Everything you ever wanted to know about Psychiatry...

As it pertains to the PA boards...
In only 100 minutes...
by
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Anxiety disorders

- Panic disorder
- Generalized anxiety disorder (GAD)
- Post traumatic stress disorder (PTSD)
- Phobias
- Obsessive–Compulsive Disorder (OCD)
Panic Attack

- Extreme anxiety
  - peaks within 10 mins.
  - typically declines within 30 mins.
  - rarely lasts >1 hr
- May/may not have identifiable trigger
Panic Attack – Symptoms

- palpitations
- tachycardia
- sweating
- trembling
- dyspnea
- sensation of choking
- chest discomfort
- nausea
- depersonalization

- fear of losing control
- fear of dying
- light-headedness
- numbness
- tingling
- chills or hot flashes
- derealization
Panic Disorder

- Recurrent, unexpected panic attacks
- Abruptly occur
- Accompanied by fear of having add’l attacks
- Fear & physical symptoms may be accompanied by
  - feeling of impending harm/death
  - fear of having heart attack/stroke
  - fear of “going crazy”
Panic Disorder

Tx
- short course benzos (alprazolam, lorazepam) then taper benzos, start SSRI – 1st line for long term tx (paroxetine, fluoxetine, sertraline, venlafaxine (SNRI))
- TCA’s not as likely to be used
- mild cases – relaxation or psychotherapy
Generalized Anxiety Disorder (GAD)

- Persistent, excess anxiety over general life events for $\geq 6$ mos
- Dx criteria: $\geq 3$
  - restlessness or hypervigilance
  - easy fatigability
  - irritability
  - sleep disturbance
  - muscle tension
  - difficulty concentrating
Generalized Anxiety Disorder (GAD)

- Age of onset 20’s
- R/O medical disorders (substance abuse, thyroid dysfunction, ETOH withdrawal)
- Tx – behavior/insight-oriented therapy + meds
  - SSRIs, SNRIs, buspirone
  - benzos as *short term adjunct*
  - TCAs may help – 2^{nd} line
Post traumatic stress disorder (PTSD)

- Exposure to/witnessing a traumatic event
- Symptoms...
  - last greater than one month
  - develop in as little as one week or...
  - develop many years after event
  - fluctuate over time
  - worsen during stressful times
- Feelings of helplessness, fear, horror that impair daily function
PTSD

- 3 major elements:
  - re-experience trauma (flashbacks)
  - emotional numbing
  - hyperarousal

- High co-morbidity with substance abuse & depression

- Common causes
  - men: combat
  - women: rape/assault
  - both: natural disasters
PTSD – Dx Criteria

1 or more:

- Persistent re-experiencing by distressing memories, dreams
- Avoids activities/places/people that remind of event, thinking/talking about event
- Unable to recall important aspect of event
- Feelings of detachment/estrangement
- Restricted range of affect, interest or anhedonia
- Believe future foreshortened due to event
2 or more increased arousal symptoms:

- difficulty falling or staying asleep
- hyper–startle response
- irritability/angry outbursts
- decreased concentration
- hypervigilance
PTSD Management

- **Tx**
  - 1st line – SSRIs (sertraline, paroxetine)
  - benzos reduce anxiety; trazodone for insomnia
  - TCA’s (imipramine, doxepin), MAOIs, anticonvulsants (carbamazepine, valproate)
    - less often used
  - therapy – crisis counseling/support groups, family
A 36 year old female presents complaining of a 7 month history of persistent worrying about general daily life events. Which would be the best long term treatment?

1. Anafranil (clomipramine)
2. Lexapro (escitalopram)
3. Wellbutrin (bupropion)
4. Xanax (alprazolam)
Phobias—Specific, Social, Agoraphobia

- Irrational fear & persistent excess anxiety when presented with object/situation
- Exposure causes immediate anxiety, can lead to panic attack
- Situation or object feared & avoided or endured with apprehension
- Pts. know fear is excessive/unreasonable
- Interferes with daily functioning

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Specific Phobia – 5 types

Fear of specific object/situation

- animal/insects
- natural phenomena (storms, heights, water)
- blood–injection injury (invasive procedures, blood, needles, contamination)
- situational (bridges, flying, confined spaces)
- other (vomiting, choking, becoming sick, death)

Onset is in childhood
Specific Phobia

Tx
- desensitization/exposure therapy/flooding most effective
- short term benzos, B-blockers as adjuncts
- insight–oriented therapy, hypnosis
Social Phobia

- Fear of social situations in which embarrassment or humiliation may occur
- Inciting events –
  - public speaking
  - using public restrooms
  - eating in public
Agoraphobia – Dx criteria

- Anxiety about placing self in situation in which incapacitating problem may occur & help unavailable
- Fear of being in public places where escape may be difficult
- Situations are avoided, endured with severe distress, or faced only with a companion
Agoraphobia

- Inciting events may include being:
  - outside the home
  - in a crowd
  - on a bus/train
  - on a bridge

- Symptoms – same as panic attack
- 50–70% have co-existing panic disorder
- $F \leq 3x > M$
Agoraphobia & Social Phobia

**Tx**
- 1st line – SSRIs (paroxetine, fluoxetine, sertraline), venlafaxine (SNRI)
- 2nd line benzos, TCAs
- beta–blockers (propanolol) can reduce hyperarousal & tremor with performance situations
- Insight–oriented therapy, gradual exposure
Obsessive–Compulsive Disorder (OCD)

- Obsessions – persistent, recurrent thoughts/images/impulses that are intrusive & inappropriate resulting in anxiety

- Compulsions – ritualistic/repetitive behaviors or thoughts pts. do to relieve anxiety caused by obsessions
  - behaviors/mental acts are excessive
  - have no connection between events pt. is trying to avoid

- Usually realize thoughts & behaviors irrational
Common obsessions–compulsions

- **Contamination** – excess hand washing, avoiding objects presumed contaminated
- **Doubt** – worry (forget to lock door, turn off stove)
- **Intrusive thoughts** – obsessive thoughts without compulsion; may be sexual/aggressive
- **Symmetry** – order & arrange objects, leads to extreme precision, slowness
- **Other** – religious obsessions, compulsive hoarding, nail biting, trichotillomania, counting/repeating a phrase
Behavioral/relaxation therapy + meds
  - 1st line med – SSRIs, often higher dose than normally Rx’d
  - TCAs (clomipramine) can help
- If refractory – gabapentin, venlafaxine, olanzapine, clonazepam, lithium, or anti-psychotic + SSRI
Attention-Deficit Disorder

- 20–50% have dysfunctional symptoms as adults
- M 2–5X >F, often firstborn son
- Dx Criteria:
  - hyperactivity, impulsivity, or inattentiveness manifesting before age 7
  - occurs in ≥2 settings
  - ≥6 symptoms of inattention, hyperactivity–impulsivity, developmentally inappropriate & present ≥6 mos
Fidgets/squirms
Leaves seat often
Restlessness
Difficulty playing quietly
Talking excessively
Blurting out
Difficulty awaiting turn
Interrupts/intrudes on others
Inattention symptoms

- Careless mistakes; trouble attending to details
- Problems sustaining attention
- Doesn’t follow through/complete assigned work
- Forgetful
- Easily distracted
- Loses items critical to assigned activities
- Avoids activities requiring sustained mental effort
- Difficulty organizing tasks
2ndary symptoms:
◦ emotional immaturity & lability
◦ poor social skills
◦ +/- motor incoordination
◦ disruptive behavior causes peer rejection, deflated self-image
◦ don’t comply with parents’ requests
◦ can be explosive & irritable
Attention-Deficit Disorder – Tx

- **1st line meds –** (caution: wt. loss & ↓ growth with stimulants!)
  - methylphenidate (Ritalin, Concerta, Daytrana)
  - dexamethylphenidate (Focalin)
  - amphetamine/dextroamphetamine (Adderall, Dexedrine)
  - atomoxetine (Strattera) selective norepinephrine reuptake inhibitor (non-stimulant)

- **2nd line/adjuncts**
  - antidepressants (guanfacine, clonidine, imipramine, bupropion, venlafaxine)

- Behavior modification, family, educational mgmt
Autistic Disorder – Dx criteria

- >6 symptoms from these categories
  - impaired social interaction
  - impaired communications
  - repetitive stereotyped patterns of behavior & activities
Impaired social interaction

- At least 2 –
  - problems with nonverbal behaviors (facial expression, gestures)
  - fail to develop peer relationships
  - does not seek sharing of interests/enjoyment with others
  - lacks reciprocal social/emotional interaction
Impaired communications

- At least 1
  - lack of or delayed speech
  - repetitive language use
  - lack of spontaneous, varied play activities
Repetitive stereotyped patterns of behavior & activities

- At least 1
  - inflexible rituals
    - intense, rigid commitment to maintaining routines
    - become agitated if routine is interrupted
    - sit in specific chair, dress in certain way, eat specific foods
  - preoccupation with parts of objects
Autism – Treatment

- Refer – Autism specialists
- Speech & language pathologist
- Audiology evaluation, +/- EEG
- Behavioral therapy
- Pharmacologics
  - 2nd gen. antipsychotics (risperidone, aripiprazole) for aggression/hyperactivity, mood lability; can also use haloperidol, carbamazepine
  - SSRIs for stereotyped/repetitive behaviors
Anorexia Nervosa

- Distorted body image
- **Egosyntonic**: average age 15–30 yrs. old
- Fear of becoming fat, even though underwtd.
- **Body wt. ≥ 15% below normal**
- Amenorrhea (absence of ≥3 cycles)
- 2 types:

<table>
<thead>
<tr>
<th>Restrictive</th>
<th>Binge eating/purging</th>
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<tbody>
<tr>
<td>eat very little</td>
<td>binge/purge</td>
</tr>
<tr>
<td>exercise to excess</td>
<td>+ laxatives</td>
</tr>
<tr>
<td>more withdrawn</td>
<td>excessive exercise</td>
</tr>
<tr>
<td>tend to have OC traits</td>
<td>+/− diuretics</td>
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<tr>
<td></td>
<td>more depression &amp; substance abuse</td>
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Amenorrhea, emaciation (BMI < 17.5)
Hypochloremia, hypokalemia, elevated BUN, metabolic alkalosis, hyponatremia, hypocalcemia
Hypothermia, cold extremities, salivary gland hypertrophy
Bradycardia, arrhythmias, cardiac arrest, low BP
Lanugo, dry skin, peripheral edema
Constipation, acute pancreatitis
Leukopenia, hypercholesterolemia, anemia
Osteoporosis, muscle cramps
Dental erosion, calluses/abrasions on back of hand
Anorexia Nervosa – Management

- Restore nutritional state!
- Hospitalize if $\geq 20\%$ below expected wt. or severe electrolyte imbalance
- Out pt. –
  - Behavioral/family therapy
  - Supervised, *gradual* wt. gain
- Pharmacologics DO NOT play major role
  - (Bupropion contraindicated – lowers seizure threshold)
Bulimia Nervosa

- Binge eating, vomiting, laxatives, diuretics, excess exercise
- Binging causes emotional distress, feel loss of control so egodystonic
- Normal or overweight
- 2 types:
  - purging – self-induced vomiting
    +/− laxatives, diuretics, enemas
  - non-purging – excess exercise or fasting
Bulimia – physical findings

- Dental erosion/caries; calloused, abraded knuckles (Russell’s sign)
- Esophagitis
- Hypochloremic, hypokalemic alkalosis
- Hypomagnesemia, hypocalcemia
- Parotid gland hypertrophy
Bulimia Nervosa – Management

- Restore nutritional state!
- SSRIs (fluoxetine, sertraline, paroxetine) reduce binge/purge behaviors
- Bupropion contraindicated
- 2nd line meds – TCAs, MAOIs
- Behavioral/family/group therapy
- Hospitalization usually not needed
Endocrine Problems due to Eating disorders

- growth hormone
- plasma cortisol
- gonadotropins (LH, FSH)
- $T_3$
- Abnl glucose tolerance test
- Abnl dexamethasone suppression
- estrogen
Somatic signs of an eating disorder

- Arrested growth
- Marked change/frequent wt. fluctuation
- Inability to gain wt.
- Fatigue
- Constipation or diarrhea
- Susceptibility to fractures
- Delayed menarche
- Hyperphosphatemia, high serum amylase
Behavioral signs of an eating disorder

- Change in eating habits
- Difficulty eating in social settings
- Reluctance to be weighed
- Depression
- Social withdrawal
- School or work absence
- Deceptive/secretive behavior
- Stealing (ie, to obtain food)
- Substance abuse
- Excess exercise
Obesity (binge-eating disorder)

- ≥20% over ideal body wt. or BMI ≥30

Dx criteria –
- recurrent binge eating ≥2 days/wk for 6 mos
- no inappropriate wt. control
- ≥3 of following:
  - Eating rapidly, until very full, large amounts when not hungry, alone out of embarrassment
  - feeling disgusted/depressed/guilty afterward
Obesity– Treatment

- Behavior modification/group therapy
- Food diaries/exercise regimen
- New eating patterns (eat slowly/not between meals/only when seated)
- Tx underlying depression with SSRIs
- Others: as adjuncts
  - sympathomimetics – phentermine (Adipex), benzphetamine (Didrex), orlistat (Xenical)
  - gastric bypass
Mood Disorders (Affective Disorders)

- Patterns of mood episodes (major depressive, manic, hypomanic, mixed) in which some mood impairment is present
- Types:
  - Adjustment
  - Major Depressive (MDD)
  - Dysthymia
  - Bipolar (types I & II)
Adjustment Disorder

- Emotional symptoms in response to identifiable stressor
  - job loss, divorce, school/financial problems, moving out of home/relocation, substance abuse, becoming a parent, retirement

- Symptoms within 3 mos of stressor, ending within 6 mos after stressor resolved

- Reaction out of proportion to stressor or impairs daily functioning
Adjustment Disorder

- Symptoms
  - depressed mood, tearfulness, anxiety, palpitations, agitation, reckless driving, fighting, truancy, vandalism

- Tx
  - 1st line – Psychotherapy
  - Benzos, hypnotics (zolpidem), antidepressants (SSRI’s), briefly if warranted
Major depressive disorder (MDD) subtypes
- seasonal affective disorder (SAD)
- melancholia
- atypical depression
- catatonic depression
- psychotic depression
- postpartum depression
重大抑郁症状 – SIG-E-CAPS
诊断：5 或更多持续至少2 周

- 睡眠：失眠/过度睡眠
- 兴趣：抑郁情绪，失去兴趣/乐趣
- 罪恶感：无价值感/罪恶感
- 精力：减少
- 注意力：思维和做决定能力下降
- 饮食：体重变化
- 心理运动：迟钝/激越
- 自杀：或反复思考死亡
Tx – Acute Major Depressive Episode

- Begin with SSRI
- If partial/no response after ~6 wks, re-assess dx &/or increase dose
- If inadequate response
  - change to another class of drugs
  - add another med
  - combine antidepressants from different classes
- Psychotherapy
- Consider ECT
Seasonal affective disorder (SAD)

- Fall or winter onset
- Often remits in spring
- More common in colder climates
- Onset age 20–40 yrs
- Tx –
  - light therapy
  - SSRIs
  - Bupropion
Melancholia

- Anhedonia
- Psychomotor retardation/agitation
- Anorexia, wt. loss
- Depressed mood (esp. in morning)
- Feelings of guilt
- Sleep disturbance (early morning awakening)
- Suicidal ideation may be present
Atypical depression

- Overeating & wt. gain
- Oversleeping
- Reactive mood
- Leaden paralysis
- Oversensitivity to interpersonal rejection

Tx –
  - MAOIs useful (Marplan, Parnate)
  - SSRIs, atypical antipsychotics may help
Catatonic depression

- Motor immobility/stupor, blurred affect
- Purposeless motor activity
- Extreme withdrawal, negativism
- Bizarre mannerisms/posturing
- Echolalia/echopraxia

Tx
- Benzodiazepines
- ECT
- Valproic acid, lithium, risperidone as adjuncts
Psychotic depression

- Presence of delusions or hallucinations
- Occurs in ~20% of severely depressed pts.
- Tx
  - benzodiazepines + antidepressant for agitation, initially
  - antidepressants + 2nd gen. antipsychotic for maintenance
Postpartum depression

- Onset of symptoms within 4 wks of delivery

- Tx
  - Therapy plus...
  - SSRIs – sertraline (Zoloft) good choice if breastfeeding; fluoxetine (Prozac), escitalopram (Lexapro), venlafaxine (Effexor)
  - Estrogen may help
Drug Treatment of Mood Disorders

- 1st line – SSRIs (fluoxetine, paroxetine, sertraline)
- Also effective – venlafaxine; nefazodone, bupropion, mirtazapine – least assoc. with sexual dysfunction
- 2nd line – TCAs/tetracyclics (overdose more lethal)
- 3rd line – MAOIs – least likely used
Precautions/Side Effects

- SSRIs – GI upset, headache, sexual dysfunction
- TCAs/tetracyclics – wt. gain, orthostatic hypotension, anticholinergic effects, somnolence
- MAOIs – need tyramine–free diet (no wine, beer, most cheeses, aged foods, smoked meats) to avoid HTNsive crisis
MAOIs, demerol, triptans, dextromethorphan + SSRIs can cause *serotonin syndrome – rapid onset*:

- mental status changes, restlessness
- hyperthermia, diaphoresis
- tremor, hypertonicity, seizures
- renal failure, coma, death

**Tx**

- benzodiazepines
- aggressive cooling
- cyproheptadine in severe cases
ECT for Tx of Mood Disorders

- Electroconvulsive therapy (ECT) beneficial for
  - severely depressed
  - unresponsive
  - intolerant of psych meds

- Safely used in elderly & pregnancy

- Side effects
  - memory loss (temporary)
  - postictal confusion
  - headache
  - nausea
  - muscle soreness
Suicide Risks

- prior attempt
- white male
- >45 yrs old
- detailed plan
- self-destructive pattern
- recent severe loss

- poor support system
- poor health
- substance abuse
- psychotic symptoms
- inability to accept help
Dysthymic disorder

- Chronic persistent mild depression
- Pessimism, brooding, loss of interest, decreased productivity, feelings of inadequacy, social withdrawal
- No psychotic or manic/hypomanic features
- MDD may develop in 10–20%, bipolar in others, 25% will always have symptoms
- Young adult onset
Dysthymic disorder – Dx Criteria

- Depressed mood most of day, more days than not, ≥2 yrs (≥1 yr in children/adolescents)
- During 2 yr period, not w/o symptoms for >2 mos at a time, no major depressive episode during 1st 2 yrs of symptoms
- At least 2:
  - poor concentration/indecisiveness
  - hopelessness
  - poor appetite or overeating
  - insomnia or hypersomnia
  - low energy/fatigue
  - lack self-esteem
Dysthymic disorder – Treatment

- Antidepressants–
  - SSRIs 1st choice
  - SNRIs
  - bupropion
  - TCAs
  - occasionally MAOIs (last choice)

  PLUS

- Insight-orientated, behavior, cognitive therapies
Bipolar I disorder

- >1 manic/mixed episodes, often cycle with depressive episodes
- Manic episodes – sudden mood escalation, abnormally/persistently euphoric, expansive, or irritable
  - may go for days without sleep
  - excessively talkative or loud
  - socially outgoing
  - overly self-confident
  - hypersexual
  - disinhibited
  - flamboyant clothing style
Bipolar I disorder

- Racing thoughts
- Flight of ideas
- Easily distracted
- Impaired judgment
  - spending sprees
  - promiscuity
  - foolish business investments
  - psychotic symptoms (hallucinations, paranoia, delusions) may be present
Treatment – Bipolar I disorder

- Acute mania – Lithium,* valproate, SGAs (olanzapine, aripiprazole), carbamazepine
- Mania maintenance – SGAs, Gabapentin, lamotrigine (Lamictal)
- If agitation – add antipsychotics (haloperidol, risperidone) or benzos
- Depressive episodes – SSRIs, quetiapine, or olanzapine + fluoxetine
- MAOIs, TCAs – least likely used
- Family/group/cognitive therapy

* narrow therapeutic window; wt. gain, tremor, nausea, excess thirst/urination, drowsiness, hypothyroidism, arrhythmias, seizures
Bipolar II disorder

- >1 major depressive & >1 hypomanic episode
- No manic or mixed episodes
- Hypomanic symptoms –
  - similar to manic symptoms but less severe & less social impairment
  - usually no psychotic symptoms, racing thoughts, or excess psychomotor agitation
- Tx – same as bipolar I
  - lithium &/or lamotrigine (Lamictal) 1st line
In general –
- disordered thought content & thought processes
- perceptual disturbances (illusions, hallucinations, delusions, impaired reality)
- social, occupational function disrupted due to affect, motivation, perception, communication
- memory or consciousness *not* adversely impacted
Psychotic Disorders

- **Brief psychotic** –
  - symptoms $\geq 1$ day but $< 1$ mos
  - often after catastrophic event
  - return to premorbid functioning

- **Schizophreniform** –
  - same symptoms as schizophrenia
  - symptoms last 1–6 mos
Psychotic Disorders

- Symptoms categorized as –
  - **positive**
    - hallucinations, bizarre behavior, delusions
  - **negative**
    - flat *affect*, apathy, *anhedonia*
    - poor grooming, social withdrawal
    - poor eye contact, poverty of speech
Delusional Disorder

- Nonbizarre delusions for $\geq 1$ mos
- Behavior not obviously odd; daily function not significantly impaired
- Subtypes of delusions –
  - erotomanic – another person in love with them
  - somatic – having a physical/medical condition
  - jealous – sexual partner’s infidelity
  - persecutory – mistreatment or persecution
  - grandiose – inflated self-worth, power, knowledge
- Treatment – antipsychotics
Chronic, debilitating course
Lack insight, don’t think their behavior is abnl
Better prognosis if…
  ◦ late onset
  ◦ acute onset
  ◦ obvious precipitating factor
  ◦ presence of positive symptoms
Onset before age 15 or after 50 is rare
Subtypes of Schizophrenia

- Paranoid – most common; persecutory or grandiose delusions or auditory hallucinations
- Catatonic – rarest; motor immobility, motor activity with no purpose, negativism or mutism, bizarre postures, waxy flexibility, stereotyped movements, grimacing, echolalia or echopraxia
- Disorganized – disorganized speech or behavior & flat or inappropriate affect
- Residual – blunted affect or odd behavior
- Undifferentiated – delusions & hallucinations are prominent
Schizophrenia – Dx Criteria

- >2 in 1 mos period & continuous signs for ≥6 mos; hallucinations/delusions not needed for dx
  - Delusions
  - Hallucinations – auditory (most common), tactile, olfactory, visual
  - Disorganized speech/thought processes
    - unable to stay on topic (loose associations)
    - unable to provide answer related to questions (tangential response)
Symptoms impair daily functioning

Disorganized behavior – unpredictable agitation, inappropriate sexual behavior, child-like silliness, catatonic motor behavior, lacking self-care/hygiene

Negative symptoms – blunted affect, poor posture, lack goal-directed activities/initiative

Impairment → inability to hold job or maintain relationships
Schizophrenia – Treatment

- Hospitalize if suicidal, unable to care for self, pose threat to self/others
- 1st line – serotonin & dopamine antagonists (SDAs); (risperidone, olanzapine, aripiprazole, ziprasidone, quetiapine, asenapine, paliperidone) for negative symptoms & less side effects
- Typical neuroleptics – dopamine antagonists (haloperidol, chlorpromazine, thioridazine, loxapine, fluphenazine) best for positive symptoms
Resistant cases – clozapine or antipsychotic + another med (benzo, carbamazepine, valproate, lithium)

Behavior–oriented/group/family therapy

Watch for side effects!
- extrapyramidal, parkinsonian symptoms, neuroleptic malignant syndrome, tardive dyskinesia – more likely with typical neuroleptics; clozapine may → agranulocytosis
Schizoaffective disorder

- Meets criteria for major depressive, manic, or mixed episode, during which criteria for schizophrenia also met
- Hallucinations or delusions present for 2 or more weeks without mood symptoms
- Better prognosis than schizophrenia, worse than mood disorder
- Tx – 2nd gen. antipsychotics
  - can add antidepressant/lithium/valproate
  - ECT as adjunct for mania/depression
Timeline/Prognoses of Psychotic disorders

- < 1 month – brief psychotic disorder
- 1–6 months – schizophreniform disorder
- > 6 months – schizophrenia

Best → worst prognosis
mood disorder→brief psychotic disorder→schizoaffective disorder→schizophreniform disorder→schizophrenia
Which of the following psychiatric disorders is most likely to develop as a result of panic disorder?

1. adjustment
2. agoraphobia
3. depression
4. schizophrenia

- Adjustment: 2%
- Agoraphobia: 84%
- Depression: 12%
- Schizophrenia: 2%

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Somatoform Disorders

- Somatization disorder
- Conversion disorder
- Hypochondriasis
- Body dysmorphic disorder
- Pain disorder

In general –
- drug treatment rarely indicated
- goal is to improve function
Somatization disorder

- Vague physical complaints involving many organ systems not explained by medical condition or substance use
- Symptoms relate to GI tract, reproductive, or neurologic systems; may complain of pain
- Stress causes worsening symptoms
- Low socioeconomic groups
- Onset < age 30; most often in adolescence
- Chronic, debilitating course
Somatization disorder

Tx

- Regular visits with healthcare provider
- Group/individual therapy to develop coping strategies
- Minimize secondary gain
- Avoid medications/use cautiously
Conversion disorder

- ≥1 neurological complaints not explained by medical/neuro disorder
- Psych factors (ie, traumatic event) often precede onset/exacerbate condition
- Symptoms –
  - paralysis, blindness, mutism
  - may display unexpected lack of concern to symptoms (*la belle indifférence*)
- Episodic, lasting few days or up to 1 mos; may remit but recur when stressed
Conversion disorder – Symptoms

- Shifting paralysis
- Blindness
- “lump in the throat” (globus hystericus)
- Mutism/aphonia
- Deafness
- Paresthesia/anesthesia
- Seizures
- Balance/coordination problems
Conversion disorder

- F 2–5X > M
- Most common in adolescence & young adult
- More common in low intelligence, low socioeconomic groups
- R/O medical cause since ~25–50% eventually dx with neuro/medical disorders
- Tx – therapy +/− short term anxiolytics
Hypochondriasis (aren’t we all?)

- Preoccupation with belief/fear of having/contracting a serious disease
- Normal bodily sensations falsely interpreted as manifestation of disease
- Often co-exist with anxiety & depression
- Course – chronic, episodic, may be exacerbated by major stressor
- Males=females; onset age 20–30
Hypochondriasis

- Fear persists though work-up finds no cause
- Belief is not delusional intensity, not limited to specific concern about physical appearance
- Duration of disturbance ≥6 mos
- Tx
  - Group/insight–oriented therapy
  - regular appts with provider for reassurance
  - meds (SSRIs) if concurrent/underlying anxiety or major depressive disorder
Preoccupation with imagined defect in physical appearance/exaggerated distortion of minor flaw

Common concerns – face/hair/skin/breasts/genitalia

High co-morbidity with depressive/anxiety disorders; linked to psychotic disorder & OCD

Stereotypes of beauty may play role

Tx – SSRIs reduce symptoms in >50%
Pain disorder

- Pain in ≥1 areas with no known cause
- May describe atypical facial/low back pain, headache, pelvic, other chronic pain
- Symptoms not intentionally produced
- F 2x>M, age at onset 40–50
- Tx – therapy, pain control prgms; SSRI’s, TCAs can be used
- Analgesics/sedatives not beneficial, can lead to abuse/dependence
substance dependence = physiologic + psychological

Impairment manifested by 3 within 1 yr period:
- tolerance
- withdrawal
- larger amounts over longer period
- unsuccessful efforts to stop/decrease amount
- continued use despite adverse consequence
Substance abuse – hasn’t met criteria for dependence but caused impairment by ≥1 in 1 yr period:
- fails to meet home/school/work obligations
- repeatedly uses substance in hazardous situations
- recurrent substance–related legal problems
- continues use, even though results in interpersonal/social problems
## ETOH – signs/symptoms/treatment

<table>
<thead>
<tr>
<th>Intoxication</th>
<th>Withdrawal</th>
<th>Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Slurred speech</td>
<td>Tremors (after 8–18 hrs)</td>
<td>Benzos (diazepam, chlordiazapoxide) for agitation</td>
</tr>
<tr>
<td>Euphoria</td>
<td>Anxiety, nausea/vomiting</td>
<td>Thiamine (prevents Wernicke’s encephalopathy), MVI, folic acid</td>
</tr>
<tr>
<td>Ataxia/incoordination</td>
<td>Seizures (7–38 hrs)</td>
<td>Haloperidol or risperidone if hallucinations</td>
</tr>
<tr>
<td>Facial flushing</td>
<td>Hallucinations (within 2 days)</td>
<td>Disulfarim + ETOH=nausea</td>
</tr>
<tr>
<td>Reduced inhibition</td>
<td>Delirium tremens (2–5 days)</td>
<td>Detox, AA/Alateen/Al–Anon, therapy</td>
</tr>
<tr>
<td>Erratic behavior</td>
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</tr>
</tbody>
</table>

### Chronic abuse

- **Elevated GGT, AST, ALT**
- Increased HDL, LDH, MCV
- Decreased LDL, BUN, RBC volume
- Acne rosacea, palmar erythema
- Hepatomegaly
- Gynecomastia/testicular atrophy
- Dupuytren’s contractures

### Withdrawal

- Tremors (after 8–18 hrs)
- Anxiety, nausea/vomiting
- Seizures (7–38 hrs)
- Hallucinations (within 2 days)
- Delirium tremens (2–5 days)

### Treatment

- Benzos (diazepam, chlordiazapoxide) for agitation
- Thiamine (prevents Wernicke’s encephalopathy), MVI, folic acid
- Haloperidol or risperidone if hallucinations
- Disulfarim + ETOH=nausea
- Detox, AA/Alateen/Al–Anon, therapy
### Stimulants (amphetamines, cocaine, crack)

<table>
<thead>
<tr>
<th>Intoxication Signs/symptoms</th>
<th>Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Euphoria</td>
<td>Benzodiazepines (diazepam, lorazepam) for agitation</td>
</tr>
<tr>
<td>Agitation/Aggression</td>
<td>Short term antipsychotics if psychotic symptoms</td>
</tr>
<tr>
<td>Transient psychosis</td>
<td></td>
</tr>
<tr>
<td>Hallucinations</td>
<td>Rehab/detox</td>
</tr>
<tr>
<td>Impaired Judgment</td>
<td>Psychotherapy</td>
</tr>
<tr>
<td>Tachycardia</td>
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<tr>
<td>Elevated BP</td>
<td></td>
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<tr>
<td>Dilated pupils</td>
<td></td>
</tr>
<tr>
<td><strong>Withdrawal Signs/symptoms</strong></td>
<td></td>
</tr>
<tr>
<td>Fatigue/depression</td>
<td></td>
</tr>
<tr>
<td>Headache</td>
<td></td>
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<tr>
<td>Profuse sweating</td>
<td></td>
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<tr>
<td>Muscle cramps</td>
<td></td>
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<tr>
<td>Hunger</td>
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</tbody>
</table>
# Opioids (heroin, morphine, oxycodone)

<table>
<thead>
<tr>
<th><strong>Intoxication Signs/symptoms</strong></th>
<th><strong>Treatment</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Euphoria</td>
<td>Methadone OR Clonidine tapering dose</td>
</tr>
<tr>
<td>Drowsiness/Lethargy</td>
<td>Benzos for mild withdrawal</td>
</tr>
<tr>
<td>Impaired concentration</td>
<td>NSAIDs for muscle aches</td>
</tr>
<tr>
<td>Hypotension, bradycardia</td>
<td>Dicyclomine for GI distress</td>
</tr>
<tr>
<td>Slurred speech</td>
<td><strong>Dependence</strong></td>
</tr>
<tr>
<td>Constricted pupils</td>
<td>Methadone maintenance program</td>
</tr>
<tr>
<td>Flushing</td>
<td>Naltrexone</td>
</tr>
<tr>
<td></td>
<td>Buprenorphine (Subutex)</td>
</tr>
<tr>
<td></td>
<td>Buprenorphine + naloxone (Suboxone)</td>
</tr>
<tr>
<td></td>
<td>Detox, psychotherapy</td>
</tr>
</tbody>
</table>

**Withdrawal Signs/symptoms**
- Lacrimation, rhinorrhea
- Sweating, hot/cold flashes
- Yawning
- Hypertension, tachycardia
- Anxiety
- Nausea/vomiting/abd cramps
- Muscle/joint pain

**Dependence**
- Methadone maintenance program
- Naltrexone
- Buprenorphine (Subutex)
- Buprenorphine + naloxone (Suboxone)
- Detox, psychotherapy

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**Rutgers PANCE/PANRE Review Course**
Treatment – Substance Use Disorders

- CNS depressants
  - gradual withdrawal of drug
  - pentobarbital or diazepam if needed

- Nicotine cravings
  - nicotine patch, nasal spray, gum, inhaler
  - bupropion (Zyban), clonidine, varenicline (Chantix)

- Marijuana, PCP, hallucinogen withdrawal
  - meds not usually needed; can use anxiolytics
  - if psychotic symptoms from PCP, hallucinogen withdrawal – can use neuroleptics (haloperidol)
Personality Disorders

- Onset in adolescence/early adulthood
- Rigid/inflexible traits cause dysfunction

In general –
- lack insight into their problems
- not distressed about maladaptive behavior

Manifested by >2
- affect = appropriateness of emotional response
- impulse control
- interpersonal relations
- cognition = ways of perceiving environment
Personality Disorders

Cluster A – “MAD” odd, eccentric, weird
- schizoid
- schizotypal
- paranoid

Cluster B – “BAD” emotional, impulsive, dramatic
- antisocial
- borderline
- histrionic
- narcissistic

Cluster C – “SAD” anxious, fearful
- avoidant
- obsessive–compulsive
Schizoid - Dx criteria - >4 of following

- Emotional detachment, social withdrawal, discomfort with human interaction
- No desire for close relationships
- Chooses solitary activities
- Takes pleasure in few (if any) activities
- Little/no interest in sex
- Few/no close friends
- Aloof, indifferent to criticism/praise
- Constricted affect, emotional coldness
- Reality testing intact
Schizoid differs from...
- avoidant in that schizoid *prefers* to be alone
- schizotypal in that latter have “magical thinking”

Tx – difficult
- Individual cognitive, group therapy +/–
  - low dose antipsychotics (olanzapine, risperidone)
  - antidepressants (SSRIs or bupropion)
  - stimulants may help
Disturbed thinking, perceptual distortion
Eccentric behavior
Social/interpersonal deficits
Few (if any) friends
Inner world based on magical thinking (bizarre fantasies/preoccupations), illusions, derealization
May be involved in cults, the occult, strange religious practices
May progress to schizophrenia
Schizotypal Dx Criteria – ≥5 of following

- Ideas of reference
- Odd beliefs, magical thinking influences behavior (ie, superstitiousness, clairvoyance)
- Unusual perceptual experiences (ie, bodily illusions)
- Odd thinking & speech (vague, over–elaborate)
- Suspiciousness or paranoia
- Inappropriate or constricted affect
- Odd/peculiar behavior or appearance
- Lack of close friends
- Excessive social anxiety assoc. with paranoid fears
Schizotypal...

- differs from schizoid & avoidant –
  - by bizarre behavior, thinking, perception, communication

- differs from schizophrenia –
  - by lack of frank psychosis but can have psychotic symptoms in times of stress

- differs from paranoid personality –
  - by exhibiting very odd behavior
Schizotypal

- May be manifested during childhood or adolescence

- Tx
  - Therapy, social skills training +/-
    - antipsychotics (risperidone, olanzapine)
    - antidepressants if depressive aspect
Paranoid (Who me? You talking about me?!)

- Long-standing mistrust & suspiciousness
- Often hostile, irritable
- Blame others for their difficulties
- Others motives thought to be malevolent
- Feel they’ve been treated unfairly
- Often unsuccessful intimate relationships due to jealousy
- Lack warmth, restricted affect
Paranoid Dx Criteria – ≥4 of following

- Suspects others being deceptive/exploitative
- Doubt loyalty/ability to trust friends or acquaintances
- Reluctant to confide in others
- Interprets benign remarks as demeaning or threatening
- Persistently bears grudges
- Perceives attack on character & counterattacks
- Recurrent suspicions about fidelity of significant other
Paranoid

- No fixed delusions or hallucinations
- Begins by early adulthood, M > F
- Higher risk with family hx of schizophrenia & delusional disorders

Tx
- 1st line – individual therapy
- behavioral techniques (social–skills role playing)
- low dose anxiolytics/antipsychotics may reduce anxiety & paranoia
Antisocial

- Inability to conform to social norms
- Disregard for rights/feelings of others
- Manipulative, deceitful, impulsive, lacking empathy
- On interview acts very charming, seems normal
- May have abnormal EEG
- M 3x > F, familial pattern, more common in urban areas, prisons

**Begins as conduct disorder**
- may be hx of physical/sexual abuse, hurting animals, starting fires
- assoc. with violations of the law
Antisocial – Dx Criteria

>3 of following & at least 18 yrs old –

- Failure to conform to social norms by breaking the law
- Deceitful/lying/conning others
- Impulsivity/failure to plan ahead
- Irritability & aggressiveness manifested by repeated physical assaults
- Reckless disregard for safety of self/others
- Irresponsible, unable to sustain work
- No remorse for actions
Antisocial – Tx

- 1st line – therapy with socially based intervention
- Meds may reduce anxiety/impulsivity/aggression
  - SSRIs
  - lithium
  - valproate
  - carbamazepine
  - 2nd gen. antipsychotics
- Caution – high abuse potential!
Borderline

- Impulsive
- Moody
- Paranoid under stress
- Unstable self image
- Labile, intense relationships
- Suicidal
- Inappropriate anger
- Vulnerable to abandonment
- Emptiness
Borderline – Dx Criteria ≥5 of following

- Unstable mood/affect/behavior
- Poorly established self-image
- Impulsivity in ≥2 harmful ways ($$, drugs, sex)
- Transient psychotic episodes, paranoia, or dissociative symptoms
- Self-mutilation/manipulative suicide attempts
- Desperate attempts to avoid abandonment
- Feelings of emptiness
- Volatile/intense relationships
- Inappropriate anger/difficulty controlling anger
Borderline

- **Splitting** – people are either all good or all bad
- **Tx** – 1st line – dialectical behavior therapy (DBT)
  - social skills, cognitive–behavioral
- Meds (+ psychotherapy yields better results)
  - antipsychotics for hostility/psychotic episodes
  - antidepressants (SSRIs) to improve mood
  - neuroleptics can improve global functioning
  - +/- short term benzos to decrease anxiety
Histrionic – Dx Criteria ≥5 of following

- Needs to be center of attention
- Seductive/provocative behavior
- Uses physical appearance to get attention
- Speech lacking in detail, impressionistic
- Dramatic/exaggerated emotions
- Easily influenced by others
- Believes relationships are more intimate than they really are
Histrionic

- Somatization, substance disorders common
- May use defense mechanism of *regression* – revert to childlike behaviors

**Tx**
- 1**st** line – group/individual therapy
- +/- antidepressants/anxiolytics can be used only for specific symptoms
Narcissistic

- Inflated self-image/grandiose, lacking empathy; consider themselves special; arrogant
- Sense of entitlement, fragile self-esteem; need to be admired; prone to depression if criticized
- Fantasies of unlimited success, beauty, brilliance; aging “gracefully” is difficult
- Exploitative/takes advantage of others
- Envious of others, thinks others envious of him/her
Narcissistic

- Tx – 1st line – psychotherapy
- Pharmacotherapy – rarely indicated
  - lithium can be used if mood swings
  - antidepressants (esp. SSRIs) can be used if mood disorder
Avoidant

- Extreme sensitivity to rejection
- See themselves as unappealing
- Intense social anxiety, feelings of inadequacy leads to withdrawal, avoid situations where may be criticized
- Shy & desire companionship but need guaranteed acceptance
- May avoid job activities involving interpersonal contact due to fear of rejection
- Show restraint in intimate relationships for fear of rejection
Avoidant

- Social phobia, anxiety, depressive disorders common

- Tx 1st line – social skills/assertiveness training

- For specific symptoms –
  - benzos for anxiety
  - SSRIs for anxiety/depression & may help decrease rejection sensitivity
Obsessive Compulsive Personality

- Preoccupied with orderliness/inflexible
- Stubborn/emotionally constricted; insist others submit to their ways, difficulty in relationships
- Perfectionism interferes with ability to complete tasks or form relationships
- Change in routine threatens perceived stability & causes anxiety
- Won’t delegate tasks; excess devotion to work/productivity
- Unable to throw out worthless objects/miserly
Obsessive Compulsive Personality (OCPD)

- Remember!
  - OCPD is ego-syntonic; no recurrent obsessions/compulsions
  - OCD is ego-dystonic; +obsessions/compulsions

- Tx
  - 1st line – cognitive-behavioral therapy
  - SSRIs help reduce anxiety/depression
  - Clomipramine – 2nd line med choice
What personality type is best characterized by a person that prefers to be alone, is emotionally cold, indifferent, socially withdrawn, and has intact reality testing?

1. antisocial
2. avoidant
3. schizoid
4. schizotypal
Acute stress disorder

- Similar to PTSD – differ in onset & duration
  - PTSD symptoms develop anytime after event & last >1 mos

- Acute stress disorder symptoms –
  - occur within 1 mos of traumatic event
  - last 2 days to 1 mos

- Populations:
  - motor vehicle accident survivors
  - violent crime victims/witnesses
  - natural disaster survivors
Acute stress disorder – Dx Criteria

- Exposure to traumatic event involving threat of possible injury/death
- During/after event, ≥3:
  - sense of numbing or detachment
  - reduced awareness of surroundings
  - derealization
  - depersonalization
  - dissociative amnesia (can’t recall important aspect of trauma)
Acute stress disorder – Dx Criteria

Event re-experienced by ≥1:

- recurrent dreams/images/thoughts/flashbacks
- sensation of reliving event; reminders of trauma causes distress

Avoid reminders of trauma (activities/places/people)

- Excess anxiety, insomnia, irritability, poor concentration, hypervigilance/exaggerated startle

- Distress impairs functioning

Symptoms occur –

- within 4 wks of event
- lasts ≥2 days & ≤4 wks
Acute stress disorder

- Adjustment disorder differs –
  - by a generally non–life–threatening, less severe stressor, less intense pathologic response

- Tx – same as PTSD
  - therapy/support group
  - SSRIs, TCAs, anticonvulsants, anxiolytics for insomnia & irritability
Two weeks ago a pt. was held up at gunpoint. Since then, he’s been having difficulty sleeping and is unable to walk down the street where the incident occurred. What disorder is the most likely diagnosis?

1. Acute stress disorder
2. Adjustment disorder
3. Panic disorder
4. Post traumatic stress
Child Abuse – physical signs

- Injury not adequately explained or inconsistent with hx given
- Bruises/lacerations/soft-tissue swelling, dislocations/fractures, **spiral fractures**
- Burns (doughnut-shaped, stocking-glove, symmetrically round)
- Bruises or injuries with regular patterns on face, back, buttocks, thighs
- Internal hemorrhages, abdominal injuries, bite marks, injury with shape of instrument used
Child Abuse – can also be manifested by...

- Anxiety
- Aggressive/violent behavior
- PTSD
- Depression or suicide
- Substance abuse
- Poor self-esteem
- Dissociative disorders
- Paranoid ideation
- Failure to thrive
Neglect can be considered if –

- minor allowed to engage in potentially harmful behavior (ie, ETOH consumption)
- child is unattended; in some states, leaving child < age 13 home alone
Child Sexual abuse

- Common ages 9–12
- Often by male known to child
- *Any* raises suspicion:
  - evidence of sexually transmitted infection
  - anal/genital bruises/pain/itching/trauma
  - knowledge about sexual acts inappropriate for age
  - initiates sexual acts with others, esp. peers
  - exhibits sexual knowledge through play
Elder Abuse – Forms of abuse

- Physical or sexual abuse –
  - bruises/puncture wounds/fractures/cuts/burns
  - poor hygiene/soiled clothing, hair loss in clumps
  - wt. loss, poor nutrition, dehydration
  - lack of eyeglasses/hearing aids
  - injuries from restraints
  - genital/rectal injuries or bleeding
  - evidence of excessive drugging
  - lack of/delay seeking medical attention
Elder Abuse – Forms of abuse

- Psychological –
  - threats/insults/verbal abuse
  - refuse to allow travel, church attendance, family visits

- Financial –
  - misuse of funds

- Neglect –
  - withholding food/meds/clothing, routine health care, basic necessities
Watch out for caregiver with...

- previous hx of abuse
- conflicting accounts of accidents
- unwilling to agree to implementation of tx plans
- inappropriate defensiveness
- Failure to allow/limits pt’s responses to questions
Domestic Violence – Precautions

The Abused...

- may close ranks with abuser, confront clinician for ‘attempting to break up family’
- who leaves abuser has greater risk of being killed than one who stays
- suffer damage to ego defenses, may not be assertive enough to believe rights were violated
- may think they deserved it, must accept abuse as price to pay (food, home)
Management of Domestic Violence

- Medical attention to address physical needs
- Recognition of abuse, non-threatening questioning to determine if it occurred; emphasize someone cares
- Contact numbers for referral agencies (legal, shelters, support groups)
- Present options, allow pt. to decide
Uncomplicated Bereavement

- Normal response to major loss
- Duration of reaction depends on...
  - suddenness of loss
  - relationship to deceased
  - age/physical condition of deceased
- Normal grief resolves within 1 yr
- Most severe symptoms within 1st 2 mos
- Some develop MDD; dx not made until grief symptoms fail to resolve
Uncomplicated Bereavement

- Symptoms: shock, confusion, sadness, numbness, guilt
- May report illusions (seeing/hearing deceased) or deny aspects of the death
- Hallucinations that persist, are intrusive, or belief that deceased still alive is not “normal”
- Tx –
  - social contact/reassurance
  - +/- benzos for insomnia
Symptoms of Mood Episode – Depression

- Depressed mood
- Anhedonia
- Excessive guilt
- Indecisiveness
- Lack of self-worth
- Insomnia/hypersomnia
- Difficulty with memory or concentration
- Psychomotor retardation/agitation
- Decreased/increased appetite or $\geq 5\%$ unintentional wt. change over 1 mos
- Decreased interest in sex
- Suicidal ideation or thoughts of death
- Chronic fatigue or decreased energy
Symptoms of a Mood Episode – Mania

- Inflated self-esteem, grandiosity
- Irritability
- Decreased need for sleep
- Pressured speech
- Flight of ideas

- Distractibility
- Impaired judgment, may pursue pleasurable activities with probable adverse outcomes
- Psychomotor agitation
Possible Effects – 1st gen. antipsychotics

- Movement disorders (dystonias, bradykinesia, akathisia, choreoathetosis)
- Anhedonia
- Sedation
- Weight gain
- Temperature dysregulation/poikilothermy
- Hyperprolactinemia/galactorrhea/amenorrhea in women & gynecomastia in men; decreased sexual function in both
- Postural hypotension
- Sunburn
- Prolonged QT interval, risk of potentially fatal arrhythmia (with thioridazine)
Possible Effects – 2nd gen. antipsychotics

- Mod–severe wt. gain (olanzapine, clozapine)
- Diabetes
- Hypercholesterolemia
- Sedation
- Moderate movement disorder
- Hypotension
- Hyperprolactinemia (risperidone)
- Seizures, nocturnal salivation, agranulocytosis, myocarditis, lens opacities (clozapine)
Glossary of selected psych terms

- **Echolalia** – mimicking sound
- **Echopraxia** – mimicking behavior
- **Delusions** – erroneous beliefs based on misinterpretation of reality such as paranoia, ideas of reference, thought broadcasting, delusions of grandeur, or delusions of guilt
- **Hallucinations** – false perceptions in any sensory modality, such as auditory/tactile/olfactory/visual
- **Concrete thinking** – thinking characterized by immediate experience rather than abstractions; may be seen in schizophrenia
Glossary of selected psych terms

- **Clang associations** – connections based on similarities in sounds of words rather than meaning

- **Loosening of association** – ideas have no discernible connection to one another

- **Word salad** – incoherent speech from extreme loosening of associations; may be seen in schizophrenia (esp. disorganized type)

- **Neuroleptic malignant syndrome** – can occur with high–potency antipsychotics --> confusion, high fever, elevated BP, tachycardia, “lead pipe” rigidity, sweating, greatly elevated creatine phosphokinase (CPK) levels
Glossary of selected psych terms

- Secondary Gain – use of symptoms to benefit the pt. (to get more attention, decreased responsibilities, avoidance of the law)
- Tolerance – either a decreased effect over time when same amount of substance is used or need for an increased amount of a substance over time to achieve a baseline
- Withdrawal – need for substance use to relieve or avoid physical symptoms associated with deprivation of it
- Delayed response – latency before responding; at the extreme, pt. may be mute
Glossary of selected psych terms

- Personality disorder – enduring & pervasive pattern of behavior that differs from the individual’s culture
- Pressured speech – rapid/accelerated/frenzied speech, difficult to interrupt; often seen in mania
- Primary Gain – expression of unacceptable feelings as physical symptoms in order to avoid facing them
- Tardive Dyskinesia – can occur with high-potency antipsychotics – darting or writhing movements of face, tongue, & head
- Tangentiality – answers become progressively less related to the original question
Glossary of selected psych terms

- Affect – behavior that expresses emotion (ie, euphoria, anger, sadness); Types of disturbance:
  - Blunted – severely reduced intensity of expression
  - Flat – absence/near absence of signs of expression, often manifest as monotonous voice/immoveable face
  - Inappropriate – discordance of voice & movements with content of speech or ideation; display of emotion not appropriate with reality or with content that it accompanies
  - Labile – abnormal variability with rapid shifts in expression
  - Restricted/constricted – reduction in expressive range & intensity of affect
Akathisia – subjective sense of restlessness with fidgeting, rocking from foot to foot, pacing or being unable to sit still

Akinesia – state of motor inhibition or reduced voluntary motor movement

Avolition – lack of initiative or goals; a negative symptom of schizophrenia

Flight of ideas – continuous flow of rapid speech with abrupt changes from one topic to another; often seen in mania
Glossary of selected psych terms

- Munchausen by proxy – form of abuse usually initiated by the mother. Symptoms made up or clinical signs are induced in a child causing repeated visits to provider. Perpetrator gets attention as being an attentive, suffering parent.
- Negativism – refusal to cooperate with simple requests for no apparent reason.
- Blocking – halt in flow of speech, unable to continue train of thought even with cueing.
References

Taking the exam after Sept. 2014

- [www.dsm5.org](http://www.dsm5.org)
- Highlights of Changes from DSM-IV-TR to DSM-5