How to cope with anxiety

JOHN P. COBB
B.A., M.R.C.P., M.R.C.Psych.

St George's Hospital Medical School, London SW17 0RE

Introduction

Anxiety is ubiquitous, and because of familiarity, the distress and disruption caused by anxiety symptoms to people's lives is often underestimated. One patient suffering from agoraphobia stoically underwent extensive and painful dental treatment, commenting that the suffering involved was infinitely less than that produced by the 'panics'. Another young woman was completely confined to her room for over 6 months, unable even to visit the bathroom because of her overwhelming anxiety. In these, and in less dramatic situations, the muttered medical reassurance 'don't worry, there is nothing wrong, it's only anxiety' is only likely to make the situation worse. Furthermore, reassurances of this type reveal a basic misunderstanding of the phenomenon. It suggests that all there is to anxiety is the physical and psychic experience. If this were so, then anxiety and fear would be identical. What distinguishes anxiety and what makes it so exquisitely unpleasant is the sufferer's knowledge that the experience is at best an exaggerated response and more often completely groundless. It is this very knowledge that leads some anxiety sufferers (quite logically in the circumstances) to harbour the hidden belief that they are in the process of 'going mad'. They experience a basic contradiction, in that subjectively something is wrong for sure, whereas objectively there is nothing wrong. Medical investigations and opinions only confirm this and heighten uncertainty. Uncertainty involves both the present and the future. 'If I don't understand what is happening right now while I'm in the middle of one of my attacks, how on earth can I hope to know what is to follow?' Collapse, fits, incontinence, other forms of loss of control, and death are frequently anticipated. Finally, and commonly overlooked, is the feeling that the fear is bound to get even worse; the fear of fear. It is to this that John Dryden referred:

The clouds dispell'd, the sky resum'd her light,
And Nature stood recover'd of her fright.

But fear, the last of ills, remain'd behind,
And horror heavy sat on ev'ry mind.

The extent of the problem can be gauged from the fact that various authorities have estimated that about 10% of all consultations that take place in general practice in the United Kingdom are predominantly or entirely a manifestation of anxiety (Shepherd *et al.*, 1966).

The experience of anxiety

Anxiety is experienced in four aspects of life; in body physiology, in patterns of thinking and attitudes, in emotions and in overt behaviour. Each anxiety sufferer has an idiosyncratic pattern which usually has elements of all four aspects, though one in particular dominates. In order to understand the experience it is important to look at the four 'dimensions' of anxiety in more detail.

(1) *Physical.* Any of the physical effects of stimulation of the autonomic nervous system can be experienced alone or in combination. Dryness of the mouth, palpitations, racing of the pulse, shakiness, gastrointestinal discomfort, urgency, tingling and 'pins and needles', excessive sweating, weakness and dizziness are common complaints. Muscle tension and pain are often identified especially tension headaches and low back pain. Less common, though dramatic when it occurs, the patient may actually vomit during an episode, or be frozen to the spot and unable to move. When physical symptoms predominate, the sufferer has the powerful impression that there is something physically wrong. Though it may be obvious to the medically trained that a particular set of phenomena represent activity of the autonomic nervous system, it is by no means obvious to the patient, particularly if the experience is quite distinct from the sensations associated with 'normal' fear and arousal.

(2) *Attitudes and ways of thinking and perceiving.* Thoughts or images that accompany states of panic are often difficult to recall in retrospect. However, if a

patient is asked to note down thoughts as they occur during an attack, or alternatively asked to describe the thoughts that occur during a panic attack experienced during an interview, it will be found that the physical sensations of anxiety are nearly always accompanied by thoughts which are themselves unpleasant and anxiety provoking. Typically these concern either illness, uncertainty or personal failure. 'I'm going to have a heart attack', 'I'm making a fool of myself again' or 'How much more can I stand?' are typical examples. Sometimes they may be directly relevant to attempts to help, for example, 'No one can possibly understand me', 'I am never going to get over this problem' or 'I'm sure that after this consultation yet another doctor is going to say there is nothing he can do and that I've just got to pull myself together'.

Sometimes patterns of thinking may be affected even when feeling relaxed. For example one patient reported feeling very comfortable while sitting in a crowded tube train, a situation which normally induced panic. Then she had the thought, 'isn't this strange, I would usually feel terrible in this situation, I wonder why I'm not pouring with sweat'. A few seconds later a typical panic attack occurred.

It is not difficult to see how such thoughts could alter a person's attitudes and the way they perceive themselves and the outside world. A common experience is of helplessness and lack of control. Anxiety seems to occur with no rhyme nor reason and to overwhelm. An American psychologist (Seligman, 1975) showed that if rats were subjected to continued inescapable and unpredictable shocks two important consequences followed. First the rats lost the ability to learn new ways of avoiding further shocks. It was as though they had learned that outside events were beyond their control. Second the rats developed symptoms which in some ways resembled the depression syndrome in humans. This phenomenon was termed 'Learned Helplessness'. Rat psychology cannot be translated direct to explain human experience, but nevertheless even at a metaphorical level the concept of 'Learned Helplessness' can help to understand the predicament of the anxious patient.

(3) *Emotional*. This component of anxiety is often difficult to put into words. Descriptions such as 'a sense of foreboding', 'panicky feelings' or 'general uneasiness', often fail to do justice to the subjective experience. Panic attacks often include depersonalization and derealization, recognized by the patient as a feeling of unreality or dreaminess, which may be the most unpleasant part of the experience, all the worse because it cannot be put into words. Mixed with fear there may be feelings of sadness and hopelessness, together with a sense of shame and inadequacy on the one hand, with irritation, frustration and exasperation on the other. Sometimes the

emotional experience may be obvious to an outside observer. Facial expression, skin colour (either pallor or blushing) and tenseness indicate that all is not well. Relatives say 'I know when he is in one of his "states" at a glance without anything being said'. Sometimes, however, the patient learns to cover his anxiety with a forced gaiety or mask-like expression. Sometimes a high-necked pullover is worn to hide the blushing of the neck. Sometimes the patient is so ashamed and distressed that a place is sought where he can hide away and cry or shake on his own.

(4) *Behavioural*. Once an episode of anxiety has started, the way the sufferer behaves depends on where the symptoms occur, on severity of the symptoms and on the way the symptoms are viewed. It is often possible to detect some degree of circularity in that some behaviours make the symptoms worse, while others alleviate discomfort. A classical example is the panic attack which occurs in a crowded supermarket and which diminishes as soon as the patient escapes from the situation. Likewise, an episode of anxiety occurring in the home, apparently out of the blue, may be cured by a telephone call to the husband at work. On the other hand, in the middle of a panic the patient may overbreathe which makes the situation worse. Likewise, awareness of change may cause symptoms to increase; for example, a man who during a panic attack on the tube would observe that his newspaper was starting to tremble. The more he tried to steady himself the worse he became.

The classical behaviour response to fear is avoidance. The spectrum from anxiety on one hand to phobias on the other depends on the degree to which the fear is fixed on a particular object or situation. When someone learns that fear is likely to occur in certain places, life is reconstructed so that the place concerned can be avoided. Domestic, personal and financial disruption may be severe. The agoraphobic wife will give up shopping and stop taking the children to school or to the park. The business man who is phobic of flying may turn down a valuable contract overseas if he has to travel in order to clinch the deal. The student who has panics in the lecture theatre may give up University. Equally, when the anxiety sufferer learns that escape from a situation results in decrease in discomfort this behaviour may become a habit. The sudden unexpected departure of a friend from a convivial evening in a restaurant, or a member of staff from a ward round, may well be the result of a surge of anxiety, or even the anticipation that a panic is about to occur, associated with the fear of 'making a fool of myself'.

As well as avoidance, the other common behavioural manifestation of anxiety is the need to seek out reassurance. Typically the effects of such reassurance are only short-lived. One anxious patient whose

requests for reassurance were measured, asked on average once every 90 sec throughout a one hour assessment session. Likewise an anxious woman rang her husband at work on average six times a day over a period of 2 weeks. Such behaviour is demoralizing and frustrating for the patient. It also disrupts the lives of others, both close relatives and medical attendants. A classical 'Catch 22' situation is set up since if reassurance is given the behaviour continues. If reassurance is refused the unfortunate anxiety ridden individual seeks it all the harder becoming more and more distressed in the process. Either way everyone ends up feeling helpless and hopeless.

Avoidance and the need for reassurance can easily lead to an escalation in symptoms. Thus the agoraphobic patient becomes more house-bound, the dental phobic develops appalling tooth decay and the social phobic becomes the social isolate.

The consequences of anxiety both for the patients and other people in their lives

Part of the problem of living with anxiety is that the physical symptoms lead to a distortion of the normal relationship between patients and doctors. The patient complains of a physical symptom, which when physical pathology can be demonstrated usually leads to a sympathetic response, a diagnosis and a prescription. However, when the doctor believes that anxiety is the underlying cause, the patient receives at best a tranquillizer and bland reassurance and at worst is dismissed with the comment that 'There is nothing really wrong with you'. If the symptoms persist, or worsen, the patient returns for more of the same, a process which is accompanied by alienation and loss of confidence. Alternatively if the patient comes to feel totally dependent on his doctor, demands for both time and medication may increase in a spiralling cycle of dependence. This in the final analysis is as unproductive for the patient as it is irksome for the doctor. Either way, both the patient and the doctor are likely to have to live with the anxiety for some considerable time and unless the anxiety is clearly an acute reaction to stress, such as an impending examination, the birth of a baby, or a crisis in a marriage, the symptoms are likely to be chronic. Various studies show that the likelihood of spontaneous remission lies between 20% and 40%. The anxious patient with the thick folder of notes is a familiar figure in the clinic.

Relief from symptoms may also be sought by persistent requests for support and reassurance from close relatives. Again a distortion of normal relationships ensues. Excessive dependence is mixed with frustration and irritation. Lurking just beneath the surface is the feeling that the anxiety sufferer is in some way responsible for the symptoms and deliber-

ately complaining in order to cause disruption. While such simulation and manipulation undoubtedly occurs, it is much less common than most doctors or close relatives assume. Usually the patient is well aware of what is happening, and what effect the symptoms produce on close relatives, though often too ashamed to discuss this openly. 'My husband is so good to me', said one woman with severe anxiety, 'He is too good really. But though we never talk about it, I know that beneath the surface he gets very fed up, and so do the children. They have to do so much more to make up for what I can't do because of my panics. My doctor is very kind too. But I think he must be fed up with me as well. There's a sort of fixed smile on his face, and though he seems to listen to me, I think he's heard it all before, and can't wait to get me out of the consulting room'. She went on to say 'I feel such a nuisance, but really you know I just can't help it'. These feelings of loss of self-esteem and helplessness only serve to increase the anxiety.

Relief of anxiety symptoms may be sought from a sedative such as diazepam or alcohol. Benzodiazepines are prescribed in vast amounts. In 1975 about 22 million prescriptions for minor tranquillisers were issued, the majority of these for anxiety. While this group of drugs is undoubtedly safer in many respects than predecessors such as barbiturates, bromides and opiates, the Committee on the Review of Medicines (1980) documented the increasing concern about their use. First, while undoubtedly producing short-term benefit, their effects are purely symptom-relieving. Second, there is no evidence that benzodiazepines are effective for the long-term treatment of chronic anxiety states. Third, while accepting that on published evidence the risk of dependence is low, the Committee on the Review of Medicines attached considerable importance to withdrawal symptoms after prolonged benzodiazepine use. Finally, these drugs have adverse effects on mental function, which leads to an impairment of the ability to drive or operate machinery. With these points in mind, it is clear that the minor tranquillizers, and in particular the benzodiazepines, can no longer be recommended as a first-line treatment for cases of chronic anxiety.

Just as reassurance may psychologically reinforce anxiety symptoms in the long term, so may sedatives physically reinforce symptoms. This is particularly noticeable when a patient who is on large doses of tranquillizer (and it is not uncommon to find people taking in excess of 50 mg of diazepam daily) tries to stop. The symptoms produced at withdrawal are usually identical to those experienced in an anxiety episode, and may be seen as just that, thus confirming the patient's view that he needs the pills. Alcohol has a similar effect. Many people drink in order to relieve anxiety symptoms. It is an effective and for many, an almost indispensable part of social life, helping to

deal with minor social anxieties and in reducing stress levels at the end of a busy working day. However, as a means of coping with severe anxiety it is all too easy to escalate the dose. Part of the 'hangover syndrome' is anxiety, and so once again a vicious cycle can be established.

Living with anxiety

How much help can be expected from drugs?

Minor tranquillizers. Minor tranquillizers (such as the benzodiazepines) seem on the surface to be an easy way of controlling discomfort. Problems with their use in long-term anxiety have already been discussed. The situation that existed 10 years ago is changing. Many people who would have taken diazepam for tension, as readily as taking aspirin for a headache, are now more concerned about the habit-forming risks. Also more people see a prescription for a minor tranquillizer as a medical brush off: 'All he gave me was more of those little yellow tablets'—a good pharmaceutical example of familiarity breeding contempt. When asked for advice about their value the patient should be told that tranquillizers should be restricted to those situations where reaction to acute stress proves intolerable. Furthermore, better control of anxiety is likely if the patient is asked to monitor his own symptoms, only taking a tablet when a certain anxiety level is reached, while not exceeding a certain maximum dose each day.

There may also be a role for minor tranquillizers in the treatment of insomnia. In this situation there are good arguments for relying on short-acting varieties such as oxazepam, temazepam, lorazepam and triazolam.

Anti-depressants. Tricyclics, such as imipramine, have been shown to be effective in reducing anxiety, particularly when manifested in the form of intermittent panic attacks. This group of drugs is not habit forming, so if a drug approach is favoured, they would appear to have a clear advantage over the benzodiazepines. Unfortunately, about 20% of patients on tricyclics discontinue treatment presumably because of side effects, and at least 2 out of 3 patients relapse when treatment is stopped. Symptoms respond even better to monoamine oxidase inhibitors, but here the essential dietary restrictions prove irksome, the relapse rate following withdrawal of medication is extremely high, and there is growing evidence that dependency can develop.

Major tranquillizers. Major tranquillizers such as trifluoperazine are sometimes prescribed in low doses to relieve symptoms of anxiety when there is no question of any psychotic disorder. While there is little or no risk of dependence with this group of drugs, the possibility of producing serious parkinsonian side effects should contraindicate their use in the management of chronic anxiety.

Beta blockers. Beta blockers appeared to have considerable potential in the treatment of anxiety when first introduced. From their pharmacological properties, it could be predicted that they should reduce the peripheral effects of anxiety, but have few if any central effects. This prediction was verified in practice. However, subsequent clinical trials failed to confirm their value in the vast majority of cases of anxiety, the only exception being a demonstrable benefit in reducing the disruptive effect of performance anxiety, particularly in musicians and public speakers.

How can someone with anxiety help themselves?

The most important point for someone with disabling anxiety to appreciate is that anxiety is an exaggeration of a normal physiological process. This has been known to psychologists for many years, and is represented diagrammatically in Fig. 1. The aim, therefore in trying to 'live with anxiety' is not to remove the experience of arousal altogether (point A) but to shift from point C to point B. Once this is accepted the patient should be made aware that there is excellent evidence that psychological strategies, based on ideas that sound like common sense, can work in helping someone control discomfort and reduce the disruption that anxiety causes to domestic, social and working lives.

FIG. 1. Emotional arousal and performance.

Over the past 20 years carefully controlled studies in several different centres in England, Holland,

Germany, Greece and the U.S.A. have established the effectiveness of behavioural methods in the treatment of both specific phobias and the agoraphobic syndrome (Marks, 1978). From the patient's point of view, the anxiety experienced in these conditions is identical to that experienced in more general anxiety states. The distinguishing feature is that in phobic disorders, there is an identifiable, external provoking stimulus, which may either be an object such as a dog or a dentist's chair, or a situation such as a crowded supermarket. Improvement in these disorders by behavioural improvements have been shown to last for up to 9 years (Mathews, Gelder and Johnston, 1981). It is hardly surprising that the production of sudden dramatic change in disabling phobic symptoms should lead to readjustments in the sufferer's family and social life. Usually these are seen as being for the better, though in some circumstances, as when successful treatment is followed by divorce, they may be for the worse. With this reservation, however, there is no evidence that a 'symptom removal' approach leads to symptom substitution as would be predicted from the psychoanalytic point of view; neither is there any evidence of other side effects. The surprising effectiveness of what appear to be simple methods of treatment and the banal mechanistic models which have been put forward to explain the disorders themselves give a false impression. Although a proportion of cases are straightforward in the sense that anxiety-provoking cues are easy to identify in the external world, many are more complex. The stimuli evoking attacks of panic may be many and varied. A 30-year-old woman was finding it increasingly difficult to travel to work because of anxiety. In her case the episodes of anxiety occurred with maximum intensity when she was travelling in a crowded train towards work with the train moving fast between two stations. Curiously, she had no attacks in a slow, empty train going to work and no anxiety at all on her way home no matter how crowded or how fast the train. The same patient had similar, though less severe attacks, on waking in the morning on weekdays, but not at weekends. Information from both her background and knowledge of the family situation at the time, made it easy to think of several plausible hypotheses to account for this particular pattern of symptoms. Subsequent successful treatment made the point that whereas complexities need to be recognized, they do not contraindicate straightforward behavioural methods. It also raises the possibility that cases of anxiety in which the provoking agent is complex or obscure may also be amenable to symptom oriented behavioural methods.

In the studies referred to above treatment had been carried out by a skilled therapist. Although better results are obtained by these means, it is still possible

for some patients to get considerable benefit by following some simple straightforward advice, particularly if they have a close relative who is prepared to help. Some self-help manuals are in use in this respect (Mathews *et al.*, 1981). A number of steps can be identified.

Use of diary

(a) Recording severity of symptoms

It is helpful for the patient to record a quantitative estimate of the intensity of symptoms at different times. An easy way to do this is to draw a 10 cm line, marking one end 'Perfectly relaxed', and the other 'Extremely anxious'. Using this as a 'Fear thermometer', the severity can be rated. Alternatively, a percentage scale can be used. With a little practice, the patient can readily learn to say 'My anxiety level is about 60%' instead of saying 'I feel terrible'. It is helpful to establish the point on the scale at which the anxiety becomes intolerable, anything below this point being labelled 'normal range of feelings'. Using this approach, the problem may be seen in a different perspective both by the doctor and the patient. One 38-year-old man who was referred with 'intolerable, continuous abdominal discomfort, probably due to anxiety', was asked to keep such a record. This showed that the symptoms only really interfered with his life about once a week and then only lasted a few minutes. An apparently 'overwhelming' problem was at least contained.

(b) Recording circumstances in which symptoms occur

Sometimes, as with specific phobias, it is obvious what produces anxiety, but sometimes the factors precipitating panic are obscure. The term 'free floating anxiety' suggests that anxiety is suspended in space, produced by some form of autogenesis, entirely independent of any precipitating events. In the circumstances, it is hardly surprising that many patients are convinced that they are suffering from some sort of physical illness. One nursing sister had been thoroughly investigated by a general physician who was unable to find a cause for her weakness, sweating and trembling. She was not at all pleased to be referred to a psychiatrist. Despite the physician's label of 'free floating anxiety' she was convinced her symptoms were physical and unrelated to any psychological trauma or stress. Behavioural assessment revealed first of all that the symptoms occurred in discrete episodes. Second, a diary that she kept for a week which documented all the episodes of anxiety, showed that the anxiety occurred in circumstances in which she was thinking either about her mother who was aged and ill, or alternatively about her son who was about to leave home. Discussion quickly led to her volunteering that both these topics were causing

her great worry. This example is typical in that the patient demonstrated that anxiety is nearly always episodic in nature and that if no external precipitating event can be found, then an internal cue can usually be identified in the form of a thought or series of thoughts. Alternatively, the cue may be some physical sensation which is experienced by the patient as unsettling. Examples include a slight discomfort in the chest, a momentary haziness of vision, or as in one very disabled young man, a tugging feeling in the groin. These sensations were rapidly associated with disturbances, thoughts such as 'there is something wrong', 'I've got heart trouble/I'm going blind/I've got V.D.'.

Accepting a rationale for anxiety symptoms

Ideally this should be a process of self discovery in which the anxiety sufferer finds out more about his or her symptoms. Self monitoring through keeping a diary as described earlier is an important part of this, and the process can be encouraged through Socratic questioning. Formal explanations given by the doctor may be helpful, though in the situation in which the patient already has a fixed attitude, resentment, rather than enlightenment results from a lecturing approach. Explanatory booklets are widely used as a supplement to discussion and have been shown to be of value. As a result of this the patient can make a certain number of discoveries about anxiety symptoms. He may appreciate that anxiety is essentially circular. Thus the cue, say a pain in the back of the neck, prompts the thought 'something is wrong with me', which leads to feelings of tension and anxiety which worsens the pain in the neck and so on. A patient related how, for the first four days after the assessment she had been free of panic. Then just as she was thinking 'that is funny I usually get my turns at this time of the day' she became aware of sweat on the forehead, which in turn was followed by the thought 'here I go again' and so to a full panic attack. The patient may also learn that the widely accepted division of human experience into physical and psychological can be misleading. It is easy to produce *real* physical sensations through mental processes and most people react to physical experiences psychologically. Various exercises can be done to illustrate this. The patient can be asked to imagine an unpleasant scene and then to note the physical effects that this has on bodily feelings. Alternatively, the patient can be asked to overbreathe and then asked to monitor what thoughts and feelings this produces. The patient can also learn that some uncomfortable physical sensations can be controlled. Pain produced by deliberate muscle contraction disappears following relaxation. Likewise, discomfort produced by imagining unpleasant scenes disappears when a

relaxing image is substituted. This introduces an element of controllability into a situation in which the patient has previously felt helpless. Finally the patient may appreciate that not only are anxiety symptoms elicited by identifiable cues, but that they are also maintained by identifiable factors. Avoidance plays a key role in the process by which symptoms are preserved and increased. By escaping from a situation when fear is at its height, not only will it be more difficult to go back into the same situation on a subsequent occasion, but also the anticipation of the next episode will be worse. Both the patient and close relatives need to be able to appreciate that for others to be supportive, reassuring and excessively helpful, may paradoxically only make matters worse.

Practising specific exercises

Exposure. Wherever possible the treatment of choice is for the patient to face whatever stimulus has been identified as causing the anxiety. It is important that the patient stays in the situation until the fear experienced has subsided, or started to subside. In a practical way the patient learns that the fear will not last for ever and that the catastrophe which was anticipated if the phobic object was faced, was in fact a fantasy. The exposure exercise can be done slowly (desensitization) or rapidly (flooding). The method chosen depends on how quick an approach the patient can tolerate and the final decision is made by the patient. It has been shown that treatment exercises are more effective if given in a few long sessions rather than in many short sessions. Thus two three-hour sessions are more effective than twelve half-hour sessions. Furthermore, and contrary to prediction from learning theory, it has been demonstrated that it is not necessary for the patient to experience high levels of anxiety in order for change to take place. In the early stages of treatment the patient usually needs to be accompanied during the exposure either by the therapist or by a relative. As treatment progresses the companion is faded out from the sessions, leaving the patient alone. It is essential that the treatment should be experienced by the patients as being under their own control; tricks, surprises or bullying are all counterproductive.

In general the easier it is to identify clear targets the more successful the exposure is likely to be. Another important factor in determining success is the influence of the family. Agoraphobics with unhappy marriages are more difficult to treat and do less well than patients with similar symptoms and happy marriages. Spouses, parents or children can often be seen to play an important part in the maintenance of symptoms. There is the husband who does not like to see his agoraphobic wife upset and

therefore takes the children out and does the shopping making it unnecessary for his wife ever to leave the house. Likewise, the wife who shares her husband's anxiety that his episodic twinges of chest pain might be the first sign of a heart attack, and who responds to her husband's distress with agitated fussing. Sometimes the anxiety is only understandable in the light of important relationship issues, as in the case of the lawyer's family in which the wife secretly and with good reason feared her husband's infidelity. Her own personality and her social position made it impossible to acknowledge her fear openly or to seek any confidante with whom to discuss the situation. She even kept her secret from the family doctor from whom she sought help for a constellation of symptoms, including palpitations, sweating and headaches.

Relaxation. Relaxation exercises, for example Jacobson's Progressive Muscular Relaxation, may help a few patients considerably but on the whole they have only weak effect on the majority of those with anxiety. Commercially available audio relaxation tapes probably sell well not because of the effectiveness but because anxious patients tend to be looking continually for an answer to their problems and will clutch at any straw.

If self help fails?

If the suggestions outlined above fail, then the patient is best advised to seek expert help from a psychiatrist or psychologist. The former are most likely to take a pharmacological approach and the latter to apply either behavioural or the more recently introduced cognitive techniques (Jannoun, McDowell and Catalan, 1981). If all efforts to help

fail for one reason or another it is still worth trying to stop things getting worse. Basic measures here are:

1. Encouragement to resist the often overwhelming temptations to avoid more and more, so that life closes in on the person concerned.

2. Discussion with close relatives to help them stop reacting in such a way to the anxious family member that they unwillingly make the symptoms worse.

3. Watching out for steadily escalating demands for minor tranquillizers or steadily increasing use of alcohol.

4. Giving thought to the difficult problem of how much professional time can be spared to cope with the demands made by the anxious patient. Some practitioners try to cope by resisting consultations as much as possible. Others find that, paradoxically, if they make a small regular commitment, say 10 min per month, that the out of hours calls and 'emergency' consultation requested by their anxious patients almost disappear!

References

- COMMITTEE ON THE REVIEW OF MEDICINES (1980) *British Medical Journal*, i, 910.
- JANNOUN, L., MCDOWELL, I., & CATALAN, J. (1981) Behavioural treatment of anxiety in general practice. *Practitioner*, **225**, 58.
- MARKS, J.M. (1978) *Living with Fear—Understanding and Coping with Anxiety*. McGraw-Hill, Maidenhead. (This is an excellent book for the 'book reading' lay person.)
- MATHEWS, A.M., GELDER, M.G. & JOHNSON, D.W. (1981) *Agoraphobia—Nature and Treatment*. Tavistock Publications, London.
- SELIGMAN, M.E. (1975) Helplessness. *On Depression, Development and Death*. W.H. Freeman, San Francisco.
- SHEPHERD, M., COPPER, B., BROWN, A. & MALTON, G. (1966) *Psychiatric Illness in General Practice*. Oxford University Press, Oxford.