01 - Chapter 1 How to Succeed in the Psychiatry Cl

Chapter 1 How to Succeed in the Psychiatry Clerkship

2 HOW TO SUCCEED IN THE PSYCHIATRY CLERKSHIP RESPECT THE PATIENTS RESPECT THE FIELD OF PSYCHIATRY ■ Dress in a professional manner. TAKE RESPONSIBILITY FOR YOUR PATIENTS Your psychiatry clerkship will undoubtedly be very interesting and exciting. A key to doing well in this clerkship is finding the balance between drawing a firm boundary of professionalism with your patients while maintaining a relationship of trust and empathy. Why Spend Time on Psychiatry? For most, your medical school psychiatry clerkship will encompass the entirety of your formal training in psychiatry during your career in medicine. Being aware of and understanding the features of mental dysfunction in psychiatric patients will serve you well in recognizing psychiatric symptoms in your patients, regardless of your specialty choice. While anxiety and depression can worsen the prognosis of patients' other medical conditions, medical illnesses can cause significant

psychological stress, often uncovering a previously subclinical psychiatric condition. The stress of extended hospitalizations can strain normal mental and emotional functioning beyond their adaptive reserve, resulting in transient psychiatric symptoms. Psychotropic medications are frequently prescribed in the general population. Many of these drugs have significant medical side effects and drug interactions. You will become familiar with these during your clerkship and will encounter them in clinical practice regardless of your field of medicine. Because of the unique opportunity to spend a great deal of time interacting with your patients, the psychiatry clerkship is an excellent time to practice your interview skills and “bedside manner.” How to Behave on the Wards Always maintain professionalism and give respect to the patients. Be respectful when discussing cases with your residents and attendings. n Regardless of your interest in psychiatry, take the rotation seriously. ■ You may not agree with all the decisions that your residents and attendings make, but it is important for everyone to be on the same page. ■ Because of the intense emotional suffering experienced by psychiatric patients, working with them can be overwhelming. Keep yourself healthy. ■ Psychiatry is a multidisciplinary field. It would behoove you to continuously communicate with nurses, social workers, and psychologists. ■ Address patients formally unless otherwise told. Know as much as possible about your patients: their history, psychiatric and medical problems, test results, treatment plan, and prognosis. Keep your intern

or resident informed of new developments that they might not be aware of, and ask them for any updates you might not be aware of. Assist the team in developing a plan; speak to consultants and family members. Never deliver bad news to patients or family members without the assistance of your supervising resident or attending. RESPECT PATIENTS’ RIGHTS

1. All patients have the right to have their personal medical information kept private. This means do not discuss the patient’s information with family members without that patient’s consent, and do not discuss any patient in public areas (e.g., hallways, elevators, cafeterias).
2. All patients have the right to refuse treatment. This means they can refuse treatment by a specific individual (the medical student) or of a specific type (electroconvulsive therapy). Patients can even refuse lifesaving treatment. The only exceptions to this rule are if the patient is deemed to not have the capacity to make decisions or if the patient is suicidal or homicidal.
3. All patients should be informed of the right to seek advance directives on admission. Often, this is done by the admissions staff or by a social worker. If your patient is chronically ill or has a life-threatening illness, address the subject of advance directives with the assistance of your resident or attending. VOLUNTEER Be enthusiastic and self-motivated. Volunteer to help with a procedure or a difficult task. Volunteer to give a 20-minute talk on a topic of your choice, to take additional patients, and to stay late. BE A TEAM PLAYER Help other medical students with their tasks; teach them information you have learned. Support your supervising intern or resident whenever possible. Never steal the spotlight or make a fellow medical student look bad. If your work for the day is completed, offer to help with tasks on other patients on your team, even if they are not your primary patients; helping to get work done may free up time for the resident or attending to spend more time teaching. KEEP PATIENT INFORMATION HANDY Use a clipboard, notebook, or index cards to keep patient information, including a history and

physical, lab, and test results, at hand. However, make sure to keep all confidential patient information secure. PRESENT PATIENT INFORMATION IN AN ORGANIZED MANNER Here is a template for the “bullet” presentation: “This is a [age]-year-old [gender] with a history of [major history such as bipolar disorder] who presented on [date] with [major symptoms, such as auditory hallucinations] and was found to have [working diagnosis]. [Tests done] showed [results]. Yesterday, the patient [state important changes, new plan, new tests, new medications]. This morning the patient feels [state the patient’s words], and the mental status and physical exams are significant for [state major findings]. Plan is [state plan].” HOW TO SUCCEED IN THE PSYCHIATRY CLERKSHIP

4 HOW TO SUCCEED IN THE PSYCHIATRY CLERKSHIP STUDY WITH FRIENDS STUDY IN A BRIGHT ROOM EAT LIGHT, BALANCED MEALS POCKET CARDS The newly admitted patient generally deserves a longer presentation following the complete history and physical format. Many patients have extensive histories. The complete history should be present in the admission note, but during ward presentations, the entire history is often too much to absorb. In these cases, it will be very important that you generate a good summary that is concise but maintains an accurate picture of the patient. How to Prepare for the Clerkship (Shelf) Exam If you have studied the core psychiatric symptoms and illnesses, you will know a great deal about psychiatry. To specifically study for the clerkship or shelf exam, we recommend: 2–3 weeks before exam: Read this entire review book, taking notes. 10 days before exam: Read the notes you took during the rotation and the corresponding review book sections. 5 days before exam: Read this entire review book, concentrating on lists and mnemonics. 2 days before exam: Exercise, eat well, skim the book, and go to bed early. 1 day before exam: Exercise, eat well, review your notes and the mnemonics, and go to bed on time. Do not have any caffeine after 2 PM. Other helpful studying strategies are discussed below. Group studying can be very helpful. Other people may point out areas that you have not studied enough and may help you focus more effectively. If you tend to get distracted by other people in the room, limit this amount to less than half of your study time. Find the room in your home or library that has the brightest light. This will help prevent you from falling asleep. If you don’t have a bright light, obtain a halogen desk lamp or a light that simulates sunlight. Make sure your meals are balanced, with lean protein, fruits and vegetables, and fiber. A high-sugar, high-carbohydrate meal will give you an initial burst of energy for 1–2 hours, but then your blood sugar will quickly drop. UTILIZE QUESTION BANKS AND/OR TAKE PRACTICE EXAMS The purpose of practice exams is not just for the content that is contained in the questions, but the process of sitting for several hours and attempting to choose the best answer for each and every question. The “cards” on the following page contain information that is often helpful in psychiatry practice. We advise that you make a photocopy of these cards, cut them out, and carry them with you.

Mental Status Exam Appearance/Behavior: Apparent age, attitude and cooperativeness, eye contact, posture, dress and hygiene, psychomotor status. Speech: Rate, rhythm, volume, tone, articulation. Mood: Patient’s subjective emotional state—depressed, anxious, sad, angry, etc. Affect: Objective emotional expression—euthymic, dysphoric, euphoric, appropriate (to stated mood), labile, full, constricted, flat, etc. Thought process: Logical/linear, circumstantial, tangential, flight of ideas, looseness of association, thought blocking. Thought content: Suicidal/homicidal ideation, delusions, ideas of reference, paranoia, obsessions, preoccupations, hyperreligiosity. Perceptual disturbances: Hallucinations, illusions, derealization, depersonalization. Cognition: Level of consciousness: Alert, sleepy, lethargic. Orientation: Person, place, date. Attention/Concentration:

Serial 7s, spell “world” backward. Abstract thought: Interpretation of proverbs, analogies. Memory: Registration: Immediate recall of three objects. Short term: Recall of objects after 5 minutes. Long term: Ask about verifiable personal information. Fund of knowledge: Current events. Insight: Patient’s awareness of their illness and need for treatment. Judgment: Patient’s ability to approach their problems in an appropriate manner. Delirium Characteristics: Acute onset, waxing/waning sensorium (worse at night), disorientation, inattention, impaired cognition, disorganized thinking, altered sleep-wake cycle, perceptual disorders (hallucinations, illusions). Etiology: Drugs (narcotics, benzodiazepines, anticholinergics [e.g., diphenhydramine], TCAs, steroids), EtOH withdrawal, metabolic (cardiac, respiratory, renal, hepatic, endocrine), infection, neurological causes (increased ICP, encephalitis, postictal, stroke). Investigations: Routine: CBC, chemistry panel, glucose, LFTs, TFTs, thiamine, folate, UA, urine toxicology screen, CXR, vital signs. Medium-yield: ABG, ECG (silent MI), ionized Ca2+. If above inconclusive: Head CT/MRI, EEG, LP. Management: Identify/correct underlying cause, simplify Rx regimen, discontinue potentially offensive medications if possible, avoid benzodiazepines (except in EtOH withdrawal), create safe environment, provide reassurance/ education, judiciously use antipsychotics for acute agitation. HOW TO SUCCEED IN THE PSYCHIATRY CLERKSHIP

6 HOW TO SUCCEED IN THE PSYCHIATRY CLERKSHIP Orientation (10): Language (9): Distractibility Irritable mood/insomnia Grandiosity Flight of ideas Agitation/increase in goal-directed activity Speedy thoughts/speech Sex—Male Age >60 years Depression Previous attempt Ethanol/drug abuse Rational thinking loss Suicide in family Organized plan/access No support Sickness Mini-Mental State Examination (MMSE) What is the [year] [season] [date] [day] [month]? (1 pt. each) Where are we [state] [county] [town] [hospital] [floor]? Registration (3): Ask the patient to repeat three unrelated objects (1 pt. each on first attempt). If incomplete on first attempt, repeat up to six times (record number of trials). Attention (5): Either serial 7s or spell “world” backward (1 pt. for each correct letter or number). Delayed recall (3): Ask patient to recall the three objects previously named (1 pt. each). ■ ■Name two common objects, e.g., watch, pen (1 pt. each). ■ ■Repeat the following sentence: “No ifs, ands, or buts” (1 pt.). ■ ■Give patient blank paper. “Take it in your right hand, use both hands to fold it in half, and then put it on the floor” (1 pt. for each part correctly executed). ■ ■Have patient read and follow: “Close your eyes” (1 pt.). ■ ■Ask patient to write a sentence. The sentence must contain a subject and a verb; correct grammar and punctuation are not necessary (1 pt.). ■ ■Ask the patient to copy the design. Each figure must have five sides, and two of the angles must intersect (1 pt.). Mania (“DIG FAST”) Thoughtlessness: seek pleasure without regard to consequences Suicide Risk (“SAD PERSONS”)

Major Depression (“SIG E. CAPS”) Sleep Interest Guilt Energy Concentration Appetite Psychomotor Δs Suicidal ideation ■ ■Hopelessness ■ ■Helplessness ■ ■Worthlessness Drugs of Abuse Drug Intoxication Withdrawal Alcohol benzodiazepines Disinhibition, mood lability, incoordination, slurred speech, ataxia, blackouts (EtOH), respiratory depression Barbiturates Respiratory depression Anxiety, seizures, delirium, life-threatening cardiovascular collapse Opioids CNS depression, nausea, vomiting, sedation, decreased pain perception, decreased GI motility, pupil constriction, respiratory depression Euphoria, increased attention span, aggressiveness, psychomotor agitation, pupil dilatation, hypertension, tachycardia, cardiac arrhythmias, psychosis, formication with cocaine Amphetamines cocaine PCP Belligerence, impulsiveness, psychomotor agitation, vertical/horizontal nystagmus, hyperthermia, tachycardia, ataxia, psychosis, homicidality LSD Altered perceptual states (hallucinations, distortions of time and space), elevation of mood, “bad

trips” (panic reaction), flashbacks (reexperience of the sensations in absence of drug use) Cannabis Euphoria, anxiety, paranoia, slowed time, social withdrawal, increased appetite, dry mouth, tachycardia, amotivational syndrome Nicotine/ Caffeine Restlessness, insomnia, anxiety, anorexia Irritability, lethargy, headache, increased appetite, weight gain First Aid for the Psychiatry Clerkship, 4e; copyright © 2015 McGraw-Hill. All rights reserved. HOW TO SUCCEED IN THE PSYCHIATRY CLERKSHIP Tremulousness, hypertension, tachycardia, anxiety, psychomotor agitation, nausea, seizures, hallucinations, DTs (EtOH) Increased sympathetic activity, N/V, diarrhea, diaphoresis, rhinorrhea, piloerection, yawning, stomach cramps, myalgias, arthralgias, restlessness, anxiety, anorexia Post-use “crash”: restlessness, headache, hunger, severe depression, irritability, insomnia/ hypersomnia, strong psychological craving May have recurrence of symptoms due to reabsorption in GI tract

8 HOW TO SUCCEED IN THE PSYCHIATRY CLERKSHIP Delirium Tremens (DTs): ■ ■Idiosyncratic, time-limited reaction. Serotonin Syndrome: ■ ■May occur at any Li level (usually >1.5). ■ ■Classic ECG finding is QRS >100 ms. ■ ■Discontinue the medication. Psychiatric Emergencies ■ ■Typically within 2–4 days after cessation of EtOH but may occur later. ■ ■Delirium, agitation, fever, autonomic hyperactivity, auditory and visual hallucinations. ■ ■Treat aggressively with benzodiazepines and hydration. Neuroleptic Malignant Syndrome (NMS): ■ ■Fever, rigidity, autonomic instability, clouding of consciousness, elevated WBC/CPK. ■ ■Withhold neuroleptics, hydrate, consider dantrolene, and/or bromocriptine. ■ ■Precipitated by use of two drugs with serotonin-enhancing properties (e.g., MAOI + SSRI). ■ ■Altered mental status, fever, agitation, tremor, myoclonus, hyperreflexia, ataxia, incoordination, diaphoresis, shivering, diarrhea. ■ ■Discontinue offending agents, benzodiazepines, consider cyproheptadine. Tyramine Reaction/Hypertensive Crisis: ■ ■Precipitated by ingestion of tyramine-containing foods while on MAOIs. ■ ■Hypertension, headache, neck stiffness, sweating, nausea, vomiting, visual problems. Most serious consequences are stroke and possibly death. ■ ■Treat with nitroprusside or phentolamine. Acute Dystonia: ■ ■Early, sudden onset of muscle spasm: eyes, tongue, jaw, neck; may lead to laryngospasm requiring intubation. ■ ■Treat with benztropine (Cogentin) or diphenhydramine (Benadryl). ■ ■If clinically appropriate, reduce the dose, discontinue the medication, or switch to another agent. Lithium Toxicity: ■ ■Nausea, vomiting, slurred speech, ataxia, incoordination, myoclonus, hyperreflexia, seizures, nephrogenic diabetes insipidus, delirium, coma. ■ ■Discontinue Li, hydrate aggressively, consider hemodialysis. Tricyclic Antidepressant (TCA) Toxicity: ■ ■Primarily anticholinergic effects, cardiac conduction disturbances, hypotension, respiratory depression, agitation, hallucinations, seizures. ■ ■Treatment includes sodium bicarbonate, activated charcoal, cathartics, supportive treatment.

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