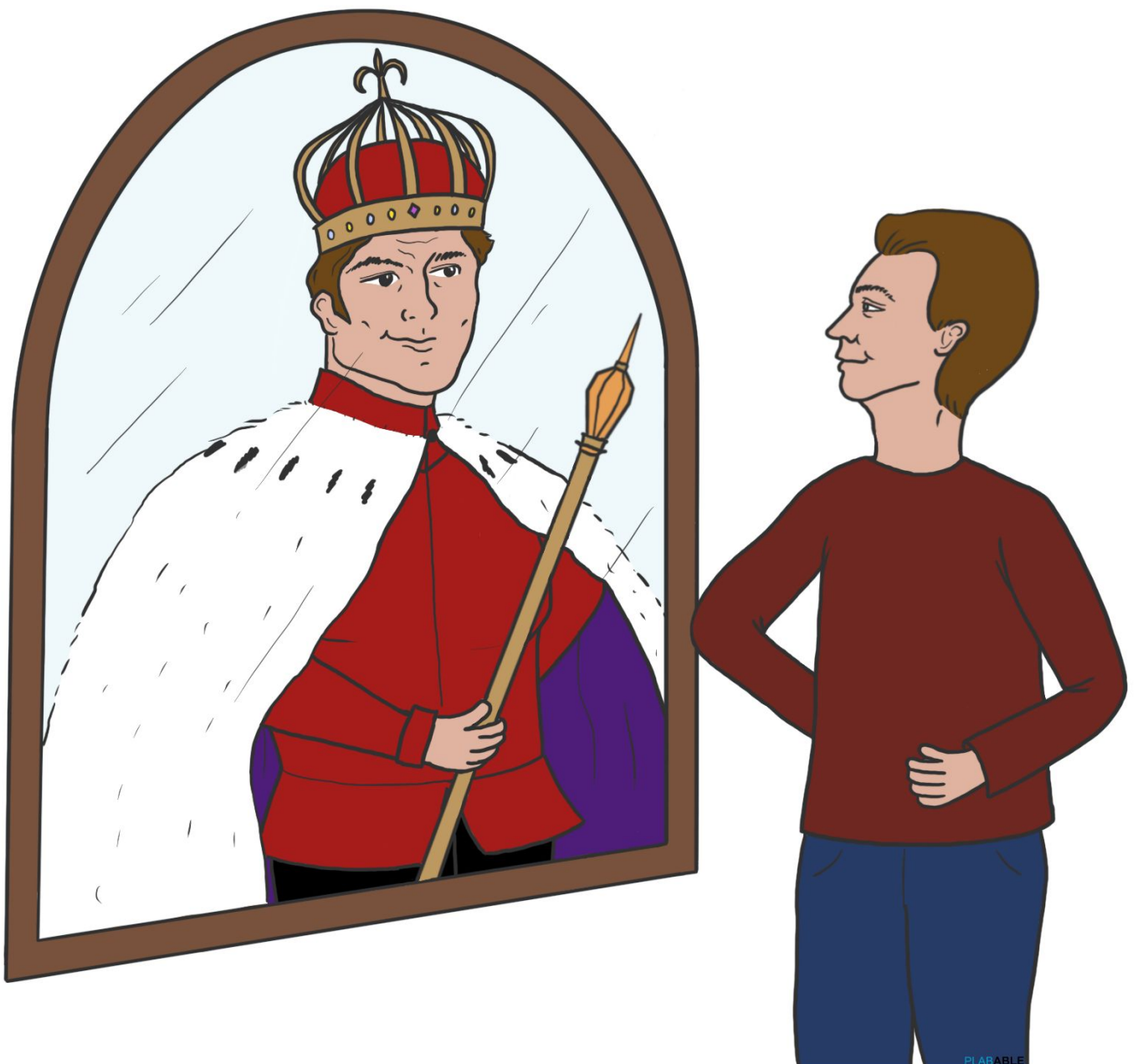


PLABABLE

GEMS

VERSION 3.9

PSYCHIATRY

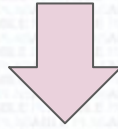


Postpartum Mental Health Issues

Postpartum Blue	Postpartum Depression	Postpartum Psychosis
● Anxious ● Tearful ● Irritable ● Benign ● Low moods	● Low mood ● Loss of pleasure ● Anxiety ● Disturbed sleep ● Loss of concentration ● Suicidal thoughts ● Occasional thoughts of harming baby	● Thoughts of harming baby ● Hearing voices saying baby is evil ● Hallucination ● Delusion ● Thoughts of suicide
Typically seen 3 -7 days following childbirth, resolves within the first week	Peaks at 3-4 weeks following childbirth	Begins 2-4 days postpartum and peaks at 2 weeks
● Reassure	● CBT ● SSRIs (Sertraline)	● Admission in hospital ● Anti-psychotics ● Mood stabilizers ● ECT

Postpartum Mental Health Issues

One way to differentiate baby blues from postnatal depression in the exam is to look at:



Duration

Both postpartum blues and postnatal depression can present with tearfulness, feeling low and feeling anxious but the timeline will give you a clue

Postpartum blues



Starts at two or three days after birth and can last anywhere from 1–2 days to a week

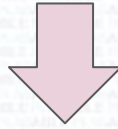
Postnatal depression



Peaks at 3 to 4 weeks postpartum and can last for months

Postpartum Mental Health Issues

One way to differentiate postpartum psychosis from postnatal depression in the exam is to look for:



Hallucinations Or Delusions

Postpartum depression



- Low moods
- Can also include intrusive thoughts of harming baby
- No hallucinations

Postpartum psychosis



- Hallucinations or Delusions

Example: Sees baby with evil eyes or feels that the maternity unit has plans to steal her baby away

Somatic Symptom & Related Disorders

Somatic symptom disorder:

- Multiple symptoms involving multiple systems
- Chronic course
- History of excessive diagnostic testings
- Rejection of previous physicians

Treatment: Psychotherapy with regular visits to the same physician

Hypochondriac or illness anxiety disorder

- Constant thinking of acquiring or having a serious illness (Cancer, HIV) despite medical evaluation and reassurance
- Minimal to no somatic symptoms

Treatment: Cognitive behavioral therapy

Examples for hypochondriac disorder

- A person believing that a simple headache is because of a cancer despite all investigations
- A person thinking tiredness is caused by HIV
- A person believing that a benign lump is a cancer despite all investigations

Somatic Symptom & Related Disorders

Munchausen's syndrome

- Intentional production / falsification / fabrication of physical or psychological signs and symptoms to obtain medical attention and treatment

Example for Munchausen's syndrome

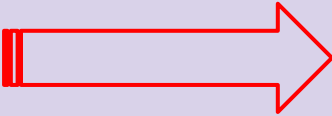
A woman always presents to the hospital with complaints of abdominal pain and bloody stools. She brings a sample from home which contains blood but is not able to produce a stool sample in the hospital. This is the 4th time she has visited the hospital. Her abdomen shows multiple scars of laparoscopic surgeries. She insists on getting more investigations.

Münchhausen's syndrome by proxy

Parent or carer produces factitious illness in a child or adult in their care

Somatic Symptom & Related Disorders

Conversion disorder:

- Loss of motor or sensory function:
 - Paralysis
 - Blindness
 - Mutism
 - Often triggered by a stressor
 - Patient do not intentionally fabricate the symptoms
- 

without organic cause

Examples:

- A 25 year old female was brought to the hospital with limb paralysis that developed after she witnessed a car accident. All the examinations are normal.
- A woman was brought to the hospital saying that she is unable to see after witnessing the death of her husband. All the examinations are normal.

Anorexia Nervosa

- Significant weight loss due to food restrictions, excessive exercise, self-induced vomiting, laxative or diuretic usage
- Fear of getting obese even though the patient is thin
- Calluses on the hands due to induced vomiting
- **BMI < 17.5**

Management

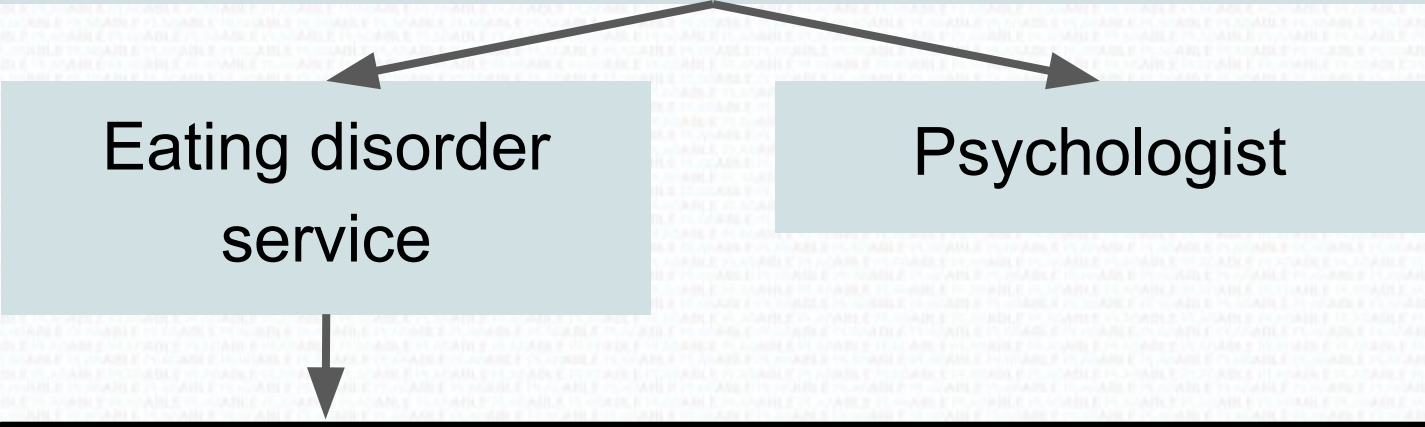
- Refer to medical ward for stabilisation with any BMI if:
 - Hypoglycemia
 - Bradycardia
 - Electrolyte imbalance - Hypokalemia
 - Signs of organ failure
- BMI <15 without medical complications refer urgently to **eating disorder unit**
- BMI 15 - 17.5 without medical complications refer to **eating disorder unit** or local community mental health team

Anorexia Nervosa

Plabable Exam Tips

If you are considering admission because of blood pressure, it has to be very low (e.g. $<80/50$ mmHg). A blood pressure of 90/60 alone does not warrant admission.

If you have a patient with a BMI that is between 15 to 17.5 kg/m^2 without evidence of system failure, and asked to pick between:



Eating disorder
service

Psychologist

Pick eating disorder service because the team is trained to handle eating disorders and can provide better support including psychotherapy

Bulimia Nervosa

- Recurrent episodes of binge eating
- Compensatory mechanism to lose weight:
 - Fasting
 - Excessive exercise
 - Self-induced vomiting
 - Laxative or diuretics abuse
- Parotid swelling
- Thickened calluses on hand due to induced vomiting
- **BMI >17.5**

Treatment

- Cognitive behavioral therapy

Autism Spectrum Disorder

Features

- Developmental impairment of social and communication skills
- Stereotyped and repetitive behavior
- Preference for only specific hobbies (collecting toys)

Management

- Behavioral and development programmes
- Speech and language therapy

Asperger's syndrome:

- Also, known as high functioning autism
- IQ is average or above average in most cases
- Difficulty with socializing

Attention Deficit Hyperactivity Disorder (ADHD)

Features

- Hyperactivity, impulsivity, and/or inattention
- Symptoms present in ≥ 2 settings (eg, school, home) before 12 years of age
- Reluctant to engage in mentally-challenging tasks
- Excessive talking
- Easily distracted
- Does not seem to listen when spoken directly to
- Failing to finish schoolworks and chores

Management

Children:

- Methylphenidate (first-line)
- ADHD-focused group parent-training programme

Adults:

- Lisdexamfetamine or methylphenidate first-line in adults
- Cognitive behavioral therapy (CBT)

Attention Deficit Hyperactivity Disorder (ADHD)

Brain trainer:

A 6 year old boy was brought to the hospital saying that he is easily distracted and interrupts other students in the school. He is also careless, unable to stay on a task for a period of time and is unable to play quietly. What is the most likely diagnosis?

➔ **Attention deficit hyperactivity disorder**

Manic Disorder

Mania

- Elevated mood and increase in quantity and speed of physical and mental activity ≥ 1 week
- Diagnosis requires severe functional impairment or hospitalization
- Grandiose ideas
- Excessive amounts of energy
- Racing thoughts and flight of ideas
- Overactivity
- Needing little sleep
- Easily distracted

One important point to distinguish mania from hypomania is the **hallucinations** and **delusions**

Hypomania

- Milder version of mania
- Does not cause marked functional impairment or need hospitalisation

Flight of Ideas

Brain trainer:

A patient describes the sensation of having an increased turnover of thoughts in his mind. What is the most likely thought disorder?

❖ **Flight of ideas**

Depression

One of the following:

- Constant low mood
- Loss of interest or pleasure in most activities

Plus three of the following:

- Fatigue
- Worthlessness
- Suicidal thoughts
- Decreased concentration
- Insomnia
- Weight loss

Symptoms should be there for > 2 weeks

Management:

- **CBT**
- Antidepressants - **SSRIs** are first-line antidepressants
 - Fluoxetine
 - Sertraline
 - Citalopram

Note:

- Drugs take 2-4 weeks to act
- Medication to be continued for at least 6 months

Dysthymia: Chronic mild depression for > 2 years

Depression

Brain trainer:

A woman presents with low mood, increased appetite, weight gain, somnolence and hypersomnia. What is the SINGLE most likely diagnosis?

→ **Atypical depression**

Depression in Adolescence



Remember, the corner stone treatment is **psychotherapy**



Following that, if antidepressants are required, **fluoxetine** is the best antidepressant to use in this age group (less than 18 years old)

Adjustment Disorder

Brain trainer:

A woman has been feeling low and having difficulty in concentrating since her mother passed away 2 months ago. She feels lethargic and has been crying more often lately. What is the SINGLE most likely diagnosis?

→ **Adjustment disorder**

Bipolar Disorder

- Mania (*or hypomania*) alternating with depression
- High suicide risk
- **Treatment:**
 - Mood stabilisers - **Lithium**
 - Cognitive behavioral therapy

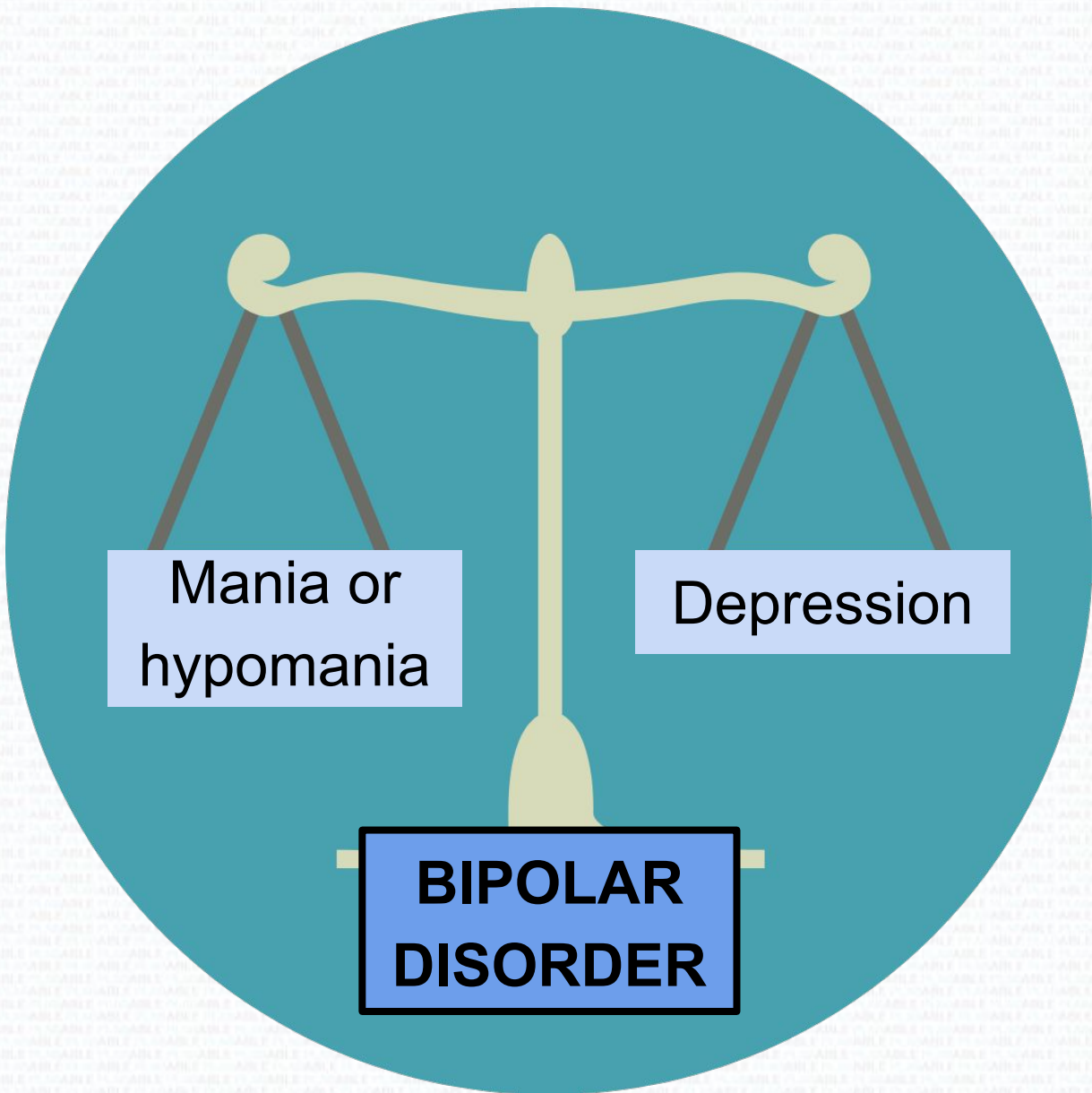
Example:

A 40 year old female has recently spent a huge amount of money on buying new accessories and clothes. She goes out with friends almost everyday. She sleeps less than usual and tends to fill her day with numerous activities. 4 years back she was on medication for depression.

Cyclothymia

Milder form of bipolar disorder fluctuating between mild depressive and hypomanic symptoms for ≥ 2 years

Bipolar Disorder



Remember, you **cannot** have bipolar unless you have both mania (or hypomania) and episodes of depression.

If you just see depression OR mania, it is NOT bipolar disorder

Lithium Toxicity

Lithium toxicity

- Coarse tremor
- Nausea and vomiting
- Drowsiness
- Hyperreflexia
- Seizure and coma

Diuretics and NSAIDs can cause lithium toxicity by increasing renal reabsorption

Management

- **Mild to moderate** - IV fluids and stop drug immediately
- **Severe toxicity** - Haemodialysis

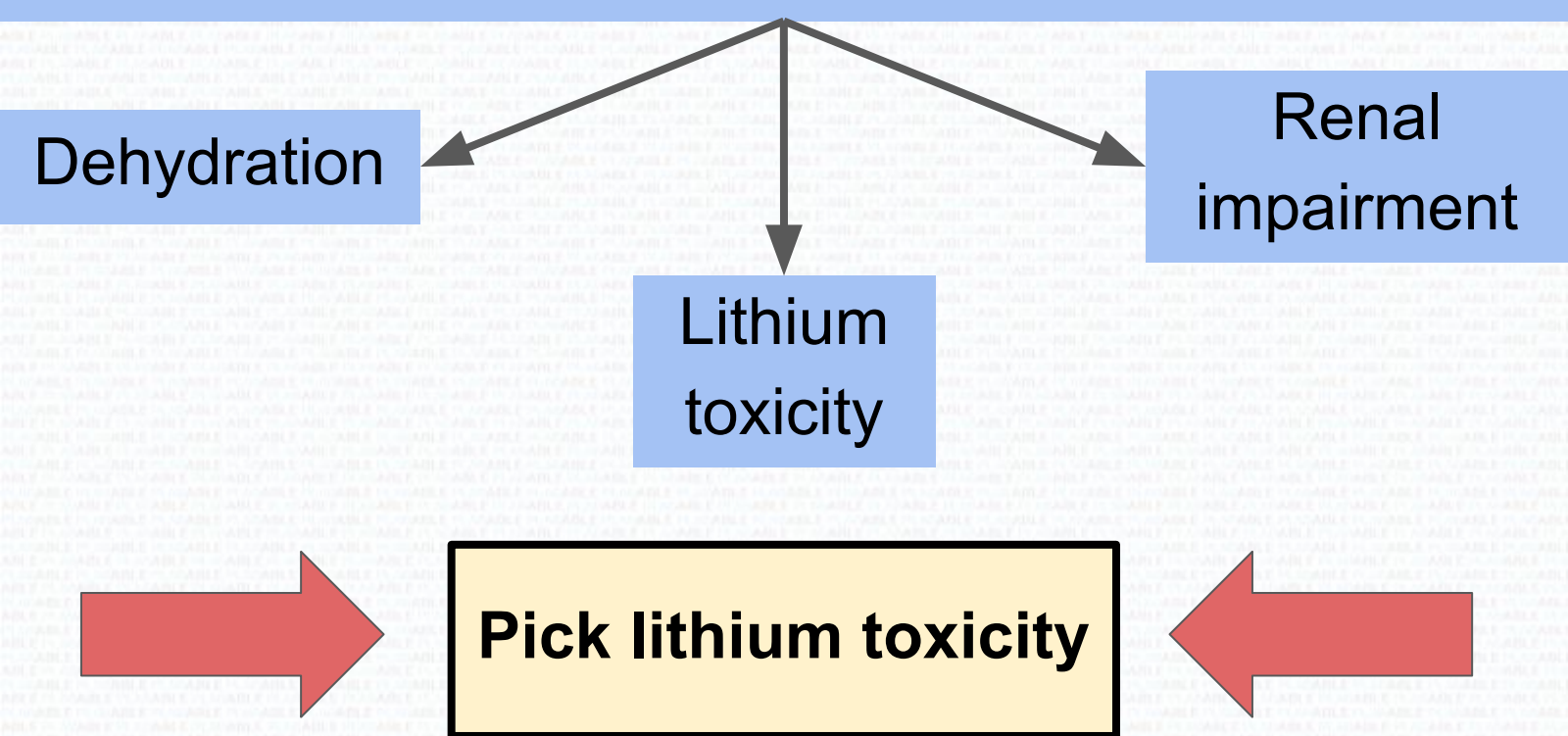
Example

A 40 year old man was brought to the hospital with complaints of tremors, vomiting and confusion. He is a known case of bipolar disorder on medication. Recently, he started using ibuprofen for knee pain. Most appropriate test → Serum lithium concentration

Lithium should not be used in pregnancy as it can cause **Ebstein's anomaly**

Lithium Toxicity

If a patient on lithium comes in with vomiting, coarse tremors, blurred vision, polydipsia, drowsiness (*basically symptoms of lithium toxicity*) and the question ask you specifically for the cause of his symptoms. What would you pick if given these options?



Avoid picking options like **dehydration** or **renal impairment**. Although dehydration and renal impairment can result in lithium toxicity in one who takes lithium, it is not the best answer to pick since the direct cause of his symptoms is lithium toxicity.

Delusion

False belief which is firmly sustained and based on incorrect inference about reality

Delusional jealousy (Othello's syndrome) -
Eg, believing a partner is being unfaithful

Grandiose delusion - belief of exaggerated self-worth

Unilateral neglect - belief that one limb or side does not exist

Delusion of Guilt

Eg: I am responsible for the hurricane / flood and thus need to be punished

Persecutory Delusion

Eg: They are spying on me, they are plotting against me

Ekbom's syndrome

Eg: I am infested by parasites

Delusion

Erotomania - Delusional belief that a person of higher social status falls in love with him/her

Folie a deux (shared psychosis)

Delusional belief and even hallucinations are shared between two individuals who are in a relationship

Delusional misidentification

Capgras syndrome:

Fixed belief that someone they know or recognize has been replaced by an imposter

Fregoli delusion:

Delusional belief that different people (More than one) are in fact a single person who changes appearance

Nihilistic delusion

Delusion that the person is already dead, or does not exist, or the world has ended or is not real. As such, nothing really matters or has any meaning.

Thought Disorder - Delusion

(Seen in schizophrenics)

Thought insertion

Thoughts are being placed into the patient's head from outside

Thought withdrawal

Thoughts have been stolen from his/her mind

Thought broadcasting

Thoughts are being accessible directly to others

Thought blocking

Sudden break in the chain of thoughts

Eg: The patient stops talking for a few seconds followed by speech in a different topic

Hallucination

Sensory perception which is experienced despite there being no external stimulus

Auditory hallucinations:

- **1st person:**
Voice is heard saying “I am walking”
- **2nd person:**
Voice is heard saying “You are walking”
- **3rd person:**
Voice is heard saying “He/she is walking”

Thought echo

Hallucination of hearing aloud his/her own thoughts a short time after thinking them

Visual hallucination

Eg. Seeing a snake when there is nothing

Note: Seeing a rope as snake is an illusion

Schizophrenia

Diagnosis requires ≥ 2 of the following symptoms:

- Delusions
- Hallucinations, often auditory
- Disorganized speech
- Disorganized behavior
- Negative symptoms - flat affect, social withdrawal

Symptoms should be present for at least 6 months for diagnosis

Management

- Atypical antipsychotics
 - Risperidone
 - Olanzapine
- Depot injections if there is non-compliance
- ECT (treatment resistance)

Schizophrenia

Side effects of antipsychotics

- Weight gain
- Akathisia
- Dystonia
- Tardive dyskinesia (Long term intake)
- Drug-induced Parkinsonism
- Neuroleptic malignant syndrome

Schizoaffective disorder

Schizophrenia + Mood disorder such as depression or bipolar disorder

Schizophreniform disorder:

Symptoms of schizophrenia lasting 1–6 months

Acute Psychosis

Brain trainer:

A schizophrenic man is brought to the ED and is agitated, making threats and is considered a danger to others. How should he be managed?

→ IM Haloperidol/IM Lorazepam

Acute Psychosis

Brain trainer:

When a person known to have a history of Parkinson's disease or dementia with Lewy bodies has acute psychosis and is elderly what is the most appropriate medication to administer?

→ IM Lorazepam

Haloperidol is usually preferred in the elderly but is contraindicated where there is a history of Parkinson's disease or dementia with Lewy bodies.

Haloperidol

Indications

- Nausea and vomiting
- Schizophrenia
- Acute delirium
- Rapid control of severe acute psychomotor agitation associated with psychotic disorder
- Persistent aggression and psychotic symptoms
- Alzheimer's dementia and vascular dementia
- Restlessness and confusion in a palliative care setting

DO NOT USE
if patient has

```
graph TD; A[DO NOT USE if patient has] --> B[Parkinson's disease]; A --> C[Dementia with Lewy bodies];
```

**Parkinson's
disease**

**Dementia with
Lewy bodies**

Haloperidol blocks dopamine receptors which worsens pre existing Parkinson's disease

Incongruent Affect

Brain trainer:

A schizophrenic man is seen laughing and smiling about his father's death whom he liked, loved and respected. What term describes his body language?

→ Incongruent affect

Clang Association

Brain trainer:

A schizophrenic says the following. “Life is unfair, I eat air, lawn chair, I like fairs, fairs have food, it must be good, in adulthood, I misunderstood”. What term describes this speech?

→ **Clang association**

Pressure of Speech

Brain trainer:

A 52 year old woman speaks rapidly without any pause and ignores interruptions. She barely even pauses to take enough breaths. What is the SINGLE best term to describe this kind of speech?

→ **Pressure of speech**

Rapid Tranquillisation

An agitated man who is being confused and aggressive

Medical history
unknown



Use Lorazepam

Medical history
known



Use Lorazepam,
Haloperidol or
Olanzapine

Always use oral medication first if patient would accept

If oral medication is not possible or appropriate
and urgent sedation with medication is needed,
use intramuscular route



IM Lorazepam



Safe in cardiac
disease



IM Haloperidol +
Promethazine



Should NOT be
used in patients
with cardiac
disease

Panic Attack

Discrete episodes of intense fear with physical symptoms

Presentation

- Discrete episodes of intense fear
- Arises rapidly
- Peaks within 10 minutes
- Can last up to 40 minutes
- Palpitations, trembling, sweating, shortness of breath, chest pain, and dizziness
- Numbness or tingling sensation (Hyperventilation → CO₂ washout → Respiratory alkalosis → Hypocalcaemia)

Management

- Breathing through the bag
- Lorazepam IM or IV can be used for acute panic attacks
- SSRI may be prescribed long-term

Panic Disorder

Recurrent panic attacks that come unpredictably and out of the blue without any triggers

Diagnosis > 1 panic attack with ≥ 1 month of ≥ 1 of the following:

- Persistent concern of additional attacks
- Worrying about consequences of attack
- Behavioral change related to attacks

Management

- **Long term:**
 - CBT (most effective, better than SSRI)
 - Antidepressants (SSRI first line medication)

Do not use benzodiazepines or sedating antihistamines

NICE does not mention the use of beta blockers however propranolol is occasionally used as a short-term adjunct like before air travel.

Generalised Anxiety Disorder

Excessive anxiety and worry for at least **six months**, about a wide range of events or activities

Symptoms

- Palpitations
- Trembling or shaking
- Constant worrying
- Sleep disturbance
- Irritability

Management

- Cognitive behavioral therapy
- SSRIs or venlafaxine (first line)

Recap of Panic Attacks, Panic Disorders and GAD

Panic Attacks

Discrete episodes of intense fear with physical symptoms

Panic disorder

Recurrent panic attacks that come unpredictably and out of the blue without any triggers

Generalised Anxiety Disorder

Excessive anxiety and worry for at least **six months**, about a wide range of events or activities

Recap of Panic Attacks, Panic Disorders and GAD

EXAMPLES

Panic Attacks

A young woman without significant medical history who suddenly develops an intense fear over the past 20 minutes with palpitations, sweating, trembling, shortness of breath and chest pain

Panic disorder

The above young woman having attacks of those nature often

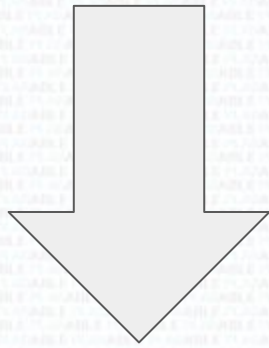
Generalised Anxiety Disorder

A woman who has a constant excessive worry about daily activities like family, finance, and housing. This worry is on most days. She focuses on possibilities of negative outcomes. She is constantly “on edge”. She also has trembling, sweating, poor sleep, and palpitations most of the day.

Panic Attack ABG

What can you expect the Arterial Blood Gas of a patient having a panic attack to be?

Because they over breath:



**High PaO₂
Low PCO₂
pH high
Bicarbs normal**

PANIC!



Social Anxiety Disorder

Presentation

Anxiety causing patients try to avoid situations like:

- Meetings
- Group events
- Eating in restaurants
- Public speaking

Management

- Cognitive behavioral therapy
- SSRIs

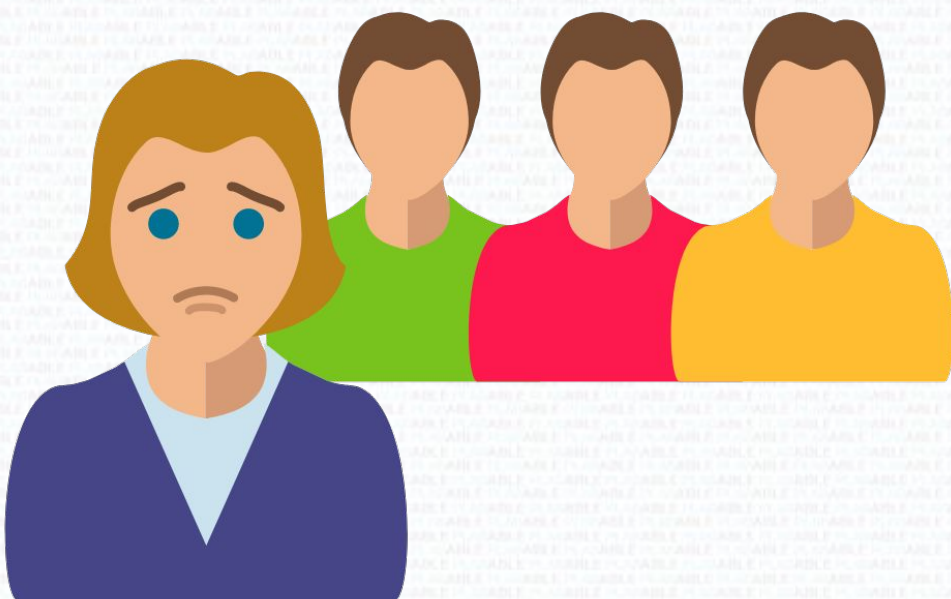
Social Phobia (Social Anxiety)

Examples:

A man who has recently been promoted but fears giving speeches. He avoids pubs and public spaces as he feels people are staring at him when he is drinking or eating.

A woman who is increasingly worried about meeting strangers and starting conversations. She has palpitations when she eats with company.

A teenager who often feels nauseous and sweaty when at large events. He develops palpitations and trembles when he speaks to someone new.



Obsessive Compulsive Disorder

Obsessions are unwanted intrusive thoughts, images or urges that repeatedly enter the person's mind. Eg. pathological doubt

Compulsions are repetitive behaviours or mental acts that the person feels driven to perform. Eg. checking a door is locked

Examples

- **Fear of contamination** - Repetitive hand washing
- **Need for symmetry** - Repetitive arranging things
- **Superstitious obsessions** - Repeating activities an exact number of times

Management

- Cognitive behavioral therapy - exposure and response prevention (first line)
- SSRIs

Post Traumatic Stress Disorder

Presentation

- **Re-experiencing:**
 - Flashbacks of the traumatic event
 - Repetitive Nightmares
- **Avoidance:**
 - Avoiding situations and people associated with the traumatic event
- **Hyperarousal:**
 - Hypervigilance for threat
 - Exaggerated startle response
 - Difficulty sleeping

Management

- **Trauma-focused CBT (first line)**
- **Eye Movement Desensitisation and Reprocessing (EMDR)**
- **Stress management**
- **Paroxetine and mirtazapine (second line)**

Phobia

Strong fear or dread of a thing or event, which is out of proportion to the reality of the situation

Agoraphobia

Fear of public and open places

- Fear of travelling in buses
- Fear of visiting a shopping mall
- Fear of even leaving the house (extreme)

Claustrophobia

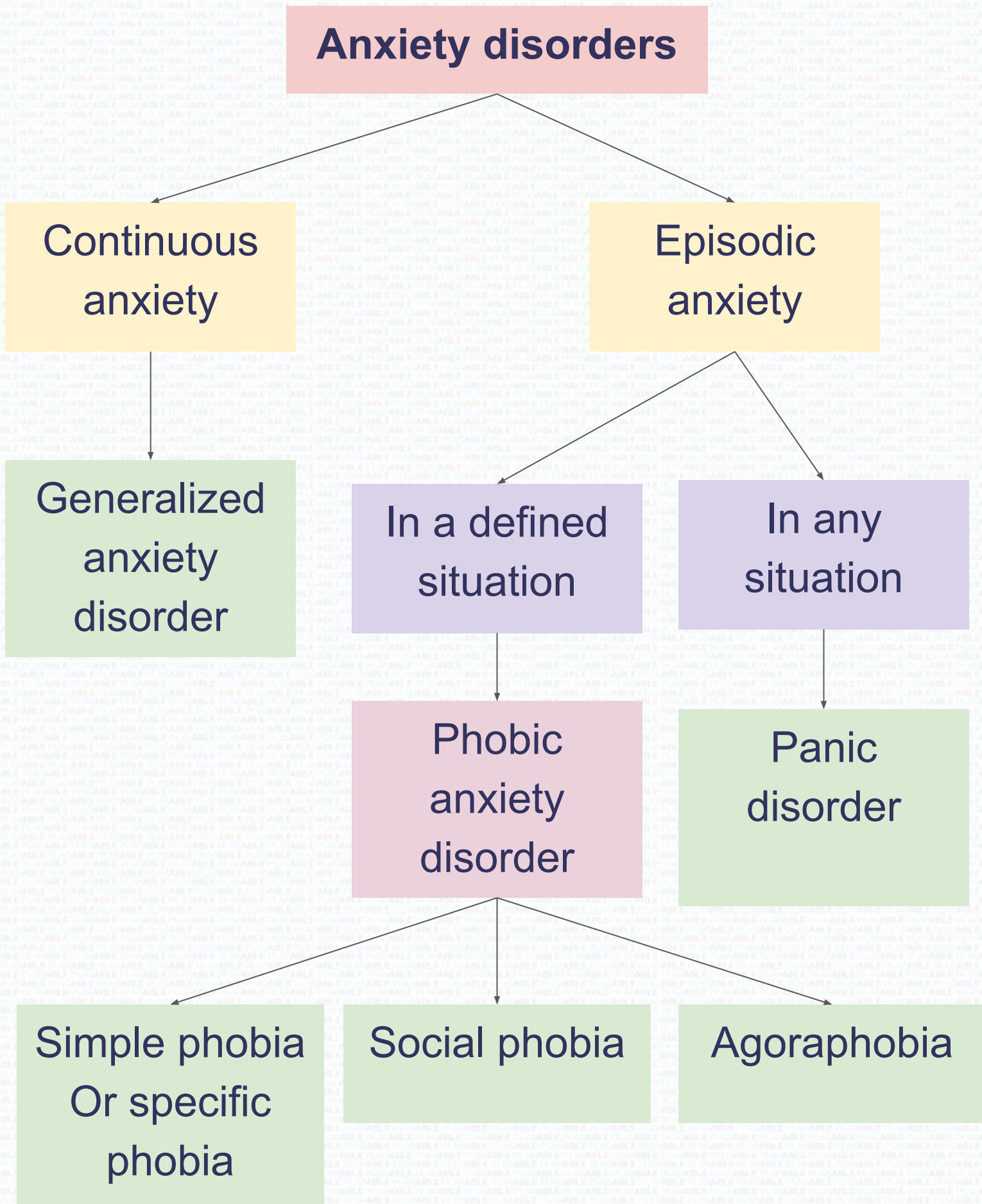
Fear of confined spaces or of being trapped

Management

- Graded exposure to reduce fear response

Anxiety Disorders

Principles of classifying anxiety disorders



Terms Used When Discussing Suicide and Self-Harm

Suicide is not synonymous with self-harm

Suicide

Death caused oneself with the intent to die

Self-harm

Deliberately injuring oneself typically as a manifestation of a psychiatric disorder or to seek attention

Suicide ideation



Thoughts and feelings of suicide (*patient may or may not have intentions or plans for suicide*)

Suicide intent



The wish to die by suicide

Suicide planning



Specific ideas for suicide (e.g. a time and setting of the event, writing a suicide note, preparing a will)

Suicide attempt

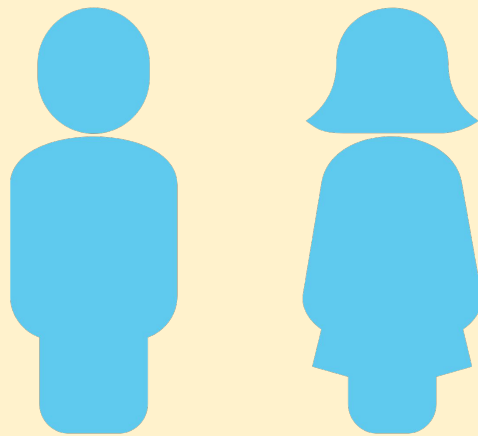


An action that is associated with intent to die

Risk Factors For Suicide

- Previous suicide attempts and self harm **(highest risk)**
- Divorce **(also a high risk)**
- Male gender *(for completed suicide i.e. managed to die from suicide)*
- Unemployment
- Mental illness such as depression
- Alcohol and drug abuse

Gender is always a confusing one for suicide.



Males tend to choose more lethal means of suicide so when they do attempt suicide, they go all the way. This means that males have a higher chance of a completed suicide.

Females tend to choose less lethal ways. So even though they have more suicide ideation and attempts, they may not actually die from their suicide attempts.

Protective Factors For Suicide

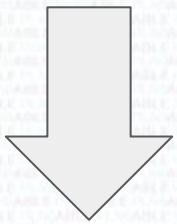
Protective factors decrease the risk of suicide

- A strong faith
- Married
- Having children

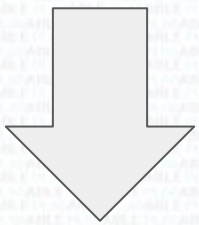


Suicide Risk Factors

**Recurrent depression + alcoholic + agoraphobia
+ history of suicide attempt**



Which risk factor is likely to lead to another suicide attempt?



History of suicide attempt

**Past
suicide
attempt**

Risk of

**Future
suicide
attempt**

Suicide Risk Factors



Remember the three “BIG” risk factors for suicide

History of suicide attempt

History of self harm

Divorce

Compulsory Admission

Brain trainer:

Under what circumstances may a patient be sectioned (i.e. be admitted to hospital and treated without his/her consent) ?

- Suffering from a mental disorder; and
- Threat to themselves or others

Alcohol Dependence

Brain trainer:

What three questions are highly correlated with alcohol dependence?

- ➔ **How often during the last year have you found that you were not able to stop drinking once you had started?**
- ➔ **How often during the last year have you failed to do what was normally expected from you because of drinking?**
- ➔ **How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?**

Developmental Disorders

Tourette's syndrome

- Repetitive tics - Both motor and verbal
- **Examples:**
 - **Motor:** Eye twitching or blinking
 - **Vocal tics:** Throat clearing, grunting and barking
- **Coprolalia** - compulsory saying of dirty words (pathognomonic)
- **Echolalia** - involuntary copying of others' words

Rett syndrome

- Normal development until 6-18 months of age followed by regression of motor, social, and language skills
- Hypotonia with hand-wringing
- Loss of eye contact
- Abnormal, stereotyped midline hand movements

Antipsychotics Side Effects

Neuroleptic Malignant Syndrome

- Hyperthermia
- Muscular rigidity
- Autonomic instability
- Due to potent antipsychotics such as **haloperidol, risperidone, clozapine and fluphenazine**
- Also can be a rare complication from antidopaminergic agents such as metoclopramide

Acute Dystonia

- Sudden onset of muscle spasms, stiffness, and/or oculogyric crisis

Akathisia

- Feeling of restlessness and inability to remain still

We believe you will be able to get through the exam without needing to know the management for these conditions as they are quite specialised so we have not included them

Antipsychotics Side Effects

Tardive Dyskinesia

- Involuntary, repetitive body movements, which may include grimacing, sticking out the tongue, or smacking the lips
- Due to chronic use of either typical antipsychotics or metoclopramide

Drug-induced Parkinsonism

- Bradykinesia
- Resting tremor
- Rigidity

Antipsychotics Side Effects

Recap

The following are what to pick when a patient is taking an antipsychotic:

Involuntary, repetitive body movements like lip smacking, repetitive chewing or tongue thrusting
→ **Tardive dyskinesia**

Confusion, neck stiffness, muscle rigidity, high temperature
→ **Neuroleptic malignant syndrome**

Pacing around the room, feeling restless and needs to move legs
→ **Akathisia**

Neuroleptic malignant syndrome

Vs Malignant hyperthermia

	Neuroleptic malignant syndrome	Malignant hyperthermia
High temperature	+	+
Muscle rigidity	+	+
Sweating	+	+
Genetic component	-	+
Cause	Antipsychotics Anti-dopaminergics	Halothane Succinylcholine
Onset	Hours to days	Minutes to hours

Personality Disorder

Borderline personality disorder

- Unstable personal relationships
- Mood swings
- Marked impulsivity
- Self-harm
- Dramatic and attention seekers

Antisocial personality disorder

- Criminal acts - does not follow the law
- Impulsiveness
- Aggressiveness - repeated physical fights
- Reckless and consistent irresponsibility
- Lack of remorse

Violence and Aggression

Brain trainer:

A young man gets agitated and violent in the department. Medical history has yet to be obtained. What is the most appropriate medication to prescribe?

→ **Lorazepam**

Ecstasy Vs LSD

Lysergic acid diethylamide (LSD)	Ecstasy (MDMA)
More hallucinogenic effects	Less hallucinogenic effects
Less of a mood enhancing and stimulant effect	More mood enhancing and stimulant effects
Higher likelihood of “bad trips”	Lower likelihood of “bad trips”

Ecstasy Vs LSD

Amused at simple things + staring at a clock that has a funny shape and changes colour

→ **LSD**

Green tie talking back to the patient and seeing sounds come out of the radio

→ **LSD**

Closing eyes and seeing colours

→ **LSD**

Increased thirst + high moods and energetic + spots of colours around peripheral vision

→ **Ecstasy**

Procyclidine

Brain trainer:

A woman has been taking an antipsychotic medication for her schizophrenia symptoms for the last 2 months. She attended the clinic describing stiffness in her right arm and she is unable to move it as easily as she used to. Cogwheel rigidity is seen on physical examination. What is the most suitable medication to be prescribed to alleviate her symptoms?

→ **Anticholinergic medication like procyclidine**

Anticholinergic like procyclidine may be added which will reduce the effects of the relative central cholinergic excess and hence reduce the symptoms of rigidity from dopamine deficiency.

Acute Stress Reaction

Occurs after a stressful event (e.g. mass shooting, rape, multiple bereavements, house fire)

The event has to be **BIG** (*i.e. breaking up with your short-term boyfriend does NOT count*)

Occurs minutes to hours after the event and can last for up to 4 weeks (*although generally, symptoms subside in a few days*). Symptoms include avoidance (*e.g. not talking about the office as it reminds her of the event*), re-experiencing (*e.g. intrusive thoughts of the event*), and hyperarousal

Other features can include those of a panic attack such as tachycardia, sweating and flushing

Adjustment Disorders, Acute Stress Reaction, and PTSD

All three can be somewhat similar

Adjustment disorder → Abnormal distress greater than what would have been expected in response to a stressor

Crying, not sleeping, low moods after a death of someone close (but symptoms more than expected of grief)

Acute stress reaction → Abnormal reaction worse and a lot longer than what is expected after a stressor with re-experiencing, avoidance and hyperarousal

Tachycardia, sweating, flushing every time one has thoughts of the BIG event (e.g. mass shooting, plane crash)

PTSD → Similar to acute stress reaction but more severe OR longer than 6 months

Adjustment Disorders, Acute Stress Reaction, and PTSD

Using **time** to differentiate the three

Adjustment disorder → Must occur within a month of the stressor and cannot last for more than 6 months

Acute stress reaction → Cannot last more than 4 weeks

PTSD → In the exam, would probably give a timeframe of more than 4 weeks

