Psychobehavioral Disorders

Addictive Behavior

- Risky = no consequences
- Abuse = consequences (crash car, arrested, fired)
- Dependence = life organized to use (wake up and need fix)
- Dependence Sx: tolerance, withdrawal, increased amounts, failure to cut down, lots of time getting/using/recovering, social retreat, use despite physical/psych problem

Anorexia Nervosa and Bulimia

Anorexia = refusal to maintain normal weight	Bulimia = binge eating
Underweight Calorie restriction > Purging Suicide common cause of death Assoc w/ bradycardia	Often normal weight Purging vs. Non-Purging types inc'd suicide *attempts* only Variable vitals

Prognosis: In Anorexia 50% good, 25% relapse, 25% poor; Bulimia has better prognosis
***Pearl**: think of Anorexia as "chronic suicide"… killing you slowly, associated w/ depression and suicide

Signs/Symptoms of Anorexia and Bulimia are the same:

- Vague: fatigue, dizzy, confused, brittle nails, lanugo, edema
- Psych: denial, other psych disorders
- Caloric restriction: **starvation ketosis**, □ SQ fat, muscle wasting
- Endocrine (HPA axis suppression): amenorrhea, infertility, osteoporosis, □ growth
- Chronic malnutrition: seizure, cardiomyopathy, arrhythmia, Wernicke's, Fe deficiency
- Electrolytes: □**Na/K/Cl, hypoglycemia, metabolic alkalosis**
- Purging: Russell's sign (lesions on knuckles), oral lacs, swallow toothbrush (accident while trying to purge), Mallory-Weiss tear, poor dentition

Treatment: IVFs, correct lytes and metabolic acidosis, hospitalize prn (low threshold)

- Anorexia: avoid TPN, less responsive to meds
- Bulimia: CBT + SSRI

Mood and Thought Disorders

A. Psychosis = hallucination *or* delusion *or* disorganized thought process

	Psychiatric	***Organic/Medical***
Hallucinations	Auditory	Visual
Affect	Flat	Labile
Oriented?	Yes	No
Cognition	Continuous symptoms	Wax and wane
Age	Younger	Older
Onset	Gradual	Abrupt

B. Schizophrenia

- Who: 1% of pop
- How: brain disease, not parenting (though there are environmental triggers)
- Onset: late adolescent/early adult
- Deteriorating function (gets worse over time)
- Positive Sx: hallucinations, delusions, disorganized speech
- Negative Sx: blunted affect, anhedonia, emotional withdrawal

C. Bipolar Disorder

- What: Mania + Depression (comorbid SI and substance abuse common)
- Type 1 = mania; Type 2 = hypomania
- How: genetic + environmental
- Tx: mood stabilizer (Li, valproate) + antipsychotic (if psychotic features)

D. Depression/Suicide

- What: Depressed mood x2 weeks + 4 of following (In SAD CAGES):
- ↓ interest, ↓ Sleep, ↓Appetite, Depressed mood, ↓Concentration, ↓Activity, Guilt (or worthlessness), ↓Energy, Suicidal ideation
- If pt suicide risk, assess for: Means, Intent, Follow-up, and Safety

Factitious Disorders

A. Malingering = conscious manipulation + gainful incentive (drugs, disability fraud)

B. Factitious = conscious manipulation + “sick role” incentive

- Munchausen syndrome = fake illness to adopt sick role
- Munchausen by proxy (medical child abuse) = person intentionally but covertly makes other person sick; possible diagnosis w/ covert cameras
- Common scenario = kid w/ perplexing presentation, biological mom (98% of time) happy with positive tests (eg, kid w/ hypoglycemia, mom giving exogenous insulin)

C. Somatoform = not intentional

Neurotic Disorders

- PTSD = trauma/flashbacks/startle
- OCD = obsessive/compulsive
- GAD = extreme worry
- Panic Disorder = spontaneous panic attack
- Social Phobia = panic attack + social fear
- Specific Phobia = panic attack + specific fear
- *Tx for all*: CBT + SSRIs

Organic Psychoses

Delirium	Dementia
Medical or tox etiology, fluctuates, rapid onset, lethargic or agitated	Insidious, progressive, sundowning

Note: Chronic alcohol or drug use can cause psychosis

Transient Global Amnesia:

- Unable to remember things you should really remember, but no focal neuro S/Sx (eg, suddenly unable to recall address/birthdate/names/etc)
- Resolves spontaneously w/o intervention

Alcohol Withdrawal

EtOH has zero order kinetics (constant rate of metabolism)

A. Delirium Tremens = severe withdrawal syndrome + autonomic instability + hallucinations + delirium + seizures
Tx: Benzos, haldol (be careful, lowers sz threshold), phenobarb (if benzos don't work)

B. Wernicke's Encephalopathy = thiamine (vitamin B1) deficiency in heavy drinkers
Tx: give thiamine; also check Mg and glucose and replete prn

Sexual Assault

- 90% female
- Do exam and collect evidence concurrently; sexually abused may have nl exam
- Woods lamp to look for body fluids, Toluidine blue to look for vaginal/anal lacerations
- Prophylaxis: plan B, GC/Chlamydia, trichomonas, BV, HBV, HIV

Personality Disorders

- What: personality trait so extreme it causes impairment/distress and abnormal behavior
- Difficult doctor-pt relationship common
- Often has other psych disorder(s) or poor medical care
- Lack of insight (they don't know they have a personality d/o)
- Externalization common (pt thinks their problems due to other people's wrong doings)

A. Cluster A: odd and eccentric

- **Paranoid**: distrust or suspicious of others, question everyone's motives
- **Schizoid**: detached socially w/ restricted range of emotions
- **Schizotypal**: detached socially w/ eccentric behavior (magical thinking)

B. Cluster B: dramatic, emotional, erratic

- **Histrionic**: excessive emotionality and attention seeking
- **Narcissistic**: grandiosity, need for admiration, lack of empathy
- **Borderline**: unstable relationships, labile affect, poor self-image, poor pulse control, "splitting" (pt designates people they meet as either worst person ever or the best)
- **Antisocial**: disregard for rights of others, lying/cheating/stealing

C. Cluster C: anxious or fearful

- **Avoidant**: social inhibition, feels inadequate, hypersensitive to criticism
- **Dependent**: indecisive, feels inadequate, submissive
- **Obsessive-Compulsive**: perfectionism/order valued more than flexibility/efficiency

Psychosomatic Disorders

ALL OF THESE ARE UNINTENTIONAL
Be careful diagnosing these… pt may have organic etiology that you're missing

- A. Somatization = unexplained perception of variety of physical symptoms
- B. Hypochondriasis = genuine fear of disease, convinced they are sick, Sx out of proportion to clinical findings
- C. Conversion disorder = unexplained neuro Sx (often physiologically impossible)…paralysis, aphonia, blind, deaf, pseudoseizures

Toxic Syndromes

A. MAOI (monoamine oxidase inhibitor) toxicity

- Common MAOIs: phenelzine, tranylcypromine, selegiline, St. John's Wort (weak)
- How: OD, take with tyramine (wine/meat/cheese), drug interaction (SSRIs, tramadol, meperidine, dextromethorphan)
- What: MAO metabolizes norepi/serotonin/dopamine…so MAO Inhibitors □ □ NE/5HT/DA □ **sympathetic toxidrome**
- Tx: supportive (no antidote)

B. Serotonin syndrome

- How: OD, drug interaction (SSRI, MAOI, sympathomimetics, St. John's Wort, Li)

- What: **sympathetic toxidrome**
- Sx: CHARM mnemonic; CNS dysfxn (confusion/coma), Hyperthermia/Hyperreflexia, Autonomic instability, Rigidity, Myoclonus
- Tx: cyproheptadine (antidote), vent support prn, benzos for rigidity, IVFs for rhabdo, bicarb if QRS widening

C. Neuroleptic Malignant Syndrome (NMS)

- When: 2 weeks after initiation of antipsychotic (typical > atypical)
- What: **sympathetic toxidrome**
- Sx: Fever and rigidity plus some other stuff (AMS, autonomic instability, rhabdo, tremor, incontinence, mutism)
- Tx: dantrolene or amantadine (controversial antidotes), supportive
- **Note**: serotonin syndrome and NMS are very similar…NMS *does not* include myoclonus or hyperreflexia

PEARLS

- Anorexics have ↓ weight, ↑ suicide, and poor prognosis; Bulimics often normal weight
- Schizophrenia can have positive *and/or* negative symptoms
- Bipolar = mania + depression
- Malingering = obvious gain; Factitious = “sick role”; Somatoform = unintentional
- Delirium = sudden onset, fluctuates; Dementia = insidious onset, progressive
- DTs Tx = benzos; give thiamine if worried about Wernicke’s in EtOH pts
- In sexual abuse remember pregnancy and STD prophylaxis
- Cluster A = weird; Cluster B = wild; Cluster C = worried
- Somatization/Hypochondriasis/Conversion disorder are UNINTENTIONAL… careful diagnosing these…there may be organic etiology
- MAOI toxicity (no Tx), Serotonin syndrome (Tx cyproheptadine), and NMS (Tx dantrolene) are similar sympathetic toxidromes