

## HUMAN BEHAVIOR COURSE BLOCK 2 EXAM CHALLENGES

### Question 2.

#### Question and Answer Key Answer.

The following are strategies DSM-IV uses to fit the spectrum of emotional signs and symptoms into a finite number of discrete categorical diagnoses EXCEPT

- A. **XX** An atheoretical and phenomenological system
- B. Diagnostic hierarchies (some diagnoses take priority over other diagnoses in the event that both are present)
- C. Comorbidity is allowed (the coexistence of two or more mental disorders at the same time)
- D. Categories that combine the features of two different categories (e.g., schizophrenia and a mood disorder).
- E. Categories that cover 'atypical' presentations that don't fit into other categories

#### Challenges.

1. All of the answers for question 2 are true according to our notes.
  - A. Slide 20 states "...DSM-III...atheoretical & phenomenological orientation...DSM-IV refined process." The notes do not state that the DSM-IV is no longer an atheoretical & phenomenological orientation, only that it was refined.
  - B. Slide 17 states "Diagnostic hierarchies (reduced emphasis since DSM-III)"
  - C. Slide 17 states "allowance for co-morbidity"
  - D. Also slide 17 "In-betweener categories"
  - E. Slide 17 again "Subsyndromal or atypical categories"'A' was shown to be the correct choice, but the information was listed on a different slide, making the question impossible to answer.
2. There is no correct answer. Examining slides 17 and 20 in the Diagnostic Assessment lecture demonstrates that B, C and E are all correct ways to describe DSM-IV, and therefore wrong answers. However, there is discussion of "in-betweeners" which I can only assume rules out answer D as well. However, DSM-III is described as "atheoretical and phenomenological" on slide 20. There is no mention that this has changed for DSM-IV, only that it has been refined. Therefore, A is also a true description of DSM-IV, and makes it not possible as a choice either. Therefore, there is no correct answer.
3. All of the answer choices are described as strategies by which DSM-IV fits the spectrum of emotional signs and symptoms into a finite number of discrete categorical diagnoses. The slides referenced below speak of each of the answer choices as strategies. The answer choice A, which is recorded as the correct answer is used to describe DSM-III and DSM-IV is described as having only "refined [the] process", suggesting that "an atheoretical & phenomenological system" is still used in DSM-IV.

Dr. Engel Response. Correct answer is A. Slide 17 page 316 in the syllabus shows the strategies that DSM-IV uses to fit dimensional reality into a categorical diagnostic system. Although it is true that DSM-IV is atheoretical and phenomenological, that is not one of the strategies that DSM-IV uses to fit a dimensional reality into categories (i.e., true, but unrelated).

### Question 3.

#### Question and Answer Key Answer.

Each of the following is a cardinal diagnostic feature of schizophrenia EXCEPT:

- A. Delusions
- B. Hallucinations
- C. Flat affect
- D. Disturbed social or occupational function
- E. **XX** Duration of symptoms of one month or longer

#### Challenges.

1. No correct answer. Page 429 in “The Text Book of Psychiatry” in Table 12-1, point C Duration states that, “this 6 month period must include at least 1 month of symptoms that meet criterion A.” The phrase ‘at least one month’ means that answer choice E is not correct. As a result there is no correct answer for this question.

Dr. Engel Response. Correct answer is E. It is true that one month of two or more symptoms (criterion A) must have occurred. Criterion A however only determines the duration of the so-called “active phase” of the illness. Six months of continuous symptoms (prodromal, attenuated, or residual symptoms in addition to the duration of active phase symptoms) are necessary to meet criteria for schizophrenia. If the active phase lasts one month or longer but the total episode is less than 6 months, then the appropriate diagnosis is *schizophreniform disorder*, NOT schizophrenia (see table 12-8 page 443 in the text).

### Question 8.

#### Question and Answer Key Answer.

Which of the following medication combinations would be the MOST useful in treating this patient?

- A. Lithium carbonate/amitriptyline.
- B. Lithium carbonate/aminophylline.
- C. **XX** Lithium carbonate/haloperidol.
- D. Paroxetine/haloperidol.
- E. Paroxetine/thiothixene.

#### Challenges.

1. Answer D: Paroxetine/haloperidol. This is the exact same question and answer series as #144 in last years Final Exam and the correct answer was D, the same answer as D this year.

Dr. Engel Response. Correct answer is C. I looked at last year’s answer sheet and it records the answer to 144 as C. The patient has bipolar I disorder and is having a manic episode. Lithium is the best-studied antimanic drug (see page 544 of the text under “Mania”). The patient is also psychotic, and the beneficial effects of lithium take 7 to 10 days to “kick in”. Therefore, the antipsychotic agent haloperidol would be a good acute treatment strategy (also page 544 of the text). One would NOT use an antidepressant (such as paroxetine or amitriptyline) in someone who is in the acutely manic phase of bipolar I disorder. Indeed, an antidepressant agent can pharmacologically induce a manic episode and other adverse effects even in the depressed phase of bipolar I disorder (see page 544 under “Bipolar Depression”) and should be used only as a second line treatment

in that context. They should be avoided altogether during mania.

As an aside: I have urged students to use study questions and old exam questions as a way of taking an active learning approach to the book. I DO NOT recommend memorizing answers without understanding their basis. Use old answer sheets at your own risk. In this case, the student is mistaken; the answer on the answer sheet from last year's final exam is answer C, not D. In some other cases, however, students from last year's class may have challenged the answer AFTER the answer sheet was distributed, and the final correct answer may have changed. Challenges with the sole rationale that "it was the answer on last year's test" will not pass muster. To successfully challenge an answer to any of the Human Behavior Course examinations, students must make a case for an alternative answer based upon statements from the book, the notes, the lectures, or the way the question is worded.

### **Question 9.**

#### Question and Answer Key Answer.

Which of the following laboratory studies would be essential to obtain prior to initiating the medications chosen in the preceding question?

- A. CT scan of the head.
- B. Electroencephalogram (EEG).
- C. Liver function panel.
- D. **XX** Pregnancy test.
- E. Vitamin B12 level.

#### Challenges.

1. Answer B: Electroencephalogram (EEG). This is the exact same question and answer series as #145 in last years Final Exam and the correct answer was B, the same answer as B this year.

Dr. Engel Response. Correct answer is D. The answer on the answer sheet that I have obtained from your class representative shows the correct answer to item 145 as D. See There is no reason to routinely obtain an EEG before initiating lithium and haloperidol. On the other hand, a pregnancy test in a reproductive age female is crucial, particularly when a key symptom of mania is hypersexuality and loss of judgment and impulse control. Also there is a known association between maternal lithium use and congenital cardiac abnormalities (the best known is Ebstein's endocardial cushion defect).

### **Question 10.**

#### Question and Answer Key Answer.

The following could contribute to the woman's symptoms EXCEPT

- A. Antidepressant medications
- B. Cocaine
- C. **XX** Religious devotion
- D. Long summer days (biological rhythms)
- E. Recent discontinuation of valproic acid (same as valproate)

#### Challenges.

1. I chose D for an answer because none of the other options seemed correct. The stated answer of C is inconsistent with the patient's stating that "God communicated directly with her." In addition, we were taught in a small group session that religious devotion frequently complicates and can even contribute to psychotic features that are present in this patient's episode.
2. There is no correct answer. Obviously, as we have learned in this class and Pharm, A, B and E all could contribute to the woman's symptoms. If D "long summer days" is referring to Seasonal Affective Disorder (even though this is more likely to occur in winter), then I guess it might also contribute, assuming that we are in the summer. However, to say that C is not something that could contribute discredits millions of people around that world that everyday act a certain way in religious devotion. Dr. Torrey eloquently described how many of the individuals that we hold as religious icons would now be considered "crazy" in today's polite society. Certainly it could have been their religious devotion that led them to their ideas and visions. Just as certainly, religious devotion could have helped this women feel that "God was speaking to her directly." There is no correct answer.
3. All of the answer choices are possible things that could **Contribute** to the woman's symptoms. The answer choices A, B, D, and E can be ruled out on medical terms as both items that could **Contribute** and also be a **Cause** of her symptoms. Answer **choice C** may not be a medical Cause of her symptoms, but Religious devotion could most certainly **CONTRIBUTE** to her symptoms. There are many people in the world who act in strange ways and performs acts of devotion that are far more bizarre than those made by this woman in the name of religion. All one has to do is look at some of the cults of the world and what they have done, mass suicides, strange protests, and other actions based on religious devotion.
4. No correct answer. All of the choices could contribute to the woman's symptoms. For A, her antidepressant medications could be poorly prescribed or she may not be compliant. For B, cocaine may cause symptoms of mania and psychotic features. For C, her religious devotion is a psychological predisposing factor. For D, long summer days could contribute to seasonal affective disorder. For E, recent discontinuation of valproic acid could cause her to experience psychotic features and mania.

Dr. Engel Response. Correct answer is C. Antidepressants (see discussion above about antidepressant induced mania), psychostimulants (e.g., cocaine), extended daylight hours (of related interest is the fact that high intensity lighting has antidepressant effects and is sometimes used to treat depression), and discontinuation of mood stabilizing agents (e.g., valproate, lithium) can induce mania. Can religion make people crazy? No – in fact there is an increasing body of evidence that aspects of religion can substantively improve health outcomes. People who are psychotic, however, often have hyperreligiosity as a manifestation of their psychosis (i.e., psychosis can contribute to hyperreligiosity but not vice-versa).

### **Question 17.**

#### Question and Answer Key Answer.

During treatment, which of the following should make the therapist LESS concerned about suicide?

- A. The patient's mood and energy level improves.
- B. The patient has a family history of suicide.

- C. The patient tells about her suicidal ideas and plans, not disavowing them.
- D. The patient made a suicide gesture one week ago.
- E. **XX** None of the above.

Challenges.

1. In our text, answers B, C, and D are clearly spelled out as making a therapist MORE concerned about suicide. They are wrong. However, nowhere in our notes or the text does it mention the effects of mood and energy level improving. However, if mood and energy level improving does NOT make the therapist less concerned, than nothing could make her less concerned and the poor therapist would have to be in a constant state of concern for the entire life of the patient. Answer A should be considered correct.
2. I believe answer A is a viable choice. Pg. 374 and 375 in the notes discuss the five minute screening interview including asking about “lost interest in or get less pleasure from, the things you used to enjoy” or “often people who are depressed have some troubling thoughts that they’d just as soon stay in bed or not wake up.” It would seem then that a patient whose “mood and energy level improves” would be at less risk for the above “suicide warning signs”!!!

Dr. Engel Response. Correct answer is E. The controversy in this question is mainly around whether or not A is true or false. This question (or some variation of it) is frequently on licensing and board examinations. All other factors equal, improvements in mood and energy would not make the therapist less concerned for a couple of reasons. Particularly in the early course of pharmacological treatment, one can see fairly rapid improvements in mood and energy, improvements that occur ahead of more cognitive complaints such as guilt and suicidal ideation. This is probably one reason why the initiation of antidepressants has been associated with suicide in some studies (page 1398 in the text). Second, there is no simple formula, symptom, or sign that should diminish the clinician’s suspicion regarding suicide in someone with recent ideation or (especially) attempts. The assessment of suicide risk involves multiple factors (e.g., reliable social support; corroborative information from those supports; patient’s convincing disclosure and rapport with the doctor; consistency/stability over time of decreasing suicidal ideas, plans and means, and level of suicidal intent). Small changes in the patient’s mental state must be placed in the context of those other factors before any conclusion can be drawn.

**Question 22.**

Question and Answer Key Answer.

All of the following are heavy metal environmental toxins with potential behavioral consequences EXCEPT

- A. Mercury
- B. Manganese
- C. **XX** Tungsten
- D. Lead
- E. Thallium

Challenges.

1. I looked in our text, our notes, and the DSM-IV and could not find the answer to this question anywhere among our testable assigned readings. Therefore, I think it should

be thrown out.

Dr. Engel Response. Correct answer is C. Please see page 288 in your text under "Laboratory Evaluation of Environmental Toxins". All of the above heavy metals are listed as having behavioral consequences except tungsten.

### **Question 25.**

Question and Answer Key Answer.

You are seeing a 28-year-old woman in the emergency room. She was sexually assaulted four days ago after she was sexually assaulted on the way to her car after work. She has not told anyone, but is now seeking care because she "is dying inside and cannot hold it in anymore". She has no prior psychiatric history, but you diagnose acute stress disorder.

Which of the following is TRUE?

- A. She will probably have post-traumatic stress disorder in two years.
- B. She is unlikely to have post-traumatic stress disorder in one month.
- C. **XX** In less than six weeks the assault will no longer cause acute stress disorder.
- D. Criteria for acute stress disorder do not require functional impairment.
- E. Inability for the woman to recall the sexual trauma would be rare.

Challenges.

1. In our notes it says that 50% of patients with ASD go on to have PTSD after 4 weeks and that the other 50% do not. When reading question 25, I was unsure what was meant by "unlikely" in answer B. I finally decided that 50% still qualifies as "unlikely" for the patient in question to go on to have PTSD. 50% is neither likely nor unlikely. Therefore, I think answer B should also be correct.
2. Furthermore, within one month she is still too short for the range for PTSD.
3. No correct answer. Acute Stress Disorder "lasts for a minimum of 2 days and a maximum of 4 weeks." (Notes pg. 467) Answer choice C is not correct because 4 weeks is less than 6 weeks. Therefore, in less than six weeks the assault could still cause acute stress disorder.

Dr. Engel Response. Correct answer is C. American Heritage Dictionary defines unlikely as "improbable". Fifty percent is just as likely as it is unlikely and is therefore not improbable. One month plus the 4 days since the actual trauma occurred is not too short of a period to meet PTSD criteria (see table 14-17 page 611 in your text). Response choice C states, "In less than six weeks the assault will no longer cause acute stress disorder." In 3 weeks and 4 days, she will no longer meet criteria for ASD and therefore from that point on, the assault can no longer cause ASD, making response choice C true. The main point of this option is to test whether one knows the duration of illness that differentiates PTSD and ASD.

### **Question 26.**

Question and Answer Key Answer.

The most important single treatment for a patient with hallucinations from alcohol withdrawal is

- A. **XX** Benzodiazepines.
- B. Brief, supportive counseling.

- C. Talking the patient down from the hallucinations.
- D. Antipsychotic medication.
- E. Behavioral therapy with strict limit setting.

Challenges.

1. In the text, when talking about treatment for alcohol withdrawal, two types of hallucinations are mentioned - those associated with delirium tremens and treated with benzodiazepines and those associated with alcoholic hallucinosis and treated with antipsychotics. Since it was not specified in the question which type of hallucinations, both answers A and D should be counted as correct.
2. Our text, The Textbook of Psychiatry (third edition) specifically describes on page 381 that Alcohol-Induced Psychotic Disorder (Alcohol Hallucinosis), which manifests itself during withdrawal from alcohol and is characterized by agitation, vivid auditory hallucinations, fear, and anxiety should be treated with a "potent antipsychotic such as haloperidol".
3. Benzodiazepines are definitely important medications in the withdrawal syndrome. On page 379 of our text, it states that "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 DT's."
 

Because the text mentions antipsychotic medications as important in the treatment of hallucinations associated with alcohol withdrawal, but also mentions the importance of benzodiazepines in the overall treatment of alcohol withdrawal, I would request that both answers A (benzodiazepines) and D (antipsychotics) be accepted for question #26.
4. The most important single treatment for a patient with hallucinations from alcohol withdrawal is...
  - a. The book states, on page 379, that benzodiazepines are preferred for withdrawal symptoms. But that was not the question that was asked. The question asked was which drug was most important for hallucinations from alcohol withdrawal.
  - d. The book states on page 381 that "appropriate treatment should be given to any patient with alcohol hallucinosis. A potent antipsychotic such as haloperidol...may be needed for patients with extreme agitation and hallucinations." Therefore, while benzodiazepines are the most important medications for alcohol withdrawal, antipsychotic medications are needed for hallucinations. The question seemed intentionally tricky and could have been interpreted either way.
5. Pg. 381 in the text: "Appropriate withdrawal treatment should be given to any patient with alcohol hallucinosis. A potent anti-psychotic such as haloperidol, may be needed for patients with extreme agitation and hallucinations." D is a correct answer.
6. Answer D) should be added. From the book, p 381: "A potent antipsychotic may be needed for patients with extreme agitation and hallucinations" While Benzos are used for the DTs the book specifically mentioned taking antipsychotics in association with hallucinations.

Dr. Engel Response. Correct answer is A. The question clearly asks for "the most important single treatment". Page 379 of the text notes, "Benzodiazepines are preferred for withdrawal symptoms because of a relatively high therapeutic index, oral and intravenous routes of administration, anticonvulsant properties, and good prevention of DTs." An antipsychotic is defensible as an adjunctive treatment for patients with severe psychosis, it should NEVER be the lone treatment of alcohol withdrawal, since

antipsychotics alone do not prevent alcohol withdrawal delirium, a life threatening medical condition. The text (page 381 under “Alcohol-Induced Psychotic Disorder”) reinforces the notion that treatment of withdrawal first, suggesting that a potent antipsychotic may be needed for some patients.

### **Question 27.**

#### Question and Answer Key Answer.

The woman’s past myocardial infarction represents a

- A. **XX** Predisposing factor
- B. Precipitating factor
- C. Protective factor
- D. Perpetuating factor
- E. None of the above

#### Challenges.

1. Pg. 270 in the notes states, “ Predisposing factors are the historical and constitutional vulnerabilities that were characteristic of the patient prior to the latest clinically relevant illness or event.” The stated answer for the question is that the woman’s past MI represents a predisposing factor, yet I fail to see how her MI represents a “constitutional vulnerability” that predisposes her to hallucinations.

Dr. Engel Response. Correct answer is A. The woman in the vignette is acutely psychotic. She should be considered to have delirium until her medical status is specifically ascertained. Two factors suggest that the likelihood of an underlying medical cause for her psychosis is high. First, her hallucinations are visual. Visual hallucinations are seldom due to purely psychiatric causes, and so one should assume there is an underlying medical problem until it is carefully excluded. Second, she has two serious diseases that can predispose her to delirium, a state indicative of potentially life-threatening medical instability that is often marked by hallucinations. This question therefore tests whether you understand what a predisposing factor is, but it also requires that you avoid the sometimes fatal assumption that psychosis automatically points to a purely psychiatric illness.

### **Question 30.**

#### Question and Answer Key Answer.

All of the following are negative symptoms of schizophrenia EXCEPT

- A. Poverty of speech content
- B. **XX** Antisocial behavior
- C. Apathy
- D. Flattening of affect
- E. Attentional impairment

#### Challenges.

1. No correct answer. Page 433 in “The Text Book of Psychiatry” in Table 12-4 lists “Anhedonia- asociality” as negative symptoms of schizophrenia. Asociality is the same thing as antisocial, “few recreational interests or activities, few relationships and impaired intimacy” to name a few symptoms from the book. If the question specifically referred to behaviors similar to Antisocial personality disorder, which fall under positive

symptoms of schizophrenia the distinction should have been made. There is no correct answer because the question did not specify antisocial personality disorder type behavior.

Dr. Engel Response. Correct answer is B. Choices A, C, D, and E are all clearly negative symptoms that are listed in the text. Positive symptoms of schizophrenia are delusions, hallucinations, or disorganization. Antisocial behavior is behavior that is opposed or detrimental to social order or the principles on which society is constituted. These behaviors are neither positive nor negative symptoms of schizophrenia, though schizophrenia is associated with antisocial behavior.

### **Question 35.**

#### Question and Answer Key Answer.

If this syndrome were amphetamine-induced psychotic disorder with delusions, the clinical history would commonly include

- A. **XX** Aggressiveness and hostility
- B. Visual hallucinations
- C. Psychomotor retardation
- D. Bulimia
- E. Strophosymbolia

#### Challenges.

1. According to the text, one of the key aspects of amphetamine use is hostility. The test question reads – “the clinical history would commonly include...”. While visual hallucinations might be the form of the amphetamine-induced psychotic disorder, a very common aspect of the clinical history would be hostility as in answer A. The question didn’t ask specifically what the visual hallucinations were like. Therefore I considered aggressiveness and hostility to be more common with amphetamine use than visual hallucinations. I think A should also be considered a correct answer.
2. Question 35 is about what kind of symptoms could u get with amphetamine induced psychotic disorder. the class is accepting B (visual hallucinations) as the only answer. I think a (aggressiveness and hostility) should also be accepted. The text book (on page 402) states that patients can present with irritability and hostility. Also in last year's final the exact same question was used and he accepted A as the correct answer before.
3. it should be both A & B on the 2000 final the answer was A aggressiveness and hostility. the book says p 402 that one of the symptoms of amphetamine-induced psychosis is hostility, though visual hallucinations are common, so both answers are correct.
4. In our textbook, on page 402, the effects of amphetamines include hostility and agitation. Answer A should be considered a correct answer in addition to visual hallucinations.
5. The HUBE 2000 Final, question 151, listed A as the correct answer. Aggressiveness and hostility ARE a consistent history with amphetamine abuse. “A” is a viable choice.
6. A should be correct. Please refer to Question #151 on last year’s final exam and the key that was distributed by the HUBE department along with the final. The answer given on the key is A...”Aggressiveness and hostility.” Additionally, amphetamines are a psychomotor stimulant, which as a class cause excitement and euphoria, decrease

- feelings of fatigue and increase motor activity.”
- The correct answer should be A, given that this exact question appeared on the final exam for last year and the answer accepted for question 151 on that exam was answer choice A.
  - Answer A: Aggressiveness and hostility. This is the exact same question and answer series as #151 in last years Final Exam and the correct answer was A, the same answer as A this year.

Dr. Engel Response. Correct answer is A. Woops! This answer was a typo. Sorry! Aggression and hostility are more common than visual hallucinations in amphetamine-induced psychotic disorder *with delusions*. On page 402 it lists hostility as one of the common side-effects of amphetamines. It also says, “Amphetamine psychosis can resemble acute paranoid schizophrenia, but visual hallucinations are common.” While visual hallucinations are more common in amphetamine-induced psychotic disorder than in schizophrenia, visual hallucinations are still decidedly less common than aggression and hostility. Since the question specifies the psychosis as “with delusions”, the primary problem is delusions rather than hallucinations, making visual hallucinations even a less likely possibility. For the reasons previously stated (see my response to question 8), I do not consider the answers distributed for last year’s exam to have any relevance to the discussion (you may also note that the wording of the question has changed slightly since it was used on the final exam last year).

### **Question 36.**

#### Question and Answer Key Answer.

A blood level of a tricyclic antidepressant is indicated in all of the following situations EXCEPT

- Questionable compliance.
- Poor response to the medication at therapeutic doses.
- Populations with sensitivity to side effects (e.g., patients over 60 years of age).
- Problematic side effects at low medication dosages.
- XX** Titration to an appropriate medication dosage in the first weeks of therapy.

#### Challenges.

- The way this question is stated, E appears to be indicated. If you are "titrating" that means that you are adjusting doses for a specific level. The only sure way to find out exact levels is to obtain blood levels. I understand that you wouldn't normally get blood levels to start a patient on TCA's, however the question asks about titrating, not routinely starting a patient on TCA's.
- No correct answer. Page 294 in “The Text Book of Psychiatry” gives situations in which a TCA blood level might be ordered. Point #5 in the first paragraph states, “patients for whom treatment is urgent and who require potentially therapeutic blood levels in as short a time as possible” might have their TCA blood level monitored. There is no correct answer because all of the choices represent possible times to monitor TCA blood levels.

Dr. Engel Response. Correct answer is E. Titration to an appropriate medication dosage in the first weeks of therapy is only rarely done under the special circumstances outlined in the text on page 294 (i.e., patients for whom treatment is urgent and who require

therapeutic drug levels in as short of time as possible). In contrast, choices A through D are routine indications for tricyclic antidepressant drug levels in people on those agents.

**Question 37.**

Question and Answer Key Answer.

Which of the following is TRUE?

- A. Over half of male physicians are married to another physician
- B. Over half of all female physicians are married to another physician
- C. Men & women in dual-doctor families earned more money than other married physicians
- D. Men & women in dual-doctor families achieved career goals significantly less often than other married physicians
- E. **XX** All of the above are false

Challenges.

1. In the article addressed in the question, 44% of female physicians are married to male physicians. When the actual percentage is so close to half, it was confusing to read a possible answer worded as B was – “over half...”. Knowing that the percentage is around 50% seems more relevant than remembering the actual number “44%”. Therefore, since the actual statistic was so close to half, it was a misleading question.
2. The information is not contained in the textbook (not assigned for this section anyway, but not found in the book) nor in our assigned readings, *The Impossible Dream*, *The Time of Our Lives: Sources of Conflict in the Medical Marriage*, or *Chapter Nine: Prevention*. We therefore have no resources with that information and could only guess at the possible answer.

Dr. Engel Response. Correct answer is E. The answer to this question comes from the article by Sobek et al entitled, “When Doctors Marry Doctors”. This reading was assigned for Dr. Privitera’s medical marriage lecture. I agree that 44% is “near half” or “about half”, but I cannot see how it is “over half” and therefore choice B is false.

**Question 39.**

Question and Answer Key Answer.

A 60-year-old man with no psychiatric history who is referred for evaluation of new-onset “Schizophrenia” most likely has

- A. Schizophrenia.
- B. Major depression.
- C. **XX** Dementia.
- D. **XX** A medical disorder (delirium).
- E. No serious problems.

Challenges.

1. Question 39 deals with what's the mostly diagnosis of a 60 yo man with new onset "schizo". The answer was dementia. I think that medical disorder should also be included there. On page 1448-1449, the book states that the new onset patient could present with inability to maintain attention, disorganized thinking, rambling speech, decreased level of consciousness, emotional disturbances (anxiety, anger, fear), and

apathy.

2. the answer should be delirium. on p. 1448 the text quotes" cognitive contributors to delirium include a predisposition to hallucinations and delusions such as that in an aging patient with a history of schizo...." Also, DDX for schizo in 5 minute clinical consult includes delirium.
3. While our text book does not give a clear answer to this question, two of the key points to answer the question are the patient's age, 60, and the "new-onset" of the disease. Alzheimer disease, the most common form of dementia, has a prevalence of 3% in the 65-74 year old range, with prevalence less (uncommon) in younger patients (Robbin's Pathologic Basis of Disease, page 1329). It also is associated with an insidious onset, with personality and psychiatric features beginning in stage II of the disease. (Psych text, page 339). Delirium, on the other hand, is associated with the highest risk group being age 60 or older with a more acute onset. The prevalence of delirium is dependent on the predisposition of the individual, but rates are from 10-15% of patients on medical or surgical wards. Being that we have no medical history of the patient, and both dementia and delirium can present in the same fashion (with hallucinations for example), then it can be supposed that the most prevalent disease in the patient's population, delirium, is what the patient is most likely suffering from.
4. A correct alternative answer is "D"-a medical disorder (delirium). Pg. 340 of the notes states that dementia has a 4% prevalence in those older than age 65. This places our patient's risk for dementia, as a previously healthy 60 y.o., in the very low category. In addition, the notes teach that delirium is a rapid onset disorder, characterized by disordered thought (similar to the "disordered thought" present in schizophrenia). Delirium is a more probable choice given the patients symptoms of "schizophrenia" and new-onset.
5. D is the correct answer. Everything in the clinical history given in the question points to delirium as the cause of this "Schizophrenia." Delirium is defined in the lecture as having an "abrupt onset," which can be inferred from a new onset problem with no psych history. Delirium is most often found in individuals 60 or older. Also, delirium has disordered thinking, a hallmark of schizophrenia. Dementia is not the answer because it is a "sustained intellectual decline" and does not have any alterations in consciousness. Also, only 4% of those who are 65-80 have developed dementia, which would make delirium even more likely just based on sheer numbers. And this question does ask us to think about what is most likely. Therefore, the answer should be D.
6. The correct answer should be Answer Choice D. The clinical findings in the patient described do not match for those used to diagnose dementia, they do however match with those of delirium. The patient is 60 y/o with a new-onset of what has been referred to us as a psychiatric problem, yet with no psychiatric history, which leads toward defining the problem as having a rapid onset, which contraindicate dementia. The clinical signs and symptoms of schizophrenia: disordered thought, delusions, hallucinations, and rapid onset match better with delirium than with dementia, suggesting that Answer choice D is the correct answer.
7. This question asks what a 60 year old man w/ new onset "schizophrenia" most likely has. This man could either have dementia or a medical disorder (delirium). Both disorders can be mistaken for schizophrenia in that both represent a mental status change in a person. In fact, delirium is a better answer than dementia because it characteristically has delusions that can be mistaken for schizophrenic symptoms. Dementia is much slower in onset, begins with mostly changes in memory and wouldn't

be mistaken for schizophrenia until it was very advanced. If this is "new onset" like the question states, and it resembles schizophrenia, according to definitions of delirium and dementia laid out in the lecture, the first option would be to suspect delirium.

8. Answer D: A medical disorder (delirium). Page 429 in "The Text Book of Psychiatry" states, "Atypical presentations such as relatively acute onset, clouding of sensorium, or onset occurring *after age 30 years* demand careful investigation." Careful investigation includes a careful history and physical to "exclude psychoses with known medical causes." For this reason, answer D, "A medical disorder" is the correct answer.
9. Answer D should also be added. Whether or not the patient really had dementia or a medical disorder is a matter of how acute "new-onset" is. If these symptoms of "Schizophrenia" were within the last couple of days, then I would say delirium. If the new-onset was within months to years, then I would say dementia. When reading the question I assumed new-onset was a matter of days, so I chose D.

Dr. Engel Response. Correct answer is C or D. This is a lousy question, since often people with previously occult dementia present initially as acutely disorganized and confused. Technically, this means the patient has delirium and dementia simultaneously. I'll fold on this one and allow both answers.

#### **Question 40.**

Question and Answer Key Answer.

Consider this man's current psychosis. In formulating his clinical situation, his past history of chronic multi-drug abuse is BEST described as a

- A. **XX** Predisposing factor
- B. Precipitating factor
- C. Perpetuating factor
- D. All of the above
- E. None of the above

Challenges.

1. This patient started abusing drugs 5 years ago. This patient's distortion in perceptions and feelings of suspiciousness started 5 years ago. Therefore, I feel that the drug use could have precipitated his psychosis. It may have been a predisposing factor, but the time correlation points to a precipitating factor as well. Like the notes and small group session said, these may not fit precisely into one category or another. (B)
2. Answer E: None of the Above. This is the exact same question and answer series as #148 in last year's Final Exam and the correct answer was E, the same answer as E this year.

Dr. Engel Response. Correct answer is A. The question asks how the man's "past history" relates to his current clinical situation. Since it is past history, it predisposes him to what is happening now. A precipitating factor is still necessary to "tip him over" now (e.g., current drug use or sleep deprivation). We don't know about his current drug use, though it seems like a good candidate precipitating factor. Last year the answer was A too. Someone(s) out there has a list of answers, but they are not the correct answers. Don't use them! (see my response to question 8)