جامعة الملك سعود
King Saud University
1957

MED437
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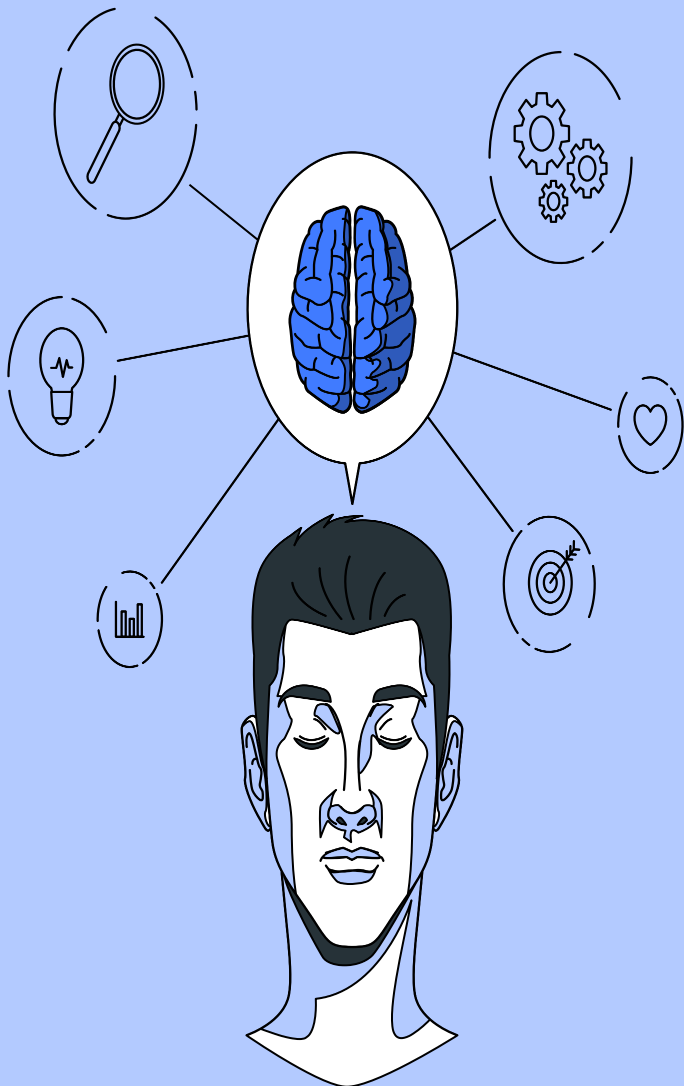

Anxiety Disorders

Objectives:

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

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- Color index: Golden notes - Dr. notes - extra

Introduction

1. Case 2. Hx 3. MSE. 4. Types of anxiety

Anxiety Disorders DSM-IV-TR

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

Anxiety Disorders in DSM5

Obsessive-compulsive and related disorder

- Obsessive-Compulsive Disorder
- Body Dysmorphic Disorder (more common in females eg. "I have one eye bigger than the other")
- Hoarding Disorder
- Trichotillomania (Hair- Pulling Disorder) (more in females)
- Excoriation (Skin-Picking) Disorder (picking scabs and not letting them heal)
- Substance/Medication Induced Obsessive-Compulsive and Related Disorder
- Obsessive-Compulsive and Related Disorder Due to Another Medical Condition

Trauma and stressor related disorders

- Reactive Attachment Disorder (in children)
- Disinhibited Social Engagement Disorder (in children)
- Posttraumatic Stress Disorder
- Acute Stress Disorder
- Adjustment Disorders

Anxiety Disorders

- Separation Anxiety Disorder (more common in children)
- Selective Mutism (eg, doesn't speak at school but talks a lot in school)
- Specific Phobia
- Social Anxiety Disorder
- Panic Disorder
- Agoraphobia
- Generalized Anxiety Disorder
- Substance/Medication- Induced Anxiety Disorder
- Anxiety Disorder Due to the Another Medical Condition

NB. In all psychiatric disorders you have to rule out:
1- Substance Use/ Medication
2- Medical Problem

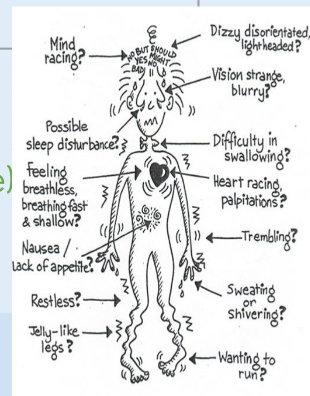
Case Vignette

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

Similar to fight or flight response

Psychological	Physical
• Excessive worries + anticipation (of something bad or negative) • Fear • Apprehension (on edge) + hypervigilance (scanning) • Difficulty concentrating (bc they are thinking of their worries. Eg have to reread pages or rewatch scenes) • Feeling of restlessness • Sensitivity to noise (startle reflex) • Sleep disturbance (initial insomnia most common type in anxiety)	• Neuro: tremors, tension headache • ENT: tinnitus, dry mouth, 'lump in throat" • CVS & CHEST: palpitations, shortness of breath (hyperventilation could cause respiratory alkalosis) • GI: Heartburn, decreased appetite, abdominal ache, nausea, vomiting, "butterflies in stomach" • Genito-urin.: Urgency, frequency, reduced sexual desire • SKIN: sweating, cold extremities, piloerection (goosebumps) • MSS: tremors, muscle tension (esp, shoulders and neck), shivering, clenching jaw and grinding teeth • Eyes: blurry vision, dilated pupil



Types of insomnia:

1. Initial Insomnia - Difficulty falling asleep (takes more than 30 min to sleep most days)
2. Interrupted Sleep - Waking up repeatedly throughout the night (for 1-2 hours each time)
3. Late Insomnia - Wakes up hours before alarm and can't sleep (AKA Early morning awakening)
4. Non-refreshing Sleep - Sleeps adequately but wakes up tires and like they never slept

Panic Disorder

Panic attack:

- a symptom not a disorder.
- Episodic sudden intense fear (of dying, going mad, or losing self-control).
- Can be part of many disorders: panic disorder, GAD, phobias, sub. Abuse, acute & PTSD. (any anxiety disorder can have panic attacks)

2 types:

1. unexpected. (sudden)
2. situationally bound. (expected)

Panic Disorder:

Disorder with specific criteria:

1. Unexpected (not triggered) recurrent (2 or more) panic attacks (+/- situationally bound). (starts as unexpected and later becomes situationally bound)
2. one month period (or more) of persistent concerns about another attack or implications (consequences) of the attack or changes in behavior. (eg. stops driving bc afraid to get panic attack while driving)
3. Not due to other disorders

Panic Attacks

Unexpected

Spontaneous.
Essential to diagnose Panic Disorder
Occurs ONLY in panic disorder.

Situationally bound

Anticipation Or immediately on exposure to the trigger
e.g. specific phobia: can be ass./with panic disorder
Occurs in most anxiety disorders as well as panic disorder.

Panic Disorder

Diagnostic Criteria 300.01 (F41.0)

A. Recurrent unexpected panic attacks.
A panic attack is an abrupt surge of intense fear or intense discomfort that reaches a peak within minutes (<30 min), 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.

1. Palpitations, pounding heart, or accelerated heart rate.
2. Sweating.
3. Trembling or shaking.
4. Sensations of shortness of breath or smothering.
5. Feelings of choking.
6. Chest pain or discomfort. (could be confused for MI)
7. Nausea or abdominal distress.
8. Feeling dizzy, unsteady, light-headed, or faint (NOT loss of consciousness. Important to know that LOC occurs in ONLY ONE anxiety disorder → Blood phobia).
9. Chills or heat sensations.
10. Paresthesias (numbness or tingling sensations).
11. Derealization (feelings of unreality) or depersonalization (being detached from oneself).
12. Fear of losing control or "going crazy."
13. Fear of dying.

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.

B. At least one of the attacks has been followed by 1 month (or more) of one or both of the following:
(these 2 points could be summarized in one word as "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).

Epidemiology

- Women > men (All anxiety disorders more common in women EXCEPT in OCD male and female are equal)
- Prevalence : 1– 3 %
- Age at onset :20 --- 35 years (most anxiety disorders occur around 20's. Except GAD which usually occurs in after 30 and specific phobias usually occur in childhood)

Etiology

- Genetic predisposition
- Disturbance of neurotransmitters NE & 5 HT in the locus ceruleus (alarm system in the brain) (on 24/7, it initiates fight or flight response)
- Behavioral conditioning (weak)
- Exact etiology remains unknown
- Mitral valve prolapse 2x ?..% not increased in Echo. MVP

Course & Prognosis

- With treatment : good
- Some pts recover within weeks even with no treatment.
- Others have chronic fluctuating course.
- Generally prognosis is good in comparison to schizophrenia, MDD and OCD

Management

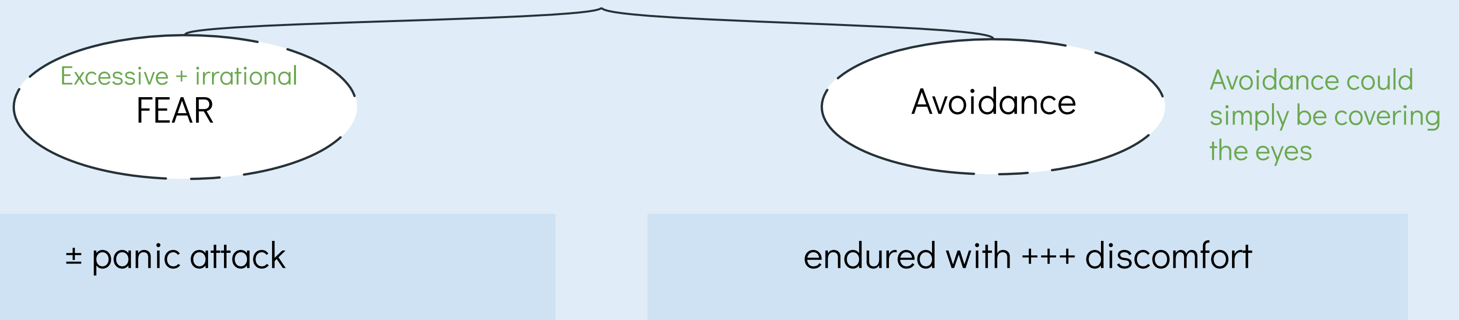
- Management = Assessment + Treatment
- Assessment: (Rule out physical causes):
  - Hypoglycemia, Hypotension, Pheochromocytoma, Hyperthyroidism, arrhythmia, myocardial infarction, and asthma attack.
- Support & reassurance & psychoeducation: These patients fear death and LOC, but neither occur in panic disorders so be sure to reassure them. Also explain to them what's happening and the "fight or flight" concept
- Bio-Psycho-Social approach important in all psychiatry
- Medications: ** The main treatment of anxiety disorders are antidepressants**
  - SSRIs / SNRIs
  - TCAs
  - BNZ benzodiazepines
- , Always start with SSRI's
- Antidepressants need 4-6 weeks to produce an effect so do not judge effectiveness till after 4 weeks.
- NB. When we give antidepressants to a patient with panic disorder, there will be an initial increase in the frequency of their panic attacks in the first 2 weeks of treatment. To avoid this we give them a short course of BNZ along with the antidepressants for the first 2-3 weeks. After which we can stop the BNZ.
- This initial short course of BNZ is ONLY given in Panic Disorder, NOT in other anxiety disorders.
- Benzodiazepines act quickly in preventing panic attacks. HOWEVER, they are not used long term as they can cause dependance (causes addiction if used daily for a month or longer)
- Medication should be continued for 6-9 months (up to a year) **after improvement** of symptoms. (the longer they are used the better)
- CBT: Psychotherapy- 40-50 minutes per session, weekly (or every 2 weeks but less effective) for 10-12 sessions.
- During these sessions they learn how to deal with their thoughts and behaviours.
- Social: The best thing you can do for a patient is to explain what is happening to them to their family.
- Disorder may also affect the patients occupational and academic life, so give sick leave when necessary
- In mild-moderate cases give EITHER CBT OR Medication. In moderate-severe give CBT AND Medication.
- Important exceptions to know:
  - OCD is the only anxiety disorder with equal prevalence between male and female.
  - Panic disorder is the only disorder that is given benzodiazepines in first 2-3 weeks.
  - Blood Phobia is the only anxiety disorder that can cause loss of consciousness.
  - Specific Phobias are treated with psychotherapy ONLY (NOT antidepressants).

PHOBIAS

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.

Phobia



Phobic Disorders

Irrational excessive fear ± panic attack on exposure + avoidance or endured with +++ discomfort

Specific	Social	Agoraphobia
Objects or situations: • blood ex. • dental clinic /dentists • hospital • airplane (height) common • Animals (eg. cats) • insects • thunder • storms • closed spaces/lifts (claustrophobia) • darkness • Clowns Notes: • Blood + injection phobia is the only phobia that can cause loss of consciousness • Specific phobias are the most common psychiatric disorder (have to affect life to be a disorder) • Psychotherapy is the only treatment for specific phobias. • CBT mainly includes "Gradual Exposure Therapy", "Habituation", "Systematic desensitization" • It usually takes 30 min for habituation to reduce fear scale to half original score. • Can give benzodiazepine for short term relief of specific phobias (eg. a person with phobia of planes has an important meeting in another city in 2 days and has to go → give benzos for trip there and back only)	Embarrassment when observed performing badly or showing anxiety features E.g. speaking in public, leading prayer, and serving guests. *Functional impairment. Notes: • Present in 10% of population • Fear is mainly of embarrassment • Public speaking is the most common • Considered a disorder when there is functional impairment • Treatment: Bio-psycho-social (CBT, antidepressants, social interventions) • Benzos can be given if person has an interview in a few days (however do not give benzos for examination as they cause dulling/slowness) • B-blockers (propranolol) can be given to reduce the physical symptoms of fear (eg. palpitations and sweating)	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. Notes: • Agora = market • Avoids crowded places, tunnels and locking doors • Eg. I can't drive on king fahd road because its congested and i may need to get out • Eg. not being to leave area, district or even the house
	Functional impair	

Specific Phobia DSM5

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).

Social Anxiety Disorder

(Social Phobia) DSM5

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.

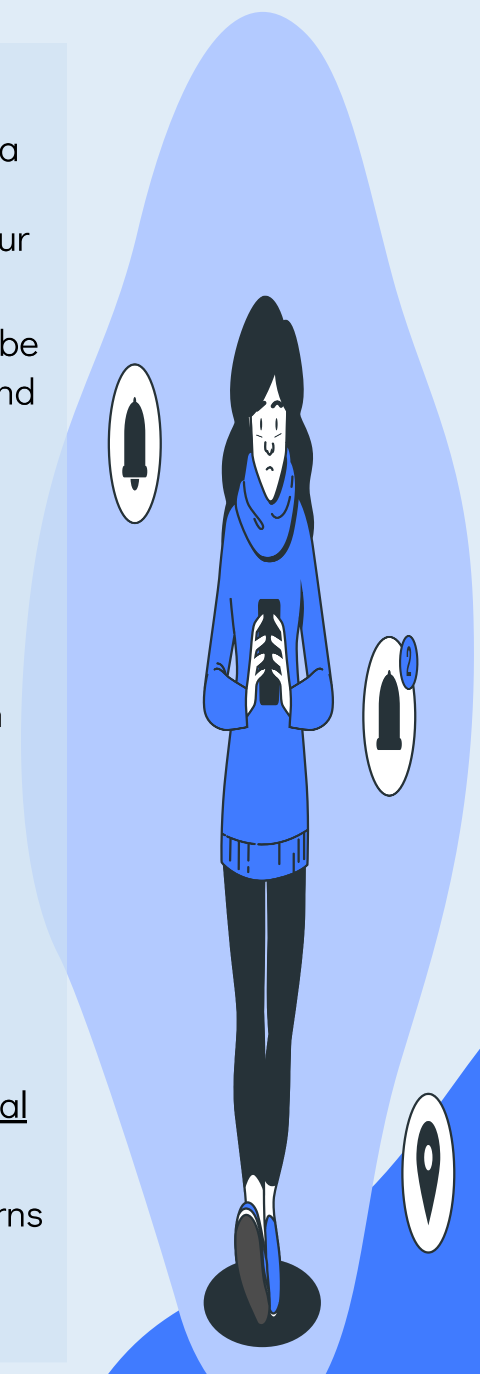
F. The fear, anxiety, or avoidance is persistent, typically lasting for 6 months or more.

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.



Agoraphobia

Diagnostic Criteria 300.22 (F40.00) A.

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.

Management: Mentioned in slide 5.

Summary : Def. of Phobia and Types: Specific Phobia, Social Phobia, Agoraphobia

*NB. 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 eg. "I'm afraid the plane will fall" then its a Specific Phobia.
- If the fear is because on being trapped eg. "I'm afraid that I will need help on the plane but i can't get out" then its agoraphobia.

Generalized Anxiety Disorder

Case Development

Her aunt is anxious for the last 8 years. She has excessive worries about daily events mainly toward safety of her kids. A classic case of GAD is a mother in her 30's and her son is just starting to drive and she calls him excessively when he goes out driving. If he doesn't answer she will automatically assume the worst has happened (will assume he is dead).

Criteria:

- Excessive worries 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 , substance abuse or other axis I psychiatric disorder.
- 6 months duration – most of the time

Generalized Anxiety Disorder

(DSM5)

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. (angry)
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).

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

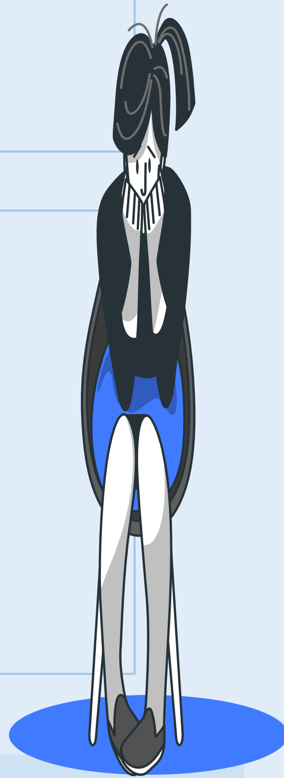
- Panic disorder - 1 month
- PTSD - 1 month
- Adjustment- <6months

Associated features

- panic attacks (episodes of short severe anxiety). (situationally bound, eg. will have panic attack if son doesn't asnwer phone)
- Sadness +/- weeping
- Overconcerned about body functions (heart, brain,...) (health anxiety)
- Secondary depression

MSE

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



Course & Prognosis

If not properly treated :

- chronic, fluctuating & worsens with stress.
- Secondary depression .
- Possible physical complications: e.g. HTN,DM,IHD

Poor Prognostic Factors

- Very severe symptoms
- Personality problems
- Uncooperative patient.
- Derealization

Management: Mentioned in slide 5.

ANXIETY .. IN GENERAL

	Normal anxiety	ABnormal anxiety
Apprehension	Proportional to the trigger (time & severity).	Out of proportion (eg. worried about an exam 2 months in advance)
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

Prognosis

Depends on:

- Dx (Psychosis ➔ Mood➔Anxiety)
- Severity
- Duration
- Support
- Compliance

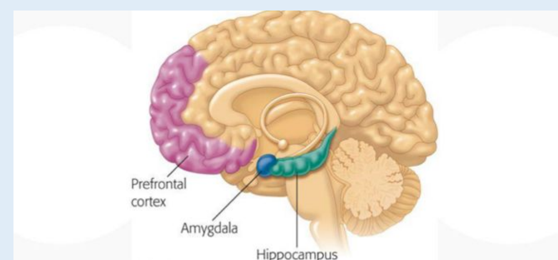


Figure 4-3 Neuroanatomical Basis for Panic and Other Anxiety Disorders The fear network in the brain is centered in the amygdala, which interacts with the hippocampus and areas of the prefrontal cortex. Antianxiety medications appear to desensitize the fear network. Some psychotherapies also affect brain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

Amygdala + locus coeruleus most important

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.

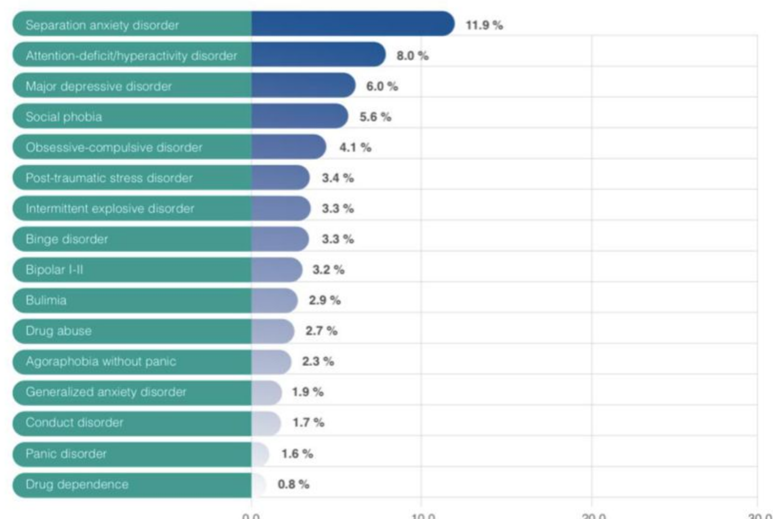
C. The disturbance causes clinically significant distress or impairment in social, academic, occupational, or other important areas of functioning.

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.

PREVALENCE IN SAUDI ARABIA

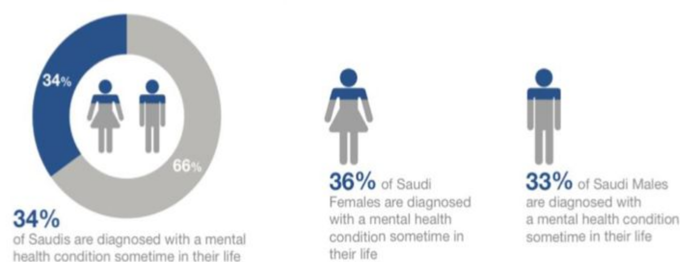
Findings

Prevalence of mental health conditions in KSA by disorders across lifetime

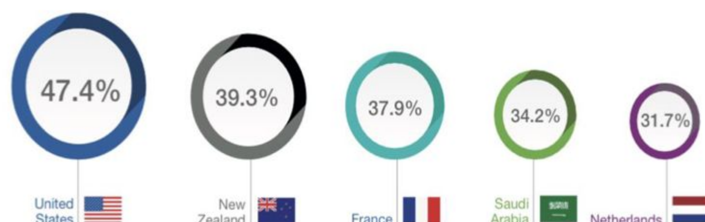


Findings

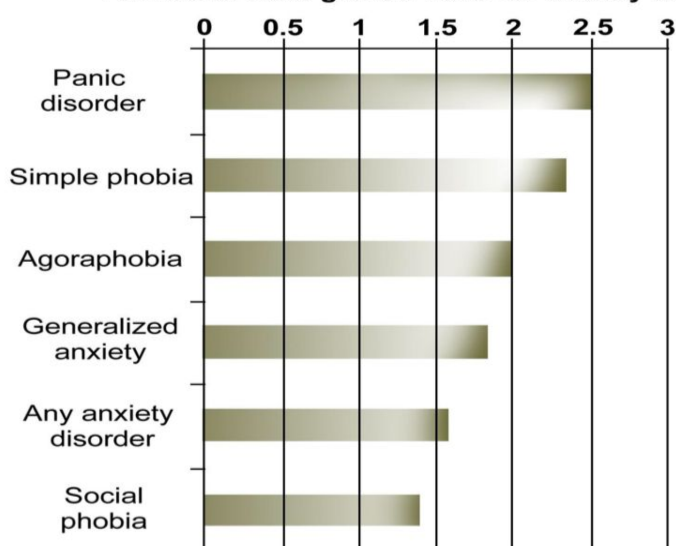
The occurrence of mental health conditions accross lifetime



The occurrence of mental health conditions accross lifetime in Saudi Arabia is comparable to:



Female to male gender ratio for anxiety disorders



Prevalence of treatments received for mental health conditions

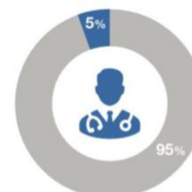
Table below shows the percentage of Saudis who sought any type of treatment for their mental health condition

Severity Levels of Mental Health Conditions	Severe %	Moderate % / Mild %	None %	Any %
General Medical	6.5	6.1	1.6	2.6
Mental Health	6.1	3.4	0.6	1.5
Non-Healthcare*	8.5	2.1	0.3	1.3
Any Treatment**	17.0	10.1	2.6	4.9
No Treatment	83	89.9	97.4	95.1

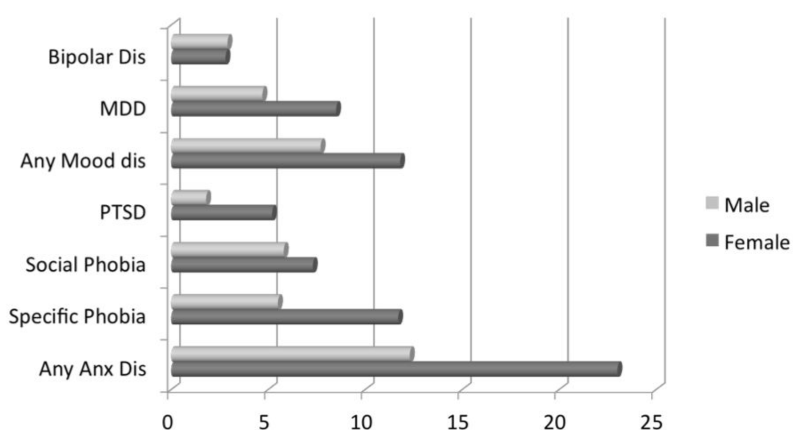
Treatment Type

*Non-Healthcare treatment includes spiritual and non-medical treatments

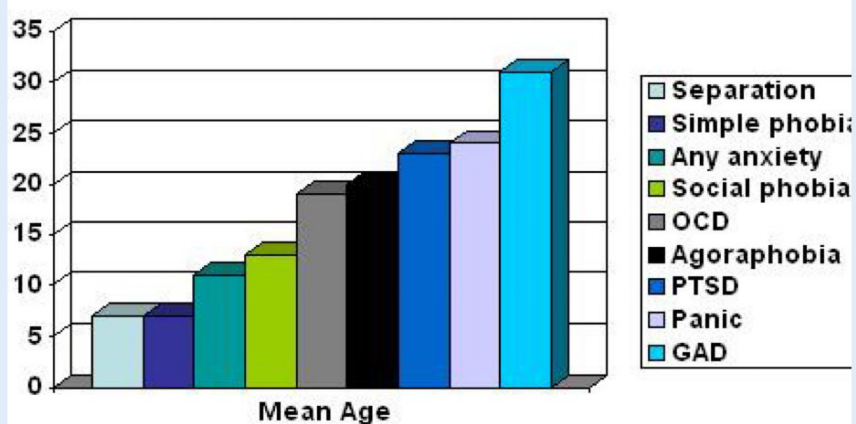
**Any treatment is a combination of General Medical, Mental Health and Non-Healthcare treatments



Mental Disorders among Adults (18 and older), in the past year (2001)



Mean Age of Onset



Once again: all anxiety disorders more common in females except in OCD the is equal gender prevalence

Know general age distribution:
-Most occur around 20's
-Separation anxiety and specific phobias occur in childhood
-GAD usually occurs after 30

OCD

Case Development

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 (images in head not hallucinations)

Intrusive, Insisting, Unwanted

Repetitive Irrational (the patient is aware that these thoughts are 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 imp.

OCD DSM5

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.

Cont. OCD DSM5

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.

Obsessive-Compulsive Disorder To Do List

Main Themes of OCD

A sense of danger and/or responsibility.

- Contamination ➔ washing. (Most common)
- Religious, (common in KSA) e.g. repeating Ablution (woudu), prayers, divorce (in men), Blasphemous (كفري eg "sometimes i think of insulting god or the prophet").
  - In religion OCD themes usually involve the concept of طهارة
  - The problem with OCD in religious themes is that people tell them the reason they think like this is because they have weak faith and are allowing iblees to يوسوس in their heads.
- Sexual.
- Aggression.
- Symmetry ➔ slowness.
  - Eg. a person will pay more attention to the formatting of an assignment than to the content and this may even lead them to not finish by deadline.
- Hoarding. (of useless stuff of no value/ mainly trash)

Course of OCD

- Gradual > acute
- Chronic
- Waxing & waning (sometimes gets better other times worse and keeps cycling.)

Prognosis of OCD

- Non – severe
- No OCPD
- Depressed / anxious mood
- Compliance with Tx
- Family support

GOOD PROGNOSTIC FACTORS

Management: Mentioned in slide 5.

THE MAIN THEMES OF OCD

Contamination and washing (e.g. contaminated by one's own excreta, shaking hands with others, etc.)

Repeated doubts concerning actions that may not have been completed adequately (e.g. ablutions, prayers, gas checking).

Insistence on symmetry: needs to have things in a particular order.

Aggressive or horrific impulses (e.g. fear of harming a child).

Sexual imagery (e.g. violent abnormal sexual practices).

Blasphemous thoughts: obsessions about religious matters.

Obsessional ruminations: internal debates in which arguments for and against even the simplest everyday actions are reviewed endlessly.

Obsessional phobias: obsessional thoughts with fearful content such as thoughts of a harmful use of knives.

Acute Stress Disorder & PTSD

Case Development

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.

PTSD is the only disorder with a clear cause

Trauma

Memorise!! Frequently asked about in exam!

1- Re-Experience

- AKA Intrusions
- Flash-backs
- Nightmares (related to the trauma)
- 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)

2- Changes in Mood & Cognitions

- Amnesia
- Negative beliefs
- Distorted cognitions ➔ blame (guilt)
- Negative emotional state
- Diminished interest
- Detachment (noticed by family)
- Persistent inability to experience positive emotions

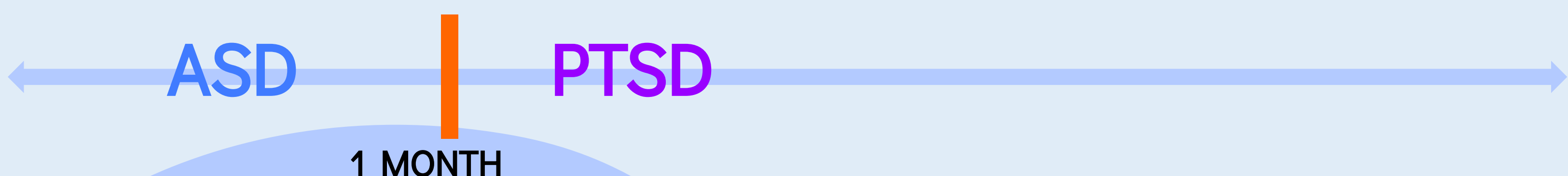
3- Avoidance

- Place, People
- Conversations
- Apathy
- Detached

4- Arousal

- Sleep
- Hypervigilance
- Irritability
- Anger
- Insomnia (interrupted sleep)

- After exposure to traumatic life events. (usually life threatening)
- 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**. (>4 weeks will be PTSD)
- The only difference between Acute Stress Disorder and PTSD is time.
- 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 (eg tsunami, floods), assault, rape, and serious accidents, for example, in cars and in burning buildings.

PTSD DSM5

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).

Cont. PTSD DSM5

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).

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.

Cont. PTSD DSM5

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).

PTSD Epidemiology

The lifetime prevalence:

- 8% of the general population
- Up to 75% in high-risk groups whose experienced traumatic events.
- 5 to 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.

Comorbidity

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

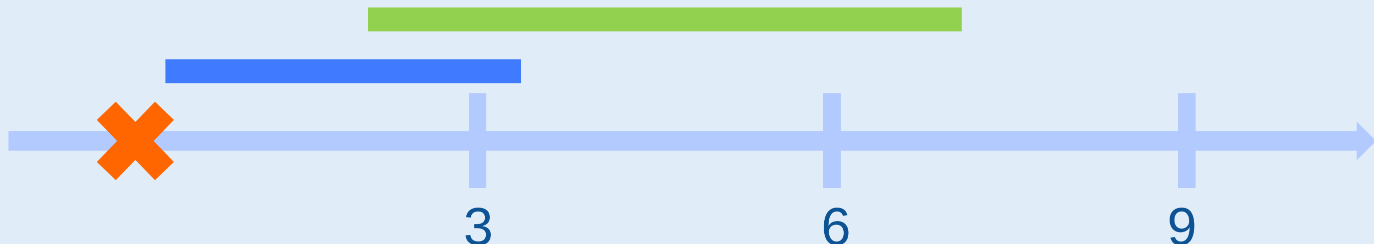
PTSD Prognosis

- Fluctuate over time and may be most intense during periods of stress.
- Untreated,
  - about 30 percent of patients recover completely,
  - 40 percent continue to have mild symptoms,
  - 20 percent continue to have moderate symptoms,
  - 10 percent remain unchanged or become worse.
  - After 1 year, about 50 percent of patients will recover.
  - Last 2 are hardest to treat
- **A good prognosis**
  - Rapid onset of the symptoms,
  - Short duration of the symptoms (less than 6 months),
  - Good pre-morbid functioning,
  - Strong social supports
  - Absence of other psychiatric, medical, or substance-related disorders or other risk factors.

Treatment of PTSD:
- Like that of panic disorder
- Bio-psycho-social approach
- Antidepressants
- CBT and psychotherapy
- Educate family

Adjustment Disorders

- The adjustment disorders: emotional response to a stressful event. (not life threatening)
- The stressor involves financial issues, a medical illness (eg cancer, HIV/AIDS), or a relationship problem. (Could also be work or academic stress)
- 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**

Adjustment Disorders DSM5

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.

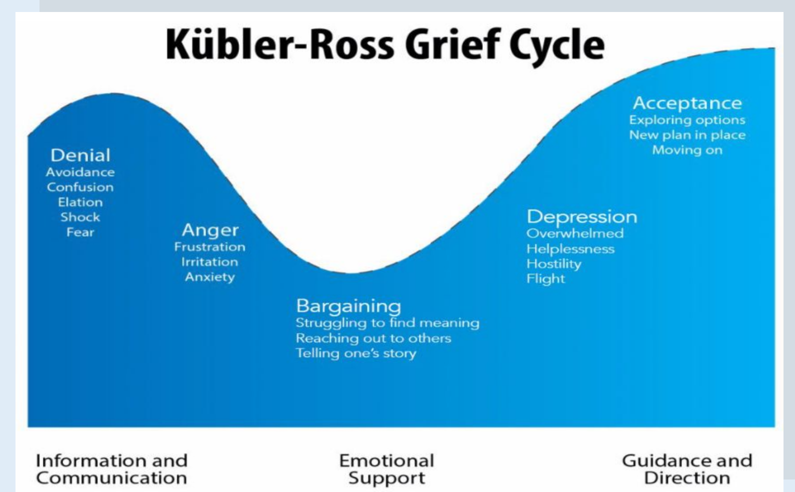
Course and Prognosis

- 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.
- Symptoms should not fulfil criteria for major depressive disorder.

Bereavement, Grief, and Mourning

- 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



- **Stage 1:** Shock and Denial
  - Lasts a few hours (1-2 days max.)
- **Stage 2:** Anger
  - Transient (hours)
  - "Why me?"
- **Stage 3:** Bargaining
  - Could be with doctor eg. "doctor if you can cure me i will give you all I have"
  - Or even with God "God if my son get cured I will give 100K to charity or I will sacrifice 7 camels"
- **Stage 4:** Depression
  - Length differs from person to person (could be months)
  - It is sadness NOT clinical depression
- **Stage 5:** Acceptance

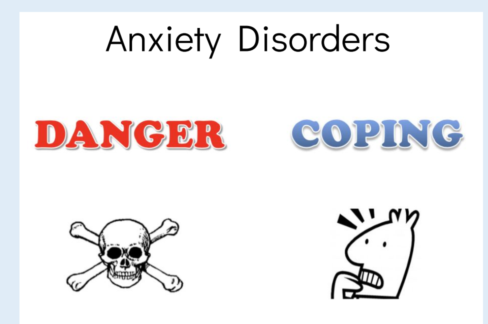
Management: Mentioned in slide 5.

Summary
Bereavement or Depression?

Keep in mind that bereavement could turn into major clinical depression. You should be able to differentiate between the two.

In bereavement:

- **NO** morbid feelings of guilt and worthlessness, suicidal ideation, or psychomotor retardation. (in depression they will say "i was the reason they died")
- Dysphoria often triggered by thoughts or reminders of the deceased. (constant dysphoria in depression)
- 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.



8

Anxiety Disorders
+
OCD
+
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:

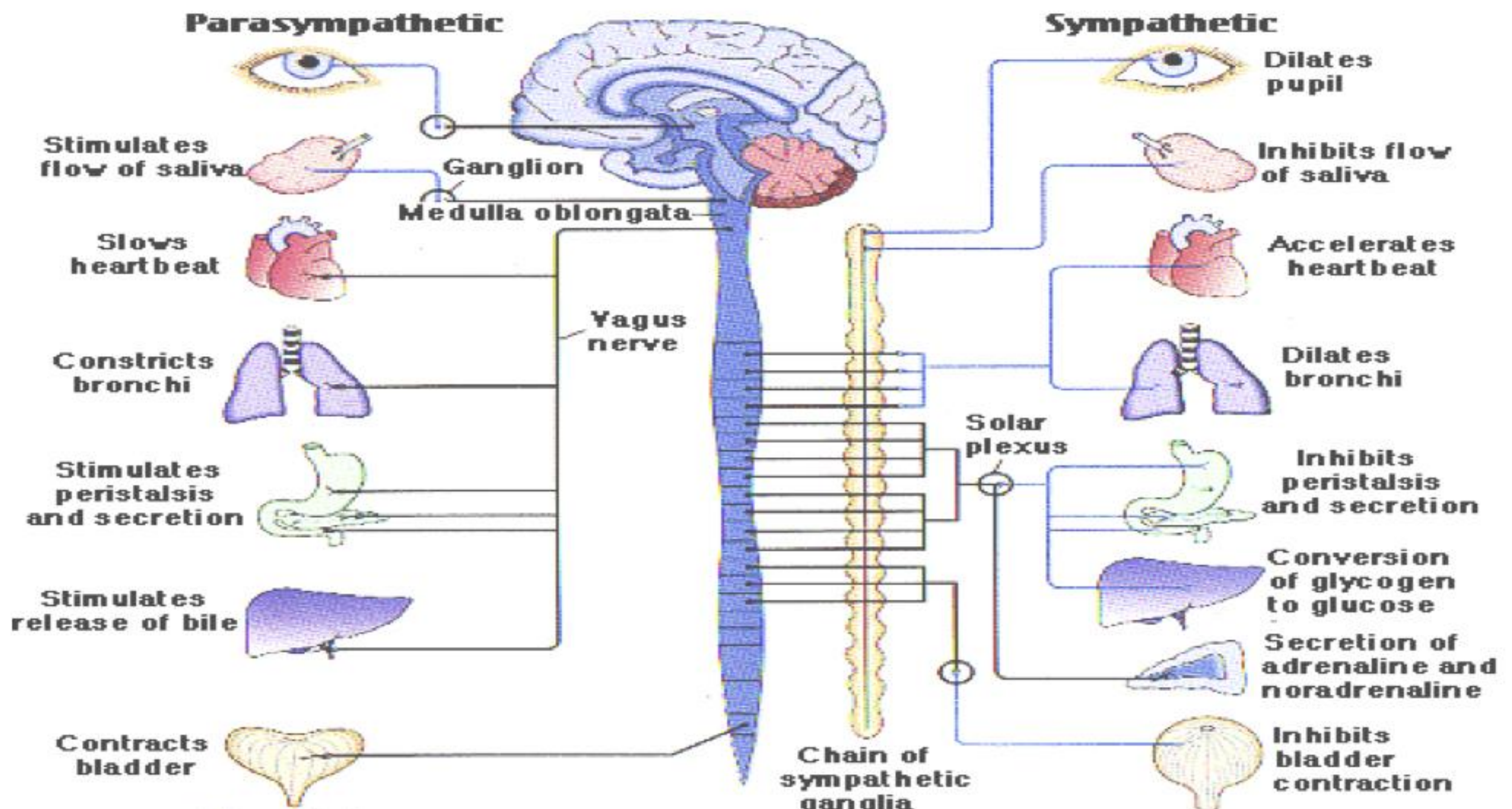
1. **Anxiety:** subjective feeling of worry, fear, and apprehension accompanied by autonomic symptoms (such as palpitation, sweating, and muscles), caused by anticipation of threat/danger. **Free-floating anxiety:** diffuse, unfocused anxiety, not attached to a specific danger.
2. **Fear:** anxiety caused 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.

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

Phobias
Situational anxiety with avoidance. (رُهاب) .

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

Agoraphobia;
Anxiety about self-safety in crowded places.

Social phobia;
Anxiety about personal performance.

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

In DSM-5 Separated in new categories :

OCD Excessive worries due to distressing obsessions.

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

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.

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.

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.

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.

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

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.

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.

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.

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).

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).

Treatment:

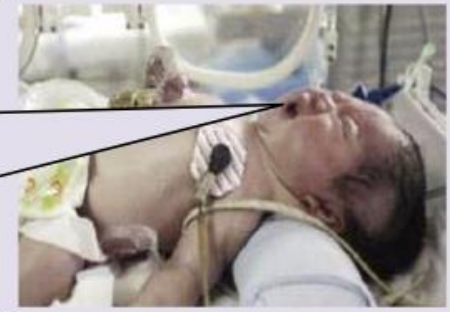
Psychological (the major approach**):**
Support – reassurance – explanation – education.
Encourage discussing stressful events and overcome patient's denial.
In vivo (imaginary) exposure with relaxation and cognitive techniques.
Eye movement desensitization and reprocessing **(EMDR)**: while maintaining 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).

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).

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).

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).

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.

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.

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).

Questions:

1- Which of the following disorders is more likely to occur at the age of thirty?

A. Specific phobia B. General anxiety disorder C. OCD D. Panic disorder

Ans: B

2- 24 y/o male presented complaining of specific phobia (Height) what is the best treatment?

A. CBT B. Mood stabilizer C. ECT D. Antidepressant

Ans: A

3- 22-year-old girl can't get into the plane because she's afraid something will happen to her and she won't be able to get help and will be embarrassed. What is the most likely diagnosis?

A. Aviophobia B. Agoraphobia C. Specific phobia

Ans: B

4- Regarding Post Traumatic Stress Disorder, insomnia falls under which of the following groups?

A. Avoidance B. Alteration in arousal &; reactivity C. Intrusion & re-experience

D. Negative alteration in cognition & mood

Ans: B

5- 24 years old female facing difficulty sleeping, because of hx of sexual assault 10 days ago. What's the most likely diagnosis?

A. PTSD B. Acute stress disorder C. dysthymic disorder D. GAD

Ans: B

5- Which one of the following is a good prognostic factor in agoraphobia?

A. Age > 35 years B. Late treatment C. Presence of panic attacks D. Absence of panic attacks

Answer: C

6-A 30 years male has excessive worries and fear of death. Which one of the following medications can be used as long-term therapy?

A. Propranolol B. Diazepam C. Paroxetine D. Alprazolam

Answer:C

7- What is a good prognostic indicator for OCD?

A. Late onset B. Presence of insomnia C. Low mood D. OCPD

Answer: C

8-Best treatment of Obsessive-compulsive disorder?

A. Behavioral thereby B. Cognitive thereby C. SSRI D. TCA

Answer: A

9- A 7 months h/o palpitations, urgency and excessive worries. P/E and investigations was normal. What is appropriate medication?

A. Paroxetine B. Imipramine C. Carbamazepine D. Haloperidol

Answer: A

10- A 45-year-old woman lost her husband 2 days ago with myocardial infarction but has no emotions until now, which one of the following describe the condition above?

A. Adjustment disorder B. Abnormal Grief C. Normal reaction D. Acute stress disorder

Answer: C

11- Patient came complaining of prolonged bathing" OCD", what medications would you order?

A. Amitriptyline. B. Valproate. C. Quetiapine. D. Olanzapine.

Answer: A

12- A 19 years old girl has recurrent pulling out of her hair resulting in noticeable hair loss. What is the diagnosis?

A. Trichotillomania B. Somatic symptoms disorder C. Obsessive compulsive disorder D. Body dysmorphic disorder

Answer: A

13- A 34-year-old man with a 3-year history of extreme fear and avoidance of crowded places. Which of the following medications is the appropriate long-term treatment?

A. Lorazepam. B. Mirtazapine. C. Paroxetine. D. Zuclopenthixol

Answer: C

14-Which of the following disorders the housebound housewife syndrome?

A. Agoraphobia. B. Social phobia. C. Specific phobia D. GAD.

Answer: A

15-A patient passed the denial phase, which phase is he most likely to enter?

A. Anger B. Depression C. Acceptance D. Bargaining

Answer: A

16-A 22 y/o man have history of 8 month of tremor, tachycardia, urinary urgency and excessive worries. Physical and history was normal . What is the MOST appropriate treatment?

A. Aripiprazole B. Paroxetine C. Haloperidol D. Bupropion

Answer: B

17- Patient Came to the clinic with a 6 month history of sleep disturbance , muscle tension and fear what is the diagnosis?

A. Panic disorder B. OCD C. Generalized anxiety disorder D. Phobia

Answer:C

18- Which of the following indicates poor prognosis of a patient with OCD?

A. presence of mood component B. family support C. compliance with treatment D. presence of OCPD

Answer: D

19-A 34 year old man has adjustment disorder following a family conflict. Which of the following describes the course and prognosis of adjustment disorder?

A. Adults recover earlier than adolescents B. The gender influences the prognosis C. Most patients maintain chronic course D. Recurrence is not common

Answer: A

20- 33.year.old female suffers from repeated episodes of panic attacks with excessive fear, palpitation, shortness of breath and headache. Which of the following statements is true regarding the prognosis and course of panic disorder?

A. Most patient recover within three weeks B. The course is usually chronic C. The gender influences the prognosis

D. All the above are true

Answer: B

21-"Patient complaining of not touching surfaces or doors after people have touched them. He is afraid they are contaminated."

Q1:Write down three questions you want to ask to help you reach a diagnosis

1- Do you have recurrent intrusive thoughts that is disturbing and hard to control?2- Do you do certain actions do reduce the anxiety produced by these obsessive thoughts?3-Is it time consuming and cause significant functional impairment? 4- Any Recurrent and persistent thoughts, urges, or images? 5- Are these acts aimed at preventing or reducing anxiety or distress?

Q2:Most likely diagnosis? OCD

Q3:What is your management (two different modalities)? Psychotherapy (CBT), Antidepressants (fuoxetine or clomipramine)

شاب تصيبه نوبات خوف ويرى أحلام مخيفة ومزعجة عندما يتذكر الحادث اللي جاه هو وأبوه وعمه وأصيبوا فيه

Give 2 differential Diagnoses:Post traumatic stress disorder and Acute stress disorder

Ask 2 History Questions and Why you do ask for each question -The time/duration of the accident? (If less than a month ASD if more then PTSD) -is there any disturbance in the cognition or mood changes like self blame? (To see if it fit the diagnostic criteria of PTSD) -Is theses symptoms are intrusive? (If it fit the criteria of dx)