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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The Second Time Around: When Having a Therapist May Come in Handy

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Cognitive therapy provides a model for short-term psychotherapy. The typical patient is anxious and/or depressed and has the capacity to utilize a system based upon identifying and disputing meanings associated with distress. Classical psychoanalytic psychotherapy, in distinction, is typically long term in nature, aims at character change, and utilizes learning about the past as a key to altering the present.

As I employ it, the cognitive model adopts a number of properties from behavior therapy and is a psychoeducational system that is typically short term. Cognitive therapy, like behavior therapy, endorses the principle that, once it is successfully applied to one area, it may later be usefully applied elsewhere. This latter characteristic often leads to a short course of therapy focused in one problem area and a later short course of therapy initiated by a new issue.

In order for this approach to work, the patient must feel he or she gained something the first time around and then take the initiative to call the therapist about a new area of distress some time later. That was the pattern of my work with Ms. A, who first consulted me for 2 months in mid-2005, and then called again 3 months after our last session.

CASE PRESENTATION

When I first met Ms. A, she was a 32-year-old divorced woman working as a paralegal. She contacted me on the recommendation of her primary care physician to get help with relationship problems. Born in Boston, Mass., Ms. A was an "Army brat," whose father was a career military man, and so she spent her childhood in several places and attended several schools. She was the eldest of 4 children, having 3 younger sisters. Her father died after suffering a heart attack at age 50, and her mother died 10 years later of cancer. Ms. A graduated from a local high school and then attended college. After college graduation, she accepted a job with a large law firm, where she had been employed for the past 10 years.

She married, at age 23, a man she met in college. They had irreconcilable differences and mutually decided on divorce after 6 years together. They share custody of their daughter, who was then 8 years old. Ms. A had met Mr. B more than 2 years before our first session, soon after her divorce was finalized. They had "broken up" on 5 separate occasions but were currently "back together again." Money and priorities were major issues of conflict for them.

Ms. A reported feeling anxious and overwhelmed during their times apart and wondered if she had "driven him away" or if he was "truly wrong for her." Worry was her constant companion. My intake DSM-IV diagnosis was generalized anxiety disorder.

FIRST PSYCHOTHERAPY

I explained the cognitive model to Ms. A, and we spent most of our second session discussing which relationship issues belonged to her and which belonged to Mr. B. We focused on her thinking errors of polarization and personalization. We explored her meanings and her view of Mr. B's meanings on

matters of concern to both of them. Subsequent sessions utilized the framework of choices and consequences.

Ms. A noted a relationship pattern that began with her making a request; Mr. B would refuse, and she would get angry, then she would withdraw and later make amends. I encouraged her to talk with Mr. B about how she felt and what she thought. She returned for a fifth session and was pleased that they had talked meaningfully for the first time. However, when she asked for his help with her daughter, his suggestion that she "call the girl's father" was disappointing to Ms. A. She wanted a man who would be there for her, and Mr. B consistently "refused to be that man," she said.

She believed their interaction over the length of their relationship was inadequate to meet her needs. Ms. A had stayed with Mr. B to please him and to avoid being alone. It was now time, she believed, to end this relationship with a man she saw as narcissistic and insensitive. She reported no longer being anxious and felt that she had learned a lot about herself in therapy. I encouraged her to call me if further sessions would be useful, and we terminated psychotherapy.

SECOND PSYCHOTHERAPY

Three months following our last session, Ms. A called for an appointment. The relationship with Mr. B was over, and she was dating other men. However, she had been dismissed from her job after 10 years of work and commendation. She spoke in detail about the circumstances of her termination, which she felt had been unwarranted. She expressed anger and began to sketch a plan for finding a new job. She underlined the centrality of work to her sense of self-worth. She was concerned that she might be "insecure, incomplete, and often inadequate." My DSM-IV diagnosis for this segment of psychotherapy was dysthymic disorder.

Two weeks later, Ms. A reported the details of a job offer she had received. The job would involve some travel and learning a different category of law. Could she do it? How was she viewed by her committee of interviewers? How did she see herself? She reported little anxiety, but more of a "crisis of confidence" about whether she could do the work. We reviewed the cognitive model: label distress, identify the relevant meanings, note the error in thinking, and find an acceptable alternative. Together, we applied it to her understanding of the requirements of this new job.

She took the job, and we continued to meet through her initial 2 months of work. Ms. A's schedule strained her capacity to maintain a social life. The agenda for the later sessions looped back to consider options for pursuing a relationship. By her ninth visit, Ms. A felt that she was doing well at work and that she had found an acceptable balance between work, social life, and parenting her daughter. The second psychotherapy segment lasted for 4 months.

By now, 9 months had elapsed since we first met. Ms. A had made excellent use of 2 separate, but related, courses of cognitive therapy. She had managed to convert 2 difficult life events—the ending of a long-term relationship and the ending of a long-term employment—into opportunities for growth. ◆