BASIC PSYCHIATRY INTRODUCTION

Your Basic Psychiatry sequence, based on your patient interviews, is integrated with your CVPR, Neuroscience, and DEMS blocks, and will introduce you to people with common psychiatric problems. No matter your specialty choice, most of you will practice psychiatry since much of medicine involves treating people with combined medical and psychiatric issues. For instance, depression, anxiety, and substance use disorders are among the most common medical complaints, and often present in patients with cardiovascular, renal or pulmonary illnesses.

Psychiatric illnesses—which impact how we feel, think, and behave—are brain diseases caused by a combination of genetic vulnerability and life experience. They are among the medical diseases that are the most responsive to treatment. In the past 35 years, psychiatric research has made major strides in the precise diagnosis and successful treatment of these illnesses. At one time, seriously mentally ill people were warehoused in public institutions; today most who suffer from a mental illness—including those that can be extremely debilitating, such as schizophrenia—can be treated effectively and lead full lives.

The term "mental illness" is misleading since it implies a false distinction between "mental" and "physical" disorders. The brain influences, and is influenced by, experience. Eric Kandel, psychiatrist, neuroscientist, and Nobel Laureate, outlined five principles for a framework for psychiatry and the neural sciences:

1. All mental processes...derive from operations of the brain.
2. ...genes and specifically combinations of genes...exert significant control over behavior... (Therefore) one component contributing to the development of major mental illness is genetic.
3. Altered genes do not...explain all of the variance of a given major mental illness. Social or developmental factors also contribute very importantly...Behavior and social factors exert actions on the brain (and) ... learning produces alterations in gene expression...
4. Alterations in gene expression induced by learning give rise to changes in patterns of neural connections...
5. Insofar as psychotherapy or counseling is effective and produces long-term changes in behavior, it presumably does so through learning, by producing changes in gene expression. (Eric Kandel, Am J Psychiatry 155:4, April 1998)

BASIC PSYCHIATRY - YEARS ONE AND TWO

We believe learning is enhanced by working with real patients. Since no patient is the same, each group will have different experiences but all groups will have the opportunity to conduct 14 patient interviews in the spring and fall. Therefore, we organized your basic psychiatry curriculum around required group patient interviews in addition to “mini” & regular lectures.

We ask you to utilize our booklet, the CU MEDICAL STUDENT ASSESSMENT OF COMMON PSYCHIATRIC PROBLEMS, which includes a description of THE 30-MINUTE INTERVIEW plus the PSYCHIATRIC SCREENS, throughout your psychiatry curriculum, including during your 3rd-year psychiatric care block.

The General Goals of Basic Psychiatry

1. To practice and begin to master THE 30-MINUTE INTERVIEW (e.g. during CVPR with patients with anxiety, depression and with a history of cardiovascular, renal, or pulmonary disease).
2. To learn to observe a patient’s feelings, thinking and behavior, to develop the vocabulary required to discuss the Mental Status Examination (MSE) and to develop a basic fund of knowledge regarding depression, anxiety and suicide.
3. To utilize appropriate screens e.g. depression, anxiety and suicide, found in the CU MEDICAL STUDENT ASSESSMENT OF COMMON PSYCHIATRIC PROBLEMS.
4. Ultimately, to conduct such an interview with particular attention paid to:
   - the use of summarizing during interviews
   - identifying why the patient volunteered to be interviewed (the “why now” domain)
   - risk for dangerous behaviors e.g. suicide
   - the patient’s current biggest worry
5. Be able to describe the presentations, etiologies, treatments of basic psychiatric problems.

**Keys to successful groups**

- Commitment to express your ideas in collegial ways
- An effective group depends on **your participation, so speak up.**
- Commitment to independent learning, as demonstrated in the group discussions.

**Sequence Structure**

15 required group meetings on selected Wednesdays 10:30-11:50, 8-9 students/2 psychiatry faculty).

**CVPR Spring, MSII**
1. In your first group, outline group expectations, 30-minute interview format and the Mental Status Examination (MSE).
2. Second group, interview patient with depression, screen for depression. Begin to utilize the 30-minute interview. Group discussion focused on the interview, the experience of interviewing, observations of the patient and the mental status examination.
3. Third group, presentation of prior week’s case, group discussion about the prior week’s interview and preparatory work for today’s interview. Then interview patient with anxiety & evaluate for symptoms of depression & anxiety. Group discussion focused on this week’s interview, the experience of interviewing, observations of the patient and the mental status examination.
4. Fourth group, presentation of prior week’s case, group discussion about the prior week’s interview and preparatory work for today’s interview. Then interview patient with cardiovascular, pulmonary or renal disease – evaluate for depression, anxiety, suicide. Group discussion focused on this week’s interview, the experience of interviewing, observations of the patient and the mental status examination.

**Neuroscience Fall, MSII**
5. Interview patient with PTSD.
6. Interview patient and family with autism.
7. Interview patient with dementia or traumatic brain injury (and/or their family).
8. Interview patient with chronic pain.
9. Interview patient with an anxiety disorder.
10. Interview patient with schizophrenia or bipolar illness.
11. Interview patient with schizophrenia or bipolar illness.
12. Interview patient with substance use disorder.

**Metabolism Fall, MSII**
13. Interview physician who has psychiatric or physical disease.
15. Interview patient with thyroid disorder.
ASSESSMENT OF STUDENT PERFORMANCE

- Since your group work is critical for your education, at the end of your first four groups, you will provide us with anonymous feedback about your group experience and make suggestions for improvement. See a copy of this form on a separate page.

- You will also receive formative feedback about your group work, which is meant to maximize your group experience and, therefore, will not become part of your academic file.

- Only a copy of the final assessment of your group at the end of the Basic Psychiatry Sequence will be sent to the Dean’s Office. You will also be asked to provide us with an anonymous evaluation of your group experience at that time as well.

- The assessment of your group work is based on your participation, your written work, oral presentations and patient interviews. The assessment form outlines the key behavioral anchors that will be assessed.
Basic Psychiatry: An integrated, longitudinal small-group curriculum based on patient interviews, lectures, discussions and reading.

SPRING 2016 FEEDBACK OF GROUP LEADER PERFORMANCE

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

1. To what extent have you been able to express your ideas in a collegial way?
   - [ ] Not at all
   - [ ] A little
   - [ ] Somewhat
   - [ ] Mostly
   - [ ] Always

2. To what extent have you personally been able to promote the work of the group?
   - [ ] Not at all
   - [ ] A little
   - [ ] Somewhat
   - [ ] Mostly
   - [ ] Always

3. What have you done well?

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

5. To what extent did you receive useful feedback?
   - [ ] Not at all
   - [ ] A little
   - [ ] Somewhat
   - [ ] Mostly
   - [ ] Always

6. What would improve the feedback you received?
SPRING 2016 FEEDBACK OF STUDENT PERFORMANCE


1. Please rate the student’s commitment to openly expressing ideas in collegial ways and promoting the work of the group:

<table>
<thead>
<tr>
<th>Poor</th>
<th>Fair</th>
<th>Good</th>
<th>Very Good</th>
<th>Outstanding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inattentive, does not participate. Comments are terse.</td>
<td>Attentive &amp; collegial. Comments add to discussion but are often reiterations of what is already known or has already been said.</td>
<td>Effectively facilitates group to expand knowledge and understanding.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2. Please rate the quality of the student’s interaction with patients:

<table>
<thead>
<tr>
<th>Poor</th>
<th>Fair</th>
<th>Good</th>
<th>Very Good</th>
<th>Outstanding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Little or no rapport with patients. Doesn’t track/listen to patients, Q &amp; A interview, overlooks key domains.</td>
<td>Engages, tracks &amp; listens to patients; summarizes to organize interview. Asks relevant questions and elicits MSE information.</td>
<td>Clarifies patient responses while maintaining good rapport.</td>
<td>Able to establish rapport and gather information at the level of a third or fourth year student.</td>
<td></td>
</tr>
</tbody>
</table>

3. Please rate the student’s fund of knowledge, clinical reasoning, and commitment to independent learning, as demonstrated in the group discussions, written work and oral presentations:

<table>
<thead>
<tr>
<th>Poor</th>
<th>Fair</th>
<th>Good</th>
<th>Very Good</th>
<th>Outstanding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Little participation; does not come prepared with questions. Demonstrates little desire to expand knowledge base.</td>
<td>Actively participates in discussions, but adds little new information/viewpoints. Questions raised and written work tend to reflect more basic level understanding.</td>
<td>Consistently raises perspectives/knowledge that lead to the increased understanding of the whole group. Questions raised and written work reflect a deeper understanding in the clinical presentation.</td>
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<td></td>
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</tbody>
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4. Please rate the student’s level of professionalism:

<table>
<thead>
<tr>
<th>Poor</th>
<th>Fair</th>
<th>Good</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comes late, or unprepared, or misses sessions. Appears not interested in patients.</td>
<td>Often not prepared.</td>
<td>Arrives on time, prepared, interested and appropriate</td>
</tr>
</tbody>
</table>

5. COMMENT ON STUDENT STRENGTHS AND POSSIBLE AREAS FOR IMPROVEMENT:

What is your assessment of this student’s overall performance in your group (circle one)?

| Poor | Fair | Good | Very Good | Outstanding |
|------|------|------|-----------|-------------|-------------|
|      |      |      |           |             |             |
BASIC PSYCHIATRY IN CVPR: Depression, Anxiety, Grief, and Suicide

Depression, suicide, anxiety and grief are clinically connected, often etiologically related, and interact bi-directionally with cardiac, pulmonary and renal disease. For instance, the burden of chronic physical illness is an important risk factor for depression and suicide. The risk of suicide in people with chronic renal disease is similar in magnitude to the suicide risk in other chronic illnesses, such as chronic pulmonary disease and stroke. Depression and anxiety adversely impact morbidity and mortality associated with cardiac, renal and pulmonary disease. (We will cover schizophrenia later, but patients with schizophrenia also have an increased risk of dying from heart disease and suicide when compared with the general population).

Unfortunately, anxiety, depression and suicide are often overlooked and under-treated in all medical settings. While 80% of patients with depression can be effectively treated, less than 50% get the help they need. (Depression and Heart Disease, NIMH Depression Publications No. 02-5004, May 2002). Depression affects 6% of men and 18% of women at any one time. Lifetime risk is 20-25% for women and 7-12% for men. Unipolar depression is the 4th leading cause of early death and disability worldwide. More than half of patients who kill themselves see their doctor in the month before they do it. Panic attacks are often misinterpreted as heart attacks and anxiety disorders are the most common psychiatric diseases in the general population.

In depression, the HPA axis is hyperactive with increased corticotrophin-releasing hormone, reduced function of glucocorticoid receptors and higher cortisol levels following the dexamethasone suppression test. Corticosteroids mobilize FFA causing endothelial inflammation and excessive clotting, and are associated with HTN, high cholesterol and glucose dysregulation. Endothelial shearing stress can lead to vascular damage and plaque formation. In addition, depressed patients may have excess norepinephrine which can stimulate platelet activity, also contributing to clotting. There is altered autonomic function in depressed patients and decreased heart-rate variability is associated with increased risk of ventricular arrhythmias and sudden death. Decreased heart-rate variability has been observed in people with panic disorder, depression and schizophrenia. Variability is decreased when sympathetic activity overrides parasympathetic influences via the vagus nerve. Depressed patients also have greater BP variation, a predictor of cardiac events. (Kemp DE et al Heart Disease and Depression. Cleveland Clinic Journal of Medicine. Vol 70:9 pp 745-761 Sep 2003)

GOALS
The general goals of Basic Psychiatry are:
1. To practice and begin to master THE 30-MINUTE INTERVIEW (e.g. during CVPR with patients with anxiety, depression and with a history of cardiovascular, renal, or pulmonary disease).
2. To learn to observe a patient’s feelings, thinking and behavior, to develop the vocabulary required to discuss the Mental Status Examination (MSE) and to develop a basic fund of knowledge regarding depression, anxiety and suicide.
3. To utilize appropriate screens e.g. depression, anxiety and suicide, found in the CU MEDICAL STUDENT ASSESSMENT OF COMMON PSYCHIATRIC PROBLEMS.

ORGANIZATION
25-minute talks, 10:00-10:25 am, on April 6, 13, 27 and May 11, 2016 followed by patient groups, 10:30-11:50 am. (See syllabus for groups, group leaders and room numbers.)

Reading assignments for each date are below. Handouts are required reading. Exam questions may be derived from the lecture, Power point presentations or handout materials.

After patient interviews, students participate in group discussions about the interview, the experience of interviewing, observations of the patient and the mental status examination. Be ready to discuss the interview, at the next meeting.

Week 1:

- Introductions.
- Review learning objectives.
- Set group ground rules and expectations (e.g., What dress is expected for interviewers? Are laptops or other devices allowed to be used during interview? Respect for confidentiality of interviewees. Being respectful of interviewees/peers during the interviews and group discussions.).
- Discuss group procedures (below).
- Discuss the importance of observing the patient (not simply listening to what they say), reading patient cues, not rigidly following a pre-set question order but following up on important content provided by the interviewee, use of open-ended vs. closed ended questions based on patient presentation, careful attention to phrasing of questions, discussion of the mental status exam.
- Assign students to conduct the CVPR interviews (i.e., Depression, Anxiety and Suicide) and the first two Neuroscience block interviews (i.e., PTSD and Developmental Disorders).

Group procedures starting Week 2:

General timing:

Students should arrive promptly following the lecture.

**First 25 minutes** – Oral presentation of subjective and objective sections of SOAP note from prior week’s interview. Discussion of last week’s interview and preparation of students for today’s interview.

**30 minutes interview** conducted by one student. At the end, the interview is opened to allow other student questions.

**25 minute discussion** of today’s interview.

Interview, SOAP note and oral presentation:

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

**Student B** is assigned to take written notes during interview 1, write an MSE/SOAP note and submit it to the group faculty by that Friday night. Faculty then provide this student written feedback to improve the MSE/SOAP note (by Sunday evening prior to next small group) and the student revises. At interview 2 student B orally presents the MSE/SOAP (max 5 minutes). That same student is assigned to conduct interview 2, while student C takes notes and prepares MSE/SOAP, etc. **Other students** submit a question/reflection by Friday nights. Faculty distribute to the group.

Footnotes:

1 During the CVPR block we are only interested in students writing and presenting the Subjective and Objective (MSE) sections of the SOAP note. Once the Neuroscience block begins we ask that students complete a full SOAP note.

2 Some groups may wish to have the interviewing student remain after the group for a brief period to...
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provide personalized feedback on interviewing and their oral presentation. Feedback is essential to fostering learning, but some feedback on strengths and weaknesses of their interview and also their oral presentation may best be provided in a private setting.

For students who require more extensive revisions of their written work (MSE/SOAP), the faculty may invite them to provide additional MSE/SOAP notes over the course of the small group (but if they are not the interviewer the following week, they would not present their MSE/SOAP orally).

After your last spring group, students complete anonymous feedback about their group experience. Group leaders complete formative feedback about student performance. (See assessment forms in syllabus.)

GROUP SCHEDULE AND GOALS

4/6, Group 1:
Read handouts. Cover sequence organization and expectations, the Mental Status Examination. Outline group goals and the evaluation of psychiatric illness. Groups might also discuss issues of patient confidentiality and group ground rules, e.g. groups are not “therapy” groups, appropriate dress when interviewing, use of electronics during the interviews, etc. Discuss & practice how patient information will be collected using the 30-MINUTE INTERVIEW: engage, assess, and focus.

One student will be scheduled to conduct each interview.
One student will also be assigned to prepare a written Subject and Objective (mental status examination) portion of the SOAP note for each interview. This written material must be submitted to their faculty group leaders by the end of the week (deadline Friday at midnight the week of the interview). Faculty will provide written feedback by Sunday evening prior to the next small group meeting. The student will revise based on faculty feedback and at the following small group will provide an oral presentation of the mental status exam to the small group (max 5 minutes).

4/13, Group 2:
Depression: (read handout)
Interview patient with depression. Students will practice the 30-MINUTE INTERVIEW and appropriate screens. Evaluate for depression. Discuss findings and issues.

Students will be able to demonstrate knowledge of:
1. Symptoms/presentation of depression and grief, particularly in medical settings, and be able to differentiate depression from normal grief.
2. Bi-directional relationship of depression & grief with medical illness: cardiac, pulmonary, renal disease, including increased mortality in survivors.
3. Basic etiologies of depression: risk factors, genetics, life experiences, basic neurobiology.
4. Very basic psychotherapeutic and pharmacologic treatments of depression & grief.

4/27, Group 3:
Anxiety: (read handout). Oral presentation reviewing subjective and objective material from last week’s interview. Discuss previous interview and MSE. Interview patient with anxiety. Practice the 30-MINUTE INTERVIEW and appropriate screens. Evaluate for depression and anxiety. Discuss findings and issues.

Students will be able to demonstrate knowledge of:
1. Symptoms/presentation of anxiety, particularly in medical settings.
2. The relationship of anxiety with depression and impact on pulmonary disease.
4. Very basic psychotherapeutic and pharmacologic treatments of anxiety disorders.
5/11, Group 4:
**Suicide:** (read handout)
Oral presentation reviewing subjective and objective material from last week's interview. Discuss previous interview and MSE. **Interview patient who has cardiovascular, pulmonary or renal disease.** Practice the **30-MINUTE INTERVIEW and appropriate screens.** Evaluate for depression, anxiety, and suicide. Discuss findings and issues. **Complete MSE and turn in to your group leaders by the Friday after the interview.**

**Students will be able to demonstrate knowledge of:**
1. The epidemiology of suicide, nationally and locally, with an understanding of the risk factors associated with suicide.
2. The symptoms/presentation of suicide, particularly in medical settings.
3. The association of suicide with medical illness: cardiac, pulmonary, renal disease.
4. Basic etiologies of suicide: risk factors and patient vulnerabilities, emotional traits, life experiences, and response to stress
5. Basic approaches to assessing suicidality
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 a 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 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), erotomaniac (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.

Judgment is 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.
### MSE GRID

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

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*Note: The table above outlines key findings and distinguishing features for each condition.*
Subjective + Objection Form:

**Subjective:**
Chief complaint:
History of Present Illness:

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**Mental Status exam:**

**PRESENTATION**
Appearance

Level of Consciousness

Attitude

Motor

Speech

**EMOTIONAL STATE**
Mood

Affect

**THOUGHT PROCESS**

**THOUGHT CONTENT**

**COGNITION** (Not Folstein MMSE)
Orientation

Memory

Concentration

Abstracting ability

**INSIGHT & JUDGMENT**