

## 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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## Making a Decision

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**M**y practice comprises a group of some of the smartest, most interesting, most successful people I have encountered in my life. Typically, in the context of an obstacle or stressor, the individual has become clinically depressed or anxious. More recently, my patient may be an individual whose life was proceeding along a fairly predictable path when he or she developed a life-threatening illness and was derailed. Each of these types of patient consults me in an effort to return to a previous level of tranquility, security, and peace. Brief cognitive therapy, for many people, provides a framework within which restoration to healthy functioning may occur fairly quickly.

Reviewing my more than 30 years of experience doing cognitive therapy, it struck me that there was another, less frequent, category of person seeking help. What precipitates this call is the perceived need to make a decision, augmented by a felt incapability to do so. Multiple examples spring to mind. A 50-year-old woman had 1 evaluation session several years ago, then disappeared. I called her to find out why. "I came to you because I didn't know whether I really wanted to marry the man I had moved to town to marry," she said. "After our talk [an intake session], I realized what I wanted to do. There was no need to come back."

A married, infertile couple consulted me years ago because they couldn't agree on whether or not to adopt a child. After 4 sessions of cognitive therapy, they each felt comfortable with their joint decision to go through with the adoption. More recently, 2 grandparents met with me to discuss their view of some parenting decisions made by their son and daughter-in-law. Their disagreement threatened to distance them from their son along with the grandchildren they dearly loved. Again, a short course of cognitive therapy, focused on their thinking, pointed to a way out.

Often these patients don't qualify for a DSM-IV diagnosis. When they do, it is no more serious than an adjustment disorder. Alternatively, a patient being treated (by someone else) for a more serious emotional disorder may be referred to me by his or her therapist. "I think some cognitive therapy might be helpful to this person," I am told. The following case presentation is offered to illustrate a consultation that aimed to facilitate making a decision.

### CASE PRESENTATION

Jack had been depressed for most of his 52 years, as best he could tell. Married for 20 years, he and Laura had a "comfortable" relationship. They had never had any children. Jack had few interests (and even fewer "passions") outside of his work. Since high school graduation, he had worked for a succession of companies (often in positions of responsibility) for significant chunks of time. He had been treated for depression, initially by his primary care doctor and more recently by a medication-managing psychiatrist, with a number of different antidepressant drugs. The aim of his treatment was to modify a recurrent

major depressive disorder. His most recent psychiatrist (for the past 5 years) had combined traditional psychotherapy with his prescription of medication. It was this psychiatrist's opinion that "antidepressant drugs had not made a significant difference" for Jack. Lately, Jack's alcohol consumption had increased in response to concerns about his job.

### PSYCHOTHERAPY

I saw Jack 3 times without eliciting from him a clear idea of what our therapy would be about. I reviewed the cognitive model with him, and he assured me that he understood the theory. I then suggested that he call me when he felt that a session might be useful, deciding that further meetings without a clear agenda made little sense.

Jack called 4 days later to schedule a session to discuss a decision about a work assignment that he felt was not in his best interest. We focused on the meanings he saw in the "facts of the case." We discussed the options he had in responding to his supervisor's request. We carefully traced the likely consequences of each option. I stressed that this decision was his to make, not one for his boss or for me.

He called again for an appointment 6 weeks later. He had indeed made a decision and implemented it but now was dissatisfied with the outcome. We worked together to specify the options open to him, as well as the likely consequences of each. At one point, I made a balance sheet on a blackboard, and Jack specified positives and negatives associated with the choices he saw. By session's end, he had decided what he wanted to do. We utilized the cognitive model as a framework but did not concretely specify situations, feelings, and thoughts in a "traditional" triple-column format. The next session would be at Jack's initiative.

He called 1 month later to make an appointment. He told me that his drinking habit had been curtailed for the past month. He was feeling "more settled and more sure" of himself. Jack set up another meeting 3 weeks later aimed at understanding his anger in the context of his work situation. Our discussion harkened back to the career decision he had made and focused on him taking responsibility for his own behavior. In fact, he had much more autonomy than he took credit for. His learned style of seeing himself as the "product of external forces" seemed to be a factor in his upsurge of anger.

After another month, Jack returned. He was depressed, he said, about the prospect of satisfying his boss' wish that he work part-time in a locale several hours from home. The nature of this job would also be a departure from the usual. Jack wanted to continue with the job responsibilities he had successfully pursued for 5 years. He saw only disadvantages in the new assignment. We discussed options for him in dealing with this new turn of events. He decided it would be best to talk with his boss and express how he felt, and he believed that his performance to date would convince his boss to acknowledge his wish.

A subsequent phone call indicated that Jack had succeeded beyond his most optimistic expectation. His boss had assured him that the company had no desire to put Jack, a valued employee, in a slot he didn't want. He would support Jack's wish to continue in his current career direction.

Throughout this 6-month period, in which I met with Jack 5 times after our initial 3 meetings, he continued his periodic visits to his long-time psychiatrist. I expect that I may see Jack from time to time in the future. He has made clear that a cognitive approach to making a difficult decision has been of significant value for him. ♦