Theme 4:
Anxiety Disorders

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Introduction

- Case
- Hx
- MSE
- Types of Anxiety

Needs assessment

- What do you need to know about Anxiety disorders?

Objectives

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

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

Anxiety Disorders

- Separation Anxiety Disorder
- Selective Mutism
- Specific Phobia
- Social Anxiety Disorder
- Panic Disorder
- Agoraphobia
- Generalized Anxiety Disorder
- Substance/Medication-Induced Anxiety Disorder
- Anxiety Disorder Due to Another Medical Condition

Obsessive-Compulsive and Related Disorder

- Obsessive-Compulsive Disorder
- Body Dysmorphic Disorder
- Hoarding Disorder
- Trichotillomania (Hair-Pulling Disorder)
- Excoriation (Skin-Picking) Disorder
- 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
- Disinhibited Social Engagement Disorder
- Posttraumatic Stress Disorder
- Acute Stress Disorder
- Adjustment Disorders

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.

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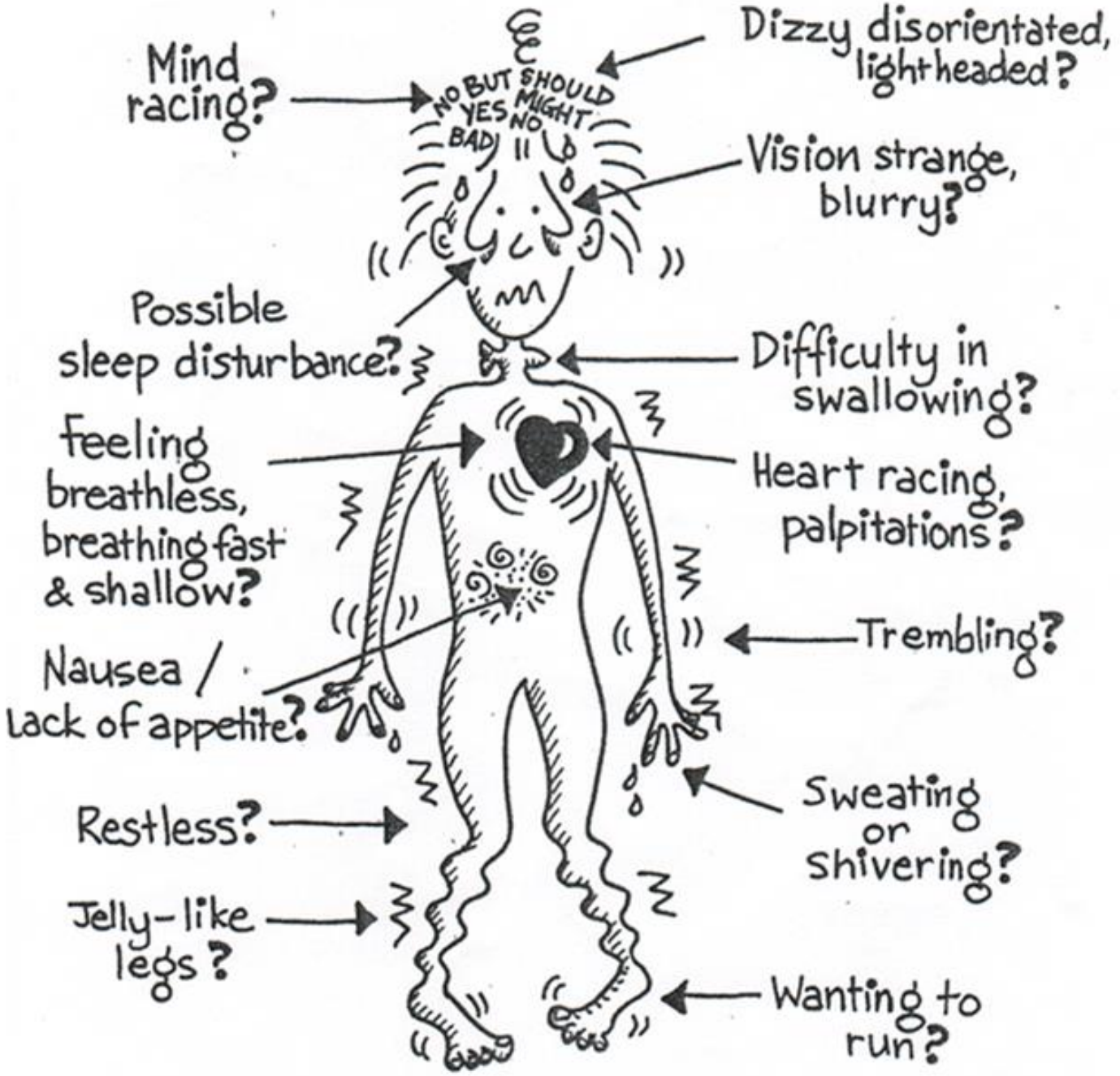
Features of Anxiety

Psychological	Physical
Excessive worries + anticipation Fear Apprehension + hypervigilance Difficulty concentrating Feeling of restlessness Sensitivity to noise Sleep disturbance	Neuro: ENT: CVS & CHEST: GI: Genito-urin.: SKIN: MSS:


Mind racing?
NO BUT SHOULD
YES MIGHT
BAD NO
Dizzy disorientated, lightheaded?
Vision strange, blurry?
Possible sleep disturbance?
Difficulty in swallowing?
Feeling breathless, breathing fast & shallow?
Heart racing, palpitations?
Trembling?
Nausea / lack of appetite?
Restless?
Sweating or shivering?
Jelly-like legs?
Wanting to run?

Imagine!!

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Panic Disorder

Panic attack :

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

2 types:

1- unexpected.

2- situationally bound.

Panic Disorder:

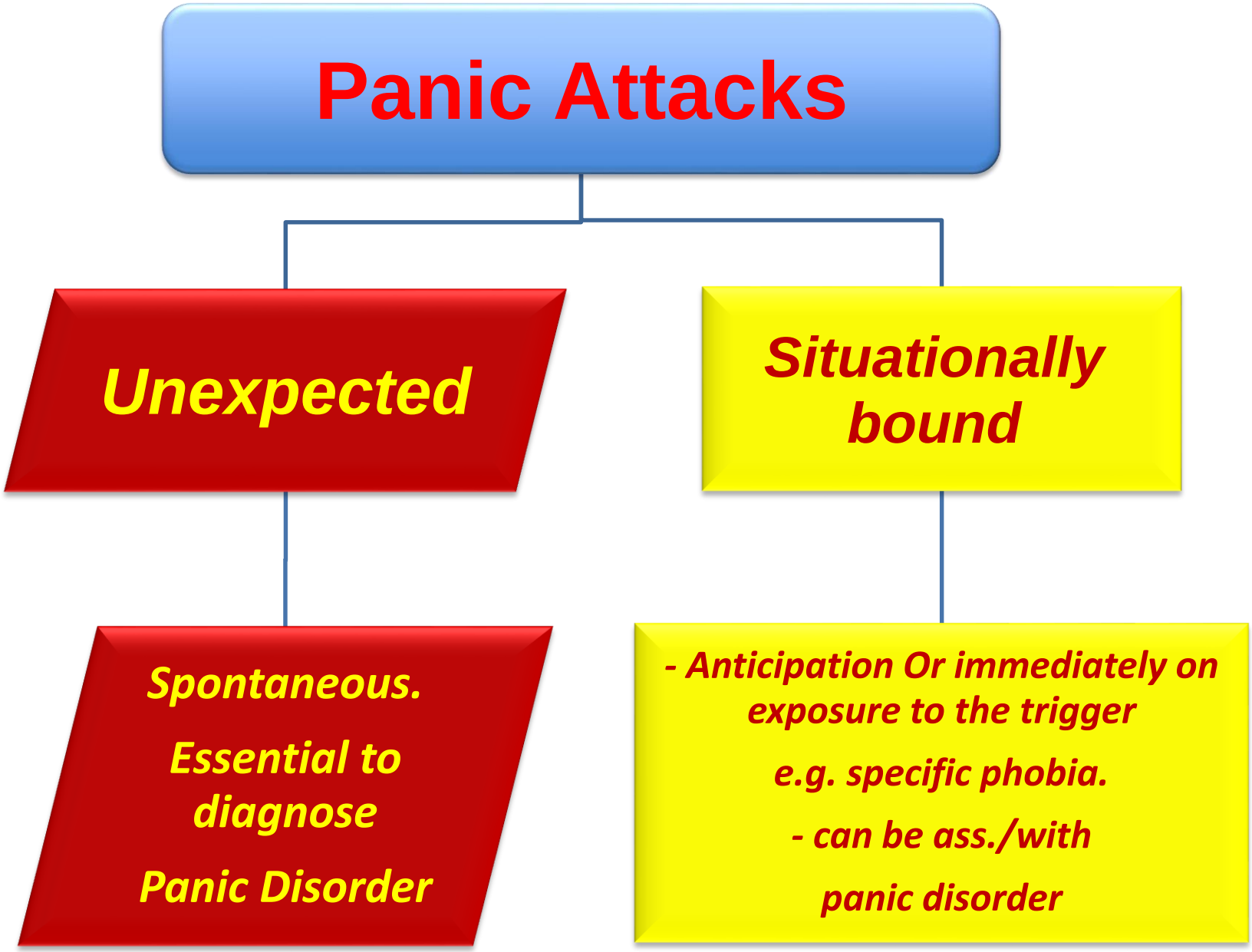
Disorder with specific criteria:

1- Unexpected recurrent panic attacks

(+/- situationally bound).

2- One-month period (or more) of persistent concerns about another attack or implications of the attack or changes in behavior.

3- Not due to other disorders


Panic Attacks
Unexpected
Situationally bound
Spontaneous.
Essential to diagnose
Panic Disorder
- Anticipation Or immediately on exposure to the trigger
e.g. specific phobia.
- can be ass./with
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, 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.

Panic Disorder

Diagnostic Criteria 300.01 (F41.0)

7. Nausea or abdominal distress.
8. Feeling dizzy, unsteady, light-headed, or faint.
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.


0:59

Panic Disorder

Diagnostic Criteria 300.01 (F41.0)

B. At least one of the attacks has been followed by 1 month (or more) of one or both of the following:

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).

Panic Disorder

Diagnostic Criteria 300.01 (F41.0)

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

Prevalence : 1– 3 %

Age at onset :

20 --- 35 years

Etiology

- Genetic predisposition
- Disturbance of neurotransmitters

NE & 5 HT

in the locus ceruleus

(alarm system

in the brain)

- Behavioral conditioning
- 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.

Management

- Rule out physical causes.
- Support & reassurance & psychoeducation
- Bio-Psycho-Social
- Medications:

  BNZ

  SSRIs / SNRIs / TCAs
- CBT
- Social

Any Qs So far?

PHOBIA s

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.

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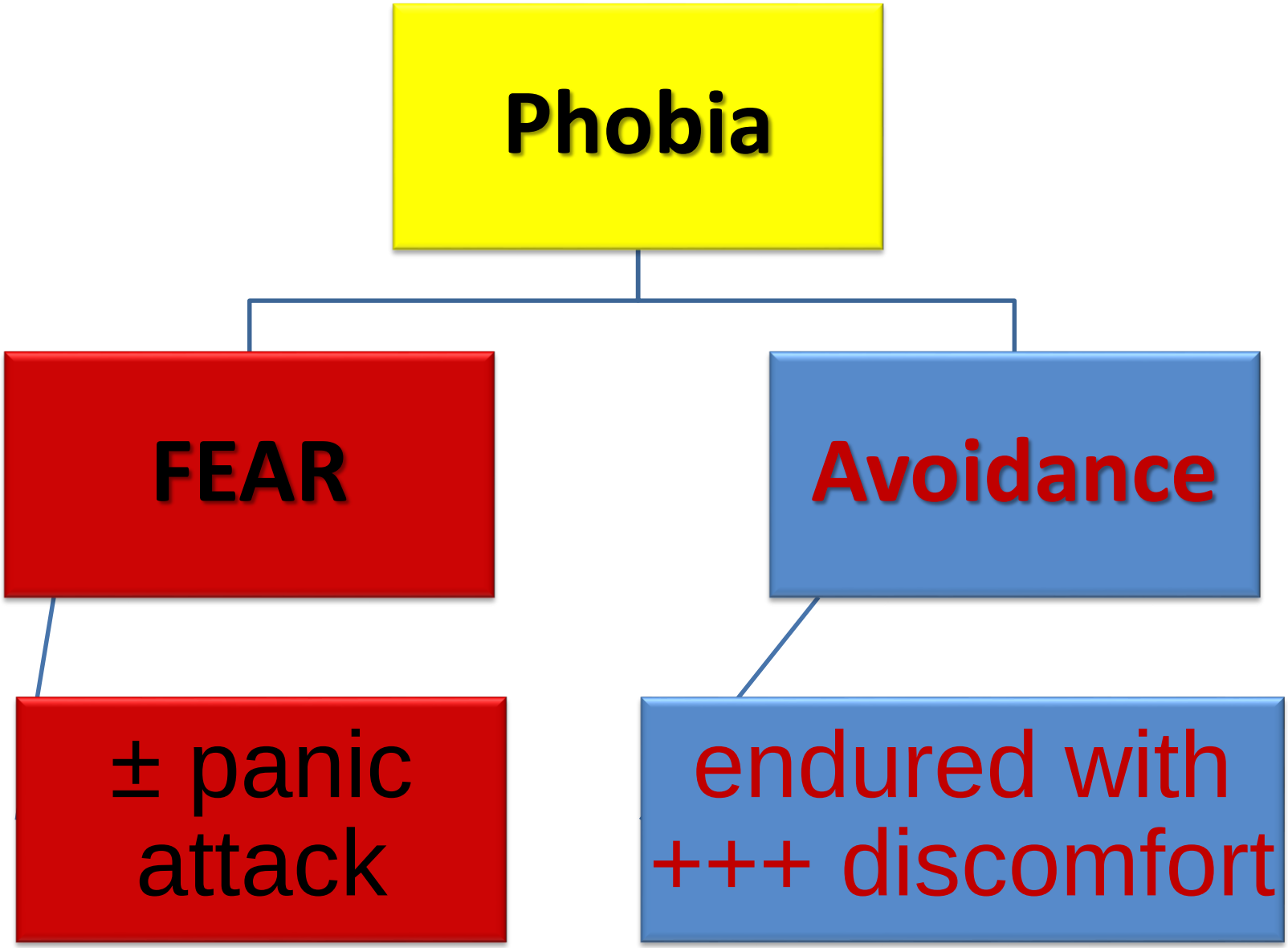
Phobia
FEAR
Avoidance
± panic attack
endured with +++ discomfort

Phobic Disorders

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

Specific	Social	Agoraphobia
Objects or situations: blood ex. dental clinic hospital airplane (height) animals insects thunder storms closed spaces/lifts darkness clowns		

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.

Specific Phobia DSM5

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).

Social Anxiety Disorder
(Social Phobia) DSM5

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.

Social Anxiety Disorder
(Social Phobia) DSM5

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).

Agoraphobia

Diagnostic Criteria 300.22 (F40.00) A.

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.

Agoraphobia

Diagnostic Criteria 300.22 (F40.00) A.

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.

Video

Management

- ❑ Rule out physical causes
- ❑ Support & reassurance & psychoeducation
- ❑ Bio-Psycho-Social

1. Medications:
    1. SSRIs / SNRIs / TCAs
    2. BNZ
2. CBT
3. Social

Summary

- Def. of Phobia
- Types
  - Specific Phobia
  - Social Phobia
  - Agoraphobia

Case Development

- Her aunt is anxious for the last 8 years. She has excessive worries about daily events mainly toward safety of her kids.

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Generalized Anxiety Disorder

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.
5. Muscle tension.
6. Sleep disturbance (difficulty falling or staying asleep, or restless, unsatisfying sleep).

Generalized Anxiety Disorder

DSM5

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).

Generalized Anxiety Disorder

Associated features:

- panic attacks (episodes of short severe anxiety).
- Sadness +/- weeping
- Overconcerned about body functions (heart, brain,...)

MSE :

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


Please God, don't Please God, don't let the ceiling fall down on my head tonight!

Generalized Anxiety Disorder

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

- ❑ Rule out physical causes
- ❑ Support & reassurance & psychoeducation
- ❑ Bio-Psycho-Social

1. Medications:
    1. SSRIs / SNRIs / TCAs
    2. BNZ
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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.

Separation Anxiety Disorder

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.

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Family History:

- 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.

Anxiety Disorders in DSM5

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OCD

Obsessions

Own: thoughts,

Impulses, images

Intrusive, Insisting, Unwanted

Repetitive

Irrational

uncontrollable

e.g. contaminated hands

Compulsions

Irresistible, Compelling Actions or mental acts

Done in response to obsessions or according to rules

to reduce anxiety or prevent dreaded events or situations

e.g. washing hands

repeatedly

Disorder

Time consuming

at least 1 hr/d

Functioning 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.

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.

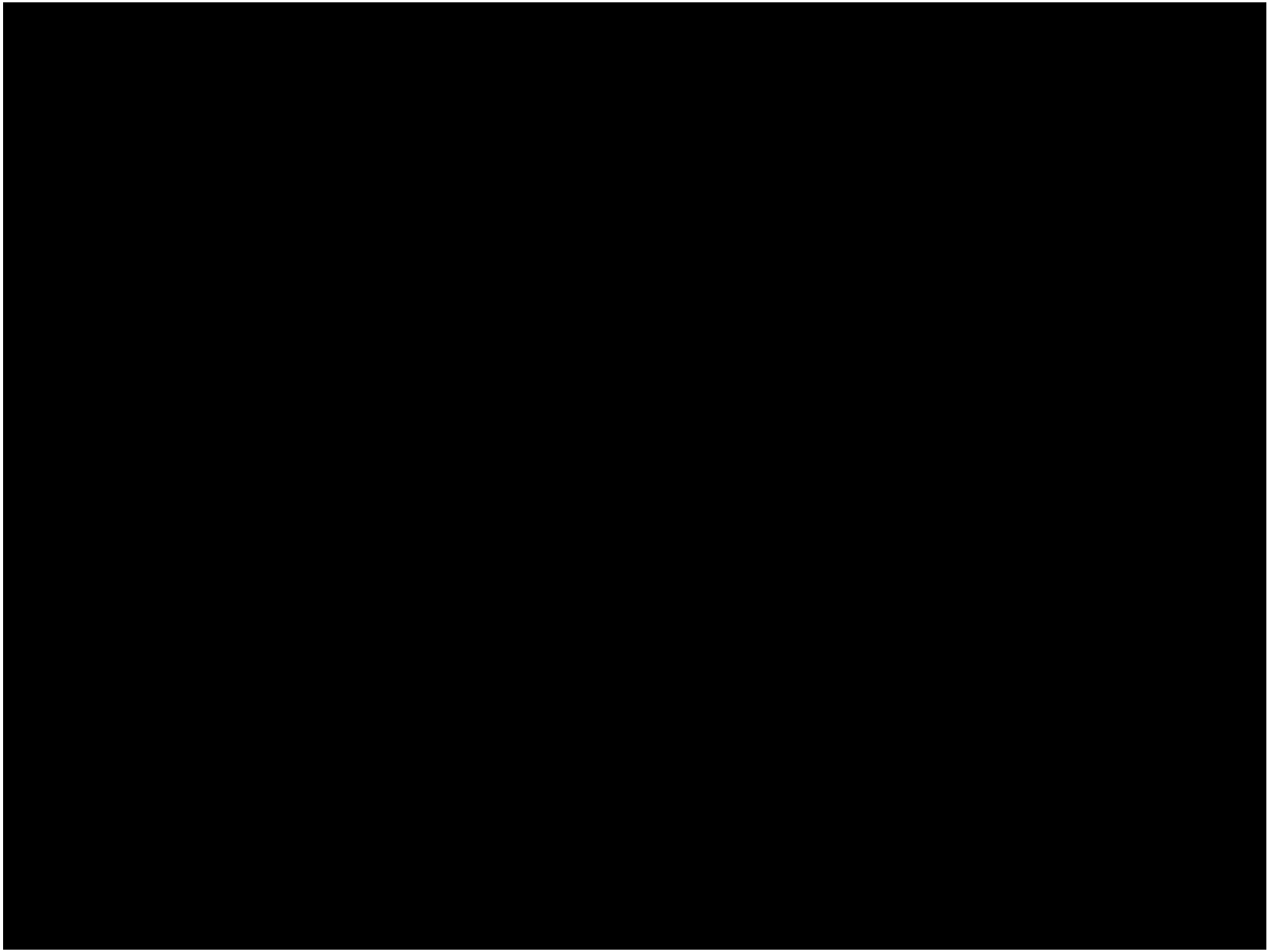
Specify if: Tic-related: The individual has a current or past history of a tic disorder.

Obsessive-Compulsive Disorder To Do List

video

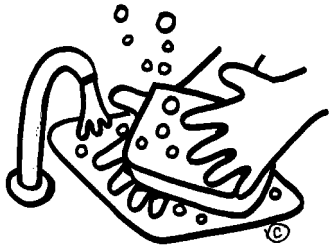
video

video



Main themes of OCD

**** sense of danger and/or responsibility.



- ❑ Contamination ➔ washing.
- ❑ Religious, e.g. repeating Ablution, prayers, divorce, Blasphemous.
- ❑ Sexual
- ❑ Aggression
- ❑ Symmetry ➔ slowness
- ❑ Hoarding

Hoarding video

Course

- Gradual > acute
- Chronic
- Waxing & waning


did you see that tv program on OCD the other night?
see it? i taped it and replayed it 367 times!

Prognosis

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

Good p. Factors

Management

- ❑ Rule out physical causes
- ❑ Support & reassurance & psychoeducation
- ❑ Bio-Psycho-Social

1. Medications:
    1. SSRIs / SNRIs / TCAs
    2. BNZ
2. CBT
3. Social

????

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.

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Re-experience

- Flash-backs
- Nightmares
- Hallucinations
- Cues ➔

Changes in Mood & Cognitions

- Amnesia
- negative beliefs
- distorted cognitions ➔ blame
- negative emotional state
- diminished interest
- Detachment
- Persistent inability to experience positive emotions

Avoidance

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

Arousal

- Sleep
- Hypervigilance
- Irritability
- Anger

TRAUMA

Acute stress disorder and PTSD

- After exposure to traumatic life events.
- Duration > a month after the event.
- Acute stress disorder: occurs earlier than PTSD **(within 4 weeks of the event)** and **remits within 2 days to 4 weeks**.
- Must significantly affect important areas of life (family and work)

Acute stress disorder and PTSD

- The stressors are sufficiently overwhelming to affect almost anyone.

- Arise from experiences in war, torture, natural catastrophes, assault, rape, and serious accidents, for example, in cars and in burning buildings.

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). Note: Criterion A4 does not apply to exposure through electronic media, television, movies, or pictures, unless this exposure is work related.

PTSD DSM5

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).

PTSD DSM5

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).

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).

PTSD DSM5

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).

PTSD DSM5

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

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

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

Specify whether:

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

1. Depersonalization: Persistent or recurrent experiences of feeling detached from, and as if one were an outside observer of, one's mental processes or body (e.g., feeling as though one were in a dream; feeling a sense of unreality of self or body or of time moving slowly).

2. Derealization: Persistent or recurrent experiences of unreality of surroundings (e.g., the world around the individual is experienced as unreal, dreamlike, distant, or distorted). Note: To use this subtype, the dissociative symptoms must not be attributable to the physiological effects of a substance (e.g., blackouts, behavior during alcohol intoxication) or another medical condition (e.g., complex partial seizures).

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

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
  - other anxiety disorders
  - bipolar disorders.

Prognosis

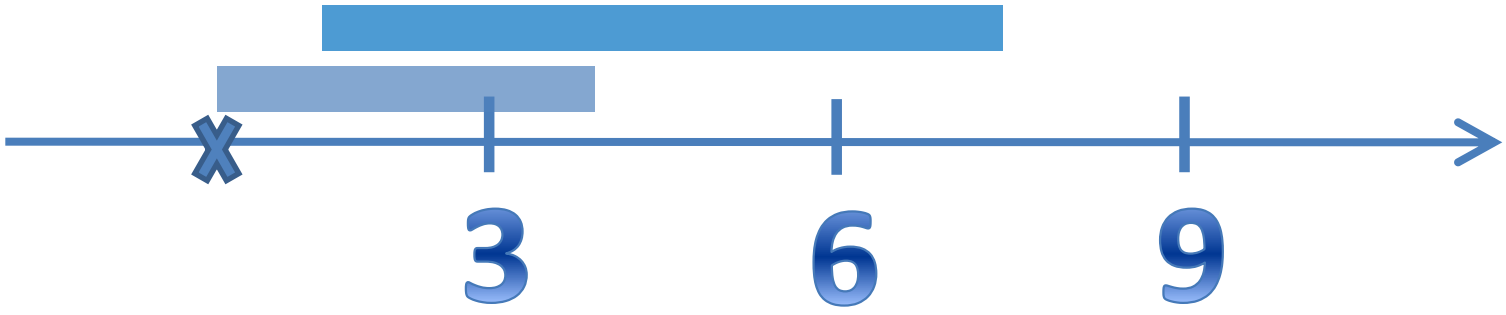
- Fluctuate over time and may be most intense during periods of stress.
- Untreated,
  - about 30 percent of patients recover completely,
  - 40 percent continue to have mild symptoms,
  - 20 percent continue to have moderate symptoms,
  - 10 percent remain unchanged or become worse.
- After 1 year, about 50 percent of patients will recover.

- **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.

video

Adjustment Disorders

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



DSM-IV-TR Diagnostic Criteria for Adjustment Disorders

Adjustment disorders are coded based on the subtype, which is selected according to the predominant symptoms. The specific stressor(s) can be specified on Axis IV.

With depressed mood

With anxiety

With mixed anxiety and depressed mood

With disturbance of conduct

With mixed disturbance of emotions and conduct

Unspecified

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.

Adjustment Disorders DSM5

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.

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
- Stage 2: Anger
- Stage 3: Bargaining
- Stage 4: Depression
- Stage 5: Acceptance

Kübler-Ross Grief Cycle

Information and Communication

Emotional Support

Guidance and Direction

SUMMARY:
Bereavement or depression ?

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

Management

- ❑ Rule out physical causes
- ❑ Support & reassurance & psychoeducation
- ❑ Bio-Psycho-Social

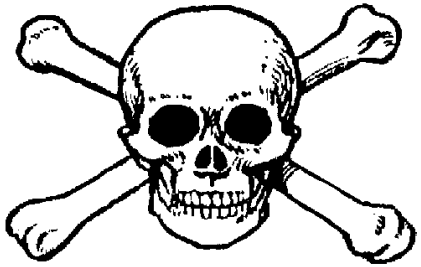
1. Medications:
    1. SSRIs / SNRIs / TCAs
    2. BNZ
2. CBT
3. Social

ANXIETY .. IN GENERAL

	NORMAL ANXIETY	ABNORMAL ANXIETY
1-Apprehension	Proportional to the trigger (time & severity).	Out of proportion
2- Attention	External trigger > body responses.	body responses > External trigger
3- Features	few - not severe - not prolonged & minimal effect on life .	Many – severe – prolonged & interfere with life.
4- Types	Trait (character) State (situational)	GAD-Panic-Phobias Acute &PTSD- …etc

Anxiety Disorders

DANGER

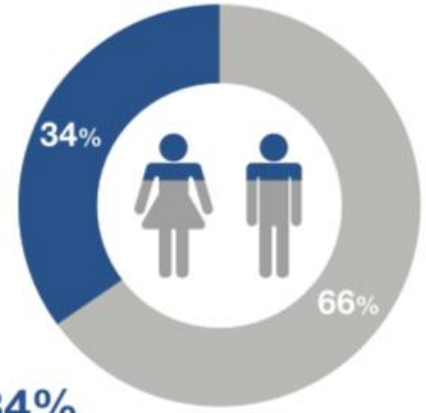


COPING

PREVALENCE IN SAUDI ARABIA

Findings

The occurrence of mental health conditions accross lifetime

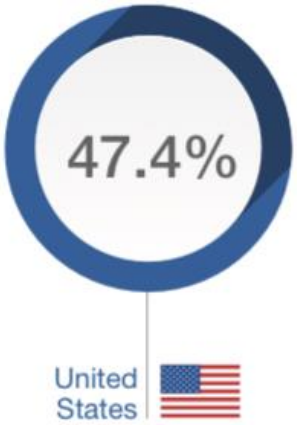


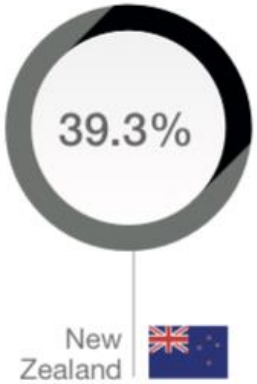
34%
of Saudis are diagnosed with a mental health condition sometime in their life

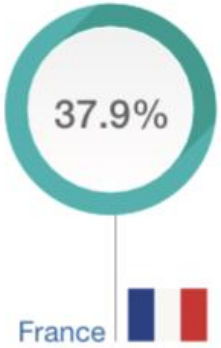
36% of Saudi Females are diagnosed with a mental health condition sometime in their life

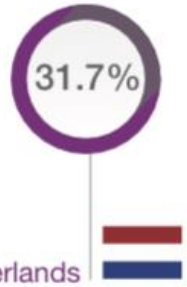
33% of Saudi Males are diagnosed with a mental health condition sometime in their life

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









Prevalence of treatments received for mental health conditions

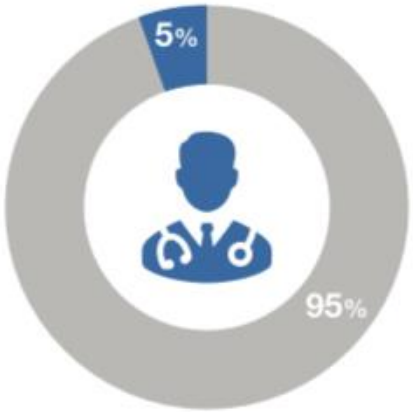
Table below shows the percentage of Saudis who sought any type of treatment for their mental health condition

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

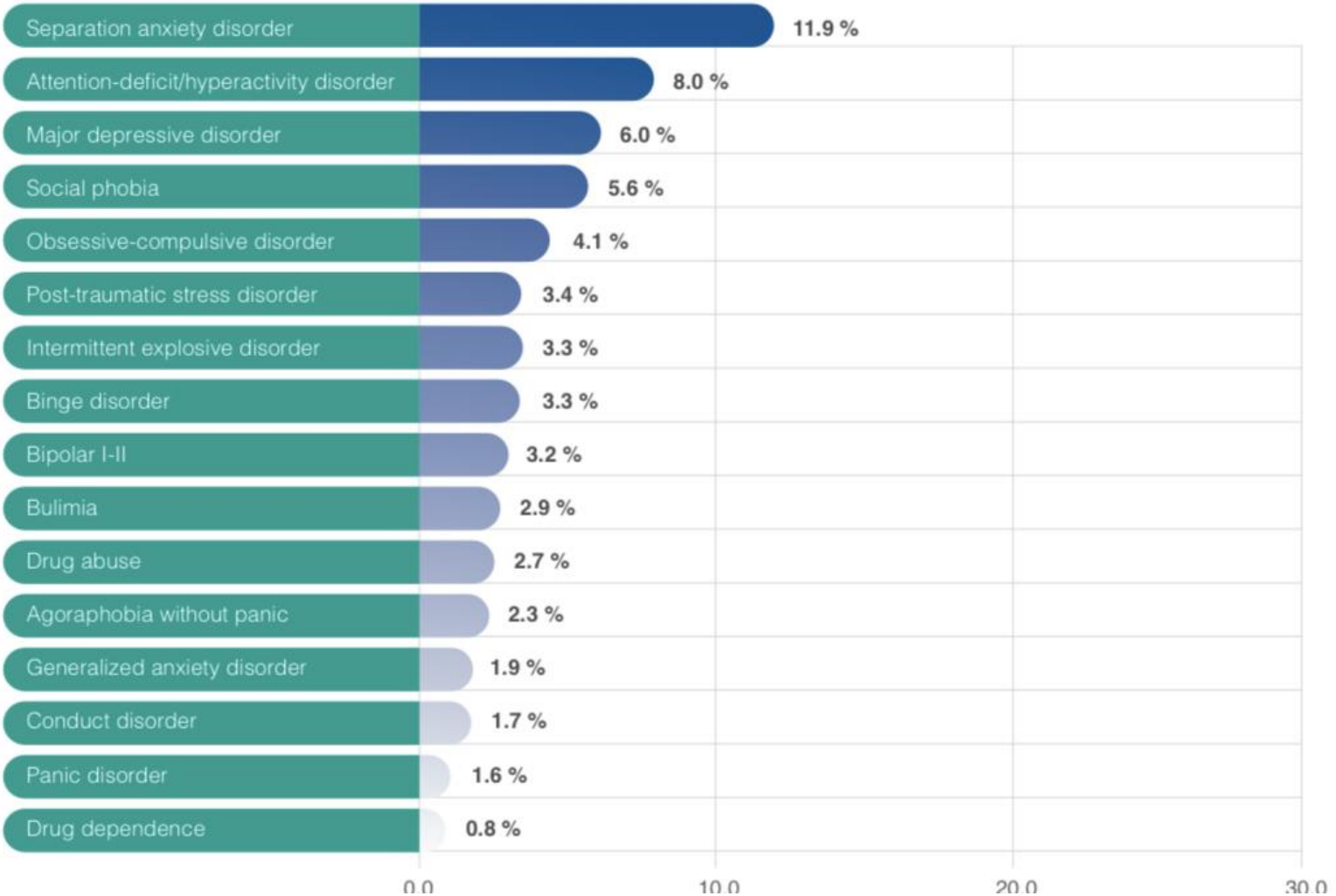
*Non-Healthcare treatment includes spiritual and non-medical treatments

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

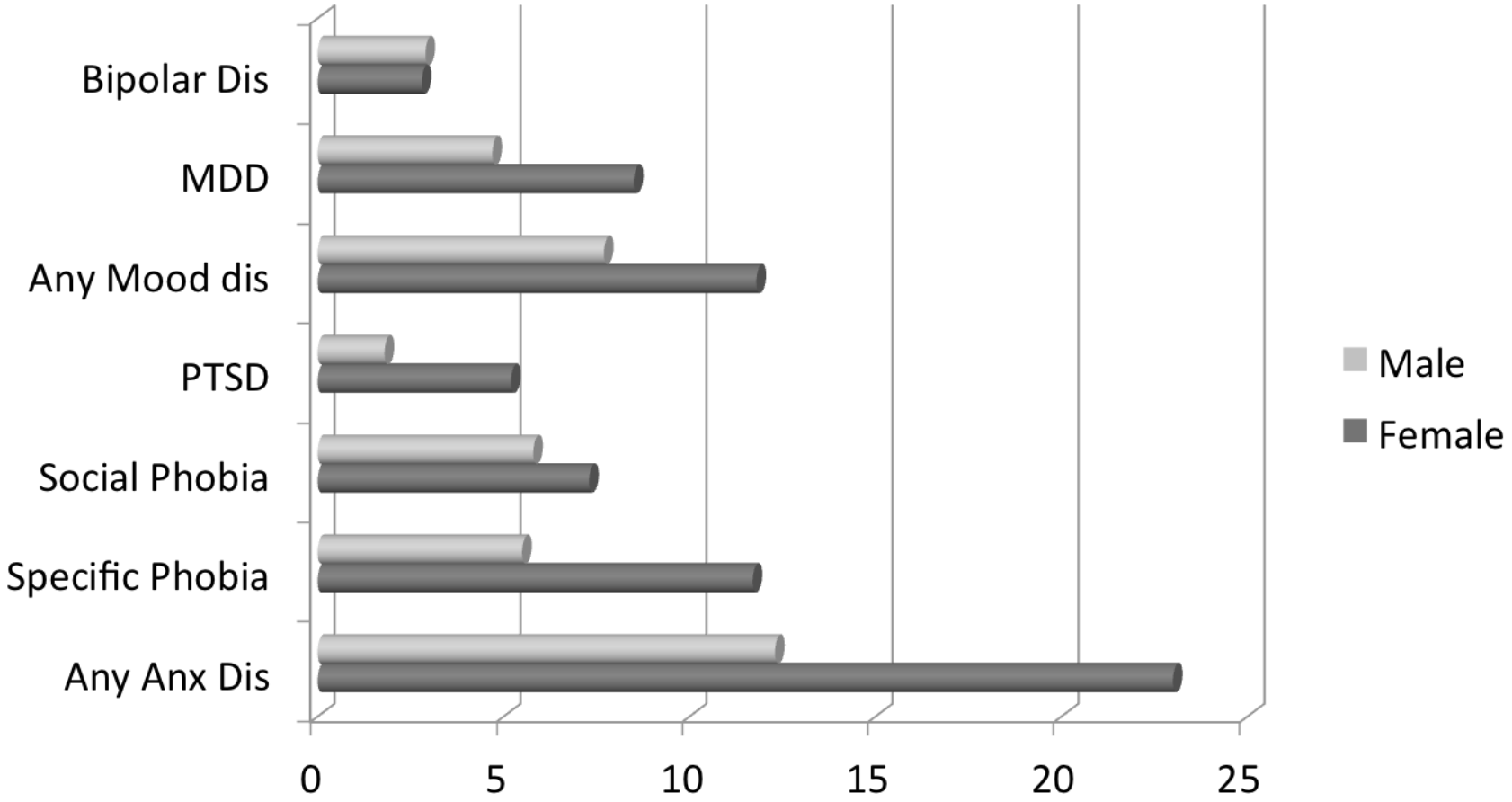


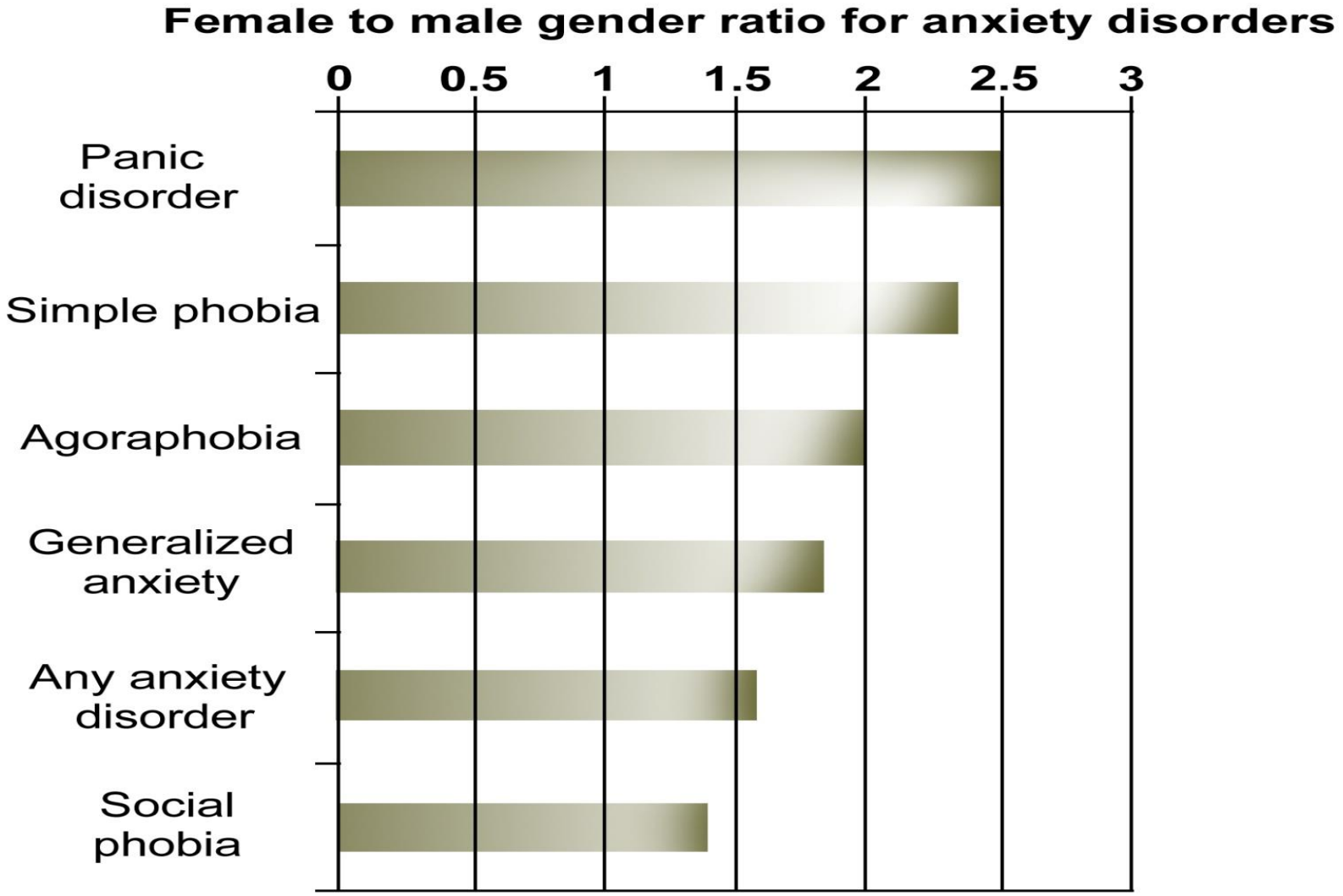
Findings

Prevalence of mental health conditions in KSA by disorders across lifetime



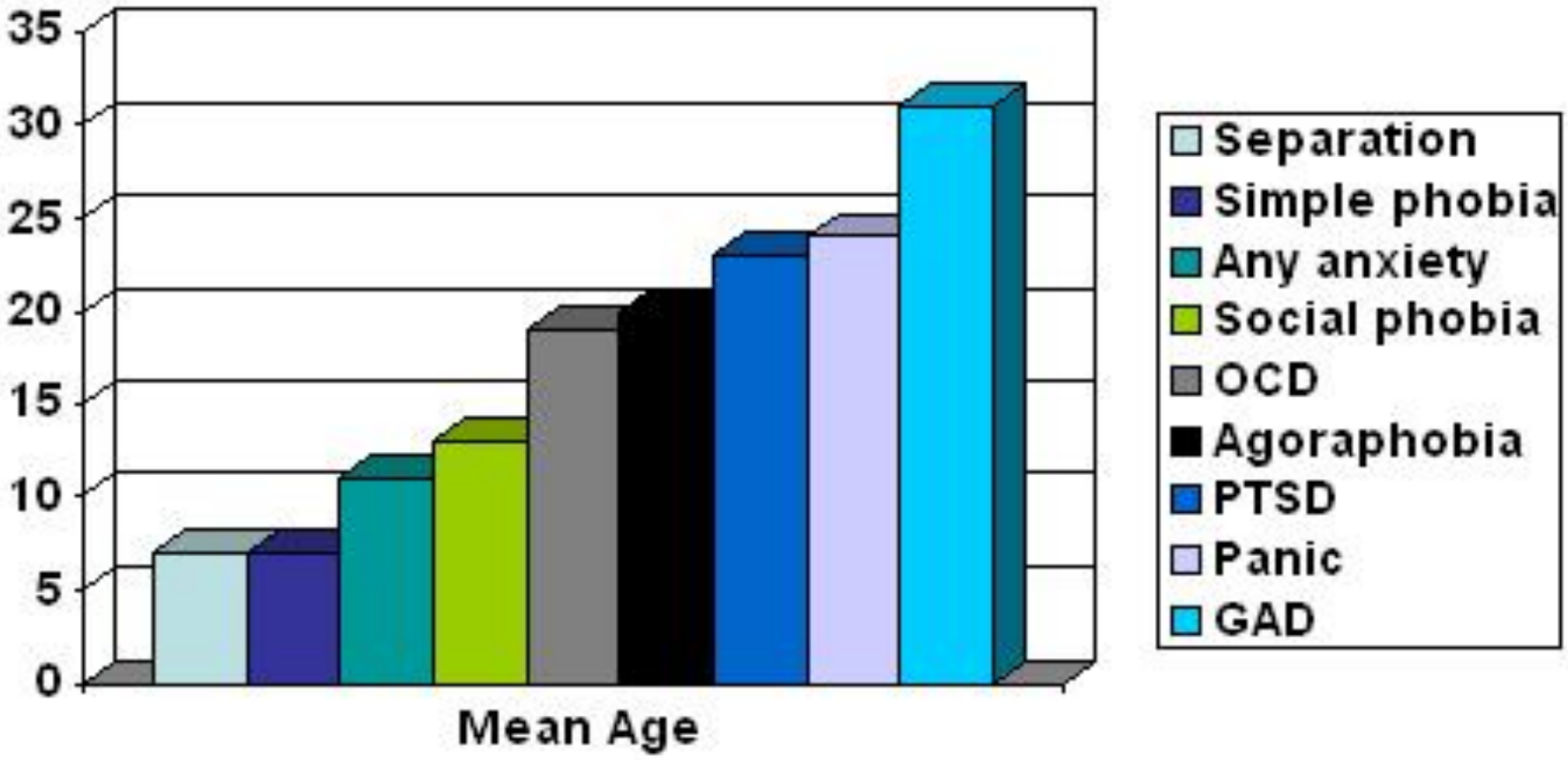
Mental Disorders among Adults (18 and older), in the past year (2001)





William R Yates, Anxiety Disorders: Multimedia 2010

Mean Age of Onset



William R Yates, Anxiety Disorders: Multimedia 2010

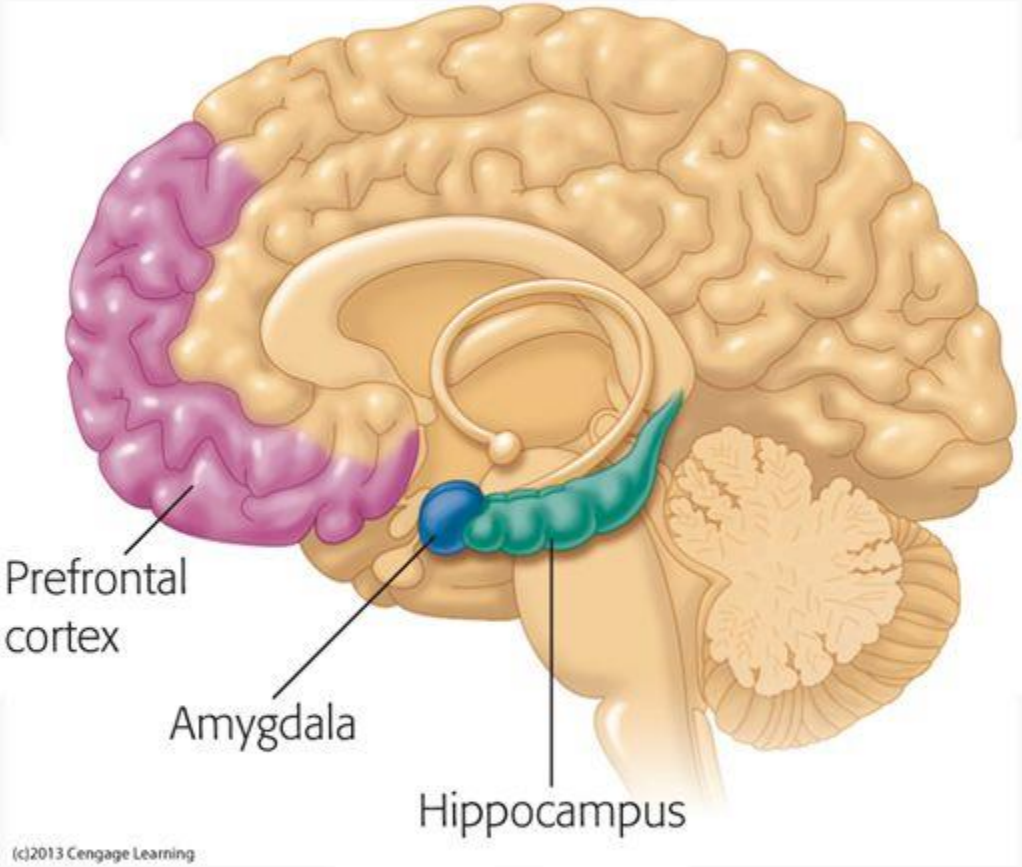


Figure 4-3 Neuroanatomical Basis for Panic and Other Anxiety Disorders The fear network in the brain is centered in the amygdala, which interacts with the hippocampus and areas of the prefrontal cortex. Antianxiety medications appear to desensitize the fear network. Some psychotherapies also affect brain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

Prognosis

- Depends on:
  - Dx (Psychosis → Mood → Anxiety)
  - Severity
  - Duration
  - Support
  - Compliance

Summary

- Case
- Hx
- MSE
- Types of Anxiety


THANK YOU
WELLS FARGO
We're on Track For a Cure