

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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Cognitive Therapy For a Complex Medicine-Psychiatry Case

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The interface of medicine and psychiatry presents some challenging patients and often the opportunity for change. Many of my patients struggle with issues on both sides of this spectrum, and frequently they have problems in each. I find myself seeking out these cases, as they can turn out to be challenging and often rewarding.

The patient who is the focus of this article was referred to me by both her previous psychiatrist and her college Student Health Center for further evaluation and management. She presented to me with the DSM-IV diagnoses of schizoaffective disorder, major depressive disorder, generalized anxiety disorder, obsessive-compulsive disorder, anorexia nervosa, hypokalemia, and amenorrhea. At first, it all seemed a bit more than the challenge I was looking for. My hope was that she would enable me to attempt to manage a patient with significant psychiatric illness and medical complications in an outpatient setting.

CASE PRESENTATION

LV, a 22-year-old, single, white woman at a local college had a chief complaint of "I need help with food issues." She described symptoms of anorexia: daily bingeing and purging episodes, amenorrhea, decreased energy, and a distorted body image. A recent visit to the emergency room prompted by light-headedness and fatigue had resulted in the diagnosis of hypokalemia.

Her symptoms of anorexia started at age 16, coinciding with her parents' divorce as well as with a decline in her schoolwork. She also endorsed symptoms of depression: poor energy, decreased concentration, disrupted sleep pattern, decreased interests, and sad mood.

During our initial visit, there were no symptoms of psychosis noted, and she did not complain of significant anxiety. She weighed 117 lb, was 5 ft 11 in tall, and had a body mass index of 16 kg/m². Her weight had ranged from a low of 115 lb to a high of 145 lb.

LV had a history of 2 inpatient psychiatric hospitalizations and multiple courses of outpatient psychiatric treatment. She reported first being depressed when interacting with classmates at around age 14 years, which was also when she had her first antidepressant drug trial. There had been multiple drug treatments since then, all with little benefit. When she took venlafaxine, she experienced decreased sleep, increased goal-directed activity, racing thoughts, and distractibility. These symptoms resolved when the medication was discontinued, and they have not recurred.

My working diagnoses using DSM-IV criteria at the conclusion of the intake visit were anorexia nervosa, major depressive disorder by history, anxiety disorder not otherwise specified, and rule out bipolar disorder. My plan was to continue to obtain historical details to clarify the diagnoses and then to attempt to streamline her medication regimen, which consisted of lamotrigine, olanzapine, and ziprasidone.

There were many avenues of psychotherapy that I felt might be helpful to her: a psychodynamic approach to try and understand the root of many of her issues, a behavioral approach to focus on her eating behaviors, and a cognitive therapy approach to work on her cognitive distortions. I chose to pursue a cognitive approach because it had not been tried in the past and because her productions were dominated by cognitive errors, including catastrophizing, overgeneralization, and black-and-white thinking.

PSYCHOTHERAPY

I began our second session by outlining my treatment plan. The cognitive model was explained, with an emphasis on the importance of thoughts and their impact on feelings and behavior. I told her about anorexia nervosa and its medical complications. When I asked about her goals for treatment, I was surprised to learn that she wanted to decrease her weight permanently to 115 lb. We explored the meaning she attached to this goal. She believed that losing weight would help her to achieve more control over her eating behavior, feel more comfortable with herself, eat a normal diet, and stop smoking!

She soon expressed the impossibility of this outcome, and then lent the goal another meaning: "It (my eating) defines me; it is who I am, and the only thing I do well." We considered next what criteria typically define people and created a list of things in her life she felt that she had done well. When I noted that her eating habits were not on this list, LV expressed surprise. It represented our initial step in initiating change.

In the third session, we focused on the meanings she associated with eating, as well as her "negative self-talk." LV believed that, since she had been diagnosed with schizoaffective disorder, her life was "useless." She thought that she would die before her friends and family and that nothing she could do would change that. She equated her illness to "natural selection," believing that she was "fated for failure."

I could elicit no history of hallucinations, speech disturbance, or negative behaviors. When I obtained her old treatment records, this absence was validated. I explained schizoaffective disorder to her and told her that I did not believe that this was her problem. An adverse reaction to

venlafaxine more likely explained the symptoms she had experienced. I stressed the likelihood of a good prognosis for the problems she did have. One consequence of this reframing was to emphasize the importance of choice in her beliefs.

During the remainder of the session, we discussed triggers for her eating disorder, studied charts she had made relevant to bingeing and purging, and reviewed dietary diaries. I suggested that she taper and discontinue ziprasidone, in part due to her recent hypokalemia, palpitations, and lack of psychosis. This was accomplished without incident.

Through sessions 4 to 8, her weight rose steadily to about 130 lb, and the bingeing and purging episodes decreased. LV noted that she felt very anxious weighing herself at home. She would equate the number registered with being "fat and unattractive to men." I asked how men would know this number and what might happen if she didn't know her weight either. She laughed and said that men would not know her weight, and it might relieve her anxiety if she didn't know her weight.

We contracted for her to leave her scale in my office, where I would record her weight at each visit, but not inform her of the number. We agreed on a weight range goal obtained from the tables she had studied. By session 12, her weight had stabilized at 140 to 145 lb, and her menses had returned. As weight became less of a concern, we shifted our focus to her symptoms of anxiety and depression, as well as to interpersonal problems.

My reformulated diagnoses were anorexia nervosa and major depressive disorder. My plan was to taper and discontinue olanzapine. The format of cognitive therapy enabled this patient to rethink her view of illness and her self-view, which brought about a rapid behavioral change and a needed normalization of her weight. She became more optimistic and willing to take responsibility for her choices.

The psychotherapy success enabled LV to discontinue medications that were predicated on inaccurate diagnoses. Her weight has continued to be stable, her menses have remained regular, and she has increased energy. We continue to meet, now utilizing cognitive therapy to address her mood disorder. ♦