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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The Accidental Therapist

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She was diagnosed with breast cancer 3 years earlier. Prior to that, she was her husband's caretaker during his lengthy bout with cancer. He had died the same year of her diagnosis. She had taken care of her brother for years, nursing him through his cancer and its treatment.

Now, 55 years old and a widow, she had been treated badly by her 3 children and rejected by her domineering mother. She cried during a routine follow-up visit with her oncologist, prompting him to offer her an appointment with "our psychiatrist." (Me!)

It is a reasonable expectation that consultative visits with a psychiatrist working in an outpatient oncology setting would be about adjusting to cancer. Cancer often does upset the balance of a person's adaptation and is a significant event for most patients' families. While this is a reasonable expectation, however, it isn't always true. Sometimes, the agenda of patients in the oncology setting varies little from that of patients referred to my psychiatry office. The issue that leads to the consultation may be only peripherally tied to the cancer illness. That was the case with Ms A.

CASE PRESENTATION

Ms A related her medical history, focusing on the events that followed her diagnosis of breast cancer 3 years before. Her husband's death followed soon thereafter, along with harassing Internal Revenue Service letters alleging monies owed the government by her husband. Her role in her brother's ongoing illness came next. Throughout, there were difficult relationships with her mother, her 4 sisters, and her 3 children. Each family member seemed to have an agenda, and each one seemingly imposed it on Ms A.

Ms A described, too, a lifetime of being taken care of and her dominant concern of pleasing others. A twin sister was her "guardian" through school. Subsequently, her competent husband met most of her needs and addressed most of the couple's life issues. Ms A had a hard time answering the question of what *she* wanted. There was little formed sense of "who she was" (identity). And now, she was alone and felt besieged, and there was no one for her to turn to for help.

Ms A met *DSM-IV* criteria for dysthymic disorder (300.40). She often felt sad. She overate. She suffered from disrupted sleep. She had low energy and poor self-esteem. She had a devilish time making decisions, unless she was directed to do so in a way that would benefit someone else. She described a sense of hopelessness.

In addition, Ms A was frequently anxious and met *DSM-IV* criteria for generalized anxiety disorder (300.02). She constantly worried and could not seem to control the tendency. She was often restless, easily tired, and had a hard time focusing her attention.

PSYCHOTHERAPY

We agreed to meet a second time in the oncology suite. At that session, Ms A reported being diagnosed with a "terminal" lung condition, which had then "disappeared." We agreed that in her present situation, she was entering a new life stage. The previously defining tasks of raising a family, being cared for by and taking care of her husband, and nursing her brother were now over. She told me that she was easily hurt by other's remarks. She saw her orientation as "submissive." She needed to learn self-assertion and to begin to define who she was (at age 55 years) and what she wanted. She labeled our initial meeting as "empowering."

When we met 2 weeks later, she related a series of proactive behaviors in which she had acted for herself and not to gain approval from others. She discussed a wide range of decisions she needed to consider. These decisions included where to live and whether and where to work, as well as whether and whom to date.

In subsequent sessions, she described situations, and we focused on the cognitions (thoughts) that governed her feelings and behavior: a casual conversation in a movie theater, a "fact" presented by a woman she met at Bible study, and her reaction to the anniversary of her husband's death. Throughout, we emphasized self-worth, identity, and anxiety prevention.

The fifth time we met, Ms A was "having a meltdown" due to a series of family problems. Our session was spent in problem solving, with alternatives defined as options, rather than as a referendum on her self-view.

In our eighth and final session, Ms A said, "I was a stick in the mud, and I had no hope. I kept busy and hid behind that. Now, I'm beginning to see myself as somebody. I always knew how to give, but not how to receive. I've learned to stop thinking like a victim and have begun to focus on what I need and how to get it."

In an oncology service established to aid the cancer patient in adjusting to illness, questions of a reconsidered identity frequently arise. There is often associated anxiety and sometimes depression. Ms A's need to craft an identity, as well as much of her anxiety, however, had little to do with cancer. Instead, she took advantage of an opportunity to set out in a healthier direction by reorienting her thinking. ◆