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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Tune-Up

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Many years ago, during the outpatient year of my psychiatric residency training, I was taught about the wisdom of follow-up. Once a course of psychotherapy was completed, making an arrangement for a visit in 1 month (or 3 or 6 months) sent the message that the therapist cared about the patient and would be available if needed in the future.

In a termination session for one of my earliest cognitive therapy patients, I broached the subject of follow-up. He responded: "I take my car for an oil and lube every 3 months. I want to take at least the same care of my emotional health. What if we met once every 3 months?" I set up an appointment for 3 months later, and we continued to meet once every 3 months for 3 years.

I began to think of these sessions as "tune-ups," an opportunity to look at one's life with the perspective of someone who had momentarily left life's path for a broader view of how they were living. It occurred to me that such a tune-up might be of value even without the course of psychotherapy that preceded it.

Fast forward to the present (30 years later) and a telephone call from a therapist (Dr. A) whom I had known distantly many years ago. "I feel burned out at work, I wonder if my current relationship is right for me, and lately I've had almost continuous anxiety," she said. "Anxiety to this degree is unusual for me," she added. "I think I could use the equivalent of a tune-up."

PSYCHOTHERAPY

I took this to mean a short course of cognitive therapy. We scheduled an intake appointment, and Dr. A discussed in detail the context for her current situation. A review of her family history, early life, psychotherapy training, first marriage and divorce, concern about her aging parents out of state, 2 successful children, love of travel, and an earlier course of psychotherapy following her divorce constituted the first step.

Diagnostically, there was no major depressive disorder and no history of generalized anxiety disorder. Rather, she had become situationally anxious once before, and now once again, prompting the call for this appointment. My diagnosis was adjustment disorder, with anxiety.

A review of the cognitive model was step 2: situations, feelings, and thoughts; identification of key meanings associated with stress, evaluation of those meanings in terms of their strategic value, and the development of alternatives. Some of Dr. A's anxiety diminished simply by laying out her story in front of a listening ear. She quickly adopted the language of cognitive therapy and began to approach each anxiety-evoking area in turn.

There were no triple columns drawn on a blackboard. Instead, we had a conversation, and I focused Dr. A's attention on her thinking in each case. She decided that her job, while stressful, was something she wished to continue for now, while preparing for an "after-career" as a

travel agent. She was taking courses in travel, with a goal of a part-time job in 3 years.

Dr. A decided that there was no real urgency attached to her current relationship, so she might as well enjoy it and see where it took her. Similarly, there was no urgent need to change course with her parents, rather an opportunity to spend some time with them as they lived out their lives.

We discussed how one's beliefs could generate anxiety and how she was in charge of that. We talked about her priorities and defined the stage of life in which she saw herself. We reviewed choices in each area and traced their consequences.

In session 3, Dr. A focused on how she had regained perspective in each of the areas that were contributing to her stress. She noted that her anxiety had virtually disappeared and that she "felt much more in control of her life." I told her that I would be happy to meet with her again in the future, if she believed that another tune-up was in order.

DISCUSSION

What we accomplished together in 3 hours used to be called "crisis intervention." It was brief, targeted, and typically present-oriented. The model of cognitive therapy lends itself well to this situation. It can help individuals experiencing distress to regain perspective and balance in their lives, and its structure and focus on meanings may provide the format for a successful brief intervention.

Like my patient said, if one attends to the maintenance of one's car, it makes sense to attend also to the maintenance of one's emotional well-being. A tune-up when needed may help a person to smooth out the bumps on the road of life. ◆