Psychiatric rehabilitation of emotional disorders

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Emotional disorder is psychological and behavioral problems of emotional domain that is different from cognitive domain, such as thought and memory. Typical emotional disorders are anxiety disorder, depression, and bipolar disorder. In the present study, we discussed on the symptoms, progression, and treatment for the anxiety disorder (panic disorder, social phobia, and obsessive compulsive disorder), depression, and bipolar disorder. The goal of treatment for the emotional disorder is removal of symptoms. In spite of the development of brain science, removal of symptoms, prevention of recurrence, and coming back to normal life require patience and effort.

Keywords: Emotional disorder, Depression, Bipolar disorder

INTRODUCTION

Emotional disorder is psychological and behavioral problems of emotional domain that is different from cognitive domain, such as thought and memory (Kaplan and Sadock, 1998; William et al., 2002). Typical emotional disorders are anxiety disorder, depression, and bipolar disorder. Symptoms of emotional disorders are completely included in domain of subjective experience of an individual. This being so, it is nearly impossible to estimate severity of emotional symptoms through objective methods. So it is very difficult to others sympathizing pains of emotional disorder patients. Even family members of patients, they could not sympathize pains of patients enough. This is the character of emotional disorders in a word; only experience can tell the pains.

Treatment goal of emotional disorder in psychiatry is removal of symptoms. Due to development of brain science, biological mechanisms of emotional disorder are now unveiling. Biological therapy, especially pharmacotherapy, is more effective. Psychiatry’s goal is the achieving of reality. Quality of life issue of patients is unsolved yet. Not only removal of symptoms but also prevention of recurrence and coming back to normal life is important. It is the goal of psychiatric rehabilitation for emotional disorder patients.

ANXIETY DISORDERS

Panic disorder

Panic disorder consists of continuous panic attack and anticipatory anxiety (Kaplan and Sadock, 1998; William et al., 2002). Major symptoms of panic attack are abrupt severe dyspnea and palpitation. Thus people in panic attack always feel fear of death. Panic attack is rare in normal life but may happen at any time. Panic attack is likely to happen more often to those who are tremble with fear. First panic attack often make anticipatory anxiety of further panic attacks. People in anticipatory anxiety always concentrate their breath and heart rate.

It is very inconvenient in life, and when people are more afraid of panic attack, it may happen more often. The long-term result of panic disorder is functional disturbance in occupation, study, and everyday social life. The common places of panic attack are long tunnel, high-level road, elevator, subway, airplane, and sauna. When panic disorder patients are in that places, they usually feel be sealed, be shut up. And such feeling may induce panic attack. Life threatening memory of panic attack can induce continuous panic attacks in the future. After this time, panic disorder patients begin frequent calling 119 emergency medical services and frequently visit emergency room of general hospital.

Long-term untreated panic disorder results in depression.
depression develops, treatment of panic disorder becomes more difficult. The first thing to do in mental rehabilitation of panic disorder is isolating of patient from the panic-inducing environment, such as too suffocating and enclosed area. And secondly, the process of correcting the cognitive distortion is necessary. The patients of panic disorder usually misunderstand the ordinary physical sign as the prodromal symptom of panic symptom. Because of this misunderstanding panic symptom develops more frequently and seriously. So, it is very important that correcting the cognitive distortion of the differentiating the ordinary physical sign and the prodromal symptom of panic symptom. And then, systematic desensitization to the avoided panic-inducing environment step-by-step is the following process. Finally, for the mental rehabilitation of panic disorder, panic patients of the improvement of symptoms make self-help group and prevent relapse the symptoms.

Social phobia
Social phobia is that the patient experiences the excessive stress and anxiety in social situation, and it occurs in occupational and social dysfunction (Kaplan and Sadock, 1998; William et al., 2002). The causes of social phobia are divided into innate factor and situational factor. Innate factor is mainly derived from biological and genetic factor, so, a patient of social phobia is shy from an early age. In severe case, a patient of social phobia has a selective mutism who consistently fails to speak in specific situation, such as school, despite speaking actively with family members at home. A situational factor is usually derived from a subjective psychiatric trauma that is linked to the experience to feel deep shame in front of many people. Most of cases, social phobia develops after the episode of being laughed by any mistakes during announcing at school time. A patient of social phobia consistently avoids the similar situations by intent, because of a shame of humiliating in front of many people. This is even worse over time. Types of social phobia vary depending on specific situation develops a fear for example stage, authority, opposite sex, one’s eye, and meeting, etc.

The mechanism of social phobia is summarized as follows. At first, a person feels extremely humiliated at the first symptom developing situation, and fixes the symptom through the process of cognitive distortion. And then, various symptoms, such as tremor, stiffen, a blush, perspiration, palpitation, etc., develop, and finally, social withdrawal avoiding social situation consistently develops. Educating for the understanding the cultural factors of social tensions is necessary for the mental rehabilitation of social phobia. Understanding on the difference of oriental and western culture is important for this education. Clear claims of their own opinions achieve recognition in western culture, but in oriental culture, it is considered as a virtue not to expose oneself too much. So, in oriental culture, shyness is not a fault.

The next step is exposure of their tension rather than hide in social situation. Through this paradoxical behavior, the patient can experience the reduction of their tension repeatedly. Homework of this paradoxical behavior is very useful in this step. If a patient’s symptom is relieved, it is important to participate into the self-help group to prevent the relapse of symptoms.

Obsessive compulsive disorder
Obsessive compulsive disorder reveals the obsessive rumination and compulsive behavior with regard to reduce the anxiety (Kaplan and Sadock, 1998; William et al., 2002). And obsessive compulsive disorder is ego-dystonic and it is distinct from ego-syntonic obsessive compulsive personality disorder. Obsessions are recurrent and persistent thoughts, urges, images, or memories, connected with a specific situation, or specific music or song that is still heard. It is characterized that the more the patient try to get rid of obsessions, the more it becomes serious. Compulsions are defined by repetitive behaviors, such as hand washing, checking the door, ordering, or various behaviors or mental acts. Compulsions are daily life rituals to specify to individual. The symptoms of obsessive compulsive disorder develop often under the stressful circumstances, and associated with the genetic factor. Usually patient of obsessive compulsive disorder attempts to ignore or suppress symptoms, however symptoms become worse. In other words, paradoxically, the efforts to resolve the problem tend to worsen the problem, and then the disease gradually gets worse.

If obsessive compulsive disorder persists for a long time, eventually, it can lead to neurasthenia or depressive disorder. Mental rehabilitation of obsessive compulsive disorder starts to stop the self-control at first, because the effort of self-control to suppress the symptoms aggravates the symptoms. And it is helpful to try to think the symptoms irrelevant to oneself instead of reactivating to the symptoms. Finally, because the symptoms of obsessive compulsive disorder could not be removed completely, it is important to have mental attitude of living with remaining symptoms.

DEPRESSION
Depressive symptoms persist at least 2 weeks and usually if depressive disorder occurs, it can last from 9 months to 2 years. Vulnerable factors for depressive disorder are for example early separation from caretaker in early developmental period, early loss of at-
tachment figure, chronic stress, recent severe stress, absence of supportive system, etc (Kaplan and Sadock, 1998; William et al., 2002). In the early stage of depression, patient becomes persistent lethargic condition in body and mind and falls into vegetative state and finally needs other's help. Recovery period after extremely severe period begins. In recovery period, patient's energy becomes to increase, but, patient's cognitive status is still negative. Therefore risk of suicide maximize in recovery period. The most critical problem is that helplessness is learned and become stuck. The negative cognitive distortion of being unable to get rid of depression arises and the vicious cycle that cognitive distortion worsening depressive symptoms occurs. Mental rehabilitation of depression starts to separate from the current stress. To prevent deterioration of depression, the process of environmental coordination and protecting the patient of depression from the current stress is necessary. The most effective method of this process is separation, that is, through a leave of absence from work and school, worker or student can separate from the current stress. And family of depressive patient as an attachment figure is educated to support the patient. If there is no supportive family or nearby friend, therapist need to play a role as a supportive system.

Next, distorted cognition should be corrected by separation emotional status and negative cognition. Depressive mood arouse depressive and negative thought. At this time under the control of negative thought, cognitive distortion that is subject never get rid of depression and everything will get worse arise. It is important to correct this cognitive distortion to a objective and realistic thought. Objective thought is that negative thought is only due to depressive mood and negative thought will change according to the improvement of depressive mood. So, patient can effectively get out of cognitive distortion which worsens depression.

Last but not least, education of prognosis of depression is important for the mental rehabilitation of depression. Because of the very long period of depression, the patient waiting for recovery can often feel the limits of patience. So, through education of prognosis of depression that is even though recovery period of depression can be a very long, but eventually depression can recover, it is helpful for the patient to endure for a long period of depression until recovery.

**BIPOLAR DISORDER**

Bipolar disorder can appear alternately a distinct period of manic and depressive mood (Kaplan and Sadock, 1998; William et al., 2002). Pharmacotherapy is the most important method in treatment of bipolar disorder because of biological etiology. After patient improved and recovered to the normal mood state, mental rehabilitation that deals with cognitive changes is also important process. Patient experience persistently elevated and expanded mood in manic state and after returning to normal mood, vivid memories of manic period remain for a long time. At this time patient can easily feel a normal mood state as like a depressed mood. Because patient feel so good in manic state, subject can make the standard a manic state to a normal mood, so, patient can feel a normal mood state as like a depressed mood. Mental rehabilitation of bipolar disorder starts to convey this cognitive distortion to the objective and realistic thought. Psychoeducation, that the manic mood state is a pathology not a normal state and real normal mood state is not so much fun and exciting, should be repeated for the patient’s realistic thought.

The next important thing in mental rehabilitation of bipolar disorder is dealing with a lack of confidence and anxiety that develop after getting an insight. Patient can get an insight that having a chronic psychiatric disease if the patient is educated and realize that memories of manic or depressed period are based on pathological state. This insight can positively help the patient to taking medicine well, but also negatively cause the patient to feel pessimistic and lose self-confidence in adaptation to reality. Therefore, it is very important thing to deal with this insight for the improvement of patient’s quality of life. In this point, psychoeducation, that the life of bipolar patient is not different from everyone’s life if the disease does not recur, is very important. So, therapist should repeatedly educate the patient that to take medicine actively to prevent a recurrence of the disease, then there is no problem in social, occupational, familial, and school life. Through this education, patient can manage one’s own disease independently and restore self-confidence in social adjustment.

The points of mental rehabilitation for bipolar disorder can be summarized as follows: education of biological characteristics of bipolar disorder, correcting of the cognitive distortion to the normal mood state, management of stress related to relapse, and objective monitoring for the preventing of recurrence of the disease.

**CONCLUSIONS**

Affective disorder, such as depression and anxiety disorder, is a painful disease that anyone can experience in a lifetime. The symptoms of affective disorder are subjective feeling, and then only those who have experienced can know the pain. Therefore, active endeavor accepting this disease and the support to the patient and patient’s
acquaintances are required. The mechanism of affective disorder is gradually revealed depending on the development of neuroscience. As a result, biological therapies, including pharmacotherapy, have significant effects. But, it is just as important as the treatment to prevent the recurrence and to restore the damaged self-esteem and quality of life. This point is the purpose of mental rehabilitation for affective disorder, and only through the process of mental rehabilitation, patient can return to the normal social life and daily life smoothly.

Mental rehabilitation of affective disorder proceeds following steps. First, separate the patient from the current stressful environment. Second, correct the triggering environment surrounding the patient to be harmless. Third, correct the cognitive distortion occurred from the disease. Forth, make the surrounding supportive system for the patient’s rehabilitation. Fifth, educate on the etiology, mechanism, progress, and prognosis of affective disorder for the understanding of this disease. The series of rehabilitation process are not tightly interconnected with each other, therefore, when any factors are lacking, it is difficult to expect good results.

**CONFLICT OF INTEREST**

No potential conflict of interest relevant to this article was reported.

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