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By Murray Krelstein, MD [2]

As a psychiatrist who has cancer, I have developed a deep understanding of how clinicians can help patients who are facing the complicated emotional aspects of dealing with a potentially life-threatening illness. When it comes to cancer, I have been through a lot and have learned a lot.

The Chemotherapy Experience

I have learned many things since I first heard those three dreaded words: “You have cancer.” It would take a book to discuss them all, so I will explore only two topics...chemotherapy and people’s reaction to my having lymphoma. All the “chemo” I received was given intravenously, so the first step was to find a relatively permanent route of access into my body. Fortunately, my veins are accessible and so a “picc” line was inserted. Finally, after three tries to insert the catheter, a radiograph showed that the tip of the line was perfectly placed right next to my heart, where it stayed throughout my hospitalizations.

At first, the catheter was somewhat annoying because it had to be handled very carefully—both by the special staff whose job it was to keep the exposed end sterile—and by me, since I had to be very careful whenever I moved. However, as time went on, my connection to this little line became deep and meaningful as I became very attached to it—both literally and figuratively. I am prone to anthropomorphizing, and I soon began to imbue this little device with great affection.

This happened because right after it was inserted, bags full of different solutions started to arrive. My line started its 24-hour-a-day job.

Of all the bags that were hung—and there were a lot—I remember most clearly the one that contained a substance so toxic that the nurses covered me with a plastic sheet and only handled the drug after they put on special gloves. There I was...receiving a solution too toxic for others to get near—and it was being delivered directly into me, next to my heart so that it could be disseminated throughout my body as quickly and directly as possible!

This experience—and many others—engendered powerful emotions. But because no psychiatrist was working with me, I had no one to talk to about what I was feeling. At the teaching hospital where I was admitted, a team of different doctors ranging in status marched in twice a day. They asked how I was feeling and marched out. They were rounding and it was clear that their mission was not to sit and talk with me. The nurses were efficient and always made sure that they were giving the correct chemo to the right person, but they also were not interested in spending any time getting to know me or learning what was in my head.

I am fortunate to have a very supportive and loving family. My wife and two children came a relatively long way to visit me every day, but they were so upset to see me lying in bed with all the bags of liquids going into my body 24-hours a day that they were in no position to be able to deal with my feelings, and I did not want to burden them any further.

One day, a clinical study organizer (a nonphysician) came in to talk with me, and I started to cry. When she saw this, I had the sense that she was ready to call for a psych consult and was considering putting me on a 5150 hold! I stopped.

If a psychiatrist had been visiting me regularly, I would have been more than eager to share my feelings—and I would have felt much better. But I quickly learned that on a “cancer ward,” feelings were not of much interest to anyone except the patient.

I did not finish the clinical trial in which I had been enrolled because the medications were too strong. I was fortunate that I did not suffer from the horrible adverse effects that I had feared so much, but my bone marrow could not take all the toxicity. I was discharged to my local hospital and referred to a local oncologist when I became significantly neutropenic and was therefore disqualified.
from the clinical trial. At the local hospital the next day, I was fortunate to meet a compassionate oncologist who, although he did not know much about the psyche, was willing to spend time and get to know me. He learned that I cry easily, and he eventually didn’t freak out when I would suddenly start to tear up as we spoke. Another thing he learned by listening to me was that when I get sick, I have no desire to eat. I had lost 40 pounds by this time, and the doctor decided to stop pushing me to eat and instead used my good old picc line for parenteral feedings in between my ongoing chemotherapy. Once again, had a psychiatrist been working with me, I would have been much better off much more quickly. I finally made it out of the hospital after 2 weeks, but I was so weak that I had to use a walker for quite a while just to get around and not to fall. Now, 2 years later, I have gained my weight back (and then some). I have also regained most of my strength except for some permanent nerve damage in my legs. I also get fatigued a bit more than before. I go for outpatient monitoring and chemotherapy every 2 months, and a CT-PET scan every 6 months. I am still in remission, and I do not know what the future holds for me. By the way, I made a mistake and did not save that little picc line that was so instrumental in saving my life. It should be in a frame over my desk. I am hopeful that I won’t have a chance to get another one.

**People’s Reactions**

My family and I become anxious every 2 months before my tests, but we just endure and hope. I am blessed with wonderful friends who care for me a great deal. But not one has ever said more to me about my disease than “Hi…how are you feeling? You look great.” I am fully comfortable talking to my oncologist about my disease. If I felt the need, I would find a therapist with whom I could also talk. But, to be honest, I don’t think I could find one who could bear to hear what I might have to say—unless he or she was trained to work with cancer patients. For this reason, I strongly believe that there should be a psychiatric fellowship in oncology. If this existed, and if I knew someone who completed this course, I suspect I would go today just to talk periodically to that person. My family and friends are wonderful people, but they really can’t handle the terror that is cancer.

Because of my experiences, I can now understand much better how cancer affects the psyche. I have a private patient who is caring for a relative with metastatic lung cancer, and I am now much more able to help him deal with caring for her. There is no question in my mind that psychiatry has a vital role to play when it comes to dealing with a patient with cancer. I can only hope that psychiatry will someday respond properly—both with psychotherapy and psychotropic medications.

**Clinical Pearls**

Cancer is a very alienating and existential disease. I know of no other common disease that immediately causes so much fear, anxiety, depression, confusion, and a sense of impending disaster in a patient or his/her significant others when they hear the word “cancer” for the first time. When the diagnosis is first made, the medical world quickly becomes activated. If the patient is not careful, he soon finds himself in situations that could not have been imagined. Because of this, care must be taken to give the patient time to assimilate what has happened to him. The therapist can be very helpful in facilitating this process. By the time the diagnosis is clear, the patient has already been through a lot. The next phase is trying to figure out what the treatment options are, and which would be best for the patient. Here again, the therapist can be very helpful in overseeing this delicate and difficult process. The tendency is to act, and not to talk, and although quick action is certainly advisable, it must not take place until the patient has had a chance to express his or her feelings. The therapist can be essential to this process.

Many patients who have cancer are facing death and they feel very isolated. The issues are so serious and frightening that the talking that usually does take place concerns the disease—not feelings. These discussions often take place between the patient and the oncologist. But this is generally not a satisfactory experience; a higher level of psychological sophistication is required. Consequently, the importance of the presence of a therapist who is not threatened or scared by cancer is all the more magnified. A treatment team is usually involved in the care of patients with cancer. In my opinion, psychiatrists should always be part of this team; however, this is seldom the case. One way to remedy this dearth is for psychiatry residency programs to develop an oncology clerkship. Residents could learn
first-hand what the cancer patient and his loved ones are going through, while learning to deal with their own difficult and uncomfortable emotions that will arise during the course of a patient’s cancer treatment.

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