

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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Keeping Cancer in Perspective

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Specialization in medicine is about a doctor in training choosing an area upon which he or she will concentrate. It involves additional education specific to that area and, if that education is continued as the doctor ages and time passes, it may produce an "expert." It is apparent that, as one becomes more and more narrowly specialized, however, one's knowledge and awareness decreases regarding areas peripheral to that central concern.

One way to combat this tendency is to recognize these ancillary areas in the care of the patient and to make provision for their treatment. Today's well-trained oncologist is often well aware of his or her patient's need to accept and adjust to cancer. Some doctors, still ahead of their time, have brought practitioners skilled in aiding adaptation into the treatment environment to talk with their cancer patients.

As one such practitioner, I have encountered many different life circumstances that form the context for a patient with cancer. One common situation arises when the index patient has lived a healthy life to date and must suddenly confront decisions regarding surgery, radiation, and chemotherapy. Life changes abruptly as it revolves around appointments with various doctors and the symptoms of disease along with the side effects of treatment. Plans may be put aside. Usual patterns are disrupted. Mortality may be confronted. Anxiety often surfaces. Depression may occur. There are multiple triggers for anger.

CASE PRESENTATION

An oncologist colleague referred to me a 60-year-old female accountant, married for 35 years, with 2 grown children. Ms. A's premorbid (prior to the diagnosis of cancer) health was excellent. She had never been hospitalized (except for childbirth). She did not smoke or drink alcohol. She was neither hypertensive nor diabetic. She exercised regularly and maintained a healthy weight. Her cholesterol was within the normal range, and she had no heart disease. She was postmenopausal and without gynecological problems.

Ms. A's marriage had been happy. Her children had maintained good contact with their parents. Her work was rewarding. She loved music, dance, and cooking. She and her husband fished, boated, and traveled together. She loved to entertain friends.

Then, at age 58 years, a routine colonoscopy led to a diagnosis of colon cancer. Surgical resection and chemotherapy followed. There were follow-up computed tomographic scans. One year later, a scan revealed several areas of liver metastasis. More chemotherapy was prescribed. Ms. A became clinically depressed, and a selective serotonin reuptake inhibitor drug was prescribed and was helpful. Three months after the spread of cancer was detected, Ms. A appeared in my office.

"I had a perfect life," she said to me, "grown kids, loved my husband, loved my job, and I was always in control. It's not easy now to be a

full-time patient.” Cancer had ushered in a new life stage. She was not now clinically depressed, nor excessively anxious. She had periods of depressed mood, but mostly she was angry, with the target of her anger not obvious to her.

Ms. A had the task of adjusting to a life with cancer. It might mean discomfort. It would entail doctor’s appointments. There would be more chemotherapy. She might need to retire from the accounting firm where she was employed. Some of her life plans and life activity might have to be put “on hold.”

PSYCHOTHERAPY

My working DSM-IV diagnosis was adjustment disorder, with depressed mood (309.0). At our second session, Ms. A reviewed her lifelong pleasures and noted which ones were difficult to pursue at this time. She talked about the value for her of a cancer support group that she attended monthly. She described her treatment obligations and expressed her concerns. A life that had been dominated by her work would now be centered around her cancer, her marriage, and her friends.

In session 3, Ms. A mentioned spontaneously that her thoughts (e.g., about chemotherapy) created anxiety for

her. We applied the cognitive therapy model to identify thoughts relevant to distress and to evaluate them for strategic worth. If she found the identified thought to be of no use, she was to dispute it. We carefully separated what in her life was controllable from what was not. Ms. A specified the bothersome side effects of chemotherapy and what she had learned she could do about each one. We discussed how much time could be usefully devoted to cancer and its treatment and what her options were for the rest of the time.

Ms. A reported for our fourth (and final) session saying that she had “reoriented herself to living” instead of “to cancer.” If she were to retire from the firm, what would her work options be? She demonstrated a return of a problem-solving orientation that had served her well at work. She specified those things that would now be important to her. She noted how her mood was better and how the anger she had felt had dissipated. Ms. A felt that she was “in control of her life” once again.

It has been said that cancer robs a person of control. Perhaps a better statement would be, “Cancer challenges the usual control mechanisms and calls for a reappraisal.” The cancer patient’s task is to find an orientation to living that meets his or her needs at this stage. ♦