

Teaching the Tools: Prolonging the Benefit of Psychotherapy

Lisa Sebotnick McLean, M.D., and Dean Schuyler, M.D.

Depression and anxiety are common diagnoses in the primary care setting. Today, the primary care provider may prescribe appropriate medications with the goal of ameliorating symptoms. Despite medication trials, however, problems and even symptoms may persist. It is at this point that patients may be referred to a psychiatrist.

In the initial intake session, the psychiatrist evaluates the current symptoms as they pertain to DSM-IV diagnostic criteria and ascertains current psychological stresses. The case presented illustrates the use of psychotherapy to treat both depressive and anxious symptoms, as well as to provide the patient with tools to deal with future stress. It also illustrates that success in this arena is quite possible even for the inexperienced therapist who can apply empathic listening skills, establish a strong therapist-patient relationship, set well-defined goals, and apply the principles of cognitive therapy.

PRESENTATION OF THE PROBLEM

Mr. S is a 52-year-old, 3-times-married white man who had been treated in primary care for sleep difficulty, depressed and anxious mood, and ruminative negative thoughts and met criteria for major depression with anxious features. He was treated with sertraline (Zoloft), titrated from an initial dose of 50 mg/day to 150 mg/day. He was sleeping better, but continued to have a mood disturbance. His symptoms began shortly after he separated from his third wife. An angry public outburst had preceded their separation, and they were currently living apart. In addition, he was having difficulties with work at a local grocery store for additional income. He had a lengthy history of relationship difficulties. He had been married twice before, with both relationships ending abruptly. He had worked as a corporate chef, 16 to 20 hours a day, managing a large kitchen. He had retired early, and this major change was a cause of stress for him. When he consulted one of us (L.M.), he was living in town with a friend and was at risk of losing his third wife. As a child, he related,

he was physically abused by his father, and they continued to have a difficult relationship. He expressed the desire for help with “anger management,” as Mr. S believed his temper was the cause of his failed marriages as well as his work difficulties.

PSYCHOTHERAPY

Much of the initial psychotherapy session was spent discussing the details of his marital separation and the role his anger outburst had played. It was Mr. S’s belief that his anger traced to his early interaction with his father. I suggested to him that this may well be true, but that our work would focus on his problems in the present time. He described himself as a “very driven person,” noting that his aggression had been seen as a beneficial trait in the workplace. With the decline in job status and the loss of home and wife, he had become depressed. He doubted his abilities, both as husband and chef. We chose to focus on his impulsive actions by examining the associated thoughts, moods, and behavior. We worked in the here and now, rather than exploring the past. I taught him the cognitive model for identifying automatic thoughts in times of distress.

In the second session, Mr. S was able to list numerous situations in which his quick temper and subsequent reaction had resulted in negative consequences as well as feelings of depressed mood and anxiety. In session 3, he told of his wife’s sale of a piece of construction equipment no longer needed at home. He noted that upon hearing this on the phone, he became very anxious without knowing why. At the end of the session, he was given the assignment to continue to look at the thoughts that occurred in distressing situations.

Mr. S reported for session 4 with typed examples of automatic thoughts. In several instances, he had become very anxious when he had to interact with coworkers. The cognitions had a persecutory quality: “She must have done the deli display incorrectly just to get at me” and “He gave

me that assignment to get at me since I had more experience than him." I asked the patient to begin keeping triple columns for homework, charting situations, feelings, and thoughts. By session 5, he had begun to question his reactions as they related to his identified thoughts. At this visit, I introduced the concept of cognitive errors. He frequently personalized others' comments, leading to inaccurate interpretations of their actions. He found some convincing alternate explanations: "Perhaps (his coworker) did the deli display as she had been instructed to, or it is possible that she made an innocent mistake." He concluded that his wife's selling of the equipment may not have been done to hurt him. "Perhaps the sale was simply an effort on her part to save money," he noted.

By session 6, Mr. S began questioning his reactions to work situations that led to anger. When he formulated alternatives, he noticed that the sadness and anxiety decreased. Looking back over his relationships, he stated: "You know, I think I've been doing this all along. I do a lot of personalization and polarization, and that's been a continuing problem." By this point, his sleep was improving along with his mood.

We then turned to the marital relationship, its history, the conflicts, and their effect on him. When Mrs. S had a conversation with a male friend at a dinner party, the patient took this as a personal affront and "flew off the handle." Next, we focused on his tendency toward all-or-nothing (polarized) thinking. In anticipating a reunion with his wife, Mr. S predicted, "Either the birds will be singing and it will be a beautiful moment, or we'll never speak again." We role-played some "middle-ground" interactions to illustrate some alternatives for him. When he began to

feel nervous during this part of the session, Mr. S said, "I'll need to think about what thoughts are making me nervous." The patient had actively incorporated cognitive techniques in his everyday life and was now designing his own homework assignments.

In later sessions, Mr. S brought a typed list of 5 scenarios for the reunion, ranging from "ideal" to "worst case." He had written out the scripts along with triple columns for each. We role-played the worst-case possibilities. I taught him some relaxation techniques (abdominal breathing and progressive muscle relaxation) to help reduce the anxiety so he could better examine his thoughts. Excitement about returning to his wife was replacing anxiety.

By our thirteenth session, the couple was once again living together. Mr. S was very pleased with the balanced way he had handled the situation. He was once again sleeping well, with less anxiety and improved energy and mood. As with learning anything, we noted, practice and frequent use would lead to mastery. Although relapses would quite likely occur, he now had the capability to deal with them.

At our final visit, Mr. S acknowledged the changes he had made in psychotherapy over a 6-month period. He felt some anxiety about ending therapy and leaving the area with his wife. He requested my e-mail address "in case of emergency." Four months later, I received an e-mail stating that things were going well and citing an example in which he had "used the tools he had learned." One year later, he contacted me again when he returned to the area for a brief visit. We met for a brief session so he could "touch base" and explain to me how our work together had benefited him and his marriage.

Editor's note: Dr. McLean is in her third year of psychiatry residency training at the Medical University of South Carolina (MUSC). Dr. Schuyler is a board-certified psychiatrist at MUSC who works part-time as a consultant to a medical clinic.