

Human Behavior Course 2000
TEST QUESTION CHALLENGES
FINAL EXAMINATION

SUMMARY: 28 questions were challenged, 9 by more than one student. Of those questions that were challenged, I added one or more correct responses to the previously answer-keyed responses in 9. Of the 9, 2 questions are a “freebies” for all. The tests will be scored at MDL, and final grades will be personally emailed to you in case you are not in the area to look them up. The email will go out late this week or early next week. It will describe the curve for the course, your score and grade for the course, the curve for the final exam, your score and grade on the final, your score and grade on the midterm, your attendance in small groups as we have it recorded, and whether or not you were penalized or helped by your participation or lack of it in the small groups. **IF YOU PREFER THAT WE DO NOT EMAIL YOUR CLASS PERFORMANCE TO YOU, PLEASE SEND A GROUPWISE EMAIL TO JENNIFER STECKLEIN OR ME.**

If you have thoughts about how to improve the course, please email them to Rosalyn Sim so she can pull them together for me to review anonymously. She needs them for her After Action Report too.

I am looking for 3 and perhaps 4 students from your year group who would be interested in sitting in on one or two (maybe even three) psychiatry department meetings in the August-September 2000 time frame (meetings are an hour long or so). The department reviews the course and that review would greatly benefit from constructive input from members of your class. I know this class is far from perfect, and I want to keep making it better (believe me, it is much better this year than last!). If you volunteer to help review the course, please do it in the spirit of improving the course for future students. I am not afraid to address the problems in the course, but a litany of complaints with no ideas for change only promotes a sense of departmental helplessness about the course and obstructs any chance to make the course into what students want it to be.

THANK YOU ALL for your very hard work in my course and the other courses at USUHS. We (the faculty) do it for you – you are the future of military medicine. I thank you all for your patience with this second of two “rebuilding years” for the Human Behavior Course. Because of your input, I hope to make the entire course as memorable for USUHS students as Dr. Gemelli’s lectures seem to be each year. Psychiatry is a wonderful specialty filled with terrific colleagues and great clinical and intellectual challenges. I want this course to more accurately convey that. If you find yourself interested in psychiatry as a career, you won’t be disappointed.

WARM REGARDS (and see you around),

Chuck Engel

Charles C. Engel, Jr., MD, MPH
Course Co-Director
Human Behavior Course 2000

Question 5

STUDENT COMMENTS...

1. On page 408 of the Textbook of Psychiatry it states that "Cannabinoids can be detected in the urine up to 21 days after abstinence in chronic abusers due to fat redistribution; however, 1-5 days is the normal urine positive period." I make the assertion that answer E (21 days) should be counted as correct in addition to answer B (1-7 days).
2. Urine samples positive after cannabinoids use up to ... Challenge E. 21 days is correct. Text p408 "cannabinoids can be detected in the urine up to 21 days ... however 1-5 days is the normal urine positive period." Question specifically asks "up to". Although 1-5 days may be the norm, there is enough positive urine tests at 21 days to include this date. E should be correct.
3. On page 408 of the textbook, it states that... "Cannabinoids can be detected in the urine up to 21 days after abstinence in chronic users due to fat redistribution; however 1-5 days is the normal urine positive urine period." The exam question is not clear if it is referring to a single use of cannabinoid in a 1st time user or in a chronic user. Depending on one's interpretation of to whom the question is referring either (B) or (E) is correct.
4. Could answer E be acceptable as well, as p.408 of the text indicates cannabinoids may be detected up to 21 days after abstinence. It seems the disagreement lies in the test's sensitivity in a new user vs. a chronic user.

DR. ENGEL'S RESPONSE...

ANSWER REMAINS B. *The question asks how long a positive urine test may be found "after a single use." Chronic cannabinoid use necessarily involves multiple drug administrations over time; therefore the high-end estimates of half-life do not apply.*

Question 8

STUDENT COMMENTS...

One student challenged this item stating they had called somewhere and learned that their was no such thing as "drugs anonymous" and that it should be considered a correct response.

DR. ENGEL'S RESPONSE...

CORRECT ANSWERS ARE A, B, C, D, E. *On my own further assessment of this item, I've decided that it is a poor question, so I've decided everyone will get credit for a correct answer.*

Questions 15

STUDENT COMMENTS...

1. Because this question specified 'treatment-resistant depression,' I assumed the present medication/treatment regime was failed which would intuitively include any possible dose modifications, in which case, based on this interpretation of the question, I would argue that choice E should be accepted. Had the question specified that an initial dosing regime had failed, of course the next move is to up the dose within safe limits.
2. The book supports answers C and E on p. 1051 under Treatment for Refractory Depression. (I answered E) "For patients with true nonresponse and for those who

achieve only partial response, treatment options include switching to another antidepressant and using an augmentation strategy...Whether to switch antidepressants or augment depends on the severity of illness, side effects of current meds and patient's willingness...A patient with milder illness, significant side effects of the current medication and a general uneasiness about taking medication will probably be better off if the medication is switched to a different, single antidepressant." The question said "treatment resistant" so I assumed dosage alone was not the issue.

DR. ENGEL'S RESPONSE...

ANSWER REMAINS D. *"Treatment-resistant" depression is treatment that is not responding to treatment. To know that a person is "treatment non-responsive" (a step past treatment-resistant in the scale of treatment response versus non-response) an adequate trial of treatment has to have been attempted. An adequate trial of medication requires adequate doses for an adequate duration of time. The most common reason for treatment failures is inadequate medication trials. Therefore, the first thing to consider when seeing a patient that has yet to respond to treatments (no matter how many treatments have been tried in the past) is whether the current treatment being tried has received an adequate trial. If it has not, then before switching to anything else, it should receive an adequate trial (or else the attempt to see if that particular medication can work for the patient has been wasted). Therefore, step one is to consider whether the dose of the current medication can be increased or offered for a longer period of time. If not (most often because side-effects or other risks preclude a drug dosage increase) then one would next consider changing medications or augmentation or ECT depending on the specific clinical circumstances. For practical purposes, you would not consider terminating therapy unless the patient was refusing further intervention and did not represent an immediate danger to self or others (in the latter case, some emergency intervention such as hospitalization would be indicated even if the patient was refusing further treatment).*

Question 22

STUDENT COMMENT...

The question wants to know, "Dissociative disorders are MOST common in patients with:".... The correct answer per the key is listed as E (Both A and D responses which are "A-Borderline personality disorder" and "D-a history of physical or sexual abuse"). I make the argument that only answer D is correct. On pages 714-715 of the textbook, much discussion is devoted to the link between trauma and/or abuse and dissociative disorders. Borderline personality disorders are discussed, but only when there is a background of childhood abuse. On page 714 it states, "Similarly, evidence is accumulating that dissociative symptoms are more prevalent in patients with Axis II disorders such as borderline personality disorder when there has been a history of childhood abuse." That statement makes dissociative disorders MOST common in patients with a history of physical or sexual abuse and therefore answer D is MOST correct.

DR. ENGEL'S RESPONSE...

ANSWER REMAINS E. *Page 808 table 22-8 in the course text lists the criteria for Borderline Personality Disorder. Criteria 9 states, "transient, stress-related paranoid ideation or severe dissociative symptoms." As the student notes, abuse is also strongly*

associated with dissociation, and within the spectrum of Borderline Personality Disorder abuse is associated with greater dissociation. Nonetheless, dissociation is an integral characteristic of Borderline Personality Disorder, even apart from past abuse (i.e., many patients with Borderline Personality Disorder have not been abused, but still manifest dissociation as a key component of their personality.)

Question 37

STUDENT COMMENT...

Two answers - D&E, On page 240 of our notes, the instructions for the GAF scale says "Do not include impairment in functioning due to physical (or environmental) limitations" (E)

DR. ENGEL'S RESPONSE...

CORRECT ANSWERS ARE D AND E. *The challenge is correct – I'll give credit for either response.*

Question 47

STUDENT COMMENT...

1. Should be 'B', Page 986 says "Individuals with anorexia nervosa who engage in self-induced vomiting or who abuse laxatives and diuretics are liable to develop hypokalemic ALKALOSIS" not ACIDOSIS so be should be FALSE and therefore the right answer.
2. #47 Choice B should be accepted as well. P.986 of the text specifies that anorexia patients often suffer from hypokalemic ALKYLOSIS as a consequence of self-induced vomiting and/or laxative abuse, not ACIDOSIS as was suggested in choice B.
3. Asks what is not a medical complication of anorexia nervosa. Key states D. Decreased renal function. Challenge B. hypokalemic acidosis is also correct. Tezt p986 states "individuals with anorexia nervosa who engage in self-induced vomiting or abuse laxatives and diuretics are liable to develop hypokalemic alkalosis." Hypokalemic alkalosis is a common medical complication of anorexia, NOT hypokalemic acidosis! So B is also correct
4. There are two potential right answers. While answer (D) is correct, answer (B) is also correct. On page 986 of the text the section entitled "Medical Complications" lists hypokalemic alkalosis, not acidosis, as a potential complication. Therefore answer (B) is also correct.
5. Page 986 of the text states that "individuals with anorexia nervosa who engage in self-induced vomiting or who abuse laxatives and diuretics are liable to develop hypokalemic alkalosis. At no point in the section on 'Medical Complications' does the text mention a hypokalemic acidosis. Thus (B) should be accepted as a correct answer.
6. Both (B) and (D) are correct. On page 986 of our text, it states that "Individuals with anorexia nervosa . . . are liable to develop hypokalemic ALKALOSIS" not acidosis.
7. according to p. 986, top of second column, hypokalemic ALKALOSIS is a complication of anorexia nervosa, not hypokalemic ACIDOSIS. Therefore B should be considered a correct response, because hypokalemic acidosis is not a medical complication of anorexia nervosa.

8. The question concerns medical complications of anorexia nervosa (an “all of the following EXCEPT” type question). The keyed answer is listed as D (decreased renal function). This answer is correct, however answer B (Hypokalemic acidosis) is also correct. On page 986 of the textbook it discusses various complications of anorexia nervosa and states that patients are “liable to develop hypokalemic **alkalosis**” not acidosis. Therefore, I contend that both answers B and D should be counted as correct.

DR. ENGEL’S RESPONSE...

CORRECT ANSWERS ARE B AND D. *The challenges are correct – I’ll give credit for either response.*

Question 50

STUDENT COMMENTS...

1. This is a difficult question because the text (p.727) indicates that the ‘Trance’ disorder is ubiquitous around the world and is so common that many scholars question its inclusion in DSM IV as a diagnosis, suggesting that its prevalence might indicate a culturally-based norm rather than a disease state. Based on my reading of the text, if the dissociative trance is to be included as a variant of dissociative disorders, then surely choice E could be as acceptable as A. Had the question stipulated ‘western culture’ or in a ‘secular setting’ then of course choice A is correct. I think, however, the wording of the question combined with the description in the text make choice E plausible.
2. Asks what is the MOST common of all dissociative disorders. Key states A. Dissociative amnesia. Challenge E Dissociative trance disorder is also correct due flawed wording in text. Text 728 "The trance and possession categories of dissociative trance disorder constitute by far the most common kind of dissociative disorder around the world." Both A and E should be accepted due to the text claiming both of them are the most common!

DR. ENGEL’S RESPONSE...

CORRECT ANSWERS ARE A AND E. *I’ll give credit for either response, since the book is terribly confusing on this point. Page 716 column 2 para 3 notes, “Dissociative amnesia is considered the most common of all dissociative disorders”. In contrast, page 728 column 1 para 1 states, “The trance and possession categories of dissociative trance disorder constitute by far the most common kind of dissociative disorder around the world.” Note that DISSOCIATIVE TRANCE IS AN EXPERIMENTAL DISORDER LISTED ONLY IN THE APPENDICES OF DSM. IT HAS YET TO ACHIEVE (and may not ever achieve) THE STATUS OF A RECOGNIZED DSM-IV DISORDER. The book is very unclear on this point. The only clues that I can see on close scrutiny is that it is not listed under dissociative disorders in the chapter on diagnostic classification (see page 247) and it is listed as an “other” diagnosis in table 18-1 on page 712 (note also that acute stress disorder is listed in DSM as an anxiety disorder, not as a dissociative disorder, though it is discussed as if it were a dissociative disorder in the chapter on dissociative disorders. In defense of the book, this is because acute distress disorder has many characteristics that render its assignment to the anxiety disorders as a topic of ongoing discussion among psychiatric nosologists).*

Question 51

STUDENT COMMENT...

Under the treatment section for obesity in our text book on p. 998, it states that "For mild obesity (20-40% overweight) the most efficient treatment is behavior modification groups, a balanced diet, and exercise. For moderate obesity (41-100% overweight), a medically supervised protein sparing fast (400-700 calories per day) is often necessary." There is nothing mentioned in our text about commercial programs with continuous care. Therefore, (B) is the most correct answer of the choices provided.

DR. ENGEL'S RESPONSE...

ANSWER REMAINS E. *The challenger has selectively quoted the book. It actually says on page 998 under TREATMENT, "For mild obesity, the most efficient treatment to date is behavior modification in groups, a balanced diet, and exercise. This is usually done by both commercial and nonprofit large organizations."*

Question 52

STUDENT COMMENT...

At no point during the 'Epidemiology' section of factitious disorders (pp. 698 – 699) does it mention a predilection for young females. Furthermore it states on page 696, the text states that "the same patient may have different presentations across time." While this may not imply (B) is correct, I do not see where we were told that (D) was true.

DR. ENGEL'S RESPONSE...

ANSWER REMAINS D. *Page 696 of the text, column 2 para 3 notes that, "Nonprototypical Munchausen patients comprise the vast majority of patients with factitious disorders. Characterized by several authors, these patients are mostly young women with conforming lifestyles and more family support and involvement."*

Question 59

STUDENT COMMENT...

The question asks "Outpatient psychiatric consultation for the patient with somatization should focus on all of the following EXCEPT" and the answer is listed as C (finding the medical cause of the symptoms). I argue that B (Prescribing psychotropic medication) should also be counted as correct. On page 675 of the textbook, it states "Because patients with somatization disorder also frequently complain of anxiety and depressive symptoms, prescription medications for the complaints should be held to a minimum and carefully monitored." It also states that "Pharmacotherapy in the management of patients with somatization disorder must be tempered with the knowledge that these patients may take medicines inconsistently and unpredictably, may develop drug dependence, and may overdose in suicide attempts or gestures." Clearly, treatment should therefore *not focus* on prescribing medications for these patients. Thus, answer B should be counted as correct as well.

DR. ENGEL'S RESPONSE...

ALL RESPONSES WILL BE CONSIDERED CORRECT. *The single best answer is C, but given a fairly jumbled discussion of this in the book, I'll give everyone credit. The main types of medications to limit are opioid narcotics, central nervous system depressants such as sedatives and most anxiolytics, and any drug that is potentially*

lethal in overdose. However, a focus on psychotropic medications is central to the treatment plan, because patients with somatization disorder nearly always suffer from comorbid depressive or anxiety disorders that are responsive to antidepressant treatment. A focus on restoring function and reducing symptoms is clearly important. Reassurance is very important; many clinicians, however, will try to figuratively pat the patient on the head and say, "this is not serious". In order to reassure the patient, first you must understand what their concern is and reassure that concern. Usually their concern relates in some way to their personal explanation for what is causing symptoms. Finding the medical cause is very definitely NOT a central focus in treatment of somatization disorder. Chasing unlikely etiologies with low yield testing results in false positive test results that lead to further unnecessary testing or errant treatment. These unnecessary tests and treatments expose the patient to any associated risk of adverse effects with virtually no chance of success (since they are based on a false premise – that some test was positive when it wasn't truly positive).

Question 62

STUDENT COMMENTS...

1. There is possibly more than one right answer. According to page 1068 of the text, anticholinergics are the first line treatment for dystonia. Amantadine is stated as being used in those patients for whom anticholinergic drugs are contraindicated. I was unable to find any contraindications to using anticholinergics in patients with schizophrenia. Therefore, according to the Table 27-15 on page 1068, benztropine, diphenhydramine, or trihexyphenidyl can be used to treat dystonia.
2. Table 27-15 on page 1068 states that for dystonia and acute extrapyramidal side effects, benztropine, diphenhydramine, and trihexyphenidyl are indicated. According to this table, (A) (B) and (C) should be given credit.

DR. ENGEL'S RESPONSE...

ANSWER REMAINS D. To answer this question correctly, one has to recognize that urinary retention is not an extrapyramidal symptom but an anticholinergic one. A, B, C, are most effective for dystonia but they are anticholinergic and will exacerbate urinary retention. The end of paragraph 2 column 1 page 1068 says, "Patients for whom anticholinergic drugs are contraindicated require careful assessment of risk-benefit ratios before initiation of medications. Amantadine should be considered for such patients if extrapyramidal effects occur."

Question 64

STUDENT COMMENTS...

1. On page 381 of our text, it is written that "A potent antipsychotic such as haloperidol . . . may be necessary for patients with extreme agitation and hallucinations [from alcohol hallucinosis]." Therefore, (D) is the correct answer.
2. Asks the preferred treatment for hallucinations from alcohol withdrawal. Key states A benzodiazepines. Challenge D antipsychotic is correct. Text p381 "appropriate withdrawal treatment should be given to any patient with alcohol hallucinosis a potent antipsychotic such as haloperidol"
3. Choice D should be accepted as the text (p.381) clearly calls for the use of haloperidol (anti-psychotic) in cases of " . . .extreme agitation and hallucination" associated with alcohol withdrawal.

DR. ENGEL'S RESPONSE...

ANSWER REMAINS A. The book is admittedly misleading in one place on the treatment of alcohol withdrawal delirium or DTs. It says on page 381 that "sedation with benzodiazepines and treatment with neuroleptics are the standard pharmacological treatment of DTs". However page 331 column 1 para 2 states more accurately: "The alcoholic patient having withdrawal symptoms must receive appropriate intervention with thiamine and a drug such as a benzodiazepine." Similarly, page 379 column 2 para 3 says, "Benzodiazepines are preferred for withdrawal symptoms because of a relatively high therapeutic safety index, oral and intravenous routes of administration, anticonvulsant properties, and good prevention of DTs." Although neuroleptics, particularly haloperidol are often discussed as a treatment for delirium, page 331 accurately notes for delirium in general "Neuroleptic prescribing practices remain controversial..." From the lecture, slide 17 from the delirium & dementia lecture notes that benzodiazepines are the first-line therapy for CNS depressant withdrawal (alcohol is a CNS depressant). Finally, it is important to understand that alcohol-induced psychotic disorder (or alcoholic hallucinosis) is not the same as hallucinations during alcohol withdrawal. The latter is essentially alcohol withdrawal delirium (or DTs) while the former is a diagnosis that is made when heavy alcohol use rather than withdrawal results in (an unusual and idiosyncratic pattern of) hallucinations. I've only seen alcoholic hallucinosis once in my clinical career.

Question 69

STUDENT COMMENT...

Should be 'A'. The question asks what the prevalence in the GENERAL POPULATION is. The data given on page 994 of our book states that the prevalence amongst FIRST YEAR COLLEGE WOMEN is 2%. Therefore the prevalence in the general population should be lower than 2%. In fact HARRISON'S quotes the prevalence to be 1.1% amongst women and .1% amongst men which would give an overall prevalence of .5% (page 462)

DR. ENGEL'S RESPONSE...

CORRECT ANSWERS ARE A AND B. I'll give credit for either response, since figures recorded in the book (page 994) from different studies include 1) 1-3.8% of females; 2) 2% of first year female college students; 3) 0.17% of girls aged 15-29 in primary care. Therefore, the correct figure is clearly less than 5%, but could include 0.5%.

Question 82

STUDENT COMMENT...

I was under the impression that the mechanism of stimulants was in fact known. Ritalin works by blocking catecholamine reuptake. Given this fact, I believe that (D) is not worded specifically enough. The mechanism is known, how it improves ADHD is not.

DR. ENGEL'S RESPONSE...

ANSWER REMAINS E. It is true that the sympathomimetic and behaviorally activating effects of psychostimulants are well understood. However, the mechanism by which psychostimulants paradoxically REDUCE behavioral activity levels in children with ADHD is not well understood. Page 848, column 1, para 4 states, "Current concepts of the mechanism or mechanisms of psychostimulant action in ADHD are undergoing

continual revision. The largely dopaminergic, lesser adrenergic, still lesser serotonergic, and probably other pharmacological effects of the stimulants are consistent with many different (and conflicting) models of ADHD. Simple single-neurotransmitter explanations are viewed as unlikely."

Question 88

STUDENT COMMENT...

Both A and B should be accepted since info from the book supports both on p. 1385. The book says 15% of people with MOOD disorders eventually commit suicide. Another study cites 15% for both unipolar and bipolar depression combined. The bottom 3 lines of the page state "In a 30-40 year follow-up of 76 bipolar and 182 unipolar patients, the suicide rates were 8.5% and 10.6% respectively." (I thought MDD was only unipolar...?) On p. 1386 top 2 paragraphs, it says "Although sparse data are available on the rate of suicide in a treated population, clinical experience suggests that it is significantly less than 15%... the NIMH Collaborative Program on the Psychobiology of Depression found the rate of completed suicide was only 3% over 10 years."

DR. ENGEL'S RESPONSE...

CORRECT ANSWERS ARE A AND B. *Shucks – can't get away with anything with you guys (smile). 15% is a long cited and now increasingly apocryphal figure for the percentage of mood disordered or major depressive disordered individuals that eventually commit suicide. I agree with what the book on p. 1386 - "Although sparse data are available on the rate of suicide in a treated population, clinical experience suggests that it is significantly less than 15%." In fact, Simon and colleagues published a population-based study of HMO enrollees and found that overall suicide mortality rate was 59 per 100,000 person-years (about a five fold increase over the general population risk), and was significantly higher among men than women (118 vs. 36 per 100,000 person-years, respectively). Risk per 100,000 person-years was 224 among patients who received any inpatient psychiatric treatment (nearly a 20-fold increase in the general population risk) to 64 among those who received outpatient specialty mental health treatment (again, about a five-fold increased risk) to 43 among those treated with antidepressant medications in primary care (a four-fold increase in risk) to 0 among those treated in primary care without antidepressants. Simon et al conclude, "Overall suicide risk among patients treated for depression is considerably lower than previous estimates based on specialty and inpatient samples." This study is new enough that it is not cited anywhere in your book. Note that these data offer incidence estimates rather than the prevalence figure requested in the test question. Nonetheless, there is accumulating evidence that the age-old figure of 15% is probably exaggerated because it was derived by following depressed psychiatric inpatients and not depressed members of the general population. So why, do you ask, did I ask the question and make 15% the correct answer? Because it remains an often cited figure that is still frequently USED ON THE BOARDS!*

Question 94

STUDENT COMMENT...

Asks which are true statements of anorexia nervosa. Key states A. subtypes. Challenge E. excessive weight loss often leads to fatigue and hypersomnia is also

correct. Text 986 "weakness and lethargy". Fatigue and hypersomnia seems equivalent enough to weakness and lethargy that E should also be accepted.

DR. ENGEL'S RESPONSE...

ANSWER REMAINS A. *Clearly, the single BEST response is A. Fatigue and hypersomnia are not the same as weakness and lethargy, though no doubt some overlap in these symptoms probably exists.*

Question 98

STUDENT COMMENTS...

1. Cognitive errors. Challenge D is also correct. Text 1208 "personalization: linking external occurrences to oneself when there is little or no basis for making these associations." A car going haywire only when the pt is there seems to be a personalization.
2. Both choices (A) and (D) are correct. Personalization is defined by our text as "linking external occurrences to oneself" (p. 1208) which is what the person is doing in choice (D).

DR. ENGEL'S RESPONSE...

ANSWER REMAINS A. *A fuller reading of the section on personalization in Table 31-2 finds that it is defined as, "linking external occurrences to oneself (e.g., taking blame, assuming responsibility, criticizing oneself) when there is little or no basis for making these associations." In choice D, the speaker is blaming external occurrences on someone or something else (Joey) rather than to him or herself. This is actually an arbitrary inference. The speaker is linking external consequences to an occurrence with inadequate or contradictory evidence (ignoring that bad things have surely happened to the speaker when he or she was with someone besides Joey or that often things go fine when out with Joey suggesting that Joey's presence may be simply coincidental). Note that this is also what is happening in choice A. In the case of illness and the Gulf War, the veterans are usually "really sick" (i.e., they are not making it up), but they have arbitrarily linked it to the Gulf War in spite of evidence that many people who didn't go to the Gulf also have developed similar illnesses. The latter consideration would logically suggest that for most and perhaps nearly all ill Gulf War veterans, the relationship to the Gulf War is coincidental.*

Question 101

STUDENT COMMENTS...

1. This question requires a 'yard-stick' to define "effective" as used in the question. In my reading of the section on treatment of cocaine addiction in the text (p.400-2) the author indicates a 9% success rate for interpersonal therapy (choice B) vs. 59% success with relapse prevention (i.e. behavior therapy, choice C), and mentions drug urine tests (choice A) as a means of verification within a behavior therapy program, as opposed to an "effective therapy" in itself. I believe, based on a reading of the entire treatment section, that choice C should be accepted as an answer given the negative tone taken by the author regarding interpersonal therapy.
2. The question concerns the effective treatment of cocaine abuse and dependence and the answer key states the D (all of the above – drug urine test, interpersonal therapy, and behavior therapy) are correct. I contend that based on a comparison of

relapse prevention and interpersonal psychotherapy which showed the latter to be only 9% effective versus 59% effective for relapse prevention, that interpersonal therapy is not an effective treatment. This study is discussed on page 400 of the textbook. Therefore the correct answer should be either A (drug urine test) or C (behavior therapy).

DR. ENGEL'S RESPONSE...

CORRECT ANSWERS ARE A, C, and D. *The discussion of these modalities for cocaine abuse found in the text (page 400-401) is difficult to extract the "truth" from. However, I think that the following should be clear after reading it: 1) Behavioral therapies are relatively effective; 2) many of these effective behavioral approaches make effective use of the urine drug test; 3) that behavioral approaches to relapse prevention are sometimes better (i.e., in severe cocaine abuse) than interpersonal therapy; 4) that interpersonal therapy is sometimes as effective as behaviorally-based relapse prevention (i.e., in less severe cocaine abuse); and 5) there is no mention that would justify interpersonal therapy as more effective than choice C. Therefore, I'll allow choices A and C, but not B as correct responses. I will allow response D, because it could be inferred from the text that all of these show some effectiveness (the challenger's point that a 'yardstick' against which to grade the therapies is not provided in the question is well-taken). However, E is obviously incorrect given even the most superficial glance at this part of your book.*

Question 102

STUDENT COMMENT...

On table 14-17 on page 611, the DSM-IV criteria for PTSD includes duration of disturbance > 1 month. This implies (B) to be correct as well as (D).

DR. ENGEL'S RESPONSE...

ANSWER REMAINS D. *See table 14-17 on page 611 in the book. Rather than simply a "persistent concern" for at least a month, DSM states clearly that there must be persistent SYMPTOMS and goes on to specify symptoms from criterion B (symptoms involving "reexperienced trauma"), criterion C (symptoms involving "numbing" or "avoidance"), and criterion D (symptoms of "physiological arousal") must all be present for a month. "Persistent concern", while close, is not specific enough to be the correct answer. On the other hand, the table shows clearly that delayed onset PTSD requires at least a six-month period before clinical onset of symptoms occurs.*

Question 103

STUDENT COMMENTS...

1. On page 835 the text states that "conduct disorder is seen in 40-70% of children with ADHD. As this is more than the 25% stated in the question, this question is flawed and should be omitted.
2. Asks what disorder is comorbid 25% in ADHD. Key states E. all of the above. Challenge only B is correct or both B and E should be accepted. Text 835-836. Conduct disorder is comorbid 40-70% in ADHD. There is no percentage for Tourette's "overrepresented in patients with ADHD" although ADHD is comorbid in 25% of Tourette patients. The only disorder stated in text to be comorbid 25% in ADHD patients is bipolar disorder. Question did not ask which is at least 25%

- comorbid, so conduct disorder should be incorrect and there is no percentage for Tourette's so it also should be incorrect.
3. The question asks "Which of the following disorders is comorbid in 25% of ADHD patients?" The key states the correct answer is E (all of the above – Tourette's disorder, bipolar disorder, and conduct disorder). I contend that A (Tourette's disorder) and B (bipolar disorder) are correct per the textbook pages 836 and 838 respectively. However, on page 835 it states "Conduct disorder is seen in 40%-70% of children with ADHD". Therefore E is clearly not the correct answer and thus both A and B should be considered correct.
 4. The answer can not be (E). According to page 836 of the text, "at least 25% of males with Tourette's disorder have ADHD." This is different than saying that 25% of those with ADHD have Tourette's. Page 835 of the text states, "Conduct disorder is seen in 40%-70% of children with ADHD" The text does say that "about 20%-25% of children with ADHD also fulfill the criteria for bipolar disorder." Therefore, the correct answer should be (B) according to the text.
 5. Poorly worded. The question asks which disorder is comorbid in 25% of ADHD patients not which is comorbid in ATLEAST 25%. Tourette's is quoted as exactly 25%, Bipolar 20-25%, and Conduct disorders 40-70%. Therefore the BEST answer would be 'A' for the way the question was worded.
 6. According to our text, (B) is the only correct answer. On p. 838, it states that "... about 20-25% of children with ADHD also fulfill the criteria for bipolar." Choice (A) is not true because on p. 836 it states that "at least 25% of males with Tourette's disorder have ADHD" but it does NOT state that 25% of patients with ADHD have Tourette's. Choice C is not true because on p. 835 it states that "conduct disorder ... is seen in 40-70% of children with ADHD."
 7. Choice B should be the correct answer in this question. Please note that on p. 836, the text states that 25% of males with Tourettes (choice A) have ADHD NOT the other way around. The question asks what is co-morbid in 25% of ADHD cases. Furthermore, the text states on p. 835 that Conduct disorder (choice C) is present in 40-70% of ADHD patients, NOT 25%. Finally, the text specifies that bi-polar disorder (choice B) is present in 20-25% of ADHD patients. In light of the above, choice E (key answer) can not be correct. Choice B is the only correct answer.
 8. This one must have been miskeyed, because the book clearly indicates that B is the only possible choice. The last sentence, second column of p. 835 states "conduct disorder is seen in 40%-70% of children with ADHD". That eliminates choices C, D, and E. P. 836 under Tic Disorders states that "at least 25% of males with Tourette's disorder have ADHD". That is definitely NOT the same as saying 25% of ADHD patients have Tourette's. That eliminates choice A. The top of p. 838 states "20%-25% of children with ADHD also fulfill criteria for bipolar disorder". That indicates B as the correct choice.
 9. The question asks "Which of the following disorders is comorbid in 25% of ADHD patients?" The key states the correct answer is E (all of the above – Tourette's disorder, bipolar disorder, and conduct disorder). I contend that A (Tourette's disorder) and B (bipolar disorder) are correct per the textbook pages 836 and 838 respectively. However, on page 835 it states "Conduct disorder is seen in 40%-70% of children with ADHD". Therefore E is clearly not the correct answer and thus both A and B should be considered correct.

DR. ENGEL'S RESPONSE...

CORRECT ANSWER IS B. *You have persuaded me that A is incorrect because the statement in the book refers to how often ADHD is a comorbid condition in patients with*

Tourette's Disorder, which tells us nothing about how often it occurs among ADHD patients. You have also convinced me that C is incorrect because more than 25% of ADHD patients have comorbid conduct disorder according to the book. That leaves B, which the book supports is seen in about 20-25% of ADHD patients. The student who said the answer provided must be a miskey gets extra credit for giving me the benefit of the doubt! ☺

Question 120

STUDENT COMMENTS...

1. Should be 'A'. The question asks about the physicians degree of concern over suicide RELATIVE to our concern over suicide as the case was presented. Since the prevalence of suicide in Major Depressive Episodes is higher than in people not in a depressive state, a physician who be LESS concerned if her mood and energy improves even though it must still be considered.
2. Why would an improvement in energy and mood be a concerning sign with respect to suicide? Does this mean to say that we are concerned if mood worsens or improves?
3. Which should make a therapist LESS concerned about suicide? Key states E, none of the above. Challenge A. mood and energy level improves. Could not find anything in notes, text, review books, or lecture which gives mood and energy improvement as a risk, warning sign, concern, etc about suicide. Can not see why A is not the correct answer, especially not in any of the materials we have been given.

DR. ENGEL'S RESPONSE...

ANSWER REMAINS E. Page 1049 column 1 para 1 states, "A patient may experience a return of energy and motivation while still experiencing the subjective symptoms of hopelessness and excessive guilt. For such patients there may be an increased risk of suicide, because a return of energy in an extremely dysphoric individual may provide the impetus and wherewithal for an act of self-destruction." Indeed, what this should tell us is that an initial treatment response, while promising in and of itself, is NOT a reason to relax one's concern regarding suicide potential.

Question 122

STUDENT COMMENT...

According to the algorithm for acute treatment of major depression on p. 1050 of our text, this patient should be treated with an antidepressant; therefore, choice (A) is the correct answer. Given that this patient's diagnosis is major depression, treatment with an antipsychotic is not appropriate (choice C) unless she has depression with psychotic features, which is not clear from her history.

DR. ENGEL'S RESPONSE...

ANSWER REMAINS C. The patient suffers from major depression with psychotic features. It is optimal to initiate treatment using both an antipsychotic and an antidepressant as in choice C. The woman's psychosis consists of a fixed somatic delusion that she has cancer. Her illness belief is of sufficient intensity to be categorized as a fixed, false belief (i.e., a delusion) because it has persisted in the face of careful diagnostic testing and multiple medical reassurances occurring over a several month period. Hypochondriasis lies along a spectrum that can become of psychotic

proportions. If the depressive symptoms were not present, one would categorize this disorder as “Delusional Disorder, Somatic Subtype.”

Question 123

STUDENT COMMENT...

The question asks us to identify the FALSE statement out of five possible choices. The listed answer is E (Amitriptyline primarily blocks the reuptake of norepinephrine). This is a true statement and cannot therefore be the correct answer. The correct answer should be D (Desipramine primarily blocks the *uptake* of norepinephrine). Both drugs are TCA's, and as discussed on pages 1029-1031, TCA's act by inhibiting the *reuptake* of neurotransmitters.

DR. ENGEL'S RESPONSE...

ANSWER REMAINS E. *The challenger has it backwards. Page 1031 column 1 para 2 notes, “Imipramine, amitriptyline, clomipramine, trimipramine, and doxepin are tertiary amines. Desipramine, nortriptyline, and protriptyline are secondary amines. The tertiary amines have more potent serotonin reuptake inhibition, and the secondary amines have more potent noradrenergic reuptake inhibition.” Therefore, D is true and E is false, making E the correct response.*

Question 134

STUDENT COMMENT...

The test key indicates that choice E, Obsessive-Compulsive Disorder (OCD) is LEAST likely to have anxiety as a prominent symptom. Please note, however, that the text (p.601) states that “Obsession is an intrusive, unwanted mental event usually evoking anxiety or discomfort.” On the other hand, through the entire introductory section on schizophrenia (text p. 428-439) to include DSM IV diagnostic criteria tables, anxiety is not mentioned at all as a prominent symptom. Symptoms characteristic of schizophrenia appear to involve behaviors or conditions that are far more outlandish than simply anxiety. In light of the text's discussion of both schizophrenia and OCD, I feel that choice A should also be accepted.

DR. ENGEL'S RESPONSE...

ANSWER REMAINS E. *The answer is obsessive-compulsive PERSONALITY disorder, not obsessive-compulsive anxiety disorder. Obsessive-compulsive disorder (the anxiety disorder) is choice C and is clearly associated with clinically important levels of anxiety. Anxiety may be present in the personality disorder, but generally, obsessive-compulsive personality disorder is “ego-syntonic” (that is, it feels natural and generally comfortable to the person who has it, except where it causes distress as a consequence of resulting dysfunction – e.g., inability to get something done because of an excessive focus on rigid detail). Schizophrenia is almost as a rule associated with high levels of anxiety. It is not an anxiety disorder because its cardinal feature is psychosis. However, the frightening nature of psychosis for nearly all who experience it translates into lots of anxiety, sometimes referred to as “psychotic anxiety”. This anxiety is ubiquitous, but usually is not the direct focus of clinical attention because there are other and much more devastating symptoms to address. For example, table 12-4 on page 433 offers a shopping list of symptoms in schizophrenic patients. A sizable proportion of patients describe some combination of persecutory delusions (feeling that others are out to get*

them), delusions of being externally controlled, delusions they can read minds, delusions that others are reading their mind, etc. As a “thought experiment” of sorts, let yourself imagine what it would feel like if you were experiencing these things and couldn’t tell if they were real or not. It would be as though you lived every day in a private Twilight Zone that you experienced as real but no one else believed you. Would you be anxious? Case closed.

Question 139

STUDENT COMMENT...

Axis II diagnosis of vignette. Key states E. none of the above. Challenge B. compulsive personality disorder is correct. Text 238 "Axis II is Personality disorders". Vignette stated several compulsive behaviors and even stated pt quite compulsive. Compulsive disorder should at least be in the differential

DR. ENGEL’S RESPONSE...

ANSWER REMAINS E. *The onset of compulsivity and the specific extent and severity of these behaviors is not known. Personality disorders start in adolescence, are pervasive across a variety of life situations and circumstances, and relatively stable over the lifespan. We know nothing beyond the very recent history. Lastly, one should generally stop short of diagnosing a personality disorder based on a single cross-sectional assessment as is described here. Lastly, dementia is likely based on the history as presented, and it is very common that compulsive behaviors start in the early phases of dementia. These usually represent the affected individual’s attempt to compensate for the initial memory changes.*

Question 147

STUDENT COMMENT...

Benztropine will also work for acute dystonic reactions. See #62. (62. Table 27-15 on page 1068 states that for dystonia and acute extrapyramidal side effects, benztropine, diphenhydramine, and trihexyphenidyl are indicated. According to this table, (A) (B) and (C) should be given credit.)

DR. ENGEL’S RESPONSE...

ANSWER REMAINS D. *The name often used to refer to this unique instance of dystonia is “oculogyric crisis”. It is a type of acute dystonic reaction due to antipsychotic administration. Giving haloperidol, choices A and B, will only exacerbate the condition. The text states (page 1068 column 1 para 2) that “Intravenous or intramuscular administration of anticholinergic medications is a rapid and effective treatment of acute dystonia, so rapid, in fact, that the dystonia may disappear before the injection is completed.” That rules out choices C and E because they are administered orally and will cause a delay in response to what is a very painful and frightening condition. That leaves D.*

Question 148

STUDENT COMMENT...

Answer should be 'D'. Since this patient could very well have a drug induced psychotic disorder or drug intoxication as suggested by question 149, the history of drug use

would be predisposing but also precipitating. In addition continual use of the drugs and addiction/dependence on them would be a perpetuating factor. Therefore all are correct answer 'D'

DR. ENGEL'S RESPONSE...

ANSWER REMAINS A. *The question asks what his HISTORY of chronic multi-drug abuse is BEST described as (in relation to the CURRENT psychosis). It cannot yet be a perpetuating factor, because his current episode just started (eventually it could become perpetuating). That excludes answers C and D from consideration. His HISTORY of CHRONIC abuse is BEST thought of as predisposing. It is true that more recent and acute drug abuse may represent a precipitating factor, but the single BEST answer is A.*

Question 168

STUDENT COMMENT...

Verbal and performance tasks. Challenge E. Halstead Reitan is also correct. Halstead Reitan is defined in Text p263 as "five tests are a category test, a tactile perception test, a speech sounds perception test, the Seashore rhythm test, and a finger oscillation test." This definition seems to be both verbal and performance tasks. So E should be accepted as well.

DR. ENGEL'S RESPONSE...

ANSWER REMAINS D. *A verbal task is one that requires the patient to either be verbal or to verbally interpret verbal input. Speech sounds MIGHT be considered verbal input. However, the question calls for the single BEST response. There is little question that the WAIS-R is the correct response, since table 8-7 on page 264 shows that all of the Wechsler tests are scored on two primary scales, the verbal and performance IQ scales.*