

5 Treatments that work in anxiety disorders

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Anxiety disorders are the commonest mental disorders in community practice, and there are practical psychological therapies that do help

On March 12 this year the Federal Minister for Health released the results of a national survey of mental health and well-being conducted by the Australian Bureau of Statistics.¹ It showed that 9.7% of adults in Australia reported symptoms in the past year that met criteria for one of the six main anxiety disorders (Box 1). In comparison, 5.8% met criteria for depression and 7.7% for a substance-use disorder. The prevalence of anxiety disorders was stable across the 18 to 55 age range but reduced progressively thereafter — we do seem to get calmer as we get older. People with anxiety disorders reported being unable to carry out their usual roles or tasks one day in 12, almost at the same level as people with chronic physical disorders like heart trouble, asthma or arthritis, yet only 28% reported using health services, and three quarters of the time this meant seeing a general practitioner. Thus, the first question is why people disabled by an anxiety disorder do not seek help, or are not recognised when they do.

The answer is, in part, related to the normality of being anxious and, on occasions, too anxious. Anxiety is a normal emotion and a powerful motivator. Mild to moderate levels of anxiety improve the ability to cope, reactions become faster, understanding is better and responses are more appropriate. This sense of increased mastery is usually pleasurable. It is good to be aroused, tense, and anxious before important events, but care should be taken to see that the anxiety does not become so severe that it impairs performance. Just as moderate levels of anxiety facilitate coping, high levels reduce the capacity to plan, to make accurate judgements or to carry out skilled tasks, or even to comprehend useful information.

Patients who are stressed complain of being disabled by anxiety, yet some level of anxiety is required to make them keen to work on their problems. This facilitating effect of moderate anxiety and the debilitating effect of high anxiety makes the prescribing of anxiolytics difficult. Sufficient medication to produce the calm that patients seek will usually result in impaired performance. There is now considerable concern about the dependency-producing potential of the benzodiazepines and many doctors are looking to alternative treatments.²

In this article, alternative and useful drug therapies will be mentioned because they tend to be the treatments used most often in general practice (details of drug therapies can be found in chapters 4 and 6),^{2,5} but, like Tyrer,^{3,4} we would encourage doctors “to introduce patients to psychological treatment whenever possible”. The results of the national survey reinforce this advice. Of people with any mental disorder (and anxiety disorders were the most common diagnoses), three quarters expressed a need for counselling



Insects, marine creatures and spiders in their webs are frequently painted by people with anxiety disorders. Reproduced with permission from the Cunningham Dax Collection of Psychiatric Art in the Mental Health Research Institute of Victoria.

Synopsis

- The anxiety disorders are common and disabling mental disorders.
- The doctor's first task is to delineate these disorders from anxiety secondary to threat or crisis, and then manage accordingly.
- For all the five major anxiety disorders — panic/agoraphobia, social phobia, obsessive-compulsive disorder, generalised anxiety disorder and post-traumatic stress disorder — psychological treatments are the treatments of choice.
- Three psychological techniques are described that can be applied in general practice: hyperventilation control to allow people to limit their anxiety and panic, structured problem solving to allow them to deal with problem situations and worries, and graded exposure to allow them to enter and master previously feared situations.
- Despite the challenges offered by these often chronic and disabling disorders, much can be done in general practice to aid recovery.

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or other “talking therapy”, significantly more than the number who expressed a need for medication. In this respect, the public are right. In the anxiety disorders, the cognitive behavioural range of treatments are mostly superior to therapy with drugs, both in short term effectiveness and in the long term, after treatment has concluded.^{6,7} These psychological treatments can restore the mental health of anxious people and overcome the debilitating effects of excessive anxiety.

Doctors must divide their time between attending to crises, caring for the chronically ill, and putting energy into people who they can cure and need never see again. The anxiety disorders are in the last category, potentially curable by psychological techniques, given a skilful practitioner and a hard-working patient.

Diagnosis of anxiety disorders

The presentation of most anxiety disorders is stereotyped and should therefore be simple to recognise. Patients with panic/agoraphobia fear collapse, insanity or death during a panic attack; patients with social phobia fear being negatively evaluated while under the scrutiny of others; unwanted and intrusive obsessions are largely confined to fears of contamination or harm; generalised anxiety disorder means irrational worry about things that may go wrong or one's inability to cope; post-traumatic stress disorder is characterised by the continual triggering of intense and fearful memories of a previous trauma. Specific phobias are limited to irrational fears of harm in very circumscribed situations (e.g., heights, insects, furry animals, snakes, still water, closed spaces, blood and injury) that probably once had survival value. Specific phobias are seldom of clinical importance and will not be discussed further apart from saying that graded exposure (discussed later) is the treatment of choice.

Most disorders have signs as well as symptoms. Anxiety is different. The experience of being chronically anxious is a private one and there is little to observe, except perhaps some tremor and an occasional burst of unexpected panicky behaviour. One central feature of all anxiety disorders is that patients complain of the physical symptoms of the “flight or fight” response — rapid heart rate, need to overbreathe, tremor and shaking, nausea, sweating and focusing of attention — that would be normal if there was a significant physical exertion required to deal with a danger. Because hyperventilation is part of this response most patients also complain of dizziness and light-headedness, tingling and numbness.

Complaints of anxiety that differ from the stereotypes — especially in patients over 40 with no previous history of anxiety — should alert the physician to the need for skilful interviewing to discover the nature of the underlying condition. Of all such conditions, a depressive disorder with secondary anxiety is the most common, and the symptoms of depression will have to be specifically elicited — depression, loss of interest,

1 Prevalence of mental disorders in Australia, 1997¹

Any anxiety disorder	9.7%
Panic disorder	1.3%
Agoraphobia	1.1%
Social phobia	2.7%
Generalised anxiety disorder	3.1%
Obsessive–compulsive disorder	0.4%
Post-traumatic stress disorder	3.3%
Any affective disorder	5.8%
Any substance-use disorder	7.7%
Any mental disorder	17.7%

loss of energy, loss of self esteem, being prey to morbid thoughts, disturbed sleep, and weight loss. Anti-depressant drugs, especially the selective serotonin reuptake inhibitors (SSRIs), are the treatment of choice.

Physical conditions such as hyperthyroidism and other mental disorders such as schizophrenia, delirium or dementia can also present with untoward anxiety. In such cases, management of the underlying disorder is the top priority and first step towards controlling anxiety.

Management

Core symptoms

Treatment should deal with the flight or fight symptoms of anxiety, as many patients misinterpret them as evidence of an underlying physical problem. Thus, doctors have a responsibility to educate their patients about the flight or fight response and about these readily treatable disorders. Most patients seen at our specialist clinic have already been to their local bookstore seeking help for their symptoms, and the quality of such books is, in general, good. Isaac Marks' *Living with fear*⁸ is exceptional, in that it was shown to be an effective treatment in a controlled trial.⁹ Andrew Page's *Don't panic*¹⁰ is an inexpensive and locally available self help book.

Anxiety secondary to threat or crisis

When a patient who is not normally nervous complains of anxiety, the first step is to delineate the nature of the threat or crisis. Mostly, it is not “things that go bump in the night” that produce anxiety, but the meaning that is given to them. If you are awakened during the night by a creaking door and decide that the cat has caused it, it is easy to drift back to sleep. However, if you decide that the noise was caused by intruders, you instantly become alert and anxious and, with a pounding heart and dry mouth, you rehearse what to do. Once it has been established that the noise was caused by the cat, it is easy to go to sleep again. It is not the event, but the thoughts about the event, that generate anxiety. The best way to reduce anxiety is to evaluate the situation, decide what to do, and then carry out what has to be done. In the consulting room, with the support of their doctor, patients can look at the ramifications of the problems causing their anxiety and begin to work out how they might cope.

It is often useful to identify four steps in helping such patients cope with a crisis:¹¹

1. Ensure that they are certain the problem is theirs; many people get needlessly upset over distressing events that do not actually threaten their own well-being.
2. Have them write down the essence of the problem, including listing the outcome if everything were to go wrong. This task will illustrate the extent of their worrying thoughts.

3. Ask them to make a list of a number of ways of solving the problem, choose the one that seems most practical, and have them write down the steps involved in effecting that solution. Coping with the problem should always be divided into steps. The patient will see some steps as being manageable, while other steps may require further thought and perhaps help from others. If necessary, make formal use of the structured problem-solving technique described below.
4. Talk about how they will manage to stay reasonably calm until the problem is solved. Many patients can be helped to remain calm by seeking comfort and support from sensible friends, by putting energy into physical tasks, or by relaxing while reading or listening to music. Alcohol is not a suitable means of relaxation for people with anxiety disorders. Very occasionally, diazepam 5–10 mg daily for 1–4 days may be of value for the patient who becomes distraught, agitated, or sleepless, while stress management programs are of value for people who are chronically under pressure because of their life circumstances or occupation.¹¹

2 Generalised anxiety disorder

Features

- Months of excessive anxiety and worry
- The worry is out of proportion to the event, pervasive and excessive, difficult to control
- Accompanied by muscle tension, hyperarousal and symptoms of the “flight or fight” response

Psychological treatment in primary care

- Education about nature of disorder
- Progressive muscle relaxation
- Structured problem solving
- Graded exposure to difficult situations
- Specialist referral to a cognitive behavioural program for non-responders

A typical presentation

A 25-year-old woman presented with worries about her health, her career and her relationships. She said that she had always worried easily, but over the past several months she had felt more tense and agitated. The current increase in anxiety began following a dispute at work with a colleague who she believed had taken advantage of her, but since then she had been unable to assert herself with this colleague. She frequently worried about the quality of her work and worried that making a mistake would ultimately cause her to lose her job. Over this time she had developed a pattern of waking frequently during the night and being unable to get back to sleep for two to three hours while thinking about all her worries. She had also come to see her general practitioner for various somatic complaints over the years, which she worried were signs of a serious physical illness.

The classic anxiety disorders

Generalised anxiety disorder (months of irrational worry accompanied by somatic symptoms of anxiety—see Box 2) is the commonest anxiety disorder. It is an acute-on-chronic disorder that arises in a person who is by nature a worrier, the habitual oversensitivity and overconcern finally getting out of control. Cognitive behaviour therapy, with the goal of bringing the worry process under control, is the most efficacious treatment.^{6,7} Benzodiazepines reduce the anxiety and worry symptoms but too often lead to dependence. Buspirone is equally effective but seldom used, and low dose sedative tricyclic antidepressants are also of use.

However, as this disorder is often an extension of a worrying nature, the cognitive behaviour therapies that can teach new ways of coping are more appropriate.¹² General practitioners can educate their patients about the flight or fight

3 Panic disorder and agoraphobia

Features

- Sudden attacks of fear or anxiety in situations of little danger
- Symptoms of the “flight or fight” response, complicated by hyperventilation and worsened by the fear of collapse or death
- Avoidance, for fear of panic, of situations from which escape is not possible or help is not available, typically public transport, travelling alone, crowded or lonely places

Psychological treatment in primary care

- Education about nature of disorder
- Hyperventilation control
- Graded exposure to feared situations
- Specialist referral to a cognitive behavioural program for non-responders

A typical presentation

A 30-year-old woman asked her general practitioner to investigate her heart. She reported that several months ago, while attending a postnatal exercise class following the birth of her first child, she noticed a dramatic increase in her heart rate. She also noticed that her breathing became difficult, there was tingling in her fingers and around her mouth, her muscles became stiff, and she felt pains in her chest. Fearing she was having a heart attack, she fled the class and sought help at the local emergency department, where an ECG showed no abnormality. Since then, she had experienced similar symptoms on numerous occasions, always seeking medical advice for reassurance. She could travel alone, provided she carried her mobile phone in case she needed to call for emergency medical help. Even so, she avoided crowded banks, shopping centres, and movies in case medical help would not be able to help her in time should she experience another “heart attack”.

response and teach them how to decrease their physical symptoms using techniques such as progressive muscle relaxation. Teaching structured problem solving (described later) is also helpful in allowing people to focus the worry constructively.

Panic disorder/agoraphobia (*sudden brief attacks of incapacitating fear that commonly lead to avoidance of precipitating situations—see Box 3*) is also common, especially in young women, who present to doctors because they feel that the physical symptoms reflect cardiac or neurological conditions.

Tricyclic antidepressants, monoamine oxidase inhibitors, high potency benzodiazepines like alprazolam and the SSRIs have all been shown to reduce panic frequency, anxiety, and phobic avoidance.⁶ Introducing the antidepressant drugs is often difficult because these patients are sensitive to side effects, and the dependency-producing potential of the high potency anxiolytics is a real cause for concern. Most importantly, these drugs relieve symptoms but do not cure the disorder.

Many patients will find that hyperventilation control (described below), if sufficiently mastered, will be effective in

controlling panic attacks. Once the panic attacks are controlled, the doctor will then have to encourage patients to enter previously feared situations using the principles of graded exposure, also described below. Cognitive behaviour therapy programs for panic disorder/agoraphobia are more effective than medication⁶ and the benefits have been shown to be stable for five years after treatment has concluded.

Social phobia (*avoidance of social interactions, for fear of scrutiny by others—see Box 4*) begins in adolescence and affects both sexes equally. It can be totally incapacitating and lead to a miserable hermit-like existence when the condition shades into avoidant personality disorder. The diagnosis is best made, not from the situations avoided or from the anxiety in those situations, but from the key fear that others will think badly of them.

Again, cognitive behavioural programs are the treatments of choice.^{6,12} Most such programs are conducted in specialised

4 Social phobia

Features

- Excessive and unreasonable fears of being the centre of attention in case of negative evaluation because of looking anxious or doing something embarrassing
- Situations that could lead to scrutiny or evaluation (social functions, being in a crowd, speaking to others) are avoided or endured with intense anxiety

Psychological treatment in primary care

- Education about nature of disorder
- Specialist referral to a cognitive behavioural program is recommended

A typical presentation

A 35-year-old man presented with anxiety at his workplace. Since a recent promotion, he had been having difficulty attending meetings where he might have to present information to his peers. He found the symptoms of pounding heart, trembling, sweating, and blushing so unpleasant that he had excused himself from many meetings and begun avoiding as many as possible. He was seeking help because his avoidance was beginning to be noticed by his superiors at work. When asked about other situations that caused anxiety, he said he had avoided many social activities since his adolescence, particularly if there was a chance that he might be the centre of attention. He did not get anxious when at home with his wife or with close friends. He was particularly worried about the possibility that he might do or say something foolish or embarrassing at work or at social gatherings, and worried that others would notice him sweating or blushing and know that he was anxious. He believed that they would evaluate him negatively because of this.

5 Obsessive–compulsive disorder

Features

- Obsessions are thoughts, images or impulses that occur repeatedly, are intrusive and distressing and can't be suppressed or neutralised
- Compulsions are repetitive behaviours used to control or neutralise the obsessions and prevent the harm and reduce the anxiety, but which are excessive and disabling

Psychological treatments in primary care

- Education about the nature of the disorder
- Advice to resist carrying out compulsions
- Specialist referral to a cognitive behavioural program for non-responders to medication

A typical presentation

A 40-year-old man presented with a long history of checking behaviour that was significantly interfering with his life. He checked on “dangerous” items repeatedly before being able to leave his home because of recurring thoughts that something terrible — like an appliance starting a fire — might happen and that he may inadvertently be responsible for harm befalling others. He performed his checking in a ritualised manner, ensuring that all electrical items were switched off and unplugged, at times having to count to four as he stared at each item. If interrupted during these behaviours or if feeling under pressure, he had to restart his checking rituals. Similarly, if the thought that some appliance might have been left on occurred during his checking behaviour, the time spent checking each item was lengthened considerably. He reported that he was consistently late in getting out of the house because of his checking, and frequently had to leave work during the day to go home and check items again. He had been asked to resign from two previous jobs because of his constant lateness and absences from work.

centres and doctors may have to encourage their patients to attend. It is important to realise that the benefits of such programs are considerable and long-lasting. Drugs from four groups (reversible inhibitors of monoamine oxidase [RIMAs], SSRIs, benzodiazepines and monoamine oxidase inhibitors [MAOIs]) have all been shown to relieve symptoms, but none lead to an enduring recovery from the disorder. Indeed, it is difficult to conceptualise that these anxiolytic and antidepressant drugs could do other than improve well-being, leaving the core issue in the disorder, “fear of scrutiny”, untouched.

Obsessive-compulsive disorder (*fears of harm following intrusive, repugnant thoughts of contamination, violence or blasphemy, controlled by ceaseless washing or checking—see Box 5*) is a rare, disabling condition that begins in adolescence and affects both sexes equally. The diagnosis, while often evident

from the excessiveness of the compulsive behaviours, is confirmed by the content of the recurrent obsession.

Cognitive behaviour therapy involving exposure and response prevention can reduce or eliminate the obsessions and behavioural and mental rituals of this disorder.⁶ About 50% of patients respond to SSRIs, with an average drop of 20%–40% in obsessions and compulsions.⁶ Again, the issue is over the relative merits of a simple but non-curative drug therapy with the limited goal of partial relief of symptoms versus a more complex psychological intervention with some chance of effecting a cure.

Specialist treatment with cognitive behaviour therapy that involves entering situations that evoke the thoughts but not carrying out the compulsions can provide superior results to medication, improvement that is usually maintained after treatment has concluded.^{7,12} Patients treated with medication should, as the intensity of the obsessions diminishes, be encouraged to resist carrying out the compulsions when entering situations that evoke the thoughts. Reassurance from the doctor which addresses the patient’s fears is contraindicated during treatment as the patient is encouraged to confront his or her fears and find them groundless.

Post-traumatic stress disorder (*nightmares, flashbacks and emotional numbing that continue months or years after surviving a dreadful experience—see Box 6*) often presents as depression, the traumatic experience being concealed. Three classes of drugs (MAOIs, tricyclic antidepressants and SSRIs) all reduce the intrusive thoughts, the anxiety and depression, and the sleep problems. These are real gains, but, while the symptoms respond to medication, the core inability to trust and feel safe again does not.

The core problem will respond only to careful and repeated exposure to the details and emotions surrounding the original experience and to the cues in the current environment that evoke the traumatic memories¹³ until they lose their power to disturb. This type of therapy should only be carried out by experienced specialist therapists, but anxiety management strategies such as hyperventilation control or progressive muscle relaxation and the drug treatment of comorbid conditions is within the range of all general practitioners.

Psychological treatment of the major anxiety disorders in general practice

*The management of mental disorders*¹⁴ is a guide published by the World Health Organization Collaborating Centre in Sydney that can be recommended to all general practitioners. It contains practical information about the recognition and treatment of people with mental disorders, patient information sheets about the common disorders and discussion of the three psychological techniques described below:

- hyperventilation control techniques to help patients lower the acute level of anxiety
- graded exposure to feared situations to eliminate the avoidance
- structured problem solving approach to facilitate crisis resolution.

Hyperventilation control and structured problem solving, along with other interviewing, prescribing and counselling skills, are also illustrated in the companion WHO-sponsored interactive CD-ROM *Counselling and management skills in clinical practice*.¹⁵

6 Post-traumatic stress disorder

Features

- Exposure to trauma
- Recurring images of the trauma
- Distress triggered by similar events
- Persistent hyperarousal, avoidance of cues

Psychological treatment in primary care

- Education about the nature of the disorder
- Hyperventilation control
- Graded exposure to cues
- Treatment of comorbid disorders, especially depression
- Specialist referral to a cognitive behavioural program is recommended

A typical presentation

A 27-year-old man presented six months after having lost his house in a bushfire. He, his wife and children had managed to escape unharmed, but one of his neighbours had died. He stated that he couldn’t get the fire out of his mind, was unable to sleep properly and that, when he did sleep, he dreamed about nearly getting caught in the fire. When asked about what happened in the dreams, he stated “We’re back in the fire. I can hear the kids screaming, crying, and then I see Joan running towards us, from her house, burning ... I’m certain we’re going to be next, and I wake in a pool of sweat.” He also related several instances when similar memories had been triggered, such as hearing fire engine sirens, seeing fires on the news, and when attending a local bonfire. When he experienced these memories, he felt and acted as if the trauma was happening all over again. Since the fire he had felt helpless, hopeless, and was unable to concentrate on much at all. His wife complained that he was not the same person she married, having become withdrawn and emotionally detached.

The hyperventilation control technique^{16,17} has two key elements: regular monitoring of respiration rates by the patient and practice of the slow breathing technique to inhibit hyperventilation when anxious. The essence of the technique is simple — “Hold your breath for six seconds and then breathe in and out in a six second cycle” (Box 7), but, because it is to be used when stressed and anxious, it needs to be overlearned if patients are to be able to use it when they need it. Thus, general practitioners need to educate their patients about the rationale, and have them regularly practise counting the respiration rate and doing the slow breathing procedure, both at home and in the doctor’s presence. Many patients will say that they already understand the technique, but if you have them rehearse during the consultation it is amazing how many think that deep breathing, which only worsens the hypocapnoea, is what is meant by slow breathing, which, of course, is aimed at reducing the hypocapnoea.

The structured problem solving approach is displayed in Box 8. At first glance it appears to be little more than applied common sense — carefully identify what troubles you, work out how to deal with it, do what has to be done, then review progress. But acting in a common sense fashion is exactly what people who are anxious have difficulty doing. The procedure was derived from problem solving techniques used in industry^{18,19} and is actually very sophisticated for, with the doctor’s guidance, the patient learns to appraise situations accurately and then develop appropriate coping techniques. After one or two crises handled in this way patients seem to learn to carry out the technique for themselves. It is a most useful technique for general practice and doctors should photocopy figure 1, enlarge it to A4 size and use it routinely with patients who are anxious or distressed.

As Mitchell mentioned and others have shown,^{5,20,21} it is effective in the management of people with depression and of value in managing people who have attempted suicide.

The first step is to get the patient to specify the key threat or problem. Overwhelming and complex problems can usually be broken down into a series of component parts, best specified as a list of discrete goals, one of which is identified as the target problem. The target problem is ideally single, specific and potentially solvable.

Next, have the patient quickly list a number of ways that this problem could be solved or modified. Also list impractical solutions because they may contain the germ of a good idea. Then have the patient discuss the main advantages and disadvantages of each solution and agree on the preferred one. Now have the patient plan the steps required to put this solution into effect. The details should be written down, including names, addresses and phone numbers, as, when anxious, patients will all too often forget or confuse the rational steps they planned. Do not offer advice during the problem solving unless something the patient proposes to do is clearly impractical. It is their problem and by learning how to solve it they will be learning a process that they will continue to use independently of the doctor. Nevertheless, one must arrange to review the results, applauding the outcome. Real problems are complex, and even if the first attempt proves to be ineffective something of use will have been learned that can be used when the process is repeated.

7 Slow breathing technique

Using the second hand on a watch or clock:

- Hold your breath for six seconds
- Breathe in and out on a six-second cycle, saying the word “relax” as you breathe out
- After one minute, hold your breath again, then continue to breathe on a six-second cycle
- Repeat the sequence until anxiety has diminished

Structured problem solving with complex problems is an iterative procedure, a procedure infinitely more powerful than the usual advice from the doctor.

Graded exposure¹² was one of the first of the powerful behavioural techniques. It is of value in assisting patients to overcome phobic situations by gradually re-exposing themselves to the feared situation in a manner that allows them to habituate themselves to it.

Confronting fears is common sense. However, few people with well established agoraphobia, social phobia or obsessive-compulsive disorder will be prepared to confront their principal fear and remain in the situation until the fear subsides. Hence the need for the graded approach.

The first step is a detailed analysis of the feared consequence. In agoraphobia the real fear is of the consequences of a panic attack, so, for example, express trains are feared because escape will be impossible and medical help unavailable should a panic attack eventuate. Conversely, in social phobia the real fear is of negative evaluation by others, and so an express train — where everyone becomes immersed in the view or their reading — is preferred to a commuter train, in which people get on and off all the time and are in a better position to notice others around them. The key question to ask about a fear is “In case what?” and most people will then usually describe the central fear. Once this central fear is understood, the doctor and patient can together generate a hierarchy of tasks — starting with one that can be done with minor discomfort and finishing with one that is almost unthinkable because of the anxiety it would provoke (Box 9).

Once the hierarchy is constructed the patient should confront the first situation repeatedly, remaining in the situation until the anxiety is halved, and repeat the task until there is little anticipatory anxiety associated with the prospect of entering the situation. By mastering the less anxiety-provoking situations, the person learns that fears that are confronted lose their power to frighten.

Benzodiazepines should not be used to make the task easier, for new learning will not occur; instead, dependence on benzodiazepines will only be reinforced. Likewise, dependence on “safety” behaviours or devices, like carrying a mobile phone to summon help, should be avoided simply because the person has to learn to face their central fear of panic and heart attack, or embarrassment and shame, unprotected by any external aids. The doctor will need to see the person regularly to check on progress, to encourage when motivation flags and to reward when tasks are achieved. Once a number of stages in the hierarchy have been surmounted, the rewards of increasing mas-

8 Structured problem solving

Step 1: What is the problem/goal?

Think about the problem/goal carefully, ask yourself questions. Then write down exactly what the problem/goal is.

Step 2: List all possible solutions

Put down all ideas, even bad ones. List the solutions *without evaluation* at this stage.

- 1) _____
- 2) _____
- 3) _____
- 4) _____
- 5) _____
- 6) _____

Step 3: Assess each possible solution

Quickly go down the list of possible solutions and assess the *main* advantages and disadvantages of each one.

Step 4: Choose the "best" or most practical solution

Choose the solution that can be carried out most easily to solve (or to begin to solve) the problem.

Step 5: Plan how to carry out the best solution

List the resources needed and the major pitfalls to overcome. Practise difficult steps, make notes of information needed.

- Step 1) _____
- Step 2) _____
- Step 3) _____
- Step 4) _____

Step 6: Review progress and be pleased with any progress

Focus on achievement first. Identify what has been achieved, then what still needs to be achieved. Go through steps 1 to 6 again in the light of what has been achieved or learned.

What has been achieved? _____

What still needs to be done? _____

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tery of a previously feared situation produce considerable motivation, but even so the doctor will need to continue to encourage regular and repeated practice until final mastery is achieved.

The good news

The anxiety disorders are common and disabling mental disorders. They respond better to psychological techniques than they do to medication.^{6,7} These psychological techniques are more demanding of the doctor's skill and time than drug therapy, but they offer hope of a cure rather than temporary symptom relief. Few patients with anxiety disorders should stay sick. And that is good news.

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9: Graded exposure

- Identify specific goals and break them into smaller, manageable steps
- Learn to master situations that cause mild anxiety
- Progressively master situations that are associated with greater anxiety
- Confront fears regularly and frequently
- Emphasise habituation to anxiety in each exposure session

Example of a graded exposure hierarchy

Goal: To travel alone by train to the city and back

1. Travelling one stop, quiet time of day (anxiety level 4/10)
2. Travelling two stops, quiet time of day
3. Travelling two stops, rush hour (anxiety level 6/10)
4. Travelling five stops, quiet time of day
5. Travelling five stops, rush hour (anxiety level 8/10)
6. Travelling all the way, quiet time of day
7. Travelling all the way, rush hour (anxiety level 10/10)

Note: Anxiety levels are those predicted by the patient before starting treatment