8

Anxiety Disorders

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OCD

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Stress-related Disorders

- Definitions & Types
- 1-Panic Disorder.
- 2-Agoraphobia.
- 3-Social Phobia.
- 4-Specific Phobia.
- 5-Generalized Anxiety Disorder (GAD).
- -Obsessive Compulsive Disorder (OCD).
- -Acute & Post-Traumatic Stress Disorder.

Adjustment Disorders

Grief Reaction

Psychological Treatment

Anti-anxiety Medications

Definitions of Relevant Symptoms:

1. **Anxiety:** subjective feeling of worry, fear, and apprehension accompanied by autonomic symptoms (such as palpitation, sweating, and muscles), caused by anticipation of threat/danger. **Free-floating anxiety:** diffuse, unfocused anxiety, not attached to a specific danger.
2. **Fear:** anxiety caused by realistic consciously recognized danger.
3. **Panic:** acute, self-limiting, episodic intense attack of anxiety associated with overwhelming dread and autonomic symptoms.
4. **Phobia:** irrational exaggerated fear and avoidance of a specific object, situation or activity.

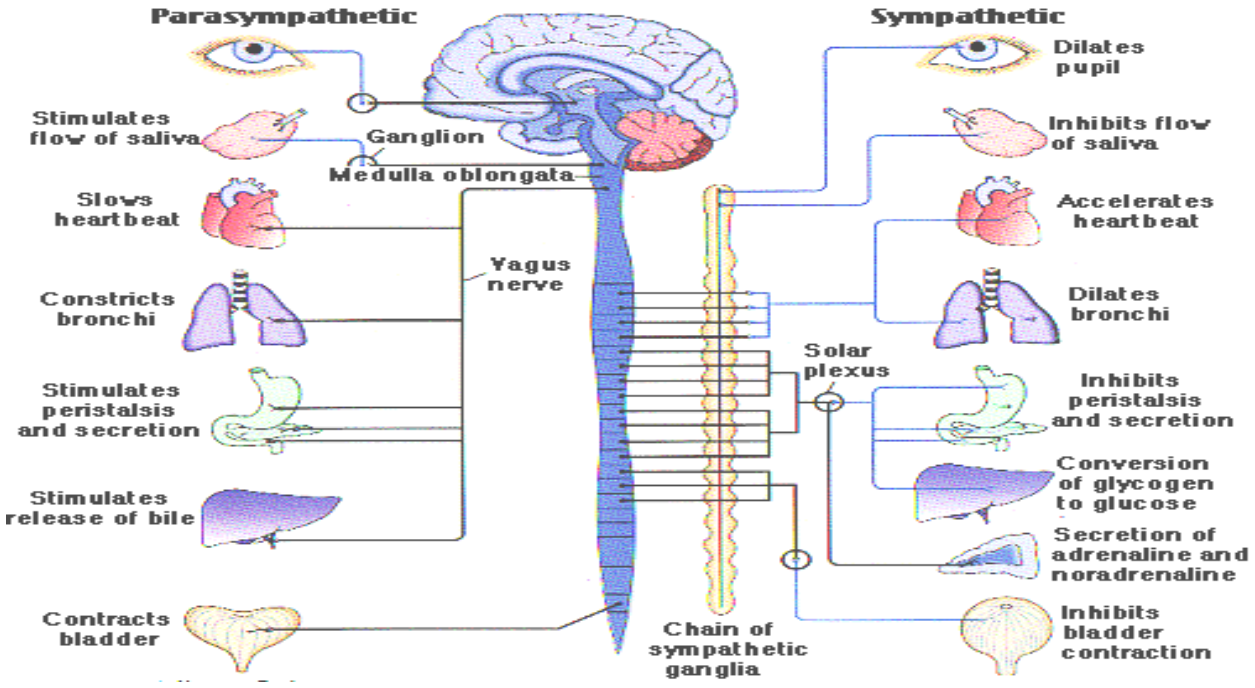
State vs. Trait Anxiety:

State anxiety (cross – sectional view): anxiety is experienced as a response to external stimuli.

Trait anxiety (longitudinal view):part of personality character in which a person has a habitual tendency to be anxious in a wide range of different circumstances.

Features of Anxiety:

Psychological	*Physical*
Excessive worries & fearful anticipation. Feeling of restlessness/irritability. Hypervigilance. Difficulty concentrating. Subjective report of memory deficit. Sensitivity to noise. Sleep: insomnia / bad dreams.	**Chest:** chest discomfort & difficulty in inhalation. **Cardiovascular**: palpitation &cold extremities. **Neurological :** tremor, headache, dizziness, tinnitus, numbness & blurred vision. **Gastrointestinal:** disturbed appetite, dysphagia, nausea, vomiting, epigastric discomfort & disturbed bowel habits. **Genitourinary:** increased urine frequency and urgency, low libido, erectile dysfunction, impotence & dysmenorrhea. **Musculoskeletal**: muscle tension, joint pain, easily fatigued. **Skin:** sweating, itching, hot & cold skin.



Mild degree of anxiety is unavoidable and is not considered abnormal.

Clues suggestive of abnormal anxiety

1- Severe/ prolonged anxiety.
2- Multiple features / beyond control.
3- Interference with functioning / relationships.
4- Worry is out of proportion to the external stimulus.
5- Attention is focused on the subjective feelings more than the external stimulus.

Anxiety disorders are a group of abnormal anxiety states not caused by an organic brain disease, a medical illness nor a psychiatric disorder.

In DSM-5 Separated in new categories :

Panic Disorder
Recurrent sudden attacks of severe fear. (اضطراب الهلع/ذعار)

Phobias
Situational anxiety with avoidance. (رُهاب) .

GAD
Prolonged nonspecific anxiety *(free-floating)*.

OCD Excessive worries due to distressing obsessions.

Acute & PTSD
Severe fear with avoidance following a life-threatening event.

Agoraphobia;
Anxiety about self-safety in crowded places.

Social phobia;
Anxiety about personal performance.

Specific phobia;
Anxiety about certain objects e.g. injections.

Panic attacks: sudden self-limited bouts of intense anxiety, with feeling of imminent doom or death and an urge to escape. Panic attacks are symptoms (not disorder) that can occur in a variety of psychiatric disorders: Panic disorder - Phobias - GAD - Acute stress &PTSD - OCD - Substance abuse - Depressive disorders & Others.

Based on the ***context*** in which the panic attacks occur. Panic attacks can be :

1. **Unexpected panic attacks:** sudden spontaneous attacks not associated with a situational trigger**.** ***Essential for the diagnosis of panic disorder.***

2. **Situationally bound panic attacks:** occur on exposure to, or in anticipation of the situational trigger, seen in phobias.

3. **Situationally predisposed panic attacks:** more likely to occur on exposure to (but are not invariably associated with) the situational trigger e.g. attacks are more likely to occur while driving.

Mr. Hadi is a 34-year-old man came to outpatient psychiatry clinic complaining of 3- month history of recurrent sudden attacks of severe fear of death, palpitation, shortness of breath, excessive sweating, and impaired concentration. The attack lasts for about 20 minutes then disappears completely. Between, the attacks, although he is free from physical symptoms, he is anticipating the next attack.

Panic Disorder

Diagnostic Criteria:

A. Recurrent sudden unexpected panic attacks.

B. At least one of the attacks has been followed by ≥ 1 month of ≥ one of the following:

1- Persistent concern about having additional attacks.

2- Worry about the implications / consequences of the attacks (e.g. going mad or death).

3- A significant change in behavior related to the attacks.

C. Not due to medical disease, substance abuse or axis **I** psychiatric disorder.

Etiology:

- Poorly regulated autonomic responses to stressors when a person becomes afraid of the consequences of symptoms of autonomic arousal.
- Pathological hyperactivity in Locus Ceruleus (alarm system in the brain essential for anxiety expression). Neurotransmitters involved are norepinephrine and serotonin.
- Genetic basis (panic disorder occurs more often among relatives).
- The biochemical hypothesis (panic attacks can be induced by chemical agents like sodium lactate, and can be reduced by drugs like imipramine).
- Mitral Valve Prolapse (MVP) is more common in patients with panic disorder (40-50 %) than in general population (6 – 20 %). Whether this association has a causal relationship, it is not clear.

Course and Prognosis:

- The usual course is chronic but waxing and waning.
- Some patients recover within weeks.
- Others have a prolonged course (those with symptoms persisting for 6 months or more).
- With therapy prognosis is excellent in most of the cases.

Epidemiology: Women > men. Lifetime prevalence is 1 – 3 % (throughout the world). One-year prevalence rates 1 – 2 %. Age at onset: bimodal distribution, with one peak in late adolescence and a second smaller peak in the mid 30s.

Panic Disorder can be either; with or without agoraphobia.

youtube.com/watch?v=E0wuys9lNp0

Treatment:

- Attention to any precipitating or aggravating personal or social problems.
- Support, ***explanation***(based on the autonomic nervous system functions, alarm system, & fight/flight response), and ***reassurance*** (that no serious physical disease behind the repeated panic attacks) .
- ***Cognitive Behavior therapy*** **(CBT)**: detection and correction of wrong thoughts & thinking process (negative cognition) about the origin, meaning, and consequence of symptoms & relaxation training.
- **Medications:** Choose one of SSRIs (selective serotonin reuptake inhibitors). All are effective for panic disorder although the most widely used is paroxetine. Imipramine or clomipramine (tricyclic antidepressants) can be a good alternative. For rapid onset of action add a benzodiazepine (usually alprazolam or lorazepam) for 2-4 weeks then taper it down slowly. SSRI (or clomipramine/imipramine) is generally continued for 6-12 months. When treatment is discontinued relapse rate is high (30-90%) even when the condition has been successfully treated. This emphasizes the role of combining psychotherapy with medications.

Mrs. Mona is a 36-year-old woman seen at outpatient clinic because of several weeks' history of excessive fear of fainting when in crowds or in situations that she cannot leave easily.

Agoraphobia

Literally, it means fear and avoidance of market places and open spaces. "**Agora**"= the open market for farmers in *Tadmur* (old Syria).

However, the term may be misleading. Fear in agoraphobic patients is about being alone in crowded places from which escape seems difficult or help may not be available in case of sudden incapacitation (places cannot be left suddenly without attracting attention e.g. a place in the middle of a row in a mosque). Fear is usually revolving around ***self-safety issues*** (fainting/losing control of behavior e.g. screaming, vomiting, or defecating) rather than *personal performance* in the presence of others (which is the case in social phobia).

Diagnostic Criteria:

- Anxiety about being in places or situations from which escape might be difficult, or in which help would not be readily available in the event of a panic attack (shopping malls, social gathering, tunnels, and public transport).
- The situations are either avoided, endured with severe distress, or faced only with the presence of a companion.
- Symptoms cannot be better explained by another mental disorder.
- Functional impairment.

youtube.com/watch?v=eCdd2ZAaXUs

Associated conditions:

- Panic disorder (in **>** 60 % of cases).
- Social phobia (in around 55% of cases)
- Depressive symptoms (in > 30 % of cases).
- As the condition progresses, patients with agoraphobia may become increasingly dependent on some of their relatives or spouse for help with activities that provoke anxiety such as shopping.
- ***Housebound-housewife syndrome*** may develop. It is a severe stage of agoraphobia when the patient cannot leave the house at all.

Etiology:

Predisposing Factors:
-Separation anxiety in childhood.
-Parental overprotection.
-Dependent personality traits.
-Defective normal inhibitory mechanisms.

Precipitating Factors:
-A Panic attack in a public place where escape was difficult.
-Conditioning (public places trigger fear of having subsequent attacks).
-Often precipitated by major life events.

Maintaining Factors:
-Avoidance reduces fear & ensures self-safety.

Epidemiology: Women: men = 2:1. Onset: most cases begin in the early or middle twenties, though there is a further period of high onset in the middle thirties. Both of these ages are later than the average onset of specific phobia (childhood) and social phobias (late teenagers or early twenties). One-year prevalence: men; about 2 %, women: about 4 %. Lifetime prevalence: 6 – 10 %.

Treatment: Cognitive-Behavior Therapy (CBT):

Cognitive Component:
Detection and correction of wrong thoughts & illogical ways of reasoning (cognitive distortions) about the origin, meaning, and consequence of symptoms. E.g. of cognitive distortions: magnification of events out of proportion to their actual significance.

Behavioral Component:
- Detailed inquiry about the situations that provoke anxiety, associated thoughts, and how much these situations are avoided.
- Hierarchy is drawn up (from the least – to the most anxiety provoking).
- The patient is then taught to relax (relaxation training).
- Exposure: the patient is persuaded to enter the feared situation (to confront situations that he generally avoids).
- The patient should cope with anxiety experienced during exposure and try to stay in the situation until anxiety has declined.
- When one stage is accomplished the patient moves to the next stage.
- The patient is trained to overcome avoidance (as escape during exposure will reinforce the phobic behavior).

Medications: as for panic disorder (SSRIs +/- anxiolytics as per need).

Prognosis:

Good prognostic factors:
1- Younger age.
2- Presence of panic attacks.
3- Early treatment.

Bad prognostic factors:
1- Age > 30 years. 2- Absence of panic attacks.
3- Late treatment.
It can be chronic disabling disorder complicated by depressive symptoms.

Social Phobia
(also called **social anxiety disorder**)

Mr. Jamal is a 28-year-old man presented with 3-year history of disabling distress when talking to important people. He would feel anxious, and his voice would become so disturbed that he had difficulty speaking.

Features:

Marked irrational performance anxiety when a person is exposed to a possible scrutiny by others particularly unfamiliar people or authority figures leading to a desire for escape or avoidance associated with a negative belief of being socially inadequate. The problem leads to significant interference with functioning (social, occupational, academic…). The person has anticipatory anxiety.
The response may take a form of panic attack (situationally- bound or situationally- predisposed).

Common complaints: palpitation, trembling, sweating, and blushing.

Examples: speaking in public (meetings, parties, lectures) - serving coffee or tea to guests- leading prayers. Social phobia can be either:
a-specific to certain situations (e.g. speaking to authority) or
b-generalized social anxiety.

Associated Features:
Hypersensitivity to criticism and negative evaluation or rejection (avoidant personality traits). Other phobias.
Complications:
Secondary depression. Alcohol or stimulant abuse to relieve anxiety and enhance performance. Deterioration in functioning (underachievement in school, at work, and in social life e.g. delayed marriage).

Differential Diagnosis:

Other phobias. However, multiple phobias can occur together.
Generalized anxiety disorder.
Panic disorder.
Depressive disorder primary or secondary to social phobia.
Patients with persecutory delusions avoid certain social situations.
Avoidant personality disorder may coexist with social phobia.

Etiology:
Genetic factors: some twins' studies found genetic basis for social phobia.
Social factors: excessive demands for social conformity and concerns about impression a person is making on others, (high cultural superego increases shame feeling), some Arab cultures are judgmental and impressionistic.
Behavioral factors: sudden episode of anxiety in a social situation followed by avoidance, reinforces phobic behavior.
Cognitive factors: exaggerated fear of negative evaluation based on thinking that other people will be critical, and one should be ideal person.

Epidemiology:
Age: late teenage or early twenties. It may occur in children. Lifetime prevalence: 3 – 13 %.
In the general population, most individuals fear public speaking and less than half fear speaking to strangers or meeting new people.
Only 8 – 10 % is seen by psychiatrists.
Local studies in Saudi Arabia suggested that social phobia is a notably common disorder among Saudis, (composes 80 % of phobic disorders). Social and cultural differences have some effect on social phobia in terms of age at treatment, duration of illness and some social situations.

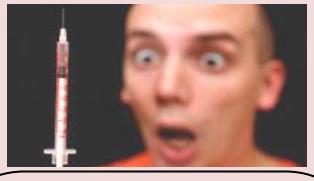
Treatment

A. Psychological:
1. Cognitive-Behavior Therapy -**CBT**-(the treatment of choice for social phobia). Exposure to feared situations is combined with anxiety management (relaxation training with cognitive techniques designed to reduce the effects of anxiety-provoking thoughts).
2. Social Skill Training: e.g. how to initiate, maintain and end conversation. **3**. Assertiveness Training: how to express feelings and thoughts directly and appropriately.
B. Medications: 1. Antidepressants (one of the following):SSRIs (e.g. fluoxetine 20mg) or SNRIs(e.g. Venlafaxine 150mg). **2**. Beta-blockers (e.g.propranolol 20- 40 mg),as they are non-sedative, they are useful in specific social phobia e.g. test anxiety to reduce palpitation and tremor. Beware of bronchial asthma. **3**. Benzodiazepines (e.g. alprazolam 1mg): small divided doses for short time (to avoid the risk of dependence).

Prognosis: If not treated, social phobia often lasts for several years and the episodes gradually become more severe with increasing avoidance. When treated properly the prognosis is usually good. Presence of avoidant personality disorder may delay the improvement**.**

Specific Phobia

Mr. Mazen is a 21-year-old college student who has excessive fear and avoidance of injections and blood. His sister Ms. Nuha, who is an 18-year-old, has excessive fear and avoidance of darkness and elevators.



Features: persistent irrational fear of a specific object or situation (other than those of agoraphobia and social phobia) accompanied by strong desire to avoid the object or the situation, with absence of other psychiatric problems.

Treatment: Behavior therapy; exposure techniques either desensitization or flooding.

Medications (e.g. benzodiazepines, beta adrenergic antagonists) before exposure sessions.

Epidemiology: prevalence in the general population: 4-8% (less than 20 % of patients are seen by psychiatrists). Animal phobia: common in children and women. Most specific phobias occur equally in both sexes. Most specific phobias of adult life are a continuation of childhood phobias. A minority begins in adult life, usually in relation to a highly stressful experience.

Hospital/needle/dental/blood phobias may lead to bad consequences. If started in adult life after stressful events the prognosis is usually good.
If started in childhood, it usually disappears in adolescence but may continue for many years.

Generalized Anxiety Disorder (GAD).

Mr. Emad is a 38-year-old married man seen at outpatient clinic for a 7-month history of persistent disabling anxiety, irritability, muscle tension, and disturbed sleep.

Diagnostic Criteria

A- ≥ 6 months history of excessive anxiety occurring more days than not, about a number of events or activities (such as work or school performance).

B- The person finds it difficult to control the worry.

C- The anxiety and worry are associated with ≥ 3of 6

1. restlessness or feeling keyed up or on edge.
2. being easily fatigued.
3. difficulty concentrating or blank mind.
4. irritability.
5. muscle tension.
6. sleep disturbance.

D- The focus of the anxiety is not confined to features of an Axis I disorder.

E- It causes significant distress or functional impairment in social/ occupational/ or other areas.

F- The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hyperthyroidism) and does not occur exclusively during a mood disorder, a psychotic disorder, or a pervasive developmental disorder.

Comorbidity:

More than 50% of patients with GAD have a coexisting mental disorder: especially anxiety disorders (social or specific phobia, or panic disorder) and major depression,

Course and Prognosis:

Chronic, fluctuating and worsens during times of stress. Symptoms may diminish, as patient gets older. Over time, patient may develop secondary depression (common if left untreated). When patient complains mainly of physical symptoms of anxiety and attributes these symptoms to physical causes, he generally seems more difficult to help. **Poor prognosis** is associated with severe symptoms and with derealization, syncopal episodes, agitation and hysterical features.

Epidemiology:

One year prevalence rate: 3 %. Life time prevalence rate: 5 %. Women > men (2:1).
Often begins in early adult life, but may occur for the first time in middle age.
There is a considerable cultural variation in the expression of anxiety. Frequent in primary care and other medical specialties.
Patients usually come to a clinician's attention in their 20s. Only one third of patients seek psychiatric treatment. Many go to general practitioners, or specialized clinics seeking treatment for the somatic component of the disorder.

Etiology:

combination of genetic and environmental influences in childhood. Maladaptive patterns of thinking may act as maintaining factors. Anxiety as a trait has a familial association.

D Dx

1. Anxiety disorder due to medical conditions /medications : e.g. anemia/hyperthyroidism.
2. Other anxiety disorders.
3. Mood disorders(depression/mania).
4. Adjustment disorders (with anxious mood).
5. Substance abuse.

Management

A- Rule out medical causes.

B- Cognitive – behavior therapy (CBT): Anxiety management training: relaxation with cognitive therapy to control worrying thoughts, through identifying and changing the automatic faulty thoughts.

C. Medications: 1. Antidepressants (one of the following):SSRIs (e.g. paroxetine 20mg) or SNRIs(e.g. Venlafaxine 150mg). **2. Buspirone:** it is more effective in reducing the cognitive symptoms of GAD than in reducing the somatic symptoms. Its effect takes about 3 weeks to become evident. **3. Benzodiazepines** for a limited period (to avoid the risk of dependence), during which psychosocial therapeutic approaches are implemented.

Obsessive Compulsive Disorder (OCD).

Ms. Maha is a 20-year-old college student seen at outpatient clinic complaining of recurrent intrusive thoughts about incomplete ablution, bathing, and prayers. She spends 3- 4 hours/day repeating prayers to feel fully satisfied and relaxed. She realizes that her thoughts are silly but she cannot resist them.

Still you are not pure.

Diagnostic Criteria

Recurrent obsessions or compulsions that are severe enough to be time consuming (> 1 hour a day) or causes marked distress or significant impairment.
The person recognizes that the obsessions or compulsions are excessive and unreasonable.
The disturbance is not due to the direct effect of a medical condition, substance or another mental disorder.

Obsessional forms	Obsessional Contents (themes)
Thoughts. Images. Urges. Feelings.	Dirt/Contamination. Religious acts/beliefs. Doubts/Checking. As if committing offences.

Associated features / complications:
Anxiety is an important component of OCD. Compulsions are done to reduce anxiety. Thus, reinforces obsessive compulsive behavior.
Severe guilt due to a pathological sense of self-blaming and total responsibility to such absurd thoughts especially in blasphemous, aggressive and sexual obsessions. **Avoidance** of situations that involve the content of the obsessions, such as dirt or contamination.
Depressive features either as precipitating factor (ie primary), secondary to, or simultaneously arising with OCD.

DDx:
OCD should be differentiated from other mental disorders in which some obsessional symptoms may occur, like:
Depressive disorders.
Anxiety, panic and phobia disorders.
Hypochondriasis.
Schizophrenia: some schizophrenic patients have obsessional thoughts, these are usually odd with peculiar content (e.g. sexual or blasphemous). The degree of resistance is doubtful.
Organic disorders: some organic mental disorders are associated with obsessions e.g. encephalitis, head injury, epilepsy, dementia.
Obsessive Compulsive Personality Disorder (OCPD).

Epidemiology: M=F. Mean age at onset = 20 – 25 years. Mean age of seeking psychiatric help = 27 years. Lifetime prevalence in the general population is 2 -3 % across cultural boundaries. About 10 % of outpatients in psychiatric clinics

Etiology: 1. Genetic Factors. 2. Neurobiological hypothesis: serotonin dysregulation.
3. Psychodynamic Theories: unconscious urges of aggressive or sexual nature reduced by the action of the defense mechanisms of repression, isolation, undoing, and reaction formation. **4.Behavioral Theory:** Excessive obsessions when followed by compulsions or avoidance are reinforced ,maintained and perpetuated.

Management

Search for a depressive disorder and treat it, as effective treatment of a depressive disorder often leads to improvement in the obsessional symptoms.
Reduce the guilt through explaining the nature of the illness and the exaggerated sense of responsibility.
Medications;
1. Antidepressants with an antiobsessional effect ;enhancing 5HT activity.
a. Clomipramine: required doses may reach 200 mg / day.
b. SSRIs (e.g. paroxetine 40-60mg). Treatment of OCD often requires high doses of SSRIs.
2. Anxiolytics (e.g. lorazepam 1mg) to relief anxiety.
Behavior therapy; for prominent compulsions but less effective for obsessional thoughts. Exposure and response prevention. Thought distraction / thought stopping. Behavior therapy may be done at outpatient clinics, day centers or as in – patient. It is important to interview relatives and encourage them to adopt an empathetic and firm attitude to the patient. A family co-therapist plays an important role. **In-patient behavior therapy** can appreciably be helpful for resistant cases and can reduce patient's disability, family burden and major demands on health care resources that are incurred by severe chronic OCD patients.

Course and Prognosis:
In most cases onset is gradual but acute cases have been noted. The majority has a chronic waxing and waning course with exacerbations related to stressful events. Severe cases may become persistent and drug resistant. Depression is a recognized complication.
Prognosis of OCD is *worse* when the patient has OCPD. Good prognosis: presence of mood component (depression/anxiety), compliance with treatment, and family support.

Acute Stress Disorder (ASD) & Post-traumatic Stress Disorder (PTSD)

Mr. Fahad is a 25-year-old man was injured in a serious road traffic accident 3 months ago in which he witnessed his friend dying. Two weeks later he developed recurrent distressing feelings of horror, bad dreams, and irritability.

Life-threatening traumas: major road accidents, fire, physical attack, sexual assault, mugging, robbery, war, flooding, earthquake.

Diagnostic Criteria:

A-Exposure to a traumatic threatening event (experienced, or witnessed) **& response** with horror or intense fear.

B-Persistent re-experience of the event (e.g. flashback, recollections, or distressing dreams.

C-Persistent avoidance of reminder (activities, places, or people).

D- Increased arousal (e.g. hypervigilance, irritability).

E- ≥ 1 month duration of the disturbance.

Etiology: Recent research work places great emphasis on a person's subjective response to trauma than the severity of the stressor itself, which was considered the prime causative factor.
The traumatic event provokes a massive amount of information and emotions, which is not processed easily by the brain (There are alternating periods of acknowledging the event and blocking it, creating distress).

Epidemiology: the lifetime incidence is 10-15% & the lifetime prevalence is about 8 % of the general population. PTSD can appear at any age but young > old & females > males.

Treatment:

Psychological (the major approach)**:**
Support – reassurance – explanation – education.
Encourage discussing stressful events and overcome patient's denial.
In vivo (imaginary) exposure with relaxation and cognitive techniques.
Eye movement desensitization and reprocessing **(EMDR)**: while maintaining a mental image of the trauma the patient focuses on, and follow the rapid lateral movement of the therapist's finger so that the traumatic mental experience is distorted and the associated intense emotions are eliminated.
Group therapy (for group of people who were involved in a disaster e.g. flooding, fire).
Pharmacological:
Symptomatic treatment; anxiolytics (e.g. alprazolam) and serotonin-selective reuptake inhibitors (e.g. sertraline) or tricyclics (e.g. imipramine).

DDx.

1. **Acute stress disorder**: similar features to PTSD but a-onset is within *1 month* after exposure to a stressor (*If symptoms appeared after one month consider post-traumatic stress disorder(PTSD).* b- duration: a minimum of 2 days and a maximum of 4 weeks(*If symptoms continued more than one month consider PTSD).*

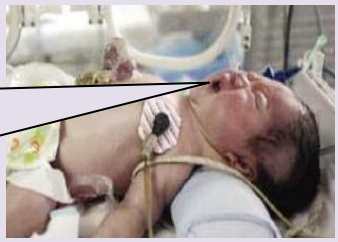
Treatment: same as for PTSD.

2. **Other anxiety disorders(GAD, Panic d., & phobias).**
3. **Adjustment disorders** (stressor is not life-threatening, no dissociative features, mental flash backs or horror).
4. **Head injury sequence** (if the traumatic event has included injury to the head, e.g. road accident). Neurological examination should be carried out to exclude a subdural hematoma or other forms of cerebral injury.
5. **Substance abuse** (intoxication or withdrawal).

Prognosis is good if:1-the person is cooperative with treatment and has healthy premorbid function, 2- the trauma was not severe or prolonged, & 3- early intervention and social support exist**.**

Adjustment Disorders

Mrs. Nora is a 35-year-old mother of 4 children delivered a baby defected with cleft palate , 3 weeks later she developed excessive crying, hopelessness, agitation, social withdrawal, & insomnia, . Her husband reported that she has low frustration tolerance when she faces moderate stresses.



Maladaptive psychological responses to ***usual life stressors*** resulting in impaired functioning (social, occupational or academic).

Presentation and Features:

Symptoms develop within *3 months* of the onset of the stressor (if more than 3 months it is less likely that the reaction is a response to that stressor). There should be a marked distress that exceeds what would be expected from exposure to the stressor. There should be a significant functional impairment. Symptoms vary considerably; there are **several types** of adjustment disorders:

- With depressed mood/With anxiety/With mixed anxiety and depressed mood/With disturbance of conduct (violation of rules and disregard of others rights)/With mixed disturbed emotions and conduct/ Unspecified e.g. inappropriate response to the diagnosis of illness, such as social withdrawal without significant depressed or anxious mood, severe noncompliance with treatment and massive denial. *In adults*: depressive, anxious and mixed features are the most common. *In children and the elderly*: physical symptoms are most common.
- Disturbance of conduct occurs mainly in adolescents.

Once the **stressor** (or its consequences) has terminated, the **symptoms** do not persist for more than an additional 6 months. Adjustment disorder can be: ***Acute***: if the disturbance lasts less than 6 months. Or ***Chronic****:* if the disturbance lasts for 6 months or longer (when the stressors or consequences continue).

Epidemiology:

Female : Males 2:1. It may occur at any age but most frequent in adolescents. Common among hospitalized patients for medical and surgical problems.

The prevalence of the disorder is estimated to be from 2 - 8 % of the general population.

Etiology:

Common in those who have preexisting vulnerability: Abnormal personality traits/ Less mature defense mechanisms/ Low frustration tolerance/ High anxiety temperament/ Overprotection by family/Lost a parent in infancy/ Loss of social support.

The severity of the stressor does not predict the severity of the adjustment disorders, because there are other factors involved (personality, nature of the stressor & It's subconscious meaning).

Management

A. Psychological (treatment of choice)

Empathy, understanding, support, & ventilation. Psychosocial Education: explanation & exploration (explore the meaning of the stressor to the patient).

Crisis Intervention: (Several sessions over 4 – 8 weeks)

The patient, during crisis, is passing through emotional turmoil that impairs problem-solving abilities.

Build good relationship with the patient.

Review the steps that have led to the crisis (stresses, defense mechanisms).

Identify and understand the maladaptive reactions.

Manipulate the environment to reduce distress (e.g. hospitalization).

Give small doses of drugs (e.g. anxiolytics) to reduce symptoms.

Encourage and support the patient until he goes through the problem.

Transform that into learning a more adaptive ways of coping strategies (for the future, to prevent such maladjustment reactions).

After successful therapy the patient usually emerges stronger.

B. Medication :

Short course of benzodiazepines in case of adjustment disorder with anxious mood.

Small doses of antidepressants might be beneficial for adjustment disorder with depressed mood.

DDx:

1. **Normal psychological reaction** e.g. bereavement.
2. **PTSD/ASD** (life threatening stressor followed by extreme fear, horror, avoidance and flashbacks).
3. **Anxiety disorders** (GAD or panic disorders).
4. **Major depressive disorder.**
5. **Personality disorders:** these are common co-existing problems e.g. histrionic, obsessive compulsive, avoidant, paranoid or borderline personality disorders.
6. **Dissociative Disorders** (dissociative symptoms).
7. **Brief reactive psychosis** (hallucinations/delusions).

Course and Prognosis:

Generally, it is favorable, particularly with early intervention. Most symptoms diminish over time without treatment especially after stressor removal.

Most patients return to their previous functioning capacity within few months.

Adults recover earlier than adolescents do.

Some patients maintain chronic course with risk of anxiety, depression and substance abuse.

Recurrence is common following other usual life stresses.

Grief ; normal & abnormal grief.

Mrs. Munirah is a 32-year-old woman lost her husband two days ago in a road traffic accident . She has lack of emotional response, anger and disbelief. She has no sadness or crying spells.

Bereavement: being deprived of someone by death.
Grief: sadness appropriate to a real loss.
Mourning: the process of resolution from grief.

Normal Grief: It is a continuous psychological process of three stages:

	1. SHOCK	2. DISORGANIZATION	3. REORGANIZATION
Duration	Few hours-several days	A week - 6 months	Weeks to months
Features	• Numbness (lack of emotional response) • Denial (disbelief or incomplete acceptance and feeling of unreality • Searching for the lost person • Anger • Yearning	• Despair ,sadness, weeping • Poor sleep & appetite • Guilt toward deceased. • Experience of presence of the dead person with illusions and pseudo hallucinations. • Social withdrawal • Somatic complaints with anxious mood.	• Symptoms subside and resolve gradually. • Acceptance of the loss with new adjustment. • Memories of good times. • Often there is a temporary return of symptoms on the anniversary of the death.

Pathological Grief: There are four types of abnormal grief:

1.Abnormally intense grief	2.Prolonged grief	3.Delayed grief	4.Distorted grief
Symptoms are severe enough to meet criteria for *major depression*: • Severe low mood. • Death wishes with suicidal ideas. • Psychomotor retardation. • Global loss of self-esteem. • Self-blame is global. • Does not respond to reassurance.	Grief lasting for ≥ 6months. Symptoms of the first and second stages persist. May be associated with depression. * Duration of normal grief varies with culture (average 6-12 months).	The first stage of grief does not appear until ≥ *2 weeks* after the death. More frequent after sudden, traumatic or unexpected death.	Features that are unusual e.g. : -marked overactivity. -marked hostility. -psychomotor features.

HELPING THE BEREAVED

Normal process of grief should be explained and facilitated: help to overcome denial, encourage talking about the loss, and allow expressing feelings. Consider any practical problems: financial difficulties, caring for dependent children.

Medications: anxiolytics for few days are helpful (when anxiety is severe and sleep is markedly interrupted). Antidepressants do not relieve the distress of normal grief and therefore should be restricted to pathological grief which meets criteria for depressive disorder.

Anti-anxiety Medications (Anxiolytics)

Benzodiazepines

They act on specific receptor sites (benzodiazepine receptors) linked with gamma aminobutyric acid (GABA) receptors in the C.N.S. They enhance GABA action which has an inhibitory effect.

- They have several actions:
  - Sedative & hypnotic action.
  - Anxiolytic action.
  - Anticonvulsant action.
  - Muscle relaxant action.
- They differ in potency and half-life:
  Relatively short acting e.g. alprazolam (xanax), lorazepam (ativan) & Long acting (more than 24 hours) e.g. diazepam (valium) and clonazepam (rivotril).

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- **Side effects:**
  - Dizziness and drowsiness (patient should be warned about these side effects which may impair functions e.g. operation of dangerous machinery, driving).
  - Release of aggression due to reducing inhibition.
  - Dependence and withdrawal:
  - If given for several weeks.
  - Short acting drugs have more risk of dependence.
- **Withdrawal Syndrome:**
  - It generally begins 2 – 3 days after cessation of short acting, and 7 days after cessation of long acting benzodiazepines and then diminishes in another 3 – 10 days.
  - **Features:**
    - Anxiety, irritability, apprehension
    - Nausea
    - Tremor and muscle twitching
    - Heightened sensitivity to stimuli
    - Headache
    - Sweating
    - palpitation
    - Muscle pain
    - Withdrawal fit may occur when the dose of benzodiazepine taken has been high.
- Withdrawal is treated with a long acting benzodiazepine (e.g. diazepam) in equivalent doses before withdrawal then the dose is reduced gradually by about 10 – 20 % every 10 days.

Buspirone (Buspar)

It has anxiolytic activity comparable to that of benzodiazepines. However, it is pharmacologically unrelated to benzodiazepines.

It stimulates 5HT – 1A receptors and reduces 5 HT (serotonin) transmission.

It's onset of action is gradual (several days – weeks) therefore, it is not effective on PRN basis.

It does not cause functional impairment, sedation nor interaction with CNS depressants.

It does not appear to lead to dependence.

Adverse effects:

- Headache.
- Irritability.
- Nervousness.
- Light-headedness.

Adrenergic Receptor Antagonists

Beta Blockers (e.g. propranolol; inderal) are frequently used to control tremor and palpitation in performance anxiety (social phobia) 10 to 40 mg of propranolol 30-60 minutes before the anxiety-provoking situation). Other uses in psychiatry:

1- **other anxiety disorders (e.g. GAD).**
2- **neuroleptic-induced akathisia**
3- **lithium-induced postural tremor.**
4- **control of aggressive behavior.**

Caution in patients with asthma, insulin-dependent diabetes, & cardiac diseases(CCF, IHD).

Psychological Treatments

Definition: a group of non-pharmacological psychotherapeutic techniques employed by a therapist to ameliorate distress, abnormal patterns of relations or symptoms (phobias, obsessions, depressive thinking…)

Cognitive Therapy

Concept:

- Maladaptive cognitive processes (ways of thinking, expectations, attitudes and beliefs) are associated with behavioral and emotional problems**.**
- Correcting maladaptive cognitive processes reduces patient's problems.

Process: maladaptive thinking is **identified**; the common cognitive errors include:

Magnification and minimization of events out of proportion to their actual significance, e.g. depressed patient magnifies his faults and minimizes his achievements.
Overgeneralization: forming a general rule from few instances and applying this rule to all situations no matter how inappropriate.
Arbitrary inferences: making an inference without backing it up with evidence, or alternatively ignoring conflicting evidences.
Selective abstraction: taking a fact out of context while ignoring other significant features and then proceeding to base entire experience on that isolated fact.
Dichotomous thinking: thinking about events or persons in terms of opposite extremes (all or none).
Personalization: relating events and incidents to self where such incidents have no personal bearing or significance.

The maladaptive thinking is then **challenged** by correcting misunderstandings with accurate information and pointing out illogical ways of reasoning. Then alternative ways of thinking are sought out and tested.

Cognitive Error	Assumption	Intervention
Overgeneralizing	If it's true in one case, it applies to any case that is even slightly similar.	Exposure of faulty logic. Establish criteria of which cases are similar to what degree.
Selective abstraction	The only events that matter are failures, deprivation, etc. Should measure self by errors, weaknesses, etc.	Use log to identify successes patient forgot.
Excessive responsibility (assuming personal causality)	I am responsible for all bad things, failures, etc.	Disattribution technique.
Assuming temporal causality (predicting without sufficient evidence)	If it has been true in the past, it's always going to be true.	Expose faulty logic. Specify factors that could influence outcome other than past events.
Self-references	I am the center of everyone's attention especially my bad performances. I am the cause of misfortunes.	Establish criteria to determine when patient is the focus of attention and also the probable facts that cause bad experiences.
Catastrophizing	Always think of the worst. It's almost likely to happen to you.	Calculate real probabilities. Focus on evidence that the worst did not happen.
Dichotomous thinking	Everything is either one extreme or another (black or white, good or bad).	Demonstrate that events may be evaluated on a continuum.

Adapted from Beck AT, Rush AJ, Shaw BF, Emery G. *Cognitive Therapy of Depression*. New York: Guilford Press.

Behavior Therapy

Concept:

The aim for the client (patient) is to increase desirable behaviors and decrease undesirable ones. Behavioral assessment seeks to observe and measure maladaptive behaviors focusing on how the behavior varies in particular settings and under specific conditions. Problems will be decreased through client's learning more adaptive behaviors.

Behavioral techniques:

1. Exposure (flooding or gradual exposure & response prevention; for phobias & OCD).
2. Thought stopping(for OCD).
3. Relaxation training (for anxiety & phobias).
4. Assertiveness training(for dependent and avoidant personality disorders)
5. Token economy (for children, chronic schizophrenic, and intellectually disabled people).

Cognitive behavioral therapy (CBT): combines cognitive and behavioral techniques. It is indicated in: depressive disorders (mild – moderate, but not severe) & anxiety disorders (GAD, phobias, panic disorders).

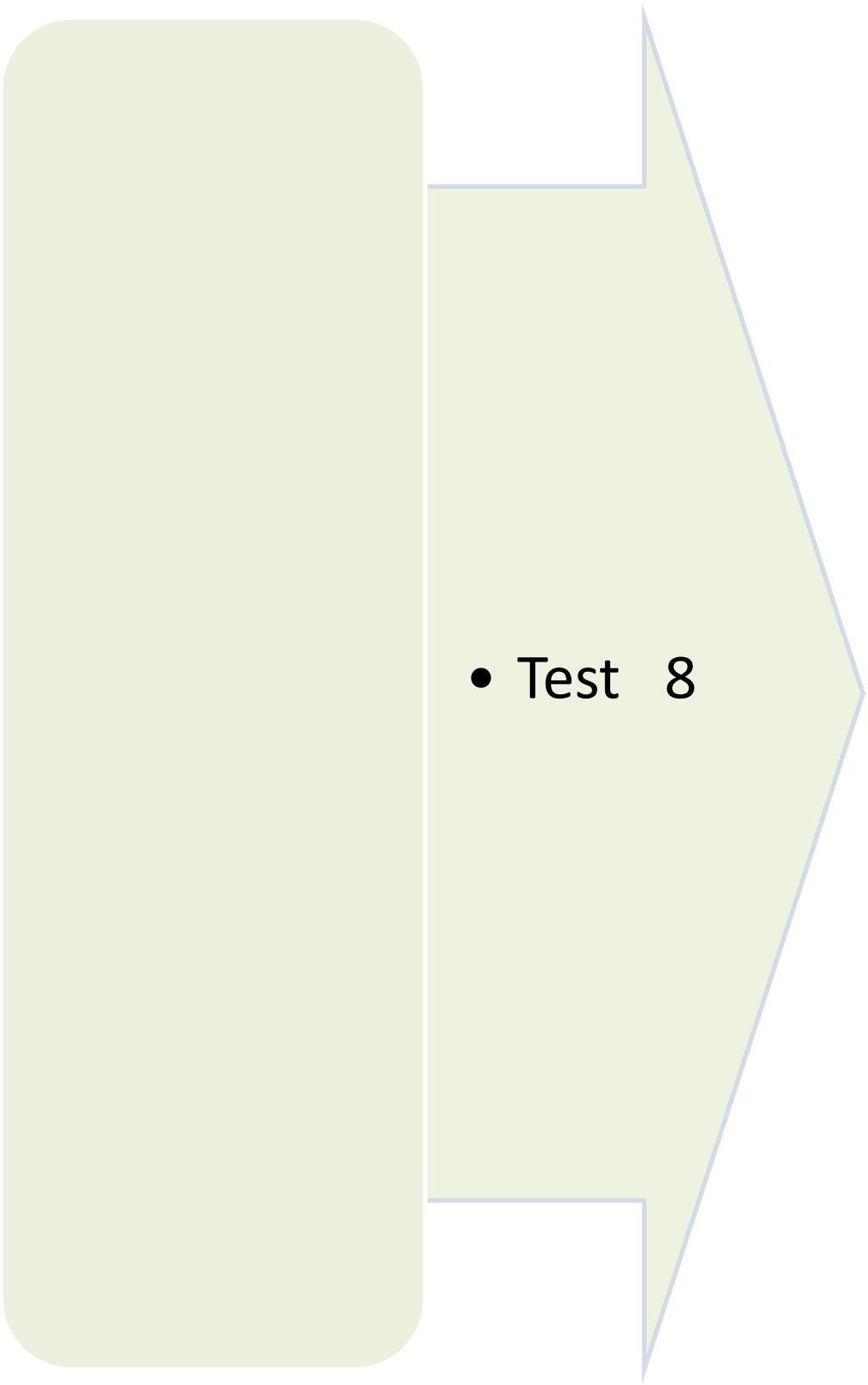
Psychodynamic Psychotherapy

Person's behavior is determined by unconscious process.
Current problems arise from unresolved unconscious conflicts originating in early childhood.
Problems will be reduced or resolved through the client attaining insight (greater understanding of aspects of the disorder) as a mean to gaining more control over abnormal behavior).
It helps some chronically depressed or anxious patients and those with personality problems.

Marital Therapy:

Indications: marital discord & when marital problems act as a maintaining factor of a psychiatric disorder in one or both partners.

- The couple and the therapist identify marital problems, such as:
  - Failure to listen to the other partner.
  - Failure to express wishes, emotions and thought directly.
  - Mind reading.
- The couple then are helped to understand each other.
- The therapist should remain neutral.
- Techniques used include:
  - Behavioral: reinforcement of positive behavior
  - Dynamic: eliciting and correcting unconscious aspects of interaction.
  - Problem solving.


• Test 8

1. A 32-year-old man presented with intense worries when he becomes in the middle of a row in the mosque as escape seems difficult. The most likely diagnosis is:
    a. Panic disorder.
    b. Specific phobia.
    c. Agoraphobia.
    d. Social phobia.

2. A 20-year-old college student presented with repeated bouts of palpitation, sweating, and excessive worries when he uses public transport. The most likely diagnosis is:
    a. Generalized anxiety disorder.
    b. Posttraumatic disorder.
    c. Agoraphobia with panic attacks.
    d. Social phobia.

3. A 37-year-old woman has one-year history of epigastric discomfort, sweating, dysmenorrhea, feeling of restlessness, sensitivity to noise, tinnitus and dizziness. The initial management step should be:
    a. Citalopram 20 mg.
    b. Exclusion of anemia.
    c. Brain CT scan.
    d. Alprazolam for 2 weeks.

4. A 35-year-old mother of three children recently delivered a baby with congenital defected. Three weeks later she became excessively worried, crying, hopeless, agitated, and socially withdrawn. Her husband reported that she always has low frustration tolerance when she faces moderate stresses. The most likely diagnosis is:
    a. Post traumatic stress disorder.
    b. Acute stress disorder.
    c. Brief psychotic disorder.
    d. Adjustment disorder.

5. A 30-year-old woman lost her husband ten days ago in a road traffic accident. She has not showed any emotional reaction. Her condition reflects
    a. A normal adjustment reaction.
    b. An abnormal grief.
    c. Adjustment disorder.
    d. Acute stress disorder.

6. A 28-year-old man witnessed death of his friend in a road traffic accident (RTA) two weeks ago. Since then, he suffers from bouts of excessive fear of driving his car, extreme distress on exposure to reminders of that RTA, and bad dreams. The following is an appropriate management step:

    a. Overcome denial.
    b. Olanzapine 15 mg.
    c. Amitriptyline 50 mg.
    d. Crisis intervention.

7. A 19-year-old woman college student failed 3 weeks ago in two subjects. She came to outpatient psychiatry clinic with 5 days history of lack of sleep, very poor appetite, excessive crying episodes, lack of pleasure and loss of hope. The most appropriate management step is:

    a. Lorazepam 2mg/day.
    b. Crisis intervention.
    c. Risperidone 4 mg / day.
    d. Behavioral therapy.

8. A 14-year-old boy was brought by his father because of 7 days' history of very severe distress, intense fear whenever he goes to his uncle's house. Ten days ago, two of his relatives raped him. The most likely diagnosis is:

    a. Agoraphobia.
    b. Acute stress disorder.
    c. Post traumatic stress disorder.
    d. Social phobia.

9. A 23-year-old man presented with extreme fear whenever he enters an elevator (lift). The most appropriate statement about his treatment is:

    a. Psychodynamic therapy.
    b. Olanzapine 5 mg.
    c. Behavior therapy.
    d. Insight-oriented therapy.

10. A 27-year-old woman referred to psychiatry outpatient clinic through ENT clinic with several months' history of continuous tinnitus, vertigo, and recurrent unprovoked episodes of palpitation. Her investigations were normal. The most appropriate statement about her treatment is:

    a. Escitalopram 10 mg.
    b. Propranolol 100 mg.
    c. Haloperidol 10 mg.
    d. Procyclidine10 mg.

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Answers:

1	**2**	**3**	**4**	**5**
C	C	B	D	B
6	**7**	**8**	**9**	**10**
A	B	B	C	A