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ANALYTICAL PSYCHOTHERAPY IN THE TREATMENT OF ONCOLOGICAL PATIENTS. A CASE STUDY

Private practice

Remembering that I'll be dead soon is the most important tool I've ever encountered to help me make the big choices in life. Because almost everything — all external expectations, all pride, all fear of embarrassment or failure — these things just fall away in the face of death, leaving only what is truly important. Remembering that you are going to die is the best way I know to avoid the trap of thinking you have something to lose. You are already naked. There is no reason not to follow your heart.

Walter Isaacson, *Steve Jobs*. Insignis Media, Kraków 2011–2013, p. 554.

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Summary

In Poland psychoanalytic psychotherapy is offered to cancer patients relatively rarely. Factors contributing to this situation involve time constraints in providing therapeutic procedures in the health care system, wider access to other forms of support and characteristics of work with people suffering from somatic disorders. Literature referring to the psychoanalytic approach towards the patients with somatic disorders and psychoanalytic therapy for oncology patients is limited in Poland and worldwide. Psychoanalytic psychotherapy may not only serve as a tool helping patients to cope with the difficulties that they face fighting the disease but also enables them to live a better and more mindful life afterwards. The aim of the article is to present selected areas of therapeutic work conducted in a sample cancer patient undergoing clinical treatment. The article shows the way in which therapy focused on the exploration of patients' unconsciousness may influence the clinical treatment process.

Introduction

Oncological diseases are currently one of the biggest health challenges in Poland and around the world. According to the World Health Organization [1], cancer is one of the most common causes of death. A cancer diagnosis is a moment that not only shakes the

patient's life, but also their family and social environment. It represents a turning point which often leads to a deep emotional and mental crisis [2]. It seems certain that the experience of illness causes most people to fear for their own lives, and the threat of death is real. The concept of death is inscribed in the inner world of every human being in the form of a psychotic catastrophe, which is why it is a difficult area to conceptualize, and the patient has a limited tolerance for this topic. In its extreme form, the fear of death can evoke the same nameless terror that grips psychotic patients in moments of loss of psychological coherence [3].

One can ask what happens to a patient if he or she never consciously confronts his existential fears or, in other words, what happens to a patient if the fragility of existence is overshadowed by repression and denial. I hypothesize that in oncological patients, who do not have a fear of death at any stage of treatment, a silent surrender to death begins, leading to the withdrawal of the life drive and often self-destruction in action.

Fear of death and defence mechanisms

Freud [4] identified five main types of fears, including the fear of annihilation, which is particularly important in the context of working with cancer patients. Winnicott claimed that the disease reactivates the primal terror of the disintegration of the self, which is close to the sensation of nothingness [3]. Anxiety in analytical terms is a reaction to danger and to disturbances caused by an increase in the drive charge (external or internal arousal), which cannot be mentally processed and transformed into libido, which puts a strain on the psychic apparatus [5]. This primal, economic dimension of anxiety is close to the concept of trauma and seems to accurately depict the situation of cancer patients in a situation where the number and intensity of their emotions becomes overwhelming for them, and at the same time difficult to understand or accept [6].

One of the basic activities of the ego is to defend itself against fear [7]. Some defence mechanisms may be adaptive, helpful and mobilizing in the process of oncological treatment, and some may be destructive [8]. Early detection of maladaptive defensive functioning can promote appropriate psychotherapeutic intervention and prevent the disease from getting worse.

There is a lot of research on the use of defence mechanisms by cancer patients. In one of them, it was shown that mature defence mechanisms are negatively correlated with depression, while in the case of more immature mechanisms [9] the opposite is true. In addition, primitive defence mechanisms correlate positively in a significant way with lower levels of quality of life in cancer patients [10]. There is also evidence that the use of mature defence mechanisms in breast cancer patients was associated with a significantly higher likelihood of survival [11].

One of the most common defence mechanisms seen in cancer patients is denial. This mechanism is often the first reaction of patients to the news of cancer. These patients seem to be doing well, dismissing or downplaying the importance of the information given to them, and in some cases even denying knowledge of the diagnosis. This may be the reason for delays in seeking treatment and poorer adherence to medical recommendations [12].

Moreover, although it has been observed that the awareness of death in people with advanced disease can coexist with a strong will to live [13], there are studies saying that denial can also have an adaptive dimension. This form of ego defence has been shown to be associated with better physical and mental health, correlated with a better quality of life, as well as lower levels of anxiety and fewer additional outpatient visits [12]. However, the authors point out that these results were obtained on the basis of patients' self-reports. Since the mechanism of denial allows the patient to overlook some aspect of reality, the individual perception of the disease can only cause an apparent improvement in the quality of life. Other researchers have observed that cancer patients who face unpleasant feelings instead of avoiding them experience better well-being [14]. Patients who suppress the traumatic experience of the diagnosis feel worse somatically, and the repressed trauma caused by the information about the disease may also be accompanied by conversion symptoms, which lead to greater impairment of physical function [15]. It has been observed that confronting death in an accepting way, as opposed to the use of avoidance-based defence mechanisms, seems to be associated with lower levels of general anxiety and existential anxiety as a whole, while denial and avoidance are associated with psychological maladjustment and the loss of meaning of life [16].

When working with oncological patients, each defence mechanism should be considered in terms of its adaptive function, taking into account the stage of treatment and the severity of the disease. Regression in terminally ill patients is clinically helpful and can be encouraged, while regression in patients in remission can be confronted and challenged. Similarly, splitting and denial in the treatment of a person close to death allow for the creation of fantasies of immortality by separating the mental self from the bodily self, which helps patients to cope with terror. Supporting the mechanisms of denial of death and separation in this particular situation is more beneficial to the patient and defends the quality of life [17].

In oncological patients, even those with a good prognosis, there are many situations that cause fear or terror. Each laboratory test carries with it the fear of a potential threat and throws the patient out of emotional balance until the absence of new lesions or tumour shrinkage is confirmed [18]. Even when treatment goes according to plan and has a good prognosis, patients face side effects of medical procedures and treatment, as well as uncertainty about the future. Overpowering anxiety can occur or worsen with active treatment (chemotherapy, radiotherapy, hormone therapy, and immunotherapy). It is not uncommon for the patient to experience pain, fatigue and sleep disturbances during this period. Body pain is a subjective psychosomatic experience that can be felt in multiple areas [19]. Moreover, how patients experience it may be related to the bodily representation of the self.

Body image and body self

When considering therapeutic work with people suffering from cancer, the aspect of the body cannot be overlooked. Alessandra Lemma [20] is guided by the belief that having a body shapes the mind. She bases her thesis on a quote from Freud: "The ego

is primarily corporeal, it is not only a surface being, but even a projection of the surface of the body" [20, p. 35]. This means that the most primitive form of self-representation is the bodily representation. The image of the body is created thanks to projection and introjection mechanisms. It has a libidinal cast function and is mediated by relationships with the object. The bodily self provides a base for building identity. At the same time, this mechanism works in the opposite direction, i.e., identity changes under the influence of bodily changes.

Body image is formed over the course of life. The way the body is treated, as well as the reactions to changes in the body that are inherent in the oncological disease, may therefore reflect the quality of the earliest identifications and relationships with objects. The body is incapable of deceiving and is a reminder of human mortality in the long run. Traces of surgeries are visible in the mirror, and the consequences in the form of deterioration of the functioning of the affected organs and treatment are felt on a daily basis. How a person copes with these changes may depend on various intrapsychic elements, including the proportion of the life drive and the death drive.

Life drive vs. death drive, fate vs. destiny drive

Melania Klein [21] recognized that the struggle between the life and death drives is a constant element of mental life, and that the fear of annihilation is behind all fears. In her reflections, she drew attention to three basic assumptions that apply to the mental life of every human being: the omnipresence of unconscious fantasy, the innate ability of an infant to establish relationships with objects, and the duality of the instincts of life and death. On this basis, she identified two elementary psychological structures that appear in early childhood and persist throughout life: the paranoid-schizoid position and the depressive position. Each of these poses reflects a certain psychological attitude and contains its own fears, defence mechanisms, and types of relationships with the subject. Unlike Freud, Klein believed in the existence of a representation of death and equated it with a representation of evil and haunting objects. She believed that the fear of death intensifies when it is experienced as an attack by hostile objects, or when depressive anxiety dominates and interferes with the perception of good internal objects. In some patients during treatment, at special times, the death drive begins to dominate over the life drive.

Christopher Bollas [22] replaced the notion of drives with the concept of idiom. Although he does not rule out the possibility that somatic drives act on the mind all the time, and that the id demands expression, he assumes that above the drives there is an idiom of our personality, a unique being, a unique personality potential. He introduced a helpful distinction between fate and the drive of destiny, which seems important in the understanding of cancer patients. People who feel condemned to their fate do not have a sense of influence over the course of events in their own lives. The present seems too overwhelming to them, and therefore there is no desire for the future in them. Versions of the future are subject to repression, as are painful experiences of the past. On the other hand, people with a sense of destiny fulfill the conditions of their inner idiom through objects and experiences, and their visions of the future represent different paths of potentials.

It happens that people suffering from cancer no longer have visions of their own future, feel defeated and condemned to a difficult fate. They face the loss of a part of themselves and mourn what could have been and what will no longer be. It is not uncommon for stabbing pain and anger to occur, and treatment may be perceived not as support and help, but as a kind of oppression.

Reactions and ways of coping with the disease are also conditioned by factors such as: personality type, gender, mental problems in the past, current life situation, individual understanding of the disease, knowledge of the prognosis and treatment methods, and past experience with oncological disease [23]. Regardless of which factor prevails, for many patients, the moment of receiving the diagnosis is a particularly difficult moment that may cause them to want help, support or psychotherapy.

The key thesis in the psychoanalytic approach is the recognition that traumatic experiences will certainly awaken the suppressed sufferings and conflicts of childhood. It often turns out that understanding the patient's present without referring to his or her past can only bring temporary calming of the effects of the trauma [6].

Method

The application of analytically oriented psychotherapy was aimed at examining the internal structures of the patient's mental apparatus and recognizing his primary internal objects and past life experiences in order to determine the impact of the oncological disease on the patient's adjustment disorders and the impact of early experiences and deficits on the way of experiencing the disease. The aim of the case study is to show the process of moving from the denial of the fear of death and the gradual withdrawal of the drive for life to the restoration of agency and the will to live.

Test procedure

The patient was consulted at a psycho-oncology clinic and then attended psychotherapy there once a week for more than a year. During the period of active treatment (radiotherapy) due to the patient's psychophysical malaise, sessions were held by telephone. A year after the end of the therapy, after receiving another diagnosis, the patient came to the private practice to continue the therapy. The psychotherapy took place 2-3 times a week and lasted 4 years. Both the treatment in the hospital wards and the systematic therapy sessions created a projection surface for the representation of parental objects and induced the transference process, which was analyzed. Prior to the consultation, the patient's medical history had been reviewed, and then the clinical material was expanded during analytical sessions.

Table 1. **Sources and variables used in the therapeutic procedure**

Sources	Variables
Data from the patient's medical records available in the hospital registry from hospitalization, oncology clinic and mental health clinic.	Diagnosis, prognosis, prescribed medical treatment, opinion of the medical staff, opinion of a psychiatrist, pharmacotherapy ordered by an oncologist and a psychiatrist.
Data from individual psychotherapy. Analysis of unconscious fantasies, internal relations with objects, repetition compulsion, defense mechanisms of transference and countertransference.	Thoughts, fantasies, feelings, beliefs.

Patient – Mr. B.

Circumstances of starting therapy

Mr. B. is a 45-year-old man referred to psychotherapy by an oncologist in order to get help in depressive states resulting from his illness. The patient himself defined the scope of his problems in a different way. In fact, he did not know what he might obtain from a psychotherapist. All he wanted was to quickly improve his material status and regain his fitness: "If it weren't for the fact that I have lost a significant part of my money for treatment, I wouldn't have any reason to go to a therapist", "My depression is only related to the fact that I have to lower my standard of living".

More than a year prior to the reporting, Mr. B. had been treated for prostate cancer. This treatment resulted in the remission of the lesions. When the patient received his next diagnosis—colorectal cancer with a poor prognosis—he became depressed, suffering from anger outbursts, depression, and sleep disturbances. The psychiatrist diagnosed the patient with adjustment disorder (F43.2).

Observation and interview data

During the first consultation, it was noticeable that Mr. B. is a man who cares a lot about his body image (appearance and strength). He was neatly and fashionably dressed so that his clothes accentuated his chiselled muscles. He presented himself as a person who had lost a significant part of his life and material status as a result of his fight with cancer. Although he continued to function well professionally, his main focus was on his financial matters. By placing a significant emotionally-charged interest on material possessions and impaired physical fitness, he diverted attention from the fears associated with the disease. Disconnected from his emotions, he recounted medical procedures and their bodily consequences believing that these were only "temporary problems". The patient was actively involved in the therapeutic process.

Mr. B. came from a poor family. He was the only child of very young parents who did not devote much time to him. They worked hard, and the patient was often left alone

or left in the care of neighbors. In addition, there was a conflict between the patient's grandparents and parents that led to the breakup of the family when he was only 8 years old. The parents separated, the father went abroad and saw his son sporadically. Both the father and the mother were experienced by the patient as uninterested in his fate in early childhood. According to the patient, the parents' relationship broke down due to financial difficulties and parental unreadiness. According to the family tradition, the patient invested his self-esteem in money and material goods. In order to prevent further disintegrations in unconscious identification, the patient lived his entire adult life focused on enriching himself, as if this would save him from mental breakdown. He quickly learned to be entrepreneurial and resourceful, and filled the gap left by intimacy deficits by associating with numerous women.

During therapy

In the course of the first year of therapy, Mr. B. realized that in male-female relationships he was repeating patterns similar to those associated with his parents. He became involved with women like his mother, who needed help (especially financial help). He took on the role of a saviour and a hero, as a result of which he later experienced only great disappointment and a sense of being used. He spoke with regret about how much he invested in relationships with women, "giving them everything", and after a while it turned out that they were with him "only for the money". He equated money and sex with a sense of love and security, and made devaluing statements about the opposite sex, believing that "women are easy to buy." He also tried to give gifts to the therapist and was very disappointed that she did not accept them. The bubble that the patient had surrounded himself with in order to maintain his false self might have persisted if it had not been for the fact that he lost his potency as a result of the radiation therapy for prostate cancer. Since then, he had been unable to endure the narcissistic humiliation of losing the function of his most important organ—his penis. At that point, the patient did not know whether the loss was temporary or permanent. He had suddenly lost his sense of omnipotence, which he had secured with sex and money, and which had protected him from pain, despair, and fragility. That was the cause of his mental breakdown.

Session X

During the next year of therapy, after the summer break, the patient showed up to the session distraught and angry. His female dog (Yorkshire terrier) fell ill and was close to death. "How could you leave me like that? My Y is dying, and you're gone. I'm getting involved, and you have time to go on vacation!" the patient shouted. Feeling abandoned by the therapist activated feelings of abandonment by important objects in his life, both by his parents and by the women he was involved with. This resulted in a regression to the level of omnipotent control and a desperate attempt to save the dog at all costs. "I can't let her (the dog) die," he said. He was convinced that he could save the animal, contrary to the opinion of veterinarians. Medication treatment did not help the dog; the tumours were not operable. Mr. B., however, could not come to terms with the loss of his companion and did

not allow her to be put to sleep. He spent a lot of money on bio-energy therapists, healers and behaviourists but to no avail. "I can't let her lie there alone in the cold ground." Any attempts at interpretation on the part of the therapist regarding the patient's unwillingness to see reality as it is, were perceived by the patient as "standing against him". Discussing the patient's life situation and previous losses, as well as showing empathy in his difficult situation, did not bring comfort to the patient. In the countertransference, the therapist felt an immobilizing helplessness, which was in opposition to Mr. B.'s maniacal actions aimed at saving the dog's life. She felt that the patient was moving away from her, that he was not accepting the interpretation, and that she had the idea that the patient would soon end the therapy because he would "die of despair". She began to wonder: Why should the patient die? She thought that Mr. B. hadn't mentioned his treatment and health for a long time, but he had described the dog's treatment in great detail and had experienced it intensively. Finally, she asked, "You have been in despair and fear of losing your dog for weeks. You are trying to save your companion's life at all costs. I wonder if you are trying to save your own life with the same commitment?"

"My life? What will it be without my Y," the patient said, and then revealed that he had an appointment for surgery to remove the bowel cancer, but decided not to continue treatment. That was before it turned out that there was no rescue for the dog. While the patient placed the desire to live in the animal, he himself wanted to die on some level. "I decided not to undergo the surgery. I don't want to be in the hospital again and go through another ordeal." He went on to describe a dream: "I was running away from a fire-breathing hyena with three heads when I realized that the only way to save myself was to jump into an abyss. And then I jumped and kept falling for a long time." The dream may have represented the aggressive and repressed parts of Mr. B., but the patient associated the hyena with the cancer that was "chasing" him, and had three heads—three types of cancer. Further analysis showed that on an unconscious level, he was aiming to die. Throughout the entire therapeutic process so far, the patient had not talked about his fear of death, nor had he mentioned suicidal thoughts. Destructive forces, however, were pushing him into a dark abyss.

Follow-up therapy

When Mr. B. realized that he was losing his life by refusing treatment, it was possible to talk not only about his fear of living with disability and bodily deficits, but also about what death meant to him. At one of the subsequent sessions, the patient said: "I associate death with emptiness, nothingness and intense cold." He then associated the image with a childhood memory in which, as a little boy, he waited long and alone for his parents. "It was a ground floor apartment, dark and cold like a basement. I don't remember the feelings. But I remember that when my mother finally came back, she was scared that I had frozen to death. I must have been so motionless that, despite the cold, it didn't occur to me to get dressed. Or maybe I didn't even feel the cold at all. I sat motionless on the floor and stared at the door. It seemed like an eternity."

The patient understood that from an early age he had learned to cut himself off from his feelings, and he realized that in this situation, as well as in many others later cited, he

experienced a paralyzing fear of death, and even felt that parts of him were dying. Deeply repressed feelings were gradually awakened with the continuation of the analysis and the imminent experience of real death. He was horrified by the thought that at the time of dying "nothing depends on him," that "death comes when it wills," like the mother he had been waiting for and whose presence he could not have foreseen. On the other hand, he saw the process of dying as "the worst cold-splitting pain." In a way, the patient wanted to take control of his death by refusing treatment. On the other hand, in doing so, he attacked himself, his introjected inner objects, his life. Understanding his own unconscious motives helped the patient integrate the hidden and unwanted parts and decide to continue his cancer treatment.

When the patient began to talk about his ideas and feelings about ending his life, he also began to experience a deep sadness resulting from the feeling that nothing would be left of him, "because he did not have any spectacular successes, he did not have a family, he did not have children."

Working through the themes of dying and death and discussing various losses facilitated the transition to the next stage of treatment, the aim of which was to strengthen the patient's desire to live by mobilizing healthy narcissistic cathexis. Gradually, they facilitated the restoration of a sense of self-agency and pleasure in life. The patient began to derive greater satisfaction from relationships with people and began engaging in new activities. He was looking for a new meaning for his current life, but he also began to create new visions and new ideas of the future. He also began to better endure the anticipation and uncertainty inherent in the process of the oncological treatment.

Conclusions

If it is not overpowering, the fear we feel in the face of the threat of death proves the presence of forces in people that make it possible to perceive the value of life. Therefore, the fear of death allows us to communicate the desire to get help, but also improves the quality of life [18]. Bion's theory [8] of containment helps explain how people can make sense of emotional experiences and think about them through the development of a mental apparatus that is built in the earliest infancy or during therapy. The process of transforming the patient's unbearable sensations, communicated through projective identification, into something to think about and tolerate, was evident in the work with Mr. B. Projective identification in this approach corresponds to an unconscious fantasy in which aspects of the self are found in other objects [24]. Mr. B.'s state of mind, both at the beginning of the therapy and in its later stages, was dominated by the processes of splitting and projection characteristic of the schizoid-paranoid position [22]. Persecutory anxiety was accompanied by frustration and anger at doctors, medical care, health care providers, and, as in the example described, at the therapist. The patient's inner life was populated by hostile objects, and numerous projections were accompanied by a sense of emptiness. Discussing the patient's life history and previous injuries had no effect, and the patient could not enter a depressive position until the projective identification was recognized. Thanks to the therapist's recognition of its communicative and evacuative function, it was possible

to discuss with the patient the feelings associated with surrendering to death. The interpretation of split feelings and projections into the animal helped the patient to notice the painful reality more broadly and to return to thinking about himself. The denial of one's own mortality, which at one stage served to cope with feelings of terror at patient's own life in the face of illness, was destructive at a later stage and required therapeutic intervention. Which was consistent with Straker's words [25] that defenses should be evaluated for their adaptive function. When the fear of death was discussed, it became less toxic and frightening. The patient was able to take back the "life" parts and thus decided to continue the oncological treatment. There is a place for feelings related to mourning for the dog, but also for the lost parts of the self and the life so far.

Summary

The subject of mortality and dying is an inevitable part of working with oncological patients. It appears in the work with the patient on a conscious or subconscious level, in a direct form or, as in the example, in a camouflaged way. It is not because the oncological disease is considered a fatal disease, but because in the face of the disease, the deepest and most primal fears are activated. Confronting these fears, on the other hand, consciously or subconsciously, influences the therapist's thoughts and feelings and the way he or she works. Sometimes we can collude with patients by withdrawing from direct conversation about death, as Freud suggested by recognizing that patients believe in their own immortality. However, it seems particularly important that patients facing real or imaginary death, near or distant, be able to talk about it at their own time. Otherwise, resignation and withdrawal from life can prevail.

Mr. B.'s analytic therapy was a four-year process that brought about a significant transformation in the patient's functioning. During this time, the patient had to face deep fears related to life and mortality. He learned to live with his own disability, illness and uncertainty about the future. He found other activities that brought him joy and satisfaction. He went from a state of deep depression and a sense of helplessness and terror to acceptance of his life situation. Gradually, he developed more mature coping mechanisms than denial, omnipotent control, and splitting.

The nature of oncological disease, taking into account its individual phases and their variability, including remission, relapse, and the terminal phase, requires a flexible approach on the part of the therapist. Psychoanalytic psychotherapy may periodically give way to crisis intervention or supportive therapy [17]. However, limiting the work with the patient to supportive therapy alone could not bring far-reaching changes. A review of the literature indicates that the diagnosis of oncological disease presents patients with complex emotional challenges. The scale of emotional reactions can be overwhelming, and the way you deal with them is strongly conditioned on your individual personality traits and previous life experiences. Psychoanalytic therapy provides tools and perspectives to help patients understand and support them in coping with traumatic experiences and often debilitating anxiety.

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