PSYCHOTHERAPY CASEBOOK

# Maintaining Professional Distance

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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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Living in a small city confronts the physician with a new set of rules. When I arrived in Charleston, S.C., in the afternoon of my first day of seeing patients, I ran into my first patient on a downtown street. The probability of this "chance" meeting would have been strikingly lower in New York City or Washington, D.C.

When a colleague or co-worker develops a medical problem, the options for acquiring a caregiver are often dramatically greater in a large city than they are in a small town. More often in a small town, the patient may consult someone they work with, or someone they "know" (socially).

We are all taught the importance of maintaining boundaries, and this is emphasized in psychiatric training. Depending upon your definition of what is "proper" and what is not, this concept may be challenged by working in a small town.

Finally, we expect caregivers to remain well and, by and large, to rarely need to assume the status of "patient." When a caregiver requires medical attention, the issues involved in treatment can test the principles of the physician and often engage his or her emotional feelings as well.

## CASE PRESENTATION

Mrs. A was a 40-year-old married mother of 5 children, who worked as a social worker in a cancer treatment center. Her husband was a prominent attorney in town. They were an attractive couple, devoted parents to their children, and highly esteemed for their professional work.

I had known Mrs. A casually in the workplace, but my oncologist colleague had worked alongside her for years. Five years ago, she was diagnosed with a melanoma on her left arm. It was removed and seemingly ceased to be a problem, however the possibility of recurrence with this tumor is well known.

Two years ago, Mrs. A consulted her family physician because of persistent abdominal pain. It took more than a year for a diagnosis of a second (pancreatic) cancer (not melanoma) to be made. She enlisted the aid of my experienced oncologist colleague to treat her.

She expressed determination to "see this through," and embarked on a course of multiple chemotherapies. She reported neither depression nor anxiety at the outset of treatment.

## PSYCHOTHERAPY

I was introduced to Mrs. A by her oncologist as a resource that might be useful to her as she navigated the difficult course anticipated for her. We first met 1 month after it was determined that the source of her pain was cancer.

She reviewed the medical events of the past year, told me something about her supportive relationship with her spouse, and talked in detail about the needs of her children. I encouraged her assertiveness, stressed my availability to her, and underlined the importance of having a plan to attack the cancer.

Two months later, I spoke with her again during an oncology appointment. As she began a series of difficult embolizations requiring travel to a distant city, she noted the onset of tearfulness, a flatness in her emotional tone, frequent nighttime awakenings, low energy, and fatigue. I discussed her symptoms with the oncologist, and he prescribed an antidepressant medication to treat major depressive disorder. I set an appointment with her to see me at a subsequent oncology visit in 2 weeks.

At this, our third, meeting, Mrs. A talked about the experience of her distant embolization treatment. We focused on establishing a perspective that would center on her needs but include her husband, her children, and cancer treatment. As a caregiver, she found it more natural to focus on others and their needs and to ignore her own. It was hard for her to stay home, when counseling others was always a major piece of her identity. When she did work at home, overdoing was a constant problem.

Two weeks later, during an oncology visit, we discussed coordinating the different elements of her treatment. It was not easy for her to “allow herself to be treated,” but it was not seen as useful for her to “direct her treatment.” At this point, her depressive symptoms had mostly disappeared.

Our next meeting occurred after a 6-week break, once again during a visit to her oncologist. We spoke in detail about how she and her husband had discussed her condition and its treatment with their children. I emphasized how each child, at his or her age, likely had a unique capacity to understand. We also discussed how each might react differently to the same explanation. There was a place for more individual discussion with each child. She described to me the content of each of their conversations. Our focus involved “normal,” as in: “When will you be normal, Mommy?” She had experienced hair loss, so we talked about the meaning of hair to her appearance and the value of being “covered” or “not covered.”

From the outset, Mrs. A’s husband had little to say to me, and offered little recognition of my place on her treatment team. That is, until one visit during which he stated: “You are planning to speak with my wife, I hope.” When I subsequently mentioned this to her, she talked about him in some detail. She noted how hard he was working, how devoted he had been to her needs, and how he seemed to “spend no time on himself.” I offered to talk with him alone, if he was interested in an opportunity to do so.

In our last session, she was noticeably less energetic and outgoing. Her cancer was demonstrably spreading, and her condition was deteriorating. She was spending long stretches of time in bed. She talked about establishing a standard to use to judge how she was doing. Should it be how she used to feel and function at work? How she had felt at her worst? I utilized the concept of stages of life to emphasize the need to establish a baseline consistent with the “new life stage” she entered when cancer was diagnosed 1 year earlier.

I was at a meeting many miles from home, when Mrs. A’s husband called to tell me that she had passed away. He thanked me for my continued involvement with her and stressed what it had meant for both of them. I told him how much I appreciated his call, how sad I was to learn that she had died, and how much the relationship had meant to me.

Mrs. A’s funeral drew a large and diverse crowd of mourners. I met her oncologist in the parking lot, and we remained together throughout. This was, especially for him, an extremely difficult time. We each spoke at length with her husband and admired the many photos that captured their life together.

Although we had each struggled to maintain professional distance, it is hard to watch someone you work with lose their life to cancer at such an early age. The feelings that are rarely expressed come easily to the fore at a funeral. Knowing that you may have helped someone to adapt to a difficult life situation eases, but never eliminates, the pain. ◆