University of Hawaii
Department of Psychiatry

John A. Burns School of Medicine

3rd YEAR MEDICAL STUDENT PSYCHIATRY CLERKSHIP HANDBOOK

(Available online at http://blog.hawaii.edu/dop/)

2014-2015

3rd YEAR PSYCHIATRY CLERKSHIP HANDBOOK
TABLE OF CONTENTS

Highly Recommended Reading Materials:

WELCOME TO PSYCHIATRY!
THIRD YEAR PSYCHIATRY CLERKSHIP (2014-2015)

Psychiatry is the medical specialty involving the diagnosis and treatment of mental illnesses. Psychiatrists care for medical conditions that affect those things that make us human – for example, how we think, how we feel, how we behave, and how we relate with others. For this reason, many believe that psychiatry is a particularly "stressful" specialty – because it seems to "hit so close to home" as our own emotions are engaged. However, an important part of training in psychiatry is learning how to appropriately handle such emotions and, in fact, to skillfully use them for the therapeutic benefit of not just "psychiatric" patients but also patients with general medical conditions. Through increasing our skill in recognizing and managing these emotions (which otherwise might catch us "off guard"), such training, properly applied, can actually help prevent the emotional "burnout" which could arise from caring for patients in any medical specialty. Most of us chose medicine as a career because we want to help people by relieving their suffering. Those of us who chose psychiatry have found a richly rewarding career that enables us to truly address all aspects of a patient's well being.

"The stereotype of the `bearded analyst' sitting by the couch is obsolete. While psychoanalysis is still practiced, most psychiatrists today are not analysts. Rather, today's psychiatrist provides a wide range of biological, psychotherapeutic, and psychosocial treatments that are tailored to the specific needs of the patient. The psychiatrist also serves as the medical expert for the mind/brain/body interface." (American Psychiatric Association "Careers in Psychiatry")

The goal of the seven-week clerkship in Psychiatry is to provide students with a basic clinical experience in the assessment and treatment of patients with psychiatric disorders. Students will learn to assess and treat patients based upon a bio-psycho-social-cultural framework (sort of like the biological, behavioral, and populational perspectives of PBL). Students will gain experience in treating a broad spectrum of acute and chronic psychiatric disorders, and will gain familiarity with multiple treatment modalities, including pharmacotherapy, psychotherapy, and use of community resources.

<u>So why study psychiatry?</u>

- Mental health conditions are common.
    - An estimated 22.1% of Americans age 18 and older (44.3 million people) suffer from a diagnosable mental disorder in a given year (NIMH, 2002)
    - According to the Surgeon General's report, 20% of children and adolescents have a mental health condition resulting in impairment (reviewed, AACAP, 2000).
- Mental health conditions are a significant cause of morbidity.
    - Leading cause of morbidity worldwide, surpassing other general medical disorders (WHO)
    - Depression, anxiety and somatoform disorders are associated with significant impairments in health-related quality of life – even relative to other "medical" conditions such as diabetes, arthritis, and cardiac disease (Spitzer et al, 1995).
- Mental health conditions are a significant cause of mortality.
    - Top leading causes of death among adolescents and young adults: accidents, homicide, and suicide; among children and adolescents ages 1-19 years, these three are the 1st, 2nd, and 3rd leading causes of death (MacDorman et al, 2002).
    - Improving access to mental health care is an important priority for violence prevention in youth (Commission for the Prevention of Youth Violence, 2001)
    - 3-5 times increase in mortality in patients who have recently had a myocardial infarction who have comorbid depression (Frasure-Smith and Penninx, 2001)
- Psychiatry is useful for all medical specialties.
    - Many patients with psychiatric symptoms on medical and surgical services can have life-threatening conditions: e.g., alcohol withdrawal, subdural hematomas, hemorrhages near the brainstem.
    - Psychiatric disorders predict length of hospital stay and medical readmission (Levitan and Kornfeld, 1981).

- Psychiatry is a much-needed specialty, based on workforce demands.
    - For example, the current supply of 6300 child psychiatrists is anywhere from 4000 to 24000 short of what's actually needed (reviewed, AACAP, 2000).
    - Federal designations for mental health shortage areas (just like primary care shortage areas).
- There's a lot of scientific evidence (e.g., randomized, controlled, double-blinded studies) that psychiatric treatment is indeed effective. "Evidence-based psychiatry" has come of age.
    - Anti-depressants and specific psychotherapies for major depression, panic disorder, obsessive-compulsive disorder; specific treatment for almost any other mental health condition.
    - Rates of success (substantial symptom reduction or remission) for psychiatric illnesses surpass those of some common medical procedures (e.g., 60%, 60-65%, and 80% for schizophrenia, depression, and panic disorder, respectively, versus 40% and 50% for angioplasty and atherectomy, respectively) (National Mental Health Advisory Council, 1993).

<u>"Dr. Dan's and Dr. Tony's top 5 reasons for you to do well in your psychiatry clerkship:"</u>

- You'll take better care of your patients – whether you go into psychiatry or not; whether you practice in an urban or rural setting.
- You may like it – and find a career that you'll be happy with for the rest of your life.
- You can get good evaluations – which help you when you apply for residency in any specialty.
- You'll meet a lot of potentially good mentors – who can help you even beyond the clerkship.
- Because you'll be better rested (e.g. not on overnight call every 4th night), this is the best time to focus upon the quality of your interactions with patients.

At the beginning of the rotation, you will be given week-specific schedules, which we hope will be helpful. However, please keep in mind that schedules may need to be flexible depending on patient care needs and other special educational activities – always consult with your supervising residents/attendings.

DEPARTMENT PHILOSOPHY ON MEDICAL STUDENT WORKLOAD:

1. A detailed schedule of recommended independent study times will be provided to each student that will reflect their specific educational schedule during their rotations at Queen's Medical Center.
2. The student clinical work-load will not exceed 80-hours/week averaged over the 7-week clerkship rotation.
3. The student's individual schedule will reflect 1-day off (or without clinical responsibility) in a 7-day period during their educational clerkship experience in psychiatry.

CLERKSHIP COMPONENTS and SPECIFIC RESPONSIBILITIES

The "big picture"

Inpatient acute general hospital psychiatry at Queen's Medical Center (7 weeks)						
Outpatient adult psychiatry						
On-call/emergency psychiatry (7 weeks)						
Orientation	Tutorial introduction/ PBL Case 1	PBL Case 2	PBL Case 3	PBL Case 4	PBL Case 5	Wrap-up
			T-Res logs due			T-res logs due
			Mid-Course Evaluation			Experiences checklist due
			CSV & Write-up due			
			Mid-term exam			NBME exam
			& review			

INPATIENT PSYCHIATRY

Students will be assigned to:

1. One general hospital setting at the Queen's Medical Center (QMC) or Kapiolani Medical Center for Women and Children (KMCWC) for 3-1/2 weeks and to a different general hospital setting at the Queen's Medical Center (QMC) or KMWCW for the remaining 3-1/2 weeks.

QMC – basic principles to help orient you:

1. On your first day on-site, find out which resident and which attending you are working with, and make sure you make contact with them.
2. Attend "Morning Report" at 8:00 am on Mondays , Tuesdays, Wednesdays and Thursdays (**NOTE:** times may vary – please check the Morning Report Schedule posted on the UT 413 door)
3. At some point, watch ECT, usually performed by Dr. Barry Carlton, or Dr. Steven Williams on Mondays, Wednesdays, and Fridays. To schedule a day/time, please page the doctors at least one day in advance. (see contact information sheet for pager numbers)
4. While at QMC, and if there are no competing obligations, you're welcome to attend (optional) neurology conferences every 4th Thursday at 12:30pm (specifics can be obtained from the UH Department of Medicine).

At QMC, you will be assigned to one of the following services:

A1. QMC/Kekela — DME: Dr. Barry Carlton
Faculty: Steven Williams, Gretchen Gavero, Residents and staff.

Basically, attend team care activities along with your assigned resident and attending.

A2. QMC/Consult-Liaison — Consult-Liaison Psychiatry Director: Dr. June Lee
Other faculty: Drs. Junji Takeshita, Brett Lu, Jon Streltzer, Residents and staff

1. Functioning as part of the consultation-liaison team, evaluate and manage psychiatric problems occurring among patients in the medical/surgical units at the Queen's Medical Center's. There will be exposure to geriatric psychiatry, substance abuse treatment, and HIV.
2. The rotation may also include an experience at the chronic pain clinic at the Queen Emma Clinics (outpatient specialty clinic).
3. On the morning of the first day of rotation, Dr. Lee or designee will go over the schedules, responsibilities, and requirements of the rotation.
4. Students from other services (e.g., Kekela, Emergency Room) who are interested in learning more about consultation-liaison psychiatry are encouraged to take a "field trip" (as allowed by their main service) to the consultation-liaison service, which makes daily teaching rounds. You may contact the consultation-liaison resident and/or attending (you may meet them in morning report).

A3. Queen's Emergency Department / Brief Treatment Unit (BTU - Kekela Mauka) - Director: Dr. Junji Takeshita; Faculty: Dr. Joy Andrade, other Residents and staff

1. Student will work primarily with ED/BTU faculty, residents and staff
2. Attend morning sign-in rounds at Queen's Medical Center; review daily schedule with faculty and residents,
3. If there is significant "down time" in the emergency room or BTC, and with permission from the emergency room and BTU resident and/or attending, the student may page the Queen's consult-liaison resident to see if there are opportunities to do consultations.
4. The goals and objectives of this experience are:
   (1) To observe and experience how patients are triaged, assessed and treated in the emergency room.
   (2) To observe a spectrum of behavioral symptoms associated with psychiatric conditions.

(3) To have hands-on experience in the assessment and treatment of patients with psychiatric emergencies.

A4. QMC Geriatric service Faculty: Drs.Junji Takeshita, Dr. Brett Lu and Geri Psych resident

1. The student will work primarily with the QMC geriatric psychiatry fellow and supervising geriatric psychiatry faculty.
2. The main experiences will be in the QMC Consult-Liaison Service and other inpatient, outpatient, and emergency sites where the geriatric team provides consultations.

A5. QMC Family Treatment Center (Child & Adolescent Psychaitry) Faculty: Dr. Barry Carlton, Dr. Diane Zuniga, Dr. Deborah Kissinger, Dr. Shaylin Chock, Child & Adolescent psychiatry residents, and staff

1. The student will work primarily with the child & adolescent resident or general psychiatry resident assigned to the family treatment center (FTC).
2. Attend morning sign-in rounds at the FTC.
3. Follow assigned patients with resident and faculty.

A6. KMCWC (Consult-Liaison child and adolescent psychiatry) - Faculty: Dr. Roshni Koli, Dr. Tony Guerrero, other faculty, child and adolescent psychiatry fellows and staff

1. The student will work primarily with the child & adolescent resident or general psychiatry resident assigned to KMCWC.
2. Attend treatment team meetings and clinical rounds at KMCWC.
3. Follow assigned patients with resident and faculty.

Write-up requirements for all sites:

You are required to submit **one (1)** typed write-up on patients from your Clinical Skills Verification (CSV) interview.

- An example of a psychiatry write up is provided for you on page 242 in Dr. Guerrero's, "Problem-Based Behavioral Science & Psychiatry-Chapter 17: Basic Principles of Evaluation: Interviewing, Mental Status Examination, Differential Diagnosis, and Treatment."

OUTPATIENT PSYCHIATRY

Through this half-day per week experience during your rotation at QMC, you will be exposed to evaluation and treatment of outpatients in clinic settings. Please refer to your individual schedules, where you will find the specific times when you are assigned to the outpatient sites.

The physicians you may be working with are:

- Kapi'olani Medical Center for Women and Children – Dr. Tony Guerrero or designee
- Queen's Counseling and Clinical Services – Dr. Jon Streltzer, Dr. Gretchen Gavero or designee
- Telemental Health (TMH) – Drs. Dan Alicata, Amanda Schroepfer, Joy Andrade, child and adolescent psychiatry fellows and staff (Riki Tanabe).
- Geriatric Psychiatry Nursing Home visits – Dr. Brett Lu or designee and Geri Resident/Psychiatry Resident.

ON-CALL/EMERGENCY PSYCHIATRY

The goals and objectives of this experience are:

(4) To observe and experience how patients are triaged, assessed and treated in the emergency room.

(5) To observe a spectrum of behavioral symptoms associated with psychiatric conditions.
(6) To have hands-on experience in the assessment and treatment of patients with psychiatric emergencies.

Students will report at 5:00 pm – 8:00 pm Monday – Friday. In general, the following procedure should be followed:

1. Page the psychiatry resident on-call and introduce yourself.
2. The resident will instruct you on what he or she expects of you during the course of the evening. You must have your beeper on at all times so that you can be paged if a patient comes into the emergency room. If okay with your resident, you may go to the medical library or any other place on the hospital grounds while you are on-call.
3. Upon leaving, notify your resident and return the beeper to Communications.
4. Make sure you give the Emergency Room evaluation form to your resident and/or attending.

*NOTE: Please do not report before 5:00 pm for call.

REMEMBER: Never see a patient without first clearing it with your resident. There are people who come into the emergency room who are violent.

Going home after call:

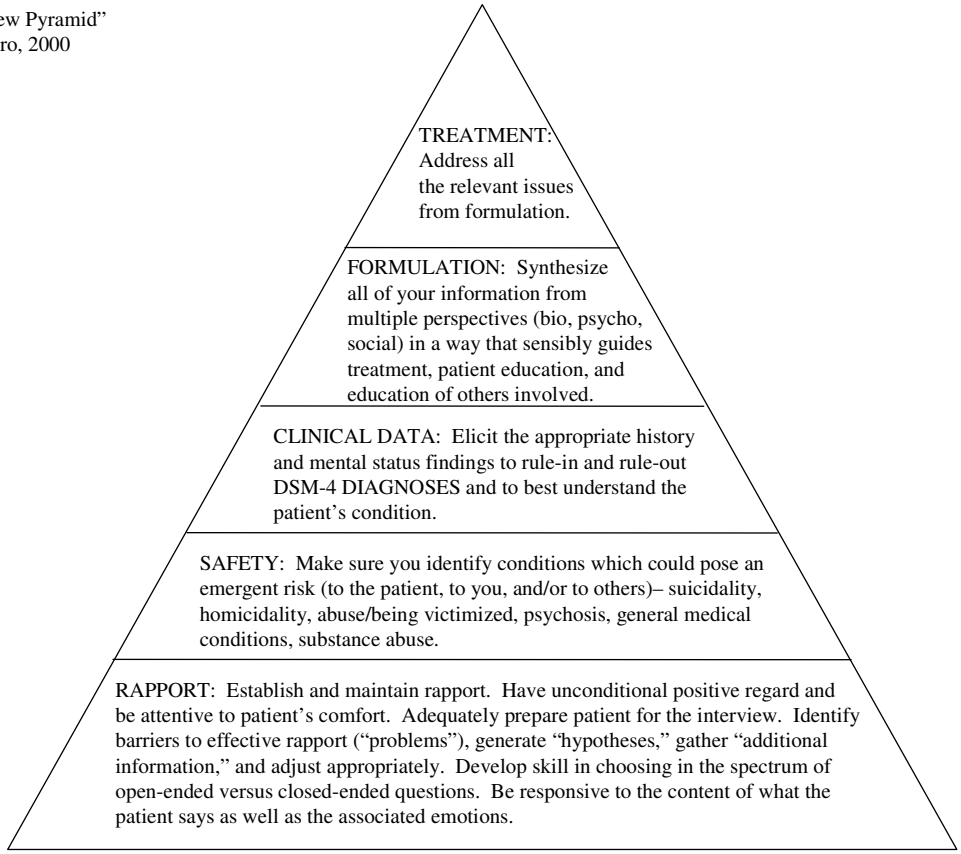
Because overnight call is not required, you may be going home after the sun has set. **Your safety is our concern.** Indeed, in a specialty where we always emphasize the safety of patients and others, we must also be concerned about your safety as student physicians. Unfortunately, the hospital has not been able to provide parking for medical students, and while this issue is being further investigated by medical school administration, we can offer the following suggestions:

1. Your call schedule will be distributed within the first few days of this rotation. With advance notice, you may want to make arrangements to be dropped off and picked up on those days.
2. If you need to walk back to your car and feel unsafe, you may page security to escort you. There may be a waiting time (should be a reasonable waiting time) if the security guards are handling an emergency in the hospital.
3. If there are absolutely no other options and you are feeling unsafe, please page me (or the faculty member covering for if I'm out-of-town), but we'd urge you to first try the other options listed above. Our pager numbers are: 363-1646 (Dr. Alicata) and 363-1243 (Dr. Guerrero).

PARKING FOR CLERKSHIP:

1. Unfortunately No parking is available at The Queen's Medical Center (for University Tower, Kekela, C/L, ER, FTC, Geri Psych) – Parking should be sought in the residential areas around the hospital. If you choose to park in any of the QMC garages, you will be responsible for any fees.
2. Parking is available at Kaheiheimalie Building while on rotation there for Day Treatment Service or Queen's Counseling Services (QCS). Note: If you park and leave, you may be towed.

"The Interview Pyramid"
Tony Guerrero, 2000



Articles that may be helpful for the interview case conference are provided in Appendix D. Another useful reference for the psychiatric interview is: Boarding Time: a Psychiatry Candidate's Guide to Part II of the ABPN Examination, by Morrison and Munoz.

OTHER IMPORTANT RESPONSIBILITIES

Follow dress code guidelines (please see section 9a: "Dress Code for Department of Psychiatry Dress Code policy)

> **Inappropriate Attire: Low cut jeans or necklines; see-through or revealing clothing; bare midriff crop-tops and tank tops. Skirts or culottes defined as shorter than four (4) inches above the knee.**

Follow Learning Resource Center rules (please see section 9b: "Welcome to the Department of Psychiatry Learning Resource Center (LRC)")
Respect confidentiality, including the confidentiality of computerized medical records (please see section 9c: "Confidentiality: Computers [AMA]")
For those on Kekela or Family Treatment Center (FTC) rotations: Obtain keys from Ms. Dana Iida

Department of Psychiatry Dress Code Policy for Medical Students, Residents, and Faculty Revision (2009-2010)

Purpose: To insure that the DOP Dress Code Policy is consistent with the dress code of sponsoring medical centers and to provide guidelines for attire that is safe, respectful and appropriate for the psychiatry settings in which you will be working..

X. DRESS CODE

Having appropriate dress and appearance is an important part of the professionalism competency. The dress code is applicable when you are in / at any training/work facilities and is in force during all working hours and during training activities, e.g., case conference, grand rounds, etc. This code is intended to describe the minimum standards of appropriate dress, and the standards of conservativeness may be exceeded by those of the medical center where you are assigned (e.g., QMC, HPH, HSH/DOH, VA, etc.), in which case the medical center's standards need to also be followed.

If you need to change clothes, please do this discreetly, in a restroom or call-rooms (QE Tower, 8th Floor). Residents should avoid walking through patient care / contact areas, including waiting rooms if you are not dressed appropriately and need to change into your work clothes.

Overly revealing clothing is inappropriate and therefore not allowed. This is defined as but not limited to the following: blouses with plunging necklines, mini-skirts, see-through clothing, tights, and low-cut pants.

Shoes:

- Dress sandals and shoes
- No slippers (flip-flops, thongs)

Pants:

- Dress pants, casual pants;
- Jeans are not acceptable
- No shorts

Shirts:

- Collared shirts
- No T-shirts
- Scrubs should be donned only in areas requiring their use (e.g., the ED). When post-call, make an effort to change out of scrubs prior to working the next day.

Miscellaneous:

- Any visible tattoos that could be considered offensive or inflammatory must be appropriately covered with clothing.

Approved:

_____

Naleen N. Andrade, M.D. date
Chair

_____

Anthony P. S. Guerrero, M.D. date
Associate Chair for Education and Training

Welcome to the Department of Psychiatry Learning Resource Center (LRC)

- For use by psychiatry residents and medical students who are on a psychiatry rotation. All other medical students should report to their respective departments for appropriate facilities for computer access on the medical center campus.

- Available 24 hour / 7 day a week.

- Books are for use in the LRC only and may be accessed through the list of library resources located in the LRC. Borrowing these items is not allowed, however photocopies are allowed.

- A list of LRC resources is available in print in the LRC and on New Innovations > Department Manuals > Library Resources > Learning Resource Center (LRC) Book List.

- Journals are available electronically through the John A. Burns School of Medicine (JABSOM) Health Sciences Library and the Hawaii Medical Library (HML) located on the QMC grounds. These resources can be accessed either on-line or on-site. Instructions for accessing these resources is available on New Innovations > Department Manuals > Library Resources > JABSOM Health Sciences Library – How to Access Full Text Articles and Ebooks.

- For trouble shooting access to JABSOM electronic resources, contact Anthony Guerrero, M.D., Associate Chair of Education at guerreroa@dop.hawaii.edu

- DVDs of past Visiting Professors and Grand Rounds Presentations are also available and can be signed out with the General Psychiatry / CME Administrative Assistant. A list of DVDs is available on New Innovations > Department Manuals > Library Resources > DVDs List (Past VPs and Grand Rounds Presentations)

- Computer terminals are available for use. Please do not change settings or install software programs or save anything on the hard drives. Anything that is saved on the hard drive may be modified and / or deleted without notice. Close all programs and log off of the computer before leaving. Any requests to install or troubleshoot software must be made to Tim Unten, IT Administrator untent@dop.hawaii.edu

Please contact Cheryl Halvorson, Program Administrator if you have any questions halvorsonc@dop.hawaii.edu or 586-2903.

E-5.07 Confidentiality: Computers.

The utmost effort and care must be taken to protect the confidentiality of all medical records, including computerized medical records.

The guidelines below are offered to assist physicians and computer service organizations in maintaining the confidentiality of information in medical records when that information is stored in computerized data bases:

(1) Confidential medical information should be entered into the computer-based patient record only by authorized personnel. Additions to the record should be time and date stamped, and the person making the additions should be identified in the record.

(2) The patient and physician should be advised about the existence of computerized data bases in which medical information concerning the patient is stored. Such information should be communicated to the physician and patient prior to the physician's release of the medical information to the entity or entities maintaining the computer data bases. All individuals and organizations with some form of access to the computerized data bases, and the level of access permitted, should be specifically identified in advance. Full disclosure of this information to the patient is necessary in obtaining informed consent to treatment. Patient data should be assigned a security level appropriate for the data's degree of sensitivity, which should be used to control who has access to the information.

(3) The physician and patient should be notified of the distribution of all reports reflecting identifiable patient data prior to distribution of the reports by the computer facility. There should be approval by the patient and notification of the physician prior to the release of patient-identifiable clinical and administrative data to individuals or organizations external to the medical care environment. Such information should not be released without the express permission of the patient.

(4) The dissemination of confidential medical data should be limited to only those individuals or agencies with a bona fide use for the data. Only the data necessary for the bona fide use should be released. Patient identifiers should be omitted when appropriate. Release of confidential medical information from the data base should be confined to the specific purpose for which the information is requested and limited to the specific time frame requested. All such organizations or individuals should be advised that authorized release of data to them does not authorize their further release of the data to additional individuals or organizations, or subsequent use of the data for other purposes.

(5) Procedures for adding to or changing data on the computerized data base should indicate individuals authorized to make changes, time periods in which changes take place, and those individuals who will be informed about changes in the data from the medical records.

(6) Procedures for purging the computerized data base of archaic or inaccurate data should be established and the patient and physician should be notified before and after the data has been purged. There should be no mixing of a physician's computerized patient records with those of other computer service bureau clients. In addition, procedures should be developed to protect against inadvertent mixing of individual reports or segments thereof.

(7) The computerized medical data base should be on-line to the computer terminal only when authorized computer programs requiring the medical data are being used. Individuals and organizations external to the clinical facility should not be provided on-line access to a computerized data base containing identifiable data from medical records concerning patients. Access to the computerized data base should be controlled through security measures such as passwords, encryption (encoding) of information, and scannable badges or other user identification.

(8) Back-up systems and other mechanisms should be in place to prevent data loss and

downtime as a result of hardware or software failure.

(9) Security: (a) Stringent security procedures should be in place to prevent unauthorized access to computer-based patient records. Personnel audit procedures should be developed to establish a record in the event of unauthorized disclosure of medical data. Terminated or former employees in the data processing environment should have no access to data from the medical records concerning patients.

(b) Upon termination of computer services for a physician, those computer files maintained for the physician should be physically turned over to the physician. They may be destroyed (erased) only if it is established that the physician has another copy (in some form). In the event of file erasure, the computer service bureau should verify in writing to the physician that the erasure has taken place. (IV) Issued prior to April 1977; Updated June 1994 and June 1998.

prev / next
Policy number

Search Tips | New Search

EDUCATIONAL GOALS OF THE PSYCHIATRY CLERKSHIP

Attitudes	**Main educational experiences**
1. To be empathetic and professionally responsible towards patients with with mental health needs (ADMSEP XXIII)	Bedside teaching, modeling, and mentorship; meaningful contribution to patient care
2. To respectfully collaborate with others involved in patient care (XXII)	Bedside teaching, modeling, and mentorship; meaningful contribution to patient care
Skills	
1. To establish and maintain rapport with patients in various contexts, and to manage emotions which arise in the course of patient care (III)	Bedside teaching, modeling, and mentorship; meaningful contribution to patient care Outpatient care
2. To assess for conditions which could threaten the safety of the patient or others (V)	Bedside teaching, modeling, and mentorship; meaningful contribution to patient care Patient care in the emergency setting
3. To perform a comprehensive history and mental status examination with application of the principles of problem-based learning (I) 4. To generate broad-based differential diagnoses for psychiatric symptoms (II)	Bedside teaching, modeling, and mentorship; meaningful contribution to patient care PBL cases Bedside teaching, modeling, and mentorship; meaningful contribution to patient care PBL cases
5. To identify the biological, psychological, social, and cultural factors which influence a patient's presentation, and to apply knowledge of such factors to patient care (IV, XXIII)	Bedside teaching, modeling, and mentorship; meaningful contribution to patient care Videotape conferences
6. To document and communicate information effectively (I)	Bedside teaching, modeling, and mentorship; meaningful contribution to patient care
7. To access resources needed to manage patients with psychiatric conditions (XIX, XXIII)	Bedside teaching, modeling, and mentorship; meaningful contribution to patient care PBL cases
8. To utilize the medical literature for the benefit of patients with psychiatric conditions (XXIII)	PBL cases Bedside teaching, modeling, and mentorship; meaningful contribution to patient care
Knowledge	
1. To be familiar with the knowledge outlined in the ADMSEP curriculum: cognitive, substance-related, psychotic, mood, anxiety, somatoform, Dissociative, eating, sexual, sleep, personality disorders (VI-XVI); child and adolescent and geriatric psychiatry (XVII-XVIII); psychopharmacology (XX); and psychotherapies (XXI)	Exposure to child/adolescent assessment Self-directed learning
2. To be familiar with the mental health needs and resources specific to the Hawai`i community.	PBL cases Outpatient care
3. To be familiar with the scope and practice of psychiatry (XXIII)	Bedside teaching, modeling, and mentorship; meaningful contribution to patient care

(Roman numerals refer to ADMSEP objectives)

So how do these fit goals fit with the clerkship components?

Clerkship components	**Core educational experiences**
1. Inpatient psychiatry	Bedside teaching, modeling, and mentorship Meaningful contribution to patient care
2. Outpatient psychiatry 3. Child and adolescent psychiatry	Exposure to face-to-face outpatient care Exposure to child/adolescent patient assessment via live and paper cases
4. Emergency psychiatry 5. PBL tutorials and videotape case conferences	Patient care in the emergency setting (on-call) Study of PBL cases Self-directed study Group discussion of videotaped student interviews

Much of the "knowledge" in psychiatry would be covered in your PBL tutorials. In practical terms, we suggest that you keep in mind the basic themes and categories in psychiatry – you can refer to the "objectives for the junior psychiatry clerkship" and also the USMLE Step 2 content description (but don't become "boards-oriented"). It also helps to find a good basic text that you can reasonably get through.

APPENDIX 1. Objectives for the junior psychiatry clerkship

Members of the Association of Directors of Medical Student Education in Psychiatry's Clerkship Objectives Committee:

Amy C. Brodkey, M.D., Chairperson
Irwin Hassenfeld, M.D., Myrl R.S. Manley, M.D., Deborah C. Roth, D.O., Kristin Van Zant, M.D., Michael Weissberg, M.D., Frederick S. Sierles, M.D., *ex officio*

I. PSYCHIATRIC HISTORY, PHYSICAL, AND THE MENTAL STATUS EXAMINATION

Overall Goal

By the end of the clerkship, the student will demonstrate the ability to obtain a complete psychiatric history, recognize relevant physical findings, and perform a complete mental status examination.

Specific Objectives

The student will be able to

1) elicit and clearly record a complete psychiatric history, including the identifying data, chief complaint, history of the present illness, past psychiatric history, medications (psychiatric and nonpsychiatric), general medical history, review of systems, substance abuse history, family history, and personal and social history;
2) recognize the importance of, and be able to obtain and evaluate, historical data from multiple sources (family members, community mental health resources, old records, etc.);
3) discuss the effect of developmental issues on the assessment of patients;
4) elicit, describe, and precisely record the components of the mental status examination, including general appearance and behavior, motor activity, speech, affect, mood, thought processes, thought content, perception, sensorium and cognition (e.g., state of consciousness, orientation, registration, recent and remote memory, calculations, capacity to read and write, abstraction), judgment, and insight;
5) use appropriate terms associated with the mental status examination;
6) for each category of the mental status exam, list common abnormalities and their common causes;
7) make a clear and concise case presentation;
8) assess and record mental status changes, and alter hypotheses and management in response to these changes;
9) recognize physical signs and symptoms that accompany classic psychiatric disorders (e.g., tachycardia and hyperventilation in panic disorder);
10) appreciate the implications of the high rates of general medical illness in psychiatric patients, and state reasons why it is important to diagnose and treat these illnesses;
11) assess for the presence of general medical illness in psychiatric patients, and determine the extent to which a general medical illness contributes to a patient's psychiatric problem; and
12) recognize and identify the effects of psychotropic medication in the physical examination.

II. DIAGNOSIS, CLASSIFICATION, AND TREATMENT PLANNING

Overall Goal

By the end of the clerkship, the student will be able to identify psychopathology, formulate accurate differential and working diagnoses, and develop appropriate assessment and treatment plans for psychiatric patients.

APPENDIX 1. Objectives for the junior psychiatry clerkship *(continued)*

Specific Objectives

Using his or her knowledge of psychopathology, diagnostic criteria, and epidemiology, the student will

1) discuss the advantages and limitations of using a diagnostic system like the DSM-IV;
2) use the DSM-IV in identifying specific signs and symptoms that compose a syndrome or disorder;
3) use the five axes of the DSM-IV in evaluating patients;
4) state the typical signs and symptoms of the common psychiatric disorders, such as major depression, anxiety disorders, bipolar disorder, dementia, delirium, schizophrenia, personality disorders, and substance use disorders;
5) formulate a differential diagnosis for major presenting problems;
6) formulate a plan for evaluation;
7) assess changes in clinical status and alter hypotheses and management in response to changes;
8) develop an individualized treatment plan for each patient; and
9) discuss the prevalence and barriers to recognition of psychiatric illnesses in general medical settings, including variations in presentation.

III. INTERVIEWING SKILLS

Overall Goal

By the end of the clerkship, the student will conduct an interview in a manner that facilitates information-gathering and formation of a therapeutic alliance.

Specific Objectives

The student will

1) explain the value of skillful interviewing for patient and doctor satisfaction and for obtaining optimal clinical outcomes;
2) demonstrate respect, empathy, responsiveness, and concern regardless of the patient's problems or personal characteristics;
3) identify his or her emotional responses to patients;
4) identify strengths and weaknesses in his or her interviewing skills;
5) discuss the prior perceptions (Objectives 3 and 4) with a colleague or supervisor to improve interviewing skill;
6) identify verbal and nonverbal expressions of affect in a patient's responses, and apply this information in assessing and treating the patient;
7) state and use basic strategies for interviewing disorganized, cognitively impaired, hostile/resistant, mistrustful, circumstantial/hyperverbal, unspontaneous/hypoverbal, and potentially assaultive patients;
8) demonstrate the following interviewing skills: appropriate initiation of the interview; establishing rapport; the appropriate use of open-ended and closed questions; techniques for asking "difficult" questions; the appropriate use of facilitation, empathy, clarification, confrontation, reassurance, silence, summary statements; soliciting and acknowledging expression of the patient's ideas, concerns, questions, and feelings about the illness and its treatment; communicating information to patients in a clear fashion; appropriate closure of the interview;

(continued)

APPENDIX 1. Objectives for the junior psychiatry clerkship (*continued*)

9) state and avoid the following common mistakes in interviewing technique: interrupting the patient unnecessarily; asking long, complex questions; using jargon; asking questions in a manner suggesting the desired answer; asking questions in an interrogatory manner; ignoring patient verbal or nonverbal cues; making sudden inappropriate changes in topic; indicating patronizing or judgmental attitudes by verbal or nonverbal cues (e.g., calling an adult patient by his or her first name, questioning in an oversimplified manner, etc.); incomplete questioning about important topics; and

10) demonstrate sensitivity to student-patient similarities and differences in gender, ethnic background, sexual orientation, socioeconomic status, educational level, political views, and personality traits.

IV. DIAGNOSTIC TESTING[18]

Overall Goal

By the end of the clerkship, the student will use laboratory testing, imaging tests, psychological tests, and consultation to assist in the diagnosis of persons with neuropsychiatric symptoms.

Specific Objectives

The student will

1) state the indications for, and limitations of, the tests that are used to evaluate the neurophysiologic functioning of persons with neuropsychiatric symptoms (e.g., thyroid function tests, electroencephalogram, rapid plasmin reagin test, dexamethasone suppression test, toxicologies, testing for the human immunodeficiency virus [HIV]);

2) discuss the use of, and indications for, neuroimaging in psychiatry;

3) summarize the similarities and differences between neuropsychological and other psychological testing, and state indications for each;

4) list the psychiatric medications that require blood level monitoring and discuss the indications for blood level monitoring for these medications; and

5) state the electroencephalogram correlates of neuropsychiatric disorders.

V. PSYCHIATRIC EMERGENCIES[18]

Overall Goal

By the end of the clerkship, the student will assess and begin emergency management and referral of a person with neuropsychiatric symptoms.

Specific Objectives

The student will

1) identify the clinical and demographic factors associated with a statistically increased risk of suicide in general and clinical populations;

2) develop a differential diagnosis, conduct a clinical assessment, and recommend management for a patient exhibiting suicidal thoughts or behavior;

3) recognize the clinical findings that might suggest a general medical cause for neuropsychiatric symptoms, such as hallucinations, delusions, confusion, altered consciousness, and violent behavior;

APPENDIX 1. Objectives for the junior psychiatry clerkship *(continued)*

4) discuss the clinical features, differential diagnosis, and evaluation of delirium, including emergent conditions;
5) recognize the typical signs and symptoms of common psychopharmacologic emergencies (e.g., lithium toxicity, neuroleptic malignant syndrome, anticholinergic delirium, monoamine oxidase inhibitor–related hypertensive crisis) and discuss treatment strategies;
6) recognize signs and symptoms of potential assaultiveness;
7) develop a differential diagnosis, conduct a clinical assessment, and state the principles of management of a person with potential or active violent behavior;
8) discuss classes, indications, and associated risks of medications used for management of acutely psychotic, agitated, and combative patients;
9) discuss the nonpharmacologic components of management of acute psychosis, agitation, and combativeness;
10) identify the indications, precautions, and proper use of restraints;
11) state the prevalence, morbidity, mortality, and risk factors associated with adult domestic violence in clinical and nonclinical populations;
12) discuss the physician's role in screening, diagnosing, managing, documenting, reporting, and referring victims of child abuse, adult domestic violence, and elder abuse;
13) list the psychiatric problems that are frequently seen in battered women and child abuse victims;
14) outline the emergency management of a rape victim;
15) discuss the indications for psychiatric hospitalization, including the presenting problem and its acuity, risk of danger to patient or others, community resources, and family support;
16) identify the problems associated with the use of the terms "medical clearance" and "psychiatric clearance";
17) discuss the clinical and administrative aspects of the transfer of a patient to another facility; and
18) summarize the process of admission to a psychiatric hospital, specifically a) the implications of voluntary vs. involuntary commitment status, b) the principles of civil commitment, and c) the process of obtaining a voluntary or involuntary commitment and the role of the physician in obtaining it.

VI. DELIRIUM, DEMENTIA, AND AMNESTIC AND OTHER COGNITIVE DISORDERS

Overall Goal

By the end of the clerkship, the student will recognize the psychiatric manifestations of brain disease of known etiology or pathophysiology, and will state the evaluation and initial management of these neuropsychiatric disorders.

Specific Objectives

The student will

1) recognize the cognitive, psychological, and behavioral manifestations of brain disease of known etiology, anatomy, or pathophysiology;
2) compare, contrast, and give examples of the following: delirium, dementia (including treatable dementia), dementia syndrome of depression (pseudodementia), cortical dementia, and subcortical dementia;
3) discuss the clinical features, differential diagnosis, and evaluation of delirium, including emergent conditions;
4) state the prevalence of delirium in hospitalized elderly patients;
5) discuss the behavioral and pharmacologic treatments of delirious patients;

(continued)

APPENDIX 1. Objectives for the junior psychiatry clerkship *(continued)*

6) discuss the epidemiology, differential diagnosis, clinical features, and course of Alzheimer's disease, vascular dementia, substance-induced persisting dementia, Parkinson's disease, and HIV encephalopathy;

7) list the treatable causes of dementia and summarize their clinical manifestations;

8) summarize the medical evaluation and clinical management of a patient with dementia;

9) discuss the diagnosis, differential diagnosis, and treatment of amnestic disorder that is due to general medical conditions (e.g., head trauma) and substance-induced conditions (e.g., Korsakoff's syndrome that is due to thiamine deficiency);

10) employ a cognitive screening evaluation to assess and follow patients with cognitive impairment, and state the limitations of these instruments;

11) state the neuropsychiatric manifestations of HIV-related illnesses; and

12) state the neuropsychiatric manifestations of seizure disorders, strokes, and head injuries.

VII. SUBSTANCE-RELATED DISORDERS

Overall Goal

By the end of the clerkship, the student will identify, clinically evaluate, and treat the neuropsychiatric consequences of substance abuse and dependence.

Specific Objectives

The student will

1) obtain a thorough history of a patient's substance use through empathic, nonjudgmental, and systematic interviewing;

2) list and compare the characteristic clinical features (including denial) of substance abuse and dependence;

3) discuss the epidemiology (including the effects of gender), clinical features, patterns of usage, course of illness, and treatment of substance use disorders (including anabolic steroids);

4) identify typical presentations of substance abuse in general medical practice;

5) list the psychiatric disorders that share significant comorbidity with substance-related disorders and discuss some criteria for determining whether the comorbid disorder should be treated independently;

6) discuss the role of the family, support groups, and rehabilitation programs in the recovery of patients with substance use disorders;

7) list the questions that compose the CAGE (test for alcoholism) questionnaire and discuss its use as a screening instrument;

8) discuss the genetic, neurobiological, and psychosocial explanations of the etiology of alcoholism;

9) list the psychiatric and psychosocial complications of alcoholism;

10) know the clinical features of intoxication with, and withdrawal from: cocaine, amphetamines, hallucinogens, cannabis, phencyclidine, barbiturates, opiates, caffeine, nicotine, benzodiazepines, and alcohol;

11) state the treatments of intoxication and withdrawal induced by the substances just listed;

12) list patient characteristics associated with benzodiazepine abuse;

13) state guidelines for prescribing benzodiazepines; and

14) discuss the difficulties experienced by health care personnel in providing empathic, nonjudgmental care to substance abusers.

APPENDIX 1. Objectives for the junior psychiatry clerkship *(continued)*

VIII. SCHIZOPHRENIA AND OTHER PSYCHOTIC DISORDERS

Overall Goal

By the end of the clerkship, the student will demonstrate proficiency in the recognition, evaluation, and management of persons with psychosis associated with schizophrenic, affective, general medical, and other psychotic disorders.

Specific Objectives

The student will

1) define the term *psychosis;*
2) develop a differential diagnosis for a person presenting with psychosis, including identifying historical and clinical features that assist in the differentiation of general medical, substance-induced, affective, schizophrenic, and other causes;
3) state the neurobiologic, genetic, and environmental theories of etiology and pathophysiology of schizophrenia;
4) summarize the epidemiology, clinical features, course, and complications of schizophrenia;
5) name the clinical features of schizophrenia that are associated with good and poor outcome, and explain the significance of negative symptoms;
6) summarize the treatment of schizophrenia, including both pharmacologic and psychosocial interventions; and
7) list the features that differentiate delusional disorder, schizophreniform disorder, schizoaffective disorder, and brief psychotic disorder from each other and from schizophrenia.

IX. MOOD DISORDERS

Overall Goal

By the end of the clerkship, the student will recognize, evaluate, and state the treatments for patients with mood disorders.

Specific Objectives

The student will

1) discuss evidence for neurobiological, genetic, psychological, and environmental etiologies of mood disorders;
2) state the epidemiologic features, prevalence rates, and lifetime risks of mood disorders in clinical and nonclinical populations;
3) compare and contrast the epidemiologic and clinical features of unipolar depression and bipolar disorders;
4) state the common signs and symptoms, differential diagnosis (including general medical and substance-induced disorders), course of illness, comorbidity, prognosis, and complications of mood disorders;
5) contrast normal mood variations, states of demoralization, and bereavement with the pathological mood changes that constitute depressive illness;
6) identify the difference in the presentation, treatment, and prognosis of major depression with and without melancholic features, psychotic features, atypical features, catatonic features, seasonal pattern, and postpartum onset;

(continued)

APPENDIX 1. Objectives for the junior psychiatry clerkship (*continued*)

7) compare and contrast the clinical presentations of mood disorders in children, adults, and the elderly;

8) describe some common presentations of depressive disorders in nonpsychiatric settings, define the term "masked depression," and develop an approach to evaluating and treating mood disorders in a general medical practice;

9) discuss the increased prevalence of major depression in patients with general medical-surgical illness (e.g., myocardial infarction, diabetes, cardiovascular or cerebrovascular accidents, hip fractures) and the impact of depression on morbidity and mortality from their illnesses;

10) discuss the identification and management of suicide risk in general medical settings;

11) outline the recommended acute and maintenance treatments for dysthymia, major depression, and bipolar disorders (manic and depressive phases); and

12) state the characteristics and techniques of the nonpharmacological treatments for depression, including psychotherapy, cognitive therapy, couples therapy, and phototherapy.

X. ANXIETY DISORDERS

Overall Goal

By the end of the clerkship, the student will recognize, evaluate, and state the treatments for patients with anxiety disorders.

Specific Objectives

The student will

1) summarize neurobiological, psychological, environmental, and genetic etiologic hypotheses for the anxiety disorders;

2) discuss the epidemiology, clinical features, course, and psychiatric comorbidity of panic disorder, agoraphobia, social phobia, specific phobias, generalized anxiety disorder, posttraumatic stress disorder, acute stress disorder, and obsessive-compulsive disorder;

3) distinguish panic attack from panic disorder;

4) list the common general medical and substance-induced causes of anxiety, and assess for these causes in evaluating a person with an anxiety disorder;

5) outline psychotherapeutic and pharmacologic treatments for each of the anxiety disorders;

6) compare and contrast clinical presentations of anxiety disorders in children and adults; and

7) discuss the role of anxiety and anxiety disorders in the presentation of general medical symptoms, the decision to visit a physician, and health care expenditures.

XI. SOMATOFORM AND FACTITIOUS DISORDERS

Overall Goal

By the end of the clerkship, the student will diagnose and discuss the principles of management of patients with somatoform disorders.

Specific Objectives

The student will

1) state the clinical characteristics of somatization disorder, conversion disorder, pain disorder, body dysmorphic disorder, and hypochondriasis;

APPENDIX 1. Objectives for the junior psychiatry clerkship *(continued)*

2) list the psychiatric disorders that have high comorbidity with somatoform disorders;

3) discuss the implications of the high rate of underlying general medical/neurologic illness in patients diagnosed with pain disorder and conversion disorder;

4) list the characteristic features of factitious disorder and malingering, and compare these with the somatoform disorders;

5) discuss the frequency and importance of physical symptoms as manifestations of psychological distress;

6) summarize the principles of management of patients with somatoform disorders; and

7) discuss difficulties physicians may have with patients with these diagnoses.

XII. DISSOCIATIVE AND AMNESTIC DISORDERS

Overall Goal

By the end of the clerkship, the student will define dissociation, state its psychological defensive role, and discuss the clinical syndromes with which it is associated.

Specific Objectives

The student will

1) list a differential diagnosis of psychiatric, substance-induced, and general medical conditions that may present with amnesia and discuss the evaluation and treatment of persons with amnesia;

2) state the clinical features of dissociative amnesia, dissociative fugue, depersonalization disorder, and dissociative identity disorder;

3) discuss the hypothesized role of psychological trauma, including sexual, physical, and emotional abuse, in the development of dissociative disorders (and posttraumatic stress disorders);

4) discuss the etiologic hypotheses, epidemiology, clinical features, course, and treatment of dissociative identity disorder; and

5) state the indications for an amobarbital interview and for hypnosis.

XIII. EATING DISORDERS

Overall Goal

By the end of the clerkship, the student will summarize the distinguishing clinical features, evaluation, and treatment of patients with eating disorders.

Specific Objectives

The student will

1) summarize the etiologic hypotheses, clinical features, epidemiology, course, comorbid disorders, complications, and treatment for anorexia nervosa;

2) summarize the etiologic hypotheses, clinical features, epidemiology, course, comorbid disorders, complications, and treatment for bulimia;

3) discuss the role of the primary care physician in the prevention and early identification of eating disorders; and

4) list the medical complications and indications for hospitalization in patients with eating disorders.

(continued)

APPENDIX 1. Objectives for the junior psychiatry clerkship *(continued)*

XIV. SEXUAL DYSFUNCTIONS AND PARAPHILIAS

Overall Goal

By the end of the clerkship, the student will summarize the process of evaluation and treatment of persons with sexual dysfunctions or paraphilias.

Specific Objectives

The student will

1) discuss the anatomy and physiology of the male and female sexual response cycles;
2) obtain a patient's sexual history, including an assessment of risk for sexually transmitted diseases, especially HIV;
3) state the implications of the high prevalence of sexual dysfunctions in the general population, particularly in the medically ill;
4) list the common causes of sexual dysfunctions, including general medical and substance-related etiologies;
5) summarize the manifestations, differential diagnosis, and treatment of hypoactive sexual desire disorder and sexual aversion disorder; male erectile disorder and female sexual arousal disorder; female and male orgasmic disorders and premature ejaculation; and dyspareunia and vaginismus;
6) define the term *paraphilia*;
7) list and define each of the common paraphilias;
8) review the management of the paraphilias; and
9) discuss the prevalence, manifestations, diagnosis, and treatment of gender identity disorder.

XV. SLEEP DISORDERS

Overall Goal

By the end of the clerkship, the student will evaluate, and refer or treat, persons with sleep problems.

Specific Objectives

The student will

1) describe normal sleep physiology, including sleep architecture, throughout the life cycle;
2) obtain a complete sleep history;
3) discuss the manifestations, differential diagnosis, evaluation, and treatment of primary sleep disorders, including dyssomnias and parasomnias;
4) describe typical sleep disturbances that accompany psychiatric and substance use disorders;
5) summarize the effect(s) of psychotropic medications on sleep; and
6) describe sleep hygiene treatment.

XVI. PERSONALITY DISORDERS

Overall Goal

By the end of the clerkship, the student will recognize maladaptive traits and interpersonal patterns that typify personality disorders, and discuss strategies for caring for patients with personality disorders.

APPENDIX 1. Objectives for the junior psychiatry clerkship (*continued*)

Specific Objectives

The student will

1) explain how the DSM-IV defines personality traits and disorders, and identify features common to all personality disorders;
2) list the three descriptive groupings (clusters) of personality disorders in the DSM-IV and describe the typical traits of each personality disorder;
3) summarize the neurobiological, genetic, developmental, behavioral, and sociological theories of the etiology of personality disorders, including the association of childhood abuse and trauma;
4) discuss the biogenetic relationships that exist between certain Axis I and Axis II disorders (e.g., schizotypal personality disorder and schizophrenia);
5) discuss the epidemiology, differential diagnosis, course of illness, prognosis, and comorbid psychiatric disorders in patients with personality disorders;
6) list the general medical and Axis I psychiatric disorders that may present with personality changes;
7) identify difficulties in diagnosing personality disorders in the presence of stress, substance abuse, and other Axis I disorders;
8) discuss the concepts of hierarchical levels of defense and regression under stress, and list typical defense mechanisms used in various personality disorders;
9) list the psychotherapeutic and pharmacologic treatment strategies for patients with personality disorders;
10) discuss the management of patients with personality disorders in the general medical setting; and
11) summarize principles of management of patients with personality disorders, including being aware of one's own response to the patient, soliciting consultations from colleagues when indicated, and using both support and nonpunitive limit setting.

XVII. CHILD AND ADOLESCENT PSYCHIATRY

Overall Goal

By the end of the clerkship, the student will summarize the unique factors essential to the evaluation of children and adolescents, and will diagnose the common child psychiatric disorders.

Specific Objectives

The student will

1) compare and contrast the process of psychiatric evaluation of children and adolescents at different developmental stages with that of adults;
2) state the value of obtaining data from families, teachers, and other nonphysicians in the evaluation and treatment of children and adolescents;
3) state the indications for psychological assessment in children and list some of the common tests in a psychometric evaluation;
4) list a differential diagnosis and outline the evaluation of academic performance and behavioral problems in children;
5) summarize the etiologic hypotheses, clinical features, epidemiology, pathophysiology, course, comorbid disorders, complications, and treatment for attention-deficit hyperactivity disorder and conduct disorder;
6) discuss the etiologies, epidemiology, clinical features, and psychiatric comorbidity of mental retardation;

(*continued*)

APPENDIX 1. Objectives for the junior psychiatry clerkship (*continued*)

7) name the major clinical features of autism;

8) differentiate developmentally based anxiety (e.g., stranger, separation anxiety) from pathological anxiety disorders in childhood;

9) describe typical clinical features of anxiety disorders at different developmental stages;

10) compare and contrast the clinical features of mood disorders in children with that of adults;

11) discuss the epidemiology and clinical features of suicide risk in adolescents;

12) state when and how a physician must protect the safety of a child who may be the victim of physical or sexual abuse or neglect; and

13) identify signs and symptoms of child sexual and physical abuse, and discuss its short- and long-term psychiatric sequelae.

XVIII. GERIATRIC PSYCHIATRY

Overall Goal

By the end of the clerkship, the student will evaluate and begin neuropsychiatric management of elderly patients.

Specific Objectives

The student will

1) employ a cognitive screening evaluation to assess and follow patients with cognitive impairment, and state the limitations of these instruments;

2) compare and contrast the clinical presentation of depression in elderly patients with that of younger adults;

3) summarize the special considerations in prescribing psychotropic medications for the elderly;

4) appreciate that multiple medications can cause cognitive, behavioral, and affective problems in the elderly;

5) compare, contrast, and give examples of the following: delirium, dementia (including treatable dementia), dementia syndrome of depression (pseudodementia), subcortical and cortical dementia;

6) state the prevalence of delirium in hospitalized elderly patients;

7) discuss the differential diagnosis, etiological hypotheses, epidemiology, clinical features, and course of Alzheimer's disease, vascular dementia, and Parkinson's disease;

8) summarize the assessment and treatment of a patient with dementia;

9) discuss the physician's role in diagnosing, managing, and reporting elderly victims of physical or sexual abuse; and

10) discuss the role of losses in the etiology of psychiatric disorders in the elderly.

XIX. COMMUNITY AND FORENSIC PSYCHIATRY

Overall Goal

By the end of the clerkship, the student will discuss the structure of the mental health system and legal issues important in the care of psychiatric patients.

Specific Objectives

The student will

1) define the term *catchment area*;

APPENDIX 1.· Objectives for the junior psychiatry clerkship (*continued*)

2) list the psychiatric services each community mental health center must provide;

3) define deinstitutionalization and discuss its effects on patients and on the community;

4) discuss the process of admission to a psychiatric hospital, specifically a) the implications of voluntary vs. involuntary commitment status; b) the principles of civil commitment; and c) the process for obtaining a voluntary or involuntary commitment and a physician's role in obtaining it;

5) summarize the elements of informed consent, determination of capacities (e.g., to consent to treatment, to manage funds), and the role of judicial or administrative orders for treatment;

6) discuss the duty to warn;

7) define the right to treatment and the right to refuse treatment;

8) discuss when and how a physician must protect the safety of a child or an elderly person who may be the victim of physical or sexual abuse or neglect;

9) discuss the economic impact of chronic mental illness on patients and their families, including the effect of discriminatory insurance coverage; and

10) discuss the financial and psychosocial burden of chronic mental illness to family members.

XX. PSYCHOPHARMACOLOGY

Overall Goal

By the end of the clerkship, the student will summarize the indications, basic mechanisms of action, common side effects, and drug interactions of each class of psychotropic medications and demonstrate the ability to select and use these agents to treat mental disorders.

Specific Objectives

Anxiolytics

The student will discuss

1) the indications, mechanism of action, pharmacokinetics, common side effects, signs of toxicity, and drug interactions of the different benzodiazepines and sedative-hypnotics;

2) the consequences of abrupt discontinuation;

3) patient characteristics associated with benzodiazepine abuse;

4) guidelines for prescribing benzodiazepines; and

5) the differences (mechanism of action, onset of effect, and indications) between buspirone and benzodiazepines.

Antidepressants

The student will summarize

1) the indications, mechanisms of action, pharmacokinetics, common or serious side effects (including overdose potential), signs of toxicity, and drug interactions of tricyclics, second generation (atypical) antidepressants, monoamine oxidase inhibitors, and selective serotonin reuptake inhibitors;

2) the pretreatment assessment and strategies of antidepressant use, including ensuring adequacy of trial and blood level monitoring;

3) the effect of antidepressants on the cardiac conduction system and electrocardiogram;

4) dietary and pharmacologic restrictions in prescribing a monoamine oxidase inhibitor; and

5) advantages of selective serotonin reuptake inhibitors.

(*continued*)

APPENDIX 1. Objectives for the junior psychiatry clerkship (*continued*)

Antipsychotics (neuroleptics)

The student will discuss

1) the indications, mechanisms of action, pharmacokinetics, common or serious side effects, signs of toxicity, and drug interactions of antipsychotics;

2) differences between high-potency and low-potency antipsychotics, including the side effects common to each group;

3) diagnosis and management of extrapyramidal side effects including acute dystonia, parkinsonism, akathisia, tardive dyskinesia, and neuroleptic malignant syndrome; and

4) the indications and special considerations in using clozapine and risperidone.

Mood Stabilizers

The student will discuss

1) the indications, mechanism of action, pharmacokinetics, side effects, signs of toxicity (neurological, gastrointestinal, renal, endocrine, cardiac), and drug interactions of lithium;

2) the pretreatment assessment and strategies of use of lithium, including blood level monitoring; and

3) the indications, mechanisms of action, pharmacokinetics, common and serious side effects, toxicity, drug interactions, and plasma level monitoring for carbamazepine, valproic acid, and calcium channel blockers.

Anticholinergics

The student will discuss

1) the indications, mechanisms of action, pharmacokinetics, common and serious side effects, signs of toxicity, and drug interactions of anti-parkinsonian agents;

2) which antidepressants and antipsychotics have a higher incidence of anticholinergic side effects;

3) special considerations in prescribing these medications in the elderly; and

4) the high prevalence of anticholinergics in over-the-counter medications.

Electroconvulsive Therapy (ECT)

The student will summarize

1) indications, physiologic effects, and side effects of ECT;

2) clinical situations in which ECT may be the treatment of choice;

3) pretreatment assessment, including conditions requiring special precautions; and

4) the medical care of the patient before, during, and after ECT treatment.

Other Topics

The student will discuss

1) the use of beta blockers in psychiatry and

2) the indications for and side effects of stimulants.

APPENDIX 1. Objectives for the junior psychiatry clerkship (*continued*)

XXI. PSYCHOTHERAPIES

Overall Goal

By the end of the clerkship, the student will understand the principles and techniques of the psychosocial therapies sufficient to explain to a patient and make a referral when indicated.

Specific Objectives

The student will

1) state the characteristics and techniques of, and common indications and contraindications for, psychodynamic psychotherapy, psychoanalysis, supportive psychotherapy, cognitive and behavioral therapies, group therapies, couples and family therapy, and psychoeducational interventions;
2) describe behavioral medicine interventions (e.g., relaxation training, assertiveness training, contingency management, stimulus control, relapse prevention, biofeedback) and know for which medical problems they are effective (e.g., smoking cessation) and ineffective;
3) define and begin to recognize transference, countertransference, and commonly used defense mechanisms; discuss the concepts of hierarchical levels of defense and regression under stress; and list some typical defense mechanisms used in various personality disorders;
4) state the major findings of studies of the efficacy of psychosocial interventions in the treatment of psychiatric and general medical disorders and in reducing health care costs; and
5) discuss techniques for increasing the likelihood of successful referral for psychotherapy.

XXII. COLLABORATION

Overall Goal

By the end of the clerkship, the student will work effectively with other health professionals.

Specific Objectives

The student will

1) participate as a member of a multidisciplinary patient care team;
2) summarize the special skills of a psychiatric nurse, psychologist, psychiatric social worker, and physician assistant;
3) demonstrate respect for, and appreciation of, the contributions of others participating in patient care;
4) participate in a family meeting with other members of the treatment team;
5) participate in discharge planning and referral of a patient to an ambulatory setting or to another inpatient facility;
6) request a consultation, in writing or by phone, from a practitioner of another specialty; and
7) work collaboratively in the care of a patient with nonpsychiatric physicians and health care teams from other specialties.

XXIII. ATTITUDES, PERSPECTIVES, AND PERSONAL DEVELOPMENT

Overall Goal

By the end of the clerkship, the student will demonstrate maturation in clinical and personal development.

(*continued*)

APPENDIX 1. Objectives for the junior psychiatry clerkship (*continued*)

Specific Objectives

The student will

1) summarize his or her strengths and weaknesses in interviewing skills, assessment, and management of persons with psychiatric disorders;
2) solicit, utilize, and provide constructive criticism;
3) demonstrate respect and empathy for patients, colleagues, and supervisors;
4) request consultation and supervision when knowledge, attitudes, or skills are insufficient for a given patient's care;
5) accept that some patients and colleagues are not cooperative and likable and that some patients and colleagues will not like the student;
6) perform clinical tasks (including soliciting assistance) under the pressure of difficult situations;
7) demonstrate comfort, concern, and responsibility in the care of psychiatrically ill persons;
8) obtain information from the psychiatric and general medical literature;
9) refute myths about psychiatric illness, psychiatric patients, psychiatric treatments, and mental health practitioners;
10) comment on the value of prompt and enthusiastic response to requests for consultation; and
11) discuss a patient incorporating multiple perspectives (i.e., biological, psychological, developmental, and social).

ADDENDUM

Sample Psychiatric Screens

Introduction

Attitudes toward psychiatry and psychiatric patients are often enhanced when students develop competence in interviewing patients about sensitive issues. The following psychiatric "screens" are useful in general medical practice. The psychiatry clerkship would be an appropriate time for students to learn these (or other) sets of questions. Some screens may be more appropriate in different clinical sites, such as psychiatric emergency departments, consultation services, or outpatient departments. However, the sites where they are practiced are less important than the fact that students achieve familiarity and comfort with using them.

The Psychiatric Workup

Seven questions should be asked about any psychiatric patient:

1. Why is the patient here now?
2. What does the patient want/expect?
3. Is a general medical illness contributing to the patient's difficulties?
4. How lethal is the situation?
5. In what ways are the patient's relationships helping or exacerbating the problem?
6. What are the patient's cultural expectations/explanations/treatments for his/her illness?
7. What is the psychiatric diagnosis?

APPENDIX 1. Objectives for the junior psychiatry clerkship *(continued)*

Sample Psychiatric Screens

1. Mini-Mental State Examination
   Note: this is a test of cognitive functioning, *not* a complete mental status examination.
   Folstein MF, Folstein SE, McHugh PR: Mini-mental state: a practical method for grading the cognitive state of patients for the clinician. J Psychiatr Res 1975; 12:189–198

2. Alcohol and Drug Abuse Screen
   Have you ever had a drinking or drug problem?
   (Yes: 70% of alcoholics, 1% of nonalcoholics): Cyr M, Wortman S: The effectiveness of routine screening questions in the detection of alcoholism. JAMA 1988; 259:51
   Has anyone else ever worried that you had a drinking or drug problem?
   Did you ever use sleeping pills, weight loss medications, or painkillers?
   CAGE questions: Ewing J: Detecting alcoholism: The CAGE questionnaire. JAMA 1984; 252:1905
   (A positive answer on two or more will identify the majority of people with alcohol abuse or dependence.)
   When is the last time you used any tobacco?
   How much are you using now (were you using then)?
   Have you used any other forms of tobacco (chew, cigarettes, cigars, pipes)?

3. Sexual Screen
   A. *General Screen*
      Are you sexually active at the present time?
         If NO, have you ever been?
      Are (were) your partners men, women, or both?
         If BOTH, which do you prefer?
      What means of birth control do you (have you) use(d)?
         Ask both males and females.
      Do you have any concerns or problems with your sexual life?
      Have there been any changes in your sexual activity?
         Changes in level and frequency of interest?
         Changes in type of interest?
      Do you or have you ever engaged in anal intercourse?
      Are there any ways in which you would like your sexual life to be different?
      Have any bad or frightening things ever happened to you sexually? For example: rape, sexual abuse, or molestation? (see Abuse Screen)
      Have you had any sexually transmitted diseases such as herpes, chlamydia, gonorrhea, syphilis, or AIDS? (see HIV Screen)
      Have you ever been treated for a sexually transmitted disease?
   B. *HIV Risk Factors*
      Do you worry about getting AIDS? Why? Why not?
      Do you practice safer sex? (Explain)
      Have you ever injected (or shot up) drugs into your veins? Have you smoked crack cocaine?
      (If male) Have you ever had sexual contact with another man or with someone who used intravenous (iv) drugs?
      (If female) Have you ever had sexual contact with someone who was bisexual or someone who used iv drugs?
      How many sexual partners have you had in the last 10 years?
      Have you ever needed a blood transfusion? What year? (1979–1985 is the risk period.)

4. Suicide and Violence Screen
   Have you ever had thoughts that life is not worth living?
   Have you ever had thoughts of killing yourself? (Now?)
   How would you do it?
   Have you taken steps to carry out your plan? (collected weapons, pills, etc.)

(continued)

APPENDIX 1. Objectives for the junior psychiatry clerkship *(continued)*

Patients who are suicidal may also be homicidal and vice versa, so ask:
Have you ever had thoughts of hurting anyone else? (Now?)
Have you ever hurt anyone else?
What plans do you now have to hurt anyone?

5. Screens for Family Violence
   A. *Child Abuse (modify for male perpetrators)*
      How did you feel during your pregnancy?
      Has your child lived up to your expectations?
      At what age do you think children know right from wrong? (Abusers often have unrealistically high expectations of children.)
      How do you feel when your child behaves badly? What do you do?
      Is there anyone you can turn to for help?
      Have you ever been concerned that anyone would hurt your child?
      Have you been frightened with thoughts of hurting your child?
      Have you or anyone else hurt your child?
   B. *Sexual Abuse Victims*
      Are there things going on in your home that you are uncomfortable with or ashamed to talk about?
      Has there been any sexual contact between family members in your home besides your parents?
      Have you been involved sexually with any adult, including either of your parents?
   C. *Partner/Elder Abuse Victims*
      I know that you may be ashamed of what happened (or might have happened), but could it be that this injury did not happen by accident?
      Is your family under a lot of stress?
      What happens when you and your partner argue?
      Do either of you have trouble with your temper?
      Have you ever fought physically with your partner? How badly have you been hurt?
      Is there a weapon in the house?
      Are you afraid to go home?
   D. *Abuse History*
      Did you ever witness any violence in your home when you were growing up?
      How were you disciplined as a child?
      Were you ever physically hurt by a family member?
      During your childhood or adolescence:
         Did a relative, family friend, or stranger ever touch your body, or have you touch them, in a sexual way?
         Did anyone attempt or succeed in having sexual intercourse with you?
         Did you ever have an unwanted sexual experience of any kind?

6. Trauma Screen
   Have you ever had anything happen to you where you thought you would be seriously injured or might die?
   Have you ever been in a life threatening accident? Fire? Disaster?
   Have you ever been attacked or raped?
   Have you ever seen these things happen to someone else?

7. Screen for Sleep Disorders
   Are you content with your sleep pattern?
   Are you excessively tired during the day?
   Does your bed partner complain about your sleep pattern?

8. Screen for Depression/Hypomania
   A. *Depression*
      How would you describe your mood?
         1. In the past month, have you felt down, depressed, or hopeless most of the day nearly every day?

APPENDIX 1. Objectives for the junior psychiatry clerkship (*continued*)

If yes: Describe what that is like for you.
Do you feel that way now?
How long have You felt depressed?
If no: When did you last feel down, depressed, or hopeless?
How long did you feel depressed?

2. Have you lost interest or pleasure in doing things you used to enjoy?
If yes: What do you usually enjoy doing?
When was the last time you did one or more of those things?
Was it enjoyable?
How long have you had difficulty getting interested in or enjoying activities?
If no: What do you enjoy doing?
When was the last time you did one or more of those things?
If A or B is positive:
Sleep, increase or decrease
Interest (previously determined)
Guilt, hopelessness, helplessness
Energy, decreased
Concentration, decreased
Appetite, increased or decreased
Psychomotor, retardation or agitation
Suicidality, active vs. passive

8. *Hypomania*
Have you had periods of needing very little sleep and not feeling tired?
Has anyone ever worried that you were excessively happy or so energetic that you were not your normal self?
Have your thoughts ever raced so that you could not control them?
Have you ever had periods of greatly increased energy when you felt you could accomplish almost anything?
Have you had periods of thrill seeking when you took physical risks, such as speeding or doing other dangerous things?

9. Screen for Anxiety Disorders
Do you feel nervous or tense?
Have your ever felt extremely frightened, physically uncomfortable, or worried that something terrible was going to happen?
If yes: Tell me about that.
Did you expect to feel that way?
Are there situations or activities that cause you a lot of anxiety or that you are more afraid of than most people would be?
If yes: What happens when you _____?
Do you avoid that (those) situations (activities)?
Do you worry a lot or have trouble getting things off your mind?
If yes: What do you worry about?
What do you have trouble getting off your mind?
Is there anything you have to do over and over again and cannot stop yourself from doing?
If yes: Tell me about that.

10. Screen for Eating Disorders
Have you lost or gained weight in the last year? How much?
How many times have you started a diet in the last year?
Have you ever felt that your eating was out of control? Have you gone on eating binges?
Have you ever vomited or spit out food after eating to get rid of it?
Have you ever used diuretics or laxatives? How often?
Have people ever given you a hard time about being too thin?

(continued)

APPENDIX 1. Objectives for the junior psychiatry clerkship *(continued)*

11. Screen for Psychosis

Have you ever had trouble with your thinking?
Has your thinking ever been so confused that you lost track of your ideas?
Have any of your thoughts seemed frightening or disturbing to you?
Have you ever felt like people were watching or following you, or that they wanted to hurt you?
Have your eyes or ears ever played tricks on you?
Have you ever had the experience of hearing a voice when nobody else was around, or of seeing things that weren't there?

"Excerpts from content description of USMLE Step 2"

1. General Principles

Infancy and Childhood
- Normal growth and development

Adolescence
- Sexuality; separation from parents/autonomy; physical changes of puberty

Senescence
- Normal physical and mental changes associated with aging

Medical Ethics and Jurisprudence
- Consent and informed consent to treatment (eg, full disclosure, alternate therapies, risks and benefits)
- Physician-patient relationship (eg, truth-telling, confidentiality, privacy, autonomy, public reporting)
- Death and dying (eg, diagnosing death, life-support, autopsy, organ donation, euthanasia, suicide)
- Birth-related issues (eg, prenatal diagnosis, abortion, maternal-fetal conflict)
- Research issues (eg, consent, placebos, conflict of interest, vulnerable populations)

Applied Biostatistics and Clinical Epidemiology
- Understanding statistical concepts of measurement in medical practice
- Interpretation of the medical literature

2. Infectious and Parasitic Diseases
(Topic covered under each organ system)

3. Neoplasms
(Topic covered under each organ system)

4. Immunologic Disorders

Health and Health Maintenance
- Anaphylaxis and other allergic reactions
- HIV infection/AIDS
- Immunization against infectious agents (eg, infants, children, adults, the elderly; patients having compromised immune systems)

Mechanisms of Disease
- Immunization
- Abnormalities of cell-mediated immunity
- Abnormalities of humoral immunity

4. Immunologic Disorders (continued)

Diagnosis

- Anaphylactic reactions and shock
- Connective tissue disorders (eg, mixed connective tissue disease and systemic lupus erythematosus)
- HIV infection/AIDS; deficiencies of cell mediated immunity
- Deficiencies of humoral immunity; combined immune deficiency

Principles of Management

(With emphasis on topics covered in Diagnosis)

- Pharmacotherapy only
- Management decision (treatment/diagnosis steps)
- Treatment only

5. Diseases of the Blood and Blood-forming Organs

Health and Health Maintenance

- Anemia (iron deficiency, vitamin-related, drug-induced, sickle cell)
- Infection (systemic)

Mechanisms of Disease

- Red cell disorders
- Coagulation disorders
- White cell disorders, including leukopenia, agranulocytosis, and neoplasms

Diagnosis

- Anemia, disorders of red cells, hemoglobin, and iron metabolism (eg, blood loss; iron deficiency anemia, nutritional deficiencies; pernicious anemia, other megaloblastic anemias; hemolytic; anemia associated with chronic disease; aplastic anemia, pancytopenia; thalassemia; methemoglobinemia, sickle cell disease; polycythemia vera; hemochromatosis)
- Bleeding disorders, coagulopathies, thrombocytopenia (eg, hemophilia, von Willebrand's disease; qualitative and quantitative platelet deficiencies; disseminated intravascular coagulation; hypofibrinogenemia; idiopathic thrombocytopenic purpura; hemolytic-uremic syndrome)
- Leukopenic disorders, agranulocytosis
- Neoplastic disorders (eg, Hodgkin's disease, non-Hodgkin's lymphomas; acute leukemia in children; acute leukemia in adults; chronic leukemic states; mycosis fungoides; multiple myeloma)
- Eosinophilia and reactions to transfusion of blood components including complications
- Infection (eg, sepsis, malaria, mononucleosis)

Principles of Management

(With emphasis on topics covered in Diagnosis)

- Pharmacotherapy only
- Management decision (treatment/diagnosis steps)
- Treatment only

6. Mental Disorders

Health and Health Maintenance

- Modification of risk factors (eg, safe sex, community/patient education [drug effects, stigma, warning signs], compliance maintenance, alcohol/substance abuse)
- Early identification and intervention (eg, suicide potential, depression, family involvement in schizophrenia, addiction/withdrawal)

Mechanisms of Disease

- Biologic markers of mental retardation syndromes
- Biologic markers of mental disorders
- Intended/unintended effects of therapeutic interventions, including effects of drugs on neurotransmitters

Diagnosis

- Mental disorders usually first diagnosed in infancy, childhood or adolescence (eg, mental retardation; communication disorders; pervasive developmental disorders; attention-deficit/hyperactivity disorder; disruptive disorders; tic disorders; elimination disorders)
- Substance-related disorders (eg, alcohol and other substances)
- Schizophrenia and other psychotic disorders
- Mood disorders (eg, bipolar disorders; major unipolar depressive disorders; dysthymic disorder; mood disorder due to a general medical condition; medication-induced mood disorder)
- Anxiety disorders (eg, panic disorder; phobia; obsessive-compulsive disorder; post-traumatic stress disorder; generalized anxiety disorder; acute stress disorder; separation anxiety disorder; anxiety due to a general medical condition; substance-induced anxiety disorder)
- Somatoform disorders (eg, factitious disorder; somatization disorder; pain disorder; conversion disorder; hypochondriasis)
- Sexual and gender identity disorders
- Personality disorders
- Other disorders/conditions (eg, child, spouse, elder abuse; eating disorders; adjustment disorders; dissociative disorders; psychological factors affecting medical conditions)

Principles of Management

(With emphasis on topics covered in Diagnosis)

- Pharmacotherapy only
- Management decision (treatment/diagnosis steps)
- Treatment only

7. Diseases of the Nervous System and Special Senses

Health and Health Maintenance

- Cerebrovascular disease, cerebral infarction
- Toxic injuries, occupational disorders and nutritional deficiencies (to the nervous system, eyes, and ears, including lead poisoning, carbon monoxide, and organophosphate)
- Infection involving the nervous system, eyes, or ears
- Congenital and developmental disorders involving the nervous system, eyes, or ears
- Degenerative and demyelinating disorders, including Alzheimer's disease and multiple sclerosis

7. Diseases of the Nervous System and Special Senses (continued)

Mechanisms of Disease

- Localizing anatomy:
  - brain and special senses
  - brainstem
  - spinal cord
  - neuromuscular system
- Anatomy of cerebral circulation
- Increased intracranial pressure
- Altered state of consciousness
- Infection
- Degenerative/developmental and metabolic disorder

Diagnosis

- Disorders of the eye (eg, blindness; glaucoma; infection; papilledema; optic atrophy; retinal disorders; diabetic retinopathy; diplopia; cataract; neoplasms; vascular disorders; uveitis; iridocyclitis; traumatic, toxic injury; toxoplasmosis)
- Disorders of the ear, olfaction, and taste (eg, deafness, hearing loss; otitis, mastoiditis; toxic damage; vertigo, tinnitus, Meniere's disease; acoustic neuroma; traumatic, toxic injury)
- Disorders of the nervous system:
  - paroxysmal disorders (eg, headache; trigeminal neuralgia; epilepsy; syncope)
  - cerebrovascular disease (eg, intracerebral hemorrhage; ischemic disorders; aneurysm, subarachnoid hemorrhage; cavernous sinus thrombosis)
  - traumatic, toxic injury (including lead, carbon monoxide, organophosphate)
  - infections (eg, bacterial, fungal, viral, opportunistic infection in immunocompromised patients; Lyme disease; abscess; neurosyphilis; Guillain-Barré syndrome)
  - neoplasms (eg, primary; metastatic; neurofibromatosis)
  - metabolic, nutritional disorders (eg, metabolic encephalopathy, vitamin B_{12} [cyanocobalamin] deficiency, vitamin B_1 [thiamine] deficiency; diabetic neuropathy; coma, confusion, delirium, dementia)
  - degenerative and developmental disorders (eg, Alzheimer's disease; Huntington's disease; parkinsonism; amyotrophic lateral sclerosis; Tay-Sachs disease; multiple sclerosis; cerebral palsy; dyslexia)
  - neuromuscular disorders, gait abnormalities, and disorders relating to the spine and spinal nerve roots (eg, myasthenia gravis; muscular dystrophy; peripheral neuropathy; neck pain; cervical radiculopathy; low back pain; lumbosacral radiculopathy; spinal stenosis)
  - sleep disorders

Principles of Management

(With emphasis on topics covered in Diagnosis)

- Pharmacotherapy only
- Management decision (treatment/diagnosis steps)
- Treatment only

PSYCHIATRY 531 MID-COURSE EVALUATION

NAME	ROTATION DATES	LOCATION

I. Life-Long Learning Skills ☐ **Satisfactory** ☐ **Unsatisfactory**

COMMENTS:

II. Knowledge of Biological Sciences ☐ **Satisfactory** ☐ **Unsatisfactory**

COMMENTS:

III. Patient Care ☐ **Satisfactory** ☐ **Unsatisfactory**

COMMENTS:

IV. Oral and Written Communication Skills ☐ **Satisfactory** ☐ **Unsatisfactory**

COMMENTS:

V. Knowledge of Populational and Community Health ☐ **Satisfactory** ☐ **Unsatisfactory**

COMMENTS:

VI. Professionalism ☐ **Satisfactory** ☐ **Unsatisfactory**

COMMENTS:

I, _____ have been counseled by Dr. _____ regarding my performance up to this point in the rotation. I agree with the discussion and understand what steps I need to take to improve my performance, if necessary.

_____ _____
3rd Year Medical Student DATE

_____ _____
Site Preceptor DATE

Reviewed by: Dan Alicata, M.D.-Clerkship Director _____ _____

Mid-Course Evaluation to be submitted on/before the mid-term exam.

University of Hawaii John A. Burns School of Medicine
Unit 6 – Psychiatry Clerkship
Clinical Experiences Checklist

Your name:_____

During the 7-week psychiatry clerkship (6B), or half-year longitudinal clerkship with 4-week block rotation (6L), the student is expected to have the following clinical experiences (one patient encounter may satisfy more than 1 category):

Clinical experience	Site	Dates	Supervisor signature
1. Participating in the care of a patient with symptoms of depression and/or anxiety in an outpatient (e.g., clinic) or general medical (e.g., emergency room, consultation-liaison, etc.) setting.			
2. Participating in the care of a patient with a cognitive disorder presenting in an acute setting (e.g., emergency room, acute inpatient, consultation-liaison, etc.)			
3. Participating in the care of a patient with a major mood disorder presenting in an acute setting.			
4. Participating in the care of a patient with a substance use disorder.			
5. Participating in the care of a patient with a psychotic disorder presenting in an acute setting.			
6. Participating in the assessment of a child or adolescent patient.			
7. Participating in the care of three patients who are followed-up several times: Patient #1			
Patient #2			
Patient #3			
8. Observing electro-convulsive therapy.			
9. Outpatient mental health site			
10. Performing two patient interviews supervised by and discussed with the attending or resident: Patient #1			
Patient #2			
11. Performing one "Acceptable" Clinical Skills Verification evaluation and Write up.			

DUE DATE: last Friday of clerkship!

PSYCHIATRY CLERKSHIP EVALUATION CRITERIA

During the 7 weeks of the Psychiatry Clerkship, you will be evaluated in order to determine how you are progressing toward achieving the basic goals of the Clerkship and ultimately, whether or not you achieve the basic goals at the end of the clerkship.

Final written examination (NBME "shelf exam" in psychiatry)	35%
Evaluation of clinical performance on the wards, clinics, and other experiences	45%
Tutorial	10%
Write-up	10%
	100%

Based on the above, a Medical Student Evaluation form will be completed and sent to the Dean of Students. Pertinent guidelines and sample evaluation forms are provided for your review.

A practice written midterm examination (not computed into the final grade) will be given during the 4th week of the clerkship.

Grading

Credit will be given to students demonstrating satisfactory performance in all areas: specifically, a passing score on the final written examination and an evaluation score in the credit/satisfactory range for each of the other evaluation measures listed.

No credit/Incomplete will be given to students with unsatisfactory performance in any of the evaluation measures listed. Remediation: Students will be required to demonstrate satisfactory performance in each of the unsatisfactory areas and in any additional make-up work as deemed necessary by the clerkship director.

Honors will be given to students demonstrating *globally outstanding* and *clearly superior* performance. Generally, the honors grade will be considered for those who show honors level performance in all major areas of evaluation (e.g., includes clinical performance and final written examination), an overall evaluation score (determined above) in the honors/outstanding range, and no deficiencies in any of the areas.

Academic Appeals Process: The JABSOM Academic Appeals Process is available through the JABSOM website : http://jabsom.hawaii.edu/JABSOM/admissions/Academic_Appeals_Policy_10-24-01.pdf)

Patient logs and clinical experiences checklist

Due dates for T-Res logs: 1) after mid-term; and 2) at end of rotation.
Logs will be checked and printed for review. Clinical experiences checklist is due at the end of the rotation.
Please submit to Ms. Iida.

UNIVERSITY OF HAWAII JOHN A. BURNS SCHOOL OF MEDICINE
SUMMARY STUDENT EVALUATION FORM

Name of Student: _____ Name of Clerkship: _____

Location: _____ Date of Report: _____

Inclusive Dates of Clerkship: _____

Type of Report: _____ Interim _____ End of Clerkship

Grade: Honors _____ Credit _____ No Credit _____ Incomplete

H = Honors C = Credit NC = No Credit

I. Life-Long Learning Skills	**H**	**C**	**NC**
Searches for, critically appraises, and applies biomedical information appropriately to patient care			
Evaluates the knowledge base supporting good patient care and recognizes gaps between prevailing and best practice			
II. Biological Sciences	**H**	**C**	**NC**
Knows the various causes of illness and the ways in which they operate on the body (pathogenesis)			
Knows the altered structure and function (pathology and pathophysiology) of the body and its major organ systems			
Applies the biological sciences to diagnosis and therapy			
III. Patient Care	**H**	**C**	**NC**
Approaches each patient with an awareness and sensitivity to the non--biological determinants of health			
Demonstrates clinical reasoning, critical thinking, and problem-solving skills			
Performs a complete or focused history and physical exam			
Formulates a problem list and differential diagnosis			
Plans appropriate diagnostic tests			
Accurately interprets patient responses, physical findings, and diagnostic test results			
Develops an appropriate therapeutic plan			
Educates patients, families, and other healthcare providers about health, illness, and the prevention of disease Performs technical skills safely under appropriate supervision and at a level commensurate with training			
IV. Oral and Written Communication Skills	**H**	**C**	**NC**
Greets patients warmly and using rapport-building techniques			
Presents cases clearly and concisely			
Writes legible, comprehensive progress notes and H&P's			
V. Populational and Community Health	**H**	**C**	**NC**
Knows the epidemiology of common illnesses within diverse populations and approaches useful in reducing such illnesses			

Knows how the health of certain subgroups of the population and ethnic groups differs from the population at large					
VI. Professionalism	**H**		**C**		**NC**
Presents a professional appearance and demeanor					
Treats patients with compassion; respecting patient confidentiality and preserving patient dignity					
Completes assignments and fulfills responsibilities promptly and with a positive attitude					
Works effectively with Peers					
Works effectively with Nurses and Ancillary Staff					
Works effectively with Attending Staff					
Works effectively with Residents					
Works effectively as a member of a team					
Open to feedback					
Proactivie, has initiative and motivation					

Summative Comments (To be included verbatim in the students' MSPE):

Formative Comments (for student's use only):

Evaluator: _____ Signature: _____

Date: _____

University of Hawaii
General Psychiatry Residency Program
Clinical Skills Verification (CSV)
(Adapted from Mayo Clinic & ABPN Task Force on Clinical Skills Verification Rater Training)

1. What is the CSV?

- Part of the new model of ABPN certification in Psychiatry
- Written examination
  - High stakes knowledge examination
- Clinical skills verification
  - Physician-patient relationship
  - Psychiatric interview, including MSE
  - Case presentation

2. Differences from previous exam

- NOT in the Minimum Requirements:
  - Case formulation
  - Differential diagnosis
  - Treatment plan
- CSV is conducted during medical student education in the psychiatry clerkship
- The student must successfully complete one CSV
  - This means they may need more than one attempt
- Conducted by the clerkship supervising faculty, residents and fellows. The student MUST NOT have previously "seen or examined" the patient
  - No prior personal or professional contact
- It is preferable for feedback may be given at the end of the evaluation
  - The evaluation is both an evaluation and a learning experience
- The standard of what is acceptable should be the same for all students

3. What we are looking for…

- Competency = Skills of a 3rd year medical student in the psychiatry clerkship The skills being evaluated [a]re:
  - Physician-patient relationship
  - Psychiatric interview, including MSE
  - Case presentation

4. CSV standards

- A passing score ($\geq$ 5) represents:
  - the <u>minimum acceptable</u> standard
  - for a student in the psychiatry clerkship

5. Evaluation Standards

- "Pass" at any time should be that of a student in the psychiatry clerkship
- Must pass all 3 major components (physician-patient relationship, psychiatric interview, including MSE and case presentation) individually
- There is no limit and no negatives for students having to retake the exam so there should not be pressure to inflate grades

6. Grading

- Scoring should NOT:
  - require excellent or outstanding performance
  - expect performance at the level above that expected of a student in the psychiatry clerkship

7. How will we do this?

- Structure
    - One examiner per exam
        - No medical record is available
    - Thirty minute interview
    - Twenty minute presentation
    - Five minute scoring by examiner
    - Fifteen minutes feedback
        - Final results can be told at this time
        - If the faculty decides that the student will need to repeat the CSV, Dana will be notified, and the student will be scheduled to repeat the CSV exam

8. **Rationale**

- Structured examination format
    - More consistent evaluation
    - Fairer to all students
    - Provides better understanding of how our students are doing

9. Post-Examination Review

- Will occur at the completion of the exam
- Review process of examination and assure there were no irregularities
- Opportunity for appeal if student requests
- Formal recording of the students' score

10. Specifics on Conduct

- Escort student into the room
- Ask the student if s/he knows the patient in any context
    - If so, provide the opportunity for the student to interview a patient that is not known to them
- Student has 30 minutes to interview the patient
- The examiner will announce when there are 5 minutes remaining for interview
- When the interview portion is over, excuse the patient and give the student a few seconds to collect their thoughts
- Ask the student to present the patient "as they would to a colleague"
- Note, we need to know if the student obtained adequate and relevant data – and really the only way to know will be to at least have the student present a case formulation and a differential diagnosis
- Do NOT ask about treatment
- If the student starts to talk about treatment, stop them and let them know we are not covering that in this examination
- The exam should continue for 20 minutes
- Take no more than five minutes to complete the grading cards
- Provide feeback for the student
- All pagers and cell phones should be turned off – for both the student and the examinerThe only material the student may bring into the room is a blank paper, a writing implement and a timing device if they desire. The paper may not be marked in any way or folded in any special way.
- The examiner should NOT take written notes during the exam

11. Completing the CSV Evaluation Form

- This document may be audited by the department of psychiatry, JABSOM or The Liaison Committee on Medical Education (LCME) and should be completed with the same degree of formality as a legal document. The CSV evaluation form will be placed in the student's clerkship folder when completed
- Every item must be completed
- The category scores must also be completed

- Any corrections must be dated and initialed
- Only choose the whole number scores; do not mark in between

12. Handing in the CSV Evaluation Form

- Review the evaluation form
- Hand in the evaluation form to Dana when completed

13. Remember

- We really want this to be constructive learning, helping the students learn how they can improve their performance
- Be kind to the students.

PSYCHIATRY CLINICAL SKILLS EVALUATION FORM (CSV v.1) page 1 of 2

Print Form

Resident Name _____ **Resident Signature** _____

Level of Training PG ☐ **Date** _____

Examiner Name _____ **Examiner Signature** _____

Patient Type _____

PHYSICIAN-PATIENT RELATIONSHIP (overall):	◯ **Unacceptable**	◯ **Acceptable**
1. Opening and closing	Awkward strategies ◯1 ◯2 ◯3 ◯4	Appropriate strategies ◯5 ◯6 ◯7 ◯8
2. Informational cues	Ignored leads ◯1 ◯2 ◯3 ◯4	Followed leads ◯5 ◯6 ◯7 ◯8
3. Affective cues	Ignored ◯1 ◯2 ◯3 ◯4	Explored appropriately ◯5 ◯6 ◯7 ◯8
4. Communication style and rapport	Insensitivity interfered with data collection ◯1 ◯2 ◯3 ◯4	Adequate language sensitivity ◯5 ◯6 ◯7 ◯8
5. Questioning techniques	Abrupt and forced choice questions ◯1 ◯2 ◯3 ◯4	Open-ended but appropriately structured ◯5 ◯6 ◯7 ◯8
6. Control and direction of interview	Scattered and fragmented questions ◯1 ◯2 ◯3 ◯4	Developed cohesive interview ◯5 ◯6 ◯7 ◯8

PSYCHIATRIC INTERVIEW (overall): **Length of interview = _____**	◯ **Unacceptable**	◯ **Acceptable**
7. Presenting problems and history of present illness	Inadequately obtained or too vague ◯1 ◯2 ◯3 ◯4	Obtained adequate data ◯5 ◯6 ◯7 ◯8
8. Past history: **Psychiatric**	Ignored major issues ◯1 ◯2 ◯3 ◯4	Gathered relevant data in at least brief form ◯5 ◯6 ◯7 ◯8
Family	Ignored major issues ◯1 ◯2 ◯3 ◯4	Gathered relevant data in at least brief form ◯5 ◯6 ◯7 ◯8
Medical	Ignored major issues ◯1 ◯2 ◯3 ◯4	Gathered relevant data in at least brief form ◯5 ◯6 ◯7 ◯8
Social / educational / occupational	Ignored major issues ◯1 ◯2 ◯3 ◯4	Gathered relevant data in at least brief form ◯5 ◯6 ◯7 ◯8

8. Past history (continued): Developmental	Ignored major issues ◯1 ◯2 ◯3 ◯4	Gathered relevant data in at least brief form ◯5 ◯6 ◯7 ◯8
9. History of drug and alcohol abuse	Ignored or too limited ◯1 ◯2 ◯3 ◯4	Sensitively gathered ◯5 ◯6 ◯7 ◯8
10. Assessment of suicidal risk	Ignored or too limited ◯1 ◯2 ◯3 ◯4	Sensitively explored ◯5 ◯6 ◯7 ◯8
11. Assessment of homicidal risk	Ignored or too limited ◯1 ◯2 ◯3 ◯4	Sensitively explored ◯5 ◯6 ◯7 ◯8
12. Mental status examination	Omitted or too limited ◯1 ◯2 ◯3 ◯4	Organized approach and performed appropriately ◯5 ◯6 ◯7 ◯8

CASE PRESENTATION (overall):	◯ **Unacceptable**	◯ **Acceptable**
13. Summary of important data	Disorganized ◯1 ◯2 ◯3 ◯4	Presented cohesively and coherently ◯5 ◯6 ◯7 ◯8
14. Mental status examination	Incomplete ◯1 ◯2 ◯3 ◯4	Accurately summarized ◯5 ◯6 ◯7 ◯8
15. Emergency issues: Suicide	Ignored ◯1 ◯2 ◯3 ◯4	Considered ◯5 ◯6 ◯7 ◯8
Violence / abuse	Ignored ◯1 ◯2 ◯3 ◯4	Considered ◯5 ◯6 ◯7 ◯8
Drugs / alcohol	Ignored ◯1 ◯2 ◯3 ◯4	Considered ◯5 ◯6 ◯7 ◯8
16. Recognition of need for additional history and collateral information	Absent or no rationale ◯1 ◯2 ◯3 ◯4	Appropriate ◯5 ◯6 ◯7 ◯8

Comments:

UNIVERSITY OF HAWAI'I JOHN A. BURNS SCHOOL OF MEDICINE
UNIT 6 PSYCHIATRY CLERKSHIP – WRITEUP EVALUATION FORM

Student's name:_____ Date:_____
Evaluator's name:_____ Location:_____

(H=honors; HP=high pass; P=pass; LP=low pass; UN=unsatisfactory)

OVERALL GRADE	**H**	**HP**	**P**	**LP**	**UN**
Criteria for passing: The student should demonstrate the specific competencies listed under each category. Criteria for honors: The student should be thinking and documenting at the level of a strong junior resident in psychiatry in the categories listed below.					

I. History	H	HP	P	LP	UN
• A history of the present illness clarified to the extent possible • Inclusion of pertinent positives and negatives • Attention to important issues of safety (suicide attempts, violence, psychotic symptoms, substance abuse, potentially dangerous medical conditions, child abuse if relevant) • Documentation of all additional historical areas: past psychiatric history, past medical history, family history, developmental history, social history, and relevant review of systems.					

II. Examination	H	HP	P	LP	UN
• Documentation of any relevant physical findings (e.g., vital signs, obvious physical findings, EPS, etc.) • Documentation of all areas of the MSE: general appearance, speech, emotions, thought, perception, cognition. • Documentation of assessment for dangerousness (suicidality, homicidality)					

III. Formulation	H	HP	P	LP	UN
• Identification of relevant biological factors (genetic, acquired). • Identification of relevant psychological factors (e.g., stressors, coping, current life stage, compliance issues) • Identification of relevant social/cultural factors (e.g., social support, availability of resources) • Integration of the above facts in a way that sensibly guides treatment, patient education, and education of others involved.					

IV. Differential diagnoses	H	HP	P	LP	UN
• Logically reasoned, broad-based • Based on thorough consideration of DSM-IV categories in appropriate axes					

II. Treatment plan	H	HP	P	LP	UN
• Addresses all relevant areas discussed in the formulation (biological, psychological, and social) • Addresses evaluation issues (diagnostic workup, collateral info.) • Addresses safety issues • Reflects review of the literature and judicious synthesis and application of knowledge. • Substantiated assessment of prognosis					

Summative comments (may be cited in final evaluation):

Formative comments (for student's use)

SO WHAT'S THERE AFTER THE CLERKSHIP?

Keep in mind that your clerkship was a *basic* introduction to psychiatry. Some things you may not have had too much exposure to: consult-liaison psychiatry (working with patients and other medical specialists in medical/surgical settings); outpatient psychiatry (working with less severe illnesses and watching improvement over time); etc. 4th-year electives are available.

Is Psychiatry the career for me? You should consider psychiatry if you are:

- Fascinated by the science of the brain and willing to rigorously understand the biological and psychosocial components of illness.
- Committed to treating medical conditions that affect emotions and behavior (in a sense, helping people to feel human again).

Psychiatry has been a very rewarding career for many, with high job satisfaction. There's big demand for psychiatric services (e.g., Surgeon General's statement on child and adolescent mental health needs).

According to the APA ("Careers in Psychiatry"):

"The average psychiatrist spends more than 48 hours each week at work. During this time, professional activities include administration, teaching, consultation, and research. Most spend over 60% of their time with patients. Two-thirds of these patients are seen as outpatients, with the rest being seen in a hospital setting or, increasingly, in partial hospital or day programs and community residential programs…

"Psychiatrists work in group or solo private practice much the same as other physicians. They also practice in the public sector, such as Veterans Administration and state hospitals and community mental health centers that are unique to psychiatry. Medical schools, HMOs, and general hospitals, as well as specialized psychiatric hospitals are settings for psychiatric practice."

Note the people who won the Nobel Prize in Physiology/Medicine for 2000 (Drs. Carlsson, Greengard, and Kandel).

Psychiatric residency (some examples):

Years 1	2	3	4	5
General Psychiatry* (first year could be in primary care)				Fellowship: Geriatric* Addiction* Forensic* Psychosomatic

General Psychiatry*	Fellowship: Child and Adolescent*

General Pediatrics ("triple-board program")	General Psychiatry*	Child and Adolescent Psychiatry*

*Indicates that the program is currently available here in Hawai'i

Other combinations:
Internal Medicine/Psychiatry (5 years)
Family Practice/Psychiatry (5 years)
Psychiatry/Neurology
Behavioral Neurology

Side note: Neurology is our "sister specialty" (we're both under the American Board of Psychiatry and Neurology). It's another specialty dealing with what is arguably the most complex and fascinating organ – the brain. Length: 4 years (neurology) or 5 years (neurology with special qualification in child neurology).

How are the residency programs here in Hawai'i?
They're excellent. One of us would be happy to talk more about them if anyone's interested.

Other information:
www.hawaiiresidency.org
www.psych.org

Good luck!

Dan Alicata, M.D.
Psychiatry Clerkship Director and
Psychiatry Director of Medical Student Education
Pager 363-1646; Office 586-7430 (Queen's)
alicatad@dop.hawaii.edu

Tony Guerrero, M.D.
Department Chair
Pager 363-1243; Office 586-1738
GuerreroA@dop.hawaii.edu

Gretchen Gavero, M.D.
Psychiatry Assistant Director of Medical Student Education
Pager: 363-0726; Office: 586-2900
gaverog@dop.hawaii.edu

We value your feedback…
Please contact us if you have any concerns or suggestions for improving the psychiatry experience.
The 4th week of every month, the medical student education committee of the Department of Psychiatry meets (Tuesday at 11:30 am) – student representatives from the block are invited to attend.

OTHER "SURVIVAL" PHONE NUMBERS AND ADDRESS

UH Department of Psychiatry:
Address: 1356 Lusitana St.,
University Tower-4th Floor
Honolulu, HI 96813
Phone: 586-2900

Dana Iida (Clerkship Coordinator)
Phone: 586-7445/e-mail: diida@hawaiiresidency.org

Part II. Appendices

B. Recommended Articles for Reference

1. Problem-Based Behavioral Science & Psychiatry-Chapter 17: Basic Principles of Evaluation: Interviewing, Mental Status Examination, Differential Diagnosis, and Treatment
2. Clinical interview
3. Diagnostic interview
4. Bio-psycho-social-cultural formulation
5. Cross-Cultural Primary Care
6. Boarding Time – Chapter 6: Taking the Psychiatric History
7. Boarding Time – Chapter 7: Mental Status Examination
8. Boarding Time – Chapter 8: The 30-Minute Hour
9. Boarding Time – Chapter 9: Case Formulation

C. Other: Psychiatry Text References

1. **Psychiatry 2010 Edition (Current Clinical Strategies) [Paperback]** Rhoda K Hahn (Author), Lawrence J. Albers (Author), Christopher Reist (Author), MD (Author, Editor), Paul D. Chan (Editor)

2. Handbook of Psychiatric Drugs, 2011 Edition (Current Clinical Strategies Medical Book) [Paperback]Lawrence J. Albers (Author), MD (Author), Rhoda K. Hahn (Author), Christopher Reist (Author)

3. First Aid for the Psychiatry Clerkship, Third Edition 2011 (First Aid Series) [Paperback]Latha Stead (Author), Matthew Kaufman (Author), Jason Yanofski (Author)

4. **Psychiatry Pre Test Self-Assessment & Review, Twelfth Edition (PreTest Clinical Medicine) [paperback]** Debra Klamen (Author), Phil Pan (Author)

5. **Kaplan & Saddock's Concise Textbook of Clinical Psychiatry, Third Edition 2008 [paperback]** Benjamin J. Saddock, M.D. (Author), Virginia A. Saddock, M.D. (Author)

Chapter 17
Basic Principles of Evaluation: Interviewing, Mental Status Examination, Differential Diagnosis, and Treatment Planning

Anthony P.S. Guerrero, Daniel A. Alicata, and Nathanael W. Cardon

This chapter helps bring everything you are learning full circle as we discuss the actual patient encounter. We compare and contrast the psychiatric evaluation to that of general medicine and describe what is expected in your psychiatric clerkship as you examine, diagnose, and develop a treatment plan. This chapter provides the context for applying the principles of psychiatry.

At the end of this chapter, the reader will be able to

1. Discuss the basic structural components of a psychiatric interview, including history and mental status examination
2. Discuss the basic principles to guide the process of an effective interview, including establishing and maintaining rapport, prioritizing safety, and efficiently gathering data sufficient to yield a differential diagnosis
3. Discuss the process of differential diagnosis according to the DSM-IV-TR
4. Discuss the process of bio-psycho-social-cultural-spiritual formulation and treatment planning

Case Vignette 17.1.1 Dan, Tony, and Melissa

Dan, Tony, and Melissa are second-year medical students who are starting their "brain and behavior" clinical skills preceptorship. They are quite apprehensive about performing their first interview, because they believe that "everything is totally different when it comes to 'psych'."

Students often worry that the basic history and examination skills they learned on other clinical services will not work in psychiatric settings. In reality, the entire assessment and treatment planning process learned in other parts of medicine are completely relevant to psychiatry, with a few relevant adaptations, as shown in Table 17.1.

A.P.S. Guerrero
Associate Professor of Psychiatry and Pediatrics, Associate Chair for Education and Training, Department of Psychiatry, University of Hawai'i John A. Burns School of Medicine

A. Guerrero, M. Piasecki (eds.), *Problem-Based Behavioral Science and Psychiatry*,

Table 17.1 Components of the psychiatric assessment

Traditional "medical exam" component	Psychiatric assessment component
Identifying data	Same
Source and reliability	Same
Chief complaint	Same
History of the present illness, with attention to "pertinent positives" and "pertinent negatives"	Same—with attention to the psychiatric review of systems and the different psychiatric and general medical conditions that should be "ruled in" and "ruled out"
Past medical history	Same *plus* a specific past psychiatric history
Family history	Same—with attention to psychiatric conditions
Social history	Same—often more lengthy because of the role of social factors in psychiatric illness
Review of systems	Same—because general medical conditions (detectable in the review of systems) can often explain psychiatric symptoms
Physical examination	Same—with more emphasis on the neurological exam and the MSE as a detailed branch step of the physical examination
	Mental status examination (described further below)
Problem list and assessment of each problem	Psychiatric formulation and differential diagnosis, based on the DSM-IV-TR
Plan, with additional information/diagnostic testing, specific treatments, and patient education	Same

Case Vignette 17.1.2 Continuation

The three students feel less anxious, knowing that they can apply the skills that they have already learned. They successfully meet the requirements of the preceptorship.

The three students are now third-year medical students new to the psychiatry clerkship. They each are about to do their first patient interview for the clerkship. Dan, who received positive recognition in his previous clerkships for his patience and his excellent bedside manner, states: "All I need to do is listen, and I think the patient will tell me what I need to know in 30 minutes (which is the time allotted to the interview)." Tony, who was recognized in his previous clerkships for his high exam scores, states: "I think I have everything figured out: all I need to do is ask the patient everything in this master template that I made, and everything will be fine." Finally, Melissa, who was recognized in her previous clerkships for her overall stellar performance, states: "I've never had a problem interviewing patients. I just need to get Honors in this clerkship because I want to go into a competitive specialty."

Following their first interview, the three students are flustered. In a de-briefing meeting with their clinical supervisor, Dan states: "I couldn't get a word in during

the interview. All I was able to find out was that this patient is married and that he is a Christian. I was totally lost during the rest of the interview, and I didn't want to interrupt him because it seemed like he would get mad." Tony states: "Even though I kept telling the patient how important it was to answer all of my questions, all he could do was give one-word answers, look quickly from one side of the room to the next, and then ask to go back to his room . . . which he did anyway after only 15 minutes. I ran out of time and we didn't even get to why he overdosed." Melissa states: "Because my patient kept crying so much, I didn't get a chance to test all of that important stuff for psychiatry, like ask about rolling stones gathering no moss and what to do with a stamped envelope."

Their supervisor, hoping to help their subsequent interviews with these patients to go smoother, encourages them to think of the interview as an opportunity to apply the problem-based approach. "What do you mean?" they ask. The preceptor encourages them to proceed with a modification of the familiar problem-based approach.

Although this is not the typical problem-based learning scenario, use of a modified PBL table may be helpful in guiding the process of the interview, as shown in Table 17.2.

Please proceed with the problem-based approach!

Table 17.2 Modified PBL table for Case Vignette 17.1.2

What are the observations about the process of the interview?	What are the hypotheses about why the interview is going this way?	What might I need to ask about and/or do next?
(for Dan) Difficult to interrupt patient "I'm lost"	Bipolar mania Schizophrenia Methamphetamine intoxication	Summarize, ask clarifying questions Do one's best to elicit relevant history
(for Tony) One-word answers Looking quickly from one side of the room to the next Wants to go back to room	Suspicion about the interview process Irritability from depression	Ask about and try to optimize patient's comfort Re-orient patient to purpose and context of interview Do one's best to elicit relevant history
(for Melissa) Crying so much	Depression Grief	Recognize patient's emotions and provide empathic comments as appropriate

While the structural elements of the psychiatric interview are essentially identical to elements of the general medical interview, a distinguishing characteristic of psychiatric interviewing is the likelihood that the very illness that one is trying to assess (such as the primary mood or psychotic disorder that Dan's patient above likely was demonstrating symptoms of) may impact the very *process* of the interview. Whenever something unexpected happens in an interview (ranging from intense tearfulness, to a request to leave the interview early, to an unusual question being asked of the interviewer), the most appropriate next step is often to use this occurrence as an opportunity to gather more information about what might be happening. For example: "I notice that you're really wanting to go back to your room . . . We'll be done in a few minutes, but I wonder if you could tell me what you're thinking right now or if there's anything we could do to help you feel more comfortable right now."

Even though it is easy to remember what the structural elements of an interview should be, students often feel challenged in getting through a "complete interview" in a time-limited period—which often needs to be done in real-life situations. We suggest that, during a time-limited interview, students should establish the following priorities:

1. *Attempt to establish and maintain rapport through*

   - Unconditional positive regard for the patient and attentiveness to patient comfort. This can be conveyed through a friendly demeanor and supportive and empathic statements ("That must have been a tough time for you").
   - Adequate preparation for the interview (explaining the context).
   - Appropriate use of open-ended (yet context-appropriate) questions, such as "What happened that led to your hospitalization?" or "Could you tell me more about that?" or "What's your understanding of what the medications are being prescribed for?"
   - Responsiveness to the patient's emotions and other potential barriers to effective rapport. For example, Tony observed irritation in his interview, and Melissa observed overwhelming sadness during her patient interview but neither responded to the patient's mood state. Failure to address such barriers may interfere with subsequent data-gathering and may be more time-costly in the long run.

2. *Assess safety, specifically*

   - Suicidality and thoughts of violence toward others: current ideations as well as previous dangerousness, command hallucinations, acute stressors, mood symptoms; and (if a recent attempt had been made), degree of premeditation (including suicide notes and other preparatory acts), method of discovery, perception of lethality, and what the patient perceives as having changed since the attempt. (Apparently, Tony did not prioritize this in his interview).
   - Abuse and being victimized (particularly for minors and dependent adults).

- Serious psychotic symptoms that impair reality testing and would interfere with a patient's ability to meet basic needs.
- Serious general medical conditions.
- Substance intoxication and/or withdrawal (which could be life-threatening).

3. *Attempt to elicit history and examination findings to at least establish a differential diagnosis* (not necessarily the definitive diagnosis—which may be unrealistic to determine in a short period of time):

   - Pertinent positives and pertinent negatives, based on criteria from the *Diagnostic and Statistical Manual of Mental Disorders*, currently in its fourth edition, text revision (DSM-IV-TR).
   - To the degree possible, review of the key areas of history and psychiatric review of systems.

Another distinguishing characteristic of the psychiatric interview is the need to thoughtfully perform a mental status examination (MSE). While it may initially seem (as it probably did to Melissa) that the mental status examination is an academic exercise with little relevance to the rest of medicine, each of the elements has practical clinical relevance and represents an indirect assessment of neurological functions. Detailed descriptions of observations are more clinically relevant than clinical jargon. A good MSE will "paint a picture" of the patient at the time of the exam. The components of the MSE are summarized in Table 17.3.

Following the psychiatric interview and mental status examination is the bio-psycho-social-cultural-spiritual formulation (discussed in Chap. 1) and a differential diagnosis according to the DSM-IV-TR, which describes diagnostic assessment according to the following five axes:

Axis I Major psychiatric conditions (all psychiatric conditions other than personality disorders and mental retardation; includes substance use disorders)
Axis II Personality disorders and mental retardation
Axis III General medical conditions
Axis IV Stressors (e.g., primary support group, occupational, educational, legal, other social)
Axis V Global assessment of functioning: current and in the past year (on a scale of 0–100; examples: 70 = mild impairment, 60 = moderate impairment, 50 = severe impairment, 40 = impairment of reality testing, 20 and below = acute dangerousness)

It may sometimes seem that the checklist approach used by the DSM-IV-TR for diagnosing psychiatric disorders is "cookbook" medicine because there is no "gold standard" along the lines of a definitive blood test or histopathological finding. However, it should be noted that other medical conditions, such as rheumatologic disorders and disorders affecting multiple systems, are diagnosed and very effectively treated through a similar approach.

Table 17.3 Components of the mental status examination

Mental status examination component	How assessed	Sample descriptive terms	Part(s) of the brain being tested or neurobiologic mechanisms	Examples of practical clinical relevance
General appearance	Observation	Well developed, well nourished, thin, overweight, good/poor hygiene, no obvious deformities, etc.	Multiple	Patients whose illness affects ability to care for self may have significant findings on general appearance
Eye contact	Observation	Good, adequate, fair, poor, etc.	Multiple	May be decreased as a result of depression or distraction from hallucinations, etc.
Cooperation with interview	Observation	Cooperative with interview, guarded, etc.	Multiple	Several conditions can impact upon rapport
Motor activity	Observation; sometimes formal testing for abnormal motor movements, tremor, and/or rigidity	Psychomotor agitation or retardation (or none), abnormal motor movements (or none), tremor and/or rigidity present (or not)	Basal ganglia, motor cortex, other areas	Major depression may cause psychomotor retardation, while mania may case psychomotor agitation. Antipsychotic medications may cause abnormal motor movements, tremor, and/or rigidity
Speech	Observation	Normal or increased or decreased rate and/or volume and/or amount; normal (or not) clarity	Multiple areas, including speech centers	Mood disorders and/or substance intoxication may affect the rate, volume, and/or amount of speech. Neurological conditions (that may also cause psychiatric symptoms) may affect clarity of speech
Mood—expressed emotional state	Direct questioning about how the patient has been feeling; rate mood from 1 to 10, 10 = best possible	Euthymic, depressed, anxious, expansive, irritable	Hypothalamus, limbic system, other parts	Mood disorders and/or substances may affect patient's reported mood and observed affect

Table 17.3 (continued)

Mental status examination component	How assessed	Sample descriptive terms	Part(s) of the brain being tested or neurobiologic mechanisms	Examples of practical clinical relevance
Affect—observed emotional state	Observation	Mood-congruency (mood-congruent, mood-incongruent) Range (broad, restricted, flat) Lability (labile or not) Overall quality (neutral, depressed, anxious, euphoric, irritable)		
Thought process	Observation	Linear (remains on topic) and goal-directed, circumstantial (goes off topic but eventually returns to the original topic), tangential (goes off topic without ever returning to the original topic), flight of ideas (without production of a coherent thought), word salad (in which even the individual words may not coherently link together)	Inappropriate mesolimbic dopamine release, poor cortical filtering; other areas	Primary psychotic disorders such as schizophrenia and/or substances may affect thought processes
Thought content	Observation, some direct questions	Delusions (present or not, with specific examples); paranoid ideations (present or not, with specific examples); future orientation; etc.		Primary psychotic disorders such as schizophrenia and/or substances may affect result in delusions; depression with suicidal ideations may lead to a patient not having a future orientation

Table 17.3 (continued)

Mental status examination component	How assessed	Sample descriptive terms	Part(s) of the brain being tested or neurobiologic mechanisms	Examples of practical clinical relevance
Perceptions	Direct questions, with some observation for distractibility of other evidence of response to internal stimuli	Auditory and visual hallucinations (present or not); appearance (or not) of seeming to respond to hallucinations; other hallucinations (e.g., tactile, olfactory, etc.) also important to note if present	See above, relevant sensory cortices (auditory, visual, etc.)	Primary psychotic disorders such as schizophrenia, substances, and/or delirium may result in hallucinations
Alertness	Observation	Alert, drowsy, stuporous, comatose	Reticular activating system	Delirium may cause fluctuations in level of alertness
Orientation	Direct questions, with some observation	Oriented (or not) to person, place, time (date, month, year), situation	Often depends on alertness and memory	Delirium may cause disorientation. Other memory-impairing conditions such as dementia may cause disorientation
Concentration	Direct questions, with some observation	Able (or not) to perform serial 7's ("take the number 100, subtract 7, and then keep subtracting 7 from your answer until I tell you to stop . . .") Able (or not) to spell five-letter words such as "world" or "ocean" backward. (Usually, one of these tests will suffice)	Reticular activating system	Delirium primarily affects alertness and concentration
Memory	Direct questions	Ability to immediately recall three unrelated words that are not objects in the room (e.g., "umbrella," "car," "happiness") and to recall these words approximately 5 minutes later (if not spontaneously recalled, prompting or giving hints may suggest more impairment of memory retrieval than memory storage) Longer-term memory may be assessed by asking the last five presidents, etc.	Hippocampus (memory encoding), other parts of the cerebral cortex	Dementia results in memory impairment along with other cognitive findings. Cortical dementias are associated with memory storage difficulties, while subcortical dementias are associated with memory retrieval difficulties

Table 17.3 (continued)

Mental status examination component	How assessed	Sample descriptive terms	Part(s) of the brain being tested or neurobiologic mechanisms	Examples of practical clinical relevance
Abstraction	Direct questions	Ability (or not) to state similarities (e.g., apple and orange are both fruits, table and a chair are both furniture, newspaper and radio both tell the news, opera and a painting are both forms of art) or accurately interpret proverbs (though proverbs often test more than just abstraction)	Frontal lobe	Schizophrenia often is associated with frontal lobe maldevelopment
Judgment	Observation, possibly direct questions	Ability (or not) to exercise good judgment with regards self-care, behaving appropriately	Frontal lobe	As above
Insight	Observation, possibly direct questions	Insight into illness, need for treatment	Frontal lobe	As above
Suicidality, homicidality, violence	Direct questions	Presence or absence: ideations and/or intentions	Multiple areas	Important to explicitly cover, in the interests of safety

General medical conditions and substance-induced conditions, while often overlooked, are important to include in the differential diagnosis of many Axis I conditions.

The final step of the psychiatric assessment is to develop a treatment plan that adequately considers the formulation and differential diagnosis. Please refer to Chap. 1 for a diagrammatic illustration of how a successful plan addresses the various components of a bio-psycho-social-cultural-spiritual formulation. The following shown in Table 17.4 helps to develop a comprehensive plan.

We close, in Appendix, with a sample write-up of a fictitious patient (with gratitude to George Lucas, creator of the Star Wars series, where many of the arbitrarily chosen fictitious names came from).

Table 17.4 Treatment planning template

	Biological	Psychological	Social/cultural
Additional information	Old records (e.g., to look at previous diagnoses and medication efficacy) Insure a recent physical exam Relevant labs, for example: Chemistry profile Complete blood count Thyroid function tests Tests to rule out infection (e.g., syphilis, HIV) Toxicology screen Neuroimaging	Additional interviews Speak with previous therapists, etc. Psychological testing: for example, intelligence testing, personality testing, projective testing (to evaluate for psychotic processes)	Talk to family, others if patient gives consent
Treatment	Continue effective medications, usually abstinence from substances	Individual psychotherapy to build rapport Groups—e.g., anger management, Alcoholics/Narcotics Anonymous	Family psychotherapy if appropriate Social services, stable living Structured setting—e.g., to remain safe, substance-free, etc. Other resources
Patient education (often covered above)	Education on benefits and side effects of medications	Psychoeducation on need for compliance, crisis resources, etc.	Family psychoeducation as appropriate

Review Questions

1. You are interviewing a patient, who suddenly becomes very quiet and possibly tearful when the topic of her childhood is discussed. The next most appropriate thing to do is to

   (a) Switch the topic to something less sensitive.
   (b) Immediately perform a cognitive examination.
   (c) Recognize the change in affect and empathically acknowledge the likely difficulty in discussing such a topic.
   (d) Immediately terminate the interview and postpone any further attempts at interview until the patient can regain composure.
   (e) Reassure the patient that you know exactly how she feels, and that it is perfectly okay to cry.

2. During the course of a diagnostic interview, your patient asks, for a second time, "Doctor, how old are you, anyway?" Which of the following is the best response?

   (a) "Once again, this interview is about you, not about me, so let's talk about something else."
   (b) "I'm old enough to be a physician and old enough to be interviewing you."
   (c) "I'm very uncomfortable talking about my personal life with patients."
   (d) "I notice that you're really interested in how old I am. I wonder what your thoughts are behind wanting to know."
   (e) "I'm somewhere between 20 and 60."

3. All of the following statements are correct EXCEPT

   (a) Affect describes one's observation of the patient's emotions during the interview.
   (b) Mood describes what the patient's emotional state has generally been.
   (c) Mood can be elicited through direct questioning of how the patient has been feeling.
   (d) Tangential thoughts never return to the original topic or question.
   (e) Circumstantiality is pathognomonic for a psychotic disorder.

4. Which of the following statements best describes the role of testing "serial 7's"?

   (a) Difficulties with this test may indicate delirium.
   (b) This test is intended to primarily test mathematical abilities.
   (c) Difficulties with this test always reflect dysfunction of the reticular activating system.
   (d) Psychotic individuals invariably have difficulty with this test.
   (e) This test must always be done in combination with asking the patient to spell "world" forward and backward and recall digit spans.

5. Which of the following statements about psychiatric assessment are correct?

   (a) A bio-psycho-social-cultural-spiritual formulation, because of its inherent inclusion of "psychiatric jargon" terms, is rarely useful for patients or other health professionals involved in patient care.

(b) Effective rapport is the foundation for all patient interviews, whether in psychiatry or in any other specialty of medicine.
(c) Psychiatrists should never perform physical examinations or order laboratory studies.
(d) Assessment of safety is merely an assessment of current suicidal or homicidal ideations.
(e) Learning disorders and pervasive developmental disorders are noted on Axis II.

Answers

1. c, 2. d, 3. e, 4. a, 5. b

Appendix Sample Write-Up

Name: Luke Skywalker, MS3
Attending Psychiatrist: Master Yoda, M.D.
Date: 05/01/2008
Identifying Data: Princess Leia is a 34-year-old cosmopolitan female, divorced, employed as a secretary.
Reason for Examination: Psychiatric consultation for patient on the general medical ward; medical student write-up #1.
Referring Physician: Obi-Wan Kenobi, M.D. (internal medicine).
Source and Reliability: Patient, who appears fairly reliable. Chart also reviewed.
Chief Complaint: Acetaminophen overdose.

History of the Present Illness:

Ms. Leia is a 34-year-old female admitted last night for an acetaminophen, acetaminophen/oxycodone, and ibuprofen overdose. This overdose occurred late yesterday afternoon (Saturday) at her apartment. She ingested several extra strength acetaminophen tablets, a few acetaminophen/oxycodone tablets, and a few ibuprofen tablets following an argument with her boyfriend over his recent infidelity. This argument started on Friday night and caused her to essentially not sleep the whole night. Immediately following the ingestion, she called her boyfriend, who then brought her to the emergency room, from where she was subsequently admitted because of an acetaminophen level in the toxic range.

Assess safety

Ms. Leia states that she thought that she would die as a result of the ingestion, but denies that she had been premeditating the act prior to yesterday's argument. She denies having left a suicide note and denies any history of giving away possessions in preparation for death. She says that what she did was "the dumbest thing I've ever done" and that she's "grateful to be alive." She cannot really say what has changed in their relationship, but says, "no matter what happens, it's not worth dying for."

Ms. Leia denies any past history of suicide attempts, command hallucinations telling her to commit suicide, or any intoxication at the time of the overdose. She notes that, for the past 4 months, she has had, more days than not, a depressed mood related to relationship difficulties, associated with: decreased enjoyment of usually pleasurable activities (e.g., going out with her friends, playing with her 6-year-old son at the beach), terminal insomnia (e.g., waking up at 3 am and not being able to go back to sleep), increased appetite with an unintentional 5-pound weight gain, decreased energy level, feelings of worthlessness, and difficulty concentrating in her job. She admits to some degree of sensitivity to perceived rejection—for example, crying when her friends go somewhere without her, or when her boyfriend is unable to make it for a planned date.

Pertinent positives and negatives

Past Psychiatric History:

Ms. Leia reports that when she was around 28 years old, she experienced similar symptoms during the ending of her 5-year marriage to her ex-husband. In retrospect, she believes that her symptoms started within about 1 month following the birth of her son. She saw a psychiatrist (Dr. Qui-Gon Jinn) and took fluoxetine for around 9 months. She reports that the fluoxetine was helpful and stopped this medication because she felt she no longer needed it.

She denies any history of manic symptoms (e.g., sustained abnormally elevated mood, racing thoughts, decreased need for sleep, rapid speech, psychomotor agitation, grandiosity, impulsive spending).

She admits to sometimes feeling, especially in the past 4 months, a fast heartbeat and lightheadedness associated with feeling "stressed and overwhelmed with everything that's going on." These feelings would last less than a minute and would occur no more frequently than every few weeks. She denies any history of feeling any impending sense of doom during these instances, and she denies any worry about feeling these symptoms again in between these instances. She denies any history of repetitive, intrusive thoughts or behaviors. She also denies any history of anxiety in places where she may be under public scrutiny. In terms of any exposure to trauma, she reports having been involved in a car accident when she was 8 years old. Her mother's car was rear-ended on the freeway by a large truck, resulting in her mother needing to be hospitalized overnight. She says she coped reasonably well with this incident, and she denies any nightmares, flashbacks, or other re-experiencing phenomena related to this incident. She denies any past experience of physical or sexual abuse, and she denies any physical abuse in her current relationship.

She admits to drinking socially since age 18 or 19. The last time she had anything to drink was last week, with her friends. She reports only having one or two drinks each time. She denies any history of alcoholic blackouts, hallucinations related to drinking, or withdrawal seizures. She responded negatively to all components of the "CAGE" questionnaire. She denies any other history of substance use.

She denies any history of binging (e.g., eating large quantities of food in one sitting, feeling a lack of control over eating) or purging behavior.

Past Medical History:

Ms. Leia is otherwise healthy, without any chronic health problems. She denies any past history of seizures, major head trauma, or loss of consciousness. However, she notes that she had her wisdom teeth extracted 5 days ago and is still experiencing a significant amount of discomfort.

Ms. Leia has been pregnant only once, with her 6-year-old son. She reports a history of irritability and sadness before and during her menstrual periods. She has just started her menstrual period and denies any possibility of current pregnancy.

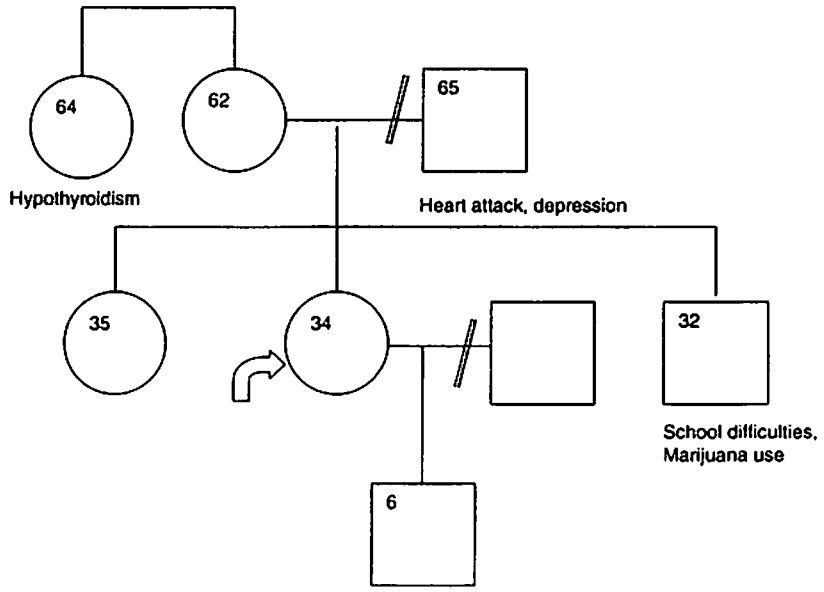
Current medications: acetaminophen/oxycodone.

Allergies: ALLERGIC TO PENICILLIN, WHICH CAUSES HIVES.

Family History:

Ms. Leia believes that her father (65 years old) may have developed depression following a heart attack. He was prescribed an antidepressant, which he took for about 1 year. Her brother also had a history of school difficulties and marijuana abuse as a teenager. She denies any other known family history of depression, completed suicides, other psychiatric disorders, or substance abuse. She has a maternal aunt with a history of hypothyroidism, for which she takes thyroid replacement on an ongoing basis.

(OPTIONAL graphic depiction)



Developmental and Social History:

Ms. Leia grew up in Honolulu. Her parents divorced when she was 3 years of age. She denies that there was any domestic violence around the divorce, only arguing. She recalls being sad when her parents divorced, but admits that she does not really remember details. Her mother raised her. While growing up, she had infrequent contact with her father, who remarried. She reports that she did not get along well with her mother, because her mother was "too strict."

Ms. Leia reports having had difficulties in school, especially in math. She reports having been in special education for a few years. She denies any particular difficulty with concentrating/paying attention in school. She dropped out of 11th grade because she was "sick of school" and wanted to be with her boyfriend at the time. She completed her GED at age 18 years. She would like to return to school sometime and obtain a college degree, perhaps in education or psychology. She has held various jobs: as a cashier, food service provider, and office secretary. Most recently, she has worked as a secretary for a research company for the past 3 years.

Ms. Leia had been married to the father of her 6-year-old son for 5 years. Prior to that, she had only been in one long-term serious relationship (from high school). She reports that the marriage ended "mostly because he started getting more and more into drinking and I couldn't count on him to be around anymore." There had not been any domestic violence. She has been with her current boyfriend for the past 2 years. She reports that they had been arguing more especially in the past 5 or 6 months, generally over his ongoing friendship with ex-girlfriends.

Ms. Leia lives with her 6-year-old son. Her sister and brother help to provide childcare while she is at work. Her son stays with his father (who shares legal custody) during the weekends and was not with her during the time of the ingestion. She states that she misses her son when he is at his father's place. Her ex-husband pays child support, but still notes that it's "hard to make ends meet" especially now that her son has started private school at their local church. She currently sees her mother at least once per week and talks to her father around once every few months. She feels close to her older sister and sees her frequently during the week. Her sister has come to visit her in the hospital and has been supportive.

Ms. Leia is active in church and reports that her friends from church are also very supportive. When she stopped seeing Dr. Qui-Gon Jinn, she had hoped she could stay emotionally well if she prayed and talked regularly to her pastor.

Ms. Leia denies having any access to firearms or other weapons.

Review of Systems:

Constitutional: History of weight gain, decreased energy level.
Eyes: Negative.

ENT: History of recent extraction of wisdom teeth.
CV: For the past 4 months, occasional fast heartbeat and lightheadedness when she is anxious. No history of any chest pain, shortness of breath, or other cardiac symptoms.
Respiratory: Negative.
GI: Some nausea following overdose; otherwise negative.
GU: Regular urinary pattern, no discharge. Recently started menses.
Musculoskeletal: Negative.
Skin: Negative.
Neuro: Negative. No headaches, speech/gait abnormalities, weakness, numbness, paresthesias.
Psych: Depressed mood, suicidal ideation (see HPI).
Endocrine: No known history of thyroid disease. Endorses some history of feeling cold easily, even when others feel warm.
All others: Negative.

Physical examination:

Constitutional: Well developed, well nourished, no acute distress. Normal body habitus, no obvious deformities. Adequate groom; dressed in hospital gown. Vital signs: temperature 98.6 °F, pulse 72 per minute, BP 110/70, RR 18, SaO_2 100% in RA.
Eyes: Pupils 3 mm, reactive.
Musculoskeletal: No abnormal movements, rigidity, or tremor. Appears to have normal use of all extremities.
Skin: Warm and dry, no diaphoresis.

Mental Status Examination:

Eye contact: Good. Cooperation with interview: Cooperated well.
Motor activity: No psychomotor agitation or retardation.
Speech: Normal rate, volume, clarity, and amount.
Mood: "Sad and depressed, not my usual self."
Affect: Congruent, depressed, and tearful at appropriate points of the interview (e.g., discussing recent relationship difficulties, discussing how she feels when her son is not there). Affect brightened somewhat upon discussing her son's achievements in school.
Thought process: Linear, goal-directed.
Thought content: No delusions or paranoid ideations. Conveys future orientation: return to work, see her son as soon as she is able.
Perceptions: Denies any auditory or visual hallucinations. Does not appear to be responding to hallucinations.
Orientation: Oriented to person, place, time, and situation.
Attention/concentration: Attended well to the interview and was able to spell "world" forward and backward without difficulty.

Memory: Able to register 3/3 unrelated words without difficulty and to remember 3/3 after 5 minutes. Able to name the past 5 US presidents in reverse chronological order.
Knowledge: Good fund.
Abstractions: Able to note similarities (apple/orange, table/chair, opera/painting) appropriately.
Judgment: Fair. She states that, if she were ever feeling suicidal again, she would call her sister or someone else who was able to assist her.
Insight: Fair. Able to recognize that her suicidal thoughts may be related to a recurrence of depression and that she may benefit from psychiatric care once again.
Suicidal ideations: Denies, even with repeated questioning. Verbally agrees not to do anything to harm herself in the hospital and agrees to inform staff if she were to feel distressed again.
Homicidal ideations: Denies.

Laboratory Studies (on Admission):

Urine toxicology: Positive for opiates, otherwise negative.
Electrocardiogram: Normal sinus rhythm, normal EKG.
Acetaminophen level: Borderline toxic range.
Acetylsalicylic acid level: negative.
CBC with differential: All values within normal range.
Comprehensive metabolic profile: All values within normal range, including LFTs.
PT/PTT: Within normal range.
Serum HCG: Negative.

Formulation:

In summary, Ms. Leia is a 34-year-old female admitted to the hospital for a potentially toxic intentional acetaminophen overdose and a history of depression.

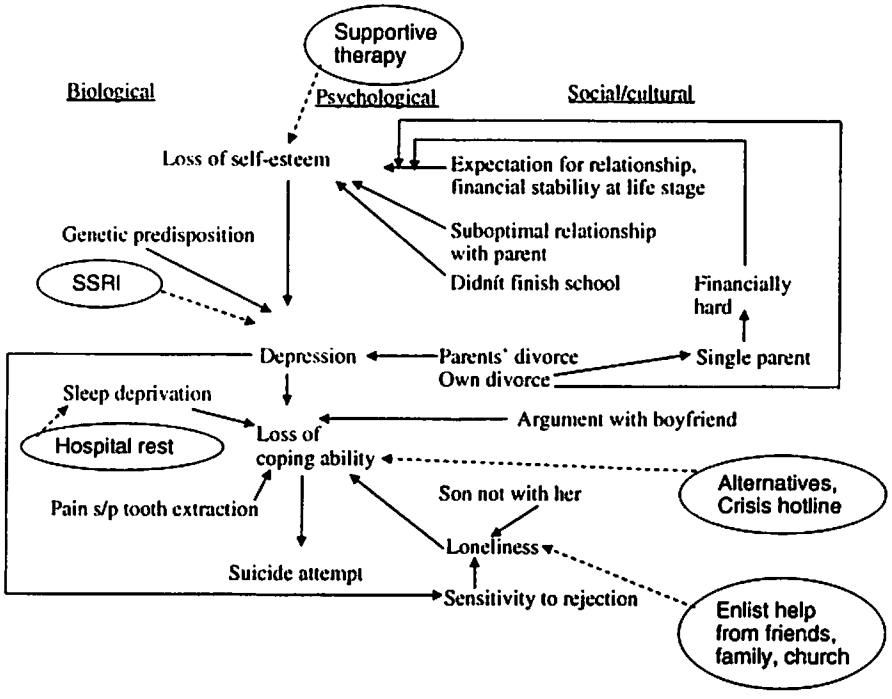
Relevant biological factors include: a possible genetic predisposition to depression (family history), recent physical discomfort (status-post tooth extraction, sleep deprivation) just prior to the suicide attempt, and possible hormonal influences (history of postpartum onset of depression, history of mood changes before and during menses, which she is currently having). Other, less prominent (though possibly still relevant) factors include: current use of a pain medication that could affect mood (oxycodone) and infrequent use of alcohol (none in the past few days).

Relevant psychological factors include: the recent argument with her boyfriend, and possibly the fact that her son was not with her at the time of the suicide attempt (as the more recent, precipitating factors); a past history of losses and transitions, including her parents' divorce, a less-than-optimal relationship with the parent who raised her, and the breakup of a previous marriage; other factors (e.g., school difficulties) that could have led to a loss of self-esteem and predisposed her to depression; and what she describes as an increased sensitivity to perceived rejection. Also,

she is at a stage in life where she may be hoping for more stability in her relationship/family life and financial situation than she currently has, and this may be an additional factor contributing to depression.

Relevant social/cultural/spiritual factors include: ongoing financial stress and working in the single parent role. She describes receiving emotional and other support from siblings and friends. She has maintained a stable job for the past few years. Her beliefs about the nature and treatment of depression may be influenced by her religious orientation. Her religious involvement is positive influence in her life.

Depicted graphically (with treatment interventions enclosed in ovals)—ALSO OPTIONAL:



Differential Diagnoses:
On Axis I:

1. Major Depressive Disorder, Recurrent: patient meets DSM-IV criteria for this diagnosis. She also may meet the criteria for atypical features.
2. Bipolar II Disorder: a consideration given the history of recurrent major depressive episodes; however, no definite history of manic symptoms endorsed in this interview.
3. Adjustment Disorder with Depressed Mood: with the stressors being the relationship difficulties; however, because she meets the criteria for a Major Depressive Disorder, the latter diagnosis would supersede.

4. Panic Disorder: patient describes a history of fast heartbeat and lightheadedness; however, does not meet full criteria for panic attacks, and these symptoms occurred only in the context of what appears to be a major depressive episode.
5. Substance Abuse (Alcohol) and Substance-Induced Mood Disorder: based on the history provided, would not meet criteria for a substance use disorder; collateral information would be helpful in ruling out this possibility.
6. Premenstrual Dysphoric Disorder: patient describes some symptoms around menses that may be consistent with this condition; however, it is unclear that they were absent following menses and not merely an exacerbation of what is likely a Major Depressive Disorder.
7. Mood Disorder Due to a General Medical Condition (with depression): thyroid disorder (given family history) and primary heart condition (with anxiety symptoms) should be considered.
8. Mathematics or other Learning Disorder: given history of school difficulties and special education.

On Axis II:

1. Borderline Personality Traits: with sensitivity to abandonment; however, it is not clear that her history is necessarily characterized by "a pattern of unstable and intense relationships . . ." or "recurrent" suicidal behavior.
2. Dependent Personality Traits: discomfort with being alone; however, it is also not clear that criteria are met for this personality disorder.

On Axis III:

1. Status: post-overdose (acetaminophen, hydrocodone, ibuprofen)
2. Status: post-tooth extraction
3. PENICILLIN ALLERGY *(important to recall, though not necessarily directly relevant to current psychiatric status)*
4. Possible thyroid disorder: family history of thyroid disorder; history of cold intolerance.
5. Possible cardiac arrhythmia: given history of fast heartbeat, lightheadedness; however, the timing of these symptoms seemed to coincide with the episode of depression, and the EKG done on admission was negative.

Working diagnoses:

Axis I	Major Depressive Disorder, Recurrent
	Learning Disorder Not Otherwise Specified (Provisional)
Axis II	Deferred
Axis III	Status-post overdose
	Status-post tooth extraction with pain
Axis IV	Primary support, relationship difficulties, financial stressors
Axis V	Current GAF = 50; Highest GAF in past year = 75

Treatment Plan:

Treatment setting: Ms. Leia should remain in the hospital because she needs general medical treatment for the overdose. A standard hospital suicide risk assessment form has been completed, and orders have been written appropriate to her level of suicide risk, with removal of potentially injurious objects and frequent nursing checks.

Other specific interventions are as follows:

	Biological/medical	Psychological	Social
Additional information	1. Review past records from previous treating psychiatrist, with attention to medication issues 2. Consider checking a TSH	1. Meet again with patient to clarify diagnostic issues as noted above 2. Review past records from treating psychiatrist 3. Consider rating scales for depression and other mood disorders	1. With patient's permission, speak with family members for collateral information 2. Assess whether son (minor) is under appropriate care currently
Treatment	1. Medical treatment of overdose as per general medical team 2. Patient may be a candidate for re-starting of SSRI, such as fluoxetine, which had been helpful in the past. Consider monitoring response using standard rating scales for depression 3. Encourage adequate rest while in the hospital	1. Individual supportive psychotherapy to be provided during medical hospitalization, with focus on psychoeducation about depression and discussion of feelings about current and past stressors 2. In the longer term, may be a candidate for cognitive-behavioral psychotherapy (e.g., to address feelings of worthlessness, rejection) or interpersonal psychotherapy (e.g., to address role transitions, losses)	1. Enlist support from family members and friends where appropriate 2. Disposition (e.g., discharge to outpatient care versus psychiatric hospitalization) to be determined during follow-up visits

(Continued)

	Biological/medical	Psychological	Social
Patient education	1. Education about the alternatives to and potential benefits/risks of treatment with SSRI 2. Advise patient to avoid drinking alcohol at this time, as it may impair judgment and render her more vulnerable to self-destructive acts	1. Provide information on crisis phone numbers 2. Provide information on the importance of depression treatment, including ongoing medical follow-up	With patient's permission, enlist family's help in insuring safety in the environment (e.g., no large bottles of dangerous medications) and in encouraging patient to make use of available resources

Prognosis: Ms. Leia's prognosis at this point would seem to be fair to good. One important risk factor is current relationship instability. However, from the standpoint of completed suicide risk, she has a fairly favorable demographic profile (young, female, employed); no past history of suicide attempts; and no apparent substance abuse problem. From the standpoint of major depression, she has a history of good response to SSRI treatment in the past. Her social supports and church involvement may also be factors that weigh in her favor.

Bibliography

American Psychiatric Association. *Diagnostic and statistical manual of mental disorders, 4th ed.*, text revision. Washington, DC: American Psychiatric Press; 2000.

Guerrero APS, Hishinuma ES, Serrano AC, Ahmed I. Use of the "Mechanistic case diagramming" technique to teach the bio-psycho-social-cultural formulation to psychiatric clerks. Academic Psychiatry 2003; 27: 88–92.

Guerrero APS, Ling CYL, Ahmed I, Takeshita J, Bell CK. Development of a structured module to teach psychiatric interviewing competencies to medical students. Focus on Health Professional Education: A Multidisciplinary Journal (in press).

Part II - B.2.

Clinical Hypocompetence: The Interview

FREDERIC W. PLATT, M.D.; and JONATHAN C. McMATH, M.D.; Denver, Colorado

In observing more than 300 clinical interviews, we have seen a high frequency of physician-engendered defects. Most of the defective examples can be classified as one or a combination of five syndromes: therapeutic lack; inattention to primary data (symptoms); a high control style; an incomplete data base usually omitting patient-centered data and active problems other than the present illness; and a thoughtless interview in which the physician fails to formulate needed working hypotheses. Proper diagnosis of these defects allows for better prescription of educational correction.

AFTER the American Board of Internal Medicine (ABIM) requested that program directors observe their residents' clinical skills 6 years ago, we began regular observations of our house staff, students, and some attending staff physicians. At this writing we have observed more than 300 clinical interviews (complete or comprehensive history-taking and physical examinations) and many hundreds of brief interactions. To our surprise all did not seem as it should be. Physicians at all levels who had previously been thought quite competent appeared defective in their interactions with patients. Our initial reaction was to distrust our observations, but repeated observations have shown great consistency, whether made on videotaped interviews or by a single observer present at the event. Although there has been much written about the optimal features of the physician-patient interaction and the ABIM has recently published a careful analysis of the components of these interactions (1, 2), our observations do not exactly parallel these analyses. Rather, the defects of interviews that we have seen seem to be classifiable into five major syndromes (Table 1). These syndromes are disorders of physicians and of their processes, not of patients. This paper exemplifies and discusses these five syndromes and the implications of such findings. The examples cited are real and are drawn from observed interviews. The discussions are the results of 2 years of weekly interview conferences held with house staff and focusing on "the problem interview—what can go wrong."

Syndrome 1: Low Therapeutic Content

CASE 1

The interviewer failed to knock at the patient's door. He introduced himself in a hasty mumble so that the patient never had his name clearly in mind. He mispronounced the patient's name once and never used it again. The physician conducted the interview while seated in a chair about 7 feet from the patient. There was no physical contact during the interview. C several occasions the patient expressed her emotional distres On each occasion the interviewer ignored the emotional conte of her statements.

A. *Dr. X:* "Exactly where is this pain?"
Patient Y: "It's so hard for me to explain. I'm trying to d as well as I can." (Turning to husband:) "Aren't I doing a well as I can?"
Dr. X: "Well, is the pain up high in your belly, or dow low?"

B. *Patient Y:* "I kept getting weaker and weaker. I didn't want to come to the hospital. I was so frightened" (weeping).
Dr. X: "Did the pain come before the weakness or after ward?"

The physical examination was brusque, the examiner neve warning his patient when painful maneuvers (for example stroking the sole of the foot) were to be done. At the end of th examination the physician failed to comment on his findings o his plans. He said in parting, "We'll do some tests and see if w can find out just what's the matter with you," and left the room before the patient had an opportunity to question him.

COMMENT:

Although physicians realize that a patient suffers from more than pain, many have not systematized the features of the patient's distress. Many physicians are unaware of the therapeutic opportunities that present during an interaction with patients. It is news to many of our house staff that a diagnostic interview should be therapeutic to the patient. (Fortunately it is good news.) The term therapeutic implies a process that is sensitive and helpful to emotional distress. In response to illness, hospitalization, and ongoing treatment, the patient has undergone a disruption of emotional equilibrium and needs help in establishing a new equilibrium. Therapeutic measures need not be directed solely to a disease but to an understanding of the patient, his personality, and his distress.

This exemplified interview was bound to exacerbate fears the hospitalized patient suffers: fears of the unknown, of dreadful outcomes, of disability, or of death. The hospitalized patient suffers depressing loss of adult status, privacy, and control of the space he lives and works in. Most painfully, he becomes isolated from his usual support systems and people—isolated with his fears. An effective diagnostic interview provides the patient with support through understanding his feelings, while failure to respond humanely to the patient can further his distress.

Therapeutic behavior includes the following.

1. Adult-to-adult amenities—knock on door to request permission before entering room, clear introductions, use of names in direct address, appropriate goodbye on leav-

▶ From the Department of Medicine, Presbyterian Medical Center, and the Department of Psychiatry, University of Colorado Medical Center; Denver, Colorado.

ing (3). The use of the familiar rituals of meeting is therapeutic in itself, for it affirms that the patient has not strayed beyond the bounds of civilization into the hands of the technicians. These are probably the easiest therapeutic steps to teach to our students and staff.

2. Attention to the patient's comfort, an effort to achieve privacy, initial explanation of the steps of the history and examination.

3. Careful listening during the interview; space and time must be provided for the patient to tell his story. Thoroughness of the history and examination.

4. Understanding or supportive statements made during the interview. Such support leads the patient to know that the physician understands his feelings (4). The message a therapeutic physician sends is always on the order of "I am with you." In fact, the task of support can be viewed simply as being with the patient.

In the two quoted excerpts of this interview the interviewer might have responded to A with, "You are doing well. I think you are doing just fine" (reassurance about her part in the project), and to B with, "It sounds like a very frightening experience" (supportive).

Novice interviewers are sometimes so eager to get the right diagnoses that they do not allow themselves to be receptive to the patient's feelings about the interview process itself. Most patients are eager to be helpful in their treatment. A physician who sees the patient as an ally, an adult like himself, burdened with discomfort they both want to relieve, will enlist the patient as a part of his treatment rather than viewing him as an object to be treated. The novice physician frequently views the patient as a container of disease, not a person with pains or problems. He has studied body parts, physiology, and pathology; it is logical that this is what he is fascinated with and anxious to prove his mastery of. He has to learn that he is a physician caring for people, not a pathologist of live bodies. A therapeutic interview strengthens doctor, patient, and the bond between them. A nontherapeutic interview leaves a doctor and patient estranged; it is devastating to patient and doctor-patient relationships. Since therapeutic interviews usually seem to be diagnostic as well, it might be wise to emphasize the therapeutic goals above all.

Syndrome 2: Flawed Data Base

CASE 2

The clinical interview took 44 min to complete. Time allocation was as follows: introduction—1 min; definition of chief complaint (cardinal symptom) and development of present illness—15 min; major past medical events, health hazards (smoking, alcohol, medications), and family illnesses—8 min; and review of systems—20 min.

Table 1. Defective Interview Syndromes

1. Interview of low therapeutic content
2. Flawed data base
3. Defective hypotheses generation
4. Failure to demand primary data
5. Inappropriately high control style

Table 2. Interview Data Base

1. Identify patient, life style, current concerns
2. Develop the story of the present illness
3. Define other active problems and health hazards
4. Identify family members and illnesses
5. Review major past events
6. Review of systems—a search for missing data

COMMENT

Three significant problems are observed in this allocation of time. First, the interview was too long. The physical examination added another 30 min. Second, there was a long and very positive review of systems. The patient uncovered many insignificant as well as a few significant active problems. Third, the data base omitted *the patient*. The interviewer knew at the end that the patient was a 70-year-old widow but knew nothing of her life, her major concerns other than health, her interests, or her way of dealing with life.

We suggest restructuring the interview more or less as follows (Table 2): [a] introduction—1 min; [b] understanding of the patient's life, habits, and interests outside the hospital—5 min (This usually develops easily with requests such as, "Before we get started on your illnesses, can you tell me a little about yourself?" "What are your most important concerns?" "Who else is important to you?" "What do you do when you are feeling well?"); [c] definition of chief complaint and development of present illness—15 min; [d] definition of other *active problems*—5 min (This usually develops easily with requests such as, "What other sorts of problems have you been having lately?" "How are you otherwise?" "What else is bothering you?" Clearly, these problems may be medical, social, psychological, or financial. This step empties the review of systems of significant positive data. If this is done well, the review of systems will largely be negative. The patient with a "positive review of systems" has invariably had an interviewer who omitted this intermediate step.); [e] major past medical events, health hazards, and family definition, including illnesses—8 min; and [f] review of systems, obliged to be short by the emptying maneuver described above—3 min.

This organization leads to a more complete data base as well as to a less tedious interview.

Syndrome 3: Failure to Generate Hypotheses

CASE 3

Dr. X: "Hello, I'm Dr. X. Are you Mr. Y?"
Patient Y: "Uh, uh—yeah" (sleeping in bed in a darkened room, he barely opens one eye halfway).
Dr. X: "I need to talk with you. I'd like you to tell me what sort of trouble you've been having."
Patient Y: "Uhuh."
Dr. X: "Why did you come here?"
Patient Y: "It hurt. It's better now."
Dr. X: "Tell me more about this hurting, can you?"
Patient Y: "Yeah, over here" (points to his flank in a vague way).
Dr. X: "Go on."
Patient Y: "Woke me up. Terrible."
Dr. X: (Silence—finally after 1-min pause.) "Can you tell me more?"
Patient Y: (Clearly sleeping.)

Table 3. Why Interviews Go Wrong

The Patient is
Confused
Asleep or sleepy
Very sick, perhaps urgently so
A theorist
Circumstantial
Telling a saga of medical care
Tangential
Angry
Depressed
Denying symptoms or their significance
Concerned with an urgent need
Psychotic
Deaf or mute
A foreign-language speaker
Aphasic
There are
Distractions in the room, for example, noisy television set
Relatives or friends in the room
Relatives or friends who perceive an urgent need

COMMENT:

Case 3, which seems so trival a problem, unfortunately exemplifies a common disturbance and one that may destroy the usefulness of the entire interview. The interviewer in Example 3 was having trouble with a sleepy patient who recently had been given a narcotic and was resting in a darkened room. It seems probable that he had not formulated any hypotheses about the nonresponsiveness of his patient since he took no steps to improve the situation (turning the lights on or sitting the patient up might have helped).

The interview process is not a passive process (5). It is a creative act shared by interviewer and patient. The interviewer continually generates hypotheses and tests them during the interview. There seem to be four sorts of hypotheses generated: [a] hypotheses about what *problems* are getting in the way *of* the *interview;* [b] hypotheses about the *story itself.* What is the symptomatic development of the patient's illness? Did the patient say, for example, that he had cough first or did shortness of breath come first?; [c] hypotheses about the *diagnoses* or problems being described. Osler's search for a unifying hypotheses; and [d] hypotheses about the *sort of person* this patient is.

No observer has access to the mind of the interviewer and no observer can know what the interviewer is thinking. The observer can, however, make estimates by listening to the interviewer's questions and comments and by watching his behavior. When the interviewer fails to act or comment appropriately, the observer must wonder what he was thinking at that time. There is nothing quite to match the frustration of observing a physician who acts as if unconscious of obvious difficulties in his interaction with a patient. The observer, if conscious himself, usually comes away dumbfounded from such an experience.

The most important types of working hypotheses may be those dealing with difficulties the interviewer is having during the interview. He must have a way of answering the question, "What is going wrong with this process?" Once he has an answer, he can act to improve the situation. Our review of observed interviews suggests that something goes wrong very often—perhaps a majority o times. The interviewer must deal with these problems and to deal with them he must first make some tentative diagnosis about the nature of the problem.

Table 3 lists some of the common patient- and setting engendered sources of difficulties. When interviews do not go well, some of the trouble stems from physician behavior. Often, however, the problem rests in a disturbance of the patient, perhaps a concern that is not being communicated to the physician.

Just as hypotheses must be formed on disorders of the interview process, one must also translate the patient's story into understandable symptoms. Weiner calls this the first half of the required "double translation", the second half consisting of a translation into medical diagnosis (WEINER S. Personal communication.). We find that interviewers may simply get the story wrong. The interviewer may correct this problem by retelling or summarizing the story at several stages of the interview. This allows his patient to correct the misheard details. In fact, we find the phenomenon of a patient who tells a different story to each interviewer largely explainable by the interviewers' failures to test the details of the story with the patient.

The novice interviewer often has little awareness that normal, nonpsychotic persons differ remarkably in their personality types and characteristic styles of coping. To such an interviewer, the idea of formulating a hypothesis about what sort of a person his patient is might be a novelty. Kahana and Bibring (6) have presented a useful differential diagnosis of normal personality types that we find useful as a starting point (Table 4).

Syndrome 4: Failure to Demand Primary Data, Acceptance of Secondary and Tertiary Data

CASE 4

Dr. X: "Hello, I'm Dr. X. Are you Mr. Y?"
Patient Y: "Yeah, I'm glad to know you, Doc."
Dr. X: "Can you tell me why you've come to the hospital?"
Patient Y: "Sure, I'm here for chemotherapy. I've got multiple myeloma, and Dr. Jones wants to try something new on me."
Dr. X: "What sort of treatment have you been getting so far?"
Patient Y: "Oh, they've given me everything but the kitchen sink. They've taken marrow samples and given me cobalt to my spine, and lately I've been on a bunch of drugs."
Dr. X: "How have you been doing?"
Patient Y: "Pretty good except that I got a bladder hemorrhage from the Cytoxan and lately my white blood cell count has been low, I guess. That's why Dr. Jones sent me over here."

Table 4. Personality Types of Nonpsychotic Persons*

1. The dependent, overdemanding personality
2. The orderly, controlled personality
3. The dramatizing, emotionally involved, captivating personality
4. The long-suffering, self-sacrificing personality
5. The guarded, querulous personality
6. The superior, very-important-person personality
7. The aloof, uninvolved personality

* From Reference 6.

Dr. X: "How low has it been?"
Patient Y: "I'm not sure Doc. Something like 500, I think. Besides I think there's something wrong with my chest x-ray they're going to check out."
Dr. X: "How long have you had myeloma?"
Patient Y: "They found it in 1973. I had gone to my family doctor for about 6 months and he never seemed to get anywhere. Finally, he sent me here, and Dr. Jones picked it up right away. He found it in my bone marrow."
Dr. X: "What did he do then?"
Patient Y: "He put me on Alkeran pills. I've taken a whole lot of them for the last few years."
Dr. X: "And when did the chest x-ray become abnormal?"
Patient Y: "That was last December. The doctor took one about 7 months before and he wasn't worried about it, but this time he thought we ought to check it out."
Dr. X: "All right, I think I have it now."

COMMENT

This interviewer has missed much of his job. It might) him to ask questions such as, "How have you been ing?" He may need to ask specifically for "symp-ns," a commonly understood word. He may have to ll the patient that he needs to know more about the ıtient's sensations and distresses—less about the doc-r's data and diagnoses. One goal of the clinical inter-.ew is to learn what it has been like to have this illness; ıe interviewer missed this goal entirely. He definitely oes *no:* "have it now." He knows nothing about the mptomatic history of his patient's illness. Without such nowledge he cannot come to any new diagnoses but nly accept those previously reached by other physicians.

The interviewing process generates a great deal of in-rmation, much of which is useful. One may learn about ıe patient's hopes and past experience with physicians nd illness, and one may learn how sophisticated the pa-ent is about diagnoses and pathophysiology. However,) reach a diagnosis one must get primary data, material *nown* to the patient. In medicine, primary data are al-ays *symptoms.* Secondary data are material known by nother and told to the patient, such as laboratory results r physical findings. Tertiary data are interpretations re-ycled by the patient; the patient retells what he thinks ıe physician said when the physician processed what he ıought the patient had told him. Both secondary and rtiary data would be viewed in a court of law as hearsay vidence, inadmissible because they were not the testimo-y of an eyewitness. Unfortunately patients often give us ıore "hearsay" material than information about their mptoms, with the mistaken notion that technical lan-uage will be more readily acceptable to the doctor than hatever a lay person could say about his illness in his wn words. It is the job of the interviewer to interrupt his flow of less useful material and lead the patient back) the symptoms of his illness. The present illness should e an elaboration of these primary data, not a saga of ıedical-care. Accepting secondary and tertiary data in eu of symptoms leads to development of a pseudohisto-y—it looks and sounds like a history but in fact tells ttle about the patient's illness. The example cited really epresents a meeting of a saga-of-medical-care-telling-pa-ent and an accepting-tertiary-data-doctor.

Syndrome 5: The High Control Style ("My Doctor Doesn't Listen to Me")

CASE 5

Dr. X: "Hello, I'm Dr. X; are you Mrs. Y?"
Patient Y: "Yes, I'm glad to know you."
Dr. X: "What sorts of troubles have you been having?"
Patient Y: "I've been going downhill for 2 years. Nothing seems to be working right."
Dr. X: "What is the worst part?"
Patient Y: "My legs. I have constant pain in my legs. It's gotten so bad I can't sleep."
Dr. X: "What about your breathing?"
Patient Y: "Oh, that's all right. I can breathe fine. I just hurt so bad in my legs.
Dr. X: "Are you still smoking?"
Patient Y: "Yes, with this pain I've gone back to cigarettes for relief. But I'm down to half a pack or so a day."
Dr. X: "Are you having pains in your chest?"
Patient Y: "No."
Dr. X: "How about cough?"
Patient Y: "No, I hardly ever cough."
Dr. X: "How much are you actually able to do?"
Patient Y: "Well, I was able to do everything until about 2 years ago, but now I can hardly walk half a block."
Dr. X: "Why is that?"
Patient Y: "My legs. They hurt."
Dr. X: "Do they swell up?"
Patient Y: "Well, they've been a bit swollen the last 2 or 3 weeks but the pain is there whether they swell or not."
Dr. X: "All right, I want to ask you some things about your medical history now."

COMMENT

This interviewer was symptom oriented. He even made an effort to elicit a chief complaint. Unfortunately he had been forewarned of a diagnosis of severe chronic lung disease, and indeed the patient appeared a bit cyanotic. It was understandable that he wanted to know about the respiratory system. However, he never was able to hear the patient's story about the leg pain. During the interview the doctor tended to talk more and more, the patient less and less. Frequently the patient seemed limited to yes/no answers. This monosyllabic patient was viewed by the interviewer as "not wanting to talk" but in fact had been forced to this point by the interviewer who used direct questions to control and limit the interview rather than facilitate it. This interviewer needs to use phrases such as, "Tell me about it." Most important, he needs to realize that the patient's job is to tell his story and the physician's job is to listen and hear. This patient was never allowed to describe her chief problem, leg pain. Although colleagues know this interviewer to be a kind, concerned, and gentle person, his interview style is such as to lead patients to view him as arrogant.

This interview style may be described as high physician control, low patient control. Much more appropriate, especially early in the interview, is a style emphasizing more equally shared responsibility by patient and physician. Silence, general requests, facilitation, and open-ended questions are more helpful than direct questions in developing the patient's story. Another benefit of a less high control style is the development of a partnership relation between patient and doctor.

It is not easy to steer between the Scylla of overdirection and the Charybdis of digression. During the patient's

narrative the interviewer may interrupt to redirect the patient toward a report of her symptoms, their relation to physiologic functions, their relieving and exacerbeting factors, and their temporal sequence. When she is on track, however, he should stay out of her way. As the interview progresses, the physician may exert more control and ask more specific questions. He can then ask for clarification of previously unclear historical material. In the beginning the patient's voice should be heard and little of the interviewer's. Later the physician may have a more vocal part in the event (7).

Discussion

Observation of more than 300 clinical interviews has led to the definition of five syndromes of defective interviewing. The differential diagnosis presented herein is unpolished. Further study may refine the syndromes discussed and perhaps will lead to etiologic understanding and improved methods of correcting these disorders of physicians. Further studies also need to be done to understand the long-term effects on the patient of defective interview process. For example, is there any relation between any specific defect of the doctor-patient interaction and such phenomena as patient noncompliance with therapy? In fact, we know very little about the clinical outcomes of what seems to us a distorted process.

There is no unanimity on the possibility of correcting these defects. Some faculties believe that clinical skills and attitudes are largely unteachable and can only be selected for, perhaps optimally before medical school. It is our contention that these skills and attitudes can be learned and taught. We believe that an essential step in the teaching of clinical skills is an accurate diagnosis of the defects present. As with other disorders, correct therapy, in this case educational, follows correct diagnosis. We believe that the thrust of clinical competence evaluation must be to correction of defects rather than to elimination of residents who show those defects. Diagnosis of a characteristic defect may best precede therapy for that defect (8). Such educational therapy is not always easy even when correctly aimed for the physician, who may respond with denial, rationalization, and other defenses. With patience and by avoiding a punitive approach, we have been pleased to see dramatic improvement in several cases.

▶ Requests for reprints should be addressed to Frederic W. Platt, M.D.; Presbyterian Medical Center, 1719 East Nineteenth Avenue; Denver, CO 80218.

Received 30 April 1979; revision accepted 27 August 1979.

References

1. COMMITTEE ON EVALUATION IN GENERAL INTERNAL MEDICINE. *Clinical Competence in Internal Medicine.* Philadelphia: American Board of Internal Medicine; 1979.
2. AMERICAN BOARD OF INTERNAL MEDICINE. Clinical competence in internal medicine. *Ann Intern Med.* 1979;90:402-11.
3. FRANK J. Physical diagnosis and the doctor-patient relation. *N Engl J Med.* 1976;294:1464. Letter.
4. BERNSTEIN L, BERNSTEIN RS, DANA R. *Interviewing: A Guide for Health Professionals.* 2nd ed. New York: Appleton-Century-Crofts; 1974:110-28.
5. BENBASSAT J, SCHIFFMANN A. An approach to teaching the introduction to clinical medicine. *Ann Intern Med.* 1976;84:477-81.
6. KAHANA RJ, BIBRING CL. Personality types in medical management. In: ZINBERG NE, ed. *Psychiatry and Medical Practice in a General Hospital.* New York: International Universities Press; 1964:108-23.
7. ENELOW AJ, SWISHER SN. *Interviewing and Patient Care.* New York: Oxford University Press; 1972:29-64.
8. MILLER GE. New instructional methods in residency training. *Association of Program Directors in Internal Medicine Newsletter.* 25 March 1979.

Part II - B.3.

A 52-Year-Old Suicidal Man

Douglas G. Jacobs, MD, Discussant

DR PARKER: MR D IS A 52-YEAR-OLD MAN WHO, IN DESPAIR, almost jumped in front of a moving train. He attributes this episode to gambling debts piled up in the prior 6 months and the ensuing conflict with his family. He is a resident of Boston and has health insurance through his blue-collar job.

Mr D describes a history of depression dating to his youth. He grew up in a "tough" family, with a father who gambled and drank and brothers who used drugs and alcohol. He has had suicidal thoughts on many occasions but strongly contemplated suicide only once before when he was briefly held in solitary confinement while in jail for a minor crime.

Despite attending a gambling addiction program, he relapsed and lost several thousand dollars gambling. His problem was magnified because he lost another individual's money as well. A family member was terminally ill at this time, and Mr D got little food or sleep. He considered staging his own accidental death so his family could collect on his life insurance. He denied any access to firearms. His family encouraged him to voluntarily admit himself to the psychiatric ward.

Mr D described his mood as "hopeless," with diminished appetite, poor sleeping, and decreased energy and ability to concentrate. He described feelings of shame and guilt. When asked why he did not jump, he answered that his religious beliefs held him back. In addition, a relative had committed suicide some years ago, and he felt some obligation to "help others prevent that."

Mr D has no prior psychiatric hospitalizations. He denied current alcohol use and admitted to past use of marijuana and LSD as a teenager. He quit smoking cigarettes many years ago. Mr D erratically attends a gambling addiction program and is in treatment with a psychiatrist who monitors his medication use. His past medical history is unremarkable.

Mr D completed high school and some college, has been married for 3 decades, and has children in their early 20s who are "doing well."

He is currently taking fluoxetine hydrochloride, 40 mg daily, and trazodone hydrochloride, 50 mg daily.

On examination, Mr D exhibits a depressed affect with slowed speech. He tends to avoid eye contact, although he became more engaged throughout the interview. There was no psychotic content. He did not know when he would be ready to leave the psychiatric ward.

MR D: HIS UNDERSTANDING AND PERCEPTIONS

I'm from a family that doesn't show emotions. A relative hung himself when he was a teenager. I think I was depressed for a long time after that. Then I lost a job, and I had all this leisure time. I have a history of having a little violence in my background. I left home when I was still a kid.

I was what they call a hippie. I'm the opposite now. My drug of choice was LSD. I used to hitchhike all over the place. I lived on the streets. I got picked up, and it was a long weekend. And I had a beef in jail, and I ended up in the hole. I did a lot of thinking in there, and I think I almost killed myself right there. I don't know why I didn't.

I started gambling, and the old saying when you're gambling is, "If I ever get even, I'll quit." Well, a few years ago, I got even and I quit. Then I broke out, and I got even and I said, "I'll quit." You get out of control. It's a compulsive thing. Everywhere I go, my compulsion is gambling. I mean, every member of my family gambles. "You know the number last night? There's $20 million in the jackpot. You going down to the race track?" My mother was a gambler, my father was an alcoholic gambler.

I got into such a financial hole, I was thinking of going out and getting even by pulling an armed robbery or something. And I got scared. That wasn't the way out. It is, and it isn't. I just started over the past month thinking whether to do that, or you know, you're on the train or waiting for the train, and you're looking at it saying, "Should I just jump in front of it?" I came within inches of jumping. I had a [feeling] as if I was seesawing . . . "Should I, shouldn't I?" And then I said, "No, I can't." I started thinking about the family, and I didn't do it. Then I started thinking about ways of doing it, so my wife would get the insurance and stuff. The biggest worry for me right now is

This conference took place at the Combined Longwood Psychiatry Grand Rounds of the Massachusetts Mental Health Center, the Beth Israel Deaconess Medical Center, and the Brigham and Women's Hospital, Boston, Mass, and was held at Beth Israel Deaconess Medical Center on February 8, 2000.

Author Affiliation: Dr Jacobs is Associate Clinical Professor of Psychiatry, Harvard Medical School, Boston, and Executive Director, Screening for Mental Health, Wellesley Hills, Mass.

Reprints: Erin E. Hartman, MS, Division of General Medicine and Primary Care, Beth Israel Deaconess Medical Center, 330 Brookline Ave, LY318, Boston, MA 02215.

Clinical Crossroads at Beth Israel Deaconess Medical Center is produced and edited by Tom Delbanco, MD, Richard A. Parker, MD, and Anne-Marie Audet, MD; Erin E. Hartman, MS, is managing editor.

Clinical Crossroads Section Editor: Margaret A. Winker, MD, Deputy Editor.

Table 1. Suicide Assessment Protocol*

1. Identify predisposing factors
2. Elucidate potentiating factors
3. Conduct a specific suicide inquiry
4. Determine the level of intervention
5. Document the assessments and treatment plan

*From: Jacobs DG, ed. *The Harvard Medical School Guide to Suicide Assessment and Intervention*. San Francisco, Calif: Jossey-Bass Publishers; 1999.[1] Copyright 1999, John Wiley & Sons. Reprinted by permission of Jossey-Bass Inc, a subsidiary of John Wiley & Sons, Inc.

Table 2. Suicide Risk Factors for Adults*

Demographic
Men at greater risk than women
Marital status: widowed, divorced, and single individuals at greater risk than married individuals (more pronounced in men)
Psychosocial
Lack of or recent loss of social supports
Recent loss of employment
Fall in social and/or economic status
Psychiatric/Medical
Presence of a psychiatric diagnosis
Comorbidity
Physical illness
Family history (genetic transmission)
Psychological turmoil (perturbation)
Previous attempt(s)
Miscellaneous
Alcohol use or abuse
Presence of firearms

*From: Klerman GL. Clinical epidemiology of suicide. *J Clin Psychiatry*. 1987;48(suppl 12):33-38.[4] Copyright 1987, Physicians Postgraduate Press. Reprinted by permission.

shaming members of my family, because we don't do this, you know.

The past 2 years have been very hectic. Even when I wasn't gambling I was getting into these uncontrollable rages. Good friends of mine would come up to me and say, "Gee, pal, you're losing control."

Around our way they have a saying, if you put time between a crime, that will be less time you do. And like, put time between the thoughts then maybe you won't do . . . what I'm looking at.

I hope you translate whatever I'm saying to benefit maybe someone else.

AT THE CROSSROADS: QUESTIONS TO DR JACOBS

What is the extent of the problem of suicide in the United States for adults? How do we evaluate suicide risk? What are particular warning signs, and how can the primary care physician identify patients in the outpatient setting who may be considering suicide? Do different methods of attempting suicide (eg, shooting, hanging, overdose, or jumping) have different implications? What are the elements of an evaluation of a suicidal patient? What role do medications play? What would you recommend for Mr D?

DR JACOBS: Specific suicide rates vary according to age and sex, but overall, suicide is the eighth leading cause of death nationwide. Of people who complete suicide, 90% to 93% have at least 1 major psychiatric disorder, usually affective disorder, schizophrenia, or alcoholism. Frequently they have comorbid mental illnesses. Men complete suicide more often than women (4:1), but women make more suicide attempts.[1]

Approximately 30 000 people commit suicide each year, which represents 1.4% of all deaths in the United States. The surgeon general recently identified suicide as a public health problem and urged the nation to focus on suicide as a national health issue. Statistics driving this national call to action focus on the increase in suicide rates among teenagers, suicide's rise from the ninth to the eighth leading cause of death nationwide within the last year, and the deep secrecy associated with suicide.[2]

Suicide profoundly affects the survivors, and, in the case of Mr D, this appears to be one of his reasons for participating in the interview. Mr D indicated that the cluster of suicides among teenagers in the mid 1990s,[3] which included his relative, was so painful for him that he agreed to take part in this case conference. He hoped his participation in the difficult interview would help physicians better understand the issue of suicide and help them prevent others from committing suicide.

Suicide Risk Assessment

I recommend using a comprehensive suicide assessment protocol (TABLE 1).[1] Many risk factors have been identified as being associated with suicide (TABLE 2). However, none of the risk factors, alone or in combination, are specific enough to predict which individuals will complete suicide. Although we cannot predict who will complete suicide, we can assess an individual's level of risk for suicide, and this helps us plan treatment.

Risk factors for suicide fall into 2 categories: predisposing factors and potentiating factors. Other authors have made similar distinctions, dividing risk factors into distal (foundation or root cause) and proximal factors (precipitating or triggering factors).[5] The predisposing (distal) risk factors include the major psychiatric syndromes of depression or affective illness, schizophrenia, alcoholism or substance abuse, and certain personality disorders. Pathological gambling, present in Mr D's case, is an addiction that increases risk in a manner similar to other addictive illnesses.[6,7]

Specific risk factors are associated with each of the diagnoses mentioned above. The number 1 distal risk factor for suicide is affective disorder (mood disorder), with more than 60% of individuals who complete suicide having some form of affective disorder.[8] Anxiety and panic symptoms that occur in the context of a major depression also increase suicide risk. This information is relevant for physicians of all disciplines because both depression and the symptoms of anxiety are risk factors that are modifiable through interventions such as medication, psychotherapy, and relaxation techniques.[9]

Based on Mr D's clinical presentation, he would be considered a suicide risk (Table 2). He is male, had a drop i

economic status, had a psychiatric diagnosis with comorbidity, was in psychological turmoil, and had suicidal ideation. In addition, he has antisocial traits, which increase suicide risk. His personality traits are likely to make him chronically vulnerable to suicidal thoughts when he feels humiliated or deeply ashamed.

Potentiating risk factors include situational stressors that, when combined with a predisposition to suicide from mental illness, increase the individual's vulnerability to suicide. The potentiating or proximal factors include: physical illness, intoxication, a toxic family or social milieu, access to guns or other methods of suicide, and intense life stresses or crises.[1] In general, the risk factors for suicide are additive such that the more risk factors an individual has, the greater the risk of suicide.[3]

The obvious potentiating risk factors in Mr D's life are the financial difficulties and estrangement from his family that result from his pathological gambling.

Screening for Depression

Mr D's symptoms would have been detected by a primary care physician using a depression screening tool, even if the physician had not first independently asked about suicidal ideation. In fact, a screening tool would have been a useful avenue for opening such a dialogue.

In the last 10 years, depression screening has proven to be an effective and efficient way of identifying those with undiagnosed depressive illness and is a useful tool for the primary care physician attempting to ascertain the likelihood and severity of depression and the presence of suicidal thoughts.[10] Besides identifying possible serious cases of depression that can lead to suicide, most depression scales include a specific question about suicidal ideation.

A nonprofit organization, Screening for Mental Health, through its annual National Depression Screening Day (NDSD)[11-13] has provided an easy-to-use screening form (the HANDS, Harvard Department of Psychiatry/National Depression Screening Day Scale, FIGURE) designed to minimize physician time by quickly identifying patients who have a positive score or who endorse a suicide question. (The screening form is filled out by the patient in the waiting room and scored by a secretary or other staff. Completed forms are placed in the patient's file for the physician's review.)

The results of this screening effort are striking. Fully 22% of primary care patients had a positive score for depression, including 45% who have received treatment for alcohol abuse, 28% of those with stroke, 19% of those with cancer, 23% with diabetes, 27% with arthritis, and 23% of those with heart disease (unpublished data analyzed by the National Institute of Mental Health from completed screening forms collected by Screening for Mental Health from participating primary care clinicians in 1999). These findings underscore the need for depression screening in primary care settings and the ease with which it can be incorporated. Depression screening is simple, cost-effective, reliable, and potentially money saving because it can identify previously unidentified depression without the time-consuming and costly burden of attempting to diagnose vague medical complaints that often bring the patient into the office for numerous visits.

Figure. The Harvard Department of Psychiatry and National Depression Screening Day Scale

THE HANDS: The Harvard Department of Psychiatry/National Depression Screening Day Scale

Over the Past Two Weeks, How Often Have You:	None or Little of the Time	Some of the Time	Most of the Time	All of the Time	For Staff Use Only
1. Been feeling low in energy, slowed down?	0	1	2	3	
2. Been blaming yourself for things?	0	1	2	3	
3. Had poor appetite?	0	1	2	3	
4. Had difficulty falling asleep, staying asleep?	0	1	2	3	
5. Been feeling hopeless about the future?	0	1	2	3	
6. Been feeling blue?	0	1	2	3	
7. Been feeling no interest in things?	0	1	2	3	
8. Had feelings of worthlessness?	0	1	2	3	
9. Thought about or wanted to commit suicide?	0	1	2	3	
10. Had difficulty concentrating or making decisions?	0	1	2	3	
				Total Score:	

Scoring Interpretation

Total Score	Interpretation
0-8	Symptoms are not consistent with a major depressive episode. Presence of a major depressive episode is unlikely.
9-16	Symptoms are consistent with a major depressive episode. Presence of a major depressive disorder is likely. In a self-selected population, such as seen on National Depression Screening Day, it is also possible the person instead suffers from a *DSM-IV* anxiety disorder.
17-30	Symptoms are strongly consistent with criteria for a major depressive episode. Presence of major depressive disorder is very likely.

Certain clinical factors should alert the clinician to the possibility of depression,[10] and screening may be particularly useful in patients who:

- have experienced a recent loss or are undergoing severe stress;
- report vague somatic symptoms (insomnia, headaches, stomachaches);
- express any of the somatic or emotional symptoms of depression;
- have a family history of depression, suicide, or mental illness;
- have a history of self-medicating behavior, including alcohol abuse;
- have a history of self-destructive behavior;
- are currently taking certain medications, particularly antihypertensives, hormones, histamine-2 receptor blockers, anticonvulsants, levodopa, or β-blockers;
- are suffering from a major physical illness such as stroke, cancer, or diabetes;
- are in the postpartum period;
- have a history of diagnosed depression.

By identifying and addressing depression, primary care physicians may also identify suicidal thoughts and behavior.

Multiple screening tools exist, including HANDS.[14] This scale is used in the National Depression Screening Day Primary Care Outreach. It was specifically created to be a brief, easy-to-score, self-report form applicable to a variety of settings that performs at least as well as longer, more complicated scales, and addresses the critical issues of sensitivity and specificity. The HANDS (Figure) has been validated for detecting the likelihood of clinical depression based on criteria for a major depressive episode from the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* (*DSM-IV*). Scores of 9 or greater give a sensitivity of at least 95% and indicate that the patient should be evaluated for the likelihood of a major depressive episode. Specificity in the general population is 94%.[14]

Specific Suicide Inquiry

Primary care providers may worry that asking about suicide will introduce the idea into their patient's minds. My clinical experience is that the opposite is often true. Many patients are relieved when their physician opens a dialogue about suicide; it gives them the opportunity to discuss a frightening and troubling subject and offers the physician the opportunity to both assess the patient and educate him or her about the relationship between suicidal thoughts and depression in particular. By being direct, the physician offers hope, providing a lifeline to a suicidal patient, who, because of feelings of hopelessness, may otherwise become isolated.

People who are experiencing suicidal feelings are almost always ambivalent in those feelings; they have the simultaneous wish to die and wish to live.[15] This ambivalence offers the clinician an opportunity to intervene and ally with the part of the patient that wishes to live.[16] Mr D described his own ambivalence about suicide by saying "I was seesawing."

If gently and tactfully done, asking about suicidal intent can encourage a patient to reveal specific suicidal plans. This can lead to a discussion of alternatives to suicide, which the patient can be encouraged to consider. I believe an inquiry into suicide should be conducted whenever the physician is concerned about suicide risk because of the patient's depression, references to hopelessness or lack of a future, or a positive response to a suicide question on a screening form. The following questions may be used to inquire about a patient's suicidal thoughts.[17]

- Do you ever get so depressed that you think life is not worth living?
- Do you think of hurting yourself or taking your own life?
- Do you have a plan?
- Do you have the means to follow through with the plan?
- Have you ever attempted suicide?

Positive responses to any of the questions should indicate to the primary care physician that the patient is at risk for suicide. The more specific the patient is with regard to a plan and the more lethal the plan is, the more severe the risk. For example, attempts involving shooting or hanging are more likely to be lethal than overdoses or wrist cutting.[1] If a patient has even passive suicidal ideation (eg, "I sometimes wish I would just die in my sleep. I think that my family would be better off without me"), referral for a psychiatric evaluation is the most prudent course. If the patient is actively and imminently suicidal (eg, "Yeah, I've been thinking about dying. I had my gun out this morning. I don't know why I didn't just do it then"), seek emergency psychiatric evaluation.

Mr D experienced suicidal ideation with a very lethal plan. His description of being "inches" from jumping in front of a train is consistent with an aborted suicide attempt, which falls somewhere between suicidal ideation and a suicide attempt in terms of risk severity.[18] If he had presented to his internist's office recently having contemplated jumping in front of a train, his physician would have needed to seek an emergency psychiatric evaluation. The fact that Mr D also was considering alternate methods of suicide increased his suicidal risk. In addition, Mr D demonstrated shame and intolerable rage. Fortunately, the presence of ambivalence and deterrents (primarily his wife and family and his religious beliefs) have positive therapeutic implications.

Determining Appropriate Intervention Based on Suicide Risk

The fourth component of assessing suicidality entails sorting out disorder-based suicidality from personality-based suicidality. Disorder-based suicidality relates to an Axis I disorder (a major psychiatric syndrome [*DSM-IV*]), such as depression, and consists of prominent feelings of anguish or pain and a wish to escape. The risk tends to be more acute. There is a compulsive, driven quality. The options for treatment include medication, hospitalization, supportive psychotherapy, or electroconvulsive therapy.

Personality-based suicidality results from feelings of anger, aggression, or vengeance. The risk tends to be more chronic. There is also a complicating impulsive quality to it. When possible, the patient should be accorded as much responsibility as possible. This can be given only in the context of assessing the treatment alliance. Regardless of the basis of suicidality, primary care physicians treating patients who have the ability to carry out a suicide plan should seek emergency psychiatric consultation, voluntary psychiatric admission, or both. If patients are unwilling to be admitted for psychiatric evaluations, the primary care physician should seek the consultation of a psychiatrist in evaluating the patient. States differ with regard to their laws pertaining to involuntary commitment.[19]

The Importance of Primary Care Intervention

Studies of completed suicides show that 75% of victims saw a physician within 6 months of their suicide and 60%, within 1 month.[20] These findings indicate that persons considering suicide appreciate that something is troubling them and make the effort to see a clinician, but do not or cannot communicate their suicidal thoughts. Primary care physicians can play a pivotal role in recognizing suicide potential in their patients.[17] At least half of the patients receiving mental health care obtain that care through their primary care provider.[21] In addition to providing psychiatric treatment, primary care providers are often at the point of entry into the health care system and decide when the patient needs psychiatric referral. As responsibility for diagnosing mental illness falls increasingly under the domain of primary care, it becomes more important for these clinicians to be informed about mental health disorders and understand when referral is necessary.[22]

The Role of Medications

Medications have proven effective in the treatment of depressive disorders. Half of people with depression are treated in the medical sector and the other half treated in the mental health care system.[21] I believe it is important when discussing the risks and benefits of antidepressant medication to educate patients and their families about dosage, the purpose and expected benefits of the medication, risks and adverse effects, and length of time for usual response and to emphasize that improvement can be uneven. The feeling of getting worse again after experiencing some improvement can be devastating to depressed patients, contributing to hopelessness and probably increasing suicide risk. If patients have been warned to anticipate that they will feel better some days and worse on others, then they are less likely to be overwhelmed by apparent setbacks.[23]

In recent years, promising reports have been published about the impact of psychopharmacologic agents on reducing suicide risk. For instance, the use of benzodiazepines may modify the risk of suicide by reducing anxiety.[9] Recent studies have determined that lithium has a strong, and possibly unique, protective effect against suicidal acts in persons with major affective disorders and particularly in bipolar forms of manic-depressive illness.[24] Several years ago there was intense media coverage of a possible link between fluoxetine hydrochloride (Prozac), suicidal ideation, and other aggressive acts. This question has been carefully studied and evidence refutes any correlation.[25-27] Clozapine treatment can reduce risk of suicidal acts in patients with neuroleptic-resistant schizophrenia.[28] In summary, recent research seems to support hypotheses that treating psychiatric disorders with appropriate medications can reduce suicide risk. Primary care physicians, however, should remember that depressed patients, particularly in the early phase of treatment, can be at risk for suicide, so that attention should be paid to appropriate follow-up, patient education, and prescription size. In the end, the therapeutic patient-caregiver relationship is a critical life-saving treatment component.

In determining the level of intervention for Mr D, his suicidality should be considered as the combination of his depression (disorder based) and personality traits (personality based). The hospitalization he had was indicated to stabilize the crisis and establish a relationship with the therapist or psychiatrist during the hospitalization. It would be important to review pharmacologic interventions, and to educate the patient and family about suicide potential and managing these comorbid illnesses.

Risk Assessment and Documentation

In the field of psychiatry, documentation of suicide risk assessment must be incorporated throughout the entire treatment process to ensure that the issue has been addressed for other health care professionals reviewing the medical records and for legal purposes. Useful guideposts for conducting assessments include: (1) the first psychiatric assessment or admission; (2) the occurrence of any suicidal behavior or ideation; (3) any noteworthy clinical change; and (4) any change in level of observation for inpatients, such as increasing privileges or giving passes before discharge. Physicians must also plan the frequency of reassessments. This is critical as it acknowledges that suicidality waxes and wanes. For the primary care physician, documentation of the suicide assessment is also crucial for clinical and risk management purposes to demonstrate that the physician has both inquired about suicide and documented the basis for the treatment decisions. In particular, use of pejorative terms such as "gesture," should be avoided when documenting suicidal behavior. Clinicians use the term *gesture* to describe patients who perform minor (rather than lethal) self-destructive acts. However, the fact that the self-destructive act is minor does not mean that the patient is not suicidal or that the intent was not lethal.

Recommendations for Mr D

Mr D has several predisposing risk factors for suicide. Because of his erratic, antisocial personality traits, he needs

exterior, sustaining resources more than most people, yet he is likely to alienate the very people he depends on for support. The combination of these factors means Mr D has a long-term, increased risk for suicide, especially an impulsive suicide in response to a crisis.

Mr D's gambling addiction, almost by definition, sets up crises that potentiate his risk for suicide. Every time he gambles away more money than he can afford to lose, he faces financial stress, rejection by his family, and a further drop in self-esteem. Mr D faces other potentiating risk factors as well: he has not been sleeping regularly, and a family member is ill. His high level of risk for suicide was obviously recognized by his physician, who arranged for his admission to the psychiatric ward.

It was appropriate and necessary to ask Mr D specifically about his access to guns. Despite his assurances that he did not have a gun and would never use one on himself, Mr D is obviously at risk for impulsive suicide. In outpatient planning, it would be prudent to talk to his wife and adult children about his access to guns. Also, it would be crucial to document the inquiry about firearms and that Mr D specifically denied having access to a firearm.[19] If a firearm were present, it would be prudent to document instructions to patient and family.

Mr D described in some detail his aborted suicide attempt when he was "inches" from jumping in front of a train. He was, however, less than forthcoming about current or continuing suicidal thoughts. One has to question whether he is keeping an escape plan to himself. Mr D also implied that his wife does not know the full extent of his difficulties. Given that his connection with his wife is probably the single most important factor keeping him alive, this relationship needs to be addressed.

While some of Mr D's suicidality is attributable to depression, it seems likely that most of his suicidality at this time is related to his personality structure and the crises he faces in his personal life. When we see Mr D interviewed, he is already in inpatient treatment. However, if a primary care physician examined Mr D, he should refer Mr D for an immediate psychiatric evaluation. Mr D needs regular suicide assessments until his acute suicidality remits. Once he is discharged, he should be asked about suicide each time he sees his physician until he is stable, and his family should be instructed to call in the event that he starts gambling again or seems more aggressive and threatening.

A central component in managing the chronic nature of Mr D's suicidality is to educate him and his family about his illness and to develop a working alliance with Mr D's health care providers. Prudent use of antidepressant medication will be useful for treating both this depression and reducing his impulsivity. Encouraging Mr D to be engaged with a gambling addiction program is an important part of building an additional support structure in his life. The challenge in caring for a patient like Mr D, who has an addictive disorder and an affective disorder, as well as elements of a character disorder, is to be supportive and nonjudgmental yet stress the need for him to take responsibility.

QUESTIONS AND DISCUSSION

A PHYSICIAN: Tell us about the decision-making process that brought Mr D into the hospital. I'm still unclear about which patients I should hospitalize and which I should send to a psychiatrist as outpatients.

DR JACOBS: If someone has a major psychiatric disorder with the presence of suicidal ideation and is not involved in a strong therapeutic relationship, then that person should be hospitalized, at least briefly. A man who has considered a lethal method, such as jumping onto a train track, or is thinking of staging an "accident" because of insurance is at very, very high risk. I think we want to believe that our patients want help, that they will tell us how they feel. If someone is feeling suicidal, in my experience, generally they tell us. I've had patients who have talked about serious suicidality in my office, and then I got nervous or anxious saying, maybe we need to do something about this. And one patient said, "Well, Dr Jacobs, if I can't feel suicidal in your office, where else can I feel it?" If individuals are not ambivalent about their suicide, they will not communicate their suicidality. . . . However, the good news is that most patients, even the seriously suicidal, are ambivalent and will communicate their suicidality, thus allowing an opportunity to intervene, whether by increasing visits, altering medications, consultation, referral, or hospitalization.

A PHYSICIAN: You mentioned the high suicide rate in patients with schizophrenia, even higher than in those with depression. But given command hallucinations and that patients with schizophrenia don't always communicate as directly, what does the literature now tell us? How do you sort it out?

DR JACOBS: Eighty percent of suicides are males, and with schizophrenic patients the proportion of males may even be higher. The issue of command hallucinations is somewhat problematic. I would hope that any schizophrenic patient who goes to an emergency department or physician's office having acute command hallucinations will be hospitalized. Part of the problem that schizophrenics have in terms of suicide intervention is their impaired ability to communicate. Because of their repressed affect, they don't appear to be in the kind of internal turmoil that a typical depressed person shows. It's sometimes hard to notice the pain of a schizophrenic person unless the individual is showing some depressive symptoms. Ironically, patients with good premorbid functioning are more aware of their decline, which places them at greater risk for suicide.[29] Male sex, chronic relapsing course, and a history of suicide attempts are risk factors for suicide in that population.

A PHYSICIAN: If the ratio of attempts to completions is about 20 to 1, how should we think about these attempts? Are people really that inept at committing suicide, or are they stopping short of a sure thing?

DR JACOBS: Statistically we believe that for every 23 attempts, there is 1 completion. Most attempts are made by females, with a ratio of 3 to 1. Clearly more females are attempting suicide and not completing it. You have to see attempts as part of the ambivalence and as an opportunity to intervene. The good news is that 90% of people who attempt suicide do not complete it.[1]

A PHYSICIAN: Can you comment on the needs of families who survive a completed suicide and the needs of clinicians whose patients complete suicide?

DR JACOBS: For the family, the issues are guilt, anger, and self-blame. Try to reach out and understand where the family is. There is also a risk-management perspective here, because they can turn that self-blame onto someone else—sometimes the physician. The myth persists among the public that suicide should not happen, and if it does happen, someone did something wrong.

Physicians need to accept that suicides do happen, despite our best efforts. Suicides are part of the work—just like death in any other branch of medicine. You can learn from a suicide, but you have to be careful to avoid confusing feelings of compassion for the family with acknowledging that you wish you had done something differently. If you feel like that, you should probably consult with a colleague or speak with a risk manager.

Funding/Support: Clinical Crossroads is made possible by a grant from the Robert Wood Johnson Foundation.
Acknowledgment: We thank the patient for sharing his story in person and in print. Dr Jacobs wishes to thank Margaret Brewer, RN, MBA, and Joelle Meszler Reizes, MA, for their thoughtful review and editing of this article and Ross Baldessarini, MD, for his helpful comments.

REFERENCES

1. Jacobs DG, Brewer ML, Klein-Benheim M. Suicide assessment: an overview and recommended protocol. In: Jacobs DG, ed. *The Harvard Medical School Guide to Suicide Assessment and Intervention*. San Francisco, Calif: Jossey-Bass Publishers; 1999:3-39.
2. Surgeon General's call to action to prevent suicide, 1999. Available at: http://www.surgeongeneral.gov/library/calltoaction/default.htm. Accessed April 24, 2000.
3. Melley B. In wake of suicides, Boston teens ask city for help. *New York Times*, Interactive edition, national news. April 25, 1997. Available at: http://www.newstimes.com/archive97/apr2597/nab.htm. Accessed February 11,2000.
4. Klerman GL. Clinical epidemiology of suicide. *J Clin Psychiatry*. 1987;48(suppl 12):33-38.
5. Moscicki EK. Epidemiology of suicide. In: Jacobs DG, ed. *The Harvard Medical School Guide to Suicide Assessment and Intervention*. San Francisco, Calif: Jossey-Bass Publishers; 1999:40-51.
6. Rosenthal RJ. Pathological gambling. *Psychiatr Ann*. 1992;22:72-78.
7. Phillips DP, Welty WR, Smith MM. Elevated suicide levels associated with legalized gambling. *Suicide Life Threat Behavr*. 1997;27:373-378.
8. Barraclough BM, Bunch J, Nelson B, Sainsbury P. A hundred cases of suicide: clinical aspects. *Br J Psychiatry*. 1974;125:355-373.
9. Fawcett JA. Assessing and treating the patient at risk for suicide. *Psychiatr Ann*. 1995;23:244-255.
10. Jacobs DG, Kopans B, Reizes JM. Reevaluation of depression: what the general practitioner needs to know. *Mind/Body Med*. 1995;1:17-22.
11. Magruder KM, Norquist GS, Feil MB, Kopans B, Jacobs D. Who comes to a voluntary depression screening program? *Am J Psychiatry*. 1995;152:1615-1622.
12. Greenfield SF, Reizes JM, Magruder KM, Meunz LR, Kopans B, Jacobs D. Effectiveness of community-based screening for depression. *Am J Psychiatry*. 1997; 154:1391-1397.
13. Jacobs DG. National Depression Screening Day: educating the public, reaching those in need of treatment, and broadening professional understanding. *Harv Rev Psychiatry*. 1995;3:156-159.
14. Baer L, Jacobs DG, Meszler-Reizes J, et al. Development of a brief screening instrument: the HANDS. *Psychother Psychosom*. 2000;69:35-41.
15. Shneidman ES. *Definition of Suicide*. New York, NY: Wiley; 1985.
16. Havens LL. Excerpts from an academic conference and recognition of suicidal risks through the psychological examination. In: Jacobs DG, ed. *The Harvard Medical School Guide to Suicide Assessment and Intervention*. San Francisco, Calif: Jossey-Bass Publishers; 1999.
17. Miller MC. Suicide assessment in the primary care setting. In: Jacobs DG, ed. *The Harvard Medical School Guide to Suicide Assessment and Intervention*. San Francisco, Calif: Jossey-Bass Publishers; 1999:520-539.
18. Barber ME, Marzuk PM, Leon AC, Portera L. Aborted suicide attempts: a new classification of suicidal behavior. *Am J Psychiatry*. 1998;155:385-389.
19. Simon RI. Clinical risk management of the suicidal patient. In: Simon RI, ed. *Clinical Psychiatry and the Law*. Washington, DC: American Psychiatric Press; 1992.
20. Blumenthal SJ. Suicide: a guide to risk factors, assessment, and treatment of suicidal patients. *Med Clin North Am*. 1988;72:937-971.
21. Narrow WE, Regier DA, Rae DS, et al. Use of services by persons with mental and addictive disorders: findings from the National Institute of Mental Health Epidemiologic Catchment Area Program. *Arch Gen Psychiatry*. 1993;50:95-107.
22. *Depression in Primary Care, 1: Detection and Diagnosis. Clinical Practice Guideline Number 5*. Rockville, Md: Agency for Health Care Policy and Research, US Dept of Health and Human Services; 1993. AHCPR publication No. 93-0550.
23. Jamison KR. *Night Falls Fast: Understanding Suicide*. New York, NY. Alfred A Knopf Inc; 1999.
24. Baldessarini, RJ. Antisuicidal effect of lithium treatment in major mood disorders. In: Jacobs DG, ed. *The Harvard Medical School Guide to Suicide Assessment and Intervention*. San Francisco, Calif: Jossey-Bass Publishers; 1999:355-371.
25. Salzman C. Treatment of the suicidal patient with psychotropic drugs and ECT. In: Jacobs DG, ed. *The Harvard Medical School Guide to Suicide Assessment and Intervention*. San Francisco, Calif: Jossey-Bass Publishers; 1999:372-382.
26. Tollefson GD, Rampey AH, Beasley CM, et al. Absence of a relationship between adverse events and suicidality during pharmacotherapy for depression. *J Clin Psychopharmacol*. 1994;14:163-169.
27. Fava M, Rosenbaum JF. Suicidality and fluoxetine: is there a relationship? *J Clin Psychiatry*. 1991;52:108-111.
28. Meltzer HY, Okayli G. Reduction of suicidality during clozapine treatment of neuroleptic-resistant schizophrenia: impact on risk-benefit assessment. *Am J Psychiatry*. 1995;2:183-190.
29. Drake RE, Gates C, Whitaker A, Cotton PG. The suicidal schizophrenic. In: Jacobs DG, Brown H, eds. *Suicide: Understanding and Responding, Harvard Medical School Perspectives*. Madison, Conn: International Universities Press Inc; 1989:183.

See Clinical Crossroads Update on next page.

Part II-B.4.

Use of the Mechanistic Case Diagramming Technique to Teach the Biopsychosocial-Cultural Formulation to Psychiatric Clerks

Anthony P. S. Guerrero, M.D.
Earl S. Hishinuma, Ph.D.
Alberto C. Serrano, M.D.
Iqbal Ahmed, M.D.

Objective: Biopsychosocial-cultural formulation is an essential skill for medical students to become familiar with during their psychiatry clerkship. The authors describe their use of mechanistic case diagramming to demonstrate to students, in a single teaching session, how to construct a biopsychosocial-cultural formulation, and they present results of an evaluation of the session's effect on students. **Methods:** *Questionnaires exploring students' views and understanding of biopsychosocial-cultural formulation were administered to 16 students before and after teaching sessions.* **Results:** *Significant increases were observed after the teaching sessions in self-reported understanding of and comfort with presenting a biopsychosocial-cultural formulation and in ratings of the importance of showing linkages between biological, psychological, and sociocultural factors.* **Conclusions:** *The technique of mechanistic case diagramming may be a useful approach for teaching biopsychosocial-cultural formulation. (Academic Psychiatry 2003; 27:88–92)*

Engel (1) introduced the biopsychosocial model as an essential framework that enables physicians to appreciate the multiple causality of disease and the need for a comprehensive approach to patient care. Authors such as Molina (2) have elaborated on the model's practical application in describing the dynamic interaction between biological, psychological, and sociocultural factors. The American Board of Psychiatry and Neurology (ABPN) deems skill in biopsychosocial formulation to be important for the competent practice of psychiatry (3). Because of its importance to psychiatry as well as to the humanistic practice of medicine, we believe that teaching the biopsychosocial formulation to medical students is integral to the role of psychiatric clerkship directors and other psychiatric faculty members.

We agree with Perry et al. (4) that a formulation has applications beyond long-term, expressive psychotherapy and that a formulation need not be elaborate and time-consuming. However, it has not always been clear to psychiatric educators how best to teach skills in effective formulation, and most of the familiar textbooks in psychiatry give little explanation of how to actually construct a formulation. In this article we describe how a process taught to our medical students during the preclerkship problem-based learning curriculum, namely, mechanistic case diagramming (5), is adapted to teaching the principles of biopsychosocial formulation during the third-year clerkship in psychiatry.

The authors are with the Department of Psychiatry, University of Hawaii John A. Burns School of Medicine. Dr. Guerrero is also with the school's Department of Pediatrics. Address correspondence to Dr. Guerrero, Department of Psychiatry, University of Hawaii John A. Burns School of Medicine, Queen's University Tower, Fourth Floor, 1356 Lusitana St., Honolulu, HI 96813. E-mail: GuerreroA@dop.hawaii.edu

DESCRIPTION OF THE TEACHING SESSION

Third-year students at the University of Hawaii John A. Burns School of Medicine were introduced to the biopsychosocial formulation in a 1.5- to 2-hour teaching session during the first 2 to 3 weeks of their psychiatric clerkship. The session involved discussion of two videotaped interviews, conducted by students, of actual patients. After group discussion of an interview, the interviewing student was asked to present the case, during which time either the instructor (A.G.) or one of the students wrote selected facts under the columns "biological," "psychological," and "social-cultural." The instructor explained that biological factors include genetic and acquired risk factors; that psychological factors include stressors, coping abilities, life stage issues, and any other significant life events; and that social factors include social support and other issues that could affect life in the community. We feel that our view of the psychological aspect of formulation is consistent with ABPN's explanation (3) that it should include predisposing, precipitating, and perpetuating factors and phase-of-life issues. The students were taught that social factors should also include relevant cultural issues, which, in keeping with the description of Carrillo et al. (6), may broadly include anything in a patient's background (including religion) that could affect their health-seeking behavior or their relationships with people.

The students were then asked to apply the technique of mechanistic case diagramming (5) to draw linkages between the biological, psychological, and social-cultural factors as they saw appropriate. Most of the students were familiar with this technique from their first two years of medical school. Briefly, the aim of the technique is to trace, in stepwise fashion, using solid arrows in a diagram, the mechanisms leading from underlying factors (including genetic and social or environmental factors) to outward manifestations of illness. Figure 1 contains a sample diagram.

After the instructor produced the diagram, the students were asked to present verbally, as a group effort, a formulation of the case. It was emphasized that a good formulation should be logical enough to diagram as a flowchart, practical enough to guide treatment and any explanations that would be provided to the patient, the family, and other professionals, and believable to its creator. To illustrate especially the second of these, after a discussion of DSM-IV diagnosis, the students were involved in a discussion of treatment planning. Important points of intervention in the patient's pathophysiology were identified (using dotted arrows) in the biological, psychological, and social areas of the diagram. It was emphasized that a strong and well-balanced formulation is an important foundation for a treatment plan and that the plan's effectiveness would be optimal by virtue of its having been comprehensive in approach.

Through construction and discussion of the diagram depicted in Figure 1, students might be able to appreciate the importance of addressing general medical conditions (including, in this case, the thyroid disorder) that could exacerbate psychiatric symptoms; gathering more details about life history and providing supportive therapy to address issues that might affect medication compliance and increase stress; and finding a stable living situation to prevent the problems with homelessness—all in addition to what would seem the obvious treatment of prescribing an antipsychotic medication.

METHOD

Sixteen students (nine men and seven women) from two third-year clerkship blocks in 2001 who were among the first to receive this teaching module were given pre- and postsession questionnaires (Figure 2) designed to assess their comfort level with and their beliefs about the biopsychosocial-cultural formulation. The questionnaire was not anonymous, and it was collected by the instructor (A.G.). All items in all questionnaires were completed.

For the purposes of program evaluation, paired t tests were used to determine whether there were any significant pre-post differences, and Pearson correlations were computed to ascertain associations between variables. Publication of program evaluation results was approved by the Committee on Human Studies of the University of Hawaii.

RESULTS

In general, all students either agreed or strongly agreed that the session was enjoyable. There were significant positive changes between pre- and postsession overall scores ($t = 4.74$, $p < 0.05$), in students' self-reported understanding of ($t = 3.28$, $p = 0.005$) and

comfort with presenting and writing ($t = 5.33$, $p < 0.0001$) a biopsychosocial-cultural formulation. There was also a significant positive change ($t = 2.42$, $p = 0.028$) in students' rating of the importance of showing linkages between the biological, the psychological, and the social. No other significant changes were observed.

In the presession questionnaire, positive correlations were observed between belief that the biopsychosocial-cultural formulation is useful in the care of all patients and belief in the importance of identifying relevant ethnic and cultural factors ($r = 0.73$, $p = 0.0013$); belief in the importance of identifying areas of strength ($r = 0.83$, $p < 0.0001$); and belief in the importance of summarizing and integrating facts in a way that can guide treatment ($r = 0.77$, $p = 0.0005$). In the postsession questionnaire, positive correlations were observed between belief that the biopsychosocial-cultural formulation is useful in the care of all patients and belief in the importance of identifying key biological, psychological, and social factors in a balanced way ($r = 0.70$, $p = 0.0026$) and belief in the importance of summarizing and integrating facts in a way that can guide explanations to patients, family members, and other professionals ($r = 0.56$, $p = 0.024$). There were no significant correlations in either pre- or postsession questionnaires between belief in the formulation's usefulness in the care of all patients and belief in the importance of providing a detailed summary of the case; detailing the biological mechanisms underlying psychiatric illness; tracing the origin of psychiatric symptoms according to psychoanalytic theory; identifying defense mechanisms; or showing linkages between the biological, the psychological, and the social.

DISCUSSION

Limitations of this study include the small sample size and the lack of any data about whether the sessions provide any lasting benefit in improving attitudes toward and skills in biopsychosocial-cultural formulation.

We also recognize the limitations in the biopsychosocial model. This model, as commonly presented, does not necessarily place clinical problems

FIGURE 1. Sample formulation structured as a mechanistic case diagram.

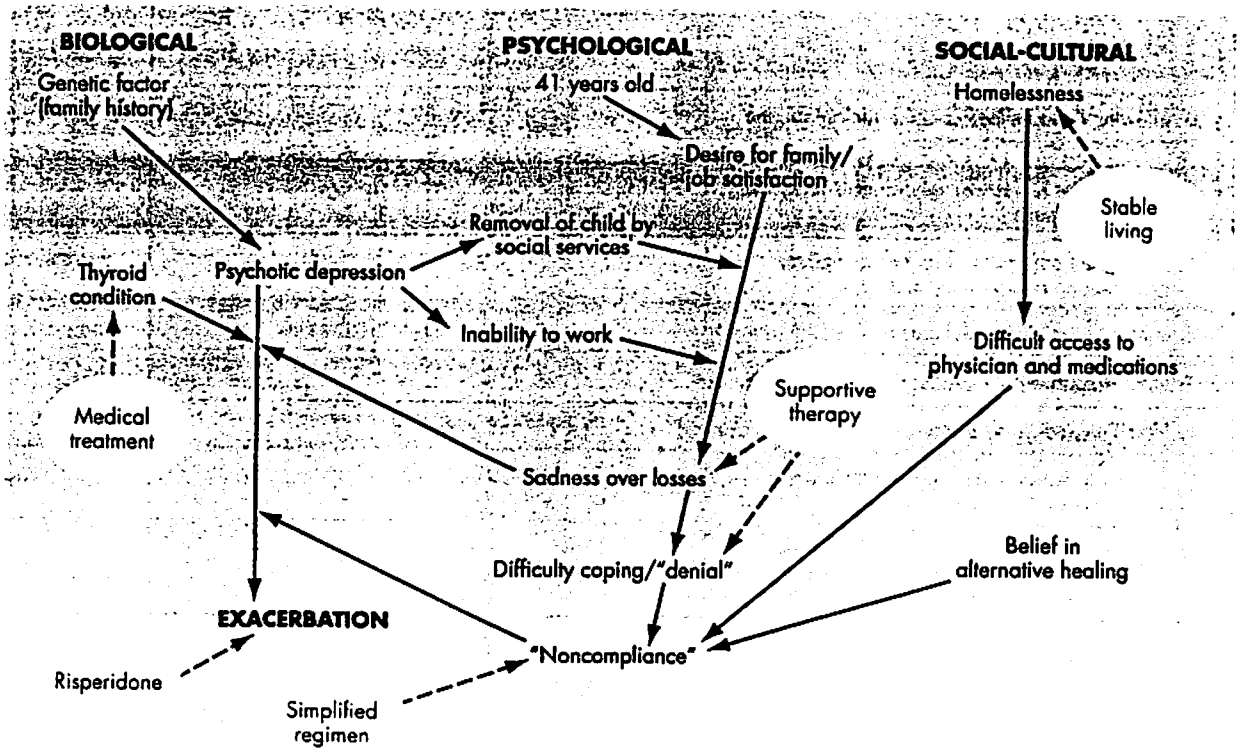


FIGURE 2. **Postsession questionnaire distributed to students. The presession questionnaire was identical except that it did not include item 4.**

UNIT 6 PSYCHIATRY CLERKSHIP

Student questionnaire, the "bio-psycho-social-cultural formualtion" (POST)

Thank you very much for taking the time to complete this questionnaire. Your honest feedback will be very helpful as we try to improve the psychiatry clerkship.

Mahalo nui loa!

Your name _____ Date _____

For each of the following statements, please indicate whether you strongly agree, agree, neither agree nor disagree, disagree, or strongly disagree.

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
1. I understand what a bio-psycho-social-cultural formulation is.					
2. I feel comfortable presenting and writing a bio-psycho-social-cultural formulation.					
3. A bio-psycho-social-cultural formulation is useful in the care of all patients.					
4. Today's session was enjoyable.					

For each of the following items, please indicate whether you feel that it is absolutely essentail, important, helpful but not essential, somewhat helpful, or not important/not helpful at all for a bio-psycho-social-cultural formulation.

	Absolutely essential	Important	Helpful but not essential	Somewhat helpful	Not important/not helpful at all
1. Providing a detailed summary of the case.					
2. Identifying key biological, psychological, and social factors in a balanced way.					
3. Showing linkages between the biological, the psychological, and the social.					
4. Detailing the biological mechanisms underlying psychiatric illness.					
5. Tracing the origin of psychiatric symptoms according to psychoanalytic theory.					
6. Identifying defense mechanisms.					
7. Identifying relevant ethnic and cultural factors.					
8. Identifying areas of strength.					
9. Summarizing and integrating facts in a way that can guide treatment.					
10. Summarizing and integrating facts in a way that can guide explanations to patients, families, and other professionals.					

Other comments:

THANK YOU VERY MUCH!

in a historical, developmental, and biographical context. Although our diagram (Figure 1) may include life-stage issues (for example, in this case, desire for family and job satisfaction at age 41) as part of a mechanism-based sequence, the arrows in the diagram may not explicitly provide information about the temporal relationship of events (for example, losing a child at age 19 was a more remote event than becoming homeless at age 41). Also, although our diagram may include references to predisposing, precipitating, and perpetuating factors, these factors are not explicitly labeled as such, making it necessary for the clinician to prioritize which of them (usually the perpetuating factors) may be most accessible to intervention. Finally, our attempt to structure diagrammatically the biopsychosocial-cultural approach does not incorporate all of the issues that are important for bedside care, including ethics and pragmatic decision making (7).

Despite these limitations, we believe that mechanistic case diagramming is a potentially useful starting point in comprehensively discussing patient care. We also believe that, as a technique familiar to our problem-based learning curriculum, it may constitute a useful step toward enhancing our medical students' ability to conceptualize and address psychosocial issues during the third year and beyond (which were recognized in an internal program evaluation as potential areas for improvement in our curriculum).

If it is true, as this preliminary study suggests, that medical students are more likely to value biopsychosocial-cultural formulation if they can appreciate its usefulness in integrating multiple perspectives in a way that effectively guides treatment and explanations, then mechanistic case diagramming (with treatment interventions included) would seem to be an optimal way to convey the importance of formulation in patient care. As a relatively concrete and atheoretical technique, mechanistic case diagramming could help students appreciate the applicability of biopsychosocial-cultural formulation to situations other than long-term expressive psychotherapy and to cases in general medicine. It might also be useful in enabling educators (in psychiatry as well as in other specialties) to assess in a semiquantitative fashion the degree to which students, residents, and other trainees think holistically and address psychosocial issues—similar to the way another educational tool, concept mapping (8), has been used in evaluating critical thinking among residents.

Overall the sessions have been enjoyable, from both the instructor's and the students' perspectives, and the students have seemed pleased to revisit a technique they had learned during preclerkship problem-based learning, which itself emphasizes the importance of the holistic approach. Because of its potential usefulness in improving and assessing skills in the comprehensive, biopsychosocial approach to patient care, we recommend that mechanistic case diagramming be further studied and possibly integrated into psychiatry curricula.

References

1. Engel GL: The need for a new medical model: a challenge for biomedicine. Science 1977; 196(4286):129–136
2. Molina JA: Understanding the biopsychosocial model. Int J Psychiatry Med 1983; 13:29–36
3. American Board of Psychiatry and Neurology: Orientation session for new examiners, May 2001
4. Perry S, Cooper AM, Michels R: The psychodynamic formulation: its purpose, structure, and clinical application. Am J Psychiatry 1987; 144:543–550
5. Guerrero APS: Mechanistic case diagramming: a tool for problem-based learning. Acad Med 2001; 76:385–389
6. Carrillo JE, Green AR, Betancourt JR: Cross-cultural primary care: a patient-based approach. Ann Intern Med 1999; 130:829–834
7. Sadler JZ, Hulgus YF: Clinical problem solving and the biopsychosocial model. Am J Psychiatry 1992; 149:1315–1323
8. West DC, Pomeroy JR, Park JK, et al: Critical thinking in graduate medical education: a role for concept mapping assessment? JAMA 2000; 284:1105–1110

Part II - B.5.

Cross-Cultural Primary Care: A Patient-Based Approach

J. Emilio Carrillo, MD, MPH; Alexander R. Green, MD; and Joseph R. Betancourt, MD, MPH

In today's multicultural society, assuring quality health care for all persons requires that physicians understand how each patient's sociocultural background affects his or her health beliefs and behaviors. Cross-cultural curricula have been developed to address these issues but are not widely used in medical education. Many curricula take a categorical and potentially stereotypic approach to "cultural competence" that weds patients of certain cultures to a set of specific, unifying characteristics. In addition, curricula frequently overlook the importance of social factors on the cross-cultural encounter. This paper discusses a patient-based cross-cultural curriculum for residents and medical students that teaches a framework for analysis of the individual patient's social context and cultural health beliefs and behaviors. The curriculum consists of five thematic units taught in four 2-hour sessions. The goal is to help physicians avoid cultural generalizations while improving their ability to understand, communicate with, and care for patients from diverse backgrounds.

This paper is also available at http://www.acponline.org.

Ann Intern Med. 1999;130:829-834.

From New York Presbyterian Hospital–New York Weill Cornell Medical Center, New York, New York. For current author addresses, see end of text.

It is much more important to know what sort of a patient has a disease, than what sort of disease a patient has.
–William Osler (1)

Concern about cultural competence in health care has increased in recent years as providers and policymakers strive to close the gap in health care between people of different sociocultural backgrounds (2, 3). Medical providers today face the challenge of caring for patients from many cultures who have different languages, levels of acculturation, socioeconomic status, and unique ways of understanding illness and health care. Patient satisfaction and compliance with medical recommendations are closely related to the effectiveness of communication and the physician–patient relationship (4). Because sociocultural differences between physician and patient can lead to communication and relationship barriers (5), teaching physicians the concepts and skills needed to overcome these barriers should lead to improved outcomes.

Implementation of culturally competent health care has been sparse and generally inadequate (6, 7). Some efforts have focused on important structural changes, including training bilingual and bicultural providers, instituting interpreter services, and developing culturally and linguistically specific literature and health care resources (8). However, many feel that providers themselves should be trained to care for patients of different sociocultural backgrounds (6–14). Such training programs often emphasize cultural sensitivity but do not teach practical cross-cultural skills. Other attempts to educate providers rely heavily on a categorical construct that lumps patients of similar cultures into groups and outlines their "characteristic" values, customs, and beliefs (15–17). Although this knowledge can be helpful, the suggestion that members of particular ethnic or racial groups behave in characteristic ways risks stereotypic oversimplification. For example, would a poor, black Cuban immigrant residing in Harlem fit into the African American or Hispanic profile? How would he compare with an upper middle-class Mexican American? This contrast also highlights the importance of socioeconomic factors, which are often underemphasized in cultural competency programs (18–20). A clear need exists for a more discerning approach.

We present the ideology and structure of a patient-based cross-cultural curriculum that we have developed and implemented. It represents a melding of medical interviewing techniques with the sociocultural and ethnographic tools of medical anthropology. The curriculum comprises a set of concepts and skills taught in five thematic modules that build on one another over four 2-hour sessions.

Structure and Content

Module 1: Basic Concepts

Culture is defined as a shared system of values, beliefs, and learned patterns of behaviors (21) and is not simply defined by ethnicity. Culture is also shaped by such factors as proximity, education, gender, age, and sexual preference. In interactive small groups, participants reflect on their own cultures and how these influence their personal perspectives on illness and health care. They also explore the extent to which the "medical culture" has become incorporated into their cultural outlook (22). Self-

realization of this potential biomedical bias is critical in negotiating cross-cultural interaction.

The definition of disease as a pathophysiologic process is compared and contrasted with the patient-centered and more subjective concept of illness (23, 24). Through descriptive clinical vignettes and videotaped patient interviews, physicians gain an appreciation for the diverse conceptualizations of illness (explanatory models) that patients may present to their physicians. The module concludes with a discussion of the attitudes that are fundamental to a successful cross-cultural encounter: the triad of empathy, curiosity, and respect.

Module 2: Core Cultural Issues

Sociocultural differences, when misunderstood, can adversely affect the cross-cultural physician–patient interaction (5, 19, 21, 25–27). Such misunderstandings often reflect a difference in culturally determined values, with effects ranging from mild discomfort to noncooperation to a major lack of trust that disintegrates the therapeutic relationship. Core cultural issues are situations, interactions, and behaviors that have potential for cross-cultural misunderstanding. These include issues relating to authority, physical contact, communication styles, gender, sexuality, and family, among other sensitive subjects. Failure to take these "hot-button" issues into account can compromise the success of the cross-cultural encounter.

To learn every aspect of each culture that could influence the medical encounter is impractical, if not impossible. Cultural groups are very heterogeneous, and individual members manifest different degrees of acculturation, making it difficult and even counterproductive to "teach" a culture as a whole. In fact, these core issues recur in many dissimilar cultures. For example, a lower level of patient autonomy and an emphasis on the role of the family in medical decision making has been found among certain subpopulations of Korean and Hispanic patients (28). Rather than attempting to learn an encyclopedia of culture-specific issues, a more practical approach is to explore the various types of problems that are likely to occur in cross-cultural medical encounters and to learn to identify and deal with these as they arise.

Once the physician recognizes a potential core issue, it can be explored further by inquiring about the patient's own belief or preference. Each patient's situation is unique and is influenced by personal and social factors as well as by culture. Direct questioning and discovery of core issues can avoid cultural pitfalls and help guide further exploration in cross-cultural encounters. The curriculum uses the following vignette to initiate dialogue within the group.

A 34-year-old, healthy Egyptian woman presents as a new visitor to a male physician. She is accompanied by her husband. Her husband seems somewhat domineering, answering all of the medical history questions himself. When the conversation is shifted back to the patient, he states that she does not speak English very well. During the physical examination, the husband leaves the room, and it becomes clear that the patient is proficient in English. A history of menstrual irregularity is elicited; this problem had been denied or minimized previously. When the patient is asked to disrobe for the physical examination, she becomes noticeably uncomfortable in the presence of the male physician.

This vignette illustrates two core cultural issues: family dynamics and the role of gender in the physician–patient encounter. Participants are encouraged to discuss their impressions of this situation and how the issues may be influenced by social and cultural factors. This leads to a focused discussion of how best to approach a dominant authority figure in a cross-cultural encounter to gain the necessary information without offending either patient or spouse. By learning to ask about patient preferences for physician gender rather than making assumptions, physicians gain a sensitivity that may help to prevent uncomfortable situations.

Module 3: Understanding the Meaning of the Illness

A patient enters the physician's office with certain beliefs, concerns, and expectations about his or her illness and the medical encounter. This conceptualization of the illness experience can be described as the patient's explanatory model (23). This is the patient's understanding of the cause, severity, and prognosis of an illness; the expected treatment; and how the illness affects his or her life. In essence, it is the meaning of the illness for the patient. Patients' explanatory models of illness are to a large extent culturally determined, but there are other important influences. Social factors, such as socioeconomic status and education, may play a role in shaping the conceptualization of an illness (29). This module of the curriculum further elaborates on the explanatory model, how it may affect the physician–patient encounter, and how to explore it with an individual patient.

The concept of explanatory models is not esoteric. An example of a simple explanatory model that physicians deal with every day is a patient's conceptualization of the common cold. Patients may understand the cold as being caused by "being out in the cold" and potentially leading to pneumonia if not treated with antibiotics. Although physicians are accustomed to the management of this scenario, more complex illnesses with less obvious explana-

tory models present greater challenges, especially when patients have sociocultural backgrounds that are unfamiliar to the physician.

The first part of **Table 1** summarizes a set of questions developed by Kleinman, Eisenberg, and Good for eliciting a patient's explanatory model (22). Although patients may initially be hesitant to reveal their beliefs and fears, this hesitation can often be overcome through further respectful questioning and reassurance. Focusing on what others may believe or on hypothetical situations may take some of the pressure off the patient. The questions can also be adapted for use in various contexts other than illness (18, 19, 23). For example, they may be used to explore the meaning of a particular procedure or treatment for a patient, such as a breast biopsy or chemotherapy. Two questions shown in **Table 1** help to determine the patient's agenda: that is, what the patient hopes to gain from the encounter. This may influence the meaning of the illness for the patient and can save time and effort when determined from the outset.

This module also emphasizes the various folk beliefs, alternative medical practices, and illness behaviors that may influence and manifest as the patient's explanatory model (30–34). Physicians learn to recognize and explore prevalent folk beliefs by using the explanatory model questions. They also learn to appreciate alternative medical practices used by patients through the illness behavior questions in **Table 1.** These questions serve as basic guidelines for further cross-cultural exploration.

The application of these techniques requires practice, which participants gain through interviewing actors specialized in medical training. In one exercise, an actress plays Mrs. B., a 58-year-old Dominican woman with hypertension. Despite being seen by several physicians, having multiple tests to rule out secondary causes, and having tried various medications over the years, her blood pressure has remained poorly controlled. On the basis of information obtained from a traditional interview, the physicians surmise that the patient may not be complying with her regimen. By using the skills they learned, the physicians explore Mrs. B.'s explanatory model for hypertension—an episodic problem related to tension and stress that requires treatment only as necessary. This understanding facilitates the ensuing negotiation process. In another exercise, an actor plays Mr. G., an Azorean fisherman whose diabetes is poorly controlled. The actor presents with "burning feet." The physicians make headway only when they explore the patient's explanatory model. They discover that Mr. G. believes that the burning in his feet is caused by hundreds of fish bites he suffered while casting nets offshore. He rarely injects insulin because this reminds him of the fish bites, and he fears that burning may develop over other parts of his body.

Table 1. Eliciting Patient Information and Negotiating

Exploring the meaning of the illness
Explanatory model
What do you think has caused your problem? What do you call it?
Why do you think it started when it did?
How does it affect your life?
How severe is it? What worries you the most?
What kind of treatment do you think would work?
The patient's agenda
How can I be most helpful to you?
What is most important for you?
Illness behavior
Have you seen anyone else about this problem besides a physician?
Have you used nonmedical remedies or treatments for your problem?
Who advises you about your health?
Social context "review of systems"
Control over environment
Is money a big problem in your life? Are you ever short of food or clothing?
How do you keep track of appointments? Are you more concerned about how your health affects you right now or how it might affect you in the future?
Change in environment
Where are you from?
What made you decide to come to this country (city, town)? When did you come?
How have you found life here compared to life in your country (city, town)? What was medical care like there compared with here?
Social stressors and support network
What is causing the most difficulty or stress in your life? How do you deal with this?
Do you have friends or relatives that you can call on for help? Who are they? Do they live close to you?
Are you very involved in a religious or social group? Do you feel that God (or a higher power) provides a strong source of support in your life?
Literacy and language
Do you have trouble reading your medication bottles or appointment slips?
What language do you speak at home? Do you ever feel that you have difficulty communicating everything you want to say to the doctor or staff?
Negotiation
Negotiating explanatory models
Explore patient's explanatory model
Determine how the explanatory model differs from the biomedical model and how strongly the patient adheres to it
Describe that biomedical explanatory model in understandable terms, using as much of the patient's terminology and conceptualization as necessary
Determine the patient's degree of understanding and acceptance of the biomedical model as it is described
If conflict remains, reevaluate core cultural issues and social context (for example, bring in family members or maximize interpretation)
Negotiating for management options
Describe specific management options (tests, treatments, or procedures) in understandable terms
Prioritize management options
Determine the patient's priorities
Present a reasonable management plan
Determine the patient's level of acceptance of this plan (do not assume acceptance—inquire directly)
If conflict remains, focus negotiation on higher priorities

Module 4: Determining the Patient's Social Context

The manifestations of a person's illness are inextricably linked to the social factors that make up his or her social environment (35, 36). A vast literature defines the relation of these social factors to health status (37–40) and elucidates the effects of social

class barriers between patient and physician (41). In this module, physicians learn practical techniques to explore and manage the social factors that are most relevant to the medical encounter. These define the patient's social context, which includes not only socioeconomic status but also migration history, social networks, literacy, and other factors.

Social context is explored through four avenues, any of which may apply to a particular patient: 1) control over one's environment (such as financial resources and education), 2) changes in environment (such as migration), 3) literacy and language, and 4) social stressors and support systems. The second part of Table 1 lists several interview questions designed to elicit this information. These should serve as a social context "review of systems." Like the traditional review of systems, they are used selectively in a focused, problem-oriented manner. They are guidelines that may be modified to fit the clinical scenario.

Mr. M. is a 53-year-old African-American man originally from North Carolina. He has a severe cough that has gradually worsened over the past year. He noticed some blood-streaked sputum 4 months ago. Mr. M. came north with his family 5 years ago and holds down two jobs. He cannot afford to take time off from work because of his illness; he is the sole wage earner for his four children, wife, and mother-in-law. Besides this, he has avoided medical attention for fear of a serious diagnosis that would prevent him from supporting his family in the future. He is also concerned about the possibility of expensive tests, medications, or operations.

This vignette illustrates the important effect that lack of control over one's environment can have on one's health-seeking behavior and symptom threshold. Some patients will present at the earliest stages of their disease. Others, like Mr. M., will tolerate a great deal of symptomatic distress before feeling sick enough to present to the medical system. Although this may reflect culture or personal characteristics, there is clearly a socioeconomic component. Knowing this helps the physician develop a plan that is sensitive to Mr. M.'s concerns, which might include accessing available financial supports and social services.

In the case of Mrs. B., the 58-year-old Dominican woman with hypertension, the physicians eventually learn that she is illiterate and has great difficulty with her complex medical regimen. This crucial aspect of the case is revealed only by respectfully asking social context questions about literacy. Issues of language and interpretation are also reviewed. The following vignette highlights the inappropriateness of a family interpreter and the inadequacy of an untrained interpreter.

Mrs. R., a 29-year-old Puerto Rican seamstress and single mother, brought her 12-year-old daughter to her first medical appointment. The physician was troubled by the child's interpreting ability and called in a female laboratory technician who is from Central American. The new interpreter summarized the patient's wordy monologue in one brief sentence. She said that the patient felt tired and fatigued during sexual intercourse. The physician ordered a complete blood count and thyroid studies and scheduled the patient for a return appointment in one month. Mrs. R. left the office feeling unrelieved. The laboratory technician had incorrectly interpreted "fatiga" and did not understand that the patient was reporting "shortness of breath," or asthma. A trained Spanish interpreter would have understood the variable regional meanings of the word "fatiga."

Important social issues may also be discovered through the explanatory model questions, particularly "How has this illness affected your life?" and "What worries you most?" Once these issues are recognized, participants discuss strategies and resources for dealing with the social issues that arise.

Module 5: Negotiating Across Cultures

Social and cultural factors determine differences in expectations, agendas, concerns, meanings, and values between patients and physicians (30). The physician serves as the expert on disease, whereas the patient experiences and expresses a unique illness (42). Thus, even when the patient's and physician's sociocultural backgrounds are similar, substantial differences may exist because of these separate perspectives. The tools of this curriculum are designed to be broadly applicable beyond the strictly cross-cultural setting.

The skills learned in the previous modules provide participants with insights that facilitate the process of cross-cultural negotiation. Reaching a mutually acceptable agreement between patient and provider is described in six phases: relationship building, agenda setting, assessment, problem clarification, management, and closure (43). The six phases are integrated with the strategies of Katon and Kleinman (44) to provide a framework for cross-cultural negotiation. Negotiation skills can be used to address both explanatory models and management options (**Table 1**).

Negotiation of explanatory models involves acknowledgment of differences in belief systems between patient and provider. If the patient does not seem to "buy in" to the biomedical explanation of an illness, a compromise can often be reached by presenting the problem in terms and concepts that reflect the patient's explanatory model. For example, Mrs. B. believes strongly that her hypertension

Table 2. Key Aspects of the Cross-Cultural Curriculum

Aspect	Explanation
Focus on the individual patient	Teaches physicians to analyze the individual patient's cultural and social dimensions rather than simply learning presumed cultural characteristics of certain ethnic groups
Case-based learning	Group analysis of cases highlights the major issues of each module
Exploration of both social and cultural factors	Teaches physicians to more efficiently and effectively study the patient's social context by targeting key aspects of the patient's social environment
Teaching techniques	Case analysis, videotaped patient expositions, and physician–actor interviews
Progressive curriculum	Five modules that build on one another are taught over four 2-hour sessions
Brief and to the point	By use of simple, direct questions and recognition of "hot-button issues," skills are honed through 10- to 15-minute interviews with medical actors

is episodic and stress-related. She may not understand the importance of taking daily antihypertensive medication because this does not fit her explanatory model. A compromise of explanatory models is reached by explaining that although her blood pressure does go up when she is stressed, her arteries are under stress all the time, which she may not feel. Taking the medication regularly helps to relieve this stress; however, it cannot take away the stress in her life. For this, she may need such measures as counseling and relaxation techniques. Patients whose beliefs are less ingrained may be quick to accept the biomedical model. Others, such as Mrs. B., may require more creative negotiation.

Conclusions

Despite the multitude of cultures in the United States, physicians are inadequately trained to face the challenges of providing quality care to socially and culturally diverse populations. The skills learned through this curriculum can help promote communication and cooperation, improve clinical diagnosis and management, avoid cultural blind spots and unnecessary medical testing, and lead to a progressive depth of understanding between patient and physician. The key aspects of this curriculum are summarized in Table 2. Experience with the cross-cultural curriculum has been very positive, and participant feedback has been enthusiastic. Evaluation done before and after the curriculum has demonstrated successful learning of the concepts and skills. The curriculum has been successfully adapted to the medical student and attending physician; specific areas are emphasized on the basis of the extent of practical clinical experience of the target audience. In general, it is weighted toward theory for medical students and applied skills for residents and practicing physicians.

The patient-based cross-cultural curriculum enables medical students, residents, and practicing physicians to cut through perceptual barriers and lift veils of social and cultural misunderstanding. This approach can facilitate all medical encounters but is particularly important in the setting of cultural and social differences. These tools help physicians do what "good doctoring" is all about—listening, asking the right questions, and meeting the patients where they are.

Acknowledgments: The authors thank Drs. Leon Eisenberg and Arthur Kleinman for their seminal work in this field and the comments and support they have provided; Dr. Richard Levins and the late Dr. Norman Zinnberg for their teachings on the social environment and the importance of the social construct in patient care; Dr. B. Robert Meyer for providing time and support for the implementation of the curriculum at Cornell Internal Medicine Associates; and Professional Actors Training and Helping (PATH) for their important role in our curriculum.

Requests for Reprints: J. Emilio Carrillo, MD, MPH, New York Presbyterian Hospital–Cornell Internal Medicine Associates, 505 East 70th Street, HT4, New York, NY 10021.

Current Author Addresses: Drs. Carrillo, Green, and Betancourt: New York Presbyterian Hospital–Cornell Internal Medicine Associates, 505 East 70th Street, HT4, New York, NY 10021.

References

1. Dubos RJ. Mirage of Health: Utopias, Progress, and Biological Change. New Brunswick, NJ: Rutgers Univ Pr; 1987.
2. Health Care Rx: Access for All. Barriers to Health Care for Racial and Ethnic Minorities: Access, Workforce Diversity and Cultural Competence. A Report Prepared by the Department of Health and Human Services and The Health Resources and Services Administration for the Town Hall Meeting on the Physician's Initiative on Race. Boston, MA. July 1998.
3. U.S. Bureau of the Census. Statistical Abstract of the United States. Washington, DC: U.S. Government Printing Office; 1992.
4. Novack D. Therapeutic aspects of the clinical encounter. In: Lipkin M Jr, Putnam SM, Lazare A, eds. The Medical Interview: Clinical Care, Education, and Research. New York: Springer-Verlag; 1995:32-49.
5. Takeuchi DT, Sue S, Yeh M. Return rates and outcomes from ethnicity-specific mental health programs in Los Angeles. Am J Public Health. 1995;85: 638-43.
6. Lum CK, Korenman SG. Cultural-sensitivity training in U.S. medical schools. Acad Med. 1994;69:239-41.
7. Bobo L, Womeodu RJ, Knox AL Jr. Principles of intercultural medicine in an internal medicine program. Am J Med Sci. 1991;302:244-8.
8. Proceedings of the National Conference on Cultural Competence and Women's Health Curricula in Medical Education. October 1995. Washington, DC: U.S. Department of Health and Human Services; 1998.
9. Welch M. Required curricula in diversity and cross-cultural medicine: the time is now. J Am Med Womens Assoc. 1998;53(Suppl):121-3.
10. Rivo ML, Satcher D. Improving access to health care through physician workforce reform. Directions for the 21st century. JAMA. 1993;270:1074-8.
11. Chugh U, Dillman E, Kurtz SM, Lockyer J, Parboosingh J. Multicultural issues in medical curriculum: implications for Canadian physicians. Med Teach. 1993;15:83-91.
12. Eisenbruch M. Medical education for a multicultural society. Med J Aust. 1989;151:574-6, 579-80.
13. Rubenstein HL, O'Connor BB, Nieman LZ, Gracely EJ. Introducing students to the role of folk and popular health belief-systems in patient care. Acad Med. 1992;67:566-8.
14. Poulton J, Rylance GW, Johnson MR. Medical teaching of the cultural aspects of ethnic minorities: does it exist? Med Educ. 1986;20:492-7.
15. Spector RE. Cultural Diversity in Health and Illness. 3d ed. Norwalk, CT: Appleton & Lange; 1992.
16. Harwood A, ed. Ethnicity and Medical Care. Cambridge, MA: Harvard Univ Pr; 1981
17. Slonim MB. Children, Culture, and Ethnicity: Evaluating and Understanding the Impact. New York: Garland; 1991.
18. Berlin EA, Fowkes WC Jr. A teaching framework for cross-cultural health

care. Application in family practice. West J Med. 1983;139:934-8.
19. Scott CJ. Enhancing patient outcomes through an understanding of intercultural medicine: guidelines for the practitioner. Md Med J. 1997;46:175-80.
20. Goldstein E, Bobo L, Womeodu R, Kaufman L, Nathan M, Palmer D, et al. Intercultural medicine. In: Jensen NM, Van Kirk JA, eds. A Curriculum for Internal Medicine Residency. The University of Wisconsin Program. Philadelphia, American Coll Physicians, 1996.
21. Low SM. The cultural basis of health, illness and disease. Soc Work Health Care. 1984;9:13-23.
22. Kleinman A, Eisenberg L, Good B. Culture, illness, and care: clinical lessons from anthropologic and cross-cultural research. Ann Intern Med. 1978;88:251-8.
23. Eisenberg L. Disease and illness. Distinctions between professional and popular ideas of sickness. Cult Med Psychiatry. 1977;1:9-23.
24. Helman CG. Disease versus illness in general practice. Journal of the Royal College of General Practice. 1981;31:548-52.
25. Muecke MA. Caring for Southeast Asian refugee patients in the USA. Am J Public Health. 1983;73:431-8.
26. Quesada GM. Language and communication barriers for health delivery to a minority group. Soc Sci Med. 1976;10:323-7.
27. Bullough B, Bullough VL. Poverty, Ethnic Identity, and Health Care. New York: Appleton-Century-Crofts, 1972.
28. Blackhall LJ, Murphy ST, Frank G, Michel V, Azen S. Ethnicity and attitudes toward patient autonomy. JAMA. 1995;274:820-5.
29. Ware NC, Kleinman A. Culture and somatic experience: the social course of illness in neurasthenia and chronic fatigue syndrome. Psychosom Med. 1992;54:546-60.
30. Kleinman A. Patients and Healers in the Context of Culture: An Exploration of the Borderland between Anthropology, Medicine, and Psychiatry. Berkeley: Univ of California Pr; 1980.
31. Pachter LM. Culture and clinical care. Folk illness beliefs and behaviors and their implications for health care delivery. JAMA. 1994;271:690-4.
32. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders. 4th ed. Washington, DC: American Psychiatric Association, 1994:843-9.
33. Hautman MA. Folk health & illness beliefs. Nurse Pract. 1979;4:24-34.
34. Demers RY, Altamore R, Mustin H, Kleinman A, Leonardi D. An exploration of the dimensions of illness behavior. J Fam Pract. 1980;11:1085-92.
35. De La Cancela V, Guarnaccia PJ, Camillo JE. Psychosocial Distress among Latinos: A Critical Analysis of Ataques de Nervios. Humanity and Society. 1986;10:431-47.
36. Helman CG. Culture, Health and Illness. An Introduction for Health Professionals. 3d ed. Boston: Butterworth-Heinemann; 1994.
37. Sorlie PD, Backlund E, Keller JB. US mortality by economic, demographic, and social characteristics: the National Longitudinal Mortality Study. Am J Public Health. 1995;85:949-56.
38. Kaplan GA, Keil JE. Socioeconomic factors and cardiovascular disease: a review of the literature. Circulation. 1993;88(4 Pt 1):1973-98.
39. Feinstein JS. The relationship between socioeconomic status and health: a review of the literature. Milbank Q. 1993;71:279-322.
40. Carrillo JE. A Rationale for Effective Smoking Prevention and Cessation Interventions in Minority Communities. Discussion Paper Series, Institute for the Study of Smoking Behavior and Policy. Cambridge, MA: Harvard Univ, John F. Kennedy School of Government; 1987:1-40.
41. Quill TE. Barriers to effective communication. In: Lipkin M Jr, Putnam SM, Lazare A, eds. The Medical Interview: Clinical Care, Education, and Research. New York: Springer-Verlag; 1995:110-21.
42. Tuckett D, Boulton M, Olson C, Williams A. Meetings between Experts: An Approach to Sharing Ideas in Medical Consultations. London: Tavistock; 1985.
43. Botelho RJ. A negotiation model for the doctor-patient relationship. Fam Pract. 1992;9:210-8.
44. Katon W, Kleinman A. Doctor-patient negotiation and other social science strategies in patient care. In: Eisenberg L, Kleinman A, eds. The Relevance of Social Science for Medicine. Boston: Reidel; 1980.

At first, Dr. Ragin worked very hard. He received patients every day from morning till dinner-time, performed operations, and even did a certain amount of midwifery. Among the women he gained a reputation for being very conscientious and very good at diagnosing illnesses, especially those of women and children. But as time passed he got tired of the monotony and the quite obvious uselessness of his work. One day he would receive thirty patients, the next day thirty-five, the next day after that forty, and on from day to day, from one year to another, though the death rate in the town did not decrease and the patients continued to come. To give any real assistance to forty patients between morning and dinner-time was a physical impossibility, which meant that his work was a fraud, necessarily a fraud. He received twelve thousand outpatients in a given year, which bluntly speaking meant that he had deceived twelve thousand people.

Anton Chekhov
"Ward 6"
Lady with Lapdog and Other Stories
Penguin; 1964:144

Submitted by:
Sue Anne Brenner, MD
Emory University School of Medicine
Atlanta, GA 30322

Submissions from readers are welcomed. If the quotation is published, the sender's name will be acknowledged. Please include a complete citation (along with the page number on which the quotation was found), as done for any reference.—*The Editor*

Part II-B.9.

Second Edition

BOARDING TIME

A Psychiatry Candidate's Guide to Part II of the ABPN Examination

James Morrison, M.D., and
Rodrigo A. Muñoz, M.D.

Chapter 9

Case Formulation

As the door closes on your departing patient, one of the examiners should ask, "Would you like a couple of minutes to pull it all together?" You bet you would! Here is your opportunity to think about the interview and to prepare your verbal presentation of the patient. If your examiners forget to ask you this question, it is perfectly acceptable to request the extra time.

Your examiners want to learn how you think about patients. Specifically, they want to understand the process by which you join the history you obtained with the observations you made during the interview to create a framework that will support a differential diagnosis. In the oral examination, this process is at least as important as the final result. Individual examiners may disagree among themselves about the most likely diagnosis, but they will generally agree as to the clarity of the thinking you used to get there.

You will be expected to integrate all the information you have obtained, weighing all the clues and balancing every finding, even when they contradict the emerging diagnosis or point to some alternative disorder. Most important, you must show that your initial thinking is broad enough to encompass a variety of (reasonable) diagnoses and that you do not allow certain data (such as the patient telling you the diagnosis of record) to stampede you into early closure.

The mental process of diagnostic decision making has been studied for years (Gauron and Dickinson 1966). The least suitable process calls for the diagnostician to decide early and then defend that diagnosis against new evidence. Another flawed strategy is to follow every lead on its own without trying to integrate it into a larger picture. The ideal diagnostic process calls for the progressive integration of data into a presumptive diagnosis that can be challenged or confirmed as new information emerges.

The material you select for presentation will provide the foundation for

your differential diagnosis and *most likely diagnosis.* These in turn will influence your recommended therapeutic approaches. While you are thinking over these matters, the contents of this chapter should flash before your eyes. As you can tell from the length of the chapter, there is a lot to consider.

Making Diagnostic Decisions

Diagnoses are used for many purposes. Among them are planning treatment, advising relatives, discharging from hospital, filling out insurance forms, and communicating with other health care professionals. The process you use to make a psychiatric diagnosis for the Boards won't be much different than it is for any of these other purposes, but you will have to defend your reasoning publicly.

For any of the above-mentioned purposes, making a diagnosis today is far more important than it was when the psychiatry Boards were first given more than 60 years ago. Diagnosis then was not particularly useful for treatment, because there were no effective somatic or drug therapies. Insurance rarely paid for mental health care. Patients were less likely to be discharged from hospitals. And diagnostic criteria of the era (e.g., Bleuler's Four A's) weren't of much use in predicting the course of psychiatric disorders.

Evaluating Diagnostic Data

Even in the brief psychiatric evaluation, you will obtain a vast store of information from history and direct observation. Most of it will be interesting, and much of it will be valuable. But some of it will be vital to your diagnostic efforts. When you sift through this welter of information, keep in mind several principles of data evaluation.

History is better than cross-sectional observation. More than clinicians sometimes realize, psychiatric diagnosis depends heavily on the longitudinal course of a patient's illness. For example, what can you deduce when a patient reports hearing voices? Is the diagnosis schizophrenia, a primary mood disorder, somatization disorder, antisocial personality disorder, cognitive disorder, alcohol withdrawal, or some type of substance abuse? Even if you learn that the hallucinations have *first-rank quality* (e.g., two or more voices speaking in complete sentences outside the head commenting on the patient's activities), all you can really conclude is that the patient seems psychotic.

To select a most likely diagnosis, you need more historical information.

How long have the voices been present? Have they ever cleared spontaneously, or only with medication? What is their relationship to the use of alcohol or street drugs? Has the patient had other major health problems? Have the hallucinations always been associated with prominent mood symptoms? Family history and legal history also can strongly influence this differential diagnosis.

Recent history is better than ancient history. This rule holds for two reasons. First, symptoms that are reported early in the course of an illness may be too general to reveal much. Consider an adolescent with symptoms of anxiety and withdrawal. Will these symptoms develop into an anxiety disorder, are they the prodrome of schizophrenia, or are they an early stage of a depression that will later change to full-blown mania? Will they simply disappear as time goes on, to be recalled later only as a period of adolescent turmoil? Only the subsequent history is likely to give you a valid answer.

Second, recent history may include new symptoms that allow a more specific diagnosis or suggest a change in treatment. An obvious example is the patient who has had several depressions. Early in the illness they may seem to be unipolar, but years later a mania may finally appear. More frequently encountered is the patient with nearly any psychiatric disorder who subsequently develops secondary alcoholism. Simply stated, recent history is more valuable because it embraces a greater span of time.

Collateral history is often better than the patient's own. After all, patients sometimes don't have enough perspective on their own illnesses. Some may lie; others may forget. Even the most alert and best intentioned of them may lack important information that families can provide—psychiatric illness in parents or grandparents, for example. If nothing else, the collateral history provides a useful verification of the patient's version. In the ideal initial evaluation you would obtain information from the patient and from informants. However, the Board examination is less than ideal, and you will have to do without information from relatives, friends, physicians, and hospital discharge summaries. But remember that this material should be there. When the opportunity arises during your case presentation, tell your examiners that if you were treating this patient, you would want to have this information and explain what use you would make of it.

Signs are better than symptoms. Signs are better because symptoms (what the patient tells you) are subject to two separate interpretations: yours and the patient's. On the other hand, the signs (what you observe) of illness are less likely to be manipulated by the patient, with or without conscious motivation. Hence, another major justification for the free speech period at the beginning of any

psychiatric evaluation is that it allows you the chance to note discrepancies between a patient's signs and symptoms. Here is a typical example:

> Your patient's complaints of depression and suicidal ideas are delivered with drama, considerable smiling, and the suggestion of seductiveness. You mentally move personality disorder nearer to the top of your differential diagnosis.

Objective findings are better than subjective judgments. Closely related to the signs-versus-symptoms principle, the argument favoring objective findings is, if anything, a little stronger. It reminds you to be wary of making diagnostic decisions based on intuition. (This insistence on diagnosis rooted in objective criteria is one of the principal virtues of the DSM-IV approach.) For example, the diagnosis of schizophrenia based on DSM-IV criteria has considerable predictive value; the diagnosis based on the clinician's perception of "schizophrenic feel" has little predictive value.

Crisis-generated data are suspect. Irrespective of any other clinical conditions or patient variables, fear can affect anyone's behavior, yielding distorted observations, forgotten experiences, and embellished stories. Thus, the narrative of someone who has just been jilted by a lover may be colored by a crisis-generated reactive depression. Retrospective falsification of historical data may accompany other negative mood states, especially anxiety and anger. But similar distortions may also occur under the influence of positive feelings such as elation and love.

It could be argued that a crisis sometimes reveals valuable information in the form of feelings and behaviors that would not otherwise emerge. Unfortunately, the one-interview format offers no reference point from which to judge the effects of crisis conditions on your patient's moods, attitudes, and behaviors. Although there are no data to demonstrate this point, we suspect that when a crisis does generate useful information, this information usually takes the form of observable behavior.

Characterizing the Valid Psychiatric Diagnosis

Selecting a good diagnosis should be no different in psychiatry than in any other branch of medicine. Of course, the first and thorniest problem is to decide what constitutes a good diagnosis. The test of goodness for most systems of classification is the ability to make accurate predictions. In the classification of medical diagnoses, this predictive ability is called validity. There can be no better beginning for discussion than to list the Robins and Guze (1970) phases for establishing diagnostic validity. These phases are described in greater detail in Appendix F.

1. Clinical description
2. Follow-up study
3. Delimitation from other disorders
4. Family study
5. Laboratory studies

What was stated originally by Robins and Guze in 1970 remains true today: no major psychiatric disorder has fully met all of the above criteria. (Possible exceptions are certain disorders such as Down's syndrome that most psychiatrists seldom encounter.) Diagnostic validity is not even guaranteed by inclusion in DSM-IV, which incorporates some disorders that have been validated less well than others. Unfortunately, that volume does not make clear which are the better-studied diagnoses.

If your working diagnosis is one that has been validated more completely according to the Robins-Guze criteria, you can have confidence in the predictions you make from it. For example, if you diagnose recurrent depressive disorder, you could reliably inform the patient about the course of illness, response to treatment, likely duration of episode, risk of recurrence, and risk of similar illness in relatives. Using carefully researched diagnostic categories will also help you feel better equipped to discuss the case with your examiners.

DSM-IV lists over 300 diagnoses. Approximately one-quarter of these could be considered discrete diagnoses; the rest are closely related, such as the subcategories of schizophrenia. Of the 300+ diagnoses, fewer than 40 may be rooted in adequate scientific study and therefore have good predictive value. Realizing that we risk criticism both for what is included and for what is left out, we present in Table 9–1 our list of the most valid psychiatric diagnoses. We have listed them in descending order of the frequency with which they may be expected in a general psychiatric setting.

The Differential Diagnosis

The diagnostic process begins when you greet your patient. From the first handshake, you are making observations, asking questions, and drawing inferences that will eventually lead you to your working diagnosis. This process is not a simple one, nor is it easy to describe. The practicing clinician does not function like a decision tree, in which key questions cause the interviewer to branch successively until the correct diagnosis has been ruled in. Nor does the clinician become a computer, number-crunching a giant database that contains the entire history to determine where the preponderance of symptoms lies. Rather, psychiatric diagnostics as practiced by the experienced clinician consist of successive

approximations that develop from one or more of several possible areas of concern.

Although you will usually identify them early, these areas of concern can show up at any time during the interview. They include those areas that form the basis for the DSM-IV decision trees:

- Psychosis
- Irrational anxiety
- Mood disorders (depression and euphoria)
- Excessive somatic concerns
- Suspicion of cognitive syndromes

Table 9–1. Most valid diagnoses, in descending order of frequency, expected in a general psychiatric population

Common
Major depressive disorder, single episode
Alcohol dependence
Bipolar mood disorder
Schizophrenia
Major depressive disorder, recurrent
Somatization disorder
Borderline personality disorder
Less common
Panic disorder, with or without agoraphobia
Dementia
Alzheimer's
Multi-infarct
AIDS
Antisocial personality disorder
Obsessive-compulsive disorder
Mental retardation, if specific etiology
Down's syndrome
Phenylketonuria
Anorexia nervosa
Rare
Learning disorders
Gender identity disorder
Tourette's syndrome
Autism
Delusional disorder

Source. Based on Morrison and Muñoz (1979).

To those we would add:

- Substance abuse
- Chronic legal and other social and personality problems

Each area of concern comprises a group of disorders that could cause the problem under consideration. Once they have been explored and the diagnoses have been arranged in order, with the most likely diagnosis at the top, they are called collectively the differential diagnosis. In arranging the diagnoses on this list, the clinician considers several hierarchies of desirability, which we discuss in the next few pages.

Diagnostic Hierarchies

These diagnostic hierarchies are organized around the principle that there is value in assigning some order of priority to any list of presumptive diagnoses. The main benefit is utilitarian: it promotes effective treatment and avoids giving the patient a pejorative diagnosis. But aesthetics also plays a role (a smaller number of diagnoses is more pleasing and intellectually satisfying than a larger number). In any event, these hierarchies provide a rational basis for choosing the most likely diagnosis and runners-up.

Hierarchies can be organized around any of several principles.

The principle of parsimony. This principle holds that, everything else being equal, it is better to explain all of the known facts with a single diagnosis than with multiple diagnoses. This idea, basically Occam's razor rehoned, was implicit in the writings of Kraepelin and was made explicit by Karl Jaspers around the middle of the twentieth century. Here is an example of the parsimony principle in action: a patient with alcoholism, depression, and auditory hallucinations would be diagnosed as having alcoholism with hallucinosis and a secondary depression. Many DSM-IV criteria recognize this principle by stating exclusion criteria. For example, a diagnosis of schizophrenia is not allowed if you can't rule out mood disorder.

The principle of chronology. For years, the sequence in which a given patient develops two or more psychiatric disorders has proven to be a useful framework around which to organize the differential diagnosis. The most obvious application of this framework has been to the diagnosis of mood disorder. Based on symptoms alone, competent psychiatrists may disagree as to whether a patient's depression is endogenous or exogenous, but they may more readily agree that this depression began subsequent to the onset of another disorder—alcohol

dependence, for example, or a personality disorder. Some would call such a depression a *secondary mood disorder.* A mood disorder that arises de novo, without a diagnosable antecedent, would be termed a *primary mood disorder.*

The advantages of using chronology as an aid to diagnosis are clear:

- It increases the grounds for agreement between diagnosticians.
- It uses operational criteria for dividing patients into naturalistic groups.
- Identification of these groups helps to promote rational treatment.

For example, consider Mr. Brinker, who drinks heavily and is depressed. If he has primary depression and drinks because of it, you might want to treat him with antidepressant medication. But if he has primary alcoholism and a secondary mood disorder, you would probably want to get him off alcohol and take a wait-and-see approach to his depression. The chronology of the relative onsets of his drinking and depression is the critical factor that allows you to choose the better course of treatment.

The principle of the "safe" diagnosis. The concept of diagnostic safety means that the patient is exposed to the smallest degree of risk. Faulty or improper psychiatric diagnosis can yield various untoward results. They include

- *Inadequate treatment.* The patient receives treatment that is ineffective or dangerous or fails to receive treatment that would be effective, or both.
- *Inaccurate prognosis.* The patient, the family, and sometimes even the physician are misled by a prognosis that is either too gloomy or too optimistic. Planning suffers: the patient lacks a solid basis on which to decide about marriage, childbearing, job training, purchasing insurance, and the myriad other decisions that might depend on accurate diagnosis.
- *Worsening symptoms from lack of adequate treatment.* Suicidal or homicidal ideas and plans may develop where there were none before. Auditory hallucinations may become insistent, and delusions may become more convincing and frightening.
- *Perpetuation of error.* The final danger is that once the diagnostic error is made, it will be passed along from chart to chart and from one physician to another.

The safety hierarchy limits risk by placing at the top those disorders that are most likely to remit spontaneously and to respond favorably to treatment. In essence, this is the concept of first making the more conservative diagnosis—operationally defined for any given pair of diagnoses as the one you would prefer for your own relative.

The subjective nature of this definition makes it hard to give an ordinal ranking for many diagnoses in this hierarchy. But most psychiatrists would agree as to which disorders belong at the two extremes of this spectrum and which should be placed in the middle ground. The details of this hierarchy can be debated endlessly and probably will be. Our proposed safety hierarchy is given in Table 9–2. Of course, mental disorders due to general medical conditions are always considered safe in that they usually resolve once the underlying condition has been effectively treated.

The principle of percentages. Finally, common things occur commonly. When all other guideposts to a good working diagnosis are missing, take into account how often you expect to encounter the diagnoses you are considering. Remember the adage, "When you hear hoofbeats in the street, think of horses, not zebras." It should remind you not to go beyond the obvious if you don't have to.

When you use this final principle, consider the diagnostic makeup of the patient population. Almost every patient interviewed for the Board examinations will be currently under psychiatric care. This means that if you use the principle of percentages to help decide your differential diagnosis, you must have a rough idea of the frequency with which the diagnoses you are considering occur in psychiatric populations. This may differ substantially from the frequency of the same diagnoses in general (nonpatient) population surveys. The

Table 9–2. Hierarchy of conservative (safe) diagnoses

Most favorable (most treatable, best outcome)
Any disorder due to a general medical condition
Recurrent depression
Bipolar I disorder
Middle ground
Alcohol dependence
Panic disorder
Phobic disorder
Obsessive-compulsive disorder
Anorexia nervosa
Substance dependence (nonalcohol)
Borderline personality disorder
Least favorable
Schizophrenia
Antisocial personality disorder
AIDS dementia
Alzheimer's dementia

latter show a high prevalence of anxiety disorders, phobias, and panic disorders, among other diagnoses (Robins et al. 1984). Percentage-wise, these disorders occur much less often in outpatient populations and are especially uncommon among hospitalized patients.

Our experience with over 2,000 psychiatric patients is incorporated into Table 9–1. The relative frequencies suggested there may differ from those you encounter, depending on the type of facility that supplies the patients for your examination. You will have a better chance of drawing a patient with schizophrenia or bipolar mood disorder if you are being tested in a public facility such as a Veterans, state, or university hospital. (Be alert: patients in these facilities may also have a variety of substance abuse and personality disorders.) If, on the other hand, the patients have been recruited from an outpatient setting, especially from a private or fee-for-service public clinic, your chances of interviewing one with a unipolar mood disorder or anxiety disorder will be enhanced. Another example of the percentage principle in action: if your patient is male, his chances of having somatization disorder are much less than for a female patient.

Although we know of no reliable data on this point, anecdotes suggest that sometimes those in charge of procuring patients for the Boards choose patients who are "interesting." That is to say, they do not conform to the specific rules of diagnosis we have discussed. Whether "different" (and difficult) patients are chosen or, as in real life, occasionally just show up, the moral for you is the same: zebras may be uncommon, but they're not extinct. If one trots by, be prepared to identify it.

Using the Principles as Guidelines

Each of these principles is only a general approach to solving diagnostic problems. None of them applies in every clinical situation, and none should be followed slavishly. (If this were not the case, we'd be giving the Boards to computers!) We can formulate a general approach to help us choose the rules that can best arrange the elements of a differential diagnosis into a descending order of probability.

1. Look first for a general medical condition. Derived from the safety principle, the logic of this first step should be obvious.
2. Because of its wide applicability and considerable validity (which stems from the fact that it uses longitudinal data), *chronology* is often useful. One example (alcoholism with depression) has already been cited. Other examples come to mind, many of which involve differentiation of primary from secondary mood disorders.

One of the best and most frequently encountered examples of the chronology principle is the co-occurrence of depression and multiple somatic symptoms. In such a case, a good history will help you pinpoint the most likely diagnosis. If the depression came first, you're dealing with primary mood disorder until proven otherwise. If the somatic symptoms have lasted a lifetime and have only recently been complicated by depression, somatization disorder with a secondary depression is much more likely.

3. If neither of the above applies, use *safety.* In many diagnostic situations, neither of the above principles applies—there's no hint of a general medical condition and precious little chronology to guide you. So next you should turn to the safety principle. Although this principle uses less information about the individual patient, it has the solidly practical effect of directing therapy to the most treatable diagnosis with the best prognosis.

Perhaps the most frequently encountered example is the patient whose agitated psychosis could be either mania or schizophrenia. The principle of the safe diagnosis asks you to consider schizophrenia second—or, better, last—after all other more treatable diagnoses with better prognoses have been eliminated. For example:

> Your depressed patient also has features of borderline personality disorder. From the history, you cannot tell how long the borderline features have been present. Because primary mood disorder is the more treatable disorder with the better prognosis, you decide that it belongs at the top of your differential diagnosis.

4. *Percentages* is the fallback position. If none of the preceding principles helps you to choose, you might have to rely on percentages, as in the following example:

> Mr. Taylor says his depression and alcoholism began at about the same time. (He meets full diagnostic criteria for both alcohol dependence and major depressive disorder.) Following the principle of the safe diagnosis (Table 9–2 suggests that primary mood disorder is the more conservative diagnosis), you would like to prescribe an antidepressant. But you worry that if Mr. Taylor does have a primary alcohol problem, you will encourage him to depend on medication and to ignore his responsibility for going to Alcoholics Anonymous (AA). What should you do?
>
> Your doubts may be partly relieved when you remember that only about 5% of male alcoholics also have a primary mood disorder. You decide that your best bet is to recommend AA first, and watch the depression closely.

In practice, the percentages principle is probably used a great deal more than clinicians generally acknowledge, but you should be wary of citing it during the exam. The examiners will greatly prefer that your working diagnosis be based on all the information concerning your patient's own history. If you must resort to statistics, be sure to justify your reasoning. Explain that you would be unlikely to make a definitive diagnosis based solely on probabilities. And you should also consider the importance of following a patient such as Mr. Taylor carefully, with the intention of changing tactics if it became clear that the depression did not improve as he dried out.

5. If *parsimony* applies, use it. An example was given earlier.

Other Diagnostic Considerations

Unfortunately, not all of diagnostics can be reduced to formulas. To every rule there are exceptions that require judgment based on experience. And some patients will test the mettle of the best clinicians.

Diagnoses Easily Overlooked

Some diagnoses are important to remember but easy to overlook. When you are preparing your differential diagnosis, be sure to consider the following:

- *AIDS and AIDS-related complex (ARC).* Even if they are far down on your list, mention them if they seem at all likely. They're on everyone's mind.
- *Substance abuse.* Never forget this one, especially in teenagers, but even in older patients.
- *Tardive dyskinesia.* There is an excellent chance that at some point your patient will have received neuroleptics.
- *Schizophreniform psychosis.* This one is really a temporary diagnosis to be used when you aren't sure whether the patient's psychotic symptoms mean schizophrenia or something else. It is there so you won't have to saddle anyone with a pejorative diagnosis unless the criteria fully justify it.
- *Mild mental retardation and borderline intellectual functioning.* These often-ignored conditions could explain stiffness of affect, "hallucinations" that don't seem quite psychotic, or a chronic course without evidence of chronic psychosis.
- *No mental illness.* This is a rare one. But those in charge of patient procurement have been rumored to press clerical workers into service when too few patients show up. The diagnosis of NMI is uncommon in a psychiatric practice, but nearly every practitioner occasionally encounters a patient who has no psychiatric illness. And remember the uproar caused by psychiatrists diagnosing psychosis too quickly in the pseudopatients of Rosenhan (1973).
- *Undiagnosed.* It may require some courage to call a patient "undiagnosed" on the Board examinations, but it's a great way to start off any differential diagnosis when you don't know exactly what's going on. "Psychiatrically ill, but undiagnosed" is the ultimate in conservative medicine. It tells the examiner that you know the dimensions of the problem well enough to avoid being stampeded into a diagnosis. You will first establish all the relevant information. Of course, you'd rather not say, "I have no idea what's wrong with Mrs. Fields." But you might express your hesitation with something on the order of this: "Until we get information from her family (old chart, previous doctor, the laboratory), I think Mrs. Fields should remain officially undiagnosed. We should first rule out hyperthyroidism with a secondary mood disorder, and although schizophrenia remains a distant possibility, she'll most likely turn out to have bipolar mood disorder, manic type."

Surviving Diagnostic Uncertainty

On a single interview, you should be able to make a solid, valid diagnosis about 80% of the time. But for the other one patient in five, whether you talk for 30 minutes or 3 hours, you probably won't be able to make a valid, definitive diagnosis. The most common reason is inadequate information. However, we don't mean to imply that in such a case the interview wasn't competent. Even the best interviewers may not get adequate information from a patient who is disorganized, psychotic, secretive, or forgetful.

Just the opposite problem—too much information—is a second cause for diagnostic uncertainty. This embarrassment of riches yields multiple, often contradictory diagnoses. It can happen when the patient

- Tries too hard to please the interviewer by responding positively to nearly every question
- Is frankly confused about the history
- Deliberately obfuscates
- Has somatization disorder or some other condition that is commonly mistaken for other psychiatric illness

But even when the patient thinks clearly and reports accurately, you still may have trouble making a definitive diagnosis if the history or presentation is atypical. Example: A patient who has a long history of psychosis shows

more affect or insight than is typical of schizophrenia.

The usual clinical solution to diagnostic uncertainty is to seek outside information. That is clearly impossible for you under the circumstances, but your evaluation alone may yet enable you to select a most likely diagnosis. One or more of the following factors may help:

1. *Length of illness.* Everything else being equal, several years' duration of psychosis suggests schizophrenia. For that matter, the longer *any* symptoms last, the more likely they are to continue. "The best predictor of future behavior is past behavior."
2. *More symptoms.* Even if continuous signs of the disorder have not been present for 6 months, as DSM-IV requires for a diagnosis of schizophrenia, your case will be strengthened if the patient has had, say, auditory hallucinations, three sorts of delusions, a schizoid premorbid personality, and a family history positive for schizophrenia. In a similar time frame, auditory hallucinations alone would make a less convincing case.
3. *Presence of typical features.* If at age 18 years a patient has had classical gunbarrel blindness and glove anesthesia, you will probably suspect somatization disorder, even if the review of systems falls one or two symptoms short of the full number required for that diagnosis.
4. *Absence of atypical features.* Your diagnosis will be more secure if there are no symptoms that suggest other more serious (or more treatable) conditions. In the previous example, you would be more reluctant to diagnose somatization disorder in the face of first-rank symptoms of schizophrenia or if there were classic features of mania such as hyperactivity, rapid speech, and euphoria.
5. *Response to treatment.* Even when you have little information other than a prolonged history of psychosis, you may not be completely lost. If your patient reports that the symptoms (you still don't know what they were) abated during 3 years of lithium therapy, no one would fault you for putting bipolar mood disorder at the top of your differential diagnosis.

Diagnostic Dilemmas

In addition to the diagnostic problems already cited, the practicing psychiatrist often encounters several other dilemmas. These usually involve conflicting diagnostic principles, and they must be dealt with on a case-by-case basis. We will mention a few of them briefly.

Alcoholism with psychotic symptoms. Diagnosis is usually a problem only if the history is unclear. The conservative approach would be first to diagnose alcohol-induced psychotic disorder, with hallucinations, but of course it is far more common to encounter schizophrenia with secondary alcoholism. If you don't have enough history to make a clear decision, simply state what you would do in practice. In this case, you would probably first rule out alcohol-induced psychotic disorder, although you may well end up treating with neuroleptics and diagnosing schizophrenia.

Panic disorder with mood disorder. The old DSM-III criteria (American Psychiatric Association 1980) stated explicitly that panic disorder could not be "due to another mental disorder, such as major depression, somatization disorder, or schizophrenia." Many physicians complained that they could not correctly diagnose patients who had mixed depression and anxiety states. DSM-IV has resolved this problem by eliminating many of the exclusion criteria that were common in DSM-III. Now, depression and most other Axis I disorders (except specific cognitive disorders) can be associated with panic disorder, agoraphobia, obsessive-compulsive disorder, phobic disorder, and even generalized anxiety disorder, provided the symptoms are not present *only* during the course of the other Axis I disorder.

Somatization disorder with primary mood disorder. This combination represents a diagnostic-therapeutic tangle. Whereas treatment is supposed to depend on diagnosis, sometimes we allow the diagnosis to rest on the results of treatment. When discussing diagnosis during the Boards, you'd rather not fall back on recommending a therapeutic trial. But primary mood disorder is the more conservative diagnosis—it is more readily treatable and carries the better prognosis—so a patient with somatization disorder who has not been treated for depression may require one (or more) trials on antidepressants. But you should remember that a favorable result does not necessarily mean that there has been a drug response: somatization disorder patients not uncommonly improve, at least for a time, with any therapeutic intervention.

Depression with borderline personality disorder. As the principle of safe diagnosis suggests, always suspect Axis I pathology before Axis II pathology. This is because you generally can't do much about personality disorder—not quickly, at any rate. If the patient is depressed and you don't have history adequate to decide which came first, you'll generally be safer if you list the more treatable diagnosis first.

Two personality disorders in the same patient. Not all personality disorders are created equal; some have been better validated than others. The criteria for some are based on careful studies, others are based on theory or intuition.

If you believe a patient qualifies for more than one personality disorder diagnosis, you can choose one of the following with somewhat more confidence:

- Antisocial
- Borderline
- Schizotypal
- Schizoid
- Obsessive-compulsive

Recommending Treatment

Psychiatric management requires attention to these potential interventions:

- Biological
- Psychological
- Social

This *biopsychosocial model* has become the framework underlying modern treatment formulation. At all costs, you should discuss each of its parts in the treatment plan of any patient you examine.

At one extreme is the schizophrenic patient who may have an exacerbation after stressful emotional interactions at home: here, you might want to recommend treatment methods from each of the three categories just mentioned. At the other extreme, a patient with antisocial personality disorder may respond only to social interventions. But, to repeat, you should initially consider that all patients could benefit from each of these three vitally important components.

Here are a few questions that might help you select an effective treatment.

Are There Controlled Studies of Treatment?

Whenever possible, choose as your preferred treatment one that has been proven effective by controlled studies. Of course, nearly all well-controlled studies are carried out on series of patients with uniform diagnoses that have been made according to well-considered and carefully applied criteria. If you have followed the steps recommended in this chapter for a valid diagnosis, you are already close to a defendable, preferred treatment.

Are There Treatments Suitable for This Patient?

Almost any patient will benefit from some kind of intervention. For some patients psychotherapy works, but it is slow and uncertain. This is especially true for patients with personality disorders (other than antisocial personality disorder, which is unlikely to respond to any treatment, no matter how leisurely). But even for the antisocial individual, you can always recommend the education of relatives about the consequences of the disorder.

Still other patients (we are gradually moving toward the top of the safety hierarchy) may respond well to any of several therapies, none of which is specific for their disorders. Alcohol dependence and anorexia nervosa are two such conditions.

Finally, for some disorders there is specific therapy that, if it is not curative, is so thoroughly palliative that not to use it would be virtually untenable. Bipolar mood disorder and recurrent depressive disorder are prime examples of this category.

How Urgent Is Treatment?

Urgency can be evaluated in a number of ways, but most psychiatrists would intervene immediately if a patient faced imminent death (by suicide or homicide), crime, marital breakup, job loss, or progressively irreversible symptoms (as in a cognitive disorder). A bit further down on the scale of urgency would be evidence that the disorder was becoming worse, though not necessarily yet catastrophic. This evidence might include

- Worsening symptoms
- Increasing numbers of symptoms
- Increasing social and personal problems resulting from symptoms

Of still less urgency are those disorders and situations that may be inconvenient but don't produce much distress or maladjustment. Examples include the milder depressions, adjustment disorders, and a wish to understand oneself better.

In the case of coexisting presenting problems or diagnoses, you would generally attack the more pressing disorder first. But you must also consider the overall clinical picture; that means you still must decide which diagnosis is primary and which is secondary. For example, most psychiatrists would move quickly to restrain a person with primary alcohol dependence who has a secondary suicidal depression, but they would not immediately begin treatment with antidepressants or electroconvulsive therapy.

How Expensive Is Treatment?

Expense means more than dollar cost. It also includes an evaluation of the unwanted effects of somatic treatment or psychotherapy. As in any other branch of medicine, the test is: do the desired effects of the treatment outweigh its unwanted effects?

How Sure Are You of the Diagnosis?

Expensive, long-term, or risky treatments are attractive only in proportion to the certainty of your diagnosis. For example, you might recommend a therapeutic trial of antidepressants for a patient with somatization disorder and depression, but you would probably withhold electroconvulsive therapy, at least until you had better evidence that this patient indeed had two "primary" diagnoses.

Are There Contraindications to Any Therapeutic Modality?

Of course, you will consider specific drug interactions and allergies, but don't forget about

- Relative contraindications to electroconvulsive therapy
- History of noncompliance with drug treatment
- Problems that might limit the use of psychotherapy (such as low capacity for insight and lack of adequate insurance coverage)

Have You Considered All Feasible Modalities of Treatment?

It is rare that a psychiatrist feels equally at home with all the available modalities of treatment. Most of us specialize in one way or another. For that reason, gaps in the therapeutic armamentarium will sometimes develop; because we don't use certain types of treatment, we tend to forget that they can be valuable. The Board examination is no place to suffer such a lapse of memory.

What Has Worked in the Past?

If your patient claims that phenelzine previously helped but tricyclics have never worked, you will probably want to stick with success.

Treating With Medication

Somatic therapies are a consideration in the treatment of most patients today. You should always mention them, even if only to indicate why you plan to avoid them. If you propose to use medication, you might be asked to discuss a number of considerations specific to the drug you choose:

1. What is its specificity for the disorder? Some drugs are more or less specific to the disorders for which they are prescribed: lithium and bipolar mood disorder are one obvious combination. Other drugs, such as SSRIs and the neuroleptics, are effective in a broader spectrum of conditions.
2. How familiar are you with the medication? You're safer discussing those you know well through personal use.
3. Do you expect to prescribe the medication for short-term use or as maintenance therapy?
4. What form of the drug (tablet, capsule, liquid, parenteral, depot) would you prescribe, and why?
5. How would you initiate treatment? Gradually, as with an antidepressant, or more rapidly, as with a neuroleptic?
6. What are the important side effects, including those common to its class (e.g., dry mouth for the tricyclic antidepressants) and those peculiar to individual drugs (nephrogenic diabetes insipidus for lithium)?
7. How will you manage important side effects? These will range from the common (extrapyramidal symptoms) to the less common (central cholinergic syndrome) to the rare (neuroleptic malignant syndrome).
8. Is there a family history of favorable response to your drug of choice? The patient may not know, but you can point out that it is a question that you could also ask an informant.
9. Are there patient-specific indicators that would make you especially cautious in initiating treatment? These might include advanced age, kidney or liver disease, history of drug sensitivity, and pregnancy.
10. Does the patient want to take medicine? Has there been a history of noncompliance that suggests you should consider a depot neuroleptic?
11. What is the likelihood of abuse of the medication? Included would be the abuse potential of the drug itself, as well as the patient's history of abusing other drugs and of drug-seeking behavior.
12. Does the patient have a history of accidental or intentional drug overdose?
13. Is the patient taking other prescribed medications that might augment or interfere with the drug you choose?

14. Would blood levels help you arrive at an optimum treatment? This question could apply not only to lithium and carbamazepine, but also to some antidepressants.
15. How often would you administer medication (divided doses versus once a day)? At what time of day? On a routine or an as-needed basis?
16. Can you recommend simplification of the present regimen by eliminating any of the patient's present drugs?
17. If you recommend a change from the patient's present drug regimen, will it be within the same class of drugs or to one of a different type? Should there be a washout period between drugs? Should the switch be gradual? Or is the patient simply not taking enough of the present medication?
18. What are the legal ramifications of your recommended drug regimen? Issues might be the patient's right to refuse treatment, informed consent, and the management of the incompetent patient.

Psychotherapy

Most patients respond to verbal interactions. The usual question in a treatment formulation is not whether psychotherapy will be used, but what kind will be used. Here are some of the factors you might consider:

1. Which of the patient's main problems would be the focus of therapy?
2. What is the goal of your treatment? The range might be from mere palliation of symptoms to a total restructuring of personality.
3. How available for therapy is the patient? Would regular activities such as work or school interfere?
4. What is the patient's capacity for insight? Personality characteristics and intelligence would be two of the factors to keep in mind.
5. To what extent can the patient afford therapy?
6. What is your own experience and expertise with the form of therapy you recommend? For example, would you refer the patient for behavior modification, or would you do it yourself as part of a comprehensive treatment plan?
7. How well motivated is the patient, and what was the success of any prior attempts at psychotherapy?
8. Would you feel capable of working effectively with this patient, or do you sense a personality conflict?
9. What would be the potential problems and pitfalls of treatment? For example, how would the therapist's absence be handled?

Social Approaches

Environmental interventions may be critical to speeding up improvement, increasing the chances for survival in the community, or ensuring compliance with other interventions. Social interventions may be especially important for many of the patients seen in the institutional settings where the Board examinations are held. Consider the following questions:

1. Are there family or friends available with whom to work? Are they interested in the patient, and have they been helpful in the past? These people could assist with transportation and reminders to take medicine, and they could call the physician if the patient does not comply with the therapeutic regimen. Be sure to consider the benefits (and possible drawbacks) of including the patient's family and friends as allies in the therapeutic process. While you are presenting the treatments you would recommend, keep in mind how you would describe them your patient's family or friends. Some examiners ask their candidates to explain the proposed treatment plan as if the patient and family were in the room.
2. Would the patient profit from vocational rehabilitation?
3. Is the patient optimally placed? Would another type of residence be more suitable?
4. What sort of legal maneuvers might be warranted, either currently or at some point in the future? Included would be involuntary commitments, conservatorships, and fiduciary arrangements, as well as assistance with wills, durable powers of attorney, restraining orders, and divorces.

For convenience, we list the various therapeutic modalities in Table 9–3. Be sure to consider some from each of the three principal approaches: your patient may be quite ill and could require a variety of therapeutic modalities.

Assessing Prognosis

At some point during the half hour after your patient interview, you will probably be asked, "What did you learn in the interview that allows you to predict how well this patient will do?" Recall the various areas that are defined by the term *prognosis:*

1. *Symptoms.* Will they be relieved completely or only partly?
2. *Course.* Will the patient recover completely? Will there be only a single episode, or do you expect remissions and exacerbations? Do you expect chronicity?

Table 9–3. Outline of psychiatric treatment modalities

- Biological
  - Drugs
  - Electroconvulsive therapy
  - Light therapy
  - Psychosurgery
- Psychotherapy
  - Individual
    - Cognitive
    - Insight oriented
    - Analysis
    - Short term
  - Group
    - Disease oriented (Alcoholics Anonymous, lithium clinics)
    - General medication clinics
    - Family therapy
    - General support groups
  - Behavioral
    - Simple reassurance
    - Systematic desensitization with reciprocal inhibition
    - Mass practice
    - Ward token economies
    - Thought stopping
- Social interventions
  - Vocational rehabilitation
  - Social skills training
  - Education of family
  - Placement for acute, intermediate, or chronic care
  - Involuntary commitment
  - Conservatorship

3. *Restitution.* Will there be complete recovery, or will there always be residual pathology?
4. *Treatment response.* Will it be slight? Moderate? Complete? How rapidly do you expect the patient to respond to the various sorts of treatment you propose?
5. *Time course.* How long will recovery take, and what will be the interval before another episode (if any)?
6. *Social sequelae.* Will the patient's level of functioning return to the premorbid level? How will the illness affect family life? Job performance? Independence? Will financial support be required? What about legal problems such as commitment, conservatorship, entering into contracts, driving a car, and voting?

7. *Heredity.* How likely is it that the illness could be passed on to the patient's children?

Several factors will contribute to your estimate of prognosis. Among them are the following:

1. *Axis I and Axis II diagnoses.* The Axis I diagnosis is usually more important for prognosis. But personality disorders can also assume considerable importance, especially if there is no diagnosable Axis I disorder or if the patient rejects or otherwise frustrates attempts at treatment. Be sure that you explain clearly which diagnosis you have in mind when you are discussing prognosis.
2. *Duration of illness.* If the patient has already been ill for years, the prognosis for a complete recovery (barring a therapeutic miracle) is probably poor. But if the history has been a series of exacerbations with complete remissions, you can feel reasonably confident as you predict another cycle.
3. *Previous response to treatment.* As a predictor, previous treatment response is only as good as the previous treatment. If the patient has mania and has never been treated with lithium, you can upgrade your prognostic optimism by an order of magnitude, at least.
4. *Compliance with treatment.* As already noted, the patient's amenability to treatment may be affected by both the Axis I and Axis II diagnoses.
5. *Availability of treatment for the primary disorder.* This factor has two parts. a) Have effective treatments been devised? b) Considering the patient's own finances and geographic location, are any of these treatments likely to be used?
6. *Available social supports.* These may include families of origin, spouses, children, friends, support groups, physicians, and religious organizations. Generally, prognosis is directly proportional to the number of bridges the patient has left unburned.
7. *Highest recent level of functioning.* Axis V, the Global Assessment of Functioning (GAF), reflects the current need for treatment or care (Table 9–4). But the highest level of functioning in the past year also has prognostic significance because that is the level to which patients usually return on recovering from an episode of illness.

Note that this scale has been revised from the DSM-III-R GAF scale published in 1987. The revision extends even to the numbering system, which now ranges from 100 (superior functioning in a wide range of activities) through 90 (absent or minimal symptoms) to 1 (recurrent violence or serious suicidal act). When you discuss level of functioning with your examiners, it is quite acceptable, perhaps even preferable, to use verbal descriptions (e.g., low, moderately high) rather than numbers. Many of us have trouble remembering numbers.

Table 9–4. Global Assessment of Functioning (GAF) Scale

Code	
100 | 91	Superior functioning in a wide range of activities, life's problems never seem to get out of hand, is sought out by others because of many positive qualities. No symptoms.
90 | 81	Absent or minimal symptoms (e.g., mild anxiety before an exam), good functioning in all areas, interested and involved in a wide range of activities, socially effective, generally satisfied with life, no more than everyday problems or concerns (e.g., an occasional argument with family members).
80 | 71	If symptoms are present, they are transient and expectable reactions to psychosocial stressors (e.g., difficulty concentrating after family arguments); no more than slight impairment in social, occupational, or school functioning (e.g., temporarily falling behind in school work).
70 | 61	Some mild symptoms (e.g., depressed mood and mild insomnia) OR some difficulty in social, occupational, or school functioning (e.g., occasional truancy or theft within the household), but generally functioning pretty well, has some meaningful interpersonal relationships.
60 | 51	Moderate symptoms (e.g., flat affect and circumstantial speech, occasional panic attacks) OR moderate difficulty in social, occupational, or school functioning (e.g., few friends, conflicts with peers or co-workers).
50 | 41	Serious symptoms (e.g., suicidal ideation, severe obsessional rituals, frequent shoplifting) OR any serious impairment in social, occupational, or school functioning (e.g., no friends, unable to keep a job).
40 | 31	Some impairment in reality testing or communication (e.g., speech is at times illogical, obscure, or irrelevant) OR major impairment in several areas, such as work or school, family relations, judgment, thinking, or mood (e.g., depressed man avoids friends, neglects family, and is unable to work; child frequently beats up younger children, is defiant at home, and is failing at school).
30 | 21	Behavior is considerably influenced by delusions or hallucinations OR serious impairment in communication or judgment (e.g., sometimes incoherent, acts grossly inappropriately, suicidal preoccupation) OR inability to function in almost all areas (e.g., stays in bed all day; no job, home, or friends).
20 | 11	Some danger of hurting self or others (e.g., suicide attempts without clear expectation of death; frequently violent; manic excitement) OR occasionally fails to maintain minimal personal hygiene (e.g., smears feces) OR gross impairment in communication (e.g., largely incoherent or mute).
10 | 1	Persistent danger of severely hurting self or others (e.g., recurrent violence) OR persistent inability to maintain personal hygiene OR serious suicidal act with clear expectation of death.
0	Inadequate information.

Source. Reprinted from the American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders*, 4th Edition. Washington, DC, American Psychiatric Association, 1994. Used by permission.

Part II-B.8.

Second Edition

BOARDING TIME

A Psychiatry Candidate's Guide to Part II of the ABPN Examination

James Morrison, M.D., and
Rodrigo A. Muñoz, M.D.

Chapter 8

The 30-Minute Hour

Performing a thorough psychiatric interview under the pressure of time is stressful at best, yet many psychiatrists do it every day. When you do a brief interview in routine practice, it is usually by choice. If you have a difficult office patient, you can always choose to spend more time interviewing and less time eating lunch.

Board candidates, with no discretionary time available, not only must perform a creditable exam in 30 minutes flat, but also must do it under the scrutiny of strangers. So it is no wonder that even as they introduce themselves, candidates typically feel they are about to run out of time. In this chapter, we discuss how you can best make use of the half hour allotted to examining a patient during the Board examinations.

Time Management

Watch the Clock

You can't manage time if you don't know how much of it you have left, and the examination room is almost certain to have no clock readily visible. Be sure to ask the examiners to give you a 5-minute warning. Place your wristwatch on the table in front of you where you can see it easily. This lacks elegance, but it beats having to steal a surreptitious glance at your wrist every few minutes, and it is vastly superior to being caught with half your interview to go and only 5 minutes remaining.

You won't learn what time you are to begin your patient interview until you

register for the exam, so you won't know whether it will begin on the half hour or at some other odd time (see Chapter 4 for time schedules). The actual patient exam is stressful enough that you shouldn't use your energy mentally subtracting minutes from, say, 10 or 50 minutes past the hour to see how much time you have left. Instead, you might consider using a stopwatch, or resetting your wristwatch so that 12 o'clock coincides with the start of your patient interview (an electronic watch with a dual time feature should work well). That way, you can concentrate on the patient's information without having to perform serial mental arithmetic of your own.

When you enter the room, you should know about how many minutes you will spend on each part of the examination. (See Chapters 6 and 7 for a more complete description of the different phases of the examination.) Of course, how you divide your time will vary with the individual patient, but as a general rule you should plan as follows:

- 5 minutes: Chief complaint and free speech
- 7 minutes: Specific questions to rule diagnoses in or out, elicit pertinent negatives, and inquire about suicidal ideas, violence, alcohol and drug history
- 5 minutes: Medical history, review of systems, family history
- 5 minutes: Personal and social history, evaluation of character pathology
- 5 minutes: Mental status examination
- 3 minutes: Buffer time to catch up on last questions and pursue other late-developing leads

In practice, most interviews are probably shaded toward more time to elaborate the present illness. But even if you don't stick to it strictly, an approximate timetable will help you to touch on all the critical points. In any event, these times may vary widely, depending on the characteristics of your patient.

"Hard" and "Easy" Patients

Board exam patients certainly can present a variety of challenges. Your patient may cause you some anxious moments with one or more of the following characteristics:

- Vague history (probably the most common attribute)
- Circumstantial speech
- Difficult-to-understand speech (actually, patients who speak in unfamiliar accents may be more of a problem for repeating candidates; first timers will usually be examined in their own part of the country)

- Suspiciousness or hostility
- Complicated history

Any one of these attributes can cause problems in a half-hour exam. Combine several, as happens often, and you will face an exacting test of your ability to forge rapport while managing the interview.

Actually, you should expect that most patients will have some quirk of personality or mental status that will tax your interviewing skills. After all, most of these people have sought treatment because of emotional or interpersonal difficulties. You cannot expect them to recite their life stories as if written up in a textbook. In this sense, there is no such thing as a bad patient—only those who present with different sorts of challenges to overcome. If the patient presents some difficulty in the interview, don't regard it as a calamity. Remember that you'll have far more opportunity to show your skill with a difficult patient than with an easy one.

Still, if your patient is intelligent, alert, and observant and can tell a coherent story that is to the point, you'll probably breathe a little easier. Although you should never try to let your patient do the work for you, an easy patient can certainly brighten your day at the Boards. But if you rely on such extraordinary luck, the consequences could be dire. Take a pointer from the disaster-planning experts: hope for the best but plan for the worst.

Develop Rapport If You Can

The word *If* is critical. You should certainly try to establish a good working relationship with your patient (see Chapter 5). But the need for rapport is relative. Although you would like to have both rapport and a complete history, the latter is more important by far. Theoretically, you could successfully negotiate the Boards with no rapport at all (as long as you showed that you tried to form a relationship with your patient), but not without information.

Of course, if you can develop a friendly working relationship, you'll get your patient's best efforts at cooperation, and that could mean you will get more information in less time. So make the effort to achieve a good working relationship; but make it quickly.

You may be able to win some sympathy if at the beginning you remind your patient that you are being tested and that you appreciate the cooperation. Establish eye contact early in the interview and continue it throughout, but avoid fixed stares. A nod or smile conveys your empathy and silently reassures the patient, "You're doing fine." (This maneuver takes no time, yet shows the examiners that you, too, are doing fine.) Be responsive and sympathetic to both the content of the history and to the patient's affect.

Your patient will probably relax and talk more freely if you seem at ease yourself. If you have to fake an air of relaxation, then do so. (Some candidates have obtained good results by practicing in front of a mirror.) Of course, your best bet for achieving good rapport is to be genuinely interested in the story your patient has to tell.

You'll definitely look and feel more relaxed if you are not madly taking notes throughout the interview. Instead, during the interview mentally organize the information you obtain and file it away (in your head) under sections of the standard interview format (see Chapter 6). Mentally note the specific information you want to emphasize during your presentation, and try to get a sense of your own feelings about the patient.

Controlling the Interview

You must be in charge of the interview, even if you have to be more firm than usual. In the most favorable case, being firm may mean nothing more than interjecting an occasional gentle question to guide the progress of the interview. But you should be prepared, after the first few minutes of free speech, to become hard-nosed and insistent if the interview begins to go awry.

Most patients won't try too hard to be controlling. Treated for years in teaching facilities, many patients have been interviewed by numerous physicians and other mental health professionals at all levels of training. They know quite well how to cooperate with an interview. Still, you could encounter a patient with a thirst for control, evidenced by manic pressure of speech, psychotic suspiciousness of your motives, or overall normal appearance but circumstantial manner. You would then have to take steps to keep your entire interview from being ruined.

Structure is the key to your success. Although you may not exactly follow the timetable you have in mind, it should remind you to cover many categories of information in your half hour. Even though you have not plumbed every depth in the psychiatric history, you must keep moving and touch on everything.

After the first few minutes, you must stop asking open-ended questions. This strategy may go considerably against the grain; however, once you know the general outline of your patient's problems, you should be able to frame a number of short-answer questions that will allow you to test and discard successive hypotheses as to diagnosis.

You won't have time to respond as completely as you would like to your patient's expressed emotion. But you can show your interest while getting further information by asking, for example, "When have you felt depressed like this before?" If your patient seems troubled by a recent problem that you have already explored, you could say something like, "I'd like to hear more about that later if we have time. Now we must move on." Periodically, you may have to reinforce your expectation of concise, informative answers. You may find yourself having to cut short attempts to expand on yes or no answers when the extra verbiage doesn't materially advance your progress. If the patient gets off the track, use variations on "We only have a few minutes" or "Now I'd like to ask you some short-answer questions."

It helps to remember that the purpose of this interview is diagnostic, not therapeutic. It isn't your job to practice nondirective psychotherapy, to give advice, or to inspect skin lesions or pictures of grandchildren. If the patient improves as a result of your talk, that's well and good, but your only real task is to pass the exam. Don't offer therapeutic recommendations to the patient, who is, after all, not *your* patient. Whatever else, don't be like one candidate who lectured an adolescent patient on morals.

No matter what you think of the present treatment plan, don't criticize it to the patient. In fact, if you make any treatment recommendations, you risk inducing mistrust of the patient's own physician. Also, you would put yourself in the impossible position of claiming some responsibility for a patient you don't know well and will never see again. Neither should you offer false reassurance; if your patient asks for help of some sort, respond with something on the order of: "Your own doctor knows you better and can give you the best advice on this." Interpretations are none of your business, either, even if you have time.

In any first interview, some topics are of little use. From such topics you are unlikely to obtain information valuable enough to justify the time spent in asking. Toilet training is one such topic; others include developmental milestones and childhood diseases. (Few adults can reliably tell you the age at which they first walked or spoke sentences, anyway.) Don't discuss dreams, even if they are offered. In the 30-minute interview, dreams are the royal road to oblivion. Keep practicing interview control: "I'd love to know that, but first. . . ." "I really need to hear about. . . ." "Our time is running short."

Always keep a tight rein on your own verbal output. Two important principles apply. 1) Anxiety may cause you to talk more freely than you normally do. 2) The more time you spend talking, the less time your patient will have to give you information. Formulate your questions as clearly and succinctly as you can. Save your opinions, complaints, and comments for later. You'll be given your own free speech time after the patient leaves the room.

Red Flags

Before we leave the subject of time management, here's another word of warning: Be alert for "red flags." These are unexpected bits of information that warn

you of areas you need to explore. Red flags can pop up any time, but they are most likely to take you unaware when you have obtained most of your history and are trying to tie up loose ends with some short-answer questions.

Here's an example: You've sailed smoothly through a history of what sounds like straightforward schizophrenia. After mopping up a last few items of family history, you're almost ready for the formal part of your mental status exam.

YOU: Mr. Carson, has anyone else in your family ever had a psychiatric illness?
PATIENT: No one except my sister. She was hospitalized for awhile just before my first blackout.

First blackout? This is the first you've heard about *any* blackouts, and you're almost at the end of the exam! What does he mean by blackouts, anyway? Seizures? (He's already denied any other health problems.) Alcoholic blackouts? (You're almost sure he doesn't drink heavily.)

What a predicament. His sister's illness might help nail down a diagnosis of schizophrenia, but you also have to follow up on his blackouts. They could have real bearing on why he is psychotic. And time is rapidly running out.

No problem. You have time—that's why you have the 3 minutes of buffer time. If you've noticed the red flag at all, you've already won half the battle. Now you can make a note—here's where one of your rare, one-word reminders on a pad of paper is warranted—to come back to this subject right after you hear about the sister's illness. Or you could jump immediately to the questions about blackouts, and return to pick up the rest of the family history later, time permitting. Even if you literally have no time to follow up on a red flag, the fact that you notice and remember it is important in itself. You can still discuss with your examiners what additional information you might have learned had you had time to dig more deeply. Tell them how diagnosis and treatment could be affected by what you might have heard.

If the Patient Resists

Although most Board examination patients will cooperate throughout the interview, a few may offer resistance of one kind or another. A variety of precipitants can cause resistance to develop. Despite the fact that all have nominally volunteered, the occasional patient may have been under some pressure from fellow patients or treating psychiatrists. Another may have the flu or be experiencing side effects of medication.

Certain diagnoses make patients more likely to offer resistance. These include manic episodes, any acute psychosis, and antisocial and borderline personality disorders. Other patients may simply feel the need to conceal information—perhaps to make a good impression or to cover up shame. Of course, any of these motives may be compounded by how you react while taking the history. Without realizing it, you might express disapproval, either verbally or by gestures—frowns, shrugs, or any of the other idioms of body language we try to eradicate in residency, but that sometimes reappear during times of stress.

To counteract resistance, you first must recognize it. The clue may be as obvious as your patient's direct statement: "I don't want to talk about that" or "That makes me feel uncomfortable." But most patients don't like to defy doctors openly, so the message is usually more subtle: silence, a sudden change of affect, or body language of the patient's own such as downcast eyes or frequent glances at the examiners or at a wristwatch. A patient may also complain about missing lunch or a therapy session, or may ask to use the bathroom or to smoke a cigarette. Vague answers to questions or the inability to remember details that should be familiar are other means by which patients may tell you that they don't want to reveal themselves further. Muteness can be due to severe psychopathology such as depression or psychosis, but it may be simply a device used by the patient to control the interview—the ultimate in nonverbal communication! Some patients may indicate resistance by nothing more than a slight hesitation before answering. As in any clinical situation, you will have to be continually alert to the nuances of the interchange between you and your patient.

Of course, you'd like to avoid saying anything that would precipitate resistance. But some subjects that may cause it are among those most important to cover in a diagnostic interview. Foremost among them are sexual habits and attitudes, psychotic thinking, suicide attempts, substance abuse, and history of criminality.

You will have to deal with resistance right away: you don't have the luxury of putting off sensitive questions until a second interview. If time is unusually short or the topic is not critical, you might first attack the problem by trying to change the subject. You could say, "I see that's a hard question for you. Maybe we should just drop it for now. Instead, let me ask you. . . ."

For example, suppose you discover that your questions about work history have rekindled the painful feelings of failure your patient had a week earlier when someone else got a coveted promotion. Because you don't have time to explore those feelings in any depth, and because you already have collected enough symptoms to diagnose major depression, you may want to back off and approach the work history from another angle. Ask how long your patient has been employed, or what the job entails. If you continue to elicit only silence, tears, or complaints, then you had better change the subject completely.

Always reserve the right to return to the topic later. Sometimes, a second try will be successful when the patient is more accustomed to you and to the interview situation. Even if you get no further the second time, you will have demonstrated your interest and perseverance.

If the question is especially important, or if the patient seems to be reacting negatively to the whole interview, then you must meet the challenge head on. Although you should try hard to avoid confrontations, you may have to make an exception if the patient appears restless, uncooperative, or otherwise uncomfortable. When it becomes clear that you are not getting the information you need, you can switch gears and comment on the patient's affect. Mention that you have noticed the silence, the change of affect, the vagueness. Try: "I notice that you are suddenly silent. Can you tell me what's wrong?" or "You look sad. What are you thinking about?" Because you've been getting nothing, you'll lose nothing by this maneuver, and a change of pace might help the patient to feel less burdened and more cooperative. Even a brief exploration of the patient's feelings or thoughts should reveal some clues to the reason behind the resistance. In turn, this may guide you to a resolution of the impasse.

In general, this is no time to explore whether the patient knows the reason for resisting. This line of inquiry is likely to be fruitless, anyway, and the clock is ticking. However, if you find yourself faced with a major roadblock (e.g., the patient becomes angry, sarcastic, or mute or tries to leave the room), you have little choice but to delve further into feelings. Usually, angry outbursts or sarcasm will be due to underlying psychopathology. If so, your patient may not be easily calmed with a few soothing words. But your inquiry may reveal a precipitant (something you said, something about your appearance) that you can discuss together and, with luck, set to rest. Whatever you do, don't allow your own anxiety to prompt a response that is itself hostile or angry. You are, after all, being tested on your psychiatric skills.

Vagueness

Vague responses may be encountered in patients who are mentally retarded or psychotic or in patients who have Axis II pathology such as histrionic personality disorder. But such responses may simply be another form of resistance that most any patient might use from time to time. Approximate answers (Question: "How long have you been depressed?" Answer: "A long time.") should be followed up with specific questions that suggest the range of answers you expect: ("A few days? A few months?") In similar fashion, patients who respond "I don't know" should be offered some choices before moving on to another subject. Ordinarily, you want to avoid any time-consuming confrontations over what the patient knows or does not know, but if your interview develops into a pattern of vague responses you should explore the reasons behind this form of resistance. Otherwise, simply make a mental note of the discrepancy between what the patient ought to know and claims to know, and discuss it with the examiners later.

Vague or circumstantial ramblings very early in the interview should prompt you to cut short the patient's free speech time and begin your focused, short-answer questioning. If vagueness forces this strategy, follow Sutton's law and "go where the money is": start right in asking about symptoms that will allow you to identify the psychiatric disorders you are most likely to encounter. These won't be much different from what you would expect to find in any other population of psychiatric patients. Mood disorders and psychoses will be most strongly represented, followed by personality disorders, cognitive disorders, and substance abuse, though not necessarily in that order. You will use your time most efficiently if you first ask screening questions for depression and psychotic symptoms: "Have you felt depressed, sad, blue, down in the dumps? Have you ever had experiences such as hearing or seeing things others couldn't see or hear? Have you felt people were following you, spying on you, talking about you, or trying to harm you?"

Even patients who are not notably vague, but who only enjoy a good chat, may need help keeping their answers short. This situation is most likely to happen during the early phases of the interview, just after the free speech portion. If your patient starts to tell you more than you need to know, don't be afraid to interrupt. Try: "I think I understand about your appetite. But has your sleep changed any?" (Notice that by asking a yes or no question you imply that now you would like a short answer.) An especially chatty patient may require several such interruptions before understanding how much you value brevity. A nod and a smile with each short answer should help reinforce the message that you want answers that are the "soul of wit."

Last Words

It is traditional in many training programs to close demonstration interviews with an invitation to the patient. This is usually something along the lines of "I've asked you a lot questions—is there anything you would like to ask me?" But the Board exam is not a training interview, and this question is one of the customary courtesies you should avoid. To obtain the maximum amount of information from your patient, keep interviewing until the examiners tell you that the time is up, and then stop at once. Express your thanks and show the patient to the door.

Special Constraints on Time

How you parcel out your time can be affected by other factors. We'll touch on two of them here—age and intellectual capacity.

The Geriatric Patient

Patients in the geriatric age group often present the person conducting a psychiatric brief interview with an embarrassment of riches: too much data. Not only can older patients have virtually any of the Axis I and Axis II psychiatric diagnoses, but because they have lived longer than the average patient, they have more experiences—both good and bad—to talk about. Their psychiatric conditions are also more likely to be complicated by medical disorders.

Plan to allow more time for reviewing personal and social histories. You may need to inquire about some experiences that would be less germane to younger patients, such as meal and food preparation, economic resources, leisure activities, and problems with transportation.

By the age of retirement, life often becomes dominated by losses: loss of health, jobs, income, and status. Older patients have lost friends and family to death; their children have moved away or might ignore them. Loss of income and physical functioning often means moving into a retirement home (loss of home). There may be no telephone, leading to loss of contact; the patient may no longer drive (loss of mobility). These are all facts of life for the older patient that demand special sensitivity from the younger interviewer, who may as yet have had little personal experience with loss.

Infirmity, with its attendant loss of control, leads to embarrassment. This in turn could result in some resistance, particularly in the form of denial. You may have to break through denial by being very concrete. For example, if your older patient denies your suspicion there has been no loss of contact with family, you might ask, "When did you last see your son?"

This may also be one of the few times when you find it expedient to share something of yourself or to allow some discrete physical contact—your hand on an arm—to help your patient feel that you can truly empathize. Speak slowly and clearly, but not too loudly. As one septuagenarian retorted during an interview, "Don't shout! I'm depressed, not deaf!"

Cognitive Disorders

Some disorders present the opposite sort of problem for the interviewer: too few data. These include mental retardation and dementias and amnestic disorders of various etiologies. Cognitive disorders not only create a difficult problem of differential diagnosis, but also may make it harder to obtain the history. You will probably realize early that the patient has a form of cognitive disorder, so you will already know a major portion of the diagnosis. You can concentrate on digging out information pertinent to its etiology.

These patients often think and speak slowly. Sometimes, they also do not speak clearly, which can frustrate an interviewer intent on reaping a bountiful harvest of information in 30 minutes. Don't condescend, and try not to rush. You are better off with less information, as long as it's accurate, than with a lot of information that's not accurate. To check on whether you have been understood, you may have to ask the patient to repeat your question. You may learn a lot just by verbally taking the patient through a typical day's activity.

In the rare, extreme case, you may not get much historical information at all. Then, whatever information you obtain must come from the mental status examination. Be specific and concrete. Here is a case where you will want to do the complete mental status exam, as outlined in Chapter 7. Remember, too, that you should be wary when you interpret your mental status findings. A person with normal intelligence would understand a shorthand phrase such as "hearing voices" to mean "hearing voices when there is no one around to speak." But a mentally retarded person might interpret it as nothing more exotic than hearing a normal conversation or the television announcer.

Finally, if you emerge from the half hour with fewer data in hand than you would like, try not to feel discouraged. Remember that no clinician, including either examiner, is likely to do much better with this sort of patient.

Part II - B.7.

Second Edition

BOARDING TIME

A Psychiatry Candidate's Guide to Part II of the ABPN Examination

James Morrison, M.D., and
Rodrigo A. Muñoz, M.D.

Chapter 7

Mental Status Examination

Originally, the mental status examination (MSE) was an amplified part of the neurological exam. Today, it is fundamental to the workup of any patient, psychiatric or otherwise. It should be no less an integral part of the monitored examination. Although occasionally you may be able to assess the patient adequately without a formal MSE, it may be 1) hard to identify that rare patient and 2) less trouble to go ahead and do an MSE than to defend not doing one. However, one examiner points out that candidates are sometimes asked to justify asking about certain items of history or performing a formal MSE when the clinical picture doesn't warrant it. We maintain that this task is infinitely easier than explaining why you didn't ask when you should have.

By now, only about 5 minutes are probably left in your patient interview. If you are like many other candidates, you may be tempted to ignore the MSE as you struggle to extract every last drop of history. Although for many patients you can omit portions of the formal MSE, the structure of the Board examinations requires that each candidate demonstrate skill at administering and evaluating it.

What Is Most Important in the Mental Status Examination?

Not every patient will require the same attention to the MSE. You probably won't be able to complete it, and your examiners don't expect you to do so. With time short, they want to know how well you can focus on what is most important for you to understand your patient. Therefore, your key question is, "Under what circumstances should I do a more thorough MSE?" For most patients you might

encounter during the Boards, you will have to choose portions of the formal MSE that are most likely to yield important data. That will require judgment on your part, but you can rely on several guiding principles:

1. Several parts of the MSE come "for free." To learn about them, you don't have to ask anything special; just pay attention while you are taking the history and you will be able to report on the patient's general appearance and behavior, the flow of thought, and portions of the sensorium.
2. Watch for behavior that suggests specific deficits. Repetitive physical actions should alert you to the possibility of obsessions; motor restlessness may be due to akathisia, which would suggest that you probe the content of thought for delusions and hallucinations.
3. Listen to what your patient tells you. For example, a history of head injury or seizures demands that you pay more attention to the details of the sensorium such as memory. If the patient reports hallucinations, do ask carefully about delusions as well.
4. Certain diagnoses in your differential require more careful testing of the sensorium. Alcoholism and dementia are two obvious examples.
5. Certain parts of the MSE should be included for nearly any patient you might encounter during the Boards. These essentials include questions about mood, suicide, and psychosis. You should be able to describe the three dimensions that characterize your patient's affect.

You should consider doing a fuller MSE for older patients (geriatric age range) and for those who have intercurrent medical disease. In particular, the suspicion of AIDS should evoke more attention to the sensorium.

The Traditional Mental Status Examination

The MSE is traditionally divided into six parts; psychiatrists traditionally differ as to the order, emphasis, and content of the parts. Which form of the MSE you use matters less than the fact that you use one at all. To ensure that you evaluate and describe every aspect of each patient's mental status, you should choose an MSE format that you are comfortable with, memorize the parts in that order, and apply that format rigorously to each patient you interview.

The following is one such format that has stood the test of time. In describing it, we will try to define briefly all the terms you need to know. But again, we emphasize that no candidate will be expected to use the complete MSE as we have outlined it here. Be sure you know it all, but choose those parts you need to evaluate your own Board patient.

I. General Appearance and Behavior

A great deal of the MSE can (and should) be done by observation alone. In that way, your senses do double duty: you gather information visually and verbally at the same time. When candidates forget this, they can come to grief.

> When Dr. Voner entered the room, the patient was already seated quietly, forehead covered by slightly unkempt hair. So the bullet hole scar in the forehead went unnoticed. When the patient left the room, the candidate (who was busy taking notes) also missed the slight limp. Observing these two physical conditions could have made a real difference in the quality of Dr. Voner's life during the next half hour. As it was, after the patient had departed, the examiners themselves had to point out these physical signs and suggest that the patient had shot himself, producing a hemiparesis and a partial lobotomy.

Your observations of appearance and behavior begin the moment you meet your patient. (We'll continue to discuss our hypothetical male patient.) Does he walk with a limp? Does he shake hands when you greet one another? Is his grip firm? Are his hands dry or clammy? Does he appear to be his stated age? How would you describe his general condition? Well nourished? Unshaven? Tousled? Malodorous? Is his clothing clean or dirty, fashionable or out of date? Does the clothing fit the climate? Is he responsive, alert, and cooperative, or does he refuse eye contact, turn away, and sulk? Notice any unusual motor activity: Is he overactive or underactive? Is he stuporous (unresponsive without being asleep)? Is he restless? Does he pick at his skin or clothes?

Notice his speech. Is it accented? Does he stutter? Does his voice have a normal lilt? (This is called *prosody.*)

He may show *mannerisms* (unnecessary behavior that is part of a goal-directed act, such as the introductory flourish some people make with a pen as they start to write) or *stereotypies* (non-goal-directed behavior, such as making the sign of the cross every second sentence or so). Is there evidence of *posturing* (striking a pose and maintaining it)? *Waxy flexibility* (resistance of limbs to passive motion, like bending a wax rod or lead pipe)? *Catalepsy* (maintaining any position, no matter how uncomfortable, for a period of time)?

Look closely for signs of extrapyramidal side effects that might indicate the use of neuroleptic drugs. Extrapyramidal side effects include *pseudoparkinsonism* (masklike face, pill-rolling tremor, and general muscular rigidity) and *akathisia* (the need to get up or pace around the room). You are unlikely to encounter a fourth extrapyramidal side effect, *acute dystonia,* during this examination. You could conceivably encounter *tardive dyskinesia* as well, but this might be manifested only by subtle signs such as tongue fasciculations. At any rate, you should be prepared to discuss this tragic side effect of medication.

II. Affect

Many psychiatrists maintain that there is a difference between *mood* and *affect*. Unfortunately, they cannot always agree as to what that difference is. Some define *affect* as a transient state of feeling and *mood* as a feeling of longer duration. Some define the terms as just the opposite. In another system, mood describes a person's subjective feeling and affect describes how the person appears to be feeling. According to the latter system of definition, affect would include downcast eyes, the slope of the shoulders, and the droop of the lip. More and more, the terms *mood* and *affect* are used interchangeably. Use them as you will, but be able to defend your usage and remember that some psychiatrists still insist on the distinction.

Too often physicians content themselves with a one- or two-word description of mood (affect): "Seems depressed" or "Flat affect." An adequate description always includes three parameters: type, lability, and appropriateness.

Type of affect. Is the patient's overall affect one of depression, anxiety, fear, irritability, euphoria, or hostility? "About medium" or "normal in type" will do as a description, if the patient's affect is unremarkable. Two affects may sometimes coexist: a manic patient may show euphoria and irritability almost at the same time. (During any given half hour, even psychiatrically normal people may show more than one affect.) However, you probably won't have the time to discover your patient's full range of affect. You will have to make do with the dominant affect(s) you detect during your interview.

Lability of affect. Does the patient's affect remain stable, or does it change noticeably during your interview? Some degree of affective lability is normal; when it is absent, we call it *blunting* or *flattening* of affect. Schizophrenia patients sometimes have blunted affect, but it is by no means diagnostic: it can also be found in severe depression and in Parkinson's disease, to name just two. *Increased lability* of affect is sometimes encountered in somatization disorder (also know as Briquet's syndrome, or hysteria) and in dementia. When severe, as in dementias, excessive lability of affect is sometimes termed *affective incontinence.*

Appropriateness of affect. Of necessity, characterizing appropriateness of affect is highly subjective. You attempt to state whether or not the patient's affect matches the situation and the content of the patient's own thought. The patient who laughs while recounting his mother's death or screams obscenities during introductions may be said to have *inappropriate affect.* In somatization disorder, you may occasionally encounter the special type of inappropriate affect termed *la belle indifférence* (lofty indifference). It means that your patient regards serious symptoms such as paralysis or blindness, which would severely upset most people, with a bland lack of concern.

III. Flow of Thought

Of course, what we really mean is *flow of speech,* but we assume that patterns of thought are mirrored in the patient's speech. Flow of thought includes 1) disturbances of association (the way in which syllables and words are strung together in phrases and sentences and the relationship of the patient's answers to the questions) and 2) disturbances of the rate and rhythm of speech. These divisions are somewhat arbitrary, and the boundaries are often blurred. We will, therefore, present them all together. (We have adapted the following discussion from Andreasen 1979a and 1979b.)

In *circumstantial speech,* the patient includes many trivial and unnecessary details, but the connection between ideas is clear and the point is eventually made. In *distractible speech,* the patient's attention may be diverted by an extraneous stimulus (a noise or movement from one of your examiners could stop your patient in midthought).

Derailment is a pattern of spontaneous speech in which one idea runs into another that may be related clearly, if incompletely, or into one that bears no apparent relationship at all. The sequence of ideas can be understood, but the direction changes often and the succession of ideas may be governed less by logic than by rhyming, punning, or other associations that may have meaning for the patient, but not for the observer.

This term replaces several others that once were thought to carry some additional diagnostic meaning but are now generally acknowledged to be unreliable. One of these, *flight of ideas,* is usually accompanied by pressured speech (see below) and has always been linked with mania. It implies that the speaker moves rapidly from one idea to the next. Another is *loose associations,* which is a generic term for thoughts that do not hang together logically. This term has classically been linked with schizophrenia. The preferred term *derailment* carries no implication of diagnosis.

> When asked how long he had been hospitalized, a manic patient responded, "I've been here a week, I was weak when they admitted me, that's quite an admission to make, don't you think?"

Tangentiality, also called tangential speech, is a term that should be used only to describe an answer to a question. The answer may seem utterly irrelevant to the question, or there may be some vague or distant relationship.

CANDIDATE. How are you feeling today, Mrs. Jordan?
MRS. JORDAN. Are you my father?
CANDIDATE. I don't think I understood that.
MRS. JORDAN. I've got bricks in my bats.

A number of other association patterns of speech occur much less often than those just mentioned. The dictionary is crammed with words and phrases used to describe them all. Some of those could come up in the context of discussing your patient (or the videotape) with the examiners. We'll review some of the more common ones.

The term *stilted speech* applies to a patient who, for example, affects a British accent (without being British) or uses quaint or out-of-fashion phrases. The patient who *perseverates* repeats the same idea (sentence, phrase, word) over and over again, despite your attempts to channel the conversation elsewhere. (Constant repetition of isolated words is sometimes called *verbigeration.*) *Echolalia* occurs when the patient slavishly repeats the words or statements of others. When a word is invented by connecting syllables in novel ways, it is called a *neologism. Incoherence,* a speech pattern that the average listener cannot comprehend, may be due to use of random words *(word salad)* or to the suspension of the usual rules of grammar. Be careful not to overdiagnose incoherence, especially when it may be due to neurological disorders or to the speech patterns of a person whose native language is not English.

Clang association occurs when words are strung together solely on the basis of a similar sound (How now, brown cow). Word associations may also show *alliteration,* in which stressed syllables have similar sounds.

> Mr. Future, a patient in Leo Rosten's novel *Captain Newman, M.D.,* uses alliterative speech: "One encounters similar contretemps with the cluttering, clamorous clods in the unmedical corps upstairs. . . ."

Push of speech refers to an increased amount of speech that is usually rapid and is often loud and difficult to interrupt. It may be accompanied by *decreased latency of response,* in which the answer is given almost before you finish your question. Although it is characteristic of mania, it can be found in other pathological conditions as well as in a few otherwise normal individuals who simply talk too fast and too much. In an examination situation, you may find yourself continually having to pull on the reins to keep control of the patient who has one of these speech patterns.

On the other hand, a depressed patient may have *poverty of speech* (a reduction in the amount of spontaneous speech). Replies may be brief or monosyllabic when elaboration of a thought is clearly called for, or speech may be offered only in response to questions. In either event, you must do more than your share of the work of the interview. You could also encounter an *increased latency of response,* in which the patient takes longer than normal to answer a question. *Blocking* occurs when speech suddenly stops, interrupting a thought sequence. *Mutism,* in which the patient does not attempt to speak at all yet presumably retains the ability to do so, should be distinguished from *aphonia,* in which the patient can only whisper or speak in a hoarse croak. The former is a more serious psychiatric symptom. The latter may have medical or neurological implications, but it may also be associated with somatoform disorders.

IV. Content of Thought

By this point in your mental status examination, you might feel tempted to cut some corners. Avoid the temptation: you must have some of this information, and your examiners will ask you about some of it.

Of all the parts of the MSE, *suicidal ideation* is perhaps the least expendable. It should be touched on by direct questioning in every patient, regardless of the suspected diagnosis. In Chapter 6, we covered the sorts of questions you should ask relevant to a history of suicidal behavior. You also must learn whether the patient is having any such thoughts now. A positive answers demands appropriate follow-up questions:

- How long has the patient entertained these thoughts?
- How serious are they now?
- Is there a current plan for suicide?
- Is there a timetable?
- Does the patient have the means to commit suicide?

Selection for your examination does not mean that your patient is certified as being free of suicidal ideas. In fact, more than once a Board examination candidate has uncovered serious psychopathology that was previously unsuspected.

Just as serious, though far less common, are *homicidal thoughts.* These ideas, plus ideas about committing other acts of violence, should always be pursued. This is especially true when the patient has admitted to a history of violent behavior or feelings of uncontrollable rage.

Phobias are intense, unreasonable fears associated with some situation or object. Psychiatrists used to stock a whole lexicon of named phobias that today seems a useless exercise in semantics. (Who cares that *siderodromophobia* means fear of travel by railroad?) *Acrophobia* (fear of heights), *claustrophobia* (fear of being closed in), and *agoraphobia* (fear of open places or of being away from home) occur commonly enough that the names are still useful. Ascertain dura-

tion (recent versus long term) and intensity (does the phobia interfere with usual activities?).

An *obsession* is a thought, idea, or belief that dominates thought content and persists despite the person's recognition that it is unrealistic or senseless. *Compulsions* are the motor counterpart of obsessions. They often result in repetitive rituals that significantly interfere with the person's activities of daily living. A defining feature of obsessions and compulsions is the patient's desire to resist them. Ask, "Have you had any thoughts that seem silly, but that you keep thinking over and over? Are there any rituals that you cannot seem to resist?" Ascertain duration and intensity as for phobias.

Hallucinations are false sensory perceptions occurring in the absence of a related external sensory stimulus. Hallucinations can be graded as to severity. For example, auditory hallucinations, the most common, could be categorized progressively as indistinct noises, mumbling, distinct words, phrases, and sentences. Many patients will understand what you mean if you simply ask, "Do you hear voices?" But people who don't hallucinate (and some who do hallucinate but who have less experience in talking with psychiatrists) may think you meant to say, "Can you hear a person's voice when you are being spoken to?" To avoid time-consuming ambiguity on this point, always ask, "Do you hear voices when there is no one around?"

Expand on positive answers by asking, "Are these voices as clear to you as my voice is now?" Ascertain location: for auditory hallucinations, do they come from within the patient's head or body, from out in the hall, or from a specific source such as the cocker spaniel or grandma's crazy quilt? How often do they occur? How does the patient explain them? (Part of an illness? Alien influence?) How does the patient react to them? (Bemusement? Fear? Obedience?) *Audible thoughts* (the experience of hearing one's own thoughts spoken aloud) are a special form of auditory hallucination; it has similar import.

Visual hallucinations are much less often encountered but may be graded progressively as flashes of light, indistinct images, fully formed people, scenes, and tableaux. The tactile hallucination of ants crawling on or beneath the skin is called *formication*. Olfactory and gustatory hallucinations occur infrequently and may indicate a delirium with psychosis.

Illusions are misinterpretations of actual sensory stimuli. They usually occur in the context of limited sensory stimulation (such as low light) and are normal—nearly everyone has had the experience of awakening at night and being momentarily afraid of attack, perhaps from the dim form of a bathrobe thrown across the back of a chair. A patient who has had an illusion will sometimes require the reassurance that it is not the same as "going crazy"; this reassurance may be given freely, if quickly.

A *delusion* is a fixed, false belief not explained by the patient's culture and education. Ask: "Have you felt that anyone was spying on you, following you, or trying to read your thoughts or influence you in some way?" *Fixed* is a key word. Before a patient's statement that "someone has parked a frankfurter in my ear" is marked down as a delusion, it must first be distinguished from an "as if" experience.

CANDIDATE. Do you really believe that?
PATIENT. Well, it hurts as much as if someone had put a frankfurter there!

The patient's response shows that he may accept another interpretation of his experience: Thus, it is not a delusion. Occasionally, a patient may say something that sounds delusional, but is really not. The high-powered industrial tycoon who agrees (perhaps partly in jest) that he is God may be an example. A patient may either uncritically accept a delusion but realize that other people disbelieve it or may expect the same uncritical acceptance of others.

Delusions also come in a variety of styles and colors. They can be circumscribed, involving one or several areas of thought and behavior, or massive, occupying nearly all of the patient's energy. A *delusional system* incorporates many life experiences that the patient interprets as a part of the central (usually persecutory) idea.

If your patient has *persecutory* delusions, he believes that he is being ridiculed, deliberately interfered with, discriminated against, spied on, or threatened. He usually believes that these indignities are undeserved, but if he also has delusions of *guilt* he may feel that they are retribution for his sins and that he deserves them. He may believe that his actions or thoughts are being controlled or influenced in an unusual way, such as by radio waves, television, or witchcraft: these are delusions of *passivity or influence*. He may claim to "know" that people are talking about, spying on, or slandering him: these are delusions of *reference*. This type of delusion may be confirmed when the patient "sees" others turn their heads and whisper as he walks by. Television, radio programs, or the newspapers may contain messages that are meant explicitly for him. If severely depressed, the patient may develop delusions of *ill health or bodily change*, believing, for example, that he has syphilis, he is becoming insane, his bowels have petrified, his brain is rotting, his genitals have shrunk, and so on. If he has delusions of *jealously*, he may believe that his partner has been unfaithful. Delusions of jealousy are typical of alcoholism, but are not confined to it. If your patient has delusions of *grandeur*, he believes that he is a person of some exalted station or has powers not accorded ordinary mortals.

Several other types of psychopathology should be distinguished from delusions. *Depersonalization* is the persistent feeling that the individual has changed, whereas *derealization* refers to the similar feeling that the environment has changed. Déjà vu (French for "already seen") is the feeling of having seen or

experienced a particular situation before, when that is probably not the case. Déjà vu is normal. *Overvalued ideas* are beliefs that are maintained in contradiction to their evident worth. Examples are the inherent superiority of one's sex, race, political party, or school of psychotherapy.

V. *Sensorium and Intellectual Resources*

Orientation. From the beginning of your interview, it should be obvious whether your patient—let's call him Mr. Johnson—knows his own name (is oriented to person). No one will fault you for not asking this question. But, although it is true that an experienced psychiatrist in everyday practice often does not ask a patient to respond to other questions on orientation, the Board exam is far from everyday. You had better find out whether your patient can tell the date (within a day or two) and place (the name of the town, the name of the building or what kind of institution you are in). At the outset of this phase of the MSE, you can lessen your discomfort at the pursuit of such obvious subjects by admitting, "Psychiatrists ask a lot of obvious questions. Now I'd like to ask you a few of these routine questions." When interpreting deficiencies, consider the possibility of impaired memory or motivation as alternative explanations.

Memory. Memory is usually divided into three parts. Most of it can be assessed without elaborate testing. You can best judge recent memory from your patient's ability to organize recent events into their proper sequence as the history of the present illness unfolds. It is traditional to test memory by asking questions such as, "What did you have for breakfast?" or "When were you married?" But because in the Board examination you cannot validate the accuracy of the response, you are probably better off not following the routine you use in your clinical practice. You might ask, "How long have you had to wait?"—which at least should be immediately verifiable. If the patient drove to the exam site, you could ask where the car is parked—which you could also verify quickly.

A test of *retention and recall* requires a little more effort, but it provides a verifiable test of memory. State a color, a person's name, and a street address. Ask for an immediate repetition to be sure the patient has heard and understood, but don't give a warning that you will ask for another repetition later (this would invite rehearsal). After 5 minutes, ask for a recitation of the items as you presented them. Be sure to take into consideration the patient's motivation when you interpret the results of this test. If you wish, lead into these questions by saying, "Have you had any problems with your memory? I'd like to ask a few questions to test it." Warning: if you use this test, be sure you remember to ask about the three items later.

Calculations. Have the patient subtract 7 from 100 and continue to subtract 7 from each successive answer. Most adults make fewer than four errors and finish within 60 seconds, but two or three successive (and successful) subtractions will probably suffice. If serial 7s are too hard, try serial 3s subtracted from 20. Can the patient do simple multiplication? As an alternative task, ask for simple, serial multiplications: $2 \times 3 = 6$, $2 \times 6 = 12$, . . . $2 \times 48 = 96$. The ability to complete this task without error correlates strongly with an IQ of 85 or better. Maxmen (1986) suggested that asking your patient to count backward by 1s from (say) 57, stopping at 42, is a less culture-bound test of attention and concentration, which is what you are really trying to evaluate by asking for calculations.

Ability with calculations must be correlated (in your presentation after the patient leaves the room) with age, culture, and education. Even when the patient is obviously bright and mathematically adept, for the sake of completeness you should probably ask for a few calculations.

General information. From your previous 25 minutes of conversation, you probably already have a good indication of what your patient knows, especially if politics, sports, and other items of current interest have come up in the course of history taking. If not, here is another portion of the MSE where you must demonstrate competence. Ask: "Who is President of the United States now? Who served just before?" Most adults can name the past five presidents in order, beginning with the current one. Other similar tests you will rarely need include the following: Name the governor of the state. Name five large cities or five rivers. In interpreting results, consider the patient's anxiety, depression, sensorium, education, motivation, and degree of political interest.

Abstractions. Inability to abstract general meaning from a proverb was once regarded as characteristic of schizophrenia. Research data have long since demonstrated that the facility for this sort of mental activity has far more to do with education, culture, and native intelligence than with sanity. How well your patient, Mr. Johnson, was able to formulate the problem that brought him into treatment should by this time have given you plenty of information about his ability to make abstractions. But if you have time to spare, you could ask: "What does it mean when I say, 'People who live in glass houses shouldn't throw stones?' " The answer "They might break windows" is a *concrete* sort of interpretation that indicates poor abstracting ability. (Note that "A rolling stone gathers no moss" commonly elicits one of two opposite, but equally valid, interpretations.)

Other, less culture-bound tasks of abstraction include the ability to tell similarities ("How are an apple and an orange alike?"—both are fruits, round, have seeds, etc.) and differences ("What's the difference between a child and a

dwarf?"—the child will grow). Many clinicians prefer similarities to proverbs as a test of abstracting ability.

With time to kill, a psychiatrist will sometimes try to learn whether a patient can identify verbal absurdities, as in the butcher story: "One day while dressing meat, a butcher accidentally cut his hand off. This made him so angry he picked up the cleaver and cut his other hand off." However, if you have this much time to spare, you may well have missed something vital in your patient's history. Don't fiddle; Rome is burning.

VI. Insight and Judgment

Insight means that Mr. Johnson realizes he is ill (if this is the case) and that he understands something about the nature of that illness. In the context of the MSE, insight does not refer to putative etiologic or psychodynamic aspects of illness. If you don't already have a good assessment of insight, ask the following sort of question: "What problems do you have?" or "Are you sick in any way?" or "What kind of sickness do people have here (in the clinic or hospital)?"

Judgment is sometimes tested by asking how the patient would respond to finding a stamped letter on the ground or discovering a fire in a crowded theater. The answer might give you some idea of the patient's ability to deal with correspondence or conflagrations, but this does not necessarily reflect an ability to cope in the real world. Judgment is better assessed by history from an informant, but the structure of the Board examination makes this impossible. However, you may be able to infer judgment from your patient's statements about any previous treatment. If not, ask: "What are your plans for the near future?" or "How does your future look to you?" or "Do you think you need treatment?"

Part II - B.6.

Second Edition

BOARDING TIME

A Psychiatry Candidate's Guide to Part II of the ABPN Examination

James Morrison, M.D., and
Rodrigo A. Muñoz, M.D.

Chapter 6

Taking the Psychiatric History

In format, the psychiatric Board examination interview is not much different from any other initial psychiatric interview. When you first meet any patient, you have two goals in mind. One is to establish a good working relationship. We discussed this in Chapter 5. Your other goal is to obtain the information you need to make a diagnosis, which then becomes the basis for your initial treatment plan. You have to accomplish these objectives quickly and under scrutiny, but that doesn't detract from the fact that you are about to show your competence in the clinical psychiatrist's stock-in-trade: the initial interview.

Keeping in mind that there is no single, approved method of obtaining a psychiatric history and that all histories are to some extent incomplete and inaccurate, we offer the following guide to the rapid psychiatric evaluation. If you normally do a far different type of initial interview, change your method long enough to pass this exam.

History of the Present Illness

Introductions

As soon as you are all seated together in the room and introductions have been made, thank the patient for helping with your examination and then start right in. (This is no time for irrelevant pleasantries. Remember that no one is going to quiz you later about baseball or the weather!)

From the type of facility where the examination is being held (a hospital, a clinic) you will probably know whether the patient is an outpatient or inpatient. So you can open by stating your interests explicitly. Ask:[1] "Why were you admitted here?" or "Why are you in psychiatric treatment?" A bit less directive, but still acceptable, is: "Tell me about your psychiatric problem." These opening questions state clearly where you would like to start, but at the same time leave the patient some room to maneuver. Note that this is not the time to offer your patient completely free rein. A very nondirective question such as "Where would you like to begin?" or "Tell me something about yourself" is an open-ended invitation to disaster.

Free Speech

Most authorities on interviewing advise that at first you allow the patient to talk freely about the reasons for seeking treatment. Even in an interview as time limited as this one, the practice of allowing the patient time for an opening statement is essential. For one thing, it should help the patient to relax and to confide in you. You will also get more of the flavor of personality from the patient who is allowed to talk freely than from one who is given only a rapid-fire burst of questions to answer. For another thing, free speech will give you a better understanding of your patient's main concerns. You might even be given the primary diagnosis within the first minute or two of the interview. (How much time you actually spend in each phase of the half-hour interview will depend on the patient and your own interviewing style. We discuss time elements more completely in Chapter 8, but we try to give a rough idea of the time needed for each phase of the interview in this chapter and in Chapter 7.) Free speech is also an opportunity, far in advance of the formal mental status examination, to assess the concordance of affect with the content of thought. Furthermore, during free speech you can demonstrate how well your interview style will set your patient at ease and foster rapport for the therapeutic sessions that would, in other circumstances, lie just ahead.

However, you shouldn't encourage a rambling discourse that goes nowhere. If Mrs. Riley starts to tell you about her trip last year to Sheboygan, don't wait for her to finish. You might end up knowing a great deal about her vacation and nothing at all about her depression. Instead, interrupt gently and give the open-

1 Throughout the next two chapters, we suggest specific questions to ask. Although we give them as direct quotations, we of course do not mean that the information must be obtained with exactly these questions. You should use an interview style that is comfortable to you and that gets the job done.

ended question another try: "You had mentioned feeling sad about that time. Could you tell me some more about that?" If this gentle prod doesn't focus the narrative sufficiently, you may have to be more direct: "Our time is short and I need to learn more about your depression. When did you start to feel bad?"

Really difficult or uncooperative patients are uncommon. Many Board examination patients are experienced interviewees, and most will be able to give a good account of themselves. The patients who volunteer for Board examinations are strongly motivated to help the candidates. They want to cooperate with you and will usually do so.

With nearly any patient you may at some point need to redirect the flow: "That was interesting about your mother, but tell me—were you depressed at other times?" Then, try to let the patient continue without interruption for another few sentences. You want an adequate sample of spontaneous speech to help you later in assessing the patient's mental status and to show your examiners that you can listen intelligently. During this phase of the interview, you should strive for an overview of the patient's problems that doesn't get lost in detail. Although some authorities on interviewing recommend that you devote up to one third of your available time to free speech, this is excessive for the brief interview necessitated by the Board exam. After 5 minutes or less (you have placed your watch where you can see it easily), you will have to move on.

Moving On to the Diagnosis

Don't ask your patient's permission to change subjects: that question is strictly pro forma, wastes time, and you don't really mean it. If the patient leaves you an opening to make a graceful transition, take it. If not, you may have to intervene more abruptly: "I think I understand some of the problems you are having. Now let me ask you about. . . ." If your patient doesn't take the hint, wait for the end of a sentence and try again: "Our time is a little short. Please tell me about. . . ." Remember that anyone can take a history from a compliant, well-organized patient. Your examiners will be very interested to learn how well you perform in more difficult interview situations.

In the free-speech phase of your interview, you will have noted clues that suggest areas to explore further. (If your patient has handed you a diagnosis on what appears to be a silver platter, examine it carefully: it may be plated!) You should spend the next 10 minutes or so developing the clues that will lead you to a diagnosis and differential diagnosis.

What sort of information will you need? Although this depends somewhat on the diagnoses you are considering, certain facts are always essential:

- Were there prior episodes of psychiatric disorder?
- When was that first episode?
- What were the possible precipitants?
- When did the patient first notice symptoms?
- When did the patient first seek treatment?
- Was there ever full recovery?

Some patients who are vague about the onset of illness may be better able to tell you when they last felt well. If you think there are two (or more) illnesses, which started first?

The history of treatment may be critically important in helping you arrive at a diagnosis quickly.

- Has the patient been hospitalized? The answer is likely to be "Yes" for Board patients.
- How many hospitalizations have there been?
- What was the overall duration?
- Does the patient know the diagnosis?
- What treatment was given?

Don't hesitate to ask questions about prior diagnoses and treatments. Anything the patient can tell you is fair game during your Board examination.

Although you will want to hear about your patient's medication history, you don't have time for a recitation of all 27 drugs that have been tried. Focus your questioning. First, if you don't already know, ask about current medicines. Try to learn the name, milligram strength, and number of doses per day of each. If your patient doesn't know the name, a description of the tablet and its side effects may help you identify it. Why was it prescribed? Don't forget to ask about electroconvulsive therapy and injectable medications.

Another potentially helpful question you can ask about drugs is, "What medicines have helped you most?" You might be surprised. The patient you thought had schizophrenia may respond, "Lithium—and I wish my doctor would prescribe it again!" Even a hospitalized patient who is currently being treated actively may tip you off to a treatment that has worked better in the past. Such information could prove valuable in the question-and-answer session later on.

As you talk with your patient, you will be roughing out the differential diagnosis in your mind. Use this time to ask questions about the symptom clusters that will allow you to rule in or out important diagnoses. Remember that the standard for diagnosis is DSM-IV, and frame your questions accordingly. If you think that your patient has bipolar mood disorder, you should be sure to identify

several criteria for a manic episode. The mention of depression should trigger questions about appetite and sleep disturbances, changes of weight, diurnal variation of mood, crying spells, loss of memory and concentration, death wishes, and suicidal ideas. For each major Axis I diagnosis you plan to discuss, quickly run through the criteria to make sure that you have asked all the relevant questions.

Suicidal Behavior

Be sure to inquire about suicidal ideation and behavior. Even if there has been no hint of death wishes or suicidal ideas during the present illness, you need to ask. You can work up to the topic gradually by asking:

- Have you been having any sad, gloomy thoughts?
- Have you ever wished you were dead?
- Have you ever thought about killing yourself?
- Have you made attempts on your life?

Be sure to get details about any positive answers.

- How many attempts have you made on your life?
- Were they medically serious?
- Were they psychologically serious?
- Did they result in hospitalization?

Your questions about suicide may draw nothing but blanks, but not to ask them risks an error of omission for which an otherwise adequate examination may have trouble compensating.

Substance Use

Like suicidal behavior, drug and alcohol abuse can be found in psychiatric patients with nearly every diagnosis. Substance abuse is so common and it can so complicate the diagnostic and therapeutic picture that it must be included in every diagnostic interview. If you haven't already gathered this information, do it now. Alcohol is the most socially acceptable drug, so you might ordinarily begin with it.

Make it easy on yourself. Don't start by asking if your patient is a heavy drinker. This only invites an evasion or a value judgment—and the patient may not share your values. Instead try, "How often do you drink alcohol?" Try to get

an answer in terms of days per week or per month. Next ask, "On the average day when you have at least one drink, how many drinks do you have?" And finally, "Have you ever had any problems as a result of drinking?" If necessary, specify the sorts of problems:

- Interpersonal (fights, loss of friends, guilt feelings)
- Loss of control (compulsive drinking, setting rules)
- Medical problems (vomiting, liver disorders such as jaundice, blackouts)
- Legal difficulties (including arrests and automobile accidents)
- Job problems (absence, tardiness, dismissal)
- Financial difficulties

For street drug use the drill is similar. You want to know which drugs, duration and frequency of use, and sequels. For all substances (including alcohol) you should learn whether the patient thinks there is a problem. Don't accept anyone's assertion that "I don't use drugs (alcohol) anymore." For some people, "anymore" really means "since Sunday." (Don't forget to inquire about abuse of medications prescribed by physicians, too.) If your patient has a serious problem with substance abuse, gathering this information will take some time. But you will have obtained data that have a significant bearing on the course of your patient's illness, to say nothing of your examination.

Review of Psychiatric Symptoms

Now take the time to screen for the major psychiatric symptoms and disorders that you haven't already evaluated. These include obsessions, compulsions, panic attacks, phobias, anorexia and bulimia, psychotic symptoms of hallucinations and delusions, manias, and, especially important, depression. You could save all these questions until the mental status examination, but that usually comes at the end of the interview, when time is running out. You'd be seriously embarrassed if you couldn't explore positive responses in any of these areas.

Background Information

You are now halfway through your examination, but you have obtained the basis for your diagnosis and differential diagnosis, so you have done three-fourths of your work. Now you could almost coast through the second 15 minutes with your patient, picking up details here and there and covering the balance of the material necessary for any complete medical evaluation. Actually, it will be a

fairly rapid "coast," because you still must cover past medical history, a review of systems, family history, personal and social history, and the mental status evaluation.

Some of these sections will be more important for certain patients than for others. You will especially want to obtain data that might corroborate major diagnoses in your working differential: family history of depression for primary mood disorder, for example, or early truancy for a patient in whom you suspect antisocial personality disorder. You also want your examiners to understand that you realize the importance of each of these sections. Therefore, you should pace your examination so that you can at least touch on each section. However, an experienced interviewer should be able to obtain the full history as outlined here from a relatively uncomplicated patient who is a good historian.

Past Medical History

With many patients, you should be able to get through this section in a minute or two. Whereas in a complete psychiatric evaluation you might want to know the age at which your patient had measles, the rapid psychiatric evaluation simply doesn't allow time for this sort of question. Ask instead about other medications the patient may be taking. You will be especially interested in agents that could cause depression or psychosis. These include birth control pills, other hormones (such as thyroid or steroids), and antihypertensive drugs. Were diuretics prescribed for someone taking lithium? Is the patient getting psychotropic drugs from nonpsychiatric physicians?

If they haven't been mentioned previously, be sure to inquire about the emotional impact of obvious physical problems such as obesity, stuttering, a missing limb, an eye patch, or a severe limp suggesting a congenital hip dislocation. The Board examination is no time for misplaced sensitivity. Physical problems are serious enough that, if they aren't causing problems now, they probably did so at some time in the past. They will whet your examiners' curiosity, and they should whet yours, too.

Ask about medication allergies. You can acknowledge the more common ones (sulfa drugs, penicillin) with a nod of your head, but obtain a brief description of any reaction a patient has had to a psychotropic agent. Be especially careful to identify extrapyramidal side effects (akathisia, pseudoparkinsonism, acute dystonia) in patients who have been taking neuroleptics. Has there been any history suggesting tardive dyskinesia?

What about premenstrual symptoms? (They are far too often forgotten, especially by male physicians.) Have there been blackouts or other episodes that suggest a seizure disorder? What about head trauma, falls, or fainting? Does the

patient receive disability benefits from Social Security, the Department of Veterans Affairs, or private insurance? A brief listing of hospitalizations for major medical illnesses and surgeries rounds out the picture of your patient's general health.

Review of Systems

No examiner can reasonably expect you to do a complete review of systems as outlined in most textbooks of medicine, but the psychiatric review of systems is our only means of reliably diagnosing somatization disorder (Briquet's syndrome), which affects about 7% of female psychiatric patients (but far less than 1% of male patients). It would be unwise to ask about *all* the DSM-IV symptoms, and simply asking whether or not a woman has enjoyed good health during her adult life has never been shown to predict the diagnosis of somatization disorder. But Othmer and DeSouza (1985) described an abbreviated screening test for somatization disorder that is quick to administer. A positive response to two or more in the following list of seven symptoms suggests a need for the complete review of systems.

The seven symptoms are

- Shortness of breath when not exerting
- Dysmenorrhea
- Burning pain in sex organs or rectum (other than with intercourse)
- Lump in throat
- Amnesia
- Vomiting
- Pain in extremities

If you don't have time to cover the complete review of systems, this checklist will at least give you some screening data in a minute or two. You can use the results later to argue the need for a full review of systems.

Family History

Although in your clinical work you might obtain a brief biographical sketch of each relative, you won't have time in the Board examination. Because a hereditary component can be identified in many psychiatric disorders, it is important to inquire about family history of psychiatric disorders. Hitting pay dirt requires careful prospecting. Ask: "Has any blood relative ever had nervousness, nervous breakdown, depression, mania, psychosis or schizophrenia, problems resulting from excessive drinking or drug abuse, suicide attempts, hypochondriasis, delinquency, legal difficulties, or hospitalization for nervousness?" (Be sure to ask slowly enough to allow your patient time to think.) Explain that by "any blood relative" you mean to include mother, father, brothers or sisters, uncles or aunts, cousins, nieces or nephews, grandparents, and children.

Remember that you cannot accept as fact an unsupported diagnosis. Your patient may not have heard the doctor correctly, or may have interpreted grandma's "spells" to mean epilepsy. Then again, one doctor's schizophrenia is another's bipolar mood disorder. Although you may not have time to mine every lode, do a little digging into the illnesses of first-degree relatives. Ask about age at onset, specific symptoms, treatment received, duration of illness, and whether the relative recovered completely or remained chronically ill. Of course, if your patient was adopted and knows nothing about any biological relatives, you should move quickly on to more fruitful inquiries.

Personal and Social History

By now you are well past the free-speech portion of your interview, and your patient should be cooperating with your increasingly structured interview style. In the typical brief interview, you will have only about 5 minutes for the personal and social history. You will be especially interested in items that have a bearing on your patient's psychiatric disorder. You will want to know how symptoms have affected the patient's life. You are also looking for events that might act as stressors—the entrances and exits of relatives and friends, for example. What changes occurred before the onset of the illness or before the current episode? Finally, your examiners will also expect you to be interested in background information that does not necessarily advance your understanding of the disease process, but only helps you get to know the patient better. Because of time constraints and the volume of information that could be developed from the personal and social history, you will have to choose carefully which questions to ask.

Childhood history. If time were no constraint, you might want to find out about your patient's formative years from open-ended questions such as, "What was it like growing up in Newark during the War?" Unfortunately, you don't have time to indulge in that luxury. Because the answers will little enhance your prospects either for diagnosis or for rapport with the patient, you should avoid certain questions that you might ask in a more extended interview This is especially true of many events from early childhood, some of which tend to be neither relevant nor reliably reported. So put aside any questions you usually ask about the patient's gestation, delivery, birth weight, breast-feeding, toilet training, and

other developmental milestones. Concentrate on material you can expect to benefit from. For the sake of this discussion, let us assume you are interviewing a man.

You want to know how many siblings he had and what his position was in that sibship. What was his father's occupation? Did his mother work outside the home? Was he reared by both parents? Were there any divorces or deaths in the family? How far did he go in school, and how well did he do academically? Did he have disciplinary problems in school? Did he attend religious services as a child? Did this change when he grew up? Was he sickly as a child, and did he receive any rewards (secondary gain) for illness behavior?

Job history. What is your patient's occupation, and how long has he held his current job? If his current employment has been brief, how many jobs has he held in the last 5 years? If he is unemployed, why? What has been the effect of illness on his job performance? If he does not support himself by working, what is his source of income?

Military history. (Although we are still talking about a theoretical male patient, remember that military history can apply to women as well. The Board examination is no time to appear sexist.) How long did the patient serve in the military? In what branch (Air Force, Army, Coast Guard, Marines, Navy)? What was the highest rank he attained? Were there disciplinary problems (captain's mast, court martial, company grade punishment, Article 15)? What kind of discharge did he receive?

Legal history. When you covered alcohol-related offenses such as driving while intoxicated or arrests for public drunkenness, you may have asked about general legal difficulties. If not, do so now. Has the patient ever been arrested? How many times? On what charges? Has he been jailed? Did he ever serve time in the penitentiary? How long was he there?

Marital and sexual history. You probably learned much earlier whether or not your patient is currently married. But is this his first marriage? If he is divorced, find out why. How old was he when first married? How long has the current marriage lasted? Are there children or stepchildren? Has psychiatric illness impaired the patient's marital relationship or ability to care for his family?

Your discussion of marriage(s) provides a natural lead-in to questions about sexual satisfaction and practices. Does the couple use birth control? Have there been severe problems with intercourse, perhaps requiring abstinence? Does the patient experience satisfactory climax with intercourse? Has there been impotence? Have there been sex partners outside the current relationship? Try

to get the patient to describe sexual dysfunctions and practices in behavioral terms: "First I . . . then she does . . . then this happens. . . ."

Even unmarried patients and adolescents should be asked about their sexual activities. Be particularly alert for evidence of multiple sexual partners, homosexuality, and other behaviors that predict exposure to the AIDS virus. Have high-risk patients been tested for HIV? Do they always use condoms?

Now would be a good time to inquire about childhood sexual molestation. Although this is a factor in the histories of 20% or more of psychiatric patients, few psychiatrists routinely obtain this information. Try to get details. What acts occurred and at what ages? Was there physical contact? Who perpetrated the acts? Was incest involved? Did the parents find out? How did they respond? How was the patient affected?

Religion. At some point, you should ask about religion. With which (if any) religion does your patient identify? Is it the same as it was during childhood? How devout is your patient? In addition to the literal responses, you may hear some ideas on the meaning of life or what organizes the universe, developed at the patient's own cognitive level.

Social relationships. All patients, including those most isolated in the back wards of a chronic facility, are social beings. The information they report to their physicians is influenced by past and current relationships. As you go through the historical items we have discussed in this chapter, you should also be forming a picture of your patient's social interactions and milieus at different times of life.

This picture will usually start with the household where the patient grew up. Your understanding of the patient's personality development may be enhanced by information about childhood relationships with parents, siblings, other relatives in the household, neighbors, and friends. You will be better able to discuss Axis II disorders, prognosis, and the indications for psychotherapy if you have learned something about your patient's relationships (and conflicts) in the current household, network of social support, and opportunities for communication. A therapeutic formulation should take into account those persons who are likely to help or interfere with treatment. You will want to know who among them will need better information or a different point of view to promote the patient's well-being.

You will be interested in knowing something about your patient's personality and leisure activities. Time permitting, you might ask: "What sort of a person do you think are you? Have you been outgoing or a loner? What do you like about yourself? What do your friends like about you? What do you do for fun?"

Finally, although you probably learned it long ago, do you know how old your patient is now? Better to ask late than never!