BRIEF BEHAVIOUR THERAPY FOR THE GENERAL PRACTITIONER

TOM KRAFT, M.B., D.P.M.
Senior registrar, St Clement's Hospital, London, E.3.
and
IHSAN AL-ISSA, PH.D.
Lecturer in psychology, College of Education, Baghdad University, Baghdad, Iraq.*

IN THEIR well-known textbook of psychiatry, Henderson and Gillespie have devoted considerable space to the treatment of neurotic reactions by psychotherapy. Special attention has been drawn to the rôle of the general practitioner in the treatment of minor psychological disturbances. The authors have stated that "the general practitioner should be competent himself to carry out the simpler forms of psychotherapy, and is best placed to treat neurotic symptoms quickly, before faulty habits of reaction have become entrenched." (Henderson and Batchelor 1962). Psychotherapeutic methods, whether psychoanalytic or otherwise, are described in their book, in a way that is difficult for the general practitioner to attempt to put into effect. Training and practice in these methods are lengthy and tedious procedures. Patients receiving psychoanalytic treatment require an average of 3–4 years continuous therapy, and during this period most patients are seen four times per week or more, i.e. over 700 sessions (Masserman 1963).

The efficacy of psychotherapy has recently been subjected to heavy criticism. In a recent review of the literature, Eysenck (1962) has demonstrated that treatment offered to patients by general practitioners, who do not employ the principles of psychotherapy, obtain very similar recovery rates to those using standard psychotherapy (Denker 1946). The aim of this paper is to put forward an alternative method of therapy which may usefully be employed by the general practitioner in dealing with simple neurotic reactions. This form of therapy is derived from the application of learning theory to the treatment of neurotic disturbances (behaviour therapy)

* Now assistant professor, department of psychology, the University of Calgary, Alberta, Canada.

(Wolpe 1958, Eysenck 1960, Rachman 1963) and is based on our practical experience over the past three years, in two outpatient clinics.

The theory underlying behaviour therapy has been summarized by Wolpe (1960) as follows: "if a response incompatible with anxiety can be made to occur in the presence of anxiety evoking stimuli, it will weaken the bond between these stimuli and the anxiety responses." Relaxation induced by hypnosis is considered to be incompatible with anxiety. When a patient is hypnotized, it becomes possible to counteract the effects of anxiety-provoking stimuli, and thus to extinguish anxiety responses. The effects then become generalized from the treatment situation to the patient's everyday life.

In contrast to psychotherapy, methods of behaviour therapy can easily be learned by the general practitioner, who may wish to apply these to the simple neuroses. In addition to ease of learning, these methods yield a high recovery rate in a relatively short space of time. Thus, Wolpe (1964) has shown that about 90 per cent of patients make a complete recovery, or improve markedly, in a mean of 54.8 sessions for complex neuroses, and 14.9 for simple neuroses. It is necessary to draw a distinction between simple and complex neuroses. In the complex neuroses, the relationship between the patient's past history and his present condition is not clearly visible, and in these cases a considerable knowledge and experience of behaviour therapy is required (Wolpe 1964). These are best treated in hospital, by an experienced behaviour therapist. In simple neurotic states, associated with specifiable situations, behaviour therapy has been easy to apply, and could well be of great assistance to the general practitioner. We suggest that the following method of treatment might be used as an alternative to conventional forms of psychotherapy.

Method of treatment

In the initial interviews with the patient, a brief history is taken, and attention focused on those situations which evoke anxiety. This may require two to four interviews. A list is then constructed, which includes all the possible anxiety-provoking stimulus situations in his everyday life. This requires the assistance of the therapist, though the patient may help by making a few notes at home. These stimuli are then ranked in stress value, from the least to the most disturbing. (This is called a ' stimulus hierarchy '.) It is imperative that the therapist ascertain which aspects of the stimulus situation (e.g. size, weight, noise, etc.) are responsible for the patient's anxiety, as it is these which need to be emphasized in the treatment sessions. The list of stimuli may consist of from five to 20 items.

Following the preliminary interviews with the patient, one or two

sessions are normally devoted to practice in hypnosis procedure. Occasionally, a patient is deeply hypnotized on the first occasion. Whereas in psychotherapy the aim of the treatment is to discover the past traumatic experiences responsible for the patient's fear reactions, which may take hundreds of sessions to discover, in behaviour therapy, recovery may be achieved by dealing solely with stimuli existing at present in the patient's everyday life (Kraft and Al-Issa 1965). In the treatment sessions, the patient, when deeply hypnotized on a couch or comfortable chair, is asked to imagine the stimuli listed in the hierarchy. He is asked to indicate if he experiences any anxiety, and the quantity of anxiety may be assessed by the nature of his reply ('A lot', 'some', 'a bit', or 'a little'). The stimulus must be repeated until he feels no anxiety whatsoever. The therapist commences with a 'neutral item' which evokes no anxiety at all, and then proceeds from the least to the most disturbing item in the stimulus hierarchy. Eventually, the patient can visualize formerly noxious stimuli without feeling any anxiety, having been desensitized to these stimuli. When the patient has been desensitized to the items in the hierarchy, it will be found that he is no longer anxious in similar situations in his everyday life (Rachman 1963). In our experience, there is a variable latent interval before this occurs. It must be emphasized, not only to the patient but particularly to his relatives, that throughout the course of treatment, he must on no account attempt any situation in life which he feels might be anxiety-provoking, as this seriously interferes with the desensitization programme. He may only be permitted to do so when he feels completely anxiety-free in such situations.

Illustrative cases

Case 1. *Disaster phobia.* A woman aged 38. Her case history began at the age of seven, when her mother died. Her father asked her to kiss her mother in the open coffin, but she could not do so, she started crying, and had to be taken away. Following this episode, she developed trembling, which continued for several months, and also a fear of the dark. Eventually these subsided and she had no further symptoms until the age of 26, when she felt faint in the market-place while accompanied by her sister. Following this incident, she developed a fear of fainting and felt that if she fainted she would fail to recover and would die. A year later, she found that she became anxious and panicky when visiting her sister in hospital, and she was severely affected by her sister's death six months later. Following her sister's death, she found that, when reading a newspaper, she could not read anything relating to accidents or death, because this produced sweating, trembling and a feeling that she could not breathe: more recently, she has not been able to read the front page of a newspaper at all. Also, she found that she could not watch any television programme involving medical work in hospital. She developed panic feelings on hearing an ambulance bell and when approaching a cemetery. Since her sister's death, she has found it difficult to walk to work, developing panic feelings on leaving the house, which increase in intensity as she gets farther from home. When travelling with her husband, she develops a fear of fainting and fears that she

might consequently die. Because of these feelings, she has been unable to travel on a bus for seven years, following an attack of panic at that time. She last travelled by train ten years ago and by Underground 15 years ago, and now even the thought of travelling by Underground is terrifying to her.

Stimulus hierarchy

1. Reading the *Daily Mirror*
2. Looking at television
3. Seeing a man of 65 die after illness of varying lengths, e.g. two months to five seconds.
4. Seeing a man die suddenly
5. Seeing a woman die suddenly
6. Seeing an ambulance
7. Seeing a cemetery
8. Seeing a grave
9. Travelling on a bus from one to seven stops
10. Waiting at a bus stop for one minute, then increasing by one minute intervals to 15 minutes
11. Waiting at a bus stop for 15 minutes and then travelling seven stops
12. Travelling to Southend with her husband by car, and then returning home after varying intervals of time
13. Travelling to, and visiting, Moorfield's Hospital
14. Being alone at home
15. Being alone in the small bedroom where her brother-in-law died
16. Going to the market alone
17. Going to the cinema alone
18. Travelling on a bus alone from one to 12 stops

Case 2. *War neurosis.* A woman aged 45. Her symptoms began at the age of 20, during the second World War. She was working in a factory when involved in a traumatic experience, in which she was buried alive during an air-raid. After her rescue, she was taken to hospital by ambulance and given treatment for ankle fractures. In the ambulance she saw the body of one of her workmates. Following this incident, she became terrified of staying indoors, and noticed that she trembled when picking up objects, e.g. cups. These symptoms have persisted for 25 years and have increased in intensity over this period. Gradually, she has found more and more situations productive of trembling, so that finally, holding any article whatsoever produces anxiety. It would appear that the weight of the article concerned is the operative anxiety-provoking factor. She also developed a variety of other symptoms, including palpitations, a tense feeling in the arms, and a rising sensation in the stomach. Later, her symptoms became generalized to situations outside the home. She found that she trembled when talking to, or shaking hands with strangers, symptoms which have interfered with her social life.

Apart from her difficulties in relation to weights, she found herself also sensitive to noise, following the original traumatic experience. Items causing this anxiety include wireless, television, record players, screeching brakes and screams of angry voices, her anxiety being directly related to intensity of noise.

Stimulus hierarchy

1. Picking up a piece of paper, a newspaper, ½ lb. sugar, and then a variety of items likely to be in a shopping bag up to 14 lb.
2. Lifting an empty mug, a ¼ full mug, ½ full mug, ¾ full mug, full mug, the same procedure being repeated with a glass, cup, etc. Also random

samples of lifting weights of varying descriptions.

3. Noise hierarchies: television full on, wireless full on, car brakes, noises of varying intensities

Case 3. *Claustrophobia.* A woman aged 36. Her symptoms began at the age of 15, when an incident occurred in which a man exposed himself to her. She screamed and the man immediately ran away. After this incident, for several months, she could no longer travel to work on her own, and then this cleared up spontaneously. At this stage, she complained of depression and attended a psychiatric outpatient department. She realized that she did not like working in a cash desk, and that confined spaces aggravated her feelings of depression. Therefore she avoided any situations of a similar nature.

In general, confined spaces aroused her anxiety, and she was particularly embarrassed when alone in a room with a man. She felt more comfortable in a large room than in a small, and was frightened of being alone with a man in the Underground, or in any other train, in case he should expose himself in front of her, as in the original experience.

Stimulus hierarchy

1. Going into a large shop such as Marks and Spencer
2. Going into a small shop
3. Travelling in the " Ladies only " compartment in a corridor train
4. Travelling in an ordinary compartment in a corridor train
5. Travelling in an ordinary compartment in a no-corridor train
6. Travelling on the Underground
   (Travelling in the above items involved starting with many passengers and then decreasing one at a time until there was no passengers apart from the patient.)
7. Being alone at home
8. Being alone in the dark

Results

Treatment of these patients involved 17 sessions for the disaster-phobia, nine sessions for the war neurosis, and eight sessions for the claustrophobia. The first patient can now go to market on her own without any anxiety, enjoys visiting friends by car, and could even take her son to Moorfield's Hospital after he sustained an eye injury. The second patient who had a war neurosis, can now lift objects of various weights in the home without trembling, is happy and sings at work, and is entirely confident. The third patient who suffered from claustrophobia, reports that she now has no difficulty in remaining at home on her own. She feels very well indeed.

This study shows that these patients are now anxiety-free from all the symptoms of their illness, and, in addition, it has been shown that the effects of the behaviour therapy have become generalized to similar situations in the patient's everyday life. A follow-up of 12 months shows that the patients remain symptom-free and there seems no question of symptom-substitution in these cases.

Discussion

The most striking aspect of behaviour therapy is its effective

application to cases of psychological disturbances familiar to the general practitioner. In these three cases, behaviour therapy has proved both effective and rapid. Although anxiety symptoms vary from one patient to another, the construction of a stimulus hierarchy is a relatively simple procedure. It is easy for the patient to list the situations responsible for his anxiety, but the development of the subhierarchies requires intelligent construction by the therapist. In the case of the disaster-phobia (case 1) we divided item 1, reading the *Daily Mirror*, into five subhierarchies.

1. Looking at the Women's page
2. Glancing through the *Daily Mirror*
3. Looking at the ' buying and selling ' column
4. Looking at the theatres and cinemas column
5. Reading about a man dying after illness of varying periods of time

The same procedure was adopted for all the other items in the stimulus hierarchies.

The present study demonstrates the ease of application of behaviour therapy in simple neurotic reactions. A practical knowledge of hypnosis may easily be acquired, either by studying a textbook on this subject (Mason 1960, Weitzenhoffer 1957), or, if possible, by attending two or three hypnosis demonstration sessions.

Summary

The aim of this paper is to put forward a simple method of therapy, in this case behaviour therapy, which may be employed by the general practitioner for the treatment of simple neurotic reactions. This method of therapy is easy to learn and apply, and it does not require lengthy training procedures.

A distinction is drawn between simple and complex neuroses, and it is recommended that the general practitioner attempts to treat only simple neurotic reactions.

The method of treatment involves the construction of a ' stimulus hierarchy ', and the patient, deeply hypnotized, is presented with the items in order of increasing stress value. In this way, the patient can visualize formerly noxious stimuli without feeling any anxiety, i.e. he has been ' desensitized '. When this occurs, it is found that he is no longer anxious in similar situations in everyday life (Rachman 1963).

Behaviour therapy is a rapid method of treatment, and the three patients have all made a good recovery, within five weeks of commencing treatment. A follow-up of 12 months shows that these patients have remained symptom-free.

Acknowledgements

The authors wish to thank Dr John Denham, medical director, St Clement's

Hospital, London, for his permission to treat these patients and his assistance with the preparation of this paper.

REFERENCES

Denker, P. G. (1946). *N. Y. State J. Med.*, **46**, 2164.
Eysenck, H. J. (1960). *Behaviour therapy and the neuroses*, Oxford, Pergamon Press.
Eysenck, H. J. (1962). *J. Consult. Psychol.*, **16**, 319.
Henderson, D., and Batchelor, I. C. (1962). *Textbook of psychiatry*, London, Oxford University Press.
Kraft, T., and Al-Issa, I. (1965). *Behav. Res. Ther.*, **3**, 55.
Mason, A. A. (1960). *Hypnotism for medical and dental practitioners*, London, Secker and Warburg.
Masserman, J. A. (1963). *Theories of the mind*, New York, Free Press.
Rachman, S. (1963). *Behav. Res. Ther.*, **1**, 3.
Weitzenhoffer, A. M. (1957). *General techniques of hypnotism*, New York, Grune and Stratton.
Wolpe, J. (1958). *Psychotherapy by reciprocal inhibition*, Stanford University Press.
Wolpe, J. (1960). In *behaviour therapy and the neuroses*, Oxford, Pergamon Press.
Wolpe, J. (1964). *Brit. J. Psychiat.*, **110**, 28.

REFRESHER COURSE EXPENSES

The following statement is published in order to remove any doubts about the expenses which, under the new system of remuneration, will be payable by the health departments to doctors attending approved refresher courses organized by universities and medical schools.

As was stated in the second report of the negotiations and the Review Body's Seventh Report, the separate payments at present made when a locum is employed will be discontinued since the basic practice allowance will include an amount which recognizes that the doctor is entitled to a period of leave each year for holidays and study, during which he will need either to employ a locum or to arrange for his patients to be cared for by a deputy for whom he himself will have to stand-in on another occasion. The B.P.A. came into effect from 1 October 1966 and locum expenses will not therefore be separately reimbursed for courses starting on or after that date. Payments for other expenses (travelling and subsistence paid direct to the doctor and tuition fees paid to the university) will continue as at present.