Rady Faculty of Health Sciences | University of Manitoba

Max Rady College of Medicine
Department of Family Medicine
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Objectives: Behavioural Medicine

Depression/Bipolar/CBT/Emergency Psychiatry

1. In a patient presenting with symptoms such as low mood or anhedonia, screen for, and if possible, diagnose unipolar depression.
2. Screen for depression and diagnose it in high-risk groups (e.g. those who suffer from substance abuse, postpartum women, people with chronic pain).
3. In a patient presenting with multiple somatic complaints for which no organic cause is found after appropriate investigations, consider the diagnosis of depression and explore this possibility with the patient.
4. After a diagnosis of depression is made, look for and diagnose other co-morbid psychiatric conditions (e.g. psychosis, anxiety, bipolar disorder).
5. In a patient diagnosed with depression, offer both pharmacologic and non-pharmacologic treatment options.
6. In a patient diagnosed with depression, be comfortable initiating cognitive-behavioural therapy (CBT) or be aware of community referral sources.
7. In a patient with a diagnosis of depression:
    a. Assess the patient for the risk of suicide
    b. Decide on appropriate management (e.g. hospitalization or close follow-up depending on severity of symptoms, psychotic features and suicide risk).
8. In a patient presenting with symptoms consistent with depression, consider and rule out serious organic pathology.
9. In a patient with depression, differentiate major depression from adjustment disorder, dysthymia and a grief reaction.
10. Following failure of an appropriate treatment in a patient with depression, consider other diagnoses (e.g. bipolar depression, schizoaffective disorder, organic disease).
11. In the very young and elderly presenting with changes in behaviour, consider the diagnosis of depression.

Anxiety/PTSD/Managing Stress

1. When working up a patient with symptoms of anxiety, and before making the diagnosis of an anxiety disorder:
    a. Exclude serious medical pathology
    b. Identify comorbid psychiatric conditions – abuse, substance abuse
    c. Assess the risk for suicide.
2. Do not automatically attribute acute symptoms of panic (e.g. shortness of breath, palpitations, hyperventilation) to anxiety without first excluding serious medical pathology (e.g. pulmonary embolism, myocardial infarction) from the differential diagnosis.
3. In patients with known anxiety disorders, do not assume all new symptoms are attributable to the anxiety disorder.
4. Offer appropriate pharmacologic and non-pharmacologic treatments for anxiety.

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5. If utilizing benzodiazepines for treatment of panic, consider and warn of issues related to dependence and tolerance.
6. In patients with symptoms of anxiety, take and interpret an appropriate history to differentiate clearly between agoraphobia, social phobia, generalized anxiety disorder, panic disorder and post-traumatic stress disorder.

Psychosis/Schizophrenia

1. In patients presenting with acute psychosis, consider a differential diagnosis that includes conditions other than schizophrenia (e.g. delirium, substance abuse, encephalopathy).
2. In patients presenting with acute psychosis, ensure the safety of the patient and staff by using appropriate pharmacologic and non-pharmacologic measures.
3. In patients, especially adolescents, presenting with problem behaviours, consider schizophrenia in the differential diagnosis.
4. In patients presenting with “negative symptoms” such as affect flattening, alogia or avolition, consider a diagnosis of schizophrenia.
5. In patients with acute psychosis or a new diagnosis of schizophrenia:
    a. Consider hospitalization
    b. Initiate acute pharmacologic treatment
    c. Ensure appropriate community resources and supports are in place prior to discharge
6. In patients with “stable” schizophrenia, regularly assess:
    a. Activities of daily living
    b. Opinions on functional status from family and caregivers
    c. Competency to accept or refuse treatment
    d. Suicidal and homicidal ideation, as well as the risk for violence
    e. Medication compliance and side effects
7. In patients with decompensating schizophrenia, determine:
    a. If substance abuse is contributory
    b. The role of medication compliance and side-effect problems
    c. If psychosocial supports have changed
8. Diagnose and treat serious complications and side-effects of antipsychotic medications (e.g. neuroleptic malignant syndrome, tardive dyskinesia).

Insomnia

1. In patients presenting with sleep complaints, take a careful history to:
    a. Distinguish insomnia from other sleep-related complaints that require more specific treatment (e.g. sleep apnea or other sleep disorders, including periodic limb movements, restless leg syndrome, sleepwalking or sleep talking)
    b. Assess the contribution of drugs (prescription, over-the-counter, recreational), caffeine and alcohol.
    c. Make a specific diagnosis if one is present

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2. When assessing patients with sleep complaints, obtain collateral history from the bed partner if possible.
3. In all patients with insomnia, provide advice about sleep hygiene (e.g. limiting caffeine, limiting naps, restricting bed activities to sleep and sex, using an alarm clock to get up at the same time everyday).
4. In appropriate patients with insomnia, use hypnotic medication judiciously (e.g. prescribe it when there is a severe impact on function, but do not prescribe it without a clear indication).

Somatization

1. In patients with recurrent physical symptoms, diagnose somatization only after an adequate work-up to rule out any medical or psychiatric conditions (e.g. depression).
2. Do not assume that somatization is the cause of new or ongoing symptoms in patients with previously diagnosed with somatization.
3. Acknowledge the illness experience of patients who somatize and strive to find common ground with them concerning diagnosis and management, including investigations.
4. In patients with somatization, inquire about the use of and suggest therapies that may provide symptomatic relief and/or help them cope with their symptoms (e.g. with biofeedback, acupuncture or naturopathy).

Personality Disorders

1. Consider the diagnosis of a personality disorder in patients with patterns of behaviour that deviate markedly from expectations and is pervasive across a wide range of situations.
2. Differentiate Cluster A, B and C personality disorders along with specific diagnoses within each category.
3. Clearly establish and maintain limits in dealing with patients with identified personality disorders (e.g. setting a set appointment length, drug prescribing practices, accessibility).
4. In a patient with a personality disorder, look for medical and psychiatric diagnoses when the patient presents for assessment of new or changed symptoms.
5. Look for and attempt to limit the impact of your personal feelings (e.g. anger, frustration), when dealing with patients with personality disorders (e.g. stay focused, do not ignore the patient's complaints).
6. In a patient with borderline personality disorder refer, if appropriate, for dialectic behavioural therapy (DBT).
7. When seeing a patient whom others have previously identified as having a personality disorder, evaluate the person yourself because the diagnosis may be wrong and the label has significant repercussions.

Child Psychiatry

1. When evaluating children, consider the various possible presentations for depression, anxiety and other mood disorders, as it may present differently.

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2. With adolescents, ensure the confidentiality of the visit and, when appropriate, encourage open discussion with their caregivers about specific problems.
3. In patients with symptoms of inattention or hyperactivity in multiple settings which is interfering with functioning, consider the diagnosis of Attention deficit Hyperactivity Disorder.
4. In treating children with ADHD utilize both pharmacologic (stimulants) and non-pharmacologic therapies (classroom interventions, exercise, individual or family therapy, anger control) appropriately.

Geriatric Psychiatry

1. Regularly screen for symptoms of depression in the elderly as the presentation may differ.
2. Differentiate between symptoms of depression, cognitive impairment and delirium.
3. Be cautious and judicious in using pharmacotherapy (e.g. benzodiazepines, antipsychotics) in the elderly, ensuring that there is a strong indication if required and that the risks and benefits are discussed with patients and, if appropriate, family.
4. In geriatric patients with depression, routinely screen for comorbid conditions such as substance abuse and suicidality.

** Mapped to the CFPC's 105 priority topics: #10-Behavioural Problems