And Overview of Treatment Options for Anxiety, Somatoform, and Dissociative disorders.

Course meets the qualifications for 2 hours of continuing education credit for MFTs and/or LCSWs as required by the California Board of Behavioral Sciences.

Course Objectives: A Brief Review Major Disorders and Treatments

An overview of major mental disturbances and abnormal behaviors listed in the DSM-IV the Diagnostic and Statistical Manual of Mental Disorders and their treatments are in following order:

Anxiety disorders: Characterized by anxiety and avoidance behaviors. Anxiety is a vague, general uneasiness or feeling that something bad is about to happen. It can be associated with a particular situation or object, or it may be free-floating i.e. not associated with anything specific. The examples of Anxiety disorders are generalized anxiety disorder, panic disorder, phobias, and obsessive-compulsive disorder.

Treatment for Anxiety: Many people with anxiety disorders can be helped with treatment. Therapy for anxiety disorders often involves medication or specific forms of psychotherapy. Medications can be effective in relieving anxiety symptoms. Most of the medications that are prescribed to treat anxiety disorders usually starts the patient on a low dose and gradually increases it to the full dose. Every medication has side effects, but they usually become tolerated or diminish with time. The patient may be advised to stop taking the medication and to wait a certain time e.g. a week or longer for certain drugs, if the side effects become a problem. When treatment is almost complete, the dosage will be gradually decreased.

Research has also shown that behavioral therapy and cognitive-behavioral therapy can be effective for treating several of the anxiety disorders. Behavioral therapy focuses on changing specific actions and uses several techniques to decrease or stop an unwanted behaviors. People who are anxious often hyperventilate, taking rapid shallow breaths that can trigger rapid heartbeat, lightheadedness, and other symptoms. One behavioral technique trains patients in diaphragmatic breathing, a special breathing exercise involving slow, deep breaths to reduce anxiety. Another technique i.e. exposure therapy, gradually exposes patients to what frightens them and helps them cope with their fears.

Research has shown that a form of psychotherapy that is effective for several anxiety disorders, particularly panic disorder and social phobia, is cognitive-behavioral therapy (CBT). It has two components. The cognitive component helps people change thinking patterns that keep them from overcoming their fears. For example, a person with panic disorder might be helped to see that his or her panic attacks are not really heart attacks as previously feared; the tendency to put the worst possible interpretation on physical symptoms can be overcome. Similarly, a person with social phobia might be helped to overcome the belief that others are continually watching and harshly
judging him or her. The behavioral component of CBT seeks to change people's reactions to anxiety-provoking situations. A key element of this component is exposure, in which people confront the things they fear.

An example would be a treatment approach called exposure and response prevention for people with OCD. If the person has a fear of dirt and germs, the therapist may encourage them to dirty their hands, then go a certain period of time without washing. The therapist helps the patient to cope with the resultant anxiety. Eventually, after this exercise has been repeated a number of times, anxiety will diminish. In another sort of exposure exercise, a person with social phobia may be encouraged to spend time in feared social situations without giving in to the temptation to flee. In some cases the individual with social phobia will be asked to deliberately make what appear to be slight social blunders and observe other people's reactions; if they are not as harsh as expected, the person's social anxiety may begin to fade. For a person with PTSD, exposure might consist of recalling the traumatic event in detail, as if in slow motion, and in effect re-experiencing it in a safe situation. If this is done carefully, with support from the therapist, it may be possible to defuse the anxiety associated with the memories.

Another behavioral technique is to teach the patient deep breathing as an aid to relaxation and anxiety management. Behavioral therapy alone, without a strong cognitive component, has long been used effectively to treat specific phobias. Here also, therapy involves exposure. The person is gradually exposed to the object or situation that is feared. At first, the exposure may be only through pictures or audiotapes. Later, if possible, the person actually confronts the feared object or situation. Often the therapist will accompany him or her to provide support and guidance. When undergoing CBT or behavioral therapy, exposure will be carried out only when the person is ready; it will be done gradually and only with his or her permission. The therapist and client will determine how much can handle and at what pace to proceed. A major aim of CBT and behavioral therapy is to reduce anxiety by eliminating beliefs or behaviors that help to maintain the anxiety disorder. For example, avoidance of a feared object or situation prevents a person from learning that it is harmless. Similarly, performance of compulsive rituals in OCD gives some relief from anxiety and prevents the person from testing rational thoughts about danger, contamination, etc. To be effective, CBT or behavioral therapy must be directed at the person's specific anxieties. An approach that is effective for a person with a specific phobia about dogs is not going to help a person with OCD who has intrusive thoughts of harming loved ones.

Even for a single disorder, such as OCD, it is necessary to tailor the therapy to the person's particular concerns. CBT and behavioral therapy have no adverse side effects other than the temporary discomfort of increased anxiety, but the therapist must be well trained in the techniques of the treatment in order for it to work as desired. During treatment, the therapist probably will assign "homework"-specific problems that the patient will need to work on between sessions. CBT or behavioral therapy generally lasts about 12 weeks. It may be conducted in a group, provided the people in the group have sufficiently similar problems. Group therapy is particularly effective for people with social phobia. There is some evidence that, after treatment is terminated, the beneficial effects of CBT last longer than those of medications for people with panic disorder; the same may be true for OCD, PTSD, and social phobia.

Cognitive-behavioral therapy teaches patients to react differently to the situations and bodily sensations that trigger panic attacks and other anxiety symptoms. However, patients also learn to understand how their thinking patterns contribute to their symptoms and how to change their thoughts so that symptoms are less likely to occur. This awareness of thinking patterns is combined with exposure and other behavioral techniques to help people confront their feared situations. For example, someone who becomes lightheaded during panic attack and fears he is going to die can be helped with the following approach used in cognitive-behavioral therapy. The therapist asks him to spin in a circle until he becomes dizzy. When he becomes alarmed and starts thinking, he is going
to die, he learns to replace that thought with a more appropriate one, such as a lesser level of controllable dizziness.

**Somatoform disorders:** Somatoform disorders involve bodily symptoms that cannot be explained by known medical conditions. They are disorders in which physical symptoms are present that are due to psychological rather than physical causes. The examples of Somatoform disorders are Hypochondriasis, Pain disorder, and Conversion disorder.

**Treatment for Somatoform disorders:** The psychiatric assessment and treatment of somatoform disorders are intended to prevent additional medical intervention. One needs to develop a cause for the appearance of somatoform symptoms to help provide a means of physical recovery. Treatment is usually in conjunction with the physician, and a psychosocial intervention that will target appropriate concerns. At the time of psychiatric referral, families often see physicians in a negative light due to the failure of an appropriate medical diagnosis. Occasionally, they have long histories of difficult experiences with physicians and the medical professions. Treatment may suggest exploring this relationships and notions between these preconceived notions of medicine and the development of somatic complaints. The clinician should be sensitive to these issues and not present the diagnosis as either purely organic or functional. In this process, the family is always free to pursue additional medical assessments as needed. The important caveat in this process is adequate communication between the designated primary medical care provider and the mental health professional.

Treatment options that focus on the symptoms of somatoform disorder include individual psychotherapy, particularly as applied to self-management skills and relaxation training. Behavioral interventions, including positive and negative reinforcement, have been successful, as have biofeedback and hypnosis.

Cognitive therapies have been effective in breaking the automatic cycle that maintains the symptoms that include repeated self-observation, false belief and continued fear. When patients are disease-phobic because they are afraid of contracting a fatal disease, exposure therapy has been successful.

Exposure therapy gradually introduces patients into environments they consider dangerous because of contagion, and teaches them relaxation techniques to relieve feelings of extreme anxiety. The presence of a major depressive disorder or anxiety disorder warrants treatment of the depressive behavior, in addition to a plan to directly address and improve the patient's physical condition.

Somatoform disorders patients have been described as frequently having rigid, controlled and obsessive personality styles. Changing these styles is a challenge, particularly because the patient is unlikely to cooperate without the support and assistance of the family. Occasionally these traits are shared by one or both of the parents, indicating a need by the therapist to be supportive and nonjudgmental in his or her approach. The reduction of physical complaints as a treatment goal may be very anxiety-provoking and will require much support. The addition of conjoint family therapy is recommended in a number of cases.

**Dissociative disorders:** We are consciously aware of who we are. Our memories, our identity, our consciousness, and our perception of the environment are integrated. Some people, in response to unbearable stress, develop dissociative disorder and lose this integration. Their consciousness becomes dissociated either from their identity or from their memories of important personal events. They are disorders in which, under stress, one loses the integration of consciousness, identity, and memories of important personal events. The examples of dissociative disorders are amnesia, fugue and identity disorder.

**Treatment for dissociative disorders:** The heart of the treatment of dissociative disorders is the use
of long-term psychodynamics and cognitive psychotherapy. It is not uncommon for survivors to need three to five years of intensive therapy work. Diagnosing and uncovering the trauma is the most important part of therapy. If any trauma and destabilization is present, therapy starts with assessment and stabilization.

A careful assessment should cover the basic issues of history. For example, what happened to the person, history of any trauma. An assessment of how the person thinks or feels about himself, and the presence of any symptoms e.g. depression, anxiety, hypervigilance, rage, flashbacks, intrusive memories, inner voices, amnesias, numbing, nightmares, recurrent dreams, safety of himself, to and from others, relationship difficulties, substance abuse, eating disorders, family history family of origin and current, social support system, and medical status.

After gathering important information, the therapist and patient should jointly develop a plan for stabilization. Treatment modalities should be carefully considered. These include individual psychotherapy, group therapy, expressive therapies art, poetry, movement, psychodrama, music, family therapy current family, psychoeducation and phamacotherapy. Hospital treatment may be necessary in some cases for a comprehensive assessment and stabilization.

The Empowerment Model for the treatment uses ego-enhancing, progressive treatment to encourage the highest level of functioning. The safe expression and processing of painful experiences within the structure of a therapy with healthy boundaries is particularly effective. Group experiences are critical to all survivors if they are to overcome the secrecy, shame, and isolation of survivorship. Stabilization may include contracts to ensure physical and emotional safety before any disclosure or confrontation related to the abuse, and to prevent any precipitous stop in therapy. A full psychiatric consultation for a full psychopharmacologic assessment and treatment.

Antidepressant and anti-anxiety medications can be helpful as a complement of treatment, but never as an alternative to psychotherapy. Developing a cognitive framework is also an essential part of stabilization. This involves sorting out how one thinks and feels, undoing damaging self-concepts, and learning about what is "normal". Stabilization is a time to learn how to ask for help and build support networks. The stabilization stage may take a year or longer--as much time as is necessary for the patient to move safely into the next phase of treatment. At the end of creative energy is released. The survivor can reclaim self-worth and personal power and rebuild life after so much focus on healing.

There are often important life choices to be made about vocation and relationships at this time, as well as solidifying gains from treatment. This is challenging and satisfying work for both survivors and therapists. The journey is painful, but the rewards are great. Successfully working through the healing journey can significantly impact a survivor's life and philosophy. Coming through this intense, self-reflective process might lead one to discover a desire to contribute to society in a variety of vital ways.

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