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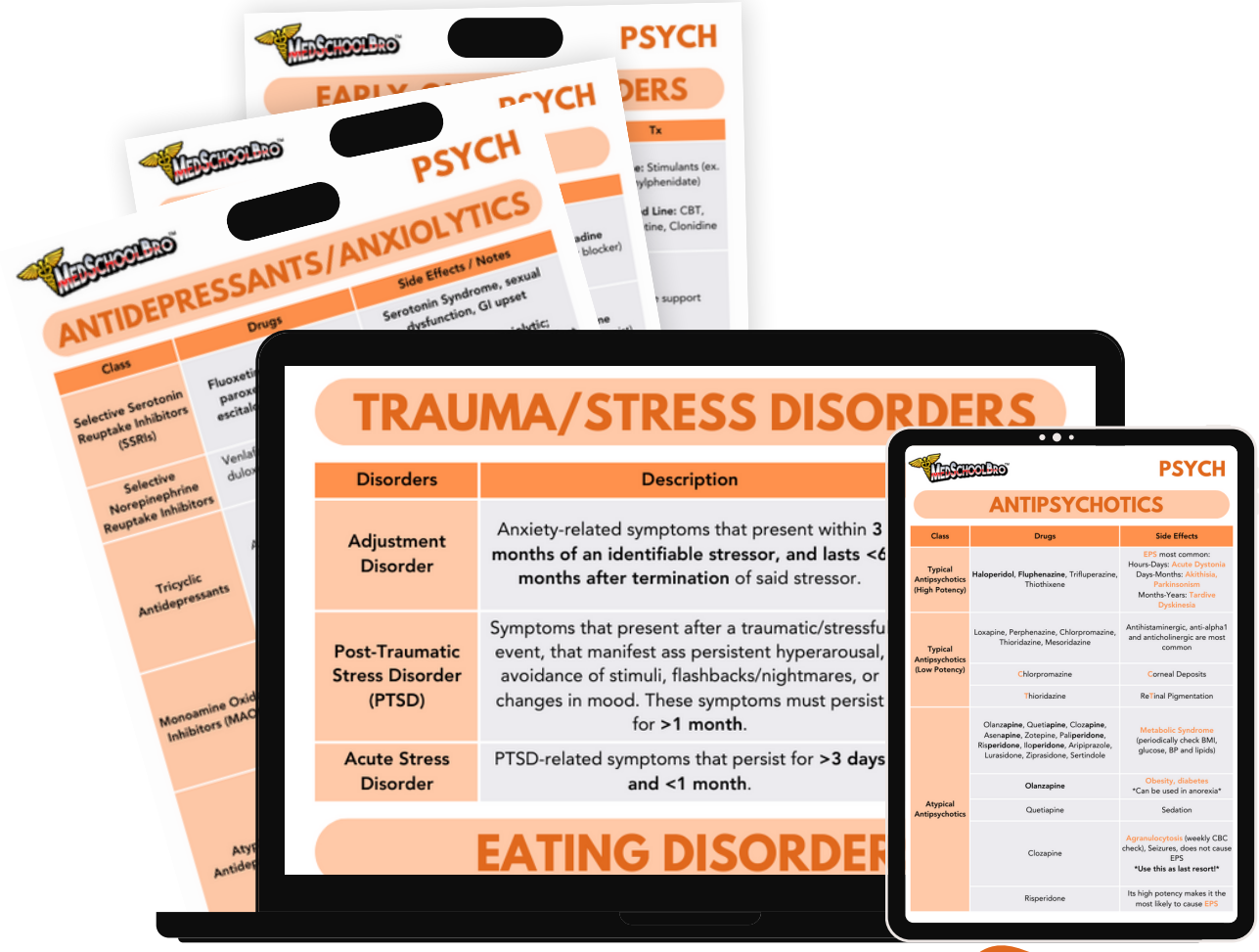
PSYCH TIPS & TRICKS

FOR MED STUDENTS, RESIDENTS, AND JUNIOR DOCTORS



WHEN STUDYING...

- Review common conditions like depression, anxiety, bipolar disorder, schizophrenia. Understand diagnostic criteria, presentation, and treatment options.
- Know your pharmacology well - antidepressants, antipsychotics, mood stabilizers, anxiolytics. Mechanisms, common side effects, drug interactions.
- Understand the black box warnings for medications like antidepressants and antipsychotics. Know what safety monitoring is required.
- Study psychotherapy modalities like CBT, DBT, EMDR, and motivational interviewing. Understand the basics of how they are applied.
- Consider formation of transference and countertransference during psychotherapy.
- Know risk assessment strategies for suicide, homicide, and inability to care for self.
- Study criteria for psychiatric holds and commitment procedures.
- Consider these resources:
- First Aid Psychiatry Clerkship
- OnlineMedEd Psychiatry section
- DSM-5 diagnostic criteria
- Anki flashcards for medications
- **The following is a high yield list of topics to be studied up on for clinic and for your shelf exam:**
    - Psychotic Disorders
    - Mood Disorders
    - Anxiety Disorders
    - ADHD
    - Social Anxiety Disorder
    - PTSD
    - Adjustment Disorder
    - Eating Disorders
    - Drug Intoxication/Withdrawal
    - Psychiatric Medications

It is very important to know these topics like the back of your hand. That being said, in the clinic, it can be hard to make decisions on diagnosis and management.

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WHEN STUDYING...

These are just a few cards from my PSYCH Reference Cards Set that encompass a lot of these conditions and provide you with the most important information to know in the field regarding them

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TRAUMA/STRESS DISORDERS

Disorders	Description	Tx
Adjustment Disorder	Anxiety-related symptoms that present within **3 months of an identifiable stressor, and lasts <6 months after termination** of said stressor.	CBT, Antidepressants
Post-Traumatic Stress Disorder (PTSD)	Symptoms that present after a traumatic/stressful event, that manifest ass persistent hyperarousal, avoidance of stimuli, flashbacks/nightmares, or changes in mood. These symptoms must persist for **>1 month**.	CBT, SSRIs
Acute Stress Disorder	PTSD-related symptoms that persist for **>3 days and <1 month**.	CBT

EATING DISORDERS

Disorders	Description	Tx
Anorexia Nervosa	Severe calorie restriction and weight loss due to a severe fear of weight gain. **BMI** will often be **< 18.5**.	Nutritional rehabilitation, psychotherapy, **Olanzapine**
Bulimia Nervosa	Recurring episodes of binge eating with compensatory purging behaviors that last > 3 months. **Purging** includes self-induced vomiting and excessive exercising. **BMI is often normal**. Common associations: parotid gland hypertrophy, enamel erosion, Mallory-Weiss syndrome, metabolic and electrolyte disturbances, and Russell sign.	Psychotherapy, Antidepressants **Bupropion is contraindicate (seizure risk)
Binge Eating Disorder	Recurring episodes of binge eating that is not followed up with purging behaviours, lasting for **>3 months**. BMI is often greatly increased.	Psychotherap SSRIs

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DRUG INTOXICATION

Disorder	Dx Criteria	Tx
Alcohol	Slurred speech, disinhibition, ataxia, blackouts, memory loss, and impaired judgment. **Long Term:** Cirrhosis, Wernicke-Korsakoff Syndrome	**BZ taper** (Diazepam, Chlordiazepoxide, Lorazepam), Disulfiram
BZ	Delirium and increased risk of falling in the elderly, respiratory depression, coma and amnesia.	Flumazenil
Opioids	Pupillary constriction, constipation, **respiratory depression**, and euphoria. *Look for tract marks*	**Naloxone** along with Methadone (long-term)
Cocaine and Amphetamines	Dilated pupils, tachycardia, **HTN**, psychomotor agitation, psychosis, and cardiac crisis.	**Supportive care or benzos** Alpha then beta blockade if in cardiac crisis
MDMA	Hyperthermia, water intoxication (hyponatremia), pupillary dilation, and psychosis.	Supportive
PCP	Physical agression, nystagmus, enhanced strength, and blunted senses.	BZ and then haloperidol if needed (used to acidify urine)
Cannabis	Conjunctival injection, increased appetite, tired, slow reflexes, and paranoia.	Supportive

DRUG WITHDRAWAL

Disorder	Dx Criteria	Tx
Alcohol, BZ	Tachycardia, HTN, tremor, Delirium Tremens, and seizures.	**Long-acting BZ taper** + short acting BZ
Opioids	Lacrimation, yawning, piloerection, diarrhea, generalized pain, and sweating.	**Methadone** (can use Clonidine as an adjunct)

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WHEN STUDYING...

Consider these resources for studying

- **DSM-5 Diagnostic Criteria:** Everything you diagnose must fit the DSM5 criteria. You will be tested very heavily on these
- **First Aid for the Psychiatry Clerkship:** This is one of the greatest resources for a pediatric clerkship, written by Latha Ganti and Matthew S. Kaufman. It covers hundreds of topics that you need to know to perform well on your shelf exams and wards.
- **OME:** A bank of notes, videos, and questions on all rotations. This is a top 3 rated resource for Step 2 CK prep.

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ANTIPSYCHOTICS

Class	Drugs	Side Effects
Typical Antipsychotics (High Potency)	**Haloperidol**, **Fluphenazine**, Trifluperazine, Thiothixene	EPS most common: Hours-Days: Acute Dystonia Days-Months: Akithisia, Parkinsonism Months-Years: Tardive Dyskinesia
Typical Antipsychotics (Low Potency)	Loxapine, Perphenazine, Chlorpromazine, Thioridazine, Mesoridazine	Antihistaminergic, anti-alpha1 and anticholinergic are most common
	Chlorpromazine	Corneal Deposits
	Thioridazine	ReTinal Pigmentation
Atypical Antipsychotics	Olanz**apine**, Quet**iapine**, Cloz**apine**, Asen**apine**, Zotepine, Pali**peridone**, Ris**peridone**, Ilo**peridone**, Aripiprazole, Lurasidone, Ziprasidone, Sertindole	Metabolic Syndrome (periodically check BMI, glucose, BP and lipids)
	Olanzapine	Obesity, diabetes *Can be used in anorexia*
	Quetiapine	Sedation
	Clozapine	Agranulocytosis (weekly CBC check), Seizures, does not cause EPS ***Use this as last resort!***
	Risperidone	Its high potency makes it the most likely to cause EPS

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MOOD DISORDERS

Disorder	Dx Criteria	Tx
Major Depressive Disorder (MDD)	One or more episodes of depression (**>5** SIG E CAPS), each occurring for a duration of at least **2 weeks**. • Sleep Disturbances • Interest Dec (anedonia) • Guilt • Energy Dec • Concentration Dec • Appetite Changes • Psychomotor retardation • Suicidality	**Psychotherapy + Antidepressants:** 1. **SSRIs or SNRIs** 2. Alternative Antidepressants *Consider **ECT** in resistant MDD or when rapid resolution of symptoms is needed*
Persistent Depressive Disorder (PDD)	Dysthymia or depression continuing over a **2-year** period (1 year in children) with no discrete episodes of illness.	Psychotherapy + Antidepressants
Bipolar I	Episodes of both mania (**>3** DIGFASTER; for at least **1 week**; causes impaired functioning) + depression • Distractibility • Insomnia • Grandiosity • Flight of Ideas • Agitation or Inc Activity • Sexual Exploitation • Talktative • Elevated Mood • Racing Thoughts	**First Line: Mood Stabilizers** (Lithium, Valproate, Carbamazapine) **Second Line**: Atypical Antipsychotics (especially if currently in a depressive episode (**Quetiapine**)) *Give a short acting BZ or Haloperidol if pt agitated* *Do not give antidepressants as it can trigger mania*
Bipolar II	Episodes of both hypomania (does **not** impair functioning; for **>4 days**) + depression.	*Refer to above*
Cyclothymic Disorder	Hypomania and dysthymia occurring over a **2-year** period (1 year in children) with no discrete episodes of illness.	*Refer to above*

BEFORE YOUR PSYCH ROTATION

- Once you receive onboarding information, feel free to reach out to the physician/resident beforehand. Let them know who you are and that you will be joining them for the next X weeks. Keep the message short though, do not try to say too much; just be genuine.
- Email is the most professional outlet to do so, but reaching out via cell phone is also widely accepted nowadays
- Practitionet (practitionet.com) is a program you can look into for assistance with reaching out and getting connected
- Once you have your schedule, check the list of patient cases for your week so you can read about them in advance. If you do this, then you can:
- Read up on the basic science and interventions regarding the disease.
- Understand any possible implications, next steps in management and more
- Know what to look for when you are operating or rounding on the case. This does not only include what is typical for different diseases, but what may also be irregular presentations of the same diseases.
- Note what to expect in terms of development based on age of presentation
- If time allows, head over to the location that you will be rotating at and get a lay of the land beforehand.
- Knowing your drugs, how they work, 1st, 2nd and 3rd line for each diagnosis is important. The biggest thing Psychiatrists like to pimp on is drugs, uses and side effects.

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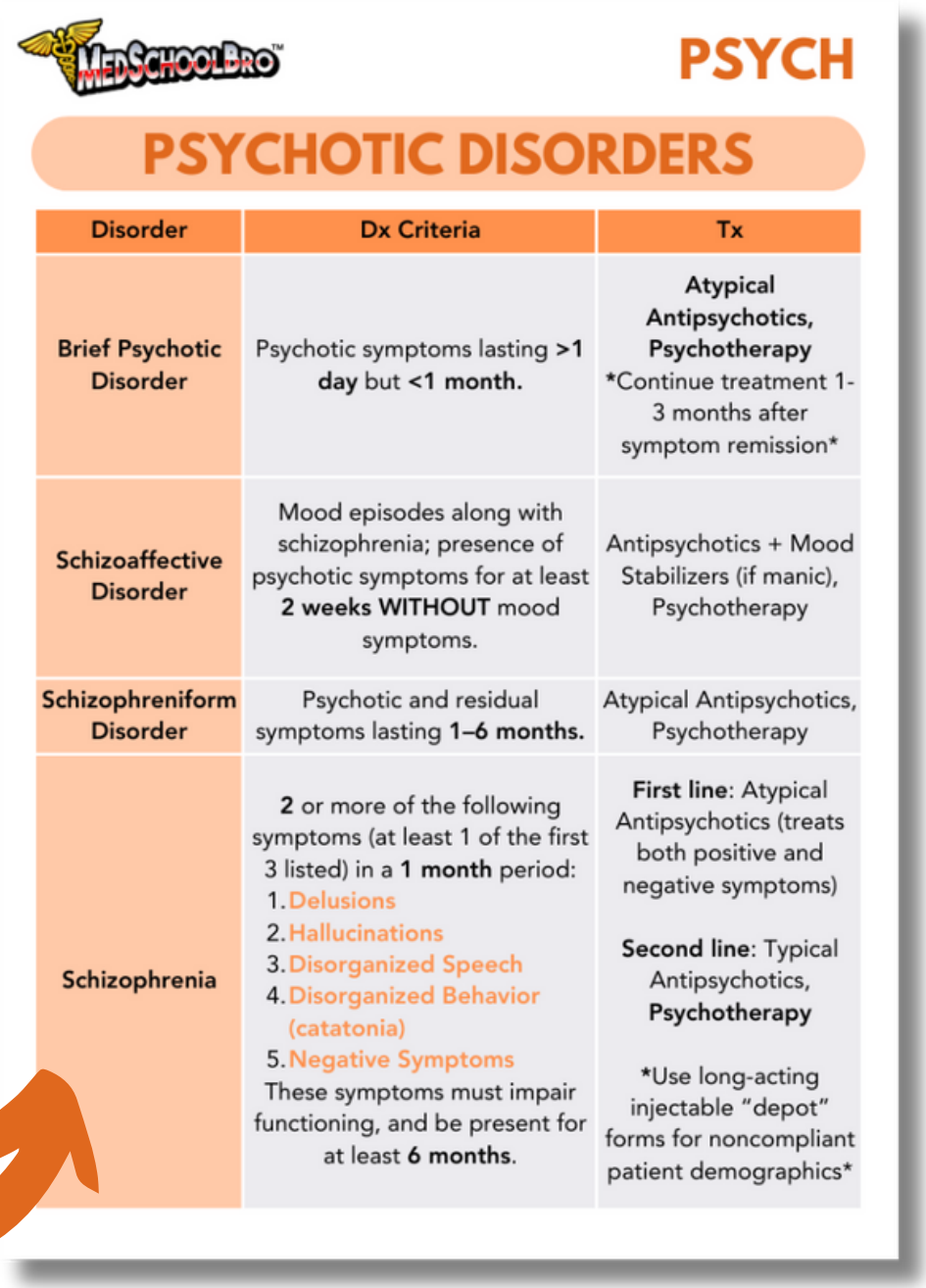
DURING YOUR PSYCH ROTATION

- Understand your intention with this rotation.
- Are you interested in specializing in psychiatry? Perfect! Use this as the opportunity to really dive in, learn, make connections, and get better at your craft. See as many patients as you can, ask to practice techniques, etc.
- Not sure if you are interested in psychiatry? That's fine! That is the whole point of the rotation. Use this time to dive in and really get your full experience. That way you can walk away from your rotation knowing you for sure want to do surgery, or for sure do not.
- No interest in psychiatry at all? Again, totally fine. But, keep this in mind: you have the next X weeks to have your experience in psychiatry for potentially the rest of your life. Live your experience to the fullest, and still be eager to learn as you can transfer a lot of your lessons into other rotations and specialties.
- Also keep in mind that your preceptor's evaluation is still something that residency programs will see. It is still important to work hard and make a good impression.
- Remember, oftentimes the patients you are seeing are in a much different mind state than you. Remember to always be respectful and mindful with whatever you may see.

Building genuine rapport with your patients is so important to helping your patients. Greeting them with a smile, showing sympathy when you can and letting them on certain topics can be helpful, especially when patients may feel more comfortable expressing a sensitive topic to you and not the preceptor. Sharing that information for the preceptor can be even more helpful for them too!

Timelines are everything! Understanding the timeline of diagnoses will be helpful throughout your rotation, for example: Schizoaffective Disorder, Schizophreniform & Schizophrenia have distinct timelines and can easily be confused.

You can use my PSYCH cards which have all timelines bolded



DURING YOUR PSYCH ROTATION

- If you see a very unique/interesting case during your time rotating, ask your preceptor if you can potentially write it up. This is a great chance for you to get published!
- Ask your preceptor for feedback. There is always room to improve so be willing to ask and receive feedback. Now, learn from this and implement the feedback.
- Ask questions! As much as psychiatrists will pimp you out, it is also okay for you to ask questions. This shows them that you are here to learn. It is always better to look like an open learner rather than a know-it-all; trust me, what you think you know, the psychiatrist knows 100 times more.
- Be fully present during patient encounters - make eye contact, avoid distraction, silence electronics.
- Practice reflective listening skills - repeat back key statements showing your understanding.
- Ask open-ended questions that can't be answered with just yes or no to encourage storytelling.
- Also ask about strengths, supports, reasons for living - not just symptoms.
- Present patient cases thoroughly with abundant subjective detail and good descriptive language. Strive to describe their internal experience.
- Pay attention to diagnosis-related behaviors - flat affect in depression, pressured speech in mania, labile affect with borderline personality
- Useful apps to use while you are in clinic:
    - **Hospitalist Handbook** helps you quickly learn how to approach different diseases or conditions that are common in the hospital setting.
    - **Epocrates** helps get you clinical decision support, and saves time with prescribing. This not only helps with choosing medications, but also with dosing.
    - **MDCalc** is a free app that allows you to calculate different risk/score calculations.
    - **UpToDate** helps you find the most up-to-date information in medicine regarding diagnoses, management, and treatment.

AFTER YOUR PSYCH ROTATION

- Consider leaving a thank you note for the psychiatrist on your last day. If possible, even a thoughtful little gift (ex. Their favorite candy, etc.). Physicians really appreciate knowing that you took something away from their rotation and so showing that gratitude goes miles. Seeing that you even took the time to write out a note over texting/emailing them also shows them how thoughtful you are.
- If this is the field you want to pursue, definitely try to maintain a long term relationship with this physician. Write a follow up letter 2 weeks after your rotation has ended. Talk about what the experience meant to you. Let them know you appreciated their mentorship and would be happy to work together in the future in some medium. Maybe even setting up some further shadowing.
- If this is the field you want to pursue, consider them for a letter of recommendation. An important thing to consider for an LOR is one that would have an institution's letterhead.
- Reflect on your capacity for empathy, cultural sensitivity, and comfort with ambiguous situations. Identify areas for personal and professional growth.

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