All content is built from lectures since we don’t actually have any real reading to do, and the reading we do have is primary literature. All questions for the exams come from the lecture slides and from small group sessions. This will remind you very much of your Biochemistry Course first year. It is NOT representative of what the USMLE requires you to know. There are mostly details in the exam; BRS will not save you. The good news is that this exam is a small piece of the foundations course, so don’t fret too much!

Keep in mind that these disorders are NOT DIAGNOSES, they are merely categorization of symptoms. The whole DSM-IV does not represent etiology nor treatment, so it gets a little frustrating. A disease is a disease because we say it is, not because of a particular pathological defect.

Learning the key points of each drug will help you hone in on the cases presented in small groups. Even if you simply familiarize yourself superficially with diseases you will excel in small groups and really consolidate the information you already know. This stuff isn’t hard, there is very little pathology in this section, but don’t just skim over it either. IT IS ALL BOARD RELEVANT.

The problem with this section is that psychiatry has difficulty differentiating one disease from another. I should say, one syndrome from another. There is often this held belief that “you don’t really know it until you see it, but once you see it, you know it.” Poorly characterizing diseases can make for confusing diagnoses, especially for linear and logic medical students.

So, they have developed this 5 axis thing, where you just write down all possibilities. If they meet the three out of 9 criteria for narcissism and the four out of eight criteria for depression, they are both depressed and narcissistic. No diagnosis has been made, but the patient is considered interviewed.

Some of the cases you will read are pretty clear cut. The good thing is the examiners at Tulane really throw a lot of cues at you to direct you in the right direction. The problem is, sometimes the questions are some erroneous nit picky detail that somehow became important.
ANXIETY

- **Adjustment Disorder with Anxious Mood**
  - Definition
    - Bad reaction to an identifiable stressor requiring alteration or notification that starts within 3 months, and lasts no less than 6 months
  - Etiologies
    - Medical
      - Acute or Chronic Mental Illness
      - Upcoming surgical procedures (like a colonoscopy, MRI, CT scans)
      - Hospitalization itself
    - Non-Medical
      - Job, Marriage, Money, Relocation, Combination
  - Treatment
    - Relaxation strategies and coping techniques
    - Brief course of **benzos**, followed up with **TCAs** if long-term course is needed

- **Generalized Anxiety Disorder**
  - Definition
    - Excessive anxiety about 2 or more circumstances, lasting more than 6 months that is not secondary to another disorder
    - These patients are always worrisome about one thing or another
  - Presentations
    - Motor tension (back pain, neck pain)
    - Autonomic Hyperactivity (sweating, diarrhea)
    - Vigilance and Scanning (always on the alert, searching environment)
  - Treatment
    - Psychotherapy, Self-regulatory, Behavior, Exercise
    - **Benzos** short term, **TCAs**/**SSRIs** if long-term is required.

- **Panic Disorder**
  - Definition
    - Discrete, intense, unexpected “attacks” that occur 4 times per month OR 1 time with persistent fear that has no organic factor
  - Presentation
    - Shortness of breath, Dizziness, Palpitations, Sweating, Choking, Fear of Death
    - **Avoidance behavior** = avoids triggers, may manifest as agoraphobia or staying away from common locations (grocery store) or actions (teeth brushing)
  - Treatment
    - Patient Education, Behavior Therapy, Psychotherapy
    - **Benzos** (high dose) short term, **Antidepressants** (SSRIs, TCAs, MAO-Is) long term
    - Beta-Blockers may help control symptoms, but not their onset
- **Obsessive Compulsive Disorder**
  - **Definition**
    - Recurrent obsessions or compulsions that interfere with daily normal routine, functioning, or relationships by causing marked distress
  - **Presentation**
    - Variable; may be one thing or many things
    - Hand-washing, Garbage Collecting in the House, “Adrian Monk”
    - Compulsion must consume **1 hr or more per day**
  - **Treatment**
    - Benzos for short periods, **Antidepressants** (SSRI / TCAs) long term
    - Behavioral therapy (exposure and response prevention) or psychotherapy

- **Post Traumatic Stress Disorder**
  - **Definition**
    - Persistent vigilance or avoidance of a particular stimuli following a **traumatic event** whereby the patient **re-experiences the trauma** at least once, **avoids cues**, and has **Hyperarousal** all of which lasts for 2 months or more
  - **Presentation**
    - Following a traumatic event (Soldiers at war, Rape Victim, Witness of Murder)
    - **Re-experience**: Reliving the event in their mind (reliving or nightmares)
    - **Hyperarousal**: Increased arousal and or vigilance (sit with their back to the wall)
    - **Avoidance**: avoids cues or triggers of event
  - **Treatment**
    - Psychotherapy, Support Groups, Frequent Visits
    - SSRIs, Benzos, TCAs, MAO-Is for long term and short term are first line
    - Lithium, Carbamazepine, Antiepileptic, and Beta Blockers for Chronic PTSD

- **Acute Stress Disorder**
  - **Definition**
    - PTSD on the scale of **2 days to 4 weeks**, the symptoms that occur right after the event, the prequel to PTSD
  - **Presentation**
    - Reexperience – same as PTSD
    - Hyperarousal – same as PTSD
    - Avoidance – same as PTSD
    - Dissociative Symptoms
  - **Treatment**
    - Doctors usually don’t see this, its gone (and PTSD has set in)

- **Simple Phobia**
  - **Definition**
    - Persistent, excessive, and unreasonable fear
  - **Presentation**
    - **Avoidance** of object or situation
    - Unrelated to panic disorder that interferes with normal functioning
    - Example: Mailmen and Dogs, Spiders, Clowns
  - **Treatment**
- **Social Phobia**
  - Definition
    - Persistent, Excessive, and unreasonable fear of social situations
  - Presentation
    - Avoidance of social situations
    - Panic Attacks, uncontrollable fear, thoughts of dying if exposed
    - Fear of public speaking, fear of interaction with coworkers
  - Treatment
    - Behavioral therapy, Cognitive Therapy
    - Beta Blockers, SSRIs, MAO-Is, Benzos

### ANXIETY DISORDERS

<table>
<thead>
<tr>
<th>Disease</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generalized Anxiety Disorder</td>
<td>Excessive anxiety about “something” 2 or more times in 6 months</td>
</tr>
<tr>
<td></td>
<td><strong>Motor Tension</strong> = fidgety, jumpy</td>
</tr>
<tr>
<td></td>
<td><strong>Autonomic Hyperactivity</strong> (Palpitations, Sweating, Chest Pain, Hyperventilation)</td>
</tr>
<tr>
<td></td>
<td><strong>Vigilance</strong> = heightened state of awareness, always on guard, always looking around</td>
</tr>
<tr>
<td></td>
<td>Treatment is <strong>benzos</strong> and <strong>buspirone</strong></td>
</tr>
<tr>
<td>Simple Phobia</td>
<td>Anxiety when faced with an identifiable object (spiders, grass, geico geckos)</td>
</tr>
<tr>
<td></td>
<td><strong>Avoidance</strong> of object exhibited, may allow for under-reporting of number of cases</td>
</tr>
<tr>
<td></td>
<td>Unreasonable Persistent and Disabling Fear the patient is aware of</td>
</tr>
<tr>
<td>Agoraphobia</td>
<td>Simple Phobia + <strong>helplessness</strong> or <strong>humiliation</strong></td>
</tr>
<tr>
<td></td>
<td>Manifests as anxiety, panic-stricken, often when patients leave the house</td>
</tr>
<tr>
<td></td>
<td>Travel restricted, usually to home</td>
</tr>
<tr>
<td>Social Phobia</td>
<td>Fear of feeling or being stupid in public, fear of failure, fear of feeling shameful</td>
</tr>
<tr>
<td></td>
<td>Leads to dysfunctional circumspect behavior, avoidance of social situations</td>
</tr>
<tr>
<td></td>
<td><strong>Stage Fright</strong> is most common, but may be more fluid into turning down promotions</td>
</tr>
<tr>
<td></td>
<td>Treat with <strong>SSRIs</strong> (paroetine) or <strong>Beta Blockers</strong> (Atenolol)</td>
</tr>
<tr>
<td>Obsessive Compulsive Disorder</td>
<td><strong>Obsession</strong> = focusing on one thought, usually to avoid another</td>
</tr>
<tr>
<td></td>
<td><strong>Compulsion</strong> = repetitive action lasting no less than 1 hr /day</td>
</tr>
<tr>
<td></td>
<td>Goal of patient is to <strong>not lose control</strong>, which can be <strong>debilitating</strong></td>
</tr>
<tr>
<td></td>
<td>Treat with benzos or antidepressants (TCA, SSRI)</td>
</tr>
<tr>
<td>Panic Disorder</td>
<td><strong>4 attacks per month</strong> or <strong>1 attack with persistent fear</strong></td>
</tr>
<tr>
<td></td>
<td>Presents with Dyspnea, Choking, Sweating, Hopelessness, Palpitations</td>
</tr>
<tr>
<td></td>
<td>Abrupt symptoms, may produce agoraphobia or social phobia</td>
</tr>
<tr>
<td></td>
<td>Treatment: <strong>acute</strong> = Benzos (tolerance a problem), <strong>chronic</strong> = TCAs</td>
</tr>
<tr>
<td>Post Traumatic Stress</td>
<td>Follows a significant stressor (War, Rape, Witness to a murder) with witnessed or felt threatened death or serious injury that induced fear or horror.</td>
</tr>
<tr>
<td></td>
<td>Patient relives experience and demonstrates heightened vigilance and avoidance</td>
</tr>
<tr>
<td></td>
<td><strong>Lasts greater</strong> &gt;1 month and usually has an onset of 2-4 weeks after stressor</td>
</tr>
<tr>
<td></td>
<td>Poor treatment prognosis; poorly controlled with drugs, psychotherapy /CBT used</td>
</tr>
<tr>
<td>Acute Stress Disorder</td>
<td>Precursor to PTSD; similar symptoms, different time frame</td>
</tr>
<tr>
<td></td>
<td><strong>Occurs and resolves</strong> within 2 days - 4 weeks of acute stressor event,</td>
</tr>
<tr>
<td></td>
<td>Re-experiencing of the event, Avoidance of Cues, and <strong>Dissociative Symptoms</strong></td>
</tr>
<tr>
<td>Adjustment Disorder with Anxious Mood</td>
<td>Reaction to change in one’s life (diagnosis, procedure, job, finances, relocation, marriage)</td>
</tr>
<tr>
<td></td>
<td>Onset within 3 months, lasts for no less than 6 months</td>
</tr>
<tr>
<td></td>
<td>Short-Term with Benzos, Long-Term with TCAs</td>
</tr>
</tbody>
</table>
PSYCHOTIC DISORDERS

Psychosis means there is impairment in reality testing. This is not a diagnosis, and does not demonstrate etiology, but a state. You will have confusion in reality, evaluate perceptions and thoughts incorrectly, and will make erroneous inferences about the external reality, irrespective of evidence.

Schizophrenia

- Definition
  - A diagnosis of exclusion which is probably a combination of diseases that presents with one common definition we have termed “schizophrenia”
- Diagnostic Criteria
  - Any one of the following (1, 2, or 3) in one week, with the condition recurring for greater than 6 months
    1. Two of these: Delusions, Hallucinations, Catatonia, Flat Affect
    2. Bizarre Delusions
    3. Running Commentary of 2 voices conversing
  - Onset is usually in early twenties or late teens
- Presentation
  - Positive Symptoms (things that are there but should not be)
    - Auditory Hallucinations
      - “Voices in my head” that may be talking to each other, talking to the patient, or speaking the patient’s thoughts out loud
      - Find out who it is, what its saying, and how they are handling voices
    - Delusions
      - Normal things are somehow spectacular or life altering
      - Being taken over by outside force, abduction by aliens
    - Disorganized Speech – they can make the right sounds, the sentences are syntactically correct, but their thought process means nothing or is loose
    - Grossly disorganized or catatonic state
      - Bizarre or inappropriate dress (winter dress in summer)
      - Strange Headgear
  - Negative Symptoms (things that should be there, but now aren’t)
    - Affective Blunting – their “affect” is reduced; cannot demonstrate emotion
    - Anhedonia – reduced ability to experience pleasure
    - Avolition – cannot carry out goal-directed activities
    - Social Isolation – either by decision or by the community
  - Cognitive Symptoms
    - Intention, Memory and Language Disturbances which may present before psychotic symptoms
    - Mean IQ is diminished, though some schizos can be geniuses
Subtypes (not terribly useful in practice, though they show up on tests)

- Disorganized
  - Regression to primitive disinhibited, unorganized behavior
  - Childlike with silly affect
  - Pronounced thought disorder

- Catatonic
  - Psychomotor disturbance involving stupor, rigidity, or posturing
  - “Put your arms up” come back 3 hours later, their arms are still there

- Paranoid
  - All schizophrenics can be paranoid
  - Delusions of persecution or grandeur
  - Late onset, and thus a better prognosis
  - There is no thought disorder – while what you are saying is ridiculous, people can follow along without problem

- Undifferentiated
  - “other;” a trash bag of “you don’t fit the other three”

Etiology and Treatment

- Largely unknown, though these are theories;

- Neurotransmitters
  - Dopamine
    - Dopamine antagonists for some reason help these patients
    - It eliminates the positive symptoms but induced parkinsonism
  - Serotonin
    - Activation of these receptors (LSD or Ecstasy) produce psychosis
    - 5-HT₂ Antagonists help more than Dopamine

- Brain Abnormalities
  - Enlargement of the ventricles (hydrocephalus ex vacuo)
  - Reduced volume of cortex
  - Hypofrontality with reduced activity in the areas that become atrophied

- Genetics
  - Highest genetic component of any psychiatric disorder, upwards of 50%
  - Runs in families, but even monozygotic twins show max 50% concordance
  - Hereditary is necessary, but not sufficient, meaning that there must be some environmental factors which are yet unknown

Treatment

- Dependent on Severity, there is no cure and there is a progressive loss of function
- Antipsychotics are the mainstay and are first line treatment
- Anxiolytics, Antidepressants, Mood Stabilizers, Electric Shock Therapy are used, but are often dependent on varying conditions
- Psychosocial elements are important (half-way houses, support groups)
**Schizophreniform Disorder**

- It is schizophrenia but it has a total duration **less than 6 months**
  - If a person has one psychotic break, and never has another, then they don’t have schizophrenia; most people who do have a psychotic break do go on to chronic disease
- There may be **no social or occupational impairment** that is often present in the full disease

**Schizoaffective Disorder**

- Cross between a mood disorder and schizophrenia
- You can be either **manic, bipolar, or depressed** but then **also have schizo symptoms**
- When the mood stabilizes, and the psychosis remains, you have schizoaffective disorder

**Delusional Disorder**

- Characterized by the presence of **systematized non-bizarre delusions** accompanied by **appropriate affect for delusion**
  - Coffee shop worker thinks the daily CEO customer is in love with her
  - A man knows that his faithful wife is cheating on him
- Things that **CAN** happen, but **AREN'T** happening, despite the belief of the patient irrespective of evidence to the contrary
- Delusion may **preoccupy and dominate** the patient’s life

<table>
<thead>
<tr>
<th>PSYCHOTIC DISORDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Disease</strong></td>
</tr>
<tr>
<td>Schizophrenia</td>
</tr>
<tr>
<td>Etiology</td>
</tr>
<tr>
<td><strong>Subtypes</strong></td>
</tr>
<tr>
<td>Catatonic</td>
</tr>
<tr>
<td>Paranoid</td>
</tr>
<tr>
<td>Undifferentiated</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Disease</strong></th>
<th><strong>Notes</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Schizophreniform</td>
<td>Psychotic break (all the symptoms of schizophrenia) that have lasted for <strong>less than 6 months</strong>. Most will progress to full blown schizophrenia, some may recover from the psychosis</td>
</tr>
<tr>
<td>Schizoaffective</td>
<td>Cross between mood disorder and schizophrenia Mood Instability combined with psychosis that <strong>persists after mood instability is alleviated</strong></td>
</tr>
<tr>
<td>Delusional</td>
<td>Systematized <strong>non-bizarre delusions</strong> (believable) with <strong>appropriate affect</strong> These may preoccupy and dominate a patient’s life, crippling their function</td>
</tr>
</tbody>
</table>
MOOD DISORDERS I – Depressive Disorders

**Major Depression** – *the severe depression that is more acute than chronic*

- **Definition**
  - A depressed (I know, its circular) mood or lack of pleasure in things one pleasurable with a combination of symptoms that generally point to “feeling down”

- **Epidemiology**
  - **Women at greater risk than men**
  - Genetics play a role *(are familial)* but are clearly not causative
  - Onset is about 20s to 30s
  - Fairly common, with a lifetime risk of approximately 6%
  - Often follows a critical event such as loss of a loved one

- **Disease Course**
  - **Recurrence** is the rule, possibly as high as 70%
  - Definitive finding is suicidal ideations or suicide attempts
    - **Women attempt** suicide more often (cutting and pills)
    - **Men succeed** more often (violent deaths; guns and hanging)
    - Men commit suicide as they age, teenage girls more than boys

- **Diagnostic Criteria**
  - 5 or more of these symptoms over a 2 week period, with at least 1 of the first 2
    - **Depressed Mood**
      - **Anhedonia** – lack of pleasure in doing something that was once pleasurable
      - Change in weight or appetite – tend to eat more, **hyperphagia**
      - Change in sleep – usually tend to sleep more, **hypersonnia**
      - Loss of energy
      - Worthlessness and guilt
      - Diminished Concentration
      - Thoughts of suicide
  - “Voices” usually associated with psychotic disorders, may appear if depression is severe or prolonged enough. If psychosis is alleviated with the mood, there was NO PSYCHOSIS

**Dysthymic Disorder** – *the sort-of-down depression that lasts a long time*

- A depressed mood most days for at least 2 years
- Depressed mood or Anhedonia with **2 concurrent symptoms** instead of 5 for major depression
- This is the guy who doesn’t want to kill himself, but he just always feels down, losing interest in things, and just can’t get going in the morning.
- This **may be** a personality disorder than a true mood disorder
- Brain Imaging
  - In general, mood changes commonly occur with **infarctions of frontal lobe**
  - MDD = **reduced hippocampal volume**
  - Decreased **functional activity** in the prefrontal cortex
  - Treated patients show a reverse in abnormalities (size and function)

- Pathology
  - Hypothalamus releases **CRH** to pituitary which releases **ACTH** which acts on adrenal glands to produce **cortisol**.
  - **Cortisol increases in the blood and CSF** = most common finding in depression
    - Abnormal **dexamethasone suppression test**. Normally, if you give dexamethasone prior to sleep, the high concentration of corticosteroid feeds back and inhibits cortisol production via feedback at the hypothalamus. In depressed patients, cortisol is still made anyway, indicating a change in function of the cortisol axis.
  - Monoamine Hypothesis
    - Since antidepressants make people better, and it usually doesn’t matter which one you pick (serotonin, norepinephrine, or dopamine) the understanding is fairly unclear.

- Treatment
  - **Monoamine Oxidase Inhibitors**
    - First to come on the market
    - **Irreversibly inhibit monoamine oxidase**, preventing breakdown of monoamines
      - MAO is in the neuron, usually presynaptically
      - After reuptake, MAO metabolizes basically all monoamines
      - Takes **weeks to reach full effect**
      - Dietary restrictions – no wine or cheese! (Tyramine causes HTN)
  - **Tricyclics (aka nonspecific reuptake inhibitors)**
    - Mechanism
      - Inhibit reuptake of norepinephrine and serotonin
      - Some may focus on NE more than Serotonin, and vice versa
    - Toxicity and Side Effects
      - Low Therapeutic Window
      - Prolong the QT interval
      - Cholinergic Blockade: dry mouth, orthostasis, memory impairment
  - **Specific Reuptake inhibitors (SSRIs, NERIs, S-NE-RIs)**
    - SSRIs = Better side effect profiles without dietary restrictions or cardiac abnormalities, though they do possess the possible **serotonin syndrome**
      - Combination SSRI + NERIs (serotonin and Norepi) have recently come on the market and are on TV as Venflaxin (Effexor) and Duloxetine (Cymbalta)
**Other Antidepressants**
- **Bupropion (Wellbutrin)**
  - Moderately potent of dopamine and norepinephrine
  - Cures the depression, but induces anxiety
  - Less sexual side effects (not as bad libido) than SSRI
  - Highest risk of seizure
- **Mirtazapine (Remeron)**
  - Blocks reuptake like an TCA without anticholinergic effects
  - Blocks norepinephrine and histamine
    - Induces sleep and fixes depression
  - Causes weight gain

**General Antidepressant Qualities**
- Response time make take 4 weeks to reach maximum effect
  - Remodeling of neurons builds synapses, taken time
- Increased risk of suicide with initiation of therapy
  - The energy boost that comes at the beginning, plus the concurrent suicidal ideations that haven’t been lost yet, together equal an increased risk of attempted suicide
  - Especially in kids

**Psychotherapy**
- Psychodynamic = long term weekly “talk sessions”
- Cognitive Behavior Therapy = block negative thoughts while they are thinking about it. Has been as effective as drugs alone; together they are best
- Interpersonal Therapy = How to make your relationships better

**Electric Convulsive Therapy**
- Has higher rates than drugs, but is expensive and has a bad stigma with it
- Usually used for refractory patients who just can’t get better with drugs or psychotherapy
  - When used for psychosis, it generally fails
  - When used for mood, it generally works well
- Must actually override the seizure threshold to have a beneficial effect
  - You must induce a seizure to have an improvement of mood
  - You must give the therapy at least 6 times for it to work
  - Results are faster (days compared to weeks)
- Causes amnesia, both retrograde and anterograde
MOOD DISORDER II - BIPOLAR DISORDERS

Bipolar

- Definition and Types
  - Bipolar Type 1: Includes manic episodes only for diagnosis, may have depressive
  - Bipolar Type 2: Must include both hypomanic episode + depressive episodes

- Mania
  - Difficult to describe “until you see it”
  - Mood is elevated, expansive, or irritable
    - May be at a state of euphoria, way beyond just “having a good day”
    - May become hostile or irritable, demanding things
  - Mood change lasts at least one week
  - Any 3 of these criteria must be met
    - Inflated self-esteem or grandiosity; may reach delusional levels
    - Decreased need for sleep
    - Fight of ideas – jumping from topic to topic, difficult to follow / no segway
    - Pressured Speech – Fast talking, difficult to interrupt
    - Distractibility – obviously conflicts with next criteria, but no long term attention
    - Pressured Speech – Fast talking, difficult to interrupt
    - Distractibility – obviously conflicts with next criteria, but no long term attention
    - Increase in goal-directed activity – some people have incredible success
    - Increased Libido

- Hypomania
  - Same criteria as manic episodes, but are simply less severe
  - They do not cause social or occupational impairment and need only last 4 days

- Depression
  - See the previous Mood Disorder section
  - Need not be a major depressive episode, but, like hypomania, there can be a milder so-called “hypodepression” (I made that word up)

- Treatment
  - Lithium
    - The first treatment discovered in 1949, approved in 1970 for mania
    - It is an alkali metal that is not protein bound and is excreted renally
    - It stabilizes uptake of Glutamate or normalize GABA levels
    - Gold standard for treatment of mania, protective of suicide
    - Causes neurotoxicity, nephrotoxicity, hypothyroid, and diabetes insipidus
  - Anticonvulsants
    - Valproate
      - Used to treat acute episodes of mania or acute major depression
      - It is teratogenic, and has a risk for pancreatitis and hepatic failure
    - Carbamazepine
      - Used to treat acute episodes of mania and for prophylaxis
      - May cause rash or agranulocytosis/ aplastic anemia
    - Lamotrigine
      - The backup for acute mania limited by rash of other drugs
      - Is a good prophylactic
### MOOD DISORDERS

<table>
<thead>
<tr>
<th>Disease</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dysthymia</td>
<td>- <strong>Low grade</strong> depression that lasts <strong>chronically (2 years)</strong>&lt;br&gt;- Milder form of major depression with fewer symptoms required for diagnosis</td>
</tr>
<tr>
<td>Major Depression</td>
<td>- Symptoms must last for 2 weeks with a change or impairment from normal functioning&lt;br&gt;- Diurnal Improvement as day progresses (gets better as the day goes on)&lt;br&gt;- <strong>Suicide</strong> is a major risk, and <strong>suicidal ideations is pathognomonic for major depression</strong>&lt;br&gt;- Associated with <strong>Anhedonia</strong> or <strong>Depressed Mood</strong>, along with increased eating / weight gain, insomnia or hypersomnia, mood congruent hallucinations, loss of libido and sex drive&lt;br&gt;- Usually acute (compared to Dysthymia)&lt;br&gt;- Caused by <strong>Monoamine Deficiency</strong> (NE, 5HT, Dopamine?)&lt;br&gt;- Treated with SSRIs, then MAO-Is, then TCAs, then “Atypicals,” then combinations</td>
</tr>
<tr>
<td>Bipolar</td>
<td>- <strong>Type 1</strong> = Manic episodes that may have depressive episodes&lt;br&gt;- <strong>Type 2</strong> = Hypomanic Episodes + Depressive Episodes&lt;br&gt;- Hypomania is just a mild version of full Mania&lt;br&gt;- Depressive Symptoms are the same as for Major Depression&lt;br&gt;- Mania is characterized by ↑self esteem or grandiosity, ↓need for sleep, flight of ideas, ↑libido, pressured speech, irritability and distractibility, ↑energy&lt;br&gt;- Treat with <strong>Lithium</strong></td>
</tr>
<tr>
<td>Reactive Depression</td>
<td>- <strong>Acute</strong> depressive symptoms following a critical event&lt;br&gt;- No clear distinction between major depression; subjective diagnosis&lt;br&gt;- Will most likely be a distractor on your exam</td>
</tr>
</tbody>
</table>

### TREATMENT

<table>
<thead>
<tr>
<th>Bipolar</th>
<th>Depression</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lithium</td>
<td>MAO-Is&lt;br&gt;- Blocks degradation of 5HT and NE&lt;br&gt;- Causes orthostatic hypotension&lt;br&gt;- Can produce HTN crisis with tyramine (avoid wine and cheese!)</td>
</tr>
<tr>
<td>Anticonvulsants</td>
<td>SSRI-s&lt;br&gt;- Blocks reuptake of serotonin&lt;br&gt;- Large therapeutic window&lt;br&gt;- May have some NE function as well&lt;br&gt;- May produce serotonin syndrome</td>
</tr>
<tr>
<td>Valproate</td>
<td>TCAs&lt;br&gt;- Blocks reuptake of monoamines&lt;br&gt;- Has a low therapeutic index&lt;br&gt;- Prolongs QT interval&lt;br&gt;- Is also anticholinergic</td>
</tr>
<tr>
<td>Carbamezpine</td>
<td>Lamotrigine&lt;br&gt;- Acute episodes of <strong>mania or depression</strong> is <strong>teratogenic</strong>&lt;br&gt;- Causes aplastic anemia and rash</td>
</tr>
</tbody>
</table>
| Acute episodes of **mania** without rash<br>Also a good prophylactic | All antidepressants may take **weeks or months for full effect** and, with initiation of treatment, may **increase risk of suicide** (motivation returns before depressive mood subsides)
HUMAN SEXUALITY – very little of this stuff was touched on by Kaplan, but this is what you need to know

**Human Sexuality throughout development**

- **Children**
  - Self-stimulation (in public) because they know it feels good, but they don’t really know
  - There are gender awareness and experimentation, “playing doctor”
- **Adolescence**
  - Gender-specific maturation (puberty) including menarche, breast development, hair growth, nocturnal emission; all secondary sex characteristics fulminate
  - Experimentation with sex
- **Adults**
  - Solidification of gender roles
  - Intimacy with a primary relationship
  - Parenting
  - Development of sexual problems and dysfunction

**Normal Sexual Behavior**

- Vast majority of couples were **faithful**, females more than males
- Frequency of sex (not desire, actual practice)
  - Married Couples = 41% two times a week
  - Single People = 23% two times a week
  - Living together but not married had sex more than two times per week
- Vaginal intercourse is the preferred method of sex for most people
- Median # of partners for males = 6, females = 2
- Masturbation is normal, 25% males and 10% females masturbate, more frequently in the 20s then in the teens (24-34 > 18-24)
- Men generally reach orgasm during sex, women only some of the time
- Fantasies
  - **Females** - Heterosexual
    - Encounters with women
    - Replacement of current partner
    - Forced Encounter with man
    - Someone watching
  - **Males** - Heterosexual
    - Replacement of partner
    - Forced encounter
    - Observing someone else
  - **Females** – Homosexual
    - Encounters with men
    - Forced encounter with women
    - Memories of past partners
    - Idyllic encounters with current partner
  - **Males** – Homosexual
    - Images of male anatomy
    - Encounter with women
    - Group sex
    - Forced Encounters with men
Sexual Physiology
- **Excitement Phase** - “getting turned on”
  - Women = pelvic congestion, clitoral enlargement, nipple erection, vaginal lubrication, increase heart rate and blood pressure
  - Men = Erection, tension of scrotal sac, nipple erection, elevation of testes, increases in heart rate and blood pressure
- **Plateau Phase** – “getting into it and approaching climax”
  - Females = Clitoral retraction, vaginal vasoconstriction, “sex flush”
  - Males = Increase in penile circumference, enlargement of testis, “sex flush”
- **Orgasmic Phase** – “climax”
  - Females = Everything (uterus, rectum, pelvis) contracts, ↑BP and ↑HR
  - Males = Everything (prostate, all male genitalia, anus,) contacts, ↑BP, ↑HR, and ejaculation if patient has past puberty
- **Resolution** - “get off me and give me a cigarette”
  - Females = return to normal, barely any refractory period
  - Males = return to normal, refractory period increases with age

**Sexual Abuse**
- Girls more likely to be abused by Males
- Earlier sex (the abuse) = more sex = more partners, more likely to be bisexual, more likely to contract disease

**Sexual Dysfunction Disorders** (these were listed and not explained, see the Kaplan chart at the end)
- **Hypoactive Sexual Desire** = decreased libido, decreased desire to have sex
- **Sexual Aversion Disorder** = viewed or regarded as nasty or disgusting and you don’t want anything to do with it
- **Male Erectile Disorder** = primary disease means that you were never able to achieve an erection; secondary means that something has changed (age, atherosclerosis, etc). It can be either biological (age) or psychological (depression)
- **Female Sexual Arousal Disorder** = the female version of male erectile dysfunction.
- Inhibited Orgasm
- Premature Ejaculation
- **Dyspareunia** = more common in women, it is genital pain during intercourse
- **Vaginismus** = painful contraction of outer third of vagina, prevents penile insertion

**Paraphilias** variety of deviant sexual behavior or fantasies for nonhuman objects or activities that involve suffering, humiliation, or any activity with non-consenting partners. Again listed in class with definitions
- **Psychological Theories for Emergence**
  - Blurring of sexual difference and poor infant-mother demarcation
  - Compromise from developmental conflict
  - Aggressive outlet or Desire of Control
  - Basically, we don’t know why these happen, but they are assumed pathological
- Presentations
  - Persistent, repetitive, intrusive fantasies that are unusual can diagnose the condition
  - Most of these don’t really matter, i.e. are **ego-syntactic**. The ones that are “weird” are weird to society, but so long as they are between consenting adults, no one really cares
  - Others are societally unacceptable – rape, pedophilia, necrophilia
  - Very rarely do patients approach a psychiatrist for information or help, most are forced by the courts to seek attention. Instead, most people go to great lengths to hide it

- Types
  - **Pedophilia** – the most common sexual assault, sexual urges towards children
  - **Zoophilia** – sex with animals
  - **Partialism** – they go for amputees
  - **Sadism** – pleasure derived from another’s pain
  - **Masochism** – pleasure from being hurt or dominated
  - **Coprophilia** – sex + defecation
  - **Urophilia** – sex + urination
  - **Rape** – forced sex with a nonconsenting partner
  - **Incest** – sex with related persons (within and including
  - **Voyeurism** – Sexual pleasure from watching, develops in early childhood
  - **Exhibitionism** – Sexual pleasure from being watched or displaying genitals to others
  - **Hypoxophilia** – sexual pleasure derived from asphyxiation, choking, or smothering
  - **Frotteurism** – clothed males rubbing against females to reach orgasm, buses and trucks
  - **Necrophilia** – preferring sex with cadavers
  - **Scatologia** – talking dirty

<table>
<thead>
<tr>
<th>SEXUAL DISORDERS</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Disorders of Sexual Desire</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Hypoactive</strong></td>
<td>Deficiency or absence of fantasies or desires, more common in women</td>
</tr>
<tr>
<td><strong>Sexual Aversion</strong></td>
<td>Aversion to all sexual contact; its “gross” or “vulgar”</td>
</tr>
<tr>
<td><strong>Sexual Arousal Disorders</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Female Sexual Arousal Disorder</strong></td>
<td>Female version of erectile dysfunction</td>
</tr>
<tr>
<td><strong>Erectile Dysfunction</strong></td>
<td>Dysfunction of arousal, lubrication, and pleasure (“tough to get going”)</td>
</tr>
<tr>
<td><strong>Primary ED</strong></td>
<td>means that they were never able to get it up (Viagra wont help)</td>
</tr>
<tr>
<td><strong>Secondary ED</strong></td>
<td>means that something changed (Viagra will help)</td>
</tr>
<tr>
<td><strong>Incidence ↑</strong></td>
<td>with Age, Smoking, and Obesity</td>
</tr>
<tr>
<td><strong>Orgasm Disorders</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Anorgasmia (inhibited female orgasm)</strong></td>
<td>Inability to have an orgasm; Chances of having orgasm ↑ with age</td>
</tr>
<tr>
<td><strong>5% of married women older than 35 have never achieved orgasm</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Retarded Ejaculation</strong></td>
<td>Usually restricted from the inability to ejaculate in the vagina (male dysfunction)</td>
</tr>
<tr>
<td><strong>These guys take a really long time to get off, the opposite of the next disease</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Premature Ejaculation</strong></td>
<td>Male regularly ejaculates before or just upon entering vagina</td>
</tr>
<tr>
<td><strong>May be normal if sex and masturbation is withheld for long periods of time</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Sexual Pain Disorders</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Dyspareunia</strong></td>
<td>Recurrent or persistent pain experienced before, during, or after sex</td>
</tr>
<tr>
<td><strong>More common in women, especially those raped or sexually abused</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Vaginismus</strong></td>
<td>Involuntary contraction of the outer third of the vagina, preventing penile insertion</td>
</tr>
<tr>
<td><strong>with is often painful (both attempted penetration and the contraction)</strong></td>
<td></td>
</tr>
</tbody>
</table>
PERSONALITY DISORDERS

General Diagnostic Criteria

- An enduring pattern of inner experience and behavior that deviates markedly from the expectation of the individual’s culture manifested by two or more of...
  - Cognition = perception of self, other people, or event
  - Affectivity = range, intensity, lability, and appropriateness of response
  - Interpersonal functioning
  - Impulse Control
- Sufferers of these diseases are ego-syntonic, that is, they are resistant to therapy since, to them, “nothing is wrong” despite challenges to their perception; “all of you are crazy”
- These are the axis II diagnosis.
- They cause elevated rates of divorce, unemployment, homelessness, perpetuation of child abuse, separation and custody hearings
- These diseases are inherently not psychotic, that is axis 1.
- We must understand clusters and into specific diseases

Cluster A = “The Weirdos” – Based on Psychosis

- These are the odd or weird patients, often considered on a range of schizophrenia
- Paranoid Personality Disorder
  - Pervasive distrust and suspiciousness of others such that their motives are interpreted as malevolent, beginning by early childhood
  - They think others are trying to harm them
  - Doubts about others, there is no trust in others, so they keep secrets
  - Either purposefully takes benign comments as malicious and they hold grudges
  - Male > Females
  - Refuse responsibility for their own feelings, though are often angry, angry and irritable
  - Antipsychotic meds may be helpful
- Schizoid Personality Disorder
  - Pervasive pattern of detachment from social relationships and a restricted range of expression of emotions in interpersonal settings, beginning by early adulthood and present in a variety of contexts, as indicated by the following:
    - Neither desired nor enjoys close relationships, and therefore has no interest in close friends, sex, or interpersonal activities
    - Appears indifferent to the praise or criticism of others
  - These patients hardly ever come to clinic because they aren’t picked up
  - This is the guy who works at IBM in an office under the stairs or is a Toll Booth Operator and is completely happy that he is there devoid of communication
  - Males > Females
  - Intact reality testing with high functionality if left alone
- **Schizotypal Personality Disorder**
  - A pervasive pattern of social and interpersonal deficits marked by acute discomfort with, and reduced capacity for, close relationships, as well as cognitive or perceptual distortions and eccentricities of behavior, beginning by early adulthood and present in a variety of contexts
    - Odd beliefs or magical thinking that influences behavior (superstition, clairvoyance, telepathy)
    - Unusual perceptual experiences, “outer body experiences”
    - Odd thinking and speech (vague, metaphorical, stereotyped)
    - Suspiciousness or paranoid ideation
    - This is close to schizophrenia, but isn’t totally delusional to fit psychosis
    - Poor idea of reference
  - They tend to lack friends, lovers, or close relationships
  - Have social anxiety and tends to be associated with paranoid fears
  - Males > Females

**Cluster B = “Bad Boys” – Based on Mood Disorders**

- These are the **dramatic, emotional, and erratic** patients. They have a social and interpersonal disability with an **unstable course**. Treatment is usually effective between psychotherapy and medication, but only if the patients actually stick with the treatment, which is rare. You will see the most of these in clinical practice.

- **Borderline**
  - Pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity by early adulthood and present in a variety of contexts as indicated by five or more of these:
    - Frantic efforts to avoid real or imagined abandonment
    - Patterns of unstable and intense interpersonal relationships characterized by alternating between extremes of **idealization and devaluation**
    - Markedly persistent unstable self image or sense of self
    - **Impulsivity** in two areas that are potentially self damaging (spending money, sex with strangers, drugs, reckless driving, binge eating)
    - Recurrent **suicidal** behavior (gestures, attempts, threats, or mutilation)
    - Chronic feeling of emptiness
    - Inappropriate intense anger or difficulty controlling anger
    - Transient, stress-related dissociative symptoms
  - Females > Males
  - These patients usually “attempt suicide” for attention, becoming successful often from a miscalculation (expecting a loved one home to find them and save them, but the loved one does not arrive)
  - Increased risk for co-morbid mood disorders, eating disorders, and PTSD
  - Install **intense countertransference**; they are incredibly difficult to work with and are incredibly manipulative, putting a lot on the doctors
  - Mood swings on the time, like instantly
- **Antisocial Personality Disorder**—*they don’t have a conscious*
  - Pervasive pattern of disregard for and violation of the rights of others occurring since age 15, as indicated by three (or more)
    - Failure to conform to social norms with respect to lawful behaviors as indicated by repeatedly performing acts that are grounds for arrest
    - Deceitful, as indicated by repeated lying, use of aliases, conning others
    - Impulsivity and the inability to plan ahead
    - **Lack of remorse or justification of actions**
    - There must be conduct disorder before age 15 (childhood criminals)
    - 75% of people in jail fit this criteria; some politicians can fit
  - It’s a misnomer: these are not avoidant and can handle society, they just violate it
  - “Sociopath” is often used as a synonym, though a true sociopath is an extreme range of this antisocial personality disorder, without the ability to properly process emotion.
    - They MUST have lack of remorse or justification of actions
    - These are the serial killers
  - Male > Female

- **Histrionic**
  - A pervasive pattern of excessive emotionality and attention seeking, beginning by early adulthood and present in a variety of contexts, as indicated by five or more
    - Must be the center of attention; they get uncomfortable when they aren’t
    - Inappropriately sexually seductive or provocative
    - Rapidly shifting and shallow expression of emotions
    - Overly dramatic with speech, often lacking detail, very “theatrical”
    - Uses physical appearance to draw attention to self
    - Considers relationships more significant than they are
  - Females > Male
  - These patients have a horrible mid-life crisis as their looks begin to fail
  - Treated well with psychotherapy

- **Narcissistic**
  - A pervasive pattern of grandiosity (in fantasy or behavior), need for admiration, and lack of empathy beginning in early adulthood and present in a variety of context
    - Grandiose sense of self-importance
      - Exaggerate their talents or experiences
      - Expect others to identify them as superior
    - Preoccupied with fantasies of unlimited success, power, or brilliance
    - Believes that the or she is “special” and requires other “special people” do understand them
    - Requires Admiration from others
    - Sense of entitlement
    - Interpersonally exploitative – you’re great while I can use you, when I can’t I lose you.
    - Lack empathy; they are just self-consumed that they aren’t able to see others have problems
    - Jealous of others, arrogant and haughty
  - Also have mid-life crisis
  - Does not respond well to therapy because “there isn’t anything wrong”
Cluster C – “The Wimps” – Based On Anxiety

- **Avoidance Personality Disorder** = *being really shy*
  - A pervasive pattern of social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation, beginning by early adulthood and present in a variety of context:
    - Avoid occupational activities and interpersonal contact. Unlike the Schizoids, these people **do want the relationships** but avoid them **for fear of failure** or rejection
    - Unwilling to get involved unless there is a certainty of being liked
    - Restrain in close relationships
    - Preoccupied with these feelings of inadequacy
    - Views self as socially inept, personally unappealing, or inferior
  - Cannot be diagnosed in teenagers
  - Look for “fear of embarrassment” in a vignette
  - Common, especially with disfiguring ailment
  - Male = Female
  - High risk for Anxiety disorders, is this really a social phobia / anxiety disorder
  - Respond well to SSRIs

- **Dependent Personality Disorder** – *stay at home mom*
  - A pervasive and excessive need to be taken care of that leads to submissive and clinging behavior and fears of separation, usually beginning by early adulthood
    - Difficulty in making everyday decisions without advice
    - Need others to assume responsibility
    - Do not disagree for fear of others withdrawing support
    - Will not start a project
    - Excessive length to obtain nurturance and support from others
    - Uncomfortable or helpless when alone, urgently seeking a close relationship as soon as one ends.
    - Unrealistic fears of being left alone or with the inability to take care of themselves
  - Females > Males
  - Often comorbid with Dysthymia, Major Depression, or Alcohol Abuse
  - Respond well to group therapy, social skills training, SSRIs

- **Obsessive Compulsive Personality Disorder**
  - This is NOT the anxiety disorder, this is a personality disorder
  - A pervasive pattern of preoccupation with orderliness, perfectionism, and interpersonal control, at the expense of flexibility, openness and efficiency
    - Preoccupied with details, rules, and organization
    - Perfectionism that interferes with task completion
    - Excessively devoted to work to the exclusion of friendship and leisure
    - Scrupulous, inflexible, is overly conscientious
    - Unable to discard worn-out or worthless object
    - Reluctant to delegate tasks
    - Shows rigidity and stubbornness
  - OCPD is ego-tonic (they are fine) while OCD is ego-dystonic (help me!)
  - Males > Females
  - Group therapies helpful, drugs not so much
# Human Behavior / Psych

## PERSONALITY DISORDERS

<table>
<thead>
<tr>
<th>Disease</th>
<th>Criteria</th>
<th>Prevalence</th>
<th>Treatment</th>
<th>Movie Example</th>
<th>Differential</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cluster A – The Weirdoes; Psychosis</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paranoid</td>
<td>Others are out to harm them. Takes things personally.</td>
<td>Males &gt; Females 0.5 – 2.5% of population</td>
<td>Antipsychotic Meds</td>
<td>“Falling Down”</td>
<td>Schizotypal, Schizophrenia, Delusional</td>
</tr>
<tr>
<td></td>
<td>Doubts others, keeps secrets</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Schizoid</td>
<td>Detached without emotion. Indifferent to praise or criticism.</td>
<td>Males 2x &gt; Females 1-7.5 % of population</td>
<td>Rarely ever treat these</td>
<td>“Sex Lies and Video Tapes”</td>
<td>Schizotypal Avoidant</td>
</tr>
<tr>
<td></td>
<td>Tend to be solitary. Don’t want Sex or Relationships</td>
<td></td>
<td>because they are not found; most function well</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Schizotypal</td>
<td>Highly Eccentric. Discomfort and reduced capacity for close relationships</td>
<td>Males &gt; Females 3% of population</td>
<td></td>
<td>“Taxi Driver”</td>
<td>Paranoid, Schizoid, Avoidant, and is Considered a mild form of schizophrenia,</td>
</tr>
<tr>
<td></td>
<td>Odd thinking, speech, appearance but is not bizarre delusional</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Cluster B – The Bad Boys = Dramatic, Emotional, and Wild; Mood</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Borderline</td>
<td>Fear of abandonment. Relationships are black and white. Impulsivity and Suicidal actions, often for attention.</td>
<td>Females 2x &gt; Males 2-3% of population</td>
<td>Psychotherapy called</td>
<td>“Fatal Attraction”</td>
<td>Bipolar, because they have mood swings, but Borderlines have Mood swings “on a dime” (rapid)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Dialectical Behavioral Therapy;</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>treatment-resistant</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Antisocial</td>
<td>Violation of Rights. Failure to conform to social norms. Lack of remorse, rationalize harm. Must have deviant behavior by 15.</td>
<td>3%Male &gt; 1%Female Up to 75% of prison population</td>
<td>Difficult or impossible to treat; they don’t care about the relationship and they can’t have a relationship</td>
<td>“Sopranos” (TV)</td>
<td>Substance Abuse (when the addiction is gone, the symptoms go away)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>“Clockwork Orange”</td>
<td></td>
</tr>
<tr>
<td>Histrionic</td>
<td>Must be center of attention. Emotions are shallow. Dramatic, Theatrical, Exaggerative.</td>
<td>Females &gt; Males Prevalence in theater</td>
<td></td>
<td>“Streetcar Named Desire” or “Gone with the Wind”</td>
<td>Dependent, Borderline, Narcissistic, Somatization</td>
</tr>
<tr>
<td>Narcissistic</td>
<td>Grandiose sense of self-importance. Need admiration and special tx. Lack of empathy, Jealous of others.</td>
<td>Males &gt; Females Prevalence Unknown</td>
<td>Do not tolerate group therapy, and usually present with depression</td>
<td>“Zoolander”</td>
<td>Borderline, Histrionic, Antisocial</td>
</tr>
<tr>
<td><strong>Cluster C – The Wimps = Anxious and Fearful; Anxiety</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Avoidant</td>
<td>Fear of rejection or criticism. Avoid interpersonal reactions for fear</td>
<td>Male = Female</td>
<td>Group Therapy, SSRI, Anxiolytics</td>
<td>“Napoleon Dynamite”</td>
<td>Social Phobia, Dependent, Schizoid</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dependent</td>
<td>Fear of separation. Needs to be cared for, taken care of</td>
<td>Females &gt; Males 2-4% of population</td>
<td>Group Therapy, SSRI</td>
<td>“What about Bob?”</td>
<td>Histrionic, Borderline, Avoidant, Agoraphobia</td>
</tr>
<tr>
<td>Obsessive Compulsive</td>
<td>Preoccupied with details and perfection at the cost of efficiency</td>
<td>Males &gt; Females</td>
<td>Group Therapy</td>
<td>“Monk” (TV)</td>
<td>Not OCD, this is OCPD</td>
</tr>
</tbody>
</table>

---

**Note:** The above table provides a summary of personality disorders, including their criteria, prevalence, treatment, and movie examples. The different clusters represent various aspects of human behavior and psychological disorders.
SOMATOFORM DISORDERS

**Delirium**
- **Definition**
  - An **abrupt change in cognition** that follows some medical event
  - Describes an **acute confusional state** affecting critical areas of mental functioning that occurs as a direct result of a medical illness or treatment
  - **High fatality rate** in the hospital, and **increased costs**
- **Criteria**
  - Disturbance of Consciousness with reduced ability to focus, sustain, or shift attention
  - Change in cognition (memory, language, or disorientation) or development of a perceptual disturbance that is not a product of a preexisting dementia or disease
  - **Rapid onset** and tends to fluctuate throughout the day
  - Patients have poor insight about their condition, often feeling as though what they are seeing, hearing, or feeling (most hallucinations) are real
- **Treatment**
  - Antipsychotics are the most effective class of medics
  - Typical antipsychotics (D2 antagonists) such as haloperidol and chlorpromazine
  - Atypicals may work too: risperidone, ziprasidone, olanzapine
- **Real World Examples**
  - Patient comes in with a fever of 105 and doesn’t respond to your shouts
  - Women comes out of surgery doped on benzos and bites, kicks, and screams at the nurse for trying to experiment on her; two days later she is lucid and normal

**Fatigue**
- **Definition**
  - Subjective sense or **persistent or overwhelming tiredness** or sustained exhaustion related to medical illnesses or medical treatment that impairs life or occupation.
- **Criteria**
  - Patients **retain** the desire and interest in resuming daily life but have no motivation
  - Patients get the treatment to fix their illness, but just can’t use their health
  - **Generalized weakness** or limb heaviness
  - Inability to concentrate or pay attention
  - Insomnia or Hypersomnia without restful sleep
- **Treatment**
  - **Exercise** is the most important element. Yeah it sucks, but working hard will get them up
  - **Stimulant Drugs** (Welbutrin, Methylphenidate/Ritalin, Dextro-Amphetamine/Adderall)
  - Treating the underlying disease or recovering from treatment is NOT ENOUGH
- **Examples**
  - Chemotherapy patients are “wiped out” after a round of therapy
  - Dialysis patients go home and sleep every other day after their treatment
Hypochondriasis

- Preoccupied with fears or ideas of having a serious disease associated with bodily symptoms
- Preoccupation persists despite appropriate medical evaluation and reassurance
- Preoccupation causes significant emotional distress and functional impairment

Conversion Disorder

- Emotional conflict leads to somatic deficit, usually in the form of pain or musculo-skeletal
- The deficit or symptom is real and is not intentionally produced nor feigned.
- Symptom cannot be explained by medical condition, and can include motor symptoms, sensory symptoms, or seizure-like symptoms

Somatization Disorder = “Super Conversion Disorder”

- Set of eight or more symptoms (four pain, two GI, one sexual, one neurologic)
  - Pain = duh, it hurts, somewhere, in four different spots
  - GI = Nausea, Bloating, Intolerance of Foods
  - Sexual = Loss of Libido, Erectile or Ejaculatory Dysfunction, Irregular Menses
  - Neurologic = ataxia, amnesia, aphonia, dysphagia, etc
- Onset before age 30, usually diagnosed in young adults who had a traumatic childhood without any support group or therapy that presents with multiple conversion-like defenses
- These deficits or symptoms are real and are not intentionally produced nor feigned.

<table>
<thead>
<tr>
<th>SOMATOFORM DISORDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Disease</strong></td>
</tr>
<tr>
<td>Delirium</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Fatigue</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Hypochondriasis</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Conversion Disorder</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Somatization Disorder</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Body Dysmorphic Disorder (from Kaplan, not lecture)</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>
Human Behavior / Psych

CHILD PSYCHIATRY

We had an hour lecture on just ADHD, which was mostly treatment (see pharm)

We had an hour lecture on just Autism, which has no treatment.

These 1 hr long sessions will not help you score on the exam, this chart should help you get the points you need.

<table>
<thead>
<tr>
<th>CHILDOOD PSYCH</th>
<th>Age, Gender</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conduct Disorder</td>
<td>Childhood form of Antisocial Personality Disorder</td>
</tr>
<tr>
<td></td>
<td>Steal, Lie, Cheat, commit crimes, but does not do harm to others</td>
</tr>
</tbody>
</table>
|                                       | By definition, it must be a child under the age of 15 | Dx in Teens
|                                       | Male > Female |
| ADHD                                  | Difficulty sustaining attention, waiting in line, or obeying commands |
|                                       | Hyperactivity = running around, jumping out of seat, impulse control issues |
|                                       | Treat with Typical Antipsychotics (Methylphenidnle or Dextroamphetamine) | Young Kids
|                                       | Male > Female |
|                                       | 10:1 |
| Asperger’s                            | Autism look-a-like; this disease has no language development impairment |
|                                       | Be aware of it, though it will most likely be a distractor | Male > Female
|                                       | 4:1
|                                       | Limited IQ |
| Autism                                | Difficulty understanding and reproducing social interaction |
|                                       | Exhibits stereotyped behavior (arm flapping, hand ringing) |
|                                       | Failure to dissociate animate objects from inanimate ones |
|                                       | Tip off is absent or abnormal language development (no words at age 2) |
|                                       | Uncertain cause = perinatal/prenatal injury; mercury in vaccines is a myth |
|                                       | No Treatment Available | Male > Female
|                                       | 2:1 |
| Mental Retardation                    | Early presentations may resemble autism – language impairment, intelligence |
|                                       | No Social Impairment; despite low IQ, patients retain social understanding |
|                                       | Function limited by severity, IQ 50-70 can live on their own, 35-49 is |
|                                       | trainable but requires constant supervision, 35 or less is worst case | Male > Female
|                                       | |
| Abuse, Trauma, PTSD                   | Symptoms are identical to adult PTSD, and often follows Sexual Abuse |
|                                       | Kids who are sexually abused are at increased risk to commit sexual abuse |
|                                       | Kids who are sexually abused are at increased risk for STD and Promiscuity |
|                                       | Re-Experiencing (nightmares), Avoidance, and Hyperarousal (Insomnia) |
|                                       | Treat with SSRIs, even with increased risk of suicide in kids | Female > Male
|                                       | Get abused; Male > Female do the abusing |

<table>
<thead>
<tr>
<th>AUTISM , ASPERSGERS, MENTAL RETARDATION</th>
<th>Autism</th>
<th>Asperger’s</th>
<th>Mental Retardation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Repetitive Movements</td>
<td>Repetitive Movements</td>
<td>No repetitive movements</td>
<td></td>
</tr>
<tr>
<td>Loss of Social Cognition and Problems Forming Social Interactions</td>
<td>Loss of Social Cognition and Problems Forming Social Interactions</td>
<td>They are socially aware, but are withdrawn because they know they are retarded</td>
<td></td>
</tr>
<tr>
<td>Language Problems; They don’t speak</td>
<td>Language retained, they speak, but it is not always comprehensible</td>
<td>Language develops, but there is trouble communicating</td>
<td></td>
</tr>
<tr>
<td>Unknown Cause, No Treatment</td>
<td>Unknown Cause, No Treatment</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Aspergers and Autism are essentially the same disease, just that aspergers is a mild form. The real difference is in the child’s ability to speak. All three diseases share a generally depreciated IQ, except that Autism may create savants. The major distinction between MR and the other two is the ability to form social interactions.
DISSOCIATIVE DISORDERS

**Dissociative Amnesia**
- **Definition**
  - Inability to recall important personal information usually of a **traumatic nature** that is too extensive to be explained by normal forgetfulness
- **Types**
  - **Global**: total loss of autobiographical information
  - **Episodic**: Specific Episodes of behavior or trauma
- **Character**
  - The incidence is common to and in equal prevalence in both males and females
  - Peak incidence is in the 3rd and 4th decades (so **adults**)
  - Amnesia lasts **24hrs to 5 days**
- **Treatment**
  - Psychotherapy, Hypnosis, Amytal Interview

**Dissociative Fugue**
- **Definition**
  - Sudden unexpected travel away from one’s place of daily activities with the inability to recall some or all of one’s past, often with the creation of **entirely new identities**
  - Dissociative Amnesia + Travel = **Fugue**
- **Clinical**
  - Males suffer just as much as females, except in times of war, where men suffer more
  - It is the **rarest** form of dissociative disorder
  - May last up to **a few days or months** (notice longer than dissociative amnesia)
  - Peak incidence in 20s and 40s
  - Rule out drugs and alcohol
- **Treatment**
  - Usually resolves **spontaneously** or with memory cuing

**Dissociative Identity Disorder**
- **Definition**
  - “Multiple Personality Disorder”
  - The presence of two or more **distinct identities or personality states** that each has its own relatively enduring pattern of perceiving, relating to, and thinking about the environment and the self
  - At least two of these identities must periodically take control of the person’s behavior
  - Associated with amnesia (the main personality does not remember because the alternative personalities had dominance at that time)
- Characteristics
  o The **dominant personality state** exists and is often aware of all other personalities
  o The other personalities (**alters**) have varying degrees of awareness of the others
  o Depression is common
  o Inner voices occur in up to half; these are not delusional voices of schizophrenia!
  o Female > Rare, but prevalence is super rare

**Depersonalization Disorder**

- Definition
  o Persistent or recurrent episodes of detachment or estrangement from one’s self
    ▪ “I’m watching myself as if I were in a movie”
- Characteristics
  o Reality testing is intact
  o Peak incidence is in adolescence and early adulthood
  o Incidence in Males = Females

<table>
<thead>
<tr>
<th>DISOCIATIVE DISORDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Disorder</strong></td>
</tr>
<tr>
<td>Dissociative Amnesia</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Dissociative Fugue</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Dissociative Identity</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Depersonalization</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>
EATING DISORDERS

Anorexia Nervosa

- Definition
  - An eating disorder characterized by lack of eating or purposeful removal of food (laxatives or vomiting) out of a fear of gaining weight or being fat;
  - A type of body dysmorphic disorder leading to low body weight

- Criteria
  - Refusal to maintain a body weight at or above a minimally normal for age and height
    - **Low Body Weight**, <85% of intended minimal weight for age and height
  - Intense fear of gaining weight or being fat, even though underweight
  - Disturbance in body perception
    - “I’m fat” even though low body weight
    - “I’m not too skinny” despite wasting and kechexia
  - Amenorrhea for at least 3 menstrual cycles

- Subtypes
  - Restrictive
    - No vomiting, No laxatives, No eating
  - Binge-Eating / Purging
    - Lots of Food, but then Lots of Laxatives/Diuretics or Self-induced vomiting
    - With purging, you develop Russell’s sign (calluses on the hands) or Lanugo hair (hair beings to fall out or thin)
    - Eventually, purging leads to dental carries and erosion

- Clinical
  - Relentless pursuit of thinness, counting calories, seemingly obsessive compulsive
  - Risk for seizures, avoid Bupropion (atypical antidepressant)
  - 90% Females : 10% Males
  - Affects teenage girls
  - High Suicide Rate
  - Comorbid Conditions = OCD, PTSD, Major Depression

- Treatment
  - **Weight Gain** is the most important treatment
  - **Psychotherapy** targets the OCD and the Body Image Issues
  - **SSRIs** are good to use because they induce weight gain and stabilize mood
**Bulimia Nervosa**

- **Definition**
  - Recurrent episodes of binge eating defined as *discrete period of lack of control* over eating *larger quantities than most the world*

- **Types**
  - Purging: same as described for Anorexia
  - Nonpurging: starvation, excessive exercise, or other means to account for calories

- **Clinical**
  - *Post Binge Anguish* = guilt or shame over their actions, ameliorated by purging
  - Most patients have an interest in physical attractiveness and a sexual interest
  - *Dehydration* and *Electrolyte Imbalances* is the most severe acute condition
  - *Mallory-Weiss* (esophageal lacerations) and *dental carries* problems of vomit purging

- **Treatment**
  - SSRIs for mood stabilization and impulse control
  - Cognitive Behavioral Therapy to control impulse and for body image issues
  - Do not give Buproprion

---

### EATING DISORDER COMPARISON

<table>
<thead>
<tr>
<th></th>
<th>Anorexia</th>
<th>Bulimia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychological</td>
<td>Fear of Being Fat; Body Dysmorphic Disease</td>
<td>Compulsion to eat, Lack of control over eating</td>
</tr>
<tr>
<td>Food</td>
<td>Eats Little or Purges</td>
<td>Eats excessive amounts then purges</td>
</tr>
<tr>
<td>Body Weight</td>
<td>&lt;85% Normal</td>
<td>Normal to Increased</td>
</tr>
<tr>
<td>Age</td>
<td>12-18, teens</td>
<td>12-40 years, Usually Teens and Twenties</td>
</tr>
<tr>
<td>Gender</td>
<td>90% Female</td>
<td>90-95% Female</td>
</tr>
<tr>
<td>Treatment</td>
<td>SSRI, Weight Gain, Psychotherapy</td>
<td>SSRI, Cognitive Behavioral Therapy</td>
</tr>
<tr>
<td>Avoid</td>
<td>Buproprion, causes seizures</td>
<td>Buproprion, causes seizures</td>
</tr>
</tbody>
</table>
DEATH AND DYING

NORMAL GREIF VERSUS DEPRESSION

<table>
<thead>
<tr>
<th>Normal Grief</th>
<th>Depression</th>
</tr>
</thead>
<tbody>
<tr>
<td>Up To 1 Year</td>
<td>Normal Grief persisting &gt; 1 year</td>
</tr>
<tr>
<td>Crying, Decreased Libido, Weight Loss, Insomnia</td>
<td>Crying, Decreased Libido, Weight Loss, Insomnia</td>
</tr>
<tr>
<td>Longing, wishing to see the loved one, talking to love one, thinking they see them in a crowd</td>
<td>Abnormal overidentification, beginning to suffer true psychosis</td>
</tr>
<tr>
<td>Loss of other – patient identifies loss</td>
<td>Loss of Self – patient fails to separate the lost loved one from self</td>
</tr>
<tr>
<td>No Suicidal Ideation</td>
<td>Suicidal Ideation</td>
</tr>
<tr>
<td>Follows Ritual or Learned Behavior of the past</td>
<td>Deviates from pattern or engages in bizarre rituals not normal for patient’s culture</td>
</tr>
<tr>
<td>Antidepressants are not useful, do not medicate!</td>
<td>Antidepressants are useful, do medicate</td>
</tr>
</tbody>
</table>

Stages of Death And Dying

- May occur in any order, and can go back and forth between stages
- Often accompanies unexpected loss, may occur facing one’s own death
- Listed in order in which they usually come,
  - Denial and Isolation – “this isn’t happening” or “you’re wrong he’s alive”
  - Anger – “it’s your fault, I’m going to kill you!”
  - Bargaining – “Please God/Doctor/Universe, I’ll do anything!”
  - Depression - “Fuck this... I can’t believe its over...”
  - Acceptance – “I’m not happy about it, but it’s time to move on”

Definitions

- Death – you aren’t legally dead until a physician signs you’ve been dead
- Grief – a feeling you have
- Bereavement – the action of expressing grief
- Mourning – the ritual you go through after some one has died

Legal

- DNR = Do not resuscitate. Unless otherwise specified this means only “do not perform cardiopulmonary resuscitation if there is cardiac arrest”
  - No shocks, no compressions
- Living Will = detailed legal document that specifies conditions of treatment if unable to say
- Euthanasia = act of killing a hopelessly ill or injured person