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.

What Does It Take?

Dean Schuyler, M.D.

We are used to thinking medically about chronic conditions in terms of management over a long period of time. Psychiatry identified chronic depression initially as a disorder of character, then as an attenuated form of major depression that lasted a long time. With either conceptualization, the treatment of long-standing "dysthymia" was expected to be measured in years, not weeks.

We have learned that antidepressant drugs can free some patients from dysthymia in a reasonably short time. Logic suggests that dysthymia may be maintained by thoughts: the meanings that people have learned to attach to situations, events, and relationships. If this is true, short-term cognitive therapy should benefit a patient with chronic depression who is motivated to change.[1]

CLINICAL PRESENTATION

A colleague in primary care referred Ms. A, a 50-year-old high school English teacher, to me. She had been married for 25 years and had 2 young adult children, a boy and a girl. My colleague had been the primary physician for Ms. A and her husband for the past 5 years, since their move to Charleston, S.C., from Atlanta. Ms. A had no major physical illnesses, but my colleague observed that she always seemed moderately depressed. At her latest annual physical, he had commented to her about his observations. She told him about a hospitalization for an anxiety problem 30 years ago and 3 courses of outpatient psychotherapy 25, 15, and 10 years ago. Little had changed, as she saw it. He offered her a trial of an antidepressant medication, which she refused. He then suggested that she consult me.

PSYCHOTHERAPY

Ms. A arrived for an intake session and stated her wish for cognitive therapy and no medication. She acknowledged that a long-standing depressed mood had worsened since she and her husband and the children had moved to Charleston. She slept well, was slightly overweight, had a variable appetite, and had chronically low energy but no real problem with fatigue. She felt better with exercise and went to the gym each day. Concentration was a continuing problem, and she had periods of difficulty with memory. Her mood was even-tempered or low.

She was not particularly a nervous person, nor was she a worrier. She had never had a panic attack. In retrospect, her hospitalization for "anxiety," she said, was most likely for an acute depression. It was the only such episode she had experienced. Neither alcohol nor drug abuse was a problem for her.

After receiving her doctor's referral to me, she had read about cognitive therapy on the Internet. It was new to her, and she was eager to learn more. Her DSM-IV diagnosis was dysthymic disorder (300.4). I explained the potential usefulness of the cognitive model and encouraged her to read some more. We would begin in 1 week, and the number of meetings would be determined by how useful she found the application of the model.

Ms. A began session 2 by telling about what she had read and her plans for further reading. I explained my version of cognitive therapy to her. She discussed feeling bored at school and lonely in Charleston after 20 years in Atlanta. We examined how she set standards by which she judged herself. She felt powerless interpersonally. We outlined her view of herself (attributes and deficiencies) and what she saw as her social needs. Her homework was to keep a triple-column log (situations, feelings, thoughts) for the next week, which we would review at our next session.

The week preceding session 3 had been a difficult one, with Ms. A preoccupied with a relationship problem brought to her by her daughter. Although we discussed the problem, the session centered on Ms. A and her right to consider herself as well as to parent her child. She revealed a tendency to polarize her thinking—"to think in extremes." We found relevant grays between her black-and-white extremes. She ended the session with, "I made real gains today."

Session 4 opened with Ms. A's observation that she had "done really well" with a range of situations during the week. We talked in detail about ways she could "make the city her own." She spoke about her relationship with her husband, its strengths and the areas in which she thought she could "do better." The concepts of choices and consequences framed much of our discussion. We talked about identity (how she saw herself), responsibility, and engagement with others.

Session 5 focused on how much better Ms. A was feeling. She attributed it to finding it easier to "let things go." Previously, she would ruminate on problems, but get no closer to solutions. She was thinking now about what formerly were "responsibilities" as "choices." She was speaking up more to her husband and found him interested in her views and encouraging to her. We did little formal triple-column work and mostly had conversation that fastened on meanings and strategy.

A disagreement with her husband formed the basis for our discussion in session 6. It involved the notion of the responsibilities of the children to make decisions about their lives. She decided that her husband had lost perspective on this issue and worked on how she could help him regain it. Ms. A noted how she felt more valued at school and at home now. We scheduled our next appointment for 1 month later.

Session 7 proved to be our last and served as a summary of Ms. A's changes and the value of the therapy for her. She had spoken effectively with her husband. She was pleased with the directions her children had chosen and with the process by which they had made decisions. She had experienced transient sadness, but noted that she could differentiate this from depression. She described dysthymia as "being on the beach, tossed by the waves." Now, she felt that she was "on the porch, watching the waves." She felt dramatically more in command of her life. Her energy level was up, she had lost 5 pounds (deliberately), and her concentration was "better than ever."

It seemed to Ms. A that sometimes small changes could make large impacts. It seemed to me that Ms. A was "ready" to work to change a chronic thinking pattern. She applied her considerable resources and, over a 2-month period, achieved significant results.

REFERENCE

1. Schuyler D. Short-term cognitive therapy shows promise for dysthymia. Curr Psychiatry 2002;1:43–49