

There is nothing too great of accomplishment for
the man who knows the power of his word, and who
follows his intuitive leads. By the word, he starts in
action unseen forces and can rebuild his body or
remould his affairs.

Florence Scovel Shinn

1871 – 1940

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Abstract

This thesis is predicated by the view that the basic paradigm underpinning Western medicine, ie that of Cartesian mind-body dualism, is fundamentally flawed.

It is described both how medicine came to think in this erroneous way and how the author's thinking evolved, starting with observations made as a student nurse and then developing over many years of practice in different specialisms, before becoming concretised as a hypothesis which predicted that addressing emotional issues would have a beneficial impact on physical disease. This hypothesis was then explored in a pilot study as part of an MA in counselling studies at the University of Keele.

The literature relevant to this area of study is reviewed, together with literature from diverse areas of human endeavour in an attempt to show the connections that link these diverse areas of human experience, from both pre-Cartesian and post-Cartesian times with the insight that is now developing into interconnectedness and which this study is designed to investigate. The full study, which was developed from the above pilot study, is described, and the results are calculated.

The results show an intervention related improvement in health status for the experimental group of over 800% at 3 months when compared to the control group, falling to 600% at the 12 months follow up. These results show considerable statistical significance, with a probability in the order of $p < 0.001$.

The results are then evaluated and the implications of the results are discussed before recommendations are made.

Acknowledgements

Sincere acknowledgements and thanks are owed to the following for their contributions to this research.

Dr RV Lewis, Consultant in Cardiology, Pontefract General Infirmary for his advice, belief and unwavering support.

Dr DI Williams, Lecturer in Counselling Studies, Hull University, for suggestions, critique and patience above and beyond the call of duty.

Judi Irving, Lecturer in Counselling Studies, Hull University, for taking over the support after Dr Williams retired.

Dr Peter Nixon, Consultant in Cardiology, Charing Cross Hospital, for his advice and support.

Dr P Wilson, University of Hull, for advice on the statistical analysis of the results.

Ms J Young, for her commitment to the study before ill-health forced her to retire.

Alvin Marper of Homework studios for the recording of the guided imagery tape and the composition of the accompanying music.

My wife and family for their support and forbearance during my many long hours at the computer.

Finally, and most importantly, the patients/clients who agreed to participate, and without whom, this study could not have happened.

Preface

In the beginning was an observation.

In 1973, I started training in mental subnormality (as it was then called) nursing in one of the old style Mental Subnormality Hospitals, where patients were kept isolated, as far as possible, from the outside world and where they were protected from the pressures of life that impinge on those of us not so incarcerated. This hospital, in keeping with most of the Victorian ‘bins’ that have only recently started to be dismantled, was located in a self contained country estate which had previously been the home of the local gentry and which had acres of beautiful grounds in which the patients could walk and commune with nature.

I noticed that those patients who had simple low intelligence, ie not complicated by any of the genetic abnormalities that created mental, intellectual and physical problems, were mostly incredibly healthy, even into very advanced age. Indeed, I can think of a number of people there in the 70 to 80+ age range who had no physical illnesses recorded in their medical records and who showed no sign of the illnesses which we have come to accept as a normal part of growing older – arthritis, failing eyesight and hearing, heart disease, pulmonary disease, bowel disorders, cancers and hormonal disorders.

As a firm disbeliever in the notion of co-incidence, I asked the question “why should this be so, that these people, who have no quality of life (as I might then have defined it), who have never accomplished anything, who are not free to go wherever they want, when they want, who have never known any other home than this not-quite-a-prison and who are dependent upon the staff for everything are so healthy and untroubled by physical ailments. I postulated, though at the time it went no further than this, that it may be due to an untroubled, stress-free lifestyle, where everything was provided, where there were no externally imposed expectations or pressures, where they were free to do whatever they wanted, within certain limits and where, because of their inherently limited intellectual ability, there was not the capacity to realise what they were missing and what the ‘outside world’ accepted as being normal.

As I have said, at the time, it went no further than a relatively idle musing, but the seed was sown, and when I moved from Mental Subnormality Nursing, to General Nursing, the seed found the conditions that it needed to start to grow.

The 'conditions' that it found were a further four observations: -

- That the majority of the people that I looked after during treatment for cancer (of any sort) were 'the nice guys'. They were the sort of people of whom it was said that they would do anything for anybody, would never say no to anyone, they were the 'salt of the earth' and how unfair it was that such a dreadful thing should happen to someone like that.

- That there seemed to be a large number of apparently healthy people admitted for a variety of illnesses, primarily cardio-vascular or gastro-intestinal, within the first two years following retirement. Many of these soon died of the illness.

- Similarly, that there seemed to be a significant number of people admitted for a variety of illnesses within the first 18 months after the death of a significant other person.

- That the majority of people admitted following a myocardial infarction (heart attack) did not fit the popular image of the driven high achiever, but did appear to be generally less than happy with life.

Over the years, this amounted to a significant body of information, albeit informal and anecdotal, that seemed to say very strongly that there was a link between mental state and physical state, a notion that was contrary to accepted wisdom at that time. Again, I did not formally do anything with this information, but it was always there in my thinking, slowly developing and maturing and awaiting the right stimulus to bring it into bloom. Probably because of this almost subliminal but omnipresent notion, it was at this time that I started to monitor my own feelings of physical and mental well-being (or otherwise) to determine if there was, or appeared to be, any correlation between the two.

What soon became clear was that there was, without doubt, a correlation. I could always relate personal episodes of sub-optimal physical health to a preceding period of emotional dis-ease, but generally, the literature did not agree with my (admittedly very limited) observations. Meyer Friedman had been developing his theory of a personality type that was causally associated with ischaemic heart disease since the late 1950's (Friedman et al, 1959), culminating in the recently published description of Type A Behaviour Pattern

(Friedman, 1974) and Hans Selye had been developing his General Adaptation Syndrome ideas since the 1930's (Selye, 1936), but the bulk of the nursing and medical professional literature continued to maintain the stance that the mind and the body were separate, and the workings of one did not impinge on the other.

This dissonance created a tension for me. The accepted view of the relevant scientific (apparently) community had no space for my observations - they simply did not fit into the existing paradigm. I use the word 'apparently' because to me, **Science** is about formulating a theory to explain the observations that one has made, and then applying that theory to an increasing number of situations to test whether it holds. If it does, all well and good, if not, then it is back to the drawing board to develop another theory that can explain the new observations. This sequence did not appear to be happening here. I could not believe that I was the only person to be making observations that appeared to be in conflict with the existing theory, but nothing seemed to be happening towards developing a more inclusive theory. On the contrary, what seemed to be happening was the development of research studies to try to invalidate similar observations. With hindsight, perhaps the people that I had thought of as scientists were, in reality, not true scientists but technicians!

Again, this tension remained with me, unacknowledged, but always present, for another few years. It was constantly informing my sense of what it meant to be human, but I did not have the opportunity or resources to attempt to formulate an investigation to test out my thoughts, working as I was in various nursing posts across the country. However, the observations continued and suggested nothing to disabuse me of the idea that was slowly developing.

The opportunity for further development of these ideas arose early in 1984 when I was asked to establish a working party to examine the provision of services for people with cancer within the District Health Authority where I had recently been employed as a Nursing Officer. This provided the impetus to read and explore more widely to discover what may be available in other areas of the country, both within and without the National Health Service (NHS), and one of the results of this exploration was the discovery of the widespread use (outside of the NHS) of different complementary therapies, either as part of the ongoing treatment of cancers or as part of the overall treatment and support of the individual so affected. Why, I asked myself, did people invest financially, emotionally and time-wise in something that the wonderful NHS did not provide and which, indeed, was condemned as useless, dangerous, raising false hope and other such derogatory statements by the authors of orthodoxy? Clearly, since the investment was being made, they got something that was not

available for free on the NHS and I started to read as widely as possible about the different approaches that were employed and to attend relevant trainings and seminars whenever I was able. What I read and heard about affirmed the attitude that I had always held of looking at the whole person rather than, as seemed to be taught, looking primarily or solely at the condition affecting the person. Further, they also seemed to concur with the observations that I had started to make 11 years earlier that there appeared to be a relationship between physical and emotional health, a notion that at the time was considered to be heretical.

The opportunity to explore further occurred in 1985 when I was awarded a Yorkshire Regional Health Authority Travel Fellowship to study the use of counselling and visualisation (or guided imagery) in the treatment of people with cancer at the Health Training and Research Center, Little Rock, Arkansas, USA. This intensive 5-day seminar was facilitated by Stephanie Simonton, a psychotherapist who had developed the approach along with her radiotherapist husband Carl Simonton (Simonton et al, 1978).

This very powerful seminar had a number of effects, not the least of which was the further affirmation of the observations that I had been making over the years, together with an explanation of the psycho-emotional mechanisms involved using insights from the psychodynamic tradition and especially the work on child development by Jean Piaget (1937). I returned to the UK inspired and enthused - and trying hard not to get carried away by 'Missionary Zeal'.

I anglicised the American visualisation scripts that I had learned and, almost certainly naively, started to offer workshops and therapy as widely as possible. Despite my naivety and lack of experience, the results that I achieved were such as to give considerable encouragement, and I therefore continued to develop the approach, mainly outside of the NHS, within the Cancer Self-Help Group that I had started in response to some of the findings from the Cancer Care Working Party of the previous year. Whilst the people actually using this approach, ie those affected by cancer, seemed to gain significant benefit, the professionals within the group were more dismissive. Indeed, I remember an oncologist saying after one of my talks on the subject "Carl, there is no way that I can imagine that *anything* that you can do with your mind will have *any* effect on the body." Strangely, he became very quiet when I asked him to picture a very beautiful girl seductively taking her clothes off in front of him, and then asked him if there was an effect on his body!

Once again, there seemed to be concurrence between the experiences of people using a psycho-emotional approach to dealing with their cancer(s) and my previous observations, but there was clearly a need for more than very limited anecdotal support for such a radical notion as the one that I was, by this time, developing – namely that physical health is to a very significant degree dependent upon psychological health. The scepticism of orthodoxy was absolutely right and proper, and what was essential was some far more rigorously scientific evidence of a causative connection between emotional health and physical health. For far too many years, the field of cancer care had been beset (and indeed still is) by ‘miracle cure claims’ based on flimsy evidence which then leads to disappointment and dismay amongst those affected and increasing antipathy on the part of orthodox practitioners towards anything which falls outside the realm of the familiar allopathic approach. Unfortunately, such was the success of this approach that the local newspaper got hold of the story and with typical journalistic excess printed a front-page story under the large banner headlines “Carl Offers New Hope for Cancer Sufferers!”

Needless to say, this resulted, especially since I was a clinical manager in the NHS, in a hugely antagonistic backlash, which effectively sealed the fate of the germ of a research idea that I had formulated to investigate my developing hypothesis. Clearly ‘cancer’ was too emotive a disease for it to be a viable subject for this type of study, especially in the first instance. However, since none of the observations, the build up of anecdotal evidence, the written work that was increasingly emerging or my belief in the fundamental rightness of this idea were in contradiction, it was equally clear that I had to find some means of investigating this hypothesis.

The combination of weathering the storm created by overly enthusiastic journalists and finding a less emotive disease as a subject for a mind/body research study took a number of years, but at least provided a breathing space to enable further reading and study to be undertaken.

The next possibility as a research subject presented itself in 1990 when I was temporarily in charge of a Unit that included a dermatology ward.

Psoriasis, a disease which is determined genetically – either one has the potential for developing it or one does not – but whose expression is moderated by emotional factors seemed to be the ideal choice. It is difficult to find a disease that is less emotive as far as the press and the general public are concerned and yet limited

experience of treating the disease indicated that it would be amenable to an intervention that focussed on addressing emotional issues.

I duly developed an outline proposal for a study and offered it to the Consultant in Dermatology who promptly dismissed it with the words “Waste of time. Level headed people get psoriasis just as much as fruitcakes do!”

In the face of such an obviously closed mind, it seemed pointless to argue the case eg by producing the work of other dermatologists, which tended to support my hypothesis, and I therefore returned once more to the metaphorical drawing board.

Fortunately, the wait this time was of much shorter duration. One of the clients with whom I was using visualisation as part of his dealing with cancer told me about a TV documentary about an American Cardiologist who used an approach which included visualisation and which had apparently recently been published in the Lancet. A quick word with a friendly librarian produced a copy of the report by Dean Ornish (Ornish et al, 1990), and even though there were a number of methodological problems with the study (see later), it was sufficiently interesting for a newly appointed Consultant in Cardiology to agree to my proposal for developing a formal study to investigate the effect of a programme using counselling and guided imagery on people with ischaemic heart disease (IHD). Since I had also just begun a MA in Counselling Studies (1991), there was a wonderful synchronicity in the timing, and this study also provided the necessary research project for the MA.

The rest is history. I developed a pilot study, using just 10 IHD patients, to test the methodology and documentation that I had developed and the results, though necessarily limited in usefulness, were of sufficient interest to warrant a more detailed study which I subsequently developed and present later in this current work.