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# Anxiety Control Training

Philip Snaith

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## The problem

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Anxiety pervades every aspect of human activity and experience. It is a normal state and a spur to action, but readily exceeds normal limits in intensity, duration and appropriateness to the stimulus or situation. Anxiety is manifest by the mood of fearfulness, behaviour marked by restlessness and avoidance of situations, increased arousal with insomnia, excessive preoccupation with thoughts on the theme of insecurity, and a wide range of somatic symptoms which are based on muscular tension, hyperventilation leading to paraesthesiae and faintness, and symptoms based on overactivity of the autonomic nervous system. Excessive anxiety and situational avoidance leads to diminution of performance and limitation of endeavour. In the context of physical illness, anxiety increases the distress of symptoms, may confuse diagnostic procedure, prolong recovery time from acute illness, cause failure to comply with effective treatment and promote destructive habits such as reliance on alcohol or excessive use of sedative drugs.

Much attention is given to the problem of depression, its personal and economic consequences, but the assessment and management of anxiety is widely neglected. A survey of prominent professional journals proves this; with the exception of a special form of anxiety termed panic disorder, studies on anxiety management are rare.

Population surveys (e.g. Lindal & Stefansson, 1993) reveal the high prevalence of anxiety disorders. Significant pathological anxiety, falling short of classification as disorders in the diagnostic systems, must be far more common, and the association of anxiety with somatic symptoms of illness is highly significant; we have, for instance, confirmed the intimate relationship of anxiety to pain in patients suffering from cancer (Velikova *et al*, 1995).

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## Therapies

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The development of effective but brief anxiety management techniques is a priority. The effectiveness must include research into the duration of the effect after contact with the therapist, the time required to produce an effect, and the training requirements for administration of the technique – in short, the cost-effectiveness of the therapy. Finally, the acceptability of the techniques to the patients is an important issue; effective techniques which have a high attendance fall-off, or which require patients to attend treatment centres far from their home, have obvious disadvantages.

Lengthy psychodynamic therapies have, over the past three decades, largely been replaced by briefer behavioural and cognitive techniques. However, these also have their drawbacks, especially in the length of time required for their delivery. There is, therefore, a growing interest in self-management of anxiety, and the literature on this has been slowly accumulating (Revel *et al*, 1988; Fahrion & Norris, 1990; Vázquez & Buceta, 1993). Self-management implies instruction to the patient on how to master his anxiety and how to become his own therapist. This must be based upon accurate diagnosis and clear explanation. Not all anxiety disorders are suitable for self-management techniques; for instance, panic disorder may resolve rapidly with low doses of imipramine (Modigh, 1987; Liebowitz, 1989), and anxiety masking underlying biogenic depressive disorder will require a higher dosage of antidepressant medication. Insistence on self-help for such patients will only induce a greater sense of inadequacy and non-compliance with therapeutic advice.

Study of the role of 'relaxation' in anxiety management has been based largely upon the rather prolonged and tedious technique introduced by Jacobson (1938). The role of meditation techniques

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has aroused some interest; indeed, the 'autogenic training' devised by Schultz (1932) is "probably the world's most widely used self-regulation therapy" (Lehrer, in Preface to Linden, 1990). Benson (1975) introduced a straightforward non-cultic form of meditation in the US, and surveyed the essential elements of meditational practice in philosophic, religious and psychotherapeutic settings (Benson *et al.*, 1974). Other useful recent contributions have been by D. H. Shapiro (1982), D. A. Shapiro (1987), Carrington (1987) and Delmonte (1985). The term 'meditation' is often equated with the transcendental variety introduced to the West by the Maharishi Mahesh Yogi in the 1960s, but such restricted applications should be avoided. For those readers wishing to follow the wider literature, the book *The Psychology of Meditation* (West, 1987) is recommended.

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## Anxiety Control Training

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At the beginning of my psychiatric career I had the good fortune to be introduced to the technique of 'autogenic training'. In my therapeutic efforts, this became mixed with the recently established 'systematic desensitisation' technique introduced by Wolpe (1958) in which he advocated a form of light hypnosis to engender more vivid experience both of anxiety situations and of the counterphobic device. At about this time the theoreticians of self-efficacy were producing important works (e.g. Bandura, 1977); Goldfried (1971) interpreted systematic desensitisation as a training in self-control. This seemed a useful development from the rather rigid tenets of the then dominant behaviour therapy and the cognitive therapies. Interest in biofeedback techniques was also flourishing at that time.

In the setting of my own psychiatric practice, with little time to spare for anxiety management and yet a growing interest in supplying a service for this neglected area of distress, the technique of Anxiety Control Training (ACT) evolved, influenced by many of the sources mentioned above.

The technique of ACT is more fully explained in my book (Snaith, 1991) and also in Sims & Snaith (1988). A videotape<sup>1</sup> is available for those wishing to receive more information on the technique. Here follows a brief summary of the procedures.

## Procedures

The essential preliminary to a self-help technique is that the subject should understand the method, should realise that relief will come through his own efforts, and should wish to receive this form of treatment. Failure of this preparation will lead to high levels of non-compliance. Suitable subjects are those with anxiety related to some particular situation, and/or those with generalised anxiety in the absence of an underlying depressive state. Selection of suitable candidates will be reinforced by inspection of scores on the Leeds Situational Anxiety Scale and the Hospital Anxiety and Depression Scale<sup>2</sup>. The latter provides an indication of the presence of a depressive disorder which would inhibit application to, and success with, the treatment.

Once a subject is thought to be a suitable candidate for ACT, he is provided with a brief explanatory booklet<sup>1</sup> and asked to read and decide whether he wishes to accept this form of treatment. The principle is stressed that the method is one of self-mastery which will be taught by the therapist in a few brief sessions, but that relief will only follow regular practice at home; twice-daily sessions are recommended, each of ten minutes, and regular timing will aid compliance. Instruction in the technique is given on a weekly basis, each session lasting some 15 minutes.

The method rests upon the self-induction of trance. The trance is a state of narrowed attention on a single experience or mental image; attention to external stimuli is reduced but not wholly abandoned. Regular practice induces a sense of personal control; that is, a skill is acquired whereby the subject may, at will, induce a sense of calmness and, as therapy progresses, induce an experience of anxiety in order to practise control over the anxiety. It is explained that ACT leads to mastery of anxiety in any situation and that continued practice leads to a gradual increase in confidence. A system of graded exposure to the feared situation, as with systematic desensitisation, is not established; instead, the subject is informed that, through regular practice, he will become aware that situations which previously caused distress do so to a lesser extent and finally not at all.

The patient is then asked to assume a comfortable posture (a chair adjustable to the patient's liking is ideal) and informed that the session will last about ten minutes, that for the first seven minutes the therapist will talk about bodily sensations (a feedback of what the subject will already be experiencing) and that then he will be asked to think of some scene or picture that induces a deepening

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1. Video and/or audio-taped material with instruction pamphlet for patients are available from: Mrs P. Sutcliffe, Media Services, University of Leeds, Leeds LS2 9JT.

2. Scales are available from: Publishing Department, NFER-Nelson, Darville House, 2 Oxford Road East, Windsor, Berks SL4 1BU.

sense of calm. When the subject is comfortable with this, he is advised to fixate his gaze on some point (this heightens the emphasis on concentration) but informed that, as the session progresses, his eyes may close. The therapist, sitting to one side where he may observe without being a distraction, commences a spiel of words directing attention to bodily sensations: "You are becoming aware of the position of your hands ... whether they are warm or cool ... tingly feelings in your hands ... the position of your arms, aware of tension ... being replaced by relaxation ... becoming heavy ... relaxation deepening" and so on, and then: "You are now letting come into your mind a calm, peaceful picture ... through looking at the picture deeper into controlled relaxation ...". In accordance with all trance induction manoeuvres (Benson *et al*, 1974) statements are given in the passive tense and *not* as active instructions such as "Now relax your arms ... now think of a calm scene". The emphasis of this spiel on bodily sensations harks back to the origins of ACT in autogenic training. The exact form of words matters little, but a person requires about seven minutes (initially) to induce a trance state and the words take up about this time. At the first session the subject is informed it will terminate by the therapist counting back from 5 to 1, but that in future sessions and in homework practice "you will bring the session to an end by your own count-down".

### Box 1. Key points

**The prevalence and destructiveness of anxiety requires management by techniques demanding little therapist time.**

**Self-management is the key to widely applicable anxiety management programmes.**

**Meditation is based upon acquisition of the skill of focused attention in the setting of a passive attitude. Trance is the characteristic of all meditational systems.**

**Non-cultic meditation may be rapidly taught. Its use to master anxiety requires regular practice outside the therapist-conducted sessions.**

**The trance state heightens suggestion and autosuggestion, enabling the subject to experience repeated self-mastery of anxiety, which then transfers automatically to real-life situations.**

**Anxiety Control Training has wide application and requires only two hours of therapist time.**

In the homework sessions the subject practises trance induction by simply thinking of a few phrases and returning to them each time attention wanders. It is helpful to ask whether any specific bodily sensations were experienced in the first session (e.g. arm heaviness or tingling) and to use the phrase in home practice: "I feel still and am becoming calm ... relaxed feelings coming to my arms". He may also use the same calm picture or change it if he wishes.

After two or three sessions and regular home practice, when the subject has become familiar with the procedure, he is advised that, in the session, he will allow an anxiety-inducing scene to replace the calm scene, for the purpose of practising control over the anxiety. After the suggestion of anxiety, the therapist observes carefully and, at any evidence of discomfort, uses the words "You are now feeling a little anxious, but may control the anxiety by thinking of the words Calm, Control ...". If anxiety is not controlled within a minute or so, the subject may be advised to return to the calm scene before bringing the session to an end. When this is successfully accomplished the subject is advised to induce the anxiety and practise controlling it in his home sessions.

Most subjects have acquired the ability to induce the sense of calm and control over anxiety within six sessions, and further attendance may then be reduced or terminated. Advice is given to continue the practice over a long period although at reduced frequency, say once instead of twice daily.

## Discussion

The technique of Anxiety Control Training requires little time input by the therapist, generally some 6–8 fifteen-minute weekly sessions. The patient is taught a simple, non-cultic meditational technique and encouraged to practise this in brief but regular twice-daily sessions. He rapidly acquires personal mastery (induction of the trance state) and uses this to induce a sense of calmness. The trance state enables heightening of visual imagery, and early in the programme, imagery of being in stressful situations is induced, followed by control over the anxiety by thinking the words 'calm' and 'control'. The subject is advised to choose the anxiety imagery for himself, but to start with situations that provoke only mild anxiety. He is informed that, through practice, he will acquire the ability to master anxiety in any situation. Generalised anxiety is lessened as practice of the method continues.

Patients who accept the ACT programme will be well motivated toward the concept of self-help and

accept that the role of the therapist is limited to the demonstration of the trance induction technique. Compliance with the method is usually good, although regular reminders of the importance of the home practice is advised. The programme is designed toward the control of anxiety in general, not simply limited situational problems. General self-confidence is thereby restored.

The technique may be adapted for group use. Specific psychological or psychiatric training is not necessary, and speech therapists, nurses and others may soon acquire competence with the method; however, the importance of screening for biogenic depressive disorder and other disorders requiring other treatment should be stressed.

So far, there has only been one outcome study conducted under acceptable conditions, that is, with independent assessment over a period of nine months following cessation of contact with the therapist (Snaith *et al*, 1992). The study, conducted on phobic patients attending an anxiety management clinic, showed that improvement continued with practice of the method; this indicates that a coping skill is acquired through which the patients consolidate treatment gains achieved with the therapist and continue further improvement. In a trial of various components of psychotherapy, a technique similar to ACT was used; in a two year follow-up (Shapiro & Firth-Cozens, 1990), a large proportion of patients who had received anxiety management reported long-term benefits in problem-solving.

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## Conclusions

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The underlying source of stress may not be cured by ACT, but reduction of anxiety will lessen distress and dependence on the medical services. Anxiety concerning examination performance is a prevalent problem in university students, frequently inhibiting academic potential and leading to abandonment of studies. I have often found ACT very useful; students often resist letting their course directors or even other students know of their problems, so a brief self-help technique is to be preferred over group counselling and cognitive therapy.

Contemporaneous with the development of ACT, other brief anxiety management methods were being introduced, such as the Anxiety Management Training (AMT) of Suinn & Richardson (1971). This method is relatively time-consuming, requiring a 30-minute session of relaxation training, an hour for training in visualisation of an anxiety-arousing

scene, and one hour of tape-recorded instructions in visualisation of the scene with switching back to a 'controlling' scene. The trance induction inherent in the ACT method no doubt leads to an abbreviation of therapist time.

The comparison with straightforward hypnotherapy may be drawn; in that technique many people resist trance induction, perceiving it as surrendering will-power to the hypnotist. The trance induction in ACT is a patient-directed procedure and the majority of people find that they acquire the skills within a short time.

There are few adverse effects. The subject is, of course, instructed not to practise the trance induction in a situation where full alertness is required. I have not found any patient retreating into a fantasy world, but would not advise it in patients currently in a borderline psychotic state or suffering from schizophrenia.

The research into management of anxiety requires considerably more attention than it receives at present. Methods require comparison not only regarding their short and long-term effects, but also with respect to acceptability, utility and the time expended on their delivery. The establishment of services for effective brief methods would have benefits far beyond patients whose anxiety disorder may be classified under the contemporary DSM or ICD systems.

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## Multiple choice questions

- 1 The use of meditational techniques is a feature of the following therapies:
- cognitive therapy (Beck)
  - autogenic training (Schultz)
  - rational emotive therapy (Ellis)
  - anxiety management training (Suinn & Richardson)
  - relaxation training (Jacobson)
- 2 The following psychotherapists have been involved in the promotion of meditation as therapy:
- H. Benson
  - E. Berne
  - C. Rogers
  - J. H. Schultz
  - E. Jacobson

- 3 Basic features of meditational devices are:
- a passive attitude
  - a device for focus of attention
  - adoption of particular bodily positions
  - sustained awareness of thought processes
  - reduction in environmental noise
- 4 The incorporation of meditational techniques with other psychotherapeutic procedures:
- gives the patient a sense of personal control
  - releases repressed mental processes
  - provides insight into patient's effect on others
  - provides a religio-philosophic purpose and direction to life
  - facilitates symptom control through self or therapist suggestion
- 5 Anxiety Control Training:
- enables a sense of personal self-control
  - requires, in all, 5–6 hours of therapist time
  - is usually conducted on a group basis
  - requires good motivation for change
  - is based on techniques common to relaxation training

### MCQ answers

- |   |   |   |   |
|---|---|---|---|
| 1 |   | 4 |   |
| a | F | a | T |
| b | T | b | T |
| c | F | c | F |
| d | F | d | F |
| e | F | e | T |
| 2 |   | 5 |   |
| a | T | a | T |
| b | F | b | F |
| c | F | c | F |
| d | T | d | T |
| e | F | e | F |
| 3 |   |   |   |
| a | T |   |   |
| b | T |   |   |
| c | F |   |   |
| d | F |   |   |
| e | F |   |   |