

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 in the private practice of adult psychiatry, specializing in adaptation to illness. He is author of the paperback book *Cognitive Therapy: A Practical Guide* (W.W. Norton & Company, 2003).

Dr. Schuyler can be contacted at deans915@comcast.net.

© Copyright 2008
Physicians Postgraduate Press, Inc.

Casebook of a Cancer Therapist, 1

Dean Schuyler, M.D.

In 14 months of work in an outpatient oncology practice, I've had 350 sessions with cancer patients. Although some consultations have involved only 1 session, many have been longer, and some have involved multiple visits over many months. While each session begins with the diagnosis of cancer and proceeds to focus on the patient's (and family's) adjustment to this new life stage, some psychotherapies venture far and wide to encompass important relationships, significant mind-sets, and many long-formed habits.

In the first of several reports on cognitive therapy for cancer patients, I present a unique set of challenges in the following case of a caretaker becoming the cared for. One challenge was overcoming the preconceived mind-sets those who have traditionally been the caretakers mistakenly adhere to, that caretakers should not "be allowed" to require care from others. However, they themselves often do require care once cancer takes hold of them. Another challenge was overcoming others' belief that caretakers should automatically know how to say "no" when they are asked to help others, because taking on further responsibilities can drain the last drop of their reserve. As most of you know, caretakers rarely say "no." In addition, when help is offered or given, the caretaker often finds it difficult to accept that help. Taking care of caretakers is an especially difficult challenge for the psychotherapist.

The support of an understanding and facilitating team of 5 oncologists has allowed me to treat a variety of cancer patients who have a wide range of problems. I have seen Mrs. T nearly twenty times over the past year. While in some sessions we have anticipated upcoming treatment and sought to keep her focus on "now" rather than an unknown "future," in others we have taken up family relationships and expectations for her health care team. In toto, my experience with Mrs. T neatly illustrates how a continuing relationship with a therapist in the cancer treatment setting can make a difference over a lengthy period of time.

CASE PRESENTATION

Mrs. T is a married, white, 60-year-old woman living in Charleston, S.C. She has a history of several serious depressive episodes. She has given birth to 5 children, 2 of whom have had debilitating emotional problems. She has been consistently involved in their care. In her early 30s, she was diagnosed with a carcinoid tumor in her lung and underwent successful surgery.

Her mother had a major psychiatric illness, and Mrs. T cared for her for many years. Mrs. T's father was alcoholic and had developed lung cancer, and she cared for him until he died 1 year after his cancer diagnosis. At this point, her mother decompensated, and Mrs. T continued caring for her over a lengthy and difficult course. Five years ago, she found a care facility that has led to her mother's finally achieving a degree of stability.

When she urged her physician husband to get a stress test, he underwent bypass surgery the following day! Needless to say, she took care of him. For nearly 25 years, she felt well and was everyone's caretaker.

Three years ago, she noted the onset of abdominal pain on a trip out West to her son's wedding celebration. Upon her return to Charleston, a significant carcinoid tumor of the liver was diagnosed, despite an initial attribution of her carcinoid symptoms to "menopause."

She was referred to the oncology practice in January 2006, and was treated concurrently in New York, N.Y. A liver resection was followed by a thoracotomy for mediastinal nodes, when carcinoid tumors were found there as well. Radiation and embolization followed. When rheumatoid arthritis was diagnosed, rituximab treatment and a recurrence of depression followed. She was treated with therapeutic doses of extended-release bupropion.

When we met, Mrs. T met DSM-IV criteria for major depression, despite her taking antidepressant medication. I started a trial of escitalopram, 10 mg, and continued 150 mg of extended-release bupropion.

PSYCHOTHERAPY

Cues during an embolization treatment in New York evoked anxiety and sadness. Mrs. T developed nightmares and panic attacks when she was given a narcotic for pain relief. She complained that her husband expected her to be "as she was" and that her doctors had little understanding of depression. Finally, she had serious anxiety anticipating a return to New York for another embolization treatment.

In our fourth session, Mrs. T revealed a preoccupation with a son's marital problems. She felt that she needed to, somehow, "fix it." We discussed her options, as well as choices for dealing with a husband she saw as "too focused on his medical work." I emphasized the need for her to be an advocate for appropriate treatment for her carcinoid tumors.

In our fifth session, the focus was on medical technicians who "wouldn't listen to her." She had responded effectively to the inadequate treatment she received from the technicians, demanding that more be done, and they had complied. Meanwhile, she had suffered serious abdominal pain during a weekend of social events relevant to her husband's job. In our next meeting, she demonstrated her new-found capability of keeping her "hands off" her son's impending divorce. We defined her new life stage, dominated by cancer and its treatment. We consistently monitored her reactions, speaking of them as "strategies." Our framework was "choices and conse-

quences." I urged her to do the cognitive work we had outlined.

Her third embolization was a far better experience than the earlier ones. "I looked at it differently, as you have taught me," she said. She was learning to apply perspective effectively. But then, a new carcinoid tumor was identified. She was disappointed, but asked what the "rational way" would be to deal with this new tumor.

Mrs. T was learning to listen to her body and to take care of herself, in addition to others. When her daughter reported a marital problem, we discussed, "What is an appropriate role for mother?" We then focused on self-worth. "What part comes from one's partner, and what part is the responsibility of oneself?"

She began to model for her children the new behaviors she was learning! She questioned the competence of some of the doctors treating her, and reviewed options of how she might respond. She returned to regular exercise, and was able to give up a daytime nap she disliked. She felt far more "engaged" in life.

At our thirteenth meeting, she prepared for a family beach vacation by discussing "expectations and boundaries" with her son. She focused on her husband's decision to retire and the "new life stage" that would usher in for both of them.

One month later, there were new symptoms she recognized as "carcinoid." We talked, respectfully, about not jumping to conclusions. Just prior to a long-planned trip abroad, a new tumor was found. She decided to go on her trip and deal with the medical situation on her return.

She came for session 17 and described her trip in detail. She related the discomfort evoked by seeing a close friend with cancer deteriorate markedly. A new embolization was scheduled, and we discussed her preparation for it. She described her occasional "meltdown" days, and we developed a strategy for dealing with them that focused on problem solving.

This treatment is ongoing, but Mrs. T bears no resemblance to the woman I met 1 year ago. Effective, an advocate for her care, less involved with others' lives, and rarely depressed or anxious, she has become a stable, reliable patient, wife, and mother. Our relationship has deepened, and it has clearly played a part in facilitating the many changes she has made. The cognitive model of therapy has formed a framework for teaching, discussing, and making fundamental alterations in her thinking. ♦