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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How Brief Can Effective Psychotherapy Be?

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Throughout this series of articles on cognitive therapy, there is a theme of the utility and efficacy of brief therapy for the treatment of a variety of emotional disorders. Not all disorders and patients are amenable to brief therapy, but, when the right clinician meets the right patient, much can be accomplished in a relatively small number of sessions. That number is typically in the range of 6 to 20 meetings. It is not unusual to see gains and improvements in a patient's clinical condition prior to the completion of even a brief course of therapy.

It is often difficult to pinpoint exactly what is responsible for the improvements when they occur so early in treatment. The cognitive therapy model hinges on helping a patient to "shift set" and generate alternatives to the thoughts that lead to anxiety, depression, despair, and hopelessness. Once the set has shifted, clinical change usually follows. The faster the set is shifted, the quicker one may see clinical improvement. In the right setting, this may happen rather quickly and dramatically, underscoring the potency of cognitive therapy.

CASE PRESENTATION

I encountered this patient in the Emergency Department (ED) in my role as a consulting psychiatrist. Debra is a 36-year-old woman with 2 children who came to the emergency room complaining of "not sleeping for 2 weeks." The ED physician elicited a history of 2 weeks of tearfulness and sleeplessness during which Debra slept an average of 2 hours in a 24-hour period. She reported that she had been increasingly upset since her separation from her husband and that she had been unable to work and effectively care for her children due to sheer exhaustion. She recently moved in with her brother's family for support but felt that she was "going crazy" because she could not stop thinking about her husband. Upon further questioning, the ED physician learned that she was initially separated from her husband 6 months prior to this visit to the ED. Debra denied any past or current thoughts of suicide, but as the examination wore on, she became increasingly tearful and stated that "I need to do something because I can't take this anymore." The ED physician called for a psychiatric consultation to further evaluate Debra's current symptoms and need for treatment.

PSYCHOTHERAPY

Upon first entering the examination room, I noted that Debra was disheveled and lying in the "fetal position" on the gurney. When I introduced myself as the psychiatrist on call she slowly sat upright but made little eye contact as she greeted me. Debra related her current symptoms, reiterating that her main concern was her lack of sleep and constant worry about her husband leaving her. She acknowledged feeling hopeless and helpless since her husband left her and was worried that she would "never make it" on her own. I was struck by her thinking, which was

riddled with cognitive errors. In addition, after making a statement with a common cognitive error, she would consistently apologize. Here's an example of this pattern:

"Ever since my husband left, I realized that I cannot do anything on my own, that I was completely dependent upon him. I'm sorry. I know that is a stupid thing to say but I just can't help thinking that way." She was making the cognitive error of over-generalization and recognizing it, but was unable to find an alternative way of thinking. She was only one step away from applying the cognitive model on her own.

Recognizing this, I offered to refer Debra to the outpatient psychiatric clinic so that she could have individual psychotherapy. Somewhat reluctant to accept this, Debra asked for an explanation of "what therapy would be like." My response focused on the triple column format of situation, feeling, and thought. The situation was defined as the separation from her husband. She was quickly able to identify her feelings of being scared, lonely, and at times angry. I defined an automatic thought for her, suggesting an example of her belief that she was helpless and dependent. I emphasized that it can feel like "you just can't help thinking that way." She seemed to readily understand.

The cognitive therapy process involves identifying the thought associated with distress, then challenging it and screening for errors in thinking. She was already able to do this, so we looked together for more examples. She identified the following cognitions in rapid succession: "It is all my fault that he left. If I was better to him, then we would still be together. I should never have married him. I will never find anyone who will love me." As we noted the cognitive errors in each of these statements, Debra began to sit up straighter and she was noticeably more engaged in our conversation.

We then proceeded to seek alternative beliefs. This was difficult for her at first. She noted that she felt she was trying to talk herself into something that she didn't believe. Slowly, she found some alternatives that made sense to her: "I guess it isn't entirely my fault that he left," she said. "In fact, I worked really hard at our relationship and even suggested counseling when things were looking bad. It seemed like he gave up." Her cognitive set was changing right before my eyes. "Things were good between us at first," she said, "but I guess we may be better off apart if he has already given up on us and was not willing to do any work. I have been able to survive on my own and even continue to take care of my children, even if it has meant living with my family for a while."

We finished our discussion by talking about the goal of "changing set," and I let her know that it might take only a limited number of sessions for her to continue her progress of finding an acceptable set of beliefs. We arranged an appointment for her to be seen in 2 weeks. She thanked me for my time, saying that she was hopeful that "just talking with someone" would help her "get through the difficult times." I discussed her disposition with the ED physician, she was discharged, and a quick check of my watch indicated that 50 minutes had passed since I had arrived and met Debra.

Ten days later, I received a message to call Debra at work. She told me that her sleep had improved and that her "set was changing all on its own." She said that she was thinking differently about her separation and was now feeling hopeful about learning to live her life "in a new way." She had been worried about the effect of the separation on her children, but a talk with her husband resulted in an arrangement for him to visit that satisfied her. "I just don't feel as confused or helpless anymore," she said, "and I realized that I am only 36 years old and have a lot of life ahead of me." She thanked me for the scheduled appointment, but told me that she didn't think she needed it right now. She planned to keep the number of the clinic and call if she began "heading back downhill again." She added: "I don't think that will happen now that I know how to keep myself thinking in the right direction."

It should not be inferred that cognitive therapy is typically effective after 1 session. It may take several sessions merely to explain the model and illustrate it and several months, at times, before real changes are evident. Each patient has his or her own way of thinking, and it is up to the therapist to harness the patient's skills to enable them to do the cognitive work. In Debra's case, she was able to think along the lines of the cognitive model before it even was explained to her. As the more formal techniques were introduced to her, she quickly applied them on her own. It seemed clear from her telephone call that she remained in an active phase of healing and continuing to shift her cognitive set. Being alert to cognitive errors that presented while taking her history enabled me to offer an extremely brief intervention at a critical time to a patient in distress.