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.

Dr. Schuyler is in the private practice of adult psychiatry, specializing in adaptation to illness. He is author of the paperback book *Cognitive Therapy: A Practical Guide* (W.W. Norton & Company, 2003).

Dr. Schuyler can be contacted at deans915@comcast.net.

Shared Care

Dean Schuyler, M.D.

One of the changes in the delivery of psychiatric care that has been discussed previously in this column is the predominance of medication management in the repertoire of the practicing psychiatrist. Whether you see this as a good trend or a bad development, for medication management to be effective, it must be combined with the knowledge of when an additional referral for psychotherapy is indicated.

Outpatients with emotional problems manifesting as anxiety and/or depression often meet criteria for Axis I diagnoses, and they may profit from treatment with antidepressant medication. Typically, however, the context for these problems is a cognitive approach by the patient that supports and perpetuates the emotional problems observed. When the psychiatrist (or family physician or internist) identifies this problem in his or her patient's thinking, often a short course of cognitive therapy can make a large difference.

CASE PRESENTATION

Ms. A, a 50-year-old married African American woman, was not the prototypical referral to my cognitive therapy practice. She was sent to me by a colleague, an older, respected, biologically oriented psychiatrist in the community. "She needs to learn a way to deal with a multitude of problems," he said to me.

Born and raised in rural South Carolina, Ms. A was the oldest of 8 children. Her mother worked as a librarian until she died at a young age of heart disease. Her father held a company supervisory position for 30 years. He had died 15 years ago. She described her parents' marriage and her childhood as "stable and happy."

After graduating from high school, Ms. A left college early to take care of her dying mother and soon met and married her husband, a successful farmer. She has been married for 25 years and is the mother of 3 children, the youngest of whom remains at home. She has worked for a large company for the past 20 years.

Her husband is described as loving, but a problem to deal with when he "over-drinks" and his behavior becomes erratic. She has constantly worried about the vulnerability and behavior of her children. She has had periods of panic attacks and, 5 years ago, became seriously depressed for the first time.

Her family doctor referred her to my colleague the psychiatrist, and she has been treated intermittently with antidepressant drugs and tranquilizers. She acknowledges an assertive and independent self that has been a casualty of her marriage and her child-raising. Now, more often, she takes a passive route, suffers quietly, and "tries to take care of her family."

Her history met criteria for DSM-IV diagnoses of major depressive disorder, panic disorder, and generalized anxiety disorder. She had read a little about cognitive therapy and was eager to begin.

PSYCHOTHERAPY

Ms. A was articulate and easily engaged in our initial evaluation session. I presented the cognitive model to her in the context of several of the problem

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areas she had raised. She had a lot to say and enthusiastically made a return appointment.

One week later, I began session 2 (as I usually do) by asking her reaction to our first meeting. "I liked coming here," she said, "because it gave me a chance to talk. I don't seem to have much opportunity to express myself." She described 4 situations in detail that formed the focus for our session. In each, she drew conclusions about herself. These self-evaluations were identified and then tested for their strategic worth. "Are they accurate?" I asked her. "Do they get you where you want to go?" We tried together to understand her thinking and then to find alternative meanings that she might find more acceptable. Her self-view was the consistent focus in this session.

She returned in a week and reported that she was "feeling better, speaking more easily with people, being more assertive with her husband, and crying less often." She described her interaction with her husband in some detail. Acknowledgment of her, from him, was rare. We discussed the importance of feedback to an individual's self-worth. She recalled how she "used to be" and spoke of the necessity of reclaiming a "self" that she had lost. She needed to be a positive role model for her young daughter and noted that her husband's model was "flawed."

Ms. A reported that she had been asked to speak to the congregation at her church and was anxious. However, she identified the underlying thoughts and, deciding that they need not rule her, she dismissed them and was very pleased with her performance. In the past, this request had been frightening for her.

We discussed the decision-making interactions of Ms. A and her husband and identified the consistent cognitive error of polarization (black and white thinking). She acknowledged often thinking "this way" and promised to be "more alert to catch myself" in the future.

Session 4 was devoted to dealing with her husband's alcohol habit. The discussion focused on what she could take responsibility for in her situation. She revealed that typically she would take personally the statements he made about her when he was intoxicated. Then, she would worry how his statements would impact their young daughter. She would get angry, and it would feed her depression.

She seemed to take away from this discussion that the process of taking responsibility could be seen in terms of the choices she was making. She could decide to see things differently and, if she did, there would be real implications for her self-worth. Furthermore, expressing her feelings more openly would spare her the continually erosive effects that the interaction with her spouse was having on her. She was "relieved" and felt "much more in control of her life."

We met for the fifth and final time 2 weeks later. Ms. A spoke in detail about how she had learned to represent herself and speak up. She gave me multiple examples of "changed behavior." She was now thinking "about most things" in terms of choice. She felt dramatically better about herself, having recaptured the self she felt she had prior to marriage.

"I think I can manage my life better now," she said. "I have less reason to be depressed or anxious. If I have more to talk about, can I call you?"

One nice feature of the cognitive therapy model is the capacity for short-term work and then occasional "booster sessions." Many of my patients avail themselves of periodic follow-up opportunities. But, they don't all do as well as quickly as Ms. A did. ◆

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