Therapeutics Decision Making Crash Course

By Dr. Michael | SuperMedPros

Title:
Psychiatric & Substance-Related Disorders: The TDM Way

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Each chapter will include:

- Story-style explanations
- Mock clinical scenarios
- Fun facts
- Tips to avoid common exam traps
- Mnemonics when needed
- TDM mindset: What's the best decision? Why?

Let's begin with:

Chapter 1: Acute Agitation

Scene:
A 38-year-old man is pacing in the ER, yelling, throwing items, refusing to sit. His history? Schizophrenia. Missed meds. Security is called. The nurse says, "We need to calm him down—fast."

Dr. Michael's Voice:
Welcome to **Acute Agitation**—where time is brain and decisions need to be fast, safe, and strategic.

What Is Acute Agitation?

Acute agitation is a **state of extreme restlessness, irritability, or violence**. It's not just "annoyance." It's a clinical emergency that may precede harm to the patient or others.

Common Causes:

- Psychiatric: Schizophrenia, mania, severe depression
- Substance: Alcohol, stimulants, withdrawal
- Medical: Delirium, head injury
- Environmental: ICU, noise, restraints

TDM Principle: First, Safety

Before picking a drug, ask:

- Is everyone safe?
- Can I de-escalate verbally?
- Do I need meds now?
- Do I know the cause?

Remember:
Treat the cause, not just the chaos.

Step-by-Step Approach

1. **Verbal de-escalation**
    - Calm voice
    - Keep distance
    - Avoid confrontation
2. **Quick assessment**
    - Vitals, mental status
    - Rule out delirium (check glucose, infection)
3. **Decide if meds are needed**
    - If yes, is the patient cooperative?
        - Yes: **Oral**
        - No: **IM (Intramuscular)**

Pharmacologic Options

Route	Drug	Key Points
Oral	Olanzapine, Risperidone, Lorazepam	Takes longer, but less traumatic

Route	Drug	Key Points
IM Injection	Haloperidol + Lorazepam	Fast, but EPS risk
IM Atypicals	IM Olanzapine, IM Ziprasidone	Good if available, fewer EPS

Important Tips

- Avoid mixing **IM Olanzapine and IM Lorazepam**—risk of **respiratory depression**
- Haloperidol? Always consider adding a benzo or anticholinergic to reduce EPS risk
- If patient is delirious, avoid sedating antipsychotics

Mock Question

A 32-year-old man with schizophrenia becomes violently agitated in the ER. He is non-cooperative. What's your best option?
A) Oral Olanzapine
B) IM Haloperidol + Lorazepam
C) IM Diazepam
D) Verbal de-escalation only

Correct Answer: B
Why? He's non-cooperative and needs quick control. IM combo is fast and effective.

Fun Fact

Did you know? The word "tranquilizer" was originally slang in the 1950s for calming zoo animals before surgery.

Exam Gold Nugget

Always look for the route.
If cooperative → oral
If aggressive → IM
If delirium → treat underlying cause first

Chapter 2: Anxiety Disorders

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Scene:
A 26-year-old woman walks into your clinic. Heart racing. Sweaty palms. “I think I’m dying,” she says. Her ECG is normal. Labs clean. You ask more questions and realize… it’s not her heart. It’s anxiety.

What is Anxiety?

Anxiety is the **anticipation of a future threat.**
It’s different from fear (which is a response to a current threat).

Common Types:

- Generalized Anxiety Disorder (GAD)
- Panic Disorder
- Social Anxiety Disorder (SAD)
- Specific Phobias
- Separation Anxiety Disorder

TDM Thinking:

You're not just calming someone down. You're managing a **chronic, relapsing condition** with **functional impairment** and **somatic symptoms**.

Step 1: Rule Out Medical Causes

Before writing any script, rule out:

- Hyperthyroidism
- Pheochromocytoma
- Arrhythmias

- Asthma/COPD
- Substance use (caffeine, stimulants, alcohol withdrawal)

Tip:
Use **GAD-7** or **HAM-A** to assess severity.

Step 2: Choose the Right Treatment

First-Line Options (Across Most Anxiety Disorders)

Drug Class	Example	Notes
SSRI	Sertraline, Escitalopram	Start low to avoid increased anxiety
SNRI	Venlafaxine	Especially useful in GAD and SAD
CBT	Cognitive Behavioral Therapy	Works well for all types

General Rules for Anxiety TDM:

- **Start low, go slow**
- Initial side effects may mimic anxiety (jitteriness, GI upset)
- Takes 2–6 weeks to work
- May worsen before it improves

Panic Disorder:

- **Key Feature:** Sudden, unexpected panic attacks
- **Best Tx:** SSRI + CBT
- **Benzos?** Maybe short-term—but **avoid long-term**

Social Anxiety Disorder:

- **Key Feature:** Fear of embarrassment or scrutiny
- **Best Tx:** CBT is often more effective than meds

- SSRI or SNRI if moderate to severe
- **Beta-blockers (e.g. propranolol)** before performance (like public speaking)

Generalized Anxiety Disorder (GAD):

- **Key Feature:** Excessive worry for 6+ months
- **First-line:** SSRI or SNRI
- **Second-line:** Buspirone, pregabalin
- Avoid benzos if possible

Benzodiazepines – Use With Caution

Drug	Half-Life	Notes
Lorazepam	Medium	Good for liver disease
Clonazepam	Long	Better for tapering
Alprazolam	Short	High abuse potential

TDM Warning:
Avoid in elderly, substance users, long-term use

Mock Question

A 30-year-old woman presents with fatigue, irritability, and constant worry for the past 8 months. She struggles to sleep. Vitals and labs are normal. What's the best first-line treatment?

A) Clonazepam
B) CBT
C) Propranolol
D) Diphenhydramine

Correct Answer: B (CBT or SSRI would both be acceptable first-line answers)

Fun Fact

SSRIs were discovered **by accident** in the 1970s while researching antihistamines!

Mini Checklist: Before Choosing Meds

- Did you rule out medical causes?
- Is CBT available or acceptable to the patient?
- Do they have a history of substance use?
- Are they pregnant or breastfeeding?

Quick Mnemonic: "CALM PANIC"

C – Check for physical causes
A – Ask about function
L – Low starting dose
M – Monitor side effects
P – Pick SSRI/SNRI
A – Avoid long-term benzos
N – Normalize timeline (2–6 wks)
I – Include CBT
C – Continue for 6–12 months after remission

Chapter 3: ADHD (Attention Deficit Hyperactivity Disorder)

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Scene:
A 10-year-old boy is constantly getting in trouble at school. He fidgets, interrupts, forgets his books. His teacher says, "He's bright, but he just can't sit still."
His parents are overwhelmed.

His grades are crashing.
You're the clinician. What do you do?

What is ADHD?

ADHD is a **neurodevelopmental disorder** characterized by:

- Inattention
- Hyperactivity
- Impulsivity

It's not bad parenting. It's not "just being active."

Subtypes:

- **Predominantly Inattentive**
- **Predominantly Hyperactive-Impulsive**
- **Combined Type** (most common)

TDM Principle: It's Not Just About Focus

Think long-term: academic failure, low self-esteem, risky behavior, substance use.

Step 1: Confirm the Diagnosis

- Use tools like **Vanderbilt**, **Conners Rating Scale**
- Symptoms must:
    - Start before **age 12**
    - Occur in **2+ settings** (e.g., home, school)
    - Last **6+ months**
    - Cause **functional impairment**

Step 2: Identify Severity & Age

Age Group	First-Line Approach
Preschool (4–5)	**Behavioral therapy** first
School-age (6–11)	**Meds + behavioral**
Adolescents (12+)	Meds ± therapy

Step 3: Choose the Right Medication

Stimulants: First-Line

Drug	Class	Key Notes
Methylphenidate	Ritalin, Concerta	Short & long-acting forms
Amphetamines	Adderall, Vyvanse	Higher abuse risk but effective

MOA: Boost dopamine and norepinephrine in prefrontal cortex
Effect: Often rapid—within hours

Side Effects to Watch

- ↓ Appetite, insomnia
- Irritability, rebound symptoms
- Rare: tics, hallucinations, ↑ HR/BP
- Growth delay (minimal, but monitor yearly)

Non-Stimulants: For Special Cases

Drug	Use When…
Atomoxetine	Stimulants not tolerated or SUD risk
Guanfacine	Tics, insomnia, or as an add-on

Drug	Use When…
Bupropion	Comorbid depression or smoking

TDM Insight: Don’t Just Prescribe—Monitor

- Start low, titrate every 3–7 days
- Reassess monthly early on
- Monitor BP, HR, weight, and sleep
- Ask teachers for feedback

Mock Question

A 9-year-old boy with ADHD is not gaining weight well and struggles to sleep. He’s on long-acting methylphenidate. What’s your next step?

A) Increase dose
B) Add bupropion
C) Switch to atomoxetine
D) Give dose earlier in the day

Correct Answer: D
Why? Giving stimulants too late in the day can cause insomnia. Adjust timing before switching drugs.

Fun Fact

Methylphenidate was approved in **1955**—before seat belts became mandatory in cars.

Pro Tips

- Give stimulant doses **after breakfast** to reduce appetite suppression
- Use **“drug holidays”** during summer (if needed) to assess function and growth
- Teens may **fake symptoms** for access to stimulants—validate with reports

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Mini-Mnemonic: FOCUS

F – Functional impairment in 2+ settings
O – Onset before age 12
C – Consider therapy + meds
U – Use rating scales to monitor
S – Start low, go slow, side effect check

Chapter 4: Bipolar Disorder

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Scene:
A 24-year-old man arrives smiling, talking rapidly. “I don’t need sleep! I started three businesses last night. I’m unstoppable!”
He hasn’t slept for days. He was hospitalized last year for depression.
His mother whispers, “It’s happening again.”

What Is Bipolar Disorder?

A **mood disorder** with extreme shifts between:

- **Mania** (high energy, risky behavior, euphoria or irritability)
- **Depression** (low mood, fatigue, guilt, loss of interest)

It’s not just “mood swings.”
These episodes are **disabling**, prolonged, and disruptive.

Types of Bipolar Disorder

Type	Key Features
Bipolar I	At least 1 manic episode (± depression)

Type	Key Features
Bipolar II	At least 1 hypomanic + 1 major depressive episode
Cyclothymia	Fluctuations, but not meeting full criteria

TDM Rule #1: Treat the Phase You're In

- Are they manic now?
- Depressed now?
- Maintenance phase?

Never treat bipolar depression like unipolar depression.
You might trigger mania.

Step 1: Treat Acute Mania

First-Line Options:

Medication	Notes
Lithium	Gold standard, but slow onset
Valproic Acid	Faster, great for mania with aggression
Atypical Antipsychotics	Olanzapine, Risperidone, Quetiapine – fast acting
Benzodiazepines	Temporary bridge for agitation

Side Effects to Monitor:

- **Lithium:**
    - Tremor, GI upset, polyuria, weight gain
    - Long-term: nephrotoxicity, hypothyroidism
    - Narrow therapeutic range (0.6–1.2 mmol/L)
    - Toxicity = tremors, confusion, seizures

- **Valproate:**
    - Liver injury, pancreatitis, weight gain
    - Teratogenic – never use in pregnancy
- **Antipsychotics:**
    - Sedation, metabolic syndrome, EPS

Step 2: Treat Acute Bipolar Depression

First-Line Choices:

Drug	Use Case
Quetiapine	Effective monotherapy
Lurasidone	Fewer metabolic issues
Lithium	Also reduces suicide risk
Lamotrigine	Especially for maintenance

Avoid: SSRIs alone—they can flip the switch to mania

Step 3: Maintenance Therapy

Prevent relapse, especially after multiple episodes.

Drug	Notes
Lithium	Best for long-term stability
Lamotrigine	Great for depressive prevention
Valproic Acid	Better for rapid cycling
Atypical Antipsychotics	Useful when monotherapy isn't enough

TDM Thinking: Know Their History

- Did they respond to lithium before?

- Is adherence a problem?
- Do they want to get pregnant?
- Have they had suicidal thoughts?

Mock Question

A 32-year-old woman with known Bipolar I is admitted for acute mania. She is pacing, talking nonstop, and hasn't slept. What is the best initial treatment?

A) Sertraline
B) Lithium
C) Lamotrigine
D) Quetiapine

Correct Answer: D
Why? Quetiapine works fast in acute mania. Lithium takes time. SSRIs may worsen mania.

Fun Fact

Lithium is a naturally occurring element found in some mineral waters—and was once in **7-Up** until 1950.

Pro Tips for Exams and Practice

- Always ask about **family history**—bipolar is highly heritable
- Check **TSH, renal function, and calcium** before starting lithium
- **Lamotrigine titration** must be slow to avoid **Stevens-Johnson Syndrome**
- Be cautious of **rapid cycling** (≥4 mood episodes/year)—may need combo therapy

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Mini Mnemonic: "MAP IT" (for Bipolar Management)

M – Mania or Depression?
A – Atypical antipsychotics for acute phase
P – Prevent relapse with maintenance meds

I – Intervene early to avoid hospitalization
T – Titrate and monitor side effects

Chapter 5: Dementia

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Scene:
An 82-year-old man is brought in by his daughter. "He keeps asking the same questions. Last week, he got lost walking to the store he's visited for 40 years."
He's polite, pleasant, and has no idea anything is wrong.
You begin the cognitive screen.

What Is Dementia?

Dementia is a **chronic, progressive decline** in cognitive function that interferes with **daily living**.
It's **not** a normal part of aging.

TDM Principle: Diagnose the Type, Guide the Treatment

Major Types of Dementia:

Type	Clues
Alzheimer's	Memory loss first, slow progression
Vascular Dementia	Stepwise decline, stroke history
Lewy Body Dementia	Visual hallucinations, Parkinsonism, fluctuating cognition
Frontotemporal Dementia	Behavior or language changes, younger onset

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Step 1: Rule Out Reversible Causes

Before calling it dementia, **check for mimics**:

- Depression
- B12 deficiency
- Hypothyroidism
- Chronic subdural hematoma
- Normal pressure hydrocephalus
- Alcohol abuse
- Medication side effects (benzos, anticholinergics)

Step 2: Confirm the Diagnosis

Use Screening Tools:

- MMSE (Mini Mental State Exam) – max score 30
- MoCA (Montreal Cognitive Assessment) – more sensitive

Score <24 (MMSE) usually points to cognitive impairment.
But always correlate with function.

Step 3: Management Approach

Non-Pharmacological First

- Establish routine
- Label items at home
- Use calendars, reminders
- Safety: remove rugs, install grab bars
- Support caregivers

Step 4: Pharmacologic Treatment

For Alzheimer's & Lewy Body:

Drug Class	Example	Notes
Cholinesterase Inhibitors	Donepezil, Rivastigmine, Galantamine	Mild to moderate stages
NMDA Antagonist	Memantine	Moderate to severe stages

They don't cure—but may slow decline.

Side Effects to Watch:

- **Cholinesterase inhibitors:**
  - Nausea, bradycardia, syncope
- **Memantine:**
  - Dizziness, confusion

TDM Red Flags: Don't Miss These

- **New aggression in dementia?** Could be pain, infection, or drug side effects
- **Sudden decline?** Rule out stroke or delirium
- **Nighttime wandering?** Think sundowning—try non-drug strategies first

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Managing Behavioral Symptoms (Agitation, Hallucinations):

1. **Non-drug methods first**
2. If severe risk: **Atypical antipsychotics** (e.g., risperidone, olanzapine)
3. Use lowest dose, short duration—**black box warning**: ↑ mortality in elderly

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Mock Question

A 78-year-old woman presents with progressive memory loss and word-finding difficulty. MMSE = 20. Labs normal. What's the best next step?

A) Start risperidone
B) Start donepezil
C) Order brain biopsy
D) Prescribe fluoxetine

Correct Answer: B
Why? Donepezil is appropriate for mild to moderate Alzheimer's disease.

Fun Fact

The **word "dementia"** comes from Latin, meaning "**out of one's mind.**"
It originally referred to madness—before science revealed the pathology.

Tips for Care and Exams

- Always check function: Can they manage money? Medication? Cooking?
- Get **collateral history** from a family member or caregiver
- Avoid meds with **anticholinergic effects** (e.g., diphenhydramine, amitriptyline)
- Never start **antipsychotics** lightly—use only when behavior is dangerous

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Mini Mnemonic: DEMENTIA

D – Daily function impaired
E – Exclude reversible causes
M – Memory loss, most common
E – Early detection with MoCA
N – No cure, but slow progression
T – Treat behavior cautiously
I – Include caregiver support
A – Alzheimer's most common

Chapter 6: Depression

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Scene:
A 42-year-old teacher says, “I’ve lost interest in everything. I sleep too much. I feel worthless.”
No energy. No appetite. No motivation.
She cries quietly.
But when asked if she has thoughts of ending her life… she nods.

What Is Depression?

Depression is more than sadness.
It’s a **clinical syndrome** that affects mood, thoughts, sleep, appetite, and function.

Key Criteria (SIGECAPS)

Need **5 or more symptoms**, including **depressed mood or anhedonia**, for at least **2 weeks**:

- **S**leep changes
- **I**nterest ↓ (anhedonia)
- **G**uilt/worthlessness
- **E**nergy ↓
- **C**oncentration ↓
- **A**ppetite changes
- **P**sychomotor changes
- **S**uicidal thoughts

Types of Depression

Type	Key Clues
Major Depressive Disorder	Most common; episodes may recur

Type	Key Clues
Persistent Depressive Disorder (Dysthymia)	Chronic, ≥2 years, less severe
Seasonal Affective Disorder	Winter months; light therapy helps
Postpartum Depression	Within 4 weeks of delivery

TDM Step 1: Rule Out Other Causes

Before starting meds, ask:

- Is there a **medical condition** (hypothyroidism, anemia)?
- Are they on **drugs** that can worsen mood? (beta-blockers, steroids)
- Is there **bipolar disorder**?
  → Giving antidepressants alone in bipolar can trigger **mania**

TDM Step 2: Assess Risk

Ask about suicidality:

- Passive vs. active thoughts
- Plans or means
- Past attempts

High risk = urgent psychiatric referral

Step 3: Choose the Right Treatment

First-Line: SSRIs or CBT (or both)

Drug	Class	Key Points
Sertraline	SSRI	Safe in cardiac patients
Escitalopram	SSRI	Clean side effect profile
Fluoxetine	SSRI	Longest half-life (good for teens)

Drug	Class	Key Points
Venlafaxine	SNRI	Good for fatigue + pain
Bupropion	NDRI	No sexual side effects; avoid in seizures
Mirtazapine	NaSSA	Causes sedation and weight gain

CBT

Works best when the patient is:

- Motivated
- Has insight
- Not in severe depression

TDM Dos & Don'ts

- Start low, monitor for **activation syndrome** (restlessness, irritability early on)
- Takes **2–6 weeks** to see full effect
- Continue for **6–12 months** after remission
- Taper **slowly** to avoid withdrawal (especially paroxetine, venlafaxine)

When To Refer

- Psychotic features (delusions, hallucinations)
- High suicide risk
- Refractory to 2+ antidepressants
- Suspected bipolar depression
- Complex social/trauma history

Mock Question

A 35-year-old woman reports sadness, insomnia, and loss of appetite for 1 month. She denies suicidal thoughts. No past psychiatric history. Next best step?

A) Start fluoxetine
B) Refer for ECT
C) Start lorazepam
D) Wait and watch

Correct Answer: A
Why? First episode of moderate MDD → Start SSRI. No need for ECT or benzos.

Fun Fact

Prozac (fluoxetine) was the **first SSRI**, launched in **1987**—nicknamed the "happy pill."

Watch Out For

- **Increased suicidality in youth** starting SSRIs
- **Bipolar red flags** (family history, mood swings, early age)
- **Sexual side effects**—common with most SSRIs (↓ libido, anorgasmia)
- If insomnia is a big issue, **mirtazapine** may help
- If fatigue is dominant, **bupropion** might be better

Mini Mnemonic: "DEPRESSS"

D – Duration ≥2 weeks
E – Evaluate suicidality
P – Physical causes ruled out
R – Right med/dose
E – Expect delay (2–6 weeks)
S – Stick with it 6–12 months
S – Side effect check
S – Slowly taper when stopping

Chapter 7: Eating Disorders

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Scene:
A 19-year-old college student faints in class. She's underweight, anxious, and cold to the touch. When asked about her diet, she says she's "eating clean" and working out daily. Her BMI is 15.
Later, she's caught hiding food in a napkin during lunch.

What Are Eating Disorders?

Eating disorders are **serious psychiatric illnesses** marked by unhealthy relationships with food, body weight, and self-image.
They carry **high medical risk** and **the highest mortality rate** of all psychiatric disorders.

TDM Rule: This Is Not Just About Food

The core is about **control, shame, and self-perception.**
So treatment must combine **medical, psychiatric, and nutritional** support.

Main Types of Eating Disorders

Disorder	Key Features
Anorexia Nervosa	Restriction, low body weight (BMI <18.5), intense fear of weight gain
Bulimia Nervosa	Binge eating + compensatory behaviors (vomiting, laxatives, fasting)
Binge Eating Disorder	Binge eating without compensation; often overweight or obese

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Subtypes of Anorexia:

- **Restricting type**
- **Binge-eating/purging type**

Step 1: Medical Assessment Comes First

Eating disorders can be fatal.
Do a **full physical and lab workup** immediately.

Key Medical Risks:

- Electrolyte imbalances (↓ K+, ↓ Mg^{2+})
- Cardiac arrhythmias
- Bradycardia, hypotension
- Osteopenia
- Amenorrhea (in AN)
- Parotid gland swelling (in BN)

Red flag = orthostatic hypotension or HR < 50 bpm → Admit!

Step 2: Make the Diagnosis

DSM-5 Criteria for Anorexia Nervosa:

- Restriction of intake → low body weight
- Intense fear of gaining weight
- Distorted body image

Bulimia Nervosa:

- Recurrent binge eating
- Inappropriate compensatory behaviors
- At least **once/week for 3 months**

Binge Eating Disorder:

- Loss of control during binge
- No purging
- Marked distress

Step 3: Treatment Plans

Anorexia Nervosa

Treatment Component	Notes
Nutritional rehab	Hospitalize if vitals unstable
CBT-E (enhanced)	Gold standard for long-term recovery
Family-based therapy	Especially in adolescents
Meds	SSRIs only **after weight restoration**

TDM Tip: Avoid **bupropion**—it lowers seizure threshold in malnourished patients

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Bulimia Nervosa

Treatment	Notes
CBT	First-line
Fluoxetine (high dose)	Only FDA-approved med for BN
Nutritional counseling	Normalize patterns

Binge Eating Disorder

Treatment	Notes
CBT	First-line
SSRIs	Help control binge urges
Lisdexamfetamine	Approved, especially with ADHD
Topiramate	Off-label, but may reduce binge episodes

Mock Question

A 21-year-old woman has a BMI of 16. She restricts food, weighs herself 10x/day, and believes she's fat. Vitals: HR 44, BP 80/50. What's the best next step?

A) Start fluoxetine
B) Refer for CBT
C) Begin refeeding at home
D) Admit for medical stabilization

Correct Answer: D
Why? She's medically unstable (bradycardia + hypotension) → requires hospitalization

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Fun Fact

Karen Carpenter, the famous singer, died from complications of anorexia in 1983. Her death brought national attention to the illness.

Common Mistakes in Practice and Exams

- SSRIs are **not effective** in malnourished patients
- Don't ignore **males** with eating disorders—they're underdiagnosed
- **Bulimia** patients are usually **normal weight**
- **Lanugo** (fine body hair) is a sign of severe starvation in anorexia
- Always check for **purging behavior** even if BMI is normal

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Mini Mnemonic: "FED UP" for Anorexia

F – Fear of weight gain
E – Eating restriction
D – Distorted body image
U – Underweight (BMI <18.5)
P – Physical signs (bradycardia, amenorrhea, lanugo)

Chapter 8: Insomnia

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Scene:
A 46-year-old executive sits in your office. “Doc, I’m tired all day. I lie in bed and stare at the ceiling till 3 a.m. My mind just won’t shut off.”
He’s tried warm milk, herbal teas, and even social media scrolling.
Nothing helps.

What Is Insomnia?

Insomnia is **difficulty initiating or maintaining sleep**, or waking too early, at least **3 nights per week**, for **3+ months**, and causing **distress or impairment**.

It’s not just “bad sleep”—it affects mood, focus, productivity, and health.

Types of Insomnia:

Type	Description
Sleep-onset	Trouble falling asleep
Sleep-maintenance	Frequent night waking
Early-morning	Waking too early and can’t fall back asleep

Step 1: Rule Out the Real Culprits

Insomnia isn’t always the problem—it’s often a **symptom**.

Check for:

- Depression, anxiety
- Chronic pain
- Caffeine or alcohol use
- Medications: steroids, stimulants, SSRIs, decongestants
- Sleep apnea or restless legs syndrome

- Poor sleep hygiene

Ask: What's keeping them up? Mind, body, or habits?

Step 2: Start With Non-Pharmacologic Strategies

Always first-line. Why?
Drugs help sleep… but don't fix why they can't sleep.

CBT-I (Cognitive Behavioral Therapy for Insomnia)

Gold standard. Works better than pills long-term.

Key Techniques:

- **Stimulus control** → bed = sleep only
- **Sleep restriction** → reduce time in bed to improve sleep drive
- **Relaxation training**
- **Cognitive restructuring** → challenge "I'll never fall asleep" thoughts

Refer to CBT-I specialist or use **apps** (e.g., Sleepio, CBT-i Coach)

Step 3: Medications (Short-Term or Targeted Use)

Drug Class	Examples	Key Notes
Non-benzodiazepine hypnotics	Zolpidem (Ambien), Zaleplon, Eszopiclone	Less hangover effect, risk of parasomnias
Melatonin receptor agonist	Ramelteon	Useful for older adults
Low-dose sedating antidepressants	Trazodone, Doxepin	Useful if comorbid depression
Antihistamines	Diphenhydramine, hydroxyzine	Avoid in elderly (anticholinergic burden)

Drug Class	Examples	Key Notes
Benzodiazepines	Temazepam, Lorazepam	Avoid long-term use; dependence risk

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TDM Cautions:

- Don’t use hypnotics >4 weeks without reevaluation
- Avoid benzos in elderly = ↑ falls, confusion
- Watch out for **next-day drowsiness**
- Reassess every 2–4 weeks for chronic cases

Mock Question

A 60-year-old man with insomnia sleeps only 4 hours/night. He tried CBT but stopped. He has no depression, but is worried about performance at work. What's the best short-term option?

A) Trazodone
B) Zolpidem
C) Fluoxetine
D) Diphenhydramine

Correct Answer: B
Why? Zolpidem is effective for short-term use. Avoid fluoxetine unless depression. Diphenhydramine not ideal for age.

Fun Fact

The average adult takes **7–15 minutes** to fall asleep.
If it’s less than 5? You’re probably sleep-deprived.

Red Flags in Insomnia Cases

- Daytime **impairment** or risk (e.g., falling asleep while driving)

- **Substance use** to sleep (alcohol, cannabis)
- Coexisting **mental health** conditions
- **Rebound insomnia** after stopping sleep meds
- Sleep apnea masquerading as insomnia

Mini Mnemonic: "SLEEP" for Insomnia TDM

S – Screen for causes
L – Limit time in bed
E – Evaluate impact
E – Educate on sleep hygiene
P – Pills only when necessary

Chapter 9: Obsessive-Compulsive Disorder (OCD)

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Scene:
A 28-year-old woman washes her hands 50+ times a day. She knows it's excessive, but the anxiety if she doesn't… feels unbearable.
She's late to work, exhausted, and avoiding doorknobs like they're radioactive.

What Is OCD?

OCD is a **chronic anxiety disorder** made up of two key parts:

- **Obsessions** = intrusive, unwanted thoughts or urges
- **Compulsions** = repetitive behaviors aimed at reducing distress

The behaviors are not pleasurable—they're driven by fear and anxiety.

TDM Principle: It's Not Just "Being Neat"

OCD is **distressing**, **time-consuming**, and **disabling**.
It's not just a "quirk" or "personality trait."

Step 1: Diagnose Using DSM-5

- Obsessions AND/OR compulsions
- Time-consuming (**>1 hour/day**)
- Cause distress or functional impairment
- Person may have insight (from good to poor)

Common Themes in OCD

Obsession Theme	**Common Compulsion**
Contamination	Excessive cleaning/washing
Doubt (Did I lock the door?)	Checking repeatedly
Symmetry/Order	Arranging items "just right"
Forbidden thoughts	Mental rituals, avoidance

Step 2: Rule Out Other Conditions

- **GAD**: Worry, but not repetitive rituals
- **Psychosis**: Delusions are fixed, not ego-dystonic
- **Autism**: Repetitive behaviors, but not driven by anxiety
- **OCPD**: Personality trait, not intrusive thoughts or rituals

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Step 3: First-Line Treatment

#1: CBT with Exposure and Response Prevention (ERP)

- Expose the patient to anxiety-provoking situations
- Prevent them from doing the compulsion

- Over time → anxiety decreases = **habituation**

Best long-term results
Can be delivered in person or online (many tools exist)

#2: SSRIs (Often Higher Doses than for Depression)

Drug	Starting Dose	OCD Dose Range
Fluoxetine	20 mg	Up to 80 mg/day
Sertraline	50 mg	Up to 200 mg/day
Fluvoxamine	50 mg	Up to 300 mg/day
Paroxetine	20 mg	Up to 60 mg/day

TDM Tip: Takes **10–12 weeks** (not just 4–6) to see full benefit

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Second-Line or Adjunct Options

Option	When to Use
Clomipramine	TCA with strong serotonin effect—more side effects
Antipsychotics	Augmentation in **treatment-resistant OCD**, especially with poor insight (e.g. risperidone)
Glutamate modulators	Still experimental

Mock Question

A 25-year-old man checks the stove 15 times before leaving home. He knows it's irrational, but can't stop. It's affecting his job. What's the best first-line treatment?

A) Olanzapine
B) CBT with exposure
C) Diazepam
D) Low-dose sertraline for 4 weeks

Correct Answer: B
Why? CBT with ERP is first-line. SSRIs help but require higher doses and more time. Benzos and antipsychotics aren't first-line.

Fun Fact

OCD was once classified under anxiety disorders—but in DSM-5, it got its **own category**: "Obsessive-Compulsive and Related Disorders."

Common Mistakes

- Using **too low a dose** of SSRI
- Giving up before **10–12 weeks** of treatment
- Skipping **therapy**—ERP is often more effective than meds
- Not checking for **insight**—poor insight needs more intensive intervention
- Assuming OCD = cleanliness. Nope. Some themes are taboo (e.g. sexual, religious, violent)

Mini Mnemonic: "OCD WASH"

O – Obsessions are ego-dystonic
C – Compulsions reduce distress
D – Daily life is disrupted
W – Wait longer (10–12 weeks for meds)
A – Antidepressants at high dose
S – Start with CBT-ERP
H – High recurrence if not maintained

Chapter 10: Post-Traumatic Stress Disorder (PTSD)

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Scene:
A 35-year-old combat veteran avoids crowded places. Loud noises make him jump. He hasn't slept through the night in years.
"I see it all over again when I close my eyes," he says.
His wife adds, "He's not the same person who came back."

What Is PTSD?

PTSD is a **trauma- and stressor-related disorder** triggered by **exposure to actual or threatened death, serious injury, or sexual violence.**

The trauma **sticks in the nervous system**, replaying like a broken tape, even when the threat is long gone.

DSM-5 Criteria (Must Last >1 Month)

To diagnose PTSD, you need:

Category	Example Symptoms
Intrusion	Flashbacks, nightmares, intrusive thoughts
Avoidance	Avoiding reminders, places, conversations
Negative mood/cognition	Guilt, detachment, distorted blame
Hyperarousal	Startle reflex, irritability, insomnia

Mnemonic: "TRAUMA"
T – Traumatic event
R – Re-experiencing
A – Avoidance
U – Unable to function normally
M – More than 1 month
A – Arousal ↑

Who's at Risk?

- Military veterans

- Sexual assault survivors
- First responders
- Children exposed to abuse or neglect
- Refugees, war-affected individuals

Step 1: Screen and Identify

Use tools like:

- **PCL-5 (PTSD Checklist)**
- **CAPS-5 (Clinician-Administered PTSD Scale)**

Ask about **timing**, **duration**, and **function**.

Step 2: Start with Trauma-Focused Psychotherapy

#1 Treatment: Trauma-Focused CBT or EMDR

Therapy	Notes
TF-CBT	Focuses on reframing trauma-related thoughts
EMDR	Eye Movement Desensitization and Reprocessing – shown to reduce flashbacks
Prolonged Exposure	Systematic desensitization to trauma cues

Step 3: Medications for PTSD

Use meds when:

- Therapy isn't accessible
- Symptoms are severe
- Patient prefers meds

First-Line: SSRIs and SNRIs

Drug	Notes
Sertraline	FDA-approved for PTSD
Paroxetine	FDA-approved for PTSD
Fluoxetine	Often effective
Venlafaxine	Also first-line

Avoid These:

Drug	Why?
Benzodiazepines	Worsen avoidance, ↑ dependence
Antipsychotics	Only in severe cases or comorbid psychosis
Bupropion	Not effective for PTSD core symptoms

Step 4: Target Specific Symptoms

Symptom	Drug Option
Nightmares	**Prazosin** (alpha-1 blocker)
Insomnia	Trazodone, mirtazapine
Irritability	SSRI, sometimes mood stabilizer (e.g. valproate)

Mock Question

A 30-year-old woman was assaulted 4 months ago. She reports flashbacks, avoids going out, and wakes in panic. What's the first-line treatment?

A) Prazosin
B) Diazepam
C) CBT
D) Risperidone

Correct Answer: C
Why? CBT is first-line. Meds like prazosin help symptoms but don't address the root.

Fun Fact

Only **~8%** of trauma-exposed people develop PTSD.
Protective factors?

- Strong social support
- High emotional resilience
- Early psychological intervention

Common Errors in Practice and Exams

- Jumping to medications without offering therapy
- Using benzos—this worsens long-term recovery
- Forgetting to ask about **childhood trauma**
- Missing **delayed-onset PTSD** (starts months after trauma)
- Ignoring functional impact—PTSD can cause work, relationship, and legal issues

---

Mini Mnemonic: "FEAR" for PTSD TDM

F – Flashbacks + other intrusive symptoms
E – Exposure therapy (CBT or EMDR)
A – Antidepressants if severe or no access to therapy
R – Rule out comorbidities (depression, substance use)

Chapter 11: Psychoses

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Scene:
A 22-year-old university student says, "People are watching me. I hear voices telling me I'm in danger."

His roommates say he's withdrawn, muttering to himself, and hasn't showered in days. He's convinced his lecturers are part of a plot.

What Is Psychosis?

Psychosis is a **loss of contact with reality**.
It can present with:

- **Delusions** (false, fixed beliefs)
- **Hallucinations** (perceiving things not there—often auditory)
- **Disorganized thinking or behavior**
- **Negative symptoms** (blunted affect, poverty of speech, lack of motivation)

Common Diagnoses Involving Psychosis

Diagnosis	Key Features
Schizophrenia	≥6 months of symptoms with social/occupational decline
Schizophreniform disorder	Like schizophrenia but 1–6 months duration
Brief psychotic disorder	Sudden onset, <1 month, full return to baseline
Schizoaffective disorder	Psychosis + mood symptoms, but also psychosis alone for ≥2 weeks
Bipolar or Depression with psychotic features	Psychotic symptoms only during mood episodes

---

TDM Principle: Always Rule Out Organic First

Before diagnosing primary psychosis, rule out:

- **Substance-induced**: cannabis, LSD, amphetamines, steroids
- **Medical causes**: seizures, tumors, encephalitis, lupus, HIV, vitamin deficiencies
- **Delirium**: fluctuating consciousness, acute onset, often medical

Get:

- Tox screen
- Brain imaging (if first episode or atypical signs)
- Labs (CBC, LFTs, TFTs, HIV, B12, syphilis)

Step 1: Antipsychotic Medications

First-line in nearly all cases.

First-Generation (Typical) Antipsychotics

Drug	Side Effects
Haloperidol	High EPS risk, QT prolongation

Use if rapid tranquilization is needed

Second-Generation (Atypical) Antipsychotics

Drug	Highlights
Risperidone	↑ EPS at higher doses
Olanzapine	Weight gain, metabolic syndrome
Quetiapine	Sedating, less EPS
Aripiprazole	Less metabolic risk
Clozapine	For **treatment-resistant** cases only

Step 2: Monitor Side Effects

Extrapyramidal Symptoms (EPS)

- Dystonia → hours
- Akathisia → days
- Parkinsonism → weeks

- Tardive dyskinesia → months/years

Manage with:

- Benztropine
- Propranolol
- Dose adjustments

Metabolic Monitoring (Atypicals):

Test	How Often
Weight/BMI	Baseline, monthly
Lipids, glucose	Baseline, then every 3–6 months
BP	Baseline, routinely

Step 3: Evaluate Function and Insight

- **Poor insight** = worse adherence
- Consider **depot injections** (e.g., long-acting risperidone)
- **Social support** and **psychoeducation** matter

Negative Symptoms = Hardest to Treat

No meds reliably reverse these.

Focus on:

- **Psychosocial rehab**
- **Cognitive behavioral therapy**
- **Occupational therapy**
- Long-term community support

Mock Question

A 24-year-old man reports hearing voices and believes aliens are watching him. Symptoms have been present for 2 months. No mood symptoms. He is disorganized and socially withdrawn.

A) Schizoaffective disorder
B) Schizophrenia
C) Brief psychotic disorder
D) Schizophreniform disorder

Correct Answer: D
Why? Duration is 1–6 months, no mood symptoms → fits schizophreniform disorder.

Fun Fact

"Schizophrenia" comes from Greek: *schizo* (split) and *phren* (mind)—but it has **nothing to do with multiple personalities.**

Common Mistakes

- Ignoring **substance use**
- Overlooking **negative symptoms**
- Forgetting to **monitor for EPS and metabolic side effects**
- Not recognizing **poor insight** as a barrier to treatment
- Confusing **psychosis in mood disorders** vs **primary psychotic disorders**

Mini Mnemonic: "PSYCHOSIS"

P – Positive symptoms (hallucinations, delusions)
S – Substance or medical rule-out
Y – Young adult onset common
C – Clozapine if resistant
H – Hallucinations ≠ only schizophrenia
O – Onset duration matters
S – Side effect monitoring (EPS, metabolic)
I – Insight affects adherence
S – Social recovery takes time

Chapter 12: Alcohol-Related Disorder

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Scene:
A 55-year-old man is brought to the ER by his son. He's shaky, sweaty, and irritable.
"Last drink?" you ask.
"Two days ago," the son replies.
The man suddenly begins to hallucinate. His vitals: BP 180/105, HR 120, T 38.5°C.
He's about to seize.

What Is Alcohol Use Disorder (AUD)?

It's not about how much you drink—it's **how drinking affects your life.**
AUD = **compulsive use, impaired control**, continued use despite problems.

DSM-5 Criteria for AUD

Need **2 or more** of the following in **12 months**:

- Drinking more or longer than intended
- Unsuccessful efforts to cut down
- Time spent drinking/recovering
- Cravings
- Failed responsibilities
- Relationship problems
- Giving up activities
- Using in hazardous situations
- Tolerance
- Withdrawal symptoms

Mnemonic: "CUT DOWN"

TDM Step 1: Identify and Screen

Use:

- **AUDIT-C** (3-item screener)
- **CAGE**:
    - **C**ut down?
    - **A**nnoyed by criticism?
    - **G**uilty about drinking?
    - **E**ye-opener?

Step 2: Assess for Withdrawal Risk

Symptom	Timeline After Last Drink
Tremors, anxiety	6–12 hours
Seizures	12–48 hours
Hallucinations	12–48 hours
Delirium tremens	48–96 hours → life-threatening

TDM Red Flag: Delirium Tremens (DTs)

- Autonomic instability (↑ BP, ↑ HR, fever)
- Disorientation
- Agitation, hallucinations
- Can be fatal without treatment

Step 3: Management of Withdrawal

First-Line: Benzodiazepines

Drug	Notes
Lorazepam	Short-acting, liver-safe
Diazepam	Long-acting, good coverage
Chlordiazepoxide	Classic choice for alcohol withdrawal

Give based on **CIWA-Ar** score (Clinical Institute Withdrawal Assessment)

Supportive Measures

- Thiamine before glucose (prevent **Wernicke's**)
- IV fluids, electrolytes
- Monitor vitals, hydration
- Magnesium, folate as needed

Step 4: Long-Term Management

First-Line Medications to Reduce Relapse

Drug	Mechanism	Key Points
Naltrexone	Opioid antagonist	↓ cravings, ↓ pleasure from alcohol
Acamprosate	Glutamate modulator	Maintains abstinence
Disulfiram	Aldehyde dehydrogenase inhibitor	Makes alcohol toxic (↑ acetaldehyde)

TDM Tip:

- Naltrexone = avoid in liver failure or opioids
- Acamprosate = good in liver disease (renal dosing)
- Disulfiram = highly motivated patients only

Wernicke's Encephalopathy vs Korsakoff Syndrome

Condition	Key Features
Wernicke's	Ataxia, ophthalmoplegia, confusion
Korsakoff's	Memory loss, confabulation (chronic)

Thiamine deficiency causes both → always give **before glucose**

Mock Question

A 45-year-old man is admitted for confusion, tremors, and hallucinations 3 days after quitting alcohol. What's the best next step?

A) Haloperidol
B) IV lorazepam
C) Fluoxetine
D) Naltrexone

Correct Answer: B
Why? He's likely in **delirium tremens** → benzodiazepines first.

Fun Fact

Alcohol withdrawal seizures are **one of the few** life-threatening withdrawal syndromes—unlike opioids, which feel terrible but rarely kill.

Mini Mnemonic: "SAFER DRINK" for AUD TDM

S – Screen with CAGE/AUDIT
A – Assess withdrawal risk
F – First-line: benzos for detox
E – Electrolytes, thiamine, fluids
R – Relapse prevention meds (naltrexone, etc.)
D – Don't give glucose before thiamine
R – Rule out Wernicke/Korsakoff
I – Identify triggers
N – Non-judgmental support
K – Keep follow-up and psychosocial support

Chapter 13: Opioid-Related Disorders

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Scene:
A 29-year-old man walks into the clinic, pale, sweating, and constantly yawning.
"My bones are aching, and I feel like I'm dying," he says.
He's not.
He's in **opioid withdrawal.**

What Are Opioid-Related Disorders?

Opioid use disorder (OUD) involves **loss of control**, **cravings**, **withdrawal**, and **harmful consequences** from opioids like heroin, morphine, oxycodone, fentanyl.

The issue isn't just physical—it's also deeply **psychological and behavioral.**

DSM-5 Criteria for OUD

(Same general structure as other substance use disorders)

Need **≥2** of the following in 12 months:

- Taking more than intended
- Unsuccessful efforts to cut back
- Craving
- Role failure
- Continued use despite harm
- Tolerance
- Withdrawal
- Giving up activities
- Using in risky settings
- Time spent using/recovering

- Ongoing use despite awareness of problems

Step 1: Recognize Opioid Withdrawal

TDM Tip:
Withdrawal from opioids is **not fatal**—but it **feels** horrible.
Onset depends on type of opioid.

Onset	Peak	Duration
Heroin: 6–12 hrs	24–48 hrs	Up to 5 days
Methadone: 24–48 hrs	3–5 days	Weeks

Symptoms:

- Anxiety, restlessness
- Runny nose, yawning, lacrimation
- Nausea, vomiting, diarrhea
- Muscle aches, chills, piloerection ("cold turkey")
- Dilated pupils, sweating
- **Not** life-threatening (unlike alcohol or benzos)

Step 2: Withdrawal Management

First-Line: Buprenorphine–Naloxone (Suboxone)

Component	Role
Buprenorphine	Partial opioid agonist → reduces cravings and withdrawal
Naloxone	Blocks misuse (IV use causes withdrawal)

Start when in moderate withdrawal (COWS score ≥8–12)
Starting too early = **precipitated withdrawal**

Other Options:

Drug	Role
Methadone	Full opioid agonist → for long-term therapy or supervised detox
Clonidine	Alpha-2 agonist → relieves withdrawal symptoms (but no craving control)
Loperamide	Antidiarrheal for GI symptoms
NSAIDs	For pain
Ondansetron	For nausea/vomiting

Step 3: Long-Term Maintenance Therapy

#1: Buprenorphine-Naloxone

- Office-based
- Safer in overdose
- Less regulated

#2: Methadone

- Supervised clinics
- More effective for high-dependence users
- More risk (respiratory depression)

#3: Naltrexone (Oral or IM)

- Opioid antagonist → blocks euphoric effects
- Must be **opioid-free for 7–10 days** before starting
- Best for **motivated patients** who've detoxed

Step 4: Psychosocial Support Is Key

- CBT
- Motivational interviewing

- Peer groups (e.g., NA)
- Social reintegration

Medications help, but recovery needs structure and support.

Mock Question

A 30-year-old man with heroin use wants to quit. He last used 24 hours ago and has a COWS score of 13. What is the best next step?

A) Start methadone
B) Give buprenorphine-naloxone
C) Start naltrexone
D) Wait 48 more hours

Correct Answer: B
Why? He's in moderate withdrawal. Buprenorphine is safe and effective. Naltrexone would cause withdrawal.

Fun Fact

During withdrawal, people yawn excessively.
It's so classic, some detox doctors call yawning the **"heroin hiccup."**

Common Mistakes

- Starting buprenorphine **too early** → precipitated withdrawal
- Forgetting **psychosocial support**
- Underestimating **overdose risk after abstinence** (lost tolerance)
- Using naltrexone **without full detox**
- Thinking of addiction as only willpower—it's a chronic brain condition

---

Mini Mnemonic: "WITHDRAWN" for Opioid TDM

W – Wait for withdrawal before buprenorphine
I – IM or oral naltrexone (post-detox only)
T – Taper with methadone or Suboxone
H – High-risk of relapse = long-term meds
D – Diarrhea, dilated pupils, dysphoria = classic signs
R – Respiratory depression = major risk in overdose
A – Avoid cold turkey detox at home
W – Watch for precipitated withdrawal
N – Non-medication support is essential

Chapter 14: Tobacco Use Disorder – Smoking Cessation

TDM Crash Course with Dr. Michael | SuperMedPros

Scene:
A 40-year-old man comes in for his annual checkup.
He smokes a pack a day and has "tried to quit 5 times."
"I quit for 3 months once… then stress hit, and boom—I was back," he says.
You ask, "What helped you last time?"
He replies, "Nothing really. I just went cold turkey."

What Is Tobacco Use Disorder?

A **chronic relapsing condition** characterized by **compulsive tobacco use** despite harmful consequences.
Nicotine is highly addictive—**more than heroin or cocaine.**

Quitting is hard not because smokers don't care…
But because **nicotine rewires the brain**.

Step 1: Assess Readiness

Ask every patient **two things** at every visit:

1. **"Do you smoke?"**

2. **“Would you like help to quit?”**

Use the **5 A’s** model:

Step	Description
Ask	Identify all tobacco users
Advise	Strongly urge to quit
Assess	Willingness to try
Assist	Give resources or prescriptions
Arrange	Follow-up support

Step 2: Withdrawal Symptoms

Begin **within hours**, peak at **2–3 days**, and fade over **2–4 weeks**.

Common Symptoms
Irritability, anxiety
Cravings
Poor concentration
Insomnia
Increased appetite
Low mood

Step 3: First-Line Pharmacotherapy

1. Nicotine Replacement Therapy (NRT)

Helps reduce cravings by delivering controlled doses.

Type	Use
Patches	Long-acting baseline

Type	Use
Gum/lozenges	Short-acting for urges
Nasal spray	Fastest onset
Inhaler	Mimics hand-to-mouth habit

TDM Tip:
Combine **patch + short-acting** product = most effective

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2. Bupropion SR

- Antidepressant
- Reduces cravings and withdrawal
- Start 1 week before quit date
- Helps **prevent relapse**, especially in depressed smokers

Contraindicated:

- Seizure disorder
- Eating disorders (e.g. bulimia)

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3. Varenicline (Champix/Chantix)

- **Partial nicotinic receptor agonist**
- Blocks nicotine's rewarding effects
- Start 1 week before quit date
- Best efficacy among all meds
- Warn about **vivid dreams**, **nausea**, **mood changes**

Step 4: Behavioral Support

- Counseling increases quit rates 2–3x
- Phone quitlines, support groups, mobile apps (e.g., QuitNow)

- Motivational interviewing
- Help set a **Quit Date**

Follow-up within 1 week of quit attempt is critical.

Mock Question

A 45-year-old smoker wants to quit. He's failed multiple cold turkey attempts. No depression, no seizures. What's the best option?

A) Nicotine gum only
B) Varenicline
C) Bupropion
D) Tell him to try again on his own

Correct Answer: B
Why? Varenicline has the highest quit success rate. He's a motivated candidate with no contraindications.

Fun Fact

Only **4–7%** of smokers succeed with cold turkey alone.
But **pharmacotherapy + counseling** boosts quit rates to **30–35%**.

Common Mistakes

- Using **NRT too conservatively**
- Ignoring **combination therapy**
- Not prepping patients for withdrawal
- Forgetting to **follow up**
- Skipping smoking status during routine visits

Mini Mnemonic: "QUIT NOW" for Tobacco TDM

Q – Question smoking status
U – Understand motivation
I – Initiate NRT, bupropion, or varenicline
T – Talk through triggers
N – Nausea? → watch with varenicline
O – Offer combination therapies
W – Work on follow-up and relapse prevention

Bonus Part 3: MOCK TDM EXAM + Live Coaching Commentary by Dr. Michae

🧠 **Mock TDM Exam – 10 Questions**

(Answer first, then scroll down for the feedback and breakdown)

Q1.

A 32-year-old woman with OCD spends 4 hours a day checking locks and stoves. She has insight and wants treatment. Which option is **first-line**?

A) Haloperidol
B) Clomipramine
C) CBT with exposure
D) Diazepam

Q2.

A 48-year-old man drank heavily for 10 years. He last drank 48 hours ago. Now he's agitated, tachycardic, hallucinating, and febrile. Next best step?

A) IM haloperidol
B) IV lorazepam
C) Oral naltrexone
D) Start acamprosate

Q3.

A 22-year-old university student believes people are reading his thoughts. No mood symptoms. Symptoms have lasted **3 weeks**. Most likely diagnosis?

A) Schizophrenia
B) Brief psychotic disorder
C) Schizoaffective disorder
D) Schizophreniform disorder

Q4.

A 37-year-old woman avoids driving after surviving a near-fatal crash. She has flashbacks, nightmares, and startles easily. These started **2 weeks ago.** What's the diagnosis?

A) Panic disorder
B) PTSD
C) Acute stress disorder
D) GAD

Q5.

Which of the following symptoms is **least** typical of opioid withdrawal?

A) Diarrhea
B) Dilated pupils
C) Hypertension
D) Seizures

Q6.

You're starting a patient on varenicline. What should you **warn them about**?

A) Addiction risk
B) Seizure risk
C) Vivid dreams and nausea
D) Sedation and constipation

Q7.

A patient taking fluoxetine for depression has insomnia. What's a **good add-on**?

A) Bupropion
B) Diazepam
C) Trazodone
D) Lithium

Q8.

A patient using heroin shows yawning, myalgias, and lacrimation. You plan to start buprenorphine. What's your next move?

A) Start immediately
B) Wait until COWS ≥8–12
C) Switch to methadone first
D) Give naloxone

Q9.

In treating insomnia, which is the **gold standard long-term treatment**?

A) Zolpidem
B) Trazodone
C) CBT-I
D) Diazepam

Q10.

Which of the following is true about PTSD treatment?

A) Benzodiazepines are first-line
B) CBT and SSRIs are first-line
C) Antipsychotics are most effective
D) Prazosin cures all symptoms

✅ **Dr. Michael's Breakdown and Coaching Feedback**

Q1: C) CBT with exposure

✔ **Correct.** ERP is first-line.
Clomipramine is second-line.
Haloperidol and benzos don't treat core OCD.

🧠 "You don't fight OCD with a pill alone—you train the brain."

Q2: B) IV lorazepam

✔ **Correct.**
This is **delirium tremens**—a medical emergency.
Start benzos stat.
Naltrexone or acamprosate is for post-withdrawal maintenance.

🧠 "Don't argue with the shaking ghost—treat it!"

Q3: D) Schizophreniform disorder

✔ **Correct.**
Duration = 1–6 months. No mood symptoms.
<1 month = brief psychotic.

6 months = schizophrenia.

⏳ Duration matters in psychosis. Always check the calendar.

Q4: C) Acute stress disorder

✔ **Correct.**
PTSD requires **>1 month**.
This is still acute phase.
Symptoms are identical, just earlier.

🧠 "Don't upgrade the diagnosis too soon."

Q5: D) Seizures

✔️ **Correct.**
Seizures are rare in opioid withdrawal.
Common in **alcohol or benzo** withdrawal.
All other symptoms fit opioid withdrawal perfectly.

🧠 "Opioid withdrawal is awful, not fatal. Alcohol? That's the killer."

Q6: C) Vivid dreams and nausea

✔️ **Correct.**
Varenicline often causes **vivid dreams**, nausea, and neuropsychiatric effects in some.
No abuse risk.

💭 "Tell your patients to expect weird dreams. And maybe… space chickens."

Q7: C) Trazodone

✔️ **Correct.**
It's a sedating antidepressant used **off-label** for insomnia.
Don't add bupropion—it's activating.
Diazepam = risky.
Lithium = wrong class.

😴 "Insomnia + SSRI? Trazodone is your sleepy little friend."

Q8: B) Wait until COWS ≥8–12

✔️ **Correct.**
Start too early = **precipitated withdrawal**
Always assess COWS first.

🧠 "COWS before codes. Always."

Q9: C) CBT-I

✔️ **Correct.**
CBT-I works long term.

Meds = short-term fixes.
Zolpidem and trazodone have their place, but **therapy wins** in the end.

🧠 “We’re retraining sleep, not just knocking people out.”

Q10: B) CBT and SSRIs

✔ **Correct.**
Benzos? **No.** They worsen avoidance.
Antipsychotics? **Only as adjuncts**.
Prazosin helps nightmares, not core PTSD.

🧠 “Treat the trauma, not just the symptoms.”

🎯 **Scoring Guide**

Score	Grade	Dr. Michael Says…
9–10	💥 Legend	“You’re ready to supervise interns.”
7–8	🚀 Solid	“Almost there—just review weak spots.”
5–6	⚠ Room to Grow	“Read again, slow down, take mock tests.”
≤4	📚 Redo Time	“Time for another lap. Let’s sharpen that brain.”