Introduction

Following on from the success of the second volume of *Case Studies* in 2016, we are very pleased to present a third collection of new clinical cases. This third collection of cases is the result of a special project of the Department of Psychiatry and Neuroscience of the University of California, Riverside, where all three editors are faculty members. Each case is taken from the clinical practices of the department and each is written by a team comprising a medical student or resident/fellow in psychiatry paired with a faculty member in the UCR psychiatry and neuroscience department. This volume of cases thus showcases not only the clinical practice in our department, but the teamwork of faculty and trainees to produce a scholarly and educational book to enrich and inform our colleagues who treat mental illness. *Stahl's Essential Psychopharmacology* started in 1996 as a textbook (currently in its fourth edition) on how psychotropic medications work. It expanded to a companion Prescriber's Guide in 2005 (currently in its fifth edition) on how to prescribe psychotropic medications. In 2008, a website was added (**stahlonline.cambridge.org**) with both of these books available online in combination with several more, including an *Illustrated* series of books covering specialty topics in psychopharmacology. The *Case Studies* shows how to apply the concepts presented in these previous books to real patients in a clinical practice setting.

Why a case book? For practitioners, it is necessary to know the science and application of psychopharmacology – namely, both the mechanism of action of psychotropic medications and the evidence-based data on how to prescribe them – but this is not sufficient to become a master clinician. Many patients are beyond the data and are excluded from randomized controlled trials. Thus, a true clinical expert also needs to develop the art of psychopharmacology: namely, how to listen, educate, destigmatize, mix psychotherapy with medications, and use intuition to select and combine medications. The art of psychopharmacology is especially important when confronting the frequent situations where there is no evidence on which to base a clinical decision.

What do you do when there is no evidence? The short answer is to combine the science with the art of psychopharmacology. The best way to learn this is probably by seeing individual patients. Here we hope you will join us and peer over our shoulders to observe 34 complex cases from our own clinical practice. Each case is anonymized in identifying details, but incorporates real case outcomes that are not fictionalized. Sometimes more than one case is combined into a single case. Hopefully, you will recognize many of these patients as similar to those you have seen in your own practice (although they will not be exactly the same patient, as the identifying historical details are changed here to comply with disclosure standards, and many patients can look

very much like many other patients you know, which is why you may find this teaching approach effective for your clinical practice).

We have presented cases from our clinical practice for many years online (e.g. in the master psychopharmacology program of the Neuroscience Education Institute (NEI) at neiglobal.com) and in live courses (especially at the annual NEI Psychopharmacology Congress). Over the years, we have been fortunate to have many young psychiatrists from our universities, and indeed from all over the world, sit in on our practices to observe these cases, and now we attempt to bring this information to you in the form of a third case book.

The cases are presented in a novel written format in order to follow consultations over time, with different categories of information designated by different background colors and explanatory icons. For those of you familiar with *The Prescriber's Guide*, this layout will be recognizable. Included in the case book, however, are many unique sections as well; for example, presenting what was on the author's mind at various points during the management of the case, and also questions along the way for you to ask yourself in order to develop an action plan. There is a pretest, asked again at the end as a posttest, for those who wish to gain CME credits (go to **neiglobal.com** to answer these questions and obtain credits). Additionally, these cases incorporate ideas from the recent changes in maintenance of certification standards by the American Board of Psychiatry and Neurology for those of you interested in recertification in psychiatry. Thus, there is a section on Performance in Practice (called here "Confessions of a psychopharmacologist"). There is a short section at the end of several cases looking back and seeing what could have been done better in retrospect. Another section of most cases is a short psychopharmacology lesson or tutorial, called the "Two-minute tutorial," with background information, tables, and figures from literature relevant to the case in hand. Medications are listed by their generic and brand names for ease of learning. Indexes are included at the back of the book for your convenience. Lists of icons and abbreviations are provided in the front of the book. Finally, this third collection updates the reader on the newest psychotropic medications and their uses, and adopts the language of *DSM-V*.

The case-based approach is how this book attempts to complement "evidence-based prescribing" from other books in the *Essential Psychopharmacology* series, plus the literature, with "prescribing-based evidence" derived from empiric experience. It is certainly important to know the data from randomized controlled trials, but after knowing all this information, case-based clinical experience supplements those data. The old saying that applies here is that wisdom is what you learn *after* you know it all; and so, too, for studying cases after seeing the data.

A note of caution: we are not so naïve as to think that there are not potential pitfalls to the centuries-old tradition of case-based teaching. Thus, we think it is a good idea to point some of them out here in order to try to avoid these traps. Do not ignore the "law of small numbers" by basing broad predictions on narrow samples or even a single case.

Do not ignore the fact that if something is easy to recall, particularly when associated with a significant emotional event, we tend to think it happens more often than it does.

Do not forget the recency effect, namely, the tendency to think that something that has just been observed happens more often than it does.

According to editorialists[1], when moving away from evidence-based medicine to case-based medicine, it is also important to avoid:

- Eloquence or elegance-based medicine
- Vehemence-based medicine
- Providence-based medicine
- Diffidence-based medicine
- Nervousness-based medicine
- Confidence-based medicine

We have been counseled by colleagues and trainees that perhaps the most important pitfall for us to try to avoid in this book is "eminence-based medicine," and to remember specifically that:

- Radiance of gray hair is not proportional to an understanding of the facts
- Eloquence, smoothness of the tongue, and sartorial elegance cannot change reality
- Qualifications and past accomplishments do not signify a privileged access to the truth
- Experts almost always have conflicts of interest
- Clinical acumen is not measured in frequent flier miles

Thus, it is with all humility as practicing psychiatrists that we invite you to walk a mile in our shoes; experience the fascination, the disappointments, the thrills, and the learnings that result from observing cases in the real world.

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[1] Isaccs D and Fitzgerald D. Seven alternatives to evidence based medicine. *British Medical Journal 1999; 319:1618.*