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When and Why Should Mental Health Professionals Offer Traditional Psychodynamic Therapy to Cancer Patients?

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Abstract

Given the recent studies promoting time-limited manualized therapies in the oncology setting, clinicians may be reluctant to offer traditional psychodynamic therapy to cancer patients. However, there are no studies directly comparing psychodynamic therapy and other therapy modalities in this patient population and no data suggesting harm from psychodynamic approaches. Therefore, it is inappropriate to draw the conclusion that psychodynamic therapy is inferior to manualized therapy from existing evidence. Manualized treatment, such as cognitive behavioral therapy, is generally short term and therefore may reduce the practitioner's own anxiety stemming from exposure to patients facing grave disability and death. However, manualized treatment is not fully effective in specific clinical scenarios. We present a case reflecting these limitations and advocate for a flexible treatment approach incorporating elements of psychodynamic therapy.

Introduction

The field of psycho-oncology has moved away from psychodynamic psychotherapy toward discrete methods of measuring psychological distress and monitoring treatment response using self-report symptom assessment scales, as recommended by clinical practice guidelines [1]. Psychodynamic psychotherapy is understood to be based upon the principles of psychoanalysis and encourages patients to speak openly and freely without any agendas or "goals" on the part of the therapist. Treatment frequency ranges from one to three times per week and lasts for a few weeks to a few years. The method involves analyzing and interpreting conflicts and other psychic forces outside of the patient's awareness. It is the resolution of these conflicts that leads to symptom improvement [2]. By contrast, manualized therapies, such as cognitive behavioral therapy (CBT), involve the use of standardized treatment guidebooks that prescribe specific techniques to be applied and goals to be attained in a designated number of therapy sessions, measuring responses with validated symptom rating scales. CBT is a time-limited intervention (with weekly sessions lasting 45-60 minutes for approximately 8-12 weeks) that emphasizes the patient's ability to change his or her emotions by modulating thoughts and behaviors [3].

To our knowledge, there are no studies directly comparing CBT or other manualized therapies to psychodynamic therapy in cancer patients. In this paper, we first discuss the general debate about the comparative efficacy of manualized treatments, such as CBT and psychodynamic psychotherapies, and then discuss the potential applicability of these therapies to oncology patients specifically. We will then present clinical scenarios that reveal the potential limitations of manualized treatment and propose a more flexible approach incorporating psychodynamic elements.

CBT versus Psychodynamic Psychotherapy: A Brief Review

Shedler notes that the push for "evidence-based" therapy, which started in the 1990s, has in the realm of psychotherapy "been appropriated to promote a particular ideology and agenda" [4]. Indeed, evidence-based therapy has become synonymous for manualized treatments, specifically CBT; this is possibly because the endpoints proposed for CBT studies (whether emotions such as anxiety or depression, or behaviors such as smoking or binge eating) are quantifiable and therefore easier to study than postulated psychodynamic therapy endpoints such as life satisfaction and quality of relationships. However, psychodynamic psychotherapy is also well established as an efficacious treatment for "harder" endpoints such as anxiety and depression, and its effects not only endure but also increase over time, in contrast to non-psychodynamic therapies whose benefits tend to decay after treatment completion [5]. Moreover, a recent meta-analysis of CBT for unipolar depression found that the efficacy of CBT has declined in a linear fashion between 1977, when it was introduced, and 2014, as measured by patient self-reports, clinician ratings, and rates of remission [6].

Psychodynamic Therapy in the Medically Ill

Because people are living longer after a cancer diagnosis than they were in the early 1970s [7], they may be more suitable candidates for, and gain lasting benefits from, a more intensive and longer-term treatment such as psychodynamic psychotherapy, even though psychodynamic therapy was regarded as beneficial then. In 1972, Wahl [8] noted that medically ill patients were in a unique position to benefit from brief psychotherapeutic interventions due to fears of death, abandonment, and physical incapacity, as well as being placed in a foreign and depersonalized setting (the hospital). Wahl noted that "this state of affairs, distressing as it so often is to the patient, can, however, be highly conducive to effective psychotherapeutic work" [9] and hypothesized that the regression—a return to a previous state of emotional development—caused by medical illness paralleled the regression that occurred in medically healthy people after long periods of time in psychotherapy. He noted of positive transference—the unconscious "transfer" of positive/loving feelings from the patient's past onto someone in the present—that "in no other category of patients is the positive transference developed so quickly and to such a degree of intensity," and added, "It is this strongly positive and trusting transference that is the sine qua non of brief, rapid psychotherapy"

[10]. We can attest to the aptness of Wahl's observation on the basis of our clinical experience. However, this result is not universal; regression may result in either positive or negative transference depending on the nature of a patient's early childhood experiences.

More recently, Postone [11] specifically addressed psychotherapeutic treatment of cancer patients, noting that "psychotherapy is particularly useful for patients whose illness has triggered an intensification of intrapsychic conflict" and that "the unconscious meaning that patients attribute to their illness and treatment becomes an important part of their illness, and frequently intensifies their suffering." An oft-encountered clinical scenario is that of survivors of childhood sexual abuse, who can experience re-activation of previously forgotten emotions in the setting of exposure to new caregivers (e.g., cancer treatment clinicians) because the perpetrators of childhood sexual abuse are often early caregivers (e.g., family members, babysitters, coaches). In our clinical experience, additional themes that arise in the psychotherapy of cancer patients include basic threats to narcissistic integrity, loss of control, dependency, fear of abandonment, loss of identity, treatment-related issues (e.g., loss of privacy during hospitalization, needle phobias), specific meaning of illness (e.g., patient's guilt about life decisions or behaviors that may have led to illness), and death anxiety.

Insight-oriented psychodynamic psychotherapy may alleviate cancer patients' reactions of mourning, rage, and aggression. For example, a patient whose father abandoned her early in life may experience anxiety after completing cancer treatment as she begins to receive less attention from her clinicians. In psychodynamic therapy, the practitioner would explore the emotional state underlying the anxiety, which might actually be a mixture of anger or sadness augmented by her childhood emotions toward her father (i.e., transference). Recognizing these core emotions while expressing, containing, and working through them in a safe professional relationship often greatly reduces the overlying anxiety. These methods do not preclude the concurrent use of problem-solving strategies to manage crises; experienced therapists have advocated for clinicians' flexibility in their work with cancer patients [12].

An additional clinical scenario seen in the cancer setting is that of requests for physician-assisted suicide. As noted by Nash, Kent, and Muskin [13], "consideration of the psychodynamic motivation for the request to die can reveal a perspective that can lead to a deeper understanding of the patient's experience and preconscious intentions" [14]. Requests to die can be expressions of patients' wishes to control their own death, maintain control over their lives, or a call for help to the clinician to find a reason to live [15]. Alternately, they may be the final enactment of a masochistic character organization or an attempt at revenge towards their family or their doctors [15]. Requests for hastened death are not well-suited to intervention via CBT or other manualized therapies except perhaps in the relatively rare instances in which a clinical

depression is the sole driver of the request. This is because patients often are not experiencing the distorted thought patterns that CBT may be best suited to address. For example, a medically healthy person with panic disorder may report feeling so anxious that he thinks he is going to die. In this case, CBT would be very beneficial to address catastrophization regarding the meaning of physical symptoms. By contrast, a patient with terminal lung cancer who is experiencing worsening dyspnea, resulting in severe anxiety, and requesting hastened death has a very realistic interpretation of the meaning of her symptoms and would not be likely to benefit from CBT.

Manualized Therapy versus Psychodynamic Therapy: A Case Study

Meaning-centered psychotherapy, a brief (seven-session) intervention offered to critically ill patients that aims to increase a sense of meaning and decrease emotional distress [16], has been shown to benefit cancer patients [16, 17]. We know of no comparable randomized studies of psychodynamic psychotherapy in the cancer setting. Hence, the claim can be made that this form of manualized therapy is a reasonably efficacious and better studied approach to treating cancer-related distress than psychodynamic psychotherapy and thus a more "ethical" strategy. To counter that postulate, we pose the following clinical scenario.

Case. Ms. A is a 38-year-old mother of two who is being treated for advanced breast cancer. She experienced treatment-related menopause and had attempted mastectomy with reconstruction but could not tolerate the constant pain from tissue expanders. She presented for mental health treatment with reports of anxiety about leaving her children and intense despair at the abrupt loss of her femininity and disruption in the intimate relationship with her partner. She also reported a history of childhood sexual assault by a family member, with a recent emergence of extremely disturbing incestuous nightmares during her cancer treatment.

Ms. A confided in her mental health clinician that she had begun to have sexual fantasies about her male oncologist and experienced their interactions as overly erotic, triggering intrusive memories of her past sexual trauma. Ms. A's clinician attempted to manage her distress with a manualized CBT approach. Ms. A's distress continued unabated, and she began to engage in splitting behaviors (which are seen in certain personality types, resulting in the patient's conflicts being enacted among others). Specifically, she praised certain members of her care team and spoke pejoratively about her oncologist, presenting variable information about her symptoms and their severity. Attempts to contain the patient's anxiety with guided imagery, problem solving, deep breathing, and challenging cognitive distortions were ineffective, because she experienced these attempts as failing to address the underlying causes of her emotional distress (which was deeply rooted in her sense of loss and her personal history of trauma). She ultimately accused her oncologist of being inappropriate during a routine exam. Ms. A's mental health clinician began to feel increasingly anxious with each visit and confided in

a colleague that she "dreaded" her scheduled visits with Ms. A. The therapist found some solace in the routine of the manualized therapy, as she was "doing something" to help the patient, and this intervention was an "evidence-based" approach. However, Ms. A became more emotionally unstable and eventually noncompliant with her oncology treatment, and she was lost to follow-up.

Commentary. The purpose of the above vignette is not to suggest that a psychodynamic approach would have necessarily led to a more favorable outcome. However, Mrs. A's history of childhood sexual abuse illustrates the significant shortcomings of an overly manualized approach for a patient with significant trauma history. A psychodynamic approach would have prioritized the shared understanding of the patient's history and the possibility that a pathological enactment (i.e., a maladaptive relational interaction based upon unresolved unconscious conflicts) could take place. A dynamic therapist would have encouraged the patient to speak about her dreams and fantasies so as to modulate the associated distress, whereas CBT would have focused more on eliminating the symptom of anxiety that was aroused by these memories, perhaps inadvertently stripping them of their meaning. While Ms. A might have experienced ongoing distress regardless of the specific intervention, a dynamic approach might have assigned the most meaning to her experience, thereby strengthening therapeutic rapport and potentially improving treatment compliance.

Other Considerations

Countertransference. While a detailed discussion of countertransference, which can be understood as the clinician's emotional reaction towards the patient, is beyond the scope of this paper, it is worthwhile to call attention to the anxiolytic effect that a manualized, time-limited treatment can have on the *clinician*. As Mendelson and Meyer have explained [18], the countertransference reaction of the clinician working with chronically or severely ill patients has the potential to lead to "pessimism, hopelessness, and despair," and exposure to patients facing imminent death can trigger significant anxiety in the clinician. Clinician anxiety often leads to avoidance, which can increase the allure of short-term therapy that offers a clearly defined end of treatment. The prospect of a time-limited approach further benefits the clinician for if, at the conclusion of the intervention, the patient continued to be significantly distressed, the clinician would—perhaps unconsciously so—regard it as the patient's "fault" for not "getting better" despite following the recommended techniques and surely not blame herself or the intervention. By contrast, a dynamic approach stipulates that the treatment may continue for a more flexibly determined period of time so that the patient can receive the most person-centered intervention for psychological distress.

Flexible approach. When evaluating if a psychodynamic approach to the mental health treatment of a cancer patient is ethical, it is imperative to determine the goals of treatment. For a patient with limited ability to tolerate affect and a pre-existing personality disorder, a manualized approach to helping the patient manage affect and tolerate anxiety so that he or she can receive necessary medical treatment is a more beneficent approach than reliance on interpretation of the patient's behavior to promote insight. For a patient with a lifelong history of depressive neurosis who seeks to gain insight and derive meaning from this experience in the waning period of life, it may be unethical to offer manualized, time-limited therapy when it would be unlikely to have lasting benefit.

Conclusion

Each patient presents with his or her own life experiences and unresolved conflicts, which in the setting of cancer diagnosis and treatment are often amplified in intensity; for many, the treatment setting is uniquely suited for psychotherapeutic intervention and rapid development of a strong therapeutic alliance (through the transference). Rather than overly standardizing their therapeutic armamentarium, psycho-oncology clinicians should carefully consider which treatments might be best suited for which patient at a given point in the medical trajectory. We are ultimately in agreement with Nash, Kent, and Muskin, who note that "the use and understanding of psychodynamics and psychodynamic theory allows [clinicians] the opportunity to interpret the life narratives of medically ill patients in a meaningful way that contributes importantly to treatment" [19].

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