



Singapore Psychologist

ISSUE 3 | 2020 Q2



ANXIETY

PERFECTIONISM | SOCIAL ANXIETY DISORDER: IS IT JUST SHYNESS? |
PROCRASTINATION: A CONSEQUENCE & DRIVER OF ANXIETY | ATTACHMENT STYLES &
ANXIETY | ANXIETY IN THE TIME OF COVID-19 | PERFORMANCE ANXIETY AND
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ANXIETY

EDITORIAL

Mok Kai Chuen | Editor-in-Chief
Annelise Lai | Deputy Editor-in-Chief
Nicole Chong | Associate Editor
Russell Lee | Associate Editor

DESIGN

Xavierlyn Tan | Lead Designer
Andrea Ong
Jasmine Chia
Ng Yu Xuan
Nicole Yeo

CONTRIBUTORS

Adrian Toh | SRP Chair, SPS
Alexandra Rodrigues
Anutra Guru
Bimali Pandithakoralage
Charmaine Leong
Daniel Chan
Gan Kai Qi
Ivy Ng
Jessy Yong
Juanita Ong
Laura Jonathan
Pansy Pan
Soh Yu Ting
Wong Hern Yee

SPECIAL THANKS

Amerie Baeg
Benjamin Low
Cassandra Neo
Esther Cheng
Hayley Su
Nicola Cann
Sara-Ann Lee
Sarah Lam
Dr. Shawn Ee
Dr. Sunita Rai

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EDITORS' NOTE

We began 2020 like we do every year – with renewed faith and hardened resolve. Yet none of this could have prepared us for one of the worst pandemics in modern history. The onslaught of COVID-19 continues to herald death and cripple our economy. Predictably, we seek to strategize against and transcend this pandemic, but as individuals we understandably feel like we are at the mercy of our own psychology.

We find ourselves more acquainted with the notion of anxiety in these troubled times. Threats, real or perceived, make us fearful, and rightly so. We fear and worry to protect ourselves from danger, so that we may grow and flourish in our human endeavours. Yet oftentimes, our fears become so overwhelming that we begin to anticipate future threats in the form of anxiety.

As we acknowledge anxiety to be evolutionary (i.e. fight-or-flight response) and valuable, we also cannot ignore the very real effects of anxiety disorders, psychosomatic or otherwise. Should we, thus, aim to be ‘fearless’ and rid ourselves completely of anxiety, or must we accept the essentiality of our fears? And therein lies the conundrum of anxiety.

In this issue, we explore the dialectics of anxiety against the backdrop of an ongoing pandemic. To understand anxiety is to first examine its varied presentations (e.g., hypervigilance and avoidant behaviours) and its disorders (e.g., social anxiety, agoraphobia, and selective mutism in children). These we have in plenty.

But as sadness is to depression (see issue #2 on depression), so fear is to anxiety disorders. In an attempt to eliminate any negative effects arisen from fear or sadness, we must not forget that these very emotions are what make us uniquely human. When does vigilance become hyper vigilance? How do we differentiate a healthy dose of caution from avoidance?

Perhaps now more than ever, we must examine the nuances of anxiety and re-evaluate our preconceived notions of anxiety as we transition to a new normal.

Read on and get psyched!

Mok Kai Chuen
Editor-in-Chief
SPS Publicity Chair

Annelise Lai Ke Yin
Deputy Editor-in-Chief
SPS Deputy Publicity Chair

PRESIDENT'S ADDRESS

Every moment is a fresh beginning - T. S. Eliot

If everyone saw things in this manner, what would our world be like? Would there be a place for fear, worries, and concerns - more commonly known as *Anxiety*? As 2019 drew to a close, we were hit by a virus that initially seemed distant. Fast forward a few months, the world was presented with a pandemic on a scale that we had never experienced before. *Anxiety* became the next buzzword. We saw people frantically buying things, hoarding supplies, and selling items at exorbitant prices. Lockdowns occurred across the world and many people were plunged into a state of constant fear and worry. A mental health pandemic was also brewing and Singapore was not spared.

In the last few months, we find ourselves in a heightened state of awareness and vigilance. In the wider community, wearing masks and gloves, signing off emails with "stay safe", and working from home have become our new normal. As psychologists, we too have had to deal with anxieties in the form of telehealth services, reduced session frequencies, and rigid safe distancing rules (e.g., 1m distance, restrictions on group therapy)—things we may not have considered in the past. Ironically, this very feeling of anxiety that restricts us is the same feeling that keeps us safe and protected during these troubled times. Anxiety, a double-edged sword.

As our society continues to grapple with this feeling, it is important that we as psychologists keep informed of the impact that anxiety has on ourselves, our clients, and the wider community. Singapore Psychological Society recognises the importance of bringing material that is relevant and timely. Hence, this issue focuses on all aspects of anxiety, ranging from clinical disorders to more general, everyday experiences. We recognise the importance of contributions from both a public and professional standpoint and as a reader, we hope that some (if not most) of these articles connect at a level that is relevant and helpful to you.

As Brené Brown once said, "Cultivate calm and stillness, let go of anxiety as a lifestyle". As *One Psych Community*, let us continue to support each other through these troubled times and stand united in our quest to help each other cultivate this new "lifestyle". May this issue of *Singapore Psychologist* shed light and bring renewed vigour in the work ahead.



A handwritten signature in black ink, which appears to be 'Cherie Chan'. The signature is stylized and fluid.

Dr. Cherie Chan
President, SPS



Anxiety and its Remedies

Benjamin Low

Anxiety is a word that connotes dread, stress, fear, and frantic attempts to cope with it. But what is anxiety and how is it different from other similar types of distress? This article clarifies the concept of anxiety, its (dis)utility, and what we can do about it. We'll see that anxiety can be an ally if we respond to it constructively.

Stress, Anxiety, Fear and their Benefits

Anxiety can be characterised along a continuum of intensity with stress and fear. Stress is an aversive feeling when our coping resources are taxed or insufficient (Butow, 2014). This emotional state is often paired with physiological changes that prepare our body to respond to a threat. These often include rapid breathing, muscle tension, sensations of a racing heartbeat, sweaty palms, and feeling heated up. Less commonly, the stress can disrupt biological processes and lead to other physical conditions (e.g., irritable bowel syndrome, headache disorders) (Nicholson et al., 2007; Weinland & Drossman, 2013). The physical symptoms are part of our fight-freeze-flight response to perceived threats. In short, stress is an emotional and physical reaction that occurs when we feel stretched.

No one likes to feel stressed. However, stress tends to encourage us to address its cause. Let's use a hypothetical person, executive David, as an example. David has a tough day ahead and thinks, "OK, I have got 3 meetings today. It will need 110% effort. I will need to finalise the revenue figures for the 10am meeting, grab a quick lunch, then present our new software to prospective clients at the next two meetings before fetching the kids from school. I can do this. Focus dude, focus." We can see how David feels stretched and his thoughts are task-oriented, but he endeavours to stay calm and productive. This is a 'fight' response. Indeed, we may go as far as to say that it will not be as helpful if he was not stressed and approached these important tasks with a calm nonchalance instead. However, prolonged or uncontrollable stress will probably make one avoid the stressor instead. That is, 'flight' becomes the main desired response.



Anxiety comes about when we feel that our coping resources may not address the situation. It is more distressing than stress and the same physical symptoms are often intensified. The person still tries to address the cause of the anxiety but his thoughts focus on anticipated negative outcomes. The ponderance of potential negative outcomes is known as worry (Borkovec, et al., 1983). Worries tend to be rapid and feel like they are ‘racing’ through our minds.

An anxious and worried David might be thinking, “What if the revenue figures are in error? I think I should check them again. The software is still new... what if bugs occur during the demonstration? How are we going to convince the customer that we can fix it? Could I ask the IT support team to join these meetings? That’s what they’re paid for right? I’ll give them a piece of my mind if they refuse!” The worries are still encouraging David to approach his tasks, but he now thinks about various negative outcomes that may not actually occur.

Anxiety and worry propel us to plan for contingencies (Borkovec et al., 1983; Butow, 2014). They also motivate safety-seeking behaviours like answer-seeking, checking, or trying to control people and events. As with stress, prolonged or uncontrollable anxiety may lead us to avoid the anxiety-provoking situation altogether. Unconstructive avoidance (e.g., procrastination) or safety behaviours (e.g., controlling others through intimidation) can lead to regrettable consequences.

The experience of fear is qualitatively different from stress or anxiety (Sylvers et al., 2011). The emotional distress and physical symptoms of fear are quite intense. Attention is fixated on the threat in the here-and-now. Fear also motivates avoidance behaviours rather than attempts to resolve the threat. There is no more “What if...?” going through our heads. Thoughts are typically absent or brief (e.g. “Please no”, “Run”). Instead, there is a strong desire to find safety by avoiding and withdrawing from the fear-inducing object or situation.

In terms of the fight-freeze-flight response, fear tends to produce 'freeze' or 'flight' reactions and the 'fight' may only occur when the freeze/flight option becomes impossible (McEvoy et al., 2014). This is readily observed in someone who is deathly afraid of flying cockroaches. They will freeze up in fear or frantically try to run away. If cornered, they will try to kill it as a last resort. A similar fear response would be helpful if you faced a knife-wielding assailant. Running away is safer than thinking about solutions. Your thoughts may not be as fast as the knife, but you will naturally feel like defending yourself if you can't run away.

When Anxiety Hurts

Anxiety can sometimes be counterproductive if it is inaccurate. Accuracy refers to whether the anxiety reflects a 'true alarm' or 'false alarm'. A true alarm means that the anxiety and its intensity is proportionate to an actual threat. A false alarm means that the presence or intensity of anxiety is disproportionate to a threat.

A true alarm is often helpful, whereas a false alarm is, at best, an unnecessarily distressing experience or, at worst, motivates responses that worsen the situation. For example, a person who wants more friends but is unduly anxious about rejection may then avoid social gatherings and miss opportunities to forge the friendships they desire.



Anxiety is considered 'disordered' when it causes significant distress or impairs a person's ability to function in social, occupational, or other important areas of life. This includes 'true alarms' that induce intolerable levels of anxiety. It does not mean that the anxious person is 'crazy'. Anxiety also tends to occur in common patterns, leading to the classification of various anxiety disorders. Some examples are listed below.



Social Anxiety Disorder (Social Phobia)	Generalised Anxiety Disorder	Illness Anxiety Disorder
<p>Marked fear or anxiety about one or more social situations in which the individual is exposed to possible scrutiny by others.</p>	<p>Excessive anxiety and worry occurring more days than not, about a number of events or activities.</p>	<p>Preoccupation with having or acquiring a serious illness.</p>
<p>The individual fears acting in a certain manner or showing anxiety symptoms will be negatively evaluated.</p>	<p>The individual finds it difficult to control the worry.</p>	<p>Physical health symptoms are not present or are only mild in intensity.</p>
<p>The social situations almost always provoke fear or anxiety.</p>	<p>The anxiety and worry are associated with some of the following six symptoms (with at least some symptoms having been present for more days than not):</p>	<p>If another medical condition is present or there is a high risk of developing a medical condition, the preoccupation is clearly disproportionate.</p>
<p>The social situations are avoided or endured with intense fear or anxiety.</p>	<ul style="list-style-type: none"> • Restlessness or feeling keyed up or on edge. • Being easily fatigued. • Difficulty concentrating or mind going blank. • Irritability. • Muscle tension. • Sleep disturbance (difficulty falling or staying asleep, or restless, unsatisfying sleep). 	<p>There is a high level of anxiety about health, and the individual is easily alarmed about personal health status.</p>
<p>The individual performs excessive health-related behaviours (e.g., repeatedly checks his or her body for signs of illness) or exhibits maladaptive avoidance (e.g., avoids doctor appointments and hospitals).</p>		
<p>The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.</p>		
<p>The symptoms are not better explained by another mental disorder or medical condition.</p>		

Adapted from the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition



Treatment does not focus on treating a ‘textbook description’ of the person. Instead, it focuses on whether the person is coping well or needs assistance promptly. This is especially true if the anxiety produces other effects like irritability, sleep problems, low mood, or self-harm that makes life harder for the person.

Disordered anxiety is a reaction rather than a choice. No one wants unpleasant emotions. Instead, the emotions find us. Let’s take illness anxiety as an example. The anxiety may seem incomprehensible to many people, but those who have undergone multiple sudden and serious illnesses like strokes, heart attacks, and so on may understandably worry the moment physical sensations arise. These may include familiar sensations, such as what they experienced before a heart attack (e.g., chest pain), or new but unpleasant ones. The anxious “What ifs...?” become understandable in the context of their medical history. The resultant illness anxiety is not a choice, but an implicitly learnt and generalised ‘rule of thumb’ that physical sensations are portents of grave danger.

Self-Help Coping Methods from Evidence-Based Therapies

There are many effective medications and psychotherapies for anxiety. Medication (McEvoy et al., 2014) tends to work faster but may have side effects, complicate existing health issues, or interact with other medications. The anxiety may also return once medication is halted. Self-medication is a bad idea and medication should only be consumed in consultation with your General Practitioner or a Psychiatrist (a medical doctor that specialises in mental health). It is possible to pair medication with psychotherapy and gain the benefits of both.

Psychotherapies for anxiety do not have side effects but require some effort to analyse and relearn the thinking patterns that produce the anxiety. Psychotherapy can be provided by certain types of practicing psychologists (e.g., clinical or counselling psychologists) and the benefits tend to be long-lasting. For present purposes, we will focus on two psychotherapeutic coping strategies that can bring short-term relief without the need for professional assistance.

Anxiety can be an ally if we respond to it constructively.

The first is drawn from the behavioural side of **Cognitive-Behavioural Therapy (CBT)**. Recalling that anxiety is both an emotional and physiological reaction, research has found that calming the body also calms the mind (Jerath et al., 2015). One simple way of doing so is controlled deep breathing. In short, extend your inhalation, hold your breath for a short while, then extend the exhale. Done right, the mind and body begins to relax after a few minutes. You can first learn this for free through an app called *Calm*.

Acceptance and Commitment Therapy (Luoma et al., 2007) also contains a mindfulness exercise that can help us cope better. There are times when we cannot control things (at least not immediately). These culminate in worries that inadvertently pop into our heads. We often 'talk back' to these worries and entertain their hypothetical scenarios. This process occurs naturally but often fosters a vicious cycle of negative thoughts that makes us feel worse while the situation remains unchanged.

Mindfulness helps us disengage from this vicious cycle by simply letting thoughts pass. This is best learned through practice and an app called *Headspace* can help you with that. It also provides animations that explain mindfulness rather well. Simply look for the free 10-session mindfulness feature.

Mindfulness can have unpleasant effects for individuals with post-traumatic stress disorder (PTSD), bipolar disorder, or psychoses, among other things (van Dam et al., 2018). If you know or suspect that you have these, please use deep breathing instead. If you are seeing a professional, please consult them instead.

When Should I Seek Professional Help?

You should seek professional help if you experience anxiety that is intense, repetitive, hard to manage, linked to unresolved past or ongoing issues, or interferes with daily life. It's natural to feel that we want to avoid situations where we talk about our anxiety. A minority of individuals may naturally get better due to chance events in their lives. Unfortunately, long-term avoidance usually entrenches the problem instead.

The author and Singapore Psychological Society are not associated with the apps listed above. There are no financial conflicts of interest.

Understanding Anxiety from Culturally Diverse Perspectives

Nicola Cann



It is widely acknowledged that culture influences how people experience and express emotional distress, and how they seek help. This has implications for assessment, diagnosis, and intervention (APA, 2013). As a diverse, multicultural city state, this is of particular relevance to us here in Singapore. As an educational psychologist, my particular interest is in how anxiety manifests in children and young people, and how we can understand the influence of culture in the prevalence and expression of anxiety in order to best serve the communities in which we live and work.

What is Culture?

Psychological research is moving beyond frameworks which consider individuals as independent from their social and cultural environments (Bodas & Ollendick, 2005). A more contextualised approach recognises that individuals function within their cultural context, and that culture is dynamic and continuously evolving (Schwartz, 2010). In the past, culture was largely equated to ethnicity, but we now recognise culture as multifaceted, contributing to our individual and societal identities, values and behaviours. This is both exciting and daunting for the psychological community, who seek to understand human behaviour in an ever-changing context.

What is Anxiety?

Whilst we probably all have some personal experience of anxiety, popular conceptualisations are problematic because they often assume that anxiety is a universal construct. Cross-cultural research suggests otherwise (Bodas & Ollendick, 2005), with people from some cultures tending to report significantly higher levels of anxiety than others (e.g. Li et al., 2008), and prevalence rates varying widely across countries.

Cross-cultural prevalence rates also vary relative to how socially acceptable anxiety-related behaviours are. In Japanese culture, for example, levels of social anxiety which would be considered excessive in Western cultures may in fact be socially adaptive within the Japanese culture because they are the social norm for that culture (Essau et al., 2011). With models of anxiety largely having been derived from European populations, they may not be applicable to other cultural groups, where there is evidence of varying conceptualisations of mental health. For example, whilst Western conceptualisations of anxiety focus primarily on psychological factors, some cultures focus on physical symptoms of distress (like headaches), and still others embed their understanding of distress within religious frameworks (Parker et al., 2001). So if anxiety is a less universal construct than initially thought, the implication is that as psychologists seeking to help, we must let go of such narrow definitions and seek to understand anxiety in a more personalised way.

Social Referencing

We cannot truly understand anxiety without considering the way we adapt our behaviour based on our social reference points. For example, parents (and presumably also teachers and peers) can inadvertently reinforce anxious behaviours in their children by modelling anxiety and giving greater attention to anxious behaviours their children demonstrate (Ollendick et al., 2001). Child-rearing and educational practices are culture-dependent, and will impact child development in complex and dynamic ways (Weisz, 1989). What is apparent is that stress increases when individuals experience conflicting cultural values. For example, where there is discontinuity between family and school values, children are more likely to experience stress and anxiety, and this needs to be understood by psychologists and educators.

The Importance of Cultural Identity

Research suggests that people are more likely to experience anxiety when there are challenges to their cultural identity, and with a high proportion of our population having emigrated to Singapore it is useful to explore the research on acculturation (for a review see Chun et al., 2003). Acculturation is the change that takes place to one's own culture as a result of contact with culturally dissimilar people, and whilst acculturation can enhance psychological wellbeing and reduce anxiety (Schwartz et al., 2010), it can also raise challenges that have been linked to increases in anxiety (Williams & Berry, 1991). Some of these challenges include conflicts around ethnic identity, shifts in religious practices, and acquiring a new language.



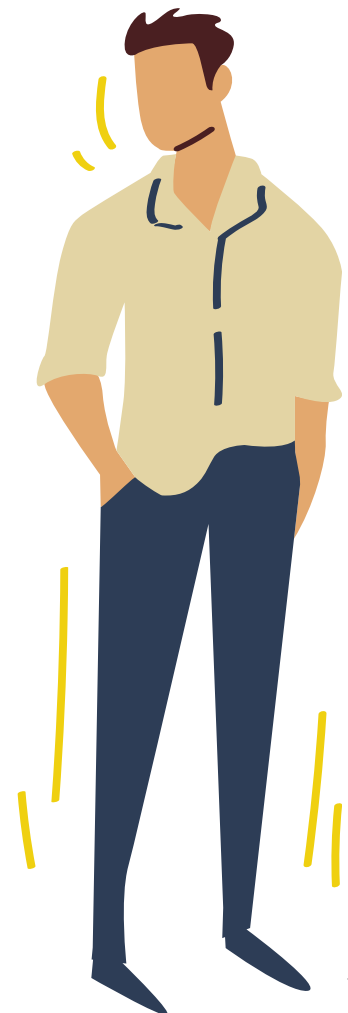
Despite these challenges, acculturation provides opportunities to integrate new and existing cultural values, and the development of a 'bicultural identity' has been associated with lower rates of anxiety (Smokowski et al., 2010). Clearly there is a role for psychologists in facilitating this transition, whether that is by providing therapy which helps clients to assimilate new cultural values into their existing ones, or by connecting people with community members to help them embed themselves in the new culture. Perhaps more exciting is the prospect of psychologists helping to establish and maintain communities in which cultural diversity is celebrated. Within my own work, I have been involved in advising schools on inclusive practices and meeting the needs of culturally diverse student populations.

Intervention Planning in a Multicultural Context

Much of the existing literature on intervention planning for anxiety either laments the low uptake from minority cultural groups (Leibowitz, 2010), or considers ways to adapt existing intervention approaches to meet the needs of different cultures (Hall, 2001). Given the research reviewed above I wish to propose an alternative approach. I believe that if interventions are to be truly effective they must focus on meeting the client's needs by seeking to understand their cultural identity, and considering them within their community and cultural context. Taking a more collaborative approach to supporting families and communities enables us to be more responsive (Quach et al., 2015), but does require a leap of faith. Moving away from pre-determined approaches towards something co-created and person-centred can be scary but also liberating, exciting, and ultimately very rewarding.

Conclusion

Learning about the cultures of the people I work with brings a depth and richness to my work. But regardless of how many research papers I read, or seminars I attend, the findings described above suggest that both anxiety and culture are multifaceted aspects of human life which are very personally experienced. As psychologists, I believe we have a responsibility to understand the complex relationships between culture and anxiety, but we cannot hope to understand the impact on individuals or communities without taking a collaborative approach. There is a need to balance evidence-based practice with more person-centred approaches. We need to be creative in developing interventions that meet the needs of the communities we serve, rather than falling into the trap of simply adapting what we're already doing. This approach can provide exciting opportunities for us individually and for the profession of psychology.



Performance Anxiety and Imagining Your Audience Naked

Daniel Chan



I'm sure most of us have heard of this age-old adage, but have you ever wondered who may have coined it? As the story goes, it was Sir Winston Churchill who first mentioned using this peculiar technique as a way of overcoming his fear of public speaking. That's right, the man widely regarded as the greatest orator of the 20th century was so terrified of audiences, he resorted to visualising them in their birthday suits. This fear of public speaking is just one example of a psychological phenomenon known as Performance Anxiety.

What exactly is Performance Anxiety?

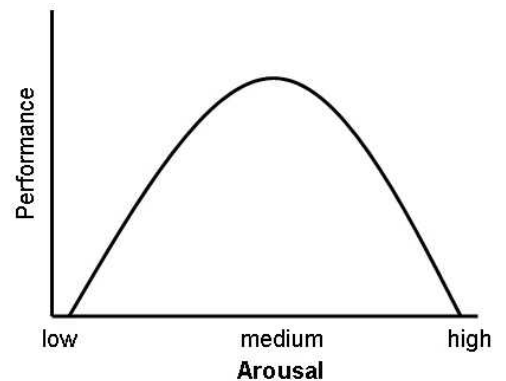
Under the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), Performance Anxiety is a specifier of Social Anxiety Disorder (SAD; American Psychiatric Association, 2013). This means that an individual diagnosed with Performance Anxiety would experience symptoms identical to that of SAD, but only when faced with situations that require speaking or performing in front of an audience. As such, clinical cases of this anxiety are mostly common among individuals who perform for a living (e.g. musicians, dancers, athletes). However, milder forms of Performance Anxiety are likely to be experienced by virtually anyone on a day-to-day basis. Giving a presentation at work to your boss, preparing for a big job interview, or taking a major examination are just a few common examples where such anxiety arises.

You may be wondering: Isn't everyone nervous before such events? What's the big deal? Well, a person may be suffering from a clinical case of Performance Anxiety if the experienced fear is out-of-proportion to the situation at hand, is detrimentally impacting one's life (particularly professionally), or if it causes an avoidance of the situation altogether. Beyond these, physiological symptoms of Performance Anxiety can also be severe. The list includes a rapid heart rate, hyperventilation, sweating, trembling, nausea, dry mouth, vision changes, and even full-blown panic attacks.

Thus, left unmanaged, Performance Anxiety has the potential to spiral into a debilitating condition. In a study conducted on professional musicians, one out of every three indicated that their Performance Anxiety was a severe problem (Fernholz et al., 2019). Closer to home, there have been numerous news articles highlighting the issue among Singaporean schoolchildren, pointing to an Organisation for Economic Cooperation and Development (OECD) study which highlighted alarmingly high levels of Performance Anxiety among our students (Davie, 2017).

How does anxiety impact performance?

Research has shown that when we're faced with a demanding situation, the relationship between arousal and performance is observed to be an inverted-U (Teigen, 1994). This is known as the Yerkes-Dodson Law. It makes intuitive sense. Most of us would agree that we find some level of anxiety necessary to perform at our best, but too much or too little would lead to less than ideal results. But why exactly does a high level of anxiety, such as in the case of Performance Anxiety, lead to a decrease in performance?



One well-supported theory is threat-interference (Angelidis, Solis, Lautenbach, van der Does & Putman, 2019). Think of your brain as a computer, with limited resources available to carry out processes such as attention, memory and executive functions. When we experience high levels of anxiety, resources are diverted so that one becomes hypervigilant and worry about perceived threats. Hence, anxiety "interferes" with our ability to perform by depleting the cognitive resources we need to be at our best.



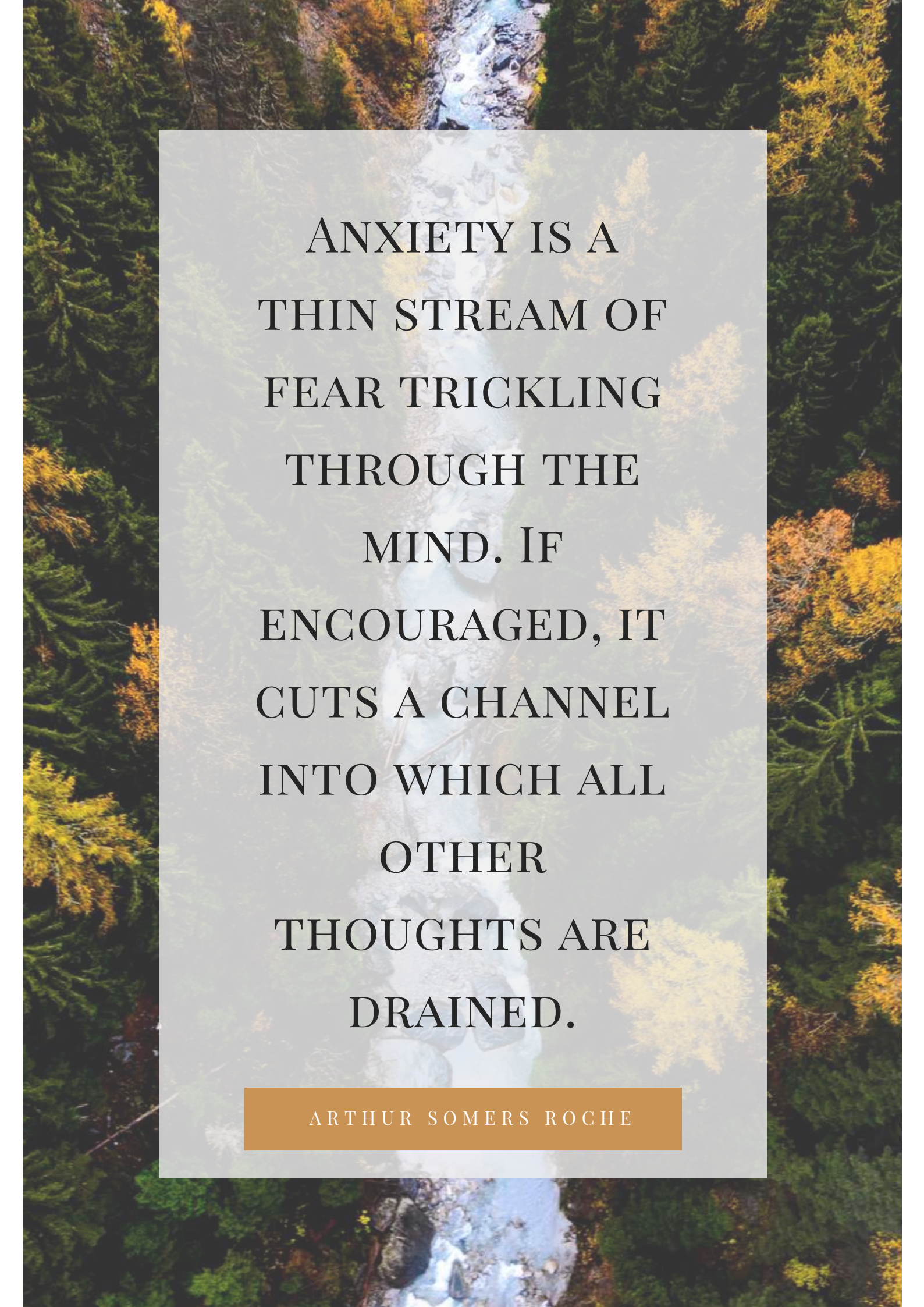


So, what can I do about Performance Anxiety?

As with all other psychological conditions, it is important that individuals seek professional help, especially if experiencing more severe symptoms of Performance Anxiety.

Psychological therapies such as cognitive-behavioural therapy, exposure therapy, and hypnotherapy have helped many manage their anxiety and boost their performance. In addition, medication, such as beta-blockers, is also available and may be helpful in achieving this goal. On a more practical note, here are some psychology-backed tips to try out the next time you're faced with an audience instead of visualising your classmates or co-workers au naturel.

- **Reframe “anxiety” as “excitement”, rather than trying to “calm down”.** Telling yourself that there is no reason to be anxious in an effort to remain calm does little to reduce anxiety. Instead, tap into your heightened arousal by reframing it as excitement by declaring a simple self-statement such as “I am excited!” before the big performance. A Harvard study (Brooks, 2014) found that participants who did so performed better in various anxiety-inducing situations.
- **Remind yourself that Performance Anxiety is NOT an indication of a lack of ability.** While a lack of ability would undoubtedly heighten anxiety, it is important to remember that this does not mean performance anxiety is simply a proxy for low levels of ability. Research has shown that performance anxiety is a psychological phenomenon that can impact anyone regardless of their level of ability (Bellock, Schaeffer & Rozek, 2017). So if you've put in the necessary preparations, know that your level of anxiety is not a signal that you lack the ability to perform well!
- **Use the “Realistic Appraisal” strategy while holding a positive view of the audience.** Go into the performance acknowledging that mistakes are bound to be made and that the audience will be understanding and forgiving of any such slips. This has been found to be the most adaptive coping strategy for Performance Anxiety (Steptoe & Fidler, 1987).
- **Practice deep breathing and self-regulation techniques.** Deep breathing is a fast way of triggering your body's parasympathetic arousal (also known as the relaxation response), and is advocated by various studies as well as professional performers (Roland, 1994; Huang, 2011).
- **Psychologically prepare yourself for the big day using principles from Exposure Therapy.** For example, vividly imagining your performance beforehand, in combination with breathing/relaxation exercises, can help to condition yourself to associate the anxiety-provoking situation with relaxation. Gradual exposure to the feared situation, starting with only mildly difficult exposures such as performing in front of a friend, will also help you perform at your best when the day comes.

An aerial photograph of a river flowing through a dense forest. The river is the central focus, winding through the trees. The foliage shows signs of autumn, with some trees having turned yellow and orange, while others remain green. The overall scene is serene and natural.

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ARTHUR SOMERS ROCHE



Social Anxiety and Shyness: When does it become a Disorder?

Adrian Toh

Social relationships are a source of joy and support, but for many, they also become a source of stress. Many people experience a sense of heightened anxiety in different or specific social situations, and that anxiety can become severe enough to limit their personal growth, keep them from professional opportunities, and eventually isolate them.

Before we dive further into understanding social anxiety disorder (SAD), it is worth separating shyness from SAD. Both involve a sense of bashfulness in social situations, but in the case of SAD, the intensity of the fear and the degree of avoidance are much higher. A shy person is usually still able to engage with others and participate in social situations despite being worried. However, a person with SAD may feel generally very anxious in social situations or have specific situations in which the anxiety becomes overwhelming. The difference between shyness and SAD lies in how much it limits the person's life and how distressing it is.

Like other emotions, shyness is acknowledged as a normal and universal characteristic that many people experience, and it can be observed to be on a continuum. Apart from genetic explanations, literature also informs that shyness has been associated with various environmental factors, including cultural differences, parental or peer rejection, and parental overprotection leading to lack of self-efficacy, as well as having specific conditioning events such as being teased and shamed in front of others or observing others being humiliated. Performance failures, traumatic events, emotional and physical abuse or neglect also contribute to shyness.

SAD has a lifetime prevalence of 4% across the world. It is especially common in the USA and other high-income countries. It tends to appear more among younger groups but can persist throughout an individual's life. Along with other anxiety disorders, this is one of the most common mental health problems worldwide.



SAD is characterised by trouble with a wide range of social situations, such as public speaking, talking to strangers, going to work, interacting with friends, and eating in public. People with SAD may struggle with ordinary tasks too, such as making an appointment on the phone or approaching a salesperson. They tend to experience overwhelming fear and dread of being judged, mocked, humiliated, or simply being in the spotlight.

This fear is disruptive and may occur with physical symptoms of anxiety (e.g., elevated heart rate or stomachache). Consequently, SAD can lead to an avoidance of any social situation that makes the individual anxious.

This, in turn, can significantly limit their social life, professional growth, and leisure. People with SAD have great difficulty, for example, going out to a party or making new friends even though they want to.

SAD is characterised by trouble with a wide range of social situations, such as public speaking, talking to strangers, going to work, interacting with friends, and eating in public.



Children with social anxiety can struggle to make friends and engage in group activities. For adolescents, this can potentially become an even bigger issue as they begin to form their sense of identity within society. Many adolescents find that they want to be more outgoing but their anxiety holds them back. For young adults, social anxiety can be a professional setback, as it may prevent them from networking or taking chances that are necessary. For all three groups, SAD can interfere with social interactions, as well as their academic and professional life.

The first-line treatment for SAD is cognitive-behavioural therapy (CBT). CBT works with the core idea behind SAD – the belief that one will be judged negatively – and with the unhelpful behaviours (e.g. avoidance of social situations). A common model that is used to direct the treatment is Clark and Wells' cognitive model of social anxiety. Clark and Wells state that individuals with SAD are more likely to view social situations as a threat to themselves.

This happens because they hold specific biases about these situations. For example, people with SAD may have excessively high standards for social relationships and interactions. These standards are so high that they do not think they can meet them, causing undue anxiety. The authors also suggest that people may not adequately process what is happening in the social situation, which keeps the negative thoughts going. As a result, they use their mistaken impressions as evidence that others are judging them. By addressing these underlying notions of SAD, it is indeed possible to help patients with SAD correct these biases.

Early treatment can be very successful and it may prevent the development of other psychological disorders stemming from social anxiety. It also allows SAD sufferers to function better at school, at work, and in their social lives.

Social Anxiety Disorder: Is it just Shyness?

Nicole Chong



Sally is a soft-spoken 27-year-old female who has always struggled with making friends. Being around other people made her feel extremely distressed and anxious. Social interactions often brought on a flurry of furious blushes and clammy hands, and she was convinced that everyone must be scrutinising her every micromovement. Sally endured them the way she did with her wisdom tooth extractions: her heart rate would rocket and breaths would quicken, while wave after wave of dread washed over her. In her mind her mantra “this too shall pass” would play on repeat. After finally managing to shake them off, she would run into the nearest toilet cubicle and burst into tears.

Sally has social anxiety disorder (SAD) and the experience above is a common occurrence for her during most social situations. As social beings, humans often enjoy (or at least tolerate) the presence of others. However, for people with SAD, social interactions are usually entwined with feelings of fear, trepidation and panic. SAD has a lifetime prevalence estimate of 4% worldwide (Stein et al., 2017) and its common age of onset is during childhood and adolescence (Jefferson, 2001). Its core characteristics include extreme fear and apprehension during social interactions, and as a result, people with SAD may behave in a way that will embarrass themselves (Tei et al., 2020). While fear of social interactions is its most common characteristic, some individuals with SAD may also feel anxious about eating in front of others or walking into a room full of people (Leigh & Clark, 2018). SAD has detrimental impacts on an individual's general functioning, and is associated with low self-esteem, negative cognitions, and impaired social skills. It is also associated with an increased risk of depression (Ratnani et al., 2017).

Commonly mistaken for a harmless personality trait or temperament, SAD differs from shyness in the extent of distress a person feels (Jefferson, 2001). If Sally were just shy rather than socially anxious, she may feel uncomfortable during social interactions, but her level of anxiety would gradually reduce to a tolerable state. An individual with a shy temperament may be completely at ease with basking in the company and familiar chatter of the people around them. However, individuals with social anxiety find the social situation “intolerable” from start to end (Yip, n.d.). They also tend to catastrophise and engage in negative rumination after the social encounter (Hofmann, 2007), and conclude that they will never be able to socialise effectively.



An individual with SAD holds a negative appraisal of their social competence and may be hypersensitive to the verbal and non-verbal cues of others. Known as interpretation bias, people with SAD are more likely to perceive ambiguous reactions from others negatively (Amir, Beard & Bower, 2005), which would confirm their initial perception of their poor social skills.

Moreover, during social situations, most of their attention is focused inwards, on how they feel, and what they perceive others think of them. This leaves little attentional capacity to truly listen to and socialise with others. They may appear to be uninvolved or disinterested in the conversation, either due to a lack of attention paid or fear of speaking up. This would then cause others to feel as if the individual does not enjoy their company, which would discourage them from wanting to spend more time with the individual. When the individual realises this, it reinforces their view of their inability to make friends or pull their weight in social situations.

Similar to other types of anxiety disorders, such fears often escape rational thought. Adults with social anxiety recognise that their fears are often irrational and unfounded (Higuera, 2018). However, all of us have an innate fight-flight system (Steimer, 2002) that kicks in when we face a perceived threat. For example, when we see a tiger in front of us, our fight-flight system activates and we can either choose fight (take the tiger head on) or flight (flee from the tiger). The activation of this system fills our bodies with adrenaline and leaves little mental capacity for logical thought. All of our body's resources unite in a devoted and concerted effort to help us survive.

For individuals with SAD, social situations are perceived as a threat. Therefore when their fight-flight system is activated, their minds become preoccupied with the desire to flee this threat, yet it is learned social conventions that prevent them from doing so, out of a fear of offending the other party. Therefore this compromises their ability to focus on the conversation at hand. Despite this, individuals with SAD do have a desire to form close bonds with others but are convinced that they do not have the ability to do so, which contributes to feelings of inadequacy and loneliness (Maes et al., 2019).

While SAD is debilitating, it is important for us to remember that social anxiety is an actual and treatable disorder, and is by no means a personality flaw. Hopefully a greater awareness of this disorder would encourage us to be more patient with those who may seem resistant to our efforts in befriending them. As with all other types of mental disorders, it would be good if our society learns to be more attuned to the invisible battles that some people wrestle with daily.

Attachment Styles and Their Impact on Anxiety and Relationships

Laura Jonathan

The type of attachment formed between a child and their parents is a crucial factor that can impact an individual's self esteem, social functioning and relationships as an adult. The attachment style between a child and their caregivers shapes the patterns of emotional regulation and coping techniques which in turn, directs the way they see the world, manage challenges and develop relationships.

Studies have found that children who had poorer attachment styles with their parents often have difficulties in their social and intimate relationships as an adult.

Additionally, a history of emotional neglect and unmet needs is associated with anxiety disorders later in life including generalized anxiety disorder and social anxiety (APA, 2013).

What are attachment styles?

The attachment theory developed by psychologist John Bowlby (1980) proposes that a child's attachment to their parents and whether their needs are being met will influence the nature of that child's relationships with others as an adult as well as how the individual perceives themselves.



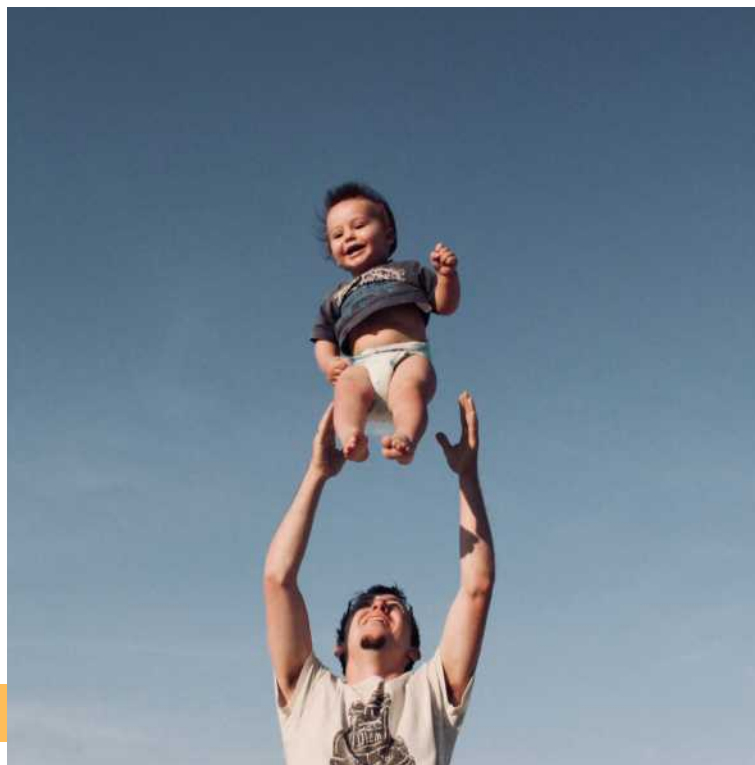
Attachment styles play an important role in emotional regulation and managing distressing situations. When a distressing event occurs, a child looks to an attachment figure for comfort and reassurance. If achieved, the child's fears are alleviated and replaced with a sense of calm. This increases the child's confidence that attachment figures are reliable when needed and they start to develop a sense of resilience to manage emotional and social situations. Conversely, when a child's attachment figures are dismissive, the individual becomes insecure about the support of others and will find other maladaptive ways of dealing with distress.

There are four main attachment styles that a person can have: secure (50% of population), anxious (20% of population), avoidant (25% of population) and anxious-avoidant (5% of population) (Lancer, 2018).

How do attachment styles impact on anxiety and relationships?

A secure attachment style generally leads to more positive and healthy outcomes, with individuals being less susceptible to exhibiting anxiety symptoms and having difficulties in relationships. On the other hand, children who have the other three attachment styles (anxious, avoidant and anxious-avoidant) are more vulnerable to experiencing anxiety symptoms and poor functioning in relationships as adults.

A secure attachment is formed when a child's needs are met regularly and consistent affection is shown. As an adult, the individual would generally have a healthy self-esteem and be able to be independent. When faced with challenges, the individual can manage better and is more willing and able to accept rejection. In relationships, the individual is better able to trust others easily, communicate their needs, feelings and affection, set healthy boundaries and enjoy satisfying relationships with others.



An anxious attachment is formed when a child's needs are not met regularly and consistently (e.g. when a child is held only occasionally). When a child's caregivers are not consistent with their love and guidance, it is understandable that the child adopts a perception of not being good enough and starts to see the self as unworthy or ineffective. As an adult, the individual is likely to exhibit anxiety symptoms which includes a lower self-esteem, needing constant reassurance from friends and their partner and may also form unhealthy or abusive relationships due to a lack of boundaries. For some, in order to achieve unmet needs of intimacy and approval, they may use their body or sex to seek closeness with others. The individual is also more likely to have difficulty trusting others and worrying that others might abandon them, which can lead to panic attacks. The individual may continue to struggle with a negative self-perception, dismiss positive experiences and feel insecure in their decision-making.



An avoidant attachment is formed when some of the child's needs are met at times while other needs are neglected (e.g. when a child is fed but is not soothed when crying). When a child's caregivers are rejecting to some of the child's needs, it is understandable that the child adopts a perception of others being unreliable and untrustworthy. As an adult, the individual is likely to exhibit anxiety symptoms which includes a sense of emotional independence and avoidance in trusting or turning to friends for emotional support. The suppression of feelings, avoidance of social support and fear of commitment perpetuates the anxiety symptoms and deters the development of close relationships.

An anxious-avoidant attachment is rare and formed when a child's needs are not met or when the child is exposed to abuse or is neglected over long periods of time. When a child experiences neglect or abuse, the child does not adopt the ability to cope with distress, has an insecure self-perception and perceives others as unreliable and potentially abusive. As an adult, the individual is likely to exhibit more severe anxiety symptoms such as having difficulty fitting in and expressing feelings clearly, and they may have dysfunctional and abusive relationships with others. Due to difficulties in communicating emotions clearly, there can be a lot of distrust and walls may be built with anyone who tries to get close. In reality, the individual may feel lonely and like an outcast and can start to develop social anxiety symptoms. Due to the lack of learning healthier responses to distress, they may turn to substance abuse or other impulsive behaviours as a means of coping which perpetuates the anxiety cycle.

What are some coping techniques to practice on?

While it is impossible to change the attachment style developed in childhood, individuals with anxiety-related symptoms or having social difficulties are encouraged to work alongside a therapist to modify some of their cognitive or behavioural patterns to increase their capacity to form healthy attachments. In the meantime, here are some techniques which you may wish to practice on your own.



Tips for Parents

1. Understand and pay attention to your child according to his/her developmental needs.
2. Respond consistently to your child's needs in a loving, sensitive and patient manner.
3. Model to your child healthy responses/emotional regulation to situations.
4. Use physical touch affection to display your love.

Tips for Individuals

1. Be aware of the patterns in your current relationships and identify the attachment style that seems to be at play.
2. Practice emotional regulation techniques by being in touch with how you feel and choosing a healthier way of reframing and responding.
3. Set healthy boundaries and learn to say no.
4. Practice expressing your needs in a clear and assertive manner.
5. Practice self acceptance by fostering a healthy self image.
6. Start communicating and sharing about yourself to a small group of people.
7. Learn to resolve conflict through compromise and meeting halfway rather than an 'all-or-nothing' approach.
8. Be self-compassionate to your own feelings and needs.

Attachment styles play a fundamental role in anxiety-related disorders and the quality of social relationships (Liu et al., 2009). Nevertheless, a lot can still be done to understand our childhood experiences and modify some of our current patterns so that we may increase our tolerance to challenges, practice healthier emotional regulation and enjoy more meaningful relationships.

Anxiety in Everyday Life: Generalised Anxiety (but not a) Disorder

Russell Lee

*"What if I don't do well on tomorrow's test? What if I don't get the job?
What if I chose the wrong course? What if I wasted my money?
What if I've got a disease?"*

I'm sure most of us have experienced moments involving worries such as these throughout our lives—moments of painful rumination, doubt and uncertainty. These are the kinds of worries you might expect to find haunting people with Generalised Anxiety Disorder, or GAD. As the term 'general' suggests, the worries that these people struggle with encompass a vast spectrum—work, health, the future (APA, 2013). Essentially, they worry about everything that all of us could worry about, but on a much more painful and affective scale. For example, if you're worried about an upcoming test, the anxiety might make it a bit hard to concentrate but you'd still be able to complete the necessary preparation.

On the other hand, a person with GAD might be so anxious they are unable to sleep, affecting their health and performance. In that sense, people with GAD are more similar to us than different. Rather than there being a definitive schism between people with GAD and people without, it's more accurate to view anxiety as a spectrum from mild to intense. To me, this highlights one thing:

**Just because you aren't
diagnosed with an anxiety
disorder, doesn't mean that
anxiety is something you don't
need to worry about.**

It doesn't change the fact that anxiety can intensify and be crippling if you let it. That is why we need to consider the GA that affects all of us as human beings and its potential repercussions on our lives. But how exactly does anxiety impact the lives of people without anxiety disorders?



For most of us, anxiety is that mild temporary discomfort that occurs when we're worried about the potential negative outcomes of a situation. It's feeling nervous before an important job interview, or around the person you're romantically interested in. It's feeling uneasy when walking out from a difficult exam, or after a fight with a friend where you said words you didn't mean. At such times, you might feel a little tense and your heart might beat faster than usual (HPB, 2020). But all these symptoms are quickly and easily shrugged off and forgotten once the issue is over. On the other end of the spectrum, we have people with GAD whose symptoms are more intense and pervasive, to the point of inflicting significant distress and functional impairment (APA, 2013). This may take the form of being unable to work or carry out daily activities, whether due to avoidance

or physical (insomnia/fatigue) or mental incapacitation (inability to concentrate) (IMH, 2019).

But what about all the people in between? What about the anxious people who can still work but are less productive? What about the anxious people who can still sleep but only poorly? To be more accurate, this isn't a question of 'who' but 'when'. After all, anxiety isn't a constant and varies depending on factors such as mood and severity of the situation. Regardless of whether we have a formal diagnosis or not, all of us are at risk of suffering episodes of heightened anxiety which may affect our productivity, health and psychological well-being. This is especially relevant in Singapore where a fast-paced and stressful lifestyle is the norm. Hence, it is important that we remain aware of our anxiety and learn how to mitigate it when necessary.

Coping strategies for anxiety (HPB, 2020; IMH, 2019):

- **Distracting yourself with hobbies or other pleasant activities can be effective for milder episodes.**
- **You can try out relaxation techniques, such as meditation, yoga or breathing exercises (See article *The Mindfulness Way to Cope with Anxiety* by Dr. Sunita Rai in this issue).**
- **You should maintain the habits of a healthy lifestyle—regular exercise, a well-balanced diet, sufficient sleep, and limited alcohol and caffeine intake.**
- **Taking note of what makes you anxious can help you mentally prepare before confronting anxiety-inducing situations.**
- **It can be very powerful to talk through your worries with a friend or loved one if you find yourself in a bad place where the anxiety is too much to bear alone.**
- **Seek professional help if necessary because leaving things unresolved can potentially lead to a spiral of worsening symptoms and lifestyle disruption.**

Most importantly, keep in mind that anxiety is not something you can erase or avoid completely. It is an essential component of our human biology and psychology, and everyone experiences it regardless of resilience or self-control. Hence, learning to accept its presence in our lives is a key first step to managing it effectively. However, it is still important to take note of our own individual susceptibility to anxiety. Some people are more vulnerable to anxiety than others by nature (Gidron, 2013), so it is important to adapt self-care according to your own needs.

Lack of a diagnosis does not mean invulnerability to mental ailments. It's like saying you'll never get cancer or heart disease just because you're healthy now. Anxiety and mental health in general exist on a spectrum and can fluctuate depending on the circumstances of your life. In fact, with the recent COVID-19 crisis rocking the world, some if not most of us may have faced periods of high anxiety lately with regard to issues such as safety and financial security.

Psychological well-being is something many of us take for granted, and with the increasing complexities of modern life, there is an increasing need for all of us to take responsibility for it with awareness and action.

In doing so, perhaps we will be able to create a mentally healthier climate in Singapore, one that accepts and respects the plights of both people with GAD and people without.





The Lure of Perfectionism

Amerie Baeg

Many of us hold the belief that the only way to improve is to hold high standards for ourselves. Consequently, letting go of this yardstick might put us in danger of underachieving. Perfectionists go further by setting extremely high or unrealistic expectations of themselves in various domains of their lives. There is also an unspoken badge of honour with being labelled a perfectionist in fast-paced, achievement-oriented societies. Many assume that perfectionism runs synonymously with success.

Surprisingly, psychologists are no strangers to perfectionism. I recall doing a poll in class during our clinical training, when all of us raised our hands at 'unrelenting standards', surrendering to the stereotype: perfectionistic, highly self-critical, extremely motivated. Fast forward a few years, the same unrelenting standards now become a risk factor for burnout and chronic feelings of anxiety and shame.

Striving for perfection can be addictive. It makes us believe that we can be happy if only we were more perfect, that there is a solution to all our pain and unwanted feelings. However, perfectionism is not the same as healthy striving. In *The Gifts of Imperfection*, Brené Brown clarifies that perfectionism is about earning the approval and acceptance of others rather than focusing on healthy growth or self-improvement.

Perfectionism dictates that we do not mess up, that we cannot allow for any mistakes, and that failure is unacceptable. Any of these will expose the underlying belief that we are not good enough. We constantly look to others for validation of our self-worth. The journey is fraught with fear, anxiety, and trepidation. And when you do get there, perfectionism sneaks up on you and asks doubtfully, "Are you really there?"

Conversely, healthy striving focuses on being a better version of ourselves, without the harsh self-criticism, unattainable goals, and over-identification with mistakes in the process. It is recognizing that we are not perfect, learning to be gentle with ourselves when we do mess up, and continuing to show up and be better.



The dark side of perfectionism

Perfectionism has been called by many other names. Karen Horney called it the “tyranny of the shoulds”. Albert Ellis gave it a cheeky spin with “musterbation”.

Contrary to the alluring myths, perfectionism is the roadblock to success. Research has linked perfectionism to an array of mental health disorders, such as depression, eating disorders, anxiety disorders, and obsessive-compulsive disorder (Egan et al., 2011).

Pursuing perfectionism comes at a cost not only to our mental well-being, but also to our opportunities in life. The self-limiting beliefs that perfectionism perpetuates – and the fear of not being good enough, being a

failure and a disappointment, or being unlovable – stop us from taking risks in life and saying “yes” to opportunities that fall outside our comfort zones. For instance, we may opt out of taking on leadership roles or hesitate to try something new because they make us feel highly anxious and afraid. Even if we do, cognitive biases make us constantly hypervigilant towards rejection or judgment by ourselves and others. We become paralyzed by our fears, living in a constant state of self-critical anxiety and restlessness, and worrying that someday our secret fears might be confirmed. Despite the perils of perfectionism, it has become a modern-day phenomenon.

By holding onto these unrealistic, inflexible ways of measuring our self-worth, we have become trapped in a constant state of self-doubting anxiety.

Changing our relationship with perfectionism through self-compassion work

Breaking out of this vicious cycle of perfectionism involves acknowledging that we have our imperfections and accepting that it is “okay”. It means cradling our feelings of shame and learning not to be afraid of the shame. It means making mistakes and learning not to define our self-worth through them. One way to do that is through self-compassion work.

Kristin Neff’s (2003) definition of self-compassion comprises three elements: self-kindness, common humanity, and mindfulness. Self-kindness is about being gentle instead of critical towards ourselves. Common humanity is the reminder that we are not alone and that our pain is a shared human experience.

Finally, mindfulness is the open awareness we bring to our thoughts and feelings that arise in the moment. Self-compassion practice invites us to establish a new relationship with ourselves that is not defined by perfectionism’s partner-in-crime: our inner critic. This frees us up to focus on healthy striving and growth.



Aiming for good enough

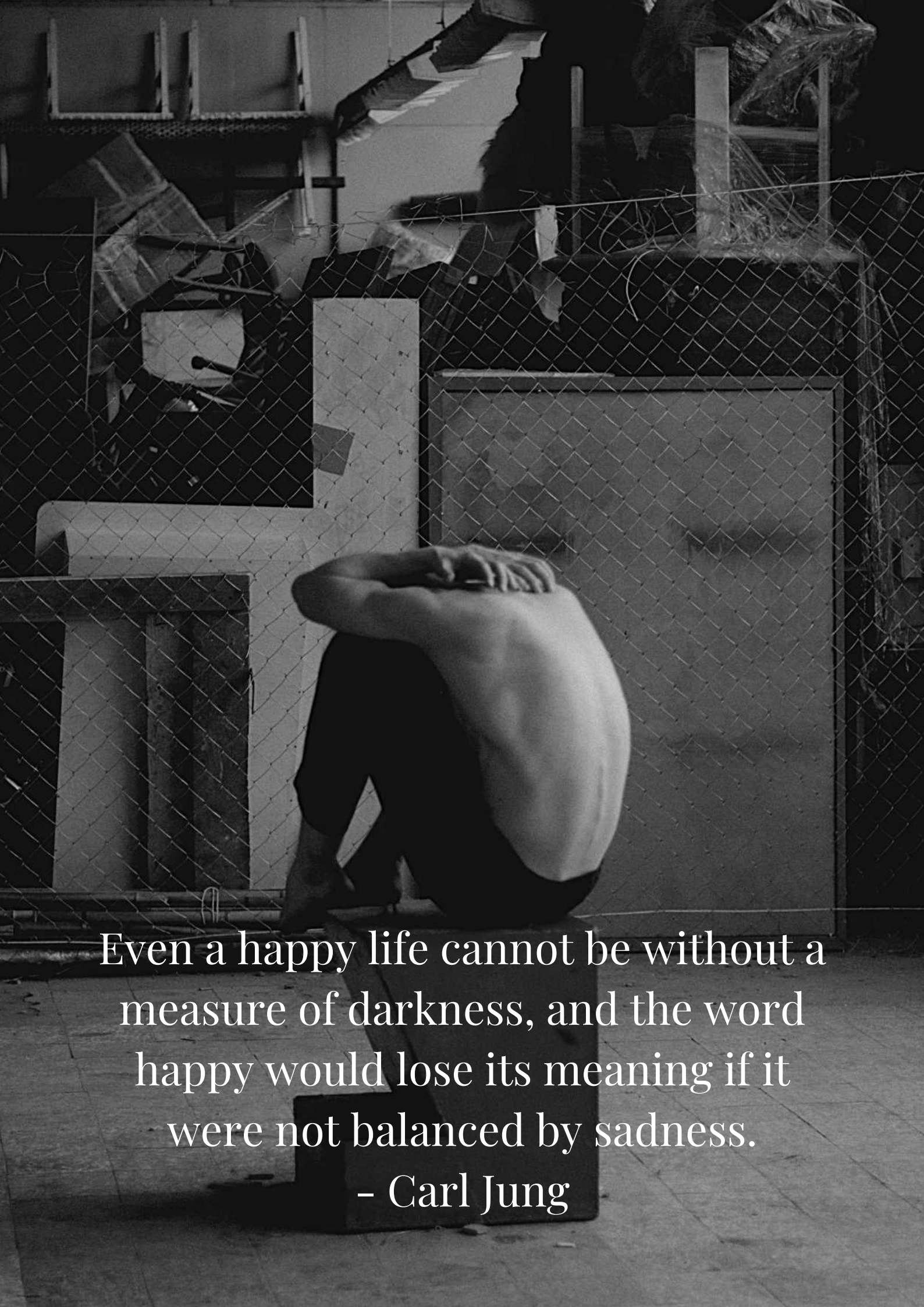
Is it so bad to make mistakes? Is it worth spending hours editing a project to “perfection” just so others will not judge us? The law of diminishing returns tells us it is probably not a good use of our time, yet perfectionism tells us we cannot slow down, that we must do more.

As psychologists, it is often easy to get caught up in measuring our self-worth based on how our clients are doing. Much as our intentions are good and we want to help everyone, not every session can go the way we hope. Sometimes sessions go awry, and clients may not resonate with us, or perhaps progress might be slow. Therapists may end up blaming themselves and questioning their abilities, forgetting that there are multiple factors for therapy not going the way we expect. Perfectionism creeps in and convinces us that we are “frauds” or “imposters”, that we are “useless”. It makes us forget about all the times therapy went well, and instead magnifies all the mistakes that we made and sessions that went wrong. In the long term, such dysfunctional thinking patterns may lead to fatigue and job dissatisfaction, making us forget why we became psychologists in the first place.

Ultimately, the irony is that because of perfectionism, we are unable to perform to the best of our abilities. Perhaps we need to allow ourselves to fumble a little, to experience vulnerability, and to be less than perfect. Perhaps good enough is good enough.



It is recognizing that we are not perfect, learning to be gentle with ourselves when we do mess up, and continuing to show up and be better.



Even a happy life cannot be without a
measure of darkness, and the word
happy would lose its meaning if it
were not balanced by sadness.

- Carl Jung

Fear is not a Four-Letter Word

Juanita Ong

Happiness – more often than not – is thought to be an unrivalled emotion. But...what if it isn't?

For centuries, happiness has been lauded by philosophers to be the highest moral purpose individuals hope to attain. Conventional wisdom would also seem to hold that pursuing happiness is the elusive secret to ensuring satisfaction in our lives. Understandably, the veracity of these axioms usually goes unquestioned. After all, it does appear counterintuitive to strive for the converse of happiness—with the unpleasant encounters entailed in emotions like sadness and fear justifying our desire to shun them. Herein, however, lies the problem.

By solely pursuing that ever elusive, feel-good state of happiness, we run the risk of negating the important roles other emotions play in our proper functioning. Additionally, we continue to buy into the narrative that happiness is the pinnacle of our emotions and, by extension, reinforce our preconceived notions about these “bad” emotions and hinder ourselves from expressing anything other than happiness.

In light of this avoidance mentality, we look to one of our other so-called negative emotions of fear and aptly pose the question:

Why are we so fearful of fear?



Fear

Before delving in to answer the question, we first need to define what fear actually is. To most, this naturally brings the aforementioned concept of avoidance to mind. With phrases like cowering in fear evoking depictions of horrifying scenes or terror-inducing scenarios, fear can indeed be said to be an emotion that concerns itself with avoidance. Yet, the contrary can also be said to be true.

In psychology, fear may be better explained as a fight-or-flight reflex, or a stress response. Consequently, this signifies that fear can result in either avoidance or confrontation. The context in which this reflex is educated, then, is of particular importance as well.

Definitionally, a fight-or-flight reflex occurs whenever individuals are faced with a perceived threatening event. During this reflex, the sympathetic nervous system activates in response to these encountered threats. This, in turn, accounts for the bodily sensations we feel such as heart palpitations, muscle tension and sweaty palms when we come across something that frightens us (Cannon, 1994).

The reason why we have these bodily sensations, as uncomfortable as they may feel, is to protect us from harm. For example, the increase in muscle tension gives the body added speed and strength that could help in either fleeing from or directly engaging in a threatening situation (Everly et al., 2019). Since this fight-or-flight reflex occurs without conscious control, we are thus able to be physiologically prepared and react more readily to any threatening situation. As such, we can begin to see how fear better equips us to face external danger.

Fear, therefore, plays an important functional role.

Fear and Anxiety

However, one may still be tempted to question how beneficial fear truly is with regard to experiences of anxiety as we know it; especially when we draw from personal past events where we may have been stressed over an interview or worried about taking a test. While these events may have undoubtedly produced unfavourable outcomes like being too nervous to answer questions calmly or recalling important information, to completely write off fear as being wholly unhelpful is also unfair.

Anxiety may itself be a misunderstood term due to its everyday use. As alluded to earlier, we seem to reserve this as an adjective to describe a stressful event that is going to occur in the future. This is contrasted to the way we often conceptualise fear as an immediate reaction to imminent danger. In the former, anxiety appears as though there is an insidious stressor we mull over and fret about over a longer period of time. In the latter, fear appears to be a clear source of distress that passes once the stressor is no longer present. However, anxiety and fear can be considered synonymous with each other.

When examined from a bodily perspective, both these anxious and fearful situations evoke the fight-or-flight response. This would consequently explain why our hearts also pound quickly and our hands start to get clammy whenever we become anxious about an upcoming event. Although the implications behind becoming anxious about our future prospects compared to threatening scenarios like running from a snake differ, the former can surprisingly benefit from activating the same fight-or-flight reflex too.

The fight-or-flight reflex, or stress response, enables us to work harder to meet our goals. In these anxiety-filled situations as we come to know them, the stress we feel about our future is in fact equipping our body to react to the looming situation in the same manner that the reflex equips us to flee from or engage with an immediate threat. Through the diversion of bodily resources towards threat perception, we are thus more able to have the energy and capacity required to preempt ourselves for our endeavours (Cornwell et al., 2012).

Moreover, in concerning ourselves over these “anxious” issues, we have an increased likelihood of diverting our attention to it instead of away from it (Eysenck et al., 2007). In one respect, this involves being less prone to procrastination, general forgetfulness or avoidance. More often than not, we can recognise how issues we are anxious about come to and remain in the forefront of our minds more easily. In another respect, the direction of attention to particular issues allows us to focus on and resolve them (Derryberry & Reed, 1998).



Fearful?

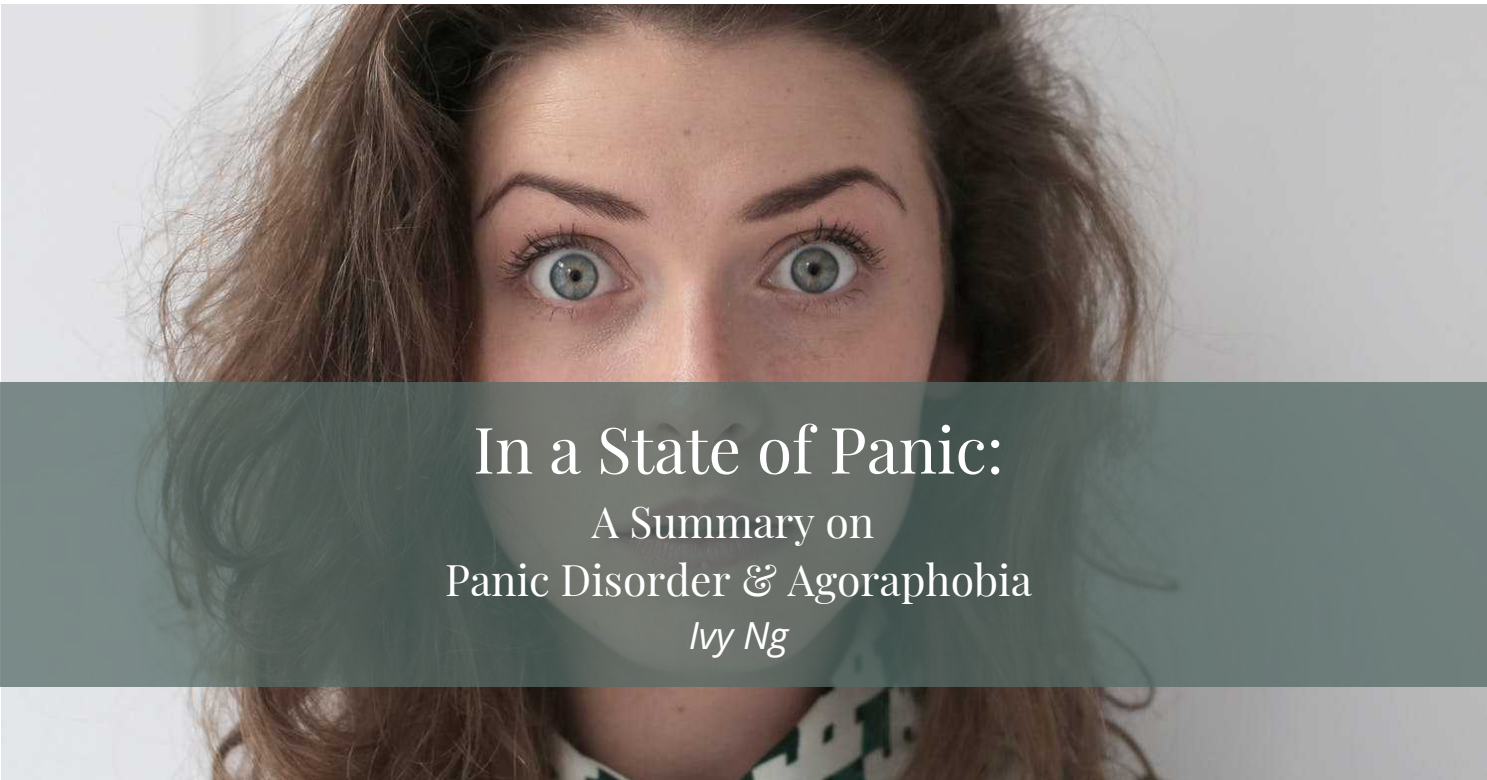
Returning now to the question posed at the beginning of this article, perhaps we are fearful of fear because we tend to undermine the benefits it can bring us, all the while accentuating the negative impact it can have on our lives. As a core emotion in anxiety disorders, fear is rightfully debilitating. Yet, we need to acknowledge how fear, in itself, should not be shunned unless, as in anxiety disorders, the fear is inordinate and incessant.

From what was elaborated on above, we can observe how fear is fundamentally important for our self-preservation – by functioning in moderate amounts to protect us when a situation calls for it. Rather than wishing away fear altogether, we should learn to appreciate the essentiality of this emotion lest we leave ourselves defenceless.

A possible manner in which we could do so would be to stop hierarchizing emotions. While emotions have surely been dichotomised into positive and negative emotions, these categories are not equivalent to how good or bad a given emotion is (Solomon & Stone, 2002). More so, these categories do not mean to suggest that emotions exist on a graded scale pitted against each other. Thus, in spite of fear falling into the category of negative emotions, negative here does not imply bad nor does it insinuate that negative emotions are any lesser than positive emotions.

At the end of the day, the complexity of emotions is what makes us uniquely human and we should, hence, celebrate this diversity instead of conforming to a fixed emotion of happiness. There is a beauty and normality in accepting our “negatives” as well as of fear and of a host of other emotions like sadness, anger and disgust.

Maybe it is in accepting emotions as equals and conceding that even “negative” emotions have their noteworthy place in our lives that we will no longer fear fear. For after all, would happiness still be the unrivalled, “positive” emotion if we rid ourselves of the other “negative” emotions of fear and sadness?



In a State of Panic:

A Summary on Panic Disorder & Agoraphobia

Ivy Ng

Panic attacks are episodes of intense dread or fear. They tend to be sudden and abrupt in onset, catching people by surprise. They also tend to be brief in duration. However, due to the seeming lack of environmental triggers, panic attacks can cause a great deal of anxiety. When one is experiencing a panic attack, they may feel a strong urge to escape, or sometimes the urge to fight against it. They may also feel unsafe, especially as they worry about losing control over their body. According to the Diagnostic and Statistical Manual of Mental Disorders (5th edition), possible symptoms include:



Cognitive symptoms

- Feelings of unreality or being detached from oneself
- Fear of losing control or “going crazy”
- Fear of dying – Some might worry that their symptoms are a sign of a life-threatening illness or that they may die from a heart attack.



Physiological symptoms

- Pounding heart or increased heart rate
- Sweating
- Trembling or shaking
- Sensation of shortness of breath
- Feelings of choking
- Chest pain or discomfort
- Nausea or abdominal distress
- Numbness or tingling sensation

When do panic attacks become a panic disorder?

Not everyone who experiences panic attacks has panic disorder. Panic attacks can happen in many other situations, such as during stressful times. According to the American Psychological Association, panic attacks develop into panic disorder when they become recurring, unexpected and:

- cause an individual to be distressed about the onset of future panic attacks or their consequences for one month or more, or
- cause a significant change in behaviour in the individual each attack.

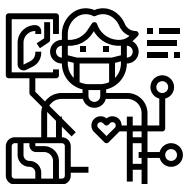
When people with panic disorders associate their panic attacks with specific types of places or situations, they may develop agoraphobia (i.e., the fear of being in spaces where escape is deemed difficult). Places that people with agoraphobia often avoid include public transport, shopping malls, theatres, or other crowded places. They may also fear being alone at home as they are unable to seek help readily during a panic attack. On top of being worried about not being able to escape or get help in time, they may fear embarrassing themselves during a panic attack.



Risk Factors for Panic Disorder



- **High interoceptive awareness.** A heightened awareness of bodily cues may signal a panic attack. These symptoms may have been present in previous attacks, making people think that these are cues that a new panic attack may occur. As such, people with previous panic attack episodes start to become hypersensitive towards these bodily cues.



- **High anxiety sensitivity.** People high in anxiety sensitivity believe that the bodily symptoms they are experiencing have harmful consequences. They misinterpret these sensations negatively and engage in catastrophic thinking. In other words, they may have exaggerated interpretations of their bodily symptoms. This kind of thinking makes the individual feel more anxious than they already are and may further increase their heart rate.



- **Genetic vulnerability** – Family history and twin studies suggest that the heritability of panic disorder is estimated at approximately 43% to 48%, but no specific gene has been identified as associated with panic disorder (Witcher, 2010).

Interventions for Panic Disorder

Self-Help Techniques



Taking deep breaths. Take a deep breath and hold it for five counts, before breathing out. Repeating this a few times may help slow down our heart rate.



Grounding. Find four things you can see, three things you can touch, two things you can smell and one thing you can taste. This helps you regain a sense of control by focusing on the environment.

If you witness someone having a panic attack, try to get their attention and help them in regaining a sense of control with either of the methods mentioned above. You could count as they take deep breaths or prompt them about their surroundings.



Professional Therapies



Cognitive Behavioural Therapy (CBT)

CBT helps individuals reframe their thoughts so they can cope better with what they are feeling. It may also involve exploring different actions that one can take to cope with the situations that make them anxious.



Exposure Therapy

Individuals go through a gradual exposure to places or events that are known to trigger these panic attacks with the intention of alleviating the fear experienced when encountering these triggers.

Discussing with a registered psychologist may help you understand your condition better and get a more accurate diagnosis. Work with your psychologist to find a tailored therapy plan that best suits you.



Are We Paying Enough Attention to Mental Health for the Elderly in Singapore?

Wong Hern Yee

We're getting old - not just at an individual level, but as a country. In other words, Singapore is an ageing society with a burgeoning elderly population.

While this isn't exactly brand new information, the updated statistics should be a cause for alarm not just for the nation's policymakers. A 2019 report from the United Nations (UN) projected that the percentage of seniors above 65 in Singapore will rise to 22.5% in 2030. It will continue to increase to 47% in 2050, which is almost half of the population (Siau, 2017). Dig deeper and you'll unearth more information on the population of elderly who live in one- or two-room flats, with no friends and family for company.

We don't need to look at the numbers to know that older people generally experience reduced mobility, a drop in socioeconomic status after retirement, and a host of health problems. These may be inextricably linked to one of the most prevalent mental disorders detected in later life - anxiety. It's interesting to note that, compared to its more famous cousin depression, anxiety is four to eight times more prevalent in elderly persons (Cassidy & Rector, 2008). Anxiety among our vulnerable elderly (and even our general anxiety towards ageing) can only be further exacerbated by our youth-obsessed culture stemming from Western ideology and beliefs (Allan & Johnson, 2008).

On top of that, many of us are guilty of dismissing the dismal reality of our elderly population's mental health as part and parcel of life, perhaps in a bid to lighten the emotional pressure that comes with caring for our elderly on top of our individual responsibilities. As a result, anxiety disorders in our elderly largely go undetected and/or untreated even though it is one of the most common types of mental illness affecting people age 60 and older.

This is why more attention is needed with regards to emotional welfare for our elderly.

You may wonder why this should be a cause for concern. It is easy for many of us to underestimate the effect of anxiety on our elderly because this emotional discomfort is a universal human emotion felt by all. Moreover, it is both complex and unique to each individual, and may, therefore, be difficult for the rest of society to truly comprehend and empathise.

However, for some of us, anxiety can develop into intense fear and paralysing dread. When that develops into a full-fledged anxiety disorder, it can yield very detrimental effects on mental health, especially on vulnerable elderly. So what happens when we don't pay enough attention to the issue of anxiety in older persons? If left untreated, anxiety can give rise to a whole host of other mental health problems. This includes but is not limited to the following:

Depressive symptoms.

According to a longitudinal study on anxiety and depressive symptoms, anxiety has a tendency to predict depression (Wetherell et al., 2001). When an elderly person has to deal with common fears related to ageing on a daily basis (i.e. falling, medical debt, loneliness and death), the consequent anxiety can wear any individual down and invite depressive thoughts. When this happens, it has to be a cause for concern. This is because anxiety-depression comorbidity tends to be associated with more severe presentations of depressive illness, which includes greater suicidality (Lenze, 2003).

Decreased memory & learning.

A study shows that the presence of anxiety is associated with reduced cognitive performance among the elderly (Biringer et al., 2005). This can reduce one's ability to concentrate on and carry out daily activities that are essential for basic survival. It's worth noting that this correlation between anxiety and cognitive ability remained significant even after excluding patients with concurrent depressive symptoms (Schultz et al., 2005), and this suggests that anxiety yields a substantial impact on an elderly individual's cognitive decline.

Increased social isolation.

This happens when an elderly person has social anxiety disorder. An elderly individual may have this disorder when he or she has a tendency to withdraw from social occasions due to a debilitating fear and anxiety for any social situation. This problem may be exacerbated due to impaired hearing, issues with incontinence, or embarrassment over using a walker or wheelchair. This can cause an increased spiral of isolation and induce a paralysing inability to interact socially.



So, what are the treatment options currently available for the elderly who are enduring the debilitating effects of anxiety?

Stress management techniques. These can include meditation, belly breathing, healthy eating habits and moderate exercise on a daily basis. It can also be as simple as limiting one's exposure to news of current events because taking in too much negative news can contribute to anxiety. Cutting down on caffeine, alcohol and nicotine can help a lot too, as these substances can aggravate or even trigger the symptoms of anxiety (Vinader-Caerols et al., 2012).

Cognitive-behavioural therapy. Negative thoughts about health and quality of life can turn into the prime breeding ground for anxiety in our elderly. When this pattern of thinking persists, cognitive-behavioural therapy can step in to help rewire thinking patterns and habitual reactions to anxiety-inducing circumstances (Stewart & Chambless, 2009). It can also teach new coping and relaxation skills and with sufficient progress, move on to exposure techniques to help desensitise the elderly patient to anxiety-inducing situations.

Medication. This includes antidepressants, anxiolytics and beta-blockers. While these medications do not cure anxiety disorders, they can help patients keep their anxiety under control. Before taking such medication, it is important for elderly patients to inform the doctor about any other drugs, herbal supplements, or alternative therapies that they are taking or participating in.

These practices are important measures and can help our elderly cope more effectively with anxiety. However, the first step to solving a problem is recognising that there is one. In other words, these measures can only work when we start acknowledging the risks that anxiety can pose to our elderly.

It is only a matter of time before their reality will catch up with the younger generations, not unless we start changing the youth-obsessed mindset that's been fuelling our general fear and anxiety towards ageing.

Anxiety does not
empty tomorrow of
its sorrows, but only
empties today of its
strength.

- Charles Spurgeon



Procrastination: A Consequence & Driver of Anxiety

Soh Yu Ting



Picture this: You have a deadline to meet next week. You know you should start but the mere thought of the work sends your stomach churning. So, you opt for an afternoon of Netflix instead, telling yourself that you'll get to it eventually. But tomorrow comes and history repeats itself till you find yourself scrambling to meet the deadline.

Does this scenario sound familiar?

Procrastination is certainly not a foreign concept to many of us. Indeed, most of us would probably have at least one or two experiences dreading certain tasks, eventually opting to escape from them, albeit temporarily, for as long as the deadline allows. Supporting these anecdotal observations of procrastination, an empirical study investigating the prevalence of procrastination among adults discovered that about 20% of participants were chronic procrastinators (Harriot & Ferrari, 1996), a term here that encompasses three styles of procrastination – decisional, arousal, and avoidant procrastination. In the first, procrastination arises from an inability to make a decision within the stipulated time. On the other hand, arousal procrastination involves purposely waiting until the last minute in order to gain a sense of thrill. Lastly, avoidant procrastination is understood as “delayed motivation by a desire to prevent performance evaluation and fear” (Ferrari, Ozer & Demir, 2009, p. 403).

Indeed,
procrastination in
itself, as an act of
delaying a task,
exemplifies the very
hallmark of anxiety –
avoidance.



Procrastination is commonly thought of as a time-management problem. Some might even point to laziness, distraction or motivation as the root of the problem. However, contrary to these common beliefs, procrastination could actually be a manifestation of anxiety.

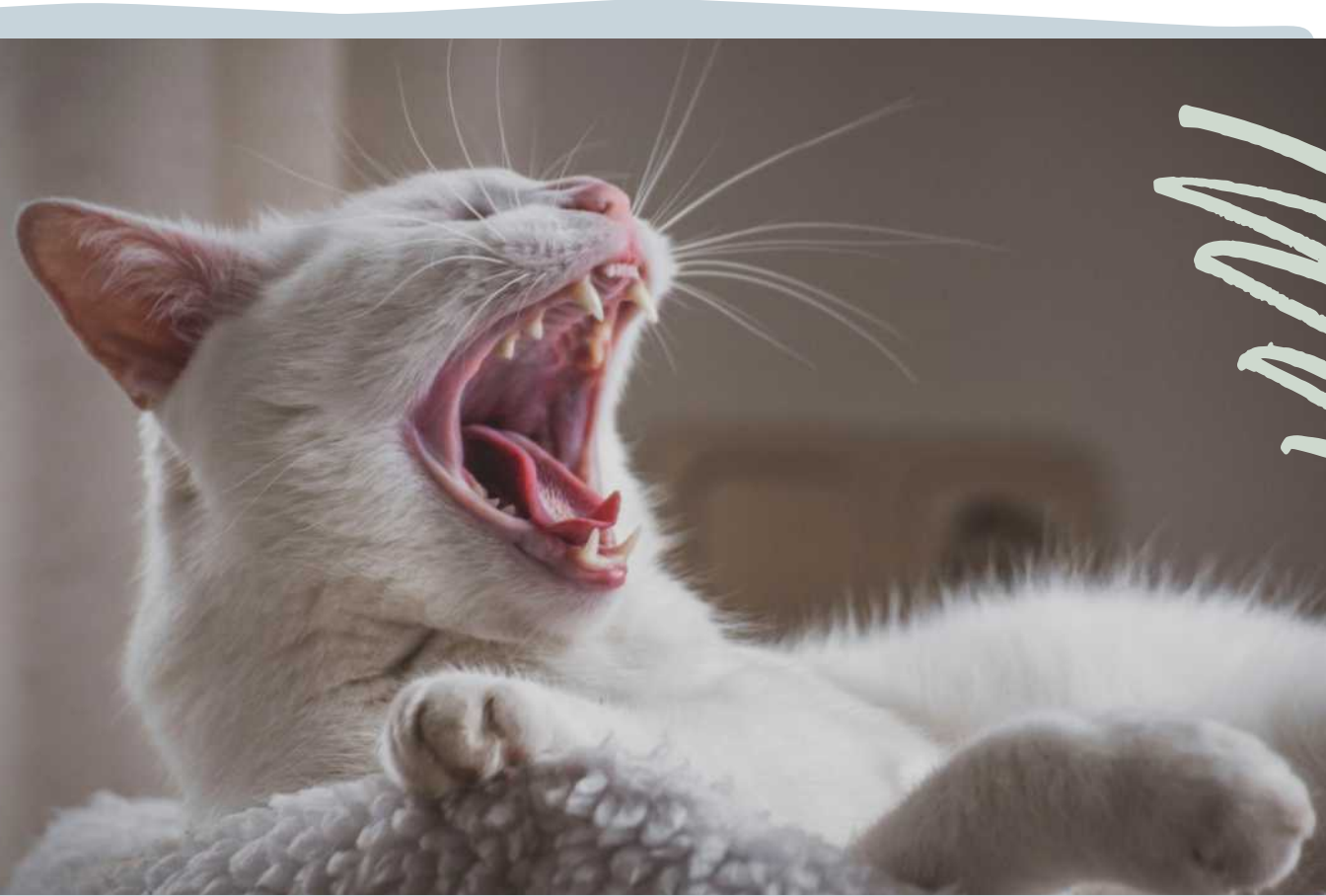
Avoidant procrastination, one of the aforementioned 3 styles of procrastination, appears especially pertinent here. A study investigating reasons behind procrastination found fear of failure, a form of evaluation anxiety, as a major reason (Afzal & Jami, 2018). In particular, people who do not see themselves as having adequate competence to successfully complete the required task may be more likely to believe that failure would bring negative and threatening consequences (Haghbin, McCaffrey & Pychy, 2012). Such beliefs in turn propagate even more negative feelings. Consequently, as a way to escape from these aversive feelings provoked by the fear of failure, some may turn to distraction – opting to engage in unrelated activities that are less anxiety provoking (a.k.a. procrastination).

In addition, studies have also demonstrated that people with higher levels of anxiety tend to procrastinate more (Fernie, Bharucha, Nikcevic & Spada, 2016; Milgram & Toubiana, 2010). Besides physiological anxiety (e.g. sweating, trembling), research has also indicated that panic disorder symptoms (e.g. dizziness, chest pain and chills etc.) predict procrastination (Hutchison, Penney & Crompton, 2018). The researchers postulate that people with panic disorder may procrastinate in order to avoid the anxiety-inducing situation. Indeed, procrastination in itself, as an act of delaying a task, exemplifies the very hallmark of anxiety – avoidance.

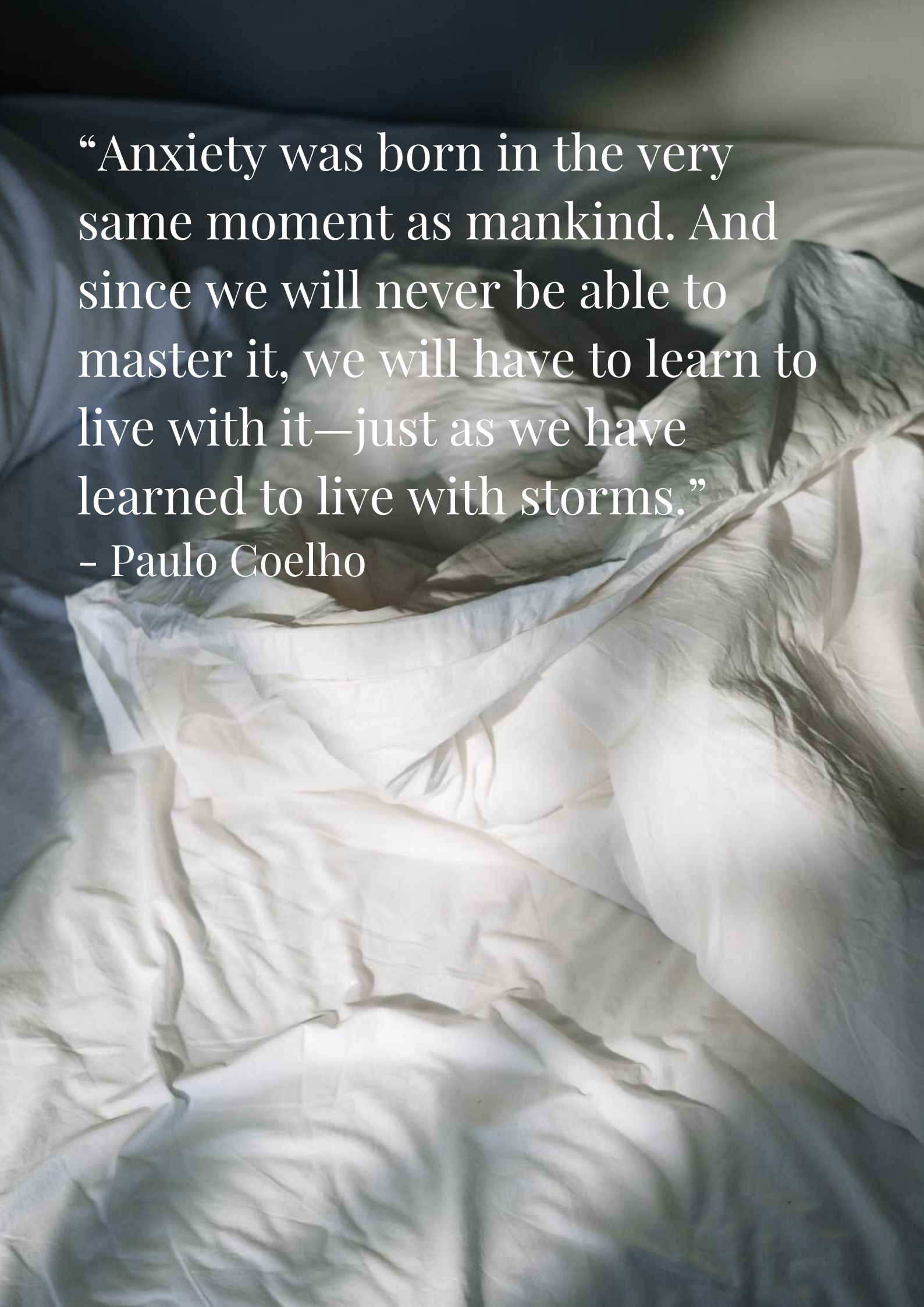
Moreover, besides being a result of anxiety, some research findings also indicate that procrastination can cause anxiety (Rothblum, Solomon, & Maurakami, 1986). These findings may not come as a surprise to many of us. Logically, the longer you delay a task, the less time you have to work on it. So, when the inevitable deadline looms closer and you're left with no choice but to confront the dreaded work – only this time, with the addition of a tighter-than-ever time pressure – it is natural that feelings of anxiety would heighten. Eventually, the ongoing bidirectional relationship between procrastination and anxiety traps the individual in a vicious cycle of anxiety.

The understanding of the link between anxiety and procrastination could help inform possible interventions. Literature suggests that exposure therapy is effective for anxiety. Likewise, given that procrastination is posited to be a manifestation of anxiety, an effective strategy to address procrastination could hence be simply taking action (i.e. exposing oneself to the dreaded situation).

More importantly, a paradigm shift in the way we understand procrastination as a consequence and driver of anxiety may help change the way we respond to it. Procrastination is oftentimes met with critical words from others and even the individual themselves. Such harsh judgements of procrastinators as “lazy” or “not disciplined enough to manage their time” may fuel the stereotype of procrastinators as people with poor self-regulation skills, in turn possibly aggravating the already negative perception of procrastination. In comparison, reframing procrastination as an issue stemming from anxiety takes some blame off the individual. Subsequently, such a reframing could encourage more self-compassion. Given that studies have demonstrated that lower levels of self-compassion are correlated with greater procrastination (Flett, Haghbin & Pychyl, 2016), the promotion of self-compassion could hence be beneficial in reducing procrastination. Particularly, procrastination is associated with negative self-evaluation and self-blame (Sirois, 2013), which may further perpetuate procrastination. Thus, self-compassion, as an effective emotion regulation style, can help break this cycle of procrastination by reducing negative moods and negative self-evaluations (Sirois, 2012).



Thus, moving forward, to address procrastination, it might be helpful to change the conversations we have around it. Instead of the usual “manage your time better” criticisms, interactions that alleviate feelings of anxiety and promote self-compassion may be more valuable. This could take the form of being mindful of self-critical thoughts, as well as being gentle with yourself and others. Making a conscious effort to trade criticism for encouragement and judgement for kindness could go a long way.



“Anxiety was born in the very same moment as mankind. And since we will never be able to master it, we will have to learn to live with it—just as we have learned to live with storms.”
- Paulo Coelho

ANXIETY: WHAT LIES BENEATH?

Dr. Shawn Ee

The Dilemma of Psychological Treatments

As psychological treatment providers, some of us may narrow (or broaden) our focus to target specific areas of our case formulations so that we can attempt to effect change in those areas of our clients' lives deemed to be the source of the problem. Depending on the approach to therapy and the framework we operate within, we may not have the luxury of time or commitment to treat many issues our clients present with at the door. Often it comes down to treating our client's problems by means of reducing their reported symptoms and calling it a day.

However, our clients can relapse and struggle to maintain their gains six or 12 months downstream, leading to a re-entry into our services as a returning client. Some may query if our therapy practices are inadequate to address their concerns, or whether our clients failed their treatment regime. Instead of taking these binary positions, surely, we are aware that there are often many factors that contribute to how well our clients take to therapy.

The Anxious Client

Consider the anxiety that erupts from knowing that our clients are back (again), and that something went wrong, or that our self-confidence takes a hit when our anxious clients put us in the hotseat by saying they need more helpful solutions. All of a sudden the tables are turned, and you're working harder than your clients do! If you're familiar with the basic concepts of projection and counter-transference in the psychoanalytic framework, you may uncover a lot more that underlies these intra- and inter-personal dynamics in your cases. Let's turn our attention to these treatment-resistant anxiety presentations.

Let us begin to think of our anxious clients differently. They form the majority of the presentations that turn up for therapy and display a range of primary to complex concerns. Where the typical controlled-breathing, cognitive restructuring or exposure type treatments are inadequate for treating the more complex cases, we could consider drawing on psychoanalytic views (or psychodynamic, as often used interchangeably) to inform our treatment decisions.

The Psychoanalytic Perspective

Psychoanalytic theory can provide a useful tool for understanding conscious and unconscious psychological phenomena that provides in-roads for us to intervene in interesting and useful ways. For instance, in the above example, desperate pleas for help made toward the therapist may render the therapist prone to feelings of being pressured to work hard to compensate for the avoidant responses of the client who cannot tolerate their own anxious feelings.

In some circumstances, these clients may display varied levels of aggressiveness toward the therapist, in passive [aggressive] ways or more demanding protests for immediate relief from the anxious affect. Some therapists may provide suggestions to relieve the anxiety by problem solving or challenging their client's beliefs in a bid to help. By adhering to the needs of the client (unbeknownst to the therapist), the therapist may inadvertently collude with the client by relieving them of the developmental task of learning to tolerate one's uncomfortable affect or emotions.

In contemporary terms, there are tendencies to rescue our clients with short-term solutions aimed at eradicating the anxiety, as opposed to addressing the underlying driving force of that same anxiety. Should there be limited reprieve from their anxieties, the client may act out their aggression toward the therapist by discontinuing with their current therapist and seeking another who will bend to their desperate wishes.

What is Psychoanalysis?

In psychoanalysis, Sigmund Freud reminds us that an instinctual drive (such as aggression, a psychological motivator) can never become an object of consciousness, unless it attaches itself to a representation or to an affect (Quinodoz, 2005). Hence, in my view, we can conceptualise the client's aggression as underlying the anxiety that is manifested as a set of conscious feelings. To Freud, when we talk of affect becoming unconscious, what we really mean is that some other psychological operation has occurred – in this case, either the anger/aggression has been repressed, or it has been transformed into anxiety. When we process what may have occurred in the course of therapy, the client may be impatient with the perceived therapist's incompetence for being unable to address their anxieties, while it is the client's own inability to regulate their own feelings that stirs their rage that is, instead, directed at the therapist.



To understand this further, we examine Freud's case of "Little Hans", the boy who presented with an unaccountable fear of horses and his avoidance (his inability to go out into the street). To go out into the street, would also mean he would have to arouse the anxiety-symptom. Freud interpreted the possibility of little Hans' psychological defensive mechanisms, of restricting his aggressiveness toward his father (when competing for his mother's affections) by unconsciously turning it against himself – an anxiety about being bitten. In essence, little Hans was unable to confront the anger towards his father due to his fears and inability to articulate his experiences meaningfully at his young age.

Psychoanalyzing Anxiety

In the situation of the anxious client, the therapist may find it a task to contain both their own and their client's feelings of insecurities and rage, thereby acting out in the session by subtle or obvious jabs at each other. Anger and aggression are interesting experiences especially when they are frequently suppressed and disowned by the individual, leading to a splitting off of what is 'bad', so what remains might be more tolerable. This unconscious dynamic can lead to process issues in therapy and ruptures in the therapy relationship. If the therapist were able to contain their own uncomfortable feelings of anger toward the client, and maintain appropriate boundaries, the client would then have to face their own anxieties head on. This is where the 'real' exposure begins.

Nevertheless, if the therapist acts on their anger by telling the client off, this can lead the client to suppress their own anger, and become more needy and demanding of help. The view that punishment can intensify attachment is consistent with the observation that many maltreated and neglected children in foster care continue to idealise and long for the very caregivers who maltreated and neglected them (Eagle, 1990, 1993, 1994). According to the theory of Object Relations (Fairbairn, 1952), such idealisation is due to the child taking the

badness of the object into himself or herself in order to keep alive the representation of the good object. In this case, the anxious client would not want to encounter their therapist's furor, and be seen as being difficult. The client may unconsciously fear the annihilation of their therapist due to the display of their own rage and frustration – this may parallel their inability to tolerate their own anxious feelings or emotions in general, such as in the case of little Hans. By exploring further into the client's history, we may reveal interpersonal disappointments with significant others who lacked the capacity to assist him/her to feel secure when distressed. This is consistent with Freud's view of anxiety as a signal (Signalangst) activated in a situation where the self is able to respond to the threat of impending danger – the fear of separation from and loss of the object [the other] (Freud, 1926).

By taking the hypothesis that anger/aggression underlies helplessness, anxiety, and frustration, any threat to the self can be a primary precipitant of aggression (Mitchell, 1993). We may then begin to interpret for our clients that their aggression is not visible, and that aggression can be constructive, arousing, and an enlivening feature of hostility. By challenging this view, we can show our clients that we are not just angry and hateful when threatened, but that aggressive experiences can be potentially vitalising and enriching. Ideally, we could guide our clients to see that they can exist in different states of mind at different times, some loving, some hateful – that they do not have to be 'all-or-nothing', an important objective of good anger management.

Apart from making sense of their daily conscious and unconscious experiences, the therapy mandate would be to assist them to articulate their suppressed anger in meaningful and accessible ways. This would be done with the objective of helping others understand their hurts, insults, and emotional needs, in a bid to have them fulfilled by others. This also discourages the cathartic use of passive aggressive slights that are, in essence, limited in their function to allow for ideal interpersonal communication. It is then that we may more fully assist our clients to contain their rage, terror, despair, and manage the treatment-resistance, as related to their presenting anxiety concerns.

This presentation of ideas is but a slice of a large body of literature concerning conscious and unconscious experience, repression, and anxiety. For a more in-depth understanding of psychoanalytic theory, we recommend starting out with "Reading Freud" (reference below), which provides an accessible outline of the whole of Freud's work. This reference is particularly useful in expressing even the most complex of Freud's theories in clear and simple language while avoiding oversimplification.

Also, look up the Psychoanalytic Association of Singapore (PAS) website at <https://psychoanalysis.sg> for more information and events.

Low-intensity Guided Self-Help for Young People with Anxiety: A Case Study

Cassandra Neo

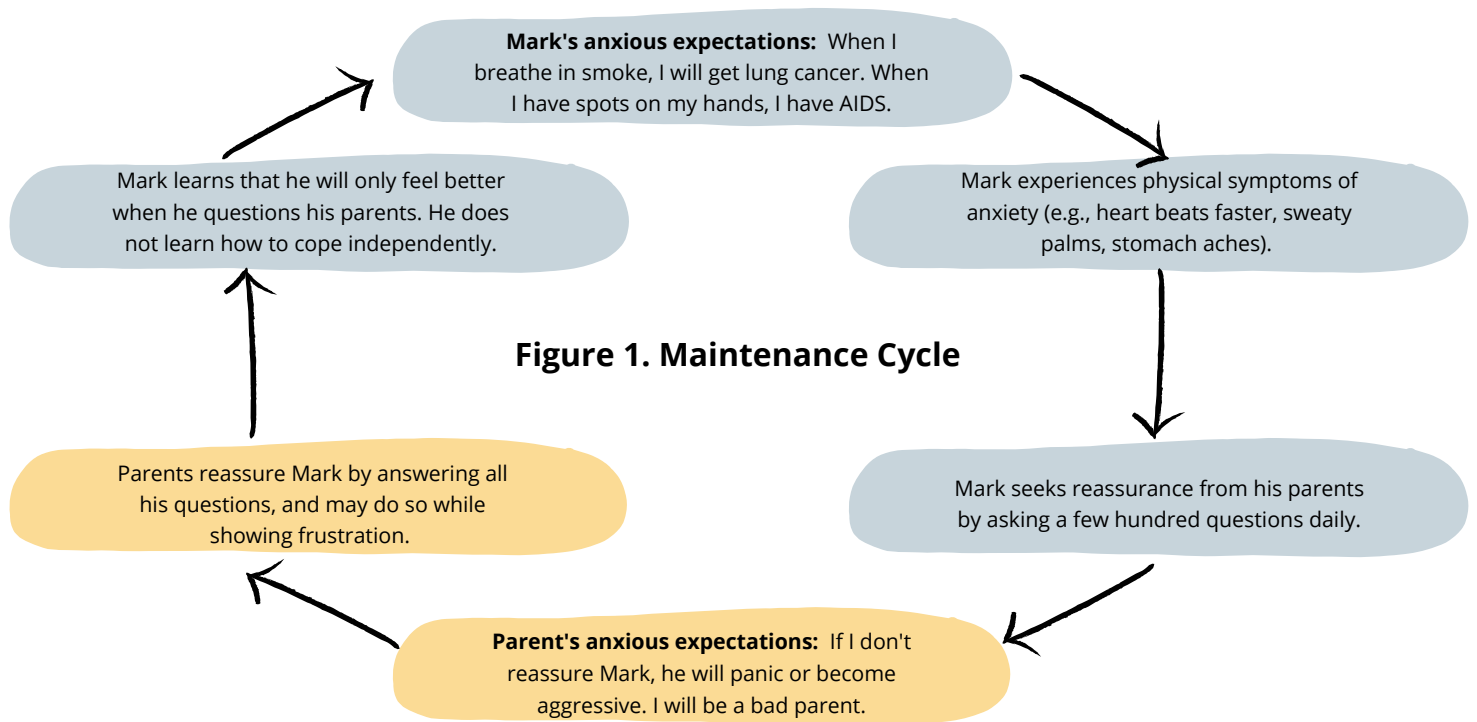


Guided Self-Help (GSH) for mild anxiety based on Cognitive Behavioural Therapy (CBT) principles is highly effective for young people with anxiety (Creswell & Willetts, 2019; Coull & Morris, 2011; Nordgren et al., 2014; Stjerneklar et al., 2019; Thirlwall et al., 2013; Thirlwall et al., 2017). GSH aims to help clients identify unhelpful cycles of thoughts, feelings, and behaviours. Clients learn to break out of these cycles by challenging or changing unhelpful thought patterns or behaviours. For an intervention to be defined as GSH, the materials or handouts provided should contain clear client instructions on how to complete the task or strategy. The client drives the intervention through setting their own goals and selecting strategies to try.

Case Study: Child Anxiety

Mark, an 11-year-old white British boy was referred to us by his paediatrician. Mark presented with worries about multiple health and world-related issues. For example, getting lung cancer when he inhales passive cigarette smoke, and worrying about World War III happening. Worrying affected Mark's happiness at school as he would become aggressive when he sensed provocation or hostility in his surroundings (Ialongo et al., 1996; O'Day & Heimberg, 2018). Mark is also more susceptible to developing anxiety disorders as this genetic trait runs in his paternal family (Creswell & Willetts, 2019; Gregory & Eley, 2011)

Figure 1 shows how Mark's anxieties were reinforced by parents' behaviours and responses (Creswell & Willetts, 2019). Mark harboured anxious expectations about his health and the wellbeing of his family. He engaged in unhelpful thinking styles like catastrophizing (Noël et al., 2011; Vasey & Borkovec, 1992). He sought reassurance from his parents by asking hundreds of questions a day. Concurrently, Mark learnt that he needed parents' reassurance and was not aware of how he could cope with his fears (Beesdo-Baum et al., 2012; Creswell & Willetts, 2019). Therefore, this vicious cycle repeats itself when another worry arises.



Treatment plan

We collaboratively decided that it would be most beneficial for Mark's mother, Claudia, to engage in the parent-led intervention for 'Child Anxiety' (Lebowitz et al., 2020; Siqueland & Diamond, 1998) based on Creswell & Willetts' (2019) self-help book for parents. Sessions consisted of face-to-face and phone sessions. The aim was to break the vicious cycle by empowering Claudia to recognize when to reduce reassurance (Beesdo-Baum et al., 2012), and use cognitive change techniques to promote Mark's lateral thinking. As far as possible, feedback and progress were tracked every session using the Goal Based Outcomes (GBO) and the Strengths and Difficulties Questionnaire (SDQ) to support shared decision making and increase effectiveness (Wolpert et al., 2015). Home tasks were also given and reviewed in subsequent sessions.


Tracking Progress and Ending

Mark's anxieties were not clinically significant at baseline on the SDQ. Early intervention was effective as Claudia felt that by Session 5, she had learnt all the necessary skills to support Mark, and his constant questioning had significantly reduced. Therefore, we ended sessions and Claudia was encouraged to continue using the strategies. We reviewed progress at the 6-week follow-up session.

At the follow-up session, his parents felt that they had met their goals and rated all of them 10/10. Mark was worrying a lot less, and happier with himself. The total parent-rated SDQ scores had reduced from 8 to 5, and the emotional subscale score had reduced from 4 to 1. Mark was discharged from our service.

Conclusion

GSH is more cost effective as it saves therapists' time, reduces stigma, and can be provided by a trained paraprofessional (Cuijpers & Schuurmans, 2007). The National Institute for Health and Care Excellence (2014), has recommended that GSH should be the first line of treatment for anxiety disorders in preference over treatment with medication. Healthcare professionals should offer the least intrusive, most effective treatment first as part of a stepped care approach (Cuijpers & Schuurmans, 2007). Having such a service targeting mild mental health difficulties in Singapore will equip Singaporeans to take action and maintain their own mental wellbeing. More than 50% of mental health problems experienced in adulthood begin around 14 years old, and 75% by 18 years old (DH, 2015). Singaporeans must not be afraid to seek help in order to prevent their mental health from deteriorating into a long term condition (DfE, 2019). Prevention is key.



“Don’t Leave Me!”

Separation Anxiety in Children

Alexandria Rodrigues & Charmaine Leong

Megan is a 6 year-old girl who experiences strong anxiety whenever she separates from her parents. When her parents drop her off at school, she often experiences sudden head pains, which her doctor has confirmed are not due to physical conditions. She repeatedly asks her parents for hugs, throws tantrums, and pleads with them not to abandon her. Megan fears that her parents might die or she might get badly injured when she is away from them. Her teachers have noted that her constant worrying has negatively impacted her school work and interaction with her peers. Her fear of separation has gotten so immense that she wakes up repeatedly during the night to make sure her parents are still there, and becomes extremely difficult to console if they are not in sight.

The fears over separation and anxiety over injuries that Megan experiences are characteristic of children that have Separation Anxiety Disorder (SAD; not to be confused with Social Anxiety Disorder). SAD is the most common anxiety disorder among children and can prevail through adulthood if left untreated. Furthermore, the isolating impacts of SAD can have long-term effects on one’s socialisation capabilities and relationship formation (Figuerola et al., 2012). In general, it is normal for children around 7-18 months to experience emotional distress when separated from their parents. However, separation anxiety becomes an issue during school-going age, when it starts interfering with age-appropriate tasks (Vaughan et al., 2017).

SYMPTOMS

According to the American Psychological Association (2013), there are eight characteristics of Separation Anxiety Disorder (SAD):

- Extreme anxiety when separated from caregivers
- Fears of harm (e.g., death, sickness) coming upon caregivers or themselves during separation, or that caregivers will never return
- An irrational fear that an unexpected event will lead to separation from the caregiver (e.g., being kidnapped or getting lost)
- Continuous refusal/reluctance to attend school because of separation anxiety
- Refusal/reluctance to engage in activities without the caregiver's presence
- Refusal/reluctance to sleep without the caregiver in the room
- Recurrent nightmares about separation
- Aches/pains (e.g., stomach aches, dizziness) when anticipating separation that are not due to medical reasons



WHY DOES SAD OCCUR?

Separation Anxiety Disorder (SAD) often occurs in children that are already anxiety-prone. For example, some children naturally possess an anxious temperament. Also, recent stressors or changes (e.g., death of loved ones, moving house) can make a child susceptible to anxiety. For example, refusing to attend school might follow extended periods of being at home due to illnesses or the school holidays (Figueroa et al., 2012).

Anxiety proneness alone does not often lead to SAD. Instead, certain experiences with caregivers make it more likely for children to experience separation as threatening. Two prominent experiences include:

- The lack of opportunities to handle age-appropriate tasks independently (Affrunti & Ginsburg, 2012). These children come to idolize their parents as the only people capable of protecting them.
- Frequent aversive reactions towards a child's independent explorations (Hurrell, Hudson, & Schniering, 2015). As children tend to model their parent's anxiety, they too might become anxious.

Forming Connections with Others

Encourage the child to familiarise with individuals outside the household such as their peers and teachers. For starters, parents could invite their child's school mates over for a play session, during which parents should refrain from hovering over their children. By allowing their child to form connections with others, they have familiar figures who can help soothe their distress when away from home.

Encouraging Independence

Allowing the child to lead interaction during play time develops their sense of agency. Hence, in situations where they cannot immediately turn to their caregiver, they will experience greater control and feel less anxious. Commend the child's brave behaviours, no matter how small, and minimize attention given to anxiety-related behaviours (Pincus et al., 2008). However, note that an overreliance on assurance is also not ideal as it may inadvertently reinforce separation anxiety (Carlson & Siroky, 2017).

Additionally, parents can have calm conversations which allow their children to express and understand their fears on a regular basis. These conversations will help build capabilities in a child's internal emotion regulation (Hurrell, Hudson, & Schniering, 2015).

Baby Steps

If the child finds it intimidating to perform a particular task independently (e.g., sleeping alone), breaking the process into smaller sub-stages (e.g., start by sleeping in the same room but different beds) might be helpful. The goal is to help the child gain confidence in being alone by succeeding at each sub-stage (Carlson & Siroky, 2017).

Modelling Positive Behaviours

Parents should model the kind of behaviours they want their children to pick up. For instance, when dropping the child off at places, try not to fuss over the child excessively (e.g., repeatedly checking up on them) since the child might interpret the situation as intimidating (Burstein & Ginsburg, 2010).

It Takes Time

Admittedly, it is normal for parents to worry about their child's well-being. It is also understandable that the facade of calmness which parents bravely put on may slip from time to time. Dealing with separation anxiety is a tricky process for both the child and parents. It is essential for parents to not feel too discouraged as improvements will come gradually.

It is not unusual for children to display some degree of separation anxiety. However, when separation anxiety becomes too overwhelming and disruptive, it might be a good idea to seek help from a trained psychologist as it might be an indicator of SAD.

To the parents who are struggling with this, know that you are not alone. There are many resources available (e.g., teachers, specialised anxiety clinics, and parental groups) to support you and your child when dealing with separation anxiety.

The Mindfulness Way to Cope with Anxiety

Dr. Sunita Rai

What is mindfulness?

Jon Kabat-Zinn, the founder of secular and evidence-based mindfulness, defines mindfulness as “the awareness that emerges through paying attention on purpose, in the present moment, and non judgmentally to the unfolding of experience moment by moment”. Mindfulness has 3 key components which are Awareness, Attention, and Acceptance. They can be presented as the triangle of mindfulness (Kathirasan, 2018).

Awareness refers to the ability to be self-aware. This includes being conscious of one’s thoughts, intentions, emotions, bodily sensations and actions.

Attention is about paying attention to the present moment non-judgementally. This includes noticing the experiences as they happen right now rather than being trapped in thoughts of the past or the future.

Acceptance is about inviting all experiences with a sense of accommodation rather than being swayed by our likes and dislikes. This requires us to be able to notice all the discomfort, pain and distractions without judging these experiences especially during mindfulness practices.

In summary, mindfulness is about being self-aware, paying attention to the present moment and having a sense of acceptance to all experiences without judging them. This is a practice definition and usually defined as ‘state mindfulness’.





Trait or dispositional mindfulness is the outcome of state mindfulness. Dispositional mindfulness has a characteristic of a relatively long lasting trait and is an outcome (Black, 2011). Dispositional mindfulness is inversely related to psychopathological symptoms, positively linked to adaptive cognitive processes and better emotional processing and self-regulation (Tomlinson et al, 2017). Dispositional mindfulness can also come natural to some without ever practicing mindfulness.

Mindfulness meditation is an evidence-based secular practice. Although it is not a religious practice, it can be practiced along with one's religious beliefs. Mindfulness has both formal and informal practices. Formal practices include body scan, mindful movement and sitting meditation (Crane et al., 2016). There are a lot more informal practices such as mindful eating or mindful perception.

Mindfulness is often distinguished from other types of meditation due to its uniqueness. One specific unique aspect of mindfulness is the acceptance of thoughts during meditation. Mindfulness is not a state of emptiness, stillness of thoughts or stopping thought streams. It is a 'thoughtful' practice and hence requires conducive attitudes for the practice to be effective.

What are the benefits of mindfulness?

Mindfulness has many benefits on the cognitive, affective, mental, physical and interpersonal levels. Shonin and Van Gordon (2016) found ten outcomes of mindfulness:

- Structural brain changes
- Reduced automatic arousal
- Perceptual shift
- Increase in spirituality
- Greater situational awareness
- Values clarification
- Increase in self-awareness levels
- Addiction substitution
- Urge surfing
- Letting go

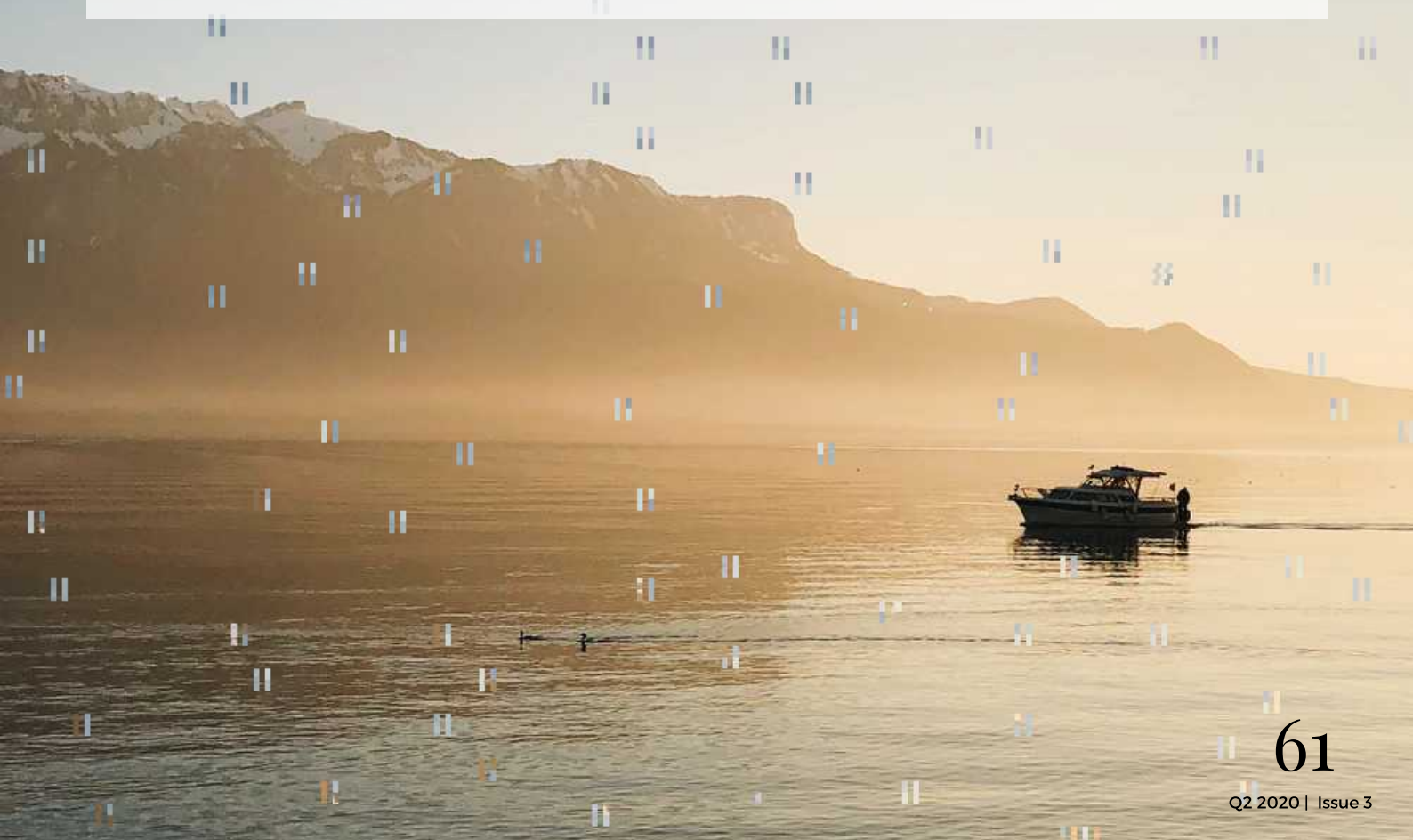
Mindfulness also positively impacts our physical and mental health, our cognitive, affective and interpersonal outcomes, and also reduces the risk of addiction and addictive disorders (Creswell, 2017). Research also showed that mindfulness increases positive states of mind, attentional and working memory capacities (Baer, 2014). In the area of anxiety, studies have shown that mindfulness can reduce state and trait anxiety, habitual worrying, social anxiety, mood symptoms, and maladaptive rumination among others.

While mindfulness research has shown multiple benefits across a wide range of settings, groups of people and diagnoses, it is not a magic pill. Though largely uncommon, the adverse effects of mindfulness include negative psychosocial outcomes (Shonin, Van Gordon, & Griffiths, 2014), false memories (Wilson et al., 2015), and withdrawal from critical thinking tasks (Brendel, 2015).

Mindfulness-based psychotherapy or counselling requires trained professionals in both psychology/counselling and mindfulness to provide an integrative intervention. One critical factor of effectiveness is the embodiment of mindfulness by the psychotherapist or counsellor. This would allow the interventions to be customised to the client's needs, diagnosis and prognosis.

What can you do when experiencing anxiety?

There are many approaches within mindfulness that can help to reduce anxiety. Some are on-demand practices to cope with immediate demands in a specific anxiety-provoking situation. Other practices are formal practices to be done daily to cultivate mindfulness so as to create a cognitive shift and possibly even reduce episodes of anxiety.



Here are three practices that I used with my clients. Each of these practices created a positive shift in them. Before starting any mindfulness practice, find a space where you will not be disturbed or interrupted while practicing.

1. Coping Breathing Space

Coping Breathing Space is an on-demand practice that you can do within 3 minutes. This practice provides a way to step out of difficult feelings and thoughts using your breath to anchor you in the present moment. I recommend that you practice this 3-5 times a day and for 3-5 minutes as necessary.

- Bring yourself into the present moment by standing or sitting in a upright manner with your shoulders wide open and your face looking forward. Close your eyes or gaze towards the floor and bring your attention inward.
- Become aware of your body by noticing or scanning your body from your feet and all the way to your head.
- Gently redirect your attention to your breathing. Noticing each in-breath and out-breath. You need not change your breath in any way except to notice your breath. If it helps, you may place your right hand on the region of your heart and your left hand on your belly.
- If your mind wanders, acknowledge that it has drifted and gently bring your attention back to your breath. Do this each time it wanders.
- Now expand your awareness around your breathing to include the sense of your body as a whole. Scan your body from your head and all the way to your feet.
- When you are ready, you may open your eyes and continue your day.

2. Awareness of Breath

This Awareness of Breath practice builds awareness of your thoughts, feelings, and sensations in the body. It focuses on breathing and uses it as an anchor as your breath is always with you. You can choose to do this practice for 5-20 minutes. I have listed the steps here for a 5-minute practice.

- Sit on a chair or on the floor with your back upright and place your palms facing downwards on your thighs.
- Once you feel comfortable in your posture, close your eyes or lower your gaze to about 45 degrees on the floor.
- Notice your body's posture and weight as you are seated.
- Bring your attention to your breathing by noticing every inhalation and exhalation.
- Notice where in your body you can observe your breath most distinctively. This could possible be at your nostrils, throat, chest, or the abdomen.
- Thoughts will enter your mind. Acknowledge these thoughts and bring your attention back to your breathing.
- When you are ready, you may open your eyes and continue your day.

3. Silent Sitting

Silent Sitting is an opportunity to be with yourself and stay with whatever that happens in your mind. Whenever you can, sit silently without doing anything. Maybe as a start, do it every morning and evening for 2-3 minutes. Sit on your bed or chair without listening to any music, reading, watching any movies or checking your phone. Just sit there with yourself. You can set a timer on your phone for 2-3 minutes so that you know when to end the practice.

If you prefer to use an audio track for Coping Breathing Space and Awareness of Breath, you can download it from the Centre for Mindfulness website which has a wide range of guided audio tracks: <https://www.centreformindfulness.sg/audio>.





Anxiety in Children: Interview with Educational & Developmental Psychologist, Hayley Su

Interviewed by: Pansy Pan

What are the most common kinds of anxiety disorders seen in your clientele?

The age range of my clientele spans from 5 to 18 years old. As an educational & developmental psychologist, common anxiety concerns in my clientele include anxiety associated with neurodevelopmental conditions (e.g. autism, ADHD, dyslexia), academic performance and social interactions.

Are there any commonalities observed among your clientele?

In the child population, anxiety is commonly manifested in behavioral issues, e.g. meltdowns, aggression and defiance. Many children may be aware of the trouble they get into because of their behaviors, but they often lack awareness and understanding of the strong emotions, urges or impulses they experience.

Is your clientele mostly referred to you by the school counsellor and teachers or brought over by parents?

It depends on the setting the anxiety concern primarily presents in, which can vary across individuals. For instance, there can be COVID-19-related or health-related anxiety. The child may not appear particularly anxious in school. However, he or she may feel and appear more anxious at home, such as constantly asking his/her parents a lot more questions or controlling the family's activities in response to his anxiety about infection. If the concerns are seen at home rather than in school, they are usually referred directly by parents. If the concerns are seen at school rather than at home, they are usually referred by counsellors, with parents' consent.

Another example would be that children may experience social anxiety outside of school where there is a higher chance for the child to encounter unfamiliar adults such as their parents' friends or strangers. In these cases, parents would also be the ones to observe signs of the child's social anxiety and school referrals may be relatively less common. School referrals may occur when the child's challenging behaviors in school such as violent behaviors or meltdowns are brought to the attention of teachers. Sometimes, anxiety may underlie these behavioral issues.



How do you build rapport with your clientele who do not talk much in sessions or may struggle with Selective Mutism?

Trust and rapport in the therapy room do not always have to be built via verbal communication. Even if the child is not speaking verbally, it does not necessarily limit interaction. Interaction can also be done by getting the child to write, draw, show or simply via the use of items such as toys and games. Having parents in the room and doing therapy activities with parents' involvement sometimes also helps young clients feel safe in the therapy room.

Do children have major difficulties coming to terms with their diagnosis? How well do they understand their diagnosis?

In therapy with children, it is not always necessary to speak with children about a diagnosis or use the words 'disorder', 'diagnosis' or 'dysfunction'. It is possible to address the struggles the child or family has with anxiety, without using these words.

How important are parents in the process of therapy?

Parents play a huge part as symptoms usually appear outside of the therapy room and in the natural environment. Hence, it is crucial for parents as part of the natural environment to learn to respond to the child's symptoms in a supportive and effective manner.



Is there anything that parents could do to help the child reduce risk of anxiety?

Anxiety is normal and natural. It is not always possible to prevent anxiety triggers. When anxiety occurs, parents could learn to work together with the child and help the child realize that it is okay to feel this way, and to find more adaptive ways of coping with the anxiety. In addition, parents could also acknowledge their own stress and anxiety when their children show distress. Sometimes, our behaviors under stress may not be helpful for the child and may make it harder for the child to cope with the anxiety they are experiencing.

Do you think that anxiety seems to be getting more prevalent among children in recent generations?

With an education system that prioritizes excellence and has a strong emphasis on academic achievement in Singapore, it is not surprising that our children commonly experience stress and anxiety relating to academic performance.

Children who are more aware of academic expectations and how far they are falling behind compared to peers are usually more anxious about their academic achievement. Sometimes, they may present with low confidence, low motivation and disengagement from learning. Besides academic stress, social media is also another source of stress and anxiety in the young generation.

Do you think teachers and schools are doing enough to address such anxiety issues?

There is definitely growing recognition of the importance of the teaching and guiding of children to learn more about their emotions and social-emotional development. However, the effectiveness would also depend on how much schools do beyond these lessons in the curriculum and whether there is an emphasis of mental health and social-emotional development in the school beyond the curricular lessons.

Any thoughts on the public's perception of anxiety or mental health in general?

Much effort advocating for mental health has been made and there is definitely greater awareness of mental health. However, too much emphasis on diagnosing and categorizing whether one has a disorder may backfire instead. We could show some signs of mental health disorders and be at risk of having a disorder, but we do not have to wait till we are formally diagnosed before we get help or support. Mental health topics are definitely not black-and-white and go beyond merely a disorder vs. no-disorder issue.

Having emotions is normal. Just like cognition and behaviors, emotions are also an integral part of us. Hence, mental health is a part of everyone's health.

When children present with anxiety, it may be uncomfortable for the people around them. Adults may try to avoid triggering the child's anxiety at all costs. For instance, teachers may avoid saying certain things or stop expecting the child to do certain work, so as to help the child avoid experiencing his or her anxiety. However, by disallowing the child from doing something which is anxiety-triggering, we may be participating in avoidant coping behaviors that may not benefit the child in the long run. It is important for the child to learn to live with anxiety, accept it as a normal emotion and learn adaptive ways to cope with anxiety when it arises. With support from close adults, the child can definitely learn to cope better with anxiety and that is far more important than avoiding anxiety.



Any difficulties encountered when working with children with selective mutism?

Sometimes, when children do not speak, it may also be related to developmental conditions or language difficulties. It may be tricky to determine whether the lack of verbal communication is rooted in anxiety and/or developmental challenges.

It is important for the child to learn to live with his or her anxiety, accept his or her anxiety as a very normal emotion and learn more adaptive ways to cope with anxiety that arises.



Thank you for giving us valuable glimpses into the work that you do as an educational/developmental psychologist! One last question: Ultimately, what do you consider a success for a child with anxiety after therapy?

Successful outcomes in therapy may look something like an increase in awareness and understanding of their own anxiety. It may also be an increase in their capacity to cope with the anxiety that arises, in ways that do not significantly impair valued aspects of their lives and relationships with people they care about.

WHAT IS SELECTIVE MUTISM?

Pansy Pan



The term 'anxiety' is not an unfamiliar term to us; all of us would have felt anxious at some point in time. However, people experience anxiety in significantly different ways and on different levels. With an increasing usage of social media and the desire to stay connected with others (Chaffey, 2020), common first-world problems such as a rapidly-draining phone battery or being FOMO (Fear of Missing Out) may exacerbate anxiety and cause undue distress in our lives (Milyavskaya, Saffran, Hope & Koestner, 2018). Anxiety can also manifest in the form of repeating your go-to McDonald's orders in your head dozens of times before you are anywhere near the cashier (Bless the self-order kiosks!). On an even higher degree of severity, anxiety in children can manifest as being able to speak freely at home like a chatterbox, but not in school. In extreme cases, one may seem completely mute and not talk to anyone in some social settings. This predicament is known as selective mutism.

If you have never heard of selective mutism before, it is understandable. Unlike other anxiety disorders such as Social Anxiety Disorder (SAD), Post-Traumatic Stress Disorder (PTSD) and specific phobias, selective mutism has a much lower prevalence rate between 0.03% and 1% (Hurley, 2018) and is less frequently portrayed in films. Conversely, SAD was found to have a relatively higher one-year prevalence rate of 7.1% and 9.1% among U.S. adults and adolescents respectively (National Institute of mental Health, 2017) while PTSD was reported to have a one-year prevalence rate between 3.5% to 4.7% (Goldstein et al., 2016). As such, selective mutism is often misunderstood as either shyness, defiance, autism or learning disorders. However, unlike shyness and communication disorders, the child does not simply grow out of selective mutism and can still speak with certain people or in certain settings.

So, after the many what-selective-mutism-is-nots, what exactly is selective mutism?

Selective mutism is characterized by the consistent failure to speak in social situations where there is an expectation to speak (e.g., school), even though the individual does speak in other situations (APA, 2013). This often stems from experiencing a fear of social embarrassment in an overwhelming social situation (Wong, 2010).



Previously known as elective mutism, the disorder was re-labelled and re-defined in DSM-IV in 1994 due to its misleading conceptualization as simply one's refusal to speak. Therefore, it is of utmost importance to understand that like many other disorders in the DSM, it has never been a matter of choice, to speak or not, for selective mutism.

There are several distinct characteristics that make selective mutism identifiable. Individuals with selective mutism often appear emotionless, do not make eye contact and exhibit stiff body language. This "shut-down" could be due to Sensory Processing Disorder, where the body is unable to interpret environmental cues appropriately (Brimo, 2016). As such, their heightened senses can lead to extreme sensitivity towards crowds, lights, touch, and sounds. This anxiety can also be experienced alongside physical, somatic symptoms such as headache and nausea. Common behaviors exhibited in unfamiliar situations include behavioral inhibition, drastic mood swings, and excessive crying.

What, then, exactly causes selective mutism? Well, there is no one exact cause of selective mutism yet identified and factors may vary across individuals. More appropriately, selective mutism can be attributed to both nature and nurture. A family history of anxiety disorders suggests the possibility of a child being predisposed to selective mutism. Brain abnormalities such as the over-activation of the amygdala can trigger fight-or-flight responses to potential threats, resulting in heightened sensitivity and anxiety. Temperamental factors such as behavioral inhibition and negative affectivity can also contribute to the development of selective mutism. Socially-inhibited or overprotective parents are a common factor of a child's insecure attachment with primary caregivers. This leads to difficulties in developing interpersonal relationships and social isolation later on.

Furthermore, studies have found speech or language disorders and SAD to be common comorbidities of selective mutism. This can exacerbate the amount of stress put on the child and, thus, make it even more difficult to speak. In some cases, selective mutism can also become an avoidance strategy to reduce distress in social situations.



Despite the growing research on selective mutism, it is believed to be under-diagnosed. Selective mutism may often go undiagnosed due to cultural expectations of a quiet child as well-behaved or traditional gender norms of a woman being reserved and not outspoken. This is a huge cause for concern as, if left untreated for a prolonged period of time, selective mutism may lead to severe repercussions such as lower self-esteem, social isolation, and manifestations of other disorders which may undermine quality of life and, at worst, contribute to suicidal ideation.

Over time, the child may also become conditioned to non-verbalizing, which would be a difficult habit to break. Hence, it is best to detect selective mutism early so that he or she can receive appropriate treatment immediately. Selective mutism would be more apparent in children aged 3 to 8 years old when they start schooling and are expected to communicate with their peers and other adults such as teachers. Parents and teachers should look out for signs of selective mutism especially in children with a history of separation anxiety and who are slow to warm up.

Among the wide range of options available, the most common and widely supported therapeutic treatments for selective mutism include Cognitive Behavioral Therapy (CBT) and behavioral strategies such as contingency management, desensitization or practicing social skills (Hurley, 2018). By providing positive reinforcement to the child for his or her verbal behavior, it aims to encourage the child to be more comfortable and motivated to engage in speaking behaviors in social settings. In addition, both psychotherapy and medication can be used simultaneously for enhanced outcomes. Nevertheless, there is no one-size-fits-all approach and interventions ought to be tailored to the child's age, comorbid mental illness and receptivity for maximum effectiveness.

Overall, it is indeed very heartening to see the rising awareness and willingness of society to understand more about mental health issues and selective mutism. However, much more can be done as selective mutism is still very often misrepresented and misunderstood. If you think your child or someone you know may be dealing with selective mutism, take early steps to seek professional help. With proper diagnosis and treatment plans, selective mutism can be overcome.

Assessment of Young People with Selective Mutism: Challenges and Tips

Sarah Lam



For those of us working with young people, it is not unusual to come across those who are chatty and those who are quiet. Of the latter group, a rare few may meet the criteria for 'Selective Mutism' – a psychiatric disorder where the individual afflicted fails to speak in specific settings despite their ability to do so in other situations. As professionals used to hearing spoken words in our work, the selectively mute client can pose a distinct challenge.

The Challenge of Diagnosis

During diagnosis, one question inevitably crops up – is the individual selectively mute or merely shy? After all, the shy person also appears quiet in unfamiliar settings. Nevertheless, despite their similarities, experts suggest that selective mutism is more than shyness (Scott & Beidel, 2011). The shy person may hesitate to speak in front of a large group or an authority figure but is better able to do so after warming up. With selective mutism, however, the struggle to produce audible speech is more persistent. During assessment, it is thus important to observe if speech is more forthcoming after reassurance and time for warming up is provided.

The next tip is to probe the extent of the individual's mutism widely. Does it differ across different conditions of audience (adult vs. peer; familiar vs unfamiliar), time (start of school term vs. middle/end of school term; start vs. middle/end of interview), place (school vs. home; classroom vs. canteen), and setting (one-to-one vs. group; formal vs. informal)? This data can help to differentiate selective mutism from its close cousins of shyness and social anxiety.

Over time, the failure to speak can lead to substantial impairment in various domains of life such as sitting for an oral examination, making purchases independently, speaking up in class, and obtaining help from an adult. Do keep a look out for evidence of functional impairment arising from the failure to speak.

The Challenge of Engagement

The in-person interview provides an opportunity to obtain a first-hand snapshot of the young person's difficulties. But how do we obtain information if our client does not speak?

Keeping things friendly and casual helps to put those who are selectively mute at ease. Rather than avoiding the true purpose and nature of the assessment, stating it upfront can moderate any anxious feelings. This may include informing them that speaking may be required ("I'll be giving you some tasks that require you to speak"), but that it is okay if they are unable to do so ("Let's see if you can speak up, but it is fine if it is too difficult for you at this point").

Visual-based materials like feeling cards, books, or games can be handy for setting up relatively low-pressure opportunities for speaking (compared to question-and-answer interviews). Present the speaking task as part of a turn-taking activity with the assessor having a go first. Do note that while some individuals with selective mutism find it difficult to respond to questions off the cuff, reading from a passage is manageable.

If the client is unable to speak audibly in close proximity, observe if they manage a whisper or speak at a distance from the assessor. Always allow a few seconds for responding. If no word is forthcoming, the assessor should praise them for their efforts and casually move on as if it was no big deal.

Having gauged the client's severity of mutism in a one-to-one setting, the rest of the assessment can be focused on obtaining information relevant to case formulation. Those of adolescent-age may write down their responses while younger children may draw or indicate on pictorial prompts (e.g., feeling cards, anxiety thermometer). Finally, the young person's non-verbal behaviours can also provide a rich source of information relevant to the assessment.



Anxiety in the Workforce: How not to mistake it for something else

Esther Cheng

Near-Depression Tendencies

Imagine finding yourself facing a boss who is very judgmental. He often shows uncontrolled outbursts of anger and makes negative comments. In fact, he constantly calls one of your colleagues a “slowpoke”, only because she prefers working at her own pace and not her boss’s. Lately, you notice another one of your colleagues withdrawing from situations and people, having difficulty concentrating and remembering things (Glasofer, 2020). He also shows a general lack of focus and interest in work. At times, he even ignores safety measures.

Now if that is not enough, your subordinate begins to be very pushy, blunt, and exhibit resistance to suggestions and feedback from you.

You are baffled. You see an impending storm and wonder how it all began in the first place. Could they be teetering on the edge of depression? Could they be exposed to anxiety and its cousins of fear and worry?



How It All Began: The Fear Cycle/Progression

It is common for all of us to begin with a deep fear. For example, it could be a fear of making mistakes for some of us. Fear, on its own, is normal because everyone is afraid of something, real or imagined. Fear is unavoidable. It is defined as a basic, intense emotion aroused by the detection of an imminent threat.

This involves an immediate alarm reaction that mobilizes the organism by triggering a set of physiological changes. In the workplace, the imminent threat of being held responsible for messing things up is very real. This is especially so when each waking day brings with it the realisation that our livelihoods are at stake. Therefore, fear needs a combination of acceptance and reassurance to be managed.

However when we do not build up tolerance for a healthy, natural amount of fear, it swells into chronic worrying (Schafner, 2017). Worrying is a state of mental distress or agitation due to concerns about an impending or anticipated event, threat, or danger. We may worry to distract ourselves from feeling the fear. Yet when we choose to worry, we allow our fears to feed on them until it swells and overwhelms us. For instance, worrying about making mistakes may aggravate our fear such that we begin rehearsing every word that we intend to say to others.

If left unchecked, worries spiral further into anxiety, and the distress will begin to spread throughout our entire bodies (Winch, 2016). Our hearts palpitate, our breathing becomes rapid and shallow, our muscles tense up, and our stomachs churn (Cherney, 2018). By now, it may not just be: "What if I missed out something important in the proposal? Will my boss think I have failed?" It may worsen into mental images of the boss tearing up the proposal and trashing it in the bin right in front of the whole department!

Anxiety, therefore, becomes unspecific to the fear and diffuses to big-picture concerns. For instance, we could be anxious about whether we can even keep our jobs or whether our friends will still value our friendship after discovering how imperfect we are. The feeling of being out of control seeps in and unlike worry, the feeling lingers. Anxiety is defined as an emotion characterised by apprehension and somatic symptoms of tension in which an individual anticipates impending danger, catastrophe, or misfortune (APA, 2013).



Escalating to a state of severe emotional distress, anxiety can bring a person to his knees as he suffers from chest pain and/or nausea among other somatic symptoms (Ankrom, 2020). No doubt, it will take a toll on one's professional and personal functioning.

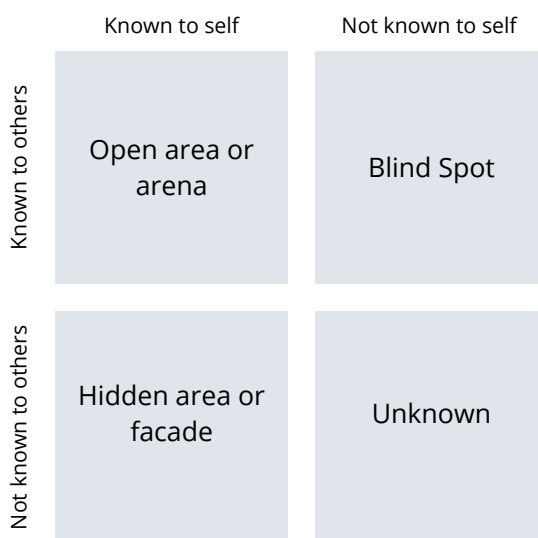
In such a vulnerable state, anyone will be susceptible to depression. In fact, just about half of those diagnosed with depression are also diagnosed with an anxiety disorder (Premier Health, 2017). People on the verge of depression express themselves differently. Some take on an active state like in the case of the judgmental, angry boss or the pushy, blunt subordinate we considered in the beginning. Others take on a passive state, like the colleague who withdraws listlessly. So how do we intervene to help them, lest this becomes a prolonged state that would warrant clinical attention?

Work Personality Blind Spots: A Fuel for Fear

What fuels the fire of fear into worry, anxiety, and depression?

From the perspective of workplace psychology, people may often be insightful or resourceful enough to know their strengths and weaknesses. Yet, many tend to overlook the elusive blind spot, and for good reason.

In 1955, Joseph Luft and Harrington Ingham created what is known today as the 'Johari Window'. They define a blind spot as a behaviour trait an individual is not conscious of but is clearly observed by others. Following from this, many would logically choose to solicit for feedback.



The Johari Window

External feedback offers observations that provide a person with valuable insights. With the help of feedback from colleagues, a person may become aware of occasions where their fear of making mistakes has permeated beyond work into their social interactions. They may become aware of a tendency of being blunt to others when project deadlines are looming, even though they are usually tactful in their communication. However, could this also create more fear?

The Travails of Uncovering Blind Spots

Uncovering our blind spots is not as simple as seeking feedback from others, no matter how well-meaning they are. No one chooses to behave negatively. Like it or not, a person expressing their feedback or opinion is always tinted by their own personality, biases, and blind spots. Even if the feedback giver and recipient are able to identify the latter's blind spots, they are likely unaware about how those blind spots came about.

For instance, a person may know they have a fear of making mistakes. In fact, it might even have already taken a toll on their work performance. Yet, the underlying traits that fuel this fear remain a mystery to them and those around. For instance, they may not be aware that their cautious nature and preference for a planned approach share a common motivation to an aversion of change. These inclinations innately motivate them to avoid making mistakes as the process of rectifying the mistakes inevitably involves managing change. Without fully understanding their blind spots, this will inadvertently cause roadblocks in their career. As these frustrating experiences happen time and again, a vicious cycle of fear, worry, anxiety and depression is birthed forth.

Tracing the Origin of Blind Spots

How are blind spots derived? If the situation is right, positive personality traits can combine and produce specific negative behaviours without the individual's awareness (Success Quotient Intelligence, 2019). In the earlier example, the person's cautious nature and preference for a tried-and-tested approach may have helped them to excel in a regulated and stable work environment before. However, the same traits that helped them succeed earlier may hinder their progress when they have to move into a volatile work environment. Perhaps, an environment of a more enterprising-creative nature?

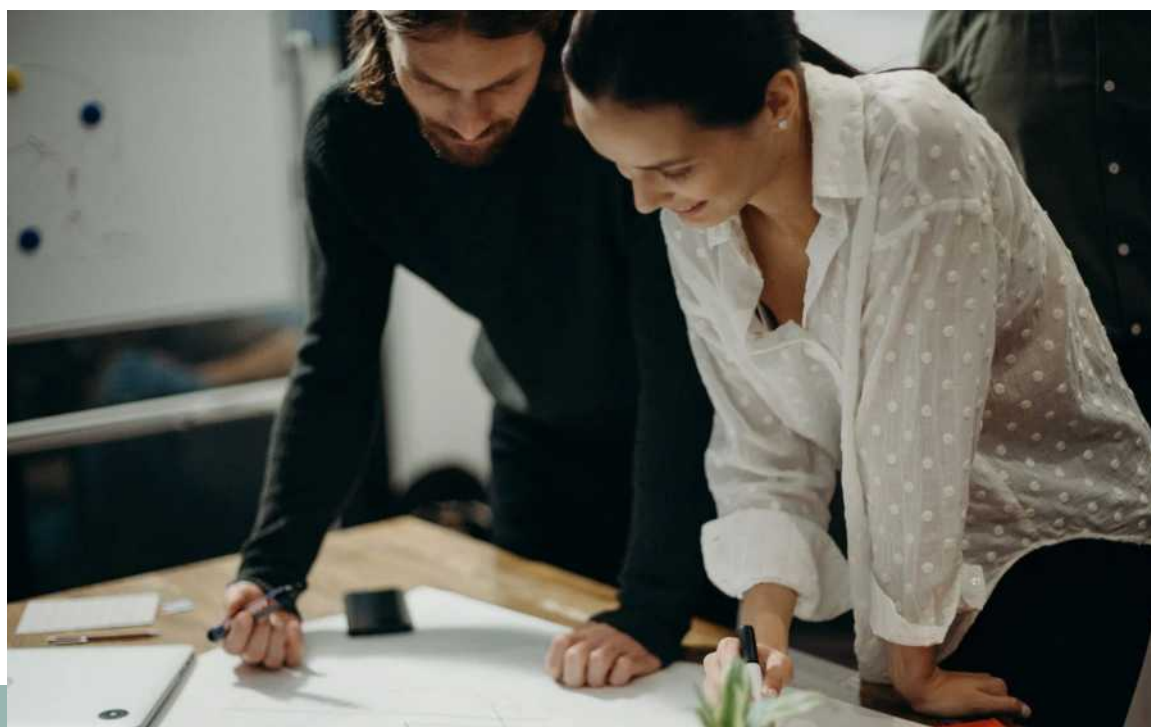
Drawing insights from Barker & Bateson's System Psychology model, the effectiveness of a behaviour is dependent on its fit with the nature of the work, the people working together and the work environment. From the earlier example, the person experiences a job-personality misfit as they move from a stable work environment to a vastly different, more volatile environment. Therefore, they may become even more fearful of making mistakes. As the fear impacts their work performance, their lacklustre performance amplifies the fear as well.

Even if they remain in a regulated & stable environment, changes do crop up within and without. Whether it is a new boss who enjoys taking up new ventures, or the economy adapting to a new virus, each scenario can trigger their fear of making mistakes. With change as the only constant, do they have a plan to expand their comfort zone so they will be less affected by change?

Stemming the Fear Cycle

Stemming the fear cycle is something we all desire. It begins with an awareness of our blind spots and the underlying root causes. We are reassured, knowing that it is common to have blind spots. Managing our blind spots is also founded on the inherent belief that no one sets out to fail. This enables us to cast aside premature conclusions and prescriptive judgements about ourselves – labels like a 'stubborn personality' or an 'extroverted personality'.

By understanding our blind spots, we begin to replace mindless worry with ideas on how we can mentally and emotionally stretch ourselves when the situations call for it. As we envision a breakthrough, the process becomes energising and goal-directed. As such, anxiety becomes under control at a healthy level. Having a healthy level of anxiety helps us to stay alert and focused, spurs us to action, and motivates us to solve problems (Marques, 2018). With hope and support from others who share in this breakthrough, there is no foothold for depression in our lives.



A Choice to Rejoice

Of course, the process requires us to be intentional yet patient with ourselves in managing our blind spots. That is because acquiring soft skills alone, such as problem-solving skills, helps us with the “how” but does not address the “why”. In other words, we can be psychologically prepared (i.e., having all the resources, knowledge and skills). However, we may still not be psychologically ready (i.e., mentally and emotionally poised to swing into action with little notice when the situation requires). Yet, the very acceptance of our own blind spots starts an inner conversation towards understanding the core issues behind our anxiety. Allowing ourselves the space to acknowledge our failures and insecurities prompt us to re-evaluate the anxiety we may be feeling. Perhaps, this will finally allow us the 'choice' to be or not to be anxious.

“Anything that’s human is mentionable, and anything that is mentionable can be more manageable. When we can talk about our feelings, they become less overwhelming, less upsetting, and less scary.”

FRED ROGERS



The Relationship Between Anxiety and Sleep

Bimali Pandithakoralage

Do anxiety disorders lead to sleep disorders or is it the other way around? According to research, it is bi-directional. It is established that anxiety correlates with sleeplessness and new research also shows that long-term sleep deprivation can lead to anxiety disorders (Medic, Wille & Hemels, 2017).

Poor sleep has a drip effect and its harmful effects are not limited to tiredness, inability to concentrate, and poor performance (Mellman, 2006). Sleeplessness puts individuals at risk for cardiovascular disease, high blood pressure, diabetes, and obesity (Knutson & Van Cauter 2008; Khan, Kella, Kunutsor, Savonen & Laukkanen, 2018).

Anxious individuals experience interpretation bias and filter information very differently from someone who does not have anxiety (Mobach et al., 2019). An anxious person reading an ambiguous article may interpret the contents ominously. Sleeplessness reduces problem-solving ability and aggravates the anxious individual's already-reduced ability to interpret information (Staner, 2003; Mobach et al., 2019). In today's data-saturated world, making sound decisions based on accurately-interpreted information is critical. Sleep, then, is a key weapon in the fight against anxiety.

Sleep hygiene is a term used in psychology to describe good sleep habits. While there are medications to treat insomnia, a holistic approach that includes Cognitive Behavioural Therapy and Relaxation Techniques can be more efficacious (Koffel, Bramoweth & Ulmer 2018). Deep restorative sleep is the springboard from which we begin our day and here are some strategies to inculcate healthy sleep habits in the long term:

ROUTINE

- Sleep around the same time every day including weekends. Regular sleep habits ensure you do not disrupt your circadian rhythm.
- Observe bedtime rituals. This can be a warm bath, deep breathing, listening to music or reading a book. A ritual is familiar and soothing and helps relax the mind.

SETTING

- Use the bed for sleeping and avoid using it for working on the laptop, watching TV, reading, eating, etc. This separation will help the brain associate your bed with sleep. Associating the bed with work may trigger memories of unfinished work or deadlines and can lead to association with anxiety.
- Ensure that your room is cool, dark, and quiet. Turning on a fan or utilizing other white noise will help obscure environmental noise.

READINESS

- If you are unable to fall asleep after trying for about 20 minutes, get up and do something like read a book or listen to soothing music before trying to sleep again.
- Stop yourself from watching the clock and engaging in prolonging thoughts like 'It's so late now, I will never get enough sleep'. Turn or cover the clock if you need to.
- Stop using devices at least 30 minutes before bedtime. The light from devices acts as a stimulant to the eye and brain. A phone alarm is a helpful reminder to turn devices off.

HEALTH

- Avoid consuming stimulants like alcohol, nicotine, and caffeine at least 4-6 hours before bedtime.
- Exercise daily but avoid strenuous exercise 4 hours before bedtime. Exercising in the morning or afternoon is best.
- Eat healthy, balanced meals and avoid a heavy stomach or an empty stomach at bedtime. Drink a warm cup of milk. The amino acid in milk is the raw material the brain uses to build serotonin and melatonin – compounds that help us relax.
- Refrain from skipping daytime activities because you have not slept well. This will only reinforce insomnia. Attend to the activities of that day even if you have not had a good night's sleep. Once you are able to fall asleep make sure you get an adequate amount of sleep. An average adult consistently needs 7-8 hours of sleep to perform at their best.

In these times of high uncertainty, sleep disturbances are to be expected as we adjust to new ways of living. Do not be overly perplexed about your current sleep patterns if you are not sleeping well. Instead, take baby steps towards incorporating some of the above-mentioned suggestions and seek professional help if you need to.

ANXIETY IN THE TIME OF COVID-19

Anutra Guru, Gan Kai Qi, Jessy Yong

Elizabeth



Elizabeth is a primary school student. Due to the Circuit Breaker, she is concerned whether she can stay friends with schoolmates she has not met in weeks. She also worries that her parents might fall ill. She has been irritable and often throws tantrums, binges on comfort foods, and finds it difficult to sleep well.

Nicholas



Nicholas, a teenager cooped up at home during the Circuit Breaker, faces boredom and uncertainties from the COVID-19 outbreak. He is no longer able to go out every weekend with his friends. Even at home, he does not have a personal safe space which makes him feel suffocated.

Rachel



Rachel is a university student. Her internship offer has recently been withdrawn due to the virus. Furthermore, her social media feed is consistently flooded with news regarding the virus. This has made her very paranoid about whether this pandemic can be contained.

Nadia



Nadia is currently working for a business firm. Upon the implementation of circuit breaker measures, she received news that she would receive a pay cut. Her husband has also received news that his company may be retrenching workers.

Uncle Soh



Uncle Soh lives alone. He is already in his 70s. His daily routine involved exercising in the nearby park and chatting with his friends at the wet market. However, during the outbreak, he is no longer able to meet his friends for a chitchat, which used to be his 9 to 5.

Alex



Alex is a recovering alcoholic. Due to the social distancing measures, the usual structure of waking up, going to work, and attending counselling sessions offline is no longer in place. The loss of this routine is creating difficulty for Alex to manage his emotions and urge for alcohol.



It is not farfetched to resonate with one or more of these stories and feel that they are too close to home. Inspired by local news reports detailing Singaporeans' lives during the COVID-19 outbreak, these stories paint a bleak picture of discomfort and anxiety that has permeated throughout our Singaporean households, affecting both young and old. Alongside a pandemic that is happening around the world, we are also fighting a psychological battle on multiple fronts.

Whether we are grappling with a fear of infection, worrying about our financial situation, or confronting loneliness and isolation, anyone can become vulnerable to the feelings of anxiety in these unprecedented times. By understanding COVID-19 anxiety and its effects, we hope to start conversations about this lesser-known psychological crisis, so that we may stay psychologically resilient as a nation. First and foremost, why is the COVID-19 situation so closely linked to anxiety? What makes us so anxious in the face of a pandemic?



Sources of COVID-19 anxiety

1) Uncertainty

One likely culprit is uncertainty. Naturally, humans tend to prefer certainty to uncertainty. When we know what is likely to happen in the future, we can prepare for situations more effectively. In our normal everyday life, we have enough information about past events and our current situation to be able to predict and anticipate what is likely to happen. Uncertainty still exists but it is small enough that we do not need to devote too much energy and resources to it.

COVID-19, however, upended everything. While we initially compared it to the SARS outbreak of 2003, COVID-19 soon showed us how wrong we could be. Globally, cases and deaths are still increasing steadily; we have over 40,000 cases in Singapore as of 1st July 2020. Singapore only had the SARS outbreak to compare COVID-19 to. For most of us, COVID-19 is the first pandemic we have experienced and SARS is but a distant memory. COVID-19 has also forced the closure of schools and workplaces both locally and globally. Job stability and financial security are no longer a certainty. Without past experiences of lockdowns to guide our way through this pandemic, we are left perplexed by the multiple, equally-plausible scenarios and outcomes for the near future – all of which are equally likely to happen. Will COVID-19 die out within the year? Would we ever get to resume the way we used to live? We have no playbooks to rely on.

Consequences of our actions, therefore, carry a greater and potentially more dangerous weight. As a result, we increase our vigilance to threat-related information, without any way to resolve any mismatch between the information (or lack thereof) that we have and the information we sorely need. These uncertainties culminate in our inability to prepare adequately and effectively for the future, contributing towards a growing sense of worry and anxiety.



2) Social Distancing

During the 1995 Chicago heat wave, close to 800 individuals lost their lives over a span of 5 days. Despite representing a quarter of the city population, Latin Americans only accounted for 2 percent of the death toll. Eric Klinenberg, an American sociologist, illustrated that the Latin Americans' densely-populated, vibrant, and busy public spaces enabled them to maintain close family ties and social support.

The Circuit Breaker measures, while essential in the fight against the COVID-19 virus, unfortunately work against sustaining these social relationships. The streets of Orchard Road are bare, facilities and park connectors are covered with warning tapes, and many of us are confined within the limits of our own homes. Psychologists have long suggested that humans are innately social beings, and forcing them to isolate themselves could lead to feelings of loneliness. And with just this feeling and perception of being alone, one is already at an increased risk of anxiety (Shukla, 2020).

Certainly, it is normal for some individuals not to experience loneliness and anxiety and they may celebrate the chance to be at home, especially if there are only minor changes to their lifestyles. However, even for homebodies, not having control over their choices and routines can worsen overall mental health (Shukla, 2020).

3) The Infodemic Phenomenon

Furthermore, it is likely that those who stay at home are more likely to kill time by watching television or browsing their social media feeds. This is already prevalent in the US, in which media companies note increases in TV and social media usage upon implementation of stay-home measures (Mander, 2020; Perez, 2020).

These media communications create a wealth of information about the virus, but may also lead to the dangers of misinformation. The World Health Organisation (WHO) terms this phenomenon as an infodemic, in which "an overabundance of information—some accurate and some not—makes it hard for people to find trustworthy sources and reliable guidance when they need it". In Singapore, government agencies have already debunked a total of 40 instances of COVID-19 fake news (Mahmud, 2020). For example, a list of places in Singapore with suspected or confirmed cases of COVID-19 was circulated on WhatsApp in early February. The Government later debunked these claims and said there was no need to avoid these spaces. In late March, it was also reported that there have been false messages of Safe Distancing Ambassadors imposing fines before such regulations were implemented.

The rise of an infodemic simply creates too much information for one to digest, be it real or fake. This creates a sense of powerlessness in the face of a pandemic. *Which sources of news should I trust? Should I err on the side of caution? Am I being overly cautious?* Fake news, often sensationalized, adds to this convoluted mess and creates overall pessimism. When faced with such intangible, yet widely publicised threat, coupled with the inability to move freely during the Circuit Breaker, it is natural for one to imagine the worst outcomes and engage in catastrophising behaviours.

Anxiety – a harbinger of the dark side of humanity?



Unfortunately, negative news often receives more attention and is propagated more readily on social media. On one end of the spectrum, we come across milder stories of self-serving acts such as the hoarding of food supplies. On the opposite end, horrific stories of racism and discrimination are divulged. Must it take a pandemic to finally see the true colours of Singaporeans? Anxiety may, in fact, be part of the reason behind these acts. One of the most widespread phenomena arising from COVID-19 anxiety is panic buying. When the Ministry of Health raised the risk assessment of COVID-19 to DORSCON Orange, masks, hand sanitisers and alcohol wipes became precious commodities overnight.

INSEAD found that when people felt a greater loss of control, they were more likely to engage in behavior resembling panic buying (Yap, 2020).



It seems that our first instinct when facing anxiety tends to be the avoidance of anxiety itself. By engaging in panic buying, we are attempting to wrestle back control in some parts of our lives and to finally remove all uncertainties present.

Ironically, an avoidance of anxiety actually sustains anxiety and can lead to more severe anxiety disorders. For instance, one common behavior in individuals with anxiety disorders is rumination. By constantly worrying about ‘what-if’ scenarios and taking maladaptive actions to ‘solve’ the problem (i.e., stocking up excessive amounts of food), the core issues surrounding one’s anxiety become obscured. A prolonged and repetitive habit of worrying and rumination creates a cycle of anxiety that can spiral into other mental health issues such as depression. The avoidance of anxiety is not the same as the acceptance of anxiety.

In London, a Singaporean student Jonathan Mok was physically assaulted by a group of teenagers merely because he was of Chinese descent. Such discriminatory and racist attitudes and behaviours, unfortunately, also function as a coping mechanism in response to heightened anxiety – albeit a cruel act universally frowned upon. The virus reminds us of our mortality and the plausibility that we may not come out of this situation unscathed. As a way to make sense of and buffer against this death-related anxiety, some may inadvertently subscribe to an us-versus-them mentality and engage in racist acts.

Terror management theory (TMT) posits that any reminder of mortality can trigger anxiety and one way we can cope with this invisible threat to our lives is to identify another group as the concrete, physical threat instead.

Indeed, when Italy was the epicenter of the outbreak, early research on COVID-19 found that exposure to information about the coronavirus led to an increase in anxiety, which then increased prejudice towards Italians (Sorokowski et al., 2020). This rather dysfunctional process is also termed as othering – the process by which members of the dominant in-group stigmatize a real or perceived difference in a subordinate, marginalized out-group in society (Staszak, 2008).

By dehumanizing the Chinese, it allows the in-group to believe they are different from the Chinese, serving to maintain a psychological distance from these dangerous foreign “others”. Unlike the virus itself, it is also much easier to avoid the Chinese in general, offering a false sense of control. Concepts of othering have also either been intentionally or inadvertently perpetuated by the media, with ill-serving terms that promote the racialization of the virus, e.g., Wuhan virus. The spreading of conspiracy theories and the sharing of racialized memes about Chinese people consuming food such as bats further exacerbated the situation. The usage of such language in the media could increase the saliency of the concept of otherness, possibly evoking feelings that the Chinese must be inherently different from them.

In one of the most unbelievable events occurring during the pandemic, Americans are protesting that stay-home mandates were infringing on their rights to freedom, with others claiming that the entire virus is a complete hoax. TMT also posits that one of our responses to death-related anxiety is to affirm that our own cultural worldview is the correct one. The notion of civil liberties (e.g., freedom to action) in America thereby became undoubtedly more important than the threat of COVID-19 itself, insofar as to help them cope with the sudden loss of freedom from stay-home mandates. Being able to go about our daily routines gives us the illusion that we have at least some form of control over the situation, reducing our uncertainty, and thus our anxiety. Culture also offers us some form of permanence, allowing us to believe that we are significant rather than a product of chance. If we are important in this world, it stands to reason that death should not come as easily for us.

While the COVID-19 pandemic showcases the darkest side of humanity, thankfully only a minority engage in such acts. The majority of us follow the rules and leadership of our government, while coping with anxiety in creative, prosocial ways and in the privacy of our own homes. Many have endured this anxiety, while seeking ways to help those in need. Healthcare workers at the frontline put their lives at risk every day they go to work, while others volunteer with charities to ensure that the needy are not neglected during this period.



Alleviating Anxiety: What can we do?

To alleviate anxiety, it is important to first recognise that anxiety is completely normal and even serves a functional purpose to our survival. Anxiety is a natural mechanism which prepares the individual to react appropriately to danger (Bergstrom & Meacham, 2016). It is even suggested that overly-optimistic responses about the COVID-19 pandemic can contribute to naïve thinking (that one is less likely to contract the disease and therefore less likely to transmit it to others) (Kuper-Smith et al., 2020). Hence, having moderate levels of anxiety may actually be beneficial in allowing one to exercise caution to safeguard their own and the community's well-being (Shukla, 2020). If the anxiety that you feel is mild to moderate (and proportionate to the actual threat), try sitting with the emotion rather than acting on it immediately. Validating and acknowledging our fears is the first step towards managing our anxieties. The overwhelming amount of information circulating in the media can also be a huge source of anxiety. One can deal with this media-related anxiety through the **SIFT technique** for evaluating information (Caulfield, 2020), as detailed below:



1. Stop. When you encounter information that induces intense emotions, take a deep breath before simply absorbing the information as an absolute fact.

2. Investigate the source. Be critical of all sources of information and ask yourself, who is providing this information? Fact-checking could help to ground us especially when we feel overwhelmed by inconsistencies in the news.

3. Find better coverage. Cross-check existing information with other trusted sources. Do they report the same thing? Are there nuanced differences?

4. Trace the information back to its original source. If the information presented is a secondary source, trace claims, quotes and media back to the original source or context.

The SIFT technique allows you to fact-check all instances of news and alleviate some of the fears and anxieties that come about due to misinformation and fear-inducing headlines. It is also recommended to refrain from incessantly seeking information from every news channel and social media platform and be intentional with your choice of information, e.g., check for updates from trusted authorities and official government information channels.


In order to build resilience and grow from this crisis, we should focus on making meaning rather than happiness (Stillman, 2020; Smith, 2020). While many psychologists have long believed in the detrimental impacts of severe stress, Richard Tedeschi and Lawrence Calhoun introduced the term “post-traumatic growth”, to show how individuals can make sense of a crisis, find positive meaning, and grow as a result (Calhoun & Tedeschi, 1999). Hence, we should not underestimate the human capacity to turn negativity into something constructive.

Although it might seem frustrating that we are restricted to our homes, we could actively work on deepening our empathy for those who are vulnerable to the virus. This would make even something as simple as physical distancing a meaningful action as it protects the health of others. We could even find meaning in staying at home, such as an opportunity to interact and grow closer with family members and loved ones.



This could also be a time for us to reflect, discover, and pursue other interests that are meaningful to us that we may not have had the time for previously. The COVID-19 pandemic may be here to stay, and future pandemics may also occur post COVID-19. Perhaps the only certainty is that the world is becoming increasingly uncertain. We must try to find meaning in embracing this new normal, to take on new challenges, and emerge as a more resilient society from this crisis.

If you are feeling a great amount of stress or anxiety during this challenging period and you wish to speak to a trained professional, you can call the National CARE Hotline at **1800-202-6868**, which is open 24/7. For more information on other hotlines, visit [go.gov.sg/hotlines](https://www.go.gov.sg/hotlines).

A close-up photograph of a wooden mannequin figure. A hand from above is pulling a string of twine that is attached to the mannequin's head and one of its feet. The mannequin is positioned on a light-colored surface, and its body is slightly tilted. The background is blurred, showing a green plant in a white pot. The lighting is soft and natural, highlighting the texture of the wood and the twine.

People become
attached to their
burdens sometimes
more than the burdens
are attached to them.

- George Bernard Shaw

ANXIETY ON THE FRONTLINE OF COVID-19

Sara-Ann Lee

As of 03 July 2020, an estimated 11 million individuals worldwide have been infected by coronavirus with close to 530,000 fatalities. The COVID-19 pandemic has sent billions of people worldwide into previously inconceivable and prolonged states of lockdown, leading to sustained social isolation. This has taken a particular toll on many already-vulnerable groups.

However, one group whose difficulties with mental health during this crisis has often gone unseen are healthcare workers.

The COVID-19 pandemic has tested the limits of healthcare systems around the world, necessitating rapid and total changes to the way healthcare workers are used to carrying out their duties while simultaneously increasing their workloads and mental burden.

With many countries easing their restrictions and the gradual resumption of international travel, healthcare workers are bracing for second waves globally. While healthcare workers may be used to being on the frontline of medical emergencies, the extent of the crisis has blindsided even seasoned professionals.

In an interview with Katie Couric, NYU Langone Health's Dr Charles Marmar has described the situation to be "extraordinarily challenging, stressful, heartbreaking, and demanding". Many frontline healthcare staff were redeployed to meet increased caseloads, working long shifts in full Personal Protective Equipment (PPE) treating sick patients with little knowledge and few effective remedies.



On top of this, Dr Marmar also highlighted their worry about catching COVID-19 and bringing it home to their loved ones. Beside healthcare workers who are fronting our fight against COVID-19, mental health professionals too have been reporting increased numbers who are referred, largely due to secondary effects of COVID-19 such as loss of livelihood, increased family violence and low mood. In addition, many have also taken on additional roles by manning crisis or mental health helplines on top of their burgeoning work schedule. The switch to telemedicine and other remote ways of providing services has also necessitated rapid changes made within a short amount of time to maintain a high standard of care towards patients.

Even after the acute threat of COVID-19 has subsided, the psychological and physical aftermath of experiencing a pandemic on the frontline will likely remain, particularly as economies and societies are ravaged by downstream crises for years. Feelings of exhaustion, anxiety, insomnia and difficulty relaxing are some of the physical and psychological reactions that may be experienced.

Therefore, it is critical that healthcare workers are adequately supported now and in the future, by ensuring ready access to resources and services supporting their mental health and wellbeing.

In a recent study published in the *Annals of Internal Medicine* of 500 healthcare workers in Singapore, 14.5% screened positive for anxiety based on self-reported symptoms. Another study published in *JAMA (Journal of the American Medical Association)* in April 2020 highlighted sources of anxiety that could be categorised into 5 requests from healthcare workers to their organisation: Hear me, Protect me, Prepare me, Support me and Care for me.



It is heartening to see that many hospitals locally have made efforts towards promoting mental health with the help of technology. Open Zoom support groups, department check-in sessions and e-sensing surveys are just some examples of what has been done to identify areas in which intervention may be necessary to help healthcare workers cope. Several institutions in Singapore are also involved in the SSafe (Staff and Safety effects of Epidemics: An international, multi-centre study to assess staff safety, psychological wellbeing and burnout amongst frontline healthcare staff during the COVID-19 pandemic) study, which aims to help identify areas of attention and guide future policy in healthcare institutions.

Apart from wholesale organisational change, creative operationalisation of existing technology for work should be embraced to promote social contact e.g. lunch dates with co-workers via videocall, dropping fellow team members short messages of encouragement or even team bonding via Zoom. As healthcare workers, we need to remain capable to do our jobs effectively as the COVID-19 fight moves into the medium- to long-term – and to do so, we need to take care of ourselves and lean on each other for mutual support in order to continue helping our patients.

Above all, remember that we put on two sets of PPE – masks, goggles, gloves and gowns to shield us and those we work with against a pandemic virus, but also a set of Psychological Protective Equipment comprising workplace support, resources and coping strategies that enables us to acknowledge the endemic anxiety and fear we feel, manage it, and so continue to fight on.



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