An understanding of death anxiety is essential to conducting HIV-related psychotherapy. Often, one of the most important tasks of the therapy is the process of coming to terms with death while focusing on the here and now. Appreciating the role of death anxiety in mental health is particularly useful in light of advances in HIV-related medical treatment and the extension of life that these drugs may offer.

It is difficult to place death anxiety—used synonymously with fear of death—into any theoretical orientation of psychology. Prior to the appearance of the concept in the literature a quarter of a century ago, the topic of death was seldom mentioned in the mental health literature. For example, Freud said very little about the matter and viewed death anxiety as stemming from phenomena he saw as more fundamental such as castration anxiety or separation anxiety.

The concept of death anxiety can be better understood by a very brief description of the broader concept of anxiety. All of us have experienced anxiety. The somatic components of anxiety include heart palpitations, sweating, breathing difficulty, dizziness, muscle tension, hot flashes, cold chills and difficulty swallowing. The cognitive components of anxiety include fear of passing out, worry, obsessive fear of losing control, concentration difficulty, dwelling on traumatic experiences and feeling something terrible is going to happen. The difference between anxiety and an anxiety disorder is a matter of degree. Anxiety is often associated with a particular object or situation, for example, fear of spiders or test anxiety. As are such phobias, death anxiety is a specialized instance of anxiety. Death anxiety includes: preoccupation with death, fear of death, fear of having surgery, cancer, or a heart attack, being troubled by the matter of life after death, preoccupation with the shortness of life, and fear regarding the death of other persons.

Correlates of Death Anxiety

A standardized Death Anxiety Scale has been used in hundreds of studies throughout the world to measure death anxiety. The result of this research, which was not for the most part focused on participants with medical illness, are some important generalizations about death anxiety:

- Women seem to have higher death anxiety than men.
- Family members tend to have similar death anxiety levels, suggesting that the degree of death anxiety is at least in part determined by the death anxiety level of significant others.
- Highly religious people tend to have lower death anxiety than persons who are less religious. In general, the strength of religious belief rather than acts of religious practice is related to the degree of death anxiety.
- People with mental illness, depression, high levels of anxiety, or maladjustment tend to have higher death anxiety.

Two factors determine the level of death anxiety a person feels: first, is an individual’s past experiences with death; second, is the general state of a person’s psychological health. If high death anxiety is primarily a function of experiences pertaining to death, then treatment should apply behavior therapy and principles of learning. If high death anxiety is primarily a function of a more pervasive
Editorial: Imagining Anxiety
Robert Marks, Editor

Butterflies in great swarms, free-floating, aching, crawling from the pit of my stomach to the back of my throat, tickling me, itching me, making me miserable. You know the feeling: anxiety. Now imagine it growing, expanding so that it demands your full attention, overwhelming any peace you thought you might eke out of a Saturday afternoon.

Yes, I have been anxious in my time. For most of us, going through such an exercise of imagining anxiety is not a difficult task.

Now suppose that you have a much better reason than I do to be obsessed with something like death, to let it take over your consciousness. Imagine that you have HIV disease or that all of your friends have died over the past 10 years.

Death Anxiety

Some theorists have suggested that all anxiety is the expression of anxiety about death.

Twenty years ago, Donald Templer developed the Death Anxiety Scale to study this phenomenon. In this issue of FOCUS, he and co-author Raymond Greer look at the relationship between death anxiety and HIV disease. They suggest that death anxiety may arise either from fears of pain and suffering associated with dying or from fears about what happens after life. Like all anxiety, there is an element of uncertainty in both of these formulations.

Not surprisingly, Templer and other researchers have found that people who build more certainty into their lives, whose world views and spiritual and religious perspectives are more settled, have lower death anxiety. This is consistent with what has always been known (but sometimes resisted) about AIDS: counseling in the context of a life-threatening disease entails confronting spiritual beliefs.

Analysis of death anxiety by 114 gay men with HIV disease who had come to terms with being HIV positive showed that those who were religious had lower death anxiety, but clinical experience suggests that this may be true.

Routine Is Not Normal

Also in this issue, Dan Karasic helps distinguish between the routine anxiety that seems to be rationally associated with everyday life and the severe anxiety that takes on the attributes of obsession. Providers working in the shadow of the epidemic can expect to come upon both forms in their practices. The good news is that like depression, anxiety is treatable through psychotherapy and in more extreme cases, by using anti-anxiety drugs.

No, imaging anxiety is not difficult: in fact, it's all too easy. Anxiety is so much a part of living that many of us—in particular, people working long hours on the front lines of the epidemic—are likely to accept it as normal. Karasic makes an important point that "routine" is not normal, or perhaps more precisely, it is not healthy. Providers need to be aware of their own biases about anxiety, distinguishing between anxiety that is a normal part of living and anxiety that, while not disabling, has a significant effect on quality of life and deserves appropriate attention.

References
that are generally stigmatized also appears to be related to decreased death anxiety. Finally, achieving acceptance of religious belief leads to reduced death anxiety.

Proximity to Death and Religion
Common sense would suggest that greater death anxiety would be associated with greater proximity to death. Common sense, however, is apparently wrong. Research indicates a low but negative relationship between death anxiety and age. From youth through middle age, there is ordinarily no relationship between death anxiety and age. Elderly people, however, tend to have somewhat lower death anxiety that further decreases with greater age. Research also demonstrates that people in poor health, such as terminally ill cancer patients, tend to have lower death anxiety than do healthy people.

But research on death anxiety among people with HIV disease, at least among HIV-infected gay men, diverges from these general findings. One possible reason for the difference is that unlike people with other life-threatening illnesses, HIV disease is stigmatized. Often abandoned by their religious communities, disavowed by family members, and shunned by friends and acquaintances, people with HIV disease bear a heavy burden that complicates feelings about death.

One study found that gay men with CDC-defined AIDS had significantly higher death anxiety scores than uninfected gay men. Among the seropositive participants, higher death anxiety was associated with greater church attendance, continuing to belong to a person’s childhood religion, the belief that religion is harmful, and limiting spiritual beliefs to formal religion. It is likely that the positive association of death anxiety and religion in this population is associated with the fact that most Christian denominations have traditionally regarded homosexual behavior as sinful and punishable by God after death. It is important to note that, although for many terminally ill people, religion is a comfort, for others it is anxiety producing.

Fortunately, many religious congregations have become more accepting of gay men and lesbians and have welcomed them, and greater numbers of clergy have declared this message in their communities. The result has been that many now fear death only in terms of having pain and suffering, without the overlay of eternal damnation. In cases where clients are without support from their congregations, it may be useful to refer them to clergy with more open attitudes about HIV disease and homosexuality. Therapists can be proactive in this respect, identifying clergy and congregations who are likely to be supportive. In addition, local AIDS service organizations may have developed specific approaches geared toward educating clergy and congregations about HIV disease, and it may be useful to help clients enlist the help of such organizations.

Finally, it might be effective to explore with clients the differences between religion and spirituality, helping them find alternative ways to express and share their spiritual beliefs and to get the social support that often comes from being part of a religious congregation. If and when clients continue to be troubled, mental health treatment should focus on the more pervasive general anxiety and depression.

Death Anxiety and Family Relationships
A second study found an inverse relationship between death anxiety and somatic integrity among seropositive gay men. It uncovered a positive correlation between death anxiety and HIV progression, perhaps because HIV-infected gay men get less support from family and religious congregations as death approaches. Families who support their children and siblings with HIV disease, particularly those near to death, can do a lot to lessen death anxiety and the shame attached to dying of AIDS.

This study also yielded the highest correlations ever reported in the literature between death anxiety and general anxiety and general depression. On the basis of these findings and the two-factor theory outlined above, it may be appropriate to reduce death anxiety by reducing general anxiety and general depression. Relaxation exercises, the companionship of friends and loved ones (and even pets such as dogs and cats), and calming music


8. Templer DI, Ruff CF, Franks CM. Death Anxiety: Age, sex, and
and surroundings may also be helpful. The support of “buddies” from HIV-related emotional volunteer programs may be particularly useful because they provide unconditional support. Physicians should consider prescribing anti-anxiety drugs, antidepressants, and even sedative drugs to help sleep.

A pioneering study found substantial positive correlations between the death anxiety of high school students and that of their parents, with the same-sex parent-child dyads sharing a greater resemblance than opposite-sex dyads.⁸ The study found even higher correlations between husbands and wives. From this, researchers inferred that death anxiety level is determined, at least in part, by close interpersonal relationships. In light of this finding, and all other things being equal, it might be ideal for therapists who have high death anxiety to avoid long-term or intensive psychotherapy with seropositive clients. Clients may sense this discomfort and be less likely to reduce their death anxiety.

Counseling and Death Anxiety
Death anxiety may be masked by other psychological phenomena, for example, general anxiety, depression, and drug abuse. While it is not appropriate to administer the full Death Anxiety Scale, which is primarily a research tool, therapists might consider employing some of the scale’s questions in the clinical setting: for instance, does the subject of life after death trouble you?; how often does the thought of death enter your mind?; or, does it make you nervous when people talk about death? In addition, therapists should be attentive to the client’s desire to talk or not to talk about death.¹

It is necessary and advantageous to prepare for one’s departure from life, however, it is counterproductive to obsess about it. Signals of death anxiety may include: dreams, nightmares, or preoccupying thoughts of a client’s own death, the death of significant others, or the possibility of terminal illness. Often clients will freely admit to levels of death anxiety that make it difficult for them to function in their everyday lives. Some people give hints, such as those a potentially suicidal person might give, as to their level of death anxiety. For example, they may make a will, give away property, and go through the process of saying “good-byes.”

Even after approaching the subject of death anxiety, many clients will not want to discuss it. It is not necessary to dwell on this topic with a client who does not want to address it; instead, dealing with a client’s presenting complaint may divulge information regarding levels and sources of death anxiety.

The goals of treatment for death anxiety are to help the client become more comfortable about death and more knowledgeable about his or her medical diagnosis and life-threatening illness, and to help the client return to prior levels of functioning. The treatment of death anxiety is in many ways the same as treatment of “general” anxiety, including relaxation and sensitization techniques and medication as needed. Showing a willingness to address the issue and using gentle confrontation, the therapist can help the client to work through anxious feelings about death. In addition, encouraging a client to talk with clergy or other appropriate religious or church leaders about philosophy regarding death, life after death, or other matters may also be appropriate.

Clearinghouse: Anxiety

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Anxiety and Anxiety Disorders
Dan Karasic, MD

To live with HIV disease is to live with uncertainty. It is to live with limits on the ability to control the illness and to acknowledge the unpredictability of T-helper cell counts and viral load levels, of disease progression, of treatment efficacy, of how other people will respond to you; of finances and the ability to work, of the dying process. Under these circumstances, periods of anxiety are normal.

Though, people with HIV disease differ widely in the amount of anxiety they may experience, most people are able to limit the impact of anxiety on the quality of their lives and deal with the stress of living with HIV disease. Only a minority of people—those with anxiety disorders—suffer anxiety of an intensity and duration that causes prolonged impaired functioning. This article defines routine and severe anxiety and suggests psychotherapeutic and pharmacologic approaches for treatment.

Anxiety is a mental and physiological response to a perceived threat. Anxiety states, for example, the separation anxiety of an infant from its parent, are normal aspects of development. Anxiety is also a survival response that guides a person away from danger or spurs actions to overcome the threat. This fight or flight response is an emotional experience accompanied by “autonomic hyperarousal,” including an increase in pulse, blood pressure, respiration rate, and perspiration, that resolves with the passing of the threat. Uncertainty and insufficient control over perceived threats may lead to ongoing anxiety, which lacks the adaptive value of the fight or flight response.

Anxiety and Coping with Stress

One way of conceptualizing the response to stress is in terms of coping style. The predominant strategy an individual uses to cope affects his or her anxiety level.1 Active-behavioral coping—taking direct action to address the stressor—is the most effective coping style in reducing anxiety. Active-cognitive coping—forming a mental framework or strategy to respond to the stressor—is of intermediate effectiveness. Avoidance coping—attempting not to address the stressor, for example, by increasing substance use or isolation—is least effective.

The anxious client can learn to cope more effectively with illness-related stressors, often through brief psychotherapeutic interventions. Studies in cancer patients have shown that changes in coping style are long-lasting and can affect not only anxiety but also the course of illness.2 Structured group therapy has demonstrated efficacy in teaching and encouraging active-behavioral coping techniques.3,4 Among these techniques are: problem-solving and communication skills; and relaxation, for example, progressive muscle relaxation, guided imagery, and self-hypnosis.

Problem-solving and communication skills training give clients the tools that allow them to address stressors more directly. Relaxation techniques foster a sense of internal control over anxiety that

Both brief psychotherapy and structured group therapy can help clients learn to apply active-behavioral coping techniques.


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See also references cited in articles in this issue.
helps prevent anticipatory anxiety, which may inhibit clients from actively addressing stressors. The group format allows members to practice newly learned coping skills through role-playing stressful situations, facilitates learning adaptive skills from other group participants, and helps reduce social isolation which may encourage more active coping.

Treatment of Anxiety Disorders

Anxiety that is so severe and persistent that it significantly impairs daily functioning may be a symptom of an anxiety disorder as defined by the Diagnostic and Statistical Manual (DSM-IV). Commonly diagnosed anxiety disorders include: generalized anxiety disorder, with excessive worry or anxiety for at least six months; adjustment disorder of shorter duration than generalized anxiety and linked to a known stressor; panic disorder, characterized by the sudden onset of severe anxiety, with a fear of losing control or dying; substance-induced anxiety disorder, including alcohol or benzodiazepine withdrawal and amphetamine or cocaine intoxication; and anxiety disorder due to a general medical condition, for example, cardiorespiratory diseases, central neurological conditions, and oxygen deficiency to the brain caused by Pneumocystis carinii pneumonia.

Traumatic events such as learning one’s HIV status, being hospitalized, or the death of one’s partner may elicit symptoms of post-traumatic stress disorder (PTSD). These include: re-experiencing the event through flashbacks or dreams; avoidance and numbing; and increased arousal or feeling “edgy.”

Accurate diagnosis is important since treatment varies from one disorder to another. After establishing a diagnosis, providers should first suggest that clients minimize caffeine and nicotine use. Second, providers should consider cognitive-behavioral therapy, which is particularly effective for panic disorder, or psychodynamic therapy, which is useful for identifying both overt and covert sources of anxiety and responding to maladaptive defenses.

Finally, providers should consider pharmacologic treatment. Benzodiazepines, including lorazepam (Ativan) and clonazepam (Klonopin), are the most commonly prescribed medications for anxiety. Benzodiazepines are relatively safe and work quickly, but may lead to tolerance, abuse, and after discontinuation, rebound anxiety and seizures. They can also cause sedation, confusion, and disinhibition, especially in those with organic brain disease. Because of the way lorazepam is metabolized, it is less likely to interact with other medications. In particular, it is useful for clients taking the protease inhibitor ritonavir (Norvir), which interferes with the metabolism of most other benzodiazepines. Benzodiazepines are particularly helpful for short-term management of anxiety, but should be used with caution among those prone to substance abuse.

Buspirone (Buspar), a safe, non-sedating medication with few side effects, is good for persistent anxiety (but not for panic disorder). Because it does not cause tolerance and addiction, it may be good for substance users. Since antidepressants have a delayed onset, short-term use of benzodiazepines may be necessary. Because ritonavir increases blood levels of antidepressants, dosages should be initially reduced by at least one-half and, with tricyclics, antidepressant blood levels should be monitored to avoid toxicity.

Conclusion

Anxiety is part of living, particularly living with HIV disease. Mental health practitioners can help clients develop the active coping skills that lead to a greater sense of control and reduce anxiety. Persistent anxiety that results in functional impairment signals an anxiety disorder, requiring accurate diagnosis for appropriate pharmacologic and psychotherapeutic treatment. Fortunately, clients with anxiety disorders usually respond well to treatment.

Correction

In “The Riddle of Oral Sex,” the second article in the September 1996 issue of FOCUS, the affiliation of David Ostrow, MD was incorrectly listed in marginal note 2 on page 5. Ostrow is a researcher at the University of Illinois School of Public Health and Medical Director at the Howard Brown Health Center in Chicago.
Anxiety, as measured by a standardized scale, was independent of stage of HIV infection and severity of immune deficiency.
Palliative Care and Quality of Life


Community teams applying a palliative care model significantly decreased anxiety levels among HIV-infected men approaching death. According to this small London study of support team care, pain control also improved significantly throughout care, but efforts to control symptoms were less successful.

Support teams were comprised of nurses, social workers, general practitioners, occupational therapists, and dietitians. Their primary goals were to address symptoms and discomfort, and to provide readily accessible counseling. Researchers measured 17 items related to quality of life among 140 male patients. Ninety-seven percent of the subjects were gay or bisexual, the mean age of the sample was 40 years, and the mean time in care preceding death was 31 weeks 5 days.

At referral, symptom control and anxiety were the most common and severe patient complaints. Over the course of the study, the percentage of subjects who complained of severe anxiety decreased significantly from 33 percent to 13 percent. Team efforts focused on increasing choices about place of care and death by providing support to both patients and their caregivers in the following areas: symptom control; counseling; 24-hour on-call service; bereavement follow-up; formal education and one-on-one advice on diagnosis, nursing, and terminal care needs.

Mood Disorders and Spectrum of Disease


The presence of anxiety and depression as measured by standardized scales was independent of stage of HIV infection and severity of immunodeficiency, and as might be expected, was associated with self-reported affective and psychosocial symptoms. In addition, according to this Australian study of gay and bisexual men, there were no significant differences among people at different stages of infection in terms of the severity, frequency, or duration of cognitive, psychosocial, neurological, constitutional, and affective symptoms.

Researchers interviewed 243 subjects—101 asymptomatic seropositive, 72 with ARC, 34 with AIDS, and 36 seronegative—using the Spielberger State/Trait Anxiety Questionnaire and the CES-D Rating Scale (for depression). Further, they asked respondents to rate the severity, frequency, and duration of 21 non-specific cognitive, psychosocial, neurological, constitutional, and affective symptoms (including perceived depression and mood swings). They derived symptom duration scores (SDS), symptom severity scores (SSS), and symptom frequency scores (SFS) by summing each subject’s duration, severity, and frequency scores for all of the 21 symptoms.

Researchers also measured T-helper cell counts, T-suppressor cell counts, and T-helper/T-suppressor ratios. Researchers excluded from the study people who had been treated with zidovudine (ZDV; AZT) for more than four weeks, potentially biasing the study by omitting those in the most severe stages of HIV disease.

Only the affective symptom factor, including self-reported irritability, depression, and mood swings, significantly predicted both trait anxiety and depression scores. The psychosocial symptom factor, including self-reported fatigue and declines in interest in sexual and social activities, significantly predicted depression scores. However, SDS, SSS, and SFS were generally correlated with both depression and anxiety, suggesting that constitutional and physical symptoms may in part mediate anxiety and depression scores.

Next Month


New this year, FOCUS will review a selection of HIV-related World Wide Web sites, to offer readers ways to navigate the rising waters of the Internet.
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