# Comorbid Generalized Anxiety Disorder, Phobia, and Panic Disorder

Nikki Brannon, M.D., and Dean Schuyler, M.D.



The patient is a 58-year-old married white woman, referred by her primary care physician because he felt that her skin rashes were very likely caused by anxiety. He had recently started her on alprazolam (Xanax) 0.5 mg/day. She has had no previous psychiatric treatment. Her other medical problems include hypercholesterolemia, glaucoma, hypothyroidism, and leg pain. Prescribed medications were conjugated estrogen (Premarin) and levothyroxine (Synthroid), in addition to alprazolam.

## PRESENTATION OF THE PROBLEM

After working in the food industry, the patient has been unemployed for several years secondary to her stated inability to remain on her feet for lengthy periods. She is in the 33rd year of her second marriage. She dropped out of school in the ninth grade because of academic difficulties, then was married at age 16. She had 3 children from her first marriage; however, 1 son died at age 3 in an accidental fire. Her first marriage ended after 5 years, shortly after the death of her son. She has no history of alcohol or drug abuse. She does have, however, a 42-pack per year history of tobacco use, which she states, "calms me down." Her family history is significant for alcoholism in her father and a maternal uncle.

On initial evaluation, the patient's chief complaints were expressed as "problems with my nerves," and "I can't deal with stress." She reported excessive worry about various situations: crowds, leaving home, traveling over bridges, initiating conversations with others, and driving a car. She was particularly afraid to drive downtown, fearing that she would get lost, be in the wrong lane, or drive too slowly. Her anxiety was so great that she had not driven downtown in 25 years, limiting her driving to short distances around her home. She had become dependent on her husband for most of her needs and voiced frustration that he "always wanted to stay home and watch television." She had suffered from panic attacks, typically triggered in crowds or in driving situations. She had some intrusive thoughts related to her son's death, but no other symptoms of posttraumatic stress.

## PSYCHOTHERAPY

When the patient first visited me (N.B.), she was well-groomed and made good eye contact. Her speech was normal in rate, volume, and tone. She described her moods as "okay," but her affect was anxious and at times was tearful. She had no psychotic thinking and no suicidal ideation. My DSM-IV diagnosis for her included generalized anxiety disorder (at least 6 months of persistent and excessive anxiety and worry), specific phobia (anxiety provoked by exposure to a specific feared object or situation, often leading to avoidance behavior), and panic disorder with agoraphobia (characterized by both recurrent unexpected panic attacks and anxiety about, or avoidance of, places or situations from which escape might be difficult).[1] I described the model of cognitive therapy to her, and we agreed to begin treatment within 1 week.

During session 2, the patient spent much of our time emphasizing that her problems were too great to be helped. Remembering that she had told me she enjoyed fishing, I made the analogy of a rock being thrown in a pond, with the resulting ripples getting bigger and bigger. I told her that even a small change in one area can have "rippling" effects in other areas. This analogy appeared to "hit home," and she referred to it often during subsequent sessions. We discussed the use of Triple Columns, in which she would describe a situation associated with distressing (usually anxious) feelings and then carefully outline her thoughts and meanings.

Session 3 was spent challenging dysfunctional beliefs about driving downtown, talking to her neighbor, and going to the beach. She took the view that if something minor were to go wrong, the outcome would be a catastrophe. I challenged this "black and white thinking," asking her to specify the likely consequences should something go wrong. The patient drove to my downtown office for

session 4. We used this as an opportunity to discuss some other places she might like to drive, such as the beach and the small town in which her son is buried. Because she felt that she was making progress, the patient requested that our next appointment be in 2 weeks, and I agreed.

By session 5, the patient was driving downtown without problem (or the need for medication). She had been able to visit her neighbor on 2 separate occasions. Sessions 6 and 7 were used to challenge dysfunctional beliefs about driving in unfamiliar areas. We discussed in detail specific routes she might take, attempting to anticipate potential obstacles and choices she might make to overcome them. We scheduled an appointment for 1 month later.

In sessions 8 through 10, the patient reported various trips she had taken, the difficulties she had experienced, and how she had approached each one without allowing anxiety and negative thoughts to prevail. These appointments were 6 weeks apart, and she used the time between them to practice what she had learned.

In our last meeting, it was noted that we had met for 11 sessions over an 8-month period. She had experienced a significant decrease in general anxiety and had conquered many specific fears. She had driven downtown, visited her son's grave, initiated conversations with others, and enjoyed a long-awaited picnic on the beach. Overall, she felt a great deal more independent. We celebrated her accomplishments, and I told her to call if she felt meeting again would be useful. With the increase in mastery and self-confidence, there was no recurrence of the original anxiety-related complaint of skin rash.

**REFERENCE**

1. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition. Washington, DC: American Psychiatric Association; 1994:393

***Editor's note:*** Dr. Brannon is a recent graduate of the psychiatry training program at the Medical University of South Carolina in Charleston. Dr. Schuyler is a board-certified psychiatrist at MUSC who works halftime 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