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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All Stressed Out

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A common complaint in today's health care office focuses on "stress." Typically, the patient attributes his or her stress reaction to a range of life events. These may fall into the category of negative events: losses, disappointments, medical illnesses; or, the events may be positive ones: the start of a new relationship, a child's graduation, starting a new job.

The symptom complex may focus on pain (typically abdominal, headache, back), gastrointestinal distress (diarrhea, constipation, nausea), respiratory distress (shortness of breath, choking), the cardiovascular system (palpitations, chest pain), or the nervous system (dizziness, paresthesias). Typical accompaniments are fatigue, irritability, and disturbed sleep.

As the multiple foci suggest, the doctor's differential considerations can go in any of several directions. Although the diagnostic evaluation is warranted, often it will turn up no useful explanation for the symptom picture. A competent primary care physician will have already added "anxiety disorder" to the list of possible etiologies.

Sometimes the current complaint will be a manifestation of a chronic problem defined by continual worrying and accompanied by restlessness, fatigue, irritability, muscle tension, and sleep disturbance. This is the picture of generalized anxiety disorder. The symptom picture may be augmented by episodic panic attacks featuring palpitations, loss of breathing control, paresthesias, and, perhaps, chest pain. The symptom picture may involve reexperiencing a traumatic event in nightmares and flashbacks and be associated with avoidance of relevant situations, emotional numbing, and increased arousal. In this case, the diagnosis will be posttraumatic stress disorder.

For each of these anxiety disorders, there are appropriate pharmacologic approaches that the physician in primary care can learn and prescribe. Most often today, they will involve selective serotonin reuptake inhibitors (SSRIs). This article is written to underscore the value for these patients of a complementary referral for brief cognitive therapy.

CASE PRESENTATION

I was recently consulted by a 28-year-old woman who had been referred to me by her family physician. He had seen her several times in the past month to investigate a constellation of complaints that included headaches, diarrhea, periodic abdominal pain, and significant fatigue. Her distress had peaked after a move to Charleston, S.C., to begin a new job with an accounting firm, on the heels of her marriage 3 months earlier.

My diagnostic impression was generalized anxiety disorder. At the tail end of an evaluative session, I explained the cognitive model to Sally. We would focus on situations that she connected to anxiety. We would first identify the automatic thoughts (meanings) she associated with these situations. Then, we would test the usefulness to her of the meanings she identified. Were they reasonable? Did they serve a strategic purpose

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(help her get where she wanted to go)? Most meanings associated with anxiety would fail at least the second criterion. We would then search together for alternative meaning choices that fit for her. It was likely, I told her, that an alternative meaning would have a different consequence than evoking anxiety. She said that she understood.

In session 2, she said that being told by her school principal that she needed to modify some of her teaching methods following an observation 6 years ago had led to her first experience of sustained anxiety. She identified her automatic thought as: "I knew then that I would be fired." Several panic attacks had followed this incident over the next 2 weeks. In testing the validity of her belief, it now made little sense to her. "I guess I was jumping the gun," she said. In fact, she taught in that school for 3 more years until she left of her own accord. She recalled that it had gotten so bad at one point that she had to fight her morning anxiety to even go to school. Headaches and diarrhea were constant problems at that time. By session's end, it was clear to her that her thinking had played a central role in the production of her anxiety. We discussed several more recent situations that had been associated with anxiety. In each, she successfully found alternative ways to think about them that made sense to her.

In session 3, she reported a day when she had "felt more under control" than she could remember feeling for a long time. We discussed normal anxiety (in the face of an identifiable danger) and contrasted it with pathologic anxiety (no real danger, or danger overestimated). There were 3 more situations raised that were associated with anxiety for Sally. In each, she identified the relevant thoughts, and, together, we generated additional options. I thought she had learned to apply the cognitive model. I wondered how she would do on her own and suggested an appointment for 2 weeks later.

Relating her successes in session 4, she stressed how her "perspective" had changed for the better. She reported on 4 situations that had evoked anxiety and how she had "mastered each one." I suggested that she utilize the model for a month and then return to evaluate with me how she had fared.

In our final (fifth) session, we separated the positions of "participant" and "observer" in anxious situations. As observer, she could comment on how she had understood the situation and could find a suitable alternative if necessary. Sally told me that she felt well prepared now to face most situations she could anticipate. I assured her that she could call for a booster session if she hit an obstacle she couldn't overcome. I agreed that she had equipped herself by acquiring a new cognitive tool to master anxiety. She sent me a note 3 months later stating how well she felt she was doing. ◆

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