Common Anxiety Disorders & Their Treatment

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By

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Abstract

The following pages will expound upon the etiology of the four most common Anxiety disorders, their most effective evidence-based treatments, and the efficacy of taking an Adlerian approach to treating the aforementioned. Treatment options that have been less studied in the Western world, such as yoga and meditation, will also briefly be discussed; as this writer believes a holistic approach may be beneficial when warranted. Through the process of conducting this literature review, it was discovered that cognitive-behavioral therapy (CBT) and its multiple related variants is the preferred approach for the treatment of anxiety disorders (Dziegielewski, 2002). More specifically, three evidenced-based methods stemming from a CBT framework include: exposure and response prevention (ERP), rational emotive behavior therapy (REBT), and acceptance and commitment therapy (ACT). In addition, Eye Movement Desensitization and Reprocessing (EMDR) will also be briefly discussed as it relates to the treatment of post-traumatic stress disorder. Finally, a portion of this writing will also discuss a fifth possible approach to treating the four anxiety disorders – the Adlerian approach. Adler believed that anxiety was manifested in an individual so that they can distance themselves from life-tasks so as to ultimately preserve their self-esteem. This “neurotic” “anxious individual will eventually have a hesitating and “yes-but” attitude towards life and other people, his or her lifestyle becoming an anxious and avoidant one so as to prevent any further damage to their self-esteem in a society that they feel they cannot “survive” or perhaps “succeed” in.
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Anxiety & Its Treatment

What is Anxiety

Generally speaking, anxiety is experienced by all individuals in one form or another at some point in their lives. Anxiety is considered to be a normal reaction to stress and can be advantageous for survival, as was the case with hunter-gatherers prior to civilization, as well as serving a purpose in the sense that it serves as motivation to complete tasks and to avoid either a perceived or a tangible pain worse than that which the initial anxiety creates. Dziegielewski (2002) notes that symptoms present with an anxiety-related disorder more often than not involve “a combination of cognitive, behavioral, and somatic responses such as nervousness, sweating, irritability, sleeplessness, fear, muscular tension, obsessive thoughts, poor concentration, compulsive actions, feelings of depression, and other types of general discomfort” (p.278).

When anxiety begins to impact the day-to-day functioning of an individual, either chronically or acutely, or begins to impact social or emotional functioning with family and friends, some form of intervention is warranted. Per Meyer (2009), anxiety comes to the point of being considered a disorder when it is consistently experienced or comes to the forefront when one is attempting to “master” his or her symptoms. The National Institute of Mental Health says that anxiety disorders affect approximately 40 million adult Americans in a given year. Per the aforementioned, women are 60% more likely to experience anxiety over their lifetime than men. Given the prominence of this particular mental health concern, and the considerable amount of money being spent to treat it – either via medications or other treatments, it stands to reason that mental health professionals would benefit from understanding what the most effective evidence-based treatments are for the most common of the anxiety disorders.
Etiology

Unlike the medical profession, where the biological etiology for a slew of diseases has been confirmed, leading to empirically based treatments; mental health disorders are unfortunately lacking in that particular area. As Ducan et al. (2010) reports, “diagnostic nosologies such as the DSM are more descriptive rather than etiological” (p.64). The aforementioned authors further say that because there is no “definitive” psychological model that determines dysfunction it is very difficult to confirm the etiological sequence.

Nevertheless, it is of the belief, like many mental health disorders, that the etiology of anxiety can be best explained via a biopsychosocial model (NIMH, n.d.). Per NIMH, studies of twins and families suggested that genetics played a role in the formation of certain anxiety disorders. In addition, it was noted that while post-traumatic stress disorder is the result of a trauma, genes may explain why certain people who are exposed to trauma develop PTSD and others do not. NIMH (n.d.) also states that “several parts of the brain” play integral roles in the formation of fear and anxiety; noting that the amygdala and the hippocampus are the two largest players when it comes to most anxiety disorders. Certain phobias, for example, are the result of “emotional memories” stored in the central parts of the amygdala; which is also responsible for alerting the brain that a threat is present – resulting in either fear or anxiety (NIMH, n.d.).

Quick Reference of Common Anxiety Disorders Discussed Hereinafter

The four most common disorders found under the umbrella of anxiety are as follows: Obsessive-Compulsive Disorder (OCD), Post-traumatic Stress Disorder (PTSD), Generalized Anxiety Disorder (GAD), and Social Anxiety Disorder (National Institute of Mental Health [NIMH], n.d.). The following chart, summarized from Dziegielewski (2010), shows the basic terms of the anxiety disorders referred to hereinafter.
A. With Obsessive-Compulsive Disorder a person will report reoccurring obsessions, classified as 'thoughts;' and compulsions, classified as 'behaviors;' both of which are significant enough to affect social, emotional, and occupational well-being and functioning.

B. Post-traumatic Stress Disorder consists of symptoms lasting at least one month. If the symptoms last more than six months after the traumatic event it is referred to as delayed onset PTSD. Also, the person must experience “reliving” the situation and the symptoms must be outside the “range” of common experience.

C. With Generalized Anxiety Disorder a person will report unjustified and consistent “worry” or “stress” for at least six months regarding at least two or more life circumstances.

D. Social Anxiety or Social Phobia will result in a person having a “persistent” fear of one or more social situations.

**Purpose and Relevance of this Literature Review**

According to Rosenblatt (2010), not only are certain anxiety disorders the most common of all mental health problems, but also the most expensive when it comes to its treatment, accounting for 3% of total mental health related costs (an estimated $46.6 billion a year). Rosenblatt also suggests that the cost of leaving certain anxiety disorders untreated, OCD and Generalized Anxiety Disorder for example, is “significantly” greater than the cost of treating it. The author also goes on to note that in the United States every year, while roughly six million visits to primary care physicians are accounted for, only about 60% resulted in some form of treatment for anxiety being offered; with “almost” 2.5 million people being left untreated. Rosenblatt makes an argument that there is a tendency in the United States, and perhaps elsewhere, for medications being the preferred treatment for anxiety when other evidence-based psychotherapeutic options are available, frequently at a lesser
cost. Asmundson et al. (2013) cite in their review of studies related to the impact of physical exercise on anxiety that not only are anxiety disorders the most commonly diagnosed of all mental health conditions, but are also the most under-diagnosed, in addition to being on the rise (p. 362). The detrimental implications for the mental health system and society in general is significant if mental health providers do not have a better grasp on anxiety in general and its treatments.

To further stress the importance of gaining a broader understanding of what constitutes “anxiety,” Dziegielewski (2002) notes that only an estimated one-fourth of individuals who present with anxiety severe enough to be classified as an actual disorder are correctly diagnosed and treated. Furthermore, he states that that is a significant concern because the treatment of anxiety in a short-term manner has a success rate larger than 70% (Roth & Fonagy, 1996; as cited in Dziegielewski, 2002). Essentially, if a practitioner is armed with the knowledge of the various anxiety disorders, their diagnostic assessments, and various treatment options, the prevalence of anxiety-related maladaptive behaviors can be reduced to a certain extent. For example, it was noted by Dziegielewski that during the diagnostic assessment phase many clients will not attribute their presenting concerns to anything anxiety-related, but rather to some form of medical condition – thus further emphasizing the need for a more streamlined process when it comes to diagnosing anxiety-related disorders.

**Obsessive-Compulsive Disorder**

**Background**

The World Health Organization (WHO) ranks Obsessive Compulsive Disorder (OCD) among the top 10 debilitating disorders of all “medical disorders in the industrialized world” (Eisen et al., 2006; World Health Organization, 2003; as cited in Pignotti & Thyer, 2011). OCD is characterized by: “recurrent and persistent thoughts, impulses, or images that are experienced at some time during the disturbance as intrusive and inappropriate and that cause marked anxiety and distress” (p. 462,
Diagnostic and Statistical Manual of Mental Disorders; American Psychiatric Association, 2003; as cited in Pignotti & Thyer, 2011).

The given lifetime prevalence of OCD is about 2 percent (Kessler, Berglund, Demler, Jin, Merikangas, & Walters, 2005; as cited in Pignotti & Thyer, 2011) and assessment of the anxiety disorder is most often conducted using the Yale-Brown Obsessive Compulsive Scale (Y-BOCS) (Goodman et al., 1989; as cited in Pignotti & Thyer, 2011).

Relevant Studies that Suggest CBT as Effective for OCD Treatment

The following paragraphs will expound on some studies that were conducted that resulted in further proving that CBT is an evidence-based practice for treating OCD and by proxy, anxiety in general. Although the respective names of each approach may seem to not have any connection, ultimately they fall under the general umbrella of “cognitive-behavioral therapy.”

One study conducted by Freeston, Ladouceur, Gagnon, Thibodeau, Rhéaume, Letarte, et al. (1997) aimed to find out the efficacy of cognitive-behavioral therapy in light of a particular population: patients who have been diagnosed with Obsessive-Compulsive Disorder as per the requirements set forth by the Diagnostic and Statistical Manual of Mental Disorders (3rd ed., revised; American Psychiatric Association, 1987), but those that did not exhibit any overt rituals commonly found in OCD patients. In other words, the purview of the study focused on OCD patients who showed only obsessive thoughts, not actions. Freeston et al. (1997) note that past exposure and cognitive therapies when it comes to OCD patients have proven effective, but those studies only took into account patients showing obvious overt rituals in addition to obsessive thoughts. Having narrowed the treatment population, it was hypothesized by the authors that the treatment group would see significant positive changes in their mentality and cognitions upon conclusion of treatment, relative to the control group, who were placed on a waiting-list and did not receive initial treatment, though they too became the treatment group after a predetermined number of weeks.
The study was quantitative and experimental in its method. It incorporated a variety of widely used and respected assessments to ultimately test the authors' hypothesis. The study addressed 29 patients who were assigned randomly to the treatment group (n = 15) and the control and waiting-list group (n = 14). All patients were French-speaking Caucasians and a little over half of the group was comprised of men. The article further breaks down the demographics into age, years of education, previous consultations for obsessions, and types of medications taken, among others, but for the constraints of this assignment I have omitted those specifics, as I will mostly do for the other studies and research presented in this paper.

Pre-treatment assessments were a significant portion of the entire studying process. The Yale-Brown Obsessive-Compulsive Scale (Y-BOCS) administered during the pre-treatment process indicated to the researchers that all patients were appropriate for this particular study. From there, patients were randomly assigned to therapists in pairs for the pre-treatment and then to groups for the treatment studies.

Outcome measures were determined via two clinicians and their ratings as well as three self-report measures. In addition to the Y-BOCS, the Current Functioning Assessment (CFA), the Padua Inventory (PI), the Beck Anxiety Inventory (BAI), and the Beck Depression Inventory (BDI) were all utilized to test the authors' assertions. The actual cognitive treatments were based on 1.5 hour sessions given twice weekly for the first two thirds of therapy. Specific methodology included: 1) detailed cognitive account of obsessions which included areas such as triggered or spontaneous obsessive thoughts and the paradoxical continuation of such thoughts; 2) explanation of the rationale behind exposure and response prevention as it relates to OCD therapy; 3) cognitive restructuring; and 4) relapse prevention.

The study's authors concluded that cognitive-behavioral therapy as administered in the study was indeed efficacious when it came to reducing obsessive thoughts in OCD patients who ranked
highly in several of the pre-treatment assessments. For example, mean scores for the Y-BOCS pre-treatment were 23.5. Those scores changed to 9.8 post-treatment and remained relatively low when follow-ups were conducted 6 months after the initial pre-treatment assessment. As Freeston et al. say, “Compared with the waiting-list control, there were significant improvements in the treatment group on the Y-BOCS total score, current functioning, self-report OCD symptoms, and self-reported anxiety” (p. 410). The same results were obtained months later when the initial control group was given similar treatment, giving further weight to the authors’ initial hypothesis.

Yet another study showcased the effectiveness of a new type of Beck-inspired cognitive therapy that does not make use of prolonged exposure and prevention of rituals. The latter two being common types of therapy for such populations. The authors emphasized that OCD treatments are most effective when behavioral therapy is combined with exposure and response prevention (ERP) and as such they wanted to test the efficacy of a treatment that would minimize ERP and exposure. Wilhelm et al. (2005) hypothesized that this particular style of Beck's cognitive therapy will prove to be just as useful as the much more common ERP therapy.

The therapeutic sessions consisted of 14 weekly 50-60-minute individual sessions of a Beckian cognitive therapy, which included psychoeducation, Beck's cognitive methods, and relapse prevention strategies. Just as in all studies of this nature, the typical self-report measures were given pre and post treatment: PI, Y-BOCS, BAI, BDI, and the Obsessive Beliefs Questionnaire (OBQ).

The authors concluded that the Beckian CT treatment was effective for all 15 of the patients in the study. The purpose of the study was essentially to determine whether or not CT with minimized ERP was effective for reducing OCD symptoms for those who had previously received only that or none at all. The study concluded that it was beneficial for both groups. Even marginal gains were seen for the patients who had previously failed ERP therapy. It can be concluded that for certain patients, this form of Beckian cognitive therapy will prove to be more effective at treating OCD and
depressive symptoms than the popular ERP. The authors speculate that this may be due to the less stressful nature of CT compared to the anxiety-inducing ERP. For those without excessive overt rituals, it is concluded that CT is a good alternative to ERP. A final interesting conclusion from the study was the fact that of the 10 patients who were asked to select between both CT and ERP, all 10 preferred CT, which further may suggest that CT is a feasible approach for the treatment of OCD.

According to Corey (2009), cognitive therapy assumes that psychological issues emanate from faulty thinking, making incorrect inferences based on insufficient or incorrect information, and failing to perceive the difference between fantasy and reality. As such, the interventions common to CT are especially conducive to OCD populations because people exhibiting symptoms of OCD frequently have faulty thinking that lead to incorrect inferences which in turn lead to compulsive behaviors.

The first CT model was proposed by Salkovskis (1989) who believed it was not the intrusive thoughts which were problematic for individuals with OCD but the manner in which those thoughts were interpreted (Wilhelm et al.; as cited in Podea, Suciu, Suciu, & Ardelean, 2009). The majority of individuals ignore intrusive thoughts but individuals with OCD tend to acknowledge these thoughts as well as generate catastrophic consequences of such thoughts. The role of CT is to mitigate such beliefs and reduce the effect of intrusive thoughts. Faulty beliefs include: “false estimation of danger and its consequences, exaggerated sense of personal responsibility, overestimation of the importance of thoughts, thought-action-fusion (TAF), uncertainty intolerance, anxiety intolerance, perfectionism” (p. 228; as cited in Podea, Suciu, Suciu, & Ardelean, 2009).

According to Corey (2009), Behavior Therapy consists of “four areas of development” that ultimately produce positive change in individuals. These four areas include: classical conditioning, operant conditioning, social learning theory, and cognitive-behavioral therapy. Behavior is said to be the result of learning and just as phenomenology plays a role in Adler's notion of the “creative self,” behaviorists believe that people are both the product and the producer of the environment around
them. Further, behavior therapy assumes that “normal” behavior is learned through reinforcement and imitation, whereas abnormal behavior is the result of faulty thinking (Corey, 2009, p. 457). Naturally, given the preceding, it is not difficult to see why bridging the behavioral therapeutic approach with a cognitive approach results in a cognitive-behavioral framework that has the most evidence behind it as far as efficacy is concerned.

Having laid down the foundation for CBT, it is believed that CBT is the chosen framework for OCD because of the fact that the prefrontal cortico-striato-thalamic brain system has been implicated as involved in OCD symptoms; CBT techniques have shown proven efficacy and result in changes of cerebral metabolic activity (Podea, Suciu, Suciu, & Ardelean, 2009). Per Duncan, Miller, Wampold, and Hubble (2010), “CBT and response prevention/exposure (RPE) are both treatments with empirical support for the treatment of OCD. It is hypothesized that CBT works by focusing on the cognitive aspects (i.e., obsessions), whereas RPE works by focusing on the behavioral aspects (i.e., compulsions)” (p. 65).

### Exposure and Response Prevention

The efficacy of ERP dates back to the 1970s (Victor Meyer in 1966; as cited in Podea, Suciu, Suciu, & Ardelean, 2009); interestingly given its utility, in a study conducted by Maltby and Tolin (2005), less than 50% of therapists reported utilization of ERP (Pignotti & Thyer, 2011). ERP is based on the concept of habituation – with repeated exposure to triggering stimuli and prevention of performing corresponding OCD rituals, a client’s anxiety is expected to decrease over time (Podea, Suciu, Suciu, & Ardelean, 2009; Pignotti & Thyer, 2011). Exposure can be done either in vivo or through guided imagery (Podea, Suciu, Suciu, & Ardelean, 2009).

It is important to note that therapists must use informed consent and gradually expose the client using an anxiety hierarchy; clinicians also usually serve as models for the client during exposure sessions (Pignotti & Thyer, 2011). A hierarchy lists most fear-inducing stimuli using
subjective units of distress (SUDS) from 0 to 100, 100 being most fearful. Clients work with the therapist to create a hierarchy that guides therapy (Podea, Suciu, Suciu, & Ardelean, 2009) with the ultimate goal being to achieve reduced anxiety emanating from previously anxiety-provoking situations. Therapy sessions usually run around 12 to 16 sessions, once a week up to two hours per session.

Work outside of that which occurs with the therapist involves using “The Four Step Method.” As with many approaches, the implementation of “homework” may have benefits that will improve treatment outcomes, especially when it comes to utilizing an exposure method. According to Schwartz and Beyette (1997), the procedure makes it easier for one to incorporate exposure and response prevention on one's own outside of a therapist's office. The method involves relabeling (relabeling intrusive thoughts and urges as obsessions and compulsions, admitting to self that thoughts and obsessions are not logical), reattributing (reattributing the intensity of a thought or urge to its root cause, that of a biochemical imbalance in the brain), refocusing (shifting attention from OCD thoughts and urges to something else entirely), and re-valuing (Podea, Suciu, Suciu, & Ardelean, 2009). ERP has shown to promote significant change in 60 to 80 of participants who complete treatment (Abramowitz, 1997; Fisher & Wells, 2005; as cited in Pignotti & Thyer, 2011), making it one of the most efficacious options available for the treatment of OCD.

For those who do not benefit from or are resistant to ERP, a readiness intervention (RI) designed by Maltby and Tolin (2005, 2008) has been utilized (as cited in Pignotti & Thyer, 2011). Developers of RI showed by using a small clinical sample that 86 percent of individuals who did not want to participate in ERP agreed to participate in RI; however, 50% of those participants did not complete ERP therapy. RI is based on the principles of motivational interviewing (MI); RI involves educating clients about what OCD treatment would look like along with creating a possible exposure
hierarchy that could be used in treatment (Arkowitz, Westra, Miller, & Rollnick, 2008; as cited in Pignotti & Thyer, 2011).

**Acceptance and Commitment Therapy**

Acceptance and commitment therapy (ACT) was proposed by Hayes, Luoma, Bond, Masuda, and Lillis (2006; as cited in Podea, Suciu, Suciu, & Ardelean, 2009). The basic premise involves accepting negative emotions and consequently, no longer fighting against having intrusive thoughts. Per Harris (2006), ACT is a mindfulness-based behavior therapy that “assumes that the psychological processes of a normal human mind are often destructive and create psychological suffering” (p. 2). Twohig, Hayes, and Masuda (2006) further elaborate by saying that the assumption behind an ACT approach is that anxiety is a part of life and it is not something that can always be systematically avoided – thus OCD patients are taught that it is not the anxiety itself that lies at the heart of the problem, but rather a person's reaction to the anxiety that will determine how effective one is when managing it. It is important to note, however, that symptom reduction is not a goal of ACT because the approach assumes that continual attempts to extinguish symptoms may result in clinical disorders themselves (Harris, 2006). Nevertheless, for purposes of outcome measurement, symptom reduction is taken into account due to clinicians having little else to measure treatment goals, progress, and positive client change with. Client values are also considered an integral part of ACT since action-oriented behavior from the client is critical. Ultimately, this particular approach is a type of cognitive behavioral therapy “that focuses on decreasing the behavior regulatory function of anxiety and related cognitions, and has a strong focus on behavior change that is consistent with client values (Codd, Twohig, Crosby, & Enno; 2011; p. 201).”

The efficacy of ACT to treat OCD is further evidenced in the following randomized clinical trial conducted by Twohig, Hayes, Plumb, Pruitt, Collins, Hazlett-Stevens, and Woidneck (2010). The authors attempted to test the efficacy of ACT compared to another popular treatment option used
to reduce the severity of OCD symptoms: progressive relaxation training (PRT). The authors found that through eight sessions of ACT, the adult population showed increased positive change at post treatment and follow-up over PRT. Assessments that were used to measure outcome included the Y-BOCS, the Beck Depression Inventory-II, Quality of Life Scale, and Acceptance and Action Questionnaire, among others. The results suggest that ACT is a promising form of treatment that can be supplemented along with other already established approaches that reduce the symptoms of OCD.

**Rational-emotive Behavior Therapy**

In “Rational Emotive Behavior Therapy, A Therapist’s Guide,” by Albert Ellis and Catharine MacLaren, it is said the theory is used with “disturbed” people who have a preponderance of irrational beliefs that are actively causing them to change their behavior and actions in light of those irrational cognitions. Of course, that definition corresponds with the OCD population quite accurately. For example, a man telling himself that he is worthless and can never be happy in light of being rejected by a woman is experiencing an irrational belief that can be amended. As per the “Activating Event, Belief, & Consequence,” or ABC framework, the man's rejection leads to his irrational beliefs about being worthless, which in turn leads to reactions like depression or hostility. REBT therapists come into play with this framework in mind, as they intervene and try and dispute the irrational beliefs held by the individual. Instead of fostering self-defeating thoughts like "she doesn't want me, therefore no one wants me," the REBT specialist tries to dispute that belief into something like "so what if she doesn't want me?" "I can be rejected by women, feel sad for a while, and then find happiness in other facets of life." Of course, it is easier said than done, but similarly, a person exhibiting overt ritualistic behaviors based on the notion that he or she must only walk on one side of the road, for example, can begin to implement the basic principles of REBT to slowly begin to challenge some of the previously undisputed beliefs and conclusions. The key of the intervention is
to change the thinking that results in extreme feelings like depression and hostility into more viable and less extreme feelings, such as sadness and annoyance (Ellis & MacLaren, 2008).

This theory suggests that people become disturbed due to their natural inclinations to be constructivist (self-helping) and destructivist (self-defeating). These tendencies interact while being impacted by environmental conditions and social learning. REBT specialists treat people on the grounds that they are disturbed cognitively, emotionally, and behaviorally (Ellis & MacLaren, 2008). Further, they say that a person cannot be understood without addressing all three of those components and noticing how they interact with each other. Of course, this is very similar to Alfred Adler's "holistic" Individual Psychology that asserts that people should not be understood by their parts, but rather as an interaction of those parts as they relate to the entire individual (Mosak & Maniacci, 1999).

The efficacy of REBT is well-documented with considerable evidence. The effectiveness of REBT can be seen in two of its major areas. For one, as Ellis and MacLaren (2008) point out, it has been shown in over a thousand studies that people are more disturbed when they have stronger and more frequent irrational beliefs than when they hold weaker and fewer ones. These studies suggest a strong correlation between irrational beliefs and the degree of emotional disturbance. Further, studies show that when people transform their irrational beliefs into rational beliefs, they end up being less disturbed.

**Conclusion: OCD**

Dziegielewski (2002) says that OCD is a chronic illness with periods of severe symptoms followed by periods of improvement. However, with sustained psychotherapy, self-help, and certain medications, such as selective serotonin reuptake inhibitors and tricyclic antidepressants, the symptoms of OCD can be managed; and as a result, a life with less anxiety can be sustained.
It is evident that CBT, REBT, ACT, and ERP are all viable options when it comes to the
treatment of OCD. The conclusion that one can draw from the aforementioned research regarding
OCD and how it is best treated is that there are indeed a few evidence-based treatments available to
address the manifestations of OCD. Ultimately, however, it will be up to the therapist to choose what
they feel will be the best fit for the client – in addition to providing the client with qualities such as
unconditional positive regard, empathy, and genuineness. If those components can be set in place,
the prognosis for OCD will look brighter.

Post-Traumatic Stress Disorder

Introduction

Post-traumatic stress disorder (PTSD), a form of anxiety, is an often chronic and severe
disability that forms in certain people following the experience of a traumatic event. Symptoms
typically include intrusive thoughts, avoidance of reminders of the event, flashbacks and/or
nightmares, hypervigilance, sleep disturbance, and other often debilitating symptoms which lead to
significant inability to perform various interpersonal, social, and occupational tasks (Meyer, 2009). In
addition, PTSD, and several of the anxiety disorders mentioned in this paper, frequently co-occur
with chemical dependence and or abuse, thus further illustrating the importance of proper treatment;
as costs associated with treating chemical dependency are significant. The underlying assumption, in
certain cases, is that if both the mental health disorder and the chemical dependency are treated
simultaneously, the overall success rate for recovery is greater than if each element was treated
separately.

Relevant Studies and Treatment Options

Pharmacological treatment for PTSD consists primarily of selective serotonin reuptake
inhibitors (SSRIs) and serotonin-norepinephrine reuptake inhibitors (SNRIs). According to Wisco,
Marx, & Keane (2012), atypical antipsychotics, although showing initial promise, are not as effective
as the former two pharmacological efforts when it comes to treating PTSD, especially when it relates to military-style trauma. In addition, due to the possibility of abuse and the fact that drug and alcohol use is common among the anxiety disorders, especially PTSD, the authors go on to state that using benzodiazepines to treat PTSD is contraindicated due to the potential for abuse and dependency.

Psychotherapy options for the treatment of PTSD include two evidence-based approaches known as cognitive-behavioral therapy (CBT) and eye movement desensitization and reprocessing (EMDR) (Wisco, Marx, & Keane 2012). Another form of an evidence-based treatment that the authors discuss is Cognitive Processing Therapy (CPT). It consists of 12 sessions of cognitive-behavioral treatment which includes cognitive restructuring and exposure/emotional processing areas. Per the authors, cognitive restructuring is used to address maladaptive thoughts that patients may be experiencing as a result of past traumas. Sessions also include having the patients write an "impact statement" during therapy describing what meaning they have prescribed to the traumatic event, homework assignments, Socratic questioning by the practitioner, and what their beliefs are on five particular domains (esteem, power/control, safety, trust, and intimacy) (Wisco, Marx, & Keane 2012). The emotional processing part of CPT consists of the patient writing down their account, in detail, of the traumatic experience with the hopes of eliciting the natural emotions of experiencing the trauma.

According to Cahill, Rothbaum, and Resick (2009), at least four randomized control trials have proven the efficacy of CPT when it comes to the treatment of PTSD in not only the military population, but among civilians as well. It was noted by Monson, Schnurr, Resick, Friedman, Young-Xu, & Stevens (2006) that one particular randomized control trial investigating veterans with military-related PTSD that those who received CPT improved "significantly" compared to those on a wait-list control group. Eventually, 40% of those who were provided with CPT no longer met the criteria for PTSD at the end of treatment (Monson, et.al, 2006). Such results indicate a great deal of promise when it comes to the future of PTSD – and perhaps anxiety in general – and its treatment.
It was also noted by Cahill, Rothbaum, and Resick (2009) that exposure therapy was another highly efficacious evidence-based treatment for those suffering from PTSD. It is said by the authors that a "manualized" form of exposure treatment known as prolonged exposure (PE) goes even further to treat PTSD. PE includes two components that the authors expound upon: in vivo and imaginal exposure. With the former, "...a hierarchy of feared situations" are created that the patient avoids due to trauma-related stress (Cahill, Rothbaum, & Resick, 2009). With imaginal exposure, the patient describes trauma memories in-session and then goes on to listen to a recording of their account outside of the session. Prolonged exposure also includes psychoeducation on trauma: the authors state that "common reactions to trauma, breathing retraining, and discussion of thoughts and feelings elicited by the exposure assignments (Wisco, Marx, and Keane, 2012, p.10)" are all integral elements of the education process that supplements the other elements of this particular treatment for PTSD.

EMDR is yet another evidence-based treatment for PTSD. Wisco, Marx, and Keane (2012) note that EMDR consists of "assessment of the trauma memory and associated negative and positive cognitions, desensitization, and reprocessing, which involves holding trauma memory in mind while making alternating eye movements, and installation of positive cognition, which involves holding positive cognitions in mind while making alternating eye movements" (p.10).

Codd et al. (2011) discussed the efficacy of using Acceptance and Commitment Therapy when it comes to treating PTSD (as well as panic disorder with agoraphobia, comorbid social phobia, and generalized anxiety disorder) and it was determined that it was indeed effective but there needing more research to conclude how effective it can be compared to the approaches previously mentioned. Although the treatment of anxiety and other mental health disorders continues to improve year-by-year, there still is a significant amount of progress that is needed.
Other Factors to Consider & Conclusion

The notion of "novel treatment approaches" is also something to consider. According to Wisco, Marx, and Keane (2012), research shows that "up to 30%" of patients may be unresponsive to any of the evidence-based treatments mentioned earlier. It was because of that fact that the authors advocate for more research and studies into what is termed "novel treatment approaches." These include approaches such as "couples and family therapy, acceptance and commitment therapy, mindfulness-based interventions, imagery rehearsal therapy, narrative disclosure, and behavioral activation, among others" (Wisco, Marx, & Keane 2012, p. 10). That statement further aligns with this writer's opinion that taking a holistic approach when treating anxiety disorders is most effective and perhaps even more cost-effective in the long-run given the lifetime prevalence of these disorders and their common misinterpretation by the one afflicted as experiencing a medical disorder as opposed to a psychological one. In addition, it was noted that new pharmacological treatments, such as Prazosin and propranolol are also being investigated as to their efficacy when it comes to treating PTSD most effectively; the former being effective when it comes to treating specific symptoms of PTSD, i.e., nightmares.

Investigating the cost effectiveness of using some of the treatments mentioned in this paper for PTSD resulted in the following conclusions. According to a study conducted by Tuerk, Wangelin, Rauch, Dismuke, Yoder, & Myrick (2013), prolonged exposure treatment may indeed be very cost-effective when it comes to treating PTSD, at least as far as "health service utilization" is concerned. The study essentially tested whether or not prolonged exposure had any impact on how often a patient went to see a medical professional for their mental health concerns (counseling, case management, medication management, etc.). The comparison consisted of assessment at a full 12 months prior to PE treatment and 12 months post PE treatment. For a broad-spectrum analysis the two groups were: ones who fully completed the 7-12 week 90-minute sessions of PE (or ended treatment prematurely
citing a symptom improvement based on the Posttraumatic Stress Disorder Check List (PCL)) and ones who ended treatment prematurely or did not receive any treatment at all. According to Tuerk e. al., (2013), the minimum associated cost for "service utilization" was $93.22 per appointment. Per the authors, the research suggested that "treatment was associated with statistically significant and meaningful declines in the need for mental health services, with approximately a 30% reduction in annual mental health service utilization and associated costs of care for the entire sample and a 45% reduction for treatment completers” (p. 406). Furthermore, 25% of PE treatment completers used mental health services only once or not at all in the year following treatment (p. 406) – further providing evidence that utilizing certain treatment options are beneficial across the entire spectrum.

Ultimately, the best treatment options for PTSD patients appears to be a psychopharmacological approach that integrates both psychiatric medications and various evidence-based practices. However, Wisco, Marx, and Keane (2012) do note that no randomized control trial has ever juxtaposed the efficacy of an exclusively medication treatment versus psychotherapy. It is because of that fact that comparing a strictly pharmacological approach with a psychotherapeutic one is not possible at the moment.

**Generalized Anxiety Disorder: Introduction**

Generalized Anxiety Disorder, or GAD, is one of the more common forms of anxiety disorders. Per NIMH (n.d.), people with GAD have difficulty completely eliminating their various worries, even though they appear to realize that the anxiety and symptoms that they are experiencing at any given moment are actually more intense than the situation warrants. Symptoms typical of someone who has been diagnosed with GAD include difficulty relaxing and sleeping, being easily startled, and difficulty concentrating on various tasks. Physical symptoms are often consistent with fatigue, headaches, muscle tension, irritability, sweating, and feeling out of breath (NIMH, n.d.). It was noted by the National Institute of Mental Health that symptoms of GAD develop slowly and
frequently during young adulthood or one's teenage years; with the average age of onset being 31 years old. GAD can lead to a rather debilitating avoidance of life tasks that permeate into several areas of life; often to the point of having great difficulty completing even the “simplest” of daily activities (NIMH, n.d.).

The prevalence of GAD is relatively high, affecting 3.1% of American adults, or roughly 18% of that particular population in any given year. NIMH (n.d.) estimates that 6.8 million American adults, including twice as many women as men, are impacted by the symptoms of GAD. Aside from the diagnostic criteria mentioned above, symptoms need to be present for at least six months for the criteria of GAD diagnosis to be met. The importance of early and accurate detection cannot be stressed enough because people who actually meet diagnostic criteria for GAD may end up needlessly taxing the medical care industry due to frequent visits to medical facilities with complaints of physical and medical symptoms (NIMH, n.d.). Providing psychoeducation on the differences between anxiety-related panic attacks and medical conditions, for example heart arrhythmias and palpitations, may go a long way in further reducing medical appointments and ER visits.

Assessments and Treatments

The most common clinical assessment tool for assessing the presence of GAD is a 7-item anxiety scale known as the GAD-7; which “has good reliability and criterion, construct, factorial, and procedural validity (Spitzer, Kroenke, Williams, & Lowe; 2006).

Treating GAD, similarly to the other conditions mentioned in this writing, include a combination of cognitive-behavioral therapy and medications. According to NIMH (n.d.), it was stated that two types of medications are commonly prescribed to treat the symptoms of GAD, notably anti-anxiety and antidepressants. As with any mental health concern, the stress-vulnerability model needs to be taken into consideration. With the S-V model, psychoeducation is provided into how a person's natural threshold to handle stress or mental health symptoms is either reduced or increased
based on a variety of factors. For example, protective factors include strong social and provider supports and medication compliance, whereas chemical use would be considered a detrimental factor. Although people with anxiety disorders may find initial reprieve from the stress and symptoms of anxiety, continual use via self-medicating with intoxicants is contraindicated and may lead to a host of other psychological and medical problems.

Similar to the other anxiety disorders mentioned in this paper, research suggests that cognitive-behavioral therapy and acceptance and commitment therapy are effective when it comes to treating the symptoms of generalized anxiety disorder. The following pages will expound on what the research indicates as far as the efficacy of the aforementioned treatments when it comes to treating the symptoms of generalize anxiety disorder.

**Efficacy of Acceptance and Commitment Therapy for Treating GAD**

The literature points to the fact that Acceptance & Commitment Therapy, or ACT, is an emerging evidence-based treatment option for treating a wide array of psychological disorders. According to Montgomery, Kim, & Franklin (2011), ACT differs from CBT in the sense that practitioners who are utilizing ACT are not attempting to have their clients change or alter their thinking and feelings but rather change and alter their response to their own thinking and feelings. It can be argued that ACT takes into consideration more of the “behavioral” aspect of CBT than the “cognitive” element. Therefore the approach is still rooted in behavior therapy while still taking into account the thoughts associated with a certain behavior. A conflict may arise with the fact that within the ACT approach, practitioners believe that both the behavior and emotion can co-exist; which is not the case with the traditional cognitive-behavioral method (Montgomery, et al., 2011). Therefore, although there is evidence that both approaches are beneficial when treating GAD, it is up to the therapeutic orientation of the practitioner to determine which approach may be most effective when treating their clients.
According to Codd et al. (2011), ACT is most appropriate when it comes to treating GAD, as far as the research is concerned. They note that one open trial and one randomized control trial as evidence for their assertion. In the open trial, 16 treatment participants who completed the program showed “significant reductions” in GAD severity, as well as depression. The treatment completers also showed an increase in quality of life. In the randomized control trial, 31 adults who had been diagnosed with GAD were either assigned ACT treatment or a waitlist control group. The study found that treatment with ACT was more effective than the waitlist group. Astonishingly, per Codd et al., 78% of treated participants “no longer met criteria for GAD” after completing treatment.

**Efficacy of CBT for Treating GAD**

Deschénes and Dugas (2012) provide a great deal of evidence when it comes to the efficacy of a cognitive and behavioral approach when it comes to treating generalized anxiety disorder. Most notable in their original piece, was the notion of “sudden gains.” They define “sudden gains” as “rapid symptom reductions between two treatment sessions” (p. 805). In their investigation, the authors looked at a sample size of 59 Francophone adults with a primary diagnosis of GAD who completed a 14-week treatment. The method of assessing symptoms improvement consisted of study participants being administered the Penn State Worry Questionnaire – Past Week on a weekly basis. Other assessments during intake and termination of treatment included the Anxiety Disorders Interview Schedule, the Worry and Anxiety Questionnaire (WAQ), and the Penn State Worry Questionnaire (WAQ) (Deschénes & Dugas, 2012). The authors confirmed that the purpose of their study was due to the fact that symptom change can vary during the course of treatment; in other words, multiple types of symptom change can occur for individuals going through treatment for mental health disorders. The authors deem something called a “trajectory of change” as being of special importance: “for instance, individuals can experience linear, gradual symptom change, as well as non-linear change” (p.805). According to the authors, an example of a “non-linear” change is a
rapid decrease in symptoms from subsequent sessions, also known as “sudden gain.” Although anyone experiencing such a gain likely indicates an overall symptom reduction, it did not imply the presence of such a gain resulting in symptom reduction throughout therapy – only overall (Deschênes & Dugas, 2012).

Ultimately, what this study determined was the evidence-based highly efficacious nature of cognitive-behavioral treatment when it comes to GAD: “our results suggest that the experience of sudden gains predicts positive treatment outcomes during cognitive-behavioral treatment for GAD” (Deschênes & Dugas, 2012; p.805).

Precursor to GAD: Subthreshold GAD

Haller, Cramer, Lauche, Gass, & Dobos (2014) discuss the notion of “subtreshold GAD” and talk about its overbearing burden on the healthcare system and the lives of many individuals living with anxiety. Their study aimed to determine the prevalence and impact that GAD, when it was below the diagnostic threshold, had on individuals and beyond. According to Haller et al. (2014), “whilst GAD proved to be a common mental health disorder, the prevalence for subtreshold GAD was twice that for the full syndrome. Subthreshold GAD is typically persistent, causing considerably more suffering and impairment in psychosocial and work functioning, benzodiazepine and primary health care use...” (p. 2). It was noted that subthreshold GAD had twice the prevalence rates of what qualifies as DSM GAD. In addition, the authors noted that subthreshold GAD was more common among women, as with GAD and anxiety in general, and among primary care patients, as opposed to the general population. The presence of this anxiety condition further illustrates and emphasizes the need for early detection and some form of uniformity when it comes to providing a particular level of care.
Social Anxiety or Social Phobia

Background

Social anxiety disorder, or social phobia, consists of individuals who have a significant fear of being embarrassed or being judged by others. The fear is so strong that it can lead to significant decompensation when it comes to attending to work, school, or other life tasks. Individuals who struggle with social anxiety or phobia find it very difficult to engage in common tasks in front of others (NIMH, n.d.). Something as natural as consuming a meal may become incredibly anxiety provoking for someone with this particular mental health ailment when it comes to having to do so in front of other people. The fear of being judged or embarrassed is so pervasive that it can lead to avoidance of public places or events which subsequently leads to on-going isolation, which of course can lead to depressive symptoms as noted in the comorbidity section that follows.

The etiology of social anxiety is difficult to ascertain. It has been noted to run in families but researchers do not know why some individuals will ail from its effects while others do not. There is on-going research that is looking into how genetics plays a role in the development of this disorder. NIMH notes that 15 million American adults are affected by social phobia or social anxiety disorder. Both women and men are equally likely to develop the disorder and its onset is usually in childhood or adolescence.

Comorbidity

Per the DSM-V, social anxiety disorder is “often” comorbid with other anxiety disorders, major depressive disorder, and substance use disorder (American Psychiatric Association, 2013, p. 208). In addition, aside from separation anxiety disorder and specific phobia, social anxiety disorder’s onset precedes that of other disorders. It was also noted that because individuals with social anxiety disorder frequently tend to isolate and spend less time in a social setting, comorbidity with depression is also quite common. The DSM-V also reports that substance use disorders are frequently present
with this type of anxiety due to the need for some individuals to “self-medicate” their feelings of social fears. Subsequently, contributing to the vicious cycle of this clinical presentation is the need to further avoid social situations due to the possibility of experiencing symptoms of intoxication and/or withdrawal (e.g., trembling and sweating). Bipolar disorder and body dysmorphic disorder are also commonly present with social anxiety disorder (American Psychiatric Association, 2013). As with any mental health condition, it is important for the practitioner to stay apprised of differential diagnoses and comorbid conditions, as that would be a necessary ingredient when it comes to best supporting the individual’s treatment plan.

Treatments

As has been the case with all of the other common anxiety conditions noted in this paper, the most effective psychotherapeutic treatment available for social anxiety disorder or social phobia is a cognitive-behavioral approach. As noted by NIMH (n.d.), a CBT approach is useful in this case because it helps individuals produce a different way of thinking, behaving, and reacting to situations with the goal of eliciting less anxious and fearful responses. Just as with other mental health diagnoses early detection and treatment is of the utmost benefit when it comes to proper management of symptoms. Willutzki et al. (2012) noted that in the absence of treatment, social anxiety disorder results in a “chronic progression, with no differences in remission rates between men and women” (p. 581).

Willutzki, Teismann, & Schulte (2012) attempted to determine the long-term effectiveness of “resource-oriented” cognitive-behavioral therapy and simply cognitive therapy. The authors indicated that the efficacy of cognitive and behavioral approaches are well established when it comes to treating social anxiety disorder and social phobia, however, they noted that research was lacking on the long-term results of a cognitive behavioral approach. Therefore, the authors engaged in a study to determine the long-term effectiveness of ROCBT and CT at two year and 10-year follow-up
assessments. The participants were asked a battery of self-report questions to determine their current standing at those points after initial treatment. The authors concluded that treatment gains were made over the 2-year point on all measures; while the 10-year follow-up found significant improvement in two social anxiety measures. There was no significant difference in overall effectiveness when it came to ROCBT v. CT. The authors explain that “resource-oriented” implies a focus on an individual’s resources and strengths.

ROCBT consists of two areas in addition to standard CBT practices, which are “assessment of resources” and “resource-oriented basic interventions.” The former has to do with analyzing an individual’s ability to attend to life tasks as a whole, in addition to past crises and current problems. Resource-oriented basic interventions consist of “deliberate exploration and development of patients’ goals rather than an in-depth examination of current problems, the exploration of exceptional situations to gain an understanding of what had worked in the past and what may work in the future, and the exploration of hypothetical solutions using the “miracle question” to help patients envisioning possible steps in progressing towards personal goals, and detailed analysis of improvements between therapy sessions” (Willutzki et al., 2012, p. 584).

Importance of Sleep

A study by Zalta et al. (2013) looked into the importance of rest and sleep not only when it comes to anxiety, but the impact sleep has on treatment outcomes when it comes to the utilization of a CBT model to treat social anxiety disorder. The authors note, “poor sleep quality may impair memory consolidation of in-session extinction learning” (Zalta et al., 2013, p. 1114). The study consisted of 169 participants who enrolled in 12 weeks of group CBT; all of them had a diagnosis of “generalized social anxiety disorder.” Of that population, 87 received D-Cycloserine (DCS; an antibiotic used in tandem with exposure-based cognitive behavior therapy when it comes to treating anxiety-related disorders and fear extinction) and 82 received a placebo; both one hour prior to
sessions 3-7. Self-reports were used to determine baseline sleep quality and feelings of restfulness. Treatment outcome was measured by the Liebowitz Social Anxiety Scale (LSAS) and the Clinical Global Impression- Severity Scale (CGI-S). Ultimately, the results indicated that individuals with a poorer baseline sleep quality had higher levels of social anxiety symptoms at baseline as well at posttreatment. In addition, those with poorer baseline sleep quality, note the authors, “showed significantly slower improvement in symptoms and severity over time” (p. 1117). Furthermore, the authors note that they controlled for several factors, including baseline severity, baseline depressive symptoms, and comorbid disorders. The authors conclude from their research that “sleep quality is not merely an indicator of general distress, but rather an independent predictor of treatment outcome” (p. 1119). The implications of the study suggest that clinicians should treat sleep difficulties prior to engaging an individual with CBT when it comes to treating their social anxiety symptoms. It can be argued that quality of sleep may have similar results when it comes to treating not only other anxiety disorders, but perhaps other mental health conditions as well.

The Adlerian Perspective: Introduction

Alfred Adler believed that all symptoms and behaviors served some purpose. According to Hjertaas (2009), many Adlerians see the anxious individual as consciously or unconsciously using their anxiety to manipulate others into achieving his or her goal or to avoid difficult life-tasks (p. 47). Hjertaas goes on to suggest that Karen Horney's definition of “basic anxiety” seems to be congruent with Adler's own notions on it. Horney, per Hjertass, believed that anxiety in its basic forms developed during childhood; so if one's upbringing was strife with inappropriate relations (emotionally unavailable parents or too controlling parents), then basic anxiety would likely develop. Adler, similarly, noted that children who were neglected, or pampered, or experienced some other form of ineffective parenting, would likely have their lifestyle impacted in an “anxious” manner. More specifically, if a child does not feel as if he or she “belongs” during developing years, the very
concept of social interest during adulthood will be difficult to comprehend for the individual; causing a marked disconnect between one's desire to fit in and to have that “fellow-feeling” and one's actual ability and confidence in his or herself to achieve it.

It is important to distinguish between anxiety in the actual clinical sense of the term and other "feelings," such as fear, for example. Fear can be best described as a cognitive conclusion to a threatening stimuli, whereas anxiety is an "emotional reaction" to that particular conclusion. With Obsessive-Compulsive Disorder, for example, anxiety may be the result of one's attempts to resist engaging in an obsessive or compulsive thought or action. With Generalized Anxiety Disorder and Panic Disorder with or without Agoraphobia, anxiety may be the result of one's attempts to overcome symptoms related to their affliction; confronting a particularly stress-inducing stimuli with a particular phobia, for instance. With PTSD, avoidance of past memories or re-living the trauma may result in avoidance and significant anxiety surrounding being around the possible trigger.

Adler believed that anxiety served one ultimate purpose – safeguarding one's self-esteem when one feels defeat at the hands of life tasks. A person with their neuroses will automatically distance themselves from certain life tasks, when they become aware of this fact, naturally, their self-esteem takes a hit. If one feels "anxious" as a result, it would be easier for one to justify their avoidance of meeting certain life tasks and goals under the ruse of it being too "difficult."

That is where the Adlerian concepts of "hesitating attitude" and "yes-but" need to be taken into consideration. Naturally, when one is not able to meet the demands of life, a sense of discouragement comes as a result. By "creating" anxiety within themselves, the discouraged individual delays any meaningful decision or action and continues to keep a certain distance from many areas of life.
Specific Adlerian Concepts and Their Implications

Mosak and Maniacci (1999) state that “The emotional tone of the home, the family climate, can have a very large effect on the developing mood of individuals” (p. 38). Therefore, it is not a stretch to assume that if a developing child's affect and mood are impacted by his or her surroundings during childhood and adolescence that their concurrent and future behaviors may be influenced as well. Further, Mosak and Maniacci emphasize Adler's contention that a person's first six years of existence played an extremely important role in formulating an approach to life, with one's recollection of past events having a sustained influence on future behavior.

This connection that Adler made can be seen in the study conducted by Aycicegi, Harris, and Dinn (2002). The authors note there is “widespread acceptance that a strict adherence to the rules or an overemphasis on perfectionism and overprotection enforced by a developing child's parents, for example, contribute to the pathogenesis of OCD (Aycicegi, Harris, & Dinn, 2002). The authors therefore set forth to determine which particular dimension, or parenting style, are most important when it comes to the development of OCD in children and beyond. The dimensions in question included overprotectiveness, lack of acceptance, authoritarian style, discouragement of risk-taking, and/or induction of guilt. The authors eventually concluded that their hypothesis was indeed correct: “a psychologically manipulative, controlling parenting style was associated with both OCD symptoms and Obsessive-Compulsive Personality Disorder traits” (p. 414). It was also noted by the authors that a mother's psychological control was more closely associated with OCD symptoms (specific behaviors such as excessive washing of hands) and a father's psychological control was more closely associated with compulsive checking behaviors (whether a door has been locked or not, for example). The authors suspect the aforementioned is the case because of traditional gender roles which although less common, are still prevalent (a mother is more likely to ask the child whether he or she washed their hands prior to sitting down at the dinner table, for example.) today.
Adler and subsequent scholars who subscribed to his notions on human behavior felt that parental relationships are so important when it comes to possible neuroses that Mosak and Maniacchi (1999) say, "The parental relationship, in particular, can have a profound effect. How the parents get along with each other can have a powerful influence upon the mood of the household and provide a model for man-woman relations" (p. 38). Lack of meaningful relationships during critical developing years may also hinder one's ability to formulate feasible and socially interested life goals that align with striving on the horizontal plane. As Corey (2009) says, “Encouragement is the most powerful method available for changing a person's beliefs, for it helps clients build self-confidence and stimulates courage” (p.105). Indeed, if the opposite is true, in other words if there is a lack of encouragement, it may result in the inability to have the “courage to be imperfect,” possibly resulting in a life-long pattern of avoidance and low self-esteem which eventually engulfs the individual to the point of being diagnosed with Generalized Anxiety Disorder or Social Anxiety Disorder, perhaps.

The notion of inferiority feelings are integral to the Adlerian approach and they are in fact normal conditions for all humans and a source of human striving. Also, they can be the wellspring of creativity, rather than a sign of weakness or abnormality (Corey, 2009). That is because they motivate us to strive for the best while overcoming and compensating for our felt minuses, or weaknesses. Yet, there is also an abnormal side to such feelings of inferiority where it consumes people and motivates them to strive for superiority on the vertical plane without taking into consideration other vital facets of a healthy existence, such as helping others and not succumbing to a hedonistic or avoidant lifestyle.

Inferiority feelings, as Adler has noted countless times, contribute to psychopathology in some form or another. Adler (1956) notes that children born with inferior organs perceive their bodies as a burden. Their compensation leads to goals that foresee and presume feelings of superiority. As they go from that felt minus to a perceived plus, they obtain a sort of “paranoia,” where they feel they are
in an enemy country and the difficulties of life are an “attack” on them (Adler, 1956). As Adler himself said, “Fighting, hesitating, stopping, escaping, much more occupied with their own persons than others, they are therefore selfish, inconsiderate, lacking in social interest, courage, and self-confidence because they fear defeat” (Adler, 1956, p. 118). Armed with that knowledge, an Adlerian approach, in combination with the previous and subsequently discussed approaches, assuming they do not contradict or create some dissonance in the person receiving treatment, may be of great benefit.

Mosak (1977) notes that social interest is of the utmost importance to mental health, that it is the feeling of connectedness one has with humanity and the community around them; concern for the welfare of others. Participating in a give-and-take process in an effort to solve life's problems, along with cooperation with others, is indicative of good mental health. The opposite of that, placing one's needs ahead of everyone else’s and cooperating solely for one's own benefit is characteristic of mental illness (Johansen, 2010). Beames (1992) echoes Adler's thoughts on the sine qua non of Individual psychology, that of social interest, when he says that neurotics, suicides, alcoholics, criminals, etc. are as such because they lack social interest, something that needs to be fostered and encouraged, as it is innate in all of us. Assuming treatment has progressed to a certain point, it would make sense for social interest to be fostered and encouraged in the individual who is experiencing discouragement and low self-esteem, which may be leading to their tendency to avoid and be anxious.

The Purposefulness of Anxiety

“Feelings prepare the body to meet a situation with a specific response (Adler, 1931, p. 42; as cited in Rasmussen & Dover, 2006). Trying to ascertain the goal of a person's behavior is one of the major components of Adlerian therapy. As such, if one is able to figure out what purpose anxiety serves for an individual, the ultimate “picture” may become more focused. Furthermore, if one is able to link those two aforementioned elements, another piece, the individual's private logic, will also
begin to become clearer. According to Rassmussen and Dover (2006), the Adlerian view on the purpose of anxiety is similar to that of what evolutionary theory espouses. Essentially, suggest the authors, evolutionary theory suggests that human beings are motivated by three evolutionary imperatives: the desire to survive and have some semblance of a life; the need to adapt to the constraints of their environments; and finally in which direction an individual focuses their welfare and concern, opting for inward/self, outward/others, or perhaps a combination of the two. The authors are able to further link the evolutionary view and the Adlerian view by rather simplistically stating that “when a person feels good that person wants to continue to feel good; when a person feels bad, that person wants to change the situation for the better (p. 370). However, it was also noted that that generality is indeed what Adler meant by “striving from a felt minus to a felt or perceived plus (Ansbacher & Ansbacher, 1956).

Benefits of Adlerian Psychotherapy to Contemporary Practice

The Adlerian approach to contemporary practice is relevant and contradictory to what may be believed given the comprehensive nature of some of the assessments and interventions unique to Adler's Individual Psychology. As noted by Carlson, Watts, & Maniacci (2008), Adler's views on the importance of pragmatism and emphasis on choice compliment contemporary approaches to the nature of human behavior. In addition, the authors say that helpers who utilize an Adlerian approach need not worry about the comprehensive and seemingly time-consuming nature of the assessments and interventions. As Carlson et al. (2008) say: “Adler was an early proponent of brief or time-limited therapy, typically limiting each client's number of sessions to 20 or fewer. In addition, many of the techniques used by many contemporary brief therapy approaches are similar or identical to ones created by Adler” (p. 8). Further, Dinkeymeyer & Sperry (2000; as cited in Carlson et al., 2008) note that Adlerian therapy is “very similar” to cognitive-behavioral, experiential, and systematic brief
therapies, while also sharing some elements to “brief” psychoanalysis in that Adler emphasized early experiences on “current functioning” and the use of insight as a treatment strategy.

Other Considerations and Potential Future Treatments

Berger & Boettcher (2014) conducted an interesting study to determine the effectiveness of Internet-based guided self-help for several anxiety disorders. The reason for the particular study conducted by the authors was noted as being due to two reasons: such as high lifetime prevalence rates of mental health disorders (upwards of 47.4%, according to Kessler et al., 2008) and the fact that professional help is at times limited for people suffering from mental health problems; for reasons such as limited availability of qualified practitioners, financial difficulties, and stigma and discrimination (Berger & Boettcher, 2014). According to Rochlen, Zack, & Speyer, 2004; & Berger & Andersson, 2009; as cited in Berger & Boettcher, 2014, Internet-based treatments are effective because they offer easy accessibility, far fewer restrictions to availability due to location and time, much privacy and anonymity, and comparatively low cost of delivery to a larger percentage of people. Of course, there exist challenges as well, notably data security concerns related to confidentiality of client records and “unprofessionalism of unregulated providers” (Rochlen, Zack, & Speyer, 2004; & Berger & Andersson, 2009; as cited in Berger & Boettcher, 2014).

Anxiety is also a concern that practitioners need to be aware of when it comes to the elderly population. Per the Society of Certified Senior Advisors, 2011, among adults over 65 years of age, “5.5 percent experience anxiety disorders, compared to 7.3 percent among younger adults” (p.81). Furthermore, the authors state that the rate of anxiety is 11.7 percent among nursing home residents and as high as 38 percent among people with medical disorders such as Parkinson’s disease and early dementia” (p. 81).

Generalized Anxiety Disorder and PTSD are especially of concern with the elderly population. It was reported by the aforementioned authors that among “community-residing older
adults,“ GAD’s prevalence is 4.6 percent, with some speculating even higher rates. It should be noted that GAD is sometimes directly the result of a medical condition, such as thyroid, cardiovascular, respiratory, metabolic, or neurological disorders (Society of Certified Senior Advisors, 2011). The estimation of the prevalence of PTSD among older adults range from 3 percent to 56 percent. The wide range, the authors note, depends on the group studied, as rates are significantly higher with former prisoners of war. According to the authors, older adults who have experienced traumatic events earlier in life tend to experience intermittent PTSD symptoms throughout their life.

Co-occurring Disorders and Prevalence of Drug & Alcohol Abuse

As with many mental health conditions, substance abuse is a prevalent co-occurring concern. With Social Anxiety Disorder, especially, the use of alcohol and illicit drugs appears to be significant. As Buckner, Jeimberg, Ecker, and Vinci (2013) note, “48% of individuals with a lifetime diagnosis of SAD also met criteria for a lifetime diagnosis of Alcohol Use Disorder (AUD)” (p. 278). In addition, it was reported that 25% of the population that was receiving treatment for AUD met the criteria for Social Anxiety Disorder (SAD) and 55% of individuals that were receiving detoxification services for their alcohol use “demonstrated at least moderate social anxiety” (Buckner, et al., 2013). Social anxiety in general, according to Buckner et al (2013), is also associated with increased dependence when it comes to tobacco and nicotine dependence. Not surprisingly, of the patients who seek treatment for anxiety disorders, non-smokers reported less social anxiety than of those who identified as smokers. Likewise, the aforementioned authors’ note, of those seeking treatment for their smoking, patients who have been diagnosed with SAD endorsed “higher levels of nicotine dependence than those with no anxiety disorder” (Buckner et al., 2013, p. 278). Regarding illicit drug use, however, the authors note that there is less evidence and research surrounding SAD and it. They claim that cannabis is the most common substance associated with SAD aside from alcohol. What is interesting is the fact that the authors report that of a particular study, “29% of individuals with lifetime cannabis
dependence met criteria for lifetime SAD, whereas rates of other anxiety disorders ranged from 6.9% (for panic disorder) to 18.5% (for post-traumatic stress disorder)” (p. 278). Furthermore, Buckner et al. reports that with social anxiety comes increased use of other illicit drugs in general. SAD patients appear to be more than “nearly” twice as likely to use stimulants, 1.5 times more likely to use hallucinogens, twice as likely to use heroin, and 1.5 times more likely to use cocaine.

The evidence continues to mount that addressing substance use disorders is an essential need when it comes to attending to the proper treatment needs of patients who have been diagnosed with some form of an anxiety disorder.

The Value of Yoga, Mindfulness, and Other Anxiety Treatments

According to the Office for National Statistics (2000), several conditions, including but not limited to mixed anxiety, depression, generalized anxiety disorder, phobias, panic disorder, and OCD make up 86% of neurotic disorders found. Due to the prevalence of the aforementioned, it would behoove all mental health practitioners to realize the importance of taking a holistic approach when creating a treatment plan and when ultimately deciding on the proper interventions.

Yoga consists of three essential components including simply and gentle stretching, strategies for breathing control, and meditation as a “mind-body intervention.” Although yoga is deeply rooted in spiritual and religious tones through Indian Hinduism, the primary form of yoga practiced in the western world is that of Hatha yoga which contains a combination of “asana,” or postures, “pranayama,” or breathing techniques, and straightforward meditation. Although, no published systematic reviews exist on the benefits of yoga for anxiety in the western world, there is growing evidence that its implementation is efficacious when it comes to its use as a therapeutic intervention, as evidenced by the proven efficacy of other relaxation techniques such as deep breathing and progressive muscle relaxation.
According to Skowronek, Mounsey, & Handler (2014), there is sufficient evidence to make the claim that yoga is beneficial to reduce symptoms of anxiety and depression not only when combined with other therapeutic efforts, but also on its own merit. A systematic review of 10 randomized control trials conducted by the authors, trials that totaled 813 heterogeneous participants between the ages of 18 and 76, resulted in seven out of the 10 RCTs providing evidence that “627 participants found statistically significant reductions in anxiety and stress in yoga groups compared to control groups” (p. 398). The trials took into account a wide variety of participants: healthy males and females, pregnant women, cancer patients, patients with chronic illnesses, and perimenopausal women, among others. Ultimately, the authors of the review conclude that yoga typically improves overall symptom scores for both anxiety and depression by 40%.

A study was conducted by Yadav, Magan, Mehta, Mehta and Mahapatra (2012) which attempted to seek the answer of whether or not a “short-term comprehensive yoga-based lifestyle” was efficacious in reducing anxiety and improving overall subjective well-being and personality. In this study, “yoga-based lifestyle” included relaxation techniques, “simple” physical exercise, stress management, diet, and other aspects deemed a “lifestyle.” The study consisted of 90 participants, all of whom had chronic diseases, who over a 10 day period received “yoga-based lifestyle interventions.” The control group of 45 did not receive any interventions surrounding yoga. The primary outcome measures consisted of assessing the change in state and trait anxiety questionnaire (STAI-Y; 40 items), the subjective well-being inventory (SUBI; 40 items), and the neuroticism extraversion openness to experience five factor personality inventory (NEO-FF PI-R; 60 items). The results of the outcome measurements indicated that the STAI-Y scores reduced significantly over the course of treatment, indicating a reduction in anxiety reports, and the scores for SUBI and NEO-FF PI-R improved, indicating an improvement in general well-being and “personality.” More specifically, the NEO-FF PI-R assessment given at the end of the 10-day treatment program showed
an “improvement in personality” as evidenced by decreased scores for neuroticism and increased scores for extraversion, being open to experience, agreeableness, and conscientiousness.

Like with yoga, there is sufficient evidence to suggest that mindfulness-based interventions are also useful when it comes to treating some mental health disorders, including for the purposes of anxiety. Goodman, Kashdan, Mallard, and Schumann (2014) conducted a pilot study to investigate the efficacy of mindfulness-based intervention, including yoga, when it comes to a particular Division 1 athletic team of 13. Over the course of five weeks, the study participants received 90 minutes of group sessions followed by 60 minutes of Hatha yoga. A control group consisting of the same number, albeit student athletes through various club sports, did not receive any yoga interventions. The participants who received yoga treatment saw greater levels of mindfulness, greater “goal-directed energy,” and “less perceived stress” following the interventions.

Meditation has also been found to be effective for anxiety when it comes to certain people. Meditation leads to enhanced breathing and awareness which can lead to changes in physiology as evidenced by the slowing of the heart rate and lowering of blood pressure. Meditation is a state of consciousness that is marked by “cortical changes that are different from those in ordinary wakefulness, relaxation at rest, and sleep” (Chung et al., 2012, p. 589). A study conducted by Chung, Brooks, M. Rai, Balk, & S Rai (2012), found that the effect of Sahaja Yoga Meditation resulted in improvements in several areas of well-being, including anxiety and blood pressure. Sahaja yoga meditation consists of silent affirmations and breathing techniques which help an individual to acquire a state of “mental silence” where all focus is on one’s present moment. People who practice this form of meditation, according to the aforementioned authors, report the experience as “soothing, relaxing, and enjoyable.” Two groups of similar demographics and clinical traits were split into a control group which received treatment at a hospital and another which received Sahaja yoga meditation treatment at a research center. 67 participated in the meditation group and 62 in the
control group. At baseline, both groups had similar anxiety levels as measured by the Clinical Anxiety Scale (CAS). Ultimately, Chung et al. (2012) found that the improvement in “quality of life, anxiety reduction, and blood pressure control was greater in the meditation group” (p. 589).

**Benefits of Physical Exercise for Treating Anxiety**

Historically, the evidence has suggested that physical exercise is very therapeutic when it comes to treating mood disorders. However, the anxiolytic effects of physical exercise has been less researched and studied. Asmundson, Fetzner, DeBoer, Powers, Otto, & Smits (2013) aimed to conduct a review of the research that has been conducted on how physical exercise impacts feelings of anxiety in individuals. Per Asmundson et al. (2013), of the recommended 150 minutes of “moderate-to-vigorous” physical activity North American guidelines suggest an individual obtain per week, only “15% of Canadian adults and 30% of American adults” actually report meeting the recommendation. The physical health gains of obtaining a certain level of exercise has been well documented – it’s beneficial for keeping a healthy body weight but in turn is also beneficial when it comes to cardiovascular health and keeping a host of medical conditions at bay. However, its impact on how helpful it is for mental health conditions, especially anxiety-related conditions, has been less studied.

Regarding PTSD, during the course of the literature review conducted by Asmundson et al. (2013), the authors mention a study with a duration of eight weeks consisting of three weekly 40-min aerobic sessions; of which the authors state “resulted in reduced PTSD, depression, and anxiety symptoms among adolescent females diagnosed with PTSD” (p. 365). Further, they note another study with an adolescent PTSD population that found 90% of those who participated (five weeks of aerobic exercise intervention) showed “significant” reductions in PTSD symptoms; with 50% showing reductions at post treatment with general anxiety symptoms as well.
The aforementioned authors note similar results with physical exercise’s anxiolytic properties when it comes to treating OCD. An aerobic program that enrolled 15 participants with OCD in a 12-week “moderate-intensity” treatment program found patients reporting “significant improvement in overall sense of well-being and significant reductions in OCD symptoms” (p. 365). Patients exercised three to four times a week and increased from 20-minute to 40-minute sessions throughout treatment. It should be noted, however, that during this particular study the participants also received weekly “CBT-based exercise counseling.” Nevertheless, there is some evidence to suggest that physical exercise is beneficial when it comes to reducing anxiety in general and symptoms associated with certain anxiety disorders. As Asmundson et al. (2013) note, however, the small sample sizes, deficiencies in adequate controls, “lack of systematic attention to possible dose-response relationships, limited consideration of maintenance of gains following treatment, and primary focus on aerobic activity” all need to be taken into consideration when making any overwhelming causative conclusions.

A study was conducted regarding the efficacy of aerobic exercise versus resistance training when it comes to treating Generalized Anxiety Disorder. As Asmundson et al. (2013) show, that too was found to be effective as it resulted in significant reductions in anxiety as measured by the popular State-Trait Anxiety Scale and worry as measured by the Penn State Worry Questionnaire. The study consisted of 37 adults with GAD of which the population was split into two halves and each was assigned to two weekly sessions of “lower-body weight lifting” or aerobic exercise consisting of leg cycling. In addition, the piece by Asmundson et al. (2013) provides evidence that “strenuous” exercise has been found to “provide physiological resilience to stressful mood states” (p.368). Research suggests that physical exercise results in “neuroendocrine adaptations, increases body temperature, changes central serotonergic systems, and increases endorphin production” (Asmundson et al., 2013, p.368). All of those factors explain the mechanisms behind how exercise correlates with
reduced anxiety symptoms. In addition, improvements in sleep are well documented when it comes to incorporating a regular exercise regimen (connecting exercise to the importance of sleep mentioned earlier). It is noted that sleep disturbances, daytime sleepiness, sleep quality, nightmares, and poor sleepy hygiene in general are all prevalent among anxiety suffers. Therefore, it is not surprising to determine why anxiety is reduced when exercise has been found to result in better and more restful nights’ sleep – the two are connected in many ways.

The notion of mastery and self-efficacy is also a welcome by-product of exercise when it comes to addressing anxiety, as well as all mental health disorders; Asmundson et al. (2013) make the claim that successfully completing an exercise regimen may “engender a sense of mastery.” In other words, successfully engaging in exercise may instill in participants the reinforcing belief that they have the power to influence their environment and “bring about desired outcomes.” As the authors note, “Mastery has been shown to moderate negative consequences of set-backs and restore hope; indeed, an increased sense of mastery is associated with positive psychological states” (p. 368). Of course, this notion of “mastery” and “self-efficacy” supplement several of Adlerian’s concepts, as far as the client having the ability to influence their environment to a certain extent in addition to their own future (the painter and the painting, for example).

**Claim that There is No Most Effective Treatment for Anxiety**

Duncan et al. (2010) make an interesting claim that in fact, there is no such notion as “most effective” when it comes to treating anxiety. Wampold (201b, 2006a; as cited in Duncan et al. 2010), according to Duncan et al., review meta-analyses of several different anxiety disorders and found that no one treatment was proven to be more effective than another, especially for PTSD. In other words, anxiety can be treated effectively with a multitude of different approaches. As Duncan et al. (2010) inform“...several treatments with very different treatment rationales have also been shown to be effective, including eye movement desensitization and reprocessing, cognitive therapy without
exposure, hypnotherapy, psychodynamic therapy, and present-centered therapy...a recent meta-analysis examining direct comparison among these treatments found all of them to be equally effective” (p. 59). Ethically, it would be in the interest of the practitioner to stay current regarding the latest evidence-based practices and the direction the field is taking when it comes to treating mental health disorders. Some might make the claim that there isn’t a “most effective treatment” for anxiety, but using a holistic approach to treatment may actually be the best course of action to take.

**Evidence Suggesting a Holistic Approach to Treatment is Beneficial**

La Torre (2001) provides perspective on the holistic approach to treating anxiety and why it should be considered by practitioners. She notes that psychotropic medication frequently plays a beneficial role when it comes to treating both acute and chronic cases of anxiety, but also talks about the importance of other treatments that can be combined with medications. Per La Torre, utilizing a cognitive-behavioral approach is valuable: “focusing on identifying the anxiety-associated belief, exploring evidence for and against the belief, and developing alternative assumptions that can be less anxiety provoking” (p. 28). La Torre also mentions utilizing cognitive-behavioral treatments with relaxation techniques, such as guided imagery and breathing exercises: “This is another important consideration for the practitioner, since relaxation approaches seem as effective in reducing anxiety as medication, while empowering the client at the same time” (p. 28). La Torre makes a claim in her piece that it has been found that the various relaxation approaches have worked so well with certain sufferers of anxiety that “there is no significant difference between using them alone or in combination with anti-anxiety medication” (p.28).

La Torre indicates that several studies show the efficacy of meditation when it comes to anxiety relief not only when it is combined with other approaches, but when it is utilized by itself as well. She goes on to suggest that because of its non-judgmental basis and emphasis on the present moment, it promotes focus, clarity, and self-management – all of which “enhance” relaxation,
promote self-esteem, and encourage behavioral change. Ultimately, she suggests that combining mindfulness and meditation with cognitive-behavioral approaches, as well as medication, “expands” treatment options.

La Torre herself has been in private practice for many years and because of that, she has over the years, been able to determine approaches and combinations of approaches that she feels are the most effective when treating anxiety disorders. She is of the belief that combining meditation and relaxation techniques which focus on increasing awareness (as opposed to desensitization) allows the client to have a “greater range of coping.” Per her theory, people experiencing anxiety, including in the moment during the session, would fare better if they engaged in relaxation strategies as opposed to deeming situations as needing to be avoided or contained (p. 29). She goes on to promote the holistic view of not only treatment options but viewing anxiety as “part of the process” rather than simply looking at anxiety in terms of symptoms “to be eradicated.” She states viewing and approaching anxiety clients in that particular way leads to clients feeling “less anxious about the fact that he/she has anxiety” (p.29). The notions of self-efficacy, empowerment, self-advocacy, and self-management, in addition to healing, growth, and learning, she says, are all promoted by taking the aforementioned “holistic” approaches to anxiety.

According to Hayes-Skelton, Roemer, & Orsillo (2013), a combined effort when it comes to treating forms of anxiety, in this particular study's case, Generalized Anxiety Disorder, may be a valuable approach. The aforementioned authors set forth to conduct a randomized clinical trial to see if combining acceptance-based strategies with “mindfulness” would improve outcomes for people with GAD. That combined approach competed against strictly behavioral approaches. As a conclusion, it was determined that acceptance-based strategies were indeed effective to treating GAD.
Key Points & Summary

Anxiety is not only the most common of all mental illnesses but also the most taxing on the mental health system as far as its treatment is concerned. That is because frequently people present themselves at a hospital thinking they are experiencing a medical consideration when in fact it is a symptom of anxiety itself. Its scope is broad and it does not live any particular demographic or culture exempt from its impact. Because of the reasons mentioned in this paper – and others – it’s important for practitioners to have a strong grasp on how to identify anxiety and how to treat it using various evidence-based treatment options. It is evident that the cognitive-behavioral approach that focuses on changing one’s thoughts in specific situations and thought patterns across various situations decreases the frequency and intensity of symptoms. It was found that a form of cognitive and behavioral therapy, called exposure and response prevention, was especially beneficial for those who had symptoms consistent with an obsessive-compulsive disorder diagnosis.

Medications provide relief as well. Benzodiazepines are especially effective, however, that particular classes effects are not very long lasting and can also be highly addictive. With the older population, “benzos” can have detrimental side-effects, notably pulmonary and cardiac concerns, as well as increased fall risks and increased confusion. Longer-lasting medications take longer to take effect but minimize symptoms for a longer period of time.

“Words” (n.d.) offers a great quote from Adler himself and one that is relevant to many of the psychopathologies common today: “I believe that I am not bound by any strict rule or prejudice but prefer to subscribe to the principle that everything can also be different. A person's opinion of himself and the environment can best be deduced from the meaning he finds in life and from the meaning he gives to his own life.” Adler emphasized a person's first six years of life in developing a life attitude, but he also espoused choice. People always have a choice to make things better. Aside
from the notion of “anything can also be different,” Sperry and Carlson (1999) note that “people cannot be understood in isolation from the social environment of which they are a part” (p. 396).
References


