# Depression & Anxiety

**Dr. Bassam Albathi**

# PHQ-9

| Over the last 2 weeks, how often have you been bothered by any of the following problems? | Not at all | Several days | More than half the days | Nearly every day |
|---|---|---|---|---|
| 1. Little interest or pleasure in doing things | 0 | 1 | 2 | 3 |
| 2. Feeling down, depressed, or hopeless | 0 | 1 | 2 | 3 |
| 3. Trouble falling or staying asleep, or sleeping too much | 0 | 1 | 2 | 3 |
| 4. Feeling tired or having little energy | 0 | 1 | 2 | 3 |
| 5. Poor appetite or overeating | 0 | 1 | 2 | 3 |
| 6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down | 0 | 1 | 2 | 3 |
| 7. Trouble concentrating on things, such as reading the newspaper or watching television | 0 | 1 | 2 | 3 |
| 8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual | 0 | 1 | 2 | 3 |
| 9. Thoughts that you would be better off dead or of hurting yourself in some way | 0 | 1 | 2 | 3 |
| | | | PHQ-9 total score: | |

**10–14 moderate** depressive symptoms

- At least 5 of 9
- At least 1 of the first 2
- For most of the day
- For most days
- For 2 consecutive wks or more

- Score of 10 - 14 are taken as cut-off point for moderate MDD

# D/D

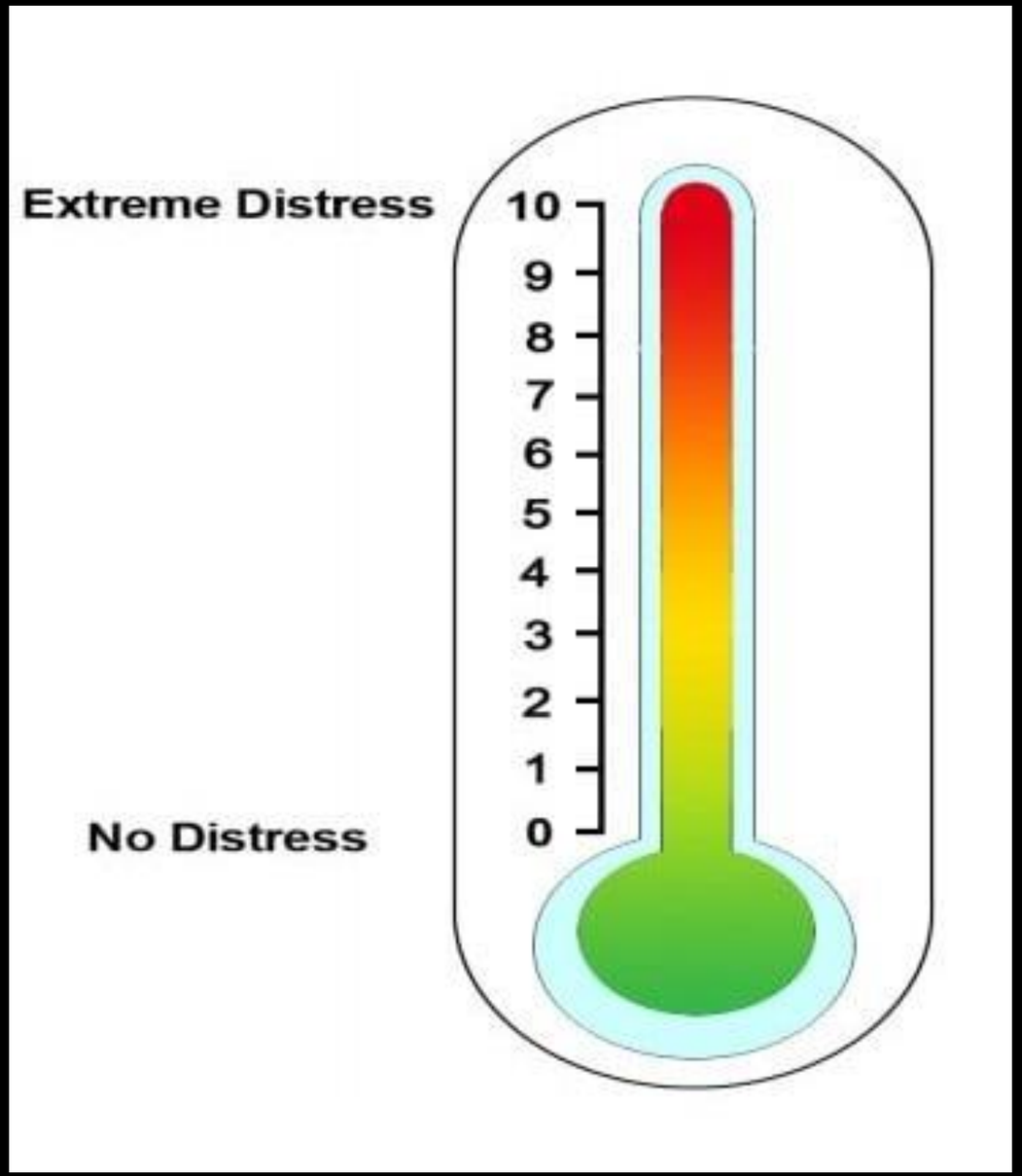
- Grief reaction
- Anxiety disorders
- Bipolar disorder
- Premenstrual dysphoric disorder
- Neurological conditions
- Substances
- Drug
- Hypothyroidism
- Obstructive sleep apnoea syndrome

# Bipolar

- Bipolar II (80%) (hypomania not mania(
- Age of onset younger (<15) (50%)
- Length of depression shorter (3 months vs 9 months)
- Atypical feature during depresion (high appetite, high sleep, psychomotor retardation, interpersonaliy sensitive)
- Family H/O
- Antidepressants response (within week feel better, quick relaps, stop working)
- Dysthemia

# MDD Rx

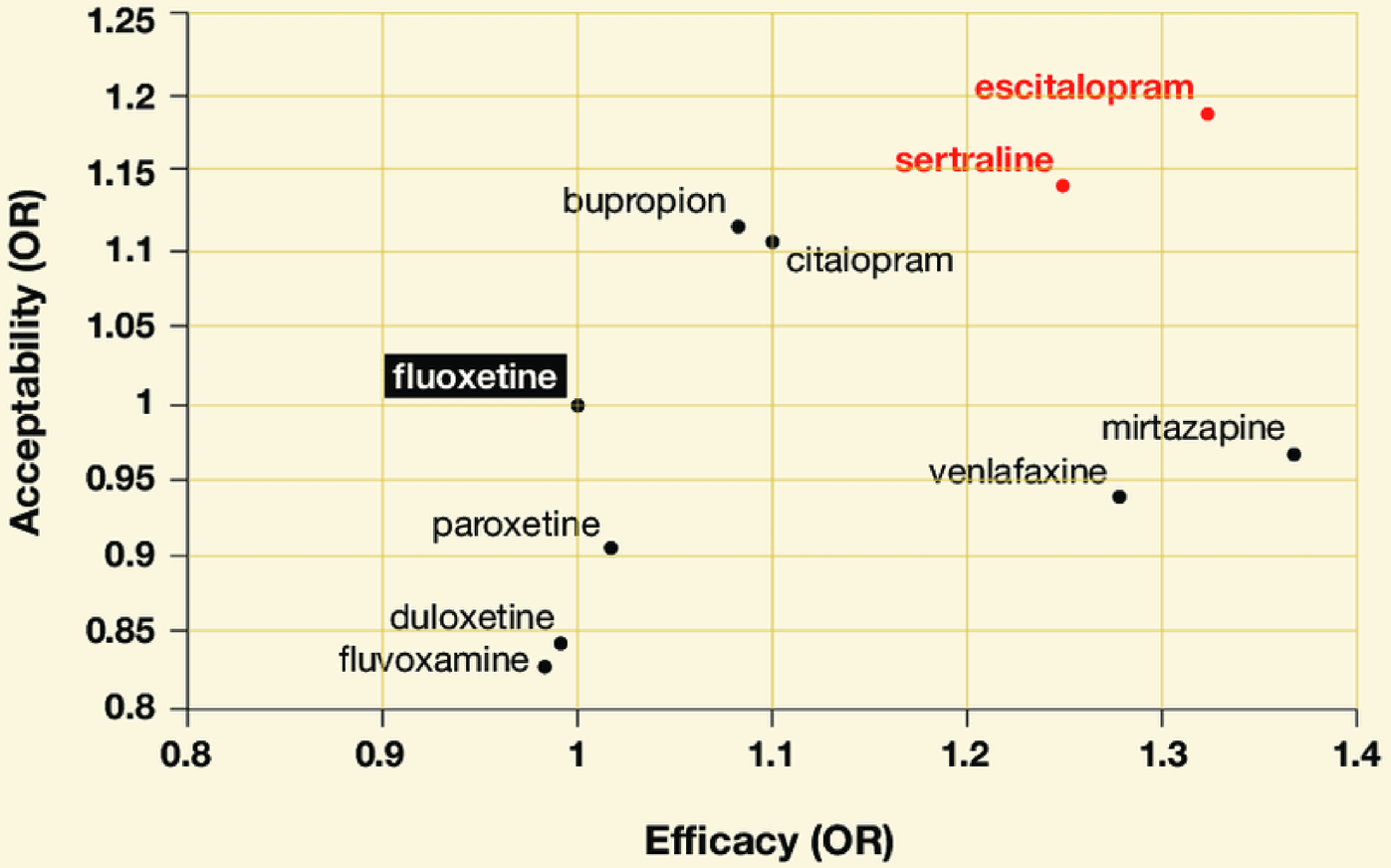
- **Assess the Severity & Risk of suicide**
- Consider any factors which may affect the development, course and severity of depression, including:
  - History of depression, comorbid mental health, mood elevation
  - Past History of chronic physical disorder
  - Drug History of treatments
  - Social History of (interpersonal relationships, living conditions, social isolation, domestic violence or sexual abuse, social support)
  - Family History of mental illness.
  - L**earning disabilities**
  - **Safeguarding**


Extreme Distress
10
9
8
7
6
5
4
3
2
1
0
No Distress

# Rx

- Life style: sleep hygiene, nutrition, light therapy, physcial exrcise
- Psychotherpy: psychoeducation, supportive psychotherpy, & (CBT).
- Medications

# Rx



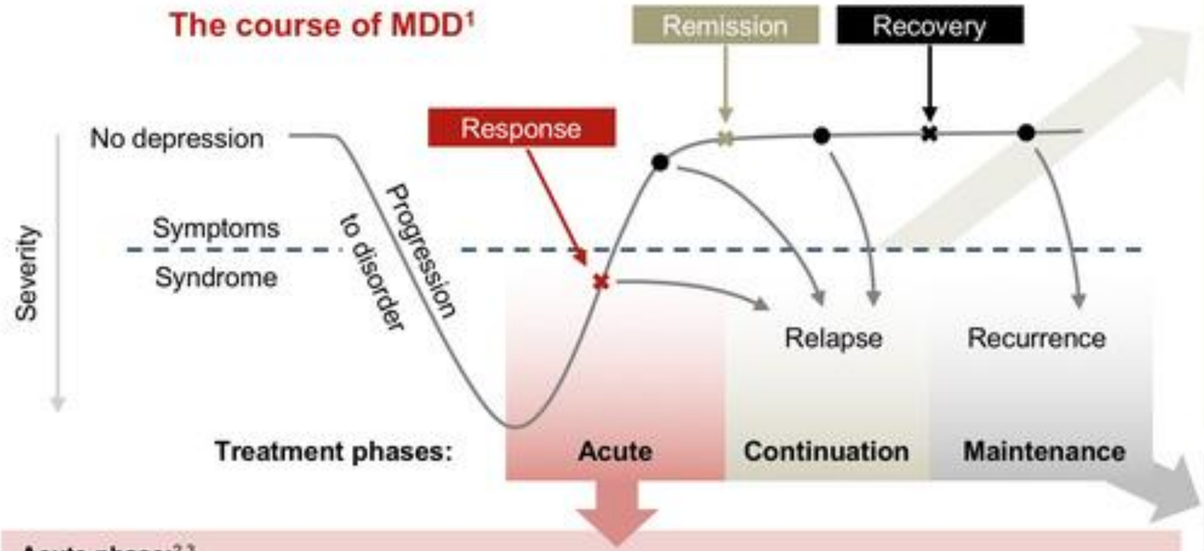

Using fluoxetine as the reference medication, the researchers analyzed various second-generation antidepressants. Sertraline and escitalopram had the best combination of efficacy and acceptability.

OR, odds ratio.

**Source:** Cipriani A et al. *Lancet.* 2009.[1]

Rx

# The course of MDD[1]




**Continuation phase:**[2,3]
- A relapse in the vulnerable period immediately following remission should be avoided
- Any unresolved symptoms should be eliminated
- Suicide should be prevented
- Patient's level of psychosocial and occupational functioning should be restored – at least to levels seen prior to the current episode and, if possible, to levels seen prior to the onset of MDD

**Maintenance phase:**[3]
- A new episode of depression (recurrence) should be prevented
- Suicide should be prevented
- Full and lasting functional recovery should be aimed

**Acute phase:**[2,3]
- Remission (removal of symptoms, such that the criteria for a major depressive episode are no longer met) should be aimed
- Suicide should be prevented
- Improvement in functioning and quality of life should be aimed

MDD=major depressive disorder


1. Kupfer. J Clin Psychiatry 1991;52(Suppl 5):28–34;
2. APA. Practice Guideline for the Treatment of Patients with Major Depressive Disorder. 3rd Edition. 2010;
3. Bauer et al. World J Biol Psychiatry 2013;14(5):334–385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# A Qualitative Study of the Perceptions of Mental Health Care in Kuwait

Nicholas C. Scull
American University of Kuwait and Fawzia Sultan Rehabilitation Institute

Neha Khullar, Nasser Al-Awadhi, and Resha Erheim
Fawzia Sultan Rehabilitation Institute

Ten adult Kuwaitis (5 men and 5 women) participated in in-depth semistructured interviews regarding their perceptions of mental health care in Kuwait. The interviews were analyzed using grounded theory and the emergent theory identified stigma as being the overarching theme, supported by cultural factors, Islamic beliefs, and therapist characteristics. More specifically, participants described a relationship between the stigma of mental health care and prominent Kuwaiti cultural factors such as familialism, gossip, and the importance of reputation. Participants also discussed how Islam informs their perceptions of mental health care and ideal therapist characteristics



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particularly in Kuwait, on how individuals view mental health care. To better understand this

Nicholas C. Scull, Department of Social and Behavioral Sciences, American University of Kuwait, and Psychological Services Department, Fawzia Sultan Rehabilitation Institute; Neha Khullar, Nasser Al-Awadhi, and Resha Erheim, Psychological Services Department, Fawzia Sultan Rehabilitation Institute.

We thank all the participants for sharing their experiences. We would also like to thank Dr. Khadeja Mousa who served as an auditor and Aisha Al-Qimlass for her assistance. We are also incredibly grateful to the Kuwait Foundations for the Advancement of the Sciences for generously funding this study.

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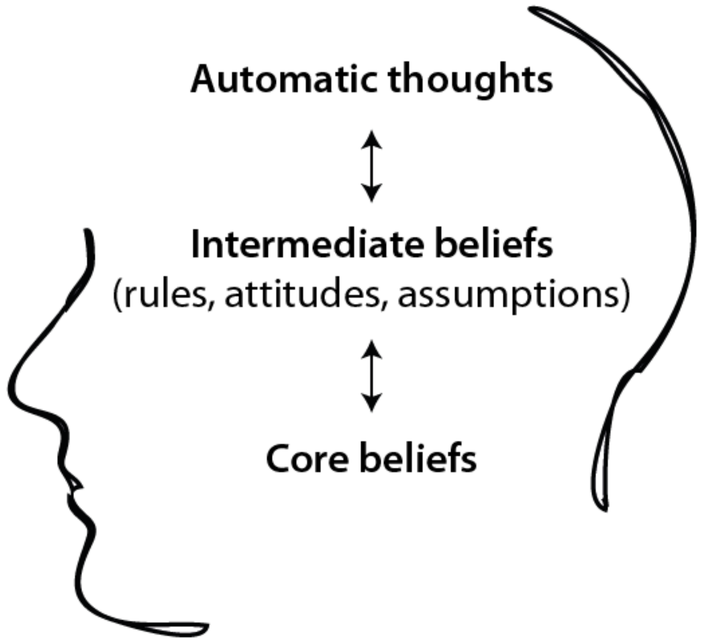
Kuwait is a relatively small country (about the size of New Jersey at 11,072 sq. miles) bordered by the Persian Gulf, Iraq, and Saudi Arabia. According to the CIA World Factbook (2014), the population of Kuwait is 2,742,711, where only 31% are registered as Kuwaiti nationals, while the remainder are either Asian (38%), other Arab (28%), African (2%), or other (1%, including those of North and South American, Australian, and European origin). The vast majority of individuals in Kuwait identify as Muslim (77%), representing both Sunnis (70%) and Shi'as (30%), while the remainder are either Christian (17%) or other and unspecified (6%). The urban population of Kuwait is 98% of the total population. Although Arabic is the national language, English is widely spoken.

# CBT




PSYCHOLOGYTOOLS

Thought Record

| Situation | Thoughts | Emotions | Behaviors | Altemate Thought |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Unhelpful **Thinking Styles**

**All or nothing thinking**

Sometimes called 'black and white thinking'

*If I'm not perfect I have failed*

*Either I do it right or not at all*

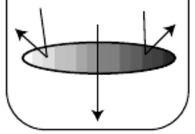
**Over-generalising**

*"**everything** is **always** rubbish"*

*"**nothing** good **ever** happens"*

Seeing a pattern based upon a single event, or being overly broad in the conclusions we draw

**Mental filter**



Only paying attention to certain types of evidence.

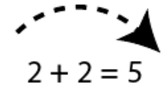
*Noticing our failures but not seeing our successes*

**Disqualifying the positive**

Discounting the good things that have happened or that you have done for some reason or another

*That doesn't count*

**Jumping to conclusions**




There are two key types of jumping to conclusions:

- **Mind reading** (imagining we know what others are thinking)
- **Fortune telling** (predicting the future)

**Magnification (catastrophising) & minimisation**

Blowing things out of proportion (catastrophising), or inappropriately shrinking something to make it seem less important

**Emotional reasoning**

Assuming that because we feel a certain way what we think must be true.

*I feel embarrassed so I must be an idiot*

**should**

**must**

Using critical words like 'should', 'must', or 'ought' can make us feel guilty, or like we have already failed

If we apply 'shoulds' to other people the result is often frustration

**Labelling**


Assigning labels to oursleves or other people

*I'm a loser*
*I'm completely useless*
*They're such an idiot*

**Personalisation**

***"this is my fault"***

Blaming yourself or taking responsibility for something that wasn't completely your fault. Conversely, blaming other people for something that was your fault.

# GAD - When to suspect ?

- Chronic, excessive worry which is not related to particular circumstances
- Symptoms of physiological arousal (increased heart rate, shortness of breath, trembling, an exaggerated startle response, restlessness, insomnia, and muscle tension).
- ***Repeated visits*** (Seeking ***reassurance*** about somatic symptoms such as Headaches, fatigue, muscle tension, gastrointestinal symptoms, back pain, and insomnia) which do not respond to treatment.
- Risk factors: Female, F/H of anxiety, stress, trauma, chroinic pain, other anxiety disorders (panic or phobias), substance abuse.

# GAD - drug h/o

- Salbutamol
- Caffeine
- Beta-blockers
- Herbal medicines (including St. John's wort, ginseng)
- Corticosteroids
- Some antidepressants.
- Alcohol
- illicit substances that can cause anxiety acutely and in withdrawal.

# GAD Diagnosis

- Use a validated assessment tool. (GAD-7)
- Generalized anxiety disorder is often co-morbid with major depression, panic disorder, phobic anxiety disorders, health anxiety, and obsessive-compulsive disorder (OCD).
- Assessement of suicidal risk if the patient has marked functional impairment, severe comorbid depression, and/or the GAD-7 questionnaire score has indicated that they have severe anxiety.

# GAD - 7

| Over the last 2 weeks, how often have you been bothered by any of 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 |
| | | | GAD-7 total score: | |

- Score of 10 - 14 are taken as cut-off point for moderate GAD

# GAD D/D

- Situational anxiety
- Adjustment disorder
- Depression
- Panic disorder
- Social phobia
- Obsessive-compulsive disorder (OCD)
- Post-traumatic stress disorder (PTSD)
- Somatoform disorders
- Anorexia nervosa
- Substance and alcohol misuse/withdrawal
- Medication-induced anxiety
- Cardiac disease
- Pulmonary disease
- Hyperthyroidism
- Anaemia
- Infection
- Irritable bowel syndrome
- Phaeochromocytoma

# GAD Rx - Step 1

1- Assess the severity of GAD. (GAD-7)

2- Enquire the factors which may affect the development, course, and severity of GAD

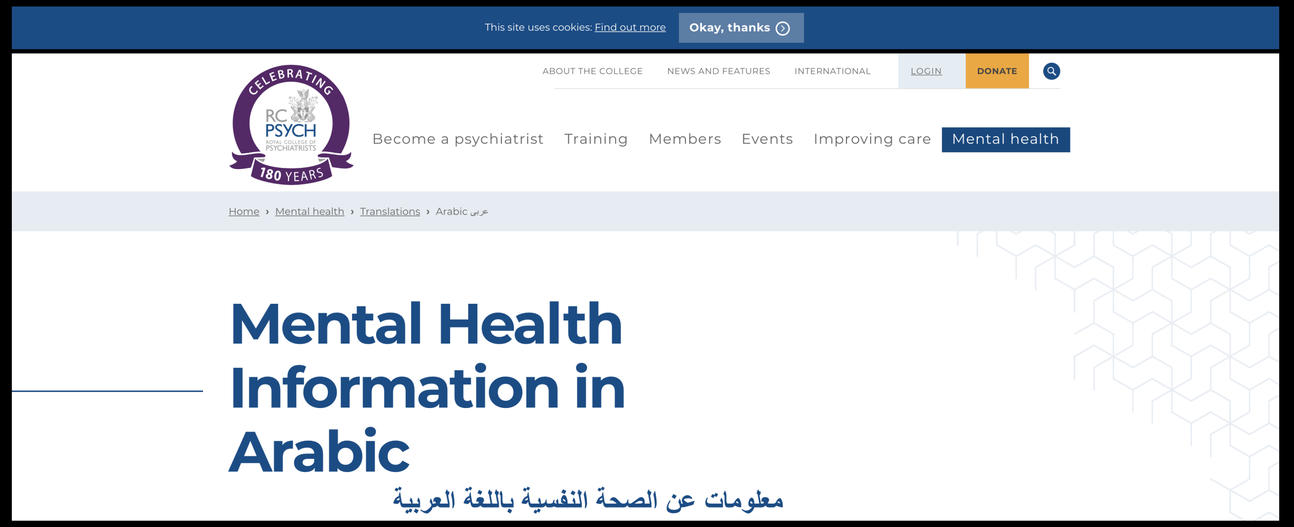
3- Consider the person's history of mental health disorders, and past experience of and response to treatments

4- Provide written material about the nature of GAD and its treatment options

5- Arrange active monitoring of the person's symptoms, functioning, and response to treatment.

# Mental Health Links in Arabic

- Alcohol and Depression: الكحول والأكتئاب
- Bipolar Affective Disorder: مرض اضطراب العاطفة الثنائي القطب
- Cannabis and Mental Health: الحشيش والصحة العقلية
- Alcohol and Drugs - What parents need to know: الكحول والعقاقيرما يجب على الأباء معرفته
- Behavioural problems and conduct in children disorder: الإضطرابات السلوكية عند الأطفال
- Bipolar disorder: اضطراب المزاج ثنائي القطب ( الهوس – الأكتئاب)
- The child with general learning difficulty: صعوبة التعلم لدي الأطفال
- Children who do not go to school: الطفل الذى لايذهب الى المدرسة
- Children who soil or wet themselves: التغوط والتبول غير المناسب للأطفال
- Chronic Physical Illness: الأمراض العضوية المزمنة وأثارها على الصحة النفسية
- Cognitive Behavioural Therapy (CBT): العلاج المعرفي السلوكي(ع م س)
- Coping with stress: التطبع مع الضغط النفسى
- Dealing with tantrums: التعامل مع نوبات غضب الاطفال
- Death in family: الوفاة فى العائلةما هو تأثيرها على الاطفال
- Self-harm in young people: ظاهرة ايذاء النفس لدى الاحداث
- Depression in Children: الكآبة لدى الاطفال والشباب اليافعين
- Depression in the workplace: الاكتئاب في مكان العمل
- Divorce and seperation: ما هو تأثير انفصال أو طلاق الأباء علي الأطفال
- Domestic Violence: ما هو تاثير العنف المنزلى على الاطفال
- Alcohol and drugs: العقاقير والكحول- سوء الاستخدام
- Eating disorders in young people: اضطرابات الطعام لدى الاحداث
- Elctro-convulsive Therapy (ECT): العلاج بالصدمة الكهربائية (ع ص ك)
- Good parenting: الرعاية الأبوية الجيدة
- Information about drugs: What parents need to know: معلومات عن العقاقير



# GAD Rx - Step 2

**- Life Style**

**- Psychotherapy**

**- Drug treatment**

- Review the effectiveness & adverse effects of the drug every 2 - 4 weeks during the first 3 months of treatment, and every 3 months thereafter. (GAD 7, compliace, & S/E)

- Absence of clinical benefit within 4 weeks suggests that a response to unchanged treatment is unlikely

- The full efficacy of the drug may take up to 12 weeks to be realised

- The course at least should be for 1 year

# Pregnnancy

- Ideally, a high-intensity psychological intervention should be offered first.
- If drug treatment is considered necessary in the first trimester, the potential risks and benefits should be discussed.
- If a woman with GAD who is stabilised on current treatment reports a pregnancy, the risk of relapse must be taken into account when considering discontinuing or switching medication.
- In cases where drug treatment is continued in pregnancy, the lowest effective dose should be used.
- Treatment with an SSRI or SNRI after around 20 weeks of pregnancy may raise the risk of persistent pulmonary hypertension of the newborn (PPHN) and/or can lead to neonatal withdrawal.

# GAD Rx - Step 3

- Refer for specialist treatment, people with severe anxiety and marked functional impairment, *and/or* GAD that has not improved, *and/or* those exhibiting, or at risk of: Self-harm, Self-neglect,

- A significant comorbidity such as substance misuse, personality disorder, or complex physical health problem, Suicide — refer urgently (same day) to the crisis resolution and home treatment team if the person is at high risk of suicide.

# Suicide

- Do not avoid using the word 'suicide'.

- Suggested questions include:
  - Do you ever think about suicide?
  - Have you made any plans for ending your life?
  - Do you have the means for doing this available to you?
  - What has kept you from acting on these thoughts?

- Be aware of danger periods such as when initiating treatment, during changes in treatment, or at times of increased personal stress.

- Identify risk factors that increase the risk of suicide.

- Assess adequacy of social support and current personal circumstances, and factors that reduce the risk of suicide, including good social support and responsibility for children.

# Suicide

- **Factors that increase the risk of suicide**
  - Previous attempts at suicide or self-harm.
  - Feelings of hopelessness.
  - Male gender.
  - Age < 30 years.
  - Advanced age.
  - Single or living alone.
  - History of substance or alcohol abuse
  - Family history of suicide.
  - Recent initiation of antidepressant treatment.
  - Psychosis.
  - Anxiety, agitation, panic attacks.
  - Concurrent physical illness.
  - Severe depression.

# OCD

## D/D

### Differential diagnosis

**The differential diagnoses of obsessive-compulsive disorder (OCD) include:**

- **Obsessive-compulsive personality disorder (OCPD)** — suggested by a preoccupation with orderliness, details, rules, organisation, or schedules, to the degree that the point of the activity is lost, with absence of obsessions and compulsions, but may involve discomfort if things are sensed not to have been done completely.
- **Body dysmorphic disorder (BDD)** — suggested by obsessive preoccupation with a perceived defect in physical appearance.
- **Somatic symptom disorder** — suggested by excessive thoughts, feelings, or behaviours related to somatic symptoms or associated health concerns.
- **Illness anxiety disorder (hypochondriasis)** — suggested by a preoccupation with having or acquiring serious illness and excessive health-related behaviours, such as repeatedly checking for signs of illness. May demonstrate maladaptive avoidance, such as avoiding medical appointments.
- **Delusional disorder** — suggested by a false belief that is firmly sustained and based on incorrect inference about reality. Compulsions may be absent.
- **Autism spectrum disorder (including Asperger's syndrome)** — suggested by stereotyped and repetitive motor mannerisms (e.g., hand or finger flapping or twisting, or complex whole-body movements, impaired social interaction, problems with verbal and non-verbal communication, and unusual, repetitive, compulsive behaviour or severely limited activities and interests. For more information, see the CKS topic on Autism in children.
- **Hoarding disorder** — suggested by persistent difficulty in discarding or parting with possessions, regardless of actual value, due to perceived need to save items and distress associated with discarding them.
- **Trichotillomania (hair-pulling disorder)** — suggested by recurrent pulling out of hair, resulting in hair loss.
- **Excoriation (skin-picking) disorder** — suggested by recurrent picking of skin, resulting in skin lesions.
- **Substance-induced or medication-induced obsessive-compulsive disorder** — suggested by OCD-type symptoms that are attributable to effects of medication or drug of abuse, and develop during or soon after substance intoxication or withdrawal or after exposure to substance.

# OCD - Diagnosis

- Recurrent obsessional thoughts or compulsive acts or, commonly, both.
- If undertreated, OCD usually persists.
- People with OCD often fear stigmatization and fail to disclose their symptoms spontaneously, leading to low rates of recognition and, consequently, undertreatment.
- Diagnosis of OCD involves assessment of :
  - Comorbidity
    - (depression, anxiety, alcohol or substance misuse, body dysmorphic disorder, or an eating disorder)
  - D/D
    - (OCPD, BDD, Somatic symptom disorder, illness or health anxiety disorder, autism, Hording, Excoriation disorder)
  - Severity
  - Risk of self harm and suicide

# OCD - DSM-5

- Must exhibit obsessions, compulsions, or both.
  - Cause marked distress
  - Time consuming (take more than 1 hour per day)
  - Interfere substantially with the person's normal routine, occupational or academic functioning, or usual social activities or relationships.
- The obsessions and/or compulsions are not attributable to the physiological effects of a **substance** or other **medical** condition.
- The disorder is not better explained by the symptoms of **another mental disorder**, such as obsession with food in the context of an eating disorder.

# OCD - DSM - 5

Obsessions

- Recurrent & persistent thoughts, urges, or images experienced, at some time during the disturbance, as intrusive and **unwanted** and in most individuals cause marked anxiety or distress.
- There is some effort by the affected person to ignore or suppress such thoughts, impulses, or images, or to neutralise them with some other thought or action (i.e., by performing a compulsion).

Compulsions

- Repetitive **activities** (e.g., hand washing, ordering, checking) or **mental** acts (e.g., praying, counting, repeating words silently) that the person feels driven to perform in response to an obsession or according to rules that must be applied rigidly.
- These behaviours or mental acts are performed in order to prevent or reduce distress, or prevent some dreaded event or situation. However, they are either clearly excessive or not connected in a realistic way with what they are designed to neutralise or prevent.

# YBOCS

## Obsessive-Compulsive Test - Yale Brown OCD Scale YBOCS

| | (0) | (1) | (2) | (3) | (4) |
|---|---|---|---|---|---|
| **Obsessions** are frequent, unwelcome, and intrusive thoughts. | | | | | |
| 1. How much time do you spend on obsessive thoughts? | None | 0-1 hrs/day | 1-3 hrs/day | 3-8 hrs/day | More than 8 hrs/day |
| 2. How much do your obsessive thoughts interfere with your personal, social, or work life? | None | Mild | Definite but manageable | Substantial interference | Severe |
| 3. How much do your obsessive thoughts distress you? | None | Little | Moderate but manageable | Severe | Nearly constant, Disabling |
| 4. How hard do you try to resist your obsessions? | Always try | Try much of the time | Try some of the time | Rarely try. Often yield | Never try. Completely yield |
| 5. How much control do you have over your obsessive thoughts? | Complete control | Much control | Some control | Little control | No control |
| **Compulsions** are repetitive behaviors or mental acts that you have a strong urge to repeat that are aimed at reducing your anxiety or preventing some dreaded event. | | | | | |
| 6. How much time do you spend performing compulsive behaviors? | None | 0-1 hrs/day | 1-3 hrs/day | 3-8 hrs/day | More than 8 hrs/day |
| 7. How much do your compulsive behaviors interfere with your personal, social, or work life? | None | Mild | Definite but manageable | Substantial interference | Severe |
| 8. How anxious would you feel if you were prevented from performing your compulsive behaviors? | None | Little | Moderate but manageable | Severe | Nearly constant, Disabling |
| 9. How hard do you try to resist your compulsive behaviors? | Always try | Try much of the time | Try some of the time | Rarely try. Often yield | Never try. Completely yield |
| 10. How much control do you have over your compulsive behaviors? | Complete control | Much control | Some control | Little control | No control |

Your Score:

If you have both obsessions and compulsions, and your total score is;
8-15 = Mild OCD; 16-23 = Moderate OCD; 24-31= Severe OCD; 32-40 = Extreme OCD
No single test is completely accurate. You should always consult your physician when making decisions about your health.

References


- Goodman, W. K., Price, L. H., Rasmussen, S. A., Mazure, C., et al., The Yale-Brown Obsessive Compulsive Scale. I. Development, use, and reliability. *Arch Gen Psychiatry*, 1989. **46**(11): p. 1006-11.
- Rapp, A. M., Bergman, R. L., Piacentini, J., & McGuire, J. F., Evidence-Based Assessment of Obsessive-Compulsive Disorder. *J Cent Nerv Syst Dis*, 2016. **8**: p. 13-29. PMC4994744.

# OCD Management

- For all people with obsessive-compulsive disorder (OCD) assess their degree of distress and functional impairment as mild, moderate, or severe
- OCD may exist with other mental health disorders
- If the person is exhibiting severe distress and/or functional impairment, co-morbid depression or another mental health disorder, or other concerns have been raised, assess their risk of suicide and self-harm. (refer urgently)
- Refer for specialist treatment people whose OCD and marked functional impairment are assessed as 'severe', *and/or* those exhibiting, or at risk of: Self-harm., Self-neglect, A significant comorbidity such as substance misuse, severe depression, anorexia nervosa, or schizophrenia.

# OCD Management

- **Mild**
  - Recommend a psychological intervention.
    - Cognitive-behavioural therapy (CBT), Exposure and Response Prevention ERP)

- **Moderate**

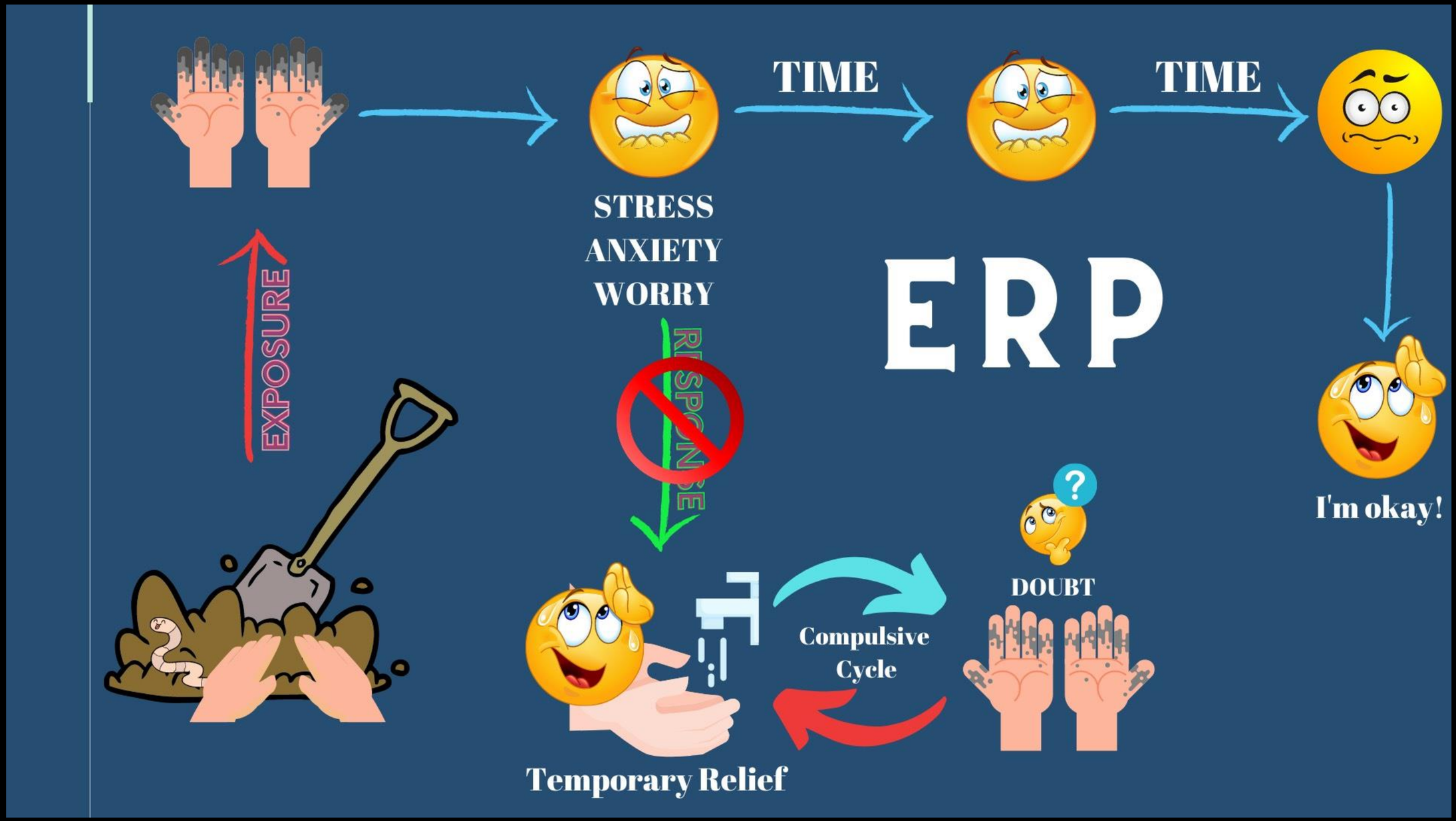
  - High intensity CBT or (SSRI); Escitalopram, fluoxetine, fluvoxamine, paroxetine, and sertraline are all licensed for the treatment of OCD in adults.

  - Consider prescribing clomipraminez (as an alternative first-line drug treatment to an SSRI) if the person prefers clomipramine or has had a previous good response to it, or if an SSRI is contraindicated.

- **Sever**

  - Refer to the secondary care mental health team for assessment.

  - Whilst awaiting assessment:
    - Consider offering combined treatment with an SSRI and CBT (including ERP).


TIME
TIME
STRESS
ANXIETY
WORRY
ERP
EXPOSURE
RESPONSE
I'm okay!
DOUBT
Compulsive
Cycle
Temporary Relief

# Panic Disorder - Diagnosis

- **Panic attack**: abrupt surge of intense fear or intense discomfort that reaches a peak within minutes, and the abrupt development of specific somatic, cognitive, and affective symptoms.
- **Panic disorder:** panic attacks lead to persistent concern or anxiety about possible recurrence and/or resulting changes in behavior, such as agoraphobia, hypochondriacal concerns, and high medical utilization. (Chronic)
- **Somatic** symptoms:  Cardiac symptoms (chest pain & tachycardia), neurologic (headaches & dizziness), and gastrointestinal symptoms (epigastric pain).
- Ptients with panic attacks can develop **agoraphobia**. (anxiety about being in situations where help may not be available)
- **Exclude**: organic causes. (angina, arrhythmias, asthma, COPD, PE, thyroid Ds,  and, very rarely, temporal lobe epilepsy or pheochromocytoma.
- **Substances**: excessive caffeine use or the use of other stimulants. (triggers or aggrevates)

# Panic Disorder - Management

- (SSRIs), (SNRIs), TCA, MAO Inhibitors, and benzo.
- Start at low doses
- 2-4 week delay with antidepressants in the onset of a therapeutic effect when treating panic disorder.
- Clinical response can take up to 8 to 12 weeks for some patients, while therapeutic effects, particularly on anticipatory anxiety and phobic avoidance, can continue to increase over the first 6 to 12 months of treatment in many patients.
- TCA are effective for panic disorder but are more poorly tolerated than SSRIs or SNRIs.
- Benzodiazepines have the advantage of more rapid onset of therapeutic effects compared with antidepressants but have a risk of abuse.
- If effective, pharmacotherapy should be continued for at least one year after symptom control has been attained.

# CBT - For Panic

- **Basic premise:** Thoughts, feelings and behaviors are inter-related, so altering one can help to alleviate problems in another.
- **Essence of therapy:** Cognitive therapy aims to help the person identify, challenge, and modify dysfunctional ideas related to panic symptoms (e.g., catastrophic consequences of bodily sensations). Avoidance of panic and panic-cues is targeted through exposure exercises, including both in vivo (e.g., going to crowded places or driving in traffic) and interoceptive (e.g., bodily sensations) exposures.
- **Length**: Approx. 12-16 sessions