



THE ROYAL AUSTRALIAN AND NEW ZEALAND COLLEGE OF
PSYCHIATRISTS

2 HOUR PRACTICE WRITTEN EXAMINATION

BRISBANE 2007

MODEL ANSWERS

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. Hypnopompic hallucination
- B. Somatic hallucination
- C. Third person hallucination
- D. Déjà vu
- E. Gedankenlautwerden
- F. Visual illusion
- G. Olfactory hallucination
- H. Thought echo
- I. Command hallucination
- J. Pareidolia
- K. Gustatory hallucination
- L. Hypnagogic hallucination
- M. Jamais vu
- N. Visual hallucination

Which abnormality of perception listed above is the 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 becomes suicidal as she continually hears voices which say "She's no good, she doesn't deserve to live". **C**

2. A woman is distressed by sometimes seeing a "scary man" in the room when she wakes from sleep. He disappears after a few seconds. She describes no other unusual experiences. **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. Psychotic depression
- B. Obsessive compulsive personality disorder
- C. Adjustment disorder with mixed anxiety and depressed mood
- D. Post natal psychosis
- E. Asperger's disorder
- F. Obsessive compulsive disorder
- G. Separation anxiety disorder with school refusal
- H. Post traumatic stress disorder
- I. Avoidant personality disorder
- J. Major depressive episode
- K. Dysthymic disorder
- L. Social phobia
- M. Acute stress disorder

Which diagnosis listed above is the most likely to be demonstrated by the following example.

Please select only ONE option.

3. Bethany is a solo mother with a three month old baby. She worries constantly that her child will catch an infection, and begins to wash her hands compulsively. She starts waking up before dawn, loses weight and becomes unable to care for herself or her baby properly. J

(not OCD, she sounds too unwell re poor self-care and inability to care for her baby, and the EMW and weight loss indicate a MDE). OCD Sx can occur in depression, esp. in postnatal depression.

Extended Matching Questions

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All questions are worth 1 mark

- A. Aristotle
- B. Galen
- C. Francis Bacon
- D. Vesalius
- E. Thomas Hobbes
- F. Thomas Kuhn
- G. Roger Bacon
- H. Pythagoras
- I. Galileo
- J. Albert Einstein
- K. Copernicus
- L. Carl Popper
- M. Isaac Newton

Which scientific thinker listed above is the author of the following quote.

Please select only ONE option.

4. "If I have seen further than most, it is because I have been standing on the shoulders of giants" **M**

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. Risperidone
- B. Paroxetine
- C. Zopiclone
- D. Olanzapine
- E. Lithium
- F. Fluoxetine
- G. Amitriptyline
- H. Haloperidol
- I. Clozapine
- J. Pimozide
- K. Venlafaxine
- L. Fluphenazine
- M. Sodium Valproate

Which medication listed above is the most likely to cause each of the following adverse effects.

Please select only ONE option, but any option may be used more than once, if required.

5. Hair loss **M**

6. Acute glaucoma **G** from anticholinergic effects

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. Corpus callosum
- B. Dorso-lateral frontal cortex
- C. Brodman's area
- D. Basal nucleus of Meynert
- E. Locus coeruleus
- F. Orbito-frontal cortex
- G. Nigrostriatal tract
- H. Cerebellum
- I. Raphé nucleus
- J. Basal ganglia
- K. Tuberoinfundibular tract
- L. Wernicke's area
- M. Occipital lobe
- N. Mesolimbic tract
- O. Brain stem
- P. Papez's circuit

Which aspect of brain structure or function listed above is most associated with each of the following items.

Please select only ONE option, but any option may be used more than once, if required.

7. Serotonin I

8. Memory P

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. Non-maleficence
- B. Utilitarianism
- C. Ethical relativism
- D. Practical wisdom
- E. Justice
- F. Categorical Imperatives
- G. Privacy
- H. Autonomy
- I. A value judgement
- J. An ethical dilemma
- K. Beneficence
- L. Accountability

Which ethical concept listed above is the most likely to be demonstrated by the following example.

Please select only ONE option.

9. An on-call registrar is concerned that a young woman seen in ED is suicidal and at significant risk, but is also aware that to admit the patient compulsorily might have harmful consequences such as regression. **J**

It's best seen as an ethical dilemma as there is a conflict between respecting her autonomy and caring for her (beneficence), versus the need to not cause iatrogenic harm (non-maleficence)

Extended Matching Questions:

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

The question is worth 2 marks.

Please select UP TO TWO responses for the question.

More than two responses will incur a mark of zero.

- | | |
|--------------------------------|----------------------------------|
| A Tangentiality | N Clanging |
| B Formication | O Nihilistic delusions |
| C Answering past the point | P Ekblom's syndrome |
| D Avolition | Q Verbigeration |
| E Poverty of content of speech | R Paraphasia |
| F Neologism | S Delusions of misidentification |
| G Capgras syndrome | T Over inclusiveness |
| H Loss of goal | U Tactile hallucinations |
| I Derailment | V Poverty of speech |
| J Circumstantiality | W Dysphoria |
| K Dysthymia | X Palilalia |
| L Hypochondriacal delusions | Y Word salad |
| M Incoherence | Z Cotard's syndrome |

For the following example, select the TWO most appropriate terms or syndromes from the list above.

Please select only TWO options for the question.

10. A man suffering from delirium tremens is admitted in a disorientated state yelling that he can feel insects crawling all over him. **B and U**

You don't have to get both for a mark. It's a mark for each answer, B and U, to a max. of 2

KEY FEATURE CASES

Case 1 (4 marks)

Florence is a 75 year old retired legal typist scraping by on a pension in a sub-standard flat which is in cold winter as she cannot afford adequate heating. She divorced from her abusive husband in her forties and has few social supports. She has developed some memory difficulties across the last year, and suffers from a weak left arm after a minor stroke. Florence is taking a statin and aspirin each day. Her GP refers her to your community mental health service for older adults as she has become depressed. He describes her as a “stoical battler” and “fiercely independent”. On assessment Florence has symptoms of a major depression but is not suicidal. You decide to start her on citalopram.

Question 1 (3 marks)

List the most useful interventions which could improve Florence’s likely adherence to citalopram treatment in the community. Give UP TO THREE answers only.

1. Arrange a pill dispenser or blister-packs (forgetfulness likely to cause poor adherence)
2. Psychoeducation to encourage her to take the medication properly (needed on more than 1 occasion due to her STM issues, and using written information etc.)
3. Frequent visits from a key-worker or yourself (community team) to engage her and establish the therapeutic relationship
4. Assist in funding the medication due to her difficult financial circumstances
<p>Scoring: 1 mark for any correct answer as above to a max. of 3 marks</p> <p>No marks for referring her for CBT/other psychotherapy as this is not as specifically an intervention aimed at adherence – is rather about the overall Rx of her depression. No marks for arranging neuropsych testing as again this is not as specifically an intervention for adherence.</p>

Question 2 (1 mark)

Which social intervention listed below would be the most appropriate to assist Florence with her recovery? Select ONLY ONE OPTION from the following list:

No – too damaging to her autonomy at this stage	Arrange a welfare guardian/ legal guardianship
Yes, sensible	Social work assistance to improve her flat’s heating and her pension
No – too damaging to her autonomy at this stage	Admission to a geriatric unit for a rehabilitation assessment
No – too damaging to her autonomy at this stage	Arrange periods of respite at a local Rest Home

KEY FEATURE CASES

Case 2 (4 marks)

Daniel is a three year old boy brought for assessment by his maternal grandmother who is worried that he is “too quiet”. He lives with his mother, a solo parent, who was supposed to come as well, but who left a message that she had a migraine and is not present. In the assessment Daniel is passive, anxiously watchful and does not engage well, and his grandmother describes intermittent temper tantrums when he is with his mother. “I have him with me as much as I can manage” his grandmother says “and he’s much better with me, he perks up a lot, but my heart’s not good so I can’t have him as much as I’d like.”

Question 1 (2 marks)

What are the key features mentioned in the vignette that would make a diagnosis of reactive attachment disorder (avoidant/inhibited) more likely in Daniel than that of a pervasive developmental disorder? Give UP TO TWO answers only.

1. Mother avoided the assessment – more typical with RAD children than PDD
2. Anxious watchfulness not typical of PDD (with PDD they would be isolative/oblivious of others in the room, not watchful)
3. Can engage and do better in another environment - with grandmother
<p>Scoring: 1 mark for any correct answer as above to a max. of 2 marks No marks for temper tantrums as these can occur in RAD and PDD</p>

Question 2 (2 marks)

Which behaviour as below would you be watching for to strengthen the diagnosis of reactive attachment disorder, when observing Daniel and his mother in a playroom assessment? Select UP TO TWO OPTIONS from the following list:

YES – mutual aloofness, poor attachment	Mother plays alongside Daniel not with him
NO	Daniel chats freely about his play with his mother
NO	Shared enjoyment in play
YES – aloofness, poor attachment	Daniel seems aloof and bored

KEY FEATURE CASES

Case 3 (4 marks)

You are a registrar called in at midnight to the Emergency Department (ED) to assess Kathy, a 26 year old woman. Kathy has a history of childhood sexual abuse, and a long history of self-harming via forearm lacerations and by paracetamol overdoses, several of which have required N-acetylcysteine treatment. She has tonight self-presented to the ED demanding lorazepam as she says that she cannot sleep and this is “making me crazy and suicidal”. She has a past history of visiting several General Practitioners so as to obtain benzodiazepines. The Crisis Management Plan which is in her ED file states that Kathy should not be given any additional benzodiazepines. Her usual medication is fluoxetine 40 mgs mane, quetiapine 200 mgs BD and clonazepam 2 mgs nocte.

On arrival at the ED you find that the staff are very busy with two traffic accidents so Kathy has not had any initial assessment. While you are interviewing her, she becomes somewhat drowsy.

Question 1 (2 marks)

What are the most important next steps that you need to take regarding Kathy’s management at this point? Give UP TO TWO answers only.

1. Get a blood test urgently to see if she has taken an overdose, esp. of paracetamol.
Allow it if you said medical screening with bloods, etc. However this is the main risk issue re her past history as she’d need the antidote in time if paracetamol level was high. In the real exam they’d be less generous and would want paracetamol level mentioned.
2. Get a physical examination done (or do it yourself) (so as to check that she is not acutely at risk physically from a current self-harm attempt)
You may have put getting a history from her re any overdose. This was not correct as is less crucial when a) she’s drowsy and may not be able to talk much b) is likely to lie anyway.

Question 2 (2 marks)

If Kathy should on this occasion require a psychiatric admission, what would the main principles be, regarding this admission?

Select UP TO TWO OPTIONS from the following list:

No - means nothing	She should sign a contract stating that she will not self-harm
Yes - keep it as a brief respite	She should not be admitted for longer than at most 4 days
No - encourages regression	She should be nursed on constant observations throughout the admission
No - meds seem sensible overall and changing prolongs admission	She should have a full medication review and trial a different antidepressant
Yes - realistically - it’s chronic	She should be expected still to have suicidal ideation at the point of discharge
No - not on an unreasonable dose and OP taper is better, if possible	She should be withdrawn from benzodiazepines

Short Answer 1 (2 marks)

Brian is treated for a chronic schizoaffective disorder with clozapine. He lives alone in his own flat with his cat Harold, and works part-time mowing lawns. He drinks a litre of grapefruit juice every day as he believes that he might otherwise develop scurvy. Brian also drinks several cups of strong coffee and smokes 20 cigarettes each day. He has a history of hepatitis C and has mild liver impairment. Despite this, at the weekends he drinks about 4 cans of beer.

Question 1 (2 marks)

List in note form any factors in the vignette as above that could affect the bioavailability of Brian's medication.

1. Coffee – *increases* bioavailability
2. Smoking cigarettes – *reduces* bioavailability (as does marijuana smoking)
3. Liver impairment (due to hep C) – *increases* bioavailability
4. Alcohol use (not very compelling but will give you it as it might add to the liver impairment although in this quantity not v. likely unless that were significant)

No effect from grapefruit juice on clozapine (it may reduce bioavailability of all the other atypicals however)

1 mark for any 2 answers

2 marks for any 3 answers (max. of 2)

You can be generous and give yourself a mark even if you didn't say in what way each thing altered bioavailability. A real exam-type SAQ would probably want that specifically, however.

There is no Question 2

Short Answer 2 (4 marks)

You are suspicious that Martin, a recently admitted man with depression, also has a serious drinking problem. You decide to start with the CAGE screening checklist.

Question 1 (3 marks)

List in note form the items asked in the CAGE screening checklist for problem drinking:

1. Cut down: Have you ever felt you should cut down on your drinking?
2. Annoyed: Have people annoyed you by criticizing your drinking?
3. Guilty: Have you ever felt guilty or bad about drinking?
4. Eye-opener: Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover?

1 mark for any 2 answers

2 marks for any 3 answers

3 marks for any 4 answers (max. of 3)

You should all have the CAGE memorised but also understand that by itself it's not sufficient to assess AoD issues.

Six months later you are on call when Martin is brought to the Emergency Department. The houseofficer calls you in due to his psychiatric history but on arrival you are concerned that Martin may in fact have Wernicke's encephalopathy.

Question 2 (1 mark)

List in note form the main features of Wernicke's encephalopathy:

1. Oculomotor signs (nystagmus, oculomotor palsies, abnormal pupil reactions etc.)
2. Encephalopathy (global confusional state, inattentiveness, or agitation, rarely come/stupor)
3. Gait ataxia (combination of polyneuropathy, cerebellar damage, and vestibular paresis)

1 mark for any 2 answers (max. of 1)

Short Answer 3 (2 marks)

Jonathan is a 61 year old man treated with risperidone for a chronic delusional disorder. He comes to see you for a regular follow-up visit. His nurse thinks that he may be developing mild tardive dyskinesia involving his mouth and tongue, so you decide to do an AIMS test.

Question 1 (2 marks)

List in note form several steps in the AIMS which are required so as to examine Jonathan's face and mouth for extrapyramidal side effects.

1. Check whether there is anything in his mouth (gum etc.) and if so remove it.
2. Check state of his teeth and if he wears dentures (and if teeth or dentures are bothering him)
3. Ask whether he notices any movements in his mouth and face. If yes, ask him to describe them and how much they bother him
4. Ask him to open his mouth and observe his tongue at rest in the mouth. Do this twice.
5. Ask him to stick out his tongue and observe for any tongue movements. Do this twice.

1 mark for any 2 answers

2 marks for any 3 answers

3 marks for any 4 answers (max. of 3)

Learn the AIMS so that you can do it from memory. Note that the Q only asked about the part of the AIMS relating to the face & mouth. Read Qs carefully.

There is no Question 2

Short Answer 4 (4 marks)

Tony is to be started on clozapine for resistant schizophrenia. He is aged 35 and is otherwise medically well.

Question 1 (2 marks)

List in note form several possible adverse effects that Clozapine can have on the haematological system.

1. agranulocytosis
2. neutropenia
3. thrombocytopenia
4. eosinophilia

1 mark for any 2 answers

2 marks for any 3 answers (max. of 2)

Question 2 (2 marks)

List several of Clozapine's possible adverse effects on the cardiovascular system

1. Tachycardia - common
2. Hypotension (orthostatic) - fairly common
3. Hypertension (rare)
4. Myocarditis (rare, but can occur in initial month or 2)
5. Cardiomyopathy (with the myocarditis)
6. Arrhythmia (rare)
7. cardiac failure (gen. due to myocarditis)
8. ECG abnormalities - ST and T-wave changes (gen. if a myocarditis) or QT prolongation (uncommon but is reported in some people)
9. Metabolic effects could cause atherosclerosis and IHD

1 mark for any 2 answers

2 marks for any 3 answers (max. of 2)

Remember the “n+1” rule in answering SAQs!

- **Need TWO answers for the initial point**
- **Need 1 extra (correct) answer than the no. of marks the Q is worth**

Critical Essay Question

(40 marks)

“What makes science strong as a means of understanding the outer, material world - objective, third-person observation – is precisely what makes it ineffectual when it comes to understanding the “inner world” of consciousness.”

- Paul Broks, “Into the Silent Land” 2003

In essay form, critically discuss this statement from different points of view and provide your conclusion.

Reminder about marking process:

There are 5 dimensions. Each dimension scores up to 8 marks. A total of 40 marks is possible.

Marking Guide:

Dimension 1. Capacity to produce a logical argument (critical reasoning)

There is no evidence of logical argument or critical reasoning.	0	Comments: A logical structure needs to be demonstrated, rather than the writer seeming to have launched into the topic with no forethought, in a random or impulsive manner. Look for: <ul style="list-style-type: none"> • A reasonable opening statement that clarifies the quote’s issues & a brief definition of consciousness, and of what “science” is as well. • A mid-section to essay with discussion addressing: <ul style="list-style-type: none"> – Arguments/examples/references in support of the quote – i.e. demonstrating that our understanding of consciousness is elusive and partial – Arguments/examples/references against the quote. This is harder, but some discussion is needed of attempts to understand mental activity via brain scans, psychological evaluations, experiments – i.e. that there is <i>some</i> objective evidence and information available. • Closing statement that summarises and provides the writer’s overall “conclusions” Points are given for examples and references, and for the overall coherence and flow of the arguments/discussion.
Points are random or unconnected or listed or Assertions are unsupported or false or There is no conclusion	1-2	
Points in essay follow logically but there is only a weak attempt at supporting the assertions made by correct and relevant knowledge.	3-4	
The points in this essay follow logically to demonstrate the argument; and assertions are supported by correct and relevant knowledge.	5-6	
The candidate demonstrates a highly sophisticated level of reasoning and logical argument. (and extra points for good references)	7-8	

Dimension 2. Flexibility

The candidate restricts essay to an extremely narrow and very rigid line of argument.	0	Comments: There needs to be some discussion both for and against the quote’s statement. Needs (ideally) to be evaluation of the strengths and weaknesses of different examples/arguments, rather than just a series of examples or statements some of which are pretty thin and unconvincing. Top points if the arguments to and fro are explained in a sophisticated manner.
The candidate considers only one point of view.	1-2	
The candidate considers more than one point of view, but the strengths and weaknesses of the views are poorly evaluated.	3-4	
The candidate considers more than one point of view and the strengths and weaknesses of each view are well evaluated.	5-6	
The candidate demonstrates highly sophisticated ability to set out and evaluate >1 point of view	7-8	

Dimension 3. Ability to Communicate

The spelling, grammar or vocabulary renders the essay extremely difficult to understand; or totally unintelligible.	0	NB: Also mark down if writing's illegible or if are multiple deletions and insertions
The spelling, grammar or vocabulary significantly impedes communication.	1-2	
The spelling, grammar and vocabulary are acceptable but the candidate demonstrates limited capacity for written expression.	3-4	
The spelling, grammar and vocabulary are acceptable and the candidate demonstrates good capacity for written expression.	5-6	
The candidate displays a highly sophisticated level of written expression.	7-8	

Dimension 4. Humanity/Experience/Maturity/Judgment

The candidate demonstrates an absence of any capacity for judgment; or judgments are grossly unethical.	0	<u>Comments:</u> This is a complex issue, and better essays will contain a similar complexity and grasp of philosophical and phenomenological issues around the concept of consciousness, acknowledging the difficulty of us as subjective beings trying to analyse this aspect of ourselves. Ethics may enter in largely regarding the need for care in handling scientific enquiry in this area, where people may have important religious/spiritual beliefs about consciousness (e.g. "the soul") versus a more objective scientific approach to the issue.
Judgments are naïve; or superficial; or extremely poorly thought through; or unethical.	1-2	
The candidate demonstrates some reasoned judgment, maturity of thinking, clinical experience and displays some awareness of the ethical issues raised by the quote.	3-4	
The candidate shows good capacity for reasoned judgment, mature thinking, clinical experience, awareness of ethical issues raised by the quote.	5-6	
The candidate demonstrates a highly sophisticated level of judgment, maturity, experience or ethical awareness.	7-8	

Dimension 5. Breadth - ability to set psychiatry in a broader context.

Candidate shows no awareness of the broader scientific, social, cultural or historical context.	0	<u>Comments:</u> The discussion needs to cover not just biological/brain sciences, but also the history of ideas of "consciousness" or the "conscious mind", religious ideas about the "soul" or consciousness (or the lack of it such as Buddhist teachings), and ideas of consciousness in other cultures. The development/history of the scientific method and its clash with religious beliefs both in the past (in/pre the Enlightenment, e.g. Galileo) and currently (evolution vs creationism) can also be mentioned. Biological sciences do however need some mention – e.g. the disruption to the "conscious self" by organic disorders that destroy memory - Alzheimer's, Korsakov's, etc.
There is a very limited understanding of the scientific, social, cultural or historical context of psychiatry or mental illness.	1-2	
The candidate demonstrates an ability to understand psychiatry or mental illness in only one of the following contexts: broader scientific, socio-cultural, historical context.	3-4	
The candidate demonstrates an ability to understand psychiatry or mental illness in two or more of the following contexts: broader scientific, socio-cultural, historical context.	5-6	
Highly sophisticated scope, demonstrating a superior understanding of the broader context of psychiatry or mental illness.	7-8	

Some General Brainstorming Ideas re Possible Content of Essay:

“What makes science strong as a means of understanding the outer, material world - objective, third-person observation – is precisely what makes it ineffectual when it comes to understanding the “inner world” of consciousness.”

Introduction:

- Opening statement that restates the quote to indicate the main points have been grasped (don't just rewrite it word for word)
- brief definition of consciousness, such as “*a person's thoughts and feelings as a whole*” (OED) - BUT - also a mention that the question of what consciousness really is the heart of the issue. Other examples are – (an attempt at a basic definition is good, as long as there is discussion that it's far more complex than that. Don't get stuck on this part and waste too much time.)
 1. *A state of being characterized by sensation, emotion, volition, and thought*
 2. *A state of awareness of oneself - both of internal and external processes and perceptions*
 3. In psychoanalysis, the conscious mind (the upper level of mental life of which the person is aware as contrasted with unconscious processes)
- brief definition of “science” - e.g. - *a system of knowledge covering general truths or the operation of general laws, as derived and tested through scientific method*

Pros:

Arguments agreeing with the quote –

- that science is indeed effective at helping us understand the “outer material world” – brief history of the development of scientific observation and experimentation – the “scientific method” set out by Karl Popper needs a brief explanation here.
- Problems of the observer and the observed – bias – subjectivity – can give examples of core problems with observation in science – e.g. quantum science - to observe subatomic particles is to alter them, etc. Problems with observer bias and assumptions in early years of modern science (Enlightenment era etc. – people deduce what they want to from data and observation – still a significant methodological issue in modern research and critical analysis). How much more so when it is ourselves we are trying to observe – our own inner world, mental activity.
- Problem of psychiatric assessment and phenomenology – we try to assess other person's inner world, but can only do so by what we perceive outwardly, and from their (subjective) account of their own perceptions, thoughts, experiences. Yet we are trying to make psychiatry “scientific” and evidence-based, when at it's core it is deeply subjective. The other person's experience is also filtered through our own consciousness – our own biases and subjective reactions. Issues around empathy, understanding, cross-cultural misinterpretation arise, let alone issues around language.
- Science has not “cracked” the issue of consciousness despite considerable observation and research. Various examples of research may be given, but there needs to be emphasis here on the short fallings of this in really understanding what consciousness is.
- Science cannot yet really address the mechanisms of subjective consciousness. And is our consciousness just linked to our brain? What about the body's representation in the brain, and vice versa – is complex. Phantom limbs (residual consciousness of the limb), dissociative states where the person feels that they are watching themselves, etc.
- Perhaps a brief mention (but keep it brief as is slightly off-topic) that there may be better ways to grasp consciousness than science – spiritual experiences, meditation, the arts, poetry, music, etc. The reason why we see psychiatry as both an art as well as a science – as we need to deal with and try to understand our patients' subjective experiences. Mention qualitative research, observation such as by early psychoanalysts like Freud – however unless data from observation can be tested objectively, is not seen as truly “scientific”.

A linked issue, but not a pro/con argument re the quote, is that the problems with science attempting to grapple with this issue, versus religions claiming to have the answers, lie behind some current controversies about consciousness. Some view consciousness as the same as the “soul” while many scientists deny such a concept and view it as purely our memory of awareness arising from a succession of brain states, and are accused of creating a mechanistic world with no room for the spiritual - “soulless science”. It's a critical issue for the modern world as people leave the established religions and are searching for some other belief system to give meaning to the problem of personal existence. Hence a new-found fascination with philosophy and concepts of consciousness.

Cons:

- Nonetheless, there is research out there on the issue. Examples being hallucinogen research, neurochemistry and protein synthesis work, research defining the function of brain areas and from deficits caused by various neurological disorders which affect the experience of the conscious self. These tend to examine outward phenomena such as behaviour, and physical brain states – e.g. via fMRI etc. Research into autobiographical memory should be mentioned - degree to which we are what we remember. Kandell's research using *Aplysia*, into mechanisms of LTM, could be mentioned.
- Also research using hypnosis, and aimed at understanding phenomenology, (psychological and neuropsychological research) - even research into animal behaviour re whether animals display evidence of consciousness, etc.
- Computers have made research into “virtual” consciousness possible – neural networks, artificial intelligence, consciousness understood as an “emergent property” of the brain (modelled by complex computers). So there are some inroads being made.
- Could also argue that properly done qualitative research is “scientific” and informative, and can overcome a lot of subjective bias in the interpretation of the results. So can produce useful information about consciousness and our “inner worlds”.

Conclusions:

Needs a balancing summary (briefly) acknowledging (e.g.) that consciousness is indeed elusive and hard to study, but that we are making some progress. Is no “right” answer to the essay – writer could decide that it will always be beyond us due to the subjective/objective problem, or may decide note that science is likely in the end, to offer more insights. Avoid mushy, waffly purple prose about “the soul”! It's supposed to be a “critical” (i.e. objective and relatively scientific) essay.

Reminder of actual CEQ Dimensional Scoring:

Dimension 1. Capacity to produce a logical argument and critical reasoning	
There is no evidence of logical argument or critical reasoning.	(0)
Points are random or unconnected or listed; or assertions are unsupported or false; or there is no conclusion.	(1)
The points in this essay follow logically but there is only a weak attempt at supporting the assertions made by correct and relevant knowledge.	(2)
The points in this essay follow logically to demonstrate the argument; and assertions are supported by correct and relevant knowledge.	(3)
The candidate demonstrates a highly sophisticated level of reasoning and logical argument.	(4)
	(5)
	(6)
	(7)
	(8)
Dimension 2. Flexibility	
The candidate restricts him or herself to an extremely narrow and very rigid line of argument.	(0)
The candidate considers only one point of view.	(1)
The candidate considers more than one point of view, but the strengths and weaknesses of the views are poorly evaluated.	(2)
The candidate considers more than one point of view and the strengths and weaknesses of each view are well evaluated.	(3)
The candidate demonstrates a highly sophisticated capacity to set out and evaluate more than one point of view.	(4)
	(5)
	(6)
	(7)
	(8)
Dimension 3. Ability to communicate	
The spelling, grammar or vocabulary renders the essay extremely difficult to understand; or totally unintelligible.	(0)
The spelling, grammar or vocabulary significantly impedes communication.	(1)
The spelling, grammar and vocabulary are acceptable but the candidate demonstrates poor capacity for written expression.	(2)
The spelling, grammar and vocabulary are acceptable and the candidate demonstrates good capacity for written expression.	(3)
The candidate displays a highly sophisticated level of written expression.	(4)
	(5)
	(6)
	(7)
	(8)
Dimension 4. Judgment, experience and maturity, ethical awareness	
The candidate demonstrates an absence of any capacity for judgment; or judgments are grossly unethical.	(0)
Judgments are naive; or superficial; or extremely poorly thought through; or unethical.	(1)
The candidate demonstrates some reasoned judgment or maturity of thinking or clinical experience or awareness of the ethical issues raised by the quote.	(2)
The candidate shows good capacity for reasoned judgment, mature thinking, clinical experience, awareness of ethical issues raised by the quote.	(3)
The candidate demonstrates a highly sophisticated level of judgment, maturity, experience or ethical awareness.	(4)
	(5)
	(6)
	(7)
	(8)
Dimension 5. Breadth: ability to set psychiatry in a broader context	
The candidate shows no awareness whatever of the broader scientific, social, cultural or historical context.	(0)
There is a very limited understanding of the scientific, social, cultural or historical context of psychiatry or mental illness.	(1)
The candidate demonstrates an ability to understand psychiatry or mental illness in a broader scientific or socio-cultural or historical context.	(2)
The candidate demonstrates an ability to understand psychiatry or mental illness in two or more of the following contexts: broader scientific, socio-cultural, historical context.	(3)
Highly sophisticated scope, demonstrating a superior understanding of the broader context of psychiatry or mental illness.	(4)
	(5)
	(6)
	(7)
	(8)

Critical Analysis Question (20 marks)

June is a 33 year old woman who presents after developing a manic episode while being treated by her GP with fluoxetine for a major depression. You decide to explore the literature so as to help to clarify whether this means that June is likely to have a bipolar I disorder, and whether this is likely to follow the usual course. You locate the following paper:

Antidepressant treatment-emergent affective switch in bipolar disorder

Tamada RS, Amaral JA, Issler CK, Nierenberg AA, Lafer B.

Rev Bras Psiquiatr. 2006 Dec;28(4):297-300. Bipolar Disorder Research Program, Institute of Psychiatry, Hospital das Clinicas, Medical School, Universidade de Sao Paulo, Brazil. rstamada@uol.com.br

Abstract (excerpt):

Objective: Treatment-emergent affective switch has been associated to cycle acceleration and poorer outcome, but there are few studies addressing this issue. The aim of this study was to prospectively compare the outcome of patients presenting treatment-emergent affective switch with patients with spontaneous mania, regarding presence and polarity of a new episode and time to relapse.

Method: Twenty-four patients with bipolar disorder according to the DSM-IV were followed for 12 months. Twelve patients had treatment-emergent affective switch (TEAS) and twelve had spontaneous mania. Patients were evaluated weekly with the Young Mania Rating Scale and the Hamilton Depression Scale until remission of the index episode, and monthly until completion of the 12-month follow-up.

Results: Eleven patients with treatment-emergent affective switch had a recurrence on follow-up, all of them with major depressive episodes. In the group with spontaneous mania, six patients had a recurrence: two had a depressive episode, and four had a manic episode ($p = 0.069$ for new episode, $p = 0.006$ for polarity of the episode).

Method (excerpt):

Twenty-four patients with bipolar disorder according to DSM-IV were divided into two groups: 12 consecutively admitted patients with spontaneous mania and 12 consecutively admitted patients with antidepressant-induced mania. Patients were recruited from the Bipolar Disorder Research Program at the Institute of Psychiatry of Universidade de Sao Paulo Medical School. Inclusion criteria were patients between 18 and 60 years of both genders with bipolar disorder according to the DSM-IV, with a manic, hypomanic or mixed episode, and a Young Mania Rating Scale (YMRS) index score of 12 points or more. Patients with rapid cycling in the last year according to the DSM-IV, current diagnosis of abuse and/or addiction to alcohol or drugs, or organic cerebral disease were excluded. Patients with antidepressant-associated mania were included only if they had received an antidepressant for at least three consecutive days within the previous two weeks. Patients with spontaneous mania were included if they had not received antidepressants in the preceding two months.

The diagnosis was made using the Structured Clinical Interview for the DSM-IV, Patient Version (SCID-P). Twenty-four subjects were rated with the YMRS and the Hamilton Depression Scale (HAM-D). Response to treatment was defined as a 50% reduction in the YMRS index score and remission as a score of 6 or less on the YMRS. Patients were evaluated once a week until remission and monthly thereafter. Data was analysed using the SPSS software version 10.0 (Statistical Package for the Social Science). Chi-square or Fisher's exact tests were used to compare categorical data.

Results (excerpt):

Patients with TEAS presented manic symptoms on average 12 weeks after starting an antidepressant. Antidepressants used were sertraline, venlafaxine, fluoxetine, paroxetine, nortriptyline, imipramine, and amitriptyline. Antidepressants were stopped in all patients with antidepressant-associated mania. Two patients were receiving only antidepressants in the index episode and a mood stabilizer was introduced during their treatment. Nine patients received a combination of two antipsychotics and four received a combination of two mood stabilizers.

Critical Analysis Problem

1.1 What type of study is this?

Select any correct options from the list below (2 marks)

- An Intervention study
- A prospective Case-Control study (1 mark)
- A Case Series
- A Causation study
- A Prognostic study (1 mark)

1.2 Discuss pros and cons of the inclusion and exclusion criteria for the study: (6 marks)

(1 mark for any of the below to a max. of 6 marks)

Inclusion:

- The age-range (18 to 60 years) and inclusion of both genders covers most adult psychiatry patients so results are likely to be widely applicable (1 mark)
- This widens the pool of subjects that can be enrolled, making collection of the patients easier. (1 mark)
- Clear definition of the diagnosis (bipolar disorder according to the DSM-IV using a structured interview) is good as an inclusion criterion (1 mark)
- However the inclusion of patients with bipolar I and II and (mania, hypomania and mixed episodes) could mean the sample was too diverse in terms of likely course, for meaningful results (1 mark)
- Young Mania Rating Scale (YMRS) score of 12 or more points was used to define the index episode, which is an acceptable way to define a manic episode (validated instrument) (1 mark)
- Patients with spontaneous mania were included only if they had not received antidepressants in the preceding 2 months, which is a reasonable way of keeping the 2 groups separate. (1 mark)

Exclusion:

- They excluded patients with rapid cycling in the last year which removes those with a much less typical course and make the results more generally applicable (1 mark)
- They excluded those with abuse/addiction to alcohol/drugs or with organic brain disease which removes some confounding factors (1 mark)
- However leaving out these groups also makes the results less applicable to “real world” patients (1 mark)
- patients with antidepressant-associated mania were excluded if they hadn't received an antidepressant for at least 3 days in the past 2 weeks. This is careful but might have missed some patients who relapsed after only 2 days of antidepressant use or who had had an antidepressant a bit more than 2 weeks prior (1 mark)

(note that you needed to mention the pros or cons of each aspect for the mark – just listing inclusion or exclusion factors as such got no marks)

1.3 The Method section states: “...Fisher’s exact tests were used to compare categorical data”. What is Categorical data and why would Fisher’s Exact Test be applicable to this study? (3 marks)

Categorical data:

Is data separable into categories that are mutually exclusive, for example, gender. (1 mark)

(In this study, the data is grouped into those with an induced or with a spontaneous presentation, and those who did, or did not have a recurrence across the year of follow-up)

Fisher's Exact Test - why applicable: (1 mark for any of the following to a max. of 2 marks)

- It's a test of significance (we need this to evaluate the results. Note that the Chi-squared test is similar but used for larger groups)
- It examines the association between 2 variables (need to evaluate if there was an association between a TEAS vs spontaneous index relapse and later recurrences - i.e. the prognosis after they develop a Rx-induced relapse)
- Used especially with small samples (which this is)
- Used with categorical data (which this is due to the categorical definition of the groups)

1.4 Draw a 2 x 2 table for the risk of a recurrence after presentation with a treatment-emergent vs a spontaneous manic episode (3 marks)

	Recurrence	No Recurrence	Total
TEAS group	11	1	12
Spontaneous group	6	6	12
Total	17	7	24

1 mark for getting TEAS and Spontaneous titles correct (any reasonable form of words)

1 mark for getting Recurrence and No-Recurrence titles correct (any reasonable form of words)

1 mark for putting in the correct figures (Totals weren't required)

Results: (excerpt)

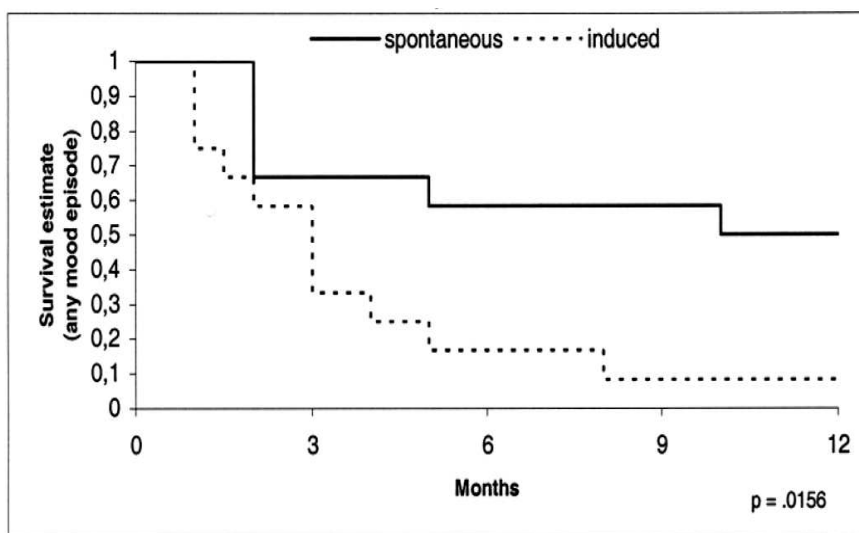


Figure 1 – Survival estimate of any mood episode

1.5 What main conclusions can you draw from the Figure 1 survival graphs? (2 marks)

- Patients with TEAS (antidepressant-induced mania) relapsed in a shorter period compared to patients with spontaneous mania (1 mark)
- More patients relapsed across 12 months in the TEAS group than the spontaneous group (1 mark)
- The p-value (0.0156 or 0.016 for short) indicates that this difference was significant (1 mark)

1.6 What are the main limitations of this study, including its relevance to your own practice? (4 marks)

- Small sample size limits generalizability of the results (low power)
- Patients were assigned to each outcome group non-randomly (might be a source of bias)
- Medication use was not controlled between the two groups (might cause confounding factors)
- Subjects were from a highly selected tertiary population (a specialist Bipolar Centre) so results may be less relevant to your own patient group
- Subjects were not the same as "real-life" patients – e.g. those with comorbid drug abuse were excluded – again, results may be less relevant to your own patient group
- The inclusion criteria led to a diverse group diagnostically (e.g. mania, hypomania and missed episodes, Bipolar I & II) which might make it harder to apply to specific patients.

(1 mark for any of the above, to a max. of 4 marks)

Modified Essay Question: (25 marks)

You are a consultation-liaison (C-L) registrar called to see a 59 year old man, Joseph, on a medical ward. Joseph is a Samoan man with diabetes who was admitted four days ago with an abscess on his right lower leg. The houseofficer's referral note states that they are concerned that Joseph has become "confused and paranoid" overnight.

Joseph is a widower, with two adult sons living in nearby suburbs. He himself lives with his sister's family, in a converted garage at the back of the property. He used to work as a bricklayer, but he has been off work and receiving social welfare payments for the last 12 years. He is usually treated with an oral hypoglycaemic and a statin from his General Practitioner. Joseph emigrated from Samoa 40 years ago and he and his family speak English well.

Question 1 (9 marks)

Outline your main areas of enquiry in the assessment of Joseph.

('areas of enquiry' = things/areas you'd investigate as part of assessment)

SCORING KEY

Use whole marks only, not ½ marks. Allot marks according to how adequately the issues are covered.

		worth	mark
From the medical records and ward staff			
A	Any further details about his psychiatric symptoms, mental state and behaviour. As much detail as possible about the time-course of his symptoms across the day, and about his mental state and behaviour on admission. Any past psychiatric history if this is available (fully assess current state and psych Hx)	2	
B	Details of his medical conditions and past treatment. What investigations they have done so far, and the results. What treatment he is currently receiving (aiming to investigate possibility of a delirium)	2	
C	Any further social history available in the records, and any recorded history of substance abuse (aiming to investigate possibility of delirium tremens)	1	
From Joseph himself			
D	As far as possible (if he is indeed confused) attempt to gather some additional history, in particular regarding alcohol abuse/dependance. Assess his mental state, especially cognition and regarding psychotic and mood symptoms.	2	
E	Try to assess possible risks in terms of his ability to take care of himself and any possibility of self-harm or aggressive behaviour to others.	1	
From Joseph's GP			
F	Clarify his past medical and psychiatric history, and in particular enquire about any substance abuse history. Check if GP had any concerns about Joseph's mental state. Ask why he has been off work.	1	
From Joseph's family			
G	Ask about his recent and past coping and any signs or symptoms of past or current psychiatric disorder or drug/alcohol abuse. Get further social Hx if possible	1	
		Up to a maximum of 9 marks in total	
		TOTAL:	

This is a Q about assessment, so care not to get muddled and write lots about management - [read the Qs carefully](#)

Modified Essay Question contd.

Two weeks later Joseph has recovered from his “confused and paranoid” state and continues to have treatment in hospital for his leg ulcer. On a follow-up visit to the ward you find him now to be very anxious and low in mood, and discover that he is worried about a debt to the “EziCash” company from which he borrowed \$600. He confides that this was to pay off gambling debts from playing pokie machines at a local bar. He is very ashamed about this, has not told his family and has been worrying about the debt and unable to sleep properly.

Question 2 (9 marks)

Discuss how you might help Joseph with his gambling problems.

(“help” is a non -specific word, so allows you to cover both assessment and management)

SCORING KEY

Use whole marks only, not ½ marks. Allot marks according to how adequately the issues are covered.

		worth	mark
A	Use a motivational interviewing approach to engage Joseph and to encourage him to find solutions to address his problems, while providing him with education about problem gambling as a condition.	1	
B	Assess the extent of his gambling – is it just the pokies, or other modalities? How often does he gamble, the pattern, the duration of the problem. Any triggers, any reasons he started gambling.	2	
C	Ensure he is not gambling due to another psychiatric disorder, e.g. to cope with depression or dysthymia. Assess him for other psychiatric disorders such as mood or anxiety disorders. Treat any such condition, if present.	2	
D	Review whether there are any other addiction problems such as alcohol or other drugs, which may be complicating the situation. Manage these as appropriate, if they are complicating factors.	2	
E	Explore the use of a budgeting service e.g. via the social services, to help him to manage his finances better and to gradually pay off the debts. Organise a social work assessment to assist him.	1	
F	Assist Joseph to contact a support organisation or helpline for gambling disorders such as Gamblers Anonymous.	1	
G	Encourage Joseph to talk with his family or with a friend or other support person such as his church pastor about the problem.	1	
H	Cultural support: Involve a Pacific Island cultural advisor or elder if possible, to advise you and to provide Joseph with support.	1	
I	Consider appropriate psychotherapy interventions for gambling problems such as CBT.	1	
Up to a maximum of 9 marks in total			
TOTAL:			

Modified Essay Question contd.

On one of your visits you meet Joseph’s sister Vaalu in the corridor. She asks you what is going on with Joseph to make him so unhappy. She says that he used to be cheerful and active but that he has “closed down” over the past two months and does not really talk to her any more. She also says that she plans to bring his pastor and some other church members to the ward to see him, for a prayer meeting.

Question 3 (7 marks)

Discuss your response to this situation.

(again, “response to this situation” is quite non -specific so allows you to cover all aspects - your response and responsibility to Vaalu, the same with Joseph, ethical issues, practical issues, etc.)

SCORING KEY

Use whole marks only, not ½ marks. Allot marks according to how adequately the issues are covered.

		worth	mark
A	Confidentiality: ideally, ensure that you have Joseph's permission before talking to Vaalu in any detail about his problems. If a MEQ raises ethical issues, specifically mention and name these.	1	
B	Negotiate: If Joseph has told you not to talk with his family or has previously refused to talk with them himself, try again to persuade him to talk with them or to allow you to do so.	1	
C	Competency and risks: If Joseph were severely unwell (e.g. depressed) and you need to involve his family in his assessment and treatment, need to weigh up the risks and decide if it is necessary to talk to Vaalu despite Joseph not agreeing. If you decide to override his wishes, need to explain to him why you are doing so.	2	
D	Meeting/talking with Vaalu: If Joseph agrees that you can talk to Vaalu, arrange some privacy for this, and discuss his problems with her in accessible language, providing psychoeducation about Joseph’s gambling disorder and any other psychiatric problems, and about the treatment that can be provided. Encourage her to talk with him and to reconcile any differences. If he doesn’t agree (and is competent to decide) still talk with Vaalu but give very limited information, explain about confidentiality, and get collateral about his recent “closed down” state.	2	
F	Reassessment: if needed, in light of collateral from Vaalu, reassess Joseph, and provide treatment as appropriate if a comorbid diagnosis is clarified.	1	
G	Spiritual support: Consider with Joseph and Vaalu whether a 1:1 talk with his pastor might be better than a prayer meeting at this stage. If Joseph wants the prayer meeting, liaise with ward staff about this. Hospital chaplain might be able to assist.	1	
H	Cultural support: Involve a Pacific Island cultural advisor or elder if possible, to advise you and to provide Joseph and Vaalu with support.	1	
Up to a maximum of 7 marks in total			
TOTAL:			