MSIII Psychiatry Clerkship

Survival Kit

- **Page 2 – How to Care for Your Own Well-Being**
  - This can apply to any clerkship experience

- **Pages 3-6 -- Psychiatric H&P**
  - Note content differences in comparison to other H&P's
  - Note the difference - "Formulation" vs "Diagnosis"
  - Note the DSMIV-TR 5 Axes, including GAF

- **Pages 7-9 -- Mental Status Exam**
  - Structure and Glossary of Terms
  - Absolutely critical to the psychiatric evaluation

- **Pages 10-11 -- Challenging Interview Tips**
  - Working with reluctant or over-talkative patients
  - Universally applicable to all fields of medicine

Pages 12-15 -- Difficult Patient-Doctor Interactions
Issues related to specific symptoms or personalities
Just for reference when you encounter a challenge

Page 16 – Common Psychiatric Rx Names
This is a non-exhaustive list, but a good start!

Pages 17 – Interested in Psychiatry?
Resources & Opportunities

Pages 18-19 – Careers in Psychiatry
If you can think it up, it's pretty much a possibility!

One more thing!

Take a look at Delirium Powerpoint (it is essential to rule out delirium before trying to assess and treat mental illness!)

K. A. Tacker

MS3 Clerkships:
How to Care for Your Own Well-Being

It is widely recognized that the stress associated with medical school can negatively impact academic performance, physical health, and psychological well-being. Studies show that over half of medical students report high levels of somatic distress and almost a quarter of medical students have symptoms indicative of a clinical level of depression. Evidence-based research has actually looked at which specific types of coping skills protect medical students from developing depression symptoms during their clinical clerkships and which types of coping skills aren't so helpful.

Engagement Coping Skills: (*these are the good ones!*)

- Problem-solving through attempts to eliminate sources of stress or alter the situation
- Cognitive restructuring to alter the meaning of the stressors
- Social support sought out
- Express emotions and feelings regarding the stressor

Disengagement Coping Skills: (*these..not so good***)**

- Cognitive or behavioral problem avoidance
- Wishful thinking/fantasies to distract from the stressor
- Social withdrawal by avoiding others
- Self-criticism by blaming or harshly judging oneself

Keep these in mind as you continue through your psychiatry (and future) clerkships. You may notice some of the disengagement pitfalls in yourself and others. Even if you aren't proficient with the most effective coping methods right now, it is possible to learn new coping skills! Pay attention to helping yourself and your colleagues foster the engagement techniques.

Reference:

Mosley, et al. Stress, Coping, and Well-being Among Third Year Medical Students. Academic Medicine. Vol. 69, No. 9, September 1994

PSYCHIATRIC EVALUATION H&P

ID/CC
Ms. X is a 31 year old white female with a hx of a, b, and c, (*significant hx of medical and psychiatric conditions*) who was brought in to the ED today (*by self, family/friend, police, ambulance*) due to x, y, and z (*significant symptoms, signs, behaviors, complaints, etc*).

LEGAL STATUS
(*voluntary/involuntary/under care of legal guardian…)*

CONTACTS
- Emergency Contact
- Current care providers (PCP, mental health provider, etc)
- Caseworker
- Other family, friends…

HISTORY OF PRESENT ILLNESS
- Typically try to begin with open-ended questions and empathic listening, and transition to specific, more directive questioning as needed.
- If problems have been present long-term, why did she come to ED at this particular time?
- Key areas to be sure to review include (***even*** if patient is focused on c/o one particular area):
    - Mood problems
    - Anxiety problems
    - Psychotic problems
    - Cognitive problems (memory, attention, concentration…)
    - * Safety issues (suicidal or homicidal ideation/attempts, access to weapons or means of harm)
    - Neurovegetative symptoms (appetite/weight, sleeping, energy level…)
    - Picking up on clues for possible personality disorder
    - Recent changes in ongoing treatment
    - Recent changes in social circumstances

CURRENT OUTPATIENT MEDICATIONS
- Rx, OTC, CAM/herbals/supplements
- When started?
- Indications?
- Taking at what time of day?
- Any side effects?
- Any periods of time not taking as prescribed?

ALLERGIES
- name
- reaction
- when first occurred

PAST PSYCH HISTORY
- Prior diagnoses (clarify if Dx actually given by health professional)
- SA/SI/HA/HI: (prior thoughts/ideation/plan/method of attempt/severity of attempt)
- Inpatient hospitalizations: (indication, location, length of stay)
- Residential tx: (indication, where, duration, why left…)
- Outpatient tx:
    - Provided by (PCP, psychiatrist, psychologist, SW…)
    - Psychotherapy (type, length of time, effectiveness…)
- Past Psych Rx:
    - Drug name
    - Indication
    - Duration of trial
    - Highest dose reached
    - Effectiveness
    - Side Effects
    - Adherence to regimen
- Other tx:
    - ECT, VNS, TM

PAST MEDICAL HISTORY

- Significant hx of undiagnosed medical symptoms and/or confirmed medical diagnoses
- Screen for hx of:
    - Head trauma/LOC
    - Seizures
    - Parkinson's
    - MS
    - HIV/AIDS
    - Thyroid abnormalities
    - Cancer
    - Hepatitis
    - Anemia
    - Chronic Illness or Disability
    - Toxins/heavy metal exposures
    - Delirium/Dementia

SUBSTANCE USE HISTORY

- First use, frequency, quantity, time of last use, evidence of tolerance/dependence, periods of sobriety, formal treatment, medical consequences, legal consequences
    - Caffeine
    - Tobacco
    - EtOH
    - Opiates (street or Rx)
    - Benzos
    - Cocaine
    - Meth
    - PCP
    - Rx stimulants
    - Hallucinogens
    - Ecstasy
    - Marijuana

DEVELOPMENTAL/SOCIAL HISTORY

- Pregnancy/birth
- Developmental milestones
- School/academics
- Childhood relationships (peers, etc)
- Childhood conduct/disciplinary issues
- Support System
- Family of Origin
- Romantic relationships/sexual orientation
- Violence/Abuse (perpetrator or victim)
- Marriage
- Children
- Living Situation
- Employment (longest job ever held)
- Military
- Financial
- Legal

FAMILY HISTORY

- Medical dx
- Psychiatric dx
- Substance use dx
- Psych hospitalizations
- Suicide attempts
- Psychiatric Tx's (outcome?)

ROS

Constitutional, Eyes, ENT, Cardiovascular, GI, GU, Respiratory, Musculoskeletal, Skin, Neuro, Endocrine, Heme/Lymph, Psych (if not already covered in HPI, Past Psych Hx, etc.)

PHYSICAL EXAM

- Vitals
- General, Skin, HEENT, Neck, Chest/Lungs, Breasts, Heart, Abdomen, GU, Musculoskeletal, Neuro (CN, Motor, Sensation, Gait, Coordination, Abnormal Movements)

MENTAL STATUS EXAM

- Appearance/Behavior
- Speech
- Mood/Affect
- Thought content
- Thought process
- Cognition (MMSE)
- Insight/Judgment

LABS

- Chem panel
- CBC with diff
- TSH
- UA
- UTox
- Rx levels

Consider: LFTs, Hep C, HIV, Lipids, HgA1c…(RPR, Ammonia, B12/folate, Vit D…)

STUDIES

- Consider:
  - Head CT
  - EKG
  - EEG
- Neuropsych testing
- Occupational Therapy evaluation

FORMULATION

Components to Consider:

- Biological (medical conditions/abnormal labs, substance use/exposures, genetic/family risk)
- Psychological (past life experiences/developmental issues, extent and depth of interpersonal relationships, central conflicts, transference/countertransference, psychological defenses)
- Social (stressors and supports within social context, cultural identity)
- Consider the 4 P's *(assess predisposing, precipitating, perpetuating, and protecting factors)*
- Summary of risk assessment
- Strengths of the patient
- Differential Diagnosis/Supportive evidence for working diagnosis, appropriate treatment goals, prognostic factors
- This is NOT just a simple Diagnostic Assessment with a limited focus on the current symptom(s), but rather an attempt to truly understand this patient's situation, the probable causes (potentially even rooting from childhood) of the current presentation, and hypothesis of the most appropriate treatment approach for this individual's unique circumstances.

DSM IV-TR

I. Axis I (primary psychiatric disorders, substance abuse/dependence)
II. Axis II (personality disorders, mental retardation)
III. Axis III (medical conditions, delirium)
IV. Axis IV (stressors)
V. Axis V (Global Assessment of Functioning scale – "GAF")

PLAN: (e.g., admit)

- Admit to inpatient unit, team 1
- Safety level (Involuntary? Need 1:1 observation? Any restrictions on possession of certain items? Fall risk? ...)
- Additional labs or studies
- Vitals checks (appropriate frequency per individual patient)
- Meal Order (may need special attention in delirious or severely demented patients due to aspiration risk, if on MAOI for depression they will need special dietary restriction of tyramine-rich foods)
- Continue appropriate outpatient medications
- Hold or D/C any outpatient medications that may complicate or be contributing to more acute problems (caution: possible W/D syndromes if sudden Rx D/C, especially with benzos)
- Additional appropriate PRN's (agitation, anxiety, insomnia, acute psychosis, acute mania, pain, GI distress, nicotine/etoh/drug W/D)
- Discussion with patient and team on initiating trial of new long-term psychiatric medication (antidepressant, mood stabilizer, antipsychotic…)

- ROI requests for pertinent individuals in patient's life that the patient agrees to involve in care
- Collateral info (records, outpatient or previous inpatient providers, family, friends, caseworker, parole officer, etc)
- Dispo Planning (post-discharge housing, community support system/resources, providers, financial/transport access to healthcare)

Patient's case discussed with supervising attending Psychiatrist, Dr. A., who agrees with the above assessment and plan except as noted in addendum.

MENTAL STATUS EXAM:

CATEGORY COMPONENTS
&
VOCABULARY TREASURE CHEST

When you are searching for just the right words to describe it all…

APPEARANCE

- Gender
- Ethnicity/cultural background
- Actual age/Apparent Age
    - *(patient does/does not appear stated age – older? younger?)*
- Attire
    - *(casual clothing, fashionable attire, hospital gown, worn/torn clothing, can include adornment such as jewelry)*
- Hygiene/grooming
    - *(malodorous, unkempt, disheveled, clean, make-up, hair styled, poor/fair/good/meticulous hygiene)*
- Body habitus
    - *(cachectic/skinny/slender/average, wnl BMI/stocky/overweight/obese, ecto/meso/endomorphic)*
- Posture
    - *(rigid, upright, stooped)*
- Gait
    - *(normal, staggered, lumbering, shuffling)*
- Physical abnormalities
    - *(deformities, amputations, scars)*
- Other
    - *(derm issues, hair patterns, tattoos, piercings)*

BEHAVIOR

- Movements
    - *(psychomotor agitation, fidgety, frequent positional shifting, hand-wringing, foot tapping, knee bouncing, nail biting, tremor, choreoathetoid, tics, tardive dyskinesia, extra-pyramidal symptoms, pacing, akathisia, hyperactive, compulsions habits/mannerisms, stereotypies/automatisms, repetitive purposeful/purposeless movements, psychomotor retardation/hypokinetic/bradykinetic/akinesia, catatonic*
- Interpersonal
    - *(cooperative, appropriate, solicitous, ingratiating, dramatic, flamboyant, childlike/childish, effusive, entitled, defiant, hostile, evasive, guarded, defensive, judgmental, critical, distracted, sullen, somber, subdued, withdrawn)*
- Eye contact
    - *(intense, piercing, periodic, appropriate normal range, avoidant, minimal, absent)*

SPEECH

- Quantity
  - *(verbose, talkative, normal/appropriate, paucity, poverty, mute)*

- Volume
  - *(screaming, yelling, loud, normal/appropriate, soft, mumbling, monotone, whispering)*
- Rate
  - *(pressured, rapid, fast, normal, slowed)*

- Fluency/Rhythm
  - *(fluid/fluent, clear, normal fluency, normal prosidy, staggered, staccato, stuttering, hesitant, latencies, mumbling, dys/aphasic, normal/odd inflection)*

MOOD

- Patient's Subjective Emotional State
  - *(usually this is taken directly from the patient's response to a question about how they are feeling/how they are feeling emotionally? This is a fantastic place to use quotes.*
    - *If the patient seems to be having trouble pinpointing their mood, encourage them – "if you had to describe how you are feeling in one or maybe two words, what would that be?" – helps to get them targeted on emotions vs thoughts)*

AFFECT

- Quality
  - *(sad, dysphoric, detached, despondent, suspicious, fearful, anxious, panicked, surprised, ashamed, disgusted, distressed, irritable, frustrated, angry, enraged, elevated, euphoric, giddy, surprised, happy, euthymic, pleased, content)*
- Range
  - *(narrow/restricted/constricted, wide/broad)*
- Degree
  - *(blunted, flat, la belle indifference, appropriate, responsive, exaggerated, dramatic)*
- Stability
  - *(fixed, even, labile)*
- Congruency
  - *(incongruent/congruent with any of the many other features of the MSE, particularly behavior, stated mood, or thought content)*
- Appropriateness
  - *(inappropriate/appropriate to the situation*
    - *laughing at a funny joke = appropriate*
      vs.
      laughing while you are describing your despairing depression over the loss of your spouse = inappropriate)
- Reactivity
  - *(ease of/degree to which affect is influenced by external factors)*

THOUGHT CONTENT

- Generally this will be the substance of your HPI that comes directly from the patient.
- Of particular importance:
    - *(over-valued ideas, delusions, paranoia, irrational/psychotic thoughts, thought insertion/blocking, bizarre/non-bizarre, obsessions, grandiosity, hyper-religiosity, hyper-sexuality, fears/phobias, thoughts of harm to self or others, hopefulness/hopelessness, locus of control)*
        - *PERCEPTION: hallucination, illusion, depersonalization, derealization, micropsia, macropsia, dysmegalopsia, hyperacusis, hyperaesthesia, deja vu, jamais vu*
- Patient's distress level
    - *(egodystonic, egosyntonic)*

THOUGHT PROCESS (think in terms of organization, logic, relevance, and flow)

- *Linear, goal-directed, circumstantial, tangential, flight of ideas, rambling, loose associations, thought blocking, derailment, fragmented, verbigeration, jargon, word salad, incoherent*

COGNITION

- LOC
    - *(alert, drowsy, lethargic, stuporous, sleeping, comatose, fluctuating)*
        - *one way you can never go wrong is by describing what they respond to, such as "patient awakens only to loud voice or touch…" instead of something more subjective like "sedated")*
- MMSE or equivalent
    - *(TESTING: orientation, abstraction, memory, intelligence, fund of knowledge, visuospatial functioning, verbal and written language, focus/concentration/attention, etc)*

INSIGHT

- Full
    - *(recognizes symptoms are part of illness and aware of probable outcomes of treatment vs no treatment)*
- Partial
    - *(acknowledges problems but not attributing to illness, understand others concerns but do not seem to share/believe them, despite evidence*
- Impaired
    - *(denial, lack of understanding of potential consequences of illness/courses of tx/concerns of others)*

JUDGMENT

- Is the patient making appropriate, rational behavioral decisions for their situation?
- Some people will assess judgment with questions like "what to do with a stamped envelope found on the street," but the best measure of judgment is the *patient's own recent behavior/choices* in real life.
    - *Poor, impaired, fair, good, excellent (these are a bit subjective, so it is nice to describe some examples of behavior with your qualifying term)*

References

- Robinson, D. The Mental Status Exam Explained. 2nd Edition. Rapid Psychler Press. 2005.

- The Mental Status Exam. psychclerk.bsd.uchicago.edu/mse.pdf. Accessed on September 16, 2009.

Challenging Interviews
Tips & Tricks

The average patient, particularly if new to the mental health care system, has no idea what is and is not important information for the psychiatric diagnosis. It is the job of the clinician to educate and guide the patient when needed.

The Reluctant or Quiet Patient

- **Open-ended Questions**
  - Any question that cannot be answered by a "*yes*" or "*no*" is a general guide.
  - Early on in an interview, very broad questions are often appropriate, such as:
    - *"What has been going on recently that brought you in to the ED/hospital/clinic?"*
  - If the patient is extremely limited in their responses, you may eventually have to narrow down to more specific and directed questions. But if the patient can provide information freely, it is often a wealth of useful information (vs a "checklist" diagnostic interview)

- **Open-ended Commands**
  - Basically like the questions, but more directive

- **Continuation Techniques**
  - Body Language
    - *Head nod, engaging eye contact (patient specific – may not be best for the paranoid patient), facial emotional expression*
    - *Keep it spontaneous and genuine!*
  - Verbal
    - *Can you tell me more about that?*
    - *Tell me more about that.*
    - *Go on.*
    - *Please continue.*
    - *Can you explain that to me in more detail?*
    - *What was that like for you?*
    - *Really?*
    - *Wow!*

- **Neutral Ground**
  - Sometimes patients can feel embarrassed or threatened when asked about mental illness. Try shifting to a non-psychiatric area for a while to build rapport and comfort
    - *(Fundamentals of social history, hobbies, work, medical history or physical ROS, factual things such as medication list, etc).*
  - Then see if you can find a segue into sensitively touching on mental health issues again.

- **The 2nd Interview**
    - If you are running in circles and not effectively getting yourself or the patient anywhere, take a break and make plans to meet again – later in the day, tomorrow, next week – depending on the clinical context.
    - The fact that you accept their reluctance may actually comfort them and allow them to open up a bit more on the next round.
    - **Remember to keep safety in mind when ending the 1st interview!**

The Over-talkative Patient

- **Closed-ended & Multiple Choice Questions**
    - Seek brief "*yes*" or "*no*" replies
    - Short answer Questions
        - *"How many hours of sleep do you get per night?" vs "How have you been sleeping?"*
    - Multiple Choice REALLY gives limits (just use caution in using leading choices – we still need info to come from the patient's own life experience or perspective!)
        - Most research shows the multiple choice questions, in general, are low risk for biasing your patients)
    - CAUTION: some patients will feel alienated by these closed-ended and MC questions. Sprinkle them here or there in the interview if possible – be judicious with them.

- **Gentle Interruption & Redirection**
    - You may feel rude – but you are not helping the patient unless you can effectively get your job done
    - Sensitive methods:
        - Empathic:
            - *"Wow, all of this sounds really distressing. Tell me, have you been doing anything in particular to cope with it all, like turning to alcohol or drugs?"*
        - Delaying:
            - *"That sounds pretty intense. I'd like to come back to that and explore it more later, but let me ask you a few other specific things first…"*
        - Educating:
            - *"We have about 20 minutes left and there are some things important to your situation that I think will be critical for us to cover so that I can help you as much as possible, such as your prior psychiatric history, medical history, family history, and then some time at the end to let us talk about a treatment plan. So for this last 20 minutes of our time together, I will ask you some really direct questions so we can try to cover it all.*
            - Or some more narrow, specific version of the above

References

- Carlat, D. The Psychiatric Interview, 2nd Edition. Lippincott Williams & Wilkins, Philadelphia, PA. 2005.

DIFFICULT PATIENT-DOCTOR INTERACTIONS

Whenever you are feeling "stuck"

** Acknowledge there is a problem*
** Try to understand exactly what the problem is*
** Remain calm*
** Address the problem with appropriate techniques*

(Simple as that, huh?...)

ISSUES OF INTERACTION STYLE

- **Dependent/Demanding**
  - Patient striving to impress clinician with urgency of needs
  - Need special attention, expect lots of it, and require a lot of reassurance
  - Often the "compliant, good patient"
  - You are made to feel the hero…and then either driven to exhaustion or punished for not meeting 100% of expectations
  - <u>WHAT TO DO</u>: set limits
    - Give written instructions
    - Verbalize boundaries on phone calls and Rx refills
    - Don't fall into the trap of promising to solve problems when it is either not an appropriate responsibility for you and/or you cannot keep the promise
    - Emphasize patient responsibility
      - *"It is important that you understand your illness… It is important that you change your eating/sleeping/exercise habits… Treatments A, B, and C will not work unless you follow through with them…"*
    - Remind the patient that the time available from the provider unfortunately does not always match up with the provider's interest or level of concern
    - Do not take credit for recovery – emphasize the patient's role in the success of the treatment – otherwise you also will risk being blamed for relapse

- **Controlling**
  - Sickness = loss of control
  - Identify with scientific process/theory
  - Attention to detail with history-taking and treatment compliance
  - <u>WHAT TO DO</u>: Help relieve their anxiety
    - Allow them control of medical care and provide positive reinforcement for their efforts
    - Provide ample explanation of what you are doing, why, and what is coming up next
    - Explain each symptom, sign, lab test, physical exam maneuver, dx, and tx component in detail
    - No loose ends
      - *"Is there anything else I can explain?"*
    - Summarize frequently
    - Taking notes may help the patient feel that all information is being heard and considered
    - Do not mention vague hypotheses, etc. If you do not know something, say so and then outline the plan to find out

- **Dramatic/Manipulative/Histrionic**
    - Illness = drama, need to be center of attention, and frustrated when your attention is elsewhere
    - Patient possibly, on some level, views illness as a personal defect/weakness
    - WHAT TO DO: get beyond the dramatics
        - Identify what the patient gains with this behavior
        - Calm, gentle, firm – understand your own boundaries
        - Frequently summarize the patient's story
        - Avoid judgmental statements/questions to the patient, focus on ***how*** the patient is behaving and not ***why*** they are behaving that way
        - Identify the patient's strengths and give feedback on this

- **Masochistic**
    - Often help-rejecting
    - Life = never-ending bad luck
    - May disregard own needs in order to help others
    - WHAT TO DO: don't blow off the patient's expressed pessimism, help validate their feelings and then work to help them see a balanced view
        - Do not be overly optimistic or cheerful
        - Don't focus solely on the patient's strengths
        - Don't patronize
        - They need to feel ***heard***

- **Guarded/Paranoid**
    - Suspicious of medical system/providers, may focus on negative prior experiences
    - Suspicion increases in times of distress (exacerbation of unhealthy coping mechanism)
    - WHAT TO DO: do not contradict/argue with patient, but focus on clarifying what you CAN do to help in the current situation
        - Remain friendly/courteous
        - Give clear explanations
        - Explain your role and clarify its limits
        - Acknowledge the patient's feelings
            - *"It must be frustrating not knowing what is going on…"*
        - Clarify your understanding of the patient's beliefs while indicating you do not necessarily agree
- **Superior**
    - May appear smug, vain, or grandiose
    - Sense of entitlement
    - May demand the "best of the best"
    - May attempt to control clinician (demands/litigation threats)
    - Easy to become angry or hostile
    - May be more prone to this when under duress (ie, from illness)
    - WHAT TO DO:
        - Acknowledge patient's point of view
        - Avoid arguing
        - Focus on how you might help in the ways you are able

SOMATIZATION

- **Nature of Somatization**
  - Expression of psychological distress or emotional discomfort via physical symptoms (not consciously doing so – SOMATIZATION IS NOT FACTITIOUS OR MALINGERING)
  - Symptoms or dysfunction not ***completely*** accounted for by organic evidence
  - Often long repeated history of many work-ups with many providers and no effective outcome
  - Often use much sick leave and disability, consume lots of clinic time, difficult to interview, and appropriate dx of somatoform d/o requires thorough review of history
  - Medical system may actually inadvertently be creating positive feedback loop to promote the patient's thought process and behavior

- **Characteristics of Patients with Somatic Focus**
  - Vague, inconsistent, bizarre symptom descriptions
  - Symptoms persist despite seemingly appropriate treatment
  - Onset is in context of psychologically meaningful situation
  - Patient denies emotional distress or psychological etiology
  - Poly-doctoring/surgery common
  - Evidence of an associated psychiatric disorder common
  - Features of hysterical personality style
  - Idiosyncratic meaning attributed to symptoms by the patient
  - Difficulty describing emotions or internal emotional experiences in words

- **Somatization in the Interview**
  - WHAT TO DO: Build trusting relationship and validate suffering through good listening and responding
    - Include some "healthy talk" in all encounters
    - Regular frequent visits (trying to replace abundance of spontaneous "crisis" care with regular maintenance care – more efficient and cost-effective)
    - Initial Assessment should be complete despite patient's obsession with specific symptoms or illness concerns
    - Try to create timeline of PMHx
    - Do not avoid regular maintenance care or standard screening tests for fear of encouraging the patient's behavior, just do not do unnecessary testing based solely on patient's persistent belief – action should be based on evidence
    - Work with the patient to prioritize concerns
    - Educate the patient on mind-body connection (ie, physical parameters of autonomic nervous system tied to anxiety states, etc)

DIFFICULT FEELINGS

- **Anxiety**
  - Illness creates feelings of helplessness, fear of pain/disability/death, uncertainty
  - Can provoke anger (or unhealthy coping mechanisms)
  - Facial flushing, sweating, rapid speech, fidgeting, trembling
  - WHAT TO DO: acknowledge the feelings and work together to proceed with interview in tolerable manner
    - Remain calm and unhurried
    - Sympathize (but not so extremely that it magnifies the patient's greatest fears)
    - Be specific in instructing the patient what to do
    - Give explanations as you proceed through various components of the H&P process

        - Normalize the anxious feeling

- **Anger**
    - Although taken out on the physician, often the source of anger is related to other aspects of the patient's situation
    - Anger may actually be masking a depression
    - WHAT TO DO: acknowledge the anger and help the patient cope
        - Validate the fact that the patient is struggling with these negative feelings (do not have to agree with the logic behind the feelings though)
        - Explore contributing factors, including underlying feelings of helplessness, disappointment, fear, etc
        - If anger directed toward you, do not get defensive
        - Help patient recognize healthy methods to cope

- **Depression/Suicide**
    - The patient may need extra time to answer questions about suicidal thoughts or attempts
        - *Do you get pretty discouraged?*
        - *What do you see for yourself in the future?*
        - *Have you had thoughts either recently or even in the past about harming or killing yourself?*
        - *Have you ever gotten to the point of coming up with a plan of how you might hurt/kill yourself?*
        - *Are you currently having thoughts of hurting or killing yourself?*

- **Denial**
    - Can lead to serious delays in care, but also may be an important acute coping mechanism, so approach with care
    - WHAT TO DO:
        - Gently explore the patient's knowledge and understanding of the situation
        - Offer clear explanations about probable outcomes

PHYSICIANS HAVE FEELINGS TOO!

- Develop strategies to enhance your own coping skills.
    - Recognize your own counter-transference
    - Give yourself some space/time briefly if needed
    - Plan ahead for patients who you know have a history of eliciting strong emotional responses in you
    - Share your feelings with supportive colleagues on a regular basis
    - Over time find ways to sensitively share some of your feelings with the patient when it has potential for improving the relationship, and therefore patient care

References

- Coulehan J, Block M. The Medical Interview: Mastering Skills for Clinical Practice, 5th Edition. F. A. Davis Company, Philadelphia. 2006

JUST GETTING THE MAIN Rx NAMES DOWN…

ANTIDEPRESSANTS

SSRI:
- Fluoxetine (Prozac)
- Citalopram (Celexa)
- Escitalopram (Lexapro)
- Sertraline (Zoloft)
- Paroxetine (Paxil)
- Fluvoxamine (Luvox)

SNRI:
- Duloxetine (Cymbalta)
- Venlafaxine (Effexor)
- Desvenlafaxine (Pristiq)

OTHER:
- Mirtazapine (Remeron)
- Bupropion (Wellbutrin)
- Buspirone (Buspar)

TCA:
- Amitriptyline (Elavil)
- Nortriptyline (Pamelor)
- Many others…

MAOI:
- Phenalzine (Nardil)
- Many others…

MOOD STABILIZERS

- Lithium (Lithobid, Eskalith)
- Lamotrigine (Lamictal)
- Valproic Acid/Divalproex (Depakene/Depakote)
- Carbamazepine (Tegretol)
- Oxcarbazepine (Trileptal)
- Antipsychotics (particularly for managing acute severe manic symptoms)

ANXIOLYTICS

1st LINE:
- SSRI/SNRI

BENZODIAZEPINE:
- Lorazepam (Ativan)
- Clonazepam (Klonopin)
- Diazepam (Valium)
- Chlordiazepoxide (Librium)
- Alprazolam (Xanax)
- Temazepam (Restoril) - hypnotic

NON-BENZODIAZEPINE:
- Buspirone (Buspar)
- Hydroxyzine (Vistaril)
- Diphenhydramine (Benadryl)

ANTIPSYCHOTICS

ATYPICALS
- Clozapine (Clozaril)
- Risperidone (Risperdal)
- Olanzapine (Zyprexa)
- Quetiapine (Seroquel)
- Ziprasidone (Geodon)
- Aripiprazole (Abilify)

TYPICALS
- Haloperidol (Haldol)
- Perphenazine (Trilafon)
- Fluphenazine (Prolixin)
- Chlorpromazine (Thorazine)
- Many others…

Interested in Psychiatry?

ONLINE RESOURCES

- **Psychiatry Online**
  - www.psychiatryonline.org
  - This website has TONS of information and resources, including entire digital textbooks on psychiatry, neuroscience, psychopharmacology, etc.
  - Can be accessed through OHSU library server (otherwise requires login and password)

ORGANIZATIONS:

- **American Psychiatric Association**
  - http://www.psych.org/
  - Abundance of on-line resources, Practice Guidelines, discussion on national mental health issues, National Conferences
- **Oregon Psychiatric Association**
  - http://www.orpsych.org/
  - Opportunities for state-level Subspecialty and Legislative Committee involvement, Regional and State-level Conferences
- **Oregon Psychoanalytic Center**
  - http://www.oregonpsychoanalytic.org/
  - Psychoanalytic Training Program, Continuing Education Courses, Arts on the Couch program

OHSU CONTACTS:

- **Medical Student Education in Psychiatry** (psych@ohsu.edu)
  - James Boehnlein -- Director
  - Marian Fireman – Clerkship Director
  - Kat Tacker – Assistant Professor

- **Psychiatry Residency Training Program** (psych@ohsu.edu)
  - Mark Kinzie – Training Director
  - Abby Schwalb – Education and Training Manager

- **Chief Psychiatry Residents** (psychief@ohsu.edu)

OHSU OPPORTUNITIES

- **Medical Student Psychiatry Interest Group**
  - James Boehnlein – faculty chair (boehnlei@ohsu.edu)

- **MS4 Elective Rotations**
  - Community Psychiatry
  - Geropsychiatry
  - Inpatient Psychiatry
  - Consult-Liaison Psychiatry
  - Intercultural Psychiatric Program

- **Psychiatry Grand Rounds**
  - Location: 8B60, 8th Floor Main Hospital
  - 1st, 3rd, and 4th Tuesdays of the month, 12pm-1pm
  - http://www.ohsu.edu/psychiatry/grandrounds/

Careers in Psychiatry

It is overwhelming to attempt to concisely describe a career in psychiatry. There are so many dramatically different paths a person can take after completing training. Psychiatry has always been a rich exploration of the human condition on the most personal level, but this has expanded in numerous ways even just over the past decade in the context of significant advances in neurobiological research, imaging, psychopharmacology, continuing research in psychotherapy methods, other novel forms of treatment, and persistent social and political advocacy for the mental health needs of patients. These socioeconomic and political aspects of the field remain a very intriguing area of activity locally and globally with considerable ethical implications. With so many diverse and far-reaching applications, a psychiatrist can create virtually any career imaginable.

Benefits:

- One of the few remaining fields of healthcare that allows you to treat the whole person – making use of both scientific medical training and the interpersonal skills that allow us to connect with one another
- Incredible flexibility in work hours
- Incredible flexibility in work settings
- Incredible flexibility in patient populations
- Ranging from solo private practice to working with an extensive multidisciplinary team
- Job security due to significant need for more mental healthcare providers virtually everywhere in the country (and certainly internationally)
- Excellent compensation (annual salaries frequently range from $173,800 to $248,198 per 2008 Physician Compensation Survey – plus enough free time to enjoy putting that money to use!)
- Recent improvements in parity legislation
- More interactive face to face patient time compared to other medical fields
- Career paths range from neurochemistry bench research to pure psychoanalysis What lies in between those poles is far too great to adequately describe in an overview handout
- Even within the world of psychotherapy, there is a very diverse array of methods with significantly different philosophies and approaches

Challenges:

- Social stigma of mental illness
- Too often there is limited coverage and few resources for the underserved mentally ill (although this is beginning to show evidence of change)
- Stigma within the healthcare system downplays the importance of mental health, and despite phenomenal advances in research *and* treatment effectiveness rates that rival or even surpass those in many other fields of medicine, psychiatry is labeled by some as a "soft science"
- Longer training process than general primary care training (minimum 4 years for general training, up to 2 additional years for subspecialty child/adolescent training, and an additional year for any other subspecialty training)
- Unknown potential impact on psychiatrists related to legislation in some areas for psychologists with supplemental training to prescribe some psychotropic medications (although ophthalmologists and anesthesiologists, who have similar situations of competition, have not appeared to suffer any deleterious impact)

Subspecialties Beyond General Adult Psychiatry:

- Addiction Psychiatry
- Child and Adolescent Psychiatry
- Clinical Neurophysiology
- Forensic Psychiatry
- Geriatric Psychiatry
- Hospice and Palliative Medicine
- Pain Management
- Psychosomatic Medicine
- Sleep Medicine

Other Non-Clinical Roles:

- Academic Research
- Academic Education/Teaching Role
- Administration
- Politics/Legislation Development

Let us know how we can further help you explore the world of Psychiatry!