

Psychotherapy of a Patient With Terminal Cancer

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We began making rounds together exactly 1 year ago, at the Hollings Cancer Center outpatient clinic: 3 hours, 6 to 8 patients, every Thursday morning. The oncologist had said (and I remember it exactly): "I'd give my eyeteeth to have a psychiatrist make rounds with me." Two expatriate New Yorkers, reveling in the beauty and peace inherent in life in Charleston, S.C. Dr. Brescia came to the Medical University of South Carolina to establish a Supportive Care Program for cancer patients whose primary disease was deemed no longer curable. As a psychiatrist, I wondered what I could contribute to the management of the palliative-care cancer patient. Now, 1 year and lots of clinical experience later, there is a funded research project and a proposed psycho-oncology fellowship program being designed, and little room for doubts. We are a team, continually expanding our reach. Let us share some of what we've learned.

When cancer crosses a person's path, it is a traumatic and life-altering experience for the individual and his or her family. It calls for a monumental adaptation to a life now filled with new and life-threatening experiences: surgery, radiation and chemotherapy, diagnostic tests and the often agonizing wait for results, statistics and probabilities, and life expectancies. For some, the event of diagnosis is followed some time later by a deadly prognostic statement: "Your cancer has spread. We are unable to remove or destroy it all." These patients will most likely die from their primary disease. At this point, sadly, some doctors withdraw their interest.

Supportive care encompasses relief of pain, insomnia, anorexia, fatigue, anxiety, and depression. It provides the physician with an excellent opportunity to engage in "doctoring" and often problem-solving. It emphasizes the third word in "doctor-patient relationship."

After we met and interacted with a significant number of terminal cancer patients, a disturbing trend became evident. Psychologically, many patients began each day focused on how few days they had left. The patients carefully noted their "last" birthday, their "final" anniversary, the "ultimate" Mother's Day or Father's Day, the "last" Christmas. It seemed logical that a dying patient would focus his or her attention on milestones on the road to

death. It seemed logical, but maybe not the best strategy. I remember thinking: "If I felt anywhere near decent, I would not want to begin my day anticipating death." That way, you stop living long before you actually begin dying. An estimate of weeks or months "remaining" seemed useful so that a patient and family could make reasonable preparations for dying. After this had been taken care of, however, I wasn't so sure how useful this framework really was.

Brief cognitive therapy had proved effective in treating depressions, as well as many of the anxiety disorders. Could it help the terminal cancer patient live out his or her life more sensibly? The question seemed worth investigating, and grant support concurred. Our research took the form of a 6-session cognitive therapy for the cancer patient "with an adjustment disorder." The case presented is a composite of the initial sample treated in our study.

CASE PRESENTATION

Phyllis is a 45-year-old white woman, married for 24 years, with 2 grown sons and 2 grandchildren. Born in California, she graduated from college in Massachusetts, and, after marriage led to multiple moves necessitated by her husband's job, she and her husband relocated to Charleston. Her mother died in her 70s of diabetes, and her father died in his mid-50s of colon cancer. She has an older brother still living in California who is in good health.

The patient and her husband have both been in good general health. She has no past history of depression or anxiety. Shortly after returning from a long-anticipated trip to Europe last summer, a routine physical examination laboratory screening showed markedly elevated liver function tests. Magnetic resonance imaging (MRI), part of the evaluation that followed, revealed several masses in the liver, which were confirmed to be metastatic cancer. A primary tumor was never located. Surgery and radiation were rejected as options, and chemotherapy began in September.

The family was devastated, but highly supportive. Phyllis began to dwell on the poor prognosis she was

given and said she “wanted to know statistics so I can plan better.” She was told she might live 4 months to 2 years. Prior to and throughout her course of chemotherapy, she was essentially asymptomatic, except for periodic fatigue. She noticed a decided elevation in her general anxiety level, but no symptoms of depression except for occasional crying “for no apparent reason.”

PSYCHOTHERAPY

With the intake completed, we began our 6-session cognitive therapy, which was aimed at improving her adaptation. I had met her during an oncology visit with Dr. Brescia, so no introductions were necessary. She was eager to start. She spoke of being “sad and scared.” She often cried when others mentioned plans for the future. She had little religious experience, but now had multiple spiritual questions. The cognitive model, with its focus on meanings, was presented to her. We talked about a person’s need for explanations. We also talked about how cancer typically robs people of the control they need in order to adapt. I introduced the Alcoholics Anonymous concept of “one day at a time.” We discussed how prognoses are arrived at and how their accuracy is measured in probabilities. She seemed engaged, motivated, and eager to meet again. “I have no one I can really talk to about my cancer,” she said.

In session 2, she examined how she might explain “being symptom-free” in the light of clear evidence of having cancer. We discussed man as a “predictive animal” and estimated the worth of spending time predicting the future. She wondered if faith was “all-or-nothing” or if she could find a home in her church that would “fit” for her. When she identified her meaning for a relevant belief, I asked if it seemed “rational,” and if so, was it “strategic” for her? We defined her beliefs as her choice and not dictated by her cancer or by anyone else. At last, here was something she could control.

In session 3, we tried to separate inference from fact. I asked her directly what she knew about her cancer and what she was inferring about it. She had talked with her husband about burial plans and found it easier to talk with him about dying, a topic they had been avoiding. She saw

how the same things had different meanings to different people. This realization helped her to accept the notion of choices and their consequences.

Our next session began with Phyllis relating how difficult her birthday had been for her, despite both children and their families coming to celebrate with her. “This could be my last birthday,” she said. She spoke of nightmares in which she saw herself dying. She felt weak in the heat and attributed this to the chemotherapy or the cancer. In each case, we focused on her logic. Did her conclusions make sense? Were her generalizations supportable? How else might she view the situations?

She began the fifth visit by discussing her “responsibility” for her husband Jack’s adjustment to her illness. “This is so unfair to him,” she said, and wondered, “How will he cope after I’m gone?” We discussed the concept of responsibility and associated guilt, and I asked if this would hold if her situation were reversed (husband ill and she well). We talked about spirituality in detail, as she had had a lengthy and useful talk with a friend’s minister. We agreed that this was an important time to remain “open to ideas.”

In our last session, she spoke of having markedly increased her activity. She continued to have no symptoms that she could definitively relate to cancer. Meanwhile, a repeat MRI suggested continued growth of the cancer, despite chemotherapy. She had driven to visit her son and his family. Company had visited for several days. She continued to treasure time spent with her husband. She told me that she began each day assessing how she felt, and then she made a plan for the day. Predictive thoughts about dying from cancer periodically recurred, and she would work to dispute their value.

She told me that these sessions were “extremely useful,” that she was “much less often anxious” and now felt “armed to deal with negative thoughts” when they occurred. She asked if we could find a way for every cancer patient to have access to this therapy. I told her that she could call and request a booster session whenever she wished.

It seemed to me that, although there is little a person can do to escape dying from terminal cancer, there is much one can do to avoid a “premature death” and to live more fully the days afforded to him or her.

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