Disorder / Episode	Diagnostic criteria : Symptoms / Duration
Mixed features (Irritable mood & valproic acid)	Mania or hypomania + 3 symptoms of MDE – ≥ 1 week
MDE : Major depressive episode	At least 5 of SIG E CAPS / 2 weeks (Depressed mood and/or anhedonia should exist.)
Manic Episode	At least 3 of DIGFAST / at least 1 week (Dx needs hospitilization or impaired functions.)
Hypomanic Episode	At least 3 of DIGFAST / at least 4 consecutive days
Major depressive disorder (MDD)	At least one MDE + no hypomanic or manic.
Bipolar I (Manic - Depression)	Manic episode ± major depressive episode / hypomanic episode.
Bipolar II (can be misdiagnosed with unipolar depression)	(one or more) Recurrent major depressive episodes + Hypomania (At least 1)
Rapid cycling	4 mood episodes within 1 year at least.
• Bipolar has poorer prognosis than MDD	• Most common psychiatric disorders (1. phobias, 2. substance abuse)
• Bipolar I has the highest genetic links.	2. phobias
• Most common subtype of depression : Atypical	
• Most common form of psychopathology : Anxiety disorders	
Persistent Depressive Disorder (Dysthmia)	Chronic symptoms / major episodes for at least 2 years without 2 months of symptoms free. (children (while adults 1 year))
Pre menstrual dysmorphic disorder	At least 5 symptoms / for 1 week before menses relieved the first days of menses Minimal/absent after 1 week menses
Selective Mutism (at childhood)	Normal comprehension and language ; But there's failure to speak in specific situations for ≥ 1 month. • associated with social anxiety. Beyond school.
Separation anxiety disorder	1 month or 1.5 month (children / adults)

1 y.o children
and peaks on 1.5 years old.

excessive and developmentally inappropriate
fear / anxiety of seperation from attachment figures
+ at least 3 symptoms:

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

GAD Generalized anxiety disorder median age = 30.

persistent, excessive anxiety about ≥ 6 months
everything and daily life activities
control is lost + ≥ 3 symptoms ↓

Associated ≥3 symptoms: restlessness, fatigue, impaired concentration, irritability, muscle tension, insomnia. sweating ↓ ↓

You can say they're same as ADHD but no.

OCD Obsessive-Compulsive Disorder ego-dystonic

Can come with anxiety, depression, Bipolar, CCPD, tic disorders
ego-syntonic

Obsessions and
compulsions that
are time consuming. / Debilitating or distressing.
ego-dystonic

Post traumatic stress disorder (PTSD)

- At least two of the following negative cognitions/mood: dissociative amnesia, negative feelings of self/others/world, self-blame, negative emotions (e.g., fear, horror, anger, guilt), anhedonia, feelings of detachment/estrangement, inability to experience positive emotions.
- At least two of the following symptoms of increased arousal/reactivity: hypervigilance, exaggerated startle response, irritability/angry outbursts, impaired concentration, insomnia.

post trauma (any time); symptoms ≥ 1 month

TRAUMA criteria
- traumatic event
- reexperience (nightmares, flashbacks)
- avoidance
- unable to function
- month of symptoms
- arousal increased

- at least 2 cognition/mood symptoms.
- at least 2 increased arousal symptoms.

Acute stress disorder

post trauma < 1 month; symptoms < 1 month.

Substance use disorders

2 at least of ↓ for 12 months or more.

- Using substance more than originally intended.
- Persistent desire or unsuccessful efforts to cut down on use.
- Significant time spent in obtaining, using, or recovering from substance.
- Craving to use substance.
- Failure to fulfill obligations at work, school, or home.
- Continued use despite social or interpersonal problems due to the substance use.
- Limiting social, occupational, or recreational activities because of substance use.
- Use in dangerous situations (e.g., driving a car).
- Continued use despite subsequent physical or psychological problem (e.g., drinking alcohol despite worsening liver problems).
- Tolerance (needing higher amounts of the substance to achieve the desired effect or experiencing diminished effects when repeating the same dose).
- Withdrawal (a substance-specific syndrome occurring when a patient stops or reduces heavy/prolonged substance use).

Panic Disorder
Da PANICS

Chronic course waxing + waning.
Depression in 65%.
Relapses when meds are stopped.
Remission is not that much.

① Recurrent, unexpected (sudden) + ② without identifiable trigger.
③ One or more panic attacks + ④ ≥ 1 month of fearing
to experience another
attacks or their consequences
and/or maladaptive behaviors avoidance

fear of the fear
debilitating anticipatory anxiety about having future attacks

Agoraphobia

6 months
2 situations

Intense fear/Anxiety in being in public places where escape or obtaining help is not possible, ~~6 months~~
in two situations of those at least:
- Outside of the home alone.
- Open spaces (e.g., bridges).
- Enclosed places (e.g., stores).
- Public transportation (e.g., trains).
- Crowds/lines.

• associated with panic disorder.

Specific phobias

1. Persistent excessive phobia. 2. Triggered. 3. Avoidance + tolerance
4. ≥ 6 months.

Social anxiety disorder (Social phobia)

- Speak, eat and pee outside — Cannot
- ~~fear~~ of fear or anxiety of scrutiny by others or being embarrassed or humiliated in front of people

Adjustment disorder

Emotional and behavioral symptoms post exposure to non-lifethreatening events, or unsuccessful events.
Symptoms develop within 3 months, end within 6 months
psychotherapy
not as bereavement

Either
- Excessive distress.
- Impaired functioning significantly.

WARDS TIP

The 5 A's of schizophrenia (negative symptoms):
1. Anhedonia
2. Affect (flat)
3. Alogia (poverty of speech)
4. Avolition (apathy)
5. Attention (poor)

DIAGNOSIS OF SCHIZOPHRENIA

DSM-5 Criteria

- *Two or more* of the following must be present for at least *1 month*:
  1. Delusions.
  2. Hallucinations.
  3. Disorganized speech.
  4. Grossly disorganized or catatonic behavior.
  5. Negative symptoms.

  Note: At least one must be **1**, **2**, or **3**.
- Must cause significant social, occupational, or functional (self-care) deterioration.

Or hospitalization

illness stays for 6 months duration or more.

- DDx for psychosis?
  - Delirium/Major neurocognitive disorder (dementia).
  - Bipolar disorder, manic/mixed episode.
  - Major depression with psychotic features.
  - Brief psychotic disorder. Acute Psychosis.
  - Schizophrenia.
  - Schizophreniform disorder.
  - Schizoaffective disorder.
  - Delusional disorder.

1 month
1 month 6 months
Confirm which ones?

- > 3 outbursts/week
- 1 year — 3 months — non-negative
- at least two settings
- < 10 yo — symptoms may start then.

DMDD
Disruptive Mood Dysregulation Disorder.

Anorexia nervosa

1- Excessive low energy intake.
2- Persistent fear of gaining weight.
3- Disturbed body image.

Bulimia Nervosa

Bing eating + inappropriate compensation at least once a week for 3 months ≈ 12 times

Binge eating

Excessive food intake for 2 hours duration + sense of lack of control.

Binge eating disorder

Excessive ----
once a week for 3 months (at least).
Distress about their binge eating not their weight
- 3 of these at least: ① Rapid eating
② Uncomfortable fullness.
③ post eating guilt.
④ When not hungry
⑤ Eating alone

Anorexia nervosa
thin
See themselves fat
compensatory behaviors

Bulimia nervosa
normal or over weight
see themselves fat
still binge eat
compensatory behaviors
feel guilt about their binge eating + weight.

Binge eating disorder
obese
don't have problem + weight
still binge eat
no compensatory behaviors
feel embarrassed about their binge eating.

Tx: Food | Antidepressants SSRI (Fluoxetine) | SSRIs.

Watch out from bupropion (bc it decreases the threshold for seizures).

Antidepressant Use in Other Disorders

- OCD: SSRIs (in high doses), TCAs (clomipramine).
- Panic disorder: SSRIs, SNRIs, TCAs, MAOIs.
- Eating disorders: SSRIs (in high doses), TCAs.
- Persistent depressive disorder (dysthymia): SSRIs, SNRIs (e.g., venlafaxine, duloxetine).
- Social anxiety disorder (social phobia): SSRIs, SNRIs, MAOIs.
- GAD: SSRIs, SNRIs (venlafaxine), TCAs.
- Posttraumatic stress disorder: SSRIs.
- Irritable bowel syndrome: SSRIs, TCAs.
- Enuresis: TCAs (imipramine).
- Neuropathic pain: TCAs (amitriptyline and nortriptyline), SNRIs.
- Chronic pain: SNRIs, TCAs.
- Fibromyalgia: SNRIs.
- Migraine headaches: TCAs (amitriptyline).
- Smoking cessation: Bupropion.
- Premenstrual dysphoric disorder: SSRIs.
- Insomnia: Mirtazapine, trazodone, TCAs (doxepin).

- Disorders with strong genetic links :-
  - OCD.
  - Schizophrenia.
  - Bipolar I (Manic-depression).
  - Hoarding disorder.
  - Panic disorder.
  - Agoraphobia. (strong genetic factor)
  - GAD
  - OCD

- Schizophrenia → Antipsychotics
  - Parkinsonism + Prolactinemia
    - Anticholinergics
    - Symptoms treatment
  - NMS : Neuroleptic malignant syndrome.

- Mood disorders → CBT
  - Antidepressants
  - Mood stabilizers (valproic acid, Lithium.)
  - Antipsychotics

* MDD → Antidepressants
  - Atypical Antipsychotics
  - CBT
  - ECT (Refractory)
  - MDD with psychosis
  - MDD without psychosis but refractory to anti depressants.

* Bipolar → Lithium, Carbamazepine, valproic acid (Mood stabilizers)
  - Atypical Antipsychotics (Alone or adjunct)
  - ~~Antidepressants are discouraged due to activation of mania.~~
  - Psychotherapy
  - ECT (refractory depression or Acute mania).

* PDD → Psycho therapy + pharma are the best
  - Antidepressants.

- Anxiety disorders → Mild psychotherapy / Moderate-Severe (combination of psychoth- and psycho pharma)

* Panic disorder — CBT + SSRIs / SNRIs (Benzo can be given)
* Agoraphobia — = = = =
* specific phobias — CBT
* Social phobia/anxiety — CBT, SSRIs/SNRIs, Benzo, B-blockers
* PTSD — SSRIs, Prazosin, Atypical antipsychotics

Psychiatric Emergencies

Delirium Tremens (DTs): Most severe form of ethanol withdrawal.

- Typically within 2–4 days after cessation of EtOH but may occur later.
- Delirium, agitation, fever, autonomic hyperactivity, auditory and visual hallucinations. sympathetic overdrive (could lead to CVS collapse).
- Treat aggressively with benzodiazepines and hydration.

Global confusion

Neuroleptic Malignant Syndrome (NMS):

- Fever, rigidity, autonomic instability, clouding of consciousness, elevated WBC/CPK.
- Withhold neuroleptics, hydrate, consider dantrolene, and/or bromocriptine. used to treat menstrual problems in women or milk leakage in men.
- Idiosyncratic, time-limited reaction.

Differs from person to another.

- Neuroleptics = Antipsychotics that block dopamine receptors in the nervous system.

Serotonin Syndrome:

- Precipitated by use of two drugs with serotonin-enhancing properties (e.g., MAOI + SSRI).
- Altered mental status, fever, agitation, tremor, myoclonus, hyperreflexia, ataxia, incoordination, diaphoresis, shivering, diarrhea.
- Discontinue offending agents, benzodiazepines, consider cyproheptadine. antihistamine

↑serotonin

Catecholamine releasing agent

Tyramine Reaction/Hypertensive Crisis: In pickled food mostly.

- Precipitated by ingestion of tyramine-containing foods while on MAOIs.
- Hypertension, headache, neck stiffness, sweating, nausea, vomiting, visual problems. Most serious consequences are stroke and possibly death.
- Treat with nitroprusside ↓BP or phentolamine.

Why we are using antihistamines also here?

Acute Dystonia: Due to dopaminergic-cholinergic imbalance.

- Early, sudden onset of muscle spasm: eyes, tongue, jaw, neck; may lead to laryngospasm requiring intubation. ***
- Treat with benztropine (Cogentin) or diphenhydramine (Benadryl).
- If clinically appropriate, reduce the dose, discontinue the medication, or switch to another agent.

Lithium Toxicity:

- May occur at any Li level (usually >1.5).
- Nausea, vomiting, slurred speech, ataxia, incoordination, myoclonus, hyperreflexia, seizures, nephrogenic diabetes insipidus, delirium, coma.
- Discontinue Li, hydrate aggressively, consider hemodialysis.

Lithium

- Orally
- Psychiatric medication.
- Bipolar and major depressive disorders.

Tricyclic Antidepressant (TCA) Toxicity:

- Primarily anticholinergic effects, cardiac conduction disturbances, hypotension, respiratory depression, agitation, hallucinations, seizures.
- Classic ECG finding is QRS > 100 msec.
- Sodium bicarbonate, activated charcoal, cathartics, supportive treatment.
- Discontinue the medication.

Mental Status Examination

WARDS TIP

If you are seeing the patient in the ER, make sure to ask how they got to the ER (police, bus, walk-in, family member) and look to see what time they were triaged. For all initial evaluations, ask why the patient is seeking treatment ***today*** as opposed to any other day.

WARDS TIP

When taking a substance history, remember to ask about caffeine and nicotine use. If a heavy smoker is hospitalized and does not have access to nicotine replacement therapy, nicotine withdrawal may cause anxiety and agitation.

KEY FACT

Importance of asking about OTC use: Nonsteroidal anti-inflammatory drugs (NSAIDs) can ↓ lithium excretion lithium concentrations (exceptions may be sulindac and aspirin).

WARDS TIP

Alcoholic hallucinosis refers to hallucinations (usually auditory, although visual and tactile may occur) that occur either during or after a period of heavy alcohol consumption. Patients usually are aware that these hallucinations are not real. In contrast to delirium tremens (DTs), there is no clouding of sensorium and vital signs are normal.

WARDS TIP

Psychomotor retardation, which refers to the slowness of voluntary and involuntary movements, may also be referred to as hypokinesia or bradykinesia. The term akinesia is used in extreme cases where absence of movement is observed.

KEY FACT

Automatisms are spontaneous, involuntary movements that occur during an altered state of consciousness and can range from purposeful to disorganized.

WARDS TIP

A hallmark of pressured speech is that it is usually uninterruptible and the patient is compelled to continue speaking.

WARDS TIP

To assess mood, ask, "How are you feeling today?" It can also be helpful to have patients rate their stated mood on a scale of 1–10.

WARDS TIP

A patient who remains expressionless and monotone even when discussing extremely sad or happy moments in his life has a *flat* affect.

KEY FACT

An example of inappropriate affect is a patient's laughing when being told he has a serious illness.

WARDS TIP

A patient who is laughing one second and crying the next has a *labile* affect.

KEY FACT

Examples of delusions:

- *Grandeur*—belief that one has special powers or is someone important (Jesus, President).
- *Paranoid*—belief that one is being persecuted.
- *Reference*—belief that some event is uniquely related to patient (e.g., a TV show character is sending patient messages).
- *Thought broadcasting*—belief that one's thoughts can be heard by others.
- *Religious*—conventional beliefs exaggerated (e.g., God wants me to be the Messiah).
- *Somatic*—false belief concerning body image (e.g., I have cancer).

WARDS TIP

The following question can help screen for obsessions: Do you think and/or worry about checking, cleaning, or counting on a repetitive basis?

WARDS TIP

An auditory hallucination that instructs a patient to harm himself or others is an important risk factor for suicide or homicide.

KEY FACT

You can roughly assess a patient's intellectual functioning by utilizing the ***proverb interpretation*** and ***vocabulary*** strategies. Proverb interpretation is helpful in assessing whether a patient has difficulty with abstraction. Being able to define a particular vocabulary word correctly and appropriately use it in a sentence reflects a person's intellectual capacity.

In assessing suicidality, do not simply ask, "Do you want to hurt yourself?" because this does not directly address suicidality (he/she may plan on dying in a painless way). Ask directly about killing self or suicide. If contemplating suicide, ask the patient if he/she has a plan of how to do it and if he/she has intent; a detailed plan, intent, and the means to accomplish it suggest a serious threat.

WARDS TIP

To test ability to abstract, ask:

1. Similarities: How are an apple and orange alike? (Normal answer: "They are fruits." ***Concrete*** answer: "They are round.")
2. Proverb testing: What is meant by the phrase, "You can't judge a book by its cover?" (Normal answer: "You can't judge people just by how they look." ***Concrete*** answer: "Books have different covers.")

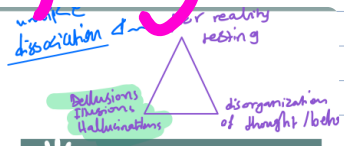
WARDS TIP

IQ Chart
Very superior: >130
Superior: 120–129
High average: 110–119
Average: 90–109
Low average: 80–89
Borderline: 70–79
Extremely low (intellectual disability): <70

KEY FACT

A prior history of violence is the most important predictor of future violence.

Psychotic Disorders



WARDS TIP

Psychosis is exemplified by delusions, hallucinations, or severe disorganization of thought/behavior.

WARDS TIP

It's important to be able to distinguish between a delusion, illusion, and hallucination. A delusion is a fixed, false belief, an illusion is a misinterpretation of an external stimulus, and a hallucination is perception in the absence of an external stimulus.

KEY FACT

Think of positive symptoms as things that are ADDED onto normal behavior. Think of negative symptoms as things that are SUBTRACTED or missing from normal behavior.

False, impossible = Bizzare

False, not true plausible. = Non-bizzare

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.

WARDS TIP

Echolalia—repeats words or phrases
EchoPRAxia—mimics behavior (PRActices behavior)

WARDS TIP

Elderly, medically ill patients who present with psychotic symptoms such as hallucinations, confusion, or paranoia should be carefully evaluated for delirium, which is a far more common finding in this population.

PPR

Record:
Delusion ✓ Illusion ✓ Hallucination ✓

WARDS TIP

To make the diagnosis of schizophrenia, a patient must have symptoms of the disease for at least 6 months. ⇐ imp

WARDS TIP

The 5 A's of schizophrenia (negative symptoms):

1. Anhedonia
2. Affect (flat)
3. Alogia (poverty of speech)
4. Avolition (apathy)
5. Attention (poor)

WARDS TIP

Auditory hallucinations that directly tell the patient to perform certain acts are called *command hallucinations.*

KEY FACT

Brief psychotic disorder lasts for <1 month. Schizophreniform disorder can last between 1 and 6 months. Schizophrenia lasts for >6 months.

KEY FACT

People born in late winter and early spring have a higher incidence of schizophrenia for unknown reasons. (One theory involves seasonal variation in viral infections, particularly second-trimester exposure to influenza virus.)

KEY FACT

Schizophrenia is found in lower socioeconomic groups likely due to "downward drift" (many patients have difficulty in holding good jobs, so they tend to drift downward socioeconomically).

KEY FACT

Akathisia is an unpleasant, subjective sense of restlessness and need to move often manifested by the inability to sit still.

KEY FACT

The lifetime prevalence of schizophrenia is 0.3–0.7%.

KEY FACT

Schizophrenia has a large genetic component. If one identical twin has schizophrenia, the risk of the other identical twin having schizophrenia is 50%. A biological child of a schizophrenic person has a higher chance of developing schizophrenia, even if adopted into a family without schizophrenia.

KEY FACT

Computed tomography (CT) and magnetic resonance imaging (M scans of patients with schizophrenia may show enlargement of the ventricles, diffuse cortical atrophy, and reduced brain volume.

KEY FACT

Schizophrenia often involves neologisms. A neologism is a newly coined word or expression that has meaning only to the person who uses it.

WARDS TIP

First-generation antipsychotic medications are referred to as typical or conventional antipsychotics (often called neuroleptics). Second-generation antipsychotic medications are referred to as atypical antipsychotics.

WARDS TIP

Patients who are treated with *first-generation* (typical) antipsychotic medication need to be closely monitored for extrapyramidal symptoms, such as acute dystonia and tardive dyskinesia.

WARDS TIP

Schizophrenic patients who are treated with *second-generation* (atypical) antipsychotic medications need a careful medical evaluation for metabolic syndrome. This includes checking weight, body mass index (BMI), fasting blood glucose or HbA1c, lipid assessment, and blood pressure.

KEY FACT

High-potency antipsychotics (such as haloperidol and fluphenazine) have a higher incidence of extrapyramidal side effects, while *low-potency* antipsychotics (such as chlorpromazine) have primarily anticholinergic and antiadrenergic side effects.

WARDS TIP

Tardive dyskinesia occurs most often in older women after at least 6 months of medication. A small percentage of patients will experience spontaneous remission, so discontinuation of the agent should be considered if clinically appropriate.

Choreoathetoid movements.

WARDS TIP

The cumulative risk of developing tardive dyskinesia from antipsychotics (particularly first generation) is 5% per year.

WARDS TIP

Clozapine is typically considered for treating schizophrenia when a patient fails both typical and other atypical antipsychotics. It is a very effective medication, but as it can rarely cause agranulocytosis, patients must be monitored (WBC and absolute neutrophil counts) regularly.

It's preserved

WARDS TIP

If a schizophrenia presentation has not been present for 6 months, think *schizophreniform disorder*.

hallucinations + Delusions — 2 weeks — Mood disorder

KEY FACT

Patients with borderline personality disorder may have transient, stress-related psychotic experiences. These are considered part of their underlying personality disorder and are not diagnosed as a brief psychotic disorder.

KEY FACT

SchizophreniFORM = the FORMation of a schizophrenic, but not quite there (i.e., <6 months).

Substance Use Disorders

WARDS TIP

It is possible to have a substance use disorder without having physiological dependence (i.e., without having withdrawal or tolerance).

WARDS TIP

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

KEY FACT

Withdrawal symptoms of a drug are usually the opposite of its intoxication effects. For example, alcohol is sedating, but alcohol *withdrawal* can cause brain excitation and seizures.

TABLE 7-1. Direct Testing for Substance Use

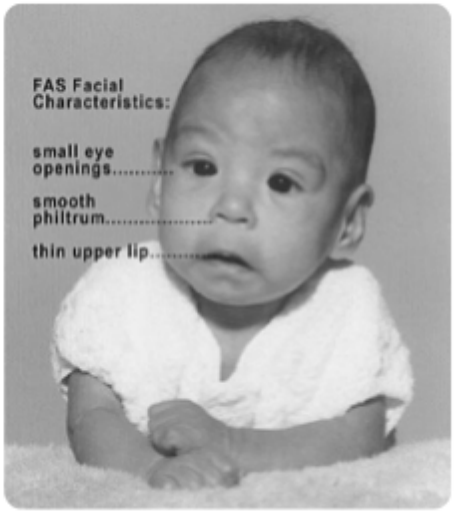
Alcohol	▪ Stays in system for only a few hours. ▪ Breathalyzer test, commonly used by law enforcement. ▪ Blood/urine testing more accurate.
Cocaine	▪ Urine drug screen positive for 2–4 days.
Amphetamines	▪ Urine drug screen positive for 1–3 days. ▪ Most assays have poor sensitivity and/or specificity.
Phencyclidine (PCP)	▪ Urine drug screen positive for 4–7 days. ▪ Creatine kinase (CK) and aspartate aminotransferase (AST) are often elevated.
Sedative-hypnotics	In urine and blood for variable amounts of time. *Barbiturates:* ▪ Short-acting (pentobarbital): 24 hours ▪ Long-acting (phenobarbital): 3 weeks *Benzodiazepines:* ▪ Short-acting (e.g., lorazepam): up to 5 days ▪ Long-acting (diazepam): up to 30 days
Opioids	▪ Urine drug test remains positive for 1–3 days, depending on opioid used. ▪ Methadone and oxycodone will come up negative on a general screen (order a separate panel).
Marijuana	Urine detection: ▪ After a single use, about 3 days. In heavy users, up to 4 weeks (THC is released from adipose stores).

It is often challenging to decide whether psychiatric symptoms are primary or substance-induced.

KEY FACT

Pregnant women should not drink alcohol as it can increase fetal alcohol syndrome in the newborn, which is a potential cause of intellectual disability.

mental retardation.



WARDS TIP

Alcohol is the most common co-ingestant in drug overdoses.

KEY FACT

Most adults will show some signs of intoxication with BAL > 100 and obvious signs with BAL > 150 mg/dL.

Blood alcohol level.

KEY FACT

Ethanol, along with methanol and ethylene glycol, can be a cause of anion gap metabolic acidosis.

KEY FACT

✓ Males with substance use disorders, especially alcohol, have higher rates of perpetrating domestic violence.

KEY FACT

✓ Alcohol is the most commonly used intoxicating substance in the United States.

WARDS TIP

At-risk or heavy drinking for men is more than 4 drinks per day or more than 14 drinks per week. For women, it is more than 3 drinks per day or more than 7 drinks per week.

KEY FACT

Risk of suicide attempts is higher among those with psychiatric disorders and substance use (especially alcohol).

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. Treatment includes supportive care and benzodiazepines.

KEY FACT

Confabulation—inventing stories of events that never occurred—is often associated with Korsakoff's "psychosis," or alcohol-induced neurocognitive disorder. Patients are unaware that they are "making things up."

KEY FACT

AST:ALT ratio ≥2:1 and elevated GGT suggest excessive long-term alcohol use; they take a few weeks to return to normal during abstinence.

KEY FACT

Alcohol can cause increase in LF s and macrocytosis (increase in MCV).

WARDS TIP

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

KEY FACT

Cocaine overdose can cause death secondary to cardiac arrhythmia, MI, seizure, or respiratory depression.

KEY FACT

Heavy amphetamine use may induce psychosis, mimicking schizophrenia.

KEY FACT

PCP intoxication symptoms—
RED DANES

- **R**age
- **E**rythema (redness of skin)
- **D**ilated pupils
- **D**elusions
- **A**mnesia
- **N**ystagmus
- **E**xcitation
- **S**kin dryness

KEY FACT

Symptoms of amphetamine intoxication include euphoria, dilated pupils, increased libido, tachycardia, perspiration, grinding teeth, and chest pain.

KEY FACT

Rotatory nystagmus is pathognomonic of PCP intoxication.

WARDS TIP

Chronic amphetamine use leads to accelerated tooth decay ("meth mouth").

KEY FACT

Tactile and visual hallucinations are found in both cocaine and PCP intoxication.

WARDS TIP

Both amphetamine and PCP use can cause rhabdomyolysis. Look for elevated creatine kinase (CK) and monitor closely for acute kidney injury. Treatment is mostly supportive and emphasizes hydration.

KEY FACT

PCP intoxication is associated with violence, more so than other drugs.

KEY FACT

Barbiturate withdrawal can be deadly, and has the highest mortality rate of all the kinds of substance withdrawals.

+ alcohol.
+ BDZ.

WARDS TIP

Flumazenil is a very short-acting BZD antagonist used for treating BZD overdose. Use with caution when treating overdose, as it may precipitate seizures.

KEY FACT

In general, withdrawal from drugs that are sedating (e.g., alcohol, barbiturates, benzodiazepines) is life threatening, while withdrawal from stimulants (e.g., cocaine, amphetamines) is not.

but cocaine overdose can be life threatening

KEY FACT

The opioid dextromethorphan is a common ingredient in cough syrup.

codeine.
↓ gag reflex.

KEY FACT

Infection secondary to needle sharing is a common cause of morbidity from street heroin usage.

KEY FACT

Opioid intoxication: nausea, vomiting, sedation, decrease in pain perception, decrease in gastrointestinal motility, pupil constriction, and respiratory depression (which *can be fatal*).

pain analgesia euphoria.

seizures, drowsiness.

KEY FACT

Meperidine is the exception to opioids producing miosis. "Demerol Dilates pupils."

+ Causes seizures (+ Tramadol)
+ Constipation vs. diarrhea

KEY FACT

Naloxone is the treatment of choice for opiate overdose.

WARDS TIP

Classic triad of opioid overdose—
Rebels **A**dmire **M**orphine
Respiratory depression
Altered mental status
Miosis

(Narcan = Naloxone)!

KEY FA

Eating large amounts of poppy seed bagels or muffins can result in a urine drug screen that is positive for opioids.

KEY FACT

THC: Tetrahydrocannabinol

Dronabinol is a pill form of THC that is FDA-approved for certain indications.

1) Antiemetic for chemoTx. 2) ↑ apetite for AIDS patients

WARDS TIP

Rapid recovery of consciousness following the administration of intravenous (IV) naloxone (a potent opioid antagonist) is consistent with opioid overdose. ✓

WARDS TIP

Cigarette smoking during pregnancy is associated with low birth weight, SIDS, and a variety of postnatal morbidities.

KEY FACT

Remember the withdrawal symptoms of opiates: flu-like symptoms (body aches, anorexia, rhinorrhea, fever), diarrhea, anxiety, insomnia, and piloerection. These are ***not*** life threatening.

TABLE 7-2. Clinical Presentation of Alcohol Intoxication

Effects	BAL
Impaired fine motor control	20–50 mg/dL
Impaired judgment and coordination	50–100 mg/dL
Ataxic gait and poor balance	100–150 mg/dL
Lethargy, difficulty sitting upright, difficulty with memory, nausea/vomiting	150–250 mg/dL
Coma (in the novice drinker)	300 mg/dL
Respiratory depression, death possible	400 mg/dL

KEY FACT

An LSD flashback is a spontaneous recurrence of symptoms mimicking a prior LSD "trip" that may last for minutes to hours.

Anxiety, others

WARDS TIP

- Most common form of psychopathology → anxiety disorders

Assess for psychopathology if an individual's symptoms are causing **S**ocial and/or **O**ccupational **D**ysfunction (**SOD**).

TABLE 5-1. Signs and Symptoms of Anxiety

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

TABLE 5-2. Medications and Substances That Cause Anxiety

SSRIs cause initial anxiety.

Alcohol	Intoxication/withdrawal
Sedatives, hypnotics, or anxiolytics	Withdrawal
Cannabis	Intoxication
Hallucinogens (PCP, LSD, MDMA)	Intoxication
Stimulants (amphetamines, cocaine)	Intoxication/withdrawal
Caffeine	Intoxication
Tobacco	Intoxication/withdrawal
Opioids	Withdrawal

WARDS TIP

Late-onset anxiety symptoms without a prior history or family psychiatric history should increase suspicion of anxiety caused by another medical condition or substance use.

KEY FACT

If a patient has a comorbid depressive disorder, consider alternatives to benzodiazepines, as they may worsen depression.

WARDS TIP

Use *b*enzodiazepines to temporarily *b*ridge patients until long-term medication becomes effective.

WARDS TIP

SSRIs typically take about 4–6 weeks to become fully effective, and higher doses (than used in treating depression) are generally required.

WARDS TIP

Pharmacologic goal: Achieve symptomatic relief and continue treatment for at least 6 months before attempting to titrate off medications.

WARDS TIP

Medications can reduce symptoms enough so that a patient can participate in therapy. Therapy can help prevent relapse if medications are no longer prescribed.

KEY FACT

Symptoms of panic attacks
Da PANICS

Dizziness, **d**isconnectedness, **d**erealization (unreality), **d**epersonalization (detached from self)
Palpitations, **p**aresthesias
Abdominal distress
Numbness, **n**ausea
Intense fear of dying, losing control or "going crazy"
Chills, **c**hest pain
Sweating, **s**haking, **s**hortness of breath

WARDS TIP

Use the *B*s to *B*lock the *P*s:
*B*eta-*B*lockers for *P*anic attacks and *P*erformance anxiety.

WARDS TIP

Smoking is a risk factor for panic attacks.

KEY FACT

When a patient presents with a panic attack, rule out potentially life-threatening medical conditions such as a heart attack, thyrotoxicosis, and thromboembolism.

WARDS TIP

A classic panic disorder case involves a woman who repeatedly visits the ER afraid she is dying when she experiences episodes of palpitations, diaphoresis, and shortness of breath. The patient has no prior medical history and the medical workup is negative.

WARDS TIP

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

Course and Prognosis

- Panic disorder has a chronic course with waxing and waning symptoms.
- Relapses are common with discontinuation of medication.
- Only a minority of patients have full remission of symptoms.
- Up to 65% of patients with panic disorder also have major depression.
- Other comorbid syndromes include other anxiety disorders (e.g., agora phobia), bipolar disorder, and alcohol use disorder.

WARDS TIP

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

SSRIs → initial anxiety.

KEY FACT

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

KEY FACT

Common Domains of Social Anxiety Disorder (Social Phobia):

- Speaking in public.
- Eating in public.
- Using public restrooms.

KEY FACT

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

Examples include **worries about having committed a sin or breaking a religious rule, blasphemous thoughts about religious figures, or fear that one is falling short morally.**

WARDS TIP

Patients with blood-injury-injection-specific phobia (fear of needles, etc.) may experience bradycardia and hypotension leading to vasovagal fainting.

KEY FACT

Substance use and depressive disorders frequently co-occur with phobias.

KEY FACT

Common Domains of Social Anxiety Disorder (Social Phobia):

- Speaking in public.
- Eating in public.
- Using public restrooms.

KEY FACT

Performance anxiety is often successfully treated with beta-blockers.

WARDS TIP

Separation anxiety may lead to complaints of somatic symptoms to avoid school/work.

KEY FACT

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

- Individuals with OCPD are obsessed with details, control, and perfectionism; they are not intruded upon by unwanted preoccupations nor compelled to carry out compulsions.
- OCD patients are *dis*tressed by their symptoms (ego-*dy*stonic).

WARDS TIP

GAD Mnemonic

Worry WARTS

- **W**ound up, **w**orn-out
- **A**bsent-minded
- **R**estless
- **T**ense
- **S**leepless

WARDS TIP

For patients with anxiety, evaluate for caffeine use and recommend significant reduction or elimination.

WARDS TIP

Exercise can significantly reduce anxiety.

WARDS TIP

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

KEY FACT

Compulsions can often take the form of repeated checking or counting.

KEY FACT

Patients with OCD often initially seek help from primary care and other nonpsychiatric providers for help with the consequences of compulsions (e.g., excessive washing).

KEY FACT

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

WARDS TIP

Etiology of PTSD: TRAUMA
Traumatic event ✓
Reexperience ✓
Avoidance ✓
Unable to function ✓
Month or more of symptoms ✓
Arousal increased ✓

KEY FACT

Use **P**razo**S**i**N**
in **P**TSD to **S**top **N**ightmares

- Antidepressants
  SSRIs, SNRIs
- Prazosin α_1 antagonist
- Atypical antipsychotics.

WARDS TIP

Cognitive processing therapy is a modified form of cognitive-behavioral therapy in which thoughts, feelings, and meanings of the event are revisited and questioned.

CBT

WARDS TIP

Addictive medications such as benzodiazepines should be avoided in the treatment of PTSD because of the high rate of comorbid substance use disorders.

v. imp

> But usually within the first 3 months of trauma.

KEY FACT

Posttraumatic stress disorder (PTSD) stressor = life threatening!
Adjustment disorder stressor ≠ life threatening.

- at any time after the event.
- within 3 months. Crossdives
- within 3 months of the event, relieved within 6 months.

Mood disorders

WARDS TIP

Major depressive episodes can be present in major depressive disorder, persistent depressive disorder (dysthymia), bipolar I/II disorder, and schizoaffective disorder.

KEY FACT

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

KEY FACT

Stroke patients are at a significant risk for developing depression, and this is associated with a poorer outcome overall.

WARDS TIP

When patients have delusions and hallucinations due to underlying mood disorders, they are usually mood congruent. For example, depression causes psychotic themes of paranoia and worthlessness, and mania causes psychotic themes of grandiosity and invincibility.

KEY FACT

Depression is common in patients with pancreatic cancer.

WARDS TIP

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

KEY FACT

Anhedonia is the inability to experience pleasure, which is a common finding in depression.

Interest.

KEY FACT

Symptoms of major depression—
SIG E. CAPS (Prescribe Energy Capsules)
Sleep
Interest
Guilt
Energy
Concentration
Appetite
Psychomotor activity
Suicidal ideation

KEY FACT

Major depressive disorder is the most common disorder among those who commit suicide.

• 15% of MDD patients, commit suicide.

WARDS TIP

Irritability is often the predominant mood state in mood disorders with mixed features. Patients with mixed features have a poorer response to lithium. Anticonvulsants such as valproic acid may be more helpful.

WARDS TIP

The two most common types of sleep disturbances associated with MDD are difficulty falling asleep and early morning awakenings.

Initial and terminal insomnia.

KEY FACT

The Hamilton Depression Rating Scale measures the severity of depression and is used in research to assess the effectiveness of therapies. PHQ-9 is a depression screening form often used in the primary care setting.

KEY FACT

Loss of a parent before age 11 is associated with the later development of major depression.

KEY FACT

Most adults with depression do not see a mental health professional, but they often present to a primary care physician for other reasons.

KEY FACT

Only half of patients with MDD receive treatment.

KEY FACT

A patient with a history of postpartum mania has a high risk of relapse with future deliveries and should be treated with mood stabilizing agents as prophylaxis. However, some of these medications may be contraindicated in breastfeeding.

WARDS TIP

MAOIs were considered particularly useful in the treatment of "atypical" depression; however, SSRIs remain first-line treatment for major depressive episodes with atypical features.

KEY FACT

All antidepressant medications are equally effective but differ in side-effect profiles. Medications usually take 4–6 weeks to fully work.

So wait!

WARDS TIP

Serotonin syndrome is marked by autonomic instability, hyperthermia, hyperreflexia (including myoclonus), and seizures. Coma or death may result.

WARDS TIP

Adjunctive treatment is usually performed after multiple first-line treatment failures.

KEY FACT

The postpartum period conveys an elevated risk of depression in women.

Sure (postmortem depression)

WARDS TIP

Triad for seasonal affective disorder: SAD

1. Irritability
2. Carbohydrate craving
3. Hypersomnia

now I have it in mind

WARDS TIP

Major depression with psychotic features is best treated with a combination of an antidepressant **and** antipsychotic **or** ECT.

KEY FACT

Bereavement is NOT a DSM-5 diagnosis—if a patient meets criteria for major depression following the loss of a loved one, the diagnosis is major depression.

Mood stabilizers.

KEY FACT

Treatment for bipolar disorder includes lithium, valproic acid, and carbamazepine (for rapid cyclers), or second-generation antipsychotics. Lithium remains the gold standard, particularly due to demonstrated reduction in suicide risk.

4 mood episodes in one year

WARDS TIP

Side effects of lithium include:

- Weight gain
- Tremor
- Gastrointestinal disturbances
- Fatigue
- Cardiac arrhythmias
- Seizures
- Goiter/hypothyroidism
- Leukocytosis (benign)
- Coma (in toxic doses)
- Polyuria (nephrogenic diabetes insipidus)
- Polydipsia
- Alopecia
- Metallic taste

KEY FACT

ECT is the best treatment for a pregnant woman who is having a manic episode. It provides a good alternative to antipsychotics and can be used with relative safety in all trimesters.

KEY FACT

Rapid cycling is defined by the occurrence of four or more mood episodes (major depressive, hypomanic, or manic) in 1 year.

WARDS TIP

Persistent *D*epressive *D*isorder (*DD*) = 2 *D*s
2 years of depression
2 listed criteria
Never asymptomatic for > 2 months

WARDS TIP

Bipolar I disorder may have psychotic features (delusions or hallucinations); these can occur during major depressive *or* manic episodes.
Remember to always include bipolar disorder in the differential diagnoses of a psychotic patient.

imp

WARDS TIP

Symptoms of persistent depressive disorder (dysthymia)—two or more of:
CHASES
Poor **C**oncentration or difficulty making decisions
Feelings of **H**opelessness
Poor **A**ppetite or overeating
In**S**omnia or hypersomnia
Low **E**nergy or fatigue
Low **S**elf-esteem

WARDS TIP

MDD is an episodic illness, while persistent depressive disorder is pervasive.

Summary.

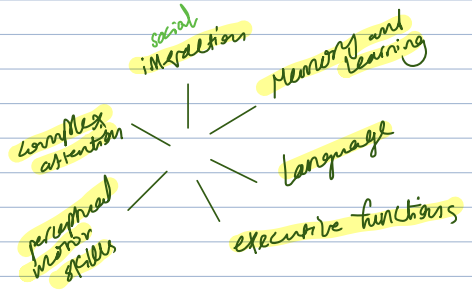
NCD

- Definition:- Group of conditions that can be defined as decline in cognitive functions from previous levels.

DSM-5 categories

- Delirium
- Mild
- Major Dementias

Non delirium.



- major NCD m.c.c s :-

1- AD.
2- VCI vascular cognitive impairment.
3- most common infection that causes cognitive impairment → HIV.

	cognitive domains affected
↓ β-amyloid ↑ Tau. AD	Memory, learning, language.
Vascular n.	Complex attention. executive functions.
• α-synuclein --? Lewy Body D.	Attention, Alertness
FTD disorders	Attention, Abstraction Problem solving, Planning.
Huntington's D.	Executive functions.
Parkinson's D.	
Prion's disease HSV infection	Executive functions, working memory, attention, psychomotor velocity.

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.

Neurocognitive Disorders

WARDS TIP

Terms commonly used for delirium include *toxic or metabolic encephalopathy*, *acute organic brain syndrome*, *acute confusional state*, *acute toxic psychosis*, and *ICU psychosis*.

WARDS TIP

Consider delirium as acute brain failure—a *medical emergency* like other acute organ failures.

WARDS TIP

The "ICU triad" includes delirium, pain, and agitation. All three of these interdependent conditions must be addressed.

WARDS TIP

Delirium is commonly experienced by patients in the ICU and postoperative recovery.

WARDS TIP

Common causes of medication-induced delirium:

- Tricyclic antidepressants
- Anticholinergics
- Benzodiazepines
- Nonbenzodiazepine hypnotics ("Z-drugs")
- Corticosteroids
- H2 blockers
- Opioids (especially meperidine)

WARDS TIP

The most common precipitants of delirium in children are febrile illnesses and medications.

WARDS TIP

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

WARDS TIP

A quick, first-glance bedside exam for suspected substance/medication intoxication is **VALEUMS**.

- **V**ital signs
- **A**lertness **L**evel
- **E**yes (pupil size and position)
- **U**rine (bladder distention or incontinence)
- **M**ucous membranes (moisture)
- **S**kin (temperature and moisture)

KEY FACT

A lesion to the frontal lobe can manifest with a spectrum of symptoms including personality changes, disinhibition, inappropriate behavior, aggression, apathy, amotivation, and paranoia.

KEY FACT

Delirium generally manifests as diffuse background slowing on electroencephalography (EEG). An exception to this is the case of delirium tremens, which is associated with fast EEG activity. EEG lacks sensitivity and specificity for making the diagnosis, but is useful for ruling out nonconvulsive seizures.

WARDS TIP

Consider obtaining a head CT for a patient with delirium under the following circumstances:

- No underlying cause evident on initial evaluation.
- In the context of head trauma.
- New focal neurologic deficits detected on exam.
- Patient unable or unwilling to cooperate with a neurologic examination.
- No improvement despite treatment of already identified causes.

WARDS TIP

Generally avoid using benzodiazepines to treat delirium. These medications often worsen delirium by causing paradoxical disinhibition or oversedation. Prescribe only in the case of delirium due to alcohol or benzodiazepine withdrawal.

KEY FACT

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

KEY FACT

Senile plaques and neurofibrillary tangles are not only found in Alzheimer disease, but also in Down syndrome and even in normal aging.

KEY FACT

Adults with Down syndrome are at increased risk of developing Alzheimer disease in midlife.

WARDS TIP

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

KEY FACT

Thyroid dysfunction can cause reversible cognitive impairment. Hypothyroidism is typically accompanied by fatigue and cold intolerance. Hyperthyroidism in the elderly may manifest as an "apathetic thyrotoxicosis," characterized by depression and lethargy. Thyroid function tests are typically included in the initial evaluation of any psychiatric illness.

KEY FACT

Symptoms of Parkinson disease can be exacerbated by antipsychotic medications.

Logic

↓ Dopamine

* Finding of NPH :-

1. Enlarged ventricles.
2. localized ↑ CSF pressure
3. normal opening pressures

KEY FACT

The 3 Ws of NPH

Wobbly = Gait disturbance

Wet = Urinary incontinence

Wacky = Cognitive impairment

KEY FACT

Rapidly progressive cognitive decline with myoclonus is suggestive of Creutzfeldt–Jakob disease.

Death within 1 year of diagnosis.

Somatization

Ms. Thomas is a 31-year-old woman who was referred to a psychiatrist by her gynecologist after undergoing multiple exploratory surgeries for abdominal pain and gynecologic concerns with no definitive findings. The patient reports that she has had extensive medical problems dating back to adolescence. She reports periods of extreme abdominal pain, vomiting, diarrhea, and possible food intolerances. The obstetrician is her fourth provider because "my other doctors were not able to help me." Ms. Thomas reports fear that her current physician will also fail to relieve her distress. She was reluctant to see a psychiatrist and did so only after her obstetrician agreed to follow her after her psychiatric appointment.

Ms. Thomas states that her problems worsened in college, which was the first time she underwent surgery. She reports that due to her health problems and severe lack of energy, it took her 5½ years to graduate from college. She did better for a year or two after college but then had a return of symptoms. She reports recently feeling very lonely and isolated because she has not been able to find a boyfriend who can tolerate her frequent illnesses. She also reports that physical intimacy is difficult for her because she finds sex painful. Additionally, she is concerned that she might lose her job due to the number of days she has missed from work due to her abdominal pain, fatigue, and weakness.

What is the diagnosis?

Somatic symptom disorder. Ms. Thomas has a history of multiple somatic complaints lasting at least 6 months, along with a high level of anxiety about her symptoms and excessive time and energy devoted to her health concerns. She has had multiple medical procedures and significant impairment in her social and occupational functioning.

KEY FACT

Somatic symptom disorder patients typically express lots of concern over their condition and chronically perseverate over it. Conversion disorder patients often have an abrupt onset of their neurological symptoms (blindness, etc.) but appear unconcerned.

WARDS TIP

When treating a patient with a somatic symptom disorder, it is important for the psychiatrist to work closely with the patient's primary care physician.

KEY FACT

Illness anxiety disorder is the only somatic symptom-related disorder that occurs as frequently in men as in women.

KEY FACT

Conversion disorder: patients "convert" psychological distress or conflicts into neurological symptoms.

KEY FACT

Münchhausen 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 children).

KEY FACT

Conversion-like presentations in elderly patients have a higher likelihood of representing an underlying neurological deficit.

A 37-year-old patient claims that he has frequent episodes of "seizures," starts on medications, and joins an epilepsy support group. It becomes known that he is doing this in order to collect social security disability money. *Diagnosis?* **Malingering.** In contrast, in **factitious disorder,** patients look for some kind of unconscious emotional gain by playing the "sick role," such as sympathy from the physician. The fundamental difference between malingering and factitious disorder is in the intention of the patient; in malingering, the motivation is external, whereas in factitious disorder, the motivation is internal.

KEY FACT

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

Review of Distinguishing Features

- **Somatic symptom disorders:** Patients *believe* they are ill and do not intentionally produce or feign symptoms.
- **Factitious disorder:** Patients intentionally produce symptoms of a psychological or physical illness because of a desire to assume the *sick role,* not for external rewards.
- **Malingering:** Patients intentionally produce or feign symptoms for *external rewards.*

Dissociation

WARDS TIP

Dissociative responses typically occur during stressful and traumatic events.

KEY FACT

Dissociative amnesia refers to disruption in the continuity of an individual's memory. Patients with dissociative amnesia report gaps in the recollection of particular events, usually traumatic ones.

WARDS TIP

Patients suffering from dissociative amnesia can experience periods of flashbacks, nightmares, or behavioral reenactments of their trauma.

KEY FACT

Although dissociative fugue is now considered a subtype of dissociative amnesia disorder, it more commonly occurs with dissociative identity disorder.

KEY FACT

Abreaction is the strong emotional reaction patients may experience when retrieving traumatic memories.

WARDS TIP

Fugue: Think of a forgetful fugitive who runs away and forms a new identity.

KEY FACT

Transient experiences of depersonalization or derealization commonly occur in many individuals during times of stress.

WARDS TIP

Symptoms of DID may be similar to those seen in borderline personality disorder or psychotic disorders. avoid

A 21-year-old woman is brought to the clinic by her boyfriend for evaluation of "memory issues." The patient recently visited her family for the holidays. The boyfriend states that "she had to deal with her abusive, alcoholic father. She seems like someone else ever since." The patient speaks in a childlike singsong voice and asks to be called by a name different than what is listed on her driver's license. She denies any concerns.

Most likely diagnosis?

Dissociative Identity Disorder (DID)

A 19-year-old man is found wandering several miles from home 3 days after a missing persons report was filed by his family. He cannot recall his full name or address, even when shown his ID card. His family reports that he recently returned from combat deployment.

Likely diagnosis?

Dissociative amnesia with dissociative fugue

Eating disorders

WARDS TIP

Suspect an eating disorder? Ask the patient what is the most/least he/she has weighed, his/her ideal body weight, if he/she counts calories/fat/carbs/protein, how much he/she exercises, if he/she binges and purges, and if he/she has food rituals (e.g., drinking water between bites).

What are some of the medical complications associated with this condition?

Patients with anorexia nervosa can present with bradycardia, orthostatic hypotension, arrhythmias, QTc prolongation, and ST-T wave changes on electrocardiogram, as well as anemia and leukopenia. They may also experience cognitive impairment, evidence of enlarged ventricles and/or decrease in gray and white matter on brain imaging, and peripheral neuropathy. Lanugo and muscle wasting sometimes become evident. Amenorrhea and loss of libido are commonly reported. In patients who regularly engage in self-induced vomiting, parotid enlargement, increased amylase levels, and electrolyte imbalances (e.g., hypokalemia) not uncommonly occur as a result.

KEY FACT

Both anorexia and bulimia are characterized by a desire for thinness. Both may binge and purge. Anorexia nervosa involves low body weight and restriction of calorie intake, and this distinguishes it from bulimia.

KEY FACT

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

KEY FACT

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

WARDS TIP

When a patient with anorexia learns that weight gain is a common side

KEY FACT

Anorexia 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.

WARDS TIP

Unlike patients with anorexia nervosa, bulimic patients usually maintain a normal weight (or are overweight) and their symptoms are more ego-dystonic (distressing); they are therefore more likely to seek help.

OCD vs. OCPD
↓
ego-dystonic

KEY FACT

Binge eating is defined by excessive food intake within a 2-hour period accompanied by a sense of lack of control.

KEY FACT

Anorexia nervosa and bulimia nervosa are risk factors for developing cardiac arrhythmias due to electrolyte disturbances such as hypokalemia.

KEY FACT

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

KEY FACT

Fluoxetine is an effective medication for bulimia.

WARDS TIP

In patients with bulimia, make sure to check that they aren't on medications that could further lower their seizure threshold, such as the antidepressant Wellbutrin (bupropion).