433 Teams

PSYCHIATRY

3. Anxiety Disorders + OCD

+ Stress-related Disorders

Lecture content:

- 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.

anual of Basic Psychiatry

octor's notes

portant

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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

- Excessive worries & fearful anticipation. Feeling of restlessness/irritability.
- Hypervigilance.
- Difficulty concentrating.
  Subjective report of memory deficit. Sensitivity to noise.
  Sleep: insomnia / bad dreams.

Physical

- **Chest:** chest discomfort & difficulty in inhalation.
- **Cardiovascular:** &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.

***Muscle tension is described as: lower back pain , neck pain.**
***Breathing will be fast and shallow.**
***insomnia in PTSD: disturbed insomnia : wake up more than 6 times and get back to sleep so hard.**
***insomnia in anxiety: early insomnia = don't sleep once they put their heads on the pillow *takes more than 30 minutes.**
***Hypervigilance حذر بزيادة، يدقق بكل شيء لدرجة تبان بلغة جسده so he starts to scan everything**
*** They never loss their conscious but get dizzy.**
*** They also feel lump in the throat**
***fatigue from muscle tension**

Clues suggestive of abnormal anxiety

1- Severe/ prolonged anxiety. * it is a matter of quantity not quality

2- Multiple features / beyond control.

3- Interference with functioning / relationships.

4- Worry is out of proportion to the externnal 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.

Panic Disorder
Recurrent sudden attacks of severe fear.

Phobias
Situational anxiety with avoidance
(باهر)

GAD
Prolonged nonspecific anxiety
(free-floating)

OCD
Excessive worries due to distressing obsessions.

Agoraphobia
Anxiety about self-safety in crowded places.

Social phobia
Anxiety about personal performance

Specific phobia
Anxiety about certain object e.g injection

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

in DSM-5 Separated in new categories :

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:

Types	**Unexpected panic attacks: sudden spontaneous attacks** not associated with a situational trigger. **Essential for the diagnosis of panic disorder.**
	Situationally bound panic attacks: occur on exposure to, or in anticipation of the situational trigger, seen in **phobias.**
	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.

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.

***common in women = they say due to hormones or because women have a lot of responsibilities or maybe because men don't seek medical help.**

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.

Panic Disorder can be either; with or without agoraphobia.

*in Saudi Arabia 19% have panic attack.

*2% in Saudi Arabia have panic disorder

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.

*Medical conditions may lead to panic attack: hyperthyroidism + MI + asthma attack + hypoglycemia + tumors (pheochromocytoma) + anima

*I should rule them out by history and exam then investigation, if all of them are negative that means it's panic disorder.

*No one has ever died from panic disorder, it is not lethal and never changes to other psychiatric illness, you should educate the patient about all of his symptoms to make him feel relieved.

* The problem is in the first 2 weeks of the treatment, the symptoms will increase because of the medications 'anti deppresent' so you need to give the patient benzodiazepine for the first 2-3 weeks then stop it to avoid dependence.

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.

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)

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

*Agoraphobia started with one sudden panic attack or heard a story of a person who had a panic attack.

*ECT have no role in anxiety

CBT: the first line and gold standard psycothepry modality in anxiety

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.

Social phobia

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)
  b-generalized social anxiety

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.

*Social phobia: the main reason they are afraid from is getting embarrassed in front of all
*In men: social phobia

صلاة الجمعة

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.

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.

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.

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.

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.

Specific phobia

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.

*** In specific phobia, we don't give medications.**

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.

Treatment:

Behavior therapy: exposure techniques either desensitization or flooding.
Medications: (e.g. benzodiazepines, beta adrenergic antagonists) before exposure sessions.
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.

*Exposure therapy: it starts gradual with something the person is afraid of, and bring it to them and never let them go until they feel relieved, after 60 minutes from exposure the anxiety will go by itself. Nothing should interrupt the exposure so the level of the anxiety stays high and decreases by itself.

*We said if specific phobia don't need to treat it by medications, but if it's urgent like from plane phobia and there is no time to do exposure therapy so in this case we give benzodiazepines.

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.

Generalized Anxiety Disorder (GAD).

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 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.

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.

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,**
***Prolonged anxiety can cause IHD.**

DDx :

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.

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.

Obsessive Compulsive Disorder (OCD).

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.
*When do we call it disorder? If it is time consuming "more than 1 hour for both thoughts and actions"

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

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.

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)

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.

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.

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.

*When do we call thoughts obsessions? insisting, repetitive and recurrent ,unwanted ,silly ,uncontrolled.
*Compulsion: actions or mental acts (e.g.: if you did not count from 1 to 10 your son will die)

- In western countries: aggression (seeing a knife and she thinks she will kill her children) so either she don't go to the kitchen or remove the knife.
- No one who has ever killed someone because of their OCD 'aggression".

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.

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

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

iagnostic Criteria:
-Exposure to a traumatic threatening event (experienced, or witnessed) & response with horror or intense fear.
-Persistent re-experience of the event (e.g. flashback, recollections, r distressing dreams.
-Persistent avoidance of reminder (activities, places, or people).
- Increased arousal (e.g. hypervigilance, irritability).
- ≥ 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).

pidemiology:
he lifetime incidence is 10-15% & the lifetime prevalence is bout 8 % of the general population.
TSD can appear at any age but young > old & females > males.

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).

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).

reatment: **same as for PTSD**.
sychological (the major approach): Support – reassurance – explanation – education. Encourage discussing stressful events and overcome patient's enial.

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).

harmacological: Symptomatic treatment; anxiolytics (e.g. alprazolam) and serotonin-selective reuptake inhibitors (e.g. sertraline) or tricyclics (e.g. nipramine).

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

*This is the only disorder in psychiatry that we know its cause.

*There is trauma (life threatening situation) or he saw it by himself.

They're divided into 4 groups:

1- re-experience the situation "flashback", nightmares, hallucination 'not psychosis' more common auditory hallucination.

2- change in mood and cognition: negative believes, amnesia, "if I did not take my brother form his house he wouldn't have died", inability to feel positive emotions.

3- avoidance: diminished interest, detachment.

4- hyper arousal: anger, irritability 'intermitted insomnia" (because of the nightmares).

Associated psychiatric problems: 1- depression 2- substance abuse

30% of patients will get better without treatment

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.

Adjustment Disorders

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.
Chronic: if the disturbance lasts for 6 months or longer (when the stressors or consequences continue).

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).

Epidemiology:

Female: Males 2:1
it may occur at any age but 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.

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.

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.

*If you get a trauma but not life threatening. like divorce, minor trauma.

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.

Grief: normal & abnormal grief.

- **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:

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

SHOCK:
- **Duration:** Few hours-several days
- **Features: n**umbness (lack of emotional response), denial (disbelief or incomplete acceptance and feeling of unreality, searching for the lost person, anger, yearning.

DISORGANIZATION:
- **Duration:** A week - 6 months
- **Features:** 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

REORGANIZATION
- **Duration:** Weeks to months
- **Features:** 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

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

2.Prolonged grief
- 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)

3.Delayed grief
- The first stage of grief does not appear until ≥ 2 weeks after the death.
- More frequent after sudden, traumatic or unexpected death.

4.Distorted grief
- Features that are unusual e.g. :
- -marked over activity.
- –Marked hostility.
- -psychomotor features.

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