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 Dysthymia

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Depression is a frequent visitor to the office of the primary care physician.[1] Typically, it is acute, problem-precipitated, and often recurrent in the patient's history. Medical practitioners today need to learn the prescription and pharmacology of several selective serotonin reuptake inhibitors (SSRIs) so they can offer the depressed patient a trial of a familiar compound. A referral for an adjunctive, problem-solving, brief psychotherapy that is focused on the present rather than the past is also useful for most patients with major depressive disorder.[2]

Perhaps less commonly encountered in primary care, but widely known socially, is the patient with chronic depression (dysthymic disorder). This man or woman has been moderately depressed "for years." A trial of an SSRI has been found to be beneficial for some chronic depressives, but not all.[3] Typically, long-term psychotherapy has been offered to help the depressive person change a lifelong personality style; however, research[4] has not documented that traditional psychotherapy is successful with these patients.

When I evaluate a chronically depressed individual in my psychiatric office, I often have the thought: "If this person could learn to think differently about a few fundamental issues, I bet they wouldn't be depressed any longer." This thought points directly to the paradox of a brief cognitive therapy as a useful treatment approach to the patient with dysthymic disorder.[5]

Finally, it is not unusual to find a person who is dysthymic and periodically experiences acute major depressive episodes. I believe this so-called "double depression" calls for pharmacologic treatment complemented by brief psychotherapy.

CASE PRESENTATION

Ms. A, a 50-year-old married mother of 2 grown children, consulted her family physician because she was "oversleeping and always tired." She had recently gained 10 unwelcome pounds and found her motivation and concentration with her real estate clients were subpar. She was becoming easily angered and periodically cried for no apparent reason.

Ms. A had a hysterectomy for fibroid tumors 3 years earlier and was not on hormone replacement therapy. But, in truth, moderate sadness had been her companion since she was a teenager. Ten years earlier, she had become acutely depressed for the first time when she left grade-school teaching to start a career selling real estate. Her family doctor prescribed paroxetine (Paxil), 20 mg, which she took successfully for 12 months. When major depressive disorder recurred 3 years later, a new doctor prescribed fluoxetine (Prozac), 20 mg, and Ms. A had another successful response. She continued the medication for 3 years and felt better.

She told her family doctor that 3 months ago her acute depression returned, leading to the recent visit to her family physician. In response to questioning, Ms. A told her family doctor about her lifelong dysthymia in addition to her 2 prior episodes of acute major depression. He

prescribed escitalopram (Lexapro), 10 mg, and referred her to me for brief cognitive therapy.

When she came to my office, Ms. A had taken escitalopram for 10 days. My working diagnosis was major depressive disorder and dysthymic disorder according to DSM-IV criteria. We agreed on a course of brief cognitive therapy to attack the major beliefs supporting dysthymia.

PSYCHOTHERAPY

By the time she reported (2 weeks later) for session 2, Ms. A acknowledged that her sleep had normalized and her fatigue was diminished. She was eager to begin work with me. I explained the rationale for the cognitive model: feelings and behavior were influenced in the here-and-now by thoughts. We discussed the concept of attribution (seeking explanations for distressed feelings) and the human habit of assigning meanings to events and situations. She went on to describe 3 situations that had provoked irritation in her. Her boss at the agency asked her to come in on a day off to discuss an incident with a client. An assistant assigned to help her had not done her job, leaving it for Ms. A to do. Finally, she was asked to advise her boss on a company policy and saw 2 equal alternatives. Asked to choose, she told her boss she could not, and he responded with frustration and disapproval.

In each case, Ms. A identified the belief underlying the emotional discomfort. In each case, her understanding of the situation did not seem sufficient to her to warrant her reaction. Together, we discussed possible alternative views. I pointed out that, with practice, this was a process she could initiate and use on her own. I encouraged her to list situations, feelings, and thoughts over the next 2 weeks to form the agenda for our next session.

Two weeks later, Ms. A brought up 2 more difficult interpersonal interactions at work, this time with coworkers. The boss had apparently been told in each case by one of her fellow salespeople that she was "unapproachable." When she found out, she felt discouraged. We reviewed the 2 situations and together generated options for her to consider. She brightened noticeably as the range of possible viewpoints increased.

In session 4, Ms. A made a series of negative predictions about the future concerning her boss at the agency. We examined her logic in detail, at one point using the blackboard to note thoughts, cognitive errors, and alternatives. The most consistent error was polarization, or black and white thinking. Together, we found multiple "grays" for her to consider.

The subsequent 3 sessions were devoted to devising a cognitive strategy to assist Ms. A in losing weight. She believed that her inability to change her appearance contributed strongly to her consistently pessimistic self view. The final 3 visits (making a total of 10) focused on how Ms. A processed feedback from others to support her negative self view. We discussed her tendency to selectively filter what she was told, accepting the negative and discounting the positive. I asked her to imagine that she had made similar comments to a highly valued friend of hers. How might someone else react to the same words?

We considered Ms. A's performance at work, her success as a parent, and her role as a spouse. What did each of these areas of function tell her about herself as a person? We compiled a list of her interests and skills. If she met a person with these attributes, how might she view this person? Ms. A reported increased self-confidence, the beginnings of optimism, and clear mastery of using the cognitive model to question her reflex thoughts when they were associated with distress.

Beyond the initial intake, we spent no time on the origins of Ms. A's negative self view. Cognitive therapy typically is grounded in an exploration of thinking in the present, not an evaluation of the past. Our sessions were conversational and not without humor at times. My note to Ms. A's primary care physician acknowledged the success of her antidepressant trial in the treatment of her acute depression. I stressed the importance of maintenance pharmacotherapy in light of her 3 acute episodes of depression. I gave Ms. A full marks as well for making a major change in her self view, ending a virtual lifelong struggle with dysthymia.

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