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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Establishing a New Referral Route

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Throughout my academic career in psychiatry, I have been an unwavering advocate for the usefulness of brief psychotherapy. I have taught psychiatric residents to do brief cognitive therapy, encouraged the referral for brief therapy of medically ill patients in primary care, and written a manual explaining my clinical work.

By the onset of the 21st century in America, the face of psychiatry was changing. Although residents were still required to master the techniques of doing psychotherapy, a new category of psychiatrist had emerged: the medication manager. These specialists would receive referrals from primary care (as well as self-referred patients), do an evaluation, and then prescribe appropriate drug therapy during brief (15–30 minute) visits.

For me, this development provided a new referral link, analogous to baseball's double play. The patient's family physician would refer to the psychiatrist for medication management, and then the psychiatrist would send the patient on to me for cognitive therapy. Once the medication manager had a clear idea of the patients and problems amenable to brief therapy, this resulted in a new referral route for my practice.

CLINICAL PRESENTATION

Ms. J is a 50-year-old African American woman, never married, who has lived alone since graduating from college. In her early life, she was the chief caretaker for her 6 brothers and sisters, as her father died when she was young and her mother worked to support the family.

Diabetes, hypertension, and emphysema as she grew older made for frequent visits to her primary care physician. For many years, her depressed mood and general level of dissatisfaction took a backseat to the management of her medical problems and were eclipsed by her academic, and then professional, success. A career as a teacher was crowned by an opportunity to make education policy at the state level.

Two years ago, after discussing her depression with her doctor, she received 2 trials of antidepressant medication. When they were unsuccessful, a psychiatric referral followed. The medication-managing psychiatrist found a drug regimen that relieved Ms. J's emotional pain. She remained, however, quite negative in her self-view, anxious and pessimistic. He referred Ms. J to me for cognitive therapy.

PSYCHOTHERAPY

In our intake session, Ms. J described herself as "lost, and unclear about who I am." She said that she needed "to get my act together." On the recommendation of her psychiatrist, she had read my book on cognitive therapy. She was anxious to see if it could help her "get on track."

She had continued her role of caretaker into her adult life. Ms. J had played a significant role in the life of her mother before she died, her sisters and brothers as they got older, several close friends, and several of her young students. In the process, a sense of self had never fully formed, and she felt like a shell of a person, defined by the needs of a succession

of others. She met DSM-IV criteria for diagnoses of major depressive disorder (improved), generalized anxiety disorder, and dysthymia.

At the conclusion of our intake session, I reviewed the cognitive model with her. She replied that it "sounded familiar," and she would have a lot of thinking to do to prepare for our next visit. She returned in a week for session 2 and described a "typical caretaking relationship" with a friend. Asked to consider a life plan, she discussed her goals at work and a wish to move closer to the city where she was raised. Asked how others saw her, she described an assertive, self-assured "fixer" who knew what she wanted and could act independently. The contrast between this view and how negatively she saw herself was striking. We examined what she found stressful and how she handled stress.

We met 2 weeks later, and Ms. J detailed "2 miserable weeks," replete with others taking advantage of her. I asked her what she wanted for herself in these situations. We discussed the consequences of saying no to others. Our major focus was on how she saw herself and what she could do to change her thinking.

She began session 4 in similar fashion, before I intervened. "In what ways are you aware of thinking differently?" I asked her. "I have done a lot," she replied. How others view her now mattered less to her. She now considered herself on the list of those demanding attention from her. She was beginning to say no. We discussed the concept of participant and observer. What her observer told her about herself could be a big help to her in forming an accurate self-view.

Session 5 featured her observations of others rather than a negative commentary on herself. She reviewed options she had seen in a variety of situations. We discussed beginning the implementation of her life plan. Changes in her outlook and her mood and the beginnings of optimism and self-efficacy were all evident.

We met 3 weeks later. Her psychiatrist had called, I told her, to comment on positive changes he had noted in her. The major technique we employed was de-centering: how a situation she was involved in might not be best understood as "about her." Ms. J commented that she felt "better than ever" and, for the first time, was seeing herself as a "person with an identity."

Ten weeks had elapsed since we had begun. With no changes in medication, Ms. J had achieved major changes in how she thought, felt, and acted. She had begun the process of defining herself, and she liked what she saw. The addition of brief therapy to her internist and psychiatrist visits was paying real dividends. ◆