

CENTER FOR MIND-BODY MEDICINE
COMPREHENSIVE CANCER CARE 2000

CONCURRENT: Mind-Body Medicine and Clinical Practice

PRESENTERS: Michael Lerner, PhD and Jeanne Achterberg, PhD

MODERATOR: Stephen Sagar, MD

COMMENTATOR: Julia Rowland, PhD

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P R O C E E D I N G S

DR. SAGAR: I'll introduce some of the leaders and pioneers of mind-body medicine them in order of speaking.

First is Jeanne Achterberg. Jeanne I personally heard speak about, oh, 2 or 3 years ago now in San Diego, the Alternative Medicines Conference. And she's continued to be an inspiration. I've read all her books.

She's a professor of psychology at the Saybrook Institute. As I mentioned, she's a pioneer of research in mind-body medicine, psychology and healing, an author of over 100 scientific papers and five books, including her recent book, Rituals of Healing.

As you heard this morning, she chairs multiple and presented multiple political presentations to governments on the role of mind-body medicine in health. And she's also past president of the Association of Transpersonal Psychology, and is an associate editor of Alternative Therapies in Health and Medicine, which I think is the best peer review journal on this subject.

Michael Lerner. Many of you must know Michael Lerner. He pioneered research into complementary therapies for cancer during a grant-sponsored review. He is president and cofounder of Commonweal, which evaluates health, and also the Commonweal Cancer Program, which he formulated originally and runs with Dr. Remen.

He's currently a leader in the assessment and implementation of mind-body therapies for cancer, and is author of the well-established book now, Choices in Healing.

Hopefully, later on, we'll have Martin Rossman. Dr. Rossman is director of the Academy for Guided Imagery. Some of you may have attended his session yesterday. He's a clinical associate at the Department of Medicine at the University of California Medical Center in San Francisco, and is on the teaching faculty of the California School for Professional Psychology.

He's pioneered the application of guided imagery and other mind-body techniques for patient care.

And last but not least, in the role that nobody envies, is Julia Rowland, who's going to be the commentator for this session. She is the director of the Office for Cancer Survivorship at the NCI. She's been a clinician, a researcher, and a teacher in psychosocial aspects of cancer. And she has also coedited that great book, Handbook of Psycho-Oncology, with the famous Jimmie Holland and has worked a lot in psycho- oncology at the Memorial Sloan-Kettering and

Lombardi cancer centers. So please welcome our speakers. And we'll be very grateful if Dr. Achterberg could start off this session.

DR. ACHTERBERG I have to tell you that I am very, very glad to see you. I'm glad to see anything this morning.

Some of you know, I testified before Congress for the first time in my life yesterday. And I was in such shock, I wasn't sure that my subjects and verbs agreed. But apparently, they did. I'll read the transcript on the Web later.

There are other reasons why I'm glad to see you. Twenty-five years ago, I had a goal and I think we're all born with some kind of a little mission in life. And my mission was to humanize the care of patients, people in the crisis of cancer.

And my gravitation was towards the mind-body field. I did a lot of research. I'll talk a little bit about that in my 15 or 20 minutes here. I thought I knew a lot of things. You know, when you think you know everything, or you think you've learned all that there is to know, the Fates pick you up by the nape of the neck, and they say, "Take a another look again, smarty-pants."

And they did that to me last July 23rd. I was given a diagnosis of a very large ocular melanoma. I was going blind. As large as it was, the speculation was that it had probably metastasized to my liver.

And that is a fast track. The life- expectancy is 3 months. So it occurred to me that I didn't have another 40 years left to try and humanize the care of patients with cancer. That may, in fact, I might have 3 months or 3 years, or 30 or 40 years. I don't know.

But that if I got through the year, and still held my public forum, I could no longer be silent. I could no longer try to say things that people liked to hear, that I had to speak directly from every cell in my body and from my heart.

And you are my first presentation after that. Because what had happened was, with such irony, I had a tumor that had never been treated before in the records -- a primary tumor -- in the records of any alternative or complementary medicine. I called all over the world. They treated metastasized tumors, but never a primary. There was no alternative medicine for me.

When I went to Western Medicine, which I fully anticipated to participate in, because Western Medicine is as full of grace as any other form of medicine, the only thing that they could offer me was to remove my eye. And I said, "No."

Now, I am not so sure that removal of the eye is any more difficult than removal of a breast, or removal of testicles. I don't know about that. But every time I checked in -- I could have radiation, which would have also eventually caused me to have my eye removed.

Every time I checked into the hospital, a big hand came and said, "No." "No." So, I didn't reject modern medicine, it continued to reject me. It continued to reject me.

The irony was that all I had left available to me, was mind-body medicine. See? Be careful what you do with your life, because you may end up in this position.

Here I'd been saying that mind-body medicine was essential medical practice and not secondary medical practice and by God, that's all I got. That's all I got.

And how am I? People want to know. Obviously, I'm not dead yet. I'm feeling a little better than I did 10 years ago. On the 17th of November, in this city, I was presenting at the Music Therapy Conference, and I had to get off the podium for the first time in my life, because my eye was swelling up to twice its size.

And I laid on a bed in a hotel room for 5 days while my eye exploded, and dared not call a physician, because I knew that the treatment would be cortisone and that that would stop the inflammatory process.

So, molecule by molecule, photon by photon, I am getting better. And on January 1st, something called the life force -- now, if you're interested in alternative and complementary medicine, read a book by Michael Goldstein called *Alternative Health Care: Medicine, Miracle, or Mirage?* You know that title. Michael Goldstein.

Anyway, he draws from common denominators in alternative and complementary medicine. One of them is that there is a belief in the life force. There is a belief in something called "vitalism," or vitality. The life force.

Francis Crick recently announced that we no longer have to talk about the life force now that we know about genes and DNA and all that kind of stuff.

And I want to tell you, Francis, that good man, has never felt the life force leaking out of him. He has never felt the breath of God breathing it back into him; and that's what I felt, beginning the first of this year.

So I'm here with this renewed dedication, grateful to have a format, knowing full well that the language and the words that I have mouthed for 25 years are absolutely true. And there is more. There is more.

I also know that the cancer practice of medicine is a brutal, and it's an assault to humanity. That I know. And I am the most privileged, I am the princess of patients. Yes? Got everything.

So, that I know now is that the practice is brutal, even in the most treasured circumstances. Even in the most treasured.

And I also know that 10 years from now, if not earlier, we're going to look back at the practice of medicine for cancer in this world, and say that anything that does not honor the core of humanity, that does not recognize the essence of what it's like to be a human being in crisis, will be declared both unethical, inhumane and illegal. It's true. That's the truth.

This cannot continue. It cannot continue. The way medicine is practiced for cancer affects every single person and every single family in this country and in this world. And it must become more humanized.

That which we're bringing forth today about mind, body, and let me add spirit, because as we've begun to work in this field, we could no longer honestly talk about mind and body without talking about the great integration, interdigitation, of spirit in all of these and that it's all part of the same cosmic mush. That we are mind, body, spirit, as human beings. It's true.

Well, just some brief history of mind-body medicine and how I see it being integrated in clinical practice and then I'll move on to my colleagues here.

In 1992, I had the great privilege of chairing a committee that was the forerunner for the Office of Alternative Medicine, a committee called in Chantilly Virginia. And we produced, at the end of that committee, a legendary document, which I understand from my colleagues yesterday, is still in print with the Government Printing Office, called "Alternative Medicine: Expanding Medical Horizons." And what Larry and Jim Gordon, my cochairs and I did, along with the great help of our committee, is put together the state-of-the-art of mind-body medicine in this country, and what we thought were the components of mind-body medicine.

What we discovered, as we wrote the report, as we brought in all the resources, is that of all the alternative medicine, herbs, nutrition, whatever, of all of them, the soundest database is provided for the mind-body therapy. The soundest database.

And in fact, the research design can serve as a golden standard for other individuals who are attempting to research alternative and complementary medicine.

Now, within that framework, we pulled in meditation, certainly guided imagery, which has been my long-term love, guided imagery, hypnosis, the expressive arts, and on and on, and lately have come to include what is being called distant intentionality, or prayer.

As I mentioned, the conclusion of this particular piece of the report, was that the mind-body therapies are not secondary to medicine, they are essential to medicine.

Now, the other thing, if I have to summarize the research in 2 minutes, let me do it this way.

Mind-body medicine is not something you do to make yourself feel better while you wait for the undertaker to come, although there is that, too. Eventually, the undertaker will come for all of us, sooner or later.

What we know, and I'm speaking to the choir here; what we know is that well-crafted support groups can increase your life expectancy by at least two times. We know that imagery, biofeedback, meditation, relaxation, a session of counseling, virtually anything, decreases the side effects to traditional Western mainstream medicine.

That one single session prior to surgery, results in fewer days in the hospital, requirement for less pain and sleep medication. There's hundreds of these studies.

We know that one session before chemotherapy, and hopefully you have more, but one session can decrease the serious incidence of preanticipatory nausea.

Is this cost-effective? You know, you get to the point where that question is not even relevant. It's not cost-effective to puke your guts out all day long, I'll tell you that. If you have to go to a therapist, and it's not covered by insurance, go for a couple of sessions. It will pay off in the long run. Instead of throwing up, you can do something productive. Play with your grandchildren. Do something.

Anyway, the cost-effective data are there, and they're not there. So I can't honestly say all this stuff is going to save you money, although deep in my heart, it does. I have no medical

expenses, because I had no treatment. You know? It can happen. I'll talk tomorrow about what kind of treatment I did have.

Okay. We know that joy, we know that love, we know that even expressing your deepest thoughts in writing, stimulates natural killer cells. And if you're a cancer patient, that's a real good thing to have stimulated. Expressing yourself. The creative arts increase the immune system.

We also know that having a supportive community, or lack thereof, is the single greatest risk factor for death from all disease, including cancer. The lack of a supportive community, however you define that. However you define that.

So all of these elements that superficially look like they're only caring, are actually curing. Are actually curing.

We know this. I'm reminding you of what you already know. Of course they are. Of course they are.

So out of all of this, my greatest interest, in looking at the research, my greatest interest was in imagery, which I'm sure Marty will talk about. Imagery is a medical protocol. It is one of the most well-studied, well-researched of all the mind-body therapies. Anybody who's read the literature would absolutely not consider not using imagery. So it is a medical protocol.

But more than that, again, as Marty I'm sure told you yesterday, those of you who were in his session, imagery is the way we communicate. From the time you walk into the clinic, from the time you walk into the hospital, you are creating and developing images, some of which are so powerful that they pull you across the threshold into life.

And some are so powerful, that they push you in the other direction. Just an example. While I was laying on this hotel room bed -- I'd much rather be in a hotel if you're dying than a hospital, incidentally. I had room service. And a minibar, which I completely cleaned out of all the nonalcoholic beer, which I have developed a fondness for. It seemed to settle my stomach. I drink this stuff by the case.

But what was happening, as people would call me, one doctor said, Oh, the cancer spewed all over your eye. Another doctor said, You've got flu in your eye.

Carl Simonton, my doctor and best friend, oldest friend in my life, said, Jeanne, number one, you don't get flu in one eye. You don't have the flu in one eye. Your immune system finally found your eye. Ah-ha. New imagery.

I'm not dying from flu in my eye. My immune system found my eye. Do you know what that does to your mind, and body, and spirit? Do you know what that does to your anxiety level, as you're hanging on for dear life? You celebrate it. God, I hurt, and this is so good.

So, imagery is the way we communicate. The words create images, and they make us feel worse or better. And it's also a medical protocol. Twenty minutes a day in imagery tends to do a lot of things for you. Again, I'm running out of time, so later, folks.

The second thing that I got very interested was supportive community and the power of prayer. And I think the research now shows that why wouldn't you pray for somebody? Why wouldn't you do distant intentionality?

Virtually every study, not all, but virtually every study shows positive effects, particularly if you are, like I was, the recipient of hundreds and hundreds of prayers. Hundreds and hundreds of prayers.

So again, my own personal view on all of this, is yes, we need good research. Good research has already been done. How many more times -- I was tired of replicating my own work over and over again and seeing other people replicate it. I was bored. Maybe I needed new material but this isn't what I planned on.

The research for the mind-body work is there. The next step that we must take in a systematic, conscious, directed way, is implementation. It's implementation.

And it's no longer safe to say, let's get government to sponsor a few more research studies. They can do that if they want to, but that's not the point of all of this.

The point of all of it, is that it is now time to make major changes, to make the wedge into medicine that has been closed off, shut down for hundreds and hundreds of years and begin to honor that place of sacred territory that we as health-givers and we as patients find ourselves in, in crisis.

Thank you.

MR. LERNER: Well, thank you, Jeanne. That was amazing. It's a joy to be here, and a joy to be here with Jeanne and Julia and Marty, all of whom are old friends.

I'm going to be giving a plenary talk at 2:00 and so I'm not going to cover much here of what I'm going to cover there, some of which is very relevant to our subject of complementary approaches in clinical practice.

I think what would be most useful here is to talk about what I know best, and what is most directly related to the clinical practice of complementary approaches to cancer, which is the Commonweal and the Smith Farm Cancer Help Program.

The Commonweal Cancer Help Program is about -- my guess is it's about 15 years old now. And the Smith Farm Cancer Help Program, three years old. This is Shanti Norris, the director of the Smith Farm Cancer Help Program, which is based here in Washington, D.C.

The Commonweal Cancer Help Program is based out in a little town called Belinas, California, just north of San Francisco, on the coast.

And if you can imagine a piece of the California coastline with an old, actually an old RCA transmitter center that we turned into a healing center out there, and imagine that over the last 15 years, that we've done about 100 week-long retreats for people with cancer.

It's been the center of my life, in many ways, over the last 15 years, is doing these week-long retreats for people with cancer. And I'd just like to kind of describe to you what I've learned from those 100 retreats, both at Smith Farm and at Commonweal.

On Monday morning, nine people who never met each other before, show up, either at Commonweal or at Smith Farm. And they are welcomed and they do some introductory interviews, intake interviews. They have lunch. Then, in the early afternoon, we do a sort of overview of the week.

That they're going to have a schedule of getting up every morning, yoga, meditation, and deep relaxation for an hour and fifteen minutes with Shanti if it's here in Washington.

And then breakfast. And then, in the morning, there will be a support group. It may be led by Rachel Naomi Remen, the medical director at Commonweal, or one of the other very gifted co-leaders of the program.

And then there's lunch, and then, in the afternoon, they either have massage or sand tray, which is a form of art therapy, or individual counseling sessions with the therapist who leads the morning support groups, or with me, or with some of the other staff people. Then, at 5:00, there's a second yoga meditation/deep relaxation session.

And then the evening sessions rotate. So the first evening, we get together and talk about why everybody's here. And the second two evenings, Tuesday and Wednesday evenings, I do a five-part talk on choices in healing, which I'll come back to.

And then Thursday evening, there is a healing circle, where people sort of do intentional healing, as Jeanne was mentioning, with each other.

And Friday evening, we do a session on essentially healing words on poetry. And then Saturday, we talk about what the week has been like, and Sunday they leave.

Now, it's very simple. It's essentially a yoga and meditation retreat for cancer patients, designed to meet their specific need. But to say it's simple, does not mean to say it's easy. Nor does it mean to say that there is any limit to how good you can get at doing this.

A couple of things I can tell you about this. One is that the technology transfer of starting another, absolutely first-rate program like the Commonweal Cancer Help Program, is a very difficult thing to do. We did it with Smith Farm and what we did there, was really fly the whole Commonweal staff across the country to Washington and then subtract them one at a time, as we got people with equal gifts.

But we are totally dedicated, because this is the point of the cancer help program, we're totally dedicated to the well-being of those nine people who are there for that week.

So the technology transfer is very difficult to do. And the heart of the technology transfer, is not the specific modalities.

For example, you could do yoga in the morning, but you could do qi gong, or you could do Tai chi, or you could do something else. It really doesn't matter enormously, which psychophysiological discipline you use in the support group in the morning.

I'm not a big believer that some specific school of psychotherapy is the key. In fact, our leaders are trained in different schools of psychotherapy. But what is essential, are the human qualities of the staff, and the intentionality that they bring to that week. That's what is the core of it.

So, as Shanti said when she was going through several of the cancer help programs at Commonweal prior to beginning the Smith Farm Cancer Help Program, she said, I finally get it. She said I thought originally, that this was about slots that we had to fill with people. And, you know, when we filled the slots, we'd have a cancer help program.

She said, I finally get it. It is not slots to be filled with people, it's all about the people.

And so, the quality of the co-leader, the quality of the massage practitioners, the quality of the art therapist; it is the quality of being and intentionality that people bring to this, that absolutely determines the quality of the cancer help program that can be created.

So, what I can tell you in that context, is that if you take a group of nine people and you do this process of having people get up in the morning and do yoga, meditation, and imagery and then breakfast, and then a support group, and then after lunch, massage or individual counseling sessions, or art and healing, and so on, and then dinner. And then the evening sessions I've described.

But in one week, for most people, there will be a transformation of the way they hold their disease that will last for the rest of their lives. And at any point in the rest of their lives when you talk to them, they will regard that one week as a turning point.

Now lots of people will say, well, you do eight or nine people, and you charge \$1500 for the week, which, by the way, is about half of our cost. So you know. And the rest is made up from contributions of prior people who have come through.

But, why don't you do it with 20 people, or 30 people, or 50 people? And my answer to that is, if you were going in for neurosurgery, would you want it done on a mass basis? And the answer is obviously not.

And then my question is, if you are working with the human soul, and the human spirit, is that intervention in fact any less delicate than neurosurgery? And I'm not convinced that it is.

You know, my whole experience tells me that the reason we limit it to eight or nine -- why? Because nine people is the maximum size for optimal, small-group interaction. I mean, we have a waiting list of 100 people all the time for this.

So, we'd love to take more people. But we haven't figured out -- though others may have done a better job than we on this, and I know there are some programs that work with larger numbers. But we haven't figured out a way for us personally to get to know every person at the level that you can, when you take eight or nine people.

Just imagine that you were having people over for your house for a weekend, or something like that. How many people could you really get to know and relate to carefully if they were coming to your house?

Well, that's essentially what happens. And it's a deeply personal thing. It's not something that we crank out in any way, shape, or form. I do eight of these a year personally, because that's the maximum number I can do on a sustained basis and stay a human being, and relate to the pain and what's going on in that room for people.

MR. LERNER: So, that's the kind of picture of this. And I want to talk a little bit about something that I'll cover in more depth in the plenary.

But in the two evenings that I give my two talks, we cover five areas. And those five areas are choices in healing, choices in conventional therapies, choices in complementary therapies, choices in pain control, and choices in death and dying.

My point of view is that whether it's cancer or anything else, that those five areas are like five great books of wisdom that any human being facing the second half of life, it's a very good idea to acquaint yourself with those five great books. Healing, conventional therapies, complementary therapies, work with pain, and work with death and dying.

And so we sort of open those five books for people. And it is a profoundly empowering thing.

I think the second-to-last set of things I'd like to say, well, actually, I'm going to talk more about the individual findings during the plenary. But I want to say one of them right now, because I think it's so important at a meeting like this.

I've studied complementary therapies for 15 years. And I have not yet seen a clear-cut cure for any form of cancer among the complementary therapies. In the sense, I want to be very clear about this -- of any treatment that if Jeanne came and said, I have a melanoma of the eye or if somebody else said, I have a breast cancer or prostate cancer, or whatever it is, that I would know to be able to say, go to this complementary therapy, it's curative on a regular basis for that form of cancer.

That does not mean that many individuals have not achieved individual cures working with complementary therapies. But in mainstream cancer therapy there are some fairly clear-cut cures for cancer in mainstream cancer medicine.

We find people coming on the Cancer Help Program, who, because of their belief in complementary therapies, have neglected to do surgery for their breast cancer, or something else where it was clearly at a curative point. And they're now facing recurrences and so on.

I think it's a great tragedy. So that just as, in the 15 years that I've been doing this work when it was dangerous to say what I'm saying to you today, which is that complementary therapies are profoundly beneficial. We also have to cut the other way, because with the tidal wave of interesting complementary therapies that's come in, there's a lot of junk that's come in with the good stuff.

If we're going to be intellectually honest and ethical, we have to be as concerned with weeding out the junk, so that people are not hurt by being misled that they can avoid conventional therapies, as we are with promoting the goal, wonderful things that Jeanne was referring to, and I'm sure Marty will talk about, that are available there.

So my deep experience is that with great intentionality, that a week-long program for cancer patients can absolutely transform the human experience of living with cancer.

I happen to believe, based on inferential evidence, that it may extend life, it may prevent, it may slow recurrence, or perhaps, in some instances, prevent recurrence, and that it contributes to survival.

But our program, I want to emphasize, makes none of those claims. Our program is an educational program for people under the care of a qualified oncologist. And we make no claims about anything, really, other than that this is an educational experience that some people find useful.

So that's a kind of brief introduction to the Commonwealth and Smith Farm Cancer Help Programs. Shanti Norris is here, if any of you want to learn about our work in Washington. And it's a great honor to be here with you all.

Thank you very much.

DR. SAGAR: Thank you. Next is Dr. Rossman.

DR. ROSSMAN: Thank you. Good morning. That's a good place to start.

Well, it's also a great honor for me to be here. I'm pleased to be here with all of you and with my esteemed colleagues and friends. And it's kind of great to be able to talk here, because I feel like almost any of us could say things that the other ones would say, so we can kind of take rotating positions, different positions.

Jeanne said that I'd probably say something about imagery, so I'll say something about imagery, but not a lot about imagery. The only thing I really want to say here about imagery is that imagery is not really important at all, except that it happens to be the Rosetta Stone of mind-body spirit interaction.

Other than that, it's not important. So I want to bring up a few questions, a few observations about the mind-body, or mind-body-spirit field. Some just for your consideration, some in the hopes that some of you will be able to have solutions that I don't have, will begin thinking about solutions, have abilities and contacts to do research, to do lobbying, to do education, because it's a movement that needs many, many champions.

It's a movement, as Jeanne said, that clearly has the soundest, deepest, longest, most convincing body of evidence to prove its efficacy in a tremendously wide range of medical situations, including with working with people with cancer. And yet, it's not part of our educational system at any level that it needs to be.

We think that it needs to be part of the educational system, beginning in kindergarten or preschool, that people shouldn't have to wait until they're middle-aged and fighting for their lives and fighting cancer to learn how to relax, learn how to go to a quiet, safe place inside, learn a way to connect with their inner wisdom to get quiet and get to a place that's wise and a place that's compassionate as best they can, and draw on that kind of information.

To learn that they're able to do things physiologically in their body, like shift blood flow to different areas, and stimulate their immune systems, and have effects on pain, and reduce anxiety, and so on and so forth, which is where we're teaching people to do it now, under extreme situations.

Now, paradoxically, and I'll talk about this at the end, for some reason, it seems like very often, it's only in extreme situations that we seem to be willing to learn these things. Or that many people seem to be willing to learn these things.

And I found myself using an interesting phrase a lot lately in our training, which is as I'm presenting various cases and various histories of people who have cancer or other life-threatening diseases, who have been chronic pain patients that have been through many neurosurgeries and drug addictions and mutilations of all kinds, even by well-meaning people, the phrase that this person was desperate enough to even try guided imagery comes to mind.

I think it probably deserves the place a little bit earlier, in the therapeutic spectrum.

I missed the first part of your talk, Jeanne. So you may have mentioned this. But something I always find interesting is how ubiquitous mind-body effects are.

Mind-body effects are the ground of, in a sense, of much of our health. And they're so ubiquitous that, for instance, you know, the whole scientific superstructure that we claim to be the gold standard of medical research, the randomized double-blind controlled trials, only exist for one reason.

The reason is, is that the power of the mind to influence health outcomes is so powerful, we have to go to these Rube Goldberg designs, to try and separate them out from any inherent effect of any given treatment.

It's the only reason it exists. If the so-called placebo effect, which is widely misunderstood. People use it to mean nothing happened. That's not what placebo means.

People use it to say, You just imagined it happening. That's not what placebo means. Placebo means something really happens. You got pain relief, relief of depression, your heart started operating better, your tumors reduced in size, because you believe that something happened that was healing. It has real, measurable physiologic and medical effects.

You know, the Physician's Desk Reference, it's about 4 inches thick now, it has about 10 to 12,000 drugs in it. There's only 10 to 15 percent of those drugs that have ever been proven to be more efficacious than placebos. And yet, they're widely accepted in medical care.

The power of the mind is so powerful, we've had to construct this whole scientific superstructure to try and get it out of the way. And that's a researcher's job. But it's not a clinician's job, and it's not a patient's job.

If you're a clinician or you're a patient with cancer, you want to maximize that effect. You want to learn, How do I -- if somebody can trick me into healing, how do I find the switch myself? How do I turn it on? What are the beliefs? What are the images? What's in the way? What do I need to do in order to be able to flip that switch myself, and get that physiologic or psychophysiologic cascade of healing to begin occurring?

It's paradoxical, the mind-body effects, because it's so ubiquitous that it becomes invisible. Everybody accepts that mind-body effects are tremendously important. You can talk to virtually any conventional physician. And they concede that mind-body effects are tremendously important.

Every acupuncturist, every chiropractor, every nutritionist. Everybody concedes they're tremendously important. And then what happens? You forget about them. You forget about them. They seep into the woodwork.

We talk about CAM. They're by far the most widely utilized CAM approaches. You look at David Eisenberg's second study; 16 percent of people utilize relaxation techniques, 4 percent use guided imagery, another 4 percent use meditation, about one percent use biofeedback and hypnosis.

If you add them up, they come up to about 24 or 25 percent. The next most widely used CAM approach is herbal medicine at about 12 percent, and then chiropractic at 11 percent.

Now, some of those people are overlapping. So let's say it's only 16 percent. It's still by far the most widely utilized CAM approach. There's been a 50 to 65 percent increase in people going to practitioners for guidance with mind-body approaches, which is good.

There's been a huge increase in insurance reimbursement for it, from 16 percent in his first study in 1990, to over 50 percent. I'm not sure where he got those figures, but that's what he reported. That's what the Journal of the American Medical Association reported.

So it's, on the one hand, the most widely accepted. On the other hand, you look at what happens in CAM programs, and everybody says, Oh, mind-body, mind-body, mind-body. Mind-body-spirit, holistic, blah-dee-blah-dee-blah.

And then you look at the program: Acupuncture, massage, chiropractic, herbal medicine, nutrients.

One of the big barriers to mind-body interventions. It's invisible. Okay. It's invisible. It's not a "thing" that you can put your hand on. It's not tangible. It's not visible. So that's one of the barriers that we need to work on making much more visible.

Before I go into barriers, let me mention this. I thought I would sit down and just write out, Well, it's a cancer conference. Let's think about are there specific ways. When people think about imagery in cancer, they think about, can I heal my cancer? Can I cure it? A very legitimate question. It would be number one on my list.

People think about that. And then they think about stimulating the immune system, which there's a tremendous amount of data to show that imagery stimulates natural killer-cell activity better than any drug that we've got.

If there was a drug that did it as well, every cancer patient in America would be on it. Every one. Except for people with immune system cancers. Every other cancer patient in America would be on that drug routinely.

And yet, we have 18 studies that show that you increase not only your natural killer-cell levels, but the aggressiveness of your natural killer-cells when they do encounter cancer cells, and it's not standard of practice yet. So we need to keep working on that.

So I thought I would sit down and write out and just see how many different ways can I think of that imagery can be useful to a person with cancer? And I just did it in a few minutes. I came up with 17, but I'm sure there's a lot more.

So, at the risk of, well, forget about the risk. I just want to run down the list, and see if there's any -- just -- because you may not be thinking of this, if you have cancer, or if somebody has cancer.

Anxiety reduction. Relaxation. Think that's important to somebody with cancer? Depression. Relief of depression by combatting hopelessness and helplessness.

Helping cancer patients make difficult decisions under fire with lack of preexisting information. This is one of the most difficult things people with cancer face. They see seven specialists, they get seven different opinions, plus the stack of books and tapes that go over their head from their well-meaning friends, and all the complementary and alternative material, and you're scared to death, and you didn't want to be there in the first place, and you're in shock, and you're asked to make decisions which may be life or death. People could use a little help. And imagery can be very helpful for that.

Jeanne mentioned reducing the adverse effects. These are things that actually are supported in the literature that have already been demonstrated to be true. These are not potential uses.

Reducing adverse effects of treatments; surgery, chemotherapy, radiation. Helping people tolerate medical procedures, from MRIs to endoscopies to bone marrow biopsies and the like.

Controlling, reducing or eliminating pain. Stimulating the immune system.

Several studies, again, of mind-body effects that are not proven to increase outcome, but are certainly indicative the Spiegel Study, the Fawzy Study that was in alternative medicine, who's with us here, and the early studies by the Simontons. So these are only four studies. But of the four studies, at least three of them are really well-designed studies. And they all show a positive outcomes benefit, not just quality-of-life benefit.

Plus, when you look at the quality-of-life literature, and you look at reducing adverse effects, and relieving pain, and increasing motivation, and so on and so forth, the clinical observation is that cancer patients using their minds well, tolerate treatments much better, and are able to complete their treatment regimens, which any oncologist feels helps them to benefit more from the treatments.

Making behavior and life-style changes, including smoking. Changing your diet. That's a big thing. The way that you eat. Whether or not you incorporate exercise. How you relate to your family. All of the psychological aspects of it. Motivation to adhere to complex and difficult treatment regimens.

Breathing. At a certain time, possibly acceptance of what's going on, and all of the end-of-life and death and dying kind of issues that come out.

So these are things that are supported by a tremendous literature, all of which can be tremendously helpful to a cancer patient and his family.

DR. ROSSMAN: Other barriers that I want to mention, just in case there's somebody here who can do something about this.

I mentioned that it's invisible. That's a problem. We need to make it more tangible. We won't make it visible, but we can make it tangible by beginning to teach kids simple techniques. Relaxation, stress management, emotional management in kindergarten.

It may or may not prevent cancer, but it will probably prevent a lot of unnecessary violence, alcoholism, drug addiction, and smoking, if we teach kids early on. And also, incorporating it into medical school curricula.

There's reimbursement and coding issues. And I just want to mention it. It's very hard to code mind-body interventions. You're forced to code them either as a medical or a psychological intervention. And the truth is, they're both and they're neither. And we need different kinds of coding situations.

Last thing I want to mention. Two other barriers that are personal and cultural barriers, not medical, legal, or economic.

One is that mind-body healing takes work. You have to pay attention. You have to dedicate time and energy, and there's a certain amount of work. And even though America's a hard-working culture, it's not hard-working inside. We don't value the inner life, we don't value our thoughts and our feelings and our creativity, and our ability to love nearly as much as we value our abilities to change the outside world.

Ultimately, that's what I want to say. I think, standing on my little soapbox, that ultimately, the problem of health care in America is the disorder of responsibility. It's a misplacement and multiply manifested disorder of responsibility.

That we need to find ways to help people become not only active agents in their own health care, but active agents in their communities and their families, to understand that health care is a personal issue, something you can work on to some degree from the inside out.

But also, as part of a family, part of a community, part of a society. And part of some larger organization that we call by many names. I think if we can write that responsibility so that what happens to me, is not somebody else's, it's not solely somebody else's fault, and somebody else's business to pay for, we're going to have a lot better outcomes in not only cancer but every treatment and prevention of every illness.

Thank you very much.

DR. SAGAR: Thank you. Dr. Julia Rowland has been volunteered to do the difficult task of providing the commentary on this session. During her 15 minutes, if you are formulating questions, can you please try make them succinct? Because there's no additional microphone, I will repeat the question, and then the panel can volunteer to answer the questions as appropriate.

But please think of your questions in a very succinct manner. So, Dr. Julia Rowland, please.

DR. ROWLAND: Thank you. Well, this is, as our moderator has said, rather a daunting task for me in this esteemed group of colleagues whose work I have been following for years, admiring, tracking over time.

It is almost an impossible task to agree to be the commentator on this, and I'm struggling for imagery here, Marty, of me standing up here calmly, making some wise and reasoned comments about this.

I think that even though I'm a native New Yorker, and I can speak very quickly, and I can fill my time up very quickly with all of this, I don't have the chutzpa, really, to critique what you've heard this morning.

So I thought I would take a slightly different tactic. And that is to step back and reflect a little bit, historically, on where all of this is fitting, over time, as we race into the new millennium, what's been happening from the sea of being in the cancer arena, or the psycho-oncology arena, which also is a field that people didn't know about as little as 20 years ago.

And I want to say that because again, we keep forgetting why this shift has really occurred, and to think about what has stimulated the interest, the growing interest in complementary and alternative medicine in the way that we practice health care and cancer in particular.

And I think, when we look back at the beginning of the century, when we had so many scientific breakthroughs. Antibiotics, and anesthesia, and vaccines, and emergency medical care. And a lot of the diseases that were rapidly fatal were turned around and either cured, or controlled in some fashion.

That was no different in the cancer arena. And pediatric cancer is probably a wonderful model. I'm going to come back to that, because as I was sitting here, I was struck by a very important paradigm that I want to throw out to you, because I think it's provocative.

Pediatric cancers, as you know, many of them, in the last 20 to 30 years, have gone from uniformly fatal diseases, acute lymphocytic leukemia in children, brain tumors, Wilms' tumors, non-Hodgkins lymphomas in children, to being largely curable. Eighty percent cures, 90 percent cures for Wilms' tumors. A dramatic, dramatic shift in outcomes for our childhood patients.

Very different than the adult arena, where we are struggling against what feels like ceilings in our ability control, or cure, or eradicate the diseases in our adult population.

It made me think, well, what's going on here? And as a developmental psychologist, and for those of you who are not familiar, those of us who train in developmental psychology, are interested in growth and development across the lifespan.

But it used to be a field that was called child development, because we assumed that after you reached the age of 19, that was it, we are finished, there wasn't any growth. We now, fortunately, know that there's growth in life after the age of 19, so we now call it womb-to-tomb psychology, because we know that there are things going on even before you arrive, long before you arrive probably or even thought about. So, that's very important.

I started in the pediatric oncology arena. And when I eventually moved up to adults, and I went up to adult medicine or adult oncology when I had my first child, the transference was too big, I couldn't stand to hear the kids cry. I left the field, had two kids, came back later, when I realized that kids weren't as vulnerable and as fragile as I thought they were.

But what was striking to me, is that the pediatric arena, we do holistic medicine. We treat the child, we treat the family, we treat the staff, we have music therapy, we have art therapy. Because we assume -- actually, we do images a lot with children, because we figure there's no other way to communicate with them. We'll show them pictures. They can get this. Until you hear these little 5-year-olds spew the names of all the drugs they're taking you realize they have a lot of language in here.

And in fact, the language of pediatric cancer patients is very sophisticated and very well-developed. Their social skills may not be, because in the past they were really restricted to an adult arena, so they have trouble with their peers. But their language is very well-developed.

But we use all of these modalities, because kids are in touch with them. And somewhere along the line as adults, we lose that. I don't see it in adult medicine.

So I want to challenge you to say, What are we doing wrong in adult medicine? We exclude the family. And yet, all of care now is delivered in the family context. Think about that. We are asking family providers to take care of patients in a different kind of a way.

And yet, we don't provide service. We say social support makes a difference for survival. What do we do to support that support system, which we know is going to have a critical role in how patients do? We do very little in that.

I think it's time for us to look at the pediatric model and say, gee, this is a model that we might think of bringing into the adult arena with all of those care components in here.

The idea of multimodal care in cancer is not new. Think of what's brought us again the success in childhood cancer: Multimodal therapy. It's radiation, chemotherapy, surgery. We've been doing multimodal care for a long time. It's adding that additional piece and combining it and saying, that's where we've had our successes. It isn't in single therapies, actually. It is in multimodal.

So that isn't a new paradigm as we move up into the new millennium. It's really getting back to adding the components in here.

And I really say that, and frame it, because you've heard some very, very wonderful and provocative information provided today and I want to go back to some of it.

Actually, I'm going to talk to Jeff White later about nonalcoholic beer and a study for outcomes here. I think it's a great idea. I like that already.

But I want to sort of reflect also on the programmatically, how we move this. And I'm here in part not just as a professional and personal person involved in this, but also as an NCI, or National Cancer Institute representative, as the director of the Office of Cancer Survivorship.

The fact that we have such an office I think is a very exciting moment in time. I think this is a very, very exciting place to be, not just at the NCI, but in that arena.

I think that if we don't show what's going on now, in complementary and alternative medicine, we have this decade to do it. So, the challenge is out, as Jim Gordon said, for people to come forward to think about getting funding.

The NCI, in a very unique fashion, has taken a new role for itself, having been driven largely by research, is now considering, under the direction of Dr. Klausner, of looking at quality of care and outcomes. That's a very new tactic for that institute to be engaged in and I think it has very exciting portent for all of us.

Having said that, I wanted to make a couple of comments about additional things that were said here. When Michael talks about the Cancer Help Program, I was very privileged to have been able to spend part of a week of one of those programs in Belinas. And for me, it was one of the more profound personal and professional experiences.

And I underline that, because when I thought back later, and what was it that was so deep and meaningful about that program? It wasn't just the intentionality of everybody there. And the integrity with which it's delivered, as you heard, has been the big challenge in bringing this to the Washington area. It was that it was those two components.

It was personal and professional. The professionals were supporting each other in the same way they were supporting the patients. And it was that truly caring full environment here, to me, that embodied some of the power of what goes on.

And I think we heard again Jim Gordon mention that in his remarks this morning, saying, time and those relationships, and those healing relationships, being able to have the time to communicate, to establish an understanding.

For someone coming out of the Office of Cancer Survivorship, as we see people living longer, oncologists having the privilege of forming those relationships over time is both a new challenge but in a very exciting way.

I think the other issue that I wanted to just touch upon is that of dissemination. We have many wonderful programs and talented, talented healers out here. And the question is, how do we get that out to a larger population? I think, again, going back to the Commonwealth experience, to take that cancer help program, and show that you can, with the same level of integrity, actually develop another program, to me is very exciting.

That's really a landmark step to have been able to do that. Because one of the issues that we confront now is, particularly in the social and behavioral medicine arena, we have been very slow to take what we have learned as interventions, like David Spiegel's work, Fawzy's work, and actually take that out into the community.

I'm pleased to be able to say that the Office of Cancer Survivorship actually is going to be helping to fund the replication study that is now continuing that David Spiegel is running to see if, in fact, he can reproduce the results that he's found.

And one of his challenges, it's a high-end problem, is that all the women are living longer. So, where he thought he would have results in 5 years, not enough women have died. Great news. Everybody is living longer, and one question is, and I always ask that because ——— in California is, gee, you know, maybe everybody's sort of a drop-in effect. They're all getting it out there. We've figured out how do it in some other and larger arena.

And I think, in closing here, I wanted to make one other comment about the nature of the work that is addressed in complementary and alternative medicine.

Again, going back to what Jim Gordon said in his presentation about these transformational moments. It used to be, my colleagues would come up to me and say, Well, gee, because all of the work that I've done as a clinician for the past 20 years, has been in the oncology arena.

So I don't do a typical clinical psychology practice. All of the people that I work with are either patients themselves, or family members or loved ones of patients, or staff members caring for them. So it's all in the oncology arena.

And my colleagues would come to me, and a lot of my colleagues won't see these patients, because they don't want to work with someone who's dying. Why do you have any patients? We're all dying. But they didn't get that part. They didn't think that was funny, either.

But I stepped back and I found myself saying, well, these poor things, you know. I found myself sort of taking the higher road, saying, well, you work with all these neurotics. They're dragging their heels in here. Somebody's forced them to come in, they don't really want to be here.

The patients who come into my office come here because they want to change. The privilege, again, we've heard expressed time and again, of having the gift to work with somebody who wants to make these changes, and taking that step back, and saying, cancer's a teachable moment.

We have this one vulnerable moment, we can step in and do something very rich and very different in here, particularly with adults, where we drop prevention.

You get to be 18, you drop out of your pediatrician's practice, and we don't pick you up again until you have your chronic illness. We're not working on prevention anywhere in any shape or form, not taking care of ourselves. Medicine has to change, not just in the oncology arena, but across the entire arena.

And those are my comments to you. As I said, I stayed away from trying to critique anything. It was just easier to do. And again, it's an honor to be here..

DR. MCKEE: A question for Dr. Rowland. I've always thought that a great —— mind resource is the many, many oncology studies which have a very small plateau, very far out to the right, of long-term survivors.

Is the Office of Cancer Survivorship in a position to initiate a study of going out and finding the 4 percent 20-plus year survivors of Stage 4 breast cancer, and ——, and try to develop a profile, or find any common element, in the long-term survivorship?

DR. ROWLAND: The question was, has NCI considered, or would NCI consider taking the studies, clinical trial studies, in which we have individuals who have survived way out into the tip of that survival curve, who were continuing to be long-term survivors beyond what we would have expected the benefits of the protocol to have manifest.

SPEAKER: The outliers.

DR. ROWLAND: The outliers. Exactly. That's a very provocative, interesting idea. I can tell you that there is, on the front end, interest now in supporting the clinical trial groups, the cooperative groups, to begin incorporating some kind of long-term follow-up measures for patients seen beyond just the year, dead or alive.

And really looking at some of the quality of life issues out here, although I don't want to take a long time. That's very controversial about how we're going to do that.

But I think the idea of looking at outliers would be very provocative, if you could get enough of a case series in here of individuals who would clearly fall into that particular pattern. Interesting idea.

MR. LERNER: I just want to make a comment on the person asking the question, Dwight McKee. Dr. Dwight McKee, is one of the real pioneers in this area. And I just want to take this opportunity, Dwight, to ask you, in your research, if you could just say, in a few phrases, what are the three most promising clinical interventions in complementary and alternative cancer treatments that you're exploring in your work right now?

DR. MCKEE: That's very kind of you, Michael. And, hi. It's been a long time. I really don't know how to answer that question, because as you know, I spent 12 years practicing holistic medicine with cancer patients, and then, the last 12 years going back into the conventional arena. And the last 5, since I finished my fellowship, I've been just trying out integrative practices.

You know, I have a number of anecdotes. But I think it's Stephen Straus' quote that the plural of anecdotes is not evidence. Although I think that could be debated.

I'm on the threshold of initiating a very ambitious project of a protocol-driven, integrative treatment and research center in Missoula, Montana, which is in -- yes, I'm sorry. I was talking to Michael. Sorry.

And we're putting together our best possibility based on our collective experience and other people's experience. I have to second, I think, that body-mind is primary, and I think that nutrition is primary.

And it's very difficult to sort out what works in complementary and alternative cancer therapies, because the body-mind is so primary, it is so powerful, that if you have patients believing, and physicians or care providers believing in what they're delivering, you can activate the healing response.

And so you see that you found in that initial study a long time ago, with Sandy and Michael, or John, about a 15 percent, you know, remarkable recoveries, with vastly different content of what they were doing. But the common element was they all believed in it, and the providers all believed in it.

So, we're putting together innovative, potent immunotherapy approaches with surgery and thermal ablation as the primary tumor burden-reducing tool, in good performance Stage 4 patients with a body-mind program including voluntary controls and imagery and such, and nutrition, and botanicals, and nutrients. And antiangiogenesis.

So, it's a very different research approach, rather than changing one incremental thing at a time, making many global interventions together. And I know, you know, there will be a lot of criticisms of that, because you don't know what works.

But we are holistic systems, and I think cancer probably as much, if not more than any other disease, demands a multimodality, comprehensive, global intervention. And I think that's been done in the pediatric arena. And that's one reason, besides the fact that kids are more resilient and they have a thymus, so they're immunologically different, and so forth.

But they've been doing holistic medicine. And they don't spend 10 minutes with a pediatric cancer patient. They spend as long as it takes, because of that nature.

So, I think we're just on the threshold of seeing what we can do with an integrative approach. And we still won't know what worked.

SPEAKER: Who cares?

MR. LERNER: Thank you. And I just want to encourage you all to keep your eyes on the work of Dr. Dwight McKee. It's going to be very interesting.

DR. ACHGERBERG: I think I'm reiterating something that Dwight said. But having watched the field of alternative cancer medicine for a long, long time, first in an official capacity with the National Cancer Institute, and then in a more or less official capacity with the Office of Technology Assessment and with OAM, I want to tell you what I've seen.

The honest-to-God truth, is that all of the alternative methods work for about 10 percent of people, and probably not much more. Michael, you said 15. We can -- it's low. It's low.

But they are the 10 percent of people that simply would have died, had they not gone in for the alternative that they chose.

Now, if this is true, if this observation is true, and I believe that it is, then we're studying the wrong variables. We're studying the treatment, when in fact these alternative treatments only work for 10 percent, and it may be true of all treatments.

What should we be studying? The patients. The patients, and the patient/health-care giver interactions. And I've been a broken record on that for a long, long time. But we're going to continue facing this wall in cancer treatment and cancer cure until we get that, that everything works for somebody, and nothing works for everybody. Period.

SPEAKER: ——— in a moment of crisis, when these techniques that require ———.

DR. ACHGERBERG: I don't know what else to say about it. I'm frustrated. And the history of medicine is that these techniques are only used in crisis.

You go back 40,000 years ago to medical artifacts and you see crisis medicine. As long as we've had written history in medicine, this is crisis medicine.

Now, I don't think that we're doomed to that for here on out. But the fact that they are expensive in time and commitment. And by God, you start doing this stuff, you might have to leave a job, you might have to divorce your spouse. You might lose friends, you might make a lot of new friends. Your whole life changes, and that's expensive. And people don't do that except in crisis.

So, I don't have an easy answer for that. It's what is true. Yes.

SPEAKER: Actually, Jeanne, I think that, you know, while crisis medicine has always existed, I think that the history of medicine also includes a lot more in the way of medicine in the way that the Native Americans use the term "Medicine" with a big M, and that it has to do with your whole life, and it has to do with the life of the community and the tribes.

And the rituals, since all premodern medicines were very highly integrated into the spiritual belief systems of the cultures. That there wasn't this separation.

That the rest of your life -- we suffer from a cultural dissociation. Our health has nothing to do with us. It has nothing to do with us. It's all random. It's completely random. It happens by chance. There's not much you can do about it. And you're dependent on a system of experts who may or may not be able to do something for you.

And again, we've gone even once more removed, in that paying for it, first of all, consists of what gets paid for, the so-called health-care system, which is not a health-care system. As Ken Palleter (?) likes to say, it has nothing to do with health, it doesn't care, and it's certainly not a system.

And he calls it a "disease management industry," which is much more appropriate. But we all participate in one way or another. So that I think, you look at traditional Chinese medicine, which for thousands of years, has a tradition of preventive treatment. And the idea that treating small imbalances, and that coming at the turn of the seasons, and seeing the practitioner, and looking at your life-styles, and so on, that these kinds of things can be treated much more easily than when disease manifests.

And talking about treating disease by the time it's already -- there's a saying in Chinese medicine, "treating disease by the time it's manifest is like starting to dig a well when you're dying of thirst," so that it's a little late.

I think it's a bit less grim than that. But they are very much proponents of preventive medicine, of wellness as a value. Doctors would get paid when people were healthy. And if the people in their village were not healthy, the doctor would take them into their house and treat them. I'd hate to do that in America. I could see doing it in a small village in China, where I know everybody and everybody knows what everybody's doing. But I'd hate to do it in urban America. I'd have to get an awfully big house.

Anyhow, there are also traditions where health and wellness are part of the whole way of living. An integration with nature, an integration with spirit, an integration with community and family. As you well know and have written about, are celebrated and approached in ritual.

That one of the first things that happens when people get sick, is prayer and ritual, and family and community, and so on and so forth. And I think we need a lot more of that. So.

DR. ACHGERBERG: Thank you for reminding us about that. Medicine is that which helps or heals. And we forget that it's a whole global picture, not just something one does in crisis.

SPEAKER: Julia, I'd like to get your thoughts about that sort of part in child development where they sort of become disembodied, where their mind and their body are not connected any more. Because I think that that may have a great deal of the difficulty that we're facing is we don't respect it, we don't care for it perhaps in the way that we could. And that something happens in their development some place, in which they lose it.

DR. ACHGERBERG: Any other developmental psychologists out there, before I --

I don't think there is a changing point that occurs in here. I think there are a lot of social pressures, cultural mores, that discourage. Good examples ——— the creativity, your draw-

inside-the-lines kind of philosophy in here that teaches youngsters not to be in touch with some of these inner resources, if you like.

The same thing in our language use. We learn to use language, not to use images.

So, I think that it is the case that children come in with all of these skills and talents in here, and just the way we live our lives, we somehow learn that out.

The good news, again, going back to all of the literature that's coming out, and that's why I find it very exciting to be in this field, is to see the new science; is that we can grow and change beyond childhood. And we can rediscover these things that we had inherently.

For the most part, we can get in touch with those things again if we take the time to learn the skills and reacquire those skills. That imagery works so well in pediatrics, doesn't mean it won't work on somebody in adult medicine to do their chemotherapy, et cetera.

In fact, those studies show that we can do the same kind of behavioral interventions with adults. We might have to use a slightly different strategy, but they're very effective.

The reason I said that we just don't know the capacity, and I think you hear it, time and again, our inner ability to hear when we see things in the press. I don't know how many of you read the article about the London cabbies growing new neural dendrites?

I thought that was very exciting. That didn't mean I was going to go out and become a London cabbie. I think they shoot them when they come drive in the District, or they, you know, probably just, you go for your license, and they take out a few neurons.

But to me, that's very exciting, because that tells us we make these assumptions that we cannot do these things, we do not have the capacity. Or the most recent, hot-off-the-press information about rehabilitation of stroke patients, where if you essentially immobilize the healthy side, that you can get the body to teach the afflicted side.

I think that's very exciting, again, that we have, perhaps, these innate capacities, and that some of that is rediscovering it.

So, that's a very long-winded answer. I don't think there's any one developmental period. Certainly the acquisition of language skills allows us to, or forces us sometimes to leave behind some of these other talents that we have. It doesn't mean they're gone forever, though.

MR. ROSSMAN: I just want to say one other thing. And if I can organize it. And it goes back to what we were talking about in terms of placebo, and in terms of expectations, and in terms of practitioner- patient communication.

You know, there's three things that have been studied in terms of placebo effect, or inducing placebo effect. There are three conditions that are known to underlie an effective placebo effect. If all three conditions are met, there's a much greater tendency for people to have a positive outcome.

And the three conditions are this. That the patient believes in the treatment, or believes that it could be helpful. The practitioner believes in the treatment, believes it could be helpful. And the patient believes in the practitioner. Okay?

If all three of those conditions are met, there's a higher chance for placebo to do its work, for people to heal.

There's a fourth quality that nobody's yet studied, and I'll put this one out there for anybody who may be in that position. What about if the practitioner believes in the patient?

What's the effect of whether the practitioner believes that the patient has innate healing abilities that can help to survive or overcome a treatment, and communicates those in a way, because what's communicated now, far too often, is exactly the opposite.

In the culture, talk about the power of imagery. The cultural images and expectations that are associated with cancer and with the treatments of cancer, and the way things are communicated to people, are, as Jeanne said, very dramatically in unfortunately experience, are atrocious. They're by and large atrocious. The power of communication -- there's no training that I know of for oncologists, for people who deliver news to cancer patients, or people that have cancer or life-threatening illnesses, that can change their lives forever.

There's virtually no training in how to deliver that message, so that you deliver accurate information on the one hand, which includes the possibility that the person can, a, do something about it, potentially, and b, potentially recover. Without lying to the person, and without engendering false expectations or hopes. And it's one of the most powerful effects in cancer.

I will tell you, that when I work with people with cancer, and work with imagery, and we work on imagery and visualization, and they connect with their inner advisers, and they do all kinds of wonderful things in their imagery. The hardest piece of work in general that I have to do with people, is treating their iatrogenic, post-traumatic stress disorder.

That's not a joke. It's a DSM IV diagnosable, post-traumatic stress disorder. And what the patient says is, I will never forget the look in my doctor's eyes when he told me I had cancer. Okay?

So, it's not just what you say, it's the expression on your face, it's your body posture, it's what you expect, it's how you approach the whole thing. And that message sticks in their mind, and they have repetitive, intrusive thinking, they have sleep disturbances, they have higher anxiety levels.

And with all the imagery they do, those same images will pop up over and over, unless you specifically treat for those things with some of the things like EMDR, along with interactive imagery, things like that.

So, there's a very powerful cultural effect going on that we need to address. And we need to learn how to communicate potentials better.

MR. LERNER: Yes. I just want to comment on Marty's points, which I think are excellent. And I just want to introduce some notes of caution for us. One is I totally agree with Marty about all of those things. But what happens when you have all four of those conditions, and then the person with cancer doesn't recover or gets worse?

And, you know, how have you prepared the person for the very real possibility, and often probability, that all of that work isn't going to reverse the cancer? That's one point I want to make.

Secondly, how are we going to feel if some of Dr. Spiegel's efforts to replicate his study don't turn out? And if some of the studies begin to show that psychosocial support doesn't necessarily extend life? How are we going to feel?

Will we greet those with the same intentionality and talk about them as much as we talk about Spiegel and Fawzy Fawzy?

And the third point I want to make, Julia Rowland has brought to my attention several studies which indicate that patients using complementary therapies have lower quality of life during the disease, than people who are not using them. I think I have that right, don't I? Yes, I do.

Now, to me, I welcome those studies. And I think we have to welcome those studies. We have to have the same integrity about the studies that don't support our beliefs, as we do the studies that do support our beliefs.

And finally, I just want to introduce the point, and again, you know, Marty's a close friend, and we agree on most of these areas, that when we talk about this wonderful point that, this sort of dissociation of our responsibility for our health we have to limit that.

Forgive my tremor. I have a benign tremor. We have to limit that, because the ozone layer is disappearing, and immune disorders are increasing, and cancers are increasing, and breast milk is now the most toxic human food. And there are huge numbers of chemicals in the environment, which are carcinogenic. And we cannot say that those can be changed by life-style.

So, I think that, you know, I'll be speaking more to that. But we really have to sort of frame these very important points that we're making, both in terms of being open to alternative findings, and in terms of the environmental health issues that we cannot address through life-style.

SPEAKER: Michael, I'm glad you brought that up, and you know that I 100 percent agree with you. And so, we run the risk of overstating. When people hear "responsibility," they sometimes hear, you mean I gave myself this cancer.

That's not what I mean by responsibility. I mean by staying present to whatever happens in your life. And that's the same thing that, in terms of delivering news and diagnosis, I've never heard it better stated than by our friend, Carl Simonton who is, in this country, one of the fathers of this movement, and who Jeanne worked with a lot.

When he says, why not tell somebody with a difficult diagnosis, you have a serious illness, you have a very serious illness, and there may be something you can do about it.

And at the same time, helping people develop skills, mind-body skills, if their intention is to recover, at the same time, also helping them cultivate the understanding that we are here in a temporary form. We don't know if this is your time, but the cultivation of that awareness is that you, like going into a competition, in some ways, having cancer, if you really utilize your mind-body skills a lot, is very much like a high-level performance. You can learn a lot from

performance psychology and sports psychology. Long-term effort that demands a lot of focus, a lot of concentration, a lot of attention.

And you go in with the attention to do your best. If that's your intention, and to win that game. And also, whatever the outcome, you cultivate the abilities to live with that. Or to die with that. That's something that we all do.

So, one, you're right, that when we get excited about talking about responsibility and what you can do, we don't mean to say that you're to blame necessarily for what happens.

The last thing I'll say is caring for our Mother Earth and the environment is the natural extension of genuinely caring for ourselves and our families and our communities and our health care. So to me, it's part of that responsibility issue that you so beautifully represent.

And I think all of you know this. But nobody has represented that more ardently and beautifully than Michael Lerner. So.

SPEAKER: Just one final comment on that particular issue, Marty and Michael. I have the dubious distinction of having been on the American Cancer Society blacklist since 1975.

And the reason was my affiliation with Carl Simonton, whose name has been brought up several times this morning.

But the main reason given for the blacklisting was that when people begin to participate in mind-body activities, they start to feel guilty about having caused their disease, or guilty because they weren't able to affect the outcome in the way that they desired.

And while I think that whenever you begin to encounter issues in your life with full consciousness, often there is a sense of what taboo did I break? How did I get off my path?

I really think that all of us who are in the mind-body field and who are health-care professionals, must take this to heart, that however we couch our language, however we deal with our patients, the issues of guilt and blame are still with us. They come out of the self-help books, they come out of the New Age movement. And they are very, very real, and very, very much -- although I think it was a false reason for listing us. I think though that we need to continue to pay attention to them.

Even mainstream America now reads self-help books, and have the tendency to feel blame and guilt when they're not able to do what it is they expect to do with their health. It's important to think about.

SPEAKER: I think there are two reasons, or two factors that contribute to the difficulty of getting mind-body medicine more integrated. And they have to do with the grammar and the cost.

The grammar of speaking of the dichotomy automatically makes it a technology rather than a perspective of this is a human being, and it is that which the human being needs that has to determine what's given.

And then the price of this, that most of us are not willing to pay, and we speak about paying attention? That is the real cost of doing this work, is paying attention to us as clinicians, to our particular mind-state, and our perspective of the patient. For the patients, or the human beings,

with whatever disease, for their paying attention to their own pain and fear, and looking at what they're actually asking for treatment.

So, if you're willing to pay the price, and you're willing to change your grammar, there is really no barrier to it.

SPEAKER: Any comment? You had a question.

DR. ACHGERBERG: Actually, sort of a dialogue. I want to talk to Marty, but I'll point this way. When you talked about the doctors delivering the bad news in a very poor manner, as a cancer patient, I'd like to say that I was one of the recipients of that.

And I found that beyond the inhuman way he did it, he dropped me, and he left me off into a void where I knew not -- he said, Now I'm out of my specialty, you're on your own.

And I truly did not know what to do. And so I think among you physicians, if you could understand that you need to be networking, so that when one of you feels the limitations of your own services, you need to be able to tell the patients, Here's the next step.

Keep the person on track so they don't feel left hanging. And also, I'd like to say -- this is interesting. I'm Susan Lord's sister. So, who could be luckier to get cancer?

Well, the irony of it was that I was in Sloan-Kettering, getting the best of traditional care, and I was hearing the best of alternative care from a very concerned sister on the phone long-distance.

And those two worlds were so antagonistic, that it tore me in half. And I knew, I had to choose one or the other. And either one was not sufficient.

So, I would really like everyone to pull together in this community.

SPEAKER: Well, we've run out of time. Time to wrap up. Please, before you go, could you fill in your assessments for this session? Did you want to make a comment? Oh, sorry.

Assessments for this session. Please fill them in. And thank you all for coming, and please take back these important messages to your communities and institutions.

(Whereupon the proceedings were adjourned.)

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