THE ROYAL AUSTRALIAN AND NEW ZEALAND COLLEGE OF PSYCHIATRISTS

MOCK WRITTENS EXAMINATION

AUCKLAND / NEW ZEALAND

DECEMBER 2004

PAPER I MODEL ANSWERS

Please realise that this is an "amateur" version of the real thing, and that the marking schedules here and for our Paper II are more idiosyncratic and not structured quite as in the real writtens, due to local question writers not being as aware of these. Make sure you do read the exams section of the College website to be clear about how the real thing is in fact marked.
E.g. ½ marks are not allowed in the real writtens, so examiners are forced to stick more strictly to the marking templates with less room for "fudging".
In the real exams all questions are as evidence-based as possible, and we tried to manage this where we could, but some questions are less EBM-rigorous and are based more on extensive clinical experience. You will not agree with all the model answers, but then that very likely parallels the real writtens as well.

Extended Matching Questions

Do not answer questions in this booklet. Use the separate answer sheet and pencil provided.

All questions are worth 1 mark

A. Munchausen syndrome
B. Body Dysmorphic Disorder
C. Hypochondriasis
D. Acute Stress Disorder
E. Depersonalization disorder
F. Bulimia nervosa
G. Factitious disorder With Predominantly Psychological Signs and Symptoms
H. Amnestic Disorder Due to Head Trauma
I. Dissociative Identity Disorder
J. Paranoid schizophrenia
K. Anorexia nervosa
L. Acute Posttraumatic Stress Disorder
M. Factitious disorder With Predominantly Physical Signs and Symptoms
N. Delusional disorder
O. Dissociative amnesia
P. Somatization Disorder
Q. Conversion Disorder
R. Pain Disorder

Which diagnosis listed above is the SINGLE MOST LIKELY to be demonstrated by each of the following examples. Please select only ONE option, but any option may be used more than once, if required.

1. A young woman aged 22 eats very little and is preoccupied with getting fat despite being quite underweight. She is unemployed and isolates herself in her room. On interview she is sure her mother is fattening her up so as to sell her as a “white slave”. She knows this from hearing “the mafia” discussing her outside the house and on the TV news. **J**

2. A woman visits her GP many times across two years complaining of abdominal “cramps and pressure”, convinced that she has bowel cancer despite negative investigations including sigmoidoscopy. She can only be briefly reassured. **C**

3. An American aid worker captured by miltiants in the Phillipines witnesses a fellow hostage being shot. Six weeks later, on sick leave after being ransomed, he feels emotionally numb, has intrusive memories of the shooting, avoids the local laundry which is owned by a Phillipine family, and suffers from insomnia and irritability. **L**

4. A man admitted to a psychiatric ward expressing suicidal ideas gives a history of his wife and child having being killed recently by a jack-knifing lorry. He claims to have no other family or friends. After a week, ward staff discover that he has used an assumed name, and find that the details of his account vary. **G**

Extended Matching Questions

Do not answer questions in this booklet. Use the separate answer sheet and pencil provided.

All questions are worth 1 mark

A. Formication
B. Prosopagnosia
C. Palinopsia
D. Simultanagnosia
E. Autotopagnosia
F. Dysaesthesia
G. Derealisation
H. Micropsia
I. Depersonalisation
J. Pareidolia
K. Déjà vu
L. Visual agnosia
M. Anosognosia
N. Jamais vu
O. Finger agnosia
P. Dysgeusia

Which aspect of abnormal perception listed above is the SINGLE MOST LIKELY to be demonstrated by each of the following examples. Please select only ONE option, but any option may be used more than once, if required.

5. A man in a confused and disoriented state post-operatively tries to brush insects off his skin, believing that he can feel them crawling on him. **A**

6. A man in a neurological ward can copy a picture of a tree but cannot tell you what the picture represents. **L**

7. A woman with epilepsy finds that familiar things seem strange and as though experienced for the first time, just prior to a seizure. **N**

Extended Matching Questions

Do not answer questions in this booklet. Use the separate answer sheet and pencil provided.

All questions are worth 1 mark

A. Sandor Ferenczi
B. Erich Fromm
C. Melanie Klein
D. Otto Rank
E. Mary Ainsworth
F. Karen Horney
G. Sigmund Freud
H. Wilhelm Reich
I. Margaret Mahler
J. Alfred Adler
K. Anna Freud
L. Ernest Jones
M. Carl Jung
N. Erik Erikson
O. Michael Balint
P. D. W. Winnicott
Q. Robald Fairbairn
R. Heinz Kohut
S. Nancy Chodorow
T. Harry Guntrip

Which psychoanalyst or theorist listed above is the SINGLE MOST LIKELY to be demonstrated by each of the following examples. Please select only ONE option, but any option may be used more than once, if required.

8. Theorised that the initial two months of an infant's life were the "autistic phase". **I**

9. Invented the concept of "object relations". **G**

10. Researched attachment theory using the "strange situation". **E**

11. Theorised that boys develop sexual identity as males by identification against their mothers' femaleness. **S**

Extended Matching Questions

Do not answer questions in this booklet. Use the separate answer sheet and pencil provided.

All questions are worth 1 mark

A. Obsessive Compulsive Disorder
B. Creutzfeldt-Jakob Disease
C. Rett's Syndrome
D. Major Depressive Disorder
E. Infantile Autism
F. Parkinson's Disease
G. Wernicke Korsakoff Syndrome
H. Pick's Disease
I. Vitamin B12 deficiency
J. Carbon Monoxide poisoning
K. Schizophrenia
L. Affective psychosis
M. Lewy body dementia
N. Alzheimer's dementia
O. Huntingdon's disease
P. Binswanger's Disease

Which condition listed above is the SINGLE MOST LIKELY to result in each of the following examples. Please select only ONE option, but any option may be used more than once, if required.

12. Patchy cell loss in the globus pallidus, hippocampus and cerebral cortex **J**

13. Atrophy of the caudate nucleus **O**

14. Spongiform neuronal degeneration of the cortex, basal ganglia, thalamus and cerebellum **B**

15. Depigmentation of the substantia nigra **F**

Extended Matching Questions

Do not answer questions in this booklet. Use the separate answer sheet and pencil provided.

All questions are worth 1 mark

A. Major depressive disorder
B. Primary insomnia
C. Dissociative fugue
D. Conversion disorder
E. Childhood disintegrative disorder
F. Delirium due to general medical condition
G. Factitious disorder
H. Panic disorder
I. Delusional disorder
J. Pseudoseizures
K. Munchausen syndrome by proxy
L. Temporal lobe epilepsy
M. Adjustment disorder with depressed and anxious mood
N. Generalised anxiety disorder
O. Borderline personality disorder
P. Posttraumatic stress disorder

Which aspect of Consultation-Liaison psychiatry listed above is the SINGLE MOST LIKELY to be demonstrated by each of the following examples. Please select only ONE option, but any option may be used more than once, if required.

16. A 24 year old student has been crying frequently and complains of being unable to sleep or eat since being told she has Crohn' s Disease three days ago. **M**

17. A 37 year old woman in an unhappy marriage develops an inability to walk and is admitted neurologically. No abnormalities are found on physical examination or other assessments. **D**

18. A 28 year old woman has frequent episodes in which she falls to the floor of the neurology ward and thrashes about with her arms and legs while screaming. She is never injured during these episodes, which occur more in visiting hours. **J**

19. A 4 year old girl is admitted repeatedly for weight loss and recurrent infections, but no cause is found. Her mother is very solicitous, always stays in her daughter's room, and gets on well with the staff. The visiting liaison psychiatrist discovers that the girl's mother has a history of childhood emotional abuse and neglect. **K**

Extended Matching Questions

Do not answer questions in this booklet. Use the separate answer sheet and pencil provided.

All questions are worth 1 mark

A.	**Verbal Fluency**	**J.**	**HoNOS**
B.	**AIMS**	**K.**	**YMRS**
C.	**HDRS**	**L.**	**Draw-a-Person**
D.	**EAT**	**M.**	**Wisconsin Card Sort**
E.	**Y-BOCS**	**N.**	**MADRS**
F.	**PANSS**	**O.**	**PASAT**
G.	**CAGE**	**P.**	**Stroop**
H.	**Paired Associate Learning**	**Q.**	**BDI**
I.	**Trail-making**	**R.**	**GATES**

Which test as listed above is the SINGLE MOST LIKELY to be useful in each of the following examples. Please select only ONE option, but any option may be used more than once, if required.

20. A psychologist wishes to explore her client's personality and perception of self and others prior to commencing psychodynamic psychotherapy. **L**

21. You want to monitor the response of a 41 year old inpatient with intractable, resistant mania to a trial of olanzapine added to his usual regime of sodium valproate and lithium carbonate. **K**

22. A 33 year old woman with schizophrenia complains of stiffness in her legs, pains in her back, agitation and pacing a month after commencing risperidone. **R**

23. A 45 year old business executive has an annual physical with his GP who notices that the patient has a raised GGT and a macrocytosis on laboratory tests. When asked if he has been drinking the patient says "No more than usual". **G**

Extended Matching Questions

Do not answer questions in this booklet. Use the separate answer sheet and pencil provided.

All questions are worth 1 mark

A. Echopraxia
B. Perseveration
C. Coprolalia
D. Catatonia
E. Verbigeration
F. Agitation
G. Dyspraxia
H. Motor tic
I. Dysgraphia
J. Wernicke's dysphasia
K. Gegenhalten
L. Dyskinesia
I. Acalculia
J. Astasia abasia
K. Psychomotor activation
L. Rhinotillexomania

Which abnormality of speech or behaviour is the SINGLE MOST LIKELY to be demonstrated by each of the following examples. Please select only ONE option, but any option may be used more than once, if required.

24. A 24 year old acutely admitted young man displays driven, erratic but purposeless bursts of movement, alternating with immobility. **D**

25. A 77 year old woman in a rest home repeats words and phrases frequently during an assessment interview. **B**

26. A 19 year old youth commenced on risperidone as an outpatient develops acute blephorospasm. **I**

27. A 35 year old woman who ceased taking her clozapine one week previously demonstrates stereotypical, senseless repetition of words and phrases. **E**

Extended Matching Questions

Do not answer questions in this booklet. Use the separate answer sheet and pencil provided.

All questions are worth 1 mark

A. lithium carbonate
B. quetiapine
C. zopiclone
D. lamotrigine
E. olanzapine
F. moclobemide
G. benztropine
H. risperidone
I. aripiprazole
J. clozapine
K. clonazepam
L. gabapentin
M. carbamazepine
N. procyclidine

Which medication listed above is the SINGLE MOST LIKELY to cause each of the following examples. Please select only ONE option, but any option may be used more than once, if required.

28. Amenorrhoea **H**

29. Stevens Johnson Syndrome **D**

30. Prolongation of succinylcholine's neuromuscular blockade **A**

31. Hypomania **L**

Extended Matching Questions

Do not answer questions in this booklet. Use the separate answer sheet and pencil provided.

All questions are worth 1 mark

A. Phenomenological qualitative research
B. Unstructured interview data collection
C. Snowball sampling
D. Data collection using video recordings
E. Selection bias in qualitative research
F. Latent level of analysis
G. Data collection by note-taking
H. Data collection using documentation
I. Semi-structured interview data collection
J. Grounded Theory
K. Focus group data collection
L. Constant Comparative Analysis
M. Ethnographic qualitative research
N. An extended case study
O. Manifest level of analysis
P. Highly structured interview data collection

Which aspect of qualitative research listed above is the SINGLE MOST LIKELY to be demonstrated by each of the following examples. Please select only ONE option, but any option may be used more than once, if required.

32. A qualitative study describing and analysing organisational change in the restructuring of a community service, across a period of two years. **N**

33. Originated with Glaser and Strauss' work in the 1960s on the interactions between health care professionals and dying patients. **J**

34. A qualitative researcher studying a mental health service gathers up the organisation's policies, mission statements, annual reports, minutes of meetings, codes of conduct, memos and notices pinned to notice boards. **H**

35. A qualitative research project looks at the experience and concept of "carers" - what does "caring" actually mean and what is it like to be a "carer"? **A**

Extended Matching Questions

Do not answer questions in this booklet. Use the separate answer sheet and pencil provided.

All questions are worth 1 mark

A. Graded exposure
B. Reinforcement-based therapy
C. Shaping
D. Implosion therapy
E. Behavioural modification
F. "ABC" analysis
G. Operant conditioning
H. Social skills training
I. Classical conditioning
J. Decelerating therapy
K. Counterconditioning
L. Exposure-based therapy
M. Aversion therapy
N. Habit reversal
O. Imaginal exposure
P. In vivo sensitisation

Which Behavioural Therapy term listed above is the SINGLE MOST LIKELY to be demonstrated in the following vignettes. Please select only ONE option, but any option may be used more than once, if required.

36. A man with a fear of heights is shown a video taken from a camera strapped to a sky diver jumping out of a plane. **D**

37. A patient and therapist discuss the triggers for a bulimic binge, what happened during the bingeing and the patient's reaction afterwards. **F**

38. A young woman with trichotillomania learns to rub a polished marble egg in response to impulses to twist her hair repetitively. **N**

Extended Matching Questions

Do not answer questions in this booklet. Use the separate answer sheet and pencil provided.

All questions are worth 1 mark

A. i.b.s. linkage analysis
B. Haplotype relative risk genetic association method
C. Ultra-rapid P450 2D6 metabolizer phenotypes
D. chromosome 22q deletions
E. P450 1A2 polymorphisms
F. Intermediate P450 2D6 metabolizer phenotypes
G. Serotonin receptor gene
H. P450 3A4 polymorphisms
I. Chromosome 21 linkages
J. i.b.d. linkage analysis
K. Genetic polymorphism affecting acetaldehyde dehydrogenase
L. Serotonin transporter gene 5HTT

Which of the examples from genetic research listed above is the SINGLE MOST LIKELY to be associated with each of the following examples. Please select only ONE option, but any option may be used more than once, if required.

39. Implicated in the aetiology of bipolar disorder. **I**

40. Patients with the "LL" genotype do better with SSRI therapy than those with the "SS" genotype. **L**

41. Linked with velocardiofacial syndrome and schizophrenia. **D**

42. Implicated in genetic vulnerability to the development of alcoholism. **K**

Extended Matching Questions:

Do not answer EMQ questions in this booklet. Use the separate answer sheet and pencil provided.

All questions are worth 2 marks each

Please select UP TO TWO responses for each question.

More than two responses will incur a mark of zero.

Answers to one question may be used for subsequent questions if required.

A. Hypothyroidism
B. Family history of anxiety disorder
C. Amphetamine abuse
D. Prematurity at birth
E. Loss of a parent before age eleven
F. Family history of depression
G. Dehydration
H. Opiate dependancy
I. Hyperthyroidism
J. High parental espressed emotion
K. Female sex
L. Birth by caesarian section
M. Cigarette smoking
N. Past cerebrovascular accident

For each of the following examples, select the TWO MOST LIKELY risk factors from the list above. Any option may be used more than once, if required.

43. A 69 year old patient taking risperidone is admitted acutely with rigidity, temperature of 38 degrees, confusion, and on investigation has an elevated creatinine kinase, leucocytosis and mildly elevated liver enzymes. **G N**

44. A 19 year old patient living at home with family and treated with fluphenazine decanoate is readmitted for the third time with a relapse of auditory hallucinations and fears of being controlled by radio waves from Mars. **C J**

Extended Matching Questions:

Do not answer EMQ questions in this booklet. Use the separate answer sheet and pencil provided.

All questions are worth 2 marks each

Please select UP TO TWO responses for each question.

More than two responses will incur a mark of zero.

Answers to one question may be used for subsequent questions if required.

A.	**desipramine**	**H.**	**propranolol**
B.	**quetiapine**	**I.**	**fluoxetine**
C.	**zopiclone**	**J.**	**clozapine**
D.	**sodium valproate**	**K.**	**clonazepam**
E.	**olanzapine**	**L.**	**sertraline**
F.	**nortriptyline**	**M.**	**carbamazepine**
G.	**benztropine**	**N.**	**procyclidine**

For each of the following examples, select the TWO MOST LIKELY medications from the list above. Any option may be used more than once, if required.

45. A 43 year old man was treated with one drug for ten weeks. His doctor ceased it and immediately commenced the second drug. Within several hours of the initial dose the patient presented to hospital with hyperthermia, confusion, tachycardia, diaphoresis, hyperreflexia and myoclonus. **I L**

46. Concomitant prescription of folic acid may reduce the risk of foetal abnormalities if either of these drugs are given during pregnancy. **D M**

Extended Matching Questions:

Do not answer EMQ questions in this booklet. Use the separate answer sheet and pencil provided.

All questions are worth 2 marks each

Please select UP TO TWO responses for each question.

More than two responses will incur a mark of zero.

Answers to one question may be used for subsequent questions if required.

A. Countertransference
B. Denial
C. Altruism
D. Anticipation
E. Parallel process
F. Isolation of affect
G. Devaluation
H. Projective identification
I. Idealisation
J. Humour
K. Resistance
L. Repression
M. Transference
N. Reaction formation
O. Displacement
P. Rationalisation
Q. Projection
R. Splitting

For each of the following examples, select the TWO MOST LIKELY descriptions of defences or psychotherapy processes from the list above. Any option may be used more than once, if required.

47. A psychiatric registrar under pressure to help her psychodynamic psychotherapy patient feels frustrated with her supervisor, as he will not give her advice about the case. At home after the supervision session, she argues with her partner about who was supposed to buy more milk. **E O**

48. A man who suffered emotional deprivation as a child develops a career in stand-up comedy, entertaining audiences with jokes about the various foster families and orphanages he has known. He donates a percentage of his earnings to charities related to children. **J C**

KEY FEATURE CASE

Case 1 (6 marks)

You are asked urgently to assess Linda, a 31 year old married nurse who is four weeks post partum after the birth of her first baby. She was reluctantly taken to her General Practitioner by her mother the previous day because she has been tearful, agitated, and sleeping poorly since returning home from the hospital 4 days post partum. The GP is very alarmed because she has told her husband that she has had thoughts of throwing the baby out of the window. He is requesting an assessment, and is particularly concerned about the safety of the baby.

Question 1

You assess Linda and determine that she has a major depressive episode.

What are the two key differential causes of Linda's thoughts, which would give the highest and the lowest risk to the baby?
List UP TO TWO differential causes only.
State which of these is high risk, and which is low risk. ***(4 marks)***

SCORING KEY

A. Thoughts are caused by depression with psychosis (± suicidality)
B. thus a high risk to the baby
C. Thoughts are obsessional symptoms linked with depression
D. thus a low risk to the baby

Scoring Algorithm	Explanation of this algorithm
1 mark for each aspect, A,B,C,D. A + B = 2 marks C + D = 2 marks A correct, B incorrect = 0 marks C correct, D incorrect = 0 marks If possibility of a psychotic depression (as opposed to just "major depression") is not mentioned at all – this section scores zero marks If possibility of thoughts being obsessional is not mentioned at all – this section scores zero marks More than 2 differentials given = 0 marks.	Both of the 2 main causes of the thoughts must be given in some form of words. The risk level associated with each must be stated accurately. The issue of suicidality associated with a psychotic depression may be mentioned, but no marks are lost if suicidality is not specifically linked with psychotic depression. Regarding the obsessional aspect, accept terms such as OCD, obsessions, obsessional thoughts, obsessional features or obsessional symptoms.

Question 2

You decide to start an antidepressant. Linda has not previously had any antidepressant treatment. She wants to continue to breast feed, and is still determined to do so after you have explained the possible risks involved.

What are the four safest antidepressant options that you might choose to treat Linda?
Select FOUR OPTIONS ONLY from the following list: ***(2 marks)***

A.	Fluoxetine	Incorrect (higher transfer into milk, half-life of drug and active metabolite too long so can accumulate)
B.	**Nortriptyline**	**Correct (TCAs other than doxepin are safe)**
C.	**Citalopram**	**Correct (citalopram and paroxetine transfer less into the milk and have shorter half-lives)**
D.	Tranylcypromine	Zero score if this selected (MAOIs cross ++ into breast milk, & possible interactions)
E.	Doxepin	Zero score if this selected (reports of doxepin causing severe reactions, e.g. apnoea)
F.	**Clomipramine**	**Correct**
G.	**Paroxetine**	**Correct**
H.	Phenelzine	Zero score if this selected (MAOIs cross ++ into breast milk, & possible interactions)

Scoring guide: ½ mark for each correct drug indicated.

Notes to Marker:
If an MAOI (Tranylcypromine or Phenelzine) or Doxepin are selected, this section scores zero marks.
If Fluoxetine is selected it scores no marks, but the section does not score zero.

KEY FEATURE CASES

Case 2 (6 marks)

James is a 54 year old unmarried cleaner with no mental illness who has a history of multiple convictions for a diverse range of sexual, property and violent offences. On this occasion he is convicted of sexual offending, his victim being his 10 year old nephew who is said to be physically and emotionally traumatised by his actions.

James, who denies this offence and previous sexual offending (despite his record and the jury' s verdict), has failed to complete correctionally based treatment programmes during prior sentences due to lack of application and disruptiveness.

Question 1
Your task is assess James for the court, regarding his risk of reoffending.

Which four factors, from the vignette, have been actuarially validated as signifying an increased risk of future sexual offending?
List UP TO FOUR. ***(4 marks)***

SCORING KEY

A. Marital status: single
B. Antisocial PD or traits/criminal history (history of past criminal offences)
C. History of prior sexual offences as such
D. That the prior sexual offences were diverse (different sorts of offence)
E. Male victim
F. Male perpetrator
G. Prior failure to complete treatment programmes

Scoring Algorithm	Explanation of this algorithm
1 mark for each aspect, A, B, C, D, E, F or G Up to a maximum of 4 marks. No marks allotted for: use of force, James' age, socio-economic status, his denial of the offences, his lack of remorse, the victim being a family member. More than 4 factors listed = 0 marks.	If past criminal offences and antisocial PD/traits are listed separetely, allot only 1 mark as they are too similar in content to attract a mark each.

Question 2
What factor not stated in the vignette is the most powerful predictor of future sexual offending?
Give ONE factor only. ***(2 marks)***

SCORING KEY

A. Positive penile phallometry
B. Deviant sexual fantasies
C. History of sexual offences against exclusively male, child victims

Scoring Algorithm	Explanation of this algorithm
A = 2 marks B = 1 mark C = 1 mark More than 1 factor listed = 0 marks.	"Positive penile phallometry" (measurement of subject's erectile response during audiovisuals that expose him to a range of sexually explicit as well as neutral material) and the other answers may be expressed in a similar form of words.

KEY FEATURE CASES

Case 3 (6 marks)

Joseph, aged 39, presents for the assessment of low mood. Routine questioning reveals that he has a strong compulsion to drink alcohol; routinely drinks larger amounts of alcohol than he intended; and that he has been unable to cut down this consumption. Joseph further reports that he spends a considerable amount of time drinking and recovering from drinking, to the extent that he has had to cut back on his work hours.

Question 1
In your assessment of Joseph, what are other KEY areas to address when considering a diagnosis of alcohol dependence? List UP TO THREE. (4 marks)

SCORING KEY
A. Symptoms of tolerance.
B. Symptoms of withdrawal.
C. Continued use of alcohol despite clear evidence of harmful consequences.

Algorithm	Scoring Key
A = 1 B = 1 C = 1 mark A + B = 2 marks A + C = 2 marks B + C = 2 marks A + B + C = 4 marks More than 3 answers = 0 marks.	1 mark for ONE of the three answers 2 marks for TWO of the three answers 4 marks for ALL THREE answers 0 marks for MORE THAN THREE answers

Explanatory notes to marker:
This question tests the candidates knowledge of the diagnosis of alcohol dependence as conceptualized by DSM- IVR and ICD 10 both of which are based on the theories of Edwards and Gross (all in Schuckit and Kaplan and Saddock). The history gives the other criteria for the diagnosis.
DSM-IV-R has seven major criteria to look for in the history. Joesph's history gives criteria 3-6, so 1, 2 and 7 (tolerance, withdrawal, and continued use despite being aware of the problems it causes) are what is being looked for.
ICD-10 has six major criteria, which are the DSMIV criteria grouped together plus craving or a sense of compulsion. Joseph's history is missing criteria 3,4, and 6 (tolerance, withdrawal, and continued use despite being aware of the problems it causes).
If tolerance and withdrawal are grouped together as one item (indicating physiological dependence) this was marked as being correct for two points
The most common mistake was including features of alcohol abuse or the CAGE questionnaire.

Question 2
Joseph asks if his drinking might have caused his depression.

What is THE KEY area in the history to explore when trying to distinguish an independent depression from a depression secondary to alcohol use?
Write ONE answer only. (2 marks)

SCORING KEY
A. The key area in the history is establishing the temporal link between alcohol use and depression. If the depression is only seen while drinking and remits in abstinence it is probably secondary. If it preceded the commencement of the alcohol problems and is unaffected by abstinence then it is probably independent.

Algorithm	Original Scoring Key
	1 mark for the temporal link 1/2 mark for each elaboration of this link as noted above

Explanatory note to marker:
Schuckit, Kaplan and Saddock, and DSM IV all emphasize the temporal link, rather than specific symptoms, the dose of alcohol, or risk factors for either disease as being the key way to differentiate. DSM IV further specifies the length of abstinence (four weeks). Candidates almost universally identified this link, but did not elaborate both elements of this: which came first and whether the depression remitted in abstinence.

KEY FEATURE CASES

Case 4 (6 marks)

Ben is a 13 year old boy referred to your clinic for assessment with a four month history of school refusal and loose bowel motions. He reports that he has no friends at school and would prefer to enrol in correspondence school. He feels nervous about leaving the house and soiling himself and has three to four loose bowel motions daily. Ben remains awake for two to three hours after bedtime, thinking about frightening scenarios involving his family being hurt or killed in car or plane crashes. He describes his family as very close and supportive.

During childhood, Ben was frequently ill and absent from school with abdominal pains, which his parents attributed to food allergies. Investigations by his GP have not indicated any clear physical explanation for his previous and current abdominal symptoms. Although temperamentally shy, Ben had several close friends, with whom he has refused contact since he stopped attending school. His mother works from home, and reports that when she needs to go out briefly, Ben becomes very distressed.

Question 1
In your assessment of Ben, which are the two most likely differential diagnoses?
List UP TO TWO. ***(2 marks)***

Scoring Key – possibilities accepted are:

A. Separation Anxiety disorder
B. Obsessive Compulsive Disorder
C. Generalised Anxiety Disorder

Scoring Algorithm:
A=1 B=1 C=1

1 mark for one correct answer 2 marks for two correct answers 0 marks for more than two answers

Ben refuses to attend the next three appointments.

Question 2
Which TWO next steps would you consider the most important at this point? ***(2 marks)***

A. Support Ben's enrolment with correspondence schooling
B. Arrange for a medical review of Ben's bowel symptoms
C. Meet with Ben's parents and sister to gain their perspectives and enlist their support
D. Commence cognitive behaviour therapy
E. Home visit Ben and focus on engaging with Ben
F. Commence Ben on lorazepam to provide immediate relief for his anxiety
G. Contact Ben's school to enquire about his progress and functioning at school
H. Discuss the possibility of a compulsory assessment with Ben's parents

Scoring Key:
C=1 E=1
1 mark for one correct answer 2 marks for two correct answers 0 marks for more than two answers

Question 3
Which TWO factors suggest a positive prognosis for Ben? ***(2 marks)***

Scoring Key:
A. Close supportive family
B. Has premorbidly sustained relationships

Scoring Algorithm:

1 mark for one correct answer 2 marks for two correct answers 0 marks for more than two answers

KEY FEATURE CASES

Case 5 (6 marks)

You are asked to see a 44 year old woman on the renal ward who has been admitted after 3 weeks of non-adherence to her daily peritoneal dialysis regime. She has a long history of poor adherence to treatment for type II diabetes. She has had chronic renal failure requiring dialysis for 6 months and says now that she doesn' t wish to continue her dialysis, she wishes to try "herbal remedies". You are asked to assess her competency to decline dialysis treatment.

Question 1

What are the main elements of competency that this patient would need to demonstrate? List UP TO FOUR main elements. ***(4 marks)***

Scoring Key:

A. understands the current situation (understands the information provided)
B. understands the options available (the consequences of choice)
C. is able to communicate her choice
D. is able to demonstrate rational decision making

Scoring Algorithm	Explanation for marker
A or B or C or D = 1 mark each, to a max. of 4 More than 4 answers = 0 marks	Reference - Appelbaum & Gross paper 1987. or Wise and Rundell text of C-L Psychiatry for a good summary of competency.

Question 2

After you complete your assessment, it is your opinion that she is competent. She however describes her sense of hopelessness at her medical situation.

Apart from suicidality, what is the key psychiatric issue that needs to be considered in this woman? Write ONE answer only. ***(2 marks)***

A. Assessment for major depressive disorder

Scoring: 2 marks for any reasonable form of words to express the need to assess for depression.

KEY FEATURE CASES

Case 6 (6 marks)

A 23-year-old Pacific Island man now living with his elderly invalid mother has recently been discharged from hospital after a brief compulsory admission for a first episode psychosis. Prior to admission he had been studying at University and in a relationship of several years with his girlfriend. He has been commenced on risperidone which has been titrated up to 2 mg daily, with some symptomatic benefit. He is not receiving compulsory treatment under the Mental Health Act.

Question 1

List several key factors which are likely to determine his adherence with medication therapy. ***(3 marks)***

Scoring key:

A. His (or his mother's/family's) attitudes to medications generally
B. His (or his mother's/family's) insight into illness
C. His (or his mother's/family's) cultural / ethnic beliefs
D. His response to treatment overall
E. Side effects (e.g. EPSE, sexual)
F. Specific symptoms intefering with insight (e.g. delusions about drug treatment or of grandeur)
G. Treatment alliance / therapeutic relationship / therapeutic alliance etc.

Scoring Algorithm	Explanation of this algorithm
A, B, C, D, E, F, G – ½ mark each to a max. of 3 marks	Any reasonable form of words conveying these issues

Question 2

You arrange follow-up via regular home visits.
What psychosocial interventions are important to consider in the initial visits? ***(3 marks)***

Scoring key:

A. Engagement
B. Cultural input
C. Psychoeducation and emotional support for patient and family
D. Debriefing for patient regarding possible trauma of admission
E. Motivational interviewing for substance use if present
F. Vocational support (liaison with University Mental Health Coordinator re support available e.g. aegrotat / 'note taker' / extended time for exams / withdrawal without penalty etc.)
G. Reduction of environmental stressors (e.g. financial factors such as a sickness benefit and social services for mother)
H. Cognitive behavioural strategies for ongoing symptoms including co-morbid conditions such as depression and anxiety

Scoring Algorithm	Explanation of this algorithm
A = 1 mark If A not given at all this section scores zero B, C, D, E, F, G, H – ½ mark each to a max. of 2 additional marks	Must mention need for engagement to get any marks for this section.

Note to Marker:
Engagement is more than "therapeutic relationship" or "rapport". Engagement encompasses all these, plus active outreach to engage patients and families, home visiting, cultural appropriateness, etc.
Therapeutic relationship (in place of "engagement") can be awarded a ½ mark (and does not lead to the section scoring zero), but *rapport* by itself does not score.

KEY FEATURE CASES

Case 7 (6 marks)

On starting work at a new community team, you pick up the care of Sheree, a 29 year old woman. Her file states that she has an eight-year history of schizoaffective disorder, with six past admissions. She has a history of extensive sexual and emotional abuse in childhood. Her main symptoms are persistent low mood, suicidal ideation, insomnia, cutting of the forearms, overvalued ideas of a persecutory nature which have during her admissions been of delusional intensity, and intractable derogatory auditory hallucinations. She has never had manic symptoms. She is treated with IM fluphenazine decanoate 50mgs monthly, oral olanzapine 20 mgs daily, clonazepam 0.5 mgs QID, lithium carbonate 1000 mgs nocte and fluoxetine 60 mgs mane. After reading the file, you have doubts about her diagnosis of schizoaffective disorder.

Question 1

What is the most likely alternative explanation for Sheree's longstanding symptoms, if she does not in fact have a schizoaffective disorder? ***(3 marks)***

The answer needs to convey three key issues for the 3 marks:

1. The abuse has led to features of Borderline Personality Disorder / or accept Chronic PTSD
2. The abuse has also led to affective instability and lowered moods / dysthymia / depressive episodes
3. The apparent psychotic Sx are more likely to be dissociative in origin and also linked to the abuse

(many canddiates interpreted the request for an "alternative explanation" too concretely and just gave a diffferential Dx, with no explanatory linkage to the serious abuse history.)

You decide to review Sheree's diagnosis and reorganise her treatment.

Question 2

Which would be the most important next steps for you to carry out?
Select THREE OPTIONS ONLY from the list below. ***(3 marks)***

A. Tell her case manager about your rediagnosis and plans to alter Sheree's medication
B. Construct a detailed record of her treatment, using timelines to record medications
C. Chart a withdrawal regime for the clonazepam
D. Refer Sheree for sexual abuse therapy
E. Meet with Sheree, assess her and start to establish a therapeutic relationship
F. Rewrite Sheree's Crisis Management plan
G. Cease the IM fluphenazine and allow it to self-taper
H. Arrange a case conference of all the health professionals involved in Sheree's care
I. Present your reformulation and plan to the multidisciplinary team at the next meeting
J. Titrate down and then cease the lithium carbonate across a 4-week period

Notes:
Correct answers are B, E and H
Essential to begin to establish a therapeutic relationship and to actually assess her before doing anything else, useful to summarize the past polypharmacy in detail, and a case conference is also useful.
A – no, need to assess her first, C – no, not before seing her and reviewing the case more thoroughly, also is too high-handed. D – too precipitate and might be harmful, F – too high-handed - such plans need to be written in consultation with all involved. G - Ceasing IMI depot too high-handed prior to assessing her. I - Telling MDT your views also too high-handed, need a conference first, not to dictate plan to others at this early stage. J - also too precipitate and would need more time for all involved to agree to this.

KEY FEATURE CASE

Case 8 (6 marks)

Suzanne, a 24 year old single woman, is picked up in town just after midnight by the police for loud and disruptive behaviour. When you speak to her she is initially suspicious and does not believe that you are a health professional. However she then starts talking rapidly about a range of topics but continues to appear tense and agitated. She angrily denies any previous history of mental disorder and keeps demanding to be able to go back and find her friends.

Question 1
In your acute assessment of her mental state, what are the most important psychiatric diagnoses to consider? List UP TO THREE (4 marks)

SCORING KEY
A. Amphetamine Induced mania/psychosis
B. Acute Manic Episode, Bipolar disorder
C. Brief Psychotic Disorder *(in retrospect, this was probably a bit specific and a more general category such as 'acute onset psychotic disorder' would have been fairer.)*

Algorithm	Explanation of this algorithm
A = 1 mark B = 1 mark C = 1 mark A + B = 2 marks A + C = 2 marks B + C = 2 marks A + B + C = 4 marks More than 3 answers = 0 marks.	1 mark for ONE of the three answers 2 marks for TWO of the three answers 4 marks for ALL THREE answers 0 marks for MORE THAN THREE answers

Explanatory notes:
A. *Time of day and place of presentation. Appears to have been out with friends. Evidence of persecutory ideation, agitation, physical tension, rapid speech.*
B. *Is awake and active late at night, out in town – possible poor judgment, reduced sleep, increased activity. Pressured speech, psychomotor agitation, with some persecutory ideas.*
C. *Apparent first presentation of mental disorder; disorganized behaviour, agitation and possible associated psychotic features such as persecutory ideation.*

Question 2
You wish to initiate some form of management. You decide to admit her to an inpatient psychiatric unit for compulsory assessment via the Mental Health Act, with assistance from the police.

What is your IMMEDIATE management plan on arrival at the inpatient unit as regards medication options? List UP TO TWO options. (2 marks)

SCORING KEY
A. No medication, monitor over 24 hours OR
B. Short acting benzodiazepine overnight OR
C. Start an atypical antipsychotic

Algorithm	Explanation of this algorithm
A = 1 mark B = 1 mark C = ½ mark A, B = 2 marks A, C = 1 ½ marks B, C = 1 ½ marks More than 2 answers = 0 marks.	1 mark for A or B answers ½ mark C answer 0 marks for MORE THAN TWO answers

Explanatory Notes:
A. *No evidence of immediate risk to self or others, past history unclear, possible substance intoxication causing presentation.*
B. *Need better history and collateral prior to initiating immediate treatment, need to reduce psychomotor agitation overnight, but not overly sedate her for review on the following morning.*
C. *Possible psychosis or mania, both of which are indications for an atypical antipsychotic. However only ½ marks because using an antipsychotic as a sedative or committing her to antipsychotic treatment when she may not need it long term are less appropriate choices overall.*

KEY FEATURE CASES

Case 9 (6 marks)

Alfred, aged 79, is referred to you by his general practitioner because of worsening memory and difficulties caring for himself. You have visited him at his home where he lives with his wife. His wife has noted a gradual deterioration over the previous two years, and reports that he has had a number of falls and believes that children visit him during the day.
You suspect that he may have a Lewy Body dementia.

Question 1
What are other key symptoms or signs that make the diagnosis probable? List up to three. ***(4 marks)***

Scoring Key
A. Spontaneous motor features of parkinsonism
B. Recurrent well formed visual hallucinations
C. Fluctuating cognition with pronounced variations in attention and alterness

Scoring Algorithm	Explanation of this algorithm
1 mark for ONE of the three answers (A, B or C) 2 marks for TWO of the three answers (A and B, B and C, or A and C) 4 marks for all THREE answers (A and B and C) 0 marks for MORE THAN THREE answers	The answer lists the key symptoms that identify probable Lewy Body dementia as per the accepted McKeith criteria.

Question 2
Following your assessment you think that the most likely diagnosis is a Lewy Body dementia. You decide to prescribe regular medication to try and control the behavioural disturbances identified by his wife.

Which of the following medications would you consider trialling initially?
Select UP TO TWO options from the following list. ***(2 marks)***

A. Rivastigmine
B. Clozapine
C. Lorazepam
D. Quetiapine
E. Risperidone
F. Citalopram
G. Carbamazepine

Scoring Algorithm	Explanation of this algorithm
1 mark for A or D 2 marks for A and D	The answer is based on clinical experience and the literature. A (rivastigmine) is correct because basically cholinesterase inhibitors are good at controlling bpsd in Lewy Body dementia. D (quetiapine) has little anticholinergic activity and little propensity to cause EPSE. *The others are wrong because:* B (clozapine), useful but not first line option, lots of monitoring, hypotensive, anticholinergic C (lorazepam), usually don't use long term/regular, risk worsening cognition, falls E (risperidone), sensitivity of Lewy Body dementia to EPSE, worsening cognition F (citalopram), might be good for depressive symptoms, but not a first line for this condition. G (carbamazepine) not an appropriate choice for this situation.

SHORT ANSWER QUESTIONS

Short Answer 1

(4 marks)

In your outpatient clinic you assess a 77 year old ex-headmaster whose daughter is concerned that he is becoming forgetful, confused and less able to cope alone at home.

Question 1

List in note form the limitations of the Folstein Mini Mental State Examination ***(2 marks)***

- Floor effect - less useful in the low range (e.g. severe impairment, language problems, poor education)
- Ceiling effect - those with v. good language skills may do well despite cognitive impairment
- Heavily weighted toward verbal/language items
- Score affected by literacy/education level/social class
- Score affected by cultural background - problems if English not 1st language
- Lack of sensitivity to mild cognitive impairment
- Lack of sensitivity in assessing progressive impairment/no comparison to past functioning
- Relatively poor test-retest reliability/learning effect on repeated testing
- Relatively poor inter-rater reliability
- No testing of frontal functions such as abstraction or executive functioning
- Visuo-spatial skill testing is very limited
- Sensory deficits may distort the score
- Score can be affected by age

½ mark for any point as above, up to a max. of 2 marks

Question 2

List in note form specific tests of frontal lobe functioning which can be performed during an ordinary outpatient clinic psychiatric assessment. ***(2 marks)***

- Verbal fluency / word generation
- Similarities test (or proverbs)
- Go No-go test
- Luria's fist-palm-edge test
- Finger tapping
- Alternating sequence perseveration tests (copying patterns)
- Paired associate learning test
- Visual grasp (antisaccade task)
- Trail-making test
- Draw a clock test

½ mark for any test as above, up to a max. of 2 marks

SHORT ANSWER QUESTIONS

Short Answer 2

(4 marks)

A 34 year old man who does not abuse substances becomes infuriated whenever his wife looks at other men or talks to them. He frequently accuses her of having affairs with men in the neighbourhood, in spite of her repeated denials. On a few occasions he has become so angry that he has hit her, and refused to allow her to leave the house. The couple have seen a marriage counsellor to try to help the patient understand that his wife has not been unfaithful to him, but he continues to refuse to believe this.

Question 1

List in note form the two most likely differential diagnoses. ***(2 marks)***

A. Delusional disorder (morbid jealousy)
B. Personality disorder (e.g. paranoid, antisocial, narcissistic, borderline, mixed PD)

mark for each diagnosis as above = 2 marks

No marks for “Paranoid schizophrenia” or other psychoses, if given.

Question 2

List in note form the factors about this patient, as given in the vignette, which increase the level of risk to the spouse. ***(2 marks)***

A. Male sex
B. Previous violence
C. Intensity (probably delusionsl) of jealous beliefs
D. Lack of insight

1 mark for each factor as above to a max. of 2 marks

SHORT ANSWER QUESTIONS

Short Answer 3

(3 marks)

Question 1

Briefly explain what formal and informal sociological rules regarding deviance are, and give an example of a changed social construction of deviance from the DSM system. *(3 marks)*

Formal rules: laws or written rules and regulations (e.g. Criminal law, School Rules) = 1 mark
Informal rules: unstated or unwritten rules / norms (e.g. not picking your nose in public) = 1 mark

Changed social construction of deviance in the DSM system:
removal of homosexuality as a disorder
(Homosexuality classified as a sexual deviation DSM II
term altered to 'sexual orientation disturbance' 1973
altered again to 'ego-dystonic homosexuality' 1978 with advent of DSM-III
DSM-III-R removed it altogether in 1987)

Or - addition of PTSD as a disorder (disorder implying a deviation from normal, as opposed to seeing it as non-deviant behaviour/experience – e.g. as normal human distress or suffering)

Or - the changing categories of personality disorders in DSM, reflecting constructions rather than absolute reality of a "disorder" (disorder implying a deviation from normal) – e.g.
Passive-Aggressive Personality Disorder
Depressive Personality Disorder
Aggressive-Sadistic Personality Disorder
Self-Defeating ("Masochistic") Personality Disorder

1 mark for any of these examples

Please note that there is no Question 2

SHORT ANSWER QUESTIONS

Short Answer 4
(4 marks)

You confer with a General Practitioner about the physical state of a mutual patient - a 22 year old woman with restrictive anorexia nervosa who you feel needs to be admitted medically due to failure to maintain a minimum weight.

Question 1
List in note form the findings on physical examination (other than low weight) which can occur with anorexia nervosa. ***(2 marks)***

A. Hypotension (esp. postural hypotension)
B. Bradycardia
C. Hypothermia
D. Dry skin/brittle nails
E. Dry hair and hair loss
F. Lanugo
G. Hypercarotenemia (yellowing seen esp. In palms and soles)
H. Atrophy of the breasts / reduced secondary sexual characteristics / hypogonadism
E. Acrocyanosis (cyanosis of the extremities)
F. Oedema of the feet and ankles
G. Cardiac dysrhythmias
H. Peripheral neuropathy
I. Constipation
J. Hyporeflexia
K. Muscle atrophy/wasting/muscle weakness/inability to stand from squatting
L. Poor dentition
M. Parotid enlargement
N. Dorsal Finger calluses from inducing vomiting
O. Dehydration

½ mark for each point to a max. of 2 marks

Despite a vast no. of options being available, many candidates listed only a few obscure features, or only those assocd with bulimia. In the end bulimic signs were allowed as the majority of AN patients have mixed features.

Question 2

List in note form the biochemical abnormalities most commonly found on laboratory blood testing, with anorexia nervosa. ***(2 marks)***

A. Hypokalaemia
B. Hyponatraemia
C. Hypomagnesaemia
D. Hypoglycaemia
E. Hypophosphataemia
F. Hypochloraemia
G. Alkalosis
H. Raised serum osmolality/urea due to dehydration

½ mark for each point as above to a max. of 2 marks

You may think this section unduly picky but the Q. asked for "biochemical abnormalities" so this was interpreted strictly. e.g. haematological and endocrine abnormalities were not accepted.

SHORT ANSWER QUESTIONS

Short Answer 5
(4 marks)

During an ECT treatment, you note that the patient has a tachycardia, dilated pupils, piloerection and facial flushing immediately afterwards; that the EEG showed good seizure amplitude, good seizure regularity, high hemisperic coherence and clear post-seizure suppression; and that the motor aspect of the seizure lasted 25 seconds.

Question 1
List in note form the FOUR key findings in the example as above for which there is the best evidence as predictors of better clinical efficacy with ECT. ***(4 marks)***

A. Good seizure amplitude on EEG
B. Good seizure regularity on EEG
C. Hemisperic cohesion on EEG
D. Post-seizure suppression on EEG

1 mark for each point
zero marks if >4 given as a specific no. were asked for.

No marks for any of the other options – research evidence is lacking re the >20/25 sec timing, and other factors can affect some of these features (e.g. patient being on anticholinergic meds could enlarge the pupils).

Please note that there is no Question 2

SHORT ANSWER QUESTIONS

Short Answer 6
(4 marks)

Your mental health community team is responsible for the care of a youth with Prader-Willi syndrome who lives in supported accommodation.

Question 1
List in note form several psychiatric or behavioural problems other than overeating, associated with Prader-Willi syndrome. ***(2 marks)***

A. Compulsive food-seeking
B. Stealing food
C. Hoarding
D. Skin-picking
E. Compulsive behaviours
F. OCD
G. Personality rigidity
H. Oppositional behaviour
I. Tantrums
J. Agression
K. Psychotic episodes
L. Affective disorder, esp. with psychosis
M. Mental retardation
N. Developmental delays - language and motor

½ mark for each point to a max. of 2 marks

Question 2

Briefly state the aetiology of Prader-Willi syndrome and the neuroanatomical site of the abnormality underlying the hyperphagia. ***(2 marks)***

A. Chromosome 15 deletion - paternal
Chromosome 15 maternal uniparental disomy
Chromosome 15 abnormality / defect etc.
Genetic abnormality / genetic cause / genetic disorder etc.
Spontaneous genetic birth defect / non-inherited genetic defect etc.

1 mark if any of the above given

"genetic inheritance" / "Inherited defect" etc. = no marks (P-W is not an inherited disorder)
"congenital" scored nil as this just means "present at birth" so was too imprecise.

B. Hypothalamus or "satiety centre" or "paraventricular nucleus (of hypothalamus)" or "reduced oxytocin neurones (in these areas)" = 1 mark

SHORT ANSWER QUESTIONS

Short Answer 7
(4 marks)

A colleague presenting a case at peer review describes a patient she has been seeing for psychotherapy as having “primitive defences”, a narcissistic personality and displaying “mirror transference”.

Question 1
List in note form the primitive defences. ***(2 marks)***

Projection
Projective identification
Splitting
Dissociation
Idealisation and devaluation
Omnipotence
Psychotic denial / Denial
Psychotic distortion / Distortion

(Ref: George Vaillant' s categorisation of defences. Regression may take a person back to a less mature developmental functioning level but is not in itself a primitive defence.
Introjection was also not accepted as a primitive defence.)

½ mark for each, to a max. of 2 marks

Question 2

What is “mirror transference”, and which psychoanalytical theoris t first decribed it. ***(2 marks)***

A. In "mirror transference" the developmentally arrested narcissistic patient experiences the therapist as part of their own self, or as extremely similar to their own self.
B. The patient expects the therapist to have no other task but to praise them, to “mirror” their excellent qualities and performance.

Reasonable version of the main issue in A or B as above, any form of words = 1 mark

C. Kohut / Heinz Kohut = 1 mark

Short Answer 8
(3 marks)

A 37 year old patient known to you from treatment of two past manic episodes across the last three years presents to your clinic with symptoms of a developing major depression. He has not been on any psychotropic medications for the last ten months. He is not a suicide risk, has no psychotic symptoms and does not require admission.

Question 1
List in note form the three first line medication choices for this patient, based on evidence from at least one adequate randomised controlled trial. ***(3 marks)***

1. Lithium
2. Lamotrigine
3. Olanzapine or Olanzapine/fluoxetine combination

Source: RANZCP Clinical Practice Guideline for Bipolar Disorder, treatment of Bipolar Depression (D.3 and D.3.4).

1 mark for each option given

Please note that there is no Question 2

SHORT ANSWER QUESTIONS

Short Answer 9

(4 marks)

Lilian, a 77 year old woman who lives in her own flat and has a history of a major depression five years ago after the death of her husband, is brought to hospital by her daughter. Lilian is in an agitated, restless state and her daughter has been unable to calm her. She was found to be in this state on her daughter's return from a 2 week holiday, but had been coping reasonably well prior to the holiday. Lilian's daughter had arranged for a neighbour to keep an eye on her. The neighbour says that Lilian had been isolative and seemed rather tense, but appeared to be coping.

Question 1

List in note form the most likely differential diagnoses you would need to consider in this case.
(4 marks)

A. Delirium with confusion and agitation
B. Major depression with agitation / psychotic depression
C. Catastrophic reaction due to dementia or cognitive decline / dementia
D. Anxiety disorder / Generalised Anxiety Disorder
E. Psychosis - due to dementia, delirium or depression, paraphrenia
F. Other organic cause - medical condition causing anxiety, pain, restlessness etc.
(only award a mark for this separately from A. if it is stated that the medical condition has not caused delirium, to account for the agitation. If answer says or implies medical/organic condition has caused delirium, mark as a variant of A.)

1 mark each for any of the above options, to a max. of 4 marks

If options A B or C are not given in some form of words, the max. that can be scored is 2 marks total.

Adjustment disorder was not scored as was felt to be somewhat less likely to cause this degree of agitation. Other diagnoses such as substance withdrawal or intoxication, or acute mania were also not hinted at in the vignette and were again felt to be slightly less likely.

Please note that there is no Question 2

SHORT ANSWER QUESTIONS

Short Answer 10

(4 marks)

A 30 year old man is admitted under your care with paranoid delusions, visual and auditory hallucinations, religiosity and over-inclusive thinking. He has a pre-existing diagnosis of temporal lobe epilepsy.

Question 1

List in note form the factors (specific to temporal lobe epilepsy) in such a patient which might give a higher risk of development of a schizophrenia-like psychosis. ***(3 marks)***

A. Severe / intractable / hard to treat epilepsy
B. Early onset of epilepsy
C. Secondary generalization of seizures
D. History of temporal lobectomy
E. Treatment with certain anticonvulsant drugs
(reports have been associated with clobazam, phenytoin, carbamazepine, barbiturates, benzodiazepines, phenacetylurea, bromosuccinimide, ethosuximide, vigabatrin)

1 mark for each point to a max. of 3 marks

Question 2

An EEG focus in which neuroanatomical region of the temporal lobe is more associated with the development of psychosis, in temporal lobe epilepsy. ***(1 mark)***

mediobasal temporal lobe focus = 1 mark

(as opposed to a neocortical temporal focus)

SHORT ANSWER QUESTIONS

Short Answer 11
(4 marks)

Question 1
List in note form the major limitations on accurate data gathering for national rates of deliberate self-harm and suicide. ***(3 marks)***

- Lack of clear and consistent definitions for DSH
- Loss of data re some suicides where coroner cannot be certain cause of death was suicide
- Not all deaths are recorded – e.g. 'missing persons'
- Loss of data re vehicular suicides where it's not clear it was a suicide
- In past data collection re DSH, only those admitted to hospital were collected – missed all those treated at ED then discharged
- Miss all those with DSH who do not present to hospital at all
- Barriers to presentation after DSH – e.g. indigenous, immigrant and rural patients may not present to hospital EDs
- Societal disapproval and stigma causing patients to conceal DSH or suicide attempts or causing doctors/coroners to conceal this (esp. in nations with religious/cultural prohibitions re suicide)
- Absence of accurate past records/varying methods of counting these statistics across the years /logistical problems with multiple sources of the data - impedes accurate assessment of the rates

1 mark for any of the above, to a max. of 3 marks

Question 2

Over what period of time after an episode of deliberate self-harm is the risk of repitition greatest.
(1 mark)

3-6 months (also accept - up to 6 months / 1st 6 months / approx. 3 months) = 1 mark

SHORT ANSWER QUESTIONS

Short Answer 12
(4 marks)

You see a 43 year old woman with schizophrenia who is living in a rehabilitation hostel. You are concerned that she appears to have gained considerable weight, and wonder if she may have developed the metabolic syndrome.

Question 1
List in note form the five main criteria of the metabolic syndrome. ***(2 marks)***

- Abdominal (and visceral) obesity / central obesity (NB: just "obesity" = 0 marks)
- Raised serum triglycerides / dyslipidaemia
- Low HDL cholesterol
- Raised fasting glucose / Insulin resistance (hyperinsulinaemia) / Glucose intolerance
- Hypertension

½ mark for each point from the general categories as above to a max. of 2 marks

Question 2

List in note form factors that may contribute to a high risk of the metabolic syndrome developing in psychiatric patients. ***(2 marks)***

A. Lack of exercise / sedentary lifestyle / inactivity
(accept medication-caused sedation, EPSE or low BP inhibiting exercise, but only if these are linked to lack of activity)
B. High caloric intake / poorly balanced diet / unhealthy diet / eating too much junk food etc.
C. Medication adverse effects on metabolism
(weight gain / increased appetite / metabolic effects / effects on glucose metabolism)
(if weight gain or increased appetite are given but not linked to medication, do not score)
D. Cigarette smoking

½ mark for each point given to a max. of 2 marks

SHORT ANSWER QUESTIONS

Short Answer 13
(3 marks)

Question 1
List in note form at least three of the key requirements for recovery from a psychiatric disorder, from the Recovery Paradigm. ***(3 marks)***

- Hope / overcoming loss and grief / future orientation
- Meaning and Purpose in one's life / meaningful activity
- Personal Power
- Positive sense of self / positive self esteem / self-confidence
- Perspective on one's disorder - seeing it as part of who one is, not as defining oneself
- Self Responsibility / self-care
- Information (on which to base informed choices)
- Self Advocacy / active involvement
- Partnership in treatment and rehabilitation (with professionals)
- Support / validation / acceptance
- Involvement in one's local community or social network

1 mark for each of the above given to a max. of 3 marks

Many candidates seemed not to have grasped the client-centred nature of the Recovery Model and gave options which were very doctor-centric and all about how we can improve what we "do to" people in rehabilitation. This missed the main point.

Please note that there is no Question 2

SHORT ANSWER QUESTIONS

Short Answer 14

(4 marks)

You decide to embark on a course of cognitive therapy with a patient recovering from depression.

Question 1

List in note form Beck's Cognitive Triad. ***(1 ½ marks)***

- Negative view of the self
- Negative view of the environment / world
- Negative view of the future

½ mark for each point

Question 2

List in note form five of the 11 common cognitive distortions described by Beck. ***(2 ½ marks)***

1. ALL-OR-NOTHING THINKING: You see things in black-and-white categories.
2. OVERGENERALIZATION: You see a single negative event as a never-ending pattern of defeat.
3. MENTAL FILTER: You pick out a negative detail and dwell on it exclusively. Also = "tunnel vision".
4. DISQUALIFYING THE POSITIVE: You reject positive experiences by insisting they "don' t count" for some reason or other. In this way you can maintain a negative belief that is contradicted by your everyday experiences.
5. JUMPING TO CONCLUSIONS: You make a negative interpretation though there are no definite facts that convincingly support conclusion.

a. Mind reading: You arbitrarily conclude that someone is reacting negatively to you and you don' t bother to check this out.

b. The Fortune Teller Error: You anticipate that things will turn out badly, and you feel convinced that your prediction is an already-established fact.

6. MAGNIFICATION (CATASTROPHIZING) OR MINIMIZATION: You exaggerate the importance of things (such as your goof-up or someone else' s achievement), or you inappropriately shrink things until they appear tiny (your own desirable qualities or the other fellow' s imperfections).This is also called the ' binocular trick' .
7. EMOTIONAL REASONING: You assume that your negative emotions necessarily reflect the way things really are: ' I feel it, therefore it must be true.'
8. SHOULD STATEMENTS: You try to motivate yourself with shoulds and shouldn' ts, as if you had to be whipped and punished before you could be expected to do anything. ' Musts' and ' oughts' are also offenders. The emotional consequence is guilt. When you direct should statements toward others, you feel anger, frustration and resentment.
9. LABELING AND MISLABELING: This is an extreme form of overgeneralization. Instead of describing your error, you attach a negative label to yourself: ' I' m a loser.' When someone else's behavior rubs y the wrong way, you attach a negative label to him: ' He' s a goddamn louse.' Mislabeling involves describing an event with language that is highly colored and emotionally loaded.
10. PERSONALIZATION: You see yourself as the cause of some negative external event which in fact you were not primarily responsible for.
11. SELF-WORTH: You make an arbitrary decision that in order to accept yourself as worthy, okay, or to simply, feel good about yourself, you have to perform in a certain way; usually most or all of the time.

½ mark for each point given, to a max. of 2.5 marks

SHORT ANSWER QUESTIONS

Short Answer 15
(4 marks)

For a period between 1995 and 1997, euthanasia was legalised in Australia's Northern Territory.

Question 1
List in note form two possible benefits from the involvement of psychiatrists in screening assessments prior to legalised euthanasia, and two possible negative effects of psychiatric screening prior to euthanasia. ***(4 marks)***

Benefits

- Psychiatric screening able to detect treatable mental illnes (that might remove the wish for euthanasia if treated)
- Exploration of psychological issues may remove the wish for euthanasia
- Psychiatrists are trained in competence assessments
- Psychiatrists can support the staff involved in physician-assisted suicide
- Psychiatrist may be able to provide support to the person undergoing the process
- Psychiatrist may be able to provide support to the person's family
- Psychiatrist may be able to arrange therapy for the person if needed
- Psychiatrist may be able to arrange therapy for the family if needed

1 mark for each item given, to a max. of 2

Negatives

- Patient may be distressed by requirement to see a psychiatrist / feel stigmatised
- Psychiatrists and Psychiatry (and the College) might become negatively viewed (stigmatised) as 'enablers' of euthanasia
- Psychiatrists may bear brunt of pro-euthanasia groups criticism as 'gatekeepers'
- Psychiatrist involved becomes to some degree ethically culpable regarding the patient's decision to have euthanasia
- Stress on the assessing psychiatrist having to deal with these ethical dilemmas
- Stress on the assessing psychiatrist having to mediate between patient, family and possibly staff - all with some level of distress

1 mark for each item given, to a max. of 2

Please note that there is no Question 2

SHORT ANSWER QUESTIONS

Short Answer 16
(4 marks)

Question 1
List in note form the Schneiderian first rank symptoms of schizophrenia. (*3 marks)*

A. Passivity phenomena
   - "made" thoughts, feelings and actions (delusions of control)
   - somatic passivity ("made" sensations)
     - ½ mark for any passivity phenomena given

B. Thought broadcasting - delusion that others can perceive patient's thoughts – ½ mark
C. Thought insertion (thoughts being inserted into the patient's head) – ½ mark
D. Thought withdrawal (thoughts being taken from the patient's head) – ½ mark
E. Auditory hallucinations:
   3rd person auditory hallucinations – ½ mark
   - auditory hallucinations commenting on the patient's actions/running commentary
   - auditory hallucinations in which two voices carry on a conversation

F. Auditory hallucinations:
   - Thought echo (echo de la pensee) - the patient's own thoughts are experienced as an audible (hallucinated) voice – ½ mark

G. Delusional perception - a non-hallucinated sensory perception whose meaning is significant in a delusional idea or system – ½ mark

½ marks as above to a total of 3 marks

Question 2

What are the prognostic implications of the presence of Schneiderian first rank symptoms in an initial episode of schizophrenia. *(1 mark)*

None – they are poor predictors of prognosis = 1 mark
(and can also occur in mood and other disorders at times)

SHORT ANSWER QUESTIONS

Short Answer 17
(3 marks)

You assess an 8 year old boy at a Child and Family mental health community clinic. He has been experiencing repetitive throat-clearing and grunting tics many times a day, nearly every day across the last two years without any periods where he has been free of these. He is beginning to get into trouble at school with teachers for interrupting, and other children are teasing him for making "stupid noises". He is otherwise well and is on no medication.

Question 1
List in note form the three core DSM-IV-R diagnostic criteria for all tic disorders. ***(2 marks)***

Diagnostic criteria for tic disorders
Shared characteristics: (DSM-IV-R)

A. Tics - defined as sudden, rapid, recurrent, nonrhythmic, stereotyped motor movement or vocalization
B. Onset before age 18
C. Not caused by direct physiologic effects of a substance (such as stimulants) or general medical condition (such as Huntington's disease or postviral encephalitis)

Scoring: ½ mark each for A, B or C. If all 3 are given correctly, total score of 2 marks.

Source: DSM-IV-TR

Question 2
Which DSM-IV-R subtype of tic disorder is described in the vignette as above. ***(1 mark)***

Chronic motor or vocal tic disorder *(is the diagnosis in the vignette)*
Scoring: 1 mark

(Criteria for Chronic motor or vocal tic disorder -

1. *Single or multiple motor or vocal tics, but not both, have been present at some time during the illness*
2. *Tics occur many times a day nearly every day or intermittently for more than 1 year, without a tic-free period of more than 3 consecutive months*
3. *Criteria for Tourette's disorder have never been met)*

(NB: Tourette's disorder -

1. *Both multiple motor and one or more vocal tics have been present at some time during the illness, although not necessarily concurrently*
2. *Tics occur many times a day (usually in bouts) nearly every day or intermittently for more than 1 year, without a tic-free period of more than 3 consecutive months)*

Source: DSM-IV-TR

SHORT ANSWER QUESTIONS

Short Answer 18

(4 marks)

Sarah is a 21 year old woman with bipolar disorder with whom you are discussing commencing sodium valproate treatment. She says that she has read on a bipolar support website that valproate can cause polycystic ovarian syndrome (PCOS). You try to reassure her that you would monitor her for this, and she asks what the chances are that she might develop it.

Question 1

List in note form the physical changes that you would need to watch for to determine if Sarah were developing PCOS after starting sodium valproate. ***(2 marks)***

- Menstrual irregularity
- Weight change / increase
- Excess facial hair
- Male-pattern hair loss
- Acne

1 mark for any of the above to a max. of 2 marks

Question 2

In what percentage of women with bipolar disorder commenced on sodium valproate does PCOS develop, and are there any factors about Sarah that might affect her risk of developing PCOS.
(2 marks)

It appears to develop in 10% of women with bipolar disorder, started on valproate = 1 mark

Sarah's relatively young age is an increased risk factor = 1 mark

Reference: http://www.womensmentalhealth.org/resources/PDFs/PCOS_poster.pdf

SHORT ANSWER QUESTIONS

Short Answer 19
(4 marks)

Question 1
List in note form several reasons why women have twice the incidence of non-melancholic major depression when compared to men. *(4 marks)*

A. Hormonal effects (allow one hormonal example for the mark, not >1)
   - premenstrual changes and menstruation
   - contraceptive drug use
   - pregnancy, childbirth and postpartum period
   - menopause and HRT drug use

B. Genetically inherited vulnerability (shown in twin & family studies)
C. Societal devaluation & opression - stereotypes / attitudes / prejudice or stigma / lower socio-economic status of women
D. Greater levels of sexual and emotional abuse and trauma
E. Societal norms – women are 'allowed' to get depressed if stressed, men are not
F. Interpersonal factors (incr. reliance on relatedness increasing vulnerability)
G. Psychological / socialisation factors, making women more likely than men to develop internalising personalities
H. Sex-role component / reduced ability to seek assistance or support (overwhelmed by care of several children etc.)
I. Greater comorbidity with anxiety disorders and eating disorders in women
J. Detection – more women present asking for help (more acceptable for women to show emotion and weakness)
K. Depression rating scale items more likely to be ticked by women (e.g. crying and appetite and weight changes) so inflating scores in women
L. Age of onset of depression earlier in adolescent girls

1 mark per points A to L as above, to a max. of 4 marks

One reference is: http://www.blackdoginstitute.org.au/depression/causes/gender.cfm

Please note that there is no Question 2