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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Cognitive Therapy Helps Plug a Leak

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Anxiety, like water leaking from a pipe in your home, flows into all available spaces. Habit, the ways people learn to react to situations, builds a repertoire that may direct anxiety into a variety of places. In a patient who has become an "anxiety-producing machine," focusing on patterns of thinking can be one road to change.

An early issue in the change process in cognitive therapy is how the patient "understands" the situation or event. If the problem is seen as external and outside the individual's locus of responsibility, little can be done. When the problem can be redefined as a thought ("how you think about it"), the location becomes internal, the person can assume responsibility, and often a solution can be found.

Change can be thought of as (1) identifying the relevant thinking associated with distress (in this case, anxiety), (2) appraising the thought as strategically useful or not (when there's distress, it never is useful), (3) finding alternative meanings for the situation, and (4) evaluating relevant probabilities for each alternative meaning.

A 25-year-old middle school teacher asked her primary care doctor, "How normal are some of my occupational fears?" When her routine physical examination was completed with no positive findings, he asked her whether she was bothered by the nervousness she related to her work. Her affirmative reply led to a referral to a medication-managing psychiatrist. The prescription of low-dose venlafaxine reduced the severity and frequency of her experience of anxiety. She then told the psychiatrist that she wanted to do something that would help her change her thinking patterns. He referred her to me for a course of cognitive therapy.

CASE PRESENTATION

During Ms. A's intake evaluation in my office, it became clear that her experience of anxiety "out of proportion to the situation" had begun in college. Situations associated with anxiety included examinations and academic performance, as well as meeting men in social settings.

After 2 years spent teaching seventh and eighth graders in a school that she "loved," Ms. A's position was suddenly "dissolved." She recalled being continuously anxious at that time. She also had her first panic attack. When an ongoing relationship ended shortly thereafter, she felt that she was "imperfect." In fact, setting perfectionistic standards was a facet of many areas of her life. An abortion during college had brought her shame and thoughts of "not being good enough."

Over the past 2 years, Ms. A had found a teaching position she desired, but anxiety was frequently a part of both her work and relational lives. She met a man and recently had married. The panic attacks were infrequent, but she could recall 5 of them over the past few years.

My DSM-IV diagnoses for Ms. A were (1) generalized anxiety disorder and (2) panic disorder. Venlafaxine 75 mg/day was helpful. She was a good candidate for a course of brief cognitive therapy.

PSYCHOTHERAPY

After only a minimal definition of terms in session 2, Ms. A described her anxiety process. "I find the worst possible scenario," she said, "then I get stuck on

it, then I apply it broadly to other situations." She recalled the process of being observed at school by the vice principal. "There is no time to prepare," she said. "I will be rated, and fail." In reality, she had done well. She then related believing that she was underpaid. "I have not done what I should," she thought. In reality, the determinants of her salary had little to do with performance. Her cognitive errors of personalization and polarization were pointed out, and alternate explanations were considered.

In session 3, Ms. A described her anxiety, noting the attention her then-fiancé showed to another woman. She related her expectation of being abandoned, and the difficulty she had discussing the interaction with her husband-to-be. Options for understanding his reaction were considered, and ways to discuss her feelings and observations with him were found.

In session 4, the patient noted that she was "taking more time to come to judgments now" and generally "thinking more." We focused on the cognitive concept of choice and the power that flowed to the chooser. Arbitrary inferences (jumps to a conclusion) were pointed out.

Two weeks later (session 5), Ms. A talked about a problem with her principal and described in detail how she had thought it out. "I had a conversation with myself before I spoke with him," she said. She also described a relationship with a friend that she had ended after 5 years of one-sided giving. "I could not have done either of these things before," she said.

Two weeks later (session 6), the patient discussed her view of her father's inadequate medical care. It was evident in her presentation that she had made real gains in self-confidence, had broadened her repertoire, and had minimized her experience of anxiety.

In our seventh (and final) meeting, Ms. A noted her priorities for married life and her attitude toward work, all in the context of high self-worth and no longer fraught with anxiety. There had been no more panic attacks, but we reviewed a cognitive approach to an episode, should one occur.

Seven sessions over 3 months resulted in a major gain in mastery and self-esteem for this woman. Anxiety, which had become a constant companion, was no longer a cause for concern. The "leaky pipe" had been replaced with one through which the water flowed smoothly. And, although the patient had consulted a "plumber," she accomplished much of the repair on her own. ◆