Resident Teaching Manual
2009/2010

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Introduction

Welcome to the wonderful world of teaching! Psychiatry is a less known area of medicine to most medical students. They have no idea what to expect when they start their rotation, except what they have heard from the years of student interns ahead of them- psychiatry is a joke, it's so easy, nobody ever calls you, it's like being on holiday… etc. As residents in psychiatry, we have an obligation to put an end to those rumors and one of they ways we can do that is by becoming more involved in medical student education and by showing the students that psychiatry is an exciting field of medicine and the material they learn can be applied to ALL aspects of medicine.

It is important for us to remember that, as residents, we have an important role as Scholars. As per the CanMEDS Guidelines 2005, it is our job to demonstrate a commitment to life long learning and to the creation, propagation, application and translation of medical knowledge. A large part of that role involves facilitating the learning of our students, fellow residents, patients, families and other health care professionals on the field of psychiatry and all that it entails. This is defined in the CanMEDS Guidelines as follows:

- Describe principles of learning relevant to medical education
- Collaboratively identify the learning needs and desired learning outcomes of others
- Select effective teaching strategies and content to facilitate others' learning
- Demonstrate an effective lecture or presentation
- Assess and reflect on a teaching encounter
- Provide effective feedback
- Describe the principles of ethics with respect to teaching

This manual was developed by residents for residents in order to assist you in both fulfilling your role as a scholar and in teaching medical students on the ward and in the emergency room. It is our hope that you will find the contents of this manual useful and we would like to extend an opportunity for you to provide us with feedback .

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How to Use this Manual

This manual is meant to act as a guideline for residents to follow when they are teaching on the wards. Residents are encouraged to supplement teaching sessions based on their own knowledge and level of student interest. As there is much to be covered within each subject area, the aim of these seminars will be to supplement the didactic teaching sessions they attend during the rotation. The **focus of the resident seminars will be clinical assessment**. Each seminar is designed to be 45 minutes. Students should be encouraged to attend their daily seminars at the University Hospital and to read around the cases they see when they are on call and on the ward.

Practical Considerations:

- Ψ The seminars are to be done primarily by PGY-II Residents, on their General Adult Rotation. For sites not involved in the PGY-II year, such as Alberta Hospital and the Royal Alex, senior residents on service at those sites will be expected to conduct the seminars as per the CanMEDS guidelines.
- Ψ The student interns are on a 6 week rotation, with exams in the middle of the 6th week. All seminars should be completed by the end of the 5th week.
- Ψ There should be a resident at each site in charge of coordinating these seminars.
- Ψ Staff at each site will need to identify appropriate dates and times for these 45 minute seminars to take place. Regular days and times for each week and each rotation will ensure they are consistently being done. These could be identified in advance to starting the seminars and identified in the student manual.
- Ψ A seminar evaluation form will be given to students at the end of the rotation so that we can further develop and improve upon the delivery and content of these seminars.

Teaching Tips

General Tips

Perhaps one of the biggest challenges you, as residents, will face when it comes to teaching med students is to figure out what works best for both yourself and the students. This takes time, patience, practice and a willingness to try different strategies. Here are some tips that will hopefully give you a bit of an idea of where to start when you see those eager/blank/unimpressed student eyes staring at you on the day you all meet for a teaching session:

- Ψ One of the most important things to remember is that if you are not interested then your students will not be interested! The more enthusiastic and excited you are about teaching psychiatry, the more your students will want to learn about it AND the more they will remember what you've taught them. Just think about some of your favorite teachers over the years, what did you like about them? Chances are if they've left a positive impression on you then they likely conveyed their enthusiasm and passion for the topic they were teaching.

- Ψ People retain more information when they have not only heard it but also when they have seen it, written it down and are able to review it with another person. This is one of the key reasons that student interns are exposed to the mantra "See one, do one, teach one!" In psychiatry, we practice a modified version of this mantra, in psych we read about it, meet a patient with it, and then talk about it. The more the students see, the more they are going to remember what they have read about and the more comfortable they are going to be at recognizing it on their own.

- Ψ Don't be afraid of asking your students how they learn best, this will give you an idea of how to run the session. For example, if you are talking about mania there are a few ways you can go about running the session:

    a) *Toss them into the fire method:* Introduce the students to a manic patient and give them 5 minutes or so to ask some questions of the patient, then go have a sit down in the cafeteria with coffee and review what they have seen.
    b) *Give them some direction method:* Go to the cafeteria, get a coffee and talk about mania- the signs, symptoms, epidemiology, etiology… etc and then introduce them to a manic patient and let them take it away.
    c) *Show them how it's done method:* Have the students watch you interview a manic patient then go to the cafeteria, get a coffee and review mania with them.

Teaching Microskills

1. Get a commitment - *What do you think is going on? What would you like to accomplish on this visit?*

2. Probe for supporting evidence - *What led you to that conclusion? What else did you consider?*

3. Where possible, teach general rules - *When this happens, do this....*

4. Reinforce what was right - *Specifically, you did an excellent job of....*

5. Correct mistakes - *Next time this happens, try this....*

6. Identify next learning steps - *What do we need to learn more about?*

Levels of Understanding

When teaching junior colleagues, it is easy to get caught up and focused solely on knowledge. However, it is important to teach clinical reasoning, application of knowledge, and synthesis of information. Try to prompt the students to use multiple levels of understanding. Here's an example of how you can use different forms of questioning to test different skills! (Adapted from Bloom's taxonomy of questions)

EVALUATION
For what reason would you favor...?
Do you agree or disagree with this statement?

SYNTHESIS
What would be your treatment approach?
What would you do if...?

ANALYSIS
What are the strengths and weaknesses of...?
How is …… related to...?

APPLICATION
What would happen if...?

COMPREHENSION
Explain the....
What can you conclude....?

KNOWLEDGE
What are the three causes of...?

Evidence Based Teaching Tips

Here are a few more points to keep in mind when teaching medical students that were addressed in a recent article by Lake and Ryan (2004) in the Medical Journal of Australia:

- Adult learning involves several assumptions:
  - Adults want to have input in their learning
    - Motivation- eager to learn vs eager to pass exam
    - Relevant Topic- emphasize why topic important, how it relates to future career
    - Practical focus
    - Objectives set forth at beginning of session
    - Participation in learning process
    - Regular feedback
    - Reflection and Self Assessment time
  - Teachers should be flexible in how they teach and the style should be based on a student's stage of learning

		Teaching Style		
		Authority	**Motivator/Facilitator**	**Delegator**
Stage of Learning	**Dependent Learner**	Good Match		
	Interested Learner		Good Match	
	Self Directed Learner			Good Match

* Taken from Lake & Ryan (2004)

  - Teachers need to be considerate of the environment in which they teach, not all moments are good teaching moments:
    - Time constraints
    - Location (busy, noisy)
    - Patient availability and maintenance of patient dignity
    - Student attitude and level of knowledge (students feel more confident at the end of their rotation versus at the beginning)
    - Student comfort (are their opinions valued, do they feel like a part of the team)

Teaching Do’s and Don’ts

From an article by Gordon (2003), here is a rather useful list of Teaching Do’s and Don’ts:

Do	Don’t
Welcome your students	Appear unprepared
Establish achievable objectives	Have vague expectations
Remember what it was like to be a student	“Nit-pick”
Keep it interesting and relevant	Humiliate, embarrass, and berate
Provide on-going feedback	Leave feedback until the final evaluation
Encourage participation	

SESSION 1- PSYCHIATRIC HISTORY

Instructions: This seminar should be done within the first few days of the student rotation, and should take approximately 45 minutes. Students have a copy of this handout in the booklet they received, you should direct them to follow along as you go through it. As there is a lot to be covered, this seminar is meant to introduce them to the structure of the history and mental status exam, and give them a sense of what kind of things to ask. During subsequent seminars on psychosis, anxiety, mania and suicide, the mental status exam will be expanded upon and practiced.

ID: Name, age, race, occupation, source of income, living arrangements

Source of History: patient, old charts, collateral info

Mode of Admission/Presentation: Form 10 – brought in by police for mental health assessment, Form 1 – certified under mental health act by a physician at a non-designated psychiatric (ie – Stony Plain, Leduc) facility & transferred for psych assessment, brought by family/friends, self presentation etc.

CC: Record in patients own words, as well as your understanding of reason for the consult…ie Pt states I need protection from the Russians", consult requested by ER physician for acute psychosis.

HPI:
Students tend to struggle with the HPI as there is much information to be gathered and they may find it difficult to organize. Emphasize the HPI section, in particular the "5 S's" as it provides a way to remember both content and organization

The 5 S's….
>**Situation** – what's been happening that led to presentation (ie – impulsive OD after breakup with boyfriend. Took pills then called boyfriend to say goodbye…boyfriend called police.)
->Stressors – what has been happening in their life that may be contributing to their current presentation
->Symptoms

- ***Mood*** –***Depression*** (MSIGECAPS)– Mood depressed, Sleep increased or decreased, Interest decreased, Guilt, Energy poor, Concentration/memory impairment, Appetite increase or decrease, Psychomotor slowing, Suicidal thoughts
  - ***Mania***-(MGSTPAID)Mood euphoric or irritable, Grandiosity (special talents?), Sleep (decreased need for) Talkativeness,

Psychomotor agitation, Appetite decrease, Impulsivity,
Distractibility

- ***Psychosis*** – hallucinations, delusions, ideas of reference, thought insertion/withdrawal/broadcasting, mind reading, paranoia
- ***Anxiety*** – generalized, panic attacks, social phobia, PTSD, OCD

->Safety – suicidal ideation/intent/plan/means

- homicidal ideation/intent/means/specific victim?->Tarasoff rules (duty to warn – will be discussed in next seminar)
- recent aggression/violence

->Substances – Drugs, alcohol, cigarettes…What? How much? When last used? Pattern of use? Has it gotten them into trouble (bar fights, DUIs, family tensions etc) ? Withdrawal? Tolerance?

Past Psychiatric History

Explain: Unlike the typical "Past Medical History", this section is not simply a list of previous diagnoses. Other info as below should be obtained to allow us to put the patient's current presentation in the context of their history and aids us in determining diagnosis and disposition at the end of our assessment, particularly in the emergency room.

- previous diagnosis and treatments
- previous treatments – which meds? What dose? How long? Did they help?
- previous group treatments/psychotherapies
- previous substance abuse treatments – AADAC, AA, Henwood etc
- regular psychiatrist? Therapist? When did they seem them last? Next appt?
- # previous hospitalizations? Where? How long did they stay?
- # suicide attempts –what where they, how serious, when
- previous self harm (parasuicidal behaviour) – cutting, burning etc

Medications – List of current meds and doses. Also include notation of any recent changes, and level of compliance.

Allergies - If the patient names an allergy, ask what type of reaction they had to the drug. Often extrapyramidal side effects to antipsychotics will be falsely named as allergies. If this is the case, they may still be used with caution, depending on the severity of the previous reaction.

Past Medical History – particularly include previous head injuries, seizure disorders & other neurologic issues, endocrine disturbances

Family History – Ask specifically about psychiatric illness – if they say someone had a "breakdown" try to find out as much as you can about what happened to them

Family/Personal Relationships

-important others/supports at present – parents, siblings, partner, children
-quality/description of important relationship

Personal History

The personal history allows us to gain a sense of who the patient is as a person, and their baseline levels of social and occupational functioning.

-Pregnancy & birth – illness, complications, maternal drugs/alcohol?
-Early development – normal milestones? Temperament/personality as a young child
-Schooling – enjoy it? How did they do? Any particular difficulties? Change in level of achievement at some point? Why?
-Social development – Able to make friends? Type of peer group
-Adolescence – deviance, truancy, drugs/alcohol
-Relationships – dating/romantic relationships? Ask them to describe significant ones, strengths and challenges of the relationships, sex of partner. If no relationships, why not?
-Occupational – how far did they go in school, post secondary training, types of jobs they have held, when they last worked
-Legal – any legal charges or convictions – particularly for assault etc …aids in risk assessment (strong predictor of violence is previous violence), DUI, drug related charges, outstanding issues/court dates pending? Do they own weapons?

Mental Status Exam

INTRODUCTION
-this is your system-specific exam for psychiatry, similar to the pelvic exam in gynecology or the respiratory exam in pulmonary medicine

-DSM IV criteria to diagnose mental illnesses rely on changes in perception, cognition, emotion, and behaviour. Any change in one can affect all.
-Begins as soon as you see the patient. Much is done by your observation during the interview, other aspects come from the content of your interview.
-Here is a review of basic components of the mental status exam. We will practice the mental status exam on patients with different illnesses in upcoming seminars.

-**Appearance –** dress, grooming, general behaviour, facial expression
-Attitude to interviewer – indifferent, passive, dependent, hostile, suspicious, manipulative, dramatic
-**Mood** (subjective) – how they describe themselves to feel
-**Affect** (objective) – How they look like they feel
    Quality – depressed, euthymic, euphoric, anxious, fearful
    Range - blunted – no emotional sensitivity
        - flat – limited emotional expression
        - constricted – decreased range of emotion

- expansive – broad range of emotion
- labile – rapid, minute to minute variability

Appropriateness – Is the affect consistent with the subjective mood, situation, or content of interview (congruent)? (ie – a patient who appears euphoric when describing the recent death of a family member has an inappropriate affect)

-**Speech** – rate (slow, fast, pressured, regular), rhythm/prosody, volume, tone

-**Thought form** – HOW are they thinking? Pattern?

- logical, linear
- Perseverative – pathologic persistence of a single idea
- Incoherent – thought processes so disrupted they do not result in a single idea
- Circumstantial – Proceeding indirecting to a goal, with the addition of many tedious and irrelevant details
- Tangential – divergent thought processes, never come back to the original issue
- Loose associations – lack of logical relationships between thoughts or ideas
- Blocking – sudden halting of thought
- Flight of ideas – rapidly skipping from one idea to the next, ideas remain connected
- Poverty of thought – decreased content
- Racing/slowing of thought processes

-**Thought content** – WHAT are they thinking?

- Suicidal & homicidal ideation
- Psychotic content (mind reading, ideas/delusions of reference, thought insertion/withdrawal?)
- Preoccupation with anything in particular?
- Obsession s – persistent unwanted, intrusive, inappropriate or distressing thoughts that cannot be eliminated
- Ruminations – repetitive, excessive worries
- Hyperreligiosity

-Perception – Hallucinations (auditory, visual, tactile), illusions

-**Cognition** – Alert and oriented? Appropriate to level of education? Should do Folstein MMSE if age>65 or if suspect organic impairment (head injury, chronic alcohol use etc)

-**Memory** – Long term & reliability of history, short term

-**Insight** – Do they recognize they are ill? Recognize need for treatment?

-**Judgement** – reasonable? Risk of impulsivity? Poor judgement? May include social, financial, planning, and other

Impression- Give summary of patient presentation and most likely diagnosis, describe any predisposing (ie + family history), precipitating (ie – med non compliance), perpetuating (ie – poor coping skills), and protective factors (ie strong social supports) to for this patient. Would this patient benefit from admission? Certified or voluntary?

Multiaxial Diagnosis
Axis I – most psychiatric disorders, and substance abuse/dependence (include your differential)
Axis II - personality disorders/traits, intellectual impairment
Axis III – medical problems
Axis IV – psychosocial stressors
Axis V – Global Assessment of Functioning (GAF)

Plan
-Biopsychosocial
-immediate, short term, long term

SESSION 2 - SAFETY CONSIDERATIONS

Instructions: This seminar should occur in close proximity to the Psychiatric History session. It may be worthwhile pointing out to students that knowing how to maintain both the safety of the patient and themselves is not only useful in Psychiatry but also in ALL other areas of medicine (ie: delirious patients, demented patients, upset children and parents…). Psychiatric patients are no more likely to be violent than patients admitted to other services.

Disclaimers

- Ψ Most psych patients do not present an acute risk of physical danger to others, however there are some who will and it is our job to help you to recognize those who do
- Ψ It is NOT the medical student's job to intervene if a patient does become violent

General Precautions

- Ψ Recognize a potentially violent patient
  - o Psychomotor agitation, pacing, fist pounding, loud and abusive language
  - o Patient that is brought in with a history of violent/aggressive behavior- such as cruelty to animals, assault history… etc
  - o Unpredictable patients that may appear "okay"- quiet, diminished eye contact, appearing to be responding to internal stimuli but it's always best to exercise caution.
  - o Patients who are intoxicated , brought in by police, confused
  - o Patients who have just been told they are going to be admitted against their will
  - o Patients who demand to be admitted but have been denied admission
  - o Patients who have just been denied a desired drug (ie: NICOTINE)

- Ψ Ensure your safety!
  - o Ensure you let your resident or the nurse know when you are going into the room to begin your assessment
  - o Sit down. Speak calmly. Avoid confrontation. Maintain a safe distance between you and the patient.
  - o Sit close to the door, but do not block it so as to make the patient feel trapped.
  - o Know where your exits are
  - o Be aware of any potential projectiles that may be in the room (ie: food, coffee, chairs, books, bed…)

- Do not be afraid to ask the resident, the staff, the nurse or security to be with you during your evaluation or at key moments (e.g. for injections, or when telling the patient something they don't want to hear).
- Trust your instincts- if your spider senses are going off or if you feel apprehensive or fearful, terminate the interview
- Inform resident, staff, nurses of situations where you have felt unsafe and talk about it with them. *By talking openly about safety we can create safer environments in the future.*

Agitation

In discussing how students should approach an agitated patient, most of the general precautions described above will come into play. It may be worthwhile repeating it in the specific context of dealing with a known agitated patient.

- Ψ Conduct interview in quiet, nonstimulating environment (but NOT the Quiet Room in the ER)
- Ψ Ensure both patient and examiner have access to an exit
- Ψ Avoid confrontational/menacing behavior- standing over patient, staring, touching
- Ψ Ensure people know where you are and, if possible have security nearby in case of an emergency
- Ψ Ask about weapons- will the patient give them up? Ensure they get placed in a secure area. Note that if a patient ever tells you they have weapons, IT IS NOT YOUR JOB TO TAKE THEM AWAY. It is your job to terminate the interview, and alert security, your resident, nurses, and/or staff physicians.
- Ψ If agitation continues or worsens or if you feel unsafe at any time, terminate the interview

Mental Health Act

- Ψ **Form 10-** filled out by a Peace Officer (usually a Police Officer). This form gives a peace officer the authority to transport someone, who they feel is a danger to themselves or others and/or ***may*** be suffering from a mental illness, to the hospital for examination. When the peace officer brings a person to a facility and accepted into the care of a physician, the legal obligations of the peace officer have been fulfilled and the responsibility falls to the accepting physician to either certify or NOT certify the patient. *Clarify with students that the Form 10 cannot be used to HOLD a patient in the hospital against his/her will, however, the patient cannot leave the*

emergency/hospital if they were brought in on a Form 10 UNTIL they have been seen by a physician.

- **Form 1**- This is a physician certificate and is, therefore, completed by a physician when he/she feels that the following 3 criteria are met:

    - The person is suffering from a mental disorder
    - The person is in a condition presenting or likely to present a danger to themselves or others
    - The person is unsuitable for admission to a facility other than as a formal patient (ie: they are not willing to stay in the hospital voluntarily)
- A completed Form 1 allows us to hold a patient in the hospital for a period of 24 hours.
- Another Form 1 completed within 24hours of the first certificate enables us to hold a patient in the hospital for up to 30 days.
- **Form 2** – this is a renewal certificate, to be completed before the second form 1 expires if the patient is still certifiable. There must be two form 2's completed within 24 hours of each other. One of the physicians completing the form must be a psychiatrist. This allows us to hold a patient in hospital for up to another 30 days.
- If the patient is still certifiable at the end of the 30 days, another set of form 2s may be completed (also valid 30 days), following this, any form 2's are valid for 6 months and then they come to mandatory review by the review board.
- Every patient has the right to appeal the Form 1 or Form 2. This is accomplished via the completion of a **Form 12**, which is generally given to patients by the nursing staff once they are brought to the ward.
- Once a Form 12 has been submitted, a Review Panel is scheduled. *Residents should discuss who is involved in a review panel and what the role of the treating physician is (ie: to demonstrate/prove that the patient suffers from a mental illness, that he/she is a danger to themselves or others, and that he/she is unwilling to stay in hospital as a voluntary patient).*

If there is sufficient time, other aspects of the mental health act could be discussed such as Form 3's and Form 8's.

Suicide – will be covered in the next seminar

Homicide and Duty to warn

Students need to know that there will be some times when they will be faced with a patient who makes threats against others. As with Suicide, the take home message is:

Always ask about homicidal thoughts, previous assaultive behavior, specific plans to harm another, the NAME of the person they wish to harm, and if they have access to firearms

- Ψ Duty to warn
  - refers to the responsibility of a physician to breach confidentiality if a patient or other identifiable person is in clear or imminent danger.
  - In situations where there is clear evidence of danger to the client or other persons, the physician must determine the degree of seriousness of the threat and notify the person in danger and others who are in a position to protect that person from harm (Herlihy & Sheeley, 1988; Pate, 1992).

- Ψ Tarasoff *briefly relay to students why the duty to warn precedent came into play, reminding them also that it is not their job to be a savior to all. We work in a team and if they come across a situation whereby a patient has described an intent to harm someone else or themselves then they need to communicate that to the resident and staff.*
  - The Tarasoff case came out of California back in 1976. A male student at the University of California was seeing a psychologist because he had a fixation on a fellow female student (Ms Tarasoff). It came to light during their sessions that this male student's attachment to Ms. Tarasoff was pathological and he had voiced the intent to purchase a gun.
  - The psychologist informed the police in both writing and verbally about the student's intent to harm Ms Tarasoff.
  - The police questioned the student and found him to be of no immediate danger and made him promise to stay away from Ms Tarasoff. Despite this, the student proceeded to stalk and kill Ms. Tarasoff.
  - The family took the case to the Supreme Court of California. The Tarasoff family sued the Univeristy Health Center, where the psychologist worked stating that the psychologist and the University Health Center had a duty to warn the family and Ms Tarasoff of the danger.

- The courts imposed an affirmative duty on therapists to warn a potential victim of intended harm by the client, stating that the right to confidentiality ends when the public peril begins

SESSION 3 - THE SUICIDAL PATIENT

Instructions: This seminar is meant to be the first of those using BEDSIDE teaching. Prior to the seminar, you will need to identify a suicidal patient on the ward, and gain their permission to bring in a small group of students for a short interview. The diagnosis of the patient doesn't really matter, although one with severe depression or strong borderline traits may best illustrate the concepts.

With the students, sit down for 10-15 minutes to talk about suicide risk factors and what type of information should be gathered from patient to assess suicide risk. Then go see the patient for another 10-15 minutes, and ask some of the questions you just identified as important. After that, sit down with the students again to discuss further.

What are risk factors for suicide?

1. Gender
   a. Men commit suicide 3 times more than women
   b. Women attempt suicide 4 times more than men

2. Method
   a. Men use more lethal methods (ie firearms, hanging)
   b. Women more commonly take overdoses

3. Age – Rate generally increases with age
   a. In men, suicide rate peaks after age 45
   b. In women, suicide rate peaks after age 65
   c. Rapid rise after age 75 in both sexes
   d. Rapid rise in males 15-24

4. Race
   a. 2/3 of suicides committed by Caucasian males
   b. Rates also higher in Natives and Inuit

5. Religion
   a. Rate lower in Catholics, Muslims, Jews.

6. Marital status
   a. Rate twice as high in single persons than in married persons
   b. Death of spouse increases risk
   c. For women, having young children at home is protective
   d. Homosexual at higher risk than heterosexual

7. Physical Health – medical illness/chronic pain a risk factor

8. Mental illness

a. Depressive Disorders – 50% of all people who commit suicide are depressed. 15% of depressed patients kill themselves
b. Schizophrenia – most often in the first few years of their illness, particularly if high functioning, high insight. Increased risk with command hallucinations or prominent delusions
c. Alcohol and other substance dependence- suicide rate 20x general population in those who are dependent on drugs
d. Personality Disorders – borderline PD has high rate of parasuicidal behavior, sometime accidental suicide! 5% with antisocial personality commit suicide.
e. Dementia/Delirium
f. Anxiety Disorder – 20% of patients with panic d/o or social phobia attempt suicide, risk increased if also depressed

9. Other risk factors
    a. Unambiguous wish to die
    b. Unemployment
    c. Sense of hopelessness
    d. Rescue unlikely
    e. Hoarding pills
    f. Access to lethal agents or firearms
    g. Family history of suicide or depression
    h. Fantasies of reunion with deceased loved ones
    i. Occupation: dentist, physician, nurse, scientist, police officer, farmer
    j. Previous suicide attempt
    k. History of childhood physical or sexual abuse
    l. History of impulsive or aggressive behavior

******* risk factors are demographic and based on population statistics therefore, each patients risk has to be assessed on an individual basis******

What might be the differences between those who attempt suicide and those who complete suicide?

Contrast Between Typical Suicide Completers and Attempters

	COMPLETER	ATTEMPTER
Sex	Male	Female
Age	Older	Younger
Impulsivity	Low	High
Substance use	High	Very high
Method	Firearms, hanging	Overdose, cutting oneself
Motivation	Self-directed	Interpersonal-directed
Suicide Note	Often	Sometimes
Chance of discovery	Low	High

Suicidal preoccupation and intent	High	Low
Plan	Well-planned	Impulsive

You can use this opportunity to contrast between a "truly" suicidal patient and a "parasuicidal" patient. Point out the differences between a 65 year old diabetic widower with a long history of depression, who plans to shoot himself with a rifle he keeps on his farm versus a 19 year old female with a history of cutting herself superficially and multiple overdose attempts in times of stress, presenting with another impulsive overdose .

How would you approach seeing a suicidal patient?
-Safety first – make sure you are seeing the patient in a safe location, and that someone else knows where you are!
-Take a full history!
-Especially important are the Full HPI to determine working Axis I diagnosis and Personal History to determine Axis II

Assuming you already have the rest of the history, what questions could you ask to thoroughly discuss suicide in particular?
Interviewing the Potentially Suicidal Patient

Presence of Suicidal Ideation

Does it ever seem like life is not worth living anymore?

Have you ever felt so bad you thought life was not worth living?

Have you been thinking about hurting yourself or taking your life?

Many patients who are depressed think about suicide. Have you had thoughts like this?

Intent

How strong are these feelings?

What would have to happen for you to commit suicide?

What would have to happen for you to decide not to commit suicide?

Under what conditions would you seriously consider suicide?

What's preventing you from committing suicide?

Why commit suicide now?

Meaning

What is the problem you are trying to resolve by committing suicide?

What will suicide do for you?

What do you hope to accomplish by committing suicide?

Plan

If you were to commit suicide, how would you do it?

What have you done in past suicide attempts?
What preparations have you made?

Past History

How have you coped with this stress before?
Have you ever tried to kill or hurt yourself before?
Have you ever attempted or seriously considered suicide before?
How close have you come to attempting suicide in the past?
What happened?
What were you hoping to accomplish?
How did others react?

Protective

Who else have you told about these thoughts?
Who can be with you during this stressful time?
Who do you have in your life for support?
Will you be safe?
If you feel increasingly suicidal, how would you handle it? What could you do instead of acting on those thoughts?

After this discussion, take the students to see a patient on the ward. Tell them to take a few minutes to discuss suicide with this patient. You may have them do it together as a group, have one student volunteer, or you can demonstrate. Be sure you have told the patient you are coming to discuss his or her suicidal thoughts.

After a short session with the patient, bring the students elsewhere to sit down and continue a discussion.

How would you describe the mental status examination of the patient we just saw? *(if needed, prompt the students through each section…what was her appearance like? How did she describe her mood? What about affect? Etc etc)*

Things you might see on mental status of a depressed patient

- lack of eye contact, slumped posture, disheveled, poor hygiene (because they don't care)
- depressed mood, congruent affect – restricted, blunted, or flat
- psychomotor slowing, including slowed speech
- hopelessness and worthlessness in thought content
- suicidal ideation/plan
- Hallucinations telling the patient they are worthless, or to kill themselves
- Psychotic symptoms – nihilistic, mood congruent delusions

- variable level of insight
- variable judgment

The presence of delirium or psychosis may make the history unreliable and predispose the patient to impulsive and unpredictable behavior, thus increasing suicide risk. The presence of “command hallucinations” (i.e., hearing voices telling the individual to kill themselves) may be especially ominous.

INTERVENTION

The ultimate goal of intervention is to protect the patient from self-harm. However, suicides will occur, despite our best efforts.

Most patients with suicidal thoughts can be treated on an outpatient basis. There is little evidence that an inpatient approach diminishes the risk of suicide in the community. Inpatient treatment interferes with the patient's normal activities and sense of autonomy, institutionalizes the "sick role," and can interfere with the therapeutic relationship (especially if involuntary).

->Indications for inpatient treatment:

Need to shelter patient from self-harm
Need to develop supports sufficient to justify outpatient treatment
Need to examine the patient in a no drugged state
Need to observe the patient to determine the risk of suicide attempt
Need to remove the patient from a stressful situation
Need to stabilize the patient's emotional state
Need to reassess outpatient treatment.

Clinical Decision Making (in psychiatry or any area of medicine you see a patient with suicidal ideation)

-Is the patient certifiable?
-Do they need admission or further assessment by a psychiatrist?

Choices to make in Emergency

1) Admit or discharge
    a. Short stay (preferably for axis II in crisis) vs. regular ward
2) Certify or not

If not admitting, APPROPRIATE FOLLOW UP MUST BE IN PLACE (and documented!) Involve supportive family and friends. Give precise instructions to the patient's social network regarding care and supervision. Have someone stay with the patient until the suicidal crisis has passed. Do not allow the patient to be alone, even in the health care facility (close observation)

Identify the patient's personal strengths and emphasize them to the patient. If the patient is to be treated as an outpatient, provide a 24-hour emergency telephone number.
* *There is no research evidence that suicide contracts are effective at lowering the rate of suicide, and they do not provide absolute legal protection, but they do promote collaboration*.

CONCLUSION

In many cases, suicide can be prevented.
Recognition of risk factors as indicators is critical. However, recall that **risk factors are demographic and based on population statistics therefore, each patients risk has to be assessed on an individual basis.**
Depression, isolation, prior suicide attempts, substance abuse, and serious mental illness rank as highly significant contributors.
Swift and decisive interventions based upon a thorough assessment can save lives.

SESSION 4 – PSYCHOSIS AND SCHIZOPHRENIA

Instructions: For this seminar you should take the students to see a psychotic patient on the ward. Spend about 10 minutes chatting with the patient, asking some open ended questions so students can get a send of thought process as well as whatever closed ended questions you may need to ask to elicit the psychotic content. You may wish to give the students opportunity to ask questions of the patient, but limit time spent to about 10 minutes, then take the students to sit down somewhere and chat about the content of this guide.

What is Psychosis?
It is the gross impairment of reality testing.

What are psychotic symptoms?

1. Hallucinations: are sensory perceptions in the absence of external stimuli.
2. Delusions: firmly held false beliefs e.g. Jealousy
   Persecutory
   Grandiose
   Somatic
   Capgras Syndrome
3. Thought disorder: disruption in the form or organization of thinking e.g. incoherent, loosening of association, overinclusive, neologism, thought blocking, clanging, echolalia, poverty of speech

How would you describe the mental status examination of the patient we just saw?
If needed, prompt the students through the different sections of the MSE…what was his appearance like? How would you describe his affect? Etc etc

What other things might you see on mental status of a psychotic patient?
Some examples…
-General Appearance: inappropriate or odd dress and poor hygiene
-Thought form: poverty of speech, tangential, incoherent, derailment, irrelevant, loose associations, thought insertion, thought withdrawal
-Thought content: paranoia, ideas/delusions of reference, suicidal or homicidal ideation
-Perceptual distortions: hallucinations (auditory most common primary psychiatric illness, visual often drug-related, tactile often drug withdrawal…ie formication with etoh withdrawal)
-Cognition: may be affected by thought content
-Attention and concentration: may be affected by perceptual distortions
-Insight – typically poor, but varying levels
-Judgment – variable but generally some impairment

When you see a psychotic patient, what is your differential diagnosis?
Differential Diagnosis:

a) Mood Disorders
   - Schizoaffective disorder: mood component is prominent and patient experiences psychotic symptoms for at least 2 weeks when euthymic
   - Bipolar disorder: psychosis only during manic or depressive episodes
   - Psychotic depression: psychosis only during depressive episodes

b) Schizophreniform disorder
   - Prodrome, active and residual phases all are of less than 6 months duration

c) Brief Psychotic disorder
   - Duration less than 1 month

d) Delusional disorder
   - Non bizarre delusions

e) Drug induced Psychosis
   - History or laboratory evidence of drug usage, visual hallucinations

f) Organic etiologies
   - Evidence of organicity clinically or from tests, atypical history or presentation

In thinking about your differential, what kind of things must you consider about your patient's assessment?

1. Ensure that you have obtained a good history, physical exam and neurological exam
2. Important diagnostic questions:
   a) Has organicity been ruled out?
   b) Is there a delirium or dementia as suggested by cognitive deficits?
   c) Is the illness episodic or continuous?
   d) Are any negative or positive symptoms present?
   e) Are there any depressive or manic symptoms?
   f) Is there a history of substance usage?
   g) What is the duration of the illness?

NOT ALL PSYCHOSIS IS SCHIZOPHRENIA

After making this point, which is a common misconception among students, you can move on to talk a little about schizophrenia itself. You may want to quickly run through these points, so you have enough time to go on and talk about drugs

Points on Schizophrenia

-1% worldwide prevalence.
-Lifetime risk equal for males and females

-Age of onset for Males – 18-25yrs, Females- 26-45yrs (20% have second peak 40-50yrs of age)

What causes schizophrenia?
-Genetic component -> Monozygotic twins 40-50%, Dizygotic concordance 10-15%
- theories of etiology include:
1. Dopamine hyperactivity
2. Serotonin dysfunction
3. Viral hypothesis
4. Stress diathesis model

What are some Biological abnormalities?
1. Reduced volume of prefrontal cortex and thalamus
2. Increased volume of lateral and 3rd ventricle and basal ganglia
3. Hypofrontality

What are the predictors of poor outcome?
1. Insiduous onset
2. Younger age of onset
3. Negative symptoms
4. Poor premorbid functioning
5. Substance abuse
6. Comorbid disorder
7. Disadvantaged minority status
8. Absence of remissions

What is the prognosis?
-Rule of 1/3…1/3 improve, 1/3 stay the same, 1/3 get worse

What are the forms of treatment?
BIOPSYCHOSOCIAL
1. Psychological – support groups, therapies as indicated
2. Social – time off work, disability, AISH, life skills training, family education, activity groups
3. Biological treatment
   - ECT
   - ANTIPSYCHOTICS
     - -> Typical – ie haloperidol, chlorpromazine
     - -> Atypical- ie – risperidone, olanzapine, quetiapine, clozapine

What are the differences between typical and atypical agents?

Typical	Atypical
	1. "Second generation"
1. D2 antagonism	2. D2 and 5HT2 antagonism

2. May produce EPS	3. Little EPS, but metabolic s/e
3. Elevate prolactin levels	4. No or little elevation of prolactin
4. Ineffective for treating negative symptoms	5. More effective for negative symptoms

What are injectable forms of antipsychotics?

1. Depot formulations:
    a) Zuclopenthixol
    b) Flupenthixol
    c) Risperidone

2. Short/intermediate acting formulations:
    a) Haloperidol
    b) Olanzapine
    c) Zuclopenthixol accuphase

What are the EPS?

1. Acute dystonia
    - Symptom/sign: involuntary muscle contraction that may involve neck (torticollis), tongue, back and eyes (oculogyric crisis)
    - Treatment: benztropine, diphenhydramine, diazepam
2. Akathisia
    - Symptoms/sign: sensation of motor restlessness most prominent in lower extremities
    - Treatment: lower dose of anti-psychotic, benztropine, lorazepam
3. Parkinsoniasm
    - Symptoms/sign: rigidity, tremor, bradykinesia
    - Treatment: lower neuroleptic dose, switch to atypical, add anticholinergic e.g benztropine
4. Tardive dyskinesia
    - Symptoms/sign: late developing involuntary choreiform movement disorder
    - Risk factors:
        a) Old age
        b) Affective disorder
        c) Female
        d) Exposure for more than 6 months
        e) History of Parkinsonian side effects
        f) High dose conventional drugs
    - Treatment: discontinue/decrease dose, switch to atypical drug, clozapine for Tardive dystonia

What are common side effects of atypical antipsychotics?

-metabolic – weight gain, DMII, high cholesterol
-orthostatic hypotension
-somnolence

-clozapine – risk of agranulocytosis and lowers seizure threshold

What is Neuroleptic Malignant Syndrome (NMS)

- Symptoms/sign: lethal complication of treatment with antipsychotic drugs characterized by hyperthermia, autonomic instability, diaphoresis, confusion, elevated CPK, fluctuating levels of consciousness and rigidity
- Treatment: discontinue drug, rehydrate, temperature control, bromocriptine or dantrolene

SESSION 5- MANIA

Instructions: For this seminar you should take the students to see a manic patient on the ward. Spend about 10 minutes chatting with the patient, asking some open ended questions so students can get a sense of the thought process, speech, and thought content as well as whatever closed ended questions you may need to ask to elicit the mania related symptoms. You may wish to give the students opportunity to ask questions of the patient, but limit time spent to about 10 minutes, then take the students to sit down somewhere and chat about the content of this guide.

What is Bipolar Disorder?

- Bipolar disorder is the general term for a group of disorders characterized by cyclical disturbances in mood, cognition, and behavior. **Bipolar I disorder** refers to patients who have had at least one episode of mania. **Bipolar II disorder** refers to patients with a history of hypomania and major depressive episodes. **Cyclothymia** refers to patients with chronic (at least 2-year duration) mood swings that fluctuate between hypomania and minor but not major depression.
- Mania is one of the defining syndromes of bipolar affective disorders (BDs), which have a 2-4% life time prevalence
- M=F (BAD I); M<F (BAD II)
- Duration of untreated manic episode= 12 weeks
- 17-19% lifetime risk of suicide (15-20x more than general population)
- 25-50% bipolar patients attempt suicide at least once during their lifetime
- bipolar depression and mixed states are frequently associated with suicidal acts

What are the manic symptoms?

- Persistently elated, angry, and/or irritable mood.
- Grandiose ideas and delusions. Predominant themes may be religious, sexual, financial, political, and persecutory.
- Decreased need for sleep.
- Pressured and/or rapid/rambling speech. Often the patient is difficult to interrupt.
- The patient may be easily distractible, rapidly going from one activity to another.
- Flight of ideas or subjective experience that thoughts are racing
- Increased goal-directed behavior and thoughts

- There is often an increase in energy with psychomotor hyperactivity or agitation
- Excessive involvement in pleasurable activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments)

How would you describe the mental status examination of the patient we just saw?
If needed, prompt the students through the different sections of the MSE…what was his appearance like? How would you describe his speech (ie: pressured, flight of ideas, clang associations)?

What other things might you see on mental status of a manic patient?

- **Appearance**: Their attire reflects the mania. Their clothes might have been put on in haste and are disorganized. Alternately, their garments often are too bright, colorful, or garish. They stand out in a crowd because their dress frequently attracts attention.
- **Behavior:** Patients experiencing the manic phase are hyperactive and might be hypervigilant. They are restless, energized, and active. They talk and act fast.
- **Affect/mood**: The mood is inappropriately joyous, elated, and jubilant. They are euphoric. They also may demonstrate annoyance and irritability, especially if the mania has been present for a significant length of time.
- **Thought content**: During the manic phase, patients have very expansive and optimistic thinking. They may be excessively self-confident and/or grandiose. They often have a very rapid production of ideas and thoughts. They perceive their minds as being very active and see themselves as being highly engaging and creative. They are highly distractible and quickly shift from one person to another
- **Perceptions**: Approximately three fourths of patients in the manic phase have delusions. The delusional content is either consistent or inconsistent with the mania. Manic delusions reflect perceptions of power, prestige, position, self-worth, and glory
- **Suicide/self-destruction**: Incidence of suicide is low in a manic patient. It is important however, to recognize the impulsivity of the manic patient as a significant risk factor for committing unintentional self harm behaviors.
- **Homicide/violence/aggression**: Persons in mania can be openly combative and aggressive. They have no patience or tolerance for others. They can be highly demanding, violently assertive, and highly irritable. The homicidal element particularly emerges if these individuals have a delusional content to their mania. They are acting out of the grandiose belief that others must obey their commands, wishes, and directives. If their delusions become persecutory in nature, they may defend themselves against others in a homicidal fashion

- **Judgment/insight**: The hallmark of this phase is seriously impaired judgment. They make terrible decisions in their work and family. They may invest the family fortune in very questionable programs. They may become professionally over-involved in work activities or with coworkers. They start a series of dramatic very unsound fiscal or professional ventures. They tend not to listen to feedback, suggestions, or advice from friends, family, or colleagues. They have little insight into the extreme nature of their demands, plans, and behavior. Often, a forced admission proves the only way to contain them
- **Cognition**: Impairments in orientation and memory are seldom observed in patients with bipolar disorder unless they are very psychotic. They know the time and their location, and they recognize people. They can remember immediate, recent, and distant events. In some cases of hypomanic and even manic episodes, their ability to recall information can be extremely vivid and expanded. In extremes of depression and mania, they may experience difficulty in concentrating and focusing.

When you see a manic patient, what is your differential diagnosis?

- Mood Disorder secondary to a General Medical Condition
- Substance induced Mood Disorder (organic causes)
- Schizoaffective disorder
- Schizophrenia
- Brief reactive psychosis
- Delusional Disorder
- Personality disorder (ie: Borderline Personality Disorder)

Organic Causes of Bipolar Mood Syndromes	
Drugs	Crystal meth, amphetamines, cocaine, steroids, Interferon
Neurologic factors	Dementia, Stroke, Vasculitis, MS, Head injury, Tumor, abscess
Metabolic factors	Thyroid disorders, postoperative states, adrenal disorders, vitamin B12 deficiency, electrolyte abnormalities
Infection	AIDS related dementia

What investigations would you do to rule out organicity AND as baseline tests prior to initiating treatment?

- CBC with diff, electrolytes, BUN, Cr, glucose
- ALT, Alk Phos, TBili
- TSH, FT4 (if indicated)
- Serum Tox Screen (if indicated)

- Urine R&M
- Urine Tox for amphetamines, narcotics, opiods, cannabis, cocaine
- CT Head (particularly if suspect MS or R frontal lobe pathology)
- Full Neurological exam

What are some other important things to know about Mania and Bipolar Affective Disorder?

- Etiology

  - **Genetic factors:** About half of all patients with Bipolar I Disorder have one parent who also has a mood disorder, usually Major Depressive Disorder. Twin Studies reveal a concordance rate of 40%. First-degree biological relatives of individuals with Bipolar I Disorder have elevated rates of Bipolar I Disorder (4%-24%), Bipolar II Disorder (1%-5%), and Major Depressive Disorder (4%-24%). If both parents have Bipolar I Disorder, the child has a 50%-75% chance of developing a mood disorder.

  - **Environmental factors:** Certain environmental factors (e.g., antidepressant medication, antipsychotic medication, electroconvulsive therapy, stimulants, drug withdrawal) or certain illnesses (e.g., multiple sclerosis, brain tumor, hyperthyroidism) or hormonal changes can trigger mania.

- Pathophysiology

  - Structural abnormalities in the amygdala, basal ganglia and prefrontal cortex have been demonstrated in manic patients. Research is now showing that this disorder is associated with abnormal brain levels of serotonin, norepinephrine, and dopamine.

- Course of Illness

  -In general, untreated mania can last 3-6 months.
  -Treatment cuts the duration in half.
  -85% risk of relapse after the first episode, 50% risk during the first year.

- Prognosis

  - Often, the cycling between depression and mania accelerates with age.
  - Factors suggesting a worse prognosis include the following:

    - Poor job history
    - Alcohol abuse
    - Psychotic features
    - Depressive features between periods of mania and depression
    - Evidence of depression

- Male sex

- Factors suggesting a better prognosis include the following:

- Manic phases (short in duration)
- Late age of onset
- Few thoughts of suicide
- Few psychotic symptoms
- Few medical problems

How do we treat Mania and Bipolar Affective Disorder?

Explain to students that with all mental illness, one must consider a BIOPSYCHOSOCIAL approach to treatment

Psychological:

- psychoeducation groups, support groups (OBAD), family groups, individual therapy

Social:

- time off work, disability, AISH, life skills training, family education, activity groups

Biological:

- Mood Stabilizers
  i. **Lithium:** first line treatment. Average doses of 1200 to 1800 mg/d. Steady state is achieved in 4 to 5 days, therefore serum Lithium can be checked on day 5 after treatment is initiated. Side effects include tremor, nausea and vomiting, diarrhea, cognitive dulling, polyuria, and polydipsia. Renal function must be monitored. Lithium may produce mild hypothyroidism.
  ii. **Valproic acid:** an anticonvulsant. Average doses of 750-3000 mg/d or in divided doses. Side effects include nausea, sedation, tremor, hair loss and rarely blood dyscrasia (must monitor platelets and liver enzymes). Relative contraindication in pregnancy as may cause neural tube defects.
  iii. **Carbamazepine**: an anticonvulsant. Average dose 300-1200 mg/d or in divided doses. Carbamazepine induces its own metabolism, so blood levels must be checked regularly and the dosage adjusted as indicated during the first several months of use. Side effects include weight gain, nausea, sedation, ataxia, anticholinergic effects in elderly patients, and temporary alopecia. May cause increase in liver enzymes and possible lowered WBC counts. Also relative contraindication in pregnancy.

- Antipsychotics
  This is a good time to review what students learned in the session on Antipsychotic treatment for psychosis. Review with them that the atypical antipsychotics are first line in the treatment of someone who is acutely manic and that often the antipsychotics are used in the short term while the mood stabilizers are being titrated up to therapeutic doses. Also review with students that typical antipsychotics are also used in instances where a manic patient is aggressive or posing a safety risk to himself or others. The typicals are one of our main means of behavioral control.

- Benzodiazepines
  Benzodiazepines are useful in decreasing psychomotor agitation, aggression, and logorrhea. They tend to normalize sleep, which in itself is therapeutic during a manic episode. Tapering of these drugs should be considered as behavior normalizes.

- ECT
  *Effective in treating **mania** and may be considered when mood stabilizers are relatively contraindicated, such as during pregnancy, in the elderly, in patients with epilepsy, and in patients with cardiovascular disease.*

SESSION 6- ANXIETY DISORDERS

INSTRUCTIONS: If possible, bring the students to see a patient with an anxiety disorder on the ward, then sit down to discuss the following questions. This may not be possible, in which case this will be a more didactic seminar. If you see a patient, make sure you have their permission to bring the students in ahead of time!

What are Anxiety Disorders ?

Anxiety disorders are a group of mental disorders characterized by any of the following: fear, worry, avoidance, obsessions, compulsions.

Generally they have a chronic waxing and waning course; and are among the most prevalent mental disorders.

When does anxiety become a disorder ?

- When it is of greater intensity and/or duration than expected
- It leads to impairment in occupational, social or interpersonal functioning OR it causes clinically significant distress
- It includes clinically significant, unexplained physical symptoms

What are the risk factors for Anxiety disorders:

1. Family history of anxiety or any other psychiatric illness
2. Personal history of anxiety in childhood or adolescence
3. Being female
4. Comorbid psychiatric disorder

What is a Panic Attack?

- Period of intense fear or discomfort, where several symptoms develop abruptly and peak within 10 minutes:
  1. Palpitations, pounding heart, or accelerated heart rate
  2. Sweating
  3. Trembling or shaking
  4. Sensations of shortness of breath or smothering
  5. Feeling of choking
  6. Chest pain or discomfort
  7. Nausea or abdominal distress
  8. Feeling dizzy, unsteady, light-headed, or faint
  9. Derealization (feelings of unreality) or depersonalization (being detached from oneself)
  10. Fear of losing control or going crazy
  11. Fear of dying
  12. Paresthesias (numbness or tingling sensations)

13. Chills or hot flushes

- Lifetime prevalence 15%

What is Panic Disorder?

- Recurrent unexpected panic attacks without any obvious trigger
- Patient may actively avoid situations in which panic attacks are predicted to occur; they may worry about the implications of the attack; they may have persistent concern of having another attack
- Intolerance of physical symptoms of anxiety
- Lifetime prevalence 4.7%
- F>M

What questions would you ask to screen for PD?

- Do you have times when you experience a sudden rush of symptoms or uncomfortable physical feelings such as racing heart or dizziness?
- Do you have feelings of fear or panic at these times?
- Have these spells ever occurred out of the blue, without any obvious trigger or cause?

What is Agoraphobia? What screening questions could you ask?

- fear of having a panic attack in a setting from which there is no easy means of escape

- Do you avoid any situations because you might experience these spells of symptoms or feelings of fear or anxiety?
  - Crowds, enclosed places, driving, leaving the house alone, or other situations

What is Generalized Anxiety Disorder?

- Excessive, difficult to control worry occurring more days than not, about several events or activities
- The worry leads to @ least 3 of: fatigue; impaired concentration; feeling restless, keyed up or on edge; impaired sleep; irritability; muscle tension
- Intolerance of uncertainty
- Life time prevalence of 6%
- F>M

What kind of questions would you ask to screen for GAD?

- What kinds of things do you worry about?
- Do you worry excessively about everyday things such as your family, health, work, or finances?

- Do friends or loved ones tell you that you worry too much?
- Do you have difficulty controlling your worry such that the worry keeps you from sleeping or makes you feel physically ill with headaches, stomach troubles or fatigue?

What is Obsessive compulsive disorder?

- Obsessions: recurrent, unwanted, and intrusive thoughts, images or urges that cause marked anxiety. These are recognized as a product of the person's own mind and are not excessive worries about every day things.
- Compulsions: repetitive behaviours or mental acts that a person feels driven to perform in response to an obsession or according to a rigid set of rules
- The person feels compelled to continue, despite an awareness that the thoughts or behaviours may be excessive or inappropriate, and feels distress if he or she cannot carry them out or if he or she stops them
- The obsessions and/or compulsions are time consuming and interfere with the person's life or cause clinically significant distress
- M=F
- Lifetime prevalence 1.6%

What questions would you ask to screen for OCD?
Obsessions:

- Do you experience disturbing thoughts, images, or urges that keep coming back to you and that you have trouble putting out of your head?
- For example, being contaminated by something, something terrible happening to you or someone you care about, or of doing something terrible?

Compulsions:

- Do you ever have to perform a behaviour or repeat some action that doesn't make sense to you or that you don't want to do?
- For example, washing or cleaning excessively, checking things over and over, counting things repeatedly?

What is Post traumatic stress disorder?

- Exposure to a traumatic event that involves real or threatened death or serious injury, or a threat to the physical integrity of self or others
- Person responds to event with intense fear, helplessness or horror; person re-experiences the event, avoids reminders of the event, and experiences emotional numbing and symptoms of increased arousal
- Intolerance of re-experiencing trauma

- Lifetime prevalence 9.2% (prevalence is higher in areas where conflict has occurred)
- F>M

What screening questions could you ask for PTSD?

- Are you bothered by memories, thoughts, or images of a very upsetting event that happened to you or someone close to you in the past? For example:
  - Being in a fire or serious accident?
  - Being raped, assaulted, or abused?
  - Seeing someone else badly hurt or killed?

What is Social anxiety disorder?

- Excessive or unrealistic fear of social or performance situations
- Intolerance of embarrassment or scrutiny by others
- Lifetime prevalence 8-12% (one of the most common anxiety disorders)
- F>M

What screening questions could you ask?

- In general, are you overly anxious or concerned about embarrassing or humiliating yourself while doing things in front of people or interacting with others?

What is a Specific phobia?

- Excessive or unreasonable fear of a circumscribed object or situation, usually associated with avoidance of the feared object
- Lifetime prevalence 12.5% (mean age onset 7 yrs)

What kind of screening questions could you ask?

- Do any of the following make you feel anxious or fearful:
  - Animals (for example, spiders, snakes, dogs, cats, birds, mice, bugs)?
  - Heights, storms, being near water?
  - The sight of blood, getting an injection or blood test?
  - Driving, flying in an airplane, enclosed places such as elevators or small rooms?
  - Does this fear interfere with your life or cause you marked distress?

What might you expect to see on Mental Status examination of a patient with an anxiety disorder?

- Furrowed brow, fidgeting/hand wringing, frantic appearance, facial flushing, minimal eye contact, raw appearing hands (from overwashing…seen in OCD)
- Stuttering, hesitant speech, low volume
- thoughts may be over inclusive or circumstantial, but not typically disordered
- subjective complaint of racing thoughts
- intrusive worries or obsessions, ego-dystonic in nature
- typically no perceptual disturbances, but may have flashbacks in PTSD
- possible suicidal ideation
- insight is typically good, judgment usually intact

How are anxiety disorders treated?

- treatment is BIOPSYCHOSOCIAL

Biological:

- SSRI, SNRI, NaSSA, TCA, MAOI and RIMA are used for various anxiety disorders
- SSRI, SNRI and NaSSA are currently preferred, being safer and better tolerated.
- Benzo's can be useful early in treatment, for acute anxiety or agitation, to help patients with crisis or while waiting for onset of antidepressants.
- Pharmacotherapy not generally required for treatment of Specific Phobia

Psychological treatment:

- Cognitive-behavior therapy (CBT) is the psychological treatment of choice
- Focus is on the relationship between thoughts-feelings-behaviours
- CBT= a process involving psychoeducation about the above relationship, gradual, graded exposure to feared stimuli, identification of maladaptive thoughts, learning relaxation techniques to cope with anxiety (deep breathing, progressive muscle relaxation), problem solving for future anxiety provoking situations
- Direct comparisons of CBT and pharmacotherapy suggest that they are about equivalent in their effectiveness
- Combination of psychological and pharmacological treatment maybe beneficial for some patients and should be considered when a single method of treatment does not produce desired effects.

Social:

- if indicated, time off work, AISH, disability

COMMENTARY

What Makes a Good Teacher? Lessons from Teaching Medical Students

Medical educators responsible for faculty development often frame teaching as a set of skills. But there is more to teaching than a checklist of skills. What is this "more"? Below are my answers to that question, based on my experience teaching—and learning—with medical students.

A good teacher wants to be a good teacher. Teaching has to be its own reward. While recognition for outstanding teaching is commendable, faculty who are motivated only by formal honors will not achieve teaching excellence. Faculty need to work as hard at teaching as they do at research or clinical practice.

The focus of instruction should always be on student learning, not faculty teaching. Too often faculty members concentrate on what they want students to know. However, medical education is professional education, and we who teach medical students should go beyond our conceptions of what we think they should know and instead should search for what they actually need to know as practicing physicians. In this regard, I have often gently chided my basic science colleagues when they lament about not understanding what medical students need to know. My solution: I urge them to visit hospitals and clinics to see what medical students and residents do related to my colleagues' disciplines. Many of the changes I have made in my own teaching have been due to insights from watching and talking to clerkship students and residents.

When instruction is focused on the accumulation of factual knowledge, learning is quickly extinguished (usually after the corresponding test), but when teaching aims at a higher level of cognition, what is learned is organized and remembered in useful ways. This is consistent with what the cognitive psychologists call "constructing knowledge." Learning is seen not as the storage of information but as the continuous process of filtering new knowledge through the structures we have developed from prior learning and experience. For example, when I am teaching evidence-based medicine (EBM), I do not ask students to memorize the hundreds of different biases that can threaten the internal validity of a study. Rather, students think about what valid research in medicine is, discuss new occurrences of bias that they encounter in reading the medical literature, and consequently develop an enriched view of bias that will allow them to more effectively critique the medical literature.

Good teachers do not talk as much as their less effective colleagues do. This is because good teachers involve the learners—asking questions, framing cases to solve, forming small groups for discussion, asking for the views of learners, pausing to allow students to think. When they do talk, good teachers use words efficiently. They make concepts and principles simple and clear; they give concrete examples to illustrate abstract points. Further, the skilled teacher adapts *while* teaching and reflects *after* having taught.

While it is necessary for a teacher to be highly knowledgeable in his or her discipline, it is perhaps more important to show enthusiasm and interest in teaching that discipline. This excitement for learning is demonstrated by being a well-organized and expressive lecturer who presents information concisely, by involving students in problem solving, and by showing how the discipline relates to real life practice.

The good teacher also shows interest and enthusiasm by attending to all aspects of effective instruction. The course syllabus is complete yet efficiently organized and easy to follow. Students have ready access to the teacher, who is eager to help with students' concerns. Evaluation of students' knowledge and skills is done in reliable, valid, and fair ways. It is apparent to students that good teachers solicit and use feedback from learners to improve instruction. In the aforementioned EBM course, written suggestions are solicited at midcourse. Meritorious improvements are added to suggestions that have accumulated through less formal methods by midcourse. Students are told in written and oral communication about second-half course changes based on their comments. Those sound recommendations for which there can be no immediate response are deferred to the next iteration of the course. At that time, students are given a brief summary of course improvements resulting from the prior course evaluation.

Good teachers are always thinking about ways to improve what and how students learn. They are always working on solutions to questions such as How can I give students more control over their learning? How can I encourage collaboration among students? How can I provide timely and effective feedback? How can I accommodate learners at

various levels of sophistication? (Regarding this last point, in my EBM course, students with backgrounds in research, statistics, and epidemiology are mixed with those who are frightened of anything quantitative.)

Furthermore, good teachers think aloud with their students about problems. In discussing EBM, I might ask: How do we balance objective evidence with other elements of medical care—financial costs, patient preferences, ethical standards, etc.?

Learning complex concepts and principles and incorporating them into one's structure of knowledge require time, both to think and to practice application. For instance, students in my EBM course are asked periodically to expand their understanding of the fundamental research designs used in medicine—randomized controlled trials, cohort studies, etc. First, the students learn the characteristics of each research design and how to distinguish one from another. In the following weeks the students learn the strengths and weaknesses of each design and how a design is chosen to match the researcher's question. Finally, the students learn how research designs are a vital component in assessing the validity of therapy, diagnosis, prognosis, and causation studies.

Good teachers create an atmosphere where students are motivated by the intrinsic rather than the extrinsic (e.g., passing the next exam, getting a high grade). In education, intrinsic motivation refers to an interest in learning because one cares about the discipline, wants to improve his or her skills, and appreciates that what is being learned can be applied to practice in real life. As practitioners in our fields we who teach are motivated by intrinsic goals—but how can we transmit this to our students?

First, we must assure that the extrinsic is not the focus by anticipating students' needs and expectations. The syllabus must be a thorough but clear and concise guide to students' learning. Examinations and other evaluations must match learning objectives and be reliable and valid. Grading must be fair.

Second, the good teacher creates an environment where curiosity is encouraged, problems related to the discipline solved, and knowledge applied to real-world situations. We who teach should always be able to answer the "so-what" question. I invite students to interrupt at any time to ask, "What is the purpose of learning that?" If I do not have a convincing answer anchored in the practice of medicine, I think about reframing the concept or eliminating it. For example, in EBM, every concept should be a part of the mosaic of improved medical practice, and EBM skills should be used to solve both individual patient and population-based clinical dilemmas. Preclinical students can work through patient cases dealing with common medical problems familiar to the general public (e.g., smoking cessation, cancer prevention) while clerkship and more advanced students can answer clinical questions related to their assigned patients.

Third, the intrinsic triumphs over the extrinsic when we as teachers manifest the best qualities in human relations—openness, respect, trust, a sense of humor. In sum, students are motivated for intrinsic reasons when (1) the course of instruction is well planned, transparent, and fair, (2) the relationship between learning and real life is clear, and (3) they see that their teachers care about their disciplines and their students.

To sum up: When colleagues ask me what the most important principles of good teaching are, I say: Be enthusiastic about your teaching and interested in the well-being of your students, prepare well for your teaching, teach knowledge in the context of solving authentic medical problems, and always be thinking about and working on the improvement of your teaching and your students' learning.

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Thank you to Dr. Harris Lari, Dr. Mohammad Al-Ghamdi, and Dr. Pravesh Vallabh for their contributions to the original version of this manual.