Mental Health: Anxiety Disorders Experience

Currently, we acknowledge anxiety disorders as the most frequent mental health disorders and among the most treatable (Skarl, 2015). It is simple to overlook how far our views have come since the first phobia meeting was held in 1978 in White Plains, New York (Skarl, 2015). The label 'anxiety disorder' had not yet been created (Skarl, 2015). Most anxiety disorders were titled phobias (Skarl, 2015). The therapists and patients who were in attendance during the early phobia meetings conversed over the need for a national organization to promote recognition of treatments for phobias (Skarl, 2015).

Anxiety disorders comprise disorders that share characteristics of excessive fear and anxiety and associated behavioral disturbances (Association, American Psychiatric, 2013). Fear is described as the emotional reaction to a real or perceived imminent threat (Association, American Psychiatric, 2013). Anxiety is defined as anticipation of future threats (Association, American Psychiatric, 2013). Anxiety and Fear do overlap, however, they do differ from one another (Association, American Psychiatric, 2013). Fear is more frequently associated with outpourings of autonomic arousal essential for fight or flight, feelings of immediate danger (Association, American Psychiatric, 2013). Anxiety is more correlated with muscle tension and attentiveness in preparation for future danger (Association, American Psychiatric, 2013).

Some of the anxiety disorders include the following separation anxiety disorder, general anxiety disorder, social anxiety disorder, agoraphobia, panic disorder, and conduct disorder (Association, American Psychiatric, 2013). Many anxiety disorders arise in childhood and tend to continue if not treated (Association, American Psychiatric, 2013). Most of the anxiety disorders emerge more commonly in females than in males with the ratio hovering around 2:1 (Association, American Psychiatric, 2013). Individuals with anxiety disorders habitually overemphasize the danger in situations they fear or avoid; the primary determinant of whether the fear or anxiety is extreme or disproportionate is made by the clinician (Association, American Psychiatric, 2013). The clinician must consider cultural contextual elements when pondering the dangers for the client (Association, American Psychiatric, 2013).

There have been many studies of psychotherapy as a treatment of anxiety. One such study was done by The Department of Psychology at The Pennsylvania State University in 1993 (Borkovec & Costello, 1993). In CBT(cognitive–behavioral therapy), all AR(applied relaxation) techniques were used, except that the extensive time spent in considerations of early cue discovery and ways of relaxing in daily life was instead dedicated to self-control desensitization and brief cognitive therapy (Borkovec & Costello, 1993). CBT clients were informed in the rationale that visualizing and rehearsing coping techniques would aid in fear elimination (Borkovec & Costello, 1993). It was also conveyed to the CBT clients by practicing these techniques they would develop a habit of coping with their individual anxiety when it comes (Borkovec & Costello, 1993). In addition, cognitive therapy would decrease anxiety-maintaining thoughts and beliefs (Borkovec & Costello, 1993). The use of cognitive products from cognitive therapy during visualization and rehearing would deliver cognitive managing along with relaxation skills (Borkovec & Costello, 1993).

During the study, desensitization was also used, after the client was genuinely relaxed, external

and internal anxiety cues were displayed until the client signified the presence of anxiety (Borkovec & Costello, 1993). The client then continued imagining the external situation while visualizing that he or she was utilizing relaxation techniques in that situation (Borkovec & Costello, 1993). At the removal of anxious feelings, he or she envisioning continued use of these techniques for 20 minutes (Borkovec & Costello, 1993). After that, all imagery was turned off, and the focuses on relaxation resumed for 20 more minutes (Borkovec & Costello, 1993). Scenes were repeated until the client could no longer generate anxiety or was able to eliminate it rapidly 5-7 times in a row (Borkovec & Costello, 1993).

In the AR (applied relaxation) sessions, clients were informed therapy would comprise of learning new managing techniques for diminishing anxiety and worry (Borkovec & Costello, 1993). Anxiety was depicted as involving a habitual spiral progression wherein threat detection leads to intermingling anxious reactions that include thoughts of worry, images, somatic reactions, affect, and avoidance (Borkovec & Costello, 1993). The thoughts of worry seem to be the most prevalent of these symptoms (Borkovec & Costello, 1993). Treatment would therefore involve clients' self-monitoring of their responses and their serial nature and ascertaining the ability to catch the spiral earlier (Borkovec & Costello, 1993). Interceding early with a variety of relaxation responses to anxious thoughts, feelings, and images to interrupt anxious spirals would thus create new behaviors (Borkovec & Costello, 1993). It is important to center attention on present experience rather than concentrate on mentally created past events or future probabilities (Borkovec & Costello, 1993). After the rationale presentation, the advancing relaxation training rationale and demonstration were delivered, following Bernstein and Borkovec's 1973 manual (Borkovec & Costello, 1993). Then clients were educated and allowed to practice slow, paced, diaphragm breathing to deliver an immediate relaxation technique for daily implementation upon anxiety cue detection (Borkovec & Costello, 1993). The significance of formal relaxation practice twice a day and frequent application was accentuated (Borkovec & Costello, 1993). Daily diaries were utilized to identify early anxiety signs (Borkovec & Costello, 1993). There was an importance placed on worrisome thoughts, fear images, and bodily reactions (Borkovec & Costello, 1993).

Sessions consisted of a review of the week and homework and further work on identifying early signs, predicting stressful events and signs (Borkovec & Costello, 1993). These would be used for coping, and formal relaxation teaching with mediational diaphragmatic breathing at the end (Borkovec & Costello, 1993). Relaxation training patterned the procedures and schedule of Bernstein and Borkovec's 1973 manual (Borkovec & Costello, 1993). Some of these procedures included cue-controlled relaxation, differential relaxation, and imagery techniques (Borkovec & Costello, 1993). The discussions progressively concentrated on the flexible choice of relaxation methods, including the notion of letting go of anxious internal events (Borkovec & Costello, 1993). Frequent in-session application of the relaxation techniques was encouraged (Borkovec & Costello, 1993). The therapist occasionally intervened when an increase in tension or anxiety was observed and asked the client to detect the cues and apply extant coping skills (Borkovec & Costello, 1993). As the client progressed they eventually did this on their own during the session (Borkovec & Costello, 1993). Homework accentuated the frequent application of relaxation techniques, centered on living in the present and behavioral method tasks to provide avenues for the extermination of anxiety and the deployment of relaxation skills (Borkovec & Costello, 1993).

Cognitive therapy during this study was patterned after Beck and Emery's 1985 methods, except that only 10–15 min per session was devoted to it (Borkovec & Costello, 1993). The

primary goal was to generate cognitive coping responses both self-statements and perspective shifts (Borkovec & Costello, 1993). These responses were used during desensitization; if time or client readiness allowed, importance was assigned on applying cognitive therapy skills more generally (Borkovec & Costello, 1993). Within these limitations, cognitive therapy included thought and fundamental belief identification, logical examination with probability, and evidence searching (Borkovec & Costello, 1993). There was a focus on cultivating alternative thoughts and beliefs, and behavioral testing of beliefs. Prominence was placed on numerous, flexible, alternative perspectives (Borkovec & Costello, 1993). The therapist habitually used the Socratic Method to stimulate cognitive change (Borkovec & Costello, 1993).

Another psychotherapy approach this study explored was ND also known as Nondirective Therapy (Borkovec & Costello, 1993). During sessions of ND (nondirective therapy), clients were told that therapy would involve the investigation of life experiences in a quiet, relaxed environment (Borkovec & Costello, 1993). The ultimate objective was to facilitate and accumulate knowledge about one's self and anxiety (Borkovec & Costello, 1993). Therapy involved an inward journey that would alter the anxious experience and amplify self-confidence (Borkovec & Costello, 1993). The clinician's responsibility would be one of arranging a safe environment for self-reflection and of aiding to clarify and focus on feelings as the therapeutic agent to facilitate change (Borkovec & Costello, 1993). The clients' role was described to highlight their unique efforts to ascertain new strengths through introspection and affective experiencing (Borkovec & Costello, 1993). The later part of the session was devoted to actual ND (Borkovec & Costello, 1993). The manual taught clinicians to generate an accepting, nonjudgmental, empathic atmosphere, to continuously direct client attention to primary feelings (Borkovec & Costello, 1993). In addition, this atmosphere was to use supportive statements, reflective listening, and empathetic communication to facilitate allowing and accepting of an emotional experience (Borkovec & Costello, 1993). In ND direct suggestions, advice, or coping methods were forbidden (Borkovec & Costello, 1993). Daily homework was given for use in subsequent sessions, clients kept a written journal to dive deeper on observations about the day's events, their thoughts, feelings, images, everything that they did differently, what effect those variations had, and understandings about their reactions (Borkovec & Costello, 1993). Each session began with an opportunity to ask questions, trailed by a review of the week (Borkovec & Costello, 1993).

Along with psychotherapy, there are some psychopharmacological treatment options (Skarl, 2015). Selective serotonin reuptake inhibitors (SSRIs) are widely used as an antidepressant in the treatment of anxiety (Skarl, 2015). SSRIs are believed to amplify the extracellular level of the neurotransmitter serotonin by limiting its reabsorption into the presynaptic cell, increasing the level of serotonin in the synaptic cleft available to bind to the postsynaptic receptor (Skarl, 2015). They have fluctuating degrees of how the other monoamine transporters are selected (Skarl, 2015). Pure SSRIs have only a weak attraction for the norepinephrine and dopamine transporters (Skarl, 2015). SSRIs are regularly prescribed for anxiety disorders, such as social anxiety disorder, panic disorders, obsessive-compulsive disorder (OCD), eating disorders, chronic pain, and occasionally, posttraumatic stress disorder (PTSD) (Skarl, 2015).

As a whole, I think the DSM-5 has done a good job at addressing anxiety disorders. The strengths of the diagnosis are the symptoms criteria for the diagnosis. The list of the symptoms is a good indication of the disorder. I think the weaknesses of the DSM-5 are in the time frame for the symptoms to be had before a diagnosis can be made. The time frames need to be shorter in my opinion. In addition, I would like to add that I have not practice in this field yet and

my opinion may or may not change after having practiced in this field for several years.

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