

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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Question Authority

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In our training to be medical professionals, we are all taught some basic rules and regulations to guide our decision-making. We are told to maintain confidentiality, to respect boundaries, to maintain optimism, to mobilize hope.

For the doctor in primary care, the advantages of treating several members of the same family are often stressed. For the psychiatrist, there is, instead, a caution against treating members of the same family. This practice is thought to endanger the relationship between therapist and patient.

There are circumstances in which this warning is wisely observed. After all, each statement made by my patient that I choose to retain is "placed in a box" in my brain. Often, my responses to that patient utilize material from that box. How easy it must be to use material from (for example) the husband's box in responding to the wife when each is your patient. The result is an unwarranted breach of confidentiality that may sabotage therapeutic success.

At times, however, this prohibition is an oversimplification. Understanding the spouse may be facilitated by having treated the partner. "My husband needs to consult a therapist," I was told by a female patient many years ago. "I talk with him after each of our sessions, and now that he is motivated for therapy, he says he will see only you. He feels like he knows you, although you've never met. He says you're like a member of the family to him."

I agreed to see her husband, and his therapy was brief and successful. It helped me to keep an open mind about the possibility of treating 2 members of the same family separately. When I teach psychiatric residents about the do's and don'ts of psychotherapy, I repeat this caution: it is often wise to treat only 1 member in a family and refer any others who present for treatment. Then, I will add: however, you may learn over time that each situation needs to be decided on its merits, and there is often an advantage conferred by working with that second family member.

CASE PRESENTATION

I met Carolyn 7 years ago. She had consulted multiple therapists over many years, both senior clinicians and residents in training. She carried an impressive load of psychiatric diagnoses, from early adolescence to midlife. These included obsessive-compulsive disorder (OCD) and panic disorder, when she was young, then generalized anxiety disorder and major depression, as she aged. She was married for the second time. She had a grown daughter by her first husband. A high school graduate, she never finished college and never established a career.

She took multiple psychoactive medications, with none established as consistently helpful. Once we met, I became her only treating psychiatrist. However, I saw her only periodically, typically for several months at a time. My treatment invested heavily in a continuing relationship, proposed many successive medication trials, and emphasized teaching Carolyn the cognitive therapy approach.

I considered diagnoses of borderline personality disorder and bipolar disorder, but she never met criteria for either one. She had never been an inpatient in a psychiatric hospital. Periodically, she spoke about her relationship with her passive, depressed second husband, emphasizing her marital dissatisfaction. It was clear that each had problems to resolve, and her husband had been in treatment with a variety of therapists.

As we approached our seventh year of knowing each other, she lamented one day about how her husband, Donald, was getting little benefit from his treatment. His continuing depression was weighing heavily on her mind. I responded with an expression of my willingness to evaluate him, and even treat him, if that seemed desirable to her.

Donald came to my office alone, seemingly relieved to be invited and pleased to shake my hand. He described a lifelong experience of depression and anxiety, few friends, a recent significant weight gain, few interests, and a strikingly low self-valuation. Intellectually, he had done well in high school and college, despite a difficult home life, but established no clear career path. There was no history of alcoholism or drug abuse.

He expressed motivation to learn the principles of cognitive therapy, believing that this had helped his wife far more than any medication. Despite multiple medication treatments, he was willing to try another medication as well. My diagnoses for Donald were major depressive disorder, generalized anxiety disorder, and dysthymic disorder.

PSYCHOTHERAPY

We agreed on a contract for brief cognitive therapy. He reported that his current job was “demoralizing, degrading, and disheartening.” After I taught him the cognitive model, his work became our initial focus. Side effects defeated my first choice of an antidepressant drug, and a second trial was begun. We applied the cognitive framework of identifying meanings, choices, and their conse-

quences to his marital relationship as well as to his work. He quickly adopted the model and discussed his applications of it with me.

By 1 month later, there was evidence of clearing of his depressive symptoms and likely medication response. He was, concurrently, working hard at keeping his focus on his responsibility and options, rather than the force of others’ comments to him, both at home and at work. He began to actively apply for a new job. He reported real progress in his relationship with his wife. He began to free himself from a powerful need for approval, both at home and at work.

One month later, he was offered 2 jobs and chose the one more desirable to him. At home, he offered that his options were dominated by his wife’s needs. We began to identify potential pleasurable activities for him. He felt like he had made unexpected progress in 9 visits over a 3-month period. He reported that his wife was more afflicted now with symptoms of OCD and depression. We planned on a series of monthly follow-up visits for him, and I suggested that he tell his wife to call me for an appointment.

Three subsequent monthly visits provided evidence to confirm the changes Donald had made. Meanwhile, Carolyn began her return visit to my office by expressing how pleased she was with Donald’s progress. She proceeded to “dive into” a highly motivated phase of cognitive work aimed at reestablishing her equilibrium.

I continue to treat Carolyn every 2 weeks. She continues to make excellent use of our relationship (which appears to have been *augmented* by her husband’s success with me), cognitive therapy, and a return to a formerly useful medication.

Donald wishes to have a continuation of monthly “check-in” follow-up appointments for now. Carolyn is progressing well. Some days, I feel more like a doctor in primary care than a psychiatrist. The flexibility of being willing to see 2 members of the same family separately seems to me to have been right on target this time. ♦