**BASIC PSYCHIATRY SEQUENCE IN NEUROSCIENCE BLOCK, FALL 2020**

**GROUPS** consist of 8-9 students and 2 group leaders.

You meet EIGHT times during the Neuroscience Block and THREE times during the DEMS (Digestive, Endocrine, and Metabolism Systems Block). Just as in CVPR, you will interview volunteer patients (many from AMC), practice the 30-minute interview and participate in discussions.

**ORGANIZATION**

* The syllabus will point you to your group leaders. Generally mini lectures are from 10:00-10:25 and your group meets 10:30-11:50. Much like in CVPR your lectures and small groups will occur via Zoom.
* 25-minute “MINI” lectures are not complete reviews but are meant to introduce you to the symptoms and problems patient volunteers may face now or faced in the past.
* Handouts are required reading—For those interested, an electronic copy of DSM-5 is also available through the HS Library (<http://dsm.psychiatryonline.org/doi/book/10.1176/appi.books.9780890425596> - or go to HSL website at <https://library.cuanschutz.edu/> and under “Top Resources” click “Library Search”, then search for “diagnostic and statistical manual of mental disorders 5th edition online”. The right drop down can be changed from “Catalog and Journal Articles” to just “Catalog” and the online version of the DSM-5 should come up in your top few searches. We will post **announcements** each week on Canvas about upcoming reading assignments, handout(s) and interviews. Exam questions may be derived from the lecture, PowerPoint presentations, handout materials or lecture-specific required reading.
* Please arrive at your Zoom small groups immediately after the lecture. It is important that everyone go to their Zoom pod immediately after the lecture (generally by 10:30) to allow the pod managers to sort everyone into their Zoom small group rooms – if you arrive late, this causes problems for your Zoom pod manager. Your small group patient volunteer will be sorted into your small group room by about 10:45 and the 30 minute interview will begin at that time.
* **Patient shortage:** Extra interviewees are recruited for each session, but at times several volunteers do not show. We identify volunteers in advance who are open to doing a second interview (e.g., one from 10:45-11:15 and a second from 11:15-11:45) – we will make every effort to have an interviewee available for group each week.

**REVIEW OF GROUP PROCEDURES:**

**Student A** is assigned to conduct the 30-minute interview for interview 1.

**Student B** is assigned to take written notes during interview, write a SOAP1 note and submit it to faculty co-leaders by that Friday night. Faculty provide this student written feedback/critiques of the SOAP note (by

**Friday night**

Student B prepares SOAP1 note and submits the SOAP note to their faculty by Friday night. Faculty provide written critiques by Monday evening. Other students email reflections about interview by Friday night. Faculty share reflections and added comments with the group.

**Wednesday Week 1**

Student A conducts the 30 minute interview2

Student B takes notes

**Wednesday Week 2**

Student B, who prepared the SOAP from the prior interview,

conducts the 30 minute interview.2

Student C takes notes

**Wednesday Week 3**

Student C, who prepared the SOAP from the prior interview,

conducts the 30 minute interview.2

Student D takes notes

**Friday night**

Student C prepares SOAP note and submits the SOAP note to their faculty by Friday night. Faculty provide written critiques by Monday evening. Other students email reflections about interview by Friday night. Faculty share reflections and added comments with the group.

Monday evening prior to next small group) and may request that the student provide a revision. **Other students** provide comments on the interview or a reflection about the case by Friday night to the faculty co-leaders. Faculty share student reflections with the group (group email) with faculty comments added. At interview 2 student B conducts interview, while student C takes notes and prepares SOAP, etc.

Footnotes:

1 The term SOAP note is used here to help students generally attend to note organization (subjective, objective, assessment, plan). However, what students write would more correctly be terms a Psychiatric Intake Note – however, we will refer to this here simply as a SOAP note. During the Neuroscience block we are now interested in students writing and presenting a complete SOAP note. Please include differential diagnoses with support from the subjective and objective portions of the interview for those diagnoses, a problem list (assessment), and a beginning plan.

2 Some groups may wish to have the interviewing student remain after the group for a brief period to provide personalized feedback on interviewing – the faculty may even wish to create a private zoom room (shared with the student interviewing) to do this. Feedback is essential to fostering learning, but some feedback on strengths and weaknesses of their interview may best be provided in a private setting. Some groups may decide to discuss this within the group setting.

For students who require more extensive revisions of their written work (SOAP), the faculty may invite them to provide additional SOAP notes over the course of the small group.

After your last group session, students complete anonymous feedback about their group experience. Group leaders complete formative feedback about student performance**.**

Reflections: We want you to get in the habit of reading relevant material after seeing patients. What might you want to know more about – could you do a quick review (e.g., UpToDate or in PubMed) and submit a relevant abstract or a summary of what you found? We want you to also be thoughtful about the volunteer’s you see and their experiences – what is it like to live with depression? What is their experience with the medical system? What is their experience with their family, co-workers, significant others? How might putting yourself in their shoes impact how you might wish to practice in the future? Think about life patterns – how might you predict this would impact your work with this patient if you were to see them longitudinally? What questions seem unanswered – how might you try to address this in a follow up appointment? How might you have approached asking about a sensitive topic? Considering the interview, what went well and what could have gone better? Why?

**OVERALL LEARNING OBJECTIVES FOR THE BASIC PSYCHIATRY SEQUENCE**

Be able to:

* utilize appropriate diagnostic screens for the weekly patients, many of which are in the *CU Assessment of Common Psychiatric Problems* (blue booklet, also referred to as “CU log”, also available on CANVAS)
* describe the diagnostic criteria for the type of problems you will see that week
* to begin utilizing the 30 minute 3-part interview in the CU log
* actively participate in the post interview discussion
* generate the appropriate written documentation.

**Keys to a successful group:**

* Groups are successful only if you participate.
* A commitment to express your ideas in collegial ways. An effective group depends on **your contribution so please, please speak up.**
* You and your leaders will evaluate how your group is functioning. This includes whether your group has slipped into a “hub and spoke” teaching mode with your leaders assuming their traditional roles as the source of all knowledge, and students becoming passive listeners.
* Groups are required

Suggested group schedule

* 10:35-10:45 - SOAP note presentation (optional). Discuss prior week’s interview and student questions/reflections
* By 10:45-11:15 – Interview of volunteer patient
* 11:15-11:50 - continued group discussion

**INTERVIEWS**

**Week 1: Wed. 8/12/20 Post-Traumatic Stress Disorder: The changed brain**

**Mini-lecture**: Kevin Vest, MD

**Suggested additional reading:** the VA/DoD Clinical Practice Guideline for the Management of Post-Traumatic Stress Guideline Summary.

**Group**: Interview patient with ***PTSD***, use appropriate screens.

**Week 2: Wed. 8/19/20 Developmental Disorders**

**Lecture**: Audrey Blakeley-Smith, PhD – 9:00-10:20 am

* Normal and abnormal psycho-social development

**Group**: Interview ***autistic person and/or their family***. Use appropriate screens.

**Week 3: Wed. 8/26/20 Delirium/Dementia/TBI**

**Mini-lecture**: Brice McConnell, MD PhD

* Cognitive Evaluation

**Group**: Interview patient ***(may be a family member)*** with a ***TBI and/or******memory impairment***. Utilize appropriate screens.

**Week 4: Wed. 9/2/20 Somatic Complaints and Pain**

**Mini-lecture:** Thida Thant, MD

* Idiopathic somatic complaints: psychosocial distress, Somatic Symptom Disorder & the differential diagnosis of the somatic complaint

**Group**: Interview ***patient with chronic pain***. Utilize appropriate screens.

**Week 5: Wed. 9/9/20** **Anxiety Disorders**

**Mini-lecture:**  Robert Davies, MD

**Group**: Interview ***patient with an anxiety disorder***. Utilize appropriate screens.

**Week 6: Wed. 9/16/20** Intro **to** **Mood and Psychotic Disorders**

**Mini-lecture:** Abraham Nussbaum, MD

**Group:** Interview ***patient with schizophrenia or bipolar disorder***. Utilize appropriate screens.

**Week 7: Wed. 9/23/20, 8:35-10:20 am, Psychotic Disorders I and II**

**Lecture:** Amanda Law, PhD

**Group**: Interview ***patient with schizophrenia or bipolar disorder***. Utilize appropriate screens.

**Week 8: Wed. 9/30/20** **Substance Use Disorders**

 **Mini-lecture**: Joseph Sakai, MD

**Group**: Interview ***AA volunteer***. Utilize appropriate screens, including CAGE.

**DEMS BLOCK:**

**Week 9: Wed, 10/21/20 10:00-10:50 am:**

**Lecture:** ***Illness among physicians*** Doris Gundersen, MD

**Group:** 11:00-11:50 am – **Discussion** **(please note this week deviates from our normal procedures – we will not assign a student to conduct an interview and instead will have a general discussion with a physician about their history)** with physician from CPHP (Colorado Physician Health Program). Utilize appropriate screens.

**Week 10: Wed, 11/11/20 10:00-10:50 am:**

**Lecture:** ***Eating Disorders*** Kenneth Weiner, MD

**Group:** 11:00-11:50 am **–** Interview patients from Dr. Weiner’s Eating Disorders Clinic. Utilize appropriate screens.

**Week 11: Wed, 12/2/20 10:00-10:30 am:**

**Lecture:** ***Endocrine-related Depression*** Austin Butterfield, MD

**Group:** 10:35-11:50 am – Final small group, no interview. Review AA reflections, open discussion about course and small groups.

**EVALUATIONS**

You will complete a course evaluation and group leader evaluations at the end of these 11 sessions. Your leaders will not see your evaluations until they have completed their evaluation of you. Constructive criticism and suggestions are very important. We thoroughly review your assessments and institute your suggestions if we can. Therefore, future STUDENTS RECEIVE THE BENEFIT OF YOUR EXPERIENCE just as you received the benefits of students who took Basic Psychiatry in the past.

**ASSESSMENT**

* You received a formative psychiatry assessment at the end of CVPR and will receive a final psychiatry assessment at the end of the metabolism block.
* Your final group assessment is based on your **group participation**, **patient interviews, and your written work. (See “Fall 2018 Feedback of Student Performance”)**

**Professionalism:**

Academic Honesty Statement

Students are expected to adhere to the Honor Code of the University of Colorado School of Medicine which states that students must not lie, cheat, steal, take unfair advantage of others, nor tolerate students who engage in these behaviors. Please check the website for information on the Medical Student Honor Code. <http://www.ucdenver.edu/academics/colleges/medicalschool/education/studentaffairs/AcademicLife/HonorCouncil/Pages/default.aspx>

Students are also expected to:

Attend all small groups and arrive on time.

Contact the appropriate faculty for all voluntary and involuntary absences (see absences below).

Complete all small group requirements on time (SOAP note, interviews, reflections, group participation).

Exhibit professional behaviors in the small group interviews and wear professional dress when interviewing.

Absences:

As stated in the Medical School White Book:

“Some aspects of a student’s education experience at CUSOM require student participation. Some instructional methods, such as small group discussions, group labs or dissections, or topics, such as Interprofessional teamwork, require all students to participate in order for the content (e.g., teamwork, physical exam skills) to be learned. In other words, required student attendance contributes to individual and peer learning. Themselves, as a full member of the CUSOM learning community, students are expected to participate in these types of required activities.”

Students may request that an absence be excused by contacting (1) the Associate Dean of the Essentials Core and (2) Dr. Sakai (joseph.sakai@cuanschutz.edu). Once an absence is approved, it is the responsibility of the student to inform their small group faculty.

Please see the following link for details and the relevant excerpts (below): <http://www.ucdenver.edu/academics/colleges/medicalschool/education/studentaffairs/studentresources/Documents/StudentHandbook.pdf>

“Possible reasons for requesting an absence include but are not limited to a healthcare appointment (that could not otherwise be scheduled outside of a required session), religious observance, attendance at weddings or funerals, or participation in an academic function (e.g. academic conference). Requests must be presented well in advance, in writing, and reasonable documentation is required.”

“Absences due to an involuntary situation include but are not limited to personal illness or family emergency.”

**FALL 2020 FEEDBACK OF GROUP LEADER PERFORMANCE**

***THIS FORM WILL BE COMPLETED BY THE STUDENTS ELECTRONICALLY UPON COMPLETION OF THE FOUR PSYCHIATRY SESSIONS IN THE CVPR BLOCK.***

1. My comfort level in discussing emotional/psychological issues with patients has increased during the Basic Psychiatry small group series.

Strongly disagree

Disagree

Somewhat disagree

Somewhat agree

Agree

Strongly agree

2. How comfortable do you feel interviewing patients about psychiatric conditions (including psychiatric symptoms, psychosocial stressors, safety and mental health history) covered over the course of this teaching series?

Not at all comfortable

Somewhat comfortable

Mostly comfortable

Very comfortable

Completely comfortable

3. How confident are you with interviewing patients with mental illness.

Not at all confident

Somewhat confident

Mostly confident

Very confident

Completely confident

4. How comfortable are you with generating appropriate documentation, in SOAP note format, for patients with mental illness?

Not at all comfortable

Somewhat comfortable

Mostly comfortable

Very comfortable

Completely comfortable

5. The Psychiatry small group sessions changed my views about mental illness.

Strongly disagree

Disagree

Somewhat disagree

Somewhat agree

Agree

Strongly agree

6. The Psychiatry small group sessions reduced biases or stigma I had toward patients with mental health concerns.

Strongly disagree

Disagree

Somewhat disagree

Somewhat agree

Agree

Strongly agree

7. To what extent have you been able to express your ideas in a collegial way?

 Not at all

 A little

 Somewhat

 Mostly

 Always

8. To what extent have you personally been able to promote the work of the group?

 Not at all

 A little

 Somewhat

 Mostly

 Always

9. What have you done well?

10. Please comment on any areas you would like to improve.

11. To what extent did you receive useful feedback?

 Not at all

 A little

 Somewhat

 Mostly

 Always

12. What would improve the feedback you received?

13. What was the overall quality of your small group experience?

 Poor

 Fair

 Good

 Very good

 Excellent

**FALL 2020 FEEDBACK OF STUDENT PERFORMANCE**

***THIS WAS COMPLETED BY THE GROUP LEADERS ELECTRONICALLY UPON COMPLETION OF THE FOUR PSYCHIATRY SESSIONS IN THE CVPR BLOCK. SPRING PERFORMANCE FEEDBACK IS FOR STUDENTS ONLY AND WILL NOT BE PART OF THE PERMANENT STUDENT FILE. THE ASSESSMENT AT THE END OF THE BASIC PSYCHIATRY SEQUENCE WILL BECOME PART OF THE STUDENT FILE.***

1. Did the student arrive on time to these sessions?

 No

 Needs Improvement

 Yes

2. Was the student actively engaged in the learning activities? Did the express ideas in collegial ways and promote the work of the group?

 No

 Needs Improvement

 Yes

3. Did the student demonstrate professional behaviors throughout the sessions?

 No

 Needs Improvement

 Yes

4. Is the student progressing toward independent demonstration of the skills from the

sessions?

 No

 Needs Improvement

 Yes

5. Did the student demonstrate rapport with patients? Did they engage, track, and listen to

patients? Did they ask relevant questions, summarize the interviews, and clarify patient

responses?

 No

 Needs Improvement

 Yes

6. Comment on student strengths and possible areas for improvement.

# **THE MENTAL STATUS EXAMINATION (MSE)**

Reaching a psychiatric diagnosis depends on the assessment of the patient’s longitudinal history and evaluation of their current state. The mental status examination is just that, an evaluation of the patient’s current feeling, thinking and behavior and analogous to performing the physical examination. And, when combined with the patient’s history, the MSE is necessary to reach a presumptive diagnosis. Both significant positive and negative findings are noted. Clinicians assess much of the MSE during history taking; thus, formal testing in all domains is not always necessary but should be commented on nonetheless. As you proceed with history taking, you are assessing whether the patient is a reliable informant which depends on the nature of their illness (Psychotic? Demented? Delirious?), the setting you see the patient in (jail?), and their possible motivations. Remember, corroboration of the patient’s history with family or friends and old-records are critical to avoid pitfalls in the diagnostic process.

PRESENTATION

Appearance: Dress and grooming? Anything unique?

**Level of Consciousness** Is the patient arousable, attentive, or distractible? Part of the cognitive exam, but assessed early since much of the MSE depends on an alert patient.

**Attitude** toward the interviewer and examination. Cooperative and reliable? Appropriate for the situation? Does it change during the interview? Describe when.

### Motor Behavior Slowed? Gait? Involuntary or abnormal movements, tremors, tics, mannerisms, lip smacking or akathisias?

### Speech Spontaneous, fluid, pressured, rapid or slowed?

## EMOTIONAL STATE

**Mood**: How the patient reports feeling in their own words. Some patients have difficulty identifying how they feel. Ask directly. "How do you feel most days?" Answers such as “not bad”, “hard to say”, “rough”, “upset”, need further clarification. Some clinicians find it helpful to have patients quantify mood (or interest in normal activities) on 1-10 scales. Mood and/or interest are key symptoms of depression. A patient who doesn’t appear depressed becomes more worrisome if they report feeling a “3”, when 1= very bad and 10= very good or when it becomes apparent that they have lost interest in normal activities.

**Affect**: The appearance of mood based on your observations during the interview (and possibly on feelings they evoke in you). Is their affect appropriate to how they say they feel? Or do they appear depressed, or angry? Is their affect labile, reactive, dramatic, and intense, constricted, flat, non-reactive or remote?

## THINKING: form and content

FORM/PROCESSES

Is the patient coherent and their thinking organized, easy to follow, logical and goal directed? When asked a question, is the patient easy to follow? Or, is there evidence for a thought disorder with weak or absent connections between responses and ideas which can be seen in patients who are actively psychotic?

**Are associations loose?** (usually schizophrenia]: “You have blue eyes, General Custer had blue eyes. You must be General Custer”. Or, does the patient have **flight of ideas** [hypo/or true mania]: a flow of rapid speech jumping from topic to topic, with discernible associations or word play, but in severe cases it is so fast the patient is unintelligible When asked a question does the patient become **circumstantial** and introduce unnecessary details, with difficulty in arriving at an end point**; tangential** and answer in an oblique and irrelevant way; or demonstrate **thought blocking** and suddenly stop and can’t recover what was said (may be seen in people attending to hallucinations)?

# Really ill patients may make up words (neologisms), mix words in a meaningless way (word salad), or clang, connect words based on their sound rather than concepts, for example by [rhyming](http://en.wikipedia.org/wiki/Rhyme) or punning. Justin Furstenfeld’s "Imagine the worst. Systematic, sympathetic, quite pathetic, apologetic, paramedic, your heart is prosthetic" might be such an example.

**CONTENT**

What are the patient’s preoccupations? Fixated on a single idea such as death, guilt, suicide, revenge? Are they delusional or hallucinating? Is there a paucity of thought or too many thoughts all jumbled together?

Hallucinations (no external stimulus) All senses can be involved. Types include auditory, visual, gustatory, tactile and olfactory. They are not always indications of psychotic illness. For example hypnagogic (i.e., the drowsy state preceding sleep) and hypnopompic (i.e., the semiconscious state preceding awakening) hallucinations can be normal or be associated with narcolepsy. Ask, "Do you hear whispers or voices when no one is around?" “Do they come from inside or outside your head?” “Are they talking about you” “Who are they?” “"Can you see things that no one else can see?" "Do you have other unexplained sensations such as smells, sounds, or feelings?"

**Command hallucinations**? “Do the voices tell you to do something?” “What?” “Do you obey their instructions or ignore them?"

**Illusions** – misinterpretation of external stimulus e.g. a crack in the ceiling becomes a dangerous snake. Seen mostly in patients who are delirious (“brain failure” due to drugs, metabolic disorders, infections, etc)

**Delusions** are fixed, false beliefs with no rational basis in reality and unacceptable in the patient’s culture. Ask some of the following questions. "Do you have any thoughts that other people might think are strange?" "Do you feel you have any special powers or abilities?" "Does the television or radio talk about you or give you special messages?" Delusions can be grandiose, religious, persecutory, ideas of influence (someone controls their thoughts), erotomanic (someone famous is in love with them), jealousy (everyone wants what they have), thought insertion (someone put thoughts into their mind), and ideas of reference (everything refers to them, the TV, newspapers).

**Obsessions** are unbidden, intrusive, repetitive, unacceptable, anxiety producing thoughts. These can be accompanied by **compulsions**, usually irrational behaviors (such as counting, repetitive hand washing) the patient feels compelled to perform which provides a temporary sense of relief.

**COGNITION**

Evaluation of cortical functions including level of consciousness, memory, orientation, thinking such as the ability to abstract and judgment. You have assessed much of this already during the interview. (This is not the **mini–mental state examination** (**MMSE**) or **Folstein test** which is a brief 30-point questionnaire used to screen for cognitive impairment).

Observation of **level of** **consciousness** occurs during history taking and is rated as (1) coma & unresponsiveness; (2) stuporous & response to pain; (3) lethargic and drowsy; (4) alert and fully aware. Waxing and waning levels are seen in delirium.

**Orientation** really tests memory of **Time, Place, Person and Situation**. You can start by asking if the patient recalls your name. If so, that is enough. Otherwise, ask about day, date, time, then location. Patients disoriented to person, but not time or place are likely either malingering or suffer from a dissociative disorder.

**Concentration and attention**: The ability to sustain a task over time takes a reasonable degree of attention and concentration. You may read a series of letters to the patient and ask them to clap when a letter, for instance E, comes up. Or do “serial 7s”: have the patient subtract 7 from 100 and continue subtracting 7 from each answer. Or, have the patient spell the word "world" forward and backward. Or, just have them count backwards from 50. Patients may forget the task, perseverate or lose their place.

[Extra: Visuospatial ability: Have the patient draw interlocking pentagons in order to determine constructional apraxia.]

**Memory.** Information is registered, stored and later retrieved. Thus, you can assess all three: immediate, recent and remote memory functioning. Can also be adversely affected by performance anxiety or cultural differences.

**Registration**, which depends on intact attention, has probably been already assessed during history taking. However, the ability to repeat information, such as a series of numbers, forward and backward, is a useful probe for **immediate memory**. It can also be tested by having the patient repeat (immediate memory) and then recall three items in 5 minutes (recent memory). The items should not be related (car, tires, steering wheel) and not in the room (table, chair, doctor). The immediate repetition is a test of registration, the recall a test of storage and recent, short-term memory.

**Long-term memory** can be divided into procedural (ability to perform a learned set of skills automatically, such as ride a bike, type or drive a car) and declarative memory. **Declarative memory** refers to remembering data or facts, is not temporary, and can be tested by asking patients past personal details such as medical history, wedding dates, all of which needs to be confirmed. Asking to list past presidents is another way to do this.

**Abstract thought** is the ability to deal with concepts and understand words beyond their literal, concrete meaning and develops, when it does, in early adolescence. Problems with abstract thinking can be seen in people with low IQs; in those with less than an 8th grade education; in people from a different culture; and be lost in those who are developing dementia and in some patients with schizophrenia.

One way to assess abstraction is by determining similarities between different objects, for example, an apple and an orange (abstract response is "fruit"; concrete is "round"), a fly and a tree (abstract, "alive, part of nature, grow”; concrete, "nothing", idiosyncratic “they both have veins”). The latter, an idiosyncratic response, can be seen in psychosis or be creative or both.

Explain that proverbs are sayings that have broader meaning. (If from a different culture, ask patients to tell you a saying or proverb and explain it to you). Ask how they would explain these sayings to a child. Start with simple ones such as “you can’t tell a book by its cover” (concrete “of course not, you have to read it first”). Proverbs of increased difficulty are “a stitch in time...”, “don’t cry over spilled milk”, “a rolling stone gathers no moss” “People in glass houses shouldn’t throw stones”, “even monkeys fall from trees” or “there is many a slip between the cup and the lip”. Some patients may have particular difficulty with “the tongue is the enemy of the neck”.

**Insight and judgment** requires conceptual thinking and abstracting ability, and are often situation specific. There is no necessary correlation between intelligence, insight and judgment. In the medical setting, insight requires recognition that they have a problem and arrive at reasonable adaptive solutions. Ask the patient if they understand their current situation and why you are speaking with them.

Judgmentis traditionally assessed by asking “what would you do if you smelled smoke in a crowded movie theater?” or “what would you do if you found a stamped addressed envelope on the street?” But, you have already learned through history taking about the patient’s ability to make generally reasonable decisions in a variety of situations.

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| **MSE GRID**  | **Delirium**  | **Dementia**  | **Depression**  | **Bipolar disorder w/ mania or hypo-mania** | **Generalized anxiety disorder** | **Schizophrenia** |
| **onset** | Hours to days  | Usually insidious  | Follow grief. Early life loss ups risk. Prevalence 5-20%, F>M | Can be sudden. 1st manic episode in 20s. May be in kids | ­often early 20s | Often, ↓pre-morbid function. Childhood or men early 20s, women late 20s |
| **Level of consciousness** | Key finding: waxes and wanes | Alert.  | Alert but may be agitated or slowed | Complicated by drug/etoh use & lack of sleep | Normal  | Normal  |
| **Mood**  | Perplexed | May be fine | **↓↓interest****or mood. May also have ↑anxiety** | Great↑↑“in the groove” | anxious | Neg. sxs: flat, asocial, low motivation Pos sxs: H/D, odd behavior |
| **Affect** | Anxious and frightened | Pleasant, placid | Normal or flat, depressed. Anxiety is common | Engaging but Easily irritated | Worried/constricted | Mixed pos and neg sxs. Blunted, flat, agitated, suspicious, hostile, odd, aggressive |
| **Form & content of thinking** | Disorganized, attention, +- fearful  | Poverty of thought. May be paranoid | Preoccupied with guilt, being bad, sad, hopeless, despair. | Grandiose, special, rapid thoughts & flight of ideas in mania. | Catastrophizes, ↑↑ worry: job, health, social, $. Doesn’t miss an opportunity to be anxious. | Loose associations, idiosyncratic, religious, paranoid, ideas of reference |
| **Hallucinations and delusions** | Often visual illusions or hallucinations | Absent unless severe.  | Present if psychotic  | Present when psychotic | May be almost delusional about worries.  | Positive sxs: H/Ds. Thought insertion, withdrawal, voices, command hallucinations |
| **Memory** | **Poor, disoriented to time, place, person** | **Poor but may deny problems** | May c/o problems but fine on gross testing if cooperates | Fine if they cooperate | Normal but pre-occupied  | normal to gross testing if cooperative |
| **Abstract thinking**  | Problems if can’t attend to questions. | Loss of abilities to abstract.Concrete.  | If forced, will abstract | Fine. MayPptate flight of ideas | normal | May become concrete despite prior functioning or education |
| **Insight, judgment** | Knows something is wrong | Poor w/progression | OK but hopelessness affects  | May have insight. Poor In mania. | Fine except when it comes to worries | Mostly poor but may have insight |
| **Suicide risk** | **High – usually impulsive** | **High in newly diagnosed** | **High, 15%** | **High, 10-15%** | **High with co-morbid depression** | **High @ illness onset** |
| **Etiology**  | Metabolic, drugs, ETOH.Primarily Brain stem  | Various e.g. vascular, AD, etc | Genetic factors. Endocrine and amine neuro-transmission, deficiencies in NE & 5HT, hippocampal cell death | Genetic factors. May be induced by ADs, stimulants, phototherapy | Inherited & environmental. Cognitive distortions; misperceives most situations as worrisome & potentially dangerous | Genetic w/ perinatal insult. Cannabis use in susceptible people. Neuro-developmental disorder. ↑ ventricles, ↓limbic volume, altered prefrontal cortex . ↑↑active DA pathways. GABA, glutamate also implicated |