## PSYCHOTIC DISORDERS (AXIS I).

**Psychosis:** break from reality with delusions, perceptual disturbances, and/or disordered thinking

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<td>Schizophrenia</td>
<td>1.1-1.5% lifetime prev Males=Females Men: worse prognosis Often born during winter months (viral?) Lower SES: ↓ drift 30-50% alcohol abuse Genetic: 50% MZ twin, 10% in 1° relatives 50% attempt suicide 15% complete suicide</td>
<td>Signs persist for 6+ months Age of onset below 45 60%: 15-25, 30%: 25-35 55% good outcomes 45% severe deterioration 1. Prodrome (years b4) 2. Psychosis 3. Residual: negative symptoms between</td>
<td>Symptoms must last for 6+ months 1+ in 1 month Delusions: Paranoia, idea of reference, grandiosity Hallucinations: auditory (common), visual, tactile Disorganized speech: content and thought process Grossly disorganized/catatonic behavior Negative symptoms: ↓ affect, anhedonia, apathy, apologia, ↓ attention 1+ Social/occupational dysfunction Ex. Work, interpersonal, self care</td>
<td>Antipsychotics: 70% improve • Typical antipsychotic meds o Block dopamine receptor (D2) o Effective treat positive symptoms o Prominent side effects • Atypical antipsychotic meds o 1st line treatment o Block DA + 5-HT receptors o More treat negative symptoms • Other drugs: Anticonvulsants, benzodiazepines, anti depressants</td>
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<td>Etiology</td>
<td>Neurotransmitters: Dopamine ↑ (limbic system): positive symptoms. Serotonin ↑ (prefrontal cortex): negative symptoms. NE: ↓ activity (anhedonia) Brain imaging: Ventricular enlargement, cortical atrophy, hypovacuity of frontal lobes upon PET</td>
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<td>Presentation:</td>
<td>Appearance: bizarre posture/behavior. Mood: depressed (25%), Judgment: usually deficient (violence: 12%). Orientation: oriented but ↓ attention. Neurological deficits: short-term memory deficit, unstable smooth pursuit, ↓ sensory gating (↓ tolerance to novel stimuli) 1. Perceptual disturbances: hallucinations (cnenesthetic), usually auditory but can be visual, tactile (common in EtOH), olfactory (common in seizures) 2. Disordered thinking: inferred from speech a. Process (Form): circumstansial (circuitsous), loose associations (disconnected ideas), tangentiality (never reach point), pressured (uninterruptable), perseverating, clang (related sounds make sentence), blocking (stop in middle of sentence), echolalia, neologisms, paraphasias. b. Content: delusions, insertion (others are placing thoughts in head), broadcasting (others can hear thoughts) 3. Delusions: Paranoid, Idea of reference (things are related to pt), Idea of influence, Grandeur, Guilt (I caused the holocaust)</td>
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<td>Subtypes</td>
<td>Disorganized – Prominent disorganized speech, inappropriate affect, NOT catatonic. Early onset Paranoid – preoccupation with particular delusion NONE OF: disorganized speech, catatonic, inappropriate affect. Later onset Catatonic – Motor immobility: catalepsy (immobile position), excessive motoric activity. Echolalia, echopraxia (mimic behavior) RAREST Undifferentiated Residual– Absence of positive symptoms for some time, but still have negative symptoms</td>
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<td>Brief psychotic disorder</td>
<td>Secondary to medical condition if: prominent delusions 1+ day but &lt;1 month with return to function</td>
<td>• 1+ of: Delusions, hallucinations, disorganized speech Disorganized speech</td>
<td>Hospital, meds, psychotherapy • Good prognosis: 50-80% have no further psychiatric problems</td>
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<td>Delusional disorder</td>
<td>0.03% More women 50% recover long term 30% have no change 1+ months of non-bizarre delusions Mean age: 40</td>
<td>Function is not impaired (vs. schizophrenia) • Erotomatic: delusions someone is in love • Jealous: unfaithful partner • Somatic: defect</td>
<td>Low dose antipsychotic</td>
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<td>Schizophreniform</td>
<td>1/3 recover, 2/3: go to schizophrenia Lasts 1-6 months, but return to function</td>
<td>Exclusion rules met for schizophrenia not other criteria</td>
<td>3-6 months antipsychotics • Supportive psychotherapy</td>
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<td>Schizoaffective disorder</td>
<td>Less than 1% More women Not clear link to Schizophrenia 2 weeks of delusions/hallucinations in absence of mood symptoms</td>
<td>No mood symptoms in absence of psychotic sx MDD, manic, or mixed episode WITH symptoms of schizophrenia Better prognosis than schizophrenia</td>
<td>Concurrent antipsychotics and antidepressants</td>
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<td>Movement definitions</td>
<td>Hemiballismus is an uncontrolled swinging of an extremity. It is usually sudden, and once initiated it cannot be controlled.</td>
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<td>Choreiform movements are involuntary, irregular, and jerky but lack the ballistic-like nature of hemiballismus.</td>
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<td>Athetoid movements, or athetosis, are slow, snake-like movements of the fingers and hands.</td>
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<td>Myoclonus is a sudden muscle spasm, and myotonia is prolonged muscle contraction.</td>
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<td>Common delusions</td>
<td>Cotard syndrome: Nihilistic, “I am dead.” “There is no world.”</td>
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<td>Capgras syndrome: family members are replaced by imposters</td>
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<td>Fregoli syndrome: shapeshifter is taking form of different people.</td>
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<td>Xacodemomania: patient is inhabited by an evil spirit</td>
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<td>Folie a deux: shared delusion</td>
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<td>Cultural psychosis</td>
<td>Koro is a traumatic fear that the penis is shrinking into the body cavity. Amok is a violent fit followed by amnesia.</td>
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<td>Pseudocyesis is the physiologic signs and symptoms of pregnancy developing in the absence of pregnancy.</td>
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<td>Couvade syndrome occurs when the husband of a pregnant woman goes into a sort of labor.</td>
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<td>Illusions</td>
<td>Micropsia and macropsia are misperceptions of visual stimuli. Objects appear smaller (micropsia) or larger (macropsia) than they are in reality.</td>
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<td>Palinopsia is the persistence of the visual image after the stimulus has been removed.</td>
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<td>Posttraumatic Stress Disorder (PTSD)</td>
<td>Females 2:1 Most frequently adolescents</td>
<td>Begins anytime; lasts &gt; 1 month</td>
<td>Re-experiencing sx: flashbacks, nightmares; called abreaction if while in therapy; avoidance of stimuli associated with trauma; numbing of responsiveness (affect, detachment); increased arousal</td>
<td>1. Psychotherapy: relaxation, EMDR 2. SSRIs or TCAs 3. Clonidine: ↓ arousal &amp; reexperiencing 4. Anticonvulsants for nightmares or flashbacks (Valproic acid)</td>
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<tr>
<td>Adjustment Disorder</td>
<td>Females 2:1 Most frequently adolescents</td>
<td>Begins &lt; 3 months after stressor; ends &lt; 6 months after stressor. (Is GAD if does not end); or chronic (&gt; 6 mo) if stressor recurs/persists</td>
<td>Distress in response to identifiable stressor; not life threatening (vs. PTSD); in excess of what is expected or impairs function; not bereavement; subtypes; depressed mood; anxiety; disturbance of conduct</td>
<td>1. Supportive psychotherapy: a. Most effective 2. Group therapy 3. Pharmacotherapy for associated symptoms (insomnia, anxiety, depression)</td>
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<td>Generalized Anxiety Disorder (GAD)</td>
<td>Females 2:1 45% lifetime prevalence 50-90% have MDD, phobia, panic</td>
<td>Lasts 6+ months; chronic and lifelong symptoms in 50%; 50% completely recover</td>
<td>Excessive worry about daily events &amp; activities; associated symptoms (3+); restlessness, fatigue, irritability; impaired concentration; muscle tension, sleep disturbance</td>
<td>Acute episode: benzodiazepines 1. Combination of psychotherapy and pharmacotherapy a. Buspirone, benzodiazepines (taper immediately), SSRIs b. Venlafaxine (Effexor™)</td>
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<td>Panic disorder</td>
<td>2-5% prevalence 4-8x if 1st relatives 40-80% comorbid MDD 20-40% substance</td>
<td>Multiple/day – 1/year; avg: 2/week; 10-20% persistent; 50% mild; 30-40% cured</td>
<td>Spontaneous recurrent panic attacks with no obvious precipitant: ~ 25 min; panic attack followed by 1+ month of: fear of panic attack, worry, change behavior</td>
<td>Rule out organic cause (MI) 1. Acute: benzodiazepines 2. Maintenance: SSRIs 8-12 mo. a. Paroxetine (Paxil™) b. Sertraline (Prozac™) 2. CBT, Relaxation, biofeedback</td>
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<td>Specific phobia</td>
<td>Phobias are the most common mental disorders (followed by substance-induced, MDE, OCD)</td>
<td>6+ months if &lt; 18</td>
<td>Anxiety brought on by specific situation; reproducible; versus panic disorder – fear of panic attack; patient knows fear is excessive</td>
<td>1. Behavioral: Sys. Desensitization a. Relaxation: Counter conditioning b. Reciprocal inhibition c. Not pharmacotherapy 2. Psychotherapy</td>
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<td>Social phobia</td>
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<td>Anxiety brought on by fear of embarrassment; ex. public speaking, public performance; versus agoraphobia: fear of having panic attack in public space and unable to get help</td>
<td>1. Pharmacotherapy a. SSRI: paroxetine (Paxil™) b. β-blocker for perc. Anxiety 2. CBT: correct automatic thoughts</td>
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<td>Obsessive Compulsive Disorder (OCD)</td>
<td>3% lifetime prevalence 4th most common mental disorder</td>
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<td>Obsessions relieved by compulsions; 75% have obsession AND compulsion but can just be intrusive thoughts (ex. sex/violence); ego dystonic (have insight) (vs. OCPD); common: contamination, doubt, symmetry</td>
<td>1. CBT: exposure and response prevention 2. SSRI (high dose) 3. TCA: clomipramine (Anafranil™)</td>
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<td>Length</td>
<td>Acute Stress Disorder</td>
<td>PTSD</td>
<td>Adjustment Disorder</td>
<td>Generalized Anxiety Disorder</td>
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<td>Begins within 1 month</td>
<td>Begins anytime</td>
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<td>6+ months</td>
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<td>Lasts less than 1 month</td>
<td>Lasts over 1 month</td>
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<td>Stressor</td>
<td>• Identifiable stressor: Death/rape/grave danger</td>
<td>• Re-experiencing, avoidance, ↑ arousal</td>
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<td>• Dissociation, derealization, depersonalization</td>
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<td>• Identifiable stressor: Not life threatening.</td>
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<td>• Not identifiable stressors: vague, diffuse, multiple (generalized)</td>
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**Bereavement:** Must be loss of a loved one  
**Grief:** Can be anything (divorce)  
**Pathological if > 1 yr or overtly psychotic (other than seeing dead relative or wanting to join them)**
### MOOD DISORDERS (AXIS I)

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| **Major depressive episode (MDE)** | • ↑ cortisol  
  o 50% impaired suppression w/dex  
  • ↓ catecholamines  
  • ↓ immune function  
  • Euthyroid  
  o 30% impaired TSH suppression w/TRH | • 2+ weeks | - Depressed mood or anhedonia plus (5+ total):  
  o SIG E CAPS: sleep changes, loss of interest, guilt or worthlessness, concentration problems, appetite changes, psychomotor slowing, suicidal ideation  
  - Can have psychotic features but must not be predominant  
  - **Must cause social/occupational impairment**  
  - Sleep:  
    o ↑ sleep latency  
    o ↑ AM awakening (melancholic), hypersomnia (atypical)  
    o REM redistributed to first half of night | 1. SSRIs, TCAs: 70% improve  
  • Minimum 16 weeks  
  • 70% effective vs 30% placebo  
  2. MAOIs if refractory  
  • Stimulants in terminally ill patients  
  • ECT indications  
    o 2-3 failed medical trials  
    o Severe suicidality  
    o Catatonia, malnutrition |
| **Manic episode** | 93% recur  
 Untreated: resolve in 3 months | • 1+ week  
 ↑ frequency with progression of disease | - Elevated mood or irritability plus (3+ total):  
  o DIG FAST: distractibility, indiscretion, grandiosity, flight of ideas, ↑ activity, sleep deficit, talkativeness (pressured speech)  
  - 75% have psychotic features | 1. Mood stabilizers: 50% improve  
 a. Lithium  
 b. Vaproate, carbamazepine  
 c. Olanzapine (Zyprexa™)  
 2. Supportive psychotherapy  
 3. Electroconvulsive therapy  
 a. ↑ effective than in MDD |
| **Mixed episode** | • 1+ week of both | - Need to fulfill criteria for both ME and MDE | |
| **Hypomanic episode** | • 4+ days | - Need 3+ manic symptoms  
 - No psychotic symptoms, no impairment of function | |
| **Major depressive disorder (MDD)** | Average onset: 40 years  
 50% recur in 2 years  
 Untreated: resolve in 6-12 months  
 2/3 suicidal ideation  
 15% complete suicide  
 MZ twins: 90% | • | - Subtypes  
  o Melancholic (40-60% of pt’s hospitalized for depression)  
    ▪ Early morning awakening, anhedonia, anorexia  
  o Atypical (most common subtype)  
    ▪ Hypersomnia, reactive mood, hyperphagia  
  o Catatonic  
  o Psychotic  
  - SAD if depression only occurs in winter months | 1. Mood stabilizers: 50% improve  
 a. Lithium  
 b. Vaproate, carbamazepine  
 c. Olanzapine (Zyprexa™)  
 2. Supportive psychotherapy  
 3. Electroconvulsive therapy  
 a. ↑ effective than in MDD |
| **Bipolar I** | Stronger genetic link (25% in 1° relatives) than unipolar depression | • 7+ days (manic) | - Only need 1 manic episode (don’t need MDE) | |
| **Bipolar II** | • 2+ weeks (MDE) | - 1 hypomanic episode AND 1 MDE | |
| **Cyclothymia** | <1% prevalence | • 2+ years | - Mild depression + hypomania for 2 years. No normal 2 mo.  
 - Often coexist with borderline PD | 2. Supportive psychotherapy  
 3. Electroconvulsive therapy  
 a. ↑ effective than in MDD |
| **Dysthymia** | 6% prevalence  
 20% get MDE  
 20% get bipolar  
 25% lifelong symptoms | • 2+ years | - Mild depression for 2 years with no 2 months euthymic  
 - Double depression: dysthymia + MDE  
 - Never have psychotic features | 1. CBT + psychotherapy are most effective  
 2. Antidepressants (need 2) |
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<td>Postpartum blues/pinks</td>
<td>• 50% of pregnancies o Predisposed to depression</td>
<td>• &lt; 2 weeks o 2-14 days postpartum</td>
<td>• Heightened emotional reactivity o Can be mild depression or mild elation</td>
<td>• Rest and social support contribute</td>
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<td>Postpartum depression</td>
<td>• 15% of pregnancies</td>
<td>• &lt;4 weeks after delivery</td>
<td>• Same criteria as for major depressive episode</td>
<td>• SSRI’s, but caution for breast-feeding • CBT</td>
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<td>Postpartum psychosis</td>
<td>• 2% of pregnancies o 30-50% ↑ risk in subsequent pregnancies</td>
<td>• Usually within 2 weeks of delivery</td>
<td>• Can have bipolar type manic symptoms and/or psychotic delusions</td>
<td>• Hospitalization • Antipsychotics</td>
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Rapid cycling: 4+ mood episodes in a year

**Suicide**
- Risk factors for attempted suicide: 1) age 45+, 2) alcohol dependence, 3) rage/violence, 4) prior suicidal behavior, 5) male gender
- Risk factors for completed suicide: white race, male gender, age > 45, single/divorced, Protestant/Jewish
- Children: more likely to ingest substances
- Adolescents: more likely to use firearms
### DISRUPTIVE BEHAVIOR (AXIS I)

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| **ADHD**                | 5-7% school age children  
Boys 3-5x  
2/3 comorbid with conduct disorder/ODD  
25% risk of developing antisocial PD  
- “Genetics most likely a primary role”  
- Psychosocial not primary.  
- Maybe toxins: lead, food additives, but no empirical support  
- **Dysregulation of NE**  
- Can have abnormal EEG  
*Some symptoms were present before age 7.* Onset may be age 3 but not detected until school age.  
**Must occur in two settings** (ex. Home AND school)  
Inconsistent with age/development  
- Preschool: temper tantrum  
- Elementary: Difficult peers/noncompliance  
- Adolescents: Internal sense of restlessness rather than motor  
- Adults: chronic disorganization  
  - 20% have symptoms continuing in adulthood | 6+ months | **Inattention** *(6+ for 6+ months)*  
- Attention to detail fail  
- Difficulty sustaining attention  
- Does not follow through  
- Organization fail  
- Avoids tasks that require sustained effort  
- Loses things, easily distracted  
- Doesn’t listen  
**OR Hyperactivity/impulsivity** *(6+)*  
- **Hyperactivity:** often fidgets  
  - Often leaves seat, runs or climbs  
  - Difficulty playing or leisuring  
  - Often “on the go”  
  - Often talks excessively  
- **Impulsivity**  
  - Often blurts out answers  
  - Often has difficulty awaiting turn  
  - Often interrupts | 1. CNS stimulants  
(Ritalin, Adderall, pemoline)  
Adjunctive: SSRI  
2. Psychotherapy  
3. Parental counseling  
4. Group Therapy |

| **Oppositional Defiant Disorder** | - 50% comorbid with ADHD  
- 25% remit spontaneously  
- May progress to conduct disorder  
- 4+ for 6+ months  
- **No violation of basic rights (vs. conduct dis.)** | 6+ months | **Loses temper (angry/resentful)**  
**Argues with adults**  
**Defies adults**  
**Deliberately annoys people**  
**Blames others for misbehavior**  
**Easily annoyed**  
**Spiteful** | 1. Psychotherapy – behavioral  
2. Parenting skills training |

| **Conduct Disorder** | 40% develop antisocial PD  
Child-onset: before 10 years old  
Adolescent-onset 10+ years old  
*3+ for 12+ months*  
Aggression to people/animals  
Destruction of property (ex. Fire)  
Deceitfulness or theft  
Serious violations of rules  
Causes significant impairment | 12+ months | 3. Multimodal  
  a. Firm rules, consistent  
  b. Psychotherapy – behavior  
4. Antipsychotics & lithium for aggression  
5. SSRI for impulsivity/aggression |

- **Constitutional-temperamental factors** – child’s behavior is not socially rewarding to parent, leads to less positive interactions  
  - Vicious circle  
- **Subpar Parenting skills** – leads to bad parent/child interactions  
  - Vicious circle  
- ODD/CD children can result from violent disciplinary techniques, less monitoring of behavior, reinforce bad behavior  
  - ¾ of variability explained by genes |

**Treatment:** Parent training is best. **Multimodal treatments:** use school, family, community resources to clearly state/enforce behavior. Expectations. Individual therapy has limited potential, doesn’t address entirety of biopsychosocial model. Medication may be used to treat aggression.
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| Reactive Attachment Disorder of Infancy/ Early Childhood | Usually before 5 years old                      | • Type I (Inhibited): Do not respond in developmentally appropriate fashion to social interactions  
  o Hypervigilant or ambivalent/contradictory  
• Type II (Disinhibited): Varied/indiscriminant attachments  
• Pathogenic care (1+)  
  o Persistent disregard for child’s basic emotional needs  
  o Disregard of physical needs  
  o Repeated changes of primary caregiver  
• Often malnourished  
• Weak crying response, no reciprocal smile response  
• Tactile defensiveness  
• Cruel to animals/siblings or other children  
• Abuse (phys/sex): 72% show L hemisphere frontal/temporal EEG abnormalities  
• Neglect: sensory deprivation leads to brain abnormalities  |                                                                 |                                                                 |                                                                 |                                                                 |
| PTSD in Children                              | 1+ month duration of disturbance  
Occurs months/years after event  
• Re-experience symptoms, fears related to trauma event  
• Bedwetting, separation anxiety, less interpersonally sensitive, less social  
• More likely to be aggressive  
• Avoidance symptoms (3+):  
  o Efforts to avoid thoughts, feelings related to event  
  o Inability to recall an important aspect  
  o Markedly diminished interest  
  o Feeling detachment/estrangement  
  o Restricted range of affect  
  o Sense of foreshortened future  |                                                                 | • Arousal symptoms (2+):  
  o Difficulty falling/staying asleep  
  o Irritability or outburst of anger  
  o Hypervigilence  
  o Exaggerated startle response  
• Psychobiological  
  o Increased muscle tone, startle response  
  o Sleep disturbance  
  o Increased catecholamine activity  
  o Limbic system abnormalities (113%)  
  o Deregulation of hypothalamic-pituitary-adrenal axis (HPA) leads to prolonged fight-or-flight responses  
• Loss of self-regulation, can’t inhibit fight-or-flight  |                                                                 |                                                                 |                                                                 |                                                                 |
| Acute Stress Disorder in Children             | 10% lifetime prevalence  
(80% of child burn victims get PTSD)  
Note: children perceive trauma differently and can be more susceptible  | Lasts 2 days – 4 weeks max  
Must occur within 4 weeks of trauma  | • Exposed to traumatic event  
• At least one re-experiencing event  
• 3+ of these during or after event:  
  o Sense of numbing, detachment, absence of emotion  
  o Derealization  
  o Depersonalization  
  o Dissociative amnesia  
  o Reduced awareness  | • Overcome denial / avoidance, teach coping skills  
• Pharma: SSRI, anticonvulsant, ACT PSA  
• Problem-focused coping  
  o Attempt to control stressor  
  o Can be most effective unless stressor is uncontrollable  
• Emotion-focused coping  
  o Attempting to reduce their own arousal and distress, stress  |
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| Anorexia Nervosa               | 1% of adolescent females 95% female Developed countries, wealthy, non black  | Peak: 12-13, 17-18 years old 30-50% recover within a few years 5-10% die after 10 yrs 20% die after 20 years | • Body weight below 85% *(vs. bulimia)*  
  • Intense fear of gaining weight  
  • Disturbed perceptions of weight/image  
  • Amenorrhea for 3+ months *(vs. bulimia)*  
  • Associated signs:  
    o Russell’s sign: scaring on dorsum of hand  
    o Salivary gland hypertrophy  
    o Hypothermia  
    o Lanugo hair  
    o Cerebral atrophy  
  • Metabolic disturbances:  
    o Hypochloremic hypokalemic met. acidosis  
      ▪ Inverted or flat T waves on EKG  
    o Hypercholesterolemia  
    o Hormones  
      ▪ Euthyroid, ↑ cortisol, ↑ GH  
    o ↑ BUN (protein catabolism)  
    o Osteoporosis (75%)  
|                                | MZ twins=50%                                                                 | Better prognosis if younger onset, restricter                           | • ½ of deaths are heart-related  
  o Russell’s sign: scaring on dorsum of hand  
  o Salivary gland hypertrophy  
  o Hypothermia  
  o Lanugo hair  
  o Cerebral atrophy  | • Psychotherapy  
  o CBT, psychodynamic  
  • SSRI adjunct: helps gain weight  
  o For comorbid depression  
  o Paroxetine *(Paxil™)*  
  o Mirtazapine *(Remeron™)*  
|                                | Theories:  
  • Hypothalamic: lack of leptin  
  • Low t3 (thyroid)  
  • Low CCK  
  • Psychological: feminine ideal  
|                                | Types:  
  o Binge/purge  
  o Restricting                  |                                                                          | • Better prognosis than anorexia  
  • 1/3 of patients are DM 1  
  • Types:  
    o Purge: vomiting, laxatives, diuretics  
    o Nonpurge: excessive exercise or fast | • Hospitalize if:  
  o Weight below 80% (BMI <18.5)  
  o Bradycardia or other arrhythmia  
  o Altered mental status  
  o Suicidal ideation  
  o Severe metabolic disturbance  
| Bulimia Nervosa                | 3% of young women 40% college females symptoms 95% female 50% anorexic get bulimia | Binge 2+ times/week for 3+ months 1/3 improve 1/3 stay the same 1/3 get worse | • Recurrent episodes of binge eating  
  o Followed by compensatory behavior  
  • Normal weight or overweight *(vs. anorexia)*  
  • Normal hormone levels *(vs. anorexia)*  
  • Perception of self-worth is excessively influenced by body weight  
  • Ego-dystonic *(vs. anorexia)*  
  • Associated signs:  
    o Russell’s sign: scaring on dorsum of hand  
    o Salivary gland hypertrophy  
    o See: anorexia  
  • Associated signs:  
  • Associated signs:  
  • Associated signs:  
|                                | Better prognosis than anorexia  
  • 1/3 of patients are DM 1  
  • Types:  
    o Purge: vomiting, laxatives, diuretics  
    o Nonpurge: excessive exercise or fast |                                                                          | • Psychotherapy, CBT, group  
  o Usually non-responsive  
  • SSRI’s, TCA’s: reduce by 50%  
| Eating disorder, NOS (Binge-eating Disorder) | Binge 2+ days/week for 6+ months |                                                                          | • Recurrent episodes of binge eating  
  o Binge not followed by compensatory behavior *(vs. anorexia & bulimia)*  
  • Eat rapidly, a lot, alone  
  • Feel uncomfortably full  
  • Feel depressed, guilty or disgusted after binge | • Psychotherapy  
  • Cognitive behavioral therapy (CBT)  
  • Pharmacotherapy  
  o Stimulants: amphetamine *(↓ appetite)*  
  o Orlistat *(Xenical™)*: inhibits pancreatic libase - steatorrhea  
  o Sibutramine *(Meridia™)*: inhibits reuptake of NE, 5HT, DA |
<table>
<thead>
<tr>
<th>Disorder</th>
<th>Epidemiology</th>
<th>Timeline</th>
<th>Symptoms</th>
<th>Treatment</th>
</tr>
</thead>
</table>
| Feeding Disorder of Infancy   | 10-30% children 1-6 years Onset before 6 years old 10% over 10 % of institutionalized mentally retarded children Male=Female Might be nutritional insufficiency (ex. Fe) or prenatal neglect | 1+ months                  | • Persistent failure to eat with decreased weight  
• Not due to lack of available food | Psychosocial/family guidance  
• Environmental  
• Behavioral |
| Pica                          | 1+ months Onset between 1-2 years. Usually remits by adolescence             |                             | • Eating of non-nutritive substances inappropriate to child’s developmental level  
• Complications: Poisoning, anemia, intestinal obstruction, parasites  
• DDx includes Fe/Zinc deficiency, Schizophrenia, Autism, Dwarfism, Klein-Levin syndrome (sleep for weeks wake up ravenously hungry) |                              |
| Rumination Disorder           | Rare-Most common in 3mo-1yr + MR children/adults 6% Male=Female (Adult = more common in males) May be genetic | 1+ months                  | • Repeated regurgitation  
• Infants: weight loss, failure to thrive  
• Adults: usually normal weight  
• Can be: pleasure, tension-relieving, learned attention-getting  
• DDx: gastroesophageal reflux, Pyloric stenosis (projectile vomiting)  
• Side effects: esophagitis, recurrent dental problems, excessive salivation, anemia, social ostracism  
• Adults: no pain/nausea, no anatomical basis, occurs in “nervous” people | Operant procedures  
o “time out”  
o Electric shock  
o Pepper sauce, lemon juice – squirt on tongue  
o Overcorrection – wash lips, use soap, use lotion  
o Satiation, bring in food often |
### Somatiform and Factitious Disorders (Axis I)

#### Primary gain
Serve to keep internal conflicts out of consciousness. Expression of unacceptable feelings as physical sx in order to avoid dealing. **The act itself helps relieve stressor – internal motivation. Not conscious of gain.**

#### Secondary gain
Able to get out of obligation and stressful situation with manifested symptoms. **The consequences of the manifested symptoms are rewarding to the patient – external motivation. Not conscious of gain.**

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Epidemiology</th>
<th>Timeline</th>
<th>Symptoms</th>
<th>Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Somatization Disorder</td>
<td>0.1-0.5% Female 80-95% Female Lower SES</td>
<td><em>Must be &lt; 30</em></td>
<td>Multiple somatic symptoms which cannot be explained medically</td>
<td>Medical management</td>
</tr>
<tr>
<td></td>
<td>Genetic – abnormal cortical function?</td>
<td>Chronic – begins in adolescence, stress precipitate symptoms</td>
<td>Patient unintentionally manifests symptoms</td>
<td>o Avoid tests and procedures</td>
</tr>
<tr>
<td></td>
<td>Comorbid: Substance abuse, GAD, phobias, depression</td>
<td></td>
<td>Involve multiple organ systems, must have:</td>
<td>o Reduce unnecessary drugs</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>o 4 pain symptoms</td>
<td>o Avoid giving sick leave</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>o 2 GI symptoms</td>
<td>o Single physician for care</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>o 1 sexual symptom</td>
<td>o Regularly scheduled PCP visits</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>o 1 pseudoneurological symptom</td>
<td>Second-line therapy</td>
</tr>
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<td></td>
<td></td>
<td></td>
<td>Seeks medical care often</td>
<td>o Relaxation</td>
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<td></td>
<td></td>
<td>o Hypnosis</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>o Psychotherapy (insight oriented)</td>
</tr>
<tr>
<td>Conversion disorder</td>
<td>1-25% admitted to general medical setting</td>
<td>Resolve in 1 month</td>
<td>DSM IV-TR Criteria</td>
<td>Medical workup to rule out medical cause (35% medical cause)</td>
</tr>
<tr>
<td></td>
<td>Underlying medical problem in 15-35%</td>
<td></td>
<td>o 1+ pseudoneurological symptom</td>
<td>• Symptoms resolve after hypnosis or amobarbital</td>
</tr>
<tr>
<td></td>
<td>2-5x females</td>
<td></td>
<td>o Associated with psychological trigger</td>
<td>• Psychotherapy (insight oriented)</td>
</tr>
<tr>
<td></td>
<td>Young, less educated</td>
<td></td>
<td>o Not due to general medical cause</td>
<td></td>
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<tr>
<td></td>
<td>5-15% of inpatients getting psych consult</td>
<td></td>
<td>o Causes distress or impairment in functioning</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>o Problem is not limited to pain or sexual dysfunction</td>
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<td></td>
<td><strong>La belle indifference</strong> – unaware/careless of symptoms</td>
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<td></td>
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<td></td>
<td>Common sx: shifting paralysis, seizures, mutism</td>
<td></td>
</tr>
<tr>
<td>Factitious Disorder</td>
<td>3-9% of hospital admits</td>
<td>History of abuse</td>
<td><strong>Intentionally manifest physical or psychological symptoms in order to assume sick role</strong></td>
<td>Avoid unnecessary procedures</td>
</tr>
<tr>
<td></td>
<td>More Males</td>
<td></td>
<td>o Want to be a patient (primary gain)</td>
<td></td>
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<td></td>
<td>More common in healthcare workers (ex. insulin)</td>
<td></td>
<td>o Symptoms worsen during observation</td>
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<tr>
<td></td>
<td>Higher intelligence</td>
<td></td>
<td><strong>No external incentives. (Not secondary gain)</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Often depressed, hallucinations</td>
<td></td>
<td><strong>Munchausen’s Syndrome:</strong> Mostly physical symptoms</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td><strong>Munchausen by proxy:</strong> create illness in another in order to get sympathy. <em>(Factitious NOS)</em></td>
<td></td>
</tr>
<tr>
<td>Malingering (most common)</td>
<td>Usually Men</td>
<td></td>
<td><strong>Production of false psych/physical symptoms with EXTERNAL incentive (like avoiding military, jail)</strong></td>
<td>Treat coexisting problems</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>o Associated with antisocial PD too</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>o Referred by an attorney</td>
<td></td>
</tr>
<tr>
<td>Hypochondriasis</td>
<td>4-6% Male=Female</td>
<td>6+ months</td>
<td><strong>No symptoms of disease</strong></td>
<td>Group psychotherapy</td>
</tr>
<tr>
<td></td>
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<td>Starts 20-30 yrs 30-50% have improvement</td>
<td>Misinterpret normal body functioning as sign of disease or fear disease</td>
<td>Reassurance</td>
</tr>
<tr>
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<td>Fears persist despite medical workup</td>
<td>Frequent regularly scheduled physicals to 1 PCP</td>
</tr>
<tr>
<td>Disorder</td>
<td>Epidemiology</td>
<td>Timeline</td>
<td>Symptoms</td>
<td>Treatment</td>
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<td>---------------------------------------------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Pain disorder</td>
<td>2x females 75 million have chronic pain 25-50% have depression comorbid</td>
<td>Acute: &gt; 6 months</td>
<td>Pain which is not fully accounted for by a medical or neurological condition</td>
<td>Rule out:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Chronic: &lt; 6 months</td>
<td>o Can coexist with medical cause but degree of impairment not explained by medical cause</td>
<td>o Medical cause</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>o 1+ anatomic site</td>
<td>o Hypochondriasis</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>o Causes distress or impairment in functioning</td>
<td>o Malingering</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>o Related to psychological factors</td>
<td>• Analgesics not helpful</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Gradual onset</td>
<td></td>
<td>• SSRI’s</td>
</tr>
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<td></td>
<td></td>
<td></td>
<td>• Nerve stimulation</td>
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<td></td>
<td></td>
<td></td>
<td>• Biofeedback</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Psychotherapy</td>
</tr>
<tr>
<td>Body Dysmorphic</td>
<td>2% of those requesting plastic surg Male=Female 50% depressed 75% psychotic</td>
<td>Gradual onset</td>
<td>Belief that body is misshapen or defective in some way – imagined or exaggerated</td>
<td>Treat coexisting anxiety, depression</td>
</tr>
<tr>
<td>Disorder</td>
<td>housebound</td>
<td></td>
<td>o Request surgery to correct perceived defect</td>
<td>• Serotonin, antidepressants</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>o Shy, self absorbed, self-centered</td>
<td></td>
</tr>
</tbody>
</table>

- **Somatiform**: patients believe they are ill
- **Factitious**: patients pretend they are ill
- **Malingering**: patients pretend they are ill with external incentives
# Substance-Related Disorders (Axis I)

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Epidemiology</th>
<th>Timeline</th>
<th>Symptoms</th>
<th>Treatment</th>
</tr>
</thead>
</table>
| Substance Abuse           | 16.8% alcohol: 13.8%  | 12+ months | • 1+ within a 12 month period                                           | o Failure to fulfill major role obligations  
  o Use when it is physically hazardous (ex. Driving)  
  o Use despite legal problems  
  o Persistent use despite problems caused             |
| Substance Dependence      | 12+ months            | 3+ within a 12 month period                                           | • Tolerance & cross tolerance (other drug)  
  • Withdrawal                                          | • Great deal of time is spent trying to obtain  
  • Use despite physical/psychological problem           |
|                           |                       |          | • Desire to cut down                                                   |                                                                                               |
|                           |                       |          | • ↓ social, occupational activities as a result                        |                                                                                               |
|                           |                       |          | • Using more than originally intended                                  |                                                                                               |

<table>
<thead>
<tr>
<th>Drug</th>
<th>Detection</th>
<th>Intoxication</th>
<th>Withdrawal</th>
<th>Treatment</th>
</tr>
</thead>
</table>
| EtOH                      | Breathalyzer or BAC  | • Disinhibition                                    | • 6-24 H: insomnia, anxiety, irritability, tachycardia, hyperreflexia, delirium, HTN, seizures, hallucinosis: hallucinations while alert and oriented | • DT: benzodiazepines  
  o Long acting if good liver function  
  o Thiamine (IM), folate  
  o Mg²⁺ for seizures  
  o Dependence: Naltrexone ↓ craving, AA                                                                 |
|                           | Hazardous drinking: Men 5+ drinks/day, women 4+ drinks/day | • Ataxia, Sedation, Respiratory depression          |                                                                                               |                                                                                               |
| Cocaine and amphetamines | Urine + for 3 days   | • Euphoria, hallucinations                         | • Dysphoria, depression                                                                      | Intoxication:  
  1. Benzodiazepines, TCAs  
  2. Psychotherapy, group therapy  
  3. Dopamine agonist                                                                 |
|                           |                      | • Dilated pupils                                    | • Irritability, fatigue                                                                      |                                                                                               |
|                           |                      | • ↑ heart & respiratory rate, HTN                  |                                                                                               |                                                                                               |
|                           |                      | • ↓ appetite                                        |                                                                                               |                                                                                               |
|                           |                      | • Seizures                                         |                                                                                               |                                                                                               |
| PCP –NMDA antagonist      | Urine + for ~ 1 week  | • Aggression, ↑ pain tolerance                     | • No withdrawal syndrome but flashbacks common                                               | 1. Acidify urine (ammonium)  
  2. Benzodiazepine, DA agonist  
  3. Haloperidol if psychosis a. But worsens hyperthermia                                                                 |
| Sedative – hypnotics     | Urine + for 1 week   | • Drowsiness                                       | • More common with short acting drugs                                                        | Intoxication: ABCs, charcoal  
  1. Barbiturates: alkalinize urine  
  2. Benzodiazepiens: Flumazenil  
  3. Tegretol/valproate                                                                 |
|                           |                      | • Slurred speech                                   | • Autonomic hyperreactivity, N/V/D                                                            |                                                                                               |
|                           |                      | • Nystagmus (rotary), ataxia                       | • Tremor, insomnia                                                                          |                                                                                               |
|                           |                      | • Muscle rigidity                                  | • Delirium, hallucinations                                                                   |                                                                                               |
| Opioids                   | Urine + for 12-36 hrs | • Drowsiness                                       | • Seizures                                                                                  | Overdose: Naloxone  
  Withdrawal: Clonidine/buprenorphine  
  Dependence: Methadone and psychotherapy                                                     |
|                           |                      | • Constricted pupil (miosis)                       | • Not life threatening. Dysphoria, dreams                                                    |                                                                                               |
|                           |                      | • Seizures/respiratory depression                  | • Lacrimation, rhinorrhea, N/V/D                                                             |                                                                                               |
|                           |                      | • Coma                                             | • Piloerrection, generalized myalgias                                                       |                                                                                               |
|                           |                      | • Serotonin syndrome with MAOI’s                   | • Dilated pupils (mydriasis), yawning                                                       |                                                                                               |
| Inhalants                 | Serum + for 4-10 hrs | • Ataxia                                           |                                                                                               | 1. ABCs, supportive treatment                                                                 |
| Hallucinogens             | LSD: Lysogenic acid | • Dilated pupils                                   |                                                                                               |                                                                                               |
| Psilocybin                | diethylamide         | • Last 8-12 hours                                  |                                                                                               |                                                                                               |
|                           |                      | • Stimulant-like effects                           |                                                                                               | 1. “talk down” patient  
  2. Benzodiazepines  
  3. Antipsychotics                                                                 |

**Notes:***
- **Chi-squared test:** 
  - Expected count too small for one cell

- **Definition:** 
  - Substance Abuse:  
    - Alcohol: 13.8%  
    - Other substances: 6.0%

  - Substance Dependence:  
    - Alcohol: 13.8%  
    - Other substances: 6.0%

- **Timeline:** 
  - 12+ months

- **Symptoms:**  
  - Failure to fulfill major role obligations
  - Use when it is physically hazardous (ex. Driving)
  - Use despite legal problems
  - Persistent use despite problems caused

- **Treatment:**
  - DT: benzodiazepines  
    - Long acting if good liver function  
    - Thiamine (IM), folate  
    - Mg²⁺ for seizures  
    - Dependence: Naltrexone ↓ craving, AA

- **Drug Detection:**
  - Breathalyzer or BAC  
    - Hazardous drinking:  
      - Men 5+ drinks/day, women 4+ drinks/day

- **Intoxication:**
  - Disinhibition
  - Ataxia
  - Sedation
  - Respiratory depression

- **Withdrawal:**
  - 6-24 H: insomnia, anxiety, irritability, tachycardia, hyperreflexia, delirium, HTN, seizures, hallucinosis: hallucinations while alert and oriented
  - Delirium tremens: <72 H (20% mortality)

- **Treatment:**
  - 1. Benzodiazepines, TCAs  
    - Psychotherapy, group therapy  
    - Dopamine agonist

- **Hallucinogens:**
  - Psilocybin, LSD
  - Lysogenic acid diethylamide
  - Dilated pupils
  - Last 8-12 hours
  - Stimulant-like effects
  - No withdrawal syndrome
  - “talk down” patient
  - Benzodiazepines
  - Antipsychotics

- **Inhalants:**
  - Serum + for 4-10 hrs
  - Ataxia
  - Dilated pupils
  - Last 8-12 hours
  - Stimulant-like effects
  - No withdrawal syndrome
  - ABCs, supportive treatment

- **PCP –NMDA antagonist:**
  - Urine + for ~ 1 week
  - ↑ CPK, ↑ AST
  - Dilated pupils
  - Last 8-12 hours
  - Stimulant-like effects
  - No withdrawal syndrome
  - “talk down” patient
  - Benzodiazepines
  - Antipsychotics

- **Sedative – hypnotics:**
  - Urine + for 1 week
  - Drowsiness
  - Slurred speech
  - Nystagmus, ataxia
  - Respiratory depression
  - Coma

- **Opioids:**
  - Urine + for 12-36 hrs
  - Drowsiness
  - Constricted pupil (miosis)
  - Seizures/respiratory depression
  - Serotonin syndrome with MAOI’s

- **Drug Detection:**
  - Urine +
  - Serum +
  - Breathalyzer or BAC
  - Alcohol: Breathalyzer or BAC
  - Other substances: Urine

- **Drug Intoxication:**
  - Euphoria, hallucinations
  - Dilated pupils
  - ↑ heart & respiratory rate, HTN
  - ↓ appetite
  - Seizures

- **Withdrawal:**
  - More common with short acting drugs
  - Autonomic hyperreactivity, N/V/D
  - Tremor, insomnia
  - Delirium, hallucinations
  - Seizures

- **Treatment:**
  - Acidify urine (ammonium)
  - Benzodiazepine, DA agonist
  - Haloperidol if psychosis a. But worsens hyperthermia

- **Drug Detection:**
  - Urine + for 3 days
  - Hazardous drinking:
  - Men 5+ drinks/day, women 4+ drinks/day

- **Drug Intoxication:**
  - Disinhibition
  - Ataxia
  - Sedation
  - Respiratory depression

- **Withdrawal:**
  - 6-24 H: insomnia, anxiety, irritability, tachycardia, hyperreflexia, delirium, HTN, seizures, hallucinosis: hallucinations while alert and oriented

- **Treatment:**
  - Benzodiazepines, TCAs
  - Psychotherapy, group therapy
  - Dopamine agonist
<table>
<thead>
<tr>
<th>Drug</th>
<th>Detection</th>
<th>Intoxication</th>
<th>Withdrawal</th>
<th>Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caffeine</td>
<td></td>
<td>•</td>
<td>• 75% symptomatic in 12-48 hours</td>
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<td></td>
<td></td>
<td></td>
<td>• Headache (50%)</td>
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<td></td>
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<td></td>
<td>• Depressed mood, irritability</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>• Cramps, nausea</td>
<td></td>
</tr>
<tr>
<td>Nicotine</td>
<td></td>
<td>• Exuberant</td>
<td>•</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>• Muscle twitching, cramps</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Palpitations</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>• Coma, respiratory failure at high dose</td>
<td></td>
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</tbody>
</table>
# MENTAL RETARDATION (AXIS II)

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Epidemiology</th>
<th>Timeline</th>
<th>Symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Developmental Disability</td>
<td>Before age 22 Service needs are life long</td>
<td></td>
<td>• Functional limitations in 3+ areas&lt;br&gt; o Self care, Learning, Mobility&lt;br&gt; o Receptive/expressive language&lt;br&gt; o Self-direction, Independent living&lt;br&gt; o Economic self sufficiency</td>
</tr>
<tr>
<td>Mental Retardation</td>
<td>Onset before 18</td>
<td></td>
<td>• Sub average IQ: &gt;70&lt;br&gt; • Concurrent deficits in 2+ areas: See list for developmental disability</td>
</tr>
<tr>
<td>Subtype: Organic (Idiopathic)</td>
<td>1.4x Males higher in non-white</td>
<td></td>
<td>• No discernable pathologic basis&lt;br&gt; • Comorbid: epilepsy, cerebral palsy, autism, fetal alcohol, downs</td>
</tr>
<tr>
<td>Subtype: Prenatal (Genetic)</td>
<td>7-15% of MR, 30-40% unknown Chromosomal: 30% severe, 4-8% mild</td>
<td></td>
<td>• Fragile-X: 30-50%, Down syndrome, TORCHES infections&lt;br&gt; • Prader-willi: 50-70% of paternal deletion</td>
</tr>
<tr>
<td>Subtype: Perinatal or postnatal</td>
<td>1.6-1.9x with mom smoker Fetal alcohol, anoxia, lead, mercury</td>
<td>5% show signs at birth. 80-90% serious problems by 2</td>
<td></td>
</tr>
<tr>
<td>Learning Disorder</td>
<td>Reading disorder (3%): 3x♂&lt;br&gt;Math disorder (5%): more ♀&lt;br&gt;Written expression (3-10%)</td>
<td></td>
<td>• &lt; expected achievement for age, education, intelligence&lt;br&gt; • Not organic cause&lt;br&gt; • R/u organic cause (ex. vision)</td>
</tr>
<tr>
<td>Expressive Language Disorder</td>
<td>Selective mutism: won’t speak in certain situations only but has normal language development</td>
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</tbody>
</table>

# TOURETTE’S AND OTHER DISORDERS

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Epidemiology</th>
<th>Timeline</th>
<th>Diagnosis</th>
<th>Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tourette’s Disorder</td>
<td>Occurs in 0.05% of children Males 3:1&lt;br&gt;Co-morbidity with OCD and ADHD&lt;br&gt;MZ twin concordance: 50%&lt;br&gt;Etiology: DA dysregulation in caudate</td>
<td>12+ months&lt;br&gt;Onset between ages 7 and 8&lt;br&gt;1. Eye: blinking/rolling&lt;br&gt;2. Facial: licking&lt;br&gt;3. Vocal: throat clearing&lt;br&gt;4. Whole body: pelvic&lt;br&gt;5. Self-abusive</td>
<td>• Motor and vocal tics (Need both)&lt;br&gt; • Tics occur many times a day, almost every day for &gt; 1 year&lt;br&gt; o No tic-free period &gt; 3 months&lt;br&gt; • Onset prior to age 18&lt;br&gt; • Distress or impairment in social/occupational functioning</td>
<td>• Pimozide/Haloperidol&lt;br&gt; • Clonidine&lt;br&gt; • Atypical antipsychotic&lt;br&gt; • Pimozide/Haloperidol&lt;br&gt; • Supportive psychoT&lt;br&gt; • Stimulants make tics worse</td>
</tr>
<tr>
<td>Enuresis</td>
<td>Normally continent before 4&lt;br&gt;7% of 5-year olds&lt;br&gt;Primary – never previously continent&lt;br&gt;Secondary – after previously continent</td>
<td>3+ months</td>
<td>• Involuntary voiding after age 5&lt;br&gt; • Occurs twice per week for 3 months&lt;br&gt; • Causes marked impairment</td>
<td>Rule out medical cause (DM, seizures, urethritis)&lt;br&gt; 1. Behavioral (classical)&lt;br&gt; 2. Pharmacotherapy&lt;br&gt; a. DDVP (ADH)&lt;br&gt; i. H₂O intoxication&lt;br&gt; b. TCAs (imipramine)</td>
</tr>
<tr>
<td>Encopresis</td>
<td>Normally continent before 4&lt;br&gt;1% of 5-year olds</td>
<td>3+ months</td>
<td>• Must be 4+ years old&lt;br&gt; • Involuntary or intentional passage of feces in inappropriate places&lt;br&gt; • Occurs once/month for 3+ months</td>
<td>Rule out medical cause (anal fissure, IBD)&lt;br&gt; • Psychotherapy&lt;br&gt; • Stool softeners</td>
</tr>
<tr>
<td>Pervasive Developmental Disorder (Axis I)</td>
<td>Epidemiology</td>
<td>Timeline</td>
<td>Symptoms</td>
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<tr>
<td><strong>Autistic Disorder</strong> 1/150 births</td>
<td>70% have comorbid MR 75% moderate severity</td>
<td>Almost always have symptoms before 3 years old</td>
<td>6+ total symptoms</td>
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<tr>
<td>NOT due to psychological trauma, bad parenting, physical abuse, separation anxiety</td>
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<td>Social Interaction Impairment (2+)</td>
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<td></td>
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<td></td>
<td>o Impairment of nonverbal behavior (ex. Poor eye contact)</td>
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<td></td>
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<td></td>
<td>o Failure to develop peer relationships</td>
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<td></td>
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<td></td>
<td>o Lack of spontaneous seeking to share enjoyment</td>
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<tr>
<td><strong>Asperger’s Disorder</strong> More common in males</td>
<td>More common in families where Asperger’s is common</td>
<td>Preschool – motor delays School – social Adults- modulation of behavior</td>
<td>Same criteria for autism except: No delay in speech, cognitive development</td>
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<td></td>
<td></td>
<td></td>
<td>No clinically significant adaptive impairment</td>
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<tr>
<td><strong>Rett’s Disorder</strong> ONLY in Females</td>
<td>MECP2 gene on X chromosome</td>
<td>Prenatal/Perinatal: Normal Normal first 5 months 5-38 months: deceleration Lifelong impairment</td>
<td>↓ head circumference growth velocity during 5-48 months</td>
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<td></td>
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<td></td>
<td>Loss of previously acquired hand skills</td>
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<td>Early loss of social interaction, usually followed by subsequent improvement</td>
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<td>Severely impaired language and psychomotor development</td>
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<td>Trunk/gait problem</td>
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<td>Seizures</td>
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<td>Cyanotic spells</td>
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<tr>
<td><strong>Childhood Disintegrative Disorder</strong> Males 4:1</td>
<td>Normal first 2 years Onset before age 10</td>
<td></td>
<td>Loss of previously acquired skills in at least two areas:</td>
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<td></td>
<td></td>
<td></td>
<td>o 1. Language</td>
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<td>o 2. Social skills</td>
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<td></td>
<td></td>
<td>▪ Bowel or bladder control</td>
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<td></td>
<td>▪ Play</td>
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<td></td>
<td>▪ Motor skills</td>
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<td>At least two of the following:</td>
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<td></td>
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<td></td>
<td>o Impaired social interaction</td>
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<td></td>
<td>o Impaired use of language</td>
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<td></td>
<td>o Restricted, repetitive, and stereotyped behaviors and interests</td>
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<tr>
<td><strong>Pervasive Developmental Disorder NOS</strong></td>
<td>Severe, pervasive impairment in development of reciprocal social interaction and verbal/nonverbal communication.</td>
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<td>Not otherwise specified by a personality disorder or schizophrenia.</td>
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<td>Sometimes called “atypical autism”</td>
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**Assessment of developmental disorders**

- Medical: RULE OUT AN ORGANIC CAUSE (EX. VISION PROBLEM)
  - Maternal age & health during pregnancy, alcohol use, smoking
  - Gestation age at birth, perinatal complications, NICU
  - Presence of infection, maternal diabetes, jaundice, birth defects
  - Neurological, cardiac problems, parents’ IQ
- Lab testing
  - Chromosomal analyses, molecular-genetic, toxicity, LEAD
- Psychological evaluation
  - Developmental/intelligence, behavioral observation scales
- Physical
  - Somatic growth-height, weight
  - Head circumference
  - Vision
- Lab testing
  - Chromosomal analyses, molecular-genetic
  - Toxicity: lead levels
- Speech & language evaluation
**PERSONALITY DISORDERS (AXIS II)**

- Deeply ingrained, inflexible patterns of relating to others that are maladaptive and cause significant impairment in social or occupational functioning.
- **Ego-syntonic**: Lack insight about their problems
- DSM IV-TR Criteria
  - Pattern of behavior/inner experience which deviates from culture, manifested by 2+
    - Cognition
    - Affect
    - Personal relations
    - Impulse control
  - Pattern is pervasive and inflexible, onset no later than early adulthood, leads to distress in functioning, not result of another illness
- Affect 1% of the population
- Not otherwise specified: Passive-aggressive, sadistic (hurt others), sadomasochistic (hurt self and others)

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Epidemiology</th>
<th>Timeline</th>
<th>Symptoms</th>
<th>Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Schizoid PD</td>
<td>7.5%</td>
<td>Don't really marry</td>
<td>• Prefer to be alone&lt;br&gt;• No desire for close relationships&lt;br&gt;• Little interest in sex (with another person)&lt;br&gt;• Take pleasure in few activities&lt;br&gt;• Indifferent to criticism&lt;br&gt;• Emotional coldness, detachment, flat affect&lt;br&gt;• Choose solitary activities&lt;br&gt;• Gravitate to solitary jobs&lt;br&gt;• No loss of reality (no ideas of reference)</td>
<td>1. Psychotherapy&lt;br&gt;- Group therapy good - can provide only social contact&lt;br&gt;2. Pharmacotherapy PRN&lt;br&gt;- Antidepressant if MDD&lt;br&gt;- Antipsychotics (short course)</td>
</tr>
<tr>
<td>(least severe)</td>
<td>Men&lt;br&gt;Can be comorbid with depression&lt;br&gt;No association with schizophrenia</td>
<td>Women may passively agree to marry</td>
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<tr>
<td>Schizotypal PD</td>
<td>3%</td>
<td>May remain stable</td>
<td>• Magical thinking (not cultural) (clairvoyance, telepathy)&lt;br&gt;o Think their thoughts can have special powers on others.&lt;br&gt;• Odd, eccentric appearance/behavior&lt;br&gt;• Odd habits, thinking, or superstition&lt;br&gt;• Suspicious of others&lt;br&gt;• Inappropriate/restricted affect&lt;br&gt;• Excessive social anxiety&lt;br&gt;• Unusual perceptive experiences&lt;br&gt;• <strong>Ideas of reference</strong></td>
<td>1. Psychotherapy&lt;br&gt;2. Pharmacotherapy PRN&lt;br&gt;- Antidepressant if MDD&lt;br&gt;- Antipsychotics (low dose)</td>
</tr>
<tr>
<td>(middle severity)</td>
<td>Men, more common familially&lt;br&gt;30-50% have MDD&lt;br&gt;10% commit suicide</td>
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<tr>
<td>Paranoid PD</td>
<td>0.5% - 2.5%</td>
<td></td>
<td>• Hostile, angry&lt;br&gt;• Preoccupied with trustworthiness/loyalty of others&lt;br&gt;• Reluctance to confide in anyone&lt;br&gt;• Interpretation of remarks as being threatening&lt;br&gt;• Recurrent suspicions of infidelity of spouse&lt;br&gt;• <strong>Ideas of reference, not delusion (vs. Schizophrenia, paranoid type)</strong></td>
<td>1. Psychotherapy&lt;br&gt;2. Pharmacotherapy PRN&lt;br&gt;- Anti-anxiety&lt;br&gt;- Antipsychotics (short course)</td>
</tr>
<tr>
<td>(most severe)</td>
<td>Males, minorities, immigrants, relatives of schizophrenics&lt;br&gt;75% comorbid with other PD</td>
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<tr>
<td>Disorder</td>
<td>Epidemiology</td>
<td>Timeline</td>
<td>Symptoms</td>
<td>Treatment</td>
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<tr>
<td><strong>PERSONALITY DISORDERS - CLUSTER B (BAD)</strong></td>
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</tbody>
</table>
| Histrionic PD       | 2-3%                               | Show less symptoms as they age | • Theatrical expression of emotion: temper tantrums  
• Uncomfortable when not center of attention  
• Inappropriately provocative. Use physical appearance to gain attention  
• Speech is impressionistic, lacks details  
• Easily influenced by others  
• Constant need for praise  
• Use regression as a defense mechanism | 1. Psychotherapy  
2. Pharmacotherapy PRN  
- Antidepressant |
| Narcissistic PD     | <1%  
50-75% MEN                      | Aging handled poorly      | • Lack of empathy. Sense of superiority.  
• Takes advantage of others for self-gain (vs. antisocial for subjugation)  
• Preoccupied with fantasies of unlimited wealth, power, success  
• Envious of others. Believes others are envious of them.  
• Believes they are special and can only associate with high-status ppl | 1. Psychotherapy  
2. Pharmacotherapy PRN  
- Don’t “prick the bubble” |
| Antisocial PD       | 3% men, 1% women  
50-75% prisoners  
Childhood conduct disorder. Hx of abuse, harming animals, fires | MUST begin in adolescence (15) and must be 18 at dx May ↑or ↓ with age | • NO REMORSE for harmful actions.  
• Won’t conform to society: violates laws  
• Impulsivity, recklessness, irresponsibility  
• Irritability, aggression  
• Manipulative – con men. Intelligent. Charming when first encountered  
• High risk for suicide, depression | 1. Psychotherapy  
2. Pharmacotherapy PRN  
- Treat anxiety and depression but caution due to addictive personality. |
| Borderline PD       | 2-3%  
2:1 Female  
Women: 3-10x likely to be victim of incest  
10% suicide. | Get worse with age – burnout. If they can survive 20s, prognosis is decent | • Unstable interpersonal relationships, self image, mood  
• Desperately avoid real or perceived abandonment  
• Impulsive: sex, substance, spending  
• Recurrent suicidal thoughts and self-mutilation  
• Problems controlling anger  
• Feel alone in the world  
• Splitting – defense mechanism, see as all good or all bad | 1. Psychotherapy  
2. Pharmacotherapy PRN  
- Antidepressants (SSRI)  
- Antipsychotics |
| Dependent           | 2.5%  
Women>men  
80% comorbid PD |                           | • Want others to make decisions, feel helpless when alone, “I’m weak”  
• Difficulty initiating projects on their own  
• Urgently seek new partner if one is lost | 1. Psychotherapy: independence  
2. Pharmacotherapy  
- Antidepressant |
| Avoidant            | 1%  
Common in timid infants  
Genetic predisposition | Can function well | • WANT FRIENDSHIPS, just hard to form (vs. schizotypal/ schizoid)  
• Fear of rejection (vs. fear of embarrassment in agoraphobia)  
• Unable to interact unless assured that person will like them  
• Prone to depression | 1. Psychotherapy  
- Encourage interaction  
2. Pharmacotherapy |
| Obsessive-Compulsive Personality Disorder | 2x men  
EGO-SYNTONIC (vs. OCD) | Course not predictable | • Preoccupation with details such that main point of activity is lost  
• Perfectionism detrimental to completing task  
• Will not delegate tasks. Miserly. Rigid, serious, formal  
• Workaholic: motivated by activity itself (vs. narcissitic by success)  
• Hoard meaningless objects. | 1. Psychotherapy: Group  
2. Pharmacotherapy  
- Antidepressants  
- Anxiolytics |
## Delirium and Dementia (Axis I)

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Epidemiology</th>
<th>Timeline</th>
<th>Symptoms</th>
<th>Treatment</th>
</tr>
</thead>
</table>
| **Delirium** secondary to______ | 2x Males 10-25% medical 30% ICU 40% hip fract. 40% ventilators Risk: age (65+), alcohol, hiv, cancer, heart surg, malnutr. | Less than 1 month Develops in short period – hours to days | • Impaired consciousness  
  o Confusion, disorientation, distractibility, decreased attention, short term memory deficits  
• Change in cognition or perception  
• Acute onset (vs. schizophrenia), fluctuates (vs. dementia)  
• Evidence of underlying cause is available | 1. Quetiapine (Seroquel™) or haloperidol  
2. Avoid benzodiazepines, especially in elderly since they can have a paradoxical worsening effect |
| **Onset** Delirium | Acute  
**Duration** Delirium | Transient  
**Alertness** Delirium | Impaired  
**Attention** Delirium | Impaired  
**Sleep** Delirium | Awake @ night  
**Alertness** Dementia | Insidious  
**Duration** Dementia | Months-years  
**Alertness** Dementia | Normal  
**Attention** Dementia | Normal  
**Sleep** Dementia | Awake @ night (“sundowning”) | • Multiple cognitive deficits and personality changes  
• Impair social/occupational functioning.  
• Short and long term memory problems | |
| **Dementia** | 15% of 65+  
5% severe  
20% over 80  
$148B | Slow onset  
**Onset** Dementia | Presenile <65  
**Duration** Dementia | Senile >65  
**Alertness** Dementia | Normal  
**Attention** Dementia | Normal  
**Sleep** Dementia | Awake @ night (“sundowning”) | • Memory impairment and 1+ of  
  o Aphasia: impairment of language  
  o Apraxia: inability to perform learned movements  
  o Agnosia: inability to correctly interpret sensory info  
  o ↓ executive function: ex. Managing finances  
  • Causes social or occupational impairment (vs. MCI)  
  • Not exclusively during delirium | 1. AChE inhibitors (rivastigmine)  
2. NMDA antagonist (memantine)  
3. PRN benzodiazepines, quetiapine(Seroquel™) |
| **Dementia – Alzheimer’s type** | 60-70% of dementia  
2-4% 65+  
50% nursing home patients Genetics – ApoE4/E2 Age is biggest risk factor | Early: <65  
Late: >65  
Usually 8 years until death | • Same symptoms as Alzheimer’s plus focal neurologic findings  
  • CT/MRI – multiple lesions of cortex/subcortical structures | Same as AD (AChE inhibit etc), treat CVD, control BP  
DDx: Alzheimer’s, TIAs – if brief symptoms and RECOVER |
| **Dementia – Vascular type** | More Males  
15-30% of all dementias  
• Risk factors: hypertension, atrial fibrillation, CHD | Variable  
**Onset** Dementia | More abrupt, earlier than Alzheimers, more stepwise | • Same symptoms as Alzheimer’s plus focal neurologic findings  
  • CT/MRI – multiple lesions of cortex/subcortical structures | Same as AD (AChE inhibit etc), treat CVD, control BP  
DDx: Alzheimer’s, TIAs – if brief symptoms and RECOVER |
<table>
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<th>Timeline</th>
<th>Symptoms</th>
<th>Treatment</th>
</tr>
</thead>
</table>
| Dementia – Frontotemporal type (Pick’s Disease) | More Males 5% of all irreversible dementia | 50-60 years old | • Primary cortical dementia  
• Atrophy of frontotemporal regions, neuronal loss  
• Impulsivity, irritability  
• Hard to distinguish from Alzheimer’s | |
| Dementia – CJ mad cow disease | 1/1million | 40s-60s Death within 6 months- 2 years | • Definite: biopsy showing spongiform change  
• Probable: Rapid onset of dementia, “burst” EEG, and 2+:  
  o Myoclonus  
  o Cortical blindness  
  o Ataxia, extrapyramidal symptoms  
  o Muscle atrophy  
  o Mutism  
• Prodrome: lethargy, fatigue, depression | NO TREATMENT |
| Dementia – Parkinson’s type | 20-30% have dementia 30-40% have cog impair | | • Slow movements, slow thinking  
• Cardinal signs: bradykinesia, tremor, rigid, posture  
• Secondary subcortical dementia  
• Degeneration of dopamine-releasing neurons in basal ganglia substantia nigra pars compacta | L-Dopa, deep brain stimulation |
| Normal Pressure hydrocephalus | | | • Wet, Wacky, Wobbly - Urinary incontinence, Dimentia, Ataxia  
• Defective CSF drainage/reabsorption | Shunting of cereb. Aqueduct |
| Amnestic Disorder | Causes: seizure, head trauma, tumor, CV disease, MS | Transient: <1month Persistent: 1+ Can be gradual/ sudden | • Inability to learn new information OR inability to recall old information  
• Due to medical condition (Axis III)  
• Immediate memory is INTACT  
• Poor insight: confabulation – make up answers  
• Lack of initiative, blunted affect  
• Causes: trauma, tumor, cv disease, alcohol use, Benzodiapines (during surg), OTC drugs | |
| Amnesia – Transient Global Amnesia | | Minutes to hours | • Inability to learn new information AND inability to recall recent information  
• Causes: transient vascular insufficiency, tumors, benzodiapines, migraines, embolism, arrhythmias  
• Personal ID not lost | Prognosis: Almost always recover |
| Amnesia - Korsakoff’s Syndrome | Alcohol induced | Can last 3 months after treatment | • Comorbid Wernicke’s Encephalopathy – confusion, ataxia, ophthalmoplegia  
• Confabulation, apathy, passivity | Thiamine helps: 25% recover totally, 25% never recover |
## SEXUAL DISORDERS (AXIS I)

<table>
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<tr>
<th>Disorder</th>
<th>Epidemiology</th>
<th>Symptoms</th>
<th>Treatment</th>
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</thead>
<tbody>
<tr>
<td><strong>Sexual Dysfunction</strong></td>
<td></td>
<td>• A disturbance in sexual response cycle or pain with intercourse</td>
<td>• The marital unit is “the patient”</td>
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<td>• <strong>Causes marked distress or interpersonal difficulty</strong></td>
<td>• Dual sex therapy: meet with male and female counselors</td>
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<td>• Not caused by substance abuse or medical condition</td>
<td>• Behavior therapy</td>
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<td>• Examples of problems: performance anxiety, spectatoring,</td>
<td>• Hypnosis, psychotherapy</td>
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<td>inadequate communication, distraction</td>
<td>• P-LI-SS-IT Model</td>
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<td>• Physiological stages of sex</td>
<td>• Permission: empathy</td>
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<td></td>
<td>o Desire</td>
<td>• Limited Information: educate</td>
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<td></td>
<td>o Excitement</td>
<td>• Specific Suggestions</td>
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<td></td>
<td></td>
<td>o Plateau</td>
<td>▪ Improve communication</td>
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<td>o Orgasm</td>
<td>▪ Intensive Therapy (specialist)</td>
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<td>o Resolution</td>
<td>▪ Trauma, serious issues</td>
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<tr>
<td><strong>Desire Phase Disorders</strong></td>
<td></td>
<td>• Persistent or recurrent deficiencies in or absence of sexual fantasies and desire for sexual activity</td>
<td>• Testosterone (if low levels)</td>
</tr>
<tr>
<td>Hypoactive sexual desire disorder</td>
<td>Mostly in women as a result of past sexual trauma</td>
<td>• Persistent or recurrent extreme aversion to, and avoidance of all genital sexual contact</td>
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<tr>
<td><strong>Excitement Phase Disorders</strong></td>
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<tr>
<td>Dyspareunia</td>
<td>11% Male or Female</td>
<td>• Pain with before/during/after sexual intercourse without findings</td>
<td>Gradual desensitization</td>
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<td>1. Muscle relaxation</td>
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<td>2. Erotic massage</td>
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<td>Vaginismus</td>
<td>5% Female only</td>
<td>• Involuntary spasm of outer 1/3 of vagina that interferes with sex</td>
<td>• Vaginal dilation with fingers or device. Kegal exercises</td>
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<td></td>
<td>Higher SES</td>
<td>o Also occurs with tampon insertion</td>
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<td>Strict religious upbringing</td>
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<tr>
<td>Female Sexual Arousal Disorder</td>
<td></td>
<td>• Inability to attain/maintain until completion of sexual activity</td>
<td>• Masturbation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Swelling response of female (60%)</td>
<td>• SS: lubricant, vaginal dilator</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Lysis of clitoral adhesions</td>
</tr>
<tr>
<td>Male Erectile Disorder</td>
<td></td>
<td>• Primary: never had an erection</td>
<td>• Yohimbine</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Secondary: have had erections in past</td>
<td>• Sildenafil (Viagra)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Most commonly psychological not biological cause.</td>
<td>• IV alprostadil</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Vacuum pump, ring, surgery</td>
</tr>
<tr>
<td><strong>Orgasm Phase Disorders</strong></td>
<td></td>
<td>• Ejaculation with minimal stimulation</td>
<td>• Gradual progression to vaginal</td>
</tr>
<tr>
<td>Premature ejaculation</td>
<td>35% of male sex disorders</td>
<td>• Ejaculation with minimal stimulation</td>
<td>• “squeeze” technique</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• SSRI side effect helps</td>
</tr>
<tr>
<td>Female/Male Orgasmic Disorder</td>
<td>30% of women</td>
<td>• Delay or absence of orgasm</td>
<td>• LI: explain conditioned response</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• SS: SSRIs, stop-start exercise</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• IT: learn to self-stimulate</td>
</tr>
<tr>
<td>Disorder</td>
<td>Epidemiology</td>
<td>Timeline</td>
<td>Symptoms</td>
</tr>
<tr>
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<td>--------------------------------------------------------------------------</td>
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<tr>
<td><strong>Gender Identity Disorders</strong></td>
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</tbody>
</table>
| Gender Identity Disorder       | Increased incidence of comorbid depression, anxiety disorder, suicide       | Gender identity is usually developed by age 3 | • Strong, persistent cross gender identification  
• Discomfort with one’s own sex which causes distress or impairment  
• Children: cross dressing, strong preference of other sex playmates  
• Adults: stated desires, passing as other sex, conviction of being other sex, request for surgery/hormones | Treatment is a long process  
• Psychosocial therapy: sex reassignment therapy, behavioral therapy, hormones  
• **Live as other sex for 12 months**  
• Sex reassignment surgery with long term psychotherapy  
• Rarely become comfortable with own biology |

| **Compulsive Sexual Behaviors** |                                                                              |                   |                                                                          |                                                                           |
|--------------------------------|                                                                              |                   |                                                                          |                                                                           |
| Nonparaphilic compulsive       |                                                                              |                   | **Normal activities taken to extremes** |                                                                           |
| Paraphilic disorder            | 6+ months  
Poor prognosis:  
• Early age of onset  
• Comorbid substance abuse  
• High frequency  
• Law enforcement  
Good prognosis  
• Self-referral  
• Sense of guilt  
• History of normal activity | | • **Unusual sexual activities or fantasies**  
• Impairs functioning in 1+ areas  
• **Causes impairment in daily functioning**  
• Types:  
  o Exhibitionism: exposure to strangers  
  o Fetishism: inanimate objects  
  o Necrophilia: dead people  
  o Telephone scatology: calling strangers  
  o Frotterism (non-consenting)  
  o Masochism (own suffering)  
  o Sadism (other suffering)  
  o Transvestic  
  o Voyeurism | | **Least restrictive therapy first**  
• Psychotherapy (insight oriented)  
• Cognitive behavioral therapy  
  o Aversive conditioning to disrupt the learned abnormal behavior  
  o Covert sensitization: pair images of negative consequences with sexually arousing fantasies  
  o Victim empathy  
  o 12-step programs  
• Pharmacological therapy  
  o Antiandrogens in hypersexual paraphilia in men |

| Paraphilic Disorder: Pedophilia | Often sexually abused                                                        | 6+ months         | • Fantasies of prepubescent under 13 years  
• For diagnosis: act on impulses and/or are distressed by fantasies  
  o **Distress not necessary** |                                                                           |

| **Hypersexual disorders**      |                                                                              |                   |                                                                          |                                                                           |
|--------------------------------|                                                                              |                   |                                                                          |                                                                           |
| Hypersexual Disorder           |                                                                              | 6+ months         | • Recurrent, intense, fantasies/urges  
• Not paraphilia  
• Compulsive: self-stimulation, multiple partners, telephone/internet  
• Comorbidites: substance abuse, mood disorders, anxiety disorders, impulse control  
• Contrast with OCD: OCD compulsion is unwanted, but hypersexual are wanted | | **Least restrictive therapy first**  
• Psychotherapy (insight oriented)  
• Cognitive behavioral therapy  
  o Aversive conditioning to disrupt the learned abnormal behavior  
  o Covert sensitization: pair images of negative consequences with sexually arousing fantasies  
  o Victim empathy  
  o 12-step programs  
• Pharmacological therapy  
  o Antiandrogens in hypersexual paraphilia in men |
## Dissociative Disorders (Axis I): Loss of memory, identity, or sense of self. NOT due to medical or substance (this would be amnestic disorder)

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Epidemiology</th>
<th>Timeline</th>
<th>Symptoms</th>
<th>Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dissociative Amnesia</td>
<td>♀ &gt; ♂</td>
<td></td>
<td>• Amnesia is the only dissociative symptom present</td>
<td>1. Retrieve memory to prevent recurrence</td>
</tr>
<tr>
<td></td>
<td>Young &gt; old Common in child abuse</td>
<td></td>
<td>• Not troubled by memory loss</td>
<td>a. Hypnosis</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Causes marked impairment or distress</td>
<td>b. Amobarbital</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Usually triggered by a traumatic/stressful event</td>
<td>c. Ativan</td>
</tr>
<tr>
<td>Dissociative Fugue</td>
<td>Alcohol/depression</td>
<td>Hours-years</td>
<td>• Sudden travel from home with inability to remember parts of past or identity</td>
<td>2. Psychotherapy</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Often assume new identity</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>• Unaware of amnesia</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>• Causes marked impairment or distress</td>
<td></td>
</tr>
<tr>
<td>Dissociative Identity Disorder</td>
<td>Rare. 90% ♀ 1/3 attempt suicide</td>
<td></td>
<td>• 2+ distinct personalities which alternate control of person</td>
<td>1. Antianxiety PRN</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Each are mostly unaware of each other</td>
<td>2. Antidepressant PRN</td>
</tr>
<tr>
<td>Depersonalization Disorder</td>
<td>♀ 2: 1 ♂ Age 15-30</td>
<td>Must be recurrent. Single episode is normal stress reaction</td>
<td>• Recurrent feelings of detachment from self, environment, social status</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>o Reality testing intact during episode</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>o Feel like an outside observer</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>• Aware of symptoms, feel like they are going crazy</td>
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</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Causes marked impairment or distress</td>
<td></td>
</tr>
<tr>
<td>Ganser Syndrome “prison psychosis”</td>
<td></td>
<td></td>
<td>• “Vorbeireden”: approximate answers to questions (ex. “2+2=5”)</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>• Somatic symptoms</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>• Reaction to extreme stress</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>• Mimic behavior of mental illness: echolalia, echopraxia</td>
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</tr>
</tbody>
</table>
### Impulse Control (Axis I): Inability to resist behavior that may be harmful to self/others. Anxiety relieved by impulse. May be remorseful or not.

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Epidemiology</th>
<th>Timeline</th>
<th>Symptoms</th>
<th>Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intermittent Explosive Disorder</td>
<td>♂&lt;&lt;♀ ↓ 5-HT</td>
<td>Episodes remit quickly</td>
<td>• Impulses of assault or property destruction</td>
<td>1. SSRI, anticonvulsant, lithium, propanolol</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Out of proportion to trigger</td>
<td>2. Group Therapy</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Usually feel remorseful afterward</td>
<td>Psychotherapy not helpful</td>
</tr>
<tr>
<td>Kleptomania</td>
<td>♂&gt;♀ ¼ of bulimics</td>
<td>May occur during stress</td>
<td>• Stealing not for personal or monetary gain</td>
<td>1. Insight-oriented psychotherapy</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Chronic course</td>
<td>• Pleasure derived from act of stealing</td>
<td>2. Behavior therapy</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>a. Systematic desensitization</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>b. Aversive therapy</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3. SSRI’s</td>
</tr>
<tr>
<td>Pyromania</td>
<td>♂&lt;&lt;♂ Common in MR</td>
<td>Prognosis better in children</td>
<td>• &gt;1 intentional fire setting</td>
<td>1. Behavioral therapy</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Tension before fire, relieved afterward</td>
<td>2. SSRI</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Fascination with fire</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Not for monetary gain or expression of anger</td>
<td></td>
</tr>
<tr>
<td>Pathological gambling</td>
<td></td>
<td></td>
<td>• 5+ symptoms of gambling addiction (do later™)</td>
<td>1. Gamblers anonymous</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2. Insight-oriented psychotherapy</td>
</tr>
<tr>
<td>Trichotillomania</td>
<td>♂&gt;♀ 1-3% Comorbid with OCD/OCPD</td>
<td>Often after stressful event (25%)</td>
<td>• Recurrent pulling out of hair resulting in visible hair loss</td>
<td>1. SSRI, antipsychotic</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>o Can be eyebrows, pubic hair</td>
<td>2. Hypnosis</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Tension before, relieved by action</td>
<td>3. Behavioral therapy</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Causes marked distress or impairment</td>
<td></td>
</tr>
<tr>
<td>Disorder</td>
<td>Epidemiology</td>
<td>Timeline</td>
<td>Symptoms</td>
<td>Treatment</td>
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<td>--------------------------</td>
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<td>--------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Chronic Pain</td>
<td>Unrelated to intensity or physical severity of original injury</td>
<td>3+ months</td>
<td>• Pain without apparent biological cause</td>
<td>Prevention</td>
</tr>
<tr>
<td></td>
<td>Psych variables (depression, anxiety) most accurate predictors, not severity of injury etc.</td>
<td></td>
<td></td>
<td>• Return to active ASAP</td>
</tr>
<tr>
<td>Chronic Pain Syndrome</td>
<td></td>
<td>6+ months</td>
<td>• Pain without apparent biological cause, which is MALADAPTIVE</td>
<td>• Take active role in own pain management</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>(distinguish from chronic pain)</td>
<td>Psychological testing</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Excessive use of medications, restriction of daily activities</td>
<td>• Beck depression inventory</td>
</tr>
<tr>
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<td></td>
<td>• Might be pain doesn’t worsen, but individual fails to adapt/cope</td>
<td>• MMPI</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Factors: depression, kinesiophobia, inactivity</td>
<td>o 1: Most pathological (CPS)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Biological factors</td>
<td>o 2: V profile (CP but not mal)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>o Physiologic dysfunction – tissue dmg</td>
<td>o 3: Chronic medical (not psyc)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>o Genetics – may be neurotransmitter</td>
<td>o 4: Normal</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>o Gender</td>
<td>Behavior- CBT</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>o Pain experience – based on prior pain</td>
<td>• Transition out of sick role</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Psychological factors – most predictive</td>
<td>• Reduce maladaptive behavior</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>o Meaning of pain</td>
<td>• Modify beliefs, attitudes</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>o Perception of control</td>
<td>Non-drug strategies</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>o Coping style</td>
<td>• Exercise, physical methods</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>o Secondary gains</td>
<td>• CBT</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>o Pain-inactivity, pain-depression cycles</td>
<td>• Chiropractic, acupuncture</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Risk factors</td>
<td>• Homeopathic, relaxation, hypnosis</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>o Depression, low activity, excessive pain behavior, maladaptive</td>
<td>• Ex. Thermal biofeedback for migraine</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>cognitions, fear/avoidance</td>
<td>o Resulted in greater reduction in headache than progressive</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>o Somatization, PTSD, Age, job dissatisfaction, substance</td>
<td>muscle relaxation or EMG biofeedback</td>
</tr>
</tbody>
</table>
Major depressive disorder
  o Initial insomnia
  o Reduced slow-wave sleep
  o Increased REM length
  o Vs. primary insomnia
    ▪ Early-morning awakenings: depression
    ▪ Rapid onset of REM – depression
    ▪ Symptoms: 1+ month insomnia, 2 weeks for depression
    ▪ Other criteria for MDD
Bipolar disorder manic phase
  o Decreased need for sleep
Seasonal affective disorder
  o Decreased slow wave sleep
  o Directly related to amount of sunlight
  o Treat with light therapy
PTSD
  o Difficulty remaining asleep
  o Fragmented sleep
  o Frightening dreams, + sleep latency
Psychotic disorders
  o Sleep deprivation increases positive symptoms of psychosis
  o Dream content less bizarre in psychotics
  o Decreased sleep efficiency
Panic disorder
  o Sleep panic attacks, difficulty falling asleep, + body mvmt
Generalized Anxiety Disorder
  o Decreased sleep efficiency, total sleep time
  o Increased sleep latency
  o Sleep problems may predate GA
Chronic Pain
  o Less restorative, less deep sleep, more fragmented
  o Increased pain sensitivity, increased spontaneous pain