

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.

Dr. Schuyler is Clinical Associate Professor of Psychiatry at the Medical University of South Carolina in Charleston. He is author of the paperback book *Cognitive Therapy: A Practical Guide*. (W. W. Norton & Company, 2003).

Dr. Schuyler can be contacted at schuyled@musc.edu.

Remote Brief Psychotherapy

Dean Schuyler, M.D.

I have, by now, treated 27 patients with short-term cognitive therapy to study and aid their adjustment to a diagnosis of cancer. The origins of this opportunity and a prototype of the patients and issues I have encountered were presented earlier.¹

South Carolina is a spacious state, with large rural areas served by a few major cities. The Hollings Cancer Center (HCC) and a dedicated staff of oncologists and health care professionals have made the Medical University of South Carolina in Charleston a place to which patients with cancer often travel significant distances to obtain quality treatment.

My research findings to date suggest that just 6 sessions of cognitive therapy can make a difference for cancer patients with an adjustment disorder. However, as the patient becomes progressively more symptomatic, his or her access to travel to obtain care often diminishes. If the therapist could easily travel to the patient's home, the benefits of psychotherapy might be more accessible to this significantly needy population.

If Mohammed can't come to the mountain, sometimes the mountain can come to Mohammed! Advances in telemedicine offer a potential solution to the problems of patient need, distant location, and limited access. By means of a videophone in my office at the HCC, I can work with cancer patients in their homes, 2 or 3 hours distant.

While video-conferencing technology is not new, and its application to psychiatric evaluation and consultation are well documented in the literature, less is known about doing psychotherapy remotely. The model of cognitive therapy would seem to lend itself well to communication by videophone. The model focuses on the patient's meanings for the factors significant to adaptation and is solidly planted in the present time. It prescribes a collaborative role for the therapist and patient and is typically conversational, allowing for easy delivery of the nonspecific relationship variables associated with successful change.

To illustrate the protocol of an intake evaluation session followed by 6 cognitive therapy sessions by videophone, a composite view of a cancer patient I treated remotely is presented.

CASE PRESENTATION

The patient was a 42-year-old married, white woman with 2 sons (aged 4 and 6 years), who had worked as a teacher in a middle school. Until 3 years before, she had been emotionally and physically well, happily married, enjoying her children, and gainfully employed. During a monthly breast self-examination, she felt a lump, told her husband, and was referred for a mammogram and an ultrasound. A biopsy brought a diagnosis of cancer, which led to a right mastectomy. Chemotherapy, then tamoxifen, followed. She decided to have reconstructive breast surgery.

Her course had been relatively uneventful, and 1 year before, the family of 4 had moved to South Carolina when the patient's husband was hired to work for a firm in a city 2 hours from Charleston. Her follow-up care was transferred to the HCC. Six months later, she found a lump

beneath the reconstruction scar. An abnormal positron emission tomography scan and nodules on a computed tomography scan led to a diagnosis of a recurrence of breast cancer. Based on the pathology, she was told she had a life expectancy of 3–5 years, and a second round of chemotherapy was started.

Although she acknowledged little fear of dying, she was concerned that her children would not know much about their mother. So far, she had kept the recurrence “secret” from her parents. She had investigated adding herbal supplements to her cancer treatment regimen. She had tried to continue teaching, despite the hair loss and fatigue that had accompanied renewed chemotherapy. Her husband had been supportive and available, but she knew that her cancer had imposed a burden on him. She had talked with him, as well as with some friends, but she remarked, “I have no one, really, to talk to about my cancer.”

She continued to sleep well, had at least some appetite for food, and had maintained her weight. Her energy level varied, and in the days immediately following weekly chemotherapy, her fatigue could be overwhelming. She had periodically taken time off from school. Her ability to concentrate and recall was largely unaffected. Her mood, however, could plunge into despair, typically for brief periods, with rapid recovery. Worry, too, was not constant. Rather, she was “periodically anxious” in a way similar to her depressed moods. At these times, her focus shifted to the future, her husband, and her children.

She did not meet criteria for major depression or dysthymia, nor did she meet criteria for generalized anxiety disorder. My working diagnosis per DSM-IV criteria was adjustment disorder, with anxious and depressed mood. Referred to me by her oncologist for consideration as a study participant, the patient was accepted into the study, signed the appropriate consent forms, and was randomized to group 3: videophone psychotherapy at home. (Group 1 receives 6 sessions of cognitive therapy, face-to-face; group 2 receives 6 sessions of cognitive therapy at home, on the telephone.) A videophone was loaned to her, and she was instructed in its use by the study technician. This intake session was completed in my office at the HCC, subsequent to one of her oncology appointments.

PSYCHOTHERAPY

To convert the usual audio phone call to video, the receiving party must press a button. After a quick “hello,” and “this is Dr. Schuyler,” the patient pressed the button and her face as well as the background of her room came into view. She, in turn, could see my face as well as the wall of pictures behind me. A comment about the pretty drapes framing her window preceded my thanking her for “inviting me into her home.” We each laughed.

“We have 6 hours to talk about issues relating to the diagnosis of cancer,” I said. “How would you like to start?” Her agenda consisted of how to talk with her parents about the recurrence of cancer, what to do about periods of preoccupation with the future and the likelihood of not “making it,” how to deal with weekends when she felt “bored,” and ways to talk with her children about cancer and the future. I explained the cognitive model to her, emphasizing its problem-solving orientation. When approaching a problem, we would aim at identifying the relevant automatic thoughts or “meanings” she had about it. Once identified, we would test the meaning’s rationality (does it make sense?) and strategic value (does it help her to approach the problem?). If it failed either test, we would search together for alternatives. Once she found an alternate meaning that was acceptable to her, we would move on to the next problem. Although the cognitive therapy approach sought to help the patient solve problems, its ultimate purpose was to teach a method of problem solving that the patient could eventually apply on her own.

In session 1, we discussed the patient’s parents in detail: their styles, her relationship with them, how they dealt with adversity, what they knew of her disease, and their expectations for it. We then considered ways of introducing the idea of a recurrence to them, their likely reactions, and how she would tolerate their reactions to the news. The patient began session 2 by telling me “how much better she felt after talking with me.” She then told me about how she dealt with situations most of her life to date by being extremely self-critical and “always taking the blame for herself.” This led to a lengthy discussion of specific examples and an analysis of whether “self-blame” in each instance met the criteria of rationality and strategic worth. When they frequently did not, we looked together for alternate explanations.

In session 3, we discussed “predicting the future.” I noted that humans are “predictive beings” and that the capacity to predict and plan for the future is one capability that sets us apart from primitive animals. That said, the concept of anticipatory anxiety suggests that prediction is not always the best strategy. Asked for an alternative, she replied, “one day at a time.” We discussed the merit in thinking about the day to come and making plans based on how she felt that day rather than her alternative: “I know I’m dying of cancer.” This was juxtaposed with making a plan for future pleasure (as in planning a trip). Here, a more adaptive approach seemed to be “anticipating that I may feel then as I do now, I’d like to be able to make that trip to Disney World in 3 months.” Then, we considered the meaning of the prognosis she had been given of living 3–5 years.

In the next session, we focused on her thoughts about her children, her cancer, and the future. She was con-

cerned that, if she died soon, her young children might never know their mother. We discussed ways she might spend time with her kids now and tried out a number of approaches to talking with each child about cancer in an age-appropriate way. Finally, we explored the likelihood that her children “would forget her.”

In session 5, the patient noted she had found that having a terminal illness tends to focus a person on what they consider important. She told me that her perspective on the “little daily annoyances” had changed. She was more involved with “living each day” and spending time doing things she thought were worthwhile. This led to a discussion of “legacy”: why we are here, and what do we leave when we are gone? The focus at this point was on what she could do to benefit others.

We spent the final hour considering the benefits to her of our sessions, the impact of the videophone, and the value of the relationship we had established. “There are so many ways to live life, even when you may be dying,” she

said. “The videophone is a great alternative to lengthy travel.” And, “I feel I was lucky to be selected for this benefit. Thank you very, very much.”

DISCUSSION

It is of interest that we devoted so little time to talk about dying: wills, possessions, funerals, arrangements. It became clear that the patient had accomplished this on her own. We spent the majority of our time together on issues of “living with cancer.” At this point, the value inherent in doing psychotherapy by videophone seems likely to be realized by study’s end. And, the benefit of brief cognitive therapy for helping the cancer patient adjust to the demands of this terrible disease appears to be significant, across a broad range of people.

REFERENCE

1. Schuyler S, Brescia F. Psychotherapy of a patient with terminal cancer. *Primary Care Companion J Clin Psychiatry* 2002;4:111–112