MED441
KING SAUD UNIVERSITY

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REVIEWED BY

Anxiety and Related Disorders

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Objectives:

- Analyze the symptoms & signs, both presented and expected in Anxiety disorders.
- Discuss possible etiological reasons.
- Discuss differential diagnosis.
- List Treatment options.

Color index:

- Important
- Golden
- Textbook
- Old notes (439/438)
- New notes (441)
- Extra

Anxiety Disorders

◄ Anxiety Disorders (DSM-IV-TR)

1. Panic Disorder.
2. Agoraphobia.
3. Specific Phobia.
4. Social Phobia (Social Anxiety Disorder).
5. Generalized Anxiety Disorder (GAD).
6. Obsessive Compulsive Disorder.
7. Post Traumatic Stress Disorder (PTSD), Acute Stress Disorder.

◄ Anxiety Disorders in DSM-5

Anxiety Disorders

1. Separation Anxiety Disorder. (school refusal)
2. Selective Mutism.
3. Specific Phobia.
4. Social Anxiety Disorder.
5. Panic Disorder.
6. Agoraphobia.
7. Generalized Anxiety Disorder.
8. Substance/Medication-Induced Anxiety Disorder.
9. Anxiety Disorder Due to Another Medical Condition.

Obsessive-Compulsive and Related Disorder

1. Obsessive-Compulsive Disorder.
2. Body Dysmorphic Disorder.
3. Hoarding Disorder.
4. Trichotillomania (Hair-Pulling Disorder).
5. Excoriation (Skin-Picking) Disorder.
6. Substance/Medication-Induced Obsessive-Compulsive and Related Disorder.
7. Obsessive-Compulsive and Related Disorder Due to Another Medical Condition.

Trauma- and Stressor-Related Disorders

1. Reactive Attachment Disorder. (Very rare + in children)
2. Disinhibited Social (Very rare + in children) Engagement Disorder.
3. Post Traumatic Stress Disorder (PTSD).
4. Acute Stress Disorder.
5. Adjustment Disorders.

Notes:

- **A general rule: any anxiety needs to last for 6 months in order to be diagnosed as a disorder, EXCEPT: PTSD, panic disorder & adjustment disorder.**
- **In general, Anxiety disorders are the most common psychiatric disorders (10%) prevalence.**
- The prevalence of all anxiety disorder is higher among females except OCD (equal prevalence).

◄ Case Vignette

- Layla is 31 year old female. She came to your clinic complaining of fearfulness, palpitations, shortness of breath and impaired concentration. She is afraid that she will die. These symptoms come suddenly in episodes for the last two months.

◄ Features of Anxiety

Psychological	Physical
• Excessive worries + anticipation. (waiting for something bad) • Fear. • Apprehension + hypervigilance. • Difficulty concentrating. • Feeling of restlessness. • Sensitivity to noise. • Sleep disturbance.[1]	• Neurological: Headache, dizziness and tremors. • ENT: Tinnitus, dizziness, dry mouth and vertigo. • CVS & Chest: Chest pain, palpitations, tachycardia, SOB • GI: Nausea, vomiting and IBS symptoms. • Genitourinary symptoms: Frequent urination, urgency. • Skin: Sweating, goosebumps (piloerection) • MSK (MSS): Muscle tension (most commonly; neck, shoulders, back, jaw, and tension headache).

Panic Attack	Panic Disorder
• A symptom not a disorder (Panic attack is not a medical diagnosis). • Episodic sudden intense fear (of dying, going mad, or losing self-control). • Can be part of many disorders: panic disorder, GAD, phobias, substance abuse, acute & PTSD. ❖ **Two Types:** 1. **Unexpected:** Spontaneous. Essential to Diagnose Panic Disorder. (only in panic disorder) 2. **Situationally bound (expected):** Anticipation Or immediately on exposure to the trigger. e.g. specific phobia. can be associated with panic disorder.(panic disorder and other anxiety disorders)	• **Disorder with specific criteria:** 1. Unexpected recurrent (at least two times) panic attacks (+/- situationally bound)(starts unexpectedly with later appearance of situationally bound attacks) 2. One-month period (or more) of persistent concerns about another attack or implications of the attack or changes in behavior. 3. Not due to other disorders. 4. Functional impairment Note: Panic disorder + ptsd (duration 1-month) all other anxiety disorder 6-months in duration

◄ DSM-5 Criteria for Diagnosis of Panic Disorder

A. **Recurrent unexpected panic attacks.** A panic attack is an abrupt surge of intense fear or intense discomfort that reaches a peak within minutes, and during which time **four** (or more) of the following symptoms occur;

Note: The abrupt surge can occur from a calm state or an anxious state.

'STUDENTS FEAR 3 C's'

(1) Sweating, (2) Trembling or shaking, (3) Unsteadiness, dizziness, light headed or faint, (NOT loss of consciousness. Important to know that LOC occurs in ONLY ONE anxiety disorder → Blood phobia) (4) Depersonalisation (being detached from oneself) or derealisation (feelings of unreality), (5) Excessive heart rate, palpitations, (6) Nausea or abdominal distress, (7) Tingling (numbness or paraesthesias), (8) Shortness of breath or smothering, (9-10) Fear of dying, Fear of losing control or going crazy, (11-13) 3 Cs: chest pain, chills, choking.

Note: Culture-specific symptoms (e.g., tinnitus, neck soreness, headache, uncontrollable screaming or crying) may be seen. Such symptoms should not count as one of the four required symptoms.

FOOTNOTES

1. Four types of insomnia: (1) initial insomnia: difficulty in falling asleep (>30 minutes), (2) middle insomnia: waking up multiple times in the middle of sleep, (3) terminal insomnia: waking up early, (4) non-restorative sleep: feeling unrefreshed despite sleeping an adequate number of hours

◄ DSM-5 Criteria for Diagnosis of Panic Disorder

B. **At least one of the attacks has been followed by 1 month (or more) of one or both of the following:** (summarized by one word "anticipation")
   1. **Persistent concern or worry** about additional panic attacks or their consequences (e.g., losing control, having a heart attack, "going crazy").
   2. A **significant maladaptive change** in behavior related to the attacks (e.g., behaviors designed to avoid having panic attacks, such as avoidance of exercise or unfamiliar situations).

C. The disturbance is **not attributable to the physiological effects of a substance** (e.g., a drug of abuse, a medication) **or another medical condition** (e.g., hyperthyroidism, cardiopulmonary disorders).

D. The **disturbance is not better explained by another mental disorder** (e.g., the panic attacks do not occur only in response to feared social situations, as in social anxiety disorder: in response to circumscribed phobic objects or situations, as in specific phobia: in response to obsessions, as in obsessive-compulsive disorder: in response to reminders of traumatic events, as in posttraumatic stress disorder: or in response to separation from attachment figures, as in separation anxiety disorder).

◄ Panic Disorder

Epidemiology & Etiology

- Women > men.

Causes of increased incidence among women. (1) Hyperemotionality of women (DOCTOR'S NOTE), (2) Hormonal, (3) Females are more expressive.

- Prevalence : 1– 3%.
- Age at onset : 20-35 years.

❖ **Etiology:**

- Genetic predisposition.
- Disturbance of neurotransmitters NE & 5-HT in the **locus coeruleus**[1] (alarm system in the brain). **MCQ !**
- Behavioral conditioning[2]
- Mitral valve prolapse 2x ?..% not increased in Echo (MVP)(worthless, largely abolished association)
- CO_2 hypersensitivity[3]

Course and Prognosis

- With treatment: good.
- Some pts recover within weeks even with no treatment.
- Others have chronic fluctuating course.
- Probability of death due to a panic attack: 0%.
- Probability of loss of consciousness due to a panic attack: 0%.
- SpO_2 are normal in panic attacks.
- The most common comorbid disorders are major depressive disorder and alcohol use disorder.

Management

- Rule out physical causes. (Any condition with sympathetic overactivity (e.g., hypoglycemia, pheochromocytoma, hyperthyroidism)
- Support & reassurance & psychoeducation.
- Bio-Psycho-Social.
- **Medications:** SSRIs (1st line), SNRIs (2nd line), TCAs (3rd line), Combination of CBT and Pharmacotherapy = most effective.[4]

1. BNZ (can be used PRN or until other medications become efficacious)(Given in the 1st two weeks of treatment to reduce the frequency of the attacks) (only used in panic disorders)
2. SSRIs / SNRIs / TCAs.
3. Beta-blockers (somatic symptoms, mild efficacy).

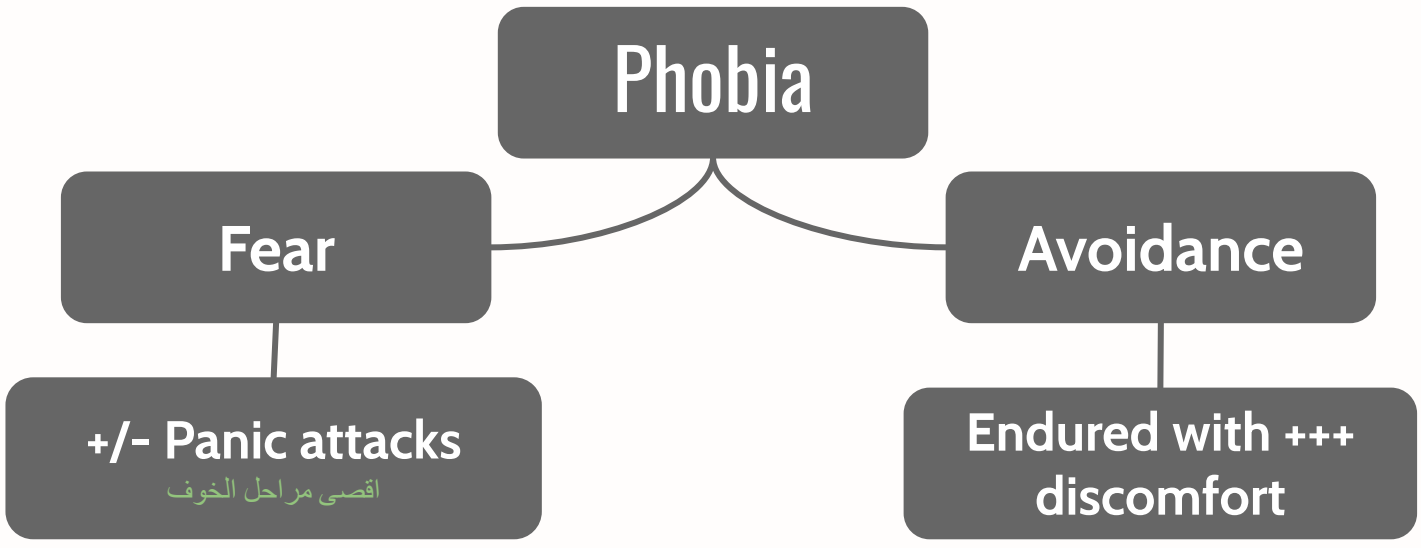
- CBT (40-50 minutes per session, weekly for 10-12 weeks)
- Social.
- Medication should be continued for 6-9 months (up to a year) after improvement of symptoms. (the longer they are used the better)

FOOTNOTES

1. VERY IMPORTANT MCQ ! Part of the reticular activating system (a collection of subcortical nuclei that sensitize cortical neurons into wakefulness). Locus coeruleus is the main source of NE in the brain. The same is true of raphe nuclei for serotonin.
2. This is partially in reference to Pavlov's conditioning experiments (e.g., dog hears a bell and salivates in anticipation of food), in this context it refers to pairing a seemingly harmless stimulus (e.g., palpitations from exercising induces a panic attack through linking this autonomic response with a previous experience, such as palpitations from a car accident)
3. Refers to central hypersensitivity to CO_2, whereby hyperventilation is induced by ever so slight drops in its concentration, producing a feeling of suffocation and secondary autonomic activation (e.g., through a hypothalamic feedback that activates other part of the sympathetic nervous system)
4. If mild-moderate start with one modality (pharmacotherapy or CBT), if severe start with a combination.

◄ Case Development 1

- Layla started to be fearful whenever she leaves her home and ask for company all the time. She anticipated these episodes.
- 10 years ago, when she was in the university, she developed same episodes only in social situations like parties and presentations.
- She also has irrational fear from injections and she has the same episodes when she is exposed to them.



Phobic Disorders: **irrational excessive fear** +/- panic attacks on exposure + **avoidance** or endured with +++ discomfort.

Specific	Social	Agoraphobia
Specific phobia is **the most common anxiety disorder.** Objects or situations: • Blood exchange. • Dental clinic. • Hospital. • Airplane (height). • Animals. • Insects. • Thunder. • Storms. • Closed spaces/lifts. • Darkness. • **Clowns.** Blood + injection phobia are the only phobia that can cause loss of consciousness	• Embarrassment when observed performing badly or showing anxiety features (e.g. speaking in public, leading prayer, and serving guests). • Functional impairment.	• Where it is difficult or embarrassing to escape or get help. 1. Away from home. 2. Crowded places. 3. Confinement :in closed spaces e.g. bridges, or in closed vehicles (e.g. bus). 4. Anxiety about fainting and or loss of control. • Functional impairment. • 70% had panic attacks before.

◀ DSM-5 Criteria for Diagnosis of Specific Phobia

A. Marked fear or anxiety about a specific object or situation (e.g., flying, heights, animals, receiving an injection, seeing blood). Note: In children, the fear or anxiety may be expressed by crying, tantrums, freezing, or clinging.
B. The phobic object or situation almost always provokes immediate fear or anxiety.
C. The phobic object or situation is actively avoided or endured with intense fear or anxiety.
D. The fear or anxiety is out of proportion to the actual danger posed by the specific object or situation and to the sociocultural context.
E. The fear, anxiety, or avoidance is persistent, typically lasting for 6 months or more.
F. The fear, anxiety, or avoidance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
G. The disturbance is not better explained by the symptoms of another mental disorder, including fear, anxiety, and avoidance of situations associated with panic-like symptoms or other incapacitating symptoms (as in agoraphobia): objects or situations related to obsessions (as in obsessive-compulsive disorder); reminders of traumatic events (as in posttraumatic stress disorder); separation from home or attachment figures (as in separation anxiety disorder); or social situations (as in social anxiety disorder).

A simplified mnemonic (**PHOBIA**): **P**ersistent (>6 months), **H**andicapping (restricted lifestyle), **O**ut of proportion, **B**eginning immediately and almost always, **I**ntense fear or anxiety about a specific object or situation leading to **A**voidance.

◀ DSM-5 Criteria for Diagnosis of Social Anxiety Disorder (Social Phobia)

A. Marked fear or anxiety about one or more social situations in which the individual is exposed to possible scrutiny by others. Examples include social interactions (e.g., having a conversation, meeting unfamiliar people), being observed (e.g., eating or drinking), and performing in front of others (e.g., giving a speech). Note: In children, the anxiety must occur in peer settings and not just during interactions with adults.
B. The individual fears that he or she will act in a way or show anxiety symptoms that will be negatively evaluated (i.e., will be humiliating or embarrassing: will lead to rejection or offend others).
C. The social situations almost always provoke fear or anxiety. Note: In children, the fear or anxiety may be expressed by crying, tantrums, freezing, clinging, shrinking, or failing to speak in social situations.
D. The social situations are avoided or endured with intense fear or anxiety.
E. The fear or anxiety is out of proportion to the actual threat posed by the social situation and to the sociocultural context.
F. The fear, anxiety, or avoidance is persistent, typically lasting for 6 months or more.
G. The fear, anxiety, or avoidance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
H. The fear, anxiety, or avoidance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition.
I. The fear, anxiety, or avoidance is not better explained by the symptoms of another mental disorder, such as panic disorder, body dysmorphic disorder, or autism spectrum disorder.
J. If another medical condition (e.g., Parkinson's disease, obesity, disfigurement from burns or injury) is present, the fear, anxiety, or avoidance is clearly unrelated or is excessive. Specify if: Performance only: If the fear is restricted to speaking or performing in public.

A simplified mnemonic (**FEAR**): **F**ear of social situations where exposed to possible scrutiny by others; **F**ears of being negatively evaluated, **E**xposure to the social situation almost always provokes fear or anxiety, **A**voids the social situation or endured with intense fear or anxiety, **R**ecognises that the fear is out of proportion.

◀ DSM-5 Criteria for Diagnosis of Agoraphobia

Notes:
- agoraphobia is excessive fear of not getting help
- 70% of agoraphobics had panic attacks

A. Marked fear or anxiety about **two** (or more) of the following **five** situations:
   1. Using public transportation (e.g., automobiles, buses, trains, ships, planes).
   2. Being in open spaces (e.g., parking lots, marketplaces, bridges).
   3. Being in enclosed places (e.g., shops, theaters, cinemas).
   4. Standing in line or being in a crowd.
   5. Being outside of the home alone.

B. The individual fears or avoids these situations because of thoughts that escape might be difficult or help might not be available in the event of developing panic-like symptoms or other **incapacitating or embarrassing symptoms** (e.g., fear of falling in the elderly; fear of incontinence).

C. The agoraphobic situations almost always provoke fear or anxiety.

D. The agoraphobic situations are actively avoided, require the presence of a companion, or are endured with intense fear or anxiety.

E. The fear or anxiety is out of proportion to the actual danger posed by the agoraphobic situations and to the sociocultural context.

F. The fear, anxiety, or avoidance is persistent, typically lasting for 6 months or more.

G. The fear, anxiety, or avoidance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

H. If another medical condition (e.g., inflammatory bowel disease, Parkinson's disease) is present, the fear, anxiety, or avoidance is clearly excessive.

I. The fear, anxiety, or avoidance is not better explained by the symptoms of another mental disorder—for example, the symptoms are not confined to specific phobia, situational type; do not involve only social situations (as in social anxiety disorder): and are not related exclusively to obsessions (as in obsessive-compulsive disorder), perceived defects or flaws in physical appearance (as in body dysmorphic disorder), reminders of traumatic events (as in posttraumatic stress disorder), or fear of separation (as in separation anxiety disorder).

Note: Agoraphobia is diagnosed irrespective of the presence of panic disorder. If an individual's presentation meets criteria for panic disorder and agoraphobia, both diagnoses should be assigned.

A simplified mnemonic (**COOPE PHOBIA**): A. Marked fear or anxiety about two or more of the five situations: **C**rowded area, **O**pen spaces, **O**utside the home, **P**ublic transport, **E**nclosed spaces.
B. **P**ersistent (>6 months), **H**andicapping (restricted lifestyle), **O**ut-of-proportion fear or anxiety, **B**ecause of thoughts that escape or help might not be available in the event of developing panic-like symptoms or other incapacitating or embarrassing symptoms, **I**ntense fear or anxiety provoked almost always with the agoraphobic situations, **A**voidance.

◀ Management of Phobia

- Rule out physical causes.
- Support & reassurance & psychoeducation.
- Bio-Psycho-Social:
  1. Medications: SSRIs / SNRIs / TCAs, BNZ.
  2. CBT.
  3. Social.

For social phobia:- mild & moderate > one type, either CBT or meds(antidepressants)
Severe social phobia > both CBT and antidepressants.
BUT, antidepressants only work after 4 weeks. So, if there is a short period, you might use BBs or BDZs only temporarily for the event. N.B. BDZs can cause darning.

Treatment of specific phobia is only CBT, not medical, mainly includes "Gradual Exposure Therapy", "Habituation", "Systematic desensitization", it usually takes 30 min for habituation to reduce fear scale to half original score

- **Benzodiazepines: Only given in urgent situations**, beta-blockers for somatic symptoms (e.g., claustrophobics who are in urgent need of an MRI, scheduled flight with no time for CBT).

Social anxiety disorder and agoraphobia: **CBT** (treatment of choice), **SSRIs** (first-line), **SNRIs** (2nd line), **TCAs or MAOI** (3rd line). Use **propranolol for performance anxiety.** Buspirone is ineffective.

- Benzodiazepines PRN for specific situations (e.g., job interview)

What is the difference between a person who fears planes due to specific phobia or due to agoraphobia?

- The reason for the fear is what differentiates the two.
- If the fear is of the plane itself (e.g., plane accident) = specific phobia
- If the fear is of being trapped (e.g., not being able to escape when needed) = agoraphobia

◄ Case Development 2

- Her aunt is anxious for the last 8 years. She has **excessive worries** about daily events mainly toward safety of her kids. A classical case of GAD is of a mother figure whose son is starting to drive and she calls him incessantly whenever he goes out for a drive. Not answering may trigger the worst assumption (e.g., being dead or severely injured in an accident)

◄ Criteria for Diagnosis of Generalized Anxiety Disorder in Brief

- Excessive worries[1] about many events: (routine themes "everyday events", Difficult to control or relax, not productive).
- Multiple physical & psychological features.
- Significant impairment in function.
- Not due to GMC (General medical condition), substance abuse, or other axis of psychiatric disorders (DSM-IV rules, now abolished).
- 6 months duration – most of the time.

1- Possible MCQ: what is the core symptom of GAD? Excessive worries

◄ DSM-5 Criteria for Diagnosis of Generalized Anxiety Disorder

A. **Excessive anxiety and worry** (apprehensive expectation), occurring more days than not **for at least 6 months**, about a number of events or activities (such as work or school performance).
B. The individual finds it **difficult to control the worry.**
C. The anxiety and worry are associated with **three (or more)** of the following six symptoms (with at least some symptoms having been present for more days than not **for the past 6 months); Note: Only one item is required in children.**
    1. Restlessness or feeling keyed up or on edge.
    2. Being easily fatigued.
    3. Difficulty concentrating or mind going blank.
    4. Irritability.
    5. Muscle tension.
    6. Sleep disturbance (difficulty falling or staying asleep, or restless, unsatisfying sleep).
D. The anxiety, worry, or physical symptoms cause **clinically significant distress or impairment** in social, occupational, or other important areas of functioning.
E. The disturbance is **not attributable to the physiological effects of a substance** (e.g., a drug of abuse, a medication) or **another medical condition** (e.g., hyperthyroidism).
F. The disturbance is **not better explained by another mental disorder** (e.g., anxiety or worry about having panic attacks in panic disorder, negative evaluation in social anxiety disorder [social phobia], contamination or other obsessions in obsessive-compulsive disorder, separation from attachment figures in separation anxiety disorder, reminders of traumatic events in posttraumatic stress disorder, gaining weight in anorexia nervosa, physical complaints in somatic symptom disorder, perceived appearance flaws in body dysmorphic disorder, having a serious illness in illness anxiety disorder, or the content of delusional beliefs in schizophrenia or delusional disorder).

◄ Associated Features

- Panic attacks (episodes of short severe anxiety that are situationally-bound)
- Sadness +/- weeping.
- Over-concerned about body functions (heart, brain, etc).
- Secondary depression

◄ Mental Status Exam

- Tense posture, excessive movement, e.g. hands (tremor) & head, excessive blinking.
- Sweating.
- Difficulty in inhalation.

◄ Course and Prognosis

- **If not appropriately treated:**
  - Chronic, fluctuating & worsens with stress.
  - Secondary depression.
  - Possible physical complications: e.g. HTN, DM, IHD.
- **Poor Prognostic Factors: (Possible MCQ)**
  - Very severe symptoms.
  - Personality problems.
  - Uncooperative patient.
  - Derealization.

◄ Management of Generalized Anxiety Disorder

- Rule out physical causes.
- Support & reassurance & psychoeducation.
- Bio-Psycho-Social:
  1. Medications: SSRIs / SNRIs / TCAs.
  2. CBT.
  3. Social.
- Most effective = **CBT + pharmacotherapy.**
- **CBT.**
- **SSRIs** (first-line) or **SNRIs** (2nd line).
- Short-term course of **benzodiazepines** or augmentation with a nonbenzodiazepine anxiolytic **buspirone** (less dependance but less effective) or hydroxyzine (antihistamine, a safer alternative to benzodiazepines).
- Sedating TCAs (e.g., doxepin, amitriptyline), and MAOIs.

DSM-5 Criteria for Diagnosis of Separation Anxiety Disorder

A. Developmentally inappropriate and excessive fear or anxiety concerning separation from those to whom the individual is attached, as evidenced by at least **three** of the following:
   1. Recurrent excessive distress when anticipating or experiencing separation from home or from major attachment figures.
   2. Persistent and excessive worry about losing major attachment figures or about possible harm to them, such as illness, injury, disasters, or death.
   3. Persistent and excessive worry about experiencing an untoward event (e.g., getting lost, being kidnapped, having an accident, becoming ill) that causes separation from a major attachment figure.
   4. Persistent reluctance or refusal to go out, away from home, to school, to work, or elsewhere because of fear of separation.
   5. Persistent and excessive fear of or reluctance about being alone or without major attachment figures at home or in other settings.
   6. Persistent reluctance or refusal to sleep away from home or to go to sleep without being near a major attachment figure.
   7. Repeated nightmares involving the theme of separation.
   8. Repeated complaints of physical symptoms (e.g., headaches, stomachaches, nausea, vomiting) when separation from major attachment figures occurs or is anticipated.

B. The fear, anxiety, or avoidance is persistent, lasting at least 4 weeks in children and adolescents and typically 6 months or more in adults.

C. The disturbance causes clinically significant distress or impairment in social, academic, occupational, or other important areas of functioning.

D. The disturbance is not better explained by another mental disorder, such as refusing to leave home because of excessive resistance to change in autism spectrum disorder; delusions or hallucinations concerning separation in psychotic disorders; refusal to go outside without a trusted companion in agoraphobia; worries about ill health or other harm befalling significant others in generalized anxiety disorder; or concerns about having an illness in illness anxiety Disorder.

A simplified mnemonic (**HUG PANDaS**): (three of eight for 4 weeks in children and adolescents or 6 months in adults) **H**arm or loss of an attachment figure, **U**ntoward event that causes separation from attachment figure worry, **G**oing out of home, **P**hysical symptoms with anticipated separation, **A**lone is a big fear, **N**ightmares involving the theme of separation, **D**istress of separation, **S**leeping without an attachment figure.

Management of Separation Anxiety Disorder

- **CBT and family therapy (most important).**
- **SSRIs** (adjunct to psychotherapy).
- Promote the child's social participation including going to school.

◄ Case Development 3

- One of Layla's sisters has recurrent intrusive silly doubts regarding ablutions and praying that she cannot resist. This makes her repeat ablution and praying frequently.

Obsessions

- Own: thoughts, Impulses, images.
- Intrusive, Insisting, Unwanted.
- Repetitive.
- Irrational.
- Uncontrollable.
- e.g. contaminated hands.

Compulsions

- Irresistible, Compelling Actions or mental acts.
- Done in response to obsessions or according to rules to reduce anxiety or prevent dreaded events or situations.
- e.g. washing hands repeatedly.

Disorder

- Time consuming at least 1 hr/d.
- Functioning impairment.

◄ DSM-5 Criteria for Diagnosis of Obsessive-Compulsive Disorder

A. Presence of obsessions, compulsions, or both:

- **Obsessions are defined by (1) and (2):**
  1. Recurrent and persistent thoughts, **urges**, or images that are experienced, at some time during the disturbance, as **intrusive** and unwanted, and that in most individuals cause marked anxiety or distress.
  2. The individual attempts to ignore or suppress such thoughts, urges, or images, or to neutralize them with some other thought or action (i.e., by performing a compulsion).
- **Compulsions are defined by (1) and (2):**
  1. Repetitive behaviors (e.g., hand washing, ordering, checking) or mental acts (e.g., praying, counting, repeating words silently) that the individual feels driven to perform in response to an obsession or according to rules that must be applied rigidly.
  2. The behaviors or mental acts are aimed at preventing or reducing anxiety or distress, or preventing some dreaded event or situation; however, these behaviors or mental acts are not connected in a realistic way with what they are designed to neutralize or prevent, or are clearly excessive. Note: Young children may not be able to articulate the aims of these behaviors or mental acts.

B. The obsessions or compulsions are **time-consuming** (e.g., take more than 1 hour per day) or cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

C. The obsessive-compulsive symptoms are not attributable to the physiological effects of a substance (e.g. a drug of abuse, a medication) or another medical condition.

D. The disturbance is not better explained by the symptoms of another mental disorder (e.g., excessive worries, as in generalized anxiety disorder; preoccupation with appearance, as in body dysmorphic disorder; difficulty discarding or parting with possessions, as in hoarding disorder; hair pulling, as in trichotillomania [hair-pulling disorder]; skin picking, as in excoriation [skin-picking] disorder; stereotypies, as in stereotypic movement disorder; ritualized eating behavior, as in eating disorders; preoccupation with substances or gambling, as in substance-related and addictive disorders; preoccupation with having an illness, as in illness anxiety disorder; sexual urges or fantasies, as in paraphilic disorders; impulses, as in disruptive, impulse-control, and conduct disorders; guilty ruminations, as in major depressive disorder; thought insertion or delusional preoccupations, as in schizophrenia spectrum and other psychotic disorders; or repetitive patterns of behavior, as in autism spectrum disorder).

Specify if: With good or fair insight: The individual recognizes that obsessive-compulsive disorder beliefs are definitely or probably not true or that they may or may not be true. With poor insight: The individual thinks obsessive-compulsive disorder beliefs are probably true. With absent insight/delusional beliefs: The individual is completely convinced that obsessive-compulsive disorder beliefs are true.

Specify if: Tic-related: The individual has a current or past history of a tic disorder.

◄ Main Themes of Obsessive-Compulsive Disorder (OCD)[1]

- **Sense of danger and/or responsibility,** lead to obsessive thoughts and compulsive acts in those aspects:
  - Contamination > washing.
  - **Religious**, e.g. repeating ablution, prayers, divorce, **blasphemous**.كفري
  - Sexual.
  - Aggression.
  - Symmetry > slowness.
  - Hoarding.

TABLE 8–2. Varied content in obsessions

Obsession	Foci of preoccupation
Aggression	Physical or verbal assault on self or others (includes suicidal and homicidal thoughts); accidents; mishaps; wars and natural disasters; death
Contamination	Excreta, human or otherwise; dirt, dust; semen; menstrual blood; other bodily excretions; germs; illness, especially venereal diseases; AIDS
Symmetry	Orderliness in arrangements of any kind (e.g., books on the shelf, shirts in the dresser)
Sexual	Sexual advances toward self or others; incestuous impulses; genitalia of either gender; homosexuality; masturbation; competence in sexual performance
Hoarding	Collecting items of any kind, typically items with little or no intrinsic value (e.g., string, shopping bags); inability to throw things out
Religious	Existence of God; validity of religious stories, practices, or holidays; committing sinful acts
Somatic	Preoccupation with body parts (e.g., nose); concern with appearance; belief in having disease or illness (e.g., cancer)

Source. Adapted from Akhtar et al. 1975.

◄ Etiology & Course

- Neurotransmitter defects (especially serotonin).
- Learning theory: anxiety is paired with a particular obsession (e.g., cleanliness [pavlovian conditioning]) and the person works compulsively in order to decrease the anxiety.
- Gearshift hypothesis[2]
- **Course:**
  - Gradual > acute.
  - Chronic.
  - Waxing & waning. يتحسن ويسوء

TABLE 8–3. Frequency of common obsessions and compulsions in 560 patients with obsessive-compulsive disorder

Obsessions	%	Compulsions	%
Contamination	50	Checking	61
Pathological doubt	42	Washing	50
Somatic	33	Counting	36
Need for symmetry	32	Need to ask or confess	34
Aggressive impulse	31	Symmetry and precision	28
Sexual impulse	24	Hoarding	18
Multiple obsessions	72	Multiple compulsions	58

Source. Adapted from Rasmussen and Eisen 1998.

◄ Prognosis

- **Good prognostic factors:**
  1. Non-severe.
  2. No OCPD.
  3. Depressed/Anxious mood.
  4. Compliance with Treatment.
  5. Family support.

◄ Management of Obsessive-Compulsive Disorder

1. Rule out physical causes.
2. Support & reassurance & psychoeducation.
3. Bio-Psycho-Social:
   1. Medications: SSRIs / SNRIs / TCAs, BNZ.
   2. CBT.
   3. Social.

- **CBT** and **pharmacotherapy.**

1. **SSRIs (first-line)**(higher dosage than depression).
2. **SNRIs** or **clomipramine**[3] **(second-line).** Clomipramine is the best TCA for ocd **MCQ!!!**
3. **Antipsychotics if refractory to the above**
4. **Refractory OCD: Psychosurgery (cingulotomy** - check footnote 2**), ECT or deep brain stimulation.**

FOOTNOTES

1. Most common complaint in Saudi is religious (e.g., repeated ablution). Most common complaint in the western world is aggressive (e.g., fearing that one might stick a knife in themselves whenever they hold it).
2. When we make a mistake three things happen, (1) mistake detection "mistake feeling" , particularly through the orbital frontal cortex which fires signals to the cingulate gyrus, (2) mistake anxiety, triggered by the cingulate gyrus, a region with rich connections to the hypothalamus allowing the release of stress hormones (e.g., cortisol) as well as connections with the autonomic brainstem centers (e.g., cardiac centers), this triggers a gut feeling of anxiety a coupled with palpitations, hyperventilations and other sympathetic responses, (3) after correcting the mistake, the caudate nucleus (a nucleus in the basal ganglia that loops around the brain) help the brain move on to the next problem. People with OCDs have a hyperactive caudate nucleus that gets stuck on the same problem and doesn't allow proper shift to the next thought.
3. Clomipramine is the TCA with the highest selectivity to inhibit the reuptake of serotonin. Other TCAs are hypothesized to work by inhibiting the reuptake of both NE and serotonin.

◀ Case Development 4

- Also, her brother Saad, has the same symptoms of Layla whenever he is exposed to cues that remind him with the car accident that he had 2 years ago. Saad had serious injuries in that accident and he was in coma for 3 weeks. His friend died in the same accident. He also has flashbacks related to that accident. Also, he refuses to talk about the accident and avoids drive in the street where the accident happened.

◀ Consequence of Trauma

At Least 6 symptoms to diagnose. 1-2-1-2. Accordingly.

Re-experience

- Also known as; intrusions
- Flashbacks.
- Nightmares.
- Hallucinations (transient)
- Cues ➔ (These intrusions usually occur after cues eg. if the car accident involved a blue car. When he sees a blue car later on it may lead to flashbacks or hallucinations)

Changes in Mood and Cognitions

- Amnesia.
- Negative beliefs.
- Distorted cognitions ➔ blame.
- Negative emotional state.
- Diminished interest.
- Detachment. (noticed by close observers [e.g., family])
- Persistent inability to experience positive emotions.

Avoidance

- External: eg, Place, People, Conversations
- Internal: eg, emotions, memories

Arousal

- Sleep.
- Hypervigilance.
- Irritability.
- Anger.
- Middle insomnia.
- Nightmares

◀ Acute Stress Disorder and Post-Traumatic Stress Disorder (PTSD)

- After exposure to traumatic life events.
- Trauma in psychiatry = life-threatening.
- OCDs often suffer from middle insomnia (waking up in the middle of the night).
- Duration > a month after the event.
- Acute stress disorder (ASD): occurs earlier than Post Traumatic Stress Disorder (PTSD) (within 4 weeks of the event) and **remits within 2 days to 4 weeks.**
- Must significantly affect important areas of life (family and work).

- The stressors are sufficiently overwhelming to affect almost anyone.
- Arise from experiences in war, torture, natural catastrophes, assault, rape, and serious accidents, for example, in cars and in burning buildings.

there are 4 forms by which PTSD occurs:-.
1- happens to you 2- witnessed by you
3- happened to a very close person
4- by seeing a video that is related to your work

It has to be life-threatening in order to be called PTSD

◀ DSM-5 Criteria for Diagnosis of Post-Traumatic Stress Disorder

Note: The following criteria apply to adults, adolescents, and children older than 6 years. For children 6 years and younger, see corresponding criteria below.

A. Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways:
   1. Directly experiencing the traumatic event(s).
   2. Witnessing, in person, the event(s) as it occurred to others.
   3. Learning that the traumatic event(s) occurred to a close family member or close friend. In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental.
   4. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains: police officers repeatedly exposed to details of child abuse or even psychiatrists). Note: Criterion A4 does not apply to exposure through electronic media, television, movies, or pictures, unless this exposure is work related.

B. Presence of one (or more) of the following **intrusion** symptoms associated with the traumatic event(s), beginning after the traumatic event(s) occurred:
   1. Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s). Note: In children older than 6 years, repetitive play may occur in which themes or aspects of the traumatic event(s) are expressed.
   2. Recurrent distressing dreams in which the content and/or affect of the dream are related to the traumatic event(s). Note: In children, there may be frightening dreams without recognizable content.
   3. Dissociative reactions (e.g., flashbacks) in which the individual feels or acts as if the traumatic event(s) were recurring. (Such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings). Note: In children, trauma-specific reenactment may occur in play.
   4. Intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).
   5. Marked physiological reactions to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).

C. Persistent **avoidance** of stimuli associated with the traumatic event(s), beginning after the traumatic event(s) occurred, as evidenced by one or both of the following:
   1. Avoidance of or efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).
   2. Avoidance of or efforts to avoid external reminders (people, places, conversations, activities, objects, situations) that arouse distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).

D. **Negative alterations in cognitions and mood** associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:
   1. Inability to remember an important aspect of the traumatic event(s) (typically due to dissociative amnesia and not to other factors such as head injury, alcohol, or drugs).
   2. Persistent and exaggerated negative beliefs or expectations about oneself, others, or the world (e.g., “I am bad,” “No one can be trusted,” ‘The world is completely dangerous,” “My whole nervous system is permanently ruined”).
   3. Persistent, distorted cognitions about the cause or consequences of the traumatic event(s) that lead the individual to blame himself/herself or others.
   4. Persistent negative emotional state (e.g., fear, horror, anger, guilt, or shame).
   5. Markedly diminished interest or participation in significant activities.
   6. Feelings of detachment or estrangement from others.
   7. Persistent inability to experience positive emotions (e.g., inability to experience happiness, satisfaction, or loving feelings).

◀ DSM-5 Criteria for Diagnosis of Post-Traumatic Stress Disorder

E. Marked alterations in **arousal** and reactivity associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:
   1. Irritable behavior and angry outbursts (with little or no provocation) typically expressed as verbal or physical aggression toward people or objects.
   2. Reckless or self-destructive behavior.
   3. Hyper-vigilance.
   4. Exaggerated startle response.
   5. Problems with concentration.
   6. Sleep disturbance (e.g., difficulty falling or staying asleep or restless sleep).

F. Duration of the disturbance (Criteria B, C, D, and E) is more than 1 month.

G. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

H. The disturbance is not attributable to the physiological effects of a substance (e.g., medication, alcohol) or another medical condition.

Specify whether: With dissociative symptoms: The individual's symptoms meet the criteria for post traumatic stress disorder, and in addition, in response to the stressor, the individual experiences persistent or recurrent symptoms of either of the following:

1. Depersonalization: Persistent or recurrent experiences of feeling detached from, and as if one were an outside observer of, one's mental processes or body (e.g., feeling as though one were in a dream; feeling a sense of unreality of self or body or of time moving slowly).
2. Derealization: Persistent or recurrent experiences of unreality of surroundings (e.g., the world around the individual is experienced as unreal, dreamlike, distant, or distorted). Note: To use this subtype, the dissociative symptoms must not be attributable to the physiological effects of a substance (e.g., blackouts, behavior during alcohol intoxication) or another medical condition (e.g., complex partial seizures).

Specify if: With delayed expression: If the full diagnostic criteria are not met until at least 6 months after the event (although the onset and expression of some symptoms may be immediate).

A simplified mnemonic (**TRAAUMA**): **T**raumatic event: (1) witnessed, (2) experienced, (3) occurred to dearest or (4) exposure repeatedly to its aversive details, **R**e-experience one of following intrusion symptoms: memories, nightmares, flashbacks, psychological distress or physiological reaction to cues symbolising the traumatic event, **A**voidance of memories, thoughts, feelings of the traumatic event or its reminders, **A**lterations in cognitions and mood negatively: forgetting, mislabelling, blaming, no positive emotions, always negative emotions, anhedonia, detachment **(two of seven), U**nable to function or cause distress/**U**nattributed to a substance or another medical condition, **M**onth or more of symptoms, **A**rousal and reactivity increased with **two of the following**: irritability, recklessness, hypervigilance, startling, concentration and sleep disturbances.

◄ Epidemiology

- The lifetime prevalence:
  - 8% of the general population.
  - Up to 75% in high-risk groups whose experienced traumatic events.
  - 5-15% may experience subclinical forms of the disorder.
- **The most important risk factors** are the severity, duration and proximity of a person's exposure to the actual trauma.
- **Risk Factors**: Single, divorced, widowed, socially withdrawn, or of low socioeconomic level.

◄ Comorbidities

- High rates.
- Two thirds (66%) having at least two other disorders.
- Common:
  - Depressive disorders.
  - Substance-related disorders.
  - Other anxiety disorders.
  - Bipolar disorders.

◄ Prognosis

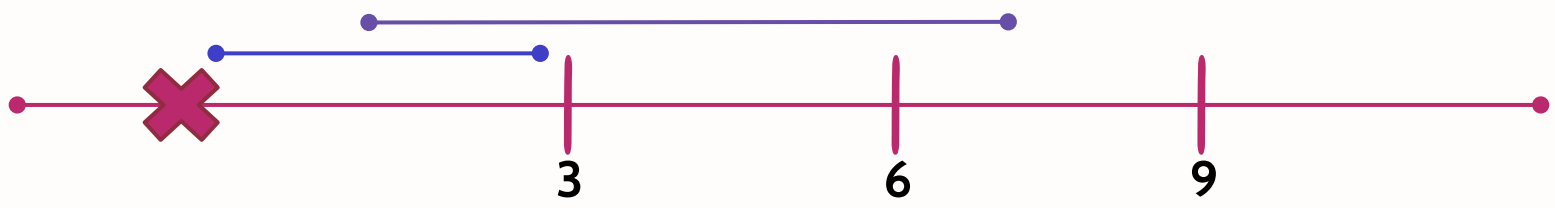
- Fluctuate over time and may be most intense during periods of stress.
- **Untreated:**
  - About 30% of patients recover completely.
  - 40% continue to have mild symptoms.
  - 20% continue to have moderate symptoms. (difficult to treat)
  - 10% remain unchanged or become worse. (difficult to treat)
  - After 1 year, about 50% of patients will recover.
- **A good prognosis:**
  - Rapid onset of the symptoms.
  - Short duration of the symptoms (less than 6 months).
  - Good premorbid functioning.
  - Strong social supports.
  - Absence of other psychiatric, medical, or substance-related disorders or other risk factors.

◄ Management of PTSD

- **CBT and pharmacotherapy (Bio-psycho-social)**.
  - **SSRIs** (first-line), **SNRIs** (second-line).
  - **Prazosin** for intractable nightmares.
  - **Benzodiazepines** (short-term treatment of anxiety).
  - **Atypical antipsychotics** in severe cases (combined with SSRIs).

◄ Adjustment Disorders

- The adjustment disorders: Emotional response to a stressful event.
- The stressor involves; financial issues, a medical illness, or a relationship problem.
- The symptoms must begin within 3 months of the stressor and must remit within 6 months of removal of the stressor.



◄ DSM-IV-TR Diagnostic Criteria for Adjustment Disorders

- Adjustment disorders are coded based on the subtype, which is selected according to the predominant symptoms. The specific stressor(s) can be specified on Axis IV.
  - With depressed mood.
  - With anxiety.
  - With mixed anxiety and depressed mood.
  - With disturbance of conduct.
  - With mixed disturbance of emotions and conduct.
  - Unspecified.

NB. In all anxiety disorders the required duration of symptoms is 6 months. Except in:

- **Panic disorder - 1 month**
- **PTSD - 1 month**
- **Adjustment disorder - <6 months**

◀ DSM-5 Criteria for Diagnosis of Adjustment Disorder

A. The development of emotional or behavioral symptoms in response to an identifiable stressor(s) **occurring within 3 months of the onset of the stressor(s).**
B. These symptoms or behaviors are clinically significant, as evidenced by one or both of the following:
   1. Marked distress that is out of proportion to the severity or intensity of the stressor, taking into account the external context and the cultural factors that might influence symptom severity and presentation.
   2. Significant impairment in social, occupational, or other important areas of functioning.
C. The stress-related disturbance does not meet the criteria for another mental disorder and is not merely an exacerbation of a preexisting mental disorder.
D. The symptoms do not represent normal bereavement.
E. Once the stressor or its consequences have terminated, the symptoms do not persist for more than an additional 6 months.

Specify whether:

- With depressed mood: Low mood, tearfulness, or feelings of hopelessness are predominant.
- With anxiety: Nervousness, worry, jitteriness, or separation anxiety is predominant.
- With mixed anxiety and depressed mood: A combination of depression and anxiety is predominant
- With disturbance of conduct: Disturbance of conduct is predominant.
- With mixed disturbance of emotions and conduct: Both emotional symptoms (e.g., depression, anxiety) and a disturbance of conduct are predominant.
- Unspecified: For maladaptive reactions that are not classifiable as one of the specific subtypes of adjustment disorder.

◀ Course and Prognosis

- With appropriate treatment, the overall prognosis of an adjustment disorder is generally favorable.
- **Most patients return to their previous level of functioning within 3 months.**
- Some persons (particularly adolescents) who receive a diagnosis of an adjustment disorder later have mood disorders or substance-related disorders.
- Adolescents usually require a longer time to recover than adults.
- It is a diagnosis of exclusion when symptoms do not meet the criteria for a depressive episode with an otherwise marked impairment in social and occupational functioning.

◀ Management of Adjustment Disorder

- **Supportive psychotherapy is the treatment of choice (individual or group).**
- **Pharmacotherapy** to target specific symptoms.
  - Depressed mood: **antidepressants (e.g., SSRIs).**
  - Severe anxiety: **benzodiazepines.**
  - Initial insomnia: **zolpidem** (ambien, a sedative-hypnotic).

◄ Other Disorders

Disorder	Trichotillomania (Hair-Pulling)	Excoriation (Skin-Picking)	Hoarding Disorder	Body Dysmorphic Disorder (Dysmorphophobia)
Key Features	• Recurrent hair pulling resulting in lesions. • Repeated attempts to decrease or stop skin picking. • Impairment in daily functioning and not due to other disorders or substances. • It can affect any body site. • Frank balding may not be visible . • More common in females	• Recurrent skin picking resulting in lesions. • Repeated attempts to decrease or stop skin picking. • Impairment in daily functioning and not due to other disorders or substances.	• Persistent difficulty discarding possessions, regardless of value. • Difficulty is due to need to save the items and distress associated with discarding them. • Results in accumulation of possessions that congest/clutter living areas and compromise use. • Impairment in daily functioning and not due to other disorders or substances.	• Preoccupation with one or more perceived defects or flaws in physical appearance that are not observable by or appear slight to others. • In response to the appearance concerns, repetitive behaviors (e.g., skin picking, excessive grooming) or mental acts (e.g., comparing appearance to others) are performed. • Impairment in daily functioning and not due to eating disorders. • More common in females
Management	Pharmacotherapy and psychotherapy (e.g., habit reversal training). • SSRIs or clomipramine. • Others: N-acetylcysteine, second-generation antipsychotics, lithium. • Topical steroids for localized itching.	• Specialized types of cognitive-behavior therapy (e.g., habit reversal training). • SSRIs.	• Treatment is challenging • Specialized CBT for hoarding • SSRIs can be used.	• SSRIs are the medications of choice and/or psychotherapy • Delusions: Add atypical antipsychotics. • Plastic surgeries are generally not recommended.
Other disorders (e.g., selective mutism) are going to be discussed in other lectures. - You're only expected to know the basic concepts of the disorders in this table, not strict memorization of their DSM-5 criteria.				

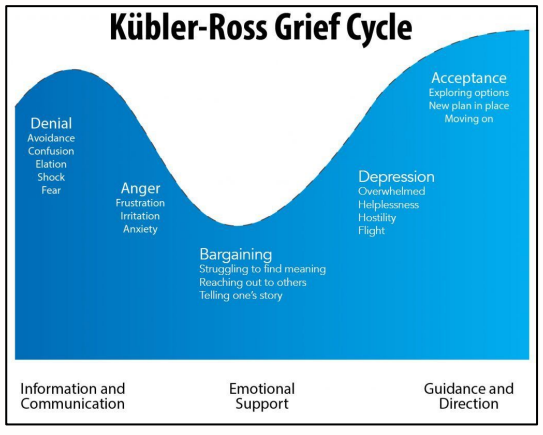
◄ Bereavement, Grief, and Mourning

Skipped by the doctor

- Psychological reactions of those who survive a significant loss.
- Mourning is the process by which grief is resolved.
- Bereavement literally means the state of being deprived of someone by death and refers to being in the state of mourning.

◄ Normal Bereavement Reactions

IMP for the exam



- Stage 1: Shock and Denial.
  - Lasts a few hours or 1-2 days
- Stage 2: Anger.
  - Usually hours
- Stage 3: Bargaining.
  - As in those who plead with God for the cure of their loved ones
- Stage 4: Depression. (Sadness)
  - Length differs from person to person
- Stage 5: Acceptance.

They may not occur in this exact order. Some may not even occur at all (e.g., bargaining with God to save you from drowning)

◄ Summary (Bereavement or Depression)?

- **In bereavement:**
  - NO morbid feelings of guilt and worthlessness, suicidal ideation, or psychomotor retardation.
  - Dysphoria often triggered by thoughts or reminders of the deceased.
  - Onset is within the first 2 months of bereavement.
  - Duration of depressive symptoms is less than 2 months.
  - Functional impairment is transient and mild.
  - No family or personal history of major depression.

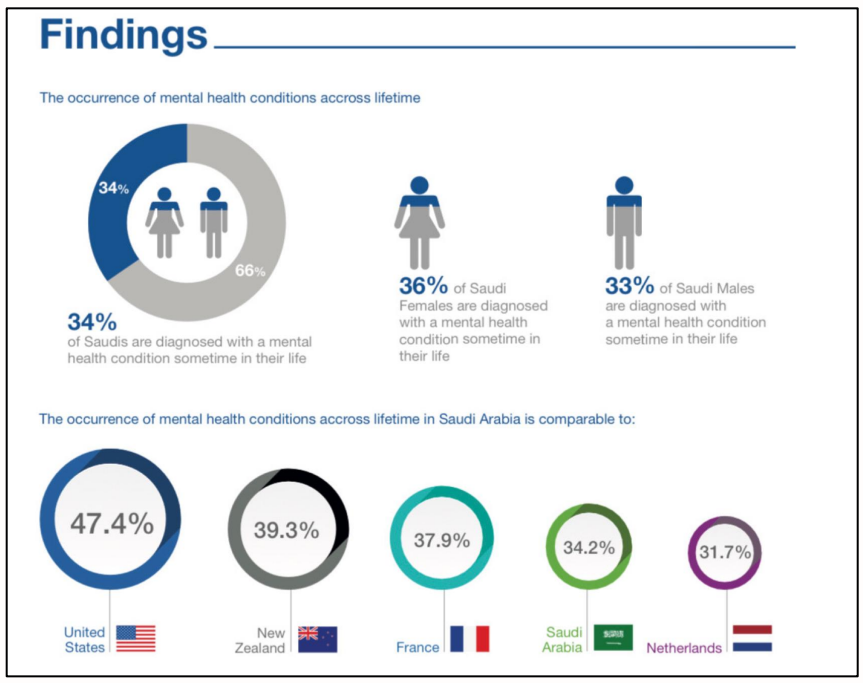
◄ Prognosis in General

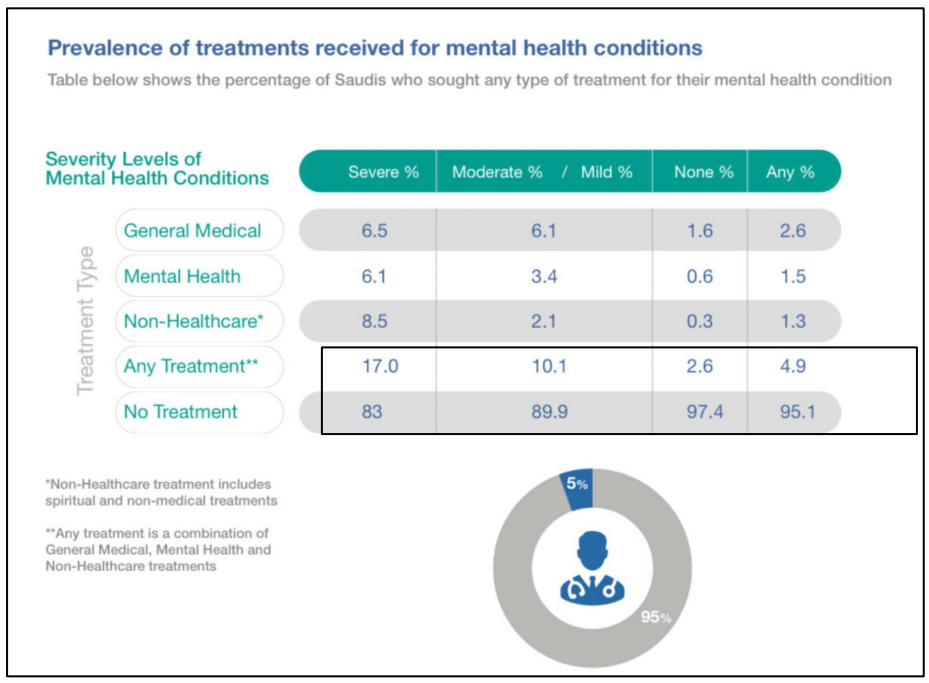
- **Depends on:**
  - Diagnosis (Psychosis → Mood → Anxiety).
  - Severity.
  - Duration.
  - Support.
  - Compliance.

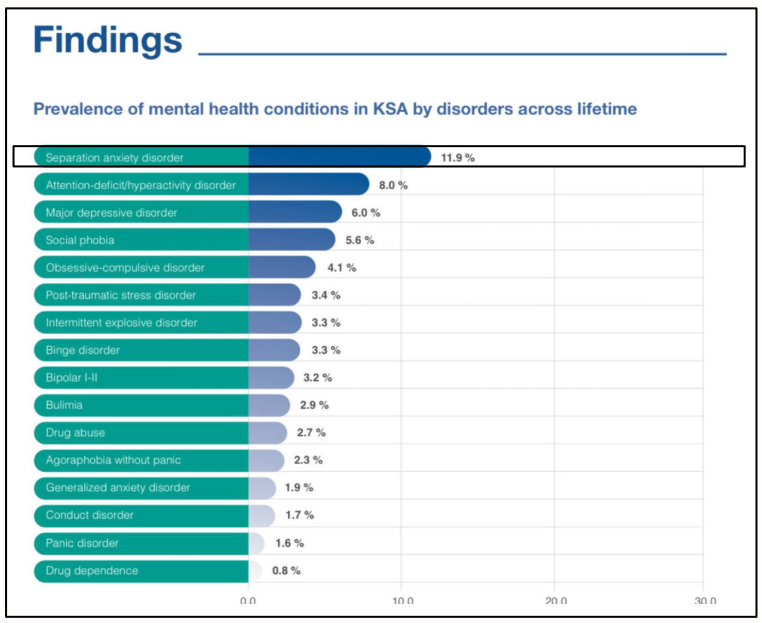
◄ Anxiety in General

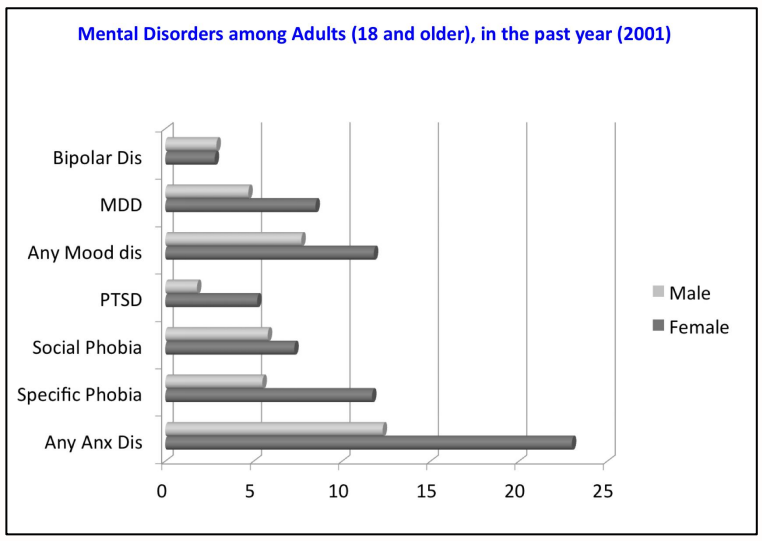
	Normal Anxiety	Abnormal Anxiety
Apprehension	Proportional to the trigger (time & severity)	Out of proportion
Attention	External trigger > body responses	Body responses > external trigger
Features	Few - not severe - not prolonged & minimal effect on life	Many – severe – prolonged & interfere with life
Types	Trait (character) State (situational)	GAD-Panic-Phobias Acute & PTSD, etc

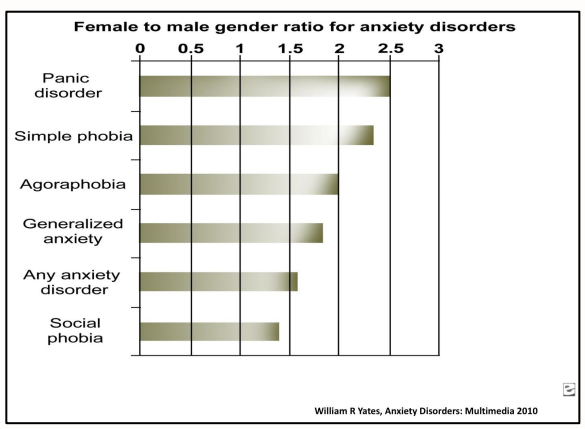
Prevalence in Saudi Arabia











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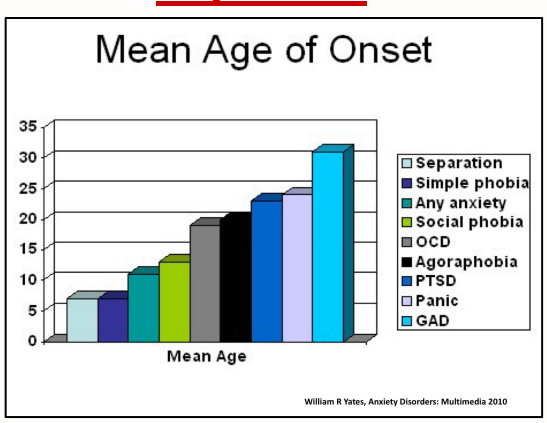


Know that Amygdala is associated with Panic disorders

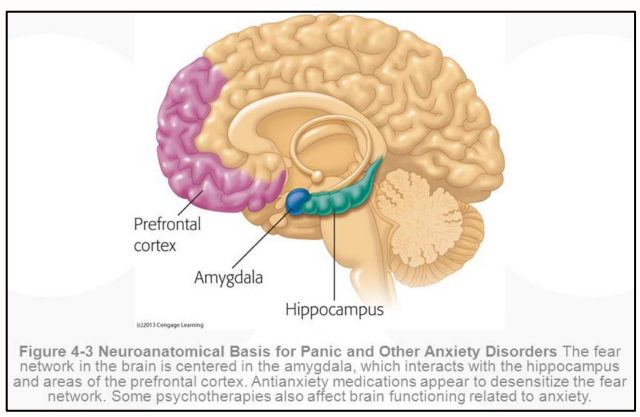


Figure 4-3 Neuroanatomical Basis for Panic and Other Anxiety Disorders The fear network in the brain is centered in the amygdala, which interacts with the hippocampus and areas of the prefrontal cortex. Antianxiety medications appear to desensitize the fear network. Some psychotherapies also affect brain functioning related to anxiety.

Most occur around the 3rd decade.

- Separation anxiety and specific phobias occur in childhood
- GAD usually occurs in the 4th decade

◄ Mnemonic Zone

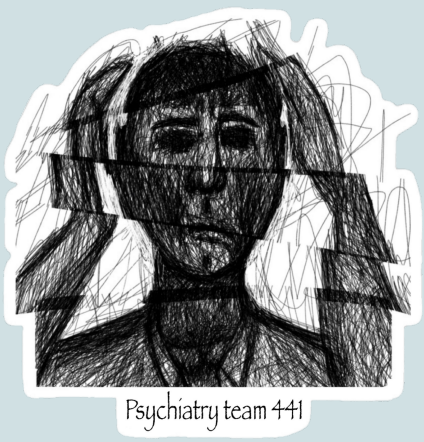
Disorder	DSM-5 Mnemonic
Panic Attacks	('STUDENTS FEAR 3 C's)' (1) Sweating, (2) Trembling or shaking, (3) Unsteadiness, dizziness, light headed or faint, (4) Depersonalisation or derealisation, (5) Excessive heart rate, palpitations, (6) Nausea or abdominal distress, (7) Tingling (numbness or paraesthesias), (8) Shortness of breath or smothering, (9-10) Fear of dying, Fear of losing control or going crazy, (11-13) 3 Cs: chest pain, chills, choking
Specific Phobia	(PHOBIA): Persistent (>6 months), Handicapping (restricted lifestyle), Out of proportion Beginning immediately and almost always, Intense fear or anxiety about a specific object or situation leading to Avoidance
Social Anxiety Disorder	(FEAR): Fear of social situations where exposed to possible scrutiny by others; Fears of being negatively evaluated, Exposure to the social situation almost always provokes fear or anxiety, Avoids the social situation or endured with intense fear or anxiety, Recognises that the fear is out of proportion
Agoraphobia	(COOPE PHOBIA): A. Marked fear or anxiety about two or more of the five situations: Crowded area Open spaces Outside the home Public transport Enclosed spaces B. Persistent (>6 months), Handicapping (restricted lifestyle), Out-of-proportion fear or anxiety, Because of thoughts that escape or help might not be available in the event of developing panic-like symptoms or other incapacitating or embarrassing symptoms, Intense fear or anxiety provoked almost always with the agoraphobic situations, Avoidance
Separation Anxiety Disorder	(HUG PANDaS): (three of eight for 4 weeks in children and adolescents or 6 months in adults) Harm or loss of an attachment figure, Untoward event that causes separation from attachment figure worry, Going out of home, Physical symptoms with anticipated separation, Alone is a big fear, Nightmares involving the theme of separation, Distress of separation, Sleeping without an attachment figure
Post-Traumatic Stress Disorder	(TRAAUMA): Traumatic event: (1) witnessed, (2) experienced, (3) occurred to dearest or (4) exposure repeatedly to its aversive details, Re-experience one of following intrusion symptoms: memories, nightmares, flashbacks, psychological distress or physiological reaction to cues symbolising the traumatic event, Avoidance of memories, thoughts, feelings of the traumatic event or its reminders, Alterations in cognitions and mood negatively: forgetting, mislabelling, blaming, no positive emotions, always negative emotions, anhedonia, detachment (two of seven), Unable to function or cause distress/Unattributed to a substance or another medical condition, Month or more of symptoms, Arousal and reactivity increased with two of the following: irritability, recklessness, hypervigilance, startling, concentration and sleep disturbances

Team leader

- **Saleh Aloraini**

Team members

- Abdulrahman Aljofan
- Faisal Alhusaini
- Alwaleed Bin shaya
- Faisal Bin moammar
- Mishari Alzoubi
- **Abdulmajeed Namshah**
- Abdulrahman bawazir
- Abdulmalik Alduraibi
- Hamad Alothman
- Sultan Alkassim
- Faisal Alshuaibi
- Abdullah Alyamani
- Talal Alanazy
- Yahya Alghamdi
- **Osama Alsaaid**



Good luck!!

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Special thanks to 439 & 438 psychiatry teams