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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Conquering Fears

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America is a melting pot. Our culture includes people who think scientifically and others who think spiritually. Some believe in ghosts, and some believe in a devil. Some people expect that everything will turn out well, and others are chronically pessimistic.

Within our society, there are some people who have phobias. They avoid public places, or won't take airplanes, or cannot drive across bridges, or fear snakes and other creatures. It is tempting to believe that those who "fear" are not as smart as those who seem fearless. Many years of clinical work, however, suggest that fear does not respect intelligence. As was the case with one woman I treated a number of years ago, some who fear are demonstrably bright and accomplished.

CASE REPORT

Ms. A, a 50-year-old woman, visited her primary care physician for an annual physical examination. She offered no medical complaints and took no routine medications. She made the appointment only because she felt that "at 50 years old, a woman should see a doctor once a year."

Born in Nigeria, Ms. A immigrated to the United States to start college, while her family remained in Africa. She graduated, obtained a Master's degree, and taught at another college for many years. She met and married her husband 2 years after college graduation. Together, she and her husband had 6 children, 3 boys and 3 girls.

Once it was established during her physical examination that there were no problems meriting treatment, Ms. A proceeded to tell the doctor about "her fears." She was afraid of flying, she could not drive a car outside her neighborhood, and she worried that her children would be kidnapped. These concerns took up a substantial amount of her time, and she wondered if she could "do something about them." The doctor recommended brief cognitive therapy and referred her to me.

PSYCHOTHERAPY

My intake evaluation provided support for 3 DSM-IV diagnoses: generalized anxiety disorder (300.02), specific phobia (300.29), and dysthymic disorder (300.40). I explained the cognitive model to Ms. A in session 2 and asked where she would like to begin. I took her response to be a good indicator of her motivation to succeed. "I'm looking forward to getting some tools to deal with my fears," she said.

As Ms. A spoke about her teenaged son and her concern that he would be kidnapped, I drew a triple column on my white board and began to fill it in. I encouraged her to utilize her anxiety as a cue to apply the cognitive system.

The process would identify the thought underlying the anxiety, and then test its likelihood as well as its strategic worth. Her example focused on an 11:00 p.m. telephone call to her son to which no one answered. Her "explanation" was typically catastrophic and led to frantic efforts to "locate him." I asked her to attach a probability to her belief that he had

been kidnapped. Then, I encouraged Ms. A to identify plausible alternatives that might satisfy her. We continued in this manner through 3 other situations. Each one concerned her children and her fears related to them.

In our next meeting, Ms. A defined the problem related to anxiety as a "thought," not an event. This redefinition, she claimed, had a calming effect on her. A 3-step process evolved that she could apply to situations evoking anxiety: (1) It's a thought, not a fact. (2) What other explanations exist for it? and (3) What are their relevant probabilities? She next focused on problems related to driving a car and flying in a plane. Her homework was to keep a triple-column log, which she could utilize to discuss with me her fears and her work to combat them.

Our fourth session began with Ms. A relating her successes employing the cognitive system. She spoke next about her periodic depressed mood states. When one of these mood states arrived, she would typically withdraw and become amotivational. Together, we assembled a mantra she could utilize during these periods: "initiate activity, sustain it, and finish it."

In our fifth and final meeting, Ms. A recounted 3 situations in the past 2 weeks that she felt she had approached differently than in the past. In each one, she had labeled the anxiety, generated the relevant thoughts, and quickly found an acceptable alternative that did not evoke anxiety. She raised the possibility of applying the cognitive model to personality style differences she had with her husband. She then asked if she could consider her anxiety work completed and address this other concern at a later date.

I assured the patient that another brief course of cognitive therapy could focus on a different problem at a later date of her choosing. I complimented her successful application of the model to her fears and stressed my future availability to her for further work. ◆

