FACING DEATH
Physicians' difficulties and coping strategies in cancer care.

Margareta Andröe
1994
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ABSTRACT: Even if the treatment of cancer has developed over the last decades 50% of the patients still die of their cancer. The doctor's way of dealing with his and his patient's anxiety must surely be of significance for the treatment the patient receives.

In the first part of the thesis earlier studies of physicians' stress and ways of coping are reported. There is a lack of systematic studies which show how doctors working with cancer patients adjust to this work. The aim of this investigation is to study cancer doctors' difficulties and coping strategies. The theoretical frame of the study embraces parts of psychoanalytical theory and coping models, emphasizing that both unconscious and conscious psychological processes play their part in the coping process.

The second, empirical part of the study includes 23 physicians strategically selected out of a population of physicians who work with institutional care and who have daily contact with adult cancer patients. The main method of data collection has been a series of recorded interviews. The focus of the interview was the physician's perception of how he reacts, thinks, talks and acts in different phases of the cancer disease. To illustrate the defence strategies of the interviewers, the projective percept-genetic test, the "Defence Mechanism Test" (DMT) is used. The "Structural Analysis of Social Behaviour" (SASB) has been used to study the doctors' self image.

The results indicate that the stated difficulties deeply affect the doctor as a human being. The statements reflect conflicting feelings and wishes in relation to authority, conflicting feelings and wishes in relation to frightening and injuring, conflicting feelings and wishes in relation to intimacy/distance. Thirty themes of coping strategies frequently recur and they have been grouped into seven categories. Most of the doctors "seek knowledge" and support from scientific literature. The majority of them state that attempting to "solve a problem" is their main strategy. Most of the doctors "seek support " as a part of their coping strategy. An interesting observation is that the doctors to a higher extent "seek a relation" to their patients rather than to their colleagues. Almost one third use "denial of the severity of a situation" as their main strategy. All the doctors consciously or unconsciously use "diverting strategies", i.e. undertake tasks which are devoid of contact with patients, such as research and administration or other activities which allow them to avoid the patient. One third use "projective manoeuvres" but this is never a main strategy.

In the third part of the study the credibility of the results and their pedagogical and practical implications are discussed.

Key words: Physician, cancer care, conflicts, coping, facing death, dying
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Physicians' difficulties and coping strategies in cancer care.

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Umeå universitets tryckeri
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In the mid-1980s I was out fell-walking with one of my best friends. We were talking about my job, my "work situation". She made a comment which really struck home, "You must be in a constant state of grief." She was right. What I had reflected over was namely the fact that half of my patients die. I kept losing them. It was not the case that my situation was different from other oncologists. The science of medicine has not come that far.

Naturally we have made very real progress in the treatment of certain forms of particular tumours but the "over all" survival rates we have not improved over the last ten years, despite all the advances in medicine and technology.

My friend could see the feelings that I myself had borne but which I had not intellectually perceived: grief and pain. My friend's remark lead me to an insight which has had major consequences for me. It gave me the idea of acquiring a better understanding of what my work entailed. Over the years I had been aware that I often expressed feelings which were regarded by certain colleagues as signs of weakness, by others as sensitivity and by still others as awareness. I could see how differently we doctors viewed death and separation. It became clear to me that there was a relation between how one viewed death and disease, how one mastered all the worry that one's work brings on a ward and how this in turn influenced one's work, i.e. the organization of one's work.

There were conversations about patients having different ways of coping with their illness. In such conversations it was often said that the patient "was taking it very well".

Doctors working with cancer patients again and again are confronted with serious and life-threatening illnesses. Every day we must do more than merely understand intellectually and tell patients about results. We feel cancer with our hands and see it in pictures and in the microscope. I have noticed that we doctors experience this differently. There was a time when I let myself be convinced that a certain way of acting and reacting was the correct way.

Step by step I came to understand what I had seen over the years, namely that certain doctors have strategies to cope with their work which offer the patient well-being but which "wear out" the doctor. Others have solutions which make the patient and staff confused and/or disappointed but which give the doctor satisfaction. There is probably a large repertoire of strategies.
This insight made me curious about how individuals deal with threats, distress and anxiety. Which initially was merely a desire to acquire for myself a new way of behaving which would be conscious and flexible led to me wanting to improve my knowledge and understanding of other cancer doctors' different emotional and behavioural responses.
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Part I

PROBLEMS, RESEARCH PERSPECTIVES AND METHODOLOGY
CHAPTER 1

PROBLEM AREA

Even if the treatment of cancer has developed over the last decades 50% of patients still die of their cancer. Probable cancer is still the most frightening of diagnoses. For most people who are struck with cancer the diagnosis brings on an existential crisis with a high measure of death anxiety. This the patient's state of crisis, has been the subject of research for many years and has given rise to knowledge on patients' attitudes and to a new way of working with the patient. What happens to the doctor is, however, of interest as well. The doctor's way of dealing with his own and the patient's anxiety of death must surely be of significance for the reception and treatment which the patient receives. A look at the literature, however, reveals an obvious dearth of systematically collected data on this area and there is a need for explorative studies.

The doctors' educational perspective

In order to obtain information about the patient the doctor has to establish a relation (Holm 1985) which can take one of many forms. The doctor interacts with another human being whether he likes it or not. The doctor's first encounter with a patient during his education may be a meeting with a dead body. This was the case at medical colleges in Sweden in the 1960s and it is still the case at certain colleges even today in the 1990s. At the same time students are recruited in Sweden as in other Western countries from a society where death is seldom present (Kastenbaum 1976). However, the clinical reality is that the threat of incurable disease, tantamount to death, is constantly present. "The doctor is confronted every day with other people's emotional imbalance, worry, suffering, fear of disease, bereavements and grief and is expected constantly to give priority to the patient's feelings and demands" (Holm 1985 p22-23).

The doctor has very little formal space to consider, both during the seven years education (Utbildningsplan 1993) and later during his professional life, the personal emotional reactions and possible difficulties which the doctor may bring along and which may be activated in the work with
seriously ill and dying patients. Medical studies entails the student to plunge, at an intensive pace, into the structure of the human body from a functional point of view as a system of genetic, molecular, cell-biological and physiological processes. Besides, he should be able to analyze and understand the complex system which the human body constitutes and above all to understand and attack the changes which can happen within this system, and which are referred to as pathological. In order to become a diagnostician the student of medicine needs this factual knowledge of the body's normal structure and biological processes to be able to detect the disturbances.

The pressure on doctors - "stress"

Doctors are prepared for intellectual challenges. The physical stress to which they are subjected to has been observed and described. During the 1970s and 80s there was a debate in Sweden, not at least amongst junior doctors, about long working days. As a matter of fact into the 1970s working hours legislation did not apply to doctors. During the 1970s and 1980s, the emotional aspects of the working environment were documented for other professional groups such as firemen, social workers and nurses (Maslach 1986). However, the emotional strains for doctors have not attracted so much attention (Fain 1989), except Balint (1966) who, as early as in the 1950s and 1960s, invited doctors to examine their own way of reacting and the consequence of their attitudes towards patients who did not comply with the prescribed therapy or who were not diagnosable according to some textbook model, i.e. heart and ulcer patients. During the last decade there have been alarming reports about psychological stress, self abuse and high divorce and suicide rates among doctors, the latter applying to female doctors in particular (Arnetz 1987; LARM 1987; Hellström M 1993; Hellström L 1982). The risk of doctors to burn out while treating AIDS sufferers, seriously ill children and when dealing with the victims of catastrophes and road accidents has been described (LeBourdais 1989; Fain 1989). Le Bourdais reports a conversation with a female doctor who looks after AIDS patients saying: "A doctor is just a short step away from God and we're used to thinking of ourselves as being so strong and not needing any help. We never get sick, we never burn out, we never fail. So it's hard for us to recognize when we are in trouble, hard for us to admit it to ourselves" (p441). However, the documentation is considerably less extensive with regard to doctors' vulnerability when caring for other chronic diseases than AIDS, such as
patients with cancer (Feifel 1965; Feigenberg 1976; Maguire 1989; Vachon 1987).

There has been a collective resistance from doctors to discuss in counselling/supervision groups, difficulties which are regarded by some as stress and by others as psychological discomfort. Allison (1981) describes a survey where students participated in discussion groups during their education. They left the groups even though the activity in the groups was committed. Many participants seemed to be genuinely interested in exploring their interactions with patients and their own emotional reactions. The reason why the students stopped attending the groups was the obvious rift between their clinical teachers and the group leaders who were psychiatrists. The students could not reconcile the teachers' apparently contradictory approaches towards medicine. Holm (1985) concluded that, "On the one hand, the students are studying to become scientifically trained and skilled clinicians, seeking so-called objective hard data and developing their intellectual capacity. On the other hand, in the discussion groups, an opportunity was offered to approach patients from a viewpoint where knowledge of emotions and insight into human relations were used to understand the patient as a whole person. The conflict was aggravated by some of the clinical teachers openly showing their sceptical attitude to the groups. In order to avoid this conflict of values and the discomfort which it brought, many of the students were forced to take their choice for or against one of the approaches. They chose the model which most enhanced the value of their education as a whole, i.e. the hard data model" (p 31).

McCue (1982) also claims that there is a reluctance to acknowledge one's emotional difficulties when one has spent up to a third of one's life bettering oneself and has expectations of one's profession which come into conflict with the reality on later encounters. He formulates the fear and notion that a doctor could possibly lose control, that a doctor could become emotionally too involved, which could prevent him from fulfilling his primary task, namely revealing the nature of the disease or injury, which is the foremost of Hippocrates' (460-377 B.C.) rules for doctors. It still guides for doctors in most parts of the world to this very day. But Hippocrates' medical school also had a second rule, to comfort and palliate, a very central tenet which Bennet (1987) expounds in "The Wound and the Doctor". He claims that in every doctor is a patient and in every patient a doctor. The doctor stands for power, knowledge and ability while the patient represents weakness, fear and helplessness. These two roles are never fully separated. No doctor is ever one hundred percent doctor and no patient one hundred percent patient. Rather there is a continuum. The doctor should be regarded as the expert which he is, but also as having the
weakness and helplessness which pertains to the role of patient: "For the practising doctor, the 'doctor pole' of the continuum is manifest and dominant, while the 'patient pole' is latent. But the latent weakness and helplessness is there, and, if it can be consciously accepted, it is what is meant by the contemporary doctor by the term 'wound'." (p208-9) It is Bennet's opinion that there is a "collective medical fantasy of the doctor as a person who is above human frailties, and who has to survive the hospital years as a kind of 'rite de passage'" (p7).

Training programmes which only focuses on the patient's feelings and behaviour are incomplete. Gorlin (1983) notes that the doctor-patient relation needs to be defined as well as the doctor's feelings and how the doctor deals with these also needs to be explored. The doctor's feelings about the patient, the disease and his own role affect the diagnostic acuity and choice of therapy, as well as the doctor's way of communicating with the patient and, in the long run, the outcome of the treatment. If only the patient's medical and psychological problems are taken into consideration throughout the course this implies that the doctor's psychological problems are trivial or should be repressed.

In her doctoral thesis, Holm (1985) shows that medical students during their education develop "instrumental thinking" and she refers to other authors who have made the same observation (Guze 1979; Parson 1951; Gorlin 1983). Gorlin (1983) describes a range of typical situations (chapter 2 p23) for example, that patients with incurable illnesses and the terminally ill make the doctor feel impotent and incompetent. His self-esteem falls and he feels frustrated. Patients in a state of emotional crisis give the doctor a sense of helplessness and loss of control. Other situations, for instance the meeting with self-destructive patients, may cause anger, whereas an over-dependent patient may initially give the doctor a sense of gratification which is followed by a feeling of impatience, guilt and anger. Whether or not these reactions are regarded as trying and stressful depends on the individual's attitude towards his own reactions (Lazarus 1984). Gorlin (1983) claims that a medical student who reacts strongly in the face of very ill and dying patients, at best, feels lonely. At worst, he experiences guilt, shame or bitterness. If the medical student understands that all doctors now and then experience positive and negative feelings and impulses, he can begin to consider whether he might share the reaction with someone else or whether it is very personal in the face of certain types of patient or certain diseases.
It does not necessarily have to be death itself which gives the doctor the feeling of, for example, being insufficient. Probably he can accept that there are limits to expert ability. The strain - "stress" - which the doctor feels may have other causes. That which disturbs or confuses does not need to be the situation or development itself but may be the surrounding preconceptions and delusions (Vachon 1987).

In this first chapter, I have described how the doctor during his education is trained chiefly to view the patient as an object and is trained to view himself as objective. However, the doctor is not merely an objectively replaceable instrument. He has both rational and irrational ways of acting, reacting and interacting. The doctor tries to assume control and to avoid a sense of incompetence. Research which expands this area is discussed in chapter 2. The way which he chooses is elucidated in this study using concepts from psychoanalytical theories and from theories of stress, which are described in more detail in chapter 3.
CHAPTER 2

EARLIER RESEARCH AND THE AIM OF THE PRESENT STUDY

Choice of search strategy

In order to answer the question how doctors every day, from year’s end to year’s end, cope with working with cancer patients, I embarked on a search for earlier documentation on the subject. I went through four databases, namely "MEDLINE", "PSYC" (Psychological abstracts), "SOCA" (Sociological abstracts), and "NAHL" (Nursing and Allied Health Literature). The focus of the search was doctors' reactions and attitudes towards cancer patients (searchwords were "doctor","stress", "anxiety", "serious disease", "cancer", "death", "psychological adjustment", "coping" and "defence"). Through MEDLINE only about ten articles were identified for the period 1966 to 1991. A couple of these describe how doctors relate to their own cancer (Mullan 1985; Stautemire 1983) and a couple describe the special vulnerability of doctors who treat children with cancer (Jankovic 1989; Mulhern 1981). Some other studies describe the communication between doctor and patient (Hill 1977) or consider doctors' attitudes towards death (Cohen 1982) or their need of further training to recognize mental disorders (Adams 1978). In PSYC (Psychological abstracts) 1967-1991 - with the same searchwords - ten more articles were found. Some describe the stress of cancer doctors (Ullrich 1990; Ahlberg 1987; Slaby 1986) and a few describe how doctors have adapted to their stressful work (Kahlra 1987; Strain 1986; Slaby 1986). Data searches through SOCA (Sociological abstracts) 1963-1991 gave the same references as PSYC (Kalra 1987). Searching through NAHL (Nursing and Allied Health Literature) gave a reference to an article on doctors' attitudes to informing a patient that he is terminally ill (Pacheco 1989). In order to obtain more articles a widened search on MEDLINE was made, i.e. I went in and studied titles and abstracts from the 1980s with a view to find interview studies describing how doctors experience situations arising at different stages of a cancer illness and how they then cope with these. I did not locate a single study. However, through the searchwords "empathy" and "patient-doctor interaction", I obtained some further references on doctors stress, reaction and coping in an article

On the other hand, several accounts of patients' ways of coping with the stress which serious and life-endangering illnesses bring have been published. Amongst others, Lazarus (1984) has in this context introduced the term "coping" and Weisman (1979) has reported his observations of cancer patients in the book "Coping with cancer". During the 1980s and 1990s, at scientific meetings such as the "European Conference on Clinical Oncology and Cancer Nursing" (ECCO) and the "European Society for Psychological Oncology" (ESPO), further studies of patients' ways of handling cancer illnesses have been reported. At these meetings, it has also been reported how caregivers experience and relate to their work with cancer patients. There have been several presentations of evaluations of training programmes for caregivers. However, few if any doctors have taken part in such training programmes with the exception of those offered and reported by Maguire (1985) since the mid-eighties.

The guilt of survivors, including staff and, in particular, doctors has been investigated. At the Nordic Conference on "Care at the End of Life" (Omsorg ved Livets Slutt) a paper was presented (Moe 1988) which referred to a British neurosurgeon, psychiatrist and stress researcher who has compiled his experiences in the book "The Wound and the Doctor" (Bennet 1987).

Analysis of earlier studies

In order to illustrate earlier research, I have chosen to present some studies in more detail. They exemplify how different methods have been used both in the collection and analysis of data. They offer examples of analyses both of statements taken from interviews, of observations performed on education courses and theoretical discussions on the basis of comparisons with other professional groups and experiences from therapy situations. In some studies concepts such as "stress" and "coping mechanisms" are used. Other studies describe the reactions which doctors have expressed in testing situations and how they adapt to and/or ward off discomfort in the situations described.

In the presentation of earlier research, I have chosen to present the different studies according to the different theoretical concepts which are variously described as: "stress", "emotional reactions" and "coping", as compared to "stress", "emotional reactions", "defensive manoeuvres" and "coping". I have grouped the studies on the basis of the concepts which the various authors
have used to illustrate the strains of the work and their consequences for the physician. After the presentation of the references, there follows a summary of the authors' theoretical perspectives and how these have influenced the layout of this study.

Stress, emotional reactions and coping

The authors of the studies being presented in this section have described not only the stress but also the emotional reactions in these stressful situations and how the physicians cope with these reactions.

The pediatricians Fain and Schreier (1989) claim that feelings of fear and vulnerability have not been permitted in the medical culture, i.e. it has not been permitted to express these feelings. They point to the necessity of support for doctors who have been involved in catastrophes of various kinds so that their reactions in the aftermath should be as small as possible. The authors write in their article, "Disaster, stress and the doctor", that they consider that there has been paid little attention to stress symptoms amongst those working in health care. They claim that great demands and expectations are placed on doctors. Their inability to save patients' lives can lead to feelings of failure and guilt. The authors refer to the body of knowledge which has been built up on post-traumatic stress in individuals and they emphasize that doctors are not emotionally immune. They claim that a face of indifference in doctors "may hide the coping mechanism which typically includes denial and detachment" (p92). Fain and Schreier offer examples of how feelings of despondency, frustration, anger, depression, desillusion, physical illness and guilt may be reduced. One method is to establish support groups that focus on certain character traits which can moderate the stress. Examples of such traits would be a high degree of involvement and a positive attitude towards taking on challenges. They discuss whether medical students should be trained to become aware of their own feelings of stress and they conclude that this is a necessity for coping with stress.

Fain and Schreier (1989) refer to McCue (1982), a doctor and who based his judgements on experience from training programmes and surveys made by other authors. It is not apparent whether Fain and Schreier base their observations on similar experiences. McCue reports in "The Effects of Stress on Physicians and their Medical Practice" that suicide is the second most common cause of death amongst medical students. The suicide rate amongst doctors is two to three times higher than in the rest of the
population and serious drug abuse is 1.6 times higher amongst doctors than amongst non-doctors. Doctors consult psychiatrists ten times more as the general population. McCue assumes that doctors' adjustment to stress leads to certain typical patterns of behaviour, such as emotional withdrawal. He gives the following example. The doctor avoids his family. The consequence of this emotional retreat, says McCue, is worry and suffering. McCue asks the question why doctors tolerate failure in their own family lives and why non-medical interests become uninteresting and lose their appeal. His conclusion is that, among other things, this is due to pressure from colleagues and fear of failing in their work. McCue holds that insecure doctors can maximize their contentment at the hospital, where they give orders and make important decisions, etc. At home the doctor is merely an ordinary spouse.

McCue (1982) gives another example of the physician's adaptation to stress i.e. social isolation. He claims that the phenomenon of withdrawing from non-medical life usually starts during the doctor's education and develops, to an almost complete avoidance of non-medical situations. He maintains that doctors are often locked defensively in authoritarian professional roles, which rarely are challenged by non-medical professionales. The isolation is difficult to break, because the doctors are defending themselves from society. This is further aggravated by the fact that non-medicals become delighted if a doctor reveals a vulnerable human face.

According to McCue, a further adjustment to stress is that the doctors and patients often conspire to deny complexities, uncertainties and limitations which are part of the medical reality. For example, the ordering of a lot of laboratory tests is used to protect against fear and insecurity.

Finally McCue (1982) states that doctors establish group support through a jargon of code words which often are cynical and insensitive. He says that this, the physician's best known and most despised adjustment to stress factors, for no obvious purpose, is probably the least damaging of behaviours.

McCue's (1982) observations show how vulnerable doctors are if they are not prepared for their own reactions to death and the suffering, the fear, the intimacy and the uncertainty they encounter in their interaction with patients. This can lead to dramatic consequences, such as suicide. McCue focuses on "negative" strategies. He believes that these negative adjustments to stress can be avoided by improved training of medical students which would provide them with an awareness of the implications of their work.
Gorlin (1983), a medical doctor, portrays both the emotional reactions and the behavioural responses in frequently occurring clinical situations. He based his observations of "Physicians' Reactions to Patients" on experiences from training programmes for medical students and doctors continued education courses. He differs from other authors in defining difficult clinical situations and describing doctors' reactions and coping strategies in these situations. According to Gorlin the physician's emotional responses in terminal illness and incurable disease have components of sympathetic identification, feelings of impotence, lowered self-esteem and frustration. The physician's behavioural responses may be denial, reluctance to discuss illness, avoidance of patient and family. He has also suggested how these negative emotional responses can be dealt with. Some examples of such coping strategies are the attempt to analyze and understand how to master feelings which lead to avoidance of the patient and also discussions with colleagues.

The keystone of Gorlin's (1983) programme is that medical students first learn to recognise and accept that destabilizing emotional reactions happen and as the next step accept that these are justified and understandable and finally learn to cope with these emotions.

Stress, emotional reaction, defensive manoeuvres and coping

In this section I present authors who describe stress, emotional reactions and the concept of coping in the light of defensive manoeuvres to avoid psychological distress.

Vachon (1987) described an individual's "coping responses" as comprising his ability to observe, and to comprehend his behaviour. She allies herself with Lazarus (1984) who by "coping responses" means "some of the things that people do, their concrete efforts to deal with the life-strains they encounter in their different roles" (p25). In her book "Occupational Stress in the Care of the Critically Ill, the Dying and the Bereaved", Vachon has presented an analysis of interviews with 600 health care professionals with different specializations and backgrounds, working in different departments at university hospitals and palliative care units, in homes for the chronically ill and community hospices in Canada, USA, Europe and Australia. 71% of the interviewees were women. Of the men 65% were doctors. Vachon's (1987) study is descriptive. Besides demographic variables, she studied the participants' conscious motivation for working with seriously ill and dying patients, their personal value systems and their "coping style".
Vachon builds her analysis of coping on perspectives which were introduced by Lazarus (1984) (chapter 3, p42). Lazarus means that the individual controls his stress partly by manipulating the cause of the stress, problem-regulation, and partly by checking his feelings towards it, emotion-regulation. As concerns cases of problem-regulation, Vachon points to the development of a group philosophy and the creation of support groups. The shaping of personnel and administrative policies, creation of formalized decision and supervision groups and training programmes, the ability to influence, the possibility of both variation in and control over the work and finally the possibility to change or quit the job belong here, as well.

Coping techniques which she primarily sees as emotion-regulating are the sense that one has the freedom to make decisions and that one has competence in the clinical situation. The ability to delimit one's field of interest, which means that one attains a sense of mastery over a limited area, should be included in this context. A further strategy which belongs here but which she regards as a problem-regulating strategy, is the lifestyle which one adopts, i.e. one's habits concerning exercise, diet, drugs. Those who worked in oncology reported this as the second most important strategy. Several of the participants expressed that they would not be able to work with dying patients if they would not have private philosophy about death. Vachon found that men gave this response more frequently than women and that doctors named this coping mechanism more often than other groups. The conscious or unconscious defensive psychological strategies cited by the participants are also included in this group of this group of emotion-regulating strategies. Vachon found that the participants tried to protect themselves from a identification with their patients. They withdraw from their patients to avoid feelings of helplessness and hopelessness. As an example of this strategy, she mentions the categorization of patients as diagnostic labels instead of people, i.e. the patient is depersonalized. She calls this a tactic of distancing and asserts that it may be far more than just a matter of physically withdrawing oneself from the patient. Furthermore, Vachon found that many health care professionals held that further training made it easier to work with dying patients. The improved knowledge and experience of dying affected both one's own awareness and one's ability to assert and apply both one's knowledge and one's ideas. Finally, humour was named as an important strategy of keeping pain at bay.

In conclusion, Vachon (1987) found that in regard to the controlling of feelings of stress, emotion regulation accounted for 64% of the identified coping mechanisms, while 36% were expressions of problem regulation. These proportions were the same for all specializations, professions and age groups and for both sexes.
Her survey is important in that it contributes to clarifying coping strategies in a vulnerable group, namely those caring for chronically sick and dying patients. However, her interest was not especially directed towards the situation of doctors. She has systematically analyzed participants' statements by using coping models and at the same time applying psychoanalytical concepts. However, the psychoanalytic perspective was not, specifically explained.

Maguire (1989), a psychiatrist, and with a long history of observing experienced doctors in training situations, focuses on how those defend themselves from coming into contact with the patient's psychological discomfort. In "Barrier to Psychological Care of the Dying" (1989) he describes how doctors constantly use distancing tactics so as not getting too close to patients' suffering and how they use these strategies to "survive". He sees a risk in the doctor building a barrier between himself and the patient. As an example of a distancing tactic, Maguire describes how the experienced doctor observes a patient's suffering and assumes that he "understands" why the patient is reacting as he does and actually answers the patient on this selective understanding. Typical manoeuvres, says Maguire, include giving false positive messages and having a selective perception towards things which distract from uncertainty or anxiety. For example, this may concern changing the subject of conversation. According to Maguire, these defensive manoeuvres are often unconscious. However, they are whether conscious or unconscious, in so far important, as they affect the dialogue with the patient.

The result of not wanting or daring to meet the patient may be that one develops a cynical, rigid attitude towards critically ill and anxious patients. One may find changes strenuous and may easily feel self-contempt. A considerably less self-destructive way of distancing oneself from the psychological distress is by using humour.

In this way, like McCue (1982), he believes that the doctor needs these defences in order to survive. Like all the other authors, Maguire holds that these defences can be moderated. An important step in this process is becoming aware of one's feelings and defence strategies.

Bennet (1987), a neurosurgeon and psychiatrist. He studied how people react to extreme physical and psychological stress. He has written a personal book from the doctor's point of view, "The Wound and the Doctor". In this work he describes the doctor's life and working situation. He does not refer to any particular study, but bases his observations and his analysis on an extensive reading of the literature, on his own studies and subjective experiences. In addition to an overview of the doctor's working
situation, Bennet gives an analysis of the doctor's behavioural response patterns and illustrates how these responses are reflected in his actions and behaviour. He bases his analyses on his perspective as a surgeon, stress researcher and psychiatrist within a psychoanalytical frame of reference. Throughout his work, Bennet uses the term "to protect oneself" to refer to the mechanisms which the doctor employs to maintain a "cohesive exterior". The physician must protect himself against an over-intrusive interaction with others. Bennet’s main aim is not only to describe the actions of the doctor but also to try to understand the doctor's needs. It is his opinion that male doctors, to a higher degree than female doctors, organize their work around their own needs.

Bennet (1987) finds it possible, by studying the individual's needs and the profit he gains through establishing a certain lifestyle, to make out the contours of the individual doctor's motivation. He claims that there is a considerable number of possible behaviours which the doctor may employ. The alternative which is chosen is intended, above all, to avoid anxiety. As described in chapter one, he asserts that when a doctor equips himself to care for a person with an illness, his medical awareness is activated. At the same time, that which Bennet describes as the patient part is activated: terror, helplessness and the longing for to be looked after. If this so-called "patient part" is repressed, the physician becomes an "all-knowing" doctor who acts as if disease were quite separate from feelings. The physician displaces the patient's experience which clashes with the rational doctor part and which does not admit any feelings. Furthermore, Bennet speculates, the doctor projects his unconscious patient part on to the patient, for example the need for intimacy and dependence.

According to Bennet (1987), adapting to the conditions of work follows certain patterns which are most clearly seen in doctors who have problems in coping with anxiety and psychological stress - pain - but which all doctors present more or less. One example is the physician who sets up a barrier of social distance between himself and the patient, pursues unique skills and esoteric knowledge which can only be practised by the doctor himself in certain places, i.e. medical temples. The following is a summary of how Bennet precisely illustrates his examples: The doctor sits face to face with a patient but with a large desk in between. The desk is covered with e.g. X-ray slides which symbolize the doctor's superiority. The atmosphere in the room is one of stress. The telephone is left to ring and people dash in and out, which prevents the patient from asking sensitive questions and even more from commenting on information from the doctor. The doctor sets up a barrier which prevents communication. The patient's opportunity to contribute is reduced which
means that decisions exclusively are made by the doctor. The doctor's power is based on his capability to intervene as no-one else can in situations of medical crisis. The ability to deal with a large amount of information gives the impression that the doctor is in possession of a vast body of knowledge, far beyond that of ordinary people. The doctor may use this belief to take control over his patients and the situation. The doctor may enhance his power in so far as he can maintain the patient's sense of insecurity in regard to the course of the disease and the effect of the therapy.

Bennet (1987) is provocative. His approach is interesting though because he does not merely study actions and behaviour but also illustrates the doctor's vulnerability and needs, to safeguard his fragile self. Bennet's important insight into the nature of the work can be exemplified by the following quotation: "The medical profession is powerful. Individual doctors are also powerful, and face to face with patients they can behave in ways which enable them to enhance their power and avoid their various anxieties...doctors are largely unaware of the ways in which they maintain their ascendancy over those they are employed to help" (p67).

Feifel (1965), a psychologist has in a frequently quoted study, "The Function of Attitudes Towards Death", examined forty doctors' attitudes towards death by means of interviews. He found that they thought less about death and that they were more afraid of death than three control groups, two consisting of patients and one consisting of non-professional health-care workers. Feifel points out that one should be aware that that which is taken for an attitude towards death may instead represent castration and separation anxiety just as well as over-protectiveness, fear of loss and of the unknown. Feifel's contribution illustrates the complexity of the feelings which the fear of death encompasses.

This brings to an end the presentation of the studies on physicians which were obtained from the various data searches undertaken. However, in October 1993 a study was published which is of relevance to this study. Holm (1993), by means of observations, interviews and psychological tests, has studied 40 physicians. They were surgeons and internists working in university clinics and smaller hospitals and general practitioners from the city and countryside. The aim of the study was to find out what strains the physicians were subject to and which psychological strategies they used to cope with these. In the analysis of her material she examined the external working situations, the various interactive contexts and the internal psychological states of the physicians. Many physicians said that problems due to the organization
were the most strenuous; one third thought that pressed time schedules were the most trying. The same proportion claimed that the stress was in dealing with the patients. A few described the treatment and diagnosis as problematic. A quarter of them thought that contact with the members of staff was the most trying aspect.

Holm (1993) grouped the psychological strategies of the physicians into eight categories, based on observations, interpretations and the physicians' reactions to her interpretations. She found that many were using a well-devised model for how to care for and handle patients and make decisions. They all sought better knowledge. Some were striving to develop their professional roles by means of continued education courses in interaction and empathy. Several underlined the importance of taking time out to reflect over things. Most of them wanted to act immediately, i.e. they tried not to put things off but to be resolute. Some made use of complete concentration and mental presence when dealing with the patient. Several named the importance of seeking stimulation through fleeting contacts with their colleagues. Some made use of jocularity, a few constantly. Some of them habitually used rigid defence mechanisms such as intellectualization, rationalization, denial, reaction formation, transference or compulsive activity. This study is of special importance because Holm has systematically investigated experienced physicians. Her starting point has been that the term coping embraces both conscious and unconscious actions and attitudes as well as unconscious defence mechanisms.

This concludes the presentation of studies on physicians' stress, emotional reactions, defensive manoeuvres and coping. However, some studies have been conducted with the purpose to examine other health care-personnel's attempts to avoid psychological distress in their work. For example, Menzies (1970), a psychologist, carried out a well-known study of nurses where she exemplifies how striving to avoid anxiety in the practice of medicine leads to the development of a social defence system. This system's method of functioning is determined, amongst other things, by the members' psychological needs for protection against psychological distress. This protective or defence system develops in time and is the result of a "secret", unspoken interaction and agreement, often unknown to the participants in the social context, e.g. a hospital department.

Menzies (1970) claims that these organisatory, socially structured defence mechanisms tend to become a "culture", part of the "external reality" which old and even new participants in the context have to adjust to. The purpose of the nature of the social defence system is to help the individual to avoid anxiety, guilt, doubt and uncertainty.
Consequences of previous research for the design of the present study

The above account of earlier research demonstrates that there is some knowledge about what doctors experience and how they react in their work with seriously ill patients. Fain (1989) Holm (1993) McCue (1982) and Vachon (1987) use terms such as stress and strain. Bennet (1987) Gorlin (1983), Maguire (1989) and Feifel (1965) describe situations as anxious. A recurrent theme is that doctors adjust and develop defensive manoeuvres against stressful feelings and situations. The strategies which the doctor uses to adjust to situations are described using concepts which can be traced back to psychoanalytical theory such as avoidance, distancing, denial, projection and repression (Bennet 1987; Fain 1989; Feifel 1965, Gorlin 1983; Holm 1993; McCue 1982; Maguire 1989). Vachon and Fain use the term coping for adjusting by means of seeking knowledge, support, lifestyle, etc. They use and define coping as a "conscious problem regulating or emotionally regulating behaviour" and assume that earlier experiences are significant for the evaluation of every situation. Holm uses the term "coping" and "psychological strategies" alternately. She holds that coping has a broad meaning embracing a combination of many different strategies, including defence mechanisms.

It is interesting to note that all the authors write about the importance of having a double perspective, i.e. focusing on the inner, emotional (psychological) world and the outer world of actions and behaviour when analyzing adjustment to stressful and anxiety-provoking situations as part of patient care.

This review of the literature shows that there is plenty of knowledge about clinical situations which are strenuous for physicians.

The studies have had a particular focus on physicians in an educational situation. However, there is an obvious lack of systematic studies of how doctors with many years' experience of working with adult patients cope with their work.

There seem to be no studies which cast light on the conflicting feelings and wishes which such situation evokes. Our knowledge about cancer physicians' coping is limited to separate observations in educational situations. There is a lack of studies which explore the strategies which exist whereas at the same time there are studies which perpetuate the myth of the doctor as the unmoved, elevated and dissociated doctor/family member.

The objective of this study is to explore the emotional and behavioural response patterns of doctors in their work with critically ill and dying patients.
patients. By means of a series of interviews, I wish to describe difficult situations and reactions by focusing on doctors with many years' experience of exclusive responsibility for cancer treatment. Finally, I wish to analyze the strategies used from the perspective that Bennet (1987) Holm and Maguire (1989) introduced, namely to examine whether they have a need for defensive manoeuvres. The starting point of the present study is to study doctors' inner worlds. It is my assumption that there occurs both unconscious and conscious activity in this world and that doctors, to some extent, reveal defensive manoeuvres in their behaviour. I assume that the doctors use these defensive manoeuvres to protect themselves from conflicting feelings and discomfort and to attain a state of psychic equilibrium and to maintain their sense of competence.
The aim of this study is to investigate experienced doctors':

1. difficulties in their work with cancer patients and to illustrate these problems through looking at the conflicting emotions and wishes which they reflect.

2. adjusting to, "coping" with, their work with cancer patients and clarifying the concept "coping" in the sense of avoiding anxiety.

In order to be able to cast light on difficulties and coping in line with the stated aims, I have chosen a theoretical framework emphasizing that both unconscious and conscious psychological processes play their part in the individual's various attempts of solutions at a given time in a given situation.

In the next chapter, psychoanalytical theories are partly presented together with the concepts which form the basis of this analysis of cancer doctors' problems and adjustment to their work.
CHAPTER 3

RESEARCH PERSPECTIVES

In the following chapter, the theoretical perspectives of the study are presented which embrace parts of psychoanalytical theory and coping models, emphasizing that both unconscious and conscious psychological processes play their part in the individual's various attempts for solutions in a given situation. I have chosen these theoretical frames of reference because they offer the concepts which I find useful for the study and description of individuals' attitudes to threatening and strenuous situations.

Psychoanalytical concepts which are relevant to this study

Sigmund Freud (1856-1939), the "father" of psychoanalytical theory made some basic assumptions which are particularly interesting for my study; that unconscious forces control the way we think and behave; that there is a complex interaction between our needs and their gratification; that the human psyche strives for balance, i.e. it avoids conflicts. How conflicts are resolved is influenced by earlier experiences, both conscious and unconscious. This striving for balance may be understood in the light of the individual's background. Earlier experiences control the way we meet difficulties here and now. The confrontation with a new task may be associated with more or less realistic perceptions of danger which, in their turn, have to do with expectations of failures and their consequences. These are basically the same: being left alone, inferior and bereft of one's strength, without the possibility of satisfying one's most basic needs and wishes (Sjöbäck 1984). We endeavour to avoid/defend ourselves from these threatening situations and employ strategies to avoid inner unconscious conflicts and to attain inner balance.

Below follows a presentation of the theoretical concepts which figure in this study.

One of Freud's models of the human mind is the structural theory. He describes the psyche as divided into three "systems" - the Id, the Ego and the Superego - i.e. three systems which are characterised by their different "tasks" and ways of functioning. The first system is the Id, which is totally
unconscious and is the source of our psychic energy. The second system is the Ego. This has both conscious and unconscious levels. The Ego tries to co-ordinate information from both the inner and outer worlds. The Ego tries to adapt and compromise between the demands of the outer world while at the same time trying to satisfy the individual's instinctive needs. If the compromise does not succeed then the Ego can distort information from the outer and inner worlds in order to reconcile conflicting needs. To help it in its work, the Ego makes defensive manoeuvres which will be discussed later (chapter 3 p36). The Ego has the ability to put off the immediate satisfaction of needs demanded by the Id and adapt the manner of their satisfaction to the demands of the individual's environment and personality. The Ego strives to adapt the individual to reality.

The third system, the Superego, is mainly unconscious. A conscious part of the Superego, called "conscience", is formed through the internalization of prohibitions and punishments during childhood. This gives rise to our moral values and our ability to feel guilt.

The subjectively experienced element of one's person is called the "Self". One's experience of oneself includes both experiences of one's body and soul. The Self develops in one's relations to others. One school of psychoanalysis is Object Relations theory. It focuses on the relation between inner self- and object-representations (Igra 1983; Winnicott 1971). This theoretical approach highlights how important our earliest relations are for our Self-image and attitude to the world around us. An early experience of "good mothering" gives us knowledge of what trust is. This knowledge then manifests itself as a sense of security and an ability to build new, trusting relationships.

**Intrapsychic conflict and guilt**

In the psyche's endeavour to avoid negative feelings, conflicting interests may arise. Intrapsychic conflicts arise when conflicting interests cannot be resolved. Throughout our lives there is a constant interplay between conflicting feelings and wishes. In Developmental Psychology the assumption is that we have all been confronted with and forced to try to resolve conflicts in some complex situation. We all have unconscious memories which are activated when one meets situations which remind one of the early experience. The feeling or the symptom which one associates with conflicts in people's inner and outer life situations is discomfort or, when stronger, anxiety.

Below follows an account of examples of intrapsychic conflicts which are relevant to this survey.
Love and hate. One may feel split, ambivalent towards a person. One can feel both love and hate and these emotions are present simultaneously. Some individuals can not cope with this. Normally they solve this by repressing one or other of the components in the conflict of ambivalence and/or they distance themselves from the person.

The non-damage/damage conflict is a variety of the love/hate ambivalence as it is characterized by aggressive impulses (Haak 1982). The feeling that the treatment may injure a person is frightening for the patient but also for the doctor. The desire to give treatment may include an aggressive attitude or awaken aggressive fantasies but it may also be a reaction to the physician's feeling of a threat from the patient and wishing to prevent the patient from becoming angry or anxious. Such aggressive impulses must be neutralized. This can be done by intervention of the ego. One "tackles" rather than "attacks". Haak (1982 p126) offers by way of an example of a situation where an impulse to injure forces its way through the ego's modifying ability when a surgeon encounters a trying situation which he can not cope with but instead "regresses to primitive levels". The previously neutralized aggressive energy with which he has performed surgery satisfactorily may become operational. The surgeon's superego attacks him for cutting up his patients. He becomes scared of being overtaken by his aggressive impulses and becomes uncertain and anxious because of this conflict, which hinders surgery. He becomes tired because so much psychic energy is engaged in this conflict. Another example of this conflict is the physician's ambition to give information which is founded on facts but will also frighten the patient.

Being big/being little. People who are subjected to a situation which brings more demands than they can cope with, often revert to some earlier stage of their development. It may be a matter of a situation which reminds them of childhood events when experience or fantasies have put a premium on unawareness. "Being special", competing and winning, may have been punished in childhood, or at least the child's fantasies have, which prevents the person daring to go into a new situation where one has to perform and take responsibility. The oedipal complex which in developmental psychology takes place between two and a half to six years is the most fundamental of all competitive conflicts and entails "desires for the destruction or disappearance of all rivals, usually the fathers/(mothers, my parenthesis) and a longing for "an exclusive ownership of the mother/(father, my parenthesis)". (Brenner 1968).
Intimacy and distance. According to object relations theory, the self develops in interaction with a "significant" adult. The development happens in an ever more obvious fluctuation between intimacy and distance in relation to this adult. The distance is necessary for the individual to test new ideas and create his own model of understanding. At the same time, the child experiences the meaning of intimacy as protection against perils and allowing identification (chapter 3 p39). The individual may have experience of being prevented from establishing distance. He may have experience of being far too close so that he has lost his ability to think and experiment in his own and new ways.

Defence theories

One of the basic assumptions of psychoanalytical theory is, as described above, that the psyche endeavours to resolve the emotional conflicts which arise as a result of conflicting feelings and wishes so that anxiety is avoided. In the mentally healthy adult, conflicts between adult and childish parts of the personality are not generally very noticeable. The individual has developed a repertoire of behavioural responses. These have developed during the early years of childhood but are, throughout life, constantly being reformed. Certain typical behavioural responses can be seen which the individual perceives as satisfying, or at least as causing as little discomfort as possible, and which have developed in relation to other significant persons. These learnt behavioural responses are often partly conscious. But in situations which are particularly demanding for the Ego, unconscious defences may be employed. One defends oneself against intruding impulses. It is not only "unpleasant" instinctive desires which one defends oneself against but also the signal foretelling an "unpleasant" situation activates defences. This entire procedure, "intruding impulse - fantasy around the threat - signal anxiety - defence", takes place on an unconscious level, even if one can sometimes notice the tensions consciously, e.g. in the form of discomfort, irritation, restlessness, worry or gloominess.

Defence mechanisms are only possible if a psychological development level with a more or less developed Ego functioning has been attained. The basic defence is repression. The other defence mechanisms reflect different aspects of repression.
Below follows a summary of the classic defence mechanisms with references to Freud (1936), Haak (1982), Sjöbäck (1984), Cullberg (1985) and Klein, as revised by Igra (1991) and Sjögren (1988).

Repression
This basic defence mechanism entails emotionally charged ideas which conflict with the ego's own interests being totally excluded from consciousness and sparing the ego from dangerous or threatening experiences. Controlling oneself, wilfully suppressing aggressive impulses is not repression but requires a certain maturity and integration of the ego. Usually repression alone is not enough, but the ego employs other defence mechanisms whose function is to deal with the impulses which repression can not manage. The following defensive manoeuvres are examples of closely related defence mechanisms.

Reaction formation
Reaction formation means that forbidden or ego-threatening tendencies are not only repressed but also that an attitude arises in the ego which is the repressed tendency's diametric opposite. This mechanism entails a behavioural tendency in the ego, which is the direct opposite of the impulse one is trying to repress, being reinforced and exaggerated. This defence is directed towards impulses and activities which have a clearly aggressive aspect. The result may be stiff and basically "cold" and ambivalent courteous conduct.

Isolation, intellectualizing
Isolation means that the emotional content of an idea is repressed and isolated, even though the action or impulse itself may be conscious. A special form of isolation is intellectualizing and rationalizing (see below). Intellectualizing means that painful and emotionally difficult events are discussed only in technical terms and one can act "coldly", without feeling. The feeling is kept at bay by the use of unfeeling reasoning. The ability to isolate and intellectualize may be a necessity in certain situations, e.g. in health care where work which must not be hindered by emotions sometimes is necessary.

Rationalization
Sjöbäck regards this defence mechanism as an example of a defence, which means that behaviour, a feeling or an action whose real reason is not compatible with one's self-esteem or one's ideal self is reformulated. By pointing to only one or two, of many possible, motives for one's behaviour
it is possible to keep the other motives which are unacceptable to one's self-esteem out of one's consciousness. As examples, Sjöbäck mentions choice of career, e.g. the doctor's, who probably has several motives. Some of these are unconscious and not compatible with the interests of the ego or superego and are therefore kept out of consciousness by means of that so-called good, acceptable motives are brought to light. This mechanism Sjöbäck regards as closely related to displacement.

**Displacement**

Displacement means that an unacceptable impulse or idea which the ego can not countenance is transferred and attached to an object or a situation which is more acceptable. By means of this mechanism one can achieve a delay in the emotional expression. An important type of displacement is sublimation, which requires a mature superego. An interest is transferred or attached to an area which is more acceptable to the superego. Freud and the early psychoanalysts claimed that intellectual activity, the desire to explore and curiosity in general were the result of the displacement to more neutral objects of sexual curiosity. Sjöbäck underlines that this type of displacement does not need to be of a pathological nature but may, under certain circumstances, give rise to productive motives.

**Regression**

Regression may be a defence strategy, i.e. a defence against discomfort and anxiety, and it means that one reverts to more primitive, childish behavioural responses. This means that one does not make use of more adult parts of the personality. One does not intellectualize or rationalize but adopts a helpless attitude and demands to be looked after. But regression is also described as a psychological mechanism which does not always need to be a defence. Play often involves a return to creativity. It is often claimed that we are not encouraged to be childlike with society's values as they are. "'Regression for the sake of the ego' means the ability to relax 'childishly' in play, sexuality or artistically creative work" (Cullberg 1985 p76). This can only happen if one is still in touch with one's earlier stages of development and childish needs. Cullberg means that "one regresses either in action, e.g. by soiling oneself or drinking or fighting, or in thought by looking for magical solutions such as idealizing or vilifying a person" (Cullberg 1985 p76).

The defence mechanisms which have been presented above and which are often called the "higher" mechanisms require a mature ego which delays impulses, distorts them and maintains different perspectives, "both one and the other". The primitive ego has a smaller register and perceives things as
"either one thing or the other". "The mechanism of splitting is one of the earliest ego mechanisms which, together with denial and omnipotence, have the same function as repression does at a later stage of ego development," writes Klein (1988). These mechanisms are complemented by projection, introjection and projective identification which entail and reflect splitting and the inability to maintain two perceptions or feelings simultaneously.

Denial
Denial may be regarded as a special form of repression. Cullberg defines it as avoiding to see and perceive threatening aspects of the inner and outer reality.

Projection
Projection may be said to be a specific form of transference in the inner psychological world from the self to the object. Projection is in fact, like regression, a general psychological mechanism which occurs in a number of different forms which are not all of a defensive nature. The defence mechanism of projection entails the transference of one's own "forbidden" and repressed impulses on to other object representations. The projection of aggression offers much scope to vent one's own aggression. In this way one can rid oneself of the content of the idea or feeling which one has without having to take responsibility for the feelings that this provokes in others.

Introjection, identification
Introjection may be said to be the opposite of projection. It is also a general psychological mechanism which only under certain conditions is of a defensive nature. Introjection as a defence means that an object in the outside reality, i.e. the idea/apperception which represents it, is admitted over the border between the "outer" and "inner" realities and is given a place in the inner psychological domain. This type of introjection mostly happens during the early years of childhood. It may be characterized as a very primitive process by which the object or person in the environment establish themselves as more or less independent, even ego-strengthening, gestalts in the deeply unconscious domain. Introjection is the basis of and an aspect of another important mechanism, identification. Identification means that one takes on character traits, motives and interests from other people and integrates them into one's own personality. Identification differs from imitation which does not require an emotional involvement.
Splitting
At an early stage of development, the ego can not cope with guilt and anxiety. Experiences of good things and bad things are split in such a way that certain people are idealized and other people are vilified. Even the person himself may have a good and a bad aspect which are integrated in the "mature" individual. "By means of splitting, the sadistic and idealistic needs are kept separate" (Cullberg 1985 p78).

Omnipotent control
In a wish-fulfilling "fantasy-hallucination" about constantly having one's "hunger" and needs satisfied, a number of defence mechanisms are at work, says Klein (1988). One of these is the omnipotent control of the outer and inner object. Klein describes this defence as denial in its most extreme form. It entails a negation on every frustrating object or situation. The consequence is that the experience of frustration, both the object which brings it on and the unpleasant feelings which it entails, seem to have ceased to exist. They have been negated and by this means the child/individual attains satisfaction. According to Klein, these processes are also present in the case of idealization. It is her opinion that the "omnipotent conjuring up of the ideal object and the ideal situation and the equally omnipotent destruction of bad, persecuting objects and the painful situation are processes which are based on splitting from both the object and the ego" (Klein from Igra 1988 p220).

Projective identification
Projective identification is an interactive mechanism in contrast with the other mechanisms which are intrapsychic. The child's outward projective placing of good and bad parts of his own world is, according to Igra, the basic form of what Klein calls "projective identification". The object of the projection is experienced as identified with that which is projected and has its goodness or badness reinforced. According to Cullberg, this gives the individual an opportunity to exercise control over another individual,"because the latter unconsciously may come to accept the mental content which is loaded on to him with the result that he is drawn into a guilt-relationship. The fantasied control becomes a real control" (Cullberg 1985 p78). But at the same time, if the other "can carry this projective identification without acting along" then he can, Cullberg says, "give the patient an opportunity to learn the difference between his inner representations and the reality of the outer world" (p79).

In the above, I have explained how the interaction between the inner psychological world and the outer reality can be described using
psychoanalytical theory. It is my intention in the present study to show how this psychological interaction affects our behaviour in situations which evoke conflicting feelings and emotions. There are other concepts which occur in theoretical models of individuals' behavioural responses in situations characterized by threat and/or stress. Below some of these concepts are presented because they are relevant to my analysis in the study as well.

The concept of coping

The term "coping" often occurs in stress-research with the sense of an attitude towards stress and difficulty. The term is derived from empirical experience and has come to be used especially in the study of patients' ways of dealing with serious illness and, above all, cancer. In this context it was introduced in the 1960s chiefly by Lazarus and Folkman and was presented in a series of different publications (1980, 1984, 1986).

The evaluation of stress

Lazarus (1984) defines psychological stress as "a special connection between the individual and the environment which is perceived by the individual as painful or as being too much for his resources and threatening his or her well-being" (p19). Lazarus considers that every individual makes an evaluation of every situation. He assumes that this "cognitive evaluation" is a process which is influenced not only by the objective external environment but also by one's individual understanding and personal desires. Each individual is presupposed to have a subjective image of both the inner and outer realities. In every testing situation he makes a primary and a secondary evaluation. The primary evaluation entails first estimating the content of the situation in terms of possible loss or threat. Then a secondary evaluation is made. This new evaluation entails sizing up one's possible choices in the situation and one's resources to deal with it. Lazarus presupposes that one's ability to evaluate is determined by so-called personality factors which affect one's handling of the situation and one's vulnerability when under stress. Lazarus says that everybody has individually formed and culturally determined value systems through which one regards the world and which affect one's understanding of personal control. He emphasizes that it is significant to the individual if he knows what would bring well-being in a given stressful situation. Things are made easier if the individual's understanding of the event and the feelings it
evokes can be improved. Better understanding makes it easier for the individual to deal with the situation.

Lazarus then says that situational factors also affect one's ability to evaluate. Examples of situational factors would be if the situation is new and uncertain or if it is predictable. A lack of clarity in one situation may be threatening whereas in another it may be used to reduce the threat. The degree of probability of an event developing in a threatening direction determines our perception of hope. Lazarus also underlines that there are "temporary factors" which influence the individual's ability to evaluate. Time is significant to our perception of hope, e.g. the amount of time it would take for a threat to be enacted. Duration, that is the length of time that a trying situation continues, is also significant for the behaviour, i.e. if the current situation is chronic and intermittent or chronic and continuous.

The coping process

Lazarus (1984) describes coping as a process which entails "cognitive and behavioural efforts to deal with outer and/or inner demands which are perceived by the individual as painful or beyond a person's resources" (p141). He claims that there is no clear division between coping and defence strategies. The object of coping is to deal with a situation not to master it. He emphasizes the importance of the primary and secondary evaluations respectively in every situation and the interaction of demands and resources within the individual. He describes coping as a process which may be observed through a person's utterances and actions in a given specific situation and in a given "context". These actions change with time. Lazarus claims that coping has definite functions which he describes as partly affect-moderating and partly problem-solving strategies. The former means that one's stress is reduced through, for example, belittling or redefining the situation which may entail different degrees of "self-deception". The latter, problem-focusing strategy means that one makes changes in the world around one, e.g. in an organization. He claims that resources such as health, positive belief, problem-solving and social talent, social support and material resources facilitate coping. On the other hand, barriers to coping would be things such as internalized cultural values or beliefs which prohibit certain feelings and activities.

Lazarus offers some examples of "significant" coping strategies. Amongst these are the ability to seek information and activity while at the same time, in another situation, the ability to refrain from action may be a way of dealing with the situation, i.e. the ability to refrain from impulsive actions. The ability to re-evaluate, deny and intellectualize Lazarus names as examples of an intrapsychic coping process and he claims that the ability to
see the opportunity offered by seeking support, turning to others, is a significant strategy.
Lazarus (1984) assumes that the evaluation and coping processes affect the individual's adaptation to a stressful situation on three levels, namely: at the social functional level in order to re-establish competence and self-esteem; at the psychological level in order to attain different degrees of short or long-term well-being; and at the somatic level because coping has an effect on one's susceptibility to disease.
In summary, Lazarus (1984) defines coping as the individual's cognitive evaluation ability, determined by previous life-history, external factors, personal factors which are important for the individual's possibilities to solve problems and adapt emotionally whilst subject to the acute or chronic strain - the stress - which, for example, an illness entails.

In his book "Coping with cancer", Weisman (1979) has used the term coping to describe cancer patients' adjustment to their situation. Like Lazarus, he underlines that coping is a description of how cancer patients deal with a difficult situation and not how they master it. Coping presupposes that one recognizes that a problem exists and then does something about it. Like Lazarus, Weisman emphasizes that one evaluates the situation and that there is an interaction between needs and resources in the individual. According to Weisman, good coping entails "good solutions to old problems, adequate solutions to new problems and resources to meet new problems" (p15). "Bad" copers adopt a passive attitude and wait for something to happen. The difference between good and bad copers, says Weisman, is the difference between wealth of resources and rigidity, between optimism and pessimism. Good copers see cancer as a burden, but not an overwhelming one. They are confrontative, do what they can, seek the support which is available, including their own inner resources. They ask and give selectively, they can face reality and know that not all problems can be solved. Weisman says that "more problems are solved through awareness and acceptance than through denial" (p43). He assumes that there is at the same time an intrapersonal and an interpersonal process going on and that the difference between defence and coping is an unconscious or a conscious way of relating. Weisman makes the same argument as Lazarus, namely that coping is a process and can be altered through changes both in the person and in the situation. His remarks are based on observations and conversations with cancer patients and he has divided their coping strategies into fifteen groups: seeking knowledge, sharing concerns, laughing it off, trying to forget, distraction, confrontation, redefining, fatalism, impulsiveness,
drugs and alcohol, isolation, blaming someone, blaming oneself and finally cooperative compliance.

**A model for understanding the connection between defence mechanisms and coping**

The concept of coping as defined by the authors cited above emphasizes how one solves a difficult situation, i.e. a situation of stress, which e.g. a cancer illness brings with it. Within the concept of coping, earlier experiences and personal resources are assumed to be of significance. The question why one chooses different solutions offers improved understanding of how difficulties are coped with. Two German psychoanalysts, Steffens and Kächele (1988), have used the psychoanalytical approach to coping and state, as does Kastenbaum (1976), that in the face of difficulty, e.g. illness, anxiety is provoked which is directed towards a real peril, but that the registering and experience of the real peril can, at the same time, call forth an earlier anxiety. "That action which serves to deal with the real peril is called coping. Coping strategies make possible a flexible interaction in relation to the varying demands of the social reality. The processes which prevent the activation of regressive anxiety belong to the defence mechanisms." (Steffens 1988 p3)

According to Borg and Poulsen (1990), two Danish psychologists who research in "health psychology", the purpose of defence mechanisms is to maintain intrapsychic stability. By means of intrapsychic defensive strategies, the self protects itself from traumatic losses of both basic safety and security. The object of the defence mechanisms is to keep the ego afloat and prevent repeated experiences of earlier traumatic situations. If the ego is functioning it can mobilize coping strategies appropriate to the present situation.

The above named authors claim that coping embraces both unconscious and conscious elements. But coping researchers have chiefly focused on the individual's conscious behavioural responses (Persson 1985) partly as a result of methodological issues. By focusing on the individual's conscious strategies, it is easier to obtain, systematize and analyze data from e.g. questionnaires.

The coping process can be said to include the individual's strategies for dealing with a trying, catastrophic situation but it can also be limited merely to the individual's ability to master the situation. Both
psychoanalytical theory and the coping models claim that the evaluation of the situation is dependent on earlier experiences and the resources which the individual has at his disposal. In the psychoanalytical perspective the assumption is that this evaluation is not only based on conscious information but also on unconscious fantasies and emotional information. The psychoanalytical perspective on the coping process increases understanding of the solutions which the individual chooses but it makes different demands of the methods for collecting and analyzing data.

The starting point which I have chosen in my analysis of doctors' behavioural response patterns is to continue with the double perspective which Lazarus (1984) and Weisman (1979) employed and which Steffens (1988), Borg (1990) developed. It is my intention to categorize doctors' behavioural responses using both coping models and a psychoanalytical perspective, in other words, relate doctors' different strategies to intended manoeuvres which may be expressions of defences against anxiety. The purpose of this perspective is to improve the understanding of such strategies.

Examples of connections between defence mechanisms and the coping strategies in the studies presented

In the following section examples of coping which repeatedly occur in the literature which has been cited are presented. Coping is examined here in relation to defence mechanisms. As has been pointed rarely out earlier, clinical experience tells us that defence mechanisms are seldom used in isolation or even two at a time. On the contrary, many are used simultaneously, even if a few are usually the most important, and the majority of individuals use both early and higher defences.

"The All-knowing physician"

Bennet (1987) takes up an argument, which was stated in chapter 2, that doctors are totally unmoved. A doctor does nothing more than give his so-called conscious expert opinion and represses all experience of his so-called "patient experience" of fear, helplessness and a wish to be looked after. If this patient part is repressed from consciousness then we are left with the all-knowing doctor who acts as if the illness were totally detached from any feelings of any worth and who either will not or can not see any feelings in the patient. This phenomenon is according to Gorlin (1983) the result of the doctor's education. He maintains that the doctor by implication has been led to understand that his reaction is either
unimportant or it should be repressed because it is never discussed during his education. This unmoved, instrumental approach may be regarded as an expression of both repression and isolation of the type which is called intellectualizing.

Reluctance towards discussing issues of pain and death
Bennet (1987) describes clinical work as being in the presence of physical pain, disfiguring surgery which limit bodily - and social - functions, while intimate matters, such as sexuality, are delved up. He assumes that death, pain, intimacy and sexuality evoke powerful associations for the doctor. These associations may be disruptive in the sense that he may not be able to handle them in a current situation and therefore he represses them from consciousness in order to feel better. Despite, the feeling remains now unconscious, it may make itself known in the doctor's conscious at any time. This repression of feeling may, as Cullberg (1984) says, be functional in certain situations but, according to Gorlin (1983), it may result in a resistance towards discussing, for example, issues of death and sexuality or at least that one minimalizes the importance of such questions. One does not merely repress these matters but one changes their meaning. Klein (Igra 1988) described this derogation and belittling as the little child's way of keeping frustration at bay; one projects outwards one's own littleness and insecurity and maintains one's omnipotent control. For the adult this may be an expression of both displacement and rationalizing: "it isn't my field of interest".

The denial of death
Kastenbaum writes that "death games" can be interpreted as an important denial function for the young child. The child tries to master or neutralize death through the game. Feigenberg (1976) claims that we live in a death-denying culture and that the doctor is influenced by his social cultural environment just as much as the patient is. Bennet (1987) claims that denial of death is particularly pronounced when dealing with a terminally ill colleague. "When the patient is one of them, death comes much closer." Cullberg (1985) also provides examples of different degrees of denial which one comes across in health care. He asserts that anxiety that oneself may become physically ill may be one reason for choosing the medical profession, something which can have major consequences in one's work with sick people.

Cynicism
In her thesis, Holm (1985) illustrates medical students' attitudes concerning the relations with the patient. She refers to surveys (Rezler 1979) which
suggest that the doctor's education contributes to the development of a cynical attitude and weakens a humanitarian tendency in the students. The students' feelings and opinions change during their education but explanations vary. Many people consider that the medical education establishes such powerful feelings of inferiority in the students that they defend themselves with cynicism. Bennet (1987) says that doctors who have anxiety over their own mortality may be quite incapable of discussing death, in extreme cases totally unable to use the word "death". He represses the psychological pain by joking or using a euphemism. Maguire (1989) says that the doctor "takes refuge in gallow humour".

Redefinition
Reformulation or something called redefinition are examples of denial. Bennet (1987) gives us examples of a dying patient's condition being redefined so that treatment is made possible. There are always indications for drop and blood transfusions as well as surgery. The student or junior colleague who questions the practice runs the risk of being mocked, humiliated or criticized for being "emotional" or unscientific. The uncertainty one feels is projected onto the junior.

Conspiracy with the patient
McCue (1982) has observed that doctors and patients sometimes conspire to deny the complexity, uncertainty, limitations and tragedies which in practice occur on a daily basis. A myriad of laboratory tests are used as a shield against fear and uncertainty. The refusal to accept the inadequacies of the treatment would be an example of denial on the doctor's part, as would "walking away from crisis". Maguire claims that some of the doctor's "distancing tactics" include giving false assurances of good health and selective observations. The doctor dismisses the complexity, reformulates the problem to subgoals which Sjöbäck (1988) defines as rationalizing. He reformulates or dismisses the problem, something which Maguire calls selective observation. He even changes the topic of conversation.

The need for dependent patients
Bennet (1987) offers examples of projection when he describes how the doctor attributes his so called "patient part" to the patient, the frightened, needful person in need of intimacy and dependency, but who at the same time needs respect and admiration. This latter could tempt him to keep the patient dependent on him. He projects his own weakness onto the patient who now has a double burden of weakness, his own and the doctor's.
Addiction to work

According to Bennet (1987), "compulsive business" may be viewed as a defence mechanism. The doctor does not allow himself or give himself time to reflect what he is doing. He sees no reason for this, because the feedback which he gets from his environment confirms his worth. For their part the patients are impressed by the busy doctor. Relations with colleagues and other staff may be good. The doctor may enthuse his staff who in return give him encouragement. This defence strategy keeps the doctor sufficiently isolated from the patient. He makes his expert opinion available, which is worth so much, and remains unmoved. This type of defence is, as Sjöbäck (1984) stated, an example of the individual reinforcing and exaggerating a behavioural tendency which is the diametric opposite of the impulse one is trying to repress and results in one losing touch with one's feelings. Sjöbäck (1984) describes the mechanism of reaction formation as covering up by asserting the opposite. But covering up also takes place through an investment in something, strictly speaking anything at all, so that attention and energy is taken away from that which is being defended against. According to psychoanalytical theory, the explanation of "addiction to work" is that it serves to disconnect impulses, feelings and ideas which could cause psychological pain. "Workaholics" fear that these would come to the fore if they are left to themselves. They use over-involvement in activity as a permanent cover-up defence.

The theoretical background to this study has now been presented. In the next chapter the planning and methodology of the empirical part of the study is presented. The empirical part will be presented in part II.
Study group

In Sweden, cancer patients are cared for both as out- and inpatients. In institutional care every kind of cancer illness is represented. The population which I have chosen to examine is doctors who work in institutional care and who have daily contact with adult cancer patients. Within this population I have made a strategic (Patton 1990) selection of doctors. They are all experienced specialists in their fields and they have sole responsibility for treatment. The assumption is that, under the course of many years, they have developed more or less evident and observable strategies for withstanding and solving the situations which arise in their work with cancer patients.

The project was presented on paper to the chief clinicians at the following departments of a hospital in northern Sweden: general oncology, surgery, internal medicine and pulmonary medicine. The respective heads of clinic thereafter informed those colleagues who had most contact with cancer patients in each clinic and left it to these doctors to decide whether they were prepared to take part in the study. As the next step, I contacted the strategically selected doctors in writing and suggested a meeting with each of them. At these meetings I informed the potential participant about the aim of the study and that participation in the survey was entirely voluntary. The idea behind this conversation was that he would have the opportunity to pose questions about the procedure of the study and how the findings were going to be treated.

All the specialist general oncologists (12) who were on service in October 1989 (excluding the four who were involved in a pilot project the year before) responded positively to contributing in some way to the study. An oncologist from the the gyne-oncological clinic offered me his participation and entered the study as well. Of the ten "non-oncologists" who were approached, all agreed to participate, but to different degrees. In total, 23 doctors were contacted for participating in the study. From these, two general oncologists and one internist declined to take part in the interview part. The number of participants who agreed to take part in the whole study
was twenty of whom eleven are specialists in oncology and nine are specialists in surgery, internal medicine and pulmonary medicine. Fifteen of them were men and five were women.

Table 4:1  Number of doctors, by specialization who agreed to take part:

<table>
<thead>
<tr>
<th>Specialization</th>
<th>in part of the study</th>
<th>in the whole study</th>
</tr>
</thead>
<tbody>
<tr>
<td>oncology</td>
<td>2</td>
<td>11</td>
</tr>
<tr>
<td>surgery</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>internal medicine</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>pulmonary medicine</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>3</strong></td>
<td><strong>20</strong></td>
</tr>
</tbody>
</table>

Method of data collection

The aim of the study was to systematically investigate experiences and coping from a theoretical perspective which holds that in all strategies a desire to attain psychic balance. Therefore a series of open interviews was chosen as the main method of collection of data. The intention was to obtain material which reflected the doctors' own experience of what their work entails and that they should consider their own reactions and behavioural responses. I preferred to conduct open interviews as my method of data collection rather than questionnaires. Questionnaires would compel the participants to keep themselves to areas which have already been defined by others. In interviews, i.e. verbal communication, one gives signals at different levels. One reveals both conscious and manifest material and latent material. By latent material I mean unconscious thoughts which have been repressed but have been reshaped and manifest themselves in conscious speech and behaviour. By listening to the doctor's description of his subjective experience of different situations and their significance, one can partly understand the unconscious wishes, values, needs, conflicts and expectations.
The Interview

The main method of data collection has been a series of recorded interviews of 30 - 40 minutes' duration. The focus of the interview was the participant's perception of how he experiences, thinks, speaks and acts when face to face with a cancer patient. During the course of the study every participant had some form of daily contact with a large number of patients at different stages of their cancer illness. The contact with cancer patients during the working day could be directly at the clinic and/or department or indirectly in the form of surgery, data collection through an epidemiological data base, experimental study of tumour tissue, follow up by means of files (case-books).

In order to give the interview a structure, I came to an agreement with each participant which meant that they would choose one of their current patients, a "new" patient with an estimated 50% likelihood of surviving five years. The therapeutic goal for the chosen patient should be curative. The doctor should be able to follow the patient's progress over a period of two years. The interviews would take place every three months over the two years period or until the patient's death. On every interview occasion, the participant would report what he had felt, thought, said and done at the preceding meeting with the patient. It was my expectation that on every interview occasion experiences would be brought up also from meetings with other patients. The selected patient would serve only as a reference patient for the doctor. The participants were informed that it was my intention to capture their experiences of reality. I emphasized that I thus was only interested in the participant's experience of reality and that I understood that it may well look different from another participant's point of view. The aim of the open and repeated interview was thus that the participants themselves would describe their understanding of what the work entailed and would reflect on their own reactions and behavioural responses.

Prior to the series of interviews using a selected patient as a reference, an "introductory interview" was conducted with each physician. It was my ambition not only to introduce the project but also to get information on the doctor's attitude to the work. I was interested in which factors made it easier or possibly harder for the physician to live up to their role expectation.

All the interviews were conducted by the author who is a specialist in obstetrics and gynaecological oncology having worked for the past seven
years in psychiatric care. I have completed the first stage of a psychotherapeutic training based on psychoanalytical theory. The interviews have been supervised by Anna-Lena Kindås Burman, a certified psychologist and psychotherapist and a qualified supervisor.

In order to illustrate the doctors' adjustment to their work from different approaches, two psychological tests have been used. These are presented in the next section.

**Defence Mechanism Test (DMT)**

In order to illustrate the interviewees' behavioural responses focusing particularly on defence strategies, I have used the projective percept-genetic test, the "Defence Mechanism Test" (DMT) which is based on psychoanalytical theory. This test was developed at Lund in the 1950s by Kragh and was primarily constructed for the selection of people for stress-related tasks (Kragh 1955). During the last decade the test has been an established instrument in selection procedures, such as selection of pilots (Olff 1991, overview) and deep-sea divers (Vaernes 1982). The test has been used in many studies in Scandinavia and is closely related to the international tradition based on subliminal perception.

The DMT is based on a test situation where a serie of anxiety-provoking pictures is successively presented in a tachistoscope with exposure times increasing from 5 milliseconds to 2 seconds. After each exposure, the proband describes verbally and in the form of a simple drawing what he has seen. The aim of this is to gain an idea of how the proband's perceptions of the picture agree with the presented picture itself. The distortions and other reactions to the stimulus picture which are reported as conditioned by the short exposure times are interpreted as attempts by the proband to control the anxiety which is provoked by the stimulus picture. In this way, the distortions have the same function as psychoanalytical defence mechanisms.

Over the past years, interest has grown in the development of the test as a clinical tool (Sundbom 1992). The results of this research show that probands' defence mechanisms are intimately associated with the degree of internalized inner self- and object representations. According to Sundbom (1992), the test should be regarded as an object relation test rather than merely a defence test. Results indicate that it is possible using pattern analysis of the test subjects' distortions on the DMT to distinguish different psychiatric diagnostic groups.
DMT testing in this project has been carried out by Elisabeth Sundbom, Ph.D. certified psychologist and psychotherapist, and lecturer at the Department of Applied Psychology, Umeå University.

Structural Analysis of Social Behaviour (SASB)

The "Structural Analysis of Social Behaviour" (SASB) has been used to illustrate the doctors' images of themselves. SASB is a method whereby interpersonal relations and self-image are analyzed by means of self-assessment. In this study the focus has been on the self-image. Theoretically, the test is based on the idea that all experiences are filtered through the self. The test is founded on a model in which self-image is described using two basic dimensions: self-control/spontaneity and self-love/self-hate. These dimensions form the axes of a rhomboid (Fig 4:1). The test consists of 36 questions, each expressing different degrees of the two basic dimensions. In the so-called "cluster version" of the SASB, the 36 questions are grouped into 8 clusters (See Fig. 4:1). Each cluster expresses different degrees of the two dimensions. For example, cluster 2 includes questions which all express self-love and spontaneity/impulsiveness. Cluster 8, on the other hand, expresses the same degree of spontaneity but now combined with self-hate instead of self-love. The test measures how the participant considers himself on these aspects at the time of completing the questionnaire. The test was intended to contribute to an illustration of participants' images of themselves and to an increasing understanding of their attitudes to their work with cancer patients.

The test has been developed by Lorna Benjamin (1974) and the method has been tested at the Department of Applied Psychology at Umeå University by associate professor Kerstin Armelius (1983) who has also analyzed the test material in this study.

The self-assessment questionnaire was presented to the participants at the beginning of the interview series and when the patient had died or when the contract was concluded. The participants completed the questionnaire on their own and sent it to Armelius in an attached envelope.
Fig 4:1 The SASB model. Cluster version

FOCUS ON SELF-IMAGE

1 Spontaneous and impulsive
2 Accepting and exploring
3 Loving and cherishing
4 Nourishing and enhancing
5 Controlling and restraining
6 Oppressing and blaming
7 Destroying and rejections
8 Neglecting and daydreaming

Data collection

Interview

Of the twenty participants who accepted the design of the interview, three (two men and one woman) have dropped out. Two of these (one man and one woman) changed the nature of their work after the completion of the DMT test and the introductory interview which was incompatible with prerequisite of "daily contact with cancer patients". One of the participants moved to another town after four interviews with the patient in focus. The participant's patient had deteriorated and the change from curative to palliative treatment was recorded. Of the remaining 17 doctors, the contract has been concluded with eight because their patients had died. One doctor "was not able" to choose a patient but has been interviewed on five different occasions at roughly three monthly intervals. The focus has been on a newly diagnosed patient, a patient in remission, a patient with a relapse, a patient for whom recidival treatment had failed and a patient in
the terminal stage. Eight participants have been followed for two years in agreement with the contract and the patients have survived. For three of these certain circumstances have not allowed the assessment of the three month interval.

Eight of the participants' selected patients died one year after the start of the study. This is in line with one of the premises of the study, namely that "about half of the patients would die".

In Table 4:2 the procedure of the study is presented in a flow chart form. In total 108 interviews took place of which 20 were introductory interviews (I:0) with the doctors who initially participated in the study. An interview (I:1-8) with each doctor, where the patient was in focus at different stages of the cancer illness, was conducted at three month intervals for two years or until the patient died. The Defence Mechanism Test (DMT) was performed before the introductory interview and the Structural Analysis of Social Behaviour (SASB) was carried out on the occasion of the first interview with the patient in focus and also when the contract was concluded.

**Table 4:2** Time table of interviews and tests

<table>
<thead>
<tr>
<th>Nov 1989</th>
<th>every 3 months</th>
<th>June 1992</th>
</tr>
</thead>
<tbody>
<tr>
<td>DMT, I:0</td>
<td>l:1 l:2  l:3 l:4 l:5 l:6 l:7 l:8</td>
<td></td>
</tr>
<tr>
<td>SASB</td>
<td>SASB at death</td>
<td>SASB</td>
</tr>
</tbody>
</table>

Introductory interview = I:0  
Interview with focus on patient = I:1-8  
Defence Mechanism Test = DMT  
Structural Analysis of Social Behaviour = SASB
In Table 4:3 the drop-out of participants during the patient-related interview period of the study is shown.

**Table 4:3** No. of doctors by specialization who dropped out during the interview series

<table>
<thead>
<tr>
<th>Specialization</th>
<th>No. of drop out</th>
</tr>
</thead>
<tbody>
<tr>
<td>oncology</td>
<td>1</td>
</tr>
<tr>
<td>surgery</td>
<td>1</td>
</tr>
<tr>
<td>internal medicine</td>
<td>0</td>
</tr>
<tr>
<td>pulmonary medicine</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>3</strong></td>
</tr>
</tbody>
</table>
Table 4:4 shows the distribution of patient-focused interviews between the different participants. In total 88 patient-focused interviews were conducted.

<table>
<thead>
<tr>
<th>Doc</th>
<th>1</th>
<th>Pat. dead</th>
<th>Moved</th>
<th>Drop out</th>
</tr>
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<tbody>
<tr>
<td>1</td>
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**Total 88**

**Defence Mechanism Test (DMT)**

Of the 23 participants, 21 were DMT-tested before the start of the interview series. Two accepted the design of the study interview but could not attend the appointments for testing. However, they have contributed to the interview series and in the SASB.
Structural Analysis of Social Behaviour (SASB)

Eleven of the eighteen participants who took part in the interview series with the patient in focus have completed and handed in two independent self-assessments (SASB1&2). Three participants handed in only the first questionnaire (SASB1), one of these moved during the course of the study. Three participants have only handed in a self-assessment after the patient's death (SASB2) and one participant has declined to do a self-assessment (SASB1&2).

Processing and analysis of data

All 108 interviews were recorded and transcribed. The analysis of the interview material, which runs to approximately 1500 A4 pages, has been performed by the author. In connection with each interview, I noted themes which had been highlighted during the interview. I also noted my own observations of the participant's behaviour towards me and in the context of the interview.

In the analysis of the interview material I have used the theoretical frame presented in chapter three for guidance. The focus of the analysis has been on the participants' statements about:

1. Difficulties, illustrated in relation to conflicting feelings and wishes.

2. Emotional and behavioural responses, i.e. coping strategies, illustrated in relation to different defence mechanisms.

Both manifest and latent material are covered by the analysis. I have sought to make a comprehensive analysis of the relation between the different areas, i.e. the categories of conflicting feelings, difficulties and coping.

The credibility of my analysis has been tested by Elisabet Sundbom Ph.D and Ulla Holm Ph.D, both certified psychologists, which is discussed in chapter 10 (p125).

Ethical considerations

The method I have chosen implied that the participants in the study were not only strategically selected but are also identifiable. The purpose of the
selection was that the individual doctor should exemplify some of the ways in which experienced doctors deal with difficulties in their work with cancer patients. Each individual doctor serves as a reference in a theoretical argument about how understanding of doctors' ways of working can be improved. Each doctor has both a background and a present-day life. I am aware that my observations of both conflicting feelings and adapting to and solving difficult situations could have been exemplified more simply if I should have reported on each doctor in more detail as a case study. The risk would then be that I would make a personality description. This, however, is not the aim of the study. I am also aware that the presentation of results would have been clearer if I could better demonstrate both the categorization and the following discussion of this categorization, i.e. if I presented more clearly in each individual case the traumas both in childhood and later on in life and also what happens to individual doctors during the course of the study. Thus it is not only for methodological reasons but also for ethical reasons that I do not present case studies. Instead, by considering the integrity of each doctor, I have preferred to make general comments such as "occurs in the group" and to partly describe the participants in the examples. The physicians are for grammatical reasons constantly referred to as "he".

Presentation of results

In chapter 5, a categorization of the stated difficulties is made. In chapter 6, background data is given together with a categorization of the participants' conflicting feelings and wishes. In chapter 7, a categorization of the participants' coping strategies is made. In chapter 8, the results from DMT and SASB are presented. The analysis of the relation between the categories in the different areas is given in chapter 9. Finally, in chapter 10 I discuss the possible practical implications of the study.
Part II

RESULTS
In this chapter a categorization is presented of those difficulties which the doctors have named in their work with cancer patients.

In the first step in this categorization, I went through each individual doctor's interview series and analyzed in each interview the statements which expressed something which was difficult, problematic or "tough". The material obtained included about 500 recurring statements about "difficult situations" in relation to some particular clinical situation.

In the next step, I analyzed the content of these stated difficulties. This analysis led to three categories of difficulties, namely those concerning the disease, the interaction with the patient and the doctor's own reactions.

I. Difficulties concerning the disease

In this category I have included difficulties connected with the objective limitations in medical science, technical expertise and organization which influence the cancer disease at different stages.

II. Difficulties concerning the interaction

Difficulties in this category are connected with the actual meeting with the cancer patient. In this category I have included problems in communication, which are connected to the physician's psychological knowledge.
III. Difficulties concerning the physician's own reactions

To this category belong difficulties which reflect conflicting feelings and wishes which stem from medical/technical limitations and/or because the situation demands psychological and organizational knowledge about the disease's different phases and in relation to different types of patients. Statements about conflicting feelings when making decisions, maintaining hope, involvement, a healthy self-image and support groups, as well as the dilemma of personal strain at work, are examples of what has been included here.

The categories are depicted in Figure 5:1 in the form of a triangle. The figure is intended to illustrate furthest to the left: the "actor" who has medical/technical expertise in order to tackle the disease as expected from him. At the bottom of the triangle: the "reactor" who is expected to understand his own reactions and who experiences the situation as trying because he has conflicting feelings and wishes. Furthest to the right: the "interactor" who is expected to have expertise in psychological caring and communicating in order to meet the person behind the disease.

Fig 5:1      The categories of difficulties

ACTOR
Difficulties concerning the disease

INTERACTOR
Difficulties concerning the interaction

REACTOR
Difficulties concerning the physician's own reaction
Several of the statements reflect simultaneous demands on both technical/medical expertise and an ability to build relations whilst at the same time indicating that conflicting feelings have been triggered. Thus they fall into one or more categories.

In the following, the distribution of the difficulties over the different categories is reported. Special situations linked to special types of patients and different stages of the disease are marked in bold. Italics indicate quotes from the physicians. The numbers in brackets correspond to the number of physicians who make statements which fall into the different groups.

I. Difficulties concerning the disease
"The ACTOR"

In the description of the difficulties of the physician as an "Actor" the statements which point to medical, technical and organizational limitations have been grouped together as follows.

Medical limitations

The doctors have said with one voice that it is no problem to read a referral for a patient who has just fallen sick. For the disease-focused doctor without any kind of relation to the patient, the fact that the patient has become ill with cancer is not problematic.

The first meeting with the patient does not seem to cause any medical problems for more than a few physicians (3).

A couple of doctors state that the difficulties begin when primary treatment fails. "We have tried three of our classic treatments which could have worked and we do not have much more to offer."

During the progress stage, one doctor reports that there can be difficulties with the timing of medical interventions, i.e. when or whether a dramatic measure should be taken.

Almost all the participants report that the biggest difficulty is when the treatment of a relaps fails. This situation seems to trigger off all the categories of difficulties. The demands on medical efforts are accentuated as is the psychological caring and one experiences problems dealing with one's own reactions. From the medical point of view, the problem consists
of knowing if and when to treat the cancer actively: "It is one of the greatest problems in oncology that far too may patients are treated for diffuse indications..."

In the terminal stage it is once again only a few doctors who say that they are doubtful about their medical/technical capabilities. One of them says, "The only times when I hesitate to go into a room where someone is waiting are when I don't really know what to do medically."

The doctors mention special treatment situations. Amongst these is deciding what to do by way of preventive treatment when patients are symptom-free, adjuvant treatment. Some doctors (3) name that it is difficult to be active and to suggest treatment at this stage of the disease. Several doctors (4) doubt this form of therapy and question whether the patient's life is prolonged at all and if there is any sense in it. The idea is discussed whether it is better to give treatment only during a relapse and not subject the patient to cytostatics during a period of good health. "The patient's life is put at risk. One has to decide how damaging treatment one dares to give." Another doctor has taken up this difficulty: "I notice and have noticed amongst other oncologists that many of us apply the matter of cytostatic treatment during a relapse to the adjuvant situation" (when the patient is symptom-free).

Another special situation is when testing new drugs, so called clinical trials. A few doctors (3) see clinical trials as a controversial medical problem. Only one doctor comments on the risks of introducing new cytostatics and gives an example: "We had a patient who took part in a trial last week and this patient died from the cytostatics."

A couple of physicians have observed that it is difficult to bring about the changes to the treatment and care routines which their and others' research findings would suggest: "In the morning I talked about the changes which the studies would result in. The procedure routines for a lot of the patients are going to be changed. People just sat and drank coffee and read things and discussed duty rosters and had nothing to say, barely listened".

Technical limitations

In each stage of the disease there are technically difficult examinations. A single oncologist expresses his technical shortcomings in the diagnostic stage. The doctor thinks it is difficult to carry out biopsies. It is mainly doctors (5) who work with invasive examination procedures who bring up
this subject: "The technical side is difficult...I am completely preoccupied with technical matters getting good tests and no bleeding". In particular, the difficulty of judging the timing for when to step in with surgery is discussed. This is especially difficult when the method is unknown.

Organizational limitations

There was only one doctor who has experienced economic limitations: "We had the technology but not the resources. There was a general helplessness that was paralyzing. It's a period which I don't want to think about."

Geographic distance is perceived as an obstacle to the medical/technical practicalities. One or two doctors mention the large distances as an obstacle to carrying out check-ups which vary from stage to stage of the illness.

The doctors name shortcomings within the organization as obstacles to their work. Some of them (4) cite the lack of leadership as the reason for this and as "a greater problem than the work with the critically ill".

Several doctors (5) have experiences of failings in the organization of policlinal work and describe the problems of maintaining continuity and medical dilemmas as a resulting from this. Two thirds of the doctors say that it is particularly difficult in the final stages of the illness.

Almost half the doctors (7) see time as a limitation in their work. They give examples of tight time-frames, e.g. ten minutes per patient for the clinical consultations and difficulties in keeping to schedules. "It was a terribly busy afternoon. I had twelve patients on my afternoon list. It was an utterly horrible list."

A few doctors (3) emphasize on the fact that different wards and clinics have different routines and that this makes things more difficult. This is particularly true when standing in "on call" when it is sometimes difficult to read the palliative needs if one has not previously had contact with the patient. One physician experiences the large number of patients on weekend rounds as "detestable", especially when dealing with patients at the terminal stage. Another participant feels it difficult if the patient chooses to be at the hospital nearest his home, especially in the terminal stage because "there are different routines".
II. Difficulties concerning the interaction. "The INTERACTOR"

Statements which have been deemed as belonging to this category of difficulties reflect problems with psychological caring such as interpreting and relating to different patients verbally and non-verbally at different stages of the illness. They are grouped around different areas such as giving information, being aware of questions and having consultations with the patient, including obtaining informed consent, and finally how to end the consultation.

Almost half the physicians speak of the difficulty of not being able to help the patient psychologically. Several (5) mention the difficulty of not being educated in "the other [part]" or "the psychological part."

Information

Some physicians (4) describe the first meeting with a patient facing death as difficult because "it hurts the person who is given the diagnosis most".

When the illness is in remission, the same number (4) say that "It is difficult to give a poor prognosis". One doctor says that one is trying to inform the patient that the disease has been cured while there is nevertheless the risk of a relapse and that there is still the need for check-ups. "In those cases where there is a slim chance of a total cure I don't talk about the prognosis." The same doctor sees in this a risk of not noticing the patient's anxiety through following a routine. "One risk is that I might miss seeing that there is something behind this. That she had a façade that was cheerful when I strolled in to her when we saw each other six or seven times. At this stage it can also be difficult to motivate check-ups."

At the next stage of the illness, i.e. when relapse is confirmed, nearly one third of the doctors (5) name how difficult it is to inform the patient. "The tricky question is whether one should say straight away that one thinks this is cancer or, as I often do, that it doesn't look good."

When the relapse treatment fails nearly all the doctors report difficulties in informing the patient that the treatment is not helping, telling them that the cancer has disseminated. For one doctor this situation provokes thoughts about honesty. "If I had stopped the treatment and told them that there was
no point in us doing anything, then I think that I would have destroyed them long before they died."

At the terminal stage, there are several (4) who report difficulties in conveying information to the patient. This is accentuated when the patient is on another ward: "It is difficult to know how the patient feels about me coming to see him."

A couple of doctors talk about different vocabularies and the consequences for information. "I think that if you succeed it isn't really down to which technical terms you use, but rather how you say it. You often end up trying somehow to say too little so that you don't say too much."

Questions

One third of the doctors (6) emphasize the difficulties associated with the patient's questions about death and the effects of the treatment. Some of them express it as walking on a tightrope so as "not to make the patient disappointed". It is difficult to "give the patient space to ask questions". One doctor discusses a specific situation where a patient died sooner than he could have expected and he had not thought of "these difficult questions" because they usually "don't come straight away but when you've met each other a few times."

Two-way communication

Many doctors see difficulties concerning the two-way communication during consultations, i.e. in interpreting or observing all the levels of communication - "probing" the patient's mind. Some (5) have difficulties because they do not succeed in establishing contact with the patient. Several (6) find it difficult with patients who do not seem to react whilst some doctors (3) have problems with silent men: "It is difficult to know what's going on because he didn't say very much. He made no response. It felt like he was leaving it all to me."

In cases of relapse and especially concerning very advanced stages, nearly all the doctors (17) talk about problems with obtaining informed consent, above all when the patient wants treatment. "You meet patients who want treatment at whatever cost...They are the straw-catchers and I think it's almost always the case that they want to have some sort of treatment. The hardest thing is trying to probe into the patient is thinking."
One doctor in particular mentions that consent is also a question of **timing:** "That you should give treatment by gauging the situation and if you ask this sort of question too early then the patient just says that it's the doctor who knows best and not me".

**Ending a consultation**

Several doctors (10) think it is difficult to bring a consultation to an end. Patients can have many things on their minds and many questions which one has not previously mentioned and "it is a big problem (knowing) exactly when to finish and you have lots of patients waiting".

**III. Difficulties concerning the physician's own reactions "The REACTOR"**

In this category, stated difficulties are included which are related to the physician's own reactions connected with different types of patients and to different medical, technical, organizational and interactional limits at different stages of the cancer illness.

**Type of patients**

Most doctors name difficulties which can be attributed to different types of patients. Nearly half (7) say that it is even more difficult when the patient is young. "Young girls who have died of miserable diseases make me feel worst." One doctor thinks there is a particular risk if the patient is a "nice" person. In that situation it can be difficult to avoid wishful thinking. Also mentioned are the so-called ungrateful (1), discontent (1) and patients who have had a delay in getting the diagnosis (9). "It was the case that we had all overlooked him somewhat so that there was some kind of collective bad conscience so that we had to try something." They express difficulties with loyalty towards colleagues, that "it is difficult to defend colleagues." "I felt some kind of anger with my colleagues and then I realized that this would crop up in the conversation and I felt some sort of conflict of loyalties."

**Medical limitationes**

Only a few, as mentioned above, have problems during the **initial stages** of the treatment. "It can be tough if the unpleasant reactions (side-effects) already happen after the second or third session".
There are just a couple of doctors who talk of their dread, when primary
treatment fails, that the medical resources are insufficient.

Many more, more than half (9), mention difficulties when the patient is in remission. They describe "how difficult it is to know about an illness with a poor prognosis". The doctors talk about not feeling "really happy because it's at the back of my mind. I think a little bit more about what can happen," and that "it is difficult not to expect a relapse". "I have the feeling all the time that ...when is the relapse going to come. I feel like I do not dare to be happy." They describe a sort of emptiness when the first short term goal has been achieved: "Now we're here. Now we can't do very much more. Things have gone well and this is where we are. What should I do?"

When a relapse has been confirmed, there are some doctors (5) who mention difficulties such as "one has to think again". "Turning everything round - that's tough." At this phase, their attitude to the treatment is problematic. "One can really wonder whether what one thinks one can do is of any use in comparison with the primary treatment when it's easier to be a bit cocky."

This is even more the case in situations when the treatment of relapse failed. As described above, all the doctors find this to be hardest of all. They describe how "I feel that it's slipping from my grip. I think that I can keep it under control. I have promised (the patient) that there is medicine and methods of treatment. I feel disappointment and a helplessness that I can't use the methods as an effective weapon, that I'm losing control. It is very frustrating." One doctor says that "it's all a wretched business and you feel frustrated and upset". This situation brings on thoughts about whether to start treatment now or whether one should have started earlier, i.e. timing. "It is a difficult problem in Swedish oncology. It is a case of treating the doctor's anxiety instead of the patient's illness." One doctor describes this feeling: "If I sort of pretend this isn't happening, pretend I haven't decided about treatment and say okay, it looks pretty good, then I think the patient would have accepted it, too. But then I would always have had the nagging feeling that, all of a sudden, things can get worse".

All the doctors describe their problems in refraining from giving treatment. A number of them use the term "straw-catching treatment" and say that it is difficult not to act. Some of the doctors talk about the treatment being psychological, that it is good to have something to offer. They know full well that it is questionable."But it's very difficult. I know how everyone says that you definitely shouldn't give treatment in situations like this, but everyone does."
After the patient has died, one doctor expresses his pain: "I must say that I'm still influenced as I speak. She's just died and it really hurts." Another doctor whose patient suddenly died accuses himself of contributing to the patient's death. "I want to be certain that we didn't do anything wrong. Because to me it looks bad."

Technical limitations

The technical examinations can above all cause problems during the diagnostic stage. This applies especially to those doctors (5) who use invasive examination techniques. "It is something really dreadful to lose a patient during an intervention. Really dreadful and I go and worry for ages afterwards."

Organizational limitations

Some doctors (3) say that it is difficult to wait for the results of examinations and tests. One doctor describes how awkward it is when new information spoils the planned course of treatment. "I feel frustrated at the moment when I get this new information." Another explains that one feels a lack of something in that one can not refer the patient to someone else who can continue to work with the patient with the new facts. One doctor mentions his reluctance to inform the patient of a relapse by telephone. This applies to patients whom he has had contact with earlier and who lives at a long distance from the clinic. Another doctor sees great difficulties if a patient receives information from different sources.

Half the doctors (9) mention the difficulty of not letting the patient down due to problems with continuity especially at the terminal stage. The sense of betrayal is even the greater if the person is an out-patient or if one is going on holiday. "I know I won't be able to keep things going. It's me she knows and I just send her to a completely unknown ward with temporary summer staff and just when it's the worst time for her. That's what I mean by betrayal." A doctor who heard that his patient had died after he had gone on leave felt that he should perhaps have been there. "Somehow I felt that once you've started such a course of treatment, given the course of the disease, then they would have needed me there." The physician discusses his own feelings and expresses the idea that he could have needed someone "here and now to clear this thing up. How much guilt I should feel and how much bad conscience should I let them put on me?" but it is also "difficult not finishing what you've already started."
One recurring theme is involvement in work and especially the patient. Half the doctors see a risk in getting too much involved, in "having lengthy contacts with social obligations" because "there are greater risks of difficulties when the patient has died if you've had contact for a long time".

Almost a third of the doctors (5) describe a vulnerability in the organization in terms of exploitation. They feel that they have too great a work-load, that it is difficult "to be always available". It is tough with "too much running the business" and "half-existing" and "having too many duties". They describe themselves as "fragmented" and some feel they can not break out and bring about changes. "I am dissatisfied that I don't have time to eat. That I don't have time to do other things." It is "heavy". Often lunches have to be skipped and often patients have to sit and wait. One doctor gives the following example. "I come home late from work and have to work overtime. I can only feel dissatisfied about that. But there is some kind of built-in principle in me that it mustn't affect my contact with the patients." One doctor feels he is being exploited. "I get many of these tough cases and I feel like a rubbish skip, brim-full. It has to do with flattery. I feel like Brother Capable who can fix everything."

Feelings of insufficiency are a key concept which are repeatedly reported by all of these doctors (5). "It's as if however much you do, it isn't enough."

Some doctors (4) dwell on the fact that competition is a problem. This is particularly so if the patient is in a ward for which one has no responsibility. If one tries to influence the treatment, one risks offending one's colleagues and to be regarded as intruders. There are some doctors (3) who report difficulties in having their own and other's research findings acknowledged. "You don't just see the idea, you see the person who you fear will slink past you whilst dashing up the career ladder, rightly of course."

Several doctors (5) see a conflict between clinical practice and scientific work. They use terms such as "shirker". "It wasn't really me who was meant to do the ward duties, there was someone else who did that. Even so I felt bloody awful and I felt lousy and like I was shirking something." Another doctor says: "My big problem is really that I want to be a researcher and sometimes there's a conflict. You have to weigh up both sides, but sometimes you feel that it's gone awry." The doctor is torn between different ambitions and it is "much harder than I make it out to be". Still another doctor describes feeling like an outsider because he does not do any research. He finds it difficult to leave the ward: "I know that there's always work to do on the ward, but it doesn't lead to anything concrete,
anything visible, it doesn't. I'm not doing any research and I feel like an outsider in that respect."
Within this area, some (3) comments have been made which illustrate the conflict between not letting the patient down and at the same time allowing oneself some private space.

The differences in support and back-up from colleagues have been mentioned. The great majority of the doctors have the opportunity to ventilate their difficulties with friends but at least one doctor feels isolated: "I don't really have any friends on the ward. If I were to say that I needed friends, it would be regarded as my private concern. I haven't been given any support whatsoever. I've felt more that, 'Oh, so you can't take the strain', as if I were unprofessional." This difficulty of not getting any help with sharing one's burdens at work can be described by others as "taking one's patient home with one" and saying that "one is living on credit".

**Interactional limitations**

**Information**

Some doctors (3) describe their distress when informing a patient of a cancer diagnosis: "It hurts to give a diagnosis of cancer." Another doctor says, "Informing the patient gave me gastritis".

All the doctors name as their task the nurturing of hope but some (4) describe the dilemma of having to be not quite honest and giving ambivalent messages. Half the doctors find the information to the patient in periods of remission hard:"It is a dilemma: (the risk of) scaring someone when the risk of a relapse is real..."

All the doctors find it difficult to inform a patient that there is no curative therapy to offer. One physician talks about his experience that involvement with the patient which was of great help at the beginning of the disease turned out to be a hinder when he had to inform of its progression. Another physician is very open about his fear of getting involved. He is afraid of not giving objective information and does not enter into a relationship with his patients whatsoever unless they are part of a study. This is in contrast to another doctor who has no fear whatsoever of close contact. "I've taken an interest in her and no other bugger's had a look in. I feel bad if I feel I'm keeping my distance." This doctor gives examples, when contact has not worked well or things have gone wrong and the patient has been dissatisfied or when he feels the patient has been difficult, that it has been when he has been uninvolved and unconcentrated, not really present.
Guilt and betrayal are terms which emerge repeatedly (4) when giving information at the terminal stage. One doctor, whose patient died sooner than he had expected, says that: "First I felt that I should have gone there the following day. .. I should have tried to tell them how bad it really looked. That's why I feel a bit guilty."

At each stage of the illness special type situations are described in the giving of information. One doctor reports how difficult it is to face a new patient who has had a relapse. He describes this situation as highly charged. "I was just confronted by her head on and I tried to explain. It was a very, very strained situation."

Others (3) give examples of a special situation which arises when patients are told they need life-endangering treatment. "It was very tough news to give; he could just as easily have died of the treatment, he was in such a bad state."

There are also difficulties in information linked to special patients. As has been mentioned earlier, some (3) have mentioned difficulties with silent patients. "It felt a bit hopeless, actually, because I felt that this was a patient who doesn't want anything, who is difficult to talk with."

It is also difficult to be the object of the patient's dissatisfaction. An example of this is given by one physician who had to inform a patient who had been seeing another doctor and who felt he had been badly treated. "I just went forward and said goodbye. I've simply had nothing to do with this patient. He just pours forth with accusations and bitterness. Wrong treatment. Everything was undone. It took two hours to sort it out. It was bloody hard work."

Questions

Many doctors (7) say that it is difficult when you do not have any good answers for questions. "I'm afraid that she'll ask, do I have a chance? That's when it gets difficult. I don't really like that situation, that I have to give reasons for hope and be honest at the same time. Sometimes I feel that I'm not really being honest when I sit there and talk about hope."

A risk at the terminal stage is being prone to questions about something which one does not know. "If you daren't do anything it's usually because you're not really up-to-date medically, you're afraid that they'll ask you something you don't know." But it is also "difficult not being asked the big question".
Consultation

Most doctors regard consulting the patient about how to plan the treatment as a minor obstacle in the first phase of the illness. It is considerably harder in the palliative phase when most of the doctors have problems. "It is highly electric, very fraught with anxiety" for both the doctor and the patient. The single doctor who thought it was difficult at the primary stage says that he has problems taking responsibility for his decisions. He feels from the beginning that there are several possibilities and that he often "finds himself" in situations where he later realizes that another alternative would have been better. The same doctor says that it is difficult with patients who do not co-operate. It is not just a problem with the consent but it is described as "an inner struggle". He describes this as a difficulty partly in relation to the patient but also in regard to his own position in the hierarchical organization.
Some doctors (3) see themselves as emotionally frigid. One doctor mentions the difficulty of not being able to address the patient's existential and religious needs. Another doctor states that "knowledge about how to relate to patients has no greater value in the academic world".
A summary of the physicians' stated difficulties

In Table 5:1 the distribution of statements about difficulties for individual doctors in different categories is shown. If the difficulties are perceived as belonging to several categories, they are presented in both or all categories.

### Table 5:1

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21% 26% 53%

None of the doctors state that the demands on them as an "Actor" (I), i.e difficulties associated with instrumental skills, i.e medical science and technical knowledge, are amongst the most pressing problems. One (no. 3) has as many statements about difficulties in the category of "Actor" as in
that of "Reactor". For all other doctors intrapsychic difficulties are more important, i.e. demands that affect the physician as a human being.

In analyzing the content of the statements there were several difficulties with the same theme. In the categorizing process I have grouped statements with themes of similar content. Therefore when the statements are summarized in the different categories for the whole group of physicians as in Table 5:2 the number of statements are less than in Table 5:1. The percentage distribution of the statements between the different categories has not been influenced.

**Table 5:2  Distribution of difficulties in the different categories (No) or the whole group of physicians**

<table>
<thead>
<tr>
<th>Category</th>
<th>No</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>The Actor</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical limitations</td>
<td>37</td>
<td></td>
</tr>
<tr>
<td>Technical limitations</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>Organizational limitations</td>
<td>30</td>
<td></td>
</tr>
<tr>
<td><strong>The Interactor</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lack of psychological knowledge</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>Information</td>
<td>36</td>
<td></td>
</tr>
<tr>
<td>Questions</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>Two-way communication</td>
<td>31</td>
<td></td>
</tr>
<tr>
<td>Ending a consultation</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td><strong>The Reactor</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Type of patients</td>
<td>19</td>
<td></td>
</tr>
<tr>
<td>Medical limitations</td>
<td>37</td>
<td></td>
</tr>
<tr>
<td>Technical limitations</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Organizational limitations</td>
<td>54</td>
<td></td>
</tr>
<tr>
<td>Interactional limitations</td>
<td>67</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>346</td>
<td></td>
</tr>
</tbody>
</table>

This is an experienced group of physicians who think they have good medical and technical knowledge. They say that they have few difficulties
in making diagnoses and decisions especially in the earlier phases of the cancer disease. Anyway, half the doctors consider that adjuvant therapy can be a medical dilemma. More than half the doctors name shortcomings within the organization as obstacles to their work, i.e. the diagnostic process and planning of treatment. 21% of the statements are linked to difficulties that are disease-focused (I).

26% of the statements are linked to difficulties that are patient-focused (II), i.e. is difficulties in the physician's interaction with the patient. The difficulties concern mainly lack of education in psychological care of the patient. The physicians think it is difficult to inform the patient in a good way and to establish two-way communication especially when treatment of relapse fails. At the terminal stage, more than half have communication problems, not only because of deficient knowledge but also due to shortcomings within the organization and differences in routines between wards.

For the own reactions-focused physician (III), the situation is extremely frustrating when treatment of relapse fails and he can not offer further curative treatment. All the doctors report feeling helpless and afraid of frightening the patient. More than half, think that it is difficult to handle knowledge about an illness' poor prognosis. They say they can not feel pleasure about spells of remission. The same number find it difficult not to feel betrayal and guilt when the patient is in the terminal stage. This is aggravated when collaboration with colleagues at times does not work, partly due to organizational hindrances such as rigid limits between ward duties and policlinal activities. More than half the doctors further report that it is painful to be part of an organization where doctors find out about colleagues' difficulties in identifying cases of cancer.

53% of the statements are linked to the physicians' own reactions. The doctor feels that he has no control. He is forced to realize that some of the conditions of the work do not always allow him to make the right diagnosis or offer curative treatment and the doctor can not always be with the patient in a supportive way.
My analysis and categorization of difficulties into three categories, as presented in the preceding chapter, indicate that the stated difficulties are predominantly intrapsychic. During the doctor's working day, clinical situations occur which are perceived as dilemmas by the doctor and are preconditions of their work. According to the theories which have been described above, the individual acts in a given situation depending on his interpretation of it. This evaluation is affected, according to psychoanalytical theory, amongst other things by the experience of danger and conflicting feelings which the situation activates and how one has previously solved similar situations. One may have experience of having solved a situation in such a way that one has faith in one's ability to cope with the conflicting feelings activated by the present situation. The situation is difficult but can be solved: it is conflict-free.

My goal has been to paint a picture of the conflicts which each individual participant physician carries within him, in order to understand his statements about difficulties and behavioural responses. The different stages in the analysis of conflicting feelings and wishes are now described.

Stage 1

In the first stage, I analyzed the introductory interview. I focused on statements which reflected situations in which the doctor had problems and which left the doctor with conflicting feelings and wishes.

Stage 2

In the next stage, I analyzed the patient-related interviews. In this analysis I focused on statements which I believed to express conflicting feelings and wishes in different situations and phases of the cancer illness. I also looked at what had triggered off these conflicting feelings.
Results

In the statements from the introductory interviews and the patient-related interviews I have found a number of themes which reflect conflicting feelings and wishes.

I have grouped these themes as follows:

Need of authority/fear of authority
Seeking to influence and determine/fear of being powerful
Seeking to assert oneself/fear of being attention-seeking
Wish to give treatment/fear of hurting the patient
Wish to be good enough/fear of failure
Wish to give straight information/fear of scaring the patient
Wish for close contact/fear of intimacy

I have grouped these themes into three categories which I have called "main conflicts":

A. Conflicting feelings and wishes related to authority

B. Conflicting feelings and wishes related to frightening and injuring

C. Conflicting feelings and wishes related to intimacy/distance

In the following, examples of and comments on statements from each respective category are given.

A. Conflicting feelings and wishes related to authority

Conflicting wishes, as described earlier in chapter 3, may be due to having actual experience of or fantasies about a situation making demands on oneself which are difficult to handle or meet or, if one manages to handle them, there is a risk of being regarded as attention-seeking. It may imply that one both wants and does not want to be prominent and take responsibility. It is described as burdensome: "the fact that I'm forced to take responsibility for my decisions as well. It's a matter of not hesitating too much or regretting decisions that I've made." The risk is that one "promises
more than one can deliver". "It's almost as if you're divided." At the same time the actual situation is such that "you can't do anything about it". In one's inner mental world, the doctor is reduced to mediocrity, something which offends one's illusions of omnipotence. But on the other hand it's not good if the patient will not accept any other doctor and if "all other doctors are useless and I get glorified and that's tough because you get unreasonable expectations".

B. Conflicting feelings and wishes related to frightening and injuring

The possibility that the treatment may injure a person is frightening for the doctor. This is of special relevance in the treatment of cancer. Both cytostatics and radiotherapy cause side-effects which are serious and sometimes life-endangering. The possibility of curing the cancer is often limited by the fact that the doses necessary for a cure would be too toxic for the healthy organs. The cancer would be cured but the patient would not survive. It is a challenge to test what the limits are of a tolerable dose. It is a challenge to try and find new methods of treatment. All the doctors describe the dilemma as "killing the patient's hope". All the doctors name as their task the nurturing of hope but some describe the dilemma of having to be not quite honest and giving ambivalent messages. "I'm afraid that she'll ask, do I have a chance? That's when it gets difficult. I don't really like that situation, that I have to give grounds for hope and be honest at the same time. Sometimes I feel that I'm not really being honest when I sit there and talk about hope." Another doctor expresses it: "For the patient, there is still hope of things getting better, but for me there's no real hope". Several are afraid of "hurting the person sitting in front of me" and say they "don't want to make the patient worried". It is difficult. "It is a dilemma: the risk of scaring someone when the risk of a relapse is real..." "It is rather the case that one has mixed feelings."

One doctor admits that it is easy to make out things are better and gloss over in such situations.

The conflict takes up much energy and time. The physician is in a situation where he can not make the patient happy. He can not count on consolation in terms of gratefulness and happiness from the patient."I'm uptight, you can see from my body and the way I am. But I can't say that myself: I just notice that my patients notice it".

One doctor has also experience of causing irritation among the people around him because he spends so much time with the patient. "I overstep
the time limits and I bring upon myself accusations that I can't bring a thing to an end. That I'm too sensitive perhaps."
Some doctors can express the conflict as a feeling of grief."Of course it's difficult. Because one is an intellectual person, one is used to talking through a situation. But a situation like this you can't talk yourself out of."

C. Conflicting feelings and wishes related to intimacy/distance

This conflict is about longing for intimacy and the fear of not being independent. The crux of the conflict is the need of distance in order to think freely (chapter 3 p36) and at the same time the wish for intimacy in order to obtain information and identify the illness and the patients' feelings. The fear of intimacy involves having fantasies about "burning out", about "coping with the patient's anxiety". Two doctors express their fear of losing their "professionality" or, to put it another way, fear "chaos if you're not professional". One doctor experiences how his involvement, which was a helpful at the beginning of a period of contact, becomes a hindrance when he has to inform about the progress of the disease. "For any other patient at all it would have been different. There would've been more professionalism and less of my own feelings. I haven't seen this as a positive challenge. I've seen it as a millstone."

The inability to get involved in the patients' situation makes others feel "thick-skinned". Some doctors see themselves as emotionally frigid. They have difficulties with feeling and crying. "You lay a layer of metal between your heart and your stomach or something like that...but it is difficult to control it, you just become emotionally blunt at work." They are scared by their own cynicism and feel they are tough and thick-skinned.

In Table 6:1 the distribution of the main categories of conflicting wishes - the "major conflicts" - within the group is given. All the doctors make statements which fit into these three categories. All but three seem to have solutions to conflicting feelings and wishes connected with authority (A). However, all the doctors feel that they lack the ability to reconcile the conflicting feelings which arise when they risk injuring or scaring the patient (B). Four doctors make recurring statements about fear of and/or inability to find ways of handling close relations with the patient (C).
Table 6:1  The main categories of conflicting feelings and wishes, the "major conflicts", are distributed as follows:

<table>
<thead>
<tr>
<th></th>
<th>A = Authority</th>
<th>B = Frighten or injure</th>
<th>C = Intimacy</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>3</td>
<td>18</td>
<td>4</td>
</tr>
</tbody>
</table>

Stage 3

The relation between conflicting feelings and the distribution of difficulties

In the next and last stage, I compared the categorization I had made of conflicting feelings and wishes with the categorization of statements about difficulties which is presented in chapter 5 p77. See Table 6:2.
Table 6:2 The "major conflicts" (A, B, C) of the doctors (Doc) linked with the distribution of their stated and categorized difficulties (I, II, III)

A = Authority  B = Frighten or injure  C = Intimacy  
I = Actor  II = Interactor  III = Reactor

<table>
<thead>
<tr>
<th>Doc</th>
<th>&quot;Major conflict&quot;</th>
<th>Difficulties</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>I</td>
</tr>
<tr>
<td>1</td>
<td>A B</td>
<td>6</td>
</tr>
<tr>
<td>2</td>
<td>A B</td>
<td>8</td>
</tr>
<tr>
<td>3</td>
<td>B</td>
<td>9</td>
</tr>
<tr>
<td>4</td>
<td>B</td>
<td>10</td>
</tr>
<tr>
<td>5</td>
<td>B</td>
<td>3</td>
</tr>
<tr>
<td>6</td>
<td>B</td>
<td>3</td>
</tr>
<tr>
<td>7</td>
<td>C B</td>
<td>7</td>
</tr>
<tr>
<td>8</td>
<td>B</td>
<td>6</td>
</tr>
<tr>
<td>9</td>
<td>B</td>
<td>12</td>
</tr>
<tr>
<td>10</td>
<td>A B</td>
<td>2</td>
</tr>
<tr>
<td>11</td>
<td>C B</td>
<td>4</td>
</tr>
<tr>
<td>12</td>
<td>B</td>
<td>1</td>
</tr>
<tr>
<td>13</td>
<td>C B</td>
<td>5</td>
</tr>
<tr>
<td>14</td>
<td>B</td>
<td>5</td>
</tr>
<tr>
<td>15</td>
<td>B</td>
<td>8</td>
</tr>
<tr>
<td>17</td>
<td>C B</td>
<td>5</td>
</tr>
<tr>
<td>18</td>
<td>B</td>
<td>7</td>
</tr>
<tr>
<td>19</td>
<td>B</td>
<td>6</td>
</tr>
</tbody>
</table>

As mentioned before most statements about difficulties are linked to the physicians' own reactions. The conflicts about authority and intimacy do not seem to influence the distribution of difficulties in the different categories. There is no difference in the pattern of distribution compared with those who have only conflicts about injury.
In conclusion, three doctors have difficulties reconciling conflicting feelings about being in authority (A). Four name the fear of getting too close (C). All the doctors name the fear of injuring or scaring the patient. One doctor states that he has no difficulty in meeting patients with other life-threatening diseases than cancer because the patient is not so scared by the diagnosis.
In this chapter, the participants' coping strategies are presented. I have analyzed the transcribed interview material. The analysis was carried out without knowledge of the outcome of the other two survey methods: the Defence Mechanism Test (DMT) and the Structural Analysis of Social Behaviour (SASB). The results of the DMT and the SASB are presented in the next chapter (8).

Categorization

The categorization of the participants' coping strategies has emerged successively during the analysis of the total interview material. The analysis has been performed in several stages.

Stage 1

Directly after each interview, I wrote down comments on what I had perceived to be themes and phenomena which reflected the doctor's behavioural and emotional responses.

Stage 2

When the interview series was over, I analyzed the recorded and transcribed interviews. The focus of the analysis was the participant's emotional and behavioural responses in his work during different stages of the patient's illness on the basis of both manifest statements and latent material. I interpreted things which seemed to be threatening or causing conflicts for the doctor. I described his behavioural responses in terms of defences and how these manifested themselves in his behaviour. After each interview and later by way of a summary of each interview series, I made a judgment of each doctor's coping (emotional and behavioural responses).
About twenty interviews have been analyzed in the same manner by one person using the same theoretical framework. This comparison was made to "calibrate" my powers of observation in respect of the theoretical framework and also to see if the data could be given the same interpretation by others, a technique which corresponds to reliability testing in quantitative research methods. (See chapter 10 on method p 126)

Stage 3

In stage 3 of this analysis, I went through the total interview material once again and focused on the doctors' own statements about their emotional and behavioural responses in the difficult situations presented in chapter 5. I wanted to obtain a picture of how the participants behaved in situations which they themselves defined as difficult. I expected, on the basis of my theoretical approach, that their coping strategies in these (explicitly) testing situations would be particularly evident.

The themes of the statements were judged from the viewpoint of my theoretical perspective on coping as a simultaneous defence and mastering process, i.e. that one uses both unconscious defence mechanisms and conscious behaviour at the same time. What would emerge was meant to be the underlying defence mechanism. Unavoidably, however, they all have common features as all defences viewed from my theoretical perspective serve to avoid feelings of anxiety. A common theme is that all the categories include some form of activity.

Presentation of categories

Over 200 statements about behavioural/emotional responses (coping) have been analyzed. Many statements about coping in explicitly difficult situations resemble each other. In this study around 30 recurring themes have been grouped together into clusters which I subsequently have formed into seven different categories. See Table 7:1.
Table 7:1  Presentation of the participants' coping strategies in seven different categories

<table>
<thead>
<tr>
<th>I.</th>
<th>Seeking knowledge</th>
</tr>
</thead>
<tbody>
<tr>
<td>II.</td>
<td>Seeking solutions or reformulating a problem so as to make it soluble</td>
</tr>
<tr>
<td>III.</td>
<td>Seeking support and guidance</td>
</tr>
<tr>
<td>IV.</td>
<td>Building up a relation with the patient</td>
</tr>
<tr>
<td>V.</td>
<td>Denying the severity of the situation</td>
</tr>
<tr>
<td>VI.</td>
<td>Distracting activities</td>
</tr>
<tr>
<td>VII</td>
<td>Projective manoeuvres</td>
</tr>
</tbody>
</table>

In the following, the significance of each of the categories is presented.

I. Seeking knowledge

This strategy entails striving to develop expertise and control. Seeking facts improves self-esteem and security and it reduces the risk of failure. The supposed defence-mechanisms involved in this category are assumed to be intellectualization and isolation.

In this category themes are included which are characterized by statements about seeking support from scientific literature, the significance of knowledge in the professional role, trying to prepare oneself and form a picture of the history of the illness and of the patient before each meeting, seeking information from the patient and the pursuit of regular channels of information "to find out exactly how things go".

Now follows an account of how statements are grouped in this category. Sixteen of the eighteen doctors seek knowledge. Some chiefly make use of research for this purpose: "At least I learn to think in new ways, think a bit more critically." A couple of doctors use this strategy to train themselves to be able to carry out technically difficult examinations: "I felt that I was one of the people who knew how to use this technique once I had learnt it. It doesn't matter what the patient is like, but it's just this security, that you have the self-confidence. It's me who's going to do it and I'm going to do it on my own." Another puts it like this: "Now I've been doing this for so long that I should be one of the best at it."

In the discussion about so called "straw-catching" therapy (chapter 5 p 69 and 71) several doctors mention the importance of being able to read scientific articles. "I felt a bit stronger (after having read the article) for
having this at the back of my head, you could say, when I met her (the patient) the next day. It was of course a slim hope, but it's a slim hope for her too, I thought...Knowing this gives a feeling of being "a little more for" her because that's what you feel for this young flower, that you're obliged to do everything you can. Then I felt that I had something to offer."

Researching new methods of treatment also offers satisfaction and the feeling that the activity is helpful. "I started by ringing the pharmacist and asking about information on this (new) preparation...There were various arrangements to be made for this patient if it was going to work."

At the terminal stage, there is above all one participant who emphasizes that knowledge of the previous course of the illness and the available forms of treatment are helpful. "Because the personnel who are worst off...are the ones who have big gaps in these medical causal relations." Another participant says that it is important not just to see the dead patient: "For me it's not perhaps about accepting that he is dead, but rather I want to know how he died."

II. Seeking solutions or reformulating a problem so as to make it soluble

This strategy does not just mean that one can formulate a problem, but there is a clear action in this coping strategy. One confronts reality and undertakes appropriate measures. One acts on the basis of one's understanding. One tackles the disease as an intellectual challenge and isolates the affect. One considers and applies possible alternatives. One accepts the situation and finds some profit by one's actions. This strategy means above all reformulating the situation into a soluble problem and this requires besides intellectualization and isolation also a rational capacity and sometimes a switching of focus.

In category II, statements have been included which have expressed the participant's attempts to take one stage at a time. Themes which fall under this category suggest striving for rules, structure and support of clearly stated goals and the benefits of evaluation and development, as e.g. trials. All the participants use this form of coping strategy. "We have identified it (the problem) and are trying to do something about it."

In this category, statements have been included such as "every new patient is a challenge". There is a challenging situation "which one tackles". One
participant describes it thus: "It's a way of getting me going, so to speak, that they're very ill."

One doctor who works with invasive exploratory methods says "When you're standing there and are going to perform the investigation you get technical. You don't see the face...it's just a hole and it's a case of doing the best job you can...I don't think about my discomfort, it's not my feelings I'm dealing with but the situation in front of me which I'm trying to decide how to proceed with. The situation is unpleasant and I can't do anything about it."

Several express the importance of establishing a routine and a frame for giving the treatment, "otherwise we're just drifting". One doctor says: "I try to keep things separated, take one thing at a time. Right now I'm concentrating entirely on getting her ready for treatment and making the diagnosis. I'll do that bit first, then I'll treat her. That'll be part two. And then I'll deal with a possible failure." Another says: "In this situation the aim is, first of all, to make treatment possible. The next is to protect her (the patient) from side effects and give her the chance to take up other questions about the illness and the future." The doctor sees his work as "monitoring and servicing". "In this situation, I think that thinking and feeling exist very much side by side with each other." Yet another says: "Generally speaking it may very well be the case that one goes straight from A to B and I don't think that upsets me too much because we have a kind of system...Yes, I don't remember most patients. It's like a system we use."

Routine also seems to be significant when giving news of results on the telephone. One participant prepares himself before making a telephone call by "taking a deep breath. I think through exactly what I'm going to say as well as how to behave and then I ring them. It's somehow easier. I take my own initiative rather than being caught out by the patient's questions. Then I feel prepared even if I'm actually prepared all along. I try to lay it out, in her case, like a plan of action both for me and for her". Several doctors have mentioned that it is helpful to take one thing at a time in those situations where the patient is in remission but where one is "painfully aware" that the patient may have a relapse. "I focus on here and now, the coming weeks. It doesn't feel bad."
III. Seeking support and guidance

This strategy includes demands for an open and two-way communication with so-called "significant persons". One seeks and uses constructive help. One accepts the support which is offered. One shares one's worries and talks with others.

This category includes strategies which entail abandoning one's omnipotent defensive position and adopting more mature strategies such as rationalization, a form of intellectualization which corresponds to the individual's endeavours "to excuse and safeguard oneself. A help for the individual to maintain self-respect when one suspects that one is in trouble." (Sjöbäck 1984)

In this category, statements about collaboration between and support from colleagues have been included. Also included are statements which describe different statements about self-reflection, self-knowledge and the possibility to establish good contacts with relatives.

Fifteen of eighteen doctors say that they use the support of colleagues. Most of them say they adopt this strategy in uncertain situations. "Yes, we discussed whether we should give cytostatics." One doctor thinks it is good "because one is afraid of becoming too powerful".

Two participants say they would wish to have supervision groups such as a Balint group. One has experience of this. "I often think that a clinic like this could operate like a Balint group. If I have a patient whom I've been seeing for a long time and have given different treatments to and the patient has progressed and then the treatment has failed...then it can be very wise to approach a colleague who is not so emotionally involved and say, 'Okay, these are the facts of the case.'" The doctor is striving for the support of a person. It need not only be from colleagues or psychologists but may also be help from relatives. Some regard relatives, in particular as a resource, above all in situations where bad news has to be given, such as news of a relapse. "In that situation I experience...that it is an advantage if a relative is present who can both see the immediate reaction and be there as a support when I've gone...And then of course I inform the nurse that the patient has been notified...so that she can be supportive." The participants say that they do not just take help from relatives but that they also take help from other staff. One says that "you would burn out if you tried to live up to coping with everything. I've tried to be human but realize my limitations. I feel that there just isn't enough time. So I ask another member of staff to step in, sit with the patient for a while and then I leave it up to them. Because
otherwise I know that I'll be holding surgery until six o'clock (in the evening) and the last patients will be really fed up and they'll be fed up at home and there'll be chaos and I think I would be the worse a doctor. But this has only happened during the last years."

Some of the doctors relate that they have developed a philosophy of death and express ideas about death. "Of course you yourself have to find a way of coming to terms with death...It mustn't be too charged with anxiety because then I don't think you can cope with it in a business like this. In that case you'd better become an eye specialist. You have to come to terms with the idea and certainly, I think, you have to come to terms with the thought of one's own inevitable death if you're ever going to cope with it." Another doctor puts it this way: "That's the way life is. It's grim and unfair and there's not much you can do about it. Somehow, if you haven't already accepted that then you can't stay in a job like this. It's some sort of survival strategy. I think that maybe you become emotionally numb."

IV. Building up a relation with the patient

This strategy assumes a meeting with the patient will take place. The doctor states that at this meeting he gains insights into the most central questions of life, i.e. how to handle life and death. It may imply that, with the patient's help, he can maintain morale for himself as well as for the patient. The assumed defences in this category are internalization (identification) and displacement with a particular focus on sublimation, which entails a displacement to the professional field of the need for intimacy. It may also mean the expression of an opposite need to be taken care of oneself. This strategy may also entail the reformulation of a technical problem into a care-work problem when the technology or the technical know-how fails. (Compare with category II)

In this category endeavours to establish "patient contacts" have been included as well as statements which describe a relation with a patient being beneficial to a participant's own personal development. Statements describe a striving for a joint effort and the sharing of uncertainty in difficult situations.

Slightly more than two thirds employ this strategy. One doctor describes it this way: "It is very difficult, this, but somehow I arm myself with the patient's help because I feel that I want to know how they reason, think things through. Because their anxiety is also my anxiety...For my own sake I
establish a close relationship. I am a little better prepared for when he comes back and is ill. And he is too and I'm convinced of that. We just don't need to say it with words just yet."

Those doctors who have this coping strategy use it above all when the treatment is failing. "And there again, when you have so little to offer and maybe can't get the analgesics right or do anything about the anxiety and nausea. Then at least I can give of myself, show them that I'm not afraid to come in and sit quietly with them."

One doctor offers examples of how he uses this strategy to obtain co-operation: "I asked him gently if it felt really bad, if it was hard even to relax...I tried to convey to him...it's about co-operation, this thing, about (finding) a way to the end, if you like. But communication is necessary, so that he really tells us when he finds it hard and dares to trust us, so we can help him properly. If we're going to help him optimally then we have to know how he feels and what he most of all wants."

This behavioural response is regarded as so essential by one of the doctors that, if it does not work, then neither will the rest of it. "It was good to be on duty over the weekend, to do the rounds in peace and quiet. It was good for my soul because I could at least give what I had to give. There's some sort of conscience eating away, that old Doctor Capable, you know."

V. Denying the severity of the situation

Statements in this category express the idea that "one forgets, laughs things off" and they include ironic twisting. Statements have been included which reflect attempts to gloss over, reduce the seriousness of the situation and use humour. In this group themes have been included which express "grim" or "macabre" humour, cynicism or a "thick-skinned" attitude. This behavioural response may entail selective indifference and defences in this category include reaction formation, displacement and denial.

The great majority of the participants show this behavioural/emotional response. One of them uses a sort of neutralizing conversational style with his patients. "I start with purely everyday events. As regards the investigation ahead there's nothing much to discuss, and when I examined him I found nothing really out of the ordinary apart from a very large lymphatic gland in the armpit, so large in fact that I strongly suspected it was a lymphoma. On the other hand I also know that very large lymph
nodes can sometimes be ordinary lymphadenites and I tried to play down my suspicion that it could be a lymphoma even though it was very strong. Sometimes you can be pushed by patients with very poor prognoses when you don't want to inform them of things like this. So you don't give bad news but rather have an ordinary conversation about everyday things, which they're quite happy about. They expect you to make the best of things."

One can also neutralize by means of a torrent of words in an "evasive oncological manner". "I know how you pile it on... in an individual case it's impossible to say... when the statistics say this or that... there are so many uncertainties, etc."

One strategy is indifference: "You suspect that these (patients) have had a rough time, suspect that they are dissimulating. I have to admit that I don't do very much actively to find out if it really is like that."

One participant gives examples of how doctors use macabre humour amongst themselves. "I think that most others want to make light of this (that the patient has had a relapse). At worst we meet it (the news) with some kind of grim humour, especially when you know that the patient can't hear anything (that you're saying)."

Some express rationalization and denying: "But, for goodness' sake, on the other hand none of us have been cured. We're all going to die sooner or later. You just have to make the journey as pleasant as possible and take one day at a time... None of us really knows what tomorrow may bring, but of course they have a greater threat hanging over them. But what's to stop me from walking under a bus tomorrow?"

VI. Distracting activities

This strategy entails the physician consciously or unconsciously undertaking tasks which are devoid of contact with patients, such as research and administration or other activities which allow them to avoid the patient. Statements have also been included here which tell of escapist tendencies and pseudotreatment. This strategy may entail the defence of displacement and intellectualizing.

Slightly more than half the participants name this strategy as the reason why they do research: "to get away" and to have activities "which help you forget" the work with seriously ill patients. Some of them are quite clear that
they have chosen administrative duties as a shelter. "...I work with other things. Maybe it's good that I've found a refuge so that I won't come to any more harm."

A couple, in particular one doctor, offer examples of how they avoid patients. "I didn't go up to the ward. I could hear her deteriorating all the time. I couldn't bear, I think, to go up and talk with her." Some say that they use this strategy when the patient has died. One of them immerses himself in the heavy workload. "I haven't got the slightest clue where I hide everything that I felt at a deeper level...I felt that it was over. And I've heard many (say) that now that it's over, the patient's dead, then it's all finished. But it's not hard, because there's so much else you can lose yourself in."

All the doctors say that they give pseudotreatment when the relapse treatment fails. "The difficulty is to try and help a person in this situation when really you know that you don't have anything. But still you want to try to do something...Sometimes, I know, I've been guilty of it, I mean, you give treatment just to do something for the patient and put the patient at ease for purely psychological reasons, although you know with 99.9% certainty that it won't have any effect on the illness."

VII. Projective manoeuvres

In this category statements are included which reflect how difficult it is to recognize one's own powerlessness and how failings are attributed to others or to the organization, the "system". This strategy is assumed to include the defence of projection.

A third of the participants make statements which can be included in this category. One of them uses this strategy above all when he is angry and unsure, e.g. in situations where the doctor's request for an examination is called into question. "I was furious with them, to put it bluntly, because it was an interruption. It interrupted the planning and I became extremely uncertain."

One physician put the heavy burden onto others. He can't identify himself with the group who finds the job frustrating: "Those who work with this find it tough, at least those who are on the ward." Still another physician lets his" desperation right out into thin air. I can't find a destination for my feelings."
Stage 4

Coping patterns

In this phase of the analysis, I examined my earlier judgments of the participants' emotional and behavioural responses in situations which they had not denoted as "difficult" (stage 2). After each interview and series of interviews, I had made a judgment of each participant's method of coping (behavioural and emotional responses) in terms of defences and how these affected their behaviour. All of the behavioural responses analyzed in this manner could be placed in one or other of the seven given coping categories. I found that the participants showed more or less clear groupings of strategies. The distribution of strategies in the different categories for different doctors revealed a "coping pattern" with one or more main strategies and sub-strategies for each doctor, respectively. By main strategy I mean recurrent coping strategies (behavioural/emotional responses) rather than a single statement in a single interview. The coping strategy has been named by the participant as significant in strenuous situations (chapter 5) and it occurs in the overall judgment of each individual doctor. By sub-strategy I mean coping strategies (behavioural/emotional responses) which can be traced in individual statements but which do not occur in the overall judgment of the doctor.

A summary of the coping strategies

As one can see from Table 7:2, almost half (8) express that they seek knowledge (I). The majority (15) of the participants state that attempting to solve a problem (II) is their main strategy. A few of them (4) seem to have the main strategy of seeking support (III). Far more (10) show this less obviously as a strategy, i.e. as a sub-strategy. Half (9) establish a relation with the patient (IV) as a main strategy and over two thirds (6) use this as part of their coping "repertoire". All but two use denial of the severity of a situation (V) as a strategy; almost a third (6) use this as their main strategy. All the participants make use of diverting strategies (VI). Only two show this as part of their main strategy. One third (6) use projective manoeuvres (VII). No-one uses these as a main strategy.
Table 7.2  The distribution of main strategies (X) and substrategies (x) for each doctor (Doc) as grouped in the described categories (I-VIII).

<table>
<thead>
<tr>
<th>Doc</th>
<th>Seeking knowledge</th>
<th>Seeking solution</th>
<th>Seeking support</th>
<th>Building relation</th>
<th>Denying severity</th>
<th>Distracting activity</th>
<th>Projective manoeuvre</th>
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<tr>
<td></td>
<td>I</td>
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<td>III</td>
<td>IV</td>
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<td>VII</td>
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<td>19</td>
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</table>

In order to further illustrate the studied doctors' coping patterns, I have used the results of the DMT and the SASB. The results are presented in the following chapter.
CHAPTER 8

THE DEFENCE MECHANISM TEST (DMT) AND THE STRUCTURAL ANALYSIS OF SOCIAL BEHAVIOUR (SASB)

The results of the survey instruments DMT and SASB are first briefly presented. The coping patterns I presented in chapter 7 are thereafter compared with DMT and SASB results in chapter 9.

The Defence Mechanism Test (DMT)

Generally speaking, the individual DMT results of the participant physicians show a pattern which frequently occurs in groups of individuals not belonging to a psychiatric clinic (Sundbom 1992). The majority (9) have a balanced and stable defence structure. Some of the participants deviate from the main group in this respect. A few have a subtle structure but show more clearly than the main group conflicts around aggression with prominent reaction formation defences. Some of the women also show conflicts around the theme aggression. They show difficulties in defending and distancing themselves. They suppress themselves and show a need for control. The conflict seems to occur within the framework of an intact ego, but the structure does not show the same nuances. Some others (3) are deemed to have an inadequately resolved authority conflict. They have internalized great demands upon themselves and have a tendency to turn aggression and criticism towards themselves.

One participant is distinguished by the fact that he is deemed to have a conflict around dependency and independency.
The Structural Analysis of Social Behaviour

The results of the SASB show a picture for the group which on the two different rating occasions is almost identical (See Fig.8:1). As can be seen in Figure 8:1, self-ratings on both occasions are dominated by cluster 2 (self-accepting), followed by clusters 4 and 5 (chapter 4 p 54). These results have been compared with, on one hand, a so-called "normal" group comprising 52 persons, students and others, aged 20-56 (M=31 years) (Bodlund & Armelius 1993) and, on the other hand, another group of doctors from three different somatic specialities (Holm 1993). The picture (See Fig.8:1) was found to fit with the "normal" pattern with the exception of the cluster which reveals positive self-image.

Figure 8:1  SASB. Self ratings of the doctors in the study at the first (Study doct bef) and the last (Study doct aft) interview with patient in focus related to comparison doctors (Doct comp) and a reference group (Ref grp).

![Graph showing self-ratings of doctors over two occasions compared to normal and comparison groups.](image)
Part III

INTERPRETATION, DISCUSSION AND CONCLUSIONS
RELATIONS BETWEEN THE DIFFERENT RESULTS IN THE EMPIRICAL STUDY

Coping patterns illustrated by means of the results from the DMT and the SASB

An analysis of the participants' statements shows that all the doctors employ a number of strategies, i.e. have a broad repertoire of coping (chapter 7). A large majority, the "main group", have statements which can be grouped within the first six categories of strategy (i.e. they seek knowledge, solutions to problems, support, build up a relation with the patients, they deny the severity of the situation and pursue distracting activities.

The coping pattern is thus fairly similar and varied for all participants. All those who, according to the DMT, show a balanced, subtle and stable defence structure are to be found in the "main group" described above.

There are strategies which certain doctors do not use. These are striving to "seek knowledge", "seek support", "building a relation with the patient" and "denying the severity of the situation" and finally "projective manoeuvres". Amongst these doctors there is no uniform agreement in regard to deeper defence structures as measured by the DMT or deviations in the self-image on the SASB. However, certain tendencies may be seen. A couple of those who do not "seek support " and who do not at all seek to "build up a relation with the patient" produce a DMT picture which suggests an inadequately resolved aggression conflict or conflict in regard to dependence/independence. Of those who do not "build up a relation with the patient", all show conflicts pertaining to aggression.
All the female doctors seek to "build up a relation with the patient". None of them shows projective strategies. One of the two participants who do not "seek knowledge" is female and her DMT picture suggests both difficulties in distancing herself and suppression of her own needs. The male doctor's DMT picture suggests a conflict pertaining to aggression.

According to the SASB there are especially two doctors who show self-evaluations with a dominating negative self image. They both have conflicts around aggression and different degrees of self-control. The one who has less self-control seeks to "build up a relation with the patient" to a higher degree than he "seeks knowledge" while the one with greater self-control "seeks knowledge" rather than "builds up a relation with the patient".
Coping strategies may also be linked to the results of the analysis of conflicting feelings and wishes which has been based on statements of the total interview material and presented in chapter 6 p86. See Table 9:1.

Table 9:1  The "main conflicts" (A, B, C)in relation to the distribution of main strategy (X) and sub-strategy (x) for each doctor (Doc) as grouped in the described categories (I-VIII)

<table>
<thead>
<tr>
<th>Doc</th>
<th>Major conflicts</th>
<th>Seeking knowledge-solution</th>
<th>Seeking support</th>
<th>Building relation</th>
<th>Denying severity</th>
<th>Distracting activity</th>
<th>Projective manoeuvre</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>A/B</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>x</td>
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<tr>
<td>2</td>
<td>A/B</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>x</td>
<td>x</td>
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<tr>
<td>3</td>
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<tr>
<td>7</td>
<td>C/B</td>
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<td>10</td>
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<td>11</td>
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<td>16</td>
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</tbody>
</table>
Table 9:1 shows that if the large group, which is deemed to have conflicting feelings only in regard to being frightening (B), is examined according to their coping strategies one finds that they show coping strategies such as "seeking knowledge", "solutions", "support" and "building up a relation with the patient". Nearly all of them employ denying and diverting strategies.

When we examine the sixteen who seek knowledge we find that in this group two of those who have statements expressing conflicting feelings in regard to being an authority (A) are missing. They do not like public appearances and competition. Those who do not "seek knowledge" to the same extent as their colleagues have, as described above, a DMT picture which may suggest a conflict in regard to aggression and difficulty in distancing themselves and also the suppression of their own needs.

In the group (of four) which I interpreted in my analysis of conflicting feelings and wishes as being afraid of getting too involved and avoiding intimacy (C) we find the three doctors who have no statements about the possibility of "building up a relation with the patient". Three of them, in comparison with the other participants, also strive to a lesser degree to "seek the support" of colleagues. They have a DMT picture which suggests an inadequately resolved aggression conflict and a conflict in regard to dependence and independence, respectively.
Conflicting feelings and wishes - DMT- coping

When the correlation between conflicting feelings and coping strategies in the light of defence mechanisms is examined we obtain the following results shown in Table 9:2:

<table>
<thead>
<tr>
<th>Conflicting feelings</th>
<th>DMT conflict</th>
<th>Coping strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Authority/ Frightening</td>
<td>Authority/ Aggression</td>
<td>Little intellectualization (they seek support and build up a relation with the patient)</td>
</tr>
<tr>
<td>Frightening</td>
<td>Balanced/stable</td>
<td>Moderate intellectualization</td>
</tr>
<tr>
<td>Intimacy/ Frightening</td>
<td>Aggression/ Independence</td>
<td>Most intellectualization (they do not seek support or build up a relation with the patient)</td>
</tr>
</tbody>
</table>

The picture may illustrate the theoretical idea about how each individual nurtures a behavioural/emotional response in order to protect himself and/or resolve the cause of conflicting feelings. Those who have difficulties with competition show less evident intellectualization strategies than those who seek emotional support while those who have problems to do with getting involved employ intellectualization strategies to a greater degree.

The survey has not been designed to allow an evaluation of whether the doctors' coping strategies are adaptive or maladaptive. The SASB shows that the doctors, compared with a normal population (students) evince less self-love. This is mainly so for the female doctors.
"It distresses me that so much which is published on coping deals with trivial issues in over-simple, one-session research designs when so much needs to be done" says Lazarus (1993 p245) almost thirty years after he had introduced the concept of coping. Today he still sees a need for studies where small groups of individuals are studied. He assumes that data on the coping processes would be far more meaningful and useful if one knows the individual's thoughts and actions in specific situations. He claims that so far in studies "thoughts and actions tend to be disembodied" (p242) from the persons being studied.

This study has used a type of design that Lazarus was proposing. A small group of individuals has been investigated using a method intending to integrate thoughts and behavioural responses in the individual being studied.

Obviously, series of interviews with experienced physicians at different stages of the cancer disease have not been carried out before. A systematic analysis of physicians' difficulties, conflicts and coping from a psychoanalytical perspective has not been carried out before either. In this study conflicting feelings and wishes contributing to the physicians' difficulties have been analyzed and the physicians' coping patterns have been interpreted on the premise that in every coping strategy there is a striving for psychological balance.

In the following section I first report and discuss a summary of the results. These are then compared with the earlier studies reported in chapter 2. After that there follows a discussion of the method of the survey, the effect of the study on the participating physicians and the practical implications for clinical work and finally proposals for educational programmes and research.
Discussion of results

Difficulties

The physicians have difficulties which have been classified in three main domains, namely: how the physicians perceive the disease, the patient and their own reactions.

In the first category belong difficulties which reflect demands for medical knowledge and which influence the disease. An example of this difficulty is the doctors' differing concepts of the indications for cytostatics at different stages of the disease. This matter is perceived by some physicians as leading to difficulties when introducing and co-ordinating treatment routines. They say that this has consequences for the course of the disease. Problems which reflect technical demands are also included in this category. Limitations in the diagnostic procedures, i.e. getting good biopsies or avoiding bleeding, are examples of this. In addition, to this category belong organizational shortcomings which might limit the medical and technical equipment. It can be difficult to get examinations done which one has requested and to wait for the results. Shortcomings in the organization of policlinal work lead to tight time-frames per patient. Consequently there is sometimes too little time to get enough data for making a proper diagnosis and for selecting adequate therapy.

However, in general the physicians say that they have relatively few difficulties concerning their medical and technical knowledge. One fifth of the statements seems to belong to this first category.

Statements which have been deemed as belonging to the second category of difficulties where the patient is in focus, reflect problems concerning limitations in the physician's knowledge of communication and psychological caring. One fourth of the statements belong to this category. Many doctors say that it is difficult to inform silent patients or those who do not seem to react. Some see difficulties in interpreting or observing all levels of communication - "probing" the patient's mind. Almost all the doctors report difficulty in two-way communication especially when the treatment is not helpful. They say that it is hard to talk with the patient once the cancer has disseminated, to tell them that there is no other treatment to offer. It is not just the fact that the doctor lacks effective medical alternatives but it is also hard to adopt a professional attitude. This is described as "professionalism" and as the knowledge to
read the patient's feelings and to interpret how much the patient has understood. This also includes knowing how to handle the patients' reactions. Some doctors relate how this difficulty is particularly prominent when one has to face a new patient. This is the case when one is a consultant doctor or "on call".

More than half the statements reflect difficulties which are related to the physician's own reactions. It is not surprising that these difficulties are predominant. It can be frustrating to be in a medically, technically, organizationally and interactionally problematic situation. In this study the physicians report that they have medical and technical knowledge and experience of most situations of the earlier phases of cancer diseases. This is the case even in the terminal stages of the disease. The emotional difficulties arise above all when the chosen therapies fail. In this situation it is evident that the different categories overlap. This situation seems to trigger off all the categories of difficulties. The demands on medical efforts are accentuated, as is the psychological caring and one experiences problems dealing with one's own reactions. In particular, the difficulty of judging the timing for when to start a treatment is discussed. This is especially difficult when the physician is not familiar with the method or he has to give life-threatening treatment.

Almost all the doctors find it emotionally difficult in situations where the patients do not accept that the therapy has failed and the disease progresses. The physicians feel that they should not give treatment but they still do. Some make the comment that they do so because they are treating their own anxiety.

It is no surprise that doctors experience difficulties when the patients have relapses or when the treatment of relapse fails. However, it is a remarkable observation that half the doctors mention that the remission period is difficult for the doctor himself. He knows a "painful fact". He expects a relapse. The doctor has experienced this many times before and fears that he will be confronted with the patient's worry, anxiety and grief if the relapse comes up. The patient and the doctor may have to face the patient's dying in the end despite the present remission.

The investigation shows that the physician's frustration and suffering is often related to organizational matters. For instance, some doctors express difficulties with loyalty towards colleagues in an competitive organization and personal needs are viewed as private and without relevance for the work.
Some say that it is emotionally taxing. They have a sense of betrayal and guilt, when they draw a line between themselves and the patients. This is the case when they leave the patient and at the same time allow themselves some private space in order to do research, have a vacation or a private life. Many say that the delimitation damages continuity but it is a necessary condition if the doctor has to cope with his work.

In this presentation of the difficulties of the physicians it has been shown that they mainly have difficulties with their own reactions. Their work entails that they face situations that can reactivate conflicting feelings and wishes.

Conflicting feelings and wishes

In this study mainly three main conflicts could be identified: conflicting feelings and wishes related to authority, to frightening and injuring and to intimacy/distance.

One sixth of the doctors speak of how they struggle with their conflicting feelings in regarding themselves as authorities vis-à-vis the patient. This conflict is of less importance in the terminal stage. The position then seems to have switched from a doctor/healer to a doctor/fellow human-being relation.

They all report conflicting feelings about giving the patient information and treatment which may harm or frighten him. They struggle with the unrealistic idea that one can give a frightening message without the patient becoming frightened. This is a problem which can be aggravated if one feels a conflict about being an authority or being in close contact with a patient.

Slightly less than a quarter of the doctors mention difficulties in finding solutions to how they should determine their distance to the patient. They express their fear of losing their "professionality" and describe their fear of not being able to be objective.

The analysis of the physicians' coping strategies shows that the doctors, within the frame of the organization, have oriented themselves towards work which gives them as few conflicts as possible. The physicians who show conflicting feelings of being an authority works in a field where competition and leadership play a lesser role in the work than, for example,
intimacy with the patient. However, those who have conflicting feelings towards intimacy with the patient copes with this above all by working in a field with limited patient contact. In this way, the individual doctor avoids being confronted with his conflicts. The important question is whether the doctors' methods of coping are adaptive or maladaptive. Another important question is which coping strategy is most rewarded by the organization in which the doctor is working. I will return to this question in the section where proposals for educational programmes are discussed.

Coping strategies

In the following, it is reported how the doctors in this study cope with their difficulties. Their coping strategies have been grouped into seven categories: "seeking knowledge", "seeking solutions", "seeking support", "building up a relation with the patient","denying the severity of the situation","distracting activities" and "projective manoeuvres".

Most of the doctors "seek knowledge". They seek support from scientific literature and emphasize the significance of knowledge in the professional role. They try at the same time to prepare themselves and form a picture of the history of the illness and of the patient before each meeting. They seek information from the patient and the pursuit of regular channels of information "to find out exactly how things go".

All the physicians "seek solutions", i.e tackle the disease as an intellectual challenge, as part of their coping strategy. This strategy means not only that one can reformulate the situation into a soluble problem but there is also an evident activity in this strategy. One confronts reality and undertakes appropriate measures. One seeks solutions on the basis of one's understanding. This is not suprising. The physicians are educated to do so and it is their duty.

Most of the doctors also "seek support" from colleagues as part of their coping strategy. They share concerns and talk with others. They seek and use constructive help from others.

What is remarkable and has not been shown earlier is that almost all the doctors, fifteen out of eighteen, state that by "building up a relation" with the patient they can gain insights into the most central of life's questions, questions about how to cope with life and death. Half the doctors say that they have this strategy as their main strategy. It is said that the challenge of the doctor's work is to find solutions to difficult problems (Fain 1989).
The establishment of a relation with a cancer patient can be a way of obtaining more knowledge about what it is like to live with the knowledge that one's lifetime is limited. The majority of the doctors say that once the patient has worked through his disappointment and outrage at not being able to stay alive, then being together and the conversations with these patients are both essential and rewarding. The patient's ability to react and cope with this difficult situation is significant for the doctor as a person. One physician says that he arms himself with the patient's help. Bennet's (1987) claim that in every doctor there is a patient emerges most clearly in these meetings in the terminal stage.

An interesting observation in this study is that the pattern of coping for the whole group shows that the doctors to a higher extent seek a relation with the patients than with their colleagues. In their relations with their colleagues they seek to clarify methods of treatment. This can ease discomfort in the decision making process. But it is not evident that they use the support of their colleagues simply to talk about their emotions even though over half the stated difficulties are to do with the physicians' own suffering and frustration. The custom of seeking emotional support from colleagues is unknown, especially at the larger clinics in this survey.

Most of the physicians have statements which reflect their attempting to gloss over, "deny the severity of the situation". They use humour together with colleagues and with the patients, too. They admit that they show "grim" or "macabre" humour, cynicism or a "thick-skinned" attitude.

All the doctors consciously or unconsciously undertake "distracting activities" which are devoid of contact with patients, such as research and administration or other activities which allow them to avoid the patient. This strategy may mean that the doctors use distracting activities to help them cope when therapies fail and patients die.

One sixth of the physicians have statements which can be interpreted as "projective manoeuvres". They reflect an attempt to project discomfort and shortcomings onto colleagues or the organization.

All the doctors in this study are experienced. There are no evident differences in their coping patterns connected with whether they have been in the field for 10 or 20 years. One can discern a tendency that the oncologists (7 out of 11) to a higher degree establish a relation with the patient as a main strategy compared with those who have some other
speciality (2 out of 7). As for the rest of them, there are no evident differences between the groups in regard to coping patterns.

The sex distribution is uneven for the group of experienced doctors which has been studied, fourteen men and four women. Allowing for this imbalance, tendencies to differing strategies can be seen. Of the eight doctors who use knowledge-seeking as their main strategy, seven are males. Of the two who do not use this strategy at all, one is male and one is a female. Both of them show conflicting feelings about being an authority and both find it difficult to assert themselves in the face of intellectual competition. All the four female doctors are among the nine who use relating to the patient as their main strategy. Those who do not use this strategy show conflicting feelings about intimacy and aggressiveness and dependence; they are males.

Some coping researchers (chapter 3 p42) have described how people deal with testing situations by modifying their feelings towards them or by seeking to achieve changes in the environment, e.g. the organization. In this study, I have focused on how the doctors use the regulation of emotion. The doctors employ strategies which seem to be universal for individuals who are close to death (chapter 3 p43).

Comparison with earlier studies

Vachon (1987) and Holm (1993) have carried out interview surveys in order to study physicians' coping. Feifel (1965) conducted interviews to study physicians' attitudes towards death. None of them have explicitly studied doctors in their work with cancer patients. Direct comparisons with other studies are difficult to make as both the spheres of interest, i.e. the focuses, and the methods of the surveys are different. Earlier investigations on physicians have focused on the symptoms of stress and/or on the social consequences which the work entails. In this investigation the focus has been on experienced doctors working with cancer patients, their reactions and subjective experiences of coping with their work.

I have found reaction patterns that which resemble what other researchers (GORLIN 1983; BENNET 1987; VACHON 1987; FAIN 1989; MAQUIRE 1989) have described by observing medical students and doctors on training courses or in ward contacts. Doctors sometimes feel insecure, frustrated, helpless and unsuccessful.
With my theoretical frame of reference, i.e. by using a psychoanalytical perspective on coping, I have tempted to find a way to understand and to elucidate the "adaptive manoeuvres" (Fain 1989; Vachon 1987) or the "defensive strategies" (Fain 1989; Feifel 1965; Bennet 1987; Gorlin 1983; McCue 1982; Maguire 1989) which other researchers have described.

If one compares the behavioural responses which the cited authors have observed with the categories of coping that I have described, a pattern appears which is shown in Table 10:1. As one can see, with few exceptions, the doctors "seek knowledge" and "solutions" and strive to "deny the severity of the situation". Agreement among the researchers is not the same in regard to their opinions on whether the physicians "seek support", "build up relations with the patients" or use "distracting activities" or "projective manoeuvres".

Table 10:1  Observed behavioural responses in earlier studies (Study) compared with the categories of coping strategies (I-IV) in this survey

<table>
<thead>
<tr>
<th>Study</th>
<th>Seeking knowledge</th>
<th>Seeking support</th>
<th>Building relation</th>
<th>Denying severity</th>
<th>Distracting activity</th>
<th>Projective manoeuvre</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fain</td>
<td>x</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>McCue</td>
<td></td>
<td>x</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gorlin</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vachon</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Maquire</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bennet</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Feifel</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Holm</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Androe</td>
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<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

118
The doctors in this survey seem to have a broad coping repertoire in comparison to what has been observed in the earlier studies except for the studies by Holm (1993) and Vachon (1987). The latter has not studied the physicians separately (chapter 2 p23).

In the repertoire of doctors there are strategies which imply that the doctors in this study "seek knowledge", "seek support", "deny the severity of the situation" and use "diverting strategies" which in some way entail that he avoids patients, as McCue (1982) and Gorlin (1983) has observed. Some doctors in this study also admit that they avoid patients in order not to "burn out" or because they lack the necessary education.

McCue (1982) and Gorlin (1983) do not discuss this avoidance from the perspective of which conflicting feelings the confrontation with the seriously ill patient may arise. Nor do Vachon (1987) and Holm (1993) who have carried out interview studies. However, they do state that depersonalization and distancing tactics may be a way for the doctors to cope with the pressure.

The coping categories in this survey have been categorized by using a theoretical frame that emphasizes that defence mechanisms play their part in the individual’s various attempts to cope in a given situation. Therefore it is also of interest to elucidate the connections between defence mechanisms and coping described earlier in reported studies (chapter 3 p45) and the coping categories resulting from this survey, as they have been categorized according to the same theoretical frame, see Table 10:2.

A physician who uses intellectualization as his main defence mechanism may at the same time be unable to vary his repertoire of defence strategies. He might be regarded as having "seeking knowledge" as his main coping strategy. He may on the other hand be an all-knowing doctor if he never "seeks support" from his colleagues nor "builds up a relation with the patient" and projects his helpless part onto the patient.

The reluctance towards discussing psychological distress and death may be deemed as the physician's strive to minimalize the importance of these questions. That may be an expression of denying and also a projection of the physician's own limitation and insecurity.

The striving to isolate and to "seek a solution" to every situation may lead to stereotypical behaviour and may have the consequence that the doctor has
to reformulate the situation in order to make it soluble. This may lead to the physician not listening to the patient's needs.

Another doctor may be inclined to conspire with the patient. He reformulates the problems to subgoals. In this way he can maintain his own and the patient's "denial of the severity of the situation" and may reinforce his defence mechanism of denial.

The need for dependent patients may be an expression of a projection of the helpless part of oneself onto the patient.

The joking or using euphemism may be a way to repress or deny psychological distress.

The addiction to work may be deemed as a disinclination and inability to confront one's own psychological distress and may find expression in "distracting activities" and "denying of the severity of the situation". The underlying defence mechanism may be denial or reaction formation.
Table 10:2 The connection between coping concepts that have been described in the reported studies (chapter 3 p45) and the coping categories (I-IIIV) in this survey

<table>
<thead>
<tr>
<th>Coping concepts</th>
<th>Seeking knowledge</th>
<th>Seeking solution</th>
<th>Seeking support</th>
<th>Building relation</th>
<th>Denying severity</th>
<th>Distancing activity</th>
<th>Projective manoeuvre</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>I</td>
<td>II</td>
<td>III</td>
<td>IV</td>
<td>V</td>
<td>VI</td>
<td>VII</td>
</tr>
<tr>
<td>The allknowing doctor</td>
<td>x</td>
<td>x</td>
<td></td>
<td></td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reluctance to discuss pain and death</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reformulating</td>
<td></td>
<td>x</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Conspiration with the patient</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Denial of death</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Dependent patients</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cynism</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Addiction to work</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td></td>
<td></td>
<td>x</td>
</tr>
</tbody>
</table>

In this study there are examples of individual physicians whose ambition it is to be all-knowing. There are also doctors who at times display a resistance to discuss the illness and its implications, above all when the illness is in remission or when treatment of relapse fails. This is chiefly when the doctors make use of "selective understanding" (Maguire 1989) which may mean that the doctor only selects information he gets from the patient which he can treat and reformulates the situation into a treatable one. Many doctors also say that it is easy to conspire with the patient and
not solely concentrate on the symptoms which can be treated but in many cases offer "straw-catching" treatment. The physician gives treatment although he knows that it will not work, in order to spare the patient and himself being confronted with talking about death.

The need for dependent patients has not been expressed by the doctors in this study. On the contrary, some see a risk in binding the patient too close to them.

Cynicism is described as a benefical regulator. Almost all the doctors say that they now and then use the "denying of severity" in their communication and a third of them say that they regularly use this coping strategy.

The addiction to work, i.e the opportunity to lose oneself in much work, is named as a way of not thinking or mourning when the patients have died.

Holm (1993) has seen that doctors can get stuck in rigid behavioural responses. Maguire (1989) says that doctors with rigid behavioural responses have difficulty to change. This may lead to self-contempt: which in this study is suggested by the SASB results (chapter 8, p102). This self-contempt is, in this study, may be linked with an inability to find a good solution to the conflict which exists between family and work, and between ward duties and research demands, respectively. In this study, self-contempt is also expressed by those who do not feel valuable in the organization. They feel that their clinical work is not appreciated. Here to, belong those who feel that they are "shirking" their clinical duties or "letting down" the patient when they do research or take time off and finally, those who feel torn between work and home-life.

A number of doctors in this study resolve the conflicts described above without having to overlook the complexity of their work. They succeed in delimiting themselves both in their research and in their clinical work. Others are less successful at delimiting themselves and overlook the complexities. They choose either research or clinical work, work or home-life, loneliness rather than the company of others. Some of them say that they are not content with their way of coping with this conflict. They do not experience enough psychical balance. They express self-contempt.
One of the coping strategies which is predominant in this study has not been paid attention to in earlier studies. It is the strategy of "building up a relation" with the patient. The doctors admit that they feel psychological distress and sorrow together with the patient, but at the same time they experience that the relation and the contact with the cancer patients is from an existential point of view of great value. They say that one of the motives for their work is the establishment of a relation with these patients. This is complicated by the conflicting feelings and wishes the meeting with them rouses.

Discussion of the method

The intention of this study has been to try to understand how a group of physicians who are in charge of cancer patients experience and manage their work. In the literature on methods (Berglund 1983; Starrin et al.1991) good reasons are given for using a qualitative methodology for an investigation of this kind where the intention is to integrate thoughts and behavioural responses in the individual being studied.

In the presentation I have tried to follow what Starrin (1991) states that a study based on one type of qualitative methodology should include. That is: an emphasis on the need for deeper knowledge in the field, a description of the selection of the participants, the role of the investigator and the presentation of the results by grouping data in categories illustrated by quotations from the interviews, tables, interpretive comments and finally a description of the research process and a summary of practical and research implications.

The concepts of validity and reliability, which in traditional quantitative research are the criteria for the quality of the study is often replaced in qualitative research by credibility (Berglund 1983).

In the following the credibility of this investigation and its interpretations are discussed.
The credibility of the investigation.

A number of criteria are regarded to be of importance in distinguishing a credible investigation (Sundberg 1988). To these belong the fact that the investigator should not misunderstand or be unacquainted with the situation and the phenomena which are investigated. The interviewer in this study has a comprehension and an experience of twenty years of clinical work as a physician, seven of them as a gynaecological oncologist. This means that I am well acquainted with the work. I have a cultural competence that has helped me to focus on certain areas of the daily work of the participant physicians which have been familiar to them and to me. This means that I have been able to pose interpretive questions to make sure that I have understood the physician correctly. I have asked the physicians what they felt, thought, said and did at the meeting with the patients in different phases of the cancer disease (chapter 4 p51). I did not ask direct questions about difficulties and coping strategies. I have had no ready hypothesis about the difficulties or coping strategies. For example, in regard to the distribution of difficulties, I had no expectations. It is interesting that the number of interviews, i.e. the length of the relationship, does not seem to have influenced the distribution of statements in the different categories. Statements about intrapsychic difficulties are the most numerous regardless of the number of interviews with the individual doctor. Thus there is no link between the number of interviews and difficulties where the doctor himself is in focus.

One consideration is that the physicians may have answered in a way that they think I wanted. The material from the interviews does not support that such systematically altered statements occur. All interviews are recorded and transcribed and may be re-examined.

The credibility of the interpretations

Kvale (1989) states that three important levels should be observed in order to make the interpretations of the interviews credible.

The first level is self-awareness. I have been aware that my own feelings and behavioural responses towards the doctors and how I experience their feelings and behavioural responses would come to influence my interpretation of the material. Therefore, by means of supervision by psychologist A-L Kindås Burman throughout the entire series of interviews and during the processing of the data, I have had the opportunity to work with my own reactions to the interviews. I have felt this to be significant so
that I would not fail to see other difficulties or solutions than those which I have experienced.

The second level, i.e. common-sense level, means that the interpretations should be so well documented and unquestionable that the reader can see if there is a connection between the interpretations of the investigator and a layman's comprehension. This level is addressed for by the way the study has been presented with quotations linked to interpretations and categories in chapter 5, 6 and 7.

The third level, the theoretical one, means that the theory should be relevant to the field of research and that the interpretations follow logically out of the theory. This level is catered for by the theoretical presentation which is reported in chapter 3 and by the discussion in chapters 9 and 10.

In qualitative studies, one cannot generalize results from a group of cases to a population in the traditional quantitative manner. In the analysis of the material I have examined every interview and series of interviews for each individual physician. In the presentation of the results (chapters 5, 6 and 7) I have tried to describe the distribution of the statements of the individual doctor in the different categories. In the discussion (chapters 9 and 10) I have also tried to describe the pattern of difficulties and coping strategies of the group of physicians who have participated and finally I have compared these with observations from earlier studies.

The aim has been to identify specific difficulties and coping strategies for the individual doctor participating in the study and to find patterns which could be common to the others in this study. Researchers such as Patton (1990) say that it is the task of the reader to judge whether the interpretations and the degree of generalization are credible. Others (Engquist 1990) suggest that an investigation should give the reader a "shock of recognition".

In order to get some idea of whether the categories in this study are credible I reported them for the physicians when the survey was over. I reported my analysis of the difficulties as well as my interpretation and categorization of conflicting feelings and behavioural responses to the doctors. The reporting was carried out both in groups and individually according to the doctor's wishes. The doctors have recognized themselves in the descriptions which have been presented. They have made comments and given further information which I have taken as confirmation of the
validity of the interpretations and categorization. Thus it can be assumed that my interpretations are credible and there should be a basis for a discussion of other doctors way of working with cancer patients.

Co-evaluator

In order to find out to what degree my categories are to be found in the empirical material I have asked others to examine my interpretations and categories. During the process of analysis and categorization of the whole material I have had a continuous discussion within a relation of supervision with Ulla Holm Ph.D., Department of Education, Uppsala University. Elisabet Sundblom Ph.D., Department of Applied Psychology, Umeå University has furthermore analyzed conflicting feelings and behavioural responses independent of my categories in three series of interviews i.e. twenty interviews. The interpretations in two out of three interviews series agree with the judgments of the doctors' conflicting feelings and wishes. In the case where the interpretation does not agree the question is if there is an intrapsychic conflict or if it is a conflict in the outer world. The evaluations of the coping strategies of the physicians in these interview series show an 80 % agreement.

Data from the psychological tests The Defence Mechanism Test (DMT) and Structural Analysis of Social Behaviour (SASB) agree with my interpretation that the majority of the doctors experience and relate to themselves and threatening situations in a similar manner but that there are variations. The DMT and SASB do not merely lend my interpretations greater validity but they can also contribute to a better understanding of the functioning and variation in the coping patterns.

Effects of the study on the physicians

The methodology of this study has contributed towards showing that doctors have difficulties connected with experiences in their inner worlds. The doctors have through out the interviews been given confirmation that it is legitimate to have difficulties. "Our conversations have made me think," says one of the most experienced doctors. He says that, for more than twenty years, he has not had any confirmation that what he has felt was normal or of any consequence. He admits that he has a negative self-image which is confirmed by his SASB result. Other doctors offer examples of how they feel themselves to be emotionally "overloaded" or like "bits of metal"
Unanimously, the doctors say that it has been a pleasure and a help to have been able to talk about their reactions and behavioural responses. It has awakened a need to acquire more knowledge. More than half say that they would like to have better knowledge about their own reactions and behavioural/emotional responses and a third, at the end of the period of contact, explicitly mention that they would like to carry on the process of selfanalysis. They ask for the names of people whom they can turn to. Some have sought therapeutic support as the study has come to an end.

I interpret this as an expression of a genuine need in a group of individuals who have been disciplined not to think about their own emotional difficulties or needs but rather to put others' problems and needs first. Perhaps it is the case that those who can not accept such a focusing on other people's problems move on to other professions.

Discussion of pedagogical and clinical implications

Feigenberg (1976) maintains that three demands should be made of doctors in the care of dying patients, namely self-knowledge, empathy and knowledge of death. Empathy entails simultaneous emotional and intellectual activity and presupposes self-knowledge. The survey has shown that the great majority of doctors have, through their clinical experience, acquired their own knowledge of psychological processes and learnt how to tackle psychologically taxing situations. But they lack a common vocabulary for these processes and behavioural/emotional responses. Such knowledge has not attained sufficient status such that it is discussed in formal groups or on the rounds.

The coping patterns show that the physicians do not "seek support" as naturally as they "seek knowledge" or "seek solutions". There are physicians in this study who have the idea that someone who expresses difficulties, shortcomings and uncertainty is viewed as completely weak or uncertain. They do not believe in getting any help by discussing difficulties together with other physicians in the way that Balint (1966) has suggested (chapter 1 p14).

One may ask how doctors, who grow up in a culture without training to notice their own feelings, who do not have the knowledge or vocabulary to put feelings into words and who do not regard feelings as important, can be expected to have the necessary knowledge, vocabulary or respect to deal
with the patients' feelings. We can not expect doctors to understand their feelings or even less be proud of their reactions and their behavioural/emotional responses if they are considered unimportant, private, as "non-problems". Feelings are silent but not "silent" knowledge.

McCue (1982) asserts that physicians as a group show a reluctance to talk about their difficulties (chapter 1 p15). The doctors in this study are not averse to talking about these problems, but they are inexperienced. As Allison (1981) earlier observed, the doctors have been interested in exploring the interaction with the patients and their own reactions. Two physicians dropped out before the interview series started and one moved because he was offered a new job. The others have fulfilled their contracts with me.

A study on medical students (Holm & Aspgren 1994) shows that empathetic ability covaries with whether the medical student has the formalized possibility to confront in a small group his own reactions to meeting a patient and the possibility to understand patients' reactions. The great majority of doctors have their roles as diagnosticians and givers of treatment defined by the medical system. But situations in which the doctor becomes afraid, disappointed, sad, fed-up or in love with the patient, i.e. when he reacts, are not so clearly defined by the medical educational system. They are above all not defined as relevant. They are not just glossed over as "non-problems" but they are down-graded to something which affects only the weak and unprofessional (chapter 5 p74).

It is evident that an analysis of one's own behavioural/emotional reactions and responses depends on how one is received by others. Several of the participants said at the outset of the interview series that they could hardly see themselves talking about their own reactions in groups. Those who "seek support" are very careful about whom they turn to. They are fastidious about who they open themselves to. It seems that the larger the clinic the more the doctor is left alone to seek support for his own reactions.

The doctor's profession presupposes that the physician has certain skills. This study shows that the physicians in this investigation perceive themselves to have medical, technical and communication skills. But besides these skills it is said that comprehension of the work is important. "Building up a relation" is a crucial motive why the physicians in this study have chosen to work with cancer patients. Therefore it is significant that the doctor's education recognizes that the doctor's work in certain fields requires a certain awareness, a certain degree of self-knowledge.
(Feigenberg 1976). This is of particular importance in the treatment of cancer where not more than 50% of patients are cured. Many patients stay alive with chronic diseases, worry and fear of a relapse (Bolund 1990; Drugge 1988; Gyllensköld 1976; Tishelman 1993). The doctor works in an organization which largely consists of situations which he is scarcely educated to deal with.

Proposals for educational programmes

Gorlin (1983) asserts that educational programmes which just focus on the reactions and the behaviours of the patients are incomplete (chapter 1 p12). Half the physicians in this study say that they are interested in gaining better skills in managing their own reactions. My conclusion from this survey is that educational programmes for doctors should include a possibility to examine comprehension of the work and to formulate their thoughts and weaknesses without being judged or compared with someone else. One observation from this study is that the doctors have experienced that the examination of their own reactions and behavioural responses has not increased their feeling of vulnerability or insufficiency but has given them insights which offer them relief from the problems which they have seen to be related to their own persons. Some said that they not only had gained an improved consciousness but also a respect for their coping strategies. They said when the study had ended that they had acquired a motivation to look at their difficulties in a group. It may be expected that they should be able to open themselves to each other's behavioural responses with a renewed interest. The aim of such a group should be to build up greater respect for each other's strategies.

More than ten years' experience from training of medical students has taught me that the system of supervision by a senior doctor which was so important in the 1950s and 1960s is fragmented today. In the 1960s there where 9000 active doctors in Sweden. In the 1990s there will be more than 25000 doctors. Good models for the medical students ought to be more numerous today. The students say that they meet different doctors in different situations of supervision. They never get acquainted with the doctor who gives supervision. This may be one of the hindrances related to why they do not talk about the difficulties which are linked to themselves as persons. One has experiences and/or fantasies that one may be diminished, used or ridiculed if one reveal one's feelings. That should be seen in the context in which the doctor works on a daily basis: with patients who expose their feelings.
My experience from the results of this study, like earlier experiences from educational programmes (Gorlin 1983), has been that a better consciousness of one's own reactions and behavioural responses will lead to a discussion about whether and how reactions and coping strategies can influence a given activity.

Through participating in this investigation the physicians seem to have gained an understanding of the same perspective that Menzies (1970) held, namely that the striving to avoid anxiety in the practice of medicine leads to the development of a social defence system. This system's method of functioning is determined, amongst other things by the members' psychological needs for protection against intrapsychic pain (chapter 2 p28).

Discussion of further research

My results raise the question of how physicians' difficulties and coping strategies in situations other than working with cancer patients look like. Holm (1993) has investigated surgeons, internists and general practitioners (chapter 2 p27). It would be of interest to examine still another group of physicians. For example, it would be of interest to examine psychiatrists and their understanding of and coping with the work with psychiatric patients.

A crucial question is whether improved awareness leads to a change in the way difficulties are perceived and whether this leads to changes in coping patterns. To get an answer to this question a group of physicians in a supervision situation could be compared with a group of doctors without supervision. The aim of such an investigation would be to examine if better self-awareness leads to a different experience of difficulties and to changes in the coping patterns.
GENERAL CONCLUSIONS

# More than half the statements reflect difficulties which are related to the physician's own reactions.

# The difficulties seem to be related to three main conflicts:

conflicting feelings related to authority

conflicting feelings related to information and treatment which may harm or frighten the patient

conflicting feelings related to intimacy.

# The analysis of the doctors' coping strategies shows that within the frame of the organization they have oriented towards work which gives them as few conflicts as possible.

# The doctors in the study have a broad repertoire of coping strategies.

Most of them "seek knowledge". They seek support from scientific literature and emphasize the significance of knowledge in the professional role.

All the physicians "seek solutions", i.e. tackle the disease as an intellectual challenge as part of their coping strategy.

Most of them also "seek support" from colleagues as part of their coping strategy.

Almost all state that by "building up a relation" with the patient they can gain insights into the most central of life's questions, questions about how to cope with life and death.

Most of them make statements which indicate that they attempt to gloss over,"deny the severity of the situation". 

All consciously or unconsciously undertake tasks, "distracting activities", which are devoid of contact with patients, such as research and administration or other activities which allow them to avoid the patient.
Some of them make statements which can be interpreted as "projective manoeuvres". They reflect an attempt to project discomfort and shortcomings onto colleagues or the organization.

The coping pattern of the whole group shows that they to a higher degree build up a relation to the patients than to their colleagues.

# They have been totally self-sufficient: they say that their knowledge of psychological caring has come from themselves.

# More than half say that they would like to acquire better knowledge of their reactions and coping strategies.
Last Word

I am grateful to the physicians who took part in this study. During the process of investigation my comprehension of and my respect for their difficulties and methods of coping have increased.

"Skäms inte för att du är människa, var stolt! Inne i dig öppnar sig valv bakom valv oändligt. Du blir aldrig färdig, och det är som det skall."

Tomas Tranströmer "Romerska Bågar"
För levande och döda (1989)
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