What Do We Think About?

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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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A cognitive therapist focuses on the thoughts that people have. So, what do we think about? We anticipate sometimes, thinking about events to come. We think about our children and sometimes about our friends. We think about ourselves: the events of our day, the relationships that we have. We think about what may be coming next in our lives. We think too about world events: terror or foreign involvements. Sometimes, we anticipate travel. And, as we age, at times we think about the "consequences of aging": loss, lost control, changes in life.

What is the result when we are diagnosed with an illness? Do we imagine what its course may be? Do we think about the likely outcomes? Do we read about it on the Internet? Do we ask others about it? Or, do we keep our own counsel and merely think about it?

A cognitive therapist who works to aid the adjustment of patients diagnosed with serious medical illness often thinks about what his or her patients think. I make the case to many whom I treat that, for example, anxiety, while often *related* to events, is not *produced* by events. Rather, anxiety is produced by the individual. Since anxiety tends to typically be unpleasant, thinking about the illness is often not the best strategy. I emphasize to my patients that the production of anxiety is his or her responsibility. If you have followed me so far, that puts anxiety within the patient's control. The patient diagnosed with cancer may or may not share his or her thoughts with others. Yet, it seems clear that the thoughts are frequently present, and patients have the choice of dealing with them, magnifying them, or focusing their attention elsewhere.

One job of the provider (the internist, the psychiatrist) is to identify these thoughts and to help the patient deal with them. After all, it is quite normal to have thoughts about an illness. My patients frequently ask, "When will these thoughts go away?" The answer, I'm afraid, is that we all have them, and they don't go away by themselves.

One way to deal with illness-related thoughts is *distraction*. Being told to count sheep when trying to fall asleep is one example of what people are sometimes advised to do. We believe that sleep will come more easily when individuals are not focused on the thoughts they may have at bedtime. Distraction works for some people and may work for a limited time. A better advisory is *engagement*. Finding something meaningful to occupy your mind can bring relief from anxiety-inducing thoughts.

Among the patients I have met at the end of their lives are a number of people who create anxiety for themselves based on the illnesses from which they suffer. Their providers can potentially increase or decrease that anxiety. Mr A had many good reasons to be concerned about his medical problems. One of my jobs, as I saw it, was to help him learn how to best think about his illness.

CASE PRESENTATION

I was asked by the staff of the unit where I work at the Veterans Affairs hospital to play a role in the treatment of Mr A. He was then a 50-year-old white man, never married, with 1 grown son. He had been admitted to the Community Living Center of the hospital only 2 weeks earlier. Born in Philadelphia, Pennsylvania, he had graduated from high school there and gone on to earn an associate's degree.

Soon thereafter, Mr A joined the Army and served for 12 years. He was stationed both at home and abroad, and during his stint, he had a son, although he never married. When his son's intestine perforated as an infant, father and son were transported back to Washington, DC. His son graduated from high school there, while being raised by a single father. Meanwhile, Mr A worked in a hospital and then got a government job.

About 7 years ago, Mr A moved to Charleston, South Carolina, to provide care for an ill relative who subsequently died. Finally, about 4 years ago, Mr A was diagnosed with a genetic illness. By this time, most of Mr A's family was living in Charleston. He had lost significant function in his arms and legs. The prognosis for his illness was poor. He hoped, however, to "regain function and to achieve independence." I was introduced to Mr A almost 3 years ago, shortly after he was admitted to our unit. The staff expected continued deterioration to be Mr A's course. His view was much more positive and in line with his stated goals.

PSYCHOTHERAPY

We met nearly weekly for almost 3 years. Mr A's expressed hope was for increasing arm and leg strength and independence. Over time, he was usually seen as a product of his illness and therefore unlikely to make significant progress. I constantly emphasized the opposite to him and thereby became an ally in his campaign for independence. Mr A acknowledged the thought that he might be dependent on others for the rest of his life. I countered, "We need to find out what you can learn to do for yourself and in what areas you need help." We discussed the strategic implications of the "dependent" thought; it would not help him achieve his goal of independence. He frequently spoke of his mentally impaired son and the son's quest for a normal life. He asked many questions. I listened and responded to his parental concerns. And, then, I redirected the focus to Mr A.

It soon became clear that Mr A's family members had distanced themselves from him. Each time this was mentioned, I redirected the focus to Mr A. Friends began to visit Mr A in the hospital. There was no sign of clinical depression or clinical anxiety. We spoke often of the physical therapy prescribed for him and how important it was that he diligently pursue it. At one early point, Mr A told me how important it was for him to set goals for himself. I supported this plan.

We spoke frequently about his parental issues with his son. Some concerns were those typical of raising a son. Others dealt with the son's view of his disabilities.

Mr A persevered through sedation (most likely drug-related) and times when his son was "insensitive" to his father's needs. Mr A learned to use his hands to feed himself. Some staff members were seen as encouraging him to do things for himself, while others were seen by him as "overburdened" and paying him little attention. I listened and then returned the focus to Mr A. His son spoke of their need to return to Washington, DC. Mr A counseled his son to "accept and make do." He spoke to me of periods of demoralization. I reminded him of his crucial role in establishing what he could do for himself.

I constantly raised the issue of Mr A's role in decision-making. I spoke with Mr A's social worker about the process of identifying a companion for him. I received a report that noted Mr A's progress as well as instances of lack of communication about him among staff.

After 9 months spent as a resident inpatient, Mr A spoke to me once again about his wish to leave the nursing home unit and live independently. We addressed what he would need to be able to do for himself and in what areas he would need help. I underlined the importance of setting a "time goal" that he could aim for.

After a 4-month period of no contact, I was asked by staff to resume seeing Mr A weekly. It seemed that there were problems with his son and that Mr A had gained significant amounts of weight. He associated the weight gain with "edema," while several of the staff assigned it to "dietary indiscretion."

For a time, Mr A's focus remained on how he was seen by staff and some of the other residents. Then, his focus shifted to the medications he was given. They had "caused" the weight gain. Then, he spoke of "feeling tired all the time." For many sessions, I listened to Mr A blame the actions of others. Finally, I confronted Mr A with his own responsibility and asked him what he proposed to do about it. A sleep study was done that revealed sleep apnea, and a continuous positive airway pressure mask was prescribed. Finally, he slept better and complained less often about fatigue. We emphasized those issues Mr A could control and acknowledged those areas for which he had no responsibility.

Mr A spoke to me about his "problems with confrontation." He followed this discussion by taking more responsibility for guiding his son. We discussed his role of "protecting" his son, and I suggested that the son had reached the age where he needed to take more responsibility for his own life. Mr A began to clearly speak out more and represent himself to staff as well as to the other residents on the unit.

After 2 1/2 years of my involvement with him, Mr A told me how much my support and our sessions together had meant to him. "You have inspired my trust," he said, "and consistently encouraged my independence." Early in our third year together, he noted once again that his focus now must shift from parenting his son to taking care of himself. He began to diligently look with a realtor for a place where he could live. He utilized our sessions to vent about areas of concern as well as to express his thoughts about himself. It is remarkable that, given a considerable amount of time spent alone with his thoughts, Mr A had been able to avoid focusing on self-defeating ideas. He had more than enough time to have the thoughts common to all of us. And, he had learned at last to pay them little mind!