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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# Collaborative Care

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It is in the treatment of the patient with disabling medical illness that the internist or the primary care doctor and the psychiatrist find their most critical common ground. After 25 years of adult psychiatry office practice, my relocation to Charleston, S.C., from Washington, D.C., introduced me to the doctors and patients of the Adult Primary Care Clinic. Many of these patients had multiple illnesses, took multiple medications, and often had adjustment issues that went unidentified. In this group, I found major depressions[1] and serious anxiety disorders[2,3] in addition to adjustment problems.[4]

After 6 years of service as an attached psychiatrist in a medical clinic, I left the university 18 months ago to start a part-time psychiatric practice. My hope was to encourage some referrals from the staff I had known and come to love and respect in the clinic. I didn't have to wait very long.

### CLINICAL PRESENTATION

I received a telephone call from my favorite internist, describing a patient of hers whom she was concerned about. Ms. A was a 55-year-old woman, married for 35 years with 2 grown sons. Management of brittle diabetes, peptic ulcer, asthma, hypertension, osteoarthritis, gastroesophageal reflux disease, and exogenous obesity had been an ongoing challenge. Her medical conditions were complicated by major depressive disorder, generalized anxiety disorder, and panic disorder. Each emotional disorder had been carefully diagnosed and was being treated by the internist. Now, however, the patient's diabetes was rarely controlled, hypertension was labile, reflux was bothersome, and her depression and panic attacks were unresponsive to medication and getting worse. The internist wanted to focus on medical management and hoped that I could take over the psychotropic drug prescription and treat the patient with cognitive therapy as well.

### PSYCHOTHERAPY

It emerged that Ms. A had been in a state of more or less stable chronicity until her mother and father had each died within a year, 3 years before. Always high-strung and nervous, Ms. A now became depressed and fearful and began having panic attacks. She had not been in favor of a psychiatric referral until the internist said one day, "Oh, he used to work with us, and I'm sure you'll like him."

At our intake appointment, Ms. A proved easy to engage and easy to like. My evaluation confirmed each of the internist's psychiatric diagnoses, and I proposed a plan to the patient that combined pharmacotherapy and psychotherapy. We would continue the antianxiety drug for now, but taper and discontinue both her antidepressant and sedative. There would be trials of a new drug to promote sleep and one for depression. I would teach her the cognitive model and explain how cognitive therapy might be useful to her. "The way you think about your medical

illnesses, how you see yourself and your future, have a great deal to do with your general well-being and how well you respond to medical treatment. Together, your internist and I will work with you to restore your quality of life," I said to her.

In session 2, we carefully reviewed the cognitive model, with blackboard drawings and explanations utilizing the history she had related. She worried that others would see her cry and was concerned about what they would think of her. She acknowledged each of her psychiatric problems. She had always been the family's pillar of strength. Now, her husband was overwhelmed by her tears.

One week later, she reported that sleeping came easier with the new medication. Crying continued but was "less frequent." She discussed fearing failure in her work for her church. She had significant anticipatory anxiety tied to an airplane flight for a friend's wedding in 2 months' time. She emphasized how difficult it was for her to concentrate on driving.

Session 4 came 2 weeks later. Ms. A reported doing better with the children in the nursery program she ran. Sleep was "no longer a problem." She worried about an upcoming trip that her son was planning to take. She talked about multiple "what-if's." I cautioned her to "stay on the page you're on," and we patiently examined each "what-if" belief for rationality and strategic worth. Ms. A defined her airplane anxiety as "fear of becoming confused" rather than fear of flying. We worked to specify her concerns and test her logic.

In session 5, Ms. A reported a visit with her internist, who told her she seemed "a lot better." Her diabetes was under control for the first time in many months, as was her blood pressure. Now, her appetite had returned, her energy was better, and she was doing "all the little things" she had stopped doing. She was markedly less anxious. She was now comfortable with both her travel plans and those of her son. Ms. A was significantly less withdrawn and reported calling several friends.

Our final visit took place 1 month later. Ms. A no longer met criteria for depression, or for generalized anxiety disorder. She had not had a panic attack in the previous 6 weeks. She felt "healthier" than she had since her parents died. She reported using a cognitive approach multiple times each day, when she felt her thinking was leading her astray.

I told Ms. A that our next visit would come at her initiative. I called the internist, and we "toasted" a successful collaboration. I remarked that it reminded me of the good old days when we worked together in the clinic.

## REFERENCES

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