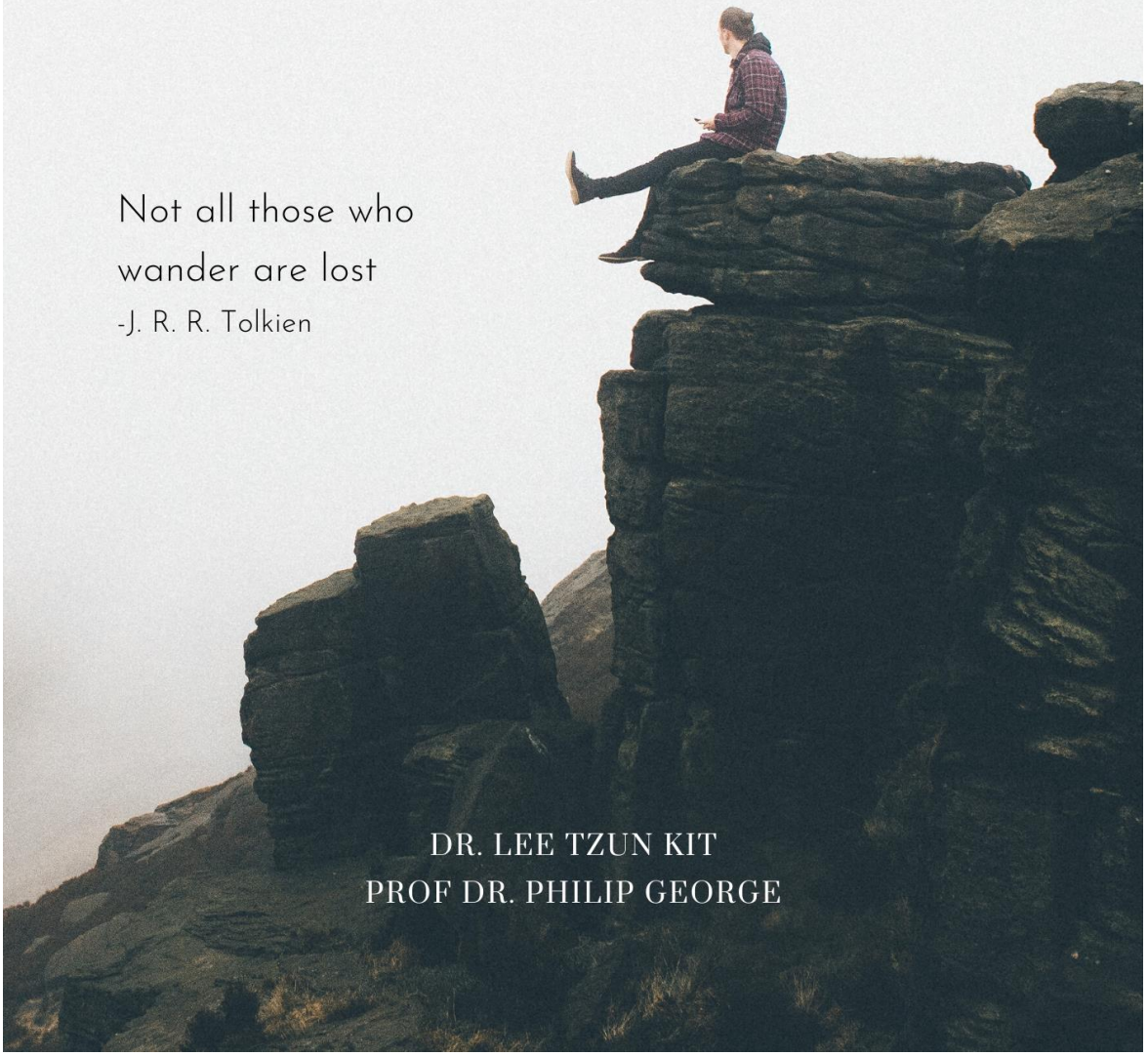
Handbook for healthcare professionals,
students and the general population

Anxiety Disorders in Malaysia

Broadens understanding of anxiety disorders
and helps to take control of your life



Not all those who
wander are lost
-J. R. R. Tolkien

DR. LEE TZUN KIT
PROF DR. PHILIP GEORGE

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The Malaysian Mental Health Association (MMHA) is a non-government organisation established to promote mental health awareness and public mental wellbeing.

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Disclaimer

The contents of this handbook is not intended to, and does not, amount to professional medical advice, diagnosis or treatment. Always seek advice from your physician or other qualified health provider if you have any questions regarding a medical condition.

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Foreword

This is a yet another easy to understand book which is a sequel to the earlier publication on Depression by Prof. Dr. Philip George and Dr. Vinodhini Thiagarajan. This time Prof. Dr. George has collaborated with main author Dr. Lee Tzun Kit and they have produced this timely publication in the midst of society struggling with anxiety surrounding the Covid-19 pandemic.

This is a refreshing approach to the subject as anxiety disorders remains one of the last medical entities in terms of public and professional understanding and awareness, leading to under diagnosis and poor quality of care.

This is a small book yet packs a punch. The authors walk readers through various types of anxiety disorders in an easy to understand manner replete with case examples and practical therapeutic techniques.

While primary care doctors in particular will find this an interesting and useful resource in their busy practice, anyone with an interest in the subject will find it a rewarding perusal.

This book will also undoubtedly be a useful companion to the existing resources of the Mental Health First Aid Training (MHFA) that is being rolled out by MMHA.

Prof. Dr. Philip George, a leading figure in the field of psychiatry in Malaysia, needs no further introduction. It is, however, very encouraging to note that the young Dr Lee Tzun Kit has demonstrated such ardour in his contribution to reduce and conquer anxiety disorders in society.

The Malaysian Mental Health Association is proud to join forces in the publication of this book.

Prof (Adj) Dato' Dr Andrew Mohanraj
President
Malaysian Mental Health Association

Preface

Since the publication of Handbook of Depression co-authored by Dr. Vinodini Thiagarajan and Prof. Dr. Philip George, the Handbook of Anxiety Disorders was quickly inspired to impart knowledge of anxiety disorders among the general population.

The number of patients diagnosed with an anxiety disorder has increased exponentially over the years. As of 2010, there are 270 million people in the world living with an anxiety disorder. The recent Covid-19 pandemic has even forced more anxious people to reach out for help as human-to-human interaction has been restricted to mere pixilated digital images. Primary care doctors and psychiatrists saw an unprecedented surge in patients diagnosed with anxiety disorders during this pandemic.

Dear Readers, anxiety disorders refer to a group of mental illnesses which necessitate medication use and psychotherapy and it is best treated at the early phase of the disease. There are abundant resources available online written mainly by western authors yet materials published in the local setting remain limited and somewhat scattered. Hence, we have set out to write this book in order to address the lack of resources within the local community.

This handbook addresses anxiety disorders in both adults and children. We have adopted the question-and-answer style in our write-up in order to ease understanding of complicated topics. Case examples, questionnaires and treatment principles are included for you to understand the illness from the start until the end.

Our dream and hard work will be rewarded if this book enables readers to understand and reduce the relentless and debilitating social stigma towards individuals with an anxiety disorder.

We wish to express our gratitude to the Malaysia Mental Health Association and the President Dato' Dr. Andrew Mohanraj for his foreword and support. Our deepest appreciation to Malaysian Healthy Ageing Society for providing the amazing images.

Lastly, we would like to thank the general public who has taken the initiative to review this handbook and provided us with constructive feedbacks. Multiple revisions have been undertaken based on your feedback to improve the overall reading experience.

Dr. Lee Tzun Kit
Prof Dr. Philip George

Biography of authors

DR. LEE TZUN KIT

Dr. Lee Tzun Kit graduated from the International Medical University (IMU) where he obtained his degree in Bachelor of Medicine & Bachelor of Surgery (MBBS) with distinction and earned the honour of being accepted into the dean's list. He developed a keen interest in psychiatry while providing care and online consultation to the general public during the Covid-19 pandemic. Surrounded by his friends and colleagues who are suffering from mental illness and living in a society with relentless social stigma on mental health diseases, he has decided to embark on a journey to understand these illnesses further in order to provide holistic care to his patients.

His passion for internal medicine and emergency medicine has earned him numerous awards in emergency medicine and traumatology related competitions. He was a member of IMU's first trauma team to participate in trauma moulage competition organized by Hospital Tawau, Sabah. He served as the president of the IMU Orthopaedic Trauma Society from 2018 to 2019. His past research includes a cross sectional study on "Complications of Diabetes Mellitus and Risk of Fall" among the general population in Seremban. The research was subsequently delivered and awarded second placing in an oral presentation which led the author to an opportunity for a poster presentation in Penang.

Biography of authors

PROF. DR. PHILIP GEORGE

Professor Dr. Philip George is a Consultant Psychiatrist who has special interest in Addiction Medicine. He is presently Head of Department of Psychological Medicine at the International Medical University and Honorary Consultant Psychiatrist at Hospital Tuanku Jaafar located in Seremban, Negeri Sembilan. He is also a Visiting Consultant Psychiatrist at Assunta Hospital and Visiting Psychiatrist at 'The Mind Faculty', Mont Kiara in Kuala Lumpur.

He obtained his Bachelor of Medicine & Bachelor of Surgery (MBBS) in 1988 from Manipal, India and did his Masters in Psychiatry in 1996 at Universiti Kebangsaan Malaysia. He also has a Certificate of Completion in Mental Health Leadership from University of Melbourne, 2003 and a Diploma on Mood Disorders from the Lundbeck Institute, Denmark, 2010. He has more than 30 publications in journals and chapters in books. His areas of interest are: Ageing, Prevention of Substance Abuse, Managing Stress and Depression.

He is a committee member of the Addiction Medicine Association of Malaysia and Malaysian Healthy Ageing Society. He is a member of the Academy of Medicine, Malaysian Medical Association, Malaysian Psychiatric Association and Malaysian Mental Health Association. He was also part of a Disaster Medical Relief Team in Nepal post-Earthquake in August, 2015 and visiting Psychiatrist, Nauru Refugee Processing Centre from 2016 to 2019.

Glossary

Glossaries included in the table below are denoted with an asterisk (*) in the main text.

1. Antidepressants	A group of medications used in depression and anxiety disorders to help improve mood and anxiety symptoms.
2. Anxiolytics	A group of medications that reduces anxiety.
3. Avoidance technique	A type of maladaptive coping mechanism characterized by avoiding something which causes distress.
4. Centre for Disease Control and Prevention (CDC)	A public health institute based in the United States.
5. Covid-19	A strain of coronavirus first detected in the late 2019 and had subsequently caused a pandemic across the globe.
6. Diagnostic and Statistical Manual of Mental Disorders (5th Edition) (DSM 5)	A manual published by the American Psychiatry Association (APA) which contains criteria to diagnose all mental health disorders.
7. H1N1	First detected in 2009, H1N1 which is a subtype of influenza A virus quickly escalated to cause a pandemic resulting in over 151,700 - 575,400 deaths.
8. Lifetime risk	A value calculated by epidemiologists to estimate the risk of a person from a specific population of getting the disease in his/her life. For example, the lifetime risk of type 2 diabetes mellitus was 32.8% in the US after the year 2000. That means for every 10 persons, around 3 of them will be diagnosed with diabetes during their lifetime.
9. Lysergic acid diethylamide (LSD)	A type of illicit drug which triggers hallucinations upon intake.
10. National Health Morbidity Survey (NHMS)	Survey conducted by the Malaysian Public Health Department every few years to determine the statistics of a particular disease/condition.
11. Prevalence	A value calculated by epidemiologists to identify the percentage of a population with the disease. For example, the prevalence of obesity in Malaysia in 2015 was reported at 17.7%. That means in 2015, for every 100 adults, around 18 of them were obese.
12. Risk factors	Situations which increase the risks or chances of a person developing certain illness(es). For example, the use of oral

	contraceptive pills (OCP) is a risk factor for breast cancer development.
13. Severe Acute Respiratory Syndrome (SARS)	First reported in 2003 in Asia, SARS is a strain of coronavirus which spread to more than two dozen countries.
14. World Health Organization (WHO)	An international public health institute based in Geneva, Switzerland.

Glossary for psychotherapy

Glossaries included in the table below are denoted with two asterisks (**) in the main text.

1. Cognitive Behavioural Therapy (CBT)	A type of psychotherapy dedicated to change a person's thinking and his/her behaviour. It is commonly used to treat major depressive and anxiety disorders.
2. Exposure and response prevention (ERP) therapy	Treatment of Obsessive-Compulsive Disorder (OCD) which encourages you to face your fears and let obsessive thoughts occur without neutralizing with compulsive actions
3. Eye Movement Desensitization Reprocessing (EMDR)	EMDR changes memories stored in the brain through incorporating the use of eye movements.
4. Family therapy	A type of psychological counselling which helps family members to better understand the mental illness so that conflicts can be resolved and communication improved.
5. Gradual desensitization therapy	Treatment for specific phobia which gradually exposes the victim to the object or situation which normally triggers the fear.
6. Group therapy	A type of psychotherapy involving one or more therapists working with several people having the same condition at the same time.
7. Relaxation therapy	A type of therapy which helps patients to reduce muscle tension and stress through various techniques such as deep breathing exercises and Dr. Jacobson's relaxation techniques.
8. Supportive psychotherapy	A type of mental health treatment that aims to improve symptoms and maintain, restore or improve confidence and skills.
9. Virtual Reality Therapy (VRT)	Similar to gradual desensitization therapy, VRT uses virtual reality technology as a tool to gradually expose the patient to the object or situation that triggers the fear thereby allowing the patient to slowly manage it
10. Insight-oriented psychotherapy	A type of mental health treatment which encourages the patient to recall situations from his or her life while the therapist observes for patterns of behaviour or feelings. The therapist then asks the patients to examine their thoughts more closely. It is aimed to help the patient to analyse the issues which have negatively impacted his/her life, in order to change his/her destructive behaviours.

Dedicated to all who suffer from anxiety

Introduction: Anxiety disorders in adults

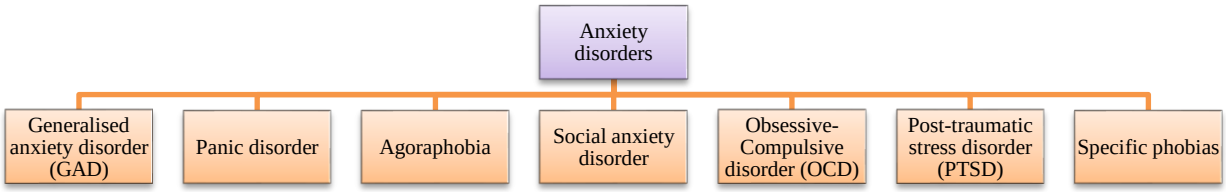
(1) What is anxiety?

Anxiety is described as an unpleasant, vague sense of apprehension often accompanied by autonomic symptoms such as headache, sweating, pounding heartbeat, chest tightness, stomach discomfort and an inability to remain seated or standing.

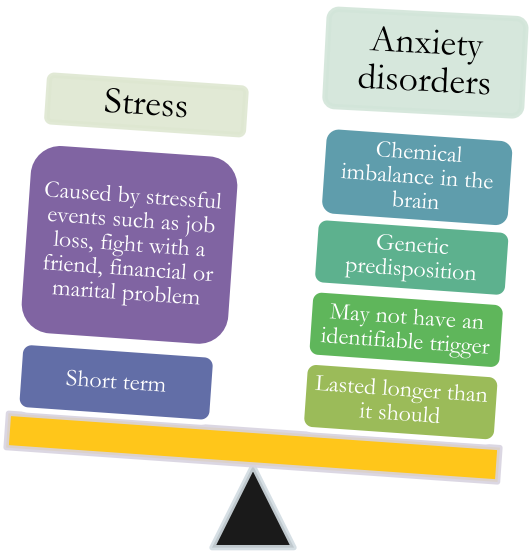
(2) When do we call it a disorder?

As part of our bodily defence mechanism programmed to fight or flight, it is normal to feel anxious or scared during stressful situations. For example, we may feel worried before an exam or a job interview. Once we have overcome these challenges, we will feel much better. For some individuals, they find it difficult to control their worries even in situations where normal individuals would not perceive it as a threat. When the feeling of anxiety reaches a point where a person is no longer able to carry out his/her daily responsibilities or cause problems in interpersonal relationship, he/she is said to have an anxiety disorder.

Anxiety disorder is an umbrella term which encompasses a group of mental health disorders including:



(3) Stress vs anxiety disorders, are they the same? No, the causes of anxiety disorders are totally different from regular stress.



(4) What causes anxiety disorders?

Biochemical factor (Brain Chemistry): Neurotransmitters are chemicals essential for brain cells to communicate with each other. Mood regulating neurotransmitters may not function normally in individuals with anxiety disorder.
Genetic factor (Familial predisposition): Breakthrough in genetic studies demonstrated appealing evidences that at least some genetic components contribute to anxiety disorder. It was found that almost half of all patients with panic disorder have at least one affected relative.
Nobel Laureate Dr. Eric Kandel showed that knocking out a gene in the mice's brain's fear hub will create mice unperturbed by situations that would normally trigger instinctive or learned fear responses.

(5) What are the risk factors* of anxiety disorders?

On-going stress in life: Persistent worry about own health conditions, work, finances as well as family conflicts are associated with anxiety.
Personality: Perfectionist, high achievers, sensitive and shy personality or people with low self-esteem are thought to be more likely to develop anxiety.
Pregnancy and childbirth: Anxiety during and after childbirth are common.
Trauma: Stressful events which cause significant distress, such as witnessing death or accidents, earthquakes, severe storms, fires or becoming a victim of sexual abuse and violence can contribute to anxiety.
Mass tragedies: Infectious disease outbreak such as Covid-19*, SARS* and H1N1*.

(6) How common is anxiety disorder?

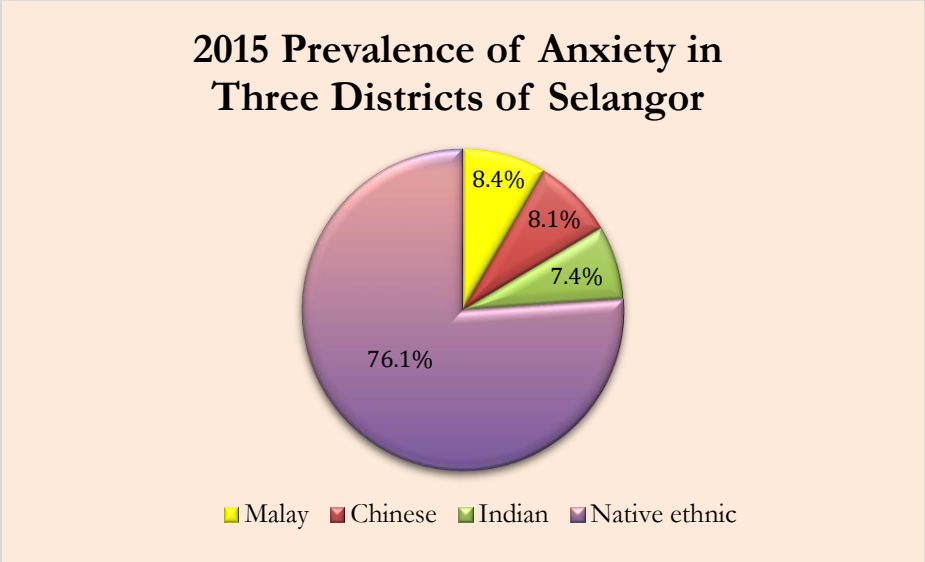
Globally, Baxter et al. reported that about 272.2 million people had an anxiety disorder at any point of time in 2010. Anxiety disorder is two times more common in females than males. Adults aged 20-64 seem to have the highest prevalence*.[1]

In Europe, 69.1 million people had anxiety disorders in 2010.[2]

In Singapore, Chong et al reported that among 6616 respondents surveyed in 2012, 1 in 100 populations had generalised anxiety disorder (GAD), while 3 in 100 populations had obsessive-compulsive disorder (OCD).[3]

In Malaysia, the Fourth National Health Morbidity Survey (NHMS-IV)* reported that about 2 in 100 adults aged 16 years and above had generalised anxiety disorder (GAD).

A more recent cross-sectional study was carried out in three districts of Selangor namely Hulu Langat, Sepang and Klang in 2015 by Siti Fatimah KM et al. These three districts combined account for almost 50% (2.2 million) of the total population in Selangor. It was reported that 119 (8.2%) of 1455 participants tested using GAD-7 questionnaire had anxiety. Mean age of the respondents was 35.36 ± 13.77 years. Anxiety was found to be higher among females than males. Prevalence* of anxiety was highest in native ethnicities (76.1%) followed by Malays (8.4%), Chinese (8.1%) and Indians (7.4%). Only marital status was found to bring about significant impact leading to development of anxiety in this study. Prevalence of anxiety was highest amongst divorcees (42.0%), followed by separated couples (33.3%), widowed (17.3%), single (9.3%) and lastly married couples (6.6%) [4]



(7) Covid-19* outbreak and anxiety disorders

Recent publication in The Lancet reported that among 1563 Chinese medical staffs surveyed in a hospital in Guang Zhou, 50.7% of them suffered from depression, followed by generalised anxiety disorder (44.7%), insomnia (36.1%) and stress-related symptoms (73.4%).[5]

While research papers reporting statistics of Covid-related anxiety disorder remained scarce in the local setting, numerous newspapers had reported an increased number of patients with anxiety and depressive symptoms seeking mental health treatment at the primary care setting as well as the psychiatry clinics. A recent cross-sectional study conducted by IMU on medical students and doctors reported that 70% of respondents experienced significant impact on their daily living due to pandemic and Movement Control Order (MCO) enforced by the country while 40% respondents reported moderate to intense anxiety about the pandemic and the risk of contracting the disease.

(8) **Medical conditions and anxiety disorder**

Hyperthyroidism (excessive thyroid hormone), hypothyroidism (inadequate thyroid hormone), hypoparathyroidism (inadequate parathyroid hormone) and Vitamin B12 deficiency are frequently associated with anxiety symptoms. Tumours on the adrenal gland (pheochromocytoma) can produce excessive amounts of hormones called catecholamines which are normally released during fight or flight situations can potentially cause episodes of anxiety symptoms.
A long list of other medical conditions associated with anxiety symptoms will not be discussed in this book.

(9) **Substance induced anxiety disorder**

Both recreational and prescription drugs can cause anxiety symptoms. Substances which can induce anxiety include amphetamines, cocaine, caffeine and many serotonergic drugs (such as LSD* and Ecstasy).
Therapeutic drugs such as beta-2-agonist commonly used to treat bronchial asthma (such as salbutamol, salmeterol and theophylline), corticosteroids, thyroid hormone replacement pills and anti-epileptics (medication used to treat seizure) can produce side effects such as rapid heartbeat, irregular heartbeats or agitations which mimic symptoms of anxiety.

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Topic 1: Generalised anxiety disorder

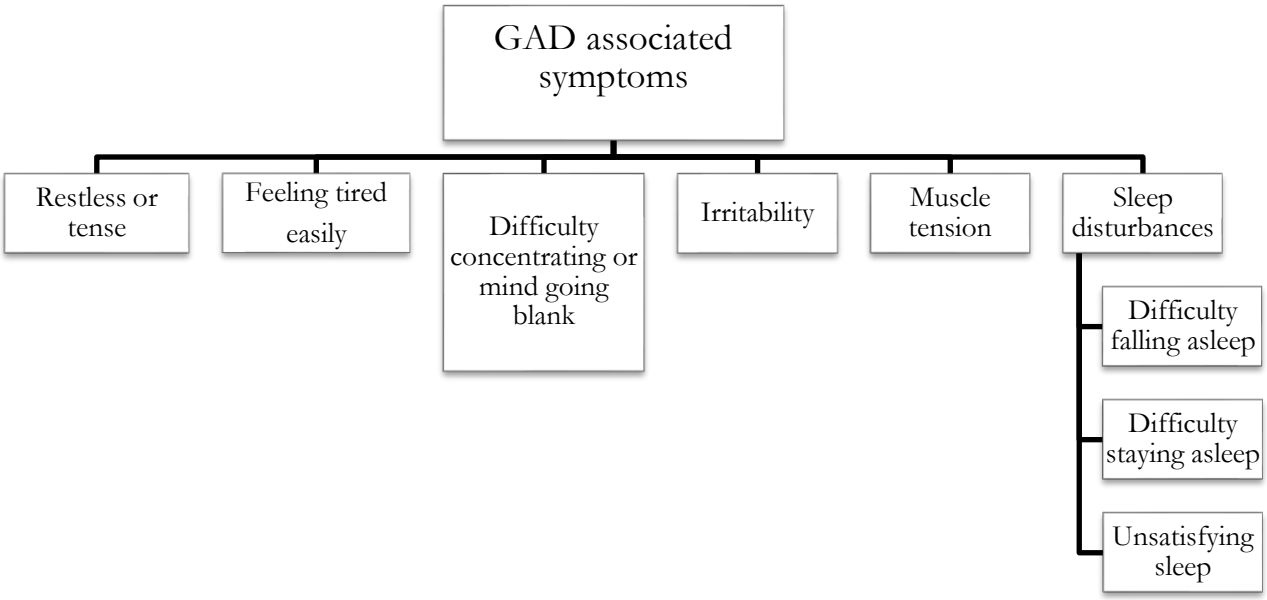
(1) Case example

Ms. M, a 28-year-old teacher presented to the psychiatric clinic for evaluation due to worsening symptoms of anxiety. Ms. M noted that for the past 1 year, she had become increasingly worried about her work performance. For example, although she had been appraised for her hard work and contribution to her job, she found herself worrying more and more about not being able to achieve the same set standard in her assignment. Similarly, although she had always been financially secured, she worried that she was going to lose her wealth due to unexpected expenses. Ms M often felt tense and irritable when she worked and spent time with her family. She experienced difficulty distracting herself from worries about the upcoming challenges for the next day. She reported feeling increasingly restless, especially at night when her worries kept her from falling asleep.

Case study adopted and edited from Kaplan and Sadock's Concise Textbook of Clinical Psychiatry 2017.

(2) What is generalised anxiety disorder (GAD)?

According to DSM-5*, GAD is diagnosed when a person experiences difficulty controlling his/her anxiety and worries about bad things that may or may not happen lasting 6 months or longer.
It is accompanied by three or more of following symptoms:



This intense worry is more than just feeling nervous or anxious about passing an exam or attending a job interview. One cannot seem to get over his/her overwhelming and persistent worry about several or many things until which he/she faces difficulty performing routine tasks in daily life or cause problems in interpersonal relationships.

(3) Statistics of GAD

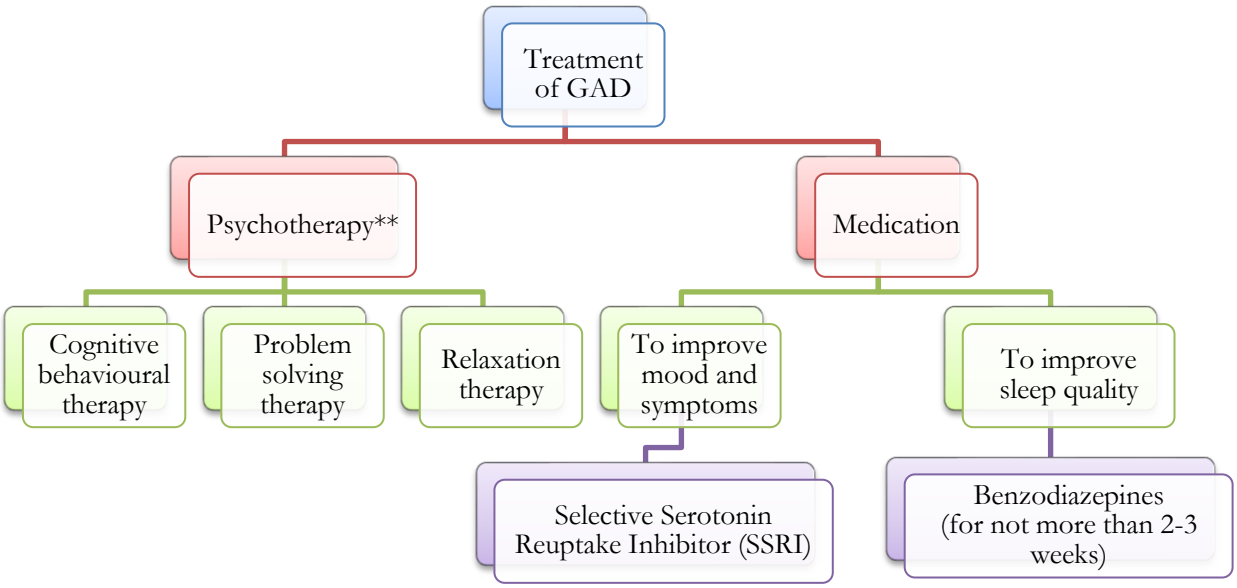
The onset of GAD usually takes place in late adolescence or early adulthood. Females are two times more likely to get GAD than male. The prevalence* of generalised anxiety disorder (GAD) was also higher among singles, widows/widowers, divorcees and those with tertiary education level. The lifetime risk* is estimated to be 5-8% according to the Epidemiological Catchment Area (ECA) study.

(4) Do you have GAD?

Please use the score sheet in **appendix 3** to self-check if you think you have GAD.

(5) Is GAD treatable?

Before you are diagnosed with GAD, your doctor will first rule out other medical conditions. Treatment of GAD includes psychotherapy and medications.



Some people respond to treatment after four to six weeks while others may take longer. If people have more than one anxiety disorder or if they suffer from other coexisting conditions, treatment may take longer. **For more information on various types of medication, please refer to appendix 2.**

Abraham Lincoln, who served as the 16th president of United State from 1847-1849 suffered from Generalised Anxiety Disorder. His condition was kept unknown to the public as individuals with a psychiatric illness were captured and locked up in mental asylum.

Topic 2: Panic disorder

(1) Case example

Mr. K, a 32-year-old man presented for psychiatrist evaluation due to repeated outbreak of panic attacks for the past 6 weeks. He was unsure what triggered the attacks. During the attack, he experienced pounding heartbeats, cold sweats, light-headedness and chilling sensation which started at his head going all the way down towards his legs. He felt that he had entered into a new dimension as he couldn't recognise anyone. The attack resolved spontaneously within 5-10 minutes. He had at least 2-3 episodes of unprovoked panic attacks in a week. He explained that he felt completely exhausted from constantly feeling worried about having an additional panic attack. He stopped going out unnecessarily and spent most of his time in his room. He had sleepless nights which resulted in poor work performance as he was unable to focus at work.

(2) What is a panic attack?

Panic attacks are episodic surge of intense panic or fear. They usually occur unexpectedly although sometimes a trigger is identifiable.
Panic attacks usually peak within 10 minutes and rarely last more than 30 minutes. During that short period of time, you may experience one or more of the following symptoms listed in the box below.

Rapid heartbeat, sweating, trembling hands and feet, feeling dizzy, feeling nauseated, tingling sensation, chills or heat sensation, having difficulty in breathing, chest pain, choking, feeling of unreality, feeling being detached from oneself, fear of losing control or fear of dying.

(3) What is panic disorder?

Panic disorder is diagnosed when one has repeated panic attacks with at least **four** of the above symptoms for **at least 1 month**. In panic disorder, you are constantly worried about having another panic attack and its consequences. As such, you search for alternative ways to carry out daily routines in order to avoid additional panic attacks such as taking shortcuts and avoidance of exercise or unfamiliar situations.

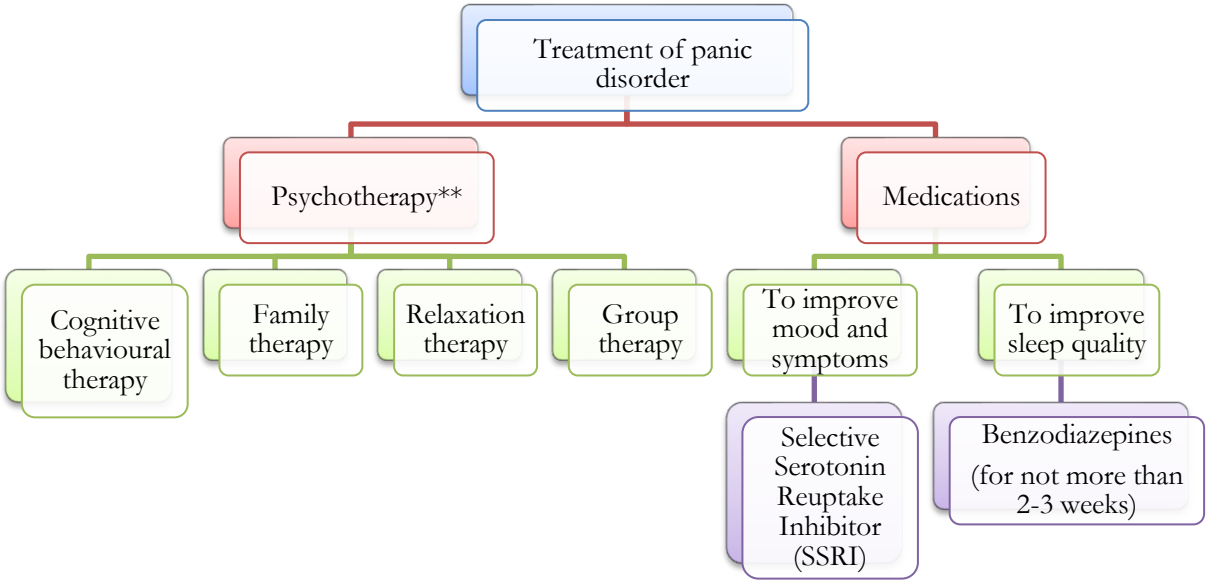
It's a good idea to check with your doctor if you have been having these features as panic disorder is treatable.

(4) What are the statistics of panic disorder?

Lifetime risk* of getting panic disorder is 1-4% and 3-6% for panic attacks. Hence, it is ok to have few panic attacks without actually having panic disorder. Similar to GAD, women are two to three times more likely to be affected than men although underdiagnosis of panic disorder in men may contribute to the skewed distribution. The underdiagnosis can sometimes be due to self-medication by males with alcohol and illicit drugs. Panic disorder is most commonly diagnosed during young adulthood with the mean age of presentation of about 25 years.

(5) **How is panic disorder treated?**

Treatment of panic disorder includes psychotherapy and medications.



For more information on various types of medication, please refer to appendix 2.

Panic attack or disorder was not given much attention historically as early civilization attributed madness to disease descended from the heavens. Panic was initially described as sensitive heart or irritable heart when doctors could not find a cause to the problem and only in 1996 was the term panic first used in psychiatry by a French psychiatrist named Henri Legrand Du Saulle.

Topic 3: Mixed anxiety and depressive disorder (MADD)

MADD is accepted as a mental disorder under the World Health Organization (WHO) 10th edition International Statistical Classification of Diseases and Related Health Problems (ICD).
The US Diagnostic and Statistical Manual of Mental Disorders (5th Edition) (DSM 5) did not include MADD as a separate mental disorder.
We discuss this topic here as it is more common in the local population and other developing countries.

(1) What is MADD?

Individuals who have mixed anxiety and depressive disorder (MADD) have both anxiety and depressive symptoms but do not meet the diagnostic criteria for either an anxiety disorder or a depressive disorder.

(2) How common is MADD?

Almost two-third of all patients with depressive symptoms have significant anxiety symptoms and one-third may suffice the diagnostic criteria for panic disorder.

(3) Do you have MADD?

Please use the score sheet in **appendix 4** to self-check if you think you have MADD.

(4) How is MADD treated?

Since neither anxiety nor depressive symptoms predominate in MADD, treatment is especially tailored to the needs of the patient depending upon the symptoms present, severity and the clinician's own level of experience.
The choices of treatment are similar to the rest including psychotherapy and medications.
Psychotherapy** approaches may involve cognitive behavioural therapy or in-sight oriented psychotherapy.
Medications for MADD include antidepressants to improve mood and symptoms as well as those to improve sleep quality.

For more information on various types of medication, please refer to appendix 2.

Topic 4: Agoraphobia

(1) What is agoraphobia?

A person is said to have agoraphobia when he/she is anxious about being somewhere where he/she perceives their environment to be unsafe or with no easy way to escape in the event of a panic attack. It is regarded as a subtype of panic disorder. To avoid a panic attack, a person with agoraphobia avoids agoraphobic situations or seeks companionship during outings.

If you have 2 of the following 5 problems, you may have agoraphobia.

- Difficulty standing in lines or being in crowded areas
- Difficulty being outside home alone
- Difficulty taking public transport
- Difficulty being in open spaces
- Difficulty being in an enclosed place such as shopping malls or cinema

The fear, anxiety or avoidance is persistent and typically lasts 6 months or more.

(2) How is agoraphobia treated?

Agoraphobia is thought to link to panic disorder. When panic disorder is treated, agoraphobia often improves with time.
Treatment involves medications and psychotherapy** such as supportive psychotherapy, insight-oriented psychotherapy, cognitive behaviour therapy (CBT) and virtual reality therapy (VRT).

Once you have overcome your fear, you can too be one of them enjoying an amazing kung-fu session with the rest of the team in an open park.

Topic 5: Social anxiety disorder (social phobia)

(1) What is social anxiety disorder (social phobia)?

Social situation refers to any situation in which you and at least 1 other person are present.

It is normal to feel nervous being in unfamiliar social situations such as before a job interview or having to perform or give a speech in front of others. We ponder on how things can turn terribly wrong if we make mistakes. This feeling is better known as social anxiety, which is normal and most of us have it.

Social phobia becomes a disorder when a person constantly feels anxious about being in social situations leading to significant distress in performing routine tasks and cause problems in interpersonal relationships. These individuals are more than just feeling anxious about being in social situations, they tend to overthink that they will do something badly that will invite negative evaluation such as being humiliated, embarrassed leading to rejection or risk offending others.

As such, situations which require interpersonal interactions such as meeting new people, taking part in gathering such as parties or dinner, going on a date or ever ordering food at a restaurant are often avoided. Situations where they think they are being observed are also steered clear including public speaking, having a meal or filling up forms in front of others or even entering a room where everyone is seated.

The fear, anxiety or avoidance is persistent and typically lasts 6 months or more.

(2) What are the symptoms of social phobia?

1) Shakiness or trembling
2) Sweating
3) Dry mouth
4) Rapid heart beat
5) Trip over your tongue or unable to say words out clearly
6) Stomach discomfort, diarrhoea

(3) Does personality contribute to the risk of developing social phobia?

A person's personality is believed to link to development of social phobia. Quiet, shy and thoughtful people are at higher risk of social phobia. They are often mislabelled as unfriendly individuals. People with social phobia want to make friends and participate in social activities but they are having difficulty doing so due to anxiety.

(4) Treatment for social phobias

The first line treatment for social phobia is cognitive behavioural therapy (CBT)**. Other modalities of treatment include medications, lifestyle modifications and e-mental health tools.

Topic 6: Separation anxiety disorder

(1) What is separation anxiety?

Separation anxiety is characterized by fears out of proportion in response to separation and abandonment by close attachment figures such as parents, partners or even pets.

(2) Is separation anxiety a childhood disorder?

Normally, separation anxiety in children peaks between age 9-18 months and slowly reduces when the child reaches about 2 ½ years of age, enabling young children to feel less anxious when they are in kindergarten and away from their parents.

Separation anxiety was initially thought to dominate in children until the 2015 World Mental Health Survey reported that 43.1% of individuals diagnosed after the age of 18 did not have history of early childhood separation anxiety.

(3) What are the risk factors*?

Females, history of childhood adversities and lifetime traumatic events were identified as significant predictors of lifetime separation anxiety disorder.

(4) What are the features of separation anxiety?

Individuals with separation anxiety disorder are reluctant to leave homes to school (in children) or to work and often find difficulty leaving their partners or parents for even a short period of time. They worry about losing major attachment figures or possible harm that may or may not happen to them such as becoming ill, getting involved in a road traffic accident, being kidnapped or even death. To avoid separation from major attachment figures, they frequently complain of sickness or having physical symptoms such as headache, stomach-ache, nausea or vomiting.

Some individuals have repeated nightmares involving themes of separation. As such, they refuse to go to sleep when they are away from home or when major attachment figures are not by their sides.

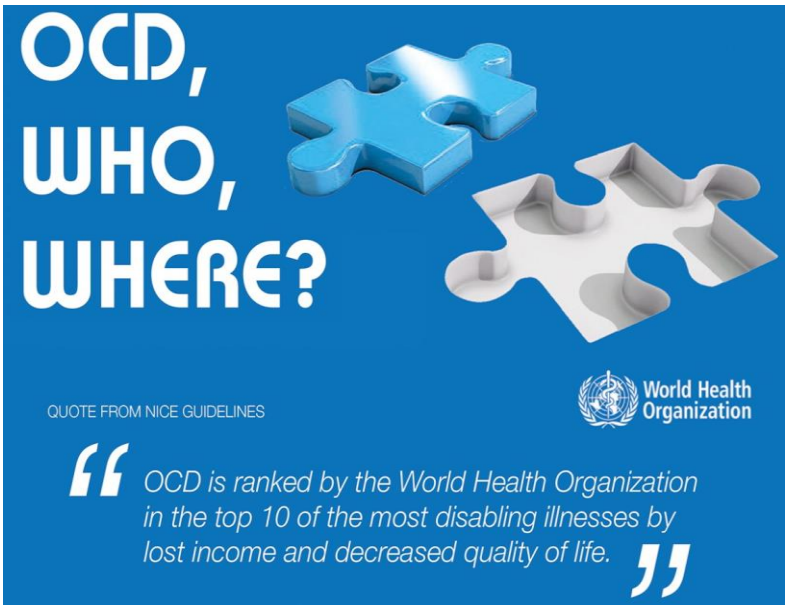
(5) Do you have or know someone who has separation anxiety disorder?

If you have the above-mentioned symptoms for the past 6 months or noticed symptoms in any children for at least 4 weeks, please seek help from your doctor.

(6) How is it treated?

Several other conditions mimic separation anxiety disorder including autism spectrum disorder agoraphobia or fear of being in an open space, generalised anxiety disorder and selective mutism. Your doctor will first rule out these conditions prior to initiation of treatment. Treatment will include psychotherapy** such as cognitive behavioural therapy (CBT) and medications in adult patients.

Topic 7: Obsessive-Compulsive disorder



(1) Case example

Mr. T is a 22-year-old man in his third-year medical studies. Ever since he started clinical rotations in hospital wards, he worried that he might contract human immunodeficiency virus (HIV). When he was assigned to a patient known to have the virus or appeared to him to have the infection, he experienced a surge of extreme anxiety and had subsequently obsessively agonized whether he could have been exposed to the virus while talking and examining his patients. He engaged in vigorous hand washing for almost 30 minutes and cleaning his stethoscope repeatedly with disinfectant spray and alcohol wipes. He explained that if he had not cleaned his stethoscope properly, he could carry the virus with him and cause harm to his patients and anyone who touched it. Despite his friends' reassurances about his safety, he frequently felt stressed about his problem. He had sleepless nights as he replayed his encounters with the patients in his mind and contemplated whether he had done enough to protect himself from the infection.

(2) What is OCD?

Obsessive-compulsive disorder (OCD) refers to a condition that a person has repetitive insensible thoughts associated with repetitive performance of certain rituals, actions or behaviour in order to relieve anxiety. When these actions begin to consume a significant amount of time and affecting your life, you are said to have OCD.

We all encountered these moments that we rush home to check whether the stove has been turned off or to make sure we didn't leave the tap running. We also check our work multiple times to make sure it is correct. They are part of our normal human instincts to be alert of potential dangers. Once we have resolved these doubts, we carry on with our tasks.

In individuals who have OCD, they experience:

- Obsessions: Repetitive thoughts or images which cause anxiety. Sometimes, these thoughts may not have an identifiable trigger.

- Compulsions: Behaviour or rituals in attempt to relieve or suppress anxiety.

Despite the effort to perform these rituals, it has done little to relieve the anxiety. Hence, they perform these actions repeatedly until they feel relief or satisfied. Such behaviour consumes a large amount of time and cause significant impairment in daily function and problems in interpersonal relationship.

***Ritual is a series of actions performed in a specific order, manner or sequence.**

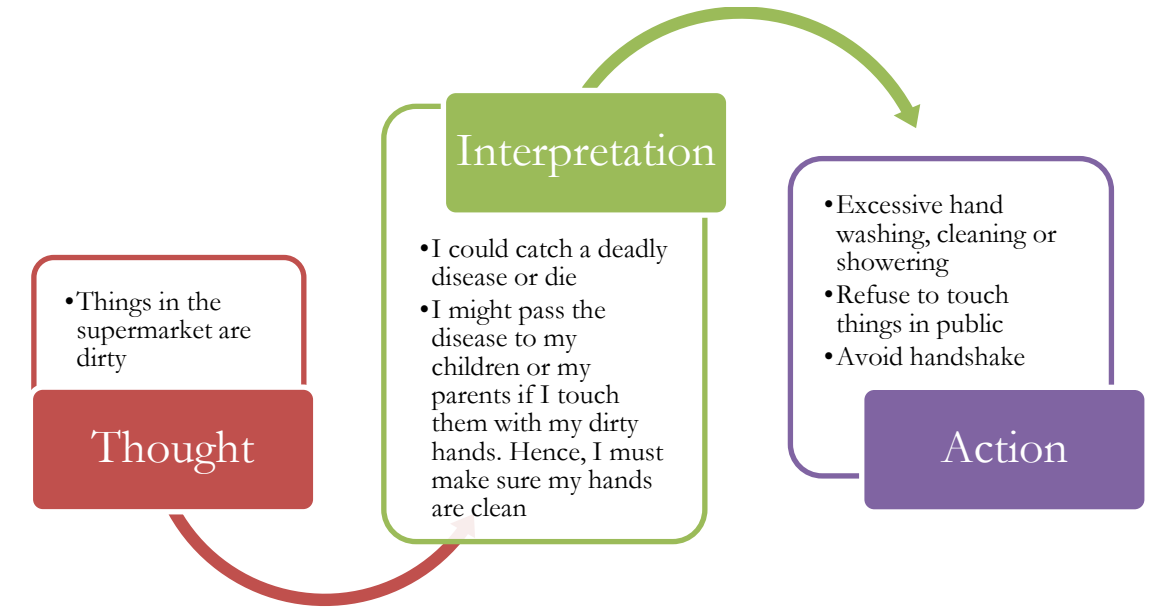
(3) What are the statistics for OCD?

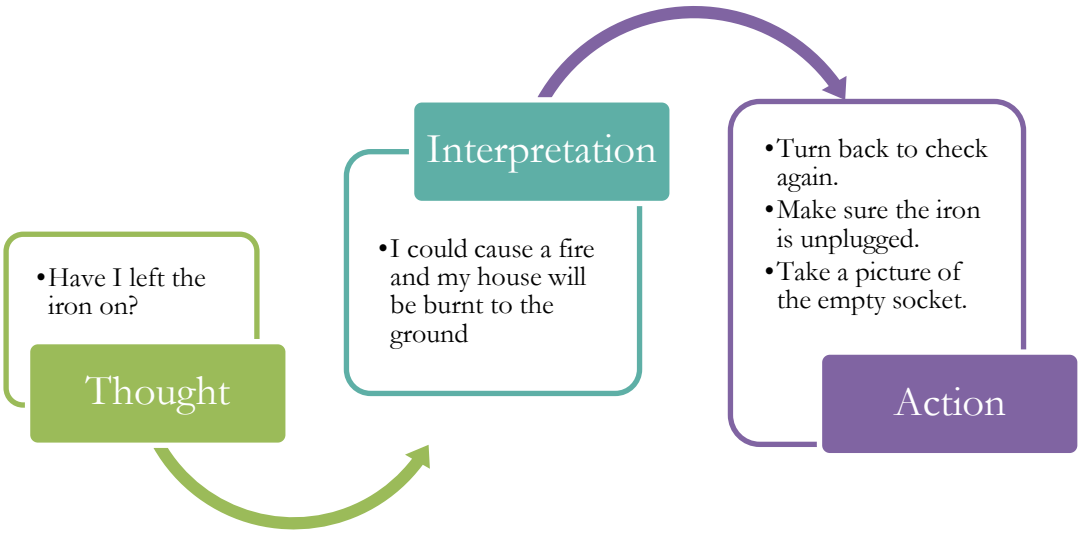
According to the World Health Organization*, Obsessive-compulsive disorder (OCD) has been listed as one of top 10 most disabling illnesses by loss of income and decreased quality of life.
In Malaysia, it is estimated that OCD occurs in 1-2% of the population affecting both males and females.

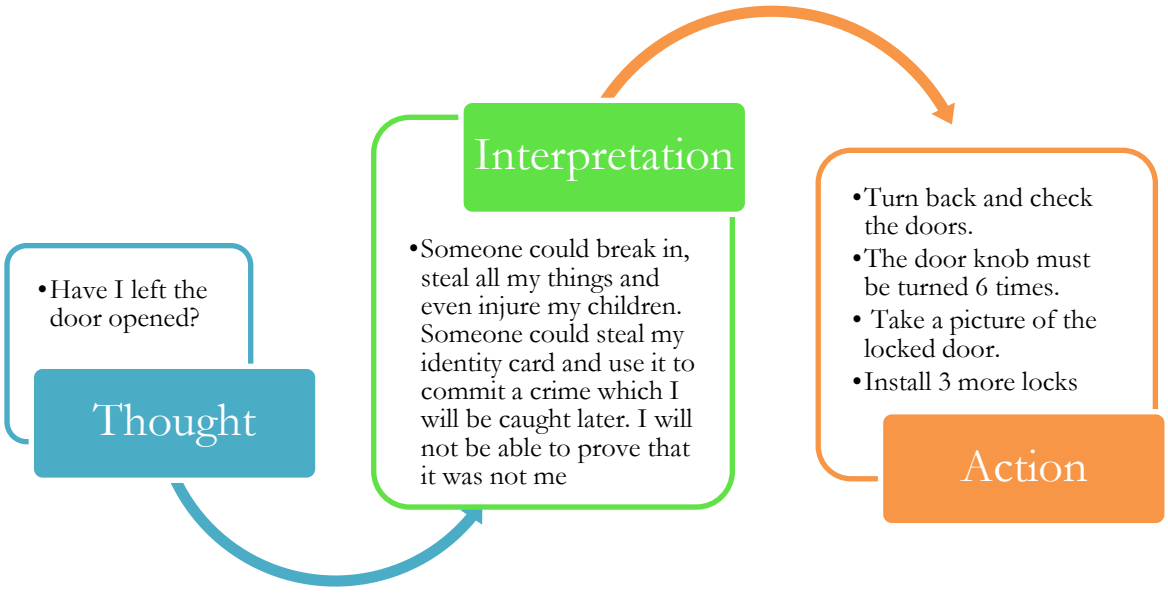
(4) What has gone wrong in OCD?

Little is known what causes of anxiety disorders although brain chemical imbalances and gene factors have always been discussed extensively in literature and psychiatry textbooks. As clinical psychologists explore deeper into understanding of human behaviour, they describe OCD sufferers as individuals who are more sensitive to things in their surroundings than an ordinary person would be. They spend a large amount of time interpreting or making assumptions on every thought that crosses their mind. Meanwhile, individuals without OCD disregard their thoughts and never spend time over thinking about them.
For example, individuals with "harm OCD" who hit a pothole while driving will be worried whether they have actually run over and injured someone. These unpleasant images or thoughts repeatedly play within the mind like a broken record triggering anxiety and uneasiness. The more they try to convince themselves that they have not hit anyone, the more they feel perplexed. At the end, they will have to turn back or look at the rear mirror just to make sure everything is fine.
These disturbing thoughts will not disappear until they have performed certain rituals to confirm what they fear will not turn out real.
In short, OCD sufferers are individuals who are desperately in need of certainty. Hence, they repeatedly seek reassurance from different people. OCD sufferers also have problem trusting their senses which explains why some of them rely upon their feelings to do something until it "feels alright".

(5) **Some examples of obsessions and compulsive behaviours in OCD.**





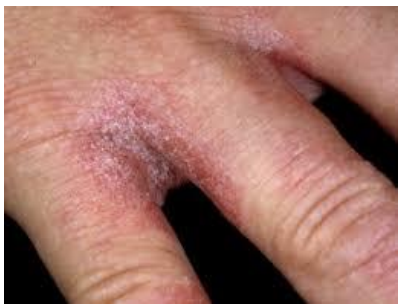


Some other OCDs include fear of losing control and harming others, intrusive sexually explicit and violent thoughts and images, excessive focus on religious or moral values and excessive attention to something considered lucky or unlucky (such as black Friday).

(6) How do you know if someone has OCD?

Most OCD starts in the late adolescence or early adulthood, typically at an earlier age of onset in boys than girls.
Individuals with OCD are ashamed of their behaviour. They may try to cover it up and not like talking about it. Depending on the what they are afraid of, these are some indications of someone with an OCD:

- Red, sore hands from excessive hand washing

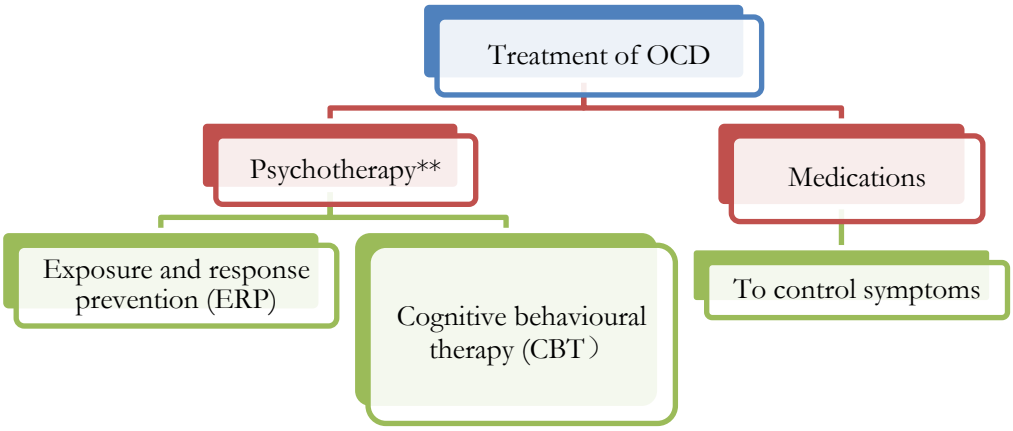


Source: https://dermnetnz.org/topics/compulsive-hand-washing/

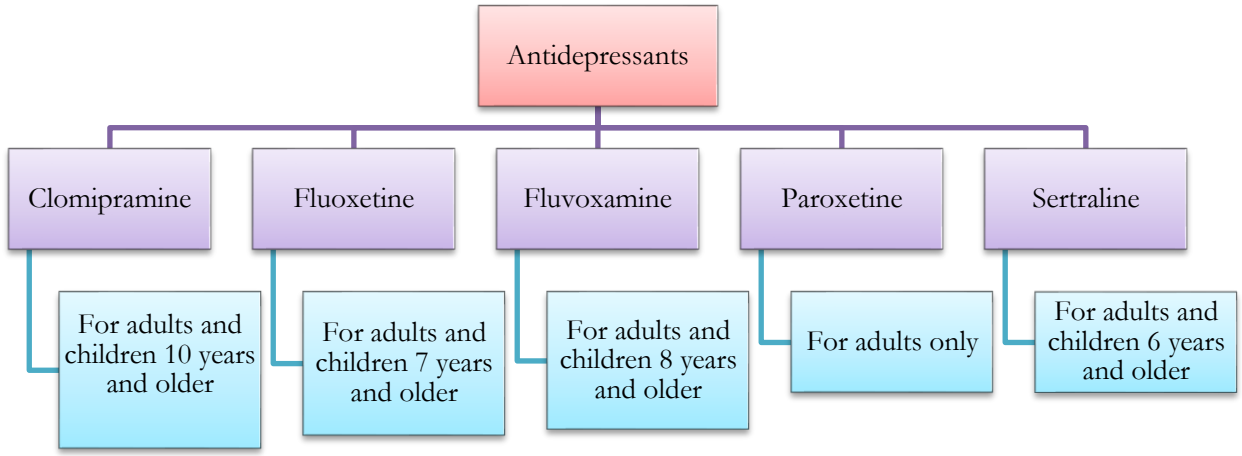
- Refuse to shake hands with others
- Refuse to touch things in public
- Intense reaction when things are out of order
- Checking things repeatedly
- Counting things repeatedly
- Inflexible or inability to adapt to new changes
- Always late due to rituals
- Repeating words and actions

(7) How is OCD managed?

Treatment of OCD includes psychotherapy and antidepressants.

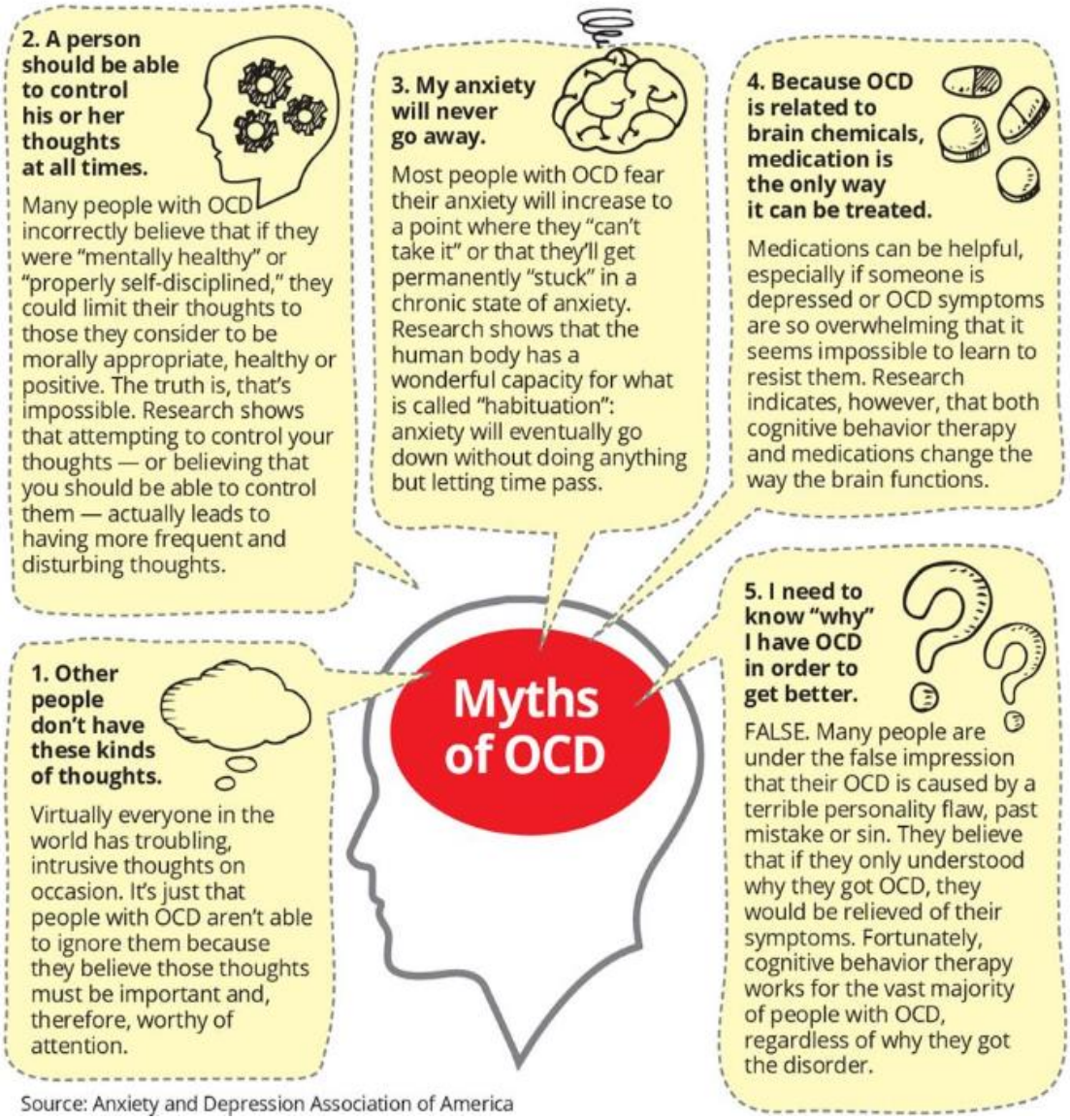


Antidepressants approved by the US Food and Drug Administration (FDA) to treat OCD.



Source: Mayo Clinic

(8) **Common myths about OCD**



(Source: The Star Online 22 Jan 2018)

Topic 8: Hoarding disorder

(1) What is hoarding disorder?

People with hoarding disorder keep items that may have little or no value resulting in excessive clutter of living or work spaces. Common hoarded items include newspapers, mail, magazines, old clothes, bags, books, lists and notes.
Hoarding disorder was initially listed as a subtype of OCD, but it is now considered a separate disease.
Hoarding is not the same as collecting. Individuals with hoarding disorder often save random items and store them haphazardly. They feel that they may need these items in the future or think that these items are valuable or have sentimental value.

Patients with hoarding disorder develop problems organizing possessions and keeping them organized. Many of them exaggerate the importance of recalling information and possessions. For example, a hoarder keeps old newspapers and magazines because they believe that if discarded, the information will be forgotten and will never be retrieved again. Additionally, patients believe that forgetting information will lead to serious consequences and prefer to keep their possession in sight so as not to forget them.

(2) Why is hoarding disorder a problem?

Serious hoarding leads to health and safety concerns, such as fire hazards, tripping hazards and health code violation (pest infestation). It can also lead to family strain and conflicts, isolation and loneliness, unwillingness to have anyone else entering the home and an inability to perform daily tasks such as cooking and bathing at home.

(3) How common is hoarding disorder?

According to the American Psychiatric Association (APA), it is estimated that 2-6% of the population have hoarding disorder. It is more common in males than females and 3 times more common in adult between the ages of 55-94.

(4) Hoarding disorder and other mental conditions

Hoarding disorder is relatively common among patients with dementia and individuals with brain injury. One study reported that 20% of patients with dementia had hoarding disorder. Other disorders related to hoarding include eating disorders, depression, anxiety disorders, substance use disorder (particularly alcohol use disorders), kleptomania (inability to resist urge to steal items not needed for use or has little monetary value) and compulsive gambling.

(5) How is it diagnosed?

Psychiatrists diagnose hoarding disorder based on the following criteria:

- Acquiring of and failure to discard a large amount of possessions that are deemed useless or of little value
- Greatly cluttered living areas precluding normal activities
- Significant distress and impairment in functioning due to hoarding

Topic 9: Post-traumatic stress disorder (PTSD)

(1) Case example

Mr. Lum, a 42-year-old 2004 Sumatra Tsunami survivor had been experiencing PTSD symptoms for more than ten years. For the past 10 years, he managed to cope with his symptoms well, but recently, he had been getting these symptoms more frequently until which they had affected his work and his relationship with his wife.

To avoid recalling memories about witnessing injuries and deaths of others related the tsunami, he kept his mind occupied with work, hobbies and activities. By the time he sought treatment from the psychiatrist, Mr. Lum had already filled his entire week with long list of obligations.

He convinced others that the tragedy had not affected him. When being asked about the disaster, he quickly changed topic and refused to discuss about it. He also avoided people who knew about his involvement in the misfortune.

For the past few months, he experienced increasing difficulty in controlling unwanted images about the tsunami especially during his free time. Additionally, his sleep quality had gotten worst with repeated awakening from sleep due to disturbing nightmares involving the tragedy. His repeated violent awakenings throughout the night had also disturbed his wife's sleep that they no longer share a bedroom.

Mr. Lum found that the more he tried to avoid these thoughts, the more frequent these thoughts would enter his mind, and that they were getting stronger each day. He feared these thoughts would drive him crazy and he would lose control of himself. He was concerned that the fear and panic that occurred when he was reminded of the trauma would last forever.

(2) What is PTSD?

Post-traumatic stress disorder (PTSD) is a group of stress reactions which results after being exposed or involved in traumatic events such as a serious car accident, natural disasters, being threatened with gun, knife or other weapons, being a victim of domestic violence or abuse, sexual assault or seeing someone being killed and badly injured. In countries seriously affected by war or terrorist attacks, both civilians and soldiers can go on to developing PTSD. Sometimes, PTSD can also develop after hearing details about tragic and traumatic events many times.

In children, triggering events include physical or emotional abuse.

(3) What causes PTSD?

Whilst research studies pin-pointed problems with neurotransmitters and hormones in the body, clinical psychologists who study human behaviour attempt to explain the problem using the vulnerability-stress model. This model explains that everyone has their own vulnerabilities and strengths. People experience psychological problems because things get to them in ways that they cannot manage and through no fault of their own. We all have our limits and when that limit is being pushed to the breaking point, anyone can and will experience severe and persistent mental health problems. People with PTSD are unable to process or rationalize the trauma that precipitated the disorder. They continue to experience stress and attempt to avoid experiencing it by avoidance technique*.

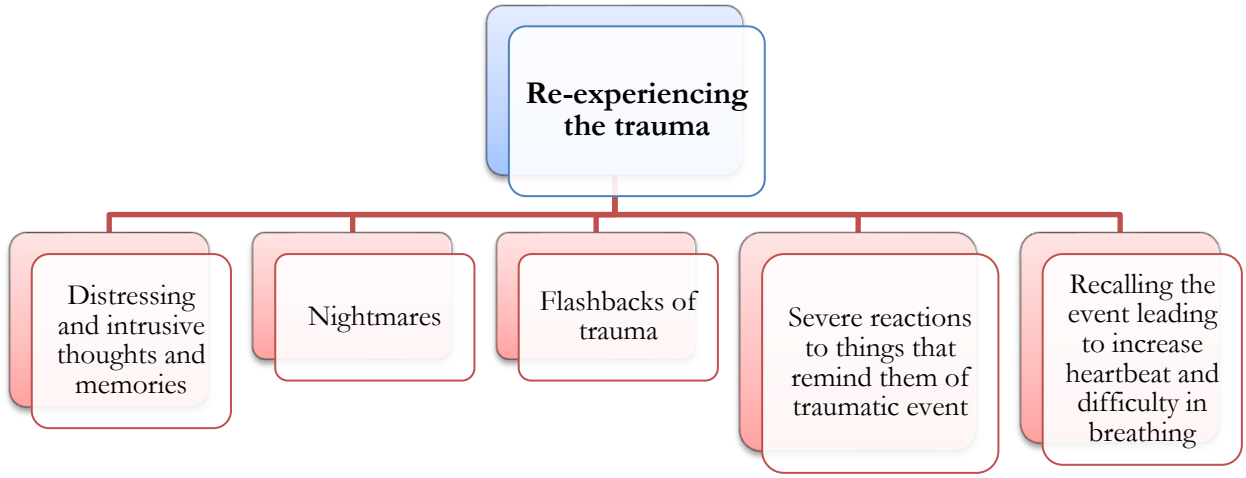
In life, we may come across traumatic and distressing events. It is normal to feel sad, angry or even fear after these events have occurred. With friends' and family's support, these feelings gradually subside and

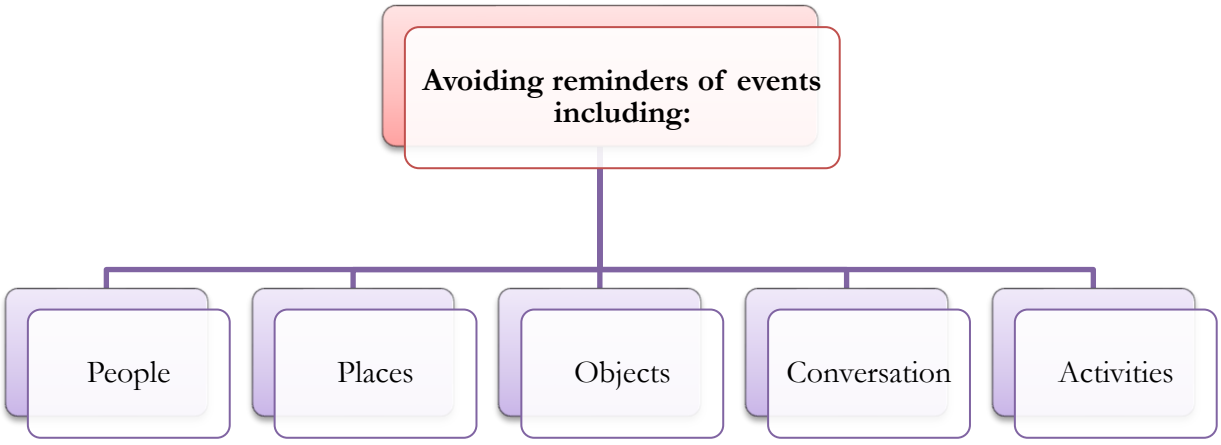
we eventually recover from it. For some individuals unfortunately, witnessing a distressing event can lead to intense feelings of anxiety, fear and anguish which can last longer than it should. These feelings eventually interfere with their daily lives, work or school.

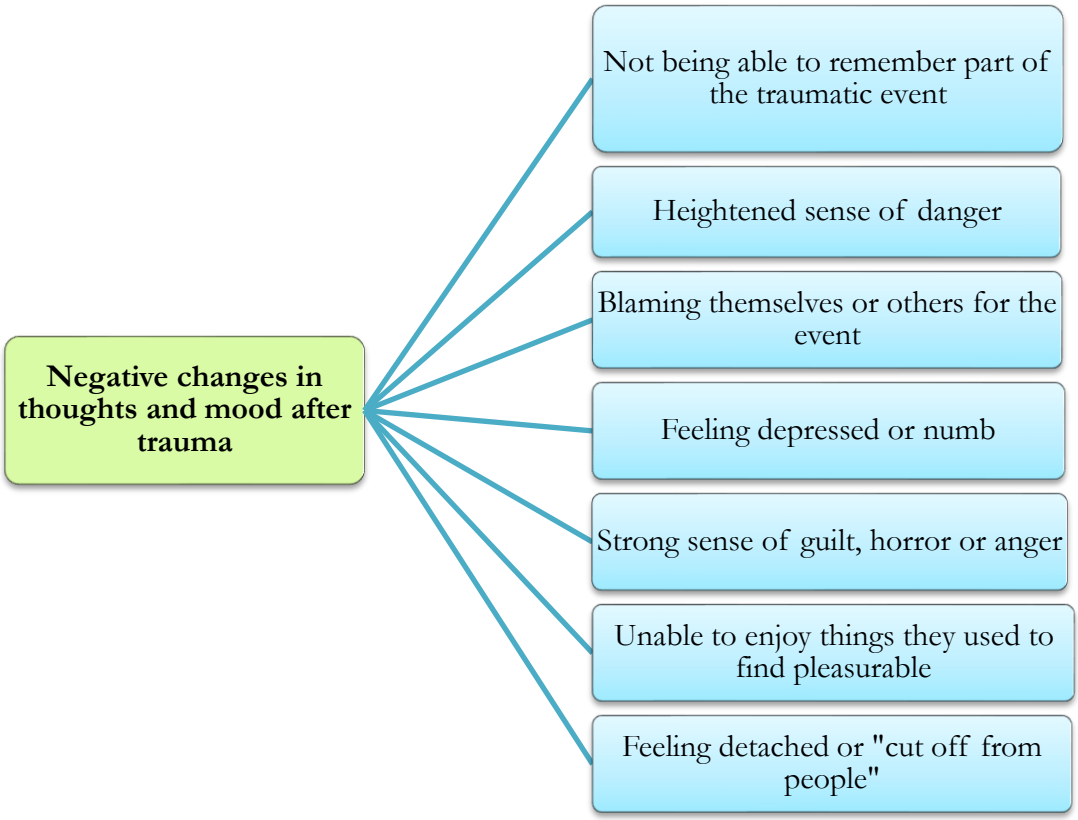
(4) What are the signs and symptoms of PTSD?

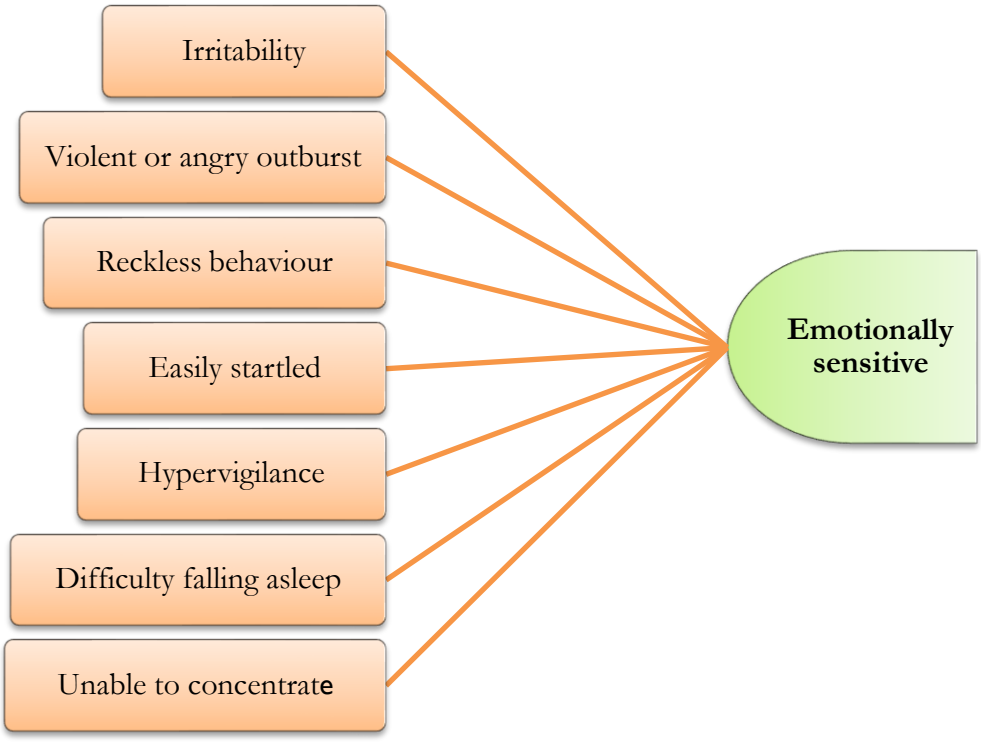
PTSD has four groups of symptoms.

Symptoms include:





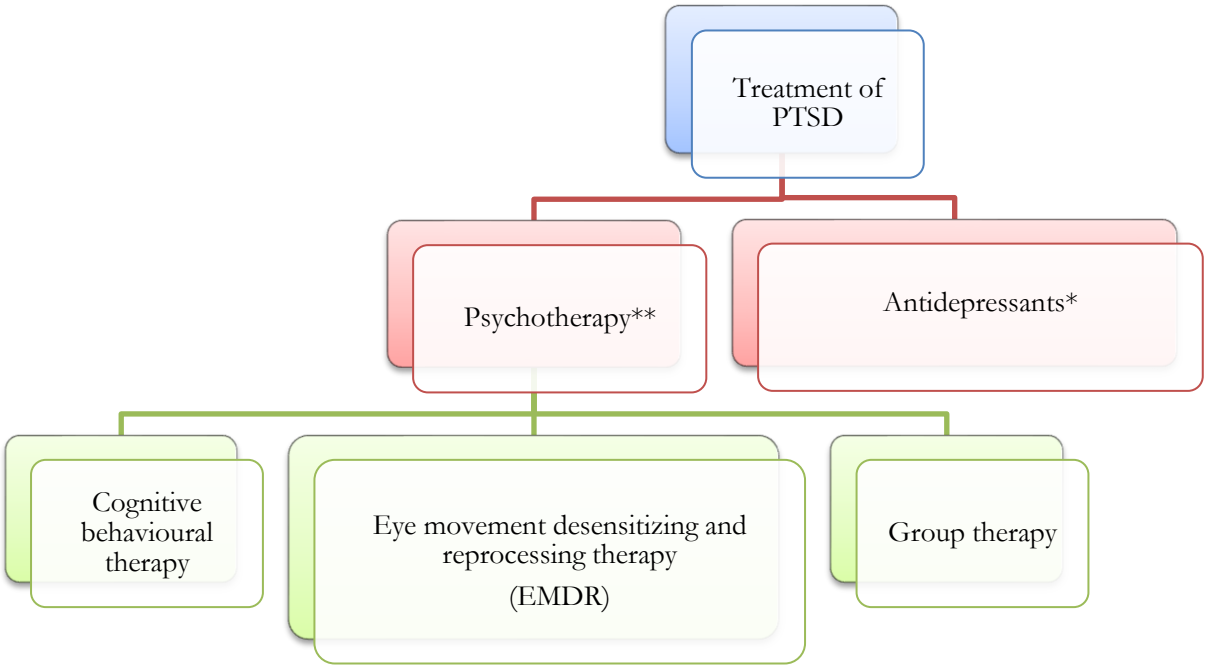




These feelings interfere with daily function and cause problems in interpersonal relationship.

(5) **How is PTSD treated?**

The mainstay treatment for PTSD is medication and psychotherapy**. Cognitive behavioural therapy (CBT), eye movement desensitisation and reprocessing (EMDR) and group therapy are some of the psychotherapies effective in treating PTSD. Antidepressants* are useful in selected individuals as decided by your doctor.

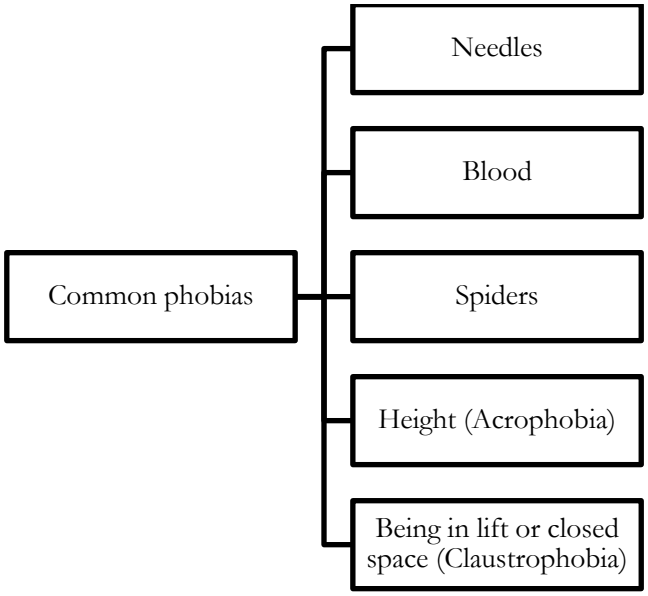


One of the deadliest earthquakes took place in Sumatra, Indonesia in 2004. The earthquake measured 9.1 Mercalli Scale, so powerful that it produced a tsunami wave of 10 metre in height. It affected at least 5 million people living in India, Indonesia, Maldives, Myanmar, Thailand, Seychelles and Sri Lanka. One survey reported at least 40% of children in Sri Lanka who were affected by the tsunami suffered from PTSD.

Topic 10: Specific phobias

(1) What is specific phobia?

Specific phobias refer to irrational fear towards one (or more) specific object or situation which leads to impairment in relationship and daily function. Individuals who have specific phobias attempt to avoid perceived threat at all costs, even when they realise there is no real danger. They are unable to control their fear.



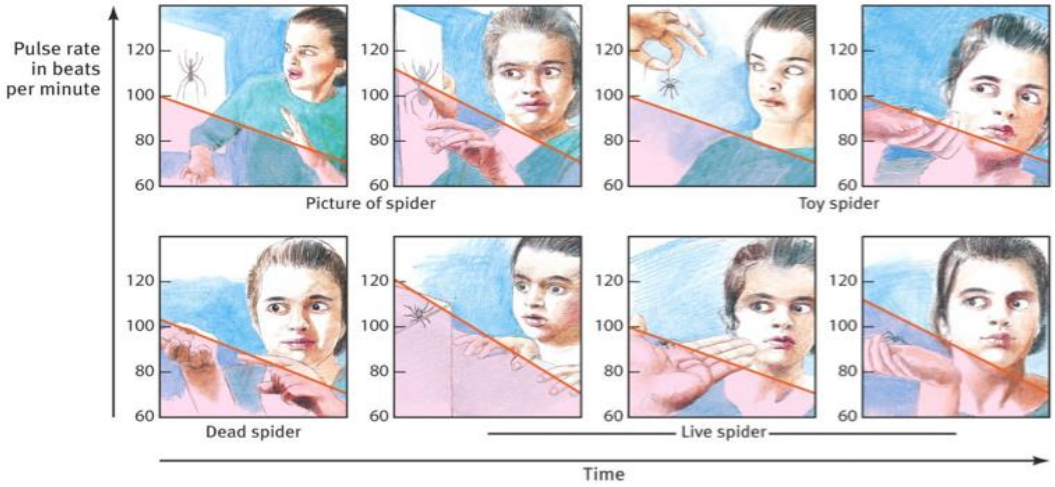
(2) What are the symptoms of specific phobia?

Panic attack is recognized as the most disabling symptom of a phobia. However, not all people with a phobia have panic attacks. Examples of symptoms include:

- Shaking or trembling
- Sweating
- Dry mouth
- Racing heart beat
- Stuttering, unable to get words out clearly
- Tummy aches, diarrhoea

(3) Management of specific phobia

Specific phobias respond well to cognitive behavioural therapy. Gradual desensitization* is the most commonly used treatment.



Picture shows treatment of spider phobia using systematic desensitization

Source: https://grimmintroductiontopsychology.weebly.com/objective-16.html

Virtual reality exposure (VRE)** has also become a choice of therapy for fear of flying.
To date, no controlled studies have been able to show the effectiveness of medication in treatment of specific phobia but the use of antidepressants* and anxiolytics* are effective in helping patients engage in psychotherapy.

Photo by Izuddin Helmi Adnan on Unsplash

Once you have overcome your fear for height, don't forget to look down at the stunning view of our national pride- The Petronas twin towers!

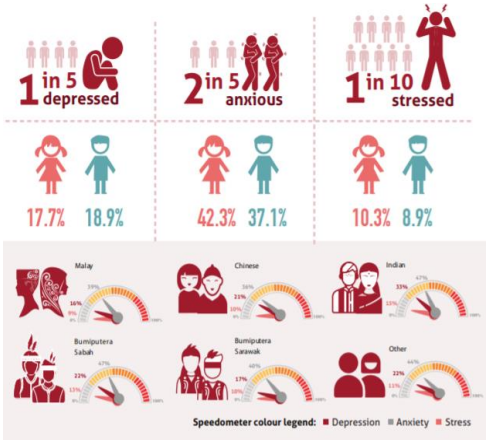
Introduction: Anxiety disorders of Childhood and Adolescence

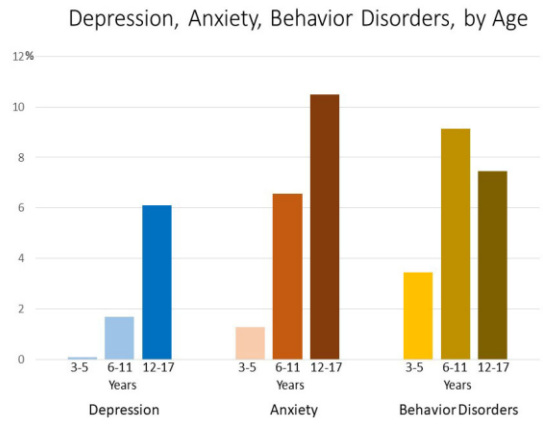
Photo by Robert Collins on Unsplash

"Childhood should be carefree, playing in the sun"- Dave Pelzer

Seek treatment earlier. Do not let mental health disorders take control of your children's life.

Statistics published by the US Centre for Disease Control and Prevention (CDC)* showed increased prevalence of anxiety disorders with age. The prevalence* of anxiety disorders in the US in children aged between 3-17 years was reported at 7.1% (approximately 4.4 million). The 2017 National Health Morbidity Survey (NHMS)* reported that 2 in 5 adolescents were anxious.





Anxiety disorders commonly found in youth include:
(1) Separation anxiety disorder, generalised anxiety disorder, social anxiety disorder
(2) Selective mutism
(3) Obsessive Compulsive disorder (OCD)

We will discuss only these three mental illnesses in the following sections.

Topic 11: Separation anxiety disorder, social anxiety disorder and generalised anxiety disorder

During doctor's evaluation, separation anxiety disorder, generalised anxiety disorder and social anxiety disorder are often considered together as they are more likely to happen at the same time and have overlapping symptoms.

Criteria	Separation anxiety disorder	Social anxiety disorder	Generalised anxiety disorder
Age of onset	Not specific		
Triggering events	Being away from home or attachment figures (parents, guardians or pets)	Unfamiliar situations or social situations with peers or specific individuals	Pressure from any type of performance or activities which are scored such as exams
Symptoms	Stomach aches, headaches, nausea, vomiting, rapid heartbeat, dizziness when anticipating separation	May have blushing, unable to maintain eye contact, soft voice or stunted posture	Stomach aches, nausea, feeling lump in the throat, breathing difficulty, rapid heartbeat when expected to perform an activity
Peer relationship	Good relationship when no separation is involved	May be affected as child is not willing to express oneself	May appear overly eager to please, reach out for reassurance from peers
Sleep	Reluctance or refusal to sleep away from home or not near attachment figures	May having difficulty falling asleep	Often difficult falling asleep
Minimum duration for doctor to make diagnosis	At least 4 weeks	At least 6 months	
Course and prognosis	Most children who recovered did so within the first year. Young children who can maintain attendance in school, after-school activities and peer relationships generally have better prognosis than children or adolescents who refuse to attend school and withdraw from social activities. Unfortunately, some children may go on developing another psychiatric disorder along the way.		
Treatment	These mental illnesses are often treated together as one or more condition may present simultaneously. Treatment include psychotherapy and medication. Psychotherapies** usually involve cognitive behavioural therapy (CBT), family education and family therapy.		

Topic 12: Selective mutism

(1) What is selective mutism?

Selective mutism is believed to be related to social anxiety disorder but has been listed as a separate mental illness by DSM 5*.
A child with selective mutism may remain completely silent or near silent (verbalizing in almost inaudible single-syllable words or whispering) during stressful situations (in schools or unfamiliar social settings).
Children with this disorder are fully capable of speaking with good eye contact when not in socially anxiety triggering situations such as being at home and in familiar settings.

(2) What are the statistics in selective mutism?

Selective mutism is an uncommon mental illness in children. A large epidemiologic survey conducted in the UK reported prevalence* rate of 0.69% in children 4 to 5 years of age. Another survey found 0.06% of children 7 years of age had selective mutism in the UK. It is also reported to be more common in girls.

(3) What are the features of selective mutism?

Children with selective mutism are often excessively shy during kindergarten, but the onset of the full disorder will not be obvious until the age of 5 or 6 years.
As aforementioned, children with selective mutism will speak exclusively at home with his or her own family members but not elsewhere, especially not in school.

(4) Diagnostic uncertainty in selective mutism

Diagnosis of selective mutism remains challenging as many disorders share similar clinical features.
Shy children in particular may have difficulty adapting to a new learning environment and thus exhibit temporary muteness when introduced to new anxiety-triggering situations. On the other hand, children who have poor command in speaking will not be able to communicate well to strangers. Such children may have an inability, rather than a refusal, to speak. Selective mutism is suspected when a child also refuses to converse in their native language even after they have gained communicative competence in the language.
To diagnose selective mutism, your doctor will first rule out disorders such as mental retardation, hearing disorder, autism spectrum disorder (ASD) and social anxiety disorder.

(5) What are the treatment options?

Studies suggested that the symptoms eventually improve as the child grows older. Multimodal approach is recommended for selective mutism involving psychoeducation** for the family, cognitive behavioural therapy (CBT) and antidepressants* such as selective serotonin reuptake inhibitor (SSRI).
For pre-school children, therapeutic nursery is beneficial.
For school age children, individual cognitive behavioural therapy (CBT) is recommended as first-line treatment along with family education.

Topic 13: Obsessive-Compulsive Disorder (OCD) in children

(1) How common is OCD among children and adolescents?

The rate of OCD increases with age.

(2) OCD in the Asian Setup

OCD is a mental illness which often starts during childhood or adolescence. If not properly addressed, the disease can go on affecting normal childhood development leading to academic underachievement in school as well as poor social and communication skills.
Children with OCD may have problems in school. For example, individuals with contamination fears may not sit still in the classroom or might have to repeatedly visit the toilet in order to perform rituals such as hand-washing. Other common rituals include the need to re-read or re-write sentences many times, which makes learning slow and mundane.
Children with OCD may also suffer poor relationships with teachers and parents as some of them have not been able to fully understand the magnitude of the problem and may go on labelling these children as being mischievous or misbehaving. Unknown to others, OCD sufferers actually feel embarrassed with their rituals yet they are unable to resist the urge to repeat these rituals in order to relieve anxiety.

(3) What are the common types of OCD in children and adolescents?

The most commonly reported obsessions in children and adolescents include extreme fears of contamination when exposed to dirt, germs or disease followed by anxiety symptoms related to harm befalling themselves or family members.
A need for symmetry, order and precision, hoarding, excessive religious or moral concerns, obsession with lucky and unlucky numbers are some of the more common obsessions.
Common compulsive rituals seen among children and adolescents include repetitive cleaning, checking, counting, touching or arranging items.

(4) What are the treatment options?

Cognitive behavioural therapy (CBT)** and antidepressants such as selective serotonin reuptake inhibitor (SSRI) have both been shown to be efficacious treatment for OCD in youth.

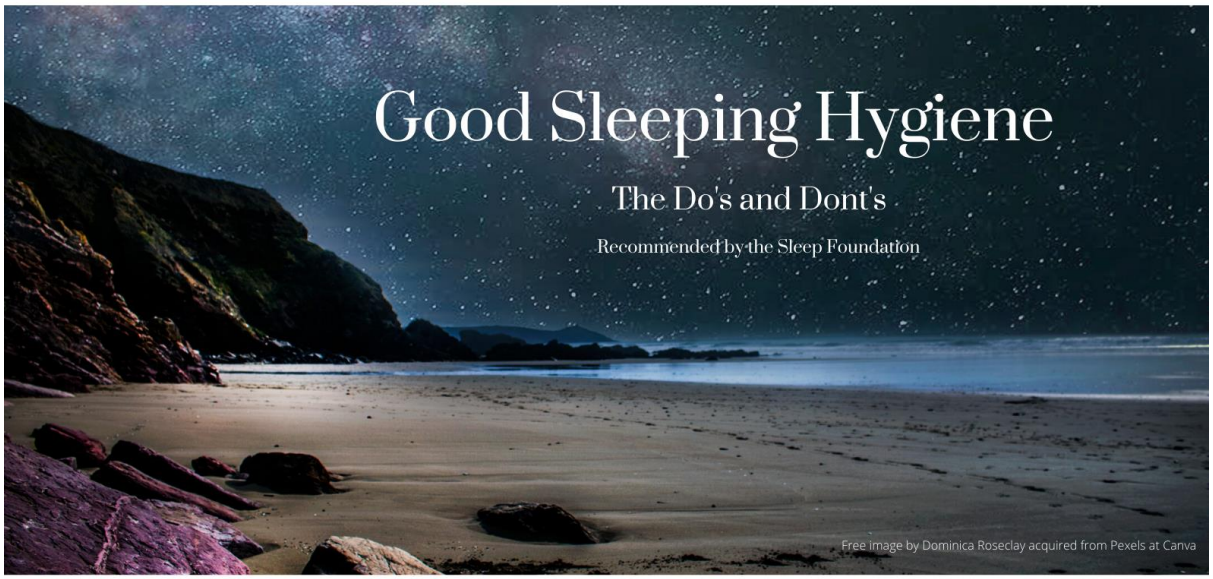
Appendixes 1: Self help

The following methods to relieve stress and anxiety are worth trying as they have been shown to be effective in some patients. They are also useful in addition to medication and psychotherapy.

- Exercise regularly at least 30 minutes a day for 5 days a week. Exercise encourages release of endorphins which makes you feel relaxed and happy.
- Get a good night's sleep with proper sleep hygiene. Follow the steps on how to improve your sleep quality on the next page.
- Mindful breathing exercises help distract your mind from overthinking. Free tutorials can be found on YouTube Channels. Do try out a video called **Mindful Breathing Meditation (Relieve Stress) by "My Life Stop, Breathe, Think".**
- Dr. Jacobson's muscle relaxation technique offers a series of movements involving tensing and relaxing different muscle groups in order to achieve stress relief. Follow the steps on how to perform these exercises on the next page.
- Online tools. Self-help applications are available at the press of a button on your mobile phones. Please refer to Black dog Institution for more details. https://www.blackdoginstitute.org.au/

Exercise is proven to be effective! Look at the smile of these Mak Ciks after an enjoyable ride with the "basikal" gang.

Good Sleep Hygiene



Dr. Jacobson's Muscle Relaxation Technique

Dr. Jacobson's Muscle Relaxation Technique

Clench your muscles for 7-10 sec and then relax for 15-20 sec

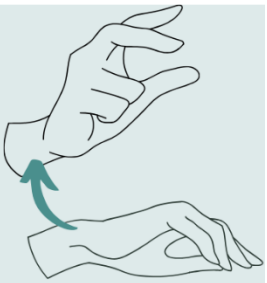
Step 1: Hand

Clench your left hand and feel the tension. Relax and let your hand hang loosely

Repeat the same on your right hand

Step 2: Wrists

Bend your wrists backwards and then relax



Step 3: Upper arms & Shoulders

Bend your elbows towards your shoulders and tense your biceps muscles.

Then

Bring your shoulders up towards ears. Relax; Let shoulders drop down

Step 4: Forehead & Eyes

Wrinkle forehead and raise your eyebrows. Relax

Close your eyes tightly. Relax

Step 5: Neck and Jaw

Turn your head to the right side until your chin touches your shoulder. Straighten and relax. Do the same on the left side.

Then

Bend your head forward and press your chin against your chest. Straighten and relax.

Step 6: Abdomen, back and thighs

Tighten your stomach muscles. Relax.

Then

Arch backwards. Relax.

Then

Stretch one leg in front of you. Tighten your thigh muscle. Relax and then repeat on the other leg

Last but not least
Step 7: Hamstrings, Calves and Feet

Push one of your heels firmly on the floor to tighten your hamstring muscles. Relax and then repeat on other heel

Then

Point your toes upwards. Relax

Then

Curl your toes downwards. Relax

That's it. Done

Source https://www.researchgate.net/figure/Dr-Jacobsons-instructions-for-progressive-muscle-relaxation-training-Muscle-group_tbl1_274656155

Free images acquired from Canva

Appendix 2: Do you know your medication?

In this section, we will discuss commonly prescribed drugs for anxiety disorders with their mode of action and some of their side effects. Please discuss this with your doctor for more detailed information as this is just a general guide.

Class	Examples	How do they work?	Side effects
Tricyclic antidepressants [Considered a second line treatment and not first choice]	Amitriptyline Clomipramine Imipramine	Increase specific brain chemicals to improve mood and relieve anxiety symptoms	• Dry mouth • Blurring of vision • Difficulty in urination • Weight gain • Low blood pressure • Rapid heartbeat • Irregular heartbeat • Drowsiness/fatigue • Tremors or hand shakiness
Selective serotonin Reuptake Inhibitors (SSRI) [Considered a first line treatment and are better tolerated]	Citalopram Escitalopram Fluoxetine Fluvoxamine Paroxetine Sertraline		• Nausea/vomiting • Diarrhoea • Insomnia • Sleepiness/Drowsiness • Dry mouth • Nervousness, agitation • Sexual problems such as reduced sexual desire, difficulty reaching orgasm or inability to maintain erection in some • Changes in appetite
Serotonin Norepinephrine Reuptake Inhibitor (SNRI)	Duloxetine Venlafaxine Desvenlafaxine		• High blood pressure • Dizziness • Constipation • Dry mouth • Sexual problems such as reduced sexual desire, difficulty reaching orgasm or inability to maintain erection • Weakness due to sodium imbalance • Insomnia • Sleepiness/Drowsiness

Noradrenergic and specific serotonergic antidepressants **(NaSSA)**	Mirtazapine		• Constipation • Weight gain • Dry mouth • Leg swelling • Dizziness • Sleepiness • Yellowish discoloration of the eyes (jaundice) • Weakness due to sodium imbalance
Multimodal serotonin modulator	Vortioxetine		• Constipation • Diarrhoea • Nausea • Dry mouth • Dizziness • Sexual dysfunction • Night sweating
Benzodiazepines (BZD) [Can only be used for short term only- typically not longer than 2 to 3 weeks]	Alprazolam Clonazepam Diazepam Lorazepam	Acts on neurons which promotes inhibition of brain activity. BZD promotes sleep helps reduce anxiety	• Drowsiness • Sleepiness • Blurred vision • Confusion • Slurred speech • Low blood pressure
Beta blockers [Only symptom control]	Propranolol Metoprolol	Reduce heart beat by blocking beta-1 receptors	• Airway spasm causing difficulty in breathing • May mask symptoms of low blood sugar as it slows down heart beat • Dizziness • Inability to achieve erection or maintaining erection • Tiredness • Constipation or diarrhoea • Dry mouth • Nausea or vomiting

Important Note: For any anxiety disorder, your doctor may start with newer antidepressants medication and then monitor for improvement. A general course of medication typically takes 4 to 6 weeks to reach their full clinical benefit. There are side-effects but these are time-limited and wear off soon. Follow your doctor's advice and you will see improvement in anxiety symptoms. The medication is used together with behavioural and other psychological treatments. Once symptoms improved, you will need to continue medication for a fixed period of time as advised by your doctor to prevent a relapse.

Appendix 3: Self-test for Generalised Anxiety Disorder (GAD)

If you get a score of 5 and above, you may have GAD.
This needs to be confirmed by your doctor.

GAD-7

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

Total Score ___ = Add Columns ___ + ___ + ___

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

Spitzer, Robert & Kroenke, Kurt & Williams, Janet & Löwe, Bernd. (2006). A Brief Measure for Assessing Generalised Anxiety Disorder: The GAD-7. Archives of internal medicine. 166. 1092-7. 10.1001/archinte.166.10.1092.

Appendix 4: Self-test for Mixed Anxiety and Depressive Disorder (MADD)

DASS 21 NAME _____ DATE _____

Please read each statement and circle a number 0, 1, 2 or 3 which indicates how much the statement applied to you over the past week. There are no right or wrong answers. Do not spend too much time on any statement.

The rating scale is as follows:

0 Did not apply to me at all - NEVER

1 Applied to me to some degree, or some of the time - SOMETIMES

2 Applied to me to a considerable degree, or a good part of time - OFTEN

3 Applied to me very much, or most of the time - ALMOST ALWAYS

		N	S	O	AA	FOR OFFICE USE D	A	S
1	I found it hard to wind down	0	1	2	3			
2	I was aware of dryness of my mouth	0	1	2	3			
3	I couldn't seem to experience any positive feeling at all	0	1	2	3			
4	I experienced breathing difficulty (eg, excessively rapid breathing, breathlessness in the absence of physical exertion)	0	1	2	3			
5	I found it difficult to work up the initiative to do things	0	1	2	3			
6	I tended to over-react to situations	0	1	2	3			
7	I experienced trembling (eg, in the hands)	0	1	2	3			
8	I felt that I was using a lot of nervous energy	0	1	2	3			
9	I was worried about situations in which I might panic and make a fool of myself	0	1	2	3			
10	I felt that I had nothing to look forward to	0	1	2	3			
11	I found myself getting agitated	0	1	2	3			
12	I found it difficult to relax	0	1	2	3			
13	I felt down-hearted and blue	0	1	2	3			
14	I was intolerant of anything that kept me from getting on with what I was doing	0	1	2	3			
15	I felt I was close to panic	0	1	2	3			
16	I was unable to become enthusiastic about anything	0	1	2	3			
17	I felt I wasn't worth much as a person	0	1	2	3			
18	I felt that I was rather touchy	0	1	2	3			
19	I was aware of the action of my heart in the absence of physicalexertion (eg, sense of heart rate increase, heart missing a beat)	0	1	2	3			
20	I felt scared without any good reason	0	1	2	3			
21	I felt that life was meaningless	0	1	2	3			
	TOTALS							

Please refer to the next page to interpret your result.

A coloured-coding is included next to each question indicating its category. (D: Depression; A: Anxiety and S: Stress). Upon completion, add the score of the same category questions together then multiply by 2. Refer to the interpretation chart below, if your total score exceeds any one of the categories, you may need further assessment and help from the doctor.

Severity	Depression	Anxiety	Stress
Normal	0-9	0-7	0-14
Mild	10-13	8-9	15-18
Moderate	14-20	10-14	19-25
Severe	21-27	15-19	26-33
Extremely Severe	28+	20+	34+

Source: http://www.brisbanenorthphn.org.au/content/Document/Pathways/DASS_21_Scoring.pdf

Future Reading

Websites

(1) Black dog Institute: https://www.blackdoginstitute.org.au/
(2) Anxiety Canada: https://www.anxietycanada.com/

Books

(1) Sadock BJ, Sadock VA, Ruiz P. Kaplan & Sadock's Concise Textbook of Clinical Psychiatry. Derived from Kaplan & Sadock's Synopsis of Psychiatry, Eleventh Edition. 4th ed. Philadelphia: Wolters Kluwer; 2017.

(2) Challacombe F, Oldfield VB, Salkovskis P. Break From from OCD. Overcoming Obsessive Compulsive Disorder with CBT. London: Vermillion; 2011.

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Do you have an anxiety disorder?

Do you have friends or family members diagnosed with an anxiety disorder?

Or, you are interested to know more about anxiety disorders yet find it difficult to understand information available on the internet?

Fear not, we got everything covered for you in this handy booklet.

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