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LETTERS TO THE EDITOR

# Cancer and "playing" with reality: Clinical guidance with the help of the intermediate area and disavowal

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**To the Editor,**

I have found that clinical reality does not get on well with conceptualisations we often find in scientific journals particularly about understanding how patients with cancer deal with strain. The conceptualisations are unfortunately too much of a superficial on/off character, which is not very helpful for the clinician. Patients deal with the threat in a more dynamic elaborative way. There is thus a gap between research and clinical practice.

In this letter I will try to outline some thoughts that might be helpful. The letter is not about what patients *say* they do in order to deal with strain, but about what they actually are *doing*. In my mind there is a lack of literature, which more theoretically tries to understand what actually is going on. With an incisive wording: Theory is a *sine qua non* for clinical guidance.

## Patient histories

Excerpts from encounters with patients displaying aspects of how they look upon their cancer:

1. "I may not be as well as I feel right now. But I feel well, I'm not bothered by any symptoms, so it seems unreasonable to believe that it's not okay."
2. The nurse notices that the patient is in pain and offers another painkiller or she notices that the patient is tired and suggests a rest in bed, but the patient just says: "No, no problems, I'm doing fine".
3. Mr. Andersen was assessed to be suicidal when he arrived at the department due to diagnosed kidney cancer. When I met him the next day he however didn't give that depressive impression at all. What struck me was that he instead was eager to tell me that upon his arrival, when having dinner in the dining room, he had listened to a man with a brain tumour, severely marked by the cancer, who was sitting in a wheelchair. I think Mr. Andersen was deeply affected by that the other man had enthusiastically told the fellow patients about his plans when he would be discharged from the hospital.
4. "I guess I'm the only one in the family who can deal with being diseased like this, so it's good that it struck me."
5. "Yes, I know I'm struck by a serious disease, but actually there is no guarantee for anyone about what will happen tomorrow."

I am sure many clinicians recognise these types and other similar types of wordings – it is everyday clinical reality. When reflecting on them, it is rather easy to see how they display different ways patients downgrade the severity of the situation and thus constitute their way of creating hope, i.e. positive prospects about the future.

In the literature on psychological aspects of oncology we find different ways of conceptualising patients' behaviour when dealing with strain, primarily by means of questionnaires. On the one hand, we have a multitude of different "coping strategies" that have evolved from studies where patients tick boxes comprising expressions of mental (emotion-focused) or behavioural (problem-focused) ways [1]. In this research we, through different wordings, get to know what kinds of predefined behaviour patients recognise (yes/no or

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rate on a multipoint scale) as doing in order to deal with the threat. However, the findings are usually purely descriptive. For instance, we get to know to what extent patients look for spiritual support (emotion-focused) or to what extent they seek information (problem-focused). On the other hand, we have studies that exclusively focus on "denial" (actually "denial" from the psychoanalytic theory of defensive processes may be regarded as the core concept from which other conceptualisations have evolved [2]), i.e. the extent of turning away from the despairing facts [3]. Compared to coping research the perspective is more restricted in scope, but nevertheless similar as it is limited to description. The patients tick boxes and more or less solid ways of turning away from despairing facts are categorised. In coping research, as well as in "denial"-research we are thus usually supplied with descriptive categories based on patients' agreements to statements of behaviour. We are, however, left without knowledge of what they are actually *doing* in a clinical context or what may enable us to understand the possible meaning of these behaviours; subsequently, this implies that we are not provided with guidance on how to interact to benefit the patient. The research is at an impasse as long as we are just collecting behaviour. We need a theory that helps us to understand the process at stake.

## The intermediate area

Donald Winnicott, the British psychoanalyst, introduced the "intermediate" or "transitional" area into psychology. To him the intermediate area is the mental space between internal world and external reality and it is thus both subjective and objective. He based this stance on the fact that children are playing with reality [4]. Without losing contact with the real here-and-now, they create another arena in which they look upon things in a different way. Their psychological needs and desires motivate them to play with reality – the elaboration helps them to not only understand external reality, but also how to deal with problematic experiences; both being caused by mental overstimulation. As parents many of us are familiar with the behaviour of our children when they return home after being away for some time. They lock themselves up in the playroom quite absorbed in their play. After an hour or so they open the door and enter the real here-and-now again. The intermediate area is the mental area of human creation: in childhood in the doll's house or the sandpit, in adulthood in the area of art and culture. When it is time to sleep and the parent leaves the room for the night, little Stina grabs the blanket and in her internal world it then transforms from a piece of cloth to a substitute for the parent. When the parent enters the room in the morning the blanket is again no more than a piece of cloth (external reality). Reality is thus given different meanings due to need and desire.

According to Winnicott the intermediate or transitional area is established in childhood as a mental space between the child and its close environment. In adulthood this mental space enables us adults to "play" in daydreams, wishful fantasies and cultural experiences.

### *Applicability of the intermediate area to patients with cancer dealing with strain*

The similarities between a child's play with reality and the cancer patient's way of looking at reality in a certain relieving light are striking. First, the motif behind both elaborations is to deal with mental overstimulation. The child needs to process experiences in order to understand and create some order and the patient needs to downgrade the meaning of having cancer. Second, the child as well as the patient can elaborate with different meanings without losing sight of the facts of reality. The child knows that the chairs are chairs, but quality of life is enhanced if the chairs are in a row they become a bus for a while. Similarly, the patient who expresses that "it's just a grade III" when asked, at the same time knows that it also is a serious malignant tumour (hope from downward comparison) [5]. Third, there is a common flexibility in the sense that the child as well as the patient with cancer occasionally enters and exits the elaboration – thus reflecting a process [6].

Winnicott's model of the intermediate area easily lends itself as a theoretical framework when regarding how patients deal with strain when confronted with negative unexpected events, such as cancer as exemplified in the introductory excerpts. As human beings we have an internal reference to the meaning of "playing" and to use it as a metaphor for the patient's elaboration with facts enables us as clinicians to *understand* what the patient is doing. It however also provides us with *guidance* for the clinical dialogue. The "playing"-metaphor puts the physician into a dynamic bi-personal field and if s/he is sensitive for the clinical encounter, s/he more or less automatically enters and shares the patient's intermediate area – just because we are humans with our own reference to "playing". Actually, I do think that this is what happens in most successful everyday consultations in oncology. It may even be suggested that when the patient finds the information or the physician rude or clumsy, this may be due to that the physician stands outside the intermediate area. S/he is therefore not in tune with the patient's way of dealing with strain, and, for instance leans on inflexible ideas that all patients want to know, and therefore should be provided with "full information" [7].

The guiding power of Winnicott's framework is furthermore strengthened if connected to the attachment theory with the physician representing a "secure base" [8]. It enables us to understand the essence in the asymmetry in the patient-physician relationship and the importance patients give to the physician's words. In so many words, there is a structural parallel between the child-parent relationship in the playroom and the patient-physician relationship in the consultation. Psychologically, the former is a precursor to the latter.

### *The intermediate area and disavowal*

What then is the character of the process that takes place in the intermediate area? The most common conceptualisation of how people deal with the strain of a cancer diagnosis is "denial", whether defined as a conscious or unconscious repudiation of reality [2]. However, "denial" with this meaning, i.e. just turning away from the stressing facts, does not acknowledge the elaborations in the presented excerpts above. The patients are turning away from facts *by* transforming or reconstructing aspects of the threatening situation, i.e. they play with reality by *creating* "cover stories" [9]. This is important because it implies that the patients are basically aware of the threat, but they actively transform its personal meaning to make it easier to cope with. There is a simultaneous acknowledgement of reality and a wished for situation.

Nearly 20 years ago, the American psychoanalyst Franz Michael Basch put his finger on this defence against external reality and advocated "disavowal" as a more proper term for this common process where the significance of the threat was evaded by distortion, rationalisation or misinterpretation – "self-deception in the face of accurate perception" [10]. It is not difficult to find this way of playing with reality in the introductory excerpts. Let me illustrate with another example: Mrs. Lund was diagnosed with a lung cancer. She had always lived in a healthy way, which included physical exercise. When the treatment failed and her physical capacity deteriorated, she related this to that she had not been training lately – she had been too lazy.

Mrs. Lund acknowledged the bodily deterioration, but disavowed its connection to the progression of the lung cancer. Instead she creates a cover story by attributing it to everyday knowledge that exercise promotes health. Later on during our talk I asked her about the status of her disease, she laconically replied, "they seem to have difficulties controlling it".

Mrs. Lund made use of the intermediate area where she could "play" with reality. She on the one hand acknowledged the reality of the treatment failure, but on the other she connected the deteriorated body to lack of exercise. In other words, she disassociated her knowledge from her bodily experiences. This lessened her vulnerability and her life was not totally invaded by the lung cancer diagnosis.

## Conclusion

The "intermediate area" and "disavowal" create a model of process and together they may guide us into everyday clinical experiences in oncology where patients deal with strain. At first sight, the model may help us to understand patients' irrational expressions, but also to find a platform for our way of communicating. Contemporary research tells us that it is not enough or even appropriate just to focus on developing communication skills in oncology [11]. The physician's task in the patient-physician relationship cannot be reduced to training behaviour – in a psychological black box. Communication training must depart from a model of the patient's psychological process when dealing with strain and its implications for the task given to the physician. Winnicott's intermediate area and Basch's interpretation of disavowal may contribute to such a model.

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