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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Prim Care Companion J Clin Psychiatry 2010;12(1):e1-e2

Published online: February 11, 2010 (doi:10.4088/PCC.10f00948blu).

Becoming

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Cognitive therapy is a model for providing short-term help to a man or woman with (typically) a well-defined problem. Often, that problem has affected the person's well-being, resulting in major depression or generalized anxiety. Sometimes, the person's system is upset by the occurrence of a severe (often unanticipated) physical illness. For the clinician, the challenge is to help this person adjust and move on with his or her life.

Decades ago, I asked a budding young therapist at the Center for Cognitive Therapy (University of Pennsylvania, Philadelphia), "Do you ever apply the model 'long term' to help a person make personality changes?" I was told, "We don't talk about that!" Subsequently, books and articles were written applying the cognitive therapy model to personality disorders, bipolar disorder, and schizophrenia.

In my book, *Cognitive Therapy: A Practical Guide*, there is a chapter devoted to "Re-parenting." Periodically, I am confronted with a young adult still in the process of identity formation. This person offers the challenge of working with someone long enough to see them overcome the original depression and anxiety with which they presented and then helping them to develop the personality attributes that will guide them through life.

While this is no longer my standard fare (short-term cognitive therapy has replaced it), it remains gratifying to be able to help a young person "become" the individual they aim to be. This was the case with Ms A.

CASE PRESENTATION

Ms A was referred to me by her primary care doctor because of depression. She was a 26-year-old advanced practice nurse living with a young doctor she had met in the hospital where they both worked. She had a distant, and somewhat conflicted, relationship with her parents (who lived back home in Minnesota), as well as with an older sister and brother, each married and living in the Midwest.

She was a graduate of nursing school (in Minnesota) and had achieved her Advanced Practice degree in an additional year there before moving to Charleston, SC. She followed a young man to Charleston to continue a relationship, which lasted for a year before it broke up. She had dated her current partner for a year before they decided to move in together.

Ms A described herself to me in our initial visit as "incredibly unhappy" for the past year. She had suffered increasing anxiety during the previous 6 months. She had disrupted sleep and a 20-lb weight gain from overeating, along with little energy and easy fatigue during this period. Her concentration was "not dependable."

Her history met criteria for *DSM-IV* diagnoses of major depressive disorder (296.30) and generalized anxiety disorder (300.02). We contracted for a course of cognitive therapy, and I prescribed escitalopram 10 mg to be taken daily for depression.

PSYCHOTHERAPY

After 6 weeks of weekly meetings (complemented by antidepressant medication), Ms A was decidedly less anxious, had lost some weight, had gained

some energy, was sleeping well, and felt markedly better. As she gained self-esteem, her view of the adequacy of her relationship diminished. In time, the relationship ended, and Ms A moved into her own apartment. She quickly saw "all the compromises" she had made to suit the man she lived with and began to define what she wanted for herself. Our visits decreased in frequency to biweekly as she outfitted her apartment with the colors and objects that she wanted to be surrounded by.

Slowly, she developed a new circle of friends centered around a shared interest in the outdoors. She felt that she was "moving on." She went on several dates. Ms A spoke with me in detail about her recent relationship that had defined for her who she was. Looking back, she was quite dissatisfied with what she had become.

She spoke about how her parents, too, had fostered her dependency. She said, "I no longer want my folks or my boyfriend defining who I am." Nine months after we met, she discontinued the antidepressant drug. Cognitively, she identified multiple areas of black-and-white thinking and worked hard to find acceptable grays. We decreased our sessions to monthly visits.

A trip home about 1 year after our meetings started put into bold relief the changes that she had made. It provided, too, a look at her dysfunctional family and left her with the resolve to be "nothing like them." She spent a session discussing her social friends in Charleston as well as her concern about "fitting in." She wasn't yet nearly who she wanted to be.

Within a month, major depression returned, and we reinstituted the antidepressant medication. As she began to return to her "normal self," we spoke about choices and their consequences. I noted the changes she had successfully made, and she focused on further changes she deemed necessary.

She joined a gym, planted a garden, and acknowledged a need for more structure in her life. I watched her become more and more relaxed and self-assured. Over 20 months of cognitive therapy, she had made significant gains and formed an identity that she liked. Then, suddenly, she was laid off by her hospital job.

Ms A discussed her job search and also noted her changing view of men. "I'm beginning to figure out what's right for me," she said. We met only 5 more times over the following 3 months. While all her problems were not resolved, she felt considerably more confident about dealing with them. She ended our sessions 2 years after they had begun. She was facing a "new stage" in her life, she told me, and was "excited and secure about the road ahead."