DEPRESSIVE DISORDERS

1.Major Depressive Disorder

2. Persistent Depressive Disorder (Dysthymia)

3. Disruptive Mood Dysregulation Disorder

4. Premenstrual Dysphoric Disorder

DEPRESSIVE DISORDERS

- Major Depressive Disorder –**5 "SIG E CAPSS"** symptoms for at least 2 weeks
- Interest loss
- Guilt or worthlessness
- Energy loss
- Concentration loss
- Appetite change
- Psychomotor agitation or retardation
- Sleep change
- Suicidal thoughts] (SIG-E- CAPSS)

PERSISTENT DEPRESSIVE DISORDER

Persistent Depressive Disorder (Dysthymia) is a long-lasting form of depression.

- You feel sad or down most days for at least **2 years**
- You also have **at least 2** of these:
  - Sleep problems
  - Low energy or hopelessness
  - Poor appetite or overeating
  - Low self-esteem
  - Trouble concentrating
- You **never feel okay for more than 2 months** at a time during those 2 years
- It causes problems in your daily life or relationships
  2:2 RATIO

Disruptive Mood Dysregulation Disorder (DMDD) is a childhood condition where:

- A child has **severe temper outbursts** (yelling or hitting)
- Chronic dysregulated mood ("moody")
- The outbursts are **too extreme** for the situation
- They happen **at least 3 times a week**
- The child is **irritable or angry most of the time**
- It lasts for **over a year**
- It starts between ages **6 and 18**

Exam Tips

- **DMDD = chronic irritability** in children
- **IED = episodic, explosive** behavior in older children/adults
- Both may use **CBT** and **SSRIs**, but **persistent irritable mood** is **key for DMDD**

DMDD vs IED — Must-Know Differences

Feature	DMDD	IED
Mood baseline	**Irritable** mood always	**Normal** between episodes
Age group	**Children** (6–18)	**Older kids/adults** (≥6 yrs)
Onset	**Before age 10**	**Anytime ≥6 years**
Outburst pattern	**Frequent** (≥3/week)	**Episodic** (sudden, <30 min)
Between outbursts	**Persistently irritable**	**No symptoms**
Triggers	**Minor frustrations**	**Unpredictable**

🔍 **Quick Recall Tip:**

- **DMDD = Daily Moody Child**
- **IED = Impulsive Explosive Outbursts**

Premenstrual Dysphoric Disorder (PMDD) is a severe form of PMS:

- Symptoms happen **about 1 week before your period**
- Must have **at least 1** of these:
  - Mood swings
  - Irritability or anger
  - Sadness or crying
  - Anxiety or tension
- Must have **at least 5 total symptoms**, which may include:
  - Loss of interest
  - Trouble focusing
  - Feeling tired
  - Changes in appetite or sleep
  - Feeling overwhelmed
  - Physical symptoms like **bloating, breast tenderness, pain, or weight gain**
- It causes **serious distress or problems** in daily life.

BIPOLAR DISORDERS

1. Bipolar I Disorder
2. Bipolar II Disorder
3. Hypomanic Episode
4. Cyclothymic Disorder

Bipolar I Disorder

INHERITABLE - CHECK FAMILY HISTORY

- **If patient is 45 > years old can be due to MEDICAL CONDITION**
- **DIGFAST Mnemonic [Distractibility, Impulsivity, Grandiosity, Flight of ideas (racing thoughts), Activities (psychomotor agitation), Sleep deficit with no fatigue, Talkativeness (rapid, pressured)] Remember Lithium is the gold standard!**

– At least 1 manic episode lasting 7 days or needing hospital care
– May have depression, but manic episode is required.
Very high (euphoric or irritable) mood and **increased energy** for **at least 1 week**
Has **3 or more** of these (DIG FAST):

- **D**istracted
- **I**mpulsive/risky behavior
- **G**randiosity (feeling very important)
- **F**light of ideas (racing thoughts)
- **A**ctivity increased (goal-driven)
- **S**leep need is low
- **T**alkative (pressured speech)

Bipolar II Disorder
– At least 1 hypomanic episode (less severe than mania)
– At least 1 major depressive episode
– No full manic episode

Hypomanic Episode
A period of elevated or irritable mood
Lasts at least 4 days
Less severe than mania, no hospital stay or major impairment

- Similar to mania but less severe
- Has 3 or more DIG FAST symptoms
- No major problems with work or social life
- No hospitalization or psychosis

Cyclothymic Disorder
– Mood swings for 2 years or more
– Many mild ups (hypomania) and mild downs (depression)
– Symptoms never fully meet criteria for Bipolar I or II

SCHIZOPHRENIA

PSYCHOTIC DISORDERS
1. Schizophrenia
2. Schizophreniform Disorder (1-6 MONTHS)
3. Schizoaffective Disorder, Bipolar type
4. Schizoaffective Disorder, Depressive type
5. Delusional Disorder
6. Brief Psychotic Disorder

Schizophrenia :

- Must have **1 positive symptom** like **hallucinations, delusions, or disorganized speech** for **at least 1 month**
- Must have **2 or more total symptoms** from:
    - Hallucinations (hearing voices)
    - Delusions (false beliefs)
    - Disorganized speech or behavior
    - Negative symptoms (low emotion, no motivation)
- Must have **poor functioning** (social, school, or work) for **6 months or more**
- **Example Scenario:**
- John is a 25-year-old who believes the FBI is spying on him through his TV (**delusion**). He hears voices telling him he's being watched (**hallucination**). He often speaks in random, hard-to-follow sentences (**disorganized speech**). He stopped going to work and has stayed in his room for months (**impaired functioning**). His symptoms have lasted over 6 months.
- → This fits **schizophrenia**.

Psychotic Disorders Time & Features — Simple Guide

Disorder	Duration	Key Features
Schizophrenia	**More than 6 months**	Symptoms like hallucinations, delusions, disorganized behavior lasting 6+ months
Schizophreniform Disorder	**1 to 6 months**	Same symptoms as schizophrenia but shorter duration (1–6 months)
Brief Psychotic Disorder	**Less than 1 month**	Sudden psychotic symptoms that last less than a month, then full recovery
Schizoaffective Disorder - Depressive Type	Psychosis **> 2 weeks** + depression shows up	Psychosis plus major depressive symptoms
Schizoaffective Disorder - Bipolar Type	Psychosis **> 2 weeks** + bipolar symptoms show up	Psychosis plus mania or hypomania symptoms
Delusional Disorder	At least **1 month**	**Non-bizarre delusions** (false but possible beliefs), **no bizarre behavior** or major mood symptoms

Quick recap:

- **Schizophrenia** is a long-term (6+ months) psychosis.
- **Schizophreniform** is like schizophrenia but short-term (1–6 months).
- **Brief psychotic disorder** is very short, less than a month.
- **Schizoaffective** has both psychosis and mood symptoms (depression or bipolar).
- **Delusional disorder** involves strong beliefs without strange behavior or mood problems.

Panic Disorder:

- You have **sudden, intense fear or discomfort** called **panic attacks**
- These panic attacks happen **repeatedly and unexpectedly**
- Diagnosis given to people who experience recurrent UNEXPECTED panic attacks - that is, the attack seems to appear from nowhere. The term recurrent refers to the fact that the individual has had more than one unexpected panic attack.
- You worry a lot for **at least 1 month** about having more attacks
- During an attack, you feel **at least 4** of these symptoms:
    - Heart pounding

    - Sweating
    - Shaking
    - Trouble breathing
    - Feeling like choking
    - Chest pain
    - Nausea
    - Dizziness
    - Feeling unreal or detached
    - Fear of losing control or "going crazy"
    - Fear of dying
    - Numbness or tingling
    - Hot or cold flashes

Treatment – FDA Approved:

- **SSRIs:**
    - Fluoxetine (Prozac)
    - Paroxetine (Paxil, Pexeva)
    - Sertraline (Zoloft)
- **SNRIs:**
    - Venlafaxine (Effexor XR)

Panic Attack

- A **sudden intense wave of fear or discomfort** that peaks within minutes
- Symptoms include:
    - Fast heart rate
    - Sweating
    - Shaking
    - Shortness of breath
    - Hot flashes
    - Feeling like something terrible will happen (impending doom)
    - Chills, nausea, chest pain, headache, numbness

Treatment Notes:

- **Benzodiazepines:** Can help but are addictive
- **Beta blockers (like Propranolol):** Help with physical symptoms but **avoid in asthma patients** because they can cause breathing problems
- Propranolol is considered **safer**

Difference Between Panic Attack and Panic Disorder

Term	Definition	Key Point
Panic Attack	A sudden episode of intense fear with physical symptoms (like heart pounding, sweating)	Can happen **once or anytime**, with or without a diagnosis
Panic Disorder	Repeated, unexpected panic attacks plus ongoing worry about future attacks for at least 1 month	A **diagnosable mental health disorder**

What is the main difference between a panic attack and panic disorder?

- A **panic attack** is a single sudden episode of intense fear.
- **Panic disorder** involves **recurrent panic attacks plus persistent worry** about more attacks for at least 1 month.

Panic Attack Exam Tips

- Watch for **"fear of dying" or "going crazy"**—classic panic features
- **Rule out medical causes** like heart problems, asthma, hyperthyroidism
- **Benzodiazepines** are effective but **risk addiction; use short-term**
- **Beta blockers** reduce physical symptoms but avoid if patient has **asthma or COPD**
- SSRIs or SNRIs are **first-line long-term treatment** for panic disorder

Agoraphobia – Simple Explanation:

- Intense fear of **2 or more** places like:
  - Public transport
  - Open spaces (parks, bridges)
  - Enclosed places (shops, theaters)
  - Crowds
  - Being far from home
- Avoids these places because of fear
- Lasts **more than 6 months**
- Causes problems at work or with social life

Generalized Anxiety Disorder (GAD)

- Worry a lot **most days** for **6 months or more**
- Have **3 or more** of these:
    - Feeling restless
    - Feeling tired
    - Trouble concentrating
    - Getting irritated easily
    - Muscle tension
    - Trouble sleeping
- Worry and symptoms affect work or social life

Separation Anxiety Disorder

- Strong fear or worry about being away from home or loved ones
- Happens more than normal and causes distress or problems

OBSESSIVECOMPULSIVE DISORDERS

1. Obsessive-Compulsive Disorder – Obsessions
2. Body Dysmorphic Disorder
3. Trichotillomania
4. Hoarding Disorder
5. Excoriation (Skin-Picking) Disorder

Obsessive-Compulsive Disorder (OCD)

- **Obsessions:** Unwanted, repeated thoughts that cause anxiety
- **Compulsions:** Repeated actions done to ease that anxiety
- Person knows these thoughts and actions are too much
- Causes big distress and disrupts daily life

Body Dysmorphic Disorder

- Obsessively worried about a **flaw in appearance** that others don't see or is minor
- Often checks mirror, grooms, picks skin, compares self, or asks for reassurance
- Causes problems at work or in social life

Trichotillomania

- Repeatedly pulls out hair, causing noticeable hair loss
- Tries but can't stop pulling
- Causes distress or problems in daily life

Hoarding Disorder

- Can't throw away things, no matter their value
- Stuff piles up and clutters the home
- Causes distress or problems in daily life

Excoriation (Skin-Picking) Disorder

- Repeatedly picks skin, causing sores or infections
- Tries but can't stop
- Causes distress or problems in daily life

NEURODEVELOPMENTAL DISORDERS

1. Attention Deficit / Hyperactivity Disorder (ADHD)
2. Autism Spectrum Disorder
3. Tourette's Disorder

ADHD (Attention-Deficit/Hyperactivity Disorder)

- Trouble paying attention or very hyperactive for **6 months or more**, starting before age 12
- **Inattention:** Often careless, distracted, forgetful, avoids tasks, loses things
- **Hyperactivity:** Fidgets, can't sit still, talks a lot, interrupts, restless
- Causes problems at school, work, or home

ADHD — Causes & Treatment (Simple & Organized)

Causes of ADHD

- **Frontal Cortex:** Problems with impulsivity and inattention
- **Basal Ganglia:** Issues with motor control, learning, executive functions, and emotions
- **Reticular Activating System:** Abnormalities affecting alertness
- **Prefrontal Cortex:** Linked to inattentive type ADHD

Treatment

1. Stimulants (First line)

- Increase focus and reduce hyperactivity/impulsivity
- **Check cardiac history – before placing patient on stimulants** (Amphetamines can raise heart rate & blood pressure, risk of heart attack/stroke)
- **Amphetamines:** Approved for children **3 years and older**
- **Methylphenidate (Daytrana patch):** Approved for children **6 years and older**

2. Non-Stimulants

- Used if stimulants aren't suitable or cause side effects
- **Alpha-2 Adrenergic Agonists:**
    - **Guanfacine** and **Clonidine** (FDA-approved for ages 6–17)

- **Atomoxetine (Strattera):**
    - Approved for ages **6 and older**
    - Also acts as an antidepressant

Assessment

It requires you to assess/observe the child in two settings (home, school) before diagnosing the child with ADHD

ADHD Diagnosis: Two Settings Requirement

- Symptoms must be present **in at least two settings**, typically **home and school**
- This ensures symptoms are **not just situational or due to environment**

Common ADHD Assessment Tools

1. **Behavior Rating Scales** (completed by parents, teachers, sometimes the child)
    - **Conners' Rating Scales** (Conners 3)
    - **Vanderbilt Assessment Scales**
    - **Behavior Assessment System for Children (BASC)**
2. **Clinical Interview**
    - Detailed history from parents and child
    - Review developmental, medical, and psychiatric history
3. **Observation**
    - Direct observation of behavior in clinical or school setting

Tourette's Syndrome or Disorder

Tourette's Syndrome = Type of tic disorder Tics = Involuntary, repetitive movements and/or vocalizations

TOURETTE'S SYNDROME OR DISORDER

● AT LEAST 2 MOTOR TICS AND AT LEAST 1 VOCAL (PHONIC) TIC HAVE BEEN PRESENT, NOT NECESSARILY AT THE SAME TIME

● Occurred for > 1 year (frequency can wax/wane)

● Tics started to appear BEFORE 18yo

● Tics are not caused by substance use or other medical condition

○ CHILDREN'S MOTOR TICS ARE FAIRLY COMMON AND CAN BE TEMPORARY

● PRIMARY NEUROTRANSMITTERS INVOLVED = DOPAMINE, Norepinephrine (noradrenaline), Serotonin (DNS) **Dopamine = (hyperactivity of dopamine can cause Tourette)

Pharmacological Treatment of Tourette's Syndrome

● Atypical Antipsychotics

○ **FDA approved medications:**

■ Haloperidol (Haldol)

■ Pimozide (Orap)

■ Aripiprazole (Abilify)

○ Alpha-2 Agonists: Clonidine (Catapres/Kapvay) and Guanfacine (Intuniv) help control behavioral symptoms (impulse control and rage attacks in patients with Tourette)

Dorsolateral Prefrontal Cortex

- Controls **executive functions** like planning, working memory, and problem-solving
- Helps focus and stay on task

Signs of Stimulant Abuse

- Trouble sleeping (insomnia) — if lasts despite sleep meds, suspect abuse if this persists.
- Tremors
- High blood pressure
- Fast heart rate
- Heart palpitations
- Agitation
- Anxiety
- Irritability
- Mood swings
- Elevated mood

Obsessive-Compulsive Disorder (OCD) – Simple Summary

- Involves **anxiety-causing obsessions** (unwanted, repeated thoughts)
- And **compulsions** (repetitive actions to reduce anxiety)
- Linked to brain chemicals **serotonin** and **norepinephrine**
- **Obsessions:** Persistent, intrusive thoughts or urges
- **Compulsions:** Behaviors or mental acts done to relieve obsessions
- Anxiety-provoking obsessions and compulsions (motor tics) that function to reduce
- patient's anxiety level (sudden, repetitive movements)

Risk Factors:

- Family history (first-degree relatives)
- **PANDAS:** Pediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcal infections — sudden OCD symptoms or tics after strep throat infection

Quick Tip:

- **OCD = persistent thoughts + compulsions + motor tics**
- **Tourette's = motor tics only**

Factitious Disorder

- Person **fakes or causes symptoms** (physical or mental) to assume the sick role.
- Examples: contaminating urine, injecting harmful substances.
- **No obvious external reward** (unlike malingering).

Factitious Disorder Imposed on Another

- Someone **makes another person appear sick** by causing or faking symptoms (often a caregiver).
- Report to **Child Protective Services (CPS)** if a child is affected.

Reactive Attachment Disorder (RAD)

- Results from **severe neglect or inconsistent care** in early childhood.
- Child **fails to form healthy emotional bonds** with caregivers.
- Symptoms:
    - Withdrawn, fearful, no emotional response to caregivers
    - Or aggressive and disruptive behavior

Anorexia Nervosa

- Very low body weight (**BMI < 15** requires hospitalization)
- Rapid weight loss (≥ 25% in 3 months), dehydration, or electrolyte problems need hospital care
- Signs:
    - Missed periods (amenorrhea)
    - Very thin (emaciation)
    - Slow heart rate (bradycardia)
    - Low blood pressure (hypotension)
- **If minor's parents refuse treatment or hospitalization, report to Child Protective Services (CPS)**

Exam Tips:

- Hospitalization needed for **medical instability or severe weight loss**
- Watch for **electrolyte imbalances** that can cause heart problems
- **Amenorrhea** is common but not required for diagnosis anymore
- **CPS involvement** is important if guardians refuse necessary treatment for minors

Autism Spectrum Disorder (ASD)

- Doesn't respond when called by name
- Little or no verbal communication
- Little or no eye contact
- Lines up, stacks, or organizes toys in long, tidy rows

Broken Mirror Theory of Autism

- Dysfunction in **mirror neuron system** may cause social and cognitive difficulties

Assessment Tools for Autism

- **Modified Checklist for Autism in Toddlers (M-CHAT)** – screening tool for young children

- **ADOS-G (Autism Diagnostic Observation Schedule – Generic):**
  A **standardized observational tool** used by clinicians to assess and diagnose autism spectrum disorders. It involves **structured and semi-structured tasks** that prompt communication, social interaction, and play.
- **ASQ (Ages and Stages Questionnaire):**
  A **developmental screening tool** completed by parents. It evaluates communication, gross motor, fine motor, problem-solving, and personal-social skills for children between **1 month and 5½ years** old.

Example in Clinical Context (for mental status exam in preschoolers):

In preschoolers (ages 3–5), formal testing like the MMSE isn't appropriate. Instead, clinicians rely on tools like the **ASQ** and **clinical observation**. The **ADOS-G** may be used if there is concern for **autism**.

Question:
A 4-year-old is brought in for evaluation due to concerns about poor eye contact, delayed speech, and lack of interest in peers. The PMHNP wants to assess for developmental delay and autism spectrum disorder. Which tools would be most appropriate to use in this evaluation?

A. MMSE and PHQ-9
B. MOCA and Vanderbilt ADHD Rating
C. ASQ and ADOS-G
D. GAD-7 and Beck Depression Inventory

Correct Answer: C. ASQ and ADOS-G

Rationale:
The **ASQ** is a parent-completed developmental screening tool for young children. The **ADOS-G** is a gold standard observational tool used for autism assessment. MMSE and MOCA are used for adult cognition, while GAD-7 and BDI are for anxiety/depression, not autism or developmental delays.

Exam tips

- Patient with irritable, depressed, liable moods, administer **MOOD QUESTIONAIRRE**
- For sleep disturbances (nightmares), assess **family/genetic history**

Major Depressive Disorder (MDD)

- Caused by imbalance of brain chemicals: **Dopamine, Norepinephrine, Serotonin (DNS)**

- Older adults with MDD can have **memory and thinking problems** called **pseudodementia**
- **Pseudodementia** looks like dementia but starts suddenly and is linked to depression
- **Dementia** causes slow, gradual memory loss and confusion over months/years
- MDD patients often say "**I don't know**," while dementia patients may **confabulate or lack answers**
- Important to **screen cognition** in older adults with depression
- Older adults may also show **irritability, agitation, hallucinations, or delusions** with MDD

Delirium

- Sudden onset (hours to days)
- Confused awareness and trouble paying attention
- Changes in thinking and concentration
- Often caused by medical illness or drugs (check urine for infection)
- Poor outlook (40% die within 1 year)

Treatment:

- Control agitation and psychosis
- **Haloperidol (Haldol)** is preferred
- Atypical antipsychotics can be used
- Benzodiazepines help only in alcohol-related delirium

Delirium vs Dementia — Key Differences

Feature	Delirium	Dementia
Onset	Sudden (hours to days)	Slow, gradual (months to years)
Attention	Poor, fluctuates throughout day	Usually, intact early on
Level of Consciousness	Altered, may fluctuate	Usually normal until late stages
Course	Fluctuating symptoms can improve	Progressive, steady decline
Cause	Medical illness, drugs, infection	Neurodegenerative (Alzheimer's, etc.)
Prognosis	Potentially reversible if treated	Usually, irreversible

Exam Tip:
If a patient is suddenly confused with poor attention and altered consciousness, think **delirium** first. Dementia is more gradual and steadier.

Dementias

To give consent: Dementia pts should be able to **repeat the risks & benefits** of the procedures, state the **alternatives**,

Do not give w/antipsychotics or benzos

Alzheimer's	Most common Amyloid deposits
Vascular	Common in men, **CV disease**, carotid bruits, fundoscopic abnormalities, enlarged cardiac chambers
Picks disease	Early: Personality & behavior changes Late: cognitive changes Sx: Hypersexual, hyperorality, placidity
CJ (mad cow)	Initial: Flu-like sx, fatigue, cognitive issues Later: aphasia, apraxia, labile, depression, MANIA, blindness, fatal within 6 months
HIV dementia	CBM Early: **depression**, apathy, **forgetfulness** Late: Cognitive (memory, reasoning, conc etc. Personality/behavior/speech problems Motor: clumsiness, poor balance. MUTISM, HALLUCINATIONS Treat w/ antiretroviral 1st
Lewy body	Visual hallucination, Parkinson sx- cogwheel rigidity, bradykinesia, tremor **Avoid antipsychotic**.
Huntingtons	Choreoathetoid movement Depression and psychosis GENETIC component,

Dementia	Pseudodementia
Insidious onset	Sudden onset
Slow progression	Rapid progression
Confabulates	I don't know;
Incongruent of affect	Depressed mood
Low suicide risk	High suicide risk

Dementia Types & Key Features

1. Cortical Dementia

- Affects outer brain layers (cortex)
- Memory & language problems (Alzheimer's)
- Memory and language problems: amnesia, aphasia, apraxia, agnosia
- Examples: Alzheimer's disease, Creutzfeldt-Jakob disease

2. Subcortical Dementia

- Affects areas beneath cortex
- Mood symptoms: depression, irritability, apathy
- Motor symptoms: poor coordination, dystonia, tremors
- Mood & movement issues (Parkinson's, Huntington's, HIV dementia)
- Examples: HIV dementia, Huntington's disease, Parkinson's disease

Specific Dementias

- **HIV Dementia** (subcortical)
  - Early: cognitive decline, motor & behavior problems
  - Late: mutism, seizures, hallucinations, mania
- **Lewy Body Disease**
  - Visual hallucinations
  - Parkinson-like symptoms (slow movement, tremor)
  - Sensitive to typical antipsychotics (use cautiously)
- **Pick's Disease (Frontotemporal Dementia)**
  - Early: personality & behavior changes, language problems
  - Late: cognitive decline, inappropriate social behavior
  - Kluver-Bucy syndrome: hypersexuality, excessive eating, calmness
- **Huntington's Disease**
  - Subcortical dementia with choreoathetoid movements
  - Psychomotor slowing, depression, psychosis
  - Onset usually 30–45 years, hereditary

Important Notes

- **PMHNPs treat psychosis symptoms only**
- **Refer to neurology for dementia management**
  Psychosis & Agitation in Dementia:
  - Try **non-drug therapies first**
  - If needed, use **atypical antipsychotics** at lowest dose

    - Avoid **benzodiazepines** (cause sedation, falls, delirium)
- **PMHNP role:** Treat psychosis symptoms only; refer for dementia care

Limbic System – Key Parts & Functions

Brain Part	Main Functions
Amygdala	Controls emotions (fear, anger, anxiety, aggression); linked to trauma
Hippocampus	Memory formation (short-term → long-term); regulates emotions, stress, motivation, learning
Hypothalamus	Regulates hunger, thirst, satiety, water balance, body temperature, sleep cycles, hormones, libido
Thalamus	Sensory relay station (except smell); prevents sensory overload; regulates emotions and memory
Anterior Cingulate	Involved in decision-making, empathy, impulse control, emotions
Cerebellum	Maintains balance and posture

Balance Tests

Romberg Test

- Purpose: Assess balance and coordination
- Procedure: Patient stands with feet together, first **eyes open**, then **eyes closed** for 30 seconds
- Interpretation:
    - **Negative Romberg (Normal):** Patient remains steady
    - **Positive Romberg:** Patient sways or loses balance, indicating a balance problem

Trendelenburg Test

- Purpose: Assess for hip muscle weakness or dysfunction

BORDERLINE PERSONALITY DISORDER

● **Recurrent suicidal behavior**
● **Self-harming behavior**
● **Fear of abandonment**
● **Rejection sensitivity**
● **PATTERN OF UNSTABLE/INTENSE INTERPERSONAL RELATIONSHIPS**
● **GIVE LITHIUM** for symptoms of:
○ **IRRITABILITY**
○ **ANGER**
○ **SELF HARMING BEHAVIOR**

● **GIVE DEPAKOTE** for symptoms of:
○ **DEPRESSED MOOD**
○ **EMOTIONAL LABILITY**

○ **INTERPERSONAL PROBLEMS**
○ **REJECTION SENSITIVITY**
○ **AGGRESSION**
○ **HOSTILITY**

Journaling or diary of symptoms is used in the process of the diagnosing for borderline personality disorder.

Dialectical Behavioral Therapy (DBT)
● **MARSHA LINEHAN**
● Used for borderline personality disorder.
● DBT decrease suicidality in patient with borderline personality disorder

SCHZOID PERSONALITY DISORDER
● Voluntary social isolation
● Indifferent to other people: shows an apparent lack of care in relation to how others perceive them
● Shows little to no interest in sexual activity with another person
● Derives no pleasure in social activities
● Lack close friends or social support
● Appears cold and detached
● Exhibits affective flattening

SCHIZOTYPAL PERSONALITY DISORDER
● Have interpersonal difficulties and social anxiety
● Few or no close friends
● Odd beliefs
● Ideas of reference
● Magical thinking
● Unusual perceptual experiences
● Paranoid ideation
● Inappropriate or constricted effect
● Behavior overtly odd

CONVERSION DISORDER
● Mental condition in which a person has blindness, mutism, **PARALYSIS, OR PARESTHESIA (GLOVE STOCKING SYNDROME)** other neurological symptoms that cannot be explained by medical evaluation.
● Symptoms usually begin SUDDENLY after stressful experience.
Therapy is mainstay: CBT, physical therapy can help with conversion disorder

Oppositional Defiant Disorder (ODD)
● **VERBAL assault, EMOTIONAL (defiant)

● Diagnosed in children (6-17yo)
● It is an enduring pattern of angry or irritable mood AND argumentative, defiant, or vindictive behavior lasting at **LEAST 6 MONTHS WITH AT LEAST FOUR OF THE**

ASSOCIATED SYMPTOMS:
○ Loses temper
○ Touchy or easily annoyed
○ Angry or resentful
○ Argues with authority
○ Actively defies or refuses to comply with request or rules from authority figures (defiant)
○ Blames others
○ Deliberately annoys others
○ Spiteful or vindictive
○ **NOT PHYSICALLY AGGRESSIVE

Non-Pharmacological Treatment of ODD
● **FAMILY THERAPY, WITH EMPHASIS ON CHILD MANAGEMENT SKILLS: TEACHING PARENTS ABOUT POSITIVE REINFORCEMENT AND BOUNDARY SETTING**
● Evidence-based treatment = Child and parent problem-solving skills training
● Adolescent Transition Program

CONDUCT DISORDER
● **PHYSICAL assault, AGGRESSION, NO REMORSE
● Diagnosed in children (6-17yo)
● Repetitive and persistent pattern of behavior in which the rights of others or societal norms or rules are violated
● 3 or more symptoms For at least 12 months (1 symptom must be present in the last 6 months):
o **AGGRESSION TOWARD PEOPLE OR ANIMALS**
o Physical fights (bullies, threatens, intimidates, or initiates violence)
o Physical harm to others (uses weapon to cause harm or is physically cruel)
o Forced sexual activity on someone
o Destruction of property (fire setting, destroying people's property/things)
o Deceit or theft (breaking into house/building/cars, lying, stealing)
o **LACK OF REMORSE**

Pharmacological Treatment of Conduct Disorder
● **TARGET MOOD AND AGGRESSION**
● Antipsychotics, Mood Stabilizers, SSRIs, and Alpha Agonists (Clonidine and Guanfacine)
Non-pharmacological: Behavioral therapy

ADJUSTMENT DISORDER

● Emotional or behavioral reaction to a stressful event or changes in person's life. Unhealthy or excessive response that occurs **WITHIN 3 MONTHS OF IT HAPPENING**
● Example = Family moving, divorce/separation, loss of pet/loved one, birth of sibling, sudden illness/medical diagnosis, chronic illness/medical diagnosis, illness of child
○ **Adjustment Disorder with DEPRESSED MOOD = PRESENTS WITH FEELINGS OF SADNESS, DECREASED INTEREST, SLEEP DISTURBANCE, APPETITE CHANGES**
○ Adjustment Disorder with ANXIETY = Restlessness, nervousness, lack of concentration
○ Adjustment Disorder with MIXED ANXIETY AND DEPRESSION = Symptoms of BOTH depressed mood and anxiety
○ Adjustment Disorder with DISTURBANCE OF CONDUCT = May violate people's rights, social norms, rules (Example = Not going to school, destroying property, driving recklessly, fighting)
○ **Adjustment Disorder with MIXED DISTURBANCE OF EMOTIONS AND CONDUCT = A CHILD HAS A MIX OF SYMPTOMS FROM ALL OF THE ABOVE SUBTYPES. FOR EXAMPLE, CHILD MAY PRESENT WITH TRUANCY, PEER CONFLICT, VERBAL ALTERCATION, INSOMNIA, FREQUENT CRYING.**

ACUTE STRESS DISORDER

● Acute stress disorder is a psychiatric diagnosis that may occur in a patient within 4 WEEKS OF A TRAMATIC EVENT. Features include:
○ Anxiety
○ Insomnia
○ Poor concentration
○ Intense Fear
○ Helplessness
○ Reexperiencing the event
○ Avoidance behaviors

Symptoms of acute stress disorder last between 3 days and 4 weeks, while symptoms of PTSD must last for at least a month and may persist for several years.

POST-TRAUMATIC STRESS DISORDER (PTSD)

- Reexperiencing **an extremely traumatic event**
- **Symptoms of increased arousal (hyperarousal)**
- **Symptoms of avoidance of stimuli associated with trauma**

Pharmacological Treatment of PTSD (p. 224)

- SSRIs and TCAs
- **Prazosin for nightmares**

Non-Pharmacological Treatment of PTSD (p. 224)

● EMDR (Eye Movement Desensitization and Reprocessing) **PHASES = DIB**
○ Goal = Achieve adaptive resolution
○ **DESENSITIZATION PHASE (1st)**
Visualize trauma (exposure)
Verbalize negative thoughts or maladaptive beliefs.
Remain attentive to physical sensations.
Occurs for limited time while the patient maintains rhythmic eye movements.
Patient is instructed to block out negative thoughts, breathe deeply, and verbalize what they are thinking/feeling/imagining
○ **INSTALLATION PHASE (2nd)**
Patient installs positive thoughts and increases strength of positive thoughts (cognitive therapy)
Positive thoughts will eventually REPLACE the original negative thought(s)
○ **BODY SCAN (3rd)**
Patient visualizes the trauma along with the positive thoughts (associate trauma with positive rather than negative thoughts without any tension present)
Scan body mentally to identify any tension within