Psychotherapy Clarified the Diagnosis and Treated the Problem

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The doctor in primary care, much like today's psychiatrist in office practice, is often confronted with the choice of medicating an emotional disorder or making a referral for talk therapy. While a combination of both may work for some patients with depression and anxiety, some people recover and make major life gains in brief psychotherapy, without medication. Such was the case with Mr. A.

PRESENTATION OF THE PROBLEM

The patient is a 36-year-old white man, married for 10 years with 2 sons (aged 14 and 10), who is currently completing a bachelor's degree in college. Simultaneously, he is working in a retail store. He had consulted the same primary care provider for 2 years and was being treated for depression. He had been prescribed a variety of antidepressant drugs and, each time, told to return in about a month's time. He claimed that his doctor registered surprise on each occasion that he was "not feeling better." While he noticed a positive effect on mood, the side effects of sweating and sexual dysfunction had defeated the 2 successful trials. After 2 years of unsuccessful treatment in the primary care setting, he was referred to our university clinic for further evaluation and treatment.

PSYCHOTHERAPY

At our initial visit, Mr. A's chief complaint was "feeling depressed." He reported previous drug treatment trials with bupropion (Wellbutrin) and fluoxetine (Prozac), each at a therapeutic dose for a reasonable period of time. He told me that he was "tired of feeling so bad about himself, feeling guilty, and being a failure." He acknowledged that his marriage was "now over," and that he and his wife were discussing a divorce. Asked about their relationship, he related that they "could never see eye to eye" and so the marriage had been "doomed from the start." When they tried to talk with each other, the result was "ineffective yelling." In addition, the patient was frustrated because his younger son "never listened to him," and he and his wife disagreed on disciplinary options with their son.

My working diagnosis was major depression, and I recommended brief cognitive therapy to start, with further medication trials to follow, if necessary. In session 2, we set goals for treatment. Mr. A grandiosely stated that he wanted to be "the funniest, smartest man he could be" and "the best dad, the best student, the best of everything." Our first task was to work together defining more realistic goals. Challenged to do so, the patient focused on changing his tendency to impulsively criticize others. As a recent example, he cited being strongly and openly critical of his supervisor at work when he was upset with the way an assignment had been planned. He believed that the major result had been a poor evaluation from this supervisor. Subsequently, he blamed himself and labeled himself as a failure.

In session 3, we focused on his easily evoked anger and impatience, which seemed to lead to impulsive outbursts. We identified thoughts that triggered the feelings and the behavior and linked them to the negative consequences. We noted physical signs that served to indicate a rapid progression to uncontrolled anger and could serve as "alerts" to lead to better self-control. We redefined as an asset his capacity to find problems in a system and worked on finding ways for him to communicate in a different fashion.

By session 4, it was clear that Mr. A had absorbed the key points in our discussions and was actively applying them both at work with his boss and at home with his son. By interrupting what he called "this cycle," the patient increased his tolerance level, curbed his impulsive tendency, and thereby diminished the subsequent guilt and failure he was experiencing. Statements indicating

that he was doing the work to identify the meanings related to his distress suggested therapeutic success was likely.

The following 2 sessions focused on "catastrophizing," the cognitive error of constantly anticipating the worst possible outcome. We discussed a variety of situations using the triple column format of examining situations, feelings, and thoughts. In relating his son's newfound interest in the opposite sex, he stated: "If he got a girl pregnant, it would be all over." He quickly labeled the errors in thinking as jumping to a conclusion and catastrophizing, and we worked on finding a more reasonable alternative approach to his thinking.

Next, we took on his tendency to compare himself with his brother and then to judge his performance a failure. Together, we reviewed his beliefs about his life and that of his brother with the aim of finding a more realistic understanding. By the eighth session, Mr. A told me that he and his wife were no longer contemplating divorce. He had written down the issues that bothered him and asked his wife to do the same. He found that they could talk now, without their interaction becoming "a shouting match." He suggested marriage counseling, and his wife readily agreed.

For the following 3 sessions, we decided to meet every 2 weeks and work on polishing the skills Mr. A had acquired. After a period of 4 months and a total of 11 sessions, we mutually agreed to terminate therapy. I did not believe that antidepressant medication was necessary, and none was prescribed. My final diagnosis was generalized anxiety disorder, with secondary depression.

I understood Mr. A as a man who would become easily overwhelmed and then act impulsively, with resultant guilt, self-criticism, and lowering of self-esteem.

If our treatment had been limited to medication management, I believe that I would have missed the diagnosis and quite likely failed to help this patient. Time spent getting to know the patient and establishing an agenda for psychotherapy facilitated Mr. A's dramatic life changes and therapeutic benefit.

Editor's note: Dr. St. Germaine is in her third year of psychiatric residency training at the Medical University of South Carolina in Charleston, S.C. Dr. Schuyler is a faculty member in the Department of Psychiatry, responsible for teaching brief cognitive therapy and supervising residents' outpatient clinical work. He works, as well, as a psychiatrist attached to a primary care clinic. 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.

For further reading: *A Practical Guide to Cognitive Therapy*. 1st ed. by Dean Schuyler, New York, NY: WW Norton & Co; 1991. ISBN: 0393701050