# Review of Common Psychiatric Disorders: Diagnosis and Management

**Todd M. Antin, M.D.**  
Chief of Psychiatry, Dekalb Medical Center

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## Mental Status Examination

<table>
<thead>
<tr>
<th>Component</th>
<th>Description</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appearance</td>
<td>Nausea, vomiting</td>
<td>Patient is poorly nourished</td>
</tr>
<tr>
<td>Orientation</td>
<td>Patient is oriented to place and time</td>
<td>Patient is oriented to place and time</td>
</tr>
<tr>
<td>Speech</td>
<td>Speech pressured and loud</td>
<td>Speech is pressured and loud</td>
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<tr>
<td>Thought Process</td>
<td>Patient exhibited flight of ideas</td>
<td>Patient exhibited flight of ideas</td>
</tr>
<tr>
<td>Thought Content</td>
<td>Patient reports command auditory hallucinations</td>
<td>Patient reports command auditory hallucinations</td>
</tr>
<tr>
<td>Thought Content</td>
<td>Patient reports delusions of grandeur and persecution</td>
<td>Patient reports delusions of grandeur and persecution</td>
</tr>
<tr>
<td>Thought Process</td>
<td>Thought is circumstantial, tangential, derailment</td>
<td>Thought is circumstantial, tangential, derailment</td>
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<tr>
<td>Thought Process</td>
<td>Thought is pressured and loud</td>
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</tbody>
</table>

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## Multiaxial Assessment

**Axis I** - Clinical Disorders, Other Conditions That May Be a Focus of Clinical Attention.  
**Axis II** - Personality Disorders, Mental Retardation  
**Axis III** - General Medical Conditions  
**Axis IV** - Psychosocial and Environmental Problems  
**Axis V** - Global Assessment of Functioning
Disorders of Cognition

Dementia: chronic state of cognitive impairment in which memory and at least one of the following (language, physical activity, social or occupational functioning) are impaired.

Delirium: acute state of cognitive impairment in which memory and attention are impaired.

Disorders of Cognition – Differences - 1

<table>
<thead>
<tr>
<th>SYMPTOM</th>
<th>DEMENTIA</th>
<th>DELIRIUM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Course &amp; duration</td>
<td>Chronic &amp; irreversible</td>
<td>Acute &amp; reversible</td>
</tr>
<tr>
<td>Memory impairment</td>
<td>Impaired</td>
<td>Impaired</td>
</tr>
<tr>
<td>Language reception</td>
<td>Impaired over time</td>
<td>✓</td>
</tr>
<tr>
<td>Language production</td>
<td>Impaired over time</td>
<td>✓</td>
</tr>
<tr>
<td>Alertness</td>
<td>Alert</td>
<td>Fluctuating</td>
</tr>
<tr>
<td>Agitation</td>
<td>Variable</td>
<td>Variable</td>
</tr>
<tr>
<td>Causes</td>
<td>Degenerative (AD)</td>
<td>Medications (sedatives, anxiolytics)</td>
</tr>
<tr>
<td></td>
<td>Infection (HIV)</td>
<td>Infection (acneulitic, UTI, HIV)</td>
</tr>
<tr>
<td></td>
<td>Nutritional (B12)</td>
<td>Hypovolemia</td>
</tr>
<tr>
<td></td>
<td>Vascular (Strokes)</td>
<td>Hyper/hypoglycemia</td>
</tr>
<tr>
<td></td>
<td>Substance (ETOH)</td>
<td>Hypertension</td>
</tr>
<tr>
<td></td>
<td>Metabolic</td>
<td>Substance (intoxication &amp; withdrawal)</td>
</tr>
</tbody>
</table>

Disorders of Cognition – Differences - 2

<table>
<thead>
<tr>
<th>SYMPTOM</th>
<th>DEMENTIA</th>
<th>DELIRIUM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most common causes</td>
<td>Alzheimer’s Disease</td>
<td>UTI &amp; Medications</td>
</tr>
<tr>
<td>Diagnostic work-up</td>
<td>Clinical impression, Brain image (CT, MRI), EEG</td>
<td>Clinical impression, Brain image (CT), EEG, Electrolytes, Blood count, Urinalysis</td>
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<tr>
<td></td>
<td>Thyroid profile, Electrolytes</td>
<td>Blood count, Urinalysis</td>
</tr>
<tr>
<td></td>
<td>Blood count, Urinalysis</td>
<td>Tic, Screen, Drug Screen, RPR</td>
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<tr>
<td></td>
<td>B12, RBC, Folate</td>
<td>RPR</td>
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<tr>
<td>Treatment</td>
<td>Medical (antidepressants)</td>
<td>Find the source and treat the underlying problem</td>
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<tr>
<td></td>
<td>Pharmacological (antidepressants)</td>
<td>Line done (Valproic, Risperidone)</td>
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<td></td>
<td>Surgical (brain surgery)</td>
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<td></td>
<td>Behavioral (psychological, physiotherapy)</td>
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<td>Psychological (counseling, therapy)</td>
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<td>Patient (education, support)</td>
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<tr>
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<td>Family (education, support)</td>
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<td>Social (education, support)</td>
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<td>Community (education, support)</td>
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<td>Legal (education, support)</td>
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<td></td>
<td>Vocational (education, support)</td>
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</tbody>
</table>

Emory University Physician Assistant Program
**Substance Abuse Disorders**

**Substance Abuse:** recurrent substance use resulting in significant adverse consequences within a 12 month period (e.g. legal, health, occupational & social problems)

**Substance Dependence:** recurrent substance use resulting in tolerance, withdrawal, and/or compulsive drug-taking behavior in addition to the adverse consequences listed for substance abuse.

### Substances

<table>
<thead>
<tr>
<th>Substance</th>
<th>Alcohol</th>
<th>Cocaine</th>
<th>Amphetamines</th>
<th>Opiates</th>
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<tbody>
<tr>
<td>Danger in overdose</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
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<tr>
<td>Danger in withdrawal</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
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<tr>
<td>Physical dependence</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
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<tr>
<td>Effect on body</td>
<td>Brain, liver</td>
<td>Brain, heart</td>
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<tr>
<td>Effect on consciousness</td>
<td>Stimulant/ sedative</td>
<td>Stimulant</td>
<td>Stimulant</td>
<td>Sedative</td>
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<tr>
<td>Treatment in overdose</td>
<td>Supportive, hydration</td>
<td>Supportive</td>
<td>Supportive, Beta blocker</td>
<td>Naloxone</td>
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<td>Treatment for addiction</td>
<td>Beta blocker, Antidepressants, Antipsychotics, Antianxiety (if applicable)</td>
<td>Supportive</td>
<td>Supportive, Naloxone (if applicable)</td>
<td>Antihistamines, Antiepileptics, Anticonvulsants, Antipsychotics</td>
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</tbody>
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**Substance Abuse Disorders**

**Substance Abuse:** recurrent substance use resulting in significant adverse consequences within a 12 month period (e.g. legal, health, occupational & social problems)

**Substance Dependence:** recurrent substance use resulting in tolerance, withdrawal, and/or compulsive drug-taking behavior in addition to the adverse consequences listed for substance abuse.
**Schizophrenia and Psychotic Disorders - 1**

**Psychosis**: Altered reality testing taking form of hallucinations, illusions, delusions, and/or gross disorganization.

**Schizophrenia**: Two or more of the following symptoms over a one month period: (delusions, hallucinations, disorganized behavior, disorganized speech, negative symptoms). Symptoms cause problems in social/occupational functioning. Overall course must be at least 6 months.

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**Schizophrenia and Psychotic Disorders - 2**

Subtypes of schizophrenia:
1. Paranoid.
2. Disorganized
3. Catatonic
4. Undifferentiated
5. Residual

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**Schizophrenia and Psychotic Disorders - 3**

Medications for treatment of schizophrenia and psychosis: Antipsychotics - Typical and atypical

Occurs 1 - 2% of world population. Inherited disorder but may be influenced by environmental factors.
**Schizophrenia and Psychotic Disorders - 4**

Differential diagnosis of psychotic disorders:
- Schizophrenia, Schizophreniform
- Schizoaffective Disorder
- Brief Psychotic Disorder
- Delusional Disorder
- Mood Disorder with Psychotic Features
- Substance Induced Psychotic Disorder
- Dementia, Delirium
- Axis II pathology (schizoid, schizotypal, paranoid personality disorders).

**Mood Disorders**

**Major Depressive Disorder**

Symptoms present for at least 2 weeks nearly all the time. Must include depressed mood OR anhedonia (loss of interest or pleasure). 5 of 9 symptoms required:
- Depressed mood.
- Anhedonia.
- Sleep disturbance.
- Guilt.
- Energy decreased.
- Concentration decreased.
- Appetite change.
- Suicidal thoughts.
- Remember: SIG E CAPS

**Medications for treatment of depression:**

- SSRIs
- Atypical antidepressants
- TCAs
- MAOIs
**Differential diagnosis of major depression**

- Dysthymic Disorder
- Bipolar I/II Disorder
- Anxiety Disorders
- Schizoaffective Disorder
- Substance Induced Mood Disorder
- Mood Disorder due to General Medical Condition
- Bereavement
- Medical Illness

**Bipolar Disorder**

**Bipolar I Disorder**: one or more episodes of mania with/without episodes of major depression

**Bipolar II Disorder**: one or more episodes of hypomania with one or more episodes of major depression

**Hypomania**: Period of elevated or irritable mood lasting at least 4 days accompanied by 3 or more of the following:
- Grandiosity or inflated self-esteem.
- Decreased need for sleep.
- Rapid or pressured speech.
- Flight of ideas or racing thoughts.
- Grandiosity.
- Increased goal-directed activity.
- Excessive involvement in pleasurable activities.

**Mania**: Symptoms more severe than hypomania and resulting in marked impairment in social or occupational functioning. Must last at least 7 days unless hospitalized before or psychotic symptoms are present.

**Treatments for Bipolar Disorder**

- Mood stabilizers: Eskalith, Eskalith CR, Lithobid, Lithane, Carbolith and Duralith (Lithium), Depakote (sodium divalproex), Depakene, Depakote ER, Tegretol (carbamazepine), Lamictal, Lamotrigine, Topamax (topiramate), Equetro
- Cautious use of antidepressants
- Atypical antipsychotics

Inherited disorder with 1-2% of world population affected.

50% of patients have comorbid substance abuse disorders.

15% lifetime suicide rate.
Anxiety Disorders

Phobias: excessive or unreasonable fear.
Specific Phobia: fear is cued by specific objects or situations (e.g. spiders, heights, closed spaces).
Social Phobia: fear is cued by being observed by others (e.g. public speaking, eating, writing, public urination).
Agoraphobia: fear of an inability to escape situations outside the home (e.g. standing in line, traveling on a plane).
Treatment of phobias:
- Cognitive-behavioral therapy
- Antidepressants
- Benzodiazepine (with extreme caution for short periods).

Panic Disorder

Panic Attack: short periods of intense fear and physical discomfort reaching a peak in 10 minutes and lasting less than an hour. Includes 4 of the following:
- Palpitations, sweating, trembling or shaking, shortness of breath, choking sensation, chest pain, nausea, dizziness, derealization. Fear of going crazy, fear of dying, tingling in arms or legs, chills or hot flushes

Panic Disorder = attacks occurring without warning and cause worry about recurrence or consequences of the attacks.
Treatment of panic disorder:
- Cognitive-behavioral psychotherapy
- Antidepressants
- Benzodiazepines (with extreme caution for short term use).

Obsessive-Compulsive Disorder (OCD)

Obsession: recurrent and intrusive unwanted thoughts (e.g. fear of germs).
Compulsions: repetitive actions to alleviate anxiety (e.g. hand washing).
OCD = recurrent obsessions OR compulsions which interfere with daily functioning.
Treatment of OCD
- SSRI-type antidepressants are treatment of choice.
**Personality Disorders**

Coded with mental retardation on Axis II
Composed of three clusters: A, B, & C
- **Cluster A:** Paranoid, Schizoid, & Schizotypal
- **Cluster B:** Narcissistic, Borderline, Antisocial, Histrionic
- **Cluster C:** Avoidant, Dependent, Obsessive-Compulsive
Patients are frequently not bothered by the disorders (ego-syntonic) and they don't generally bring them to treatment. Instead, they present for treatment of other problems such as depression or anxiety which may be complicated by the presence of the personality disorders.

**Treatment of personality disorders:**
Difficult, many therapeutic approaches tried. DBT is a new technique. Use medication to treat comorbid Axis I disorders (depression, anxiety, impulse control, psychosis).

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**Psychiatric Emergencies**

**Suicide**

One of the most serious problems confronting psychiatric patients. Hospitalization: Serious consideration must be given to hospitalize suicidal patients even against their will. Most states have laws which address involuntary hospitalization.

**Risk Factors:**
- Age: elderly with smaller rise in adolescence.
- Gender: male more likely to complete, female more likely to attempt.
- Race: Native American, white, fewer African-Americans.
- Marital Status: divorced, single, widowed
- Religion: Protestant>Catholic>Jewish
chronic medical illness, previous attempts, family history of suicide depression, substance abuse, readily available firearms social isolation/recent stressors/recent death

**Assessment of suicide attempt**
- Lethality: how likely method is to result in death
- Intentionality: how badly patient wanted attempt to succeed.

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**Homicidality and Dangerousness**

**Hospitalization:** Serious consideration must also be given to hospitalize homicidal patients even against their will.

**Tarasoff Ruling:** Clinicians are required to make a good faith effort to notify intended victims of a homicidal patient. If unable to notify intended victim, then local authorities should be notified.

**Treatment of aggression and agitation:** Judicious use of antipsychotics and benzodiazepines may be necessary to prevent harm to patient or others.
**Eating Disorders - 1**

**Anorexia Nervosa:** a refusal or inability to maintain weight at 85% of ideal body weight; in women, cessation of menstrual cycling is also required. Body image and control issues are prominent. Appetite is usually normal (i.e. patients are hungry but refuse to eat). Weight reduction can be achieved by decreased intake, purging, or excessive exercise.

**Treatment of Anorexia Nervosa:**
- Difficult, long term psychotherapy often warranted.
- May require hospitalization when medically compromised.
- Behavioral plans may be helpful.
- Fluoxetine (Prozac) may be helpful at high doses. Avoid bupropion.
- Appetite inducing medications do NOT work.

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**Eating Disorders - 2**

**Bulimia Nervosa:** periods of binge eating interspersed with periods of compensatory behaviors including dieting, purging, and excessive exercise. Body image distortions are also prominent. Weight is usually normal to slightly obese.

**Treatment of Bulimia Nervosa:**
- Antidepressant therapy (especially Prozac).
- Behavioral plan.
- Cannot recommend appetite suppressant therapy.
- IOP/PHP may be helpful.

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**Eating Disorders - 3**

**Binge Eating Disorder:** periods of binge eating without extreme compensatory behavior. Make up 50% of visitors to weight loss clinics. No significant body image distortions.

**Treatment of Binge eating disorder:**
- Similar to treatment of bulimia nervosa.
Antianxiety Agents

Major Classes
- Benzodiazepines
- Antihistamines
- Buspirone
- Barbiturates

Antianxiety Agents

Benzodiazepines (BZD)

- Treat: insomnia, agitation, alcohol withdrawal, seizures, amnestic/anesthetic agents during medical procedures.
- BZDs have largely replaced the barbiturates due to their improved safety. While very effective, BZDs may produce psychological and physical dependency with prolonged use.
- The BZDs with the highest addiction potential are those which have: Rapid onset (Xanax, Valium) and shorter duration of action (Xanax)
- Patients will occasionally "doctor shop" to get more medication than their physician intends.
- Failure to taper BZDs once physical dependency occurs can result in dangerous/fatal withdrawal syndrome including trembling, anxiety, status epilepticus.
- Metabolism: BZDs are all eliminated by the liver. Patient with liver problems may better tolerate lorazepam (Ativan) or oxazepam (Serax) which are more easily metabolized by the liver.

Antianxiety Agents

Benzodiazepines (BZD)

Lorazepam (Ativan) is perhaps the most versatile of the BZDs as it may be administered by various routes, has an intermediate duration of action, and is easily metabolized.
- When combined with alcohol, narcotics, and/or other medication, the effect of the BZD may be additive or synergistic.
- BZD with longer half-lives may accumulate and be especially troublesome for the elderly and the demented.
- Overdose may be treated with flumazenil (Mazicon); however, this may induce withdrawal in dependent patients. Death by overdose of BZDs alone is rare but when it occurs it is by CNS depression.
- BZDs are teratogenic and should not be used in pregnancy.
**Antianxiety Agents**

**Antihistamines**

These medications have varied uses including: insomnia, allergic reactions, and the side affects of antipsychotics. Because they are anticholinergic, they pose special problems for the elderly and demented. Other prominent side effects are drowsiness, weight gain, dry mouth and nasal passages. Commonly used antihistamines include: diphenhydramine (Benadryl), hydroxyzine (Vistaril, Atarax). Antihistamines are not considered especially dangerous in overdose but should be avoided in pregnancy.

**Antianxiety Agents**

**Buspirone (BuSpar)**

An atypical antianxiety agent with a very low side affect profile. Uses include anxiety and perhaps the reversal of SSRI induced sexual side affects. Onset of action is delayed over several weeks in contrast to BZDs. NOT useful for panic disorder or for insomnia.

**Antimanic Agents (Mood Stabilizers)**

**Major Agents:**
- lithium (ex. Lithobid)
- sodium divalproex (Depakote)
- carbamazepine (Tegretol)

Other agents: clonazepam (Klonopin), gabapentin (Neurontin), lamotrigine (Lamictal), and the atypical antipsychotics (as a class).
Antimanic Agents (Mood Stabilizers) - Lithium

Along with Depakote (sodium divalproex), it is a first-line treatment for acute mania.
Useful as prophylactic mood stabilizer and as an antidepressant.
Also used as an adjunctive booster to other antidepressants.
Narrow therapeutic window: patients easily become toxic if dehydrated or with even small overdoses.
Multiple tests required before initiating (CBC, Chem-7, TSH, EKG, and BetaHCG).
Side effects may be severe and include tremor, weight gain, acne, polyuria, polydipsia, GI distress, hypothyroidism, leukocytosis.
Symptoms of toxicity include tremor, ataxia, slurred speech.
Category X in pregnancy due to risk of heart defects in first trimester.
Metabolism: NONE. Excreted unchanged by kidneys.
Side effects may be severe and include tremor, weight gain, acne, polyuria, polydipsia, GI distress, hypothyroidism, leukocytosis.
Symptoms of toxicity include tremor, ataxia, slurred speech.
Category X in pregnancy due to risk of heart defects in first trimester.
Metabolism: NONE. Excreted unchanged by kidneys.

Antimanic Agents
Carbamazepine (Tegretol)

Second line treatment for acute mania.
Used as a prophylactic mood stabilizer, anticonvulsant, and for neuropathic pain.
Difficult to achieve stable blood levels due to autoinduction of metabolic enzymes.
Multiple tests required before initiating (CBC, Hepatic profile, BetaHCG).
Side effects include nausea, GI distress, agranulocytosis, and chemical hepatitis.
One of the medications with the greatest number of drug-drug interactions due to its prominent effect on metabolic enzymes.
Category X in pregnancy due to significant risk of neural tube defects such as spina bifida.
Metabolism by liver.

Antimanic Agents
Olanzapine (Zyprexa)

FDA indication for acute mania.
Weight gain, sedation, possible Type 2 diabetes and hyperlipidemia possible (Metabolic syndrome). Also, tardive dyskinesia must be addressed.
quetiapine (Seroquel), risperidone (Risperdal, Risperdal Consta), ziprasidone (Geodon), clozapine (Clozaril)
Antipsychotic Agents
(Neuroleptics, Major Tranquilizers)

Used to treat acute psychosis (of various etiologies). Also used to treat acute agitation, Tourette’s Disorder, chronic hiccups and nausea.
All have potential to produce tardive dyskinesia. Other side effects include sedation, weight gain, reduced seizure threshold, etc.
Side effects of high potency agents may be offset by anticholinergic medications including diphenhydramine (Benadryl) or benztropine (Cogentin).
Haldol may be most versatile in that it is available in oral tablets, oral concentrate, decanoate, and short-term IM/IV formulations.
Neuroleptic Malignant Syndrome (NMS) is a potentially life-threatening complication.

Comparison of Typical Antipsychotics

<table>
<thead>
<tr>
<th>Complementary Effects</th>
<th>Low Potency</th>
<th>Medium Potency</th>
<th>High Potency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anticholinergic</td>
<td>Dry mouth, urinary retention, delirium, constipation</td>
<td>**</td>
<td>+</td>
</tr>
<tr>
<td>Antihistaminic</td>
<td>Sedation, weight gain</td>
<td>**</td>
<td>+</td>
</tr>
<tr>
<td>Antidopaminergic</td>
<td>Parkinsonism, dystonias</td>
<td>**</td>
<td>+</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Examples</th>
<th>Chlorpromazine Thoridazine</th>
<th>Loxapine Perphenazine</th>
<th>Haloperidol Fluphenazine Thiothixene Trifluoperazine</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relative Potency</td>
<td>100 mg.</td>
<td>10 mg.</td>
<td>1 mg.</td>
</tr>
</tbody>
</table>

Antipsychotic Agents
Atypical Antipsychotics

Major agents:
- Clozapine (Clozaril)
- Risperidone (Risperdal)
- Olanzapine (Zyprexa)
- Quetiapine (Seroquel)
- Ziprasidone (Geodon)
- Aripiprazole (Abilify)

Advantages include lower risk of tardive dyskinesia and dystonias, ability to treat positive and negative symptoms of schizophrenia, and perhaps decreased likelihood of developing NMS.
Disadvantages include cost, oral dosing only.
Clozaril requires weekly to biweekly blood testing to ensure early detection of potential agranulocytosis. If this develops, Clozaril must be STOPPED.
Antidepressant Agents

Tricyclic Antidepressants.  
Selective Serotonin Reuptake Inhibitors (SSRIs).  
MAO Inhibitors.  
Atypical Antidepressants.

Antidepressant Agents
Tricyclic Antidepressants (TCAs)

Useful in the treatment of depression, OCD, panic disorder, neuropathic pain, migraines, insomnia.  
Most commonly used TCAs are amitryptyline (Elavil), nortriptyline (Pamelor), and imipramine (Tofranil).  
Clomipramin (Anafranil) is most commonly used for OCD.  
Dangerous in toxicity with an LD50 of 2000 mg.  
Causes of death in toxicity include cardiac arrhythmias, status epilepticus, and respiratory depression.  
50% of patients who die in overdose present with stable vital signs in the emergency room.  Patient MUST be admitted and placed on cardiac telemetry until at least 48 hours AFTER drug levels have returned to normal range.

Antidepressant Agents
Selective Serotonin Reuptake Inhibitors (SSRIs) - 1

Useful in the treatment of depression, panic disorder, anxiety, OCD, bulimia, nervosa, possibly anorexia nervosa, neuropathic pain.  
Agents available in the U.S. include fluoxetine (Prozac), paroxetine (Paxil), sertraline (Zoloft), fluvoxamine (Luvox), citalopram (Celexa), and escitalopram (Lexapro).  Lexapro has the fewest drug-drug interactions of the SSRIs and may have fewer sexual side effects at therapeutic doses than other SSRIs.  Should NOT be combined with one another or with MAOIs.  
Adequate clinical trial consists of 6 weeks continuous administration at recognized therapeutic doses.
**Antidepressant Agents**

**Selective Serotonin Reuptake Inhibitors (SSRIs) - 2**

Abrupt cessation can cause an unpleasant but not dangerous discontinuation syndrome.

All are pregnancy category C.

Common side effects include GI distress, headache, dizziness, delayed orgasm, decreased sexual desire. GI side effects are frequently transient and can be minimized by taking medication with meals.

Prozac has a half-life of 7-9 days compared to about 1 day or less for the other agents.

Paxil is sedating and given at night while Prozac and Zoloft are typically given in the morning. Luvox must be given twice daily and is only indicated for OCD in the U.S.

**Antidepressant Agents**

**Monoamine Oxidase Inhibitors (MAOIs)**

Useful for the treatment of depression, panic disorder, and OCD.

Most common agents include tranylcypromine (Parnate) and phenelzine (Nardil).

Patients must be maintained on a strict tyramine diet to avoid lethal accumulation of toxic metabolites. Foods to be avoided include aged cheeses, beer, wine, and smoked meats. Now in a transdermal delivery system (Emsam)

Have potentially fatal interactions with other medications including meperidine (Demerol), sympathomimetics (e.g. Sudafed), and SSRIs.

Must wait at least 14 days after stopping an MAOI before using any of these medications.

**Antidepressant Agents**

**Atypical Antidepressants**

Agents available in the U.S. include bupropion (Wellbutrin, Zyban), nefazodone (Serzone), mirtazapine (Remeron), and venlafaxine (Effexor), and duloxetine (Cymbalta).

All are useful for the treatment of depression, wellbutrin, effexor, cymbalta may also be used to treat ADHD. Wellbutrin can aid in smoking cessation, and may be the preferred antidepressant in bipolar depression. Serzone and Remeron may be particularly helpful in the treatment of anxious depression. Venlafaxine is useful for the treatment of GAD.

Side affect profiles are varied. Bupropion is contraindicated in patients with a history of seizure, anorexia nervosa, or bulimia nervosa. Effexor at high doses may cause elevation of blood pressure.

Remeron may cause weight gain and sedation.
**Psychostimulants/ADD Medications - 1**

Useful for the treatment of ADHD, narcolepsy, and as adjunctive treatments for depression in medically compromised patients. Commonly used agents include methylphenidate (Ritalin), dextroamphetamine (Dexedrine), and pemoline (Cylert).

All of the above have a high abuse potential and are carefully regulated by the FDA. Long-acting and transdermal delivery systems are safer.

Side affects include insomnia, irritability, anxiety, agitation, decreased appetite, tics, and rarely psychosis. Pemoline may also induce a chemical hepatitis thus requiring baseline and periodic hepatic profile.

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**Psychostimulants/ADD Medications - 2**

Provigil (modafinil) is a “selective” psychostimulant that works at the level of the hypothalamus. While it is a schedule IV drug as well, it appears to have little abuse potential. It is indicated by the FDA for narcolepsy but has off label applications in psychiatry for medication induced somnolence and may be useful as an adjunctive antidepressant agent.

Strattera (atomoxetine) released in 2003 is a Norepinephrine reuptake inhibitor. Usually given once per day with food. It may also be useful for antidepressant augmentation. The starting dose may be 18 mg to 25 mg. Its major side affect is possible nausea, no weight gain, and no abuse potential.

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**Abuse Deterrents**

Disulfiram (Antabuse)

Used only to sustain abstinence from alcohol. May cause dangerous reactions if alcohol is consumed.

Naltrexone (ReVia, Vivitrol)

Used to encourage abstinence from opiates and possibly alcohol.

Methadone

Useful for chronic opiate dependence to reduce craving and also to treat pain. Controversial, as it is itself an opioid.

Bupropion (Wellbutrin, Zyban)

An antidepressant also useful to reduce nicotine craving during smoking cessation (see above).
**Eating Disorder**

**Medications - 1**

**Antidepressants**
Fluoxetine is best studied. It appears to reduce bingeing and purging behaviors in anorexics and bulimics during the short term.

Bupropion is also effective but carries a high risk of seizure in these patients and is therefore contraindicated.

**Appetite Inducers**
Tested agents include cyproheptadine (Periactin) and tetrahydrocannabinol (Marinol) which is the active ingredient in marijuana.

Unfortunately NOT particularly helpful in the treatment of anorexia.

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**Eating Disorder**

**Medications - 2**

**Appetite Suppressants**
Commonly used agents include phentermine (Lonamin, Fastin) and sibutramine (Meridia) which work by neurotransmitter reuptake blockade in the brain.

Dexfenfluramine (Redux) and fenfluramine (Pondimin) were previously used but removed from the U.S. Market in 1997 after many patients developed cardiac valve abnormalities.

Xenical (Orlistat) - taken (3) times daily with meals to prevent digestion of dietary fats. Works by inactivating lipases produced by the pancreas. May exert its greatest benefits by psychologically modifying dieter’s intake of fat calories. Some have dubbed this medication ‘Antabuse for the Overweight’.

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**ECT (Electroconvulsive Therapy)**

This treatment is highly effective for depression, mania and catatonia. It has also been used to treat neuroleptic malignant syndrome (NMS). It is used only after patients have been sedated and is usually administered in courses of 6-12 treatments over several weeks. It is given unilaterally or bilaterally. There is controversy about which laterality is more effective. There can be side affects of short-term memory loss and anterograde amnesia.

Headaches are a common side affect post treatment. There are no strict contraindications to its use and it is effective up to 80% of the time. It may be treatment of choice in the suicidally depressed and in the medically compromised.
VNS (Vagal Nerve Stimulation)

- First and only FDA approved treatment (August 2005) for treatment-Resistant Depression (TRD)
- Works via afferent sensory fibers (CN X) to limbic brain structures to increase NE and 5-HT
- Minimal side effects with reasonable results in difficult patient population