The Anxiety Disorders
&
The Obsessive-Compulsive & Related Disorders
&
The Trauma and Stress Related Disorders
&
The Dissociative Disorders

Part I: 09/03/2025
0800-1000
&
Part II: 09/05/2025
1300-1500
Live ZOOM

Jeffrey Zwerin, D.O.

Objectives

At the end of this 4 hour lecture the student will better understand:

1. What is anxiety and when it can be helpful
2. Freud and theories related to anxiety
3. The adaptive function of anxiety
4. The physical signs of anxiety
5. The Anxiety Disorders found in DSM-5-TR

Objectives (continued)

At the end of this 4 hour lecture the student will better understand:

6. The prevalence of the Anxiety Disorders
7. What is a Panic Attack
8. What are the symptoms of a Panic Attack
9. What is a Panic Disorder
10. What is agoraphobia

Objectives (continued)

At the end of this 4 hour lecture the student will better understand

11. Phobias
    a. The most common types of Phobias
    b. Specific Phobias
    c. Treatment of Phobias

Objectives (continued)

At the end of this 4 hour lecture the student will better understand

12. What is Social Phobia (Social Anxiety Disorder)
    a. Treatment of Social Phobia
13. Generalized Anxiety Disorder, and its treatment
14. What is a Substance /Medication Induced Anxiety Disorder
15. What is an Anxiety Disorder due to another Medical Condition
16. What is Other Specified Anxiety Disorder
17. What is an Unspecified Anxiety Disorder

Objectives (continued)

At the end of this 4 hour lecture the student will better understand

Obsessive Compulsive and Related Disorders

1. Obsessive Compulsive Disorder
2. Body Dysmorphic Disorder
3. Hoarding Disorder
    a. Animal Hoarding
4. Trichotillomania (Hair Pulling Disorder)
5. Excoriation (Skin Picking) Disorder

Objectives (continued)

At the end of this 4 hour lecture the student will better understand

Obsessive Compulsive and Related Disorders (continued)

6. Other Obsessive-Compulsive Related Disorders

a. Substance/ Medication-Induced Obsessive Compulsive and Related Disorder

b. Obsessive Compulsive and Related Disorder Due to Another Medical Condition

Objectives (continued)

At the end of this 4 hour lecture the student will better understand

Obsessive Compulsive and Related Disorders (continued)

7. Body Dysmorphic Disorder
8. Hoarding Disorder
9. Hair-Pulling Disorder (Trichotillomania)
10. Excoriation (Skin Picking) Disorder

Objectives (continued)

At the end of this 4 hour lecture the student will better understand:

The Trauma and Stressor Related Disorders

1. Posttraumatic Stress Disorder
2. Acute Stress Disorder
3. Adjustment Disorders
4. Prolonged grief Reaction
5. Other Specified Trauma-& Stressor-Related Disorder
6. Unspecified Trauma-and Stressor-Related Disorder

Objectives (continued)

The Dissociative Disorders:

At the end of this 4 hour lecture the student will better understand:

1. Dissociative Identity Disorder (Formerly Multiple Personality Disorder)
    A. Criteria noted in DSM-5-TR
        1. Symptoms typically displayed
        2. Postulated causes
        3. Treatment approaches

2. Dissociative Amnesia
    A. Criteria noted in DSM-5-TR
    B. Important epidemiolocal data
    C. The specifier of fugue and its meaning

3. Depersonalization/Derealization Disorder
    A. Criteria noted in DSM-5-TR

4. Important clinical points Regarding the Dissociative disorders

Note: This lecture and or the video(s) that accompany it contain content that may elicit uncomfortable feelings in some students.

Anxiety

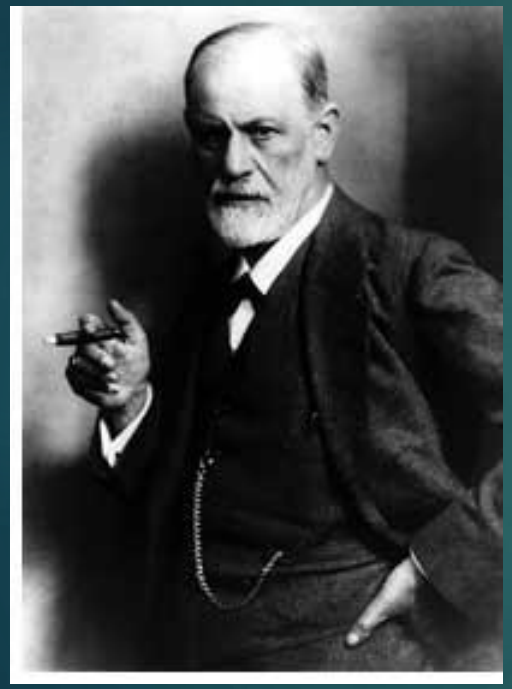
- We all have experienced anxiety.
- It is experienced as unpleasant, vague sense of apprehension.
- Often accompanied by ANS symptoms such as:
  - Headache, perspiration, chest tightness, restlessness, inability to sit still, etc.

Anxiety Versus Fear

Anxiety can be a **Normal Alerting Mechanism**

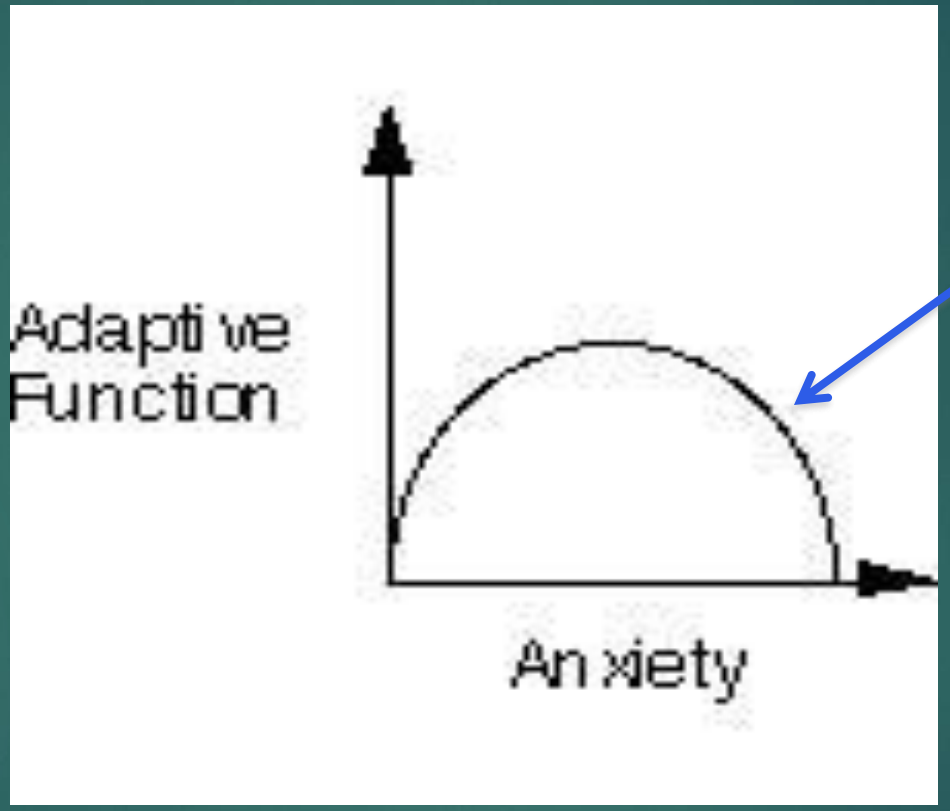
- **Anxiety**: Response to threat either unknown, vague or conflictual, out of proportion to external stimulus
- **Fear**: A *Normal* Response to a known, external, definite or non-conflictual threat.

Theories About Anxiety



- <u>Freudian Theories</u>
  - ✓ ID or Impulse Anxiety
    - Direct Change Of Sexual Impulses into Somatic Symptoms
  - ✓ Structural Theory of Intra-psychic Conflict
    - Ego Uses Anxiety to alert the Ego of Internal Danger
      - ▶Danger due to conflict: Ego/Superego / Id

Some Anxiety Can be a Good Thing



Inverted U-Shaped Curve

Anxiety can prevent a bad outcome by alerting the person to carry out an act (studying) to forestall the danger (e.g., failing a test).

Some Physical Signs of Anxiety

- Dizziness, lightheadedness
- Palpitations
- Hypertension
- Diarrhea
- Restlessness (e.g., pacing)
- Tachycardia
- Tremors
- Dilated Pupils
- Sweating
- Syncope
- Tingling in extremities

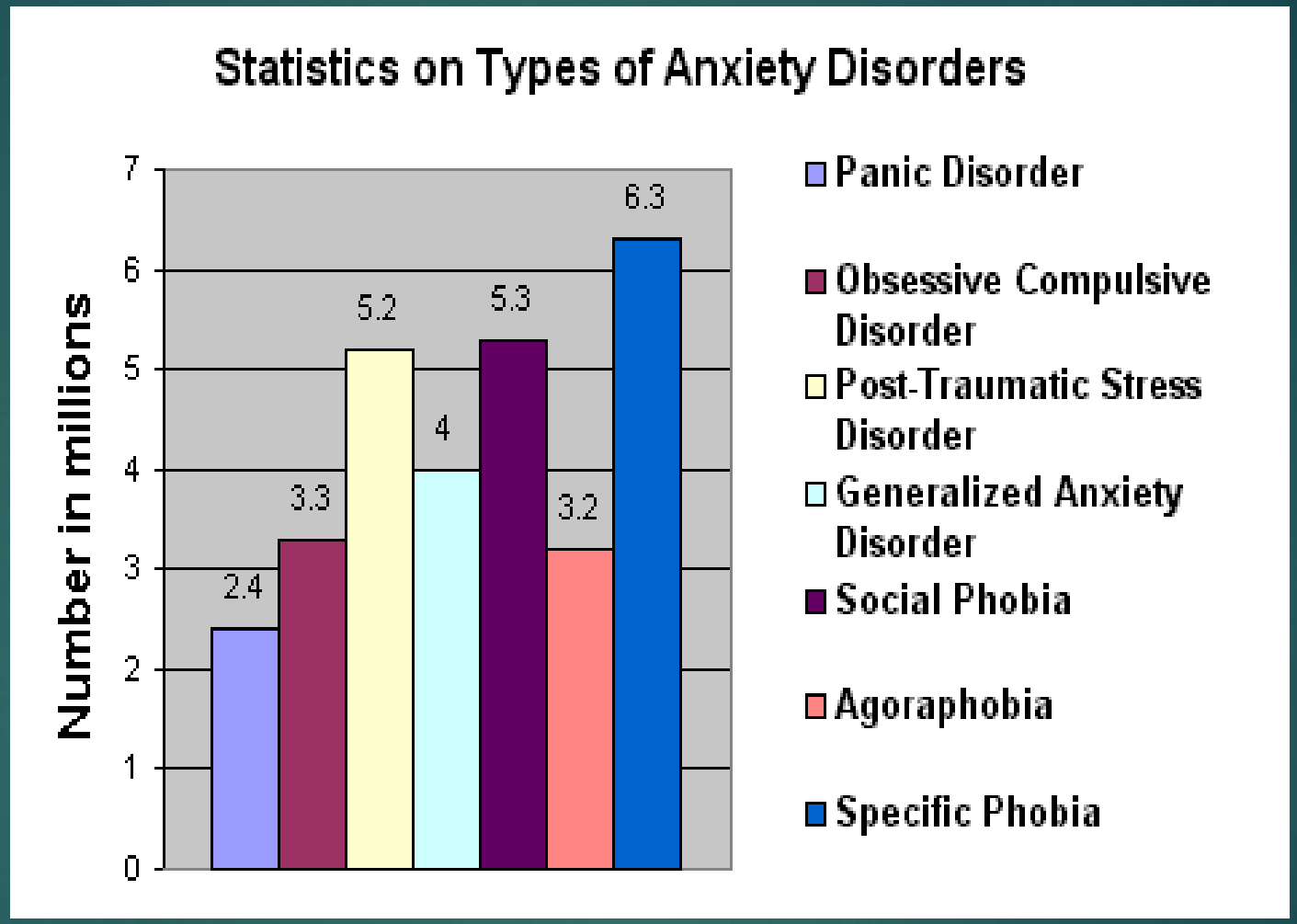
DSM-5-TR-TR Anxiety Disorders

- A. Panic Disorder
- B. Agoraphobia
- C. Specific Phobia
- D. Social Anxiety Disorder

  (formerly Social Phobia)
- E. Generalized Anxiety Disorder

DSM-5-TR Anxiety Disorders
(CONTINUED)

- F. Substance/Medication-Induced Anxiety Disorder.
- G. Anxiety Due to another Medical Condition
- H. Other Specified Anxiety Disorder
- I. Unspecified Anxiety Disorder


Statistics on Types of Anxiety Disorders
Number in millions
0
1
2
3
4
5
6
7
2.4
3.3
5.2
4
5.3
3.2
6.3
Panic Disorder
Obsessive Compulsive Disorder
Post-Traumatic Stress Disorder
Generalized Anxiety Disorder
Social Phobia
Agoraphobia
Specific Phobia

Anxiety Disorders

- One Psychiatric illness in which the patient can be placed into remission
- These patients work hard to get well

Anxiety Disorders

Prevalence	Lifetime	1 Year
Simple Phobia	11.0%	8.8%
Agoraphobia	5.0%	2.8%
GAD	5.0 %	3.0%
Social Phobia	13.0%	7.9%
Panic Disorder	3.5%	2.3%
Any Anxiety Disorder	24.9%	19.1%

Anxiety Disorders

- **Panic Attack**
- **Intense Fear With Abrupt Onset of at least 4 Symptoms in < 10 Minutes**

Panic Attack Symptoms

1. Palpitations
2. Sweating
3. Shaking or trembling
4. Sensation of shortness of breath
5. Chest pain or discomfort
6. Choking sensation
7. Nausea or abdominal distress
8. Feeling dizzy or faint

Panic Attack Symptoms

- 9. Chills or heat sensations
- 10. Paresthesias (Numbness or tingling sensation)
- 11. a. **Derealization** (feelings of unreality)

  b. **Depersonalization** (feeling being detached from oneself)

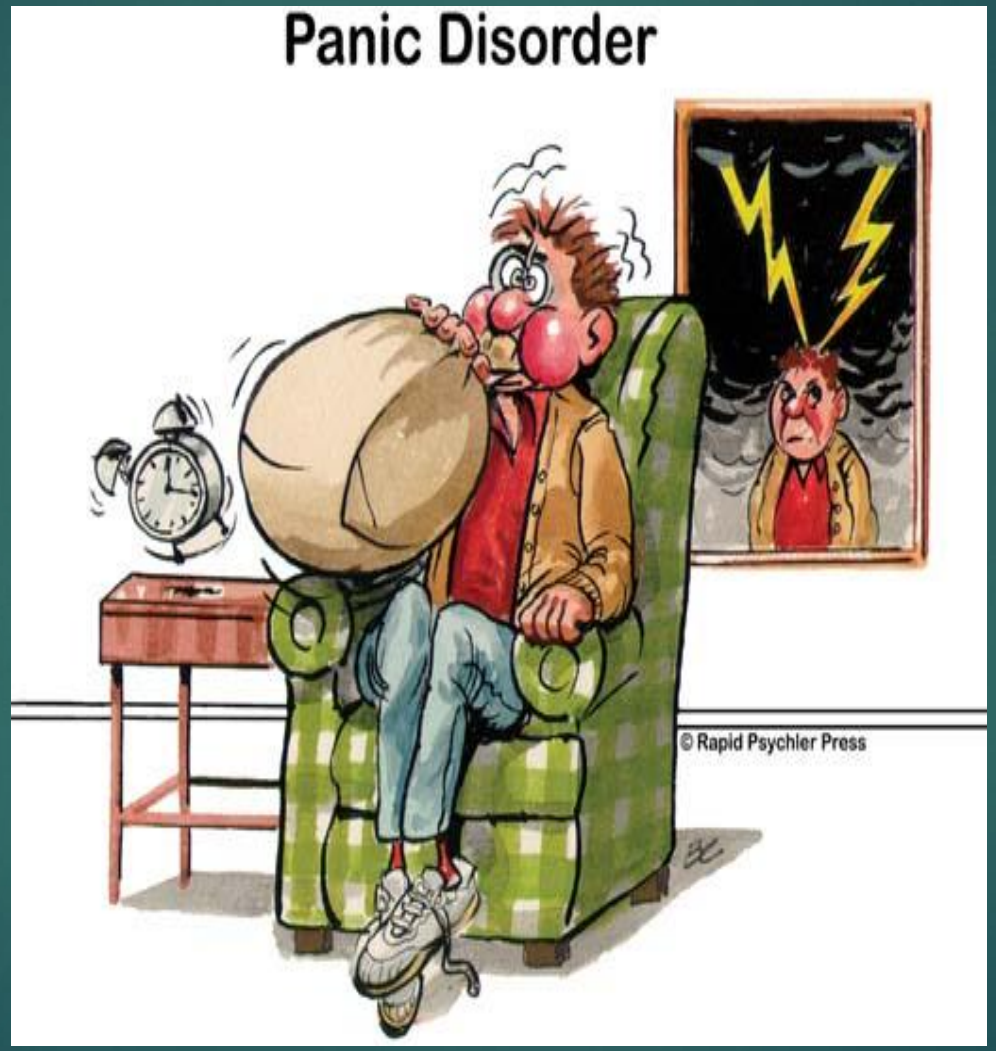
  Note: we will discuss these two terms in greater detail later in this lecture

Panic Attack Symptoms

- 12. Fear of Losing Control or “going crazy”
- 13. Fear of Dying

Panic Attack

- Lasts about 5 - 20 minutes
- **Hyperventilation:**
  - A Key Feature
- ***Anticipatory Anxiety***
  - Develops over time
- About 9% of population has had 1 panic attack


Panic Disorder
© Rapid Psychler Press

Panic Disorder

- **DSM-5-TR.**
- **A. Recurrent and Unexpected Panic Attacks**
  - At least 4 of the following is noted during a panic attack:
    1. Palpitations, pounding heart, or accelerated heart rate.
    2. Sweating
    3. Trembling or shaking
    4. Sensations of shortness of breath or smothering
    5. Feelings of choking
    6. Chest pain or discomfort
    7. Nausea or abdominal distress

Panic Disorder

- **A. Recurrent and Unexpected Panic Attacks**
  - At least 4 of the following is noted during a panic attack: **(continued)**
    8. Feeling dizzy, unsteady, light-headed or faint.
    9. Chills or heat sensations
    10. Numbness or tingling sensations
    11. Derealization (feelings of unreality) **or** depersonalization (being detached from oneself)
    12. Fear of losing control or "going crazy"
    13. Fear of dying

Panic Disorder *Continued*

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

1. Persistent concern about future panic attacks or their consequences (e.g., losing control, heart attack, going crazy)
2. Significant maladaptive change in behavior related to the attacks to avoid panic attacks such as avoiding exercise or unfamiliar situations)

Panic Disorder *Continued*

C. The disturbance is not due to effects of an illicit substance or medication or another medical condition (e.g., hyperthyroidism cardiopulmonary disorders)

D. Not due to another mental disorder

Panic Disorder

- Often of short duration
- Not Sure if Real or Imagined Symptoms
- In face of Undiagnosed attacks, Patients will:
  - Restrict Activities
  - Avoid Crowds

Panic Disorder Differential

- Cardiovascular
  - Myocardial Infarction
  - Angina
  - CHF
- Pulmonary
  - Embolism
  - Hyperventilation
  - Asthma
- Neurologic
  - CVA
  - Tumor
- Endocrine
  - Hyperthyroidism
  - Diabetes
- Drug intoxication
  - Amphetamine
  - Cocaine
  - Marijuana
- Drug withdrawal
  - ETOH
  - Sedative hypnotics

With all these possible medical causes to rule out, this is why many people with panic disorder are seen initially in an EDR

Panic Disorder Symptoms

- Triad of Panic
  - **Acute Panic Attack(s)**
    - Locus Coeruleus
  - **Anticipatory Anxiety**
    - Hippocampus
    - Fear Of Next Attack
  - **Phobic Avoidance**

Panic Disorder

- A Common Chronic Disorder
- Found in 1-3% Of General Population (Note: 2/3=Women)
- 6% Of Primary Care Patients have this Disorder
- Studies show up to ~50% seeing cardiologist have PD
- Onset: Typically mid-20s, and 8/10 < age 30.
- 1/3-1/2 of Panic Disorder patients have Agoraphobia
- Some patients report onset after a serious life event (e.g., illness, accident, or relationship breakup) or it occurred after using drugs such as LSD or marijuana.

Agoraphobia

DSM -5-TR:

A. Fear and Anxiety of ≥ 2 of following 5 situations:

1. Using public transportation
2. Being in open spaces (parking lots, markets, bridges)
3. Being in enclosed places (shops, theaters)
4. Standing in lines or being in a crowd
5. Being outside of the home alone

Agoraphobia

DSM -5-TR: (Continued)

B. The individual fears or avoids these situations because of thoughts that escape might be difficult or that help might not be available in the event of developing panic-like symptoms or other incapacitating or embarrassing symptoms (e.g., fear of falling in elderly; fear of incontinence).

C. Agoraphobic situations almost always provoke fear or anxiety

D. Agoraphobic situations are actively avoided, require the presence of a companion, or are endured with intense fear or anxiety

Agoraphobia

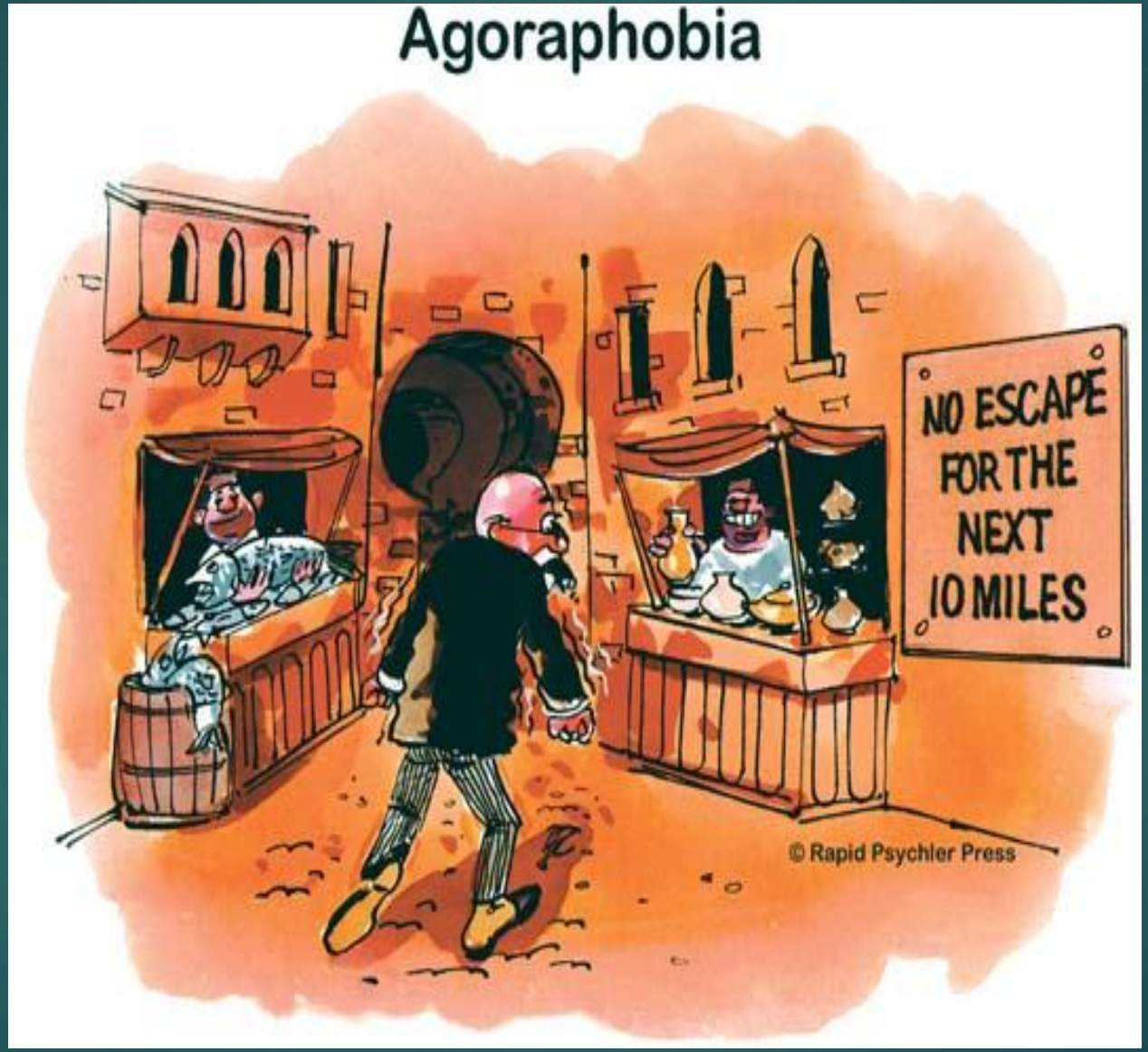
DSM -5-TR: (Continued)

E. The fear or anxiety is out of proportion to the actual danger posed by the agoraphobic situations and sociocultural context.

G. Fear, anxiety or avoidance causes clinically significant distress or impairment in social occupational or other important areas of functioning.

H. If another medical condition is present (e.g., inflammatory bowel disease , Parkinson's disease) is present, the fear, anxiety or avoidance is clearly excessive.

I. Fear, anxiety or avoidance not better explained by symptoms of another mental disorder


Agoraphobia
NO ESCAPE FOR THE NEXT 10 MILES
© Rapid Psychler Press

Trapped at Home...Agoraphobia

Is she Depressed?

Agoraphobia

- **Typical Fears**
  - Public Transportation
  - Crowds
  - Shopping Centers
  - Elevators
  - Waiting in Lines
  - Tunnels
  - Airplanes
- Severe Case may become **Housebound**
  - **Need ***Phobic Companion*** *to leave home*****

Panic / Agoraphobia

- High Incidence of:
  - Marital Discord
  - Job Loss
  - Alcohol/Substance Abuse
    - Up to 20% who have panic disorder have substance misuse issues
  - **Depression !!!!!!**

Panic Disorder

Depression:

Major depression noted in 50-65% with Panic Disorder

- 1/3 Major Depression preceded Panic Disorder

Increased Risk of Suicide if Panic and Major Depression co-exist

a. 7% suicide with Panic Alone
b. 8% suicide with Major Depression alone
c. 14% Suicide with both present.

Panic Disorder Treatment

- A. Therapeutic Overview
  - Present to the Patient a complete explanation-
    - Unfortunately, only about 10% respond to complete explanation of the problem.

Panic Disorder Treatment

B. Cognitive Behavioral Therapy (CBT)

1. Usually involves 10-20 sessions of 1-2 hours.
2. Provide Information on link between thoughts and anxiety response
3. Allows testing of new ways to think
   a. My heart is beating fast, it is unpleasant but not dangerous.
4. Allows patient to apply a new response in stressful situations

Panic Disorder Treatment

C. **Behavior Therapy**

Relaxation Response

a. Patient sets up hierarchies

b. Breathing

c. Imagining (ex.: Place patient may enjoy)

D. **Systematic Desensitization** (Exposure Therapy)

a. **Flooding**: Rapid Therapy

b. **Graded Exposure**: Slower

Panic Disorder Treatment

E. **Medications**

- **Antidepressants** (1st Line Treatment)
  - **SSRIs** (Try 1-2) (Blocks panic attacks in 70-80% patients)
    - Must stay on meds 6 months to a year to prevent relapse
  - **TCAs** (Try 1-2)
  - **MAOIs** (dietary issues)
- **Benzodiazepines (2nd Line Treatment)**
  - Useful for **Anticipatory Anxiety**
  - Works rapidly
  - Contraindicated for substance abuser

Panic Disorder Treatment

F. **Relapse**

Common after stopping medication

Many recommend staying on medications for at least a year to prevent relapse.

Will need to restart Medications if relapse occurs after stopping meds

Anxiety Disorders:
63 minutes of clips

The Anxiety Disorders Video: Panic Disorder

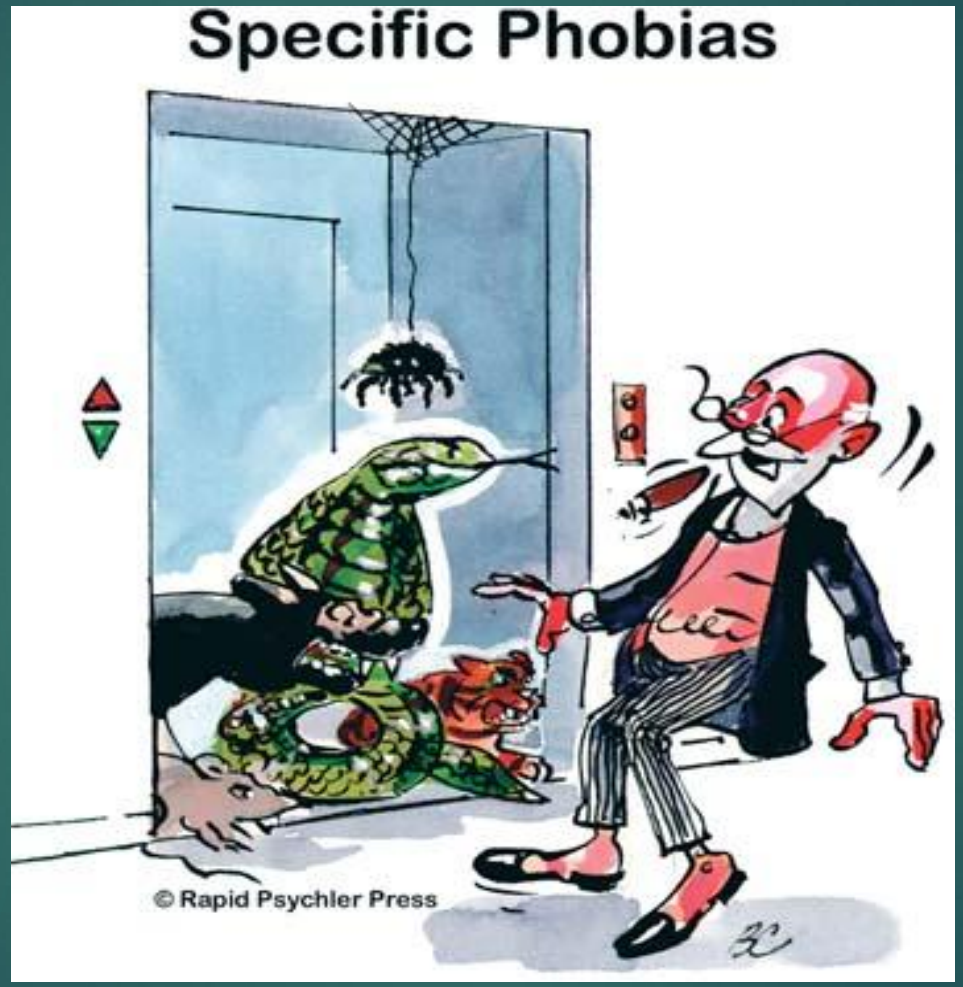
- Clip # 1
  - 1.1

00.00-00:46

~ 10 minutes

Points to listen for or observe for in the video

1. What are some symptoms described by the patients and or the psychiatrists?
2. Where are patients having a panic attack most often seen?
3. How does a panic attack differ from a panic disorder ?
4. How do the patients describe the way they restricted their lives.
5. One patient noted she patient stayed in her home 8 years. (actually agoraphobia)
6. Watch Ted, Donna's husband, closely. See if you notice something interesting.
7. How is PD it treated?
8. Were TCAS effective?
9. What is the problem using a benzodiazepine?
10. What is the "double benefit" one can derive when using an SSRI for PD?


Specific Phobias
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Specific Phobia

- **DSM -5-TR**
  - A. Marked fear or anxiety about a specific object or situation (e.g. flying, heights, animals, injections, seeing blood)
  - B. The phobic object or situation almost always causes immediate fear or anxiety
  - C. The phobic object or situation is avoided or endured with intense fear or anxiety
  - D. Fear or anxiety is out of proportion to the actual danger posed by the object or situation

Specific Phobia

- DSM -5 (continued)
  - E. The fear, anxiety or avoidance is persistent, typically lasting for 6 months or more.
  - F. The fear, anxiety or avoidance causes clinically significant distress or impairment in social, occupational or other important areas of functioning.
  - G. The disturbance is not better explained by the symptoms of another mental disorder

Specific Phobias

- Fear of Specific Objects, Situations or Activities
  - Three Parts:
    - **Anticipatory Anxiety** of Phobic Stimulus
    - **Central Fear Itself**
    - **Avoidance of Object** to Decrease Anxiety

Most Common Specific Phobias High to Low

- **Animals:** Zoophobia.
- **Storms:** Brontophobia.
- **Heights:** Acrophobia
- **Illness:** Nosophobia
- **Injury:** Traumatophobia.
- **Death:** Thanatophobia.

Specific Phobia Types

- **Animal Type**
  - Horses, Dogs, Snakes
- **Natural Environmental**
  - Heights
  - Storms
  - Water
- **Blood-Injection-Injury Type**
  - Associated with fainting
  - Often familial

Situational Type

- Planes,
- Elevators
- Enclosed Places

- **Other Types:**
  - Choking,
  - Falling

  etc.

Blood Injection-Injury Type

Is this a snake phobia?

Perhaps I can wait till we reach our hotel

Fear of Cars or Riding in Car

Amaxophobia

Fear of Flying

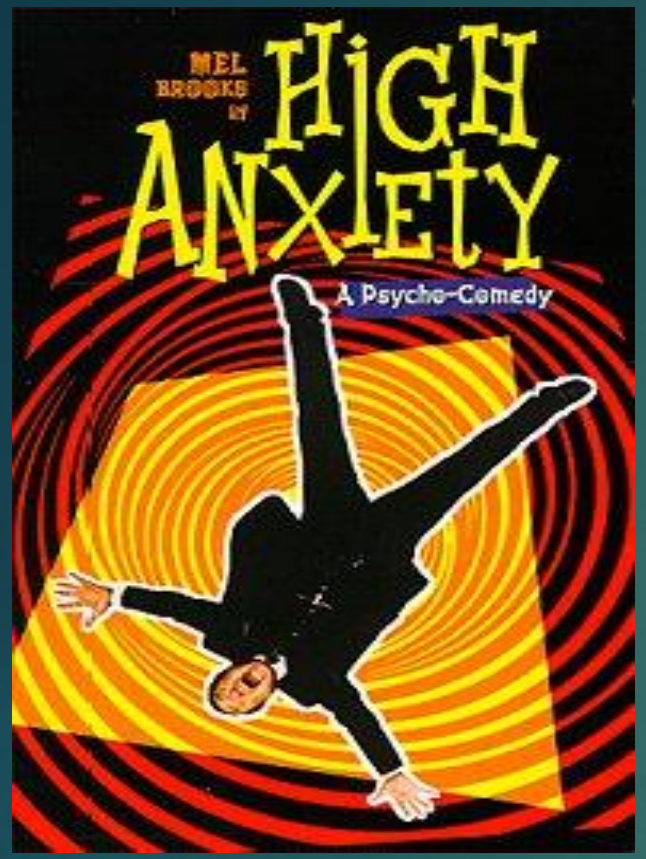
aviophobia

John Madden

Treatment of Phobias

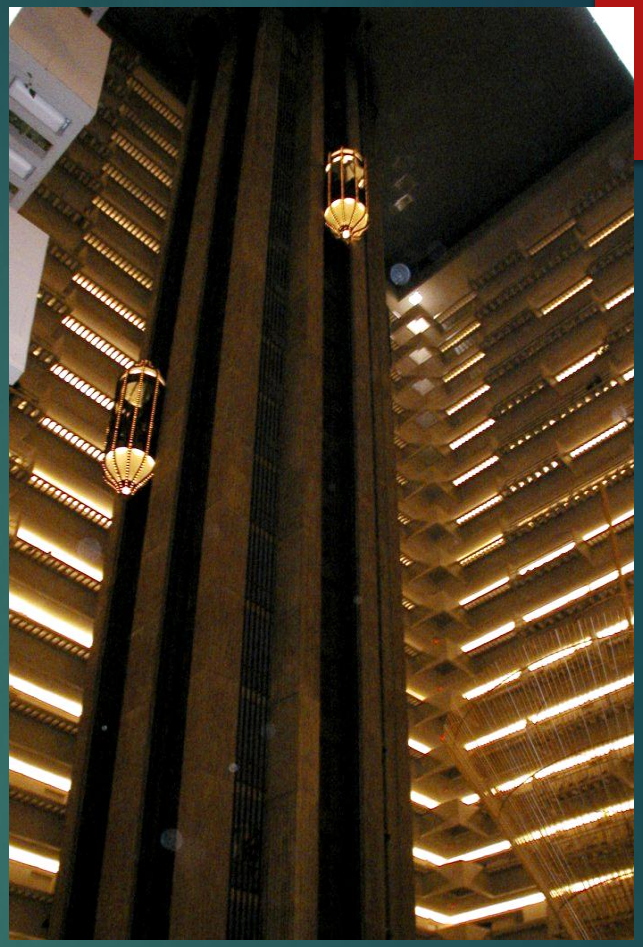
- Specific Phobia
  - Exposure
  - Medications
    - Note: Use <u>medications only</u> if associated with Panic

Phobias



1977 Film

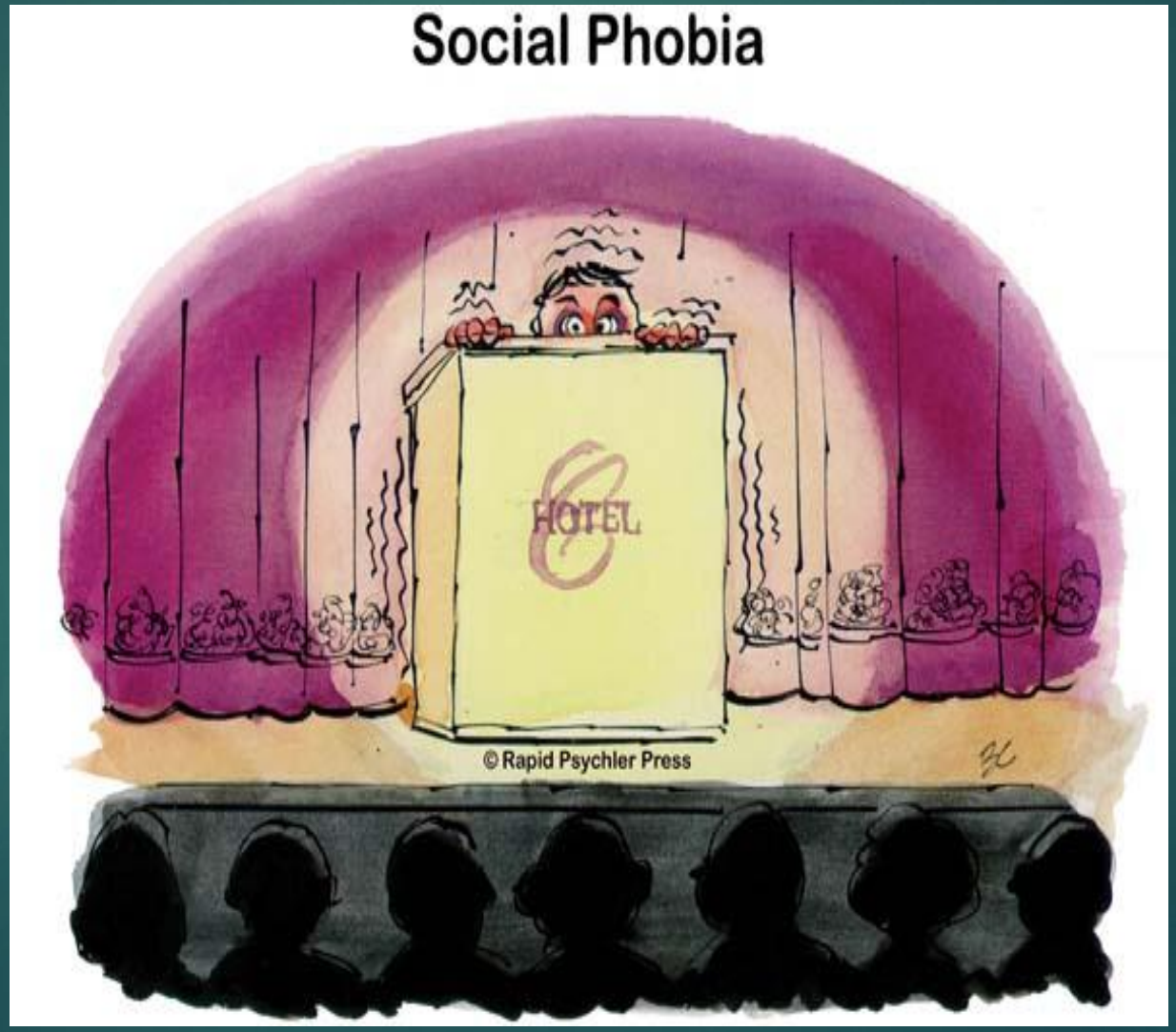
- **VIDEO TAPE** Clip # 2
  - 2.1
  - 00.00-0028
  - (~ 4 min)



The Hyatt Regency S.F.

Although no treatment is described for his fear of heights (acrophobia), one might argue that he received exposure therapy…was it graded or flooding? Do you think it helped him?

Social Anxiety Disorder



Social Anxiety Disorder

Social Anxiety Disorder
(Social Phobia)

- **DSM -5-TR Criteria**
  - A. Marked and persistent fear of one or more social situations in which the person is exposed to possible scrutiny by others. Examples include social interactions (e.g., having a conversation, meeting unfamiliar people), being observed (e.g., eating or drinking), and performing in front of others (e.g., giving a speech)
  - B. The individual fears that he or she will act in a way (or show anxiety symptoms) that will be negatively evaluated (i.e., humiliating or embarrassing; will lead to rejection or offend others.

Social Anxiety Disorder
(Social Phobia)

- **DSM -5-TR Criteria (continued)**

- C. Social situations almost always provoke fear or anxiety
- D. Social Situations are avoided or endured with intense fear or anxiety
- E. The fear or anxiety is out of proportion to the actual threat posed by the social situation

Social Anxiety Disorder
(Social Phobia)

- **Criteria DSM-5-TR (continued)**
  - F. The fear, anxiety or avoidance is persistent typically lasting **6 months or more**.
  - G. The fear, anxiety or avoidance causes clinically significant distress or impairment in social, occupational or other areas of functioning.
  - H. The fear, anxiety or avoidance is not due to a substance (illicit drug or medication).
  - I. Not better explained by another medical condition
  - J. Not better explained by another mental condition such as panic disorder, BDD (body dysmorphic disorder)
  - K. If another medical condition (e.g., Parkinson's disease, obesity, burn disfigurement or injury) is present the fear, anxiety or avoidance is unrelated or is excessive.
  - **Note**: **Performance only**: if fear is restricted to speaking or performing in public.

Social Anxiety Disorder
(Social Phobia)

- **Excessive Fear of Humiliation or Embarrassment in Social Situations**
  - Public Speaking
  - Urinating in Rest Room
  - Asking Someone out for a Date
  - Going to Parties
  - Eating at a Restaurant

Social Anxiety Disorder
(Social Phobia)

- Public Speaking Fears:
  - Onset typically from age: 13-20
  - Fears Typically Concern:
    - A. Doing or saying something embarrassing
    - B. Mind going blank
    - C. Unable to continue talking
    - D. Saying foolish things or not making sense
    - E. Trembling, shaking, or showing signs of anxiety
- About 10% reported a marked interference with social life, education or caused marked distress.

Social Anxiety Disorder (Social Phobia)

- **Prevalence**
  - 3-13% Up To 20%
- **Symptoms Noted**
  - Blushing
  - Muscle Twitching
  - Anxiety over Scrutiny
  - 1/8 develop **substance misuse**. (e.g. Alcoholism)
  - **Depression** common: Up to **50%**

Social Anxiety Disorder
(Social Phobia)

- Treatment
  - Most SSRIs
  - MAOIs hypertensive crisis (Tyramine)
    - Avoid:
    - Sympathomimetic Amines (cough meds etc.)
    - Foods: Various cheeses, cured meats
    - Treat with an adrenergic antagonist e.g.. Thorazine (chlorpromazine)…lowers BP in 5 min
    - Note Fatal reactions were noted when MAOI was used with Demerol or Fentanyl (These weak serotonin reuptake inhibitors can lead to Serotonin Syndrome/toxicity) * (NY Times)
  - Benzodiazepines (Alprazolam (Xanax)…use with caution
- Try to avoid
  - TCAs…may cause jitteriness
  - Buspirone (buspar): Not Effective??
  - B-Blockers…May help with public speaking

Social Anxiety Disorder
(Social Phobia)

- **Treatment**
  - Behavior Therapy
    - Systematic Desensitization and flooding
  - Cognitive Behavior Therapy
    - People are not scrutinizing you any more than anyone else
      - "Toastmasters" for practice after CBT

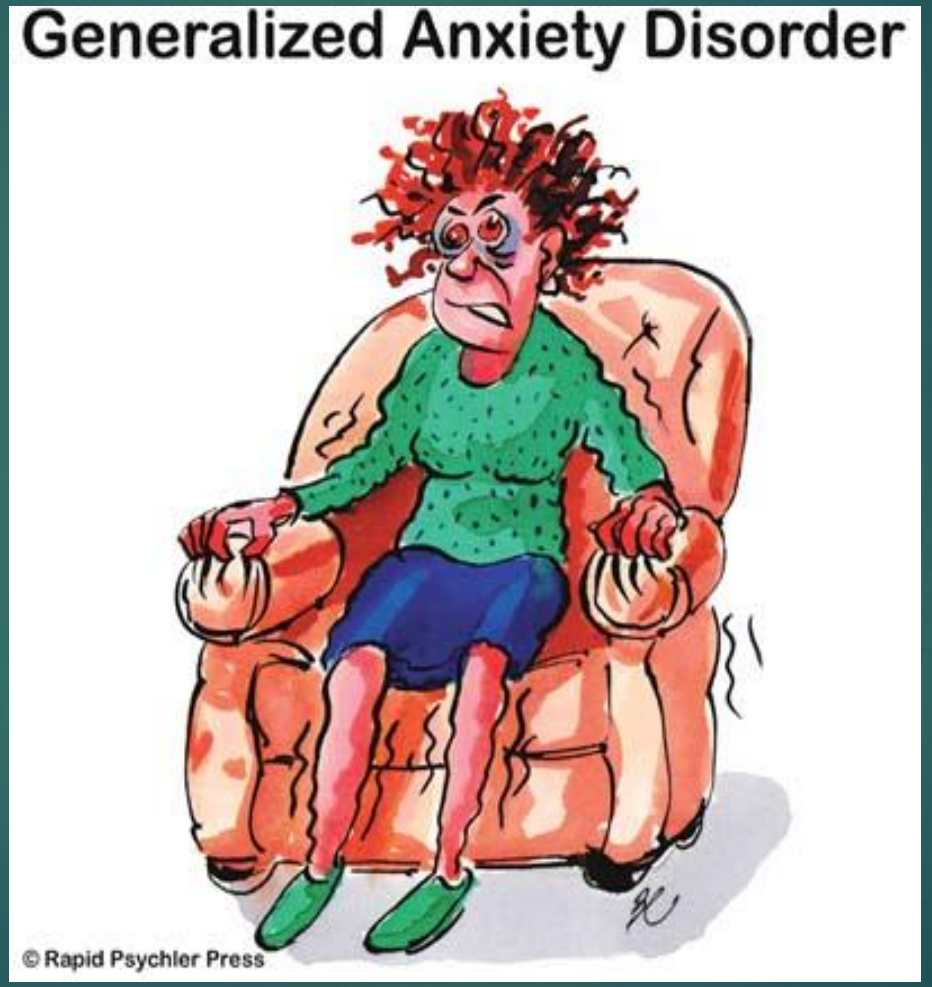
Social Anxiety Disorder (SAD)

(Social Phobia)

VIDEO
Clip # 3
3.1
00.00-00.20
(~10 min)

Thoughts to ponder:

1. Is SAD the same as shyness?
2. Do these patients experience symptoms of anxiety in social situations?
3. Do they fear being center of attention?
4. Do they often have a fear of speaking in front of others,
5. Is depression noted in SAD?
6. Is alcoholism and or illicit drug use noted a part of SAD?
7. Is depression noted in SAD
8. What is the treatment of SAD
9. (Not part of the video)
   How does SAD differ from avoidant and schizoid personality disorders?


Generalized Anxiety Disorder
© Rapid Psychler Press

Generalized Anxiety Disorder

- **DSM-5-TR**
- A. Excessive Anxiety and Worry (Apprehensive Expectation) occurring more days than not ≥6 months about number of events, (e.g., work or school performance)
- B. Individual finds it difficult to control the worry
- C. ≥3 of following present most days in a month (some present 6 months):
  - 1. Restless or keyed up, on edge
  - 2. Easily Fatigued
  - 3. Difficulty Concentrating, or mind going blank
  - 4. Irritable
  - 5. Muscle Tension
  - 6. Sleep Disturbance (DFA or restless sleep)

Generalized Anxiety Disorder

- **DSM -5-TR (Continued)**
- D. The anxiety, worry or physical symptoms cause clinically significant distress, or impairment in social, occupational or other important areas of functioning.
- E. The disturbance not attributable to physiologic effects of a substance (e.g., drug of abuse, a medication) or another medical condition (e.g., hyperthyroidism)
- F. The disturbance is not better explained by another mental disorder

Generalized Anxiety Disorder

- **Epidemiology**
  - Fairly common: 4-7% of general population
  - **Women > Men**
  - **Leading cause of workplace disability in the U.S.!!!!**
  - Usually begins age 20-30
  - In only 33.3% of such cases is psychiatric treatment initially sought
    - (2/3) (Internal Med. for SOB, palpitations, sleep issues)
    - **Most common anxiety disorder in primary care setting**
  - **Panic Disorder noted in 25% with GAD**
  - **Complications**
    - **Depression**: Seen in **up to 80%** of patients over time
    - **Substance Abuse** is noted (alcohol/drugs to control symptoms)

Generalized Anxiety Disorder

- **Other Facts**:

  Patients typically present with:
  Muscle pain,
  headache,
  irritability,
  insomnia,
  fatigue,
  restlessness,
  muscle cramps

Generalized Anxiety Disorder

Other Facts: (continued)

4. **90% with GAD answer yes** to the following question:
    1. "During the past 4 weeks, have you been bothered by feeling worried, tense or anxious most of the time?"
5. GAD can worsen a physical condition if the GAD is untreated
6. In GAD there is emphasis of worry about everyday or real life problems.

Generalized Anxiety Disorder

- **Treatment:** Which approach to utilize must be a shared decision.
- **SSRIs: Jost feel they shoudlbe ocninued for aobut a year.**
  - Paroxetine (Paxil) (20-50 mg./day)
  - Escitalopram (Lexapro) (10-20 mg./day)
- **SNRI**
  - Venlafaxine (Effexor) (75-225/day)
- **TCAs**

Generalized Anxiety Disorder

- **Treatment: continued**
  - Benzodiazepines
    - Addictive Potential (give only briefly)
  - Clonazepam (Klonopin)
    - Long acting benzo; less abuse potential
      - So good choice if benzo is given for brief time
  - Lorazepam (Ativan)
    - 0.5 mg. BID - TID
      - Sedation is side effect; short acting
  - Alprazolam (Xanax)
    - May cause rebound anxiety so give total dose in 4-5 divided doses; short acting, sedating, hard to get off this med
  - Buspirone (Buspar) (10-40 mg/day) (typically need 30+ mg/day)
    - 30+ days to work
    - No dependence, no tolerance,
    - No sedation or agitation
    - Low potential for abuse or addiction

Treatment Continued

- Cognitive Behavioral Therapy (CBT)
  - Some patients may may opt for CBT I they do not want medications.
  - Some patients are concerned about length of time and number of sessions for CBT so opt for medications.
  - Some patients with co-existing depression may not be able to tolerate CBT
  - Patients with substance abuse , will do best if the abuse and GAD are both treated

Generalized Anxiety Disorder

I just can't stop worrying.
Almost anything worries me
I worry about worrying.

- VIDEO TAPE
- Clip # 4
  Joan
- 4.1

00.00-00.47 (~5 min)

Points to Ponder

1. What makes her worry?
2. Does she worry about many things.
3. Has she taken psychiatric meds?
4. Has she been Hospitalized?
5. Does she have MDD?
6. Is she suicidal?
7. Does she use illicit substances?
8. Does she have trouble leaving home or going out in public?
9. Does worrying interfere with her work?
10. What do you notice about her hands?

Substance/Medication Induced Anxiety Disorder

- **DSM -5-TR Criteria**
- A. Panic attacks or anxiety predominate clinical picture
- B. Evidence from history, physical examination or lab findings of both (1) and (2).
  - 1. Symptoms in Criterion A develop during or soon after substance intoxication or withdrawal or after exposure to a medication
  - 2. The involved substance/medication is capable of producing the symptoms in criterion A.

Substance/Medication Induced Anxiety Disorder

- DSM -5-TR Criteria
- C. Disturbance not better explained by an anxiety disorder
- D. The disturbance does not occur exclusively during the course of a delirium
- E. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- Note: Use this diagnosis instead of substance intoxication/withdrawal only if symptoms in criterion A predominate the clinical picture and are sufficient to warrant clinical attention.

Anxiety Disorder Due to Another Medical Condition

- **DSM -5-TR Criteria**
- A. Panic attacks or anxiety is predominant in clinical picture.
- B. Evidence from history, physical examination or laboratory findings that the disturbance is due to another medical condition.
- C. The disturbance is not better explained by another mental disorder.
- D. Disturbance does not occur exclusively during course of a delirium
- E. Disturbance causes clinically significant distress or impairment in social, occupational or other important areas of functioning.
- Note: List the medical condition causing the anxiety

Other Specified Anxiety Disorder (Not on Test)

- DSM -5-TR Criteria
- A. This category is applied when symptoms of an anxiety disorder are present but do not meet the full criteria for any of the disorders in the anxiety disorders class.
- Use when clinician wants to communicate reason presentation does not met criteria.
- Examples:
  - 1. Limited symptom attacks
  - 2. Generalized anxiety, but not occurring more days than not.

Unspecified Anxiety Disorder (Not on Test)

- DSM -5-TR Criteria
- This category is applied when symptoms of an anxiety disorder are present but do not meet the full criteria for any of the disorders in the anxiety disorders class.
- Used in situations in which the clinician chooses not to specify the reason the criteria are not met for a specified anxiety disorder and includes presentations in which there is insufficient information to make a more specific diagnosis (e.g., in emergency room settings)

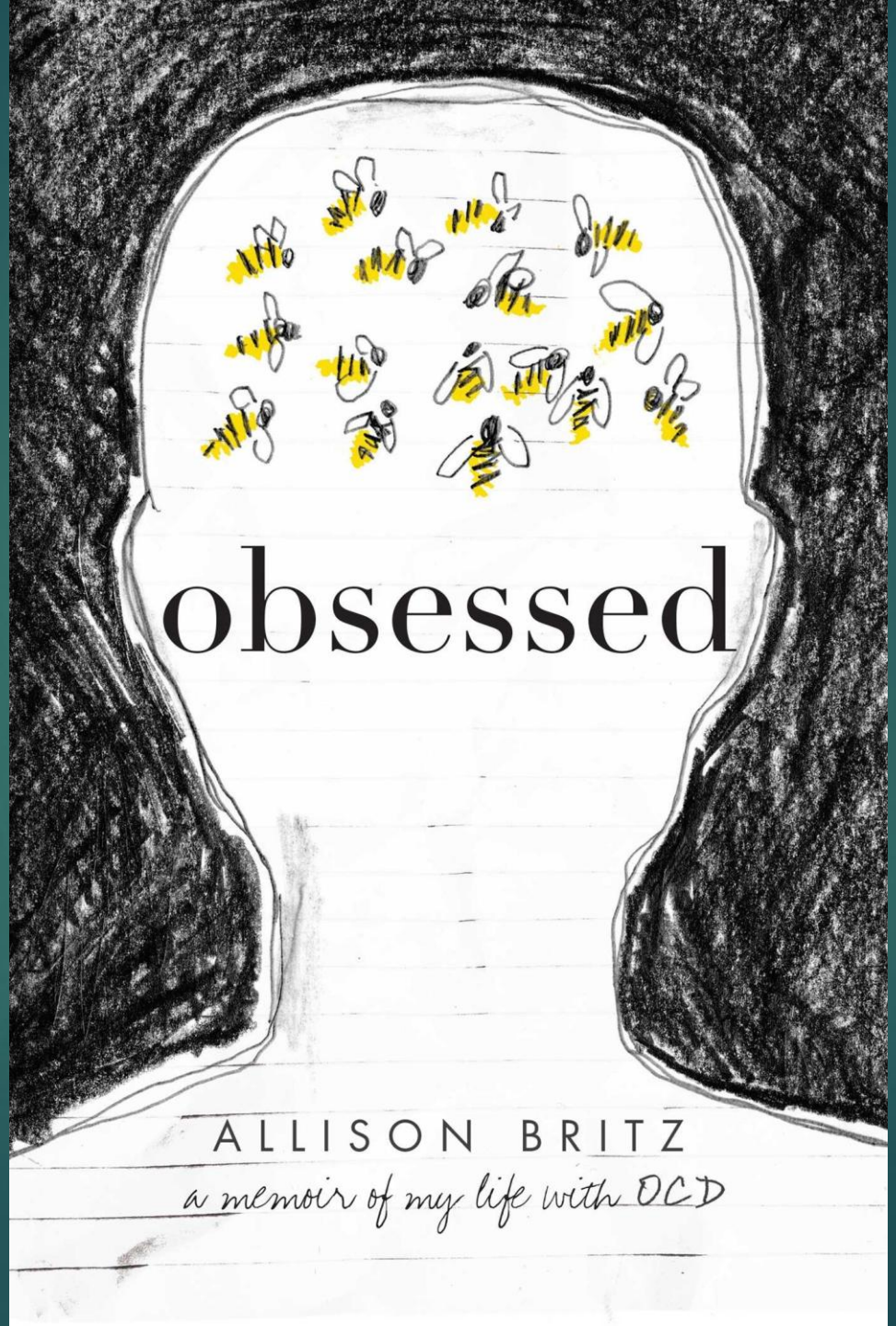
Obsessive-Compulsive and Related Disorders

Obsessive-Compulsive and Related Disorders

- DSM-5-TR

1. Obsessive Compulsive Disorder (OCD)
2. Body Dysmorphic Disorder (BDD)
3. Hoarding Disorder
4. Trichotillomania (Hair-Pulling Disorder)
5. Excoriation (Skin Picking) Disorder
6. Substance /Medication-Induced Obsessive Compulsive and Related Disorder
7. Obsessive Compulsive and Related Disorder Due to Another Medical Condition
8. Other Specified Obsessive–Compulsive and Related Disorder (not on test)
9. Unspecified Obsessive–Compulsive and Related Disorder (not on test)

True story of a HS student who suddenly is convinced she has cancer (obsession) and the various acts/rituals (compulsions) she then must perform to deal with this belief.
Nice discussion of Exposure Response Prevention (ERP).
Excellent book that is hard to put down.



Obsessive Compulsive Disorder (OCD)

- **DSM -5-TR** Criteria
- A. Presence of obsessions, compulsions or both
- Obsessions: defined by (1) and (2):
  - 1. Recurrent and persistent thoughts, urges or images experienced as intrusive and unwanted and that in most individuals cause marked anxiety or distress
  - 2. Individual tries to ignore or suppress such thoughts, urges or images or neutralize them with some other thought or action((i.e., performing a compulsion)

Obsessive Compulsive Disorder (OCD)

- **DSM -5-TR Criteria** (continued)
- A. Presence of obsessions, compulsions or both
- Compulsions: defined by (1) and (2):
  - 1. Repetitive behaviors (e.g., hand washing, ordering, checking) or mental acts (e.g., praying, counting, repeating words, silently) that the individual feels driven to perform in response to an obsession or according to rules that must be applied rigidly.
  - 2. Behaviors or mental acts aimed at preventing or reducing anxiety or distress or preventing a dreaded event or situation; however behaviors or mental acts not connected in realistic way with what they are designed to neutralize/prevent or are clearly excessive

Obsessive Compulsive Disorder (OCD)

- **DSM -5-TR Criteria** (continued)
- B. Obsessions or compulsions are **time consuming** (e.g., > 1 hour/day) or cause clinically significant **distress** or **impairment in** social, occupational, or other **important areas of functioning**.
- C. The obsessive-compulsive symptoms not due to substance or another medical condition.
- D. Disturbance not due to another mental disorder (e.g., excessive worries as in generalized anxiety disorder, preoccupation as in body dysmorphic disorder, etc.
- Specify degree of insight:
  - 1. Good/fair: Recognizes beliefs are not or probably not true
  - 2. Poor: Beliefs are probably true
  - Absent Insight/delusional beliefs: Convinced beliefs are true

OCD Epidemiology

- 2% - 3% of the general population
- Mean age onset is 22 years
- Can begin at any age but usually begins in late teens or early 20s.
- Most have developed the illness by age 30
- Men = Women
- 1 / 200 Children are affected
- Recurrent periods of major depression occur in 70%-80% of patients

OCD Etiology

- Cause is unknown, but
- Many favor a neurobiological model because:
  - Found in various neurological disorders e.g., :
    - Brain trauma
    - Epilepsy
    - Sydenham's Chorea
    - Huntington's Chorea
  - PANDAS (Pediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcal infections)
    - They develop obsessions and compulsions, and emotional lability, separation anxiety, and tics
- Appears to have some genetic component
- Appears linked to Tourette's Disorder

Obsessions

- Recurrent persistent **thoughts, impulses,** which are experienced as intrusive & cause marked anxiety
  - **Not merely worries about real life problems**
    - (I knew I should never have purchased that condo on Haiti. I lost all my money and got cholera to boot)
  - Efforts to ignore the thoughts/impulses is tried but not successful
  - Individuals know these thoughts are their own thoughts (i.e. not thought insertion)

Obsession	Foci of Preoccupation
Symmetry	Orderliness in arrangements, i.e., books
Aggression	Physical or verbal assault on self /others; accidents, mishaps, wars, disasters, war.
Contamination	Excreta, dirt, dust body fluids, germ , illness VD, AIDS, etc.
Sexual	Incestuous impulses; genitalia; homosexuality; sexual performance competence
Hoarding	Collecting items of any kind, especially with no value; inability to throw things out.
Religious	Committing sinful acts, Existence of God, etc.
Somatic	Preoccupation with body parts , appearance concern, belief in having a disease

Compulsions

- **Repetitive behaviors** (hand washing, ordering, checking) or mental acts (praying, counting, or repeating words silently) that person feels driven to do, **in response to an obsession**
- Such behaviors are **intended to reduce or avoid a dreaded event or situation**

Compulsions

- **75-95% Have both Obsessions and Compulsions**
- **Obsessions = Thoughts**
- **Compulsions = Behavior**
- **Usually strong desire to resist, but only about 50% actually do**

Compulsions

- Causes marked distress/time consuming
- Interferes with normal routine, occupation or school functions

Frequency of Obsessions and Compulsions

Obsession	%	Compulsion	%
Contamination	50	Checking	61
Pathological Doubt	42	Washing	50
Somatic	33	Counting	36
Symmetry Need	32	Need to confess	34
Aggressive Impulse	31	Symmetry/precision	28
Sexual Impulse	24	Hoarding	18
Multiple Obsessions	72	Multiple Compulsions	58

Treatment of OCD

- A. Pharmacotherapy
  - I. Serotonin Specific Reuptake Inhibitor (SSRI)
    - Fluoxetine (Prozac)
    - Paroxetine (Paxil)
    - Sertraline (Zoloft)
    - Fluvoxamine (Luvox)
  - II. TCA
    - Clomipramine (Anafranil) (many side effects)
  - Note:
    - Expect up to 3-4 months to see beneficial effects
    - 40% do NOT respond to the SSRIs
    - Usually only 35% symptom decrease
    - Relapse > than treatment of depression
    - Need higher dosages than if treating a depression

Treatment of OCD

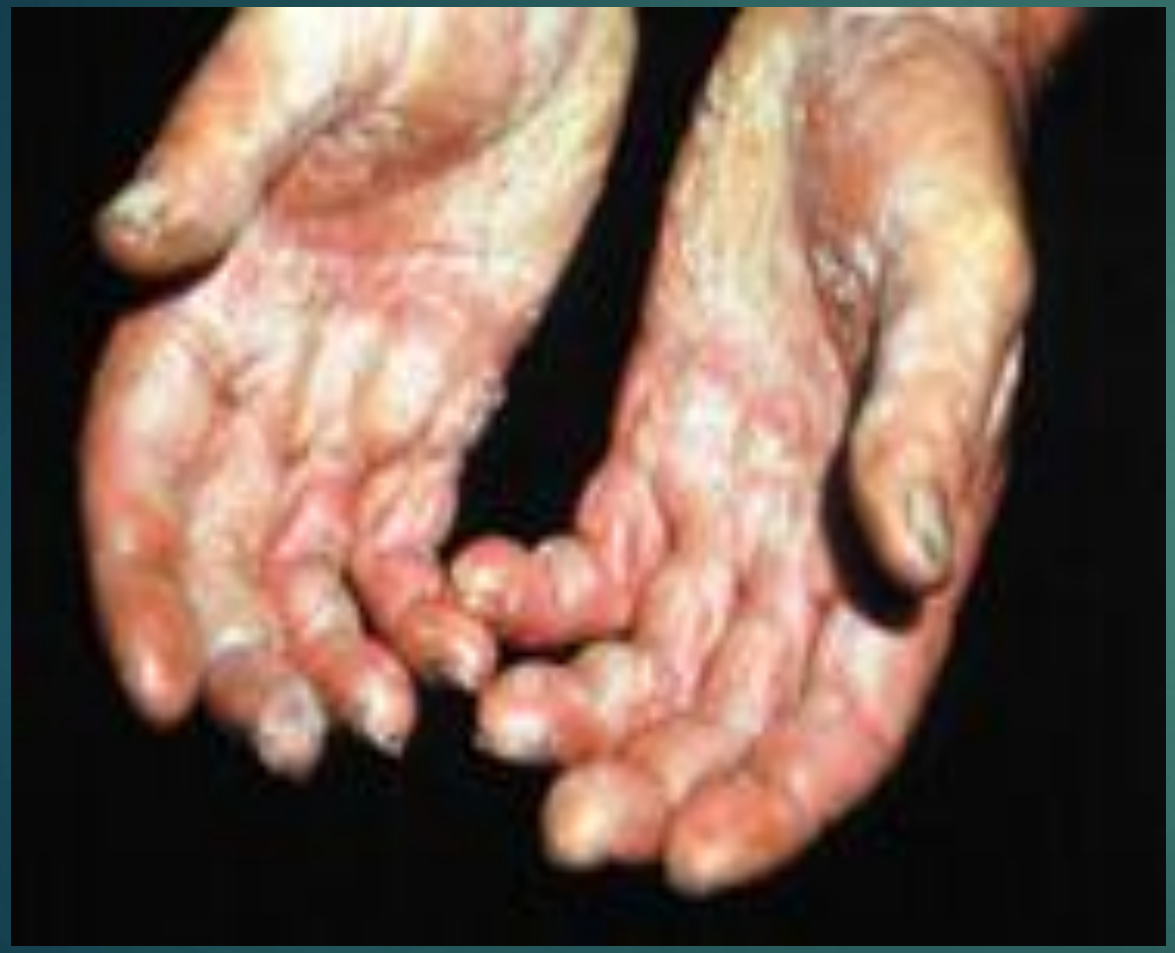
- B. **Behavior Therapy**
  - Best success with rituals
  - Many patients do well
  - Must do behavioral analysis to look at:
    - Target Behaviors
    - **Exposure and Response Prevention (ERP)**
      - Involves repeated and prolonged exposure to situations that provoke obsessional fear along with abstinence form compulsive behaviors . This will allow the patient to learn that these situations are not harmful and the anxiety will subside.
      - Effective ERP requires that the patient remain in the exposure situation until the obsessional distress decreases spontaneously , without attempting to reduce the distress by withdrawing from the situation, or by performing compulsive rituals, or neutralizing strategies.
      - Mild OCD: Recent studies show ERP is good first choice before meds.
      - If SSRIs not effective or not available, ERP can be quite useful
      - Ex: Patient is asked to touch a "contaminated" object, such as a door knob and then asked not to wash his or her hands.
    - Studies have shown that one likely to achieve Poorer results with CBT (ERP) If:
      - Hostile family members (lowest chance of success)
      - Severe depression (but OK if mild or moderate depression)
      - Poor insight

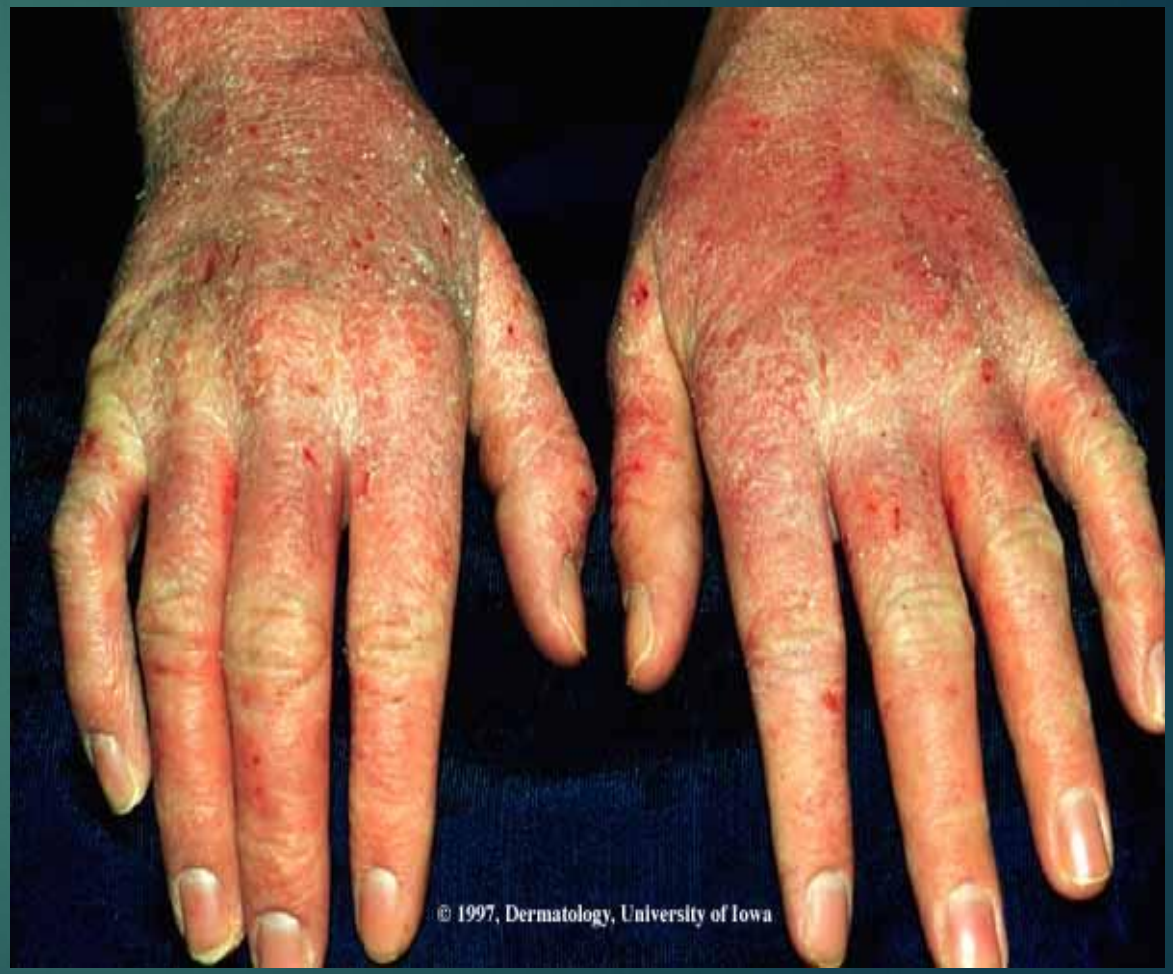
- C. **Internet Behavioral Therapy:** recently utilized with some success. Best for those unable to get to a therapist.
- D. **Individual Therapy**
- E. **Family Therapy:** Vey useful to avoid family hostility reducing chances for success.

OCD Comorbidity

- Depression !!!!!!!!
- Anxiety Disorders
- Eating Disorders
- Substance Abuse
- Tourette's Syndrome
  - Motor and Vocal Tics
  - Many have Obsessions and Compulsions
- Trichotillomania
  - Repetitive or compulsive hair pulling

Hand Washing Compulsion





VIDEO TAPE

OCD
Clip # 5
5.1
00.00-00.15
(8 min)

Points to Ponder

1. When do most cases begin.
2. Is it diagnosed quickly in most cases?
3. What is the difference between an obsession and a compulsion?
4. Why is OCD underdiagnosed?
5. Is there comorbidity with anxiety and depression?
6. What is the best treatment for OCD?

Video Clip # 6
6.1
00.00.-00.09

Points to Ponder

What compulsions does he exhibit?

1. Must turn the lock on door a specific # of times.
2. Can only use gloves 1 time
3. Uses multiple bars of soap
4. Soap tapped on sink a specific # of times
5. Water must be HOT.

(~ 1 min)

Body Dysmorphic Disorder

Body Dysmorphic Disorder

- **DSM -5-TR Criteria:**
  - A. Preoccupation with one or more perceived defects or flaws in physical appearance that are not observable or appear slight to others.
  - B. At some point during the course of the disorder, the individual has performed repetitive behaviors (e.g., mirror checking, excessive grooming, skin picking) in response to the appearance concerns.
  - C. The preoccupation causes clinically significant distress or impaired social, occupational or other important areas of functioning.
  - D. Appearance preoccupation not better explained by concern with body fat in a patient who meets an eating disorder criteria.

Body Dysmorphic Disorder

- Clinical facts
- Preoccupation: exists even after reassurance
- Typical Complaints
  - Flaws of face or head
  - Flaws of skin
  - Shape of head
  - Other body parts such as genitals, breasts extremities
  - Usually desire cosmetic surgery
  - Preoccupation may reach delusional proportions

Body Dysmorphic Disorder

- **Mirror Gazing**
  - is most common repetitive behavior (80%)
  - Most are disgusted by their reflection.
  - Some try to hide behavior by staring at any reflective surface even a spoon.
  - Use mirror to compare 3 different images:
    - What they saw in mirror
    - What they perceived as ideal image of themselves
    - Distorted image of themselves

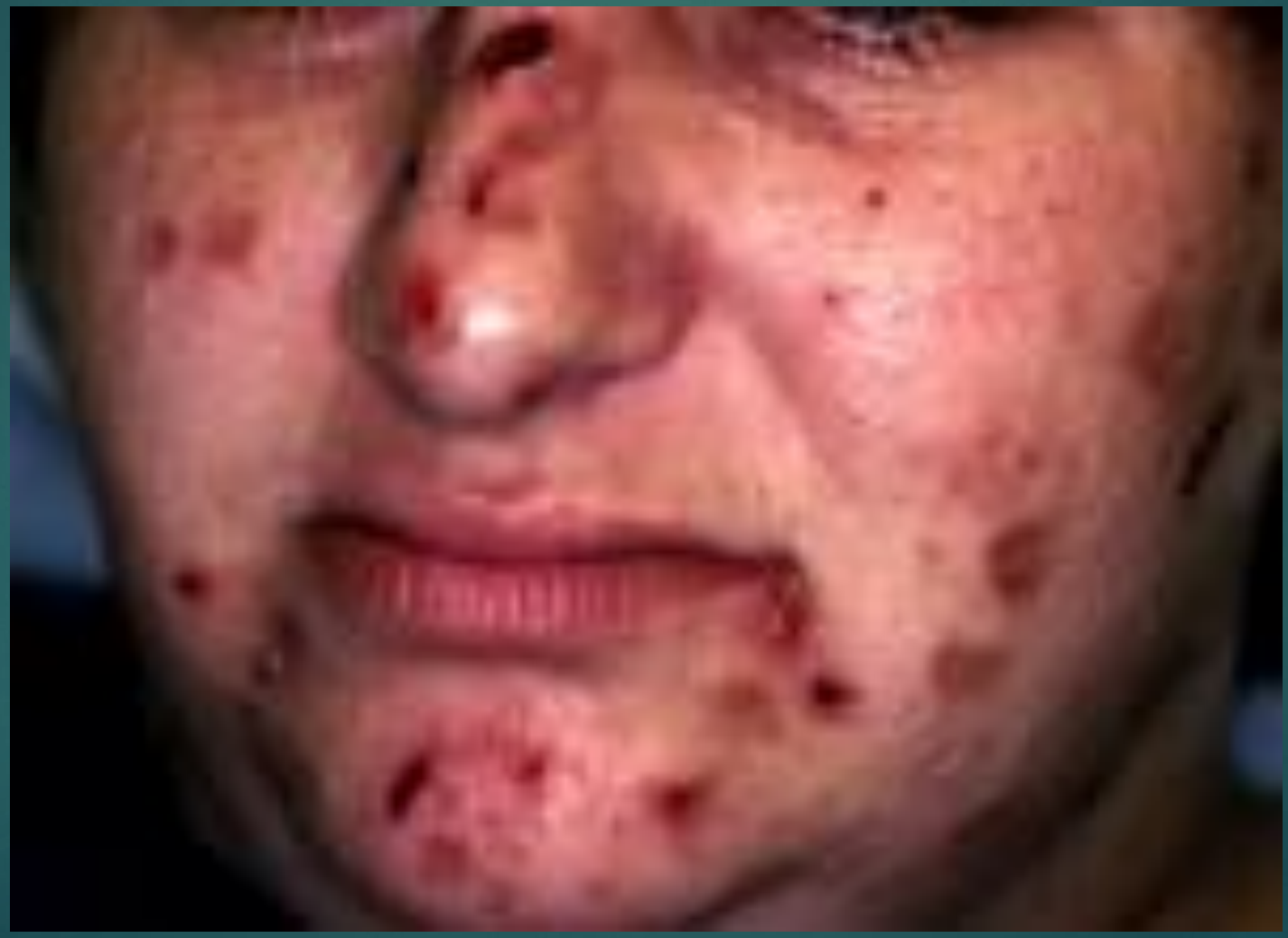
Mirror, Mirror On The Wall...Am I The Ugliest Of Them All?

Body Dysmorphic Disorder

- Compulsive Skin Picking (27%) to improve appearance. Some may do it for hours daily
- Some use knives, etc. (A Woman exposed her carotid artery after compulsive digging/picking)
- Most will camouflage their appearance if they go out in public
- Some will push their noses, skin etc. to try to get it to appear better

Body Dysmorphic Disorder

Skin Picking



APA Convention in SF

Body Dysmorphic Disorder

- **Differential Diagnosis**
  - Social Phobia-due to isolation
  - Histrionic Personality
  - (Illness Anxiety Disorder) Hypochondriasis
  - Major Depression
  - Schizophrenia

Body Dysmorphic Disorder

- Clinical Course
  - Onset: Adolescence early adult
  - Chronic condition usually
  - Rarely fully remits
  - May become highly incapacitating
  - 75% never marry
  - About 1/3 become housebound
  - Most feel embarrassed concerning their defect
  - Superimposed **depression common**
  - Suicide ideation/attempts are common
    - 1/5 try suicide

Body Dysmorphic Disorder

- Epidemiology
  - About 2% general population may have disorder
  - Estimated 7-15% seeking cosmetic surgery have this disorder
    - Rarely is surgery "curative"
    - Violence toward doctors by BDD patients occurs
  - Typically get to psychiatrist on referral from dermatology, plastic surgery, or ENT

Body Dysmorphic Disorder

- **Treatment**
  - Very difficult to treat effectively
  - Try to avoid plastic surgery
  - Lately SSRIs have shown positive response
  - (positive response = less distressed by "defect")
    - Fluoxetine (Prozac)
    - Clomipramine (Anafranil)
    - CBT
  - ***Other Issues*:**
    - *Anorexia Nervosa is excluded because in A.N. goal is to be thin, not to look normal.*
    - *Normal adolescent concerns about appearance are transient and teenager can typically be reassured*

Did Michael Jackson Have BDD?

Had 30+ plastic surgeries

Body Dysmorphic Disorder

VIDEO Clip # 7

7.1 Gloria

00.00-0043

(~5.30 min)

Points to ponder

1. What is the reason she is seeing a psychiatrist?
2. Has she seen multiple physicians?
3. When the psychiatrist reassures her about her hair loss, how does she respond?
4. Has her concern about her defect affected her job?
5. Do you think having surgery will lead to improvement in her functioning

Hoarding Disorder

Hoarding Disorder

- **DSM-5-TR Criteria (new category in DSM-5)**
- A. Persistent difficulty discarding or parting with possessions, regardless of their actual value
- B. This difficulty is due to a perceived need to save the items and to distress associated with discarding them.
- C. The difficulty discarding possessions results in accumulation of possessions that congest/clutter active living areas and markedly compromises their intended use. If living areas are uncluttered, it is due to the intervention of third parties(e.g., family members, cleaners, authorities)
- D. Hoarding causes marked distress or impairment in social, occupational or other important areas of functioning. (including safe environment for self or others)

Hoarding Disorder

- **DSM -5-TR Criteria (continued)**
- **E. Hoarding is not attributable to another medical condition (e.g., brain injury, cerebrovascular disease)**
- **F. Hoarding is not better explained by symptoms of another mental disorder e.g., delusions in schizophrenia, decreased energy in major depressive disorder, cognitive deficits in major neurocognitive disorder.**

Hoarding Disorder (continued)

- I. Prevalence
- A. 2-6%, with Males> Women
- B. May start in teens and by 30s cause significant impairment
- C. Typically chronic course with worsening with age.
- D. Risk factors
  - 1. Indecisiveness: prominent feature of patient and 1st degree relatives
  - 2. Stressful and traumatic life events
  - 3. 50% report having a relative who hoards
- II. Consequences of Hoarding
  - 1. Impairs normal activities in the house: cooking, sleeping, walking, etc.
  - 2, Utilities may be shut, due to difficult access
  - 3. Increased risk for fire, falls, poor sanitation
  - 4. Associated with poor health, impaired occupations, strained family relationships

Hoarding Disorder (Continued)

- **Comorbidity**
  - 1. About 75% have comorbid mood or anxiety disorder
    - **Major Depressive disorder** is noted in 50%
    - Social Anxiety Disorder (Social Phobia)
    - Generalized Anxiety Disorder (GAD)
    - OCD criteria is met in about 20%
  - 2. Seeking Treatment
    - Most do not come for hoarding treatment but rather for comorbid symptoms.
    - Often home visits are warranted to assess the risks.
    - Hoarding is rarely asked about during interviews.

Hoarding Disorder (continued)

- Associated Features: **Animal Hoarding**:
  - A. Accumulation of a large number of animals
  - B. Failure to provide minimal standards of nutrition, sanitation and veterinarian care, and
  - C. Failure to act on deteriorating condition of the animals (including disease, starvation, or death) and
  - D. The environment (e.g. severe overcrowding, extremely unsanitary conditions.
  - E. Animal hoarding may be a special manifestation of hoarding disorder. Most individuals who hoard animals also hoard inanimate objects.
  - F. The most prominent differences between animal and object hoarding are the extent of the unsanitary conditions and the poorer insight in animal hoarding.

A new category In DSM-5-TR

Hoarding


© TLC

Animal Hoarding

Hoarding Disorder

Treatment

Think outside the box.

1. Medication and psychotherapy do not appear to be particularly helpful.
2. Some patients benefit from hiring a personal organizer to help clear out the house, if feasible.
3. Personal organizers need to monitor the home of the hoarder to prevent the reaccumulation of clutter.
4. Some may show some improvement with CBT

Trichotillomania (Hair Pulling Disorder)

- **DSM -5-TR Criteria**
- A. Recurrent pulling out of one's hair resulting in hair loss.
- B. Repeated attempts to stop or decrease hair pulling
- C. Hair pulling causes clinically significant distress or impairment in social, occupational or other important areas of functioning.
- D. The hair pulling is not due to another medical condition (e.g., dermatological condition)
- E. Hair pulling is not better explained by symptoms of another mental disorder (e.g., attempts to improve a perceived defect or flaw in appearance in body dysmorphic disorder)

Trichotillomania (Hair Pulling Disorder)

- **Associated features**
- A. May have rituals regarding hair
  - May pull hair from specific site, may twist/bite or eat pulled hair.
  - B. May be triggered by boredom or anxiety
- C. Hair pulling typically does not cause pain
- D. Complete alopecia may occur
- E. Eyebrows and eyelashes may be completely absent
- F. Rarely occurs in presence of others except family members
- G. Some may pull hair from dolls, pets, or fibrous materials (e.g., carpets and sweaters)
- Some swallow the hair (trichophagia) which can lead to GI blockage

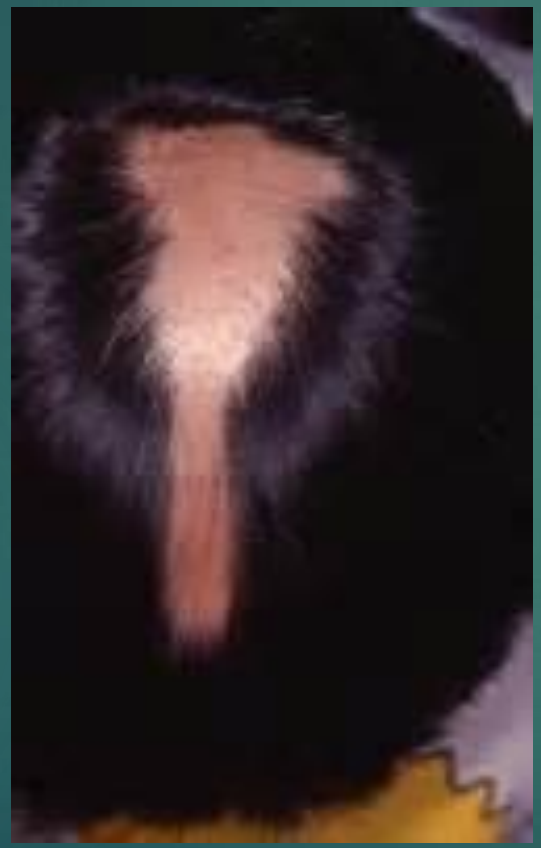
Trichotillomania (Hair Pulling Disorder)

- I. Prevalence
- A. 1-4% of adolescents and college students.
- B. Females>Males (10:1)
- C. Usually begins during childhood
- II. Comorbidity
  - 1. Major Depressive Disorder (MDD)
  - 2. Anxiety disorders
  - 3. Excoriation (Skin Picking Disorder)

Trichotillomania (Hair Pulling Disorder)

- Treatment
- A. Medication
  - SSRIs
  - Clomipramine
  - N-acetylcysteine
- B. Habit reversal therapy
  - Patient learns to identify when hair pulling will occur and tries to to substitute a benign behavior.
    - Squeezing a ball
- C. Barrier usage
  - Wear gloves or a hat.

Trichotillomania



Trichotillomania

DSM - 4
VIDEO 2-1
2.1 (08.34-1400
Ann Marie
(~5.25 min.)

Excoriation (Skin Picking) Disorder

AKA: Dermatillomania

- **DSM-5-TR Criteria**
- A. Recurrent skin picking resulting in skin lesions.
- B. Repeated attempts to stop or decrease skin picking
- C. Skin picking causes clinically significant distress or impairment in social, occupational or other important areas of functioning.
- D. The skin picking is not due to another medical condition
- (e.g., scabies or effects of a substance (e.g., cocaine, meth.)
- E. Skin picking is not better explained by symptoms of another mental disorder (e.g., delusions or tactile hallucinations in a psychotic disorder, attempts to improve a perceived defect or flaw in appearance in body dysmorphic disorder, or intention to harm oneself in non-suicidal self-injury)

Excoriation (Skin Picking) Disorder

AKA: Dermatillomania

- I. Associated Features
- A. May search for scab to pull
- B. May play with scab after pulling it.
- C. May be triggered by anxiety or boredom
- D. Pain not typically reported
- E. Some pick skin in response to sense of skin irregularity
- F. usually done only around family
- II. Prevalence
- A. 1.4% , 3 women/1 male
- B. 25% are not consciously aware of their skin picking
- C. Onset: around puberty
- D. May begin with dermatologic condition such as acne
- E. More common in individuals with OCD

Excoriation (Skin Picking) Disorder

AKA: Dermatillomania

- III. Other Features
- A. Only about 20% even seek medical treatment
- B. In studies of those with picking disorder it was noted:
  - 17.4% used illegal drugs,
  - 22.8% used tobacco products
  - 25.0% used alcohol to relieve feelings
- C. Many with BDD and OCD engage in skin picking
- D. Most report picking 4-5 sites at same time (allow sites to heal)
- E. Picking can result in localized infections and even septicemia
- F. May require topical and or systemic treatment

Excoriation (Skin Picking) Disorder

AKA: Dermatillomania

IV. Treatment recommendations:

A. Perform thorough psych evaluation to make diagnosis and

B. Perform thorough psych evaluation to rule out co-occurring psych disorders

C. Refer to dermatologist to assess for skin conditions that may cause or worsen skin picking (scabies, fungus, etc.)

D. Maintain close contact with internist for rapid treatment of any infections

- May need referral to surgeon for severe infections (abscesses)

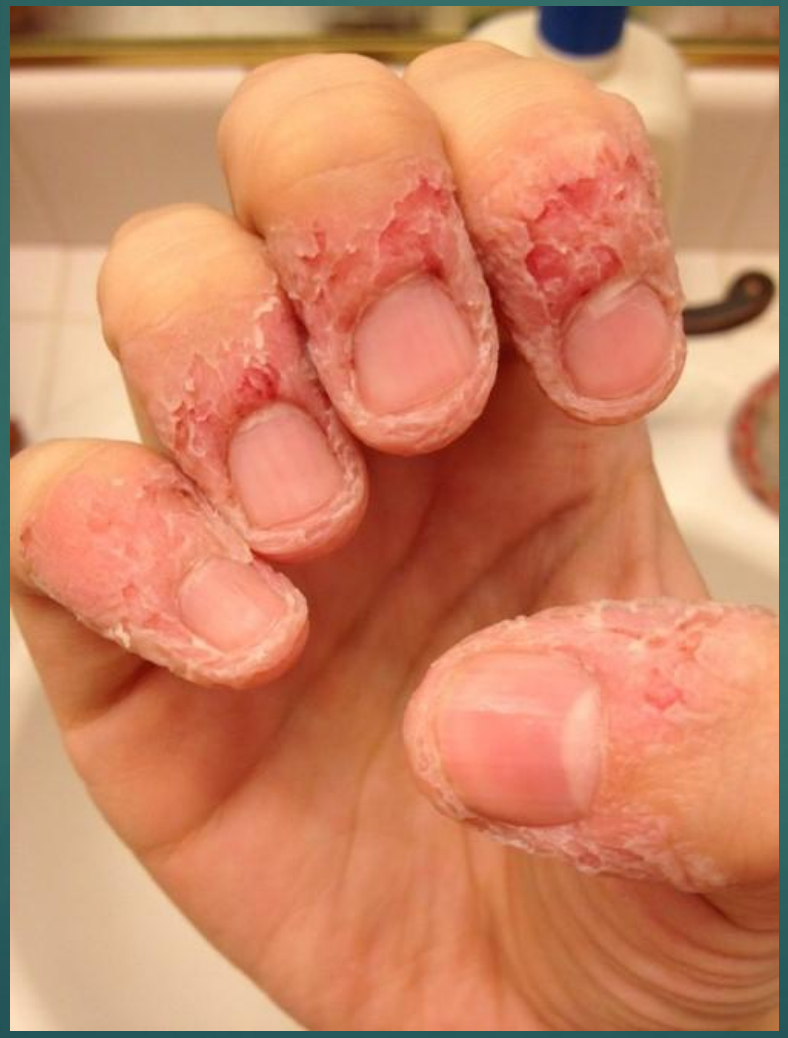
E. Provide cognitive-behavioral therapy and

F. Habit reversal techniques may be useful

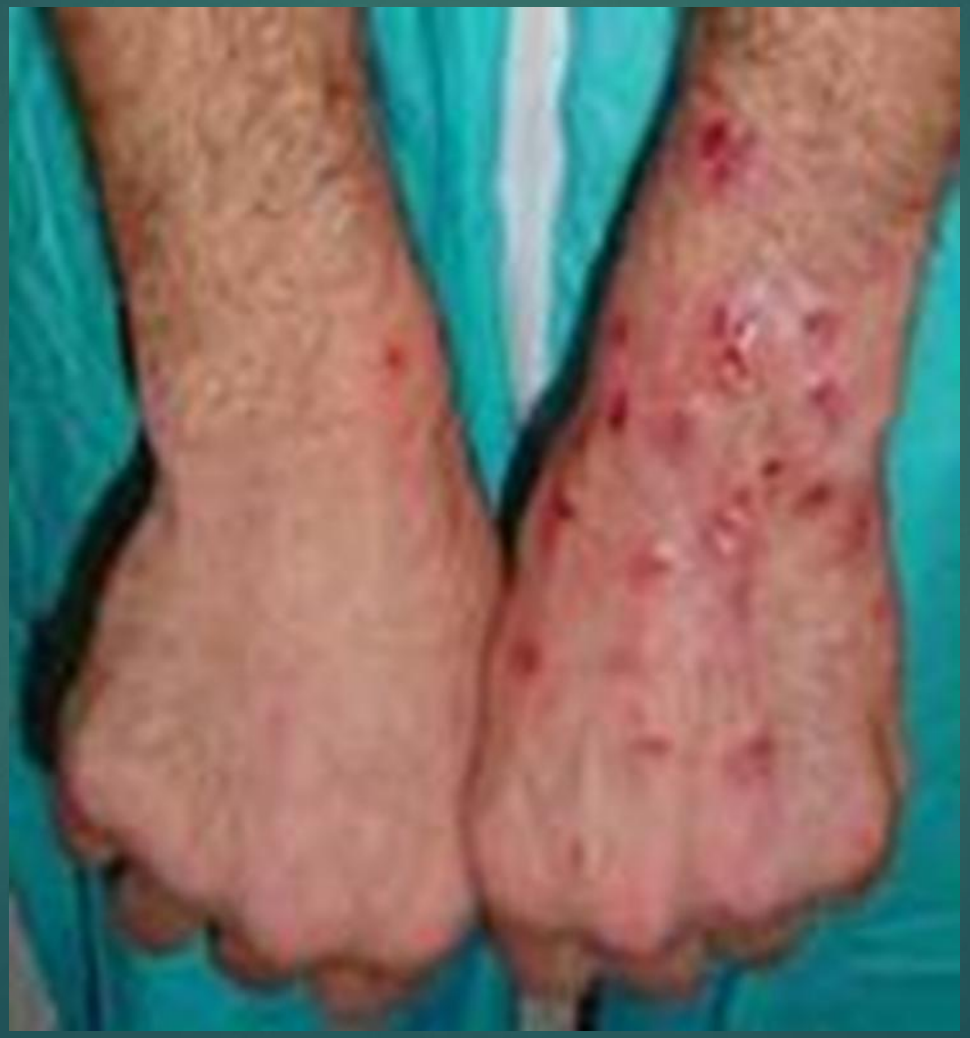
G.. Medication:

- serotonin reuptake inhibitors,
- N-acetylcysteine (often used in acetaminophen overdose), or
- Naltrexone (more often used to help patients stay off drugs or alcohol)

An Example of Skin Picking



Skin Picking, but Not Due to Excoriation Disorder



Other Obsessive-Compulsive Related Disorders

Substance/ Medication-Induced Obsessive Compulsive and Related Disorder

- **DSM -5-TR Criteria**
- A. Obsessions, compulsions, skin picking, hair puling and other body focused repetitive behaviors or other symptoms characteristic of the obsessive compulsive and related disorders predominate in the clinical picture.
- B. There is evidence from the history, P.E., lab findings of both (1) and (2):
  - 1. Symptoms in criterion A. developed during or soon after substance intoxication or withdrawal or after exposure to a medication
  - 2. The involved substance/medication is capable of the symptoms in criterion A.
- C. The disturbance is not better explained by an obsessive compulsive or related disorder that is not substance /medication induced.
- D. The disturbance does not occur exclusively during the course of a delirium
- E. Causes clinically significant distress or impairment in important areas of functioning

Obsessive Compulsive and Related Disorder Due to Another Medical Condition

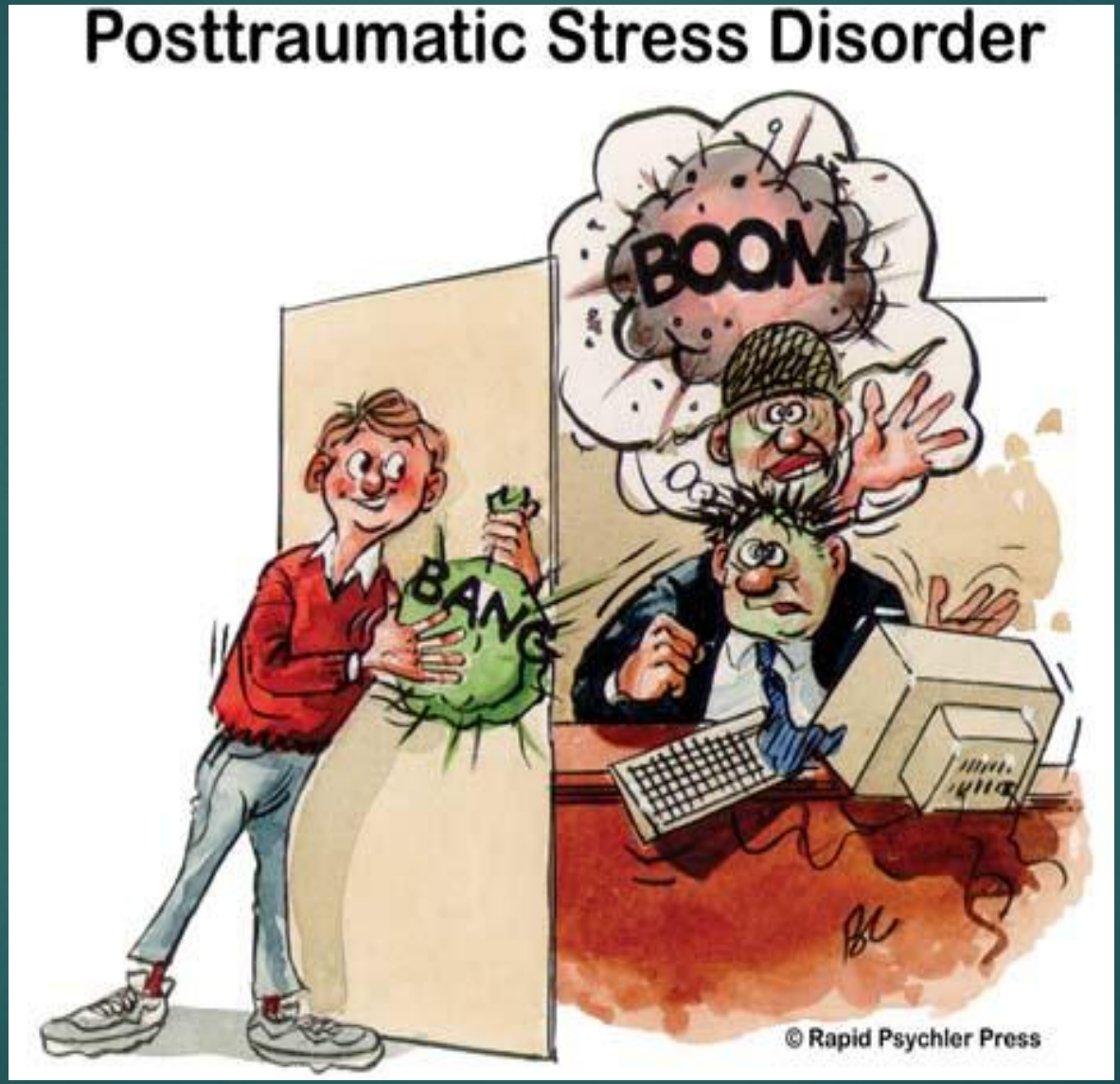
- **DSM -5-TR Criteria**
- A. Obsessions, compulsions, preoccupation with appearance, skin picking, hair pulling, other body focused repetitive behaviors or other symptoms characteristic of the obsessive compulsive and related disorders predominate in the clinical picture.
- B. There is evidence from the history, P.E., lab findings that the disturbance is the direct pathophysiologic consequence of another medical condition.
- C. The disturbance is not better explained by another mental disorder.
- D. The disturbance does not occur exclusively during the course of a delirium
- E. The disturbance causes clinically significant distress or impairment in social, occupational, or important areas of functioning
- Specify if
  - With obsessive compulsive disorder–like symptoms
  - With appearance preoccupation
  - With hoarding symptoms
  - With hair-pulling symptoms
  - With skin-picking symptoms

Trauma and Stressor Related Disorders

DSM-5-TR

1. Posttraumatic Stress Disorder
2. Acute Stress Disorder
3. Adjustment Disorder
4. Prolonger Grief Disorder (New in DSM-5-TR)
5. Other Specified Trauma-and Stressor Related Disorder (NOT)
6. Unspecified Trauma-and Stressor Related Disorder (NOT)

Posttraumatic Stress Disorder


Posttraumatic Stress Disorder
BOOM
BANG
© Rapid Psychler Press

Posttraumatic Stress Disorder

- **DSM -5-TR criteria**
- A. Exposure to actual or threatened death, serious injury, or sexual violence in one or more of following ways:
  - 1. Person directly **experienced** traumatic event(s)
  - 2. **Witnessing** events in person as it occurred to others
  - 3. **Learning** that the traumatic events occurred to a close family member or close friend. (Such events must have been violent or accidental)
  - 4. Experiencing **repeated or extreme exposure** to aversive details of the traumatic events (e.g., first responders collecting human remains, police officers repeatedly exposed to details of child abuse)

Posttraumatic Stress Disorder

- DSM -5-TR Continued
- Note Criterion A4 does not apply to exposure through electronic media, TV, or pictures unless work related
- B. Presence of 1 or more of following Intrusion Symptoms after event occurred:
  - 1. Recurrent, involuntary intrusive distressing memories of traumatic event
  - 2. Recurrent distressing dreams of event
  - 3. Dissociative reactions (flashbacks) as if traumatic event were recurring
  - 4. Intense or prolonged psychological distress at exposure to internal or external cues that resemble an aspect of the traumatic event(s)
  - 5. Physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).

Posttraumatic Stress Disorder

- **DSM -5-TR** (continued)
- C. Persistent **Avoidance** of stimuli associated with the trauma as evidenced by one or both of the following: following:
  - 1. Efforts to avoid memories, thoughts, or feelings associated with the traumatic event(s)
  - 2. Efforts to avoid external reminders (people, places, conversations, situations) that that arouse distressing recollections of traumatic event(s)

Posttraumatic Stress Disorder

- DSM -5-TR (continued)
- D. Negative alterations in cognitions and mood associated with traumatic event as noted by 2 or more of following:
  - 1. Inability to remember an important aspect of trauma
  - 2. Persistent and exaggerated negative beliefs and expectations of oneself others or the world
  - 3. Persistent negative emotional state (e.g., fear horror, anger guilt, shame)
  - 4. Persistent distorted cognitions about cause or consequence of event that led individual to blame himself or others
  - 5. Markedly decreased interest in significant activities
  - 6. Feelings of detachment or estrangement from others
  - 7. Inability to experience positive emotions (e.g., loving feelings, satisfaction)

Posttraumatic Stress Disorder

- E. Marked alterations in arousal associated with the trauma and evidenced by indicated by at least 2 of following
- 1. Irritable and angry outbursts expressed in verbal or with physical aggression to others
- 2. Reckless or self-destructive behavior
- 3. Hypervigilance
- 4. Exaggerated startle response
- 5. Problems with concentration
- 6. Sleep disturbance (DFA or restless sleep)

- F. Duration of disturbance (B,C,D, and E)> 1 month

Posttraumatic Stress Disorder

- Specify whether:
  - With dissociative symptoms: The individuals symptoms meet the criteria for PTSD , and in addition in response to the stressor , the individual experiences persistence or recurrent symptoms of either of the following:
    - 1. Depersonalization: Persistent or recurrent experiences of feeling detached from, and as if one were an outside observer of, one's mental processes or body (e.g., feeling as though one were in a dream; feeling a sense of unreality of self or body or of time moving slowly).
    - Derealization: Persistent or recurrent experiences of unreality of surroundings (e.g., the world around the individual is experienced as unreal, dreamlike, distant or distorted.
  - Specify if:
    - With delayed expression: The full criteria not met for at least 6 months.

PTSD Risk Factors

- **Proximity** to the stressor
- Physical **Injury**
- **Poverty** / Lack of resources (social support)
- **Prior Trauma**
- **Prior Psychiatric History**
- **Age**: Younger at greater risk
  - Ex: 80% children with burn injury develop PTSD…only 30% Adults with similar injury

Proximity + Injury

PTSD Epidemiology

- 1-3% of the General Population
- High Risk Population
  - Combat Veterans: 5-75%
    - Vietnam Veterans: 30% had PTSD
  - Civilians
    - Men: Combat Experience
    - Women: Rape or Assault

PTSD and 9/11

- Study showed > 80% children had at least 1 symptom of PTSD
  - Correlated to amount of TV watched by child
- Another study 9 months after 9/11:
  - Surveyed 8,000 children in NYC (age10-13)
    - 11% had PTSD

PTSD & Primary Care

- Depression
- Nightmares
- Somatization
- Substance Abuse
- Workaholism

PTSD & Psychopharmacology

- **Antidepressants**
  - Decrease Depressive Symptoms
  - Reduce Intrusive Symptoms (nightmares, flashbacks, and improve sleep)
  - **Selective Serotonin Reuptake Inhibitors (SSRIs)**
  - **Tricyclics (TCAs)**
    - Imipramine (Tofranil)
    - Amitriptyline (Elavil)
  - **MAOIs**

PTSD & Psychopharmacology

Sedatives

- **Trazodone** (Desyrel)
  - Actually an antidepressant
  - Very good for insomnia (though not FDA approved for this use and some recent studies have rebuked this finding)
    - **1/10,000: Priapism…medical emergency**
- **Benzodiazepines**
  - Avoid if possible…potential abuse potential
  - If used give for days or perhaps a few weeks.
- **Beta Blockers**
  - Some evidence that B-Blockers (Propranolol) given right after a trauma might/can decrease/eliminate PTSD symptoms **(controversial)**

PTSD & Psychopharmacology

Medications

- Alpha 1-adrenergic antagonist
  - Prazosin (Minipres):
  - Treats PTSD related nightmares → Improved sleep.
  - Not addictive or sedating.
  - Typically used for treating HBP and BPH symptoms. (Start at low dose(1mg./day) then slowly titrate to 3-15 mg. /day.
  - May take month to achieve effective dose
  - Used with success with military vets. However recent studies have been less enthusiastic.

PTSD: Cognitive Behavioral Model

- Patient Education
- Cognitive Exercises
- Drills to reduce patients own fears.
  - *Recent study 2007 indicated starting therapy early was best predictor for fewest long-term symptoms*

  (Introspective Exposure)
- Practice Confronting Fear Provoking Situations
  - Return to site of rape
  - Return soldier to the front

PTSD Treatment

- Most feel that combined therapy is best overall treatment
  - Treatment should last at least 6-8 months
  - Patients usually benefit in 2-4 weeks
    - Especially in number and frequency & intensity of panic Attacks

PTSD & Psychotherapy

- Supportive Therapy
- Group Psychotherapy
- Cognitive / Behavioral

- **KEY**: Change from victim To survivor to a thriver
- **Abreaction**
  - Process of describing an event and re-experiencing emotions that had occurred

Anxiety Disorders PTSD TAPE

Clip # 9
John
8.1
~6.min 20 sec.

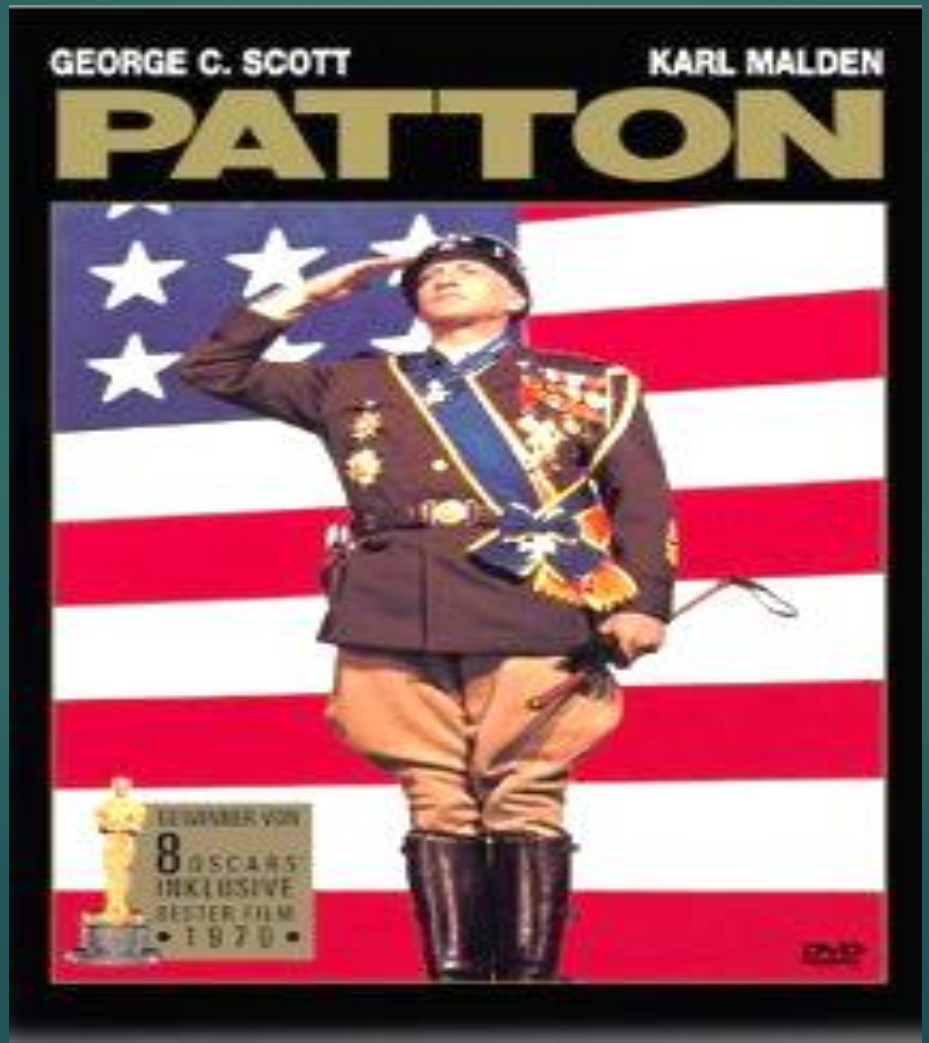
Watch for criteria of PTSD:

1. Was he in a life-threatening situation?
2. Did he have any intrusive symptoms? Such as dreams/nightmares?
3. Did he try to avoid anything that reminded him of the trauma? (when does he not drive?)
4. Did he have an issue with his memory of the event?
5. Does he admit he has Irritability (short with people?)
6. Hypervigilance: Lot of anxiety… when?
7. Does he have issues with his concentration?
8. Has he believe that his job been affected?
9. Has he experienced insomnia
10. Have his symptoms lasted for over a month?
11. Did he have a delayed expression of the PTSD?

Former Names for PTSD

- **Civil War:**
  - Soldier's Heart
- **WWI:**
  - Shell Shock
- **WWII**
  - Combat Neurosis/Fatigue
- **Vietnam War**
  - PTSD
- **Gulf War:**
  - Gulf War Syndrome

Clip # 10
9.1
00.00-00:29
Time Permitting



(~ 4 minutes)

Acute Stress Disorder

Acute Stress Disorder

- DSM -5-TR criteria
- A. Exposure to actual or threatened death, serious injury, or sexual violence in one or more of following ways:
  - 1. Person directly experienced traumatic event(s)
  - 2. Witnessing events in person as it occurred to others
  - 3. Learning that the traumatic events occurred to a close family member or close friend. (Such events must have been violent or accidental)
  - 4. Experiencing repeated or extreme exposure to aversive details of the traumatic events (e.g., first responders collecting human remains, police officers repeatedly exposed to details of child abuse)

Acute Stress Disorder

- DSM -5-TR Continued
- Note This does not apply to exposure through electronic media, TV, or pictures unless work related
- B. Presence of 9 or more of following symptoms from any of the 5 categories of intrusion, negative mood, dissociation, avoidance, and arousal after the traumatic event occurred:
  - Intrusion Symptoms
  - 1. Recurrent, involuntary intrusive distressing memories of traumatic event
  - 2. Recurrent distressing dreams of event
  - 3. Dissociative reactions (flashbacks) as if traumatic event were recurring
  - 4. Intense or prolonged psychological reactions to internal or external cues that resemble an aspect of the traumatic event(s)
  - 5. Physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).

Acute Stress Disorder

- DSM -5-TR (continued)
- Dissociative Symptoms
- 6. An altered sense if the reality of one's surroundings or oneself (e.g., seeing oneself from another's perspective, being in a daze, time slowing).
- 7. Inability to remember an important aspect of traumatic event (typically due to dissociative amnesia and not to other factors such as head injury, alcohol or drugs).

Acute Stress Disorder

- DSM -5-TR (continued)
- Avoidance symptoms

- 8. Efforts to avoid distressing memories, thoughts, or feelings associated with the traumatic event(s)
- 9. Efforts to avoid external reminders (people, places, conversations, situations) that that arouse distressing recollections of traumatic event(s)

Acute Stress Disorder

- DSM -5-TR (continued)
- Arousal Symptoms .
- 10. Sleep disturbance (DFA or restless sleep)
- 11. Irritable behavior and angry outbursts expressed as verbal or with physical aggression to others
- 12. Hypervigilance
- 13. Problems with concentration
- 14. Exaggerated startle response

- Note Symptoms in criterion B must be present for > 3 days ≤ 1 month after trauma exposure.
- D. Causes significant distress or impairment in social/occupation or other areas of functioning
- E. Not caused by effects of a substance (e.g., medication or alcohol) or another medical condition (mild traumatic brain injury) and is not due to a brief psychotic disorder.

Adjustment Disorders

Adjustment Disorders

- DSM -5-TR
- A. The development of emotional or behavioral symptoms in response to an identifiable stressor(s) within 3 months of the onset of the stressor(s)
- e.g.: a. Termination of romantic relationship; b. marked business troubles +marital difficulties, c. living in crime ridden area, painful illness with increasing disability

- B. Symptoms are significant as noted by one or both of the following:
  - 1. Marked distress that is out of proportion to the severity or intensity of the stressor, taking into account the external context and cultural factors
  - 2. Significant impairment in one's overall functioning

Adjustment Disorders (continued)

- DSM -5-TR (continued)

- C. Stress related disorder does not meet the criteria for another mental disorder, and is not an exacerbation of a preexisting mental disorder
- D. Symptoms do not represent normal bereavement
- E. Once stressor or consequences terminated, symptoms end in no more than 6 additional months.

Types:

With depressed mood (dysphoria, tearful, hopelessness)

With anxiety (psychic anxiety, palpitations, hyperventilation)

Mixed Anxiety & Depression:

Disturbance of conduct: (vandalism, fighting, drive reckless)

Mixed disturbance of emotions & conduct

Adjustment Disorders (continued)

- **DSM -5-TR (continued)**
  - **A Common Condition**
    - 5%-20% psychiatric clinics and hospitals
    - Very common on consultation in hospitals
      - i.e., 51% cardiac surgery received this diagnosis in a study
      - Those patients did not have preexisting psych problems
      - Medical units: Endured long hospitalizations for serious illness such as cancer or diabetes.
    - Those who did not have a medical problem usually had marital or financial problems
    - **If no stressor…Cannot diagnose an Adjustment disorder**
    - If stressor exists, one must still rule out another mental disorder such as major depression.
    - **Do not diagnose if due to normal bereavement.**

Adjustment Disorders (continued)

- **DSM -5-TR (continued)**

  Major stressors noted (partial list)

Adolescents	Adults
School Problems	Marital Problems
Parental Rejection	Separation/divorce
Alcohol/drug abuse	Move
Parental divorce/separation	Financial problems
Boy or girlfriend problems	School problems

(Andreassen 1980)

Adjustment Disorder With Depressed Mood
DSM-3
1.3
00.03-00.05

(~4min)
Angela (H)

Points to Ponder

1. Do you think she would be better off seeing a psychiatrist or a PCP?
2. Do you think she is depressed?
3. What questions were asked to assess if she was depressed?
4. Would you place her on an antidepressant?
5. Do you feel she is suicidal?
6. Do you think she should be hospitalized?
7. What were the major differences between Angela and John who experienced PTSD?

Prolonged Grief Reaction

DSM -5 TR (New Category)

A. The death , at least 12 months ago, of a person who was close to the bereaved individual (for children and adolescents > 6 months ago)

B. Since the death the development of:

A persistent grief response characterized by one or both of the following symptoms, which have been present most days to a clinically significant degree. In addition, the symptoms have occurred nearly every day for at least the last month:

1. Intense yearning/longing for the deceased person
2. Preoccupation with thoughts or memories of the deceased person (In children and adolescents , preoccupation may focus on the circumstances of the death).

Prolonged Grief Reaction (Continued)

DSM -5 TR (New Category)

C. Since the death, at least three of the following symptoms have been present most days to a clinically significant degree. In addition, the symptoms have occurred nearly every day for at least the last month:

1. Identity disruption (e.g., feeling as though part of oneself has died) since the death person
2. Marked sense of disbelief about the death.
3. Avoidance of reminders that the person is dead. (In children and adolescents by efforts to avoid reminders).
4. Intense emotional pain (e.g., anger bitterness sorrow) related to the death.
5. Difficulty reintegrating into one's relationships and activities after the death(e.g., problems engaging with friends, pursuing interests, or planning for the future.
6. Emotional numbness (absence or marked reduction or emotional experience) due to the death.
7. Feeling life is meaningless as a result of the death
8. Intense loneliness as a result of the death.

Prolonged Grief Reaction (Continued)

DSM -5 TR (New Category)

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

E. The duration and severity of the bereavement reaction clearly exceed expected social, cultural or religious norms for the individual's culture and context

F. The symptoms are not better explained by another mental disorder, such as major depressive disorder or posttraumatic stress disorder and are not attributable to the physiological effects of a substance (e.g., medication, alcohol) or another medical condition.

Prolonged Grief (PG) Differentials

Prolonged Grief

1. Severe grief reactions > 12 months
2. Interfere with functioning
3. Exceed cultural, social, religious norms
4. Clinically significant symptoms present most days in past 30 days.
5. Distress focused on feelings of loss and separation from loved one, not low mood
6. Most common symptoms:
   a. Yearning for deceased
   b. Upset by memories of deceased
   c. Feel life is empty
   d. Disbelief
   e. Inability to accept the death.
7. Suicidal thoughts in up to 60%

Depressive Disorders

1. Focus is on suicidal thoughts , low mood and crying. Not on loss or separation from a loved one.

PTSD

1. Those who experience bereavement due to violent or accidental death may develop PTSD and prolonged grief disorder.

2.Intrusive thoughts in PTSD are of the traumatic event, while intrusive memories in PG focus on an aspect of the relationship with deceased
Avoidance in PTSD involves avoiding memories of or feelings of the traumatic event leading to death of loved one (e.g., fatal accident that killed the loved one, while PG avoidance is of reminders that loved one is no longer present (avoid activities carried out with the deceased)
IN PG there is a yearning for the deceased, This Is not noted in PTSD.

	PTSD	Acute Stress Disorder	Adjustment disorder
DSM-5-TR Criteria	A. Exposure to actual or threatened death, serious injury, or sexual violence in one or more ways: 1. Direct experience. 2. Witness 3. Occur to family or friend 4. Repeated exposure to to aversive details B. Intrusion symptoms: 1. Recurrent memories 2. Recurrent dreams 3. Dissociative reactions (flashbacks) 4. Distress at exposure to internal or external cues 5. Psychological reactivity on exposure to cues C. Persistent avoidance of stimuli associate w/ trauma: 1. Avoid memories, thoughts, feelings associated with traumatic event 2. Efforts to avoid external reminders D. Negative alterations in cognitions and mood associated w/ traumatic event: 1. Inability to remember aspect of trauma 2. Persistent, exaggerated negative beliefs, expectations 3. Persistent negative emotional state 4. Persistent distorted cognitions about cause/consequence of event 5. Decreased interest in significant activities 6. Feeling detached or estranged from others 7. Inability to experience positive emotions E. Marked alterations in arousal: 1. Outbursts expressed in verbal or physical aggression to others 2. Reckless or self-destructive behavior 3. Hypervigilance 4. Exaggerated startle response 5. Problems w concentration 6. Sleep disturbance		A. Development of emotional/behavioral sx in response to stressor(s) within 3 mos of onset of stressor B. Sx are significant: 1. Distress out of proportion to severity or intensity of stressor 2. Impairment of overall functioning C. Does NOT meet criteria for another mental d/o or exacerbation of preexisting d/o D. Sx are not normal bereavement E. Once stressor/consequence terminates sx end in NO more than 6 mos
DSM-5 Duration	> 1 mos	>3 days, </= 1 mos	Ends within 6 mos after stressor terminates

Clinical Points for Anxiety disorders

1. Patients with mild cases of panic may respond to cognitive behavioral therapy, but many will need medication.
   - SSRIs are drugs of choice due to their effectiveness and tolerability
   - TCAS do work well, but are a second choice due to many adverse effects and danger in overdose.
2. Gently encourage the patient with agoraphobia to get out and explore the world.
   - Progress will not occur unless the patient confronts the feared places or situations. Some will need formal behavioral therapy.
3. Have patients minimize use of caffeine, a known anxiogenic

Clinical Points for Anxiety disorders (continued)

4. Behavioral techniques (e.g., exposure, flooding, desensitization, will help most patients with social anxiety disorder and specific phobias.
5. Generalized anxiety disorder (GAD) might respond to simple behavioral techniques (e.g., relaxation training) but many patients will benefit from medication
   a. Buspirone , venlafaxine, and the SSRIs paroxetine and escitalopram are effective FDA-approved treatments
   b. Benzodiazepines when used, should be prescribed for a limited time e.g., weeks or months)
   c. Hydroxyzine is a relatively benign alternative

Clinical Points for Obsessive-Compulsive and related disorders

1. Educate the patients about their obsessive-compulsive disorder
    a. Reduces feelings of isolation, fear and confusion
    b. Reassure worried patients that people with OCD rarely act on their frightening or violent obsessions.
    c. Point out "up" side: people with this disorder tend to be conscientious dependable and likeable..
2. Establish an empathic relationship
    a. Do NOT tell patients simply to stop their rituals as they cannot. That is why they seek treatment.
    b. Explain that talking about their obsessions and compulsions will not make them worse.
3. Patients usually do best with both medication and cognitive behavioral therapy

Clinical Points for Obsessive-Compulsive and related disorders
(continued)

4. BDD patients often responds well to SSRIs.
5. With hoarding disorder think outside the box.
6. Trichotillomania probably responds best to habit reversal therapy.
    a. Habit reversal methods include substituting more benign behaviors such as squeezing a ball, and using barriers to to prevent pulling.
    b. SSRIs or clomipramine may reduce the urge to pull but response is inconsistent
    c. For patients with extensive hair loss, wigs or other forms of hair replacement may be a sensible solution
    d. Men might consider shaving their scalp to disguise bald patches.
7. As excoriation disorder resemble trichotillomania, habit reversal techniques could be useful

Clinical Points for trauma and stressor related disorders

1. PTSD tends to be chronic, but many patients will benefit from a combination of medication and cognitive behavioral therapy.
   a. Paroxetine (Paxil) and Sertraline (Zoloft) are FDA approved for treatment of PTSD, but the other SSRIs likely are effective as well.
   b. Many PTSD patients will benefit from the mutual support found in group therapy.
   c. Group therapy has been used to treat veterans with PTSD.
2. Adjustment disorders can evolve into better defined disorders such as major depressive disorder, so be alert for changes in mental status and the evolution of the patient's symptoms.
   a. Most adjustment disorders are transient. Time and supportive psychotherapy are usually all that is needed.
   b. Psychotropic medications taken for days, or perhaps weeks, should target the predominant symptoms.
      - Hypnotics (e.g., zolpidem , 5-10 mg. at bedtime) for those with insomnia.
      - Benzodiazepines (e.g., lorazepam , 0.5-2.0 mg BID) for those with anxiety

Other Specified Trauma-and Stressor- Related Disorder (Not on test)

- **DSM -5-TR**

- This category is used in cases in which there are symptoms characteristic of a trauma and a stressor related disorder with significant distress and decline in functioning, but does to meet any of the full criteria for any of the other disorders in this diagnostic class.
- The clinician uses this category when he wishes to communicate why it not meeting the criteria.
- Ex:
  - A. Adjustment like disorders with delayed onset of symptoms occurring >3 months after the stressor.
  - B. Adjustment like disorders with prolonged duration > 6 months without prolonged duration of stressor.

Unspecified Trauma-and Stressor- Related Disorder

Not on Test

- DSM -5-TR

- This category is used in cases in which there are symptoms characteristic of a trauma and a stressor related disorder with significant distress and decline in functioning, but does to meet any of the full criteria for any of the other disorders in this diagnostic class.
- The clinician uses this category when he chooses not to specify why it not meeting the criteria. It includes situations in which there is insufficient information to make a more specific diagnosis. (e.g., in emergency room settings)

The Dissociative Disorders

The Dissociative Disorders

Dissociate: "To split off some part or component of mental activity, which then acts as an independent unit of mental life."

Dissociation: An Unconscious defense mechanism involving the segregation of any group of mental or behavioral processes from the rest of a person's psychic activity. A sense of being detached from reality.

Person may say that things do not feel real but knows they are real.

In psychosis there is a loss of reality. Thus, they do not recognize what is real and what is not. (Ex: those voices coming from the wall are aliens.)

The Dissociative Disorders

Dissociation:

A disruption of and/or discontinuity in the normal integration of consciousness, memory, identity, emotion, perception, body representation, motor control, and behavior . When one or more of these functions are disrupted, characteristic impairments can be seen.

Examples : Consciousness – Impaired consciousness is characterized by decreased responsiveness to external stimuli.

Memory – Memory impairment, referred to as "dissociative amnesia," affects the ability to recall autobiographical information, which is often of a traumatic or stressful nature.

Identity – Dissociation can cause confusion about or discontinuities in one's identity.

Awareness of body, self, or environment – Symptoms of impairment include depersonalization and derealization.

The Dissociative Disorders

Dissociation: (Continued)

Dissociation occurs along a spectrum:

1. Normal: A normal part of human experience:

   Examples: A. Driving a car while listening to music and then wondering how you got there as you really have not paid attention to the traffic/road.

   B. Listening to headphones while walking in the city and not paying attention to the street corners but still walking without falling or banging into anyone

   C. Day dreaming

   D. Getting disturbing news and then not remembering what you did the rest of the day.

2. Abnormal: In some people the dissociative process becomes distorted and interferes with one's functioning, causing distress and disability.

Note: Hypnosis and meditation are both induced forms of dissociation

Dissociative Disorders

The Hallmark of these disorders is a disturbance of, or alteration in normally well integrated functions of one or more mental functions, such as:

memory, identity, or consciousness.

Events which are normally experienced on a smooth, integrated continuum are isolated from the other mental processes with which they would ordinarily be associated.

Note: Although dissociation is typically found in the dissociative disorders, it can also occur in people with PTSD, borderline personality disorder and somatic symptom disorders.

Dissociative Identity Disorder

(Previously multiple personality disorder)

DSM -5-TR

A. Disruption of identity characterized by two or more distinct personality states, which in some cultures may be described as an experience of possession. The disruption in identity involves marked discontinuity in sense of self, and sense of agency*, accompanied by related alterations in affect, behavior, consciousness, memory, perception cognition and /or sensory-motor functioning. These signs and symptoms may be observed by others or reported by the individual.

* the feeling of control over one's actions and their consequences.

Dissociative Identity Disorder
(Previously multiple personality disorder)

DSM -5-TR (continued)

B. Recurrent gaps in the recall of everyday events , important personal information, and/or traumatic events that are not consistent with ordinary forgetting. Many patients report losing time beyond what one would expect from ordinary forgetfulness.

C. Symptoms cause clinically significant distress or impairment in social, occupational or other important areas of functioning.

D. The disturbance is not a normal part of a broadly accepted cultural or religious practice (Note: In children symptoms are not better explained by imaginary playmates or other fantasy play.)

E. Symptoms are not due to physiologic effects of a substance (e.g., blackouts or chaotic behavior during alcohol intoxication) or another medical condition (e.g., complex partial seizures.)

Dissociative Identity Disorder

(Previously multiple personality disorder)

1. Some may feel they have suddenly become outside observers of their own speech and actions, which they might feel powerless to stop.
2. Prevalence of 1.5% in general population and 5-15% in inpatient and outpatient psychiatric settings.
3. Most with Dissociative Identify Disorder are women.
4. Has a childhood onset typically before age 9, is often chronic and tends to run in families.
5. Cause: Experts theorize it results from severe physical and sexual abuse during childhood.

   Postulated that the disorder is product of self-induced hypnosis used to cope with abuse, maltreatment or neglect

Dissociative Identity Disorder

(Previously multiple personality disorder)

6 . Symptoms:

a. Markedly different moods
b. Having at least one alter (many have proper names (e.g., Sally, John)
c. Different accents
d. Inner conversations (auditory hallucinations) (pseudo hallucinations) (hallucinations ae product of one's own mind and patient realizes it is due to illness and voices are not real.)
e. Different handwriting
f. Amnesia for a previously learned subject
g. Multiple physical complaints: e.g., headaches and amnesia are common. (often may meet criteria for Somatic Symptom Disorder)

7. Borderline personality disorder in~70% of dissociative disorder patients. (mood instability, identity disturbance, deliberate self-harm, etc.)

Dissociative Identity Disorder

(Previously multiple personality disorder)

Treatment

1. There is no standard treatment however many recommend:
   a. Long-term individual psychotherapy to try to integrate their multiple alters (average # alters is 7-10 in several studies).
   b. Cognitive behavioral therapy to assist in reintegration
   c. Most agree core features of Dissociative Identity Disorder do not respond to medication. However best to treat with an antidepressant a coexisting major depressive disorder and anxiety disorder (blocks panic attacks).

Note: Must rule out medical/neurological cause such as closed head trauma, drug use, seizure disorders, dementia, etc.)

Dissociative Amnesia

DSM -5-TR

A. An inability to recall important biographical information, usually of a traumatic or stressful nature, that is inconsistent with ordinary forgetting.

   Note: Dissociative Amnesia most often consists of localized or selective amnesia for specific event(s); or generalized amnesia for identity/life history

B. Symptoms cause clinically significant distress or impairment in social, occupational or other important areas of functioning.

C. Symptoms are not due to physiologic effects of a substance (e.g., alcohol or other drug of abuse, a medication) or a neurological or other medical condition (e.g., complex partial seizures, transient global amnesia, sequalae of a closed head injury/traumatic brain injury, or other neurological condition).

D. Disturbance is not better explained by dissociative identity disorder, PTSD, acute stress disorder, somatic symptom disorder, or major or mild neurocognitive disorder.

Specify: if With Dissociative Fugue: Apparently purposeful travel or bewildered wandering that is associated with amnesia for identity or other important biographical information.

Dissociative Amnesia

1. Individual is typically confused and my not recall important personal information including his/her name.

2. Amnesia can develop suddenly and last minutes to days or longer (majority in large study the amnesia lasted a week)

3. More women affected than men

4. Often occurs after severe physical or psychosocial stressors.
   a. Study of combat veterans found 5-20% were amnesic for their combat experience. (PTSD)

Dissociative Amnesia

5. **Dissociative fugue**:
   a. subtype of dissociative amnesia
   b. Inability to recall one's past.
   c. Assumption of a new identity
   d. Involves sudden or unexpected travel from home, or workplace
   e. Typically occurs after stressful situations such as natural disasters/ war
   f. May last for months

Dissociative Amnesia

5. Dissociative fugue: (continued)

Example (True case)

A 33 y/o woman leaves work at her law practice & is abducted and sexually assaulted. Her car is found abandoned. Family/police cannot find her. Belief is that she was murdered. A month later she calls her family from a psychiatric hospital over 1000 miles away. She tells her family she could not remember anything from the time of the abduction, including who she was. She managed to hitchhike to her current location. She was found wandering aimlessly. Luckily police were notified and took her to a hospital and with the treatment of a MH professional she recovered her memory and identity. She returned home and resumed her former job.

Dissociative Amnesia

6. Types of Amnesia

a. **Localized amnesia**: Inability to recall events related to a circumscribed period of time. (Cannot remember the combat)

b. **Selective amnesia**: Ability to remember some, but not all, of the events occurring during a circumscribed period of time. (Cannot recall most of the battle, but does recall trying to save his buddies who were wounded.)

c. **Generalized amnesia**: Failure to recall **parts of, or one's entire life** (retrograde amnesia)

d. **Continuous amnesia**: Failure to recall **successive events** as they occur (anterograde amnesia)

e. **Systematized amnesia**: Failure to remember a **category** of information, such as all memories relating to one's family or to a particular person

Depersonalization/Derealization Disorder

DSM -5-TR

A. The presence of persistent or recurrent experiences of depersonalization, derealization or both: (often occur together)

1. **Depersonalization:** experiences of unreality, detachment, or being outside observer with respect to one's thoughts, feelings, sensations, body or actions (e.g., perceptual alterations, distorted sense of time, unreal or absent self, emotional and/or physical numbing. Feel detached from oneself. Feel like outside observer, feel like a robot.

   Ex: May look in mirror and say," that is not me".

2. **Derealization:** Experience of unreality or detachment with respect to surroundings being a mental fog(e.g., individuals or objects are experienced as unreal, dreamlike, lifeless or visually distorted.). Familiar places like their own home or street may seem foreign to them.

Depersonalization/Derealization Disorder

DSM -5-TR

B. During the depersonalization or derealization experiences, reality testing remains intact. **(in other words not psychotic.)**

C. The symptoms cause clinically significant distress or impairment in social, occupational or other important areas of functioning.

D. The disturbance is not due to the physiological effects of a substance (e.g., a drug of abuse, medication) or another medical condition (e.g., seizures).

E. The disturbance is not better explained by another mental disorder, such as schizophrenia, panic disorder, major depressive disorder, acute stress disorder, PTSD, or another dissociative disorder.

Depersonalization/Derealization Disorder

Other points regarding Depersomnalization/Derealization (DPDR) :

1. Normal people may transiently experience depersonalization or derealization.

   (ex: sleep deprived, travel to unfamiliar area, intoxicated with hallucinogens, marijuana or alcohol)
2. Those exposed to a life-threatening situation can experience DPDR
3. Usually starts in early adulthood but rarely after age 40.
4. Episodes may last hours, days or weeks.
5. May recur after psychologically stressful situations such as loss of an important relationship.
6. Symptoms may be noted in patients with: schizophrenia, MDD, phobias, panic attacks, OCD, PTSD and drug abuse. So, one must rule out these conditions.
7. Symptoms may be noted in patients with medical conditions (e.g., complex partial seizures, migraine) as well as sleep deprivation and drug induced states so these must be ruled out as well

Depersonalization/Derealization Disorder

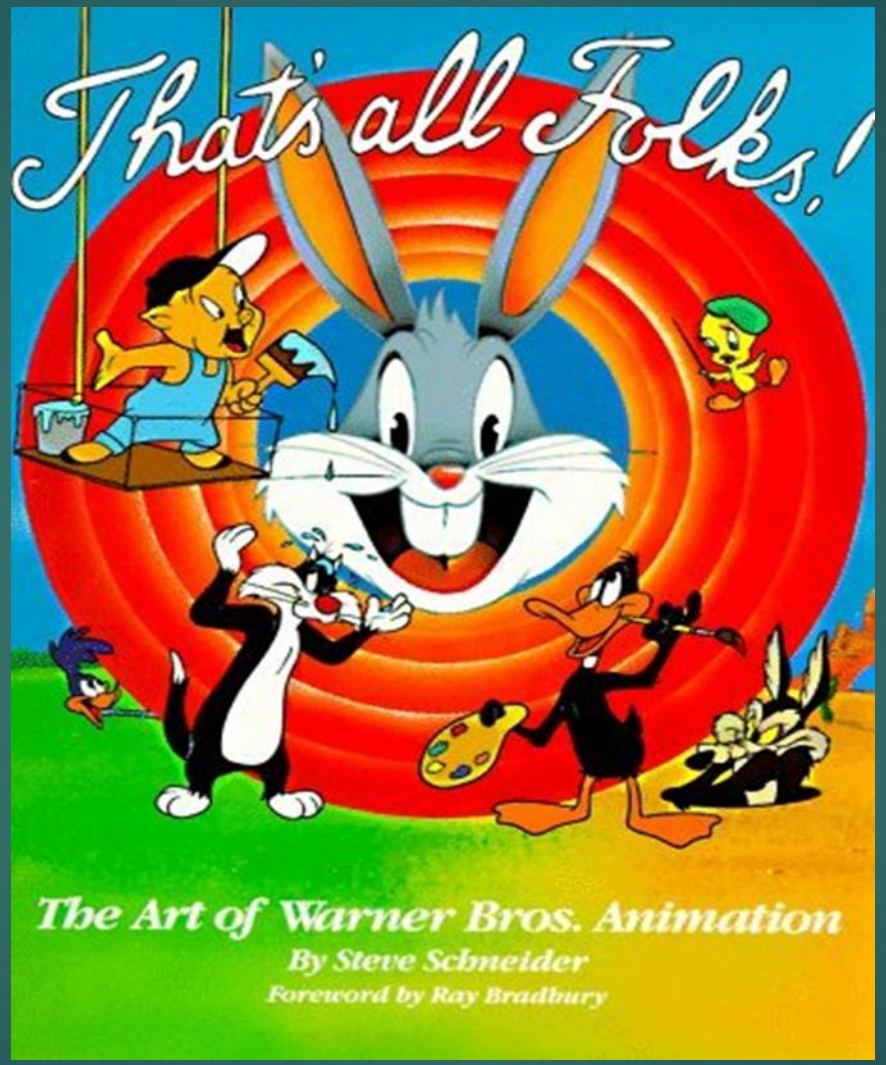
Treatment of Depersonalization/Derealization

There is no standard treatment but the following may be of some benefit.

1. **Psychotherapy:**
   - A. Cognitive-behavioral therapy:
   - B. Dialectic-behavior therapy:
   - C. Family therapy:
   - D. Creative therapies: Art or music therapy
   - E. Hypnosis
2. **Medication:** There isn't a specific medicine for depersonalization/derealization disorder.
   - A. Treating depression or anxiety with an antidepressant may help

Clinical Points for The Dissociative Disorders

1. Rule out medical disorders (e.g., tumors, temporal lobe epilepsy,) as a cause of the amnesia, dissociation or depersonalization/derealization.
2. Be supportive and patient as in most cases of amnesia, memory will return rapidly and completely.
3. Patients with dissociative identity disorder are challenging and therapy may be long term. Consider rereferral to therapist experienced in treating this disorder.
4. Medications have no proven benefit for treating dissociative disorder, although antidepressants might help some patients with depersonalization/derealization disorder.
    a. Benzodiazepines may help reduce the anxiety that can accompany depersonalization.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