Tuesday, 10:00 – 11:30, A2

ANXIETY—ALL STRESSED UP & KNOW WHERE TO GO!

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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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The Right Door
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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)

Levels of Anxiety

- Mild
- Moderate
- Severe
- Panic

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 <u>immediate</u> 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 **<u>Specific</u>** 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'ls overt behavior is aimed at decreasing anxiety
- Much **<u>Direction</u>** is needed

PANIC

- Awe, dread, & terror
- Details are blown out of proportion
- Loss of control
- **<u>Unable</u>** 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

**In Children, persons with Severe/Profound ID only 1

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