Objectives:

Identify effective methods for the practical application of concepts related to improving the delivery of services for persons with developmental disabilities

Notes:
ANXIETY—THE “ROCK AND ROLL” PART OF THE PROGRAM!!
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• **Anxiety**: Defined as a feeling of apprehension, uneasiness, uncertainty, or dread resulting from a real or perceived threat whose actual source is unknown or unrecognized.
• **Fear**: Has a specific source or object that the person can identify and describe.
• **Fear** involves the intellectual appraisal of a threat, **Anxiety** is the emotional response to that appraisal

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Prevalence of Anxiety

• Most common of Psychiatric Disorders in America
• <40 million people afflicted /yr. (1 of 4)
• Only 1/3 receive adequate treatment
• Affects almost 20% of the population (NIH, 2005)
• In US cost of $42 billion/yr. (1/3 of MH costs)
• People with Panic Disorder (37 med. visits vs. 5 in general pop)
• > 25% of people with panic disorders seek help
• 2-3X more common in PWDD

Common Co-Morbidities

• Intellectual Disabilities (at least 2X more common)
• Autism (3X more common)
• Personality Disorders (especially Borderline PD)
• Substance abuse disorders
• 60% with Depression (may be higher)

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Levels of Anxiety

• Mild
• Moderate
• Severe
• Panic

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Mild Anxiety

• PERSON IS ALERT
• PREPARES PEOPLE FOR ACTION
• SHARPENS THE SENSES
• PERCEPTUAL FIELD IS INCREASED
• HEIGHTENS AWARENESS OF ENVIRONMENT
• CAN MOTIVATE LEARNING
• CAN PRODUCE OPTIMAL GROWTH & CREATIVITY
MODERATE

- Focus is on **immediate** concerns
- Narrowing of perceptual fields
- Less alert of environment
- Blocks out selected areas
- Concentration & attention span decrease
- Can attend if directed
- May need help with problem solving
- May see muscular tension & restlessness

SEVERE

- Focus is on **Specific** detail
- Does not think of anything else
- Very reduced perceptual field
- Attention span is extremely limited
- May see physical Sx of HA, GI upset, insomnia
- May see emotional Sx: confusion, dread
- Discomfort is so severe that an ind’ is overt
  behavior is aimed at decreasing anxiety
- Much **Direction** is needed

PANIC

- Awe, dread, & terror
- Details are blown out of proportion
- Loss of control
- **Unable** to follow direction
- Disorganization of the personality
- Increase in motor activity
- Decrease in ability to relate to others
- Distorted perceptions
- Loss of rational thought
- Frightening & paralyzing

Cognitive Theory = Change cog. distortions

- All-or-nothing thinking
- Overgeneralization
- Mental filter
- Jumping to conclusions
- Magnification or minimization
- Labeling
- Personalization and blame

Process of Anxiety- result of dysfunctional appraisal of the situation.
(Automatic Thinking)

- (Stressful) Event (creates)
- Perception (which creates)
- Anxiety (creates/leads to)
- Behavior
- Remember what is stressful for one person (cupboard door open, take a different route to school), may be meaningless for someone else.

Biological

- Anxiety disorders = inc. sympathetic tone
  Responds excessively to stimuli
  Anxiety disorders have poorly regulated nor-adrenergic systems (catapres =dec.anxiety)
  Serotonin- modulates HPA axis
  GABA= breaks anxiety
  Brain imaging (CAT,MRI,PET)=abnormalities in frontal lobe
  Abuse before 18= limbic dysfunction
  These are all areas of concern for PWDD
CRISIS

• Stress is a constant
• Stress can be caused by both positive and negative events.
• Most issues resolve with natural supports.
• ASSUMES ONE HAS NATURAL SUPPORTS
• A crisis occurs when an unexpected event in one’s life, during which time usual coping strategies are ineffective.

Types of Crisis

• Maturational: developmental events requiring role changes, i.e., change in schools, siblings’ “advancing” faster, limited employment/relationships
• Situational: external & unexpected, i.e., job loss, staff changes, medical illness, financial constraints
• Adventitious: (also grouped under “situational”) natural disasters such as Storms, droughts, earthquakes, etc.

Crisis Responses

• 1st Phase: Stressor/anxiety (reaction to stressor) activates typical coping
• 2nd Phase: increased anxiety d/t previous coping mechanisms fail
• 3rd Phase: New coping mechanisms tried, or threat “redefined” so old mechanisms can “work” (may be positive or negative)
• 4th Phase: severe/panic levels of anxiety lead to psychological disorganization.

Crisis Responses in PWDD

• Sense of control in the crisis
• Whatever old coping strategy the person uses (used) will be employed first i.e., SIB, aggression
• Poor sleep, GI upset may be aggravated
• “What do you mean she wants 4 baths in a day?”
• “Regression” is universal

Crisis Intervention

• GOAL: Return to a pre-crisis level of functioning. May actually facilitate growth (but this is not the primary goal)
• Immediate response reduces risk of long-term consequences
• Short Term (4-6 wks.)
• Self Limiting

In the Real World…

• Most people go through periods of crisis with natural supports successfully
• Persons with pre-crisis coping deficits will exhibit more symptoms
• History of significant losses/traumas can be brought back by the current crisis for compounded symptoms
• What if you have no ‘natural supports’, or “positive” coping strategies?
Crisis brings on need to restore equilibrium

- Positive factors:
  - Realistic perception of event
  - Adequate situational support
  - Adequate coping
  - Results in: Resolution of the problem
  - Equilibrium restored
  - NO CRISIS

- Negative factors:
  - Distorted perception of the event
  - Inadequate supports
  - Inadequate coping mechanisms
  - Results in: Problem continues
  - Disequilibrium continues
  - CRISIS

Behaviors Common After Crisis

- Narrow perceptions of event
- Terror/fear
- Increased anxiety
- Irritable/aggressive
- Physical Symptoms
- Isolation
- Crying, yelling
- Difficulty Sleeping

Behaviors-cont.

- Anger
- Changes in eating patterns
- Regression, repression, denial, acting out
- Nightmares
- Emotional Numbing
- Physical Sx of Stress
- Increase in smoking/Drugs/ETOH/risky behaviors
- Decrease Memory/Concentration

Focused Assessment

- Precipitating event or stressor

- Client’s perception of event/stressor not staff’s

- Nature & strength of support system/Coping system

- Client’s previous strengths/coping skills

Interventions

- Environmental Manipulation
  - Crisis home
  - More localized supports
  - Encourage leisure,
  - Or conversely, maintain routine as best as able
  - Medications as a LAST (not first) resort.
  - If sleep is an issue, PRN Rx MAY help i.e. Melatonin

Acute to Chronic Stress = Anxiety Disorders
**DSM V & DM-ID II ANXIETY DISORDERS**

- **Common features**
  - Restlessness, keyed up/edgy
  - Easily fatigued
  - Poor concentration
  - Irritability
  - Muscle tension

- **More features**
  - Poor sleep
  - Physical features
    - GI upset
    - Headaches
    - Chest pain
    - Trouble breathing
    - "The shakes"

**Anxiety Disorders**

- Separation Anxiety Disorder
- Selective Mutism
- Specific Phobia
- Social Anxiety Disorder
- Panic Disorder
- Agoraphobia
- Substance/Medication-Induced Anxiety Disorder

**General Anxiety Disorder (GAD)**

- 3-4% of the population affected
- 8-20% of PWDD?
- Onset early 20’s, common in children as well
- Women > Men

**GAD**

- A. Excessive anxiety or worry more days than not over 6 mos.
- B. Individual finds it difficult to control the worry.
- C. Anxiety & worry in 3** or more of the following:
  - Restless-keyed up
  - Easily fatigued
  - Difficulty concentrating
  - Irritability
  - Muscle tension
  - Sleep disturbance

Above causes significant impairment in social, occupational, or other areas of important functioning

**Obsessive Compulsive Disorders**

- OCD, Body Dysmorphic D/O, Hoarding D/O, Trichotillomania, Excoriation (Skin Picking) D/O
- Much more common in persons with ID/DD
- Core feature of ASD
- In OCD: Either obsessions OR compulsions
  - A. Obsessions= intrusive thoughts
  - B. Compulsions= repetitive behaviors
  - 3. Obsessions may not be as prominent nor co-occurring in ID/DD

**OCD vs. OCPD**

- OCPD=Obsessive Compulsive Personality Disorder
- OCPD= “ego-syntonic” OCD
- Who has the problem?
- OCPD in persons with Down Syndrome
- Increase in OCD symptoms prodromal to Dementia??
Trauma & Stressor Related Disorders

• Reactive Attachment Disorder
• Disinhibited Social Engagement Disorder
• Post Traumatic Stress Disorder (next slide)
• Acute Stress Disorder
• Adjustment Disorders

Post Traumatic Stress Disorder (PTSD)

• Occurs in at least 8% of the population (May be more)
• Speculations of up to 25-30% of PWDD
• Exposure to a traumatic event - threatened death or injury to self or others
• Response - fear, helplessness, or horror
• Avoidance of stimuli - triggers re-experiencing the event
• Numbing of responses (feelings)
• May experience:
  • Sleep disturbance, Hyper vigilance, poor conc., or guilt about surviving

Treatment for Anxiety

• Relaxation exercises
• CBT/DBT/Other Therapies
• Meds:
  – Antidepressants
  – Antihypertensives
  – Gabapentin
  – Benzodiazepines***

CBT—As An Example

• Change the cognitive distortion to a positive thought process
• I can
  • “I made a mistake”
• This is VERY difficult for persons who already feel “stupid”/“retarded”
• Helping to normalize “we all make mistakes” a huge help

More Interventions

• Keep your anxiety LOWER than the anxious person
• Help the person to focus - verbally
• Help the person to problem solve
• Recognize the person’s distress
• LISTEN
• Evaluate effective past coping
• Explore alternatives to problem Situations
• TEACH Coping Strategies

Problem Solving

• NOT TO BE DONE AT THE TIME OF CRISIS
• Identify the Problem
• Explore alternatives
• Review the pro’s & cons of each altern.
• Make a decision
• Try the alternative solutions
• Evaluate
• Try another alternative