

# PRE-TEST FOR PHONE CONFERENCE

THURSDAY 10/18/2007, 11:00

MICHAEL T. WITKOVSKY, MD

## OPPOSITIONAL DEFIANT DISORDER

1. THE COMMUNITY PREVALENCE OF ODD IS
  - a. 2%
  - b. 16%
  - c. 9%
  
2. WHICH OF THE FOLLOWING PAIRS OF ETIOLOGIES (CAUSES) AND SYMPTOMS (OUTCOMES) ARE UNIQUE TO ODD AND NO OTHER DSM-IV DIAGNOSIS
  - a. FIRST PAIR
    - i. HIGH REACTIVITY AND DIFFICULTY BEING SOOTHED IN PRESCHOOL
    - ii. OFTEN LOSES TEMPER
  - b. SECOND PAIR
    - i. THERE MAY A VICIOUS CYCLE IN WHICH THE PARENT AND THE CHILD BRING OUT THE WORSE IN EACH OTHER
    - ii. OFTEN ACTIVELY DEFIES OR REFUSES TO COMPLY WITH ADULTS' REQUESTS OR RULES IN A MANNER THAT IS NOT DEVELOPMENTALLY ACCEPTABLE\EXPECTABLE
  - c. THIRD PAIR
    - i. DURING SCHOOL YEARS, THERE IS MOOD LABILITY, INFLATED SELF-ESTEEM, LOW FRUSTRATION TOLERANCE, SWEARING AND PRECOCIOUS USE OF ALCOHOL
    - ii. OFTEN ARGUES WITH ADULTS
  
3. WHICH OF THE FOLLOWING ARE "BEST PRACTICES", OR EVIDENCE BASED PRACTICES, FOR THE TREATMENT OF ODD?
  - a. PEER BASED GROUP THERAPY ALONE OR THOSE INCLUDING EXPERIENTIAL PROGRAMS SUCH AS BOOT CAMPS

- b. MEDICATION TREATMENT AS SINGLE AGENT MANAGEMENT, INCLUDING ATYPICAL ANTIPSYCHOTICS (RISPERIDONE); STIMULANTS (RITALIN®, STRATERRA®, AND OTHERS); SEROTONIN REUPTAKE INHIBITORS (SRI) FOR DEPRESSION AND ANXIETY (FLUOXETINE/PROZAC®); AND A MOOD STABILIZER (DEPAKOTE® OR LITHIUM.) COMBINATIONS OF THESE MEDICATIONS INTO BLENDED POLYPHARMACY USUALLY ENHANCE EFFECTIVENESS. IN ODD CHILDREN AND FAMILIES, SUCH COMBINATIONS ARE HIGHLY VALUABLE.
  - c. PARENT MANAGEMENT TRAINING
4. WHAT FEATURES OF ODD ARE MOST LIKELY TO PERSIST INTO ADULTHOOD?
- a. NOT MUCH, 2/3 OF ALL CHILDREN DIAGNOSED WITH ODD AND CD WILL BE WITHOUT SYMPTOMS 3 YEARS AFTER FIRST DIAGNOSIS.
  - b. CONDUCT DISORDER: 10% OF ALL CHILDREN DIAGNOSED WITH CD WILL MOVE INTO ADOLESCENCE AND THEN ADULTHOOD MEET MEET CRITERIA FOR CONDUCT DISORDER AND THEN ANTISOCIAL PERSONALITY DISORDER.
  - c. EARLY AGE OF ONSET (PRE-SCHOOL) IS ASSOCIATED WITH GREATER RISK OF ADHD IN YOUTH, THEN ANXIETY AND DEPRESSION IN ADULTHOOD.
  - d. ALL OF THE ABOVE

### **ATTENTION DEFICIT DISORDER WITH HYPERACTIVITY**

5. WHAT IS COMMUNITY PREVALENCE RATE OF ATTENTION DEFICIT WITH HYPERACTIVITY DISORDER?
- a. 1-3%
  - b. 3-7%
  - c. 8-15%
6. WHICH OF THE FOLLOWING IS A CLINICAL FEATURE IN ADHD AND ONLY IN ADHD?
- a. IS OFTEN "ON THE GO" OR OFTEN ACTS AS IF "DRIVEN BY A MOTOR"
  - b. OFTEN HAS DIFFICULTY SUSTAINING ATTENTION IN TASKS OR ACTIVITIES

- c. OFTEN BLURTS OUT ANSWERS BEFORE QUESTIONS HAVE BEEN COMPLETED

7. WHICH OF THE FOLLOWING IS BEST PRACTICES/EVIDENCE BASED PRACTICES FOR ADHD?

- a. STIMULANT MEDICATION ONLY
- b. STIMULANT MEDICATION WITH PARENT TRAINING
- c. NON-STIMULANT MEDICATIONS (E.G.: STRATERRA/ATOMOXETINE) AND COGNITIVE TRAINING

8. WHICH FEATURE OF ADHD IS MOST LIKELY TO PERSIST INTO YOUNG ADULTHOOD?

- a. HYPERACTIVITY
- b. SUBSTANCE USE/ABUSE
- c. IMPULSIVITY

### **AUTISTIC SPECTRUM DISORDERS**

9. WHAT IS THE COMMUNITY PREVALENCE RATE OF AUTISM?

- a. .1%
- b. 5%
- c. 10%

10. WHICH OF THE FOLLOWING SETS OF SYMPTOMS ARE UNIQUE TO AUTISM, ASPERGER'S SYNDROME, OR HIGH FUNCTIONING AUTISM AND FOUND IN NO OTHER DIAGNOSIS?

- a. FAILURE TO DEVELOP PEER RELATIONSHIPS IN A MANNER APPROPRIATE TO AGE
- b. INFLEXIBLE ADHERENCE TO NON-FUNCTIONAL, SPECIFIC ROUTINES OR RITUALS

- c. PERSISTENT PREOCCUPATION WITH PARTS OF OBJECTS, PEOPLE, OR THE WHOLE THING ITSELF
11. WHICH OF THE FOLLOWING INTERVENTIONS ARE BEST PRACTICES FOR THE TREATMENT OF AUTISTIC SPECTRUM DISORDERS?
- a. INTENSIVE BEHAVIOR SHAPING PROGRAMS
  - b. RISPERIDONE
  - c. PARENT TRAINING + RISPERIDONE
  - d. LOVASS + IN-HOME SERVICES
12. WHICH OF THE FOLLOWING ASPECTS OF AUTISM ARE MOST LIKELY TO PERSIST OR CHANGE INTO SOMETHING ELSE IN ADULTHOOD, AND BECOME CODIFIED AS ADDITIONAL DIAGNOSES?
- a. SCHIZOPHRENIA
  - b. SOCIAL ISOLATION
  - c. POOR OCCUPATIONAL FUNCTIONING
  - d. STEREOTYPIC MOTOR MOVEMENTS

### **BIPOLAR AFFECTIVE DISORDER**

13. WHAT IS THE COMMUNITY RATE OF PREVALENCE OF BIPOLAR DISORDER IN YOUTH?
- a. 0.1%
  - b. 5.8%
  - c. 13.3%
14. WHICH OF THE FOLLOWING TRAITS AND SYMPTOMS EXCLUSIVELY EXIST IN BIPOLAR DISORDER IN CHILDREN?
- a. PERSISTENT MOOD OF ELATION

- c. DECREASED NEED FOR SLEEP
- d. DISTRACTIBILITY
- e. HYPER-SEXUALITY
- f. IRRITABILITY, EXPLOSIVITY
  - i. A, B, C
  - ii. B, D, F
  - iii. A, C, E
  - iv. ALL OF THE ABOVE

15. WHICH OF THE FOLLOWING COMBINATIONS OF TREATMENTS ARE BEST PRACTICES FOR THE INTERVENING WITH BIPOLAR DISORDER AND ITS IMPAIRMENTS?

- a. ACUTE PHASE:
  - i. LITHIUM
  - ii. DEPAKOTE®
  - iii. ZYPREXA®
  - iv. LAMICTAL®
- b. MAINTENANCE PHASE:
  - i. LAMICTAL® + WRAP-AROUND SERVICES
  - ii. LITHIUM ONLY
  - iii. PROZAC® + DAY TREATMENT
  - iv. GROUP THERAPY FOR SKILL ACQUISITION IN SELF REGULATION
- c. RELAPSE PREVENTION:
  - i. ZYPREXA® + ZOLOFT®
  - ii. CLOZAPINE + COGNITIVE RETRAINING
  - iii. LITHIUM + WELLBUTRIN® + FAMILY THERAPY

16. WHICH SETS OF TRAITS, SYMPTOMS AND IMPAIRMENTS FOLLOW BIPOLAR INTO ADULTHOOD?

- a. SUICIDALITY
- b. FAILED SOCIAL RELATIONSHIPS ESPECIALLY MARRIAGES, NOT ASSOCIATED WITH SUBSTANCE ABUSE DISORDERS
- c. RECURRENT MANIA
- d. ALL OF THE ABOVE

### DEPRESSION DISORDERS

17. WHAT IS THE COMMUNITY PREVALENCE RATE OF DEPRESSION, ALL SUBTYPES FOR YOUTH?

- a. 0.9% IN PRE-SCHOOLERS
- b. 2% IN SCHOOL AGE CHILDREN
- c. 5% IN HIGH SCHOOL STUDENTS
- d. LIFETIME RISK, BY THE END OF HIGH SCHOOL, 10%; 5% OF ALL FEMALE STUDENTS WITH 2 OR MORE EVENTS; 1.5 % OF ALL MALE STUDENTS WITH 2 OR MORE EVENTS
  - i. C, D
  - ii. A, B
  - iii. D ONLY
  - iv. ALL OF THE ABOVE

18. WHICH SYMPTOMS, IF ANY, ARE UNIQUE TO DEPRESSION ONLY?

- a. DEPRESSED, IRRITABLE MOOD BUT NO IMPAIRMENT IN FUNCTIONING AT SCHOOL, HOME OR WITH PEERS
- b. SLOW MOVEMENTS WITH MONOTONE SPEECH WITH DETERIORATED FUNCTIONING
- c. SUICIDAL IDEATION

- d. PHYSICAL AGGRESSION TO INTIMATE PERSONS (FAMILY AND FRIENDS)

19. WHICH GROUPING OF DEPRESSION AND ITS TREATMENT IS EVIDENCE BASED FOR

a. ADOLESCENTS:

- i. FAMILY THERAPY + AMITRIPTYLINE
- ii. GROUP THERAPY + INTERPERSONAL PSYCHOTHERAPY + PROZAC
- iii. INDIVIDUAL THERAPY + LITHIUM

b. WHICH IS EVIDENCE BASED FOR CHILDREN?

- i. INDIVIDUAL THERAPY + ZOLOFT
- ii. GROUP THERAPY + ANY ANTIDEPRESSANT
- iii. PLAY THERAPY + PROZAC

c. IS THERE A DIFFERENCE BETWEEN BEST PRACTICES FOR MALES VERSUS FEMALES?

- i. FEMALES ARE BETTER PSYCHOTHERAPY CANDIDATES
- ii. MALES HAVE FEWER SAFETY ISSUES
- iii. GENDER SPECIFIC THERAPY GROUPS ARE CRITICAL

20. WHICH COMPLICATIONS FROM JUVENILE DEPRESSION ARE MOST LIKELY TO AFFECT AN ADULT, OR SHAPE SPECIFIC CONCERNS IN ADULTHOOD?

- a. RISK FOR SUICIDAL FEELINGS AND SUICIDE ATTEMPT IN 3<sup>RD</sup> & 4<sup>TH</sup> DECADES
- b. RISK FOR USING HYPERSEXUALITY, EXCESSIVE SUBSTANCES USES, SPENDING MONEY THAT THEY DON'T HAVE TO COMPENSATE FOR RESURGENCE OF DEPRESSION
- c. CHANGES IN SIGNIFICANT RELATIONSHIPS AND JOBS MORE THAN EXPECTED (EVEN IF A GEN X'ER)
- d. ALL OF THE ABOVE



DEEP EXPLORATORY RECOVERY TX  
SRI MEDICATION (ZOLOFT, PROZAC  
MOOD STABILIZERS  
ANTI-PSYCHOTICS  
DIALECTICAL BEHAVIORAL  
THERAPY

d. PTSD

24. IF A CHILD HAS HAD A BONA FIDE ANXIETY DISORDER, WHAT LIKELY ADVERSE ISSUES WILL FOLLOW THEM INTO ADOLESCENCE AND ADULTHOOD?

- a. A PATTERN OF INTENSE, UNSTABLE INTERPERSONAL RELATIONSHIPS ALTERNATIVE BETWEEN EXTREMES OF IDEALIZATION AND DEVALUATION
- b. OVER USE OF SUBSTANCES THAT ACTIVATE THE GABA NEUROTRANSMITTER SYSTEM WHICH IS IMPLICATED IN ALCOHOL ABUSE, ALSO SHOWING A STRONG PREFERENCE FOR SUBSTANCES SUCH AS HALLUCINOGENS THAT PROMOTE LOSS OF CONTROL
- c. THERE WILL BE A PATTERN OF FREQUENT FITS AND STARTS IN THERAPY WITH LITTLE TOLERANCE FOR INTIMACY OR CONFRONTATION IN THAT RELATIONSHIP. AN OVER-USE OF THE DEFENSES OF PROJECTION, SPLITTING AND DENIAL WILL ALSO CHARACTERIZE THE THERAPY.
- d. SIMPLE PHOBIA RESOLVE EASILY, BUT MAY TRANSITION FROM ONE OBJECT TO ANOTHER. THERE IS INCREASING SELF-REGULATORY SKILL WITH THESE TRANSITIONS HOWEVER.

