Prescribing Brief Psychotherapy

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Brief psychotherapy has demonstrated its effectiveness in treating emotional disorders and helping with problems that typically present to primary care physicians. Because practitioners receive little instruction about this treatment option and often have erroneous preconceived ideas about it, psychotherapy remains underprescribed. Effective brief therapy enables the patient to problem-solve, facilitates the relationship with the provider, and ultimately clarifies the patient's situation. Referral of appropriate patients for psychotherapy will enhance the effectiveness of the doctor in primary care.

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Mrs. Brown is a 31-year-old married woman with 2 children who presents with the problem of episodic chest pain. Her history reveals associated symptoms of hyperventilation, paresthesias, and dizziness. When cardiac and pulmonary etiologies are ruled out, you consider a diagnosis of panic disorder and discuss pharmacologic options with her.

Mr. Green is a 42-year-old married man with 3 children whose chief complaint is unusual fatigue and disrupted sleep. Further history adds a decrease in appetite, a loss of usual interests, a loss of sexual desire, and poor concentration and memory. You diagnose major depression and consider the array of available antidepressants.

Ms. Rhedd is a 38-year-old single attorney who, in the midst of a visit ostensibly about the onset of an annoying cough, discloses a history of a traumatic sexual assault 10 years earlier. She tells you about a series of arousal symptoms and avoidances she has been experiencing lately.

Dr. Black, a 53-year-old male physician, inquires about a plan to reduce the accumulating stresses he faces both at work and at home. He speaks, uncomfortably, about the pain of years of marital discord and the impact he fears it has had on his 4 teenaged children.

Mrs. Blue, a 65-year-old housewife, has reached the limit of her capacity to care for her husband, diagnosed with Alzheimer's disease 5 years earlier. She asks your help in wrestling with the decision to seek live-in help or consider nursing home placement for him.

Mr. Gold, a 27-year-old divorced journalist, continues to be preoccupied with the death of his mother 2 years earlier. He has not reestablished social activity, preferring to go to work and then stay home in the evening. He is concerned that his life may always be like this.

Although it is unlikely that these 6 patients will sit together in your waiting room on a given day, it is highly likely that you have seen each problem at some point in a general medical practice. Even though pharmacologic approaches are available (and likely known to you) for some of these problems, there is a similar approach to all 6 patients that you may know less about. Each is a candidate for brief psychotherapy, and most people with the problems illustrated are likely to benefit immeasurably from it.

Unfortunately, physicians in primary care are typically taught little about psychotherapy. They bring preconceived ideas to the prospect, little different from those of the uninformed man or woman "on the street." This deficiency is remediable.

As a psychiatrist hired to work half time in a medical clinic, I observe this deficiency almost daily, along with the real motivation among many of my medical colleagues to address it. This article aims to provide a step in that direction. Its long-term goal is to make the prescription of brief psychotherapy as easy for the practitioner as prescribing medication.

PRECONCEIVED IDEAS

Although society affords general physicians a responsibility that includes counseling and educating patients, it ill-prepares them to discharge this task. Practitioners of psychotherapy have not helped when they have alluded to their practice as "mysterious" and not subject to the usual rules of logic. The stigma associated with attending a psychiatric clinic or acknowledging an emotional disorder, less now than it once was but not yet scrapped, has not helped either. The estrangement of the psychiatrist and the general internist is a third negative factor. It is my hope that the continuing availability of a psychiatrist in the primary care setting will play a role in overcoming this distance.[1]

Unfortunately, common sense applied to psychotherapy is often juxtaposed with the misrepresentation in film and books of this approach to problems.[2] Psycho-

therapy, as seen by an outside observer, is often boring and tedious. Seeking a story to tell, and often a comedic turn, the media have portrayed the therapist as "weird" or "goofy." Too often, the therapist is painted as a charlatan: one who either does nothing while the patient continues to suffer or is ineffectual. Information disclosed by the patient is often discussed with others, advancing the story line but compromising confidentiality, thus undermining one of the pillars that supports successful psychotherapy. Inappropriate (often romantic) relationships between therapist and patient abound in the fictionalized portrayal, thereby undermining a second pillar: the need to respect boundaries. Finally, in an attempt to build suspense, the psychotherapeutic process is described often as a "search for a central trauma."[2] Once the therapy identifies it, the patient is seen as "cured." This make-believe depiction badly misses the mark of most successful psychotherapy.

The symbols by which psychotherapy is represented and the myths about its process contribute to misunderstanding as well. Few therapists today employ "the couch." Patient and doctor sit in comfortable chairs, facing each other. The duration of brief therapy, by definition, is measured in weeks and months, not years. Sessions, often weekly, are limited to 10 to 20 in number (sometimes as few as 5). The interaction is more often a dialogue than a patient monologue. A focus on childhood is no longer the norm, and the myth of blaming parents is rarely upheld. While some patients expect the therapist to hear their dilemma and then give advice, most therapists avoid advising and stress the patient's responsibility for decisions in his or her life.

WHAT IS PSYCHOTHERAPY ABOUT?

It has been established that patients receiving psychotherapy report greater improvement than those who do not.[3] One respected therapist, Paul Watzlawick, along with his colleagues has written that "Psychotherapy is sought not primarily for enlightenment about the unchangeable past, but because of dissatisfaction with the present and a desire to better the future."[4(p.ix)] In commonsense terms, psychotherapy is about relationship and conversation.

Many of the relationship factors identified as central to successful psychotherapy apply equally to the establishment of a healing connection between general physicians and their patients. Warmth, acceptance, genuineness, and empathy (the so-called WAGE factors) head the list.[5] For a successful outcome, the relationship must be confiding and often emotionally charged.[6] An early task for the pair is "engagement": the formation of a therapeutic partnership in which both members are "on the same wavelength."

In addition, I was taught in my residency training at the University of Pennsylvania that therapy success is made more likely by a "therapeutic match" between participants. This concept encompasses a similarity in personality style, the therapist's familiarity with the type of problem the patient presents, an appropriateness of the therapist's technique to the patient's problem, and a fit between that technique and the patient's expectations.[6]

The office setting impacts both the relationship and engagement by affecting the patient's expectations. In the ideal situation, the decor and ambience convey prestige (credentials, training) and safety (ethics, confidentiality, boundaries).

Within the context of a therapeutic relationship, the transaction will focus on the second major factor: conversation. Whether formally stated or informally observed, most psychotherapy sessions are guided by an agenda. Initially, the patient presents his or her version of "the problem." The therapist asks questions to establish the context in which the problem occurs. This "history taking" may involve most of the initial meeting. In the second session, a plan is agreed upon to structure the approach of the therapy "team" to the problem. It is important that the therapist's approach includes an explanation for the patient's distress.[3] In addition, there must be a sensible procedure offered for change.

HOW CHANGE MAY OCCUR

Change may be approached in a variety of ways. Exposure (whether actual or virtual) may help a person overcome fear. Regaining lost perspective is a common ingredient of most psychotherapies and focuses on the meanings an individual assigns to situations and relationships. Promoting self-esteem, particularly when it has been diminished or minimal throughout a patient's life, may enable the patient to find solutions or approaches to previously insoluble problems. Similarly, insight that applies earlier learning to help explain current obstacles may serve to unleash the patient's problem-solving capacities. An important caveat to remember is that the therapist can direct, guide, or clarify, but change typically occurs only when the patient acts.

Factors promoting change may be stated more directly. The therapist may point out discrepancies between the patient's stated beliefs and "reality." He or she may help the patient to separate the controllable aspects of a problem from the uncontrollable. Typically, the therapist is mindful of mobilizing the patient's hope. It is often critical to stress the need for the patient to take responsibility for himself or herself.

Whatever problem the patient brings to psychotherapy, demoralization typically is brought as well.[6] This phenomenon has been described as a "loss of one's effectiveness." In treating depression, for example, drugs may relieve many distressing aspects of the syndrome. They do not, however, affect demoralization. Changing this element often requires psychotherapeutic intervention. By

successfully changing the patient's thinking about action and effect, demoralization becomes a casualty of rising self-worth.

The psychotherapy process typically provides opportunities to teach mastery. An able therapist will encourage the patient to focus on personal meanings as opposed to events. In the process, the patient is encouraged to become an observer of himself or herself.

Even brief psychotherapy can teach new skills. For the patient who is not prohibited from using what he or she knows, but rather is ill-equipped for the task, this is the usual approach. Role-modeling and the use of examples can help to teach assertiveness, expression, and independence. Central to this teaching is a framework that stresses multiple choices for most situations and then views likely consequences for each choice.

An overarching concern for most brief psychotherapy has been called *reframing*. This process entails changing the viewpoint within which something is understood (placing it in another "frame"). Changing the choices or sequencing within the same field is the order of change that most of us employ most of the time. Watzlawick et al.[4] have called this "first-order change." My grandmother captured this concept when she described housecleaning as "rearranging the dust." Second-order change[4] has been well described by the 1990s concept of "moving outside the box." More concretely speaking, it involves changing the rules on which the system is based. This is the essence of reframing.

COMPLICATING FACTORS

The delivery of brief psychotherapy has been affected by the proliferation of groups with an interest in the process. Previously, the matter involved doctor, patient, and, at times, an insurance company. Today, the prescription of psychotherapy may be impacted by the patient's employer, a managed care organization, various consumer groups, and patients' rights advocates.

In addition, the range of theoretical models applied to brief therapy has been extensive, adding to the confusion of the primary practitioner who may not know what approach patients will find in the therapist's office. Fortunately, there are 3 general categories into which most psychotherapies can be grouped. In cognitive therapies, the focus is on meanings, thoughts, and reframing.[6] In behavior therapy, the approach concentrates on habits, exposure, and teaching skills.[7] In dynamic therapy, insight is imparted by understanding the present in the light of past conflicts and origins.[8]

WHO TO REFER

The introduction to this article represents an attempt to illustrate those problems typically amenable to brief psychotherapeutic interventions. Generally, depressive disorders, anxiety disorders, and posttraumatic stress disorder are prime candidates. The patient with marital, work, or parenting problems can usually be helped. Those who are bereaved, caretaking, or themselves coping with physical illness should also be offered psychotherapy. Finally, the demoralized, those of low self-worth, and people who have lost perspective are good referrals for psychotherapy.

CONCLUSION

It is useful for the primary care practitioner to assemble a number of psychotherapists with whom he or she can speak comfortably. Miscommunication between primary care practitioner and therapist has been a disabling problem in the past, but need not be. An understanding that the patient will continue in the care of the general internist will facilitate the verbal or written contact that provides for the best patient care.

Hopefully, the 21st century will see a closer working relationship develop between primary care and psychiatry. We have much to teach and learn from each other.

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