Psychiatry 5th year

Chapter 5: Stress-Related Disorders

Done by: Alia Hatem and Aya Alfaleh (018)
Done by: Amr Shawar, Mohammad Horoub (018)

Re-Edited by: Lejan 021

ANXIETY DISORDERS

DEFINITION

- Anxiety disorders are characterized by excessive or inappropriate fear or anxiety.
- The criteria for most anxiety disorders involve symptoms that **cause clinically significant distress** or **impairment in social and/or occupational functioning**. These symptoms include:

TABLE 5-1. Signs and Symptoms of Anxiety

Constitutional	Fatigue, diaphoresis, shivering
Cardiac	Chest pain, palpitations, tachycardia, hypertension
Pulmonary	Shortness of breath, hyperventilation
Neurologic/ musculoskeletal	Vertigo, light-headedness, paresthesias, tremors, insomnia, muscle tension
Gastrointestinal	Abdominal discomfort, anorexia, nausea, emesis, diarrhea, constipation

DEFINITION

Fear is manifested by a transient increase in sympathetic activity (“fight or flight” physiologic response, thoughts, feelings, behaviors) in a situation perceived as dangerous or threatening. By contrast, anxiety involves apprehen- sion regarding the possibility of a negative future event

TABLE 5-2. Medications and Substances That Cause Anxiety	
Alcohol	Intoxication/withdrawal
Sedatives, hypnotics, or anxiolytics	Withdrawal
Cannabis	Intoxication
Hallucinogens (PCP, LSD, MDMA)	Intoxication
Stimulants (amphetamines, cocaine)	Intoxication/withdrawal
Caffeine	Intoxication/withdrawal
Tobacco	Intoxication/withdrawal
Opioids	Withdrawal

LSD, lysergic acid diethylamide; MDMA, 3,4-methylenedioxy methamphetamine; PCP, phencyclidine.

TABLE 5-3. Medical Conditions That Cause Anxiety	
Neurologic	Epilepsy, migraines, brain tumors, multiple sclerosis, Huntington disease
Endocrine	Hyperthyroidism, hypoglycemia, pheochromocytoma, carcinoid syndrome
Metabolic	Vitamin B12 deficiency, electrolyte abnormalities, porphyria
Respiratory	Asthma, chronic obstructive pulmonary disease (COPD), hypoxia, pulmonary embolism (PE), pneumonia, pneumothorax
Cardiovascular	Congestive heart failure (CHF), angina, arrhythmia, myocardial infarction (MI)

ETIOLOGY AND EPIDEMIOLOGY

- Anxiety disorders are the most common form of psychopathology.
- They are caused by a combination of genetic, biological, environmental, and psychosocial factors.
- Primary anxiety disorders can only be diagnosed after determining that the signs and symptoms are NOT due to the physiological effects of a substance or another medical condition.
- Major neurotransmitter systems implicated: norepinephrine, serotonin (5-HT) and GABA.
- More in women than men, 2:1 ratio.

TREATMENT OF ANXIETY DISORDERS

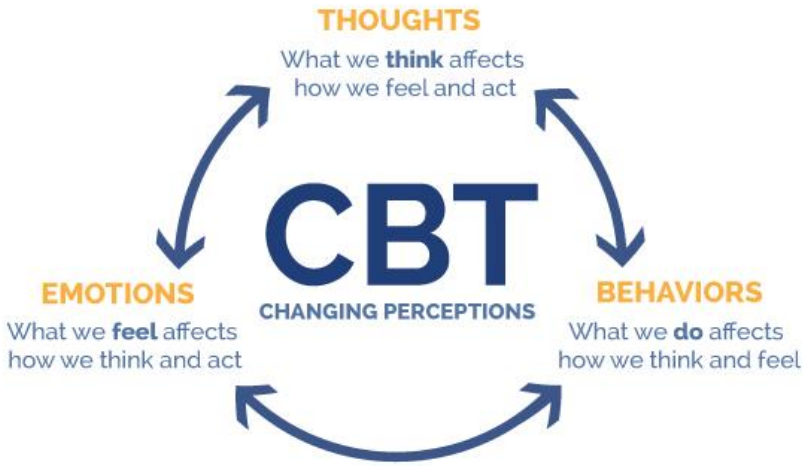
It is based on the severity of symptoms. *Psychotherapy is initiated for mild anxiety while a combination of therapy and medication for moderate to severe anxiety should be considered.*

- Psychotherapy:

1- Cognitive behavioral therapy (CBT)

2- Psychodynamic psychotherapy is **an approach that involves facilitation of a deeper understanding** of the development of anxiety symptoms, leading to more adaptive coping styles and subsequent improvement over time.

- Pharmacotherapy: goal is to achieve symptomatic relief and continue treatment for at least 6 months before attempting to titrate off medications.



WARDS TIP

Start SSRIs or SNRIs at low doses and ↑ slowly because side effects may initially worsen anxiety, especially in panic disorder.

PHARMACOTHERAPY (OVERVIEW)

a) SSRIs e.g., sertraline and SNRIs e.g., venla-faxine are first-line medications.

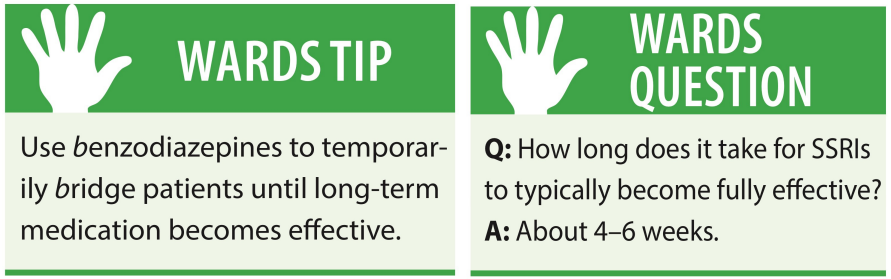
b) Benzodiazepines work quickly and effectively, but regular use results in dependence, so use, duration and dose should be minimized. MOA: enhance activity of GABA at GABA-A receptor.

c) In patients with comorbid substance use, consider non-addictive anxiolytic alternatives for use as needed (PRN), such *as diphenhydramine and gabapentin*.

d) Buspirone is a non-benzodiazepine anxiolytic which has partial agonist activity at the 5-HT1A receptor. Typically prescribed only as augmentation with other drugs.

e) Beta-blockers may be used to help control auto-nomic symptoms (e.g., palpitations, tachycardia, sweating) of panic attacks or performance anxiety.

f) TCAs and MAOIs may be considered if first-line agents are not effective. Their side-effect profile makes them less tolerable and more dangerous.



PANIC DISORDER

A panic attack is a fear response involving a sudden onset of intense anxiety which may be triggered or occur spontaneously. Panic attacks peak within minutes and usually resolve within half an hour. Although classically associated with panic disorder, panic attacks can also be experienced with other psychiatric disorders and medical conditions.

Symptoms of a panic attack include the following (Da PANICS)

WARDS TIP

Carefully screen patients with panic attacks for suicidality. They are at an increased risk for suicide attempts.

PANIC DISORDER

- Spontaneous, recurrent panic attacks which occur suddenly but patients may also experience some panic attacks with a clear trigger.
- The frequency of attacks ranges from multiple times per day to a few monthly.
- Patients develop debilitating anticipatory anxiety about having future attacks—“fear of the fear.”
- Diagnosis and DSM-5 Criteria

Recurrent, unexpected panic attacks without an identifiable trigger	one or more of panic attacks followed by ≥1 month of continuous worry about experiencing subsequent attacks, and/or a maladaptive change in behaviors	Not caused by the direct effects of a substance, another mental disorder or another medical condition

PANIC DISORDER

- **Etiology** of panic disorder: Genetic and psychosocial factors.

Increased incidence of stressors (especially loss) prior to onset of disorder; history of childhood physical or sexual abuse.

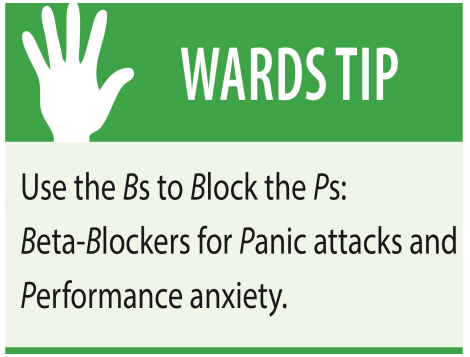
Greater risk of panic disorder if a first-degree relative is affected.

- **Epidemiology**
- Lifetime prevalence: 4%.
- Higher rates in woman compared to men. 2:1.
- Median age of onset: 20–24 years old.

- **Course and Prognosis**
- Chronic course with waxing and waning symptoms.
- Relapses are common with discontinuation of medication.
- Only a minority of patients have full remission of symptoms.

- **Treatment**: Combination of CBT and Pharmacotherapy is most effective
- First-line: SSRIs. SNRIs are also efficacious.

WARDS TIP: Smoking is a risk factor for panic attacks.



AGORAPHOBIA

- It is an intense fear of being in public places where escape or obtaining help may be difficult. It often develops with panic disorder.
- Diagnosis and DSM-5 Criteria

1- Intense fear/anxiety about being in **two or more situations of the following** due to concerns of difficulty escaping or obtaining help in case of panic (from the figure on the right)

2- The triggering situations cause fear/anxiety out of proportion to the potential danger posed, leading to intense anxiety or avoidance of the triggering situations which may become as extreme as complete confinement to the home.

3- Symptoms cause significant social or occupational dysfunction.

4- Symptoms last ≥6 months.

5- Symptoms not better explained by another mental disorder

KEY FACT

Characteristic situations avoided in agoraphobia include bridges, crowds, buses, trains, or any open areas outside the home.

AGORAPHOBIA

- Etiology

- Strong genetic factor: Heritability about 60%.
- Psychosocial factor: Onset frequently follows a traumatic event.

- Course/Prognosis

- More than 50% of patients experience a panic attack prior to developing agoraphobia.
- Onset is usually before age 35.
- Course is persistent and chronic, with rare full remission.
- Comorbid diagnoses include other anxiety disorders, depressive disorders, and substance use disorders.

- Treatment

- Similar approach as panic disorder: CBT and SSRIs (for panic symptoms).

SPECIFIC PHOBIAS

- A phobia is an irrational fear that leads to anxiety and/or avoidance of the feared object or situation.
- A specific phobia is an intense fear of a specific object or situation (i.e., the phobic stimulus).
- DSM-5 criteria

Persistent, excessive fear elicited by a specific situation or object which is out of proportion to any actual danger/threat.	Exposure to the situation triggers an immediate fear response.	Situation or object is avoided when possible or tolerated with intense anxiety.
Symptoms cause significant social or occupational dysfunction.	Duration ≥6 months.	Symptoms not solely due to another mental disorder, substance (medication or drug), or another medical condition.

SPECIFIC PHOBIAS

- Common specific phobias include animals and natural environment.
- Epidemiology
  - More common in women compared to men (2:1) but vary depending on the type of stimulus.
  - Phobias are the most common psychiatric disorder in women
  - Second most common in men (substance-related is first).
  - Lifetime prevalence of specific phobia: >10%.
  - Mean age of onset is 10 years.
- Treatment of choice: CBT.(With Exposure)

SOCIAL ANXIETY DISORDER (SOCIAL PHOBIA)

- It is the fear of scrutiny by others or fear of acting in an embarrassing way. As a result, social situations causing significant anxiety may be avoided altogether, resulting in social impairment.
- The diagnostic criteria for social phobia are similar to specific phobia except the phobic stimulus is related to social scrutiny and negative evaluation. The patients fear embarrassment, humiliation, and rejection.
- This fear may be limited to performance or public speaking.
- Median age of onset is 13 years.
- Occurs equally in men and women.
- Treatment

- Treatment of choice: CBT.
- First-line medication, if needed: SSRIs (SNRIs for debilitating symptoms)
- Beta-blockers may be used for performance anxiety/public speaking.

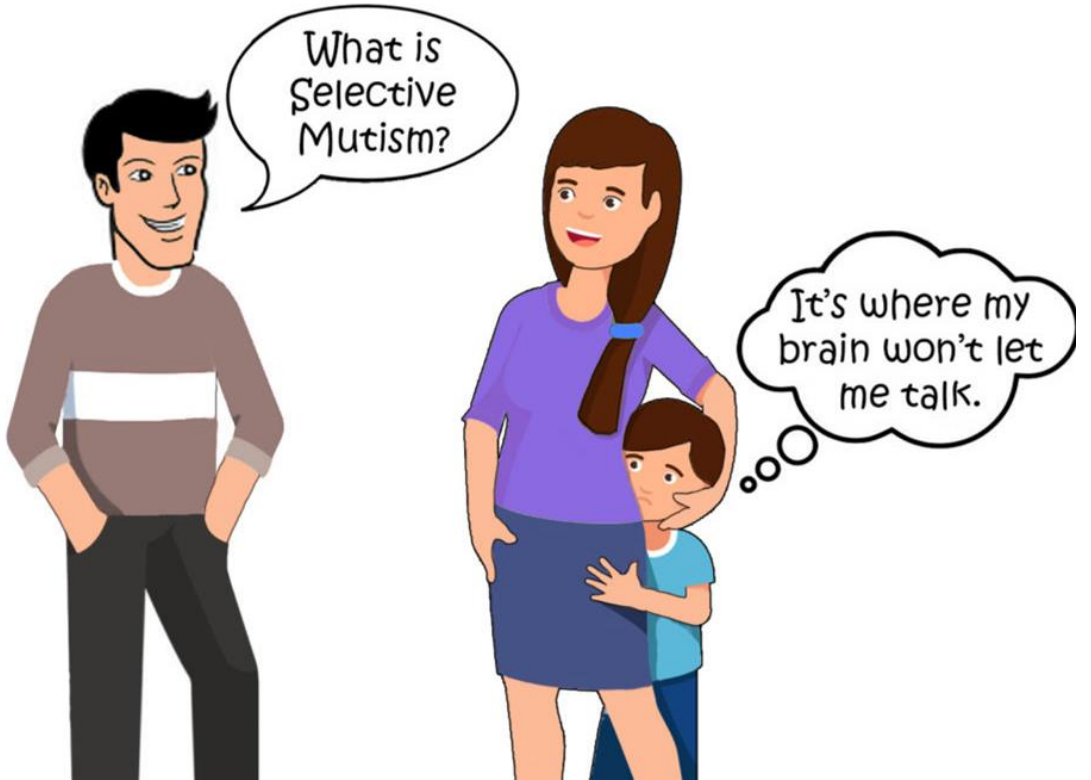
SELECTIVE MUTISM

- It is a rare condition characterized by a failure to speak in specific situations for at least 1 month despite the intact ability to comprehend and use language.

- Onset: typically during childhood.

- The majority of these patients suffer from socia anxiety.

- The patients may remain completely silent or whisper or use nonverbal means of communication, such as writing or gesturing.



SELECTIVE MUTISM

- Diagnosis and DSM-5 Criteria

Consistent failure to speak in select social situations despite speech ability in other scenarios.	Mutism is not due to a language difficulty or a communication disorder.	Symptoms cause significant impairment in academic, occupational, or social functioning	Symptoms last >1 month

- Treatment:

- Psychotherapy: CBT, family therapy.
- Medications: SSRIs (especially with comorbid social anxiety disorder).

SEPARATION ANXIETY DISORDER

- Separation anxiety typically emerges by 1 year of age and peaks by 18 months. When the anxiety due to separation becomes extreme or developmentally inappropriate, it is considered pathologic. It may be preceded by a stressful life event.

- Diagnosis and DSM-5 Criteria

Excessive and developmentally inappropriate fear/anxiety regarding separation from attachment figures, with *at least 3* of the following:

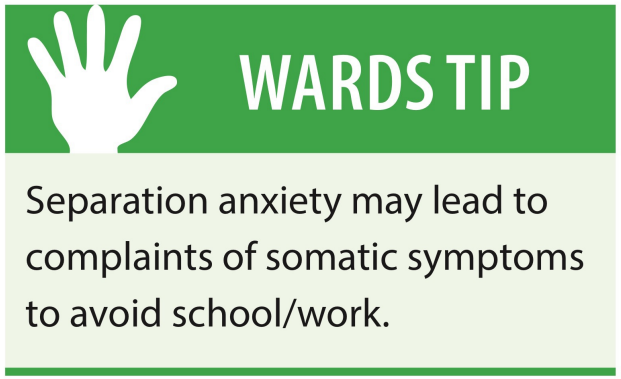
1) Separation from attachment figures leads to extreme distress.
2) Excessive worry about loss of or harm to attachment figures.
3) Excessive worry about experiencing an event that leads to separation from attachment figures.
4) Reluctance to leave home, or attend school or work.
5) Reluctance to be alone.
6) Reluctance to sleep alone or away from home.
7) Complaints of physical symptoms when separated from major attachment figures.
8) Nightmares of separation and refusal to sleep without proximity to attachment figure.
9) Lasts for ≥4 weeks in children/adolescents and ≥6 months in adults.
10) Symptoms cause significant social, academic, or occupational dysfunction.
11) **Symptoms not due to another mental disorder.**

SEPARATION ANXIETY DISORDER

- Treatment

- Psychotherapy: CBT, family therapy.

- Medications: SSRIs can be effective as an adjunct to therapy.

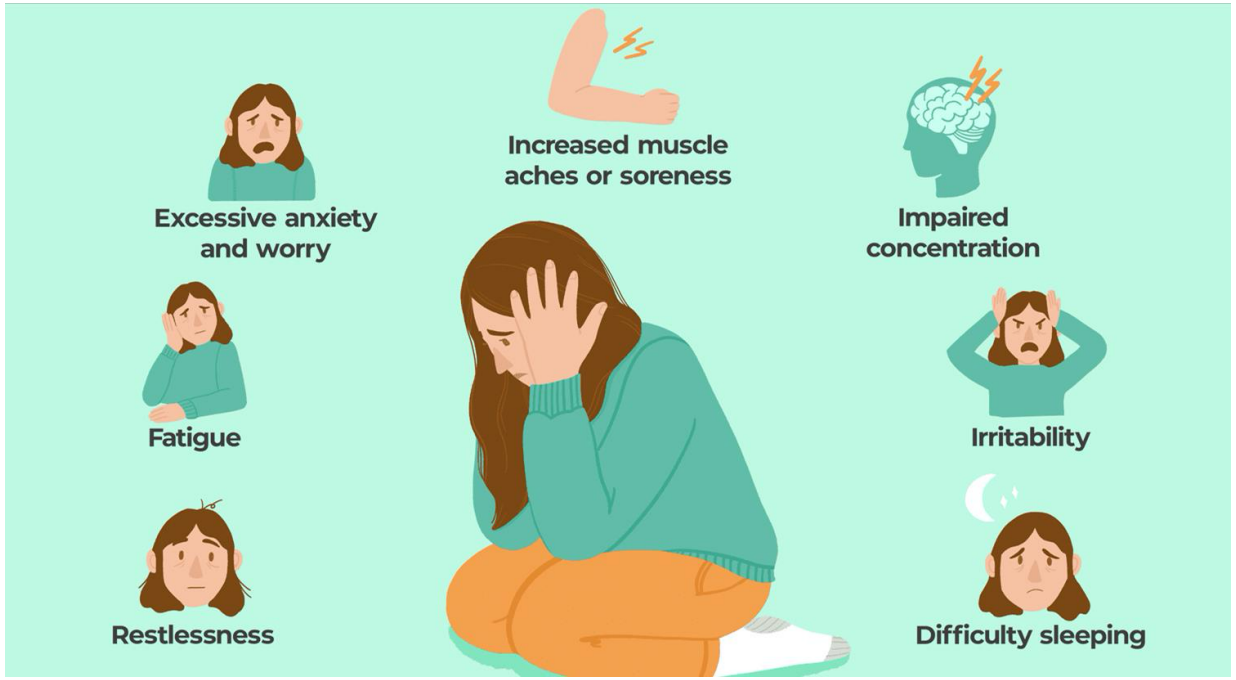


GENERALIZED ANXIETY DISORDER (GAD)

Patients with GAD have persistent, excessive anxiety about many aspects of their daily lives. Often they experience somatic symptoms including fatigue and muscle tension.

WARDS TIP

GAD Mnemonic
Worry WARTS
Wound up, **w**orn-out
Absent-minded
Restless
Tense
Sleepless



DIAGNOSIS AND DSM-5 CRITERIA FOR GAD

- Excessive, anxiety/worry about various daily events/activities ≥6 months.
- Difficulty controlling the worry.
- Associated ≥3 symptoms: restlessness, fatigue, impaired concentration, irritability, muscle tension, insomnia.
- Symptoms are not caused by the direct effects of a substance, or another mental disorder or medical condition.
- Symptoms cause significant social or occupational dysfunction.

GENERALIZED ANXIETY DISORDER (GAD)

- Epidemiology/Etiology
  - Lifetime prevalence: 5–9%.
  - GAD rates higher in women compared to men (2:1).
  - One-third of risk for developing GAD is genetic.

WARDS TIP

The worries associated with *GAD* are free-floating across various areas, as opposed to being fixed on a specific trigger.

- Course/Prognosis
  - Symptoms of worry begin in childhood.
  - Median age of onset of GAD: 30 years.
  - Course is chronic, with waxing and waning symptoms.
  - Rates of full remission are low.
  - GAD is highly comorbid with other anxiety and depressive disorders.

- Treatment
  - The most effective treatment approach combines psychotherapy and pharmacotherapy: CBT and SSRI/SNRI.
    - Can also consider a short-term course of benzodiazepines or augmentation with buspirone.
    - Much less commonly used medications are TCAs and MAOIs.

A 24-year-old law student presents to an outpatient psychiatry clinic with a chief complaint that she is "so stressed out, worrying about everything." She is overwhelmed with her academic workload and upcoming exams. She has had trouble falling asleep and feels chronically fatigued. The patient also suffers from frequent headaches and muscle tightness in her neck and shoulders.

The patient's husband describes her as "a worrier. She's always concerned about me getting into an accident, her flunking out of school, not finding a job—the list goes on."

The patient reports that she has always had some degree of anxiety, but previously found it motivating. Over the last year since law school began, her symptoms have become debilitating.

What is the most likely diagnosis?

With the patient's history of *excessive worrying* about *everything,* the most likely diagnosis is generalized anxiety disorder (GAD). Like many patients with GAD, she is described as a *worrier*. She reports typical associated symptoms: insomnia, fatigue, and impaired concentration. Her symptoms have been present for over *6 months*.

What is the next step?

A complete physical exam and medical workup should be performed to rule out other medical conditions or substance use contributing to or causing her anxiety symptoms.

What are treatment options?

Treatment options for GAD include psychotherapy (usually CBT) and pharmacotherapy (typically SSRIs). A combination of both modalities may achieve better remission rates than either treatment alone.

WARDS QUESTION

Q: What medication often successfully treats performance anxiety?

A: Beta-blockers.

Obsessive-Compulsive and Related Disorders

Obsessive Compulsive Disorder (OCD)

- Obsessions: Recurrent, intrusive, anxiety-provoking thoughts, images, or urges that the patient attempts to suppress.(like he forgot the stove open)
- Compulsions: Repetitive behaviors or mental acts the patient feels driven to perform in response to an obsession the behaviors are excessive and are not realistically connected to what they are meant to prevent (so the patient check the stove 20 times before going to work for ex)

Obsessive Compulsive Disorder (OCD)

- Obsessions are thoughts , compulsions are behaviors aimed to relive these thoughts

Obsessive Compulsive Disorder (OCD)

- Patterns of Obsessions and Compulsions:

Obsessions	Compulsions
Contamination	Cleaning or avoidance of contaminant
Doubt or harm	Checking multiple times to avoid potential danger
Symmetry	Ordering or counting
Intrusive, taboo thoughts	With or without related compulsion

Obsessive Compulsive Disorder (OCD)

Diagnosis

- The patient has Experienced obsessions and compulsions that are time-consuming or cause significant distress or dysfunction.
- Make sure that the symptoms are Not caused by the direct effects of a substance, another mental illness, or another medical condition

Obsessive Compulsive Disorder (OCD)

- Epidemiology
- Lifetime prevalence: 2-3%.
- No gender difference

Obsessive Compulsive Disorder (OCD)

Etiology

- Significant genetic component: Higher rates of OCD in first-degree relatives and monozygotic twins than in the general population

Course

- Chronic, with waxing and waning symptoms
- Less than 20% remission rate without treatment.
- Suicidal ideation in 50%, attempts in 25%
- High comorbidity with other psychological disorders

Obsessive Compulsive Disorder (OCD)

Treatment

- combination of psychopharmacology and Cognitive behavioural therapy
- First-line medication is SSRIs typically at higher doses
- Second-line agents: SNRIs (e.g., venlafaxine) or the most serotonin selective TCA, clomipramine
- Can add atypical antipsychotics → In severe cases !!!
- In treatment-resistant cases can use psychosurgery (cingulotomy) or (ECT).

Body Dysmorphic Disorder

Body Dysmorphic Disorder

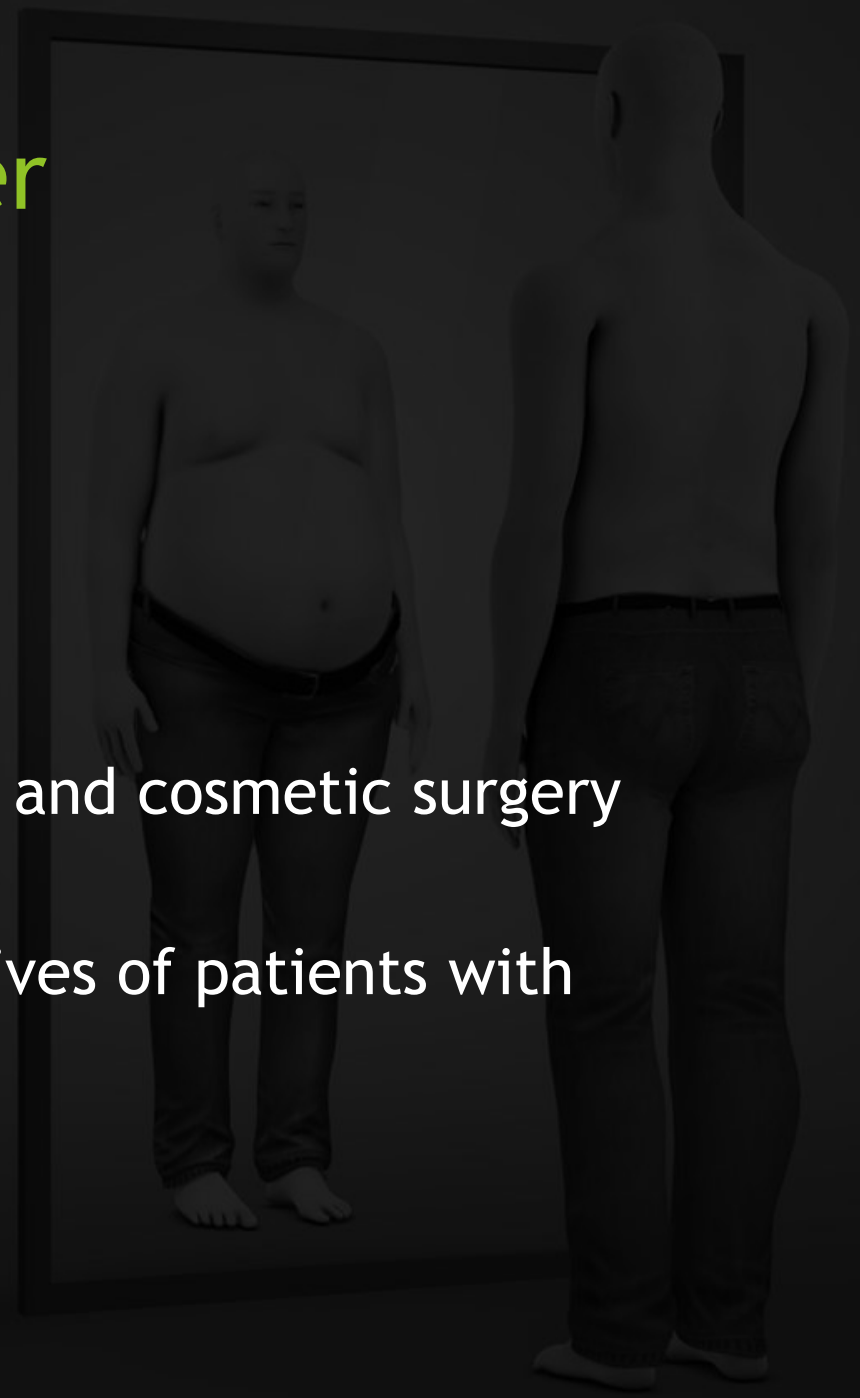
- Patient that are preoccupied with nonexistent or minor physical defects that they regard as severe or ugly
- These individuals spend significant time trying to correct perceived flaws with makeup, dermatological procedures, or plastic surgery

Body Dysmorphic Disorder

For diagnosis

- Preoccupation with perceived defects or flaws in physical appearance that are not observable by or appear slight to others.
- repetitive behaviors like skin picking or mental acts like comparing with others In response to the appearance concerns
- causes significant distress
- Cannot be accounted for other disease like eating disorders

Body Dysmorphic Disorder



- Epidemiology
- Mean age of onset: 15 years.
- slightly more common in women
- Higher prevalence in dermatologic and cosmetic surgery patients.
- Increased risk in first-degree relatives of patients with OCD

Body Dysmorphic Disorder

Body Dysmorphic Disorder

Course and prognosis

- Begin in early adolescence , gradual and tend to be chronic
- Surgical or dermatological procedures don’t satisfy the patient
- High rate of suicidal ideation and attempts
- Comorbidity with other psychological disorders depression, social anxiety disorder (social phobia), and OCD.

Body Dysmorphic Disorder

Treatment

- SSRIs and/or CBT may reduce the obsessive and compulsive symptoms in many patients.

Hoarding Disorder

Hoarding Disorder

- is where someone acquires an excessive number of items and stores them in a chaotic manner, usually resulting in unmanageable amounts of clutter

Hoarding Disorder

Diagnosis

- Persistent difficulty discarding items, regardless of value
- due to need to save the items and distress associated with discarding them
- Results in accumulation and clutter in living area
- It cause clinically significant distress or impairment in social, occupational, or other areas of functioning
- not attributable to another medical condition or another mental disorder.

Hoarding Disorder

Epidemiology and etiology

- prevalence of significant hoarding is 2-6%
- three times more prevalent in older population
- Onset often preceded by stressful and traumatic events
- Fifty percent of individuals with hoarding have a relative who also hoards

Hoarding Disorder

Course and Prognosis

- begins in early teens get worse with time and tend to be chronic
- Seventy-five percent of individuals have comorbid mood (MDD) or anxiety disorder (social anxiety disorder)
- Twenty percent of individuals have comorbid OCD

Hoarding Disorder

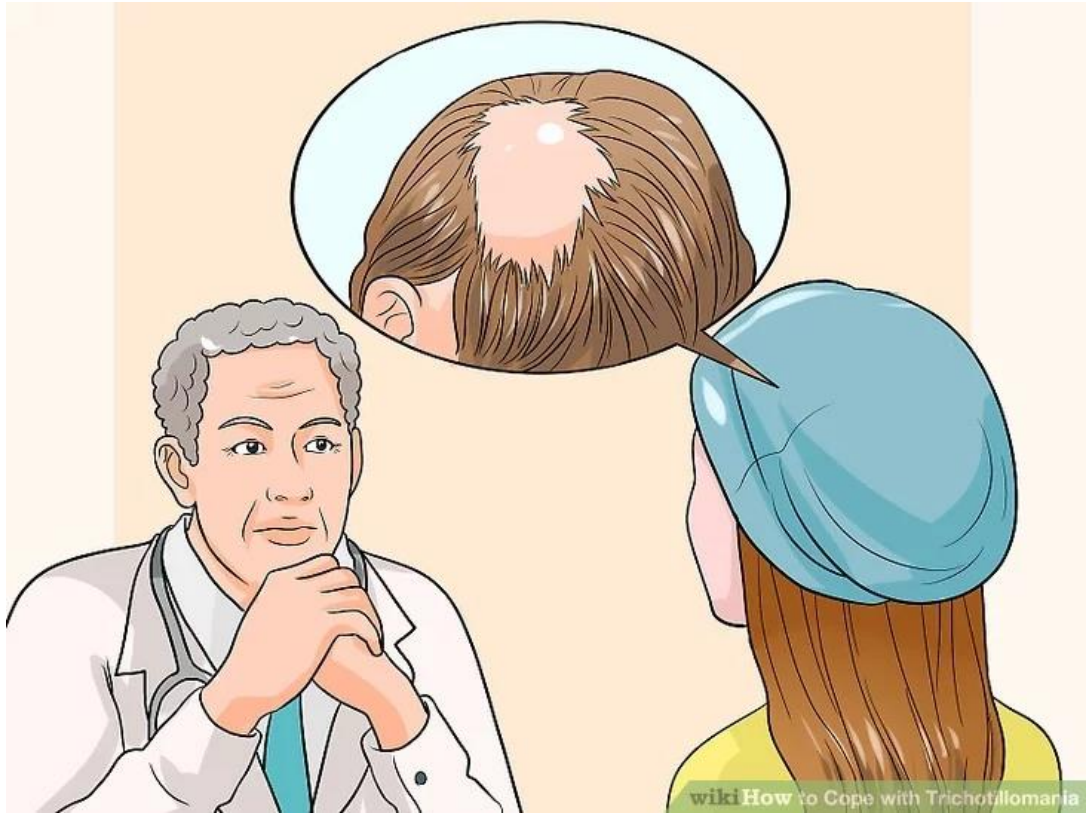
Treatment

- Very difficult to treat
- Specialized CBT for hoarding
- SSRIs can be used.

Trichotillomania

Trichotillomania

- Hair-Pulling Disorder
- is **when someone cannot resist the urge to pull out their hair**



Trichotillomania

Diagnosis

- Recurrent pulling out of hair, resulting in hair loss
- Repeated attempts to decrease or stop hair pulling
- Causes significant distress
- not due to another medical condition or psychiatric disorder.
- involves the scalp, eyebrows, or eyelashes. May include facial, axillary, and pubic hair

Trichotillomania

Epidemiology and Etiology

- Lifetime prevalence: 1–2% of the adult population
- More common in women than in men (10:1 ratio)
- Onset usually at puberty. Frequently associated with a stressful event
- Etiology may involve biological, genetic, and environmental factors
- Increased incidence of comorbid OCD, major depressive disorder, and excoriation (skin-picking) disorder

Trichotillomania

Course

- Course may be chronic with waxing and waning periods. Adult onset is generally more difficult to treat.

Treatment

- Treatment includes SSRIs, second-generation antipsychotics, lithium, or N-acetylcysteine.
- Specialized types of cognitive-behavior therapy (e.g., habit reversal training)

Recommended

excoriation (Skin-Picking) Disorder

Skin-Picking

diagnosis

- recurrent picking of one's skin resulting in skin lesions
- Repeated attempts to decrease or stop skin picking
- Causes significant distress
- Skin picking is not due to a substance, another medical condition

Skin-Picking

Epidemiology and Etiology

- Lifetime prevalence: 1.4% of the adult population
- More than 75% of cases are women.
- More common in individuals with OCD and first-degree family members

Skin-Picking

Course

- Skin picking begins in adolescence.
- Course is chronic with waxing and waning periods if untreated.
- Comorbidity with OCD, trichotillomania, and MDD.

Skin-Picking

Treatment

- Specialized types of cognitive-behavior therapy (habit reversal training)
- SSRIs have shown some benefit

Trauma and Stressor-Related Disorders

Post traumatic Stress Disorder (PTSD) and Acute Stress Disorder

- PTSD is the development of multiple symptoms after exposure to one or more traumatic events like:
- intrusive symptoms (e.g., nightmares, flashbacks)
- Avoidance
- negative alterations in thoughts and mood
- increased arousal.
- Symptoms last >1 month , at any time after the trauma

Post traumatic Stress Disorder (PTSD) and Acute Stress Disorder

- Acute Stress Disorder similar symptoms as PTSD but for a shorter duration
- Less than one month
- The onset of symptoms occurs within 1 month of the trauma

TABLE 5-4. Posttraumatic Stress Disorder and Acute Stress Disorder	
Posttraumatic Stress Disorder	**Acute Stress Disorder**
Trauma occurred at any time in past	Trauma occurred <1 month ago
Symptoms last >1 month	Symptoms last <1 month

Post traumatic Stress Disorder (PTSD)

Diagnosis

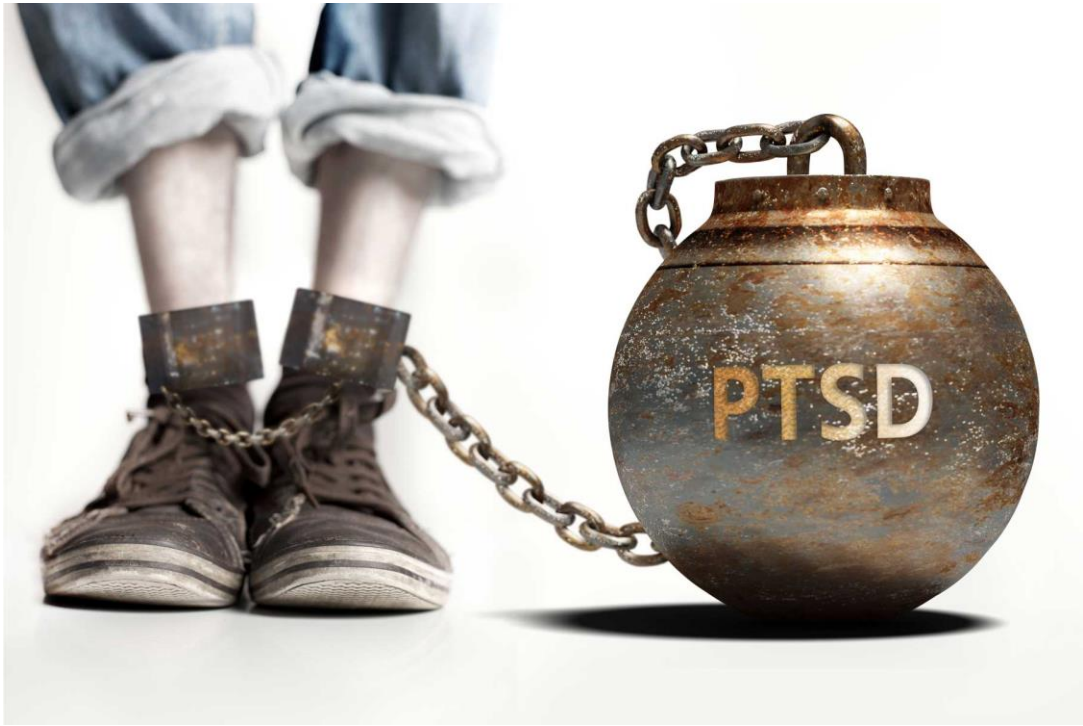
- The patient has to be exposed to actual or threatened death, serious injury, or sexual violence
- Recurrent intrusions of re-experiencing the event via memories, nightmares, or dissociative reactions like flashbacks
- intense distress at exposure to cues relating to the trauma
- physiological reactions to cues relating to the trauma.

Post traumatic Stress Disorder (PTSD)

- Active avoidance of triggering stimuli like memories, feelings, people, places, objects
- two of the following negative cognitions/mood
- dissociative amnesia
- negative feelings of self/others/world
- self-blame
- negative emotions like fear, horror, anger, guilt
- Anhedonia (**the inability to feel pleasure)**

Post traumatic Stress Disorder (PTSD)

- feelings of detachment/ estrangement
- inability to experience positive emotions.



Post traumatic Stress Disorder (PTSD)

two of the following symptoms of increased arousal

- Hypervigilance
- exaggerated startle response
- irritability/angry outbursts
- impaired concentration
- insomnia.

Post traumatic Stress Disorder (PTSD)

- not caused by a substance or another medical condition
- Symptoms result in significant impairment in social or occupational functioning.
- The presentation differs in children less than 7 years

Post traumatic Stress Disorder (PTSD)

Epidemiology and Etiology

- Lifetime prevalence of PTSD: >8%.
- Higher prevalence in women due to greater risk of exposure to traumatic events
- Exposure to prior trauma, especially during childhood, is a risk factor for developing PTSD

Post traumatic Stress Disorder (PTSD)

Course

- begins within 3 months after the trauma.
- Symptoms may manifest after a delayed expression.
- Fifty percent of patients recover within 3 months.
- Symptoms diminish with older age.
- Eighty percent of patients with PTSD have a comorbid mental disorder

Post traumatic Stress Disorder (PTSD) treatment

Pharmacological

- First-line antidepressants SSRIs or SNRIs
- Prazosin, α1 -receptor antagonist, for nightmares and hypervigilance
- atypical (second-generation) antipsychotics in severe cases

Psychotherapy

- Specialized forms of CBT like exposure therapy, cognitive processing therapy
- Supportive and psychodynamic therapy.
- Couples/family therapy.

Adjustment Disorders

Adjustment Disorders

- an emotional or behavioral reaction to a stressful event or change in a person's life.
- Like divorce, death of a loved one, or loss of a job
- It differ from (ptsd) that its not life threatening

Adjustment Disorders

Diagnosis

- Development of emotional or behavioral symptoms within 3 months in response to stressful life event causing distress and impairment in daily functioning
- symptoms are not those of normal bereavement
- Symptoms resolve within 6 months
- The stress-related disturbance does not meet criteria for another mental disorder.

Adjustment Disorders

Epidemiology

- Five percent to twenty percent of patients in outpatient mental health clinics have an adjustment disorder.
- May occur at any age.

Etiology

- Triggered by psychosocial factors.

Adjustment Disorders

Prognosis

- May be chronic if the stressor is chronic or recurrent

Treatment

- Supportive psychotherapy.
- Group therapy.
- pharmacotherapy can target associated symptoms (insomnia, anxiety, or depression).


Thank You!