Cognitive Behavioral Therapy for Chronic Illness and Disability

Renée R. Taylor

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With 94 Figures

Springer

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This book is dedicated to my mother and to the memory of my father. Thank you for your love and support.

Preface

The linkage between chronic illness, impairment, psychological adjustment, and health-related behavior is a topic of significant and wide-ranging concern worldwide. This book was developed to offer empirically based practical guidance to providers of psychotherapy and rehabilitation services for people with chronic illnesses and impairments. It should also be of use to researchers involved in conducting, evaluating, and thinking critically about the efficacy of cognitive-behavioral approaches to the management and treatment of these chronic conditions.

Three important developments have influenced the writing of this book. First, the book reflects my experience as a clinical psychologist evaluating and treating individuals with chronic illness and impairment in practice. Second, it was shaped by my research into the nature and consequences of these conditions and the therapeutic services designed to address them. Finally, the book is the result of personal experience living with, caring for, and witnessing the lives of close family members with chronic illnesses and impairments.

The conditions covered in this book will be grouped in terms of four cross-cutting symptom categories: fatigue, pain, sleep dysfunction, and gastrointestinal difficulties. Because these symptom categories may be shared by individuals with chronic illnesses or impairments, the term "chronic conditions" will be used in this book to incorporate individuals with chronic illnesses or impairments. These four categories were selected because they represent broad symptom groupings that are commonly observed and experienced across a number of the most prevalent chronic conditions facing the international population. Fatigue, pain, sleep dysfunction, and/or gastrointestinal difficulties occur with all of the following conditions or as a result of treatments for these conditions: heart disease, cancer, diabetes, stroke, HIV/AIDS, all forms of arthritis, lower back pain, thyroid disease, multiple sclerosis, lupus, and Crohn's Disease (among countless others). Additionally, these cross-cutting symptoms also represent some of the most commonly observed problems in individuals with physical impairments and difficult-to-treat syndromes such as chronic fatigue syndrome, fibromyalgia and other chronic pain disorders, multiple chemical sensitivities, and irritable bowel syndrome.

In an effort to illustrate applications of therapeutic strategies in the most straightforward way possible, the same four cases, each describing an individual with a condition that involves one of the four cross-cutting symptoms, will be presented and utilized throughout the book. These case examples illustrate how approaches to cognitive behavioral therapy can vary depending upon variations in the symptomatology of chronic conditions. Both long- and short-term approaches to therapy are presented to illustrate the extent to which timing and setting demands can affect treatment goals and methods used.

It should be noted that the term "disability" is used in the title because in contemporary usage it continues to be the term that most professionals would understand as referring to individuals that have some type of enduring limitation of functional capacity. This book does not aim, specifically, to address the numerous social and environmental issues experienced by individuals with chronic illnesses and impairments (e.g., disability oppression and discrimination, stigmatization, limited access, the phenomenology of disability, and disability identity). It is widely acknowledged that these issues, in addition to numerous other key aspects of disability experience, have a significant influence upon an individual's beliefs about his or her own illness or impairment. Although some of these issues are covered in the book and incorporated into recommended therapy procedures, full and adequate treatment of the social and environmental issues that accompany chronic illness and disability is admittedly beyond the scope of this book. For full treatment of these issues, readers are referred to the works of renowned authors such as James Charlton (1998), Michael Oliver (1990), and Simi Linton (1998). In order to be consistent with the argument that disability is created when a person with impairment confronts environmental barriers, the term "impairment" will be used throughout to refer to limitations of functional capacity.

This book draws most heavily upon the contemporary work of Aaron Beck (1996) and Judith Beck's (1995) cognitive therapy. Major theoretical ideas and techniques from cognitive therapy are applied as a framework for understanding and treating individuals with a wide range of chronic illnesses and impairments. Beckian cognitive therapy was chosen as the central framework because Beck's cognitive theory of psychopathology and cognitive therapy strategies have been subjected to a high level of critical thought and empirical examination (Beck 1996; Clark, Beck, and Alford 1999; Dobson and Dozois 2001; Ingram, Miranda, and Segal 1998). Moreover, there is substantial evidence to suggest that cognitive therapy is the most well-researched and successful approach to therapy for a growing number of conditions, including a number of chronic illnesses (Dobson and Dozois 2001; White 2001; Winterowd and Beck, and Gruener 2003). Although the book draws most heavily upon Beckian cognitive therapy, many other approaches and techniques covered in this book have been drawn from the broader domain of cognitive behavioral therapy (e.g., Greenberger and Padesky 1995; Nicassio and Smith 1995; Turk, Michenbaum, and Genest 1983). To reflect the incorporation of these more broadly derived methods, the more comprehensive term "cognitive behavioral therapy" will be used.

The development of this book was also influenced by existing theoretical and empirical knowledge from three additional domains, which will be labeled "areas of related knowledge" for purposes of definition and clarity. I chose to include areas of related knowledge because cognitive therapy has been described as an integrative psychosocial treatment and a flexible and continually evolving approach to psychotherapy (Beck 1991; Beutler, Harwood, and Caldwell 2001). Beck (1991) has explained that the main operant of cognitive therapy, cognitive change, is a variable that has been found to cut across all therapies that have reported effective outcomes. Accordingly, Beckian cognitive therapists are permitted to select interventions from a variety of theoretical orientations, provided that they are appropriately applied in any given case (Beutler et al. 2001).

Specifically, the three areas of related knowledge that will be incorporated in this book include self psychology (Gardner 1991; Kohut 1971), positive psychology (Seligman and Csikszentmihalyi 2000), and the model of human occupation (Kielhofner 2002). I selected these three bodies of knowledge with the specific aim of using theoretical knowledge and strategies offered in these areas to supplement or highlight three specific aspects of the therapeutic process that are controversial, underdeveloped or underemphasized within the current cognitive behavioral therapy literature—and particularly within the literature that covers the application of cognitive behavioral therapy to chronic illness and impairment. Broadly speaking, these include empathy, hope, and volition. These specific areas of related knowledge are included as modest, supplemental resources, with the understanding that Beckian cognitive therapy is the central orientation guiding the theoretical framework and treatment strategies described in this book. These areas of related knowledge are only intended to supplement existing theoretical and empirical knowledge of the application of cognitive behavioral therapy approaches to specific chronic conditions; they are not presented as a means of suggesting a new model or orientation to psychotherapy.

Finally, the ideas presented in this volume should be viewed as early in their development. As such they will require further clinical and empirical evaluation and ongoing dialogue about their application. It is hoped that this book and its organization around cross-cutting symptom areas might lead to the further refinement and focus in outcomes studies of the use of cognitive behavioral therapy for chronic illness and impairment.

Chicago, Illinois, USA **Renée R. Taylor**

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A number of people have contributed to the thinking, contents, and development of this book. First I would like to thank the psychotherapy clients and research participants that I have had the privilege of knowing, working with, and learning from. Their unwitting contributions to my knowledge of chronic illness and impairment have formed the basis for this book. I would also like to thank Dr. David Greenberg for introducing me to cognitive behavioral therapy and for educating me about its practice in health care and rehabilitation settings. I would like to thank Dr. Gary Kielhofner for introducing me to the model of human occupation and to its application in mental health settings, and I would like to thank Dr. Betty Contorer for introducing me to the theory and practice of self psychology. In addition, I am very grateful to a small group of clinical supervisors and mentors who, in particular, have influenced my general development as a practitioner: Drs. Catherine Pines, Sheila Ribordy, Richard Volden, Sarah Kallick, Larry Craven, and James O'Keefe. In addition, I would like to extend special thanks Michelle Query and Jennifer Utz for serving as my graduate assistants and helping with numerous organizational and editorial tasks. I would also like to thank Megan Agner for her support in conducting literature searches and entering references for this manuscript. Finally, special thanks go to Sharon Panulla, Executive Editor, Joseph, Zito, Assistant Editor, Michael Koy, Senior Production Editor, Julia S. Brainin, Copyeditor, and the rest of the production staff at Springer for their unwavering consistency, support, and care in editing and producing this manuscript.

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Section One

Theoretical Foundations and General Practice Guidelines

Introduction

This first section of the book reviews the theoretical foundations of cognitive behavioral therapy and specifies general guidelines for practicing cognitive behavioral therapy with individuals with chronic conditions. Chapter 1 introduces four cases that will serve as a basis for application of key concepts presented throughout the book. Chapter 2 provides an overview of cognitive behavioral therapy and highlights its relevance to persons with chronic conditions. Chapter 3 covers issues facing professionals involved in the treatment of individuals with chronic conditions, discusses the linkage between cognition, stress and chronic illness, and provides a rationale for the application of cognitive behavioral therapy to individuals with chronic conditions. Chapters 4 through 9 describe specific cognitive behavioral approaches as they are applied to people with chronic conditions. Chapter 10 discuses the complexities of cognitive behavioral therapy for clients with chronic conditions and the necessity of adjusting traditional approaches to accommodate these unique issues.

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Introduction: The Four Case Examples

This book addresses the application of cognitive behavioral therapy to persons with chronic illness and/or impairment. Rather than emphasizing diagnostic categories, it focuses on cross-cutting symptom categories of fatigue, pain, sleep dysfunction, and gastrointestinal problems. Individually or in combination, these symptom categories most frequently characterize chronic conditions. While each of these categories of symptoms requires some special considerations, the book will illustrate how the major therapeutic strategies of cognitive behavioral therapy can be applied across them.

In this chapter, four case examples are introduced, each presenting with one of the four major symptom categories. The first case example focuses on fatigue as the primary symptom and describes the experiences of Nina, a 35-year-old woman with chronic fatigue syndrome. The second focuses on pain as the primary symptom and describes the experience of Paulette, a 42-year-old woman with rheumatoid arthritis. The third case example highlights the role of sleep disorder in chronic illness and describes Curtis, a 60-year-old man with advanced prostate cancer. The fourth case example focuses on gastrointestinal difficulties as the primary symptom and describes Alex, a 23 year-old man with Crohn's Disease. These case examples are composite representations of actual cases seen by the author. Significant sociodemographic details, diagnostic information, aspects of the medical history, and background information have been altered so that it is impossible to trace any of the case examples to the individuals that were actually treated.

These case examples reappear throughout the book and serve as bases for illustrating the application of key concepts of cognitive behavioral therapy. They each vary in terms of the degree to which Axis I and II psychiatric overlay is also present to illustrate nuances involving therapy pacing, differing approaches to the integration of related knowledge, and to reveal the real-world complexities that can arise when conducting cognitive behavioral therapy with individuals with chronic illness.

The choice to present some of the case examples as having psychiatric overlay was made in an effort to best reflect variation in the types of clients with chronic conditions that would most likely be referred for psychotherapy. Though the author's belief is that all individuals experiencing the focal symptoms of this book

have the potential to benefit from cognitive behavioral therapy approaches to symptom management, individuals with a greater degree of overlapping psychopathology are more likely to be seen in clinical psychotherapy practice than those without. Importantly, the choice to present some clients with psychiatric overlay is not intended to stigmatize individuals with chronic conditions or to suggest that most individuals with chronic conditions will also exhibit clinically significant psychopathology.

Nina: A Woman with Severe Fatigue

Nina is a 35-year-old married woman of mixed European-American origin. She has a bachelor's degree and is the mother of a 10-year-old daughter. Before the onset of her illness and subsequent impairment, Nina worked as a salesperson for a small, family-owned packaging company. She specialized in the design and sale of packaging for athletic products. Her job involved being on the road and in and out of her car, calling on as many as five clients within a 70-mile radius of her home on a daily basis. Nina's job also required her to fly out of town to various major cities within the U.S. at least once a month. In addition to her job, Nina also liked to participate in sports; she had always been an avid athlete along with her husband, a physical therapist. Together they had always enjoyed participating in a number of activities together, including skiing, sailing, horseback riding, and snowmobiling.

Diagnosis and Health History

With the exception of a series of severe infectious illnesses during childhood (e.g., chicken pox, mumps, whooping cough, and multiple episodes of influenza) and a concussion she sustained while snowmobiling at the age of 30, Nina considers herself to have been in excellent health for most of her life. Two years ago, Nina became ill with mononucleosis and was hospitalized for four days because of a sustained high fever and inflammation within her throat that was so severe it obstructed her breathing.

After she returned home from the hospital, Nina's fatigue and other infectious symptoms continued. Although there were brief periods of time (e.g., five to seven days) when she felt strong enough to function, these periods would typically be followed by fatigue and symptoms that were almost as severe as her initial episode of mononucleosis. Her recurrent episodes of debilitating fatigue were accompanied by recurrent sore throats, chronically swollen lymph nodes, pain in multiple joints and muscles, severe difficulties with short-term memory and concentration, unrefreshing sleep, and dizziness/fainting episodes that occurred when sitting upright or standing still for longer than a few minutes at a time.

Nina describes her fatigue as an "all-encompassing feeling of mental and physical exhaustion." Of her physical fatigue she notes, "I am exhausted and yet my heart is beating and my body feels like an electric current is running through it."

Nina describes the mental fatigue as "feeling and acting spacey – in a dangerous way that scares my husband sometimes." She also complains of losing her ability to concentrate, becoming unusually forgetful, and occasionally becoming disoriented and confused. She reports that these symptoms concern her most when she is driving and suddenly realizes she does not know where she is. Despite her fatigue, she can't sleep or even rest very well.

In addition to her myriad symptoms, Nina, a strikingly beautiful and athletic woman prior to her illness, lost a significant amount of weight. In addition, she developed a pale and ashen complexion and complained that her hair had become dry and brittle. Her limited energy made it difficult for her to maintain all the personal care activities she had previously done to "look her best." One of her friends commented that she appeared to have aged a decade in less than a year.

When Nina's symptoms had persisted for six months, she began what for the next year was a series of visits to various physicians specializing in infectious diseases, rheumatology, endocrinology, neurology and cardiology. Nina found most of these visits to be highly discouraging and unhelpful. Because blood testing and radiology results revealed no apparent cause for her symptoms, Nina was often referred back to her general practitioner with no diagnosis or treatment recommendations. When she was provided with an explanation for her symptoms, she was diagnosed as having somaticized depression or anxiety and referred to a psychiatrist. Following several consultations, one physician specializing in infectious diseases referred her to a general practitioner who specialized in post-infectious fatigue syndromes.

Six months ago, Nina was diagnosed with chronic fatigue syndrome by this physician. Following the diagnosis, he prescribed a series of different antidepressant medications, antianxiety medications, analgesics, and stimulants. With the exception of the analgesics, all of the medications failed to provide any significant or lasting relief for her symptoms. Moreover, some of them produced side effects that Nina was unable to tolerate. Nina's physician also recommended that she cut back on more stressful work-related activities, begin a graded exercise program, and consider a career change. Nina has consistently rejected those recommendations, maintaining that she has already cut back on her activities enough. Because she felt her physician did not understand her and was not competent enough to treat her, Nina was considering changing physicians. However, given her prior history of negative interactions with health care providers, she was reluctant to seek additional referrals and did not know to whom she should turn.

Recent Psychosocial History

Following a four-month leave of absence from her job due to her illness, Nina returned to work, only to discover that her boss had requested that his son take over all of her sales accounts during her long absence. She was told she would have to start from scratch to develop new accounts. This meant tracking new products and cold-calling potential clients to offer them alternatives to their current

packaging choices. Because Nina had always believed that sales was a very visual and image-oriented profession and she believed she once benefited from her attractive physical appearance, she had significant concerns about how she would ever be able to regain the sales volume she once had.

In the face of these concerns and despite the unfair and discriminatory behavior of her company, Nina began to set appointments and to call on new clients in an effort to develop relationships and reestablish a customer base. However, her productivity and capacity to make these calls had declined significantly. Compared to her previous rate of calling on up to five customers per day, Nina now considers herself lucky to be able to call on two customers per week.

In addition to her job-related concerns, Nina also reported that her family relationships had changed. Though her husband remains supportive, he has also stopped his involvement in sports and has gained a significant amount of weight. In Nina's opinion, he always appears exhausted, depressed and emotionally withdrawn.

Nina's 10-year-old daughter now does dishes, helps clean the house, and even helps her mother with basic dressing tasks during times when Nina's husband is not available. In addition, she has decreased her contact with friends and her involvement in after-school sports and extracurricular activities. Although Nina's daughter appears to have coped with the all the changes by assisting her mother and assuming more responsibility within the family, she has become highly anxious and more pressured about her schoolwork. Nina reports feeling very guilty and responsible for the changes in her family that she perceives to have come about as a result of her illness.

Background Information

Nina reported that she grew up in a supportive family but that she often felt pressured to perform well both academically and as an athlete. Nina has one brother, aged 30. Nina's parents remained married until they both died in a major car accident when Nina was 23 years old. In addition to her husband, Nina's aunt and uncle became a major source of social support following her parents' death. With the exception of a brief episode of simple bereavement following her parents' death, Nina denied any prior symptoms of psychiatric problems or emotional distress.

Reason for Referral

For six months, Nina's physician had been recommending that she see a psychologist for psychotherapy. The physician recommended psychotherapy for three reasons:

- Nina had not responded well to any of the prescribed medications or treatments he has recommended. The physician believed that psychological variables may have been interfering with Nina's ability to follow a recommended treatment regime.

- Nina reported increased stress and conflict related to her relationship with her husband and daughter and she was concerned about their well-being.
- As time passed, Nina appeared increasingly demoralized and anxious about her symptoms and about her level of impairment in completing usual daily activities. She was tearful at almost every appointment and would often call her physician between appointments, sobbing on the phone and pleading with him to find some other way to help her. She was no longer able to participate in athletic activities, which had been very important to her. She was feeling overwhelmed by her work and finding it increasingly difficult to maintain an optimistic outlook on life.

Each time the physician suggested that Nina seek counseling, she rejected his referral for psychotherapy, insisting that her symptoms are "in her body and not in her head." Though Nina had repeatedly rejected the physician's recommendations for therapy, ultimately she was willing to see a psychotherapist that specialized in the treatment of individuals with fatigue. The turning point came when her physician indicated that he knew of a therapist that specialized in treating individuals with chronic illnesses that involved fatigue. He informed Nina that this therapist was very collaborative in her approach and that the work would mainly involve identifying strategies for managing her disabling fatigue.

Paulette: A Woman with Severe Pain

Paulette is a 42-year-old woman of unknown ethnicity. She has a master's degree in special education and works part-time as a special education teacher at a local grammar school. She lives with her second husband and her two adolescent sons from a previous marriage.

Diagnosis and Health History

Paulette reported a history of good health prior to her diagnosis of rheumatoid arthritis (RA). Paulette recalls that she was first diagnosed with RA at the age of 24, following the birth of her first child. Routine blood testing revealed an elevated sedimentation rate. This led her obstetrician to run additional blood tests, which revealed a positive anti-CCP, a positive rheumatoid factor, and an elevated level of C-reactive protein. She was diagnosed with rheumatoid arthritis and referred to a rheumatologist.

At that time, Paulette was experiencing periodic pain flare-ups that involved soreness, stiffness, and aching, particularly in the joints of her fingers and wrists. This was accompanied by soft tissue swelling and redness in the fingers of both hands and wrists. However, she was able to maintain the basic functions of her job well enough with the use of various non-steroidal anti-inflammatory drugs (NSAIDs). The rheumatologist prescribed a second medication designed to slow the progression of the disease and prevent joint destruction and deformity

(a disease-modifying anti-rheumatic drug, or DMARD). After trying several DMARDs, Paulette decided to stop taking them. She reported that she did not see any immediate results and that they caused her to have a number of uncomfortable side effects, including rashes and severe gastrointestinal symptoms. In addition to discontinuing her DMARD therapy, Paulette did not return to see this rheumatologist because she did not find her to be very supportive or helpful. Instead she chose to obtain prescribed NSAIDs from her obstetrician.

Since her 20s and in the absence of careful management, Paulette's condition has progressed. Paulette now experiences stiffness, limited joint mobility and range of motion, and pain flare-ups that are more frequent, more pervasive, and more severe. Because the flare-ups are so severe, the pain does not respond even to high dosages of the various non-steroidal anti-inflammatory medications that she has been using to treat her symptoms. As a result, Paulette now sees a rheumatologist regularly for corticosteroid injections. She has developed obvious malformation in the joints of her hands and feet, and she is showing some evidence of muscle atrophy. During flare-ups, Paulette also experiences pervasive fatigue, sleep difficulties, and occasional fevers. She has quit her volunteer activities and is beginning to wonder whether she can continue working, even on a part-time basis.

Paulette is now considering trying anti-rheumatic medications again because the rheumatologist informed her that her pain, joint degeneration, and mobility limitations would only get worse if she did not take one of these drugs. However, she has not yet accepted any prescriptions for this class of medications because she is fearful of their side effects. Depending on the specific DMARD, side effects can include rash, diarrhea, liver and bone marrow damage, kidney damage, and visual problems. However, because of concerns about other long-term side effects of repeated corticosteroid injections, her rheumatologist is threatening to discontinue the injections if Paulette does not decide to take the prescribed anti-rheumatic medication.

The rheumatologist has also recommended that Paulette consult a physical therapist and an occupational therapist to work on improving her joint range of motion, to obtain hand splints to wear to improve joint alignment, and to begin a graded aqua-therapy exercise program to increase overall physical functioning, decrease pain, and increase mobility. However, because Paulette's health insurance is very limited and does not cover rehabilitation services, Paulette has not pursued these recommendations.

Recent Psychosocial History

In addition to her job as a special education teacher, Paulette had also enjoyed volunteering once a week at the local nursing home, going to casinos, doing artwork, clothes shopping, attending her youngest son's musical concerts, and watching her eldest son participate on various sports teams. However, in the past two years she has slowly given up many of the activities she once enjoyed. Paulette acknowledged that she has struggled with periods of feeling

sad, apathetic, and hopeless for most of her life. Paulette describes herself as a "chronic worrier" and has felt very anxious and agitated at times, particularly during her first marriage. Until now, her mood and symptoms of RA had never interfered to the extent that they affected her ability to work and function in her roles as wife and mother.

When she is not working, Paulette currently spends most of her time in her home and only participates in activities that she feels are obligatory. She reports that her pain and stiffness prevent her from getting out to parties and social gatherings like she used to. She reports feeling depressed, physically unattractive, lonely, and sad.

Background Information

Paulette has an extensive history of interpersonal difficulties and losses, dating back to early childhood. As an infant, Paulette was severely burned on her legs by the boyfriend of her biological mother. Because her biological mother was unable to provide adequate care and protection for her infant, Paulette was placed into protective custody within a foster home. Her biological mother was 15 years old at the time of the incident. After two and a half years, her biological mother stopped visiting Paulette and relinquished all parenting rights. Paulette was placed for adoption at the age of three.

Paulette was adopted into a family of four boys, who were all biological offspring of her adoptive parents. Her father was the principal of a local high school and her mother taught kindergarten. She described her brothers as "more or less okay – they provided me with a lot of advice and stuck up for me at school." She described her adoptive father as loving and supportive of her. In addition, Paulette had a particularly close relationship with her paternal grandmother. She described her adoptive mother as "hot and cold and sometimes verbally abusive toward us, depending on her mood."

Paulette and her ex-husband had a long history of marital conflict, with two isolated episodes of domestic violence during which Paulette's ex-husband struck her on the side of the face with his hand early in their marriage. After a period of separations and reunifications, Paulette was divorced from her husband when she was 30 years old. She raised her two boys mostly on her own until she married her current husband at the age of 38.

Paulette's current husband, a 43-year-old master carpenter, enjoys hunting and playing cards with friends. Paulette loves her current husband and describes him as "much more supportive than [her] first husband." However, she is concerned that her current husband may have a drinking problem. She is also concerned that he may be losing interest in her. On numerous occasions she has witnessed him become inappropriately angry with her or with one of her two sons, particularly when he is drinking. Paulette reported that these problems began soon after they were married but have gotten worse as her illness has progressed.

Paulette has had a number of previous experiences with various forms of counseling and psychotherapy, but she has never received cognitive behavioral therapy. Paulette received crisis counseling within the emergency room both times

after her ex-husband hit her. Her first experience with a longer-term counseling relationship was domestic violence counseling that she received at a local shelter during her first marriage. She also received court-mandated divorce mediation sessions with her ex-husband in order to plan for their anticipated divorce. She reported that she found the mediation sessions helpful in "keeping the divorce proceedings civil" but "otherwise useless."

Following her divorce, Paulette developed symptoms of anxiety and depression and sought psychotherapy from a psychodynamically oriented psychotherapist. In describing this episode of treatment, she reported that the "only helpful aspect of that two-year journey into hell was the first session or two." That therapeutic relationship ended poorly and without resolution. Paulette reported that she left feeling like she had wasted her time and money on someone that ultimately "looked down on [her]" and "made [her] think negatively about [her] mother." From that point on, Paulette had been reluctant to seek further psychotherapy.

Reason for Referral: Severe Pain

Paulette referred herself for psychotherapy when faced with the dilemma of her rheumatologist threatening to discontinue her corticosteroid injections. She had read about the benefits of cognitive behavioral therapy for managing pain in a magazine article that was published by a self-help organization for individuals with arthritis. She obtained a referral for a cognitive behavioral therapist in her area from this organization. Her rheumatologist supported her decision to seek cognitive behavioral therapy and provided Paulette with a list of goals to take to therapy. However, Paulette's primary goal was to find relief from her pain.

Curtis: A Man with Secondary Insomnia

Curtis is a 60-year-old married man that identifies as African-American. He has been married for 25 years and has one daughter, aged 20. He has an Associate's Degree in business and has worked in retail for most of his life. He currently works as a furniture salesman.

Diagnosis and Health History

With the exception of mild hypertension and some orthopedic problems resulting from old injuries, Curtis had no prior history of any major physical illness and he had no history of sleep difficulties. Approximately one month ago, Curtis was diagnosed with prostate cancer by a urologist. At first Curtis had thought that the cancer would be entirely curable through surgical removal of the prostate. However, following surgery that originally aimed to remove the prostate, Curtis was informed that his cancer was inoperable and would likely metastasize within

the next six months to one year. Following this news, Cutis developed difficulty getting to sleep, multiple awakenings during sleep, and frequent nightmares. He began napping during the day and was caught three times sleeping on the job when business was slow.

Recent Psychosocial History

Curtis had no history of mental illness and had never been seen in psychotherapy. He had been coping well with his diagnosis of prostate cancer until he learned that his cancer was inoperable. At that point he developed insomnia, nightmares, anxiety attacks and reactive symptoms of depression. Curtis responded positively to a prescribed anti-depressant medication, and with ongoing support from his wife, daughter, and extended family, all of his emotional symptoms subsided within approximately three months.

Background Information

Curtis had a successful 25-year marriage to his wife, a strong relationship with their daughter, and an extended kinship network of family and friends that he described as "close." Curtis described his relationship with his wife as "a very loving and close partnership." He had a history of ongoing and relatively stable employment in various kinds of retail sales positions and described himself as a "sociable," "peaceful," and "well-liked" person. Curtis was the eldest of two children. He and his younger sister were raised by both parents in an urban neighborhood. His father worked as a mechanic and his mother worked as a cashier. He described his father as "hardworking, with a good sense of humor" and his mother as "strong," "self-confident," and "a good mother."

Reason for Referral: Secondary Insomnia

Although Curtis's emotional symptoms responded well to the antidepressant, his insomnia only seemed to be getting worse. After three months Curtis was referred to a sleep specialist for a sleep study. Following the sleep study he was diagnosed with secondary insomnia. The formal DSM-IV diagnosis was "dyssomnia not otherwise specified." This diagnosis was given because the sleep specialist had difficulty determining whether the sleep disorder was solely the result of his depression, a direct result of a physiological process involved in his cancer, or a side effect from a cancer medication or treatment. A change in antidepressant medication was recommended, and Curtis was prescribed Nefazodone, a serotonin-2 receptor antagonist with sedating and sleep-inducing properties. Although this helped attenuate some of his difficulties initiating sleep, the effects were mild in comparison to the magnitude of his insomnia. His urologist referred him to a cognitive behavioral therapist to learn more about the management of his sleep disorder and to learn sleep hygiene techniques. At this point Curtis decided to accept this recommendation.

Alex: A Man with Gastrointestinal Dysfunction

Alex is a 23-year-old man of mixed European-American origin. He has a Bachelor's degree in psychology and is currently enrolled as a graduate student in social work program. Alex has never been married and has no children.

Diagnosis and Health History

During late adolescence, Alex periodically experienced episodes of severe gastrointestinal upset that were occasionally accompanied by what felt like a mild fever. These episodes involved symptoms of severe, persistent diarrhea and abdominal pain. At first, he attributed these episodes to having recurrent bouts of a "stomach flu." He did not seek medical attention because they tended to "come and go on their own." Alex explained that his family had always minimized health concerns, and that people did not go to the doctor unless something was "really wrong." Alex described himself as physically strong and very healthy during childhood, and, with the exception of minor colds and episodes of influenza, this had been his only recurrent health problem.

As Alex entered young adulthood, he noticed that these episodes and their symptoms appeared to be getting worse and more frequent with time. At the age of 21, Alex had a similar episode, but this time it involved profuse vomiting, rectal bleeding, severe fatigue and weakness, and stomach pain, which he described as unbearable. Alex went to the emergency room and underwent surgery for a bowel obstruction. At that time, Alex was diagnosed with Crohn's Disease.

In the two years following his diagnosis, Alex had no major relapses. He followed all treatment recommendations, and his adherence to his prescribed medications was excellent. He graduated from college with honors and entered graduate school. However, during his graduate school training, his symptoms reemerged and, at the age of 23, he experienced another relapse.

Recent Psychosocial History

In addition to graduate school, Alex also enjoyed watching movies, working on computers, going out with friends, and dating. Alex had no history of psychiatric problems and had never received counseling or psychotherapy. Until his recent relapse, Alex had been coping very well with having Crohn's disease.

Given that he had worked so hard to maintain healthy GI functioning and given that it occurred approximately two weeks before final exams, Alex had much more difficulty adjusting to this relapse than he did to his initial diagnosis two years prior. He was shocked and angered by the relapse, and had some significant concerns about the potential effects of his worsening health on his academic performance. His physician explained that it is not unusual for second obstructions to occur following a surgery because scar tissue develops and the disease simply relocates itself to the next available part of the bowel.

This explanation only made Alex feel demoralized and less hopeful about his future. Alex had once read that some individuals with Crohn's disease that progresses into the large intestine are forced to have their entire large intestine removed and have to wear a colostomy bag. Alex worried about this possibility and was also concerned that he would not be able to fulfill his dreams, which included graduating from social work school, finding a partner that would accept him, and possibly starting a family. Because his intestine was not yet completely obstructed and his symptoms and pain were not as severe as they had been, Alex had some time to buy before the date of his surgery.

Background Information

Alex is the only child of working-class parents. His father had a high-school education and worked full-time in a meat packing company. His mother also had a high-school education and worked part-time as a waitress. Alex grew up in a small rural community. Alex's uncle, who took over the family farm after the early death of Alex's grandfather, lived in a neighboring town. While Alex was growing up, he and his parents often helped his uncle on the farm, particularly during harvest time. Alex's parents had always valued education, and they encouraged him to attend college. Alex described his father as "strict," his mother as "a worrier," and his uncle as "a workaholic." He also mentioned that "otherwise they're pretty normal."

Alex had a history of average to above-average performance in school, was skilled at fixing computers, and was an avid reader. In addition, Alex enjoyed being with people, was very comfortable in social situations, and had a large network consisting of close friends, friends from graduate school, neighbors, and other acquaintances. He decided that he wanted to become a medical social worker following his diagnosis with Crohn's disease.

Reason for Referral: Gastrointestinal Problems

Alex's graduate school advisor recommended that he seek psychotherapy for two reasons:

- She was aware of Alex's recent health difficulties
- It was becoming clear to her that Alex was struggling to maintain his grades and was becoming increasingly preoccupied about his overall performance within the training program

Although Alex was receptive to his advisor's recommendation, he requested that she refer him to someone skilled in short-term therapy. He reported that he did not wish to enter a long-term therapy relationship at this time because he was concerned that he would not have enough time to address his concerns before finals week and before his surgery. Due to the nature of his request, his advisor referred him to a therapist specializing in cognitive behavioral therapy.

Conclusion

This chapter introduced four individuals who will be featured as case examples throughout this book. Information about each client's health and psychosocial history was presented, and the reason for referral for cognitive behavioral therapy was provided. Additional information about each case (including psychiatric diagnosis, cognitive behavioral therapy assessment findings, and information about the course and outcomes of therapy) will be presented later in the book. Throughout this first section the cases will be used to illustrate various aspects of the cognitive behavioral therapy process. In Section Two the cases will be used to illustrate use of related knowledge. The cases will be concluded with outcomes in Section Three.

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Overview of Cognitive Behavioral Therapy

When an individual is initially diagnosed with a chronic illness or acquires a new impairment, a number of very realistic concerns and fears may rapidly come to mind. These include worry about physical pain (Will I be able to endure this pain?) overall quality of life (Will I ever be able to eat what I like again? How will this affect my sex life?), and mortality (Am I going to die?). There may be apprehensiveness about the perceptions and opinions of others (What will people think when they see I am wearing a wig?) and desirability to others (Who would want to marry me now?). There may be economic concern (How will I pay for all the medical expenses?) and questions about how the condition will this affect his or her involvement in daily activities, roles, and responsibilities (Will I be able to keep my job? What kind of a parent will I be?). An individual may also wonder how the condition will affect close friends, partners, or family members and worry about who will take care of dependent children or elders.

These are only a few of the many potential concerns that a person with a chronic condition might have. Cognitive behavioral therapy is an approach that can be used by psychotherapists and other medical and rehabilitation professionals to address such concerns. It can facilitate improved quality of life and adaptation for individuals with chronic conditions.

What is Cognitive-Behavioral Therapy?

A variety of approaches to therapy are generally considered to fall within the broader domain of cognitive behavioral therapy (Dobson and Dozios, 2001). These approaches share three assumptions:

- Cognition affects behavior
- Cognition can be monitored and altered
- Behavior change is mediated by cognitive change

Cognitive behavioral therapy always involves cognitive mediation of behavior as the fundamental core of treatment.

According to Dobson, (2001), cognitive behavioral therapies can be grouped under three broad categories:

- Coping skills methods
- Problem-solving methods
- Cognitive restructuring methods

These categories reflect differences in the degree of emphasis on cognitive versus behavioral change (Dobson and Dozios, 2001). A more comprehensive analysis of the nuanced differences between many approaches to cognitive behavioral therapy can be found in Dobson, (2001). This book reflects some degree of integration of all three of these approaches to cognitive behavioral therapy.

It is generally accepted that the different categories of therapy are best suited for different kinds of presenting problems (Dobson and Dozios, 2001). For example, the coping skills therapies are best applied to clients that are reacting to problems or situations occurring outside of themselves. These approaches focus on changing cognitions that serve to exacerbate the consequences of a negative event and on improving cognitive and behavioral approaches to coping with that event. Cognitive restructuring methods are best applied to problems emerging from within the psyche and thus require a more comprehensive and multilevel approach to cognitive change.

The theory and procedures of cognitive therapy (Beck, 1995; Beck, 1996) will be emphasized most centrally in this book. This approach emphasizes the way in which systematic errors in thinking and unrealistic cognitive appraisals of events can lead to negative emotions and maladaptive behaviors. Because this book also draws upon knowledge produced within the broader area of cognitive behavioral therapy, cognitive behavioral therapy will be the term that is used. Though at first glance cognitive behavioral approaches may be classified more narrowly as relying primarily on cognitive restructuring methods, recent applications to individuals with chronic conditions consider the necessity of working with realistic cognitions that occur as clients face adverse life circumstances (Moorey, 1996).

Cognitive behavioral therapy is a structured form of therapy guided by the cognitive model. The cognitive model proposes that dysfunctional thinking and unrealistic cognitive appraisals of certain life events can negatively influence feelings and behavior and that this process is reciprocal, generative of further cognitive impairment, and common to all psychological problems (Beck, 1985, 1991, 1995, 1999). Because this model will be emphasized and elaborated throughout the book, this chapter will limit itself to an overview of only the core concepts.

Core Concepts

As shown in Figure 1, the core of Beck's (1991, 1995, 1999) cognitive model incorporates a hierarchy involving three levels of cognition:

- Core beliefs
- Intermediate beliefs
- Automatic thoughts and images

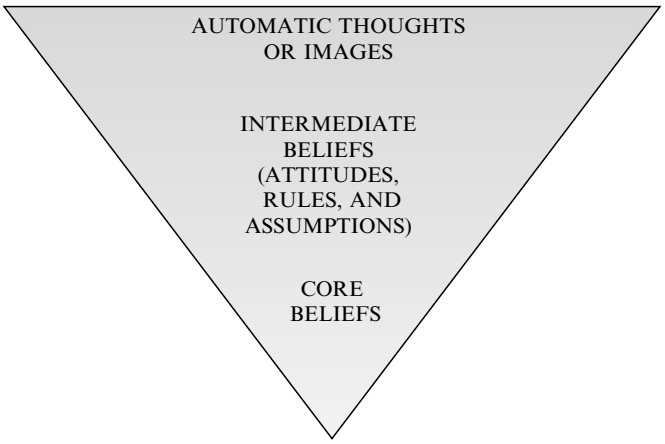

FIGURE 1. A Hierarchy of Three Levels of Cognition

Core beliefs are the most entrenched and inner level of beliefs. The core beliefs of well-adjusted individuals allow them to interpret, appraise, and respond to life events in realistic and adaptive ways. When dysfunctional, core beliefs represent distortions of reality and tend to be global, rigid, and overgeneralized (e.g., "I am a burden to others.") (Beck, 1995).

Intermediate beliefs are defined as often unarticulated attitudes, rules, expectations, or assumptions (conditional statements). The following are examples of intermediate beliefs:

- "Sick people are a burden."
- "No one wants to hear about another person's medical problems."
- "People get sick because they don't take care of themselves."
- "If I fail to follow any of my physician's recommendations, I'll be punished with a relapse."
- "I will be an example of the worst prognosis of this disease."
- "If I ignore my symptoms I won't be such a burden to others."

Importantly, intermediate beliefs influence an individual's view of a situation, and ultimately, his or her thinking, feelings, and behavior.

Automatic thoughts are defined as the most superficial level of cognition. The following are examples of a negative automatic thought:

- "I won't be able to get up today."
- "Those people were offended by my appearance."
- "That pain means I'm getting worse."
- "I can tell they will be relieved when I'm gone."

As the examples show, automatic thoughts are the actual sayings or images that go through one's mind in a given situation.

These three aspects of cognition are organized in terms of a hierarchy such that core beliefs drive intermediate beliefs and both ultimately manifest themselves in terms of automatic thoughts. Core beliefs serve to organize and process incoming information (Beck, 1991, 1996). Both core beliefs and intermediate beliefs arise as a result of people's attempts to interpret and make sense of their life experiences and environment. The way in which they approach this interpretation depends largely on the approaches to thinking they learned earlier in their development (Beck, 1995).

The Goal of Cognitive Behavioral Therapy

The goal of cognitive behavioral therapy is to teach a client to replace distorted thinking and unrealistic cognitive appraisals with more realistic and adaptive appraisals. The initial stages of therapy involve educating clients about the relationships between situational triggers, automatic thoughts, and emotional, behavioral, and physiological reactions according to the cognitive model (Beck, 1995).

The initial stages of therapy also involve creating homework assignments, behavioral experiments and learning experiences that teach clients to identify, monitor, and evaluate the validity of automatic thoughts. This generally leads to a degree of symptom relief. The later stages of therapy involve identifying and modifying the intermediate and core beliefs that underlie the automatic thoughts, cut across situations, and predispose individuals to engage in dysfunctional thinking. The final stages of therapy focus on relapse prevention and on empowering the client to function as his or her own therapist. Judith Beck (1995) has outlined 10 general principles that define the cognitive behavioral approach. These are summarized in Table 1. These principles and the corresponding specific techniques of cognitive behavioral therapy as they apply more uniquely to individuals with chronic conditions will be elaborated in subsequent chapters.

Why Cognitive Behavioral Therapy?

There are three general reasons why cognitive behavioral therapy is particularly useful for individuals with chronic conditions. These are that cognitive behavioral therapy

- Is useful for treating psychological symptoms that can accompany a chronic condition or become exacerbated as a result of stressors associated with the chronic experience of illness or impairment,
- Readily addresses the practical problems and unique challenges that clients with chronic conditions face, and
- Has substantial empirical support for its efficacy.

Each of these reasons is discussed below.

TABLE 1. Beck's general principles of cognitive behavioral therapy.

- Therapists construct an ongoing case conceptualization based on the cognitive model and make revisions to that conceptualization as more information becomes available.
- Therapists make multiple efforts to ensure a strong therapeutic relationship. This includes ongoing solicitation of feedback from the client about the relationship.
- Therapists expect collaboration and active participation on the part of the client.
- The therapeutic relationship is characterized by collaborative empiricism and guided discovery.
- Therapists emphasize structured approaches to goal setting based upon the enumeration of specific problems.
- In the initial stages of therapy, therapists emphasize problems occurring in present time.
- Therapists educate clients about their conditions and about the cognitive model in order to promote self-treatment and prevent relapses.
- Therapists and clients set goals regarding the overall length of treatment so that clients will bear in mind that treatment is generally time-limited.
- Therapists ensure that sessions are structured and that they include a specific agenda.
- Clients learn to identify, evaluate, and respond to dysfunctional cognitions through Socratic questioning.
- Therapists are permitted to utilize techniques from other orientations

Solving Practical Problems and Psychological Symptoms

In addition to treating undiagnosed psychiatric disorders or isolated symptoms of anxiety or depression, cognitive behavioral therapy can serve a number of other important functions for clients with chronic conditions (White 2001). Cognitive behavioral therapy can address a number of practical issues faced by a client and his or her health care professionals. These include, but are not limited to, the ten uses presented in Table 2.

TABLE 2. Ten reasons to use cognitive behavioral therapy for clients with chronic conditions.

- Facilitate compliance with medical treatments
- Provide emotional support and stability to a newly diagnosed client in crisis
- Prevent or reduce behaviors that have negative consequences for a client's health (eating disorders, overactivity or underactivity, smoking, substance abuse)
- Increase clients' access to social, economic, and physical resources
- Empower clients to take responsibility for their own health care and decrease reliance on medical providers and family members for care
- Facilitate a sense of perceived control over symptoms and teach clients to become their own therapist
- Provide clients with health-related education and a framework within which to make decisions about treatment options
- Improve health status and immune functioning through stress management
- Address nonspecific symptoms of chronic conditions that are often difficult to manage and treat with medication or other medical treatments alone
- Reduce a client's overall health expenditures due to anxiety-related somatic symptoms or misinterpretation of minor symptoms as serious problems, overutilization of medication, and excessive doctor-shopping

Addressing Unique Challenges of Psychotherapy with Clients with Chronic Conditions and Impairments

The practice of psychotherapy with individuals with chronic conditions presents unique challenges that are not always encountered in general psychotherapy practice with individuals without chronic conditions (Guthrie, 1996). The inevitable stressors and losses associated with chronic illness are invariably linked to a heightened intensity and wider range of psychological symptoms and emotional reactions to everyday stressors. Clients with chronic illness may also be more likely to present in states of crisis and can present existential issues that involve suicide or other issues associated with death and dying.

In many cases, clinicians are presented with ambiguity regarding issues involving differential diagnosis and the origin of symptoms. For example, anxiety and depressive disorders are sometimes difficult to identify in individuals with chronic conditions given the significant amount of overlap between physical symptoms that may be common to both disorders. Symptoms such as low self-worth, depressed or anxious mood, hopelessness, suicidal ideation, and adhedonia can serve as key discriminators between psychological and physical conditions. Identifying cognitive errors, such as catastrophic thinking about a nonterminal chronic condition that does not warrant this kind of thinking, can also serve as an important discriminator.

Another challenge involves difficulties differentiating between somatic presentations of psychological symptoms and the actual physical disorder itself. Still other challenges may involve alterations in the way clients are referred for therapy, changes to the length of sessions, and new settings in which psychotherapy takes place. There may also need to be adjustments to the pace of psychotherapy based upon client stress levels and reactions to the change process.

One of the most significant of these challenges involves achieving an accurate understanding of the client's physical, emotional, and cognitive experience of chronic illness and the ongoing synergies between them. Cognitive assessments and other more informal approaches to ongoing evaluation, such as Socratic questioning, serve an integral aspect of cognitive behavioral therapy. The heavy reliance on ongoing assessment in cognitive behavioral approaches is ideal for clients with chronic conditions because assessments offer a direct and highly structured means of ongoing monitoring of cognitions, affective experience, physical symptoms, and behaviors. This not only facilitates clients' awareness of the cognitive model, or conceptualization of their problem, but it also leads to self-monitoring and self-management of symptoms.

Empirical Support

Other reasons for using cognitive behavioral therapy to treat individuals with chronic conditions include the fact that it has the most empirical support, and is arguably the psychotherapy of choice, for many chronic illnesses, including HIV/AIDS, cancer, rheumatoid arthritis and other chronic pain disorders, insomnia,

gastrointestinal disorders, and chronic fatigue syndrome (White, 2001). A growing number of research studies point to positive outcomes of cognitive behavioral approaches that involve reductions in symptom severity and improvements in self-efficacy, physical functioning, and quality of life (e.g., Antoni et al., 2001; Haddock et al., 2003; Lorig, Manzonson, and Holman, 1993)

Why Include Related Knowledge along with Cognitive Behavioral Therapy?

Although the primary focus of this text is on the use of cognitive behavioral theory and approaches, it will include the use of other "related" knowledge and approaches. An increasing number of studies have shown that cognitive behavioral therapy is in an ideal position to be the therapy of choice to treat individuals with a wide range of chronic conditions. However, like all approaches, cognitive behavioral approaches in general do have limitations (Beck, 1996). These limitations may be more pronounced when considering chronic conditions that often involve complex symptom pictures that include both physical and psychological components.

One of the main strengths of the cognitive behavioral approach is that it allows for the incorporation of techniques from other orientations. Related knowledge and therapeutic strategies offered by other orientations can serve to strengthen, supplement, and add to existing cognitive behavioral techniques in the treatment of individuals with chronic conditions. In this book, three areas of related knowledge will be highlighted as offering certain perspectives and therapeutic strategies not emphasized in traditional approaches to cognitive behavioral therapy. These include the emphasis on empathy offered by self psychology (Kohut, 1971, 1977, 1984), the emphasis on hope offered by the positive psychology movement (Seligman and Csikszentmihalyi, 2000), and the emphasis on volition offered by the model of human occupation (Kielhofner, 2002).