EDITOR'S NOTE

Through this column, we hope that practitioners in general medical settings will gain a more complete knowledge of the many patients who are likely to benefit from brief psychotherapeutic interventions. A close working relationship between primary care and psychiatry can serve to enhance patient outcome.

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In for the Long Haul

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My interest in helping cancer patients adjust to their illness began in 2000, when I started a 3-year collaboration with an oncologist.[1] I saw about 1200 of his outpatients, while making clinic rounds with him 1 morning a week for 3 years.[2] This experience led to the design of a research study of the value of brief (6-session) cognitive therapy to aid in adjustment to cancer.[3]

One of my earliest study subjects asked to have our sessions continue, once monthly, "for life." We met continuously over a period of 18 months.[4] I reported earlier[5] on my treatment approach while serving as a liaison between a man with cancer and his oncologist. That patient and I met for 6 study sessions and then in my office for the following year.

It has been useful to provide for patients with cancer a brief course of cognitive therapy to aid in adjustment, to answer questions, and to provide an outlet and a forum that might otherwise not be available. Why, then, would I meet with a man who lived 2 hours northeast of Charleston, S.C., 34 times over a 2½-year period? The following case presents a rationale for a lengthy course of psychotherapy.

CASE PRESENTATION

Mr. A is a 55-year-old man married for 38 years and the father of 2 grown daughters and 1 grown son. He was "never sick for a day in his life" until lung cancer was diagnosed after a routine chest film alerted his primary care physician in 2002. He underwent surgery, and then radiation treatment. He is a nonsmoker. He recalls being told that there was a 90% chance of the cancer not returning. He has since had several recurrences of metastatic disease.

Mr. A related a life-long battle with anxiety, rumination, and insomnia "since Moby Dick was a minnow." He was never clinically depressed. Mr. A sought psychiatric help for his anxiety disorder on 2 occasions, each since his diagnosis of cancer began providing the context for the lion's share of his anxiety. His treatment included 3 trials of selective serotonin reuptake inhibitors, each of no benefit. He was prescribed antianxiety drugs, and they too made no difference for him.

His oncologist (near home) suggested that he travel to Charleston to see if cognitive therapy might be of help to him. During the initial intake, we connected immediately. He discussed his preoccupation with cancer and a general focus on "predicting the future." He was skeptical that any psychotherapy could help him alter "life-long patterns of thinking." My DSM-IV diagnosis was generalized anxiety disorder (300.02). He agreed to sessions once every 2 to 3 weeks, despite the time and distance they entailed. A chemical engineer now retired for the past 5 years, he had "Nothing better to do, anyway," he said.

PSYCHOTHERAPY

Predictably, Mr. A caught on to the cognitive-therapy model after 1 simple explanation. He bought and read my book on cognitive therapy

and agreed to keep an automatic thought record. In it, he would list his concerns relevant to cancer as they occurred.

In sessions, we worked in a triple column format, listing situations in which anxiety was manifest and the related thoughts. He readily accepted the relationship between what he was feeling (anxiety) and what he was thinking. Consistent with an obsessive-compulsive style, he made frequent lists, graphs, and mood ratings. He learned the concept of attribution to account for many of his explanations.

Several of Mr. A's cognitive errors took the form of arbitrary inferences (jumps to a conclusion, without data). He learned to identify these errors. From his (at times, faulty) conclusions, he frequently proceeded to overgeneralize. I described "catastrophizing" to him as my grandmother's favorite error: too often she accepted a highly improbable outcome as the one most likely to occur. He immediately recognized this process in himself.

As time passed, I would wonder out loud: Did Mr. A utilize techniques he had learned to dispute the thoughts when he was anxious and *not* in my office? "Sometimes," he replied. Much of his anxiety revolved around seeking explanations for physical sensations. Cancer headed the list of his alternatives.

As our sessions moved beyond the bounds of brief cognitive therapy, I asked him why he thought he continued to come to my office. Clearly, the relationship that had evolved played a part and "someone to talk to about cancer" did as well. More important, he told me, the sessions served as a continual reminder to "do the work of cognitive therapy" when anxiety was present.

Over the long haul, we discussed every major event in the course of his cancer and many "false alarms," proven to be unrelated to his disease. With each recurrence, there was a continual need for perspective and the establishment of a reasonable orientation to daily life.

His wife (who often accompanied him to Charleston) told me on numerous occasions how much better he was when he utilized what he had learned. Mr. A and I discussed the concept of "participant" and "observer" at length, and he identified "observer" as the culprit when he experienced anxiety. We discussed ways to interrupt a rumination cycle, particularly when it occurred in the middle of the night.

Over time, he utilized cognitive techniques to promote having a good night's sleep. He told me that his oncologist frequently asked if he was "still seeing that doctor in Charleston" and encouraged him to continue. In the later sessions, he identified, and learned to combat, a tendency to polarized "black and white" thinking. Throughout, it was emphasized that his anxiety was not produced externally. Rather, he was in charge and sometimes functioned as an anxiety-generating machine.

Analogies and self-disclosure were frequent components of our sessions. They served to establish contact ("You are not unique.") and suggested that he could think more competently about his disease and its likely consequences.

Mr. A learned to apply a problem-solving approach to his experience of anxiety. Finally, 30 months after we began, he decided he could "go it alone" if he could call me periodically, if necessary. I assured him that he could call, or visit, as needed.

Looking back, the journey with Mr. A was well worth my time and effort. He felt that it had been of enormous benefit to him. His calls now, from time to time, are more social than clinical. For me, they recall a relationship that was both functional and pleasurable. Sometimes, even brief therapists need to be in it for the long haul.

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