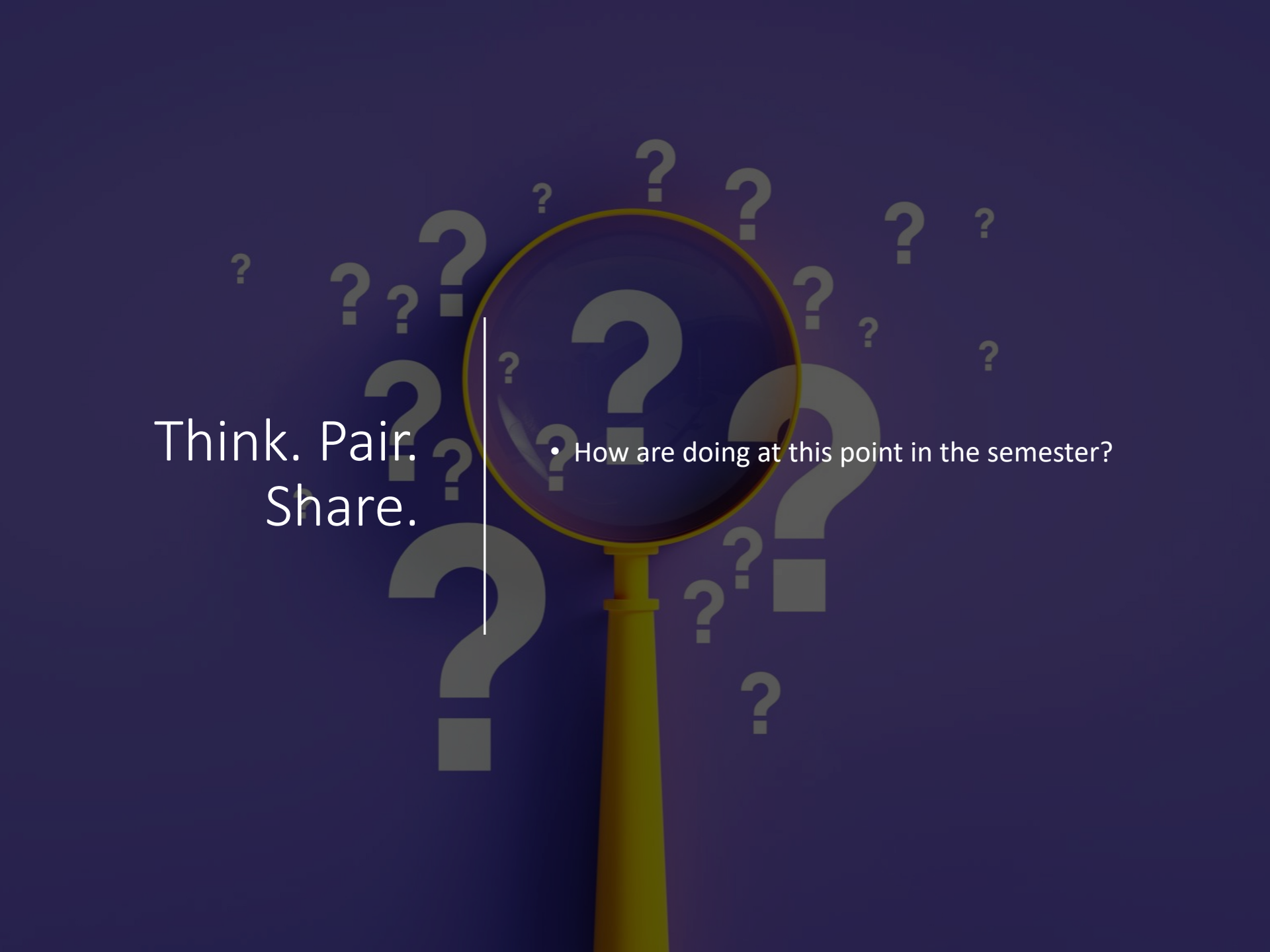
Anxiety Disorders and Obsessive-Compulsive Disorders

Rachel Speer

Class 5



Think. Pair. Share.

- How are doing at this point in the semester?

Case Study

Quick Review

What is anxiety?

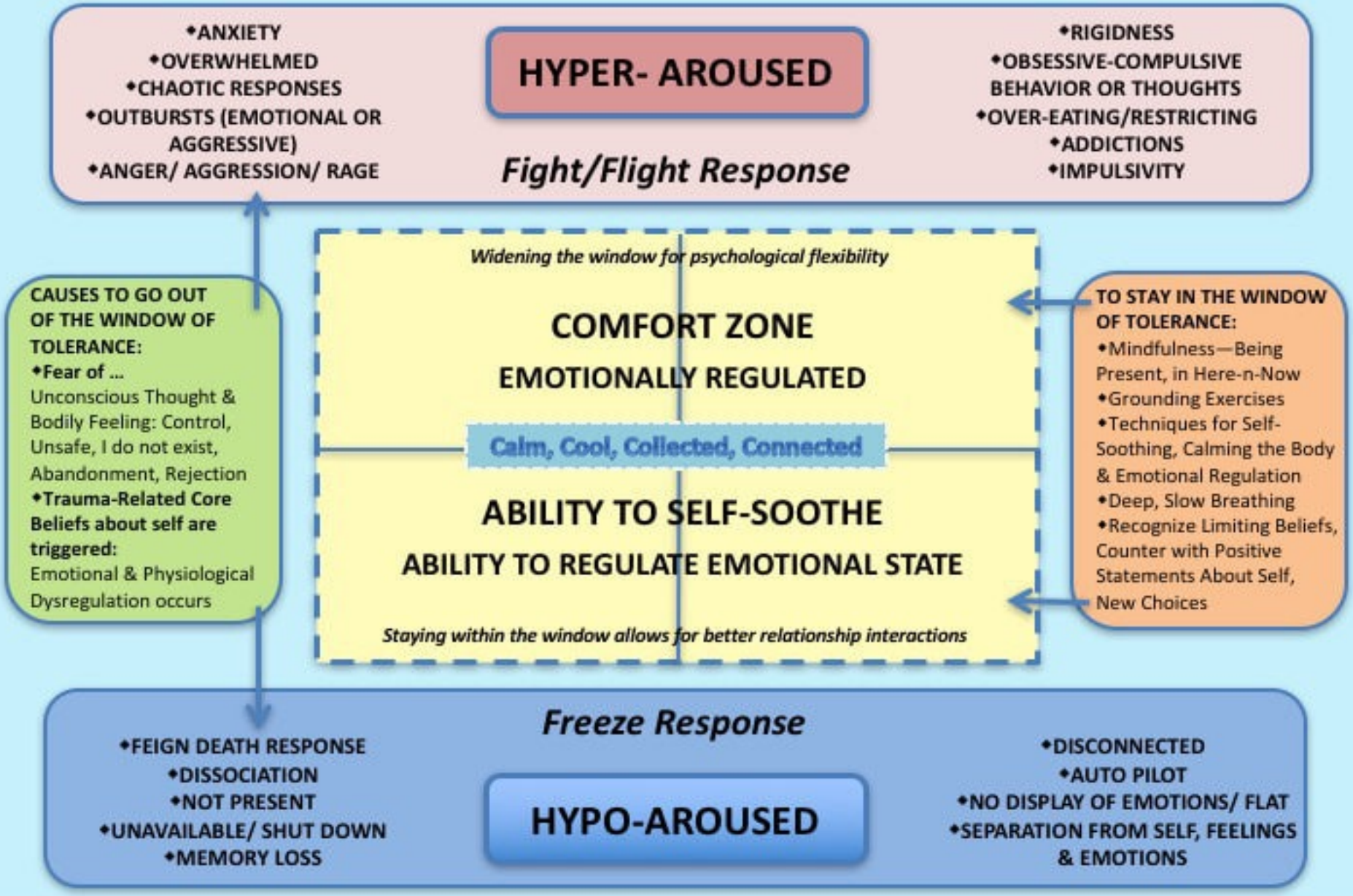
Austrian pg. 12: “Anxiety is a response to a threat. It alerts the individual to danger. It differs from fear in that the source is often unknown, although there are circumstances in which a specific identified stressor will result in situational anxiety that recedes when the stressful event is over. Anxiety is described as an unpleasant feeling, directed toward the future.”

“Anxiety is an anticipatory signal that there is a conscious or unconscious threat to life, emotional stability, or equilibrium.

Marie S. Dezelic, PhD © 2013

WINDOW OF TOLERANCE- TRAUMA/ANXIETY RELATED RESPONSES:

Widening the Comfort Zone for Increased Flexibility



Assessing For Anxiety Disorders

- Examine
  - Physiological response
  - Overwhelmed by concerns of harm (cognitive)
  - Lack of logical reasoning in reducing anxiety
  - Maladaptive coping strategies
  - The Panic Attack
    - Definitions and consequences
    - Out of the blue
    - Out of proportion
    - Avoidance

Some Anxiety Disorders

- Panic Disorder
- Agoraphobia
- Generalized Anxiety Disorder
- Social Phobia
- Specific Phobia
- Obsessive-Compulsive Disorder

Eexample:
GAD

Page 208 in the DSM

How is anxiety treated?

- Psychodynamic perspectives
- Cognitive perspectives
- Biological perspectives
- Systems perspectives

Anxiolytic Medications

8 million+ prescriptions written every year, mostly by internists

SSRIs

Benzodiazepines

Diagnostic Application

Samantha worried (age 35) about the fact that she couldn't stop thinking about washing the floor and the walls of her home. Upsetting images of filth, dirt, grime, and contamination popped into her head at all hours of the day and night. She did her best to get the thoughts out of her mind, but the only thing that worked was sweeping the floor (from the northern end of the house to the southern, then from east to west); mopping the floor (using precisely 1 and 3/8 cup of her brand of cleaning detergent and precisely 3 3/8 cups of water—nothing else cleaned correctly); getting down on her hands and knees and scrubbing the floor (with the blue, and *only* the blue, brush—it was the only one that would do); and then letting the floor dry and repeating the entire procedure. She did this several times per day, and sometimes all night. Any interruption or distraction meant that she had to start the entire process over. Samantha had tried unsuccessfully to ignore her cleaning impulse but found that she became so upset she could not think about or do anything else until the floor was fully *clean*. The entire process took hours every day and left Samantha unable to do much else, including work or spending time with friends or family.

Small Group Reflection

1) How will you differentiate between developmentally normative fear versus anxiety that is excessive or persisting beyond developmentally appropriate periods?

2) How do you take cultural context into consideration when determining what is out of proportion?

3) How might an individual's social identity play a role in their fear and how might that impact how you determine what is out of proportion?

4) What disorder-specific scales have you used or know are available to better characterize the severity of each anxiety disorder and to capture the change in severity over time?

5) What limitations do you see in this section related to the DSM or ICD?

Major risk factors for suicide include:

- Age (teenager and being over 45) /Sex (men) /Gender Identity
- Prior suicide attempt(s)
- Misuse and abuse of alcohol or other drugs
- Mental disorders, particularly depression and other mood disorders
- Access to lethal means
- Knowing someone who died by suicide, particularly a family member
- Social isolation
- Situational Stress that cannot be changed
- Chronic disease and disability
- Lack of access to behavioral health care

Dynamic risk factors: mental illness (depression, substance abuse, psychosis, Bipolar Mood Disorder), medical illness, social isolation, bereavement, recent financial losses, homelessness

Imminent intent, available means, hopelessness
Shea, 2017

*This list is not exhaustive

SUICIDE AS A TRAUMATIC EVENT

- Exposure to suicide as a traumatic event can lead to PTSD
- Risk Factors: witnessing the suicide, feeling connected to the person who dies, having a history of psychiatric illness
- Traumatic Grief

sprc.org/about-suicide/warning-signs

SEARCH ABOUT SPRC CONTACT US LOGIN

Suicide Prevention Resource Center

About Suicide Effective Prevention Resources & Programs Training News & Highlights Organizations

NATIONAL SUICIDE PREVENTION LIFELINE

8255
1 (800) 273 TALK

Immediate Risk

Some behaviors may indicate that a person is at immediate risk for suicide.

The following three should prompt you to immediately call the National Suicide Prevention Lifeline at 1-800-273-TALK (8255) or a mental health professional.

- Talking about wanting to die or to kill oneself
- Looking for a way to kill oneself, such as searching online or obtaining a gun
- Talking about feeling hopeless or having no reason to live

Serious Risk

Other behaviors may also indicate a serious risk—especially if the behavior is new; has increased; and/or seems related to a painful event, loss, or change.

- Talking about feeling trapped or in unbearable pain
- Talking about being a burden to others
- Increasing the use of alcohol or drugs
- Acting anxious or agitated; behaving recklessly
- Sleeping too little or too much
- Withdrawing or feeling isolated
- Showing rage or talking about seeking revenge
- Displaying extreme mood swings

*This list is not exhaustive

Protective Factors

1. Attitudes, values, and norms prohibiting suicide, e.g., strong beliefs about the meaning and value of life
2. Social skills, e.g., decision making, problem solving, and anger management
3. Good health and access to mental and physical health care
4. A healthy fear of risky behaviors and pain
5. Hope for the future – optimism
6. Sobriety
7. Medical compliance and a sense of the importance of health and wellness
8. Impulse control
9. Strong sense of self-worth or self-esteem
10. Sense of personal control or determination
11. Access to a variety of clinical interventions and support for seeking help
12. Coping skills
13. Resiliency
14. Reasons for living
15. Being married or a parent

Shea, 2017

*This list is not exhaustive

Table 17.1 Useful Acronyms in Suicide Assessment

SAD PERSONS SCALE	NO HOPE ACRONYM
• **S**ex • **A**ge • **D**epression • **P**revious attempt • **E**thanol abuse • **R**ational thinking loss • **S**ocial supports lacking • **O**rganized plan • **N**o spouse • **S**ickness	• **N**o framework for meaning • **O**vert change in clinical condition • **H**ostile interpersonal environment • **O**ut of hospital recently • **P**redisposing personality factors • **E**xcuses for dying are present and strongly believed

Shea, 2017

Loose Ends and a New Mnemonic

A new mnemonic was devised under the auspices of the American Association of Suicidology in 2006.[55] It was an attempt to focus solely upon dynamic risk factors, (emphasizing those dynamic factors that are best supported by research literature as representing warning signs of imminent risk). The three-word mnemonic is as follows:

IS PATH WARM

Ideation (suicidal)

Substance abuse

Purposelessness

Anger

Trapped

Hopelessness

Withdrawing

Anxiety

Recklessness

Mood change

Shea, 2017

ASK ABOUT SUICIDE

- Directly ask the client if they have thoughts of suicide, plan, intent, means,
- Ask about the client's history of suicide (single most reliable predictor
- Family history of suicide
- How does your agency handle actively suicidal clients?

THOUGHTS OF SUICIDE

- More people think about suicide than actually do it

- If clients have thoughts of suicide:
  - When do they have these thoughts?
  - How frequent?
  - Are the thoughts increasing?
  - How comfortable are they with the thoughts?
  - Prior attempts?
  - Plan? Means?
  - Can the client carry out the plan?
  - What will happen as a result of the suicide ?

Suicide assessment

- "SLAPP"
  - Specifics
  - Lethality
  - Availability
  - Proximity to others
  - Plan

TREATMENT

- Safety is the number one priority
- Focus on the problems that the person is perceiving suicide as a solution for
- Focus on positive coping skills
- Acknowledge the struggle, pain, and loss
- Develop a plan that includes exploring social supports and crisis numbers

Case example: In Sook

- What risk factors or warning signs do you see?
- What protective factors are at play?
- Is she at significant risk for suicide?
- What questions would you ask to further assess her suicidality?
- Would you ensure she had an emergency evaluation (in PA I believe either a 201 for voluntary hospitalization or a 302 for involuntary hold but please discuss with your field supervisor)? Why or why not? What would you need to feel confident in not seeking an immediate evaluation?

Group Reflection

Ethical Considerations: How can clinicians balance patient confidentiality with the duty to prevent harm, especially when dealing with suicidal ideation?

Policy and Resources: What improvements could be made to current mental health policies and resources to address better the needs of individuals struggling with anxiety and suicidal thoughts?

End of class exercise

Questions?

Comments?