Psycho-oncology

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Psychotherapeutic Issues

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Although psychological interventions for patients with cancer were slow to develop, since the 1950s efforts to develop and test interventions have grown steadily because of greater emphasis on quality of life of patients with cancer. The types of interventions most commonly utilized by health professionals working with cancer patients are education, behavioral training, group interventions, and individual psychotherapy. This chapter provides an overview of psychotherapy with cancer patients, outlining its indications, goals, and clinical management issues which arise for the psycho-oncologist.

It has been assumed that psychotherapy is beneficial to cancer patients; personal and clinical accounts support this view (1–4). It has been difficult, however, to carry out studies that test in a standardized way because psychotherapy is usually individualized to some extent for each patient. Psychotherapy research in general, however, has become more sophisticated, and methods for testing efficacy in medically ill patients have been developed. Relevant work has been reviewed by several individuals in recent years (5–8). For a detailed critique of the studies of psychosocial interventions see Chapter 59. Crisis and brief therapy is reviewed in Chapter 58.

WHO SHOULD RECEIVE INTERVENTIONS?

As attention to psychological aspects of cancer has grown, and studies have shown the efficacy of psychosocial interventions, the issue has repeatedly been raised of which patients should receive psychosocial interventions. Some enthusiasts have advocated offering counseling to all patients on the assumption that they need help, and, of course, want it. In fact, however, Worden and Weisman found that many patients rejected the offer of help (9). Investigative efforts turned to attempts to assure early identification of patients who were most distressed and for whom an intervention might prevent poor adaptation and more serious psychological problems.

Worden and Weisman used this approach with 372 patients with newly diagnosed cancer in the aforementioned study. Utilizing their Index of Vulnerability as a screen for risk of poor adjustment, they identified patients who were found to be at high risk (10). Only about two-thirds of the patients identified as at high risk accepted counseling. Those who refused had a positive outlook, minimized the implications of their diagnosis, and viewed the offer of therapy as a threat to their emotional equilibrium by opening the possibility of increasing their distress by unleashing suppressed emotions. Patients who accepted counseling were less able to deny the diagnosis and its implications; they were less hopeful and were more apt to experience their situation in religious or existential terms. Among those who accepted counseling, an improvement in their psychological state was seen, supporting the concept that early identification of those at risk allows for helpful intervention. One might speculate that, among those who refused counseling initially, some might have accepted it later, if their positive stance was seriously threatened. At any rate, those who were identified as vulnerable and accepted help did benefit from it.

In Canada, Stam et al. found that 20% of 449 ambulatory cancer patients seen in a single cancer center, which received most cancer patients within the geographic area, were referred and seen for psychosocial counseling over a 1 year period (11). This may be an underestimate of actual need for help. Family and personal problems were the most common reasons for seeking help. Interventions were either psychotherapeutic or educational in type. Clearly, a subset of patients in the range of a quarter to a third of them

have greater distress and interventions would likely be quite beneficial.

DEFINITION, GOALS, AND PSYCHOTHERAPEUTIC METHODS

Psychotherapeutic intervention is a one-on-one interaction of a patient with cancer and a therapist with the goal of increasing morale, self-esteem, and coping, while simultaneously decreasing distress. It has the effect of enhancing the individual's sense of personal control during the struggle with illness and helps bring a better resolution of the practical problems being faced (12). The goal of providing insight is limited to recognition of relationships to the past that bear on adaptation to illness (e.g., the experience of having the same type of cancer as a parent). The therapy described here is an integration of crisis intervention, supportive psychotherapy, and is based on psychodynamic principles which must be modified somewhat for application in the medically ill.

Psychotherapy with a patient who has cancer has several goals that include maintaining a primary focus on the illness and its implications, while exploring those issues from the past and present that affect the adjustment to illness (6,13). Using a brief therapy crisis intervention model, focus is kept on the illness and present concerns. Feelings and fears about the illness and its outcome are foremost in the patient's mind; they are often considered to be too painful and too burdensome to reveal to family and friends. Hence, the therapist, by virtue of being outside the situation, plays a useful role by encouraging exploring feelings which otherwise are unexpressed. The patient rapidly sees that most of the fears are not unique to his or her situation; they are, in fact, universal.

WHO SHOULD PROVIDE PSYCHOTHERAPY?

Psychotherapy is best provided by mental health professionals, or by those who develop skills through added special training in psychotherapy. Both should be familiar, however, with the special issues involved in psychotherapy with a patient with medical illness and cancer in particular. Social workers, psychiatric nurse-clinicians, psychologists, and psychiatrists have a background and training that equips them to work effectively with medical patients, however; it is essential that the therapist from any of these backgrounds be generally familiar with types of neoplasms, stages of disease, and treatments available with each type of cancer since patients are struggling with medical decisions and clinical outcomes which the therapist must understand.

The term therapist is used to indicate such a mental health professional who, irrespective of background, undertakes the difficult psychotherapeutic task of working with individuals who have a life-threatening illness or cancer. It is important to keep in mind that some patients require that a therapist have some special skill to achieve the desired outcome, such as cognitive behavioral techniques. Each mental health professional should, therefore, be aware of his or her own strengths and limitations, and should be able to recognize when the special skills of another mental health discipline might be better applied. A willingness on the part of the professional to obtain consultation for specialized skills is important.

In many settings, however, a single mental health professional assumes all these responsibilities simultaneously and must function truly as a generalist without opportunity for consultation. In larger centers, where several mental health professionals may be present and where the role of each is new and evolving, the potential for nonproductive professional jealousies to develop is great. The issues arise because neither the staff nor the newly assigned mental health professionals have a clear picture of expected roles or functions in a setting in which these roles are new and ill-defined (see Chapter 90). Conflicts can be avoided by mutual respect for the contributions of each discipline, and by maintaining a constant review of the nature and quality of management of all psychosocial aspects of care given within a unit or center, making changes in staff members and disciplinary background as needed. The most effective model is to provide these services in a single integrated unit by a single multidisciplinary team. Such a model encourages full and constructive use of all resources.

PSYCHOTHERAPEUTIC FRAMEWORK

The diagnosis of cancer leads many individuals to enter psychotherapy. The primary focus is the emotional stress engendered by the illness, rather than more general intrapsychic and interpersonal concerns of the physically healthy person. Aspects of the psychotherapeutic framework to which a psycho-oncologist must give special attention are: *(1)* time; *(2)* space; *(3)* the identity of the patient; *(4)* the therapeutic content and process; and *(5)* the therapeutic relationship. How that framework is defined will vary with the exigencies of the illness. However, flexibility does not give the therapist license to ignore, reject or take lightly the basic ground rules. Rather, the utmost challenge lies

in adapting a structure to the illness reality, even as the illness changes, without sacrificing the uniqueness of the therapeutic interaction.

Time

Awareness of the irreversible passage of time pervades any experience of potential or imminent loss. Thus a diagnosis of cancer acutely heightens the sense of time for the patient and family. Its subjective meaning is inextricably entwined with the reality of the clock and calendar (13). Time becomes the organizing pivot of the experience: "If one can eliminate time sense, one can also avoid the ultimate separation that time brings—death" (1:6). It is this omnipresent awareness of time that makes the threat of loss more critical than any other life stress.

The time commitment in psychotherapy is composed of these facets: frequency, duration and appointed time of sessions. In traditional psychotherapy, a consistent structure is critical to the containment of the process. Thus, there is both theoretical and practical adherence to the "50 minute hour". With increasing levels of illness or approaching death as the reality at hand, the scheduling of sessions will need to be flexible and may vary considerably. In cancer survivors or those in remission, the adherence to the traditional structure is more appropriate. Equally important is the therapist's availability to meet these time commitments, since the therapist's consistent and abiding presence is an aspect of the time component of psychotherapy with patients with cancer.

Not only is there an ebb and flow in the frequency of sessions, but also the patient must be given specific "permission" to participate in the regulation. The patient's request for more frequent contact during a stressful period often parallels the reality of the severity of illness or the toxicity and side effects of treatment. Conversely, one encounters phases when patients request diminished frequency, or cessation, of sessions. The reasons for such a request may be highly adaptive to the individual's functioning. The patient who is facing the enormity of loss may at times need to control his or her emotional "thermostat," and shut off confrontation and intensity. In exercising this option, the patient must be secure in the knowledge that contact with the therapist may be reinitiated without fear of reprisal. The understanding that the frequency of sessions may vary is a sine qua non of psychotherapy with patients with cancer. A therapist who responds to the patient's "self-regulation" as a narcissistic blow has not accepted this modification. A therapist's sense of relief at lapses in the process may reflect his or her own difficulty in handling the level of intensity on a sustained basis; a patient's retreat may be in reaction to such cues. While the therapist must certainly be alert for manipulation or resistance on the part of the patient, such motivation should be inferred with caution in the patient with cancer.

The frequency of sessions also depends upon whether the patient is being treated in the hospital or in an outpatient clinic. Time assumes a different meaning in the hospital. Hours and days often stretch out so that more frequent meetings, even on a daily basis, may not feel different to the patient from weekly sessions. During brief or uneventful admissions, there may be no need for such an increase. Whether or not the therapist works at the treatment institution will place bounds on his or her availability. However, telephone contact can bridge time between sessions or, if necessary, serve as a temporary substitute for face-to-face encounters.

Duration

The duration of individual sessions depends on the patient's physical status, as well as the concerns at hand. On occasion, particularly during hospitalizations, the therapist must interpret the meaning of a patient's illness behavior. For example, the patient may claim to be too sick to see or talk at any length with the therapist. Is the patient really incapable of interaction, or is the illness being used as a means of avoidance? An error in interpretation in either direction can be damaging to the theraeputic alliance.

If the therapist implies that the patient is using the illness to avoid emotional issues, when the patient is in fact physically drained, a "blame-the-victim" cycle is set in motion. The patient experiences justifiable resentment at the accusation. At some later point he or she may confront the therapist. However, it is often too threatening for a patient to express anger toward a caregiver and thus the basic trust of the therapeutic alliance may be ruptured beyond repair. Another avenue is that taken by the patient who passively accepts being labeled an "avoider." the vulnerability and powerlessness in the face of physical illness are now further exacerbated for this individual.

The therapist must maintain caution in another direction: that of permitting a patient to disengage under the guise of the illness when, in fact, the patient is clinically depressed. While the patient gives messages of wanting only to be left alone, on a more basic level he or she may be overwhelmed by depression, yearn for contact, and yet be unable to take the initiative. The firm, persistent, and gentle efforts of the therapist are often a turning point in the patient's reengagement.

What cues are available for the therapist to make a differential interpretation of illness behavior? First, it is imperative that the therapist understand the patient's medical condition. There is no substitute for facts. Second, the therapist weighs the patient's self-report with his or her own observations. Third, and of utmost importance, the therapist must communicate with other members of the caregiving team. They can give a general index of the patient's physical and emotional status,which then serves as a baseline for the therapist's assessment.

Appointment Time

The structured and secure expectation of meeting at a regular time can do much for the patient's sense of stability within the therapeutic relationship and in coping more effectively with illness. During hospitalizations, an appointed time provides the patient with a critical pivot for the day. However, as much as is positive in the regularity, there are obvious drawbacks to the "office-hours" regimen:

> It is in the middle of the night when I feel most depressed. The dark is associated with death; there is the feeling that you are going to die alone; and there are times when I really feel the need to talk to somebody. (2:177)

Although the patient is encouraged to discuss such night fears during regular therapy sessions, it is common knowledge that he or she may never mention them, even in response to the therapist's direct inquiry. What emerges is the necessity for a flexible "on-call" schedule among therapists working with these patients. A patient's night anxieties are often assuaged simply by knowing of the therapist's availability. Furthermore, night staff can be trained in focused listening skills and thus provide a measure of comfort and relief.

Space

Space—the physical setting—establishes concrete boundaries for the therapeutic process. As the therapy hour is a time apart, so the setting affords a private space from daily life. The office becomes an extension of the therapist, with some of the same projective attributes.

> A woman had a regularly scheduled therapy session prior to each hospital admission. She often verbalized how the therapist's office was a "refuge" before the onslaught. Upon hearing that the therapist would be away at the time of her next admission, the patient asked whether she might sit in the office alone. She felt that just being in the setting would help to prepare her.

In oncology, a consistent setting cannot always be depended upon for structure and "protection." Whereas the therapist's office serves as the base, other locations which may need to be additional bases are the clinic, hospital, or the patient's home. Especially when the patient is seen in the hospital, the setting no longer stands protected and apart. Rather, the therapeutic process is enmeshed in the physical and emotional confrontation of the illness.

A hospital room affords little privacy. During hospitalizations, psychotherapy sessions may be constricted, interrupted, or abbreviated by the presence of other patients, staff or visitors. At other times, the hospitalized patient may experience the therapist's presence as engulfing because the framework is altered: the therapist comes to the patient. With curtailment of physical autonomy, the patient's anxiety may escalate dramatically. It is a rare patient who asks directly that the therapist leave or that a session is ended. In compensation for this sense of "captivity," the therapist must be acutely sensitive to the patient's cues concerning spatial boundaries.

Visits to the home for the patient who is no longer physically able to come to the therapist's office are important for the patient and the therapist, since it may become the setting for saying goodbye. The sense of such a patient that the therapist's commitment extends to making home visits can be extremely reassuring in the face of advancing illness (see Chapter 87).

Identity of the Patient

In traditional psychotherapy, the identity of the patient is strictly defined: as an individual, a couple, a parent-child dyad, or a family. When a therapist works with a patient with cancer, the contract regarding "who is seen" is more open from the start. Although psychotherapy may be initiated with the physically ill patient, or with a family member, this one individual becomes the therapist's point of entry into the family system. By no means does all individual therapy become family-based. However, in the face of life threatening illness, bridging maneuvers to involve the entire family can be critical (see Chapter 85). Because of this broader definition of the identity of the patient, the boundaries of confidentiality may be more permeable than is traditionally dictated. The therapist bears heightened responsibility for handling privileged communication within the emotionally intense family system.

The therapist plays a pivotal role in the integration of the patient's total care. With the ethic of confidentiality as a guide, and with the patient's consent, the therapist may share selective aspects of the therapeutic

material with the care-giving team. The therapist communicates only essential content which bears directly on the care of the patient. For example, it may be important to make a statement about the patient's emotional or mental status in relation to a precipitating event, if relevant; discussion of the individual's ability to cope; and, recommendations for aspects of medical care by other team members that will affect coping. Information that does not contribute to these categories is generally best left unsaid. The intimate nuance and subtlety of the material belong exclusively within the therapeutic relationship.

Rumors abounded as to whether the mother of an adolescent patient died naturally, or had committed suicide. The girl confided to the therapist that the death had been a suicide, and talked at length about its impact on her. The therapist's communication to the staff outlined: the fact that the patient's mother had committed suicide after a long psychiatric history; the feelings of abandonment and guilt described by the girl; how the experience might affect her coping with the illness; and her need for reassurance despite a counter-dependent facade. When the therapist provided factual data, the "sensationalism" vanished, and the staff developed a new sensitivity toward this patient.

Therapeutic Content and Process

A hallmark of traditional psychotherapy is the unstructured flow of content and process. Past, present, and future interweave in the unfolding of themes. Letting a process emerge at its own pace and time is a luxury precluded by the very nature of life-threatening illness. Its immediacy demands a focus on the present, framed by the themes of separation and loss.

The patient's and family's previous experiences with loss will bear significantly on the present. Thus, an individual's "loss history" is a critical tool in highlighting areas of strength and vulnerability. The history encompasses loss in its broadest sense; for example, through illness and death, termination of relationships (such as divorce), geographical separation, and loss of employment. The history should include the person's earliest memory of loss from childhood, subsequent experiences up to the present, and a description of how he or she functioned in each context. What were the most stressful aspects of the experience? What type of support was positive, deleterious, or lacking altogether? It is of utmost importance to know the patient's and family's past "acquaintance" with the illness they are now facing. Have they known anyone with the disease, and if so, what was its trajectory and outcome? Was a parent, sibling, or grandparent treated for cancer? What was the outcome and how did it affect the person? The meaning of the same diagnosis can vary dramatically depending upon these factors. Through this carefully focused assessment, the groundwork is laid for therapeutic intervention.

A man diagnosed with an early stage malignancy was given an excellent prognosis by his physician. Despite this reassurance, the patient maintained that he was sure to die within the year. It turned out that the one person he had known with the same disease had died, and thus he viewed his own diagnosis as an unequivocal death sentence.

For the individual with cancer, psychological defenses are coping mechanisms for the present, rather than barriers to the past. An individual's defensive structure has developed over a lifetime of negotiating reality. Faced with the ultimate reality—the threat of death—his or her defenses may be mobilized to the hilt. Defensive patterns which appear to be constructive for the patient are identified as "psychological tools." Those with deleterious impact become grist for the therapeutic process of change. The therapist thus serves as an advocate of the patient's defensive structure, in the service of optimal coping.

There is a future for both patient and family, albeit in markedly different ways. The family must focus on plans which go beyond the patient's illness and death. Fear and guilt often accompany the acknowledgment that despite the loss of one family member, life does continue. The patient, on the other hand, can consider the future only within the context of the present illness.

And as my diet and my tumor have restricted my movements in space, so the probability that I shall die soon has restricted me to the immediate present in time. It has erected around me an invisible barrier that I bump into a dozen times a day . . . I'm reasonably sure I'll be alive a month from now, and I sincerely hope I'll be alive three months from now; but beyond that I don't know . . . In short, I have no future any more. And that I think is the greatest change of all. (3:46)

The therapist must constantly maintain an acute awareness of both the "real" and affective facets of time. On a cognitive level, the therapist monitors the reality of temporal issues; for example, how long the patient is expected to live, when the family is available, how much time should be devoted to therapeutic intervention at different points in the illness. For the patient and family, however, cognitive time may be out of phase with its affective counterpart. Thus, a family may panic over separation when, in fact, the patient's condition is stable and death is not imminent. Or, in contrast, a denial of impending loss may occur when time is short. These seeming inconsistencies arise from the fact that the patient and family live within a dualistic realm of time. The clock and calendar, by their imposition of finite limits, bespeak the reality of adult time. Especially in confronting life-threatening illness,

"the calendar is the ultimate materialization of separation anxiety." (13:190) The contrast is child time: the magical, omnipotent belief in endless time forever. While the context for psychotherapy is finite time, a shift into child time does not necessarily imply denial or blocking.

A man acknowledged that there were no further treatment options for his advanced disease. Within the same sessions, he talked about travel plans for the following summer. When the therapist confronted him with the juxtaposition, the man replied: "Of course I am aware of the reality of my illness and—I nonetheless hope for something better."

The patient may also be testing the therapist: "Which time framework will you buy? Or, can you tolerate the fluctuation which is the essence of my experience?" Adherence to child time, to the exclusion of impinging reality, may signify fear dysfunction. However, most families flow between the two sets of time, in a normal and adaptive process of maintaining hope. The therapist need only follow.

The Therapeutic Relationship

The therapist's role for the patient is highly specific: he or she is an anchoring presence in a life situation that otherwise feels unstable and vulnerable. The transference and countertransference come to mirror the themes of attachment and loss that the patient is confronting in every relationship. In the urgency of life-threatening illness, the luxury of operating exclusively with the transference simply does not exist. Rather, the therapist must constantly translate back to the patient's "outside" life, maintaining a close correspondence between the transference material and its implications for the patient's significant relationships. Ideally, the therapist strives to foster a transference whose depth and intensity can fuel the tasks of living so crucial for the patient with limited life expectancy.

An aspect of the countertransference that is aroused in therapists who work with seriously ill individuals is the "rescue fantasy." In wanting to protect the vulnerable patient, the therapist encounters the danger of overinvolvement, a loss of boundary and role. The patient may feel threatened by an inordinate closeness to the therapist, while at the same time welcoming and needing the relationship. Ultimately, the patient may feel trapped into "choosing" between family and therapist, with a simultaneous fear of alienating either. The therapist must prevent the patient from ever experiencing such a forced choice position. One safeguard is to be found in the interpretation of the transference material. If the patient understands that the intense feelings which develop toward the therapist also have meaning for his or her other relationships, the sense of threat is minimized.

The family could feel estranged and supplanted just at the time they are desperately trying to "keep" the patient. Their pain is only exacerbated if they feel that the therapist is "better" than they in achieving closeness. The therapist and other caregivers must be aware of their own feelings of competition: such rivalry often serves as a danger signal of inappropriate involvement, coupled with a family's difficulty in relating to the patient.

The discussion at a case conference focused on a man's inadequate support of his wife during her prolonged hospitalization. The staff noted the husband's infrequent visits, and his discomfort in his wife's presence. Both the therapist and the nurses described their closeness to the patient. It was at this point that the therapist realized the staff's error: all were vying for a "special relationship" with the woman to compensate for the apparent problems within her marriage. Furthermore, the husband's behavior was clearly an indication of his own difficulty in coping with his wife's illness. The therapist was able to highlight these issues in the conference, and subsequent work focused on the couple's relationship.

COUNTERTRANSFERENCE

Psychotherapy with patients with cancer does not allow the luxury of maintaining an objective stance as one would with a physically healthy patient. More interaction is necessary with the patient and hence the issues of countertransference become critically important in the psychotherapist. Knowing one's own "loss history" becomes important to help in understanding why a certain patient's illness or impending death is more painful than another. Understanding this is critical to "survival" as a psycho-oncologist. Equally important is the assurance that someone is available to review and discuss the patient who has raised significant distress in the therapist. It is sometimes wise to transfer such a patient to a colleague, if the therapist senses some deep-seated relationship from the past that may be confounding the care of a particular patient and resulting in countertransference that is interfering.

Although no psychotherapy is ever complete, this fact is strikingly evident in work with individuals with cancer. The therapeutic process and the illness reality are inextricably bound: interruption or termination may occur at any point. Thus, each encounter should be complete in and of itself. The therapist must possess a high tolerance for ambiguity in order to step into the lives of those whose existence is predicated on such uncertainty. In essence, the therapist must be committed to the individual's quality of life—for however long that life may last. Furthermore, in

the absence created by the patient's death, he or she must acknowledge the loss with the family, provide a sense of continuity for them, and offer grief counseling, if appropriate, or refer them for treatment. There is often a strong bond felt by families for the therapist who took care of their relative, and a desire to continue because of the fact that the therapist knew the deceased and provides an intimate continuing link. Bereavement counseling with the family is sometimes a useful interaction for grieving members.

SUMMARY

Therapists who provide psychotherapy for patients with cancer should know both theory and techniques of individual psychotherapy, be familiar with oncological diagnosis, prognosis, and treatment, and be aware of their personal responses to patients who have a life-threatening illness. Finally, psychotherapeutic work with cancer patients is challenging and requires commitment to do it effectively; it is also highly personally rewarding.

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