International Journal of Humanities & Social Science Studies (IJHSSS)
A Peer-Reviewed Bi-monthly Bi-lingual Research Journal
ISSN: 2349-6959 (Online), ISSN: 2349-6711 (Print)
Volume-III, Issue-IV, January 2017, Page No. 348-354
Published by Scholar Publications, Karimganj, Assam, India, 788711
Website: http://www.ijhsss.com

Management of Anxiety: Psychological Techniques

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Abstract

Negative psychological states like anxiety and depression have been the major focus of psychology over the last hundreds of years. People experience these negative psychological states as a part of their response to their threatening life events. These states sometimes help to cope with threatening situations. Humans are hard wired to response in these ways as they are adaptive subsequent to traumatic events. Anxiety is one of the most common mental health concerns in our society. They are often experienced as a complex set of emotional and functional challenges. In the daily life of people, they are exposed to stressful situations; sometimes these stressors may lead to an illnesses and mental disorders like clinically significant anxiety and other negative psychological states.

The current paper will briefly describe the nature, symptoms and psychological strategies to manage anxiety. The paper will help health professionals to know the basic interventions in anxiety management and thereby improve their well-being.

Keywords: Anxiety, management of anxiety, psychological techniques.

Introduction: According to Nijhawan (1972), anxiety is one of the most pervasive psychological phenomena of the modern era, refers to a "persistent distressing psychological state arising from an inner conflict". Similarly, May (1950) defined anxiety as "the apprehension cued off by a threat to some value which the individual holds essential to his existence as personality".

Anxiety is "a reaction to an unknown danger and it is undecided intense apprehension that is usually reflected in a characteristic combination of visceral-motor disturbances and skeletal tensions" (Rubin & Krochak, 1988).

Anxiety is a normal, emotional, reasonable and expected response to real or potential danger, also, it is the environment we are living in is physically, mentally, emotionally, socially and morally dynamic and challenging; we possess effective mechanisms to meet every day stress (Shri, 2010). Freud wrote extensively on anxiety. He asserted that anxiety is the base on which all psychopathology develops.

Symptoms of Anxiety:

Emotional symptoms: Emotional symptoms include non-stop worrying and uncontrollable anxiety. The individual is not able to stop thinking about those thoughts that cause anxiety. The individual also loses the ability to tolerate uncertainty and desperately wants to know the future.

Physical symptoms: These symptoms are physiological changes that include biological effects on the body that resulted from anxiety. Generally, these symptoms reflect elevated sympathetic autonomic nervous system activity (blood pressure, muscle tension and so on).

Behavioral symptoms: The behavioral symptoms influencing the act of the patients; they have no ability to relax, or enjoy quiet time (e.g. being easily fatigued) (Barlow, 1992).

These three types of symptoms include the following symptoms: difficulty concentrating, difficulty sleeping, irritability, fatigue/exhaustion, muscle tension repeated stomach aches or diarrhoea, sweating palms, shaking, rapid heartbeat and neurological symptoms such as complaints of numbness/tingling of different parts of the body.

Management of Anxiety: Anxiety is considered as motivational force for driving behavior. It propels humans toward a specific goal. Anxiety becomes pathological when it starts impairing people's day to day functioning. For example if a person avoids going to social functions because of social anxiety, then it is a matter of concern. If a student experiences excessive anxiety before his/her exam, the academic performance is impaired. Hence, it is essential to learn to manage anxiety through psychological techniques. The techniques are described briefly in the following paragraph.

Relaxation Training: Different forms of relaxation training have been experimentally tested for decades. An early meta-analysis (Hyman et al., 1989) identified 48 experimental studies of relaxation techniques used to treat a variety of clinical symptomatology. The effect sizes ranged from 0.43 to 0.66 for the treatment of health-related symptomatology and were largest for nonsurgical samples with hypertension, headaches, and insomnia. Relaxation techniques like Jacobson Progressive Muscular Relaxation (JPMR), applied relaxation, deep breathing, pranayama etc are often used in cases of cognitive and physiological arousal conditions like anxiety, anger etc. These techniques help to reduce arousal therapy reducing anxiety. It is to be remembered that some relaxation techniques like JPMR and applied relaxation are contraindicated in patients with depression because they will further lower their arousal which might make depressed individual more depressed. In India, Rangaswami (1990) used deep relaxation training as an adjunct to anger control training with a child who exhibited uncontrolled aggression.

Autogenic Training: A specific self-relaxation procedure has been extensively used as a relaxation strategy. It was developed by Schultz in 1932. This technique is based on the principle of desensitization. Like other types of relaxation training, autogenic training is used to treat physical disorders, such as tension headaches and hypertension, as well as psychological disorders, such as anxiety and functional insomnia. A meta-analysis of 60

studies on autogenic training showed medium effect sizes, both pre treatment to post treatment and in comparison to control conditions (Stetter & Kupper, 2002). Autogenic training worked as well, no better or worse overall, than other psychological treatments for the same disorders.

Social Skills Training: Social skills are the ability to express both positive and negative feelings in the interpersonal context without suffering consequent loss of reinforcement. The social skills model postulates four assumptions about the relationships between social skills and problem solving skills and social functioning:

- Social competence requires the integration of a set of component behaviors
- Impairments in component skills contribute to poor social competence
- Social skills are learned or are learnable
- Deficits in social and problem solving skills can be rectified by skills training

Deficits in social skills are often associated with generalized anxiety disorder, social phobia, depression and even in schizophrenia.

An early meta-analysis (Corrigan, 1991) examined the effectiveness of social skills training in 73 studies for four adult psychiatric populations: developmentally disabled, psychotic, non-psychotic and legal offenders. The effect sizes were large across various outcome measures. Patients participating in social skills training roadened their repertoire of skills, maintained these gains several months after treatment, and showed diminished psychiatric symptoms related to social dysfunctions. Looking specifically at skills training for people with schizophrenia, another meta-analysis (Kurtz & Mueser, 2008) examined the effectiveness of social skills training in 22 controlled studies, including 1,521 clients. Results revealed a large effect for content-mastery exams (d ¼ 1.20), a moderate effect size for performance of social and daily living skills (d ¼ .52), a moderate effect size for community functioning (d ¼ .52), and a small effect size for relapse (d ¼ .23). That is, social skills training is effective in improving psychosocial functioning in schizophrenia but less so in preventing relapse. Social skills training for children with emotional and behavioral disorders have also been extensively investigated. The results of six meta-analyses suggested that social skills training for such youth are effective, showing a 64% improvement rate relative to controls (Gresham et al., 2004). Social skills training was effective across a broad range of behavioral difficulties, including aggressive externalizing behaviors and internalizing disorders.

Stress Inoculation: Stress Inoculation training is a cognitive behavioral intervention method intended to help patients prepare themselves in advance to handle stressful events successfully and with a minimum of upset. The use of the term "inoculation" is based on the idea that a therapist is inoculating or preparing patients to become resistant to the effects of stressors in a manner similar to how a vaccination works to make patients resistant to the effects of particular diseases.

Stress inoculation has three phases:

a) In the initial conceptualization phase, the therapist educates the patient about the general nature of stress and explains important concepts such as appraisal and cognitive distortion that play a key role in shaping stress reactions. The idea that people often and quite inadvertently make their stress worse through the unconscious operation of bad coping habits is conveyed. Finally, the therapist works to develop a clear understanding of the nature of the stressors the patient is facing. A key part is the conceptualization stage is the idea that stressors are creative opportunities and puzzles to be solved, rather than mere obstacles. Patients are helped to differentiate between aspects of their stressors and their stress-induced reactions that are changeable and aspects that cannot change, so that coping efforts can be adjusted accordingly. Acceptance-based coping is appropriate for aspects of situations that cannot be altered, while more active interventions are appropriate for more changeable stressors.
b) The second phase of SIT focuses on skills acquisition and rehearsal**.** The particular choice of skills taught is important, and must be individually tailored to the needs of individual patients and their particular strengths and vulnerabilities if the procedure is to be effective. A variety of emotion regulation, relaxation, cognitive appraisal, problem-solving, communication and socialization skills may be selected and taught on the basis of the patient's unique needs.
c) In the final SIT phase, application and follow through**,** the therapist provides the patient with opportunities to practice coping skills. The patient may be encouraged to use a variety of simulation methods to help increase the realism of coping practice, including visualization exercises, modeling and vicarious learning, role playing of feared or stressful situations, and simple repetitious behavioral practice of coping routines until they become over-learned and easy to act out.

SIT has been conducted with individuals, couples, and groups (both small and large). The length of intervention can be as short as 20 minutes or as long as 40 one hour weekly and biweekly sessions. In most instances, SIT consists of 8 to 15 sessions, plus booster and follow-up sessions, conducted over a 3-to-12-month period.

A meta-analysis (Saunders et al., 1996) determined the overall effectiveness of stress inoculation training devised by Meichenbaum (1985). The analysis was based on a total of 37 studies involving 1,837 clients. The overall effect size of .51 on performance anxiety and .37 on state anxiety revealed moderately powerful effectiveness. Thus, stress inoculation treatment has been shown to be effective in reducing both performance and state anxiety and far better than no treatment or control treatments. Biofeedback several researchers have meta-analytically examined the efficacy of biofeedback for treating various conditions. With respect to migraines, biofeedback produced a medium effect size (d ¼ .58) and proved stable over an average follow up phase of 17 months. Biofeedback was more effective than no treatment and placebo (Nestoriuc & Martin, 2007). Biofeedback with home training was found to be more effective than therapies without home training. With respect to tension headaches, biofeedback produced medium-to-large effect sizes (d ¼ .73). Biofeedback proved more effective than headache monitoring, placebo, and relaxation therapies.

Behavioral Activation: The efficacy of behavioral activation was compared with cognitive therapy and antidepressant medication in a large, controlled trial with 241 adults suffering from major depression. Among more severely depressed patients, behavioral activation was comparable to antidepressant medication, and both outperformed cognitive therapy (Dimidjian et al., 2006). When followed for 2 years after the initial treatment, patients receiving behavioral activation and cognitive therapy experienced similar outcomes (Dobson et al., 2008). Patients treated with medication but withdrawn onto pill-placebo suffered more relapses than patients receiving either psychotherapy. Both therapies proved less expensive and longer lasting than medication in the treatment of depression.

Self-Statement Modification: Dush and colleagues (1989) performed meta analyses on the effectiveness of self-statement modification separately for children and adults. The self-statement modification was oriented explicitly around Meichenbaum's self-instructional training. For children, results of 48 outcome studies showed that self-statement modification surpassed no treatment and placebo treatment by roughly half a standard deviation. The average effect, weighted equally by study, was .47. For adults, results of 69 studies showed that self-statement modification evidenced considerable gains beyond no treatment. The average effect size of .74 can be viewed as analogous to shifting the average treated client from the 50th percentile of control subjects to the 77th percentile. Alternative therapies shifted patients to the 67th percentile, on average (effect size ¼ .49).

Contingency Management: A novel application of contingency management is to addictive disorders. The method aims to systematically increase reinforcement for non-drug related activities and to remove such reinforcement for drug use. A meta-analysis was conducted on the effectiveness of contingency management in treating substance abuse. The results demonstrated that contingency management was effective in reducing use of opiates, cocaine, other drugs, and to a lesser extent.

Problem Solving: All of us face day to day challenges in our personal, academic and professional life. It is almost impossible to lead any sphere of our life which is problem free. So, it becomes utmost important to learn the skills to resolve our day to day issues effectively. Most of our day to day issues can be handled effectively if proper skills are used to solve them. It is important to remember, however, that some problems will be easy to resolve and some will require more efforts and need more time to solve. There are always multiple effective ways to handle problems. So, it is important that we continue to focus on different ways to find the solution. The core idea is that *we all should become problem solvers and solution oriented* rather than just pondering about the problem(s).When we are just fixed at the problem only, we are feeding negativity to our brain and it will generate negative emotions which in turn further block our decision making skills and hinder the possibility of generating solutions. So, *remain focused on solution finding* is the key for handling the issue. It is also important to remember that most if not all all human day to day challenges can be solved to a significant extent if effective skills are used.

A recent meta-analysis of 31 studies (2,895 participants) examined the efficacy of problem-solving therapy in reducing mental and physical health problems. Problem-solving therapy emerged as significantly more effective than no treatment (d ¼ 1.37) and attention placebo (d ¼ .54), but just barely more effective than other bona fide treatments offered as part of the study (d ¼ .22). Assigning homework increases the effectiveness of the problem-solving treatment (Malouff et al., 2007). Looking specifically at depression, 13 controlled studies of problem-solving therapies were subjected to a meta-analysis (Cuijpers et al., 2007). The average effect size of .83 indicated that short-term problem-solving therapy can be an effective treatment for depression, certainly more so than waiting list, pill placebo, or psychological placebo. At the same time, as with any treatment, problem solving therapy was less effective with patients who suffered from more severe depression.

Conclusions: Anxiety is often considered as a perception of threat that something bad going to happen. Continuous threat and worry significantly impair one's day to day functioning. Different techniques of anxiety management are quite useful to learn to deal with threat and pressures of everyday living. The type of technique useful for an individual depends on his or her personality style, nature and severity of anxiety, and social support available, his/her cognitive, behavioral, affective and spiritual resources.

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