
UNIT 4 PSYCHOTHERAPY IN TERMINAL ILLNESSES (AIDS, CANCER)

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4.0 INTRODUCTION

In this unit we are dealing with psychotherapy in terminal illnesses such as cancer and AIDS. We start the unit with an introduction to terminal illnesses and how psychotherapy could be used in a dying person etc. We then discuss the goals of psychotherapy with dying person. Then we take up the different therapeutic approaches and discuss them in terms of their important features and how the same could be used in the cases of dying persons. We discuss under this category the psychodynamic, humanistic, behavioural and family therapy. Then we dealt with the major therapy issues related to dying person. We discuss the psychology of the dying person and follow it up with the four stages of dying put forward by Weisman. Then we take up depression, anxiety and anger and discuss these emotional reactions as part of dying and how to handle the same in therapy. This is followed by psychotherapy for specific illnesses such as cancer and AIDS. Here we present the problem focused psychotherapies, supportive expressive therapies, integrative approaches to psychotherapy and interpersonal psychotherapy etc.

4.1 OBJECTIVES

After completing this unit, you will be able to:

- Define and describe terminal illness and psychotherapy in that context;
- Describe the goals of therapy with dying persons;
- Discuss the differences between typical therapy and therapy with dying persons;
- Explain the major therapy issues and the stages of dying and therapy at different stages;
- Elucidate the various psychotherapies for specific illnesses such as cancer AIDs etc.;
- Discuss the psychology and emotional reactions of the dying persons; and
- Analyse the issues and therapy for persons with cancer and AIDS.

4.2 TERMINAL ILLNESS AND PSYCHOTHERAPY

Terminal illness is used to describe patients with advanced disease and a drastically reduced lifespan, with perhaps months or weeks to live. Inevitably the range and severity of physical symptoms will have increased, and will be having a profound effect on how the patient lives his life. General symptoms such as fatigue, pain and sleeplessness will all be taking their toll, and even patients who have coped well find the final insidious decline taxing their psychological reserve.

How well a patient copes is dependent on a number of variables, age of patient, level of education, religion, previous experience of illness, social support, personality and medical factors such as pain to name but a few. An optimal adjustment also depends on how bad news is delivered, and how the various reactions to this are managed.

In many cases, but not all, the patient will only have reached the terminal phase of the illness after a period of declining health and failed treatment. Both the patient and his family may well be aware of the possibility that the prognosis is grave, but this is different to being told that death is certain in so many months. There are also cases where the patient may present with metastatic disease, and the diagnosis and prognosis may come as an enormous shock to patient and family alike.

Psychotherapy with dying patients shares many features with all other psychotherapy. However, the unique status of the dying person presents special problems for the mental health professional. Clearly, everyone will die, and in this sense all therapy is done with patients of a limited life span. The labeling of a person as a “dying patient”, identifies that person as belonging to a special category of humanity, and creates profound changes in the emotional, social, and spiritual climate of therapy. The dying person is one who is seen to be in a life-threatening condition with relatively little remaining time with little or no hope of recovery. This unique existential position of the dying person necessitates some adaptations of the typical psychotherapeutic attitudes and strategies. The goals, structure, and process of therapy must change to meet the special needs and circumstances of the dying patient.

There are several features which distinguish therapy with a dying person from “typical therapy”. They are:

First, therapy is more time-limited and time-focused.

The dimension of time takes on special urgency with the dying patient.

While many therapies are time-limited, often they proceed as if time were an inexhaustible resource.

The brief remaining time for the dying patient intensifies the therapy process, and accelerates it.

Second, the goals of therapy with dying patients are often more modest.

Recognising the limits of possible change is an essential feature of therapy with the dying.

What can be accomplished is quite restricted by time, disability, and other aspects of the patient’s condition.

Third, the treatment of the dying patient often requires careful coordination with a variety of medical, nursing, and religious professionals.

The physical condition, medical treatments, and institutional settings of the patient complicate the practical and psychological context of therapy.

4.3 GOALS OF THERAPY WITH DYING PERSONS

The major goals of therapy with the dying patient can be summarized in a few simple statements.

- To allow open communication with patients regarding their conditions, and to provide honest, factual information about those conditions.
- To facilitate the expression of important emotions and to help patients learn to manage these emotions as well possible under the circumstances.
- To provide a relationship in which patients can experience support in the confrontation with death.
- To intervene between patients and other significant people such as family, friends, and medical staff.

Self Assessment Questions

1) Explain psychotherapy with dying persons.

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2) Differentiate between typical therapy and therapy with dying persons.
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3) What are the goals of therapy with dying persons?
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4.4 THERAPEUTIC APPROACHES

Prior to Elisabeth Kubler-Ross’ seminal work, “On Death and Dying”, very little systematic attention had been given to psychotherapy with dying patients. One important exception to this neglect was the humanistic approach described by Bowers, Jackson, Knight, and LeShan in their book, “Counseling the Dying”. The prime impetus, though, was certainly Kubler-Ross, who provided an integrated theoretical and therapeutic perspective for use with the dying patient.

Following her lead, hundreds of books and articles have appeared in the last decade. Reflecting the increased maturity of the field, there are presently many therapists and researchers focusing on this population, and in addition several scholarly journals which devote some attention to the care of the dying person. Psychotherapy is beginning to be incorporated into the more general and growing field of clinical thanatology, which is concerned with the overall care and treatment of the dying person - mind, body, and spirit.

Modern psychotherapies are divided into four main groups – psychodynamic, humanistic, behavioural, and family therapy.

The main features of these therapies as used with all patients are preserved in the treatment of the dying, but each has been modified somewhat to fit the unique needs of dying persons.

4.4.1 The Psychodynamic Approach

The psychodynamic approaches are primarily concerned with the emotional conflicts and defense mechanisms of the individual. Special issues of conflict and defense arise in the dying person, and this approach addresses them in the hope of resolving the psychic crisis to the fullest extent possible. Dying is the ultimate crisis of ego development, and as such is associated with intense intrapsychic turmoil. Psychoanalyst Erik Erickson labels the last stage of ego development, “ego integrity versus despair”, and identifies it with the crisis

provoked by the confrontation with one's mortality. The fear of death may precipitate a breakdown of previously integrated ego functioning, and result in an attitude of despair and disgust.

In most people the threat of death generates powerful defensive reactions, and although these defenses provide some limited relief of emotional distress, in the end they prohibit the person from effectively coping with the death crisis. Common defenses which are found in the dying person include denial, displacement, projection, and regression. As Kubler-Ross pointed out, denial is a very typical reaction of the dying person. The refusal to accept the reality of death makes it impossible for people to prepare themselves and their families adequately for it.

Through the displacement defense the fear of dying is channeled into other, "substitute" fears. For example, one may become preoccupied with anxiety about family members, personal business, household jobs, or other matters, and, thus, obtain partial release of one's death anxiety. The dying person's projection defense typically expresses itself in hostility and resentment toward others, e.g., doctors, nurses, and family. The person may irrationally blame others for the illness, or accuse them of not doing enough to cure or help. Regression in the dying person is often manifested in increasingly immature, dependent, and occasionally self-threatening behaviours and attitudes. An example is the extremely helpless, "infantilised" position of the person who has completely given up and merely waits for death.

A major goal of dynamic therapy with the dying is to help the person recognise, confront, and replace the defenses which run counter to an emotionally healthy attitude toward death. In the process it may be necessary to try to work through some long-standing problems and fixations which are intensified by the death crisis. For instance, a patient with a history of anxiety over separation from family members may be more distressed over the issue of loss/separation than by other death-related concerns. Dynamic therapy with dying patients is not directed as much toward the goal of insight, as it is with others. Time limits the course of therapy with the dying, and the goals are therefore more short term changes; rather than long-term personality change. The strategy of Kubler-Ross is a good model of a dynamic approach to defenses and emotional conflicts in therapy with the dying.

"On Death and Dying" provides many wonderful examples of a therapeutic approach that begins by accepting the defensive position of the patient, and then proceeds to work with the patient to overcome the self-defeating results of those defenses. Below is an example of one of Kubler-Ross' cases:

Mr. R was a successful businessman dying of Hodgkin's disease. During his stay in the hospital he behaved like a tyrant with his family and the staff. He blamed his cancer on his own "weakness" and claimed that "it was in his own hands to get up and walk out of the hospital the moment he made up his mind to eat more." His wife consulted with Dr. Ross for help in dealing with his domineering behaviour.

"We showed her - in the example of his need to blame himself for 'his weakness' - that he had to be in control of all situations and wondered if she could give him more of a feeling of being in control, at a time when he had lost control of so

much of his environment. She did that by continuing her daily visits but she telephoned him first, asking him each time for the most convenient time and duration of the visit. As soon as it was up to him to set the time and length of the visits, they became brief but pleasant encounters. Also, she stopped giving him advice as to what to eat and how often to get up, but rather rephrased it into statements like, "I bet only you can decide when to start eating this and that". He was able to eat again, but only after all staff and relatives stopped telling him what to do".

As Mr. R. began to regain a sense of control over his environment and his activities, his anger, guilt, and tyrannical behaviour decreased, and his relationship with his family improved.

Another significant concern which has been addressed by the psychodynamic approach is countertransference, the emotional reactions of the therapist. The therapist must be particularly careful to avoid letting personal fears and conflicts over death interfere with helping the patient.

The three potential negative results of countertransference are:

- 1) The therapist unwittingly supports the patient's denial of death by avoiding the issue.
- 2) The therapist regresses to a helpless position in doing therapy with the patient.
- 3) The therapist engages in an anxious avoidance of the patient and his concerns.

In order to minimize the effects of the therapist's own attitudes toward death on the therapy, the therapist should explore and confront personal death attitudes before initiating treatment.

4.4.2 The Humanistic Approach

More than other approaches the humanistic view of therapy clearly integrates a philosophy of human nature in which death plays an essential role. Existentialism is a philosophy which has had a significant effect on the humanistic approach, and in this philosophy living the "good life" demand a confrontation with the reality of death. Death awareness helps us to clarify our values and purpose in life, and motivates us to live our lives with fullness and meaning. Death is the absolute existential threat, and it forces us to acknowledge the limit of our life plans and face "nothingness".

Humanistic therapy aims to help the dying patient live as full a life as possible in the face of death. Without giving false hope or optimism, the therapist attempts to mobilise the patient's will to live, to encourage the expression and growth of the self, and to facilitate the patient's self-actualisation. LeShan, an advocate of this approach, expresses his view of humanistic therapy with the dying in the following remark:

"Help is really needed in terms of how to live, not how to die."

With the dying patient humanistic therapy is more intensely focused than with others. According to LeShan psychotherapy should "move strongly" with the dying patient. An example of his approach is given in this dialogue. (Given in the box)

Patient (P): "I'm afraid of my cancer. I want to live"

Therapist (T): "Why? Whose life do you want to live?"

P: "I detest it! I've never lived my own life. There was always so much to do at the moment. So much to ...I never got around to living my life."

T: "You never even were able to find out what it was."

P: "That's why I drink. It makes things look better. Not so dark."

T: "Maybe the better way would be to find out what is your way of life and start living."

P: "How could I do that?"

T: "That's what we are trying to do here."

Feigenberg describes the main features of his humanistic, "patient-centered" approach in the following way:

- 1) It emphasises building a strong, supportive, and empathic relationship with the client.
- 2) It allows the client to set the pace of the treatment.
- 3) It enables the client to actively and positively participate in the process of dying.

4.4.3 The Behavioural Approach

The behavioural approach to therapy relies on educating patients about more adequate coping skills to help deal better with the death crisis. Impending death is a terribly stressful situation, and it produces extreme emotional reactions like anxiety and depression, which inhibit patients from living out the remainder of their lives in a satisfactory way. The symptoms of the dying patient are partially manageable through some standard behavioural techniques. For example, relaxation training and desensitisation can help to alleviate excessive fear and tension. Other self-management skills, like biofeedback and self-hypnosis, are also useful in controlling the distressing emotions of the patient.

One example of a valuable behaviour therapy technique is "stress inoculation training". With the dying patient this strategy may be used to help cope with the physical and emotional aspects of pain. In this approach the patient is taught how to employ cognitive and behavioural skills in preparing for pain and managing pain. Some of the "self-statements" learned in this technique for pain control are shown below. (In the box)

Preparing for Pain: "What is it I have to do?" "I can develop a plan to handle it." "Just think about what I have to do."

Confronting and Managing Pain: "I can meet the challenge." "Just handle it one step at a time." "Just relax, breathe deeply."

Self-Reinforcing Statements: "Good, I did it." "I handled that pretty well." "I knew I could get through it."

A basic goal of behaviour therapy is to provide some Coping skills so that the patient can reduce discomfort and gain a measure of control over life. The loss of control over one's body, one's actions, and one's future which is experienced by the dying patient can lead to emotional distress and to feelings of helplessness and passivity. The acquisition of productive coping skills will not only enable

the patient to manage negative feelings better, but can also improve self-esteem by providing a sense of competence and self-efficacy.

The behavioural approach to therapy tends to focus on specific and concrete symptoms. It does not directly attend to the developmental and personality issues which are so important in dynamic or humanistic approaches. The goal of the therapy is primarily to relieve negative emotions and to enable the patient to cope more effectively in the remaining time.

4.4.4 Family Approach

The impending death of a family member places the entire family in a state of crisis. Death presents a threatening situation for each member of the dying person's family. The degree of disturbance in the family depends on many factors such as the role of the dying member, the stage of development of the family, and the quality of relationships among family members. A family systems approach conceives of the entire family, not just the dying person, as the recipient of therapy. This approach seeks to provide the family unit the opportunity to learn to deal with the tragedy. Some therapists will continue treatment beyond the death, offering grief counseling for the survivors.

Though family therapy may be integrated into therapies of various types, there are several issues on which family therapists are more likely to focus. Dying patients often experience a need to feel the closeness and support of their families in facing the death crisis. In families where past conflicts have interfered with relationships between the patient and others, family therapy can facilitate more open and productive communication. This can benefit all members concerned in terms of finding closure for "unfinished business". The defenses of family members can make it very difficult for the dying patient to confront death. It often happens that family members share the defensive reactions of the dying person, such as denial of the facts and displaced anger.

An advantage of the family approach to therapy is that it offers an experience that may enable everyone to accept the facts and to work together to enhance the quality of life for the dying person. Families generally experience a range of intense emotions regarding the dying patient, including anger, guilt, fear, and depression. In family therapy members are encouraged to understand and express these feelings in anticipation of the death of their loved one.

As she was in many other areas, Kubler-Ross was a pioneer in involving families in the therapeutic process with the dying. The case below, from Kubler-Ross, illustrates some common emotional dynamics in families with a terminally ill member.

"I am reminded of an old woman who had been hospitalised for several weeks and required extensive and expensive nursing care in a private hospital...

Her daughter was torn between sending her to a nursing home or keeping her in the hospital, where she apparently wanted to stay. Her son-in-law was angry at her for having used up their life savings... When I visited the old woman she looked frightened and weary. I asked her simply what she was so afraid of ... She was afraid of 'being eaten up alive by the worms'. While I was catching my breath and tried to understand the real meaning of this statement, her daughter

blurted out, ‘If that’s what’s keeping you from dying, we can burn you’ by which she naturally meant that a cremation would prevent her from having any contact with earthworms. All her suppressed anger was in this statement.”

Kubler-Ross encouraged the mother and daughter to communicate honestly for the first time about their individual concerns, and they were able to console each other and make arrangements for the mother’s cremation. The mother died the next day.

Self Assessment Questions

1) Describe psychodynamic approach with dying persons.

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2) What is humanistic approach? How is used in dying persons?

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3) Describe the behavioural approach with dying persons.

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4) How do we help persons dying with family approach?

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4.5 MAJOR THERAPY ISSUES

4.5.1 The Psychology of Dying Person

The best known theory of the dying process is that of Kubler-Ross, who proposes that many dying people progress through five stages of dying, described below:

Stage 1: Denial: Initially the reaction is “No! Not me!” Though the denial is rarely complete, most people respond with disbelief in the seriousness of their illness.

Stage 2: Anger: In this stage the dying person expresses anger, resentment, and hostility at the “injustice” of dying, and often projects these attitudes onto others.

Stage 3: Bargaining: The dying person tries to “make deals” to prolong life, e.g., making promises to God.

Stage 4: Depression: Here the individual may become overwhelmed with feelings of loss, hopelessness, shame and guilt, and may experience “preparatory grief”.

Stage 5: Acceptance: In the final stage one comes to terms with death, not necessarily happily, but with a feeling of readiness to meet it.

Some researchers have questioned the generality of Kubler-Ross’ five stages, pointing out that they do not necessarily apply to all dying people and that the therapeutic implications of the theory are not necessarily appropriate for everyone.

An alternate view of the “trajectory” of the dying person is offered by the psychiatrist, Avery Weisman. He believes that Kubler-Ross’ theory describes some common reactions to loss, rather than general stages of dying. Weisman proposes four very flexible stages:

4.5.2 Weisman’s Four Stages of Dying

- 1) **Existential Plight:** The dying person experiences an extreme emotional shock at the awareness of his/her own mortality.
- 2) **Mitigation and Accommodation:** The individual attempts to resume a “normal” life after first learning of the terminal nature of the illness.
- 3) **Decline and Deterioration:** When illness and its treatment begin to take full control over one’s life and normal living is no longer possible, this stage begins.
- 4) **Pre-Terminality and Terminality:** This final stage refers to the very end of life, when treatment is no longer helpful and the “death watch” begins.

Whether they accept stage theories or not, most researchers and practitioners recognise that there are many common features in the emotional reactions of dying people. The core emotions on which therapies focus include depression, anxiety, and anger.

4.5.3 Emotional Reactions

- 1) **Depression:** Depression is perhaps the most typical response of the dying person. Although they are not inevitable, feelings of hopelessness and powerlessness pervade the experience of most dying people. The physical impairments that result from terminal illnesses and the restrictions on hospitalised patients only add to these feelings. The mental and physical condition of the dying person fosters a sense of alienation and withdrawal.

Patients may slowly become estranged from family and friends, and they begin to disengage from “normal” living at the point where death is the prognosis. Depression is also associated with the loss of control over life events experienced by the patient. As death nears it is easier to slip into a state of passive resignation and despair. The potential of suicide is also a matter of great concern. The demoralisation, hopelessness, and physical pain of the dying patient contribute to a greater risk for suicidal action. The relatively high rates of suicide among the elderly may reflect depression in this group because of the infirmities of old age.

- 2) **Anxiety:** For most people the thought of death provokes anxiety. In facing death people typically experience a wide range of anxieties and related emotions like fear, dread, and panic. An analysis of the anxiety of the dying person identifies several central concerns. Surely, everyone confronts death in a unique way dependent on one’s individual needs, personality, culture, and social situation, but the majority of dying persons experience intense feelings of anxiety and associated emotional stress. Some of the common elements of this anxiety are described below:

The physical condition of the patient is certainly an obvious and significant source of anxiety. Pain, suffering, and the physical debilitation of the terminally ill person contribute significantly to insecurity, stress and anxiety. In addition terminally ill patients whose medical treatments are painful or aversive, e.g., chemotherapy for cancer victims, may develop conditioned anxiety reactions to the treatment setting and anticipatory anxiety regarding further treatments. Anxiety and shame can also result from the physical changes which occur in the dying person. The patient who insists “I don’t want anyone to see me like this!” may be expressing a fear of rejection by others because of unacceptable bodily alterations from the illness.

The social dimension of anxiety is also an important issue with the dying. Many worry about the effects of their illnesses on family members and friends. For people whose social roles are critical to the well-being of others, this anxiety may be as pronounced as self-concern. For instance, a single mother with two young children is quite likely to experience great fear for the future and safety of her children. Another aspect of social anxiety in the dying - involves the fear of loss and disruption of relationships. As suggested above social anxieties may be due to anticipated rejection because of physical revulsion, or to other factors, e.g., the fear of not being needed or wanted by others.

The spiritual and existential aspects of death anxiety are also part of the psychology of dying. Questions about the meaning of one’s life and the possibilities of life after death are common concerns of the dying person. It

is not unusual for people to show sudden increases in religious feelings when facing the prospect of personal annihilation. In dealing effectively with these concerns psychotherapists do well to cooperate with the priests or clergy and pastoral counselors, who are proficient in helping people through religious crises.

- 3) **Anger:** In Kubler-Ross' model anger is an essential stage of dying. The disorganisation of and threat to life felt by the dying person generates frustration, resentment, and hostility. These emotions can easily be turned against others or turned in on the self. Family members, friends, hospital staff, and therapists are likely to bear the brunt of this anger. The reactions of the recipients of anger may include withdrawal, anxiety, defensiveness, and anger in return. This will only complicate an already tension-filled situation. When the patient's anger is internalised, it leads to self-recrimination, self-blame, guilt, and lower self-esteem. As many psychologists have pointed out, anger turned on the self often fuels depression. The anger of the dying person is not always focused on others or the self, but is for many a diffuse, untargeted feeling. The pain, injustice and absurdity of dying cannot always be blamed on anyone or anything but the human condition, and that cannot be changed.

A case reported by Kubler-Ross illustrates some of the common features of a patient's anger.

Bob, a 21 year old cancer victim, was troublesome with the staff and other patients. His intense hostility prompted Kubler-Ross' consultation with him. On seeing his collection of "Get Well" cards she asked him, "Bob, doesn't that make you mad? You lie on your back in this room for six weeks staring at this wall with these pink, green, and blue get well cards?"

"He turned around abruptly, pouring out his rage, anger, envy, directly at all the people who could be outside enjoying the sunshine, going shopping, and picking a fancy get-well-soon card. And then he continued to talk about his mother who spends the night here on the couch.

Big deal! Big sacrifice! Every morning when she leaves, she makes the same statements - "I better get home now, I have to take a shower!" 'And he went on, looking at me, most full of hate, saying, 'and you too, doctor, you are no good! You, too, are going to walk out of here again.'

What counsel and advice can be offered to the dying person who experiences these intense emotions, and the many associated problems accompanying them? Often, the answer depends on the theoretical orientation of the therapist. As discussed earlier, different theories recommend different strategies for treating emotional distress. Behavioral therapies can assist the patient to take some control over these feelings through techniques like desensitisation, stress management, and relaxation training. Even a small measure of control can improve the condition of the patient. Humanistic therapists seek to help the patient confront death in as active and positive a way as possible, relying on an exploration of the individual's values, goals and self understanding. Dynamic therapy attends to the defensive reactions of the patient, and attempts to overcome self defeating defenses in order to help the patient through the dying process.

Despite considerable diversity in theory, the practical demands on counselors of the dying have led to some common concerns. As a rule therapists working with dying people take an “eclectic” approach. That is they choose from various theories those ideas which are most applicable to the individual needs of their patients.

If there is one fundamental principle of therapy with the dying person, it is to facilitate communication about the person’s needs. A primary task of therapists is to assist patients in meeting their individual needs in their remaining time. Of course, each one has different needs, depending on life history, personality, and many other factors, but there are some common needs shared by most dying people. These needs include, but are not necessarily limited to, security, affection, support, dignity, and self-expression.

<p>Self Assessment Questions</p> <p>1) What are the five stages of dying?</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>2) What are the four stages of dying according to Weisman?</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>3) Describe the three emotional reactions to dying.</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p>

4.6 SPECIFIC ILLNESSES AND PSYCHOTHERAPY

In considering the treatment context of the dying person one factor of fundamental importance is the specific disease from which the patient suffers. Specific terminal illnesses create unique medical, psychological, and social problems for patients. Though there are obviously many diseases which kill people, only a few have

received special attention by those working with the dying. Two diseases and their implications for psychotherapy will be discussed here: cancer and AIDS.

4.6.1 Cancer

Therapists have attended to cancer victims more than any other terminally ill group. Some of the features of terminal cancer which set it apart from other illnesses are its prolonged course, periods of remission, and its stigma. Because cancer may be a progressively debilitating disease, the cancer victim can anticipate a long and often painful struggle, associated with aversive medical treatments. For many cancer patients the disease involves a rollercoaster ride from remission to relapse, which is enormously stressful.

i) Cancer-Related Psychosocial Morbidity

Faulkner and Maguire (1994) have suggested that psychosocial adjustment to cancer is associated with six hurdles: (1) managing uncertainty about the future; (2) searching for meaning; (3) dealing with a loss of control; (4) having a need for openness; (5) needs for emotional support; and (6) needs for medical support. They suggest that a failure to deal with these results in psychosocial problems. Increasing medical advances have meant that people with cancer are now tending to live longer than used to the case, a factor that means that cancer is increasingly being conceptualised as a chronic illness. Patients who are told that they have cancer experience distress, but some have a normal adjustment reaction with limited distress that does not cause lasting psychological problems. Others experience psychological problems that significantly interfere with their quality of life; some of these will develop symptoms of an adjustment disorder, major depressive disorder, or an anxiety disorder.

ii) Cancer Treatment

Cancer treatment is also associated with a number of psychosocial concerns, some of which comprise quality of life and contribute to anxiety or depression. Nonphysical treatment side-effects such as anger, anxiety, or apprehension are often rated by patients as being more severe than physical side-effects such as nausea or hair loss. Indeed, some patients drop out of chemotherapy because of psychological problems.

Some treatment procedures (e.g., bone marrow transplantation) result in psychological problems because of the particular demands that accompany them. Many patients have to face treatment regimens that are difficult to tolerate, may involve behavioural demands such as frequent hospital visits and levels of motivation that may be difficult to generate or sustain.

Advances in drug therapies have resulted in a reduction in the incidence of nausea and vomiting associated with chemotherapy. However, conditioned nausea and vomiting do still occur and aversions to food can also develop. Even after the end of treatment, patients' lives may be affected throughout the follow up period, as they attend appointments to determine whether the cancer has returned.

Some psychological problems are more commonly experienced at particular times during the patient's 'cancer journey': at diagnosis, during the early months of treatment, at the end of treatment, at the discovery that the cancer has spread, or at recurrence. Some patients find that they notice persistent negative psychological

consequences only at the end of treatment. Most, however, do not experience any lasting negative psychological consequences. Others develop an increased vulnerability to future psychosocial problems as a result of the impact of an episode of cancer and cancer treatments. Some become more avoidant in their thinking about illness, having greater illness concerns and diminished capacity to work.

4.6.2 Problem-Focused Psychotherapies

Psychoeducational and cognitive-behavioural interventions are the most commonly problem-focused therapies for cancer patients. Psychoeducational interventions are typically of short duration and concentrate on didactic teaching of skills and strategies. This is in contrast to cognitive behaviourally based therapies that include instruction in specific skills and strategies but that are based on a cognitive and behavioural conceptualisation of the individual patient.

These therapies typically seek to help patients reduce their emotional distress by fostering control and regulating affective responses via the application of behavioural strategies (e.g., activity scheduling) or cognitive strategies that address distortion in thinking and/or enable people to test and develop more helpful alternatives to their dysfunctional ideas.

4.6.3 Supportive Expressive Psychotherapies

Supportive-expressive therapy has been traditionally delivered in a group and in the context of research activity that has sought to evaluate the impact of participation in such groups on survival. One of the major goals of this modality is to enable individuals to express all emotions (negative and positive). Based on the premise that most people tend to avoid the fear and anxiety associated with the possibility of death, supportive expressive therapy enables someone to express and tolerate the affect associated with thoughts of death and dying. This has been referred to as 'detoxifying death'. It has been suggested that therapy with this focus may be more appropriate for patients with advanced cancer.

4.6.4 Integrative Approaches to Psychotherapy in Cancer

Kissane et al. (1997) have integrated elements of cognitive, supportive, and existential therapies in group therapy, including elements of Spiegel's work (i.e., the development of a supportive network and addressing issues of death) with an existential focus on the management of uncertainty and awareness of one's own mortality.

Supportive expressive work shares some similarities with other modalities. The 'detoxification' of death, for example, enables patients to express their feelings about death. It can also, from a cognitive perspective, provide patients with evidence about the impact and consequences of the expression of emotion. In practice, most clinicians tailor therapy to the individual, taking account of the presenting problems, and emphasise particular educational, supportive, expressive, or existential elements.

In conclusion, therapists working with cancer patients will focus on the cycle of optimism and despair which accompanies changes in the symptoms of the disease. In addition there are stress and pain management techniques that are helpful in enabling patients to get through the more noxious periods of medical treatment,

e.g., chemotherapy. Behavioral therapy techniques such as desensitisation and relaxation training have been useful to help cancer patients learn to control the anticipatory stress and nausea related to chemotherapy.

Self Assessment Questions

1) Name the six hurdles which are associated with psychosocial adjustment to cancer?

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2) What are three potential negative results of countertransference in therapy with a dying person?

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4.6.5 Aids

The past few years have seen an enormous amount of interest in AIDS (acquired immune deficiency syndrome). Some predictions indicate that AIDS will reach epidemic proportions in the next 20 years. For now though mental health professionals have begun to examine the specific therapeutic needs of AIDS victims. As great as the stigma of cancer may be, it pales in comparison with the stigma of AIDS. Several reasons for this stigmatisation are apparent. It is primarily transmitted through intimate sexual contact and sharing of needles by intravenous drug users. The prevalence of AIDS in homosexuals, prostitutes, and drug abusers gives it an association with “deviant” sexuality and antisocial behaviour.

Aside from its association with groups who are negatively perceived, the disease is typically fatal, thus allowing little or no hope for recovery on the part of victims. For now at least, a diagnosis of AIDS is equivalent to a death sentence, and the fear generated by this disease among the public has often been turned against its victims and those in high AIDS-risk groups.

Where most other terminally ill patients are pitied, AIDS victims are often shunned, rejected, and met with open hostility, even by those family members and friends who are most needed by the patient.

Psychotherapy with people with AIDS who are at the end stage of their illness generally occurs in one of two clinical situations. The first is where the individual has been in some form of on-going counselling prior to entering the final phase of life. In the other case, a client seeks out a mental health professional as a direct result of being diagnosed as HIV positive or as a result of having deteriorated

due to wasting or an opportunistic infection. AIDS has challenged psychologists in private practice as well as those who are employed in hospitals, nursing homes, hospices, community based AIDS organisation, and other home health care agencies to become prepared for working with people who are dying and their loved ones.

As people develop symptoms of advanced AIDS they increasingly lose control over their bodies and lives. One task of counselling is to help people living with HIV and AIDS recognise what they can control. An individual's physical and mental deterioration has an impact on his/herself as well as the people he or she lives with. Family therapy can be a valuable tool to help family members adjust to the changes that the progression of a loved one's illness has on the family structure and dynamics.

Clients living with a progressive disease like HIV/AIDS require help in planning for hospitalisations and debilitating illnesses. It is best for the clinician to raise the difficult and painful issues such as hospitalisation, care of dependent children, living will, medical proxy and issues to be taken care of after their death etc., long before there is any apparent need for them. The rationale for this is that when the client is still well he or she is more likely to have the necessary physical and psychic energy to plan for the ensuing difficult realities.

Therapists need to question and often challenge clients' unwillingness to discuss concrete plans or desires for a living will or treatment options. It is helpful to stress to the clients that by addressing these issues now they can insure that they will have a measure of control over what happens to them later. Obviously this has the potential to confront a client's denial, and thus the clinician must be prepared to be the target of the client's anger in response to initiating such necessary queries.

Negative core beliefs about the 'self' such as an HIV-positive patient's conception of himself as defective and unlovable can usefully be targets of cognitive approaches to case conceptualisation and treatment. The labeling of inaccurate inferences or distortions may help the patient become aware of the unreasonableness of such automatic patterns of thought.

Cognitive probes and questioning may be used to elicit automatic thoughts. Such automatic thoughts can then be tested with the therapist who carefully attends to the possibility of exaggeration and catastrophizing. Relaxation techniques can also be useful with patients who are anxiously worried about the impact of their diagnosis on various aspects of their lives.

4.6.6 Interpersonal Psychotherapy

Interpersonal psychotherapy has been shown to have particular advantages for HIV patients (Markowitz et al., 1998). Interpersonal therapy relates mood changes to environmental events and resultant changes in social roles. For example, the interpersonal therapist defines depression as a medical illness and then assigns the patient both the diagnosis and the sick role. She then engages the patient on affectively laden current life issues, and frames the patient's difficulties within an interpersonal problem area: grief, role dispute, role transition, or interpersonal deficits. Strategies then address these problem areas, focusing in the present on what the patients want and what options exist to achieve this.

4.6.7 Exploratory Psychodynamic Treatments

These treatments including psychoanalysis may be usefully employed with the HIV positive patient grappling with these issues. In patients with AIDS, evaluation and treatment should focus on helping patients receive life-enhancing medical care, resolving troubling psychological issues and making the best use of whatever time is left.

4.7 LET US SUM UP

Psychotherapy basically offers the dying person much the same that it offers anyone – a supportive relationship in which the individual has opportunities to work on significant personal concerns. The unique life situation of the dying person places limits on the process of therapy and demands greater modesty on the part of therapists regarding possible outcomes. Regardless of theoretical orientations therapists working with dying patients rely first and foremost on communication. Therapy is best used as a forum for exchanging information, educating, expressing fears, and discussing needs.

4.8 UNIT END QUESTIONS

- 1) Discuss in detail how the major therapeutic approaches have been modified to the unique needs of dying persons?
- 2) Discuss the psychology of the dying person?
- 3) Describe the core emotional reactions of a dying person?
- 4) Write about the psychosocial morbidity related to cancer? Discuss the therapy approaches with cancer patients?
- 5) Write about the issues and therapy with persons with AIDS?

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