HIGH-YIELD MEDICAL REVIEW

Comprehensive Psychiatry Summary Notebook

An Exhaustive Chapter-by-Chapter Guide Integrated with Past Papers & High-Yield Exam Concepts V.2.0 (Special thanks to 018 Team and Malek Abu-Rahma for P.P)

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Chapter 1: Introduction to the Psychiatry Clerkship

1. General Principles & Patient Rights

- **Confidentiality:** Never discuss patient information in public areas.
- **Right to Refuse:** All patients have the right to refuse treatment (even lifesaving) **UNLESS** they lack capacity, or are actively suicidal/homicidal.
- **Advance Directives:** Must be addressed, especially in chronically or terminally ill patients.

> 💡 **Clinical Pearl:** When taking a substance history, always include caffeine and nicotine. Nicotine withdrawal in hospitalized heavy smokers can cause severe anxiety and agitation that mimics primary psychiatric conditions.

2. The Mental Status Exam (MSE) & MMSE

- **Appearance/Behavior:** Note hygiene, pupil size (intoxication/withdrawal), needle tracks, and signs of self-harm.
- **Speech:** 🚨 *Pressured speech* is rapid, uninterrupted, and compelled.
- **Mood/Affect:** Mood is subjective (what the patient says, scale 1-10); Affect is objective (what you observe, e.g., *flat affect*).
- **Automatisms:** Spontaneous, involuntary movements during an altered state of consciousness.
- **Psychomotor Retardation:** Slowness of voluntary/involuntary movements (hypokinesia/bradykinesia).

3. Essential High-Yield Mnemonics

> 🧠 **Mania ("DIG FAST")**
> **D**istractibility
> **I**rritable mood/Insomnia

Grandiosity
Flight of ideas
Agitation / Increase in goal-directed activity
Speedy thoughts / Speech
Thoughtlessness (seeking pleasure without regard for consequences)

🧠 **Major Depression ("SIG E. CAPS")**
Sleep changes
Interest (loss of)
Guilt (worthlessness)
Energy (lack of)
Concentration (poor)
Appetite changes
Psychomotor changes (agitation/retardation)
Suicidal ideation

🧠 **Suicide Risk ("SAD PERSONS")**
Sex (Male)
Age (>60 years)
Depression
Previous attempt
Ethanol/drug abuse
Rational thinking loss
Suicide in family
Organized plan/access
No support
Sickness

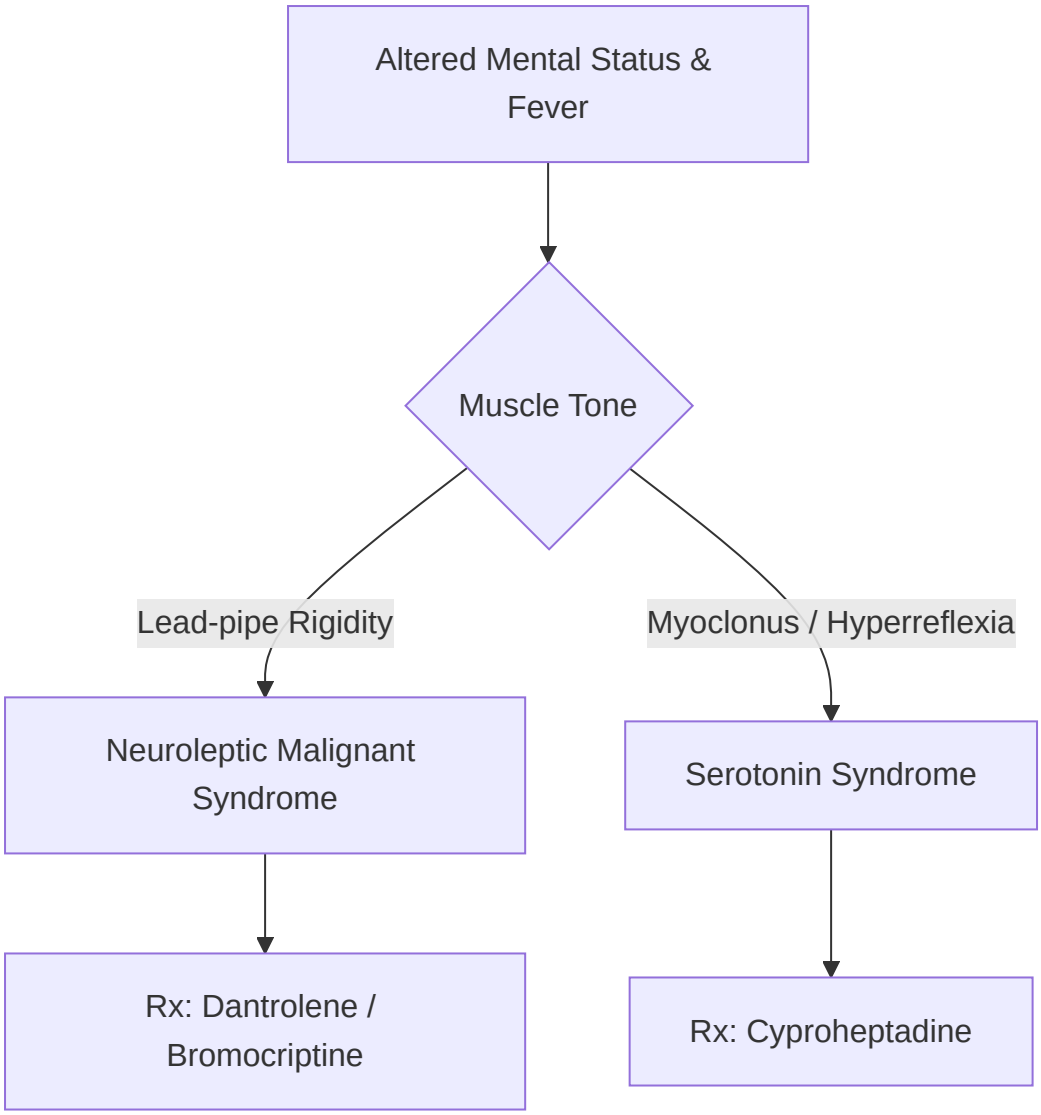
4. Drugs of Abuse: Intoxication & Withdrawal

Drug Class	Intoxication Features	Withdrawal Features
Alcohol / Benzodiazepines	Disinhibition, ataxia, slurred speech, respiratory depression.	Tremor, tachycardia, hypertension, seizures, hallucinations, DTs.
Opioids (e.g., Heroin)	CNS & respiratory depression, miosis (pupil constriction),	Increased sympathetic activity, N/V, diarrhea,

	sedation. 🚨 *Highest mortality.*	yawning, piloerection.
Amphetamines / Cocaine	Euphoria, aggression, pupillary dilation, tachycardia, psychosis. 🚨 *Formication (cocaine).*	"Crash": severe depression, hunger, hypersomnia, strong craving.
PCP	Belligerence, vertical/horizontal nystagmus, hyperthermia, ataxia.	Recurrence of symptoms due to GI reabsorption.
Cannabis	Euphoria, delayed time perception, increased appetite, amotivational syndrome.	Irritability, anxiety, sleep disturbances (generally mild).

🚨 **High-Yield Alert: Psychiatric Emergencies**

- **Delirium Tremens (DTs):** 2-4 days post-EtOH cessation. Agitation, hallucinations, autonomic hyperactivity. Treat aggressively with benzodiazepines.
- **Neuroleptic Malignant Syndrome (NMS):** Fever, rigidity, elevated CPK/WBC. Stop offending antipsychotic, give dantrolene/bromocriptine.
- **Serotonin Syndrome:** Altered mental status, fever, tremor, myoclonus, hyperreflexia. Often MAOI + SSRI. Treat with cyproheptadine.
- **Acute Dystonia:** Sudden muscle spasm (eyes, tongue, neck). Treat with IV benztropine or diphenhydramine (procyclidine).
- **Lithium Toxicity:** N/V, slurred speech, ataxia, seizures, diabetes insipidus. Hydrate; hemodialysis if severe.
- **TCA Toxicity:** Anticholinergic effects, cardiac arrhythmias (widened QRS >100ms). Treat with Sodium Bicarbonate.


Altered Mental Status & Fever
Muscle Tone
Lead-pipe Rigidity
Myoclonus / Hyperreflexia
Neuroleptic Malignant Syndrome
Serotonin Syndrome
Rx: Dantrolene / Bromocriptine
Rx: Cyproheptadine

Chapter 2: Examination and Diagnosis

1. The Psychiatric History & Doctor-Patient Relationship

- **Doctor-Patient Relationship:** The patient must play an **active role**, and the doctor should nourish a *patient-centered* relationship. Do not be strictly paternalistic.
- **History Taking:** Focus on the **4 Ps** (Predisposing, Precipitating, Perpetuating, and Protecting factors).
- 🚨 *Note:* The **Developmental History** is a crucial unique part of the psychiatric history. **Physical exam** is NOT part of the Mental Status Exam!

2. The Mental Status Exam (MSE)

The MSE evaluates a patient's current state (it can change daily). It does not include a physical exam.

Mood vs. Affect

- **Mood:** Subjective. What the patient *says* they feel (e.g., "I feel sad").
- **Affect:** Objective. What the examiner *observes*.
  - *Flat:* Expressionless/monotone.
  - *Labile:* Rapidly shifting emotions (laughing one second, crying the next).

> 🚨 **High-Yield Alert: Thought Process (HOW they think)**
>
> - **Circumstantiality:** Overinclusion of trivial details, but *eventually reaches the point*.
> - **Tangentiality:** Wanders off topic and *never reaches the point/answers the question*.
> - **Flight of Ideas:** Abruptly changing from one idea to another (often rapid/pressured speech, typical of Mania).
> - **Loose Associations:** No logical connection between thoughts.
> - **Thought Blocking:** Abrupt cessation of speech mid-sentence.
> - **Clang Associations:** Word connections based on rhyming/phonetics ("My car is red, I've been in bed").

🚨 **High-Yield Alert: Thought Content (WHAT they think)**

- **Delusions:** Fixed, false beliefs not shared by the patient's culture. They are *always pathological*. (e.g., Grandeur, Paranoid, Reference, Thought Broadcasting).
- **Suicidality:** Always ask **directly** about suicide, intent, and plan. Do not just ask if they want to "hurt" themselves.

Perceptual Disturbances

Disturbance	Definition	Tested Pearl
Hallucination	Perception without any external stimulus.	*Command hallucinations* (voices instructing harm) are major risk factors for suicide/homicide. Visual hallucinations often indicate *organic* brain disease.
Illusion	Misinterpretation of an *existing* external stimulus.	Always pathological misinterpretation (e.g., mistaking a coat rack for a person in the dark).
Depersonalization	Feeling that one's self is unreal or detached.	"I feel like I am not real / out of my body."
Derealization	Feeling that the world/surroundings are unreal.	"I feel like the world is a dream."

💡 **Clinical Pearl: Approaching the Delusional Patient**
Do NOT directly challenge the delusion or argue that it is untrue, but also do NOT imply that you believe it. Simply acknowledge that you understand the *patient* believes it to be true.

3. Diagnostic & Psychological Testing

- **Intelligence Tests:** WAIS (Wechsler Adult, 16-90 years), WISC (Children, 6-16 years).
- **Objective Personality Tests:**

    - **MMPI-2 (Minnesota Multiphasic Personality Inventory):** Standardized questionnaire testing personality traits and psychopathologies.
- **Projective Personality Tests:** No structured response format; subjective interpretation.
    - **TAT (Thematic Apperception Test):** Creating stories based on ambiguous pictures.
    - **Rorschach Test:** Interpretation of inkblots to identify thought disorders/defenses.

Chapter 3: Psychotic Disorders

1. Schizophrenia

Schizophrenia is characterized by a constellation of abnormalities in thinking, emotion, and behavior. It is equally prevalent in men and women, but men typically present earlier (15-25 years) and have a worse prognosis.

> 💡 **Downward Drift Hypothesis:** Schizophrenia is more common in lower socioeconomic groups because the illness impairs functioning, causing patients to "drift" downward socioeconomically over time.

A. The 3 Phases

1. **Prodromal:** Decline in functioning that precedes the first psychotic episode (e.g., social withdrawal, poor school performance).
2. **Psychotic (Active):** Perceptual disturbances, delusions, disordered thought process (e.g., Neologisms—newly coined words).
3. **Residual:** Post-active psychosis, marked by mild hallucinations, social withdrawal, and negative symptoms.

B. The 3 Symptom Categories

- **Positive Symptoms:** Hallucinations (e.g., voices referring to the patient in the 3rd person), delusions (e.g., paranoia), disorganized speech.
- **Negative Symptoms:** Often treatment-resistant. See mnemonic below.
- **Cognitive Symptoms:** Impaired attention and executive function.

> 🧠 **The 5 A's of Schizophrenia (Negative Symptoms)**
> **A**nhedonia (lack of pleasure)
> **A**ffect (flat)
> **A**logia (poverty of speech)
> **A**volition (apathy/lack of drive)
> **A**ttention (poor)

C. Prognostic Factors

Good Prognosis	Poor Prognosis
Late onset, Acute onset	Early onset, Gradual onset
Female gender	Male gender
Good social support & premorbid functioning	Poor social support & family history of Schizophrenia (12% risk if 1 parent affected)
Positive symptoms, Mood symptoms	Negative symptoms

🚨 **High-Yield Alert: The Dopamine Hypothesis & Pathways**

- **Mesolimbic Pathway:** *Excessive* dopamine → **Positive symptoms**.
- **Prefrontal Cortical Pathway:** *Inadequate* dopamine → **Negative symptoms**.
- **Nigrostriatal Pathway:** Blocked by antipsychotics → **Extrapyramidal symptoms (EPS)** (Parkinsonism, Dystonia, Akathisia).
- **Tuberoinfundibular Pathway:** Blocked by antipsychotics → **Hyperprolactinemia** (gynecomastia, galactorrhea, sexual dysfunction).

2. Psychopharmacology & Side Effects

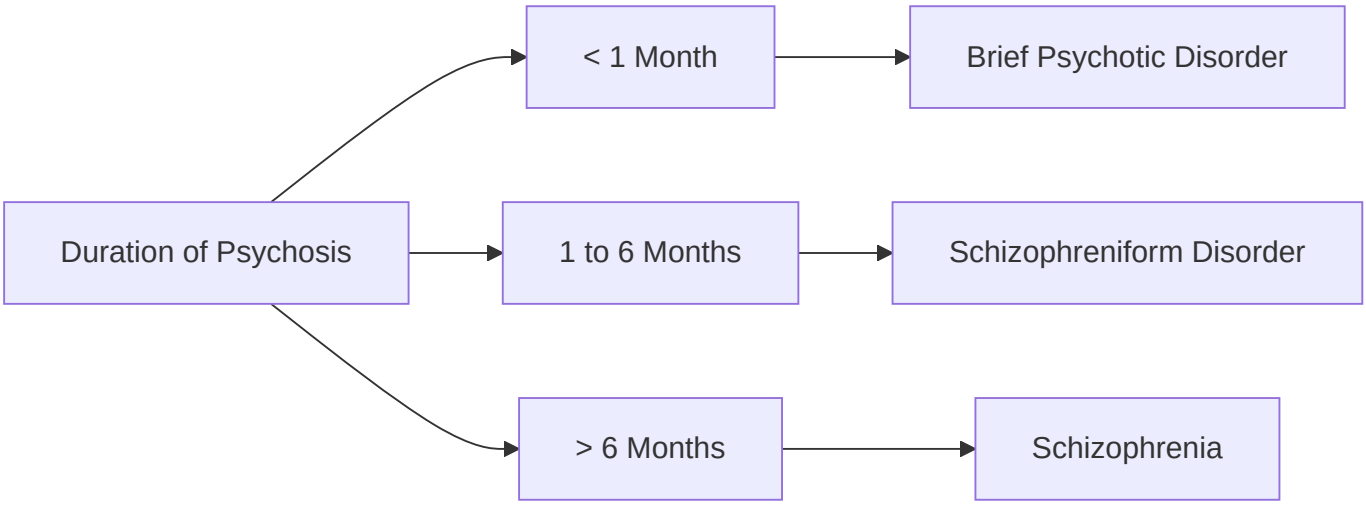
- **First-Generation (Typicals):** e.g., Haloperidol. Higher risk of EPS and Tardive Dyskinesia. *(Haloperidol is the drug of choice for calming an aggressive psychotic patient in the ER).*
- **Second-Generation (Atypicals):** e.g., Olanzapine, Quetiapine. Lower risk of EPS, but **higher risk of Metabolic Syndrome** (weight gain, dyslipidemia, diabetes).
- **Clozapine:** Reserved for refractory schizophrenia. High risk of **agranulocytosis** and metabolic syndrome.

🚨 **High-Yield Alert: Management of EPS**

- **Acute Dystonia:** (e.g., patient walks like a robot or has neck spasms). **Rx:** Anticholinergics (IV Procyclidine, Benztropine, or Diphenhydramine).

- **Akathisia:** (severe restlessness). **Rx:** Beta-blockers (Propranolol) or Benzodiazepines.

3. The Schizophrenia Spectrum (Time-Based Distinctions)



4. Other Psychotic Disorders

- **Schizoaffective Disorder:** Distinct mood episodes (Mania or Depression) with psychosis persisting for **at least 2 weeks in the absence of mood symptoms**.
- **Substance-Induced Psychosis:** Always suspect in young patients with good premorbid functioning presenting acutely with agitation and visual/tactile hallucinations. Culprits: LSD, PCP, Amphetamines, Cocaine, Cannabis, MDMA. **Rx:** Haloperidol.

💡 **Quick Distinguishing Features for "Schizo-" Terms**
Schizotypal (Personality): Magical thinking, odd beliefs, eccentric (Cluster A). No overt psychosis.
Schizoid (Personality): Solitary activities, prefers to be alone (Cluster A). No psychosis.

💡 **Additional Exam Pearls: Schizophrenia**

- **Phases:** Progresses through Prodromal, Active (Psychotic), and Residual phases.
- **Prognosis:** *Good prognosis:* late onset, female, acute onset, precipitating factors, positive symptoms. *Poor prognosis:* early onset, male, gradual onset, negative symptoms.
- **Neologisms:** Invention of new, meaningless words.

- **Organic vs. Psychiatric:** Complex visual hallucinations and high fever strongly point to an organic cause (e.g., delirium) rather than a primary psychosis.
- **Schizophreniform Disorder:** Differentiated from schizophrenia solely by duration (**1 to 6 months**).

Chapter 4: Mood Disorders

1. Major Depressive Disorder (MDD)

Defined by one or more Major Depressive Episodes (MDE) with **no history of a manic or hypomanic episode**.

> 🧠 **Diagnosis of MDE: SIG E. CAPS**
> Must have at least 5 symptoms for at least **2 weeks**. (Must include depressed mood or anhedonia).
> **S**leep (↓ or ↑), **I**nterest (anhedonia), **G**uilt, **E**nergy, **C**oncentration, **A**ppetite/weight changes, **P**sychomotor activity, **S**uicidal ideation.

> 🚨 **High-Yield Alert: Sleep Changes in MDD**
>
> - Initial insomnia (difficulty falling asleep) and terminal insomnia (early morning awakenings).
> - **Polysomnography shows:** Decreased REM latency (enter REM faster), increased total REM sleep, and **decreased Stage 3/4 (deep/slow-wave) sleep.**

A. Important Specifiers & Subtypes

- **Melancholic Features:** Severe anhedonia, early morning awakenings, weight loss, depression worse in the morning.
- **Atypical Features:** Hypersomnia, hyperphagia (increased appetite), **mood reactivity** (brightens to positive events), leaden paralysis. *Treatment: SSRIs are first-line.*
- **With Psychotic Features:** Delusions/hallucinations present *only* during the depressive episode. **Rx: Antidepressant + Antipsychotic OR ECT.**

B. Differential Diagnosis & Medical Causes

Always rule out medical causes before diagnosing primary MDD. Most tested medical causes of depression: **Hypothyroidism, Stroke/Cardiovascular disease, and Pancreatic cancer**. Measure severity using the **HAM-D** (Hamilton Depression Rating Scale).

C. Antidepressants & Treatment Pearls

- **SSRIs:** First-line. Side effects: GI disturbances, sexual dysfunction. *FDA Black Box Warning: Increased suicidality in adolescents/children.*
- **Serotonin Syndrome:** Autonomic instability, hyperthermia, and **hyperreflexia/myoclonus**.
- **Electroconvulsive Therapy (ECT):** Indicated for refractory depression, psychotic depression, or rapid stabilization (e.g., refusing to eat). **Highly safe and the best treatment for manic/depressive episodes in pregnancy.**

2. Bipolar Disorders

A. Bipolar I vs. Bipolar II

Bipolar I	Bipolar II
Requires at least one **Manic Episode**.	Requires at least one **Hypomanic Episode** + one **MDE**.
Mania lasts **≥ 7 days** (or any duration if hospitalized).	Hypomania lasts **≥ 4 days**.
Severe impairment; often has psychotic features.	No severe impairment; **never** has psychotic features.

> 💡 **Mania Mnemonic: DIG FAST**
> **D**istractibility, **I**nsomnia, **G**randiosity, **F**light of ideas, **A**ctivity/Agitation, **S**peech (pressured), **T**houghtlessness (impulsive/risky behavior like shopping sprees).

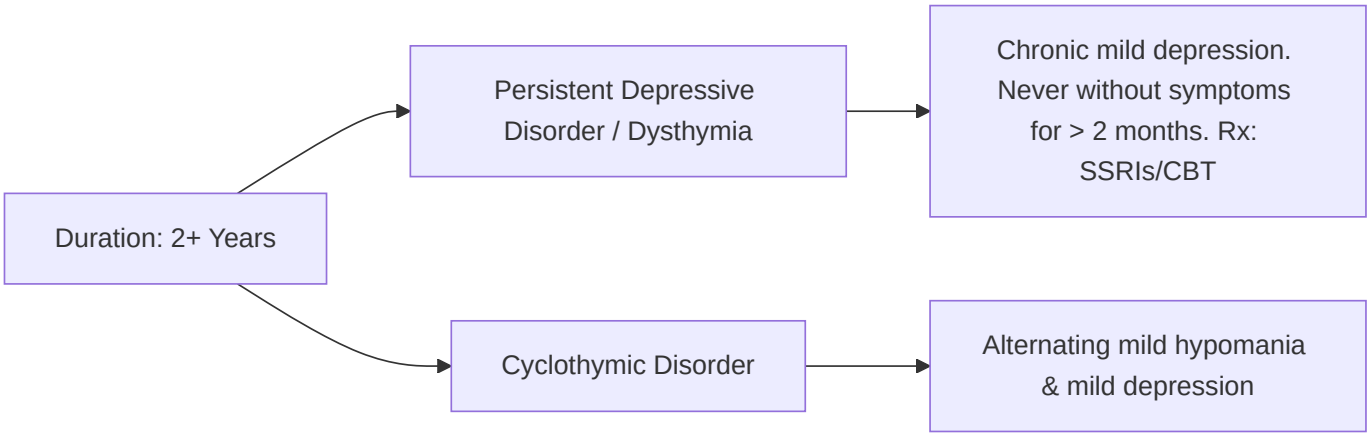
B. Treatment of Bipolar Disorder

First-line: Mood stabilizers (Lithium, Valproic Acid, Carbamazepine) or Atypical Antipsychotics. *Avoid antidepressant monotherapy as it can trigger mania.*

> 🚨 **High-Yield Alert: Lithium**
>
> - **Benefit:** Specifically known to **reduce suicide risk**.

- **Side Effects:** Weight gain, tremor, GI disturbances, **hypothyroidism/goiter**, polyuria (nephrogenic diabetes insipidus).
- **Toxicity:** Very narrow therapeutic index (0.8–1.2 mEq/L).

3. Chronic Mood Disorders



- **Persistent Depressive Disorder (Dysthymia):** Depressed mood for ≥ 2 years. Must have 2 symptoms (CHASES). Worse long-term prognosis than MDD. Usually does not require hospitalization.

🚨 **High-Yield Additions from Past Papers: Mood Disorders**

- **Depression Criteria:** Significant weight loss is defined as losing **5% or more of body weight in the past month**.
- **Etiology:** Linked to Monoamine system abnormalities (decreased serotonin/dopamine).
- **Severity:** The **HAM-D** scale is commonly used to measure depression severity.
- **Postpartum Psychosis:** Rare (1:500 deliveries) and heavily associated with underlying bipolar/affective disorders.
- **Bipolar Pitfall:** Antidepressant monotherapy in undiagnosed bipolar disorder can trigger a manic episode.

Chapter 5: Anxiety, Obsessive-Compulsive, and Trauma-Related Disorders

1. Anxiety Disorders

The most common form of psychopathology. **Always rule out medical causes** (hyperthyroidism, hypoglycemia, arrhythmias) or substance use (caffeine, stimulant withdrawal) before diagnosing a primary anxiety disorder. **Anxiety is a major risk factor for poor physical health and decreased performance.**

A. Panic Attacks vs. Panic Disorder

- **Panic Attacks:** Sudden onset of intense fear peaking in minutes. (Palpitations, abdominal distress, nausea, intense fear of dying, chills, sweating, shortness of breath).
- **Panic Disorder:** Characterized by *spontaneous, unexpected* panic attacks, followed by ≥ 1 month of continuous worry about future attacks ("fear of the fear").
- **Agoraphobia:** Fear of places where escape is difficult or help is unavailable (e.g., bridges, crowds, leaving the house). Highly comorbid with Panic Disorder.

> 🚨 **High-Yield Alert: Treatment of Panic & Anxiety**
>
> - **Long-term control:** SSRIs or SNRIs + CBT.
> - **Short-term bridging:** Benzodiazepines (Avoid long-term use).
> - **Performance Anxiety (e.g., giving a seminar):** Beta-blockers (Propranolol).

B. Phobias

Fear that is **out of proportion** to the actual stimulus. The patient will go to great lengths to avoid the stimulus.

- **Specific Phobia:** e.g., Claustrophobia (closed spaces). *Note: Blood-injection phobias can cause bradycardia and vasovagal syncope.* **Treatment:** CBT with exposure therapy.

- **Social Anxiety Disorder (Social Phobia):** Fear of **negative evaluation or scrutiny by others** (e.g., speaking or eating in public).

C. Generalized Anxiety Disorder (GAD)

Free-floating, excessive worry about multiple daily events lasting **≥ 6 months**. Associated with physical symptoms like muscle tension, fatigue, and sleep disturbances.

> 🧠 **GAD Symptoms: Worry WARTS**
> **W**ound up, **A**bsent-minded, **R**estless, **T**ense (muscle tension), **S**leepless.

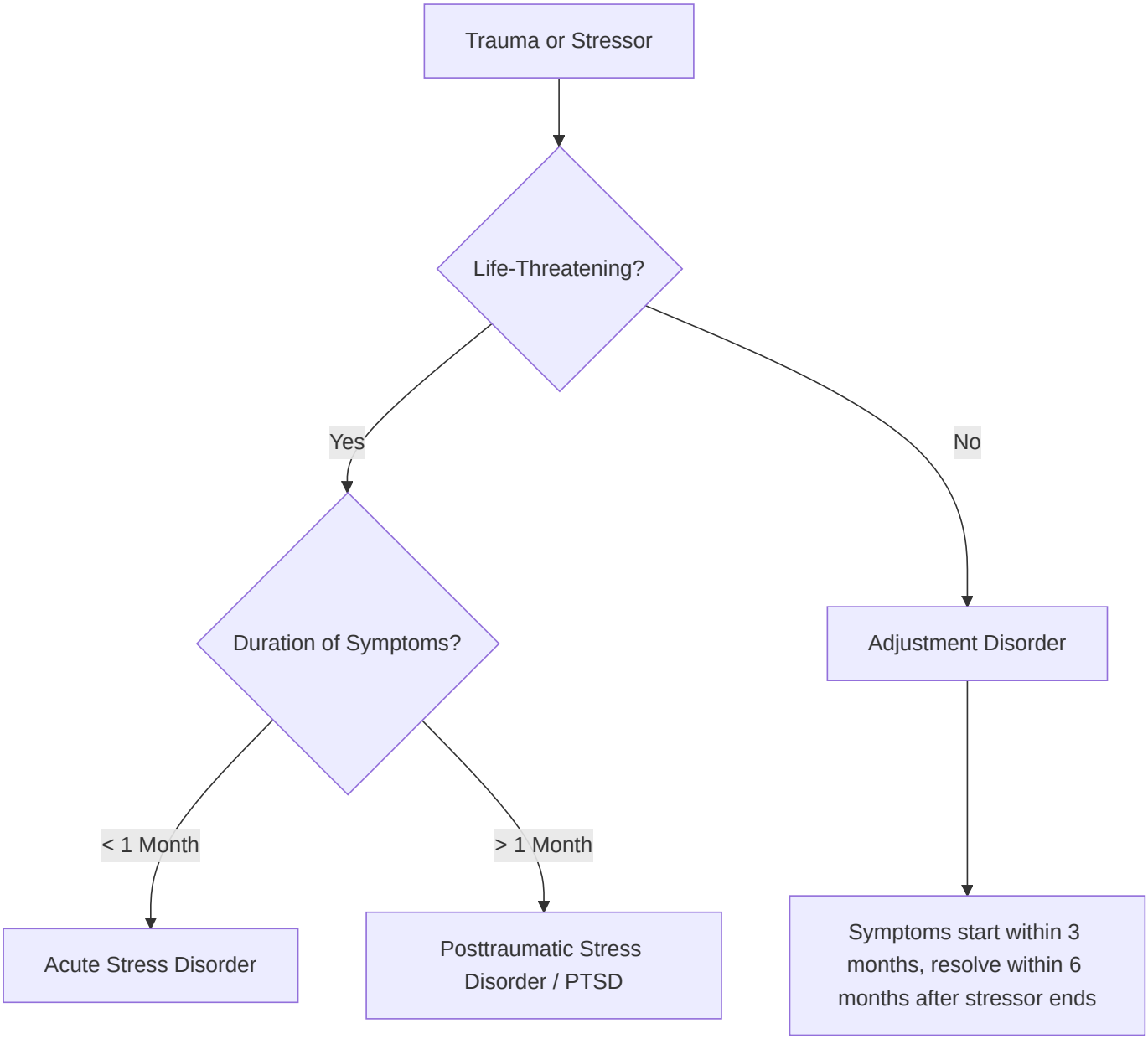
2. Obsessive-Compulsive Disorder (OCD)

- **Obsessions:** Intrusive, recurrent, anxiety-provoking thoughts (e.g., contamination, symmetry).
- **Compulsions:** Repetitive behaviors or mental rituals performed to reduce anxiety (e.g., washing, checking).

> 💡 **Clinical Pearl: OCD Insight**
> OCD is **ego-dystonic**; patients generally *know* their behaviors are irrational but feel compelled to do them anyway to reduce extreme anxiety.

Treatment: High-dose SSRIs, **Clomipramine** (a highly serotonergic TCA), and CBT focusing on **Exposure and Response Prevention (ERP)**.

3. Trauma and Stressor-Related Disorders



A. Posttraumatic Stress Disorder (PTSD)

- Requires exposure to actual or threatened death, serious injury, or sexual violence.
- **Symptoms (TRAUMA):** **T**raumatic event, **R**eexperience (flashbacks/nightmares), **A**voidance, **U**nable to function, **M**onth or more of symptoms, **A**rousal increased (hypervigilance, startle response).
- **Treatment:** Trauma-focused CBT, SSRIs/SNRIs.

> 🚨 **High-Yield Alert: PTSD Pharmacology**
>
> - **Prazosin:** Alpha-1 receptor antagonist specifically used to target and reduce nightmares in PTSD.
> - Avoid Benzodiazepines due to the high rate of comorbid substance use disorders in this population.

💡 **Additional Exam Pearls: Anxiety & OCD**

- **Specific Phobias:** Fear of public speaking is often managed with beta-blockers (Propranolol). Patients often avoid seeking medical care because they simply avoid the stimulus. More common in women.
- **Body Dysmorphic Disorder:** High risk of suicide, more common in females, treated with SSRIs and CBT.
- **Hoarding Disorder:** Persistent difficulty discarding possessions regardless of value.
- **Panic Attacks:** Can occur as a specifier in almost any psychiatric condition (e.g., GAD).

Chapter 6: Personality Disorders

Personality traits become a **disorder** when they are pervasive, inflexible, and cause significant distress or impairment in social/occupational functioning.

> 💡 **Clinical Pearl: Insight**
> Most personality disorders are **ego-syntonic** (patients do not believe they have a problem and their behaviors are acceptable to them).

1. Cluster A ("Weird" - Odd/Eccentric)

Familial association with psychotic disorders.

- **Paranoid:** Distrust and suspiciousness of others. Attributes malevolent motives to others. *No fixed delusions.*
- **Schizoid:** Lifelong social withdrawal. They have **no desire for close relationships** and are content being alone (e.g., night-shift worker who avoids people). Restricted emotional range.
- **Schizotypal:** Odd/eccentric behaviors, **magical thinking**, and peculiar speech. *Note: This is the premorbid personality often seen in schizophrenia.*

> 🚨 **High-Yield Alert: Schizoid vs. Avoidant**
>
> - **Schizoid (Cluster A):** Prefers to be alone; no desire for relationships.
> - **Avoidant (Cluster C):** Desires relationships but is extremely afraid of rejection and criticism.

2. Cluster B ("Wild" - Dramatic/Emotional)

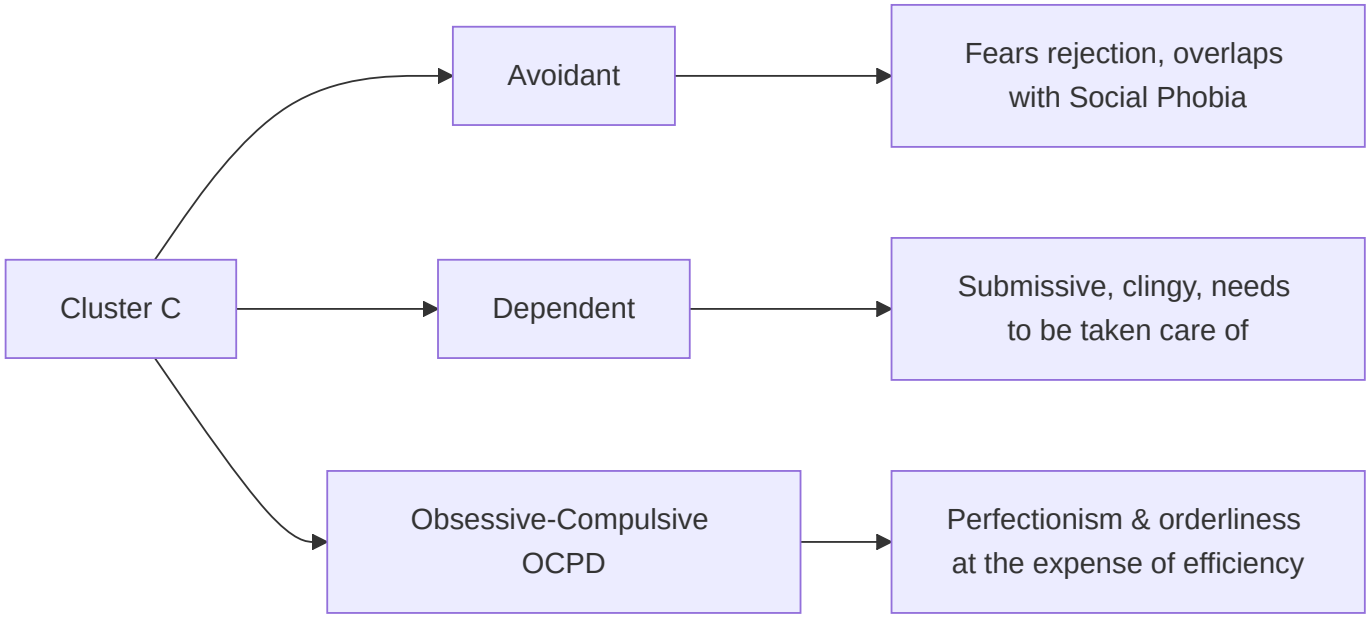
Familial association with mood disorders. Very common in psychiatric settings.

- **Antisocial:** Disregard for and violation of the rights of others. **Must be ≥ 18 years old** and have a history of **Conduct Disorder before age 15**. Lacks remorse.

- **Borderline:** Unstable relationships, self-image, and affects. Extreme fear of abandonment. High rate of suicide attempts/self-mutilation.
    - **Defense Mechanism:** *Splitting* (viewing others as all good or all bad).
    - **Treatment:** Dialectical Behavior Therapy (DBT).
- **Histrionic:** Attention-seeking, provocative/seductive behavior, shallow shifting emotions. Often uses the defense mechanism of *regression* (reverting to childlike behaviors).
- **Narcissistic:** Grandiosity, needs excessive admiration, and **lacks empathy**. Exploits others for status/recognition (whereas antisocial exploits for material gain).

3. Cluster C ("Worried" - Anxious/Fearful)

Familial association with anxiety disorders.



- **Avoidant:** Hypersensitive to rejection. Wants friends but is too shy and inhibited.
- **Dependent:** Poor self-confidence. Let others make decisions. Predisposed by *childhood medical illness* and *separation anxiety*.
- **Obsessive-Compulsive Personality Disorder (OCPD):** Preoccupied with details, rules, and lists to the point where the main task is often not completed.
    - **OCD vs. OCPD:** OCD is ego-dystonic (patient is distressed by their obsessions). OCPD is **ego-syntonic** (patient believes their way is the "right and best" way).

> 🚨 **High-Yield Additions from Past Papers: Personality Disorders**
>
> - **Cluster Differentiations:** *Schizoid* (prefers to be alone) vs. *Avoidant* (wants relationships but fears rejection). *Histrionic* (seeks attention) vs. *Narcissistic* (seeks

admiration).

- **Antisocial Personality Disorder:** Requires a documented history of **Conduct Disorder before age 15**. Highly comorbid with substance abuse. Characterized by a lack of response to punishment and no capacity for guilt.

Chapter 7: Substance-Related and Addictive Disorders

> 💡 **Clinical Pearl: Abuse vs. Dependence**
> *Based on classic test questions (pre-DSM-5):*
> **Substance Abuse:** Substance use causing negative consequences (e.g., getting fired, family problems, DUI) but WITHOUT tolerance or withdrawal.
> **Substance Dependence:** Requires evidence of **tolerance** (needing more for the same effect) or **withdrawal**.

1. Alcohol Use and Withdrawal

Alcohol is a potent CNS depressant (GABA agonist, glutamate antagonist). Withdrawal causes rebound CNS excitation.

> 🚨 **High-Yield Alert: Alcohol Withdrawal Progression**
>
> - **6-36 hours:** Tremors, anxiety, diaphoresis.
> - **6-48 hours:** Tonic-clonic **Seizures**.
> - **48-96 hours: Delirium Tremens (DTs)** - Hallucinations (visual/tactile), severe agitation, autonomic instability (tachycardia, hypertension, fever). *Life-threatening!*
>
> **Treatment of Withdrawal: Benzodiazepines** (Diazepam, Chlordiazepoxide; use Lorazepam if the patient has liver disease).

Wernicke-Korsakoff Syndrome

- **Wernicke Encephalopathy Triad:** Ataxia, Confusion, Oculomotor abnormalities (Nystagmus). *Reversible with IV Thiamine.*
- **Korsakoff Syndrome:** Anterograde amnesia and **confabulation**. *Usually irreversible.*
- **Crucial Rule:** Always administer Thiamine **BEFORE** Glucose to avoid precipitating Wernicke's.

2. Substance Intoxication vs. Withdrawal Profiles

Substance	Intoxication Findings	Withdrawal Findings & Management
Opioids (Heroin, Morphine)	**Miosis (pinpoint pupils)**, respiratory depression, sedation. *Note: Meperidine is the exception (dilates pupils).* **Antidote:** Naloxone.	Dilated pupils, yawning, piloerection ("cold turkey"), rhinorrhea, lacrimation, diarrhea. *Note: Opiate withdrawal is highly unpleasant but **NOT life-threatening** (no seizures).* **Management:** Mild/Moderate: Clonidine (autonomic), NSAIDs (pain), Loperamide (diarrhea), Dicyclomine (cramps). Severe: Buprenorphine or Methadone detox.
Cocaine / Amphetamines	Dilated pupils, tachycardia, hypertension, paranoia. **Formication** (tactile hallucination of bugs crawling). *Note: Never give Beta-Blockers (causes unopposed alpha vasoconstriction).*	"Crash": hypersomnolence, severe depression, fatigue, increased appetite. *No seizures.* **Management:** Primarily supportive care. Severe psychiatric symptoms may warrant hospitalization.
Sedative-Hypnotics (Benzodiazepines, Barbiturates)	Slurred speech, ataxia, respiratory depression (especially when mixed with alcohol). **Antidote for Benzos:** Flumazenil.	Similar to alcohol withdrawal (anxiety, tremors, autonomic instability). **Seizures** can occur and are **life-threatening**. **Management:** Benzodiazepine taper. (Note: Carbamazepine/Valproic acid taper is not as beneficial).

Phencyclidine (PCP)	Agitation, aggression, decreased pain perception, **Rotary Nystagmus**, hypertension.	No classic withdrawal syndrome.
Cannabis (Marijuana)	Conjunctival injection (red eyes), increased appetite, dry mouth, perceptual distortions.	Irritability, insomnia, anorexia. **Management:** Supportive and symptomatic.

🧠 **Life-Threatening vs. Non-Life-Threatening Withdrawals**
Cause Seizures/Death: Alcohol, Benzodiazepines, Barbiturates.
Do NOT Cause Seizures/Death: Opioids, Cocaine, Amphetamines, Marijuana.

🚨 **High-Yield Additions from Past Papers: Substance Use**

- **Screening:** The **CAGE** questionnaire is heavily tested for alcohol dependence.
- **Specific Drugs: Heroin** causes the highest mortality. **Cannabis** is the most common illicit drug (active component THC). **Cocaine** causes hyperthermia (not hypothermia).
- **Wernicke-Korsakoff:** Classic triad: Ophthalmoplegia (nystagmus), Ataxia, and Confusion (due to Vitamin B1 deficiency).

Chapter 8: Neurocognitive Disorders

1. Delirium vs. Dementia (Major NCD)

Distinguishing between delirium and dementia is heavily tested. Note that **patients with preexisting dementia are at extremely high risk for superimposed delirium** when hospitalized.

Feature	Delirium	Dementia
Onset	**Acute** (hours to days).	**Insidious** (months to years).
Course	**Fluctuates** (waxing and waning, worse at night).	Progressive decline.
Attention/Consciousness	Impaired (disoriented, fluctuating alertness).	Intact until very late stages.
Reversibility	**Usually Reversible** (Treat underlying cause).	Usually Irreversible (with some exceptions).
Hallucinations	Often present (especially visual).	Generally absent (except Lewy Body Dementia).

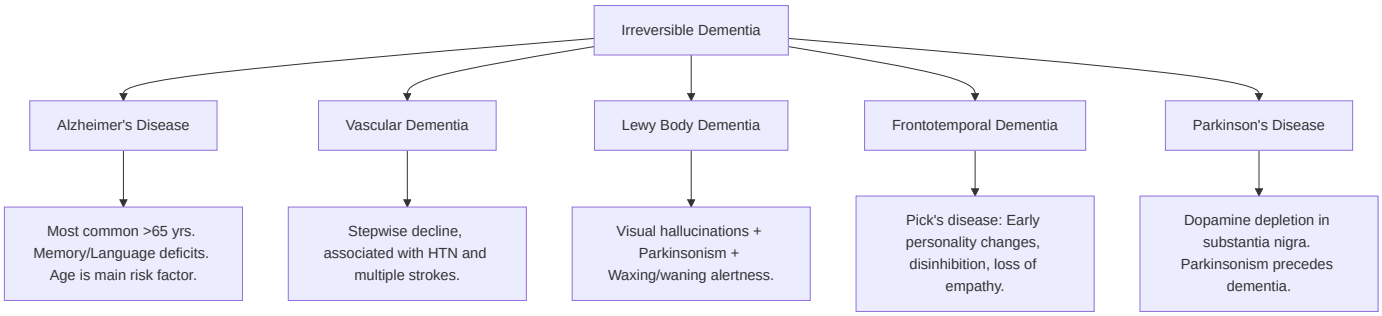
> 🚨 **High-Yield Alert: Delirium Truths**
> - It is a **medical emergency**.
> - It is *not* more common in young people; it is highly prevalent in the elderly.
> - It is caused by an underlying physiological defect (e.g., UTI, pneumonia, medications, substance withdrawal).

2. Causes of Dementia

A. Reversible Causes

- **Normal Pressure Hydrocephalus (NPH):** Triad of **Wobbly** (Gait apraxia/magnetic gait), **Wet** (Urinary incontinence), and **Wacky** (Cognitive impairment). Treatable with a VP shunt.
- **Vitamin B12 Deficiency:** Look for a vegan diet, macrocytic anemia, paresthesias, and ataxia.
- **Hypothyroidism:** "Apathetic thyrotoxicosis" in the elderly, fatigue, cold intolerance.
- **Others:** Neurosyphilis, Subdural Hematoma, Alcohol-induced (sometimes).

B. Irreversible Causes



💡 **Clinical Pearls for specific dementias:**

- **Lewy Body Dementia:** These patients are **extremely sensitive to antipsychotics**. Giving them Haldol can cause severe Extrapyramidal Symptoms (EPS) or Neuroleptic Malignant Syndrome (NMS).
- **Parkinson's Disease:** Caused by dopamine deficiency (NOT serotonin) in the substantia nigra. Remember: Parkinsonism appears *before* cognitive decline (unlike Lewy Body).
- **Creutzfeldt-Jakob Disease (Prion):** Rapidly progressive dementia accompanied by **myoclonus** (startle response).
- **Huntington's Disease:** Autosomal dominant (CAG repeats). Triad of chorea, executive dysfunction, and psychiatric symptoms (high suicide rate).

🚨 **High-Yield Additions from Past Papers: Neurocognitive Disorders**

- **Delirium vs. Dementia:** Delirium shows a **diffuse background slowed pattern** on EEG, distinguishing it from dementia (often normal EEG early on).
- **Reversible Causes:** Always rule out reversible dementias: Normal Pressure Hydrocephalus (NPH), Hypothyroidism, Vitamin B12 deficiency, and Alcohol-induced (Wernicke-Korsakoff).

- **Alzheimer's:** Pathophysiology is strongly tied to Acetylcholine deficits.

Chapter 9: Geriatric Psychiatry

> 💡 **Clinical Pearl: Suicide in the Elderly**
> Do not underestimate depression in the elderly. **White elderly males living alone** have the highest rate of completed suicides of any demographic. It is a misconception that older age protects against suicide. Furthermore, **ECT (Electroconvulsive Therapy) is safe and highly effective** in the elderly, especially if they are actively suicidal or refractory to medications.

1. Pseudodementia vs. True Dementia

Depression in the elderly frequently presents with cognitive deficits and memory impairment, mimicking dementia. This is known as **pseudodementia**.

Feature	Pseudodementia (Depression)	True Dementia (Major NCD)
Onset	Relatively acute.	Insidious and gradual.
Response to Questions	Often answers **"I don't know"**.	Will guess or **confabulate**.
Insight	**Aware** of their cognitive problems and distressed by them.	**Unaware** of their problems (poor insight).
Sundowning	Uncommon.	Common (confusion worsens at night).

*Note: Always treat suspected pseudodementia with an antidepressant trial (SSRIs). If the cognitive deficits improve, the diagnosis was depression. Remember to **"Start low and go slow"** with elderly dosing.*

2. Bereavement vs. Major Depression

- **Normal Bereavement (Grief):** Feelings of sadness, guilt, and sleep disturbances after a loss. It is **normal** to hear the voice or briefly see the deceased person. Symptoms typically abate within 6 months.
- **Major Depression:** Suspect this if the patient has severe feelings of worthlessness, generalized hopelessness, psychomotor retardation, or **suicidal ideation**. If criteria for MDD are met for at least 2 weeks, it should be treated as such.

3. Normal Sleep Changes in Aging

Elderly patients frequently complain of poor sleep. Understand what constitutes normal physiological changes versus a disorder:

> 🚨 **High-Yield Alert: Sleep Architecture in the Elderly**
>
> - **Total Sleep:** Decreased.
> - **REM Sleep:** Decreased REM latency and decreased total REM.
> - **Non-REM Sleep:** Increased Stage 1 and 2 (light sleep). **Decreased Stage 3 and 4 (deep/slow-wave sleep).**
> - **Sleep Cycle:** Phase advance (they go to bed earlier and wake up earlier).
> - **Efficiency:** Decreased (frequent nocturnal awakenings).

4. Pharmacological Considerations

Elderly patients have decreased muscle mass, increased fat, and decreased renal/hepatic clearance. They are highly sensitive to medication side effects.

- **Anticholinergics:** Avoid if possible (worsens confusion/memory). If a TCA must be used, **Nortriptyline** has the fewest anticholinergic effects.
- **Mirtazapine:** Excellent choice for an elderly depressed patient who also suffers from insomnia and weight loss (increases appetite and is sedating at lower doses).

Chapter 10: Psychiatric Disorders in Children

1. Intellectual Disability & Communication Disorders

- **Intellectual Disability (ID):** Requires deficits in both **intellectual functioning** (IQ) and **adaptive functioning**. Severity is based on the level of adaptive functioning (not just IQ scores).
  - **Down Syndrome:** Most common chromosomal cause.
  - **Fragile X Syndrome:** Most common inherited cause.
  - **Fetal Alcohol Syndrome:** Leading preventable cause (look for smooth philtrum, short palpebral fissures).
- **Communication Disorders:** Includes Language Disorder, Speech Sound Disorder, Childhood-Onset Fluency Disorder (Stuttering), and Social (Pragmatic) Communication Disorder.

2. Attention Deficit/Hyperactivity Disorder (ADHD)

Characterized by persistent **inattention, hyperactivity, and impulsivity** (the major features). Caused by decreased dopamine.

> 🚨 **High-Yield Alert: ADHD vs. Conduct Disorder**
> ADHD is **NOT** primarily characterized by aggressiveness or cruelty. If a child is bullying other kids, getting into fights, or breaking laws, the diagnosis is **Conduct Disorder**, not ADHD.

- **Criteria:** Onset before age 12. Symptoms must be present in **TWO or more settings** (e.g., home and school).
- **Treatment: Stimulants** (methylphenidate, dextroamphetamine) are the approved, first-line pharmacological treatments.

3. Autism Spectrum Disorder (ASD)

Characterized by impairments in **social communication** and **restricted, repetitive behaviors**.

💡 **Exam Truths & Myths: Autism**

- **TRUE:** It is much more common in **boys** (4:1 ratio).
- **TRUE: Regression** (loss of previously acquired language or social skills) is highly indicative of ASD.
- **FALSE:** Vaccines do *not* cause autism.
- **FALSE:** "Refrigerator mothers" or poor parenting do *not* cause autism.

4. Disruptive Behavior Disorders

Disorder	Key Features	Important Distinctions
Oppositional Defiant Disorder (ODD)	Irritability, defiance, argumentative behavior towards authority figures.	They do **NOT** violate the basic rights of others and are not physically aggressive.
Conduct Disorder (CD)	Aggression to people/animals, destruction of property, theft, serious rule violations (truancy).	**Violates the rights of others.** Often a precursor to Antisocial Personality Disorder (which cannot be diagnosed until age 18). *Note: It is FALSE to say they are "well-adjusted at school".*

5. Enuresis (Bedwetting)

Developmentally inappropriate voiding of urine in a child **at least 5 years old**.

🧠 **Enuresis Fast Facts**
- Nocturnal enuresis is more common in **males**.
- **Primary Enuresis:** The child has *never* had active control of micturition (has never been dry for more than 6 months).
- **Treatment Steps:** Psychoeducation/Reassurance → Behavioral modifications → **Urine Alarm** (most effective long-term) → Medications (**Desmopressin/DDAVP** or Imipramine).

6. Tic Disorders (Tourette's)

- **Criteria:** Multiple motor tics AND at least one vocal tic lasting for > 1 year.

- **Treatment:** Psychoeducation/Behavioral therapy. If meds are needed: **Alpha-2 agonists** (Guanfacine, Clonidine) are first-line.

7. PANS/PANDAS

- **PANS (Pediatric Acute-onset Neuropsychiatric Syndrome):** Sudden, acute onset (often described as "overnight") of **Obsessive Compulsive Disorder (OCD)** or severely restricted food intake.
- **PANDAS:** A subtype of PANS where the acute onset or exacerbation of OCD and/or Tic disorders is temporally associated with **Group A Streptococcal infections**.

8. Child Abuse & Neglect

Doctors are **mandated reporters** and must legally report all cases of suspected child abuse.

- **Physical Abuse:** Look for delayed medical care, inconsistent explanations, cigarette burns, or spiral bone fractures.
- **Sexual Abuse:** Look for recurrent UTIs, STDs, or prepubertal vaginal bleeding. *Note: If a child reports sexual abuse, it should be taken seriously as it is rarely unfounded.*
- **Neglect:** The failure to provide basic needs. Often presents as poor hygiene, malnutrition, or failure to thrive. It accounts for the majority of reported cases.

> 💡 **Additional Exam Pearls: Child Psychiatry**
>
> - **Autism Spectrum Disorder:** Look for regression of milestones, impaired language, and repetitive behaviors. Must rule out deafness with formal **auditory testing**.
> - **ADHD:** Symptoms must be present in **at least two different settings**. Linked to decreased dopamine.
> - **Enuresis:** More common in boys. First-line is behavioral (bell and pad).
> - **Conduct Disorder:** Bullying, violating rules; the childhood precursor to Antisocial Personality Disorder.
> - **School Refusal:** Typically rooted in separation anxiety and triggered by parental discord.

Chapter 11: Dissociative Disorders

> 💡 **Clinical Pearl: The Core Mechanism**
> Dissociative responses typically occur during or after highly stressful and traumatic events. It is a disruption in the integrated sense of self, utilized as a defense mechanism to buffer the impact of trauma.

1. Depersonalization/Derealization Disorder

These terms are frequently tested as straightforward definitions:

- **Depersonalization:** Experiences of unreality or detachment from **one's self** (e.g., feeling like an outside observer of one's own body, an "out-of-body" experience).
- **Derealization:** Experiences of unreality or detachment from the **surroundings** (e.g., feeling that the surrounding environment is unreal, like being in a dream or movie).

> 🚨 **High-Yield Alert: Reality Testing**
> In Depersonalization/Derealization disorder, **reality testing remains INTACT**. The patient knows that what they are experiencing isn't strictly "real," which differentiates this disorder from psychotic disorders like schizophrenia.

2. Dissociative Amnesia

An inability to recall important autobiographical information (often traumatic). This is NOT ordinary forgetfulness.

- **Memory Preservation:** While episodic/autobiographical memory is lost, **procedural memory** (like how to ride a bike or drive a car) is **preserved**. This distinguishes it from organic dementias.
- **Dissociative Fugue:** A subtype where the patient exhibits sudden, unexpected **travel away from home** accompanied by amnesia for their identity.

3. Dissociative Identity Disorder (DID)

Formerly known as Multiple Personality Disorder. It is characterized by the presence of **two or more distinct personality states**.

Key Feature	Description
Etiology	Almost always linked to severe, chronic **childhood trauma** (physical or sexual abuse). ~90% of patients have this history.
Comorbidity	High rates of PTSD, Major Depression, and Borderline Personality Disorder.
Risk	Extremely high risk for suicide. More than 70% of patients attempt suicide.
Treatment	**Psychotherapy** is the standard of care. Medications are only used for comorbid conditions (e.g., SSRIs for depression).

Chapter 12: Somatic Symptom and Factitious Disorders

> 💡 **Clinical Pearl: Primary vs. Secondary Gain**
> **Primary Gain:** Unconscious psychological benefit, like avoiding an internal conflict (Conversion Disorder) or getting medical attention/playing the "sick role" (Factitious Disorder).
> **Secondary Gain:** Conscious external benefit, like receiving money, avoiding jail, or getting time off work (Malingering).

1. The Big Three: Distinguishing Intent and Motivation

This is arguably the most heavily tested concept in this chapter. You must know whether the symptoms are intentionally produced and what the motivation is.

Disorder	Are Symptoms Intentional?	Motivation / Gain
Somatic Symptom Disorders	**NO** (Unconscious)	Unconscious / N/A. Patients truly *believe* they are ill.
Factitious Disorder (Munchausen)	**YES** (Conscious)	**Primary Gain** (Internal motivation). They want to assume the "sick role". There is an *absence of obvious external rewards*. *Note:* ***Munchausen syndrome by proxy*** *(Factitious disorder imposed on another) is intentionally producing symptoms in someone else (usually a child) under one's care.*
Malingering	**YES** (Conscious)	**Secondary Gain** (External rewards). Money, avoiding work/jail, getting narcotics. *Note: Malingering is NOT a psychiatric diagnosis.*

2. Specific Somatic Disorders

A. Conversion Disorder (Functional Neurological Symptom Disorder)

- **Symptoms:** One or more **neurological** symptoms (e.g., blindness, paralysis, seizures/PNES, mutism) that are incompatible with recognized medical conditions.
- **Presentation:** Often presents with *la belle indifférence* (surprising calmness or unconcern about their severe neurological symptom).
- **Past Paper Truth:** The "primary gain" in conversion hysteria refers to keeping an internal psychological conflict out of conscious awareness.

B. Somatic Symptom Disorder (formerly Briquet's Syndrome)

- **Symptoms:** One or more somatic symptoms that are highly distressing. Patients devote excessive time, energy, and anxiety to these symptoms.
- **Fact:** Up to 60% of depression in primary care settings presents predominantly as somatic symptoms.
- **Management:** Schedule regular, brief appointments with a **single primary care physician** to avoid unnecessary workups.

C. Illness Anxiety Disorder (formerly Hypochondriasis)

- **Symptoms:** Preoccupation with having or acquiring a serious illness. Crucially, somatic symptoms are **NOT present** (or are very mild). The disease is the fear itself.
- **Behaviors:** High level of anxiety about health. Performs excessive health-related behaviors (e.g., repeatedly checking body for signs of illness).
- **Duration:** The preoccupation persists for at least **6 months** (though the specific illness that is feared may change over time).

Chapter 13: Impulse-Control Disorders

> 💡 **Clinical Pearl: The Core Pattern**
> All impulse-control disorders follow a specific cycle: Increasing internal tension prior to the act → The impulsive act → Feelings of pleasure, gratification, or relief. (Followed often by intense guilt or depression).

1. Intermittent Explosive Disorder (IED)

Characterized by recurrent behavioral outbursts resulting in verbal and/or physical aggression that are **grossly out of proportion** to the triggering event.

- **Key Features:** The outbursts are *not* premeditated and are *not* committed to obtain a desired reward.
- **Neurobiology:** Associated with **low levels of serotonin**. Specifically, cerebrospinal fluid (CSF) testing may show low mean **5-HIAA** (a serotonin metabolite).
- **Treatment:** SSRIs (fluoxetine), mood stabilizers (lithium, anticonvulsants), and CBT.

2. Kleptomania

Failure to resist uncontrollable urges to steal objects that are **not needed** for personal use or their monetary value. Usually, objects are given away, returned, or hoarded.

> 🚨 **High-Yield Alert: Comorbidity**
> Kleptomania has a highly tested comorbidity with eating disorders, particularly **Bulimia Nervosa**. An estimated 65% of patients with kleptomania also suffer from bulimia nervosa.

- **Treatment:** CBT, SSRIs, and **Naltrexone** (to block the reward pathways mediated by endogenous opioids).

3. Pyromania

Deliberate and purposeful fire setting on more than one occasion.

- **Motivation:** Fascination with, or attraction to, fire. Relief/pleasure is experienced when setting fires or witnessing the aftermath.
- **Exclusions:** The fire setting is *not* for monetary gain, vengeance, concealing criminal activity, or part of sociopolitical ideology (which would point towards Conduct Disorder or Antisocial Personality Disorder instead).

> 💡 **Additional Exam Pearls: Impulse-Control**
>
> - **Trichotillomania:** Hair-pulling disorder is historically tested as an impulse-control disorder.

Chapter 14: Eating Disorders

> 💡 **Clinical Pearl: The Core Distinction**
> The absolute key to distinguishing Anorexia from Bulimia is **body weight (BMI)**. Anorexia is marked by significantly low body weight (BMI < 18.5, or 20% below normal), while Bulimia is marked by a normal or even elevated BMI.

1. Anorexia Nervosa

Disturbed body image and intense fear of gaining weight leading to severe restriction of caloric intake. It is often associated with obsessive-compulsive personality traits.

Subtypes:

- **Restricting type:** Has not regularly engaged in binge-eating or purging behavior; weight loss is achieved through diet, fasting, and/or excessive exercise.
- **Binge-eating/purging type:** Eating binges followed by purges (self-induced vomiting, laxatives, enemas, diuretics). Some purge after eating small amounts without binging.

> 🚨 **High-Yield Alert: Exam Traps**
> - **Appetite:** Patients with anorexia actually have a *good* appetite (unlike in major depression), but they actively starve themselves.
> - **Binge Eating:** Binge eating bouts are **NOT** a core diagnostic feature of Anorexia (it points to Bulimia, or the specific binge/purge subtype of Anorexia). In fact, "binge eating" is a sign of *poor prognosis* in Anorexia.
> - **Medications:** It is **FALSE** to say that pharmacotherapy is more effective in anorexia than bulimia. SSRIs do *not* work well for core anorexia symptoms (but are great for bulimia).

- **Physical Findings: Amenorrhea** (highly tested classic sign), **Lanugo** (fine, soft body hair like a newborn), bradycardia, cold intolerance, osteopenia.
- **Complications:** Purging can lead to **hypokalemia**, which causes potentially lethal cardiac arrhythmias. **Refeeding Syndrome** can cause dangerous fluid/electrolyte shifts (decreased Phos, Mg, Ca) if refed too quickly.
- **Treatment:**

    - **Food is the best medicine.** Hospitalization for supervised refeeding is required if dangerously below ideal body weight (>20-25% below) or if there are serious medical complications.
    - **Therapy:** Family therapy (e.g., the **Maudsley approach** is the gold standard for teenagers) and CBT.
    - **Medications:** SSRIs are ineffective for anorexia itself (used only for comorbid anxiety/depression). Olanzapine may help with weight gain/preoccupation.

2. Bulimia Nervosa

Characterized by recurrent episodes of **binge eating** followed by inappropriate compensatory behaviors (purging, excessive exercise, fasting).

- **BMI:** Patients maintain a **normal weight** or are overweight.
- **Physical Findings:** Dental erosion/caries, parotid gland enlargement (sialadenosis), and **Russell's sign** (calluses/abrasions on the dorsum of the hand from self-induced vomiting).
- **Treatment:**
    - **Therapy + SSRIs** (Fluoxetine is the only FDA-approved medication).
    - **Contraindication:** Avoid **Bupropion (Wellbutrin)** in these patients because it lowers the seizure threshold (which is already lowered by electrolyte imbalances from vomiting).

3. Binge-Eating Disorder

Recurrent episodes of binge eating **without** the compensatory behaviors seen in bulimia. Patients are typically obese and experience severe distress/guilt after eating.

- **Treatment:** SSRIs (first-line), Lisdexamfetamine (Vyvanse - an FDA approved stimulant for this), and CBT.

Chapter 15: Sleep-Wake Disorders

Sleep disorders are classified into two main categories: **Dyssomnias** (insufficient, excessive, or altered timing of sleep) and **Parasomnias** (unusual sleep-related behaviors).

1. Normal Sleep Architecture & Changes in Depression

Sleep alternates between Non-REM (NREM) and REM sleep every 90 minutes.

REM Sleep	NREM Sleep (Slow-Wave)
Dreaming happens here.	Has a **restoration function**.
Penile erection occurs here.	Erection does **NOT** occur here.
Characterized by increased BP, HR, and Respiratory Rate.	Sleepwalking and sleep terrors occur here.

> 💡 **Exam Truths: Sleep in Depression**
>
> - **Decreased REM latency** (Time from falling asleep to 1st REM period is shortened).
> - **Increased REM sleep**.
> - Decreased slow-wave (deep) NREM sleep.
> - Early morning awakening (terminal insomnia) or initial insomnia.

2. Dyssomnias

Disorders of sleep amount, quality, or timing.

A. Insomnia Disorder

- **Criteria:** Difficulty initiating/maintaining sleep or early-morning awakening. Occurs at least 3 days/week for > 3 months.
- **Treatment: Cognitive-behavioral therapy (CBT) is first-line.**

- **Pharmacology: Trazodone** is the most common antidepressant prescribed. Benzodiazepines are effective short-term but cause tolerance, addiction, and rebound insomnia. Non-benzos (like Zolpidem) increase the risk of falls and cognitive impairment in the elderly.

B. Hypersomnolence Disorder

- **Features:** Excessive sleepiness despite at least 7 hours of sleep. Characterized by *sleep inertia* (sleep drunkenness—impaired performance upon awakening) and nonrestorative sleep.
- **Treatment:** Modafinil (first-line) or stimulants.

C. Breathing-Related Sleep Disorders

- **Obstructive Sleep Apnea Hypopnea:** Repetitive collapse of the upper airway. Snoring, daytime sleepiness, morning headaches, hypertension. Risk factors: obesity, large neck circumference. Treated with CPAP and weight loss.
- **Central Sleep Apnea:** Driven by lack of respiratory effort. Can be Cheyne-Stokes breathing (associated with heart failure, stroke, renal failure) or opioid-induced.
- **Sleep-Related Hypoventilation:** Decreased respiration and elevated CO2 levels.

D. Narcolepsy

- **Classic Tetrad:**
    1. **Sleep attacks:** Irresistible urges to sleep.
    2. **Cataplexy:** Sudden loss of muscle tone triggered by intense emotion (e.g., laughing or anger). *Note: Night seizures are NOT associated with narcolepsy.*
    3. **Hallucinations:** Hypna**go**gic (when **go**ing to sleep) or Hypnop**omp**ic (when transitioning **from** sleep).
    4. **Sleep paralysis.**
- **Pathophysiology:** Linked to a loss of hypothalamic neurons that produce **hypocretin**. CSF shows hypocretin deficiency. Polysomnography shows reduced REM sleep latency.
- **Treatment: Modafinil** (for daytime sleepiness), **Sodium Oxybate** (highly effective for cataplexy).

E. Circadian Rhythm Sleep-Wake Disorders

- **Delayed Sleep Phase Disorder:** "Night owls." Delay in sleep onset and awakening. Preserved quality of sleep once asleep. Treat with bright light in early morning,

melatonin in evening.

- **Advanced Sleep Phase Disorder:** "Early birds." Sleep onset and awakening are earlier than desired. More common in older adults. Treat with bright light prior to bedtime.
- **Shift-Work Disorder:** Due to night shifts or rotating shifts.
- **Jet Lag Disorder:** Self-limiting condition after crossing time zones.

3. Parasomnias

Abnormal behaviors, experiences, or physiological events that occur during sleep or sleep-wake transitions.

A. Non-REM Sleep Arousal Disorders

These occur during slow-wave (NREM) sleep, typically in the **first one-third** of the night. Patients are **disoriented/confused** upon awakening and have **amnesia** for the episode.

- **Sleepwalking:** Simple to complex behaviors (sitting, walking) with a blank, glassy stare. Difficult to arouse. Usually benign/self-limiting; ensure environmental safety.
- **Sleep Terrors:** Sudden terror arousals, screaming/crying, with extreme **autonomic arousal** (tachycardia, diaphoresis, mydriasis).

B. Nightmare Disorder

- **Features:** Occurs during **REM sleep** (typically the last third of the night). Patients awaken **fully oriented** with vivid recall of the frightening dream.
- **Associations:** Highly comorbid with PTSD (seen in 50-70% of PTSD cases).
- **Treatment:** Imagery Rehearsal Therapy (IRT). Prazosin is often used for PTSD-related nightmares.

C. REM Sleep Behavior Disorder (RSBD)

- **Features:** Repeated arousals associated with vocalization or complex motor behavior (acting out dreams, punching, kicking) due to a **lack of normal muscle atonia** during REM sleep.
-
> 🚨 **High-Yield Alert: Associations**
> RSBD is highly associated with underlying neurodegenerative disorders, especially **Neurocognitive disorder with Lewy bodies** and **Parkinson disease**.

- **Treatment:** Clonazepam and environmental safety.

D. Restless Legs Syndrome (RLS)

- **Features:** Urge to move legs accompanied by unpleasant sensations. Relieved by movement, aggravated by inactivity, worsens in the evening.
- **Workup & Treatment:** You must check **Serum Ferritin**, as RLS is strongly associated with iron deficiency. Dopamine agonists (Pramipexole, Ropinirole) are first-line.

E. Substance/Medication-Induced Sleep Disorder

- Severe sleep disorder caused by substance intoxication or withdrawal (e.g., severe insomnia during alcohol/benzodiazepine withdrawal).

> 🚨 **High-Yield Additions from Past Papers: Sleep Disorders**
>
> - **NREM Sleep:** Night Terrors, Sleepwalking, and Nocturnal Enuresis occur here.
> - **REM Sleep:** Nightmares and vivid dreaming occur here.

Chapter 16: Sexual Dysfunctions and Paraphilic Disorders

1. Normal Sexual Response & Aging

The normal sexual response cycle consists of four stages: **Desire** → **Excitement/Arousal** → **Orgasm** → **Resolution**.

> 💡 **Neurotransmitter Effects**
> **Dopamine** *enhances* libido. **Serotonin** *inhibits* sexual function (which is why SSRIs are notorious for causing sexual dysfunction).

Changes with Aging

- **Men:** Require more direct stimulation, erections are less reliable/strong, and the **refractory period increases**.
- **Women:** Post-menopause (decreased estrogen) leads to vaginal dryness, thinning, decreased libido, and reduced sensitivity.

2. Sexual Dysfunctions

These disorders involve problems in the sexual response cycle that cause clinically significant distress and are not exclusively caused by another medical condition or substance.

> 🚨 **High-Yield Alert: Differential Diagnosis**
> Always rule out medications and medical conditions first! Antihypertensives, anticholinergics, SSRIs, and antipsychotics can all cause dysfunction. **Atherosclerosis** and **Diabetes** frequently cause erectile dysfunction due to vascular occlusion and peripheral neuropathy.

- **Erectile Disorder (ED):** The most common sexual disorder diagnosed in men. Treated with Phosphodiesterase-5 inhibitors (e.g., sildenafil) which *require* sexual stimulation,

or Alprostadil (injected/transurethral) which works *without* stimulation.

- **Premature (Early) Ejaculation:** Recurrent pattern of ejaculation within 1 minute of penetration. This is highly tested! **Treatment:** SSRIs (which delay ejaculation) or Clomipramine. Behavioral techniques include the "squeeze technique" and "stop-start technique."
- **Genito-Pelvic Pain/Penetration Disorder:** Includes **dyspareunia** (pain on or after intercourse) and **vaginismus** (involuntary muscle spasms preventing penetration). Treated with gradual desensitization.
- **Hypoactive Sexual Desire Disorder:** Absence of sexual thoughts/fantasies for >6 months.

3. Gender Dysphoria

Replaced "gender identity disorder." The pathology is not gender diversity itself, but rather the **distress** caused by the incongruence between the gender a person was assigned at birth and their identified gender. Transitioning can be social, medical (hormones), or surgical.

4. Paraphilic Disorders

Engagement in unusual sexual activities or preoccupation with unusual sexual urges/fantasies. **To be diagnosed as a disorder, they must either be acted on with a nonconsenting person OR cause significant distress/impairment.**

> 💡 **Exam Truth: Rape**
> Rape is a violent crime, **NOT** a paraphilia.

The Specific Paraphilias

Paraphilia	Definition
Pedophilic Disorder	Sexual acts/urges with prepubescent children (≤13 years). The offender must be ≥16 years old and at least 5 years older than the child.
Voyeuristic Disorder	Sexual arousal from observing an unsuspecting nude or disrobing individual (e.g., "Peeping Tom").

Exhibitionistic Disorder	Sexual arousal from exposing one's genitals to an unsuspecting person ("flashing").
Frotteuristic Disorder	Sexual arousal from touching or rubbing against a nonconsenting person (often in crowded places).
Sexual Masochism Disorder	Sexual arousal from being humiliated, beaten, bound, or made to suffer.
Sexual Sadism Disorder	Sexual arousal from the physical or psychological suffering of another person.
Fetishistic Disorder	Sexual arousal from nonliving objects (e.g., women's shoes) or nongenital body parts.
Transvestic Disorder	Sexual arousal from cross-dressing (distinct from Gender Dysphoria, as the primary goal here is sexual arousal, not gender identity).

Treatment: Very difficult to treat. SSRIs, antiandrogens (chemical castration in severe cases), and cognitive-behavioral therapy are used.

> 💡 **Additional Exam Pearls: Sexual & Gender Disorders**
>
> - **Terminology:** *Dyspareunia* is painful intercourse. *Premature Ejaculation* is successfully treated with SSRIs.
> - **Paraphilias:** *Voyeurism* involves deriving pleasure from watching unsuspecting people.
> - **Gender Identity:** Internal sense of being male/female is well established by 12 to 36 months of age (distinct from gender role).

Chapter 17: Psychotherapies

1. Psychoanalysis & Freud's Theories

Psychoanalysis aims to resolve unconscious conflicts by bringing repressed experiences into awareness (insight-oriented therapy). It is **not** indicated for psychotic or actively manic patients.

Structural Theory of the Mind

- **Id:** Present at birth. Unconscious; involves instinctual sexual/aggressive urges and primary process thinking.
- **Ego:** Develops after birth. Serves as a mediator between the id, superego, and external environment. Uses defense mechanisms.
- **Superego:** Completed by age 6. The aspect of the psyche that represents **morality, society, and parental teaching** (internalization of cultural rules).

> 💡 **Key Psychoanalytic Concepts**
> - **Transference:** The patient projects unconscious feelings regarding important figures in their life onto the therapist (e.g., patient gets angry when therapist is late, mimicking repressed feelings of abandonment by a parent).
> - **Countertransference:** The therapist projects their own unconscious feelings onto the patient.

2. Defense Mechanisms

Defense mechanisms are used by the ego to protect oneself and relieve anxiety. They are hierarchically classified.

Mature Defenses (Healthy & Adaptive)

Defense	Definition / Classic Example
Altruism	Performing acts that benefit others to vicariously experience pleasure.

Humor	Expressing uncomfortable feelings without causing discomfort.
Sublimation	Satisfying socially objectionable impulses in an acceptable manner (channeling, not preventing). *Ex: A former gang member becomes a police officer working to prevent gang violence.*
Suppression	**Consciously** ignoring an unacceptable impulse to diminish discomfort and accomplish a task.

Neurotic Defenses

Defense	Definition / Classic Example
Displacement	Shifting emotions from an undesirable situation to a personally tolerable one (e.g., mad at mother, yells at teacher).
Intellectualization	Using reasoning/intellectual functions to block confrontation with an unconscious conflict.
Rationalization	Attempting to justify behavior to make it acceptable. *Ex: Buying an unreasonably expensive watch and saying it's necessary to get to appointments on time.*
Reaction Formation	Doing the **opposite** of an unacceptable impulse (e.g., attracted to coworker, so you insult them).
Repression	**Unconsciously** preventing a thought from entering consciousness (e.g., forgetting details of an assault).

Immature Defenses

Defense	Definition / Classic Example
Acting Out	Giving in to an impulse to avoid the anxiety of suppressing it (e.g., skipping therapy because you are mad the therapist is going on vacation).
Denial	Not accepting a painful reality.

Regression	Returning to an earlier developmental stage (e.g., an adult bringing a childhood teddy bear to the hospital).
Projection	Ascribing one's own objectionable qualities onto others. *Ex: A cheating husband accuses his wife of having an affair.* **High-Yield:** This is the hallmark defense mechanism in **Paranoid Personality Disorder**.

> 🚨 **High-Yield Alert: Splitting**
> **Splitting** is labeling people as "all good" or "all bad" (e.g., "The nurses are angels, but the doctors are idiots"). It is the hallmark defense mechanism of **Borderline Personality Disorder (BPD)**.

3. Behavioral Therapy & Learning Theory

Based on the principle that behaviors are learned (conditioning) and can be unlearned (deconditioning).

- **Classical Conditioning (Pavlov):** A neutral stimulus evokes a conditioned response.
- **Operant Conditioning (Skinner):** Behaviors are learned when followed by positive or negative reinforcement.
  Exam Trap: **Negative reinforcement** is encouraging a behavior by **removing** an aversive stimulus (e.g., putting on a seatbelt to stop the annoying car beep). It is **NOT** the same as punishment!

4. Specific Psychotherapies & Techniques

Psychoanalysis-Related Therapies

- **Psychoanalytically Oriented / Brief Dynamic Psychotherapy:** Similar to psychoanalysis but briefer, less intense, and face-to-face (no couch).
- **Interpersonal Therapy:** Brief therapy (3-4 months) focusing on reassurance, clarification of emotions, and improving interpersonal communication. Highly efficacious for Depression.
- **Supportive Psychotherapy:** Not insight-oriented. Focuses on empathy, understanding, and education to build up the patient's healthy defenses. Common adjunctive treatment for severe mental disorders.

Behavioral Therapy Techniques (Deconditioning)

- **Systematic Desensitization:** Patient performs relaxation techniques while being exposed to increasing doses of an anxiety-provoking stimulus. Used for phobic disorders.
- **Flooding and Implosion:** Patient is confronted with a real (flooding) or imagined (implosion) anxiety-provoking stimulus and not allowed to withdraw until they feel calm.
- **Aversion Therapy:** A negative stimulus is repeatedly paired with a specific behavior (e.g., prescribing Disulfiram/Antabuse to make an alcoholic ill when they drink).
- **Token Economy:** Rewards given after specific behaviors to positively reinforce them (e.g., on rehab units).
- **Biofeedback:** Physiological data (HR, BP) given to patients as they try to mentally control physiological states (used for migraines, hypertension, agoraphobia).

Cognitive Therapies

- **Cognitive-Behavioral Therapy (CBT):** Focuses on a patient's current symptoms by examining the connection between thoughts, feelings, and behaviors. It corrects "cognitive distortions" (faulty assumptions).
  High-Yield: CBT is the best psychotherapeutic treatment for **Obsessive-Compulsive Disorder (OCD)**.
- **Dialectical Behavioral Therapy (DBT):** Developed by Marsha Linehan. Incorporates cognitive/supportive techniques with Buddhist "mindfulness."
  High-Yield: DBT is the primary treatment for **Borderline Personality Disorder**.

Systemic and Group Therapies

- **Group Therapy:** Includes peer-led groups (like Alcoholics Anonymous). Advantages: immediate feedback from peers and gaining insight by listening to others with similar problems.
- **Family Therapy:** Psychopathology may arise from family dysfunction. *High-Yield:* **High expressed emotion** (critical/over-involved attitudes) negatively impacts mental health. Therapists work to correct overly rigid or permeable boundaries, and "triangles" (two members allying against a third).
- **Couples Therapy:** Treats conflicts/communication problems. Can be conjoint (together), concurrent (separate but same therapist), collaborative (separate

therapists), or four-way (two therapists). Contraindicated if one spouse has severe illness like schizophrenia.

Chapter 18: Psychopharmacology

This is arguably the highest-yield chapter for psychiatry exams. Focus heavily on side effects, drug interactions, and lethal toxicities.

1. Major Side Effects & Toxicities

> 🚨 **NMS vs. Serotonin Syndrome**
> **Serotonin Syndrome:** Hyperreflexia, myoclonic jerks, and hyperactive bowels. (Treatment: Stop meds, supportive care, **cyproheptadine**).
> **Neuroleptic Malignant Syndrome (NMS):** "Lead pipe" rigidity, hyporeflexia, markedly elevated CPK, and autonomic instability. (Treatment: **dantrolene**, bromocriptine, amantadine).

Extrapyramidal Symptoms (EPS)

Caused by dopamine blockade in the nigrostriatal pathway. Typical (first-generation) antipsychotics are the most common culprits.

Condition	Onset	Presentation & Treatment
Acute Dystonia	Hours to days	Sustained painful muscle contractions (e.g., torticollis, oculogyric crisis). **Treatment:** IV Benztropine (Cogentin), Diphenhydramine, or Procyclidine.
Akathisia	Days to weeks	Restlessness, inability to sit still ("ants in the pants"). **Treatment:** Beta-blockers (propranolol) or dose reduction.
Parkinsonism	Days to weeks	Mask-like face, cogwheel rigidity, pill-rolling tremor, bradykinesia ("walks like a robot"). **Treatment:** Benztropine or dose reduction.

Tardive Dyskinesia (TD)	Months to years	Choreoathetoid (writhing) movements of mouth/tongue. Often **irreversible**. Clozapine is least likely to cause TD.

Other Notable Side Effects

- **Hypertensive Crisis:** Occurs when MAOIs are combined with tyramine-rich foods (red wine, cheese, cured meats).
- **HAM Side Effects:** Anti-**H**istamine (sedation, weight gain), Anti-**A**drenergic (orthostatic hypotension), Anti-**M**uscarinic (dry mouth, blurry vision, urinary retention). Common in TCAs and low-potency typical antipsychotics.

2. Antidepressants

- **SSRIs:** First-line. **GI disturbances** are the most common side effect. Can cause sexual dysfunction. Wait 2 weeks (5-6 weeks for fluoxetine) before switching to an MAOI to avoid serotonin syndrome.
- **Bupropion (Wellbutrin):** Norepinephrine-dopamine reuptake inhibitor. **Least likely to cause sexual side effects.** Lowers the seizure threshold. *Contraindicated* in patients with epilepsy or eating disorders.
- **Trazodone:** Used primarily for insomnia. *Mnemonic:* "Trazo-bone" (causes **priapism**).
- **Mirtazapine:** Alpha-2 antagonist. Causes sedation and weight gain (great for depressed, elderly patients with insomnia and weight loss).
- **TCAs:** Highly lethal in overdose (**3Cs: Cardiotoxicity, Convulsions, Coma**). Overdose causes widened QRS. Treat toxicity with **IV sodium bicarbonate**.

3. Antipsychotics

- **Typical (First-Generation):** High-potency (Haloperidol, Fluphenazine) cause more EPS. Low-potency (Chlorpromazine, Thioridazine) cause more HAM side effects. *Note:* Haloperidol IM is the drug of choice for acutely aggressive/agitated patients. Typicals are ineffective for the *negative* symptoms of schizophrenia.
- **Atypical (Second-Generation):** Block dopamine and serotonin. Less EPS, but high risk for **Metabolic Syndrome** (weight gain, hyperlipidemia, hyperglycemia).
    - **Clozapine:** Only drug proven for treatment-refractory schizophrenia, and the only drug proven to decrease suicidality in schizophrenia. **Critical Risk:**

Agranulocytosis. Must monitor Absolute Neutrophil Count (ANC) weekly for the first 6 months.

4. Mood Stabilizers

> 💡 **Lithium Toxicity and Monitoring**
> Lithium is the only mood stabilizer proven to **decrease suicidality**. It has a narrow therapeutic window and toxicity is deadly.
> *Mnemonic for pre-Lithium labs (P THY BEER):* **P**regnancy (causes Ebstein's anomaly), **Thy**roid, **B**enign leukocytosis, **E**lectrolytes, **E**KG, **R**enal (BUN/Cr).

- **Carbamazepine:** Induces its own metabolism (autoinduction - "PacMan"). High risk for neural tube defects, agranulocytosis, and Stevens-Johnson syndrome.
- **Valproic Acid (Depakote):** Risk of neural tube defects. Can cause hepatotoxicity and thrombocytopenia (check LFTs and CBC).
- **Lamotrigine:** Excellent for bipolar depression. Risk of Stevens-Johnson syndrome (requires very slow titration).

5. Anxiolytics (Benzodiazepines)

Benzodiazepines can be lethal when mixed with alcohol due to severe respiratory depression. In chronic alcoholics or patients with liver disease, you must use benzodiazepines that are not metabolized by the liver. *Mnemonic (LOT):* **L**orazepam, **O**xazepam, **T**emazepam.

> 🚨 **High-Yield Additions from Past Papers: Psychopharmacology**
>
> - **Benzodiazepine Metabolism:** Lorazepam, Oxazepam, and Temazepam (**LOT**) are preferred in liver disease as they are not hepatically metabolized. They act by enhancing GABA.
> - **Antidote Risks:** Flumazenil (benzo antidote) can dangerously lower the seizure threshold.
> - **Antidepressants:** Carry a black-box warning for increased suicide risk in adolescents. TCAs (like Imipramine and Amitriptyline) are the most dangerous in overdose. SSRIs commonly cause early GI disturbances and transient anxiety.
> - **Antipsychotics:** Highest risk of metabolic syndrome with **Clozapine** and **Olanzapine**. Clozapine is best for treatment-resistant schizophrenia.
> - **Pathways:** Mesolimbic pathway targets positive symptoms; Nigrostriatal pathway blockade causes extrapyramidal symptoms.

- **MAOIs:** Avoiding tyramine-rich foods (aged cheese, liver) is critical to prevent hypertensive crisis.
- **ECT:** Absolute contraindication is brain tumor/increased ICP.
- **Therapy Limitations:** CBT is not effective for paranoid schizophrenia; flooding is not used for social phobia.

Chapter 20: Approach to the Psychiatric Patient in the Emergency Department

1. Safety and Initial Assessment

Safety is the primary concern when evaluating an acutely psychiatric patient in the ED.

- **Positioning:** Always position yourself on the patient's **nondominant side** (usually the left; look at their watch or belt buckle).
- **Exits:** Position yourself close to the exit and ensure the exit is clear.
- **Visual Sweep:** Perform a quick visual check for objects that could be used as weapons (IV poles, needles).

2. De-escalation Techniques

- Speak softly (forces them to be quiet to hear you).
- Offer food, drink, or a blanket (EDs are cold, and patients are often hungry).
- Speak to them as an individual to disrupt their defensive mindset (e.g., "Where were you born and raised?").
- Ask for their permission to examine them to respect their personal space.

3. The Acutely Agitated Patient

If de-escalation fails, chemical restraints may be necessary.

> 💡 **The "5 and 2"**
> To quickly sedate a severely agitated or aggressive patient, the standard combination is **5 mg of IM Haloperidol** and **2 mg of IM Lorazepam**. Ordering a benzodiazepine and an antipsychotic together results in a lower total dose of medication required.

- **Haloperidol:** The drug of choice for calming acutely psychotic and aggressive patients. Highly tested on exams.

- **Geriatric Consideration:** Elderly patients (>65 years) are very sensitive to medications and should be started on smaller doses. They may also experience **paradoxical agitation** with benzodiazepines.

4. Medical Clearance & Reversing Overdoses

Before transferring a patient to the psychiatric floor, you must rule out urgent medical conditions (medical clearance).

> 🚨 **High-Yield Reversal Agents**
> **Naloxone:** Reverses opiate/opioid overdoses.
> **Flumazenil:** Reverses benzodiazepine overdoses. **CAUTION:** Can cause life-threatening **seizures** (due to rapid benzodiazepine withdrawal), especially in patients with a low seizure threshold. Use with extreme caution and have an airway cart ready.

5. Altered Mental Status & Delirium

Altered mental status requires an investigation for physiological causes (e.g., hypo/hyperglycemia, electrolyte imbalances, hypoxemia, endocrine disorders).

> 💡 **Exam Truths about Delirium**
> Delirium is characterized by a fluctuating level of consciousness. It is **usually reversible** once the underlying physiological defect is treated. It **can present with hallucinations** (especially visual). It is far **more common in the elderly** (it is WRONG to say it is more common in young people). Visual hallucinations should always prompt a search for a medical/organic pathology rather than a primary psychiatric illness.

Addendum: High-Yield Concepts Frequently Tested in Past Papers

A final review of the past papers and clinical vignettes reveals several highly-tested details that were not explicitly grouped in the earlier chapters. Memorize these for guaranteed points:

1. Schizophrenia: Negative Symptoms & Catatonia

- **Negative Symptoms:** Flattened affect, anhedonia, **alogia** (poverty of speech), and **avolition** (lack of drive/motivation). These symptoms are extremely treatment-resistant.
- **Catatonic Features:** Look for **catalepsy** (immobility / unprovoked muscular rigidity), **waxy flexibility**, extreme negativism, and echolalia. *Treatment:* Lorazepam or ECT.
- *Exam Trap:* Do not confuse catatonic catalepsy (muscular rigidity) with narcoleptic cataplexy (sudden loss of muscle tone triggered by emotion).

2. Psychopharmacology Nuances

- **Buspirone:** A non-benzodiazepine anxiolytic (5-HT1A partial agonist). Does NOT cause sedation or addiction, but has slow onset (takes weeks). Used for GAD augmentation.
- **Aripiprazole (Abilify):** A unique atypical antipsychotic because it is a **partial D2 agonist**. It is "weight-neutral" (unlike Olanzapine) but can cause significant akathisia.
- **Disulfiram (Antabuse) Mechanism:** Blocks **aldehyde dehydrogenase**, leading to a toxic buildup of **acetaldehyde** if alcohol is consumed (causes flushing, nausea, tachycardia).

3. Cultural Syndromes

- **Amok:** A culture-bound syndrome (typically seen in Southeast Asia) characterized by a sudden, unprovoked outburst of violent, aggressive, or homicidal behavior, followed by exhaustion and amnesia for the event.

4. Final "One Last Scan" Exam Pearls

- **Extrapyramidal Symptoms (EPS): Benzhexol** (Trihexyphenidyl) is another anticholinergic frequently tested as a treatment for acute dystonia/EPS.
- **ECT Contraindications:** A **Recent Myocardial Infarction (MI)** is considered an absolute contraindication to ECT (along with increased ICP).
- **Drug-Induced Depression: Methyldopa** (an alpha-2 agonist used for hypertension) is notoriously tested for causing depression.
- **Suicide Risk Modifiers:** Interestingly, **war situations** are associated with a *decrease* in the suicide rate. Recent marriage also decreases risk.
- **Symptom Definitions: Echopraxia** is imitating the examiner's movements (like echolalia is for speech). **Stupor** is characterized by mutism and immobility despite appearing awake and alert.
- **OCPD vs OCD: Punctuality** and perfectionism are classic features of Obsessive-Compulsive Personality Disorder (OCPD).
- **Drug Classifications (Exam Traps): Pimozide** is a typical antipsychotic, NOT a benzodiazepine. **Maprotiline** is a tetracyclic, NOT a TCA.
- **Phobias:** A key characteristic of a phobia is that it is an irrational fear that **cannot be reasoned out**.
- **Bulimia Nervosa:** Frequent purging causes electrolyte imbalances such as hypokalemia and **hypomagnesemia**.
- **Conversion Disorder:** Patients are highly **suggestible** (symptoms can sometimes be modified by suggestion).
- **SSRI Side Effects: Anorgasmia** (delayed or absent orgasm) is a highly tested, characteristic side effect.
- **Erectile Dysfunction:** A history of **Mumps** can cause orchitis, leading to organic erectile dysfunction.

Good Luck on Your Exams! لاتنسونا من الدعاء

You have completed the full high-yield psychiatry review notebook. Review the key pearls, tables, and mnemonics for top scores!

Mastery Complete