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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Prim Care Companion J Clin Psychiatry 2010;12(2):e1-e2

Published online: March 18, 2010 (doi:10.4088/PCC.10f00976blu).

Cancer as a Precipitating Event

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Anxiety is ubiquitous. It is part of the normal experience. Kept within bounds, anxiety can facilitate performance. Attached to multiple situations, or even to one event at a high intensity, anxiety can be highly disruptive.

A diagnosis of cancer typically evokes anxiety. A cardinal manifestation of anxiety is worry. With cancer, that worry often takes the form of "what if's." What if I am in constant pain? What if the treatment doesn't work? What if I can no longer do what I've always done? What if the cancer comes back?

When the range of "what if's" occurs to some cancer patients, they manage to keep the time spent on the cognition within bounds. For others, there is an inordinate focus on predicting the course of their illness. The consequences they perceive are magnified. By a process of overgeneralization, the consequences may spread to engulf other areas of life and concern.

Working alongside an oncologist, seeing his patients and then discussing their adaptation to their illness with him, there was a recurring question he posed to me: "Do you think this person has 'always' thought like this, or is it a specific response to a diagnosis of cancer?" For the psychiatrist, this is one of the central considerations in helping the cancer patient adapt to his or her disease.

When the reaction of the patient is specific to a diagnosis of cancer, the treatment may be as simple as a few sessions of instruction and listening to the patient discuss his or her thinking. When a cancer diagnosis is met by an outpouring of anxiety that has been typical of this patient's response to many prior situations, a more elaborate treatment is indicated.

The good news is that cancer as a precipitating event may afford some individuals the opportunity to change a lifelong anxiety-laden pattern. Such was the case with Ms A.

CASE PRESENTATION

My oncologist colleague referred Ms A to me for an evaluation for depression. Diagnosed with breast cancer about 1 year earlier, she had a lumpectomy, followed by radiation, and then a course of tamoxifen. The oncologist continued to see her for the purpose of surveillance and had noted some changes in her mood state that warranted investigation.

Ms A was a 38-year-old single mother of 2 teenage daughters, 16 and 18 years old. She had worked for the past 10 years as a paralegal in a large law firm. She began our meeting talking not about cancer, but rather about her divorce 12 years ago. Her focus then shifted to her job and the evaluations she had received from the lawyer with whom she worked most closely. Finally, she spoke about the difficulties entailed in raising the girls.

When I asked her to discuss the diagnosis of cancer and its treatment, she noted her surgery and radiation treatments as well as the multiple questions that she had considered and asked of her oncologist. It became clear that not only was anxiety tied to the cancer diagnosis but also that it was equally associated with her divorce, her job, and her children. There was no major depression.

Her contact with counseling was limited to the time following a difficult divorce when she and her (then) young children sought help briefly in another city. Her anxiety and worry appeared to manifest nearly daily for much of her

adult life. She found the worry difficult to control, and it seemed to attach readily to multiple life areas. She was often "keyed up," typically too easily tired, and had periods of impaired concentration. At times, she had real trouble falling asleep. She suffered from chronic tension headaches and periodic back pain. My *DSM-IV* diagnosis for Ms A was generalized anxiety disorder, 300.02.

My plan was to briefly teach her the cognitive therapy model and then to help her apply it to her life circumstances, including breast cancer.

PSYCHOTHERAPY

To complete our initial session, I explained the cognitive model to Ms A as "the framework in which we would work." When she reported for session 2, she talked in detail about what she had taken home from our first meeting: "I'm in charge, not events. What-if's can produce anxiety. Events in my life can provide practice so that I can learn how to deal with things with much less anxiety." She related feeling "much better" over the ensuing 2 weeks. We discussed her job and the choices she had and what she saw as their consequences. We labeled what she could control and what was uncontrollable. She talked about dating issues for her daughters. There was no mention of cancer, but she was learning to apply the cognitive therapy model.

In session 3, her focus was on problems she had experienced in thinking about a new relationship with a man. She considered consequences for her daughters and for their relationship with their father, who they visited periodically. She related the advice she had been given by a close friend and wondered how applicable it was to her.

In session 4, she broached the issue of cancer and its treatment. She talked about what she could control and what she could not. When there was a decision or a problem, we focused on a problem-solving approach. We defined (again) the "what-if's" and illustrated the process of magnification.

In session 5, she returned to a consideration of how to meet men—the Internet, dating services, going to bars, and referrals from friends. She had privacy concerns. She had the examples of girlfriends. My focus was consistently on what she wanted for herself and the ways in which to get it that made sense to her.

Our next meeting followed after a month. She noted more comfort in her workplace. She had accepted some realistic limits on what she could and could not do. She utilized the framework of choices and consequences. Ms A talked in detail about making parenting decisions, as well as the effect of her behavior on her young daughters.

By session 6, she acknowledged being anxious much less often. The symptoms accessory to anxiety were now gone. "Taking an action" was resulting in her feeling much better. She discussed expectations for cancer, for Christmas, and for her daughters. What were realistic standards for a single mom, working, with 2 growing girls?

Two weeks later, she called to discuss a problem that had arisen that was associated with "hurt feelings." When we had our seventh (and final) meeting, she reflected back on this brief discussion as a "pivotal point" for change. "Something snapped, and a light switch went on," she said, "and I've been calm and in control ever since." Perspective had been important, along with learning to trust herself. She felt comfortable now managing work, parenting, cancer, and relationships.

I am guessing that Ms A would not have consulted a therapist had she not been diagnosed with cancer. Her achievement was in turning this difficult life event into an opportunity for making a major positive change. ◆