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PSHYCHOONCOLOGY

Informing cancer patient based on his type of personality:The self-sacrificing patient

George Kallergis
Department of Mental Health and Behavioral Sciences, School of Health, University of Athens, Athens, Greece

Summary

Imparting the bad news has become a hard task for the doctor, and is usually perceived as unpleasant by the patient to whom the bad news is revealed. It is vital that the physician's approach be tailored to the cancer patient's personality. Gathering by the informing process protocols already suggested the hardest step for the doctors to take is empathic understanding which, presupposes tailoring to the individual's needs.

The aim of this article was to describe the self-sacrificing type of personality thoroughly, so that any physician can make a diagnosis and tailor the information strategy to their needs.

As method of research was used the qualitative method through groups with doctors and nurses, while research within groups lasted for 5 years.

Assessing the denial mechanism is hard for a person that regards disease as punishment and propitiation. The physician must mobilize his countertransference, the sense he gets from the discussions with the patient and their overall communication. If he finds that the patient has self-control, then the approach of imparting the news resembles that of the controlling-orderly personality. If he ascertains that the patient has a lasting embarrassment, he should be more careful and impart the news gradually, his approach resembling that of the dependent person.

Key words: *indifference to comfort, modesty, self sacrifice*

Introduction

Imparting the bad news has become a hard task for the doctor, and is usually perceived as unpleasant by the patient to whom the bad news is revealed [1,2]. But there is one type of personality who makes doctors feel uneasily because either he does not react badly to the news or because he takes it in like something absolutely normal.

This type of personality is the self-sacrificing person. It is vital that the physician's approach be tailored to the cancer patient's personality [3-5]. Research on informing during the 1980s had aimed at quality rather than quantity. Indeed, the central question that had to be answered was: "Is it possible to determine who should be told what, when and how?" [5].

Gathering by the informing process protocols already suggested [6,7] the hardest step for the doctors to take is empathic understanding which, presupposes tailoring to the individual's needs. Kahana and Bibring have already argued for the use of personality traits in the psychological management of the psychically ill patient [8,9].

The aim of this article was to describe the self-sacrificing type of personality thoroughly, so that any physician can make a diagnosis and tailor the information strategy to their needs.

Method

This study was carried out at the Psychiatric Department of "Metaxa" Cancer Hospital at the end of 1980s as part of C-L Psychiatry and it is still in process

Correspondence to: Georgios Kallergis, MD. 11, G. Theotoki Street, 185 38 Piraeus, Greece. Tel: +30 210 60 40 681, Fax: +30 210 45 28 025, E-mail: gkallerg@nurs.uoa.gr
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at the School of Health Sciences of the University of Athens [4,10,11].

As method of research the qualitative method of research was used [12-14] through groups with doctors and nurses, while research within groups lasted for 5 years.

During the 5 years 8 groups were formed, 3 with doctors and 5 with nurses. The number of members in each group was 12-15 and the meetings lasted 90 minutes per week and took place for one academic year with total time 60 hours per year.

The group process was based on the training experiential group, taking into consideration the therapeutic factors, particularly the cohesiveness, interpersonal learning and universality, while the group coordinator should be trained in group psychotherapy [15-17].

The procedure of discussion was based on the inductive method and on the Socratic method according to Beck and Emery [18] and Perris [19].

The procedure took into account the following:

1) The Balint's group studies on countertransference feelings in the doctor-patient relationship [20,21].

2) The psychodynamic concepts in the understanding the medical patients [22,23].

3) The understanding of patient through the types of personality [8].

In the framework of C-L Psychiatry, in collaboration with the medical, surgical and radiotherapeutic clinics, the Psychiatric Department participated in training programs which discussed clinical issues over the informing cancer patients.

From the group studies and from the literature, especially the works of Kahana and Bibring [8,9], Schneider [24,25], Oldham [26,27], Manos [28], Livesley [29] and Reich [30], the profile of the Self-Sacrificing type of personality is drawing. As point of reference we used the Kahana and Bibring proposal [9] where it is suggested to employ characters or personality types for empathic understanding of the physically ill patient.

Results

The most prominent characteristics are a tendency to give *himself and self-sacrifice.* His recompense is to be of service to others and the society as a whole without asking for anything back, whereas moral recompense suffices.

The term of masochism is also employed to denote this personality's tendency to engage into actions that are turned against his wellbeing and his own interest. He also manifests a tendency to enter –and withstand - life situations of suffering and pain. The term "masochism" is accompanied by confusion since it is rooted in masochistic sexual behavior. This confusion goes back a long time; for this reason Freud spoke of "moral masochism" as against "sexual masochism". The term "masochism" would definitely direct one's thoughts to pathology, but we are dealing with normal traits, without specific pathological effusion. Therefore, we should avoid the use of the term masochism, since we found out in practice that it carries a lot of confusion still up to this day. It would be safer to employ more terms in the description of personality traits. Alas, the use of an epithet, in addition to confusion, also facilitates the labeling of people, which we must avoid at all costs.

The history of these persons thrives with suffering that may be associated either with sickness and adversities or what we simply call misfortunes and failures. Such a person faces life situations where he "saves", supports or hopes to change another person or persons who have been led astray. It often happens that because he comes across violent and manipulating people, he suffers serious financial problems and/or physical violence as a result.

His tendency to fall into misery situations is unconscious, and often others get the impression that he inflicts upon himself such situations. He tends to neglect his own comfort by attending others and this is regarded as offer by him. If something pleasant and good happens to him, he convinces himself to accept it by rationalizing it i.e. I had really strived for it, I had suffered terribly, so God repaid me for it. If he accepts it without rationalizing, he feels that something bad will happen that will counterbalance joy and happiness. When he gets sick he may accept the disease like a punishment and/or a relief to his emotions of guilt or to something that he feels he has done wrong or that he has committed some sin. He unconsciously perceives this misfortune like a chance to redeem himself and a chance to fight and stand up. His fundamental unconscious need lies in earning love, affection and acceptance through his offer, whereas he feels unworthy of these feelings without self sacrifice and pain.

To avoid any confusion to the above terms, the doctor should bear in mind that a person with self-sacrificing elements of moral masochism causes grief and pain to himself hoping consciously or unconsciously that he will succeed in doing some greater good. A typical example that helps shed light in understanding those terms is the case of a woman who, despite having suffered, been tortured or even molested by her husband, she tolerates her torment with the hope of achieving some greater good that would justify it. For instance, she hates to break the family apart; she believes that by acting so she helps her children (that wouldn't have to lose their father), and that she could even change her husband's attitude. Her

cycle of friends and relatives feel embarrassed and/or angry at her attitude because they see that staying in that marriage is far more destructive than leaving it. Their embarrassment and anger usually increase at their attempts to help her out of the marriage. Notwithstanding their efforts, nothing comes out of it and they sense this woman's passiveness. Unfortunately, even physicians may make mistakes by trying to make her strong enough to react and show her might.

In terms of countertransference, attention should be paid to the embarrassment felt by the physician when the patient does not stop complaining despite the progress already made. Thus, the following paradox occurs: the more he is consoled, encouraged and improvement is stressed upon, the more he complains and emphasizes on aspects of his illness that have not been improved. Embarrassment often leaves the physician hopeless, as he does not know how to treat this quiet, modest patient. Thus, he ends up avoiding him discreetly and politely.

The main approach for this patient is this: the effort to improve should be presented like a fight to get well not for his own sake but for his family's and children's sake. It would help to know beforehand which areas of life he devotes himself in i.e. family, some institution, children etc. In the absence of specific data, we should stress to him in general that he should be useful to others and to the society.

We should bear in mind of the mistake we tend to make in regarding this patient as suffering from depression. The patient looks like he has suffered a lot; he looks serious, modest, sad. Such an image leads the doctor astray. We are occasionally summoned by physicians to examine these cases in the context of C-L Psychiatry as depression is the main suspect. This differential diagnosis is important since the approach of a depressive person who accepts consolation is different than that of a self-sacrificing personality. To establish the differential diagnosis we should bear in mind that the emotional-hypothymic personality may manifest increased elements of a tendency to give himself and self-sacrifice.

These, however, are secondary to the basic, prevailing elements of the emotional-hypothymic personality. The self-sacrificing personality, as earlier demonstrated, causes embarrassment to physicians with the exception of those who share the same traits and those who are emotional-hypothymic personalities who show the maximum empathic understanding.

The denial mechanism is hard to estimate to a person who accepts illness as a punishment and propitiation. Despite the realistic front, the therapist senses confusion behind it. He usually abandons his fate to God's hands: This approach may be a way of dealing with denial, in other words, "I don't know why but perhaps God does".

The patient accepts the diagnosis with stoicism and so the therapist struggles to decipher the messages, what really happens in the mind of the patient.

If the doctor senses that this attitude shows self-control, he will impart the news using almost the same tactic as for the controlling-orderly patient. If he feels embarrassed, then he will probably avoid the imparting of unpleasant news, almost just like for the depending patient. Processing these countertransferring emotions will enable the doctor to adjust informing and the patient will feel empathic understanding which is always *the key to communication in a therapeutic relationship*, perhaps a bit more for the giving-self-sacrificing patient.

Discussion and Conclusions

The doctors and nurses attending the self-sacrificing personality have numerous difficulties in diagnosing this patient. So far they had known his expression in the erotic field and most of all the pathology. Thus, special training should be carried out in order to clear out the confusion. The self-sacrificing person gives rise to sympathy, as he is quiet and does not disturb the staff. Because the patient looks like as a depressive patient, the doctor must do the differential diagnosis from the emotional- hypothymic patient [31].

To establish the differential diagnosis we should bear in mind that the emotional-hypothymic personality [31] may manifest increased elements of self-sacrifice.

In order to evaluate the denial mechanism [10] the doctor should use his countetransferences feeling.

If the doctor senses that this attitude shows self-control, he will impart the news using almost the same tactic as for the controlling-orderly patient [32]. If he feels embarrassed, then he will probably avoid the imparting of unpleasant news, almost just like for the depending patient [33]. Processing these countertransfering emotions will enable the doctor to adjust informing and the patient will feel empathic understanding which is always *the key to communication in a therapeutic relationship*, perhaps a bit more for the giving-

self-sacrificing patient.

The self-sacrificing person and his family (Table 1): The self-sacrificing patient does not wish to involve the family but will not insist upon it either. To his family we should stress that the fight to deal with the patient's problem is worthwhile and will benefit the family as well. The amount of information supplied could be analogous to that supplied to the controlling patient [32] but in a milder way.

Summarising on the main points, we conventionally propose a scale of the degree of denial and the degree of information supplied to the patient, thus providing a point of reference for these parameters [34].

We take into consideration the main or fundamental characteristic: *the self-sacrificing element.*

- minimal - small - medium - large - very large

Main characteristic: self-sacrifice with a tendency to give himself to the extent that he consciously disregards reciprocation.

Attributes: history of torment, shows indifference to his own comfort, humility to the point of modesty.

Assessing the *denial* mechanism is hard for a person that regards disease as punishment and propitiation. He seems to be a realist, and the physician senses confusion behind his "depressive" front.

Compensation mechanism: guilty elements are turned into self-giving elements (as if he ought to pay).

The physician must mobilize his countertransference, the sense he gets from the discussions with the patient and their overall communication.

If he finds that the patient has self-control, then the approach of imparting the news resembles that for the controlling- orderly personality – and this is usually the case.

If he ascertains that the patient has a lasting embarrassment, he should be more careful and impart the news gradually, his approach resembling that of the dependent person.

If he insists that "God will take care of everything etc", he indirectly leaves all power to the physician as if he were God.

The approach of presenting his effort to improve his health as an additional fight and that he will be of use to others greatly facilitates the assessment of denial as well as the quantity of information imparted.

Family: He is not eager on letting the family get involved but without being insistent on it. Once the physician has dealt with his embarrassment, he will also assist his relatives to deal with their own embarrassment due to the patient's coping with the disease as if it were a punishment.

Table 1. Overview of the self sacrificing personality

Main characteristics : self-sacrifice, a tendency to give himself.

Attributes:

- History of repeated torments either from disease or misfortunes and failures.
- Unconscious tendency to cause their own miseries either by getting into difficult situations or reacting emotionally to unpleasant situations due to their increased sensitivity.
- They tend to be unconcerned with their own comfort and like to serve others.
- Despite their humility and modesty, they tend to show off their suffering.
- They earn others' sympathy and approval but also cause their embarrassment and nervousness.
- They have an unconscious need for punishment; to relieve unconscious feelings of guilt. Therefore, bad luck or disease may also come in the form of propitiation.
- Basic need: To earn the love, attention and acceptance of others despite their feelings of guilt.
- They always complain about how much they suffer because of their illness.
- Paradox: the more they receive consolation and encouragement, the more they complain and stress on elements of the disease that have not been improved.

Managements:

We need to present the attempt to improve his health as a fight to be well, so that he can be useful to others and help his family

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