All this will require some rethinking of medical education and the way in which our clinical schools and postgraduate programmes are organised in the future; the profession will have to take on board and accommodate individuals with a much broader range of scientific skills than has been necessary hitherto. This will require some

urgent thought by those who are concerned with training our doctors in the future. I hope that this new series will help to provide some of the background information on which we can develop an informed debate on how these changes might be made while, at the same time, maintaining high standards of patient care.

Contemporary Themes

Phobias and their management

ISAAC MARKS, JOHN HORDER

Abstract

Disabling phobias and phobia like compulsive rituals are surprisingly common in the general population, though only a minority ask for help. Behavioural treatment (exposure) and antidepressants are the most helpful approaches. Most patients can help themselves if they use a self exposure approach systematically under the guidance of a clinician. The method seems well suited for use by general practitioners. Antidepressants are a useful adjuvant, not a substitute, for exposure when there is evidence of depression complicating the phobias or rituals.

Introduction

Phobias are fears of particular situations that do not normally bother most people. People with phobias tend to avoid the feared situations. Such phobic avoidance may cause considerable handicap. The patient knows that the fear is unreasonable, given the lack of objective danger. Phobias are distinguished from the normal fears that most people have by the intensity of the anxiety and the urge to avoid. The most common phobias are of public places (agoraphobia), of doing things under social scrutiny, and of specific cues like enclosed spaces, heights, darkness, thunderstorms, and particular types of animals and insects.

A related syndrome is obsessive-compulsive disorder. The anxious phobic avoidance in this syndrome closely resembles that in phobic disorders except that the frightening avoided situations are different.¹ Obsessive-compulsive phobias are not of the public places feared by agoraphobics, the social cues that frighten social phobics, or the heights, darkness, thunder, animals, or other cues of panic in specific phobias. Instead, patients with this disorder have a phobia of imagined dirt, infection, or harming other people and

avoid "contaminating" or "harmful" situations. Unlike in phobic disorder, obsessive-compulsive patients usually also engage in endless rituals such as washing and checking. These are usually done to reduce the fear or to avoid the cues that provoke the fears and rituals.

The results of recent epidemiological studies have shown that phobias and obsessive-compulsive disorder are surprisingly common. In the average general practice population of 2000 there are likely to be roughly 100 people with disabling phobias or obsessive-compulsive disorder.² Only a minority of them ask for help despite effective treatment being available in recent years. More women than men tend to be sufferers, most phobias begin in young adult life, and all social classes are affected about equally.

Almost every psychiatric treatment has been used for phobias, though few have been shown to be effective. In more than 100 carefully controlled studies in Europe and North America (reviewed by Marks,¹ chapters 14-16), the best evidence of lasting help was for the behavioural treatment called exposure (other names for its various forms include habituation, desensitisation, and flooding). Exposure treatment helped phobics and ritualisers whether it was carried out in outpatient departments, general practitioners' surgeries,^{3,4} or at home⁵ and whether it was given by doctors, psychologists, nurses,³ or the patients themselves instructed by a self help manual,^{5,7} or computer.⁷ Most phobics and ritualisers find exposure therapy acceptable. Despite previous chronic disability about 85% of patients who start exposure treatment complete it; two thirds or more of those obtain moderate or appreciable relief of avoidance and panic—and of rituals in obsessive-compulsive disorder.¹

Certain drugs, especially antidepressants, also help some types of phobia. Drugs are easy to prescribe and are part of the traditional medical role. Antidepressants take several weeks to act and have appreciable side effects; moreover, relapse often occurs when the drugs are stopped¹ so patients might have to take drugs for years. That is a drawback in syndromes such as those of anxious avoidance, which can last for decades. High doses of benzodiazepines give some relief in hours, but the effect evaporates even more quickly on stopping the drugs so there is a strong risk of drug dependence.

In contrast, exposure treatment is relatively new, and may at first sight seem more complicated than drugs and to need specialist staff. In fact exposure treatment can be fairly simple to prescribe and monitor for motivated patients yet be enduringly effective⁶—in six follow up studies of four to seven years cohorts maintained their gains.^{1,5} Its main drawback is that the patient has to work hard and systematically over weeks or months to achieve reliable gains.

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Who goes to the doctor?

Many phobias may come for a few months and then remit spontaneously without any treatment, but doctors tend to see patients whose symptoms have continued for more than a year.⁸ Such cases can be expected to continue for many years and even decades.¹ Given the strong evidence for its enduring efficacy it is worth applying the exposure approach with these patients. Some patients who could be helped stay away because they do not realise that help is possible, or are ashamed of their problem, or find it difficult to confide in others; others are reluctant to change despite their handicap.

For example, an agoraphobic woman might start by walking alone just a few yards outside her front gate if she thinks she cannot go further. She decides how far she can go without escaping. She remains there for up to an hour or more until she senses that the fear has decreased. She repeats this minimal task daily until she can do it with relatively little fear. She then proceeds further. This will evoke fresh fear so this further task is dealt with in the same way. In stages she will get herself to the local shops, then more distant ones, on to empty and then crowded buses, and finally into the rush hour crowds.

She is asked to record each exposure effort in a homework diary, which enables her and the general practitioner to keep track of her

Patient's exposure homework diary⁶

Prescribed daily exposure tasks for week starting 1 September 1986

- (a) Walk to local supermarket and stay in and near it for an hour
(b) Ride two miles on the No 90 bus outside rush hour
(c) Walk to local park and stay there for an hour

Day	Date	Began	Ended	Exposure task performed:	Peak fear during task (0 = calm, 8 = panic)
Mon	1 Sep	2 30 pm	4 30 pm	Walked to nearby supermarket and shops, bought food and presents for family, had coffee in cafe	7
Tue	2 Sep	10 am	11 30 am	Walked to local park, sat there for 1/2-1 hour till I felt better, caught a bus to town and back home	6
Wed	3 Sep	2 pm	4 pm	Rode bus to town and back three times till I felt better	5
Thur, Fri, Sat, Sun, etc					

Planned exposure tasks for week starting 8 September 1986 (formulated by patient)

Repeat (a), (b), and (c) from previous week until fear is no higher than 3
Then (d) go to hairdresser and (e) do short surface train journeys

Patient's exposure homework diary

Day	Date	Began	Ended	Exposure task performed:	Peak fear during task (0 = calm, 8 = panic)
Sat					
Sun					
Mon, etc					

Explaining and supervising exposure treatment

Exposure treatment is based on a simple principle—persuading the phobic to re-enter the frightening situations that he or she has long avoided and to stay in them sufficiently long (preferably an hour or more) for the fear to lessen. A clinician does not need to be with the patient at the time. The patient can do this alone. The doctor's role is to explain to the patient what is required, help the patient to map out a self exposure programme, and support and encourage the patient in trying to complete it. Praise for completing appropriate tasks gives the patient heart to do more. Knowing the patient well is an advantage, but exposure can be successful even when the doctor has met the patient for only a few minutes. If the first few steps in treatment are carried out it is worth persevering until the programme has been completed. If even the initial stages are balked at the patient should be referred for specialist help.

The first thing the general practitioner has to do is to allow the patient to describe the problem and say in what way it is a handicap. Most people can do this fairly quickly. The doctor then probes for more detail about exactly what is avoided because it brings on discomfort or rituals. This yields a list of avoided situations that will form the basis of the self exposure programme.

The general practitioner explains that avoiding situations perpetuates phobias. Rapid escape prevents the patient from learning that by staying in the phobic situation long enough the anxiety would subside anyway. The task for the patient is to remain there until he or she feels a bit better. The exposure will be more effective if it continues for long rather than short periods. The exercise should be repeated regularly until the fear is at an acceptable level. Because the task is difficult the patient can start self exposure with less frightening situations, extending the programme only as he or she gets used to each situation. The programme is best carried out without taking alcohol or benzodiazepine drugs. It may be helpful for the doctor to prescribe the first few exposure tasks which the patient freely agrees could be completed (table). The patient sets more tasks as the earlier ones are completed.

progress (table). The doctor praises achievements attained, encourages further exposure tasks to cover all avoided situations, and supports the patient over the occasional setbacks (unexpected resurgences of fear) that are inevitable. Setbacks are especially apt to occur if the patient is already upset for some other reason. They should be the cue to repeat the exposure tasks until the fear has again been overcome. Even patients who are doing well should be told to expect setbacks now and then for some years and that these can be overcome by applying the same methods.

The patient should be given freedom to telephone the general practitioner if the going gets hard. This brief contact alone can be a great support even if no advice is proffered. The frequency of face to face and telephone contact is gradually lessened as the patient acquires confidence.

In dealing with compulsive ritualisers one more principle has to be added to exposure. The ritualising patient has to be encouraged not only to contact the feared stimuli for prolonged periods but also to desist from yielding to the urges to ritualise—for example, wash or check repeatedly—that will ensue. Because this urge may be very strong the patient may find it easier to desist at first for only a few minutes and gradually to lengthen this period of "response prevention" to several hours or even days.

How much help do patients need?

There is much variation in the amount of help different patients need to overcome their problem. Many need a minimum of advice after they have read a self instruction booklet (such as *Living with Fear*⁶) and can then carry out most of their self exposure programme themselves.^{5,7,9} Many can be treated successfully, needing relatively little of the doctor's time. Some patients require regular monitoring to tide them over the difficult periods. A few fail to progress after months of effort, and they are probably best referred to nurses, psychologists, or psychiatrists who have special experience with the exposure approach for such problems.

Phobics and ritualisers who are depressed

Quite a few phobias and rituals start during a period of depression and remain after the depression clears. Other pre-existing phobias and rituals worsen during a depressive episode. Such patients can benefit from antidepressants given over several months. Although some believe that certain compounds have special value, this is based on impressions from within group effects not from reliable controlled between group results (reviewed by Marks, chapter 16¹). Which particular tricyclic or monoamine oxidase inhibitor is used is not especially important, but the dose must be sufficient. Provided the patient is not mentally retarded, it is important that the antidepressants are used as an addition to exposure, not as a substitute for it.^{1,9-11}

Role of relatives

Many phobics and ritualisers suffer their severe handicap in silence, too ashamed to admit their problem even to close relatives. Others who confess their problem meet with incredulity and lack of sympathy or understanding. "Pull yourself together" is a common response. A cynic might argue that behavioural psychotherapy is precisely that—an exercise in willpower. But it shows the patient how to do it systematically in manageable bits. The general practitioner can help the phobic by explaining the nature of the problem and its remedy to a close relative and perhaps recruit that relative as a cotherapist to support the hard work needed to complete an exposure programme successfully.

What instruction does the doctor need?

Some doctors can prescribe and monitor exposure treatment after reading instruction manuals written for patients.^{5,6} Others want additional tuition. A brief course with specific clinical teaching under regular supervision is run by IMM for doctors at the Institute of Psychiatry.

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Lesson of the Week

Pneumothorax in the supine patient

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Chest radiographs of critically ill patients are often taken with the patient supine. Such radiographs are not ideal for the diagnosis of a pneumothorax, which may also escape clinical detection, at the very time that it is likely to matter most to the patient. The radiological signs of a pneumothorax in a supine patient are largely reported in radiological publications and are less well known to clinicians, who are usually the first to see the radiograph.

We describe three cases in which recognition of these signs by a clinician was or might have been crucial in determining the outcome for the patient.

Pneumothorax may be almost impossible to detect in supine radiographs and be manifested only by certain subtle signs; clinicians concerned with the critically ill should ensure that they can recognise these signs

Case histories

Case 1—A 71 year old man was admitted having fallen from a second floor window. He had sustained injuries to the head, left wrist, and chest with fractures of the third to ninth ribs on the right side, the third and fourth ribs on the left, and the left clavicle. Minor surgical emphysema was present but initially there was no evidence of a pneumothorax. He was given assisted ventilation. Five days after admission he developed a right pneumothorax. A chest drain was inserted and removed four days later. On the 12th day his condition deteriorated; the pulse rate rose slightly and the blood pressure fell to 90/60 mm Hg. Chest expansion appeared unequal with reduced movement, hyperresonance, and decreased breath sounds on the left. A left pneumothorax was suspected, but the signs in the supine radiograph (figure) were not recognised. The patient became hypoxic and the clinical signs persisted. Six hours later a repeat supine chest radiograph showed an obvious left pneumothorax with complete collapse of the left lung. A chest drain was inserted and the patient's condition rapidly improved.

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