

Conquering his fears, one step at a time

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Mr. Q fears crossing the street. Nightmares and flashbacks fuel his phobia, and a stutter worsens his anxiety and blocks communication. Which problem would you address first?

How would you handle this case? 

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CASE The big freeze

Mr. Q, age 34, is afraid to cross the street. As he steps off the curb, his legs “cramp up.” As the cramping intensifies and his feet stiffen, his heart races, he begins to sweat, and he turns back for fear his legs will buckle in the street. While on the sidewalk, he stays within reach of a building or car in case he falls.

Six months before presentation, Mr. Q walked to church during a blizzard, only to find the church closed because of the storm. He returned home and shoveled snow for 1 hour, during which he repeatedly leaned forward and backward to dump the snow.

The following Sunday, Mr. Q’s legs started to “hurt” as he crossed the street. Thinking he had severely injured himself while shoveling, he began to fear street crossings. At work, he asked coworkers to help him cross over to the subway. By spring, he had become so humiliated by his dependence that he stopped working. His phobia intensified until he presented to us at his family’s urging.

During evaluation, Mr. Q says he can cross only side streets and holds on to his father while crossing. His father, who is retired, spends much of his day helping his son get around.

Complete physical exam by Mr. Q’s primary care physician reveals a possible pulled muscle in his right leg but no other medical problems. Neurologic exam results are normal, ruling out nerve damage.

Later in the evaluation, Mr. Q mentions that at age 10 he was struck by a car. The impact fractured the left side of his skull and left leg, and he temporarily lost consciousness.

Shortly after the accident, Mr. Q developed mild memory and concentration impairments and a moderate stutter. He also experienced nightmares, but they disappeared within days. He says he never received speech therapy or other psychiatric treatment because his family did not have medical insurance.

Mr. Q did not lose function after the accident, but in college his stuttering led to difficulty speaking in class and interacting socially. He suffered panic attacks while on the telephone or during job interviews. He now mostly stays home, where he lives with his parents and a nephew. He interacts only with family members.

During the evaluation, Mr. Q effortlessly walks around the therapist’s office and reports no trouble walking at home. He says the cramps almost never surface at home because he feels “calm” with walls close by. When trying to cross the street, he manages to turn back without falling despite the cramps.

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continued

Clinical Point

PTSD symptoms can develop months to years after the precipitating incident

Upon considering this conflict, Mr. Q seems to realize that his fear of street crossings protects him from social situations. His stuttering, however, confounds the evaluation because he has trouble communicating his symptoms.

Mr. Q's affect is constricted as he describes his anxiety and fear. He says he feels limited and at times depressed by his inability to cross streets, yet shows little dysphoric affect or mourning and seems unusually calm when discussing the problem. He appears relaxed knowing that he can keep avoiding social situations.

Mr. Q's symptoms suggest:

- social anxiety
- panic disorder with agoraphobia
- a specific phobia

The authors' observations

Mr. Q's history of fearing interviews and telephone conversations suggests social anxiety, and his fear and avoidance of street crossings suggest a specific phobia. Panic disorder with agoraphobia is not present because the patient never experienced spontaneous panic attacks.

Anxiety is more prevalent among persons who stutter than in fluent speakers.^{1,2} Persons who stutter:

- more commonly report speech anxiety³
- are significantly more uneasy in social situations and tend to avoid them^{4,5}
- might not be motivated to eliminate barriers that thwart social interaction.

Mr. Q's stuttering has contributed to his isolation and enabled his phobia. Stuttering has caused significant social discomfort throughout his life, and staying home protects him from that hardship. His fear of street crossings gives him a reason to stay home.

Worse, his stuttering makes it difficult to ascertain his symptoms or plan treatment because it takes him so long to finish a sentence.

EVALUATION Flashing back

Later in the evaluation, Mr. Q says that whenever he considers or tries crossing a street, he recalls his childhood vehicular injury and fears he will be struck again. He has nightmares of being run over, and these nightmares and flashbacks have been occurring twice weekly since the snowstorm.

During the mental status examination, Mr. Q is well related with fair to poor eye contact, probably because of his stutter; he looks away from the speaker when his stuttering intensifies. His nightmares and flashbacks suggest comorbid posttraumatic stress disorder (PTSD), although he has no persistent symptoms of increased arousal. He also shows no evidence of acute mood disorder, psychosis, or cognitive disturbance.

Mr. Q developed comorbid PTSD:

- after his childhood accident
- after the snowstorm/injury

The authors' observations

PTSD symptoms can develop months to years after a precipitating incident,^{6,7} and repeated trauma can make patients more susceptible.

Interestingly, Mr. Q briefly suffered PTSD symptoms after the childhood accident but had no full-blown symptoms until adulthood. In addition to triggering avoidance behaviors, the muscle pull apparently reignited long-dormant PTSD symptoms (flashbacks, nightmares).

Mr. Q suffered no other PTSD symptoms. His stuttering might have signaled a psychogenic anxiety disorder, rather than being an incidental finding that developed after acute brain trauma at age 10.

Stuttering also might have contained Mr. Q's PTSD symptoms for 24 years, until his snow-shoveling injury shattered that containment. Further, while shoveling in the street amid slippery conditions, he might have subconsciously feared he would have trouble eluding an oncoming vehicle.

Which symptoms would you treat first?

- a) street-crossing phobia
- b) speech impediment
- c) nightmares and flashbacks
- d) all symptoms at once

The authors' observations

We must address Mr. Q's stuttering, phobia, and PTSD simultaneously to restore function. If we were to target his street-crossing phobia alone, we would face considerable resistance while exposing the underlying social phobia.

Supportive psychotherapy and exposure therapy—which would involve taking Mr. Q to an intersection and guiding him across—could help him overcome his fear of being run over. Cognitive-behavioral therapy (CBT) alone or with medications also could help.^{8,9}

Mr. Q's anxiety, however, is severe enough to keep him from trying exposure therapy. Because staying home is his shield from social contact, he is not motivated to leave his apartment. Although he presented voluntarily, like many patients he is ambivalent toward exposure therapy.

Also, Mr. Q's stutter makes it difficult to engage him in conversation. His stuttering is so severe that we have trouble doing an adequate CBT case formulation. At times his speech is almost incomprehensible.

Improving Mr. Q's speech is crucial to completing an assessment, decreasing his social anxiety, and motivating him to conquer his fear of crossing streets. By addressing his stuttering and phobia simultaneously, we can treat his anxiety on 2 fronts:

- the stuttering that stemmed from his car accident at age 10
- the street-crossing phobia that developed after he pulled a leg muscle as an adult.

TREATMENT 5-step approach

Negative medical results convince Mr. Q that anxiety is holding him back. This allows us to

Box 1**Mr. Q's progress:
A step-by-step recap**

Week 1—After much coaxing and encouragement, Mr. Q works through a leg cramp and takes 1 step off the curb, first with the therapist and then alone.

Week 2—Mr. Q takes 2 steps into the street—first with the therapist and then alone—after repeated coaxing and despite leg cramping.

Month 1—Patient proceeds 4 steps into the street unaccompanied. When his legs cramp, he intensifies the cramp and releases, then says 'I can do this.'

Month 2—Patient walks 6 steps into the street, first with the therapist, then alone.

Month 3—Mr. Q walks 8 steps into the street, first with the therapist, then alone.

Month 4—Patient begins crossing 1-way streets alone. After the therapist guides him to the center of a 2-way street, he walks the rest of the way by himself.

Month 5—Patient crosses a 2-way street unassisted.

Month 6—Mr. Q crosses busy intersections near his church, where the cramping began.

target his anxiety with CBT, in vivo exposure, deep breathing/relaxation, speech therapy, and pharmacotherapy, all of which we start immediately.

CBT. We plan therapy by having Mr. Q list 10 street crossings and rank them from least fearful (side streets) to most fearful (busy intersections). During cognitive interventions, we encourage him to recognize that his fears might be protecting him from social situations, thereby prompting him to catastrophize his muscle cramps.

As part of Mr. Q's psychoeducation, we reiterate his negative physical examination results and point out that his childhood vehicular injuries might be perpetuating his fears. We work on getting him to recognize that leg tightness does not predict falling and getting hit by a car.

Clinical Point

Negative medical results can convince a patient that anxiety is causing his physical symptoms

Clinical Point

Psychotropics with relaxation exercises can compromise exposure therapy but might be necessary if anxiety is severe

Box 2

Interventions Mr. Q found helpful—from most to least

1. **Medications**, which help him 'feel calm'
2. **Relaxation breathing**
3. **Saying 'I can do it. I feel calm'** when legs cramp up in the street
4. **Soaking legs** in warm water for 10 minutes twice daily
5. **Progressive muscle relaxation**
6. **Cognitive intervention:** internalizing that anxiety—not a medical problem—is holding him back
7. **Self empowerment exercise:** further cramping his legs, then releasing them when they cramp up

In vivo exposure. During our first session, we walk Mr. Q to a 1-way street and—after much coaxing and guidance—lead him into taking 1 step off the curb. The following week, we guide him through a second step. For homework, we have him practice crossing streets daily, at first with family members and then alone.

When his legs cramp up while trying to cross, we have him say out loud, "I can do it. I feel calm;" this helps him proceed across the street. We also teach self-empowerment by having him purposely cramp up his legs, then release them to stop the cramping.

Week by week, Mr. Q steps further into the crossing until—after 5 months of painstaking in vivo therapy—he crosses the street both ways on his own. Two weeks later, he crosses busier streets near his church with minimal anxiety (*Box 1, page 91*).

Deep breathing/relaxation. We teach Mr. Q progressive muscle relaxation and slow rhythmic breathing exercises, which he does before crossing streets to reduce his anxiety. For homework, he practices these exercises and soaks his legs in warm water for 10 minutes twice daily to relax his muscles and prevent cramping.

Speech therapy. The primary therapist devotes 20 minutes of each session to speech therapy. She employs relaxation training and therapy techniques such as Easy Onset,¹⁰ in which the patient stretches each sound, syllable, or word for up to 2 seconds, allowing him to speak at a smooth, slow rate. Mr. Q also practices these speech exercises at home.

After 6 weeks, Mr. Q's stutter improves slightly but he still has trouble communicating. We refer him to a consulting speech therapist, who sees him twice weekly and leads Easy Onset and relaxation exercises. This gives us more time for supportive psychotherapy.

As his speech becomes more fluent, Mr. Q's social anxiety and fear of street crossings decreases.

Pharmacotherapy. We instruct Mr. Q to take paroxetine, 20 mg/d, and clonazepam, 0.25 mg bid, 30 minutes before in vivo work to manage his anxiety. We titrate clonazepam to 0.5 mg bid over 1 month. He responds well to this regimen but fears he will become dependent on it.

During therapy, Mr. Q and the therapist rank the above interventions from most to least therapeutic (*Box 2*) so that we can effectively treat him should he relapse.

The authors' observations

Although Mr. Q's case is unusual, we feel our diagnostic and treatment methods can be applied to similar cases. His stutter, however, prevented us from conducting a structured diagnostic interview—which would have uncovered his symptoms more quickly—or performing standard manualized therapy.

Some data¹¹ suggest that combination psychotropics and relaxation therapy can compromise long-term exposure therapy outcomes, as the patient's fear could return once medication is stopped. Mr. Q's anxiety was crippling, however, and had to be addressed before we could consider exposure therapy.

More research is needed on overcoming patient communication barriers that can

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hamper treatment. Rapport with patients often makes or breaks psychiatric treatment, and communication problems can prevent that connection. As clinicians, we must watch for linguistic, cognitive, and cultural impediments to treatment.

FOLLOW-UP 'I can cross'

Six months after presentation, Mr. Q crosses all types of streets—from 1-way streets to 6-lane intersections—with minimal anxiety. He has resumed his previous level of functioning and is searching for work. His stutter, though greatly improved, is still audible.

We see Mr. Q monthly. We stop paroxetine after 8 months but continue clonazepam to address his many underlying social anxieties. By November—approximately 1½ years after presentation—we have reduced clonazepam to 0.5 mg each morning. We try reducing the morning dose to 0.25 mg, but Mr. Q's debilitating anxiety resurfaces.

In December, we increase clonazepam to 0.5 mg bid, then reduce it to 0.5 mg each morning 2 months later. In April, we cut clonazepam to 0.25 mg each morning. So far, Mr. Q is functioning well.

The authors' observations

Patients who begin antistuttering intervention as adults have a poorer speech improvement prognosis than those who start speech therapy in childhood.¹² In leaving his stuttering untreated for 24 years, Mr. Q likely sacrificed quality of life. Speech intervention at an earlier age might have improved his speech and prognosis early on.

Related Resources

- Anxiety Disorders Association of America. www.adaa.org.
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Drug Brand Names

Clonazepam • Klonopin
Paroxetine • Paxil

Disclosure

The authors report no financial relationship with any company whose products are mentioned in this article or with manufacturers of competing products.

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Clinical Point

If severe anxiety resurfaces while tapering anxiolytics, return to previous dosage and try tapering again in approximately 2 months

Bottom Line

Watch for symptoms of posttraumatic stress disorder (PTSD) in patients with severe anxiety. Ask about past trauma, as PTSD can surface years after the precipitating event. Concomitant psychotropics, cognitive-behavioral therapy, psychoeducation, and exposure therapy might be necessary if anxiety is debilitating.