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Chris Aiken, MD
Editor-in-Chief

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IN THIS ISSUE

Focus of the Month:
Psychotherapy

Learning Objectives
After reading these articles, you should be able to:

1. Understand the relationship between abortion, unwanted pregnancies, and mental health.
2. Identify the components of a strong therapist-patient relationship.
3. Determine the best approach for treating trichotillomania.
4. Summarize some of the current research findings on psychiatric treatment.

Does Abortion Lead to Psychiatric Issues?

Sarah K. Rivelli, MD. System Director, Consult Liaison, Department of Psychiatry and Behavioral Medicine, Carilion Clinic.

Dr. Rivelli has no financial relationships with companies related to this material.

Your patient became pregnant during a recent manic episode and seeks guidance on her options. She is worried that her mental health will worsen if she keeps the baby, while her family is concerned that termination puts her at risk for becoming less stable.

Abortion is becoming more difficult to obtain in the United States, and the arguments against legalization of abortion include the claim that it is harmful to a woman's mental health. This is particularly relevant for psychiatric patients, who often suffer from behavioral problems that place them at risk for unwanted pregnancies and abortion. In this article, we'll explore that claim and look at the psychiatric impact of abortion.

Highlights From This Issue

Feature article
Elective abortions are rumored to worsen mental health. The rumor does not match the facts.

Q&A on page 1
Dr. Allen Frances explains why evidence-based psychotherapy needs a personal touch.

On page 5
Most medications failed in trichotillomania, but the glutamatergic amino acid N-acetylcysteine (NAC) has a positive trial.

In 2011, a controversial review in the *British Journal of Psychiatry* concluded that elective abortions increase a woman's risk of mental health problems by 81%, and that abortion is responsible for one in 10 mental health disorders among

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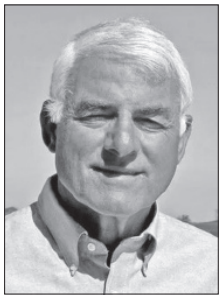
Q&A With the Expert

The Enduring Value of Talking Therapy
Allen Frances, MD

Chair of the DSM-IV Task Force; Professor and Chairman Emeritus of the Duke University Department of Psychiatry; founding editor of the Journal of Personality Disorders *and the* Journal of Psychiatric Practice; *co-host of the podcast* Talking Therapy.

Dr. Frances has no financial relationships with companies related to this material.



TCPR: Tell us about your interest in psychotherapy.
Dr. Frances: I always had a practice of 10 or 15 hours a week that included psychotherapy, but I also see it as part of every contact with the patient, even a brief encounter in the emergency room or inpatient unit. I taught at the Columbia Psychoanalytic School for 10 years, but I've also worked to unify the various schools of psychotherapy so that residents wouldn't come out saying "I'm a psychodynamic psychotherapist," "I'm a cognitive therapist," or "I'm a behavioral therapist." Now I'm working on a podcast along these lines with Marvin Goldfried, *Talking Therapy.*

TCPR: Some of those psychotherapies bring unique techniques to the table. How important is that?
Dr. Frances: It's the common factors in psychotherapy,

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rather than the specific techniques, that matter most, and these apply whether you are doing therapy or prescribing medication. The clinician has to build a trusting, healing relationship through qualities like empathy, warmth, genuineness, and positive regard for the patient. Clinicians must explain the problem and the treatment in a way that is jargon-free, engages the patient, instills hope, and combats demoralization (Wampold BE, *World Psychiatry* 2015;14(3):270–277). Technical factors still play a role, though, depending on the patient. The simpler and more contained the problem, the more likely that one or another technique is going to be helpful.

TCPR: What are "simple" problems?

Dr. Frances: Social or simple phobia or panic disorder. A single episode of major depressive disorder that was triggered by a clear-cut stressor. PTSD from a single trauma, like a car accident. Primary insomnia. All of these benefit from manualized therapies. The reality is that we don't see simple problems too often in practice. The patients psychiatrists see tend to have multiple stressors, chronic medical disorders, and comorbidities like personality disorders or addictions. It's easier to do research on simple problems, but real life is more complex.

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TCPR: Does that mean manualized therapy is better suited to simple problems?

Dr. Frances: Yes. The more complex the problem, the less likely you can develop a simple manual to deal with it. Manuals still have a role in complex problems like schizophrenia and bipolar disorder, but here they largely provide guidance on disease management. In bipolar disorder, for example, that includes medication adherence, but also regular sleep, sleep hygiene, not using substances, not traveling the world all the time, not overexciting the nervous system with constant stressors and constantly changed experience.

TCPR: Can manuals cause harm?

Dr. Frances: They can lead people to follow the manual instead of following the patient. It's easier to teach people technical procedures than it is to teach them to be really good interpersonally. The experience I've had is that really great therapists are born—they're not taught—and they don't become great by following a manual.

TCPR: I understand your point, but I've heard that outcomes are better when therapists follow a manual.

Dr. Frances: Some of the early studies found that patients did better when their therapist followed the manual more closely. The interpretation at the time was, "Aha, if you follow the manual, you get better results." But it's really a case of confusing correlation with causality, and the causality probably runs in just the opposite direction.

TCPR: How do you mean?

Dr. Frances: "Easy patients" let you follow the manual, and outcomes are better with easy patients. If a patient is difficult, you will need to be creative and flexible; they won't let you say rotely, "We do this today and this tomorrow." They force you to respond to their current need. As more studies came out, the supposed association faded, and a meta-analysis found no relationship between outcomes and manual adherence (Webb CA et al, *J Consult Clin Psychol* 2010;78(2):200–211). Manuals can give you the general principles of the therapy, but they won't help you get close to where your patient experientially needs you to be at any given moment. The best continuing education in psychotherapy is learning from the next patient you get to see.

TCPR: Many of these manuals were written by psychotherapists who developed the field. Do they follow their own manuals?

Dr. Frances: I've been fortunate to see many of them in practice, and one thing I've noticed is how similar they are. They all form remarkably good bonds with the patient, whether it's Marsha Linehan with dialectical behavior therapy, Aaron Beck with cognitive behavioral therapy (CBT), or David Barlow with behavior therapy. Psychotherapy manuals were developed originally because NIMH funding for psychotherapy studies required them. I worked on that committee for many years in the 1980s. Our thinking was that you couldn't interpret the results of studies if the treatments weren't delivered in a standardized way. But this is one of those odd disconnects between research and practice. Research required manuals, but slavish adherence to the manuals is bad for the clinical practice that research hopes to inform.

TCPR: It reminds me of fixed-dose studies, where they titrate everyone to the same dose. That is not what we do in practice.

Dr. Frances: Yes, and it's even more true for psychotherapy. You would never want to issue standardized psychotherapy in practice. The Becks—Aaron and his daughter Judy—did not use the manual as a training tool and do

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not recommend it as a way of conducting therapy. Likewise with Marsha Linehan. Her therapy is for complex patients with borderline personality disorder, and rote adherence to a manual is not going to work very well there. Knowing the manual and using its principles flexibly can make a good therapist better, but rigidly following it can make a bad therapist worse.

Psychotherapy and Pharmacotherapy

TCPR: How do psychotherapy outcomes differ from medication outcomes?

Dr. Frances: For many mild to moderate conditions, the outcomes are similar, but one of the most powerful findings is that psychotherapy tends to have a more enduring effect for depression and anxiety. It may be slightly slower in producing gains, but the gains are more enduring (Spielmans GI et al, *J Nerv Ment Dis* 2011;199(3):142–149).

TCPR: What about severe depression?

Dr. Frances: For very severe depressions, the ones that require hospitalization or have melancholia or delusions, psychotherapy is less helpful because the person is too withdrawn and doesn't have the energy to participate. Therapy might just feel like an added stressor. But for severe depressions that are just short of that, psychotherapy in a medically supportive way can be quite useful. But psychotherapy alone will rarely be sufficient in severe depressions.

TCPR: People can score high on self-rated scales even when they have adjustment disorder. How do you distinguish that from clinical depression?

Dr. Frances: Most patients who present with transient problems that result from stress and don't have a long history of preexisting psychiatric problems are going to do just fine with time, normalization, watchful waiting, increasing supports, and reducing stress in their life. Many of them do a lot better without getting a diagnosis beyond adjustment disorder because once a diagnosis is made, it tends to haunt people for life.

> **"Knowing the manual and using its principles flexibly can make a good therapist better, but rigidly following it can make a bad therapist worse."**
>
> Allen Frances, MD

TCPR: In our culture, many patients see medications as the only answer. How do you help them see other possibilities?

Dr. Frances: It's easy to help people without medications—but it takes more time. If the average PCP is seeing a patient for 10 minutes and that patient has been primed to want something concrete out of the too-brief contact, then writing a script is the quickest way to get them out of the office reasonably satisfied. This explains why 12% of the population is taking antidepressants. It's not that way across the globe. In the UK, the NICE guidelines do not recommend antidepressants for mild depression. Instead, they recommend CBT, regular sleep, and exercise. If PCPs had enough time, they could get to know the person and say, "You're up against a tough situation right now. Anyone would feel bad. It's a tough thing for anyone to go through what you're going through. These things tend to sort themselves out with time, and with changes you can make, and with help from the people around you. Let's see what happens over the next few weeks. If things haven't gotten better, we can try psychotherapy. Medication probably won't be necessary, but we will have it in reserve." That's normalizing the patient's distress and communicating that there are a number of options.

TCPR: Psychiatrists are also short on time. What can we do?

Dr. Frances: In Japan, psychiatrists often can't spend more than 10–15 minutes with each patient, but they still see their contact as an important moment in the patient's life, not to be taken trivially. It may be routine for us to see two to four patients an hour, but for the patient, that visit can be very meaningful. Those encounters are inherently psychotherapeutic, whether we know it or not. I think of patients I saw briefly in the emergency department who approached me years later in the hallway to say, "Doc, you probably don't remember me, but you said something that stuck with me and helped change my life." On the other hand, I worked with someone for 14 years twice a week with no real impact.

TCPR: What did you do in 10 minutes?

Dr. Frances: For example, I've seen many patients with acute panic attacks who were beginning to avoid trigger situations. In just a few minutes, it's possible to explain the mechanism behind the physical symptoms—how they relate to hyperventilation—and to teach breathing hygiene, and to reassure them that they're not "crazy." This reverses their demoralization and all their fears and uncertainties that can otherwise lead to agoraphobia. In depression, I've seen surprising improvements result from advice that patients include more good minutes in their day, such as taking a walk, enjoying nature, listening to music, and speaking to friends. Good minutes help spark virtuous cycles to replace the vicious cycles of demoralization.

TCPR: You spoke about factors that are common across therapies. How much do they influence pharmacotherapy?

Dr. Frances: A strong therapist-patient relationship is a major factor in the medication response because it often includes a large dose of placebo response. Different disorders have different rates of placebo response, and the response also varies by severity. For very mild depressions, the placebo response rate is 50%. For the average run-of-the-mill depressions, it is 30%. For severe depressions, it is probably below 10%. Doctors with good people skills are likely to have better results with medication because they enhance the placebo response.

TCPR: Can these common factors like empathy be taught?

Dr. Frances: Training can make good therapists much better, but it probably can't turn bad therapists into good therapists. That is why selection is important. To develop a good mental health system, we need to identify people who have those interpersonal skills that have been wired in or acquired through their previous experiences so that they're starting

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Does Abortion Lead to Psychiatric Issues?

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women (Coleman PK, *Br J Psychiatry* 2011;199(3):180–186). A vigorous round of letters followed, robustly critiquing the review's methodology, results, and conclusions, and even calling for retraction. The Academy of Medical Royal Colleges conducted an independent review on the topic. They found methodologic flaws with the 2011 review and argued that the study could not qualify as a systematic review. Women with unwanted pregnancies, they concluded, have the same risk of psychiatric problems whether they seek an abortion or carry the pregnancy to term.

Some scientists noted that the review's author was a known antiabortion activist, but in fairness, the critics may have had political biases of their own. Lacking randomized controlled trials, studies can only compare groups of women who chose to have an abortion with those who did not, and those populations differ in many ways beyond the abortion itself.

Abortion is a common procedure. About one in three women in the US will have had an abortion by the time they are 45 years old. Women seek to terminate a pregnancy for various reasons, many of which overlap with risk factors for mental illness. Poverty, lack of social support, being too young, needing to complete education, employment considerations, and intimate partner violence are among the most common.

Early studies suggested that psychiatric problems are more common after an elective abortion, but that difference disappeared when investigators controlled for preexisting mental illness. For example, the National Comorbidity Study assessed 936 women with a structured DSM-IV psychiatric interview, 28% of whom had had an elective abortion. Compared to women who carried their pregnancy to term, those who chose abortion had higher rates of mood and anxiety disorders, substance use disorders, or suicidal ideation (Steinberg JR et al, *Obstet Gynecol* 2014;123(2 Pt 1):263–270). That difference disappeared, however, in a later analysis that controlled for preexisting psychiatric problems.

Controlling for confounding variables is an imprecise science, so a cleaner approach would be to compare groups of women who are similar in most respects *except* for the elective abortion. The Turnaway study came close to that ideal (Horvath S and Schreiber CA, *Curr Psychiatry Rep* 2017;19(11):77). All of the 956 women from 21 states in this study had unwanted pregnancies and sought an abortion. However, 543 were denied abortion because their gestational age was slightly past their state's legal limit for elective abortion, which ranged from 10 weeks to the end of the second trimester. Twenty-one percent of those turned away went on to have an abortion elsewhere during the study period, and the authors were able to examine those women separately as well.

At first, mental health appeared worse among those denied an abortion, with higher rates of anxiety, low self-esteem, and poor life satisfaction in this "turned-away" group (Horvath and Schreiber, 2017; Biggs MA et al, *JAMA Psychiatry* 2017;74(2):169–178). However, those differences settled over the next six to 12 months, suggesting only transient symptoms rather than actual disorders. On follow-up five years later, 95% of the women who'd had an abortion felt it was the right decision.

The Turnaway study also looked at posttraumatic stress symptoms using the Primary Care PTSD Screen. Though nearly half (39%) of the women had PTSD symptoms, the rates were similar for those who had abortions and those who gave birth (Biggs MA et al, *BMJ Open* 2016;6(2):e009698). Most of these PTSD symptoms were due to sexual, emotional, or physical abuse rather than abortion or pregnancy. Other prospective studies have also found no evidence of posttraumatic symptoms after an elective abortion (Biggs et al, 2016).

The Turnaway study suggests that being denied an abortion may be detrimental to mental health, as does another study of women who became pregnant prior to the 1973 Supreme Court decision that legalized abortion in the US. This study compared women with unwanted pregnancies who could not abort to women with planned pregnancies. When the women were followed up 35 years after childbirth, the rates of both depressive symptoms and full clinical episodes were higher among those who carried unwanted pregnancies to term, even after controlling for confounders like socioeconomic status (Herd P et al, *Am J Pub Health* 2016;106(3):421–429). Studies of more recent cohorts support that trend. Postpartum depression is more common when women give birth after an unintended pregnancy, and it is also more common in states that prohibit Medicaid funding of abortions (Steinberg et al, 2014; Medoff MH, *Soc Work Public Health* 2014;29(5):481–490).

Putting it into practice

Elective abortions are unlikely to harm or help a woman's mental health, and we can tell our patients that fears of psychological consequences need not guide their decision. This may conflict with the official messages they receive. In some states, abortion providers are required to warn patients that the procedure can impair their ability to bond with future children or cause mental health problems such as depression, substance use disorders, or suicide (particularly Kansas, Louisiana, Michigan, Nebraska, North Carolina, South Dakota, Texas, and West Virginia, according to the Guttmacher Institute).

There is no evidence to support those claims. Rather, it is the circumstances surrounding abortion that can impact mental health, such as feelings of stigma, perceived need for secrecy, exposure to antiabortion picketing, and low social support for the abortion decision (American Psychological Association. *Report of the APA Task Force on Mental Health and Abortion*; 2009). We can help our patients by listening without judgment, encouraging open dialogue, and helping them connect with social and community supports.

CARLAT VERDICT

Whether or not to terminate a pregnancy is a personal and individual decision. Unwanted pregnancies and the stressors that accompany them may worsen mental health, but we can let our patients know that abortion itself does not.

Trichotillomania: Diagnosis and Treatment

Michael Posternak, MD. Psychiatrist in private practice, Boston, MA.

Dr. Posternak has no financial relationships with companies related to this material.

Trichotillomania (TTM) is a disorder that seems to lurk in the shadows. We hear about it but rarely see it. The question of whether it is an anxiety disorder, an impulse control disorder, or a behavioral addiction remains murky. And if asked how to treat it, most of us would probably shrug our shoulders and guess some combination of an SSRI plus cognitive behavioral therapy. That answer, however, isn't quite right, and in this article, I'll bring you up to date on the disorder and its treatment.

What is TTM?

TTM (Greek for "hair-pulling madness") is a syndrome where individuals pull out their hair despite repeated attempts to stop. The scalp, eyebrows, and eyelashes are the most common sites. In some cases, patients eat their hair after pulling it out (trichophagia), which in rare instances can cause gastrointestinal obstruction.

TTM was originally conceptualized as a stereotyped, repetitive behavior where mounting anxiety is relieved by the plucking of a hair follicle. Although some patients do engage in this type of "focused" hair-pulling, the majority pull their hair out "automatically" (ie, outside of their awareness). TTM typically has its onset in early adolescence and affects around one in 60 people. Rates are similar for women and men, but the effects tend to be more noticeable and more bothersome for women.

Textbooks claim that TTM is underrecognized in practice, possibly because of the shame associated with the behavior. To test that out, I screened 100 consecutive patients in my outpatient practice who had no record of TTM, and indeed I was surprised by how common it was: 7% were actively pulling hairs and another 3% had done so in the past. But like most behaviors, hair-pulling occurs on a spectrum of what might be considered normal behavior, and most of the "new cases" I found were mild and caused minimal impairment or distress.

DSM-5 changed the classification of TTM from an impulse control disorder to an OCD spectrum disorder (along with hoarding, skin picking or "excoriation," and body dysmorphic disorder), but its diagnostic resting place is far from settled. A recent study evaluating TTM's comorbidity, for example, found that it had more in common with impulse control disorders such as kleptomania, pyromania, and bulimia. Additionally, a factor analysis study of 2,705 individuals in the community concluded that TTM might best be conceptualized as self-grooming behavior similar to skin-picking and nail-biting (Gerstenblith TA et al, *Compr Psychiatry* 2019;94:152123; Maraz A et al, *PLoS One* 2017;12(9):e0183806). In all likelihood, hair-pulling is the final common pathway whose roots may originate as a cognition, an impulse, or a stress-reduction behavior, depending on the individual.

Pharmacotherapy

Before starting new medication for TTM, be aware that some of the medications we prescribe can actually cause the syndrome. Hair-pulling, nail-biting, and other compulsive behaviors can occur with dopaminergic drugs, such as stimulants, medications for Parkinson's disease, as well as cocaine.

SSRIs generated early hope in small, open-label studies, but a subsequent series of placebo-controlled trials with sample sizes ranging from 20 to 40 each yielded negative results, and two meta-analyses have concluded that SSRIs are no more efficacious than placebo (Bloch MH et al, *Biol Psychiatry* 2007;62(8):839–846; Rothbart R et al, *Cochrane Database Syst Rev* 2013;(11):CD007662).

With SSRIs off the table, researchers have had to travel down less conventional roads. One interesting candidate is the natural supplement N-acetylcysteine (NAC). NAC reduces synaptic release of glutamate, and glutamatergic dysfunction has long been implicated in the pathogenesis of OCD. In the largest positive study conducted to date for TTM, Grant and colleagues randomized 50 patients to either NAC 1200–2400 mg/day or placebo in a double-blind manner over the course of 12 weeks (Grant JE et al, *Arch Gen Psychiatry* 2009;66(7):756–763). Subjects receiving NAC reported significantly less hair-pulling at endpoint ($p<0.001$) and an overall improvement of about 40%. Side effects were minimal. Unfortunately, these results have never been replicated, and similar studies in pediatric populations have failed to find benefit, casting doubt on NAC's true efficacy.

Olanzapine was helpful in one small double-blind placebo-controlled trial (n=25) that used a flexible-dose strategy, arriving at a mean of 5.7 mg/day (Van Ameringen M et al, *J Clin Psychiatry* 2010;71(10):1336–1343). Clomipramine, naltrexone, and modafinil failed in small placebo-controlled trials, while a cannabinoid (dronabinol) yielded positive effects in 12 of 14 patients in one open-label trial (Grant JE et al, *Psychopharmacology (Berl)* 2011;218(3):493–502).

Psychotherapy

All of the above should suggest that medications play only a limited role when treating TTM. Indeed, in the few studies that have compared psychotherapy to medications, psychotherapy has typically been found to be more efficacious.

Pure cognitive therapy is not useful for TTM because patients usually can't identify specific cognitions related to the behavior. Instead, the most promising and best-studied technique for TTM is habit reversal therapy (HRT). This is a sequential treatment that starts by focusing on increasing the awareness of the behavior (remember that hair-pulling is often done automatically). Awareness training can be done, for example, by keeping a log, watching oneself in the mirror, etc. Second, the patient learns to identify triggers of TTM both internally (eg, boredom, anxiety) and externally (eg, studying, driving). Once the patient has a heightened awareness of the behavior, the final step is to develop a competing action that replaces hair-pulling, such as squeezing a ball or gently biting down on one's lips. This competing action should be continued until the urge to pull subsides.

Ten randomized controlled trials of HRT for TTM have been performed

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Research Updates IN PSYCHIATRY

PTSD

Who Responds to SSRIs in PTSD?

Richard Moldawsky, MD. Dr. Moldawsky has no financial relationships with companies related to this material.

REVIEW OF: Nøhr AK et al, *Psychiatry Res* 2021;301:113964

STUDY TYPE: Secondary analysis of a controlled trial

SSRIs are often used in PTSD, but it is not clear that they work for all kinds of trauma. Trials of SSRIs are generally positive in women and people with a history of sexual trauma, while trials involving combat-related trauma tend to be negative. The current study aimed to better identify predictors of response.

The investigators recruited patients from an ongoing controlled study of 390 patients with PTSD, conducted in 13 countries including the US. Patients were treated open-label with sertraline (100–200 mg/day) or paroxetine (20–40 mg/day) over 12 weeks, these medications being the two SSRIs with FDA approval in PTSD. All patients had experienced a trauma within the past 15 years, including assault with a weapon (31%), death or harm to someone else (21%), sexual assault (13%), or combat or war-zone experience (10%). Just under half had a history of childhood trauma. Ages ranged from 18 to 75, and 62% were female. Symptoms were tracked with the Clinically Administered PTSD Scale (CAPS) along with a patient-rated scale for depression and anxiety. The investigators used a sophisticated statistical technique called growth mixture modeling to attempt to identify predictors of drug response.

The overall response rate was 58.5%, defined as a 30% reduction in the CAPS. Sertraline and paroxetine were equally effective. Sexual assault and female gender were the main predictors of response, including a childhood history of sexual assault. A longer time between the trauma and the treatment also predicted a faster and higher rate of response. Symptoms of depression and anxiety did not predict response to the SSRI.

One limitation of the study was the exclusion of patients with active suicidality or a history of recent treatment for major depression, anxiety disorders, or substance use disorders. On the one hand, this pure sample reduces the possibility that responses were due to treatment of comorbid disorders. On the other hand, it limits the generalizability of the findings, as does the high dropout rate (40%).

CARLAT TAKE

You can expect to see better response rates to SSRIs when treating PTSD in women and in individuals with a history of sexual trauma. This study confirms that finding, which is pretty consistent across the clinical trials, and adds a little more. Depressive and anxiety symptoms did not predict response, but those with more distant traumas were more likely to respond to SSRIs.

DEPRESSION

Side Effects in Depression

Fernando Espí Forcén, MD. Dr. Forcén has no financial relationships with companies related to this material.

REVIEW OF: Braund TA et al, *Transl Psychiatry* 2021;11(1):417

STUDY TYPE: Secondary analysis of a randomized controlled trial

Side effects are burdensome to patients, but do they also get in the way of recovery? This study sought to clarify how side effects change over time and whether they impede recovery in major depressive disorder.

This was a secondary analysis of the International Study to Predict Optimized Treatment in Depression (iSPOT-D) trial, a randomized controlled trial that began in 2008 and is still ongoing. The trial randomized adults in psychiatric and primary care clinics with major depression to open-label treatment with escitalopram, sertraline, or venlafaxine XR (there was no placebo arm). This analysis gathered data from 1,008 participants (mean age 38) at day 4 and weeks 2, 4, 6, and 8. Side effects were assessed with a seven-point patient-rated scale, the Frequency, Intensity, and Burden of Side Effects Rating scale. Depression was measured with the Hamilton Depression Rating Scale (HDRS) and the Quick Inventory of Depressive Symptomatology (QIDS), and anxiety was assessed with the anxiety/somatization factor in the HDRS. A linear mixed-effects model tested whether side effects or anxiety had any effect on mood outcomes.

The frequency and intensity of side effects peaked at week 2 and then tended to fade over the next six weeks. However, the perceived burden of these side effects did not diminish over time. Frequency and intensity were not associated with mood outcomes, while the perceived burden of side effects was associated with poorer outcomes on the patient-rated QIDS but not the clinician-rated HDRS. This association between burden and mood outcomes was detectable at day 4 and remained significant until the end of the study. Anxiety did not influence the outcomes, and neither did the type of antidepressant.

The main weakness of this study was that side effects were assessed globally rather than specifically. Also, the study was a secondary analysis of a trial that was not designed to test the study's hypothesis.

CARLAT TAKE

Side effects of SSRIs and SNRIs tend to peak after a couple weeks and then fade over time. However, the burden of these side effects may remain even as their intensity decreases, and lingering side effects can get in the way of recovery from depression.

CME Post-Test

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1. What did the Turnaway study find about how levels of anxiety initially compared between women who were denied an abortion and women who underwent an abortion (LO #1)?

   [ ] a. There were higher rates of anxiety among the women who underwent an abortion

   [ ] b. There were higher rates of anxiety among the women who were denied an abortion

   [ ] c. Both groups of women had similarly low levels of anxiety

   [ ] d. Both groups of women had similarly high levels of anxiety

2. According to Dr. Frances, what impact does manual adherence have on patient outcomes (LO #2)?

   [ ] a. Improves outcomes when used on patients with complex, comorbid disorders

   [ ] b. Improves outcomes for all types of patients

   [ ] c. Worsens outcomes when used on patients with simple disorders

   [ ] d. There is no relationship between outcomes and manual adherence

3. What percentage mean improvement was observed in patients with trichotillomania who received N-acetylcysteine (LO #3)?

   [ ] a. 13% [ ] b. 20% [ ] c. 40% [ ] d. 67%

4. A 2021 study involving 390 patients with PTSD found what percentage decrease in symptoms after patients' SSRI treatment (LO #4)?

   [ ] a. 10% [ ] b. 21% [ ] c. 30% [ ] d. 56%

5. What were the findings of the Turnaway study regarding levels of PTSD symptoms in patients who carried out an abortion versus those who delivered (LO #1)?

   [ ] a. There were higher levels of PTSD symptoms in the patients who had an abortion

   [ ] b. There were higher levels of PTSD symptoms in the patients who delivered

   [ ] c. PTSD symptoms did not develop in either group

   [ ] d. The rates were similar for those who had abortions and those who delivered

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to date. Though results are still preliminary, the bulk of evidence suggests that the technique is probably effective (Lee MT et al, *Front Behav Neurosci* 2019;13(79):1–15). Furthermore, one follow-up study found that the gains made with HRT were maintained through at least three to six months of follow-up (Grant JE and Chamberlain SR, *Am J Psychiatry* 2016;173(9):868–874).

Unfortunately, finding a local therapist trained in HRT can be difficult, if not impossible. Teletherapy is one option, and there are therapist-guided (www.trichstop.com) and self-guided (www.stoppulling.com) programs available online. Another option is to offer HRT yourself. The techniques are easy to learn and can be taught to motivated patients in a 30-minute session (See: Woods D and Twohig M. *Trichotillomania: An ACT-Enhanced Behavior Therapy Approach Workbook.* Oxford University Press; 2008).

One last avenue being explored involves utilizing devices to break the TTM habit. Gloves (such as winter or driving gloves) offer the most accessible intervention and are certainly worth trying, but they may not be a realistic option in all settings. A high-tech option that is currently being investigated is a wrist band that senses early hair-pulling movements and alerts the patient when they occur (Himle JA et al, *J Obsessive Compuls Relat Disord* 2018;16:14–20). One device is commercially available, the Keen bracelet ($80 from HabitAware), and although patients have found it useful, I'm not aware of any specific studies of the Keen.

CARLAT VERDICT

Hair-pulling is probably more common than you think, and when it causes distress or impairment, a diagnosis of TTM is likely. HRT is the best approach. Medication options are limited, and they include the low-risk antioxidant NAC and, for severe/refractory cases, olanzapine.

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with a high baseline of empathy, of interpersonal comfort, with the capacity to not just understand what people are feeling but feel it with them in a way that conveys a sense of great concern on the part of the therapist. It is crucial that therapists convey realistic optimism even in the face of difficult problems—not false assurance. Really good people are usually really good therapists.

TCPR: Are there experiences in your own life that raised or lowered your capacity for empathy?

Dr. Frances: Practicing psychotherapy made me more empathic. I felt like a better person when I was doing psychotherapy than I did in any other role in my life. The psychotherapy relationship is the most unselfish of all relationships. I'm not an inherently selfish person, but even in my relationship with my wife and kids, there would be times when I would pick me rather than them. With patients, there have been very few moments when I ever did something because it was better for me than it was for them. Doing psychotherapy enriches your life in a way almost equivalent to getting married or having children. I think without having been a therapist I would have been a pretty shallow, feckless, good-time-Charlie kind of person, and I'll always be grateful to my patients for making me a better person.

TCPR: Thank you for your time, Dr. Frances.

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