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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Unconventional Psychotherapy

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Robert Smith is dead. He died at home, alone, after 2 brief hospital stays to treat consequences of his rapidly progressive liver cancer. Offered the services of hospice to ease his final days, Robert, at first, politely declined. Observers on medical rounds during the first of these final hospitalizations noted his surprise upon being told that his cancer was now rapidly spreading and that he would not live much longer.

For me, Robert's death at age 50 years marked the end of a nearly 5-year relationship. We met at the university at which Robert was an oncology patient and I was making rounds 1 morning a week with my oncologist colleague.[1,2] I spoke with Robert briefly after the oncologist and nurse had left the room. He seemed like a good candidate for a research study I was conducting that offered a cancer patient 6 sessions of cognitive therapy to aid adjustment to the disease.[3] The oncologist supported my suggestion that Robert join the study, and the patient readily agreed.

CASE PRESENTATION

A self-proclaimed "army brat," Robert was raised in the north and south of the United States, as well as abroad. He had an older brother, with whom he had little contact. He was educated through high school (in Alabama) and then attended various trade schools. He worked for an automobile company assembling cars. He was married at age 30 years and divorced at age 40 years. There were no children. He had no contact with his former wife.

Robert continuously abused alcohol from age 18 to 43 years. He had few friends. He managed to stay nearly continually employed. Alcohol brought him liver cirrhosis, and later anemia and insomnia, but neither depression nor delirium tremens. Robert never sought consultation for an emotional disorder. He was diagnosed with hepatic cancer in 2001.

My study intake DSM-IV diagnosis was schizoid personality disorder. Robert completed the 6-session cognitive therapy study and was grateful for my interest in him and for what he had learned. Periodically thereafter, he would call me with questions about his diagnosis and management. On 1 occasion, when Robert's oncologist was on vacation, I became concerned about his report of abdominal distention and arranged to have him evaluated by an oncologist colleague, who admitted him to the hospital.

On November 1, 2003, I left the university. I was not surprised to receive a call at my new office from Robert barely 3 weeks later. He "had some questions" and wanted an appointment.

PSYCHOTHERAPY

Robert arrived for the first of what would be 16 outpatient sessions over the subsequent 30 months. He brought Internet material he had copied relevant to an experimental cancer treatment he had been offered. We discussed cancer (there was little change), alcohol (there was none for 5 years), and the drug that was the subject of his consultation with me. He

was angry about his treatment and concerned about his inability to sleep, and he expressed many different ideas about the consequences of the proposed treatment.

I prescribed a sedative drug but left the issue of a return appointment to his initiative. (I followed this course for 2½ years.) He called about 1 month later. In session 2, he spoke for the first time with me about "having a terminal disease" and having "nothing to look forward to." We focused on his thinking and generated together some options for him to pursue.

Robert called about 1 month later. He complained about increasing anxiety and difficulty "finding projects" that interested him. A similar dialogue (as the prior session) resulted in the prescription of clonazepam 1 mg twice daily to ease his anxiety.

The next call came 6 weeks later, and the session that followed focused on his anger "at the health care system." His dog (with whom he was close) "got better treatment." He had attended an oncology appointment and wanted to know the "meaning of what he was told." Robert reported experiencing significantly less anxiety.

The next session came subsequent to another oncology visit. We went over what he was told in a systematic way, and he asked questions. I called his oncologist (during the session) to clarify a portion of what Robert had related to me.

In subsequent visits, the problem focus shifted to anemia, more likely related to cirrhosis than to his, so far indolent, cancer. Nevertheless, he insisted upon continuing to seek care for this medical condition (anemia) from an oncologist and a psychiatrist. He claimed (in an aside) to have never seen radiographic evidence of his cancer. We generated (and he wrote down) questions that he would bring to his next oncology appointment. He would ask to see his magnetic resonance imaging.

As Robert's questions became more urgent in subsequent sessions, I routinely called his oncologist (with the patient present), serving as a go-between to produce answers and to generate alternate explanations. Over the next few months, his dog suddenly died, and we spent several sessions in grief work related to his loss. On 1 occasion, he asked if his visiting brother could come with him to a session. They came together and were each concerned about Robert's abdominal distention. A call to his oncologist registering their concern (and my concurrence) led directly to a brief hospitalization for paracentesis to remove accumulated fluid.

Subsequent visits were often dominated by questions about his medical management. Typically, Robert would say, "I asked them, but I didn't get (or understand) an answer." At times, I would clarify. At times, I would call the oncologist to relay the patient's concerns.

For 4 years, there was little evidence of tumor activity, but when metastasis began, it began in earnest. Our final visit came 1 week before Robert's death. He had been hospitalized twice briefly for symptomatic treatment. He had lost a considerable amount of weight. He had initially refused hospice care. He had called me, however, for this appointment.

We reviewed the events of his recent hospital stay. We reviewed the 5 years since his cancer diagnosis and how slowly the cancer had grown. He told me that a neighbor had been dropping off prepared meals. He missed the presence of his dog. We discussed his view of the future. We each stressed the meaningfulness of our contacts. I assured him of my continuing availability to him, should he want or need it. We said good-bye.

DISCUSSION

A typical course of cognitive therapy in my office is brief. I saw Robert a total of 22 times over nearly 5 years. Was it worthwhile?

For a man who discouraged relationships with others, our relationship had endured. He ventilated, posed questions, and shared and sought information. The problem solving that occurred was aimed at his obtaining quality medical care. He often encouraged me to "call his doctors" and to "ask questions." The role I served was, for me, quite unconventional. The session content was unusual.

I already miss my time with Robert. He is a man, I believe, I will never forget.

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