PSYCHIATRY STUDENT KIT

Dr Peled

Welcome to the psychiatric clerkship

This is an introductory kit containing the basic schema for a psychiatric evaluation and the elementary concepts of psychiatric disturbances. It will help you in your encounter with the psychiatric patients, it will help you in your study of psychiatry, it will help you to pass the exams, and it will be most helpful if you read it in the weekend before the clerkship

Good luck

Dr Peled

<u>סיכום / דווח- בדיקה פסיכיאטרית</u> תאריך
בדיקה:_____

פרטים אישיים:
מס"-זהות:
שם:
גיל:
מצב משפחתי:

השכלה:
מוצא:
עיסוק/ מקצוע:
כתבת:
טלפון:
הערות:

<u>הפניה: [המפנה, וסיבת/ נסיבות הפניה]</u>

<u>תלונה עיקרית/ קו-שבר/ טריגר:</u>

<u>מחלה נוכחית: [סימנים וסימפטומים]</u>

<u>תולדות פסיכיאטרים: [טיפולים ואשפוזים]</u>
לפני – הטיפול תאריך – אחרי

<u>התפתחות ואישיות:</u>

<u>תולדות גופניים: [מחלות/ חבלות/ סמים ואלכהול]</u>

<u>תולדות משפחה: [גנטיקה/אובדנות/ סמים ואלכהול]</u>
-

<u>סטטוס מנטלי:</u> (סכם בתמצות)

הופעה:
התנהגות:
דיבור:
יחס לבודק:

חשיבה: ארגון החשיבה: תוכן החשיבה:
תפיסה:
אפקט: איכות: תגובה: התאמה:

התמצאות: [זמן /מקום /אנשים]
ריכוז:
זיכרון: [מיידי/קצר/ בינוני/ארוך]

שיפוט:
תובנה:

-

<u>אבחנה+ אבחנה מבדלת:</u>

<u>סיכון:</u>

<u>המלצות: [אשפוז (חוק) טיפולים ביולוגיים פסיכולוגיים ואחרים]</u>

MENTAL STATUS

הופעה:	**התנהגות:**	**דבור:**	**יחס לבודק:**
היגיינה (ציפורניים) מטופח מסודר מרושל מוזנח הבעת פנים איפור תסרוקת גילוח לבוש	<u>היפואקטיביות (רגוע)</u> <u>היפראקטיביות (אי שקט)</u> <u>תנועות מיוחדות</u>	<u>דבור-יתר:</u> <u>מיעוט דיבור</u>: <u>ארגון הדיבור</u> (*קופץ מנושא לנושא לא עונה לעניין*)	משתף פעולה (קשר-עין) לא משתף פעולה (לא מצליח או מתנגדות) חשדן עוין דורשני מאיים מתלונן מתפרץ תיאטרלי דביק חסר-גבולות סדאקטיבי מניפולטיבי מנותק אדיש אפאתי .....

חשיבה:	**תפיסה:**	**אפקט:**
<u>ארגון החשיבה:</u> עקיפנות חשיבה מקבילית רפיון אסוציאטיבי: קל בינוני קשה בלוקינג פרסבראציה קלנג אסוציאציה <u>תוכן חשיבה:</u> מחשבות שווא: ביזאריות, שידור קליטת מחשבות, יחס, פראנוידיות (רדיפה ציתות קנאה) גדלות (כוח השפעה) ארוטומניה, סומאטיות, ניהיליסטיות, סיסטמיות, overvalued Mood congruent דלות צמצום בחשיבה יכולת אבסטראקציה וקטגוריות	הלוצינציות: ראיה, שמיעה, ריח, תחושתיות מורכבות, פשוטות קבועות, זמניות, קשורות לסמנים אחרים. פעילות, לא פעילות (פועל אלפיהם). היפנוגוגיות היפנופומפיות	<u>איכות</u> אאוטימי דיספורי מרומם אופורי אקסטאסיה עצוב מדוכא אפאתי אנהדוני מפוחד חרד בפאניקה מתוח עצבני סף-התפרצות מנותק מסוגר דל מצומצם שטוח <u>התאמה</u> התאמה לתוכן דיבור התאמה לסיטואציה בבדיקה התאמה להרגשה סובייקטיבית <u>תגובה</u> משך ועוצמה לאביליות

מודע: ערפול סטופור דלירים קומה

התמצאות:	**ריכוז:**	**זיכרון:**
זמן מקום אנשים		מיידי-קצר-בינוני-ארוך אכסון-שליפה אנטרוגרדי-רטרוגראדי כללי-ממוקד-מתמשך-"חורים"-(קונפבולציות)

שיפוט:	**תובנה:**
בוחן מציעות כללי לקוי 1. עיוות המציאות (דלוזיות הלוצינציות דיבור או התנהגות לא-מתאימה) 2. ניתוק מהמציאות (אוטיסים דיסוציאציה סטופור התקף-אפילפסיה-כללית)	למחלה

שאלון SCID
שאלות לראיון <u>לא-מובנה</u>

הקדמה:
אני עומד לשאול אותך על בעיות או קשיים שאולי היו לך וארשום לעצמי הערות. האם יש לך שאלות בטרם נתחיל.
פרטים דמוגראפים: שם: _____ שם משפחה: _____
מ"ס תעודת זהות:_____ מין:___ תאריך לידה:_____ גיל:___
מצב משפחתי: _____ילדים:_____ חינוך
והשכלה:_____
תעסוקה:_____
(היסטוריה תעסוקתית:
כמה זמן אתה עובד שם ?
אם פחות מחצי שנה- במה עבדת ליפני ?
אם לא עובד- איך אתה מתפרנס?
האם אי פעם הייתה לך תקופה שלא יכלת לעבוד [או ללמוד], אם כן, למה?)

סקירה של מחלה נוכחית:

מתי פנית לטיפול?
מה גרם לך לפנות לעזרה לטיפול?

מה הדבר העיקרי שהביא אותך לחפש עזרה?

אם לא נותן פרטים- עודד למסור מידע- ספר יותר על כך... למה אתה מתכוון?
מתי זה התחיל (תלונות סימפטומים)?

כמה זמן זה נמשך? מתי לאחרונה הרגשת OK היית עצמך?

האם זה (תלונות סימפטומים) משהוא חדש או חזרה של דבר מקודם?

מה קרה בחיי יום-יום באותה תקופה שזה (תלונות סימפטומים) התחיל?
האם חל שינוי בחייך או אירוע כל שהוא ליפני שזה (תלונות סימפטומים) התחיל?

לאחר שזה התחיל, מה קרה בהמשך? (האם דברים נוספים הפריעו לך?)

מאז שזה התחיל מתי הרגשת הכי גרוע?
אם יותר משנה- בשנה האחרונה מתי הרגשת הכי גרוע?

מתי לראשונה נבדקת בגלל בעיה נפשית? מה הייתה הבעיה? איזה טיפול קבלת (תרופתי או אחר)?

האם אושפזת אי פעם במוסד לבריאות הנפש? אם כן מאיזה סיבה?
במקרה של תשובה מעורפלת- לאמת בעדינות- .....אנשים אינם מתאשפזים בד"כ בבריאות הנפש רק כיוון שהיו עייפים או עצבנים...

האם אושפזת אי פעם עקב בעיה גופנית?
אם כן- מדוע?

האם סבלת מבעיות נוספות פרט לאלו שספרת לי בחודש האחרון?

מה מצב הרוח שלך לאחרונה?

האם אתה נוטל תרופות נוספות פרט לאלו שכבר דווחת לי?

האם אתה שותה אלכהול או משתמש בסמים?
אם כן- איזה? ובאיזה דחיפות?

איך אתה מבלה את זמנך הפנוי?
עם מי אתה מבלה את זמנך הפנוי?
[נסה להבין את רמת התפקוד החברתי בין-אישי]

SCREENING MODUL	סמן ב ✔
האם אי פעם שתית יותר מחמישה בקבוקים, או פחיות, (אלכהול) בפעם אחת?	כן_לא
האם אי פעם השתמשת בסמים?	כן_לא
האם אי פעם התמכרת לתרופה או נזקקת לתרופה הרבה יותר מאשר אישר לך הרופא?	כן_לא
האם סבלת אי פעם מהתקף פאניקה, שבו הרגשתה פתאום פחד וחרדה, ופיתחת הרבה סימפטומים גופניים?	כן_לא
האם אי פעם פחדת לצאת מהבית לבדך, להיות בקהל ביו אנשים, או לנסוע באוטובוסים או רכבות?	כן_לא
האם פחדת, או הרגשת לא בנוח, לאכול, לדבר או לכתוב בנוכחות אנשים נוספים?	כן_לא
האם יש דברים נוספים העלולים להפחיד אותך במיוחד כגון: לטוס, מראה דם, גבהים, מקומות סגורים, בעלי חיים או חרקים?	כן_לא
האם אי פעם הוטרדת ממחשבות לא הגיוניות, שחזרו ונישנו למרות שניסית לגרשם?	כן_לא
האם קרה שנזקקת לחזור שוב ושוב על פעולה כל שהיא ולא הצלחת להתנגד לה, כגון: רחיצת ידיים, ספירה, בדיקות שפעלת נכון וכו..?	כן_לא
האם קרה שחשת תחושות מוזרות, או הרגשת שהסביבה משתנה, לדוגמה שמעתה שפונים אליך גם כאשר היית לבדך, הרגשתה מסרים מהסביבה או חשת שרוצים לפגוע בך, ראית דברים שאחרים לא יכלו לראות, חשת שיש לך כוחות או יכולות מיוחדים שאין לאחרים?	כן_לא
האם אי פעם סבלת משינויים קיצוניים או תנודות חזקות במצב הרוח?	
האם אי פעם סבלת מתנודות במשקל, אנשים האירו לך שהשמנת או רזית מאד?	כן_לא
האם אי פעם חשת שהרגלי האכילה שלך יצאו משליטה?	כן_לא
האם אי פעם סבלת משינויים קיצוניים בהרגלי השינה שלך?	כן_לא
	כן_לא
	כן_לא
	כן_לא
	כן_לא

Table 2 major psychiatric signs and symptoms

Name	Clinical manifestation
Abulia	A lack of will or motivation, which is often expressed as inability to make decisions or set goals. Often, the reduction in impulse to action and thought is coupled with an indifference or lack of concern about the consequences of action.
Acting out	This is the process of expressing unconscious emotional conflicts or feelings via actions rather than words. The person is not consciously aware of the meaning or etiology of such acts. Acting out may be harmful or, in controlled situations, therapeutic (e.g., children's play therapy).
Agoraphobia	Anxiety about being in places or situations in which escape might be difficult or embarrassing or in which help may not be available should a panic attack occur. The fears typically relate to venturing into the open, of leaving the familiar setting of one's home, or of being in a crowd, standing in line, or traveling in a car or train.
Alogia	An impoverishment in thinking that is inferred from observing speech and language behavior. There may be brief and concrete replies to questions and restriction in the amount of spontaneous speech (poverty of speech). Sometimes the speech is adequate in amount but conveys little information because it is overconcrete, overabstract, repetitive, or stereotyped (poverty of content).
Ambivalence	The coexistence of contradictory emotions, attitudes, ideas, or desires with respect to a particular person, object, or situation. Ordinarily, the ambivalence is not fully conscious and suggests psychopathology only when present in an extreme form.
Anhedonia	Inability to experience pleasure from activities that usually produces pleasurable feelings. Contrast with hedonism.
Anxiety	The apprehensive anticipation of future danger or misfortune accompanied by a feeling of dysphoria or somatic symptoms of tension. Diarrhea, dizziness light-headedness, palpitation hypertension, tachycardia restlessness tremor and tingling of extremities urinary frequency, and upset stomach (butterflies), are possible accompanying symptoms. Contrary to “fear” anxiety is reflective more of a threat that is not apparent or imminent in the real world.
Apathy	Lack of feeling, emotion, interest, or concern.
Auditory hallucination	A hallucination involving the perception of sound, most commonly of voices.
Automatism	Automatic and apparently undirected nonpurposeful behavior that is not consciously controlled. Seen in psychomotor epilepsy.
Avolition	An inability to initiate and persist in goal-directed activities. When severe enough to be considered pathological, avolition is pervasive and prevents the person from completing many different types of activities (e.g., work, intellectual pursuits, self-care).
Bizarre delusion	A delusion that involves a phenomenon that the person's culture would regard as totally implausible.
Blocking	A sudden obstruction or interruption in spontaneous flow of thinking or speaking, perceived as an absence or deprivation of thought.
Blunted affect	An affect type that represents significant reduction in the intensity of emotional expression
Circumstantiality	Pattern of speech that is indirect and delayed in reaching its goal because of excessive or irrelevant detail or parenthetical remarks.
Clanging	A type of thinking in which the sound of a word, rather than it’s meaning, gives the direction to subsequent associations.
Compulsion	Repetitive ritualistic behavior such as hand washing or ordering or a mental act such as praying or repeating words silently that aims to prevent or reduce distress or prevent some dreaded event or situation. The person feels driven to perform such actions in response to an obsession or according to rules that must be applied rigidly, even though the behaviors are recognized to be excessive or

	unreasonable.
Concrete thinking	Thinking characterized by immediate experience, rather than abstractions. It may occur as a primary, developmental defect, or it may develop secondary to organic brain disease or schizophrenia.
Constricted affect	Affect type that represents mild reduction in the range and intensity of emotional expression.
Delusion	A false belief based on incorrect inference about external reality that is firmly sustained despite what almost everyone else believes and despite what constitutes incontrovertible and obvious proof or evidence to the contrary. The belief is not one ordinarily accepted by other members of the person's culture or subculture (e.g., it is not an article of religious faith. Delusions are subdivided according to their content. Some of the more common types are: bizarre; delusional jealousy; grandiose; delusion of reference; persecutory; somatic; thought broadcasting; thought insertion.
Delusion of reference	A delusion whose theme is that event, objects, or other persons in one's immediate environment have a particular and unusual significance. These delusions are usually of a negative or pejorative nature, but also may be grandiose in content.
Depressed Mood	Depression is accompanied by sets of signs and symptoms as follows: diminished interest, weight loss sleep disturbances psychomotor retardation or agitation, fatigue loss of energy, feeling of guilt and worthlessness thoughts of despair and suicide reduced concentration and cognition.
Depersonalization	An alteration in the perception or experience of the self so that one feels detached from, and as if one is an outside observer of, one's mental processes or body (e.g., feeling like one is in a dream).
Derailment	("Loosening of associations") A pattern of speech in which a person's ideas slip off one track onto another that is completely unrelated or only obliquely related. In moving from one sentence or clause to another, the person shifts the topic idiosyncratically from one frame of reference to another and things may be said in juxtaposition that lack a meaningful relationship.
Derealization	An alteration in the perception or experience of the external world so that it seems strange or unreal (e.g., people may seem unfamiliar or mechanical).
Dereistic	Mental activity that is not in accordance with reality, logic, or experience.
Dysphoric mood	An unpleasant mood, such as sadness, anxiety, or irritability.
Dissociation	A disruption in the usually integrated functions of consciousness, memory, identity, or perception of the environment. The disturbance may be sudden or gradual, transient or chronic.
Distractibility	The inability to maintain attention, that is, the shifting from one area or topic to another with minimal provocation, or attention being drawn too frequently to unimportant or irrelevant external stimuli.
Expansive mood	Lack of restraint in expressing one's feelings, frequently with an overvaluation of one's significance or importance. irritable Easily annoyed and provoked to anger.
Flat affect	An affect type that indicates the absence of signs of affective expression.
Flight of ideas	A nearly continuous flow of accelerated speech with abrupt changes from topic to topic that are usually based on understandable associations, distracting stimuli, or plays on words. When severe, speech may be disorganized and incoherent.
Formal thought disorder	An inexact term referring to a disturbance in the form of thinking rather than to abnormality of content. See blocking; loosening of associations; poverty of speech.
Fragmentation	Separation into different parts, or preventing their integration, or detaching one or more parts from the rest. Feelings of falling apart, as a loss of identity, or as a fear of impending loss of one's vitality and of psychological depletion.
Grandiosity	An inflated appraisal of one's worth, power, knowledge, importance, or identity. When extreme, grandiosity may be of delusional proportions.
Grandiose delusion	A delusion of inflated worth, power, knowledge, identity, or special relationship to a deity or famous person.
Gustatory	A hallucination involving the perception of taste (usually unpleasant).

hallucination	
Hallucination	A sensory perception that has the compelling sense of reality of a true perception but that occurs without external stimulation of the relevant sensory organ (i.e., perception without stimulus).
Hypersomnia	Excessive sleepiness, as evidenced by prolonged nocturnal sleep, difficulty maintaining an alert awake state during the day, or undesired daytime sleep episodes.
Idealization	A mental mechanism in which the person attributes exaggeratedly positive qualities to the self or others.
Ideas of reference	Incorrect interpretations of casual incidents and external events as having direct reference to oneself. May reach sufficient intensity to constitute delusions.
Illusion	A misperception or misinterpretation of a real external stimulus, such as hearing the rustling of leaves as the sound of voices. See also hallucination.
Inappropriate affect	An affect type that represents an unusual affective expression that does not match with the content of what is being said or thought.
Incoherence	Speech or thinking that is essentially incomprehensible to others because words or phrases are joined together without a logical or meaningful connection. This disturbance occurs within clauses, in contrast to derailment, in which the disturbance is between clauses.
Intellectualization	A mental mechanism in which the person engages in excessive abstract thinking to avoid confrontation with conflicts or disturbing feelings.
Introversion	Preoccupation with oneself and accompanying reduction of interest in the outside world. Contrast to extraversion.
Labile affect	An affect type that indicates abnormal sudden rapid shifts in affect.
Loosening of associations	A disturbance of thinking shown by speech in which ideas shift from one subject to another that is unrelated or minimally related to the first. Statements that lack a meaningful relationship may be juxtaposed, or speech may shift suddenly from one frame of reference to another. The speaker gives no indication of being aware of the disconnectedness, contradictions, or illogicality of speech.
Magical thinking	The erroneous belief that one's thoughts, words, or actions will cause or prevent a specific outcome in some way that defies commonly understood laws of cause and effect. Magical thinking may be a part of normal child development.
Mood-incongruent psychotic features	Delusions or hallucinations whose content is not consistent with the typical themes of a depressed or manic mood.
Negative symptoms	Most commonly refers to a group of symptoms characteristic of schizophrenia that include loss of fluency and spontaneity of verbal expression, impaired ability to focus or sustain attention on a particular task, difficulty in initiating or following through on tasks, impaired ability to experience pleasure to form emotional attachment to others, and blunted affect.
Negativism	Opposition or resistance, either covert or overt, to outside suggestions or advice. May be seen in schizophrenia.
Neologism	In psychiatry, a new word or condensed combination of several words coined by a person to express a highly complex idea not readily understood by others; seen in schizophrenia and organic mental disorders.
Nihilistic delusion	The delusion of nonexistence of the self or part of the self, or of some object in external reality.
Obsession	Recurrent and persistent thought, impulse, or image experienced as intrusive and distressing. Recognized as being excessive and unreasonable even though it is the product of one's mind.
Olfactory hallucination	A hallucination involving the perception of odor, such as of burning rubber or decaying fish.
Overvalued idea	An unreasonable and sustained belief that is maintained with less than delusional intensity (i.e., the person is able to acknowledge the possibility that the belief may not be true).
Panic attacks	Discrete periods of sudden onset of intense apprehension, fearfulness, or terror, often associated with feelings of impending doom. During these attacks there are symptoms such as shortness of breath or smothering sensations; palpitations, pounding heart, or accelerated heart rate; chest pain or discomfort; choking; and fear of going crazy or losing control. Panic attacks may be "out of the blue" or

	situationally bound (see phobia).
Persecutory delusion	A delusion, in which the central theme is that one (or someone to whom one is close) is being attacked, harassed, cheated, persecuted, or conspired against.
Perseveration	Tendency to emit the same verbal or motor response again and again to varied stimuli.
Phobia	A persistent, irrational fear of a specific object, activity, or situation (the phobic stimulus) that results in a compelling desire to avoid it. This often leads either to avoidance of the phobic stimulus or to enduring it with dread.
Pressured speech	Speech that is increased in amount, accelerated, and difficult or impossible to interrupt. Usually it is also loud and emphatic.
Pseudodementia	A syndrome in which dementia is mimicked or caricatured by a functional psychiatric illness. Symptoms and response of mental status examination questions are similar to those found in verified cases of dementia. In pseudodementia, the chief diagnosis to be considered in the differential is depression in an older person vs. cognitive deterioration on the basis of organic brain disease.
Psychomotor retardation	Visible generalized slowing of movements and speech.
Regression	Partial or symbolic return to earlier patterns of reacting or thinking. Manifested in a wide variety of circumstances such as normal sleep, play, physical illness, and in many mental disorders.
Systemized delusion	A non bizarre delusion that is stable and engulfs the real experience, every new event in daily experience is interpreted according to the content of the delusion thus biased false and the delusion grows over time.
Splitting	A mental mechanism in which the self or others are reviewed as all good or all bad, with failure to integrate the positive and negative qualities of self and others into cohesive images. Often the person alternately idealizes and devalues the same person.
Stereotyped movements	Repetitive, seemingly driven, and nonfunctional motor behavior (e.g., hand shaking or waving, body rocking, head banging, mouthing of objects, self-biting, picking at skin or body orifices, hitting one's own body).
Tactile hallucination	A hallucination involving the perception of being touched or of something being under one's skin. The most common tactile hallucinations are the sensation of electric shocks and formication (the sensation of something creeping or crawling on or under the skin).
Tangentiality	Replying to a question in an oblique or irrelevant way. Compare with circumstantiality.
Thought broadcasting	The delusion that one's thoughts are being broadcast out loud so that they can be perceived by others.
Thought insertion	The delusion that certain of one's thoughts are not one's own, but rather are inserted into one's mind.
Verbigeration	Stereotyped and seemingly meaningless repetition of words or sentences.
Visual hallucination	A hallucination involving sight, which may consist of formed images, such as of people, or of unformed images, such as flashes of light.
Word salad	A mixture of words and phrases that lack comprehensive meaning or logical coherence; commonly seen in schizophrenic states.

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Background: The history and Mental Status Examination (MSE) are the most important diagnostic tools a psychiatrist has to obtain information to make an accurate diagnosis. Although these important tools have been standardized in their own right, they remain primarily subjective measures that begin the moment the patient enters the office. The clinician must pay close attention to the patient's presentation, including personal appearance, social interaction with office staff and others in the waiting area, and whether the patient is accompanied by someone (ie, to help determine if the patient has social support). These first few observations can provide important information about the patient that may not otherwise be revealed through interviewing or one-on-one conversation.

When patients enter the office, pay close attention to their personal grooming. One should always note things as obvious as hygiene, but, on a deeper level, also note things such as whether the patient is dressed appropriately according to the season. For example, note whether the patient has come to the clinic in the summer, with 3 layers of clothing and a jacket. These types of observations are important and may offer insight into the patient's illness. Other behaviors to note may include patients talking to themselves in the waiting area or perhaps pacing outside the office door. Record all observations.

The next step for the interviewer is to establish adequate rapport with the patient by introducing himself or herself. Speak directly to the patient during this introduction, and pay attention to whether the patient is maintaining eye contact. Mental notes such as these may aid in guiding the interview later. If patients appear uneasy as they enter the office, attempt to ease the situation by offering small talk or even a cup of water. Many people feel more at ease if they can have something in their hands. This reflects an image of genuine concern to patients and may make the interview process much more relaxing for them.

Legally, a mental status if conducted against the patient's will is considered assault with battery. Therefore, it is important to secure the patient's permission or to document that a mental status is being done without the patient's approval if in an emergency situation.

The time it takes to complete the initial interview may vary; however, with experience, interviewers develop their own comfortable pace and should not feel rushed to complete the interview in any time that is less than comfortable for either the interviewer or the patient. All patients require their own time

during this initial interview and should never be made to feel they are being timed.

Beginning with open-ended questions is desirable in order to put the patient further at ease and to observe the patient's stream of thought (content) and thought process. Begin with questions such as "What brings you here today?" or "Tell me about yourself." These types of questions elicit responses that provide the basis of the interview. Keep in mind throughout the interview to look for nonverbal cues from patients. As they speak, for example, note if they are avoiding eye contact, acting nervous, playing with their hair, or tapping their foot repeatedly. In addition to the patient's responses to questions, all of these observations should be noted during the interview process.

As the interview progresses, more specific or close-ended questions can be asked in order to obtain specific information needed to complete the interview. For example, if the patient is reporting feelings of depression, but only states "I'm just depressed," determining both the duration and frequency of these depressive episodes is important. Ask leading questions such as "How long have you had these feelings?" or "When did these feelings begin?" and "How often do you feel this way?" or "How many days in the past week have you felt this way?" These types of questions help patients understand what information is needed from them. For safety reasons, both the patient and the interviewer should have access to the door in case of an emergency during the interview process.

At some point during the initial interview, a detailed patient history should be taken. Every component of the patient history is crucial to the treatment and care of the patient it identifies. The patient history should begin with identifying patient data and the patient's chief complaint or reason for coming to the clinic. The patient's chief complaint should be a quote recorded just as it was spoken, in quotation marks, in the patient's record. This also is where all history of illness is recorded, including psychiatric history, medical history, surgical history, and medications and allergies. Of interest, it is important to make direct inquiry to items such a family history of members being murdered—patients often do not volunteer this information.

Additionally, listing any family history of illness is important. This information can be very useful later, when determining treatment options. If a family member has a history of the same illness and had a successful drug regimen, that regimen may prove to be a viable option for the current patient. If possible, record the medications and dosages family members took for their illnesses. If these medications and dosages worked for family members, the chance is good that they may work for the current patient.

Obtain a complete social history. This addition to the patient history can be most crucial when discharge planning begins. Inquire if the patient has a home. Also ask if the patient has a family, and, if so, if the patient maintains contact with them. This also is the area in which any history of drug and alcohol abuse, legal problems, and history of abuse should be recorded.

Imperative to the recording of a patient's social history is any information that may aid the physician or other clinicians in making special accommodations for the patient when necessary. This would include an accurate record of the last grade completed in school, whether the patient was in special education classes, or if the patient required special assistance at work or school (ie, special listening devices for the hard of hearing).

Following completion of the patient's history, perform the MSE in order to test specific areas of the patient's spheres of consciousness. To begin the MSE, once again evaluate the patient's appearance. Document if eye contact has been maintained throughout the interview and how the patient's attitude has been toward the interviewer. Next, in order to describe the mood aspect of the examination, ask patients how they feel. Normally, this is a one-word response, such as "good," "sad," or another.

Next, the interviewer's task is to define the patient's affect, which will range from expansive (fully animated) to flat (no variation). The patient's speech then is evaluated. Note if the patient is speaking at a fast pace or is talking very quietly, almost in a whisper. Thought process and content are evaluated next, including any hallucinations or delusions, obsessions or compulsions, phobias, and suicidal or homicidal ideation or intent.

Then, the patient's sensorium and cognition are examined, most commonly using the Mini-Mental State Examination. The interviewer should ask patients if they know the current date and their current location to determine their level of orientation. Patients' concentration is tested by spelling the word "world" forward and backward. Reading and writing are evaluated, as is visuospatial ability. To examine patients' abstract thought process, have them identify similarities between 2 objects and give the meaning of proverbs, such as "Don't cry over spilled milk." Once this is completed, perform the physical examination and needed laboratory tests to help exclude medical causes of presenting symptoms.

A compilation of all information gathered throughout the interview and MSE leads to the differential diagnosis of the patient. Once this diagnosis is established, a treatment plan is formulated. At this point, involving the treatment team (eg, social workers, nurses, others) is important to help carefully explain to patients what their treatment will entail. Be sure to ask patients if they have any questions regarding their treatment plans. Discuss the details of the medications chosen, including adverse effects. Give details of the hospital stay if patients are to receive inpatient treatment, such as estimated length of stay, visiting hours, and other aspects. Inform patients that even though the interviewer is the treating physician, their input and concerns are valuable and necessary in order to fulfill treatment goals.

Every patient interview affords the health care professional an invaluable opportunity to provide patient education. While different illnesses may require specialized attention, this time can be used to discuss such patient issues as medication compliance, nutrition, the importance of follow-up appointments with primary care physicians and other specialists (eg, obstetricians,

gynecologists), the urgency of seeking emergency medical help at the emergency department when necessary, the prevalence of psychiatric disorders, and general education concerning the patient's illness. Never overlook providing needed education to patients.

The process of conducting an accurate history and MSE takes practice and patience, but it is very important in order to evaluate and treat patients effectively. This part of psychiatry is so important that it comprises part II of the Board Certification Test. The history and MSE are crucial first steps in the assessment and are the only diagnostic tools psychiatrists have to select treatment for each patient and, therefore, ultimately are the deciding factor for initial treatments. This fact alone should make the interviewer cognizant of the essential role the history and MSE play each time a patient is evaluated.

Identifying data

Ask patients their name or what name they prefer to be called. If the patient is a child or adolescent, asking what grade the patient is in also may be appropriate. Also, ask patients their marital status, occupation, religious belief, and living circumstance. Also document their sex and race in this section.

Chief complaint

This is the patient's problem or reason for the visit. Most often, this is recorded as the patient's own words, in quotation marks. This statement allows identification of the problem by identifying symptoms that lead to a diagnosis and, eventually, a specific treatment plan. To elicit this response, the interviewer should ask leading questions such as "What brings you here today?"

History of present illness

This is the main part of the interview because there are no specific elements that will lead to the diagnosis and ultimately treatment besides the interview. An exact history allows one to gather basic information along with specific symptoms including timing in the patient's life to allow the healthcare provider to take care of the whole patient.

The important part of taking a history of present illness is listening. One should have an organized format but not too rigid in administering the examination. For example, if asking about medication allergies and the patient brings up problems with alcohol, follow the patients lead and obtain information regarding the new data but then guide the patient back to the interview to allow all information to be gathered. Without a specific format, important information may be missed.

Remember to include both pertinent positives and negatives because these could be important aspects in determining diagnosis and treatment in complicated cases. Record important life events to complete this part of the evaluation, and this may help in establishing rapport with a patient.

This is the patient's story of the presenting problem and any additional details that led the patient to visit the psychiatrist. This includes information regarding why the patient is seeking help at a particular time (the "why now" aspect of the patient's life). This usually involves a triggering event or something that caused the patient to choose this point in life to seek help.

Realize there is no one particular way to take the history of present illness. Each person may differ in obtaining this important part of the examination. Remember different approaches may be needed depending on the circumstances (eg, emergency department consult versus a forensic evaluation).

Past medical history

List medical problems, both past and present, and all medical illnesses. At least ask a few screening questions regarding medical illnesses such as do you see a doctor regularly. If possible, try to obtain the patient's entire medical records rather than depending solely on the patient's self-report. Even the most minute detail of a patient's medical history, from as far back as childhood, could play a significant role in the presenting problem. Be certain to inquire about specific events that may have occurred in childhood, such as falls, head trauma, seizures, and injuries with loss of consciousness. All of these could be relevant to their current problems.

Past surgical history

List all surgical procedures the patient has undergone, including dates. Be as specific as possible when recording dates, and obtain medical records for review when possible. Patients may not volunteer this information unless asked specifically about operations.

Medication

List the patient's current medications, including dosages, route, regimen, and whether or not the patient has been compliant. If possible, have the patient bring his or her medications to the visit. Also, inquire about past medications. Additionally, with all past medications, look for signs or patterns of noncompliance. If noncompliance issues or even drug-seeking behaviors appear evident, ask the patient who prescribed the medications and when or why the patient discontinued taking them.

Allergies

List all drug and food allergies the patient currently has or has had in the past, and list what type of reactions the patient had to the medications.

Past psychiatric history

List all of the patient's treatment, including outpatient, inpatient, and therapy-based (ie, individual, couples, family, group), including dates. Inquire about

past psychotropic medications and response, compliance, and dosages. Ask patients if they feel that they received any benefits from the treatments. If so, inquire about the specific type of benefit. Additionally, ask patients which medications they feel helped them most in the past and ask which ones helped them least. From an insightful patient, this information may offer clues as to which class of medication the patient responds to best. If possible, try to obtain old psychiatric records.

Family history

List any psychiatric or medical illnesses, including method of treatment such as hospitalization (medical and psychiatric) of family members and response. Once again, the emphasis here is strong. Record any information obtained because it may help in treatment planning. If a patient's family member has been diagnosed with the same psychiatric illness and has been treated successfully, treating the current patient with that same medication may be appropriate. This may be a reasonable place to begin.

Social history

Obtain a complete social history of the patient. Ask patients their marital status. Also, inquire about employment status. If the patient is employed, inquire about the frequency of absences from work. If the patient is not employed, inquire about whether the patient currently is looking for work. Also inquire if a previously held job was lost as a result of the illness. Obtain as much detailed information as possible.

Recording an accurate educational history is imperative. Inquire how far the patient went in school. Ask if he or she was in special education classes. Ask if the patient has a learning disability and if the patient has any other problem such as a hearing impairment or speech problem. These issues are very important in the evaluation of patients undergoing psychiatric assessment, and patient care could be jeopardized if they are not addressed. A patient's communication problems, for example, could be due to a language disorder rather than a thought disorder, and the initiation of psychiatric medications could further affect communication, not to mention cause legal concerns for the prescribing physician. All of these things must be kept in mind at all times when completing the social history.

Record the number, sex, and age of the patient's children. Ask if any of the children have any medical or psychiatric problems. List the patient's toxic habits, including past and current use of tobacco, alcohol, and street drugs. This is important because many patients can become dependent on prescribed medications. Try to determine whether the patient has a history of drug abuse.

Include any military history, including length of service and rank. This could help determine if a patient is eligible for US Veterans Administration benefits or other assistance.

Another important issue in obtaining a very thorough patient history is the patient's housing status. This becomes a vital part of the discharge plans. Ask if the patient has a home. Inquire if they have a family and if they have contact with that family. Ask where the patient will go at the completion of his or her hospital stay. Also ask who will ensure that the patient remains compliant with medication therapy. These become crucial points when finding placement for patients at discharge and planning long-term follow-up care. Therefore, careful recording of housing and support is very important.

Inquire about the existence (and number) of siblings, their names and phone numbers, and any church affiliations, just in case the information is needed later.

Also in the history section, record any legal problems the patient may have had in the past. This should include jail time, probation, arrests (eg, for driving while intoxicated or driving under the influence of drugs), and any other relevant information that can provide insight into the patient's problems with the law.

Patient history also should include hobbies, social activities, and friends. If the patient has any history of abuse, mental or physical, it should be recorded here. Any other relevant information that may be useful in treating the patient or helpful in aiding in aftercare should be recorded in the patient history.

Inquire about the patient's and the patient's parents' religious beliefs. Did the patient grow up in a strict religious environment? Does the patient have a particular religious belief and has that changed since childhood, adolescence, or adulthood? Investigate what effect the patient's beliefs have on treatment of psychiatric illnesses or suicide.

Perinatal and developmental history

Record any relevant perinatal and developmental history. Ask if the patient was born prematurely. Ask about any complications associated with their birth. Ask if they were told how old they were when they spoke their first word or took their first step.

Assets

List attributes of the patient. Examples may include that the patient agreed to voluntary acceptance of treatment, has strong verbal skills, or exhibits above average intelligence, just to name a few.

Appearance

Record the patient's sex, age, race, and ethnic background. Document the patient's nutritional status by observing the patient's current body weight and appearance. Remember recording the exact time and date of this interview is important, especially since the mental status can change over time such as in delirium.

Recall how the patient first appeared upon entering the office for the interview. Note whether this posture has changed. Note whether the patient appears more relaxed. Record the patient's posture and motor activity. If nervousness was evident earlier, note whether the patient still seems nervous. Record notes on grooming and hygiene. Most of these documentations on appearance should be a mere transfer from mind to paper because mental notes of the actual observations were made when the patient was first encountered. Record whether the patient has maintained eye contact throughout the interview or if he or she has avoided eye contact as much as possible, scanning the room or staring at the floor or the ceiling.

Attitude toward the examiner

Next, record the patient's facial expressions and attitude toward the examiner. Note whether the patient appeared interested during the interview or, perhaps, if the patient appeared bored. Record whether the patient is hostile and defensive or friendly and cooperative. Note whether the patient seems guarded and whether the patient seems relaxed with the interview process or seems uncomfortable. This part of the examination is based solely on observations made by the health care professional.

Mood

The mood of the patient is defined as "sustained emotion that the patient is experiencing." Ask questions such as "How do you feel most days?" in order to trigger a response. Helpful answers include those that specifically describe the patient's mood, such as "depressed," "anxious," "good," and "tired." Elicited responses that are less helpful in determining a patient's mood adequately include "OK," "rough," and "don't know." These responses require further questioning for clarification.

Establishing accurate information pertaining to the length of a particular mood, if the mood has been reactive or not, and if the mood has been stable or unstable also is helpful.

Affect

A patient's affect is defined in the following terms: expansive (contagious), euthymic (normal), constricted (limited variation), blunted (minimal variation), and flat (no variation). A patient whose mood could be defined as expansive may be so cheerful and full of laughter that it is difficult to refrain from smiling while conducting the interview. A patient's affect is determined by the observations made by the interviewer during the course of the interview.

Speech

Document information on all aspects of the patient's speech, including quality, quantity, rate, and volume of speech during the interview. Paying attention to patients' responses to determine how to rate their speech is important. Some things to keep in mind during the interview are whether patients raise their

voice when responding, whether the replies to questions are one-word answers or elaborative, and how fast or slow they are speaking.

Thought process

Record the patient's thought process information. The process of thoughts can be described with the following terms: looseness of association (irrelevance), flight of ideas (change topics), racing (rapid thoughts), tangential (departure from topic with no return), circumstantial (being vague, ie, “beating around the bush”), word salad (nonsensical responses, ie, jabberwocky), derailment (extreme irrelevance), neologism (creating new words), clanging (rhyming words), punning (talking in riddles), thought blocking (speech is halted), and poverty (limited content).

Throughout the interview, very specific questions will be asked regarding the patient's history. Note whether the patient responds directly to the questions. For example, when asking for a date, note whether the response given is about the patient's favorite color. Document whether the patient deviates from the subject at hand and has to be guided back to the topic more than once. Take all of these things in to account when documenting the patient's thought process.

Thought content

To determine whether or not a patient is experiencing hallucinations, ask some of the following questions. "Do you hear voices when no one else is around?” "Can you see things that no one else can see?" "Do you have other unexplained sensations such as smells, sounds, or feelings?"

Importantly, always ask about command-type hallucinations and inquire what the patient will do in response to these commanding hallucinations. For example, ask "When the voices tell you do something, do you obey their instructions or ignore them?" Types of hallucinations include auditory (hearing things), visual (seeing things), gustatory (tasting things), tactile (feeling sensations), and olfactory (smelling things).

To determine if a patient is having delusions, ask some of the following questions. "Do you have any thoughts that other people think are strange?" ”Do you have any special powers or abilities?" ”Does the television or radio give you special messages?" Types of delusions include grandiose (delusions of grandeur), religious (delusions of special status with God), persecution (belief that someone wants to cause them harm), erotomanic (belief that someone famous is in love with them), jealousy (belief that everyone wants what they have), thought insertion (belief that someone is putting ideas or thoughts into their mind), and ideas of reference (belief that everything refers to them).

Aspects of thought content are as follows:

- Obsession and compulsions: Ask the following questions to determine if a patient has any obsessions or compulsions. "Are you afraid of dirt?" "Do you wash your hands often or count things over and over?" "Do you perform specific acts to reduce certain thoughts?" Signs of ritualistic type behaviors should be explored further to determine the severity of the obsession or compulsion.
- Phobias: Determine if patients have any fears that cause them to avoid certain situations. The following are some possible questions to ask. "Do you have any fears, including fear of animals, needles, heights, snakes, public speaking, or crowds?"
- Suicidal ideation or intent: Inquiring about suicidal ideation at each visit always is very important. In addition, the interviewer should inquire about past acts of self-harm or violence. Ask the following types of questions when determining suicidal ideation or intent. "Do you have any thoughts of wanting to harm or kill yourself?" "Do you have any thoughts that you would be better off dead?" If the reply is positive for these thoughts, inquire about specific plans, suicide notes, family history (anniversary reaction), and impulse control. Also, ask how the patient views suicide to determine if a suicidal gesture or act is ego-syntonic or ego-dystonic. Next, determine if the patient will contract for safety. For homicidal ideation, make similar inquiries.
- Homicidal ideation or intent: Inquiring about homicidal ideation or intent during each patient interview also is important. Ask the following types of questions to help determine homicidal ideation or intent. "Do you have any thoughts of wanting to hurt anyone?" "Do you have any feelings or thoughts that you wish someone were dead?" If the reply to one of these questions is positive, ask the patient if he or she has any specific plans to injure someone and how he or she plans to control these feelings if they occur again.
- Sensorium and cognition: Perform the Folstein Mini-Mental State Examination (see Images 1-2).
- Consciousness: Levels of consciousness are determined by the interviewer and are rated as (1) coma, characterized by unresponsiveness; (2) stuporous, characterized by response to pain; (3) lethargic, characterized by drowsiness; and (4) alert, characterized by full awareness.
- Orientation: To elicit responses concerning orientation, ask the patient questions, as follows. "What is your full name?" (ie, person). "Do you know where you are?" (ie, place). "What is the month, the date, the year, the day of the week, and the time?" (ie, time). "Do you know why you are here?" (ie, situation).
- Concentration and attention: Ask the patient to subtract 7 from 100, then to repeat the task from that response. This is known as "serial 7s." Next, ask the patient to spell the word world forward and backward.
- Reading and writing: Ask the patient to write a simple sentence (noun/verb). Then, ask patient to read a sentence (eg, "Close your eyes."). This part of the MSE evaluates the patient's ability to sequence.
- Visuospatial ability: Have the patient draw interlocking pentagons in order to determine constructional apraxia.

- Memory: To evaluate a patient's memory, have them respond to the following prompts. "What was the name of your first grade teacher?" (ie, for remote memory). "What did you eat for dinner last night?" (ie, for recent memory). "Repeat these 3 words: 'pen,' 'chair,' 'flag.' " (ie, for immediate memory). Tell the patient to remember these words. Then, after 5 minutes, have the patient repeat the words.
- Abstract thought: Assess the patient's ability to determine similarities. Ask the patient how 2 items are alike. For example, an apple and an orange (good response is "fruit"; poor response is "round"), a fly and a tree (good response is "alive"; poor response is "nothing"), or a train and a car (good response is "modes of transportation"). Assess the patient's ability to understand proverbs. Ask the patient the meaning of certain proverbial phrases. Examples include the following. "A bird in the hand is worth two in the bush" (good response is "be grateful for what you already have"; poor response is "one bird in the hand"). "Don't cry over spilled milk" (good response is "don't get upset over the little things"; poor response is "spilling milk is bad").
- General fund of knowledge: Test the patient's knowledge by asking some of the following questions. "How many nickels are in $1.15?" "List the last 5 presidents of the United States." “List 5 major US cities." Obviously, a higher number of correct answers is better; however, the interviewer always should take into consideration the patient's educational background and other training in evaluating answers and assigning scores.
- Intelligence: Based on the information provided by the patient throughout the interview, estimate the patient's intelligence quotient (ie, below average, average, above average).

Insight

Assess the patients' understanding of the illness. To assess patients' insight to their illness, the interviewer may ask patients if they need help or if they believe their feelings or conditions are normal.

Judgment

Estimate the patient's judgment based on the history or on an imaginary scenario. To elicit responses that evaluate a patient's judgment adequately, ask the following questions. "What would you do if you smelled smoke in a crowded theater?" (good response is "call 911" or "get help"; poor response is "do nothing" or "light a cigarette").

Impulsivity

Estimate the degree of the patient's impulse control. Ask the patient about doing things without thinking or planning. Ask about hobbies such as coin collecting, golf, skydiving, or rock climbing.

Reliability

Estimate the patient's reliability. Determine if the patient "seems reliable," if it is "difficult to determine," or if the patient seems "unreliable." This determination requires collateral information of an accurate assessment, diagnosis, and treatment

Perform a complete physical examination, including a neurological examination. Obtaining collateral information from family members, friends, and colleagues is important. These individuals all can help in formulating an accurate account of the events that led to the patient's visit to the psychiatrist.

- Psychological evaluation: Some evaluations require a battery of psychological tests, including neuropsychological testing when deemed appropriate. This series of tests can help determine what types of deficits the patient might have, can help identify any Axis II diagnoses, and can help identify other factors, such as factitious disorders or malingering.
- Laboratory testing (see Lab studies)
- Diagnosis: Use the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision* (*DSM-IV-TR*) Axis I-V.
- Differential diagnosis: Determine the patient's differential diagnosis, for both medical and psychiatric illnesses, based on all information gathered from the patient interview, MSE, psychological testing, review of medical history, and current laboratory reports.
- Formulation: Use the biopsychosocial model. The formulation is for the current situation and identifies the specific event, state of mind, topics of concern and defense mechanism(s) used, relationships, and the strengths that the patient brings to the treatment setting. The Cultural Formulation is appropriate for patients from various cultural backgrounds, and it can be found in Appendix I of the *DSM-IV-TR.*
- Treatment: The treatment approach that is best suited as a starting point should be noted, including psychotherapeutic, psychopharmacologic, behavioral, and social interventions. This also is an excellent place to document further consultations that are deemed necessary. A statement regarding the patient's agreement (or lack thereof) with participating in the various portions of the recommended treatment also is wise to add.
- Prognosis: Patients' prognoses are dependent on the specific illness with which they are diagnosed. However, patients should be encouraged to pursue treatment regardless of their prognosis and should be encouraged to be compliant with the treatment plans formulated for them. Make them understand that their prognosis is always better when they are compliant with medications and follow-up appointments and instructions.

Physical

- Causes - Multiple etiologies based on findings from history, MSE, physical examination, lab studies, and other required diagnostic tests
- Differential diagnosis - Multiple etiologies
    - Differentials - *DSM-IV-TR* Axis I-V

    - Other problems to consider - Medical and neurological illnesses

Workup

- Lab studies
    - Routine - Sequential multiple analysis, CBC count with differential, urinalysis, urine drug screen, thyroid-stimulating hormone and thyroid function test, urine pregnancy test, rapid plasma reagent, and HIV test if indicated
    - Other laboratory tests based on interview and other examinations - Vitamin B-12/folate levels; medication levels, including lithium, imipramine, and digoxin; prothrombin time, activated partial thromboplastin time, and International Normalized Ratio; amylase, lipase, sedimentation rate, luteinizing hormone, follicle-stimulating hormone, hepatitis panel, and copper level
- Imaging studies - CT scan, MRI, other imaging studies based on interview (eg, positron emission tomography scan, ultrasound)
- Other tests - Electroencephalogram, ECG
- Procedures - Dexamethasone-suppression test, catecholamine level, lumbar puncture, Amytal interview, hyperventilation, sodium lactate infusion
- Histologic findings - Based on final diagnosis (eg, Alzheimer disease amyloid plagues)
- Staging - Based on final diagnosis

Treatment

- Medical care - Based on final diagnosis
- Surgical care - Based on final diagnosis
- Consultations - Neurologist, internal medicine specialist, psychologist, social services personnel, others
- Diet - Based on final diagnosis
- Activity - Based on final diagnosis, restrict if patient represents a danger to self or others or is gravely disabled
- Medications - Based on final diagnosis

Follow-up

- Further inpatient care - If patients are suicidal, homicidal, or incapable of taking care of themselves
- Further outpatient care - Based on final diagnosis
- In/out patient medications - Based on final diagnosis
- Transfer - Hospital, nursing home, jail, long-term care facility, or other (based on final diagnosis)
- Deterrence/prevention - Education, early intervention, medication compliance
- Complications - Based on final diagnosis
- Prognosis - Based on final diagnosis

- Education - Medication, disease process, social skills training, vocational rehabilitation, coping, problem-solving skills

Medical/legal pitfalls

Become familiar with local, state, and national laws regarding specific situations. Cases of domestic violence are reportable in certain states; therefore, be aware of the physician's responsibility to the patient and to the law.

Special concerns

- Confidentiality: Health care professionals should discuss with the patient what can and cannot be kept confidential based on both legal and ethical considerations. In most cases, patients must give permission to release information and their medical records. The exception to confidentiality is cases of suicidal and homicidal ideations.
    - Child abuse, abuse of elderly people: Clinicians are mandatory reporters of abuse and must do so if abuse is suspected.
    - Tarasoff I (1976): This case resulted in the “Duty to Warn,” as established by the case of Tarasoff versus the Regents of the University of California.
    - Tarasoff II (1982): This case was the second ruling, expanding Tarasoff I and resulting in the “Duty to Protect.”
- Admission types
    - Informal voluntary: These are patients admitted to the hospital but who are free to leave at any time, even against medical advice.
    - Formal voluntary: These are patients admitted to the hospital who can leave the hospital only when discharged by the physician. Requests to leave the hospital may be made by the patient, but they must be made in writing. During a specific period of time, the person is evaluated by the physician and is either released or committed (ie, changed to involuntary type of admission for further evaluation and treatment).
    - Involuntary: Patients not recognizing their need for hospitalization may be placed in the hospital to ensure the safety of themselves or others or because they are considered gravely disabled. Before patients are admitted under this type of admission, they are evaluated by a physician and, if deemed necessary, admitted for safety reasons. Patients are then evaluated by a second physician. Both physicians must agree to keep a patient in the hospital. The judicial system may place someone in the hospital for treatment, but generally, patients are kept in the hospital under the least restrictive measure to receive treatment. Patients do have the right to file a "writ of habeas corpus," a legal procedure to allow the courts to decide if a patient has been hospitalized without due process of law.
- Seclusion (empty room for safety) and restraint (device to restrict patient's movement for safety) procedures: The American Psychiatric

Association task force on seclusion and restraint provides guidelines for these procedures. Become familiar with local laws and hospital rules regarding the use of these procedures.

- Informed consent procedures: Written or at least verbal confirmation, with documentation in the medical record, of informed consent must be obtained before performing a procedure or administering a medication. The patient must be competent to discuss the risks, benefits, alternatives, and adverse effects of a procedure or medication. A competent adult may refuse treatment. If a patient is not competent to give informed consent, a guardian may give consent or the court may rule about administering a procedure or medication to ensure the safety of the patient or others.

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