01 - Chapter 5 Anxiety, Obsessive Compulsive, Trau

Chapter 5 Anxiety, Obsessive-Compulsive, Trauma, and Stressor-Related Disorders

48 ANXIETY, OBSESSIVE-COMPULSIVE, TRAUMA, AND STRESSOR-RELATED DISORDERS Anxiety Disorders WARDS TIP Assess for psychopathology if an individual's symptoms are causing Social and/or Occupational Dysfunction (use mnemonic SOD). WARDS TIP Late-onset anxiety symptoms without a prior history or family psychiatric history should increase suspicion of anxiety caused by another medical condition or substance use. TABLE 5-1. Signs and Symptoms of Anxiety WARDS QUESTION Constitutional Fatigue, diaphoresis, shivering Q: In a patient with comorbid anxiety and depression, would treatment with a benzodiazepine be a first-line treatment? A: No. Avoid use of benzodiazepines because they may worsen depression. TABLE 5-3. Medical Conditions That Cause Anxiety Anxiety disorders are characterized by excessive or inappropriate fear or anxiety. Fear is manifested by a transient increase in sympathetic activity ("fight or flight" physiologic response, thoughts, feelings, behaviors) in a situation perceived as dangerous or threatening. By contrast, anxiety involves apprehension regarding the possibility of a negative future event. The criteria for most anxiety disorders involve symptoms that cause clinically significant distress or impairment in social and/or occupational functioning (see Table 5-1). DSM-5 anxiety disorders include generalized anxiety disorder, panic disorder, agoraphobia, social anxiety disorder, selective mutism, and specific phobias. ■ Anxiety disorders are caused by a combination of genetic, biological, environmental, and psychosocial factors. ■ Primary anxiety disorders are diagnosed after determining that symptoms are NOT due to the physiological effects of a substance, medication (see Table 5-2), or another medical condition (see Table 5-3). ■ Major neurotransmitter systems implicated: norepinephrine (NE), serotonin (5-HT), and gamma-aminobutyric acid (GABA). Cardiac Chest pain, palpitations, tachycardia, hypertension Pulmonary Shortness of breath, hyperventilation Neurologic/ musculoskeletal Vertigo, light-headedness, paresthesias, tremors, insomnia, muscle tension Gastrointestinal Abdominal discomfort, anorexia, nausea, emesis, diarrhea, constipation TABLE 5-2. Medications and Substances That Cause Anxiety Alcohol Intoxication/withdrawal Sedatives, hypnotics, or anxiolytics Withdrawal Cannabis Intoxication Hallucinogens (PCP, LSD, MDMA) Intoxication Stimulants (amphetamines, cocaine) Intoxication/withdrawal Caffeine Intoxication/withdrawal Tobacco Intoxication/withdrawal Opioids Withdrawal LSD, lysergic acid diethylamide; MDMA, 3,4-methylenedioxy methamphetamine; PCP, phencyclidine. Neurologic Epilepsy, migraines, brain tumors, multiple sclerosis, Huntington disease Endocrine Hyperthyroidism, hypoglycemia, pheochromocytoma, carcinoid syndrome Metabolic Vitamin B12 deficiency, electrolyte abnormalities, porphyria Respiratory Asthma, chronic obstructive pulmonary disease (COPD), hypoxia, pulmonary embolism (PE), pneumonia, pneumothorax Cardiovascular Congestive heart failure (CHF), angina, arrhythmia, myocardial infarction (MI)

■ Most common form of psychopathology. ■ More frequently seen in women compared to men, approximately 2:1 ratio. Treatment Guidelines ■ Determine treatment course based on the severity of symptoms. ■ Initiate psychotherapy for mild anxiety. ■ Consider a combination of therapy and medication for moderate to severe anxiety. Pharmacotherapy ■ Selective serotonin reuptake inhibitors (SSRIs) (e.g., sertraline) and serotonin-norepinephrine reuptake inhibitors (SNRIs) (e.g., venlafaxine) are first-line medications. ■ Benzodiazepines can be used as an adjunctive short-term treatment to achieve acute reduction of severe anxiety symptoms (e.g., while getting stabilized on an SSRI), but regular use can result in dependence. Therefore, minimize the use, duration, and dose, and avoid in patients with a history of substance use disorders, particularly alcohol. ■ Mechanism of action: Enhance activity of GABA at GABA-A receptor. ■ In patients with comorbid substance use consider nonaddictive anxiolytic alternatives for PRN use,

such as gabapentin and antihistamines with anxiolytic properties (e.g., diphenhydramine or hydroxyzine). ■ Buspirone is a non-benzodiazepine anxiolytic which has partial agonist activity at the 5-HT1A receptor. Due to minimal efficacy as monotherapy, buspirone is typically prescribed only as augmentation. ■ Beta-blockers (e.g., propranolol) may be used to help control autonomic symptoms (e.g., palpitations, tachycardia, sweating) of panic attacks or performance anxiety. ■ Tricyclic antidepressants (TCAs) and monoamine oxidase inhibitors (MAOIs) may be considered if first-line agents are not effective. Their sideeffect profile, especially cardiovascular effects, makes them less tolerable and more dangerous. Psychotherapy ■ Many modalities of psychotherapy are helpful for patients suffering from anxiety disorders. ●Cognitive-behavioral therapy (CBT) has proven effective for anxiety disorders. CBT examines the relationship between anxiety-driven - cognitions (thoughts), emotions, and behavior. ●Psychodynamic psychotherapy facilitates insight into the development of anxiety symptoms, leading to more adaptive coping styles and subsequent improvement over time. PANIC ATTACKS A panic attack is a fear response involving a sudden onset of intense anxiety which may either be triggered or occur spontaneously. Panic attacks peak ANXIETY, OBSESSIVE-COMPULSIVE, TRAUMA, AND STRESSOR-RELATED DISORDERS WARDS TIP Use benzodiazepines to temporarily bridge patients until long-term medication becomes effective. WARDS QUESTION Q: How long does it take for SSRIs to typically become fully effective? A: About 4–6 weeks. WARDS TIP The goal of medication treatment is to achieve symptomatic relief and continue treatment for at least 6 months before attempting to titrate off medications. WARDS TIP Medications can reduce symptoms sufficiently so that a patient can participate and learn the skills offered in therapy. Therapy can additionally be used as maintenance treatment to prevent relapse.

50 ANXIETY, OBSESSIVE-COMPULSIVE, TRAUMA, AND STRESSOR-RELATED DISORDERS KEY FACT Symptoms of panic attacks Da PANICS Dizziness, disconnectedness, derealization (unreality), depersonalization (detached from self) Palpitations, paresthesias Abdominal distress Numbness, nausea Intense fear of dying, losing control or “going crazy” Chills, chest pain Sweating, shaking, shortness of breath PANIC DISORDER Diagnosis and DSM-5 Criteria WARDS TIP Use the Bs to Block the Ps: Beta-Blockers for Panic attacks and Performance anxiety. Etiology WARDS TIP Epidemiology Smoking is a risk factor for panic attacks. ■ Lifetime prevalence: 4%. ■ Median age of onset: 20–24 years old. WARDS QUESTION Course and Prognosis Q: When a patient presents with the new onset of a panic attack, what potentially life-threatening medical conditions should be ruled out? A: Heart attack, cardiac arrhythmia, electrolyte dysfunction, hypoglycemia, thyrotoxicosis, and pulmonary embolism. within minutes and usually resolve within half an hour. Patients may continue to feel anxious for hours afterwards and believe they are experiencing a prolonged panic attack. Although classically associated with panic disorder, panic attacks can also be experienced with other psychiatric disorders and medical conditions. Panic disorder is diagnosed in patients who experience spontaneous, recurrent panic attacks and who are fearful of reoccurring attacks. These attacks most often occur suddenly, out of the blue, although they may sometimes have a clear trigger. The frequency of attacks ranges from multiple times per day to a few times per month. The keystone feature of panic disorder is that patients develop debilitating anticipatory anxiety about having future attacks—“fear of the fear.” ■ Recurrent, unexpected panic attacks without an identifiable trigger. ■ One or more of panic attacks followed by ≥1 month of continuous worry about experiencing subsequent attacks or their consequences, and/or a maladaptive change in behaviors (e.g., avoidance of possible triggers). ■ Not due to the physiological effects of a substance, another medical or neurological condition (e.g., traumatic brain injury), or another mental disorder. ■ Genetic factors: Greater risk of panic disorder if a first-degree relative is

affected. ■ Psychosocial factors: Increased incidence of stressors (especially loss) prior to onset of disorder; history of childhood physical or sexual abuse. ■ Higher rates in woman compared to men, approximately 2:1. ■ Panic disorder has a chronic course with waxing and waning symptoms. ■ Relapses are common with discontinuation of medication. ■ Only a minority of patients have full remission of symptoms. ■ Up to 65% of patients with panic disorder also have major depression. ■ Additional comorbid syndromes include other anxiety disorders (e.g., agoraphobia), bipolar disorder, and alcohol use disorder. Treatment Combination of CBT and Pharmacotherapy = most effective. ■ First-line: SSRIs (e.g., sertraline, citalopram, escitalopram). ■ SNRIs (e.g., venlafaxine, desvenlafaxine, duloxetine) are also efficacious. ■ If the above options are not effective, can consider TCAs (e.g., clomipramine, imipramine). ■ Can use benzodiazepines (e.g., clonazepam, lorazepam) as scheduled or PRN, until other medications reach therapeutic efficacy.

AGORAPHOBIA Agoraphobia is an intense fear of being in public places where escape or obtaining help may be difficult. It often develops with panic disorder. The course of the disorder is usually chronic. Avoidance behaviors may become as extreme as complete confinement to the home. Diagnosis and DSM-5 Criteria ■ Intense fear/anxiety about at least two situations due to concerns of difficulty escaping or obtaining help in case of panic or other humiliating symptoms: ●Outside of the home alone. ●Open spaces (e.g., bridges). ●Enclosed places (e.g., stores). ●Public transportation (e.g., trains). ●Crowds/lines. ■ The triggering situations cause fear/anxiety that is out of proportion to the potential danger posed, leading to endurance of intense anxiety, avoidance, or need for a companion. This holds true even if the patient suffers from another medical condition such as inflammatory bowel disease (IBS), which may lead to embarrassing public scenarios. ■ Symptoms cause significant social or occupational dysfunction. ■ Symptoms last ≥6 months. ■ Symptoms not better explained by another mental disorder. Etiology ■ Strong genetic factor: Heritability about 60%. ■ Psychosocial factor: Onset frequently follows a traumatic event. Course/Prognosis ■ More than 50% of patients experience a panic attack prior to developing agoraphobia. ■ Onset is usually before age 35. ■ Course is persistent and chronic, with rare full remission. ■ Comorbid diagnoses include other anxiety disorders, depressive disorders, and substance use disorders. Treatment ■ CBT and SSRIs SPECIFIC PHOBIAS A phobia is defined as an irrational fear that leads to endurance of the anxiety and/or avoidance of the feared object or situation. A specific phobia is an intense fear of a specific object or situation (i.e., the phobic stimulus). Diagnosis and DSM-5 Criteria ■ Persistent, excessive fear elicited by a specific situation or object which is out of proportion to any actual danger/threat. ■ Exposure to the situation triggers an immediate fear response. ■ Situation or object is avoided when possible or tolerated with intense anxiety. ANXIETY, OBSESSIVE-COMPULSIVE, TRAUMA, AND STRESSOR-RELATED DISORDERS WARDS TIP A classic panic disorder case involves a woman who repeatedly visits the ER because she is afraid of dying when she experiences episodes of palpitations, diaphoresis, and shortness of breath. The patient has no prior medical history and the medical workup is negative. WARDS TIP Carefully screen patients with panic attacks for suicidality. They are at an increased risk for suicide attempts. WARDS TIP Start SSRIs or SNRIs at low doses and ↑ slowly because side effects may initially worsen anxiety, especially in panic disorder. KEY FACT Characteristic situations avoided in agoraphobia include bridges, crowds, buses, trains, or any open areas outside the home. KEY FACT Common Domains of Social Anxiety Disorder (Social Phobia): • Speaking in public. • Eating in public. • Using public restrooms.

 KEY FACT ■ Duration ≥6 months. Common Specific Phobias: Animal—spiders, insects, dogs, snakes, and mice. Natural environment—heights, storms, and water. Situational—elevators, airplanes, buses, and enclosed spaces. Blood-injection-injury—needles, injections, blood, injuries, and invasive medical procedures. Epidemiology Treatment ■ Treatment of choice: CBT with exposure. WARDS TIP Patients with blood-injury- injection-specific phobia (fear of needles, etc.) may experience - bradycardia and hypotension leading to vasovagal syncope. KEY FACT Substance use and depressive disorders frequently co-occur with phobias. Epidemiology WARDS QUESTION Treatment ■ Treatment of choice: CBT. Q: What medication often successfully treats performance anxiety? A: Beta-blockers. SELECTIVE MUTISM ■ Symptoms cause significant social or occupational dysfunction. ■ Not due to the physiological effects of a substance, another medical or neurological condition (e.g., traumatic brain injury), or another mental disorder. ■ Phobias are the most common psychiatric disorder in women and second most common in men (substance-related is first). ■ Lifetime prevalence of specific phobia: >10%. ■ Mean age of onset for specific phobia is 10 years. ■ Specific phobia rates are higher in women compared to men (2:1) but vary depending on the type of stimulus. SOCIAL ANXIETY DISORDER (SOCIAL PHOBIA) Social anxiety disorder (social phobia) is the fear of scrutiny by others or fear of acting in a humiliating or embarrassing way. The phobia may develop in the wake of negative or traumatic encounters with the stimulus. Social situations causing significant anxiety may be avoided altogether, resulting in social and academic/occupational impairment. The diagnostic criteria for social anxiety disorder (social phobia) are similar to specific phobia except the phobic stimulus is related to social scrutiny and negative evaluation. The patients fear embarrassment, humiliation, and rejection. This fear may be limited to performance or public speaking, which may be routinely encountered in the patient’s occupation or academic pursuit. ■ Median age of onset for social anxiety disorder is 13 years. ■ Social anxiety disorder occurs equally across genders. ■ First-line medication, if needed: SSRIs (e.g., sertraline, fluoxetine) or SNRIs (e.g., venlafaxine) for debilitating symptoms. ■ Benzodiazepines (e.g., clonazepam, lorazepam) can be used as scheduled or PRN. ■ Beta-blockers (e.g., atenolol, propranolol) PRN for performance anxiety/ public speaking. Selective mutism is a rare condition characterized by a failure to speak in specific situations for at least 1 month, despite the intact ability to comprehend and use language. Symptom onset typically starts during childhood. The majority of these patients suffer from anxiety, particularly social anxiety, as the

mutism manifests in social settings. The patients may remain completely silent or just whisper. They may use nonverbal means of communication, such as writing or gesturing. Diagnosis and DSM-5 Criteria ■ Consistent failure to speak in select social situations (e.g., school) despite speech ability in other scenarios. ■ Mutism is not due to a language difficulty or a communication disorder. ■ Symptoms cause significant impairment in academic, occupational, or social functioning. ■ Symptoms last >1 month (extending beyond first month of school). Treatment ■ Psychotherapy: CBT, family therapy. ■ Medications: SSRIs (especially with comorbid social anxiety disorder). SEPARATION ANXIETY DISORDER As part of normal human development, infants become distressed when they are separated from their primary caregiver. Stranger anxiety begins around 6 months and peaks around 9 months, while separation anxiety typically emerges by 1 year of age and peaks by 18 months. However, when the anxiety due to separation becomes extreme or developmentally inappropriate, it is considered pathologic. Separation anxiety disorder may be preceded by a stressful life event. Diagnosis and DSM-5 Criteria Excessive and developmentally inappropriate fear/anxiety regarding separation from attachment figures, with at least three of the

following: ■ Separation from attachment figures leads to extreme distress. ■ Excessive worry about loss of or harm to attachment figures. ■ Excessive worry about experiencing an event that leads to separation from attachment figures. ■ Reluctance to leave home or attend school or work. ■ Reluctance to be alone. ■ Reluctance to sleep alone or away from home. ■ Complaints of physical symptoms when separated from major attachment figures. ■ Nightmares of separation and refusal to sleep without proximity to attachment figure. ■ Lasts for ≥4 weeks in children/adolescents and ≥6 months in adults. ■ Symptoms cause significant social, academic, or occupational dysfunction. ■ Symptoms not due to another mental disorder. Treatment ■ Psychotherapy: CBT, family therapy. ■ Medications: SSRIs can be effective as an adjunct to therapy. ANXIETY, OBSESSIVE-COMPULSIVE, TRAUMA, AND STRESSOR-RELATED DISORDERS WARDS TIP Separation anxiety may lead to complaints of somatic symptoms to avoid school/work.

54 ANXIETY, OBSESSIVE-COMPULSIVE, TRAUMA, AND STRESSOR-RELATED DISORDERS WARDS TIP GAD Mnemonic Worry WARTS Wound up, worn-out Absent-minded Restless Tense Sleepless GENERALIZED ANXIETY DISORDER (GAD) WARDS TIP For patients with anxiety, evaluate for caffeine use and recommend significant reduction or elimination. Diagnosis and DSM-5 Criteria ■ Difficulty controlling worry. WARDS TIP Exercise can significantly reduce anxiety. Epidemiology/Etiology ■ Lifetime prevalence: 5–9%. WARDS TIP Course/Prognosis ■ Symptoms of worry begin in childhood. The worries associated with GAD are free-floating across various areas, as opposed to being fixed on a specific trigger. ■ Median age of onset of GAD: 30 years. ■ Rates of full remission are low. A 24-year-old law student presents to an outpatient psychiatry clinic with a chief complaint that she is “so stressed out, worrying about everything.” She is overwhelmed with her academic workload and upcoming exams. She has had trouble falling asleep and feels chronically fatigued. The patient also suffers from frequent headaches and muscle tightness in her neck and shoulders. The patient’s husband describes her as “a worrier. She’s always concerned about me getting into an accident, her flunking out of school, not finding a job—the list goes on.” The patient reports that she has always had some degree of anxiety, but previously found it motivating. Over the last year since law school began, her symptoms have become debilitating. What is the most likely diagnosis? With the patient’s history of excessive worrying about everything, the most likely diagnosis is generalized anxiety disorder (GAD). Like many patients with GAD, she is described as a worrier. She reports typical associated symptoms: insomnia, fatigue, and impaired concentration. Her symptoms have been present for over 6 months. What is the next step? A complete physical exam and medical workup should be performed to rule out other medical conditions or substance use contributing to or causing her anxiety symptoms. What are treatment options? Treatment options for GAD include psychotherapy (usually CBT) and pharmacotherapy (typically SSRIs). A combination of both modalities may achieve better remission rates than either treatment alone. Patients with GAD have persistent, excessive anxiety about many aspects of their daily lives. Commonly associated physical symptoms include fatigue and muscle tension, which often lead to an initial presentation to primary care. ■ Excessive anxiety/worry about various daily events/activities ≥6 months. ■ Associated ≥3 symptoms: restlessness, fatigue, impaired concentration, irritability, muscle tension, insomnia. ■ Not due to the physiological effects of a substance, another medical or neurological condition (e.g., traumatic brain injury), or another mental disorder. ■ Symptoms cause significant social or occupational dysfunction. ■ GAD rates higher in women compared to men (2:1). ■ One-third of risk for developing GAD is genetic. ■ Course is chronic, with waxing and waning symptoms. ■ GAD is highly comorbid with other anxiety and depressive disorders.

Treatment The most effective treatment approach combines psychotherapy and pharmacotherapy: ■ CBT. ■ SSRIs (e.g., sertraline, citalopram) or SNRIs (e.g., venlafaxine, duloxetine). ■ Can also consider a short-term course of benzodiazepines or augmentation with buspirone. ■ Much less commonly used medications are TCAs and MAOIs. Obsessive-Compulsive and Related Disorders OBSESSIVE-COMPULSIVE DISORDER (OCD) OCD is characterized by obsessions and/or compulsions that are time-consuming, distressing, and impairing. Obsessions are recurrent, intrusive, and undesired thoughts that increase anxiety. Patients may attempt to relieve the anxiety by performing compulsions, which are repetitive behaviors or mental rituals. Anxiety may increase when a patient resists acting out a compulsion. Patients with OCD have varying degrees of insight. Diagnosis and DSM-5 Criteria ■ Experiencing obsessions and/or compulsions that are time-consuming (e.g.,

> 1 hr/day) and cause significant distress or dysfunction. ●Obsessions: Recurrent, intrusive, anxiety-provoking thoughts, images, or urges that the patient attempts to suppress, ignore, or neutralize by some other thought or action (i.e., by performing a compulsion). ●Compulsions: Repetitive behaviors or mental acts the patient feels driven to perform in response to an obsession, or a rule aimed at stress reduction or disaster prevention. The behaviors are excessive and/or not realistically connected to what they are meant to prevent. ■ Not due to the physiological effects of a substance, another medical or neurological condition (e.g., traumatic brain injury), or another mental disorder. Epidemiology ■ Lifetime prevalence: 2–3%. ■ No gender difference in prevalence overall. Etiology ■ Significant genetic component: Higher rates of OCD in first-degree relatives and monozygotic twins than in the general population. Higher rate of OCD in first-degree relatives with Tourette's disorder. Course/Prognosis ■ Chronic, with waxing and waning symptoms. ■ Less than 20% remission rate without treatment. ■ Suicidal ideation in 50% and suicide attempts in 25% of patients with OCD. ■ High comorbidity with other anxiety disorders, depressive or bipolar disorder, obsessive-compulsive personality disorder, and tic disorder. Treatment Utilize a combination of psychopharmacology and CBT. ANXIETY, OBSESSIVE-COMPULSIVE, TRAUMA, AND STRESSOR-RELATED DISORDERS KEY FACT Compulsions can often take the form of repeated checking or counting. KEY FACT Patients with OCD often initially seek help from primary care and other nonpsychiatric providers for help with the consequences of compulsions (e.g., excessive washing). KEY FACT The triad of "uncontrollable urges"—OCD, ADHD, and tic disorder—are usually first seen in children or adolescents. KEY FACTS Common Patterns of Obsessions and Compulsions Obsessions Compulsions Contamination Cleaning or avoidance of contaminant Doubt or harm Checking multiple times to avoid potential danger Symmetry Ordering or counting Intrusive, taboo thoughts With or without related compulsion

 Differentiating OCD and obsessive-compulsive personality disorder (OCPD): • Individuals with OCPD are obsessed with details, control, and perfectionism without experiencing unwanted

preoccupations or compulsions. • OCD patients are distressed by their symptoms (ego-dystonic). BODY DYSMORPHIC DISORDER Diagnosis and DSM-5 Criteria Epidemiology ■ Mean age of onset: 15 years. Course/Prognosis ■ High rate of suicidal ideation and attempts. Treatment HOARDING DISORDER Diagnosis and DSM-5 Criteria CBT focuses on exposure and response prevention: prolonged, graded exposure to ritual-eliciting stimulus and prevention of the relieving compulsion. ■ First-line medication: SSRIs (e.g., sertraline, fluoxetine), typically at higher doses. ■ Second-line agents: SNRIs (e.g., venlafaxine) or the most serotonin selective TCA, clomipramine. ■ Can augment with atypical antipsychotics in severe cases. ■ In debilitating, treatment-resistant cases, consider psychosurgery (cingulotomy) or electroconvulsive therapy (ECT). ■ Patients with body dysmorphic disorder are preoccupied with nonexistent or minor physical defects that they regard as severe, grotesque, and repulsive. ■ These individuals spend significant time trying to correct perceived flaws with makeup, dermatological procedures, or plastic surgery. ■ Preoccupation with one or more perceived defects or flaws in physical appearance that are not observable by or appear slight to others. ■ In response to the appearance concerns, repetitive behaviors (e.g., skin picking, excessive grooming) or mental acts (e.g., comparing appearance to others) are performed. ■ Preoccupation causes significant distress or impairment in functioning. ■ Appearance preoccupation is not better accounted for by concerns with body fat/weight in an eating disorder. ■ Slightly more common in women than men. ■ Prevalence elevated in those with high rates of childhood abuse and neglect. ■ Increased risk in first-degree relatives of patients with OCD. ■ Higher prevalence in dermatologic and cosmetic surgery patients. ■ The onset is usually gradual, beginning in early adolescence. Symptoms tend to be chronic. ■ Surgical or dermatological procedures are routinely unsuccessful in satisfying the patient. ■ Comorbidity with major depression, social anxiety disorder (social phobia), and OCD. ■ SSRIs and/or CBT may reduce the obsessive and compulsive symptoms in many patients. ■ Persistent difficulty discarding possessions, regardless of value. ■ Difficulty is due to need to save the items and distress associated with discarding them.

■ Results in accumulation of possessions that congest/clutter living areas and compromise use. ■ Hoarding causes clinically significant distress or impairment in social, occupational, or other areas of functioning. ■ Hoarding is not attributable to another medical condition or another mental disorder. Epidemiology/Etiology ■ Point prevalence of significant hoarding is 2–6%. ■ Hoarding is three times more prevalent in the elderly population. ■ Onset often preceded by stressful and traumatic events. ■ 50% of individuals with hoarding have at least one hoarding relative. Course/Prognosis ■ Hoarding behavior begins in early teens and tends to worsen over time. ■ Usually chronic course. ■ 75% of individuals have comorbid mood (MDD) or anxiety disorder (social anxiety disorder). ■ 20% of individuals have comorbid OCD. Treatment ■ Very difficult to treat. ■ Specialized CBT for hoarding. ■ SSRIs can be used. TRICHOTILLOMANIA (HAIR-PULLING DISORDER) Diagnosis and DSM-5 Criteria ■ Recurrent pulling out of one’s hair, resulting in hair loss. ■ Repeated attempts to decrease or stop hair pulling. ■ Causes significant distress or impairment in daily functioning. ■ Hair pulling or hair loss is not due to another medical condition or psychiatric disorder. ■ Usually involves the scalp, eyebrows, or eyelashes. May include facial, axillary, or pubic hair. Epidemiology/Etiology ■ Lifetime prevalence: 1–2% of the adult population. ■ More common in women than in men (10:1 ratio). ■ Onset usually at puberty and frequently associated with a stressful event. ■ Etiology may involve biological, genetic, and environmental factors. ■ Increased incidence of comorbid OCD, major depressive disorder, and excoriation (skin-picking) disorder. ■ Course may be chronic with waxing and waning periods. Adult onset is generally more difficult to

treat. Treatment ■ Recommended: Specialized types of cognitive-behavior therapy (e.g., habit reversal training). ■ Pharmacologic treatment includes SSRIs, second-generation antipsychotics, lithium, or N-acetylcysteine (NAC). ANXIETY, OBSESSIVE-COMPULSIVE, TRAUMA, AND STRESSOR-RELATED DISORDERS

58 ANXIETY, OBSESSIVE-COMPULSIVE, TRAUMA, AND STRESSOR-RELATED DISORDERS EXCORIATION (SKIN-PICKING) DISORDER Diagnosis and DSM-5 Criteria ■ Recurrent skin picking resulting in lesions. Epidemiology/Etiology ■ More than 75% of cases are women. Course/Prognosis ■ Skin picking begins in adolescence. Treatment ■ SSRIs have shown some benefit. Trauma and Stressor-Related Disorders ■ Repeated attempts to decrease or stop skin picking. ■ Causes significant distress or impairment in daily functioning. ■ Not due to the physiological effects of a substance, another medical or neurological condition (e.g., traumatic brain injury), or another mental disorder. ■ Lifetime prevalence: 1.4% of the adult population. ■ More common in individuals with OCD and first-degree family members. ■ Course is chronic with waxing and waning periods if untreated. ■ Comorbidity with OCD, trichotillomania, and MDD. ■ Specialized types of cognitive-behavior therapy (e.g., habit reversal training). A 19-year-old freshman is brought to the ER by her college roommate due to her concerns that she “really needs to get some help—she hasn’t been herself since a party we went to together.” The freshman has been hypervigilant, tearful, and crying out so loudly in her sleep that she wakes up her peers. The roommate discloses concern that a traumatic incident occurred at a party last month. The patient is guarded and reluctant to talk about details. She reports that since the party, she has experienced intrusive thoughts and nightmares. The patient is afraid to leave her room, and feels on edge most of the time. What is the most likely diagnosis? The patient has been suffering from symptoms of posttraumatic stress disorder (PTSD) for the last month after a traumatic incident with associated low mood, avoidance, hypervigilance, intrusive thoughts, and nightmares. POSTTRAUMATIC STRESS DISORDER (PTSD) AND ACUTE STRESS DISORDER PTSD is characterized by the development of multiple symptoms after exposure to one or more traumatic events: intrusive symptoms (e.g., nightmares, flashbacks), avoidance, negative alterations in thoughts and mood, and increased arousal. The symptoms last for at least a month and may occur immediately after the trauma or with delayed expression. Acute stress disorder is diagnosed in patients who experience a major traumatic event and suffer from similar symptoms as PTSD (see Table 5-4) but for a shorter duration. The onset of symptoms occurs within 1 month of the trauma and symptoms last for less than 1 month.

TABLE 5-4. Posttraumatic Stress Disorder and Acute Stress Disorder Posttraumatic Stress Disorder Acute Stress Disorder Trauma occurred at any time in past Trauma occurred <1 month ago Symptoms last >1 month Symptoms last <1 month Diagnosis and DSM-5 Criteria ■ Exposure to actual or threatened death, serious injury, or sexual violence by directly experiencing or witnessing the trauma. ■ Recurrent intrusions of reexperiencing the event via memories, nightmares, or dissociative reactions (e.g., flashbacks); intense distress at exposure to cues relating to the trauma; or physiological reactions to cues relating to the trauma. ■ Active avoidance of triggering stimuli (e.g., memories, feelings, people, places, objects) associated with the trauma. ■ At least two of the following negative cognitions/mood: dissociative amnesia, negative feelings of self/others/world, self-blame, negative emotions (e.g., fear, horror, anger, guilt), anhedonia, feelings of detachment/ estrangement, inability to experience positive emotions. ■ At least two of the following symptoms of increased arousal/reactivity: hypervigilance, exaggerated startle

response, irritability, angry outbursts, impaired concentration, insomnia. ■ Symptoms not caused by the direct effects of a substance or another medical condition. ■ Symptoms result in significant impairment in social or occupational functioning. ■ The presentation differs in children <7 years of age. Epidemiology/Etiology ■ Lifetime prevalence of PTSD: >8%. ■ Higher prevalence in women, most likely due to greater risk of exposure to traumatic events, particularly rape and other forms of interpersonal violence. ■ Exposure to prior trauma, especially during childhood, is a risk factor for developing PTSD. Course/Prognosis ■ PTSD usually begins within 3 months after the trauma. ■ Symptoms may manifest after a delayed expression. ■ Fifty percent of patients with PTSD have complete recovery within 3 months. ■ Symptoms tend to diminish with older age. ■ Eighty percent of patients with PTSD have a comorbid mental disorder (e.g., MDD, bipolar disorder, anxiety disorder, substance use disorder). Treatment ■ Pharmacological ●First-line antidepressants: SSRIs (e.g., sertraline) or SNRIs (e.g., venlafaxine). ●Prazosin, a1-receptor antagonist, targets nightmares and hypervigilance. ●Consider augmentation with a second-generation antipsychotic in severe or treatment-resistant cases. ANXIETY, OBSESSIVE-COMPULSIVE, TRAUMA, AND STRESSOR-RELATED DISORDERS WARDS TIP Q: What medication has shown some efficacy as an adjunct treatment for nightmares in patients with PTSD? A: Prazosin. WARDS TIP Criteria of PTSD: TRAUMA Traumatic event Reexperience Avoidance Unable to function Month or more of symptoms Arousal increased

60 ■ Psychotherapy ANXIETY, OBSESSIVE-COMPULSIVE, TRAUMA, AND STRESSOR-RELATED DISORDERS WARDS TIP Cognitive processing therapy is a modified form of CBT in which thoughts, feelings, and meanings of the event are revisited and questioned. ●Couples/family therapy. ADJUSTMENT DISORDERS WARDS TIP Addictive medications such as benzodiazepines should be avoided in the treatment of PTSD because of the high rate of comorbid substance use disorders and the lack of efficacy. Epidemiology KEY FACT ■ May occur at any age. PTSD stressor = life threatening. Etiology Adjustment disorder stressor ≠ life threatening. ■ Triggered by psychosocial factors. Treatment ■ Supportive psychotherapy. ■ Group therapy. ●Specialized forms of CBT (e.g., exposure therapy, cognitive processing therapy). ●Supportive and psychodynamic therapy. Adjustment disorders occur when behavioral or emotional symptoms develop after a non-life-threatening, stressful life event (e.g., divorce, death of a loved one, or loss of a job). Diagnosis and DSM-5 Criteria

1. Development of emotional or behavioral symptoms within 3 months in response to an identifiable stressful life event. These symptoms produce either: • Excessive distress in relation to the event. • Significant impairment in daily functioning.
2. The symptoms are not those of normal bereavement.
3. Symptoms resolve within 6 months after the stressor has terminated.
4. The stress-related disturbance does not meet criteria for another mental disorder. Subtypes: Based on a predominance of either depressed mood, anxiety, mixed anxiety and depression, disturbance of conduct (such as aggression), or mixed disturbance of emotions and conduct. ■ 5–20% of patients in outpatient mental health clinics have an adjustment disorder. Prognosis May be chronic if the stressor is chronic or recurrent. ■ If clinically indicated, pharmacotherapy can target associated impairing symptoms (insomnia, anxiety, or depression).

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