

# CLINICAL PSYCHIATRY COURSE 462

**Course Name: Psychiatry**  
**Course Code & No: 462 Psych**  
**Credits: 4 ( 2+2 )**  
**Duration: 5 week**  
**StudyYear:4<sup>th</sup> Year**

اسم المقرر: الطب النفسي  
رقم المقرر ورمزه: 462 ظنف  
الساعات المعتمدة: 4 ( 2+2 )  
مدة المقرر: 5 أسابيع  
سنة الدراسة: السنة الرابعة

## MANUAL FOR TUTORS AND STUDENTS

**Developed by Teaching Committee:**

**Fahad Alosaimi: (Cognitive theme)**

**Mohammed Alyousef: (Psychosis theme)**

**Abdullah Aldaoud: (Mood theme)**

**Ahmed Alhadi: (Anxiety theme)**

**Noor Almodihesh: (Child theme)**

**Department of Psychiatry**

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## **INTRODUCTION**

We welcome you to course 462 Psych (the clinical psychiatry course) and we hope it will be an enjoyable and stimulating educational experience. This course aims at studying psychiatry as one of the most rapidly growing specialties of medicine in our country and the world. Thus, you will learn basic psychiatric knowledge and clinical skills that will enable you to function at the level of primary care and emergency psychiatry and take safe decisions when assessing and treating psychiatric patients. This will be accomplished through a variety of educational activities.

We expect full commitment and punctuality in the course activities and high respect towards people with psychiatric problems.

This manual is written in details for the tutors and students to strictly adhere and comply with to maintain the excellence of the teaching process.

## OBJECTIVES

To provide the undergraduate medical students with 1-knowledge 2-attitude 3-clinical skills relevant to clinical psychiatry and essential for their future career as non-psychiatric clinicians in whatever specialty they choose.

### 1- Knowledge:

To acquire basic essential facts in clinical psychiatry that includes:

- a. Phenomenological psychopathology (signs and symptoms) of psychiatric disorders.
- b. Classification and etiology in clinical psychiatry (bio-psycho-social).
- c. Common psychiatric disorders:
  - Clinical features and course.
  - Epidemiology and etiology.
  - Differential diagnosis.
  - Treatment (bio-psycho-social) and prognosis.
- d. Treatment modalities in psychiatry:
  - Physical: pharmacotherapy, electroconvulsive therapy (ECT) and others.
  - Psychological: behavioral, cognitive, supportive psychotherapy and others.

### 2- Attitude:

To develop the scientific attitude towards:

- a. Psychiatric patients and their families
- b. Psychiatric interventions (bio-psycho-social)
- c. Mental health and providers (psychiatrists, psychologists, social workers and others)
- d. Psychiatry as a branch of medicine.

### 3- Clinical Skills:

- a. To conduct a full psychiatric interview with:
  - Proper interview techniques and skills.
  - Sufficient psychiatric history.
  - Standard “mental state examination”.
- b. To present a diagnostic formulation for common psychiatric disorders based on the most recent classificatory systems in psychiatry.
- c. To set an outline of a management plan for common psychiatric disorders following the bio-psycho-social approach (both short and long term).
- d. To assess and appropriately refer psychiatric patients in the primary care settings.
- e. To assess and deal competently and safely with psychiatric emergencies.
- f. To assess and dispose properly consultation-liaison cases.

## **COURSE OVERVIEW**

The course lasts for 6 weeks (including consolidation and examination weeks) during which varieties of educational activities are conducted to fulfill the objectives of the course with great emphasis on the applied clinical psychiatry. These activities are namely:

1. Cognitive Disorders Theme
2. Psychotic Disorders Theme
3. Mood Disorders Theme
4. Anxiety Disorders Theme
5. Child Psychiatry Theme
6. Clinical Activities (in-patient, outpatient, consultation-liaison, child psychiatry)  
include clinical cases log with a help of an assigned supervisor

# COURSE CONTENT

## I. Cognitive Disorders Theme:

### Case Vignette:

Abdullah is a 72-year-old male. He was brought to the Emergency Department by his son for vomiting, new onset urinary incontinence, confusion, and incoherent speech for the past 2 days. The patient was disoriented and could see people climbing trees outside the window. He had difficulty sustaining attention, and his level of consciousness waxed and waned. He had been talking about his deceased wife. Patient was also trying to pull out his intravenous access line. Past history included diabetes mellitus, hyperlipidemia, osteoarthritis, and stroke. On examination, the patient was drowsy and falling asleep while practitioners were talking to her. Patient was not cooperative with the physical examination and with a formal mental status examination. Limited examination of the abdomen indicated that it was flat and soft with normal bowel sounds. The patient moves all 4 limbs and plantar is bilateral flexor. Laboratory test results revealed elevated BUN and creatinine levels, and the urine analysis was positive for urinary tract infection. CT scan of the head showed cortical atrophy plus an old infarct. The patient's family physician had recently prescribed Tylenol with codeine for the patient's severe knee pain 5 days earlier.

### ***A. Analysis of symptoms, MSE and psychopathology especially perception; differential diagnosis discussion (including drug intoxication and withdrawal):***

1. Analyze the symptoms (presented and expected) in this case and signs, including mood, thoughts, cognition, perception and physical aspects
2. Discuss other elements related to the case includes possible etiological reasons
3. Discuss the initial possible diagnosis of this case and different types of such clinical presentation

### **Case Development 1:**

Past history inquiry indicated that he has two years of deteriorating memory. He forgot mostly recent things. He has difficulty to name some familiar people to him. 6 months ago, he lost his ability to drive and to pray appropriately. However, his attention was well except of few days' prior current admission. There is positive family history of sever memory problem in his eldest brother.

4. Analyze the symptoms (presented and expected) in this case and signs, including mood, thoughts, cognition, perception and physical aspects
5. Discuss other elements related to the case includes possible etiological reasons
6. Discuss the initial possible diagnosis of this case and different types of such clinical presentation
7. Discuss Cognitive disorders related psychopathology

### **Case Development 2:**

Abdullah's son reluctantly reported that his father has current history of occasional alcohol drinking and using Diazepam to sleep well. He admits that he were heavy alcohol drinker 10 years ago. He had bouts of memory impairments and family problem secondary to his heavy drinking. He used to have tremors and craving for drinking at early morning. After searching patient's old medical notes, you found that the patient has been admitted to ICU 10 year ago with fever, sweating, tremor, dilated eyes, disorientation, confusion and seeing small animals.

Moreover, the patient's medical notes indicates that he came to ER 25 years ago complaining of runny nose, stomach cramps, dilated pupils, muscle spasms, chills despite the warm weather, elevated heart rate and blood pressure, and low grade fever. At that time, he has asked ER physician some "meds" to tide him over until he can see his regular doctor.

8. Discuss possible differential diagnosis including drug intoxication and withdrawal

***B. Case Management Discussion including ability to give consent and take decision:*** (Considering the case above)

1. Discuss about the acute use of antipsychotics and benzodiazepine
2. Discuss about Dementia treatments, indication, side effects, etc
3. Discuss about ability to give consent and take decision



### ***C. Psychosomatic Medicine:***

#### **Case Development 3:**

Past medical and psychiatric history indicated that the patient has left side CVA 7 years ago. Post stroke, he had 3 months history of low mood, loss of interest, crying spells, excessive guilt feelings and death wishes. Moreover, he had decreased sleep, appetite, energy and concentration. He became isolated and not cooperative during physiotherapy session. After been assessed and managed by psychosomatic psychiatrist, patient's mood and motor function have improved very well.

1. Discuss about Depression in medical ill patients.
2. Discuss about Psycho-pharmacology in medically ill populations

#### **Case Development 4:**

Elaborating more in his past history, His wife reported that when she was pregnant with her last child 27 years ago, she has needed to get help of psychiatry -because of sadness, crying, anxiety and disturbed sleeping. Also, after delivery, she became behaviorally disturbed plus hearing voices asking her to kill her child.

At that time (27 years ago), our patient (Abdullah) started to complain of multiple pains in his body associated with headache and dizziness. He spent his saving for medical checkup for years with no conclusive results till he was met his psychiatrist and he started to improve.

3. Discuss about Somatoform disorders
4. Discuss about Perinatal psychiatry

## **II. Psychotic Disorders Theme:**

### **Case Vignette:**

Ahmad is a 28 year-old single male who came to Emergency room by his family with progressive changes in his behavior started 7 months ago. Since then, he became agitated; eat only canned food but not his cooked food by his family afraid of being poisoned. He talks to himself and stares occasionally on the roof of his room.

He had two brief psychiatric hospitalizations in his late teens that were precipitated by anger at his boss and voices commenting about his behavior.

His personal history indicated that he was a healthy child, but his parents report that he was a bed wetter and seemed slower to develop than his brothers and sisters.

### ***A. Analysis of symptoms, MSE and psychopathology especially thoughts:***

1. Analyze the symptoms (presented and expected) in this case and signs, including mood, thoughts, cognition, perception and physical aspects
2. Discuss other elements related to the case includes possible etiological reasons
3. Discuss the initial possible diagnosis of this case and different types of such clinical presentation

### **Case Development 1:**

Ahmad smokes tobacco frequently to calm himself.

During his early adolescence he used to smoke Hash heavily plus occasional use of amphetamine. He stopped both Hash and Amphetamine use 5 years ago. His father disclosed to his psychiatrist that Ahmad used to have brief fixed persecutory (paranoid) ideas towards his brothers associated with the use of amphetamine.

4. Analyze the symptoms (presented and expected) in this case and signs, including mood, thoughts, cognition, perception and physical aspects
5. Discuss other elements related to the case includes possible etiological reasons
6. Discuss the initial possible diagnosis of this case and different types of such clinical presentation
7. Discuss psychotic disorders related psychopathology

***B. Traits that resemble this case (cluster A) and commonly used defense mechanisms and differential diagnosis:***

### **Case Development 2:**

Premorbidly, Ahmad used to have chronic sense of insecurity and suspiciousness towards others and having difficulties to initiate new relationships with few and superficial social relations.

1. Discuss traits related to this case and other cluster A traits
2. Discuss commonly used defense mechanisms by such clients

### **Case Development 3:**

Family history indicated that his maternal uncle has been diagnosed with Schizophrenia. Another remote uncle used to have a relapsing chronic mental illness (patient's father is unaware about the diagnosis) but it was close to the clinical picture of the patient. However, during his illness course, he has few weeks' recurrent episodes of talkativeness, hyperactivity, distractibility, irritability and overspending of money.

3. Discuss possible differential diagnosis

### ***C. Case Management Discussion and antipsychotic side effects***

#### **Case Development 4:**

He sees a psychiatrist for 15 minutes every two months but sometimes misses his appointment. His parents support him financially and he has a social worker whom he sees often. Ahmad was treated with Haloperidol which gave him muscle cramps especially in his neck, he was then treated with Olanzapine and gained 20 pounds and developed Diabetes Mellitus. During his illness course, the patient's family became less supportive to him & he became less compliant on his treatments. His psychiatrist would like to switch him to long acting injectable antipsychotic treatment but Ahmad is afraid of injections and isn't sure that he needs medication.

(Considering the case above)

1. Discuss the types of antipsychotics, indication, side effects, etc
2. Discuss the role of psychotherapy and other social approaches
3. Discuss in detail Extrapyramidal side effect and NMS

## ***D. Aggressive Patient Assessment and Management:***

### **Case Development 5:**

**9 months later, during the patient's regular visit to the clinic, he presented with irritability and started to be verbally abusive towards his father, threatening to beat him. He looked during the interview perplexed and agitated.**

#### **1. Assessment:**

- What is agitation:
  - o Tension state in which anxiety is manifested in psychomotor area with hyperactivity. Seen in depression, schizophrenia & mania.
- What is aggression:
  - o Hostile or angry feelings, thoughts or actions directed towards an object or person. Seen in impulsive disorders, impulse control disorders & mania.
- How to interview aggressive patient:
  - o Do not be close in closed room
  - o Sit near the door
  - o Have security guard nearby or in the room
  - o Sit limits
  - o If patient seems too agitated terminate interview
- How to manage agitated patient:
  - o Medication – Haloperidol, Benzodiazepines
  - o Physical restraints
  - o Rule out reaction to other medication, e.g. Cortisol paranoia, anticholinergic delirium.
  - o Examine for command hallucination or delusional (paranoid) to which patient is responding.
- Causes:
  - o Mental illness: Depression, Acute psychosis, mania, schizophrenia
  - o Physical: Delirium, dementia, epilepsy, alcohol and drug intoxication, W.D.
  - o Personality Disorder: Borderline, antisocial
- General strategy in evaluating the patient:
  - o Protect self
  - o Prevent harm to self or others
  - o Assess the suicidal risk factors

- Assess the violent risk: ideas, wishes, intention, male, lower S.E. status, little social support, past history, substance abuse, psychosis.
- Assessment of dangerousness

## **2. Management:**

- Hospitalization:
  - Locked vs. unlocked ward
  - Voluntary vs. involuntary
  - 1 – 1 precaution vs. no precaution
- Crisis intervention:
  - Reliable and motivated patient
  - Reliable accessory persons
  - Confrontation
  - Restraint (physical)
  - Immediate follow up
  - Avoidance of provocation
- Medication:
  - Major tranquilizer
  - Benzodiazepines
  - Mood stabilizer
  - ECT

## **III. Mood Disorders Theme:**

### **Case Vignette:**

Huda is a 25 yr-old single female teacher. She had an episode -of at least 2 weeks duration- of low mood associated with loss of interest, isolation, crying spells, excessive guilt feelings, death wishes, suicidal ideation and reduction in libido. Her mother has history of bipolar disorder and one of her sisters had post-partum psychosis.

### ***A. Analysis of symptoms, MSE and psychopathology:***

1. Analyze the symptoms (presented and expected) in this case and signs, including mood, thoughts, cognition, perception and physical aspects
2. Discuss other elements related to the case includes possible etiological reasons
3. Discuss the initial possible diagnosis of this case and different types of such clinical presentation

### **Case Development 1:**

When she was 20 years, she had an episode of irritable mood, talkativeness, hyperactivities, decrease need for sleep, taking off her clothes in front of her adult brother. It lasted for 3 week.

4. Analyze the symptoms (presented and expected) in this case and signs, including mood, thoughts, cognition, perception and physical aspects
5. Discuss other elements related to the case includes possible etiological reasons
6. Discuss the initial possible diagnosis of this case and different types of such clinical presentation
7. Discuss mood disorders related psychopathology

***B. Traits that resemble this case (cluster B) and commonly used defense mechanisms and differential diagnosis:***

**Case Development 2:**

Premorbidly, she described herself with chronic sense of boredom, and having difficulties to keep friends.

1. Discuss traits related to this case and other cluster B traits
2. Discuss commonly used defense mechanisms by such clients

**Case Development 3:**

Her mother reported that her daughter was complaining of fever and headache few days prior the episodes when she was 20. She also reported that her daughter had new problematic friends few months prior that episode and she is suspecting the use of illicit drugs.

3. Discuss possible differential diagnosis

***C. Case Management Discussion including ECT:***

(Considering the case above)

1. Discuss the types of antidepressants, indication, side effects, etc

2. Discuss the types of mood stabilizers, indication, side effects, etc
3. Discuss the use of antipsychotics and benzodiazepine
4. Discuss the role of psychotherapy
5. Discuss about ECT, description, indication, side effects, etc

### ***D. Suicidal Patient Assessment and Management:***

#### **Case Development 4:**

During follow up, the psychologist in your team inform you that Huda discloses her deep wishes to die and refuse to elaborate more.

#### **1. Assessment:**

- Definition of suicide
- Definition of terminology related, parasuicide, deliberate self-harm, attempted suicide, completed suicide, suicide risk.
- Assessment of the suicide risk:
  - a. The present attempt:
    - Situation
    - Mean
    - Suicidal note
    - Planning
    - MSE
  - b. Past History:
    - Past attempts
    - Past psychiatric disorder
    - Medical disease
    - Present factors
    - Living status
    - Social support

#### **2. Management:**

- Immediate:
  - Admission: psychiatric vs. medical wards
  - Instructions to nurses
  - Management of medical problems



- Involvement of family
- Short-term:
  - Transfer to psychiatric ward
  - Treat psychiatric disorder
  - Manage social stress
  - Psychological treatments
- Long-term:
  - Maintenance of treatment
  - OPD follow-up
  - Social support
  - Samaritans (easy contact to service)
  - Watch of relapse

#### **IV. Anxiety Disorders Theme:**

##### **Case Vignette:**

Layla is 31 year old female. She came to your clinic complaining of fearfulness, palpitations, shortness of breath and impaired concentration. She is afraid that she will die. These symptoms come suddenly in episodes for the last two months. Layla started to be fearful whenever she leaves her home and ask for company all the time. She anticipated these episodes.

She also has irrational fear from injections and she has the same episodes when she is exposed to them.

##### ***A. Analysis of symptoms, and MSE:***

1. Analyze the symptoms (presented and expected) in this case and signs, including mood, thoughts, cognition, perception and physical aspects
2. Discuss other elements related to the case includes possible etiological reasons
3. Discuss the initial possible diagnosis of this case and different types of such clinical presentation

##### **Case Development 1:**

10 years ago, when she was in the university, she developed same episodes only in social situations like parties and presentations.

4. Analyze the symptoms (presented and expected) in this case and signs, including mood, thoughts, cognition, perception and physical aspects
5. Discuss other elements related to the case includes possible etiological reasons
6. Discuss the initial possible diagnosis of this case and different types of such clinical presentation

***B. Traits that resemble this case (cluster C) and commonly used defense mechanisms and differential diagnosis:***

**Case Development 2:**

Layla describes herself as shy person, not assertive and cannot express herself well. She is very sensitive for criticism.

1. Discuss traits related to this case and other cluster C traits
2. Discuss commonly used defense mechanisms by such clients

**Case Development 3:**

Family History:

One of Layla's sisters has recurrent intrusive silly doubts regarding ablutions and praying that she cannot resist. This makes her repeat ablution and praying frequently.

Also, her brother Saad, has the same symptoms of Layla whenever he is exposed to cues that remind him with the car accident that he had 2 years ago. Saad had serious injuries in that accident and he was in coma for 3 weeks. His friend died in the same accident. He also has flashbacks related to that accident. Also, he refuses to talk about the accident and avoids drive in the street where the accident happened.

Her aunt is anxious for the last 8 years. She has excessive worries about daily events mainly toward safety of her kids.

3. Discuss possible differential diagnosis

***C. Case Management Discussion:***

(Considering the case above)

1. Discuss the types of antidepressant, indication, side effects, etc
2. Discuss the types of anxiolytics, indication, side effects, etc
3. Discuss the role of family support

***D. Psychological Treatments:***

**Case Development 4:**

Layla reported that she had more than 12 psychological sessions with the help of the university psychologist 10 years ago. She is not sure about what type of therapy but she described it as having home work about thoughts' recording. Furthermore, after college she followed with a psychotherapist for 3 years to discuss about her emotions, childhood experience, etc.

1. Cognitive Behavioral Psychotherapy
2. Psychodynamic/ Psychoanalysis Psychotherapy
3. Others

## **V. Child Psychiatry Theme:**

### **Case Vignette:**

Saleh is a 7 year old boy, was brought by his mother to pediatrician for assessment of abdominal pain, vomiting, headache, crying and tiredness before going to school. Otherwise, he is doing well during weekend days.

### ***A. Analysis of symptoms, MSE:***

1. Analyze the symptoms (presented and expected) in this case and signs, including mood, thoughts, cognition, perception and physical aspects
2. Discuss other elements related to the case includes possible etiological reasons
3. Discuss the initial possible diagnosis of this case and different types of such clinical presentation

### **Case Development 1:**

3 months later, he was brought by his mother to pediatrician for assessment of his behavior. His teacher noticed that he has problem in staying in his seat & playing in the class a lot. He needs a lot of prompt

and direction to follow his teacher. He always answers before the question is completed.

At home, his mother complains that he always is active, forgetful, and his room looks miserable.

4. Analyze the symptoms (presented and expected) in this case and signs, including mood, thoughts, cognition, perception and physical aspects
5. Discuss other elements related to the case includes possible etiological reasons
6. Discuss the initial possible diagnosis of this case and different types of such clinical presentation

## ***B. Differential diagnosis and Case Management Discussion***

### **Case Development 2:**

His mother reported that he had delayed milestone, he used to play with younger children and fight with them. He is not able to be dry day time. When his needs are not met, he screams and cries till he get what he wants. He cannot serve himself in feeding and need assistant in dressing.

1. Discuss possible differential diagnosis

### **Case Development 3:**

In family history, His 5 year old sister never speaks a sentence except one word. She does not maintain eye contact with them and never relate to them. She seems not listening if they call her name. When she sets, she always moves back and forth. She likes to play with one toy only and gets irritated if lost or moved from her.

2. Discuss possible differential diagnosis

Considering the case above:

3. Discuss the role of psychosocial interventions
4. Discuss the use of antidepressants

5. Discuss the use of antipsychotics
6. Discuss the use of stimulants

## **VI. Clinical Activities (Out-patient Clinics and Ward Round Attendance):**

Students will be assigned in small numbers to attend the outpatient clinics (new and follow-up) and the ward rounds in inpatient wards. This provides an opportunity to observe the real clinical setting in psychiatry where, receiving the patient, interviewing the patient and his family, watching response of the patients, responses to treatments, side-effects of drugs and all possible interactions that occur in real life practice. Each student expected to attend 2 clinical activities weekly.

### **Guidelines:**


1) The students group will be divided into 6 groups & during each clinical session:

- A) 4 out of the 6 groups will be assigned to attend 4 different general, consultation liaison or child clinical psychiatry activities.
- B) 2 out of the 6 groups will meet their supervisors.

2) Each student should log all clinical cases (minimum is one case per clinical session) that they see while joining different clinical teams.

3) Each subgroup will meet their supervisor once weekly (3 times per rotation). These meetings will include:

- A) Training on various important clinical skills in psychiatry which is the standard psychiatric interview using role models and role play:

 First session: collecting history

✚ Second session: conducting mental state examination (MSE)

✚ Third session: formulation differential diagnoses, making provisional diagnosis, and discussion about management plan and prognosis.

B) Discussion about various logistics/cultural/ethical issues that students may face during their clinical work.

# **COURSE ORGANIZATION**

## **I. Administrative Responsibility:**

- a. The course is under the direct supervision of the chairman of the department and in close collaboration with the undergraduate teaching committee in the department and the course organizer.
- b. The course organizer responsibilities are:
  1. Preparing of timetable of the educational activities
  2. Following attendance / absence of the students
  3. Preparing and arranges for exams (MEQ & Finals)
  4. Supervising marking of student answers and registers their marks.
  5. Presenting the results to the educational committee and the departmental board meetings
  6. Being in direct contact with the students

## **II. Students Distribution:**

Psychiatric themes will be delivered to all students as one group. For the clinical rounds and out-patient clinics attendance, students will be divided into groups.

The academic and clinical activities take place in the Psychiatry Department, level 0 (Wards 01 – 02 & outpatient psychiatry clinic, lecture theater, Kardex room in King Khalid University Hospital).

Students' distribution for exams will be announced ahead of time.

## **III. Secretary of the Department:**

- Responsible for secretarial work of the course through the course organizer.



## **COURSE ASSESSMENT & EXAMINATION**

### **1. Clinical activities assignments: 10 Marks**

A. overall evaluation of student's attitudes & skills by supervisors.

### **2. Modified Essay Questions (MEQ): 30 Marks**

A. It is an MEQ exam of five clinical cases; four questions each, of twelve minutes each and held in the first day of the fifth week.

### **3. Final Examination: 60 Marks**

A. An MCQ exam will be held at examinations week (for 2 rotations together), 60 MCQs (30 marks).

B. An OSCE exam will be conducted at examinations week (for 2 rotations together), 5 OSCE stations (30 marks).

**The pass mark is 60 out of 100.**

**4. There will be two session held one at the start of the course to discuss the objectives & all logistics related to the course and one more session after the MCQ exam to get feedback from the students regarding the course.**

## 5. COURSE TEXTBOOKS

1. ***Basic Psychiatry*** – Professor M. A. Al-Sughayir, King Saud University Academic Publishing & Press
2. ***First Aid for the Psychiatry Clerkship, Third Edition***, [Latha Stead](#) , [Matthew Kaufman](#) , [Jason Yanofski](#)
3. ***Others:***
  - Textbook of Psychiatry, by Linford Rees, Oxford University Press.
  - Pocket Handbook of Clinical Psychiatry by Kaplan & Sadock, Williams & Wilkins.
  - Emergency Psychiatry by Allen, Micheal. American Psychiatric Press.
  - Clinical Manual to Psychosomatic Medicine: A guide to Consultation-liaison Psychiatry (Concise Guide), By Michael Wise & James Rundle, American Psychiatric Publishing.
  - Trusted Psychiatry websites including , UpToDate , medscape psychiatry..etc

## **COURSE EVALUATION**

Evaluation forms will be given to students at the end of the course (after the final exam) to have a feedback about the course process, activities and tutors. Feedback will be discussed in the undergraduate teaching committee and departmental board for further improvement and development. A copy of the student feedback form is attached.

بسم الله الرحمن الرحيم

استمارة تقويم  
Student Feedback Form

جامعة الملك سعود

كلية الطب

قسم الطب النفسي

مقرر 462 طنف

الشعبة :

الفترة :

طلبة / طالبات

العام :

عزيزي الطالب / عزيزتي الطالبة :

أولاً: نرجو تقويم الأنشطة التعليمية المختلفة التي مررت بها خلال مقرر الطب النفسي 462 طنف وسيكون هذا التقويم أساساً في تطوير المقرر وتحسين مستوى التجربة العلمية المستقبلية.

يمكن استعمال المفتاح التالي لتقويم كل نشاط على حدة:

1= لا أوافق بشدة 2= لا أوافق 3= لا تعليق 4= أوافق 5= أوافق بشدة

النشاط	حصلت على معلومات جديدة	اكتسبت مهارة سريرية مفيدة	أطلع لهذا النشاط	تزيد رغبتني لتعلم المزيد	يجب أن يستمر هذا النشاط
1 المحاضرات Case-based Lectures					
2 الاجتماع الإكلينيكي الصباحي Patient Clinical Discussion					
3 مناقشة الحالات نظرياً وإكلينيكيًا Literature and case presentation					
4 المهارات الإكلينيكية Meetings with supervisors					
5 حضور الأجنحة و العيادات الخارجية Out_pt Clinics & WR					

ملحوظات أخرى : أكتب ما لديك بكل صراحة ووضوح , وليكن نقدك بناءً وإيجابياً.

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ثانياً: نرجو تقويم أعضاء هيئة التدريس و الاستشاريين حسب النقاط الموضحة وباستعمال نفس مفتاح التقويم السابق. ومن لم يشارك خلال الفترة التي درست خلالها المقرر بإمكانك وضع علامة ( - ).

1 = لا أوافق بشدة 2 = لا أوافق 3 = لا تعليق 4 = أوافق 5 = أوافق بشدة

