

## Early Psychosis Dissemination Sites: Template Guidelines for Referral

The following are guidelines to decide whom to refer to (program). Acceptance into the program will be based on further screening and assessment. Referents should continue to follow up with individuals referred and explain to the person being referred that they are being referred for an assessment to determine whether the program is a good fit for them. The team may provide consultation or occasionally consider accepting individuals by exception if they do not meet one of the guidelines but seem appropriate for the program and are not receiving adequate services.

### Must meet all of the following:

- \_\_\_ 1. Resides in (geographic area).
- \_\_\_ 2. Age (min 15-25); can go as low as 12 or as high as 30
- \_\_\_ 3. The person has an IQ of 70 or above.
- \_\_\_ 4. The person has not received treatment for a psychotic illness prior to the last 12 months.
- \_\_\_ 5. Psychotic symptoms are not known to be caused by the temporary effects of substance Intoxication, major depression or to a known medical condition.

### Must meet *either* 6 or 7 below:

- \_\_\_ 6. The individual has experienced a significant worsening or new symptoms in at least **one of the following areas in the last 6/12 months:** [Sites must decide time frame]
  - a. Thought disorganization as evidenced by disorganized speech and or/ writing. (Examples: confused conversations, not making sense, difficulty directing sentences to goal, never getting to a point, unintelligible).
  - b. Behaviors, speech or beliefs are uncharacteristic and/or bizarre.
  - c. Complains of hearing voices or sounds that others do not hear.
  - d. The individual feels that other people are putting thoughts in their head, stealing their thoughts, believes others can read their mind (or vice versa), and/or hear their own thoughts out loud.

OR

- \_\_\_ 7. If the person does not meet the criteria in 6 above, he/she must be experiencing **three** of the following that are **new in the last 6/12 months:** [Sites must decide time frame]
  - a. Episodes of depersonalization (Example: They believe that they do not exist or that their surroundings are not real).
  - b. Significant decline in academic/vocational functioning, social functioning and/or personal hygiene.
  - c. Significant changes in sleep (sleeping less or sleeping too much).
  - d. Heightened sensitivities (lights, sounds etc.) and/or is experiencing visual distortions.
  - e. Increased fear or anxiety for no apparent reason or for an unfounded reason.
  - f. Family history of major psychotic disorder.

If the individual you are referring is in *an immediate danger to self or others* you will need to refer directly to the local crisis system. The crisis system will refer to (program name) when the crisis resolves.

### How to make a referral:



**Information in all areas should be obtained by multiple sources if possible (individual, family, records etc.)**

**Safety risks (be sure to complete full Risk Assessment):**

Evidence of suicidality or self-harm:

Aggression:

Access to weapons:

**Health risks:**

Pregnancy ☐ YES ☐ NO

Medical problems

**Evidence of psychosis: (Explore duration, severity, level of distress, quality of each psychotic symptom).**

hallucinations:

delusions:

unusual thought content:

disorganized speech:

**PRODROMAL SYMPTOMS:**

Difficulties in thinking (attention, concentration, memory, organization):

Difficulties in speaking or writing:

Anxiety:

Drop in functioning (work, school, self-care, activities):

Perceptual disturbances/sensitivities:

Suspiciousness, ideas of persecution:

Grandiosity:

Social isolation or withdrawal:

Decreased emotional expressiveness or sense of loss of emotions and self:

Odd/bizarre behavior or appearance:

Disturbances of:       sleep

mood

motor functioning

appetite/nutrition

**Family psychiatric history:**

**Stressors:**

**Substance abuse history:**

**Education and work history:**

**Current Treatment (include attitude about):**

**Current Medications (include attitude about):**

**Previous Treatment (hospitalizations, physicians, therapists, evaluations, medications):**

**Family and social supports:**

**Significant Psychosocial History:**

**Young person and/or family's beliefs (use Family intake form) about current problem:**

**Recommended referral/engagement:**

**Insurance/Medicaid:**

**Special Notes:**



INDIVIDUAL'S NAME: \_\_\_\_\_

DOB: \_\_\_\_\_

**EARLY ASSESSMENT AND SUPPORT ALLIANCE (EASA)  
SCREENING FORM**

REFERRING PERSON/AGENCY: \_\_\_\_\_

EVALUATOR'S NAME (QMHP): \_\_\_\_\_

DATE(S) OF EVALUATION: \_\_\_\_\_

INDIVIDUAL'S AGE AT EVALUATION: \_\_\_\_\_

Does the individual speak a language other than English as the primary language?

No ☐ Yes ☐ If yes, what language: \_\_\_\_\_

Household language \_\_\_\_\_

Is a translator needed: No ☐ Yes ☐ If yes, when \_\_\_\_\_

Special Communications Needs: ☐ None Reported ☐ TDD/TTY Special Device ☐ Sign Language Interpreter

☐ Assistive Listening Device(s) ☐ Other If Other, explain: \_\_\_\_\_

**Clinical Interview/Observation:** (check all that apply)

☐ Individual ☐ Parent(s) ☐ Guardian(s) ☐ Family/Friend ☐ School Personnel

☐ Other \_\_\_\_\_

**Presenting Problem:** (Reason for referral, presenting behavioral or mental health symptoms, pathway to care)

**Significant Biopsychosocial Factors:**

(Family constellation, psychosocial, cultural, spiritual, environmental stressors, legal, medical/physical, developmental and sexual history, trauma history/symptoms, client/family explanatory model, family mental health history, etc.)

**Cognitive:** (IQ, highest grade, IEP)

**Medical Concerns:** (Associated/major physical conditions, head trauma, medications, insurance, PCP, dentist)

INDIVIDUAL'S NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

**MENTAL STATUS**

Appearance:	<input type="checkbox"/> Appropriate	<input type="checkbox"/> Inappropriate	<input type="checkbox"/> Unusual	<input type="checkbox"/> Disheveled
Hygiene:	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor	<input type="checkbox"/> Other:
Body Movement:	<input type="checkbox"/> Unremarkable	<input type="checkbox"/> Accelerated	<input type="checkbox"/> Agitated	<input type="checkbox"/> Slowed <input type="checkbox"/> Erratic
Speech & Tone:	<input type="checkbox"/> Appropriate	<input type="checkbox"/> Loud	<input type="checkbox"/> Soft	<input type="checkbox"/> Rapid <input type="checkbox"/> Slow <input type="checkbox"/> Pressured
Attitude:	<input type="checkbox"/> Unremarkable	<input type="checkbox"/> Friendly	<input type="checkbox"/> Helpful	<input type="checkbox"/> Open <input type="checkbox"/> Outgoing <input type="checkbox"/> Uncooperative
	<input type="checkbox"/> Interested	<input type="checkbox"/> Withdrawn	<input type="checkbox"/> Dependent	<input type="checkbox"/> Irritable <input type="checkbox"/> Rude <input type="checkbox"/> Suspicious
Affect:	<input type="checkbox"/> Congruent	<input type="checkbox"/> Incongruent	<input type="checkbox"/> Flat	<input type="checkbox"/> Restricted <input type="checkbox"/> Blunted <input type="checkbox"/> Labile
Mood:	<input type="checkbox"/> Euthymic	<input type="checkbox"/> Euphoric	<input type="checkbox"/> Depressed	<input type="checkbox"/> Anxious <input type="checkbox"/> Angry
	<input type="checkbox"/> Labile		<input type="checkbox"/> Other:	
Orientation:	<input type="checkbox"/> Person	<input type="checkbox"/> Place	<input type="checkbox"/> Time	<input type="checkbox"/> Circumstances
Thought Process:	<input type="checkbox"/> Goal-Directed	<input type="checkbox"/> Concrete	<input type="checkbox"/> Circumstantial	<input type="checkbox"/> Tangential <input type="checkbox"/> Confused <input type="checkbox"/> Latencies
	<input type="checkbox"/> Perseveration	<input type="checkbox"/> Loose	<input type="checkbox"/> Flight of Ideas	<input type="checkbox"/> Other:
Thought Content:	<input type="checkbox"/> Unremarkable	<input type="checkbox"/> Hallucinations	<input type="checkbox"/> Ideas of Reference	<input type="checkbox"/> Delusions <input type="checkbox"/> Paranoia <input type="checkbox"/> Religiosity
Intellectual Level:	<input type="checkbox"/> Above Average	<input type="checkbox"/> Average	<input type="checkbox"/> Below Average	<input type="checkbox"/> Difficult to Assess
Attention:	<input type="checkbox"/> Good	<input type="checkbox"/> Poor	<input type="checkbox"/> Inattentive	<input type="checkbox"/> Distracted
Memory:	<input type="checkbox"/> Intact	<input type="checkbox"/> Deficit, short-term	<input type="checkbox"/> Deficit, long-term	
Judgment:	<input type="checkbox"/> Intact	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor	<input type="checkbox"/> Bizarre
Insight:	<input type="checkbox"/> Absent	<input type="checkbox"/> Good	<input type="checkbox"/> Limited	<input type="checkbox"/> Poor

**Comments on Mental Status:** (Presentation, eye contact, relatedness, content of delusions/hallucinations, pertinent quotes)

**Mental Health Symptoms:** (Precipitants; etiology of primary and secondary symptoms; at-risk symptoms; course of illness, onset, duration of symptoms; impaired functioning, behavioral/conduct problems, sleep, appetite, social withdrawal, deterioration at work/school, pre-morbid functioning)

**Treatment History:** (past mental health treatment, effectiveness)

**Substance Use/Abuse:** (Current/past, treatment history, stage of change, gambling)

INDIVIDUAL'S NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

**RISK:**

**SELF HARM** *Assessment for suicide potential is required (If current or history, must describe below)*

	Current	History	None
Suicidal Ideation:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Plan:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Concrete steps taken toward plan:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Previous attempts of Suicide:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
More than one attempt:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Losses within the past year:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Family history of suicide:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Friend history of suicide:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Self Injurious Behavior:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Summary:** (Describe risk factors including accessibility/lethality of means and methods used on all current or history items that are checked.)

**HARM TO OTHERS**

(If current or history, describe below)

	Current	History	None
Homicidal Ideation:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Plan:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Concrete steps taken toward plan:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Aggressive Physical Behavior:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fire setting Behavior:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sexually Abusive Behavior:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Summary:** (Describe risk factors including accessibility/lethality of means, methods used on all current or history items that are checked.)

Are there firearms/other weapons in the home? No ☐ Yes ☐ If "yes," please describe.

**Additional Risk Factors:** (Related to individual's level of impulsivity, sense of urgency or hopelessness, level of agitation, anger, anxiety, use of substances, relevant health issues, history of abuse/neglect, history of exposure to violence, relationship to authority figures, history of bullying/being bullied.)

INDIVIDUAL'S NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

**Goals/Strengths & Relieving Factors:** (Individual/family goals and strengths; what's worked in the past)

PROVISIONAL DSM DIAGNOSIS  
AXIS I: \_\_\_\_\_

QMHP Signature & Credentials: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_

**Individual is appropriate for continued assessment and engagement:** ☐ Yes ☐ No

**If no, reason:**

**Plan:**



## Differential Diagnosis of Psychosis

Diagnosis	Common Age Onset	Differentiating Features
Schizophrenia	Late adolescence (can be older but incidence drops significantly)	<ul style="list-style-type: none"> <li>• Often has prodromal period</li> <li>• 80% have auditory hallucinations; most common outside, 3<sup>rd</sup> person, often multiple, often can't identify</li> <li>• Most sensitive to schizophrenia: Delusions of reference, thought broadcasting</li> <li>• Often have negative symptoms</li> <li>• Visual hallucinations less common (15%)</li> <li>• Not due to substance abuse</li> </ul>
Endocrine disorders (hypoglycemia/diabetes, thyroid)	Often older	<ul style="list-style-type: none"> <li>• Physical sx's: faint, weak, nauseated, diarrhea, thirst, frequent urination</li> <li>• Low blood sugar</li> <li>• Thyroid abnormality</li> <li>• Hyperthyroid: hot, hyperactive, hair loss, sweaty, elevated blood pressure/pulse</li> <li>• Weight gain</li> <li>• Menstrual problems</li> </ul>
Brain tumor	All	<ul style="list-style-type: none"> <li>• Severe, frequent headache</li> <li>• Blurry</li> <li>• Nausea</li> <li>• Focal seizures</li> </ul>
Brain trauma	All	<ul style="list-style-type: none"> <li>• History of trauma/loss of consciousness</li> <li>• Level of consciousness affected</li> <li>• Bad headache</li> <li>• Blurry vision</li> </ul>
Drugs	All	<ul style="list-style-type: none"> <li>• Used within last week</li> <li>• Physical symptoms: agitation, sweating, dry mouth, pupil changes</li> <li>• More insight into psychosis</li> <li>• Often paranoid delusions</li> <li>• Often auditory and visual plus insight</li> <li>• Acute onset</li> </ul>
PTSD	All	<ul style="list-style-type: none"> <li>• Visual hallucinations associated with trauma</li> <li>• Auditory hallucinations- inside head, first person, remind of perpetrator, associated with negative affect/quality</li> </ul>

Depression	All	<ul style="list-style-type: none"> <li>• Sad affect</li> <li>• Auditory hallucinations, mood specific, typically inside head</li> <li>• No prodrome</li> <li>• Might see negative symptoms</li> <li>• Mood congruent delusions</li> </ul>
Infection	All	<ul style="list-style-type: none"> <li>• Temperature</li> <li>• Ill</li> </ul>
Bipolar disorder		<ul style="list-style-type: none"> <li>• Sleeplessness</li> <li>• Mania</li> <li>• Grandiose</li> <li>• Pressured speech</li> <li>• Goal directed</li> <li>• Respond quicker to treatment</li> </ul>

**Heritability- Note: First-degree relatives are parents, siblings or offspring only**

### **Schizophrenia-**

Concordance rates are higher in monozygotic twins than in dizygotic twins- note: the existence of substantial discordance rates in monozygotic twins also indicates the importance of environmental factors. Some relatives of individuals with Schizophrenia may also have an increased risk for a group of mental disorders termed the schizophrenia spectrum- it probably includes Schizoaffective D/O and Schizotypal Personality D/O.

A child with one parent with Schizophrenia- 15x greater chance of developing Schizophrenia than the general population.

Person with Schizophrenia- siblings about 10x greater than that in the general population, uncles and aunts 2% greater, nephews and nieces, 2.2 % greater, grandchildren 2.8% greater, half siblings 3.2% greater

**Schizoaffective D/O-** Increased risk for Schizophrenia in first degree biological relatives of individuals with Schizoaffective D/O- relatives of individuals with Schizoaffective D/O are at increased risk for Mood disorders.

**Delusional D/O-** There is limited evidence that Avoidant and Paranoid Personality D/Os may be especially common among first-degree biological relatives of individuals with Delusional Disorder.

**Major Depressive D/O-** 1.5-3 times more common among first-degree biological relatives of persons with this disorder than among the general population. Also evidence for an increased risk of Alcohol Dependence in adult first-degree biological relatives, and there may be an increased incidence of an Anxiety D/O or ADHD in the children of adults with this disorder.

**Dysthymic D/O-** more common among first-degree biological relatives of people with Major Depressive D/O than among the general population. In addition, both Dysthymic D/O and Major Depressive D/O are more common in the first-degree relatives of individuals with Dysthymic D/O.

**Bipolar I D/O-** first degree relatives have elevated rates of Bipolar I D/O- ( 4%- 24%), Bipolar II D/O (1%-5%) and Major Depressive D/O ( 4%-24%) Twin and adoption studies provide strong evidence of a genetic influence for Bipolar I D/O.

**Bipolar II D/O-** Some studies have indicated that first-degree biological relatives of individuals with Bipolar II D/O have elevated rates of Bipolar II D/O, Bipolar II D/O, and Major Depressive D/O compared with the general population.

**Panic D/O-** First-degree biological relatives with Panic D/O are up to 8 times more likely to develop Panic D/O. If the age of onset of the Panic D/O is before 20, first-degree relatives have been found to be up to 20 times more likely to have Panic D/O. ( in clinical settings, as many as one half to three quarters of individuals with Panic D/O do not have an affected first biological relative) Twin studies indicate a genetic contribution to the development of Panic Disorder.

**Specific Phobia-** Increased risk for Specific Phobias in family members of those with Specific Phobias. Also, there is some evidence to suggest there may be an aggregation within families by type of phobia. Fears of blood and injury have particularly strong familial patterns.

**Social Phobia-** Appears to occur more frequently among first-degree biological relatives of those with the disorder compared with the general population. Evidence for this is strongest with the Generalized subtype.

**OCD-** Concordance rate for OCD is higher for monozygotic twins than it is for dizygotic twins. The rates of OCD in first-degree biological relatives of individuals with OCD and in first-degree relatives of individuals with Tourette's D/O is higher than in the general population.

**PTSD-** Evidence of a heritable component to the transmission of PTSD. Also, a history of depression in first-degree relatives has been related to an increased vulnerability to developing PTSD.

**GAD-** Twin studies suggest a genetic contribution to the development of this disorder. Genetic factors influencing risk of GAD may be closely related to those for Major Depressive D/O.

**Prevalence-Lifetime (the chance that a person will develop this disorder in his lifetime) and Course**

**Psychotic Disorders 1.5% (for all Psychotic Disorders)**

**Schizophrenia-** Lifetime prevalence is between 0.5 and 1.5%

Course: Median age of onset is early to mid-20s for men, late 20s for women. The onset may be abrupt or insidious- but majority have prodromal symptoms (social withdrawal, loss of interest in work/school, deterioration in hygiene, unusual behavior, outbursts of anger) Course is variable, complete remission is probably not common. Positive symptoms respond better to tx, and will typically diminish, but negative symptoms often persist in between episodes of positive symptoms.

**Schizoaffective Disorder-** Unknown, but lower than the lifetime prevalence of Schizophrenia

Course: Typical age of onset is early adulthood, although onset can occur anywhere from adolescence to late in life. (Prognosis is somewhat better for Schizoaffective D/O than Schizophrenia, but considerably worse than the prognosis for Mood Disorders. The outcome for Schizoaffective D/O Bipolar type may be somewhat better than that for Schizoaffective D/O; Depressive type).

**Delusional Disorder-** Population prevalence is 0.03%, lifetime morbidity risk between 0.05 and 0.1%

Course: Age of onset is variable, from adolescence to late in life, course quite variable- esp. in the Persecutory type, the disorder may be chronic, with a waxing and waning of the beliefs, or have full periods of remission with subsequent relapses, or it may remit in a few months with no further relapses.

**Brief Psychotic Disorder-** Uncommon

**Shared Psychotic Disorder-** Unknown

**Mood Disorders 25%**

**Major Depressive Disorder-** Lifetime risk: women 10-25%, men 5-12%

Course: May begin at any age, with average age of onset in the mid-20s. The number of prior episodes predicts the likelihood of developing subsequent episodes- At least 60% who have had single major depressive episode can be expected to have a second. Those who have had 2 episodes have a 70% chance of having a third, and those who have had 3 episodes have a 90% chance of having a fourth. Note- about 5%-10% of individuals with had a single episode will develop a manic episode.

\*Note: Major Depressive D/O recurrent means that the person has had at least 2 major depressive episodes. *Chronic is used to describe the current or most recent major depressive episode and indicated that criteria for the major depressive episode have been continuously met for at least 2 years)*

**Dysthymic Disorder-** Lifetime prevalence is 6%

Course: Often has an early and insidious onset in childhood, adolescence or early adult life as well as a chronic course. In clinical settings, individuals with Dysthymic Disorder usually have superimposed Major Depressive D/O- and if Dysthymic D/O precedes the onset of Major Depressive D/O, there is less likelihood that there will be spontaneous full inter-episode recovery between Major Depressive episodes and a greater likelihood of having more frequent subsequent episodes.

**Cyclothymic Disorder-** Lifetime prevalence is from 0.4 to 1%

Course: Usually has an insidious onset and a chronic course. There is a 15-50% chance that the person will subsequently develop Bipolar I or II disorder. Usually begins in adolescence or early adult life. Onset of this disorder late in adult life may suggest a Mood Disorder Due to a Gen Med Condition such as Multiple Sclerosis.

**Bipolar I D/O-** Lifetime prevalence is between 0.4 and 1.6%

Course: Average age of onset is 20 for both men and women. Bipolar I D/O is a recurrent disorder- more than 90 % of individuals who have a single Manic episode go on to have future episodes. Roughly 60-70% of Manic episodes occur immediately before or after a Major Depressive episode. Manic episodes often precede or follow the Major Depressive episode in a characteristic pattern for a particular person. The number of lifetime episodes (both manic and major depressive) tends to be higher for Bipolar I D/O compared with Major Depressive D/O, recurrent. Studies on the course of Bipolar I D/O prior to lithium maintenance suggest that on average, 4 episodes occur in 10 years. (Note: mood stabilizers do not prevent further mood episodes- they decrease the frequency of these episodes) 5-15% of those with Bipolar I D/O have 4 or more mood episodes within a given year- this is noted by the specifier With Rapid Cycling.\* 20 to 30% continue to display mood lability and other residual mood symptoms between episodes. As many as 60% experience chronic interpersonal or occupational difficulties between acute episodes. Incomplete inter-episode recovery is more common when the current episode is accompanied by mood-incongruent psychotic features.

**Bipolar II D/O-** Lifetime prevalence is 0.5%

Course: Roughly 60-70% of the Hypomanic episodes in Bipolar II D/O occur immediately before or after a Major Depressive episode. Hypomanic episodes often precede or follow the Major Depressive episodes in a characteristic pattern for a particular person. The number of lifetime episodes (both Hypomanic and Major Depressive) tends to be higher for Bipolar II D/O compared with Major Depressive D/O, recurrent. Approx. 5-15% of individuals with Bipolar II D/O have multiple (four or more) mood episodes that occur within a given year. Approx. 15% continue to display mood lability and interpersonal or occupational difficulties between episodes. Psychotic symptoms do not occur in hypomanic episodes, and they appear to be less frequent in the Major Depressive episodes in Bipolar II D/O than is the case for Bipolar I D/O. Over 5 years, about 5-15% of individuals with Bipolar II D/O will develop a Manic episode.

*\*Rapid Cycling specifier- can be applied to either Bipolar I or II- At least 4 episodes of a mood disturbance in the previous 12 months that meet criteria for a Major Depressive, Manic, Mixed or Hypomanic episode- episodes are demarcated by partial or full remission for at least 2 months or a switch to an episode of opposite polarity.*

## **Anxiety Disorders 35%**

**Panic Disorder with/without Agoraphobia-** Lifetime prevalence is between 1 and 2 %

Course: Age at onset varies considerably, but is most typically between late adolescence and the mid-30s. There may be a bimodal distribution, with one peak in late adolescence and a second smaller peak in the mid-30s. A small number begin in childhood, and onset after 45 is unusual but can occur. Usual course is chronic but waxing and waning. Some individuals may have episodic outbreaks with years of remission in between, and others may have continuous severe symptomatology. Limited symptom attacks may come to be experienced with greater frequency if the course is chronic. Onset of Agoraphobia is usually within the first year of occurrence of recurrent panic attacks, and its relationship to the course of Panic Attacks are variable.

**Specific Phobia-** Lifetime prevalence is between 7.2 and 11.3%

Course: Usually occurs in childhood or early adolescence and may occur at a younger age for women than men. Mean age at onset varies according to the type of Specific Phobia. Age at onset for Specific Phobia, Situational Type, tends to be bimodally distributed- with a peak in childhood and a second peak in the mid- 20's. Specific Phobias, Natural Environment Type (e.g. heights) tend to begin primarily in childhood, although many new cases of height phobia develop in early adulthood. Phobias that result from a traumatic event or from unexpected Panic Attacks tend to be particularly acute in their development and do not have a characteristic age of onset. Specific phobias that persist into adulthood remit only infrequently.

**Social Phobia-** Lifetime prevalence is from 3 to 13%

Course: Onset typically in the mid-teens, sometimes emerging out of a childhood history of social inhibition or shyness. Some report an onset in early childhood. Onset may abruptly begin after a stressful experience, or it may be insidious. Course is often continuous, and the duration is frequently lifelong. May fluctuate with life stressors and demands.

**OCD-** Lifetime prevalence is 2.5%

Course: Usually begins in adolescence or early adulthood, it may begin in childhood. Modal age of onset is earlier in males than in females: between ages 6 and 15 years for males and between ages 20 and 29 years for females. For the most part, onset is gradual, but an acute onset has been seen in some cases. Majority have a chronic waxing and waning course, with exacerbation of symptoms related to stress. About 15% show progressive deterioration in occupational and social functioning. About 5 % have an episode course with minimal or no symptoms between episodes.

**PTSD-** Lifetime prevalence is 8%

Studies of at-risk individuals yield variable findings- with the highest rates (ranging from 1/3 to over half of those exposed) found among survivors of rape, military combat and captivity, and ethnically or politically motivated internment and genocide.

Course: Can occur at any age, including childhood. Symptoms usually begin within the first three months after the trauma, although there may be a delay of months or years

before symptoms appear. The symptoms and the relative predominance of re-experiencing, avoidance, and hyper-arousal symptoms may vary over time. Complete recovery occurs within three months for approx. half of cases, with many others having persisting symptoms for longer than 12 months after the trauma. In some cases, the course is waxing and waning. Symptom reactivation may occur in response to reminders of the original trauma, life stressors, or new traumatic events. The severity, duration, and proximity of an individual's exposure to the traumatic event are the most important factors affecting the likelihood of developing this disorder.

**GAD- Lifetime prevalence is 5%**

Course: Many individuals with this disorder report that they have felt anxious and nervous all their lives. Over half report onset in childhood or adolescence, onset occurring after age 20 is not uncommon. The course is chronic but fluctuating- and often worsens during times of stress.



## **Symptoms of Psychosis- Definitions**

**Psychosis:** Traditionally meant loss of reality testing and impairment of mental functioning-manifested by delusions, hallucinations, confusion and impaired memory- commonly has become synonymous with severe impairment of social and personal functioning characterized by social withdrawal and inability to perform the usual household and occupational roles.

**Positive symptoms:** “Reflect an excess or distortion of normal function”, “experiences that would be considered grossly abnormal”, marked distortion of reality, typically associated with the acute phase of the disorder. DSM 5 specifies that the positive symptoms include distortions in thought content (delusions), perception (hallucinations), language and thought process (disorganized speech) and self monitoring of behavior) grossly disorganized or catatonic behavior). It further divides positive symptoms into two “dimensions”- “psychotic dimension”- delusions and hallucinations and the “disorganization dimension”- disorganized speech and behavior.

**Hallucinations:** False sensory perceptions that are disconnected from an appropriate source.

Auditory hallucination (most common type- occurring in nearly 50% of all patients with Schizophrenia) : Usually experienced as voices, whether familiar or unfamiliar, that are perceived as distinct from the person’s own thoughts, (If occur while falling asleep “hypnagogic”, or waking up “hypnapompic”- they are considered to be within the range of normal experience).

**Certain types of auditory hallucinations have been considered to be particularly characteristic of Schizophrenia- two or more voices conversing with one another or voices maintaining a running commentary on the person’s thoughts or behaviors- if these types are present, then only this single symptom is needed to satisfy Criterion A for Schizophrenia.**

Visual hallucinations: False perception involving sight consisting of both formed images (persons) and unformed images (flashes of light) :**most common in medically determined disorders.**

Tactile hallucination: False perception of touch or surface sensation, as from an amputated limb, crawling sensation on or under the skin.

**Delusions:** Fixed, false beliefs that are not subject to reason or contradictory evidence (one source estimates that approximately 90% of patients describe delusional beliefs at some point in their illness. A delusional belief involves four features 1) objectively false 2) idiosyncratic 3) illogical 4) stubbornly maintained. Three distinct entities- Delusions of

influence (delusions of being controlled, thought insertion or thought withdrawal), Self-significance delusions (grandeur, reference, guilt/sin) and delusions of persecution.

Bizarre delusions are beliefs that are totally out of the realm of physical possibility, if they are clearly implausible, not understandable, do not derive from ordinary life experiences. **If bizarre delusions are present, then only this single symptom is needed to satisfy Criterion A for Schizophrenia.**

**Disorganized Speech** (must be severe enough to substantially impair effective communication): “Derailment” or “loose associations” where the person “slips off track, “tangentiality” where the person responds obliquely or completely off subject to a query, or, rarely- “word salad” / incoherence where speech is so disorganized that nearly incomprehensible and may resemble receptive aphasia-

#### **Behavior –**

##### Disorganized:

Problems may be noted in any form of goal-directed behavior, leading to difficulties in performing activities of daily living, client may appear noticeably disheveled, may dress inappropriately, may display clearly inappropriate sexual behavior, or unprovoked and unpredictable agitation.

##### Catatonic:

Marked decrease in reactivity to the environment, sometimes reaching an extreme degree of complete unawareness, maintaining a rigid posture and resisting efforts to be moved, active resistance to instructions or attempts to be moved, the assumption of inappropriate or bizarre postures, or purposeless and unstimulated excessive motor activity (**nonspecific symptom- may occur with other mental disorders, in general medical conditions or be induced by medications**).

**Negative symptoms:** “Reflect a diminution or loss of normal function”- difficult to tease out whether these may be in relation to positive symptoms- must stand on their own to be used in diagnosis of Schizophrenia- excellent test is the test of time- do they persist?

**Affective flattening:** Person’s face appears immobile and unresponsive- the person’s range of emotional expressiveness is clearly diminished most of the time.

**Alogia:** Poverty of speech, decreased fluency and productivity of speech.

**Avolition:** Inability to initiate and persist in goal-directed activities.

## Assessment and Interview of Psychotic Patients

- I. Evaluation should be more focused and structured than that of other patients. You must provide an organization for thinking that the client cannot provide themselves.
  - A. Short, direct questions as opposed to open-ended and abstract.
    1. Introduce yourself to the patient, mention the purpose of the interview, see how this accords with the patient's perceptions, and give the patient an opportunity for comment.
    2. Research has shown that patients with schizophrenia often have a fear of the unknown- so, for a first meeting, approach the person from the front, let them "look you over"- Offer them a chair, tell them where you will be sitting, ask them if they are comfortable with that.
  - B. People reporting auditory hallucinations should be asked about: content, context, volume, clarity, what they make of it, and their response to it.
    1. "Have you had any unusual or strange experiences, such as hearing voices that no one else seems to hear?" "Have you seen things that other people haven't seen. Or felt things when there was nothing there?" –
      - a) "When was the first time, the last time that you remember hearing voices?" "Are you hearing the voices now?" "How does it make you feel to hear the voices?"
    2. For delusions- "Sometimes people worry more than they should that other people are spying on them, or planning to get them into trouble. Has anything of that sort ever happened to you?- for thought insertion "Do you ever get the feeling that other people or the radio or TV are putting thoughts into your head?"
    3. Thought broadcasting- "Do you ever get the feeling that your thoughts are being transmitted to other people or come out on the radio or TV?"
      - a) Need to distinguish between true hallucinations on the one hand, and illusions, hypnagogic, hypnapompic and vivid imaging on the other hand.
    4. With patients with schizophrenia, impulses for suicide, homicide and assault often enter consciousness as hallucinations and/or delusions. Ask about whether the voices or delusions they have described ever give them commands to obey or suggestions to follow- if so, when did they last have them, how close did they come to acting on them, are they having the thoughts now, do they want help controlling them?
  - C. "No collusion with delusion"- Dr. Norman Reider of the Mt. Zion hospital in SF, CA ("No, that is not what I believe, but I am interested in is how things look to you").

1. Without agreeing with their delusions, you should find an area of agreement- finding something that is bothersome or tormenting to them, that can help build a therapeutic alliance.
  2. Countering paranoia with sweetness/affability may add to a client's paranoia/ they may think you are trying to trick them- instead remain reserved, businesslike- research has shown that patients with schizophrenia often have a fear of the unknown- so, for a first meeting, approach the person from the front, let them "look you over".
  3. Avoid pronouncements about what you are seeing from the client, make an observation and then ask the client instead.
- II. No clinical sign or symptom is pathognomonic for schizophrenia: every sign or symptom seen in schizophrenia occurs in other psychiatric and neurological disorders- thus, a patient's history is essential for the diagnosis of schizophrenia.
- A. Epidemiology: Lifetime prevalence of schizophrenia is about 1%, is found in all societies and geographic areas, and prevalence rates are roughly equal worldwide.
1. Gender and age: equally prevalent in men and women.
    - a) Onset is earlier in men: peak ages of onset are 10 to 25 for men.
    - b) Onset in women is 25 to 35- unlike men, women have a bimodal age distribution, with a second peak occurring in middle age (related to menopause).
    - c) Onset before age 10 or after 60 is extremely rare.
    - d) When onset occurs after 45- disorder is characterized as late onset.
    - e) Outcome is generally better for female patients than men.
    - f) Some studies have indicated that men are more likely to be impaired by negative symptoms than women, and that women are more likely to have better social functioning prior to onset.
    - g) Males are more vulnerable to schizophrenia than females- median male: female risk ratio of 1.4. Overall worse outcome for males who develop schizophrenia.
  2. Infection and Birth season
    - a) Persons who develop schizophrenia are more likely to have been born in the winter and early spring.
  3. Reproductive factors
    - a) Morbid risk in the monozygotic twin of a proband is estimated to be 48% compared to 1% for the general population. The risk

for children with one parent with schizophrenia is 10-15x greater than in the general population.

#### 4. Suicide risk

- a) Leading cause of mortality in persons suffering from schizophrenia.- Suicide rates are elevated above not only population rates, but also rates for other psychiatric disorders. The risk of suicide is significantly increased in the first year after discharge following inpatient admission, but especially in the first few weeks after discharge. As many as 15% may die because of a suicide attempt (risk factors to be noted are being white, socially isolated, depressive illness, history of suicide attempts, unemployment and recent rejection- a post-discharge course involving high levels of psychopathology and functional impairment - in addition, persons who have a realistic awareness of the deteriorative effects of the illness and a non-delusional assessment of their future mental deterioration, hopelessness, excessive dependence on treatment or loss of faith in treatment have an increased risk of suicide- risk of mortality is especially high in the young, early in the course of the illness) \* Recent studies the portion of suicides in total deaths (proportional mortality) of people with schizophrenia is estimated at about 30%. Risk for suicide in people with schizophrenia markedly decreases with age as opposed to that for most general populations (which increase with age)- severe negative symptoms tend to be a protective factor- reducing risk.

#### 5. Immigrants and Ethnic Minorities

- a) Migrants have a higher risk of developing schizophrenia in their own or their adoptive countries.

#### 6. Childhood Stressors

- a) Separation from a parent, death of a parent thru suicide, and sexual abuse in childhood have been reported as independent risk factors for schizophrenia.

### B. Course

1. Factors associated with a poorer longitudinal illness course include being male, early onset of illness, poor pre-morbid social and occupational adjustment, low pre-morbid IQ, a predominance of negative symptoms, and a lack of affective symptoms.
2. Poor outcome is also perpetuated by delayed, suboptimal or intermittent treatment with anti psychotic medication and ongoing illicit substance use. Also a strong association between poor outcome and a family environment characterized by a so-called high expressed emotion (EE). This encompasses critical comments, hostility, and/or

over involvement of family members with nominally more than 72 hours per week of face to face contact with the individual.

3. The disease construct of schizophrenia comprises several relatively independent symptom dimensions, with negative symptoms and cognitive impairments remaining relatively stable over the illness course, and positive symptoms occurring in most patients on an episodic basis.
4. Full remissions without subsequent relapses persist in about 20% of cases in the long-term.
5. Recovery or major sustained improvement occurs mostly in the first years following illness onset. Patients who do not improve in the first years, or who deteriorate slightly or markedly, tend to continue this trend in the long term, too.

#### C. Onset

1. In about 75% of cases, schizophrenia onset occurs with slowly mounting depressive and negative symptoms that involve increasing functional impairment and cognitive dysfunction. Less than 10% of cases start with positive symptoms only.

### III. Differential Diagnosis- **Always always always rule out biological/drug induced First-** flags for these- when the age of onset and the timeline of the symptoms is not consistent with what we know about Schizophrenia.

- A. Psychotic Disorders 1 ½ % of the population, Anxiety disorders 25% of the population, Depressive disorders 15% of the population, Bipolar Disorders 1 ½% of the population.
- B. Psychotic symptoms vs. intrusive thoughts in panic and obsessive-compulsive disorders.
  1. In both cases, intrusive thoughts are unwanted or unacceptable to the person experiencing them and are perceived as uncontrollable-essential difference that psychotic symptoms are seen as coming from **outside the mind** ( do not mean "outside their head" ), while the anxiety symptoms are perceived by the person **as coming from their own mind**.

#### C. Hallucinations versus Flashbacks

1. PTSD flashbacks will involve more than one type of hallucination at one time- as the person will experience themselves in a different place and time than they actually are- but, in both cases, the person will lose touch with reality.

#### D. Bipolar Disorder vs. Schizophrenia

1. Patients with mania may have a wide variety of psychotic symptoms- including hallucinations, paranoid delusions, and formal thought

disorder- with mania, these psychotic symptoms will be abrupt and the affective symptoms will predominate.

E. Depressive disorder vs. Schizophrenia

1. People with depressive episodes may also experience hallucinations and/or delusions (the only DSM depressive disorder with psychotic features is coded severe)- the psychotic symptoms are usually mood-congruent when stemming from a depressive episode...so should be consistent with depressive themes- also, when patients with depressive disorder have hallucinations they are of shorter duration and fragmented and within the context of the depressive disorder.





## **EASA SCENARIO ONE**

Beth is a 13 y/o female referred to EASA from a school counselor. The referral was at the recommendation of a school outreach crisis counselor who assessed Beth following threats of suicide and homicide (she reported wanting to kill her step-father). During the counselor's assessment Beth reported she heard voices.

The EASA screening revealed the following:

Beth reported feeling stressed because of having to see so many counselors. She did not think anything was wrong with her.

She denied all illicit substance use. This was viewed as a reliable account confirmed by family. Her friends at school also do not use substances.

Beth over the course of her schooling has been considered an outcast and was often a victim of bullying. Her grades were all As and Bs with the exception of a D in Math. She reported she is doing better with her school work this year. She also continued to compete on the school cross country team.

Prior to the SI/HI Beth has never had mental health treatment.

Beth reported she does not get along with her step-father or her sister. She reported that her sister has threatened to kill her and to protect herself she will keep a knife in her room. She did not give specific reasons why she did not like her stepfather other than they do not get along. Although sexual and physical abuse was denied by Beth, it was documented in the crisis counselor assessment that Beth had reported her step-father was entering her room at night and touching her sexually. A report was also made to CPS. With further probing Beth reported the abuse. She indicated this behavior and other sexually inappropriate behaviors have occurred for about a year.

Beth denied all SI/HI at the time of the screening but did disclose that she cuts her arms superficially 2-3xs per week with a kitchen knife or safety pin. She reported that she had been doing this for the past two years. She reported she does this because "it feels good". Beth reported she tried to end her life a year ago by cutting her wrists. The cuts were not deep and she did not seek out medication attention. She did talk about wanting to run away.

Further exploration of the voices revealed that they occur 1-2x per day in the form of her name being called. She reported that they were bothersome, and could not indicate what may be causing them other than it could be her imagination. The voices were poorly localized. Beth could not tell for sure if they were inside or outside of her head. She was not able to identify the gender. She is unsure when they started but she thinks it was about a year ago. Beth also reported seeing shadow figures that others could not see. She reports she sees these figures 2-3x a day lasting a few seconds each time for the last year. She reports the figures are scary.

Beth denied thought insertion, withdrawal and broadcasting. There was no evidence of magical thinking or ideas of reference. Beth did report she feels suspicious of people and general and sometimes worries that people are following her. This feeling has been present for about a year.

No cognitive changes were indicated. No drop in functioning in the areas of academics, self care or social activities. No report of perceptual distortions or increased sensitivities. No evidence of mania. She did make some statements of derealization, "it feels like my life is a dream".

Beth reported significant sleep difficulties (falling and staying asleep). She described this problem as new. She reported when she did sleep she experienced nightmares of people hurting her. Her mood was apathetic and affect showed full range of emotions. She reported feeling fatigued most days and she did not have much of an appetite.

Beth's mom reported that she suffers from bipolar disorder, but is currently not in treatment. Beth also had an aunt who was also reported to have suffered from bipolar disorder and methamphetamine addiction.

## EASA SCENARIO TWO

Wendy is a 14 y/o female referred to EASA from her mother at the prompting of an ER physician following an incident of cutting her arm and wishing to die. Wendy also reported to the physician that she heard voices.

The EASA screening revealed that both of Wendy's parents suffer from depression. Wendy's father also reported that he was in recovery from substance abuse and at times would get psychotic from his use.

Wendy reported that she experiences a great deal of stress at school, because one of her friends had turned on her and was telling lies about her. Wendy also reported that she has been experienced increased thoughts/flashbacks around her past abuse. She was physically abused by one of her mother's former boyfriend from that age 3-12.

Wendy denies all current illicit substance use; she did report she tried THC 1x 2 weeks ago. She reported that she did not like how it made her feel and does not have plans to continue to use. She does report she drinks ETOH at times (usually during the summer break) to the point of intoxication.

Academically Wendy reported that starting junior high has been a struggle for her. Her grades have dropped from Bs and Cs to Cs and Ds. Socially Wendy has one best friend and a boyfriend.

Wendy has been involved with school counseling over the last two weeks and reported it was helpful. Other than that she has had no mental health treatment.

Wendy reported some ongoing suicidal ideation with no plan. She reported that she cuts her arm 2x a month to the point where it will bleed. She reports she does this to relieve stress. She had one suicide attempt 8 months ago when she ingested several Tylenol and ibuprofen. She reported she never told anyone about it and just slept it off.

Exploration of the voices indicated that she hears several voices outside of her head that say her name. She described them as "creepy". She reported this has been happening for about a year at the rate of 2x per week at random times throughout the day. She reports they are both male and female and last up to 30 minutes.

Wendy also endorsed she sees shadows daily that pass by her briefly. She reported this started a year ago. She also reported seeing colors, like after a camera flashes.

The screening indicated no thought insertion, withdrawal, broadcasting or magical thinking or ideas of reference. She did report she felt like people are watching her and in general people were against her.

There was no evidence of cognitive decline, other than Wendy reported she occasionally spaces out. There was not reported decline in social functioning or self care. No evidence of increased sensitivities. No evidence of mania.

Wendy reported sleep difficulties (staying asleep and getting to sleep). She also reported nightmares sometimes of past abuse. Wendy's reported he mood as depressed and really only feeling better when she was with her boyfriend. She also reported increased irritability with her parents. She reported she was eating less.



### EASA SCENARIO THREE

Gary is a 16 y/o male who was referred by his mother to EASA at the request of Gary's PCP. The PCP was concerned that Gary may be delusional.

The EASA screening revealed that Gary's great grandmother suffered from schizophrenia and spent most of her life at the State Hospital.

Gary reported that he thought he was seeing the EASA counselor to get help with "wanna be gangbangers" that were trying to hurt him and to deal with the stress that his ex girlfriend was keeping his 6 mo old child from him. Gary's mom confirmed that he did have a six month old child and the relationship between he and ex was strained and not healthy. Mom also confirmed he had some run-ins with some guys at the bus stop that harassed him for looking Mexican. She however did not feel the extent to which Gary felt the gangbangers were involved with him was in touch with reality. Mom reported that some people Gary accused of being in gangs were the elderly neighbors.

Gary reported that he smoke a third of a pack of cigarettes a day and drinks beer 2-3x a week. He reported he use to drink more frequently to point where he would pass out. He reported he has been cutting back on his drinking over the last year. He also reported frequent THC use starting about a year ago, but reports he has not used for the last 2 months. He reported he stopped because "it was messing with my head". Gary's mom believed that Gary's account of his substance abuse was reliable.

Gary had just completed his GED at the downtown learning center. He reported that he had to go the GED route for his education because he was expelled from high school for carrying a knife. He reported that he carried the knife for his protection. He could not specify whom he felt threatened by; just that he did not feel safe at school. He reported (confirmed by mom) he was failing all of his classes except Trends in the Workplace and Math. Historically (going back to middle school) Gary never did well in school.

Gary has no previous history of mental health treatment.

Review of Gary's psychosocial history indicated no physical or sexual abuse. It was noted that Gary's father died when he was 2 of a lung disease and that his mom remarried shortly after that, divorced suddenly then married another man who has raised Gary. Gary reports the relationship with his step father is "ok".

Mom reported that Gary has lost all of his friends, which the exception of a few who will talk to him briefly on the phone.

Gary denied all suicidal and homicidal ideation. He did report that he use to cut his arms, but stopped 6 months ago. Gary does endorse thoughts about death, but with no plan to take his own life. Gary also had a history of physical altercations at school, but no one was hurt and no legal charges filed.

In review of the reported delusions, Gary reported that there are cameras in his home (denied by mom) that were filming him and his family. He believed this with 100% conviction. He reported the cameras

had been there for about 3 weeks. He reported they were placed there by neighbors who are also in a gang. He looks for the cameras but cannot find them. He reports he still believes that they are there because he could hear the neighbor's thoughts in his head and they could also hear his thoughts. He also reported that the gang members were sending messages through his computer that were accusing him of being a pedophile. Gary denied hearing voices other people could not hear.

In review of cognition, historically Gary has had difficulties in the areas of concentration, attention and organization. His mother reported she had noticed a sharp decline in his memory which was described as a change. Gary said that his memory challenges were due to his pot use. Gary also reported that people were reporting to him that they were having a hard time understanding him when he spoke. During the screening Gary's speech volume was soft and the content was impoverished. His emotional range was also restricted.

Gary reported that his mind races, but if he tries he can slow down his thoughts. He reported this was worse during times of stress. Mom reported Gary appears very anxious in the home. She reported that he paces around the house, looking out of windows.

Gary reported that his hearing was much sharper recently and that he can hear his mom talking from the downstairs living room when she is in her bedroom. He also reported being able to hear the neighbors outside his house. No other reported sensitivities or perceptual distortions.

No mania was indicated by Gary or his mother.

No reported depersonalization or derealization.

Gary presented as unkempt his clothes (all black) were dirty and his hair was greasy and uncombed.

Gary reported that he sleeps "ok". He reported it was worse when his thoughts were racing.

Gary reported that his mood was "depressed" and sometimes he feels like crying for no reason. He also reported that he has stopped eating as much as he did and his mom reported he had lost some weight.

#### **EASA SCENARIO FOUR**

Vickie is a 17 y/o female referred to EASA by the local crisis center. The crisis center staffed referred Vickie because during a crisis screening Vickie told the staff that she hears voices and sees shadows.

The EASA screening revealed that Vickie's mother suffers from depression.

Vickie reported that she would like help with "depression and low self-esteem".

During her school years Vickie was a poor to average student with a few good friends. She was involved with the school band playing both the drums and trumpet. This pattern was consistent throughout middle school and high school up to her junior year. Vickie reportedly started doing even worse in school. Vickie reported that was due to a lack of motivation. Vickie's mother reported that Vickie had become very depressed. Vickie attempted to complete her GED, but stopped the GED program after she found out she was pregnant. Vickie was also working at a retail store during this time period.

Vickie currently lives with her parents, her sister and the father of her child.

Vickie is currently in outpatient counseling for depression which she finds supportive but not helping her depression. She has no previous mental health treatment.

Vickie and her mother deny any form of abuse. They both report Vickie had never even been to a hospital up until she delivered she child 6 months ago.

Vickie denies any use of illicit substances.

Vickie reported that she "sometimes" thinks about ending her life but would never do it, because it would leave her son without a mother.

Cognitively Vickie had good focus, attention and abstract ability. She did report that her memory seemed worse as evidenced by forgetting where things were and dates of events.

She denied any unusual sensitivities other than the water coming out of the faucet seem louder.

No evidence of mania.

Further exploration of the depressive symptoms indicated that Vickie's mood became more melancholic following the birth of her child. She endorsed symptoms of amotivation, and ahedonia. She reported that she lacks the energy to care for her child, and has a reduced interest in going out dancing with friends and completing her education. She reported she feels sad all the time with crying spells at least 2x per week. She reported she does not know why she feels so sad. She reported her appetite is normal (although her mother reports she has lost several pounds and worries she may be developing an eating disorder). She reported that she is able to go to sleep but wakes up 3-4x each night and it takes 30 minutes to fall back asleep. She also reported nightmares of people dying.

Further exploration of the voices and complaint of seeing shadows, revealed that she has heard a man's voice saying "hey and shhh" that was localized outside of her head (she reported she heard it outside

the door) and she thinks she has heard her mom's voice say her name. She reported the voices have occurred 3x, the first and last time of this experience was 3 months ago. She reported seeing shadows running by her 1-2x. She reported this experience frightened her. She believed that both the voices and the shadows happened because she was very tired.

Vickie also reported that she sometimes gets confused whether or not her dreams are real, and asks family members if what she dreamed was something that really occurred. She reported she feels suspicious at times and worries that maybe someone is watching her. She reported a vague unusual experience where at times she sensed that some of the cartoons she watched with her son gave her "odd feelings". There was no evidence of thought insertion, broadcasting or withdrawal. Vickie does not believe she is going crazy, she just knows that her mood is not right.