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Framing the Cancer Patients' Life Experiences and Attitudes: a Psychosomatic Approach

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Abstract:

Our study addresses the relationship between life experiences, interpretations and the presumed somatic effects in terminal diseases, especially in cancer. The causes and the evolution of cancer were subject in the beginning to experiments and presuppositions, and only later the knowledge began to rely on experimental data and countless case studies. Beside the imperative need to find a treatment, there are numerous questions regarding diagnosis, early intervention or our capacity to do something to prevent the onset of this illness. These questions also include aspects as vulnerabilities, risks and psychological factors. One of the schools of thought that emerged was the psychosomatic medicine, who focused on the relationship between body impact of life experiences and attitudes. Considering this perspective, we searched for individual and social features, and the individual attitudes or beliefs that can be related with the onset or evolution of cancer in a number of cases. Our subjects were 7 patients, diagnosed with cancer, treated in the Palliative Care Unit in Municipal Hospital Pașcani, Romania. They agreed to participate to the evaluation and to discuss openly their life experiences' histories. Using a case-study design with qualitative and quantitative measures, our analysis suggest a relationship between

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characteristics of the lived experiences, personal responses (reaction) and the localization and the type of cancer involved.

Keywords: *palliative care, cancer, psychosomatic approach, emotional expressions.*

1. Introduction

The historical perspective indicates an intense preoccupation for the identification and the treatment of cancer, the first accounts being quoted by Murkherjee (2011), beginning with 1986 when Edward Smith bought a papyrus from Luxor, Egypt. This papyrus written in the 17th century B.C. was actually a transcription of a manuscript dated 2500 B.C., translated in 1930. This document contained Imhotep's teachings whose passions were neurosurgery, architecture and astrology. In a period dominated by the magic, he wrote about objective and organic findings including, on the whole, the influence of a being having supernatural powers that can influence a person's span of life. Once these researches started, although in the beginning they took shape of some experiments and presuppositions, finally they became scientific, based on experimental data and numerous case studies.

Together with the development of medicine as an independent subject, more and more prominent preoccupations appeared for in the patient care area, the old conceptions treating only the disease being replaced by the new paradigm „there are no illnesses, there are only ill people”, suggesting in this way the importance of the somatic construction of a person besides his/her psychic oneness.

The analysis of the factors that could influence the beginning and the evolution of the somatic affection was largely debated and reinforced by the psychosomatic medicine and then by the psycho-neuro-immunology, here being also included the conception according to which the stress can have an influence in injuring the soma.

Taking into consideration the increasing number of patients suffering from this disease, some almost rhetorical questions appear and take shape of guiding lines for the future of scientific research. What precisely releases the disease? What can be done for the treatment? But,

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more important, can the onset be controlled? The answers are scarce at this point and are often reduced to applying the conventional treatments.

Together with the increasing number of cancer cases, we can notice the increase of medical studies, focusing on medical interventions and new treatments. It is important to notice the contribution of contemporary psychology, as well as of the common psychotherapies in fighting against cancer- this entity which seems to be independent.

The disadvantages of focusing on only one dimension of this approach can shortly become a trap of mind separation from the body, avoiding in this way an integration of the two components that contribute together to the disease's problems on the whole. Fortunately, the actual tendency is the integrative one, that of holistic approach of the affection.

Goswami (2006) noticed that the intellectual person discovers new contexts just for the thinking act and less for a balanced way of life, a way of life that he/she could promote otherwise, being actually the prisoner of his/her own desideratum, unable to live at the level of emotions, feelings, in other words the intellectual person detaches himself/herself from the body. The author cited considers that cognitive understanding shouldn't be separated from the emotional one, from the context afferent to feelings; they can exist harmoniously in the same time. The time given to the knowledge and acceptance of the emotional dimension that can emphasize the contents beyond the capacity of empirical observation is necessary.

The idea of somatic affections that start from the psychological factors is not new; it has been studied by the scientists intrigued by the difficulty of finding an appropriate treatment. The last century brought big benefits in the medical field, beginning with the discovery of antibiotic that led to the eradication of potentially lethal diseases. Thus a new opportunity, both a medical and pharmaceutical one, was opened. In the same time the last century was the promoter of the implication of psychology in explanatory description of a number of somatic phenomena, including here the large sphere of psychosomatic affections as well.

A series of trends in psychology and medicine showed interest in the way the mental states can influence the body. In 1846, Dr. W. Walsh Hyle (quoted by Schreiber, 2008) considered that there is an influence of

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personal premises in cancer. He asserted that denying the evidence he reached after studying the sick patients would mean to contradict the reality of the disease.

The hypothesis of the connection between body and mind was mentioned by Freud in the concept of the unconscious, followed by Jung who developed the concept of shadow, and later by the psychosomatic medicine through the assumption of the intra-psychic conflicts. Among the theorists, an important figure is Franz Alexander, who sees the body as the temple of symbolic expressions, suggesting and arguing that a language of intra-psychic conflicts can be highlighted starting with the first symptoms and ending with the severe affections, like cancer. R. Dahlke can also be mentioned being the one that brought to light the concept of *normopathia*, concept which refers to socially over-adapted persons, their behaviour being oriented to satisfying the others, becoming unable to refuse them, often neglecting their own needs, and in the end being difficult for them to recognize their own needs and emotions.

Considering the above mentioned approaches, we aimed in this study to evaluate the life experience and attitudes of the patients diagnosed with cancer diseases, referring to the explanatory models of the psychosomatic approach.

2. Methods

The participants to this study were hospitalised patients diagnosed with cancer. It is important to mention a series of restrictions regarding the inclusion of a patient as eligible for our research:

- The hospitalisation period constituted an important factor because our empirical observation concluded that a longer period of hospitalisation allows the self-disclosure of the patient to a greater extent than a short period of hospitalisation. We argue that it is important to establish a therapeutic frame, the contact with the patient, so that he/she would perceive the space as being secure, condition that will later contribute to a better communication and an active participation in therapy;
- The capacity to intuit and verbalise the emotions. In these case studies we have selected patients who have a greater capacity of intuition and verbalisation of emotions. We give as an argument of

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this choice the native or educated possibility of the individual to analyse and synthesize the data of the experience by managing fast connections, which facilitate the self-analysis and the insight. A good capacity to identify emotions and to express them was also an important factor in getting and correlating more and more information. The choice of these criteria has been made starting with the anamnestic questionnaire, as well as with the evaluation of the cognitive model of the patient's emotional and situational context, choosing those patients having an appropriate emotional expression;

- The availability for introspection. By this concept we understand the patients' attitude towards self-analysis and an objective view upon themselves;
- The cultural level. We have chosen those patients whose cultural level touches or exceeds the average, because without a good capacity of verbalisation, intuition and understanding, the personal analysis would be possible only to a lesser extend;
- The cognitive integrity and the capacity of understanding. In the case studies we have selected the patients without organic injuries, which could have generated confusion, temporal and space disorientation;
- We have also selected the patients with cognitive and mnemonic intact capacities, without language disorders, due to an organic injury or to a psychic disorder.

Characteristics of the studied patients: gender – 6 feminine, one masculine; aged between 40-73 years old. The diagnostics were: breast cancer – 2 patients; one of the patients suffers from spine metastasis; hepatoma; ovarian cancer; cervix cancer – suffers from pulmonary metastasis, skin cancer and has a surgery on vocal cords in order to eliminate a tumour; gastric tumour on the male patient; muscle cancer.

The evaluation of psychological factors included cognitive and behavioural assessment and psychosocial information from multiple sources. Instrument used included anamnestic interview and observation; Holmes and Rahe Scale, CIM 10-AM classification (2004). The Cognitive, emotional and situational evaluation of the disease included the perception of the disease, the understanding of the diagnosis and

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disease, his/her knowledge of the disease, life situations that preceded the onset of disease, emotional context when the disease appeared. All patients were subjected to the same procedures.

3. Results and discussion

Data analysis has identified a number of common features to all the interviewed patients, features that are presented below. Both quantitative measures from the scales and the themes emerged from text analysis were used to interpret their attitudes, emotions and the meanings attributed to the events (during interviews).

3.1. The lack of contact with his/her emotions

This aspect has been identified in all 7 studied patients. The expression has a rationalized aspect, with a reduced emotional introspection. It is observed the tendency to internalize the emotions with a protective purpose. For the patients in study, analysing and feeling their own emotions can be such a generator of stress and anxiety, that this lack of contact with his/her own self can appear as a natural defence mechanism. We cannot state with certainty that this precisely attitude has led to the development of such a severe somatic pathology, but we can mention Alexander's work (2008) where he asserted that our body is a field for symbolic expression of the conflicts. It is the scene where an almost silent drama is played, where the actors pass untouched by the events with an emotional impact. A hypothesis deriving from here is that the patients not only don't express their emotions, but it is also possible that they could not identify and name them, and this could lead to a significant emotional lack both in the relation with his/her own self and in the relation with the others. We can bring Alexander's argument further on, taking into consideration that the lack of emotional expression, no matter its cause, either ignorance or anxiety, could play a role in starting and maintaining the cancer disease. In other words, what is not expressed outside comes back inside, getting stronger, bursting in the less protected zone. This is what Alexander called organ vulnerability, the least resistant field. A hypothesis is that the lack of contact with one's own emotions can be due to both education and culture. Thus, being in contact with the medical environment, the patient is asked to express what he/she feels, how he/she feels, but to a smaller

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extend. Many times these aspects are not interesting; a greater importance is given to the somatic symptoms, treatments, objective evolution of the case. The patients are usually not asked how they are feeling, but the person who gets in contact with them considers that he/she knows how they are supposed to feel and acts consequently without validate what they think about the patient.

3.2. Locus of control

It is observed in all studied patients an assignment of external causality regarding the onset and the development of the disease. The studied patients manifest the tendency to associate the illness with an external cause, beginning with the nutrition and ending with the stressing events. They do not admit their personal implication, the way in which they manage their own conflicts. It is almost totally strange the idea that the person himself/herself could release and manage the disease and its development. The majority of the patients show surprise when they are asked what role they think they have played in the disease. This vision according to which the disease is totally moved away from the person can be the result of education, of the concepts achieved in a life time, where the personal influences are totally excluded. According to most of the patient's beliefs the disease appears as a result of many factors: it can be divine punishment, it can be the adopting of a behaviour blamed by the society in the form of a vice, such as smoking, or drinking alcohol, it can be the wounds after a fight with a neighbour. Other causes identified by the patients are multiple stresses from the work place, the events having a stressful potential, which through their action produce a lack of balance in the person's life leading to disease. It is totally excluded from the patient mind the hypothesis according to which there is always the possibility to choose the way in which a person can relate to the events in his/her life, the attitude summarised by the cognitive stress theories in the adequate coping mechanism. The majority of the patients have a tendency to catalogue the events in good or bad. It should be mentioned that the emphasis falls on the negative events, here is where the greater part of the energy is consumed. The positive events pass by almost unnoticed. Another factor that can contribute to this vision of disease can also be the traditional medicine which continues to underline the

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importance of the external factors in the onset and the development of the disease, such as pathogenic agents, viruses, bacteria, etc.

3.3. Self-blame is another aspect proposed as a hypothesis for the external assignment of the locus of control. We explore the possibility that the patients feel guilty when it is emphasized the importance of considering the personal factor in the disease start and development. It is not excluded that, when the patients face this new point of view, it seems they have waste very much time seeking for external help instead of seeking for internal help, in order to solve the inner conflict. To the same extent it is very important to understand the conception regarding the individual capability to influence the disease, capability potentially separated from guilt and more associated to self-awareness. It is observed in most patients a regression and an attitude of addiction both to family and medical staff, attitude deriving from incapability, belief in miracles, as well as allotting authority to the doctor.

All these aspects - the education, which has learned the individuals that there are good and bad things, and some of them are supposed to be kept away; the culture, that has emphasized the doctor's role as an universal healer; the regression and attitude of dependency - can contribute to maintain a helplessness attitude and to lack of hope, and also to an emphasized search for miraculous treatments, obviously of an external origin. The self-blame dimension should be carefully observed and diminished, in order not to lead the individual towards demoralization and depression. However, there is the possibility that external orientation could have as goal the protection from guilt and implicitly of disease responsibility.

3.4. Self-disclosure

We observe in patients a reduced level of disclosure that changes altogether with the establishment of the therapeutic relation and with the extension of the hospitalisation period. The reduced level of self-disclosure can also appear as a protection measure from violating the intimacy. Thus, in the first phase of the therapeutic contact it is natural its maintenance as a sign of a faulty therapeutic frame or of a patient's emphasized tendency to protect from what could bring a sincere conversation and an authentic therapeutic labour. Once having the

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patient status, the patients get used to repeat endlessly what at a certain moment becomes the story of their lives. Often, the members of the medical staff want to find out details, to know how it started, to know what treatments he/she has done, what actually has happened, a frame that offers the individual the possibility to repeat the same information, which at a certain moment benefits of a big degree of stylistically improvement, the patient himself/herself succeeding in finding various occurrences that could explain his/her disease. Some patients associate the onset of the disease with a traumatism, with an influenza, with certain external life conditions. To the patient's status is it also added the major difficulty of keeping both physical and personal intimacy, the hospital environment having a tendency to expect the patient to be totally "naked", without secrets and restraints, but with an excess of obedience. Any tendency to keep certain data is catalogued as being faulty and criticised, which induces in the patients a personal exposure to which he/she can adjust or which ends up being a disadvantage. Taking into consideration these aspects, we can consider the reduce self-disclosure as being the patient's possibility to keep a part of his story for himself/herself. This story sometimes is scarce, the person doesn't have all data, doesn't find explanations, and the cancer prognostication is so sombre that it paralyses any tendency to optimism and the use of personal resources the reality of the illness. Not very often does the rationalization mechanism interfere with the patient explanations when he tries to fill the gaps in his personal story. The reduced disclosure can be associated with the lack of contact with one's own emotions. As we have previously mentioned, once the patient is not asked to undertake this analysis, after a long period of hospitalisation and treatment he/she gets to ignore what he/she feels, the central point of interest being the physical body and less the emotional dynamics behind the body. Therefore, being in the situation of expressing their feelings, to talk about emotions, personal beliefs, the patients become anxious. This undertakes a process of reorientation which needs time and availability from the therapists.

3.5. Control tendency

Another element is the exacerbated tendency to control, as being the only way to manipulate the external world. What the patient refuses

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to do in their disease frame- meaning assuming the control- exacerbates outside, in the relationship with the medical staff, the doctors, and even the relatives. This tendency to control it's not always manifested, but it can take dissimulated shapes, such as the manifestation of an exaggerated attitude towards the medical staff, by repeated or inappropriate demands, all of them meaning a way to control the anxiety level.

3.6. Cognitive and emotional aspects

All the studied patients acknowledge their diagnosis, but five of them openly express the awareness of the prognosis as well. The patient diagnosed with breast cancer and spine (cervical) metastasis anchors herself in a denial stage, twisting the reality according to her will. In the same way, the patient diagnosed with gastric cancer show anxiety, his verbal and non-verbal language demanding help and support, with no wish to talk about the disease's evolution. With this patient we can talk about an anchoring in the regression and dependency phase, with a behaviour demanding attention and encouragement.

3.7. Stressful life events

In six studied patients we can identify elements with a traumatic potential, in other words the life events were decoded in a negative way, along with reactions of lack of expression or denial.

The patient diagnosed with ovarian cancer makes no causal connection between her disease and her family difficulties in the initial phase of the interview, only later she associates the causes with the divine power, and appreciates that the life events can influence her current state. These examples suggest that theoretical elements the elements that our paper is based on. Thus, some authors such as Alexander, Dahlke, and even Simonton suggest the existence of a possibility of interaction between the life events and the onset or the evolution of the disease. However, some theories are asserting that not the life event itself is the one that has an overwhelming importance, but the way in which the individual relates to it. Alexander is the one who studies thoroughly the association affirming that these emotional conflicts can cause continuous variations of blood pressure, which in time can stress the vascular system. This functional phase of varying blood pressure can cause an organic vascular alteration in time, and

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eventually it can cause a noxious irreversible form of hypertension. These observations have been crystalized in the concept of psychogenic organic disorder.

The disorder according to this theory develops in two stages. First, the functional distortion of a vegetative organ is caused by a chronic emotional disorder. In the second stage, the chronic emotional functional disorders conduct step by step to alterations of the issues and to an irreversible organic disease. It is obvious the fact that both emotional disorder and organic disorder are in close relation, getting to influence one another, and both have a major contribution in the development of a severe pathology.

Generally speaking, Dahlke (2008) is asserting that there are people who strive to live as much as possible, adjusting to the extreme, not wanting to draw attention to them, nor to be considered a burden for someone, and desiring to obey the norms.

Regarding the Simonton and Simonton (1978) theory, the central premise of their applied therapy is that the somatic disease- namely the cancer- has not just a physical component, but it also refers to a problem of the entire person, of the entire human system, which includes not only the body, but also the mind and emotions. The authors assert that the mental and emotional states play an important role, regarding both the susceptibility of the disease appearance and the process of recovery. Consequently, the cancer represents a sign of the individual's problems as an existential problem, aggravating or made up of a series of stressor factors by so called traumatic events, which took place six up to eighteen months before the cancer onset.

3.8. Resources

All the patients assert the impossibility of being cured, as well as the lack of their contribution in curing the physical body, demanding and waiting for their healing to come from the divinity or the doctors. Studying the patients, their lack of involvement and awareness appears as flagrant, a lack that can be related to the previous mentioned aspects, namely the fear of awareness, self-blame, as well as the educational premises which support an almighty medicine, possessing magical knowledge of healing almost inaccessible to the inexperienced. Another hypothesis deduced from here is that there can be a fear specific to the

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patients- the fear of managing their involvement in disease, taking into consideration the novelty of the concept as well as the lack of knowledge in this matter. As an example, a patient asks himself: „If it is true that I can be cured, how could I cure myself? How could I do it? But if I go wrong it is my responsibility”. The idea of patients’ involvement in their recovery it’s not without risks. This can results in lack of confidence in doctors, applying inefficient or even dangerous self-treatments, or the alteration of the communication between patient and doctor.

3.9. The lack of control in disease

The patients have a tendency to learned helplessness passing the responsibility over a superior instance, from their point of view to the divinity, refusing to decide or act on their own. In the experiments quoted by Schreiber (2007, 2008), when tumour cells were implanted to the rats and they were subjects to electric shocks, this will ease the evolution of the disease in a learned helplessness condition, as a source of stress (they cannot escape to an adverse stimulus), differently to the rats from the controlled condition of the experiment, which were not stressed and whose symptomatic evolution was improving. These experiments underline the importance of the learned helplessness as an intervening factor in the onset and evolution of the disease. We can speculate further that the way in which the patients managed their existential problems up to the onset of disease, contributed to this. In the same way the educational component can leave its mark over the coping style, the beliefs and the individual’s way of reacting.

3.10. Emotional expression

Non-verbal language (mimic, gestures expressed during interviews) suggests anxious and depressing elements, varying in intensity expressed by depression, fear, anxiety, a tendency to severe crying crises, reduced tolerance to frustration, emphasized by frequent nervous bursts or complaints. In six studied patients the elements of anxiety and depression, present in the non-verbal language, were in contrast with the verbal statement of the patient; only in the case of the patient diagnosed with gastric cancer, the anxiety manifested both verbally and nonverbally (he was asking for attention and care or he had crying episodes).

4. Conclusions

The psychological evaluation of the patient's condition showed a reduced level of emotional expression and disclosure, together with exacerbated tendency of control and rigidity concerning the changes produced by the life events. We identified a number of life events considered as negative (divorce, loss of a parent or a child, etc.), to which patients answer by reactions of internalization, lack of expression or denial.

In the presented cases, the history of a life person, the familial or social model seem to shape certain psychological experiences, which can sometimes find expression in a number of somatic disease, including cancer. The cancer evolution, the somatic localisation of cancer, the family history, all give evidence that support the psychosomatic theories, promoted by Dahlke, Alexander and others. Theoretical aspects previously presented may guide the approach toward the factors present in the potential development and evolution of the somatic diseases, including cancer.

The historical perspective show ancient and recent studies emphasizing the importance of a unique individual psychological mechanism regarding the approach of the life situations, their interpretation, as well as the adopted coping model.

These case studies intended to analyse in-depth a number of patients' life situations; further studies are necessary to analyse in detail both quantitatively and qualitatively the existence of a possible relationship between life events, patients' subjective interpretation and the localization of the illness - *locus minoris resistentiae*.

Observing the effects of stressful life events can have implications in prevention. Once we identify the context that may have led to the onset and progression of the disease, a dedicated therapeutic intervention may restore the affected somatic balance. The characteristics of the study (number of subjects, health condition) don't allow generalization; still, they provide indication of relations between events, personal response (reaction), the localization and the type of cancer involved.

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