

# Basic Knowledge on Common Non-Psychotic Disorders and Treatments

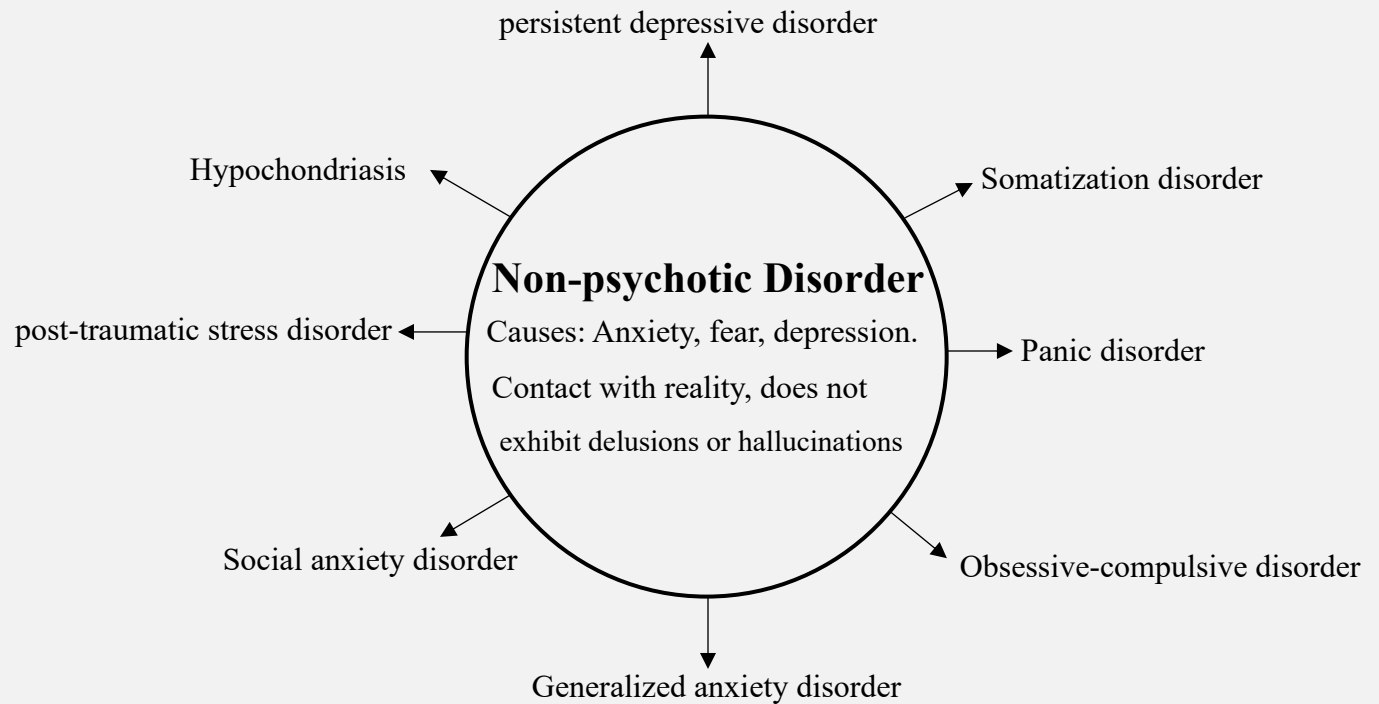
Written By:

Md Rasel Mahamud

PHARMACIST

B.Pharm(Professional) from Jahangirnagar University

**Non-Psychotic Disorder:** Neurotic disorders are a group of mental disorders characterized by chronic distress (such as anxiety, fear, or depression) in which the individual maintains insight and contact with reality and does not exhibit delusions or hallucinations. Some examples of non-psychotic disorders are Panic disorder, Obsessive-compulsive disorder, Generalized anxiety disorder, Social anxiety disorder, post-traumatic stress disorder, persistent depressive disorder, Somatization disorder, Hypochondriasis, Neurasthenia.



[**Note: Psychotic Disorder:** Psychotic disorders are a group of severe mental disorders characterized by a loss of contact with reality, manifested by symptoms such as delusions, hallucinations, and disorganized thinking, often accompanied by impaired insight. Some examples of Psychotic disorders are Schizophrenia, Delusional disorder, Brief psychotic disorder, Substance-induced psychotic disorder, Psychotic depression]

## **GENERALIZED ANXIETY DISORDER (GAD)**

Generalized Anxiety Disorder (GAD) is a chronic neurotic disorder characterized by excessive, persistent, and uncontrollable worry about multiple aspects of life, lasting for at least 6 months, and accompanied by physical and psychological symptoms.

### **Common symptoms:**

At least 3 or more of the following (in adults):

- Restlessness or feeling “on edge”
- Easily fatigued
- Difficulty concentrating (“mind goes blank”)
- Irritability
- Muscle tension
- Sleep disturbance (insomnia, poor sleep)

### **Causes / risk factors:**

- Genetic predisposition
- Imbalance of neurotransmitters (e.g., serotonin, GABA)
- Chronic stress or trauma
- Personality traits (e.g., high sensitivity, perfectionism)

### **Diagnosis of GAD:**

The diagnosis of Generalized Anxiety Disorder (GAD) is based on specific clinical criteria. It is characterized by excessive anxiety and worry occurring more days than not for at least six months, involving multiple events or activities such as work, health, family, or finances. The individual finds it difficult to control the worry, which tends to be persistent and overwhelming. In addition, the anxiety is associated with at least three symptoms (only one required in children), including restlessness or feeling “on edge,” easy fatigability, difficulty concentrating or episodes where the mind goes blank, irritability, muscle tension, and sleep disturbances such as difficulty falling or staying asleep or experiencing restless sleep. Furthermore, the condition must cause clinically significant distress or impairment in social, occupational, or other important areas of functioning. Finally, the symptoms should not be attributable to the effects of substances, medications, or underlying medical conditions such as hyperthyroidism.

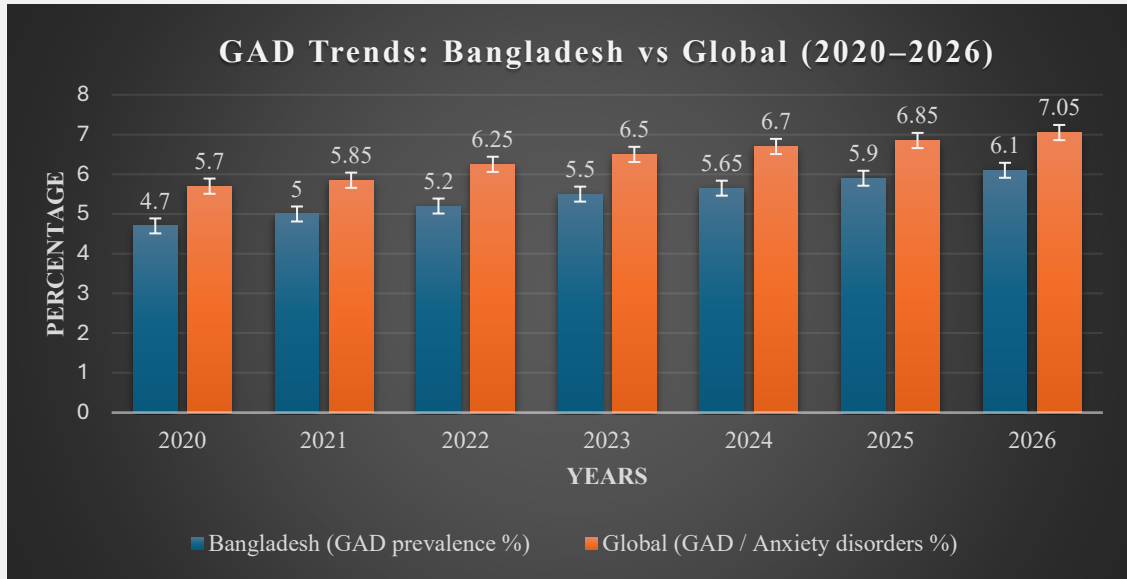
### **Treatment:**

The treatment of Generalized Anxiety Disorder (GAD) involves a combination of psychotherapy, pharmacotherapy, and supportive lifestyle measures. Among non-pharmacological approaches, Cognitive Behavioral Therapy is considered the first-line treatment, as it helps patients identify and modify maladaptive thought patterns, reduce excessive worry, and develop effective coping strategies. Mindfulness-based therapies and relaxation techniques may also be beneficial adjuncts.

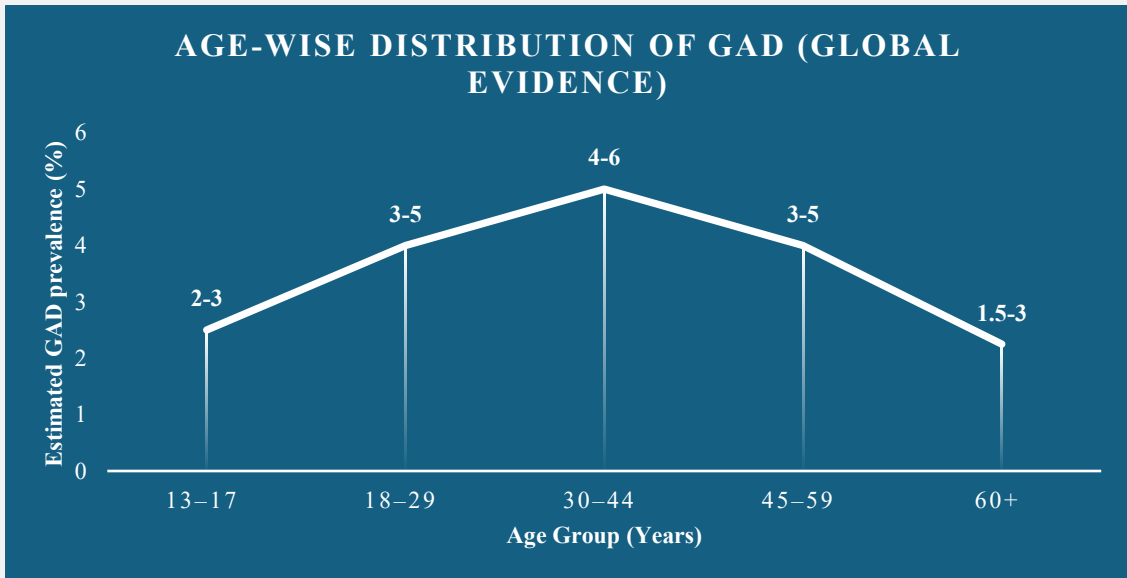
Pharmacological treatment is indicated in moderate to severe cases or when psychotherapy alone is insufficient. First-line medications include Selective Serotonin Reuptake Inhibitors such as Sertraline and Escitalopram, as well as Serotonin-Norepinephrine Reuptake Inhibitors like Venlafaxine and Duloxetine. These drugs are preferred due to their efficacy and safety profile, although they may take a few weeks to achieve full therapeutic effect. For short-term relief of acute anxiety symptoms, Benzodiazepines such as Diazepam may be used cautiously because of the risk of dependence and sedation. Other alternatives include Buspirone, Pregabalin, and Hydroxyzine, which can be used based on patient needs and tolerability.

In addition to these treatments, lifestyle modifications such as regular physical exercise, proper sleep hygiene, stress management, and avoidance of caffeine and other stimulants play an important supportive role. Overall, an individualized and combined treatment approach is most effective in managing GAD and improving the patient’s quality of life.

**Comparing Bangladesh and global GAD Graphically:**



**Comparing Age-Wise Distribution of GAD:**



# PANIC DISORDER

A panic attack is a sudden surge of intense fear or discomfort that reaches a peak within minutes and includes strong physical and psychological symptoms.

## **Common Symptoms:**

A panic attack is characterized by the sudden onset of intense fear or discomfort, during which four or more symptoms typically appear rapidly. Individuals often experience palpitations or a rapid heart rate, accompanied by sweating and trembling or shaking. Breathing may become difficult, leading to a sensation of shortness of breath, while chest pain or discomfort can further increase distress. Many people also report dizziness or a feeling of faintness, along with nausea. Sensations of chills or sudden heat may occur, adding to the physical discomfort. Alongside these bodily symptoms, there are strong psychological reactions, including a fear of losing control or “going crazy,” and an overwhelming fear of dying.

## **Causes / Risk Factors:**

Panic disorder is influenced by a combination of biological and environmental factors. A genetic predisposition plays an important role, as individuals with a family history of anxiety or panic disorders are more likely to develop the condition. In addition, a neurochemical imbalance, particularly involving neurotransmitters such as serotonin and norepinephrine, can disrupt the brain’s regulation of fear and stress responses, increasing vulnerability to panic attacks. Stressful life events, including trauma, major life changes, or prolonged psychological stress, often act as triggers that precipitate the onset of the disorder. Furthermore, substance use, especially the excessive intake of caffeine or stimulants, can heighten physiological arousal and provoke or worsen panic symptoms, contributing to the development or persistence of panic disorder.

## **Diagnosis of Panic Disorder:**

The diagnosis of panic disorder is primarily clinical and is based on established criteria such as those outlined in the DSM-5. It requires the presence of recurrent, unexpected panic attacks—sudden episodes of intense fear or discomfort that reach a peak within minutes and are accompanied by symptoms such as palpitations, sweating, trembling, shortness of breath, chest pain, dizziness, or fear of losing control or dying. For a formal diagnosis, at least one of the attacks must be followed by a period of one month or more of persistent concern about having additional attacks or their consequences, or significant maladaptive changes in behavior, such as avoidance of situations that might trigger attacks. It is also essential to rule out other medical conditions (e.g., cardiac disorders, thyroid dysfunction) and substance use that could explain the symptoms. Differential diagnosis is important to distinguish panic disorder from other psychiatric conditions such as Generalized Anxiety Disorder, Social Anxiety Disorder, and Specific Phobia. A thorough clinical interview, patient history, and sometimes physical examination and laboratory tests are used to ensure an accurate diagnosis.

## **Treatment:**

The management of panic disorders is multimodal, involving a combination of psychotherapy, pharmacological treatment, and supportive lifestyle modifications. The primary aim is to reduce the frequency and intensity of panic attacks, prevent relapses, and restore the individual’s normal daily functioning. Treatment is usually individualized depending on the severity of symptoms and patient response.

Psychotherapy is considered the first-line treatment, with Cognitive Behavioral Therapy (CBT) being the most effective and widely recommended approach. CBT works by helping patients understand that panic attacks, although distressing, are not life-threatening. Through psychoeducation, patients learn about the

nature of panic symptoms, which reduces fear and misinterpretation. Cognitive restructuring helps identify and correct irrational thoughts such as “I am going to die” or “I am losing control.” Another key component is exposure therapy, which includes *interoceptive exposure*—where physical sensations like rapid breathing are intentionally induced to reduce fear—and *situational exposure*, where patients gradually confront avoided situations such as crowded places or traveling. In addition, relaxation techniques, including deep breathing exercises and progressive muscle relaxation, help reduce physiological arousal. Overall, CBT helps break the vicious cycle of panic → fear → avoidance → increased panic.

Pharmacotherapy is introduced when symptoms are moderate to severe or when psychotherapy alone does not provide sufficient relief. The first-line medications are selective serotonin reuptake inhibitors (SSRIs) such as Sertraline, Fluoxetine, and Paroxetine. These drugs are generally started at a low dose and gradually increased to minimize side effects. Patients should be informed that therapeutic effects may take 2–4 weeks to become noticeable, and treatment is usually continued for 6–12 months after symptom improvement to prevent relapse. An alternative option includes serotonin-norepinephrine reuptake inhibitors (SNRIs) such as Venlafaxine.

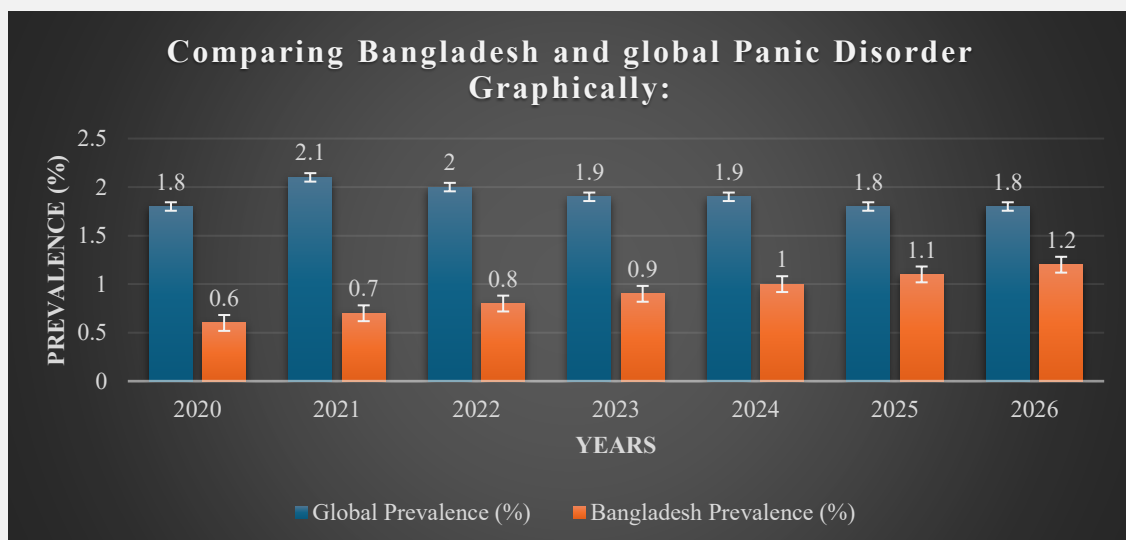
For short-term relief of severe anxiety or acute panic attacks, benzodiazepines like Alprazolam and Clonazepam may be used. However, their use is limited to brief periods due to the risk of dependence, sedation, and cognitive impairment. Other less commonly used medications include tricyclic antidepressants such as Imipramine and monoamine oxidase inhibitors, which are typically reserved for treatment-resistant cases.

In addition to medical and psychological interventions, lifestyle and supportive measures play an important role in recovery. Patients are advised to avoid stimulants such as caffeine and nicotine, maintain regular physical exercise, ensure adequate sleep, and practice stress management techniques like meditation or yoga. Education of both the patient and their family is essential to improve understanding, adherence to treatment, and emotional support.

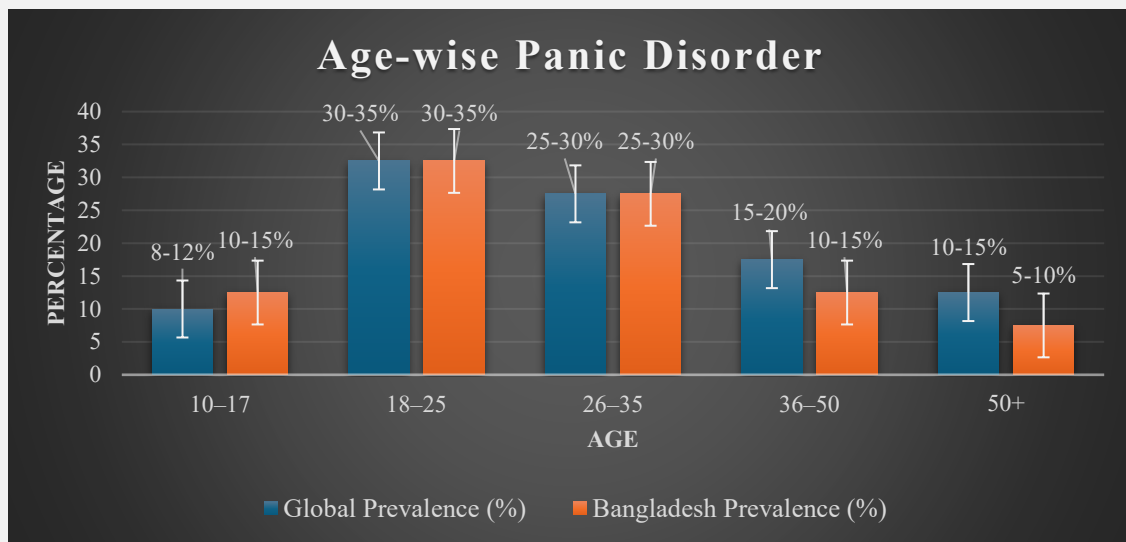
A stepwise approach is often followed in management. Mild cases may respond well to CBT alone, while moderate cases usually require a combination of CBT and an SSRI. Severe cases may need SSRIs along with short-term benzodiazepines and psychotherapy. In resistant cases, switching medications or referring to a specialist is recommended.

The prognosis of panic disorder is generally good with appropriate treatment. Many patients achieve significant improvement or complete remission. However, relapse can occur, especially if treatment is discontinued prematurely, highlighting the importance of adherence and follow-up.

### Comparing Bangladesh and Global Panic Disorder Graphically:



## Age-Wise Panic Disorder:



## OBSESSIVE-COMPULSIVE DISORDER (OCD)

Obsessive-Compulsive Disorder is a chronic neurotic disorder characterized by the presence of obsessions (intrusive, unwanted thoughts, urges, or images) and/or compulsions (repetitive behaviors or mental acts) that a person feels driven to perform, causing significant distress and impairment treatment.

### Common Symptoms:

Obsessive-Compulsive Disorder (OCD) is characterized by a pattern of obsessions and compulsions that significantly interfere with daily life. Obsessions are persistent, intrusive, and unwanted thoughts, urges, or images that cause marked anxiety or distress. Common examples include fears of contamination (e.g., germs or dirt), excessive concern about harm coming to oneself or others, unwanted taboo thoughts (such as aggressive or sexual images), and a strong need for symmetry or exactness.

In response to these distressing thoughts, individuals develop compulsions, which are repetitive behaviors or mental acts performed to reduce anxiety or prevent a feared outcome. Typical compulsions include excessive handwashing or cleaning, repeated checking (such as ensuring doors are locked or appliances are off), counting, arranging items in a specific order, or silently repeating words or prayers. Although these behaviors may provide temporary relief, they do not address the underlying anxiety and often become time-consuming.

People with OCD usually recognize that their thoughts and behaviors are irrational or excessive, but they feel unable to control them. Over time, these symptoms can lead to significant impairment in social, academic, or occupational functioning, making early recognition and treatment essential.

### **Causes or Risk factors:**

Obsessive-Compulsive Disorder does not have a single known cause. Instead, it develops through a combination of biological, psychological, and environmental factors that interact over time.

One major factor is **genetics**. Individuals with a family history of OCD or other anxiety disorders are at a higher risk, suggesting a hereditary component. However, genes alone do not determine whether someone will develop the disorder.

**Neurobiological factors** also play an important role. Research indicates abnormalities in certain brain areas—particularly those involved in decision-making, impulse control, and habit formation (such as the orbitofrontal cortex and basal ganglia). Imbalances in neurotransmitters, especially **serotonin**, are believed to contribute to OCD symptoms.

Another contributing factor is **behavioral and cognitive patterns**. People who are overly perfectionistic, have a heightened sense of responsibility, or tend to overestimate danger are more vulnerable. These thinking styles can make intrusive thoughts more distressing and harder to dismiss.

**Environmental factors** can trigger or worsen OCD. Stressful life events—such as trauma, illness, loss of a loved one, or major life changes—may precipitate symptoms, particularly in those already predisposed. In children, certain infections (like streptococcal infections) have been linked to sudden onset OCD symptoms in rare cases, a condition sometimes referred to as PANDAS.

Additionally, **personality traits** such as being highly organized, rigid, or detail-oriented may increase susceptibility, although they do not directly cause the disorder.

In summary, OCD arises from a complex interaction of genetic vulnerability, brain chemistry, psychological tendencies, and environmental stressors, rather than a single identifiable cause.

### **Diagnosis of OCD:**

Obsessive-Compulsive Disorder is diagnosed clinically based on characteristic symptoms and their impact on daily functioning. There is no single laboratory test to confirm OCD; instead, mental health professionals rely on established diagnostic criteria and careful assessment.

The diagnosis is commonly guided by criteria from the DSM-5. According to these guidelines, the key features include the presence of obsessions, compulsions, or both. Obsessions are recurrent, persistent, intrusive thoughts, urges, or images that cause significant anxiety or distress. Compulsions are repetitive behaviors (such as washing or checking) or mental acts (like counting or praying) that a person feels driven to perform in response to an obsession or according to rigid rules.

For a formal diagnosis, these symptoms must be time-consuming (typically taking more than one hour per day) or cause clinically significant distress or impairment in social, occupational, or other important areas of functioning. Additionally, the person usually recognizes that the obsessions and compulsions are excessive or unreasonable (although this insight may vary).

It is also essential to rule out other causes. The symptoms should not be due to the effects of substances (such as drugs or medications) or another medical condition. Clinicians also differentiate OCD from related disorders such as generalized anxiety disorder, phobias, or psychotic disorders.

Assessment often includes a detailed clinical interview and may use standardized tools like the Yale-Brown Obsessive Compulsive Scale to measure the severity of symptoms and monitor treatment progress.

### **Treatment:**

Management of Obsessive-Compulsive Disorder is multimodal, combining psychotherapy, medication, and supportive strategies. The goal is to reduce obsessive thoughts, control compulsive behaviors, and improve overall functioning.

The first-line treatment is psychotherapy, particularly Cognitive Behavioral Therapy (CBT). A specialized form of CBT called Exposure and Response Prevention (ERP) is considered the most effective approach. In ERP, patients are gradually exposed to anxiety-provoking situations (such as touching a contaminated object) and are guided to resist performing compulsive behaviors. Over time, this reduces anxiety and weakens the cycle of obsession and compulsion.

Medications are also widely used, especially in moderate to severe cases. The most commonly prescribed drugs are Selective Serotonin Reuptake Inhibitors (SSRIs), such as Fluoxetine, Sertraline, and Fluvoxamine. These medications help regulate serotonin levels in the brain and reduce OCD symptoms. In some cases, a tricyclic antidepressant like Clomipramine may be used, particularly if SSRIs are not effective.

For patients who do not respond adequately to standard treatments, augmentation strategies may be considered. This can include adding low-dose antipsychotic medications or combining different therapeutic approaches. In severe, treatment-resistant cases, advanced options like deep brain stimulation or neurosurgical procedures may be explored.

In addition to medical and psychological treatments, lifestyle modifications play a supportive role. Stress management, regular physical activity, adequate sleep, and family support can help reduce symptom severity and improve coping.

### **Comparative Table: Global Vs Bangladesh.**

<b>Parameter</b>	<b>Global</b>	<b>Bangladesh</b>
Lifetime prevalence	~ 2-3 %	~ 0.5 – 1.5 %
12-month prevalence	~1-2 %	~ 0.3 – 1 %
Trend (2020-2026)	Increase during COVID and then stable	Gradually increasing.

Gender distribution	Females are slightly more affected.	Similar or slightly higher in females.
Age of onset	Adolescence to early adulthood	Same, but often diagnosed later.
Most affected age group	18-35 years	18-35 years
Urban Vs rural	Higher in urban areas	Much higher in urban areas.
Awareness level	High	Moderate but improving
Treatment access	Moderate to high	Limited
Treatment gap	~ 30 – 50 % untreated	~ 70 – 90 % untreated

## **SOCIAL ANXIETY DISORDER (SOCIAL PHOBIA)**

Social Anxiety Disorder is a neurotic (anxiety) disorder characterized by an intense, persistent fear of social or performance situations where a person may be scrutinized, judged, or embarrassed by others, leading to avoidance and significant distress.

**Common Symptoms:**

Social Anxiety Disorder is characterized by an intense and persistent fear of social or performance situations where an individual may be exposed to scrutiny by others. A central feature is the fear of negative evaluation, where the person worries about being judged, embarrassed, humiliated, or rejected. This fear is often disproportionate to the actual situation but feels very real and overwhelming to the individual.

People with this disorder commonly experience marked anxiety in social interactions, such as speaking in public, meeting new people, eating in front of others, or participating in group activities. These situations are either avoided or endured with extreme distress. The anxiety may manifest physically through symptoms like sweating, trembling, blushing, rapid heartbeat, or difficulty speaking.

Another important feature is anticipatory anxiety, where individuals worry excessively about upcoming social events days or even weeks in advance. After the event, they may engage in post-event rumination, repeatedly analyzing their behavior and fearing they performed poorly.

Individuals with social anxiety disorder often recognize that their fear is excessive, yet they feel unable to control it. Over time, this leads to avoidance behavior, which can significantly interfere with academic performance, work responsibilities, and relationships. The condition is typically chronic if left untreated but can be effectively managed with appropriate therapy and support.

**Causes or risk factors:**

Social Anxiety Disorder develops due to a combination of biological, psychological, and environmental influences rather than a single identifiable cause. One important factor is *genetic predisposition*. Individuals with a family history of anxiety disorders are more likely to develop social anxiety, suggesting that inherited traits play a role in vulnerability.

*Brain function and neurobiology* also contribute to the disorder. Overactivity in areas of the brain involved in fear processing—particularly the amygdala—can make individuals more sensitive to perceived social threats. Imbalances in neurotransmitters such as serotonin may further influence anxiety levels and emotional regulation.

*Personality traits* are another key factor. People who are naturally shy, introverted, or behaviorally inhibited during childhood are at greater risk. These individuals tend to be more cautious and fearful in unfamiliar social situations, which can gradually develop into persistent anxiety.

*Cognitive factors* also play a role. Individuals with social anxiety often have negative thinking patterns, such as fear of embarrassment, excessive self-consciousness, and a tendency to overestimate how critically others are judging them. These distorted beliefs reinforce avoidance behaviors.

*Environmental influences* are equally significant. Experiences such as bullying, criticism, rejection, or humiliation, especially during childhood or adolescence—can trigger or worsen social anxiety. Overprotective or highly controlling parenting styles may also limit a child's ability to develop confidence in social interactions.

## **Diagnosis:**

Social Anxiety Disorder (also known as social phobia) is diagnosed clinically based on a detailed psychological assessment and established diagnostic criteria. Mental health professionals rely primarily on guidelines from the DSM-5 to confirm the condition.

The diagnosis requires the presence of a marked and persistent fear of social or performance situations in which the individual may be exposed to scrutiny by others. Common examples include speaking in public, meeting new people, or eating in front of others. The person fears that they will act in a way that will be embarrassing or lead to negative evaluation.

Exposure to such situations almost always provokes intense anxiety, which may take the form of panic attacks or severe distress. As a result, individuals tend to avoid social situations or endure them with extreme discomfort. For a formal diagnosis, these symptoms must be persistent (typically lasting 6 months or more) and cause significant impairment in social, academic, or occupational functioning.

An important diagnostic feature is that the fear is out of proportion to the actual threat posed by the situation. In many cases, individuals recognize that their fear is excessive, although this insight may vary. Clinicians must also rule out other possible causes. The symptoms should not be attributable to substances, medical conditions, or other mental disorders such as panic disorder, body dysmorphic disorder, or autism spectrum disorder. A thorough clinical interview is often supplemented by standardized assessment tools, such as the Liebowitz Social Anxiety Scale, to evaluate severity.

## **Treatment:**

Social Anxiety Disorder is a highly treatable condition, and effective management typically involves a combination of psychotherapy, medication, and supportive lifestyle strategies. The primary goal is to reduce fear in social situations, improve confidence, and restore normal social and occupational functioning.

The first-line treatment is Cognitive Behavioral Therapy (CBT). This therapy helps individuals identify and challenge negative thought patterns, such as fear of embarrassment or rejection, and replace them with more realistic and balanced thinking. A key component of CBT is exposure therapy, where individuals are gradually and systematically exposed to feared social situations (e.g., speaking in public or interacting with strangers). Over time, repeated exposure reduces anxiety and builds confidence.

Medications are often used, especially in moderate to severe cases. The most commonly prescribed are Selective Serotonin Reuptake Inhibitors (SSRIs), such as Sertraline and Paroxetine. These help regulate serotonin levels and reduce anxiety symptoms. Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs) like Venlafaxine are also effective alternatives. In specific situations, such as performance anxiety, short-term use of beta-blockers like Propranolol may help control physical symptoms like tremors and rapid heartbeat.

Other supportive approaches include social skills training, relaxation techniques (such as deep breathing and mindfulness), and stress management. Involving family or support groups can also enhance recovery by providing encouragement and reducing isolation.

In summary, treatment of Social Anxiety Disorder focuses on a structured combination of therapy and medication, with CBT as the cornerstone. With proper intervention, most individuals experience significant improvement and are able to function more comfortably in social situations.

## **POST-TRAUMATIC STRESS DISORDER (PTSD)**

Post-Traumatic Stress Disorder is a mental health disorder that develops after exposure to a traumatic or life-threatening event, causing persistent symptoms such as re-experiencing the trauma, avoidance, negative mood changes, and increased arousal, lasting for more than one month.

**Common Symptoms:** Post-Traumatic Stress Disorder is characterized by a variety of psychological and physical symptoms that develop after experiencing or witnessing a traumatic event. One of the most common symptoms is re-experiencing the trauma, where the individual may suffer from distressing memories, flashbacks, or nightmares related to the event. People with PTSD often try to avoid reminders of the trauma, such as certain places, people, or conversations, because these triggers increase anxiety and emotional distress. Another major symptom is negative changes in mood and thinking, including feelings of fear, guilt, hopelessness, emotional numbness, and loss of interest in daily activities. Individuals may also experience hyperarousal symptoms, such as irritability, anger, difficulty concentrating, sleep disturbances, and being easily startled. These symptoms can significantly interfere with social relationships, work, and daily functioning if not properly treated.

### **Causes or Risk Factors:**

Post-Traumatic Stress Disorder (PTSD) develops after exposure to a traumatic or life-threatening event, but not everyone who experiences trauma develops the disorder. Several biological, psychological, and environmental factors increase the risk of PTSD. Severe trauma such as war, physical assault, sexual violence, natural disasters, serious accidents, or the sudden death of a loved one are major triggering factors. Individuals who experience repeated or prolonged trauma are at greater risk. A previous history of anxiety, depression, or other mental illnesses can also make a person more vulnerable. Childhood abuse, neglect, or early-life trauma significantly increase susceptibility later in life. Lack of family or social support after the traumatic event may worsen emotional distress and hinder recovery. Genetic predisposition and abnormalities in stress-related brain chemicals and hormones may also contribute to the disorder. In addition, high levels of stress, poor coping skills, substance abuse, and ongoing life difficulties can increase the likelihood of developing PTSD. Overall, PTSD results from a combination of traumatic exposure and individual vulnerability factors that affect the person's ability to cope with extreme stress.

### **Diagnosis:**

The diagnosis of PTSD is primarily based on clinical evaluation and history taking. A person is diagnosed with PTSD when symptoms develop after exposure to a traumatic event such as war, physical assault, natural disaster, serious accident, or sexual violence. According to diagnostic guidelines, the symptoms must persist for more than one month and cause significant distress or impairment in social, occupational, or personal functioning.

The clinician first confirms whether the individual has experienced or witnessed a traumatic event. After this, the patient is assessed for the major symptom clusters of PTSD, including intrusive symptoms, avoidance behavior, negative changes in mood and cognition, and hyperarousal symptoms. Intrusive symptoms include flashbacks, nightmares, and distressing memories related to the trauma. Avoidance symptoms involve avoiding places, people, or situations that remind the person of the traumatic event. Negative mood symptoms may include guilt, hopelessness, emotional numbness, or loss of interest in activities. Hyperarousal symptoms include irritability, sleep disturbance, poor concentration, and exaggerated startle response.

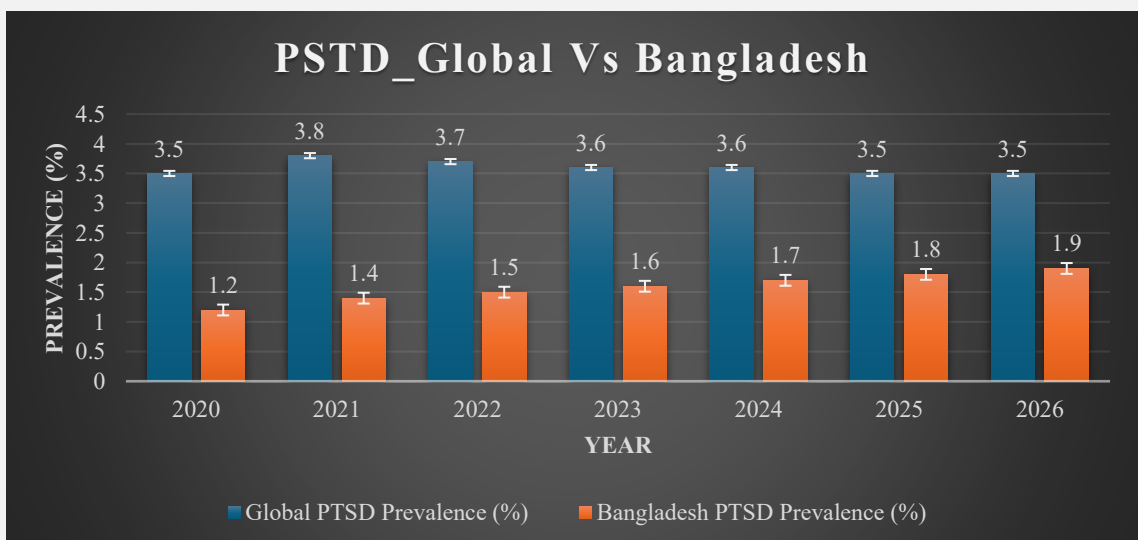
Mental health professionals may use structured interviews and standardized screening tools, such as the PTSD Checklist (PCL-5) or the Clinician-Administered PTSD Scale (CAPS), to support diagnosis. It is also important to rule out other mental disorders, substance abuse, or medical conditions that may produce similar symptoms. Early and accurate diagnosis is essential because proper treatment can significantly improve the patient's quality of life and reduce long-term complications.

### Treatment:

Treatment of Post-Traumatic Stress Disorder mainly involves psychotherapy, medications, and supportive care. The primary goal of treatment is to reduce traumatic memories, control anxiety, improve emotional stability, and help the patient return to normal daily functioning. Psychotherapy is considered the first-line treatment, especially trauma-focused Cognitive Behavioral Therapy (CBT), which helps patients identify and change negative thoughts related to the traumatic event. Exposure therapy is also effective, as it gradually helps individuals face trauma-related memories and situations in a safe environment, reducing fear and avoidance behaviors. Another important therapy is Eye Movement Desensitization and Reprocessing (EMDR), which helps patients process traumatic memories in a healthier way.

Medications are commonly used when symptoms are severe or persistent. Selective Serotonin Reuptake Inhibitors (SSRIs) such as Sertraline and Paroxetine are widely prescribed to reduce anxiety, depression, and intrusive thoughts. In some cases, anti-anxiety medicines or sleep medications may be used for short-term relief of insomnia and severe distress. Supportive measures such as family support, counseling, stress management, regular exercise, relaxation techniques, and maintaining good sleep habits are also important parts of recovery. Early diagnosis and proper treatment can significantly improve quality of life and help individuals manage PTSD symptoms effectively.

### Comparison of PTSD between global and Bangladesh.



## **PERSISTENT DEPRESSIVE DISORDER (DYSTHYMIA)**

Persistent Depressive Disorder is a chronic mood disorder characterized by a persistently depressed mood lasting for at least 2 years in adults (or 1 year in children and adolescents), accompanied by symptoms such as low energy, poor self-esteem, hopelessness, and disturbed sleep or appetite.

### **Common Symptoms:**

Common symptoms of Persistent Depressive Disorder include a long-lasting depressed mood that persists for most of the day and continues for at least two years in adults. Individuals with this disorder often feel sad, hopeless, or emotionally empty for extended periods. They commonly experience low energy and fatigue, making daily activities difficult to perform. Sleep disturbances are also frequent, including insomnia or excessive sleeping. Changes in appetite may occur, leading to either poor appetite or overeating. Many patients develop low self-esteem and feelings of inadequacy, often believing they are incapable or unsuccessful. Difficulty concentrating, poor decision-making, and reduced productivity are also common. In addition, people with persistent depressive disorder may lose interest in social activities and struggle to enjoy life. Although the symptoms are usually less severe than major depressive disorder, they are chronic and can significantly affect personal, social, and occupational functioning over time.

### **Causes or risk factors:**

The causes and risk factors of Persistent Depressive Disorder are multifactorial and involve biological, psychological, and environmental influences. One of the major risk factors is a genetic predisposition, as individuals with a family history of depression or other mood disorders are more likely to develop the condition. Neurochemical imbalances in the brain, particularly involving neurotransmitters such as serotonin, norepinephrine, and dopamine, also play an important role in the development of persistent depressive disorder. Chronic stress, traumatic life events, emotional neglect, childhood abuse, or long-term social difficulties can contribute significantly to the disorder. Certain personality traits, such as low self-esteem, pessimism, excessive self-criticism, and dependency, may increase vulnerability. In addition, ongoing medical illnesses, substance abuse, lack of social support, and financial or relationship problems can worsen the risk. Because the disorder develops gradually and lasts for a long time, many patients may not recognize their symptoms early, which can delay diagnosis and treatment.

### **Diagnosis:**

Diagnosis of Persistent Depressive Disorder is mainly based on a detailed clinical assessment of the patient's emotional state, behavior, and duration of symptoms. A healthcare professional evaluates whether the individual has experienced a chronic low mood for a prolonged period along with associated emotional and physical difficulties. During the diagnostic process, the clinician carefully explores the patient's personal history, daily functioning, relationships, work performance, and emotional responses to identify persistent depressive patterns. Mental status examination is also important to assess mood, thought content, concentration, motivation, and self-esteem.

To establish the diagnosis, doctors must rule out other psychiatric and medical conditions that may produce similar symptoms, such as major depressive disorder, bipolar disorder, thyroid disease, substance abuse, or medication-related mood changes. Laboratory investigations may sometimes be performed to exclude underlying physical illnesses. Screening tools and psychological questionnaires can support the evaluation, but diagnosis ultimately depends on clinical judgment and established diagnostic criteria. Early recognition is important because persistent depressive disorder often develops gradually and may remain unnoticed for many years, significantly affecting social, occupational, and personal functioning.

**Treatment:**

Treatment of Persistent Depressive Disorder requires a long-term and comprehensive approach because the condition develops gradually and often persists for many years. The main objective of treatment is to improve mood, increase motivation and functioning, prevent worsening into major depression, and help the individual regain emotional stability and quality of life. Since people with persistent depressive disorder may become accustomed to chronic sadness and low self-esteem, treatment often focuses not only on symptom relief but also on changing deeply rooted negative thinking patterns and unhealthy coping behaviors.

Psychotherapy plays a major role in management. Cognitive Behavioral Therapy (CBT) is widely used to help patients recognize persistent negative beliefs, self-criticism, hopelessness, and pessimistic thinking. Therapy teaches healthier thought processes, emotional regulation, and practical problem-solving skills. Interpersonal therapy can also be beneficial, especially when chronic relationship conflicts, social isolation, or unresolved emotional experiences contribute to the depressive symptoms. In long-standing cases, supportive psychotherapy helps individuals rebuild confidence, improve communication skills, and develop healthier social interactions.

Pharmacological treatment is often necessary when symptoms significantly interfere with daily functioning. Antidepressant medications help regulate neurotransmitters involved in mood control and emotional balance. Improvement may occur slowly, so treatment is usually continued for an extended period to prevent relapses. Careful monitoring is important because patients with chronic depression may experience fluctuations in mood, motivation, sleep, and appetite during recovery.

Lifestyle modification is another essential component of treatment. Regular physical activity can improve energy levels and stimulate positive mood-related brain chemicals. Establishing a consistent sleep schedule, maintaining balanced nutrition, and reducing alcohol or substance use are important for emotional stability. Social support from family, friends, or support groups helps reduce feelings of loneliness and hopelessness. Stress-management techniques such as mindfulness, meditation, relaxation exercises, and structured daily routines may also improve long-term outcomes.

In severe or treatment-resistant cases, additional interventions may be considered under specialist supervision. Early recognition and continuous treatment are important because untreated persistent depressive disorder can negatively affect academic performance, employment, relationships, and overall quality of life. With proper therapy, medication, and psychosocial support, many individuals can achieve significant improvement and lead productive lives.

## **SPECIFIC PHOBIAS**

Specific Phobia is an anxiety (neurotic) disorder characterized by an intense, irrational, and persistent fear of a specific object, situation, or activity, leading to immediate anxiety and avoidance behavior, even when the actual danger is minimal or absent.

**Common Symptoms:**

The common symptoms of Specific Phobia usually appear when a person encounters, anticipates, or even thinks about a particularly feared object or situation. The reaction is often immediate and much stronger than the actual level of danger. Individuals commonly experience an overwhelming sense of fear, nervousness, or dread that feels difficult to control. Many people become intensely aware of their surroundings and may feel trapped or helpless in the presence of the feared stimulus. Even imagining the situation can produce marked emotional discomfort and anticipatory anxiety.

Physical symptoms are also very common because the body activates a strong “fight-or-flight” response. A person may experience rapid breathing, chest tightness, dry mouth, shakiness, muscle tension, or a sudden feeling of weakness. Some individuals feel lightheaded or unstable, while others report stomach discomfort, nausea, or a choking sensation. In certain cases, exposure to the phobic trigger can provoke a full panic-like reaction with overwhelming fear and a strong urge to escape immediately. Blood-injection-injury phobias are somewhat unique because they may cause a sudden drop in blood pressure, leading to dizziness or fainting.

Behavioral symptoms mainly involve avoidance. People often go to great lengths to stay away from the feared object or situation, even when doing so interferes with daily activities, education, travel, work, or relationships. For example, someone with a fear of elevators may climb many flights of stairs, while a person afraid of flying may avoid important travel opportunities. Over time, this avoidance behavior can become habitual and may significantly restrict a person’s lifestyle and independence.

Emotional and cognitive symptoms are also important features. Individuals frequently recognize that their fear is excessive or irrational, yet they still feel unable to control it. Persistent worry about accidentally encountering the feared situation can create ongoing stress and tension. Some people become embarrassed by their reactions and may hide their fear from others to avoid judgment or criticism. Long-term untreated phobias can gradually reduce self-confidence and increase social withdrawal or emotional distress.

### **Causes or Risk Factors:**

The development of Specific Phobia is usually the result of a combination of biological, psychological, and environmental influences rather than a single cause. One important contributing factor is genetic vulnerability. Individuals with a family history of anxiety disorders or phobias are more likely to develop similar conditions, suggesting that inherited traits may influence how the brain processes fear and threat. This genetic predisposition does not directly cause the disorder but increases sensitivity to anxiety-provoking stimuli.

Another major risk factor is early life experiences and conditioning. A specific phobia may develop after a traumatic or frightening encounter involving a particular object or situation. For example, a distressing experience such as being bitten by an animal or experiencing a panic episode in an enclosed space can create a strong fear association. Over time, the brain learns to link the previously neutral stimulus with danger, leading to persistent fear responses even in safe conditions.

Observational learning also plays an important role. Children, in particular, may develop phobias by observing fearful reactions in parents or close caregivers. If a child repeatedly sees a family member showing extreme fear toward something like insects or heights, they may internalize that fear as a learned behavior. Similarly, cultural or environmental influences can reinforce avoidance behaviors and contribute to long-term fear development.

From a neurobiological perspective, abnormalities in brain structures involved in fear processing, especially the amygdala, are believed to contribute to excessive fear responses. An overactive fear system may cause harmless stimuli to be perceived as threatening, leading to exaggerated anxiety reactions. Imbalances in neurotransmitters that regulate mood and fear, such as serotonin and gamma-aminobutyric acid (GABA), may also increase vulnerability.

Personality traits can further influence risk. Individuals who are naturally more inhibited, sensitive, or cautious may be more prone to developing phobias. Such traits may make a person more reactive to stress and more likely to avoid unfamiliar situations, reinforcing fear over time. Additionally, chronic stress, lack of coping skills, and limited exposure to challenging situations during development can strengthen avoidance patterns.

**Diagnosis:**

Diagnosis of Specific Phobia is primarily a clinical diagnosis, meaning it is based on careful assessment of symptoms rather than laboratory tests or imaging. The diagnostic process begins with a detailed psychiatric history, where the clinician explores the patient's fear response to a particular object or situation, its duration, severity, and impact on daily life. A key aspect of diagnosis is identifying whether the fear is out of proportion to the actual danger and whether it consistently triggers strong anxiety when the person is exposed to or anticipates exposure to the phobic stimulus.

During evaluation, the clinician assesses the pattern of avoidance behavior, as individuals with specific phobias often go to great lengths to avoid the feared object or situation. This avoidance may interfere with normal functioning, such as avoiding travel due to fear of flying or refusing medical procedures due to fear of needles. The diagnosis also considers whether the fear response is persistent, typically lasting for six months or longer, to distinguish it from normal transient fears that many individuals may experience. A thorough mental status examination is conducted to evaluate the emotional and physiological response when the phobic stimulus is discussed or imagined. Patients may show visible signs of anxiety such as increased heart rate, sweating, trembling, or distress. Importantly, clinicians ensure that the fear is not better explained by another mental disorder, such as social anxiety disorder, panic disorder, or obsessive-compulsive disorder, where fears may be more generalized or linked to different mechanisms.

Diagnostic guidelines also require assessing the level of functional impairment, which means determining how much the phobia disrupts the person's occupational, academic, or social life. In some cases, standardized questionnaires or structured interviews may be used to support the diagnosis, but they are not strictly necessary.

**Treatment:**

Treatment of Specific Phobia focuses mainly on reducing fear responses, eliminating avoidance behavior, and helping the person regain normal functioning when exposed to the feared object or situation. The most effective approach is psychological treatment, especially techniques that directly address fear conditioning.

A key method is graded exposure therapy, where the individual is gradually and systematically exposed to the feared stimulus in a controlled and safe environment. The process usually starts with the least frightening situation and slowly progresses to more challenging exposures. For example, someone with a fear of elevators may first look at pictures of elevators, then stand near one, and eventually ride it. This repeated exposure helps the brain learn that the feared situation is not actually dangerous, leading to a gradual reduction in anxiety.

Another important psychological approach is systematic desensitization, which combines relaxation techniques with gradual exposure. The patient is trained in deep breathing or muscle relaxation and then exposed to fear-related stimuli while maintaining a relaxed state. Over time, this reduces the physical anxiety response associated with the phobia. Cognitive techniques are also used to challenge irrational beliefs and replace them with more realistic interpretations of the feared situation.

In some cases, short-term medication may be used to manage severe anxiety symptoms, especially when exposure therapy is being initiated. These medications do not cure the phobia but can help reduce extreme anxiety that interferes with therapy. For performance-related or situational fears, temporary medication may be prescribed to control physical symptoms such as rapid heartbeat or tremors.

Supportive counseling is also important, as it helps patients understand the nature of their fear and builds confidence in facing avoided situations. Education about the condition, reassurance, and encouragement from family or therapists can improve treatment outcomes. Relaxation training, mindfulness practices, and stress management techniques further support recovery by lowering overall anxiety levels.

With consistent treatment, most individuals with specific phobias show significant improvement and can gradually overcome their fears, leading to better daily functioning and quality of life.

## **SOMATIZATION DISORDER (SOMATIC SYMPTOM DISORDER)**

Somatic Symptom Disorder is a mental disorder characterized by persistent physical symptoms that cause significant distress and disruption in daily life, accompanied by excessive thoughts, anxiety, or behaviors related to those symptoms, even when no serious medical cause is found or the symptoms are disproportionate to the actual medical condition.

### **Common Symptoms:**

Common symptoms of Somatic Symptom Disorder involve persistent physical complaints that cause significant distress and interfere with daily functioning, even when medical examinations cannot fully explain the severity of the symptoms. Individuals with this disorder experience excessive thoughts, anxiety, and concern about their physical health. The symptoms are real to the patient and may affect multiple body systems over a long period of time.

One of the most common symptoms is chronic pain, which may occur in areas such as the head, abdomen, back, joints, or muscles. The pain often changes in intensity and location and may persist despite medical treatment. Fatigue and weakness are also frequent complaints, causing reduced energy levels and difficulty performing routine activities. Many patients experience gastrointestinal symptoms such as nausea, bloating, stomach cramps, diarrhea, constipation, or indigestion. Neurological-like symptoms can also occur, including dizziness, numbness, tingling sensations, faintness, or difficulty concentrating.

Patients with somatic symptom disorder commonly become highly preoccupied with their health and may repeatedly check their bodies for signs of illness. Minor physical sensations are often interpreted as serious diseases, leading to frequent doctor visits, repeated medical tests, and excessive health-related anxiety. Some individuals may constantly seek reassurance from healthcare professionals or family members, while others may avoid activities due to fear that symptoms will worsen.

Emotional and psychological symptoms are also closely associated with the disorder. Anxiety, depression, irritability, sleep disturbances, and difficulty coping with stress are common. The person may become overly focused on physical discomfort, causing social withdrawal, impaired work performance, and strained relationships. Symptoms often worsen during periods of emotional stress or conflict.

The severity of symptoms can vary from mild to disabling. Although the physical complaints may not be fully explained by a medical condition, the distress experienced by the patient is genuine and can significantly affect quality of life. Early recognition, psychological support, stress management, and appropriate treatment can help reduce symptom intensity and improve daily functioning.

### **Causes or Risk Factors:**

The causes and risk factors of Somatic Symptom Disorder are complex and involve an interaction of biological, psychological, and social factors. The disorder develops when emotional distress or psychological conflict is expressed through physical symptoms such as pain, weakness, fatigue, or gastrointestinal complaints. Although the symptoms may not be fully explained by a medical condition, they are real and can significantly affect a person's daily life and functioning.

One important contributing factor is psychological stress and trauma. Individuals who experience chronic stress, emotional neglect, abuse, family conflict, or traumatic life events may unconsciously convert emotional distress into physical symptoms. Childhood adversity, including physical or sexual abuse, is strongly associated with the later development of somatic symptom disorder. Some individuals may have difficulty expressing emotions verbally, so psychological distress appears in the form of bodily complaints.

Biological factors also play a role. Certain people may have an increased sensitivity to physical sensations and pain. Abnormal functioning of neurotransmitters involved in mood, stress, and pain perception may contribute to the disorder. Genetic predisposition can increase vulnerability, especially when there is a

family history of anxiety, depression, or other mental health conditions. Individuals with chronic medical illnesses may also become excessively focused on physical symptoms and health concerns.

Personality traits and coping styles are important risk factors as well. People who are highly anxious, emotionally sensitive, pessimistic, or excessively concerned about health are more likely to develop somatic symptom disorder. Poor coping skills and difficulty managing stress can increase symptom severity. Some individuals may unintentionally receive attention, sympathy, or emotional support because of their physical complaints, which can reinforce illness-related behaviors over time.

Social and environmental influences can further contribute to the disorder. Low educational level, financial difficulties, social isolation, family stress, and lack of emotional support may increase the risk. In some cultures, emotional suffering is more socially accepted when expressed physically rather than psychologically, leading individuals to focus more on bodily symptoms. Excessive exposure to medical information, repeated healthcare visits, or fear of serious illness can also intensify health anxiety and symptom preoccupation.

### **Treatment:**

Treatment of Somatic Symptom Disorder focuses on reducing excessive health-related anxiety, improving daily functioning, and helping the patient manage physical symptoms in a healthier way. Because individuals with this disorder experience persistent physical complaints that are closely linked to psychological distress, treatment requires a long-term, supportive, and multidisciplinary approach rather than repeated unnecessary medical investigations. The physician should establish a strong therapeutic relationship with the patient, provide reassurance without dismissing the symptoms, and schedule regular follow-up visits to reduce frequent emergency consultations and “doctor shopping.” Psychotherapy is considered the cornerstone of treatment. Cognitive Behavioral Therapy (CBT) is especially effective because it helps patients identify maladaptive thoughts, catastrophic interpretations of bodily sensations, and excessive illness-related fears. Therapy also teaches coping strategies, stress management, emotional regulation, and behavioral techniques that reduce symptom preoccupation. Mindfulness-based therapy and supportive psychotherapy may help patients become more aware of the connection between emotional stress and physical symptoms. Family therapy can also be useful when family dynamics reinforce illness behavior or dependency. Medications are mainly used when somatic symptom disorder is associated with anxiety, depression, insomnia, or chronic pain. Antidepressants are the most commonly prescribed class of medications because they help regulate mood, anxiety, and pain perception. Selective Serotonin Reuptake Inhibitors (SSRIs) such as Sertraline, Fluoxetine, and Escitalopram are frequently used to reduce anxiety and depressive symptoms. Serotonin–Norepinephrine Reuptake Inhibitors (SNRIs) such as Venlafaxine and Duloxetine may be particularly helpful when chronic pain is prominent. Tricyclic antidepressants (TCAs) like Amitriptyline can sometimes be prescribed in low doses for persistent pain symptoms and sleep disturbance. In selected cases with severe anxiety, short-term use of anxiolytic medications such as Clonazepam may be considered, although long-term use is generally avoided because of dependence risk. If insomnia is significant, non-benzodiazepine sleep aids or sedating antidepressants may also be used cautiously. Lifestyle modification is another important part of management. Patients are encouraged to maintain regular physical activity, structured daily routines, adequate sleep, and balanced nutrition. Relaxation exercises, breathing techniques, yoga, and meditation can reduce stress-related physical symptoms. Educating patients about the interaction between psychological stress and bodily sensations helps improve insight and treatment adherence. Avoiding excessive diagnostic testing and unnecessary medications is essential because repeated medical procedures can reinforce illness anxiety and worsen symptom focus. Successful treatment usually requires patience and continuity of care because symptom improvement tends to occur gradually. With proper psychotherapy, appropriate medication management, social support, and regular follow-up, many individuals experience significant reduction in distress and improvement in overall quality of life.

## **HYPOCHONDRIASIS (ILLNESS ANXIETY DISORDER)**

Illness Anxiety Disorder, formerly known as hypochondriasis, is a mental disorder characterized by excessive fear or preoccupation with having or developing a serious illness, despite having little or no physical symptoms and repeated medical reassurance.

### **Common Symptoms:**

Common symptoms of Illness Anxiety Disorder involve excessive fear and persistent worry about having or developing a serious medical illness, despite little or no medical evidence of disease. Individuals with this disorder become highly sensitive to normal body sensations and often misinterpret minor physical changes as signs of severe illness. The anxiety is usually disproportionate to the actual health condition and continues even after medical reassurance from doctors and diagnostic tests.

One of the most common symptoms is constant preoccupation with health and bodily functions. A person may repeatedly check their body for abnormalities such as lumps, skin changes, heartbeat variations, or breathing patterns. Minor symptoms like headaches, stomach discomfort, mild fatigue, or temporary pain may be interpreted as signs of dangerous diseases such as cancer, heart disease, or neurological disorders. This persistent fear often causes severe emotional distress and interferes with daily functioning.

People with illness anxiety disorder frequently seek reassurance from doctors, family members, or the internet. They may visit multiple healthcare providers, request repeated medical tests, or constantly search online for disease-related information. However, reassurance usually provides only temporary relief, and anxiety quickly returns. In some cases, individuals may show the opposite behavior by avoiding hospitals or medical appointments because they fear discovering a serious illness.

Psychological symptoms commonly include excessive anxiety, nervousness, irritability, difficulty concentrating, and constant fear about health-related issues. Sleep disturbances are also common because the individual remains mentally preoccupied with possible diseases. Many patients become highly aware of normal physical sensations, leading to repeated self-examination and compulsive monitoring behaviors. The disorder can significantly affect social, occupational, and personal life. Constant health worries may reduce work performance, create family stress, and limit participation in normal activities. Individuals may repeatedly discuss their fears with others or become socially withdrawn due to ongoing anxiety. Symptoms often persist for at least six months and may fluctuate depending on stress levels or exposure to illness-related information.

Overall, illness anxiety disorder is characterized by excessive health-related fear, repeated reassurance-seeking, misinterpretation of normal bodily sensations, and persistent anxiety that continues despite medical evaluation and reassurance.

### **Causes or Risk Factors:**

Hypochondriasis, now more accurately referred to as Illness Anxiety Disorder (IAD), is a psychological condition in which a person has a persistent and excessive fear of having a serious medical illness, despite having little or no physical symptoms. The development of this disorder is not caused by a single factor; rather, it results from a complex interaction of psychological, biological, environmental, and social influences.

At the psychological level, one of the most important contributors is heightened health anxiety and maladaptive thinking patterns. Individuals with Illness Anxiety Disorder tend to misinterpret normal bodily sensations—such as a mild headache, fatigue, or stomach discomfort—as signs of severe disease. This cognitive distortion is often reinforced by catastrophic thinking, where minor symptoms are immediately linked to life-threatening conditions like cancer or heart disease. Many patients also have underlying traits such as perfectionism, high sensitivity to bodily sensations (somatic hypervigilance), and difficulty tolerating uncertainty, which increase their vulnerability.

Early life experiences play a significant role as well. A history of serious childhood illness, either in the individual or in close family members, can condition a person to associate normal physical sensations with danger. Similarly, growing up in an environment where caregivers were overly protective or excessively worried about health can reinforce the belief that the body is fragile and constantly at risk. Exposure to repeated medical situations or hospital environments during childhood may also contribute to the development of illness-related anxiety later in life.

From a behavioral perspective, reinforcement cycles are crucial in maintaining the disorder. For example, when a person experiences anxiety about a symptom and then seeks medical reassurance (through doctor visits, internet searches, or repeated checking of the body), the anxiety temporarily decreases. This relief reinforces the behavior, making it more likely that the person will repeat it in the future. Over time, this creates a pattern of compulsive health-related checking and reassurance-seeking, which strengthens the disorder rather than reducing it.

Biological and neurological factors may also be involved. Some research suggests that individuals with illness anxiety may have heightened sensitivity in brain regions responsible for processing bodily sensations and fear responses, such as the insula and amygdala. This may lead to an exaggerated perception of normal physical changes. Genetic predisposition to anxiety disorders in general can also increase vulnerability, meaning that individuals with a family history of anxiety or depression may be at higher risk.

Social and environmental influences are another important component. The widespread availability of medical information on the internet has significantly contributed to “cyberchondria”, where individuals repeatedly search symptoms online and become increasingly convinced that they have a serious illness. Cultural beliefs about health and disease can also shape how symptoms are interpreted. In some societies, high emphasis on physical health or fear-based health messaging may increase health-related anxiety.

### **Treatment:**

Hypochondriasis, now more accurately termed Illness Anxiety Disorder, is a chronic psychological condition where an individual is persistently preoccupied with the belief that they have or will develop a serious medical disease, despite minimal or no physical symptoms. The treatment of this disorder is often challenging because patients strongly believe their concerns are medically justified. Therefore, effective management requires a combination of psychotherapy, pharmacotherapy, and supportive medical care.

The cornerstone of treatment is psychotherapy, particularly Cognitive Behavioral Therapy (CBT). CBT helps patients identify and modify distorted thought patterns, such as catastrophizing normal bodily sensations or misinterpreting minor symptoms as signs of severe illness. Through structured sessions, patients learn to reduce excessive health-related checking behaviors (such as repeatedly checking the body for symptoms or frequently seeking medical reassurance) and gradually develop tolerance for uncertainty about their health. Exposure techniques are also used, where patients are gently exposed to health-related triggers (like reading about diseases) without engaging in reassurance-seeking behaviors, which helps reduce anxiety over time.

Another important psychological approach is psychoeducation, where patients are educated about the nature of anxiety and how it can produce physical sensations such as palpitations, dizziness, or fatigue. Understanding the mind–body connection reduces misinterpretation of normal bodily signals. Additionally, mindfulness-based therapies can be helpful by encouraging patients to observe bodily sensations without judgment or immediate negative interpretation. This reduces the cycle of anxiety and health-related rumination.

In cases where symptoms are moderate to severe, or when psychotherapy alone is not sufficient, pharmacological treatment may be introduced. Selective Serotonin Reuptake Inhibitors (SSRIs) such as sertraline, fluoxetine, or paroxetine are commonly used. These medications help regulate serotonin levels in the brain, thereby reducing anxiety, obsessive thoughts, and health-related fears. In some cases,

Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs) may also be prescribed. Medication is typically used alongside psychotherapy rather than as a standalone treatment, and improvement may take several weeks.

A crucial but often overlooked aspect of management is the doctor–patient relationship. Patients with illness anxiety disorder frequently consult multiple physicians or undergo repeated medical tests. This behavior can unintentionally reinforce anxiety. Therefore, it is recommended that patients have a single primary care physician who coordinates care, limits unnecessary investigations, and provides consistent reassurance in a structured manner. Scheduled follow-up visits rather than on-demand consultations help reduce repeated reassurance-seeking behavior.

Lifestyle modification and supportive strategies also play an important role. Regular physical exercise, adequate sleep, stress management techniques, and avoidance of excessive online health information (“cyberchondria”) can significantly reduce symptom severity. Family support is equally important; family members are encouraged not to repeatedly validate illness fears but instead support therapeutic strategies and encourage treatment adherence.

Overall, the treatment of illness anxiety disorder requires patience and long-term commitment. With consistent psychotherapy, appropriate medication when needed, and structured medical support, most patients experience significant improvement in anxiety levels, reduced health-related preoccupation, and better overall functioning.

## **NEURASTHENIA (CHRONIC FATIGUE SYNDROME-RELATED)**

Neurasthenia is a psychological and somatic condition historically described as a state of nervous exhaustion. It is characterized by persistent fatigue, reduced physical and mental energy, irritability, poor concentration, and a feeling of being “mentally drained” even after minimal effort.

### **Common Symptoms:**

Neurasthenia (often historically described and in modern discussions loosely related to Chronic Fatigue Syndrome / Myalgic Encephalomyelitis (CFS/ME)) is characterized by a persistent state of mental and physical exhaustion that is not adequately relieved by rest. Although the term *neurasthenia* is less commonly used in modern psychiatry, many of its described symptom patterns overlap with what is now understood in Chronic Fatigue Syndrome, a complex and disabling condition affecting multiple body systems.

#### **1. Persistent and Debilitating Fatigue**

The hallmark symptom is chronic fatigue that is disproportionate to activity levels. Individuals experience an overwhelming sense of exhaustion even after minimal physical or mental effort. Importantly, this fatigue is not relieved by sleep or rest, which distinguishes it from ordinary tiredness. Patients often describe it as a “drained battery” feeling that persists throughout the day and may worsen after exertion.

#### **2. Post-Exertional Malaise (PEM)**

A defining feature of ME/CFS-related presentations is post-exertional malaise, where symptoms significantly worsen after physical, cognitive, or emotional stress. Even mild activities—such as walking short distances, reading, or concentrating for extended periods—can trigger a delayed crash lasting hours, days, or even longer. This symptom is central to functional impairment.

### 3. Cognitive Difficulties (“Brain Fog”)

Many individuals report cognitive impairment, commonly referred to as brain fog. This includes:

- Difficulty concentrating or sustaining attention
- Impaired short-term memory
- Slowed thinking and processing speed
- Trouble finding words or organizing thoughts

### 4. Sleep Disturbances

Despite extreme fatigue, sleep is often non-restorative. Patients may experience:

- Difficulty falling or staying asleep
- Frequent nighttime awakenings
- Early morning awakening
- Feeling unrefreshed even after long sleep durations

### 5. Neuromuscular Symptoms

Neurasthenia-related fatigue syndromes frequently include muscle weakness, heaviness, or aching without clear inflammation or injury. Some individuals report:

- Generalized body pain
- Muscle twitching or discomfort after minimal exertion
- Reduced physical endurance

### 6. Autonomic and Physical Dysregulation

A subset of patients experience symptoms suggestive of autonomic nervous system dysfunction, such as:

- Dizziness or lightheadedness, especially when standing (orthostatic intolerance)
- Palpitations or irregular heart sensations
- Temperature sensitivity (feeling too hot or too cold easily)
- Sweating abnormalities

### 7. Emotional and Psychological Symptoms

While not considered purely psychiatric, chronic fatigue syndromes often involve secondary emotional effects, including:

- Irritability and low stress tolerance
- Anxiety due to persistent ill health
- Depressive symptoms resulting from functional limitation
- Reduced motivation and social withdrawal

### 8. Sensory Sensitivities

Some individuals develop heightened sensitivity to:

- Light (photophobia)
- Noise (phonophobia)
- Environmental stimuli such as crowds or multitasking environments

## **Causes or Risk Factors:**

Neurasthenia (historically described as a condition of persistent mental and physical exhaustion) is closely related in modern clinical understanding to what is now often discussed within the spectrum of Chronic Fatigue Syndrome (ME/CFS). Although the exact cause is not fully established, current research suggests that it is a multifactorial disorder, meaning it arises from the interaction of biological vulnerability, psychological stressors, and environmental triggers rather than a single identifiable cause.

### **1. Post-infectious Triggers**

One of the most widely recognized risk factors is the development of symptoms after an infection. Many patients report the onset of chronic fatigue following viral or bacterial illnesses. In particular, infections such as Epstein–Barr virus (EBV), influenza-like illnesses, COVID-19, and other systemic infections have been associated with long-term fatigue syndromes. In susceptible individuals, the immune system may fail to fully return to baseline after infection, leading to persistent inflammatory signaling, which contributes to prolonged fatigue, cognitive slowing, and reduced physical endurance.

### **2. Immune System Dysregulation**

Abnormal immune responses are frequently observed in individuals with neurasthenia/CFS-like conditions. Instead of a balanced immune reaction, some patients show chronic low-grade inflammation or altered cytokine activity. This dysregulation may affect brain function, energy metabolism, and sleep regulation. Autoimmune tendencies have also been explored as a contributing factor, where the immune system may mistakenly target healthy tissues, contributing to ongoing fatigue and malaise.

### **3. Neuroendocrine (HPA Axis) Dysfunction**

The hypothalamic–pituitary–adrenal (HPA) axis plays a central role in stress response and energy regulation. In many affected individuals, this system appears to function abnormally, often showing reduced cortisol output or a blunted stress response. This can impair the body’s ability to manage physical or psychological stress, leading to persistent exhaustion, poor stress tolerance, and reduced recovery after exertion.

### **4. Psychological Stress and Emotional Factors**

Chronic emotional stress, anxiety, depression, and prolonged psychological strain are significant risk factors. While they are not considered the sole cause, they can contribute to the onset or worsening of symptoms. Long-term stress may alter neurotransmitter balance, disrupt sleep patterns, and increase physical fatigue. Individuals exposed to high levels of academic, occupational, or emotional stress without adequate recovery time are particularly vulnerable.

### **5. Sleep Disturbances**

Sleep abnormalities are both a risk factor and a maintaining factor. Poor sleep quality, non-restorative sleep, insomnia, or disrupted circadian rhythm can significantly contribute to fatigue syndromes. Even when total sleep duration appears normal, the quality of deep restorative sleep may be reduced, preventing full physical and cognitive recovery.

### **6. Autonomic Nervous System Dysfunction**

Dysregulation of the autonomic nervous system (which controls involuntary functions such as heart rate and blood pressure) has been linked to chronic fatigue conditions. Some patients experience symptoms like dizziness, palpitations, orthostatic intolerance, or rapid fatigue upon standing or physical activity. This dysfunction can reduce blood flow regulation and energy efficiency in the body.

## 7. Genetic and Biological Susceptibility

There is evidence suggesting a genetic predisposition in some individuals. Family clustering of fatigue-related conditions indicates that inherited traits may influence immune regulation, stress response, or metabolic efficiency. This does not mean the condition is directly inherited, but rather that certain individuals may be biologically more vulnerable when exposed to triggers.

## 8. Physical Overexertion and Deconditioning

In some cases, prolonged physical inactivity following illness or stress can lead to deconditioning, where muscles and cardiovascular systems become less efficient. Conversely, excessive physical or mental exertion without adequate rest may trigger or worsen symptoms, particularly in individuals with underlying vulnerability. This “post-exertional malaise” is a key feature in chronic fatigue-related conditions.

## 9. Personality and Behavioral Factors

Certain personality traits such as perfectionism, high achievement orientation, and difficulty coping with stress may increase risk indirectly. These traits can lead individuals to ignore early fatigue signals, overwork themselves, and delay recovery periods, thereby contributing to symptom development or persistence.

### **Treatment:**

Treatment of Neurasthenia, particularly when related to Chronic Fatigue Syndrome (CFS) or Myalgic Encephalomyelitis/Chronic Fatigue Syndrome (ME/CFS), focuses on reducing symptoms, improving daily functioning, and enhancing quality of life. Since there is no single curative treatment, management usually involves a combination of medical care, psychological support, lifestyle modification, and symptom-based therapy. The treatment plan should be individualized because symptoms and severity vary greatly among patients.

### 1. Patient Education and Support

One of the first steps in treatment is educating the patient about the condition. Many individuals with neurasthenia or CFS feel misunderstood because the disorder often lacks obvious physical findings. Explaining that the symptoms are real and medically recognized helps reduce anxiety and frustration. Emotional support from family members, healthcare professionals, and support groups can also improve coping ability and mental well-being.

### 2. Lifestyle Modification and Energy Management

Patients are encouraged to maintain a balanced lifestyle with proper rest, nutrition, and daily routine. A key strategy is energy conservation or pacing, which means balancing activity and rest to avoid overexertion. Excessive physical or mental activity can worsen fatigue, a phenomenon known as “post-exertional malaise.” Therefore, patients should learn to recognize their physical limits and gradually organize activities according to their energy level.

Sleep hygiene is also important. Maintaining regular sleep schedules, avoiding caffeine late in the day, and creating a comfortable sleep environment may improve sleep quality.

### 3. Psychological Therapy

Psychological therapies can help patients manage stress, emotional distress, and the impact of chronic illness on daily life.

Cognitive Behavioral Therapy (CBT)

Cognitive Behavioral Therapy (CBT) is commonly used to help patients identify negative thought patterns, reduce illness-related anxiety, and develop healthy coping strategies. CBT does not cure the condition but may help improve functioning and emotional adjustment in some patients.

Stress management techniques such as relaxation training, mindfulness, meditation, and breathing exercises can also reduce tension and mental exhaustion.

#### 4. Physical Rehabilitation and Exercise

Carefully supervised physical activity may be beneficial for some individuals. Gentle stretching, walking, yoga, or low-intensity exercises can help maintain muscle strength and flexibility. However, exercise programs must be gradual and individualized because excessive exertion can worsen symptoms. Patients with severe fatigue should avoid intense exercise routines.

#### 5. Nutritional Support

A healthy and balanced diet is recommended to support overall health and energy production. Patients are advised to consume adequate protein, vitamins, minerals, fruits, vegetables, and fluids. In some cases, nutritional deficiencies such as vitamin D, vitamin B12, or iron deficiency may be corrected if identified. Some individuals report improvement with dietary regulation and avoiding alcohol, excessive sugar, or processed foods, although scientific evidence remains limited.

#### 6. Medication Management

There is no specific medication that completely cures neurasthenia or CFS, but medicines may help control associated symptoms.

- Pain relievers may be used for headaches, muscle pain, or joint pain.
- Antidepressants can help patients with associated depression, anxiety, or sleep disturbances.
- Sleep medications may be prescribed for severe insomnia.
- In some cases, medications for dizziness, allergies, or gastrointestinal symptoms are also used depending on the patient's condition.

Drug treatment should be carefully monitored because some patients with CFS are sensitive to medication side effects.

#### 7. Treatment of Coexisting Conditions

Many patients experience associated conditions such as depression, anxiety disorders, fibromyalgia, irritable bowel syndrome, or sleep disorders. Treating these conditions can significantly improve overall functioning and quality of life.

#### 8. Social and Occupational Rehabilitation

Long-term fatigue may interfere with education, employment, and social activities. Counseling, workplace adjustments, flexible schedules, and rehabilitation programs may help patients maintain productivity and independence. Supportive environments reduce emotional stress and improve recovery outcomes.