Anxiety Disorders in Adults

OPTIMAL OUTCOME OF TREATMENT/RECOVERY:

The client experiences remission of anxiety symptoms that brought him/her to treatment/recovery, or returns to full interpersonal and occupational functioning (as defined by the client) by developing the ability to regulate his/her anxiety symptoms through acquired symptom management skills and psychotherapeutic/ psychopharmacologic support.

ASSESSMENT PRINCIPLES: (See Assessment Guidelines for Adults)

1. The therapist shall be aware of the possibility that underlying medical causes may produce anxiety symptoms. Medical evaluation may be indicated to determine that there is no underlying physical problem, i.e., sleep apnea, mitral valve prolapse, thyroid conditions, etc.
2. Clients with anxiety disorders may be at increased risk for suicide. Clients shall be assessed for possible danger to self or others and crisis intervention shall be provided as needed.
3. Clients with anxiety disorders often self-medicate. Clinicians shall assess for use or abuse of over-the-counter, prescription, or street drugs and alcohol.
4. Clients with anxiety symptoms shall be assessed for depressive features. If the symptoms of depression meet the full criteria for the current diagnosis, this diagnosis shall also be made.

<u>Post-Traumatic Stress Disorder (PTSD)</u>

1. The clinician shall differentiate between Acute and Chronic PTSD, utilizing the current criteria, to determine treatment/recovery approach.
2. The relative prominence of dissociative features shall be assessed. Predominately dissociative symptoms are often an index of severity and may be predictive of chronicity.
3. The meaning of the traumatic circumstance shall be assessed according to the individual's interpretation. Ethnic and cultural factors may be important in this assessment.
4. Generally, it is not the role of the clinician to seek substantiation of reported trauma. However, in specific cases, seeking substantiation may be effective to rule out factitious disorder or malingering. Clinical indications shall be used to determine the necessity of seeking substantiation.
5. Assessment of pre-morbid functioning and personality traits may be helpful in determining factors that predispose towards chronic effects of trauma.

6. Co-morbid conditions (such as substance abuse, personality disorders, and mood disorders) are likely to occur with this condition, and shall be assessed and diagnosed.
7. Protective factors, such as social support and self-soothing skills, shall be assessed and incorporated into the treatment/recovery plan.

TREATMENT/RECOVERY PRINCIPLES: (See Treatment/Recovery Guidelines for Adults)

1. Many clients, due to the discomfort of the anxiety symptoms, become avoidant of anxiety-inducing situations, including therapy. The first priority of treatment/recovery is to establish a collaborative relationship that supports the client through the discomfort of coping with their anxiety. It is critical that the first therapeutic contact emphasizes rapport-building and expression of hope.
2. Anxiety disorders such as panic disorders, phobias and obsessive-compulsive disorder are often best treated by the application of a specific cognitive-behavioral component. The therapist shall be proficient with such a model or shall seek consultation/ referral. Post-traumatic stress disorders often require a more comprehensive treatment/recovery approach including supportive therapy, individual and/or group settings, and psychosocial rehabilitation as indicated.
3. Referral for medication evaluation shall be considered. Long-term use of anti-anxiety medications for chronic forms of anxiety disorder may be appropriate for some clients. Non-addictive medications shall be considered.
4. The progression of treatment/recovery shall emphasize early skill-building success to reduce the likelihood of loss of hope and early termination.
5. Efforts shall be made, when appropriate, to recruit significant others to provide increased support and coaching to the client. This shall include education concerning the condition and its treatment/recovery.
6. Therapy shall address the avoidance patterns of the anxious client. Encouragement and specific skills-coaching shall work towards the client successfully confronting anxiety inducing situations.
7. Relapse potential may be high with some clients with anxiety disorders. Stress inoculation training (which helps the client anticipate stressors that they confront, and practice coping skills) may be helpful prior to discharge. The therapist may convey to the client that "booster sessions" can be used to reduce the likelihood of relapse.
8. An essential part of treatment/recovery is education about the disorder, and helping the client accept the normal experience of anxiety. Educate the client in areas including symptom identification and management.

Post-Traumatic Stress Disorder (PTSD) Acute Type

1. The goal of treatment/recovery of Acute PTSD is to desensitize the client to the traumatic stimuli, which requires rapid exposure therapy over a short course. Low doses of neuroleptics may assist the client in tolerating the distress in the short-term.

Post Traumatic Stress Disorder (PTSD) Chronic Type

1. The treatment/recovery approach shall include both skills training and development of the capacity to employ these skills under times of duress.
2. When working with clients with profound dissociative symptoms, specialized skills or supervision are necessary.
3. Exposure therapy for PTSD chronic type has a high-risk of producing decompensation and is rarely indicated.
4. The treatment/recovery focus shall be on use of supportive psychotherapy, which emphasizes the establishment of a strong therapeutic alliance relationship, which facilitates the development of self-soothing skills, boundary development, and safety issues. Although trauma issues may be a periodic focus of treatment/recovery, therapy aimed at "resolving" the trauma is unlikely to result in direct therapeutic benefit for a client with chronic type PTSD.

These Guidelines have been revised by the Utah Behavioral Health Clinic Sub-Committee and approved by the Utah Behavioral Health Committee

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