EDITOR'S NOTE

Through this column, we hope that practitioners in general medical settings will gain a more complete knowledge of the many patients who are likely to benefit from brief psychotherapeutic interventions. A close working relationship between primary care and psychiatry can serve to enhance patient outcome.

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Casebook of a Cancer Therapist: Relationship

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If you are a clinician who treats cancer patients, I hope you agree that many of them would benefit from talking with a professional about adjustment to their illness. If you are interested in helping cancer patients adjust or in referring them for help, you may wonder what the rules are that govern this transaction.

The therapist needs a model to guide his or her work with the cancer patient. While my model has been cognitive therapy, any framework agreeable to the therapist and patient is acceptable. Much (but not all) of the work with this problem will be short term. It can be successfully carried out in a room with a closeable door and 2 (or 3) chairs. The locale can be the therapist's office (by referral) or an outpatient oncology room. If the latter, the appointment can be associated with a medical visit for cancer treatment.

The cognitive model will likely focus on the patient's thoughts about cancer: its prognosis, its treatment, or its course. Changes in routine related to illness or treatment may be approached by defining a new life stage with the patient. Constant prediction about the future is discouraged in favor of a focus on the present. How to communicate about cancer with one's spouse or children is a common issue to consider. Therapy may involve helping the patient to rework his or her concept of self-worth. Issues of control, acceptance, and maintenance of life activities are commonly discussed.

The hallmark of any successful psychotherapy is often the establishment of a working relationship between therapist and patient. At times, the process of engagement (forming the relationship) may be treatment's biggest challenge. This was the situation I encountered with Ms A.

CASE PRESENTATION

Ms A was referred to me by her oncologist while I was working as an employee of an outpatient oncology practice. Her doctor was aware that she had consulted multiple therapists over her lifetime, and he was concerned that she might now be depressed. I met this 65-year-old, married mother of 4 adult children (and 10 grandchildren) in a treatment room in 1 of the 3 locations in which these oncologists practiced.

Two years earlier, Ms A had noticed the sudden onset of hematuria. Her initial evaluation led to a diagnosis of bladder cancer. A lifetime of chronic anxiety had led her to consult with 8 different therapists. At various times during her adult life, she had been diagnosed with, and treated for, major depression as well as generalized anxiety disorder. Her interaction with therapists had not always been pleasant and frequently was brief in duration. She tended to follow their pharmacologic recommendations, but had also found these to be conflicting at times.

Her cancer treatment had included radiation and chemotherapy as well as the surgical removal of 1 kidney. When she presented to me, her psychotropic medications included paroxetine 60 mg/d, zolpidem 10 mg/d,

and lorazepam 1 mg/d. She was sleeping well, had a moderate appetite, and was maintaining her weight. She had some energy but was frequently exhausted. Concentration was impaired, but her long-term and short-term memory were each intact. Her mood was often anxious and rarely sad. She prided herself on doing regular exercise but had not done any in the past year. Her husband and children were each described as "supportive."

My initial impression was a *DSM-IV* diagnosis of generalized anxiety disorder (300.02), with a past history of major depression (296.30). I wondered whether she needed the large dose of paroxetine, an antidepressant. One hour after our initial appointment, when I had not called in a renewal prescription for lorazepam, she angrily called my office to complain.

PSYCHOTHERAPY

It was evident from the outset that it would be important (and likely difficult) to establish a working therapeutic relationship with this patient. At our second meeting, I suggested that we replace her antianxiety medication lorazepam with the longer-acting clonazepam (0.5 mg twice daily). We also discussed various ways in which she could resume exercising. I endeavored to answer her questions about cancer. We reviewed her past "bad experiences" with therapists.

When she reported for session 3, she emphasized that she was feeling calmer and attributed this to my prescription of clonazepam. She had resumed a number of her formerly usual life activities. She was "more into living, and less into moping." I was "different," she told me, "from previous therapists." It seemed to her that I was genuinely interested. Some of this "interest" may have been attributable to the cognitive therapy model, which stressed dialogue, present-orientation, and problem solving. She wanted to discontinue her night-time sedative, as it was no longer necessary.

In session 4, I raised the question of how much paroxetine she needed. I suggested that we taper it by 10 mg per week to find out. She eagerly agreed. We discussed her mindset about cancer as well as her fear of losing her bladder to surgery. She wondered whether she would be able to wear a bathing suit and take her grandchildren to the beach that summer.

She systematically reduced paroxetine from 60 mg to 30 mg without incident. However, when she reached 20 mg, a telephone call revealed the return of depressive symptoms. I presented this to her as "finding an endpoint" rather than as "a defeat" and suggested that she resume taking a dose of 30 mg/d. Over the course of 7 visits (each in the oncology office), there were no new cancer events or symptoms. She was living a close approximation of her usual life. Her depression was controlled, and her anxiety was minimal. We decided to terminate our sessions.

I had no contact with Ms A over the next 6 months. Then, she called for an appointment at my office and wondered if she could bring her daughter along whom she wanted me to meet. I readily agreed. In reviewing her course over the 6-month period, she noted evidence of tumor spread to her lung and liver despite chemotherapy. She noted, too, an increase in anxiety and a focus on religion and planning a funeral. Her daughter told me that she felt that her mother was depressed and had been doing a lot better when we were seeing each other.

I emphasized her capacity to work with her thoughts to determine her behavior as well as to control her anxiety. She talked at length about what she could "no longer do," and we found activities that could form the basis for this latest life stage. She told me how calming it was to be together again, how glad she was that her daughter and I could meet, and how much our earlier sessions had meant to her. We planned to meet again in 6 weeks.

In our last session together, Ms A reported further cancer spread, in addition to severe side effects from a recently prescribed chemotherapy agent. Her family wanted her to "continue fighting," but she felt strongly that she had "led a full life" and was ready to discontinue all but palliative efforts. We said goodbye, reviewed our time together, and I stressed my availability to her husband and any of her children should they wish to talk with me. Ms A died peacefully at home 6 weeks later, and her husband called to let me know. We had a 20-minute conversation.

EPILOGUE

As with most psychotherapies, the establishment of a caring relationship seemed critical to the benefit Ms A achieved. While her previous "bad experience" with therapists was not a good omen, it served only as a challenge to establishing a positive relationship. Her feedback and behavior indicated that this had occurred. I believe that it made the final year of a 3-year bout with cancer more bearable for Ms A and her family. ◆