

In an effort to help efficiency I think it's important to establish some guidelines of what we look for and what we can do for our patients. This page is obviously open to additions and feedback.

THINGS TO LOOK AT IN ALL PATIENTS

Therapy

I will frequently hear nurses or family recommending therapy for a patient. "Don't you think it would be nice for them to have someone to talk to?"

THIS IS NOT THERAPY.

That is the equivalent of signing someone up for a once a month personal training session because it would be nice to have someone to work out with.

Therapy is about work. And it is more about work outside of the therapy hour. So the next time you are wondering whether someone will benefit from therapy ask yourself, "Will they do the work of therapy?"

I ask this because I will frequently see people who are not mood charting in what amounts to seconds a day being recommended for therapy. Do you really think someone is going to keep a though record and log that requires minutes a day when we can't get them to write down how many hours they slept?

My point is that you should be encouraging journaling using our guide for anyone were considering therapy for realizing that this is the groundwork for therapy. Patients that are starting to explore themselves, look at themselves objectively outside of our office, are the ones who will benefit from long-term therapy the most.

Nearly everyone benefits from journaling. And it helps us to better understand them.

THINGS TO LOOK AT IN ALL PATIENTS

Psychotherapeutic Techniques to Help Patients

Avoiding taking responsibility for things out of control: A common supportive psychotherapy technique is reminding people to not take more responsibility than control. Serenity prayer...etc.

Self-Support: Another common supportive technique is encouraging patients to support themselves, pat themselves on the back and realize that what they are going through is difficult and they need to be in their own corner as well instead of beating themselves up.

Good Circadian Integrity (keeping a good schedule)

Routine helps sleep.

It helps anxiety.

It helps productivity.

Getting a good routine will help most of our patients.

25% of patients with intractable insomnia admitted to a sleep lab (saying that nothing ever works) will sleep just fine with only sleep hygiene if strictly enforced.

Exercise

Exercise helps sleep. Exercise helps pain. Exercise helps anxiety.

Exercise helps depression. First establish a behavior. Then modify it.

What this means is that you get people to commit to exercise 5 minutes every day. (Even if it's walking out to the mailbox. If they miss a day, make it 10 the next so that they can keep their streak alive. Don't worry about intensity, worry about establishing a long-standing pattern that can later be modified.)

Diet

Avoiding Caffeine at night.

Overload of carbohydrates mixed with fats.

No vegetables.

Primarily using carbohydrates as long-term fuel instead of fat. These are diet basics that can help nearly everyone feel better.

IS IT TIME TO START LOWERING A MED?

(This is the single biggest mistake I see from every provider in the office. The reluctance to take people off or down on dangerous medications because they are doing well. Any bipolar on an antidepressant, any patient on a benzo or antipsychotic, should always be considered for a dose reduction. I almost never have anyone else bring this up and they should. Doing well isn't good enough. Doing well while exposing patients to least risk is our goal.

IS IT TIME FOR LABS?

This is another almost no one ever does.

ANTIPSYCHOTICS/LITHIUM/DEPAKOTE: If stable every 3-6 months

ANTIDEPRESSANT LABS: YEARLY

DRUG TESTING? FOR PATIENTS NOT IMPROVING.

CRISIS PATIENTS

RISK ASSESSMENT

Is this patient dangerous? Do they have a plan or intent to hurt anyone? Do they have means? Do they abuse substances? What stops them from taking these actions? Will someone responsible watch them? Do they feel hopeless?

These are the basics of a risk assessment. And should be included for crisis patients.

OPTIONS

HOSPITAL - BIGGEST BENEFIT IS THAT IT OFFERS THE SAFEST ENVIRONMENT FOR DANGEROUS PATIENTS.

PARTIAL HOSPITAL - ALLOWS CLOSE MONITORING AND GROUP THERAPY.

SHOULD THEY COME BACK TOMORROW OR IN A FEW DAYS?

SHOULD SOMEONE STAY WITH THEM?

SHOULD WE CALL AND CHECK ON THEM?

SHOULD DCF COME AND CHECK ON THEM?

SHOULD HOME HEALTH COME AND CHECK ON THEM?

THESE ARE ALL POSSIBLE SOLUTIONS DEPENDING ON THE INDIVIDUAL CIRCUMSTANCES.

DEPRESSION PATIENTS

Psychotic component? MMPI may help find this. If present we will add an antipsychotic sooner.

Seasonal Component?

Recent Labs?

Increase a current Antidepressant

Change to a different antidepressant

Augment with nutraceuticals (Deplin, Fish oil, Sam-E, 5-HTTP)

Augment with simple safe agents (buspar, an antidepressant with different action)

Augment with riskier options (Lithium, Thyroid Hormone, Antipsychotic)

Anti Depressants (Different classes/mechanism of actions)

SSRI (mostly just serotonin) (prozac, paxil, zoloft, lexapro, celexa)

SNRI (serotonin and neupinephrine: Cymbalta, Effexor, Pristiq, Fetzima)

Dopamine (Wellbutrin, Stimulants)

Direct Serotonin Simulation (Vibrid, Brentillax)

Glutamate Brentillax, Namenda

SUBSTANCE ABUSE

DEA WEBSEARCH

AVOID BENZOS AND ALCOHOL TOGETHER

AVOID TWO BENZOS TOGETHER

AVOID HIGH DOSE UPPERS AND DOWNS TOGETHER

ENCOURAGE INPATIENT DETOX OFF OF ALCOHOL AND BENZOS IF INDICATED.

SHOULD WE DRUG TEST PATIENT?

SHOULD WE TERMINATE PATIENT?

ARE WE ENABLING OR HELPING?

ANXIETY PATIENTS

PTSD

Low dose benzo with alpha blockade (prazosn, clonidine, guanfacine)

MMPI? May help us to add antipsychotics sooner if indicated.

ANTI HISTAMINE (Vistaril)

SEROTONIN AGENT (SSRI)

MOOD STABILIZER (Depakote, Trileptal)

ANTIPSYCHOTICS

Routine

Exercise

Staying Busy

Therapy

Benzo

Ativan: cleanest and best if it works

Valium and Xanax: Fastest onset, erratic and complicated metabolism

Klonopin: Most hangover