Disclosures

- None

Plan for Today

- What is Executive Dysfunction?
- What is Interpersonal Psychotherapy?
- What is IPT-ci?
- Video illustrations
- Breakout Exercise
- Review
- Q &A

Cognitive Impairment:
Causes and Presentations

- Alzheimers Disease
- Vascular dementia
- Fronto-temporal dementia
- Diffuse Lewy Body Dementia
- Other neurodegenerative Syndromes

Cognitive Impairment:
Causes and Presentations

- Alzheimers Disease – begins with slowly progressive memory loss

Cognitive Impairment:
Causes and Presentations

- Vascular dementia
  - patchy and step-wise deterioration
  - often motor impairment
  -emotional lability

Cognitive Impairment: Causes and Presentations

Fronto-temporal dementia

- disinhibition or personality change first
- executive dsyfunction
- memory loss later

Cognitive Impairment: Causes and Presentations

Diffuse Lewy Body Dementia (DLB)

- Parkinsonian symptoms (rigidity, tremor, wide based gait, masked facies, bradykinesia
- Often visual hallucinations of people or animals
- memory loss is a later feature

Cognitive Impairment: Causes and Presentations

- Other neurodegenerative syndomes- Parkinsons Disease, Huntingtons Disease, Multiple Sclerosis and others
  - –motor symptoms precede cognitive

The Spectrum of Cognitive Impairment

Normal--------MCI----------Dementia

Executive Dysfunction often precedes memory loss

Families often misattribute problem behaviors

Executive Dysfunction (ED)

- to be distinguished from the "other" ED (erectile dysfunction)

ED Defined

Impaired:

verbal fluency
planning, strategy development
psychomotor speed
spatial working memory
apathy and impaired insight
initiation and perseveration
problem solving

Executive Dysfunction

Declines in :
insight , judgment, impulse control
problem solving skills
social graces, empathy
initiative, organization, planning
multi-tasking ability
self-perception, patience

CEO Analogy for Executive Function

- Final decision-maker
- Analyzes data (prices, market, labor costs, advertising)
- Quality control
- Manage the managers, morale etc.
- Must prioritize tasks, time, and trouble shooting
- Maintain an overall sense of how it is going (integration)

Neuroimaging studies show abnormalities most consistently in the frontal lobe connectivity in ED

- the cortical-striatal-pallidal-thalamus-cortical pathways
- dorsolateral prefrontal cortex
- anterior cingulate
- Also caudate, putamen and basal ganglia

Tests that reveal ED

- Stroop
- Cambridge Neuropsychological Test Automated Battery
- Wisconsin Card Sort
- EXIT
- Trails B
- Montreal Cognitive Assessment (screening)

Introducing the MBI-C Mild Behavior Impairment Checklist

- Can predict the onset of cognitive decline before MCI
- Collaborative Testing is ongoing
- with Ismail Zahinoor
- Use as a teaching tool?

Depression with Cognitive Impairment

- Slower and incomplete response to antidepressant medications
- More disability
- Higher relapse rates
- Greater risk for suicide?
- More dependency on others

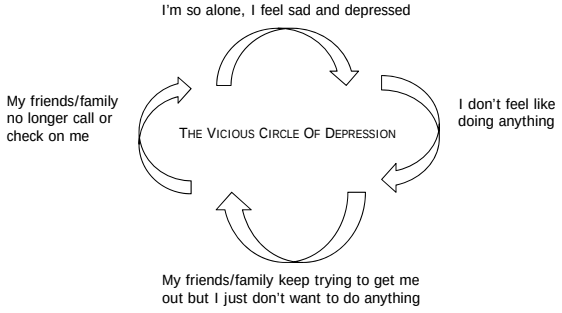
Depression
Secondary to
Cognitive Impairment

- Awareness of growing cognitive impairment
- Direct brain damage to mood circuitry causing depression
- Drug side effects

INTERPERSONAL MODEL OF DEPRESSION

- Depressive symptoms have genetic and environmental causes
- Symptoms linked to something going on in the client's personal life
- Behavior is viewed as influencing
- "Interpersonal style" may influence negative feedback

INTERPERSONAL MODEL OF DEPRESSION



INTERPERSONAL MODEL OF DEPRESSION

Depression is viewed as having 3 parts

- **Symptoms**—emotional, cognitive and physical symptoms. (fatigue, guilt, loss of interest)
- **Social and interpersonal life**—the ability for the client to get along with important people in their life (family, friends, work peers).
- **Personality**—how the clients assert themselves, express their anger.

THE MOTIVATION OF IPT

- Attempt to understand the client's interpersonal picture in which the depressive symptoms began and how these symptoms relate to the current social and personal context.
- Looking at what is happening in the client's life now, rather than past issues.
- Interpersonal therapy helps the client to improve functioning, particularly in current relationships, in order to break the depressive cycle

GOALS OF IPT

1) To diagnose depression explicitly
2) To educate the client and family about depression, its causes, and the various treatments available for it
3) To identify the interpersonal context of depression as it relates to symptom development
4) To develop strategies for the client to follow to improve coping to reduce depressive symptoms

DISTINCTIONS

Unlike other psychodynamic approaches, IPT:

- Is brief (12-16 sessions)
- Is focused (1-2 problem areas)
- Emphasizes the ways in which a person's current relationships and social context cause or maintain symptoms
- Does not explore the deep-seated sources of the symptoms
- Views rapid symptom reduction and improved social adjustment as its goals
- Frequently leads to more satisfying relationships in the present

IPT--PROCEDURE

First Phase (sessions 1-3)

- Review of depressive symptoms (conduct Ham D or other assessment tool)
- Explain what depression is and the treatment options
- Review client's interpersonal inventory
- Make link between depression and interpersonal focus
- Make treatment contract
- Give client the 'sick role'

THE "SICK ROLE"

- The concept of the "sick role" is based on the notion that illness is not merely a condition but a social role that affects the attitudes and behaviors of the client and those around him or her.
  - It is helpful to make analogies to other medical conditions: "If you had pneumonia, you wouldn't blame yourself for being unable to perform at your best. Depression is no different. You are fighting an illness, but it's a treatable illness."
- Clients and caregivers are informed that depression will limit the client's abilities to perform as well (to prevent excessive criticism)
- Clients are encouraged to maintain participation in activities in order to help alleviate symptoms and prevent additional problems from isolation, etc.

THE INTERPERSONAL INVENTORY

1. **When did your symptoms first begin? (month/year)**

   Is this the first time in your life you've been depressed? Yes/No

   If not, how many times have there been altogether? ___

   When was the first time? ___(month) _____(year)

   When was the last time ? ___(month) _____(year)

THE INTERPERSONAL INVENTORY

2. **Think about what was going on in your life when you started to feel depressed this time.**

Who are the important people in your life these days? Tell me about your relationships with them.
Did someone you care about die?
Was it the anniversary of someone's death?
Were you thinking about someone who died?
Were you having problems at home with your spouse or partner?
Were you having problems with your children/parents/siblings/in-laws?
Were you having problems with friends/coworkers/peers?
Were you having problems at work?
Were there more arguments with family or friends?
Were you disappointed in a love relationship?

(Weissman, Markowitz & Klerman, 2007)

THE INTERPERSONAL INVENTORY

--continued--

Did your marriage begin to have problems?
Were you going through a divorce or separation?
Did your children leave home?
Did you start a new job/lose a job/get promoted/retire?
Did you move/did someone move in with you?
Did you have financial problems?
Did you start living alone?
Was there serious illness in your family?
Did you become ill?
Were you put in a situation where you had to meet new people?
Were you lonely/bored?
Were there any big changes in your life?

(Weissman, Markowitz & Klerman, 2007)

IPT: AREAS OF FOCUS

IPT is typically focused on 1-2 of the following problem areas:

- **Unresolved Grief**—complicated bereavement following the death of a significant other
- **Role Disputes**—struggle, disagreement with family/friend/coworker
- **Role Transitions**—life change, graduation, new job, divorce, moving away, retirement
- **Interpersonal Deficits**—no acute life events—none of the above, lack of attachments, loneliness, isolation

1. UNRESOLVED GRIEF

In normal bereavement, a person experiences symptoms such as sadness, disturbed sleep, and difficulty functioning but these usually resolve in two to four months

Key factors to consider

- Client's social support system
- Identifying deficits that were compensated for by deceased spouse
- Quality of the lost relationship

GOALS =

- to facilitate the mourning process
- help the client re-establish interests and relationships that can begin to fill the void of what has been lost

(Hinrichsen & Clougherty, 2006)

2. ROLE DISPUTES

" This is not what I thought my retirement would be like."

"I love watching my grandchildren, but sometimes I wish they wouldn't come over every day"

"All of a sudden my children think I'm not safe to drive"

2. ROLE DISPUTES

Interpersonal role disputes occur when the client and at least one other significant person have differing expectations of their relationship

Keys factors to consider
- Identify disputes
- Negotiate options
- Examine and change relationship expectations
- Clarify and alter communication styles

GOALS =
- help the patient identify the nature of the dispute
- decide on a plan of action
- begin to modify unsatisfying patterns, reassess expectations of the relationship, or both

Do not direct the client to one particular resolution or attempt to preserve unworkable relationships

(Hinrichsen & Clougherty, 2006)

2. ROLE TRANSITIONS

"I really miss being a full-time mother, what am I supposed to do now?"

"I felt like I had a purpose before with work…"

- *Feeling overwhelmed rather than successfully aging*
- *Mourning loss of cognitive/physical abilities, mobility, intimacy, etc.*

(Miller, 2009)

3. ROLE TRANSITIONS

Depression associated with role transitions occurs when a person has difficulty coping with life changes that require new roles (e.g., initiation of romantic relationship, transition to retirement or changes to independence)

Role Transitions in depressed people:
- Experienced as losses rather than opportunities

GOALS =
- Help client to give up the old role
- Encourage expression of the accompanying feelings of guilt, anger, and loss—mourn the old role
- Develop a new attachments/social network around the new role
- Recognize the positive parts of new role

(Hinrichsen & Clougherty, 2006)

4. INTERPERSONAL DEFICITS

Typically involves impairment in developmental tasks (e.g., making friends, beginning romantic relationships, forming social ties, making choices about romantic commitment, vocation, sexuality)

IPT helps identify specific role that deficits play in current & past relationships, consider what needs to be changed, and encourages those changes

Key factors to consider
- Asking clients to practice new behaviors outside of therapy sessions

GOALS =
- Focus on the client's past relationships, the present relationship with the therapist, and ways to form new
- Explore patterns of strengths and limitations in these relationships
- Reduce the client's social isolation

(Hinrichsen & Clougherty, 2006)

INTERPERSONAL THERAPY

Second Phase (sessions 4-10)

- Continue work on the area of focus
- Use techniques specific to each area of focus
  - Role Transition—assist client to mourn loss of role and explore new roles
  - Role Dispute—assist client to identify disagreement, choose a plan of action and modify ways of communication/expectations as needed
  - Grief—help facilitate mourning and reestablish interests and relationships
  - Interpersonal Deficits—review past relationships (good & bad), explore patterns of strengths and difficulties in relationships and explore client's feelings about current or past relationships

INTERPERSONAL THERAPY

Final Phase (sessions 10-12)

- Conclude the acute treatment
- Discuss how ending treatment is a role transition
- Improve client's sense of accomplishment and independence
- Explore grief and blame if IPT treatment is not successful
- Discuss continuation or maintenance treatment (helps prevent relapse to have month appointments for a short time following resolution of acute symptoms)

CASE DISCUSSION

Client and wife both in mid 50s. Married 20+ years. Both retired young from governmental positions. Both have lived very active lives.

Client has been diagnosed with early onset dementia. Spouse has become caregiver which involves:

- All household chores
- All cooking
- Bathing and dressing of client
- Transporting to appointments
- Arranging PT/OT
- PLUS THE CAREGIVER'S OWN NEEDS:
  - APPTS
  - REQUISITE BREAKS
  - SHOPPING
  - HOBBIES

CASE DISCUSSION—CONTINUED

- Spouse included in initial session. Client unsure of reason for appt but spouse clearly looking for assistance.
- Client was unable to provide a lot of detail. Open ended questions often go unanswered or answered with "I don't know". Reframe. Use closed-ended.
- Body language—be open to it from caregivers. (what was the spouse trying to tell me without telling me?)
- Watch the dynamics at play between the client and the caregiver. How do they respond to each other? Can a role dispute or role transition be identified in either of them, or both?

CASE DISCUSSION—CONTINUED

- Client has progressed to immobility and moderate to severe CI. He is unable to recall much from the day or previous days. He finds his wife to be dishonest, telling his providers that he is worse off than he really is. He feels capable of returning to independence and has lack of insight to his actual abilities and safety issues. (on O2, smokes when he can find them, etc). The therapy I am doing with him is focused on his losses: loss of role; loss of independence; loss of life he expected to live in retirement; loss of mobility.

- Spouse is approaching the end of her ability to care for client independently. Spouse is also suffering losses: loss of life she expected to have with client; loss of independence in her own retirement; loss of companionship; Overwhelming guilt given feedback she gets from client.

CASE DISCUSSION—CONTINUED

- What is the focus of therapy presently?
  - Psycho-education for caregiver
  - Review of life for client
  - Helping prepare caregiver for changes (cognitively and physically) and make arrangements for more care
  - Assisting the caregiver in understanding her own anger/frustration/sadness with the role dispute and transition.

Why use IPT in Cognitive Impairment?

- IPT was developed as a depression treatment
- Depressed elders often present with a mixture of depression and cognitive impairment
- Functional capacity is impacted by multiple factors:
  - Depression
  - Cognitive Impairment
  - Physical disability
  - Adequacy of support systems

Geriatric Depression and/or Cognitive Impairment

- The clinical approach to working with older patients with depression or cognitive impairment is similar in the necessity to engage the patient and their support system, complete an adequate medical work-up, administer appropriate psychotropic medication and provide ample psycho-education for all parties in a prioritized way such that using IPT/IPT-ci is a practical format for managing both conditions acutely and long term.

IPT approach to Depression

- Engage patient
- Thorough interview and diagnostic work-up
- IPT contract
- Assign the sick role
- Interpersonal Inventory
- Establish Focus and intervene accordingly
- Reassess progress and attribute improvement to changes made
- Terminate or consider maintenance treatment

IPT-ci for Depression and Ci

- Engage patient and caregiver(s)
- Thorough interview and diagnostic work-up
- IPT contract to include flexible individual/joint meetings
- Sick role (define the disability)
- Interpersonal Inventory (Who needs education? Who can help?)
- Establish Focus (priorities, target behaviors, mood)
- Reassess progress and relate it to changes in attitude/actions
- Flexible Schedule for long-term follow -up

Support Systems

- Caregivers
  - Spouses
  - Adult Children
  - Other family
  - Friends
  - Volunteers, Churches, Elder Services etc.
  - Paid help

"Caregiver" Defined

- Anyone who takes action to assist or provide surveillance for an elder who appears to have declining ability to function independently

Becoming a Caregiver

- The line can be crossed unknowingly from a fully functioning parent/child relationship to a caregiving role where more attention, help or watchfulness is deemed necessary

All Caregivers are not alike

- Caregivers vary in intellect, education, personal problems, and coping skills----- - begin where you find them

Caregivers often
Misunderstand ED

- ED is less recognized although more common than memory loss in progressive cognitive decline
- ED is often misinterpreted as willful opposition, laziness, or merely as inexplicable behavior

Caregiver reactions to ED

- Empathy
- Proactive mobilization of resources
- Perplexity, anger
- Sadness (for lost abilities)
- Ineffective coping
- Elder abuse

Role Transitions in
Cognitive Impairment

- Memory Loss
- Declining problem solving ability
- Declining mobility
- Declining Social Outlets
- Declining capacity for enjoyment
- Increased dependency

Caregiver Issues

- The caregiver is not the IPT patient
- Advocate/Refer for help as indicated (their own IPT?)
- Acknowledge Caregiver's role-transition too

Caregiver Issues (cont.)

- Work with caregiver(s) insofar as it impacts their ability to give care optimally
- IPT-ci therapist attempts to create a bridge of better understanding and cooperation and provide a forum for individual or joint problem solving

IPT-ci Interventions

- The first meeting is very important
- Psycho-education may need to be in stages
- Close collaboration with medical colleagues is a must
- Observe interaction with caregivers and elicit their greatest concerns
- Explain that the evaluation process (to evaluate depression and C.I. will take several visits)

IPT-ci Interventions (cont.)

- Be able to explain dementia/ neuro-psych testing results
- Be ready to meet with caregiver's separately
- Use written reminders for actions to be taken
- Collaborate with prescribers for psychotropic meds
- Use flexible follow-up intervals
- Work toward a "Steady State"

IPT-ci Intervention for ED

- Meet the patient and caregiver at their current level
- Decide on a course of psycho-education best for both
- Consider working with the caregiver separately first
- Prepare for joint problem solving sessions
- Present yourself as an advocate for both parties with a focus on the identified patient's welfare

Steady State

- Depressive symptoms are minimized through treatment
- Cognitive impairment is defined and appropriate psychotropic meds are in place
- Caregivers and patient are adequately educated
- Appropriate Changes in attitude/actions are made
- A long term follow-up plan is outlined

Modifying IPT for Depressed Elders with Cognitive Impairment

- Traditional IPT targets individuals
- Caregivers are often frustrated and stressed
- Patients often lack insight
- Patients often show memory impairment
- Patients often show executive dysfunction
- Patients and caregivers often have disputes

Caregiver Issues

- Caregiver is not the IPT patient
- Assess their competence to give care
- Advocate/Refer for help as indicated
- Acknowledge Caregiver's role-transition too!
- Work with caregiver insofar as it impacts their ability to give care optimally
- IPT therapist attempts create a bridge of better understanding and cooperation

IPT-CI Features (Cognitive Impairment)

- IPT plus special emphasis
- Caregiver Integration into the treatment
- Psycho-education about depression and ci (tailored differently for patient and caregiver)
- Option of joint problem solving sessions
- Caregiver as Potential Coach

IPT-CI Features (cont.)

- Techniques to compensate for memory loss
- Seek "Steady State" Status
- Preparation for more cognitive decline
- Not short term- for life of patient
- Targeted for use in Primary Care Settings as in PROSPECT model

Field Testing

Benedum Geriatric Center
University of Pittsburgh
Mark D. Miller

In-Home Support Program
Binghamton University
Cassandra Bransford

Using IPT/IPT-ci in a Multidisciplinary Geriatric Care Clinic: A Feasibility and Acceptability Pilot Study

- IPT and its adaptation for cognitively impaired patients (IPT-Ci) was taught to social workers and nurses who then delivered it to consecutive new admissions in an ambulatory, multidisciplinary geriatric clinic (Benedum Geriatric Clinic in Pittsburgh).

- The treatment incorporated the IPT-ci approach into their usual social work assessment and care management strategies that included engaging all available caregivers.

Results

- An analysis of the first 15 patients showed them to have cognitive function ranging from scores ranging form 12-28 on the MOCA screening and PHQ-9 scores from 3-22 at baseline. ALL but 2 subjects were accompanied by caregivers, 6 of whom were spouses and the rest were adult children.

- The IPT focus was role transition to a less functional state in 14 subjects , and interpersonal deficit in one

- . Ten subjects showed a baseline PHQ-9 of 10 or greater with a mean scores of 17.6 at baseline, 10.2 at 3 months , 9.1 at 6 months and 7.5 at 12 months. Nonparametric statistical comparison of change from baseline to 3 months: n=9, p= 0.0625; to 6 months, n= 9 ,p=0.0078; to 12 months , n=7, p=0.0313

Limitations

- No independent raters
- Variable follow-up intervals

IPT-ci Summary Slide

- Engage patient and caregivers
- Educate, empathize, strategize
- Flexible individual/joint meetings
- Role Dispute Resolution
- Seek Steady State
- Long term advocate, liaison with team
- Anticipate future, End of life planning

IPT-ci Publications

Miller MD, Richards V, Zuckoff A, Martire LM, Morse J, Frank E, and Reynolds CF: A model for modifying interpersonal psychotherapy (IPT) for depressed elders with cognitive impairment. Clinical Gerontologist, 30(2):79-101, 2007

Miller MD, and Reynolds CF: Expanding the usefulness of Interpersonal Psychotherapy (IPT) for depressed elders with co-morbid cognitive impairment. International Journal of Geriatric Psychiatry, 22:101-105, 2007

REFERENCES

- Bransford, C.L. & Choi, S. (2012). Using Interpersonal Psychotherapy to Reduce Depression among Home-Bound Elders: A Service-Learning Research Collaboration. *Best Practices in Mental Health*, 8, 1-15.
- Hinrichsen, G.A. & Clougherty, K.F. (2006). *Interpersonal Psychotherapy for Depressed Older Adults.* Washington, DC: American Psychological Association.
- Miller, M.D., personal communication May 28, 2015.
- Miller, M.D. (2009). *Clinician's guide to interpersonal psychotherapy in late life: Helping cognitively impaired or depressed elders and their caregivers.* New York: Oxford University Press.
- Miller, M.D. (2008). Using interpersonal therapy (IPT) with older adults today and tomorrow: A Review of the literature and new developments. *Current Psychiatry Reports, 10,* 16-22.
- Weissman, M.M., Markowtiz, J.C. & Klerman, G. L. (2007). *Clinician's Quick Guide to Interpersonal Psychotherapy.* New York: Oxford University Press.

Mild Behavioral Impairment Checklist (MBI-C)

Label

Date: _____

Rated by: Clinician Informant Subject

Location: Clinic Research

Circle "Yes" **only** if the behavior has been present for at least 6 months (continuously, or on and off) and is a change from her/his longstanding pattern of behavior. Otherwise, circle "No".

Please rate severity**: 1=Mild** (noticeable, but not a significant change); **2= Moderate** (significant but not a dramatic change); **3=Severe** (very marked or prominent, a dramatic change). If more than 1 item in a question, rate the most severe.

This section describes interest, motivation and drive	**Yes No**	**SEVERITY**
Has the person lost interest in friends, family, or home activities?	Yes No	1 2 3
Explain:		
Does the person lack curiosity in topics that would usually have attracted her/his interest?	Yes No	1 2 3
Explain:		
Has the person become less spontaneous and active-for example, is she/he less likely to initiate or maintain conversation?	Yes No	1 2 3
Explain:		

Has the person lost motivation to act on her/his obligations or interests?	Yes	No	1	2	3
Explain:					
Is the person less affectionate and/or lacking in emotions when compared to her/his usual self?	Yes	No	1	2	3
Explain:					
Does she/he no longer care about anything?	Yes	No	1	2	3
Explain:					
This section describes mood or anxiety symptoms					
Has the person developed sadness or appear to be in low spirits? Does she/he have episodes of tearfulness?	Yes	No	1	2	3
Explain:					
Has the person become less able to experience pleasure?	Yes	No	1	2	3
Explain:					

Has the person become discouraged about their future or feel that she/he is a failure?	Yes	No	1	2	3
Explain:					
Does the person view herself/himself as a burden to family?	Yes	No	1	2	3
Explain:					
Does this person become more anxious or worried about things that are routine (e.g. events, visits, etc.)?	Yes	No	1	2	3
Explain:					
Does the person feel very tense, having developed an inability to relax, or shakiness, or symptoms of panic?	Yes	No	1	2	3
Explain:					
This section describes the ability to delay gratification and control behavior, impulses, oral intake and/or changes in reward					
Has the person become agitated, aggressive, irritable, or temperamental?	Yes	No	1	2	3
Explain:					

Has she/he become unreasonably or uncharacteristically argumentative?	Yes	No	1	2	3
Explain:					
Has the person become more impulsive, seeming to act without considering things?	Yes	No	1	2	3
Explain:					
Does this person display sexually disinhibited or intrusive behavior, such as touching (themselves/others), hugging, groping, etc., in a manner that is out of character or may cause offence?	Yes	No	1	2	3
Explain:					
Has the person become more easily frustrated or impatient? Does she/he have troubles coping with delays, or waiting for events or for their turn?	Yes	No	1	2	3
Explain:					
Does the person display a new recklessness or lack of judgement when driving (e.g. speeding, erratic swerving, abrupt lane changes, etc.)?	Yes	No	1	2	3
Explain:					

Has the person become more stubborn, or rigid, i.e. uncharacteristically insistent on having their way, or unwilling/unable to see/hear other views	Yes No	1 2 3
Explain:		
Is there a change in eating behaviors (e.g. overeating, cramming the mouth, insistent on eating only specific foods, or eating the food in exactly the same order)?	Yes No	1 2 3
Explain:		
Does the person no longer find food tasteful or enjoyable? Are they eating less?	Yes No	1 2 3
Explain:		
Does the person hoard objects when she/he did not do so before?	Yes No	1 2 3
Explain:		
Has the person developed simple repetitive behaviors or compulsions?	Yes No	1 2 3
Explain:		

Has the person recently developed trouble regulating smoking, alcohol, drug intake or gambling, or started shoplifting?	Yes	No	1	2	3
Explain:					
This section describes the ability to follow social norms and having social graces, tact, and empathy					
Has this person become less concerned about how her/his words or actions affect others? Has she/he become insensitive to others' feelings?	Yes	No	1	2	3
Explain:					
Has the person started talking openly about very personal or private matters not usually discussed in public?	Yes	No	1	2	3
Explain:					
Does the person say rude or crude things or make lewd sexual remarks that she/he would not have said before?	Yes	No	1	2	3
Explain:					
Does the person seem to lack the social judgement she/he previously had about what to say or how to behave in public or private?	Yes	No	1	2	3
Explain:					

Does the person now talk to strangers as if familiar, or intrude on their activities?	Yes	No	1	2	3
Explain:					
This section describes strongly held beliefs and sensory experiences					
Has the person developed beliefs that they are in danger, or that others are planning to harm them or steal their belongings?	Yes	No	1	2	3
Explain:					
Has the person developed suspiciousness about the intentions or motives of other people?	Yes	No	1	2	3
Explain:					
Does she/he have unrealistic beliefs about her/his power, wealth, or skills?	Yes	No	1	2	3
Explain:					
Does the person describe hearing voices or does she/he talk to imaginary people or "spirits"?	Yes	No	1	2	3
Explain:					

Does the person report or complain about, or act as if seeing things (e.g. people, animals, or insects) that are not there, i.e., that are imaginary to others?	Yes No	1 2 3
Explain:		