

2004 HUMAN BEHAVIOR COURSE BLOCK FOUR EXAM CHALLENGES

24 QUESTIONS CHALLENGED
55 TOTAL CHALLENGES
6 CHANGES TO THE ANSWER KEY.

Question 9.

Question and Answer Key Answer.

You now consider the psychiatric diagnosis. The syndrome Lynn is experiencing is a defining feature of which of the following psychiatric disorders?

- A. Bipolar I disorder
- B. Bipolar II disorder
- C. Major depressive disorder
- D. **XX** All of the above
- E. None of the above

Challenges.

1. According to Cohen, the definition of Bipolar I Disorder: "One or more manic or mixed episodes (usually, but not invariably, accompanied by major depressive episodes)" (p.142). The book spends quite a bit of time emphasizing the point that the "presence of one or more manic or mixed episodes is all that is necessary to make the diagnosis" (p.143), and therefore a depressive episode is not a "defining feature" of the disorder.
2. The approved answer was D all of the above; however, I wish to challenge that. According to Cohen, P. 143, "In bipolar I disorder, the presence of one or more manic or mixed episodes is all that is necessary to make the diagnosis." Given this statement, all of the above answers should not be correct. The correct answers should be B: Bipolar Disorder II and C: Major Depressive Disorder. Thus I challenge that C also be an acceptable answer.
3. A Major Depressive Episode is a defining feature of Bipolar II and MDD. It can be and is often present in Bipolar I, but it is not a defining feature of Bipolar I. As B and C were both correct, but A technically wasn't, (we are expected to know these "technical details" in differentiating these conditions), I would argue that all answers be accepted for this one as the question seems flawed. I got this one "right," but others may have missed it, especially when comparing with question

Dr. Engel Response. Correct answer is D. The question asks for 'defining features'; that is, features that are part of the definition of the disorder. Bipolar I, Bipolar II, and Major Depressive Disorder all have Major Depression as part of the definition for the disorder. That said, it is indeed true that it is neither necessary nor sufficient to have had a Major Depressive Episode to meet criteria for Bipolar I.

Question 11.

Question and Answer Key Answer.

Which of the following statements is true about treatment Lynn's psychiatric disorder?

- A. Cognitive-behavioral therapy is effective
- B. Fluoxetine is effective
- C. Psychotherapy and pharmacotherapy together is better than either alone.
- D. **XX** All of the above

E. None of the above

Challenges.

1. The approved answer was D: All of the above. I challenge that C should also be a correct answer in that it incorporates both answers A and B. "All of the above" essentially re-iterates answer C. It is just like having an answer C: both A and B with an answer D: all of the above. It is a given that a combination of approved treatments are much better than each individual method alone. Thus C should also be accepted.

Dr. Engel Response. Correct answer is D. The reasoning behind the challenge is incorrect. If, for example, both CBT and fluoxetine were ineffective (in truth both are effective) but the combination was effective, then C would be correct and D would be incorrect. D is the single best response.

Question 12.

Question and Answer Key Answer.

Of the following, the most effective long-term pharmacotherapy for panic disorder is

- A. SSRI antidepressant
- B. Conventional antipsychotic
- C. **XX** Benzodiazepine
- D. Buspirone
- E. A mood stabilizing agent (e.g., anticonvulsant or lithium)

Challenges.

1. I put A (SSRI), because the class notes list benzodiazepines as being the ACUTE form of treatment. See Block II class notes, page 346, slide 31 for panic disorders. The slide actually reads "benzodiazepines (acutely)".
2. On pg 529 of the note set, in slide 16, it says that benzodiazepines are only used acutely for panic disorders. Therefore, it would not be the most effective long term therapy. SSRI's would be a better choice.
3. I believe that A is an appropriate answer. From page 269 of Cohen, "Benzodiazepines often are prescribed initially, either on an as-needed or a standing dose basis. Concomitantly, longer-term therapy can be initiated with an SSRI or a TCA...For many clinicians, SSRI's have become the first-line agents...Sometimes the clinician will elect initially to use both an SSRI and benzodiazepine, as the benzodiazepine is more rapidly effective and may help combat the nervousness that can be associated with initiation of SSRI treatment." It appears that benzodiazepines are definitely more effective in the short term, but this question is asking about long term, and it appears that SSRI's may be the more effective treatment in the long term.
4. Cohen, pg. 269 first column, discusses treatments for panic disorder. It states that the best short term therapy is benzodiazepines (Question 6, answer C), and the first line agents for long term treatment are SSRIs. Benzodiazepines are only discussed in context with acute treatment, whereas SSRIs are mentioned multiple times as the best long term option for physicians.
5. The approved answer was C: Benzodiazepine. However, according to Cohen P 269, 2d full paragraph, "Benzodiazepines often are prescribed initially...Concomitantly, longer-term therapy can be initiated with an SSRI or TCA. As in GAD, these agents don't take effect as rapidly but are as effective for longer-term prophylaxis and are

not associated with physical or psychological dependence.” This makes SSRIs and TCAs a much better and as effective long term therapeutic. Thus, answer A: SSRI antidepressant should also be accepted as correct.

6. I think this was just a mistake on the key. Cohen, pg 269 2nd and 3rd paragraph talk about benzodiazepines for short term and SSRIs or TCAs for long term treatment of panic disorders. It also states that SSRIs are front line treatment for many clinicians. The answer should be A, SSRI, not C Benzodiazepine.
7. According to Cohen, p268 269 on treatment of Panic Disorder, "Benzodiazepines often are prescribed initially, either on an as needed or a standing dose basis. Concomitantly, longer term therapy can be initiated with an SSRI or a TCA. As in GAD, these agents don't take effect as rapidly but are as effective for longer term prophylaxis and are not associated with physical or psychological dependence. For many clinicians, SSRIs have become the first line agents." According to this, A could be argued to be correct, as Benzodiazepines have more undesirable side effects, (i.e. dependence, etc.) and SSRIs are as effective for long term therapy.

Dr. Engel Response. Correct answer is A. This is a miscode on the answer key. Benzodiazepines are an initial treatment for panic disorder as most of the challenges indicate. Antidepressants are the better long-term therapy.

Question 14.

Question and Answer Key Answer.

Which of the following personality disorders usually improves with initiation of a low dose of an antipsychotic medication?

- A. Narcissistic personality disorder.
- B. Antisocial personality disorder.
- C. Histrionic personality disorder.
- D. **XX** Borderline personality disorder.
- E. Immature personality disorder.

Challenges.

1. The problem I have with this question is the word usually. Wording is everything, and usually to me means more often than not. Pg. 309 2nd column first paragraph mentions that medications can sometimes play a very useful complementary role. Sometimes is not usually. Later in the paragraph it says, "Low doses of antipsychotics may be helpful..." Again, may be helpful is not the same as usually improves. Everyone should receive credit for poorly worded questions.
2. The approved answer was D: Borderline Personality Disorder. However, I challenge that Answer B: Antisocial disorder should also be accepted. Per Cohen, P 305, "A similar case could be made for anticonvulsant medications, lithium, and atypical antipsychotics medications...it may be useful in decreasing impulsive aggression..." A decrease of the impulsiveness can be seen as an improvement and therefore satisfies the requirement being asked in the question stem.

Dr. Engel Response. Correct answer is B or D. I agree that one could quibble over the wording of this (usual versus sometimes). That having been said, the instructions are to choose the single best answer, and that answer is clearly D. With some reluctance, I'll allow B, antisocial personality disorder, because Cohen does indeed mention it. To be clear, however, antipsychotics are rarely used for patients with antisocial personality disorder, and I have never seen them specifically recommended or helpful for this

disorder. I don't doubt, however, in their desperation to treat some of the more treatment refractory patients with antisocial personality disorder, antipsychotic medications have been tried.

Question 15.

Question and Answer Key Answer.

Beta adrenergic antagonists are effective for the treatment of

- A. Major depressive disorder
- B. Panic disorder
- C. Social phobia
- D. **XX** All the above
- E. None of the above

Challenges.

1. On p.91 of Cohen, "Propranolol, a Beta adrenergic receptor antagonist, has no antidepressant effects (and may even cause depression in some individuals)." Answers B and C should be accepted.
2. The approved answer was D: all of the above. However, I challenge that the only correct answer should be C: Social phobia. It is stated in the notes, P 350, Block 2, Slide 40 and Cohen P, 100, "These drugs [beta adrenergic blockers] therefore are most useful in cases of social phobia or performance anxiety." However, according to Cohen P 269, "Other agents such as clonidine and Beta blockers have been used but with much less success (in the context of Panic Disorder). Additionally, there is no mention of beta blockers in the notes or Cohen P 201-205 (Treatments for Mood Disorder). Thus answer C is the only true correct answer and not D: All of the above.

Dr. Engel Response. Correct answer is C. I must have been half asleep when I wrote the answer key – beta blockers are only effective for social phobia. They are not effective for either major depressive disorder (in fact they can actually cause depression in some patients) or panic disorder (though many cardiologists try this in their patients with so-called 'atypical chest pain' or 'mitral valve prolapse' -- diagnoses often used for patients that have chest pain of undiscovered etiology who really have undiagnosed panic disorder).

Question 16.

Question and Answer Key Answer.

Ms. Lonelihart is a 27-year-old woman who suffers from a chronic pattern of shifting moodiness. She also has a pattern of unsatisfying relationships characterized by rapid infatuation and a period of intense sexual activity. Her relationships seem to burn out as fast as they start however, and she ends up hating the men she had previously dated. Most of the time between these relationships, Ms. Lonelihart feels chronically empty, alone, bitter, and abandoned. She often drinks heavily for several weeks after her relationship breakups. Ms. Lonelihart's symptoms are most consistent with

- A. Cyclothymic disorder
- B. Histrionic personality disorder
- C. Dysthymic disorder
- D. **XX** Borderline personality disorder
- E. Dependent personality disorder

Challenges.

1. There is not enough from this to tell if it is Borderline or Cyclothymic. It could very well be either. The fact that her moodiness has a pattern of shifting that seems to be weeks at a time rather than days at a time suggests Cyclothymic as more likely than Borderline. Therefore A would be correct.

Dr. Engel Response. Correct answer is D. It could indeed be cyclothymic disorder, but the single best answer based on the information given is unquestionably borderline personality disorder.

Question 17.

Question and Answer Key Answer.

Buspirone (Buspar) is effective for which of the following disorders?

- A. **XX** Generalized anxiety disorder
- B. Avoidant personality disorder
- C. Panic disorder
- D. Post-traumatic stress disorder
- E. Major depressive disorder

Challenges.

1. On p.185 of Cohen the antidepressant effect of Buspirone at higher doses is discussed as is its use as an adjunct therapy in patients only partially responsive to SSRI. Since the question does not specify effective use as monotherapy, A and E should be accepted.

Dr. Engel Response. Correct answer is A. The single best answer is A. It is the only FDA approved indication for buspirone.

Question 18.

Question and Answer Key Answer.

Which of the following is a correct statement about antisocial personality disorder?

- A. It is more frequently diagnosed in women than men
- B. Female first degree relatives have an elevated rate of somatization disorder
- C. Those affected are loners and prefer a solitary existence
- D. A low dose of antipsychotic medication is often effective
- E. **XX** Affected individuals often have an extensive criminal history

Challenges.

1. I think this was another miskey. There are two reasons why E is the wrong answer and B is the correct answer. This is question 72 from the 2002 test, and since this was an except type question that makes E in 2004 a wrong answer.
2. The one and only correct answer in 2004 is B: Female first degree relatives have an elevated rate of somatization disorder, which can be found on page 304, 1st column last paragraph. "Gender appears to influence the presentation: if a family has one member with antisocial personality disorder, the males in that family more often have antisocial personality disorder and substance related disorders, whereas the females more often have somatization disorder."
3. p. 381 Cohen, "Interestingly, male relatives of female patients with somatization disorder are not more likely to have somatization disorder than are other members of

the general population , but they are more likely to have antisocial personality disorder and alcohol dependence." This being true, mathematically, the converse would also have to be true that female relatives of males with Antisocial personality disorder would have elevated rates of somatization disorder, at least on average. Accordingly, B would be correct.

4. Also, E depends on what the word often means. How much is often? It is definitely true that criminals often have an extensive history of antisocial personality disorder. However, it is not necessarily true that those with antisocial personality disorder often have extensive criminal histories, at least not according to the new DSM IV guidelines. Some definitely would, but most would not. (P. 303 Cohen).
5. The genetic component of antisocial personality disorder is explained on p.304 of Cohen. "Biological relatives of persons with this disorder also are more likely than the average person to have somatization disorder". As well, "gender appears to influence the presentation" of the underlying temperamental dispositions and "if a family has one member with antisocial personality disorder... the females [in the family] more often have somatization disorder". Finally, "there is an increase in the prevalence of all of these disorders[antisocial, somatization disorder, substance related disorder] ... compared with the general population". I think that answer choice B should therefore be accepted in addition to E.
6. In the Cohen book, on page 304, last paragraph in left column, it states: "if a family has one member w/ antisocial personality disorder, the males in that family more often have antisocial personality disorder and substance-related disorders, whereas the females more often have somatization disorder." thus implying that "B" is also a correct answer
7. Cohen, pg. 304 bottom of the first column, states that genetics play an important role in this disorder and that first degree female relatives of people with antisocial PD have an increased rate of somatization disorder. This would make question B correct. Also, answer E is confusing. A previously mentioned that, while many criminals have antisocial PD, most with antisocial PD are not criminals.
8. In pg 560 of the notes, slide 8, it says that biological relatives of people with APD are at greater risk to have somatization disorders. So B should be a right answer.
9. I put B (female first degree relatives have an elevated rate of somatization disorder). Block IV notes, page 560, slide 8 lists that this is a common occurrence in female relatives of those with antisocial PD. The Cohen book also talks about this. However, neither the notes nor Cohen specifically says that those with antisocial PD often have an extensive criminal history. They may have a criminal history, but not necessarily extensive. The notes and book suggest that the correct answer to this question is B.

Dr. Engel Response. Correct answer is B or E. E is very clearly true, but so is B. I botched this question – it was never intended to have two answers! Snap out of it Dr. Engel! :-)

Question 22.

Question and Answer Key Answer.

Selective serotonin reuptake inhibitor (SSRI) related sexual dysfunction can occur at which of the following phases of the sexual response cycle?

- A. Desire and excitement
- B. **XX** Excitement and orgasm

- C. Desire and orgasm
- D. Excitement only
- E. Orgasm only

Challenges.

1. Cohen states that SSRIs have a negative impact on all three phases of the sexual response cycle listed in the question; "sexual side effects... include decreased libido[desire], delayed orgasm or anorgasmia, and impotence[excitement]" (p.178).
2. On p 178 of Cohen, the sexual side effects of SSRI "include decreased libido, delayed orgasm or anorgasmia, and impotence. The correct answer to the question should have been desire, excitement and orgasm, but this was not a choice so A and B should be accepted.
3. Hales and Yudofsky page 751, last paragraph, references a study on SSRIs and sexual dysfunction. It reads, "Of the 344 patients, 200 reported some form of sexual dysfunction. The adverse effects varied by type of SSRI?exual dysfunctions included loss of libido, delayed orgasm or ejaculation, anorgasmia, and erectile dysfunction.? In addition, Cohen, pg 419 first paragraph, discussing SSRIs states, ?these agents are tolerated well, but sexual side effects can occur, including decreased libido, decreased intensity of orgasm, and erectile dysfunction.? Stedman's defines libido as "conscious or unconscious sexual desire.? Therefore it is quite clear that SSRIs can cause dysfunction of desire, excitement, and orgasm, making choices A, B, and C correct answers.
4. There are actually no correct answers here as SSRIs can cause dysfunctions in Desire, Excitement and Orgasm. p. 410 of Cohen says they decrease arousal and orgasm. However, p. 178 , 2/3 of the way down the page, left column says a common side effect of SSRIs is decreased libido. It also says this in numerous Pharm texts. According to several prominent Medical Dictionaries (I finally stopped looking after the definition was the same time after time), libido is defined as sexual DESIRE. Therefore, if a common side effect of SSRIs is decreased libido, as every pharm text says and as Cohen says, they also cause dysfunction in the desire phase.
5. The approved answer was B: Excitement and orgasm. However, I challenge that answer A: Desire and excitement, also be accepted as a correct answer. According to Cohen P 178, "Sexual side effects also are prevalent with SSRIs. They include decreased libido, delayed orgasm or anorgasmia, and impotence." Decreased libido falls under the phase of desire , according to Cohen P 408, "...such factors include one's underlying degree of libido, the physical presence..." (in context of the desire phase). Thus answer A should also be a correct answer.
6. Answers A,B,& C are all correct. Page 178 or Cohen, "Sexual side effects also are prevalent with SSRIs. They include decreased libido, delayed orgasm or anorgasmia, and impotence." Steadman's definition of libido: Conscious or unconscious sexual desire. Therefore Desire is a definite answer. B was listed as the correct answer, and it includes Excitement and Orgasm. Therefore, Desire, Excitement, and Orgasm are all correct answers making A,B,&C all correct.
7. A, B, & C are all correct. Pg 178 Cohen, 2nd paragraph "Sexual side effects also are prevalent with SSRI's. They include decreased libido" (desire phase), "delayed orgasm or anorgasmia" (orgasm phase), "and impotence" (physical response during excitement phase).

Dr. Engel Response. Correct answer is A, B, & C. The question was written from Cohen on page 410 where it indicates only arousal and orgasm. In my clinical experience,

SSRI's don't reduce libido, but since Cohen offers some conflicting information about it, I'll allow all three.

Question 23.

Question and Answer Key Answer.

Which dopaminergic pathway is responsible for the negative symptoms of schizophrenia?

- A. Nigrostriatal tract
- B. Mesolimbic tract
- C. **XX** Mesocortical tract
- D. Tuberoinfundibular tract
- E. None of the above

Challenges.

1. I put B (Mesolimbic). Page 228 of Cohen says that the mesocortical (correct answer C) "may" be responsible for the negative symptoms. It does not say that it "is" responsible. Furthermore, if the mesolimbic tract is responsible for pleasure reward circuits, it would seem logical that this tract, were it adversely affected in the neuropathology of schizophrenia, would also have a causal role in the negative symptoms of schizophrenia, such as flat affect and withdrawal.

Dr. Engel Response. Correct answer is C. It is the conventional wisdom whether the qualifying word used is "is" or "may".

Question 25.

Question and Answer Key Answer.

Which dopaminergic pathway is responsible for the positive symptoms of schizophrenia?

- A. Nigrostriatal tract
- B. **XX** Mesolimbic tract
- C. Mesocortical tract
- D. Tuberoinfundibular tract
- E. None of the above

Challenges.

1. I put C (Mesocortical). Similar to the challenge for question #23, page 228 of Cohen says that the mesolimbic (correct answer B) "may" be responsible for the positive symptoms, but does not say that it "is" responsible. It would seem that auditory and visual hallucinations/delusions, which involve "higher processes" (vision is mediated by occipital lobe visual CORTEX; hearing is mediated by temporal lobe and auditory cortex) could be affected by the mesocortical tract.

Dr. Engel Response. Correct answer is B. Again, this is the conventional wisdom that will come up on various examinations you take in the future, so you might as well learn it.

Question 30.

Question and Answer Key Answer.

Which of the following are the elements of informed consent?

- A. Privacy, information, voluntariness
- B. Confidentiality, privacy, privilege
- C. **XX** Information, competency, voluntariness
- D. Confidentiality, information, voluntariness
- E. Capacity, information, voluntariness

Challenges.

1. I believe that E is an appropriate answer. The difference between the given correct answer of C and answer E is the difference between competency(C) and capacity (E). Informed consent is initially accomplished through an interaction between patient and care provider. The care provider can make assessments about a patient's capacity, but "only a judge can declare a patient incompetent"(Cohen 518). Therefore, at the initial level of informed consent, it would be an issue of capacity and not competency making answer E the correct answer. I can see how answer C would be acceptable as well if this were to go before a judge. Therefore it seems to me that both answers C & E should be correct.

Dr. Engel Response. Correct answer is C. This is right out of the lecture slides and a very standard response. This is not a trivial differentiation. It reinforces the notion that informed consent is a legal and not a clinical matter. Only a court can override any patient's right to give informed consent.

Question 32.

Question and Answer Key Answer.

Involuntarily hospitalized patients forfeit their right to

- A. Decline psychoactive medications
- B. Free communications
- C. Medical privacy
- D. Medical confidentiality
- E. **XX** None of the above

Challenges.

1. I put A (decline psychoactive medications). This point was not made clear in the lecture, lecture notes, or the Cohen text. Cohen contains statements that suggest that patients who are declared incompetent (a process that must occur before involuntary hospitalization can be implemented), can be treated despite their refusal. Page 510 (Cohen) reads: "The goals of these various parties sometimes are at odds with each other, especially in situations where patients' rights to refuse treatment are in conflict either with their potential need for treatment or with the community's interests in protecting public safety. Examples include laws regulating involuntary civil commitment to psychiatric hospitals..." Page 521 (Cohen) reads: "The key point here is that competent patients have the right to refuse any treatment." This statement by nature implies that incompetent patients cannot refuse treatment, therefore they "forfeit" their right to decline medications, even if they don't do so willingly.

Dr. Engel Response. Correct answer is E. Dr. Benedek very clearly emphasized this point in his lecture. In short, the only involuntary part of involuntary hospitalization is the hospitalization itself.

Question 33.

Question and Answer Key Answer.

An intern receives an urgent call to the psychiatric ward to see a patient who is complaining that his eyes are “stuck on the ceiling”. On examination, the patient cannot move his eyes except by moving his head, and his eyes are locked in an uncomfortable upward gaze. The patient was admitted only hours before with acute psychosis and placed on oral fluphenazine, a high potency conventional antipsychotic. What is the best management strategy?

- A. Lower the dose of the patients' fluphenazine
- B. **XX** Administer IV or IM anticholinergic medication
- C. Increase the dose of the fluphenazine
- D. Switch to a different antipsychotic medication
- E. Immediately transfer the patient to the intensive care unit

Challenges.

1. B looks like the best answer, but page 230 2nd paragraph also supports D: Switch to a different antipsychotic medication. The book states, “In some cases, the patient may benefit from a switch to a lower potency agent...”

Dr. Engel Response. Correct answer is B. The best and most immediate management strategy is to administer IV or IM anticholinergic medication. Within moments, this dystonic reaction of the extraocular muscles (sometimes called an “oculogyric crisis”) will resolve. Once the situation is under control, switching to another drug may become an important option. If you switch the drug first, however, it could be days before this painful dystonic reaction resolves.

Question 35.

Question and Answer Key Answer.

Which of the following is an important diagnostic feature of schizophrenia?

- A. Delusions
- B. Flat affect
- C. Loose associations
- D. **XX** All of the above
- E. None of the above

Challenges.

1. I think that C should also be accepted as correct. While all three of the listed symptoms can be found in schizophrenia, only “Loosening of Associations” (answer C) is specific for this disease. Delusions can occur in delusional disorder. A flat affect can be detected in patients with a mood disorder. Since the question asked for important diagnostic features of schizophrenia, it makes logical sense that the correct answer to this question be something that only occurs in schizophrenia and not symptoms that arise in other disease processes.

Dr. Engel Response. Correct answer is D. None of these are “specific” for schizophrenia. Loosening of associations commonly occurs in the psychosis associated with depression and mania. The question doesn't ask for features “specific” for schizophrenia. It only asks for “important diagnostic features”. A, B, and C are all important diagnostic features of schizophrenia.

Question 36.

Question and Answer Key Answer.

Police bring an agitated 24-year-old unmarried man to the emergency room. He has a five-year history of multiple-drug abuse. He does not work and lives with people he meets on the streets. In the past, he has supported himself through drug dealing and shoplifting. He reports having no friends.

About five years ago, he began to develop feelings of vague suspiciousness. He recognized that this was just his way of perceiving the world rather than reality. However, three days ago his suspiciousness increased. He now has trouble sleeping. He has become convinced that his neighbor is a member of the Mafia and is plotting to kill him. This evening, he went to his neighbor's house in an attempt to eavesdrop. The neighbor saw him and came to the door. The patient shot him.

This patient's attorney could argue that his client is not legally responsible for shooting his neighbor because

- A. **XX** He was suffering from a substance-induced psychotic disorder at the time
- B. The neighbor was, in fact, a member of the Mafia
- C. He is incompetent to stand trial
- D. He didn't know the gun was loaded
- E. None of the above

Challenges.

1. There is not enough information to be able to say A is correct. A is ambiguous. One can read A to be a statement of fact, as did I. i.e. "He was suffering from ..." There was not enough information to suggest that this was in fact true, therefore, I chose E.
2. I believe that C is also an appropriate answer. While the patient's attorney can not determine the competence of his client, he could still make the argument that his client is incompetent to stand trial as a defense. Obviously, it would be up to a judge to determine the defendant's competence and decide if this is a valid argument or not. Nonetheless, it is an argument that the attorney could try to make. Therefore answer C is also correct.
3. Answer A is only correct in some states; voluntary intoxication is not a valid legal defense in many states, even if it results in a psychotic state where the person cannot discriminate between right and wrong (my home state happens to be one of these states, which is why I put E). See referenced online paper: http://www.law.msu.edu/lawrev/98_4/fitzpatrick.htm#8 . E should be correct also

Dr. Engel Response. Correct answer is A. The patient has a five-year history of multiple substance abuse. It would therefore be quite reasonable for an attorney to argue that his extensive history of drug abuse was the cause of his psychosis (apart from whether or not he was still using drugs at the time of the crime). In addition, the individual was clearly operating on a mistaken assumption (due to his psychosis) that the neighbor was a member of the mafia, and therefore he was unable to distinguish right from wrong at the time he shot the neighbor. We are not given any information about the individual at the time of the trial, so we don't have any information that would suggest he could be defended as incompetent to stand trial. The latter is a determination that can only be made at the time of the trial because it could change quite dramatically over time. For example, effective treatment of an individual who was previously determined incompetent to stand trial could and likely would result in a declaration of competence by the court and the initiation of judicial proceedings.

Question 41.

Question and Answer Key Answer.

A 50-year-old man has been on an antidepressant for six weeks. He is having no side effects. Symptoms of depression are showing slight improvement. The best thing to do next is

- A. Terminate antidepressant therapy.
- B. Begin electroconvulsive therapy (ECT).
- C. Augment the current medication with a second drug.
- D. **XX** Increase the dose of the current antidepressant medication.
- E. Change to another antidepressant.

Challenges.

1. Concerning best treatment in depressed 50 year old man. C and E are also correct. Pg 168 of Cohen, last sentence, "when a patient either doesn't respond to a medication or only demonstrates a partial response, they might still achieve a clinical response by switching to an alternative medication or by augmenting the first drug....." Also supported in the last paragraph of pg 201 of Cohen extending to pg 202, "When a patient has not responded to a single agent....."

Dr. Engel Response. Correct answer is D. The key point here is that you do not know yet whether the patient has responded to drug one. The patient is showing improvement at six weeks and having no side-effects. Two options could be pursued, either increase the dose of medicine (if you are dissatisfied with the improvement to date, you have room to increase the dose because he is having no side-effects) or maintain him at the current dose and follow him up to see if improvement occurs (if you are satisfied that even though the improvement is slight there is a clear temporal trend in the right direction). However, it would be premature to stop drug one at this time because the patient is tolerating it well and getting better, even if only gradually. It is also premature to switch medications, move to multiple medications, or change course and introduce ECT before an adequate trial of drug one has occurred. If you make these changes, you have done so without adequately determining whether drug one alone might have achieved the desired effect.

Question 48.

Question and Answer Key Answer.

The most important diagnosis to rule out in a depressed patient before administering an antidepressant is

- A. Panic disorder
- B. **XX** Bipolar disorder
- C. Obsessive-compulsive disorder
- D. Substance-induced depressive disorder
- E. Depression due to a general medical condition

Challenges.

1. I put E (general medication condition). Though it is true that bipolar must be ruled out to avoid sending a depressed patient with bipolar into a manic episode, it should also be as important that one rule out a general medication condition, which can CAUSE depression. Depression due to a GMC can often still be treated with

antidepressants, but as we have learned all year long in various courses, doctors are to treat the root of the problem if at all possible. Therefore, you would want to begin treating the GMC immediately, and add antidepressants if indicated. In order to know whether you must treat a GMC, you must attempt to rule it out first.

2. The approved answer was B: Bipolar disorder. I challenge that answer D: Substance-induced depressive disorder, is also a correct answer for this question. From my very limited (2 years of medical school education), I would think that ruling out a substance-induced problem would be an important thing before starting any medication. IF the medication (stimulus) is taken away, the problem can be easier solved. Additionally, one of the lessons learned in pharm and this course was to try and avoid polypharmacy as much as possible since there are many interactions between just about every drug. If the patient is depressed due to a medication he is taking, wouldn't it be important to know what so as not to give another drug (i.e anti-depressant) that might have an adverse affect? Based on this reasoning, I feel that answer C also be accepted as correct.

Dr. Engel Response. Correct answer is B. This question is not about whether one should look for alternative causes of depression. The answer to that question is very clearly "yes". One point of this question is that one doesn't have to have these other causes excluded before starting the antidepressant. One can always pursue the work up of causes while the patient is on the antidepressant and (perhaps but not necessarily) discontinue the antidepressant if an alternative cause is found. It is best not to wait until the cause of the depression is clearly defined for a couple of reasons: 1) it takes up to 12 weeks to achieve the full therapeutic effect of an antidepressant, so it is important to start that clock ticking immediately if you can; 2) antidepressants can improve depressive symptoms resulting from substance abuse and underlying medical problems, so even if you discover an underlying medical condition or substance use disorder, you may well want to keep the patient on the antidepressant. Panic disorder and obsessive compulsive disorder both respond to SSRI antidepressants, so this is not a rule out that is critical at this early stage. However, B, bipolar disorder, should be ruled out before starting the antidepressant because the addition of the antidepressant in someone with bipolar disorder could cause "pharmacologic mania".

Question 53.

Question and Answer Key Answer.

The principal ethical obligation of the forensic psychiatrist is to the

- A. Patient
- B. Prosecution team
- C. Narrative truth
- D. **XX** Historical truth
- E. Defense team

Challenges.

1. I believe that answer C is also an appropriate answer. From Cohen page 517: "It would be naïve for the forensic clinician to "believe the defendant," whereas believing the patient is common in clinical work." While this statement shows that a forensic psychiatrist must know the historical truth in order to make his evaluation, his principal ethical obligation is to determining the capacity of the patient. With this in mind, the narrative truth vs. the historical truth is what must be evaluated. Therefore, both parts are equally important to the forensic psychiatrist's evaluation, making both

answers C & D correct. It is not the ethical obligation of the forensic psychiatrist to collect the historical truth, it is only his obligation to use his expertise in evaluating the patient.

Dr. Engel Response. Correct answer is D. The obligation of the forensic psychiatrist is to the events as they actually happened (historical truth). Narrative truth is the events as the patient narrates or describes them. Certainly, the forensic psychiatrist is committed to hearing out the truth as the patient recalls it or describes it, but only as a tool to get at what “really happened” (historical truth).

Question 58.

Question and Answer Key Answer.

A 73-year-old man with no previous personal or family psychiatric history who is referred to a psychiatrist for the sudden occurrence of “new onset schizophrenia” probably has

- A. Schizophrenia
- B. Major depression
- C. Dementia
- D. **XX** Delirium
- E. Dissociative fugue

Challenges.

1. This question is nearly identical to an old exam question. This question reads, “A 73 year old man with no previous personal or family psychiatric history who is referred to a psychiatrist for the sudden occurrence of “new onset schizophrenia? probably has ____? I remembered seeing this question before and when I looked back through the old tests, that I used to study for this exam, I found it. Question 39 from the 2001 block II exam reads, “A 60 year old man with no psychiatric history who is referred for evaluation of new onset “Schizophrenia? most likely has ____? In 2001, the correct answer was dementia (choice C) and not delerium (choice D). I don’t know how this could change over time, and therefore I think credit should be given for choice C (dementia) on the 2004 final.

Dr. Engel Response. Correct answer is D. The first onset of a primary psychiatric disorder (choices A, B, and E) would be rare at age 73. That leaves delirium or dementia. This is differentiated by the fact that the onset is sudden. A hallmark of delirium is its sudden or rapid onset, while dementia has a slow or insidious onset.

Question 60.

Question and Answer Key Answer.

Effective pharmacological treatments for post-traumatic stress disorder (PTSD) symptoms include

- A. Thioridazine (Mellaril)
- B. Propranolol
- C. Diazepam (Valium)
- D. **XX** Sertraline (Zoloft)
- E. All of the above

Challenges.

1. I believe that E, All of the above is a correct answer. D is the correct given answer.

A, Thioridazine can be used as a low dose antipsychotic for violent urges in PTSD. B, Propranolol is useful for mitigating PTSD symptoms. C, Diazepam can be used to rapidly relieve anxiety in PTSD. Therefore all are correct. This question does not ask which of the listed drugs is any better than the others, it just asks for effective pharmacological treatments. All of these drugs have been used and are currently being used in patients with PTSD. I found many articles on the internet documenting the usage of all 4 drugs separately for PTSD. I can look them up again and print them out if you would like.

2. Cohen page 279 indicates that SSRIs and Benzodiazepines (used with caution) can be used to treat PTSD. Cohen page 486 states that propranolol is useful in treating PTSD. If these three drugs can be used to treat PTSD, then choice E, all of the above, should be given credit.
3. Pg 279 2nd column paragraphs 3 6 imply that Propranolol, SSRIs, and Benzodiazepines, are all effective for some of the associated symptoms of PTSD. Since this question had more than one true answer, and an all of the above as a choice, I had to use test taking logic, which is if there is more than one correct answer with an all of the above you must choose all of the above. So that's why I think this should be one of those freebies where everyone gets credit.
4. I think that E should also be accepted. In the Cohen text, on page 279 (right column) it mentions that SSRIs are used effectively in PTSD. It also mentions that there "has been the case for treatment with clonidine, naltrexone, and propranolol." Since I knew that both beta blockers and SSRIs have been used in PTSD treatment (as mentioned in the text), and seeing that both of these were possible answers for this question, answer E (all of the above) made the most sense as the answer, since it was the only one that would account for both of these agents that are used in PTSD treatment.

Dr. Engel Response. Correct answer is B, C, D or E. I apologize for this question given that the book is vague about the relative effectiveness of these drugs. The only agents that are currently FDA approved for PTSD are sertraline and paroxetine (both SSRIs), and this was the intended answer (it is the answer you should chose if the question comes up on USMLE). None of the other drugs have been found to be effective in randomized controlled trials. Conventional antipsychotics are clearly wrong because they can cause tardive dyskinesia with chronic use and should never be used unless a patient is clearly psychotic. However, I'll allow B and C because the book and Dr. Osuch's slides mention them. I'll allow E because knowing that B, C, and D are correct from the book may well lead a reasonable person to select "all of the above".

Question 62.

Question and Answer Key Answer.

Which of the following should cause a clinician's to strongly suspect possible malingering?

- A. **XX** Patient has filed a lawsuit for accident-related injury
- B. Patient is a female
- C. Patient has avoidant personality disorder
- D. Patient requests a medicine for symptoms
- E. Patient fails to pay his medical bills on time

Challenges.

1. I think that answer D should also be accepted as true. In the Cohen text, on page

388 (right column) it states: "The malingerer consciously feigns having a disease in order to obtain some conscious external gain, such as avoiding military service, avoiding work, obtaining financial compensation in a lawsuit, evading criminal prosecution, or obtaining a prescription for a controlled substance." Since both answer A (pt has filed a lawsuit for accident related injury) and answer D (pt requests a medicine for symptoms) are mentioned in the text as symptoms of a malingerer, I think that both answers should be accepted as correct.

Dr. Engel Response. Correct answer is A. The best answer is A. In this day and age of direct-to-consumer marketing of medicines, many patients will request medications (there is no specific mention here of controlled substances per se).

Question 68.

Question and Answer Key Answer.

The prevalence of substance dependence in the military dropped throughout the 1980s. Which of the following factors contributed to the decline?

- A. Reductions in the number of officers
- B. Reductions in the divorce rate
- C. **XX** Increases in women on active duty
- D. Greater acceptance of social drinking in American society
- E. None of the above

Challenges.

1. I put E (none of the above). I cannot find any notes to address this question, because the speaker did not provide notes when he gave the talk on substance abuse. Cohen does not directly address this issue in regards to the military and its recent history of substance abuse statistics. Therefore, we had no way to go back and study this material in order to answer the question correctly.
2. Causes of decreasing alcohol dependence in the 80s was not covered in lecture or the book. The argument could be made that we should arrive at answer C by knowing that alcohol dependence is more common in men, but we are not told in the question (nor should we be expected to know) that the number of active duty women increased STEADILY and DISPROPORTIONATELY to men. A, B, and D are definitely wrong, but E should be correct also.

Dr. Engel Response. Correct answer is C. Dr. Holloway discussed this in his lecture on substance use disorders. The slides, though not provided in the printed syllabus, were and are available via the website.

Question 69.

Question and Answer Key Answer.

Which of the following DSM-IV mood disorders is characterized by AT LEAST ONE major depressive episode?

- A. Bipolar I disorder
- B. **XX** Bipolar II disorder
- C. Dysthymic disorder
- D. Cyclothymic disorder
- E. None of the above

Challenges.

1. B is not correct when looking at the grammar of the question. Major Depressive Disorder is characterized by at least one major depressive episode. Bipolar II disorder is characterized by at least one major depressive episode accompanied by at least one hypomanic episode. A major depressive episode is a characteristic of Bipolar II, but Bipolar II is not characterized by a major depressive episode, but rather a major depressive episode with a hypomanic episode. Furthermore, using question 9 as a bouncing board, question 9 and question 69 are both flawed. Question #9 says that a major depressive episode is a defining feature of Bipolar I, Bipolar II, and MDD. A major depressive episode is in fact only a defining feature of the latter two, though it may be and often is present in Bipolar I. This being the case, E, none of the above would be correct for #69. Likewise, #9 could be a bit confusing.

Dr. Engel Response. Correct answer is B. The best answer is B because one can have bipolar I disorder, dysthymic disorder, or cyclothymic disorder without ever experiencing a major depressive disorder. However, any patient with bipolar II disorder necessarily has a history of at least one major depressive disorder (can't receive the diagnosis without having one).