Debrief for Psychosis Case

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The following text is envisioned to help case based learning of Psychosis by providing a background context. This is also to show how the scenario may present in real life when you are faced with a similar patient rotating through the ER.

Background Information (provided in the stem as the nurse's report):

Sam is a 23 y.o male in 3rd year of Computer Science Undergraduate program

- Currently single
- Supported financially by parents, lives on campus
- Academically doing well until one year ago, since then his grades have fallen.
- Has been found to be isolating to his room and was previously quite social and a member of many university groups. Has been drawing strange symbols on the walls of his room. There is poor personal hygiene.

Collateral provided by his University friend and University Police – Nurse spoke to them before and made a note.

Past Psychiatric History: Learning disability in language diagnosed in grade 6. Psychological report also highlights moderate deficits in working memory.

Saw the University Psychological Services 6 months ago for vague complaints around anxiety and depression with social withdrawal. Was prescribed Escitalopram, but did not fill the prescription. No other history.

Past Medical History:

- None

Family History:
- Maternal Aunt has Schizophrenia

Social History:
- Delay in language milestone
- Grew up in a stable home
- Difficulties in academics in English/language subjects predominantly
- Some history of bullying

Labs:
- Urine Tox positive for THC only
- Physical exam by ER MD was reported as “normal”
- Initial blood work (CBC, lytes) “normal” TSH pending
- No CT ordered

Techniques used in this video to demonstrate interviewing skills:

- Often very simple close ended and multiple-choice questions are asked as the patient may be quite disorganized, and the interviewer has to make an attempt to organize the history for the patient.

- Being respectful and non-judgmental which will help build a rapport.

- Empathetic statements can help. For example, “I am sorry to hear that you are going through such a distressing time”

Other important things to include in the interview (not demonstrated in the video) which are relevant to this case:

- Try to understand the patient’s delusional beliefs or delusional system. Often this can highlight safety concerns such as homicidality or suicidality. It can also be used to understand the pt. as a whole to inform future treatment.

- It might be a good idea to question now or later on during the interview if the patient can see anything wrong or evil through the interviewer’s eyes as the patient was staring intently at times (an important safety check).

- Other important factors are: use of recreational drugs, such as stimulants, can precipitate/exacerbate psychosis or may be causative of it.

- Different hallucinations are inquired into. Usually auditory and visual hallucinations are routinely inquired into while somatic – gustatory, tactile or olfactory can also be asked about if clinically indicated. These as well as visual type point more towards an organic etiology.

- Schniderian Criteria: Voices conversing with each other or keeping a running commentary. Used to be pathognomic of Schizophrenia as per DSM IV. This was a finding in this case. One can also ask about the number of voices and characterize the hallucinations further.

- Try to establish a timeline (Onset, course and progression of psychotic symptoms). Sometimes it is difficult to establish – can use collateral history to establish this. An attempt can be made to establish the relationship between recent stressors and psychotic symptoms. Try to establish precipitating events such as recent stressors and stoppage of psychotropic medications (although not applicable in this case, this is very often is a precipitating factor).

- Often forgotten and difficult to characterize are negative symptoms of schizophrenia. From collateral, history from pt or by MSE: try to inquire into anhedonia, alogia, asociality, avolition, cognitive problems with executive functioning and planning. There can also be problems with working memory. There are some standardized scales for this assessment.

- Try to understand level of insight – which is clearly quite poor here, although direct questions can be asked

- Complete psychiatric functional inquiry.
    - Ask about current stressors, mood symptoms (rule out mania or depression).
    - Complete safety assessment – ask about suicide. In other cases where it is not as obvious, always ask about thoughts of hurting others (homicidal ideation).

- Also make sure patient isn't neglecting self-care (sometimes psychotic patients do not eat food because they are paranoid about it being poisoned).
- Find out about other safety concerns such as child care responsibilities or driving.
- Inquire into current and past medical history to rule out medical causes of psychosis.
- Ask family history and social history as much as is possible.

Notes about Safety

- Always remember that safety is first. If at any point you feel threatened, leave the room and ask for assistance. The assessment can be finished with the help of a nurse, PA or security. At other times, the patient is so agitated that an emergency chemical restraint is necessary before assessment can be completed for the safety of the patient and medical personnel. The assessment may also have to be deferred. However, try to ask questions re SI/HI or other pertinent safety risks in order to be able to make a clinical decision.

Important aspects of assessment and management of this case:

- Obtain collateral history
- Make a differential diagnosis – Schizophrenia spectrum, substance induced, delirium and secondary to GMC
- Order appropriate laboratory investigations and other tests to rule in or out different diagnoses.
- Management plan
  - Ensure safety of patient and others, meets 'risk of harm to others' criteria for Form 1.
  - Ensure ongoing assessment of capacity and the need for a substitute decision-maker
  - Difference between keeping someone in hospital on a form and "treating" the patient with medication
- Attend to the patient's psychosocial needs
- Pharmacotherapy (both acute and maintenance)
- Psychosocial (e.g., community and family resources, housing)
- Treating any underlying disorders or comorbidities;
- Counseling and supporting patient/caregiver/family about psychosis
- Refer the patient for specialized care once stabilized – in this case First Episode Psychosis Clinic