

Table 10-17: Common Clinical Misperceptions Regarding Psychiatric Issues

Psychiatric Issue/ Disorder	Clinical Misperceptions	Remember to Ask About
Major depression	“Anyone would be depressed or grieving,” forgetting biologic depression	Vegetative symptoms (early morning awakening, diurnal mood variation, appetite disturbance); anhedonia more than sadness
Bipolar mood disorder	“Depressed mood must mean depression,” forgetting bipolar symptoms	Hypomanic/manic symptoms (history of racing thoughts, hyperactivity, no need for sleep, grandiose plans, irritability)
Psychosis	“The patient seems normal,” forgetting hallucinations and paranoia	Psychotic symptoms: “Do you ever hear your name called, turn around and no one is there? or a phone ringing?” “Ever feel like people are talking about you walking down the street?”
Delirium	“The patient is clearly schizophrenic or psychotic,” forgetting acute medical etiologies	Distractibility, disorientation, dysarthric speech; inability to sustain, focus attention; misperceptions; mumbling or muttering
Sexual abuse/assault history	“Too personal; may embarrass or offend”	“Were you ever sexually, physically abused in childhood? Assaulted as an adult?” Do not ask details.
Anxiety, panic, agoraphobia	“Must be drug-seeking;” “Anyone would be anxious”	Panic symptom, sense of doom, tachycardia (repeated episodes), impairment of function; avoids crowded places
Domestic violence	“Seems like a nice person”	“Is there anyone in your life now or in the past who makes you feel unsafe?”
Suicidal ideation	“May plant the thought in their mind, provoke it”	“Have you ever felt like hurting or killing yourself? Have a plan? Have the means?”