A Marriage Between Pharmacotherapy and Psychotherapy

Marc E. Dalton, M.D., M.P.H., and Dean Schuyler, M.D.

With the recent trend toward biological management of psychiatric disorders, it is a good assumption that primary care physicians today are familiar with the medications now available for the treatment of emotional disorders. The value of a referral for brief psychotherapy as an adjunct to pharmacotherapy seems less often appreciated in primary care settings than in psychiatric settings. This mind-set may be a result of successful product marketing by pharmaceutical companies, along with inadequate training of providers in the utility of psychotherapy and its indications. The following case presentation illustrates how a combination of pharmacotherapy and cognitive therapy allowed a patient with a major psychiatric disorder not only to stabilize his mood, but also to take better control of his life by allowing him to become "thought observant." Psychotherapy was empowering for this patient, facilitating his finding a self-definition other than that provided by his disorder.

PRESENTATION OF THE PROBLEM

Mr. K is a 25-year-old Asian American male who recently completed a graduate degree in public policy. He was self-referred to one of us (M.E.D.) at the Medical University of South Carolina Residents Clinic for management of a previously diagnosed bipolar affective disorder (manic-depression). He had just relocated to be closer to his family following an episode of depression that had required hospital treatment. Mr. K reported a lengthy period of stability in which he was maintained on lithium carbonate, 600 mg/day, and sertraline, 25 mg/day, for approximately 5 years. When he consulted a new family physician, it was recommended that he try a newer mood-stabilizing agent for the management of his symptoms. During that trial, his depressive symptoms reemerged: decreased mood, lost energy, and diminished appetite. He stated that his sleep cycle became markedly erratic, and suicidal ideation appeared. No manic symptoms preceded the episode of depression; however, he did report having had 2 episodes of mania in the past, neither of which resulted in a hospitalization.

At the time of Mr. K's intake evaluation, which was approximately 2 weeks following his hospitalization, he reported depressed mood, decreased energy, and trouble sleeping. He also stated that he felt anxious, confused, and that his thinking was "clouded." He was "sleepy all the time." He denied any symptoms of mania or panic anxiety, obsessive thoughts or compulsions, or substance abuse. He wanted some clarification regarding his medication regimen. Our initial encounter revealed that he had not benefited from the change in medication and had a desire to return to his previous regimen.

Mr. K also exhibited low self-esteem and had come to view the world in an "all-or-none" fashion. He had come to the conclusion that he would not be able to have a successful relationship with a woman and would probably not be able to hold down a respectable job. He worried about becoming dependent on his family. He began to feel more frustrated and guilty about having to rely on them for financial support.

My diagnosis was bipolar affective disorder, type I, currently depressed. A second visit was scheduled for 1 week later to continue information gathering and explore further treatment options.

PHARMACOTHERAPY

By the end of our second visit, it was decided to add sertraline, 25 mg/day, to his treatment regimen and to titrate lithium upward, while tapering the extended-release mood stabilizer. A Beck Depression Inventory (BDI) score of 24 was suggestive of a current depressive state. Our third meeting took place approximately 3 weeks after Mr. K had returned to his original treatment regimen. His serum lithium level was in the therapeutic range. Additional tests ruled out other possible causes of depression, including thyroid abnormalities and anemia. A second BDI score was recorded as 0. Mr. K noted that

his thinking was no longer clouded. He stated that he felt better, but still did not feel as if he had the confidence to proceed with his life. This "loss of effectiveness" commonly accompanies depression, is not generally responsive to medication, and has been called demoralization. Psychotherapy was presented once again as an adjunctive option for this patient.

PSYCHOTHERAPY

While listening to Mr. K's thought patterns during our second session to establish a plan for medication management, I became aware of cognitive distortions (not to be confused with psychosis). It became evident to me that his erroneous thought patterns might be contributing to his demoralized state, thereby preventing him from achieving his future goals. When I introduced the idea of cognitive therapy as a treatment option for him, he stated that he had tried psychotherapy in the past. He described a nondirective approach in the tradition of psychoanalytic psychotherapy. I explained how dynamic therapy explored the past as a way to identify established patterns of thought with the hope of recognizing symptom origins and initiating change. I contrasted this with cognitive therapy, which focuses instead on meanings in the present and teaches the patient to examine his thoughts and choose ways to think that facilitate achieving stated goals. Mr. K stated that he had never thought about psychotherapy in that way, but agreed to try.

In session 3, I presented Mr. K with the triple column model (situations, feelings, and thoughts) of examining a problem. He learned the method after 2 or 3 examples of everyday situations, which I chose from my daily life, such as not performing well on a test. After these examples, we applied the method to some of his current life concerns. He discussed meeting a woman at work that he was interested in dating. He had recently acquired a part-time job at a local art gallery in order to feel more productive during his day. He believed that having a mental illness would prevent him from having a meaningful relationship with her. He was convinced that, for him, dating would be associated with failure.

Mr. K discounted the fact that his last relationship had lasted for approximately 3 years. Further, he generalized his pessimism to include an inability to maintain health in all areas of his life. He felt he was "doing nothing with his life." This formulation ignored how he had recently completed graduate school, had taken control of his illness, and had acquired a job. We prepared several triple columns and examined his cognitive errors. These included discounting (an inability to accept positive feedback), overgeneralizing (reaching a conclusion not supported by the data), and catastrophizing (believing that the worst possible outcome was the most likely to occur). Mr. K expressed surprise that he could actually think himself into a state of feeling depressed about himself.

During our fourth and fifth sessions, the patient demonstrated that he had mastered the technique of identifying key meanings so well that we no longer used the structure of the triple column. Mr. K defined situations, I pointed out cognitive errors, and we challenged them together. During the fourth session, I learned that Mr. K had established a relationship with a female colleague at work. We discussed an episode in which he had not heard from her in approximately a week and how he had felt depressed. We identified his cognitive errors, specifically mind reading (jumping to conclusions) and catastrophizing. He believed that she had lost interest in him because he had discussed his illness with her. We explored possible outcomes, both good and bad. We discussed how he had associated the outcome of this relationship to his thinking about himself and the depressive feelings that followed. This session allowed us to consider that, although bad things do happen, personalizing events can result in guilt and blame that often are misplaced. He returned for session 5 to proclaim that he had learned that his fears were unfounded, establishing some data he could use subsequently to challenge the anticipated consequences of his cognitive errors.

By sessions 6 and 7, Mr. K was able to talk freely with me and often catch his own cognitive errors. He subsequently obtained a better job working as a public relations officer for a local events management company. He acknowledged that at times he had the tendency to revert to prior ways of thinking. I assured him that we all have automatic thoughts that may not facilitate our reaching our goals. I explained to him that the key is to become "thought observant" and not be trapped by our own erroneous thought patterns. During our eighth session, Mr. K stated that he had started a new relationship and noticed no visible signs of a psychiatric disorder. His thinking was no longer catastrophic in nature. He seemed energized by being in a new relationship, unencumbered by his previous beliefs.

In session 8, we decided to end the brief psychotherapy intervention and focus subsequent infrequent meetings on medication management. Our ninth appointment was set for 2 months later. Mr. K continued to manage his illness well, and he had become successful in his new job. Even-

tually, he decided to move to another area of the country to live on his own and follow his aspirations for a more lucrative job. We recalled together how this decision would have been impossible for him earlier. He stated the difference to him was being able to recognize how his thoughts influenced his mood. When we met for our final session, Mr. K was stable on his medications and anticipated the move with excitement.

It is possible that with medication management alone he might have achieved the same goals. However, the impact of empowering a person cannot be underestimated. A physician can eliminate many depressive symptoms by prescribing medication alone. Achieving desired life changes, however, may require the addition of brief psychotherapy. Hence, the coupling of pharmacotherapy and psychotherapy in such instances makes sense.

Editor's note: Dr. Dalton is presently taking child psychiatry fellowship training at Harvard University, following 3 years of adult psychiatry residency at the Medical University of South Carolina (MUSC) in Charleston, S.C. Dr. Schuyler's work combines teaching brief cognitive therapy with consultative work in a primary care clinic, both at MUSC.