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.

Significant Others

Dean Schuyler, M.D.

As the large baby boomer population nears 60 years old, Medicine's clinical awareness is changing. Caretakers, people who aid the daily life of patients suffering from severe medical or emotional illness, are becoming more evident as their numbers increase.

When I was at the university, a wonderful grant proposal was submitted to support work to help these people who help others, often at their own physical and emotional expense. Unfortunately, it was turned down. In that same time frame, I was invited by a forward-looking pharmaceutical company to speak at a meeting of caretakers for Alzheimer's disease patients in their families.

During my 3-year period of working alongside an oncologist in his outpatient clinic, I met numerous caretakers: spouses, children, neighbors, and friends. They were each profoundly affected by their loved one's cancer and devoted their time and energy to the cause of helping out. Few of them sought help for themselves.

It was, therefore, a welcome referral when a psychiatrist colleague asked if I would evaluate the wife of his young bipolar disorder patient. "She's having a tough time dealing with his ups and downs, has problems of her own, and could use some exclusive attention," my colleague said.

CASE PRESENTATION

Rachel was 25 years old, married for 2 years to Joseph, and the middle child of 3 children raised in New York State. Her mother and father were educators, and her 2 brothers were college graduates on desired career paths. One was married and one was single. The single brother had suffered from both physical and emotional illness.

Rachel had compiled an outstanding high school record and continued to excel through her college education at Duke. She had known Joseph since high school, and their marriage was an event in a long-standing relationship. He was diagnosed with bipolar disorder 2 years before they married.

Rachel described herself as a "caretaker who takes on everyone else's problems." Then, she spoke of the onset of her own depression, late in high school. A friend in school had suffered from depression and obsessive-compulsive disorder, and Rachel became very involved with her. She associated the onset of her own anxiety and then panic attacks with her close contact with her needy friend. Depression followed closely behind.

When Joseph's illness became evident, Rachel noted an increase in her tendency toward perfectionism, as well as a return of symptoms of depression. Her anxiety symptoms affected her in social situations as well as when she anticipated a public performance at work. Neither alcohol nor drug abuse were problems for Rachel.

My working diagnoses were major depressive disorder, panic disorder, generalized anxiety disorder, and social anxiety disorder. Our plan was for cognitive therapy. An internist was treating her concurrently with bupropion sustained release, 300 mg/day.

© COPYRIGHT 2006 PHYSICIANS POSTGRADUATE PRESS, INC.

PSYCHOTHERAPY

I carefully presented the cognitive therapy model to Rachel at the end of our initial meeting. I illustrated it by inquiring about the meanings underlying her depression when her husband became noticeably ill. Her homework was to compile a list of situations, feelings, and thoughts (a triple column), where the feelings were distressing to her.

She returned with a list of 4 situations, in which the associated beliefs indicated a solid understanding of the model. We reviewed each situation in turn, focusing first on the identified meanings. Then, together, we sought alternatives with consequences that were desirable for her. Each circumstance presented related to her perceived need to be perfect or to be seen as perfect by others.

At session 3, Rachel commented that our discussion on perfectionism had been helpful and that she had thought a lot about it. Further, the notion of "living in the gray" as opposed to thinking in black-and-white terms was likewise attractive. "Once I see the logic of an alternative," she said, "I know I can do something to change things." Her 4 situations this meeting encompassed perfectionism, anticipatory anxiety, a need to set limits for herself, and a need for approval from others. Her choices and their consequences provided the format for our discussion.

Time spent on vacation with just her husband underscored for Rachel that she had learned a great deal. Her spouse expressed how proud he was of her. She saw clearly how much of her stress was self-imposed and therefore could be eliminated by changes in her thinking. Her depression was no longer evident. Her anxiety, in all forms, was markedly reduced. We agreed to meet again in 1 month.

Sessions 5, 6, and 7 demonstrated further gains. This period included a lengthy exacerbation of Joseph's illness, during which she performed better than ever, to the benefit of each of them. In session 8, she discussed her therapy gains and changes, and we agreed that subsequent meetings would be at her initiative.

So far, she has called for 1 follow-up meeting, focused on her search for a job more worthy of her capabilities. Her self-view has undergone a radical revision, so that it now seems appropriate to her demonstrated skills. She has not been depressed and reports only minimal, manageable anxiety.

Joseph has had lengthy periods of well-being and has expressed his "relief" at the changes she has made in herself. Clearly, the gains of a caretaker have benefited both her and her significant other. ◆