

For my first history and physical presentation during my psychiatry rotation, I evaluated a 28-year-old male with a history of Bipolar I Disorder with psychotic features and Cannabis Use Disorder who was admitted to the inpatient psychiatric unit following escalating agitation, aggression toward family members, and worsening psychotic symptoms. The patient was brought to the hospital by EMS and NYPD after his sister called 911 due to increasing grandiosity, irritability, and disorganized behavior. During the interview, the patient stated that he was God, believed that hospital staff was attempting to poison him with medications, and expressed plans to become a billionaire because he was the smartest person in the world. Mental status examination revealed pressured speech, expansive and labile affect, tangential thought processes, grandiose and paranoid delusions, poor insight, and impaired judgment. Collateral information obtained from his sister revealed worsening symptoms following a recent transition from lithium to a long-acting injectable antipsychotic. Based on the patient's history, mental status examination, collateral information, and prior psychiatric diagnoses, the most likely diagnosis was Bipolar I Disorder, current manic episode with psychotic features. Treatment focused on inpatient stabilization with lithium, olanzapine, supportive therapy, and close monitoring of psychotic and manic symptoms. This case reinforced the importance of obtaining collateral information from family members, as well as recognizing the role that medication nonadherence and medication changes can play in psychiatric decompensation.

For my second history and physical presentation, I evaluated a 32-year-old male with no prior formal psychiatric diagnosis who was admitted to the inpatient psychiatric unit for worsening paranoia and persecutory delusions. The patient was brought to the hospital by EMS and NYPD after his sister reported increasing suspiciousness, behavioral disturbances, and threats to defend himself against a cousin whom he believed was physically harming him while he slept. During the interview, the patient remained guarded and insisted that his cousin was abusing him despite multiple negative medical evaluations and a lack of objective evidence. He also expressed beliefs that individuals from his home country were monitoring him and attempting to persecute him. Mental status examination demonstrated fixed persecutory delusions, poor insight, impaired judgment, and guarded behavior, while speech, mood, and thought organization remained relatively intact. Collateral information revealed a progressive three-year history of paranoia, social withdrawal, poor sleep, and declining occupational functioning. Based on the chronic course of illness, functional deterioration, and persistent delusional beliefs, the most likely diagnosis was a schizophrenia spectrum disorder. Management included initiation of risperidone, inpatient psychiatric stabilization, diagnostic evaluation to rule out medical causes of psychosis, and continued observation. This case highlighted the importance of differentiating primary psychotic disorders from other psychiatric and medical conditions while utilizing collateral information to better understand the progression of symptoms.

Across these experiences, I learned the importance of obtaining thorough collateral information from family members, EMS, outpatient providers, and other available sources, particularly in inpatient psychiatry, where patients may have impaired insight, disorganized thought processes, or unreliable recall. Collateral data often provides essential context regarding baseline functioning, symptom chronology, medication adherence, and recent stressors or medication changes that may not be accurately reported by the patient. Working alongside attendings, residents, nurses, social workers, and case managers further emphasized the value of a multidisciplinary approach to care. This rotation strengthened my ability to perform mental status examinations, synthesize collateral and clinical findings, and recognize psychiatric

pathology across a diverse patient population. It also reinforced that effective psychiatric treatment extends beyond pharmacologic intervention and requires addressing social, cultural, and environmental determinants of health. Overall, my experience at Elmhurst Hospital Center enhanced my clinical reasoning, communication skills, and commitment to delivering compassionate, patient-centered psychiatric care.