

Hodgkin's Lymphoma During Residency

Several months into my second year of residency, I began to feel unusually fatigued. I tire easily, but this felt different and decidedly abnormal. Minimal exertion left me winded and I needed to nap immediately upon returning home from the hospital. I initially dismissed the fatigue as either symptoms of a minor and transient viral illness or a consequence of being a resident. Wellbutrin samples from our clinic stockpiles initially helped, but a few months later, I noticed tightness in my chest and a persistent dry cough.

With each additional symptom, my fantasies about what was happening to my body evolved. Medical knowledge made it easy to rationalize away fears of a serious illness. Even when a sentinel lymph node enlarged in my neck, I did not become alarmed. I convinced myself that I must have contracted an atypical pneumonia, an illness of the sort that thrived in the public psychiatric hospitals where I worked at the time. The possibility that I had lymphoma had crossed my mind, but only as a fleeting, morbid fantasy. It was too far down on my own differential to be realistic.

As my fatigue and struggles to breathe worsened, I turned to my primary care physician for help. I was fortunate to have a kind and caring internist who enjoyed spending time with his patients. He was clearly more concerned than I was and he immediately ordered a chest CT scan. I thought a CT scan was being alarmist, but I was in denial of what was likely obvious to him.

The day after my CT scan, I walked over to the radiology reading room to see the results of my chest CT. I was accustomed to going to radiology to review films of patients in the hospital, so it seemed like a routine decision. Upon entering the reading room, I overheard the attending radiologist discussing a film with eagerly attentive residents sitting beside him. The attending was explaining the intricacies of needle biopsies and the difficulty in biopsying the mass on the film without hitting the aorta. Even to a psychiatrist, it was a very abnormal CT scan with white spheres scattered throughout the mediastinum.

The attending radiologist asked me if there was a patient film I would like to discuss, but before I had the opportunity to speak, I noticed the film they were discussing was mine. At the same moment, the attending saw the name on my hospital ID badge and realized the awkwardness of the situation. It was likely the first time he had to give a bad news to a patient and it was the last time I sought my own test results. Fortunately, the radiologist was unaware of the sentinel nodes in my neck, which were far safer to biopsy than the mass around my aorta. The pathology report confirmed a diagnosis of Hodgkin's Lymphoma.

I was a terrible patient. I was not accustomed to asking anyone for help and I was well defended against the terrifying experience of having a serious illness. I was a narcissistically vulnerable child who walked with a sense of omnipotence, invulnerability and detachment. I wanted to believe I was immune to any of the serious illnesses we as physicians treat. I tried to contain my fears by aggressively fighting the healthy regression into a 'sick role' and to maintain some sense of control over what was happening to me by trying to manage my medical workup.

To help me contain my anxiety, I spend an inordinate amount of time in the library reading about the prognosis and treatment options of Hodgkin's. I was worried not only about

the survival rates, but also about chemotherapy and radiation. The five-year survival rates and survival curves quickly became immaterial; reassuring news could not change my outlook and it was difficult to see beyond the word 'cancer'. Chemotherapy was also terrifying. I immediately associated to a metaphor used by a former teacher; it is the process of killing rats in a barn by burning it down and praying the building survives.

Fear is a reaction to the unknown and the unknowable and I falsely assumed knowledge about my illness and about the details of a treatment regimen would alleviate my fears. The more I read about Hodgkin's, however, the more anxious I became. I routinely used my own medical knowledge to sooth the fears and anxieties in my own patients and believed knowledge would be my own elixir. Like a branding iron, however, it matters which end of the poker one is holding.

I was fortunate to be under the care of an oncologist who was respected and skilled in the treatment of lymphoma. In contrast with my primary care physician, however, he was not a warm man. He seemed to pay little attention to the importance of the physician-patient relationship. Additionally, as a patient, I would have been difficult to reach. I was out of touch with the roiling turbulence within me. I was terrified, but could not acknowledge it. I wanted a paternalistic, loving physician to care for me, but could not acknowledge that either. Blind to my own inner experiences, I became belligerent. I needed someone to fight. That person was to be the oncologist.

As I projected my internal struggles onto my oncologist, I fought for control over the treatment plan. He did not fight back. He responded by giving me the authority over decision-

making I required. He left me to decide how to balance the amount of chemotherapy and radiation I received. I never learned if he consciously understood what I was going through.

With hindsight, I was severely mistaken in my demand to have this much control over my treatment planning. I wish I could have allowed him to assume the responsibility of making critical decisions about my treatment.

Years after my treatment ended, as my anxieties shifted away from surviving a crisis to thinking about relapse, I began to realize that relapse would have a different meaning in the context of having decided my own treatment regimen. If the cancer returned, would it have been my fault? Did I relapse because toward the end of chemotherapy, I decided to end early and substitute the lost chemotherapy with more radiation? I realized I set myself up to feel guilt associated with the belief – real or not – that I determined my own fate or disease recurrence.

Chemotherapy proved to be far more painful and traumatic than I imagined. The first treatment was tolerable, but successive treatments became progressively harder over the four months of infusions. When my IV was opened, I could smell the PVC of the lines just before the veins in my arm began to burn. Vomiting became routine and for years after treatment, the smell of PVC or the sight of cranberry juice colored liquids made me nauseous. For inexplicable reasons, the IV tape branded the skin in my forearms. The marks slowly faded over a decade after my last infusion. Even today, I occasionally have the bizarre experience of suddenly being feeling as if all of the subcutaneous veins in my forearms are on fire.

The clinic space was demoralizing. The infusion suite was on the first floor of the hospital with floor to ceiling windows overlooking a patient drop off point. I felt like a zoo exhibit with patients waiting on their rides watching us from the other side of the window. I was

the youngest patient in the chemotherapy suite by decades and I tired of what felt to be intrusive questions by the other well-meaning patients in the clinic. As a physician, I felt privileged and entitled to a more private suite.

Throughout the four months of chemotherapy and two months of daily radiation treatments, I continued to work as many days as reasonably possible. I used my accumulated sick days and vacation days for the year to take a few days off during each chemotherapy infusion. While the radiation treatments were daily, they were brief and could be scheduled early in the morning. My co-residents were extremely supportive and allowed me to rest during the day when necessary. It was psychologically important for me to continue working, to hold onto an illusion of normalcy. Losing my day to day rhythm would have given me too much time to think about my anxieties.

I was newly married at the time of my diagnosis. I met my wife in medical school and we married before starting residency. We were both emotionally distant people at the time, brought together by the shared misery of medical training. Instead of bringing us together, my experiences with cancer strained our relationship to the point of breaking. She managed the stress by withdrawing, leaving me feeling more isolated and lonely at a time when I needed support. A year or so after my treatment ended, we decided to separate. The stress of the diagnosis and treatment exposed vulnerabilities in our relationship that were too deep to repair.

After my treatment ended, I was officially labeled 'in remission'. My anxiety progressively evolved from fears of surviving treatment, to fears of relapse and then to fears of the long-term consequences of chemotherapy and radiation. The latter of these anxieties are still very much in my thoughts and I am frequently reminded of these fears when my own patients

struggle with the long-term consequences of the cancer treatments that saved their lives. While every rogue cancer cell may have been annihilated, the psychological echo continues to resonate, slightly quieter with every passing year.

The chaos of everything I experienced led me to start my own personal psychotherapy, an experience I had not considered prior to that point in my life. Fortunately, it turned out to be a valuable experience, introducing me to the benefits of psychodynamic psychotherapy. My first therapist, a psychoanalyst, was attentive and supportive, an experience I did not have with my oncologist. I learned much about myself, how I related to others and my emotional vulnerabilities. Several years later, I began my own psychoanalysis with another analyst – who had to be a training analyst – and then entered into psychoanalytic training. Psychoanalysis now defines my career.

As any psychodynamically oriented psychiatrist knows, trauma never completely fades. Despite knowing the therapeutic benefits of writing, I was surprised that it is still somewhat difficult to revisit these memories as I write this. I can only conclude that it is a healthy reminder that the psychological work associated with personal illness never ends.

COMMENTARY

Scott Schwartz, M.D.

Attending Psychiatrist, St. Barnabas Hospital, New York City

Secretary, American Academy of Psychodynamic Psychiatry and Psychoanalysis

This moving account inflects the sense of being "strong" (denial and stoicism) in conflict with an ever-present lurking fear (regression and the need to be coddled). To me, the most powerful aspect of this narrative is not so much what actually took place in the treatment, the pain and its side effects, but ironically, the resident's fear of feeling better. For him, feeling better implicitly triggered the accompanying possibility of what could be next during the time during when he received no treatment. The gaps in between were the real issue.

As a cancer survivor myself, I responded to this account with an association surprisingly unrelated to medical treatments. In 1973, I was in my final year of medical school when I was awakened by what sounded like an enormous dump truck gunning its engine outside my window. "What the hell are they doing at this hour?!" Suddenly, I heard shouts in the street "Terremoto!! [Earthquake!]" In groggy denial, I thought, "What idiots! Turn the damn engine off!" Then, a crack split my wall from floor to ceiling! Time to get out, no more denial. After a very short time all was normal. There was no problem, no big deal. With my friends and neighbors, I laughingly shared stories and life went on. Then I learned a new word: aftershock. Any time, any place, any intensity. I stopped sleeping. I started imagining rumbles when there were none. It took a very long time to feel safe at night. My experience, like that of this resident, was, "You're ok—now. But any moment it could come again, perhaps fatally this time." It is the same for those surviving battles or bombardments. It is that same unquenchable anticipatory anxiety we find in PTSD.

Fortunately, this resident's dreadful experience and how he managed the fear of recurrence contributed to his living fully and meaningfully