

## When Brief Therapy Worked and Medication Did Not

F. Andrew Kozel, M.D., and Dean Schuyler, M.D.

Not long ago, long-term psychotherapy was recognized as the gold standard, and brief psychotherapy was the second-rate patch. Responding to a consumer mandate, a trend toward evidence-based medicine, and the regulatory impact of managed care, the positions are now reversed. There are, today, multiple models of brief therapy, and long-term therapy is difficult to find and is often seen as less desirable.

Before there was brief therapy, crisis intervention was the alternative to the traditional long-term psychotherapy. Crisis interventions usually involved a maximum of 6 sessions dealing with a specific event. How shall we define the length of brief therapy? The case presented here remains an "open file" after 23 sessions over an 8-month period.

In addition to being "time-limited," brief therapy typically takes a here-and-now focus, prescribes an active (dialoguing) role for the therapist, and features a flexible therapist role. Although goals are stated at the outset, one successful therapy segment may pave the way for a second or third. A "succession" of successful brief therapies may occupy more time or involve more work than the concept of "brief" usually implies.

### PRESENTATION OF THE PROBLEM

The patient is a 56-year-old employed, widowed mother of 2 children who had been treated with medication for depression and anxiety by her primary care physician for 2 years. Because of worsening symptoms, a psychiatric consultation was obtained while the patient was still in the primary care clinic. The evaluating psychiatrist diagnosed a bereavement reaction and noted the history of major depression and panic disorder. A recommendation was made for brief therapy to help her in the task of "re-creating her life."

The patient had been widowed 27 years earlier. Recent stresses in her life included the cancer-related death of "the love of her life," a man with whom she had had an intimate relationship for 20 years. Owing to circumstances beyond her control, she was unable to be with him during the latter

part of his illness and death. She was also denied an opportunity to grieve openly. In addition, her daughter, who was suffering from bipolar affective disorder, and her daughter's 2 young children had been living with the patient for the past 3 years, creating added stress and life disruption.

The initial evaluation by the treating psychiatrist revealed a long history of difficulty with depression and panic attacks, but no treatment until 2 years earlier. The treatment provided some relief, but not complete control of her symptoms. The recent stress of the "loss of the love of her life" had significantly worsened the depression and increased the frequency of panic attacks. The patient's depression was manifested as a worsening of neurovegetative symptoms including periods of disrupted sleep with middle-of-the-night awakenings followed by hypersomnia, low interest in daily life, very low energy, intense guilt feelings, poor concentration, and weight gain traced to an increased appetite, but no thoughts of self-harm. Her general level of anxiety was elevated, and she was having severe panic attacks 3 times a week. These attacks consisted of rapid breathing, diaphoresis, palpitations, and disorientation. She had begun to avoid malls and crowds, thus restricting herself from activities previously enjoyable for her.

The patient's past psychiatric history revealed the onset of panic attacks in her teens. She had an episode of postpartum depression following the birth of her second child, who died soon after birth. As part of a research project studying psychiatric illnesses in the primary care setting, the patient was evaluated on 2 occasions prior to the death of her romantic partner of 20 years. The first evaluation revealed a significant improvement after taking paroxetine, 30 mg/day for 2 months. She was not having panic attacks, but she still had multiple somatic complaints and a number of neurovegetative symptoms of depression and was not working. She described her remaining symptoms to be of moderate severity. The second evaluation, about 9 months later, revealed a significant worsening of neurovegetative symptoms and a return of full-blown panic attacks. She was not able to get out of bed 3 to 4 days a week. Her somatic complaints were also dramatically increased. The paroxetine dose was subsequently raised to 40 mg/day, and trazo-

done, 50 mg, was added at night to aid sleep. Clonazepam, 0.5 mg twice a day, was later added to help with her anxiety. There were no psychiatric hospitalizations, suicide attempts, or other medication trials. She had no history of substance abuse. Her medical history included 3 live births, obesity, a gastric bypass for obesity, the removal of a colon polyp, and the onset of menopause. Her current medications were paroxetine, 40 mg at night; conjugated estrogen, 0.125 mg once daily; trazodone, 50 mg; and clonazepam, 0.5 mg 2 times a day.

The patient was a high school graduate, marrying soon after graduation. Her husband had died 10 years after their marriage in a fishing accident. She was currently unemployed, having stopped work as a restaurant manager 2 years earlier owing to "nerves."

The treating psychiatrist diagnosed major depressive disorder, recurrent; panic disorder; and bereavement complicating depression using DSM-IV criteria. The recent stress of the loss of a loved one in the context of a stressful home life and limited social support had contributed to a significant worsening of her symptoms. Brief therapy to address her loss, along with a continuation of her medications, was offered to the patient.

### PSYCHOTHERAPY

The therapy began by encouraging the patient to talk about the events and emotions associated with the loss of her lover. By providing an opportunity to focus on her loss and establishing a framework in which to understand it, some of her depressive symptoms rapidly abated. At the second session, she requested that clonazepam be taken only at night, owing to daytime sleepiness. This was agreed to and was to be the only medication change made. She next addressed the current stresses in her life, in the context of their impact on her well-being, and what she could do about them. She was encouraged to express and deal

directly with feelings, even if negative or painful. She and the therapist examined her thoughts to see if they seemed reasonable. By session 3, there was a dramatic improvement in her depressive symptoms and a diminution in the frequency of panic attacks. From the fourth through the sixth sessions, the focus was on stresses in her past and present life and ways to cope with them. By session 6, her panic attacks had ceased and her depressive symptoms were gone. The therapy had achieved what medication alone had not done, even prior to the recent loss of her loved one. She was able to begin a job caring for a young child. Treatment could reasonably have been terminated at this point, since the agreed-upon goals had been met, but a decision was made to help the patient reclaim those elements of her life that had been lost during her illness.

Sessions 7 through 12 were devoted to helping the patient reconnect with lost social contacts. She became more active in church and began to go out and take part in social activities. With a support network now reestablished, she experienced a return of preoccupation with her lost lover. This was our focus from sessions 12 through 16. She was able to deal with the loss and begin to look toward the future. This progress led to our next focus, which involved her relationship with her adult daughter and her wish for the daughter to move out. Using techniques she had learned earlier, the patient worked on this for sessions 17 through 23, and achieved her goal.

Although problems remain, she has learned ways to help her deal with them. She is currently working and is planning a return to school. She has an active social life and participates in a number of organizations. She has experienced no return of depressive symptoms or panic attacks. We are increasing the intervals between visits, leading to periodic meetings for medication management. If the patient finds herself in a situation in which her coping techniques are overwhelmed, I have assured her that we can reinstate a brief therapy to deal with that circumstance.

**Editor's note:** Dr. Kozel is in the fourth (and final) year of psychiatric residency training at the Medical University of South Carolina. Dr. Schuyler is a board-certified psychiatrist at MUSC who works half-time in a medical clinic. As a follow-up to his article "Prescribing Brief Psychotherapy" (February issue), Dr. Schuyler and colleagues will discuss cases referred by primary care physicians. 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.

For further reading: *A Practical Guide to Cognitive Therapy*. 1st ed. by Dean Schuyler, New York, NY: WW Norton & Co; 1991. ISBN: 0393701050