The Massachusetts General Hospital / McLean Hospital

Residency Handbook of Psychiatry

By the Residents & Faculties of the Massachusetts General and McLean Hospitals

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Residency Handbook *of* Psychiatry

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To our faculty, for teaching us the how
and
our patients, for reminding us of the why
and
our families, especially Anna, Jason and Nikki,
for their unwavering support

INTRODUCTION

The tripartite mission of Massachusetts General Hospital (MGH) and McLean Psychiatry is clinical care, training, and scholarship. With this volume, our residents, past and current, have "hit the trifecta" by teaming up to create a guide to patient care; to offer a scholarly, evidence-informed resource; and to help their fellow trainees everywhere. We are very proud of these people for what they have accomplished, from before they joined the MGH/McLean Residency to how they go about their work now and for their producing this stellar text. That they came together around this project is not surprising; the defining characteristic of our residency classes has been their dedication to others through community service, care of patients, and support of each other. With this volume, they have broadened that support of their fellow residents from within our program to include all of their fellow residents from coast to coast and around the world. With this volume, not only will psychiatry residents have a practical guide and a reference for their training journey, but they will also have some of the most inspiring young psychiatrists in their pocket to accompany them. With pride, we are inspired by them to introduce this book to you.

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FOREWORD

Every July, our program's attention turns to welcoming new PGY 1 and 2 residents with much teaching, supervision, and support from our senior residents. To that end, we have a residency handbook that covers many clinical and practical aspects for a beginning resident in our program. Using this handbook as a PGY-2 resident in 2007, James Niels Rosenquist and Sherry Nykiel (Class of 2009) decided to expand the content of our handbook into a useful book that would be helpful to residents beyond our program. That began a 2-year odyssey that quickly caught the hearts and minds of the residents and faculty at MGH and McLean.

Every year, 16 residents join our program, and 16 residents graduate. Our residents come from all over the United States and other countries. They represent a unique group of psychiatry residents in their brilliance, generosity, collegial spirit, curiosity, and desire to have fun while pursuing rigorous training. This training provides them a shot at a star-studded career in academic psychiatry and as outstanding clinicians wherever they find themselves practicing. Nearly two thirds of each class stay in Boston, and we are continually enriched by their passion for psychiatry and contributions to our field. This handbook is one contribution that we present to you with the hope that our enthusiasm and commitment to learning touches you as you consult it around the clock, whether alone or with others. The heartfelt efforts of our residents imbue this handbook, and I encourage you to appropriate their wit, wisdom, and grit as you go about the task of using your clinical experiences to become the best psychiatrist possible!

Kathy Sanders, MD
Director, MGH/McLean Adult Psychiatry
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EDITORS' PREFACE

It is fair to say that psychiatry is the most ambiguous of the medical professions, both in terms of diagnosis and treatment. Although this provides a particular (and to many in our field, exciting) clinical challenge, it does not mean that a careful and systematic approach to the practice of psychiatry is unnecessary. This book seeks to provide those in clinical training with a concise and accurate source of diagnostic and treatment information for quick reference. In the design and production of this book, we, as both editors and residents, have been guided by a simple proposition—what do we need most and most often? At times, our answers to these questions deviated from existing references, particularly in terms of the organization and presentation of the material. We welcome feedback on these and all other aspects of the book as we seek to improve it for future editions.

This book is the result of a large collaboration between the residents of the MGH/McLean residency program and the faculty of both institutions. Although this book has been written by residents for residents, our work would have proven impossible without the significant assistance of the numerous faculty members who served as guides to us in this project. We as residents have been blessed with these faculty who have served, with little tangible reward, as our teachers, mentors, and friends as we worked our way through the challenges of psychiatric training.

James Niels Rosenquist, MD, PhD

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Boston, Massachusetts
September 2008

LIST OF FACULTY ADVISORS

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HOW TO USE THIS BOOK

As in all of medicine, a systematic approach is invaluable both in the diagnosis and treatment of impaired mental functioning. This book is designed to provide an easily accessible and basic guide to assist clinicians-in-training in their work-up and care of psychiatric patients both in the inpatient and outpatient setting.

In this vein, the book is divided into six sections, roughly corresponding to different clinical settings and activities:

Chapter 1: The Psychiatric Evaluation

- Provides an overview of a psychiatric diagnostic interview
- Includes information on instruments such as the Mental Status Exam and the Mini-Mental Status Exam as well as important laboratory tests to consider in psychiatric patients

Chapter 2: Psychiatric Emergencies

- Provides information on the workup and treatment of individuals with acute alterations in mental status
- Designed for use in emergency department settings and for acute inpatient consultations

Chapter 3: Psychiatric Symptoms and Management

- Provides an overview of the major psychiatric symptoms encountered both in inpatient and outpatient settings
- Considers both diagnosis and treatment of specific symptoms

Chapter 4: Special Populations

- Provides an overview of population-specific considerations in the diagnosis and treatment of psychiatric symptoms

Chapter 5: Treatment Modalities

- Provides a brief overview of pharmacological, somatic, and psychotherapeutic methods of treatment

Chapter 6: Clinical References

- Provides brief reference sections in medicine and neurology that have specific relevance to psychiatrists-in-training
- Includes specific advice on the evaluation of research papers

Numerous cross-references appear throughout the text to allow for quick access to key material. Although the book is designed as a reference guide, it may also be useful to students and others seeking to gain an introduction to this fascinating field.

CONTENTS

Chapter 1

THE PSYCHIATRIC EVALUATION

A psychiatric evaluation follows the same approach as any medical evaluation, with additional components designed to test for evidence of underlying psychiatric disorders. The format of a psychiatric evaluation contains the information listed in Table 1-1.

TABLE 1-1 Approach to the Evaluation of Psychiatric Patients

History

Sources of Information
Chief complaint
Identifying information
- Age, gender, ethnicity, relevant psychiatric history, means of presenting, symptoms, context of symptoms
- *Example: This is a 46-year-old married white woman with a past psychiatric history of depression who presents to the ED in an ambulance with worsening depression and suicidal ideation in the context of recent economic and relationship stressors.*

History of Present Illness
- Nature of symptoms (in the patient's own words when possible)
- Onset, duration, qualities, what makes it better or worse
- Recent stressors that may be contributing to symptoms
- Detailed questions regarding feelings of safety

Psychiatric Review of Systems
- Depression and suicidal ideation (see page 65 for more details)
- Anxiety (see page 52 for more details)
- Mania (see page 76 for more details)
- Psychosis (see page 92 for more details)

Psychiatric History
- Previous diagnoses and age(s) diagnosed
- Previous hospitalizations (where, when, why)
- Previous treaters
- Previous medication trials
- Current treaters (with contact numbers), including therapists, psychopharmacologists, primary care physician, other specialists
- Current medications and allergies

Medical History
- All medical diagnoses and past surgeries
- Medications including dosages
- Allergies

Family History
- Type of relative (relation, maternal vs. paternal)
- Conditions
- Suicide attempts; completed suicides

Social History
- Where born and raised and by whom
- Siblings(s) information (level of functioning including education, employment and relationships)

(*continued*)

TABLE 1-1 Approach to the Evaluation of Psychiatric Patients (*continued*)

- Abuse (see page 72 for more details)
- Highest level of education
- Past and current employment
- Current source of income
- Current relationships (married, single, children?)
- Substance abuse history: Substances used, amount, time since last use, treatment history (see page 102 for more details)
- Legal issues

Medical Review of Systems

Focus on major organ systems as well as neurologic symptoms (see Appendix I)

Physical Examination

General medical and neurologic examination (see Appendix II)

Mental Status Examination

Psychiatric mental status (see below for details)
Mini-mental status examination in all geriatric patients and when otherwise appropriate

Laboratory Studies, Imaging Studies, and Other Diagnostic Tests

First-line tests: Toxicology screens (blood and urine), chemistries, thyroid-stimulating hormone level, complete blood count, urinalysis
Second-line tests, if indicated: Dependent on particular symptoms

Global Assessment of Functioning

91–100: Superior functioning in a wide range of activities; life's problems never seem to get out of hand; is sought out by others because of his or her many qualities. No symptoms.

81–90: Absent or minimal symptoms; good functioning in all areas; interested and involved in a wide range of activities; socially effective; generally satisfied with life; no more than everyday problems or concerns.

71–80: If symptoms are present, they are transient and expectable reactions to psychosocial stresses; no more than slight impairment in social, occupational, or school functioning.

61–70: Some mild symptoms OR some difficulty in social, occupational, or school functioning but generally functioning pretty well and has some meaningful interpersonal relationships.

51–60: Moderate symptoms OR any moderate difficulty in social, occupational, or school functioning.

41–50: Serious symptoms OR any serious impairment in social, occupational, or school functioning.

31–40: Some impairment in reality testing or communication OR major impairment in several areas, such as work or school, family relations, judgment, thinking, or mood.

21–30: Behavior is considerably influenced by delusions or hallucinations OR serious impairment in communications or judgment OR inability to function in all areas.

11–20: Some danger of hurting self or others OR occasionally fails to maintain minimal personal hygiene OR gross impairment in communication.

1–10: Persistent danger of severely hurting self or others OR persistent inability to maintain minimum personal hygiene OR serious suicidal act with clear expectation of death.

0: Not enough information available to provide global assessment of function.

(*continued*)

TABLE 1-1 Approach to the Evaluation of Psychiatric Patients (*continued*)

Assessment and Plan
Items to Include • Identifying information (from HPI) • Symptoms present • Formulation • Diagnosis (or diagnoses) with discussion of differential **Plan** • Level of acuity • Recommended behavioral interventions (if any) • Recommended pharmacologic or somatic interventions (if any)

Specific diagnostic components of the psychiatric evaluation include the mental status examination and (when appropriate) the mini-mental status examination. Mental Status Exam:

- Can be thought of as physical exam in assessing CNS function
- Should address key areas of mood, thought, and cognition
- Use precise language when describing exam

TABLE 1-2 Terms Used in the Mental Status Examination

Category	Terms
General/ appearance	No apparent distress (NAD) (Normal) Posture Normal gait or gait disturbance Well-developed, well-nourished, undernourished Obese, thin, cachectic Appears stated age or appears younger or older than stated age Good hygiene, appropriately dressed Disheveled, unkempt Malodorous
Attitude/ behavior	Cooperative, engaged, friendly, pleasant Uncooperative Hostile Guarded Evasive Masked facies Apathetic Disorganized behavior Hostile or defiant
Psychomotor	Normal Agitated or restless Retarded or slowed Tremor, mannerisms, tics, rigidity or dystonia, dyskinesias Pacing, decreased arm swing Stereotyped behavior, gesticulations, posturing Akathisia

(*continued*)

TABLE 1-2 Terms Used in the Mental Status Examination (*continued*)

Eye contact	Appropriate Downcast Staring Avoids or evasive Furtive Glances Intense or glaring
Speech	Fluent or nonfluent Incoherent or garbled Mute Tone: Normal, high, low, monotonous Rate: Normal, increased, decreased Prosody: Normal, abnormal, flattened, amplified, exaggerated, staccato Amount: Talkative, reticent Style: Pressured, hesitant, slurred, mumbling, muttering, dysarthric Stuttering Accent Paraphasic errors Aphasia
Mood (in patient's own words)	Happy, sad, OK, depressed, angry
Affect (expressed emotion)	Congruent or incongruent Appropriate or inappropriate Labile or non-labile Flat, blunted, restricted Reactive Expansive Euphoric Apathetic
Thought content (in patient's own words)	Suicidal ideation (SI): Passive, plan, means, intent, impulsive, preparation, attempt Homicidal ideation (HI): Passive, plan, means, intent, target, impulsive, preparation, attempt Delusions: Paranoid, persecutory, grandiose, erotomanic, jealous, somatic, control Preoccupations or ruminations Somatic or hypochondriacal Obsessions or compulsions Phobias Poverty

(*continued*)

TABLE 1-2 Terms Used in the Mental Status Examination (*continued*)

Thought process (observed)	Linear, coherent, goal directed Ruminative, perseverative Rambling Impoverished Looseness of association, circumstantial, or tangential Magical thinking Responsive to internal stimuli Ideas of reference Thought blocking Racing thoughts or flight of ideas Disorganized or confused Word salad Incoherent Neologism Clanging Rhyming Echolalia Thought insertion, broadcasting, or withdrawal
Sensorium (observed)	Awake and alert Sedated and drowsy Barely arousable Disoriented Fluctuating sensorium Obtunded Hallucinations: Auditory, visual, olfactory, gustatory, tactile
Cognition	Memory grossly intact: Normal or abnormal remote, recent past, immediate or recall **Folstein Mini-Mental Status Examination** • Published by Psychological Assessment Resources • More detailed test of bedside cognitive testing • Useful tool to assess for dementia • Standard part of geriatric evaluation Confabulations Concentration: Good, poor Abstraction: Good, poor Fund of information: Good, average, poor Attention span: Normal, impaired, distractible Language: Normal, impaired naming, repeats, writing Vocabulary: Normal, impaired Intelligence: High, above average, average, below average
Impulse control	Good, fair, questionable, poor, impaired
Insight	Good, fair, questionable, poor, impaired
Judgment	Good, fair, questionable, poor