CLUES YOU MAY HAVE A PSYCHIATRY OSCE STATION

- Patient has a psychiatric chief complaint in the case stem (e.g. psychotic, manic, bizarre behavior, depressed, anxious, suicidal, homicidal, agitated, abuse, etc)
- Patient is "medically cleared" (eg all normal investigations) in the case stem or question period
- Patient has a "medical" chief complaint but little on their medical HPI/PMHx and a rich SHx

COMPONENTS OF PSYCHIATRIC INTERVIEW

- **Wash hands, introduce** yourself
- Subjective history
    - **ID** (name, age, sex, marital status, dependents, housing, employment status) and chief complaint **(CC)**
    - History of presenting illness **(HPI)** including
        - **Psychiatric review of systems (psychosis, mania, depression, anxiety including trauma, suicidal/self-harm/homicidal ideation, substance use)**
        - **FIFE (level of functioning, ideas on what they have, fears of what they may have, expectations for care)**
    - Past psychiatric and medical history **(PψHx/PMHx)**
    - **Medications and allergies**
    - Family psychiatric history **(FψHx)**
    - Social history (**SHx**; "PHEADS")
        - **P**regnancy/delivery complications, developmental history
        - **H**ome life, childhood growing up including traumatic events
        - **E**ducation and employment
        - **A**ctivities (hobbies, legal involvement)
        - **D**rugs (recreational)
        - **S**exual history, social supports
- Mental status examination **(MSE)**

SAMPLE SCREENING QUESTIONS FOR PSYCHIATRIC ROS

- Mood (depression/mania)
    - In general: "How is your mood? How would you rate your mood from 0 to 10?"
    - For depression: "Do you feel sad/depressed/like crying most of the time? Do you still enjoy things as much as you used to?"
    - For mania: "Have you ever felt the opposite of depressed where you are too happy for your own good?"
- Anxiety and related disorders
    - For anxiety: "Is worry a problem / do you describe yourself as a worrier?" If yes = "What do you worry about?"
    - For obsessions: "Do you have any bothersome thoughts, images, or urges that repeatedly pop into your head no matter what you do?"
    - For trauma: "Have you ever experienced a traumatic event in your life?" If yes = "How does that still impact you today, if at all?" (incorporate empathy as this is a sensitive topic!)

- Psychosis
    - For delusions: "Do you worry that other people are out to hurt you/get you?" → If yes, confirm this is a delusion by checking if belief is
        - False (ie misinterpreting reality): "How do you know this is happening?"
        - Fixed (ie held firmly): "How convinced are you that this is actually happening?"
    - For hallucinations: "Do you hear things that other people don't hear? See things that other people don't see?" If patient appears distracted during interview, point it out to patient and ask why (e.g. "I noticed you look distracted. I wonder what's going on?")
- Safety
    - For SI: "Do you feel that life isn't worth living anymore?" → If yes, ask about:
        - Plans: "What would be your plan to hurt yourself (method, time, location)?"
        - Passive vs active intent: "How close have you acted on these thoughts / how likely do you think you'll act on these thoughts?"
        - Access to weapons: "Do you have any access to medications you can overdose on? Guns? Things you want to hang yourself with?"
        - Future orientation: "What would you be doing the rest of this week?"
        - Protective factors: "What stops you from hurting yourself?"
        - Previous suicide attempts: "Have you ever tried to end your life before?" → If yes: "What happened? What was your intent at the time? Did you get any help afterwards? How do you feel about surviving?"
    - For self-harm ideation: "Do you have thoughts of wanting to hurt yourself?" → If yes, similar follow-up questions to suicidal ideation
    - For homicidal ideation: "Do you have thoughts of wanting to hurt other people?" → If yes, ask about
        - Target: "Who do you have thoughts about hurting?"
        - Plan: "How would you hurt them?"
        - Intent: "How likely do you think you would act on these thoughts?"
        - Access to weapons: "Do you have access to weapons?"
        - Protective factors: "What stops you from acting on these thoughts?"
        - Previous aggression: "Have you ever tried to physically hurt someone before?" → If yes, "What happened?"
- Substances
    - For substance use: "How much caffeine do you normally drink? Energy drinks? Do you smoke cigarettes? Anything else like marijuana? How much alcohol do you normally drink? What street drugs have you used, even once, in your life, if any? Ever touched any needle drugs?" → If yes, screen for substance use disorder e.g. with "CAGE" questionnaire (originally designed to screen for alcohol use disorder but also good for other substance use disorders; positive if yes to 1+/4 in females, 2+/4 in males)
        - "Do you feel like you should **C**ut down on your drinking?"
        - "Do you feel **A**nnoyed when other people comment on your drinking?"
        - "Do you feel **G**uilty or bad about your drinking?"
        - **E**ye opener: "Do you drink first thing in the morning to get rid of a hangover?"

INTERVIEW TIPS

- Build rapport with the patient
    - Try to make the patient comfortable as possible (e.g. ensuring privacy)
    - Use open body language (keep your arms/legs uncrossed, keep good eye contact)
- Start with open ended questions then closed ended questions
    - Avoid complex medical terms
    - Avoid stacking or leading questions
    - Follow-up on vague or unclear answers
- Demonstrate active listening verbally (e.g. summarizing patient's responses) and non-verbally (e.g. nodding head)
- Try to include all components of your psychiatric history, including all 6 components of your psychiatric review of systems as it can drastically change your DDx and management plan!
- It is important you know the key clinical features of each psychiatric diagnosis as it will allow you to use your critical thinking skills more effectively

COMPONENTS OF MENTAL STATUS EXAMINATION (MSE)

- The mental status exam (MSE) is your objective assessment of the patient's mental state (ie cognition, perception, thinking, feelings, and behavior)

MNEUMONICS

- "ASEPTIC" = **A**ppearance and behavior (and cooperation/reliability), **S**peech, **E**motions (mood and affect), **P**erceptions, **T**hought process and content, **I**nsight and judgment, **C**ognition
- "ABC STAMP LICKER" **= A**ppearance, **B**ehavior, **C**ooperation, **S**peech, **T**hought process and content, **A**ffect, **M**ood, **P**erception, **L**evel of consciousness, **I**nsight, **C**ognition, **K**nowledge fund/base, **E**ndings (suicidal, homicidal), **R**eliability

APPEARANCE

- Appearance is a description of how the patient looks like
- Example description: "Patient is a *[ethnicity] [fe/male]* appearing *[their/younger than their/older than their]* stated age and of *[average/slim/overweight etc]* body habitus and *[average/short/ tall etc]* stature. S/he has *[special features eg heavy make-up, hairstyle, glasses, tattoos, piercings, etc]* and is dressed in *[clothing]* with *[appropriate/poor]* grooming and hygiene *[and special details about grooming/hygiene e.g. is malodourous, dirty fingernails, etc]*."

BEHAVIOR

- Behavior is a description of what the patient is doing throughout the interview and notes any **psychomotor retardation/agitation** and movement abnormalities
- Example descriptions
    - "Patient is sitting throughout the interview with no psychomotor disturbances noted."
    - "Patient was pacing around the room but stopped to pray on the floor occasionally."
    - "Psychomotor retardation was noted as patient walked and moved slowly."

COOPERATION AND RELIABILITY

- Cooperation refers to patient's willingness to participate in interview
- Reliability refers to the accuracy of subjective information provided by patient
- Example description. "Patient was *[cooperative/guarded/refused to speak]* and *[un/reliable historian vs in/consistent throughout the interview vs noted to minimize/exaggerate specific parts of interview, etc]*

SPEECH

- Speech describes the **spontaneity, rate, volume,** and **rhythm** of what the patient is saying
- Example descriptions
    - "Speech was unremarkable"
    - "Patient's speech was pressured, difficult to redirect, and loud."
    - "Patient *[demonstrated poverty of speech vs spoke in one-worded sentences vs demonstrated speech latency]* and spoke in a quiet, slow, monotonous voice."

EMOTIONS (MOOD AND AFFECT)

- Mood is the patient's subjective description of their emotional state
- Affect is an objective description of the patient's emotional state, which includes the following components (can use mnemonic "TRAIL" to remember):
    - **T**one (main emotional state)
    - **R**ange (capacity of patient to express a variety of emotions)
        - From least to most severe: Full > restricted > blunt > flat affect
    - **A**ppropriateness (congruence of affect to patient's stated mood and context)
    - **I**ntensity (severity of patient's affect)
    - **L**ability (how quickly patient shifts from one emotional state to the next)
- Example description: "Patient's mood was *[quote patient's mood eg "happy", "anxious", "terrible", etc]* and their affect *[in/congruently] [tone e.g. euthymic (normal)/dysthymic (sad)/abnormally euphoric/anxious/irritable]* of *[low/moderate/high]* intensity and *[full/restricted/blunt/flat]* range and *[no lability noted vs labile with periods of tearfulness when discussing topic, etc]*.

PERCEPTIONS

- Perceptions refer the presence of
    - **Hallucinations** (sensory perceptions in the absence of external stimuli) vs **illusions** (misperception of a real external stimuli)
    - Dissociation ie **derealization** (feeling disconnected from one's own body) vs **depersonalization** (feeling disconnected from external environment)
- Sample screening questions
    - For hallucinations = see "Sample Screening Questions for Psychiatric ROS"
    - For dissociation: "Do you ever feel disconnected from your own body? Do you ever feel like the world around you isn't real?"
- Tip: Non-auditory hallucinations are often a red flag for secondary psychosis
- Example descriptions

- "Patient denies perceptual disturbances and is not seen responding to internal stimuli"
- "Patient endorses derealization and auditory hallucinations. Patient was seen talking to him/herself prior to interview and was notably distracted throughout the interview."

THOUGHT PROCESS (AKA THOUGHT FORM)

- Thought process describes how the patient flows from one topic to another
- From least to most severe
  - **Linear/goal-directed** (patient directly answers question; variant of normal)
  - **Circumstantial** (includes unnecessary details but ultimately answers your question directly; variant of normal, can be seen in anxious patients)
  - **Flight of ideas** (rapid and frequent shifts between thoughts/ideas (more severe compared to tangential thought form) that are marginally connected eg by double meaning, rhyming, etc; commonly associated with mania)
    - Clang association (type of thought disorder where patient connects topics based on similar sounds)
  - **Disorganized/loose associations** (type of thought disorder where no meaningful connection exists between topics; commonly associated with psychosis)
    - **Tangential** (type of thought disorder where flow of ideas are connected but ultimately does not answer question)
    - Thought blocking (sudden involuntary stopping of thought and speech, where patient is often not aware of same; commonly associated with psychosis)
    - Word salad (severe form of loose association to the point patient loses proper sentence structure; commonly associated with psychosis)
- Tips
  - Starting with an open-ended question and allowing the patient to speak for a couple of minutes will allow you to assess their thought form
  - If a thought disorder (abnormal thought process) is present, try to provide direct quotes as examples in your MSE
- Example description: "Patient's thought process was overall circumstantial, but at times had flight of ideas with clang association e.g. 'My mood is good because I should like food.'"

THOUGHT CONTENT

- Thought content is a description of what the patient is saying, which includes screening for pertinent positives/negatives including
  - **Suicidal ideation (SI), self-harm, and homicidal ideation (HI)**
  - **Delusions** (fixed false beliefs that are held firmly despite indisputable evidence to the contrary and deviates markedly from cultural/religious norms; most common delusion is persecutory delusion (paranoia)) **vs ideation** (subthreshold delusions)
  - **Obsessions** (recurrent and persistent thoughts/images/urges that was once viewed as intrusive/unwanted and causes marked anxiety/distress in most individuals, that leads to individual attempting to ignore/suppress these thoughts/images/urges or neutralize them with a thought/action (ie compulsion))
- Example descriptions

- "Thought content aligned with interview questions. Patient denied suicidal/self-harm/homicidal ideation. No evidence of delusions or obsessions."
- "Thought content evident for themes of hopelessness and poor self-esteem. Patient endorsed suicidal ideation with plans to overdose on acetaminophen. High intent to act on same, has been stockpiling medications at home. Limited future orientation and protective factors. Patient endorses multiple previous suicide attempts via overdose and self-harm via cutting. Currently denies self-harm and homicidal ideation. Patient endorses persecutory delusions that her neighbors have been breaking into her house and stealing her food."

INSIGHT AND JUDGEMENT

- Insight is the patient's level of self-awareness about their own illness/situation
- Judgment is the patient's ability to make rational/reasonable decisions based on relevant facts
- Sample screening questions (can be screened for at various points in the interview)
  - For insight: "What brings you here today? Do you think you have a mental illness? Do you have a history of mental illness? Do you agree with your [previous diagnoses]? What do you take your medications for?""
  - For judgment: "Do you think you need to be here with the doctor today? Do you think you need your medications?"
- Example description: "Patient has [good/partial/poor] insight and judgment"

COGNITION

- Cognition is a description of the patient's thinking abilities, which can include commenting on patient's level of consciousness, orientation, attention, intelligence level, and other cognitive functions (memory, executive function, visuospatial function, language, etc)
- Sample screening questions
  - For orientation: "What's your name? What is the name of this building? What day is it?"
  - For inattention: "Can you count the months / spell WORLD backwards? Can you subtract 7 from 100 and keep on subtracting 7 until I tell you to stop?"
  - Complete cognitive screening test (eg Mini-Mental Status Exam (MMSE) or Montreal Cognitive Assessment (MoCA))
- Example descriptions
  - "Cognition appears grossly intact but not formally assessed"
  - "Patient was drowsy and only oriented to person and place. Patient was able to recite months backwards."

CONSTRUCTING YOUR DIFFERENTIAL DIAGNOSIS

Remember the diagnostic hierarchy!

- Rule out medical causes (ie medications, substances, medical conditions) first...
- …then rule out primary psychiatric disorders in the following order
  1. Primary psychotic disorders
  2. Primary bipolar and related disorders
  3. Primary depressive disorders

4. Primary anxiety and related disorders
5. Other primary psychiatric disorders & personality disorders
6. Adjustment disorder

★ Note that all primary psychiatric disorders must
1. Not be better explained by a medical cause AND
2. Cause clinically significant distress or functional impairment

KEY CLINICAL FEATURES OF SUBSTANCE USE DISORDERS (aka "addictions")

- "4 C's of addiction" = **C**ravings to use, **C**ompulsions to use, use despite negative **C**onsequences (on health, relationships, employment, legal, etc), loss of **C**ontrol of amount/frequency of use

KEY CLINICAL FEATURES OF PRIMARY PSYCHOTIC DISORDERS

- Schizophrenia = continuous psychotic symptoms (ie prodromal, active, and/or residual symptoms of psychosis) for at least 6 months, which includes at least 2/5 of the following psychotic symptoms x 1 month (1 symptom must be either hallucinations, delusions, or disorganized speech):
  - Delusions
  - Hallucinations
  - Disorganized speech
  - Grossly disorganized or catatonic behavior
  - Negative symptoms (e.g. flat affect, avolition, poverty of speech)
- Brief psychotic episode = similar to schizophrenia but duration $\geq$ 1 day but < 1 mo
- Schizophreniform disorder = similar to schizophrenia but duration $\geq$ 1 mo but < 6 mo
- Delusional disorder = isolated delusions for at least 1 mo (ie no other psychotic symptoms)
- Schizoaffective disorder = 2+ weeks isolated psychotic symptoms + mood episode present for majority of duration of psychotic illness

KEY CLINICAL FEATURES OF PRIMARY MOOD DISORDERS

Mood episodes (ie major depressive episode, manic episode, hypomanic episodes) are syndromes of specific mood symptoms but are not diagnoses in themselves! Rather, different combinations of mood episodes +/- other psychiatric symptoms create different psychiatric diagnoses.

- Major depressive episode (MDE) = 2+ week period of 5+/9 "SIGMECAPS" criteria (1 symptom must either low mood or anhedonia)
  - **S** = altered sleep, either increased (hypersomnia) or decreased (insomnia)
  - **I** = loss of interest/pleasure in previous activities (anhedonia) most of the day, nearly every day
  - **G** = feelings of excessive guilt or worthlessness
  - **M** = low mood most of the day, nearly every day (may be irritable in pediatrics)
  - **E** = low energy
  - **C** = poor concentration
  - **A** = change in appetite and/or weight, either increased or decreased
  - **P** = psychomotor retardation or agitation
  - **S** = suicidal ideation

- Manic episode = 1+ week (or shorter if hospitalized) of abnormally elevated, irritable, or expansive mood with abnormally increased energy/goal-directed activity, accompanied with 3+/7 (4+/7 if irritable mood) "DIGFAST" criteria
    - **D** = distractibility
    - **I** = impulsivity in high-risk activities
    - **G** = grandiosity or inflated self-esteem
    - **F** = flight of ideas or racing thoughts
    - **A** = increased goal-oriented activity or psychomotor agitation
    - **S** = decreased need for sleep (very common symptom of manic episodes)
    - **T** = increased talkativeness
- Hypomanic episode = similar to manic episode except minimum 4 day duration that does not require hospitalization, severe impairment in functioning, or psychotic symptoms

- Major depressive disorder = major depressive episode(s) with no hypo/manic episodes
- Bipolar I disorder = manic episode +/- major depressive episode +/- hypomanic episode
- Bipolar II disorder = hypomanic episode + major depressive episode with no manic episode
- Persistent depressive disorder (aka dysthymia) = "rule of 2" i.e.
  2+ years (1 year if pediatric) of depressed mood
  with no euthymic period lasting longer than **2** months
  accompanied by **2**+ related depressive symptoms (hopelessness, poor concentration, poor appetite, poor sleep, poor energy, poor self-esteem)
- Premenstrual dysphoric disorder = intermittent mood symptoms that are present for the majority of menses
- Cyclothymic disorder = 2+ yr (1 yr if pediatric) history of subthreshold hypomanic and depressive symptoms not meeting criteria for hypomania and MDE, with no euthymic period lasting longer than 2 months
- ★ The specifier "with psychotic features" can be added to major depressive disorder or bipolar disorder if the mood disorder is accompanied with psychotic features that are only present when a mood episode is present

KEY CLINICAL FEATURES OF PRIMARY ANXIETY AND RELATED DISORDERS

- Generalized anxiety disorder (GAD) = 6+ mo of excessive anxiety of generalized nature, accompanied with 3+/6 (1+/6 if pediatric) of "SCREAM" criteria
    - **S** = poor sleep
    - **C** = poor concentration
    - **R** = restlessness or feeling on edge
    - **E** = poor energy
    - **A** = anger/irritability
    - **M** = muscle tension
- Social anxiety disorder (SAD; aka social phobia) = 6+ months of excessive fear of being negatively judged by others with avoidance of social situations
- Panic disorder = recurrent untriggered panic attacks, with 1 month of the following: excessive fear of having another panic attack OR maladaptive change in behavior related to panic attacks
- Agoraphobia = 6+ months of excessive fear of being in certain environments (outside of home alone, open/enclosed spaces, public transportation, standing in crowds/lines) for fear

that escape might be difficult or help not available in the event of developing panic-like or embarrassing symptoms

- Separation anxiety disorder = 6+ months (4 weeks if pediatrics) of developmentally inappropriate and excessive fear of being separated from an attachment figure
- Selective mutism = 1+ month of consistent failure to speak in specific social situations not better explained by language barrier, lack of knowledge, communication disorder, psychosis
- Specific phobia = 6+ months of excessive fear about a specific object/situation with avoidance of same (or enduring object/situation with intense fear/anxiety), not better explained by other anxiety disorders
- Post-traumatic stress disorder (PTSD) = 1+ month meeting "TRAUMA" criteria
    - **T** = traumatic event (death / near death, serious injury, sexual violence), exposure to
    - **R** = re-experiencing symptoms of traumatic event (e.g. flashbacks, nightmares, marked psychological/physical reactions to stimuli related to event)
    - **A** = avoidance of stimuli associated with traumatic event
    - **U** = unable to function
    - **M** = mood or cognitive symptom since the traumatic event, 2 or more (negative emotional state, anhedonia, inability to experience positive emotions, social withdrawal, exaggerated negative beliefs about self/others/world, inappropriate blame of self/others for cause of event, inability to remember part of trauma)
    - **A** = (hyper)arousal symptoms since the traumatic event, 2 or more (hypervigilance, exaggerated startle response, poor concentration/sleep, reckless behavior, anger)
- Acute stress disorder = similar to PTSD but duration 3+ days to < 1 mo
- Adjustment disorder = emotional or behavioral symptoms (e.g. low mood, anxiety, acting out) due to a clear stressor and occurring within 3 months from onset of stressor, that is not better explained by other primary psychiatric disorders
- Obsessive-compulsive disorder (OCD) = presence of either obsessions (defined above) and/or compulsions (repetitive behaviors/mental acts done in response to an obsession or set of rigid rules, in which the purpose of the act is to prevent/decrease anxiety or a dreaded event but act is either done excessively or not realistically connected to what it is intended to prevent)

★ The specifier "with panic attacks" can be added most anxiety disorders if panic attacks are present, which is defined as a period of intense fear/discomfort that peaks within minutes, accompanied by various other physical symptoms (e.g. lightheadedness, fear of losing control, fear of dying, derealization, choking sensation, choking sensation, chest discomfort, shortness of breath, palpitations, GI distress, paresthesia, heat/chill sensations, shakiness)

KEY CLINICAL FEATURES OF COMMON PRIMARY PEDIATRIC PSYCHIATRIC DISORDERS

- Attention-deficit/hyperactivity disorder (ADHD) = 6+ month pattern of developmentally inappropriate difficulties with inattention and/or hyperactivity/impulsivity in 2+ more settings and onset prior to 12 yoa
- Oppositional defiant disorder = 6+ month pattern of angry/irritable mood, argumentative/defiant behaviors towards authority figures, and/or vindictiveness

- Conduct disorder = 12+ month pattern of violating basic rights of others (e.g. aggression, stealing, property destruction) , violating major age-appropriate norms (e.g. skipping school, running away from home) not better explained by antisocial personality disorder if 18+ yo
- Anorexia nervosa = restricted intake leading to abnormally low body weight, accompanied with intense fear of gaining weight/becoming fat and disturbance in perception of one's own body weight or shape (e.g. poor insight towards seriousness of low body weight, self-esteem based on body weight/shape) +/- binge eating/purging behaviors
- Bulimia nervosa = 3 month period of recurrent episodes of binge eating and inappropriate compensatory behaviors to prevent weight gain (e.g. self-induced vomiting, abuse of laxatives/diuretics, excessive exercise) without abnormally low body weight
- ★ These diagnoses are typically diagnosed in the pediatric population, but can also be seen in the adult population

KEY CLINICAL FEATURES OF NEUROCOGNITIVE DISORDERS

- Delirium = (1) and (2) and (3 or 4):
    1. Acute onset (hours to days) and fluctuating course
    2. Inattention (i.e. hypoalert or hyperalert)
    3. Altered level of consciousness (i.e. hypoactive or hyperactive)
    4. Disorganized thought process or perceptual disturbance
- Major neurocognitive disorder (aka dementia) = gradual and significant cognitive decline (e.g. with memory, attention, executive functioning, visuospatial skills, language, social cognition) from one's cognitive baseline resulting in functional impairment; there are many different causes of major neurocognitive disorder, common ones including:
    - #1 overall: Alzheimer's disease = gradual cognitive decline starting with predominantly short-term memory deficits; family history of same common
    - #2 overall: Vascular dementia = stepwise progression of cognitive deficits; cardiovascular risk factors common
    - #2 neurodegenerative cause: Dementia with Lewy Bodies = gradual worsening of persistent and fluctuating cognition, recurrent detailed visual hallucinations, parkinsonism (onset within 1 yr or after onset of cognitive deficits), REM sleep behavior disorders, and/or sensitivity to antipsychotic side effects
    - #2 in patients < 60 yo = Frontotemporal dementia = gradual impairment in behavior (e.g. apathy, disinhibition, compulsive behaviors, dietary changes) and/or language abilities
- Mild neurocognitive disorder (aka mild cognitive impairment (MCI)) = significant cognitive decline but with no functional impairment

KEY CLINICAL FEATURES OF PERSONALITY DISORDERS

A general personality disorder is an enduring pattern of inner experience and behavior (i.e. perception of self/others, affect, impulsivity, interpersonal functioning) that causes clinically significant distress or functional impairment that markedly deviates from the expectations of their culture. This pattern is inflexible, present in various personal/social situations, and over time as it can be traced back to adolescence/early adulthood. It is not better explained by a primary

psychotic, mood, or anxiety disorder. There are many different types of personality disorders (divided over 3 clusters), including

- Cluster A ("weird")
  - Paranoid personality disorder = pervasive pattern of distrust and suspiciousness towards others
  - Schizoid personality disorder = pervasive pattern of detachment from social relationships and restricted range of emotional expression
  - Schizotypal personality disorder = pervasive pattern of eccentric behaviors, beliefs, or perceptual distortions and reduced capacity for close relationships
- Cluster B ("wild")
  - Borderline personality disorder = pervasive pattern of instability in affect (mood swings, inappropriate anger, chronic feelings of emptiness), impulsivity (including chronic suicidal ideation/self-harm), cognition (unstable sense of self, dissociation/transient paranoia with stress), and relationships (unstable relationships, frantic efforts to avoid perceived/real abandonment)
  - Antisocial personality disorder = 18+ yo person with pervasive pattern of disregard for and violation of rights of others (e.g. repeatedly breaking law, repeated lying, aggression, irresponsibility, lack of remorse from hurting others) with premorbid conduct disorder
  - Narcissistic personality disorder = pervasive pattern of inflated self-esteem, need for admiration, and lack of empathy
  - Histrionic personality disorder = pervasive pattern of attention seeking behaviors and excessive emotionality
- Cluster C ("wimpy")
  - Obsessive-compulsive personality disorder = pervasive pattern of preoccupation with perfectionism, orderliness, mental/interpersonal control, and inflexibility
  - Avoidant personality disorder = pervasive pattern of social inhibition related to feelings of inadequacy and hypersensitivity to negative judgement from others
  - Dependent personality disorder = pervasive pattern of excessive need to be taken care of others that leads to submissive/clinging behavior and fears of separation

CONSTRUCTING YOUR MANAGEMENT PLAN

Use the biopsychosocial approach to formulate your management plan

- Remember safety first! Consider admission if this patient is high risk for suicide/homicide or is unable to be managed properly in the community (e.g. due to lack of insight)
  - High risk suicidal ideation = clear plan and intent, access to weapons, limited future orientation, no protective factors, previous suicide attempts
    vs low risk suicidal ideation = no plan or intent, future orientation present, strong protective factors, no previous suicide attempts
  - High risk homicidal ideation = clear target, clear plan, high intent, access to weapons, limited protective factors, prior history of violence
    vs low risk homicidal ideation = no clear target, no plan, no intent, no access to weapons, strong protective factors, no prior history of violence

- Biological treatments include
    - Ordering relevant investigations to rule out medical causes and for baseline/follow-up investigations for medications
    - If secondary cause = treating underlying medical conditions and removing offending medications/substances
    - If primary cause = adding psychotropic medications +/- adding other biological therapies (e.g. ECT, light therapy)
- Psychosocial treatments include psychoeducation (teaching the patient/family about their illness), psychotherapy (i.e. counselling), social work (e.g. for financial/legal/housing assistance)

KEY POINTS OF MANAGING SPECIFIC PRIMARY PSYCHIATRIC DISORDERS

- Primary psychotic disorder = antipsychotics (first line = atypical antipsychotics; clozapine for treatment refractory schizophrenia (i.e. failed 2+ antipsychotics)); usually requires admission
- Bipolar disorder = atypical antipsychotics and/or mood stabilizer (avoid antidepressant monotherapy for bipolar depression; if using antidepressants, should also be in combination with atypical antipsychotic or mood stabilizer); manic episodes usually require admission
- Major depressive disorder = antidepressants (1st line = SSRIs, SNRIs, mirtazapine, and bupropion; 1st line in pediatrics = fluoxetine) + psychotherapy (CBT or interpersonal therapy); ECT indicated if catatonic, psychotic, severe SI, or tx refractory (i.e. failed 4+ antidepressants)
- Most primary anxiety disorders (GAD, SAD, social anxiety, panic disorder, agoraphobia), PTSD, and OCD = cognitive behavioral therapy (CBT; can also use EMDR (eye movement desensitization and reprocessing) for PTSD) and/or SSRI/SNRI ("start low, go slow, aim high" for dosing) +/- short-term use of benzodiazepines
- ADHD = psychostimulants, CBT, educational/occupational accommodations
- Oppositional defiant disorder, conduct disorder = individual and family psychotherapy
- Eating disorders = ensure proper diet, psychotherapy (family-based therapy > CBT), +/- psychotropic medications (e.g. fluoxetine for bulimia nervosa; olanzapine for anorexia nervosa), +/- hospitalization for anorexia nervosa if high risk SI/HI, failed outpatient treatment, or develop medical complications (HR < 40, orthostatic changes in BP, temperature < 36, <85% ideal body weight, kidney/cardiac/GI complications))
- Delirium = treat underlying cause (#1 priority), comfort rounds (frequent orientation, clocks/calendars available, familiar objects/people available, ensure eating/voiding/bowel movements, optimize sleep-wake cycle)
- Major neurocognitive disorder = anticholinesterase inhibitors if Alzheimer's/dementia with Lewy Bodies, treat vascular risk factors if vascular dementia, behavioral interventions, memory aids, assess need for assisted living, capacity assessment
- Personality disorders = psychotherapy (dialectical behavioral therapy is gold standard treatment for borderline personality disorder)
- Adjustment disorders = psychosocial interventions

RECOMMENDED READINGS

- DSM V
- DynaMed Plus

- Introductory Textbook of Psychiatry by Nancy Andreasen

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