Brief psychotherapy for persons with recurrent cancer: a holistic practice model

Marilyn M. Rawnsley, DNSc, RN, CS
Associate Professor
Division of Nursing
New York University
New York, New York

CANCER is everybody's business. The likelihood of avoiding the experience of cancer—either directly as the afflicted person, or indirectly as a friend, family member, or professional—is remote. As a professional discipline committed to the understanding and treatment of the whole person, nursing has a responsibility to examine the data generated from clinical situations to clarify the issues and conflicts that surface when persons struggle with this disease. A holistic model for brief psychotherapy that is designed to help persons with recurrent cancer move toward as much self-actualization as possible within the realistic limits of the situation is presented here.

BACKGROUND

It is becoming apparent that cancer does not in itself create a set of emotional responses peculiar to the disease. Instead, as an intense pervasive stressor, it summons the customary coping mechanisms

0161-9268/82/0051-0069$2.00

used by the person when faced with a threatening event. It exaggerates the conflicts and inadequacies that existed premorbidly.[1] Caplan[2] has described responses to stressful events in four interrelated phases. Phase I behaviors are aimed at eliminating the stress by direct action or by escape. Phase II behaviors involve the acquisition of new learning to achieve mastery over the stressor and its consequences. Phase III and phase IV behaviors involve the intrapsychic processes of defense and internal readjustment that are necessary components of resolution. The importance of a support system is emphasized.[2(pp413-417)]

The initial diagnosis of a malignancy is a serious challenge to the integrity of the living system. But through a variety of treatments and rehabilitative methods—and with emphasis on eradication of the disease—persons with a reasonable network of social support usually achieve mastery of this episode. These coping processes, designed to eliminate the source of the stress and to facilitate adjustment to any physical sequelae, correspond to phase I and phase II behaviors described by Caplan as adaptive responses to stressful events.

If the cancer recurs following an ostensible cure, or if the primary malignancy does not respond to treatment, the stricken individual is forced to confront the reality of personal vulnerability. Life-occluding cells are supplanting life-sustaining cells. Cancer is perceived as the alien invader whose strength and voraciousness were underestimated; it is, as Sontag says, "metaphorically, the barbarian within."[3(p61)] Anxiety overwhelms; if the first treatments could not prevail over this insidious chaos, will different methods check its relentless advance? Will loved ones grow weary of the struggle? Will anyone be there in the frightening, helpless times? Is there any surviving of the self that can be counted on, or will everything eventually be lost?

There are no ready reassurances for people reaching the lonely awareness that intolerable life changes imposed by this illness are ultimately borne alone. There is no ritual consolation for those who realize that the end of their earthly existence is unthinkable—only to themselves. Recurrent cancer constitutes a focal experience of existential anxiety. It is unmitigated separation anxiety precipitated by actual and anticipated loss.

The recurrence or metastasis of cancer constitutes a crisis in that the usual problem-solving methods are ineffective in controlling anxiety. Moreover, the totality and intensity of the threat dramatically evoke what Mann has called the "basic universal conflict situations."[4(p25)] This proposed model for intervention is founded on two assumptions inherent in these observation: (1) Recurrent cancer precipitates psychological crisis and (2) the emotional ordeal of each person with cancer represents a microcosm of the human condition; it is a concentrated exercise in coping with unwanted change, complicated yet paradoxically clarified by the unavoidability of the task.

The emotional ordeal of each person with cancer represent a microcosm of the human condition.

THE INQUIRY PROCESS IN A CLINICAL SCIENCE

Bronowski contends that "all science is the search for hidden likenesses"[5(p13)] and that "the progress of science is the discovery at each step of a new order which gives unity to what long seemed unlike."[5(p15)] Theory generated by systematic study is evaluated according to its usefulness in explaining relationships among the variables within its scope, its accuracy in predicting subsequent occurrences, and its capacity for stimulating research. The ultimate purpose of theory for a clinical science is to guide practice.

Clinical theory is appropriately developed using both inductive inference and deductive logic. Data are gathered from clinical situations, and inferences or hypotheses are formulated about their probable meaning. Relevant theories are examined to enrich the interpretation. From concepts and principles of these theoretical sources, clinical hypotheses are deduced and stated as expected outcomes of treatment. In psychotherapy, the clinical session is the laboratory condition under which the goodness of fit between the theoretical concepts and the empirical evidence is continually evaluated. In this way additional data are amassed and the scientific process of inquiry is perpetuated.

This is the methodology that has guided the development of this model of brief therapy for persons with recurrent cancer. Qualitative analysis of data gathered during ten years of professional participation in the psychosocial aspects of oncology revealed common themes in the verbal and symbolic communications of these patients. Validation of these observations was readily available in professional, popular, and classical literature through a variety of descriptive accounts of persons who struggle with this disease.

A general construct termed *fear of disintegration* was postulated as a holistic explanation of these resonating themes. Specific threats contributing to this phenomenon were identified and categorized according to the major source of the anxiety. The first classification, fears relating to the management of the disease process, include fears of intractable pain, physical deterioration, loss of control of bodily functions, side effects of chemotherapy, physical helplessness, depletion of financial resources, and inaccessibility of needed treatments. The fears classified as concerns about relatedness to significant others are increasing dependency, alienation through anger or apparent ingratitude, uselessness, loss of respect, increasing isolation, social stigma, and emotional abandonment. The final category is composed of fears related to the dissolution of the self such as loss of intellectual function, panic or complete loss of emotional control, loss of courage or giving up too soon, inability to find purpose in the suffering, inability to assign value to the past, and bitterness and despair. These approximate classifications correspond to the hierarchy of human needs proposed by Maslow.[6] Expressed as fears, they represent anticipated deprivation of essential physiological, safety, self-esteem, belongingness, and spiritual needs. With the authenticity of these issues established through direct clinical observation and substantiated in the literature, the next phase, that of deriving a theoretical framework from relevant sources, assumes priority.

THEORETICAL FRAMEWORK

The theoretical framework of this practice model represents a synthesis of knowledge from sources judged to be logically consistent with each other as well as with the assumptions and inferences generated by the clinical data. Time-limited psychotherapy as explicated by Mann[4] is poignantly appropriate for persons with metastatic or recurrent cancer who are becoming acutely aware of the value of time.[7] The universal conflict situations described by Mann as arising out of the crisis of separation/individuation are conceptually analagous to the fears of cancer-afflicted persons. According to Mann, conflicts of dependency, passivity, diminished self-esteem, and unresolved or delayed grief "express all the ways that humans experience loss."[4(p27)] Persons with recurrent cancer are threatened with loss on every level, from loss of possessions and familiar surroundings, to estrangement of others, to loss of their own life. The adaptive efforts to deal with these actual and anticipated losses will be reminiscent of lifelong management of separation anxiety. Conversely, by examining the coping history of the patient, the strengths and inadequacies that will operate in this current challenge can be estimated.

Most of the procedures of the therapy contract as described by Mann are appropriate for this population, such as structuring the number and length of visits, choosing a central focus, and ruling out frankly psychotic or other persons who would be "unable to engage in the work of psychotherapy."[4(p17)] One adaptation suitable for persons with cancer is allowing for flexibility in the exact number of sessions. Most persons are asked to participate in a minimum of ten sessions; after that a mutual decision will be made about continuing to the maximum of twenty. In addition, clients are encouraged to seek assistance from persons or groups within the institution in which they are receiving their medical treatment so that they may have continued support when therapy ends.

Potential for independence

Winnicott's insights into the nature of the human "journey from dependence to independence"[8(p83)] enriches the understanding of this developmental phenomenon and contributes to the interpretation of the plight of the person experiencing the crisis of recurrent cancer. The hallmark of crisis is that it is a turning point; the individual must move in the direction of growth or turn toward regression.

In Winnicott's view, healthy growth is characterized by progression from absolute dependence, to relative dependence, to independence.[8] Regression is recognized by the emergence of behaviors associated with a more primitive position on this dependency continuum. The realistic need to rely on the treatments and on the professionals who administer them and the heightened need for sustaining relationships combined with fear of abandonment intensify the sense of fragility precipitated by the advancement or recurrence of cancer. In an effort to appease their own anxiety, many of these patients willingly submit to the wishes and directions of others, relinquishing control in a desperate—and temporary—bargain for safety. Instead of behaving as active participants who discriminate between the needs they can meet for themselves (such as involve-

ment in decision making about treatment) and which needs must be determined by others (the administration of the agreed-on treatments), they choose passive spectatorship, hastening a state of absolute dependency. At this level, the environment is invested with unquestionable power to supply or withhold what is needed. Anxiety is not diminished by passivity; instead, it becomes global.

According to Winnicott, "a facilitating environment makes possible the steady progress of the maturational processes,"[8(p85)] helping one to realize potential for independence. The therapy sessions in this model are structured to simulate a facilitating environment, a safe, dependable, predictable situation that allows for creative fit between the emotional maturity of the client and the active participation of the therapist.

Four standards of health

The clinical hypothesis deduced from the adaptation of the theoretical perspectives of both Mann and Winnicott, stated as the expected outcome of time-limited psychotherapy, is that the client will demonstrate progress toward health. Therefore, the guidelines by which health is assessed must be articulated. Through a philosophical investigation into definitions and values of health from ancient Greece to modern thought, Smith concluded that health can be conceived as both an ideal state and as a relative condition.[9,10] As an ideal state, health means optimum well-being. In a relative sense, health is a comparison between a specific individual and some standard. Four standards or models of health were elucidated by Smith.[9,10]

The most narrow bounds of health are set by the clinical model, which requires complete absence of the signs and symptoms of disease or malfunction. Clearly, this standard is inadequate as the only measure of health in persons with recurrent cancer or, for that matter, for anyone with a chronic disease, since it does not address other dimensions of human potential.

The second standard, the role performance model, offers a somewhat broader interpretation because it considers work-related behaviors as an index of health. When this explanation is expanded to include adequacy of performance in expressive roles with significant others, it provides a sound basis for evaluating the relative health of persons with cancer.

The adaptive standard appraises health as a correlate of the self-corrective or coping responses used to accommodate changes in the physical and social environment. The demonstration of novel problem-solving approaches to salient treatment or relationship issues is considered evidence of progress toward health at the adaptive level.

The final standard, the eudaemonistic model, encompasses ideals "found in aspects of ancient Greek medicine and in the moral philosophies of Plato and Aristotle. A significant modern representative of this conception of health is Maslow."[9(p45)] Motion toward the self-fulfillment and personal integrity intrinsic to this standard is judged by an increase of empathic activity on behalf of others, by the client's self-reported value shift from material to emotional and spiritual gains, and by interest in establishing coherence between personal life experience and religious or philosophical explanations of human existence.

The eudaemonistic model is postulated

to subsume the characteristics of the other three. However, it is reasonable to consider each standard separately as a relative measure of health. To determine the central focus for time-limited therapy, prospective clients are evaluated according to the adequacy of function on all four levels. Clear communication to the patient that change in the physiology of the disease process itself is not the purpose of the proposed psychotherapy, a current situation involving dependency, passivity, self-esteem or grief, is selected as the initial focus of therapy.

A clinical illustration

Marie was thirty-nine years old at the time of referral. At age 36, her uterus and one ovary were removed following her chief complaint of heavy menstrual bleeding. Two years later, because of abdominal pain and swelling, she again had surgery, and the remaining ovary, which had developed a large malignancy, was removed. A schedule of outpatient chemotherapy was begun.

Three months after her second surgical procedure Marie's 17-year-old daughter, the middle child of three, had her left optic nerve removed due to severe inflammation that had not responded to a month of medical treatment. She appeared to adapt to the loss of sight in her left eye, and she entered college as planned.

After 6 months of chemotherapy (within 3 months after her daughter's surgery), Marie became ill with what she described as "flu-like" symptoms. New surgery revealed pelvic invasion of the tumor adhering to the bowel and bladder. Radiotherapy, followed by intravenous infusions of Cis-platinum with Adriomycin, began.

Shortly thereafter, her daughter left college due to severe headaches, right-sided weakness, and slurred hesitant speech. After treatment at a community hospital failed to reverse the continuing debilitation, she was transferred to Massachusetts General Hospital, where a diagnosis of Kohlmeier-Degos disease was made. Within 1 year after the initial symptoms, the 18-year-old girl was dead.[11]

Three weeks after her daughter's death, while an inpatient receiving her monthly chemotherapy, the nursing staff and her oncologist assisted Marie in contacting me. The initial encounter took place in her hospital room. Although she could barely breathe between tears and the vomiting from chemotherapy, she was able to verbalize her desperation and her feelings that she could not go on. Her husband was interested and supportive but exhausted. Her other two children, a son, 20, and another daughter, 17, were also showing great strain and were becoming distant from issues of illness and death.

Despite the difficulty in interviewing due to the severity of her distress, Marie demonstrated the characteristics set forth by Sifneos[12] and supported by the research of Strupp[13] that indicate suitability for short-term therapy such as motivation, a history of good interpersonal relationships, satisfactory work or academic performance, and presence of a central issue. The central issue, restated at the first session, was grief work related to her daughter's death as a preliminary to coping with the new way of life that the recurrence of her cancer had imposed. It was agreed that her progress would be jointly evaluated at our 10th session, at which time we would decide whether to continue to the maximum of 20 sessions. The sessions were held for one hour a week in the therapist's office. The data from these encounters, too intricate to be summarized here, are preserved on the audiotapes that were part of the therapy contract. At the 10th session, the patient described an image of herself as halfway up

a mountain. Behind her, the mountain was covered with brambles and sharp rocks. Ahead, the climb was steep, but the path to the top was visible.

By the 20th, or final, session the patient had resumed homemaking and leisure activities that she had put aside when the cancer recurred one year earlier. Her relationship with her husband and children was vastly improved, and family activities were less strained. She arranged for continued support through the social service department at the hospital where she received chemotherapy. Four videotaped follow-up interviews conducted between 2 and 6 months after termination of brief psychotherapy indicate that in addition to strengthening personal relationships, Marie continued to move in the direction of health on both the adaptive and eudaemonistic levels. Her self-evaluation of her progress was consistent with this assessment. Eight months after the termination of psychotherapy, she returned to her secretarial position on a part-time basis.

RESEARCH IMPLICATIONS

The research implications are clear. The theoretical validity of the concepts that underlie this practice model are sound enough for quantitative as well as qualitative study to proceed. A study to examine universal conflict patterning in persons with recurrent cancer is now underway. Meanwhile, persons with cancer must try to maintain courage without the support of established clinical protocols that are both theoretically sound and cost effective. Adapting the principles of time-limited psychotherapy within a framework of holistic health is a cost-effective practice model derived from a sound theoretical base that mobilizes persons with recurrent cancer to move in the direction of greater independence and health. Developing a facilitating environment in the clinical setting where the patient receives primary medical treatment and nursing therapy is the next step in ensuring that the gains made in therapy are reinforced.

Some final words about the therapist are warranted. Being the "transitional object"[7(p166)] for persons who are ahead of us in passage from the familiar to the unknown is not without conflict. But the transitional figure is so significant that Greek mythology has a prototype. Hermes, the herald of the gods, accompanied the souls of the newly dead to the edge of the river Styx. No soul had to travel alone. But, unlike the immortal Hermes, the therapist on this journey must ask the same existential questions as the patient. When willing to explore the uncertainty of death, the therapist and patient become open to the experience of the other, learning that what is most personal is universal.

Hermes, the herald of the gods, accompanied the souls of the newly dead to the edge of the river Styx. No soul had to travel alone.

REFERENCES

1. Weisman AD: *Coping with Cancer.* New York, McGraw-Hill, 1979.

2. Caplan G: Mastery of stress: Psychosocial aspects. *Am J Psychiatry* 1981;138:413-420.

3. Sontag S: *Illness as Metaphor*. New York, Farrar, Straus & Giroux, 1978.
4. Mann J: *Time-Limited Psychotherapy*. Cambridge, Mass, Harvard University Press, 1973.
5. Bronowski J: *Science and Human Values*. New York, Harper & Row, 1965.
6. Maslow A: *Toward a Psychology of Being*. Princeton, NJ, Van Nostrand, 1962.
7. Rawnsley M: *The Perception of the Speed of Time and the Process of Dying*, doctoral dissertation. Boston University, 1977.
8. Winnicott DW: *The Maturational Processes and the Facilitating Environment*. New York, International Universities Press Inc, 1965.
9. Smith JA: The idea of health: A philosophical inquiry. *Adv Nurs Sci* 1981;3(3):43-50.
10. Smith JA: *The Idea of Health*, doctoral dissertation. New York University, 1979.
11. Scully R, Galdabini J, McNeely B (eds): Case 44-1980 of the case records of the Massachusetts General Hospital. *N Engl J Med* 1980;303:1103-1111.
12. Sifneos PE: *Short-Term Psychotherapy and Emotional Crisis*. Cambridge, Mass, Harvard University Press, 1972.
13. Strupp HH: Success and failure in time-limited psychotherapy. *Arch Gen Psychiatry* 1980;37:595-603, 708-716, 831-841, 947-954.