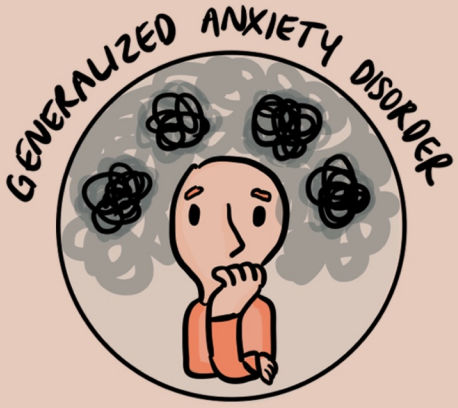
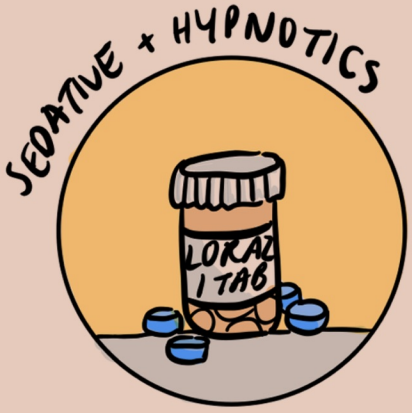


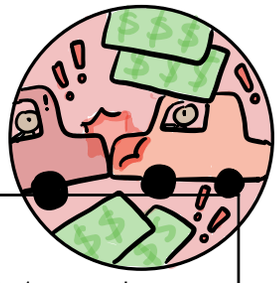


Summary Package 5

Designed by: **Kathryn Yu**

PsySOM
Psychiatry Society of Monash

Adjustment Disorder



Definition

A stress response syndrome is a short-term condition which happens when one has great difficulty managing with, or adjusting to, a particular source of stress, such as a major life change, loss, or event.

Epidemiology

Prevalence of adjustment disorder:

- 2-8% of the general population
- Outpatient psychiatry: Up to 20%
- Inpatient psychiatry ward: Up to 50%

Patient factors:

Adults: F >> M (especially single women)

Children: Equal prevalence in boys and girls

Low socioeconomic status

Immature defence mechanisms

Insecure attachment with primary caregiver

Comorbidities

Major depressive disorder (MDD)

Obsessive compulsive disorder (OCD)

Suicide attempts and completed suicides

What is a stressor?

It can be a single event or multiple events (car crash, workplace harassment) that is potentially recurring or constant.

Common adulthood stressors:

- Finances
- Relationship breakdown

Common childhood stressors:

- School issues (failing a test)
- Parental separation
- Parental rejection

Differentials to consider

Normal stress response

Bereavement

MDD

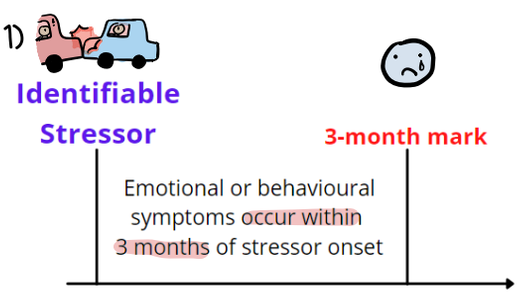
Anxiety & trauma-related disorders

Somatoform disorders

Personalities (borderline/antisocial)

Diagnostic Criteria

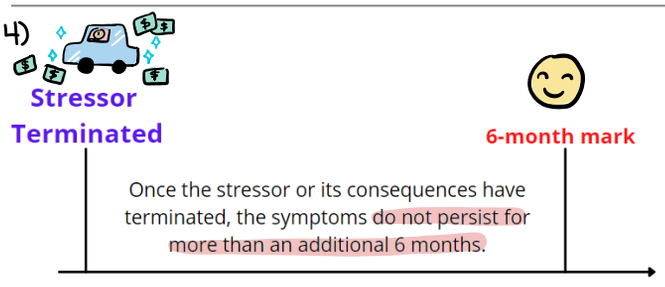
1)



2) Emotional or behavioural symptoms cause either a) marked distress that is out of proportion to severity of stressor or b) significant impairment in social, occupational or other areas of functioning.

3) Symptoms **do not** represent normal bereavement.

4)



Management

Remove or Reduce Stressor

Removing the stressor is not a cure in itself. If the patient is exposed to a stressor in the future, it is likely they will elicit the same pathological response. Thus, psychotherapy is useful to understand the stress response.

Manage Stress Response

- CRISIS INTERVENTION:
  - Increased support or
  - Reassurance or
  - Hospitalisation
- PSYCHOTHERAPY:
  - Psychoeducation to the patient and the family
  - Group therapy (useful for patients with similar stressors)
  - Individual psychotherapy (to understand their reactions)
- MEDICATION (no evidence of the efficacy but short-term therapy can alleviate symptoms):
  - Antidepressants
  - Benzodiazepine
- LIFESTYLE:
  - Cessation of harmful substances
  - Healthy diet and exercise

Contributor: **Tess Ryan**
Reviewer: **Ajeeta Singh**

Panic Disorder

Definition

- A single panic attack: sudden period of intense fear or apprehension that something bad is going to happen
- Panic disorder: recurring (≥2), unexpected panic attacks that begin to impact on a patient's life

Epidemiology

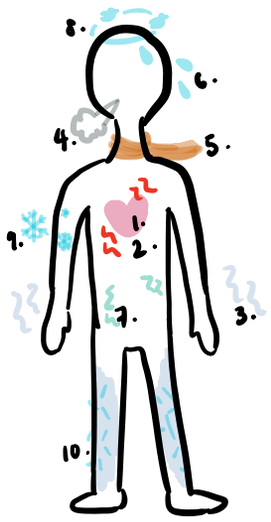
- 2.6% of the population
- Gender: F>M
- Median age of onset: 30 years

Risk factors

- FHx of anxiety disorders
- Traumatic life events: especially Hx of divorce/separation, neglect/abuse as a child
- Environmental triggers
    - Work/stress/relationships

DSM 5 criteria

- A. Recurrent (≥2) unexpected panic attacks. A panic attack is an abrupt surge of intense fear, reaches a peak within minutes, during which time ≥4 symptoms occur:
    - Somatic symptoms
        - 1. Palpitations, pounding heart, accelerated heart rate
        - 2. Chest pain or discomfort
        - 3. Trembling/shaking
        - 4. Sensations of shortness of breath or smothering
        - 5. Feelings of choking
        - 6. Sweating
        - 7. Nausea or abdominal distress
        - 8. Feeling dizzy, unsteady, light-headed or faint
        - 9. Chills or heat sensations
        - 10. Paraesthesias (numbness or tingling sensations)
    - Cognitive symptoms
        - 11. Derealisation (feelings of unreality) or depersonalisation (being detached from oneself)
        - 12. Fear of losing control or 'going crazy'
        - 13. Fear of dying
- B. At least one of the attacks has been following by 1 month (or more) of one or both of the following:
    - 1. Persistent concern or worry about additional panic attacks or their consequences (e.g. losing control, having a heart attack, 'going crazy')
    - 2. A significant maladaptive change in behaviour related to the attacks (e.g. behaviours designed to avoid having panic attacks, such as avoidance of exercise or unfamiliar situations)
- C. The disturbance is not attributable to the physiological effects of a substance or another medical condition
- D. The disturbance is not better explained by another mental disorder



MNEMONIC

STUDENTS FEAR the 3 C's

Sweating	Excessive HR / palpitations	Fear of dying
Trembling	Nausea	Chest pain
Unsteadiness / dizziness	Tingling	Chills
Depersonalisation / derealisation	Shortness of breath	Choking

Differentials

Organic	• Cardiovascular: angina, acute coronary syndrome, arrhythmias • Respiratory: pulmonary embolism, asthma, COPD, hypoxia, hyperventilation • Neurological: TIA, seizures (esp. temporal lobe epilepsy), vestibular dysfunction • Endocrine: hyperthyroidism, hypoglycaemia, hypo or hyperparathyroidism, phaeochromocytoma, Cushing's syndrome, electrolyte imbalance, menopause/oestrogen deficiency • Haematological: anaemia • Others: anaphylaxis
Drug use/ medications	• Caffeine • Simulants: cocaine, amphetamines, MDMA/ecstasy • Salbutamol, theophyllines • Medication withdrawal: anxiolytics, alcohol, benzodiazepines, SSRIs, TCAs, opioids
Other anxiety conditions	Specific phobias: PTSD, OCD, GAD
Rule out	Mania & psychotic disorders

Examination

- Mental state examination
  - Patient will appear to be in distress, anxious, rate of speech may be increased, patient may be ruminating on events/stressors
- Physical examination
  - Aim is to rule in/out the organic causes
  - Conduct a cardiovascular, respiratory, neurological and endocrine examination

Investigations (Note: Investigation will depend on Hx/Ex findings)

Investigation	**Rationale**
Urine drug screen	To check for any substance intoxication
ECG/Holter monitor	To rule out cardiac causes
CXR, d-dimer	To rule out any respiratory causes
FBE, iron/folate/B12	Anaemia can cause anxiety-like symptoms
UEC/CMP	To check for electrolyte disturbances
TFTs	Thyroid dysfunction can cause panic-like symptoms
PTHs	Parathyroid hormone dysfunction is also a DDx
Cortisol	To rule out Cushing's syndrome as a DDx
Plasma free metanephrines	To rule out phaeochromocytoma
LH/FSH	If considering menopause/oestrogen deficiency as a cause
EEG/MRI	If considering neurological causes for the presentation

Management

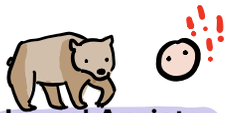
- Immediate management
  - Use of relaxation/'grounding' techniques to help manage the acute symptoms
  - Conduct a thorough risk assessment
  - Perform necessary history/examination/investigations (as above)
- Depending on severity
  - Mild: Cognitive Behaviour Therapy (CBT)
  - Moderate - Severe: CBT or SSRI/SNRI or CBT + SSRI/SNRI
  - Severe: start with CBT + SSRI/SNRI
- Biological
  - if no response to initial treatment within 4 - 6 weeks
  - Medications: SSRIs (first line, but if inadequate) → trial another SSRI → SNRIs → TCAs → MAOi/mirtazapine
  - Effect of medications should be reviewed after 4-6 weeks
  - note: benzodiazepines can also be used but only in the short-term
- Psychological
  - dCBT: 8 - 12 sessions of face-to-face
    - Stage 1: psychoeducation, formulation, symptom monitoring
    - Stage 2: identify and reduce catastrophic cognitions, reduce avoidance and use of safety behaviours
    - Stage 3: relapse prevention
  - Psychoeducation
  - Systematic desensitisation (used when particular triggers are identified)
- Social/lifestyle
  - Maintain adequate diet/exercise
  - Ensure good sleep hygiene
  - Avoid substances that may worsen symptoms: e.g. limit caffeine/alcohol/tobacco
- Long-term
  - Referral to psychological/psychiatrist for follow-up and ongoing care

Complications/comorbidities

- Avoidance (of panic attacks) can progress to fear of being in public spaces → agoraphobia (if they are worried about being trapped) or social phobia (if they are worried about being judged)
- Depression
- Generalised anxiety disorder
- Alcohol use disorder

Contributor: **Jasleen Grewal**
Reviewer: **Amin Hajamohideen**

Generalised Anxiety Disorder



Normal Anxiety

Anxiety is a normal alerting signal for an impending danger, and enables us to take measures to manage the threat.

Pathological Anxiety

Anxiety becomes pathological when it is almost constant and affects our day-to-day life, work and relationships.

Annually, 1 in 7 Australians experience an anxiety condition.	**Nearly 6% of the Australian population will experience GAD in their lifetime.**	**It can be caused by a combination of family history, stressful life events and personality traits.**

Diagnostic Criteria

- Excessive worry and anxiety on most days for more than 6 months about a number of events and activities
- Difficulty controlling their worry
- Associated with >= 3 symptoms;
  - Restlessness
  - Fatigue
  - Difficulty concentrating
  - Irritability
  - Muscle tension
  - Sleep disturbance
- Causes significant impact on psychosocial functioning

Mnemonic

Worry WARTS

- Wound up
- Worn out
- Absent-minded
- Restless
- Touchy
- Sleepless

Screening Questions

- Do you think you are a worrier by nature?
- When you do worry, what is the worst thing that can happen?

Comorbidities

- Depression, hypertension & gastric conditions

Management

Biological

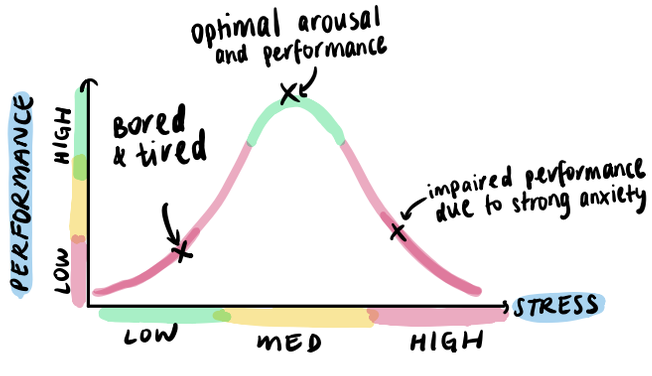
- Antidepressants: SSRI (first-line: escitalopram, sertraline, paroxetine) > SNRI (venlafaxine, duloxetine)
- Benzodiazepines (avoid long-term use and in patients with history of substance abuse)

Psychological

- Patient education on anxiety (see Yerkes-Dodson Law on stress performance)
- Cognitive behavioural therapy

Social

- Active self-monitoring to identify triggers
- Involve patient's family or significant others where possible



Contributor: **Ajeeta Singh**
Reviewer: **Simran Bhopal**

Sedatives + Hypnotics

Benzodiazepines

Drugs	MOA	Indications	Side effects & Contraindications	Other
Short duration (<6hours) Midazolam Triazolam Oxazepam	Benzodiazepines are indirect GABA-A receptor agonists → increase affinity of GABA to GABA-A receptors → increase opening frequency of chloride channels → hyperpolarization of the postsynaptic neuronal membrane → reduce neuronal excitability Decreases duration of N3 phase in REM sleep → reduce sleepwalking and night terrors	Procedural sedation Anaesthesia induction Sleep-onset insomnia	**General - ABCDEFO** Alcohol interaction - ↑ depressant effect Balance & reaction time - ↓motor tone → should not drive / operate machinery Cognition & memory – anterograde amnesia Dependence & tolerance – Develop withdrawal symptoms Extra sleepy – Drowsiness / sedation AFfects liver – toxicity & OD (hepatic metabolization) Others – paradoxical effects → ↑ movement, anxiety, and aggression (elderly), ↑ appetite **Contraindications** • Myasthenia gravis, sleep apnoea, bronchiolitis, COPD → risk of respiratory depression • Major depression → can precipitate suicidal tendencies and be used for suicidal overdose • Hx of alcohol / opioid / barbiturate abuse → life-threatening interaction • Pregnancy → cleft palate, floppy infant syndrome, neonatal withdrawal syndrome (use diazepam or chlordiazepoxide – lowest effective dose for shortest period) • Elderly → sensitive to adverse effects (memory, daytime sedation, impaired motor coordination, falls, risk of hip fractures)	**Withdrawal symptoms** **Common**: Insomnia, gastric problems, tremors, agitation, fearfulness, muscle spasms **Less common:** irritability, sweating, depersonalisation, derealisation, depression, psychosis, seizures / status epilepticus, delirium tremens **Withdrawal Management** • Use for short duration & least dose possible • Slowly taper off (not abrupt) • Give diazepam • Chlordiazepoxide (alternative) **Overdose (OD)** • Rare if taken alone but complications arise in combination with alcohol, opiates, TCAs - ↑toxicity • Temazepam is more toxic in OD **Symptoms of OD** Drowsiness, slurred speech, nystagmus, hypotension, ataxia, coma, respiratory depression, cardiorespiratory arrest **Management of OD** Flumazenil
Intermediate duration (6 – 8hrs) Lorazepam Temazepam Lormetazepam		Anxiety disorders Sleep-onset & sleep-maintenance insomnia Alcohol withdrawal syndrome (lorazepam) Catatonia (lorazepam) Status epilepticus (lorazepam)		
Long duration (>12hours) Alprazolam Diazepam Clonazepam Chlordiazepoxide Tetrazepam		Anxiety and panic attacks Epilepsy Alcohol withdrawal syndrome Night terrors, sleep walking Eclampsia (2nd line) Paranoia Stress disorder		

Other sedatives and hypnotic medications			
Zolpidem	Similar to benzodiazepines Selective for GABA-A receptors Short-acting due to fast metabolization by liver enzymes	Only intended for nocte use for insomnia and short-term use Useful for sleep onset but not for sleep maintenance	Headache, paradoxical reaction, dizziness, drowsiness/sedation. **Parasomnias** – abnormal movements, behaviours, emotions, perceptions, and dreams that occur while falling asleep *Avoid in people with personal/family history of sleepwalking *Do not use in patient with myasthenia gravis → severe respiratory impairment **Zopiclone:** Like zolpidem + **bitter taste** Dependence and tolerance occur (but less often) Potentially fatal in overdose Contraindications similar to benzodiazepines
Zopiclone			
Eszopiclone	Non-benzodiazepine hypnotic agent. Similar MOA to zopiclone Longest half-life compared to Zopiclone and Zolpidem		

Contributor: **Amin Hajamohideen**
Reviewer: **Simran Bhopal**

Post Traumatic Stress Disorder

Brief Overview

- A disorder characterised by failure to recover after experiencing/witnessing a terrifying event, that may last for a prolonged duration and be triggered by memories or thoughts that evoke intense physical and emotional reactions.
- Lifetime prevalence of 5 – 10%

Risk factors

- Psychiatric comorbidities
- Low socioeconomic status
- Childhood trauma
- Lack of social support

Common triggers

An exposure to traumatic events such as:

- Sexual abuse (most common)
- Physical abuse
- Accidents
- War
- Witnessing death of another person

Management

Immediate:

- Psychological first aid – to reduce distress and attend to basic needs following a traumatic event using simple interventions

Biological:

- Pharmacological
  - Antidepressants
    - SSRIs (sertraline, paroxetine, escitalopram)
    - SNRIs (venlafaxine)
  - Atypical antipsychotics (adjunct therapy in complex cases)
  - Hypnosedative agents (reduces anxiety, treats insomnia)
    - Short-term use of benzodiazepines
    - Prazosin (effective treatment of nightmares)

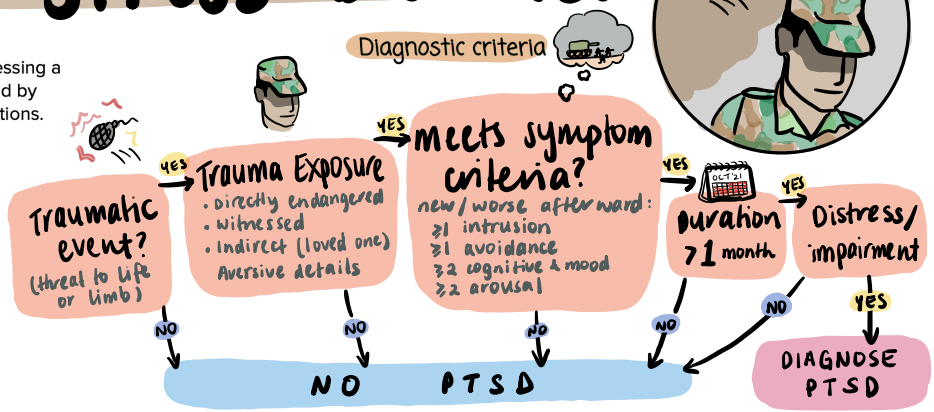
Psychological:

- Eye Movement Desensitization and Reprocessing (EMDR)
  - Involves processing upsetting memories, thoughts and feelings while paying attention to either a sound or a back-and-forth movement
- Trauma-focused CBT

Social:

- Access to support groups
- Equip with better coping mechanisms (sleep, healthy lifestyle)

Diagnostic criteria



Intrusion Symptoms	Avoidance Symptoms	⛔Negative Alterations in Cognition	Arousal & Reactivity Symptoms
*At least **one** of:* • Distressing memories • Distressing nightmares • Flashbacks • Intense or prolonged psychological distress to trauma reminders • Marked physiological reactions to trauma reminders	*At least **one** of:* • Efforts to avoid distressing **internal** trauma reminders (*memories, thoughts, feelings*) • Efforts to avoid distressing **external** trauma reminders (*people, places, activities*)	*At least **two** of:* • Amnesia • Negative beliefs about self, others, or the world • Distorted trauma-related cognitions • Negative emotional state (fear, horror, anger, guilt, shame) • Anhedonia • Detached from others • Apathy	*At least **two** of:* • Irritability • Self-destructive behaviour • Hypervigilance • Exaggerated startle • Poor concentration • Poor sleep

Contributor: **Amin Hajamohideen** Reviewer: **Ajeeta Singh**

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Sedative and Hypnotic drugs

- https://www.ranzcp.org/files/resources/college_statements/practice_guidelines/ppg5-use-of-benzodiazepines.aspx
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