

# Brief Psychological Therapy in Primary Care: The Psychologist's Challenge

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Psychologists working in primary care in New Zealand often face unique challenges in the way they deliver their interventions. The development of a managed care model or funded therapy session packages has led to psychologists being expected to work within a very brief therapy window, most often only four to six sessions. In this article two psychologists working for the primary health care organisation, ProCare in Auckland, describe how they have adapted their practice using the Biodyne Model of Psychotherapy, to account for the limitations of managed care. The authors demonstrate how they have adapted to the tension between competent clinical practice and the funding environment, and appropriately conclude that this is a useful way to work.

The New Zealand Primary Mental Health Strategy has led to the Ministry of Health funding a variety of initiatives designed to improve the access to and provision of mental health services to the primary care population, to utilise funding efficiently and to serve the population effectively (Dowell, Garrett, Collings, McBain, McKinlay, & Stanley, 2007). Many of the Primary Health Organisation (PHO) initiatives provide “packages of care” – funding for brief psychological interventions of approximately four to six sessions. A recent review of the initiatives reported that they are making a positive impact, with almost 80 per cent of service users reporting significant benefit (Dowell et al., 2007).

Primary care psychology is distinguished from secondary care, where clients typically present in a severe and chronic state and often with high risk issues. A primary care psychologist has been described as “a general practitioner who has skills in the psychological assessment of and intervention with common health problems of patients and families throughout the lifespan” (Frank,

McDaniel, Bray, & Heldring, 2004, p.64). Ministry of Health initiatives regarding provision of psychological therapy at the primary care level have introduced psychologists to opportunities for therapeutic interventions while people are in the mild to moderate level of emotional distress.

## The ProCare Context

ProCare is one of the largest PHO networks in New Zealand, comprising three geographically based PHOs in the greater Auckland area. The three PHOs include approximately 177 practices involving 500 general medical practitioners, 450 practice nurses, and an enrolled population of approximately 650,000 people, of which over 130,000 are of Māori or Pacific ethnicity.

The ProCare network developed its Primary Mental Health Programme approximately five years ago in response to the Primary Mental Health Strategy and to other evidence indicating interventions were needed at the primary care level, for example, the Mental Health and General Practice Investigation (The MaGPIe Research Group, 2005).

The ProCare Primary Mental Health Programme addressed barriers to the provision of primary mental health care, including cost, accessibility and patient reluctance to seek help (Chiplin, 2002; MaGPIe, 2005), by providing three core strategies:

- Building capacity through continuing education and training to GPs and Practice Nurses to recognise and treat common mental health conditions adequately.
- Resolving barriers of cost and time by targeted funding for extended consultations for GPs to discuss mental health issues with patients using the “Engage” program.
- Ready access to evidence-based brief psychological interventions: psychological service integrated with and alongside general practice.

The third core strategy resulted in the development of ProCare Psychological Services (PPS), situated in two Auckland localities (central and south), providing brief psychiatric and psychological interventions for a variety of common primary mental health presentations, including depression, anxiety, relationship problems, trauma, and adjustment disorders. Additionally, health psychology interventions are provided for management of chronic health conditions and functional disorders such as irritable bowel syndrome, chronic pain and chronic fatigue syndrome. PPS has typically employed at least one psychiatrist and several psychologists (including

clinical, health, child and adolescent), as well as psychotherapists, who are supported by administrative and operational staff. Therapists employ a variety of therapeutic approaches including cognitive-behavioural therapy, transactional analysis, motivational interviewing, problem solving, and psychotherapy.

Most PPS clients are funded by the DHB generally for up to six sessions. Six session therapy packages feature highly in managed care settings overseas (for example, in Australia, as discussed by Kohn and colleagues (2001)). Funding is aimed at clients who have mild to moderate mental health needs, and the funding is separate from the top three per cent of mental health needs that are served by Community Mental Health Centres (CMHC) and other DHB services for severe mental illness including people with safety issues. To qualify for funding clients must meet criteria set by the funder and the PHO. In addition clients are rated using the Kessler-10 or Patient Health Questionnaire-9 instruments to measure severity, which are standard instruments used across the primary mental health initiatives (Dowell et al., 2007).

### **Brief Therapy: Development and Practice**

The assumption that therapy needs to be of an extended period is likely an artefact of the roots of modern psychotherapy in Freudian psychoanalysis. A full course of psychoanalysis frequently required several sessions during the week over a period of three to five years. Consequently, psychoanalysis was available only to those with the time and the money to purchase the treatment. The aim of therapy was to cure the client of their neuroses; accordingly a return to therapy was frequently perceived as a therapeutic failure (Hoyt & Austad, 1992).

While over the course of the past century theorists have developed different theoretical perspectives about human development, behaviour, and how to reduce human distress, the notion that human behaviour change requires therapy over a long period has tended to persist. In conflict with the notion that therapy takes a long time and is

expensive, has been the developing need to respond effectively and ethically to limited funding and the psychological needs of the people. The response has come in the form of managed care, which has its roots in the USA and is an outcome of efforts to increase access to health services, particularly to the lower socioeconomic groups. The move to time-limited therapy parallels occurrences in many general health services: treatments have tended to become shorter, outpatient services are used in preference to inpatient settings, and efforts are made for treatments to be less intrusive (Austad & Hoyt, 1992; Hoyt & Austad, 1992).

It appears within the field of time limited therapies there is a lack of consensus about how many therapy sessions comprise a time limited intervention (Bedics, Henry, & Atkins, 2005; MacNeil, 2001; Miller, 2000). However, there is agreement that time limited therapies all share at least one commonality and therapeutic tool: time. The time constraint helps to focus the therapist and the client for full engagement in therapy and requires the therapist to be active in establishing attainable therapeutic goals, to be disciplined and pragmatic. Time-limited therapy aims for each session to be an intervention with a discrete outcome so that the client experiences change as soon as possible (Fosha, 2004).

Time limited therapies propose that most clients in the low to moderate range of psychopathology can be helped relatively quickly. Research about the efficacy of brief therapies has shown similar outcomes for time-limited and time-unlimited therapies and that gains tend to be rapid at first and then slow significantly. Various studies have supported the finding that most gains are made within the first ten sessions (Bloom, 2001; Miller, 2000).

While there are models of brief intervention for specific problems and principles for undertaking brief therapy, there is no model of therapy for six sessions or less as is the operational protocol for ProCare Psychological Services (PPS). The PPS protocol of six sessions or less per client is based on historical mean frequencies of therapy sessions and the limitations of managed care. PPS aims to provide the most

efficient use of funding to the population group while providing opportunity for a good therapeutic outcome for the client.

### **The Biodyne Model of Psychotherapy**

The approach to therapy used by PPS is based on the Biodyne Model of Psychotherapy, which is a theoretical approach to therapy and not a therapy in and of itself (Cummings, 1991). It is a structure in which to contain the therapeutic model used by the therapist. Three significant assumptions are incorporated into the model: firstly, the therapist's role can be likened to that of the family doctor and similarly the therapist provides necessary and sufficient treatment as required; secondly, the developmental view of people is taken rather than that of cure. For example, people tend to present for therapy at periods of change in their lives and many of these transitions are predictable, such as new relationships, work difficulties, birth of a child, and divorce. Therapeutic intervention during these times aims to improve overall coping strategies and problem solving methods. Thirdly, therapeutic interventions that are specific and parsimonious are the most beneficial. The therapist takes an eclectic approach making use of effective treatment techniques and combining them to respond efficiently to the client's needs.

Several targeted goals of the therapist, as suggested by Cummings (1991), have been found to be of help within the PPS brief therapy setting. To begin with, the therapist "must hit the ground running" meaning that the first session must have a discrete outcome. The therapist needs to develop an operational diagnosis, replace the implicit contract with a therapeutic contract, do something novel in the first session, and give homework assignments.

An operational diagnosis answers the question: "Why does this client present now?" The answer to this question holds the key to the real reason why the client is presenting for therapy. For example, a diagnosis of major depression could not be considered an operational diagnosis because there is

no immediacy involved. If, on the other hand, the therapist learns that the client's husband has threatened to leave her if she does not seek help for her symptoms, the basis for an operational diagnosis has been reached, such as "I don't want my husband to leave me."

The implicit contract is about the client's conscious and unconscious expectations of treatment, such as: "Fix my partner and I will be happy"; "Cure me now"; and "Even you can't fix me." The therapist needs to become aware of the implicit contract and replace it with an operational diagnosis and therapeutic contract. An important distinction between the implicit and operational contracts is that the implicit contract generally places responsibility for change with the therapist and the operational contract provides for a collaborative approach. It is also important to find something novel in the first session with the intention of appealing to the client idiosyncratically highlighting the individuality of therapy (Cummings, 1991).

Between session homework is an important aspect of the therapeutic process as it encourages the client to engage in the therapeutic process, to take responsibility for change, facilitates early change of behaviours, and demonstrates to the client other possible ways of perceiving self and others. Furthermore, the homework generally assists in the assessment of change from session to session. If the homework is not attempted, obstacles to homework completion can be explored and patterns of maladaptive behaviours can be identified.

Within the time constraints of managed care, it is expected that an assessment sufficiently adequate on which to develop a formulation should be undertaken in the first one hour session. Probably the key difference between the time limited and unlimited settings is an increased focus on the history and behavioural aspects of the presenting problem. Consequently the first question is always "Why do you present now for therapy?" Of course background history is gathered, but with a tendency to the highlights rather than in-depth investigation, and safety is assessed. Clients considered to be at moderate to high risk of harm to self or

others are referred to CMHC for care. However, the intended format of such an interview is not always possible. Sometimes reducing client distress is the total focus of the initial session, and at other times the entire session focus may be understanding the development of the presenting issues if the client presents with a complex history. As is usual with psychological assessment, it continues throughout the therapy and new information may be added to adjust the formulation.

To illustrate the practical application of the Biodyne Model of Psychotherapy to brief therapy each author presents a case study. Identifying features for each case, including names, have been altered to preserve the privacy of each client. The first case study presents Mele, a 34-year-old Pacific woman, referred for depression and recurrent incapacitating headaches. The second is Karen, a 40-year-old New Zealand European, referred for symptoms of depression and general physical health problems.

### Case Study: Mele

Mele, 34-years-old and a New Zealand born woman of Pacific heritage, was referred by her GP with symptoms of depression characterised by low mood, social withdrawal, irritability, and frequent severe headaches for which she tended to stay in bed for extended periods. Medical tests for pathology were negative. The GP requested therapy for relief of the headaches, which had limited response to medication, and for the depressive symptoms for which Mele was unwilling to take antidepressants.

### History

Mele was the third daughter of a family of six sisters. While growing up she witnessed many episodes of domestic violence usually precipitated by her father's excessive alcohol consumption. She remembered being afraid of her father and distressed for her mother. Early in childhood Mele had close relationships with her sisters but as they got older their interpersonal conflicts increased and escalated to physical fights. Mele now saw her sisters infrequently and she described relationships that appeared settled but with little closeness. Mele left home

and school aged 16 without academic qualifications and worked in various factory jobs. Her parents remained together. While Mele enjoyed a close relationship with her mother, despite living in a different town, she tended to keep her distance from her father and they seldom spoke.

Mele met John, a New Zealand born European, when she was 19: they had been married for 14 years and were financially stable. Mele was not in paid employment and cared at home for their six children aged from 5 months to 13 years. John enjoyed his work as an auto mechanic.

One year prior to presentation Mele and her family had moved from Northland to Auckland for her husband's employment. Mele associated her symptoms with moving to Auckland and said that they worsened after the birth of her 5-month-old daughter.

### Assessment

Upon initial presentation Mele scored 46 on the Kessler-10, indicating severe distress but without suicidal ideation. Mele's main complaints were that she was not her usual happy self, had recurrent headaches that incapacitated her, and no longer enjoyed parenting her children. She was distressed that she yelled frequently at her children and sometimes pushed them. In contrast to her positive memories and experiences of parenting while in Northland, Mele said that she now felt crowded by her children, angry and irritated with them, and was disorganised at home. Mele worried about the general safety of her children in her new community.

Mele identified two significant losses associated with moving to Auckland: firstly, her belief that the children were safe in the community, which meant she now kept them at home and they had few outside activities; and secondly, the loss of support from her mother-in-law including friendship and practical help with the children.

Significant historical adverse events included Mele being raped in her late teens on separate occasions by two different men, both of whom she had known and had previously trusted. She did not inform anyone. Mele disclosed, for the first time that she "beat up on John..." a couple of times a month

and had done so for several years. The frequency of assaults had increased to three or four times a month since moving to Auckland. Mele was distressed by and ashamed of her behaviour.

John had sought medical assistance twice in the past year because of the domestic violence. John, as far as Mele knew, had never told anyone that she assaulted him regularly. She described John primarily in positive terms noting that he helped at home, had good relationships with the children, and had always provided financially. However she was resentful about moving to Auckland and thought that John did not understand how much harder it was to care for the children in Auckland compared to Northland. She had found him increasingly irritating and experienced dislike for him. It appeared that she would assault him when her feelings of irritation escalated to anger, which occurred in various circumstances.

The operational diagnosis and answer to "Why now?" for Mele was "I feel like I'm going out of control and I'm afraid of what I will do next." The implicit contract offered by Mele appeared to be, "I'm bad and you need to stop me doing bad things." The idiosyncratic approach to assessment was to discuss her physically abusive behaviours towards her husband and to present her behaviours as serious and unacceptable, but resolvable given cooperation and effort on her part with therapy.

### *Formulation*

Predisposing factors for Mele's condition included a disrupted childhood characterised by feelings of fear and modelling of violence by her father as the primary problem solving strategy. Mele had negative self perceptions most significant of which were that she was bad and unworthy.

Perpetuating factors for Mele's condition included the loss of emotional and practical support from her mother-in-law and the previous routines she had established with her children, including their ability to play outside frequently. It appeared that these losses further supported Mele's belief that she was undeserving of good things and triggered childhood feelings of

rejection. Mele had developed feelings of blame, resentment and anger towards her husband for moving away from Northland. Her negative emotions towards her husband and her negative self perceptions were likely to have been maintained by emotional intrusions from the past such as those associated with her father's abusive behaviours and with the two rapes that Mele had suffered.

Precipitating factors for Mele's condition appeared to be the stress of adjusting to her new circumstances, including the absence of her mother-in-law's support, the birth of her baby, social isolation exacerbated by her distrust of the community, awareness that her parenting quality had deteriorated since moving and internal conflict about her abusive behaviours towards her children and husband. Mele had beliefs that she and her children were unsafe in the community. These beliefs appeared to trigger her negative emotional experiences from childhood, primarily anxiety and fear, which then resulted in the problematic behaviours: keeping in close proximity to her children; yelling at and pushing her children; and being verbally and physically abusive towards her husband. Mele's negative self perceptions resulted in her feeling guilty about caring for herself and so did not take time out from her children or engage in any enjoyable activities for herself. It appeared that Mele's prime emotional experience was of fear and she responded with efforts of self defence, e.g., attacking others.

### *Treatment*

The goal of therapy, as identified by Mele, was to stop abusive behaviours towards her husband and children. Treatment began at the end of the first session by discussing the seriousness of domestic abuse and speculating about the effects of physical abuse on Mele's husband. Mele was supported by reframing her problematic behaviours as solvable by addressing anger management and problem solving skills, and self care activities.

On presentation to the second session Mele was withdrawn and defensive. Further investigations revealed that Mele was feeling exposed, vulnerable and ashamed about her disclosures of abusive behaviours. Mele

was supported by exploring her negative emotional experiences and developing them as motivators for change. Black and white thinking (e.g., I should always look after the kids first) as well as catastrophising (e.g., The kids might get kidnapped) were identified as negative cognitive patterns. It was hypothesised that increasing self care would reduce feelings of stress and therefore Mele's tendency to catastrophic thinking. Consequently her homework was to replace the word "always" with "sometimes"; e.g., "Sometimes I put the kids first and sometimes I put my own needs first so that I can be a less stressed mum." Specifically, Mele was to set aside time, in cooperation with her husband, to have a bath on her own and to read a magazine. Therapy also explored some of Mele's parenting interactions. For homework Mele was to reflect on the question "What am I teaching my children by doing this behaviour?" But in paradoxical fashion it was requested that she not make any changes to her behaviours.

Mele presented to Session 3 as motivated and engaged with therapy. She had reflected on the homework question. Significant outcomes included that Mele had made an association between how she had felt during childhood and how her children may be feeling when she yelled at them. This insight initiated discussion about her childhood experiences as well as exploring alternative parenting strategies. Additionally, her insight that her children were probably experiencing fear and anxiety become a demotivator to abuse behaviours and motivator to problem solve. Mele was supported by speculating empathetically about the causes of her father's abusive behaviours. An empathic understanding about parental behaviour was taken to support her relationships with her parents while allowing Mele to acknowledge and validate her negative childhood experiences. Mele had completed her self care behaviours for homework and found that she enjoyed them and felt a little less stressed.

Session 4 explored Mele's relationship with her husband identifying problematic patterns of behaviours using Imago relationship therapy techniques (Hendrix, 2008). The significant outcome

was the following self understanding: "At times I perceive John to be ignoring and rejecting of me. I try and get him to be acknowledging and accepting of me so that I can feel accepted, loved, and encouraged. I sometimes stop myself from getting what I need by withdrawing, yelling and attacking him." Mele was encouraged by understanding her own behaviours, especially her use of childhood coping strategies and how they contributed to difficulties within the marital relationship. Alternative coping strategies were discussed including articulating the problem and her feelings to her husband. Homework was to continue with developing parenting strategies, such as giving warning and then indicating to children desired behaviour, for example, "Finish what you are doing because it is bath time very soon"; to ask herself "What am I teaching my child by doing this behaviour?" and to continue with self care activities.

Sessions 5 and 6 worked on developing parenting skills and problem solving strategies for which Mele responded well to structured formats. She had noticed that increased self care activities reduced her feelings of stress and improved coping. She was well supported by her husband in undertaking active problem solving and in her anger management, exhibited by reduced yelling at children and absence of physical abuse. Mele had noticed that her headaches had reduced and she was feeling much happier about her behaviours. The final session included discussion about how Mele could continue to support her own recovery.

### Outcomes

Mele concluded her six therapy sessions with a strong feeling of hopefulness about her ability to build on changes made in therapy. In particular she enjoyed using the new parenting strategies that had improved her relationships with her children as well as the communication techniques that had improved her marital relationship. Supported and facilitated by a ProCare Community Health Coordinator, Mele was looking forward to undertaking a parenting programme and to building relationships within the community which supported her Pacific identity. As indicated by her Kessler scores,

46 at intake and 10 (indicating low or no risk of anxiety/ depression ) at discharge, Mele's condition improved significantly.

### Case Study: Karen

Karen, a 40-year-old New Zealand European woman, was referred by her GP with symptoms of depression characterised by low mood, anxiety, anhedonia, poor concentration, negative self-talk, irritability, insomnia, and social withdrawal. Karen also presented with a recent history of physical health symptoms including headaches, muscle tension, and significant weight gain.

### History

Karen reported a chronic history of low mood and poor self-esteem. She had no prior treatment for depression, apart from recently commencing antidepressant medication prescribed by her GP.

Karen was the youngest child of four. There were family rumours that she had been conceived from an affair between her mother and her father's brother. Karen thought that she was treated differently whilst growing up, "like a dirty secret" and felt unwanted and rejected from a young age. She thought that her mother's approval and acceptance were conditional upon achievement and work. In her family there was a focus on "getting on with things" and inability to cope was considered weakness.

Karen left school with minimal qualifications and married her first husband at the age of 20, but left him after three years. She described him as an alcoholic, physically and emotionally abusive to her and, at times, their two children. She later entered into a new relationship with George and they had a child, Mark. George was killed suddenly in a motor vehicle accident while she was pregnant with Mark.

Karen reported being grief stricken by the loss and found it difficult to be a solo parent of three children for the next five years, with little support from her family. Mark, in particular had a difficult time whilst growing up, with lacking a father and a sense of identity. Mark found it unfair that his older siblings were able to visit their father, while he was not. He had

behaviour problems that were difficult to manage and this escalated into more serious behaviours during adolescence, including associating with gangs and using illicit drugs. Mark had a criminal record for theft and his most recent offending had led to prison time.

Karen met Daniel, her current husband, 12 years ago and they had been married for 11 years. They blended their families of her three and his two children. None of the children currently lived at home. Karen and Daniel both worked: she as an administrator and he as a team leader. They were financially stable. Karen described Daniel as a "good man" who cared for her and provided well, but she reported being unhappy with his disapproval of Mark.

### Assessment

Upon initial presentation, Karen scored 35 on the Kessler-10 indicating a high risk of anxiety and/or depression. She reported occasional suicidal ideation but no active intent or plans. Karen presented extremely distressed and tearful. She reported having feelings of shame for needing to see a psychologist for support and feelings of helplessness and guilt which had persisted since her son Mark had been imprisoned for stealing six months previously.

Karen internalised her own feelings but was a confidante to many. Karen learnt from a young age that she was not going to receive any sympathy for not coping and as a consequence simply "boxed on". Her fear of others' disapproval and rejection led her to be overly submissive with poor boundaries and to be extremely critical and harsh of herself, with unreasonable expectations.

Karen often felt fatigued and thought that "everything is an effort." She was paranoid about what others were thinking about her or her son and extremely sensitive to criticism of her son or herself. She felt resentful of others who had an easier situation and of her family for failing to provide her with unconditional support.

Karen was having difficulty coping at work, with tearful outbursts, and difficulty controlling her feelings of anger and irritation at her work colleagues and towards her husband. She felt upset that she had been snapping

at people and wanted to improve her communication. Karen was also concerned that her physical health had deteriorated, indicated by fatigue and headaches, due to her stressful circumstances, resulting in a significant amount of time off work. She was concerned that she was no longer able to internalise her feelings and present the image of a happy and pleasing person to her husband, work colleagues, and acquaintances. Karen was afraid of losing relationships and wanted others to be approving of her.

The operational diagnosis and answer to "Why now?" for Karen was "I can't keep my mask intact any longer and I'm afraid of losing everything." Karen's implicit contract appeared to be "I'm a failure because I can't cope. I won't be able to please you and you're going to tell me I'm useless." The idiosyncratic approach to assessment was to reduce her feelings of shame for seeking psychological assistance by framing the funded therapy she was receiving as a "gift," an opportunity to improve herself that she would have willingly recommended to others, and normalising her experience as shared by many.

### Formulation

Predisposing factors for Karen's condition included an invalidating childhood characterised by feeling inadequate and unwanted which were repeated in her core beliefs. Her experience of an abusive marriage, plus her family of origin's lack of support to her during the abusive marriage and the years of solo parenting following the death of George had served to reinforce her negative core beliefs.

Perpetuating factors for Karen's condition included her internalisation of feelings, being passive and pleasing to others, and her strong inner critic.

Precipitating factors for Karen's condition included her son's imprisonment, resulting in feelings of guilt, shame and helplessness with regard to her parenting of him, as well as her perception that others perceived her negatively (due to her son's imprisonment), thus triggering her negative core beliefs and feelings of inadequacy and of being unwanted.

### Treatment

The goals of therapy, as identified by Karen at the initial session, were to equip her with coping skills for her distress and to learn skills to communicate more assertively with others.

Karen presented at the second session significantly less distressed than the first. She reported that the experiences of allowing vulnerability and openness with another person were cathartic and liberating. Since our first session she had continued her passive-aggressive behaviour towards others, with angry outbursts at her husband for not helping her with housework. Karen reported not disclosing to her work colleagues the reason why she had to leave work early (to come to the session) and reported feeling guilty about this. She described an emotional visit to her son Mark in prison and how she felt manipulated by him to provide him with items.

The session was spent sharing and discussing the initial formulation and validating Karen's current presentation and making sense of this in the context of her past history. Psycho-education was provided on "lifetraps" or "schemas", utilising the Schema Therapy approach (Young, Klosko, & Weishaar, 2003). Karen was given the homework of reading some introductory information from the client handbook "Reinventing Your Life" (Young & Klosko, 1993).

Upon presentation to the third session, Karen had read the introductory information and we discussed her primary lifetraps of "subjugation" and "unrelenting standards." She identified well with the lifetraps approach and had become more aware of her passivity and lack of boundaries. We discussed her anxiety symptoms of worry, rumination and muscle tension and she was taught the coping skills of progressive muscle relaxation and a mindfulness technique. Her homework was to practice these coping skills as well as read the chapters from "Reinventing Your Life" on "subjugation" and "unrelenting standards" (Young & Klosko, 1993).

At the fourth session, Karen felt significantly improved since the last session. Reading the information on her lifetraps had enabled her to have greater empathy and understanding

for herself, and she had recognised the need for improved self care. She reported going for walks with a friend, practicing the relaxation techniques, taking up her old hobby of cross stitch, and lowering her standards with regard to her housework.

She had recognised from the lifetraps information that other members of her family also had lifetraps of their own which influenced their behaviours. This insight had enabled her to understand and empathise with their behaviours and to reduce her tendency to personalise. Karen recognised that she and her son had a parallel process with identical lifetraps.

At Session 5, Karen reported that despite ongoing psychosocial stressors, she had managed to maintain and improve upon the gains made last session. She was engaging in self care activities, being more assertive and setting improved boundaries with her son, her husband, and her work colleagues. She was pleasantly surprised at the outcome, with positive responses from all. Further psycho-education introduced assertiveness to reinforce her current behaviour changes. Karen was sharing her work in therapy with her husband and consequently they were experiencing improved communication, including her husband explaining some of his own issues and difficulties. They both recognised that he also carried "baggage" that affected their marital relationship.

At the sixth session, Karen reported feeling significantly improved in the four weeks since the last session, notably feeling cheerful and laughing again. Her whole outlook on life had changed, as she had become more forgiving of herself and others. She also noted improved relationships with her husband, son, family and work colleagues.

Karen and Daniel had gone to see the GP to discuss a referral to PPS for marital therapy and the GP had asked Daniel to complete a depression questionnaire. Daniel's score indicated a high level of distress and a referral to PPS for individual therapy was made. Karen was pleased with this outcome and hoped it would lead to further improvements in their relationship. As this was the final funded session,

relapse prevention was discussed and developed including direction for further self-help.

### Outcomes

Karen finished her six therapy sessions with significant improvements in mood, self-care behaviours and interpersonal relationships. Her Kessler-10 score upon discharge was 12 (indicating low or no risk of anxiety/depression), showing a significant improvement compared to her intake score of 35.

### Conclusion

As illustrated by the above two case studies it is possible for primary care psychologists to adapt their clinical practice to produce positive therapeutic outcomes within a brief therapy context. The initial challenge for therapists is to give up the notion of cure and of addressing all of the many psychological issues a client may present. Instead the therapist must be content with seeing developmental evolution in action and view the client as a work in progress. This can be a very difficult mind set shift for therapists, especially when other areas of client need are evident and funding has ended. The authors' have balanced the goal of cure versus developmental progress with a simple optimistic view: the glass is half full rather than half empty. For example, Mele had resolved important issues which had influenced her behaviour and family relationships positively, but nonetheless retained issues associated with being raped during childhood and she had unresolved father-child and sibling conflicts.

Another challenge for therapists is balancing client self exploration with a therapist directed approach to therapy. To work effectively in a brief therapy model the therapist constantly focuses on finding the most efficient way of achieving the therapeutic goals. The therapist is aiming to achieve the goals of therapy in a brief time and this means focusing the client toward goal achievement; consequently, likely opportunities to explore other problematic areas will be ignored. For instance with Mele, insight was directed around the marital relationship and understanding the likely experiences of

her children through reflecting on her own childhood experiences, but little time was spent exploring directly the effects of childhood abuse on her.

Creating change as soon as possible is the primary focus of therapy, thus there is an increased emphasis on initiating behavioural change compared to developing insight, although both are important. A key guiding question for the therapist would likely be: What specific insight would assist change for this client under the current circumstances? The therapist uses newly presented adverse events experienced by the client from the preceding week as the salient material for developing behaviour change and insight for achieving the therapeutic goals. For example with Karen, negative interpersonal interactions between the initial and second session, such as feeling manipulated by her son during a prison visit, were used to highlight problematic behaviour patterns and to introduce the notion of "lifetraps" as a therapeutic intervention.

Notably, during brief therapy the therapist assists the client to maintain a fundamental balance between change and stability. Because of the limitations of time the therapist must be cautious about teasing apart coping strategies and defence mechanisms that the client has developed. In Karen's case, whilst we acknowledged the negative effects of her tendency to simply "box on," we also accepted that it had been a useful coping strategy for success at work.

Overall the primary care psychologist needs to take an eclectic and pragmatic approach to the client's problems, look for the parsimonious way of assisting the client to achieve the therapeutic goals and view the client as their own best asset and resource. The client presents usually feeling stuck or overwhelmed because some of their usual coping methods are no longer working. The therapist's job is to assist the client to develop adaptive coping for the particular circumstance that he or she is finding problematic. The client may choose to return to therapy when another problematic situation presents and he/she is motivated to change. Until then the therapist must be content with seeing developmental evolution in action and move on to the next client and therapeutic encounter.

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