

'DISTRACTING' PATIENTS FROM ANXIETY

Drs. Narsimha Pinninti and Rajnish Mago offer a brief, easy-to-use intervention to teach patients to control their anxiety. ("In-session anxiety: 5 steps to help patients relax," *CURRENT PSYCHIATRY*, August 2005, p. 49).

In step 4, the authors recommend having a patient with cognitive symptoms "look around the room and describe in detail what he sees" over 3 minutes. They also suggest having a patient with physiologic/affective symptoms "close his eyes and (remember) when he felt safe and content," also known as the "safe-place technique."

Distraction—the central ingredient in both interventions—is often used in cognitive-behavioral therapy (CBT), an empirically supported treatment for anxiety disorders. In CBT, however, the therapist first conceptualizes what is generating and maintaining the anxiety and hypothesizes what the intervention will teach the patient. For example, a patient who fears flying might use distraction to decrease pre-flight anxiety.

In other instances, such as during panic attacks, distraction may be a "safety behavior" that allows patients to control or avoid anxiety out of fear that the physical sensations they experience during panic are dangerous. While these behaviors may provide temporary relief (via negative reinforcement), they condition patients to rely on them to feel safe, thus perpetuating the anxiety.¹ These patients should be encouraged to gradually and systematically experience anxiety symptoms and learn to manage or tolerate them.

Likewise, interventions such as those found in step 4 may help most anxious patients feel better



during the session (via avoidance/distraction) but might maintain the anxiety that patients (and doctors) want to reduce.

Rather than applying a universal or "Procrustean" approach, psychiatrists should tailor interventions such as those suggested in step 4 to each patient's anxiety.² This way, they can be applied when appropriate with more durable and meaningful results.

Simon A. Rego, PsyD
Katherine L. Muller, PsyD
Colleen Jacobson, PhD
Cognitive-Behavioral Therapy Program
Montefiore Medical Center, Bronx, NY

References

1. Lazarus AA. Behavior therapy and beyond. New York: McGraw-Hill; 1971.
2. Mowrer OH. Learning theory and behavior. New York: Wiley; 1960.

The authors respond

Dr. Rego et al raise some excellent points.

We agree that techniques based on distraction are among several that a clinician should consider. We do not advocate use of these interventions for long-term anxiety control or as complete cognitive-behavioral therapy.

Techniques based on distraction, however, can have unique advantages when used appropriately. First, distraction techniques are obviously more likely to work when in-session anxiety is pronounced. Also, as Dr. Rego et al note, distraction techniques can be valuable in acute situations.

Second, associated dysfunctional beliefs often fuel anxiety. For example, patients commonly believe that they cannot control their anxiety. Some also believe that they need PRN medications such as benzodiazepines to



control the symptoms (safety behavior), leading in some cases to abuse of prescribed medications. The steps we suggest would help show patients that they don't need PRN medication. Learning not to rely on these agents can improve their sense of self-efficacy and reduce their overall anxiety.

Third, patients engage in a range of "safety behaviors"—from simple distraction to substance abuse. In some instances, helping the patient change his or her safety behavior from medication reliance to reliance on self-regulated activities is a reasonable short-term therapeutic goal. We have found that these techniques have helped some patients reduce PRN medication use.

Narsimha R. Pinninti, MD
School of Osteopathic Medicine
University of Medicine and Dentistry of New Jersey, Camden

Rajnish Mago, MD
Thomas Jefferson University, Philadelphia, PA

NEUROBIOLOGY AND MEDICATION ADHERENCE

Deborah S. Finnell, APRN, advises promoting medication adherence one stage at a time (CURRENT PSYCHIATRY, August 2005, p. 88). Research suggests that neurobiologic interventions can help achieve this objective.

Blood pressure reduction is associated with longer, less-recurrent speech hesitation pauses (SHPs) of approximately 2 seconds.¹ This supports the hypothesis that promoting neuroplasticity in small steps may have a lasting benefit in adults.²

SHPs are linked to rhythmic and prefrontal cortical modulation of dopamine lateralized to the right hemisphere, regulating brainstem cardiovascular control and coping behavior.¹ Matching SHPs in spontaneous dialogues is a joint, mutually responsive rhythm with prelinguistic origins.

These findings suggest that interventions can be tailored to match the clinician's communication style with that of the patient.¹ This may influence the patient's knowledge and beliefs about medica-

tion, help him/her become more engaged in and satisfied with treatment, and promote adherence.³

Ernest H. Friedman, MD
East Cleveland, OH

References

1. Friedman EH. Neurobiology of managing perceived stress (letter). *J Natl Med Assoc* 2005;97:583-4.
2. Hayward P. Small steps to neuroplasticity in adults. *Lancet Neurology* 2002;1:401.
3. Friedman EH. Non-adherence research design in bipolar disorder (letter). *Clin Approach Bipolar Disord* 2005;4:19.

Dr. Finnell responds

In concert with Dr. Friedman's point about congruent communications, clinicians should be ready to teach patients about a medication's pharmacodynamics. Helping patients discover the neurobiological basis for mental disorders and psychotropics empowers them, eases their defenses, and reduces the stigma they experience.¹

While this instruction is important during the precontemplation stage described in my article, clinicians should continue educating patients as they adopt medication-taking behavior. As patients gain experience with taking medications and understand more about them, additional evidence-based information should be provided.

Deborah S. Finnell, DNS, APRN
Assistant professor of nursing
State University of New York, Buffalo

Reference

1. Finnell D. The case for teaching patients about the neurobiological basis of addictions. *J Addict Nurs* 2000;3/4:149-58.

CORRECTION

In the article "Yoga: A breath of relief for Hurricane Katrina refugees" (CURRENT PSYCHIATRY October 2005, p. 55-67), e-mail addresses for the International Association for Human Values (IAHV) and the Art of Living Foundation (AOLF) International Research Committee were listed as Web page addresses. The correct e-mail addresses are:

- IAHV: relief@iahv.org
- AOLF International Research Committee: research@artofliving.org