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REFLECTIONS ON PSYCHODYNAMIC PSYCHOTHERAPY FOR PATIENTS WITH CANCER FACING EXISTENTIAL THREAT

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This paper explores the role of psychodynamic psychotherapy in the treatment of patients with cancer, a therapeutic approach that has faced criticism for various unexamined reasons. Given the limited literature on this subject, we aim to contribute by examining (i) the specificity of the cancer experience, particularly its five main existential dimensions and dialectics, (ii) the psychological challenges patients with cancer encounter from a psychodynamic perspective and (iii) the relationship between these psychological dimensions and the existential dialectics experienced by patients, which we consider central to psychodynamic psychotherapy. Notably, this last aspect has not been addressed in the literature. To illustrate our perspective, we present a case vignette of a patient who underwent 2 years of weekly psychotherapy before ultimately succumbing to the disease. Through this discussion, we aim to demonstrate that psychodynamic psychotherapy is particularly well suited for patients experiencing existential threat who wish to benefit from psychological support. Additionally, we hope to contribute to clinician training and to the destigmatisation of psychodynamic psychotherapy within somatic care settings.

KEYWORDS: CANCER, PSYCHODYNAMIC PSYCHOTHERAPY, EXISTENTIAL DIMENSIONS OF DISEASE

INTRODUCTION

In a recent paper published by the British Journal of Psychotherapy, Rai and Ross (2024) reviewed the limited literature on psychotherapy for patients with cancer and observed that psychodynamic approaches appear to be underutilised (Rai & Ross, 2024). As a possible explanation, the authors identified a prevailing caution regarding psychodynamic theory, particularly its historical association with the psychogenesis of somatic illness, which may cause discomfort in the context of cancer. They also highlighted the reality of the disease that patients with cancer must confront, and the anxiolytic effects of manualised treatment approaches, attenuating the

existential threat in therapists treating patients with cancer. In contrast, when exploring psychodynamics-oriented psychotherapists' experiences in the treatment of patients with cancer, the researchers found that they considered psychodynamic approach as highly valuable. According to these clinicians, psychodynamic psychotherapy is particularly beneficial because cancer is a deeply personal experience, and the psychodynamic framework enables patients to establish connections between their illness and childhood experiences, patterns of thinking or relating to others, past traumas and fears, complex and ambivalent emotions and the symbolic meaning of cancer. Despite these insights, therapists reported encountering scepticism from colleagues, patients and society regarding the appropriateness of psychodynamic therapy for individuals with cancer.

We commend the authors for their comprehensive and thoughtful review of the literature and their exploration of practitioners' lived experiences in treating patients with cancer. However, it was notable that none of the reviewed articles or interviews addressed the following issues: (i) the specificity of the cancer experience with its existential dimensions and (ii) the articulation between the psychological dimensions and the existential dialectic by means of psychodynamic psychotherapy. To the best of our knowledge, although these aspects are central to psychodynamic psychotherapy for patients with cancer, they have not yet been explored in the literature.

The following reflections are based on our psychodynamic psychotherapeutic training, with one of the authors being an International Psychoanalytical Association candidate (LM), and our clinical and academic activities as psychotherapists and supervisors in cancer care settings (Danesi, Bourquin, Stiefel, Zaman, & Saraga, 2020; De Vries, Forni, Voellinger, & Stiefel, 2012; De Vries & Stiefel, 2018; Krenz, Godel, Stagno, Stiefel, & Ludwig, 2014; Ludwig et al., 2014; Stiefel & Bernard, 2008; Stiefel & Bourquin, 2018; Stiefel, Bourquin, & Michaud, 2024).

We outline the specificity of the cancer experience with its existential dimensions and dialectics, discuss its associated psychological challenges from a psychodynamic perspective and illustrate the psychotherapeutic articulation between psychological dimensions and existential dialectics through a case vignette of a patient who underwent 2 years of weekly psychotherapy before ultimately succumbing to the disease.

THE SPECIFICITY OF CANCER: AN EXISTENTIAL EXPERIENCE

Cancer is a potentially life-threatening disease that, unlike acute, reversible or chronic diseases, represents an existential crisis that forces individuals to confront fundamental aspects of their existence (Fuchs, 2021). The five main existential dimensions, often overshadowed by daily concerns, are the awareness of mortality (i), the sense of isolation as a singular human being (ii), the perception of vulnerability (iii), the experiences of liberty and associated responsibility (iv) and the search and need for meaning (v). To avoid misunderstandings that have been identified

when existential issues are discussed in the medical literature (Boston et al., 2011), we first define these existential dimensions.

Karl Jaspers, a philosopher and psychiatrist, coined the term "limit situations" (Jaspers, 1986) to describe experiences when humans face unusual challenges, such as being confronted with severe diseases provoking existential experiences. According to Jaspers, limit situations cannot be managed using conventional social skills or coping mechanisms; rather, they require creativity and a willingness to "tinker with what is at hand".

The experience with limit situations in cancer can manifest in various ways. Awareness of mortality may emerge at the time of diagnosis, often shaped by the general perception of cancer, which continues to exist despite remarkable therapeutic progress, during remission when the so-called "sword of Damocles" hangs over one's head, or in times of relapse and disease progression. The feeling of isolation may emerge from the beginning of the disease when realising that one has left the world of the healthy and may deepen due to the recognition that no one else can fully share or alleviate the biopsychosocial burdens imposed by cancer. The perception of vulnerability is a recurring experience throughout the cancer journey, exacerbated by heavy treatments that also damage healthy cells. The experience of autonomy, and the associated burden of responsibility and anxiety may arise when patients must make critical choices regarding treatment and termination of anticancer treatment. Finally, together with the awareness of finitude, a need to turn to the past and future often occurs, and patients search for the meaning of life, their lives or the occurrence of the disease.

The way these existential dimensions play a role in the experiences of illness depends of course on the specific medical, psychological and social situation of each patient. For example, if the cancer is curable, treatment limited to surgical excision and a patient feels to be cared in a safe environment, existential issues may be less prominent. This may also be the case if patients are denying the threat of the disease or are more focused on other concerns such as the situation of their children: existential preoccupations may be absent or perceived with less intensity. Moreover, each patient past may interfere with the present experience, with patients having benefited from a holding environment being less exposed than those who have experienced attachment failures early in their life and are thus experiencing re-traumatisation and fear of breakdown (Winnicott, 1974). Bearing these individual determinants and the heterogeneity of cancer patients in mind, we acknowledge that our case vignette does not allow any generalisations regarding the experiences of patients and the psychotherapeutic approaches to be taken.

EXISTENTIAL DIALECTIC

As illustrated in the clinical case vignette below, we observed that when existential dimensions emerge in the cancer experience, they manifest dialectically.

The inevitability of finitude and the irrepresentability of death may trigger intense defence mechanisms; in this respect, Yalom has identified two specific defences

under existential threat, which are narcissistic invulnerability, often manifested as (at times psychotic) denial, and the hope of the arrival (in time) of "saviour", which can take, the form of idealised transference towards the oncologist or the firm believe that the inclusion in a phase I trial may cure cancer (Yalom, 1980). However, at times, particularly in a safe environment and contained in trustful relationships, patients may also be enabled to face, at least for moments, their own finitude, and sometimes address the issue of death and dying, thus sharing associated feelings and concerns. Most patients with cancer alternate between avoiding and confronting death and experience this existential dimension dialectically.

Feelings of isolation can alternate with feelings of being connected, for example, by encountering others with the same destiny, but also by deepening existing relationships which, in view of a possible loss, become more valuable. Feelings of isolation are thus dialectically experienced with feelings of connectedness, as Heidegger said, "Sein ist immer Mit-Sein" (being is always being with) (Rentsch, 2015).

Vulnerability and loss of independence are particularly pronounced following a cancer diagnosis. However, receiving care and support can initiate an evolution towards the dialectical experience in which one acknowledges vulnerability yet learns to live with it.

The liberty to make medical decisions may provoke anxiety (e.g. regarding possible regrets) and a feeling of being burdened by a shared medical decision, but it may also dialectically provide a sense of control, pride and fulfilment in determining one's own course of treatment and destiny.

Finally, periods of meaninglessness and endured absurdity may dialectically alternate by finding meaning collectively shared (through religion and other belief systems) or individually experienced in life and illness.

PSYCHOLOGICAL CHALLENGES OF PATIENTS WITH CANCER: A PSYCHODYNAMIC PERSPECTIVE

It is beyond the scope of this manuscript to comprehensively describe the different psychological challenges patients with cancer face and to discuss how valuable psychodynamic theory can be for their understanding. We will thus solely address by means of a few emblematic clinical examples how key psychodynamic concepts help to understand patients' response to the psychological challenges of the cancer experience.

First, defensive and unconscious mechanisms play a crucial role. Confronting cancer and its existential threats provokes intense emotions such as sadness, anxiety, anger, jealousy and guilt, which would overwhelm and exhaust patients if they could not count on defences, mediating between the inner and (harsh) outer reality. Not respecting these defences - except in case they interfer with pressant and relevant medical decisions - may have serious consequences. As Weissman has summarised in his book Coping with Cancer, patients cope if they can, defend themselves if they must, and become psychotic if they are forced to do so (Weisman et al., 1979). In the oncology setting, patients' intellectualisation, denial

or projection are not distorted thoughts to be corrected but expressions of psychological pressure, which must be contained, metabolised and restored in a prudent way, with the aim of making the underlying emotions accessible and working through their origins. Understanding unconscious forces and phantasies, such as omnipotence or guilt, allows psychodynamic psychotherapists to feel when a more confrontational or supportive approach is indicated. Thus, perceiving defences and the unconscious not only helps fine-tune the relationship and diminish feelings of existential isolation and vulnerability, but also allows us to go beyond the reality of cancer and to identify how each patient has his or her singular way to face the disease. While cancer and its associated existential dimensions cannot be modified, the relationship established between this situation and the resulting dynamics, which at times can be more exhausting than the disease, can be the focus of therapeutic attention (Stiefel & Bernard, 2008).

Second, early development and transference must be considered. Conceiving patients as customers or clients clearly falls short when discussing patients with cancer. Similar to other illnesses, cancer cannot be experienced without a certain degree of regression, which might be intensified by the medical care environment. The way to relate to caring and the ability to be cared for are coloured by early development and attachment. This can explain phenomena such as a patient's delay or refusal of treatment but also strong dependency or difficulties in separating and with the transition to palliative care (Krenz et al., 2014; Ludwig et al., 2014). On the other hand, the concept of countertransference is necessary to understand oncology clinicians' reactions, attitudes and behaviours such as therapeutic obstinacy (Stiefel & Krenz, 2013) or situations of collusion between patients and clinicians (Deliyanidis et al. 2025).

Finally, the interplay of psychic structures—superego, ego, id—along with intrapsychic conflicts, further shapes patients' experiences of illness. Considering that cancer interferes with the loss of daily functioning, one can easily understand how strong and persistent superego demands may provoke, for example, depressive states or how the gap between the ego and the ego ideal may increase, leading to shame.

A psychodynamic understanding surpassing the consideration of manifest symptoms and linking them to an intrapsychic origine resonating with the external reality are thus useful to realise that cancer is often only a trigger and revealer of past psychological patterns, as demonstrated by M. Viederman, who conceived the psychodynamic life narrative for short psychotherapeutic intervention in the medical setting (Viederman & Perry, 1980; Viederman & Taylor & Francis, 1983). Such an understanding is not only beneficial to target psychotherapeutic interventions and work through conflicts (Christian, Eagle, & Wolitzky, 2017) and other difficulties but is also key to providing the meaning of cancer patients' experiences. This last issue is also most important in individual and group supervision to re-establish the relationship with so-called difficult patients, whose behaviour is cryptic to clinicians working in the oncology setting; once they understand why and how such patients are the way they are, empathy is often restored. In conclusion, these examples

illustrate that psychodynamic theory provides a highly relevant framework for oncology settings (Stiefel, Nakamura, Terui, & Ishitani, 2017).

It goes without saying, that other approaches, be they systemic, cognitive-behavioural or specifically designed short interventions such as meaning-centred or dignity-conserving therapies, may be of help. However, we consider—as explained in a critical review of some of these interventions (Stiefel, Bourquin, & Michaud, 2024)—that specificity of interventions may sometimes lead to forget that the psychic apparatus possesses some general features, independent of situations faced by the concerned individuals, that non-specific factors are always at work in psychotherapy and that a strong focus on technique and specific contents may hamper a deeper encounter with the patient. Finally, as mentioned in the introduction, the literature on psychotherapy in the cancer setting is scarce, especially regarding empirical data, which calls for a certain modesty regarding the effectiveness of our own approaches.

THE PSYCHOTHERAPEUTIC ARTICULATION BETWEEN THE PSYCHOLOGICAL AND EXISTENTIAL DIMENSIONS OF CANCER

Patients may or may not perceive the existential dimensions associated with life-threatening diseases. However, when existential dimensions are part of the patient's experience, they must be considered and articulated with the psychological dimensions. From our perspective, in sharp contrast to the recent development of interventions targeting patients in existential situations, such as meaning-centred psychotherapy and interventions aimed at promoting post-traumatic growth, gratitude, altruism or hope, —we disagree that psychology, unlike theology or philosophy, should directly focus on existential dimensions (Stiefel, Bourquin, & Michaud, 2024). However, we consider that psychotherapy, particularly psychodynamic psychotherapy, can help understand and work through psychological dimensions which in turn influence the experience of the existential dimensions and, more specifically, how they may unbalance the above-described existential dialectic of the cancer experience. This proposition is illustrated in the following case vignette.

EXISTENTIAL DIALECTIC AND PSYCHODYNAMIC PSYCHOTHERAPY IN PATIENTS WITH CANCER: A CASE VIGNETTE

A 64-year old former museum curator with advanced stomach cancer began psychotherapy in the spring of 2021. She attended weekly one-hour sessions, which continued until her death 2 years later. During the first year, she consulted with the first author in person; as her condition progressed and her physical strength declined, therapy transitioned to video sessions to accommodate her limitations.

The patient was referred by an oncologist for symptoms of anxiety and depression. The therapist considered anxiety to be related to the threat of the existential dimensions triggered by cancer and depression to the multiple losses endured (e.g. loss of health and physical functions), resonating with her experiences as a neglected child.

Finitude

In one of the first encounters, not yet weakened and almost without physical symptoms, the patient started the session in a very agitated state. Upon the question of what happened, she reported, "You know, everybody in the hospital tells me that I have a good quality of life!". After being assured that she was the only person legitimised to judge her quality of life and that she had the right to disagree with the clinicians' appreciation, she said, "How can you have a good quality of life while having advanced stomach cancer?". After a pause, the therapist asked her if she was thinking about her finitude, and when she nodded, he added, "Thinking about one's death is hard, but it is even more painful when one must leave this world with the impression of not having received enough…" (alluding to her history as a neglected child). After a few tears, the agitation ceased. This confrontation with death, shaped by early (and as later discovered also actual experience of neglect), was certainly painful, but also brought relief and insight, as well as an experience of feeling understood. The patient came to realise why she had made such efforts to avoid the existential dimensions associated with cancer and was, for the first time able to talk about death and dying. The oncology clinicians' perception of her distress and their attempts to reassure her by referring to the "good quality of life", seemed rather counterproductive, and one wonders why they continued to repeatedly underline her good quality of life. Was it truly intended to support the patient, alleviate her agitation or to simply avoid addressing this uncomfortable topic of finitude that resonated with their own existential concerns (Stiefel, Bourquin, & Michaud, 2024)?

This progression can be interpreted as follows: by gradually navigating the conflict between avoiding and confronting death, the patient was able to begin integrating the reality of her finitude, reducing her inclination to withdraw from this inevitable truth and herself. The psychological dimensions related to the patient's early and repeated experiences of neglect unbalanced the existential dialectic towards an intensified avoidance of the reality of finitude, which, however, rather than disappearing began to manifest in agitation, which in turn, prompted oncology clinicians offer reassurance in a manner that further alienated her even more from them and herself. This vicious cercle was finally broken by providing the patient with a safe therapeutic space and insights into the origins of her agitation, allowing her to feel understood and to encompass both poles of the existential dialectic. In other words, the existential dialectic was rebalanced and made bearable, and the first signs of anticipatory mourning emerged (tears instead of agitation).

Isolation

A few months later, the patient reported experiencing loneliness. Her husband, who had also endured childhood neglect, exhibited a pattern of emotional dependence throughout their relationship, even as her health deteriorated. She had assumed the nurturing role, while he remained largely passively in receiving her attention. The patient also expressed a sense of detachment from the "world of the healthy" and conveyed envy towards her daughter's in-laws, who would have the opportunity

to witness their grandchildren grow up. This decompensated oral collusion between her and her husband (Stiefel, Bourquin, & Saraga, 2023), and her experience of being separated from the healthy explained her feelings of intensified isolation, which were attenuated when the therapist invited the husband to two sessions and addressed this issue. The husband became more attentive and was able to provide practical support. Moreover, the patient showed increased autonomy and, despite her low self-esteem related to past and present neglect, she found the confidence to challenge her husband's views and behaviour. Experiencing a more engaged husband, along with her growing sense of autonomy allowed the patient to better tolerate existential feelings of isolation. In addition, a key element of this transformation was the therapeutic relationship, which the patient deeply valued, as illustrated by a postcard sent to her therapist from an exhibition stating, "In another life, we would have been friends".

In this case, the existential pole of "being-with" ("Mit-Sein") had moved out of sight during the illness, unbalancing the existential dialectic. The oral collusion with her husband, understood as a consequence of neglect, was a successful defence against psychic suffering and echoes from the past (passively endured neglect turned into an active stance of nurturing and a feeling of being nurtured by proxy), but became inoperant when she felt ill. The two sessions with the husband addressing collusion, and the therapist's relationship rebalanced this existential dialectic.

Vulnerability

The vulnerability of the patient's body manifested itself by symptoms of weakness and fatigue, a reduced capacity to walk and an increasingly "restricted" world (Goldstein, 2014). When she addressed these issues, the therapist pointed out that the restricted world might also have been related to her difficulty in showing herself as needing assistance and feeling shame, which was intensified by her longstanding struggle with low self-esteem. The patient considered these thoughts and finally accepted the use of a wheelchair, which allowed her to enjoy nature and the city where she lived. Moreover, the husband was motivated to practically support her on these small excursions, which also eased their marital tensions.

The existential dialectic turning around vulnerability and the possibility of partially overcoming vulnerability were obscured by conflicts over dependence, independence and low self-esteem related to shame, which hampered her acceptance of help. Addressing the origins of her stance allowed the patient to historise herself and rebalance the existential dialectic.

Choice, liberty and responsibility

Another existential dimension emerged when the disease started to progress rapidly: the question of choice, the liberty and responsibility to refuse further treatment and anxiety about eventually regretting it. The desire to terminate active anticancer treatment provoked intense anxiety in the patient. However, after different discussions with the therapist, who also addressed the advantages of palliative care,[1] the patient

decided to stop treatment and felt relieved and less torn between the two options. This was not the case for her oncologist, who felt distressed and insisted on seeing her again for re-evaluation of the indication for chemotherapy. When the patient politely answered that she would like to be now followed by her general practitioner, who knew her for over 20 years, the oncologist still proposed another appointment, "just to see how things are going". And when the patient finally thanked him and said that she believes it was time to say goodbye, the oncologist answered, "let me phone you next week" (we will come back to this issue of "existential and psychological countertransference"). Reporting this conversation to the therapist, the patient smiled and stated that she felt not only less anxious but also proud that she was able to make this decision (Sartre, 2013).

The existential dialectic between liberty, choice and the burden of responsibility is always a source of anxiety (Sartre, 2013). However, liberty is not only be associated with anxiety but also with a feeling of agency, which might be anxiolytic and provide feelings of joy and pride. The newly gained insight into the psychological functioning of herself and others (the oncologist) and with the help of a therapeutic auxiliary ego, the patient overcame ambivalence and rebalanced the existential dialectic, allowing her to make an informed choice.

Meaning

Finally, the last existential dimension that emerged from psychotherapy was the issue of meaning. Higher forces and potential religious beliefs were not topics the patient desired to discuss—it might be that she had no access to spiritual experiences or religion, or she considered her therapist not to be an adequate interlocutor for such issues—but she talked about the meaning related to her life trajectory, biographical meaning. Indeed, with increasing insight, she linked past and present experiences, understood how they shaped the way she faced life and realised how the neglect played a key role in her development, marital choice and low self-esteem, as well as how she experienced illness and its associated existential dimensions. Somehow her life seemed to make sense, she felt less "enduring her existence without understanding what happens" and became a more active agent. This biographical meaning—how painful it was sometimes to discuss—was finally acceptable to her, as was her life. In the last session—she had an increasing intoxication by morphine and reported that she felt like having had a glass of wine too much—she laughed at the end and, when saying goodbye, added "Prosit". These were her final words with the therapist. "Prosit", which means "to your health". The therapist understood these words as her final message for him.

The existential dialectic between the meaning and absurdity of life (Camus, 1985) was not addressed in this psychotherapy; the process of psychotherapy as it stands was a means of creating biographical meaning and rebalancing initial experiences of enduring absurdity.

Existential countertransference

Preoccupied, the therapist contacted after this last session, with the patient's agreement, her general practitioner to inform him about his impression that the patient might be intoxicated by morphine and suggested opioid rotation to remedy these symptoms. The practitioner replied that the patient also showed signs of sub-ileus. The therapist insisted that octreotide could be used to treat the ileus. Here, the general practitioner kindly reminded the therapist that the patient had voiced a request for assisted suicide some weeks ago and that he had delivered her the necessary documents, and he rightly closed the conversation by stating that "we might now let nature do its work". Two days later, the patient died peacefully in her apartment in the presence of her general practitioner.

The last episode illustrates how intense relationships can develop when working with severely ill patients. One can interpret the therapist's countertransference reaction, mirroring the oncologist's countertransference, as an indicator of separation anxiety activated by facing a dying person (Roose, 1969). De M'Uzan has in his remarkable chapter "Death never confesses" (de M'Uzan, 2018) described the countertransference intensity that dying patients evoke in therapists and how they defend themselves from the idea of their own mortality, for example, by feeling coldness after a period of grief. However, from an existential perspective, the therapist's reaction can be understood as existential resonance. Existential resonance is not "treatable" and needs no treatment; on the contrary, existential resonance witnesses that therapists truly encounter their patients, and on the same time discover their own finitude, vulnerability, struggle with choice and responsibility, and their own search for meaning. This may be the reason why Adams-Silvan describes in her article "That Darkness – Is About to Pass. The Treatment of a Dying Patient" (Adams-Silvan, 1994), that countertransference persisted after the death of her patient. The existential countertransference persisted for a while; this is unavoidable because therapists and patients do not differ regarding existential dimensions, they only differ in terms of the psychological dimensions which might imbalance the existential dialectic we encompass.

CONCLUSIONS

We propose that psychoanalytic perspectives on human existence are not only relevant for patients with cancer but also for clinicians working in the oncology setting, psycho-oncologists with their duties as therapists and supervisors and for society. As demonstrated in his recent book on "Loss", the sociologist A. Reckwitz considers that modernity has been characterised by a discourse, narrative and imperative of constant progress in every domain of human life such as economic development, individual freedom, civil rights, security and technique (Reckwitz, 2024). Typical motors and representatives of this discourse on progress are formed in the fields of economics (constant growth), science (advances in knowledge and means, especially in medicine), politics (the growing democratisation of societies) and lifestyle (social ascension and well-being). According to Reckwitz, in the postmodern period,

following the "trente glorieuses" (the glorious 30 years after WWII), this discourse has eroded and serious doubts about eternal progress and growth emerged. According to this author, one of the consequences is that the issue of loss (completely obscured in modernity because of these narratives) resurfaces acutely, and people experience loss (of unlimited growth, nature, democracy and a better future) with a certain helplessness. Reckwitz calls for an attitude and narratives in which vulnerability, limits and finitude can have a voice and views psychoanalysis as a method to integrate such a perspective, since psychoanalysis recognizes the negative, limits, the non-controllable (unconscious) and loss (during development and individuation).

We fully align with this view. Indeed, as observed in the vignette discussed above, when there is no space to acknowledge the "dark" aspects of a patients' experience, there is a risk of failing to meet them where they are, by imposing an expectation of where they should be (Stiefel, Bourquin, & Michaud, 2024).

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The authors declare that they have no conflicts of interest.

ENDNOTE

1. The therapist, trained also in internal medicine and palliative care, felt comfortable to discuss these issues.

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QUESTIONNAIRE
C4(26) Part 1 of 2
Reflections on psychodynamic psychotherapy for patients with cancer facing existential threat

INSTRUCTIONS

- Read through the article and answer the multiple-choice questions provided below.
- **Some questions may have more than one correct answer;** in which case you must mark **all** the correct answers.

Introduction and Background

Question 1: What observation did *Rai and Ross* (2024) make regarding psychodynamic approaches to therapy for patients with cancer?

- **A:** They appear to be overutilized
- **B:** They appear to be applied too selectively – only focusing on a limited number of approaches
- **C:** They appear to be underutilised
- **D:** They appear to be the subject of a comprehensive literature base

Question 2: What is one possible explanation identified by *Rai and Ross* (2024) for the underutilization of psychodynamic approaches in the context of cancer?

- **A:** A lack of therapists trained in oncology
- **B:** A prevailing caution regarding psychodynamic theory, particularly its historical association with the psychogenesis of somatic illness
- **C:** The high cost and limited accessibility of manualised treatment approaches
- **D:** A general societal preference for existential therapy over psychodynamic therapy

Question 3: According to psychodynamics-oriented psychotherapists, why is the psychodynamic framework particularly beneficial for cancer patients?

- **A:** It is less time-consuming than manualised treatments
- **B:** It focuses exclusively on the symbolic meaning of cancer and unconsciously lessens the “pain” of past trauma
- **C:** It enables patients to establish connections between their illness and childhood experiences, past traumas, and complex emotions
- **D:** It primarily offers anxiolytic effects, reducing existential threat in therapists treating patients with cancer

Question 4: Despite the perceived value of the psychodynamic approach, what did therapists report encountering from colleagues, patients and society?

- **A:** Encouragement to publish their work
- **B:** Scepticism regarding the appropriateness of psychodynamic therapy for individuals with cancer
- **C:** Requests for more psychodynamic training opportunities
- **D:** High demand for psychodynamic therapy referrals

Question 5: What key aspect, central to psychodynamic psychotherapy for cancer patients, had not been addressed in the reviewed literature or interviews?

- **A:** The articulation between the psychological dimensions and the existential dialectic by means of psychodynamic psychotherapy
- **B:** The integration of cognitive-behavioural techniques.
- **C:** The impact of chemotherapy on psychological well-being
- **D:** The prevalence of anxiety and depression in cancer patients.

The Specificity of Cancer: An Existential Experience

Question 6: How do the authors characterize cancer in relation to acute, reversible or chronic diseases?

- **A:** As another chronic disease that forces unique lifestyle changes
- **B:** As a disease that can only be managed through complex coping mechanisms
- **C:** As a potentially life-threatening disease that represents an existential crisis
- **D:** None of the above

Question 7: Which of the following is **NOT** one of the five main existential dimensions of the cancer experience discussed in the article?

- **A:** The search and need for meaning
- **B:** The perception of vulnerability
- **C:** The automatic perception of one's life as a failure
- **D:** The awareness of mortality

Question 8: Who coined the term "limit situations" to describe experiences when humans face unusual challenges, such as being confronted with severe diseases provoking existential experiences?

- **A:** Sigmund Freud
- **B:** Irvin Yalom
- **C:** Donald Winnicott
- **D:** Karl Jaspers

Question 9: The awareness of mortality in cancer patients may emerge during which of the following phases?

- **A:** At the time of diagnosis
- **B:** During remission
- **C:** In times of relapse
- **D:** With disease progression

Question 10: TRUE/FALSE: The feeling of isolation in cancer patients only emerges in the final stages of the disease.

- **A:** TRUE
- **B:** FALSE

Existential Dialectic

Question 11: According to *Yalom* (1980), what are two of the specific defences identified when under existential threat?

- **A:** Intellectualisation often manifesting as over-researching the disease
- **B:** Narcissistic invulnerability often manifesting as (at times psychotic) denial
- **C:** Displacement, often manifesting as anger toward family members
- **D:** Hope of the arrival in time of “saviour”

Question 12: How do most patients with cancer experience the existential dimension of death?

- **A:** By consistently confronting and dealing with it
- **B:** By maintaining a firm belief in a "saviour"
- **C:** By alternating between avoiding and confronting death dialectically
- **D:** By denying their finitude

Question 13: The feelings of isolation experienced by cancer patients are dialectically experienced with which of the following?

- **A:** Feelings of anxiety
- **B:** Feelings of deep regret
- **C:** Feelings of self-pity
- **D:** Feelings of connectedness

Question 14: The liberty to make medical decisions may provoke anxiety, but it may also dialectically provide which of the following?

- **A:** A sense of shared medical burden
- **B:** A sense of control, pride and fulfilment in determining one's own course of treatment and destiny
- **C:** A detachment from the medical reality
- **D:** A tendency to defer all responsibility to the oncologist

Psychological Challenges from a Psychodynamic Perspective

Question 15: Which of the following statements are **TRUE** in the context of psychological challenges faced by cancer patients?

- **A:** Defensive and unconscious mechanism play a crucial role
- **B:** Confronting cancer provokes intense emotions (defences) such as sadness, anxiety, anger and guilt – but never jealousy
- **C:** According to Weisman, cancer patients cope if they can, defend themselves if they must and become psychotic if they are forced to do so
- **D:** All the above

THE END

QUESTIONNAIRE
C4(26) Part 2 of 2
Reflections on psychodynamic psychotherapy for patients with cancer facing existential threat

INSTRUCTIONS

- Read through the article and answer the multiple-choice questions provided below.
- **Some questions may have more than one correct answer;** in which case you must mark **all** the correct answers.

Psychological Challenges from a Psychodynamic Perspective

Question 1: How do psychodynamic psychotherapists interpret the use of defence mechanisms like intellectualisation, denial, or projection by patients in the oncology setting?

- **A:** Distorted thoughts to be corrected
- **B:** As signs of impending psychosis
- **C:** Expressions of psychological pressure, which must be contained, metabolised and restored in a prudent way
- **D:** As interfering with relevant medical decisions

Question 2: TRUE or **FALSE:** While cancer and its associated existential dimensions cannot be modified, the relationship established between this situation and the resulting dynamics, which at times can be more exhausting than the disease, should **NOT** be the focus of therapeutic attention.

- **A:** TRUE
- **B:** FALSE

Question 3: The concept of countertransference is necessary to understand which phenomenon in the oncology setting?

- **A:** Patients' regression to earlier developmental stages
- **B:** Oncology clinicians' reactions, attitudes and behaviours such as therapeutic obstinacy
- **C:** Patients' ability to form new, strong attachments
- **D:** All the above

Question 4: TRUE/**FALSE**: A psychodynamic understanding is useful to realise that cancer is often only a trigger and revealer of past psychological patterns.

- **A:** TRUE
- **B:** FALSE

Question 5: What is a key benefit of a psychodynamic understanding in individual and group supervision regarding "difficult patients"?

- **A:** It helps to enforce stricter boundaries between patient and clinician
- **B:** It creates an understanding of the daily challenges faced by clinicians
- **C:** It allows clinicians to understand why and how such patients are the way they are, often restoring empathy
- **D:** It allows patients the space for emotional discharge

Psychotherapeutic Articulation and Case Vignette

Question 6: In contrast to interventions that directly target existential situations, what are the authors' position regarding psychotherapy and existential dimensions?

- **A:** They disagree that psychology, unlike theology or philosophy, should directly focus on existential dimensions
- **B:** They agree that meaning-centred interventions should focus on post-traumatic growth, altruism and hope
- **C:** They believe psychodynamic psychotherapy is the preferred approach to target existential dimensions
- **D:** They believe that when existential dimensions are part of the patient's experience, they must be considered and articulated with the psychological dimensions

Question 7: The patient in the case vignette presented with anxiety and depression. What did the therapist consider the anxiety to be related to?

- **A:** Her low self-esteem
- **B:** Depression due to the multiple losses endured (i.e. loss of health and physical function)
- **C:** The threat of the existential dimensions triggered by cancer
- **D:** Her current experience resonating with her experiences as a neglected child

Question 8: When the patient in the case vignette confirmed that she was thinking about her finitude, what did the therapist at that time link the pain of thinking about death to?

- **A:** The frustration of hearing "she had a good quality of life"
- **B:** The impression of not having received enough, alluding to her history as a neglected child
- **C:** Actual experience of neglect
- **D:** Emotional distance between herself and her husband

Question 9: The patient's agitation in response to oncology clinicians' reassurances of "good quality of life" was interpreted as ……..?

- **A:** An intensified confrontation with mortality
- **B:** An intensified avoidance of the reality of finitude
- **C:** An unbalancing of the existential dialectic
- **D:** An acceptance of her vulnerability

Question 10: The patient's loneliness, detachment from the "world of the healthy," and envy towards her daughter's in-laws were explained by her feelings of intensified isolation and ……..?

- **A:** Her low capacity for self-reflection
- **B:** Her husband's complete withdrawal of support
- **C:** A decompensated oral collusion between her and her husband
- **D:** A lack of religious belief

Question 11: The patient's shame and difficulty in showing herself as needing assistance were related to which existential dimension?

- **A:** Meaning
- **B:** Isolation
- **C:** Vulnerability
- **D:** Liberty

Question 12: The patient's final decision to stop active anticancer treatment and pursue palliative care led to which dialectical outcome?

- **A:** Increased anxiety and regret about the decision
- **B:** Complete submission to the oncologist's wishes
- **C:** A definitive end to her existential concerns
- **D:** Feeling less anxious but also proud that she was able to make this decision

Question 13: In the case vignette, what type of meaning was the patient interested in discussing, rather than higher forces or religious beliefs?

- **A:** Biographical meaning (linked to her life trajectory)
- **B:** Hypothetical meaning (what if I had lived differently)
- **C:** Collective meaning (what is the meaning of life in general)
- **D:** Abstract meaning (philosophical discussions)

Existential Countertransference and Conclusion

Question 14: TRUE/FALSE: According to the authors, existential resonance is "treatable" and requires therapeutic intervention.

- **A:** TRUE
- **B:** FALSE

Question 15: According to sociologist A. *Reckwitz*, why does psychoanalysis provide a method to integrate the perspective of vulnerability, limits and finitude in the postmodern period?

- **A:** Because psychoanalysis is a technique-focused intervention
- **B:** Because psychoanalysis recognizes the negative, limits, the non-controllable (unconscious) and loss
- **C:** Because psychoanalysis is completely separate from the discourse of constant progress
- **D:** Because psychoanalysis encourages an intense focus on specific positive contents

THE END

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ANSWER SHEET

C4(26)

Reflections on psychodynamic psychotherapy for patients with cancer facing existential threat

***Time spent on activity** **hour** **min**

You can complete any one, or all the parts of this activity.

PART 1												PART 2											
	A	B	C	D	E		A	B	C	D	E		A	B	C	D	E		A	B	C	D	E
1						8						1						8					
2						9						2						9					
3						10						3						10					
4						11						4						11					
5						12						5						12					
6						13						6						13					
7						14						7						14					
						15												15					

How relevant was the content of this activity to your scope of practice?			
Not at all	Somewhat	Mostly	Extremely

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