### Anxiety disorders

<table>
<thead>
<tr>
<th>Generalize anxiety disorder</th>
<th>Post-traumatic stress disorder (PTSD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Most common anxiety disorder</td>
<td>• The complex somatic, cognitive, affective, and behavioral effects of psychological trauma</td>
</tr>
<tr>
<td>• 5% lifetime prevalence, 2:1 female/male ratio</td>
<td>• Characterized by intrusive thoughts, nightmares, flashbacks, avoidance of reminders, hypervigilance, and sleep disturbance</td>
</tr>
<tr>
<td>• Can be treated effectively with CBT, medication, or a combination of the two</td>
<td>o All of which lead to social/occupational dysfunction</td>
</tr>
<tr>
<td>• 30-50% also meet the criteria for MDD</td>
<td>• Types of trauma → sexual relationship violence (33%), interpersonal-network trauma (sudden death of loved one – 30%), interpersonal violence, exposure to organized violence, participation in organized violence, other</td>
</tr>
<tr>
<td>• DSM</td>
<td>• 8% of the adult population (lower outside the US) – 60% prevalence in combat soldiers and assault victims</td>
</tr>
<tr>
<td>o Excessive worry for most days for at least 6 months revolving around several life events</td>
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<tr>
<td>o Anxiety is difficult to control</td>
<td>o Gender (women x4)</td>
</tr>
<tr>
<td>o At least three of the following:</td>
<td>o Age at trauma</td>
</tr>
<tr>
<td>▪ Restlessness</td>
<td>o Race</td>
</tr>
<tr>
<td>▪ Fatigue</td>
<td>o Low SES</td>
</tr>
<tr>
<td>▪ Difficulty concentrating</td>
<td>o Previous trauma</td>
</tr>
<tr>
<td>▪ Irritability</td>
<td>o Personal/family psych history</td>
</tr>
<tr>
<td>▪ Muscle tension</td>
<td>o Initial severity of event</td>
</tr>
<tr>
<td>▪ Sleep disturbance</td>
<td></td>
</tr>
<tr>
<td>o Anxiety does not revolve around fear of a panic attack</td>
<td></td>
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<tr>
<td>o Causes significant distress or impairment of functioning</td>
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</tr>
<tr>
<td>o Not caused by meds etc</td>
<td>o Occurs after a traumatic event associated with intense fear/horror</td>
</tr>
<tr>
<td>Need for treatment?</td>
<td>o Persistent re-experiencing of event (nightmares, flashbacks)</td>
</tr>
<tr>
<td>• Mild → (sx don’t interfere significantly with functioning), pt can forgo treatment initially, but follow the patients every 6 months to monitor</td>
<td>o May have detachment, anhedonia, restricted affect</td>
</tr>
<tr>
<td>• Moderate-Severe → initial treatment choice of meds or CBT can be made on basis of availability and patient preference</td>
<td>o Avoidance of thoughts/activities that may bring reminders or trauma</td>
</tr>
<tr>
<td>• CBT → 10-15 60 minute sessions</td>
<td>o Increased arousal after trauma – poor concentration, hypervigilance, exaggerated startle response, insomnia, irritability</td>
</tr>
<tr>
<td>• Meds → first line are SSRIs (or venlafaxine), no SRI has been shown to have superior efficacy</td>
<td>o Sx have to persist for at least 1 month</td>
</tr>
<tr>
<td></td>
<td>o Sx cause significant distress or social occupation/dysfunction</td>
</tr>
<tr>
<td></td>
<td>• Tx:</td>
</tr>
<tr>
<td></td>
<td>o SSRIs, Prazosin (nightmares), psychotherapy, CBT, support groups, family therapy</td>
</tr>
<tr>
<td>o Other meds → benzos (avoid long term), pregabalin and buspirone</td>
<td></td>
</tr>
<tr>
<td>o Other antidepressants → mirtazapine</td>
<td></td>
</tr>
<tr>
<td>o Antipsychotic meds → SGAs (typically quetiapine)</td>
<td></td>
</tr>
</tbody>
</table>
### Obsessive compulsive disorder (OCD)
- 2.5% prevalence – 1:1 ratio, earlier onset in males
- DSM
  - Either obsessions OR compulsions are present
  - Obsessions = recurrent, persistent thoughts, impulses, or images experienced as intrusive and causing marked anxiety
  - Compulsions = repetitive behaviors or acts that the person feels driven to perform in response to obsessions
  - Person recognizes that obsessions or compulsions are excessive or unreasonable (children may not)
  - This causes distress, occupy more than one hour per day, and interferes with normal functioning
- Tx:
  - CBT (exposure and response prevention)
  - Sertraline, paroxetine, fluoxetine, citalopram, etc
  - Clomipramine (TCA)

### Panic disorder (PD)
- 1-3.5% prevalence, 3:1 female/male ratio
- Onset in mid 20s
- DSM
  - Required: recurrent unexpected panic attacks, reaches peak in 10 min, characterized by intense fear, palpitations/sweating/shaking/SOB/feeling of choking/chest pain/nausea/dizziness/depersonalization/fear or losing control of going crazy, fear of dying, paresthesias
  - Required: chills or hot flashes
  - At least one month of fear or having additional attacks, worry about cause of attacks, significant change in behavior due to attacks
  - Can occur with or without agoraphobia
- Tx
  - CBT, meds (SSRI, then SNRI, last tricyclics)
  - Benzos can be used short term

### Acute stress disorders
- Develops shortly after an individual is exposed to a traumatic event
- Characterized by feelings of helplessness, intense fear, and a number of dissociative sx
- Occurs within the first 4 wks after the traumatic event
- Can resolve without progressing to PTSD
- Diagnosis:
  - Must occur within 4 wks, and last for a minimum of 3 days, also must have 9/14 sx in the following categories
  - Intrusion sx → involuntary & intrusive memories of event, distressing dreams, dissociative reactions where the individual feels as it the event is recurring, physical distress reactions to external cues that resemble an aspect of the event
  - Negative mood → inability to experience positive emotions
  - Dissociative sx → altered sense of reality of surroundings
  - Avoidance sx →

***meets criteria for PTSD, but sx <1 month***
- Tx: first line is trauma focused CBT (exposure based)
  - Short term benzo use

### Adjustment disorders
- DSM-V: development of an emotional response to a specific stressor within 3 months of the onset of that stressor
  - Clinically significant sx develop as a response to the stressor
  - Sx do not persist longer than 6 months after the stressor
  - Different subtypes → depressed mood, anxiety, mixed anxiety and depressed mood, disturbance of conduct, unspecified
  - Diff from depression bc depression continues after stressor is removed
- Treatment
  - Tx of choice is psychotherapy, group therapy can be helpful
  - Meds are not usually indicated, but temporary meds for sleep can help
  - If the event was a traumatic stressor, relaxation techniques, changing locks on doors, etc, can be helpful
- ***Children will often show signs of irritability and short temper vs. depression and sadness***
### Social anxiety disorder (Phobias)
- **The most common mental disorder in the US**
- **An irrational fear that leads to avoidance of feared object or situation**
- **Causes** → likely a combination of genetic, behavioral, and neurochemical factors
- **DSM**
  - Persistent, excessive fear brought on by specific situation or object
  - Exposure to the situation brings out an immediate anxiety response
  - Pt recognizes that this fear is excessive
  - Situation is avoided when possible
  - Duration must be >6 months
- **Tx**
  - Meds for specific phobias are not effective
  - Use systemic desensitization + benzos during session
  - Supportive psychotherapy
  - Paroxetine effective for social anxiety disorder
  - Propranolol for performance anxiety

### Eating Disorders
#### Anorexia nervosa
- **Restrictive type** → eat very little, vigorous exercise, withdrawn with obsessive compulsive traits
- **Binge/purge type** → binges followed by purging, laxatives, exercise or diuretics
  - Melanosis coli = darkening of colon secondary to laxative abuse
  - Comorbid MDD or substance abuse
- **DSM**
  - Body weight at least 15% below normal
  - Intense fear of gaining weight or becoming fat
  - Disturbed by body image
  - Amenorrhea
- **Management**
  - Admit if <20% of normal body weight
  - Refer for psychotherapy/family therapy
  - Meds ONLY AFTER weight is restored → atypical antipsychotics, tricyclics, SSRIs, Lithium, anxiolytics before eating
- **Prognosis**
  - Mortality of 5-20%, average duration of illness is 6 yrs

#### Bulimia nervosa
- **Purging type** → use vomiting, laxatives, or diuretics to counteract binge eating
- **Non-purging type** → use excessive exercise or fasting to counteract binge
- **Sx**
  - Normal weight or overweight
  - Embarrassed by binging
  - Esophagitis, dental erosion, callused knuckles, salivary gland hypertrophy
  - Co-morbid mood disorder, impulse control disorder, alcohol abuse
- **DSM**
  - Recurrent episodes of binge eating
  - Binge/purge at least twice a week x3 months
  - Perception of self-worth is influenced by body weight and shape
- ***Chem panel will show hypochloremic hypokalemic acidosis***
- **Tx** → psychotherapy, SSRIs, TCAs
- **Prognosis**
  - Better than anorexia, may relapse, half will recover

#### Binge eating disorder
- **Excessive amount of food in a 2 hr period with lack of emotional control**
- **Emotional distress associated with overeating, no use of laxatives or vomiting, often obese**
- **Comorbid mood or anxiety disorder**
- **DSM**
  - Binging occurs at least 2 days/wk for 6 months with no purging
- **Tx** – psychotherapy, strict diet and exercise program, meds to support weight loss (stimulants, orlistat)

### All eating disorders
- More common in upper/middle class families
- Etiology = psych, social, biological
- Screening = SCOFF
- Work up = EKG, BMP, TSH, vitamin levels, DEXA
- Complication of re-feeding syndrome (shift from fat to CHO metabolism causes a drop in phosphates → CV collapse, seizures, delirium, rhabdo
- Complication of wernicke’s - prevented with thiamine supplementation
### Mood disorders

**Major Depressive Disorder** (SIG E CAPS)

- **Best therapy**
  - SSRI (sertraline, paroxetine, citalopram, fluoxetine, or fluvoxamine)
  - SNRI (venlafaxine, desvenlafaxine, duloxetine, levomilnacipran) **Duloxetine can be used for painful diabetic neuropathy**
  - Bupropiun (Wellbutrin), blocks NE and dopamine reuptake
  - Mirtazapine (Remeron), good for sleep

- **Common side effects of pharm treatment**
  - GI symptoms, sleep disturbances, tremor, dizziness, diaphoresis, sexual dysfunction

- **1 in 7 ppl will suffer from depression, women are affected twice as much as men (mean age of 40), genetics play a role, 85% lifetime recurrence, and 40% recurrence in 1 yr**

- **DSM**
  - Depressed mood/anhedonia >2wks
  - Mood is a change from baseline
  - Impaired fxn: social/school/work
  - At least 5 of these (SIG E CAPS):
    - Sleep, Interest, Guilt, Energy, Concentration, Appetite, Psychomotor, Suicidality

- **DDX**
  - Medical → Hypothyroidism, MS
  - Meds → antihypertensives, substance use
  - Psych → bipolar, anxiety, personality disorders, psychotic disorders
    - **Depression meds can worsen bipolar, ask about mania and fam hx**

- **Suicidal risk factors** → older age, alcohol or drug abuse, prior attempts, male gender, fam hx
  - Suicide rate = 15% - 2:1 female to male

- **Peripartum depression** → “baby blues” = up to a week, don’t treat as depression

- **Other treatments**
  - Combination of two medications
  - ECT – good for MDD with psychotic features or where rapid response is required
  - rTMS (repetitive transcranial magnetic stim) – good for pts who can’t tolerate – can be outpatient
  - Meds that worked in the past are likely to work again at the same dose
  - CBT and insight oriented therapy

- **MDD Chronic** → at least 2 yrs
- **MDD w/ catatonic features** → catatonic sx
- **MDD w/ melancholic features** → anhedonia, worse in the morning, weight loss, guilt
- **MDD w/ atypical features** → significant weight gain, hypersomnia, rejection sensitivity
- **MDD w/ postpartum onset** → within 4 wks of birth
- **MDD w/ seasonal pattern**

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<tr>
<th>Mania</th>
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<tbody>
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<td><strong>Manic episode DSM</strong></td>
</tr>
<tr>
<td>- At least 1 wk of abnormal elevated, expansive, irritable mood, can be less than one wk if hospitalized</td>
</tr>
<tr>
<td>- Must have 3 of the following:</td>
</tr>
<tr>
<td>- Inflated self-esteem or grandiosity, decreased need for sleep,</td>
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<tr>
<td>- Pressured speech, flight of ideas,</td>
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<tr>
<td>- Distractibility, increased goal-directed activity or psychomotor agitation</td>
</tr>
<tr>
<td>- Sex, spending money, gambling</td>
</tr>
<tr>
<td>- Does not meet criteria for mixed episode and not caused by medications, substance use, or medical conditions</td>
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<th>Bipolar I</th>
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</thead>
<tbody>
<tr>
<td><strong>Manic episode DSM</strong></td>
</tr>
<tr>
<td>- At least 4 days of elevated /irritable mood</td>
</tr>
<tr>
<td>- At least 3 sx of mania</td>
</tr>
<tr>
<td>- Noticeable to others, but does not require hospitalization, no psychotic features, no marked social or occupational dysfunction (this distinguishes it from full mania)</td>
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<thead>
<tr>
<th>Mixed mood episode DSM</th>
</tr>
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<tbody>
<tr>
<td>- Meets DSM criteria for manic &amp; depressive episode for at least 1 week</td>
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<tr>
<th>Bi polar I</th>
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<tbody>
<tr>
<td>- 0.5-1.5% lifetime prevalence, Male-to-female ratio = 1:1, Suicide rate 10-15%, Strong genetic component (5-10% lifetime risk in 1st degree relative)</td>
</tr>
<tr>
<td><strong>DSM</strong></td>
</tr>
<tr>
<td>- One or more manic or mixed episodes</td>
</tr>
<tr>
<td>- Commonly accompanied by one or more MDE, but this is not needed for the dx</td>
</tr>
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<table>
<thead>
<tr>
<th>Classification</th>
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<tbody>
<tr>
<td>- Describe most recent episode as manic, hypomanic, mixed, or depressive</td>
</tr>
<tr>
<td>- Further classify about psychotic, catatonic, or postpartum features</td>
</tr>
<tr>
<td>- Rapid cycling → presence of at least 4 mood episodes within 1 yr, most be sx free for at least 2 months between episodes or must switch to an opposite episode</td>
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<thead>
<tr>
<th>Tx</th>
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<tbody>
<tr>
<td>- Mood stabilizers</td>
</tr>
<tr>
<td>- ECT</td>
</tr>
<tr>
<td>- Use caution with antidepressants (may precipitate mania)</td>
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<tr>
<td>- Psychotherapy, antipsychotics if needed</td>
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<tr>
<th>Bipolar II</th>
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<tbody>
<tr>
<td>- 0.5% lifetime prevalence, more common in females</td>
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<tr>
<td>- one or more depressive episodes and at least one hypomanic episode</td>
</tr>
<tr>
<td>- same tx as type I</td>
</tr>
<tr>
<td><strong>Dysthymic disorder</strong></td>
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<tr>
<td>-----------------------</td>
</tr>
<tr>
<td>- A more chronic, less severe depressive disorder</td>
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<tr>
<td>- 6% lifetime prevalence, 3:1 female-to-male ratio</td>
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<tr>
<td>- Onset usually in childhood or late adolescence</td>
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</tbody>
</table>
| - **DSM**  
  o Depressed mood for most of day, more days than not, **for at least 2 yrs**  
  o Presence of at least 2 or more of the following:  
    ▪ Appetite changes  
    ▪ Sleep changes  
    ▪ Low energy  
    ▪ Low self-esteem  
    ▪ Poor concentration  
    ▪ Hopelessness  
  o Never been without sx for more than 2 months  
  o No MDE during first 2 yrs |  
  o Many periods of depression and hypomania for at least 2 yrs  
  o Depressive episode cannot reach level of MDE  
  o Cannot be sx free for more than 2 months |
|  | - **Tx:**  
  o Mood stabilizers – lithium, use antidepressants cautiously to avoid precipitating manic episode |

| **Tx with antidepressants and psychotherapy** |  |

<table>
<thead>
<tr>
<th><strong>Sleep Disorders</strong></th>
<th><strong>Narcolepsy</strong></th>
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</table>
| **Insomnia** | - Repeated, sudden attacks of sleep in the daytime for at least 3 months with associated cataplexy (collapse due to sudden loss of muscle tone during emotion/laughter), short REM latency, sleep paralysis, hallucinations while falling asleep or just waking up  
  Management ➔ timed daily naps, stimulant drugs, SSRIs, sodium oxalate for cataplexy |
| - Difficulty initiating or maintaining sleep, resulting in daytime drowsiness or difficulty fulfilling tasks  
  - Disturbance occurs 3+ times a week for at least 1 month  
  - Exacerbated by anxiety and preoccupation with getting enough sleep |  |

<table>
<thead>
<tr>
<th><strong>Hypersomnia</strong></th>
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</table>
| - At least 1 month of excessive daytime sleepiness or excessive sleep not attributable to a medical condition, meds, poor sleep hygiene, insufficient sleep, or narcolepsy  
  - Usually beings in adolescence  
  - Meds ➔ [stimulants, sometimes SSRI](https://www.example.com) |  |

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<tr>
<th><strong>Psychotic disorders</strong></th>
<th><strong>Schizophrenia</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Acute phase schizophrenia → phase of schizophrenia characterized by both positive and negative symptoms</td>
<td>• *<strong>Auditory hallucinations are common</strong> (voices)</td>
</tr>
<tr>
<td>• Negative symptoms → lack of emotional responses, flat affect, alogia (decreased spontaneous speech), and avolition (decreased motivation), apathy, blunting</td>
<td>• Positive symptoms → hallucinations, delusions, ideas of reference, grossly disorganized speech, tangentiality, incoherent thoughts</td>
</tr>
<tr>
<td>• DSM-V</td>
<td>• DSM-V Criteria:</td>
</tr>
<tr>
<td>o At least two of the following have been present for <strong>at least one month</strong></td>
<td>o Patient must exhibit psychotic symptoms consistent with the <strong>acute phase of schizophrenia</strong></td>
</tr>
<tr>
<td>▪ Delusions, hallucinations, disorganized speech, disorganized or catatonic behavior, negative symptoms</td>
<td>o Psychotic sx are accompanied by prominent mood symptoms (mania or depression) at some points of the illness</td>
</tr>
<tr>
<td>o <strong>Some symptoms must be present for at least 6 months</strong>, this can include only negative sx or less intense positive sx</td>
<td>o <strong>At other points of the illness, must have delusions or hallucinations for at least 2 weeks without significant mood sx</strong></td>
</tr>
<tr>
<td>o Significant social/occupational dysfunction</td>
<td>o <strong>Mood sx must be present for a significant portion of the illness</strong></td>
</tr>
<tr>
<td>o Rule out drugs, schizoaffective</td>
<td>o Disorder cannot be caused by substance or medical conditions</td>
</tr>
<tr>
<td>• Extreme social isolation and dysfunction</td>
<td>• Ddx:</td>
</tr>
<tr>
<td>• 1% of general population, for men it starts in early to mid twenties, late twenties for women</td>
<td>o Cocaine or amphetamine intoxication can cause manic sx, cocaine withdrawal can cause depressive sx</td>
</tr>
<tr>
<td>• 20% attempt suicide, 5% complete it</td>
<td>o Steroids and antiparkinsonian medication</td>
</tr>
<tr>
<td>• Suicide risk factors = command AH to harm, depressive sx, substance abuse, unemployment, recent psychotic episode, hospital discharge, younger age, male gender</td>
<td>o Schizophrenia appears similar, but the mood sx are generally more transient</td>
</tr>
<tr>
<td>• <strong>DDX</strong> → Steroids, anti-cholinergics</td>
<td>o Major depression and bipolar typically pre-date the psychoses</td>
</tr>
<tr>
<td>• Treatment</td>
<td>• *<strong>Younger patients may exhibit more severe symptomology</strong></td>
</tr>
<tr>
<td>o Holistic approach (psychotherapy)</td>
<td>• Tx</td>
</tr>
<tr>
<td>o Often begin with second generation antipsychotics (SGA’s) because of their reduced risk of side effects</td>
<td>o <strong>Psychotic sx with antipsychotic meds</strong></td>
</tr>
<tr>
<td>o <strong>Clozapine is the most efficacious anti-psychotic, but is reserved for resistant cases due to risk of agranulocytosis</strong>, it is also the only med with anti-suicidal properties</td>
<td>o <strong>Depressive sx with antidepressants</strong></td>
</tr>
<tr>
<td>• Nicotine is the most frequently used substance by schizophrenics, smoking induces cytochrome P450 which decreases serum levels of clozapine</td>
<td>o <strong>Mood sx with mood stabilizers</strong></td>
</tr>
<tr>
<td><strong>Classifications of schizophrenia</strong></td>
<td>• ECT may be necessary for severe mood sx</td>
</tr>
<tr>
<td>• <strong>Paranoid type</strong> → <strong>best prognosis</strong>, preoccupation with delusions or auditory hallucinations and do not have disorganized speech, behavior, or inappropriate affect</td>
<td></td>
</tr>
<tr>
<td>• <strong>Disorganized type</strong> → <strong>worst prognosis</strong>, prominent disorganized speech, behavior, and odd affect</td>
<td></td>
</tr>
<tr>
<td>• <strong>Catatonic type</strong> → 2 or more of the following: immobility, excessive motor activity, negativism, mutism, peculiar movements, echolalia or echopraxia</td>
<td></td>
</tr>
<tr>
<td>• <strong>Undifferentiated type</strong> → <strong>moderate prognosis</strong>, not characterized by other types</td>
<td></td>
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<tr>
<td>• <strong>Residual type</strong> → continued negative sx or 2+ attenuated positive sx</td>
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<tr>
<th><strong>Schizoaffective disorder</strong></th>
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<tbody>
<tr>
<td>• Best medication: <strong>haloperidol or risperidone</strong></td>
</tr>
<tr>
<td>o Depressive type: can add an antidepressant (SSRI) if this is not effective alone</td>
</tr>
<tr>
<td>o Bi-polar type: can add mood stabilizer like valproic acid, lithium, or carbamazepine</td>
</tr>
<tr>
<td>• Psychosocial rehab can be used</td>
</tr>
<tr>
<td>• TMS is an experimental treatment</td>
</tr>
<tr>
<td>• Hospitalization is not needed if the patient is not in danger to themselves or others</td>
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<tr>
<td>• DSM V Criteria:</td>
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<td>o <strong>Psychotic sx with antipsychotic meds</strong></td>
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<td>o <strong>Depressive sx with antidepressants</strong></td>
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<tr>
<td>o <strong>Mood sx with mood stabilizers</strong></td>
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ECT may be necessary for severe mood sx
### Schizophreniform disorder
- Meets full criteria for schizophrenia, but duration of illness is 1-6 months. Diagnosis is deferred because 30-50% of cases may resolve or differentiate into a different diagnostic category.

### Delusional disorder
- Delusions with no other psychotic symptoms present for at least one month
- “non-bizarre” delusions
- Behavior/functioning not significantly impaired

### Brief psychotic disorder
- Hallucinations, delusions, disorganized behavior or speech
- 1 day – 1 month

### Somatoform Disorders
#### Conversion
- The most common somatoform disorder – more common in women and low SES
- Voluntary motor or sensory deficits that suggest a neurologic condition but are medically unexplainable
- Preceded by physiological distress
- Paralysis, aphony, blindness, deafness, feeling a lump in the throat, pseudoseizures
- Patient is surprisingly calm while describing dramatic sx (la belle indifférence)
- Focus is ONE sx (not many as in somatization disorder)
- Co-morbid schizophrenia, MDD, or anxiety
- Must have at least 1 neuro sx
- 50% ultimately receive an underlying medical cause
- sx usually resolve in 1 month, 25% relapse

#### Somatization
- More common in females, low SES, genetic and familial predisposition
- Signs → multiple vague complaints involving numerous office visits
- DSM
  - 2 GI sx
  - 1 sexual sx
  - 1 neuro sx
  - 4 pain sx
  - Onset before age 30
  - Can't be explained by medical condition or meds

#### Hypochondriasis
- Prolonged, exaggerated concern about health and possible illness
- Misinterpret normal sx as indicative of disease
- Waxing and waning of sx
- Exacerbation when under stress
- Comorbid MDD or anxiety disorder
- More focused on DISEASE
- DSM
  - Fears present for at least 6 months
  - Fears persist despite medical evaluation
  - Fear based on misinterpretation of normal sx

#### Factitious disorder
- Intentionally faking disorder in order to assume the sick role (without gain of external incentives)
- Frequent presentation = wound healing problems, excoriations, infection, bleeding, hypoglycemia, GI ailments
- Often have hx of abuse or neglect

#### Malingering
- Intentionally faking or grossly exaggerating sx for an obvious incentive, such as avoiding work or criminal prosecutions, obtaining room and board, financial compensation, meds

#### Munchausen Syndrome
- A factitious disorder with predominantly physical complaints, often demand specific meds, highly skilled at feigning sx necessitating hospitalization

#### Body Dysmorphic Disorder
- Imagined or exaggerated defect in physical appearance
- Spend significant time trying to correct perceived flaws with make-up, derm procedures, or plastic surgery
- Comorbid depression, anxiety, of psychosis
- SSRI might help

#### Pain disorder
- Pain in one or more sites associated with psychological factors that have an important role in the onset, severity, exacerbation, or maintenance of the pain
- Pain not due to a medical disorder
- Not intentionally produced or faked
- SSRI might help

### Munchausen Syndrome by proxy
### Personality Disorders

#### Cluster A  \( \rightarrow \) MAD, odd and eccentric (WEIRD)

<table>
<thead>
<tr>
<th>Schizoid</th>
<th>Schizotypal</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Loner, detached, flat affect, restricted emotions, generally indifferent to interpersonal relationships</strong> outside immediate family</td>
<td>Odd, eccentric, magical thinking, paranoid, not psychotic</td>
</tr>
<tr>
<td>Little interest in sexual activity</td>
<td>Perceptual distortions, few close relationships</td>
</tr>
<tr>
<td>Often functional at work as long as it does not require much interpersonal connection</td>
<td>Tx with psychotherapy, anxiolytics, antipsychotics if needed</td>
</tr>
<tr>
<td>Indifferent to praise or criticism</td>
<td>As a clinician, use a low-key, technical approach</td>
</tr>
<tr>
<td>Sometimes have a rich fantasy life</td>
<td>Therapy does not work well</td>
</tr>
<tr>
<td>Does not have “fixed delusions”</td>
<td>Psychotherapy is the tx of choice, antipsychotics/antidepressants if needed</td>
</tr>
<tr>
<td>As a clinician, use a low-key, technical approach</td>
<td><strong>Schizoid &amp; schizotypal are more likely to develop schizophrenia or to have a first degree relative with schizophrenia</strong></td>
</tr>
</tbody>
</table>

Paranoid  
- Pervasive distrust of others  
- Distrustful and suspicious, constricted affect  
- More verbally hostile than  

***paranoid schizophrenia will have “fixed delusions”***  
- Tx with psychotherapy, anxiolytics, antipsychotics if needed

#### Cluster B  \( \rightarrow \) BAD, dramatic, erratic (WILD)

<table>
<thead>
<tr>
<th>Histrionic</th>
<th>Narcissistic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Excessively emotional, attention seeking</td>
<td>Grandiosity, lack of empathy</td>
</tr>
<tr>
<td>Uncomfortable when not the center of attention, inappropriate behavior, theatrical, perceives relationships as being more intimate than they really are</td>
<td>Self-important, needs admiration, dismissive of the feelings of others</td>
</tr>
<tr>
<td>Tx: psychotherapy</td>
<td>Believes they are special, sense of entitlement</td>
</tr>
<tr>
<td>Chronic course, may improve with age</td>
<td>Arrogant/haughty</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Antisocial</th>
<th>Borderline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disregard for rules, violation of rights of others, behavior since age 15</td>
<td>Impulsive, unstable relationships, affective instability</td>
</tr>
<tr>
<td>Lacks empathy toward others, acts out, aggressive, must have met criteria for conduct disorder as a child</td>
<td>Unstable self-image</td>
</tr>
<tr>
<td>Failure to conform to social norms</td>
<td>Frantic efforts to avoid real or imagined abandonment</td>
</tr>
<tr>
<td>Lack of remorse for actions</td>
<td>Self-damaging impulsivity</td>
</tr>
<tr>
<td>Want material gain</td>
<td>Reactivity of mood, chronic feelings of emptiness</td>
</tr>
<tr>
<td>Tx: psychotherapy is tx of choice, caution in treating anxiety or depression as there is high addiction potential in these patients</td>
<td>SIB</td>
</tr>
<tr>
<td>Sx may improve with aging</td>
<td>Should be treated with psychotherapy for at least 20 wks</td>
</tr>
</tbody>
</table>

#### Cluster C  \( \rightarrow \) SAD, anxious and timid (WORRIED)

<table>
<thead>
<tr>
<th>Avoidant</th>
<th>Obsessive compulsive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social inhibition, feelings of inadequacy</td>
<td>Perfectionist, “control freak”, hyperfocused on orderliness</td>
</tr>
<tr>
<td>Hypersensitive to criticism, socially uncomfortable, seeks out relationships with great discomfort</td>
<td>More common in men and oldest children</td>
</tr>
<tr>
<td>Intense fear of rejection, Comorbid depression/anxiety</td>
<td>Appear serious, still, and formal, constricted, poor interpersonal skills, inflexibility</td>
</tr>
<tr>
<td>Tx</td>
<td>Excessive devotion to work, will not delegate</td>
</tr>
<tr>
<td>o Psychotherapy with assertiveness training</td>
<td>OCD = ego-systonic (not aware of the problem)</td>
</tr>
<tr>
<td>o Propranolol for autonomic anxiety sx</td>
<td>Tx: Psychotherapy</td>
</tr>
<tr>
<td>o SSRI for depression</td>
<td>Course is unpredictable, some will develop OCD, schizophrenia or MDD</td>
</tr>
<tr>
<td>Particularly hard in adolescence</td>
<td><strong>Sx</strong> may improve with aging</td>
</tr>
</tbody>
</table>
Dependent
- Submissive, clinging, needs to be taken care of, sees others to make decisions for him/her
- Tx = psychotherapy, treatment of comorbid anxiety or depression
- Sx might improve with age

Attention Deficit Disorder and Disruptive Behavioral Health

**Attention deficit hyperactivity disorder**
- Can be inattentive, hyperactive/impulsive, or combined
- Diagnosis → six or more sx of inattention or hyperactivity/impulsivity, present before age 12, more than one setting, significant impairment, present for >6 months
  - Inattention sx: careless errors, difficulty focusing, not listening, failing to follow directions, difficulty organizing tasks, avoiding tasks that require sustained mental effort, losing things, distraction, forgetfulness
  - Hyperactive sx: fidgety/squirmy, leaving seat, difficulty being quiet, “on the go”, excessive talking
  - Impulsive sx: blurtting out answer, difficulty waiting for turn, interrupting
- 3-5%, boys usually have hyperactive/impulsive, girls usually have inattentive
- Etiology: dopaminergic and nonadrenergic tracts of the prefrontal cortex, dorsal anterior cingulate gyrus, dorsolateral prefrontal tracts
- DDX → oppositional defiant disorder/conduct disorder, bi-polar early onset, lead intoxication can lead to hyperactivity, petit mal seizures can lead to poor attention (get EEG)
- ***if ADHD and ODD are present it may be mistaken for bi-polar
- Treatment → 80% of kids will respond to stimulant medication
  - AEs: decreased appetite, slowed growth, insomnia, irritability, dysphoria, HA, tics
  - Have a rapid onset of action, wear off by the end of the day
  - **Stimulants**: methylphenidate & amphetamine preparations
  - **Atomoxetine**: inhibitor of the presynaptic NE transporter, good alternative to stimulants, gradual onset (2-3 wks), 24 hr length of action
  - Clonidine and guanfacine improve sleep and appetite AND help ADHD sx, can be used with stimulants or as monotherapy
  - Bupropion & imipramine might help, worry about QTc prolongation and tic worsening

**Conduct disorder**
- In children
- Caused by genetic and psychosocial features
- Comorbid ADD and learning disorders
- DSM
  - A pattern of behavior that involves violation of the basic rights of others or of social norms and rules, with at least 3 acts within the following categories in the past year
    - Aggression towards people and animals
    - Destruction of property
    - Deceitfulness
    - Serious violations of others
- Tx → reinforcement of firm rules, psychotherapy based on behavior modification and problem solving skills
  - Antipsychotics or Lithium
  - SSRI for irritability
- **Prognosis** → 40% risk of developing into antisocial personality disorder in adulthood
### Oppositional Defiant Disorder
- **20% of kids > 6**
- Comorbid substance abuse, mood disorders, and ADD
- **DSM** → at least 6 months of hostile/defiant behavior with at least 4 of the following:
  - Frequent loss of temper
  - Arguments with adults
  - Defying rules
  - Deliberately annoying people
  - Easily annoyed
  - Anger and resentment
  - Spitefulness
  - Blaming others for mistakes
- **Tx** → psychotherapy based on behavior modification and problem solving skills, parental training
- **Prognosis** → remits in 25%, may progress to conduct disorder

### Paraphilias and Sexual Dysfunction Disorders
- **Classifications:**
  - Hypoactive sexual desire disorder
  - Sexual aversion disorder
  - Exhibitionism; Fetishism
  - Sexual masochism
  - Pedophilia
  - Voyeurism (spying)
- **At least 6 months and impair daily functioning**
- Most common are pedophilia, voyeurism, and exhibitionism
- **Tx** → insight oriented therapy, anti-androgens in men
- Prognosis poor with early age of onset, comorbid substance abuse, high frequency of behavior, related arrest
Prognosis good with self-referral for treatment, sense of guilt associated with behavior, history of otherwise normal sexual activity in addition to the paraphilia

### Delirium
- **DSM**
  - Disturbance of consciousness with reduced ability to focus, sustain, or shift attention
  - The change in cognition or perceptual disturbance isn’t due to dementia
  - The disturbance develops over a short period of time (hrs to days) and **fluctuates over the course of the day**
  - There is clinical evidence that the disturbance is caused by a general medical condition and/or substance use withdrawal
- **Tx**
  - Treat the underlying condition
  - Treat agitation with Haldol. Quetiapine, lorazepam, and a quiet environment with close observation
  - Restraints may be needed

### Dementia
- Prevalence increases with age: alzheimers is the most common (50-60%) followed by vascular dementia (13%)
- **DSM**
  - The development of multiple cognitive deficits manifested by
    - Memory impairment
    - One or more of the following: aphasia, apraxia, agnosia, disturbance in executive functioning
  - The cognitive deficits cause significant social and occupational impairment and represent a significant decline from a previous level of functioning
  - The deficits are not the result of delirium
- **Tx**
  - Treat underlying condition
  - Minimise CNS depressants and anti-cholinergic meds
  - Treatment of AD
    - Mild → cholinesterase inhibitors (donepezil, galantamine, rivastigmine, tacrine)
    - Can give vit E if no CV disease
    - Moderate → add NMDA agonist memantine, may be neuroprotective
  - Treatment of vascular dementia: HTN management, aspirin
- **Classification**
  - AD, vascular dementia, AIDs, head trauma, PD, HD, picks disease, creutzfeld-jakob disease, lewy body dementia, substance induced persistent dementia
- **Life expectancy is 3-8 yrs**
- **Work up**
  - TSH, B-12, depression screen, CT,
### Amnestic syndrome
- The amnestic disorders are a group of disorders that involve loss of memories previously established, loss of the ability to create new memories, or loss of the ability to learn new information.

### Dissociative disorders
- Dissociative identity disorder, previously called multiple personality disorder, is usually a reaction to trauma as a way to help a person avoid bad memories.
- Dissociative identity disorder is characterized by the presence of two or more distinct personality identities. Each may have a unique name, personal history, and characteristics.
- Treatment is talk therapy.

### Substances

<table>
<thead>
<tr>
<th>Substance</th>
<th>Effects</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Tobacco</strong></td>
<td>- Withdrawal occurs 2-3 hrs after last cigarette, peak in 2-3 days, resolution in 1 month</td>
</tr>
<tr>
<td></td>
<td>- Increased sx if &gt;25 cigs a day, first cig within 30 min of waking</td>
</tr>
<tr>
<td><strong>Alcohol</strong></td>
<td>- Onset in 12-24 hrs after last drink, peak at 24-48 hrs</td>
</tr>
<tr>
<td></td>
<td>- Mortality with treated DT = 5% (20% untreated)</td>
</tr>
<tr>
<td></td>
<td>- Mild – 6-36 hrs – tremor anxiety, Gl upset</td>
</tr>
<tr>
<td></td>
<td>- Seizures – 6-48 hrs</td>
</tr>
<tr>
<td></td>
<td>- Hallucinosis – 12-48 hrs</td>
</tr>
<tr>
<td></td>
<td>- Delirium tremens -48-96 hrs</td>
</tr>
<tr>
<td><strong>Cocaine</strong></td>
<td>- Withdrawal lasts 1-2 wks → malaise, fatigue, depression, hunger, constricted pupils, vivid</td>
</tr>
<tr>
<td></td>
<td>dreams, psychomotor agitation and retardation</td>
</tr>
<tr>
<td></td>
<td>- Give benzos, Haldol if severe</td>
</tr>
<tr>
<td><strong>Amphetamine</strong></td>
<td>- Similar to cocaine</td>
</tr>
<tr>
<td><strong>Sedative hypnotic</strong></td>
<td>Similar to alcohol</td>
</tr>
<tr>
<td><strong>PCP</strong></td>
<td>- Intoxication = impaired judgement, rotatory nystagmus, seizures, coma, rhabdo, assaultingness, HTN, reckless</td>
</tr>
<tr>
<td></td>
<td>- Withdrawal – no syndrome (may have flashbacks)</td>
</tr>
<tr>
<td><strong>Inhalant (glue)</strong></td>
<td>- Intoxication: lethargy, nystagmus, slurred speech, respiratory depression can be fatal, belligerence, perceptual disturbances</td>
</tr>
<tr>
<td></td>
<td>- Manage with ABCs</td>
</tr>
<tr>
<td><strong>Opiate</strong></td>
<td>- Intoxication – drowsiness, N/V/C, slurred speech, <strong>constricted pupils</strong>, seizures, respiratory depression</td>
</tr>
<tr>
<td></td>
<td>- Withdrawal → begins in 8 hrs and lasts up to 3 days, anxiety, insomnia, cramps, rhinorrhea, diarrhea, fever, chills, HTN</td>
</tr>
<tr>
<td><strong>Hallucinogen</strong></td>
<td>- Pupillary dilation, give quiet room, can do benzo</td>
</tr>
</tbody>
</table>

### Substance use disorders (Substance dependence, abuse and/or withdrawal)

- DSM for **ABUSE**
  - Pattern of substance use leading to impairment or distress for at least 1 year with 1+ of the following
    - Failure to complete tasks at work, school or home
    - Use in dangerous situations
    - Recurrent related legal problems
    - Continued use despite social problems

- DSM for **DEPENDENCE**
  - Substance leading to impairment or distress manifested by at least 3 in a 12 month period
    - Tolerance, withdrawal, unsuccessful efforts to cut down use, significant time used to get substance/recovering from substance, decreased activities, continued despite physical or psychological problems
### Sexual dysfunction
- Dual sex therapy, behavior therapy, hypnosis
- Treat low testosterone
- Erectile disorder → yohimbine, sildenafil, vacuum pumps
- Dyspareunia → gradual desensitization, muscle relaxation techniques
- Vaginismus → vaginal dilators

### Acute grief reaction
- Acute grief is a definite syndrome characterized by psychological and somatic symptoms:
  1. Sensations of somatic distress that occur in waves lasting for 20 minutes to an hour characterized by: Tightness in the throat. Choking.

### Bereavement
- Bereavement is the period of grief and mourning after a death. When you grieve, it’s part of the normal process of reacting to a loss. You may experience grief as a mental, physical, social or emotional reaction. Mental reactions can include anger, guilt, anxiety, sadness and despair.

### Grief
- **Normal grief**
  - Feelings of guilt and sadness
  - Mild sleep disturbance and weight loss
  - Illusions of the deceased (visual and auditory)
  - Attempts to resume daily activities
  - Sx resolve in a year
- **Abnormal grief**
  - Severe guilt and worthlessness
  - Significant sleep disturbance and weight loss
  - Hallucinations or delusions
  - No attempt to resume activities
  - SI
  - Symptoms persist >1yr

Tricyclic antidepressants → (desipramine, nortriptyline, imipramine), has anticholinergic effects (dry mouth, dry eyes, constipation), potential lethal with cardiac arrhythmias

### Definitions

#### Catatonia:
- A neuropsychiatric syndrome occurring in psychiatric or medical disorders that presents with three or more psychomotor sx including
  - Stupor, catalepsy, waxy flexibility, mutism, negativism, posturing, grimacing, mannerism, stereotypy, agitation, echopraxia, echolalia

#### Delusions
- Fixed, false beliefs which lack cultural sanctioning

#### Disorganized speech
- Word salad → lack of connections between words
- Loose associations → lack of connections between ideas

#### Neuroleptic Malignant Syndrome
- The most severe, potentially life threatening complication with altered mental status, fever, dysautonomia, and muscle rigidity

#### Prognosis from best to worst
- Mood disorder with psychotic features → schizoaffective disorder → schizophrenia

#### Atypical/Second Generation Antipsychotics (SGAs)
- Reduced risk of side effects
- "Increased efficacy in treating negative symptoms
- SE: increased risk of metabolic syndrome (abdominal obesity, dyslipidemia, hyperglycemia, HTN
  - Clozapine and Olanzapine have the most metabolic side effects
  - Ziprasidone and aripiprazole have the least
- Clozapine is the most effective in treating schizophrenia, but the risk of agranulocytosis prevents it from being used as a first line drug

#### Typical Antipsychotics
- Higher likelihood of causes extrapyramidal symptoms (akathisia, dystonia, and parkinsonism), hyperprolactinemia, and tardive dyskinesia
- Acute dystonia → can be treated with anticholinergics (benztropine or diphenhydramine)
- Akathisia → (the sensation of inner restlessness), may respond to benzos or a beta-blocker (propranolol)
- Parkansonian sx → can be managed by adding benzotropine
- Tardive dyskinesia → from long term use, hard to treat

---

**Note:**
- Definitions and medical terms are provided for educational purposes. Always consult a medical professional for accurate and up-to-date information.
**MEDS:**

**NMS**
- tx with **dantrolene and bromocriptine** (hydration and cooling blankets)
- increased CPK, WBC, fever, htn, tachy
- movement disorder
- caused by antipsychotics

**MAOIs** – block destruction of monoamines, been tyramine free diet

**First Gen Antipsychotics** – non-selective DA-R ANTAGONISTS
- Haldol –IM 30 min
- Fluphenazine –IM depot
- Thioridiazide – retinosis pigmentosa, QTc, less EPS
- Mesoridazine - torsades
- Chlorpromazine

**Second Gen Antipsychotics** – block post-synaptic DA-R
- **Respiradone** – first line (prolactinemia), injection
- **Olanzapine** – high risk of weight gain
- Quetiapine – cataracts
- **Clozapine** – agranulocytosis
- Lurasidone – best at reversing metabolic syndrome
- Palliperidone – comes in injection form

**Mood Stabilizers**
- Carbamezapine – SJS, OCPs/warfarin interactions, block Na channels
- Valproate – increases GABA
- Lithium – inhibits adenylate cyclase, hypothyroidism, DI
- Lamotrigine – pregnancy C, SJS

**TCAs** – inhibits reuptake of serotonin and NE

**SSRIs** – inhibit reuptake of serotonin (slight inhibition of histamine and muscarine)
- Fluoxetine – longest half life, no D/C syndrome, 5 wks before MAOIs
- Paroxetine – shortest half-life
- Sertraline – high GI sx
- Citalopram – low sexual SE
- Fluvoxamine – low sexual SE
- Escitalopram – low sexual SE

**SNRIs** – inhibit serotonin and NE uptake, HTN, pain
- Venlafaxine
- Duloxetine
- Desvenlafaxine

**Benzo** – GABA-R agonists

**ADHD**