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# Pancreatic cancer, depression, and spirituality in therapy: "Unio Mystica" and "Achrayut," 2 case reports

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**Case Report**

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## Abstract

**Objectives.** Pancreatic cancer is a major site of gastrointestinal tumors and remains a leading cause of cancer death in adults in the United States. There is also a strong association between pancreatic cancer and depression. When struggling with cancer, along the different phases of illness, a human being is confronted with manifold issues, which might profoundly interfere with their sense of meaning and purpose.

**Methods.** From this standpoint, several different therapeutic techniques have been designed to manage the psychological needs of the patients. Here we provide 2 clinical scenarios, where there was a strong religious correlation to the therapeutic techniques employed with patients suffering from pancreatic cancer.

**Results.** The 2 cases described showed some improvement in their overall life view and could recalibrate their expectations based on a strong religious foundation.

**Significance of results.** The role of religion and spirituality in health has also received increasing attention in literature. Religion and spirituality can help patients with cancer find meaning in their illness, provide comfort in the face of existential fears, and receive support from a community of like-minded individuals. In effect, they also provide evidence toward the scope of and integrating the domain of spirituality into holistic cancer care.

## Introduction

The pancreas is the second most common site of gastrointestinal tumors, after colorectal cancer, and the fourth leading cause of cancer death in adults in the United States (Siegel et al. 2019). Even with improved modern-day systemic and local therapies such as enhanced surgical techniques, the median survival for late-stage disease is still abysmal and the overall survival at 5 years remains roughly 9% (Breitbart et al. 2021). An area of historical and contemporary fascination is the uncanny association between pancreatic cancer and depression. Jean Fernel, who introduced the term "physiology" to describe bodily functions, proposed that melancholia (along with hypochondriasis) originated in the pancreas in the 16th century (Boyd and Riba 2007). Various studies have demonstrated the immense impact of psychological distress on life quality and illness trajectory in patients with pancreatic cancer. In this respect, pancreatic cancer is the tumor entity with the highest incidence rate of depression among all other tumors of the digestive system (Sotelo et al. 2014).

Evidently a neoplasm of grave prognosis, pancreatic cancer has indeed been linked with Major depressive disorder predominantly among the other cancers. Apart from the obvious psychological implication deriving from a cancer diagnosis per se, the underlying inflammatory changes, particularly the interleukins and cytokines, also have been proposed to be a harbinger of the depressive episode, in a landmark multicentric study conducted by Breitbart et al. (2014), which showed an association of increased IL-6, triggered by pancreatic cancer with depression. This in essence gives a very organic basis of the interlinkage of pancreatic cancer and depression.

When struggling with cancer, along the different phases of illness, a human being is confronted with manifold issues, whose complexity and disorienting potential may profoundly interfere at many levels: physical functioning, daily life, social role, relationships and affects, and sense of meaning and purpose. This is true both for the person suffering from cancer and for his/her family members (Breitbart et al. 2014). In this light, it is widely recognized that psychological intervention is an essential component of good-quality cancer care, that the psychosocial domain should be integrated into routine care, and that psychosocial cancer care is a universal human right (Caruso et al. 2017). From this perspective and the perspective of comprehensive person-centered oncology (the care *of* the person's whole health, *for* the person, namely the fulfilment of the person's health aspirations, *by* the person, with physicians extending themselves as total human beings, and working respectfully *with* the person affected by cancer;

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Holland et al. 2011), several different therapeutic techniques (Supportive therapy/Interpersonal therapy/Meaning-centered therapy) have provided as valuable instruments in the arsenal of the astute clinician.

While the different modalities of therapy have their own space in the armamentarium of the psycho-oncologist, the role of religion and spirituality in health has also received increasing attention in the scientific and lay literature. The National Health Interview Survey found that 69% of the patients with cancer reported praying for their health compared to 45% of the general U.S. population (Grassi et al. 2017). Religion and spirituality can help patients with cancer find meaning in their illness (Ross et al. 2008), provide comfort in the face of existential fears (Park 2013), and receive support from a community of like-minded individuals (Preau et al. 2013). Here we provide 2 clinical scenarios, where there was a strong religious correlation to the therapeutic techniques employed with patients suffering from pancreatic cancer. In effect they also provide evidence toward the scope of and integrating the domain of spirituality into holistic cancer care.

## Clinical case 1

Mr. X is a 71-year-old Caucasian male who lives with his domestic partner, with recent history of pancreatic cancer status post Whipple procedure with curative intent, now under radiographic surveillance. His postoperative course was unfortunately complicated by multiple infections with protracted hospitalization. Whereas the early detection of the cancer was beneficial for Mr. X and technically he was not end-of-life care, the suddenness of the surgery within 2 months after diagnosis was quite traumatic to the patient. On his first clinical encounter with psychiatry, he presented with symptoms suggestive of a major depressive episode, including a low and anxious mood, lethargy, anhedonia, and a noted reduction in appetite and sleep. These depressive symptoms were occurring alongside a state of existential dread, and he was almost terrified of "vision-like" thoughts which came to his mind sporadically, in which he would be visualizing his own funeral services.

In terms of psychosocial development, Mr. X had a childhood entwined in a strongly catholic Jesuit tradition, starting in a parochial school of education, preparatory school and then going on to a Catholic school system and finally graduating from college. All along he had maintained contact with the Christian cohort from his school and had tried to engage himself in the evangelical tradition of Christianity, and regularly saw his priest for spiritual health. Of a neurotic predisposition, Mr. X also narrated some events of extrasensory perceptions in his life which also had a strong religious connotation to it (hearing a voice reassuring him when he felt alone and desperate in a foreign country, labeled it as like Mother Teresa). Childhood and prior history also revealed absence of a father figure in his life, and a sense of longing for companionship in him; this was partly satiated through the Christian cohort.

### *Christianity and the concept of "Unio Mystica"*

In the New Testament, Jesus, in prophesying about his death and resurrection, said in John 14:19–20 "Yet a little while and the world will see me no more, but you will see me. Because I live, you also will live. In that day you will know that I am in my Father, and you in me, and I in you" (Alcorn et al. 2010). In this passage, Jesus refers to the connection between individuals and people. In Latin, it's called "unio mystica." In English, it's called the "mystical union" (Bible 1970). In rather simple parlance it means the mystical union between believer and creator/Jesus.

This concept of the sacred and secure union between Jesus and his followers was what part of our work with Mr. X was based upon, in general to address his existential dread, and in particular to reframe the disturbing vision that he was having; in process allaying some of the fears associated with it. This reframing was done under the aegis of imagery rehearsal therapy (Dupré 1989). The following section describes the process undertaken. It should be added that Mr. X while in the hospital had been screened by Inpatient Spiritual services, as part of the Hospital Admission Protocol (Memorial Sloan Protocol) and had since then intensely followed up by the Chaplain service (was seen about 15 times, in a span of 3 months.) Also during the outpatient care, he had been seeing his priest in the regular church.

### *Imagery rehearsal therapy and mystical union*

Mr. X was initially started on an antidepressant (mirtazapine) to target his mood symptoms, although there was a reduction in his depressive symptoms, the visions of him dying and watching his own funeral being conducted remained an oft quoted complaint with the accompanying dread, it is at this point that imagery rehearsal training (Krakow and Zadra 2006) was employed with the patient. In short, imagery rehearsal therapy entails targeting nightmare disorders by developing an alternate arc to the storyline which emerges repeatedly in the nightmare, and voluntarily inducing a different but pleasant ending to the nightmare, in effect creating a joyful experience, rather than unpleasant one. As Mr. X's visions were very similar to a dream-like state, this specific modality was employed with the groundwork based on the Christian principle of "Unio Mystica." As he mentioned that he was able to visualize his own funeral process going on, a story arc was developed where he was initially encouraged to view his Christian cohort (whom he relates with closely) attending the funeral, and on subsequent sessions, he was told to focus on these friends surrounding his hearse/coffin as a closely circumscribed group, and then touching him on his hand. As this vision was formulated, there was the sense of warmth and oneness that the patient felt and the affective valence of the whole experience which was initially quite fearful and in a way depressive for him was converted to a more acceptable one. As his life trajectory had showed, he had been of an anxious and dependent predisposition, so additionally this sense of oneness he felt with his brethren, even in his quasi-dream-like state, was comforting and somewhat satisfying for his ego-function.

In a way, this sense of oneness, which the patient was rehearsed into, bears semblance to the feeling of "Unio Mystica," the story arc was also constructed with this as well as his longing for the company/validation of others, given the religious affiliation and his temperament, the patient also responded well to the therapeutic technique.

## Clinical case 2

Ms. Y is a 72-year-old woman with past medical history of pancreatic periampullary tumor status post Whipple procedure, similar to our prior case, had a difficult postoperative course complicated by infection, and although cancer free, had a poor quality of life. Psychiatry had been consulted on the medical inpatient unit for the evaluation and management of depression in the context of her infectious course. She initially appeared dysphoric and endorsed

feelings of anhedonia, withdrawal from society overall, in conjunction with difficult sleep, reduction in appetite, lethargy, and irritability since her cancer diagnosis a few months ago. She also reported a past psychiatric history which seemed to be another depressive episode for which she had started escitalopram and trazodone for the last 15 years with reported good effect for some time.

On subsequent outpatient follow-ups, the patient expressed this angst attributed to the adjustments needed in her role as a patient of pancreatic cancer. Prior to her cancer, she had been a highly motivated, and driven individual who would relish responsibilities and autonomy. Cancer and the subsequent surgery and infections had made her physically and psychically weak, to the point that she was dependent on her husband for her activities of daily living. This produced a sense of anger and resentment in her, and while waiting for adjuvant chemotherapy, she directed this anger was displaced to her husband (the primary care giver), her oncologists (whom she felt were not giving her enough chances), and above all toward herself (anger for having the cancer). In terms of spirituality, Ms. Y was adherent to Judaism, and though not strictly orthodox, aligned with the Jewish laws of Halakha. Similar to Mr. X, Ms. Y too had received an initial spiritual assessment while being in the inpatient setting. However, unlike Mr. X, she had declined further evaluations, with the Spiritual service, as she was more focused on her tangible physical symptoms, rather than spiritual health.

### *De-reflection and Achrayut*

De-reflection forms one of the central tenets of Viktor Frankl's conception of logotherapy (Krakow and Zadra 2010). De-reflection, which is based on self-transcendence, seeks to redirect one's attention from oneself or one's own goals toward others. This technique posits that when one is self-absorbed and is struggling with issues in one's life, one can significantly improve one's situation by altering one's focus and being concerned about those around. In a way, it recalibrates the individual's attentional cathexis decreasing the vicious cycle of altering between hyper-intention and hyper-reflection, focusing on the pathology and on a wider context contributes to the finding of meaning in suffering. This runs almost parallel to the Jewish notion of *Achrayut* (אחריות) or "responsibility," (Frankl 1975). It means more than just being accountable for success or failures of your own decisions. *Achrayut* (אחריות) in translation to English would mean Altruism, but there is a deeper meaning – which also calls for taking responsibility in that Altruistic act, In effect the deeper layer of *Achrayut* (אחריות) is "knowing that we are called, to address the needs of others." As stated, this is in close alignment to the de-reflection strategy in logotherapy which we employed with this patient.

### *De-reflecting anger and finding meaning*

As mentioned earlier, a large part of the outpatient session with Ms. Y was focused on her shock at the sudden diagnosis of cancer and the resulting angst and anger which she felt universally, but due to the proximity, her husband was the most frequent target ("I feel terrible that he has to do most things for me, and I feel like a baby, It's like my independence has been snatched away"), throughout the sessions, this loss of autonomy and independence manifested as the driving force of her anger. After much reflection and interpreting her statements, it became evident that anger and angst was directed more so at herself and her cancer diagnosis "I feel terrible, I feel angry, why does this have to be me? "At this point of time, the therapist engaged the patient in a Socratic manner, the hypothetical scenario was pointed to her in which her husband was the one supposedly with cancer and she was in the caregiver's role, and her reaction to it was gauged. She stated that she would feel terrible and would be devastated to see her partner of 48 years suffer through the disease. Here was where the reflective statement was made by the therapist that her disorder had indeed spared her from the mental agony and suffering which her husband was going through, providing some degree of meaning to it, and therein came her responsibility toward bearing the ambivalence which came with her cancer diagnosis (Feldman 2003). Allusion was drawn to the concept of *Achrayut*, she was able to relate the interconnectedness of the 2 concepts, as well as resonate with the deeper meaning of responsibility and her cancer diagnosis, and acknowledge that even though it lead to a very definite role transition, it also placed her on a unique and challenging position to bear responsibility. In a way, this sense of psychical responsibility also engendered a sense of autonomy in her, and gave her some control, or at least a sense of it. She could also relate this sense of autonomy, to her precancer state where she reveled in taking up responsibilities. Indeed as time has passed on, the patient has become more functional and although not yet back to her baseline precancerous functional status, has been able to adjust well to her "new normal."

## Discussion: spirituality and psychiatry

Historically, much psychiatric care has been provided within a spiritual or religious context. In medieval Europe, the shrines of St Mathurin and St Acairius in France, and St Dymphna in Flanders held a particular reputation for miraculous cures of the mentally ill (Frankl 1985). In 1247, the priory of St Mary of Bethlehem was founded in Kent, England, for the care of the insane. Spirituality is a distinctive, potentially creative and universal dimension of human experience arising both within the inner subjective awareness of individuals and within communities, social groups, and traditions. It may be experienced as a relationship with that which is intimately "inner," immanent, and personal, within the self and others, and/or as relationship with that which is wholly "other," transcendent and beyond the self. It is experienced as being of fundamental or ultimate importance and is thus concerned with matters of meaning and purpose in life, truth, and values (Cook and Powell 2022). The word religion on the other hand has the same root as ligament, ligature, and oblige. It is that grounding of faith and basis of life to which people might regard themself as being bound for their survival, a rope that ties them to God and to other believers (Cook 2004). Spirituality is increasingly being included as a component of psychiatric treatment and as an independent and dependent variable in treatment research.

The French philosopher René Descartes (1596–1650) argued that the natures of mind and body are completely different from one another, and each could exist by itself (Skirry 2005). In psychiatry, this translates to the debate of psyche and soma, and as we had discussed initially in the relationship of pancreatic cancer with depression, there is a distinct mediation of the inflammatory interleukins. However, as we look into the etymological origin of the term "psychiatry," which derives from the medieval Latin *psychiatria*, literally "a healing of the soul," from Latinized form of Greek *psykhē* "mind" + *iatreia* "healing, care", such a distinction between the mind and body becomes superfluous, and here is where the close relationship between faith, religion, and medical care becomes paramount even in a cases of depression which might be medically dictated (Stefanek et al. 2005).

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## *Clinical implications*

In essence, studies examining the effects of religion/spirituality on health outcomes in patients with cancer have reported mixed results, likely due in part to small samples and heterogeneous measures of religion, spirituality, and physical health (Cook and Powell 2022). However, as the case examples reported here show psychotherapy and counseling based upon religious frameworks of belief, or else offered within the context of a faith community, undertaken within proper professional and ethical boundaries and when appropriately offered, potentially might bring in some benefit and relief for the individuals.

Cancer care at present does and should involve a holistic understanding of the individual, catering to their needs both in the physical and psychical realm. As spirituality and religiosity often times color the psychical makeup of an individual, it's essential that a well-informed clinician keep them in consideration during a clinical encounter. We believe these 2 clinical scenarios would help shed some light in this yet unexplored area, and encourage further research into the field.

## Limitations

As these were case reports, and that also based on the clinical encounter with 2 individuals, was limited in scope by its qualitative nature and the sample size. In general, exploration and interpretation of the spiritual/religious belief system of an individual brings to a degree its own subjectivity and the clinician has to be careful in acknowledging/interpreting her/his own belief system, while engaging in a non-encroaching and inquisitive manner with the patient. This brings with it an added dimension to the conventional patient–physician clinical relationship. Furthermore, for the first scenario (Mr. X), we felt that more incisive psychodynamic exploration of the patient's interpretation of his dream-like states, as well as religious reconciliation performed by a priest might have gone a long way in giving a more comprehensive and deep sense of comfort and closure to the patient. However, as the therapy techniques dealt in this paper were more or less short-term time-limited maneuvers, these provisions were not necessarily included. We sincerely hope and expect further studies which would be able to illuminate and strengthen the connection between conventional psychotherapy and spirituality.

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