MED441
KING SAUD UNIVERSITY

BH
Bassam Alhubaysh
REVIEWED BY

History Taking and Mental State Examination

By Dr. H. Alshahwan "I will not write the Qs"

Objectives:

- To describe history-taking in psychiatry
- To learn how to take psychiatric history
- To describe the Mental Status Examination (MSE) components
- To learn how to conduct the MSE.

Color index:

- Important
- Golden
- Textbook
- Old notes (439/438)
- New notes (441)
- Extra

The Psychiatric Interview

◄ Introduction

- Components of the psychiatric interview: beginning, interview itself and closing,
- One supreme skill of any physician is **active listening**.
- Physicians should monitor:
  - The **content** of the interaction (what patient and doctor say to each other)
  - The **process** of the interaction (what the patient and doctor may not say but clearly convey in many other ways)
- Physicians **should be sensitive to the effects** of patient background, culture, environment, and psychology on the **doctor–patient relationship**
  - Because patients are multifaceted people and a physician should not consider diseases or syndromes only.

- The more that doctors understand themselves, the more secure they feel, and the better able they are to modify destructive attitudes.
- Increased flexibility leads to
  - responsiveness to the subtle interplay between doctor and patient
  - Tolerance to the uncertainty present in any clinical situation with any patient

◄ Models of Doctor-Patient Relationship (Szasz and Hollender Classification)

1. The mutual participation model (the best model)
   a. Treating physician and patient are responsible of the therapeutic process
   b. Decisions are satisfactory to both parties
   c. The most appropriate model for chronic diseases

2. The active-passive model
   a. Treating physician is responsible of the therapeutic process regardless of patient cooperation
   b. Decisions may not be satisfactory to both parties
   c. The most appropriate method for some emergencies

3. The guidance-cooperation model (teacher-student, parent–child model)
   a. Treating physician is responsible of the therapeutic process and the patient cooperates
   b. Decisions may not be satisfactory to both parties
   c. The most commonly used method in medical practice

4. The friendship (socially intimate model)
   a. May arouse boundary issues

◀ Aims of the Psychiatric Interview

- **Obtain** the necessary information in order to:
  - Make a diagnosis and generate a treatment plan
  - Document patient details in a readable format
- **Understand** the person with the illness
- Understand the **circumstances** of the patient
- Form a therapeutic relationship with the patient (rapport)
  - Best established by first asking the patient about themselves (e.g. what do you do for a living?, what do you do for fun?)
- Provide the patient with information about the illness, recommendation and prognosis

TABLE 2–1. Outline of the psychiatric evaluation

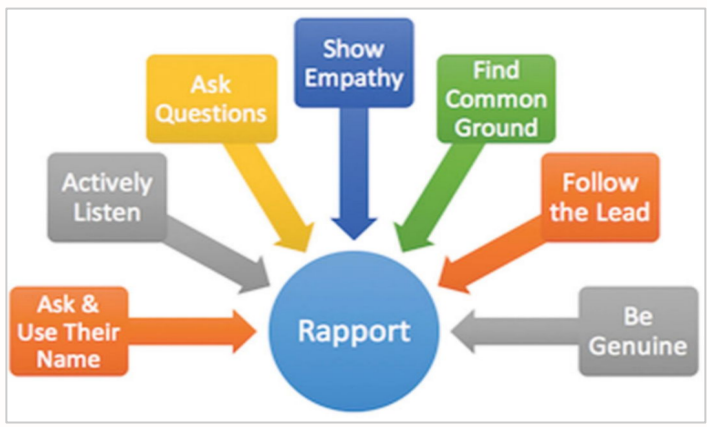
Identification of patient and informants
Chief complaint
History of present illness
Past psychiatric history
Family history
Social history
General medical history
Mental status examination
General physical examination
Neurological examination
Diagnostic impression
Treatment and management plan

◀ Interview Opening: General Advice

1. Introduce yourself and greet the patient by name
2. Reassure privacy and **confidentiality**, separate room.
3. Put patient at ease
   a. L-shaped position, No intervening disk, Not directly in front of each other.
4. Suitable distance (e.g. with a geriatric or an aggressive patient)
5. Be supportive, attentive, non-judgmental and encouraging
   a. Adding a subtle sentence such as لا قدّر الله after mentioning a seemingly taboo act still carries a judgemental flavour, (e.g., have you ever لا سمح الله consumed alcohol?)
   b. Judgement may be verbal or nonverbal
6. Explain the purpose of interview and expected time needed
7. Observe the patient's nonverbal behavior and avoid excessive note-taking
   a. People with persecutory delusions might become apprehensive in such circumstances
8. With whom you will start (the patient or their relative)
   a. The source of information should be mentioned in the summary
   b. Rate the adequacy of the obtained information and opine on the need of more details
   c. Determine the reliability of the informant (explained in page 4)
9. Why did they come with a relative? (psychosis vs. neurosis)
10. Start with open ended questions (Then be more specific)
    a. Ideally each patient should be observed talking freely without interruptions for 3-4 minutes. This serves to evaluate the coherency of the thought process and narrows the list of differential diagnoses.
    b. Close-ended questions are used either when time is lacking or a specific piece of information needs to be obtained
11. Diagnose based on criteria and constellation of symptoms that affect functioning level (e.g. Social phobia VS paranoid schizophrenia)

◀ Six Strategies to Develop Rapport

1. Putting patient **at ease**
2. Finding patient's pain and **expressing compassion**
3. Evaluating patients' insight and **becoming an ally**
4. Showing **expertise**
5. Establishing **authority** as a physician or therapist
6. **Balancing** the roles of empathic listener, expert, and authority



Interview Skills and Techniques

1	Reflection	A doctor repeats to a patient in a supportive manner something that the patient has said
2	Facilitation	Doctors help patients continue in the interview by providing both verbal and nonverbal cues
3	Silence & Empathy	To allow freedom of expression and assess the patient thought navigational process - Sympathy: Emotional acknowledgment of other people's distress - Empathy: Emotional acknowledgement plus understanding the reasoning behind the distress
4	Confrontation	Meant to point out to a patient something that the doctor thinks the patient is not paying attention to, is missing, or is in some way denying. (e.g., a patient who avoids attending the holiday festivities with his family, the psychiatrist might suggest a probable cause, such as avoiding a certain individual)
5	Clarification	Attempt to get details from patients about what they have already said • An attempt should be made to clarify the vagueness of a chief complaint
6	Interpretation	Most often used when a doctor states something about a patient's behavior or thinking that a patient may not be aware of.
7	Summation	Periodic summarization of what a patient has said thus far.
8	Explanation	Explain treatment plans to patients in easily understandable language and allow patients to respond and ask questions
9	Transition	Allows doctors to convey the idea that enough information has been obtained on one subject; the doctor's words encourage patients to continue on to another subject • It describes a transition across different areas of the history structure, the transition should be smooth and non-interruptive
10	Self-revelation	Limited, discreet self-disclosure by physicians may be useful in certain situations, and physicians should feel at ease and should communicate a sense of self-comfort - Though the placement of boundaries is still pivotal
11	Positive reinforcement	• Positive reinforcement: A behaviour is encouraged by introducing a pleasant stimulus/ or promise • Negative reinforcement: A behaviour is encouraged by removing an aversive stimulus • Positive punishment: A behaviour is discouraged by introducing an aversive stimulus • Negative punishment: A behaviour is discouraged by removing a pleasant stimulus
12	Reassurance and advice	
13	Obstructive technique	

- **Transference**
  - The patient is transferring feelings toward others in their life onto the physician
  - For example if a patient had problems with their father they unintentionally redirect these emotions to their physicians as they might see him as a father figure becoming angry or attacking
- **Countertransference**
  - Emotional reactions to the patient from the doctor
  - Often involves the doctor's past experience/relations, For example when a pt reminds the dr of an old pt that he saw, the dr may treat this pt the same as the old.

The Psychiatric patient history

- It is the chronological story of the patient's life from birth to present
- It includes information about who the patient is, his problem (Bio-Psycho-Social aspects) and its possible causes and available support
- Information elicited both from the patient and from one or more informants

1. Personal Information

- Identification of the patient: (name, age, nationality, sex, marital, education, job, residency) Age serves in narrowing your differential diagnosis, the occupation gives an indication on the functional status of the patient
- Referral source & reason: brief statement of how the patient came to the clinic and the expectations of the consultation
- Chief complaint: exactly why the patient came to the psychiatrist, preferably in the patient's own words (a verbatim statement): If vague, ask for a clarification
- Duration
- **Source of information:** always mention the source of information when summarizing the history and rate its adequacy and the need for more details
- **Reliability**: Refers to the consistency of the self-reported information of the patient. (e.g., a psychotic patient who is in a continuous belief that they are the antichrist may very well be considered reliable). The determinant is the consistency of information with other reported information, the degree of contradictions is the most important indicator of reliability (e.g., contradictions may expose malingering patients)

2. History of Presenting illness

- Chronological background of the psychiatric problem (nature, onset, severity, course).
- Review of the relevant problems
- Precipitating & relieving factors
- Check for function: effects on the patient (social life, job, family...)
- Any medical intervention (seek medical advice, medication {nature and effect})
- Symptoms not mentioned by the patient
- Important negatives (e.g., history of mania in depressed patient)
- Don't forget S.O.A.P.
  - S: Suicidal & homicidal.
  - O: Organisity (e.g. traumatic brain injury, hypothyroidism or Parkinson's etc...)
  - A: Addiction
  - P: Psychosis: (e.g., delusion, hallucination) should lead to prompt safety evaluation of the patient. Delusions should be differentiated from overvalued ideas, delusions are fixed and are often believed with full certainty, whereas overvalued ideas have a healthier degree of doubt.
- Ask for support, Stressors

3. Past Medical & Surgical History

- **Psychiatric:** any previous illness (nature,dates,treatment.outcome),inpatient admission/emergency visits, biological and psychosocial treatment
- **Medical and surgical** (follow-up, admission (number, duration and reason, all major illnesses should be listed)
- **Medications** (Name, dose, response, side effects), Drug/food allergies.
- Don't forget (head trauma, epilepsy, thyroid, and systematic review)
- To summarize: hospitalization should be listed in a chronological (1) age of the first hospitalization, (2) number of hospitalizations, (3) detailed description of each event (e.g. complaint, treatment, presence of manic episodes in depressed individuals), with the additional usual questions of past medical and surgical history.

4. Family History

- Parents (age, consanguinity, illness, if died mention age and cause of death, and patient's age at that time)
- Psychiatric illnesses in other first and 2nd degree relatives (siblings grandparents, uncles, aunts, nephews, & nieces)
- Positive history of (psych, drug, homicide, suicide, substance abuse)
- Relationship between patient and family and order between siblings

5. Social History

- Childhood (preg. Development).
- Schooling (age, level ,performance, relations, misconduct).
- Marital (age, consanguinity, children, relation past & current).
- Occupation (age, duration, relation, performance).
- Forensic (arrest, prison & why).
- Social (living situation, financial stat, support).
- Don't forget detail & reason of any (stop of school, change or quit of job, divorce & other wife's)
- If the patient is unemployed inquire about previous occupations, a history of firings may be relevant in narcissistic personalities

6. Premorbid Personality

(A description of the patient's personality traits prior to the onset of the disorder)

- How is it described by others?
- Prevailing mood
- Social skills
- Hobbies
- Impulsivity: (e.g., relationships, decisions, eating and sexual behaviors), it is often marked by a follow-up sensation of regret. Planned actions that are conventionally deemed inappropriate (e.g., drifting, criminality, serial killing) are not necessarily impulsive
- Coping

7. Personality Traits

- Attitude to self (self-appraisal, performance, satisfaction, past achievements and failures, future).
- Moral and religious attitudes and standards
- Prevailing mood and emotions
- Reaction to stress (ability to tolerate frustration and disappointments, pattern of coping strategies)
- Personal interests, habits, hobbies and leisure activities
- Interpersonal relationships.

8. Summary & Formulation

- Current symptoms
- Precipitating factors.
- Brief past psychiatric history
- Predisposing factors (biopsychosocial).
- Safety.
- Important points in treatment

9. Diagnosis & Management

- Biopsychosocial in assessment & treatment.
- Short & long term treatment
- Be specific, (e.g. I'll start patient on Risperdal 2mg NOT I'll start patient on atypical antipsychotic).
- Education of patient & family.

The mental status examination

- MSE is a cross-sectional (one point in time), systemic documentation of the quality of mental functioning at the time of interview.
- It is the psychiatric equivalent of a physical examination
- It serves as a baseline for future comparison and to follow the progress of the patient
- it is an Observation of patient's feelings, thoughts, perception, and behavior during the interview

TABLE 2–2. Outline of the mental status examination

Appearance and attitude	General information
Motor activity	Calculations
Thought and speech	Capacity to read and write
Mood and affect	Visuospatial ability
Perception	Attention
Orientation	Abstraction
Memory	Judgment and insight

1. Appearance

- Bodybuild
- Grooming (Self-care. Including hygiene, clothes, hair, or nails)
- Facial expressions
- Signs of chronicity: Weight loss, stated-age appropriateness (If patient looks older than their stated age suspect chronic disease or substance abuse)

Others

- **Substance abuse signs**
  - Pupil size: Drug intoxication/withdrawal
  - Needle marks/tracks: Drug use
  - Appearance older than the stated age
- **Physical harm signs**
  - Bruises in hidden areas: ↑ suspicion for abuse.
  - Superficial cuts on arms: Self-harm.
- Eroding of tooth enamel: Eating disorders (from vomiting)(e.g., bulimic patients)

2. Behaviour

- Both the quantitative and qualitative aspects.
- Level of activity
- Posture and eye to eye contact
- Unusual movements (tics, grimacing, tremor, disinhibited behaviour, catatonia hallucinatory gestures,...etc.)(Discussed in other lectures)

3. Attitude

- Verbal & non verbal
- interested, bored, cooperative, uncooperative, sarcastic, guarded or aggressive
- Disinhibition

4. Mood

- Mood (Mood=thymya, e.g. dysthymia = low mood) is the **self-reported emotion** that the patient tells you about (symptom)
- low, depressed, ,happy, anxious, ok(discussed in other lectures)

5. Affect

- Affect is the perceived emotional state **observed** by **Doctor** (sign)

1. **Type of affect:** Euthymic, euphoric, neutral, dysphoric.
2. **Range or variability** describes the depth and range of the feelings shown. Parameters: flat (none), blunted (shallow), restricted or constricted (limited), full (average), intense (more than normal).
3. **Motility** describes the quickness in shifting between emotional states. Parameters: sluggish, supple, labile
4. **Appropriateness** to content describes whether the affect is congruent with the subject of conversation or stated mood. Parameters: appropriate, not appropriate.
5. Nature (e.g. anxiety, depression, elation...).

Mood	Affect
• The long term feeling state through which all experience are filtered. • The emotional background • Last days to weeks. • Changes spontaneously, not related to internal or external stimuli. • Symptom (ask patient)	• The visible and audible manifestations of the patient emotional response to external and internal events • The emotional foreground • Momentary, seconds to hours (Current emotional state) • Changes according to internal & external stimuli • Sign (observed by others)

6. Speech

1. Quantity or rate of production: pressured, slowed, regular
2. Quality: (a) rhythm (i.e., prosody), (b) articulation: dysarthria, stuttering
3. Accent/dialect
4. Volume, flow and tone
5. Coherence, continuity, spontaneity and speech impairments (stuttering, dysarthria, etc..)

7. Thoughts (inferred from speech)

Form	Content
The way in which a person puts together ideas and associations. Examples (all are discussed in signs and symptoms lectures) • Goal-directed thinking • Loosening of associations or derailment • Flight of ideas • Tangentiality • Circumstantiality • Word salad or incoherence • Neologisms • Clang associations (rhyming) • Punning (double meaning) • Thought blocking	What a person is actually thinking about. Examples (all are discussed in signs and symptoms lectures) • Delusions • Preoccupations • Obsessions and compulsions • Phobias • Suicidal or homicidal ideas • Ideas of reference and influence • Poverty of content

Thought stream: Pressured thought, poverty of thought, and thought block

8. Perception

- **Illusion**: misinterpretation of an external stimulus
- **Hallucinations**: No external stimulus

  - Which sensory system (e.g. auditory, visual..etc...)

  - Content

  - person: 2nd person (imagined speech directed to the patient), 3rd: (imagined group of people talking about the patient)

  - Patient reaction to hallucination

  - Hypnagogic hallucinations (before sleep), hypnopompic hallucinations (after waking up)

  - Pseudohallucinations: recognized by the person as being unreal
- **Depersonalization and derealization**: extreme feelings of detachment from the self or the environment
- **Formication**: The feeling of bugs crawling on or under the skin

9. Cognitive Functions

A. **Cognitive functions:**

- Consciousness level and orientation (to rule out delirium)
- Attention and concentration: Spelling a word backward, serial 7 test (also a test of calculation, confounder is level of education), if unable to perform → serial 3 test → weekdays in backward

B. **Abstract VS concrete thinking** (prefrontal cortex)

i. It is the ability to deal with concepts and to make appropriate inferences.

ii. Inability to comprehend abstract thought is termed concrete thinking, which is abnormal

iii. It can be tested by

1. Similarities: ask the patient to tell you the similarity between 2 things (e.g. car and train), and the difference between 2 things (e.g. book and notebook)

2. Proverbs: ask the patient to interpret one or two proverbs (e.g. people in glass houses should not throw stones) the patient may give a concrete answer (e.g. stones will break the glass)

C. **Visuospatial Ability** (parietal, occipital cortices): When brain pathology is suspected: Ask the patient to copy a figure such as interlocking pentagons

D. **Judgment**:

i. The patient's predicted response and behaviour in imaginary situation. E.g. Asking what he/she would do in a fire. From recent history. Judgement is assessed by scenarios and placing obstacles. (e.g., you smelled smoke in the house and you're highly suspicious of fire eruption, what are you gonna do? If the patient answered with "I am going to call the fire department, of course." You must then place an obstacle "Let's say you didn't have a phone with you", ideally you should impose three to four obstacles.

9. Cognitive Functions cont.

E. **Insight**

(1) **Complete denial of illness -> Lack of insight**
(2) **Slight awareness of** being sick and needing help but refusing care -> **Partial insight**
(3) **Awareness of being sick** but blaming it on others, on external factors, or on organic factors. Awareness that illness is due to something unknown in the patient.
(4) **Intellectual insight**: admission that the patient is ill and that symptoms or failures in social adjustment are due to the patient's own particular irrational feelings or disturbances without applying this knowledge to future experiences
(5) **True emotional insight:** emotional awareness of the motives and feelings within the patient and the important people in his or her life, which can lead to basic changes in behavior ○ Patient's compliance with psychiatric treatment depends on his insight.

Patient's compliance with psychiatric treatment depends on his insight.

Alternative classification:

1. Full-complete insight: They know they have a disease + knows they need treatment
2. Partial insight: know they have a disease but treatment isn't needed OR thinks they don't have a disease but believes treatment helps them
3. Poor Insight: Thinks he doesn't have disease and doesn't need treatment.

Or you may describe it as present or absent, though this is not preferred

F. **Language and reading**

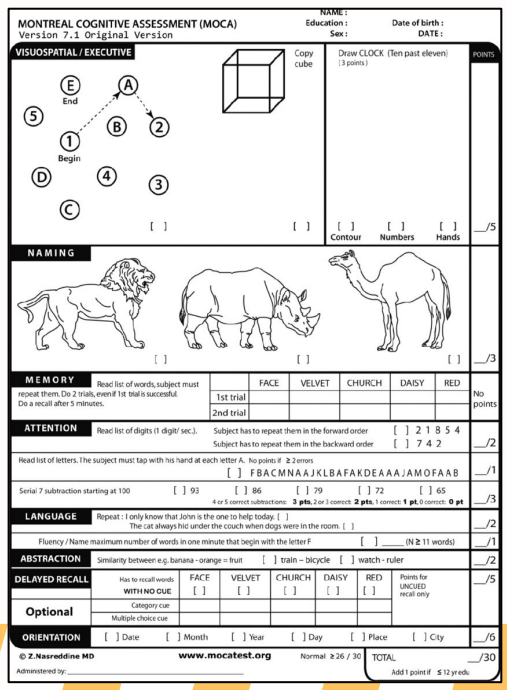
1. Nominal aphasia: name two objects (e.g. a pen and a watch)
2. Expressive aphasia: repeat after you certain words
3. Receptive aphasia: carry out a verbal command
4. Reading comprehension: read a sentence with written command (e.g. close your eyes)

h. **Memory**

1. Immediate memory / Registration (Spell the word "world" backward) (sensory cortices)
2. Short term memory E.g. give pt three words and ask about them after 5 mins (sensory cortices + prefrontal cortex)
3. Recent memory E.g. asking about recent national event (prefrontal cortex and temporal lobe)
4. Remote memory (long-term memory) E.g. asking about pt's graduation (temporal lobe)

◀ Bedside Cognitive Assessment

1. MoCA: Montreal Cognitive Assessment
2. MMSE: Mini-mental state examination
   - All will be discussed more fully in neurocognitive disorders lecture
   - There are numerous other tests but these were the discussed ones


MONTREAL COGNITIVE ASSESSMENT (MOCA)
Version 7.1 Original Version

NAME :
Education :
Sex :
Date of birth :
DATE :

VISUOSPATIAL / EXECUTIVE — POINTS
Copy cube
Draw CLOCK (Ten past eleven) [3 points]
[ ] Contour [ ] Numbers [ ] Hands __/5

NAMING
[ ] [ ] [ ] __/3

MEMORY — Read list of words, subject must repeat them. Do 2 trials, even if 1st trial is successful. Do a recall after 5 minutes.

	FACE	VELVET	CHURCH	DAISY	RED	No points
1st trial						
2nd trial						

ATTENTION — Read list of digits (1 digit/ sec.). Subject has to repeat them in the forward order [ ] 2 1 8 5 4. Subject has to repeat them in the backward order [ ] 7 4 2 __/2
Read list of letters. The subject must tap with his hand at each letter A. No points if ≥ 2 errors
[ ] F B A C M N A A J K L B A F A K D E A A A J A M O F A A B __/1
Serial 7 subtraction starting at 100 [ ] 93 [ ] 86 [ ] 79 [ ] 72 [ ] 65
4 or 5 correct subtractions: 3 pts, 2 or 3 correct: 2 pts, 1 correct: 1 pt, 0 correct: 0 pt __/3

LANGUAGE — Repeat : I only know that John is the one to help today. [ ] The cat always hid under the couch when dogs were in the room. [ ] __/2
Fluency / Name maximum number of words in one minute that begin with the letter F [ ] ____ (N ≥ 11 words) __/1

ABSTRACTION — Similarity between: e.g. banana - orange = fruit [ ] train – bicycle [ ] watch - ruler __/2

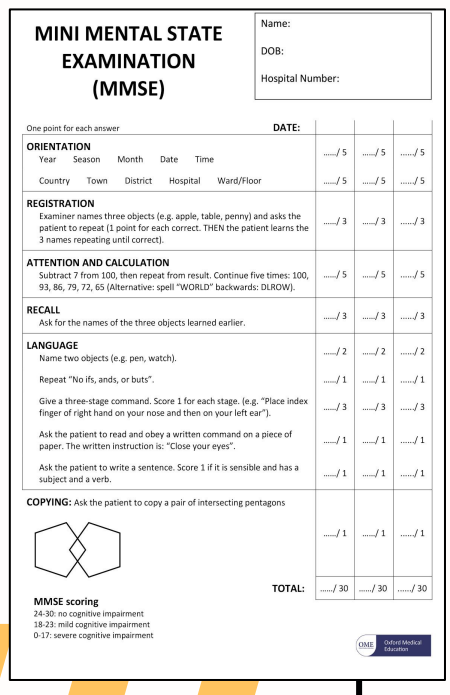
DELAYED RECALL — Has to recall words WITH NO CUE

	FACE	VELVET	CHURCH	DAISY	RED	Points for UNCUED recall only
	[ ]	[ ]	[ ]	[ ]	[ ]	
Optional: Category cue						
Optional: Multiple choice cue						

__/5

ORIENTATION — [ ] Date [ ] Month [ ] Year [ ] Day [ ] Place [ ] City __/6

© Z.Nasreddine MD www.mocatest.org Normal ≥ 26 / 30
TOTAL __/30
Administered by: _____ Add 1 point if ≤ 12 yr edu.


MINI MENTAL STATE EXAMINATION (MMSE)

Name:
DOB:
Hospital Number:

One point for each answer — DATE:

ORIENTATION Year Season Month Date Time	...../ 5	...../ 5	...../ 5
Country Town District Hospital Ward/Floor	...../ 5	...../ 5	...../ 5
REGISTRATION Examiner names three objects (e.g. apple, table, penny) and asks the patient to repeat (1 point for each correct. THEN the patient learns the 3 names repeating until correct).	...../ 3	...../ 3	...../ 3
ATTENTION AND CALCULATION Subtract 7 from 100, then repeat from result. Continue five times: 100, 93, 86, 79, 72, 65 (Alternative: spell "WORLD" backwards: DLROW).	...../ 5	...../ 5	...../ 5
RECALL Ask for the names of the three objects learned earlier.	...../ 3	...../ 3	...../ 3
LANGUAGE Name two objects (e.g. pen, watch).	...../ 2	...../ 2	...../ 2
Repeat "No ifs, ands, or buts".	...../ 1	...../ 1	...../ 1
Give a three-stage command. Score 1 for each stage. (e.g. "Place index finger of right hand on your nose and then on your left ear").	...../ 3	...../ 3	...../ 3
Ask the patient to read and obey a written command on a piece of paper. The written instruction is: "Close your eyes".	...../ 1	...../ 1	...../ 1
Ask the patient to write a sentence. Score 1 if it is sensible and has a subject and a verb.	...../ 1	...../ 1	...../ 1
COPYING: Ask the patient to copy a pair of intersecting pentagons	...../ 1	...../ 1	...../ 1
TOTAL:	...../ 30	...../ 30	...../ 30

MMSE scoring
24-30: no cognitive impairment
18-23: mild cognitive impairment
0-17: severe cognitive impairment

Oxford Medical Education

◄ Miscellaneous Tests

- **IQ (Intelligent quotient)** is a test of **intelligence** with a **mean of 100** and **a standard deviation of 15**
- An **IQ** of **100** signifies that **mental age equals chronological age**
- **Intelligence tests** assess cognitive function by evaluating comprehension, fund of knowledge, math skills, vocabulary, picture assembly, and other verbal and performance skills. Two common tests are:

- **Wechsler Adult Intelligence Scale (WAIS):**
  - Most common test for ages **16–90.**
  - Assesses overall intellectual functioning.
  - Four index scores: Verbal comprehension, perceptual reasoning, working memory, processing speed.
- **Wechsler Intelligence Scale for Children (WISC):** Tests intellectual ability in patients ages 6–16.

IQ Chart
Very superior: >130
Superior: 120–129
High average: 110–119
Average: 90–109
Low average: 80–89
Borderline: 70–79
Extremely low (intellectual disability): <70

◄ Concluding the Interview

- Differential diagnoses
- Provisional (working) diagnosis
- Management plan: Acute or chronic, outpatient Vs. inpatient, Biopsychosocial treatment, address safety concerns, investigations (CBC, LFT, TSH)
- Full explanation about the plan (S/E, efficacy, risk of addiction, and any other questions from the patient)
- Prognosis
- Doctors explain treatment plans to patients in easily understandable language and allow patients to respond and ask questions.

- Professional Boundaries (It's the doctor's responsibility to maintain it)

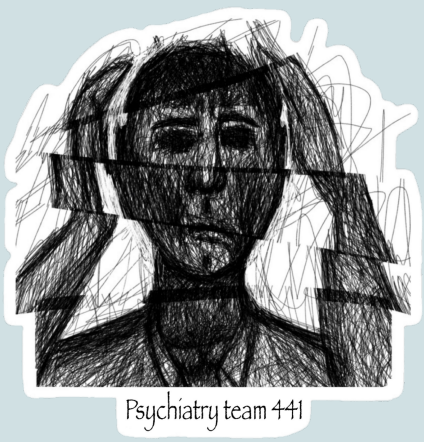
Difficult Doctor-Patient: (Relationships)
  - The Seductive Patient
  - The "Hateful" Patient
  - The Patient With a Thousand Symptoms
  - The Patient in the Hospital Setting
  - The Mentally Disturbed Patient
  - The Dying Patient

Team leader

- **Saleh Aloraini**

Team members

- Abdulrahman Aljofan
- Faisal Alhusaini
- Alwaleed Bin shaya
- Faisal Bin moammar
- **Mishari Alzoubi**
- Abdulmajeed Namshah
- Abdulrahman bawazir
- Abdulmalik Alduraibi
- Hamad Alothman
- Sultan Alkassim
- Faisal Alshuaibi
- Abdullah Alyamani
- Talal Alanazy
- Yahya Alghamdi
- Osama Alsaaid



Good luck!!

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Special thanks to 439 & 438 psychiatry teams