

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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Diagnostic Dilemma

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When it becomes known that you are a cognitive therapist, you receive some referrals of patients who have not been helped by other approaches. While cognitive therapy is far from a panacea for "everything," the model is easy to understand and apply, and the therapist and patient typically learn quickly whether it will prove helpful. The success of cognitive therapy is dependent upon the therapist's knowledge of the method and the patient's motivation to do the work to apply it.

Some of the patients who were not helped elsewhere may have been misdiagnosed. While the descriptive phenomenology of depression is fairly straightforward, discriminating bipolar disorder from major depressive disorder is not always easy. In some cases, the DSM-IV criterion of 1 month of depressive symptoms may also not be met. Rather, a history of brief, reactive depressions that last for 2 weeks or less may be the clinical presentation.

When Ms. A was referred to me by my colleague in primary care, she presented a diagnostic dilemma. She had been treated by a psychiatrist for bipolar disorder for 5 years and recently had begun to question the accuracy of the diagnosis. When she told her doctor the story at a routine physical examination, he referred her to me.

CASE PRESENTATION

In situations like this one, it is crucial to start by taking a careful history. Ms. A was a 48-year-old woman, married for 25 years, with 4 teenaged children. Born in Chicago, Ill., she was the eldest of 3 children and the only girl. Her mother was a nurse, and her father was a career Army engineer.

She described a happy childhood followed by high school graduation with average grades. She was accepted at George Washington University, graduating 4 years later with an A.B. degree. She took and passed a real estate examination and lived in a suburb of Washington, D.C. She met the man she would marry in church, and they were wed in 1980. Her husband's job brought them to Charleston, S.C.

She reported no family history of depression, emotional disorder, or substance abuse. Ms. A was emotionally well until 10 years before we met, when she began to experience short episodes of depression. These episodes would seemingly occur during stressful periods in her life and would typically begin with fatigue. Her sleep would then become disrupted, and concentration would become difficult. She would feel sad but would not cry. Within 2 weeks, the episodes would end. She recalls having 2 to 3 such episodes a year for the next 4 years. There was no history of mania or hypomania.

Five years ago, when she experienced her sixth brief depression that year, she talked with her primary care physician and was referred to a psychiatrist. He diagnosed bipolar disorder and prescribed lithium carbonate (900 mg) and bupropion (400 mg). She took the medication,

accepted the diagnosis, and saw the psychiatrist periodically over the ensuing 5 years.

After reading about bipolar disorder and talking with friends, she decided to present her history of depression and its treatment to her new family physician. He questioned whether Ms. A's history met criteria for manic-depressive illness and referred her to me for another opinion and cognitive therapy.

PSYCHOTHERAPY

Ms. A wanted a "different approach" to her disorder and had read about the cognitive model. After an intake session, I presented my version of cognitive therapy to her. She was eager to begin. Using examples from her history, we started to apply the cognitive model together. There were multiple examples of "what ifs" and the frequent application of negative conclusions about events to her view of herself. I illustrated and we applied the triple-column technique to a variety of situations she presented. We focused on the meanings she assigned to events, questioning their relevance and strategic worth. I asked her to keep a triple column for homework, and we set up a third appointment for 2 weeks later.

Ms. A returned to describe in detail a career change that she was considering. She noted that she had always had a strong need for approval. We discussed her work goals in a format of choices and consequences. I emphasized perspective, and we focused on the present time. She asked what I thought about decreasing first her antidepressant medication and then the mood stabilizer. I responded that we couldn't be sure, but I did not think that she suffered from bipolar disorder. I would help her taper and discontinue the medication.

I saw Ms. A twice more (a total of 5 sessions), and she successfully weaned herself off bupropion and then lithium carbonate. She was using the cognitive therapy model

to validate her self-view and had made real gains in self-confidence and assertiveness.

FOLLOW-UP

Over the ensuing 2 years, I received several letters that spoke of progress and positive changes. Two years after our last session, Ms. A called for an appointment. After 2 years of no episodes, a recent stressful period had been followed by 2 weeks of lethargy, anxiety, and disrupted sleep. Over the next 2 weeks, Ms. A developed a clear episode of major depressive disorder. She had visited her family physician who had started a trial of sertraline, and she was now taking 100 mg/day.

Together, we applied the cognitive model to understanding current problems with her adolescent children. We generated choices and discussed consequences. I suggested an increase in sertraline to 150 mg/day. The depressive syndrome resolved over a 6-week period. We employed cognitive therapy to dispute some personal conclusions as well as some anxiety about the future. We met for a sixth and final time 1 month later.

Ms. A was now "returned to her normal self." We discussed her attributes as applied to work and to parenting at home. We examined her effect on others both at work and at home. We appraised the meaning of this depressive episode with regard to a diagnosis. I thought the best diagnosis for Ms. A was DSM-IV major depressive disorder (296.30). The only major depressive episode had been preceded by years of brief, reactive depressions. I continued to doubt the diagnosis of bipolar disorder. No mood stabilizer was prescribed. Sertraline was to continue for 1 year.

It is now 2 years since this last visit, and her occasional letters relate that Ms. A continues to do well. She is no longer taking any medication and credits cognitive therapy with teaching her a new and successful way to view herself, the world, and the future. ♦