

PREP XI RR

STUDY NOTES

PSYCHIATRY

18

VIDEOS

109

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PREMIUM STUDY MATERIAL

PREP XI RR

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1. BASICS OF PSYCHIATRY

BIG QUESTION 1: What is psychiatry, and what is the systematic approach to evaluating a psychiatric patient, including history, mental status examination, and key abnormalities of mood and affect?

Broad Answer:

- Psychiatry, coined by Johann Christian Reil, is the branch of medicine dealing with mental disorders. Evaluation involves history, physical examination, and Mental Status examination assessing appearance, speech, mood vs affect, and abnormalities like flat or labile affect.

DETAILED QUESTIONS

Q1.1: What is the origin of the term "psychiatry," who coined it, and how is it defined?

Answer:

- Psychiatry comes from two Greek words: "psyche," meaning mind, and "iatry," meaning healing or cure
- It was coined by the German physician Johann Christian Reil
- Definition: It is the branch of medicine that deals with problems of the mind and their treatment

Q1.2: What are the key steps in the comprehensive approach to a psychiatric patient?

Answer:

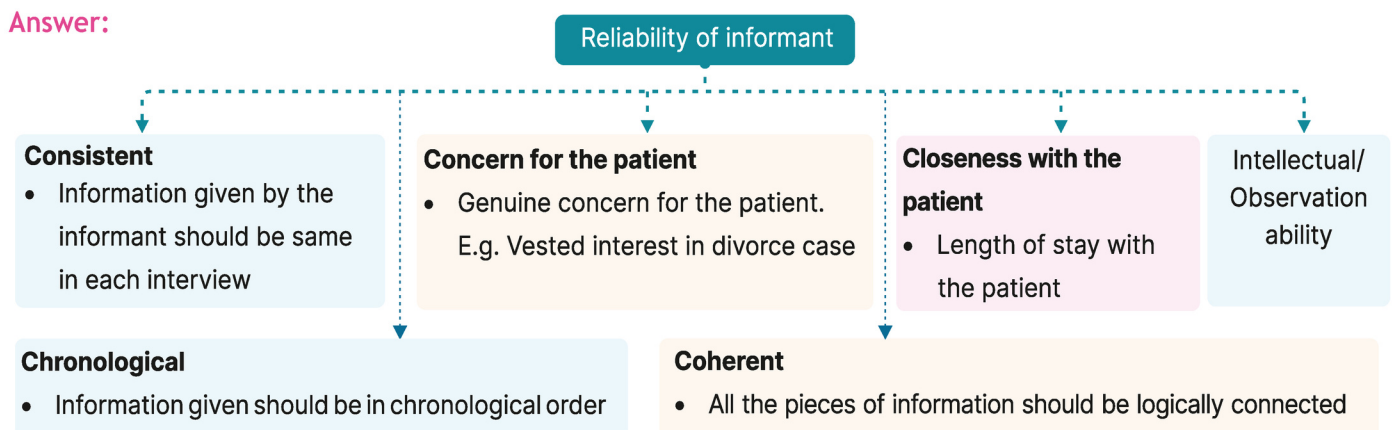
History	• Taken from the patient as well as the informant.
Examination	• General physical examination • Systemic examination • Mental status examination (MSE).
Investigation	• Limited role • To rule out other abnormalities
Diagnosis	• Diagnose and treat/ manage the patient

Q1.3: How is the history of a psychiatric patient taken?

Answer: History is taken directly from the informant

Q1.4: How is the reliability of an informant assessed in psychiatry?

Answer:



Q1.5: What is the purpose of a Mental Status Examination (MSE), and what does it assess?**Answer:**

- MSE - Primary examination of a psychiatric patient, designed to assess their current mental state
- It evaluates several components, including general appearance and behavior, speech, and mood and affect

Q1.6: How are general appearances evaluated during an MSE?**Answer:**

- Dressing: Appropriate clothing with respect to weather conditions
 - E.g., A patient who wears layers of warm clothes on a hot day may suggest an illness such as schizophrenia
- Grooming: Self-care
 - E.g., A patient presenting with uncombed hair, foul odor, and poor grooming may suggest an illness such as schizophrenia

**Q 1.7: How is speech evaluated during Mental Status Examination?****Answer:**

- Speech
 - Rate of speech: The number of words a person speaks in a minute
 - Mania: High rate of speech, speaks very fast
 - Depression: Low rate of speech, speaks very slowly
- Coherence
 - Whether speech is understandable
 - Incoherent speech: Seen in illnesses such as schizophrenia

Q1.8: What is the difference between mood and affect?

PYQ: FMGE 2019

Answer: Denotes the feelings and emotions of a person.

Mood	Affect
• Persistent and pervasive emotional state.	• Expression of emotion that is observed by the therapist. • Expressed on the face and through body language.
• The mood is something that the patient will tell.	• Affect is something that is observed by the therapist.
• An internal phenomenon.	• An external phenomenon.
• The mood is long-term: Emotional state present for some time.	• Affect is cross-sectional: Observed at that very moment.

Q1.9: What are the key abnormalities of affect, and what conditions are they associated with?**Answer:**

Flat affect (Blunt affect)	• Emotion does not change even with stimuli. • E.g. No change in emotions seen when a patient is talking about a sad event or a good event in his life. • Seen in conditions like schizophrenia.
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Labile affect

- Rapid and abrupt changes in emotion without any stimuli.
- E.g. Patient starts laughing/crying without any reason.
- Seen in mania and organic mental disorders.

Q1.10: What are Anhedonia and Alexithymia?**Answer:**

- Anhedonia: A decreased interest in pleasurable activities
 - It is a symptom of both depression and schizophrenia
- Alexithymia: Inability to express or understand emotions

Q1.11: Which structure in the brain is responsible for the generation and regulation of emotion?**Answer:**

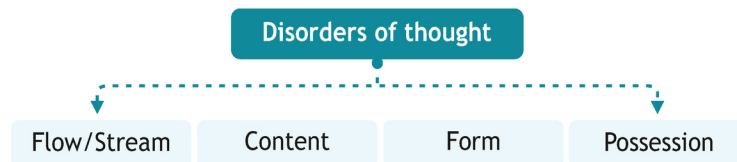
- Generation of emotions: Limbic system
- Regulation of emotions: Frontal lobe



2. DISORDERS OF THOUGHT

BIG QUESTION 1: What are the different types of thought disorders and their clinical features, with examples?

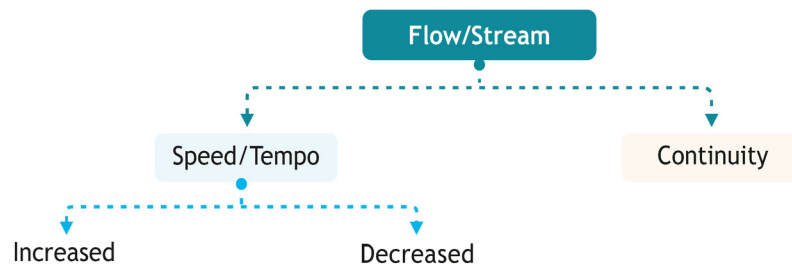
Broad Answer: Thought disorders are a core feature of many psychiatric illnesses, particularly schizophrenia. **Thought disorders** (abnormalities of thought form or organization).



DETAILED QUESTIONS

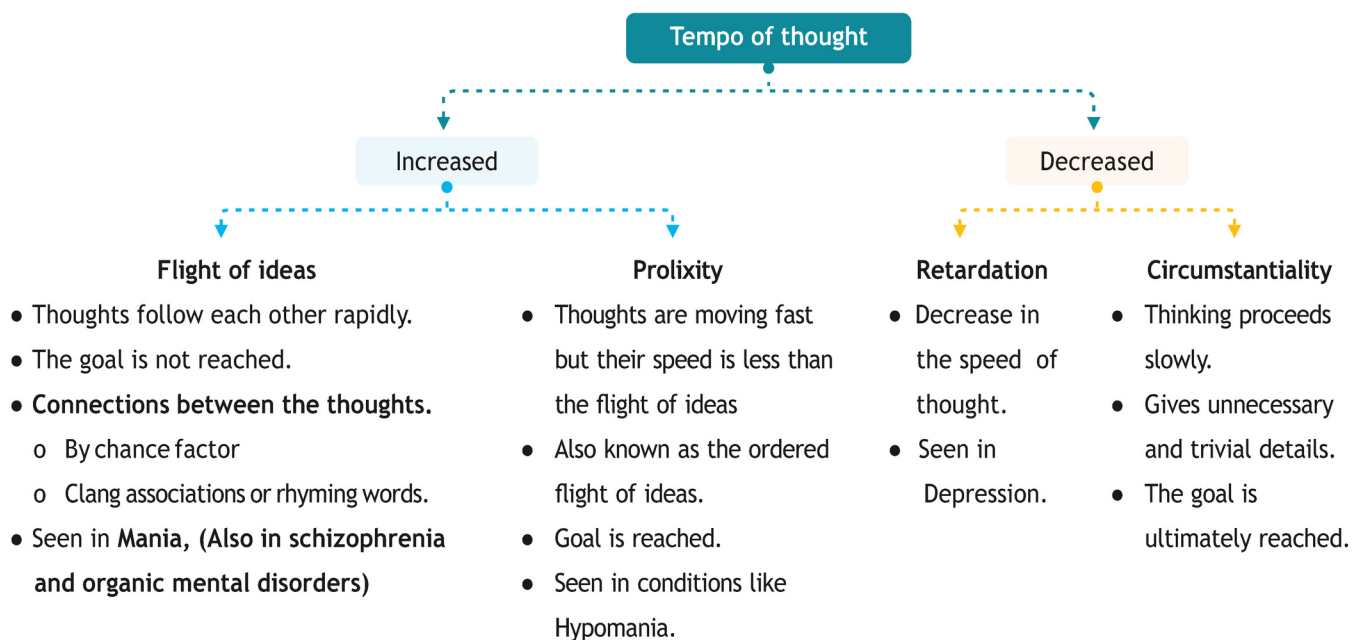
Q1.1: What are the components of the flow (stream) of thought?

Answer:



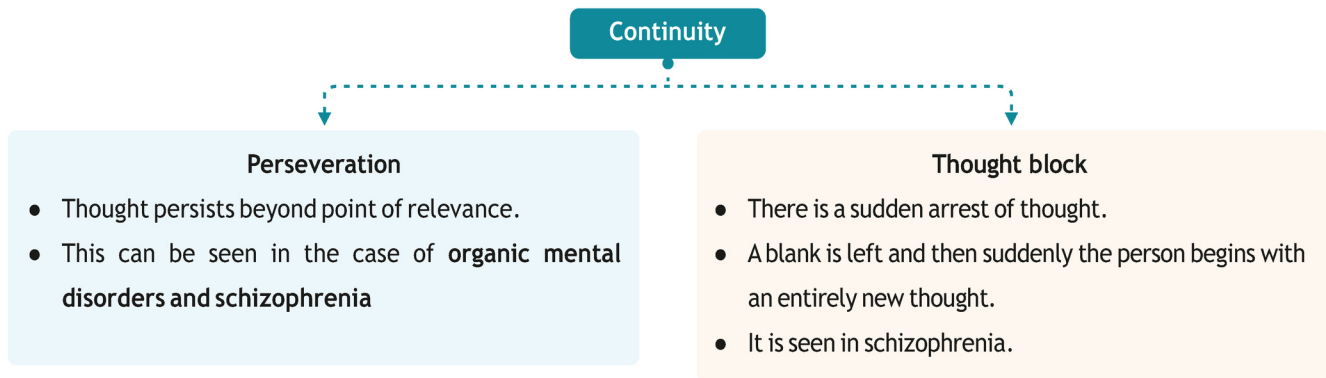
Q1.2: What is the tempo of thought and its disorders?

Answer:



Q1.3: What are the types of continuity of thought?

Answer:



Q1.4: What is a delusion, and what are its key characteristics?

🔍 PYQ: FMGE 2019, 2021

🔍 PYQ: NEET PG 2019

Answer:

- Delusion is a disorder of **thought content**.
- A **delusion** is a **false, fixed, and unshakeable idea or belief** held with extraordinary conviction, despite evidence to the contrary.
 - E.g.: 20-year-old male claims that his neighbors want to kill him. After a lot of effort from the family as well as the neighbors, he cannot be convinced otherwise.
- It's not a delusion if it's a shared cultural, social belief and educational background of the person.
 - E.g.: If a certain culture refuses to cross the road after a black cat crosses, it is not a delusion because it is a shared cultural belief/superstition.

Q1.5: What are the different types of delusions, providing examples and associated conditions?

Answer:

🔍 PYQ: FMGE 2020

Delusion of Persecution	• Most common delusion. • The patient believes that someone is planning to harm him or kill him.
Delusion of Reference	• The patient believes that someone is talking about him or spying on him.
Delusion of Grandiosity	• The patient believes that he is God, has supernatural powers, knows famous people, has vast knowledge, or is very wealthy. • Seen in conditions like schizophrenia and Mania.
Delusion of Nihilism	• Delusion of Negation • The patient denies existence of his own body, loved ones, the world, and everything. • Seen in disorders such as schizophrenia, and depression. • Cotard syndrome: A patient with depression having delusion of nihilism
Declerambault's Syndrome/Erotomania/ Delusion of Love	• The patient believes that someone (usually of a higher stature) is in love with the patient.
Othello's Syndrome/ Delusion of infidelity/ Morbid jealousy	• The patient believes that the partner or spouse is having an affair even though that is not true. • Prolonged alcohol use: Linked to this condition.
Delusional Misidentification syndrome	• Problem in the identification of other people

Q1.6: What are the differences between Capgras and Fregoli syndromes?

Answer: Both are types of delusional misidentification syndromes. ? PYQ: FMGE 2021, 2022 ? PYQ: NEET PG 2022, 2023

Capgras Syndrome	• Patient believes that someone who is closely related to him has been replaced by an exact double. • Physical appearance remains the same and it is acknowledged. • Argument with the close person. • CAPGRAS: Close person replaced by a stranger.
Fregoli Syndrome	• Patient believes that a familiar person is posing as a stranger (can take multiple appearances). • Physical appearances change and it is acknowledged. • Argument with a stranger.

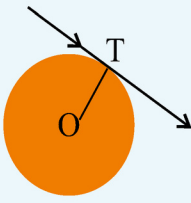
Q1.7: What is a formal thought disorder?.

Answer:

- Form means organization.
- Thoughts have a start, a middle part, and an end.
- Abnormality of thought is known as formal thought disorder.
- For example, in schizophrenia
- Normal thought examples
 - o In normal thoughts, everything is logically connected.
 - o E.g., Normal train of thought if one is planning to go on a date would be to book a cab, reach the cafe, order coffee, drink the coffee, pay for the drink, and come back.

Q1.8: What are the types of Abnormal thoughts?.

Answer:

Loosening of association	• Break in logical connection between the thoughts (sentences do not make sense). • E.g.: Order a coffee would be ordering coffee, coming back home, reaching the cafe, black shirt, drinking, and booking a cab. • Seen in schizophrenia. • Speed is normal and lack of connections is observed in this (Increased speed and presence of connections are present in flight of ideas)
Derailment/ Knight's Move Thinking	• Jump off the track, to move to a different topic (no logical connection) • Thought block: Shift to a new topic and problem of continuity along with a pause. • Derailment: Only shifting to a new topic, no pause. ? PYQ: NEET PG 2021
Tangentiality 	• A reply to a question is oblique or tangential. ? PYQ: FMGE 2019 • The patient touches the topic and then moves away and does not ever return to the topic of the question or answer it. The goal is not reached
Neologism	• A completely new word or phrase is being used by the patient whose derivation cannot be understood.

Neologism	• E.g.: If one is talking to a patient who only knows the English language, and the patient says that he brought a new "pratnityat". He goes on to describe its color and design and then points to his watch and says, "This is the new "pratnityat". It is not understood by anyone how he derived that word for the watch. • Seen in disorders like schizophrenia.
Incoherence/ Word Salad	• Thoughts are incomprehensible and do not make any sense. • E.g.: The patient says "I will go umbrella black fly water". • Seen in disorders like schizophrenia.
Talking past the point/Vorbeireden	• The reply of the patient shows that he understood the question (known from his answer) but is deliberately talking about the associated topic. • E.g.: The patient is asked what the color of grass is, and he replies that it is red. • Ganser Syndrome: When talking past the point is seen in prisoners. • It can be seen in other populations also.

Q1.9: What is thought possession?

Answer: Possession means loss of control or loss of sense of possession of thinking.

Q1.10: What are the important abnormalities of thought possession?

 PYQ: AIIMS 2020

Answer: Two important abnormalities of thought possession are:

Obsession	Thought alienation/ Passivity phenomenon
• R - Recurrent thoughts/Images/Impulses • O - Own thoughts • S - Senseless • I - Irresistible - o E.g. Patient gets recurring thoughts that his hands are dirty; he acknowledges these thoughts as his own and knows that they do not make any sense. (unable to stop these thoughts). - o Seen in obsessive-compulsive disorders.	• The patient claims that thoughts are under outside influence. • Thought Insertion: Patient feels that outside thoughts are inserted in his mind. • Thought Withdrawal: The patient feels that someone is taking away the thoughts from his mind. • Thought Broadcast: The patient feels that his thoughts are being broadcasted to everyone. • Seen in disorders like schizophrenia- First-rank symptoms for schizophrenia.



3. PERCEPTION

BIG QUESTION 1: Discuss the abnormalities of perception, focusing on the key differences between illusions and hallucinations.

Broad Answer: Perceptual abnormalities include illusions (the misperception of real objects, e.g., mistaking a rope for a snake) and hallucinations (perceptions without external stimuli, vivid and involuntary, like real perception)

DETAILED QUESTIONS

Q1.1: What is the difference between an illusion and a hallucination?

Answer:

- Illusion - False perception of a real object
 - o For example, mistaking a rope for a snake in the dark
- Hallucination - False perception without a real object, i.e., the patient perceives something that is not there

Q1.2: What are the key characteristics that differentiate normal perception from hallucination?

Answer:

Characteristics of Normal Perception/Object	Characteristics of Hallucination
• Clear	• Clear (as vivid as real)
• Normal perception of the real object occurs in outer objective space.	• Occurs in the Outer Objective Space
• Normal perception of a real object is independent of one's will.	• Independent of the Person's Will

Q1.3: What are the characteristics of a true hallucination, and how does it differ from a pseudo-hallucination?

Answer:

- True hallucination
 - o Psychotic symptom
 - o The characteristics of a true hallucination resemble those of real objects
 - o For example, in a movie depiction, a person was shown perceiving Mahatma Gandhi as clearly as a real person
- Pseudo-hallucination
 - o Clear and involuntary, just like hallucinations
 - o Pseudo-hallucinations occur in the inner subjective space

PYQ: FMGE 2023

Q1.4: What are the five main types of hallucinations?

Answer:

Auditory Hallucination	• The most common type. • The patient is able to hear something.
Visual hallucinations	• E.g., the flashing of lights, an animal, a human face, or an entire human. • The most common hallucinations in organic mental disorders are visual hallucinations. • Seen in Schizophrenia.

Olfactory hallucinations	The patient perceives an unpleasant odor, while others do not
Gustatory hallucinations	- Patients can taste something sweet, sour, or bitter. - Seen in disorders like schizophrenia. - Olfactory and gustatory hallucinations are seen in temporal lobe disorders like temporal lobe epilepsy.
Tactile hallucinations	- Superficial or over the skin: Hot, cold, tingling, etc. ? PYQ: FMGE 2021 Tactile hallucinations are also known as formication. Patients experience small insects crawling under the skin. These are also called cocaine bugs or magnum bugs. - Cocaine users complain of the feeling of crawling bugs under their skin. - Clinically a lot of scratch marks are seen in these patients.

Q1.5: What is a reflex hallucination, and what is its associated condition?

Answer:

- A real stimulus is given in one sensory modality, and a hallucination is produced in a different modality
- E.g., The patient says that when he hears the ringtone (real perception), he sees a man walking into the room
 - Real perception - auditory modality; hallucination - visual modality
- It is seen in psychotic disorders and hallucinogens like LSD.

Q1.6: How is a delusion different from a hallucination?

Answer:

Delusion	Hallucination
False belief (I know)	False perception (I see, hear, taste, etc.)
Delusion of infestation: The patient says that he knows there are insects under her skin. It is a belief, not experiencing it	However, in tactile hallucinations, patients experience it.

4. SCHIZOPHRENIA AND OTHER PSYCHOTIC DISORDERS



BIG QUESTION 1: What is schizophrenia? Discuss its historical context, key etiological factors, and diagnostic criteria.

Broad Answer:

- Schizophrenia, once called dementia praecox, is a psychotic disorder caused by genetic and neurotransmitter factors (↑ dopamine/serotonin)
- It presents with positive (delusions, hallucinations), negative, disorganized, or catatonic symptoms, and diagnosis requires ≥ 2 symptoms for 1 month, with a 6-month disturbance

DETAILED QUESTIONS

Q 1.1: What is Schizophrenia?

Answer: It's the prototypical psychotic disorder

Q1.2: Who are the key figures in its historical definition of schizophrenia?

Answer:

- Emil Kraepelin - Coined Dementia Praecox
- Eugene Bleuler - Coined the term Schizophrenia
 - o Schizo = split, Phrenia = mind

Q 1.3: What are Bleuler's four fundamental symptoms of schizophrenia?

Answer:

- Bleuler's "4 A's"
 - o Association Disturbances- such as Loosening of Association
 - o Affective Flattening
 - o Autism: Fantasy Thinking (patient is engrossed in their own world)
 - o Ambivalence: Inability to make decisions

Q 1.4: What are Schneider's First Rank Symptoms of schizophrenia?

Answer:

- Auditory hallucinations:
 - o Audible thoughts / thought echo (First-person auditory hallucination)
 - o Voices discussing the patient (Third-person auditory hallucination)
 - o Voices commenting on one's action/ Running commentary
- Thought Alienation
 - o Thought insertion
 - o Thought withdrawal
 - o Thought broadcasting
- Passivity experiences:

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- o Made impulses, made feelings, made acts → Patient experiences that his impulses/feelings/acts are being influenced by others (Made Phenomenon)
- Somatic passivity: Bodily sensation imposed by external agency → E.g., Patient is claiming pain in abdomen caused by radio waves sent by aliens
- Delusional Perception: Delusional meaning given to normal perception → E.g., Patient sees his wife in a red saree and claims she wants to kill him (Red - Danger)

Q 1.5: What are the key epidemiological features of schizophrenia?**Answer:**

- Gender: The prevalence of schizophrenia in males and females is nearly equal
- Late onset schizophrenia: After 45 years of age → Good prognosis

Gender	Male	Female
Peak age of onset	10 - 25 yrs	25 - 35 yrs >40 yrs
Prognosis	Bad	Good

Q1.6: What are the genetic factors associated with schizophrenia?**Answer:**

- Concordance rate is higher in monozygotic twins (Monozygotic twins > Dizygotic twins)
- Higher risk of schizophrenia in family members of patients with schizophrenia and bipolar disorder
- Chromosome 22q11.2 Deletion syndrome/ Di-George Syndrome/ Velocardiofacial syndrome (VCFS) → 30% of these cases may develop schizophrenia

Q 1.7: Which neurotransmitter abnormalities are implicated in schizophrenia?**Answer:**

- Dopamine hypothesis → Increased levels of dopamine in patients with schizophrenia
- Serotonin (5HT) → Increased levels in the brain of patients with schizophrenia
- GABA, Glutamate, Norepinephrine, Acetylcholine → Decreased in schizophrenia

Q 1.8: What is an important substance-related risk factor for developing schizophrenia?

Answer: Cannabis use: People who use cannabis during the adolescent period may develop schizophrenia (increased risk of schizophrenia)

Q1.9: What are the main positive symptoms of schizophrenia and their underlying mechanism?**Answer:**

 PYQ: FMGE 2018, 2019, 2023

- Mechanism - Caused by increased levels of Dopamine (DA) in the Mesolimbic pathway
- Delusion
 - o M/C - Delusion of Persecution
- Hallucinations
 - o M/C - Auditory Hallucination

Q 1.10: What are the main negative symptoms of schizophrenia, their cause, and treatment response?**Answer:**

- Mechanism: Caused by decreased levels of Dopamine (DA) in the Mesocortical pathway
- Symptoms

- o Anhedonia - decrease in interest (activities the patient enjoyed earlier)
 - M/C negative symptom
- o Avolition - decrease in will/drive
- o Affective blunting - decrease in the expression of emotion
- o Asociality - decrease in socialization
- o Alogia - decrease in the verbal output
- Treatment
 - o Patients with positive symptoms respond well to antipsychotics, whereas patients with negative symptoms respond less well

Q 1.11: What are the disorganized symptoms of schizophrenia?

Answer:

- Disorganized speech/thought → Formal thought disorder
- Disorganized behavior → Bizarre behavior
- Disorganized affect - E.g., in a funeral, the patient sees the dead body and starts laughing

Q1.12: What are catatonic (motor) symptoms in schizophrenia?

Answer:

- Stupor: Extreme Hypoactivity / Immobility
- Excitement: Extreme hyperactivity; non-goal directed
- Mutism: No/Little verbal response
- Catalepsy: Odd posture for a long time; a Passive phenomenon
- Posturing: Odd posture for a long time; an Active phenomenon
- Waxy Flexibility: A Person can be molded like a wax candle
- Negativism: Oppose/No response to instructions
- Automatic Obedience: Excessive cooperation/obedience
- Mannerism: Repetitive odd movements; Purposeful movements
- Stereotypy: Repetitive odd movements; Non-purposeful movements
- Echolalia: Repeating words (of examiner)
- Echopraxia: Repeating actions (of examiner)
- Grimacing: Maintenance of odd facial expressions
- Ambitendency: Inability to decide the motor movement

Q1.13: What is the criterion for diagnosing catatonia?

Answer: Catatonia is diagnosed if the patient has 3 or more of the catatonic symptoms

Q1.14: What are the diagnostic criteria for schizophrenia according to DSM-5?

Answer:

- According to DSM-5, there are 5 symptoms of schizophrenia:
 - o Delusions
 - o Hallucinations
 - o Disorganized speech
 - o Catatonic or grossly disorganized behavior
 - o Negative symptoms

- DSM-5: 2 or more symptoms (At Least one symptom should be present from the first 3 symptoms: Delusions, Hallucinations, Disorganized speech) for at least 1 month duration.
- Total duration of disturbance: 6 months
- ICD-11 states that the duration of schizophrenia should be 1 month

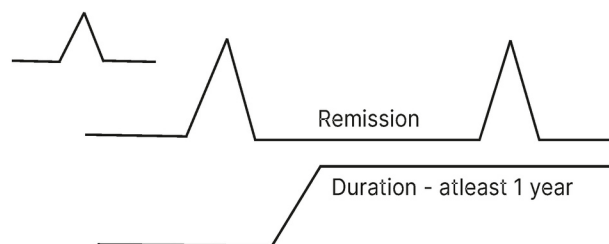
Q 1.15: How have subtypes of schizophrenia changed in DSM-5 and ICD-11 compared to earlier classifications, and what is the first-line treatment for catatonia?

 PYQ: AIIMS 2020

Answer:

- It was present earlier in ICD-10 and DSM-IV, and was based on symptoms
- However, it was removed from the newer classification, i.e., DSM-5, ICD-11
- In ICD-11 (DSM-5), schizophrenia is classified based on the course of illness

- o Schizophrenia, First episode →
- o Schizophrenia, Multiple episodes →
- o Schizophrenia, Continuous course →



- In ICD-11 and DSM-5, they kept catatonia under a separate diagnostic category
- First-line treatment of catatonic symptoms → Lorazepam (IM/IV/Orally) and ECT

Q 1.16: What is the leading cause of premature death in patients with schizophrenia?

Answer:

- Suicide
 - o Rate of suicide (DSM-5): 5-6% of patients (in earlier studies, it was around 10%)
 - o Attempted suicides: Around 20% of patients
- Patients with schizophrenia → Reduction in life expectancy - nearly 20% (because of suicides, CVS disease, physical injuries, accidents)

Q1.17: What are the key prognostic factors for schizophrenia?

 PYQ: AIIMS 2020

Answer:

Good prognostic factors	Bad prognostic factors
Acute (<2 weeks)/ Abrupt (<2days) onset	Insidious onset(develops in months or years)
Late age of onset	Early onset
• Catatonic subtype of schizophrenia - Catatonic symptoms; Best prognosis • Paranoid subtype of schizophrenia - has delusions and hallucinations; m/c subtype	• Simple type of schizophrenia - has negative symptoms; worst prognosis • Hebephrenic type of schizophrenia - has Disorganized symptoms
Female	Male
Prominent positive symptoms	Prominent negative symptoms
Presence of mood symptoms	Absence of mood symptoms
Family history of mood disorder	Family history of schizophrenia
Married	Unmarried

Good social support	Poor social support
Good premorbid functioning	Poor premorbid functioning
Employment	Unemployed
Precipitating factor: Present	Absent

Q1.18: Differentiate between first-generation (typical) and second-generation (atypical) antipsychotics based on their mechanism of action, side effects, and therapeutic efficacy.  PYQ: AIIMS 2020

Answer:

Antipsychotics		
First Generation / Typical Antipsychotics		Second Generation / Atypical Antipsychotics
D2 Antagonist	MOA	D2 & 5HT2A Antagonist
More	S/E: EPS (Extra pyramidal symptoms → occur due to blockage of D2 receptors)	Less
Less	Metabolic S/E (Weight gain, HTN, Diabetes, Hyperlipidemia → occurs due to 5HT2C Antagonism)	More
Positive symptoms	More effect on	Positive and Negative symptoms

Q 1.19: What is the primary cause of Extrapyramidal Symptoms (EPS) in patients taking antipsychotic medications?

Answer:

 PYQ: INICET 2022

- EPS - Caused by the blockade of D₂ receptors in the nigrostriatal pathway
- Seen more in Typical Antipsychotics (especially high potency drugs) > Atypical Antipsychotics

Q1.20: What are the different types of Extrapyramidal Symptoms (EPS) in schizophrenia?

Answer:

- Mnemonic: **DPAT Night**
 - o Acute Dystonia
 - o Drug-Induced Parkinsonism
 - o Akathisia
 - o Tardive Dyskinesia
 - o Neuroleptic Malignant Syndrome (NMS)

Q1.21: What is acute dystonia? When does it occur, what are its common manifestations, and how is it treated?

Answer:

- Acute dystonia is a sudden muscle contraction
- Onset: Earliest
- Common manifestations
 - o Eyes rolling upwards: Oculogyric crisis
 - o Neck: Torticollis
 - o Jaw muscles: Trismus

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- o Laryngospasm
- Treatment: Parenteral Anticholinergic, Benztropine, Promethazine

Q1.22: When does drug-induced Parkinsonism occur, what are its features, and how is it treated?

Answer:

- Onset → days to weeks
- Manifestation
 - o Tremors (coarse tremors)
 - o Rigidity, Bradykinesia
 - o Rabbit syndrome (Perioral tremors): Usually at a later stage
- Treatment: Anticholinergic drugs such as Benztropine, Diphenhydramine, Trihexyphenidyl

Q1.23: How does akathisia present, and what is its treatment?

Answer:

- Most common EPS
- Objective signs: Rocking motion while sitting; Pacing around
- Subjective feeling is also present in the patient
- Treatment: Beta blockers - Propranolol (DOC)

Q1.24: When does tardive dyskinesia occur, what causes it, how does it present, and what is its treatment?

Answer:

- Tardive means late onset
- It may occur after months of treatment with antipsychotics
- Occurs because supersensitization of D₂ receptors
- Clinical manifestation
 - o Involuntary movements: Lip smacking/chewing
 - o Tongue protrusion (fly catching)
 - o Choreiform hand movements (piano playing); Pelvic thrusting movements
- Treatment
 - o Valbenazine, Tetrabenazine (VMAT-2 Inhibitors-Vesicular monoamine transporter)
 - o Reduce dose/stop
 - o Switch to clozapine/ Atypical antipsychotics (less EPS)

Q1.25: What is Neuroleptic Malignant Syndrome (NMS), what are its features, and how is it treated?

Answer:

- Life-threatening complication
- Clinical manifestation
 - o Fever, rigidity
 - o Increased creatinine phosphokinase(CPK)
 - o Tachycardia, sweating, leukocytosis, altered consciousness
 - o Increased levels of liver enzymes
- Treatment
 - o Stop drug; Supportive care
 - o DOC: Dantrolene (skeletal muscle relaxant)
 - o Bromocriptine, Amantadine (dopamine agonists)

Q1.26: What are the endocrine side effects of anti psychotics?**Answer:**

- Caused by blockade of D_2 receptors in the Tuberoinfundibular pathway
- In this pathway, Dopamine (DA) is inversely proportional to Prolactin (PRL)
- Hence, prolactin levels will increase → Hyperprolactinemia
- This, in turn, causes
 - In males and females → Decreased libido
 - In females → Galactorrhea, Amenorrhea

Q1.27: What are the main side effects of typical (first-generation) antipsychotics based on receptor blockade?**Answer:**

- D_2 blockade
 - EPS
 - Endocrinal S/E → High potency drugs (Haloperidol)
- Low-potency drugs
 - M_1 Blockade (muscarinic): Anticholinergic S/E, i.e., blurring of vision, dry mouth, urinary and fecal retention
 - Alpha 1 Blockade: Orthostatic Hypotension
 - H_1 Blockade: Sedation, weight gain

Q1.28: What are the important adverse effects and receptor actions of Chlorpromazine?**Answer:**

- Adverse effect
 - Corneal and lenticular deposits
 - Photosensitivity (Blue-gray color on sunlight exposure)
 - Cholestatic jaundice
- MOA: Blocks: M_1 , Alpha-1 and H_1 receptors (moderate risk of weight gain)

Q1.29: What is the main adverse effect of Haloperidol?

Answer: High D_2 potency drugs → have High EPS

Q1.30: What are the important adverse effects of Thioridazine?**Answer:**

- Retinal pigmentation (Irreversible)
- Cardiac arrhythmias (increase the QTC interval)
- Retrograde ejaculation
- Least EPS (among typical antipsychotics)

Q1.31: Which antipsychotic has the longest duration of action?

Answer: Penfluridol

Q1.32: What are the key features and side effects of atypical (second-generation) antipsychotics?**Answer:**

- MOA: D_2 and 5HT-2A antagonism
- Less EPS, Hyperprolactinemia
- Metabolic S/E → Weight gain, Diabetes, hyperlipidemia, HTN, Cardiovascular disease

Q1.33: What are the important adverse effects of Olanzapine, Risperidone, and Amisulpride?**Answer:**

- Olanzapine: Weight gain (drugs with high risk of weight gain)
- Risperidone: Increased EPS, Hyperprolactinemia
- Amisulpride: Increased EPS, Hyperprolactinemia

Q1.34: What are the key features and adverse effects of Ziprasidone and Aripiprazole?**Answer:**

- Ziprasidone: Increased QTC interval → cardiac arrhythmias
 - Low risk for weight gain
- Aripiprazole: Partial agonist of D_2 ; Antagonist - D_2 , 5HT_{2A}
 - Akathisia can be seen
 - Low risk of weight gain and low risk for increased prolactinemia

Q1.35: What are the mechanisms and key clinical points of Brexpiprazole, Cariprazine, and Pimavanserin?**Answer:**
 PYQ: NEET PG 2023

- Brexpiprazole: Partial agonist of D_2 , 5HT_{1A}; Antagonist - 5HT-2A
- Cariprazine: Partial agonist of D_2 , D_3 , 5HT-1A ($D_3 > D_2$); Antagonist - 5HT-2A
- Pimavanserin: 5HT-2A inverse agonist
 - Used as the Rx of delusion/hallucination of Parkinson's disease
 - Causes an increase in the QT interval

Q1.36: What is the unique role of Clozapine, and what are its major side effects?
 PYQ: INICET 2023
Answer:

- Antagonist $D_4 > D_2$ (Least EPS)
- Only antipsychotic → anti-suicidal property
- Used for treatment-resistant schizophrenia (No response to at least 2 antipsychotics, then we give clozapine)

Q1.37: What are the side effects of clozapine?**Answer:**

- Sedation (M/C)
- Weight gain (Maximum among all antipsychotics)
- Sialorrhea (hypersalivation)
- Serious S/E
 - Seizure (dose dependent)
 - Agranulocytosis: Weekly monitoring of patients for the first 6 months (WBC and neutrophil counts) and then every 2 weeks, then every month
 - We stop the drug if the WBC count is $<3000/\text{mm}^3$ and the ANC is $<1500/\text{mm}^3$
 - Myocarditis
- Agranulocytosis and myocarditis are not dose-dependent s/e; they are idiosyncratic

Q1.38: Where is Clozapine contraindicated?**Answer:**

- WBC Count $<3500/\text{mm}^3$

- Previous bone marrow disorder
- H/O agranulocytosis during clozapine treatment
- Use of another bone marrow suppressant, like carbamazepine

BIG QUESTION 2: Discuss other psychotic disorders, including Acute Psychotic Disorder, Schizoaffective Disorder, and Delusional Disorder.

Broad Answer:

- Other psychotic disorders involve delusions or hallucinations but differ from schizophrenia in symptom type and duration:
 - o Acute Psychotic Disorder: sudden onset, short duration
 - o Schizoaffective Disorder: psychotic and mood symptoms coexist for most of the illness
 - o Delusional Disorder: persistent delusions without major psychotic symptoms or functional impairment

DETAILED QUESTIONS

Q2.1: What is Acute Psychotic Disorder, and what are its key features?

Answer:

- Patient has symptoms similar to schizophrenia (delusions, hallucinations, disorganization symptoms)
- Do not meet the duration criteria (of schizophrenia)
- Abrupt onset
- Often resolves completely
- They may be preceded by a stressor:
 - o Stressful life event (e.g., death of a family member)
 - o Fever

Q2.2: If a patient presents with fever and sudden onset of delusions, hallucinations, or abnormal behavior, what are the main differential diagnoses, and how can they be distinguished?

Answer:

- Acute psychosis
- Delirium
- These differential diagnosis is differentiated from each other as Delirium has impairment of consciousness, which acute psychosis does not have

Q2.3: How do ICD-11 and DSM-5 classify psychotic disorders based on duration?

Answer:

- In ICD-11, Duration of 1 month → Acute psychotic disorder
 - o Duration of <1 month Acute and transient psychotic disorder
- In DSM-5, Duration of <1 month → Brief Psychotic Disorder
 - o Duration of >1 month, < 6 month → Schizophreniform Disorder

Q2.4: What is the treatment of acute psychotic disorder?

Answer: Antipsychotics

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Q2.5: What is Schizoaffective Disorder?

Answer: Patients have symptoms of both schizophrenia and mood disorder for the majority of the time during the illness

Q2.6: When is a diagnosis of Schizoaffective Disorder made?

Answer: A patient has had hallucinations/delusions for 8 months, and within these 8 months, there have been depressive symptoms for 7 months → Majority of the period, Schizoaffective disorder

Q2.7: What are the subtypes of Schizoaffective Disorder?

Answer:

- Bipolar Type: Manic Symptoms
- Depressive Type: Depressive Symptoms

Q2.8: What is the treatment of Schizoaffective Disorder?

Answer:

- Bipolar type: Antipsychotics + Mood Stabilizer
- Depressive type: Antipsychotics + Antidepressant

Q2.9: What is Delusional Disorder, and how is it treated?

Answer:

- Patient has only delusions
- Patient has 1 or more delusions (usually related), persistent
- Hallucinations are usually absent. If it's present, it would not be prominent and would have a short duration
- Functioning is not markedly impaired (function is normal in areas unaffected by delusion)
- Treatment: Antipsychotic



5. MOOD DISORDERS

BIG QUESTION 1: What are the mood disorders, and also describe depression and bipolar disorder?

Broad Answer: Mood disorders, also known as affective disorders, are conditions where the primary disturbance lies in mood. The two major types are depression and bipolar disorder. Depression, referred to as major depressive disorder (DSM-5) or depressive disorder, is considered unipolar since the abnormality is confined to the lower pole, with only depressive episodes and no occurrence of manic, hypomanic, or mixed episodes. The mood in depression is persistently sad and represented solely on the lower axis. In contrast, bipolar disorder is characterized by mood fluctuations that can range from sadness to elevated or irritable states, with the presence of manic or hypomanic symptoms. Both depression and bipolar disorder are episodic in nature, with the possibility of multiple recurring episodes.

DETAILED QUESTIONS

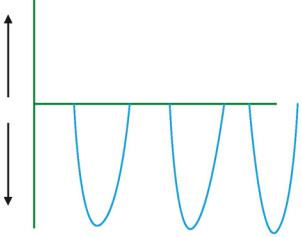
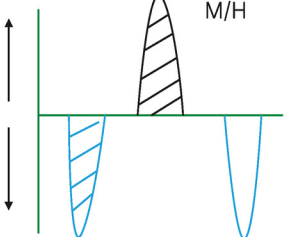
Q1.1: What is a mood disorder?

Answer: Mood disorders are also called affective disorders with a predominant abnormality of the mood.

- 2 major categories of mood disorders are:
 - o Depression
 - o Bipolar disorder

Q1.2: What are the basic differences between depression and bipolar disorder?

Answer:

Depression	Bipolar Disorder
 • Mood is sad- Represented in the lower axis only. • Multiple episodes can occur. • Episodic illness	 • Mood may be sad or happy/irritable. • Show manic or hypomanic symptoms. • Episodic

Q1.3: Why is depression considered a unipolar disorder?

Answer: Depression, also called Major Depressive Disorder (DSM-5) or Depressive Disorder, is considered unipolar because the abnormality is confined to the lower pole, with only depressive episodes and no manic, hypomanic, or mixed episodes.

Q1.4: Describe the epidemiology of depression.

Answer:

- Most common mental disorder in India, as per the National Mental Health Study 2015-16 → Depression.
- Most common mental disorder in the world → Anxiety disorder (specifically phobia).
- Second most common mental disorder in the world → Depression.
- More common in females than males: 2:1.
- Mean age of onset: 40 years (middle-aged females).
- Maximum DALY (Disability-adjusted life years) is associated with depression.

Q1.5: Describe the etiology of depression.

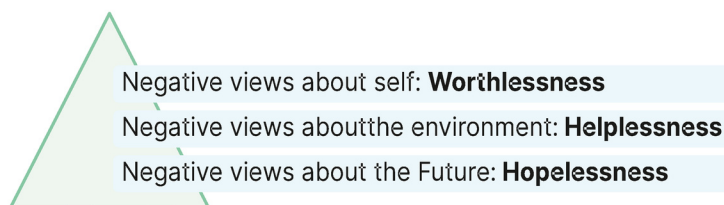
Answer: Biological factors:

Neurotransmitter	Endocrinal disturbances
• Monoamine hypothesis - Serotonin, Norepinephrine, and dopamine are implicated in the development of depression • The levels are reduced in patients with depression	• Hypothyroidism - Associated with depression. • Thyroid hormone is used as an augmenting agent in the treatment of depression.

Q1.6: What is the psychological theory associated with depression?

Answer: Cognitive theory:

- Given by Aaron Beck.
- Depressive patients develop cognitive distortions- negative patterns or inaccurate ways of thinking (negative automatic thoughts) which can be used in cognitive behavioral therapy.
- **Cognitive triad of depression:**



Q1.7: What are the symptoms of depression?

Answer: Symptoms of depression (Mnemonic is **SIGE CAPSS**):

PYQ: FMGE 2019, 2023

PYQ: NEET PG 2018

- Sad/Depressed mood
- Interest reduced / Anhedonia
- Guilt/worthlessness
- Energy is reduced/easy fatigability
- Concentration is reduced
 - Also known as pseudodementia, experiences forgetfulness
- Appetite
 - Some experience appetite and weight loss. Whereas some experience an increase in appetite and weight gain.
 - Significant weight change in a month >5%.
- Psychomotor retardation/agitation
- Suicidal thoughts or acts
- Sleeping disturbances
 - Early morning insomnia- Waking up at least 2 hours before the usual time.
 - Hypersomnia

Q1.8: What are the diagnostic criteria of depression based on the symptoms?

Answer: According to DSM-5 → 5 or more symptoms (at least 1 symptom from the first two, i.e., either sad mood or anhedonia must be there) for a duration of 2 weeks.

Q1.9: What is the recurrent depressive disorder?**Answer:** Recurrent depressive disorder is defined by:

- ≥ 2 episodes of depression
- Minimum duration of normal period between 2 episodes is 2 months.

Q1.10: What are the different specifiers for depression?**Answer:**

- Depression with Psychotic features
- Depression with Melancholic features
- Depression with Atypical Features
- Catatonia
- Postpartum Onset

Q1.11: Describe depression with Psychotic features. **PYQ: NEET PG 2020****Answer:** Psychotic depression is characterized by the presence of delusions or hallucinations occurring alongside depressive symptoms, with the illness beginning as depression.

- Mood congruent
 - o Content of delusion or hallucination is consistent with the theme of depression
 - o Delusion of nihilism
- Mood incongruent
 - o Content of delusion or hallucination is inconsistent with the theme of depression
 - o Delusion of grandiosity
- **Treatment:** Antidepressant with antipsychotics

Q1.12: Describe depression with Melancholic features. **PYQ: AIIMS 2019****Answer:** Involution melancholia, melancholic depression

- Very severe kind of depression
- Usually seen in old age
- Higher risk of suicide.
- **Presents with:**
 - o Loss of pleasure to all activities/ lack of reactivity to all the pleasurable stimuli.
 - o Distinct quality of depressed mood -profound despondency/ despair/ empty mode.
 - o Early morning awakening
 - o Anorexia/ weight loss.
 - o Mood is worse in the morning.
 - o Excessive guilt.
 - o Psychomotor disturbance.

Q1.13: Describe depression with Atypical Features. **PYQ: AIIMS 2018****Answer:** Mnemonic: **My WIL High**

- Uncommon features in depression:
 - o **M** - Mood reactivity: Mood brightens in response to a positive event.
 - o **W** - Weight gain/increase in appetite
 - o **I** - Interpersonal rejection sensitivity: The patient is sensitive to events and feels hurt/ rejected by others.

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- o L - Lethargy, where the limbs feel heavy.
- o H - Hypersomnia (increase in sleep)
- **Treatment:** Respond better to SSRIs, MAOI, and bupropion. They do not respond well to TCAs

Q1.14: Describe Catatonia.**Answer:**

- Depression with catatonic symptoms.
- These symptoms are more common in mood disorders than in schizophrenia.
- **Treatment:**
 - o Lorazepam with antidepressant
 - o Sometimes ECT is also given.

Q1.15: Describe postpartum onset depression.**Answer:** Also known as **Postpartum depression**.

- A female having depressive symptoms during pregnancy or within 4 weeks of delivery is called postpartum depression.
- **DSM-5:** During pregnancy or after delivery. It is also called peripartum onset.

Q1.16: Describe suicide in depression.**Answer:**

- In depression, about 10 to 15% of people commit suicide.
- Most common psychiatric disorder associated with suicide → Depression.

BIG QUESTION 2: Describe the pharmacotherapy options for depression and their main side effects.

Broad Answer: Selective serotonin reuptake inhibitors (SSRIs) such as sertraline, fluoxetine, paroxetine, citalopram, and escitalopram are the first-line drugs for depression, with common side effects including gastrointestinal upset, anxiety, insomnia, and sexual dysfunction. Serotonin norepinephrine reuptake inhibitors (SNRIs) like venlafaxine share these side effects and may also cause hypertension. Tricyclic antidepressants (TCAs) block serotonin and norepinephrine transporters but are limited by anticholinergic and cardiotoxic effects. Monoamine oxidase inhibitors (MAOIs) prevent monoamine metabolism but can trigger hypertensive crises when interacting with tyramine. Atypical antidepressants such as bupropion (an NDRI) have fewer sexual side effects but carry a risk of seizures.

DETAILED QUESTIONS**Q2.1: How to treat depression?**

Answer: For treating depression, we have 2 therapies: Pharmacotherapy and Psychotherapy.

Q2.2: What are the features of pharmacotherapy?

Answer: Pharmacotherapy is chosen based on the side effect profile, and it typically takes 3-4 weeks to show action.

Q2.3: Which SSRIs are used in the treatment of depression?**Answer:**

 PYQ: AIIMS 2018, 2019  PYQ: FMGE 2020, 2023

- **Drug of choice** for the treatment of Depression is Selective Serotonin Reuptake Inhibitor (SSRI):
 - o Sertraline

- o Fluoxetine
- o Paroxetine
- o Citalopram
- o Escitalopram
- o Vilazodone
- o Fluvoxamine
- o Escitalopram: Most serotonin selective drug
- **Vilazodone:** SPARI (serotonin partial agonist & reuptake inhibitor). It is an SSRI but also a 5-HT_{1A} partial agonist.
- **Fluvoxamine:** used for OCD.

Q2.4: What are the side effects of SSRIs?

 PYQ: INICET 2020

Answer:

- **GI:** Nausea is the most common side effect, diarrhea, anorexia, dry mouth, weight gain, and constipation, especially with paroxetine (due to anticholinergic side effects)
- **CNS:** Anxiety, insomnia, sedation, vivid dreams
- **Sexual dysfunction:** Most common side effect with long-term treatment. Decrease in libido, delayed ejaculation, and inhibited orgasm.
- **Miscellaneous:** Hyponatremia, especially in the elderly

Q2.5: Describe the serotonin modulator & stimulator that can be used in depression.

 PYQ: INICET 2022

Answer: Vortioxetine:

- Agonist at 5-HT_{1A}
- Partial Agonist at 5-HT_{1B}
- Antagonist at 5HT_{1D}, 5HT₃, 5HT₇
- 5-HT reuptake Inhibitor property
- Sexual side effects can occur

Q2.6: What is the risk associated with SSRIs and SNRIs in pregnancy?

 PYQ: AIIMS 2018

Answer:

- SSRIs and SNRIs are not major teratogens.
- Paroxetine → avoided in pregnancy → can result in cardiovascular defects.
- SSRIs and SNRIs, if given, especially late in the pregnancy, are known to cause persistent pulmonary hypertension in the newborn

Q2.7: Describe SNRIs.

Answer: Serotonin Norepinephrine Reuptake Inhibitors (SNRIs) are also known as dual reuptake inhibitors.

- Some SNRIs used in depression are:
 - o Venlafaxine
 - o Desvenlafaxine
 - o Levomilnacipran
 - o Duloxetine
 - o Milnacipran
- **Side effects of SNRIs:**
 - o Similar to SSRIs.
 - o Hypertension - especially with a higher dose of Venlafaxine

Q2.8: Describe discontinuation syndrome.**Answer:**

- Due to the abrupt discontinuation of the drug → withdrawal symptoms.
- Seen with short-acting drugs like venlafaxine, fluvoxamine, and paroxetine.
- Not seen with long-acting drugs such as fluoxetine.
- **Symptoms**
 - o Flu-like symptoms (lethargy, weakness, and headache).
 - o Insomnia
 - o Nausea
 - o Irritability

Q2.9: Describe Tricyclic and Tetracyclic Antidepressants (TCAs).**Answer:**

- **MOA:** TCA blocks the transporters of serotonin and norepinephrine (increasing their levels).
- **Secondary effects of TCAs:** Due to the blockage - Antagonist at muscarinic receptors, causing anticholinergic effect, hence should be avoided in Narrow angle glaucoma and shows antagonism at H₁, α-1, α-2 receptors and voltage-sensitive sodium channels.
- **Examples of tricyclic drugs:** Clomipramine, Amitriptyline, Imipramine, Nortriptyline

Q2.10: What happens if the toxicity of TCAs occurs?**Answer:**

- **Triad of TCA toxicity:**
 - o **CNS:** Altered sensorium, Respiratory depression, Seizures, Coma
 - o **CVS:** Hypotension, ECG: PR, QRS, QT, interval, AV block, RAD, QRS>100ms
 - o **ANS:** Dry mouth, Blurred vision, Urinary incontinence, Mydriasis, Hyperthermia
- Metabolic Acidosis (2° to tissue Hypoxia, Cardiovascular abnormalities, seizure).

Q2.11: How to treat TCA toxicity?**Answer:** Treatment of TCA toxicity:

- I.V. sodium bicarbonate (Serum alkalization)
- Activated charcoal
- No role in hemodialysis because of the high volume of distribution

Q2.12: What is the role of MAOIs in the treatment of depression?

PYQ: FMGE 2023

Answer:

- Monoamine Oxidase Inhibitors (MAOIs) → **1st class of approved antidepressants.**
- Inhibits the metabolism of monoamines (5HT, NE, DA).
- **Cheese reaction/tyramine-induced hypertensive crisis:**
 - o Cheese, bear, fish, and red wine contain tyramine. Tyramine is sympathomimetic, metabolized in GI tract.
 - o MAOIs inhibit the tyramine metabolism, which enters the circulation and causes a hypertensive crisis.

Q2.13: What atypical antidepressants are used in the treatment of depression?

PYQ: NEET PG 2023

Answer:

- NRDI (Norepinephrine dopamine reuptake inhibitors): Bupropion

- NaSSA (Noradrenergic & specific serotonin antidepressants): Mirtazapine
- Novel agents: Esketamine (S-enantiomer of Ketamine)
- Gepirone

Q2.14: Describe atypical antidepressants used in the treatment of depression?

Answer:

NRDI (Norepinephrine dopamine reuptake inhibitors)	
Bupropion	• Has a low risk of sexual dysfunction, sedation, and weight gain • Also used for smoking cessation
Side effects	• Seizure (especially at higher dosage). • Contraindicated in bulimia nervosa and anorexia nervosa
NaSSA (Noradrenergic & specific serotonin antidepressants)	
Drug	• Mirtazapine
Side effect	• Sedation (mc) • Weight Gain • Sexual S/E (Not seen)
Novel agents	
Drug	• Esketamine (S-Enantiomer of Ketamine)
MOA	• N-methyl-D-Aspartate (NMDA) Antagonist
Route	• N-methyl-D-Aspartate (NMDA) Antagonist
FDA approved 2019	• Treatment-resistant Depression • In conjunction with oral Antidepressant
Gepirone	
• Agonist/ partial agonist at 5HT_{1A} • Approved by the FDA in 2023 for MDD • Contraindicated in: - o Prolonged QTc interval > 450 msec - o Congenital long QT syndrome	

BIG QUESTION 3: Describe the psychotherapy and other treatment modalities for depression treatment.

Broad Answer: Psychotherapy, especially CBT, is effective in correcting cognitive distortions and maladaptive behavior. Rejoyn (CT-152) is the first FDA-approved digital therapeutic for MDD, used with antidepressants in adults ≥22 years. Best outcomes come from combining drugs with psychotherapy—CBT alone for mild cases, drugs plus CBT for moderate to severe. ECT is indicated for suicidal risk, severe or catatonic depression, and is safe in pregnancy.

DETAILED QUESTIONS

Q3.1: Describe psychotherapy used in the treatment of depression.

 PYQ: FMGE 2021

Answer: Psychotherapy is treatment using psychological methods:

- **Cognitive Behavioural Therapy:**
 - o Has the best evidence

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- o Correcting cognitive distortions
- o Maladaptive behaviour
- **Rejoyn (CT - 152):**
 - o 1st prescription digital therapeutic approved by FDA for MDD
 - o Used as an adjunct to OPD care for patients with MDD, age ≥ 22 years, on an antidepressant.

Q3.2: What is the treatment of choice for depression?

Answer:

- A combination of pharmacotherapy + psychotherapy has a higher response.
- Single therapy alone is sufficient for most of the part.
- Mild cases → CBT
- Moderate or severe cases → Drugs + CBT

Q3.3: What are the indications for Electroconvulsive therapy (ECT) in depression?

Answer:

- Depression + suicidal risk.
- Can be given even in pregnancy
- Severe depression with stupor.
- Depression with catatonic symptoms



6. COGNITIVE FUNCTIONS

Big Question 1: Define Cognitive function, and what are the various types?

Broad answer:

- Defined as the mental process of knowing and becoming aware
 - It's impaired in a neurocognitive disorder
 - Various types of cognitive functions are
1. Basic mental functions
 - Orientation
 - Attention
 - Concentration
 - Memory
 2. Higher mental functions
 - Abstract thinking
 3. Judgement
 4. Insight

DETAILED QUESTIONS

Q1.1: Define Orientation?

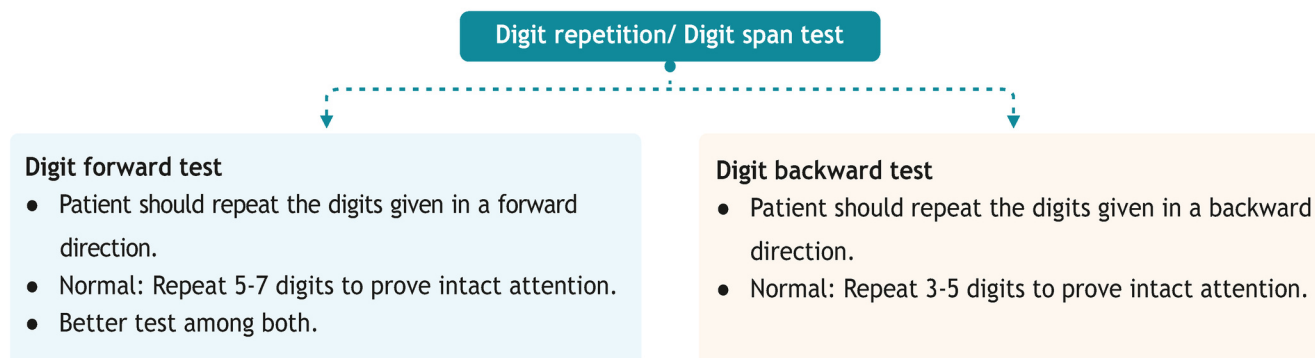
Answer :

- Awareness of self and surroundings with respect to time, place, and person.
- Disorientation is commonly seen in cases of delirium.

Q 1.2: Define attention and the tests used to assess it?

Answer:

- Ability to attend to a specific stimulus without being distracted.
- Tests to assess attention: Digit repetition and digit span tests.



Q 1.3: Define concentration, and what are the tests used to check concentration?

PYQ: FMGE 2023

Answer:

- Concentration is sustained attention, i.e., attention maintained over an extended period.

- Test for checking concentration: Serial 7s Subtraction Test (100-7 test).
- The patient is asked to subtract 7 from 100 and continue subtracting 7 from each subsequent answer.
- Concentration is considered intact if the patient is able to perform the task correctly up to 5 times.

Q 1.4: What are the various types of memory?

Answer :

Immediate/short term memory	Recent memory	Remote memory
• Memory of the past few seconds • Test: Test for attention & concentration. • Specific test: Digit forward test	• Memory of the past few mins/ hours/ days • Test: 24 hour recall method. • Patient is asked to recall certain events that happened in the past 24 hours & correlated with family members	• Memory that goes back to months/ years. • Test: Ask for personal information such as the name of the school friends, name of the past three prime ministers

Q 1.5: What is the next test to be done if basic mental functions are intact?

Answer :

- If basic mental functions are intact, higher mental functions such as abstract thinking are checked.
- Abstract thinking :
 - o It is the ability to understand hidden meanings and abstract concepts.

Proverb testing	Similarity testing
• Patient is asked meaning of a proverb, such as “Pen is mightier than the sword” • If the patient is unable to answer, it suggests loss of abstract thinking. • This is known as concrete thinking.	• Patient is asked to point out the similarity between two objects. E.g., Cars and airplanes. Functional similarity • Patient may say that both of these are means of transport. • Abstract thinking is present. Structural Similarity • Patient may say that both have tyres, both are made of metals. • Suggests loss of abstract thinking. • This is known as concrete thinking.

Q 1.6: Define judgment, and how do you test it?

Answer :

- Making the right decision after analyzing the choices.
- Test of judgment:
 1. A hypothetical situation is given to the patient. For example, the patient is asked what he will do if the neighbor's house catches fire and answers by saying he will add more fuel to the fire, which means that he has impaired judgment.
 2. Impaired judgment is seen in psychosis, such as schizophrenia.

Q 1.7: What are the five grades of insight?

Answer :

- Insight is the awareness of illness.

- Sometimes, psychiatric patients may not be aware of their illness.

Grade 1	• Complete denial of illness.
Grade 2	• Slight awareness of being ill but denying it at the same time.
Grade 3	• Awareness of the illness present, • The patient attributes it to external/physical/medical/unknown factors
Grade 4	• Also known as intellectual insight. • Awareness of illness due to his own irrational feelings or emotions, but the patient refuses to apply this knowledge to change his behavior. • E.g.: Refusing to take medication despite knowing that the patient is suffering from depression.
Grade 5	• Called true emotional insight. • Awareness of his illness due to his own irrational feelings or emotions and agrees to apply such knowledge to change his behavior. • E.g., the patient takes his medicine properly, attends therapy sessions, and is taking steps to improve his lifestyle. • Highest level of insight.

- Psychiatric illnesses are divided into neurosis and psychosis.
 - o In neurosis, insight is present.
 - o In psychosis, insight is absent.

Big question 2: What are the classifications in psychiatry based on symptoms?

Broad Answer :

ICD-11

- International Statistical Classification of Diseases, 11th revision.
- By WHO.
- This is for all disorders, including medicine, surgery, dermatology, OBG, etc.

DSM-5

- Diagnosis and Statistical Manual of Mental Disorders, 5th Edition
- By the American Psychiatric Association.
- Exclusive for mental disorders.
- In India, both of these are followed.

 PYQ: NEET PG 2018

DETAILED QUESTIONS

Q 2.1: What's the difference between organic and functional disorders?

Answer:

Organic disorders	Functional disorders
• Psychiatric symptoms following a visible cause. • E.g. Following a head injury, CT scan show injury. • Conditions: - o Delirium - o Dementia - o Amnestic disorders	• No visible cause. • E.g., Depression • Further divided into: - o Neurosis - o Psychosis

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Q 2.2: What are the differences between Neurosis and Psychosis?

Answer :

	Neurosis	Psychosis
Insight	Present	Absent 
Reality testing	Intact	Impaired
Judgment	Intact	Impaired
Delusion and Hallucination	Absent	Present
Examples	• Anxiety Disorders • OCD • Somatoform and related disorders • Depression	• Schizophrenia • Acute psychosis • Delusional disorders • Mania • Psychotic depression

Q 2.3: What criteria to be fulfilled to name it as a Disorder?

Answer:

Fulfilment of symptom criteria	Certain number of symptoms should be fulfilled to call it a disorder.
Fulfilment of duration of criteria	Example: In depression, the symptom should be present for at least 2 weeks.
Impairment of functioning	Patient's occupational, social and personal activities are affected.



7. BIPOLAR DISORDERS

Big question 1: What are the key characteristics, symptoms, and treatment approaches for bipolar disorder, including manic, depressive, hypomanic, and mixed episodes?

Broad Answer:

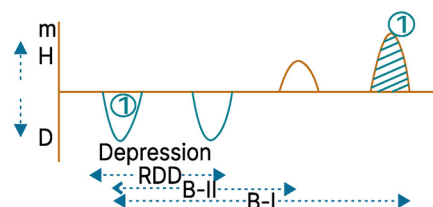
- Bipolar disorder is a mood disorder characterized by episodes of mania, depression, hypomania, and mixed episodes.
- The symptoms and treatment approaches vary depending on the type and severity of the episode.
- Manic episodes are marked by elevated mood, increased energy, and impulsive behavior, while depressive episodes are characterized by low mood and energy.
- Hypomanic episodes are similar to manic episodes but less severe, and mixed episodes involve a combination of manic and depressive symptoms.
- Treatment approaches include mood stabilizers, antipsychotics, and antidepressants, with the goal of managing symptoms and preventing future episodes.
- Lithium and valproate are commonly used for maintenance treatment, and the choice of treatment depends on the phase of illness and individual patient needs.

DETAILED QUESTIONS

Q1.1: What characterizes Bipolar I and Bipolar II disorders in terms of episodes of mania, hypomania, and depression?

Answer:

- Episodes of Mania, depression, hypomania, and mixed episodes are seen.
 - Mixed episodes: Patient symptoms may fluctuate between depression and mania.
- Bipolar I disorder: Patient has at least 1 episode of Mania + 1 episode of Depression.
- Bipolar II disorder: Patient has at least 1 episode of Hypomania + 1 episode of Depression.
- Even a single episode of mania is considered under bipolar disorder. (both in ICD-11 and DSM-5)



Q1.2: What is the epidemiology of bipolar disorders?

Answer:

PYQ: INICET 2022

- Bipolar I disorder
 - Prevalence is 1 %

Bipolar I disorder	Bipolar II disorder
M = F	F > M

Q1.3: What's the etiology of bipolar disorders?

Answer:

- Etiology
 - Levels of neurotransmitters, especially dopamine, are increased in patients with mania.
- Genetic Factors

- o Chromosomes 18q, 22q (Strongest evidence), and 21q

Q1.4: What are the symptoms of mania?

 PYQ: NEET PG 2021

Answer: Mania: Symptoms (Mnemonic : ME DIG FAST)

- | | |
|---|---|
| <ul style="list-style-type: none"> • Mood euphoric/ Irritable • Energy ↑ • Distractibility • Impulsivity <ul style="list-style-type: none"> o Hyper Sexuality o Overspending o Over Socialization o Over Religious | <ul style="list-style-type: none"> • Grandiosity/ Inflated self esteem • Flight of ideas • Activity level ↑ • Sleep (↓ need for sleep) • Talkativeness |
|---|---|

Q1.5: What's the diagnostic criteria for mania?

Answer:

- First 2 symptoms (mood elation + increased energy) along with 3 or more other symptoms for a duration of 1 week.
- Mania with psychotic symptoms
- Mania with delusion/hallucination:
 1. Mood congruent
 2. Mood incongruent

Q1.6: How do you differentiate hypomania from mania?

Answer:

- Symptoms are similar to mania.
- Not severe enough to cause marked impairment of social and occupational functioning.
- Does not have a flight of ideas or psychotic symptoms.
- Duration of hypomania is 4 days.
- Hospitalization is not required.

Q1.7: What is a mixed episode, and what duration is required for diagnosis?

Answer:

- A mixed episode occurs when a patient experiences both manic and depressive symptoms.
- Symptoms must persist for at least seven days.

Q1.8: Describe the treatment approach for Bipolar disorder?

Answer:

- Depends on the phase of illness:
 1. Acute phase: It includes manic or hypomanic, depressive, and mixed episodes.
 2. Maintenance phase: Prophylaxis.

Q1.9: How do you treat Acute manic or Hypomanic episodes?

 PYQ: FMGE 2022

Answer:

- The first step will be to stop the antidepressant.
- Medications that can be used:

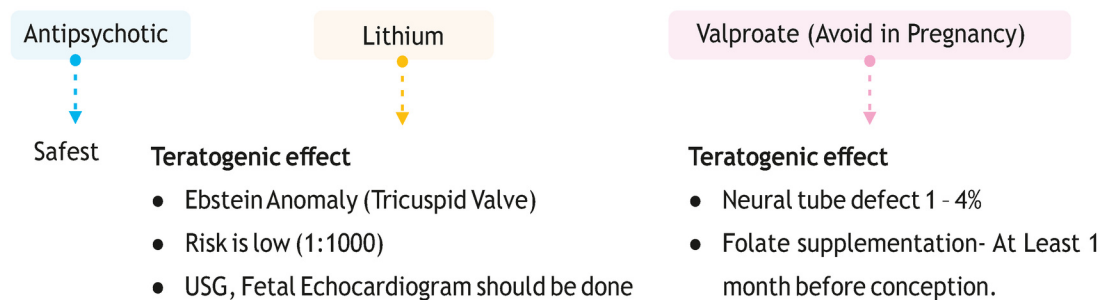
First line drugs		
Antipsychotics	Lithium	Valproate
• Olanzapine • Risperidone • Quetiapine • Aripiprazole • Cariprazine • Ziprasidone • Asenapine • Paliperidone • Iloperidone • Used especially if psychotic symptoms are present	• Onset of drug action: 1-3 weeks • Prototypical mood stabilizer • Euphoric mania	• Rapid onset of action & better tolerability • Surpassed Lithium in acute mania. • Dysphoric mania • Not to be given in hepatic disease • Can cause PCOD in females can be given but not recommended

- Benzodiazepines: They can initially be used to calm the patient.

Q1.10: What is the treatment consideration to be done in a pregnant person with mania?

 PYQ: FMGE 2022

Answer: In pregnancy:



- Severe symptoms:
 - o Lithium + Antipsychotic
 - o Valproate + Antipsychotic

Q1.11: What's the treatment approach for Acute depression (Bipolar depression)?

Answer: Treatment of Acute Depression (Bipolar Depression)

- In acute depression (bipolar depression), do not use antidepressants alone.
- If only antidepressants are given, there is a risk of a switch to mania.
- Some of the drugs that can be used are:
 1. Lithium, Lamotrigine (depression > mania)
 2. Quetiapine, Lurasidone
 3. Olanzapine (Antipsychotic) + Fluoxetine (SSRI)
 4. Antidepressant + Mood stabiliser (Lithium, Valproate, Lamotrigine)
 - Lamotrigine: In pregnancy, it is safer than valproate, carbamazepine (CBZ), and lithium.

Maintenance (Prophylaxis)

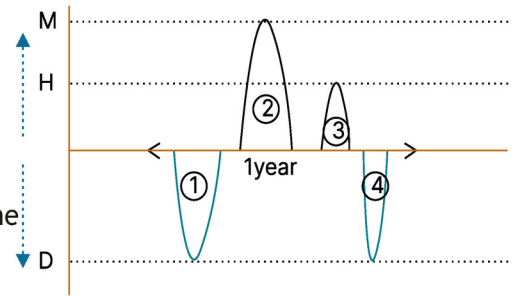
- 2 or more episodes or after a single episode of mania (associated with significant risk).
- The treatment of choice is lithium and valproate (lithium > valproate)
- Minimum duration is 2 years.

Q1.12: Define Rapid cycling bipolar disorder and its treatment?

PYQ: FMGE 2020

Answer:

- A patient with bipolar disorder has 4 or more episodes of mania, hypomania, or depression in 1 year.
- Factors favoring the occurrence
 1. Female
 2. Borderline hypothyroidism
 3. Menopause
 4. Temporal lobe dysrhythmias
 5. Substance abuse - alcohol, minor tranquilizer, stimulant, or caffeine
 6. Long-term, aggressive use of antidepressants
- Treatment: Valproate, Lamotrigine.

**Big question 2 : What are the characteristics and symptoms of persistent mood disorders?**

Broad answer: Dysthymia and cyclothymia are persistent mood disorders characterized by mild depressive symptoms and alternating manic/depressive symptoms, respectively, lasting at least 2 years with minimal functional impairment.

DETAILED QUESTION**Q2.1: What are the differences between Dysthymia and Cyclothymia?****Answer:**

Dysthymia	Cyclothymia
Presence of mild depressive symptoms, which are not enough to diagnose depressive episodes.	A milder form of bipolar disorder in which Manic and depressive symptoms occur but are not severe enough to make a diagnosis of mania/ hypomania or depressive episodes.
Duration: 2 years	Duration: 2 years
Functional impairment: not severe	Functional impairment: not severe

Big question 3: What are the psychiatric aspects of postpartum pregnancy?**Broad answer:**

- Postpartum blues, aka baby blues, are mild, transient depressive symptoms like sadness, irritability, and sleep disturbances.
- Postpartum depression is characterized by depressive symptoms, insomnia, suicidal thoughts, and thoughts of harming a baby
- Postpartum psychosis includes insomnia, fatigue, and it may lead to delusions and hallucinations

DETAILED QUESTION**Q 3.1: What are the differences between postpartum blues, depression and psychosis?****Answer:**

PYQ: FMGE 2021, 2022 PYQ: NEET PG 2020, 2022, 2023

	Postpartum blues	Postpartum depression	Postpartum psychosis
Occurrence	30 to 75% of women after childbirth	Seen in 10 to 15% of women after childbirth.	0.1 - 0.2 % after childbirth

Onset	Seen after 3 to 5 days after childbirth.	During pregnancy, within 4 weeks to 3 months of delivery • Increased risk of bipolar disorder	Within 2 to 3 weeks of delivery.
Symptoms	Mild transient depressive symptoms like sadness, irritability, and sleep disturbances.	• Depressive symptoms, low mood, insomnia, irritability • Anhedonia guilt is most often. • Suicidal thoughts may be present. • Thoughts of harming the Baby may be present	• Initial symptoms include insomnia, tearfulness, mood lability, and fatigue. • This can also lead to delusion or even hallucination.
Treatment	No professional treatment is required. • Supportive care	• SSRI, CBT • Brexanolone (IV infusion, continuous over 60 hours)- 2019 • Zuranolone (oral)- 2013 • New drug • It is identical to endogenous allopregnanolone. • Decreases after childbirth • Positive allosteric modulator of GABA receptors.	• Psychiatric emergency • Treatment includes antipsychotics + lithium • Often in a combination of anti-depression.

Big question 4 : What are the key risk factors and characteristics of suicidal behavior in India, and how can they be identified and addressed ?

Broad Answer: Suicidal behavior in India is a significant concern, with a rate of 12.4 per 1 lakh population. Key risk factors include previous attempts, hopelessness, depression, substance abuse, and lack of social support. Identifying these risk factors and providing adequate support and treatment can help mitigate suicidal behavior. It's also essential to be aware of paradoxical suicide, copycat suicide, and para-suicide, which can occur in specific contexts.

DETAILED QUESTIONS

Q 4.1: What's the rate of suicide in India and the most common method used for it, and which psychiatric disorders are at a higher risk of suicide?

Answer:

- Suicide rate in India, according to the 2022 NCRB: 12.4 per 100,000 population.
- Most common method - hanging, followed by poisoning
- Depressive disorder has a higher risk of suicide among psychiatric disorders.

Q 4.2: What are the risk factors for suicide?

Answer:

Important risk factors	• Previous suicide attempts • Hopelessness
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Other risk factors (Mnemonic: Mad Persons)	• Male sex • Age more than 45 years, Abuse • Depression • Previous attempt • Excess alcohol or substance abuse • Rational thinking loss (delusion, hallucination) • Social support lacking • Organized plan (suicide note) • No spouse (divorced, separated, single), no job • Sickness: Chronic • Family history of suicide
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Q 4.3: What is paradoxical suicide, copycat suicide and para suicide?

 PYQ: AIIMS 2019

Answer:

Paradoxical Suicide	• In the initial stages of treatment or recovery, the patient may try suicide attempt • It is because of gain of energy
Copycat Suicide	• Mimicry of another suicide method, which the person attempting suicide knows either by local knowledge or media • Common in adolescence
Para Suicide	• Self-injurious behavior • No intent to kill themselves • Seen in borderline personality disorders



8. ANXIETY DISORDERS

BIG QUESTION 1: What are the key clinical features and epidemiology of anxiety disorders?

Broad Answer: Anxiety is a diffuse, unpleasant sense of apprehension often accompanied by physiological symptoms such as sweating, tachycardia, tremors, restlessness, chest pain, and cold, clammy skin. Anxiety disorders are the most common psychiatric disorders worldwide, with specific phobias being the most frequent individual disorder. They are more prevalent in females.

DETAILED QUESTIONS

Q1.1: What is anxiety, and what are the main clinical features of anxiety?

PYQ: FMGE 2020

Answer:

- Diffuse, unpleasant sense of apprehension (nervousness)
- Physiological symptoms:
 - o Sweating
 - o Tachycardia
 - o Tremors
 - o Restlessness
 - o Chest pain
 - o Cold clammy skin
 - o Headache

Q1.2: What is the most common psychiatric disorder worldwide?

Answer: Anxiety disorders

Q1.3: Which is the most common individual anxiety disorder?

Answer: Specific phobias

Q1.4: What is the gender distribution of anxiety disorders?

Answer:

- All anxiety disorders are more common in females than in males
- Exception: Social anxiety disorder is equally common in males and females

Q1.5: What are the major types of anxiety disorders?

Answer:

- Panic disorder
 - o Phobias (situational anxiety)
 - o Agoraphobia
 - o Specific phobias
 - o Social phobias
- Generalized anxiety disorder

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BIG QUESTION 2: What are the clinical features, differential diagnosis, and management of panic attacks and panic disorder?

Broad Answer: A panic attack is a sudden episode of intense anxiety with palpitations, breathlessness, chest pain, and fear of doom. Panic disorder is diagnosed when attacks recur for ≥ 1 month. Differentials include cardiac, respiratory, seizure, and endocrine causes. Treatment: SSRIs (first-line), short-term benzodiazepines for acute relief, and CBT. Best outcomes with SSRIs + CBT.

DETAILED QUESTIONS**Q2.1: What is a panic attack?**

PYQ: NEET PG 2021

Answer: Acute, sudden onset of intense anxiety

Q2.2: What are the clinical features of a panic attack?

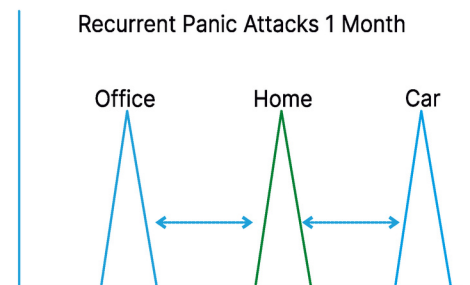
Answer:

- Symptoms: palpitations, sweating, tremors, shortness of breath, chest pain
- Psychological features: fear of impending doom, fear of dying, fear of losing control or “going crazy”
- Attacks are unexpected, not tied to a specific situation
- Duration: usually 20-30 minutes, rarely > 1 hour

Q2.2: How is panic disorder defined?

Answer:

- Recurrent panic attacks lasting at least 1 month
- Patients are normal between attacks, though some may have anticipatory anxiety

**Q2.3: What are the important differential diagnoses for panic disorder due to overlapping somatic symptoms?**

Answer:

- Cardiovascular: Myocardial infarction, angina, mitral valve prolapse, anemia
- Respiratory: Asthma, pulmonary embolism
- Neurological: Seizure disorder, migraine
- Endocrine: Hypothyroidism, pheochromocytoma, hypoglycemia

Q2.4: What is the pharmacological treatment for panic disorder?

Answer:

- SSRIs - Drug of choice
- Short-term benzodiazepines - DOC for acute attack
- Venlafaxine
- SSRIs + benzodiazepines (Short term)

Q2.5: Which psychotherapy is most effective for panic disorder?

Answer: Cognitive Behavioral Therapy (CBT)

Q2.6: What is the treatment of choice for panic disorder?

Answer:

- Combination of pharmacotherapy and psychotherapy

- o SSRIs + CBT

BIG QUESTION 3: What are the clinical features, types, and management of agoraphobia and specific phobias?

Broad Answer: Agoraphobia is the fear of situations where escape seems difficult, often linked with panic disorder, while specific phobias involve irrational fears of certain objects or situations. Treatment is mainly behavior therapy (desensitization, exposure, flooding), with SSRIs or benzodiazepines as adjuncts.

DETAILED QUESTIONS

Q3.1: What is agoraphobia, and what are its key clinical features?

 PYQ: FMGE 2019

Answer:

- Fear or anxiety in two or more situations:
 - o Public transportation
 - o Open spaces
 - o Closed spaces
 - o Crowded places/standing in line
 - o Being alone outside the home
- Patients experience anxiety in situations where escape might be difficult

Q3.2: What is the most common psychiatric comorbidity associated with agoraphobia?

Answer: Panic disorder

Q3.3: What are specific phobias, and what are some examples?

Answer: Definition: Strong, persistent, irrational fear of a specific object or situation

Q3.4: Give a few examples of specific phobias.

Answer:

	Fear of
Acrophobia	Heights
Ailurophobia	Cats
Cynophobia	Dogs
Claustrophobia	Closed spaces
Mysophobia	Dirt and germs
Hydrophobia	Water
Thanatophobia	Death
Nyctophobia	Dark
Xenophobia	Strangers
Pyrophobia	Fire

Q3.5: What is the psychotherapy of choice for specific phobias?

Answer:

- Behavior therapy (preferred over CBT)
- Systematic desensitization: Coined by Joseph Wolpe

- o Therapy of choice
- o Relaxation techniques + hierarchy (from least anxiety to maximum anxiety-provoking situations)
- o Patient moves up to the next step once he masters relaxation in the previous situation

Q3.6: What are other behavioral therapy techniques used in phobias?

Answer:

- Therapeutic graded exposure: Aka In-vivo exposure/ Exposure and response prevention
 - o Similar to systematic desensitization, except that no relaxation techniques are used
 - o Patient learns to get habituated to anxiety
- Flooding/ Implosion
 - o Patient is exposed to supra-maximal stimulus
 - o Patient experiences intense anxiety, which gradually decreases

Q3.7: What is the pharmacological treatment for phobias?

Answer: SSRIs ± benzodiazepines

Q3.8: What are the key clinical features of social anxiety disorder?

 PYQ: FMGE 2022

Answer:

- Fear of social situations, especially those involving contact with strangers
- Fear of embarrassing oneself in front of others

Q3.9: What pharmacological treatments are used in social anxiety disorder?

Answer:

- SSRIs ± benzodiazepines (short-term)
- SNRIs: Venlafaxine
- B-blockers, e.g., propranolol, are used for performance anxiety

Q3.10: What is the psychotherapy of choice for social anxiety disorder?

Answer: Cognitive Behavioral Therapy (CBT)

BIG QUESTION 4: What are the clinical features and treatment options for generalized anxiety disorder (GAD)?

Broad Answer: Generalized anxiety disorder is marked by continuous, excessive, and hard-to-control worry about everyday matters like health or deadlines. Management involves SSRIs or SNRIs, short-term benzodiazepines for relief, and psychotherapy, especially CBT.

DETAILED QUESTIONS

Q4.1: What are the key clinical features of generalized anxiety disorder (GAD)?

 PYQ: FMGE 2021

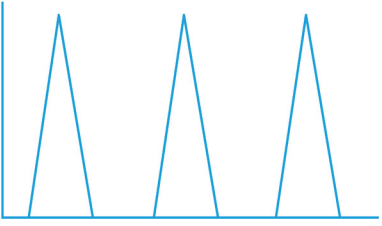
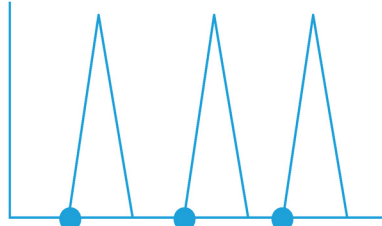
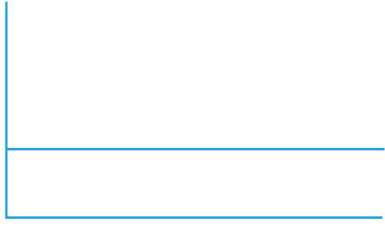
Answer:

- Excessive anxiety and excessive worries
- Generalized and persistent anxiety not restricted to any particular situation (free-floating anxiety)
- It occurs continuously
- Excessive worries may involve simple daily activities, deadlines, and health

Q4.2: What pharmacological treatments are used in GAD?**Answer:**

- SSRIs ± benzodiazepines (short term)
- SNRIs: Venlafaxine

Q4.3: What psychotherapy is used in GAD?**Answer:** Cognitive Behavioral Therapy (CBT)**Q4.4: List the main types of anxiety disorders and briefly describe each.****Answer:**

1. Panic Disorder • Sudden intense anxiety with feeling of impending doom/fear of dying 	Phobias situational Anxiety 2. Agoraphobia 3. Specific phobia 4. Social phobia 	5. Generalized Anxiety Disorder (GAD) Generalized not restricted to situation (free-floating) • Apprehension (worries) 
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9. OBSESSIVE COMPULSIVE RELATED DISORDERS

BIG QUESTION 1: What are the core clinical features, underlying neurobiological basis, and treatment approaches for Obsessive-Compulsive Disorder (OCD), and how does it differ from related disorders?

Broad Answer: OCD involves intrusive obsessions and/or compulsions that are distressing and time-consuming. It is linked to serotonin imbalance and CSTC circuit dysfunction. Common symptoms include contamination fears and washing rituals. Treatment includes SSRIs and CBT. Related disorders like hoarding and body dysmorphic disorder share compulsive traits but differ in focus.

DETAILED QUESTIONS

Q 1.1: What is Obsessive-Compulsive Disorder (OCD)?

Answer:

- Patient has recurrent obsessions and compulsions
- Obsession is an abnormality of possession of thought

Q 1.2: How are obsessions and compulsions defined in their clinical presentation?

Answer:

🔍 PYQ: NEET PG 2021 🔍 PYQ: FMGE 2020, 2021

Obsessions		Compulsions
Mnemonic - 'ROSI'		• Repetitive behaviors (e.g., washing, checking) or Mental acts (e.g., counting). • Performs in response to obsessions or in a rigid rule-bound manner. • They are often time consuming (e.g.: >1 hour/ day) • Cause clinically significant distress/ impairment in functioning
R-Recurrent	• Recurrent and intrusive thoughts / images / impulses • Not pleasurable	
O-Own	• Patient acknowledges that thoughts are his own, not imposed by others.	
S-Senseless	• Patient also acknowledges them to be senseless • Helps to differentiate from delusion	
I-Irresistible	• Wants to rid of these thoughts, but these are irresistible	

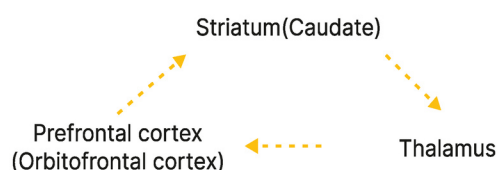
Q 1.3: How are obsessions and compulsions in Obsessive-Compulsive Disorder perceived by the patient?

Answer: Obsessions and Compulsions are ego-dystonic (ego alien) and unacceptable to the mind

Q 1.4: What symptom patterns can a patient with Obsessive-Compulsive Disorder present with?

Answer:

- Only obsessions
- Only compulsions
- Both obsessions and compulsions (most common)

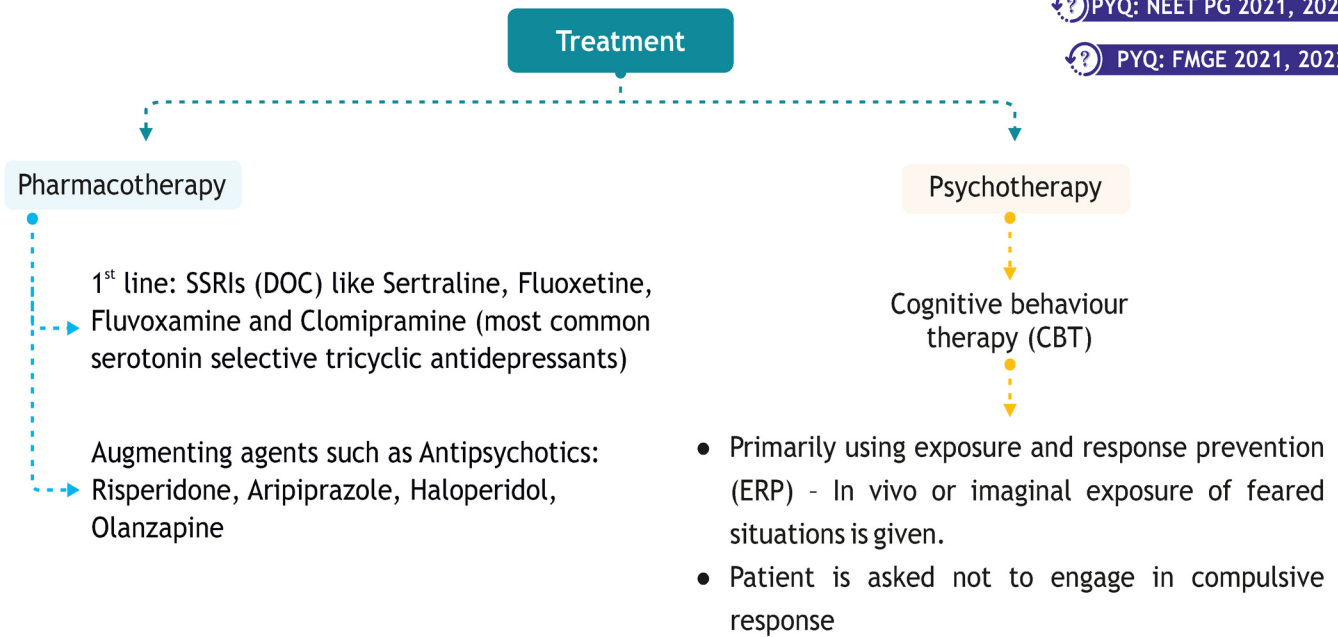
Q 1.5: What is the lifetime prevalence of Obsessive-Compulsive Disorder?**Answer:** 2 to 3%**Q 1.6: What is the most common comorbid psychiatric condition associated with Obsessive-Compulsive Disorder?****Answer:** Depression**Q 1.7: What is the etiology of Obsessive-Compulsive Disorder?****Answer:** Serotonin hypothesis of OCD: Serotonin dysregulation**Q 1.8: What is the neuroanatomical model of OCD?****Answer:****Q 1.9: What neuroanatomical abnormalities are implicated in Obsessive-Compulsive Disorder?****Answer:**

- Dysfunction in Cortico - Striatal - Thalamic - Cortical (CSTC) Circuit → OCD
- Bilaterally smaller caudates

Q 1.10: What are the major symptoms and common patterns observed in Obsessive-Compulsive Disorder?**Answer:**

Most common Obsessions	Compulsions
Contamination: Most common	Checking: Most common
Pathological doubt: 2 nd most common	Washing: 2 nd most common
Need for symmetry	Counting
Aggressive	Symmetry & precision
Sexual	Multiple
Multiple	

Q 1.11: What is the most common symptom pattern seen in Obsessive-Compulsive Disorder?**Answer:** Contamination and washing**Q 1.12: What is the treatment of choice for Obsessive-Compulsive Disorder?****Answer:** Treatment of choice: Combination of pharmacotherapy and psychotherapy**Q 1.13: What are the main treatment approaches for Obsessive-Compulsive Disorder?****Answer:**



Q 1.14: What somatic therapies are available for treatment-resistant or extreme cases of Obsessive-Compulsive Disorder (OCD)?

Answer:

- Electroconvulsive therapy (ECT)
- Psychosurgery can be considered:
 - o Subcaudate tractotomy
 - o Anterior cingulotomy
 - o Anterior capsulotomy/ gamma knife capsulotomy

Q 1.15: What defines Body Dysmorphic Disorder (BDD)?

Answer: Preoccupation with perceived defects or flaws in physical appearance

Q 1.16: What are the most common areas of concern in Body Dysmorphic Disorder (BDD)?

Answer: Face and head (e.g., hair, nose, skin)

Q 1.17: What is the differential diagnosis for Body Dysmorphic Disorder (BDD)?

Answer: Delusional dysmorphophobia- the patient is totally convinced that their body part is flawed

Q 1.18: What are the main characteristics and consequences of Hoarding Disorder?

Answer:

- Acquiring and not discarding things of little or no value
- Leads to cluttering, causing clinically significant distress, and impairment of functioning (eating, sleeping, safety issues)

Q 1.19: What motivates the behavior in Hoarding Disorder?

Answer: Fear of losing something important or distorted emotional attachment to the item

Q 1.20: What is the treatment approach for Hoarding Disorder?

Answer:

- Difficult to treat
- Psychotherapy: Cognitive behavior therapy (CBT)

Q 1.21: What is Trichotillomania?

 PYQ: FMGE 2020

Answer:

- Recurrent pulling of one's hair, resulting in hair loss
- Accompanied by unsuccessful attempts to decrease or stop the behavior.

Q 1.22: What is trichophagy, and how is it related to Trichotillomania?

Answer:

- Trichophagy is the mouthing of hair
- It can occur as a behavior following hair-pulling in Trichotillomania.

Q 1.23: What are some potential complications of Trichotillomania?

Answer: Trichobezoars, malnutrition, and intestinal obstruction.

Q 1.24: What is Excoriation (Skin Picking Disorder)?

Answer:

- Recurrent picking of one's own skin, resulting in a skin lesion
- Accompanied by unsuccessful attempts to decrease or stop the behavior



Q 1.25: What are the most common body areas affected in Trichotillomania?

Answer: Face, hands, fingers, arms, and legs

Q 1.26: What disorders are classified under Obsessive-Compulsive and Related Disorders in the DSM-5?

Answer:

- OCD
- Body dysmorphic disorder
- Hoarding disorder
- Trichotillomania (hair-pulling disorder)
- Excoriation (skin picking) Disorder

Q 1.27: What disorders are classified under Obsessive-Compulsive and Related Disorders in the ICD-11?

Answer:

- OCD
- Body dysmorphic disorder
- Hoarding disorder
- Body-focused repetitive behaviour disorder
 - o Trichotillomania
 - o Excoriation disorder
- Olfactory Reference Syndrome (preoccupation that one is emitting a foul smell, unnoticeable/ slightly noticeable to others)
- Hypochondriasis



10. TRAUMA OR STRESSOR-RELATED DISORDERS

BIG QUESTION 1: What are trauma/stress-related disorders?

Broad Answer: Trauma- and stressor-related disorders are a group of mental health conditions that can develop in response to a traumatic or highly stressful event. These disorders are defined by the symptoms that arise after direct or indirect exposure to an event that involves actual or threatened death, serious injury, or sexual violence. These disorders require exposure to stressors or trauma.

DETAILED QUESTIONS

Q1.1: Give a few examples of trauma or stressors leading to major life-threatening events.

Answer:

- Serious accidents
- Exposure to war
- Physical assault, kidnapping
- Sexual violence (rape)
- Natural disasters (earthquakes, tsunamis, etc.)
- Serious illness

Q1.2: What are the two most important disorders that can occur because of major life-threatening events?

Answer:

- Post-traumatic stress disorder (lasts ≥ 1 month)
- Acute stress disorder (lasts < 1 month)

Q1.3: What is the primary cause of Post-Traumatic Stress Disorder (PTSD)?

PYQ: FMGE 2019

Answer:

PYQ: NEET PG 2018

- PTSD is caused by exposure to a **major life-threatening or traumatic event**, such as war, serious accidents, sexual violence, or natural disasters.
- The symptoms must persist for **at least one month** for a diagnosis of PTSD.

Q1.4: What are the symptoms of Post-Traumatic Stress Disorder?

Answer: Mnemonic: MAHI

M - Mood and Cognitive symptoms	• Develops negative emotional state like fear, anger and guilt. • May develop negative beliefs
A - Avoidance	• Tries to avoid feelings, memories or thoughts of people, places, and objects that are related to the trauma.
H - Hyperarousal	• Irritability • Hypervigilant • Insomnia • Decreased concentration

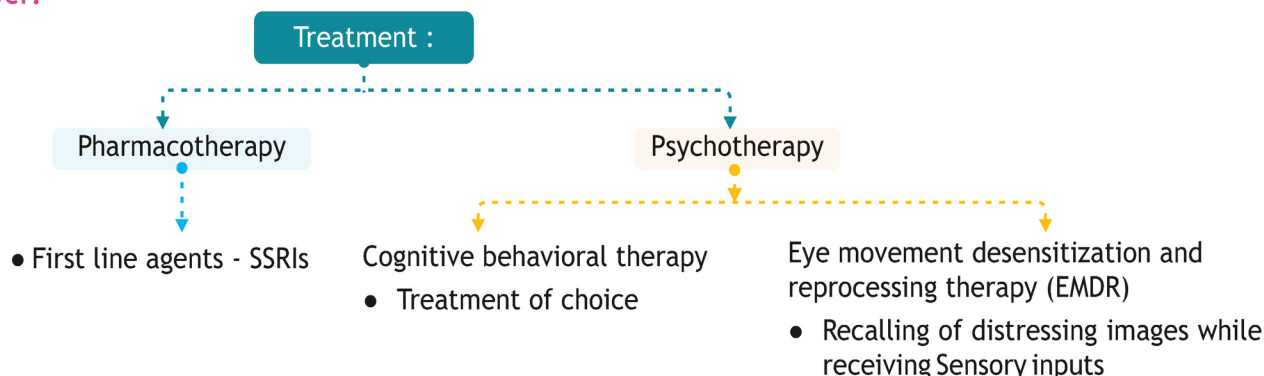
I - Intrusion symptoms

- Distressing dreams, memories- Re-experiencing symptoms
- Flashbacks of the event.

Q1.5: What is the treatment for Post-Traumatic Stress Disorder?

PYQ: NEET PG 2018

Answer:



BIG QUESTION 2: What are Impulse Control Disorders?

Broad Answer:

- **Impulse control disorders** are a class of mental health conditions characterized by a feeling of increasing tension and arousal before performing a certain act, which provides a sense of relief or gratification. The act is impulsive rather than premeditated for external gain.
- Two key examples are **Pyromania** and **Kleptomania**.

DETAILED QUESTIONS

Q2.1: What are Impulse Control Disorders?

Answer:

- An **impulse** is a feeling of increasing internal tension and arousal that builds until a person performs a specific act.
- In Impulse Control Disorders, this act provides a sense of pleasure or relief, but it is often followed by regret or guilt.
- The behavior is driven by this internal tension rather than by a desire for an external reward.

Q2.2: What are the key characteristics of Pyromania?

Answer:

- **Pyromania** is an impulse control disorder defined by the **recurrent, purposeful setting of fires**.
- The act is performed to relieve internal tension, and it lacks a clear motive such as financial gain (e.g., insurance fraud), revenge, or political objectives.

Q2.3: What are the key characteristics of Kleptomania?

Answer:

- **Kleptomania** is characterized by the **recurrent stealing of objects**.
- The items are not stolen for personal use or for their monetary value. The primary motivation for the theft is the need to relieve the tension and arousal that builds before the act. The act itself provides a feeling of gratification.

BIG QUESTION 3: What are dissociative disorders?

Broad Answer:

- Dissociative disorders, previously classified as hysteria, are mental health conditions where there's a disturbance in a person's memory, identity, perception, or consciousness, without any underlying physical cause.
- They're often linked to a psychological stressor or trauma.
 - o Dissociative Amnesia
 - o Depersonalization-Derealization Disorder
 - o Dissociative Identity Disorder

DETAILED QUESTIONS

Q3.1: What are dissociative disorders?

Answer: Disturbance in one or more mental functions, such as memory, identity, perception, consciousness, or motor behavior

Q3.2: Define Dissociative Amnesia and provide an example.

Answer:

- **Dissociative Amnesia** is the inability to recall important personal information, usually about a traumatic event, which is inconsistent with normal forgetting.
- For example, a person rescued two days after a kidnapping might be unable to recall anything from those two days, even though their memory of everything before and after the event is intact
 - o However, he remembers everything before those two days and everything thereafter.
 - o Investigations and examinations are normal
 - o No physical or anatomical conditions justify the amnesia
- After therapy, if the stress is resolved, the person will be able to remember things

Q3.3: What is Depersonalization-Derealization Disorder? Differentiate between depersonalization and derealization.

 PYQ: AIIMS 2019

Answer: Depersonalization-Derealization Disorder is characterized by recurrent episodes of **depersonalization**, **derealization**, or both, while the person's ability to test reality remains intact.

Depersonalization	Derealization
• Feeling of detachment from the self • Person may feel like he is watching himself in the movie	• Feeling of detachment from the world. • Person feels as if the world is unreal.

Q3.4: Describe Dissociative Identity Disorder (Multiple Personality Disorder) and provide an example

Answer:

- **Dissociative Identity Disorder** is a condition where two or more distinct personalities, or **alters**, exist within one individual.
- Only one personality is evident at a time, and the alters are often unaware of each other's existence.
- The personalities are also known as alters, having their own pattern of thinking and behaving.
- The alters are usually unaware of each other's existence.
- For example, a timid, mild-mannered man who is scolded at work might, in another situation, become aggressive and violent, as if a second, different personality has taken control.

BIG QUESTION 4: Define Conversion Disorder, including its classification in both ICD-11 and DSM-5.

Broad Answer:

- **Conversion Disorder**, also known as **Functional Neurological Symptom Disorder** (DSM-5) or **Dissociative Neurological Symptom Disorder** (ICD-11), is a condition where a patient experiences neurological symptoms that are not caused by an actual physical or organic problem.
- The symptoms are a conversion of psychological stress into a physical manifestation.

DETAILED QUESTIONS

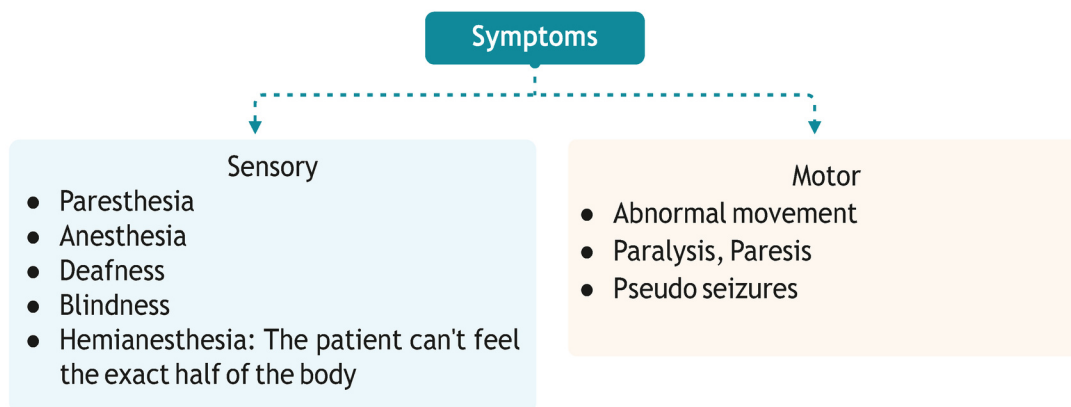
Q4.1: What is Conversion Disorder, and how is it classified in ICD-11 and DSM-5?

Answer:

- Conversion Disorder is a condition in which psychological stress is expressed as physical, functional neurological symptoms without an organic cause.
- In **ICD-11**, it's classified under dissociative disorders and called **Dissociative Neurological Symptom Disorder (DNSD)**.
- In **DSM-5**, it's categorized under somatic symptom disorders and called **Functional Neurological Symptom Disorder**.

Q4.2: What are the symptoms of conversion disorder?

Answer:



- E.g., A seven-year-old girl overhears her parents arguing and finally decides to separate. After a few minutes, she started reporting that she was unable to see anything. There is a sudden presentation of blindness. Thorough examination and investigation came out to be normal.
- After therapy, stress is resolved, and the child can see everything
- Due to high stress, the mind converted that stress into neurological symptoms, such as blindness.

Q4.3: Explain the concept of "La belle indifference".

PYQ: INICET 2022, 2023

Answer:

- **"La belle indifference"** is an attitude sometimes seen in patients with Conversion Disorder. It refers to a patient's **inappropriately calm or unconcerned attitude** toward their serious neurological symptoms.
- For instance, the girl who is unable to see may be sitting calmly without showing the distress one would expect from a person who has suddenly lost their vision.

BIG QUESTION 5: Discuss Somatic Symptom and Related Disorders.

Broad Answer:

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- **Somatic Symptom and Related Disorders** are characterized by a preoccupation with physical symptoms or health concerns that are not fully explained by a medical condition.
- **Somatic Symptom Disorder** (previously called somatization disorder or Briquet's syndrome) is when a patient has multiple physical symptoms, like pain or nausea, for a long time without any abnormalities found on medical investigations.
- In contrast, **Illness Anxiety Disorder** (or hypochondriasis) is a preoccupation with the belief of having a serious illness, even when symptoms are minimal or absent and medical reassurance is given.
- **Factitious Disorder** involves the deliberate faking or production of symptoms to gain medical attention and assume a "sick role," while **Factitious Disorder Imposed on Another** is when a person (usually a caregiver) fakes symptoms in someone else, like an infant, for the same purpose.
- The key difference between these two is the target of the fabricated symptoms.

DETAILED QUESTIONS

Q5.1: Define Somatic Symptom Disorder.

Answer:

- Previously known as somatization disorder or Briquet's syndrome.
- ICD-11 uses the term "bodily distress disorder".
- Preoccupied with somatic symptoms
 - The patient, for a few months or years, complained of pain in the abdomen, tingling sensations, nausea, and vomiting.
- The patient has many symptoms, but upon investigation, everything is normal.
- The symptoms are caused by the mind and not by the body.

Q5.2: What is hypochondriasis?

Answer:

- Illness Anxiety Disorder (DSM-5) or Hypochondriasis (ICD-11)
 - Preoccupied with having or acquiring a serious illness.
 - Symptoms may or may not be present
 - Example: A patient may correlate a headache with a brain tumor.
 - The preoccupation persists despite normal investigations and reassurances by the doctor.

Q5.3: What is a Factitious Disorder?

Answer:

- Also known as Munchausen syndrome.
- The patient produces fake physical or psychological symptoms to assume a sick role with the aim of receiving medical attention.

Q5.4: How does Factitious Disorder Imposed on Another differ from Factitious Disorder?

Answer:

- Also known as Factitious disorder by proxy or Munchausen syndrome by proxy.
- A person (usually a caretaker) produces symptoms in another person to gain medical attention.
- E.g.: A mother deliberately says that her infant is not eating and vomiting
 - She deliberately uses the symptoms of another person so that she can receive medical attention

Q5.4: What is Deliberate falsification of symptoms?

Answer:

- Depending on the aim, it can be divided into different types
- If the Aim is to receive medical attention
- Example:
 - o If the patient repeats multiple medical admissions, this is called Factitious disorder, which requires treatment



11. SUBSTANCE USE AND ADDICTIVE DISORDERS

BIG QUESTION 1: Discuss the concept of substance dependence and its key features. Detail the clinical presentation of alcohol intoxication.

Broad Answer:

- Substance dependence is a pattern of behavior characterized by a strong **craving** for a substance, the development of **tolerance** and **withdrawal symptoms**, and a lack of control over its use, leading to a neglect of other interests despite harmful consequences.
- Alcohol, a CNS depressant, causes intoxication, which can lead to anterograde amnesia
- Alcohol withdrawal follows a predictable time course, beginning with **tremulousness** and other signs of autonomic hyperactivity, progressing to **alcoholic hallucinosis**, then **seizures** ("rum fits"), and culminating in the most severe form, **delirium tremens**.
- Treatment involves two phases: **detoxification** and **pharmacological therapy**

DETAILED QUESTIONS

Q1.1: What are the key features of substance dependence according to DSM-5?

Answer:

- Substance dependence, diagnosed as **Substance Use Disorder** in DSM-5, is characterized by:
- **Craving:** A strong desire to use the substance.
- **Withdrawal symptoms:** Physical or psychological symptoms that occur when use is reduced or stopped.
- **Tolerance:** A need for increased amounts of the substance to achieve the desired effect.
- Difficulty in controlling substance-taking behavior.
- Progressive neglect of alternative pleasures and interests.
- Persistent substance use despite clear evidence of harmful consequences.

Q1.2: What is the clinical picture of alcohol intoxication, and what is the legal blood alcohol limit in India?

Answer:

- Alcohol is a **depressant of the Central Nervous System (CNS)**.
- Intoxication is marked by high blood alcohol concentration, which can lead to **anterograde amnesia**, also known as alcohol blackouts, at concentrations of 200-300 mg/dL.
- The legal blood alcohol level in India is **30 mg/dL**.

Q1.3: Describe the time course of alcohol withdrawal symptoms

PYQ: AIIMS 2019

PYQ: FMGE 2020-2021

Answer: Symptoms that develop after reducing or stopping alcohol intake

PYQ: NEET PG 2021

Time since stopping Alcohol	Symptoms
6-8 hours	• Classical or the most common sign- Tremulousness, (coarse tremors) Other symptoms • GI symptoms: Nausea, Vomiting • Autonomic Hyperactivity: Anxiety arousal, Sweating, Mydriasis, Tachycardia, Hypertension.

8-12 hours	- Alcoholic hallucinosis: Auditory Hallucinations more common, visual hallucinations may be seen in clear consciousness. - Tactile hallucinations can also occur
12-24 hours	- Seizures: Generalized Tonic-Clonic Seizures (GTCS). - Also known as Rum fits.
Within 72 hours (Peak: 48-72 hrs)	Delirium tremens - Disturbance of consciousness, - Disoriented (To time, place, person). - Hallucinations, particularly visual (most common -visual, auditory hallucinations can also occur) - It is the most severe form of alcohol withdrawal - It is a medical emergency Untreated: Mortality rate of 20%

Q1.4: What is the drug of choice for managing alcohol withdrawal symptoms?

 PYQ: FMGE 2023

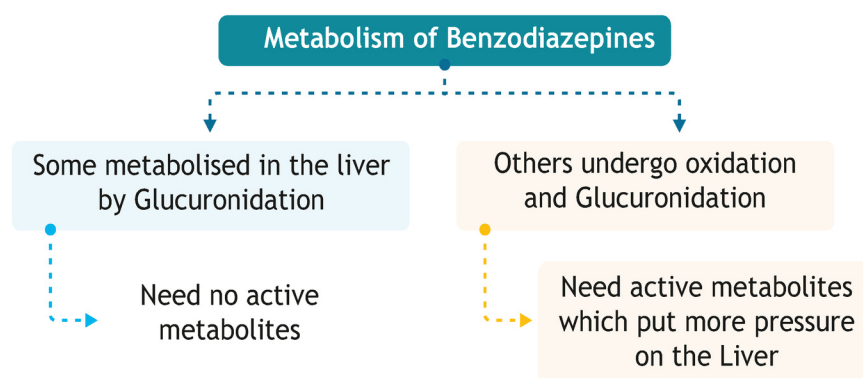
Answer:

- DOC: Benzodiazepines (BZD), for all withdrawal Symptoms
- Along with Benzodiazepines, Thiamine is also added
- Drug of choice is Benzodiazepines + Thiamine
- Short-acting drugs: Lorazepam is common
- Long-acting drugs: Chlordiazepoxide, Diazepam

Q1.5: What is the treatment approach for a patient with alcohol withdrawal and liver disease?

Answer:

- For patients with deranged liver function tests, **benzodiazepines that undergo glucuronidation** and have no active metabolites are preferred.
- These include **Lorazepam and Oxazepam** (mnemonic: Liver OK).
- Long-acting benzodiazepines like chlordiazepoxide and diazepam are avoided in this population.



Q1.6: What is the purpose of the maintenance phase of alcohol treatment?

Answer:

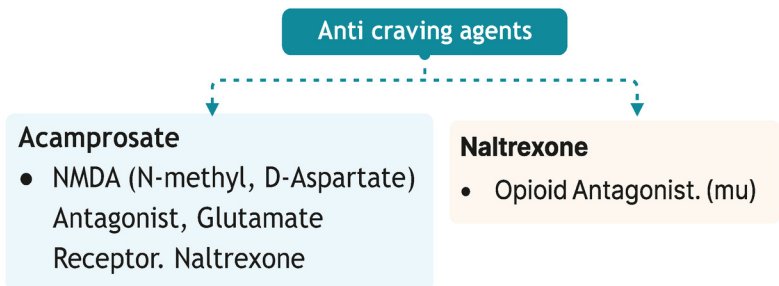
- The maintenance phase aims to maintain abstinence from alcohol.
- Pharmacological Treatment
- Non-Pharmacological Treatment

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Q1.7: What are the anticraving agents used in alcohol maintenance therapy?

Answer:

- Besides disulfiram, other anticraving agents include: (Mnemonic: **Alcohol NOT Best Friend**)
 - Alcohol- Acamprosate
 - Naltrexone
 - O- Ondansetron (a 5HT₃ antagonist)
 - T- Topiramate (an antiepileptic agent)
 - Best**- Baclofen (a GABA-B agonist)
 - Friend**- Fluoxetine (an SSRI)



Q1.8: What are the screening tests used for alcohol use disorder?

Answer:

Cage Questionnaire	(Need to) Cut down on Drinking. - Annoyance when asked about your drinking. - Guilty about your drinking. (Need for) Eye openers the morning after heavy drinking Positive response on 2 or more is suggestive of Alcohol Use Disorders.
AUDIT	Alcohol use disorder identification test
MAST	Michigan alcoholism screening test
Other Tests	SADQ: Severity of alcohol dependence questionnaire

Q1.9: What is the duration of alcohol detoxification?

Answer:

- Manage the withdrawal Symptoms.
- Duration of treatment: 7-14 days.

Q1.10: What is the treatment for Alcohol withdrawal Hallucinoses, Alcohol withdrawal Seizures, and Alcohol withdrawal DT?

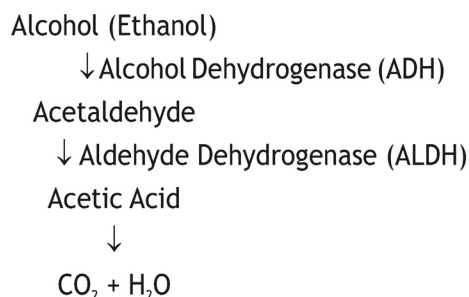
Answer:

- Drug of choice: Benzodiazepines (BZD) in any case.
- Higher doses of Benzodiazepines will be required initially, and gradually the drug will be stopped. Dose reduction: 20% dose reduction every day from the dose of the first day.
- By the 7th to 14th day, Benzodiazepine is stopped

Q1.11: Which drug acts as a deterrent (aversive) agent in alcohol dependence?

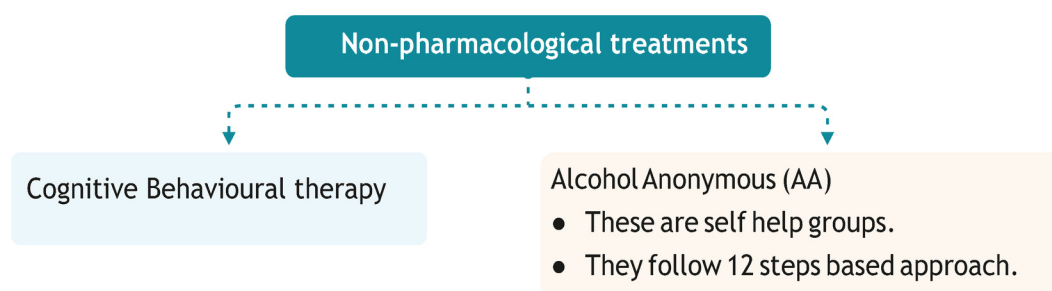
Answer:

- Disulfiram** irreversibly inhibits **aldehyde dehydrogenase (ALDH)**, causing acetaldehyde accumulation after alcohol intake → produces unpleasant symptoms (nausea, vomiting, flushing, abdominal burning; severe cases → MI, respiratory depression).
- It should only be used in **motivated patients who are willing to abstain from alcohol**.
- Mechanism of Action of Disulfiram:
 - Irreversible Inhibitor of Aldehyde Dehydrogenase (ALDH) enzyme.



Q1.12: What is the non-pharmacological treatment to maintain alcohol abstinence?

Answer:



Q1.13: What is the active ingredient in an alcoholic beverage?

Answer: Ethyl alcohol or ethanol ($\text{C}_2\text{H}_5\text{OH}$)

BIG QUESTION 2: What are the alcohol-induced neurocognitive disorders?

Broad Answer:

- Alcohol-induced neurocognitive disorders are associated with long-term alcohol use.
- The two main alcohol-induced neurocognitive disorders are Wernicke's encephalopathy and Korsakoff syndrome.
 - o Wernicke's encephalopathy has an acute onset and is characterized by the classic triad of global confusion, ophthalmoplegia, and ataxia, with lesions symmetrically involving the mammillary bodies.
 - o Korsakoff syndrome is a chronic, irreversible condition marked by severe anterograde and retrograde amnesia and confabulation.

DETAILED QUESTIONS

Q2.1: What is the clinical presentation of Wernicke's encephalopathy?

Answer:

- Mnemonic: **GOA**
 - o **G**: Global Confusion
 - o **O**: Ophthalmoplegia 6th nerve Palsy is most common, & 3rd nerve Palsy is second most common
 - o **A**: Ataxia

Q2.2: What is the cause of Wernicke's encephalopathy?

Answer:

- Thiamine (Vitamin B1) Deficiency
 - o Due to poor nutrition.
 - o Due to poor absorption of nutrients in chronic alcoholics

Q2.3: What neuropathologic lesions are involved in Wernicke's encephalopathy?

Answer: Neuropathologic lesions with symmetrical involvement of the Mammillary bodies, Thalamus, and Hypothalamus

Q2.4: How is Wernicke's encephalopathy managed?

Answer:

- Thiamine Supplementation- Rapid response to parenteral /oral Thiamine.
- Symptoms can be reversed
- If there is no response to Thiamine treatment, then the symptoms may not be of Thiamine
- It may be Pellagric encephalopathy
- In this condition, treatment is given with Niacin

Q2.5: What are the symptoms and causes of Korsakoff syndrome?

Answer:

- Onset: Chronic
- Symptoms
 - o Impaired recent memory
 - o Anterograde amnesia- More common, inability to form new memories
 - o Retrograde amnesia- Inability to recall old memories
 - o Confabulation: Making false stories to fill memory gaps
- Cause: Thiamine (Vitamin B1) deficiency

Q2.6: How is Korsakoff syndrome treated?

Answer:

- Supplementation of Thiamine: 100 mg, 2-3 times/day for 3-12 months
- Symptoms may not totally reverse; full recovery is seen in only 20% patients o It is irreversible

BIG QUESTION 3: Discuss opioids, their abuse, and the management of opioid intoxication and withdrawal.

Broad Answer:

- Opioids, derived from the opium poppy plant *Papaver somniferum*, are highly abused substances, with **heroin** being the most common illicit opioid.
 - o Street names of Heroin: Smack, Brown sugar which will also have some impurities like chalk powder, quinine
- Opioid intoxication is a medical emergency characterized by a classic triad of respiratory depression, pinpoint pupils (miosis), and coma, and it is treated with the opioid antagonist naloxone.
- Management involves two phases: detoxification and maintenance
- Maintenance includes Opioid Substitution Therapy (OST).



DETAILED QUESTIONS

Q3.1: What are the clinical features and treatment for opioid intoxication?

Answer:

- The classic clinical triad of opioid intoxication is

- o Respiratory depression
- o pinpoint pupils (miosis)
- o Coma
- The drug of choice for treatment is **IV naloxone**, a short-acting opioid antagonist that rapidly reverses these effects.

Q3.2: What are the key symptoms of opioid withdrawal?

Answer:

- Develop symptoms after stopping/Reducing the opioids.
- Opioid withdrawal symptoms are often described as **flu-like**.
- They include:
 - o Muscle and abdominal cramps, and bone aches.
 - o Diarrhea, lacrimation, and rhinorrhea.
 - o Piloerection (gooseflesh).
 - o Yawning.
 - o Pupillary dilation (mydriasis).
 - o Insomnia, temperature dysregulation, and other autonomic fluctuations.

Q3.3: What are the two main phases of opioid withdrawal management?

Answer:

- The two main phases are detoxification and maintenance.
 - o Detoxification focuses on the immediate management of acute withdrawal symptoms.
 - o Maintenance aims to prevent long-term relapse and support the patient's recovery.

Q3.4: What pharmacological agents are used during the Detoxification phase of opioid withdrawal?

Answer:

- Methadone (an opioid agonist) and buprenorphine (a partial mu opioid agonist) are the primary drugs used to manage withdrawal symptoms during detoxification.
- Clonidine, an alpha-2 adrenergic agonist, can be used for symptomatic relief of autonomic withdrawal symptoms like sweating, restlessness, and tremors.
- NSAIDs: Pain
- Benzodiazepines: Insomnia.

Q3.5: What pharmacological agents are used during the maintenance phase of opioid withdrawal?

Answer:

- Opioid Substitution Therapy (OST)
 - o Principle: Replace illicit, unsafe, short-acting opioids with a safer, long-acting agonist under medical supervision.
 - o Drugs used:
 - Methadone - a full μ -opioid receptor agonist.
 - Buprenorphine - partial μ -opioid receptor agonist.
- Opioid Antagonist Therapy
 - o Drug: Naltrexone
 - o Mechanism: μ -receptor antagonist → blocks opioid receptors.
 - o Effect:

YOURWISH

- Daily intake keeps receptors occupied.
- Opioid use produces no euphoria → reduces reinforcement.
- With time, the patient loses interest in opioid use.

Q3.6: What are the non-pharmacological treatments for opioid dependence?

Answer:

- Narcotics Anonymous (NA) is a 12-step, self-help group.
- Cognitive Behavioral Therapy (CBT).

BIG QUESTION 4: Discuss Cannabis, including its psychoactive ingredient, intoxication, and withdrawal symptoms.

Broad Answer:

- Cannabis, derived from the Cannabis Sativa plant, is the most common illicit substance worldwide and in India. Its main psychoactive ingredient is Δ^9 -Tetrahydrocannabinol (Δ^9 -THC).
- Cannabis intoxication can cause a feeling of euphoria, a sense of time distortion, and redness of the conjunctiva.
- Cannabis withdrawal symptoms, while generally mild, can include irritability, anxiety, sleep difficulties, and decreased appetite.

DETAILED QUESTIONS

Q4.1: What is the primary psychoactive ingredient in cannabis, and what are its common street names?

Answer:

- The primary psychoactive ingredient is Δ^9 -Tetrahydrocannabinol (Δ^9 -THC).
- Cannabis is the most common illicit substance both in India and worldwide, known by various forms and names, including Ganja, Bhang, Hash, Charas, Marijuana, Grass, Pot, and Weed.

Q4.2: What are the main symptoms of cannabis intoxication and withdrawal?

 PYQ: FMGE 2023

Answer:

- **Intoxication** symptoms include:
 - o Euphoria
 - o Sense of time distortion (time appears to slow down)
 - o Redness of the conjunctiva
 - o Increased appetite
 - o Hallucinations (at high doses, it can even cause delirium).
- **Withdrawal** symptoms include:
 - o Irritability and anxiety
 - o Sleep difficulties (insomnia, disturbing dreams)
 - o Decreased appetite
 - o Physical symptoms like tremors, sweating, fever, and chills.

Q4.3: What are a "Bad Trip" and a "Flashback" in cannabis use?

Answer:

- A **"Bad Trip"** is an unpleasant experience after cannabis use, characterized by feelings of restlessness, fear, and panic symptoms.
- A **"Flashback"** is when a person re-experiences the symptoms of cannabis use days or weeks after their last use.

Q4.4: What is "Cannabis-Induced Psychotic Disorder"?**Answer:**

- This disorder, also known as **Hemp Insanity**, occurs when psychotic symptoms like delusions and hallucinations appear after cannabis consumption.
- The symptoms typically disappear within a month after use is stopped. Cannabis is a known **risk factor for the development of schizophrenia**.

Q4.5: What are "Amotivational Syndrome" and "Running Amok"?**Answer:**

- **Amotivational Syndrome** is a condition that develops after chronic cannabis use. It is characterized by apathy and a person's unwillingness to persist in a task, such as at school or work.
- **Running Amok** is a state of rage that can develop after cannabis use, leading a person to hurt or even kill others.

Q4.6: What is the treatment for cannabis withdrawal?**Answer:**

- Mild withdrawal symptoms: Supportive care
- Moderate to severe symptoms: Short-term use of Benzodiazepines can be used

Q4.7: What is the most common substance abuse in India and the world?**Answer:**

- In India, Tobacco > Alcohol
- In the world, Alcohol > Tobacco
- Now, the most common substance: Caffeine

BIG QUESTION 5: Describe hallucinogens and the psychological phenomena associated with their use.**Broad Answer:**

- Hallucinogens are a class of psychoactive substances that can induce hallucinations and delusions.
- They include **PCP, Ketamine, LSD, Mescaline, Psilocybin, and MDMA**.
- Their use is associated with several psychological phenomena.
 - o Bad Trip
 - o Flashbacks
 - o Reflex Hallucination

DETAILED QUESTIONS**Q5.1: What are some common examples of hallucinogens?****Answer:**

- Common hallucinogens include:
 - o **Phencyclidine (PCP)**, also known as **Angel Dust**.
 - o **Ketamine** is an anesthetic agent.
 - o **LSD** (Lysergic Acid Diethylamide).
 - o **Mescaline**, derived from the cactus.
 - o **Psilocybin**, derived from mushrooms.
 - o **Methylenedioxymethamphetamine (MDMA)**, also known as **Ecstasy**.

Q5.2: What is a "Bad Trip," and which hallucinogen is it most associated with?**Answer:**

- A **"Bad Trip"** is a negative experience associated with hallucinogen use, often involving feelings of restlessness, fear, and panic.
- It is most commonly associated with **LSD**.

Q5.3: Explain the phenomenon of "Flashbacks" associated with hallucinogens.**Answer:**

- **Flashbacks** are characterized by re-experiencing the symptoms of a substance's use days or weeks after the last use.
- For hallucinogens, this can include flashes of colors, visual distortions, halos, and changes in the perceived size of objects, such as **macropsia** (objects appearing larger) or **micropsia** (objects appearing smaller).
- This phenomenon is specifically seen with **LSD**.

Q5.4: What is "Reflex Hallucination"?**Answer:**

- **Reflex Hallucination (Morbid Synaesthesia)** is a special type of hallucination where a real stimulus in one sensory modality produces a hallucination in a different modality.
- For example, hearing a ringtone might cause someone to see colors in the air.
- This phenomenon is seen with hallucinogens such as **LSD**.

Q5.5: What are the withdrawal symptoms associated with hallucinogens?**Answer:**

- No, hallucinogens generally **lack physical withdrawal symptoms**.
- This means that they do not cause physical dependence.

BIG QUESTION 6: What are the stimulant drugs?**Broad Answer:**

- Stimulants
 - o Cocaine
 - o Amphetamine
- Cocaine is a potent stimulant derived from the *Erythroxylum coca* plant.
- It is most commonly used by **snorting** a finely chopped powder, which can lead to adverse physical effects like **nasal septal perforation** due to its vasoconstrictive properties.

DETAILED QUESTIONS**Q6.1: From what plant is cocaine derived, and what are its common methods of use and associated physical effects?****Answer:**

- Cocaine is derived from the ***Erythroxylum coca* plant**.
- The most common method of use is **snorting** the powder into the nose.
- This can lead to physical adverse effects such as **rhinorrhea, nosebleeds, and nasal septal perforation** due to vasoconstriction.
- Long-term use can also cause a **jet-black pigmentation of the tongue**.

Q6.2: What are the main signs and symptoms of cocaine intoxication?**Answer:**

- Cocaine is a potent **sympathomimetic drug** that causes both psychological and physical effects.
- Symptoms of intoxication include:
- Clinical Features
 - Euphoria
 - Pupillary dilation (mydriasis)
 - Tachycardia
 - Hypertension
 - Sweating
 - Respiratory depression
 - Cardiac arrhythmias
 - Seizures
- Psychiatric Manifestations
 - Auditory hallucinations
 - Paranoid ideations

Q6.3: What are "cocaine bugs"?**Answer:**

- "Cocaine bugs," also known as **formication** or **magnum bugs**, are a type of **tactile hallucination** where a person feels as though small insects are crawling under their skin.
- Clinically, a patient experiencing this will have **scratch marks** all over their body.

Q6.4: What is the nature of cocaine dependence, and how is its withdrawal treated?**Answer:**

- Cocaine use causes a strong **psychological dependence**.
- Because of this, withdrawal symptoms are usually mild, and there are no specific pharmacological agents that are used to reduce their intensity.
- Treatment: **supportive care**.

Q6.5: What is the significance of a "speedball"?**Answer:**

- A **speedball** is a combination of **cocaine and heroin**.
- It is often used to get the euphoric effects of both drugs while the user hopes to avoid the negative side effects of each.

Q6.6: What are the adverse effects of cocaine use?**Answer:**

- It causes Vasoconstriction
 - In the peripheral vessels, it may cause Hypertension, Damage to End organs such as the brain, Kidney, or intestine.
 - ↑ Heart rate
 - Causes a Myocardial infarction

Q6.6: What is cocaine Induced Psychotic Disorder?**Answer:**

- Hallmark is Paranoid Delusions (Delusion of Persecution), Auditory Hallucinations
- Visual hallucinations or Tactile Hallucinations may also be present.
- They mimic Schizophrenia

BIG QUESTION 7: Discuss tobacco use disorder. What is the active ingredient causing addiction? Describe the common forms of tobacco consumption.**Broad Answer:**

- Tobacco use disorder is the most common substance use disorder in India (excluding caffeine).
- The active ingredient responsible for addiction is **nicotine**.
- Tobacco is consumed in various forms, such as **inhalational forms** (cigarettes, bidis) and **oral forms** (gutka).

DETAILED QUESTIONS**Q7.1: What is the most common substance use disorder in India?****Answer:**

- The most common substance use disorder in India, excluding caffeine, is **tobacco use disorder**.
- Tobacco products are consumed in: Inhalational forms: Beedi, Hooka, Cigarettes, and oral forms: Gutka
- The active ingredient that causes addiction is **nicotine**.

Q7.2: What are the common withdrawal symptoms associated with tobacco?**Answer:**

- Withdrawal symptoms include:
 - o Intense craving for tobacco.
 - o Irritability and anxiety.
 - o Difficulty concentrating.
 - o Insomnia.
 - o Bradycardia.
 - o Increased appetite and weight gain.

Q7.3: What is Nicotine Replacement Therapy (NRT)?**Answer:**

- **Nicotine Replacement Therapy (NRT)** is a treatment strategy that provides nicotine in a pure form, without the harmful carcinogenic substances found in tobacco products. It is used to manage withdrawal symptoms and reduce cravings. Forms of NRT include:
 - o Nicotine Gums
 - o Nicotine Lozenges
 - o Nicotine Patches
 - o Nicotine Nasal Spray
 - o Nicotine Inhalers
 - o E-cigarettes were also a form of NRT, but are now banned in India due to their carcinogenic nature.

Q7.4: What are the non-nicotine medications used for tobacco treatment besides NRT?
 **PYQ: INICET 2022**
Answer:

Varenicline	• Partial agonist at $\alpha_4 \beta_2$ Nicotinic acetylcholine receptors. • It reduces the reinforcing effects of Nicotine • Most efficacious out of all pharmacological agents • Serious Adverse Effects ◦ Neuropsychiatric adverse effects: Depression, Suicidal ideations. Recent researches have found that these symptoms may not worsen / occur with Varenicline. ◦ Cardiovascular Adverse Effects: Congestive cardiac failure and Arrhythmia especially who have Cardiovascular risk factors.
Bupropion	• Antidepressant: Norepinephrine Dopamine Reuptake Inhibitor (NDRI). • Contraindications ◦ Seizure Disorders ◦ Current/Past Bulimia or Anorexia Nervosa. Note: Bupropion is used in ADHD, Smoking cessation also

BIG QUESTION 8: What are club drugs?

Broad Answer:

- **Club drugs** are a group of psychoactive substances often associated with dance clubs and rave parties.
- This category includes
 - Ecstasy (MDMA)
 - Flunitrazepam
 - Gamma Hydroxy Butyrate (GHB)
 - Ketamine
 - LSD
 - Methamphetamine.

DETAILED QUESTIONS

Q8.1: What are "Date rape drugs"?

Answer: The drugs most commonly misused as "date rape drugs" due to their sedating and disorienting effects are Ketamine, GHB, and Flunitrazepam.

Q8.2: What is Gaming Disorder?

Answer:

- **Gaming Disorder** is a new diagnosis included in the ICD-11 (International Classification of Diseases, 11th Revision).
- It is persistent or recurrent gaming behavior (Digital or video gaming), online (over the internet) or offline, which is presented by:
 - Impaired control over gaming
 - Takes precedence over daily activities
 - Continuation despite negative consequences

Q8.3: What is a Gambling disorder?

Answer:

- In Gambling disorder, there are persistent and recurrent gambling behaviors

- It may be online or offline, which is manifested by:
 - Impaired control over gambling
 - Takes precedence over daily activities
 - Continuation despite negative consequences.



12. CHILD PSYCHIATRY

BIG QUESTION 1: What are the clinical features, diagnostic criteria, subtypes, epidemiology, and course of attention deficit hyperactivity disorder (ADHD)?

Broad Answer: ADHD, formerly called minimal brain damage/dysfunction, is a neurodevelopmental disorder characterized by inattention, hyperactivity, and impulsivity. According to DSM-5, symptoms must begin before 12 years of age and occur in two or more settings. ADHD has subtypes—combined, inattentive, and hyperactive. It is more common in boys, with partial or full remission in adulthood. Hyperactivity usually remits first, while inattention persists longer, leaving some patients at risk for antisocial personality disorder and substance use disorder.

DETAILED QUESTIONS

Q1.1: What are the core clinical features of ADHD related to inattention?

PYQ: NEET PG 2018

Answer:

- Fails to give close attention to details
- Makes careless mistakes
- Difficulty sustaining attention
- Fails to finish work
- Easily distracted

Q1.2: What are the core clinical features of ADHD related to hyperactivity and impulsivity?

Answer:

- Fidgeting with hands or feet
- Leaving the seat when expected to remain seated
- Always "on the go" (parents describe as "driven by a motor")
- Talks excessively
- Interrupts others
- Difficulty waiting for their turn

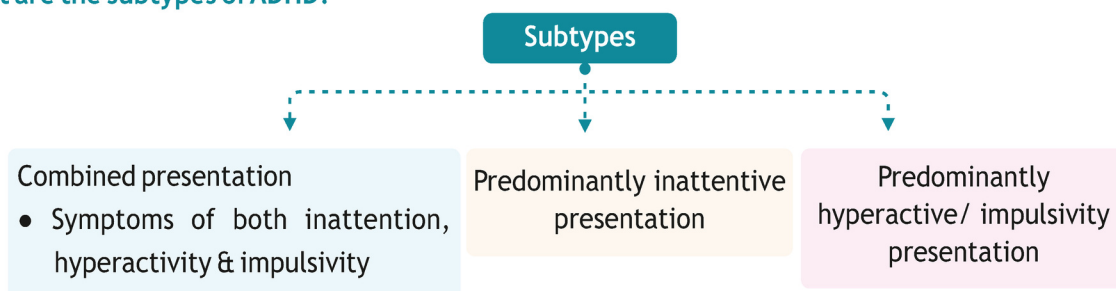
Q1.3: What is the DSM-5 criterion for diagnosing ADHD?

Answer:

- Onset of symptoms before 12 years (DSM-IV required onset before 7 years)
- Symptoms present in two or more settings (e.g, home, school)

Q1.4: What are the subtypes of ADHD?

Answer:



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Q1.5: What is the epidemiology of ADHD?

Answer: More common in boys than in girls

Q1.6: What is the natural course of ADHD?

Answer:

- 40% show remission at puberty or early adulthood
- Hyperactivity is the first symptom to remit
- Inattention is the last symptom to remit
- Partial remission cases are at risk for antisocial personality disorder and substance use disorder

BIG QUESTION 2: What are the pharmacological treatment options for ADHD and their important clinical considerations?

Broad Answer: ADHD requires pharmacological management, with CNS stimulants being the first-line therapy. Methylphenidate is the drug of choice, followed by amphetamines. **Modafinil** is sometimes used in adults, but it is not FDA-approved. Non-stimulants like atomoxetine, α 2-agonists (clonidine, guanfacine), and bupropion are useful when stimulants are contraindicated, poorly tolerated, or ineffective. Each drug class has specific indications, side effects, and FDA approval status that guide therapy.

DETAILED QUESTIONS

Q2.1: What is the first-line approach to treating ADHD?

Answer:

- Pharmacotherapy is the first line (Mnemonic: **MAM teaches A2 B**)
- Two main categories: CNS stimulants and Non-stimulants

Q2.2: What are the CNS stimulants used in ADHD and their key points?

Answer:

1. Methylphenidate (Drug of choice)

- o Dopamine agonist
- o Side effects: headache, nausea, insomnia, growth suppression
- o Can exacerbate tics
- o A drug holiday is recommended if growth suppression occurs
- o FDA approved

2. Amphetamine (2nd drug of choice)

- o Used if methylphenidate fails
- o Dopamine agonist
- o FDA approved

3. Modafinil

- o Modafinil is a wakefulness-promoting agent; the mechanism involves dopamine transporter inhibition and increased hypothalamic histamine activity.
- o Sometimes used in adult ADHD
- o Not FDA approved

Q2.3: When are non-stimulants indicated in ADHD treatment?**Answer:**

- Poor response to stimulants
- Side effects such as tics
- Contraindications (e.g., cardiac risk)

Q2.4: What are the important non-stimulant drugs for ADHD and their features?**Answer:****1. Atomoxetine**

- o Norepinephrine reuptake inhibitor
- o Increased risk of suicidal ideation

2. α -2 agonists (Clonidine, Guanfacine)

- o Adverse effects: sedation, headache, fatigue, hypotension
- o Useful in comorbid tic disorder
- o Can be given at night due to sedation
- o Uses: ADHD, tic disorder, substance use disorder (detox)

3. Bupropion

- o Norepinephrine-dopamine reuptake inhibitor
- o Antidepressant used in ADHD
- o Risk: seizures at high doses
- o Not FDA approved
- o Uses: Antidepressant, smoking cessation, ADHD

BIG QUESTION 3: What are the diagnostic features, associated conditions, overlapping disorders, and genetic factors in Autism Spectrum Disorder (ASD) and Specific Learning Disorder (SLD)?

Broad Answer: Autism Spectrum Disorder (ASD), previously termed PDD (Pervasive Developmental Disorder), is a **neurodevelopmental disorder** characterized by deficits in social communication and restricted, repetitive behaviors. DSM-5 and ICD-11 subsume autistic disorder, Rett syndrome, Asperger disorder, childhood disintegrative disorder, and PDD-NOS into a single diagnosis of ASD. Genetic associations include fragile X syndrome and tuberous sclerosis. Rett syndrome is due to a MECP2 mutation, with regression of skills and stereotyped hand wringing. Specific Learning Disorder (SLD), another neurodevelopmental condition, presents with persistent difficulties in reading, writing, or mathematics despite a normal IQ, with subtypes including dyslexia, dysgraphia, and dyscalculia.

DETAILED QUESTIONS**Q3.1: What are the core diagnostic features of Autism Spectrum Disorder according to DSM-5/ICD-11?****Answer:**
 **PYQ: FMGE 2023**

- Two core symptoms:
 - o Deficits in social communication and interaction
 - o Restricted, repetitive patterns of behavior, activities, or interests
- Language impairment is no longer a core symptom (may be associated).
 - o Removed from core symptoms in both DSM-5 and ICD-11.
 - o Not a defining feature, maybe an associated feature.

Q3.2: What are the clinical features of ASD?

Answer:

Deficits in Social Communications	Restricted, Repetitive Behaviors
- Poor reciprocal social skills. In infants: - Lack of social smiles. - Lack anticipatory posture for being picked up. Childhood and adolescents: - Poor eye contact. - Poor attachment behavior - may not acknowledge the presence of their parents or other important persons. - Awkward social behavior. - May have difficulty making friends or romantic relationships.	- Activities are rigid, repetitive and monotonous. - Often plays with toys in a ritualistic manner. - Specific stereotypies, mannerisms and repetitive spinning or banging may be seen. - Any changes or disturbances in their routine may upset them or cause panic or fear.

Q3.3: What physical and genetic associations are seen in ASD?

Answer:

- Higher incidence of abnormal dermatoglyphics
- Intellectual disability in ~30% of patients
- Genetic factors: Fragile X syndrome (most common), Tuberous sclerosis (2nd most common)

Q3.4: What are the overlapping disorders included under Autism Spectrum Disorder in DSM-5/ICD-11?

Answer:

- Autistic disorder
- Asperger disorder
- Rett syndrome
- Childhood disintegrative disorder
- PDD-NOS

Q3.5: What are the features of Rett syndrome?

 PYQ: NEET PG 2022, 2023

Answer:

- More common in females
- Mutation in X-linked gene encoding methyl-CpG-binding protein 2 (MECP2) on chromosome Xq28
- Normal development for the first 5 months, then regression (6 months-2 years)
- Characteristics seen from 6 months to 2 years:
 - Loss of acquired motor skills replaced by stereotypic hand movements such as hand wringing.
 - Loss of acquired speech.
 - Microcephaly.
 - May develop poor muscle coordination, unsteady gait, and ataxia.
 - Seizures are seen in 75% of children.
 - Abnormal EEG findings
- Drugs approved by the FDA in 2023: **Trofinitide**
 - For treatment of Rett syndrome in adults & pediatric patients more than or equal to 2 years
 - It is a Tripeptide - a Synthetic analog of Glycine-Proline-Glutamate, of N-terminal tripeptide of insulin-like growth factor-1 (IGF-1)

Q3.6: What is Specific Learning Disorder (SLD) and its subtypes?

Answer:

- Defined in ICD-11 as a **developmental learning disorder**
- Normal IQ but persistent difficulty in academic skills (reading, writing, mathematics)
- Inconsistent with the intellectual ability of the child.
- The IQ range is usually normal.

Subtypes:

 PYQ: FMGE 2020

Specific learning disorder with impairment in reading (Dyslexia)	• Difficulty in recognizing words. • Poor comprehension. • Difficulties with spellings
Specific learning disorder with impairment in written expression (Specific Spelling Disorder) / Dysgraphia	• Poor writing skills. • Poor spelling. • Poor handwriting.
Specific learning disorder with impairment in mathematics (dyscalculia)	• Difficulty learning numerical. • Difficulty remembering signs such as +, -. • Slow, inaccurate calculations.
Mixed disorder of scholastic skills	• Combined impairment of reading, written expressions and mathematics.

BIG QUESTION 4: What are the diagnostic criteria, severity grading, genetic factors, and treatment options for Intellectual Disability (Intellectual Development Disorder)?

 PYQ: NEET PG 2022

Broad Answer: Intellectual Disability (ID), previously termed mental retardation, is recognized in DSM-5 and ICD-11 as a neurodevelopmental disorder. It is characterized by significant limitations in intellectual functioning and adaptive behavior, with onset before 18 years. Diagnosis is supported by IQ assessment, **where IQ <70 indicates ID**, though adaptive behavior is also considered. Severity is classified as mild, moderate, severe, and profound. Genetic causes include Down syndrome and fragile X syndrome. Management includes psychosocial interventions such as behavioral therapy and pharmacotherapy for associated symptoms.

DETAILED QUESTIONS

Q4.1: How do DSM-5 and ICD-11 define Intellectual Disability?

Answer:

- DSM-5: Intellectual Disability / Intellectual Development Disorder
- ICD-11: Disorder of Intellectual Development
- Both definitions emphasize limitations in intellectual functioning (reasoning, learning, problem-solving) and adaptive behavior (conceptual, social, and practical skills)
- Onset: before 18 years

Q4.2: How is IQ calculated and interpreted in Intellectual Disability?

Answer:

- Intelligence is usually measured by calculating IQ.
- IQ is an intelligence quotient.
- Chronological age- Age calculated from the date of birth.
- Mental age- It is calculated by performing a test

$$IQ = \frac{\text{Mental Age}}{\text{Chronological Age}} \times 100$$

- Denominator (chronological age) should not exceed 15 years
- Example: 17-year-old with mental age 10

$$IQ = \frac{10}{17} \times 100 \approx 59$$

- Normal IQ: 90-109
- Borderline IQ: 70-89
- Intellectual Disability: IQ <70

Q4.3: What are the severity grades of Intellectual Disability?

Answer:

1. Mild ID: IQ 50-69
 2. Moderate ID: IQ 35-49
 3. Severe ID: IQ 20-34
 4. Profound ID: IQ <20
- IQ levels are not necessary for mental retardation, even adaptive behaviors can tell the severity of Mental retardation
 - In Mild MR, adaptive behavior is less affected, while in profound MR, adaptive behavior is severely affected

Q4.4: What are the genetic causes of Intellectual Disability?

Answer:

- Most common cause overall: Down syndrome > Fragile X syndrome
- Most common single-gene cause: Fragile X syndrome

Q4.5: What are the treatment options for Intellectual Disability?

Answer:

- Psychosocial interventions
 - o Behavioral therapy for maladaptive behaviors (aggression, self-injury, hyperactivity)
 - o Contingency management: reward desired behaviors, punish undesired behaviors
- Pharmacotherapy (symptomatic)
 - o Antipsychotics for aggression
 - o SSRIs for depression



13. ORGANIC MENTAL DISORDER

BIG QUESTION 1: What are neurocognitive disorders? Describe the clinical features, diagnostic assessment, and management of delirium.

Broad Answer: Neurocognitive disorders, as per DSM-5 and ICD-11, are conditions with cognitive impairment due to a neurological cause. The three major types are Delirium, Dementia, and Amnestic disorder.

Delirium is the most common organic mental disorder, characterized by an acute onset, fluctuating course, impairment of attention, and a reversible nature. Dementia involves intact consciousness but impaired cognition, while an amnestic disorder primarily affects memory.

DETAILED QUESTIONS

Q1.1: What is the new terminology for organic mental disorders in DSM-5 and ICD-11?

Answer: They are termed Neurocognitive disorders because they involve cognitive impairment with a neurological cause.

Q1.2: What are the important types of Neurocognitive disorders?

Answer:

Delirium	Dementia	Amnestic disorder
Impairment of consciousness and impairment of cognition	- Consciousness is intact - Cognition is impaired	Memory is affected

Q1.3: What are the key features of Delirium?

PYQ: FMGE 2018

Answer:

PYQ: AIIMS 2018

- Most common organic mental disorder
- Acute onset (hours to days) with fluctuating course
- Impairment of consciousness, attention, memory, language, and perception (visual hallucinations common)
- Associated with motor, sleep, and emotional disturbances

Q1.4: What are the predisposing factors for Delirium?

Answer:

- Elderly age
- Chronic medical illness
- Surgical history (e.g., bypass surgery, appendicectomy, fracture femur, RTA)
- Post-operative period
- Substance abuse or alcohol withdrawal (delirium tremens)

Q1.5: How is Delirium diagnosed?

PYQ: INICET 2020

PYQ: NEET PG 2019

Answer:

Cognitive impairment	Consciousness and attention	M - Motor disturbance
- Memory (recent is impaired while remote is intact) - Language is affected - Abnormality in Perception (hallucinations, illusions) - Visual hallucination is more common	- Consciousness and attention - Impairment of consciousness clouding of consciousness, confused state, altered sensorium and reduced orientation. - Impairment of attention: Reduced ability to focus, sustaining/shifting attention.	- Increased activity - Decreased activity

Sleep disturbances	Emotional disturbances
- Decreased sleep - Excessive sleep	- Sadness - Irritable

Q1.6: How is Delirium assessed?

 PYQ: FMGE 2018, 2019

Answer:

- Confusion Assessment Method - diagnostic tool
- EEG - shows diffuse slowing of cortical activity
 - Exception: alcohol/sedative-hypnotic withdrawal shows low voltage fast activity.

Q1.7: What are the treatment principles for Delirium?

Answer:

Treatment		
Treat the Underlying Cause	Pharmacotherapy	
	Antipsychotics For management of Delusions, Hallucinations, and Agitation	Benzodiazepines - To treat insomnia - Treatment of choice in Alcohol withdrawal delirium (Alcohol tremens)

BIG QUESTION 2: What are the types, clinical features, and causes of dementia?

Broad Answer: Dementia is a progressive cognitive impairment occurring in clear consciousness. It presents with deficits in memory, language, attention, perception, social cognition, and executive function, along with behavioral and psychological changes.

DETAILED QUESTIONS

Q2.1: What is Dementia?

Answer: Dementia is a progressive cognitive impairment in clear consciousness, where consciousness remains intact, but multiple cognitive domains are impaired.

Q2.2: What are the cognitive symptoms of Dementia?

Answer:

Memory	Amnesia: Impairment of memories.
Language	• Aphasia: Disturbance in the language. • Difficulty in word-finding.
Attention	Impairment of complex attention
Perceptual motor	• Apraxia: Inability to perform the learned motor functions. Ex : Patient is unable to button and unbutton his clothes - o Patient is not able to tie the shoe laces • Agnosia is the inability to recognize objects or identify people's faces
Social cognition	Inability to recognize the emotions of others
Executive function	• Inability to perform any planning or organizing - o Activities of daily living are affected

Q2.3: What behavioral and psychological symptoms occur in Dementia?

Answer:

- Personality changes
- Delusions
- Hallucinations
- Aggression
- Agitation
- Depression
- Anxiety

Q2.4: What are the most common causes of Dementia?

Answer:

1. Alzheimer's disease - 70-80% (most common)
2. Lewy body dementia - 15-35%
3. Vascular dementia - 5-20% (third most common)

Q2.5: What is early-onset Dementia and its causes?

Answer:

- Onset before 65 years
- MCC:
 - o Alzheimer's disease
 - o Frontotemporal dementia

Q2.6: What are the reversible causes of Dementia?

Answer:

- ~10-15% of dementia is due to reversible causes.
- 1. Neurosurgical:
 - a. Subdural hematoma
 - b. Normal Pressure Hydrocephalus
 - I. Hakim's Triad: Cognitive decline, Gait abnormality, Urinary incontinence
 - c. Brain tumors, abscess

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2. Infections:

- a. Encephalitis
- b. Meningitis

3. Metabolic: Deficiency of B12, folate, niacin, thiamine; thyroid/parathyroid disorders

4. Others: Drugs, toxins, alcohol

Q2.7: How is Dementia classified based on brain region involvement?

Answer:

Cortical dementia	Subcortical dementia
• Early cortical involvement, motor system normal. • Examples: - o Alzheimer's - o Pick's disease (FTD)	• Early subcortical involvement (basal ganglia, brainstem nuclei, cerebellum), motor system abnormality • Examples: - o Parkinson's disease - o Huntington's disease - o MS - o PSP - o Wilson's disease

Q2.8: What are the types of mixed dementia?

Answer:

- Vascular dementia
- Lewy body dementia

BIG QUESTION 3: What are the clinical features and pathology of Alzheimer's disease?

Broad Answer: Alzheimer's disease is the most common cause of dementia, with a gradual, insidious onset and female predominance. It typically presents with memory deficits and later involves language, agnosia, and apraxia. Treatment involves drugs that enhance acetylcholine or reduce glutamate activity.

DETAILED QUESTIONS

Q3.1: What is the most common cause of dementia?

Answer: Alzheimer's disease

Q3.2: What is the clinical presentation of Alzheimer's disease?

Answer:

- Gradual and insidious onset
- Predominantly in females > males
- Most common symptom: memory deficits
- Language disturbances
- Progressive involvement of other cognitive domains → agnosia, apraxia

Q3.3: What are the microscopic findings in Alzheimer's disease?

Answer:

1. Amyloid plaques (senile/neurotic plaques, Aβ deposits)
2. Neurofibrillary tangles (hyperphosphorylated tau protein)

Q3.4: What neurotransmitter changes occur in Alzheimer's disease?

PYQ: NEET PG 2020

Answer:

- Decreased Acetylcholine
- Increased Glutamate → excitotoxic damage

Q3.5: What are the treatment strategies in Alzheimer's disease?**Answer:**

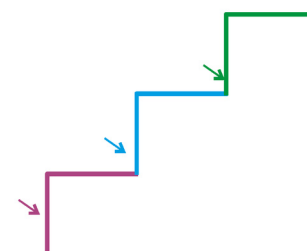
- Drugs to increase acetylcholine
- Drugs to decrease glutamate activity

BIG QUESTION 4: What are the clinical features, pathology, diagnosis, and management of multi-infarct dementia, Pick disease, and Lewy body dementia?

Broad Answer: Besides Alzheimer's, important dementias include Vascular dementia (multi-infarct dementia), Frontotemporal dementia (Pick's disease), and Lewy body dementia. Vascular dementia presents with a step-ladder pattern of deterioration after strokes. Frontotemporal dementia causes early-onset dementia with frontal or temporal lobe atrophy and Pick bodies. Lewy body dementia presents with fluctuating cognition, visual hallucinations, Parkinsonism, REM sleep behavior disorder, and is associated with α -synuclein-containing Lewy bodies.

DETAILED QUESTIONS**Q4.1: What are the features of Vascular Dementia (Multi-infarct dementia)?****Answer:**

- Due to ischemic or hemorrhagic stroke
- More common in males
- Step-ladder pattern: Sudden deterioration after a vascular event → plateau → further decline after subsequent stroke

**Q4.2: What is Frontotemporal dementia (Pick disease) and its pathology?**

PYQ: INICET 2020

Answer:

PYQ: AIIMS 2018

- Atrophy of the frontal and temporal lobes
- Pick bodies: cytoskeletal inclusion masses
- The second most common cause of early-onset dementia
- Two variants:

Behavioral variant	Language variant
• Occurs in the frontal lobe. • Patient shows ◦ Disinhibitory behavior ◦ Apathy ◦ Stereotypy and hyperorality. ◦ Personality and emotional disturbances	• Occurs in the temporal lobe. • Patient shows language impairment

Q4.3: What are the core, suggestive, and supported features of Lewy body dementia?

PYQ: INICET 2023

Answer:

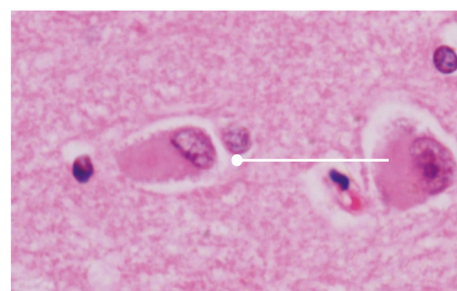
PYQ: FMGE 2023

Core features	Suggestive features	Supported features
- Fluctuating cognition (Variation in attention and alertness) - Visual hallucination - Motor features of parkinsonism (Tremors, Rigidity, Bradykinesia)	- REM sleep behavior disorder: Shows the failure of having atonia. Reenacting their dreams like punching or hitting - Severe neuroleptics sensitivity: - More sensitive to Extrapyrasidal symptoms - Due to Antipsychotics	- Repeated falls, syncope - Transient loss of consciousness - Severe autonomic dysfunction - Hallucination in other modalities- Other than Visual hallucinations, auditory and tactile are also seen. - Systematized delusion: Delusion of persecution, Capgras syndrome

Q4.4: What is the pathology of Lewy body dementia?

Answer:

- Lewy bodies: spherical intracytoplasmic eosinophilic inclusions, fibrillar α -synuclein deposits
- Lewy bodies may also be seen in Parkinson's disease.



Q4.5: How is Lewy body dementia differentiated from Parkinson's disease dementia?

Answer:

Lewy Body Disease	Parkinson's Disease
Cognitive symptoms begin first with or without motor symptoms	Motor symptoms develop first followed by cognitive symptoms (with a gap of one year between the two symptoms)

BIG QUESTION 5: How is dementia assessed and managed? Discuss the clinical evaluation, investigations, and treatment approaches.

Broad Answer: Dementia assessment is primarily done using the Mini-Mental State Examination (MMSE), with a score < 24/30 being suggestive. Management includes treating the underlying cause and pharmacotherapy targeting neurotransmitters, such as cholinesterase inhibitors and NMDA antagonists.

DETAILED QUESTIONS

Q5.1: How is Dementia assessed clinically?

Answer:

- Mini-Mental State Examination (MMSE) - Screening tool
- Given by Folstein et al
- Assesses cognitive symptoms
- Score < 24 (out of 30) suggests dementia

Q5.2: What are the pharmacological treatment options for Dementia?

Answer:

a. Cholinesterase inhibitors (reversible acetylcholinesterase inhibitors)

- Prevent breakdown of acetylcholine

↑ Ach $\xrightarrow{\text{AChE}}$ A + Ch

- Examples:
 - Tacrine (not used due to hepatotoxicity)
 - Donepezil (available as a transdermal patch)
 - Rivastigmine (available as a transdermal patch)
 - Galantamine

b. NMDA antagonist

- Memantine (non-competitive NMDA antagonist)
- Used in moderate to severe Alzheimer's disease
- Given as monotherapy or in combination with Donepezil

c. Newer monoclonal antibodies (Anti-amyloid drugs)

- Aducanumab - IgG1 monoclonal antibody; IV infusion; for mild cognitive impairment/mild AD; questionable efficacy
- Lecanemab - Humanized IgG1 antibody; IV infusion; for mild AD; side effects: headache, infusion reactions, ARIA
- Donanemab - Humanized IgG1 antibody; IV infusion; FDA approved for mild AD



Q5.3: How are behavioral and psychological symptoms in Dementia managed?

Answer:

- SSRIs - for depression, anxiety
- Antipsychotics - for agitation, delusions, hallucinations
 - Preferred: Risperidone, Olanzapine (less EPS)
 - Clozapine - used in Parkinson's disease and Lewy body dementia (no EPS)
- Pimavanserin - 5HT2A inverse agonist, approved for psychosis in Parkinson's disease
- Brexpiprazole - Partial D2 agonist, FDA approved for agitation in Alzheimer's dementia
- Benzodiazepines - for agitation and insomnia

BIG QUESTION 6: What are Amnesic disorders, their features, and causes?

Broad Answer: Amnesic disorders are characterized by memory impairment without global intellectual decline or impairment of consciousness. They typically involve anterograde amnesia (inability to form new memories) and retrograde amnesia (difficulty recalling past events), while immediate memory remains intact. Causes include CNS insults such as trauma, tumors, seizures, infections, and systemic factors such as thiamine deficiency (Korsakoff syndrome), which is classically associated with alcohol use.

DETAILED QUESTIONS

Q6.1: What type of memory is affected in Amnesic disorders?

Answer:

- Recent memory is impaired:
 - Anterograde amnesia: inability to learn new information
 - Retrograde amnesia: inability to recall past events
- Immediate memory remains intact

Q6.2: How do Amnestic disorders differ from dementia and delirium?**Answer:**

- Amnestic disorder: isolated memory impairment, consciousness intact, no global intellectual decline
- Dementia: multiple cognitive domains impaired, progressive course
- Delirium: impaired consciousness, fluctuating attention, and sensorium

Q6.3: What are the common causes of Amnestic disorders?**Answer:**

- CNS causes: Seizures, Head trauma, Tumors, Infections
- Systemic causes: Thiamine deficiency (Korsakoff syndrome), Alcohol-induced amnestic disorder (via thiamine deficiency)



14. SLEEP-WAKE EATING DISORDERS

BIG QUESTION 1: What are the physiological stages of sleep? How do NREM and REM sleep differ in brain and muscle activity, and what are the common parasomnias associated with each stage?

Broad Answer: Sleep has two main stages: NREM (with three stages, including deep sleep) and REM (with brain activity like waking but muscle paralysis). NREM parasomnias include sleepwalking and night terrors, while REM parasomnias include narcolepsy and REM sleep behavior disorder.

DETAILED QUESTIONS

Q1.1: What are the two main physiological states of sleep?

Answer:

- NREM: Non-Rapid Eye Movement
- REM: Rapid Eye Movement

Q1.2: What are the different stages of Non-Rapid Eye Movement (NREM) sleep?

Answer:

- NREM is further divided into 3 stages
 - o Stage 1: N1 stage
 - o Stage 2: N2 stage
 - o Stage 3 and Stage 4: Stages 3 and 4 have been combined into one stage known as the N3 stage

Q1.3: What are the key EEG features of the N2 and N3 stages of NREM sleep?

Answer:

N2 stage	• EEG: 2 important EEG findings N2 Stage - o Sleep spindles: A burst of waves of 12-14 Hz are seen.  - o Presence of K complexes: These are negative sharp waves followed by positive waves. 
N3 Stage: Deep sleep	• EEG: d waves (slow waves) of 0.5-3 Hz will be seen. The amplitude will be high.

Q1.4: What are the characteristic EEG findings during REM sleep?

 PYQ: FMGE 2020

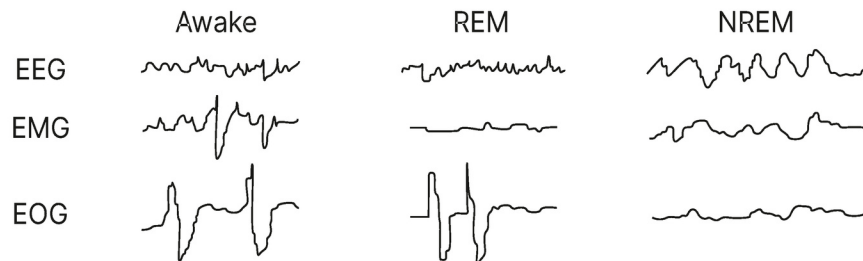
Answer:

EEG findings	• EEG activity is increased similar to the awake state (b activity) along with the return of alpha activity. • Typical appearance of these waves which are known as Sawtooth waves or Sawtooth appearance- high frequency and low amplitude waves  • Paradoxical sleep: Even though the person is sleeping the EEG shows activity similar to the awake state.
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Q1.5: What happens to muscle activity during REM sleep, and what do EEG, EOG, and EMG measure in sleep studies?

Answer:

- Muscles are paralyzed in REM
 - o EEG (Electroencephalogram): Measures the electrical activity of the brain
 - o EOG (Electrooculogram): Measures the activity of eye movements
 - o EMG (Electromyogram): Measures muscle activity



Q1.6: How do EEG, EMG, and EOG activities differ across awake, REM, and NREM sleep states?

Answer:

	Awake	REM sleep	NREM
EEG	Fast	Fast	Slow
EMG	Fast	slow	Some activity
EOG	Fast	Fast	Slow

Q1.7: What are the main differences between NREM and REM sleep?

Answer:

NREM	REM
• Known as orthodox sleep • Brain activity & physiological activity lower than the awake state. • Dreams are not remembered. • Penile erection is absent. • Body movements: Present	• Paradoxical sleep - asleep but the EEG is showing the activity of the active day. • Brain activity and physiological activity are increased or same as in the awake state except for the muscle tone (muscles are in state of paralysis). • Dreams are remembered • Penile erection is present • Body movements: Absent

Q1.8: Which sleep disorders are associated with NREM and REM sleep?

Answer:

NREM	REM
Disorders: • Somnambulism • Night terror • Bruxism • Somniloquy • Nocturnal enuresis	Disorders: • Narcolepsy • Nightmares • REM sleep behavior disorder (Also seen in lewy body dementia) • Sleep apnea

Q1.9: What are parasomnias, and how are they categorized based on sleep stages?**Answer:**

- Disorders of Partial Arousal
- Classification
 - o NREM-related parasomnias
 - o REM-related parasomnias

Q1.10: What are the features of Somnambulism (Sleepwalking), and how does it typically progress?**Answer:**

- The person may engage in some motor behavior while the person is unconscious. E.g., opening the door and going downstairs.
- Difficult to awaken
- May appear confused if awake and react violently
- Remits in adulthood

Q1.11: What is the treatment for Somnambulism (Sleepwalking)?

Answer: Benzodiazepines

Q1.12: What are the key features of Sleep Terrors (Night Terrors)?**Answer:**

- Sudden arousal with fearfulness
- The person may scream or cry, or there may be panic symptoms
- May appear confused when awakened
- Unable to recall any dream

Q1.13: What is Bruxism/ Teeth grinding?

Answer: There is grinding of the teeth, which makes a loud sound and may damage the enamel.

Q1.14: What is the treatment for sleep-related Bruxism?

Answer: A mouth guard to protect the teeth

Q1.15: What is Somniloquy?

Answer: Talks during sleep and is unable to recall in the morning.

Q1.16: What are the key features of Nightmare Disorder?**Answer:**

- There is a sudden arousal and fearfulness
- The person can recall any dream

Q1.17: What are the four classic symptoms (tetrad) of Narcolepsy?**Answer:**

- Sleep attacks
 - o Strong urge for excessive daytime sleepiness
- Cataplexy
 - o Sudden loss of muscle tone

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- o A person may fall
- o Triggered by emotional disturbances
- Sleep Paralysis
 - o A person wakes up but is unable to move their body
- Hypnagogic and Hypnopompic Hallucinations
 - o Hypnagogic hallucinations occur when the patient is going to sleep
 - o Hypnopompic hallucinations occur when the patient is coming out of sleep

Q1.18: What is the primary cause of narcolepsy?

Answer: Deficiency of the Hypocretin (Orexin) neurotransmitter in the lateral hypothalamus

Q1.19: What are the treatment options for narcolepsy?

Answer:

- A regimen of forced naps at regular intervals
- Pharmacotherapy
 - o Modafinil is the first-line treatment
 - o It is an Alpha1 agonist

Q1.20: What are the characteristic symptoms and clinical course of Kleine-Levin Syndrome?

Answer:

- Patient presents with episodes of
 - o Hypersomnia - excessive sleepiness
 - o Hyperphagia - the patient may eat a lot
 - o Hypersexuality - an increase in sexual activities
 - o Disinhibition - behaviors like aggression may be seen
- In between the episodes, the patient may be asymptomatic

BIG QUESTION 2: What are the core features, subtypes, and treatment approaches of major eating disorders like Anorexia Nervosa, Bulimia Nervosa, and Binge Eating Disorder?

Broad Answer: Eating disorders like Anorexia, Bulimia, and Binge Eating mainly affect adolescent females. Treatment includes nutrition, therapy, and medication. Anorexia has high mortality; Bulimia causes electrolyte and dental issues.

DETAILED QUESTIONS

Q2.1: What are the key demographic features and typical age of onset for Anorexia Nervosa?

 PYQ: FMGE 2022

Answer:

- Females > Male (10:1)
- Age of onset: 14 to 18 years, young adolescent females

Q2.2: What are the main symptoms and clinical features of Anorexia Nervosa?

Answer:

- Restriction of energy intake resulting in a lower body weight than normal, ICD-11: Body Mass Index (BMI)
 - o $<18.5 \text{ kg/m}^2$ in adults
 - o Under the 5th percentile in children and adolescents

- Intense fear of weight gain or obesity
- Disturbance of body image
- Many adolescent patients have delayed sexual development
- Adults may show decreased interest in sexual activities
- Medical complications secondary to starvation

Q2.3: What important change regarding amenorrhea was made in the DSM-5 and ICD-11 criteria for Anorexia Nervosa?

Answer: Amenorrhea has been removed as a necessary criterion (in DSM-5 and ICD-11)

Q2.4: What are the subtypes of Anorexia Nervosa?

Answer:

- Restricting type
- Binge eating/ purging type

Q2.5: What are the types of anorexia nervosa?

Answer:

Restricting Type	Binge Eating/ Purging Type
Seen in 50% of the patients	• Binge eating: Intake of large amount of food in short duration • Purging: Compensatory mechanism for excess calories by self induced vomiting, laxative/ diuretic/ emetic use
Highly restricted food intake	
May do excessive exercise	May do excessive exercise

Q 2.6: What is the course and prognosis of Anorexia Nervosa?

Answer: High mortality rate, as high as any psychiatric illness

Q2.7: What is the most common cause of death in Anorexia Nervosa?

Answer: Medical complications of low weight and malnutrition

Q2.8: What challenges are faced in treating patients with eating disorders like Anorexia Nervosa?  PYQ: AIIMS 2019

Answer:

- Patients are often secretive
- They may deny their symptoms and resist the treatment

Q2.9: What are the treatment modalities in severe eating disorders?

Answer:

Hospitalization	• Restoring nutritional status • Managing complications like - o Dehydration - o Electrolyte imbalances (Na, K, Cl). • 20% below the normal weight for height.
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Treatment goal	- Nutritional rehabilitation and weight restoration - At start 1500-1800 Kcal/day (divided meals)
Monitoring the Patient	- To prevent self-induced vomiting - 2 hours after each meal. - For Refeeding Syndrome (PO_4^{3-}, Mg^{2+}, K^+) - Due to increased food intake compared to pretreatment intake.

- Behavioral management
- SSRIs may be used

Q2.10: What are the key features and typical onset of Bulimia Nervosa?

PYQ: FMGE 2022

Answer:

- Females > Male (10:1)
- Age of Onset
 - Late adolescence and young adulthood
- Episodes of binge eating combined with inappropriate ways of preventing weight gain

Q2.11: What are the clinical features of Bulimia Nervosa?

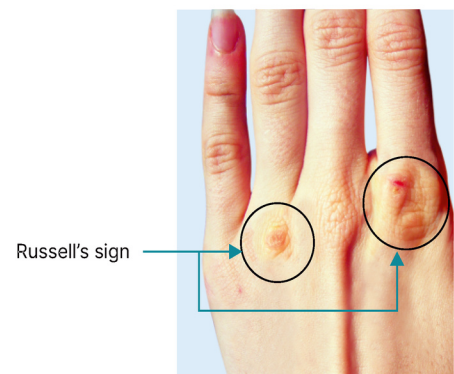
Answer:

- Episodes of binge eating in which a large amount of food is usually consumed in a short duration
- Followed by compensatory behavior to prevent weight gain, which includes:
 - Laxatives, diuretics, emetics
 - Excessive exercise, fasting
- Occurrence: 1/week for 3 months
- May have a fear of weight gain or desire to lose weight
- Weight: Normal or increased compared to anorexia nervosa, where weight is reduced

Q2.12: What are the features secondary to purging in Bulimia Nervosa?

Answer:

- Enamel erosion, Dental caries
- Swollen parotid and salivary glands
- Russell's Sign: Callus on knuckles- due to self-induced vomiting, the knuckles get injured by the teeth
- Hypokalemia, Hypochloremia, Hyponatremia, Alkalosis
- Rarely: Gastric and esophageal tears

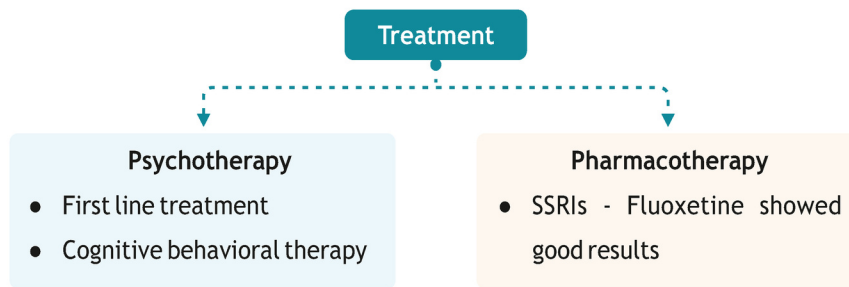


Q2.13: Can the secondary features of purging in Bulimia Nervosa also occur in Anorexia Nervosa?

Answer: Yes

Q2.14: What is the typical setting for treating Bulimia Nervosa?

Answer: OPD treatment



Q2.15: What are the key features of Binge Eating Disorder (BED)?

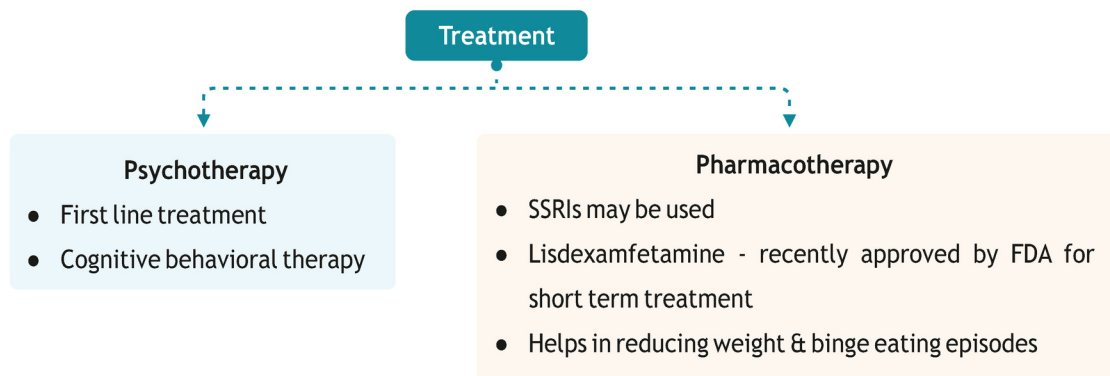
Answer:

- New entity in DSM-5
- Females > Male (1.75:1)
- Episodes of binge eating, but there is no compensatory behavior
- Sense of lack of self-control
- Weight: Overweight or obese range

Q2.16: What is the treatment approach for Binge Eating Disorder (BED)?

PYQ: NEET PG 2019

Answer:



Q2.17: Which is the most common eating disorder?

Answer: Binge eating disorder

Q2.18: What is the lifetime prevalence of Anorexia Nervosa and Bulimia Nervosa?

Answer:

Type of Eating Disorder	Lifetime Prevalence
Anorexia Nervosa	2-4%
Bulimia Nervosa	2%



15. SEXUAL PERSONALITY DISORDERS

BIG QUESTION 1: What are the phases of the sexual response cycle and the common dysfunctions associated with each phase? What are the key features of Gender Identity Disorders, and how are they managed?

Broad Answer:

- The sexual response cycle includes four phases: Desire, Excitement, Orgasm, and Resolution. Low desire affects the Desire phase, erectile dysfunction occurs in the Excitement phase, and premature ejaculation is linked to the Orgasm phase. The Resolution phase usually has no dysfunctions.
- Gender Identity Disorders involve a strong desire to be the opposite sex, seen in children and adults. Treatment may include hormone therapy and surgery.

DETAILED QUESTION

Q1.1: What are the phases of the sexual response cycle?

Answer:

- Mnemonic: 'DEOR'
 - o Desire Phase
 - o Excitement (Arousal) Phase
 - o Orgasm Phase
 - o Resolution

Q1.2: What is the Desire phase of the sexual response cycle?

Answer: First stage: Includes sexual urges, sexual wishes

Q1.3: What is the Excitement (Arousal) Phase of the sexual response cycle?

Answer: Subjective feelings of sexual pleasure are accompanied by physiological changes like an increase in heart rate, blood pressure, and sweating.

Q1.4: What physiological changes are seen during the Excitement phase?

Answer:

- Males: Penile erection
- Females: Vaginal lubrication
- Disorder: Erectile dysfunction seen in males

Q1.5: What characterizes the orgasm phase in the sexual response cycle?

Answer:

- Smallest stage lasting for 3-15 seconds
- Peak of sexual pleasure

Q1.6: What physiological changes occur in males and females during the orgasm phase of the sexual response cycle?

Answer:

- Males: Ejaculation of semen occurs
- Females: Involuntary contraction of the lower 1/3rd of the vagina and contraction of the uterus

Q1.7: Which sexual dysfunction is associated with the orgasm phase?

Answer: Premature ejaculation

Q1.8: What happens during the resolution phase of the sexual response cycle, and how long does it typically last?

Answer:

- Lasts for 10-15 mins
- The body goes back to the resting stage

Q1.9: What is male erectile disorder (erectile dysfunction)?

Answer: Marked difficulty in obtaining or maintaining an erection during sexual activity for sexual intercourse

Q1.10: During which phase of the sexual response cycle does male erectile disorder occur?

Answer: Excitement phase

Q1.11: What are the causes of male erectile disorder (erectile dysfunction)?

Answer:

Psychogenic Erection Dysfunction	Organic Erectile Dysfunction
• Caused by psychological factors anxiety, marital problems.	• Caused by medical causes: Diabetes mellitus, Arteriosclerosis, Neurological disorders.
• Experiences early morning erections and nocturnal erections	• Does not experience early morning or nocturnal erections

Q1.12: What investigations are used to record nocturnal erections in cases of erectile dysfunction?

Answer:

- Nocturnal penile tumescence
- Penile plethysmography (which measures blood pressure in the penis)

Q1.13: What is the pharmacological treatment for erectile dysfunction?

Answer:

Pharmacotherapy	Phosphodiesterase-5 inhibitors (PDE-5 inhibitors) • Nitric oxide enhancers- facilitates blood flow into the penis and enhances erection. • Drugs: Sildenafil, Tadalafil, Vardenafil and Avanafil.
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Q1.14: What are the key components involved in this psychotherapy approach to erectile dysfunction?

Answer:

Psychotherapy	Dual Sex Therapy (Sex Therapy) • It was derived by Masters and Johnson. • It is also effective for other sexual disorders as well. • It means it treats the couple (not individual). Both the partners are involved in the treatment. Exercises/ Sensate focus exercises • It has two stages: - o Non-genital sensate focus - o Genital sensate focus
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Q1.15: What is premature ejaculation?

PYQ: NEET PG 2019

Answer: A pattern of persistent or recurrent ejaculation with minimal sexual stimulation before or immediately after vaginal penetration

Q1.16: During which phase of the sexual response cycle does premature ejaculation occur?

Answer: Orgasm phase

Q1.17: According to DSM-5, how is premature ejaculation defined?

Answer: Ejaculation occurring within <1 minute following vaginal penetration

Q1.18: What are the behavioral treatments for premature ejaculation?

PYQ: NEET PG 2018, 2023

Answer:

- Squeeze technique
 - o Given by Masters & Johnson
 - o When the male partner gets a feeling of impending ejaculation, he or his partner squeezes the coronal ridge of the glans, resulting in the inhibition of ejaculation.
- Stop - Start technique.
 - o Given by Semans, known as Semans' technique
 - o When the male partner gets a feeling of impending ejaculation, sexual activity is stopped for some time and restarted once excitement has decreased.

Q 1.19: What pharmacological treatment is used for premature ejaculation?

Answer:

- SSRIs (selective serotonin reuptake inhibitors)
 - o Delayed ejaculation is a side effect of SSRI's which can be used to treat premature ejaculation.

Q1.20: What is nymphomania?

PYQ: NEET PG 2018, 2023

Answer: Excessive sexual desire in females

Q1.21: What is satyriasis?

Answer: Excessive sexual desire in males

Q 1.22: How are Gender Identity Disorders described under DSM-5 and ICD-11?

Answer:

- DSM-5: Gender Dysphoria
- ICD-11: Gender Incongruence

Q 1.23: What is the definition of gender identity?

Answer: It is a sense one has of being male/female, which corresponds most often to a person's anatomical sex.

Q 1.24: What are the key features of Gender Identity Disorder in childhood?

Answer:

- Marked incongruence between expressed gender and assigned gender
- Strong desire to be of the other gender

Q 1.25: Which age group is most commonly affected by Gender Identity Disorder?

Answer: Prepubertal children

Q 1.26: What behaviors and feelings characterize Gender Identity Disorder in children?

Answer:

- Preference for cross-dressing, for toys or games engaged by the other gender
- May have a dislike of one's sexual anatomy

Q 1.27: What is transsexualism?

Answer:

- Desire to live and be accepted as a member of the opposite sex
- Usually accompanied by a sense of discomfort with, or inappropriateness of, one's own anatomical sex
- Patient may say, "I am a man trapped in the body of a woman"

Q 1.28: What is the minimum duration a transsexual identity must be present for a clinical diagnosis?

Answer: For at least 2 years

Q 1.29: How is transsexualism treated?

Answer:

- Patients who insist on sex change, sex reassignment surgery can be done
- Hormonal therapy usually accompanies

BIG QUESTION 2: What are personality disorders, how are they classified into clusters, and what are the key features and treatments associated with major types within these clusters?

Broad Answer:

- Personality disorders are long-term patterns of behavior causing distress or dysfunction, starting in adolescence or early adulthood.
- They're classified into three clusters: Cluster A (odd/eccentric), Cluster B (dramatic/impulsive), and Cluster C (anxious/fearful). Common treatments include psychotherapy, like dialectical behavior therapy for borderline personality disorder.

DETAILED QUESTIONS

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Q 2.1: What are personality disorders?

Answer:

- Pattern of behaviors and inner experiences that deviate significantly from an individual's cultural standards
- Leads to clinically significant distress or impairment in functioning

Q 2.2: When do personality disorders typically occur?

Answer: Usually in adolescence or early adulthood

Q 2.3: How do personality disorder symptoms evolve?

Answer:

- The pattern is stable for a long duration, and symptoms remain stable once developed.
- Some personality disorders (like antisocial and borderline) tend to become less evident or remit with age; maturation occurs by 40 years.

Q 2.4: How are personality disorders classified?

Answer:

Cluster A personality disorder	Cluster B personality disorder	Cluster C personality disorder
Includes • Paranoid PD • Schizoid PD • Schizotypal PD	Includes • Antisocial PD • Borderline PD • Histrionic PD • Narcissistic PD	Includes • Avoidant PD • Dependent PD • Obsessive compulsive PD
• Appear Odd/eccentric: Weird	• Appear Dramatic/impulsive: Wild	• Anxious/fearful: Worried

Q 2.5: What are the key features of Paranoid Personality Disorder?

Answer:

- Long-standing pattern of suspiciousness or distrust
- No hallucinations and no delusions
- Suspect others without basis (exploiting and harming)
- Reads hidden threatening meanings and benign events
- Bears grudges

Q 2.6: What are the characteristic traits of Schizoid Personality Disorder?

Answer:

- Long pattern of social withdrawal
- Emotionally cold, indifferent to praise or criticism
- Prefer solitary activities
- Lacks close friends

 PYQ: AIIMS 2018

 PYQ: INICET 2020

Q 2.7: What are the features of Schizotypal Personality Disorder?

Answer:

- Exhibit social difficulties and eccentric behavior.
- Exhibit odd beliefs and magical thinking, e.g., superstitious, belief in the sixth sense, telepathy.

- Speech may be vague, over-elaborated, and reflect odd thinking
- May have an illusion or ideas of reference
- Increased risk of schizophrenia

Q 2.8: What are the key characteristics of Antisocial Personality Disorder?

Answer:

- Don't have regard for the rights of others and often violate them
- Frequently involved in unlawful activities (theft, lying, conning)

Q 2.9: What additional behaviors are often associated with Antisocial Personality Disorder (ASPD)?

Answer:

 PYQ: FMGE 2022

- Irritability and aggressiveness (physical fights or assaults)
- No guilt or remorse for their actions, or they may even blame others for their actions
- Substance use disorder may be frequently present.

Q 2.10: Who is more commonly affected by Borderline Personality Disorder, and what causes it?

Answer:

- Females > Males
- Unstable interpersonal relationships (idealization/devaluation)

Q 2.11: What type of identity disturbance is observed in Borderline Personality Disorder?

Answer: Unstable self-image (sudden shift in goals, values, sexual identity, etc.)

Q 2.12: What is impulsivity in Borderline Personality Disorder?

Answer: Potentially self-damaging behavior (spending, reckless driving, substance abuse)

Q 2.13: What are the key emotional and behavioral symptoms of Borderline Personality Disorder?

Answer:

- Recurrent suicidal behaviour, gestures, threats (such as wrist slash)
- Mood instability: Intense episodic anger outbursts
- A chronic feeling of emptiness almost always appears in a state of crisis
- Micro-psychotic episodes along with Fleeting, doubtfulness

Q 2.14: What is the primary treatment approach for Borderline Personality Disorder?

Answer: Psychotherapy

Q 2.15: What are the key psychotherapeutic treatments for Borderline Personality Disorder?

Answer:

- Dialectical behavior therapy (DBT):
 - Correction of the all-or-none phenomenon/ splitting
 - All or none phenomenon: Patient looks at everything as either all good or all bad
- Mentalization-based therapy (MBT)
- Transference-focused psychotherapy (TFP)

Q 2.16: What are the main features of Histrionic Personality Disorder?**Answer:**

- High degree of attention-seeking behavior
- Exaggerated Speech and Emotions
- Behave in a colorful, dramatic, extroverted way
- They want to be the center of attention
- Inappropriate sexual seductive behavior, flirtatious
- Uses physical appearance to draw attention

Q 2.17: What are the characteristic features of Narcissistic Personality Disorder?**Answer:**

- Heightened sense of self-importance
- Expects to be recognized as superior without any achievements
- Preoccupied with fantasies of the power of success
- Requires excessive admiration
- Exploitative, may lack empathy

Q 2.18: What are the key features of Avoidant (Anxious) Personality Disorder?**Answer:**

- Extremely sensitive to rejection
- Fear of criticism, disapproval, or rejection
- Views oneself as socially inept or inferior

Q 2.19: What are the main characteristics of Dependent Personality Disorder?**Answer:**

- Difficulty in making everyday decisions
- Dependent on others for advice and reassurance
- Need others to assume responsibility for most areas
- Difficulty expressing disagreement because of fear of loss of support
- Lacks confidence and cannot initiate new things



16. FORENSIC PSYCHIATRY

BIG QUESTION 1: What are the key provisions of the Mental Healthcare Act (MHCA) 2017, and what are the important treatments, therapies, and tests related to psychiatric practice?

Broad Answer: The MHCA 2017 is a rights-based legislation that regulates treatment and rights of patients with mental illness in India. It emphasizes patient autonomy through capacity assessment, advance directives, and nominated representatives. It restricts certain procedures like direct ECT and psychosurgery, and decriminalizes suicide attempts. Psychiatric treatment involves drugs such as lithium (a mood stabilizer with anti-suicidal property), somatic therapies like ECT, rTMS, VNS, DBS, and psychosurgery. Depression has clinical signs like omega sign and Veraguth's fold. Psychological evaluation includes projective tests such as Rorschach, TAT, and cognitive screening with Bender Gestalt test.

DETAILED QUESTIONS

Q1.1: What is the concept of capacity under MHCA 2017?

Answer: Capacity to make mental health care or treatment related decisions

- Ability to **understand the information** relevant to take decision related to treatment
- Understand the consequences of decision or lack of decision.
- Ability to communicate decisions - verbally or through writing.

Q1.2: What is an advance directive under MHCA 2017?

PYQ: AIIMS 2018, 2019

Answer:

- Every person who is not a minor can make an advanced directive.
- He can mention
 - o The way he wishes **to be treated for a mental illness** or
 - o The way he wishes **not to be treated for a mental illness**
 - o Can also mention whom he wants to appoint as a nominated representative
- Applicable only when he/she loses the capacity to take decisions

Q1.3: Who is a nominated representative?

Answer:

- Any person can appoint a nominated representative
- If a person loses the capacity to make mental health care or treatment-related decisions, their nominated representative will help (or will take) in taking decisions related to the treatment of the person

Q1.4: What types of admissions are allowed under MHCA 2017?

PYQ: NEET PG 2021

Answer:

Independent admissions	Supported admission
• If he wishes to get admitted • When he has capacity to make mental health care or treatment related decisions	• One who needs admission because of threatened/attempted bodily harm to himself or others or unable to take care of himself leading to risk of harm to himself

YOURWISH

	- Has lost capacity to make mental health care or treatment decisions and needs high level support from nominated representative - Nominated representative can give consent for admission-supported admission
	Section 89: Admission and treatment of person with mental illness with high support needs up to 30 days

Q1.5: What procedures are prohibited or restricted under MHCA 2017?

Answer:

ECT without use of anesthesia and muscle relaxants	Direct ECT banned
ECT for minors	If psychiatrist considers the need: - Take informed consent from guardian - Permission from mental health review board
Restriction of psycho surgery for persons with mental illness	If psychiatrist considers need - Take informed consent from patient - Approval from mental health review board

Q1.6: What does MHCA 2017 state about suicide?

Answer: Decriminalization of suicide

- Any person who attempt to commit suicide shall be presumed to have severe stress and shall not be tried or punished under section 309 of IPC

BIG QUESTION 2: What are lithium's key features, toxicity management, and brain stimulation treatments?

Broad Answer: Lithium is a mood stabilizer with anti-suicidal effects, excreted by the kidneys, with toxicity above 1.5 mEq/L. Side effects include tremors, thyroid issues, and DI. Toxicity is treated with hydration, GI decontamination, or hemodialysis. Brain stimulation techniques include ECT, rTMS, vagal nerve stimulation, deep brain stimulation, and psychosurgery, used mainly in treatment-resistant psychiatric conditions.

DETAILED QUESTIONS

Q2.1: What are the key pharmacological aspects of Lithium?

Answer:

- Monovalent ion, Mood stabilizer; discovered by John FJ Cade (conducted studies to prove lithium to be a mood stabilizer)
- Absorption: Complete oral, not plasma protein bound, not metabolized, excreted by kidneys
- Anti-suicidal property
- Therapeutic range: 0.5-1.5 mEq/L
 - Acute mania: 1-1.5 mEq/L
 - Maintenance: 0.6-1.2 mEq/L
 - Toxicity: >1.5 mEq/L

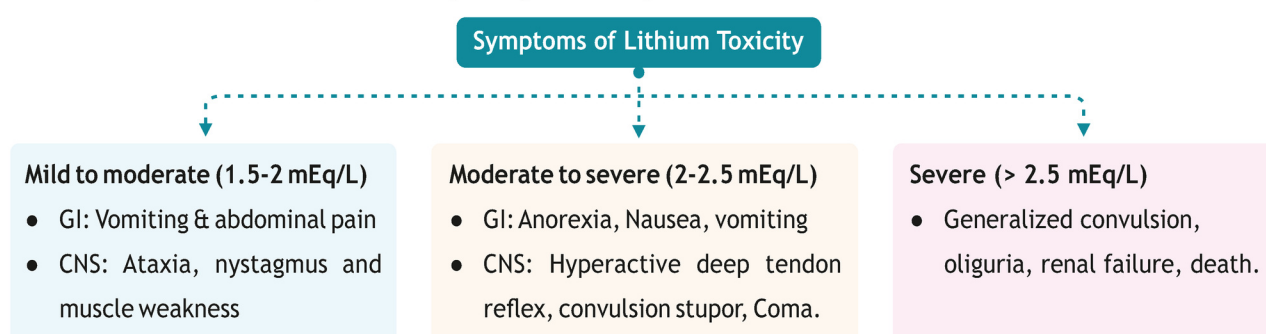
Q2.2: What are the adverse effects of lithium?

Answer: Adverse effects (*Mnemonic: LITHIUM*):

- **L** - Loss of hair/appetite
- **I** - Increased leukocytes
- **T** - Tremors (DOC propranolol)
- **H** - Hypo/hyperthyroidism
- **I** - Increased urine → DI
 - o DOC: Thiazides, K-sparing diuretics
 - o Drug interaction: Thiazides decrease lithium clearance- lithium toxicity may occur
- **M** - Maternal: Ebstein anomaly

Q2.3: What are the key features of Lithium toxicity?

Answer: Body treats lithium like sodium so in certain conditions like low sodium diet or dehydration body tries to absorb sodium and also absorb lithium, and subsequently to toxicity.



Q2.4: What is the treatment of lithium toxicity?

Answer:

- Stop lithium, correct hydration
- Removal of unabsorbed lithium from the GI tract: Polyethylene glycol, sodium polystyrene sulphonate
- Severe cases: **Hemodialysis**

Q2.5: What are the non-invasive brain stimulation techniques in psychiatry?

Answer: Other techniques

Non-invasive	Invasive
ECT	VNS
rTMS	DBS (Deep Brain Stimulation)
	Psychosurgery

Q2.6: What are the key features of Electroconvulsive therapy?

Answer: Electroconvulsive Therapy (ECT)

- Electrical stimulation is given to produce convulsions
- Direct ECT is banned in India
- Indirect ECT / Modified ECT is used
- ECT is administered after giving
 - o **Anesthetic agents:** Methohexital- most commonly used
 - o **Others:** Thiopental, etomidate, ketamine, alfentanil, propofol
 - o **Muscle relaxants:** Succinylcholine- most commonly used



Q2.7: What are the Indications for ECT?

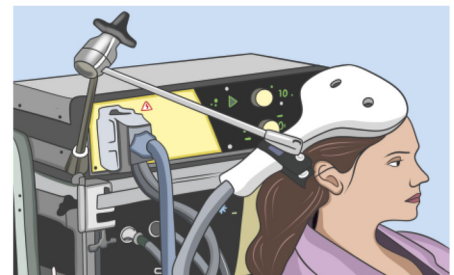
Answer:

- **Major depressive disorder:**
 - Depression with suicidal risk
 - Depression with stupor / agitation / psychotic symptoms
 - Patients who failed medication trials
- **Manic episodes:**
 - Medications are unresponsive / intolerant
 - Manic behavior has led to dangerous levels of exhaustion
- **Schizophrenia:**
 - Catatonic schizophrenia
 - Used for unresponsive / intolerant individuals
- **Other indications:**
 - OCD
 - Neurotic malignant syndrome
 - Intractable seizure disorder
 - Hypopituitarism
 - On-off phenomenon of Parkinsonism

Q2.8: What are the key features of Transcranial magnetic stimulation?

Answer:

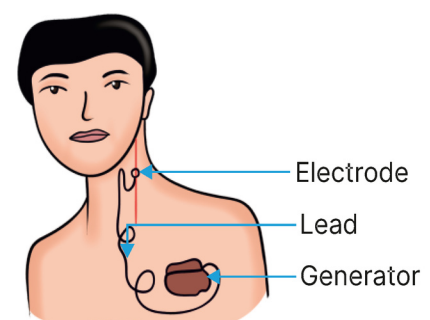
- Patient is awake and conscious
- Uses short pulses of magnetic energy to stimulate nerve cells
- rTMS: Repetitive Transcranial magnetic stimulation produces focal secondary electrical stimulation of cortical regions
- Non-convulsive
- No anesthesia required
- Safe side effect profile
- No cognitive side effects
- The FDA has approved rTMS for cases failing to achieve satisfactory improvement from 1 antidepressant
- Most common side effect: Scalp pain / discomfort



Q2.9: What are the key aspects of Vagal nerve stimulation?

Answer:

- Invasive method
- Electrodes stimulate left vagal nerve via a pulse generator implanted on chest
- Serotonin neurons are stimulated
- Long-term adjunct treatment of chronic or recurrent depression in adults who have not had an adequate response to ≥ 4 antidepressants.



Q2.10: What is Deep Brain Stimulation (DBS)?

Answer:

- Implantation of leads into specific brain areas
- Being studied for chronic, intractable depression

Q2.11: What is Psychosurgery?

Answer:

- Specific areas are targeted
- Used for OCD

Q2.12: Which antipsychotic is known for its anti-suicidal property?

Answer: Clozapine

BIG QUESTION 3: What are some key clinical signs and psychological tests used in assessing depression and cognitive function?

Broad Answer: The Omega sign and Veraguth's fold are facial features commonly associated with depression. The Rorschach and TAT are projective personality tests, while the Bender Gestalt Test screens cognitive functions and brain disorders.

DETAILED ANSWERS

Q3.1: What is the Omega sign?

Answer:

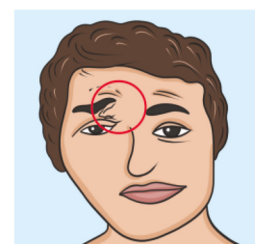
- Omega-shaped fold in the forehead above the root of the nose
- Excessive use of the corrugator muscle
- Seen in depression



Q3.2: What is Veraguth's fold?

Answer:

- Triangular fold in the nasal corner of the upper eyelid
- Change in tone of the corrugator and zygomatic facial muscles
- Seen in depression



Q3.3: What is the Rorschach inkblot test?

Answer:

- Developed by Herman Rorschach
- Most frequently used projective personality test
- Consists of 10 inkblot cards (ambiguous, symmetrical)
- Patient is asked what he sees in the cards
- Projective test: Patient projects his internal conflicts on the test, and based on the answers patient's personality is assessed.



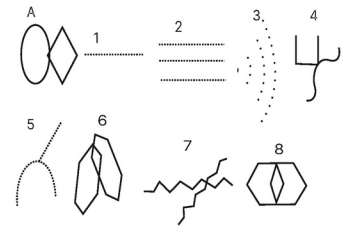
YOURWISH

Q3.4: What is the Thematic Apperception Test (TAT)?**Answer:**

- Consists of 20 pictures depicting individuals involved in a variety of activities
- Person is asked to make stories about them
- Projective personality test

**Q3.5: What is the Bender-Gestalt test?****Answer:**

- Also known as the Bender Visual Motor Gestalt test
- To assess various cognitive functions such as memory, sensory and motor functions, language, executive functions, arithmetic, visual spatial functions etc.
- Used as a screening tool for organic brain disorders





17. PSYCHOLOGY

BIG QUESTION 1: What were Sigmund Freud's major contributions to psychoanalysis and how did he conceptualize the structure and functioning of the mind?

Broad Answer: Sigmund Freud, known as the *Father of Psychoanalysis*, coined the term "psychoanalysis" and developed a revolutionary framework for understanding the human mind. His theories include the Topographical Model of the Mind (dividing the mind into conscious, preconscious, and unconscious) and the Structural Theory of the Mind (Id, Ego, and Superego).

DETAILED QUESTIONS

Q1.1: Who is called the Father of Psychoanalysis, and what did he coin?

Answer: Sigmund Freud is called the Father of Psychoanalysis, and he coined the term psychoanalysis.

Q1.2: What is the difference between transference and countertransference?

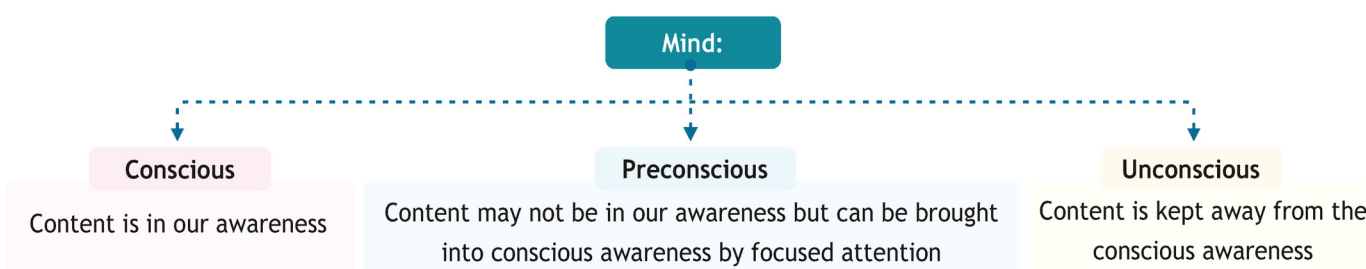
Answer:

PYQ: NEET PG 2021

Transference	Countertransference
- Feelings of a patient towards the therapist. - Can be both conscious or unconscious. - Based on past relationships with a significant figure in the patient's life. - It can be both -ve and +ve. Example Scenarios - Negative feelings: A 30-year-old female went to a 50-year-old therapist and says you are very rude just like my stepfather. - Positive feelings: A 30-year-old female went to a 50-year-old therapist and says you are very kind just like my father. - Transference can be used in therapy to know the unconscious feelings the patient is having	- Feelings of a therapist towards the patient. - It can be both conscious and unconscious. - It can be both -ve and +ve. Example Scenarios - The therapist is missing appointments. - During the interview, the therapist is sleeping.

Q1.3 What is Freud's Topographical Model of the Mind?

Answer: Freud's Topographical Model divides the mind into:



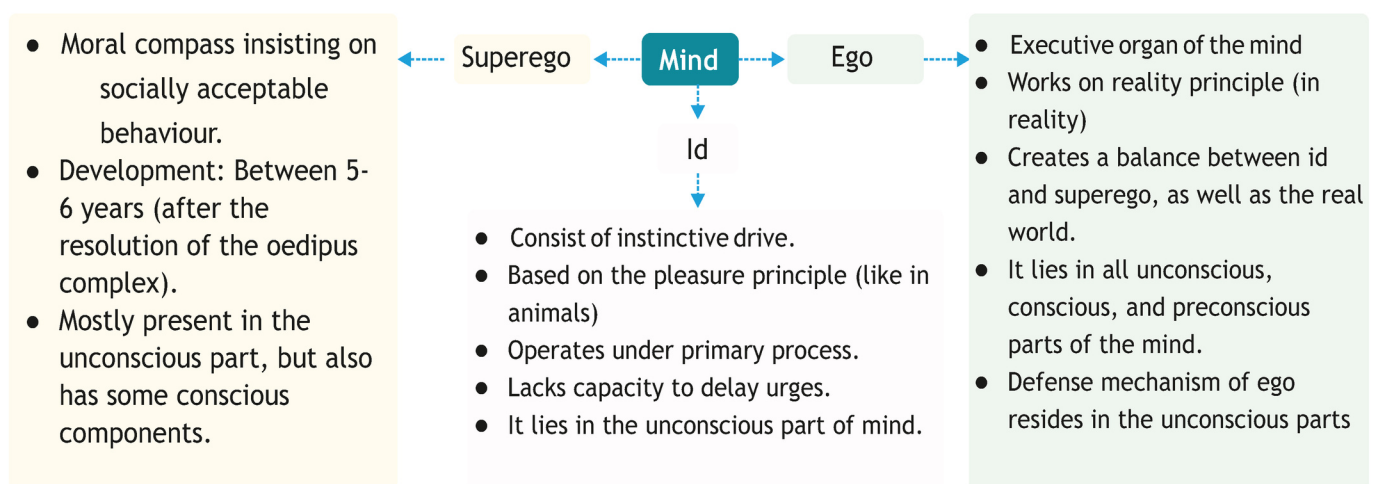
Q1.4: How can unconscious content cross the repression barrier?

Answer:

- Free association
 - o The therapist sits near the couch without being visible to the patient
 - o The patient is allowed to speak uninterrupted and is advised to say whatever comes to mind without censoring any thoughts
 - o Outcome: The patient may speak a few thoughts from the unconscious mind
- Slip of the tongue (Parapraxis)
 - o Sigmund Freud says that a slip of the tongue is not a simple mistake
 - o It may be important information about the unconscious mind

Q1.5: What is Freud's Structural Theory of the Mind?

Answer: Mind is divided into three parts



Q1.6: Give examples of Freud's Structural Theory of the Mind using a case scenario.

Answer:

- Id: Primitive drives, pleasure principle *"Let's go out and party"*
- Superego: Morality and ideals *"We should study for exams"*
- Ego: Reality principle, mediating between Id and Superego *"Let's study half a day, then go out"*.

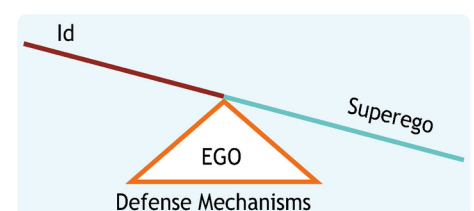
BIG QUESTION 2: What are the defence mechanisms used by Ego to overcome the friction between Id and Ego?

Broad Answer: Defense mechanisms used by the ego to manage conflict between the id and superego include repression, projection, regression, rationalization, displacement, reaction formation, intellectualization, dissociation, undoing, inhibition, and acting out. Mature defenses like altruism, humor, and suppression (the only conscious one) also help the ego cope with internal tension.

DETAILED QUESTIONS

Q2.1: What are defence mechanisms and what is their purpose?

Answer: Defence mechanisms are unconscious strategies used by the Ego to reduce conflict between Id and Superego, helping to prevent excessive anxiety.



Q2.2: Which defence mechanism is the only conscious one?

Answer: Suppression is the only conscious defence mechanism.

- Most defense mechanisms are in the unconscious mind.

Q2.3: Give examples of projection, acting out, and regression.

Answer:

Defense	Features	Example
Projection	A person projects his own desires onto someone else. Seen in psychosis.	Mr. P is having an affair but is convinced that his wife is having an affair.
Acting out	Unconscious wishes are enacted in behavior to avoid being aware of them. Seen in impulse control disorders (ICD).	The student is angry with his friend, Rather than telling him he throws a book at him (not intentionally).
Regression	Return to an earlier stage of development (to avoid the anxiety of later stages). People may act childish/ younger.	Husband returns after a stressful day, converses with wife in baby talks.

Q2.4: What are inhibition, intellectualization, and isolation of affect?

Answer:

Defense	Features	Example
Inhibition	Unconsciously limiting an aim and accepting partial fulfillment of desire.	A person is unable to clear the entrance exam for MBBS, he becomes a veterinary doctor.
Intellectualization	Excessive use of intellect to escape painful emotions.	After getting diagnosed with a metastatic tumor, a person starts discussing a great deal about its technical aspects.
Isolation of affect	Separation of emotions related to a stressful event, but reality is accepted.	A man comes home and tells his family of his lung cancer without any emotions.

Q2.5: Explain displacement and dissociation with examples.

Answer:

Defense	Features	Example
Displacement	Unconscious shifting of impulses from one object to another, to solve a conflict.	A man gets angry with his boss, shouts at his wife, shouts at her son, and punches his toy.
Dissociation	Separation of one or more mental functions from remaining functions to avoid distress.	A person was kidnapped and tortured, he says it was as if he was floating on the ceiling and watching it.

Q2.6: What are undoing, rationalization, and reaction formation?

Answer:

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Defense	Features	Example
Undoing	An act to nullify a previous act.	A man is sexually provoked by a woman he sees, leaves, and buys flowers for his wife.
Rationalization	Giving logical explanations for unacceptable behaviors. It is mostly seen in Substance use disorders.	A person says he drinks alcohol because it kills all the germs in his body.
Reaction formation	Unacceptable impulse transformed into its opposite.	A boy is fascinated by porn, organizes antipornography campaign.

Q2.7: What is repression, and how is it different from suppression?

Answer:

Defense	Features	Example
Repression	Idea/ feeling eliminated from consciousness which you cannot access. You forget, and then you forget that you forgot.	A child has been abused by his mother, and now has no memory of that abuse.
Suppression	Conscious decision to postpone attention to a conflict.	A student decides to forget about the upcoming exam and take a day's break.

Q2.8: Which defense mechanisms are considered relatively adaptive?

Answer: Altruism (constructive service to others), suppression, and humor.

Defense	Features	Example
Altruism	Constructive gratifying service to others, to deal with their own feelings. It may be harmful to the person.	After the death of the husband, due to smoking, the wife starts a 'No smoking' campaign. She does not look after her health.
Suppression	Conscious decision to postpone attention to a conflict.	A student decides to forget about the upcoming exam and take a day's break.
Humor	Using humor to deal with unpleasant situations	A man comes out and laughs after getting scolded by the boss.

Q2.9: Which defense mechanisms are commonly seen in OCD?

Answer:

- Inhibition
- Isolation
- Displacement
- Undoing
- Reaction formation

BIG QUESTION 3: What are Freud's stages of psychosexual development, and how does fixation at different stages lead to psychiatric disorders?

Broad Answer: Sigmund Freud proposed **five stages of psychosexual development**, where each stage is characterized by a primary source of pleasure and conflict resolution.

Oral stage	• Age: Birth- 1.5 years. • Site of pleasure: Oral cavity/ oral gratification by biting, sucking, chewing • Fixation: Schizophrenia, Substance dependence.
Anal stage	• Age: 1.5-3 years. • The major site of gratification: Anal. • The child derives pleasure through excretion. • Fixation: Obsessive Compulsive Disorder.
Phallic stage	• Age: 3-5 years. • Site of pleasure: Genital area. • The child derives pleasure by stimulating genital areas. • Fixation: Hysteria, Sexual deviations.
Latent stage	• Age: 5/6-11/13 years • There is relative sexual quiescence (inactivity). • The Oedipus Electra complex is usually resolved at the beginning of this Stage. • The superego is formed. • Mastery of skills (child learns new skills). • Fixation: Neurotic disorders.
Genital stage	• Age: 11/13 years-Young adulthood. • Maturation of genital functioning, development of adult sexuality & adult identity. • Fixation: Neurotic disorders.

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DETAILED QUESTIONS

Q3.1: What are Freud's five stages of psychosexual development?

Answer:

1. Oral (Birth-1.5 years)
2. Anal (1.5-3 years)
3. Phallic (3-5 years)
4. Latent (5/6-11/13 years)
5. Genital (11/13 years-young adulthood)

Q3.2: What is fixation in psychosexual development?

Answer: Fixation is when development becomes arrested at a particular stage due to unresolved conflicts, leading to psychiatric disorders later in life

Q3.3: What are the characteristics and psychiatric outcomes of the oral and anal stages?

Answer:

- Oral stage: Pleasure through sucking, biting, chewing Fixation: Schizophrenia, substance dependence
- Anal stage: Pleasure through excretion Fixation: Obsessive-compulsive disorder

Q3.4: What happens in the phallic stage, and what complexes are involved?

Answer: Phallic stage (3-5 years): Pleasure derived from genital stimulation

Male child	Oedipus complex	Castration anxiety
	• An attraction towards mother. • Mom (m-male child, o-oedipus complex, m-mother).	• Fear of castration by the father. • If he finds out the child's attraction towards the mother. • Resolved by identification with the father, attempting to adopt the father's characteristics.
Female child	Electra complex	Penis envy
	• Attraction of a daughter towards the father	• Discontent with female genitalia following a fantasy that resulted from the loss of the penis. • Desire to bear a penis. • Resolved by identification with the mother. • Fixation: Hysteria, Sexual deviations

Q3.5: What occurs during the latent stage?

Answer:

- Sexual quiescence (relative inactivity)
- Oedipus/Electra complex resolved
- Superego develops
- Mastery of new skills
- Fixation: Neurotic disorders

Q3.6: What defines the genital stage and its fixation outcomes?

Answer:

- Age: 11-13 years (young adulthood)
- Development of adult sexuality and adult identity
- Fixation: Neurotic disorders



18. MCQ DISCUSSION

Q1. A patient says, "I am Tom, I am a con, my friend is gone, I want an iPhone, time is dawn, let's call Shaun." Which of the following symptoms is seen in the patient?

- A. Tangentiality
- B. Preservation
- C. Loosening of association
- D. Flight of ideas

Answer: D. Flight of ideas

Explanation: The patient's speech is rapid with clang associations (Tom-con-gone-iPhone), a hallmark of flight of ideas seen in mania. In loosening of associations, speed is normal, but connections between thoughts are illogical.

Q2. While interviewing a second-year psychiatry resident, a patient admitted to the ward is asked, 'What will he do if he sees his neighbour's house on fire?'. What is the test being conducted by the resident?

- A. Test judgement
- B. Insight
- C. Abstract thinking
- D. Social judgment

Answer: A. Test judgment

Explanation: Hypothetical questions assess the patient's judgment. Insight involves awareness of illness, abstract thinking is tested with proverbs, and social judgment is inferred from actual social behaviour.

Q3. A 64-year-old male was admitted for bypass surgery. On the 2nd post-operative day in the hospital, he started saying irrelevant things and would continue to say that he was at his home. He would appear irritable and would sometimes try to remove his catheter. Which of the following is the most likely diagnosis?

- A. Schizophrenia
- B. Mania
- C. Acute psychosis
- D. Delirium

Answer: D. Delirium

Explanation: Acute onset of confusion, irritability, irrelevant speech, and fluctuating consciousness after surgery is typical of delirium. Schizophrenia and mania have preserved orientation.

Q4. A patient with a diagnosis of schizophrenia is not responding to haloperidol and thioridazine. Started on another medication, Drug A, with the side effects of sialorrhea, dyslipidaemia, and hyperglycaemia. This drug requires regular blood monitoring for a serious side effect. What is the drug A?

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- A. Clozapine
- B. Risperidone

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- C. Aripiprazole
- D. Ziprasidone

Answer: A. Clozapine

Explanation: Clozapine is used for **treatment-resistant schizophrenia**. It causes sialorrhea, metabolic syndrome, and agranulocytosis; hence, CBC monitoring is mandatory.

Q5. A female was brought to the psychiatrist, 3 weeks after her delivery. She appears fearful, irritable, and has suicidal thoughts. What is the likely diagnosis?

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- A. Postpartum blues
- B. Postpartum psychosis
- C. Postpartum depression
- D. Panic disorders

Answer: C. Postpartum depression

Explanation: Symptoms beginning after 2 weeks postpartum with low mood and suicidal ideation, but without psychosis, indicate postpartum depression.

Q6. A patient is brought in with symptoms of anxiety, palpitations, sweating, breathlessness, chest pain, and feeling she might have a heart attack/feeling of impending doom. The patient had 5-6 episodes in a month, 30 minutes each, for 6 months. What is the likely diagnosis?

- A. Depression
- B. Panic disorder
- C. Generalized anxiety disorder
- D. Agoraphobia

Answer: B. Panic disorder

Explanation: Recurrent, unexpected panic attacks with fear of impending doom and spontaneous resolution within 30 minutes are characteristic of panic disorder.

Q7. A 17-year-old female eats food by arranging it in pieces and takes very small bites each time, spending a lot of time eating his meal. Which of the following is the likely diagnosis?

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- A. Anorexia nervosa
- B. Obsessive-compulsive disorder
- C. Panic disorder
- D. Generalized anxiety disorder

Answer: B. Obsessive-compulsive disorder

Explanation: Ritualistic and repetitive eating behaviours (arranging food, small bites) represent compulsions, seen in OCD, not eating disorders.

Q8. The parents brought a 3-year-old child because of the concern that he was not developing appropriately. The child often is unable to engage with others using eye contact and does not play with other children. He continuously bangs his chin against the wall and remains confined to himself most of the time. What is the most likely diagnosis?

- A. Social phobia
- B. ADHD
- C. Depression
- D. Autism

Answer: D. Autism

Explanation: Lack of social reciprocity, impaired communication, and stereotyped behaviours (chin-banging) are classical features of Autism Spectrum Disorder.

Q9. A 40-year-old male presents with c/o tremors, sweating, and anxiety for 2 days. On taking history, the patient reports taking alcohol for 13 years, but could not take it in the past 2 days due to some religious reasons. His LFTs are deranged. What is the drug of choice in this condition?

- A. Thiamine
- B. Diazepam + thiamine
- C. Lorazepam + thiamine
- D. Lorazepam

Answer: C. Lorazepam + thiamine

Explanation: Alcohol withdrawal with deranged liver function is best treated with lorazepam (a short-acting benzodiazepine not dependent on liver metabolism) plus **thiamine** to prevent Wernicke's encephalopathy.

Q10. A male patient comes with a history of marital conflicts and complains of early ejaculation. Which of the following nonpharmacological methods may be useful in the condition?

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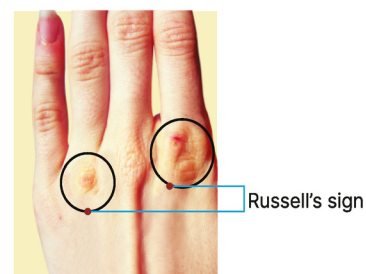
- A. Squeeze technique
- B. CBT
- C. Exposure and response prevention
- D. Relaxation

Answer: A. Squeeze technique

Explanation: Premature ejaculation is treated with behavioural methods like the squeeze technique and start-stop method, which delay ejaculation.

Q11. A 21-year-old female is brought to the clinic by her mother, whose symptoms are consistent with depression. On examination, she presents with increased body weight and the following clinical sign notes, as shown in the image below. Which is the likely diagnosis?

- A. Obsessive-compulsive disorder
- B. Anorexia nervosa
- C. Bulimia nervosa
- D. Binge eating disorder



Answer: C. Bulimia nervosa

Explanation: Russell's sign indicates **self-induced vomiting**. The presence of normal/increased body weight rules out anorexia nervosa, confirming bulimia.

Q12. A 25-year-old female with bipolar disorder was on lithium. Which of the following statements is incorrect?

- A. Lithium decreases thyroid function
- B. Thiazides increase lithium toxicity
- C. Lithium is avoided in pregnancy due to its teratogenic effects
- D. Haemodialysis is not useful in lithium toxicity

Answer: D. Haemodialysis is not useful in lithium toxicity

Explanation: Haemodialysis is the treatment of choice in severe lithium toxicity. Lithium can cause hypothyroidism, toxicity with thiazides, and Ebstein anomaly in pregnancy.