Cognitive Therapy for Adjustment Disorder in Cancer Patients

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Normal adjustment to cancer can be defined as an ongoing process of trying to gain mastery or control over cancer-related events. The specific challenges confronting the patient vary with the clinical course of the disease. Common nodal points are diagnosis, surgery, radiation, chemotherapy, treatment ending, remission, recurrence, palliative care, or survivorship. Successful adjustment is indicated by minimal disruption to life roles, effective regulation of emotional distress, and the capacity to remain actively involved in life. Unsuccessful adjustment is indicated by disengagement, withdrawal, and helplessness. The task of adjusting to cancer can be conceptualized as pitting the demands of the situation against the resources the individual possesses to meet them.

**Issues and Reactions to Cancer Diagnosis**

Holland et al have specified normal adjustments to a diagnosis of cancer. Initially, there is disbelief, denial, and shock. Dysphoria, including sadness and anxiety, follows. Successful coping comprises the final stage. Once treatment is proposed and then instituted, there is apprehension about procedures, along with fear of unwanted side effects (e.g., hair loss, vomiting, fatigue, pain). Disruption of daily life is an adjustment task for all.

When treatment ends, patients often feel vulnerable without active therapy. This will strike the clinician as a “catch-22.” This reaction competes with a fear of recurrence and uncertainty regarding the future. Patients may become hyper-vigilant to health concerns. These anxiety-evoking beliefs are particularly bothersome as the patient approaches a visit with his or her oncologist or a diagnostic test.

When there is a recurrence of the cancer, or if the patient’s situation offers no possibility of cure, accepting the option of palliative care ushers in a new set of necessary adjustments. Holland and colleagues have charted this period as well. Normal adjustment to a plan for palliative care may begin with sadness, crying, anger, and withdrawal, calling for a major shift in expectations. In this process, the maintenance of hope is central to a good adaptation. Spiritual beliefs, whether present premorbidly or not, may play a role.

Speaking with cancer survivors, some patients have reported benefits from having experienced the illness, including a greater appreciation for life, reprioritizing, and a strengthening of spiritual beliefs.

**Diagnosing Adjustment Disorders**

In an early study published by Derogatis et al in 1983, 47% of 215 cancer patients studied met criteria for an emotional disorder. Of these patients, 68% had an adjustment disorder (32% of the total sample). More recent surveys have confirmed that adjustment disorder is the most commonly diagnosed emotional disorder in the cancer patient. Two aspects of this diagnosis bear highlighting: (1) a persistent adjustment disorder may progress to a more serious mental disorder; and (2) adjustment disorders have no specific symptom set, so this is often a difficult diagnosis to make.

The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR) defines adjustment disorder as a reaction to an identifiable stressor (e.g., the diagnosis of cancer). It is held to be less severe than a “diagnosable emotional disorder” such as major depression or generalized anxiety disorder, and it is in excess of what is expected. Finally, adjustment disorder results in impaired social or occupational functioning.

**Treatment**

There is no specific drug treatment for an adjustment disorder. Only 2 studies have focused specifically on treating this problem in cancer patients. In 1998, Moorey et al randomly assigned 57 patients to an 8-week cognitive therapy protocol or to 8 weeks of supportive psychotherapy. The group receiving cognitive therapy
showed "a significant change in spirit, coping, anxiety, and self-defined problems" that persisted after a 4-month follow-up. A second study published in 2003 by Trask et al found cognitive therapy useful in reducing distress and increasing quality of life in a group of patients with melanoma.

In July of 2000, I was offered the opportunity to function as a psychiatric consultant making weekly rounds with an oncologist in his university hospital outpatient clinic. This experience, coupled with a career-long focus doing and studying cognitive therapy, led to the development of some ideas for aiding the adaptation of the cancer patient.

What evolved was a pilot study applying the principles of cognitive therapy to the treatment of the cancer patient with an accompanying adjustment disorder. Because of the significant distances which many cancer patients in South Carolina traveled to receive care at the Hollings Cancer Center at the Medical College of South Carolina, a remote teleconferencing capability was built into the study.

Our findings supported the value of a brief (6 session) cognitive therapy intervention for the cancer patient with an adjustment disorder. This outcome held, whether the therapy was conducted face-to-face in the clinic or utilizing teleconferencing equipment.

Cognitive Therapy

The model of cognitive therapy seemed well suited to the task of aiding adjustment to cancer. Its primary focus is on meanings in the here-and-now. It is designed to be short-term, conversational, and collaborative in nature. It encourages the cancer patient to consider a variety of ways of thinking that might aid in adaptation.

I worked with 17 cancer patients at the Hollings Cancer Center in Charleston, South Carolina, each referred by their oncologist with a suspected diagnosis of an adjustment disorder. Each patient received a diagnostic evaluation and, if the diagnosis was confirmed, the patient was invited to join the study. Each patient in the study underwent 6 sessions of cognitive therapy with me. In group 1, all sessions were face-to-face in an office in the oncology clinic. In group 2, all sessions were conducted remotely, utilizing a videophone loaned to the patient and used from his or her home.

The protocol I followed both in the study and in my outpatient practice began with teaching the patient the cognitive model. This process typically took 5 to 10 minutes, with additional time set aside for questions. I would begin by saying to the patient, "Situations and events are seen as directly linked to reactions in primitive animals. When we build a larger brain (and progress from mice to humans), one added capability is the assigning of a meaning to the event that is distressing. As an example, when you were initially told of your cancer diagnosis, what were the initial beliefs that came to mind?"

Cognitive therapy focuses first on identifying the automatic thoughts or meanings tied to the patient's distress. Next, I would ask the patient if his or her meaning "made sense." Occasionally it does not, but most often the meaning is seen as reasonable. The second criterion is "strategic worth." I may ask, "Does this meaning point you in a direction you want to go?" Especially in light of the associated distress, the answer this time is nearly uniform and is "no."

The third and final task of this cognitive therapy is to find alternative meanings that work for the patient. Contributing options can be a joint exercise (involving the therapist and patient) as long as the clinician's offerings are not seen as "advice." In a typical collaborative cognitive therapy, this

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Figure 1. THE DISTRESS CONTINUUM

Psycosocial distress exists on a continuum ranging from normal adjustment issues through the DSM-IV-TR Adjustment Disorders; to a level close to, but below, the threshold (ie, meets some diagnostic criteria but not all) of diagnosable mental disorders; to syndromes that meet the full diagnostic criteria for a mental disorder (eg, major depressive disorder).

rarely seems to happen.

Outcomes

The study plan called for an eventual total of 25 patients in each group. I left the university in November of 2003, and started a part-time outpatient psychiatric practice. The study was discontinued and, not surprisingly, I received a number of referrals of patients with cancer and adjustment problems from my oncologist colleagues.

Over my 3 years of contact with cancer patients, some issues have stood out as commonly encountered. The list begins with the statement, “I have no one to talk with about my cancer.” This aids the establishment of a useful working relationship and typically is associated with the patient working hard at the tasks of therapy. A common second question is, “Why me?” Searching for an explanation, the cancer patient may see the diagnosis as retribution for an unworthy act. Even in a patient for whom religion has not been a central concern, spiritual issues (eg, “What do I believe in?”) invariably are raised. For most cancer patients I have met, the disease is seen as robbing its victim of control over one’s life. It may help to distinguish those areas of continued control, those where control is uncertain, and those beyond the patient’s reach.

Typically, the time frame surrounding a diagnosis of cancer seems to be future oriented, even if that “future” is not very distant from the present. I have found a derivative of the Alcoholics Anonymous phrase, “One day at a time,” to be a useful orientation to suggest.

“What goes through your mind when you wake up in the morning?” I often ask. “That I am dying of cancer,” is the common response. I then inquire, “How would it change things if you were to instead ask yourself how you are feeling that day and then plan the day on that basis?”

Similarly, a frequent concern among patients is, “How much time do I have left?” We often discuss the difficulty to the oncologist of making a useful response to this question. Often, the doctor won’t know, the patient won’t know, and “only God knows.” The broader issue here is the desire to predict the future. This may take the form of a statement such as, “This is my last birthday/anniversary/Mother’s Day.” Analogies about the situations of other people may be useful in cognitive therapy to challenge one of the patient’s beliefs. More than once, I have related how one of my family members who was dying said goodbye to her oncologist as he was leaving for a long-planned vacation—and ended up saying hello when he returned. You just never know.

When clear cognitive errors are made in the conclusions drawn by the patient, I point them out. Polarization (ie, thinking categorically as in black or white; no grays), personalization (focusing only on the self), and over-generalization (drawing conclusions beyond the available data) are the most common errors in thinking. Finally, the patient will often focus on the dependency upon him or her of a spouse or child. “What will they do once I’m gone?” the patient asks. When this concern is offered, we work as a team to problem-solve some viable options for the significant other.

When a cancer patient is referred to me who turns out to have a major depression complicating their adjustment, I offer a trial of a selective serotonin reuptake inhibitor (SSRI) in addition to brief cognitive therapy. When a diagnosable anxiety disorder is presented,17 a longer cognitive therapy may be offered, which may or may not be supplemented by a trial of an anxiolytic drug (eg, SSRI, venlafaxine, buspiron, or a long-acting benzodiazepine). For the vastly more common adjustment disorder without any other complicating psychiatric diagnosis, a short-term psychotherapy typically has been adequate and greatly appreciated.

REFERENCES


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