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WHEN CANCER ENTERS THE THERAPY ROOM: THE LIVED EXPERIENCE OF PSYCHODYNAMIC THERAPISTS WORKING WITH CLIENTS WITH A RECENT DIAGNOSIS OF CANCER

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The psychological impact of cancer is becoming well-acknowledged. Given its prevalence, practitioners will encounter cancer in their therapy rooms. There is limited research on the experience and application of psychodynamic therapy for clients with cancer. This study generates a new understanding through the experience of psychodynamic practitioners. Semi-structured interviews were conducted with eight UK psychodynamic therapists on their lived experience of working with client(s) with a recent (less than 5 years) diagnosis of cancer. The data were analysed using Interpretative Phenomenological Analysis. The findings reveal that psychodynamic therapists' experience with clients with cancer is emotionally demanding, mentally stimulating and deeply personal. They point to the unique space that psychodynamic therapy provides and highlight some of the challenges. The analysis is understood through the framework of psychodynamic theory and practice.

KEYWORDS: PSYCHODYNAMIC, PSYCHOTHERAPY, CANCER, IPA, QUALITATIVE RESEARCH, PHENOMENOLOGY, DEATH, FREUD

INTRODUCTION

Cancer is not just any illness. It is 'a "whispered about" illness that has metamorphosed into a lethal shape-shifting entity imbued with penetrating metaphorical, medical, scientific, and political potency' (Mukherjee, 2011, p. xvii). Cancer is a subject that is feared and avoided, but due to its prevalence, it is always in our awareness. Every 2 minutes someone in the UK is diagnosed with cancer. There is a one in two lifetime risk of cancer. One in four of all deaths in the UK are caused by cancer, so cancer is directly associated with dying. Yet survival rates have doubled in the last 50 years (CRUK, 2024), and more than 3 million people are living with or beyond cancer. There is an increased awareness of the psychological impact

of cancer, yet 58% of people with cancer feel their emotional needs are not looked after as much as their physical needs (Macmillan Cancer Support, 2014). NICE guidelines (2004; 2009) recommend patients be offered specialist psychological support and the National Cancer Peer Review Programme's psychological support measures (2011) outline standards, measures, and workforce and service requirements for the delivery of psychological support within hospital settings.

Psychodynamic therapy's place in addressing the psychological impact of cancer in the UK is not clear. Considering its prevalence, therapists have or will encounter clients with cancer at some stage. This study focuses on psychodynamic therapists' experience when working with clients with a diagnosis of cancer. Their understanding brings us closer to offering a more meaningful way of working and gives insight to therapists reflecting on their practice when cancer becomes the third object in the room. It also helps us understand what function psychodynamic therapy can have in society's attempts to address the psychological impact of cancer.

LITERATURE REVIEW

The literature on the emotional aspects of cancer and therapeutic engagement reveals the sheer emotional complexity of cancer. From a psychodynamic perspective, there are very few research studies.

More than just a disease

The word cancer describes much more than a disease. Cancer is an invasion, a war, a crusade, the enemy, a traitor invading from within, a stigma, a failing, a curse, a punishment. We become cancer 'victims' or 'survivors'. Recovery is expressed with uncertainty as remission. The disease has come to personify the threatening other. 'One does not simply have an illness, one "fights the big C"; one does not simply die, one succumbs after a valiant battle' (Sabini & Maffly, 1981, pp. 127–128). A cancer diagnosis is considered a disability, protected by law from discrimination. Even though cancer can be a long-term illness with realistic outcomes, the diagnosis is strongly associated with death/dying. Death was an inherent meaning of cancer in more than a third of the 102 studies included in a global research study (Vrinten et al., 2017). Cancer is both feared in society and is a social stigma that affects the patient's perception of herself and others' perception of her (Goldie, 2005).

Cancer's link to emotions

The link between cancer and stress and other emotional factors stems from antiquity. Medical literature from the 18th century onwards connects cancer to depression and loss. Groddeck, a pioneer of psychosomatic medicine, as well as Jung, saw cancer as a symbolic reference to unmet emotional needs. LeShan thought cancer patients had a weak will to live (1989). Booth (1973) referred to tumours representing the lost object. Temoshok (1987) identified patterns of coping behaviours as risk factors. Other studies linked cancer to various psychological issues: conflict

with the mother (Bacon et al., 1952); denial of destructive impulses (Greer & Morris, 1975); role of a distressful life event (Chen et al., 1995; Geyer, 1991); stress and progression of cancer (Spiegel, 1996, 2012); stress and recurrence of cancer (Perego et al., 2020).

The perception of a mind–cancer relationship is widespread amongst patients. The belief that psychological issues have caused the illness is very common amongst breast cancer patients (Panjari et al., 2012). Vrinten et al.'s (2017) research points to widespread belief that cancer could result from worrying, thinking or even talking about cancer. A study of the public, patients and oncologists showed over 60% believe psychological factors affect cause, progression and cure (Lemon et al., 2008). Beliefs about what caused their cancer are a central facet of patients' experience (Bergner, 2011, p. 268).

Oncologists and the wider medical are sceptical about emotional causes, pointing to studies that found no or limited relationship (Petticrew et al., 1999; Sampson, 2002). The focus in clinical practice has since moved from the etiological role of emotions to the emotional consequences of having cancer and undergoing treatment.

There is widespread acceptance that a cancer diagnosis results in significant psychological impact (Cancer Net, CRUK, Mayo Clinic, Macmillan, National Cancer Institute USA, NICE). Research suggests the 'prevalence of psychiatric disorders in cancer patients is about twice as high as in patients with other diseases and three times higher than in the general population' (Razavi & Stiefel, 1994, p. 223). Half of cancer patients experienced significant psychological distress that manifested primarily as anxiety and depression (Postone, 1998). Overall, 32% of people living with cancer have relationship problems (Macmillan Cancer Support, 2014).

The growing presence of cancer memoirs have opened an understanding of the cancer patient's emotional experience (Leahy, 2019) beyond narrow definitions of clinical anxiety and depression. These explore death, dying, the impact on self-esteem, reactions from others, etc (Kalanithi, 2016, Riggs, 2017; BBC's, 2018 'You, me and Big C'). 'Unlike academic work, which needs to be critiqued to gain credibility and meaning, this work needed only to be heard' (Jain, 2013, p. 218).

Working with or caring for cancer patients results in emotional challenges. Goldie believes the question whether to tell a patient the truth arises in connection with cancer differently from other diseases. 'What patients are told may be determined by fantasies about the illness and reactions to it by both doctor and patients' (2005, p. 102). Segal (2017) describes how in the UK issues of death and dying are avoided by splitting off patients into palliative care and Macmillan nurses. Most doctors are not equipped to have difficult conversations with patients about cancer and death. Doctors and nurses describe an inherent emotional strain in their interactions with patients. To manage this, staff control their communication with patients—restricting intimacy and avoiding psychological care (McLean et al., 2011).

Psychotherapy and cancer

Studies have been conducted on understanding the efficacy of therapy on cancer patients. Most of these have taken place in the USA; some in Europe and Asia. Multiple studies of psychological interventions measuring emotional outcomes yielded favourable survival outcomes (Spiegel, 2012). There is scarce literature specifically on psychodynamic interventions for cancer patients but the few that exist point to positive outcomes and potential benefits (Abed et al., 2020; Ludwig et al., 2013; Zwerenz et al., 2012).

These studies seems to focus on whether survival time increase or measurable depressive symptoms reduced. The psychotherapy was short-term and supportive in nature and does not adequately address the intra-psychic consequences of having cancer (Postone, 1998). The prime concern is 'the preservation of the patient's life – not how she would live that life' (Goldie, 2005, p. 14).

Several case studies and articles (Burke, 2013; Goldie, 2005; Judd (in Burke, 2013); Himes, 2005; Orbach, 2020; Parkinson, 2006; Postone, 1998; Straker, 1998, 2013, 2020; and Yuppa & Meyer, 2017) demonstrate the effective use of psychodynamic thinking and interventions when confronting cancer. Despite the presence of cancer and medical realities of the treatments, the analytical process remains the same—'about the patient's unconscious and how it manifests in the present' (Judd, 2013, p. 30). Straker (1998) notes how psychoanalysis's focus on countertransference is of significance in avoiding unhelpful self-protective mechanisms that other practitioners may adopt when dealing with death.

There seems an opportunity for psychodynamic therapy to deal with the intrapsychic and interpersonal conflicts generated by the experience of cancer. Despite this potential and these case studies, psychodynamic therapy for cancer patients is not the norm. Existential and cognitive approaches are typically utilised in the oncology setting, even though it is psychodynamic approaches that engage with the unconscious fantasy and dynamics in patient's cancer experience (Bergner, 2011). The reason for this is unclear. Postone (1998) suggests this modality has been underutilised because it has been linked historically to work with patients with psychosomatic illnesses. Perhaps the approach of looking at specific measurables, as well as everyone's anxieties around cancer, have led to the provision of support that relates to dealing with the immediate conscious crisis of cancer through cognitive-behavioural therapy (CBT). Yuppa and Meyer (2017) suggest the use of manualised treatments is preferred over psychodynamic therapy because they reduce the practitioner's anxiety stemming from exposure to patients facing disability or death.

The silence around cancer in psychodynamic therapy

Death and dying is rarely addressed in the curriculum of psychodynamic trainings (Schaverien, 2020). Psychodynamic treatment of cancer patients is a neglected area in practice and literature (Straker, 2020). Searles recalls his reluctance to write an article on cancer was an unconscious reaction to its relevancy and a way to manage

his anxieties about the topic (in Burke, 2013). The reluctance of psychoanalysis to engage with cancer is surprising considering Freud's long battle with cancer. 'Freud himself says very little about his cancer. It was never a topic he addressed in all his publications' (Ross, 2022). Perhaps his silence set a precedence. There is evidence in his conversations, letters and reflections that point to how Freud was in fact deeply affected by his cancer (Ross, 2022; Schmidt, 2013; Schur, 1972). At the time of his diagnosis, Freud used the language of death and destructiveness rather than pleasure-seeking. In '*Ego and the Id*' (Freud, 1923), the conflict of the life-instinct and the death-instinct became central. Lin reflects 'cancer epitomizes the workings of the death drive in its aim of returning the organism to a state of inertia, and yet it also, perhaps counterintuitively, encompasses the strivings of the life instincts with cancer cells refusal to comply with the internal necessity of dying' (Lin, 2017, p. 47). Inherent in Freud's theories and methods may lie the intuitive experience of the trauma of a cancer diagnosis and the impact on one's psyche. Freud may not have referenced his own cancer, but he was impacted by it.

The therapist's experience

'Relating to another begins with identification with the other's physical experience. Inter-corporeality, in other words, must precede intersubjectivity' (Vickers, 2017, p. 1460). Reading cancer memoirs 'creates a disturbing dynamic in the reader' (Burke, 2013, p. 198). 'The listener must be present as a potentially suffering body to receive the testimony that is the suffering body of the teller' (Frank, 1995, p. 144). Postone (1998) felt illness is a challenge to the therapist's rescue fantasies and wishes for omnipotence. Adler refers to how 'countertransference hate is a likely consequence of working with medically ill patients, therapists may be reminded of their own inevitable physical decline, helplessness, suffering, and death' (Adler, 1984, p. 91). However, the therapist's actual experience of what and how cancer unfolds in the therapy room is still unclear. Research exploring the nature of this experience for the therapist is limited, which limits the psychological support of cancer patients.

RESEARCH METHODOLOGY

This study used 'the lived experience' of therapists captured, through interpretative phenomenological analysis (IPA), a qualitative research approach. 'IPA has particular value in examining emotions, complex and ambiguous topics where the phenomenon examined is elusive and difficult to articulate' (Smith & Osborn, 2015). It is therefore best suited to examine the emotive phenomenon of facing someone with cancer.

Following IPA best practice, a small, targeted and homogenous sample of six to eight practitioners were sought. Recruitment efforts involved reaching out to practitioners based on their online profiles individually and more broadly through the use of a poster emailed to psychodynamic/psychoanalytical associations and institutions. Most responses were from southeast England.

Data were gathered via semi-structured interviews conducted in person with 8 UK-based psychodynamic therapists. Questions asked were open ended. All eight participants had private practices. Three participants were males and five females. Information on participants' experience working with cancer clients is below.

Number[a]	Years in practice	Number of cancer clients	Also worked in palliative care/cancer charities
1	>12	18+	✓
2	>10	25+	✓
3	>10	1	
4	>20	2	
5	>16	3	
6	<2	1	
7	>11	25+	✓
8	>20	5	

[a]To secure participant anonymity the serial number doesn't match the participant no. (P#).

After transcription and analysis, initial themes emerged, and both implicit and explicit meanings were examined from each narrative. The initial, emergent themes were aggregated into thematic clusters, which consequently resulted in the identification of superordinate themes and master themes.

During the recruitment process, several psychodynamic practitioners with years of experience (ranging from 3 to 25+ years) responded stating they had not worked with any client with cancer. This resulted in considerable curiosity given the prevalence of cancer, leading to the addition of a question to open an understanding of any real or perceived obstacles in psychodynamic work with cancer patients.

Ethical considerations and reflexivity

The study received ethical permission after a rigorous university process. Participants gave informed consent, were offered a debrief post-interview and were guaranteed confidentially. There was researcher awareness of the highly emotive nature of the topic and sensitivity to participants personal associations with cancer. In IPA, access to the participant's experience depends on and is complicated by the researcher's perceptions (Smith & Osborn, 2008). This was especially important as one of the author's has a lived experience of surviving cancer. A deliberate attempt at every stage was made to bracket personal associations and conscious experiences to the subject, allowing the phenomena to speak for themselves.

RESEARCH FINDINGS

An analysis of the data resulted in four phenomenological master themes:

Master themes	Superordinate themes
1. Cancer is deeply personal	a. Creates a deep and enduring bond
	b. The response to cancer is very personal
2. A very different fear	a. The ultimate unknown
	b. Confronting mortality is unbearable
3. Exceptionally evocative experience	a. Identification with the client
	b. Intensely difficult work
4. Seeking connections	a. A unique resource
	b. Adaptation to the frame
	c. Dealing with perceptions

Although all themes are discussed, the last theme is the focus of this article.

Cancer is deeply personal

This research reveals how the experience of cancer, leaves a deep and enduring impact. Most participants had a personal (direct or indirect) experience of cancer and expressed vulnerability while acknowledging difficulty in separating their experiences from their clients. They felt their experience offered a deeper understanding of the client.

> I know, how frightening and isolating the experience can be …how taboo the subject matter is … how rubbish we are at talking about illness (P8:45).

> rightly or wrongly the personal experience [was] … of everything stopping. And the terror and the fear and the trauma… I can see it without having to be in it (P1:542).

The work also offered an opportunity to heal. 'There was something I could learn or work through in relation to my father's death as well, by supporting him (client)' (P3:97). Participants pointed to deep connections with their clients with cancer, often years after ending. At various points, participants shared how these clients were more on their mind because they leave in the 'shadow of their condition' (P3:512) or because '… when someone like that dies, you are … stuck with …the projections and the transference' (P5:511).

The research shows how everybody's response to cancer is deeply personal. Participants shared how varied their client's needs from therapy were. Clients' responses had little to do with the reality of their prognosis. All participants referred to how their client's reaction related to their internal world and past experiences. Old, pre-existing anxieties are re-invoked. Previous traumas and patterns of dealing with difficulties reappeared. Participants saw how clients were forced back into states of dependency, triggering childhood feelings and experiences.

> It drags you all back to that unconscious impotence, the unconscious childhood, … infantile behaviours of powerlessness and frustrations (P8:403).

> Something that was split off in their childhood … comes charging up to the foreground (P2:489).

The research highlights that often cancer wasn't the focus of the therapy rather what the cancer evoked in clients.

> impotency when discovered and realised, reflected an earlier impotence … in relationship with his mother as a child. He had a very controlling mother …. the key feature is impotence and infantile rage…. which the cancer has literally enforced on him (P3:400).

The focus of therapy was around issues of relationships and experienced losses (e.g. work, appearance, sense of self). Participants revealed how the cancer evoked complex and ambivalent emotions including rage, anger, fears, losing control, wanting to connect and relate, isolation, abandonment, guilt, shame and neediness. It also included acceptance, relief and triumph. Participants described clients who wanted to talk about their cancer and others who did not. Some clients were interested in symbolic thinking and some not. Some wanted to 'draw a line to their cancer experience and move on from therapy' and some wanted to keep their therapists for 'longer as an insurance policy' (P1:226). Clients could be heavily defended and deny their fears or be paralysed with their fears unable to live. Participants refer to the delicate task of balancing moments of choosing when and how much to speak and moments to just accept clients' defences in dealing with the reality of their situation.

A very different kind of fear

This research highlights how even the word cancer brings intense fear. Cancer described as the ultimate unknown, was instantly equated to uncertainty and death. Participants show acceptance that cancer is often very treatable but that did not alter their emotional associations.

> 'it always feels quite final the word cancer … I know they have a very good success rate with prostate cancer … it still feels final' (P6:121).

> 'it's got this like kind of connotation … fear, anxiety, slight sense of desperation that someone is going to die on you … the thought goes very quickly from hearing the word cancer to are people going to die on you' (P5:468).

Participants described cancer and fears associated to it as being distinct from other fears and illnesses. When exploring what makes it distinct, there were repeated references to feelings of being 'out-of-control' and the terror associated with 'not-knowing'.

> There is something … particularly about cancer rather than other illness that feels … very out of control from your body. Your body has turned … against itself … you have no control over it … I think that's why it feels like a trauma (P1:46).

> He is not cured. This therapy (treatment) is very expensive…will it continued to be funded? We don't know…. Will it continue to be effective? We don't know …that was …for me what was most upsetting (P4:187).

Participants also referred to the indiscriminate nature of cancer with sentiments like 'it could be anyone of us next', highlighting the sweeping and senseless nature of the disease.

Participants narratives pointed to how cancer forces a confrontation with mortality and how unbearable that is. Some participants spoke directly about their desire to deny death even in the face of its inevitability.

> the best word I … have been able to think of to describe my reaction to somebody dying … has been shock. … which I think to me means … that in the build-up to the death I have not been acknowledging that is…this is only going to end one way. It's been ….a wish not to acknowledge the prospect of death and then when it happens….i just find it so unspeakably shocking (P4:364).

> I don't like saying this but I was in denial. I didn't think he was going to die. …I didn't want him to die-—and I didn't think he was going to … Even though we spoke about death and dying all the time. I didn't expect him to die (P5:195).

> knowing that I was working in palliative care … I know I am going to be working with people who are dying. When I first started working it doesn't prepare you nonetheless for the shock. And how very hard it was to *even* think about it let alone talk about it (P7:86).

Participants reveal how often their clients presenting problems could only obliquely be linked to mortality revealing the real fear in confronting it. There were mentions of the fears of dependency in a society that 'tends to be anti-dependency' (P7:76). Mortality, death and cancer were all referred to as a taboo—to be avoided or simply denied.

P1 brought her valuable experience as a client after her own cancer diagnosis. Her therapist avoided engaging with her fears around cancer and death. I 'got a feeling that she could not almost bear it. I don't know if it *touched anything in her … or the vulnerability of the patient... she'd avoid it'* (334). If the therapist could engage with or simply accept the fear and the desire to avoid facing mortality in others and themselves, they would be more available to their clients. Opening oneself to the terror of confronting mortality proved both meaningful and liberating. His 'diagnosis…accelerated things in terms of development. He really turned towards life after his diagnosis…it took …the definitive idea that death was … on the cards. That allowed him to engage with life' (P5: 274).

Exceptionally evocative experience

Participants shared experiencing something close to a personal trauma. The intensely difficult nature of the work was conveyed emphatically.

> A very evocative thing to have happened, very painful… It felt really, really traumatic (P5:20).

> it's so … bloody difficult … I will only have one, one patient in a week with that situation. It is so draining and so painful and so hard … It's about three times as bad as negative transference (P8:345).

Participants shared their clients' intense feelings of isolation, helplessness, loss, terror, anxiety and injustice. 'I very much fear that he was deprived of time that he should have had. And I feel I was deprived of time I should have had to work with him. … I feel so cheated' (P5:258). The identification was also the client's unbearable feelings projected outwards. 'Whoever works with cancer there is going to be some anxiety… oh my God…have I got that … There is also a lot of projective anxiety' (P1:36). 'That dread that you might feel, … Its actually their dread … it's the weight of it all' (P8:367).

There were feelings of helplessness in identification with the patient and for the therapist who feels powerless in the therapy. 'It triggers … the powerlessness in the therapy…the impotence in the therapist' (P8:124). Participants used evocative language to describe the impact of this work. P5 had 'sleepless nights' (238) while she struggled with the decision to send the last bill; and P6 described feeling '*haunted*' (270) by her client's desire to remain in treatment.

Participants sit opposite some unbearable considerations in the transference. 'There are all sort of things that get evoked … there is the envy of the well therapist. …And that is difficult… because I think … it can't be spoken of and is a bit more unbearable' (P1:277). Participants share visual memories of the physical impacts of their client's treatments and disease revealing the embodied trauma and pain therapists are confronted by.

Seeking connections: Psychodynamic and cancer

This master theme focuses on the psychodynamic practice of participants in their work with cancer patients. Three superordinate themes emerged from the data that point to the powerful use of psychodynamic thinking and the navigation required around first the practice and frame and secondly around the perceptions of psychodynamic therapy for cancer patients.

A unique and valuable resource: Participants compellingly shared how they applied psychodynamic thinking to understand their client's psychic conflict. They drew links to childhood experiences: patterns of thinking or relating to others; traumas and fears evoked; complex and ambivalent feelings; and the symbolic meanings of cancer.

> It was cancer of the bile duct… so we have talked about his bile, and his hatred …. the anger that he had been unable to express throughout his life… the diagnosis gave him access to … what he had not been able to to express previously (P4:233).

> Some people would find it extremely helpful to have a space especially as they are facing something like… death to get in touch with their more aggressive impulses … their hatred and their nasty feelings, and the guilt which the psychoanalytical approach … allows (P4:588).

There is space for complex, ambivalent feelings:

> he got diagnosed with cancer and he thought great. His life had been so miserable … However he had two children…. what he came to me for – was he felt very, very, very guilty. And his first question was – should I get treatment? (P8:237).

This was expressed as very different to the support offered by loved ones, medical staff and charities that provided a gentler space in which positive thinking was encouraged. P1 reflected that one of the reasons that she left her role in the cancer charity was their avoidance of negative thoughts. She felt she could not talk about death anxiety and was expected to remain positive. Participants working psychodynamically in palliative care and cancer charities highlighted how the psychodynamic approach is very helpful in such places. P7 shared how the psychodynamic lens provides a deeper understanding not just of the client but of the functioning of the organisation and team.

Adaptations to the practice: Participants while reflecting on whether they had to adapt their usual way of working with cancer clients expressed how any adaptation was similar to anyone presenting with a live trauma. Participants felt comfortable to follow their instincts and adapt where appropriate.

> Did I change my technique with him a little bit. Did I become a little bit more concrete at times or you know directive? Possibly … the dynamic did change P5 (176).

Even while being confident of the need to accommodate the realities of cancer, three participants expressed doubts about whether their response had been sufficiently 'psychodynamic'. P2 felt she was drawn to offering reassurances at the time of the diagnosis adding that probably she found it easier to work psychodynamically after the treatment (174). P1 mentions offering flexibility to her client to attend hospital appointments but then mulled over whether she had been colluding with her client's chaos rather than containing (112). P7 in an emotive exchange with her client, wonders if her instinctive reaction was less psychodynamic.

> She looked at me in the eye and she said but I don't want to die and this is where… psychodynamically you might think just wait with that, I found myself compelled to say, I don't want you to die either (256).

The aberration from participants' regular frame was prominently observed with their missed sessions policy. Even those participants who have strict policies (charging for absences related to illnesses, hospital appointments, and a birth even) made exceptions for patients with cancer. All participants share how they readily and willingly offered more flexibility in attendance. P3 agreed to not charge the month that the client was in hospital. P8 worked over the telephone for the first time in his practice to continue therapy. P4 worked for the first time through the summer break. The rationale given for these adaptations was to accommodate the reality of the treatment or the feeling of responsibility felt because these clients intensely relied on them.

Dealing with perceptions: There were instances whereby participants reveal perceptions amongst practitioners, clients, society that questions whether psychodynamic therapy is right for someone with cancer. P2 quotes her colleague (with 21 years of psychodynamic practice) who questions P2's cancer specialism. 'People have support in their hospitals. They don't need to come outside and speak to a psychotherapist about cancer … that is not something that you are trained in' (526). One participant doubts her ability to help, wondering if her client is better suited to a more specialist therapy than what she provided. P5's client of 4 years, when diagnosed gave her the option to pull out, 'He explicitly said I know you have not signed up for this, … so I understand if you want to finish the therapy now' (63).

Instances were shared of participants' clients struggling to voice that they need therapy following their cancer diagnosis. Both a fear about the subject and uncertainty about whether psychodynamic therapy is the place for it meant cancer patients aren't sure where to turn.

The views society holds of illness may also have a role.

> I think there is this … patronising view … of needing support rather than needing to think about it as a trauma (P1:351).

> There is a general conception that when you are so ill you need someone really kind and very gentle … supportive. Not that psychoanalytical therapy is not supportive. It is. But in a very different way (P5:593).

DISCUSSION

It is clear that the subject of cancer and psychodynamic theory, and practice is under-researched and highly emotive. This research provides greater depth to the feelings and associations referred to in the literature. It provides fresh insights into the personal and professional experience of therapists. All four master themes were

present in each participants' narratives. The research findings are reliable and robust as each theme echo across all participants.

Cancer is deeply personal

A close encounter with cancer—directly or indirectly—changes you. The word cancer gets linked to ones' deeply personal experience of it. This fits with the literature on how cancer is experienced as so much more than a disease. The personal bond participants felt for their clients was particularly strong. Glimpses into this emotional connection was apparent both for clients that survive and particularly for those that didn't. Freud notes how 'Towards the actual person who has died we adopt a special attitude: something like admiration for someone who has accomplished a very difficult task.' (Freud, 1915, p. 290).

The personal dimension of cancer also presents in how it relates to the individual's specific internal world. This fits with the literature about how people react with personal meaning to cancer. References to clients' reactions link to childhood experiences and how it re-evokes traumas previously split off, although present in some cancer memoirs, has not been explored in research studies. Bergner (2011) draws attention to how therapists may feel a seductive pull into symbolism-based understanding to balance their own feelings of impotency while working with cancer patients however this is not supported by the experiences shared in this study.

The clients brought complex feelings with individual nuances that needed voicing, exploring or simply to be borne. P2 with years of experience with cancer patients comments on how she learnt to 'concentrate on the whole person not the cancer'. It is likely therapy is the only place professionals working with cancer patients can do that. Patients are otherwise surrounded by professionals categorising them by cancer-type, treatments, statistics, visible side-effects and measurable depressive symptoms instead of focusing on the personal experience of their disease.

Cancer brings a very different fear

The literature informs us that cancer is inordinately feared and that this fear transcends time, geographies and advances in medicine. This theme explores why this fear is so different and intense. The unpredictable, incontrollable nature of cancer directly links to humanity's ultimate unknown and ultimate fear—death. Other emotional consequences of cancer include depression, anxiety, relationship issues and suicide possibly links to the fear of having no control over your body and the terror of uncertainty.

The immense variability of cancer disappears in the fear-filled responses of most participants. Participants reinforce the view that cancer is associated directly with death and that society avoids engaging with death and dying.

P1's narrative offers glimpses into the client experience when her therapist couldn't bear to talk about her cancer. Clients are left very isolated when the reality of what they are facing cannot be talked about. Therapist's efforts in facing their

fears around mortality is a first step in helping clients deal with theirs. Instead of a collusion to avoid vulnerability 'the therapist must be a whole real human being—only then can the patient find himself and become a person in his own right' (Guntrip, 1977, p. 66).

The participants mentioned how the prospect of facing death accelerates the work. It 'provided a real catalyst to look at important issues' (P3), 'brings a focus on the self' (P1), 'gave him access to what he had been unable to express' (P4), 'became psychologically healthier' (P5), 'gave a tangible reason to ask for support' (P6), and 'creates an intensity of wanting to relate … to make sense of things' (P7). Straker (1998) highlights how time pressures by cancer often enhance the motivation for psychological change and allow the patient and therapist to work productively towards resolving long-standing conflicts.

Exceptionally evocative experience

Practitioners described this work as more emotionally challenging than other client work. The findings highlight the evocative nature of the work through the identification with the client's trauma and isolation, the fears aroused and the feelings of sheer helplessness. P8 comments on what makes this work so difficult.

> The thing … with long-term illness and death is that it's going to happen to us too. It's one of the few times that the therapist and the patient are in the same boat. The patient is going to die, and we are going to die (109).

Unlike with most clients where therapist may or may not experience their client's trauma—this is one trauma they will inevitably face. The embodiment of cancer in the room reminds practitioners of their own vulnerability (and of loved ones) to the exact terror the client faces. They are reminded of their own potential physical helplessness and ultimate death. The psychosocial dynamics around impairment and disablement (Watermeyer, 2013) are also likely to be present, especially as cancer treatments often result in disabilities. Awareness on supporting therapists in their training and supervision is advocated. One participant mentioned the difference she felt when the palliative care unit created spaces for shared grief within staff.

Repeatedly mentioned is how unbearable the phenomenon of uncertainty is. The awareness of the pressures of time deeply tests therapists' ability to wait for the therapy to unfold. In a world where death and disease is seen as a failure—this work tests practitioners rescue phantasies (Postone, 1998). A dying patient represents a failure not just of themselves but for all professionals who couldn't save them. Practitioners voiced an internal struggle. As P4 pointed out, 'therapy is not going to cure somebody's cancer … I am not going to be able to tell them how they can make this better' (303). Participants, however, found that they did have something to offer, with moving illustrations of the therapist's ability to 'hold' (Winnicott, 1956) and provide 'containment' (Bion, 1962).

Seeking to connect: Psychodynamic practice and cancer

This research highlights the invaluable support psychodynamic therapy offers to someone with cancer. There are helpful places that provide advice, support, information, shared experiences and encouragement, but psychodynamic therapy offers a unique form of psychological support in which dark, unacceptable thoughts, ambivalent, complex feelings and fantasies can be expressed, explored and contained. It offers a focus on the client's personal experience of their diagnosis alongside what the cancer has triggered and the psychological conflict it represents. It can be a space that recognises that 'each death was as individual as the life that preceded it and that the whole experience of that life was reflected in a patient's dying' Saunders (1996, p. 1600).

Splitting, projections, sitting with the unknown, life/death instincts, loss of omnipotence, the psychological impact of physical scars/ body changes, defences amid persecutory anxieties, a search for meaning, loss and mourning, psychic effects of surviving, reparation of damaged internal objects, attention to transferences and countertransference were concepts these practitioners powerfully and judiciously applied to generate an understanding of their clients. This research also reveals the extent to which participants made allowances in offering flexibility or missing payments, emphasising a willingness to accommodate. This is possibly influenced by feelings of helplessness or the anxiety of being aware of the finite time a client might have. Also, the therapist sits across very uncomfortable feelings like the 'envy of the well-therapist' (P1), so it is possible that the consequent 'guilt of the well-therapist' is managed through the offer of more flexibility. The reality of the participants experience was that clients usually attended and paid, however, *worries* about client's attendance are likely to exist. P5 shares what might be a consideration for many.

> 'It did cross my mind this might get very messy. I might not get paid … he might miss so many sessions. Am I going to charge for them … I think these are very important questions because you … have to earn your living' (573).

A psychodynamic practitioner with 20+ years of experience responded to the request to participate this way:

> People with cancer or any chronic illness are not available emotionally for long term psychotherapy and self-reflection on unconscious motivations to their patterns of behaviour. Even if they are in remission, they tend to lean toward CBT therapy for behaviour and emotional support.

This sentiment is unlikely to be unique. Recruitment to this study revealed that it is common for psychodynamic practitioners to not have worked with a cancer patient. Given the many years in practice represented by these practioners and the prevalence of cancer this is something crucial to reflect on. Questions around the relevance of psychodynamic therapy for cancer clients were raised by clients, colleagues and medical staff. This study identifies reasons why: avoiding

confronting mortality; helplessness; uncertainty on how the therapy can help; the emotional and practical consequences of working with cancer clients. And then there lies this belief that psychodynamic therapy is unsuitable for people with cancer—as a defence against the emotional availability demanded from the therapist.

IMPLICATIONS FOR CLINICAL PRACTICE

An understanding has been obtained through the *lived experience* of the therapist, giving real insight to their experience of the challenges, the significance and value of the work and the nature of how the process unfolds. The lived experience of these therapists may make an important contribution to understanding psychodynamic therapeutic work with cancer clients more broadly.

These findings provide direction and encouragement to psychodynamic practitioners to welcome work with cancer patients and reflect on their practice when cancer becomes the third object in the room.

It could help therapists currently working with dying/cancer patients to feel less isolated and more confident in the value of their work and in seeking support. In addition, hospitals and hospices can consider the benefits of providing psychodynamic therapy to cancer patients. This study challenges any perception that cancer patients are not available or keen to undergo deeper self-reflection.

The research highlights the significance of practitioners' need to acknowledge and face their fears and feelings around the topic of mortality. This can inform practitioners' work with all clients because the fear of death and disease are both universal and inescapable.

LIMITATIONS OF THE RESEARCH

The study is based on a sample of eight, which though is characteristic of an IPA study is nevertheless small. Several participants had personal associations to cancer. It is possible that a personal need to heal and help was present that may influence the findings. It is likely that practitioners with less life experience, more financial pressures, and anxiety about adapting their practice might have a different experience.

CONCLUSION

'To share a phenomenal world with someone else, you have to be willing to take their physical experience as a template for your own' (Vickers, 2017, p. 1460). This research with its phenomenological emphasis sought to understand the process and experience of how therapists bear and relate to the cancer-body of their clients. An understanding that is essential to bringing us closer to providing meaningful support to patients with cancer.

The findings are consistent with existing theory and literature reinforcing perceptions, fears, and the psychological impact of facing cancer. However, being a

qualitative study of lived experiences, it provides depth and dimension and an understanding of the nature of these fears, the feelings behind the emotional challenges and the impact of confronting cancer on people's psyche. The unique focus on exploring the psychodynamic practitioner's experience has resulted in an understanding with practical benefits on how psychodynamic practice interacts and connects with cancer.

Participants' experience touches on Kubler-Ross's moving reflections of her work – 'to be a therapist to a dying patient makes us aware of the uniqueness of each individual in this vast sea of humanity. It makes us aware of our finiteness' (Kubler-Ross, 1969, p. 247). The findings echo Straker's (Straker, 1998) experience that 'Dynamic psychotherapy with cancer patients is emotionally challenging, intellectually stimulating, and highly rewarding'.

Alongside the above, the recruitment process for this research and the perceptions gathered reveal that the role of the UK psychodynamic community in providing psychological support to cancer patients appears to be limited. Further research can bring a critical and informed understanding of the extent of this and the reasons. But in the meantime, we can turn to the findings of this study that point to how psychodynamic theories and their application have the potential to play a significant role in helping patients with cancer.

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