Liaison Psychiatry on an Oncology Ward

F. Meerwein

Mühlebachstraße 82, 8008 Zürich, Switzerland

In this chapter I shall describe the liaison psychiatric service as now organized on the oncology ward of Zurich University Hospital. It is operated by a physician, who is also a psychotherapeutically trained psychologist, two clinical psychologists, and the author (Training Analyst of the Swiss Psychoanalytical Association). The clinical psychologists and the supervisor function on an hourly basis, the physician, delegated by the psychiatric outpatient clinic, on an all-day basis. Neither the Cantonal Government nor the Swiss or the Zurich Cancer Society was prepared to finance the activity of the two psychologists. For this purpose it was necessary for the Foundation of Psycho-oncology to be established, which collects private donations and in this way guarantees the effectiveness of our liaison-psychiatric activity.

Liaison-psychiatric activity can be defined as an attempt to unite and to bind together whatever, in the cancer patient’s understanding of himself or in his life and in his familial and clinical milieu, has been separated owing to the outbreak of the illness. Such separations or severings can arise, for example, between the patient’s physical and his emotional life, between his past and his present, between the patient and his family, and between the patient and his doctor concerning their ideas about the cause and method of treatment of the illness, and can lead to conflicts which are detrimental to the treatment and to the chances of recovery. However, emotional tension can also give rise to such severings; this can be tension between patients, doctors, and nurses, between doctors and members of patients’ families, between winners and losers in the struggle to cure the patient, or between survivors and the dying. Finally, severance can result between the conscious and the unconscious experience of patients, between love and hate, between hope and despair. Wherever such severings make their appearance, they influence the functioning of the oncology ward as a diagnostic and therapeutic system and often have a negative effect on the quality of life of the patients.

The liaison psychiatrist or psychologist does not regard himself as a rival of the oncologist and his nursing team and would not like to be so regarded. As far as his professional competence is concerned, he is the equal of the oncologist. However, his competence operates at a level of understanding that is quite distinct from that of somatic medicine. He is concerned not only with the patient’s cancer as a dis-
ease but also with the cancer as a metaphor expressing a total threat to the patient’s individual life and with its effect on the patient, his family, and the clinical team treating him. It is the task of the liaison psychiatrist or psychologist to reestablish the connection between these different levels of understanding, no matter where and how this connection has been interrupted or has collapsed. The liaison psychiatrist is, so to speak, a “communication specialist.” Owing to his presence on the oncology ward, at presentations of cases, reports on patients’ social milieus, and at team conferences, he makes himself available as such a contact man, with advisory and interpretive functions. At the request or instigation of the oncologist, he can also concern himself with individual patients in separate psychotherapeutic sessions. On the oncology ward of the Zurich University Hospital, art therapy can also be administered in individual, especially appropriate cases. How this functions has been described in several more detailed publications. Thus although the activity of the liaison psychiatrist is conceived to be complementary to and not in competition with that of the oncologist, tensions and conflicts are inevitable even between these members of the clinical team. These conflicts make necessary a continuous supervision of the activity of the liaison psychiatrist by a trained supervisor. I would like at this point briefly to set down a number of these possible conflicts.

1. Conflicts can arise when the oncologist fears that the liaison psychiatrist claims a higher human competence for himself than that possessed by the oncologist. Such apprehensions, however, are as a rule wholly unfounded. As already described, the competence of the liaison psychiatrist is different from that of the oncologist but not of higher worth. What it has in view is complementary and not competitive activity. This is often not sufficiently taken into consideration.

2. Tensions between oncologists and liaison psychiatrists can come about when the oncologist succumbs to the erroneous notion that the psychiatrist wishes to “psychiatrize” the patient, i.e., psychically to pathologize and clinically label him. There is no basis whatsoever for such a misgiving, which stems from an unconscious hyperidentification by the oncologist with the problems of his patients and a simultaneous defence against them. The liaison psychiatrist regards the cancer patient as, in the first instance, a psychically healthy human being whose psychological equilibrium has possibly been disturbed by the onset of the illness. This disturbance, however, is in most cases not to be equated with a psychic illness.

3. Numerous psycho-oncological examinations have repeatedly revealed that cancer patients display a marked tendency to what is known as harmonization, i.e., a denial of conflicts, and a “high social desirability score” [13]. This means that they have a strong tendency to adapt quietly to given situations and to appear complaisant. This can result in their internal suffering remaining concealed and, owing to its denial, in their making excessive energetic and emotional demands on themselves. In my experience this overexertion is often easier for the liaison psychiatrist to recognize than for the oncologist, so that differences of opinion between the oncologist and the liaison psychiatrist can arise regarding the nature and the scope of the assistance to be offered.

4. Cancer patients, like many markedly regressive patients, often have the tendency to divide up their “objects,” that is, the persons immediately surrounding