For my first site evaluation, I presented a case of a 54-year-old male with a history of bipolar I disorder, PTSD, and substance use disorder who was admitted for worsening depression and active suicidal ideation. The patient reported that although depression is a baseline part of his life, over the past week he developed increasingly severe suicidal thoughts with a plan to walk into oncoming traffic. Although the patient was adherent to his medications, he was faced with stressors like social isolation and limited support systems that contributed to his overall decline in functioning. I chose this case because it was a patient I had built rapport with, which made the experience feel more personal and showed me how much trust can influence what patients are willing to share, especially around sensitive topics like suicidality. My evaluator noted that my differential diagnosis and management plan were appropriate, but they suggested that I could further strengthen my assessment by incorporating more collateral information when available.

For my second site evaluation, I presented a case of a 33-year-old male with a history of schizophrenia, substance use disorder, and significant medical complications (urinary and fecal incompetence) from a prior severe suicide attempt. He was admitted after presenting to the psychiatric emergency department with an acute psychotic episode in the setting of medication nonadherence. I chose this case because it really stood out to me how quickly and dramatically a patient's condition can decompensate when medications are stopped, especially in someone with a long history of severe psychotic illness. This case was also a rather interesting one because the patient's delusions were so fixed that they directly influenced him to travel from the opposite side of the country to NYC in search of his "online" girlfriend. My evaluator didn't suggest any major changes to my differentials and plan but recommended that the patient is better suited in a nursing facility rather than discharge back to the community.

For my journal article, I focused on the impact of THC and CBD in individuals with schizophrenia, specifically looking at how cannabis-derived compounds may influence psychotic symptoms and cognition. I chose this article because I noticed that during my rotation many of the patients that I saw with schizophrenia had a significant history of cannabis use, often starting at an early age. This pattern made me curious about whether cannabis use was simply correlated to schizophrenia severity. The article concluded that THC is consistently associated with worsening psychotic symptoms and cognitive impairment, while CBD appears to be better tolerated and has emerging evidence for potential antipsychotic effects. The latter part really stood out to me because if CBD could somehow be fully isolated from cannabis, then it can be used as a future adjunct to treat schizophrenia. Overall, this article helped me better understand the complex relationship between cannabis use and psychotic disorders and gave me a clearer perspective on why substance use is so important to assess in this population.