



**THE ROYAL AUSTRALIAN AND NEW ZEALAND COLLEGE OF  
PSYCHIATRISTS**

# MOCK WRITTENS EXAMINATION

(from the Auckland New Zealand program)

**December 2010 / May 2011**

**PAPER II**

## **Model Answers**

Note that these Mock Writtens papers are produced by local psychiatrists with no connection to the Examination Committee and are not vetted, test driven and perfected by committee in the way that the real papers are. The main point is not to get fixated about whether the question writers were “right” and you were “wrong” in the model answers, but to practice the marathon of doing 2 full 3-hour papers and practising the technique of the various question types. If you disagree with the factual detail of an answer, research the issue and decide for yourself.

## Critical Essay Question (40 marks)

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

*“This separation of normal sadness and depressive disorder is a sensible and legitimate, indeed a crucial one. It is consistent not only with the general distinction between normality and disorder used in medicine and traditional psychiatry, but also with common sense, and it has both clinical and scientific importance. Yet contemporary psychiatry has come to largely ignore this distinction.”*

From: “The Loss of Sadness: How Psychiatry Transformed Normal Sorrow into Depressive Disorder” by Allan Horwitz and Jerome Wakefield (2007)

### 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	<p><b>Comments:</b> 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:</p> <ul style="list-style-type: none"> <li>Reasonable opening statement clarifying the quote (ideally not just parroting it)</li> <li>Should be a brief definition of “depressive disorder”</li> <li>A mid-section to essay with discussion addressing: <ul style="list-style-type: none"> <li>Arguments/examples/references against the quote (i.e. arguing that Psychiatry does distinguish appropriately between ‘normal sadness’ and Depression)</li> <li>Arguments/examples/references in support of the quote (i.e. arguing that Psychiatry does <i>not</i> distinguish appropriately between ‘normal sadness’ and Depression)</li> </ul> </li> <li>Closing statement summarising, and providing the writer’s overall “conclusions”</li> </ul> <p>Ideally we want relevant examples and (ideally) references, and a good overall coherence and flow in the arguments and discussion.</p>
Points are random or unconnected or listed <b>or</b> Assertions are unsupported or false <b>or</b> 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; <b>and</b> assertions are supported by correct and relevant knowledge.	5-6	<p><u>Examples of points that may be included:</u></p> <ul style="list-style-type: none"> <li>Recent research showing little real antidepressant effect in mild to moderate depression – possibly indicating that we are trying to medicate “normal sadness.”</li> <li>Vast increase in use of antidepressants since the advent of the SSRIs in particular</li> <li>Pressure from Big Pharma to prescribe &amp; to “medicalise” sadness (Ethics)</li> <li>Pressure from funders/services to diagnose “sadness” as Depression for access to various treatments or therapies (Ethics)</li> <li>Internal pressures on psychiatrists to “do something” – the need to help, so medicalising sadness and treating it when faced with patients with difficult/insoluble life dilemmas (or with the psychiatrist’s own inadequacies in trying to help)</li> <li>Society’s and hence patients’ unrealistic expectations that all unhappiness is depression so can &amp; should be treated – intolerance of normal sadness. Family and caregiver expectations similarly.</li> </ul>
The candidate demonstrates a highly sophisticated level of reasoning and logical argument. (and extra points for good references)	7-8	<ul style="list-style-type: none"> <li>May be some exposition on the concept of “normality” vs “disorder” as in the quote – i.e. discussion of diagnostic systems being descriptive and not all that well supported by research hence somewhat arbitrary re precise criteria.</li> <li>Discussion of the complexity of Depression, re its bio-psycho-social causes and underpinnings, how it does form a continuum with “normal sadness” and the lack of strong genetic evidence for Depression as a clear-cut and separate disorder</li> <li>Mention of Life Events research re link of Depression to normal life stressors</li> <li>Mention of the antipsychiatry movement historically who accused Psychiatry of medicalising normal life dilemmas – etc. etc.</li> </ul>

### Dimension 2. Flexibility

The candidate restricts essay to an extremely narrow and very rigid line of argument.	0	<u>Comments:</u> There needs to be discussion both for and against the quote's statement as outlined above. Ideally we need a balance of arguments, with some discussion on both sides.  Needs (ideally) to be evaluation of the strengths and weaknesses of different examples or arguments, rather than just a series of (often sweeping) statements, which are either unsupported, or are thin and unconvincing.  Higher marks if the arguments for and against are laid out 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; <b>or</b> totally unintelligible.	0	NB: Also mark down if writing's illegible or if there 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; <b>or</b> judgments are grossly unethical.	0	<u>Comments:</u>  Candidate needs to have a balanced view, neither totally dismissing the quote's arguments or strongly supporting these unthinkingly.  Some discussion around ethical issues is expected – e.g. the ethics and causes of over-prescribing, and the dilemma of the need to medicalise in many systems as patients cannot access services unless given a clear diagnosis.  Better answers will have mature discussion of life's inevitable sadness/tragedy and the individual's/society's response to this.
Judgments are naïve; <b>or</b> superficial; <b>or</b> extremely poorly thought through; <b>or</b> 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 <b>or</b> 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>  There is plenty of scope in the quote for arguments and examples adding breadth. The essay should not focus purely on Depression as a psychiatric entity, or on a purely DSM or biological approach to this. Examples are: <ul style="list-style-type: none"> <li>• Different presentations of Depression across different cultures which may indicate a greater acceptance that life is hard and "depression" is a normal part of life (hence present more with the biological/vegetative Sx) – something about which the West had lost perspective.</li> <li>• Historical attempts to develop diagnostic systems for mood disorders – e.g. descriptions of severe melancholia as a definite entity in ancient Greek writings.</li> <li>• Discussion of diagnostic systems as such.</li> <li>• Discussion of the concept of "normality" in other philosophical and scientific arenas.</li> <li>• Etc.</li> </ul>
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	

## 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)

### 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)

### 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)

### 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)

### 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)

## MODIFIED ESSAY QUESTION 1

You are working as a registrar in a community mental health team for people over the age of 65. A local General Practitioner (GP) has sent a referral to your service, seeking an urgent assessment:

*“Could you please review Iris Daniels, a 72-year-old widow who lives by herself? Iris has had little contact with my practice. Today in clinic she reported being very anxious & low in mood. I couldn’t otherwise get a clear picture from her of her symptoms and recent events in her life. She seems to have lost weight since I saw her a year ago, but otherwise appeared physically well. Her physical observations were within normal limits. According to my records Iris has mild hypertension, but no other medical problems. Her only medication is Atenolol (beta blocker). I’m not aware of any mental health disturbance previously.”*

### Question 1.1 (10 marks)

Outline your approach to this assessment.

		worth	mark
A.	<b>General assessment principles:</b> including the need to establish rapport & therapeutic relationship, need for collateral history if possible (? family, ? friend), confidentiality & its limits, assessment considerations for older adults (i.e. slower pace, optimizing vision/hearing, at home).	2	
B.	Obtain <b>presenting history:</b> including screening for symptom clusters of anxiety, depression, psychosis, cognitive impairment, longitudinal history of various symptoms, her level of functioning, any potential triggers (eg. medical illness, grief, psychosocial issues).	2	
C.	Clarify <b>past history:</b> including previous mental health problems and treatment, family mental health history, medications (esp. those with potential to cause mood or cognitive problems), past medical history (esp. those with potential to affect mood or cognition such as cerebrovascular disease, thyroid problems, low B12/folate, head injuries), alcohol & drug use.	2	
D.	Clarify relevant personal & social history, premorbid personality, Enduring Power of Attorney status	1	
E.	<b>Mental state examination:</b> with particular reference to features suggestive of a depressive or anxiety disorder (ie. psychomotor agitation/retardation, mood, affect, speech changes), cognition, including MMSE & tests examining frontal lobe function, any focal neurological features.	2	
F.	<b>Investigations:</b> Check what investigations have been done already. Ensure full range of appropriate investigations done, including bloods (FBC, U&Es, TFTs, B12, folate, Ca PO4, ESR/CRP), MSU. Head radioimaging could be mentioned, but is not essential at this stage. Better answers will give reasons for seeking tests (eg. rule out delirium, identify any medical disorders contributing to low mood).	2	
G.	<b>Risk Assessment:</b> Candidates should consider risk issues broadly, including potential impairment of basic self-cares (ie. adequate oral intake, taking Rx), domestic affairs (ie. managing finances, shopping, cooking), driving, suicidality.	1	
Up to a maximum of 10 marks in total <b>TOTAL:</b>			

### Modified Essay Question 1 contd.

You visit Mrs Daniels at home. She reports symptoms of anxiety and depression developing gradually over the past 3 months. She reports being "agitated" and "hopeless". She reports eating very little & losing weight, but it's unclear how much. She wakes in the early hours of the morning and cannot get back to sleep. Mrs Daniel has stopped all of her usual external activities. She watches TV at home, but doesn't enjoy her favourite programmes. She reports intermittent passive death wishes, but denies any suicidal ideation or plans. Mrs Daniel is convinced she has no money and will be declared bankrupt soon. She also firmly believes she has a sinister medical illness such as cancer that will kill her soon. There are no other psychotic symptoms.

On mental state examination Mrs Daniels is thin, has dry mucous membranes in her mouth, exhibits significant psychomotor agitation, is objectively severely agitated, has affect restricted to the anxious range with little or no reactivity, speaks very little, and is excessively concerned regarding money and dying soon. Her Mini Mental State Examination scores 28/30, with 2 marks lost for attention. She acknowledges being anxious, but denies having a mental health disorder.

Blood and urine tests obtained that day are unremarkable, apart from mildly elevated urea and creatinine, and mildly decreased albumin.

#### Question 1.2 (5 marks )

**State and justify your preferred diagnosis and the main differentials to be excluded, and discuss what additional assessments you might obtain to support or exclude the diagnosis.**

	worth	mark
<p><i>Preferred diagnosis:</i></p> <p>Major Depressive Disorder, current Major Depressive Episode, severe, with features of agitation &amp; psychosis.</p> <p>[ Better answers will use DSM-IV diagnostic terms, cite relevant diagnostic criteria]</p>	2	
<p><i>Main differentials to be considered:</i></p> <p>Generalised Anxiety Disorder Late onset primary psychotic disorder Dementia (possibly comorbid with MDE)</p> <p><i>Other differentials which are less likely, but need to be ruled out:</i></p> <p>Mood Disorder secondary to a GMC Mood Disorder secondary to undisclosed substance use BPAD with current MDE Somatoform Disorder</p>	2	
<p><i>Additional assessments to clarify diagnosis:</i> could include</p> <ul style="list-style-type: none"><li>• Nursing observations obtained by admitting her for a full assessment</li><li>• Full physical examination (by yourself or GP), with particular note of any focal neurological features (to rule out an organic CNS cause), and looking for dehydration, muscle wasting, etc.</li><li>• Fuller cognitive testing / neuropsychological testing</li><li>• CT head or MRI (to rule out an organic CNS cause)</li><li>• Occupational therapy assessment</li></ul>	2	
<b>Up to a maximum of 5 marks in total</b>		
<b>TOTAL:</b>		

### Modified Essay Question 1 contd.

Mrs Daniels is admitted involuntarily to an acute old age psychiatry inpatient unit two days after your initial assessment, after continuing to eat and drink very little, and refusing community contact with either your team or the General Practitioner. Her mental state is otherwise unchanged. On physical examination Mrs Daniels is moderately dehydrated. On the ward Mrs Daniels is unable or unwilling to drink more than 300ml of fluids per day, while her only solid food consists of 2-3 biscuits and a pottle of yoghurt per day. The nursing staff feel able to manage Mrs Daniels on the old age psychiatry inpatient unit, and can provide basic medical cares.

#### Question 1.3 (5 marks )

**Outline optimal management at this point, excluding the use of electro-convulsive therapy (ECT).**

	worth	mark
<b>A.</b> <b>Nursing Care:</b> Ward limits and very close nursing observations (treat in a high-dependency part of unit if such exists), support and reassurance, encourage her to eat and drink, monitor/record her oral intake & urine output, monitor for objective signs of low mood (sleep, appetite, reactivity), remove potentially dangerous items from her vicinity. Manage IV/subcut fluids as needed.	2	
<b>B.</b> <b>Medical Care:</b> Regular mental state and physical reviews and risk assessment, monitor renal function (ie. U&Es), arrange dietary supplementation, consider subcutaneous or intravenous fluids as needed.	2	
<b>C.</b> <b>Psychiatric treatments:</b> Trial an antidepressant. Better answers will discuss the relative merits of antidepressant classes in this situation (e.g. RANZCP guidelines suggest use of TCA or Venlafaxine for psychotic depression, but these medications may be less tolerated in an older & physically compromised patient). Ideally, some administration details of an appropriate well-tolerated SSRI antidepressant will be given (e.g. start Citalopram at 10mg mane initially, increasing to 20mg after about a week, monitoring for potential adverse/side-effects of gastrointestinal disturbance, paradoxical agitation, exacerbation of insomnia and hyponatraemia).  Shorter-term use of second-generation antipsychotic for her mood-congruent delusions. Shorter-term use of sedatives or hypnotics.  Candidates can also refer to general non-Rx measures such as engagement, liaison with family, psychoeducation. Talk therapy can be an option, but better candidates will identify obstacles to psychology currently (e.g. limited engagement, possible cognitive impairment, agitation, limited insight).	2	
<b>Up to a maximum of 5 marks in total</b>		
<b>TOTAL:</b>		



### Modified Essay Question 1 contd.

Mrs Daniels is now refusing oral medications.

#### Question 1.4 (4 marks )

**Outline the main indications and potential risks regarding the use of ECT to treat Mrs Daniels.**

	worth	mark
<b>A.</b> <b>Indications:</b> Serious major depression, risk of physical compromise from inadequate intake (dehydration), refusal of oral medications, delayed onset of action of antidepressants (even if she would take them), potential intolerance of antidepressants due to her age, the existence of psychotic and melancholic features.	2	
<b>B.</b> <b>Risks:</b> Dehydration – e.g. she might be hypotensive, risk of post-ECT confusion and other cognitive impairment such as autobiographical memory loss, risk of headache/muscle-aching or nausea post-ECT, risk of cardiovascular arrhythmias during treatment, risk of mania.	2	
<b>Up to a maximum of 4 marks in total</b> <b>TOTAL:</b>		

## MODIFIED ESSAY QUESTION 2

You are the registrar for a consultation liaison service. At the morning triage meeting for the team, you are allocated a patient, Mr Paleopa, from the Emergency Department (ED) short-stay ward who has been referred by the Private Hospital where he has been living. The Private Hospital manager says they cannot cope with him and they are not willing to have him back.

Mr Paleopa is a Samoan gentleman aged 62 who, last year, was diagnosed with a tumour on his jaw. He underwent surgery, chemotherapy and radiotherapy but he was unable to return home because of ongoing high nursing needs, hence the Private Hospital placement.

He moved to the Private Hospital three months ago and has been generally irritable and abusive to the staff and other residents. Now, he has struck a staff member, leading to the admission to your hospital's Emergency Department short-stay ward last night.

You have been specifically requested by the Emergency Department team to organise placement in a dementia unit where his challenging behaviours can be appropriately managed.

### Question 2.1 (8 marks )

Describe how you would proceed from this point, excluding the interview with the patient.

		worth	mark
A.	<i>Get information from ED:</i> Go to the ED. Liaise with the ED staff and read their notes. Review physical examination findings and investigations from the patient's current ED admission.	2	
B.	<i>Review Old Records:</i> read the patient's old files including details of his tumour, whether any spread, any other medical conditions.	2	
C.	<i>Talk to Private Hospital staff:</i> to clarify details of the presenting problems.	2	
D.	<i>Talk to the patient's family.</i>	2	
E.	<i>Talk to the patient's GP.</i>	2	
F.	<i>Attempt to clarify the Differential Diagnosis:</i> Establish where the diagnosis of dementia came from. Check that delirium been considered and appropriate investigations ordered. Ensure no hasty conclusions about presentation being bad behaviour only have been reached.	2	
Up to a maximum of 8 marks in total			
TOTAL:			

## Modified Essay Question 2 contd.

### Question 2.2 (4 marks )

What are the three most likely categories of differential diagnoses that should be considered at this point to account for Mr Paleopa's challenging behaviour, prior to interviewing the patient?

		worth	mark
A.	<i>An Organic Disorder:</i> For example Delirium, Dementia, Possible brain metastases from the tumour (causing disturbed behaviour)	2	
B.	<i>Depression</i> (causing disturbed behaviour)	2	
C.	<i>An Adjustment Disorder</i> (causing disturbed behaviour)	2	
Up to a maximum of 4 marks in total TOTAL:			

## Modified Essay Question 2 contd.

You go to see Mr Paleopa at the ED short-stay ward. He is in a partially curtained-off bed in the main area, with several other patients also in the large room and a central nursing station. When you arrive he is talking angrily to someone, in Samoan, on a cordless phone. His nurse tells you that he has been very irritable so they allowed him to call his wife so as to “calm him down a bit”.

### Question 2.3 (8 marks )

Outline your approach to assessing Mr Paleopa.

		worth	mark
A.	<i>Arrange the setting for the assessment so as to maximise his cooperation:</i> Find a more private place to talk with him, allow him to finish his phone call first, see whether an interpreter is needed. See him with a Pacific Island cultural worker if possible.	2	
B.	<i>Try to improve therapeutic engagement:</i> Attempt to establish rapport. Validate his angry feelings. Start with an open mind, get his side of the story.	2	
C.	<i>Assess and manage any risks:</i> Check that it is safe to interview him, in terms of his level of aggression or confusion or any risk of him running away. Possibly arrange for security staff to be nearby during your assessment.	1	
D.	<i>Assess him for the possible diagnosis of dementia which has been raised:</i> If possible, get his account of any problems with memory, etc. Attempt cognitive testing once some rapport has been established.	2	
E.	<i>Assess for Depression:</i> Enquire carefully about symptoms of depression, also for somatic symptoms which might be an expression of depression in his culture.	2	
F.	<i>Assess physical symptoms that might affect his behaviour:</i> Enquire about pain and about functional consequences of the tumour – e.g. has it restricted his eating or speech?	1	
G.	<i>Assess his social situation and stressors:</i> What are the current family issues? Are there any other stressors apart from the tumour? How did he find the Private Hospital and how would he feel about moving to a rest home?	2	
Up to a maximum of 8 marks in total TOTAL:			

## Modified Essay Question 2 contd.

You have now interviewed Mr Paleopa and gathered background and collateral information. Although you are not certain of the diagnosis at this point, you have concluded that he does not have dementia and that the plan suggested by ED of organising his transfer to a dementia unit is completely inappropriate. Despite this, the ED staff are putting pressure on you to discharge him from the ED short-stay ward.

### Question 2.4 (4 marks )

**Describe your approach to this situation.**

		worth	mark
A.	Remain calm and maintain a professional manner with the ED staff.	2	
B.	Remain involved in the case, but do not take on sole responsibility for discharging Mr Paleopa from the ED.	2	
C.	Continue to assess Mr Paleopa and review any new information/investigations/risks so as to advise what ongoing mental health involvement may be appropriate and required.	2	
Up to a maximum of 4 marks in total <b>TOTAL:</b>			

## MODIFIED ESSAY QUESTION 3

### Modified Essay Question 3 (23 marks)

You are a registrar working in a community mental health centre. A local General Practitioner (GP) refers Doug, a 35 year old man of European descent, to your clinic for “anger problems” and “depression”. The referral letter notes Doug is a loner and mistrustful of others. Doug has been taking paroxetine 20 mg daily for the past five years as prescribed by his GP following a break up with his wife and has been on a long-term social welfare benefit/pension across that time. He has one son to his estranged partner – the boy is in his ex-partner’s care. Doug has a history of intravenous opiate dependence but has been “clean” for 10 years.

#### Question 3.1 (7 marks )

**Outline your approach to the assessment of this man.**

	worth	mark
<b>A.</b> Call the GP and clarify the urgency of the referral and arrange an assessment time, and to obtain further details of the problems, if possible.	<b>2</b>	
<b>B.</b> Ensure the presence of staff/security to guarantee safety during the initial assessment.	<b>1</b>	
<b>C.</b> Carry out the assessment - a comprehensive History and Mental State Examination.	<b>2</b>	
<b>D.</b> Consider a physical examination or asking the GP about relevant aspects of Doug’s physical health e.g. communicable diseases or complications of his intravenous drug abuse.	<b>2</b>	
<b>E.</b> Arrange physical investigations: urine drug screen, neuroimaging, viral serology (in particular).	<b>2</b>	
<b>Up to a maximum of 7 marks in total TOTAL:</b>		

### Modified Essay Question 3 contd.

At interview Doug is a thin man looking older than his stated years. He has a number of home-made tattoos on his face and hands. He makes poor eye contact and rapport is difficult to establish. Doug is reluctant to disclose much about his past but does tell you he has previously spent time in prison for assault. He accuses you of making fun of him during the interview and is sarcastic. He is angry with his ex-father-in-law who he says is “making my life difficult by going behind my back” and says that he intends to “sort him out”. Doug forbids you to seek collateral information from any family or friends. He tells you he is sleeping poorly and asks for sleeping pills. He laughs when asked about any suicidal ideas.

#### Question 3.2 (10 marks )

Discuss your initial management.

	worth	mark
A. Discuss the need for <i>additional information</i> – collateral history from Doug’s ex-partner and her father, and a domiciliary assessment.	2	
B. Discussion is needed of the arguments for and against breaching <i>confidentiality</i> and going against Doug’s refusal to allow collateral information.	2	
C. Need to <i>assess the immediate suicide and violence risk</i> – comprehensive risk assessment, taking account of higher-risk features (male, history of depression, substance abuse). (Risk management is covered in parts D-F).	2	
D. Consideration of use of the <i>Mental Health Act</i> , depending on his mental state, the level of risk and his degree of cooperation and capacity to consent.	2	
E. <i>Medication</i> : Discussion is needed of the arguments for and against the prescription of an hypnotic, or about a change in antidepressant, or about use of antipsychotic medication.	2	
F. Brief discussion is needed about Doug requiring <i>ongoing close follow-up</i> if he is not unwell enough to admit. Also mention of Crisis Team back-up of some sort, and ensuring Doug knows how to contact them/encouraging him to do so rather than to act out angrily.	2	
Up to a maximum of 10 marks in total TOTAL:		

### Modified Essay Question 3 contd.

In your second session with Doug he reveals he has a rifle and has been carrying it in his car “for protection”. He reveals he has been thinking of using it on his ex-father-in-law who he believes is making it difficult for him to access his son by conspiring with the Child Protection Services.

#### Question 3.3 (6 marks )

**Discuss your approach to managing the violent threats made by Doug.**

	worth	mark
<b>A.</b> <i>Revise the Risk Assessment.</i> Is there a definite plan. Is the firearm loaded? Accessibility of victim - where is the father-in-law? Evaluate the likelihood of violence on basis of new information. (The risk of violence is increased)	<b>3</b>	
<b>B.</b> <i>Discussion of the possibility of continuing to treat Doug while monitoring his homicidal ideation.</i> Supervision and advice of a senior colleague is necessary if this is considered as an option.	<b>2</b>	
<b>C.</b> <i>Discussion of the ethics of duty to warn:</i> patient confidentiality vs public safety. (duty to warn the father-in-law). Ideally a brief mention of “Tarasoff”.	<b>2</b>	
<b>D.</b> <i>Discussion of arguments for and against involving the Police,</i> and how to achieve this. e.g. Enquire whether the fire arm is licensed. Discuss with Doug the need to keep self and others safe. Ask Doug to voluntarily hand his firearm over to Police.	<b>2</b>	
<b>Up to a maximum of 6 marks in total TOTAL:</b>		



## MODIFIED ESSAY QUESTION 4

You are working as a registrar in a Community Mental Health Centre where you are asked to urgently see a 51 year old man, Tom, who is expressing suicidal ideation. This is Tom's first contact with psychiatric services. He has been treated by a GP and is taking 300mg venlafaxine daily, having previously trialled therapeutic doses of paroxetine and nortriptyline. The referral letter gives a history of depression for the past year, excessive alcohol consumption and a significant family history of suicide in the men of the family. Tom's wife is very career-focussed, he has two teenage sons and has a responsible job working as a manager in a pharmaceutical company. He is knowledgeable about pharmaceuticals, has easy access to these and feels an extreme sense of shame about being referred to psychiatric services. He denies any stressors or precipitants. His wife is concerned about his safety.

### Question 4.1 (8 marks )

Outline which aspects you would focus on when interviewing this patient.

		worth	mark
A.	Ascertain his safety. Determine his intentions, plan, previous history of self harm, access to the means to harm himself.	2	
B.	Clarify his diagnosis. Screen for depression, dysthymia, bipolar disorder, adjustment disorder, underlying anxiety disorder. Check there is no evidence of psychosis.	2	
C.	Assess his substance use. Degree of dependence, abuse, use of other substances, sequelae to substance use, any history of past treatment or attempts to stop.	2	
D.	Assess his personality profile. Degree of narcissism or obsessionality. Defences.	1	
E.	Take medical history and check his current physical health. Especially concerning alcohol effects, alcohol withdrawal.	2	
F.	Gather personal and family history. Previous losses, history of trauma, patterns of relationships, work history. Screen for childhood deprivation, unresolved grief. Check for mental illness in parents or other family members.	2	
Up to a maximum of 8 marks in total TOTAL:			

### Modified Essay Question 4 contd.

Tom tells you that he is not imminently suicidal but feels desperate as the venlafaxine does not seem to be working. He has neurovegetative features of depression, has lost a significant amount of weight and insists that he needs to continue working. He minimises his use of alcohol and does not believe that this interferes with his work. He insists that he requires more medication and denies any relationship problems. He describes a troubled childhood with emotional neglect due to a chronically depressed mother and an abusive father who was frequently intoxicated.

#### Question 4.2 (6 marks )

Outline the main aspects of your management plan for this patient.

	worth	mark
A. <i>Manage Risks:</i> Monitor his safety. Ensure access to after hours Crisis Team cover. Develop the therapeutic alliance.	2	
B. <i>Optimise Biological Treatments:</i> Review his treatment of depression. Consider an alternative such as sertraline or another effective antidepressant. Consider augmentation of venlafaxine (e.g. with mirtazepine or a mood stabiliser). Consider a course of ECT.  NB: Prescribing hypnotics or benzodiazepines is not recommended due to his alcohol use and the chronic nature of his issues – likely to become dependent.	2	
C. <i>Treat Substance Abuse:</i> Address his alcohol use. Use motivational interviewing, a diazepam-assisted withdrawal, consider admission to a detoxification unit.	2	
D. <i>Support and Educate:</i> Provide psychoeducation for him and his wife. Consider whether he needs need for time off work or whether maintaining work is essential for his self-esteem.	2	
E. <i>Plan Psychotherapy:</i> Consider a course of CBT (or other appropriate structured therapy such as IPT), or of psychodynamic psychotherapy (once he is less at risk and his depression has improved).	2	
Up to a maximum of 6 marks in total <b>TOTAL:</b>		

### Modified Essay Question 4 contd.

You are looking for a long psychodynamic psychotherapy training case and Tom is interested to engage in this as well as his biological treatment options. He tells you that he has had a somatic symptom, which he describes as “reflux”, since doing weight training in his twenties. He eventually resorted to surgical intervention for this as no medication was helpful. In spite of a subtotal gastrectomy he still complains of “reflux”. He now says that his mental state is the result of a genetic loading for depression and that he had a “good” childhood. He thinks that if he keeps working it means that he is capable and indispensable.

#### Question 4.3 (3 marks )

**What defence mechanisms are demonstrated above which could potentially interfere with the therapy process?**

	worth	mark
A. Somatisation (or accept hypochondriasis)	1	
B. Denial	1	
C. Rationalisation	1	
D. Intellectualisation	1	
E. Repression	1	
Up to a maximum of 3 marks in total TOTAL:		

*NB: Do not accept or sublimation or suppression as these are relatively mature defences and not likely to interfere. Other possible defences are not described above so attract no marks.*

### Modified Essay Question 4 contd.

You commence psychodynamic psychotherapy with Tom. Tom attends his weekly therapy appointments with you, although he maintains that therapy is not helping. He has been suspended from work due to arriving intoxicated one morning and he is still depressed. He arrives at his next therapy session with a gift for you.

#### Question 4.4 (6 marks )

How should you approach this situation?

	worth	mark
<b>A.</b> Continue regular, weekly therapy and carefully monitor his level of risk.	<b>2</b>	
<b>B.</b> Monitor your countertransference reactions.	<b>1</b>	
<b>C.</b> Discuss the possible meanings of the gift-bringing with Tom: hostility, guilt, gratitude, manipulation.	<b>2</b>	
<b>D.</b> Discuss with Tom the appropriateness of your accepting gifts or not - eg. a small gift before Christmas is reasonable, a large, expensive gift is not appropriate (discuss appropriate boundaries).	<b>2</b>	
<b>E.</b> Discuss the issues in supervision.	<b>1</b>	
<b>Up to a maximum of 6 marks in total</b>		
<b>TOTAL:</b>		

## MODIFIED ESSAY QUESTION 5

Jane is a 14 year old, locally born Chinese girl living with both parents, her maternal grandmother and her younger brother. She is in Year 9 at school. Her parents were born overseas and immigrated shortly before Jane's birth.

Jane presents to the Emergency Department (ED) after hours because of a fainting episode and is noted to be extremely thin. You are called to see her because her parents say that she "won't eat." She has never been seen by any services in relation to this.

ED staff have made the following observations: "extremely emaciated, BMI 16.2, weight less than 3<sup>rd</sup> percentile, height 50<sup>th</sup>ile, acrocyanosis of hands and feet, standing BP 70/50, lying 95/75, pulse 52, T 35. Mild dehydration, examination including neurological otherwise normal". Her Full Blood Count shows a mildly low white count, ESR is 10, liver function tests, sodium and potassium are normal. Jane's urea and creatinine are mildly raised. An ECG shows low voltages but is otherwise normal. The ED staff think that she has Anorexia Nervosa and are planning to admit her to a paediatric ward. They ask you to assess her and advise on inpatient management in a medical setting.

### Question 5.1 (10 marks )

**Describe your assessment of Jane's eating problems and how you would gather this information so as to develop a plan for her inpatient management.**

		worth	mark
A.	History of eating problems and weight: Duration of problems, weight loss history, highest and lowest weight. Food avoidance history, food habits, food ideas, food restriction.	2	
B.	History of additional symptoms supporting a diagnosis of AN: such as vomiting, purging, exercise. Menstrual history.	2	
C.	Other psychiatric history: of anxiety or depressive symptoms, plus history of any past deliberate self-harm.	2	
D.	Developmental history: of her early development, psychological issues and personality/coping style.	2	
E.	Social history: school - educational and social abilities, and social supports.	2	
F.	Carry out a Mental State Examination: including body image distortion, mood and anxiety symptoms, suicidal or self-harm ideas, screen for psychosis, assess rapport and her motivation and level of insight.	2	
G.	Family history: of eating disorders, mood, anxiety disorders. Plus the family's general coping, social circumstances, and ability to support her.	2	
H.	Sources of history: from Jane herself, and also from her family to corroborate AN symptoms from her parents re background and duration. Also history from GP or paediatric/Plunket nurse weight records.	2	
Up to a maximum of 10 marks in total TOTAL:			

### Modified Essay Question 5 contd.

Jane's parents say that she is a top student and she is sitting a school exam tomorrow as well as a Grade 8 music exam in two days. Jane herself is insistent that she doesn't need to be in hospital. Both her parents and Jane want to continue with these plans and don't want her to go into hospital. They say that they want to take her home so that her grandmother can cook her special food.

The medical staff say that Jane requires hospitalization and ask you to "convince" her parents to make her stay.

#### Question 5.2 (8 marks )

Outline what information you would require and how you might intervene.

	worth	mark
<i>Information Gathering:</i>		
A. Risk Assessment: clarify the level of risk with the medical team, re risk of what? (e.g. cardiac collapse, renal impairment). Note that mortality from AN is 5% per decade, approx 10% overall for adult chronic cases.	2	
B. Review Jane's mental state especially her ability to give informed consent to treatment: is she able to clearly understand the pros and cons of treatment vs no treatment?	2	
C. Arrange a family meeting with the relevant family and a Chinese cultural support worker - to clarify their understanding of her illness and assess any cultural or language barriers. Involve Jane's grandmother as well if possible. May well require an interpreter.	2	
<i>Interventions:</i>		
D. Work with the family: Provide them with psychoeducation about Anorexia Nervosa, the risks, reading materials, website information, and discuss their concerns. Ideally, persuade them that Jane needs to remain in hospital.	2	
E. Compulsory Treatment: There is a high risk due to the medical issues, therefore Jane could be compelled to stay in hospital, via the Mental Health Act or Child Protection/Welfare legislation (may vary state to state or in NZ).	2	
F. If Jane's parents cannot be persuaded or do not seem to appreciate the risks, attempt other means to convince them before resorting to Child Welfare Services to override their wishes. E.g. a further meeting with the Chinese cultural worker, a second opinion from a colleague who would also meet with them and attempt to persuade them, involve the GP to talk with them, if they have a good relationship with their GP.	2	
Up to a maximum of 8 marks in total TOTAL:		

### Modified Essay Question 5 contd.

Jane's parents eventually agree to the medical admission. The paediatric team begin a process of re-feeding, including using naso-gastric feeding. Jane finds this very distressing and scratches her arms every time, after she eats or is fed. The paediatric team ask you to advise on strategies for supporting Jane during this period in hospital. Jane's family are also asking what kind of therapy she will require in the future.

You assess Jane's history of distress, including her cognitions, mood and behaviour in relation to feeding. You also get collateral history from staff and her family about their strategies for helping Jane.

#### Question 5.3 (6 marks )

**Describe your recommendations for Jane's therapeutic management in hospital and after discharge. Note any supporting evidence for these therapies.**

	worth	mark
A. <i>Psychoeducation for Jane:</i> about basic strategies for distress tolerance, with a CBT approach (e.g. distraction, relaxation, breathing).	2	
B. <i>Psychoeducation for her carers:</i> also teach the staff and family members caring for Jane basic strategies such as distraction, relaxation, breathing. A C-L nurse might help provide this if there is a multidisciplinary C-L team.	2	
C. <i>Weight restoration:</i> comes first, as the initial therapy. Better answers will mention the need to aim for weight restoration to 50 <sup>th</sup> percentile re height, or that patients cannot usually engage well in psychotherapies until they have reached 90% of ideal body weight.	2	
D. <i>Family based treatment/Family Therapy:</i> is the only evidence-based model (Maudsley, Locke etc.) once Jane's weight is higher.	2	
E. <i>CBT:</i> might be tried as part of follow-up, but there is no Level 1 evidence for CBT in adolescents with Anorexia Nervosa.	1	
F. <i>Individual psychodynamic or supportive therapy:</i> (again, there is no level 1 evidence).	1	
G. <i>Medications:</i> might trial benzodiazepines or olanzapine. However there are no RCTs for these in Anorexia Nervosa.	1	
Up to a maximum of 6 marks in total <b>TOTAL:</b>		

## MODIFIED ESSAY QUESTION 6

Maria is a 49 year old locally born woman of Serbian parentage who lives with her 43 year old sister Tatjana in their own home. Maria has been referred to the Community Mental Health Centre (CMHC) where you are a registrar, for assessment, by her General Practitioner (GP). The GP's letter states that he is concerned that Maria is "excessively religious, not eating or sleeping properly, losing weight, and becoming a risk to herself and her sister." The sisters have lived alone since the death of their father from a heart attack 15 years previously. Their mother died when they were aged 22, of cancer. Their father was a wealthy furniture store owner and the sisters now live (frugally) off their inheritance, and do not need to work. They both used to be closely involved with their local Orthodox church, but Maria has drifted away and no longer attends. The GP's letter says that Maria has become more and more "eccentric and isolated" across the past year. He apparently managed to get her to see a psychologist for some psychotherapy eight months ago, but she ceased attending after three sessions, saying that the therapist tried to use "demonic possession" on her.

The CMHC triage nurse reports that she called Maria to explain about the GP referral, but that Maria denied any problems and refused an assessment.

### Question 6.1 (6 marks )

**How would you approach this situation so as to decide whether or not to proceed with an assessment under the Mental Health Act?**

		worth	mark
A.	<i>Clarify the degree of risk:</i> contact the GP and explain that Maria is refusing the assessment. Get as much history as possible about Maria, and clarify why the GP is so concerned.	2	
B.	<i>Get collateral information from Tatjana to assess the risks:</i> This can be justified even if Maria does not give permission, if the GP's history indicates the possibility of significant risk.	2	
C.	<i>Get collateral information from the prior therapist to assess the risks:</i> This can be justified even if Maria does not give permission, if the GP's history indicates the possibility of significant risk.	2	
D.	<i>Ask the GP to persuade Maria:</i> see if the GP can talk some more to Maria and persuade her to accept the assessment. Possibly even see her at the GP's practice, with the GP, if this would help.	2	
E.	<i>Risk Assessment:</i> assess whether the risks as evaluated after all the above are sufficient to warrant a compulsory assessment.	2	
F.	<i>Use her Church to try to engage Maria:</i> may not be feasible as she is somewhat estranged, but could try to engage her through her priest or other Church supports.	1	
Up to a maximum of 6 marks in total <b>TOTAL:</b>			





### Modified Essay Question 1 contd.

Tatjana tells you that Maria is actually a saint and the second incarnation of “the Holy Mother”. She says that Maria realised this over a year ago “in a vision from God” and that although Tatjana at first did not believe it, now she is convinced. Tatjana says that Maria believes that she does not need to eat “earthly foods” and has been fasting so as to be “closer to God”. Tatjana says that she feels blessed to share her home with a “living saint” but that she worries about how thin Maria has become. Also, Maria sometimes talks of “going to God” by which Tatjana thinks she means ending her life by jumping off a local motorway overpass. Maria also once said that Tatjana would be with her when she “goes to God”. This frightened Tatjana, even though she loves her sister and believes that she is a “holy saint”.

#### Question 6.2 (2 marks )

What is Tatjana’s most likely diagnosis?

	worth	mark
<p><i>Shared psychotic disorder.</i></p> <p><b>A.</b> Also accept <i>Folie à Deux</i> or <i>Induced Psychotic Disorder</i> or <i>Shared Delusional Disorder</i>.</p> <p><i>NB: Psychosis/Psychotic disorder/Delusional Disorder/Schizophrenia etc. without the “shared” or “induced” aspect receives no marks.</i></p>	<b>2</b>	
<b>Up to a maximum of 2 marks in total</b>		
<b>TOTAL:</b>		

### Modified Essay Question 1 contd.

Maria is assessed via the Mental Health Act and a diagnosis of Delusional Disorder is made. She is refusing treatment, but Tatjana is more open to follow-up and medication.

#### Question 6.3 (8 marks)

**Outline your approach to managing Maria's and Tatjana's mental disorders in the short to medium term – cover initial management and biological management.**

		worth	mark
A.	<i>Determine place of treatment:</i> Maria will need admission as she is refusing treatment, but Tatjana could possibly be treated at home with close Community Team follow-up, if she will accept this. Mention should be made that the sisters need to be treated <i>separately</i> – i.e. one as inpatient and the other at home, or if both admitted, in different wards. (To avoid too much continuing influence on Tatjana of Maria's delusions).	2	
B.	<i>Complete physical assessment as both are 1<sup>st</sup> episode presentations (and later onset):</i> Both sisters need a full physical with careful neurological examination, routine screening blood tests and a CT or MRI. Need to rule out an organic cause. Baseline ECG also advisable re medications to be used.	2	
C.	<i>Therapeutic engagement:</i> Mention is needed of the need to establish a therapeutic relationship with each sister, despite Maria's poor insight. May be easier initially with Tatjana.	1	
D.	<i>Monitor Risks and Mental State:</i> In Maria's case, ask ward staff to note evidence of psychotic symptoms, general self-care and any other symptoms. In Tatjana's case (if at home) ask Community team staff to do likewise. Assign Tatjana a case-worker if treated at home. Ongoing risk assessment for both.	2	
E.	<i>Biological Treatment: Maria</i> - she needs to commence antipsychotic medication. Attempt to persuade re oral meds. Failing that, start with short-acting parenteral form e.g. haloperidol 2mgs. If tolerates that could use Acuphase in initial week or two. Change to oral medication as soon as she becomes more cooperative. If continues to refuse, consider IMI depot like Risperdal Consta. Higher risk of TD as she is older and female, so risperidone or other atypicals are preferred. Monitor intake and physical state.	2	
F.	<i>Biological Treatment: Tatjana</i> - might not need medication. Once apart from Maria and with support and psycho-education, her ideas may normalise. Monitor and assess this. Might need a shorter course of an atypical like risperidone or olanzapine.	2	
G.	<i>Medico-legal issues:</i> Continue the Mental Health Act for Maria until she responds to treatment and education and is cooperative with medication and follow-up.	1	
Up to a maximum of 8 marks in total <b>TOTAL:</b>			

## Modified Essay Question 1 contd.

### Question 6.4 (6 marks )

Outline your approach to managing Maria's and Tatjana's mental disorders in the short to medium term – cover other aspects of their management and follow-up.

		worth	mark
A.	<i>Medico-legal issues:</i> Continue the Mental Health Act for Maria until she responds to treatment and education and is cooperative with medication and follow-up (for several weeks or longer-term if need be).	1	
B.	<i>Psychological Interventions:</i> Psychoeducation for both sisters, and general support. Possibly CBT later on as out-patients, to assist with symptom resolution if insight has considerably improved. Maintain engagement and therapeutic alliance.	2	
C.	<i>Social Interventions:</i> Ensure that Tatjana can cope alone at home. Arrange extra assistance if she needs this (budgeting, social work help). Facilitate the sisters seeing each other regularly unless visits are distressing for Tatjana while Maria is more acute. Most likely they will want to resume living together on discharge, but if not, discuss accommodation options with them, with social work help. Both or either may need an OT ADL assessment.	2	
D.	<i>Cultural/Spiritual Interventions:</i> If possible, get permission to talk with the priest at their Orthodox church and orientate him, and involve him as a support, esp. for Tatjana, but possibly also Maria if her more extreme beliefs settle. Explore whether there is any other Serbian cultural support – probably will just be their friends from church however. Care with confidentiality issues.	2	
E.	<i>Relapse Prevention Planning:</i> In Maria's case, combined with discharge planning. Early warning signs plans, network of support people (GP, maybe the priest). Set community follow-up in place for Maria, decide if same case-worker for both sisters, or different ones (are pros and cons either way). NB: Tatjana's mental health is likely to depend on Maria remaining well. Assertive community follow-up is needed, esp. if Maria's insight remains poor.	2	
Up to a maximum of 6 marks in total TOTAL:			