

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 Difference

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I have been preoccupied for the past 25 years with the active ingredient question: When psychotherapy works, why does it work? I explored the answers to this question as the basis for the opening chapter of my new book, *Cognitive Therapy: A Practical Guide*.

It is true that clinicians (as well as common folk) sometimes can't see the forest for the trees. It is also true that the aim of a psychoeducational approach like cognitive therapy is to teach the patient, but we still have much to learn from our patients.

Recently, a patient of mine served as a reminder that there is something more important for us to do than teach and that there is perhaps even a more important question to ask than the one about active ingredients. A card that she sent me 6 months after a brief course of cognitive therapy had ended focused my attention on "making a difference."

The more I thought about it, that simple phrase captured my motivation for treating terminal cancer patients and, perhaps, explained why I've always "enjoyed" working with depressed and anxious patients as well. It seems right to share this young woman's story with other clinicians in the hope that they will be reminded of people in whose lives they've played a similar role.

CASE PRESENTATION

Rachel, unmarried and a single mother to her 8-year-old daughter Eileen, was a frequent visitor to her family physician. She was 28 years old and a high school graduate, and she had "lived a lot of difficult life" in a short time. She had an apartment with her daughter, near the house where she had been raised by her mother and father, along with a younger brother.

She had worked a succession of undefined, short-term jobs to pay the rent and support herself and her daughter. Marrying the man who made her pregnant, she was "abandoned" by him 3 years later. His support for his daughter was inconstant, and his relationship with Rachel was a source of continual disappointment. Her visits to the family physician had focused on persistent fatigue, periodic severe headaches, unreplenishing sleep, and symptoms of an irritable bowel.

After 2 years of moderate complaints, Rachel had recently developed affective symptoms of major depressive disorder. Her doctor prescribed sertraline and referred her to me for cognitive therapy.

PSYCHOTHERAPY

Rachel told me she could only afford to come every 2 weeks (even at the reduced fee I proposed). My working diagnosis was major depressive disorder (296.30) and generalized anxiety disorder (300.02). After a careful history and diagnostic assessment session, and after she authorized a lengthy brainstorming telephone session with her doctor, I taught her the cognitive model in session 2. I illustrated situations and feelings from incidents she related during our initial meeting and asked her to supply the corresponding thoughts. She seemed to grasp the model, and I felt we had established rapport in our 2 hours together.

By session 3, there were indications of medication response to sertraline (I had increased her dose to 100 mg). We had already discussed her personal habits of diet and exercise, the question of whether she and her daughter should relocate, and how to prepare for occasional visits by her ex-husband to see his daughter. She commented that, as she gained some control and understanding of her responses to others, she was feeling “stronger in her dealings with the world.”

In session 4, she stressed the need to be successful in trimming 40 lb of unwanted weight. We worked on a plan for weight loss. She discussed anxiety surrounding visits to the dentist, focusing on her underlying expectations. She returned for session 5, having embarked on and become committed to weight loss and exercise. She had dealt skillfully with a visit from her in-laws. She was designing a plan to market her artwork—formerly an enjoyable hobby, now seen as a marketable commodity. She discussed fears about aging, the future, and responsibility.

By session 6, she had found a house to move into, had negotiated a raise at work, and “was no longer scared to be alone.” We reviewed her relationship with her ex-

husband, her parenting of Eileen, and her concerns for the future. The centerpiece of our common concern was Rachel’s changing view of herself and her increasing sense of self-efficacy.

We met again 3 weeks later. She felt strongly that she was now able to make important life choices and able to speak her mind when she felt that she needed to.

There was a sustained positive change in self-worth. Our final meeting (session 8) produced the statements, “I am no longer so worried about what others think, no longer have multiple fears, and have learned that how you think about things can change you so much. It’s amazing.”

The card came almost 6 months later. “I am grateful to you for helping me to turn things around,” she wrote. “When I first came to you, I was helpless and lost. You showed me a different way to think about things and taught me not to be so hard on myself. Thank you for helping me to believe in myself.”

The active ingredients in this therapy? Medication, cognitive therapy, the relationship? All probably contributed to the outcome. What was priceless? Making a difference!