation where the normally distinct boundaries between self and not-self are blurred.

Freud's psychosexual phases of development formulate a normal progression towards psychosexual maturity. If early stages of development are not mastered, the personality remains stuck—fixated—at an early level of functioning. When fixation occurs before self and not-self separate and become distinct from one another, the consequences are quite severe. While physical maturity may proceed, the narcissistic adult remains an emotional child housed in an adult body (alongside an adult intellect, often enough). Primary narcissism, a normal developmental phase in early infancy, is now pathological narcissism—a self/object fusion that is no longer appropriate.

Alternatively, differentiation may have occurred, but the original self/not-self fusion reappears regressively in dedifferentiation.

* This article is excerpted from Dr. Goldberg's latest work, *Deceits of the Mind (and Their Effects on the Body)*, to be published in 1990.

Normal maturation leads to an increasing desomatization of reactions, toward maximal use of integrated muscle action and toward replacement of action by talk and by thought; and to a concomitant reduction of vegetative discharge phenomena. In a state of regression, these advances are lost, and the organism once again responds indiscriminately with body or mind and with self and not-self fused.

The extent to which the self/not-self distinction fails to be made is both the extent of the regression, and the determinant of the degree of neurotic pathology. Carried to its most extreme state, the condition becomes manifest by the clinical condition we refer to as schizophrenia. This psychotic state is marked by a “pathological fusion of self and object images”—the same “oceanic” experience that Freud referred to in his description of the experience of the new-born.

The bizarre behaviors that we see exhibited in schizophrenia are often attempts to force on the self, often in painful ways, a felt experience of the self/not-self distinction. The head-knocking and self-biting frequently observed in autistic children can be seen as pathological attempts to sharpen awareness of the body self and to reinforce boundary integrity. It is as though the feeling of the definition of self is so dull, so blunted, that only this terrible assault has the hope of stimulating the experience of self. Hallucinations, too, may arise when internal and external sensations are experienced as a continuum, rather than as discrete entities located in the alternative sites of self or object. The schizophrenic, then, has difficulty discriminating between false impressions and realities. Investment in order is abandoned, and perception exists unchanged in its raw, unfiltered, and unrefined form. The process of de-differentiation rules.

Other patients who maintain some level of self/not-self distinction may still suffer from the lack of a secure and well-grounded self. The boundaries between self and not-self may remain blurred and indistinct and commerce between self and notself is still profoundly disturbed. The narcissist, then, having failed to bring objects (that is, persons whose separate reality is evident) into existence, is left with an empty psychic house, with no stable internalized objects to provide a sense of comfort and security.

Investigations into the process of self/not-self differentiation on the level of the mind had convinced researchers that the most profound mental disorders arose from failures at this early stage of

development (**Mahler, 1968**); parallel research on the level of the body led to an understanding of the fundamental issues in the development of the disease of cancer.

What emerged from the research on the body was the fact that the fundamental dysfunction in pathological narcissism was precisely the same one seen in cancer. The cancer cell, in fact, acts as though it were schizophrenic.

The boundary-less state in narcissism is mirrored in the nature of the cell. It is, in fact, this biological mechanism that leads to the change that is cancer's most characteristic attribute—that of unrestrained growth. A normal cell will, in a state of growth, be impeded through its contact with other cells. It will hit up against the adjoining cell, and a separating membrane will serve as a barrier against intrusion of one cell into another. Thus, cells are normally permitted both to grow and, simultaneously, to maintain integrity of form and function.

The cancer cell, however, respects no boundaries. In a similar state of growth, it will continue to reproduce, unimpeded by cellular contact inhibition (**Loewenstein, 1966**). The adjoining cell, in allowing its normally strong barrier membrane to yield to this invasion, colludes in the enterprise.

And, as the psychic structure in narcissism has regressed to an earlier mode of functioning, so too does the function of the cancer cell reflect a turning back. Cancer cells begin as not qualitatively different from normal cells. Normal cells, when young, divide but remain undifferentiated—just as cancer cells do. It is here, though, that the cancer cell begins to manifest its pathology. Instead of maturing into a specialized cell with a specialized function, the cancer cell remains in a state of undifferentiation. It has become stuck in an immature phase. Whatever may have been the original intent of that cell in differentiation into a specialized cell with a particular function, as a cancer cell it now defies the laws that would assign it to a rightful and ordered place in the economy of the organism.

Further research (**Burnet, 1970**) led to even greater clarification of the cancer condition. World War II provided researchers with a very large population in which to study the immune reaction. In treating severe burn cases, surgeons attempted to transplant skin from one site on the patient's body to another. They were confounded by lack of success. The body's ability to reject such notself entities as viruses and bacteria was well known. Now the body was found to react to its own tissue cells as though they were

foreign invaders merely if they weren't exactly where they were supposed to be.

The body had doubtless been struggling against microbes from the external world from time immemorial. It was easy to understand how natural selection favored such a defense. But, why would thousands of generations of selection have preserved a built-in reaction to tissue transplants? How had we come to have such a highly developed capacity of this kind?

Lewis Thomas (1959) proposed a startling answer. He said that the immune system functions to police the body from internal as well as external threats. The nature of the internal threat was the spontaneous and daily production of thousands of cells which are abnormal, genetically different, and potentially cancerous. It is possible that this whole rejection process evolved as a surveillance mechanism against the cancer cell.

By the 1950s resistance to diseases had been formulated on both the psychological and physiological levels: the defense mechanisms protect us against unwelcome intrusions on the psychic level, and the immune system protects us from them on the physical level. It is only when sufficient differentiation of self has been achieved that the organism has the ability to recognize the invasion of not-self entities. Inadequate discrimination of self/not-self entities on the psychological level characterizes the disease of narcissism, and, the same inadequacy on the somatic level results in cancer. The schizophrenic mind and the cancer body appear to be mirror images. *Cancer is a condition of biological narcissism.*

All that remained for the re-emergence of an integrated theory of mind/body involvement in disease was the scientific determination that the psychological defensive apparatus interacted with the physiologic immune system, and that dysfunction in one could cause disease in the other. Psychic factors can play a role in the contraction and progression of somatic diseases; similarly, physical factors can contribute to psychic disturbance.

Psychosomatic medicine was the name given the relatively new discipline whose express purpose is the study of the interface of mind and body (**Deutsch, 1927**). Freud's work with hysterics raised some of the questions for the first time, but provided few answers because the hysteric only mimicked physiological involvement. These people clearly demonstrated that mental disarray could play a role in the body's integrity. But the conversion symptoms of Freud's hysterical patients had no real organic basis.

Their apparent physical symptoms were symbolic representations of unconscious conflicts.

The idea of actual somatic involvement posed a somewhat different problem. Here, there needed to be postulated some mechanism whereby the mental apparatus could create physiological change. There is no evidence that body organs or the autonomic nervous system can express ideas; they have no connection with the part of the brain that produces ideas. Thus it seemed unlikely that symbolic meaning of emotionally charged ideas, as it occurs without real organic involvement in the conversion symptoms of hysteria, could be carried over into the dysfunction of the vegetative organs.

It wasn't until more precise understanding of the hormonal, endocrine and central nervous systems was acquired that researchers could explain the mind/body interaction that created psychosomatic illness. Early psychosomaticists observed correlations between specific organic illnesses and personality traits (**Dunbar, 1954**). How the process of human psychophysical maturation and difficulties in the process could lead to somatic, as well as psychic, dysfunctions was also noted. Freud's recognition that the enemy is within (drive theory rather than seduction) paved the way for an understanding of psychosomatic illness.

As the child grows, his mind becomes an increasingly specialized, differentiated and sophisticated instrument. He develops judgment, perception, thought, affect, fantasy. These tools, then, become valuable when conflict arises again. The child's now adequately developed mental apparatus will allow him to find a means of reducing the level of tension so that conflict does not reach the level of intensity that is painful and/or destructive. If psychological development is stunted, though the child remains unable to reduce the level of tension through the use of his mental apparatus, and he may resort to an earlier mode of discharge. There remains an incapacity to reduce tension through any means other than the body itself.

Experimental research on the psychosomatic cancer patient confirms that there is, indeed, a dysfunction arising very early in the maturational sequence (**Klopfer, 1957**; Kissen, **1963, 1967**; **LeShan, 1977**), and that this psychological dysfunction parallels the difficulty on the level of the body. In the cancer patient, the psychological defense system, like the physical defense apparatus, is inadequately activated. The responses to dangerous stimuli that

would normally act as warning signals to the ego either are never aroused, or are aroused with insufficient strength to generate a response.

We know that activation of the physical defense system means stimulation of autonomic chemical and hormonal processes over which we have little conscious control. When we refer to the psychological defense system, we think in terms of the psychological representation of physical processes; we think in terms of feelings. According to Freud the defensive apparatus was activated by anxiety: “Anxiety is reaction to danger,” he said (**Freud, 1926**). For Freud, danger included both real and present dangers, and anticipated dangers that may exist only in the mind. Freud situated this response in the ego. Later, the feeling states of pain, guilt, shame and anger were added.

In the psychosomatic cancer patient, these feeling signals appear to be dulled. This lack of acknowledgement of feeling states—which clinicians observe to be quite strenuously worked for—is in stark contrast to the more spontaneous and flexible emotions that mark a more normal adaptation (**McDougall, 1980**).

It is this inactivation of the psychological defense system which the experimental researchers have isolated as the main component in the make-up of the cancer personality. **Greer (1975)** observed in many cancer patients an “inordinately pleasant personality;” **Schmale (1966)** found a tendency for cancer patients to be lacking in their experience and expression of aggression; Rennaker (1981) refers to the Pathological Niceness Syndrome, by which he means an indiscriminate, even promiscuous niceness. Each of these researchers has found that cancer patients demonstrate a pathological denial and repression of both their own and others' “negative” emotions, particularly anger.

In the face of this disconnection from important parts of his inner self, the cancer patient is left to create a veneer of a personality—generally a pleasant, likable persona, but one which, in its incapacity to recognize danger and thus mobilize its own defensive strategy against it, is supremely vulnerable.

This patient reminds us of the unfortunate “boy in the bubble,” who was born without any immune potential. Any intrusion of a germ into his defenseless body would have meant death to him, and he was forced to live his short life completely enclosed in a sterile environment, cordoned off and protected from the living environment. Cancer patients are like that boy, but without his protective shield of glass. In the light of inadequate defenses, both

psychological and physical, the situation seems hopelessly fragile and precarious.

Research has afforded us a comprehensive understanding of how mind and body normally develop. We have seen that, initially, mind and body proceed seemingly in parallel fashion; what one does, the other reflects. Both engage in the essential process of differentiation, and in so making an adequate self/not-self distinction, allow for the emergence of the immunological and defensive systems. Research has further given us a vivid picture of the pathological outcomes of interference with this process of differentiation: cancer, on the level of the body, and schizophrenia, on the level of the mind. The cancer cell, like the schizophrenic ego, is undefended, wild, dangerously out of control. The cancer cell appears to be in a state of biological narcissism.

But the mind of the cancer patient seems to be in stark contradistinction to the unruly cancer of the body. Cancer is a state of wild expansiveness, growth unchecked by any normal control apparatus. The mind of the cancer patient is, in contrast, characterized by constriction, a control too tightly held. The cancer patient lacks the freedom of mind normally afforded us by our dreams and fantasies and our ability to imagine options for ourselves. Feelings and thoughts lead to psychic dead-ends for the cancer patient.

It may occur to us at first to postulate a breakdown of communication between mind and body. But the very consistency of their opposition leads to the idea that there may be some profound link between them. Indeed, it looks as though mind and body are operating in some compensatory fashion. The mind seems to want to counteract the excessive growth of the body; and the body seems to want to compensate for the excessive constriction of the mind. The very rapid change in the body is counteracted by stagnation in the mind. With the body out of kilter and the mind rigidly balanced, the two seem to be making an awkward and surely ill-fated attempt at homeostatic restoration by serving as complements to one another.

It is within the realm of the unconscious mind that this communicative link can be found. On the biological level, consciousness is not an essential ingredient in communication. The autonomic functionings of both the neural and hormonal systems are examples of exquisitely complex mechanisms for transmitting the effects of what happens in one part of the body to other parts, independent of conscious awareness. Freud applied this principle

to the workings of the psyche, and found that parts of our psyche communicate with other parts without our conscious participation or awareness. The very definition of neurosis is based on the idea of the functional separation between conscious purpose and underlying psychic intent.

And in fact, it appears that while the conscious mind of the cancer patient operates, as we have seen, in a manner inversely related to the functioning of the body, the unconscious mind incorporates the very characteristics of the cancer process. This is to say that the mind of the cancer patient embodies certain characteristics of the cancer itself. Rorschach responses of cancer patients, for example, tend to follow the formal characteristics of the cancer (**Booth, 1965**). On the cards where isolated images are presented, cancer patients, unlike most others, ignore the segmental and restrained presentation of the image and, instead, see the picture as one large, expansive image, attempting often to incorporate the entire card into the one image. We are reminded of the invasive nature of the cancer cell, threatening to subsume the whole body through its manifestation of a pathological expansiveness.

Further, when there was obvious symmetrical configuration of form in the Rorschach, as in the cards where the blots appear to be the result of paper being folded over on itself to produce a symmetrical, mirror image, where the usual response is to see these figures as related and interacting with one another, cancer patients saw them as separate and unrelated. Here we are reminded of the incomplete communicative capacity found in the cancer patient. Where body and mind should be connected, they seem, in the cancer patient, to be dangerously out of touch with one another; where the intrapsychic and social worlds should mesh to allow for the possibility of intimate interaction between self and other, the cancer patient seems isolated and alone, cut off from meaningful contact.

Additional research suggests that this isomorphic relationship between the body and the unconscious aspects of the psyche exists also in the formal characteristics of the particular organ site affected. Patients with exterior cancers (e.g., breast) had substantially higher “barrier” scores on the Rorschach, and patients with interior cancers (e.g., of the cervix) had higher scores on the “penetration” scale (**Fisher and Cleveland, 1958**). The data are convincing evidence for the idea of a meaningful link between the physical aspect of the cancer in terms of its location choice, and the psychological

analogue, as represented by discrimination of intrapsychic boundary dimensions.

It would seem, then, that in a cancer situation, mind and body operate such that both do not go wildly out of control simultaneously. This inverse relationship appears to pertain to the schizophrenic condition, as well. Just as the constricted psyche of the cancer patient demonstrates attributes diametrically opposed to the wild-growing cancer, similarly, the schizophrenic rarely contracts cancer. It has been estimated that schizophrenics have a cancer rate two to four times lower than the rest of the population (**Freeman, 1928; Sheflen, 1951**).

There is one exception to this rule, and it is a telling one. In paranoid schizophrenics cancer occurs four times as often as in the general population (**Chevans, 1931; Freeman, 1928; West, 1954; White, 1929**). Paranoia is, of course, a state of exaggerated defensiveness (**Freeman, Cameron and McGhie, 1966**). It is the one form of schizophrenia where the defensive structure is too strong. It stands in sharp contradistinction to both cancer and all other types of schizophrenia, where it is precisely the weakened defense system that is the cause of the pathology.

It is perhaps the relative frequency of cancer in the paranoid condition that has made the alliance of these two dysfunctions a fertile area for speculation. Clinical observations on the waxing and waning of the paranoid state strongly support the theory of an inverse and perhaps compensatory relationship between psychosis and cancer.

All forms of schizophrenia represent a situation of severe psychological disorganization. The paranoid patient, however, is the only type of schizophrenic in whom the response to the deterioration takes the form of an over-reaction against this disorganization of mental life. Elaborately detailed fantasies are constructed; often, there is enough contact with what's actually possible that the delusions can be quite compelling, even to normal individuals. There is a mere misinterpretation of environmental events—an arbitrary selection of perceptual experience—rather than the creation of a whole new delusional reality. Hallucinations are uncommon among paranoids. It might be the kind of accident of interpretation that any of us could make under conditions unfavorable to accurate perception, except that the mistake is so exaggerated, the process of error so elaborately and relentlessly pursued.

This holding onto a fragment of reality, tenuous though it may

be, is in contrast to the other schizophrenic reactions where the disorganization (or, dedifferentiation) of mental life is more archaic and infantile. In profound cases, detachment and withdrawal from the environment are virtually complete.

The paranoiac, then, in having a closer hold on reality, wages a desperate battle between reality contact and disintegration of personality. The usual profuse verbalization of the paranoid, unlike the stone-wall silence of the catatonic schizophrenic and the “word-salad” utterings of the hebephrenic schizophrenic, makes the extent of the hold onto and the slipping away from reality relatively easy to follow.

A number of clinicians working with paranoid schizophrenics with cancer have observed that as the psychosis becomes more apparent, the cancer regresses or goes into dormancy (West, 1954). The converse also seems to be true: if the psychosis responds to treatment and the patient is brought back into the realm of reality, the malignancy resumes its activity. The interplay between physical and psychic disease manifestation is impressive, and suggests a possible survival function of psychosis.

Explanation for this fluctuating phenomenon is found in yet another attribute that the cancer cell and the schizophrenic mind have in common. Both are murderous. The cancer cell has the distinction of committing a double killing—first murder, in its killing its host organism, and as the immediate consequence of this, suicide—without its host, it, too, must die, of course.

The schizophrenic, too, is caught in a web where it seems that the only solution is murder. The aggressive drive is thought to begin as early as intrauterine life, and its expression is an attempt to maintain a homeostatic balance between tension and tension relief. The inability to constructively handle the arousal of biologically innate aggression is now considered the prime cause of schizophrenia.

It is, in particular, the dependency of both the cancer cell, on the biological level, and the human mind, on the psychological level, that results in this murderous solution.

The cancer cell cannot exist without a source of nourishment, and that source is the organism in which it resides. In its biological immaturity, it feeds off its host, homicidally invading and consuming as it grows, depriving its host of the necessities for survival, until, finally debilitated, exhausted, and malnourished, the host ceases to be able to perform life-sustaining functions, and

expires. The cancer cell, without the host on whom it depended, now succumbs itself.

The human organism has the capability of partnering itself in this same dance of death. We are born into a state of biological and psychological dependence incomparable to any other stage in our life. The infant quickly becomes aware that its survival is dependent on its mother's responsiveness to its fundamental needs of food, warmth, and love. The intangible phenomena of feelings—a sense of security, of being lovingly cared for and attended to—are not luxuries; they are essential needs, without which the infant is susceptible to disease and death. These very early experiences around feeding and love determine lifelong characterological patterns. How feelings of dependence are handled in this initial stage will influence the way in which dependence is handled when that infant grows into an adult.

The kind of destruction that results from the parasitic relation between host and parasite in cancer and schizophrenia is not, however, a biological necessity. Nature does, under normal circumstances, make other provisions. Nature is replete with examples of parasitic relationships where survival of both the host and parasitic organisms is assured.

The example of maggots is a good one. Some species of maggots, like the cancer cell, depend on live tissue for food. These maggots will seek out a larger living insect, puncture its skin with their stingers, and lay eggs in the body of the larger insect. The eggs must be deposited in a live animal because the newly hatched maggots will feed on the flesh of this insect. If a vital organ were to be destroyed, causing the death of the insect, all hatching maggots would perish, as well. The intelligence of this relationship is that nothing of the living insect is eaten except parts not essential for its survival.

The condition of human pregnancy is an equally successful parasitic relationship. Pregnancy shares some attributes with cancer, for instance, that of unparalleled growth. The gestation period of nine months for the human fetus is a biological necessity for survival. The rate of growth of the brain, and the consequent growth of the head size during the last phases of pregnancy, proceed at a pace so rapid that continuation of the gestation period would render a later birth impossible. The expulsion of the fetus before its virtual entrapment within the chamber of the womb permits the survival of both mother and fetus (Montagu, 1971).

The implantation of the fetus in the mother's body is accomplished by a sort of trick the body plays on itself (similar to the trick that is artificially induced in transplants): the self, the mother's body, comes to believe that the not-self entity of the fetus is not a foreign being (Silberner, 1986). Precisely how this trick of illusion is accomplished is still only partially understood, but we know that it demands a joint effort between mother and fetus. On the one hand, the uterus of the mother is uniquely designed to allow the mother an immunity lapse for the necessary nine months. Additionally, the fetus cuts down on rejection potential by successfully hiding those parts of self which the mother's body would recognize as foreign.

Proteins in the cells called transplantation antigens permit the body to distinguish self from not-self. In each of us, some of these proteins are derived from the genetic structure of the mother and some come from the father. The pregnant woman will recognize those proteins in her fetus derived from herself as being uniquely hers; those from the father will be recognizably foreign. To limit the provocation of an immune response, the cells derived from the father stay deep in tissue, away from the immunologically sensitive parts of the uterus.

The mother aids this process through a precarious balancing of her rejection response. White blood cells that hover in the uterus near the placenta become lazy, and don't respond to the normally immune-stimulating chemical interleukin-2. Killer T-cells remain quiet. As well, the human chorionic gonadotrophin (HCG) hormone is lowered.

Yet the total suppression of the mother's immune system in the very early stages will be fatal to the fetus. Spontaneous abortion then occurs for the same reason as the death of a cancer patient. Partial stimulation of the mother's immune system is necessary to prompt the protective defenses of the fetus. If the genetic material from the father is too similar to the mother, his contribution will not be recognized as different, the initial provocation will not take place, and the fetus never learns to defend itself. Subsequent inevitable attack by the mother's immune system results in the fetus' abortion and death (Silberner, 1986).

This relative inactivity of the immune system and the lowering of the HCG factor are conditions that exist in only one circumstance other than pregnancy. This is the condition of cancer. Here, too, the body's innate ability to recognize an invasion of not-self (the cancer cell) is diminished, and, as in pregnancy, the invading

cell is allowed to reproduce and grow. In the pregnancy situation, after nine months the HCG factor spontaneously rises and the fetus is ejected through the process of birth. The outcome in the cancer situation is, of course, quite different. The host organism remains indifferent to the existence of the intruding cell, and the normal process that limits growth is never activated. The cancer growth is like an unending pregnancy, and unchecked, causes death—its own, along with its host's.

The mind, though, rarely acts as primitively as the cancer cell. The human organism is capable of consciousness, and the mind is able to perceive that murderous impulses discharged towards an object on whom it remains dependent for its own survival are, indeed, an act of suicide. Whatever life-preservative wish is present, no matter how slight, is usually sufficient to prevent the human organism from engaging in an activity that would directly cause its own death.

It is not an accident that cancer is a disease which has its usual end in the death of the host organism, and that schizophrenia is not. It is the stimulation of the psychological defensive apparatus in the schizophrenic that permits preservation of life. The discovery and elaboration of the pathological use of narcissism as a defense mechanism, by Hyman Spotnitz in the early 1950s, was the final clarifying point in understanding the malfunctioning of the defense systems in the cause of mental disease (**Spotnitz, 1985**). Recognizing the murder in narcissism was the breakthrough. The murder that takes place for the schizophrenic is on the level of the mind. The ego functioning of the mind is obliterated, a sacrifice made in the service of object protection.

It becomes clear, then, that both schizophrenia and cancer arise out of the early, undifferentiated phase of development. Since the organism first discharges aggression somatically, the production of a potential cancer condition would come earlier than the organization of a schizophrenic nucleus.

In any event, this defensive maneuver remains relegated strictly to the realm of the unconscious. The schizophrenic assiduously avoids becoming aware of his own murderous rage, and gives ample demonstration of Freud's original precept that patients would rather be sick than know their own impulses. It is, again, in this defensive maneuver that insures unconsciousness, that the psychological functioning of the cancer patient mimics that of the schizophrenic.

The unconscious mind of the cancer patient is replete with fantasies

of revenge, destruction and murder. It is only through the creation of the false persona of the pleasant, compliant cancer personality, and the disconnection between conscious and unconscious urges, that these impulses can be bottled up and ignored.

What clinicians had been observing about the psyches of their cancer patients for centuries was provided with powerful experimental validation in 1946. Caroline Thomas administered extensive psychological and physiological testing to medical students in order to discover precursors to five primary diseases: hypertension, heart disease, cancer, mental disorders and suicide. She had originally conceived of cancer as being a condition without psychological factors, and was startled to find that the personality profile for students who later developed cancer looked remarkably similar to the profile for those who had become suicide victims **(Thomas, 1959)**.

The dictum “out of sight, out of mind” stops making sense when the unconscious is brought into consideration. Where the destructive drive is inadequately channeled, its power to destroy is great. At its height, it seems to follow its inward path along alternative routes. When turned against the body, the result is cancer; when turned against the mind, schizophrenia results.

The destructive urges of the cancer patient are manifested overtly only on the physiological level—the cell runs rampant and takes in its wake anything that interferes with its unrelenting growth. Massive repression and denial of destructive urges are apparent on the level of the psyche. Locked away in the recesses of the unconscious, however, is the secret wish to kill. Unconscious suicidal and murderous wishes are revealed when repression is lifted. The cancer cell knows, and lives out, the murderous intent that the cancer psyche has denied.

So, too, it is with the schizophrenic. The mind is destroyed in the service of keeping the murderous impulses hidden. On the level of the unconscious, a choice is made—insanity or death. Norman Mailer's thought that “cancer is madness denied” may contain as much scientific as it does poetic truth **(Brody, 1977)**.

References

- Alexander, F. (1939), Psychological aspects of medicine. *Psychosom. Med.*, 1: 7-18. [→]
- Booth, G. (1965), Irrational complications of the cancer problem. *Am. J. Psychoanal.*, 25: 41-60. [→]
- Brody, S. (1977), Psychoanalytic experiences with cancer patients. *Archives of the Foundation of Thanatology*, 6: 9-10. [→]
- Burnet, F.M. (1970), *Immunological Surveillance*. Pergamon Press: Oxford.
- Chevans, L.C.F. (1931), The correlation of cause of death with type of sanity. *Journal of Mental Science*, 77: 562.
- Deutsch, F. (1927), Psychoanalysis and internal medicine. In *Evolution of Psychosomatic Concepts*, eds. M. R. Kaufman and M. Heiman. International Universities Press, Inc.: New York. 1964.
- Dunbar, F. (1954), *Emotions and Bodily Changes*. Columbia University Press: New York.
- Federn, P. (1952), *Ego Psychology and the Psychoses*. Basic Books: New York.
- Fisher, S. and S. Cleveland, (1958), *Body Image and Personality*. D. Van Nostrand: New York, pp. 301-306.
- Freeman, T., J. Cameron and A. McGhie, (1958), *Chronic Schizophrenia*. International Universities Press, Inc.: New York.
- Freeman, T., J. Cameron and A. McGhie, (1966), *Studies on Psychosis*. International Universities Press, Inc.: New York.
- Freeman, W. (1928), Biometrical studies in psychiatry—the chances of death. *Am. J. Psychiatry*, 8: 425.
- Freud, S. (1926), Inhibitions, symptoms and anxiety. *Standard Edition*. London: Hogarth Press, Vol. 20. [→]
- Greer, S. and T. Morris, (1975), Psychological attributes of women who develop breast cancer: a controlled study. *Journal of Psychosomatic Research*, 19: 147-153.
- Kernberg, O. (1975), *Borderline Conditions and Pathological Narcissism*. Jason Aronson: New York. [→]
- Kissen, D.M. (1963), Personality factors in males conducive to lung cancer. *Brit. J. Med. Psychol.*, 36: 27.
- Kissen, D.M. (1967), Psychosocial factors, personality and lung cancer in men aged 55-64. *Brit. J. Med. Psychol.*, 40: 29.
- Klopfer, B. (1957), Psychological factors in human cancer. *Journal of Projective Techniques*, 21: 331-340. [→]
- LeShan, L. (1977), *You Can Fight For Your Life*. M. Evans: New York.
- Loewenstein, W.R. and Y. Kanno, (1966), Intercellular communication and the control of tissue growth: lack of communication between cancer cells. *Nature*, 209: 1248-49. [→]
- Mahler, M. (1968), *On Human Symbiosis and The Vicissitudes of Individuation: Volume 1, Infantile Psychosis*. International Universities Press, Inc.: New York. [→]
- McDougall, J. (1980), *Plea for a Measure of Abnormality*. International Universities Press, Inc.: New York.
- Montagu, A. (1971), *Touching: The Human Significance of the Skin*. Columbia University Press: New York.

- Schmale, A.H. and H. Iker (1966), The psychological setting of uterine cervical cancer. *Annals of the New York Academy of Sciences*, 125: 807-813.
- Sheflen, A.E. (1951), Malignant tumors in the institutionalized psychotic population. *A.M.A. Archives of Neurology and Psychiatry*, 66: 145.
- Silberner, J. (1986), Survival of the fetus. *Science News*, 130: 234-235.
- Spotnitz, H. (1985), *Modern Psychoanalysis of the Schizophrenic Patient*, Second Edition. Human Sciences Press: New York. [→]
- Thomas, C. and D.R. Duszynski (1974), Closeness to parents and the family constellation in a prospective study of five disease states: suicide, mental illness, malignant tumor, hypertension, and coronary heart disease. *The Johns Hopkins Medical Journal*, 134: 251-270.
- Thomas, L. (1959), In H.S. Lawrence, Cellular and humoral aspects of the hypersensitive states. In *Symposia of the Section on Microbiology, New York Academy of Medicine*, Cassel: London.
- West, P.M. (1954), The psychological variables in human cancer. In *A Symposium*, eds. J.A. Gengerelli and F.J. Kirkner. University of California Press: Berkeley, CA. pp. 92-93.
- White, M.A. (1929), The social significance of mental disease. *Archives of Neurological Psychiatry*, 22: 873.

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