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# Psychotic Patients

A Practical Approach to Evaluation and Treatment  
An Overview of the Objectives in the Psychosis  
Module of the OUCOM Psychiatry Block

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Kendall L. Stewart, M.D.  
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**Psychotic patients are major clinical challenges. Because these suffering persons can be so intimidating, you will want to have a plan about how to proceed before you begin your evaluation. Here is one such plan. Pay attention. Give them space. Be safe. Figure out what is wrong. Consider the cognitive disorders. Consider schizophrenia and the other psychotic disorders. Identify any underlying medical conditions. Consider substance-induced psychosis. Remember that other mental disorders often present with psychotic symptoms. Come up with a treatment plan. Know when to ask for help.**

## Introduction

These patients are strange. Sometimes they are scary. You will realize right away that these persons are suffering some unspeakable horror and you will feel helpless. You won't know what to do. Your inability to communicate effectively with them will render your interviewing skills worthless, erode your self-confidence and make you wonder why you went into medicine. Their unpredictability will make you uneasy, perhaps even afraid. Of three things you will be certain. Something is terribly wrong. Folks are expecting you to figure out what it is and what to do. You won't enjoy your first encounters with these patients.

They may be confused or agitated. They may talk nonsense. They may even be aggressive or combative. They sometimes hear voices commanding them to hurt themselves or others. If they present restrained and escorted by the police, think

twice before ordering them released. To some degree, they are always out of touch with reality. They may be excited and hyperactive, or they may be withdrawn. In a word, these patients are a mess.

This essay can help. These practical guidelines will help you think incisively, question precisely, act decisively and compose rap lyrics. Seriously, these miserable people are among the most challenging patients in medicine. Because they are so complex and intimidating, it is easy to go astray. You may want to hold on to this little paper and read through it again before your first ER rotation. Going through the steps and mastering the objectives outlined here will make you a better doctor.

### **Pay attention.**

When you first walk into the room, turn your clinical sensitivities up to high gain. Listen carefully to every sound the patient makes. Focus on every movement, stereotyped behavior and gesture. Watch for eye contact or the lack of it. Take in the expression on the patient's face. Make a mental note about how the patient is dressed and his or her overall appearance.

And pay careful attention to how it feels to be in this patient's presence. Some of these folks will make the hair on the back of your neck stand up. You do not want to miss or ignore such an important early warning signal.

Listen to the staff. Take what family members tell you very seriously. Examine the chart for clues about etiology. Because of these patients' disorganization and confusion, direct questioning will be of limited value. Since you cannot rely on your usual approach to obtaining the history, you will need to find other sources of information. All of us like to look under the same rocks. With these folks you must remember to turn over different rocks.

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### **Give them space.**

The last thing a psychotic patient needs is more stimulation. Think about it. Their heads are filled with accusing voices. They are fearful or angry. They can't tell what is real and what is not. They can't concentrate or focus. Patients who have recovered sufficiently to write about what it is like to be psychotic describe a frightening cataract of assaulting perceptions, raging emotions and the awful conviction that others are not to be trusted. While no

two psychotic states are the same, much of the consciousness that is quintessentially human is distorted, disrupted and frighteningly transformed into a dark canyon where macabre echoes terrorize and forbidding walls put hope and peace out of reach.

Don't touch these patients. It is usually best to avoid shaking hands at first. For heaven's sake, don't hug them. Stand several feet away from them and make sure that quick escape is possible. Speak in a calm, soft voice and ask simple questions. When you see that the patient can't organize his or her thoughts to answer your questions, acknowledge their struggle and cut the session short. Don't ignore your gut feeling that a particular patient may be dangerous. If you get this feeling, suspend the interview and get help.

### **Be safe.**

Psychotic patients are sometimes dangerous. Untreated schizophrenic patients are occasionally violent, as are patients with cognitive disorders. Persons flailing in a chemical fog are

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particularly dangerous. None of us is very good at predicting violence except when it has already begun. Because these patients are sometimes violent and because they are unpredictable, it only makes sense for you to take reasonable precautions. You should always anticipate violence from any patient who is psychotic, hostile, agitated, threatening, restless, abusive, or who possesses diminished internal control for any reason. Don't mess around. Get help. Ask about weapons and never see an armed patient. Offer help, food or medication. While the risk of violence from psychotic patients is a real and present danger, it is helpful to bear in mind that these persons are more likely to be victims of violence than they are to be

perpetrators of it.

It is sometimes necessary to restrain these patients for their own safety and for the safety of others. If this becomes necessary, restrain quickly, firmly and kindly with overwhelming force. Do not try to do this by yourself. Do not leave restrained patients alone. Sedative medication can play a very helpful role, and most agitated patients will accept this offer.

**Figure out what is wrong.**

Psychiatric diagnoses depend primarily on the history. Certain symptoms cluster together and form the basis for a specific diagnosis. When a specified list of symptoms is present and when other specific symptoms are not present, you have the basis for making a psychiatric diagnosis.

The published inclusion and exclusion criteria for the psychiatric diagnoses are contained in the Diagnostic and Statistical Manual of Mental Disorders (DSM).<sup>1</sup> It is the Bible of psychiatric diagnosis. Since no one can possibly remember all of the criteria for every disorder, you will need to keep a pocket edition of the DSM nearby when you evaluate patients with psychiatric symptoms. After a while, you will become familiar with the criteria for the mental disorders you see most frequently, but since a specific psychotic disorder often calls for a different treatment, it is important that you use the DSM to make an accurate diagnosis.

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Obtaining an adequate history when the patient is psychotic often requires persistence and innovation. Persons immersed in a florid psychosis are usually unable to contribute meaningfully to the history. You will need to talk to the staff or members of the patient's family. The medical record may be the only available source. You may have to proceed initially without a complete history. When it is difficult to obtain a history, you will be tempted to let it slide or to settle for incomplete data. This you must never do.

Despite the daunting obstacles, you must obtain a detailed history,<sup>2</sup> perform a mental status examination,<sup>3</sup> and record your observations. You will usually order additional testing<sup>4</sup> to help you make the correct diagnosis. You must come up with a differential diagnosis<sup>5</sup> and a working diagnosis<sup>6</sup> right away. Many of these patients are desperately ill and you cannot afford to fool around. You will need to develop a clinical problem list<sup>7</sup> and a practical treatment plan.<sup>8</sup> The patient and family members must be informed, reassured and educated.<sup>9</sup> These patients and their families will want you to direct them to information sources where they can learn more after this crisis is past.<sup>10</sup>

The question about whether your patient is capable of giving informed consent for treatment will come up regularly, and you will often choose to consult<sup>11</sup> with your psychiatric colleagues for assistance with these emergencies and their appropriate follow

up care. Everyone and his brother have published guidelines about when to refer patients to various specialists and, in that spirit, here are Stewart's tried and tested guidelines for referring to a psychiatrist. You should refer when you don't know what is wrong, when you know what is wrong but you don't know what to do, when you know what is wrong and what to do, but it ain't working, and any other time it seems like a good idea.

Patients with psychotic symptoms can usually be placed in one or more of five clinically significant categories.<sup>12</sup> The first category includes the Cognitive Disorders such as Alzheimer's Disease or delirium. The amnestic disorders also fall into this category. The second category includes schizophrenia and similar psychotic disorders. The third category encompasses those psychotic symptoms that are substance-induced. The fourth category includes those psychotic symptoms caused by some underlying general medical condition. The fifth category involves those patients with other mental disorders that present with associated psychotic symptoms.

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Psychotic symptoms are not very specific. They can and do occur in a lot of different clinical situations. Placing your patient in the proper clinical category early on will facilitate proper diagnosis and treatment and diminish your own anxiety. This module will help you hone this essential clinical skill. We will now examine each of these categories in greater detail.

### **Consider the cognitive disorders.**

These disorders will be covered in the neurology block. We will not address them directly in the psychiatry block, but brief summaries are included here for completeness and at no additional charge to you.

The essential feature of *delirium* is a disturbance of consciousness accompanied by diminished cognitive functioning that is not better explained by dementia. It usually develops over a few hours or days, and the symptoms of confusion and agitation tend to fluctuate. The history and examination usually reveal that the delirium is a consequence of some general medical condition, some medication, a substance-induced intoxication or withdrawal or some combination of the above. Delirium is a frequent hospital complication in the elderly, but it is likely to resolve in a few days if the underlying cause is identified and treated appropriately.

*Dementia of the Alzheimer's Type* is the most common form of dementia. This is a devastating illness associated with gradual memory loss and disabling cognitive impairments. Between 2% and 4% of persons over 65 are affected, and the incidence increases with age. It is slowly and relentless progressive. On average, patients live 8-10 years after the diagnosis is made. As we live longer, more and more of us will end our lives trapped in bodies providing life support to minds already embalmed by amyloid. Current treatments may retard the progress of Alzheimer's Disease, but a cure is not yet available.

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The *Amnesic Disorders* are characterized by a disturbance in memory that is due to some general medical disorder or the persistent effect of some substance. These disorders are usually preceded by a delirium that never entirely resolves. The course of these disorders depends on the cause. Head trauma and chronic substance abuse are often the culprits.

**Consider schizophrenia and the other psychotic disorders.**

*Schizophrenia* is the cancer of mental illness. The lifetime prevalence<sup>13</sup> of this costly mental illness is 1% to 1.5%. Women and men are equally affected but the onset occurs earlier in men. It is often discussed as if it were one disease, but schizophrenia is really a group of disorders, probably with somewhat different causes,<sup>14</sup> but with similar behavioral symptoms. There is a genetic component, but that is not the whole story. Symptoms<sup>15</sup> include delusions – a false belief strongly held in spite of contradictory evidence, hallucinations – a sensory perception not based in reality, disorganized speech, grossly disorganized or catatonic behavior or negative symptoms such as affective flattening, alogia or avolition. Intriguingly, no single sign or symptom is pathognomonic for schizophrenia. The history is essential. A one-time mental status examination will not suffice. Exacerbations and remissions characterize the course.<sup>16</sup> After the initial psychotic episode, these patients usually don't return to their premorbid levels of functioning. Only about 10% to 20% can be said to have a good outcome. Antipsychotic drugs and psychosocial support are the treatments<sup>17</sup> of choice.

The essential features of *Schizophreniform Disorder* are the same as those for schizophrenia except that the duration of this disorder is greater than 1 month but less than 6 months. If the

illness persists longer than 6 months, the diagnosis should be changed to schizophrenia.

*Schizoaffective Disorder* is characterized by an uninterrupted period of illness during which mood symptoms coexist with the symptoms of schizophrenia. Residual and negative symptoms are usually less prominent than in schizophrenia. These patients tend to do a bit better than patients with schizophrenia, and less well than patients with pure mood disorders.

Patients with *Delusional Disorder* have one or more non-bizarre delusions that persist for at least 1 month and usually a lot longer. Hallucinations, if present at all, are not prominent. This disorder is divided into various subtypes depending on the nature of the delusions. Persons with the *Erotomaniac Type* are convinced that another person is in love with them. Persons with *Grandiose Type* insist that they are personages of great import – the rest of the world just does not see them for who they really are. Patients with the *Jealous Type* are convinced that their spouses are unfaithful and they cannot be persuaded otherwise. Persons with the *Persecutory Type* are insistent that they are being conspired against, cheated, harassed, disrespected, or maliciously maligned. You will come across a good many doctors with this. (I'm just kidding). Other folks have the *Somatic Type*. They are convinced that a certain part of their bodies emits a foul odor, that they are infested with insects or parasites, that parts of their bodies are horribly misshapen or that certain organs are not functioning properly. The persecutory type is the most common. The course of these disorders is variable but usually chronic.

*Brief Psychotic Disorder* involves the sudden onset of at least one of the symptoms of schizophrenia. This lasts at least one day, but less than a month. If it lasts more than a month – you've got it – the diagnosis must be changed to Schizophreniform Disorder.

*Shared Psychotic Disorder (Folie a Deux)* is the stuff of late night movies. In this disorder, a patient – involved in a close relationship with another person with his or her own psychotic disorder – develops a delusion too. The patient comes to share the delusional beliefs of the “primary case” in whole or in part. As you might suspect, these disorders tend to persist so long as these individuals continue their lives together.

### **Identify underlying general medical conditions.**

A lot of general medical conditions exert physiological effects on the brain that result in psychotic symptoms. Hallucinations and delusions are the most common psychotic

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manifestations of an underlying general medical condition, but all kinds of other psychotic symptoms can make your evaluation of these patients more difficult. You do not want to miss an underlying general medical condition. It's not good for your patient, and it's not good for your reputation. Because the questions of whether an underlying disorder exists is so

critical in the assessment of psychotic patients, you should force yourself to consider this possibility *every time* you are confronted with such a patient.

In order to make this diagnosis,<sup>18</sup> you must demonstrate that an underlying general medical disorder is present, and you must make a compelling case that the psychotic symptoms are the direct result of some physiologic mechanism. This is easier said than done. A temporal relationship between the onset, exacerbation or remission of a general medical condition will help to make your case. Atypical psychotic symptoms, such as olfactory hallucinations suggest something other than a traditional psychiatric disorder.

Many different general medical conditions cause psychotic symptoms<sup>19</sup> including neurological conditions, endocrine conditions, metabolic conditions, fluid or electrolyte imbalances, hepatic or renal disease, and autoimmune disorders with CNS involvement.

### **Consider substance-induced psychosis.**

You know that substances can produce psychotic symptoms.<sup>20</sup> You may have already had first hand experience with such symptoms. The important thing is to consider this possibility *every time* you evaluate a psychotic patient. A Substance-Induced Psychotic Disorder usually differs from a primary Psychotic Disorder in its course and in the symptoms' association with the recent ingestion of a known brain toxin. Indeed, if the psychotic symptoms persist long after the toxin is gone, you will lean toward the diagnosis of a primary Psychotic Disorder.

Psychotic symptoms can occur as a result of *intoxication* with alcohol, amphetamines and related substances, cannabis, cocaine, hallucinogens, inhalants, opioids, phencyclidine, and related substances, sedatives, hypnotics and anxiolytics. This is a large but partial list. As long as we human beings ingest substances to blunt the realities of our everyday lives, psychotic symptoms will probably complicate our efforts to escape.

*Withdrawal* from these and other substances can produce psychotic symptoms too.<sup>21</sup>

**Consider the other mental disorders that may present with psychotic symptoms.**

As mentioned above, psychosis is not very specific. Many other psychiatric disorders may present with psychotic symptoms. Severe mood disorders, particularly the bipolar disorders in young patients, are frequently accompanied by psychotic symptoms. Some personality disorders present this way too. The Dissociative Disorders are sometimes so bizarre that a primary Psychotic Disorder must be considered. Though not ordinarily grouped with the psychotic disorders, we will consider the Dissociative Disorders and Borderline Personality Disorder in this module.

The Dissociative Disorders include Dissociative Amnesia, Dissociative Fugue, Dissociative Identity Disorder and Depersonalization Disorder. These dramatic disorders are characterized by a disruption in the usual integrated functions of consciousness, memory, identity or perception of the environment. The onset of these disturbances may be sudden or gradual and the course may be transient or chronic.

*Dissociative Amnesia* is characterized by the inability to recall important personal information, usually of a traumatic or stressful nature, that cannot be reasonably explained by ordinary forgetfulness. *Dissociative Fugue* involves unexpected travel away from home or work along with the inability to recall the past and confusion about personal identity or the assumption of a new identity. You probably know *Dissociative Identity Disorder* by its former moniker – Multiple Personality Disorder. We psychiatrists change the names of these disorders every few years to throw you off. Two or more distinct personalities or “parts” that recurrently take control of the individual’s behavior characterize this controversial, made-for-TV disorder. *Depersonalization Disorder* involves a persistent or recurrent feeling of being detached from one’s mental processes or body. These disturbing convictions are accompanied by intact reality testing. In this module, we will discuss the prevalence,<sup>22</sup> the putative etiologies,<sup>23</sup> some of the clinical features<sup>24</sup> and the treatments<sup>25</sup> of these disorders.

The Personality Disorders are characterized by enduring patterns of inner experience and behavior that deviate markedly

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from the expectations of that person's culture. These patterns are pervasive and inflexible. They begin early in life, are stable over time, and they lead to significant stress or impairment.

Persons with *Borderline Personality Disorder* desperately seek to avoid real or perceived abandonment. Their interpersonal relationships are unstable.<sup>26</sup> They experience strong surges of overwhelming emotion in response to the usual hard knocks of everyday life, and they are exceedingly impulsive. About 2% of the general population are affected.<sup>27</sup> The course varies, but tends to become a chronic struggle. Psychotherapy<sup>28</sup> is the treatment of choice.

### **Come up with a treatment plan.**

When you have made up your mind about what is wrong, you will wonder about what to do next. Actually, with psychotic patients you will have usually already done something. These demanding encounters often require that you put the cart before the horse. Their agitation and assaultive behaviors may force you to sedate them before you really figure out what is wrong. Even if they improve dramatically with your emergency interventions and everybody feels better, don't neglect to back and figure out what the underlying problem is.

These troubling patients will also raise all kinds of complicated medical-legal issues. Are they competent? Can they

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give informed consent? Can they refuse treatment? What about your duty to warn others they may have threatened? Do they meet the criteria for involuntary commitment? What about confidentiality issues? What malpractice risks do these patients bring? You are doubtless thinking, "This is medical school, not law school – give me a break." You don't need to be a lawyer to treat these folks right, but you will need to understand a few basic legal principles.<sup>29</sup>

What treatments are effective for psychotic symptoms? The antipsychotic medications are the mainstays of treatment. You must understand the basic pharmacological actions<sup>30</sup> of these medications, their therapeutic indications,<sup>31</sup> precautions and adverse reactions,<sup>32</sup> the significant drug interactions<sup>33</sup> and some of the administration issues<sup>34</sup> with these agents. You should be able to discuss the underlying neurophysiology including the dopamine hypothesis,<sup>35</sup> and the

effects of over-activity of the mesolimbic, nigrostriatal, mesocortical and tuboinfundibular pathways.<sup>36</sup> You must be able to describe the four actions of a typical antipsychotic agent including dopamine blockade, muscarinic cholinergic blockade, alpha adrenergic blockade and histamine blockade.<sup>37</sup> You should be familiar with the differences between the “typical” and the “atypical” antipsychotic medications.<sup>38</sup> Become familiar with the theory of action of the serotonin-dopamine antagonists and the agents that are currently on the market.<sup>39</sup> Understanding the cost/benefit ratio<sup>40</sup> of atypical antipsychotic is important; you may need to explain to the insurer that while the atypical agents are indeed more expensive, improved adherence and enhanced patient productivity help to make a compelling case for using these agents first. You will want to be comfortable with the use of clozapine in schizophrenia,<sup>41</sup> and you will need to understand why physicians not skilled in managing such medications should be cautious about altering established regimes before consulting with the patient’s psychiatrist.<sup>42</sup> Make sure you understand the signs, symptoms and treatment of serotonin syndrome, anticholinergic crisis and neuroleptic malignant syndrome.<sup>43</sup> Hospitalization<sup>44</sup> is sometimes necessary. Various psychosocial interventions<sup>45</sup> can make a world of difference. You will likely consult a psychiatrist to assist you with the initial evaluation and treatment of these complicated patients, but many chronically psychotic patients are followed regularly by primary care physicians.

### Conclusion

These are among the most challenging patients in all of medicine. We know a great deal about what is wrong with them and what will help them, but we still don’t know nearly enough.

Theories abound. In psychosis, as in much of contemporary psychiatry, the stress-diathesis model is the best way to explain what we observe. Persons with some preexisting vulnerability experience some stress, and symptoms emerge as a result. Then there are biological<sup>46</sup>, genetic<sup>47</sup> and psychosocial factors<sup>48</sup> to consider.

This we do know. These patients are suffering enormously. Their psychotic symptoms disrupt their lives and the lives of those who love them. They will come to you for help. If you are compassionate, careful

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and competent you can make a difference in their lives. Mastering the learning objectives in this module is not just about passing a quiz and moving on. This stuff really matters.

### References

1. American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, American Psychiatric Association, 1994
2. Kaplan HI, Sadock BJ, Synopsis of Psychiatry, Eighth Edition, Williams and Wilkins, 1988
3. Stahl SM, Essential Psychopharmacology: Neuroscientific Basis and Practical Applications, Cambridge University Press, 1996
4. Goldman HH, Review of General Psychiatry, Fourth Edition, Appleton & Lange, 1995

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### Performance Objectives

*After completing your professional education, you will be able to*

- <sup>1</sup> Explain how to use the DSM to make a specific psychiatric diagnosis
- <sup>2</sup> Elicit an appropriate clinical history
- <sup>3</sup> Conduct a mental status examination
- <sup>4</sup> Suggest appropriate diagnostic testing including
  - <sup>4.1</sup> Laboratory testing
  - <sup>4.2</sup> Psychological testing
  - <sup>4.3</sup> The administration of clinical rating scales
- <sup>5</sup> Create a differential diagnosis
- <sup>6</sup> Specify a working diagnosis
- <sup>7</sup> Construct a patient-specific clinical problem list
- <sup>8</sup> Develop an effective treatment plan
- <sup>9</sup> Provide understandable patient education
- <sup>10</sup> Identify pertinent health care information resources
- <sup>11</sup> Outline psychiatric referral guidelines

### Enabling Objectives

*At the conclusion of this module, you will be able to*

- <sup>12</sup> List the five categories of psychotic symptoms
- <sup>13</sup> Estimate the lifetime prevalence of the Psychotic Disorders
  - <sup>13.1</sup> Schizophrenia
  - <sup>13.2</sup> Schizophreniform Disorder
  - <sup>13.3</sup> Schizoaffective Disorder
  - <sup>13.4</sup> Delusional Disorder
  - <sup>13.5</sup> Brief Psychotic Disorder
  - <sup>13.6</sup> Shared Psychotic Disorder
- <sup>14</sup> Discuss the etiologies of the Psychotic Disorders
  - <sup>14.1</sup> Refer to Objectives 13.1 through 13.6
- <sup>15</sup> Specify the diagnostic criteria for the Psychotic Disorders
  - <sup>15.1</sup> Refer to Objectives 13.1 through 13.6
- <sup>16</sup> Describe the common clinical features of the Psychotic Disorders
  - <sup>16.1</sup> Refer to Objectives 13.1 through 13.6
- <sup>17</sup> Discuss the effective treatments for the Psychotic Disorders

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17.1 Refer to Objectives 13.1 through 13.6

- 18 Describe three of the diagnostic features of Psychotic Disorder Due to a General Medical Condition
- 19 List five categories of general medical conditions that may cause psychotic symptoms
- 20 List three diagnostic features of a Substance-Induced Psychotic Disorder
- 21 Identify ten categories of substances that can produce a Substance-Induced Disorder
- 22 Estimate the lifetime prevalence of the Dissociative Disorders
- 22.1 Dissociative Amnesia
- 22.2 Dissociative Fugue
- 22.3 Dissociative Identity Disorder
- 22.4 Depersonalization Disorder
- 23 Discuss the etiologies of the Dissociative Disorders
- 23.1 Refer to Objectives 22.1 through 22.4
- 24 Specify the clinical features of the Dissociative Disorders
- 24.1 Refer to Objectives 22.1 through 22.4
- 25 Discuss the effective treatments for the Dissociative Disorders
- 25.1 Refer to Objectives 22.1 through 22.4
- 26 Describe the clinical features of Borderline Personality Disorder
- 27 Estimate the lifetime prevalence of the Borderline Personality Disorder
- 28 Discuss the treatment of Borderline Personality Disorder
- 29 Discuss five medical-legal principles that should guide your approach to psychotic patients
- 30 Describe the pharmacological actions of the antipsychotic medications
- 31 List the indications for using antipsychotic medications
- 32 Detail the common precautions with and the adverse reactions of the antipsychotic medications
- 33 Identify the common drug interactions with the antipsychotic medications.
- 34 Discuss significant administration issues with the antipsychotic medications
- 35 Briefly describe the dopamine hypothesis
- 36 Discuss the effects of over-activity and blockade of post-synaptic receptors in the mesolimbic, nigrostriatal, mesocortical and tuboinfundibular pathways
- 37 Describe the results of the four actions of a typical antipsychotic agent including dopamine blockade, muscarinic cholinergic blockade, alpha adrenergic blockade and histamine blockade
- 38 Define the term “atypical antipsychotic agent”
- 39 Describe the theory of action of serotonin-dopamine antagonists and name the available agents
- 40 Analyze the cost/benefit ratio of atypical antipsychotic treatment
- 41 Describe the use of clozapine in the treatment of schizophrenia
- 42 Define the role of the primary care physician in altering an established medication program for treatment of a thought disorder
- 43 Review the signs, symptoms and treatment of neuroleptic malignant syndrome, anticholinergic crisis and serotonin syndrome
- 44 Discuss the indications for the hospitalization of psychotic patients
- 45 Describe the various psychosocial interventions that may be helpful in the treatment of psychotic patients
- 46 Discuss the biological theories of psychosis
- 47 Summarize the evidence for the role of heredity in Schizophrenia
- 48 Identify the key psychosocial issues in the development and treatment of Schizophrenia