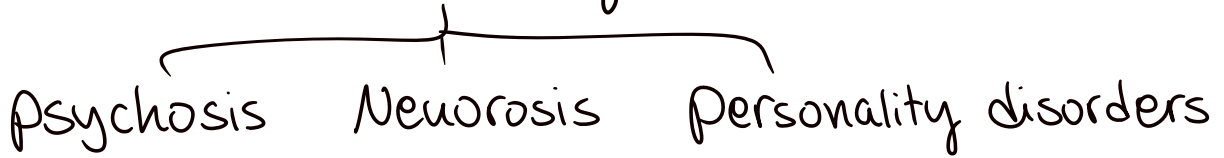


* psychiatry *



(Schizophrenia / Bipolar / ...) (GAD / OCD / phobias / ...) (Borderline PD / Avoidant PD / ...)

* Need for hospitalization:

- 1) Homocide / Suicide plan 3) Mania
2) psychotic who refuse Tx 4) Addiction

Mental State Examination		في الملاحظة الحالية للمريض من قبل الطبيب
• Appearance And Behavior 1) Grooming, hygiene, characteristics of clothes. 2) Appearance and clothes goes with his age. 3) Unusual physical gait or movement "ticks, jerks". → منتزح حركة ابيه ليميد عتاش يطرد الحزن وحيفك 4) Patient attitude and ability to interact. 5) Degree of eye contact (attention). 6) Inhibited behavior (تصرفات غير لائقة). 7) Scars, cuts, tattoos, ... جرح ستورة واحد كان حاط لفرقة جرحه رقبه نسا به الدكتور عليها حكي خذت حالي باصطد مكان الطلح الحزن من جواني	• Speech (spontaneous or induced ?) 1) Rate (normal, slow or pressured) 2) Volume (normal, high or normal volume) 3) Tone (normal or monotonic) 4) Quantity (poverty or normal) in depressed pts 5) Articulation (stammering ثلثة , stuttering لدغة) 6) Word-finding difficulties (expressive dysphasia) 7) Neologisms, inappropriate (sensory dysphasia) 8) Rhythm 9) latency	
• Thought Process 1) Coherent\incoherent. Clang association: word connection due to phonetics 2) Logical\non logical 3) Circumstantiality 4) Tangentiality 5) Preservation of the words. 6) Losing of association: (No logical connection from one thought to another) 7) Flight of ideas. (in mania) 8) Neologism. (in schizophrenia) thoughts change abruptly from one idea to another the point of solution is reached with over-inclusion of irrelevant details Can follow conversation but point never reached psychotic features: 1-2 يمكن حد طبيعي حتى مريض نفسه	• Mood & Affect 1) Mood : كيف المريض شايف حاله 2) Affect : كيف إننا شايف المريض - Anxiety / Stress - Nature of the affect (depressed\elevated\...) - Reactivity of the affect (Flat\Blunted\Constricted\full\intense) - Appropriation to his mood. (congruent or incongruent) - Motility of expressions (how quick he shifts emotional states)	
• Perception 1) Hallucinations auditory, visual, olfactory 2) Illusions 3) Depersonalization 4) Derealization	• Thought content 1) Delusions: fixed, false beliefs 2) Thought insertion 3) Thought withdrawal 4) Thought broadcasting	
• Cognitive state 1) Consciousness (alert, drowsy, lethargic, stuporous, coma) 2) Orientation (place, person, time) 3) Memory (immediate, recent, remote) راح أعطيك 3 كلمات احفظهم وعيدهم، و راح أسالك عنهم كمان شوي اسأله عن أحداث في الأمس، قبل شهر، في الطفولة 4) Attention & concentration بدي إياك تعكس حروف كلمة "منتصر" --- "رصنتم" 5) Reading\writing	• Abstract Concept بتحكيو مثل وبتطلب منو يشرحك إياه مثل عقد لحافك مد رجلحك، أو عصفور في اليد خير من عشرة على الشجرة، وجه الشبه بين البرتقالة و التفاحة. • Judgment اسأله عن حكمه في الأمور، لو شميت ريحة دخان في البيت شو بتسوي، لو لقيت طفل صغير بالشاعر كيف حتتصرف؟ • Insight مدى ادراكه لمرضه، شو نوع مرضك؟ هل أنت مريض، حاب تتعالج؟ • Do: احكي للمريض يسوي حركة من 3 خطوات، ينسخ شكل معين	

* Psychotic disorders

DDx:

- ⊖ Psychotic disorder due to another medical condition
- ⊖ Substance / Medication - induced psychotic disorder
 - Delirium / Major neurocognitive disorder (dementia)
 - Schizophrenia > 6 months
 - Schizophreniform disorder 1-6 months
 - Schizoaffective disorder (Schizophrenia features + mood symptoms < depression / mania)

Note: • if psychosis occurs only during mood episodes: mood disorder with psychotic features

• if psychosis occurs without mood symptoms majority of the time: schizophrenia

• schizoaffective in between (* psychosis is present in between mood symptoms)

* يعني psychosis موجود طول الوقت ، وبيجي فترات مع mood symptoms
وفترات بدون ، بس الفترات الي بين اسبوعين مش أكثر ✓

- Brief psychotic disorder < 1 month

- Bipolar I (always remember to include bipolar disorder in the DDx of a psychotic patient!)

- MDD with psychotic features

1) schizophrenia

- core symptoms (for at least 6 months)

⊖ **[a] Positive symptoms**: delusions, hallucinations (esp. auditory), disorganized thought / speech / behavior
↳ Neologism

⊖ **[b] Negative symptoms**: 5 A's → 1. Anhedonia
2. Affect (flat)
3. Alogia (poverty of speech)
4. Avolition (apathy)
5. Asociality (social withdrawal)

⊖ **[c] Cognitive symptoms**: impairment in ^①attention, ^②executive function, and ^③working memory

+ **catatonia** : ☆ **Motor immobility** or ☆ **Excessive motor activity**

WARDS TIP

Stereotyped movement, bizarre posturing, and muscle rigidity are examples of catatonia, a syndrome which can be seen in schizophrenia, depression, bipolar disorder, and other psychiatric conditions.

▷ So symptoms include :

mutism / stupor / posturing / waxy flexibility / echolalia / echopraxia /

Negativism / **Catalepsy** : maintaining a posture imposed by the examiner or self, even when its uncomfortable waxy flexibility (subtype of catalepsy)

Symptom	Description
Waxy flexibility	Limbs stay in position they're placed
Negativism	Resistance to instructions
Echolalia	Mimicking speech
Echopraxia	Mimicking movements

▷ Tx : IV lorazepam (1st-line)
ECT for refractory cases

- First-Rank (Schneiderian) symptoms

- thought content * Thought insertion / withdrawal / broadcast (عدم حفظ التفكير بواسطة) (عدم سحب التفكير من لاسه) (الفكره ثبتت والناس ليسوا بها)
- perception * Auditory hallucinations (commenting / arguing voices)
- thought content ss * passivity phenomena : The patient feels that their are being controlled by an external force ✓ actions feelings impulses
- thought content * Delusional perception

- phases

• symptoms of schizophrenia often present in the following three phases :-

- [a] prodromal** ; Decline in functioning that precedes the first psychotic episode. The patient may become socially withdrawn and irritable. They may have physical complaints, declining school/work performance, and/or newfound interest in religion or the occult
- [b] psychotic** ; Perceptual disturbances, delusions, and distorted thought process/content
- [c] Residual** ; Occurs following an episode of active psychosis. It is marked by mild hallucinations or delusions, social withdrawal, and **negative symptoms**.

- Course & prognosis :

- Onset typically in early adulthood (18 - 25 yrs)

↪ • Good prognostic factors →

Later onset
Good social support
Positive symptoms
Mood symptoms

Acute onset
Female gender
Few relapses
Good premorbid functioning

• Poor prognostic factors →

Early onset
Poor social support
Negative symptoms
Family history
Gradual onset

Male gender
Many relapses
Poor premorbid functioning
(social isolation, etc.)
Comorbid substance use

- Neurobiology

- Linked to dopaminergic hyperactivity (esp. mesolimbic pathway) → +ve symptoms like delusions/hallucination/...
- Also involves serotonin, glutamate abnormalities
- Neuroimaging; temporal & limbic atrophy

Pathway	Action	Effect in schizophrenia
Mesolimbic	excessive dopaminergic activity ($\uparrow$ dopamine)	positive symptoms
Mesocortical (prefrontal cortical)	inadequate dopaminergic activity ($\downarrow$ dopamine)	Negative symptoms
Nigrostriatal	blocked by antipsychotics	EPS (acute dystonia / akathisia / parkinsonism / TD)
Tuberoinfundibular	blocked by antipsychotics	prolactin elevation

KEY FACT

Akathisia is an unpleasant, subjective sense of restlessness and need to move, often manifested by the inability to sit still. Severe akathisia can be a risk factor for suicide.

Tx: BB

DOWNWARD DRIFT

Lower socioeconomic groups have higher rates of schizophrenia. This may be due to the **downward drift hypothesis**, which postulates that people suffering from schizophrenia are unable to function well in society and hence end up in lower socioeconomic groups. Many homeless people in urban areas suffer from schizophrenia.

KEY FACT

Schizophrenia is more prevalent in lower socioeconomic groups likely due to "downward drift" (many patients face barriers to higher education, regular employment, and other resources, so they tend to drift downward socioeconomically).

* Illness cause drop in SES

* Not social causation = poverty increases risk of illness

◆ Psychotic Symptoms Definitions * Insight is lacking in psychosis, but often preserved in OCD. (ego-dystonic)

Term	Meaning
Delusion < bizarre non-bizarre	Fixed false belief not shared by culture (delusions of persecution, reference, control, grandeur, guilt, somatic) الاعتقالات بتناقضها وبتناقضها على ثقافتها المعتقد الذي على اعتقاديون، لم يكن حقيقي
Hallucination	Perception without stimulus (auditory, visual, olfactory, tactile) الاعتقالات بدون منبه ما يرى المريض من غير منبه
Illusion	Misinterpretation of real stimulus mc type of organic hallucination: visual mc type of psychiatric hallucination: auditory
Thought blocking	Sudden cessation in the flow of thought seen in schizophrenia
Thought insertion	External force putting thoughts into mind
Thought echo	Hearing one's own thoughts spoken aloud (المريض يسمع عسى لثقله)
Circumstantiality	Over-detailed speech that eventually reaches point

Tangentiality

Can follow conversation but point never reached or questions never answered

seen in [Neologism
schizophrenia

a newly coined word or expression that has meaning only to the person who uses it

Echolalia

repeats words or phrases

Echopraxia

mimics behavior (PRActices behavior)

TABLE 3-1. Schizophrenia versus Delusional Disorder

Schizophrenia	Delusional Disorder
■ Bizarre or nonbizarre delusions ■ Daily functioning significantly impaired ■ Must have two or more of the following: ■ Delusions ■ Hallucinations (auditory) ■ Disorganized speech (neologism) ■ Disorganized behavior ■ Negative symptoms (S A's)	■ Usually nonbizarre delusions ■ Daily functioning not significantly impaired ■ Does not meet the criteria for schizophrenia, as described in the left column

- Tx: Typical antipsychotics

Low potency (chlorpromazine / Thioridazine)

Mid potency (Loxapine / Thiothixene / Molindone / Prephenazine)

High potency (Haloperidol / Fluphenazine / Trifluoperazine / Pimozide)

S.E; Anti-dopaminergic effect:

- EPS (acute dystonia, parkinsonism, akathisia, tardive dyskinesia)
- hyperprolactinemia

NMS

Anti-HAM (low potency 1st generation antipsychotic)

Elevated liver enzymes, jaundice

Ophthalmologic (retinal pigmentation, corneal & lens deposits)

Dermatologic (rashes, photosensitivity, blue-gray discoloration)

Seizures (lower seizure threshold)

Atypical antipsychotics

clozapine: treat refractory schizophrenia & only antipsychotic that decreases risk of suicide

Risperidone: S.E → hyperprolactinemia

Aripiprazole: partial D₂ agonist

S.E; Metabolic syndrome (check weight, BMI, fasting blood glucose or HbA1c, lipid assessment, Bp)
hyperprolactinemia (risperidone)
+ may need to give metformin

Mortality & stroke in elderly (FDA black box)

some Anti-HAM effects

Elevated LFTs

QT prolongation

Less likely to cause EPS, NMS

Behavioural therapy / family therapy / group therapy

Comparing Time Courses and Prognoses of Psychotic Disorders

Time Course

- <1 month—Brief psychotic disorder.
- 1–6 months—Schizophreniform disorder.
- >6 months—Schizophrenia.

Prognosis from Best to Worst

Mood disorder with psychotic features > schizoaffective disorder > schizophreniform disorder > schizophrenia.

QUICK AND EASY DISTINGUISHING FEATURES

- **Schizophrenia:** Lifelong psychotic disorder.
- **Schizophreniform:** Schizophrenia for >1 and <6 months.
- **Schizoaffective:** Distinct mood episodes with psychosis persisting between mood episodes.
- **Schizotypal** (personality disorder): Paranoid, odd or magical beliefs, eccentric, lack of friends, social anxiety. Criteria for overt psychosis are not met. → premorbid for schizophrenia
- **Schizoid** (personality disorder): Solitary activities, lack of enjoyment from social interactions, no psychosis.

* Mood disorders

- Mood disorder due to another medical condition
 - Substance / Medication-induced mood disorder
 - MDD
 - Bipolar I & II
 - PDD (dysthymia)
 - cyclothymic disorder
-

* Mood vs. Affect

- **Mood**: (subjective) - a description of one's internal emotional state
 - **Affect**: (Objective) - the external expression of that mood / how I see the patient
-

* Mood episodes

□ MDE

- can be seen in **MDD / PDD / Bipolar I or II / schizoaffective disorder**

- Symptoms: low mood / anhedonia / guilt / worthlessness / suicidal ideation
 - patients may not acknowledge their depressed mood or may express vague, somatic complaints such as;
headache / body pain / GI complaints / fatigue / muscle tension
-

2] Manic episode

- Elevated mood, decreased sleep, impulsivity, grandiosity, flight of ideas, increase activity
- Symptoms lasting one week or need hospitalization
- We have mania $\left\{ \begin{array}{l} \text{with psychotic features} \\ \text{without psychotic features} \end{array} \right.$

بنام ساعتين ومع ذلك بعضي نشيط
وعينه طاعة
مثلا ينام على راسه عددا
لصا به

KEY FACT

Symptoms of mania—**DIG FAST**
Distractibility
Insomnia/Impulsive behavior
Grandiosity
Flight of ideas/Racing thoughts
Activity/Agitation
Speech (pressured)
Thoughtlessness



WARDSTIP

A manic episode is a psychiatric emergency; severely impaired judgment and impulsivity can make a patient dangerous to self and others.

3] Hypomanic episode

- Similar symptoms but less severe
- No psychosis
- lasting 4 days

DIFFERENCES BETWEEN MANIC AND HYPOMANIC EPISODES

Mania

Lasts at least 7 days
Causes severe impairment in social or occupational functioning
May necessitate hospitalization to prevent harm to self or others
May have psychotic features

Hypomania

Lasts at least 4 days
No marked impairment in social or occupational functioning
Does not require hospitalization
No psychotic features

1) MDD

- At least 1 MDE in his life
- More prevalent in Females
- Risk of suicide $\sim 10\%$, especially in those with previous attempts, substance abuse, or social isolation

Q) What are the most common psychiatric disorders among those who commit suicide? Bipolar I & MDD

↓ انخفاض
أبت التفكير بآراء
عقول بطيئا

↓ ما منهم
طاقة

- Symptoms of major depression:
 - Sleep disturbances ($\downarrow$ REM latency & early morning awakenings) or some may experience difficulty falling asleep
 - Anhedonia: inability to experience pleasure
 - Apathy: inability to feel interested or motivated
 - Guilt
 - Low energy
 - Low concentration
 - Psychomotor activity disturbances (restlessness or slowness)
 - Appetite ($\uparrow$ or $\downarrow$) * weight loss $\geq 5\%$ in 1 month = significant or gain
 - Suicidal ideation
 - + somatic symptoms: headache, body pain, fatigue, ...
- often misdiagnosed in elderly due to somatic complaints.

↑ sleep
latency

SPECIFIERS FOR DEPRESSIVE DISORDERS

- **Melancholic features:** Present in approximately 25–30% of patients with a MDE and more likely in severely ill inpatients, including those with psychotic features. Characterized by *anhedonia*, early morning awakenings, depression worse in the morning, psychomotor disturbance, excessive guilt, and anorexia. For example, you would list the diagnosis as MDD with melancholic features.
- **Atypical features:** Characterized by hypersomnia, hyperphagia, reactive mood, leaden paralysis, and hypersensitivity to interpersonal rejection.
- **Mixed features:** Manic/hypomanic symptoms present during the majority of days during a MDE: elevated mood, grandiosity, talkativeness/pressured speech, flight of ideas/racing thoughts, increased energy/goal-directed activity, excessive involvement in dangerous activities, and decreased need for sleep.
→ in schizophrenia / MDD / bipolar / ...
- **Catatonia:** Features include catalepsy (immobility), purposeless motor activity, extreme negativism (resistance to instructions), staring, mutism, bizarre postures, and echolalia. Treatment is lorazepam (Ativan) though catatonia is especially responsive to ECT. (May also be applied to bipolar disorder.)
- **Psychotic features:** Characterized by the presence of delusions and/or hallucinations. Present in 24–53% of older, hospitalized patients with MDD.
- **Anxious distress:** Defined by feeling keyed up/tense, restless, difficulty concentrating, fears of something bad happening, and feelings of loss of control.
- **Peripartum onset:** Onset of MDD symptoms occurs during pregnancy or 4 weeks following delivery.
- **Seasonal pattern:** Temporal relationship between the onset of a MDE and particular time of the year (most commonly the winter but may occur in any season). Patients with fall-onset SAD (seasonal affective disorder or “winter depression”) often respond to light therapy (a 10,000 lux white light for 30 minutes in the early morning).

- Tx of MDD :

Antidepressant & Psychotherapy

- Tx of MDD with psychotic feature :

Antidepressant & Antipsychotic (2nd gen) or ECT

* Note ; medications take 4-6 weeks to reach peak efficacy
+ Need to be given for 6-12 months ✓

- Hamilton Depression Rating Scale (HAM-D)

- measures the severity of depression
- used in research to assess the effectiveness of therapies

- PHQ-9

- a depression screening form often used in the primary care setting.

✗ Misconceptions

Misconception	Correction
MDD = weakness some people think MDD means being weak or lazy	✗ It's a neurobiological illness. (medical disorder, just like DM or HTN)
Weight loss is not important (somatic)	✗ $\geq 5\%$ weight loss or gain is diagnostic.
Physical signs are uncommon	✗ Common in MDD. ↳ headache / body pain / GI complaints / ...

◆ Grief vs Depression

✓ Complicated Grief:

Feature	Normal Grief	Major Depression
Duration	<6 months (usually)	>2 weeks (criteria)
Mood	Sadness in waves	Persistent low mood
Self-esteem	Preserved	↓ Worthlessness, guilt
Psychosis	Absent	May be present
Functionality	Variable, often preserved	Markedly impaired

- Lasts >6 months
- Preoccupying, disabling
- Risk of major depression, suicidality

2) Bipolar disorder

- Mania / Hypomania / depressive episode
- Bipolar I → $\pm$ a history of psychosis
 - at least 1 manic episode
 - $\pm$ depression or hypomania
 - may have psychotic features (delusions or hallucinations) during major depressive or manic episode not in between
- has the highest genetic link of all major psychiatric disorders
- Bipolar II →
 - at least 1 hypomanic & 1 depressive episode (No mania)
 - misdiagnosed as unipolar depression (MDD)

Note ; there is usually a return to baseline functioning between mood episodes

Note ; if we have psychotic feature → mania
(psychosis = mania)

 **WARDS QUESTION**

Q: What is the difference between bipolar I and bipolar II disorder?

A: Bipolar I disorder requires at least one *manic* episode but not necessarily a MDE, whereas bipolar II disorder requires both a *hypomanic* episode plus at least one MDE.

- Tx : Mood stabilizer → Lithium
valproate
lamotrigine
carbamazepine
atypical antipsychotics

Note; Always remember to include bipolar disorder
in the differential diagnosis of psychotic patient

- Rapid cycling: ≥ 4 mood episodes (major depressive / hypo manic / or manic) in 1 year

* Lithium $\rightarrow$ 1st line / $\downarrow$ suicide risk

Therapeutic range $\rightarrow$ $0.6 - 1.2$

Toxic $\rightarrow > 1.5$

potentially lethal $\rightarrow > 2$

 **KEY FACT**

Side effects of lithium include:

- Weight gain
- Tremor
- Gastrointestinal disturbances
- Fatigue
- Cardiac arrhythmias
- Seizures
- Goiter/Hypothyroidism
- Leukocytosis (benign) carbam, valproic acid, ...
leukopenia
- Coma (in toxic doses)
- Polyuria (nephrogenic diabetes insipidus)
- Polydipsia
- Alopecia
- Metallic taste

Note: Lithium's toxidrome has a similar presentation though it is more severe.

+ Ebstein's anomaly

Lithium has well-known effects on both
* Kidney + thyroid !

4. 2 classes of medication that increase serum level of lithium?

- Thiazide diuretics.
- NSAIDs.
- ACE inhibitors.
- Metronidazole.
- Tetracycline.

Labs :

Pregnancy

Thyroid

Benign Leukocytosis

Electrolyte

EKG

Renal

* valproic acid $\rightarrow$

therapeutic range 80 - 120 $\mu\text{g/ml}$

teratogenic (neural tube defect)

* Carbamazepine →

therapeutic range 8-12

Stevens-Johnson syndrome

teratogenic (neural tube defect)

valproic acid & carbamazepine for rapid cycling & mixed features

* Lamotrigine →

Stevens-Johnson syndrome

Efficacy for bipolar depression

* Topiramate →

beneficial S.E.: wt loss

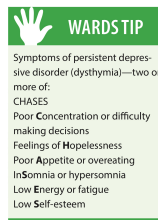
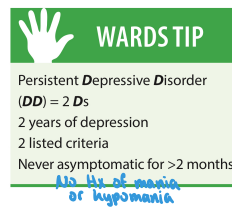
most limiting S.E.: cognitive slowing & sleepiness

- Antidepressants are discouraged as monotherapy due to concerns of activating mania or hypomania. They are occasionally used to treat depressive episodes when patients concurrently take mood stabilizers.

✗ Misconceptions

Statement	Verdict	Why
Treated with CBT <u>only</u>	✗	Needs pharmacological mood stabilization. <i>lithium valproate lamotrigine</i>
Lifetime risk 7%	✗	Lower than stated. $\approx 1\%$ <i>medications + CBT + ECT all can be used</i>
Affects only middle-aged <i>(40-60 yrs)</i>	✗	Typically starts in young adulthood. <i>(18-25 yrs)</i>

3) PDD (Dysthymia)



- Chronic depressive symptoms > 2 yrs
- Less severe than MDD, but more persistent
- often associated with low self-esteem, fatigue, concentration issues

4) Cyclothymic disorder

- periods of hypomanic symptoms (but not a full hypomanic episode) & periods with depressive symptoms (but not a full MDE) for at least 2 yrs.

≥ 2 yrs of hypomania + depressive symptoms

* suicide →

- R.F: [SAD PERSON]

S: Male sex

A: Age < 19 or > 45 (adolescents & elderly)

D: Depression

P: previous attempt

E: Excess alcohol or substance use

R: Rational thinking loss

S: social supports lacking

O: Organised plan

N: No spouse

S: Sicknes

+ Mental illness (MDD, bipolar, schizophrenia)

+ personality disorders (borderline, antisocial)

+ Recent loss or stressors

- Indicators of serious intent

- suicide note
- use of lethal method
- Angry after rescue
- prior attempts
- precautions to avoid discovery

- Females attempt more, but males use more lethal methods
- The only antipsychotic that decreases risk of suicide → Clozapine (atypical)
- The only mood stabilizer that decreases risk of suicide → Lithium

✗ Myths

Myth	Reality
Females more likely to complete	✗ Males complete suicide more often.
Suicide is impulsive	✗ Many plan it. (notes/precautions / method selection)
Talking about it increases risk بعض الناس يتكلمون عن السؤال ويزرع الفكرة بالمريض او يزيد الرغبة	✗ Asking about suicide helps. يساعد على تقييم خطورة الوضع وفتح مجال للتدخل المبكر والدعم النفسي وإزالة الوسائل القاتلة

* Anxiety & OCD

1) GAD

- chronic excessive worry for ≥ 6 months
 - Associated symptoms: fatigue, restlessness, muscle tension, insomnia
 - Tx: CBT, SSRI/SNRI, short term benzo or augmentation with buspirone (non-BZD anxiolytic)
-

2) panic disorder

- panic attack vs. panic disorder
(عرف ممكن يظهر في عدة اضطرابات)
- **Panic attack**: a fear response involving a sudden onset of intense anxiety which may either be triggered or occur spontaneously (peak within minutes & resolve within half an hour)
- **Panic disorder**: patients who experience spontaneous, recurrent panic attacks and who are fearful of reoccurring attacks (fear of fear)
- Recurrent unexpected panic attacks
- peak within 10 min: palpitations, chest pain, breathlessness, dizziness, fear of dying ↗

 **KEY FACT**

Symptoms of panic attacks
Da PANICS
Dizziness, disconnectedness,
derealization (unreality), **depersonalization** (detached from self)
Palpitations, paresthesias
Abdominal distress
Numbness, nausea
Intense fear of dying, losing control or "going crazy"
Chills, chest pain
Sweating, shaking, shortness of breath

- Avoidance behaviour may lead to **agoraphobia**
- Tx: CBT, SSRI / SNRI, BZO for short term (Long-term BZO discouraged) [because of dependence, tolerance, and withdrawal]
- Beta-blockers for panic attacks & performance anxiety - public speaking

Note:


WARDSTIP

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

◆ **Phobias** → irrational fear that leads to endurance of the anxiety and/or avoidance of the feared object or situation

Type	Feature
Agoraphobia	Intense fear of being in public places where escape or obtaining help may be difficult. It often develops with panic disorder. <i>more in F / Tx: CBT & SSRI</i>
<u>Social Anxiety</u>	Fear of social scrutiny, public speaking, criticism <i>F = M / Tx: CBT & SSRI</i>
Specific Phobia	Irrational fear of specific object/situation (e.g., spiders, heights) <i>more in F</i> elevators, airplanes <i>Tx: CBT with exposure</i>

✗ Myths

Misconception	Clarification
"Phobia is proportional to danger"	✗ It's out of proportion <i>شدة الخوف ما يتكافئ خطورة الموقف فعلياً</i>
"Phobia = voluntary behavior"	✗ Phobic responses are involuntary

- phobias are the most common psychiatric disorder in women & the 2nd most common in men (substance-related is first)

selective mutism + separation anxiety disorder

2) OCD

✓ Core Concepts

- Obsessions: intrusive, **unwanted** thoughts, cause distress.
- Compulsions: repetitive behaviors **aimed to reduce anxiety**.
- Patient has insight into irrationality (unlike psychosis). (*ego-dystonic*)

✓ Treatment

- CBT with exposure & response prevention (ERP).
- SSRIs (e.g., ~~fluoxetine~~). **Fluvoxamine**
- **Clomipramine** (TCA) is also effective.

✗ Notable Points

Statement	Verdict
OCD thoughts are pleasant	✗ Intrusive and distressing
Patient lacks insight	✗ Usually has good insight
Compulsions = pleasure	✗ Done to relieve anxiety, not enjoyment

KEY FACT

Differentiating OCD and obsessive-compulsive personality disorder (OCPD):

- Individuals with OCPD are obsessed with details, control, and perfectionism without experiencing unwanted preoccupations or compulsions.
- OCD patients are *distressed* by their symptoms (*ego-dystonic*).

KEY FACTS

Common Patterns of Obsessions and Compulsions

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

KEY FACT

The triad of “uncontrollable urges”—OCD, ADHD, and tic disorder—are usually first seen in children or adolescents.

3) Body dysmorphic disorder

- More common in women & surgical or dermatological procedures are routinely unsuccessful in satisfying the patient

4) Hoarding disorder

5) Trichotillomania (hair-pulling disorder)

6) Excoriation (skin-picking) disorder

7) PTSD & Acute stress disorder

النزط يكون المحدث
life-threatening

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



WARDSTIP

Criteria of PTSD: TRAUMA

Traumatic event
Reexperience
Avoidance
Unable to function
Month or more of symptoms
Arousal increased



WARDSTIP

Q: What medication has shown some efficacy as an adjunct treatment for nightmares in patients with PTSD?

A: Prazosin. (α1 receptor antagonist)

- Tx : SSRI / prazosin / 2nd gen antipsychotic
CBT (exposure therapy, cognitive processing therapy)
couples or family therapy

8) Adjustment disorder

- non-life threatening stressful event
(divorce, death of a loved one, loss of a job)

- Symptoms within 3 months in response to stressor, lasting < 6 months

- Tx: supportive psychotherapy
Group therapy



KEY FACT

PTSD stressor = life threatening.
Adjustment disorder stressor ≠ life threatening.

* personality disorders

- General features →

- Begin in adolescence or early adulthood
 - Lead to maladaptive behaviour, distorted perception, and relationship dysfunction
- ### - Shared characteristics
- Difficult to treat
 - Cause significant dysfunction
 - Deviation from social norms & expectations

✗ Not True of All:

Myth	Correction
Diagnosed in childhood	✗ Diagnosed in adulthood عادة التشخيص الرسمى بعد سن ١٨
Patients seek treatment	✗ Often ego-syntonic, resist help المرضى عادة ما يتولى سلوكياتهم مشكلة ويتأخرون العلاج

Cluster A: Odd/Eccentric

Disorder	Key Traits
Paranoid	Suspicious, mistrustful
Schizoid	Social withdrawal, prefers solitude, emotionally detached
Schizotypal	Magical thinking, odd behavior, ideas of reference, social anxiety

بعض اصحاب

بعض يعرفون
بكونهم يخافون
من الرفض



WARDS TIP

Q: What is the premorbid personality seen in schizophrenia?

A: Schizotypal personality disorder.

Cluster B: Dramatic/Emotional

Disorder	Key Traits
Antisocial	Disregard for rights, associated with conduct disorder in youth <i>every antisocial was conduct but not every conduct will be antisocial (50%)</i> <i>Tx: mood stabilizer, SSRI, anti-psychotic</i>
Borderline	Emotional instability, fear of abandonment, impulsivity, recurrent suicidal behavior <i>Common defense mechanism: Splitting (they view others & themselves as all good or all bad)</i> <i>R.F. → sexual abuse + family conflict</i> <i>Tx: DBT</i>
Histrionic	Attention-seeking, dramatic <i>Common defense mechanism: regression (they revert to childlike behaviours)</i> <i>يتوقف الناس بها لها صياح عبيد أو حضراء غريب (أبيض أو اسود)</i>
Narcissistic	Grandiosity, lack of empathy, need for admiration

mc PD in psychiatric inpatients

تعريف شديد من العجز

يتوقف الناس بها لها صياح عبيد أو حضراء غريب (أبيض أو اسود)



WARDS TIP

Symptoms of antisocial personality disorder—**CORRUPT**
 Cannot follow law
 Obligations ignored
 Remorselessness
 Reckless disregard for safety
 Underhanded (deceitful)
 Planning deficit (impulsive)
 Temper (irritable, aggressive)



KEY FACT

Antisocial personality disorder begins in childhood as conduct disorder. Patient may have a history of being abused (physically or sexually) as a child or a history of hurting animals or starting fires. It is often associated with violations of the law.

Antisocial Personality Disorder (ASPD) and the Law

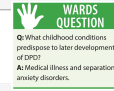
- ASPD itself is not punishable by law → having a psychiatric diagnosis is not a crime.
- BUT people with ASPD often violate the rights of others and break laws (lying, stealing, aggression, lack of remorse, etc.).
- So, if a person with ASPD commits a criminal act, they are legally responsible and can be punished by law.

Why?

- Unlike psychotic disorders (e.g., schizophrenia with loss of reality testing), patients with ASPD generally know right from wrong and have intact reality testing.
- Their behavior is a choice, even if influenced by personality traits.
- Therefore, the legal system holds them accountable for their actions.

Cluster C: Anxious/Fearful

Disorder	Key Traits
Avoidant	Social inhibition, hypersensitive to criticism <i>overlap with social anxiety disorder (social phobia)</i>
Dependent	Submissive, clingy, fear of separation <i>common defense mechanism: regression (going back to a younger age of maturity)</i>
Obsessive-Compulsive PD	Preoccupation with order, perfectionism, control — distinct from OCD (no obsessions/compulsions) <i>هشاشة الشخصية مقاومة في النفسية وسس مرتبطة للتعرض مشي زي انا OCD</i>



What childhood conditions predispose to later development of CPD? As Medical illness and separation anxiety disorders.

Defense mechanisms :

splitting → In border line PD

Regression → In Histrionic PD & Dependent PD

- Schizoid vs. Avoidant :

- Schizoid patients (cluster A) prefer to be alone / have psychotic symptoms
- Avoidant patients (cluster C) want to be with others but are too scared of rejection / have anxiety symptoms

- Multiple PD can coexist ✓

✓ Distinctions Worth Noting

Trait	Borderline PD	Bipolar Disorder
Mood changes	Minute-to-minute	Weeks
Self-harm	Impulsive	During depression
Treatment	DBT (psychotherapy)	Mood stabilizers

Trait	Obsessive-Compulsive PD	OCD
Insight	Low (ego-syntonic)	High (ego-dystonic)
Symptoms	Rigidity, perfectionism	Obsessions + compulsions

* Substance - use disorders

- Substance - induced mood symptoms improve during prolonged abstinence, whereas primary mood symptoms persist

عشان فيك لو ثقتا خصر alcoholic عند depression مهم نعرف بتوبلى اول
 We will admit him. do inpatient detoxification program then
 within one month we see if depression symptoms persist
 within the same intensity → major depressive disorder
 While if the patient after detoxification most of the depressive
 symptoms gradually decrease → this is alcohol induced depression

Stage	Definition	Example
Precontemplation	Patients do not view their addiction as a problem. They may see substance use as helpful and/or enjoyable.	A college student who drinks heavily feels that they need alcohol to overcome social anxiety and enjoy parties. They do not identify any negative consequences from their use.
Contemplation	The patient begins to think about cutting down or stopping altogether. They recognize potential benefits of making a change, but may be ambivalent or feel unable to do so.	The student misses several deadlines due to hangovers from drinking the night before. They think cutting down on alcohol might improve their grades, but aren't sure they want to stop.
Preparation	The patient plans for the process of change. They collect information, and may experiment with very small changes. <i>بدور على النت، نطلب مساعدة اصحابنا ورفيقه</i>	The student begins researching self-help strategies for reducing alcohol intake. They look up campus resources for individual and group therapy.
Action	The patient takes direct steps toward reducing or stopping substance use.	The student begins attending substance-use-focused groups on campus, and talks with their primary care doctor about starting naltrexone.
Maintenance	The patient has successfully made significant behavior change, and works to avoid relapse.	The student continues to drink, but limits themselves to 1–2 drinks per day, and only consumes alcohol on weekends.
Relapse	After a successful period of remission, patients resume substance use (or fall back into unhealthy patterns of use).	After graduating, the student is unemployed. They begin drinking again to cope with stress and unstructured time, and quickly escalates to near daily use.

1) Alcohol (sedating agent) Alcohol $\xrightarrow[\text{alcohol dehydrogenase}]{} \text{Acetaldehyde} \xrightarrow[\text{aldehyde dehydrogenase}]{} \text{acetic acid}$

[a] Intoxication

- start showing $\left\{ \begin{array}{l} \text{some sign of intoxication when } \text{BAL} > 100 \text{ mg/dL} \\ \text{obvious sign of intoxication when } \text{BAL} > 150 \text{ mg/dL} \end{array} \right.$
- Symptoms:

Impaired fine motor control

Impaired judgment & coordination

Ataxic gait & poor balance

Lethargy, difficulty sitting upright, difficulty with memory

N & V

Coma

Respiratory depression, death

- Management: Monitor ABCs, thiamine before glucose, folate, supportive care, correct electrolytes & acid-base status

[b] Withdrawal alcohol: sedating agent
alcohol withdrawal: brain excitation & seizures

* Fatal withdrawal: Alcohol / benzo / barbiturates ✓

▷ 6-24 h: tremor / anxiety / seizures / hallucinations
insomnia / autonomic hyperactivity

▷ 12-48 h: Generalized tonic-clonic seizures

▷ 48-96 h: DTs

KEY FACT

Delirium tremens is a dangerous form of alcohol withdrawal involving mental status and neurological changes. Symptoms include disorientation, agitation, visual and tactile hallucinations, and autonomic instability (increase in respiratory rate, heart rate, and blood pressure). It carries a 5% mortality rate but occurs in only 5% of patients that experience EtOH withdrawal. Patients often require ICU level of care; treatment includes supportive care and benzodiazepines.

(TOP MEDICAL EMERGENCY)

- Management:

Acute withdrawal: benzo (e.g., diazepam) &

Carbamazepine or valproic acid for mild cases

+ correct electrolytes,

+ give thiamine / folate / multivitamin (banana bag)

TABLE 7-4. Timing of Alcohol Withdrawal Symptoms

Syndrome	Clinical Findings	Onset After Last Drink
Minor withdrawal	Tremulousness, mild anxiety, headache, diaphoresis, palpitations, anorexia, gastrointestinal upset; normal mental status	6 to 36 hours
Seizures	Single or brief flurry of generalized tonic-clonic seizures, short postictal period, status epilepticus rare	6 to 48 hours
Alcoholic hallucinosis	Visual, auditory, and/or tactile hallucinations with intact orientation and normal vital signs	12 to 48 hours
Delirium tremens	Delirium, agitation, tachycardia, hypertension, fever, diaphoresis	48 to 96 hours

[C] Alcohol use disorder

- Prevalence: $M > F$
 - 1) Frequency of drinking
 - 2) Quantity of drinking
 - 3) Frequency of heavy drinking
- Screening: AUDIT-C questionnaire / CAGE questionnaire
- Biomarkers: BAL, AST/ALT (AST:ALT $\geq 2:1$), $\uparrow$ GGT, $\uparrow$ MCV (macrocytosis), urine ethyl glucuronide
 - AST often > ALT
- TX: Naltrexone
Acamprosate
Disulfiram
Topiramate

Answer: Have you thought to CUT DOWN drinking
Have people ANNOYED you by criticism
Do you feel GUILTY About drinking
Have you felt the need to drink first thing in the morning (EYE OPENER)
Most probably 2 points out of 4, the doctor said she will consider 2 or 3 correct, not sure.

- Long-term complications of Alcohol-intake:

* Wernicke's encephalopathy:

caused by thiamine (vit B1) deficiency resulting from poor nutrition

- ① Confusion, ② ataxia, ③ ocular abnormalities (nystagmus, gaze paresis)
- Tx of Wernicke's encephalopathy?
high dose parenteral (IV or IM) thiamine should be given for 2-7 days, followed by daily oral thiamine
- If untreated may progress to Korsakoff syndrome

* Korsakoff syndrome

Russell's sign
↓
because of induce
vomiting to counteract
alcohol intake

- severe memory impairment & cognitive deficit
(impaired recent memory / anterograde amnesia / compensatory confabulation: unconsciously making up answers when memory has failed)
- usually progression of untreated Wernicke's

* So; Give all patients with altered mental status **thiamine before glucose**, to avoid precipitating Wernicke-Korsakoff syndrome. Thiamine is a coenzyme used in carbohydrate metabolism

* Alcoholic Ketoacidosis

- seen after binge + vomiting + poor intake
- high anion gap metabolic acidosis
- Tx: IV fluids / replace electrolytes

* Liver cirrhosis + pancreatitis

2) Cocaine (stimulant effect)

1) Intoxication

General: psychomotor agitation or depression, ↑ or ↓ BP, dilated pupils, weight loss, tachycardia or bradycardia, euphoria, heightened self-esteem

Dangerous: seizures, cardiac arrhythmias, hyperthermia, paranoia, hallucinations (tactile) ⇒ ^{1) Cocaine + 2) amphetamines + 3) OTs} cause **formication**

Deadly: Cocaine's vasoconstrictive effect may result in MI, intracranial hemorrhage, or stroke

- Management:

- For mild-to-moderate agitation and anxiety: Reassurance of the patient and benzodiazepines.
- For severe agitation or psychosis: Antipsychotics (e.g., haloperidol).
- Symptomatic support (i.e., control hypertension, arrhythmias).
- Temperature of >102°F should be treated aggressively with an ice bath, cooling blanket, and other supportive measures.

[2] withdrawal

* Abrupt abstinence is not life-threatening

hypersomnia, ↑ appetite, depression, constricted pupils
fatigue, anhedonia, ...

Tx: supportive

[3] Cocaine use disorder

- NO FDA-approved drug
- off-label medications (naltrexone, modafinil, topiramate)
- Psychological interventions (contingency management, relapses prevention, ...) are the mainstay of tx



WARDS QUESTION

Q: Why should beta-blockers be avoided for patients who regularly use cocaine?

A: Cocaine has both alpha- and beta-adrenergic effects. If a beta-blocker is given simultaneously, unopposed alpha-adrenergic activity can cause coronary vasoconstriction and induce myocardial infarction.

3) Amphetamines (club drugs) (have both stimulant & hallucinogenic properties)

[1] Intoxication **same as cocaine**

- euphoria, dilated pupils, increased libido, tachycardia, perspiration, **grinding teeth**, chest pain
- rhabdomyolysis (**amphetamines + PCP**), renal failure

[2] Withdrawal

prolonged depression, fatigue

4) Phencyclidine (PCP) (stimulant effect)

[1] Intoxication

agitation, depersonalization, hallucinations,

synesthesia, impaired judgment, memory problems, **nystagmus**, ataxia, dysarthria
(especially rotary)

← **cross sensory stimulant**
e.g., hearing a violin note makes you see blue flashes!

[2] Withdrawal

No withdrawal symptoms. Flashbacks may occur

hallucinogens

Tx:

Monitor vitals / minimize sensory stimulation / benzo / antipsychotics

5) sedative - hypnotics (benzo, barbiturates, ...) (sedating agent)

[1] Intoxication

- drowsiness, confusion, hypotension, slurred speech, incoordination, ataxia, impaired judgment, nystagmus, respiratory depression, coma, death
- Symptoms are synergistic when combined with EtOH or opioids/narcotics
- Tx: ABC / activated charcoal & gastric lavage / supportive care
 - For barbiturates: Alkalinize urine with sodium bicarbonate to promote renal excretion
 - For BZD: Flumazenil

[2] Withdrawal

 **WARDS QUESTION**

Q: Which substances of abuse have potentially fatal withdrawal syndromes?

A: Alcohol, benzodiazepines, and barbiturates.

- Symptoms same as EtOH withdrawal
- tonic-clonic seizures may occur & can be life threatening
- Tx:
 - Benzo
 - carbamazepine or valproic acid

مضاد تشنج
مضاد صرع

6) opioids (sedating agent)

[1] Intoxication

- drowsiness, N&V, constipation, constricted pupil,
seizures, respiratory depression, death

A Fatal intoxication triad of opioids:

- 1) miosis (pinpoint pupil)
- 2) Altered mental status
- 3) Respiratory depression

p.p.
① 2 S.E that do NOT develop tolerance easily:
constricted pupil & constipation

- Meperidine & monoamine oxidase inhibitors taken in combination may cause serotonin syndrome →
hyperthermia / confusion / hyper or hypotension / hyperreflexia

* Meperidine cause Mydriasis Not miosis!

- Tx:
ABC / naloxone / ...

[2] Withdrawal

- Not life-threatening
- dysphoria / insomnia / lacrimation / rhinorrhea /
yawning / weakness / sweating / ...

[3] Opioid - use disorder

- Tx: Methadone / Buprenorphine /
Naltrexone / Naloxone

⇒ Hallucinogens (LSD / psilocybin / mescaline)

[1] Intoxication

- perceptual changes: illusions / hallucinations /

body image distortion, labile affect, dilated pupils, HTN, tachycardia, tremors, sweating, ...

- severe anxiety, panic, paranoia
psychosis
- Tx: reassurance, benzo, antipsychotic

[2] withdrawal
None

8) Marijuana (cannabis, THC) (atypical hallucinogens)

[1] Intoxication

Euphoria, anxiety, impaired coordination,
perceptual disturbances, tachycardia,
conjunctival injection, dry mouth, ↑ appetite

[2] withdrawal

- irritability, anxiety, restlessness, aggression
strange dreams, depression, headache

- Tx: supportive

9) Inhalants (glu / solvents / laughing gas / ...)

[1] Intoxication

perceptual disturbances / paranoia / lethargy /
dizziness / N&V / ...

[2] withdrawal

Not typical, but may include irritability,
sleep disturbance / anxiety / depression

Tx: supportive

10) caffeine

11) Nicotine

Tx: Nicotine replacement

P.P [**veneniline**
Bupropion] → (miscellaneous antidepressant)
- have no sexual dysfunction, so
often used if SSRIs cause sexual dysfunction
- contraindicated in pts with epilepsy,
because it lowers seizure threshold

12) Gambling disorder

* Neurocognitive disorders

1) Delirium

2) Mild NCDs

3) Major NCDs (dementia)

} Chronic cognitive decline

[1] Dementia



WARDS TIP

Antipsychotics carry a black box warning about increased risk of death in patients with dementia.

used for agitation & depression but because they are associated with ↑ mortality in patients with dementia, low doses closely monitored

Warning about atypical antipsychotics: although they are used to treat the behavioral symptoms of neurocognitive disorders (dementias) and delirium, studies show an increased risk of all-cause mortality and stroke when using these agents in the elderly, which, as a result, is listed as FDA black box warning for these medications.

→ Alzheimer's disease

- Most common cause of dementia > 65
- Gradual onset^①, progressive memory loss^②, language difficulties^③, executive dysfunction, learning problems
- Neurobiology: ↓ acetylcholine, senile plaques, neurofibrillary tangles



KEY FACT

Senile plaques and neurofibrillary tangles are found in Alzheimer disease, as well as Down syndrome and even in normal aging.



WARDS QUESTION

Q: What are the "four As" of Alzheimer disease?

A: Amnesia, agnosia, apraxia, and aphasia.

{ Amnesia → memory loss
Agnosia → Failure to recognise objects/people
Apraxia → loss of learned movement
Aphasia → language disturbance



KEY FACT

Postmortem pathological examination of the brain is the only way to definitively diagnose Alzheimer disease.

- Tx: cholinesterase inhibitors
NMDA receptor antagonists

→ Vascular dementia

- stepwise progression
- Due to multiple infarcts
- Often comorbid with cardiovascular risk factors
(HTN / DM / Smoking / CAD / advanced age / obesity)

→ Lewy body dementia

- Lewy body: pathologic aggregations of alpha-synuclein
- Dementia + visual hallucinations, parkinsonism, fluctuating cognition
+ ^{diminished sense of smell}
- CT: Frontal lobe atrophy may be seen
- sensitive to antipsychotics (can worsen symptoms)
- Tx: cholinesterase inhibitors for cognitive & behavioral symptoms
Quetiapine or clozapine for psychotic symptoms

→ Frontotemporal Degeneration

→ HIV Infection

→ Huntington disease

→ parkinsonism disease

→ prion disease (transmissible spongiform) encephalopathies

→ Normal pressure hydrocephalus

→ Reversible causes

Cause	Notes
Alcohol-induced	Common reversible cause
Normal pressure hydrocephalus	Triad: gait disturbance, urinary incontinence, dementia
Hypothyroidism	Screen TSH
B12 deficiency	Subacute combined degeneration
Benign brain tumors	Especially if frontal lobe involved

✗ Misconceptions

Statement	Verdict
Alzheimer's is reversible	✗ Irreversible
Delirium = dementia	✗ Delirium is acute and fluctuating
Hallucinations are rare	✗ Common in Lewy body and <u>DTs</u> <i>visual & tactile</i>

2 Delirium

ETIOLOGY

- Almost any medical condition can cause delirium (see examples in Table 8-1).
- The *DSM-5* recognizes five broad categories:
 - Substance intoxication delirium.
 - Substance withdrawal delirium.
 - Medication-induced delirium.
 - Delirium due to another medical condition.
 - Delirium due to multiple etiologies.

- Features:

- Acute onset, fluctuating course, ^(typically worsening at night) inattention, ^{orientation} ↓ awareness, hallucination ^(often visual), disorganized thinking, altered consciousness
_(distractibility)
_(derailment or loose association)
↳ [hyperalert / normal / lethargic / stuporous / comatose]
- Common in elderly, especially with infections or medications (e.g., benzo, anticholinergics)

TABLE 8-2. *DSM-5* Criteria for Delirium

- | |
|---|
| ■ Disturbance in attention and awareness . |
| ■ Disturbance in an additional cognitive domain . |
| ■ Develops acutely over hours to days, represents a change from baseline, and tends to fluctuate . |
| ■ Not better accounted for by another neurocognitive disorder . |
| ■ Not occurring during a coma . |
| ■ Evidence from history, physical, or labs that the disturbance is a direct consequence of another medical condition, substance intoxication/withdrawal , exposure to toxin , or due to multiple etiologies. |

RISK FACTORS

- Advanced age.
- Preexisting cognitive impairment or depression.
- Prior history of delirium.
- Severe or terminal illness.
- Multiple medical comorbidities.
- Hearing or vision impairment.

PRECIPITATING FACTORS

- Polypharmacy, including the use of psychotropic medications (especially benzodiazepines and anticholinergic drugs).
- Alcohol use or withdrawal.
- Infection.
- Pain.
- Dehydration.
- Malnutrition.
- Impaired mobility.
- Sleep deprivation.
- Organ failure.
- Mechanical ventilation.



WARDS TIP

Suspect delirium if a patient presents with altered mental status, disorientation, confusion, agitation, or sudden onset of psychotic symptoms.



WARDS QUESTION

Q: What are the two most common precipitants of delirium in children?

A: Febrile illnesses and medications.

- Management (It's a MEDICAL EMERGENCY)

نقطة **Treat the underlying cause**

Supportive care; reorientation, reduce stimuli, optimize sleep

Low dose haloperidol if severe agitation (D₂ antagonist - antipsychotic)

* Avoid benzo (except in alcohol or benzo withdrawal), why?
as they may worsen delirium by causing paradoxical
disinhibition or over-sedation



WARDS QUESTION

Q: In what scenarios is it appropriate to use benzodiazepines to treat delirium?

A: Alcohol and benzodiazepine withdrawal.

Feature	Delirium	Dementia
Onset	Acute	Gradual
Consciousness	Fluctuates	Clear
Hallucinations	Often visual	Can be present
Reversible	Often	Usually not

* Child psychiatry

Intellectual disability (Intellectual & adaptive dysfunction)

* a single IQ score doesn't adequately capture this and is no longer used solely

 **KEY FACT**

Fragile X Syndrome Facts and Stats

- Most common inherited form of ID.
- Second most common cause of ID.
- Due to *FMR-1* gene mutation.
- Males > females.

ADHD

- Core features :

• Types

- a) Inattention (more in F) } يخفون مع الوقت او الكبر في
- b) hyperactivity (more in M) } يتعلم تكيف كيف يركز وهيئ
- c) Impulsivity (most difficult to treat)
- d) combined type (the mc)

• Onset before age 12

• Associated with learning difficulties, oppositional defiant disorder, and sometimes conduct disorder

دما بأذي يلي حواله
في الحيوانات

ODD $\rightarrow$ conduct $\rightarrow$ Antisocial
موديعاً موديعاً 50%

- Tx:

1st line → CNS stimulants (methylphenidate, amphetamine)

2nd line → * alpha-2-agonist (clonidine, guanfacine)

* Norepinephrine reuptake inhibitor (atomoxetine)

+ Behavioural therapy, especially in younger children

✗ Misconceptions:

Statement	Verdict
Aggression is core symptom	✗ Not core; may co-occur
More common in girls	✗ More common in boys
High concentration is typical	✗ Inattention is key issue

ASD

- Features:

• we have ① social communication deficits ⊕

② repetitive behaviors

• More common in Males

• Language delay is a poor prognostic factor

• Dx usually before age 3

• Associated sign: fixation on routines, poor eye contact, regression of milestones, repetitive movements

① → what are the changes that may be seen when he becomes an adult? intellectual dysfunction and language impairment

• Tx: alpha-2 agonist (clonidine / guanfacine) / behavioral therapy / ...

* but there is no curative treatment for autism *

* Note → Fragile X syndrome = most common known single gene cause of ASD

Elimination disorders

Enuresis

- Involuntary urination **beyond age 5**
- Nocturnal enuresis (during sleep) : more common in boys
- Diurnal enuresis (waking hours) : more common in girls
- Tx :
 - Behavioral therapy = mainstay (e.g., bell and pad, star charts)
 - pharmacologic : imipramine , desmopressin (TCA)

✗ Myths:

Myth	Truth
More common in girls	✗ Boys are more affected
Behavioral therapy is ineffective	✗ First-line treatment
Abnormal if it occurs after age 3	✗ Diagnosis after age 5

Tic disorders

- Tics : sudden, rapid , recurrent movements or vocalizations < motor tics
vocal tics
- Tourette's : both motor + vocal tics for > 1 year ; onset before age 18
- Associated with OCD & ADHD

- Tx :

- Habit reversal therapy

Antipsychotics (e.g., risperidone)

Alpha-2-agonists (e.g., clonidine , guanfacine)

Disruptive & conduct disorders

- * ODD → Defiant , angry , argumentative with authority بس ما بأذي اي
حواليه او الحيوانات
- * CD → violates rights of others , aggressions , stealing

ODD → conduct → Antisocial
موديناً موديناً
50%

* Somatic symptoms, conversion, and factitious disorders

◆ Somatic Symptom Disorder (SSD)

✓ Features:

- Multiple physical complaints without an organic basis, causing distress or impairment.
- Often involve more than one organ system (e.g. GI, musculoskeletal).
- Symptoms are not intentionally produced.
- Duration ≥ 6 months.

✗ Misconceptions:

Claim	Verdict
Symptoms are faked	✗ Involuntary and unconscious process
Always one symptom	✗ Often multi-system
Always short-term	✗ ≥ 6 months for diagnosis

◆ Conversion Disorder (Functional Neurological Symptom Disorder)

✓ Features:

- Sudden onset of neurological symptoms (e.g., paralysis, blindness) with no medical cause.
- Often follow a psychological conflict or stressor.
- Patients may show la belle indifférence (surprising lack of concern).
- Gain: typically primary (internal psychological relief).

✓ Key Point:

- It is classified as a somatoform disorder, not a factitious disorder or malingering.

✗ Misconceptions:

Myth	Truth
Symptoms are faked	✗ They are unconsciously produced
Always chronic	✗ May resolve when the conflict is resolved
Always concerned	✗ Often indifferent to symptoms


KEY FACT

Munchausen syndrome is another, older name for factitious disorder with predominantly physical complaints. Münchhausen syndrome by proxy is intentionally producing symptoms in someone else who is under one's care (usually one's child).

◆ Factitious Disorder (e.g., Munchausen Syndrome)

✓ Features:

- Intentional production of symptoms without external reward.
- Motivation is to assume the sick role.
- Subtype: Munchausen by proxy – caregiver causes illness in another (usually a child).

Factitious Disorder
 Patients with factitious disorder intentionally falsify medical or psychological signs or symptoms in order to assume the role of a sick patient. They often do this in a way that can cause legitimate danger (central line infections, insulin injections, etc.). The absence of external rewards is a prominent feature of this disorder.

✗ Distinction Table:

Disorder	Intention	Awareness	External Incentive
Somatization	✗	✗	✗
Conversion	✗	✗	✗
Factitious	✓	✓	✗
Malingering	✓	✓	✓ (e.g. money, shelter)


WARDS QUESTION

Q: Are patients with conversion disorder consciously faking their symptoms?

A: No. Patients with conversion disorder unconsciously produce symptoms, and cannot control when they occur. Symptoms may persist even after they become aware of their conversion disorder.

◇ Malingering

Malingering involves the intentional reporting of physical or psychological symptoms in order **to achieve secondary (external) gain**. Common external motivations include avoiding incarceration, receiving room and board, obtaining narcotics, and receiving monetary compensation. Note that malingering is **not** considered a psychiatric condition.



KEY FACT

Malingering is the *conscious* feigning of symptoms for some secondary gain (e.g., monetary compensation or avoiding incarceration).

◆ Somatic Symptom vs Illness Anxiety Disorder

Feature	Somatic Symptom Disorder	Illness Anxiety Disorder
Somatic symptoms	Present and distressing	Mild or absent
Focus	Symptoms	Fear of illness
Duration	≥6 months	≥6 months
Reassurance	Doesn't help	Doesn't help

* Eating disorders

1) Anorexia Nervosa

KEY FACT

Classic example of anorexia nervosa:
An extremely thin teenage girl with amenorrhea, whose mother says she eats very little, does aerobic exercise for 2 hours a day, and *ritualistically* performs 400 sit-ups every day (500 if she has "overeaten").

- Core features :

Intense fear of gaining weight - **despite being underweight** -

Body image disturbance : sees self as overweight even when emaciated

May exhibit: a) restrictive type (calorie restriction)

b) binge-purge type

* **binge eating**: excessive food intake within a 2-hour period accompanied by a sense of lack of control

- Clinical signs :

Low BMI (< 17.5), may drop $> 15\%$ below ideal weight

Amenorrhea, bradycardia, hypotension, general weakness

vomiting may occur but not always

low self-esteem, perfectionism, parental conflict are common

Denial of seriousness is typical يعني ما يتوفا نفسي وزنهم
او صغف تقدر يتحكم مشكلة خطيرة

- Labs & complications:

Electrolyte imbalance, especially $\downarrow K^+$ if purging

Osteoporosis, Lanugo, dry skin, hypothermia, leukopenia

Endocrine: $\downarrow$ FSH, LH, estrogen, functional hypothalamic amenorrhea

Sudden cardiac death due to arrhythmia is a risk

✗ Common Misconceptions

Myth	Truth
Loss of appetite is defining	✗ Appetite may remain; refusal is psychological يعني المريض ممكن يتسمر بالاكل بس ما ياكل لأسباب نفسية
High BP is common	✗ Typically hypotensive سبب ضغط المنخفض
BMI >20 rules it out	✗ Most have BMI <17.5
Concerned about weight loss	✗ Often deny illness; see thinness as goal على العكس المريض يتكبر خطورة وزنه المنخفض ويجعل الخسارة هدف من أهدافه

! Poor Prognostic Factors:

- Vomiting
- Binge/purge behavior
- Early age of onset with severe restriction
- Family dysfunction

- Tx : CBT + Family therapy / SSRI not affective
(cognitive behavioral therapy)

2) Bulimia Nervosa

KEY FACT

Classic example of bulimia nervosa: A 20-year-old college student is referred by her dentist because of multiple dental caries. She is normal weight for her height but feels that "she needs to lose 15 pounds." She reluctantly admits to eating large quantities of food in a short period of time and then inducing vomiting.

- core features:

- Recurrent binge eating, followed by inappropriate behavior; **vomitting, laxatives, diuretics, fasting, excessive exercise**
- Patients are distressed by behavior, often feel out of control
- Typically maintain normal or slightly overweight BMI **نقطة**

- physical signs:

Russell's sign → **calluses on knuckles from inducing vomiting**



parotid gland swelling

Dental erosion (acid from vomiting)

Electrolyte disturbances: $\downarrow K^+$, metabolic alkalosis

 **WARDS QUESTION**

Q: What is a potentially lethal complication of both anorexia nervosa and bulimia nervosa?

A: Cardiac arrhythmias due to electrolyte disturbances such as hypokalemia.

- Psychological profile

★ More insight than anorexia

★ High comorbidity with depression, substance use

★ Impulsivity more common than anorexia

- Tx:

- First line CBT
- SSRIs (**fluoxetine**) are effective even without comorbid depression

 **WARDS QUESTION**

Q: What is the only FDA-approved medication for the treatment of bulimia?

A: **Fluoxetine.**

◆ Distinction Table

Key Differences: Anorexia vs. Bulimia		
	Anorexia Nervosa	Bulimia Nervosa
Main concern	Concern about body weight with intense fear of gaining weight	Concern about body weight
Eating behavior	Avoids eating (restricting), $\pm$ purging	Binge eating with compensatory behavior (purging, exercise)
Weight	Underweight	Normal weight/Overweight
Medical complications	Nutritional deficiencies Hypotension	Nutritional deficiencies Russel's sign Dental/esophageal problems

Feature	Anorexia Nervosa	Bulimia Nervosa
Body weight	Significantly underweight	Normal/slightly overweight
Insight	Often poor	Usually preserved
Amenorrhea	Common	Rare
Vomiting	May be present (binge-purge type)	Present
Electrolytes	$\downarrow K^+$, metabolic alkalosis	$\downarrow K^+$, metabolic alkalosis
Personality traits	Perfectionistic, rigid	Impulsive, emotional
Treatment	Nutritional rehab, CBT, may need hospitalization	CBT + SSRIs (e.g. fluoxetine)

KEY FACT

Compared to patients with bulimia nervosa, cortisol is often increased in patients with anorexia nervosa.

* Note →

WARDS QUESTION

Q: What are the core differences between anorexia and bulimia?

A: Anorexia is marked by *low body weight* and restriction of caloric intake, while bulimia is marked by *normal (or over) body weight*.

+ their symptoms are more ego-dystonic (distressing); they are therefore more likely to seek help



KEY FACT

Anorexia nervosa versus major depressive disorder: Appetite
Anorexia nervosa: Patients have a *good appetite* but starve themselves due to distorted body image. They are often quite preoccupied with food (e.g., preparing it for others) but do not eat it themselves.

Major depressive disorder: Patients usually have *poor appetite*, which leads to weight loss. These patients have no or decreased interest in food.



KEY FACT

Refeeding syndrome refers to dangerous electrolyte and fluid shifts that occur when severely malnourished patients are refeed too quickly. Look for fluid retention and decreased levels of phosphorus, magnesium, and calcium. Complications include arrhythmias, respiratory failure, delirium, and seizures. Manage by replacing electrolytes and slowing the feedings.

3) Binge eating disorder

- Core features:

Recurrent episodes of excessive food intake,

Without compensatory behaviors (e.g., purging, vomiting)

[so they don't try to control their weight by purging or restricting calories]

Eating rapidly, until uncomfortably full, often when not hungry

Associated with distress, shame, obesity

Not as fixated on their body shape & weight

* being overweight/obese is common but Not part of diagnostic criteria ✓

-Tx:

CBT

SSRI

Lisdexamfetamine, topiramate (FDA-approved meds)

SSRI



Distinctions:

Feature	Bulimia	Binge Eating Disorder
Purging	Present	✗ Absent
Weight	Normal	Often overweight/obese
Insight	Present	Present
Guilt	Present	Present

* Sleep disorders

→ Normal sleep cycle:

The 2 stages of normal sleep are: REM & NREM

About every 90 min, NREM sleep alternates with REM sleep

NREM induces transition from the waking state to deep sleep

In REM sleep, brain wave patterns resemble the EEG of an aroused person + $\uparrow$ BP, HR, RR

Awakening from REM sleep is associated with vivid dream recall

 **KEY FACT**

As one ages there are the following changes that occur in the sleep pattern:

- Increase in time it takes to fall asleep, known as sleep latency
- Decline in total amount of REM sleep achieved
- Increase in sleep fragmentation with more frequent nighttime awakening

→ sleep disorders $\left\{ \begin{array}{l} \text{Dyssomnias} \text{ (insomnia, hypersomnia, or altered timing of sleep)} \\ \text{Parasomnias (unusual sleep-related behaviors)} \end{array} \right.$

□ Dyssomnias

- Insomnia disorder $\left\{ \begin{array}{l} \text{Acute} < 3 \text{ months} \\ \text{chronic} \geq 3 \text{ months} \end{array} \right.$

- Difficulty initiating sleep (*initial or sleep-onset insomnia*).
- Difficulty maintaining sleep (*middle or sleep-maintenance insomnia*).
- Early morning awakenings (*late or sleep-offset insomnia*).
- Waking up feeling fatigued and unrefreshed (*nonrestorative sleep*).

- Tx:

sleep hygiene measures

CBT

Benzo / non-Benzo / Antidepressants
↳ (trazodone)

 **WARDS QUESTION**

Q: What is the most common antidepressant prescribed for chronic insomnia?

A: Trazodone.

- hypersomnolence disorder

DSM-5 Criteria

- Excessive sleepiness despite at least 7 hours of sleep, with at least one of the following: recurrent periods of sleep within the same day; prolonged, nonrestorative sleep more than 9 hours; difficulty being fully awake after awakening.
- Occurs at least three times per week for at least 3 months.
- Causes clinically significant distress or impairment in functioning.
- Does not occur exclusively during the course of another sleep-wake disorder.
- Not due to the physiologic effects of a substance or medication.
- Coexisting mental and medical disorders do not adequately explain the hypersomnolence.

- OSA

Chronic breathing-related disorder characterized by repetitive collapse of the upper airway during sleep and evidence by polysomnography of multiple episodes of apnea or hypopnea per hour of sleep.

Features

- Excessive daytime sleepiness.
- Apneic episodes characterized by cessation of breathing or hypopneic episodes of reduced airflow (more than 15 per hour).
- Sleep fragmentation.
- Snoring.
- Frequent awakenings due to gasping or choking.
- Nonrefreshing sleep or fatigue.
- Morning headaches.
- Hypertension.

Risk Factors

Obesity, increased neck circumference, airway narrowing.

Treatment

- Positive airway pressure: Continuous (CPAP) and in some cases bilevel (BiPAP).
- Behavioral strategies such as weight loss and exercise.
- Surgery, including tonsillectomy and selective upper airway stimulation implants.

- Central sleep apnea
- Sleep related hypoventilation
- ~~Narcolepsy~~ (sudden sleep attacks, cataplexy, in REM)

Narcolepsy is characterized by excessive daytime sleepiness and falling asleep at inappropriate times.

DSM-5 Criteria

- Recurrent episodes of need to sleep, lapsing into sleep, or napping during the day, occurring at least three times per week for at least 3 months associated with at least one of the following:
 - Cataplexy (brief episodes of sudden bilateral loss of muscle tone, most often associated with intense emotion).
 - Hypocretin deficiency in the CSF.
 - Reduced REM sleep latency on polysomnography.
- Hallucinations and/or sleep paralysis at the beginning or end of sleep episodes are common (but not necessary for diagnosis in the DSM-5).



KEY FACT

Hypnagogic hallucination: When going to sleep.
 Hyponompic hallucination: When transitioning from sleep.

Q) What study is useful in diagnosing narcolepsy?

Polysomnography ✓

- Circadian rhythm sleep-wake disorder
 - Delayed sleep phase disorder
 - Advance sleep phase disorder (older age)
 - shift-work disorder
 - Jet lag disorder

Disorders	Definitions	Risk Factors	Treatments
Delayed sleep phase disorder (DSPD)	Chronic or recurrent delay in sleep onset and awakening times with preserved quality and duration of sleep	■ Puberty (secondary to temporal changes in melatonin secretion) ■ Caffeine and nicotine use ■ Irregular sleep schedules	■ Timed bright light phototherapy during early morning ■ Administration of melatonin in the evening & Zolpidem ■ Chronotherapy (delaying bedtime by a few hours each night)
Advanced sleep phase disorder	Normal duration and quality of sleep with sleep onset and awakening times earlier than desired	Older age	■ Timed bright light phototherapy prior to bedtime ■ Early morning melatonin not recommended (may cause daytime sedation)
Shift-work disorder (SWD)	Sleep deprivation and misalignment of the circadian rhythm secondary to nontraditional work hours	■ Night shift work ■ Rotating shifts ■ Shifts >16 hours ■ Medical and psychiatry residents	■ Avoid risk factors ■ Bright light phototherapy to facilitate rapid adaptation to night shift ■ Modafinil may be helpful for patients with severe SWD
Jet lag disorder	Sleep disturbances (insomnia, hypersomnia) associated with travel across multiple time zones	Recent sleep deprivation	■ Disorder is usually self-limiting ■ Sleep disturbances generally resolve 2–3 days after travel

2] parasomnias

- Abnormal behaviors, experiences, or physiological events that occur during sleep or sleep-wake transitions.
- Symptoms may include abnormal movements, emotions, dreams, and autonomic activity.
- Isolated episodes common in childhood and adolescence.
- Include non-REM sleep arousal disorders, nightmare disorder, REM sleep behavior disorder, restless leg syndrome.

- Non-REM sleep arousal disorder
- sleepwalking (Ambulation, unresponsive, in NREM)
- sleep terrors (Screaming, no memory, In NREM)
- Nightmare disorder (Frightening dream, remembered / in REM)
- REM sleep behavior disorder (aggressive violent behavior) (NCDs with Lewy bodies commonly associated with REM sleep behavior disorder)
- Restless leg syndrome
- ↳ serum ferritin must be tested in a person diagnosed with restless leg syndrome
- Substance/Medication-induced sleep disorder

◆ Sleep in Depression

Change	Observation
REM latency	↓ shortened
Total REM	↑ increased
Early morning awakening	Common
Stage 4 sleep	↓ decreased

في بعض الحالات يمكن المريض
يواجه difficulty falling
asleep

↓
↑ REM latency

* Sexual & Gender disorders

◆ Gender Dysphoria

- Strong desire to be of another gender, mismatch between experienced and assigned gender.
- Gender identity is established by age 3.
- Treatment includes psychotherapy, hormonal, and surgical options in adulthood.
- Common in Western cultures.

◆ Sexual Dysfunctions

Dysfunction	Definition
Dyspareunia	Painful intercourse
Vaginismus	Involuntary contraction of vaginal muscles <i>that prevents penetration</i>
Impotence	Erectile dysfunction
Dysorgasmia	Painful or unsatisfying orgasm

- Treated with psychotherapy, SSRI (e.g. for premature ejaculation), or medical interventions.

◆ Paraphilic Disorders *(Atypical sexual interests that cause distress or harm)*

Disorder	Feature
Voyeurism	<i>sexual arousal from</i> Watching others undress/have sex
Exhibitionism	<i>sexual arousal from</i> Exposing genitals <i>to strangers</i>
Fetishism	Sexual focus on non-living objects
Pedophilia	Sexual focus on children
<u>Sadism</u> / <u>Masochism</u>	Pleasure from <u>inflicting</u> / <u>receiving</u> pain

Frotteuristic *Sexual arousal from touching or rubbing against a nonconsenting person*

Transvestic *Sexual arousal from cross-dressing*

✗ Note:

- Pedophilia, voyeurism, sadism = paraphilias
- Vaginismus, dyspareunia = sexual dysfunctions (not paraphilias)

Psychotherapies

◆ Types of Therapy

Therapy	Description	Indications
Cognitive Behavioral Therapy (CBT)	Restructures negative thinking and maladaptive behavior	Depression, anxiety, OCD, PTSD
Behavior Therapy	Modifies behavior through conditioning	Phobias, ADHD, OCD
Exposure & Response Prevention (ERP)	Type of CBT used in OCD	Prevents compulsions after triggering obsessions
Systematic Desensitization	Gradual exposure + relaxation	Phobias
Flooding	Immediate, intense exposure	Phobias (rarely used)
Modeling	Learning through observation	Social skills, phobias
Dialectical Behavior Therapy (DBT)	Specialized for borderline PD	Reduces self-harm, improves emotional regulation

CBT & Family therapy

Anorexia nervosa

◆ Other Therapies

Therapy	Use
Psychoanalysis	Insight-oriented therapy exploring unconscious conflicts
Client-centered (Rogerian)	Non-directive, emphasizes empathy and unconditional positive regard
Hypnotherapy	Used for habit disorders, trauma
Interpersonal Therapy	Focuses on current relationship issues (used in depression)

Key Notes

- CBT is effective for:
 - Depression
 - Anxiety disorders
 - OCD
 - PTSD
 - Panic disorder
 -  Not effective for paranoid schizophrenia or catatonia
- ERP is first-line non-pharmacologic treatment for OCD.
- DBT is the only psychotherapy shown to reduce suicidal behavior in borderline personality disorder.



◆ ECT (Electroconvulsive Therapy)



Indications: (If patient is unresponsive to pharmacotherapy, if patient cannot tolerate pharmacotherapy (e.g., pregnancy), or if rapid reduction of symptoms is desired (e.g., immediate suicide risk/refusal to eat or drink/catatonia))

- Severe depression with suicidality
- Catatonia
- Mania
- Treatment-resistant schizophrenia



Safe in:

- Pregnancy (relative safety)
 - Elderly
- * Primary risk is from anesthesia ✓



Contraindications:

Absolute	Relative
Recent MI	Raised ICP
Brain tumor	High anesthetic risk



Side Effects:

Effect	Explanation
Amnesia (retro & anterograde)	Most common, usually short-term (resolve within 6 months)
Headache, confusion nausea, muscle soreness	Early side effects
No amenorrhea	✗ Not a typical side effect

* Note →

- Seizure should last between 30 & 60 sec, and no longer than 90 sec
- 6-12 treatments are administered over 2-3 week period
70-120 volts

* What drug should be withheld 1 day before doing ECT? Benzo

◆ Common Confusions

Pair	Distinction
OCD vs OCPD	Ego-dystonic vs ego-syntonic
Bipolar vs Borderline PD	Episode duration vs rapid mood shifts
Delirium vs Dementia	Acute & fluctuating vs chronic & progressive
Somatization vs Factitious	Unintentional vs intentional without gain
Factitious vs Malingering	Internal psychological vs external reward

The End
GOOD LUCK ☺
Done by : Rama Elayyan

* Tx summary →

[1] schizophrenia

Typical antipsychotics

Atypical antipsychotics

Behavioral therapy / Family therapy /
group therapy

[2] MDD

→ MDD:

Antidepressants + psychotherapy (CBT / interpersonal psychotherapy)

→ MDD with psychotic features:

Antidepressants + 2nd gen antipsychotics

or ECT

[3] Bipolar

Mood stabilizer:

Lithium / valproic acid / carbamazepine / lamotrigine / Topiramate

2nd gen antipsychotics (for bipolar I)

Antidepressants (for depressive episodes)

↳ but combine them with mood stabilizer

Antidepressants are discouraged as monotherapy!
because they can induce mania or hypomania

[4] pDD

psychotherapy: cognitive therapy / interpersonal therapy /
insight-oriented psychotherapy

pharmacotherapy → SSRI / SNRI / ...

[5] Cyclothymic disorder
Mood stabilizer

[6] Suicide

The only antipsychotic that decreases risk of suicide → Clozapine (atypical)

The only mood stabilizer that decreases risk of suicide → Lithium

[7] GAD

CBT, SSRI or SNRI, benzo for short term or
augmentation with buspirone (non-benzo anxiolytic)

[8] Panic disorder

CBT, SSRI or SNRI, benzo for short term

* Long-term BZD discouraged, why?

because of dependence / tolerance / withdrawal

[9] Panic attack & performance anxiety - public speaking

BB

[10] Agoraphobia

CBT & SSRI

III Social anxiety

SSRI & BZD

BB

[12] specific phobia
CBT with exposure

[13] OCD
CBT with ERP (Exposure & Response prevention)
SSRI (Fluvoxamine)
TCA (clomipramine)

[14] PTSD
SSRI
 α_1 -receptor antagonist: prazosin for nightmares
CBT (exposure therapy / cognitive processing therapy)

[15] Adjustment disorder
supportive psychotherapy
group therapy

[16] Antisocial PD
mood stabilizer
SSRI
anti-psychotics

[17] Alcohol intoxication :
ABC / thiamine / glucose / folate / supportive care / correct electrolytes / acid-base status

Alcohol withdrawal :
Benzo / correct electrolytes / give thiamine / glucose / folate / multivitamin (banana bag)

Alcohol use disorder :

Nalotrexone / acamposate / disulfiram / topiramate

[18] Wernicke's encephalopathy (confusion / ataxia / ophthalmologic abnormalities (nystagmus / gaze paresis))
thiamine

[19] Alcoholic Ketoacidosis
IV fluids + correct electrolytes

[20] Cocaine intoxication :
mild - to - moderate agitation / anxiety → reassurance + BZD
severe agitation → antipsychotics
symptomatic support → control HTN / arrhythmia / hyperthermia

Cocaine withdrawal :
supportive

Cocaine use disorder :
- No FDA - approved
- psychological interventions (contingency management, relapses prevention, ...) are the main stay of Tx
- off-label meds : nalotrexone + topiramate

Note : Don't give BB for patients who regularly use cocaine

(because unopposed alpha-adrenergic activity can cause coronary vasoconstriction and induce MI)

[21] PCP withdrawal

Monitor vitals / minimize sensory stimulation / benzo / antipsychotics

[22] Sedative-hypnotics intoxication

ABC / activated charcoal & gastric lavage / supportive care

- For barbiturates: Alkalinize urine with sodium bicarbonate to promote renal excretion
- For BZO: Flumazenil

[23] Sedative-hypnotics withdrawal: benzo

[24] Opioids intoxication

ABC + naloxone + ...

[25] Opioid use disorder

Methadone / buprenorphine /
naltrexone / naloxone

[26] Hallucinogens intoxication

reassurance / benzo

[27] Nicotine

patches

Bupropion

venicline

[28] Delirium

نقطة **Treat the underlying cause**

Supportive care; reorientation, reduce stimuli, optimize sleep

Low dose haloperidol if severe agitation (D₂ antagonist - antipsychotic)

* Avoid benzo (except in alcohol or benzo withdrawal), why?
as they may worsen delirium by causing paradoxical
disinhibition or over-sedation

[29] ADHD

1st line → CNS stimulants (methylphenidate, ^{dextro}amphetamine)

2nd line → * alpha-2-agonist (clonidine, guanfacine)

* Norepinephrine reuptake inhibitor (atomoxetine)

+ Behavioural therapy, especially in younger children

[30] ASD

alpha-2 agonist (clonidine / guanfacine) /
behavioral therapy / ...

* but there is no curative treatment for autism *

[31] Enuresis

- Behavioral therapy = mainstay (e.g., bell and pad, star charts)

- pharmacologic: imipramine, desmopressin
(TCA)

[32] Tic disorder

- Habit reversal therapy

Antipsychotics (e.g., risperidone)

Alpha-2-agonists (e.g., clonidine, guanfacine)

[33] Anorexia nervosa

CBT + Family therapy

SSRI are not effective

[34] Bulimia nervosa

CBT

SSRI (Fluoxetine)

[35] Binge-eating

CBT

SSRI

Lisdexamfetamine / topiramate / SSRI

[36] Insomnia

sleep hygiene

CBT

Benzo / non-benzo / antidepressant
Zolpidem

trazodone

[37] Narcolepsy

Modafinil

Armodafinil

+ for cataplexy:

Na oxybate or antidepressants

sudden brief bilateral
loss of muscle
tone

[38] Serotonin syndrome (myoclonic jerk / hyperreflexia / confusion / flushing)
stop medication
supportive care
cyproheptadine
ECT

- To switch from SSRI to MAO → wait 2 weeks
- But fluoxetine → wait 5-6 weeks!

[39] Hypertensive crisis (HTN / N&V / tachycardia / sweating / photophobia)
IV phentolamine
sublingual nifedipine
MAO + tyramine rich food

[40] EPS
Acute dystonia: diphenhydramine + benztropine
parkinsonism + dystonia: benztropine
akathisia: BB propranolol

[41] NMS (Neuroleptic Malignant syndrome)

stop drug
hydration
cooling
Sodium dantrolene
bromocriptine
amantadine
ECT

FALTERED

Fever
Autoimmune instability
Leukocytosis
Tremor
Elevated CPK
Rigidity (lead pipe)
Excessive sweating
Delirium
Hyporeflexia

[42] Fluoxetine
longest half-life
wt neutral
bulimia nervosa

[43] seratine
wt neutral

[44] paroxetine
wt gain

[45] Fluvoxamine
in OCD

[46] SNRI
venlafaxine → watch BP
Duloxetine → watch liver

[47] Bupropion (miscellaneous)
ADHD
smoking cessation
No sexual dysfunction
contraindicated in epilepsy

[48] trazodone (miscellaneous)
given with SSRI to improve
insomnia

TCA:
[49] Amitriptyline → migraine
imipramine → enuresis

[50] catatonia

IV lorazepam or ECT for refractory cases

OT → supportive + benzo
Catatonia → IV lorazepam

[51] chlorpromazine

loxapine
haloperidol

clozapine	↓ suicide refractory schizophrenic
risperidone	hyperprolactinemia
aripiprazole	partial D ₂ agonist
olanzapine	

The End

