Managing Cancer and Living Meaningfully (CALM): A Brief Psychotherapeutic Intervention for Patients with Cancer and other Illness

As Adapted by the Women’s Cancer Resource Center

Based on the work of Dr. Gary Rodin & Dr. Sarah Hales and their team Princess Margaret Cancer Centre University Health Network Toronto, Canada

Introduction to CALM Structure and Approach – as practiced at the Princess Margaret Cancer Centre

- 4-6 individual sessions
- 45-60 minutes in length each
- Delivered over 6 months
- 2 additional “booster” sessions available later
- For individuals with primary caregiver, at least one joint session to explore inter-relational dynamics and support the couple in anticipating and preparing for future. Usually the second session in the series.
The CALM Therapist is...
- Familiar with cancer, its treatment, and the disease course
- Attentive to empathic attunement, genuineness and presence in the moment
- Comfortable with the “non-expert” role and the “unsolvable” existential problems faced by patients with illness, especially advanced illness
- Reflective, aware of their own philosophy, sense of meaning and purpose, and challenges in the face of mortality

Elements of CALM Therapy:
- The supportive relationship
- Shifts in frame and flexibility
- Modulation and toleration of affect
- Encouragement of reflective functioning/mentalization
- Renegotiation of attachment security
- The joint creation of meaning interpretation
- Attention to transference and countertransference
- Facing the limits and boundaries together (attending to death-related distress)

Theories involved in CALM Therapy:
- Brief therapy
- Attachment theory (client and caregivers)
- Attachment theory and access to medical care
- Mentalization
- Existential theory
- Death-related distress
- Obstacles to exploring death anxiety
Working in a Brief Therapy

- Not waiting to capture developmental history
- Inviting discussion of dying and death in the first session
- Making every session therapeutic
- Being prepared that every session may be the last

Attachment Theory

- Humans are innately equipped with behavioral systems, selected through evolution, that lead to our protection/survival
- Attachment is the emotional bond between 2 individuals based on expectations of provision of care in times of need
- Stable differences on dimensions of attachment anxiety and avoidance

Attachment Theory

- Attachment styles are both inherent and develop with environmental interaction
  - From infancy, develop schemas based on caregivers’ responses, particularly during encounters with threat
  - These styles are life-long templates for relational interactions
  - Consistent and attuned parental caregiver is associated with greater attachment security in infants
- Attachment security is associated with greater
  - Ability to identify and regulate one’s emotions
  - Empathy
  - Reflective functioning/ability to mentalize
Attachment and Caregiving

- Caregiving requires empathy and comfort with interdependence
- Secure attachment associated with more attuned and responsive care
- Avoidant attachment associated with discomfort around interdependence, disapproval of other's vulnerability and needs (controlling caregiving)
- Anxious attachment associated with focus on own distress and needs (compulsive caregiving)


Attachment and Access to Medical Care

- Among primary care patients
  - Anxious and disorganized attachment associated with greater self-report of symptoms
  - Anxious attachment associated with highest primary care costs and utilization
- Among advanced cancer patients, anxious attachment is associated with higher rates of referral to psychosocial oncology services


Attachment and Medical Care

- Attachment styles, while often stable over time, can be influenced by situation and relationships
- Health care providers can serve as "secure base" for cognitive and affective exploration
- Research in medical settings, such as diabetes care, has demonstrated that attention to attachment style can improve medical outcomes

Examples of Adult Attachment Measure Questions

- I prefer not to show other people how I feel deep down.
- Just when other people start to get close to me I find myself pulling away.
- I don’t feel comfortable opening up to other people.
- I worry about being abandoned.
- I worry that other people won’t care about me as much as I care about them.
- I need a lot of reassurance that I am loved by people with whom I feel close.


Mentalization

- Capacity to reflect on feeling states, to distinguish them from literal facts, and to accept the possibility of multiple perspectives on events.
- Can aid in the process of affect regulation, promote positive affect and help individuals accept and cope with negative affect states.
- The therapist promotes mentalization of death by validating multiple and complex psychological responses to an incontrovertible dire prognosis.


Existential Theory

- Conflicts highlighted at the end of life.
  - Death: is it possible to live while dying?
  - Freedom: was life lived correctly?
  - Isolation: is connection to others possible when death will be faced alone?
  - Meaninglessness: what is of value in the face of death? What is the purpose of suffering?

- Goal not to eliminate these problems but to help tolerate the anxiety (“angst”) generated by facing these issues.

Death and Illness Related Distress

- Future suffering and disability
- Future loss of independence and control
- Impact on loved ones
- Loss of future and opportunities
- Timing of death


Obstacles to Exploring Death Anxiety

- The unsolve-ability of death
- The pressure of positivity
- Fear of upsetting the other
- Difficulty expressing double awareness

The Domains

- Themes to be addressed with all patients at some point
- Initial patient interview briefly explores each area and allows an individualized approach with focus on those areas most pressing or problematic
- Themes are intertwined, can move between them or collapse them as the patient and therapist see fit
The Domains of CALM

Domain 1: Symptoms & Communication with Health Care Providers

- Understanding the disease and managing symptoms
- Making treatment decisions
- Developing collaborative relationships with health care providers

Domain 2: Self and Relationships

- Understanding how illness has changed self-concept; grieve losses and recognize remaining strengths and abilities
- Understanding how the cancer experience may increase/alter needs and affect how care is provided and experienced within the family or wider circle
- Attending to the unique needs of children within the family
Exploring Domain 2: Self and Relationships

- "Tell me what you’re like in relationships”, and if more specificity is needed, “Do you tend to be pretty self-reliant or someone who needs to lean on others in times of stress?”
- “Have you found that cancer has changed the way people behave towards you?”, and if so, “How?”
- “How has your cancer affected your partner?”
- “How has your cancer affected your children?”
- “What has changed in your household since the cancer?”
- “Do you talk about your cancer at home?”, “What do you discuss?”, “What don’t you discuss?”, “Is this working?”

Domain 3: Spirituality, Meaning and Purpose

- Understanding the personal meaning of the experience of suffering, dying and death
- Encouraging meaning-making as an adaptive response to a situation beyond one’s control
- Re-evaluating priorities and goals in the face of advanced disease, facilitating an active approach to last days

Exploring Domain 3

- “How do you make sense of what is happening to you?”
- “Do you consider yourself a spiritual or religious person?”, and if so, “What does that mean to you?”
- “What has been important to you in life?”
- “Have your priorities or values changed since you became ill?”
Domain 4: Future, Hope & Mortality

- Acknowledging, validating, normalizing death anxieties and anticipatory fears
- Encouraging balance of living and dying processes
- Encouraging attention to advance care planning, life closure and death preparation as necessary

Exploring Domain 4

- “When you look to the future, what do you see ahead of you?”
- “Do you think about dying and death?”
- “What are your feelings about dying and death?” (If endorse fears) “Specifically, what is it that scares you about dying or death?”
- “What might help you prepare for what lies ahead of you?”

BEGINNING CALM THERAPY
Elements of the First Interview

- Introduction of CALM (goals, domains, number of sessions)
- Cancer story
- Current distress and associated stressors
- Brief exploration of CALM domains
- Developmental history collection
- Conveying understanding of the patient and their main problems
- Planning future sessions (including bringing caregiver if that is part of tx plan)

Tasks of the First Session

- Setting the therapeutic “frame”
- Facilitating a sense of being supported and understood

WORKING WITH COUPLES IN CALM
The Importance of Patient-Caregiver Dyad

- Greater attachment security can help the family unit cope with what lies ahead
- The illness may have caused disruptions in attachment that need repair: mutual understanding ~ greater attunement~ new care-seeking care-giving behaviors~ increase in felt support
- Goal is not to fix longstanding relational dysfunction

Goals of the Joint Session(s)

- Exploration of the relationship history and how have managed past crises
- Encouraging empathic understanding and facilitating reflective functioning (i.e. “how do you think your husband/wife is coping?”)
- Acknowledgement of the shared vs. non-shared experience
- Emphasize strengths in the couple

Tensions Faced By CALM Therapists

- Being flexible within a structure
- Doing a lot while saying little (in brief amount of time)
- Being useful despite potential feelings of uselessness, futility in face of patient experience
- Knowing disease course which patients may not want to explore or prepare for
Tensions Faced by CALM Therapists- cont’d.

- Introducing painful topics while supporting and respecting patient’s defenses
- Supporting needs of both patients and caregivers
- Facilitating change while recognizing unresolvable disappointments
- Terminating a brief therapy when more problems lie ahead for patients and families

Termination and Patient Death

- Sudden deterioration or death may prevent completion of 6 sessions of CALM therapy
- Therapists may have different reactions to endings
  - Distancing in order to protect from grief
  - Questioning of the therapy and their usefulness
  - Guilt at not being available to patient/family at end