Fear of Recurrence: A Case Report of a Woman Breast Cancer Survivor with GAD Treated Successfully by CBT

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General anxiety disorder (GAD) characterized by persistent, excessive and unrealistic worry about everyday things can affect everybody, including cancer patient survivor.

In this paper, we present a case report of a breast cancer survivor with GAD treated by cognitive–behavioural therapy (CBT), who was excessively worried about recurrence of the disease 2 years after the end of any treatment.

Cognitive reframing, associated to behavioural exposure and relaxation, were used in order to treat this woman. We describe precisely how the therapy was conducted.

Results showed a substantial improvement of the fear of recurrence which ‘naturally’ extended to other stressful situations not worked during the therapy.

Actually, these results are encouraging since it showed that CBT can be efficient in complicated situation involving survivor of a serious disease like cancer who additionally suffers from an anxiety disorder. It also underlines how it is important to be concerned by the distress of cancer survivors. Copyright © 2010 John Wiley & Sons, Ltd.

Key Practitioner Message:
• Fear of recurrence is a real problem for cancer’s survivors.
• Cancer’s survivors affected by psychic disorders need a special psychological assistance.
• CBT prove to be efficient with these patients.

Keywords: Cancer Survivor, CBT, Fear of Recurrence, GAD

INTRODUCTION

Generalized anxiety disorder (GAD) is characterized by persistent, excessive and unrealistic worry about everyday things. People with the disorder, which is also referred to as GAD, feel that worrying is beyond their control and they are powerless to stop it. They often expect the worst, even when there is no apparent reason for concern. This anxiety or worry occurs for at least 6 months. Exaggerated and unrelenting worry often centres on issues of health, family, money or work, and it can interfere with all aspects of a person’s life (APA, 2000).

Several models have been proposed to explain the cognitive process in GAD (e.g. the intolerance of uncertainty model: Dugas, Gagnon, Ladouceur, & Freeston, 1998; Dugas, Letarte, Rheauame, Freeston, & Ladouceur, 1995; Ladouceur, Talbot, & Dugas,

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1997; the emotion dysregulation model: Mennin et al., 2002). The metacognitive model (Wells, 1995, 1997) is remarkable enough. In this model, worry is viewed not only as a symptomatic consequence of anxiety, but also as an active coping with threat driven by metacognitive beliefs. In this perspective, worry is used to cope with anticipated danger or threat. When a trigger (image, thought) is encountered, positive metacognitive beliefs (e.g. ‘Worrying is useful to me since it helps me to cope’) lead the subject to continue to worry until it meets its goals of generating acceptable coping responses. It is what the author calls Type 1 worrying. But when negative beliefs (e.g. ‘Worry may have an effect on my health’) appear pathological, worrying characteristics of GAD are also present. Then, the subject with GAD believes that the worry is uncontrollable and potentially dangerous. Such negative appraisal is called Type 2 worry or metaworry. It leads to an escalation of anxiety so that subject experience need to worry in order to feel that he is able to cope. The dissonance between positive and negative beliefs can be deleted by avoiding triggers for worrying precocely (e.g. behavioural avoidance, reassurance seeking). But these responses prevent the subject to experience that worrying can be controlled, and that is harmless.

So what happen when GAD meet a serious disease like cancer? During the active phase of the disease, GAD patients may fear that no one will care for them even though they have adequate and willing social support, or that the disease outcome will be wrong despite the optimism of the physicians. Several years after, patients with GAD may be excessively worried about a potential recurrence of the disease. Many studies on cancer survivors showed that concerns and worries are still present after treatments and may be persistent (Constanzo et al., 2007; Kornblith & Ligibel, 2003; Lampic et al., 1994; Thomas, Glynne-Jones, Chait, & Marks, 1997) whatever the culture or gender (Matthews, 2003; Thompson, Littles, Jacob, & Coker, 2006).

Earle, Neville, and Fletcher (2007) matched 1111 survivors to 4444 controls. Cancer survivors were more likely than controls to have a mental health diagnosis, accounted for mostly by anxiety and sleep disorders. Survivors had more outpatient medical visits in general and specifically more mental health visits than did controls.

van den Beuken-van Everdingen et al. (2009) measured the prevalence of concerns about disease recurrence in former breast cancer patients and identified potential predictors. More than half (56%) of former breast cancer patients indicated moderate to severe concerns about disease recurrence. Health and death worries were the most prominent.

However, concerns and worries tend to decrease with the time (Lampic et al., 1994). Moreover, even though this fear of recurrence is not exceptional in most of cancer survivors (Lee-Jones & Dixon, 1997), it is easy to imagine how cancer survivors who suffer with GAD are even more vulnerable to this kind of fear. Excessive anxiety may produce increased vigilance to somatic sensations resulting in false positives, the identification of a symptom that is unrelated to the disease (Salkovskis, 1989).

Cognitive behaviour therapy (CBT) proved to be especially efficient in the treatment of GAD (Khele, 2008; Norton & Price, 2007). Osborn, Demoncada, and Feuerstein (2006) showed that CBT was also effective for anxiety of cancer survivors.

Moorey and Greer (1989, 2002) put forward the importance of adjuvant psychological and cognitive therapy for cancer patients to promote the expression of negative emotions and a fighting spirit. The intervention program developed by these authors is based on CBT framework and is applicable at every stages of the illness. This model illustrates the interaction between thoughts, emotions, physical manifestations of emotions and associated behaviours. The premise is that it is not the illness itself that produces the emotional response, but the meaning of the illness for the person involved.

Actually, into psychotherapy, it is important to take account of illness beliefs and representations. Indeed, in accordance with Leventhal, Meyer, and Nerenz’s common sense model of illness (1980), a person’s fear of recurrence will vary depending on their illness representation.

In this paper, we present a case report of a breast cancer survivor with GAD treated by CBT, who was excessively worried about recurrence of the cancer 2 years after the end of any treatment.

CASE REPORT

Subject Description

Ms X is a woman of 60 years. She has been diagnosed with a breast cancer more than 2 years ago. She underwent a lumpectomy followed by radiotherapy. Now, she is under medical supervision since the end of the radiotherapy. She has medical exam about every 6 months. All the medical exams
She took the decision to consult a psychologist under the advice of her physicians and her family who observed that Ms X was more and more anxious.

The diagnosis made on the basis of the DSM-IV-TR (APA, 2000) confirmed the presence of a GAD, a trouble which was likely ancient in the life of Ms X. Indeed, Ms X presented for several years, a persistent, excessive and unrealistic worry about everyday things. This worry was source of impairment in her everyday life even though Ms X learnt to use her own coping strategies to cope with this trouble. However, since the beginning of her cancer, and more especially since the end of her treatment, Ms X felt that her anxiety increased and was more focused on the potential recurrence of cancer. Indeed, Ms X reported more and more ruminations about recurrence and potential consequences in her life. Of course, the fear of death was showing just beneath the surface. She recognized having more and more difficulties to cope with the uncertainty.

No specific event was reported by Ms X as related to the beginning of the GAD. However, the end of the treatment seemed to be a critical period for her GAD evolution.

When we have met Ms X the first time, she was married and had two children who live their own life. She was retired. Her family was evoked by Ms X as supportive materially and emotionally.

Ms X did not present any psychiatric history except anxiety disorders (claustrophobia and GAD). She used to take bromazepam (anxiolytic) one-fourth daily.

The conceptualization of this complex case is presented in Figure 1.

**Description of the Therapy**

The therapy included 15 seances of 30–45 minutes. After having explained the aim of a CBT, the first sénances were devoted to the establishment of the diagnosis and to the choice of the problem on which we will work. During these first seances, we took some times to investigate the illness beliefs of Ms X. Then, Ms X chose to work primarily on her fear of recurrence which impaired her daily life very much.

We gave to Ms X some information about GAD. We helped her to understand the relationship between this trouble and her fear of recurrence. We used a diagram in order to explain to Ms X the interaction existing between emotion, cognition and behaviour. We also explain to Ms X the interest to do between each seance the homework that we will prescribe to her. Indeed, it reinforces what is acquired during the therapy. Ms X also benefited during the CBT from several seances of relaxation (including imagery) and was able to practise this technique at home. We encouraged Ms X to use relaxation as soon as she felt that the first signs of anxiety occur.

The main technique used during this therapy was cognitive reframing. According to Beck (1975), the problem is with one’s thinking. Most often, an anxious patient has distorted/maladaptive/
dysfunctional/irrational thinking. He tends to anticipate the worst. The objective of the cognitive reframing is to help patient to conform his/her thinking to reality. The main assumption of this technique is that we can be taught to thinking differently. If we think differently, we will feel better. In order to help Ms X to better identify the stressing situations, emotions, beliefs and behaviour, we used the technique of Beck which consists to fill a table with several column including the problem’s situation and the emotion, belief and behaviour associated. Between each seances of CBT, Ms X had to fill this table. It allowed us to have some material to work during the therapy. We tried to show to Ms X how to put a new ‘frame’ around a thought. She had to understand that different frames can draw out different aspects of a picture. Our aim was to give her the ability to view a situation differently without deny the reality of the situation. As a result, she will be helped to improve her ability to cope.

Given the changes of her way of thinking after some seances, we used behavioural technique (exposure) in order to confront Ms X to what she fears (Figure 2).

Evaluation of the Therapy

In order to appreciate the efficacy of our intervention, we used several self-report questionnaires. The State-Trait Anxiety Inventory (STAI) afforded us to assess anxiety. The STAI Form Y serves as an indicator of two types of anxiety, the state and trait anxiety, and measure the severity of the overall anxiety level. The STAI Form Y is an administered analysis of reported anxiety symptoms. The first subscale measures state anxiety, the second measures trait anxiety. The range of scores is 20–80, the higher the score indicating greater anxiety (Spielberger, Gorsuch, & Lushene, 1970). Some of the questions relate to the absence of anxiety, and are reverse scored. Results of the STAI can be used in the formulation of a clinical diagnosis; to help differentiate anxiety from depression. Its validity and reliability have been well established (Spielberger et al., 1970, Spielberger, Reheiser, Ritterband, Sydeman, & Unger, 1995).

The Hospital Anxiety and Depression (HAD) rating scale (Zigmond & Snaithe, 1983) was used to assess depression and anxiety. This scale enclose two different subscales of seven items each, one for depression and one another for anxiety. The sum of these two subscales corresponds to a total score. It has been established as a much-applied and convenient self-rating instrument for anxiety and depression in patients with both somatic and mental problems, and with equally good sensitivity and specificity as other commonly used self-rating screening instruments (Bjelland et al., 2002; Herrmann, 1997). Moreover, it has been validated in cancer populations (Moorey, Greer, & Watson, 1991; Razavi, Delvaux, & Farvacques, 1990). The Penn State Worry Questionnaire (PSWQ) (Meyer, Miller, Metzger, & Borkovec, 1990) assessed worries and is particularly relevant for the GAD. In scoring the PSWQ, a value of 1, 2, 3, 4 and 5 is assigned to a response depending upon whether the item is worded positively or negatively. The total score of the scale ranges from 16 to 80.

RESULTS

Rapidly during the therapy, the fear of recurrence took a more subtle form. The belief that the least symptom would announce the recurrence of the disease stopped to be replaced by the belief that the least stressful situation could have an effect on her emotion, and then, could trigger the recurrence of the cancer. Thus, Ms X tended to avoid any situations that she perceived as risky. Therefore, we decided to use behavioural technique of exposure by confronting Ms X to the situations she feared. We encouraged her to keep contact with
the member of her family with whom she had a conflict. She applied our counsel by continuing to take care of this person (e.g. she accompanied her to the doctor) and by continuing to invite her at home despite the stress induced. This early intervention prevents Ms X to fall into the trap of the avoidance which generally reinforces the disorder. By confronting herself to the stressful situation, its coping abilities were reinforced, and she could observe that the stress decreased through the time. Table 1 gives some examples of the beliefs of Ms X at the beginning of the CBT, then during the therapy. We can observe the change of her beliefs with the time.

Figures 3 and 4 display the level of anxiety and depression of Ms X before and at the end of the CBT. As it is showed in Figure 3, the improvement was especially observable on trait anxiety, which is logical for a patient with a GAD. The decrease of the score of anxiety was remarkable since it was of 36% on the STAI-B (trait anxiety) and of 80% on the HAD-anxiety subscale. As we can see on Figure 4, the level of depression is low before and at the end of the CBT.

The score of Ms X’s worries decreased substantially from 42 to 30 points (29%) on PSWQ as we can observe in Figure 5.

We also want to underline that, as the PSWQ showed it, even though the fear of recurrence was present more than ever at the beginning of the therapy, the worries of Ms X extended to many other situations (e.g. worries about her children,
about her sister who did not give news for a long time, about works into her home . . .). However, we tried to focus our therapy on a single situation chosen by Ms X: the fear of recurrence. Interestingly, we noticed an extension of the benefit of the CBT to many other situations of Ms X’s life. Indeed, the decrease on the PSWQ score revealed this extension.

Actually, out of questionnaires scoring, Ms X described a large benefit of our intervention in her daily life.

DISCUSSION

According to previous works (Dugas et al., 1995, 1998; Ladouceur et al., 1997), we noticed that Ms X overestimated the usefulness of worry and that she was unable to tolerate uncertainty. When confronted to negative beliefs she tended to avoid very much (Wells, 1995, 1997). The CBT helped her to re-evaluate her beliefs and to tolerate emotions associated to situations she feared. She learnt to develop other more functional coping strategies than the one which consist to worry and to avoid.

The extension of the benefit of the CBT on situations not worked during the treatment has already been observed in other anxiety disorders like phobia (Montel, 2009; Montel & Leduc, 2008). It seems that people who benefit from CBT learn useful techniques to cope with different situations more or less close one another. It is a form of ‘unconscious learning’ which likely refers to the procedural memory. Thus, after several seances of CBT, Ms X was able to say that most of situations, even though stressing, are controllable.

We would like to underline the importance of the relaxation therapy associated to the CBT in the improvement of Ms X’s anxiety level (Borkovec & Costello, 1993; Norton & Price, 2007). Indeed, the ability to get relaxed when symptoms of anxiety occur, gives the patient the confidence that he/she is able to cope with stressing situations.

Finally, behavioural exposure to situations that the patient fears is absolutely essential, in order to, first, prevent behavioural and cognitive avoidance, and second, be conscious of his/her cognitive distortions about the situations.
More than 6 months after the therapy, Ms X does not feel the need of a psychological assistance anymore. Now, Ms X comes to the hospital only for control exam which is an adding proof of her mental well-being.

Actually, these case report results are encouraging since it showed that CBT can be efficient in complicated situation involving cancer survivors who additionally suffer from an anxiety disorder. It also underlines how it is important to be concerned by the distress of cancer survivors.

REFERENCES


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