

## THE PSYCHIATRIST'S TOOLBOX

## The Wonders of Cognitive Restructuring

More than 20 years ago, two physicians I knew—a cardiologist and nephrologist—called my office to see if I would see a patient with hypertension that was not well controlled by medications. He was a corporate attorney, and a consultant to many Fortune 500 companies.

Both doctors described this patient as a fine gentleman and a “lawyer’s lawyer” with the kind of reverence reserved for legendary physicians referred to as “doctor’s doctors.” In this case, the patient’s own physicians were unable to satisfactorily control his hypertension.

They knew that I specialized in symptom control in many areas of psychiatry and medicine, including ancillary work in hypertension when medications were not as effective as the treating physicians wanted them to be (The Psychiatrist’s Toolbox, “The Mind and Medicine,” CLINICAL PSYCHIATRY NEWS, April 2005, p. 67).

The patient called, and we set up an appointment. During our first meeting, I took a detailed history of his medical problems, which essentially were the uncontrolled hypertension. He was no stranger to psychotherapy: Years earlier, after the death of a loved one, his grieving went on far too long, in his estimation, and he had a positive result with psychotherapy.

I explained the approach that I would use to control his hypertensive illness. He understood and was more than happy to give it a try.

I began by taking his blood pressure. Then I taught him a hypnotic/imagery technique to simply relax. Afterward, I introduced the idea of him visualizing a sphygmomanometer. As he relaxed more and more, taking slow, deep breaths, I had him visualize the column of mercury slowing as it went down. We did this for about a half hour. Then I took his BP and, to my surprise, there was no change from the original increased BP.

He was an enthusiastic patient who liked the strategy and wanted to try it again. So we did.

Again, his BP did not decline, despite the results I had seen with numerous other pa-

tients who also had been referred, and despite the literature, which showed that various relaxation therapies and strategies do work as an ancillary method to help control increased BP. Before the visit ended, I taught him how to use the hypnotic relation technique on his own and encouraged him to continue trying and to take his own BP.

Two weeks later, he called and reported no decline in BP but wanted another appointment. I made the next appointment, explaining that the strategy I would use would not be much different from the one I had used during our previous 90-minute visit. He was okay with this.

I got back to the two referring physicians and reported my lack of success, but they encouraged me to see him again. Their respective views were: “He wouldn’t want to return if he weren’t getting something out of it” and “This guy knows what he wants, so do it.”

We had our second visit, and the results were the same—no decrease in BP. I suggested that other short-term techniques were available, particularly biofeedback, which I thought would fit well with his cognitive personality style. He declined. He said he wanted to continue working with me. I explained my thinking: If a strategy fails, it makes sense to move on to something different.

I agreed to continue seeing him, but I planned to try something different. It would require maybe 3-6 months of a focused type of talk therapy that he could end at any time. Before starting, I decided to get in touch with a well-respected cardiologist, friend, and colleague, Dr. Edwin Weiss of the NYU Medical Center. I boned up on the most current thinking on hypertensive disease and then sought his opinion about this case.

He went rather quickly through medical issues of high blood pressure and told me that when we write the scientific reasons for medical illness, including hypertension, we must remember to “write the evidence in pencil.” His suggestion was very clear: “You like this guy. He wants an approach to solve the problem. Use your ap-

proach on his heart and circulation by being his psychiatrist, and do your best.”

The patient agreed to the 3- to 6-month time period and we began to move forward. My plan was to use the Learning, Philosophizing and Action technique that I had developed at the NYU Medical Center’s short-term psychotherapy program. This approach is my integration of behavior modification, learning theory, and cognitive therapy to help patients gain control and empower themselves to overcome emotional problems.

Because the action phase, which I used with this gentleman at the onset, was unsuccessful, I planned to focus on the learning and philosophizing aspects.

This patient was an expert pragmatist. He was focused, to the point, fair minded, and willing to learn and understand. He was not only a lawyer’s lawyer but, as it turned out, a very fine person.

From the moment I met him, though, there was one thing I noticed. He reminded me of the line from a song that says “it takes a worried man to sing a worried song.” In short, he looked worried.

In fact, he was worried and defined himself as a worrier. My experience with psychologically treating hypertensive patients was that most presented with excessive worrying.

My plan was to use the learning phase of the LPA technique to its fullest. I returned to what my father taught me about psychosomatic medicine and to my residency training at the NYU and Bellevue medical centers, and I began discussing with this patient the ideas of Dr. Helen Flanders Dunbar and Dr. Franz Alexander.

I tried to relate the patient’s excessive worry to a state of tension and possible spasm of voluntary or smooth muscle that would fit the Dunbar model. Too much tension developed by worry could lead to smooth muscle spasm of the vascular system, leading to increased BP.

The Alexander model, as I recalled, focused on very self-controlled, aggressive, and anxious responses in people who were indeed easygoing. Certainly, excessive worrying could fit both theories. So we worked this cognitively, and we both learned how mental processes could be a factor in his uncontrolled hypertension based on the worrying “gene.”

We all know that the psyche has a great

influence on short-term bodily functions—sweating, headache, diarrhea, backache, and many others. We can document this connection in a linear way. At promotion time, we again get some psychophysiological response. However, when we don’t have the exact linear cause and effect, the explanations get more complicated, and sometimes, by expanding learning theory concepts, we can develop sensible approaches to an individual’s specific problems.

To come out and say that the patient worried too much would not have been therapeutic in this case, but as we developed a language of cognitive understanding of mind-body relationships based on those theories, we noticed, at about the 2-month point, a decrease of 2-3 mm Hg in systolic and diastolic blood pressure.

As modest as these numbers might appear, a consistent 2-3 mm Hg decrease in blood pressure through rethinking techniques is appreciated by cardiologists.

What I believe occurred in this reexamination of the patient’s “worry system” was a reprocessing of what needed to be worried about and to what intensity. In other words, a hierarchy of worries was established, which this super-intelligent attorney had not had before. We ended our formal treatment around the 4-month period but kept in contact for 2 or 3 years with periodic reinforcement visits. I planned to schedule four or five visits a year, which he felt was useful.

Taking the Dunbar and Alexander theories and placing them in context with a learning/cognitive process worked. The patient had some benefit. He was pleased. So were his other doctors, who continued a medication regimen. A specific cognitive/relearning technique worked for this patient. The patient did cognitive restructuring using hypothetical constructs.

In this patient’s case, and in many others, learning about worries and philosophizing about theories—some real, some imagined—made a difference.

E-mail me at [cpnews@elsevier.com](mailto:cpnews@elsevier.com) and let me know about your experiences with treating patients with psychophysiological problems. I’ll try to pass these ideas along to my readers. ■

DR. LONDON is a psychiatrist with the New York University Medical Center and Lutheran Medical Center, New York.



BY ROBERT T. LONDON, M.D.

## Depression Linked to Increased Risk of Cardiac Arrest

MARY ANN MOON  
Contributing Writer

People with clinical depression are at nearly twice the risk for cardiac arrest as those who are not depressed, independently of their other cardiovascular risk factors, said Dr. J.P. Empana of Hôpital Paul Brousse, Villejuif, France, and associates.

There may even be a dose effect in which the risk of cardiac arrest rises as the severity of depression increases, they said.

They assessed the relationship between

physician-diagnosed depression and out-of-hospital cardiac arrest using data from a large U.S. HMO. The study compared the prevalence of depression among 2,228 patients aged 40-79 years who had incident cases of cardiac arrest with 4,164 controls.

Unlike previous studies of this issue, this investigation evaluated “a large population with a wide range of demographic and clinical characteristics,” Dr. Empana and associates said (Arch. Intern. Med. 2006;166:195-200).

However, the population studied was

not racially diverse; 93% of the subjects were white.

The risk for cardiac arrest was almost twice as high for people with clinical depression than for those without depression, with an odds ratio of 1.88. After the data were adjusted to account for numerous cardiovascular risk factors, the odds ratio remained elevated, at 1.43.

This association between depression and cardiac arrest was seen across all demographic subgroups. Men and women were equally affected, as were elderly peo-

ple and younger adults. The risk of cardiac arrest increased with increasing severity of depression, so that people who required hospitalization for their depression within the preceding year were at highest risk.

A previous case-control study suggested that the use of tricyclic antidepressants may raise the risk of sudden cardiac death. However, that suggestion seems to be refuted in this study. Excluding the subset of 277 patients who were taking antidepressants, 82% of whom were taking tricyclics, did not alter the results, they said. ■