Emotions and thoughts of a psychotherapist from therapy with cancer patients

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Abstract

Cancer often acts as a terrifying force that confronts the individual with feelings of captivity, powerlessness, and persecution. Patients feel under constant threat, something that also carries over into the psychotherapeutic relationship. Therapists are called upon to face and contain the anxiety of death and to manage the fact that they are not omnipotent. The life drive can be mobilized, and meaning can be sought where there once seemed to be only desolation. Through the therapist's maternal function, they aim to listen and help the patient reorganize their psyche, to stir within them feelings of self-love through a journey where old traumas seek healing. The illness can serve as a final opportunity for meaning-making.

Key-words: death anxiety, persecution, connection, mourning, trauma, omnipotence, idealization, hammock effect, life drive, libidinal investment, transference, counter-transference

Emotional states of captivity and exile

I sit in an office at the Day Center, in an armchair, with the patient across from me. Or maybe in the kitchen. Or in the reception area. The doorbell rings. I don't need to go to the door. I open it remotely, by pressing the switch on the wall. The sound of the door opening, then closing, is heard. Footsteps. And then, gunshots. Deafening. Repeated. From a machine gun. A figure dressed in all black rushes in and aims at me. I am next. Without any chance to react, completely powerless to defend myself, with no way to stop it. Unprovoked, sudden, and inevitable.

I had this fantasy for the first time shortly after I started working at the Day Center for Psychological Support of Cancer Patients (DCPSCP), a unit of the Society of Social Psychiatry Panagiotis Sakellaropoulos. It is not at all coincidental that it emerged in the space of the Day Center and unfolded there. It was related to the nature of my work; it was related to cancer. From my contact with the patients, this is how my psyche perceived the threat of the disease. As a terrorist who invades and strikes randomly and indiscriminately. Without verbalizing it, the patients had communicated in our sessions their feelings of being threatened, of being attacked, of being in a state of captivity, with no ability to control anything, and all of this, suddenly and inevitably.

As therapists, in our contact with the other — someone different and yet similar to us, threatened by a serious illness — we are called to welcome and contain death anxiety. Cancer establishes a grim reality in the subject's life, one that irrevocably marks their story. It is no coincidence that patients divide time into "before" and "after" cancer, which traumatizes them both physically and emotionally. The same applies to their relatives: life before and life after cancer.

The patient's needs and how they will move forward, as well as where the psychotherapeutic work will focus, are influenced by the characteristics of the disease: whether the prognosis is good or bad, the time that has passed since the

diagnosis, the stage and progression of the disease, and the response to treatment. The patient's ability for psychological processing itself is also affected by the worsening or the remission of the disease. The goal is for a therapeutic relationship to contain the patient's suffering, thoughts, and unspoken emotions so that the cancer patient can connect with an inner psychic life, integrate and give meaning to the disease as part of their story, and connect with those around them. This is crucial for preventing them from feeling stigmatized and isolated. The first thing the diagnosis threatens is this connection.

The persecution that the patient experiences will be brought into the therapeutic relationship. It is striking how often different patients utter the same phrase: "I don't want to feel sad or cry because that will harm me." This too is a form of persecution. How they should and should not feel. They feel threatened and censor themselves, forbidding themselves from feeling and expressing fear. It is as if by speaking about what they fear, it will become a reality. They regress like a fairytale hero, and resort to magical thinking. They deny their aggression, their assertiveness, fearing they might be punished for it. Anger, rage, and fear are exiled. All of their aggressive feelings are projected onto the disease, and they feel these emotions persecuting them from within. "The cancer is eating me. My own self is fighting me." The patient's psychic reality is filled with persecutory content, leading to a violent eviction of this psychic material.

Often, the patient will even refuse chemotherapy, absolutely terrified and trapped between the *evil* cancer and the *evil* drug that enters their body, which makes them feel like a hostage. Not complying with a medical suggestion, a medication regimen, or a medical protocol is a final attempt to regain the control they feel they have lost. A patient who withdraws their investment from the body that betrayed them, from their life and relationships as they experienced them - which made them sick - cannot engage in the mourning process for the body that is changing, the functions that are lost, a quality of life that is threatened, or an emotional relationship with a significant other — often a parent — that they lost or never found in the way they needed. Another goal of psychotherapy is to

facilitate the mourning process. To connect the trauma of the illness with an older emotional trauma, to relive it, and attempt healing.

Frequently, the patient wishes to exile whatever they feel is mentally persecuting them, and seeks to internalize good objects. They turn to art, to nature, in search of redemption. They may resort to splitting or divisions — "good doctor and bad doctor, good self and bad self, old self and new self." They may develop ideas of omnipotence and self-healing, seek out powerful objects, or idealize the doctor or therapist. The latter may be swept away by their own desire for the triumph of life over death, and, due to inexperience or difficulty in mourning the limitations of their abilities and of science, may believe that together with the patient they can defeat the cancer, in order to maintain this idealizing condition.

In our work, we operate with the concepts of *containing* and *content*. We are not passive receptors or passive recipients. In response to the patient's defenses, the therapist may unconsciously erect defenses of their own. Confronted with an expression of psychic emptiness, the therapist may feel helpless or invalidated and withdraw their own most vital part. When faced with the persecutory elements that threaten the patient internally and are projected onto them, the therapist himself may feel desperate, threatened, or persecuted. They may either, defensively and aggressively, resort to dogmatic adherence to theory or become excessively giving towards the patient, thus violating boundaries. Personal therapy, meetings with the therapeutic team, increasing experience, and supervision, weave the safety net for the therapist, enabling them to protect the therapeutic relationship.

The Hammock Phenomenon

The psychological distance between the members of the therapeutic dyad is modified according to transference and counter-transference movements. In psychiatry, there is a phenomenon that describes the fluctuation of closeness and distance between the patient and the therapist, depending on the

persecutory anxieties activated between them. As I understand it, I would describe it as being *close enough as needed, and far enough as required*. This principle organizes the appropriate distance between the two protagonists of the therapeutic dyad to provide perspective to their relationship. When persecutory anxieties dominate, either the therapist or the patient may create a distance, thus regulating the tidal movements that shape their relationship. The therapist may remain silent, in waiting, if they sense in countertransference that the persecutory anxieties or death anxiety are overwhelming the patient, and approach again when these anxieties subside and the possibility of communication and processing opens up. They detect and respect the patient's boundaries — how far they can go, and what psychological depth they can reach. But the therapist, defensively against the death anxiety raised by the illness, may also seek to regulate their distance from the patient to remain close. The patient will bring to the therapeutic relationship their need for fusion, numbness, emptiness, despair, fear, freezing, anger, envy, betrayal, and longing. These are states that require processing, appropriate reception, and containment by the therapist, which are feasible only when the therapist accepts their own limits and need for momentary escape to protect themselves from the emotional onslaught triggered by the patient, thereby avoiding their own death anxiety and destructive fantasies it raises. The important thing is that this recognition of their own emotions does not cause them to escape but to remain steadily at the patient's side.

The Paradox of Cancer

"Are you saying that if, as the doctor suggested, a part of your tongue was removed through surgery, it would increase your survival rate?" "Yes." "And you refuse it?" "Yes... I can't have my tongue removed now that I've just started speaking."

Cancer can offer an opportunity to search for the lost thread in the patient's history — a thread that connects them to their inner truth. In people's narratives, it is not uncommon to find a condition where the individual had retreated into solitude as a refuge from alienating relationships, ultimately isolating them from

their environment and even from themselves. With the onset of illness, emotions "thaw," they are put into words or are transformed into emotion, crying, and being articulated in a narrative. The illness can awaken the desire for life, mobilize the life drive against the desolation of the psyche. The wounded body can push the psyche towards redemption and regeneration, prompting the individual to reassess priorities, renegotiate their relationship with themselves and others. Freud speaks of the disappearance of psychic pain when the body falls ill. Krzysztof Kieslowski, a Polish director, and screenwriter, in his film "Blue", depicts the protagonist, who is mourning, self-harming by rubbing her fist against a rough stone wall as she walks beside it. Physical pain as a counterbalance to psychic pain or as an expression of psychic pain. Often, the body speaks. In my work with patients, I observe any physical changes. I do not hesitate to ask patients about any changes I observe in their bodies. My aim is to highlight the importance of somatic experience, the importance of observing the body and its functions, and what the body may be telling us when it aches, hurts, falls, or malfunctions. The appearance of cancer may signify a mobilization for the healing of psychic traumas. Self-destructive behaviors may diminish or be abolished in the face of the threat to life, through a libidinal investment in the illness that narcissistically nourishes the individual to reconstitute themselves.

Maternal Management

Early experiences of the patient with the maternal object, if these were traumatic, may make them ambivalent and cautious towards the therapist's availability, and affect how the meeting can be experienced as a positive, reparative experience. Despite their need for support and help, they may hesitate to trust the other person, whether it be the doctor, nurse, or psychotherapist, because depositing oneself in another has been associated with painful emotions. The patient's investments are reorganized if the therapist can endure the destructiveness brought by the patient, whether through positive or negative symptoms: they come but do not speak, speak as if everything is rosy, downplay the process, deny the worsening of the illness, or attack, experiencing their environment as hostile.

The psychotherapist follows and explores the path that unfolds with the patient. They observe how the patient's emotions are expressed through transference. They rely on their countertransference to bring forth emotions belonging to the patient that "hover" between them, allowing the patient to recognize these emotions as their own and connect them to their personal history.

Along with containing all the difficult aspects and alleviating the ambivalence of the psychologically and physically traumatized patient, the therapist's maternal function aims to provide an emotional tone to the communication with the patient, to stimulate libidinal arousal where it appears flat, to facilitate spontaneous and more genuine expression, and to calm the storm of stimuli by acting as a soothing buffer. If we imagine what a mother does with her baby, we can understand this containing function. Overall, it aims to enliven the communication with the other. The therapist listens to everything related to the patient's progress or obstacles and seeks to support their psychic reorganization. They are called to map out, in the patient's psychic field, areas dominated by destructive drives, as well as where loving motions are hidden, that contribute to survival and make life worth living. They are tasked with evoking within the patient emotions of self-love through a journey where old traumas seek healing.

Instead of an epilogue

What I attempt to convey from my experience in psychotherapy with cancer patients might also explain why a psychotherapist might choose not to work with cancer patients. However, by accepting this challenge, the harsh reality of serious physical illness serves as a reminder that balances and prioritizes what is important in life. It is a reminder that the good things in life cannot be taken for granted, just as life itself is not a given. At the same time, it is a reminder that the loss of life due to a serious physical illness is also not taken for granted in our time, especially as science progresses. When a cancer patient shares their thoughts and experiences, they gift us with their proximity to death and enrich us by making us more humble.

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