MAPS MENTALS

CLINICAL MANUAL OF PSYCHIATRY

COMPLETE AND UPDATED GUIDE

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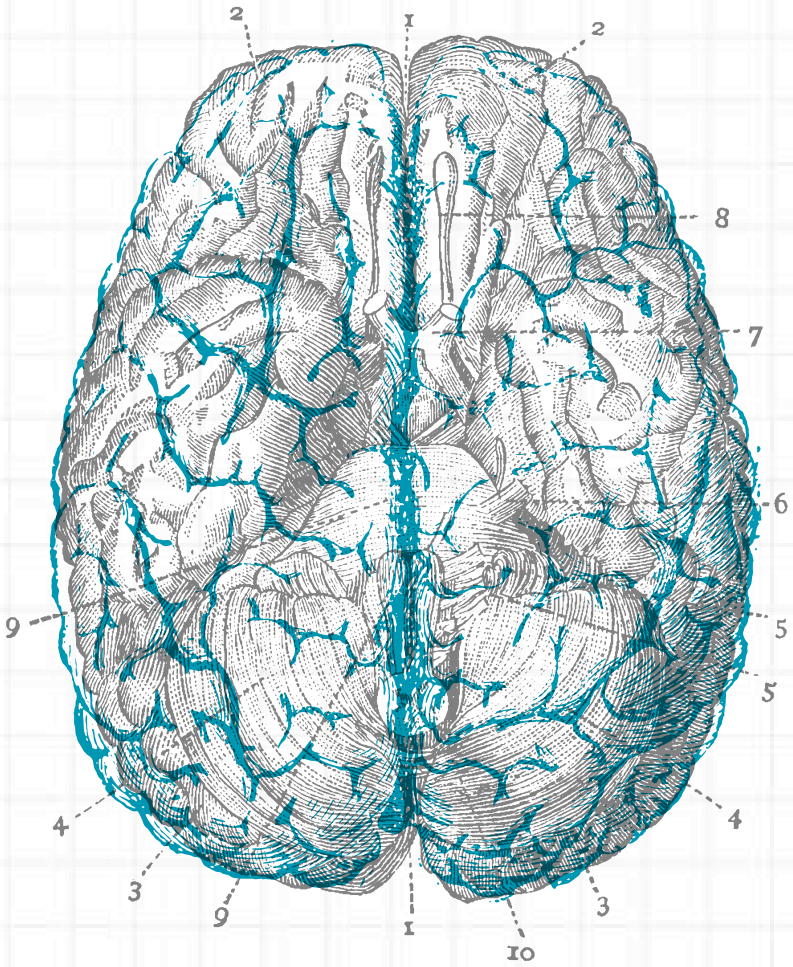
PART I

GENERAL INTRODUCTION TO

Psychiatry



MENTAL DISORDERS

CONCEPT

Cognitive, emotional and behavioral disturbance that reflects on psychological, biological processes and interpersonal and individual relationships.

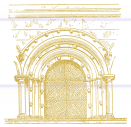
- Interview and detailed anamnesis;
- Thorough psychological examination;
- It involves the patient's personality and the sociocultural environment;

HISTORY

Antiquity: Mental illnesses were often attributed to supernatural causes. Mental disorders were believed to be the result of divine punishment. Treatment approaches involved religious rituals, exorcisms and mystical practices.

Middle Ages: Mental disorders influenced by religious and philosophical beliefs. Asylums began to emerge, used to confine and isolate people considered insane.

13th Century: The Enlightenment brought a more scientific approach, where Philippe Pinel, in France, proposed treating the mentally ill with humanity, emphasizing the importance of understanding the causes of mental illnesses.



19th century: Emil Kraepelin introduced the idea of classifying mental illnesses based on symptoms and prognoses. Electroconvulsive therapy (ECT) has been used as a treatment for certain disorders.

20th century: Sigmund Freud developed psychoanalysis, which emphasized the importance of the unconscious and personal history in understanding mental disorders. Behaviorism and cognitive-behavioral therapy also emerged.

MENTAL DISORDERS

Second Half of the 20th century: Deinstitutionalization movement, with the idea of treating patients with serious mental illnesses in communities. There have also been advances in the development of psychotropic medications, such as antipsychotics, antidepressants and mood stabilizers.

Current context: Research in neuroscience, complex interaction between genetic, biological and environmental factors in the origin of mental disorders. Importance of mental health and global well-being, promoting prevention and promotion of mental health.

Proposed questions
What is the cause of your problem, in your opinion?
How does your body react to the problem?
What could have triggered the problem?
How serious is your problem? Is it short or long lasting?
What type of treatment do you believe you should receive to resolve your problem?
What problems has the disease caused you?
What results do you expect from your treatment?
What do you fear about treatment and the disease?

Fonte: Kleinman, Eisenberg e Good, 1978.

PROPOSALS FOR TREATMENT

Culturally Sensitive Care
Developed by Arthur Kleinman

- Invite the patient to talk about their perceptions about the problem, diagnosis and care.

The culture of psychiatry includes the use of classification and diagnostic systems to categorize mental disorders, such as: Diagnostic and Statistical Manual of Mental Disorders (DSM) and the International Classification of Diseases (ICD), which standardize communication between mental health professionals and to facilitate research and treatment.

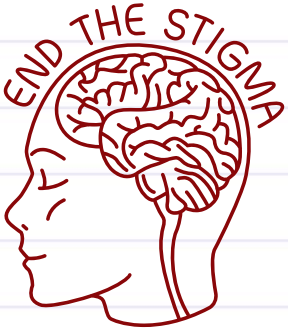
MENTAL DISORDERS

CULTURAL STIGMA

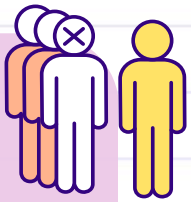
It refers to discrimination, prejudice and negative stereotypes associated with people who suffer from mental health problems or who seek psychiatric treatment.

MAIN CAUSES

- Limited knowledge;
- Fear and preconception that a mental disorder means violence;
- Negative representations in the media;
- Lack of resources and support contributes to stigma;
- Lack of adequate funding for mental health programs;



CONSEQUENCES



- Social isolation;
- Resistance in seeking care and adhering to treatment;
- Lower employability rate;
- Reduced functionality;
- Damage to interpersonal relationships;
- Low self-esteem;
- Lower quality of life;

Initiatives to raise awareness, educate and promote a culture of acceptance and understanding in relation to mental health.

PART II

ANAMNESIS IN

Psychiatry

INITIAL INTERVIEW

FIRST CONSULTATION

- All information provided may contain diagnostic value;
- Doctors must appear friendly and welcoming to alleviate tension;

1 OPENING PHASE

- Usual greeting, followed by a brief presentation by the doctor.
- Reason for the interview/consultation.
- First question should be comprehensive, allowing the patient to speak freely about their condition.
- Average duration of 5 to 10 minutes.

2 INTERVIEW BODY

- Collection of data necessary to compose the clinical history;
- Observation of behaviors, emotional reactions, what is said, how it is said and what seems to be avoided from being said
- Patient-focused assessment, writing briefly (in bullet points) to detail later
- Duration 30 to 40 minutes.

3 CLOSING PHASE

- Impressions about the symptoms described, diagnostic hypotheses and therapeutic options for the patient.
- If medication is prescribed, the expected effects, response time, possible side effects and how to proceed if they occur should be clarified.
- Lasts 5 to 10 final minutes.

PSYCHIATRIC INTERVIEWS

INTERVIEW TECHNIQUES

BONDING TECHNIQUES

- **Empathy: understanding what the patient is feeling.**
- **Knowledge: validating the patient's feelings, asking questions that address the diagnostic picture.**
- **Authenticity: present yourself in a simple, empathetic way, building an open relationship with the patient.**
- **Therapeutic alliance: building trust, welcoming and bonding with the patient.**

FACILITATING TECHNIQUES

- **Non-verbal incentives: Maintain eye contact, nod your head or tilt your body;**
- **Verbal incentives:**

- **a) reinforcing expressions ("I understand", "continue", "I understand");**
- **b) reflective listening, when the patient's last words are repeated, such as an interjection or question;**
- **c) request for more information;**
- **d) preparation of a summary;**

QUESTION TECHNIQUES

- **Open: They influence the patient to express themselves;**
- **Focused: Direct exploration to a specific topic (sleep, stressful situations);**
- **Closed: They explore conditions not yet discussed, restricting responses to affirmative or negative.**

SENSITIVE TOPICS

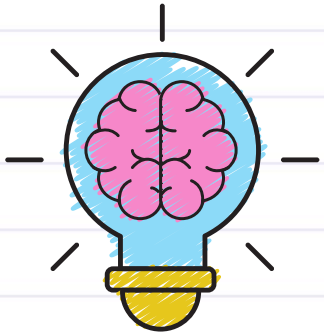
- Normalization of the condition;
- Use terms belonging to the patient's context;
- Suggestion of more severe symptoms so that the patient feels comfortable speaking precisely;
- Do not make value judgments about the patient's actions.

CLINICAL HISTORY

ANAMNESIS

IDENTIFICATION

- Data collected by the doctor himself to maintain patient privacy.
- Name, biological sex, skin color, date of birth/current age, level of education, marital status, profession, religion, address and contact form.
- When accompanied, observe information described by companions (dementia or cognitive disorders).



HDA

- Signs, clinical symptoms, complaints and behaviors;
- They follow chronological order of emergence;
- Acute or insidious onset?
- Psychosocial factors that occurred before the onset of the disorder?
- Events that aggravate or benefit the symptoms?

MAIN COMPLAINT

- When there is a broad set of symptoms and inaccuracy in the time of onset, the record can be started by the history of the current illness (ADH), in which the QP will be inserted.

PREGRESS

PATHOLOGIES

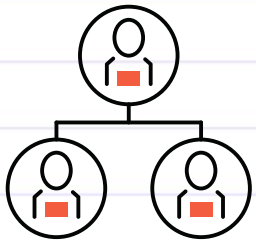
- Chronic debilitating diseases, traumatic brain injuries, seizures, CNS infections, thyroid dysfunctions;
- Drug interactions;

CLINICAL HISTORY

ANAMNESIS

FAMILY HISTORY

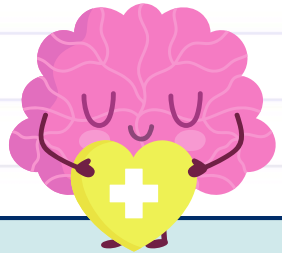
- Family psychopathological dysfunctions;
- The patient's relationship with their closest relatives (children, parents and spouse);



PREMORBID PERSONALITY

- Neuropsychomotor development and approximate age at which speech and walking begin;
- Experiences of losses and early separations, as well as signs of physical or sexual abuse.
- It concerns how the patient was before becoming ill.

MENTAL EXAM



- Conscience;
- Orientation in time and space;
- Attention;
- General aspects and non-verbal communication;
- Memory;
- Sensoperception;
- Thought and judgment;
- Language;
- Cognition;
- Affectivity;
- Psychomotricity;

LABORATORY EXAMS

IMPORTANCE

- General assessment of the patient: systemic functioning in order to indicate or contraindicate medications or detect comorbidities;
- Drug treatment: evaluating organic stability to the treatment regimen;
- Adjust medication dosage: ensure that the treatment regimen remains within therapeutic margins, reducing the possibility of side effects.

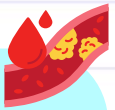
BLOOD COUNT AND COAGULOGRAM

Psychiatric medications can alter these exams. (Clozapine leading to agranulocytosis and carbamazepine inducing leukocytosis, psychotropic drugs can alter the coagulation cascade).

LIVER FUNCTION (ALT AND AST)

Medications, such as sodium valproate, phenobarbital, clozapine, naltrexone, disulfiram, and agomelatine, can cause liver damage. Baseline liver damage limits the use of medications, such as benzodiazepines (with the exception of lorazepam) and the drugs previously listed.

LIPID AND GLYCEMIC PROFILE



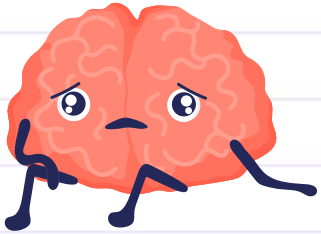
Increased risk of developing metabolic syndrome, weight gain, increased appetite; Medications that cause metabolic syndrome: olanzapine and mirtazapine

Tests: Total cholesterol and fractions, triglycerides, fasting blood glucose

LABORATORY EXAMS

THYROID FUNCTION

By blocking the glandular release of T3 and T4, studies indicate that the use of lithium can cause goiter in up to 40% of cases and hypothyroidism in up to 20% of cases.



BETA- HCG

Women of childbearing age before starting treatment with psychotropic drugs, the majority of whom have a risk classification of C during pregnancy and lactation.

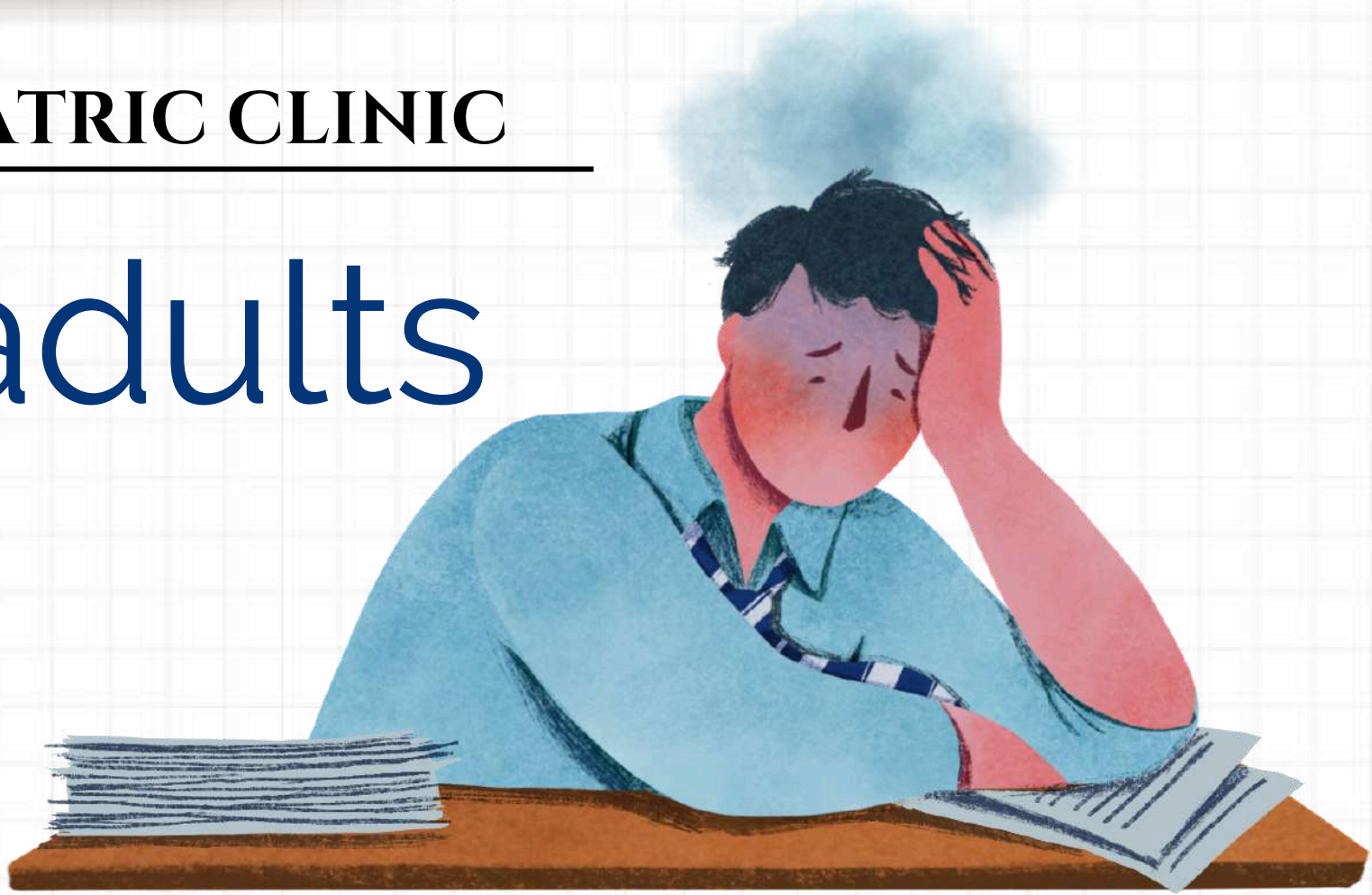
BIOMARKERS

DIAGNOSIS	BIOMARKERS
Depression	Combination of AAT, BDNF, epi-lipoprotein C3, EGF, cortisol, resistin, prolactin, ↑ b Activity in frontal regions of the brain
Bipolar disorder	↑ pro-inflammatory markers, ↑ GDF-15; ↑ HPX; ↑ HPN; ↑ RBP-4; ↑ TTR ↓ BDNF
Schizophrenia	↑ ethylene; ↑ ammonia ↑ IL-6; ↑ IL-18, ↑ TNF-alpha; ↑ Activity b in all regions of the brain ↑ Activity u in the superior temporal gyrus
Post-traumatic stress disorder	↓ BNP ↓ Hippocampal volume in the right cerebral hemisphere ↑ CRH
Attention deficit disorder	↑ the combination between the NET-1 and SNAP-25 genes Presence of SNAP-25 gene polymorphism ↓ Brain iron
Alzheimer's disease	↑ beta-amyloid; ↑ Tau; ↑ Tau-phosphorylated Cerebral atrophy;

PART III

PSYCHIATRIC CLINIC

In adults



DEPRESSION

CONCEPT

Characterized by a sad, irritable or empty mood, associated with cognitive and somatic changes, lasting ≥ 2 weeks.

Source: American Psychiatric Association - Diagnostic and Statistical Manual of Mental Disorders 5th edition.

CRITERIA

Mandatory: at least one.

- Depressed mood much of the time, in addition to irritability in children or adolescents.
- Anhedonia: loss of satisfaction and pleasure in accomplishing things that previously brought joy.

CRITERIA

At least 5 of the below:

- Weight loss or gain, without any change in eating pattern;
- Change in sleep pattern: Insomnia or hypersomnia;
- Fatigue and loss of energy;
- Loss of concentration and slowed speech;
- Feelings of worthlessness and guilt;
- Psychomotor retardation or agitation;
- Morbid thoughts or suicidal ideation;

Atypical depression: Hypersomnia and weight gain, generally linked to bipolar disorder.

DEPRESSION

CLASSIFICATION

MILD DEPRESSIVE EPISODE

In addition to the mandatory symptoms, 2 of the other criteria;

MODERATE DEPRESSIVE EPISODE

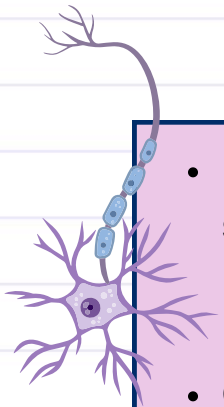
In addition to the mandatory symptoms, 3 or 4 of the other criteria;

SERIOUS DEPRESSIVE EPISODE

In addition to the mandatory symptoms, more than 4 of the other criteria;

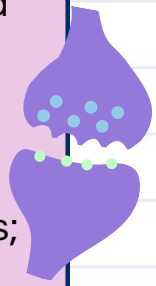
SEVERE WITH PSYCHOTIC SYMPTOMS

If it occurs: delirium, hallucinations, catatonia.



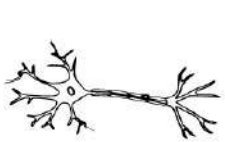
PATHOPHYSIOLOGY

- Brain areas with lower serotonergic and noradrenergic responsiveness;
- Greater release and concentration of glucocorticoids, due to continued stressors;
- Sustained elevation of cortisol and dysregulation of the HPS axis;
- Suppression of neurogenesis by increased levels of glucocorticoids;
- Changes in the neurotransmission of acetylcholine, glutamate, GABA.



DEPRESSION

PATHOPHYSIOLOGY

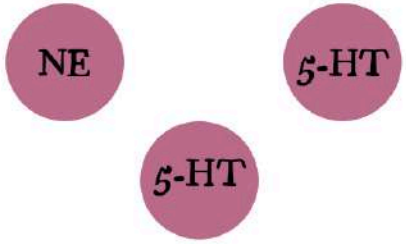


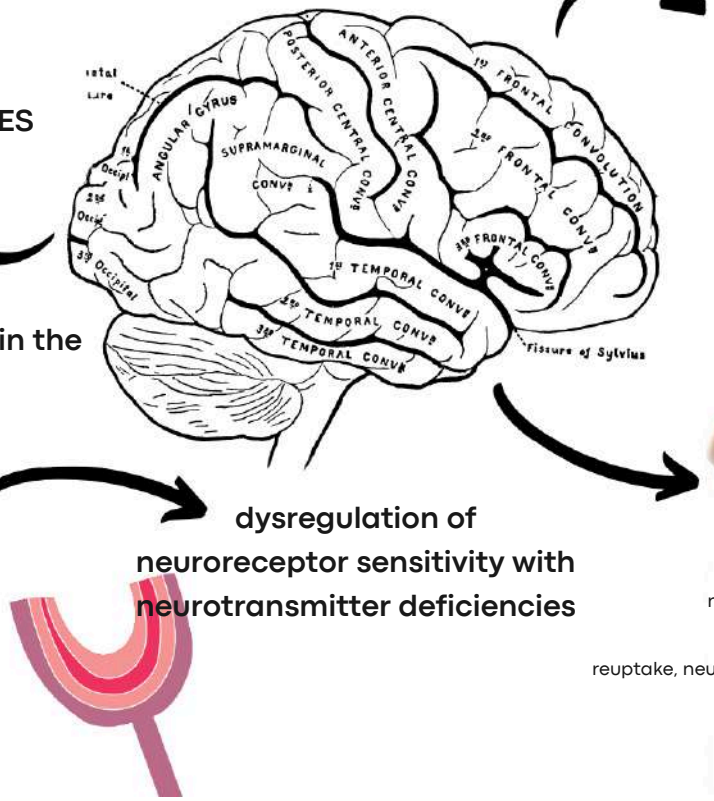
HYPOTHESES

central noradrenaline deficit

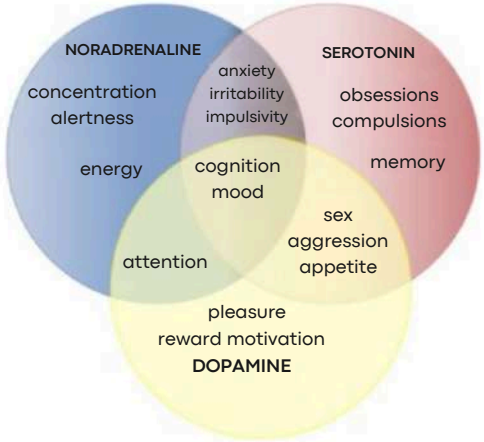
decreased amount of neurotransmitter in the cleft

synaptic





dysregulation of neuroreceptor sensitivity with neurotransmitter deficiencies



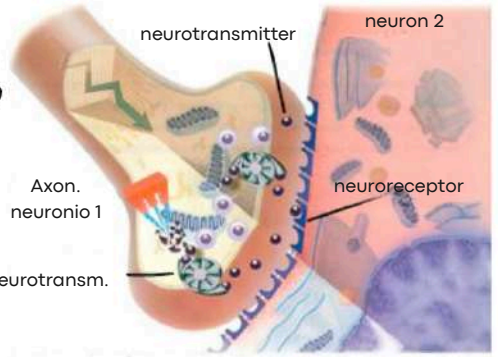


Fig. . In Depression there is an increased number of neuroreceptors and low levels of neurotransmitters

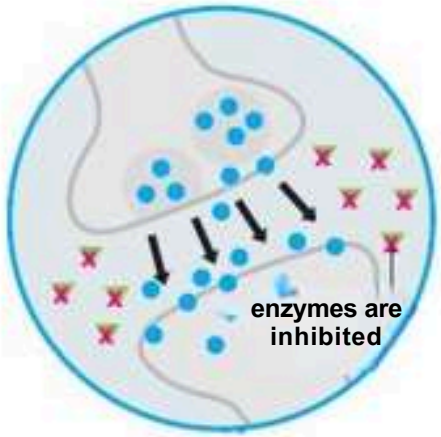
Dysfunction in the amount of monoamine neurotransmitters causes overregulation of the postsynaptic receptors of these neurotransmitters, leading to depression;

DEPRESSION

ANTIDEPRESSANTS

- Blocking the reuptake pump, increasing the amount of neurotransmitters in the synapse;

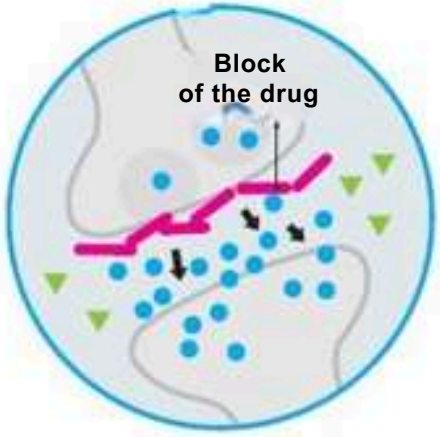
Selective monoamine oxidase inhibitors (MAOI)



(Tranylcypromine; Moclobemide; Selegiline) Little used today due to side effects, they inhibit the action of the monoamine oxidase enzyme, which eliminates the neurotransmitter after the synapse has taken place. Inhibiting the enzyme causes the substance to remain active in the cleft for longer.

SIDE EFFECTS: risk of interaction with cheeses, wines and sausages, which can trigger a considerable increase in blood pressure.

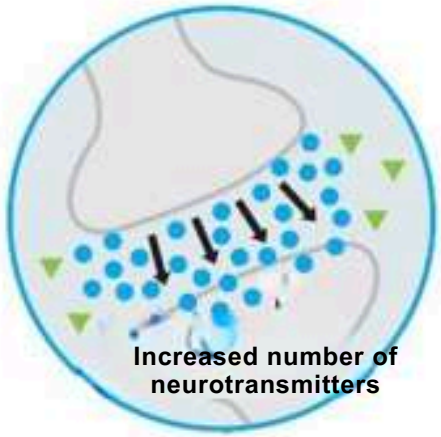
serotonin reuptake



(Fluoxetine, paroxetine) Fluoxetine was the first of this class of medications, its advantage was in its milder side effects. The drug prevents the serotonin-emitting neuron from recapturing the substance. Thus, it remains available for longer in the communication process between neurons, is absorbed in greater quantities by the receptor and has its action maximized.

SIDE EFFECTS: nausea, insomnia, reduced libido and appetite.

Tricyclic antidepressants

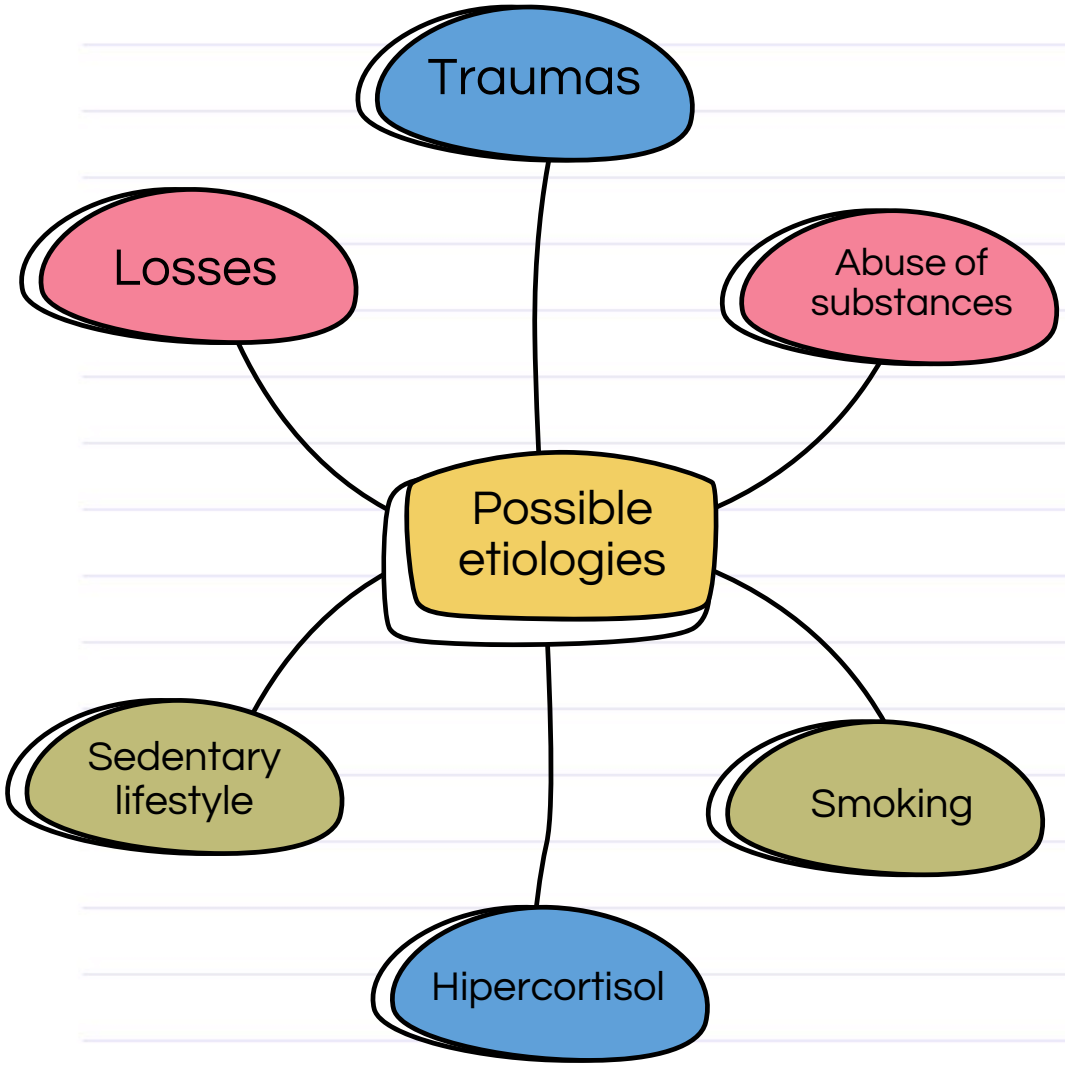


(Amitriptyline, clomipramine, imipramine and nortriptyline) Prevent the sending neuron from recapturing noradrenaline and serotonin. Increase the amount of neurotransmitters in the synapse, prolonging the communication time between neurons.

SIDE EFFECTS: changes in blood pressure and heart rate, increased sleep, as it has a sedative effect.

DEPRESSION

ETIOLOGIES



TREATMENT

Most used class!

Selective serotonin reuptake inhibitors (SSRIs)

- Fluoxetine
- Sertraline
- Fluvoxamine
- Paroxetine
- Escitalopram
- Citalopram

Serotonin and norepinephrine reuptake inhibitors (SNRIs)

- Venlafaxine
- Duloxetine
- Desvenlafaxine

Monoamine oxidase inhibitors (MAOIs)

Non-selective and irreversible:	Selective and irreversible:	Selective and reversible:
• Iproniazid; • Tranylcypromine; • Phenelzine;	• Clorgilina • (MAO-A)	• Brofaromin; • Moclobemide; • Befloxacin;

Non-selective monoamine reuptake inhibitors (Tricyclic antidepressants)

- Imipramine; Clomipramine; Amitriptyline; Nortriptyline;

Serotonin reuptake inhibitors and ALFA-2 antagonists (IRSA)

- Nefazodone; Trazodone;

Selective dopamine reuptake inhibitors (SSRIs)

- Amineptine; Bupropion; Minaprine;

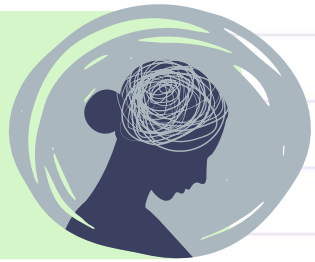
DYSTHYMIA

CONCEPT

It is equivalent to persistent or chronic depressive disorder, with prevalent symptoms for 2 years, or 1 year in children and adolescents.

Source: American Psychiatric Association - Diagnostic and Statistical Manual of Mental Disorders 5th edition.

It is common for the patient to consider themselves in this way "always", due to a prolonged period of time.



The worsening of a dysthymic condition with an episode of major depression is called double depression.

SYMPTOMS

- Persistent depressed mood;
- Changes in appetite;
- Low self-esteem;
- Difficulty concentrating;
- Low ability to make decisions;
- Insomnia or hypersomnia;
- Hopelessness

TREATMENT

Combination of psychotherapy and pharmacotherapy, with the use of SSRIs, venlafaxine and bupropion, with higher doses and for a longer period of time (2 to 3 years).

BIPOLAR DISORDER

CONCEPT

Characterized by persistent mood changes, with periods of elevation and remission.

Source: American Psychiatric Association - Diagnostic and Statistical Manual of Mental Disorders 5th edition.

HYPOMANIA

Depressive pole, symptoms lasting for at least 4 days, not causing severe impairment.

MANIA

Euphoric pole, with symptomatic duration of at least 7 days, with loss of functionality and psychotic symptoms.

SYMPTOMS

- Grandiosity, inflated self-esteem;
- Flight of ideas, racing thoughts;
- Inattention;
- Psychomotor agitation or excessive time dedicated to a specific activity;
- Less need for sleep;
- Involvement in risky activities;

CLASSIFICATION

Type I

At least one episode of mania in their lifetime.

Type II

At least one episode of hypomania and 1 episode of depression, without presenting a manic episode.

Cyclothymia

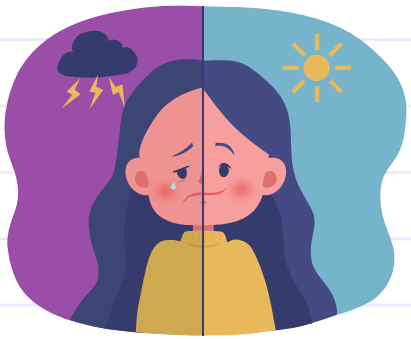
Fluctuations between the depressive and manic poles.

BIPOLAR DISORDER

CLINICAL CONDITION

CHARACTERISTICS	BIPOLAR DEPRESSION	UNIPOLAR DEPRESSION
SYMPTOMS	• Hypersomnia; • Hyperphagia; • Psychomotor retardation or agitation; • Psychotic symptoms; • Fault; • Affective lability; • Acceleration of thoughts	• Insomnia; • Anorexia; • Weight loss; • Symptomatic complaints; • Pain;
COURSE	• Early onset < 25 years; • Multiple previous episodes > 5; • Brief episodes; • Mixed symptoms;	• Late onset > 25 years; • Long duration of current episode > 6 months;

Fonte: adapted from Yatham et al., 2018.



MANIC EPISODE

- ✓ Expansive, euphoric, irritated mood;
- ✓ Increased energy and decreased amount of sleep;
- ✓ Accelerated thinking;
- ✓ Increased self-esteem, grandiosity;
- ✓ Impulsiveness, without risk assessment;
- ✓ Psychotic episodes: greater severity;

Hypomanic episodes have similar symptoms with lower intensity and without psychotic symptoms, functional impairments are limited.

- Rapid cycling: presence of at least 4 mood episodes that correspond to manic, hypomanic or major depressive episodes in the last 12 months.

DSM-5: American Psychiatric Association.

BIPOLAR DISORDER

TREATMENT

Lithium carbonate (gold standard)

- Initial dose of 300mg, 2x-3x/day;
- Increase by 300mg every 5 days;
- Therapeutic level: 900 to 1,800mg/day;

Valproic acid - anticonvulsant

- Initial dose of 500 to 750mg/day;
- Increase by 250mg to 500mg every 3 days;
- Therapeutic level: 1,500mg to 2,500mg/day;

2nd generation antipsychotics - atypical

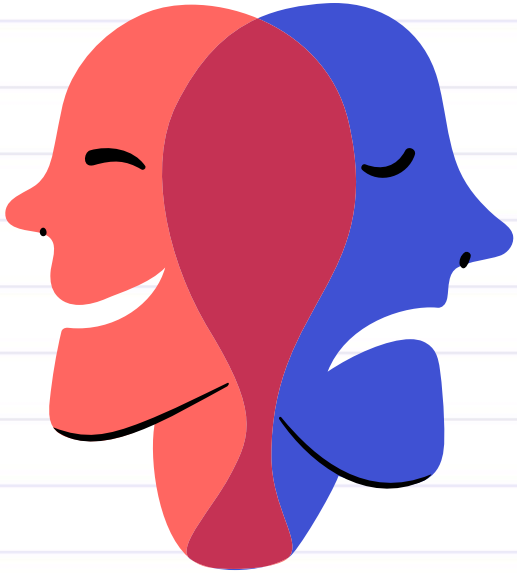
- Faster onset of action in controlling manic and psychotic symptoms, without the need for monitoring. Examples:

- Aripiprazole: 5-10mg, increase by 5mg every 7 days;
- Asenapine: 5-10mg, 2x/day, increase by 5mg in 7 days;
- Clozapine: 25mg, increase by 25-50mg every 3 days;
- Lurasidone: 20mg, increase by 20mg every 2-7 days;
- Olanzapine: 5-10mg, increase by 5mg every 7 days;
- Quetiapine: 50mg, increase by 50-100mg each day;
- Risperidone: 1-2mg, increase by 1mg every 1 to 2 days;

VOLTAGE SENSITIVE SODIUM CHANNELS INHIBITORS

- Reduce excessive neurotransmission, which reduces the flow of ions through voltage-sensitive sodium channels;
- Antimanic effects: Inhibition of the VSSC would lead to a reduction in sodium influx and a reduction in glutamatergic excitatory neurotransmission;

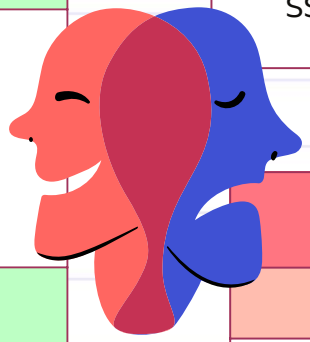
ANTICONVULSIVANTS AS MOOD STABILIZERS



BIPOLAR DISORDER

RECOMMENDED THERAPY

MANAGEMENT OF ACUTE MANIA
First line – Monotherapy
Lithium, Sodium valproate, Quietiapine, Asenapine, Aripiprazole, Palperidone (>6mg), Risperidone and Cariprazine
Combined therapy (1st line)
Lithium/divalprovate + Quetiapine; Lithium/divalproex + Aripiprazole; Lithium/divalproex + Risperidone; Lithium/divalproex + Asenapine;
Second line
Olanzapine, Carbamazepine, Ziprasidone, Haloperidol Lithium + Sodium valproate Olanzapine + Lithium or sodium valproate



BIPOLAR DISORDER TYPE 1
First line – Monotherapy
Quietiapine, Lithium, Lurasidone, Lamotrigine Lithium or sodium valproate + Lurasidone
Second line
Sodium valproate, Cariprazine Olanzapine + Fluoxetine SSRI or bupropion + Lithium or sodium valproate

BIPOLAR DISORDER TYPE 2
First line – Monotherapy
Quietiapine
Second line
Lithium, Lamotrigine, Bupropion, Sertraline, Venlafaxine

GENERALIZED ANXIETY DISORDER

CONCEPT

Characterized by chronic excessive worry, accompanied by hyperactivity and restlessness.

Source: American Psychiatric Association - Diagnostic and Statistical Manual of Mental Disorders 5th edition.

SYMPTOMS

- Restlessness;
- Irritability;
- Muscle tension;
- Unsatisfactory or restless sleep;
- Fagida;
- Difficulty concentrating;

TAG RATING SCALE (GAD-7)

	Not at all	Many days	More than half of the days	Almost everyday
In the past two weeks, how often have you been bothered by the following problems?				
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is difficult to sit still	0	1	2	3
6. Becoming easily irritated or irritable	0	1	2	3
7. Feeling scared as if something terrible could happen	0	1	2	3
Total score =	Add columns	____ +	____ +	____

The total score (0 to 21) is the sum of the individual items.

Total scores of 5 to 9 indicate mild anxiety;
Total scores of 10 to 14 indicate moderate, clinically significant anxiety;
Total scores of 15 to 21 indicate severe anxiety and treatment is likely necessary.

GENERALIZED ANXIETY DISORDER

PANIC DISORDER

Paroxysmal anxiety crisis, dyspnea, palpitations, tremors, chest pain.

TREATMENT

For generalized anxiety disorder (GAD) and panic;

First Line Medicines
Selective serotonin reuptake inhibitors
Escitalopram, Fluoxetine, Fluvoxamine, Paroxetine and Sertraline
Serotonin Reuptake Inhibitors
Duloxetine (for GAD) and Venlafaxine
Buspirona

Second Line Medications
Tricyclic antidepressants
Amitriptyline, Imipramine, Quetiapine, Pregabalin, Nortriptyline;
Hydroxyzine

Adjunct Treatment
Benzodiazepines
Alprazolam, Clonazepam, Diazepam (TAG), Lorazepam

PANIC DISORDER

CONCEPT

Paroxysmal anxiety crisis lasting an average of 30 minutes;

Source: American Psychiatric Association - Diagnostic and Statistical Manual of Mental Disorders 5th edition.

CRITERIA

At least 4 of the symptoms

- Sweating;
- Palpitations, tachycardia;
- Dyspnea;
- Tremors;
- Chest discomfort;
- Asphyxiation;
- Chills or hot flashes;
- Paresthesia;
- Death phobia;
- Unreality or depersonification;
- Fear of losing control;

TREATMENT

First Line Medicines

Paroxetine: Initial dose of 10mg, therapeutic range of 20-60mg;
Fluoxetine: Initial dose of 5mg, therapeutic range 25-75mg;
Fluvoxamine: Initial dose 50mg, therapeutic range 100-150mg;
Sertraline: Initial dose 25mg, therapeutic range 50-200mg;
Citalopram: Initial dose 10mg, therapeutic range 20-40mg;
Escitalopram: Initial dose 5mg, therapeutic range 10-20mg;
Venlafaxine XR: Initial dose of 37.5mg, therapeutic range of 150-225mg;

Benzodiazepines

Alprazolam: 0.25-0.5mg, 3x/dia;
Clonazepam: 0.25-0.5mg, 2x/dia;
Diazepam: 2-5mg, 2x/dia;
Lorazepam: 0.25-0.5mg, 2x/dia;

SCHIZOPHRENIA

CONCEPT

Characterized by psychosis for a continuous period of at least 6 months.

Source: American Psychiatric Association - Diagnostic and Statistical Manual of Mental Disorders 5th edition.

Persecutory delusions: Patient believes he is being persecuted.

Hallucinations: Perceptual experiences involving the 5 senses, without external stimulus.

CRITERIA

2 symptoms, for at least 1 month

- Hallucinations (positive);
- Delirium (positive);
- Disorganized speech;
- Negative symptoms - affective dullness;
- Disorganized behavior;

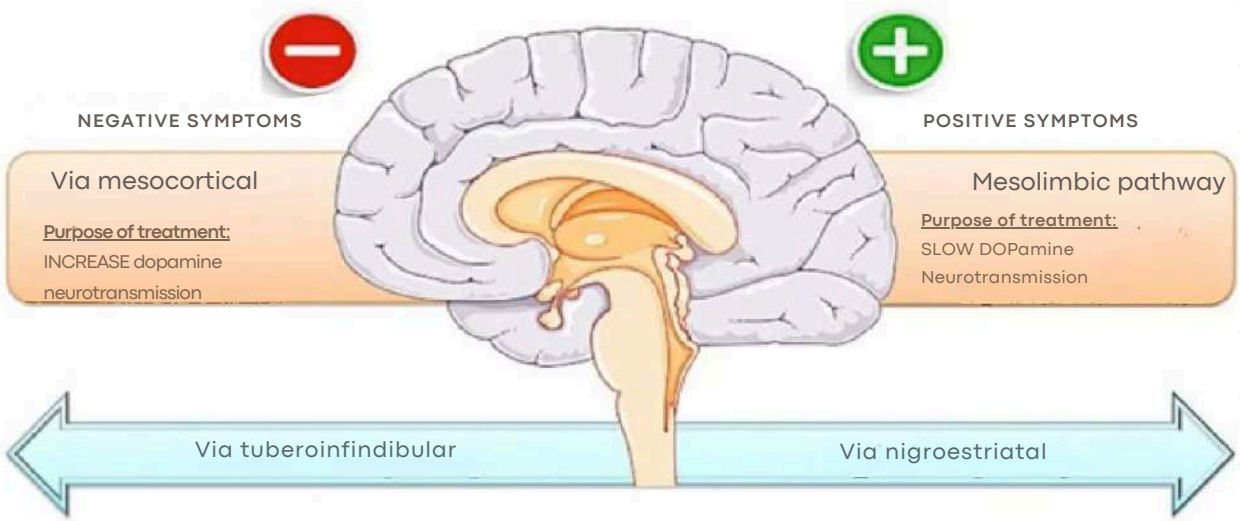
Negative symptoms: social distancing, anhedonia, decreased energy or initiative, affective dullness, lack of will.

- Distortions of sensory perception, emotions, thoughts, language, behavior or feelings.
-
- It involves genetic risk factors and exposure to environmental factors.

SCHIZOPHRENIA

PATHOPHYSIOLOGY

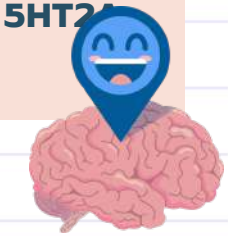
DOPAMINERGIC PATHWAY



- Hyperdopaminergy in the nucleus appears to be the cause of the positive symptoms, hypodopaminergia in the frontal cortex is responsible for the negative and cognitive symptoms of the disease.

ATYPICAL ANTIPSYCHOTICS

- Similar clinical profile;
- Few extrapyramidal symptoms;
- Menor hiperprolactinemia;
- **Serotonin-dopamine antagonists, with simultaneous antagonism of serotonin 5HT2A and D2 receptors;**



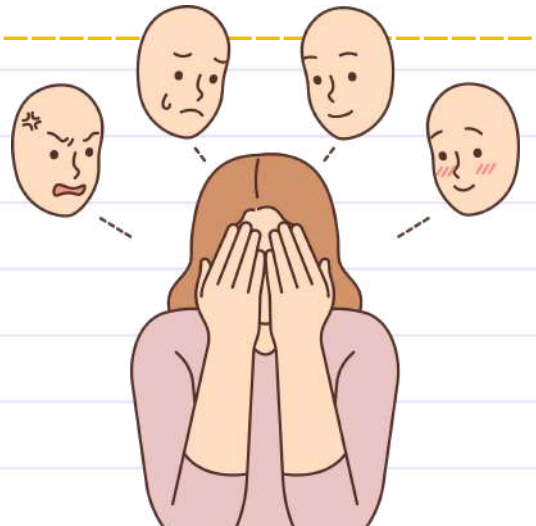
CONVENTIONAL ANTIPSYCHOTICS

- **Blocking the binding of dopamine to the D2 receptor in the mesolimbic dopaminergic pathway, reducing hyperactivity in this pathway;**
- In untreated schizophrenia: excess dopamine in the synapse that causes positive symptoms, such as delusions and hallucinations.

SCHIZOPHRENIA

INDICATIONS OF ADMISSION

- Diagnostic purposes;
- Medication stabilization;
- Disorganized behavior harmful to health;
- Safety in cases of suicidal ideation;
- Inability to take care of basic needs (food, shelter and clothing);



TREATMENT

Main typical antipsychotics
Haloperidol: Initial dose of 2.5-5mg and usual doses of 10-20mg;
Chlorpromazine: Initial dose 25-50mg, with usual doses of 300-600mg;

Main atypical antipsychotics
Clozapine: Initial dose of 12.5-25mg, Usual dose of 300-600mg;
Quetiapine: Initial dose of 25-50mg, with usual dose of 300-800mg;
Risperidone: Initial dose 1-2mg, with usual doses of 2-10mg;
Aripiprazole: Initial dose of 5-10mg, with usual doses of 10-30mg;
Olanzapine: Initial dose of 5-10mg, with usual doses of 10-20mg;

SCHIZOPHRENIA

SCHIZOPHRENIFORM DISORDER

DURATION

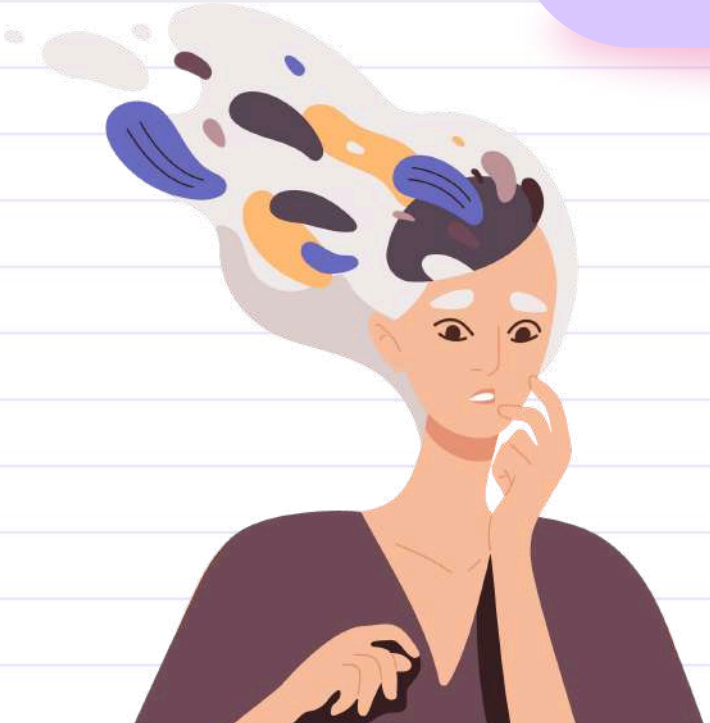
A month or less!

SYMPTOMS

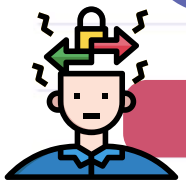
- Hallucinations (positive);
- Delirium (positive);
- Disorganized speech;
- Negative symptoms - affective dullness;
- Disorganized behavior;

DIFFERENTIAL

It differs from schizophrenia in terms of time, depressive or bipolar symptoms rarely occur, when they do occur, they were present for less of the total duration of the active periods.



OBSESSIVE-COMPULSIVE DISORDER

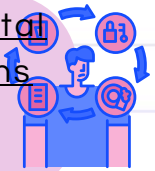


CONCEPT

Characterized by the presence of compulsions and obsessions.

Source: American Psychiatric Association - Diagnostic and Statistical Manual of Mental Disorders 5th edition.

Compulsions repetitive behaviors or mental acts performed in response to obsessions



Obsessions: unwanted, persistent thoughts or urges that cause significant anxiety

CRITERIA

In addition to the above, necessarily:

- Affect the individual's quality of life;
- Consume time (for more than one hour of the day);
- Evident suffering, with losses in interrelationships;

Associated with reduced serotonergic activity, also associated with glutamatergic pathways

- Other obsessive-compulsive disorders: hoarding disorder, body dysmorphic disorder, trichotillomania and skin-picking disorder; However, in these cases the patient has obsessions and compulsions limited to their disorder.

OBSESSIVE-COMPULSIVE DISORDER

TREATMENT

- Because it is associated with serotonergic pathways, Selective Serotonin Reuptake Inhibitors (SSRIs) are first-line drugs in its treatment.

Paroxetine: Initial dose of 20mg and therapeutic dose between 20-60mg;
Fluvoxamine: Initial dose of 50mg and therapeutic dose of 100-300mg/day;
Citalopram: Initial dose of 20mg and therapeutic dose of 40-60mg;
Fluoxetine: Initial dose of 20mg and therapeutic dose of 40-60mg;
Sertraline: Initial dose of 50mg and therapeutic dose of 50-200mg;
Escitalopram: Initial dose of 10mg and therapeutic dose of 20-40mg;

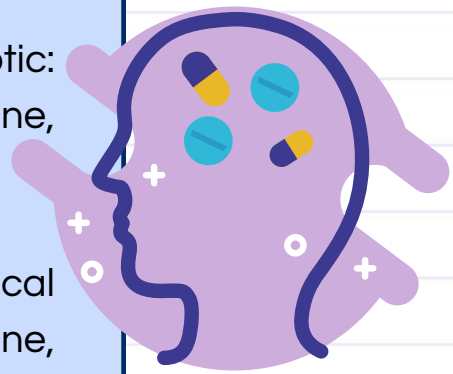
- Cognitive behavioral therapy for OCD often includes techniques such as exposure and response prevention (EPR), in which the person is gradually exposed to the situations that trigger their obsessions, learning to resist the compulsions.

POTENTIATION

"SRS + Clomipramine

SSRI + atypical antipsychotic: olanzapine, risperidone, quetiapine, aripiprazole

Clomipramine + atypical antipsychotic: olanzapine, risperidone, quetiapine, aripiprazole"



USE OF PSYCHOACTIVE SUBSTANCES

CLINICAL HISTORY

EVOLUTION OF CONSUMPTION	First consumption, frequency of use, routes of administration, attempted abstinence
PROBLEMS RELATED TO USE	Health, family, social, work
EVOLUTION OF DEPENDENCE	Loss of control, impact on activities, physical and psychological symptoms, previous treatments
DAILY ROUTINE	Activity and consumption schedule
PERSONALITY	Changes after use
WORK/RELATIONSHIPS	Number of time spent and influence of consumption
FOOD	Schedules, food content, dissatisfaction with weight or image
SOCIOECONOMIC CONDITIONS	Money management, social network

Source: USP Psychiatric Clinic Practical Guide - Volume 4.

ALCOHOLISM DISORDER

CONCEPT

Alcohol is a Central Nervous System depressant and in smaller doses has euphoric effects. The disorder is caused by a condition of substance dependence.

CRITERIA

- Unhealthy usage patterns;
- Use patterns with high risk of harm (7-14 doses per week, 3-5 standard doses per day)
- Patterns of use associated with the existence of harm to health (physical, psychological or social).

Source: American Psychiatric Association - Diagnostic and Statistical Manual of Mental Disorders 5th edition.

ALCOHOL LEVELS AND SYMPTOMS

10-50mg/dL

Tachycardia, tachypnea, decreased attention and judgment, loss of inhibition, euphoria, relaxation.

60-100mg/dL

Slow reflexes, decreased attention, coordination and muscle strength, reduced judgment.

101-150mg/dL

Changes in balance, difficulty speaking, changes in visual functions, emesis.

160-290mg/dL

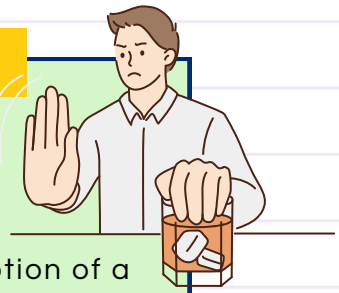
Exaggerated emotional state, disturbance of sensation and perception, falls.

300-390mg/dL

Profound lethargy, loss of consciousness.

ALCOHOLISM DISORDER

CRITERIA



Harmful use

(ICD-10 F10.1): mode of consumption of a psychoactive substance that is harmful to health. Complications can be physical, such as hepatitis, for example, or psychological, such as depressive episodes secondary to heavy alcohol consumption.

Addiction syndrome

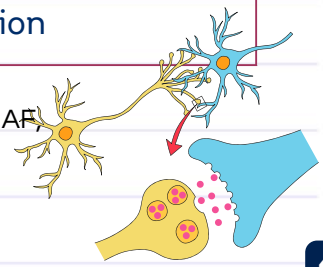
(ICD-10 F10.2): set of behavioral, cognitive and physiological phenomena that develop after repeated consumption of a psychoactive substance, typically associated with the powerful desire to take the drug, the difficulty in controlling consumption, persistent use despite its consequences, a greater priority given to the use of the drug to the detriment of other activities and obligations, an increase in tolerance for the drug.

Fonte: World Health Organization.

NEUROTRANSMITTER PATHWAY AFFECTED BY ALCOHOLISM

Via Glutamaérgica	Reduced cognition, attention deficit, impaired sleep-wake regulation
Via Gabaérgica	CNS inhibition, sedation, loss of inhibitions, relaxation
Dopaminergic pathway	Pleasure, satisfaction, increased search for alcohol
Via Endocanabidoide	Motor incoordination, difficulty with logical reasoning
Serotoninergic pathway	Well-being and mood elevation
Via Neuroesteroides	Reduced sleep duration, motor inhibition

Costardi JVV, Nampo RAT, Silva GL, Ribeiro MAF, Stella HJ, Stella MB, Malheiros SVP

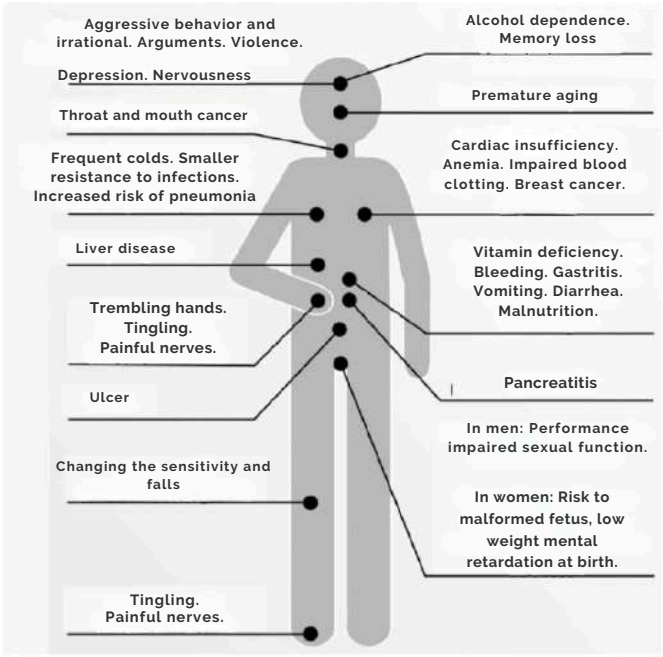


ALCOHOLISM DISORDER

CONDUCT

- Behavioral Counseling

- Introduce the subject based on the AUDIT results.
- Clarify effects of use.

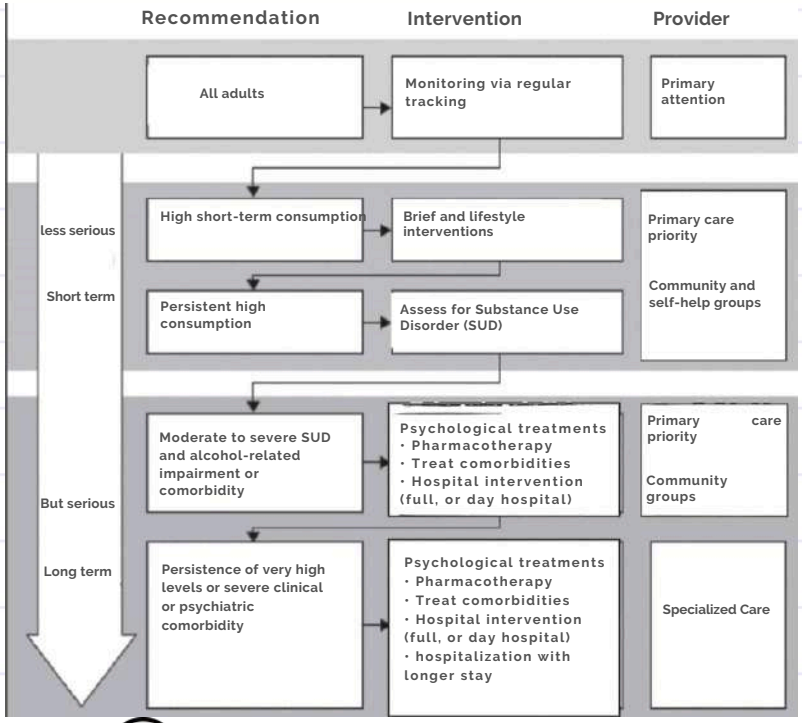


- Discuss the need to cease use or reduce use.

TREATMENT

Naltrexone: 50mg, 1 tablet/day, orally, which can progress to 100mg/day after 1 week.
Topiramate: Start with 25 mg/day, with weekly increases of 25 mg until the desired dose.
Baclofen: Start with 1/2 tablet (5mg), 3x/day. Increase the dose every 3/5 days according to tolerability. Therapeutic dose: 30-80mg/day.
Ondansetrone: 4-16ug/kg, 2x/day. Usual doses of 4mg-16mg/day.

Driving



Carvalho AF, Heilig M, Perez A, Probst C, Rehm J.

COCAINE AND STIMULANTS

CONCEPT

Cocaine Use Disorder is a disorder related to the compulsive use of the psychoactive substance cocaine, leading to an increase in dopamine in the brain, resulting in an intense feeling of euphoria, energy and increased excitement.

CRITERIA

- Consumption in large quantities or over a long period.
- Persistent desire or unsuccessful efforts to reduce or control use.
- Large amount of time spent on activities related to cocaine use.
- Intense desire or craving for the drug.
- Continuous use despite the physical, psychological or social problems it causes.
- Abandonment of important social, occupational or recreational activities in favor of use.
- Recurrent use of cocaine in situations that could be dangerous.
- Tolerance, with the need for increasingly larger doses to obtain the desired effect.
- Withdrawal symptoms when use is stopped or reduced.

Presence of at least two of the following symptoms during a 12-month period.

Source: American Psychiatric Association - Diagnostic and Statistical Manual of Mental Disorders 5th edition.

COCAINE AND STIMULANTS

TREATMENT

Disulfiram: Initial dose of 250mg, with a maximum dose of 500mg/day;

Topiramate: Initial dose of 25mg, with a maximum dose of 300mg/day;

Assess psychiatric comorbidities and initiate treatment when necessary.

Refer to specialized services when available (Psychosocial Care Center – Alcohol and other Drugs) or for psychiatric and psychological evaluation.

CONDUCT:

Listen with empathy and avoid judgments related to the patient's actions.

Positively reinforce the patient's act of seeking help for their condition.

Carry out a detailed clinical assessment, requesting laboratory tests and imaging when necessary.

SMOKING

CONCEPT

Chronic disease characterized by nicotine dependence, behaving differently from psychoactive substances as it does not produce intoxication or change in the state of consciousness during abstinence.

CRITERIA

- Persistent desires;
- Inability to reduce use;
- Crack/need for use;
- Consumption in large quantities;
- Recurrent use;
- Continued use even if there are social or interpersonal problems;
- Social activity reduced by use;
- Use in situations of danger to physical integrity (e.g. smoking in bed);
- Tolerance, need for progressively larger quantities;
- Abstinence;

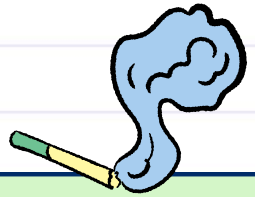
PATHOPHYSIOLOGY

- Nicotine, a psychoactive substance found in tobacco, has a direct impact on the central nervous system (CNS) by binding to nicotinic acetylcholine receptors.

- These receptors are present in dopaminergic neuronal nuclei located in the mesocorticolimbic pathway. By stimulating these neurons, nicotine promotes the release of dopamine in structures of the limbic system, triggering a sensation of pleasure.

Continuous exposure to nicotine causes neuroadaptations, including decreased sensitivity and increased numbers of nicotinic receptors. These changes are considered responsible for the need for higher doses to obtain the same effect (tolerance).

SMOKING



THEY TESTED PHAGE CURRENT

- Assessment tool used to measure physical dependence on nicotine and the intensity of addiction in smokers.

- The total score of the questionnaire provides a measure of nicotine dependence, with pharmacotherapy being indicated at a score ≥ 5.

Teste de Fagerström*

How long after waking up do you smoke your first cigarette?	In the first 5 minutes After 6-30 minutes After 31-60 minutes After 60 minutes	3 2 1 0
Is it difficult for you not to smoke in areas where smoking is prohibited (cinemas, plane trips, etc.)?	Yes No	1 0
Which cigarette would you have the most difficulty giving up?	First in the morning Others	0 1
How many cigarettes do you usually smoke per day?	<=10 11 - 20 21 - 30 > 31	0 1 2 3
Do you smoke more frequently in the first few hours after waking up than during the rest of the day?	Yes No	1 0
Do you smoke, even when you are sick and in bed?	Yes No	1 0

Presence or possibility of withdrawal symptoms:

Number of cigarettes > 10/day.
Time until first cigarette ≤ 30 minutes.
Description of withdrawal symptoms.
Higher score ≥ 5 on the Fagerström Tolerance Questionnaire.

TREATMENT

Varenicline: 0.5mg/day for 3 days, followed by 0.5mg twice a day for 4 days and then 1mg twice a day.

Buproprion: Start at 150mg/day and increase to 300mg/day on the 4th day. Quit smoking abruptly or within 1-2 weeks of starting.

SOMATIZATION DISORDER

CONCEPT

Characterized by psychological distress and impairment in daily life with one or more somatic symptoms.

Source: American Psychiatric Association - Diagnostic and Statistical Manual of Mental Disorders 5th edition.

Reminder!
Somatic symptoms are not pathophysiologically well explained by medicine, and are not sufficient to make a diagnosis. The diagnostic basis is the significant disturbance caused by somatic symptoms.

CRITERIA

At least one of 3 symptoms:

- ✓ Disproportionate thoughts about the severity of symptoms;
- ✓ Excessive anxiety about health and symptoms;
- ✓ Excessive spending of time and energy on symptoms and health concerns;

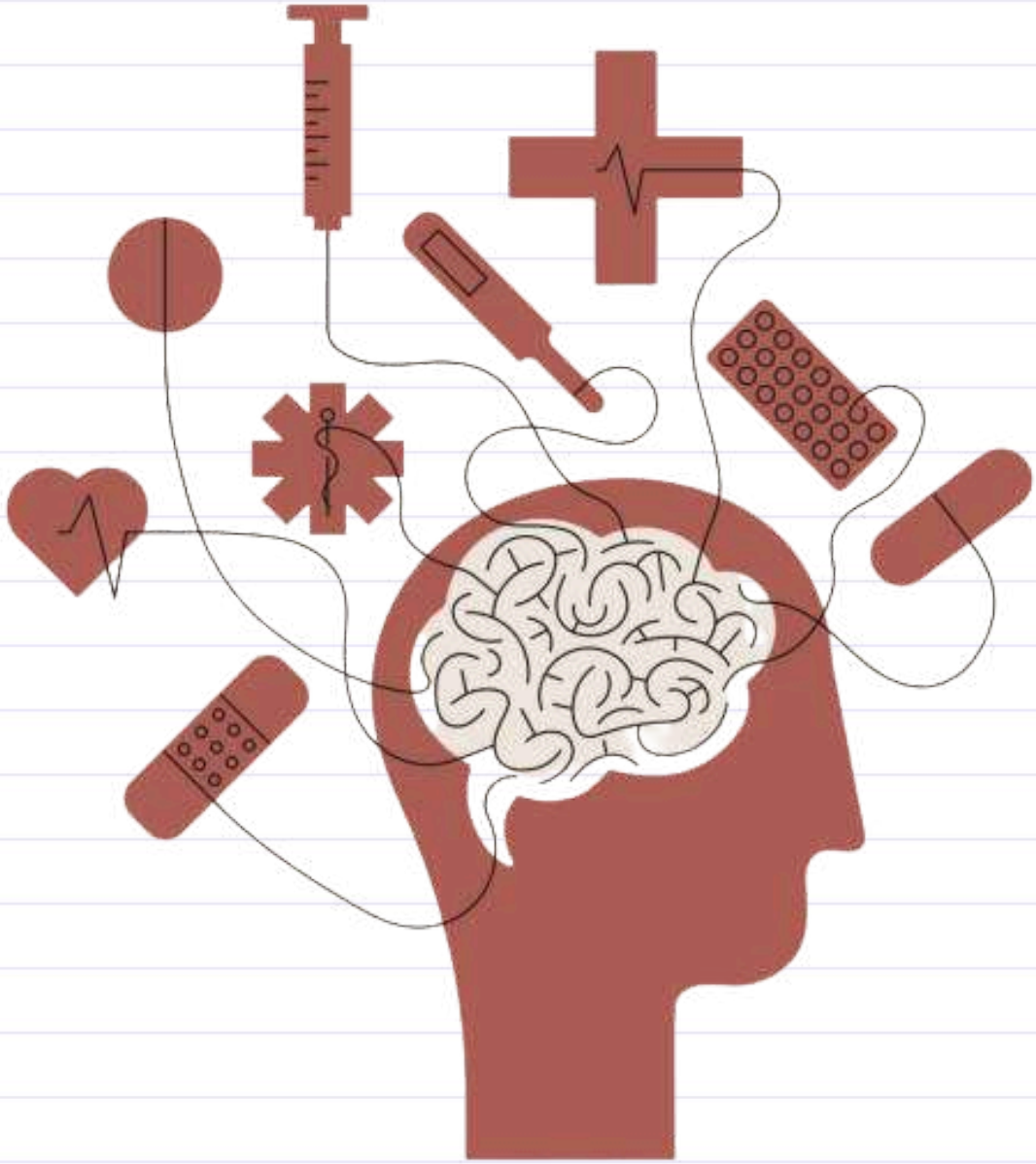
Investigation of somatic symptoms

- Multiple complaints (> 5)
- Coexistence of depressive or anxious symptoms
- Temporal relationship of symptoms with conflicts in personal life

SOMATIZATION DISORDER

CONDUCT

- Schedule routine appointments as a way to reduce anxiety;
- Refer to the psychiatrist;
- Healthy lifestyle incentives (physical activities, nutrition);
- Indication to Cognitive-Behavioral therapy;
- Avoid polypharmacy or unnecessary expenses with exams;
- Pharmacological: serotonin and norepinephrine reuptake inhibitor antidepressants;



CONVERSION DISORDER

CONCEPT

Called hysteria, characterized by psychic symptoms that converge into pseudoneurological ones.

Source: American Psychiatric Association - Diagnostic and Statistical Manual of Mental Disorders 5th edition.

CRITERIA

- One or more symptoms of altered motor or sensory function;
- Physical findings revealing incompatibility between the symptom and the neurological conditions found;
- It causes clinically significant distress and is not well explained by another mental or medical disorder.

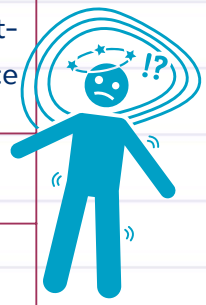
Inconsistent findings on physical examination that assist in identification:

- Hoover's sign: where weakness of hip extension returns to normal strength with flexion of the contralateral hip against resistance.
- Marked weakness of ankle plantar flexion when tested in bed in an individual capable of toe walking.
- Positive findings in the tremor diagnostic test. In this test, a unilateral tremor can be identified as functional if it changes when the individual is distracted from it.
- In attacks resembling epilepsy or syncope (psychogenic non-epileptic seizures), the presence of closed eyes with resistance to opening or a normal simultaneous electroencephalogram.

CONVERSION DISORDER

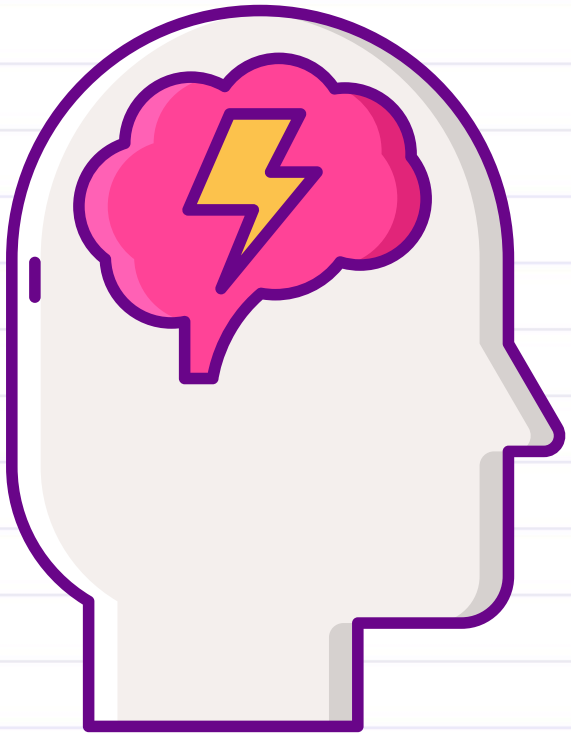
DIFFERENTIAL DIAGNOSIS

PSYCHOGENIC SEIZURE	EPILEPTIC SEIZURE
Gradual onset and prolonged duration, trauma-free fall, cushioned	Abrupt onset, fall can cause trauma
No change in corneal reflex	Corneal reflex with postictal impairment
Eyelids closed during crisis	Open eyelids during crisis
Absence of plantar response	Plantar extensor response after seizure
No tongue injury	Tongue bite injury and post-seizure urinary incontinence
Normal breathing	Postictal noisy breathing
Resistant eyelid opening	Easy eye opening



CONDUCT

- Cognitive Behavioral Therapy;
- Drug treatment only indicated when there are psychiatric conditions.



FACTICIOUS DISORDER

CONCEPT

Unconscious defense mechanism in which the patient motivates to participate in the health service and receive care.

Source: American Psychiatric Association - Diagnostic and Statistical Manual of Mental Disorders 5th edition.

- Symbolic symptoms with the aim of being in a caring position.
- Tendency to intensify complaints in a theatrical way;
- The use of substances with the aim of altering laboratory tests is common.

CRITERIA

- Individual presents as injured or disabled;
- Clear fraudulent behavior;
- Falsification of physical or psychological signs or symptoms or induction of injury or illness, associated with identified fraud;

CONDUCT

- Psychiatric assessment;
- Strengthen the therapeutic bond, recognizing biopsychosocial factors associated with the illness process;
- Pharmacotherapy is not indicated, however, serotonin reuptake inhibitors have a positive response in reducing impulsive behavior;

DISSOCIATIVE DISORDERS

CONCEPT

Disruptions of mental processes, such as: consciousness, memory, identity, motor control and perception.

Source: American Psychiatric Association - Diagnostic and Statistical Manual of Mental Disorders 5th edition.

CHARACTERISTICS

- Derealization: Feeling of estrangement from the surrounding environment;
- Depersonality: Detachment from one's own body, emotions, actions and thoughts.

TYPES

DISSOCIATIVE IDENTITY DISORDER

- Subtle and discreet identity discontinuity;
- Recurrent gaps in memory of important events in personal life;

DISSOCIATIVE AMNESIA

- Localized amnesia of a specific life event;
- Not accompanied by neurological injuries that justify it;
- Specified by DSM-5 as a dissociative, trauma-related fugue;

CONDUCT

- Question about traumatic events;
- Interview people close to the patient;
- Inform family members about the disorder and triggering factors;
- Pharmacotherapy indicated for the benefit of reducing anxiety, such as SSRIs (Serotonin Reuptake Inhibitors);

PERSONALITY DISORDERS

HARMED AREAS

IMPULSIVITY

- Lack of control and loss in the execution of plans.

COGNITION

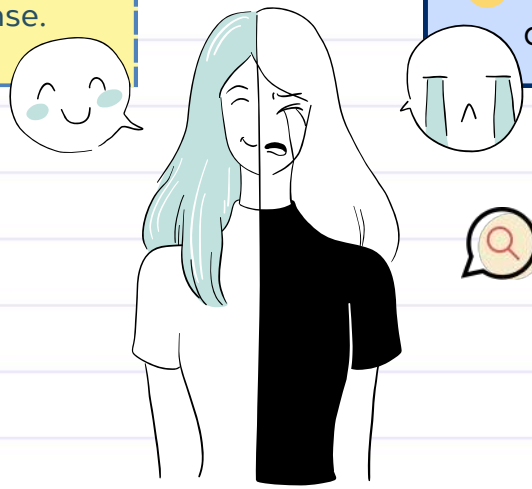
- Disturbances in the way of perception and interpretation of facts.

INTERPERSONALITY

- It may be impaired, unstable or excluded.

AFFECTIVITY

- Altered emotions, mood, affects, varying in intensity, lability and adequacy of the emotional response.



CRITERIA

- ✓ Persistent pattern (A);
- ✓ Multiple personal and social situations (B);
- ✓ Causes losses and suffering (C);
- ✓ It appears in early adulthood and is stable (D);
- ✓ Not associated with another mental disorder (E);
- ✓ Not attributed to the effect of drugs or other conditions (F);

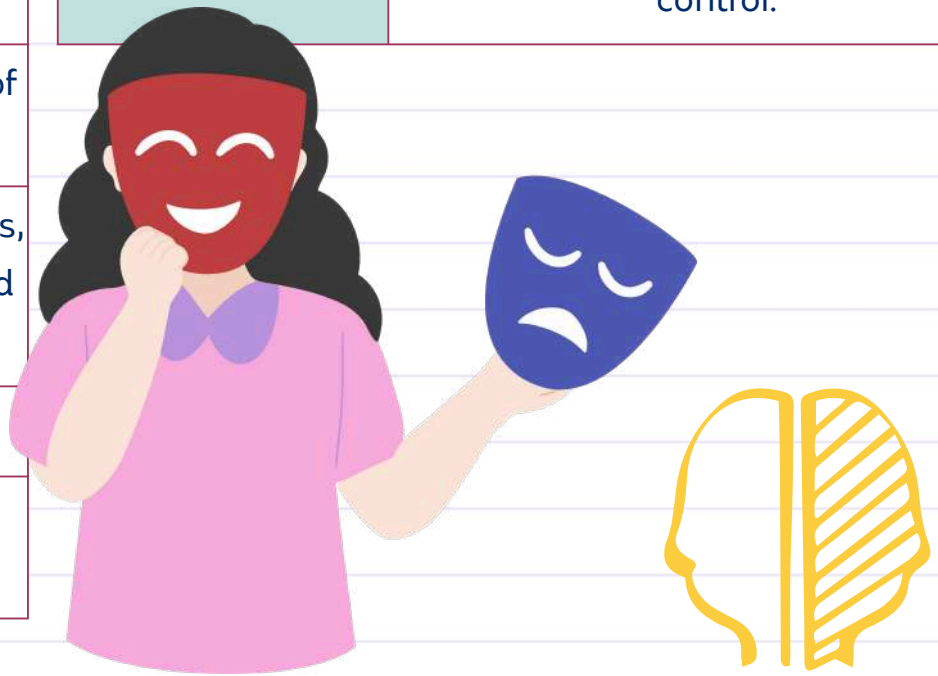
Source: American Psychiatric Association - Diagnostic and Statistical Manual of Mental Disorders 5th edition.

PERSONALITY DISORDERS

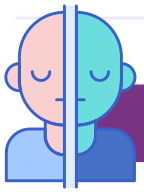
TYPES

PARANOID	Pattern of mistrust and suspicion regarding the motivations of others.
SCHIZOID	Distancing from social relationships and restricting emotional expression.
SCHIZOTYPICAL	Cognitive or perceptual distortion, behavioral eccentricities.
ANTISOCIAL	Disrespect and violation of the rights of others.
BORDERLINE	Instability in interpersonal relationships, affections and self-image, with marked impulsiveness.
HISTRIONIC	Excessive attention seeking.
NARCISSISTIC	Pattern of grandiosity, need for admiration and little empathy.

AVOIDABLE	Social inhibition, hypersensitivity to negative evaluation, inadequacy.
DEPENDENT	Submissive and attached pattern, excessive need to be taken care of.
ANANCASTIC	Perfectionism, concern for order and control.



TP GROUP A



CONCEPT

This group encompasses paranoid, schizoid and schizotypal personality disorders.

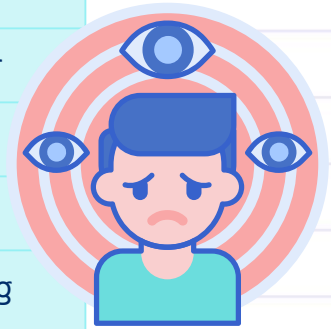
Source: American Psychiatric Association - Diagnostic and Statistical Manual of Mental Disorders 5th edition.

SCHIZOID

- Choose solitude
- Disinterest in sexual experiences
- Displeasure in carrying out activities
- No close friends who are not first-degree relatives
- Coldness and emotional detachment
- Indifferent to praise or criticism

PARANOID

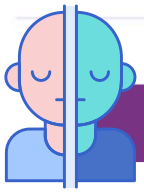
- Unjustifiable doubts about the loyalty of those around you
- Mistrust and unfounded fear
- Persistent grudge
- Recurring suspicions
- Notices hidden or threatening meanings in comments
- Perception of being deceived, exploited or mistreated



SCHIZOTYPICAL

- Strange speeches
- Unusual perceptual experiences
- Inappropriate or constricted affection
- Distrust or paranoid ideation
- Strange and magical beliefs, inconsistent with subcultural norms
- Excessive social anxiety

TP GROUP B



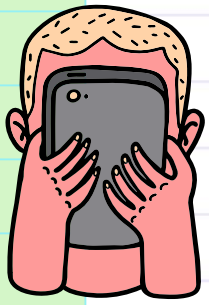
CONCEPT

This group includes antisocial, borderline and histrionic personality disorders.

Source: American Psychiatric Association - Diagnostic and Statistical Manual of Mental Disorders 5th edition.

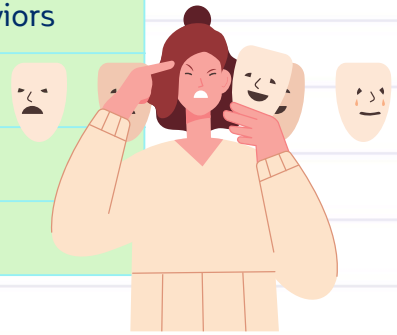
ANTISOCIAL

- Difficulty adjusting to social norms and legal behaviors
- Disregard for the safety of self and others
- Irritability and aggressiveness
- Impulsiveness
- Irresponsibility
- Lack of remorse
- Tendency to falsehood



BORDERLINE

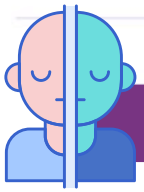
- Desperate efforts to avoid abandonment
- Unstable or intense relationship patterns
- Self-destructive impulsivity
- Recurrence of self-mutilating behaviors
- Chronic feelings of emptiness
- Intense dissociative symptoms
- Difficulty controlling anger



HISTRIONIC

- Discomfort when not being the center of attention
- Superficial expression of emotions
- Self-dramatization
- Considers personal relationships to be more intimate than they actually are
- Uses physical appearance to attract attention
- Seductive or inappropriate behavior

TP GRUPO C



CONCEPT

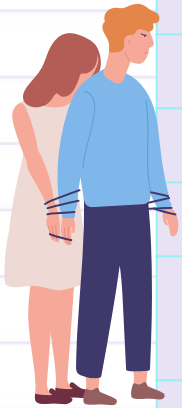
This group includes avoidant, obsessive-compulsive and dependent personality disorders.

Source: American Psychiatric Association - Diagnostic and Statistical Manual of Mental Disorders 5th edition.

AVOIDABLE

- Avoid interpersonal contact
- They are not willing to get involved with people unless they are sure of a good reception.
- Worries about rejection or criticism
- Observes yourself as socially incapable, inferior or unattractive
- Resists taking risks or engaging in ne activities

DEPENDENT



- Difficulty making decisions without hearing opinions
- Difficulty expressing disagreement
- Little initiative in projects
- Goes to extreme lengths to get affection and support
- Feel uncomfortable alone
- Urgency to start a new relationship after the previous one ends
- Fear of abandonment

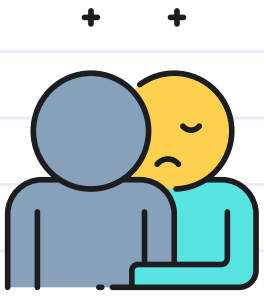
OBSESSIVE-COMPULSIVE

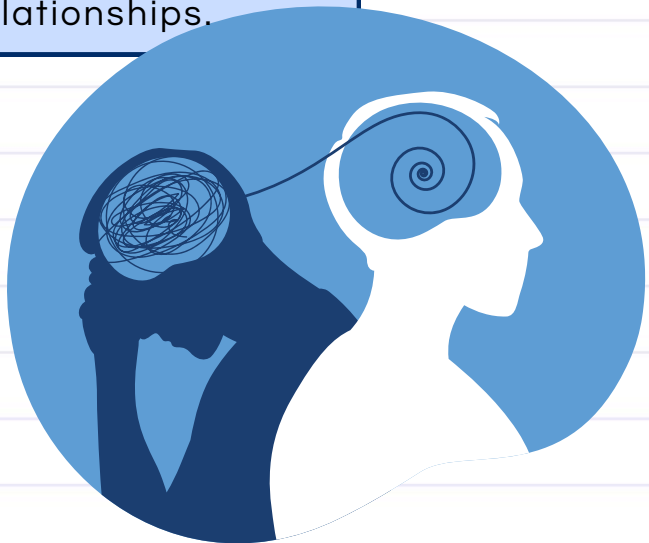
- Excessive concern with order, lists, rules
- Perfectionism
- Difficulty completing tasks
- Meticulous and strict with morals and ethics
- Rigidity and stubbornness
- Dedicated to work and productivity to the detriment of leisure and friendships

PERSONALITY DISORDERS

CONDUCT

- Psychotherapy (first-line treatment);
- Normally the patient is reluctant to accept the diagnosis;
- The involvement of PD patients in treatment is difficult due to the excessive fear of being criticized and rejected, presenting a resistance to creating and maintaining interpersonal relationships.





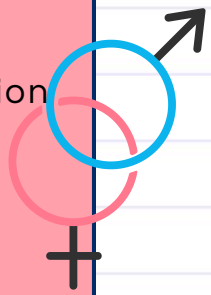
Medications, such as serotonin reuptake inhibitors, can also be used when the patient has comorbidities with anxiety disorders.

- Stabilization of crises: patients with personality disorders may experience worsening of the condition, with suicidal and aggressive crises. A safety plan must be implemented in which the patient takes responsibility for their own safety. Hospitalizations should be carried out in extreme cases, when there is a high risk of suicide or heteroaggression.

SEXUALITY DISORDERS

SEXUAL RESPONSE

- Excitation phase: physiopsychological stimulation stage.
- Plateau Phase: period of continuous excitement.
- Orgasm Phase: Discharge of intense pleasure.
- Resolution phase: Subjective state of well-being that is characterized by being refractory, requiring rest.



CLASSIFICATION

- Sexual dysfunctions;
- Paraphilic disorders;
- Gender dysphoria;

Source: American Psychiatric Association - Diagnostic and Statistical Manual of Mental Disorders 5th edition.

SEXUAL DYSFUNCTIONS

Hypoactive sexual desire is characterized by a persistent lack of sexual interest or desire. It can lead to a decrease in the pursuit of sexual activity and cause significant distress.

Female sexual arousal disorder Persistent difficulty achieving or maintaining adequate sexual arousal, resulting in difficulty performing sexual activities.

Erectile Disorder Known as impotence, it is the persistent inability to obtain or maintain an erection for satisfactory sexual activity.

Premature or delayed ejaculation Recurrent ejaculation that occurs before or shortly after sexual penetration/ Occurs long after sexual intercourse.

Genitopelvic pain disorder is characterized by genital pain during sexual activity. This may include pain during penetration (dyspareunia) or pain during vaginal contraction (vaginismus).

SEXUALITY DISORDERS

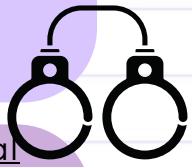
PARAPHILIACS

Pedophilia Involves persistent and intense sexual attraction to pre-pubescent children. This attraction may involve fantasies, behaviors, or acts of sexual abuse against children

Exhibitionism It is characterized by sexual excitement obtained by exposing the genitals to other people without their consent.

Fetishism Refers to sexual attraction to specific inanimate objects or parts of the body, necessary to obtain gratification.

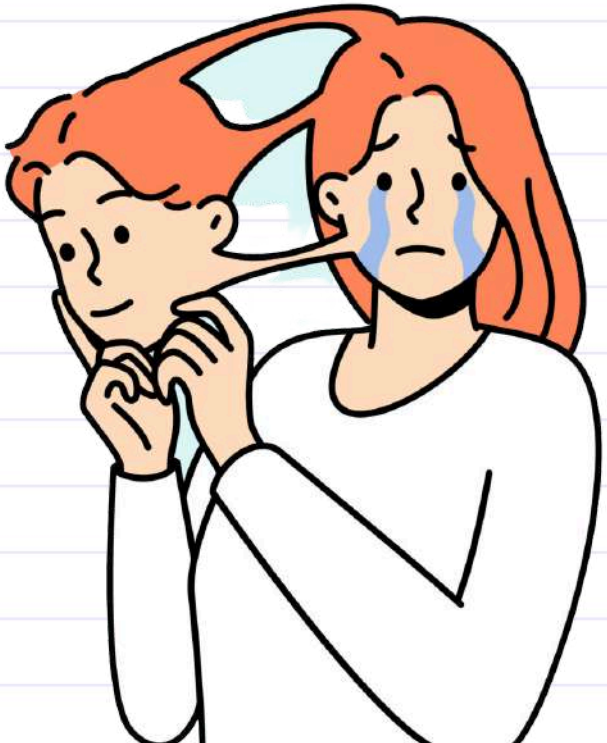
Sexual sadism It implies sexual pleasure obtained through the infliction of pain, humiliation or physical or psychological suffering on another person.



Sexual masochism involves obtaining sexual pleasure through receiving pain, humiliation, or physical or psychological suffering.

GENDER DYSPHORIA

Dysphoria
Psychological suffering associated with the feeling of incongruity between the gender assigned at birth and the gender identity experienced by the person. People with gender dysphoria may feel deeply uncomfortable with the sex they were assigned at birth and may have a strong desire to live and be recognized as belonging to the opposite gender.



SEXUALITY DISORDERS

GENDER INCRONGUENCE

Cisgender	Gender identity agrees with birth gender and behavior
Transsexual	A person whose gender identity is different from the gender assigned at birth
Transvestite	A person who was born with the physical characteristics of the male gender, but identifies as the female gender. They experience feminine gender roles, but do not recognize themselves as men or women, but as members of their own gender.
intersex	Men or women who were born with some anomaly or malformation in the male or female genitalia and, sometimes, require hormone therapy or surgery during their development
Non-Binary	They do not identify with the male or female gender or move between genders
Cross-dresser	They like to wear clothes or accessories related to the gender opposite to their birth, most of the time not full time, and there is no personal identification with the opposite gender.
Drag queen	A person who dresses or uses accessories like a stereotypical or exaggerated woman for shows and artistic performances
Drag king	A person who dresses or uses accessories like a stereotypical or exaggerated man for shows and artistic performances
Transformist	Term designated to men who dressed as women for performance performances, without identifying with the female gender or sexual pleasure

SEXUALITY DISORDERS

CONDUCT

- Essentially clinical diagnosis, observing the patient's complaints;

Criterion

Minimum period of 6 months of symptoms

TREATMENT

PREMATURE EJACULATION

- **Antidepressants (SSRI): Fluoxetine, paroxetine, sertraline;**
- **Tricyclic antidepressants: amitriptyline, clomipramine;**
- **Anxiolytics: alprazolam or bromazepam;**
- **Topical applications of lidocaine;**
- **Centrally acting analgesic opioid (tramadol): Increases intravaginal latency time;**
- **Phosphodiesterase inhibitors + SSRI: maintain penile rigidity.**
- **Sex therapy/ psychotherapy/ couples therapy;**

Source: American Psychiatric Association - Diagnostic and Statistical Manual of Mental Disorders 5th edition.

ERECTILE DYSFUNCTION

- **Healthy habits - changes in lifestyle;**
- **Tadalafil: 1 tablet, 2-3x/week (20mg) or daily use of 5mg;**
- **Sildenafil citrate: 1 tablet/day (25.50 or 100mg);**
- **Vardenafil hydrochloride: 1 tablet/day (5,10 and 20mg);**
- **Udenafil: 1 tablet/day (100mg);**
- **Papaverine/ Phentolamine: intracavernous application of a vasoactive substance;**

HYPOACTIVE SEXUAL DESIRE

- **Treatment of depression: antidepressants with less impairment of sexual function - Bupropion (150-300mg/day); Buspirone (30-60mg/day); Mirtapazine (15-45mg/day); Trazodone (200-400mg/day);**
- **Androgen therapy: indicated only when there is a clinical picture characteristic of androgenic disorder of male aging (ADEM) and testosterone levels below < 300 ng/dL**

SEXUALITY DISORDERS

TREATMENT

PARAPHILIC DISORDERS

- **Psychotherapy (to identify the elements associated with paraphilic disorder and the development of more appropriate alternatives for sexual relationships);**
- **Medications (which inhibit libido, helping to control deviant sexual activity, while creating a new sexual alternative)**
- **The medication used in these cases are antidepressants (e.g., 80 mg of fluoxetine per day) and, less frequently, antipsychotics.**

Source: American Psychiatric Association - Diagnostic and Statistical Manual of Mental Disorders 5th edition.

GENDER DYSPHORIA

- The procedure involves a multidisciplinary team (psychiatrist, endocrinologist, surgeon, psychologist, social worker) for diagnostic formulation, psychiatric assessment, psychological and psychotherapeutic support, administration/correction of hormone use, assessment of family and social conditions, preparation for surgery, act surgery and post-operative follow-up (in the short and long term).
- In Brazil, to undergo sexual reassignment surgery, the individual must be over 21 years old (reduction to 18 years old is under discussion at the Ministry of Health) and have been followed for at least 2 years of psychotherapy. The psychiatric report (guaranteeing transsexuality) and previous procedures are essential. Mistakes in the assessment can result in depression, psychotic conditions, suicide attempts and patient suicide.

IMPULSE DISORDERS

CONCEPT

Categories of psychiatric disorders related to compulsive and uncontrolled behaviors.

Source: American Psychiatric Association - Diagnostic and Statistical Manual of Mental Disorders 5th edition.

They have in common the difficulty in resisting impulses or repetitive behaviors that can cause significant physical, emotional, financial or social harm

EXPLOSIVE-INTERMITTENT

- Impulsive and recurrent aggression
- Verbal attacks on objects or physical violence on people
- Actions disproportionate to the stimulus, triggered by social interactions

It can have high intensity with low frequency or low intensity and high frequency

ONIOMANIA

- It's about compulsive buying
- Association of shopping episodes with negative emotional states, such as anguish and frustration
- Impulsivity, acquisitions and extensive debt

PYROMANIA

- It involves an irresistible and recurring urge to start fires, deriving pleasure or emotional relief from this action.
- History of arson behavior since childhood

CLEPTOMANIA

- Uncontrollable desire to steal objects that are unnecessary for personal use
- Constant conflict between the pleasure of stealing and fear of the consequences
- The need to steal and the inability to stop are impulsive behaviors, as they are poorly planned, risky and have a negative outcome

IMPULSE DISORDERS

PATHOPHYSIOLOGY

- Subdivisions in the prefrontal cortex are associated with pondering, planning, anticipation, inhibition of action, control of emotions, assignment of objective value, and evaluation of outcomes.

- Limbic structures interact in complex ways with reward and stress systems resulting in approach or avoidance incentives.

- The deficit in behavioral control systems is counterbalanced by the development of compensatory functions. For a patient to manifest impulsivity, there must be a simultaneous failure in more than one system, resulting in a failure to prevent an action from being initiated.

CONDUCT

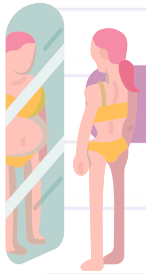
- Psychotherapeutic interventions such as psychoeducation with guidance from the patient and family regarding the disorder;

- Psychotherapy must focus on cognitive distortions that cause dysfunctional interpretations and responses.

- Measures such as physical activity and a balanced diet are important for maintaining quality of life;

- Antidepressants such as SSRIs are prescribed when there is an association with depression and anxiety;

ANOREXIA NERVOSA



CONCEPT

Characterized by a disturbance in the perception of body weight, causing intense fear of weight gain;

Source: American Psychiatric Association - Diagnostic and Statistical Manual of Mental Disorders 5th edition.

CRITERIA

- Restriction of caloric intake, causing significantly low weight compared to normal;
- Intense fear of gaining weight, with persistent behavior that interferes with weight gain;
- Disturbance in self-assessment and lack of recognition of the severity of low weight;

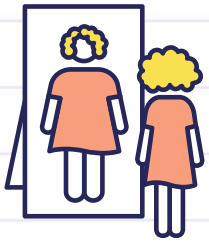
CLASSIFICATION

Purgative binge-eating type anorexia nervosa	Recurrent episodes of binge purging such as self-induced vomiting and induced use of dietetics, laxatives or enemas
Restrictive type anorexia nervosa	Recurrent episodes of fasting, fear of dieting and excessive physical exercise, causing severe weight loss

ANOREXIA NERVOSA

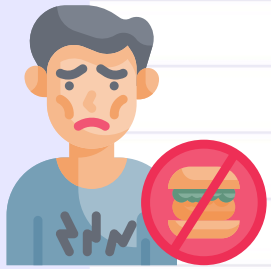
CLASSIFICATION OF GRAVITY

- Leve (IMC > 17 kg/m2);
- Moderada (IMC 16-16,99 kg/m2);
- Grave (IMC 15-15,99 kg/m2);
- Extrema (IMC <15 kg/m2).



COMPLICATIONS

- Gastrointestinal: constipation and abdominal pain;
- Hematological: anemia, leukopenia, thrombocytopenia;
- Skin and appendages: hair loss, brittle nails, dry skin;
- Electrolytes: Hypokalemia, hyponatremia, hypoglycemia and dehydration;
- Musculoskeletal: osteopenia, osteoporosis;
- Renal: edema, insufficiency, kidney stones;
- Metabolic: hypoglycemia and hypercholesterolemia;



CONDUCT

Multidisciplinary team composed of nutritionist, psychologist and psychiatrist;

First Line: Psychotherapy with the aim of suspending purgative and restrictive practices, normalizing eating patterns and deconstructing distorted beliefs about body image;

Second Line: Pharmacotherapy, however, there are no medications that produce significant improvements in symptoms. SSRIs may improve weight gain or prevent relapses, but have no proven role.

Behavioral nutrition:
Gain. weight loss of 500-1,400g/week
Refeeding of 6,000kJ/day increasing by 2,000kJ to prevent refeeding syndrome

BULIMIA NERVOSA

CONCEPT

Characterized by recurrent episodes of binge eating followed by inadequate compensatory behaviors to avoid weight gain.

Source: American Psychiatric Association - Diagnostic and Statistical Manual of Mental Disorders 5th edition.

CRITERIA

- Binge eating: Eating a large amount of food and feeling unable to stop eating.
- Binge episodes at least once a week in the last 3 months;

Compensatory methods: Improper use of laxatives, enemas, diuretics, prolonged fasting, self-induced vomiting, excessive exercise;

CLASSIFICATION

Light	1 to 3 episodes of compensatory behaviors per week
Moderate	4 to 7 episodes of compensatory behaviors per week
Grave	8 to 13 episodes of compensatory behaviors per week
Extreme	⩾ 14 episodes of compensatory behaviors per week.

Source: American Psychiatric Association - Diagnostic and Statistical Manual of Mental Disorders 5th edition.

BULIMIA NERVOSA

CONDUCT

Multidisciplinary team composed of nutritionist, psychologist and psychiatrist;

- Hospitalization in cases of significant electrolyte abnormalities, arrhythmias, rapid and persistent weight loss, suicidal ideation;

- Pharmacotherapy: Antidepressant medications such as SSRIs (e.g. fluoxetine) are beneficial for reducing the frequency of binge eating and purging;

- Psychotherapy is the gold standard, first line of treatment for cases of eating disorders.

- Behavioral nutrition.

RISK FACTORS

- History of childhood obesity;
- History and family transmission of the disorder;
- History of sexual or physical abuse;
- Low self-esteem;
- Depressive symptoms;
- Social or generalized anxiety disorder;

FOOD COMPULSION

CONCEPT

Characterized by recurrent episodes of binge eating without compensatory methods to prevent weight gain.

Source: American Psychiatric Association - Diagnostic and Statistical Manual of Mental Disorders 5th edition.

CRITERIA

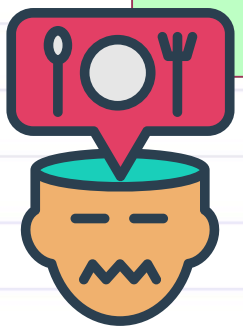
At least one of 3 symptoms:

- Eating faster than normal;
- Eat until you feel uncomfortably full;
- Eating in large quantities in the absence of hunger;
- Eating alone out of embarrassment about the amount of food;
- Feeling guilty or depressed;

Correlation with type 2 diabetes and ADHD

PATHOPHYSIOLOGY

The neurobiological bases of the urge to eat and appetite regulation are related to the hypothalamus and the connections of the hypothalamic nuclei with reward circuits in the brain. Neuropeptide Y, ghrelin, orexin and leptin play an important role in regulating appetite. In this way, the hypothalamus acts as a control center, influenced by a complex network of brain circuits and substances that regulate appetite and the urge to eat.



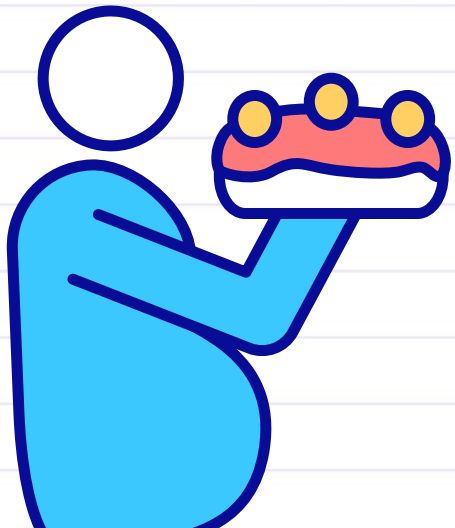
FOOD COMPULSION

CONDUCT

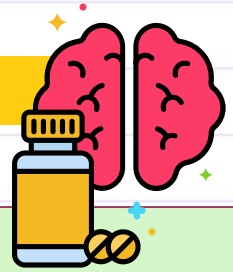
- Treatment focused on compulsion disorder, so that weight loss is a consequence of the psychological change in mindset.

- Pharmacotherapy indicated in moderate to severe cases, aiming to control impulsive eating.

- Selective serotonin reuptake inhibitor drugs are frequently used in treatment.



TREATMENT



Sertraline 50-200mg
Fluvoxamina 50-300mg
Escitalopram > 30mg;
Fluoxetina 60mg

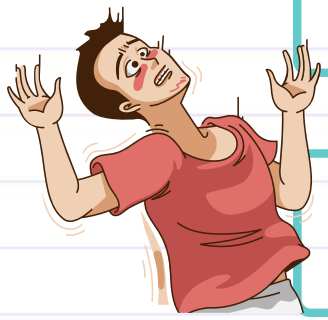
- Reduction in binge frequency;
- Decrease in BMI and weight;
- Reduction in the severity of the disease;
- Improvement in the general picture;

EPILEPSY

CONCEPT

Characterized by abnormal brain activity that results in recurrent episodes of seizures.

Seizures: sudden and temporary episodes of altered brain function, which can affect consciousness, behavior, sensations and body movements.



MYOCLONIC EPILEPSY

It involves brief, sudden, rapid muscle contractions that can affect a muscle or muscle groups.

TONIC-CLONIC EPILEPSY

Characterized by convulsions involving muscle rigidity (tonic phase) followed by rhythmic involuntary movements (clonic phase).

EPILEPSIA DO LOBO FRONTAL

It originates in the frontal lobe of the brain and can cause a variety of symptoms, including complex movements, abnormal behavior and changes in consciousness.

EPILEPTIC DISORDERS

TEMPORAL LOBE EPILEPSY

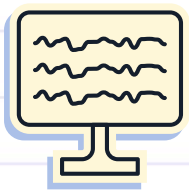
Characterized by seizures that originate in the temporal lobe of the brain. It can cause changes in behavior, memory and emotions.

ABSENCE EPILEPSY

Characterized by brief episodes of loss of consciousness, usually accompanied by a vacant or absent gaze.

WEST SYNDROME

Characterized by infantile spasms (episodes of sudden and involuntary movements), developmental delay and EEG (electroencephalogram) abnormalities.



EPILEPSY

ASSOCIATIONS

Epilepsy is a risk factor for the emergence of mental disorders, making it more serious.

Preictal mental disorders

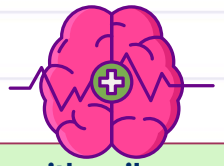
They are established a few hours or days before the epileptic crisis and end after the ictus.

Ictal mental disorders

They correspond to the psychopathological manifestation of the epileptic seizure.

Postictal mental disorders

They begin after the occurrence of crises, immediately or later, within an interval of hours or days.



Mood disorders: People with epilepsy may have an increased risk of developing depression and bipolar disorder. The relationship between epilepsy and mood disorders may be influenced by neurobiological factors, side effects of antiepileptic medications and psychosocial stress.

Anxiety disorders: Epilepsy may also be associated with generalized anxiety disorders, panic disorder, and post-traumatic stress disorder. The impact on quality of life and side effects of medications can contribute to the development of these disorders.

Sleep disorders: Epilepsy can be associated with sleep disorders such as insomnia, sleep apnea and parasomnias. Additionally, sleep disturbances can trigger seizures in people with epilepsy.

Attention deficit hyperactivity disorders (ADHD): There is an association between epilepsy and ADHD, such that seizures can affect attention and concentration, contributing to symptoms similar to ADHD.

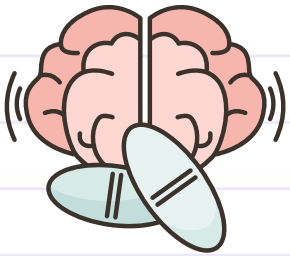
EPILEPSY

CONDUCT

- The main objective of drug treatment is to achieve seizure control, minimize medication side effects, and improve the quality of life of individuals with epilepsy.

- The choice of medication will depend on several factors, including the type of epilepsy, the patient's age, the presence of other medical conditions, and the individual's response to the medication.

- Cognitive behavioral therapy, occupational therapy, physical therapy, epilepsy surgery or nerve stimulation devices,



TREATMENT

Carbamazepine (200 mg) 2-3 tablets PO every 8 hours. Schedule gradual escalation: 200 mg, every 5 days;
Valproic acid: start with 10-15 mg/kg/day in 1-3 divided doses; increase by 5-10 mg/kg/day at weekly intervals until attacks are controlled or side effects prevent further increases. Daily doses > 250 mg should be administered in divided doses. Maintenance dose: 30-60 mg/kg/day in 2-3 divided doses;
Lamotrigine as monotherapy. Weeks 1 and 2: 25 mg/day; increase based on response and tolerability; Weeks 3 and 4: 50 mg/day; Week 5 and beyond: Increase by 50 mg/day every 1-2 weeks; Usual maintenance dose: 225-375 mg/day (immediate release) or 300-400 mg/day (extended release).
Clobazam: Start with small doses (5-15 mg/day), gradually increasing to a maximum of 80 mg/day.
Topiramate: Initial dose: 25-50 mg twice a day. Increase by 25-50 mg every 3 to 7 days; The usual average dose is 200-600 mg/day.

INSOMNIA

CONCEPT

Characterized by sleep disruption, caused by chronic pain, gastroesophageal reflux, depression, anxiety, obstructive apnea.

Persistent difficulty in initiating, lasting, consolidating or quality of sleep, which results in some type of daytime impairment.

Source: American Psychiatric Association - Diagnostic and Statistical Manual of Mental Disorders 5th edition.

Ask about conditions related to sleeping, such as the quality of the bed, calmness and temperature in the environment that interfere with the opportunity for this to happen.

INVESTIGATION

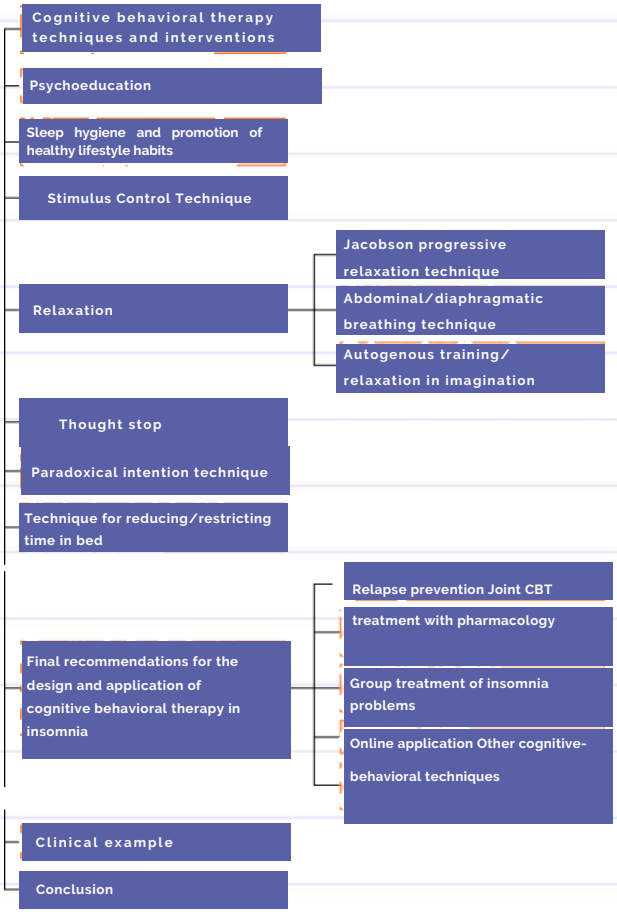
Daytime	Before Bed	Nocturnal
Naps (quantity and time)	Usual bedtime	Awakenings (quantity and time)
Wake up time	Routine before bed	Snoring
Lifestyle	Room environment	Dreams and nightmares
Substance use	Medication use	Respiratory symptoms
Somnolence	Night feeding	Motor activities
Daytime commitment	Sleep onset latency	Satisfaction with sleep

Schutte-Rodin S, Broch L, Buysse D, Dorsey C, Sateia M

INSOMNIA

CONDUCT

- Cognitive Therapy has significant improvements in sleep efficiency, total sleep time and waking time after the onset of sleep.



HYGIENE MEASURES

WHERE I AM

- Sleep as long as necessary to feel rested;
- Avoid excess liquid or heavy meals at night;
- Calm, dark, comfortable environment;
- Avoid using caffeine, nicotine and alcohol 4 to 6 hours before going to bed;
- Avoid vigorous exercise 3 to 4 hours before going to bed;
- Go to bed and wake up at the same time every day;
- Avoid noisy environment;
- Avoid sleeping during the day;

INSOMNIA

TREATMENT

- When it is impossible to access Behavioral Therapy, non-adherence or therapeutic failure.

Selective benzodiazepine receptor agonists
• Zolpidem: Usual dose: 5 mg SL or 10-12.5 mg PO in the evening, immediately before bed. Maximum dose: 10 mg or 12.5 mg, if extended-release tablet;
• Eszopiclone: Initial dose: 1 mg/day PO, immediately before going to bed and only if the patient has 7-8 hours of sleep available;
• Zoplicon: 3.75-7.5 mg/day PO;

Antidepressant sedatives
• Amitriptyline: 25-300 mg/day PO (for insomnia, doses of up to 50 mg in general are recommended);
• Mirtazapine: 7.5 mg-45 mg/day PO;
• Trazodone: 50-150 mg/day orally, divided into 2x or in a single dose at night;

Atypical antipsychotics
• Quetiapine (25 mg/cp or 50 /cp extended release or 100 mg/cp) 25 mg - 100 mg/day PO.

Anticonvulsants
• Gabapentin: (300 mg/cp) 300-1,800 mg/day PO (start with 300 mg at night and gradually increase the dose as needed).

Melatonin receptor antagonist
Ramelteone: 8 mg/day PO, 30 minutes before bedtime.

OBSTRUCTIVE APNEA

CONCEPT

Characterized by pauses in breathing during sleep, causing hypoxia or hypercapnia.

Source: American Psychiatric Association - Diagnostic and Statistical Manual of Mental Disorders 5th edition.

It occurs due to total (apnea) or partial (hypopnea) collapse of the oropharynx due to the negative pressure exerted by the lungs. muscular tension is ineffective in keeping the airway open, interrupting airflow.

CRITERIA

At least 1 of the criteria:

- A- Polysomnographic evidence of at least 5 apneas or hypopneas per hour of sleep and symptoms:

  1- Snoring, difficult or panting breathing, pauses in breathing during sleep.

  2- Drowsiness, fatigue during the day.

- A- Polysomnographic evidence of 15 or more apneas or hypopneas per hour of sleep, regardless of symptoms.

CLASSIFICATION

- Mild: 5-15 breathing pauses/hour;
- Moderate: 15-30 breathing pauses/hour;
- Severe: more than 30 respiratory pauses/hour;

TREATMENT

- Lightweight: Intraoral appliance that promotes gradual protrusion of the jaw.
- Moderate to severe: Continuous air pressure devices (CPAP, avoiding oropharyngeal collapse during inspiration;

PARASSONIAS

CONCEPT

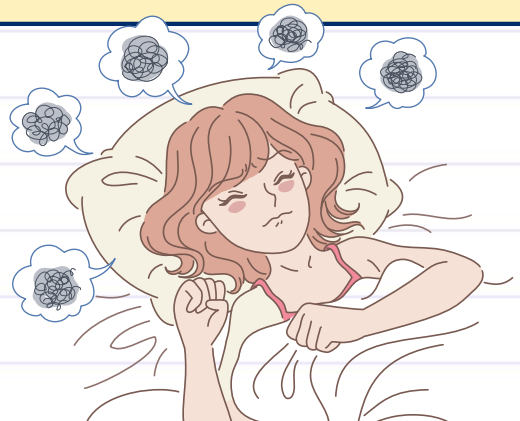
These are experiences that occur when falling asleep, during sleep or when waking up, classified according to the stage of sleep in which they occur: REM or NREM.

NREM

- Confusional awakening: recurrent episodes of incomplete awakenings during the first third of sleep;
- Night terrors: episodes of sudden awakenings that begin with a panicked scream. Signs of autonomic stimulation such as tachycardia, tachypnea, mydriasis and sweating are present.
- Sleepwalking: Consists of wandering during sleep, characterized by fixed gaze and lack of communication response.

REM

- Behavioral sleep disorder: Oneirism, which corresponds to effective motor activity during dreams, commonly with violent themes, which can cause accidents.
- Sleep paralysis: Characterized by an awakening with continued sleep atonia, which may be accompanied by illusions or hallucinations.
- Nightmare disorders: Recurrent unpleasant and distressing dreams generating awakening.

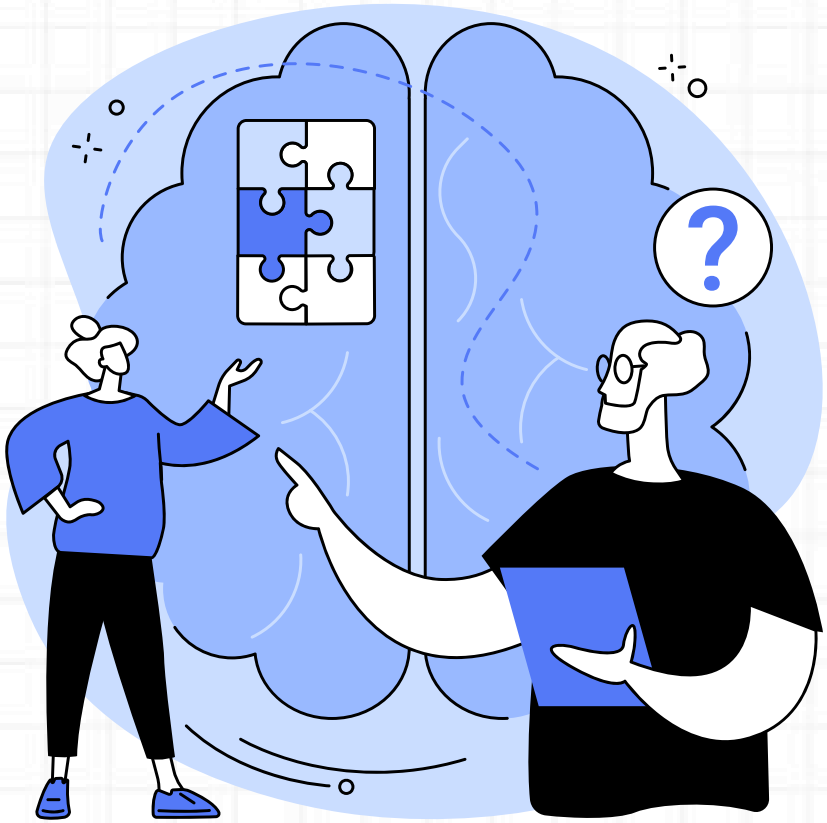


Source: American Psychiatric Association - Diagnostic and Statistical Manual of Mental Disorders 5th edition.

PART IV

PSYCHIATRIC CLINIC

Throughout the Life



DEMENTIA

CONCEPT

Characterized by global cognitive decline, being a major neurocognitive disorder.

Source: American Psychiatric Association - Diagnostic and Statistical Manual of Mental Disorders 5th edition.

ETIOLOGIES

ALZHEIMER'S DISEASE

Progressive memory impairment, mainly.

- Memory and learning disabilities;
- No mixed etiology;
- Progressive decline in cognition: language, attention, orientation;
- Characteristic genetic mutation;

VASCULAR DEMENTIA

Impairment of executive functions, information processing and attention;

- Stepped degeneration;
- After cerebrovascular events;
- Changes in neuroimaging

OF LEWY BODIES

Parkinsonian symptoms, cognitive deficits and visual hallucinations;

- Syncope;
- Susceptibility to falls;

FRONTOTEMPORAL

Progressive behavioral, language and executive function deficits;

- Atrophy of the frontal and/or temporal lobes;
- Behavioral changes;
- Linguistic impairment;

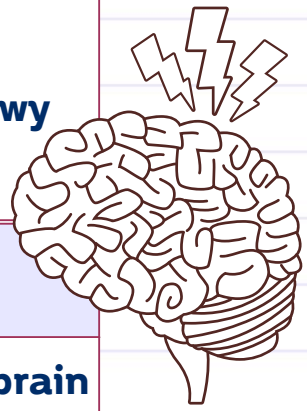
DEMENTIA

CLASSIFICATION

Degenerative

Associated with progressive brain injury processes.

Ex: Alzheimer's disease, Frontotemporal dementia, Lewy bodies



Non-degenerative

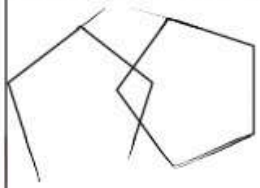
Associated with acute/sudden brain injury processes.

Ex: Vascular Dementia, Inclusion Bodies and Traumatic Injury

MINI EXAM

DO MENTAL STATE

Table 1 - Mini Mental State Examination (MMSE)

Temporal orientation (5 points)	What is the approximate time?
	What day of the week is it?
	What day of the month is today?
	What month are we in?
	What year is it?
Spatial orientation (5 points)	Where are we?
	What place is this here?
	What neighborhood are we in or what is the address here?
	What city are we in?
	What state are we in?
Registration (3 points)	Repeat: CAR, VASE, BRICK
Attention and calculation (5 points)	Subtract: 100-7=
Evocation memory (3 points)	What are the three objects asked above?
Name 2 objects (2 points)	Watch and pen
REPEAT (1 point)	"No aqui, no ali, nemli"
Stages command (3 points)	Take this sheet of paper with your right hand, fold it in half and place it on the floor
Write a complete sentence (1 point)	Write a sentence that makes sense
Read and execute (1 point)	Close your eyes
Copy diagram (1 point)	 Copy two intersecting pentagons

Source: Brucki SMD, Nitrini R, Caramelli P, Bertolucci PHI, Okamoto IH. Suggestions for using the Mini-Mental State Examination in Brazil. Neuropsychiatrist Arq. 2003; 61(3B):777-81.

Suggested note:

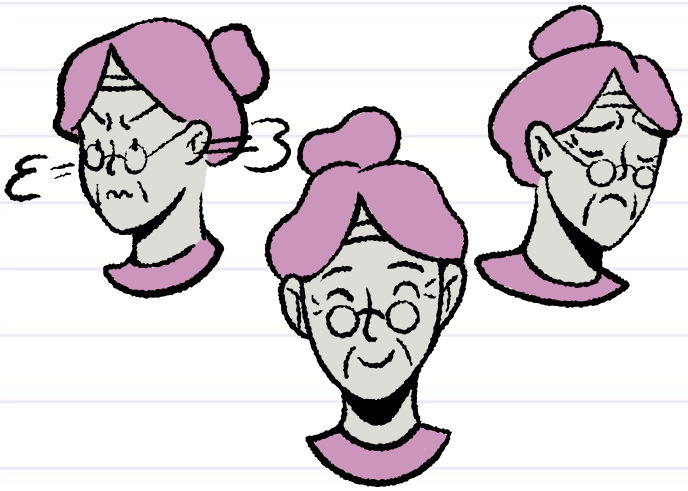
< 4 years of education: less than or equal to 17;

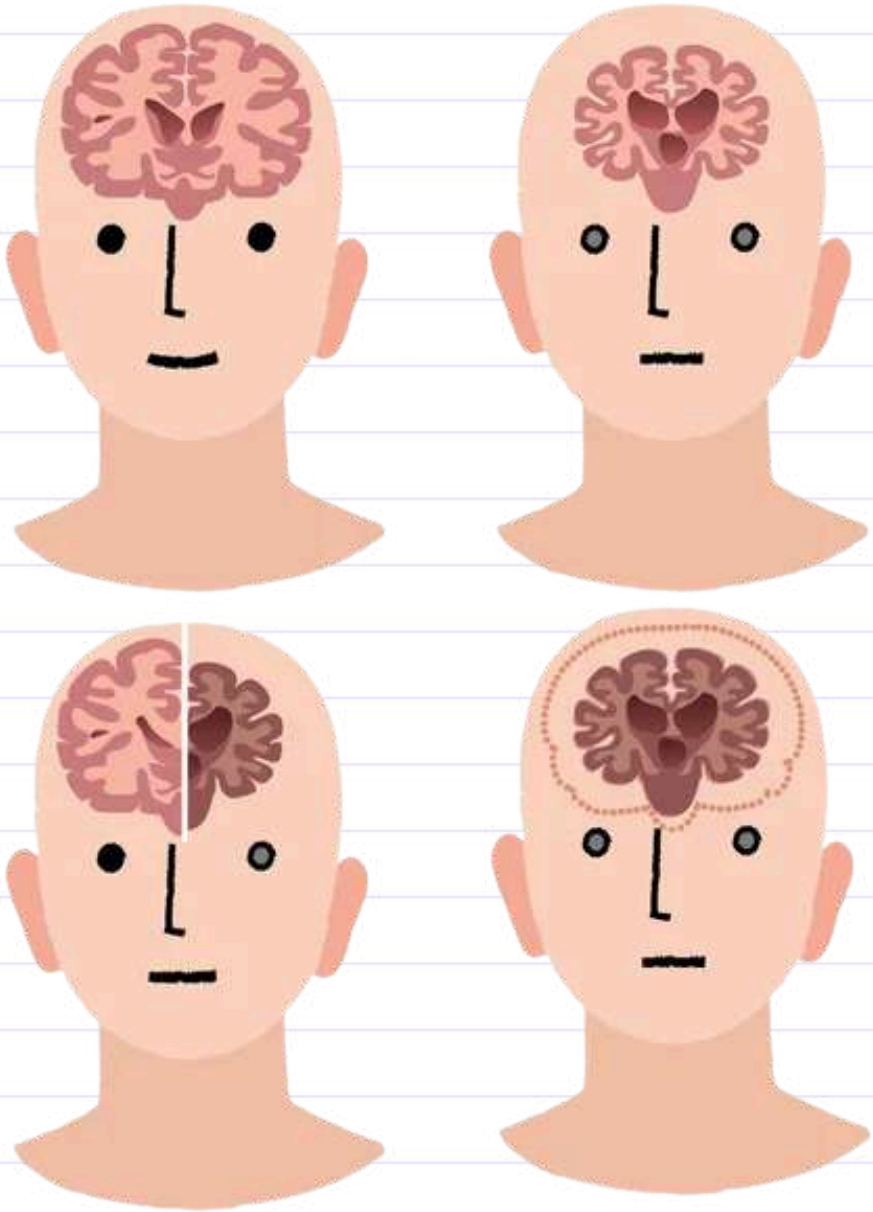
> 4 years of education: Less than or equal to 24;

DEMENTIA

TREATMENT

ALZHEIMER'S DISEASE
Memantine: Initial dose of 10mg, up to therapeutic dose of 10-20mg;
Galantamine: Initial dose of 8mg, up to therapeutic dose of 16-24mg;
Rivastigmine: Initial dose of 1.5mg, up to therapeutic dose of 1.5-6mg;
Donepezil: Initial dose of 5mg, up to therapeutic dose of 5-10mg;





DELIRIUM

CONCEPT

Also called acute confusional state, characterized by a sudden and transient change in consciousness and cognitive capacity.

Source: American Psychiatric Association - Diagnostic and Statistical Manual of Mental Disorders 5th edition.

CRITERIA

- Disturbance of attention and consciousness;
- Changes in consciousness that tend to fluctuate in severity throughout the day;
- Criteria not explained by another pre-existing neurocognitive disorder;
- It can be caused by intoxication or substance withdrawal or multiple etiologies;

METHOD

The most recommended instrument is the CAM (Confusion Assessment Method).

A	Acute confusional state with fluctuating course
B	Attention deficit
C	Disorganized thinking and speech
D	Change in level of consciousness

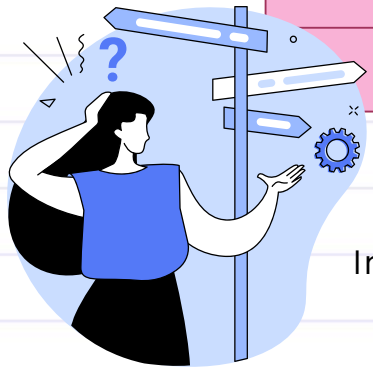
Delirium is considered in the presence of topics A and B, added to C and/or D.

DELIRIUM

CONDUCT

Non-pharmacological measures

- Ambient lighting during the day to allow you to see the outside.
- Quiet environment, with calendars and clocks available.
- Encouraging visits and bringing family and caregivers closer together.
- Encourage nutrition and hydration.
- Assist in early mobilization and functional independence of the patient.
- Avoid unnecessary catheters and invasive devices.



TREATMENT

Haloperidol: Initial doses of 0.25mg to 1mg (IM or PO);
Risperidone: Initial doses of 0.25mg to 1mg/day;
Olanzapine: Doses of 2.5mg-10mg/day;
Quetiapine: Doses of 12.5-25mg/day;

In patients with withdrawal syndrome (alcoholic or benzodiazepine):

Diazepam 10mg, orally every hour up to a maximum of 60mg/day;
Lorazepam, PO, 2mg every hour up to a maximum of 12mg/day.

CHRONIC PAIN

CONCEPT

Persistent, ongoing pain that lasts beyond the time expected for an underlying injury or illness to heal.

- Psychiatric disorders correspond to risk factors for the emergence or worsening of chronic pain;
- There are psychological factors that are associated with a greater risk of persistent chronic pain and disability: emotional distress, depressed mood, tendency to catastrophize situations and somatization of physical symptoms.

Mood influences brain circuitry, the response to analgesic medications, and the expression of chronic pain.

ANGUISH

The presence of emotional distress, such as anxiety and stress, can amplify the perception of pain and make it more difficult to tolerate.

CATATROPHISM

Pattern of thinking in which the person tends to exaggerate the severity of pain and anticipate negative consequences, leading to a greater perception of suffering.

SOMATIZATION

It refers to the tendency to express emotional distress through physical symptoms, which can contribute to the persistence and worsening of pain.

CHRONIC PAIN

CLASSIFICATION

Nociceptive Dor

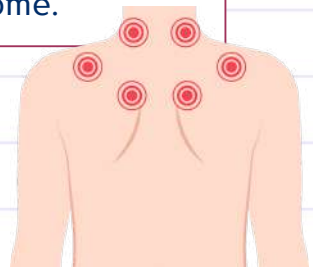
Resulting from non-neural tissue damage, due to activation of nociceptors, with preserved functioning of somatosensory pathways.

Neuropathic pain

Resulting from primary injury or disease of the nervous system, including lesions of the PNS and CNS, which signal the painful stimulus.

Dor Nociplastica

Absence of clear tissue damage that explains the presence of pain, without diagnostic biomarkers. Ex: Fibromyalgia, migraines, irritable bowel syndrome.

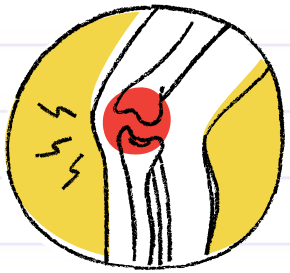


Neuropathic	Nociceptiva	Nociplastica
	Heavy, burning pain associated with movement	Difficult to characterize pain associated with different physiological systems
Mechanical or thermal hypoesthesia, hyperalgesia, dysesthesia	Biomechanical changes, pain on palpation, flushing	No changes on physical examination

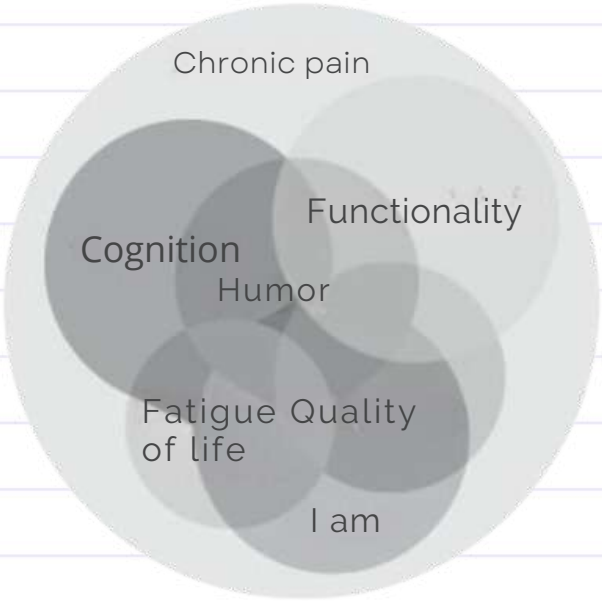
ACCORDING TO THE CID

Primary: Pain is the disease itself, not a symptom. Ex: Diffuse pain, primary headaches.

Secondary: Pain secondary to an underlying disease. Ex: Chronic neuropathic, cancer-related, secondary visceral.



CHRONIC PAIN



Source: USP Practical Guide to Psychiatric Clinics - Volume 4.

CONDUCT

- Interdisciplinary treatment;
- The use of anticonvulsant antidepressants and analgesics;
- Early approach to analgesic measures and pain-related conditions.

TREATMENT

- Tricyclic antidepressants: Amitriptyline and nortriptyline have a myorelaxant effect and contribute to the treatment of sleep and mood disorders.
- Serotonin and norepinephrine reuptake inhibitor antidepressants can be used, with the advantage of helping to control mood disorders in smaller doses and being better tolerated, when compared to tricyclics.
- Opioids as a second line of treatment should be evaluated as long as the patient does not present a tendency to abuse substances.

ADHD

CONCEPT

Characterized by inattention, hyperactivity and impulsivity, which begins in childhood and lasts until adulthood;

CRITERIA

Hyperactivity

- Movement of feet and hands on chairs;
- Difficulty staying still for a long time;
- You are unable to have leisure in a calm way;
- Getting up from the chair or squirming in it;
- Difficulty waiting your turn;
- Interrupts or answers questions before they are completed;

Inattention

- Difficulty completing tasks to the end.
- He doesn't seem to listen when people speak to him.
- Doesn't pay attention to details.
- Difficulty maintaining attention during recreational activities.
- Difficulty organizing tasks.
- Easily distracted and forgetful in everyday activities.

DIAGNOSIS

Requires 6 or more changes in inattention and/or 6 or more changes in hyperactivity/impulsivity

TIME OF AT LEAST 6 MONTHS.

- Presentation of symptoms before 12 years of age.
- Interference in social life and professional functioning.
- Manifestation of symptoms in at least 2 different environments.
- There are no other mental disorders that could justify the symptoms.

Source: American Psychiatric Association - Diagnostic and Statistical Manual of Mental Disorders 5th edition.

ADHD

CLASSIFICATION

- Combined presentation: with criteria of inattention and hyperactivity;
- Predominantly hyperactive/inattentive presentation;

LIGHT	When the patient manifests few symptoms and does not cause many daily problems.
MODERATE	Intermediary
GRAVE	Multiple symptoms, with serious damage to daily life.

PATHOPHYSIOLOGY

- Inattention: functional deficit in dopaminergic and noradrenergic neurotransmission;
- Impulsivity: Hyperactivity of dopamine and noradrenaline, reduction of the prefrontal cortex and cerebellum;

RISK FACTORS

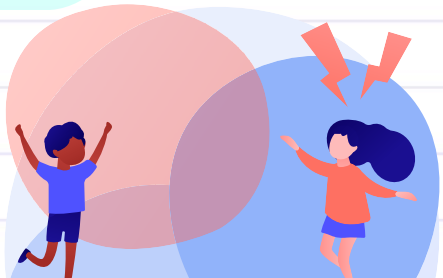
Presence of the disorder in first-degree relatives (dopamine transporter gene inheritance hypothesis)

Environmental factors: Low birth weight, child abuse, smoking and alcoholism during pregnancy and exposure to toxins.

ADHD

CONDUCT

- General guidelines: Positive reinforcement training, study environment with few distractions and predictable routines;
- Guidelines for the school: Need for a well-structured classroom, with few students; consistent daily routines and predictable school environment; individualized service; placing the child in places with little distraction during classes;
- Cognitive-behavioral therapy: For guidance on associated comorbidities and addressing associated symptoms;



TREATMENT

FIRST LINE OF TREATMENT

Methylphenidate:

Short-acting (Ritalin®): 0.3-1 mg/kg/day (20-60 mg/day) PO 2x/day (morning and noon), duration of 4 hours; Long-acting (Ritalin LA®): 20 mg/day in a single dose in the morning. If necessary, increase the dose by 10 mg/week with a maximum dose of 60 mg/day.

SECOND LINE OF TREATMENT

Lisdexamfetamine 30, 50 or 70 mg

Start with 30 mg and increase according to clinical need, every 20 mg, with intervals of 1 week between each increase, up to a maximum of 70 mg/day PO.

ASD

CONCEPT

Characterized by repetitive behavior patterns, restricted interests and difficulties in social communication.

Source: American Psychiatric Association - Diagnostic and Statistical Manual of Mental Disorders 5th edition.

CRITERIA

According to DSM-5:

- Low affective attunement and socio-emotional reciprocity:
- Deficits in non-verbal communication, such as difficulty maintaining eye contact;
- Restricted and repetitive patterns of behavior, with inflexible routines;
- Sensory hyper- or hypo-reactivity to sensory stimuli;
- Symptoms present in childhood, which may not manifest completely;
- Symptoms cause impairment in the daily functioning of activities and in social areas;

CLASSIFICATION

LEVEL 1
Losses caused by the deficit in social communication
Difficulty initiating social interactions
Inflexibility of behavior
Difficulty switching activities
Independence affected by organization and planning problems

ASD

LEVEL 2
Deficits in verbal and non-verbal communication skills;
Limitation in initiating social interactions;
Reduced abnormal responses to social overtures
Difficulty dealing with changes
Frequent restricted behaviors, accompanied by distress when changing actions

LEVEL 3
Severe deficits in communication
Great limitation in initiating social interactions;
Low level of reciprocity
Extreme difficulty dealing with change
Frequent restricted behaviors causing harm, such as great distress

METHODS

Screening Scale (M-CHAT)

Modified Checklist for Autism in Toddlers (M-CHAT)
Diana Robins. Deborah Fein & Marianne Barton, 1999

Please complete this questionnaire about your child's usual behavior. Answer all questions. If the behavior described is rare (e.g. has been observed once or twice), respond. as if the child does not present it. Circle the answer "Yes" or "No".

1	Do you like playing on your lap, playing "horse", etc.?	Sim	NO
2	Are you interested in other children?	Sim	NO
3	Do you like climbing objects, such as chairs and tables?	Sim	NO
4	Do you like to play hide and seek?	Sim	NO
5	Play pretend, for example, talk on the phone or feed a boneca, etc.?	Sim	NO
6	Do you point with your index finger to ask for something?	Sim	NO
7	Do you point with your index finger to show interest in something?	Sim	NO
8	Do you play appropriately with toys (cars or Legos) without putting them in your mouth, shaking them or throwing them on the floor?	Sim	NO
9	Have you ever brought him objects (toys) to show him something?	Sim	NO
10	Does the child maintain eye contact for more than one or two seconds?	Sim	NO
11	Are you very sensitive to noise (e.g. covering your ears)?	Sim	NO
12	Do you smile in response to your facial expressions or your smile?	Sim	NO
13	Do you imitate the adult (e.g. make a face and she imitates)?	Sim	NO
14	Do you respond/look when people call you by name?	Sim	NO
15	If you point to a toy on the other side of the room, does the child follow with LOOK?	Sim	NO
16	Already walking?	Sim	NO
17	Do you look at the things the adult is looking at?	Sim	NO
18	Do you make strange movements with your hands/fingers close to your face?	Sim	NO
19	Do you try to draw your attention to what you are doing?	Sim	NO
20	Have you ever worried about your hearing?	Sim	NO
21	Do you understand what people tell you?	Sim	NO
22	Do you sometimes stare into space or wander randomly through spaces?	Sim	NO
23	Are you looking for your facial reaction when you are faced with unfamiliar situations?	Sim	NO

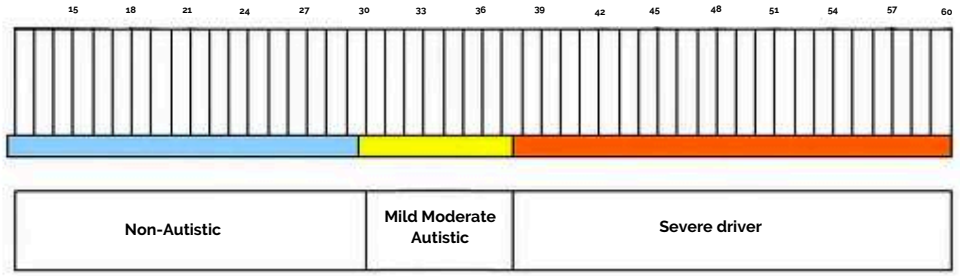
Translated by the Autism Unit Child Development Center - Coimbra Pediatric Hospital Authorization Diana Robins

ASD

Diagnostic Scale - CARS (Childhood Autism Rating Scale)

QUOTATION SCALE			
	DOMAINS		COMMENTS
I	Relationship with people	1 1,5 2 2,5 3 3,5 - 4	
II	Imitation		
III	Emotional response		
IV	Body use		
IN	Use of objects		
WE	Adaptation to change		
VII	Visual response		
VIII	Auditory response - to sound		
IX	Response to taste, smell and touch		
X	Fear or anxiety		
XI	Verbal communication		
XII	Non-verbal communication		
XIII	Activity level		
XIV	Level and consistency of intellectual response		
XV	Global impression		
	Total Quote:		

TOTAL QUOTE



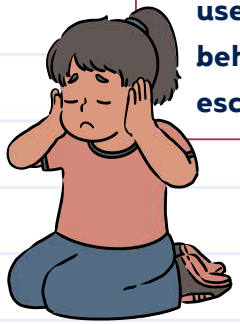
Scores between 30 and 37 indicate mild to moderate ASD, while scores between 38 and 60 indicate severe ASD.

CONDUCT

- Cognitive-Behavioral Therapy - 1st line of treatment.
- Music therapy: assists social interaction and verbal communication.
- Pharmacotherapy:

MAIN MEDICATIONS

- **Risperidone: 1.5-2mg/day;**
- **Aripiprazole: 5-15mg/day;**
- **Methylphenidate (Association between ASD and ADHD): 2.5-10mg;**
- **SSRIs (Selective Serotonin Reuptake Inhibitors), used to improve repetitive and aggressive behaviors: Sertraline, fluoxetine, citalopram, escitalopram;**



OPPONENT AND DEFIANT DISORDER

CONCEPT

Characterized by a persistent pattern of defiant, aggressive and disobedient behavior in relation to established social norms and rules

Source: American Psychiatric Association - Diagnostic and Statistical Manual of Mental Disorders 5th edition.

CHARACTERISTICS

- High reactivity and limited emotional self-regulation;
- Interpretation of neutral actions of others as hostile;
- Aggressiveness and conflicts towards people's actions;
- Goals of self-defense and hypervigilance for hostility;

ODD

(Oppositional and Defiant Disorder)

Irritable and angry mood
Unstable and challenging behavior, usually in one environment
Damage to social relationships
Vengeful and hostile stance
Difficulty controlling anger

CD

(Conduct Disorder)

Violation of social norms and the rights of others
Violations in different locations
Aggressive behavior, with threats, provocations
Physical damage and use of weapons or objects
Lack of remorse or guilt

OPPONENT AND DEFIANT DISORDER

CRITERIA

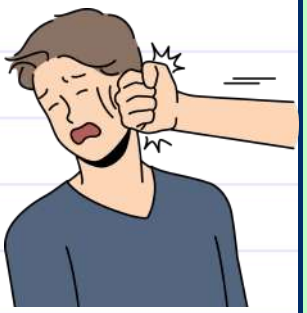
Based on DSM-5 for oppositional defiant disorder

A Irritable mood, challenging behavior, vindictive nature towards different people over a period of at least 6 months;

! For children under 5 years of age, symptoms should occur most days; for over 5 years old, at least once/week.

B Symptoms cause suffering to people in the social context;

C Behaviors do not occur exclusively in the course of substance use, depressive, psychotic, bipolar or disruptive disorders.



Based on DSM-5 for conduct disorder

A Pattern of violation of social norms, basic rights, threats or physical fights, theft, serious damage;

B Symptoms cause suffering for the individual or for people in the social context;

C Criteria for antisocial personality disorder must not be met in those over 18 years of age;

OPPONENT AND DEFIANT DISORDER

CONDUCT

- Psychotherapeutic intervention with the work of a multidisciplinary health team.
- Family therapy as a form of training to deal with disruptive family members as therapeutic tools, establishing rules and communication between members.
- Cognitive-Behavioral Therapy: correction of cognitive distortions, development of reflection skills and creation of problem-solving strategies.
- School interventions: Pedagogical inclusion projects, individualized planning as a way to improve performance and adherence.

TREATMENT

Restricted pharmacotherapy in cases of young people with severe aggressive behaviors, associated with emotional dysregulation.

If there is comorbidity with ADHD:
Methylphenidate (10 mg/cp LA, 18 mg/cp, 20 mg/cp LA, 30 mg/cp LA, 36 mg/cp, 40 mg/cp LA, 54 mg/cp).
Common formulation (without prolonged release): start with 5 mg 1 or 2x/day PO. Adjust the dose as the condition evolves, increasing 5-10 mg/week. Average dose: 0.4-1.3 mg/kg/day divided into 2-3 doses. Last take until 6pm.

In cases of aggression:
Risperidone (1 mg/cp, 2 mg/cp, 3 mg/cp, 1 mg/mL)
Initial dose: 0.25 mg if < 20 kg and 0.5 mg if > 20 kg PO, preferably at night.

- **Mood stabilizers (lithium carbonate, sodium valproate and carbamazepine), buspirone, clonidine and propranolol to reduce aggression.**

PART V

MENTAL HEALTH OF

woman

PREMENSTRUAL DYSPHORIC DISORDER

CONCEPT

Characterized by increased sensitivity to normal hormonal fluctuations in estrogen and progesterone, with action on mood, cognition and anxiety regulatory mechanisms.

CRITERIA

- Intense mood swings that are disproportionate to the circumstances.
- Physical symptoms: Fatigue, bloating, breast pain, headaches, muscle and joint pain.
- Emotional instability.
- Difficulty concentrating.
- Increased or decreased appetite, specific food cravings.
- Insomnia or excessive drowsiness.

PATHOPHYSIOLOGY

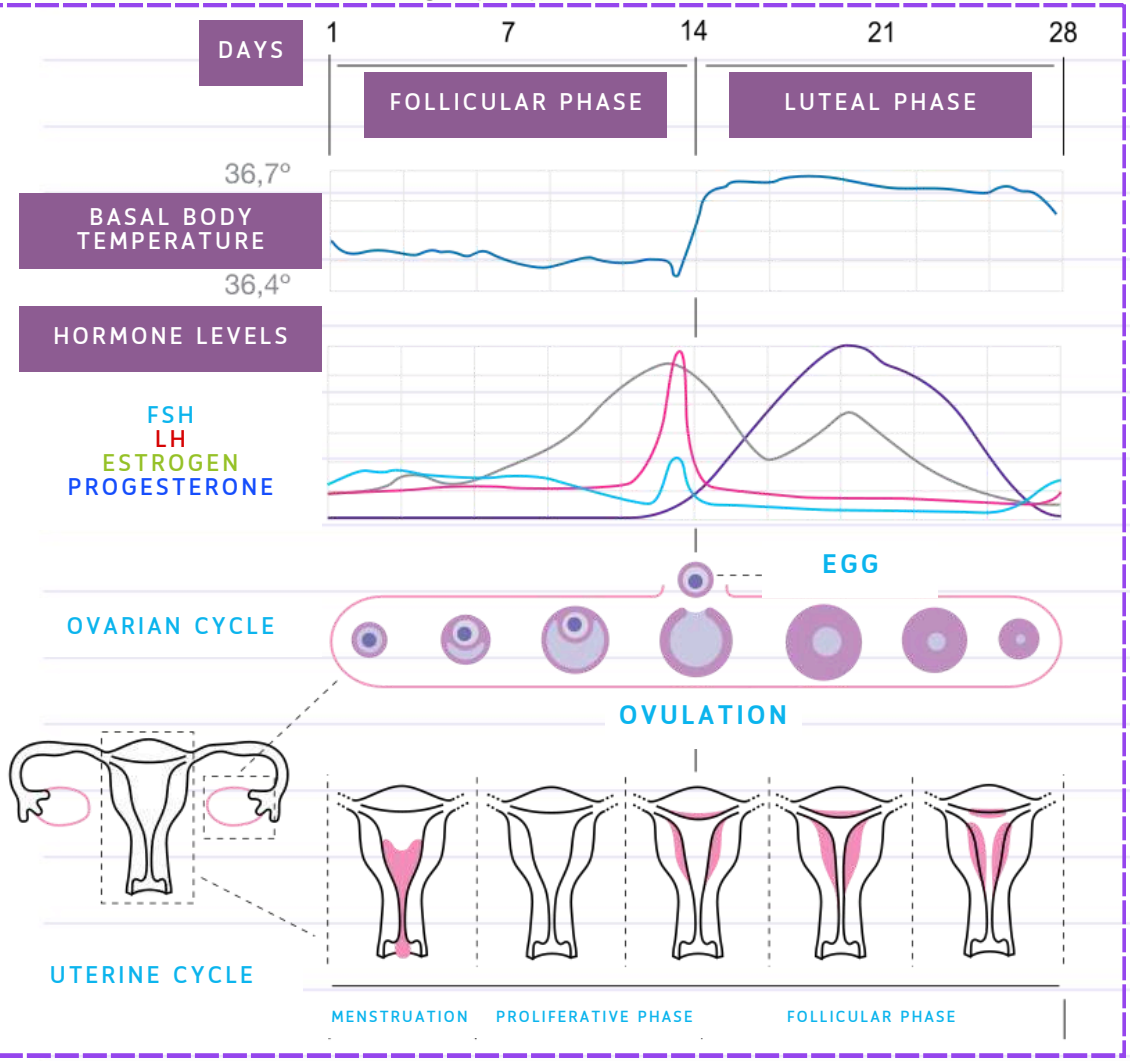
- Neurotransmitter systems are modulated by sex hormones.
- There is the presence of estrogen and progesterone receptors in brain regions involved in mood regulation (prefrontal cortex, hippocampus, thalamus, amygdala).
- Reduction of progesterone (luteal phase): anxious symptoms;
- Estradiol reduction: mood symptoms.

The ICD-11 defines PMDD as a pattern of mood changes, somatic symptoms (lethargy, joint pain and overeating) or cognitive symptoms, starting days before the start of menstruation, with improvement during menstruation.

PREMENSTRUAL DYSPHORIC DISORDER

DIAGNOSIS

Monitoring the menstrual cycle and observing symptoms



TREATMENT

NON-PHARMACOLOGICAL
Relaxation and stress management techniques
Regular physical exercise
Diet (avoid red meat, excess salt, sugar, coffee and alcohol)
Supplementation (calcium - up to 1,200mg/day; tryptophan; pyridoxine - B6 80mg/day)

PHARMACOLOGICAL
Near the luteal phase: Fluoxetine (10-20mg), Sertraline (50-150mg), Citalopram (5-20mg);
Buspirone (anxiety), spirolactone (edema), bromocriptine (mastalgia), anti-inflammatories (colic and pain).
Oral contraceptive: combination of 20mcg of ethnyl estradiol + 3g of drospirenone

DEPRESSION AND GESTATIONAL ANXIETY

CONCEPT

Characterized by depressive and anxious symptoms that can affect the emotional health and well-being of the pregnant woman and her baby.

RISK FACTORS

- Previous history of psychiatric illness
- Obstetric history (abortions, stillbirths or fetal malformations);
- Socioeconomic factors;
- Absence of a partner;
- Unplanned pregnancy;
- Lack of social and family support;
- Use of alcohol and drugs;

CLINICAL CONDITION

- Depressed mood;
- Sleep changes: Insomnia, difficulty sleeping or sleeping excessively.
- Loss of interest;
- Appetite changes: Significant loss or increase in appetite.
- Feeling of constant tiredness, lack of energy and motivation.
- Anxiety: Excessive worry, irritability and nervousness.
- Concentration difficulties: Difficulty concentrating, making decisions or remembering things.
- Feelings of guilt;
- Low self-esteem;

The risks of maternal treatment with psychotropic drugs must be compared to the known risks of the untreated disorder for mother and baby. Firstly, priority should be given to: Psychotherapy, Counselling, Phototherapy (for depression) and in severe disorders, pharmacotherapy should be indicated.

GESTATIONAL BIPOLAR DISORDER

CONCEPT

It involves extreme fluctuations in mood, ranging between episodes of mania and depression. It is important to address this condition appropriately to ensure the health of both mother and baby.

CHARACTERISTICS

- Impulsive behaviors;
- Psychotic symptoms;
- Sleep deprivation;

RISKS OF NON-TREATMENT

- Increased risk of complications;
- Increased risk of prematurity;
- Risk of spontaneous abortion;
- Increased exposure to drugs;
- Risk of postpartum depression;
- Poor perinatal care;
- Lower Apgar scores;
- Increased risk of low birth weight;

Risks of pharmacotherapy: teratogenicity, abortion, neonatal symptoms and impact on neurodevelopment.

- Selective Serotonin Reuptake Inhibitors (SSRIs): Examples include sertraline (Zoloft), fluoxetine (Prozac), and escitalopram (Lexapro). SSRIs have been antidepressants considered a safe option, with a low risk of congenital malformations.

- Tricyclics: Some tricyclic antidepressants, such as amitriptyline, may be considered during pregnancy. However, these medications may be associated with specific risks, such as perinatal withdrawal symptoms.

LOWER RISK MEDICATIONS

Sertraline, fluoxetine, citalopram, nortriptyline
Short half-life benzodiazepines (in low doses)
Haloperidol, risperidone, olanzapine, quetiapine Lithium, lamotrigine, oxcarbazepine;

DISORDERS IN THE PUERPERIUM

PUERPERAL DYSPHORIA

Mild depressive symptoms leading to anxiety, irritability, insomnia, emotional lability.

BABY BLUES

Depressive symptoms around the 3rd week postpartum, progressing with feelings of sadness and low self-esteem.

PUERPERAL PSYCHOSIS

Psychiatric emergency that occurs in the first 72 hours postpartum, resulting in mood changes, irritability, psychomotor agitation, catatonia, affective lability.

All medications are secreted into breast milk, to a greater or lesser extent!

- Antidepressants: nortriptyline, sertraline, paroxetine and fluvoxamine are the safest options for use during breastfeeding, due to the low serum concentration and few adverse effects.
- Benzodiazepines: should be avoided during breastfeeding.
- Lithium: use is possible, but must be very careful, given the risk of poisoning in exposed babies.
- Mood stabilizers: valproic acid and carbamazepine are not contraindicated for use during breastfeeding.
- Antipsychotics: there are few studies on the use of antipsychotics during breastfeeding.

SAFER MEDICINES

Sertraline, Nortriptyline, Fluoxetine, Citalopram, Paroxetine, Fluvoxamine, Valproic acid, Carbamazepine.

PERIMENOPAUSE DEPRESSION

CONCEPT

Perimenopause involves intermittent cessation of menstruation and a decrease in ovarian hormones, such as estrogen and progesterone;

CHARACTERISTICS

- Dyspareunia;
- Vaginal dryness;
- Reduced libido;
- Urinary incontinence;
- Frequent urogenital infections;
- Depressive symptoms;
- Lack and energy;
- Anhedonia (loss of pleasure);
- Intolerance and irritation;
- Low self-esteem;

CONDUCT

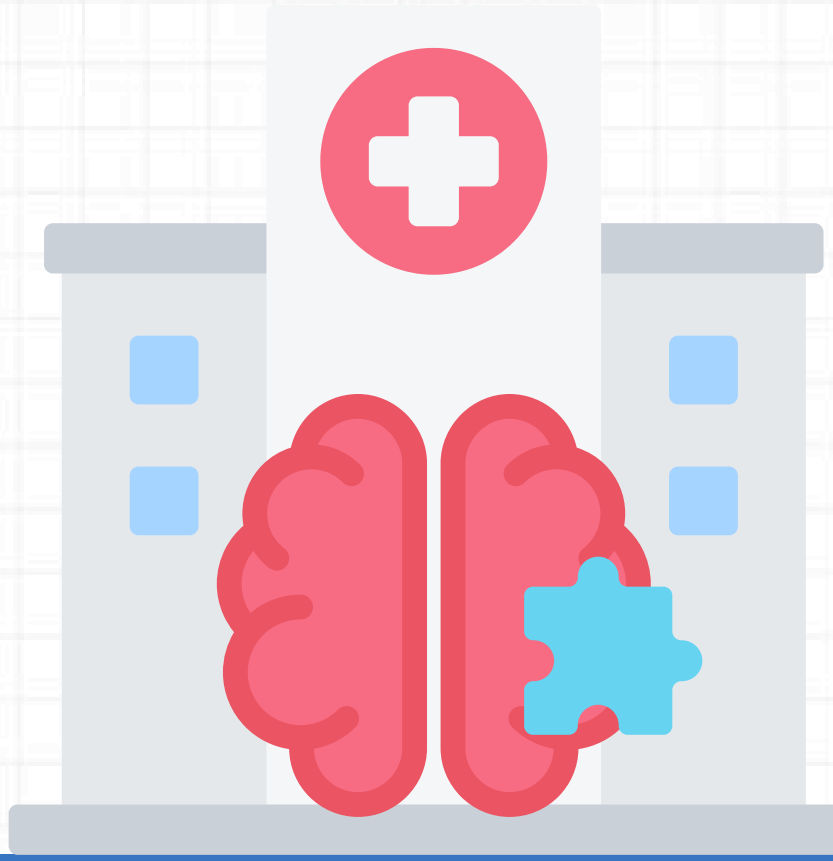
- First Line of Treatment: Hormone replacement therapy of estrogen combined or not with progesterone - modifying vasomotor symptoms, vaginal dryness, urinary complaints;
- Antidepressants: Paroxetine, Escitalopram, Citalopram, Desvenlafaxine and Venlafaxine;
- Physical activities, psychotherapy, pharmacological treatment;

Treatment for the first depressive episode usually lasts an average of 2 years; in the presence of two or more episodes, continued use of the medication is recommended.

PART VI

EMERGENCIES

Psychiatric



PSYCHIATRIC EMERGENCIES

CONCEPT

- Mental state conditions associated with imminent risk to the patient's physical or psychological integrity.
- They demand immediate therapeutic intervention.

STAGES

- Investigate symptoms, excluding organic causes of symptoms and observing intoxication or substance withdrawal.
- Employ stabilization measures to reduce associated risks.
- Avoid coercive measures by promoting the most appropriate treatment.
- Form a therapeutic alliance so that there is greater reliability and quality of the information obtained and, consequently, greater effectiveness of proposed interventions.
- Coordination with the mental health network, making appropriate referrals for continued treatment.

PSYCHOMOTOR AGITATION

CONCEPT

State of restlessness and excessive and inappropriate motor/verbal activity, accompanied by psychic excitement and increased responses to stimuli.

- Presence of aggressiveness;
- Related to increased noradrenergic and dopaminergic activity of the hypothalamic-pituitary-adrenal axis, as well as decreased serotonergic and GABAergic activity.

Investigate:

- Mental disorders (schizophrenia, depression, anxiety, and personality disorders);
- Intoxication or withdrawal;

CONDUCT

- Promotion of a peaceful and safe environment;
- Verbal approach with careful listening, avoiding provocative attitudes and offering choices;
- Pharmacological Containment:

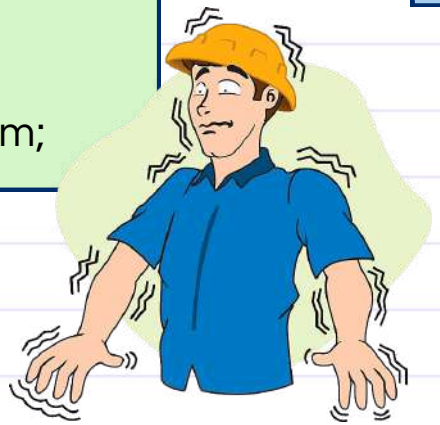
- **Typical antipsychotics: Haloperidol (5mg repeated every 30min up to a maximum dose of 20mg), Chlorpromazine (25 to 50mg every 1/4h);**
- **Atypical antipsychotics: Risperidone (2mg every 2h, up to 8mg/day), Olanzapine (10mg, every 2h up to 40mg/day);**
- **Benzodiazepines: Diazepam, Midazolam, Lorazepam (2mg every 2 hours, with a maximum dose of 12mg);**

CATATONIA

CONCEPT

Motor and behavioral changes that can range from complete immobility to extreme agitation.

- Immobility/stupor;
- Lack of verbal response;
- Caricatural actions;
- Ecopraxia (imitation of gestures);
- Absent responses to instructions or external stimuli;
- There may be agitation, hyperthermia, rigidity, delirium;

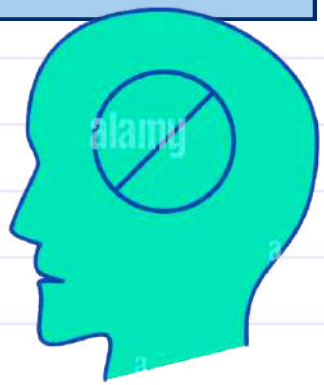


CONDUCT

- Exclusion of organic causes such as: uremic and hepatic encephalopathy; diabetic ketoacidosis; use of medications (amoxicillin, azithromycin, clarithromycin); neurological conditions such as encephalitis, trauma, neoplasms; hydroelectrolyte changes;

Lorazepam: 8 - 24mg/day;

Electroconvulsive therapy (severe conditions);



ALCOHOLIC WITHDRAWAL

CONCEPT

Autonomic hyperactivation, hypertension, sweating, anxiety, irritability, tachycardia, tachypnea, tremors, nausea and vomiting;

- Symptoms begin 6 to 12 hours after the cessation or reduction of alcohol use in chronic users, peaking at 48 to 72 hours.
- Symptoms disappear in 5 to 14 days.

CONDUCT

Complications:
Seizures;
Delirium;
Lowering of the level of consciousness;
Disorientation;
Hallucinations;
Arrhythmias;

- Vitamin replacement: Thiamine (100 mg/mL). Dose: 250-300 mg IM or IV 1x/day for 3 days. Afterwards, 300 mg/day PO.
- Benzodiazepines: Diazepam 20 mg/day PO; Lorazepam 4 mg/day. Gradual withdrawal in one week.

SEROTONINERGIC SYNDROME

CONCEPT

Clinical manifestation of excess serotonin in the central nervous system, caused by therapeutic use or overdose of serotonergic medications.

- ✓ Tremor;
- ✓ Muscle Rigidity;
- ✓ Hyper-reflection;
- ✓ Change in the level of consciousness;
- ✓ Diarrhea and vomiting;
- ✓ Hyperthermia;
- ✓ Changes in mental status;

CONDUCT

- Discontinuation of serotonergic drug;
- IV hydration;
- Correction of hydroelectrolyte disorders;

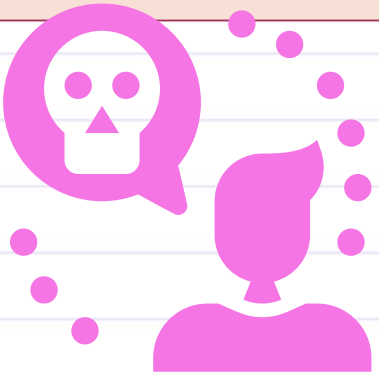
Serotonergic antagonists:

- Cyproheptadine (loading dose of 12 mg and 2 mg every 2 hours, up to a maximum of 32 mg/day);
- Chlorpromazine (50 to 100mg, IM or slow IV, every 6 hours, maximum dose of 400mg/day);

SUICIDE

Signs and symptoms of suicidal risk

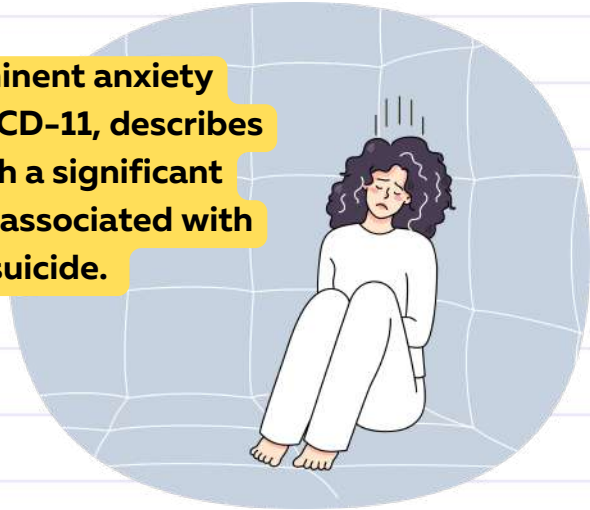
Previous suicide attempt or fantasy
Anxiety, depression, exhaustion
Availability of means
Verbalized suicidal ideation
Concern about the effect of suicide on family members
Family history of suicide
Drafting a will after agitated depression
Widespread hopelessness and pessimism



RISK FACTORS

- Depression;
- Anxiety Disorders;
- Schizophrenia;
- Personality Disorders;
- Panic Attacks;
- Use of alcohol and substances;
- Psychosis;
- Social isolation;

The qualifier "with prominent anxiety symptoms," introduced in ICD-11, describes a depressive episode with a significant anxiety component that is associated with increased risk of suicide.



SUICIDE

Suicidal Behavior

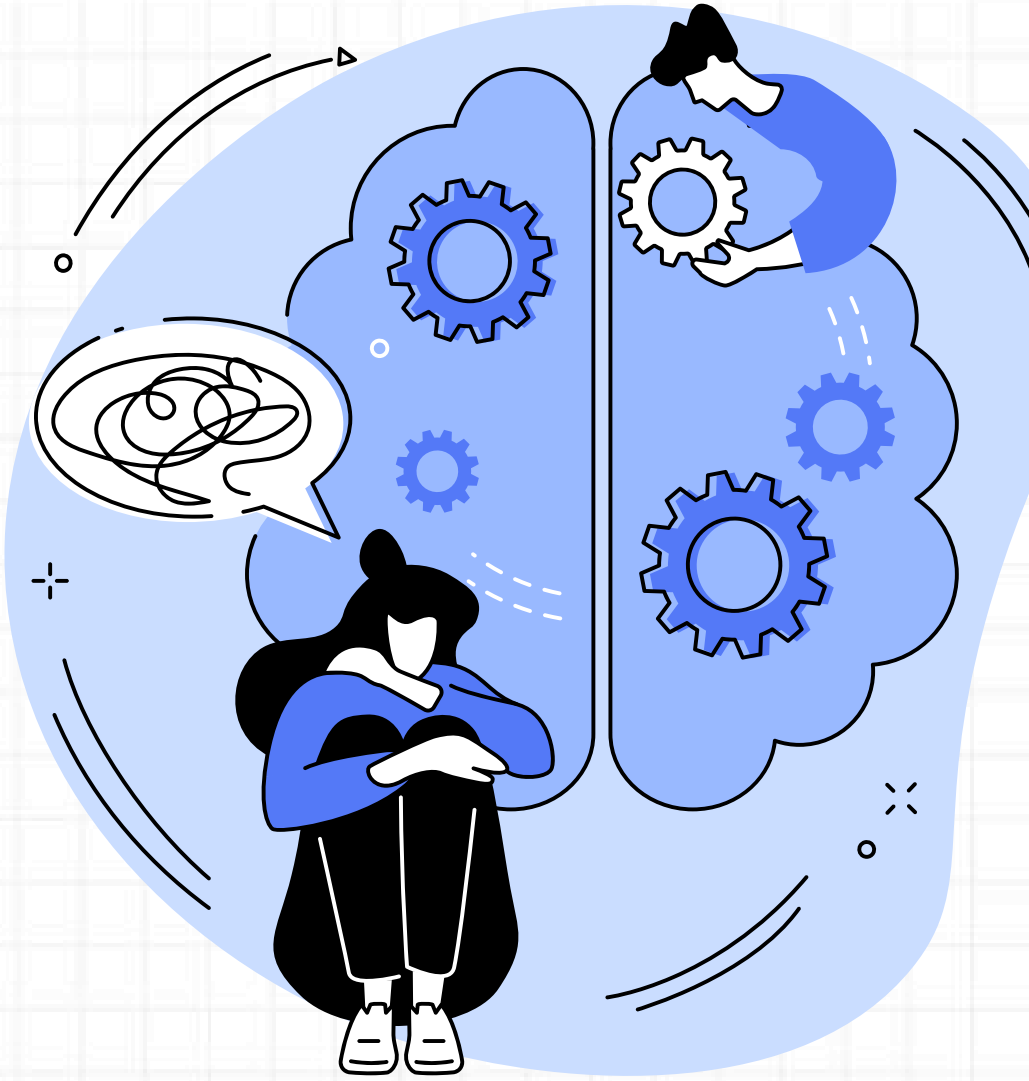
Emotional Instability	Acute stress, lack of impulse control	Cognitive impairment, stereotypical behavior	Depression, previous attempt and alcohol dependence
Emotionally unstable personality disorder	Impulse control disorder	Autism, self-harm	Suicide attempt
Psychotherapy, benzodiazepines, valproic acid, antipsychotics	Psychotherapy, benzodiazepines, valproic acid	Benzodiazepines, valproic acid	Risk assessment and hospitalization, if necessary

Sources: Adapted from Mavrogiorgou et al., 2011.

PART VII

THERAPEUTICS

Psychiatric



PSYCHIATRIC TREATMENTS

CLASSIFICATION

Biological Therapeutic Interventions

- Psychopharmacology: drug intervention;
- Electroconvulsive therapy: mood disorders and schizophrenia with therapeutic failure with the use of psychotropic drugs;
- Brain stimulation by firing electrical currents;

Non-biological Therapeutic Interventions

- Psychotherapeutic intervention;
- Multidisciplinary care team: occupational therapy, physiotherapy, speech therapy;

IMPORTANT FACTORS

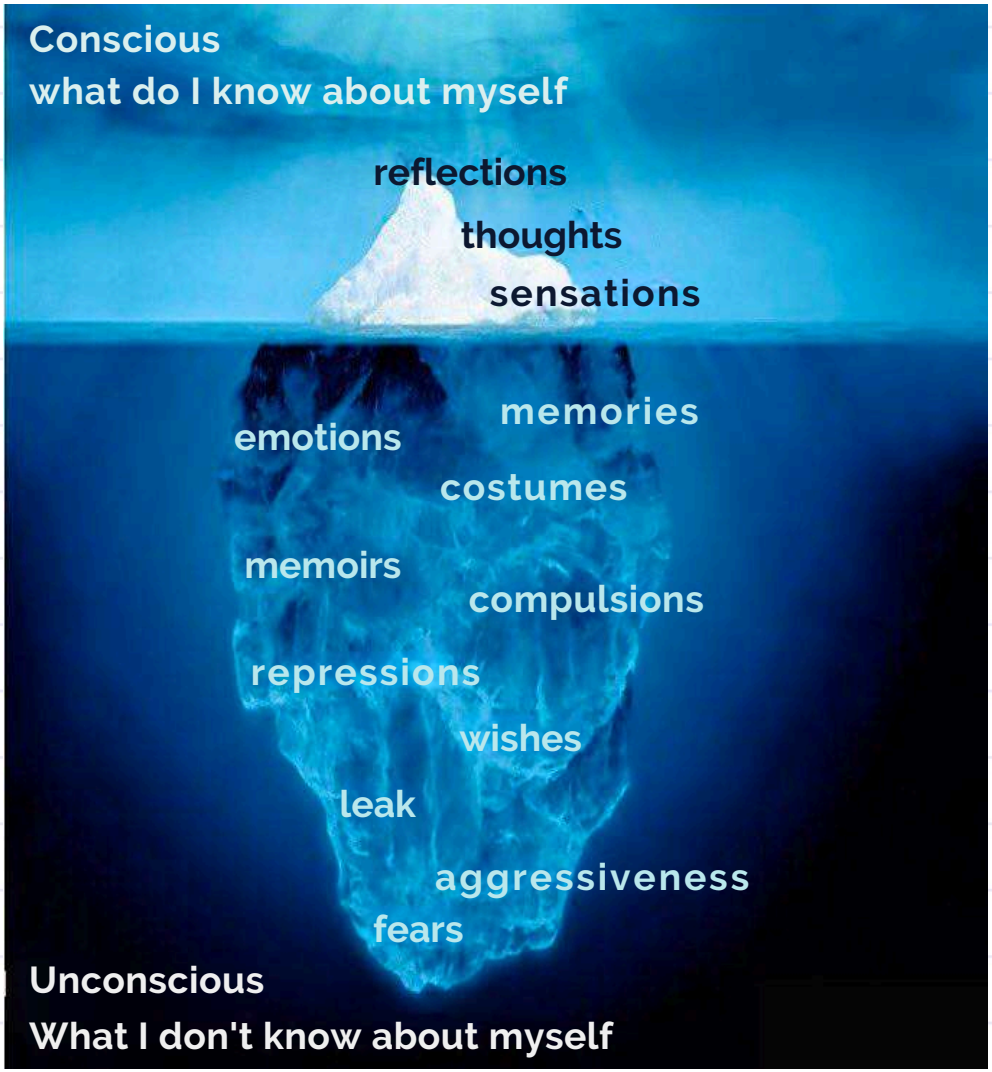
- Therapeutic relationship based on trust;
- Acceptance of the patient as influential in the health-disease process;
- Active collaboration between the patient and therapist to complete the therapeutic objective;
- Monitoring the process and requesting feedback from the patient, with mutual collaboration;

PSYCHOANALYSIS

CONCEPT

Therapeutic method created by Sigmund Freud at the end of the 19th century, which seeks to understand and treat psychic disorders, investigating unconscious processes and psychological mechanisms that influence human behavior.

- Unconscious: According to psychoanalytic theory, where mental processes occur. These repressed contents, such as repressed desires, memories and emotions, can influence behavior and cause psychological symptoms.

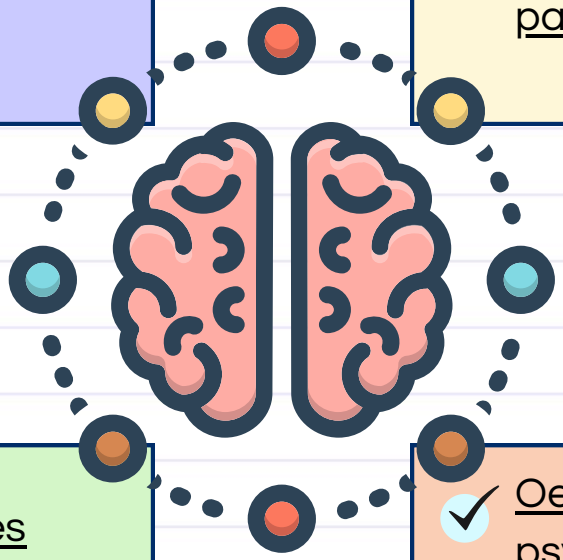


Freud's Iceberg Theory

PSYCHOANALYSIS

- Defense mechanisms: unconscious psychological mechanisms that help deal with internal conflicts and reduce anxiety. Examples: repression, projection, denial and rationalization.

- Transference: Refers to the feelings and emotions that a patient directs to the therapist, often projecting onto them significant figures from the past, important for exploring relationship patterns.



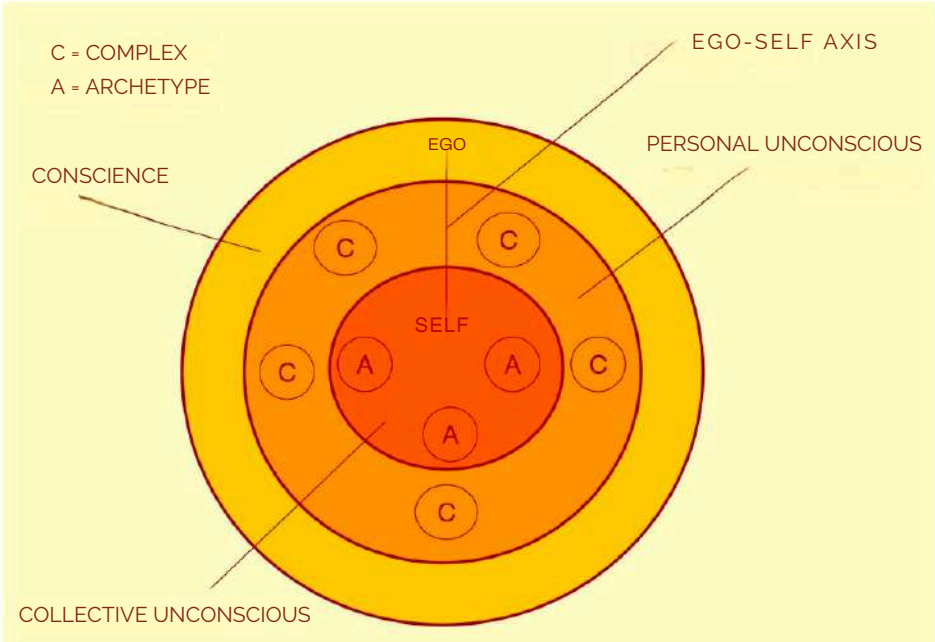
- Libido: Psychic energy that drives human drives and desires. Freud believed that libido is a motivating force behind human behavior, including sexuality.

- Oedipus Complex: According to psychoanalytic theory, during childhood, children develop feelings of sexual attraction towards the parent of the opposite sex and rivalry with the parent of the same sex, being an aspect of psychosexual development.

JUNGIAN PSYCHOTHERAPY

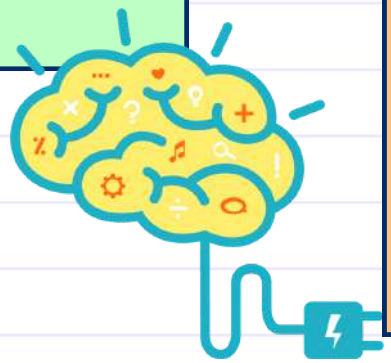
CONCEPT

Analytical psychology developed by Swiss psychiatrist Carl Gustav Jung, which is based on the elaborate concepts and theories of the collective unconscious, archetypes, the process of individuation and the importance of understanding symbols.



Structural diagram of the Jungian model of the psyche

- Collective unconscious: existence of a level of unconscious shared by humanity, containing universal images and patterns called archetypes, which influence thoughts, feelings and behaviors.



- Archetypes: primordial patterns or images present in the collective unconscious. Examples of archetypes include the hero, the mother, the father, the sage. They can manifest themselves in dreams, fantasies and everyday life.

Jungian psychotherapy

- Individuation process: self-development and self-realization, in which the person seeks to integrate and balance different aspects of the personality, including conscious and unconscious aspects.

- Symbols: expressions of the unconscious and can provide insights and guidance for individuation. They are explored through symbolic interpretation and dialogue with symbols present in dreams, active imagination and personal experiences.

- It uses techniques such as amplification, which involves the exploration of symbols and the interpretation of dreams, which seeks to understand their symbolic meaning for the individual's understanding.

PSYCHODRAMA

CONCEPT

Therapeutic approach created by Jacob Levy Moreno in the 1920s that uses theatrical techniques to explore emotional, social and psychological issues, based on the idea that the dramatic representation of situations can allow understanding and conflict resolution.

- Psychodrama encourages spontaneity in participants, allowing them to experiment with new ways of expressing themselves and interacting. Dramatic acting offers the opportunity to explore different perspectives and solutions to personal problems.

- Participants take on roles and act out a scene based on an actual past experience, a current situation, or an imagined fantasy. Through acting, participants have the opportunity to express their thoughts, feelings and desires.

- Dual role: is a technique in which another person takes on the role of a significant character in the participant's life, allowing for a new perspective and understanding. It is the time when participants share their experiences and insights with each other.

BRIEF DYNAMIC PSYCHOTHERAPY

CONCEPT

Therapeutic approach with a more specific focus and a limited duration of treatment. This approach aims to help individuals identify and resolve specific emotional and behavioral problems in a shorter period of time, typically 12 to 20 sessions.

- Narrow Focus: Focus on a specific problem or issue that the customer is facing. Instead of exploring the full life story, the therapist focuses on aspects related to the current problem.

- Targeted interventions: May include techniques for reflection, interpretation, exploring relationship patterns, identifying psychological defenses, and promoting awareness and behavioral change.

- Focus on resolution: The goal is to enable the client to develop internal resources to deal with challenges and function in a more adaptive manner.

- The therapist helps the client explore the unconscious motivations, repetitive patterns, and internal dynamics that may be contributing to the current problem.

GROUP PSYCHOTHERAPY

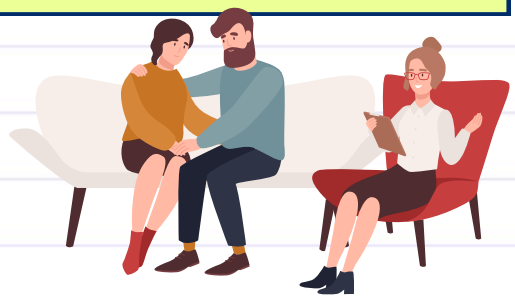
CONCEPT

Therapeutic modality that involves the participation of a therapist and several clients. In this environment, group members have the opportunity to share their experiences, support each other and work together to achieve therapeutic goals.

APPROACHES

- Educational: objective to provide information and teach specific skills to group members. The therapist provides educational resources, guidance, and practices to help members develop healthier coping strategies and life skills.

- Psychodramatics: Emphasizes the importance of the unconscious, internal conflicts and relational patterns. The therapist seeks to explore group dynamics, unconscious processes and transferences between members to promote understanding and resolution of emotional and behavioral problems.



TYPES

- Couple psychotherapies: The role of the therapist is to pay attention to the relationship, promoting communication between them.
- Family psychotherapy: The family therapist takes care of the relationship and dynamics of the family group, and should not have preferences or take sides.

BEHAVIORAL PSYCHOTHERAPY

CONCEPT

Therapeutic approach that emphasizes the influence of the environment and behavior on well-being and mental health. It focuses on understanding and modifying problematic behaviors, seeking to promote positive changes through specific techniques and strategies.

THEORETICAL CONCEPTS

- Classical conditioning: The idea that a neutral stimulus can become associated with an emotional response through repetition and association. For example, an individual may develop phobias after a traumatic experience.

- Operant conditioning: The notion that behavior is influenced by the consequences that follow it. Behaviors that are rewarded or reinforced tend to be repeated, while behaviors that are punished tend to decrease.

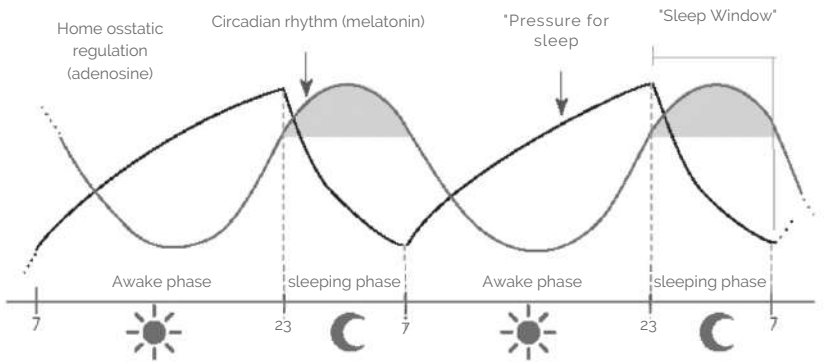
- Social learning: The belief that people can learn behaviors by observing others and imitating them.

- Functional analysis: The approach of analyzing the functions and antecedents of problem behaviors to understand what triggers them, what maintains them, and how to change them

LIFESTYLE PSYCHIATRY

CONCEPT

Focuses on the impact of lifestyle on mental health. It recognizes that factors such as diet, exercise, sleep, relationships, stress management and other aspects play a significant role in promoting psychological well-being.



ASPECTS

- Healthy eating: variety of nutritious foods that provide the nutrients necessary for proper brain function.

- Physical activity: encourage regular exercise, which helps improve mood, reduce anxiety and promote quality sleep.

- Restful sleep: Provide guidance on the importance of a consistent sleep routine, with sufficient hours of sleep.
- Stress management: Facilitate the recognition of negative responses to stress, identify coping mechanisms and reduction techniques.
- Healthy relationships: Social connection is essential for emotional resilience.
- Avoid toxic substances: Use of alcohol, tobacco and other substances.

NEUROMODULATION

CONCEPT

It involves the application of electrical, magnetic or chemical stimuli to specific regions of the nervous system to modulate neuronal activity. The goal is to influence neural pathways and brain circuits to treat or alleviate symptoms of various neurological and psychiatric conditions.

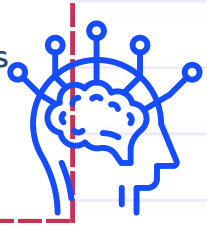
TYPES

Transcranial Magnetic Stimulation (TMS)

- It uses magnetic fields to stimulate specific areas of the brain.
- Repetitive rTMS involves the repeated application of magnetic pulses to a specific area of the brain to regulate neural activity.
- It is often used to treat depression.

Transcranial Electrical Stimulation (TSE)

- TSE involves the application of low-intensity electrical current to the brain.
- Forms of TSE: Transcranial Direct Current Stimulation (tDCS) and Transcranial Alternating Current Stimulation (ETCA).
- They can be used to treat conditions such as depression, chronic pain, anxiety disorders and sleep disorders.



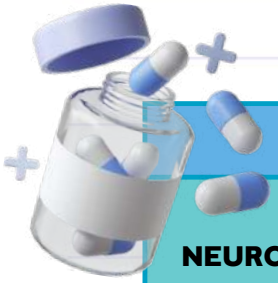
Deep Brain Stimulation (DBS)

- It involves implanting electrodes into the brain to deliver constant, precise electrical stimulation to specific areas.
- It is used to treat Parkinson's disease, dystonia, essential tremor and obsessive-compulsive disorder (OCD) refractory to treatment.

Vagus Nerve Stimulation (VNS)

- It involves electrical stimulation of the vagus nerve, which is an important neural pathway that connects to the brain.
- It is used to treat conditions such as treatment-resistant depression, chronic migraines and epilepsy.

PSYCHOPHARMACOLOGY



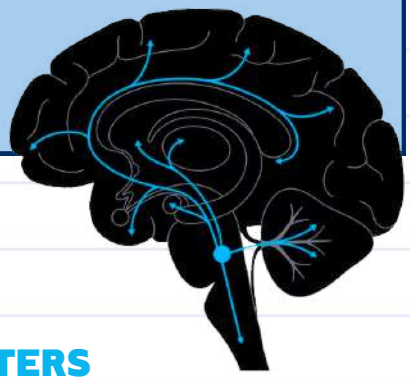
ACTIONS OF NEUROTRANSMITTERS			
NEUROTRANSMITTER	**RECEPTOR LINKED TO G PROTEIN**	**PHARMACOLOGICAL ACTION**	**THERAPEUTIC ACTION**
Dopamine	D2	Antagonist or partial agonist	Antipsychotic and antimanic
Serotonin	5HT2A	• Antagonist or inverse agonist; • Agonist;	• Antipsychotic actions in psychosis of Parkinson's disease, dementia, schizophrenia. Mood stabilization and antidepressant actions, improvement of insomnia and anxiety. • Psychomimetic actions, refractory depression and other disorders;
Norepinephrine	• Alpha 2 • Alpha 1	• Antagonist and agonist • • Antagonist	• Antidepressant actions; Improved cognition and behavioral changes in ADHD • Improved sleep and agitation in Alzheimer's disease. Side effects of orthostatic hypotension and sedation;
FRONT	• GABA-B	• Agonist	• Cataplexy, Drowsiness in narcolepsy, Pain reduction in chronic pain and fibromyalgia Possible usefulness in alcohol withdrawal;
Acetylcholine	• M1 • M4 • M2/3	• Agonist/Antagonist • agonist • Antagonist	• Pro-cognitive and antipsychotic/Sedation side effects; • Antipsychotic • Dry mouth, blurred vision, constipation, urinary retention;

PSYCHOPHARMACOLOGY

MECHANISMS OF ACTION

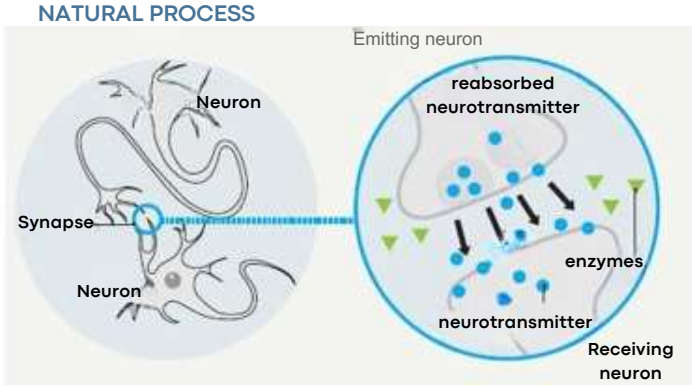
NORADRENERGIC PATHWAY

Neurotransmitters involved in the pathophysiology of mood disorders:
Noradrenaline;
Dopamine;
Serotonin;



MEMORIZE!

MONOAMINE NEUROTRANSMITTERS



Serotonin regulates the release of dopamine through the 5HT1A, 5HT2A and 5HT2C receptors, in addition to regulating the release of noradrenaline through the 5HT2C receptors and also the release of dopamine and noradrenaline through the 5HT3 receptors;

Noradrenaline regulates the release of serotonin, acting as a brake on the release of serotonin in the cortical α2 receptors of the axon terminals and as an accelerator of the release of serotonin in the α1 receptors in the somatodendritic area.

PSYCHOPHARMACOLOGY

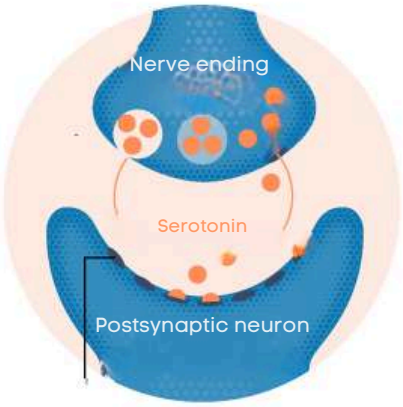
DEPRESSION

Dysfunction in the amount of monoamine neurotransmitters causes overregulation of the postsynaptic receptors of these neurotransmitters, leading to depression;

SSRI ANTIDEPRESSANTS

- Blocking the reuptake pump, increasing the amount of neurotransmitters in the synapse;

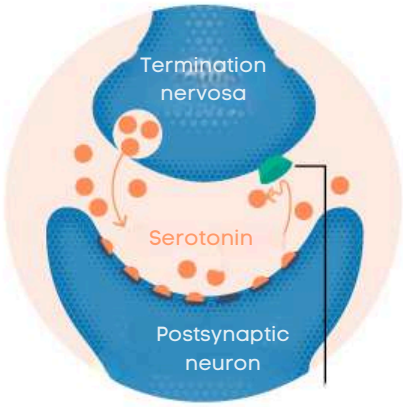
UNMEDICATED



Receptor

After a neuron releases serotonin to stimulate a neighboring cell, it gains serotonin again.

MEDICATED

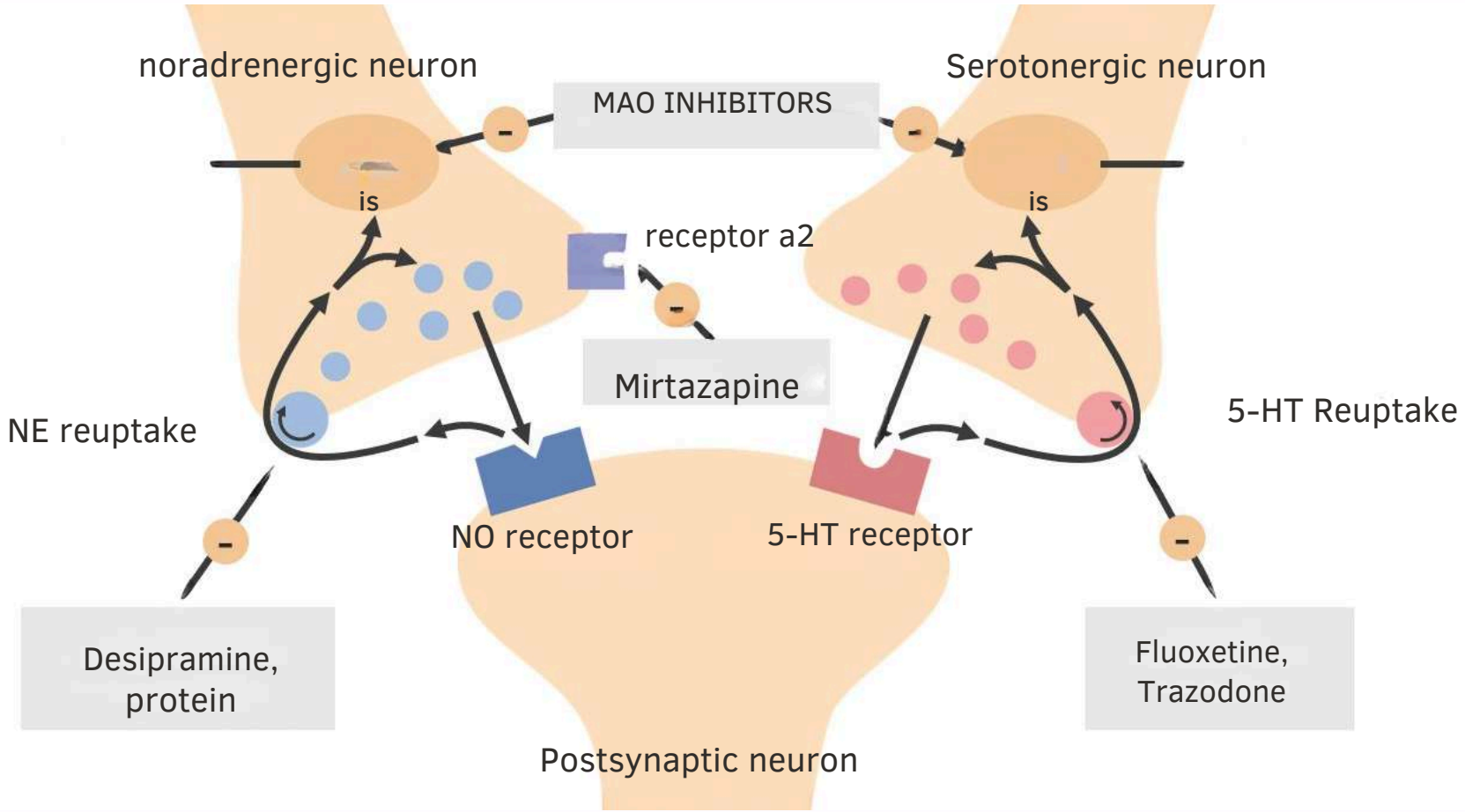


ISRSS OR SSRIS

By blocking reuptake, SSRIs increase serotonin levels in the synapse.

MAO INHIBITORS

- **MAO: Enzyme that metabolizes serotonin, norepinephrine and dopamine;**
- Increased brain levels of neurotransmitters after MAO inhibition;



TRICYCLIC ANTIDEPRESSANTS

- Block the reuptake of norepinephrine;
- Block voltage-sensitive sodium channels;
- Serotonin reuptake pump inhibitors;

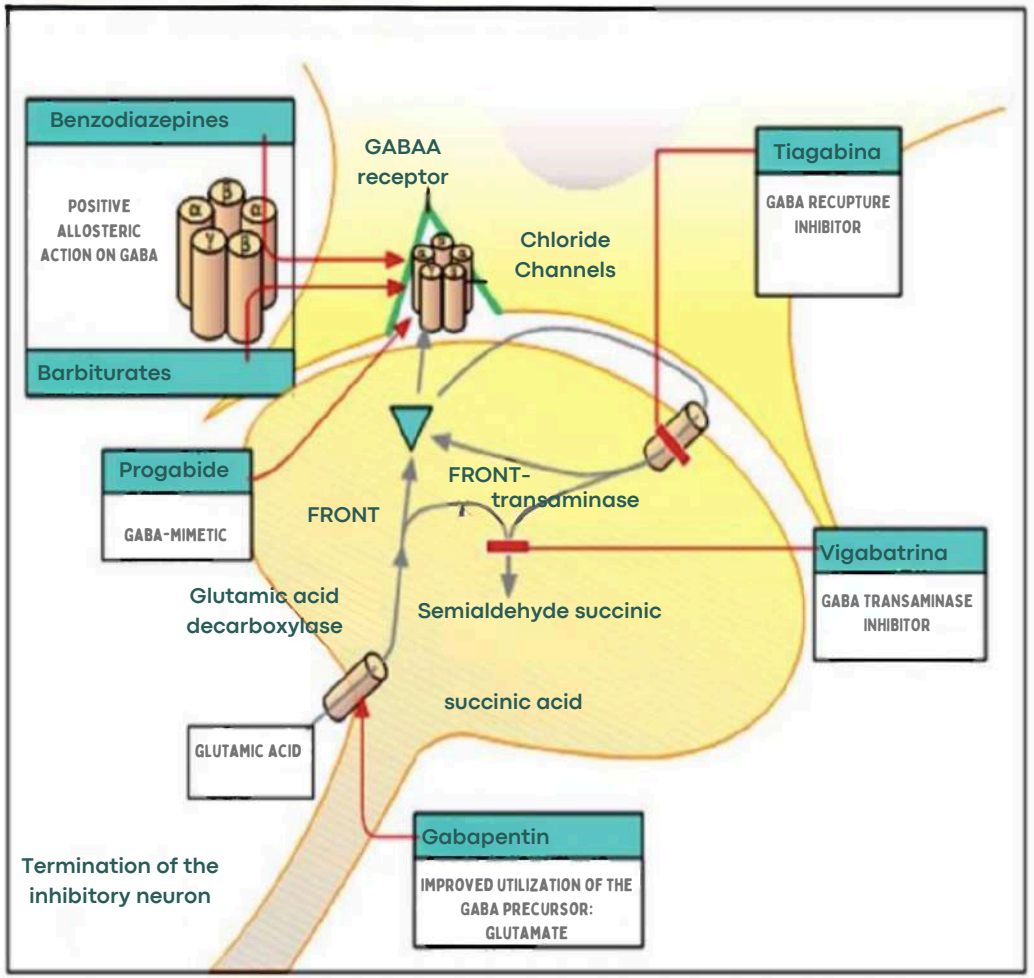
MOOD STABILIZERS

VOLTAGE SENSITIVE SODIUM CHANNELS INHIBITORS

- Reduce excessive neurotransmission, which reduces the flow of ions through voltage-sensitive sodium channels;
- Antimanic effects: Inhibition of the VSSC would lead to a reduction in sodium influx and a reduction in glutamatergic excitatory neurotransmission;

GABAergic action of anticonvulsants

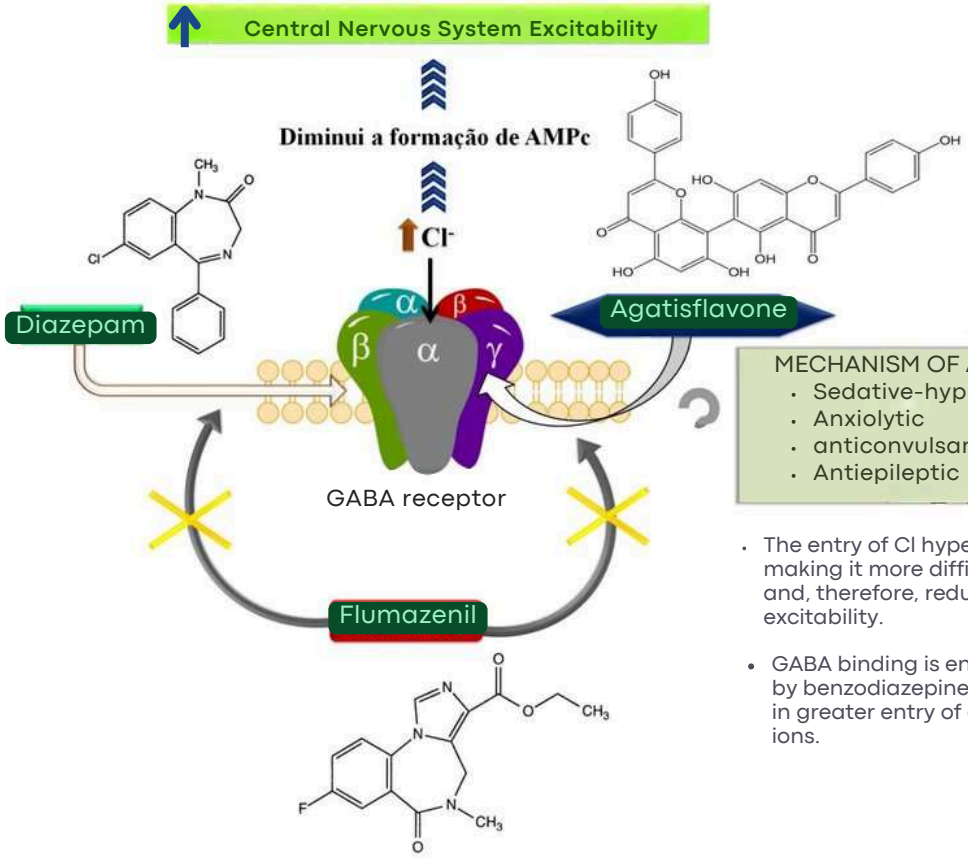
B. Sites of action of anticonvulsants at the GABAergic synapse.



PSYCHOPHARMACOLOGY

BENZODIAZEPINES

- **GABA: Inhibitory neurotransmitter;**
- **They act by intensifying GABAergic neurotransmission, relieving anxiety;**
- **The association of GABA with benzodiazepines increases the frequency of opening of inhibitory chloride channels. The end result consists of greater inhibition and anxiolytic action.**



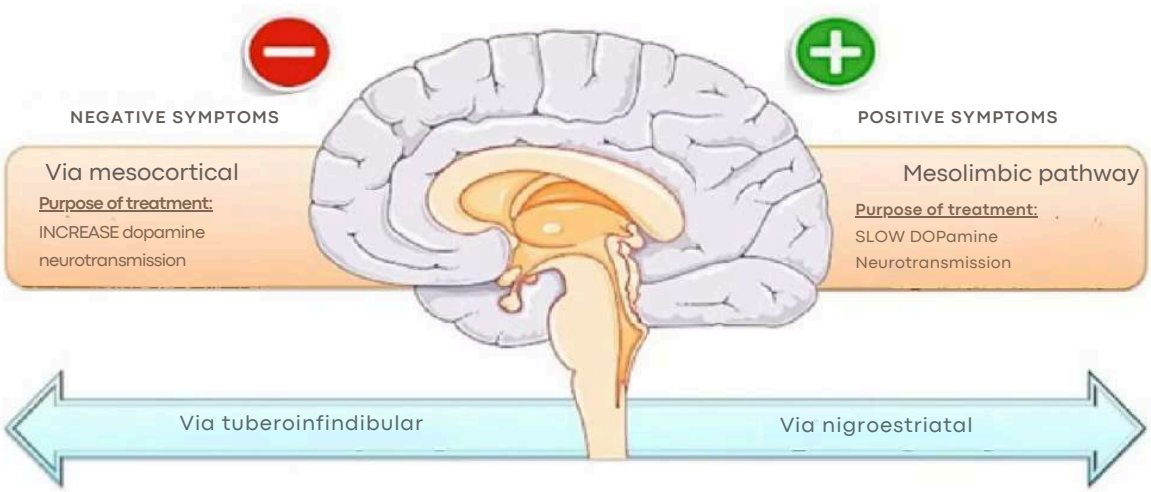
MECHANISM OF ACTION
- Sedative-hypnotic
- Anxiolytic
- anticonvulsants
- Antiepileptic

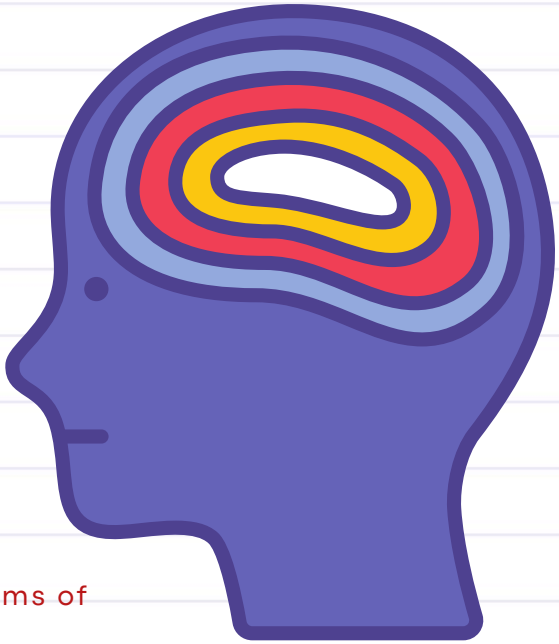
- The entry of Cl hyperpolarizes the cell, making it more difficult to depolarize and, therefore, reduces neuronal excitability.
- GABA binding is enhanced by benzodiazepine, resulting in greater entry of chloride ions.

DOPAMINERGIC PATHWAY

Hyperactivity of the mesolimbic dopaminergic pathway accounts for positive psychotic symptoms, which are part of schizophrenic disease, drug-induced psychosis or that accompany mania, depression or dementia.

PSYCHOPHARMACOLOGY





Hyperactivation of the mesolimbic dopaminergic pathway induces positive symptoms of schizophrenia via increased D2 receptor stimulation in limbic areas.

Hypoactivation of the mesocortical dopaminergic pathway causes negative symptoms and cognitive disorders with decreased activation of the D1 receptor in cortical areas.

- pure D_2 antagonist

CONVENTIONAL ANTIPSYCHOTICS

- **Blocking the binding of dopamine to the D2 receptor in the mesolimbic dopaminergic pathway, reducing hyperactivity in this pathway;**
- **In untreated schizophrenia: excess dopamine in the synapse that causes positive symptoms, such as delusions and hallucinations.**

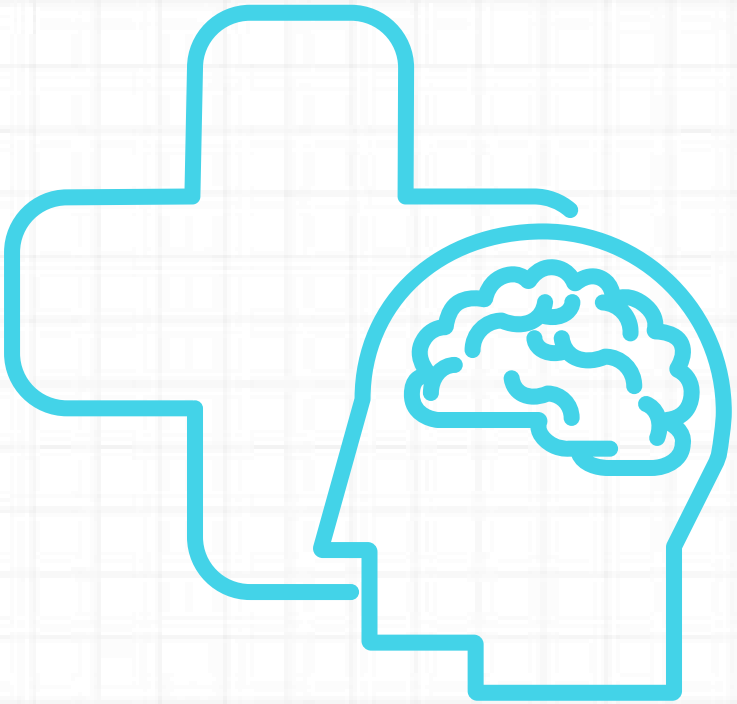
ATYPICAL ANTIPSYCHOTICS

- Similar clinical profile;
- Few extrapyramidal symptoms;
- Lower hyperprolactinemia;
- Serotonin-dopamine antagonists, with simultaneous antagonism of serotonin 5HT2A and D2 receptors;

PART IX

PATIENTS' RIGHTS

Psychiatry



PATIENT RIGHTS

Patients with mental disorders have rights guaranteed by law that aim to protect their dignity, autonomy and access to adequate treatment.

DIGNIFIED TREATMENT

Right to be treated with dignity, respect and consideration for your mental health condition. They should not be subjected to any form of discrimination or stigma.

End the Stigma

CONSENT

Patients must receive adequate information about proposed procedures, medications and therapies, and have the right to give or refuse consent to any intervention, except in cases of imminent risk to their own safety or the safety of others.

INFORMATION

Patients have the right to receive clear and understandable information about their mental health condition, the diagnosis, the proposed treatment, their rights and the consequences of their treatment decisions.

CONFIDENTIALITY

Patients have the right to privacy of their mental health information. Healthcare professionals must maintain the confidentiality of personal and clinical data, except when there is a risk of harm to themselves or others, or when required by law.

PATIENT RIGHTS

TREATMENT

Patients have the right to access quality mental health services, including assessment, diagnosis, treatment and rehabilitation. Treatment must be evidence-based, respect the patient's individual needs and be culturally appropriate.

JUDICIAL REVIEW

Patients have the right to pursue legal proceedings to challenge any violation of their rights, including involuntary hospitalization or other restrictions on their freedom.

SOCIAL INCLUSION

Patients have the right to be included in society, with equal opportunities, and to actively participate in the community. They must have access to adequate education, employment and housing, as well as social reintegration programs.

Types of psychiatric hospitalization:

Voluntary hospitalization: one that takes place with the user's consent.

Involuntary hospitalization: one that takes place without the user's consent and at the request of a third party.

Compulsory hospitalization: that determined by the Court.

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