Skills not pills: learning to cope with anxiety symptoms

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SUMMARY. A pilot project to assess the benefit of a psychology service in general practice for patients with anxiety is described. A course of lessons in 'anxiety management skills' was provided at two practices. At a follow-up appointment one year later two thirds of the 35 patients studied had stopped taking anxiolytic medication and two thirds reported an elimination of their anxiety symptoms. It is proposed that a psychology service be provided for general practitioners, in health centres and health clinics, as a possible alternative to repeat prescribing of anxiolytic medication.

Introduction

MEDIA criticism of doctors who prescribe anxiolytic medication in large quantities presents the doctor with a dilemma.[1] What is the general practitioner to do when a patient asks for his help in reducing the symptoms of anxiety when there are no problems that the doctor can counsel or advise about? A prescription for a tranquillizer can be a reflection of the doctor's desire to do something to help his patients and is not necessarily 'a therapeutic failure', as implied by the editorial comments in the *Journal,* that 'a prescription for diazepam is beginning to look like the doctor's excuse for not listening'.[2] Also, when official statistics indicate that psychoactive drugs comprise 16.4 per cent of prescriptions,[3] it is useful to look at repeat prescribing of tranquillizers from an economic point of view and to consider how time-consuming it is for the general practitioner to see chronic users of anxiolytic medication.[4,5]

The research literature indicates that patients can be taught a variety of skills to control their anxiety states.[6,7] Any service in the primary care setting for patients with anxiety needs to be capable of accommodating large numbers of referrals because of the prevalence of psychosocial problems in the general practitioner's casework.[8,9] The most cost-effective way to help large numbers of anxious patients and provide general practitioners with an alternative to prescribing tranquillizers was perhaps to run courses in 'anxiety management skills' at the surgeries. It was hoped that a service could be developed not only to suit patients with long-term anxiety states who persistently need consultation and prescription but also to prevent new patients from becoming persistent users of tranquillizers. This model of working is along the lines of early prevention proposed by Stachnick.[10]

The course

The project was set up in two practices, each containing five general practitioners. The doctors referred to the psychologist those patients who presented with anxiety-related symptoms. Examples of common symptoms referred were panic attacks, palpitations, tension headaches, muscle twitches, nervous rashes, indigestion, lumps in throat, insomnia, hyperventilation and dizziness, and spastic colon. Each patient had an individual appointment with the psychologist for assessment and was then allocated a place on a course.

The courses were held in each surgery in one of the doctor's rooms. The setting was made more educational and less clinical by using an overhead projector. Handouts summarizing the information given were provided at the end of each lesson. Each patient was expected to record the practising of the week's homework, which usually involved the skills taught at that session. The size of the rooms limited the number of patients attending each course to six.

The course consisted of six one-hour lessons held at lunchtime over a period of six weeks, each lesson providing different information and training in different skills. At the start of the course, every patient was asked to record the frequency of his or her main anxiety symptom and this information was used as a baseline from which to measure change. Information about anxiolytic medication was collected. After attending the course, each patient was seen for a follow-up appointment after three months and again after one year to assess the amount of medication and frequency of anxiety symptoms.

The lessons

Lesson one focussed on education about central nervous system arousal and those body changes which lead to symptoms of anxiety. In this way it was hoped that the patients' symptoms would become more understandable and less frightening for them.

Lesson two provided education about the involvement of muscle tension in anxiety. Patients were taught a shortened version of Jacobsonian progressive relaxation. In the relaxation exercises the emphasis was placed on learning to discriminate between relaxed and tense muscles and on becoming skilled at relaxing muscles quickly and voluntarily from minimal muscle tension.[11]

Lesson three again emphasized physical relaxation techniques. Each patient was given an audio cassette of the psychologist describing exercises. Cognitive control skills were discussed and thought distraction techniques taught.

Lesson four taught methods of modifying inappropriate thought patterns, with the emphasis on how to develop a rational and problem-solving thinking style, and how to increase the frequency of positive thoughts.[12]

Lesson five discussed ways of modifying lifestyle to reduce stress and taught techniques to 'cue' in relaxation (cognitive and physical) at regular intervals throughout the day. For example, all patients had to put a red spot on the face of their wrist-watches and, each time they saw the spot, to check on their muscle tension and thought patterns and to try to control them.

Lesson six summarized the previous lessons, emphasizing the need for practising the anxiety control skills over the coming year. Patients were given advice on how to maintain these skills and substitute them for anxiolytic pills by a gradual weaning process.

Assessment of the course

Information about the first 35 patients to be seen for their one-year follow-up appointment showed that 66 per cent of patients were female. It may be argued that a course of lessons is only suitable for intelligent, middle-class patients, but it is interesting to note that 43 per cent of the patients in this study were in social classes III, IV, and V. The average age of the patients was 44 years 6 months, ranging from 33 to 77 years.

Of the 35 patients, five were taking no medication prior to the course although they would have been if the course had not been immediately available as an alternative. The average length of time for taking anxiolytic medication continuously was two years nine months, the range being from three months to 18 years. All patients were taking benzodiazepines except for one patient on Largactil. The average period of suffering from the target anxiety symptom was eight years four months, ranging from four months to 30 years.

At the one-year follow-up appointment 22 of the 35 patients reported that their target anxiety symptom was eliminated, 12 reported improvement. None of the patients felt that it was the same or worse. Similarly, 24 of the patients were taking no medication one year after the course, five were taking less and six were taking the same amount or more. The subjective reports of the patients was supported by information in the patient's medical file on the anxiety symptoms involved in consultation with the general practitioner and prescriptions for anxiolytic medication.

Discussion

One way to reduce the use of tranquillizers is to provide general practitioners with alternative treatment. Providing anxiety management training courses may be a useful approach to repeated prescribing for general anxiety states. This pilot study showed that two thirds of the patients attending courses—both long-term users of tranquillizers and newly presenting patients—were able to become independent of medication and two thirds of patients were able to eliminate their anxiety symptom altogether.

Running a course of classes rather than providing a traditional one-to-one treatment does allow large numbers of patients to have access to a psychology service. Since access to a course was made available to all general practitioners in the Walsall district over 160 patients have attended between January and September 1983. The educational setting encourages patients to compete with others in the class to get better rather than to compete to see who has the worst symptoms. Group pressure was used to facilitate improvement of both new patients and those with a long history. Also, attending a course of lessons, rather than receiving treatment, places the responsibility for improving their emotional state firmly on the patient's own shoulders.

Now that large numbers of patients have access to an anxiety management training course the next stage of the project will be to undertake a quantitative controlled trial.

Acknowledgements

I am grateful to Drs T. B. Stirling, M. Hoskisson, D. Whitehouse, D. Wells, M. Seymour Smith; and to S. S. Taylor, J. P. Lester, A. K. Haire, A. W. Newton, and I. Watson for allowing the department to use their surgeries to try out this new method of helping patients.

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Whenever possible, bookings should be made well in advance and in writing. Telephone bookings can be accepted only between 08.30 and 18.30 on Mondays to Fridays. Outside these hours, an Ansafone service is available.

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Allergies and month of birth

The distribution by month of birth among 7,796 patients, who consulted Danish general practitioners during a one-year period (1977–78) because of asthma and/or allergic rhinitis is presented. Among allergic rhinitis patients births in March and April were significantly overrepresented, and July underrepresented. As a whole February–May were overrepresented and July–January underrepresented. The distribution of month of birth of asthma patients did not differ from the distribution of the total Danish population.

Patients suffering from both asthma and allergic rhinitis presented a pattern similar to that of allergic rhinitis patients. Families with a high prevalence of allergy may take advantage of this knowledge when planning child births, as the findings may be explained partly by exposure to pollen during infancy.

Source: Pedersen PA, Weeke ER. Month of birth in asthma and allergic rhinitis. *Scand J Prim Health Care* 1983; **3-4:** 97-101.

Reye's syndrome

In view of the lack of epidemiological knowledge about Reye's syndrome (RS) in children of all ages in the British Isles, a joint British Paediatric Association and PHLS Communicable Disease Surveillance Centre (CDSC) voluntary RS reporting scheme was started in August 1981 in order: to document the occurrence and describe the characteristics of RS in the British Isles and to monitor long-term trends; and to provide a central case register and serum and tissue bank for clinical or laboratory research. The results obtained in the first year of the surveillance scheme are published in the report referred to below.

Source: Public Health Laboratory Service. Reye's syndrome in the British Isles: BPA/CDSC surveillance scheme. *Communicable disease report* 1983; CDR 83/39: 3–6.