Treating Anxiety with MBSR, CBT and Other Models

Name

Institution

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Presentation of the Case

The agency is known as Better Health Management, and it is working to create a system that allows people have easy access to better healthcare. The agency was established with a purpose of helping people suffering from various mental health problems who do not know what type of treatment to seek and how to find solutions. The client, a twenty-one-year-old woman, was escorted to the institution by her mother who was concerned about helping her daughter in dealing and managing her anxiety as her episodes of attacks have been increasing. I am the mental health case manager, and my duties include examining a client's psychological state, carrying out a physical examination, monitoring the client, designing a mental health treatment plan, and recommending the management and support services. My role, therefore, is to ensure that the patient receives a better treatment plan that will help to recover quickly.

Literature Review

The Presented Problem

Despite advancements in the quality of interventions related to mental health in the recent years, many people still do not have access to quality management programs. Anxiety disorder is among the most prevalent mental health illnesses, even though it is less visible compared to depression, schizophrenia, and bipolar disorder. Anxiety is a chronic condition that tends to impair an individual's daily functioning and can result in secondary comorbid conditions. Anxiety is a subjective feeling characterized by discomfort, uneasiness, fearful concern and apprehension accompanied by numerous somatic and autonomic manifestations (Bandelow & Michaelis, 2015). Anxiety was initially a healthy emotional state and a response to real danger. In most of the recent cases, people are experiencing prolonged, severe, disproportionate and

irrational symptoms even in the absence of threat or stressful events that obstruct daily activities, and this is what is currently known as an anxiety disorder.

The symptoms of anxiety are grouped into two: the physical and the emotional components that often alter the cognitive process of a person. The physical sensations include but are not limited to nervousness, isolation, insecurity, self-consciousness, and irritability (Bandelow & Michaelis, 2015). The emotional components, on the other hand, are stomach pain, ulcers, increased blood pressure, weakness, body ache, nausea and headaches among others (Bandelow & Michaelis, 2015). When these sensations combine, they impair thinking, decision-making, memory, and concentration ability. Since anxiety shares many characteristics with other mental illnesses, it can be difficult for physicians to identify the problem, thus leading to mismanagement of the disease.

Epidemiology of Anxiety

Most of the anxiety disorders start to develop in childhood and adolescence, and as many studies have shown, due to poor management, many children do not grow out it. The general lifetime prevalence of anxiety disorders is estimated at 12.1%, and according to this data, anxiety illnesses are found to be even more disastrous than substance abuse, especially in the developed nations (Goldin et al., 2016). The prevalence of anxiety is not easy to highlight directly because even the slightest change in the diagnostic area or methodology readily alter the results. Panic as a branch of anxiety disorder is more prevalent in women compared to men. However, men also show higher comorbidity rate with depression than women. Generalized anxiety disorder is also more common in women at the rate of 5.1%, and it is comorbid with other illnesses (Michael, Zetsche & Margraf, 2007). Post-traumatic stress disorder is prevalent equally across every gender at the rate of 1%, but its first symptoms are mostly observed in children than in adults

(Michael, Zetsche & Margraf, 2007). As seen from these figures, one can quickly conclude that anxiety disorders affect women more than men, and it is prevalent in youths than in adults.

Etiology

There is no single unifying cause of anxiety as it is triggered by various related events that are psychodynamic, psychoanalytic, biological, genetic, cognitive, and behavioral. All these combined are known as biopsychosocial factors that may lead to the onset of anxiety (Bandelow & Michaelis, 2015). Some of the common biological causes include illness, genetics, medications, neurotransmitter imbalance, and nutritional factors. It is highly likely that if the parents suffered from anxiety disorder, then the children might as well develop the same condition (Bandelow & Michaelis, 2015). Psychosocial factors arise when the mental processes, impulses and instincts conflict thus resulting in distress (Bandelow & Michaelis, 2015). These are usually caused by overwhelming internal and external stresses on an individual's coping abilities. Therefore, psychological triggers include personality traits, negative emotions, developmental crises, and cognitive dissonance. Social causes, on the other hand, involve adverse life experiences, inadequate social skills, conflicts of the societal norms, work-related stress, and the lack of social support.

Negative Outcomes Associated with Anxiety

Anxiety can have numerous adverse effects on the patient, but most of them are short-term though some consequences may last for a long time. The short-term effects include shortness of breath, sweating, headaches, fatigues, dizziness, rapid breathing, irritability, inability to concentrate, and trembling among others. These short-term outcomes may vary from time to time and from one person to another, and therefore, the list can at times be endless. The long-term consequences alternatively include early memory decline because anxiety with time

damages the hippocampus cells that associate with learning and memory, but this is mainly common in elderly patients (Bandelow & Michaelis, 2015). Anxiety triggers flight and fight hormones, and constant release of these can lead to the fatal stroke. The other associated risk is insomnia, and this is often one of the first symptoms as well (Bandelow & Michaelis, 2015). Lastly, anxiety can have a detrimental effect of emotional distraction resulting in the lack of concentration in activities thus causing poor performance and inability to maintain relationships.

Interventions Used in Treating Anxiety

Mindfulness-based stress reduction. According to Rapgay & Bystrisky (2009), mindfulness is one of the interventions used in managing anxiety, and in its modern versions, mindfulness-based stress reduction is considered the best clinical application in treating anxiety. The authors explain that this is an idea that has mainly been practiced by Buddhists, and the impacts are evident in their lifestyles. However, they go further by stating that mindfulness can only be applicable as a medical tool if clinicians modify it to address particular and fitting clinical issues (Rapgay & Bystrisky, 2009). The idea is supported by Greeson et al. (2015): in their study to understand whether individual differences affect the efficiency of mindfulness-based stress reduction program, they noted that neuroscientists look at mindfulness as a form of meditation that combines emotional and attention-training administration established to enhance emotional regulation and cultivation of well-being. The other definition of mindfulness, according to Jon Kabat-Zinn, is that it is the ability to have an open, accepting and nonjudgmental awareness of every moment (Kushid & Vythilingam, 2016). From these perspectives, it is easy to gather the general idea of mindfulness that mindfulness-based stress reduction (MBSR) originated from. MBSR, therefore, is the modern and advanced form of mindfulness that is accepted in clinical practice.

Bergen-Cico, Possemato and Cheon (2013) in their study of assessing the efficiency of brief MBSR highlighted the idea that MBSR program involves teaching a patient how to do a body scan, which is is a means of encouraging the individual to have an open, nonjudgmental observation and acceptance of negative thoughts and unpleasant sensations so that instead of entertaining and improving the effects of anxiety, he or she avoids them. Since MBSR has been proven to help in treating various mental disorders, this intervention will be used in managing the presented problem.

Cognitive behavioral therapy. Goldin et al. (2016) noted that cognitive behavioral therapy is one of the most effective ways to manage social anxiety disorder in their study investigating treatment outcome between CBT and MBSR. Their research found out that CBT may improve the chances and the ability to direct and maintain attention through numerous training methods. Enhanced attention is one of the programs identified by Goldin et al. (2016), and it can easily be shared by both MBSR and CBT to alter the existing attention biases. Results from CBT have shown that this method of intervention enhances the quality of the patient's life. Unlike MBSR, CBT is a short-term process that is skill-focused. Its primary aim is to alter the maladaptive emotional response by changing the thoughts and the behaviors of the patients. As considered by Goldin and Gross, (2010), CBT works by targeting the distorted areas of someone's life by assessing the evidence that triggers the automatic thoughts and then transforming the maladaptive beliefs that result in a change of the problematic behaviors.

Mindfulness-based cognitive therapy. Mindfulness-based cognitive therapy (MBCT) is an intervention framework built upon the practices of MBSR and CBT. Dimidjian and Segal (2015) in their article *Prospects for a Clinical Science of Mindfulness-Based Intervention* explained that MBCT considers the idea that both MBSR and CBT are established around utilization of

mindfulness meditation along with clinical practices. While trying to evaluate the strength of MBCT in treating depression and anxiety, Kaviani, Javaheri and Hatami (2011) indicated that MBCT shares a lot in common with MBSR, except that in MBCT the intervention is more of a manualized group skill training system made up of eight weekly sessions that last for two and a half hours of therapy. Additionally, they noted that MBCT aims at treating depression and anxiety related disorders by helping people understand that thoughts and feeling are just ideas in mind and not self-defining truths. According to Dimidjian and Segal (2015), the original plan for establishing MBCT was to help people struggling with depression, but as the benefits of the practice became evident, practitioners started employing it in treating anxiety as well.

Impact of Each Treatment on the Problem

MBSR

MBSR is a meditation-training program that helps to mitigate various depressive symptoms. MBSR involves a program that goes for eight weeks where the patients have trained the process of mindfulness meditation that can aid them in dealing with stress and illnesses (Greeson et al., 2015). In this intervention, practitioners give the participants homework related to meditation, yoga and self-assessment tests on a daily basis that assist them in enhancing their observation power (Praissman, 2008). The patients are often directed to integrate meditation into their daily activities so that these routine activities become meditation practices (Praissman, 2008; Riley & Kalichman, 2014). As the patients continue with this form of cultivation, they awaken the state to see the unexamined and unaddressed feelings, thoughts, and sensations (Krasner, 2004). Thus, the patients gain the ability to heal their distorted ideas that trigger anxiety. In a study examining the effectiveness of managing depression, anxiety and other mental illnesses across a population, the results showed that the lives of the patients are greatly

improved (Niazi & Niazi, 2011). Therefore, MBSR reduces the symptoms of anxiety through modification of emotion regulation abilities including situation selection, situation modification, cognitive change, response modulation and attentional deployment (Goldin & Gross, 2011). However, some of the challenges encountered with this form of intervention include faith, cohort dynamics, environment, and psychological difficulties related to the practices (Martinez et al., 2015). Goldin & Gross (2011) stated that it is thus essential to address these barriers for the intervention to be effective on the anxiety patient.

CBT

Studies assessing the effectiveness of this intervention suggested that the patients who adhered to and completed their treatment showed stronger psychological outcomes than those applying other modes of treatment (Riley & Kalichman, 2014). CBT requires that the patients adhere to the given tasks, complete them and report to the therapist so that he or she can assess the progress that the patient is making. In doing so, it is easy to analyze the areas that the patients are not developing and create a better way of helping them. Predicting outcomes is essential in any intervention, and CBT offers the practitioners a chance to foretell and measure the progress and the results of the therapy sessions.

MBCT

MBCT is the combination of the practices in MBSR and CBT, and hence it strives to produce quality outcomes that cannot be attained by the other two methods. MBCT gives both the patient and the therapist an opportunity to work together in understanding the areas of weakness, allowing the latter to guide the individuals in the areas they cannot manage by themselves. The one significant advantage of this practice is that it can control any other illnesses apart from the presented problem concurrently (Dimidjian & Segal, 2015). This, nonetheless,

limits the ability to focus on a single disease to enable specific treatment, and it is suggested that it best treats depression and related disorders (Dimidjian & Segal, 2015). MBCT promotes the quality of life by helping the patient focus on the current moment instead of being overwhelmed by thoughts of the past or even the future (Kaviani, Javaheri & Hatami, 2011). In turn, the patients learn how to single out current problems and address them rather than flooding oneself with ideas that trigger anxiety.

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