CLERKSHIP ORIENTATION OVERVIEW

• Review of Phase 3 Policies
• Clerkship Objectives
• Important Psychiatry Clerkship Components
• Psychiatric Interview
  • Suicide Risk Assessment
• Mental Status Exam
• Psychopharmacology Overview
• Mental Status Exam D2L Assignment
Clerkship Director: Chelsea Carson, M.D.

Associate Clerkship Director: Anjum Ara, M.D.
CLERKSHIP SITE DIRECTORS

SW Campus: Joe Morgan, M.D.

NE/Athens Campus: David Paulk, D.O.

NW/Rome Campus: Joe Seal, M.D.

SE Campus: Mike Mobley, M.D.
PSYCHIATRY CLERKSHIP POLICIES

• Attendance/Late arrival/absences:
  • Contact supervising attending, resident if applicable, as well as clerkship director and coordinator ASAP
  • Illness and family emergencies are excused absences
  • Cannot miss more than 3 days for this 4-week rotation
  • May require make up or remediation of clerkship
PSYCHIATRY CLERKSHIP POLICIES

• Duty hours
  • Cannot exceed more than 80 hours per week averaged over 2 weeks
  • 10 hours free between shifts
  • 1 day off per 7-day week
  • Cannot work more than 28 hrs consecutively (no overnight call for psych)
PSYCHIATRY CLERKSHIP POLICIES: PROFESSIONALISM

• Professional attire includes NO:
  • Easily visible tattoos or body piercing (e.g., lip, eyebrow, tongue)
  • Unusual hair coloring or style
  • Casual clothing (e.g., jeans and shirts without collars for men, sandals)
  • Revealing or ill-fitting clothing
  • Unwashed or unkempt appearance
  • WHEN IN DOUBT, ASK!

• Cell phone use: Always ask if you want to have it out or let your preceptor know if you are looking up information. Otherwise keep it out of sight during clinical work/rounds.

• Timeliness and attendance at all clinical activities

• Notification of any absences
PSYCHIATRY CLERKSHIP POLICIES

• Supervision
  • Adequate supervision by faculty is required
  • If you do not feel comfortable or feel you are not receiving adequate clinical supervision, please notify clerkship coordinator and director immediately so we can rectify the situation ASAP.
PSYCHIATRY CLERKSHIP POLICIES

• NBME Shelf Exam
  • See excused absences for absence from shelf
  • Exam must be taken on campus on which student is assigned to for clerkship unless otherwise requested by student
  • Must be requested by end of first week of clerkship (first Friday) and must be submitted to curriculum office and involved regional campus dean
PSYCHIATRY CLERKSHIP POLICIES

• NBME Shelf Exam
  • Must achieve 5<sup>th</sup> percentile in raw score cutoff to pass (“C”)
  • 30<sup>th</sup> percentile to be eligible for a “B”
  • 70<sup>th</sup> percentile to be eligible for an “A”
  • Conversion and cutoffs are calculated using the Quarter 1 National Data for the first three (3) months of the academic year and then Academic Year National Data for the remainder of the academic year.
  • If testing accommodations are needed, please notify clerkship coordinator and director prior to the clerkship or on first day of clerkship at the latest. TODAY!!
PSYCHIATRY CLERKSHIP POLICIES

• **Retake policy**
  • If no failing NBME shelf scores at end of year, may retake one (1) subject exam with possibility of raising final grade by one (1) letter grade
  • Academic Year National Data is used to calculate cutoffs and conversion scores on the retake.
  • Students may retake up to two (2) failed NBME subject exams, with the potential of raising the grade to a C.
PSYCHIATRY CLERKSHIP POLICIES

Grade appeals

- Do NOT contact your supervising attending(s); doing so will forfeit grade appeal request!
- Contact clerkship director directly within 2 weeks of date of final grade posting to first discuss your concern
- Submit documentation/evidence supporting grade appeal within 2 weeks of date of final grade posting
- Ad hoc committee of 3 faculty members will review grade appeal and make recommendation to clerkship director
- Clerkship director will make final decision and notify student of decision within 2 weeks of receipt of student’s grade appeal request
PSYCHIATRY CLERKSHIP POLICIES

• Grade appeals continued
  • May appeal decision of clerkship director by contacting the department chair within 1 week of receiving decision from clerkship director
  • Chair will make decision and inform student of decision within 2 weeks of receipt of student’s appeal
  • May appeal department chair’s decision via appeal to Vice Dean of academic affairs within 1 week of receipt of chair’s decision. Student then notified of decision within 2 weeks.
PSYCHIATRY CLERKSHIP POLICIES

• Mistreatment

  • Review policy for what constitutes mistreatment
  
  • If at any time you feel you are being mistreated in any way, contact clerkship coordinator and director immediately so the situation can be rectified ASAP
PSYCHIATRY CLERKSHIP POLICIES

• SPEL Logs
  • Log **ALL** patients seen and **ALL** diagnoses for **EVERY** patient
  • Minimum of 30 patients to be logged
  • Notify clerkship coordinator and director if you have concerns you will not see all required diagnostic categories
  • Complete interprofessional education (IPE) requirement within SPEL log (AT LEAST 1 patient)

• Mid-rotation Feedback
  • Completed with faculty member and turned in to clerkship coordinator by **COB on 2\textsuperscript{nd} Friday of the clerkship**
  • **IF NOT COMPLETED, RESULTS IN NR UNTIL TURNED IN!**
PSYCHIATRY CLERKSHIP POLICIES

• Observed Psychiatric Interview and Mental Status Exam Presentation
  • Must be completed by faculty
  • Must be completed by last clinical day of rotation and turned in to Clerkship Coordinator by day of NBME shelf exam

• IF ANY REQUIRED CLINICAL EXPERIENCE OR DOCUMENTATION IS NOT COMPLETED BY COB ON DAY OF NBME SHELF EXAM, 4 POINTS CAN BE DEDUCTED OFF FINAL GRADE
  • Observed Interview & MSE Presentation
  • SPEL Logs
  • IPE

• IF YOU HAVE AN UNEXCUSED ABSENCE FROM ANY CLINICAL ACTIVITY (ECT, CLINIC, ETC.), YOUR PROFESSIONALISM GRADE WILL BE AFFECTED!
PSYCHIATRY CLERKSHIP POLICIES

• Communication
  • Almost all communication regarding the clerkship is done via email and it will be done very frequently **SO CHECK YOUR EMAIL DAILY AT THE VERY LEAST!!**
CLERKSHIP OBJECTIVES (C.O.)
C.O. 1. PATIENT CARE

A. Perform a thorough psychiatric interview of a patient with mental illness.

B. Perform and describe a mental status examination.

C. Appraise the information obtained in a psychiatric interview.

D. Formulate a psychiatric differential diagnosis.

E. Recognize the need for clinical testing (i.e., neurocognitive disorder evaluation, diagnostic testing).

F. Appraise the appropriate treatment modalities for psychiatric disorders.

G. Demonstrate the ability to educate patients and their families/support systems about diagnoses, and subsequent care or mental disorders.
C.O. 2 MEDICAL KNOWLEDGE

A. Recognize the pathophysiology, epidemiology, clinical picture, and principles of treatment for the following disorders:
   • Psychiatric aspects of medical disorders
   • Neurocognitive disorders
   • Psychotic disorders
   • Bipolar and depressive disorders
   • Anxiety disorders and trauma/stressor related disorders
   • Personality disorders
   • Substance use disorders
   • Childhood and adolescent psychiatric disorders

B. Appraise the indications, contraindications, and possible side effects of the following drug classes in formulating a treatment plan:
   • Antipsychotics
   • Anxiolytics
   • Mood stabilizers
   • Antidepressants
   • Sedatives/hypnotics
   • Other drug classes that display psychiatric side effects

C. Distinguish the indications for the major types of psychotherapy occurring in individual or group format: supportive; cognitive; behavioral; psychodynamic.

D. Demonstrate an understanding of social history within the bio-psycho-social formulation of mental illness.

E. Demonstrate an understanding of the epidemiology of suicide risk.
C.O. 3 PRACTICE-BASED LEARNING AND IMPROVEMENT

A. Demonstrate genuine intellectual curiosity and desire to learn, focused inquisitiveness in asking questions, and enduring persistence in the pursuit of learning.

B. Choose and appraise medical literature that pertains to at least one (1) of their patients’ mental illness.

C. Complete a mid-rotation feedback form including goals for self-improvement.

D. Accept constructive criticism and modify behavior based on feedback.
C.O. 4 INTERPERSONAL AND COMMUNICATION SKILLS

A. Give an oral presentation of a patient in a succinct and organized manner using findings from the psychiatric interview and mental status exam.

B. Write complete histories and physicals and progress notes in a succinct and organized manner using findings from the psychiatric interview and physical exam.

C. Communicate empathically with patients with mental illness and their families or support system members.

D. Communicate with others in a respectful, professional, and non-judgmental manner, and demonstrate effective listening skills.

E. Recognize barriers to communication if they occur during a psychiatric interview.

F. Educate patients assuring their understanding on healthy behavior change when appropriate (i.e., substance use, treatment adherence).

G. Educate patients assuring their understanding on medical risk and benefits when appropriate (i.e., medication side effects).
C.O. 5 PROFESSIONALISM

A. Students will demonstrate utmost respect for all with whom they interact (patients and their families and support system, colleagues, and team members)

B. Describe the importance of protecting patient privacy and identifying personal health information, including when and when not to share information; required institutional training and assessment

C. Maintain appropriate professional appearance and composure.

D. Recognize and address personal limitations, attributes or behaviors that might limit one’s effectiveness as a physician, and seek help when needed.

E. Demonstrate sensitivity and responsiveness to a diverse patient population, including but not limited to diversity in gender, age, race, religion, disabilities, and sexual orientation.
C.O. 6 SYSTEMS-BASED PRACTICE

A. Demonstrate the ability to work within a multidisciplinary patient care team, with an understanding of the physicians’ role as team leader and the importance of ancillary staff.

B. Examine medical errors and quality problems using a health systems approach and describe available methods to minimize them.
STUDENT AND PATIENT SAFETY

• Ask your resident and/or faculty about any site-specific safety protocols and/or recommendations
  • I.e. Panic buttons
• Do NOT interview patients in their bedrooms
  • Utilize common areas, interview rooms, or other areas where staff are present
• Monitor both your and patient’s personal boundaries; keep a safe distance
• If you feel uncomfortable, let your resident/attending know and ask them to assist your interview or take a break
  • Watch for signs of agitation, substance abuse
• Stay between patient and door when possible
• Know where patients and staff are at all times and in which direction your back is facing
YOUR JOB DURING THE CLERKSHIP

• Enjoy every day! People will tell you amazing life stories in the next month.

• Study from day 1: Departmental and NBME exam are difficult and do not strictly examine purely psychiatric knowledge.

• Respect/learn from your team!
  • Attending, SW, psychologists, counselors, occupational therapists, peer support specialists, nurses, pharmacists

• Report any problems EARLY to your attending, clerkship director, and/or coordinator so we can address and/or fix something.
PSYCHIATRY CLERKSHIP DO’S & DON’TS

DO’S:

- Ask for contact numbers for attending/resident
- Arrive early to wards/clinics
- Ask questions
- Ask for feedback on your interviews and write-ups
- Offer to present cases or short (5 min) literature reviews
- Respect and advocate for your patients
- Send short/part-time evals to residents and faculty
- Evaluate your sites, preceptors and residents
- Submit your D2L assignments (not just save!)
- Always carry your clerkship survival guide!

DON’TS:

- Be late or call in late after you’ve already missed part of the day
- Be overly familiar with patients and staff (watch out for self-disclosure)
- Break confidentiality barriers
- Contact your site preceptor for appeals
- Miss mandatory didactics/clinical activities (professionalism)
- Miss D2L deadlines for quizzes/assignments: Sundays 10pm
PSYCHIATRIC INTERVIEW

• IT TAKES SKILL!

• SKILL TO ENCOURAGE DISCLOSURE OF PERSONAL INFORMATION FOR A PROFESSIONAL PURPOSE

• EMPATHY → RAPPORT → THERAPEUTIC ALLIANCE
Content vs. Process

• *What* information we get

• *How* we get it ....

Diagnostic vs. Dynamic

• **Diagnostic**: Happens early

• **Dynamic** interview = Extended process; elicits bio-psycho-social and cultural aspects of the illness
INTERVENTIONS

Affirmation: “I see”

Advice/praise: “I’m so proud of you that you stopped smoking!”

Empathic validation: “It hurts to be treated that way”

Encouragement to elaborate: “Tell me more about your mother”

Clarification: Pull together patient’s verbalizations in a more coherent way

Confrontation: Address something patient does not want to accept. Reflects back to patient a denied or suppressed feeling.

Interpretation: One of most expressive forms of treatment; therapist’s decision-making; makes something conscious that was previously unconscious.
PSYCHIATRIC INTERVIEW

• **Chief complaint:** Patient’s own words
  - What brought the patient in?
  - Why now and not 6 months ago? Past week? Past 24hrs?

• **HPI:**
PSYCHIATRIC INTERVIEW

- **Chief complaint:** Patient’s own words
  - What brought the patient in?
  - Why now and not 6 months ago? Past week? Past 24hrs?

- **HPI:** Same as other specialties
  - Onset
  - Location
  - Duration
  - Character
  - Aggravating/alleviating factors
  - Region/radiation
  - Timing
  - Severity
PSYCHIATRIC INTERVIEW

• Psychiatric History: ??
PSYCHIATRIC INTERVIEW

• **Psychiatric History**: Course/treatment
  • Onset of initial treatment?
  • Who initiated it?
  • Current and previous diagnoses
  • Outpatient (including PHP, IOP) vs. inpatient/hospital setting
  • Treatment: Medication, psychotherapies, group therapies, somatic treatments, substance abuse treatment
  • History of aggressive behavior and HI:
    • Toward people, property, animals
  • Previous suicide attempts, self-harm, suicidal ideation (SI)
SUICIDE RISK

- 95% of suicide completers are mentally ill:
  - 80% have mood d/o
  - 10% have schizophrenia
  - 5% have delirium/dementia
  - 25% alcohol dependence + other illness

- Completers: Male, 40-59 yo, high lethality

- Attempters: ♂, <35 yo, low lethality

- 10% of attempters will complete suicide

- Native American >Caucasian> Asian >African American and Hispanic (CDC data 2012: 17.3 to 5 per 100,000 people)

- ↓ CSF 5-HIAA (serotonin metabolite) associated with violent suicide
SUICIDE RISK

• **Mood disorders:** 15-20%
  - Bipolar mixed=highest risk
  - Delusional depression

• **Schizophrenia:** 5-10% (young male, insight, high IQ, command hallucinations)
  - 3 wks - 3 mo. from hospitalization

• **Substance abuse:**
  - Young male, multiple substances, recent loss, comorbidities, previous OD

• **WHAT WORKS TO DECREASE RISK:** LI, CLOZAPINE, ECT, psychotherapy!!
ADDITIONAL TERMINOLOGY

• An **interrupted attempt**: Stopped by someone else: for example, pt holding pills in their hand, someone grabs them by the hand; noose round neck but has not started to hang and is stopped; pointed gun toward self, someone else takes the gun

• An **aborted attempt** is stopped by the person after they took steps toward making an attempt

• **Preparatory behavior**: Did this include anything beyond verbalizing a thought? For example collecting pills, getting a gun, giving away valuables or writing a suicide note?
### COLUMBIA SUICIDE SEVERITY RATING SCALE

#### SUICIDAL IDEATION

Ask questions 1 and 2. If both are negative, proceed to “Suicidal Behavior” section. If the answer to question 2 is “yes”, ask questions 3, 4 and 5. If the answer to question 1 and/or 2 is “yes”, complete “Intensity of Ideation” section below.

<table>
<thead>
<tr>
<th>Question</th>
<th>Lifetime</th>
<th>Past 6 Months</th>
</tr>
</thead>
</table>
| 1. Wish to be Dead<br>Subject endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up.<br>
Have you thought about being dead or what it would be like to be dead?<br>
Have you wished you were dead or wished you could go to sleep and never wake up?<br>
Do you ever wish you weren’t alive anymore?                                 | Yes      | No            |
|                                                                          |          | Yes No        |
| If yes, describe:                                                        |          |               |
| 2. Non-Specific Active Suicidal Thoughts<br>General, non-specific thoughts of wanting to end one’s life/commit suicide (e.g., “I’ve thought about killing myself”) without thoughts of ways to kill oneself/associated methods, intent, or plan during the assessment period.<br>
Have you thought about doing something to make yourself not alive anymore?<br>
Have you had any thoughts about killing yourself?                          | Yes      | No            |
|                                                                          | Yes No   |               |
| If yes, describe:                                                        |          |               |
| 3. Active Suicidal Ideation with Any Methods (Not Plan) without Intent to Act<br>Subject endorses thoughts of suicide and has thought of at least one method during the assessment period. This is different than a specific plan with time, place or method details worked out (e.g., thought of method to kill self but not a specific plan). Includes person who would say, “I thought about taking an overdose but I never made a specific plan as to when, where or how I would actually do it...and I would never go through with it.”<br>
Have you thought about how you would do that or how you would make yourself not alive anymore (kill yourself)? What did you think about? | Yes      | No            |
|                                                                          | Yes No   |               |
| If yes, describe:                                                        |          |               |
| 4. Active Suicidal Ideation with Some Intent to Act, without Specific Plan<br>Active suicidal thoughts of killing oneself and subject reports having some intent to act on such thoughts, as opposed to “I have the thoughts but I definitely will not do anything about them.”<br>
When you thought about making yourself not alive anymore (or killing yourself), did you think that this was something you might actually do?<br>
This is different from (as opposed to) having the thoughts but knowing you wouldn’t do anything about it. | Yes      | No            |
|                                                                          | Yes No   |               |
| If yes, describe:                                                        |          |               |
| 5. Active Suicidal Ideation with Specific Plan and Intent<br>Thoughts of killing oneself with details of plan fully or partially worked out and subject has some intent to carry it out.<br>
Have you ever decided how or when you would make yourself not alive anymore/kill yourself? Have you ever planned out (worked out the details of) how you would do it?<br>
What was your plan?<br>
When you made this plan (or worked out these details), was any part of you thinking about actually doing it? | Yes      | No            |
|                                                                          | Yes No   |               |
| If yes, describe:                                                        |          |               |

#### INTENSITY OF IDEATION

The following feature should be rated with respect to the most severe type of ideation (i.e., 1-5 from above, with 1 being the least severe and 5 being the most severe).

<table>
<thead>
<tr>
<th>Most Severe Ideation:</th>
<th>Most Severe</th>
<th>Most Severe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type # (1-5)</td>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Description of Ideation</th>
</tr>
</thead>
<tbody>
<tr>
<td>How many times have you had these thoughts?</td>
<td>Write response</td>
</tr>
<tr>
<td>(1) Only one time</td>
<td>(2) A few times</td>
</tr>
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<td></td>
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</tbody>
</table>
### Suicidal Behavior

*(Check all that apply, so long as these are separate events; must ask about all types)*

**Actual Attempt:**
A potentially self-injurious act committed with at least some wish to die, as a result of act. Behavior was in part thought of as a method to kill oneself. Intent does not have to be 100%. If there is any desire to die associated with the act, then it can be considered an actual suicide attempt. **There does not have to be any injury or harm,** just the potential for injury or harm. If person pulls trigger while gun is in mouth but gun is broken so no injury results, this is considered an attempt.

**Inferring Intent:** Even if an individual denies intent to die, it may be inferred clinically from the behavior or circumstances. For example, a highly lethal act that is clearly not an accident so no other intent but suicide can be inferred (e.g., gunshot to head, jumping from window of a high floor story). Also, if someone denies intent to die, but they thought that what they did could be lethal, intent may be inferred.

**Did you ever do anything to try to kill yourself or make yourself not alive anymore? What did you do?**

<table>
<thead>
<tr>
<th>Did you ever hurt yourself on purpose? What did you do?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did you... as a way to end your life?</td>
</tr>
<tr>
<td>Did you want to die (even a little) when you...?</td>
</tr>
<tr>
<td>Were you trying to make yourself not alive anymore when you...?</td>
</tr>
<tr>
<td>Or did you think it was possible you could have died from...?</td>
</tr>
</tbody>
</table>

**If yes, describe:**

**Has subject engaged in Non-Suicidal Self-Injurious Behavior?**

**Has subject engaged in Self-Injurious Behavior, intent unknown?**

**Interrupted Attempt:**
When the person is interrupted (by an outside circumstance) from starting the potentially self-injurious act (if not for that, actual attempt would have occurred).

**Overdose:** Person has pills in hand but is stopped from ingesting. Once they ingest any pills, this becomes an attempt rather than an interrupted attempt.

**Shooting:** Person has gun pointed toward self, gun is taken away by someone else, or is somehow prevented from pulling trigger. Once they pull the trigger, even if the gun fails to fire, it is an attempt. Jumping: Person is poised to jump, is grabbed and taken down from ledge. Hanging: Person has loose Around neck but has not yet started to hang - it stopped from doing so.

**Has there been a time when you started to do something to make yourself not alive anymore (end your life or kill yourself) but someone or something stopped you before you actually did anything? What did you do?**

| If yes, describe: |

**Aborted Attempt:**
When person begins to take steps toward making a suicide attempt, but stops themselves before they actually have engaged in any self-destructive behavior. Examples are similar to interrupted attempts, except that the individual stops him/herself, instead of being stopped by something else.

**Has there been a time when you started to do something to make yourself not alive anymore (end your life or kill yourself) but you changed your mind (stopped yourself) before you actually did anything? What did you do?**

| If yes, describe: |

**Preparatory Acts or Behavior:**
Acts or preparation towards imminently making a suicide attempt. This can include anything beyond a verbalization or thought, such as assembling a specific method (e.g., buying pills, purchasing a gun or preparing for one’s death by suicide (e.g., giving things away, writing a suicide note).

**Have you done anything to get ready to make yourself not alive anymore (to end your life or kill yourself)- like giving things away, writing a goodbye note, getting things you need to kill yourself?**

| If yes, describe: |

**Suicidal Behavior:**
Suicidal behavior was present during the assessment period?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

### Answer for Actual Attempts Only

**Actual Lethality/Medical Damage:**

| 0. No physical damage or very minor physical damage (e.g., surface scratches). |
| 1. Minor physical damage (e.g., lethargic speech; first-degree burns; minor bleeding; sprains). |
| 2. Moderate physical damage: Medical attention needed (e.g., conscious but sleepy, somewhat responsive; second-degree burns; bleeding of major vessel). |
| 3. Seriously severe physical damage, medical hospitalization and likely intensive care required (e.g., coma, with reflexes intact; third-degree burns less than 20% of body; extensive blood loss but can recover; major fractures). |
| 4. Severe physical damage, medical hospitalization with intensive care required (e.g., coma, without reflexes; third-degree burns over 20% of body; extensive blood loss with unstable vital signs, major damage to a vital area). |
| 5. Death |

**Potential Lethality: Only Answer if Actual Lethality = 10**

- **Likely lethality of actual attempt if no medical damage:** The following examples, while having no actual medical damage, had potential for very serious lethality: put gun in mouth and pulled the trigger but gun fails to fire so no medical damage; laying on train tracks with oncoming train but pulled away before run over. |

| 0 = Behavior not likely to result in injury |
| 1 = Behavior likely to result in injury but not likely to cause death |
| 2 = Behavior likely to result in death despite available medical care |

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<table>
<thead>
<tr>
<th>Psychiatric risk factors resulting in suicide:</th>
<th>Socio-demographic risk factors:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Major Depression</td>
<td>Male</td>
</tr>
<tr>
<td>Bipolar Depression</td>
<td>Living alone</td>
</tr>
<tr>
<td>Alcohol and drug use disorders</td>
<td>Completers: male, 40-59 yo, high lethality</td>
</tr>
<tr>
<td></td>
<td>Attempters: ♀, &lt;35 yo, low lethality</td>
</tr>
<tr>
<td></td>
<td>10% of attempters will complete suicide</td>
</tr>
<tr>
<td></td>
<td>Native American &gt;Caucasian&gt; Asian &gt;African American and Hispanic</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>Separated, widowed or divorced</td>
</tr>
<tr>
<td>Eating disorders</td>
<td>Unemployed or retired</td>
</tr>
<tr>
<td>Antisocial personality disorder</td>
<td>Occupation: health-related occupations higher (dentists, doctors, nurses, social workers) ; especially high in women physicians</td>
</tr>
<tr>
<td>PTSD</td>
<td></td>
</tr>
<tr>
<td>Borderline personality disorder</td>
<td></td>
</tr>
</tbody>
</table>

**PREVENTION:**

1) **Antidepressant treatment**;
2) **Psychotherapy**: cognitive-behavioral, interpersonal or dialectic behavioral therapy;
3) **Means restrictions**: Firearm safety; jumping site barriers; detoxification of domestic gas; improvements in the catalytic converters in motor vehicles; restrictions on pesticides; reduce lethality of prescriptions; lower toxicity antidepressants; Medications in blister packs; Restrict sales of lethal hypnotics (i.e. Barbiturates).
SUICIDE RISK ASSESSMENT: SAD PERSONS

- Sex (male)
- Age (<20yrs; >45yrs)
- Depression or hopelessness
- Psychiatric history/previous suicide attempts
- Excessive alcohol or drug use
- Rational thinking loss (psychosis or severe depression)
- Separated/divorced/widowed
- Organized suicide plan
- No social supports
- Sickness/chronic medical illness
CASE VIGNETTE

A 28yo M with schizophrenia is brought to the ER by family due to refusal to eat and to leave his room, agitation, and paranoia. He is treated in the hospital and then placed in a personal care home. His antipsychotic medication is changed within the month after discharge due to side effects. Within the same week he completes suicide by hanging.

What are your concerns/what could have contributed to his suicide?
PSYCHIATRIC REVIEW OF SYSTEMS

• Symptom inventory, sequence & duration
  • Depressive or bipolar
  • Psychosis
  • Anxiety, obsessive-compulsive, and trauma-related disorders
  • Substance & alcohol use
  • Neurocognitive disorders
  • Other disorders: neurodevelopmental, somatic symptom, factitious, impulse control, dissociative, sexual dysfunctions, feeding and eating, sleep-wake, disruptive, impulse control and conduct disorders
  • Personality

• Explore temporal relationships: Cause vs. Co-morbidity
PSYCHIATRIC INTERVIEW:
OTHER HISTORIES

• **Medical history:** Allergies, medical problems, surgeries

• **Family medical & psychiatric history**
  • Psychiatric illness, substance abuse, legal history, suicide

• **Social history:**
  • Living situation
  • Marital status/sexual history/relationship history
  • Occupational history
  • Educational history
  • Abuse – Physical, sexual, emotional/psychological, neglect

• **Substance use**
  • Type (name them for patient)
  • Age of first and last use
  • Quantity/frequency
  • Longest period of sobriety
  • Withdrawal symptoms
  • Any treatment

• **Legal history**

• **Religious affiliation**

• **Cultural identification**
PSYCHIATRIC INTERVIEW:
OTHER HISTORIES

**• Developmental:**
- In utero exposures to medications, drugs
- Pregnancy and/or delivery complications
- Full-term vs. premature
- NICU/Early illnesses requiring hospitalization
- Delays in meeting developmental milestones?
- Family structure
- DFCS or other involvement
OBJECTIVE/PHYSICAL EXAMINATION

• Vital signs
• Mental status exam
• +/- Cognitive exam (for example MOCA, MMSE) in the last 5 minutes
DIFFERENTIAL DIAGNOSIS/FORMULATION/TREATMENT PLAN

• **Differential diagnosis:** Most likely 2-3 (sometimes more to start) and why? Specific examples and factors for and against
  - R/O depressive and bipolar, psychosis, anxiety, obsessive-compulsive and trauma-related, substance & alcohol use, neurocognitive, neurodevelopmental, personality, and other disorders

• **Formulation:**
  - **Biologic:** Genetic d/o / substance / medical
  - **Psychologic:** Relate childhood / development to current conflicts
  - **Social-cultural:**
    + Prognosis: Function at work, hobbies, stable relationships, faith, volunteer: reflect ego strength
    - Prognosis: Poor relationships, impulsivity, bad work history, non-adherence

• **Treatment:**
  - State goals of each of the following (include patient’s goals):
    - **Medication:** Why / side-effects / complications / compliance problems.
    - **Therapy:** Individual / group
      - Supportive / insight: behavioral / cognitive / psychodynamic
ASK ABOUT STRENGTHS

• What did you use to enjoy before you became ill?
• What are you good at?
• How has your illness and its treatment affected your
  • Physical activities
  • Relationships with family and friends
  • Job and hobbies
  • Feelings about yourself
  • Spiritual/religious beliefs
• What is the most difficult thing about your illness and its treatment?
• Any positive experience with your illness/treatment?
HOW TO PRESENT A PATIENT CASE: NEW PATIENT

- Patient is a [age] [ethnicity] [sex] with a hx of [diagnoses] who presents for [cc].
  - HPI
  - Psych ROS

- All additional histories w/ pertinent positives and negatives

- Objective:
  - VS
  - MSE
  - Any labs

- Differential dx/formulation

- Treatment Plan
HOW TO PRESENT A PATIENT CASE: FOLLOW-UP PATIENT

- Patient is a [age] [ethnicity] [sex] with [diagnoses] who was admitted for/is following up for [cc/dx].

- Yesterday/At last visit [what was done/med changes/etc.]

- Since then [updated status]

- Objective:
  - VS
  - MSE
  - Any new labs

- Current meds

- Updated diagnoses/formulation

- Treatment Plan
MENTAL STATUS EXAM
MENTAL STATUS EXAM (MSE)

• The objective portion of your psychiatric H&P and daily “SOAP”/progress notes

• Provide a description of your patient that your resident/attending can visualize prior to actually seeing your patient

• Objective snapshot in time

• Helps build your differential diagnosis

• Describe, describe, describe if you’re not sure what to call something!
MSE COMPONENTS

- ID/appearance/behavior
- Orientation
- Psychomotor behavior
- Speech
- Mood
- Affect
- Thought process
- Thought content
- Perception
- Insight
- Judgment
- Memory/concentration/attention
- MMSE/MoCA
ID/APPEARANCE/BEHAVIOR

• ID: age, sex, ethnicity, marital status

• Appearance:
  • Apparent age
  • Body habitus
  • Clothing
  • Grooming
  • Odor
  • Scars
  • Tattoos/piercings

• Behavior:
  • Toward interviewer
  • Eye contact
  • Attentiveness
  • Level of consciousness
ORIENTATION

• Person
• Place
• Time
• Situation

“A&Ox__/4” (ID what is incorrect; what patient says)
PSYCHOMOTOR BEHAVIOR

• Retarded
• Accelerated/agitated
• Involuntary movements
  • Organic vs. Medication-induced?
SPEECH

- Spontaneous/ Nonspontaneous
- Volume
- Rate
- Tone
- Articulation
- Speech latency
- Paucity of speech content
- Pressured
MOOD

• Subjective
• Elicited from the patient themselves
• Depressed, sad, dysphoric, euphoric, anxious, angry, irritable, happy, hostile…

“Quote the patient”
AFFECT

• Objective – patient’s expression of mood

Flat/blunted \(\rightarrow\) constricted/restricted \(\rightarrow\) full \(\rightarrow\) expansive/broad

• Congruent/incongruent with mood
• Appropriate/inappropriate
• Labile/stable
THOUGHT PROCESS

- Speed: Rapid → Slow

Linear/goal directed/logical → Tangential →
Circumstantial → Flight of ideas → Looseness of association/derailment

- Incoherent/word salad
- Clang associations
- Neologisms
- Perseveration
- Echolalia
- Thought blocking
THOUGHT CONTENT

- Preoccupations
- Obsessions
- Phobias
- Overvalued ideas
- Suicidality
- Homicidality

- Delusions
  - Grandiose, persecutory, somatic, nihilistic, religious, jealousy, erotomanic, culture-bound, control (thought broadcasting or insertion)
  - Mood congruent/incongruent
  - Bizarre/non-bizarre
PERCEPTION

• Hallucinations and illusions
  • Sensory system: auditory, visual (hypnogogic, hypnopompic), tactile, olfactory
  • Depersonalization/derealization = detachment

• Dreams
  • Nightmares, recurrent dreams
  • Fantasies, daydreaming
INSIGHT & JUDGMENT

• Insight
  • Patient’s understanding of their illness

• Judgment
  • Examples of harmful behaviors
  • Test an imaginary situation
    • Stamped addressed envelope
  • Abstraction
    • Proverb
MEMORY/ATTENTION/CONCENTRATION

• Serial 7’s
• World $\rightarrow$ dlrow
• Immediate and delayed recall
MINI-MENTAL STATUS EXAM (FOLSTEIN, 1975 – PROPRIETARY)

Orientation
- What is the (year) (season) (date) (day) (month)?
- Where are we: (state) (county) (town) (hospital) (floor)?

Registration Temporal
- Name 3 objects: one second to say each. Ask the patient all three after you have said them. Give 1 point for each correct answer. Then repeat them until he/she learns all three. Count trials and record:

ATTENTION AND CALCULATION Frontal
- Serial 7's. One point for each correct. Stop after five answers. Alternatively spell “world” backwards.

Recall Temporal
Ask for the three objects repeated above. Give one point for each correct.

Language Fronto-temporal
- Repeat the following “no ifs, ands or buts.” (1 pt.) Follow a 3-stage command: “take a paper in your right hand, fold it in half, and put it on the floor” (3 pts.)
- Name a pencil, and watch (2 pts.) Occipital
- Read and obey the following: close your eyes (1 pt.) Write a sentence (1 pt.) Copy design (1 pt.)

Parietal

Consciousness RAS
Alert; drowsy; stupor ; coma.
http://enotes.tripod.com/MMSE.pdf
EXECUTIVE FUNCTION - FRONTAL

= Ability to think abstractly, plan, initiate and sequence, monitor and stop complex behavior; insight, judgment

Bedside measures

• Luria motor test: Alternate hand movements; fist, cut; slap.

• Word fluency test: “Tell me 5 words starting with the letter “a”

• Similarities: Ability to apply abstract concepts.

• Proverb interpretation: Conceptual thinking ability

• Clock drawing: “This circle represents a clock face. Please put the numbers, so that it looks like a clock and then set the time to 10 minutes past 11” (parietal and frontal lobes involved)
5 point scale (Shulman):

5 points: Perfect clock

4: Minor visual-spatial errors

3: Inaccurate representation of 10 past 11 with good visual-spatial representation

2: Moderate visual-spatial disorganization, such as accurate representation of 10 past 11 is impossible

1: Severe visual-spatial disorganization

0: No reasonable representation of a clock

Fig. 1. Severity scores from 5 to 0
### Montreal Cognitive Assessment (MOCA)

**Version 7.1 Original Version**

#### Visuospatial / Executive

- **Copy Cube**: [ ]
- **Draw Clock**: Ten past eleven (3 points)

#### Naming

- Rhinoceros: [ ]
- Elephant: [ ]
- Camel: [ ]

#### Memory

- Read list of words, subject must repeat them. Do 2 trials, even if 1st trial is successful. Do a recall after 5 minutes.
  - 1st trial: [ ], [ ], [ ], [ ], [ ]
  - 2nd trial: [ ], [ ], [ ], [ ], [ ]

- Read list of digits (1 digit/sec.).
  - Forward order: [ ], [ ], [ ], [ ], [ ], [ ]
  - Backward order: [ ], [ ], [ ], [ ], [ ], [ ]

- Serial 7 subtraction starting at 100:
  - [ ], [ ], [ ], [ ], [ ], [ ], [ ], [ ]
  - Points: 3 pts, 2 or 3 correct: 2 pts, 1 correct: 1 pt, 0 correct: 0 pt

#### Attention

- Read list of letters. The subject must tap with his hand at each letter A. No points if ≥ 2 errors.
  - [ ], [ ], [ ], [ ], [ ], [ ], [ ], [ ], [ ], [ ]

#### Language

- Repeat: I only know that John is the one to help today. [ ]
  - The cat always hid under the couch when dogs were in the room. [ ]

- Fluency / Name maximum number of words in one minute that begin with the letter F: [ ]...[ ] (N ≥ 11 words)

#### Abstraction

- Similarity between e.g. banana - orange = fruit [ ]
  - Train - bicycle [ ]
  - Watch - ruler [ ]

#### Delayed Recall

- Has to recall words with no cue:
  - FACE [ ]
  - VELVET [ ]
  - CHURCH [ ]
  - DAISY [ ]
  - RED [ ]

- Points for uncued recall only: [ ]

#### Optional

- Category cue: [ ]
- Multiple choice cue: [ ]

#### Orientation

- Date [ ]
- Month [ ]
- Year [ ]
- Day [ ]
- Place [ ]
- City [ ]

---

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[www.mocatest.org](http://www.mocatest.org) Normal ≥ 26 / 30

Administered by: __________________________

[Add 1 point if ≤ 12 yr educ.]
PSYCHOPHARMACOLOGY BASICS
ANTIDEPRESSANTS: SSRIS

MOA: Inhibit 5HT reuptake

Side Effects:

**GI** 5HT3 receptors activation

**Sexual** D2, Ach blockade, 5HT reuptake inhibition

**Endocrine** SIADH; hyponatremia more frequent in older ♀

**Discontinuation sdr.**

**Pregnancy** paroxetine - class d

**Increased suicidal behavior in children & adolescents**

**Serotonin syndrome** with other serotonergic agents:
- neuromuscular-myoclonus, autonomic instability, mental status,
- GI symptoms

**CYP450 interactions**: fluoxetine, paroxetine, fluvoxamine-most, citalopram and sertraline-least
ANTIDEPRESSANTS

**SNRIs:** Venlafaxine, duloxetine, desvenlafaxine
- BP elevation at higher dose

**NDRI** (norepi, dopamine reuptake inhibitor):
- Bupropion: Dose dependent seizures; contraindicated in eating d/o

**Mirtazapine:** Selective α2 adrenergic antagonism with increase in serotonergic and noradrenergic activity; 5ht2c and 5ht3 receptor blockade $\rightarrow$ 5ht1a activation
- Sedation, weight gain, neutropenia

**5HT2 antagonists/reuptake inhibitors:**
- Nefazodone: Sedation, visual trails, many drug interactions cyp450 3a4, hepatic failure-rare
- Trazodone (metabolite mcpp, a strong serotonin agonist-anxiogenic and induces anorexia), priapism
ANTIDEPRESSANTS

**TRICYCLICS:** Inhibit NE and 5HT uptake and less DA

- Sedation, anticholinergic toxicity (treat with bethanechol), CV-arrhythmias (order EKG >40 years old, avoid in heart disease)
- **Lethal in overdose:** Wide-complex arrhythmia, seizure, hypotension
- Nortriptyline therapeutic window: 50-150 ng/ml

**MAOIs:** Inhibit MAO-A and -B which metabolize NE, 5HT and DA; nonselective-phenelzine, tranylcypromine (selective: selegiline; reversible-rima: moclobemide)

- Serotonin syndrome with SSRIs, SNRIs, triptans
- Hypertensive crisis with adrenergic agents, meperidine and high monoamine content foods; treat with phentolamine, chlorpromazine, nifedipine; **DO NOT GIVE β BLOCKERS**
- Require low monoamine diet
<table>
<thead>
<tr>
<th><strong>GENERIC BRAND ANTIDEPRESSANT NAMES AND FDA APPROVED INDICATIONS</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sertraline</strong></td>
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<tr>
<td><strong>Fluoxetine</strong></td>
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<tr>
<td><strong>Fluvoxamine</strong></td>
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<tr>
<td><strong>Paroxetine</strong></td>
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<tr>
<td><strong>Citalopam</strong></td>
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<tr>
<td><strong>Escitalopram</strong></td>
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<tr>
<td><strong>Venlafaxine</strong></td>
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<tr>
<td><strong>Des-venlafaxine</strong></td>
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<tr>
<td><strong>Duloxetine</strong></td>
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<tr>
<td><strong>Bupropion</strong></td>
</tr>
<tr>
<td><strong>Mirtazapine</strong></td>
</tr>
<tr>
<td><strong>Nefazodone</strong></td>
</tr>
<tr>
<td><strong>Trazodone</strong></td>
</tr>
<tr>
<td><strong>Phenelzine</strong></td>
</tr>
<tr>
<td><strong>Tranylcypromine</strong></td>
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<tr>
<td><strong>Selegiline</strong></td>
</tr>
<tr>
<td><strong>Amitriptyline</strong></td>
</tr>
<tr>
<td><strong>Nortriptyline</strong></td>
</tr>
</tbody>
</table>
ANTIPSYCHOTICS

1st generation DISCUSS/MONITOR RISK

D2 blockade

- **Movement d/o:** Parkinsonism at 80% blockade (treat with anticholinergics), akathisia (tx with β blockers or benzos), acute dystonia (tx with IM antichol.), tardive dyskinesia (eliminate offending agent)
- **NMS:** Rigidity, hyperthermia, tachycardia, ↑CPK, AMS, potentially lethal! — Supportive measures
- **Anticholinergic**
- **Sexual** (increased prolactin)
- **Retinitis pigmentosa:** chlorpromazine and thioridazine
- **QT prolongation** black box: thioridazine
2nd generation DISCUSS/MONITOR RISK

Risperidone, paliperidone, olanzapine, quetiapine, ziprasidone, aripiprazole, iloperidone, asenapine

D2 (also D3 and D4), 5HT2 blockade, glutamate?

• **Metabolic**: Weight gain and direct effect on triglycerides, serum leptin

• **Sexual**

• **Movement**: risperidone anticholinergic treatment

• **Orthostatic hypotension**: titrate slowly (quetiapine, iloperidone)

• **QT prolongation**: ziprasidone, iloperidone
CLOZAPINE  MINIMAL D2 BLOCKADE (D1, D2, D3, D4), 5HT2A (ALSO 5HT2C, H1, M1, A1)

FIVE BLACK BOX WARNINGS
1. Agranulocytosis: Do not give or d/c if WBC is <3,500 or ANC < 2,000, MONITOR these numbers weekly x 6mo, twice/mo x 6 mo., Then monthly for lifetime
2. Cardiovascular events: Myocarditis, pulmonary emboli
3. Patients with neurocognitive disorders: Increased risk of death – blanket warning for ALL 2nd generation antipsychotics
4. Orthostatic hypotension
5. Seizures

Advantages
• Indicated in refractory schizophrenia (failed ≥ 2 antipsychotics)
• Improvement continues long term: at 6 mo., One year and 5 years
• It decreases suicide risk and violence in patients with schizophrenia
• Along with quetiapine, used in psychosis in Parkinson’s patients because it does not induce EPS
<table>
<thead>
<tr>
<th>Generic Brand Antipsychotic Names</th>
<th>FDA Approved Indications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fluphenazine Prolixin (oral, IM, decanoate)</td>
<td>Schizophrenia</td>
</tr>
<tr>
<td>Haloperidol Haldol (oral, IM, decanoate)</td>
<td>Schizophrenia</td>
</tr>
<tr>
<td>Trifluoperazine Stelazine</td>
<td>Schizophrenia</td>
</tr>
<tr>
<td>Thioridazine Mellaril</td>
<td>Schizophrenia</td>
</tr>
<tr>
<td>Chlorpromazine Thorazine</td>
<td>Schizophrenia, MDD</td>
</tr>
<tr>
<td>Risperidone Risperdal (oral, long acting inj.)</td>
<td>Schizophrenia (+ children 13-17), bipolar mania (+ children 10-17) and irritability in autism; long acting risperidone is approved for schizophrenia and bipolar I disorder.</td>
</tr>
<tr>
<td>Paliperidone Invega (oral, long acting inj.)</td>
<td>Schizophrenia and schizoaffective disorder</td>
</tr>
<tr>
<td>Olanzapine Zyprexa (oral, IM, long acting injection)</td>
<td>Schizophrenia, acute treatment of mania and mixed episodes of bipolar d/o, maintenance tx. Of bipolar; acute agitation in schizophrenia and bipolar mania for the short acting IM injection. Adults and children over 13 years old.</td>
</tr>
<tr>
<td>Quetiapine Seroquel</td>
<td>Schizophrenia, acute treatment of mania and mixed episodes of bipolar d/o, maintenance tx. Of bipolar; adjunct treatment of MDD</td>
</tr>
<tr>
<td>Ziprasidone Geodon (oral, IM)</td>
<td>Schizophrenia, schizoaffective and bipolar mania (the latter indication + children 10-17)</td>
</tr>
<tr>
<td>Aripiprazole Abilify (oral, IM)</td>
<td>Schizophrenia, acute treatment of mania and mixed episodes of bipolar d/o, maintenance tx. Of bipolar; adjunct treatment of MDD; irritability in autism; acute agitation in schizophrenia for short acting IM formulation</td>
</tr>
<tr>
<td>Iloperidone Fanapt</td>
<td>Schizophrenia</td>
</tr>
<tr>
<td>Asenapine Saphris</td>
<td>Schizophrenia, acute manic and mixed episode</td>
</tr>
<tr>
<td>Clozapine Clozaril, FazaClo</td>
<td>Refractory schizophrenia</td>
</tr>
<tr>
<td>Lurasidone Latuda</td>
<td>Schizophrenia</td>
</tr>
</tbody>
</table>
MOOD STABILIZERS

Lithium:

- Serotonin effect; **Li** protects rat cerebral cortex and hippocampus from glutamate induced cell death
- Anti-suicidal effect in bipolar d/o
- Side effects:
  - **Lethal in overdose:** Therapeutic window 0.6-1.2 meq/L; > 3.5 meq/l fatal
  - Long term: Hypothyroidism, renal insufficiency
  - NSAIDs, ACE inhibitors, thiazide diuretics, tetracycline, salt restriction ↑ levels
  - Theophylline, caffeine, osmotic diuretics ↓ levels
  - Can use K sparing diuretics to treat nephrogenic diabetes insipidus (amiloride)
  - Pregnancy class D: Ebstein anomaly rare 1/2,000 births
MOOD STABILIZERS

• **Valproate**
  • Increases brain GABA levels, modulates glutamate
  • Risk of pancreatitis and liver failure
  • Drug interactions: Increases levels of drugs metabolized through glucuronidation (lamotrigine, lorazepam)
  • Pregnancy class D: Neural tube defects (3-5% spina bifida risk)

• **Lamotrigine**
  • Inhibits Na channels; stabilizes neuronal membranes; modulates glutamate
  • Risk of Stevens Johnson Syndrome 3/1,000

• **Carbamazepine**
  • Blocks Na channels, modifies adenosine receptors; inhibits glutamate; increases extracellular serotonin
  • Agranulocytosis, hyponatremia, induction of other drugs’ hepatic metabolism
  • Pregnancy class D: Neural tube defects
BENZODIAZEPINE ANXIOLYTICS

GABA-A agonists

- **Effects:**
  - Anxiolytic: anxiety, insomnia, acute agitation, withdrawal syndromes
  - Hypnotic: useful in anesthesia
  - Anticonvulsant: seizure control
  - Muscle relaxation

- All are pregnancy category D drugs; fetus with possible congenital abnormalities; fetus may suffer withdrawal

- Dependence, tolerance, withdrawal

- In patients with liver failure give lorazepam, oxazepam, temazepam metabolized by glucuronidation only (Out The Liver)
<table>
<thead>
<tr>
<th>Medication</th>
<th>Brand Names</th>
<th>Uses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Valproate</td>
<td>Depakote (ER)</td>
<td>Mania (mixed episodes and high number of illness manic episodes &gt;10 predict response to valproate), migraine, seizures</td>
</tr>
<tr>
<td>Carbamazepine</td>
<td>Carbatrol, Tegretol XR, Equetro</td>
<td>Seizures, trigeminal neuralgia and (Equetro only) manic and mixed episodes of bipolar disorder</td>
</tr>
<tr>
<td>Oxcarbazepine</td>
<td>Trileptal</td>
<td>Seizures, seizures</td>
</tr>
<tr>
<td>Lamotrigine</td>
<td>Lamictal</td>
<td>seizures</td>
</tr>
<tr>
<td>Gabapentin</td>
<td>Neurontin</td>
<td>Seizures, post-herpetic neuralgia</td>
</tr>
<tr>
<td>Topiramate</td>
<td>Topamax</td>
<td>Seizures, migraine</td>
</tr>
<tr>
<td>Alprazolam</td>
<td>Xanax</td>
<td>Various benzodiazepines are approved by FDA as hypnotics, to treat anxiety disorders (panic, GAD, social anxiety), and in the case of clonazepam, as adjunct in treatment of acute mania</td>
</tr>
<tr>
<td>Diazepam</td>
<td>Valium (oral, IV)</td>
<td></td>
</tr>
<tr>
<td>Lorazepam</td>
<td>Ativan (Oral, IM, IV)</td>
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<tr>
<td>Oxazepam</td>
<td>Serax</td>
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<tr>
<td>Temazepam</td>
<td>Restoril</td>
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<tr>
<td>Hydroxyzine</td>
<td>Vistaril</td>
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<tr>
<td>Benztropine</td>
<td>Cogentin (oral, IM)</td>
<td></td>
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<tr>
<td>Diphenhydramine</td>
<td>Benadryl (oral, IM)</td>
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<tr>
<td>Buspirone</td>
<td>Buspar</td>
<td>GAD</td>
</tr>
<tr>
<td>Naltrexone</td>
<td>Revia (oral, long acting injectable)</td>
<td>Adjunct in treatment of alcoholism</td>
</tr>
<tr>
<td>Disulfiram</td>
<td>Antabuse</td>
<td>Alcohol dependence</td>
</tr>
<tr>
<td>Buprenorphine and Naloxone</td>
<td>Suboxone</td>
<td>Opiate dependence</td>
</tr>
</tbody>
</table>
OTHER SOMATIC TREATMENTS

- FDA approved
  - ECT: Triggers seizures in normal neurons by application of pulses of current through the scalp that propagate to the entire brain.
  - VNS: Stimulation of left vagus nerve; pulse generator in chest wall
  - TMS: Pulsatile high-intensity electromagnetic field induces focal electrical currents in the underlying cerebral cortex
- Not FDA approved
  - Light therapy, neurosurgery in OCD, deep brain stimulation for OCD and refractory depression
VAGUS NERVE STIMULATION (VNS)

• FDA approved for epilepsy; FDA approved for treatment resistant depression 2005

• Pulse generator implanted in left chest wall area, connected to leads attached to left vagus nerve

• Mild electrical pulses applied to CN X for transmission to the brain
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