NR 547 MIDTERM STUDY GUIDE

The NR547 exam questions are taken from the Course Activities, lectures, linked resources and required readings.

Mid-Term Exam: The Mid-Term has 75 questions worth two points each. You will have one attempt to complete the exam with a time limit of 75 minutes.

Week 1: Foundations in Differential Diagnosis Formulation

1. The differential diagnosis:
    1. Importance of the differential diagnosis: critical step in providing safe, quality care. It helps discern an accurate diagnosis; helps PMHNP gather useful responses to formulate and narrow the list of potential diagnoses based on client's presenting symptoms.
    2. Analysis of:
        a) presenting symptoms: identify symptoms; ask length of time and any fluctuations in severity; determine presence of stressors included; identify factors that alleviate or exacerbate symptoms;
        b) clinical data such as physical exam: must decide if medical, surgical, or neurological condition is the cause of mental disorder; once determined that no disease process can be held accountable, then the diagnosis of a mental health disorder can be made; knowledge and understanding of physical signs and symptoms enables providers to recognize signs and symptoms that may indicate possible medical or surgical illness.
        c) laboratory analysis: vital in achieving goals of arriving at accurate diagnoses, identifying medical comorbidities, implementing appropriate treatment, and delivering cost effective care; CBC, CMP (serum electrolytes, LFTs, BUN, Cr), thyroid function tests, serum B12, vitamin D, toxicology screen, and urinalysis.
        d) Medical history including medications: includes treatments both past and present; past surgeries should also be reviewed; essential to understand patient's reaction to illnesses and coping skills employed; important when determining potential causes of mental illness as well as comorbid or confounding factors and may dictate possible treatment options or limitations; Medical illness can precipitate a psychiatric disorder (ex. Anxiety in an individual recently diagnosed with cancer); Medical illnesses can mimic a psychiatric disorder (ex. Hyperthyroidism resembling an anxiety disorder); Medical illness can be precipitated by a psychiatric disorder or its treatment (ex. a metabolic syndrome in a patient on a second-generation antipsychotic medication); Medical illnesses can influence the choice of treatment of a psychiatric disorder (ex. renal disorder and the use of lithium carbonate); pay special attention to neurologic issues (seizures, head injury, pain disorder); know any hx of prenatal or birthing problems or issues with developmental milestones; reproductive and mensgtrual history is essential as well as a careful assessment of the potential for current or future pregnancy.

    Medications: include all current psych meds and how long they have been used, compliance, effects, and any side effects; non-psych meds, OTC meds, sleep aids, herbal, and alternative meds should also be reviewed; it is wise to advise patient should be asked to bring all medications to interview; Allergies to medications should also be assessed (including which medication and the nature of the extent of and the treatment of the allergic response)

    3. Evidence-based screening tools and psychiatric rating scales
        a) Scoring
        b) Advantages and disadvantages: key role is to standardize the info collected across time and by various observers; This standardization ensures a consistent, comprehensive evaluation that may aid treatment planning by establishing a diagnosis, ensuring a thorough description of symptoms, identifying comorbid conditions, and characterizing other factors affecting treatment response. Also, the use of a rating scale can establish a baseline for follow-up of the progression of an illness over time or in response to specific interventions. helps to monitor patients over time or for providing information that is more comprehensive that what is

generally obtained in a routine clinical interview; helps providers identify symptoms and assess their severity and can assist with the evaluation of response to treatment; healthcare administrators and payors are increasingly requiring standardized assessments to justify the need for services or to assess the quality of care; also used in research that informs the practice of psychiatry; most rating scales also offer the user the advantages of a formal evaluation of the measure's performance characteristics. This allows the clinician to know to what extent a given scale produces reproducible results (reliability) and how it compares to more definitive or established ways of measuring the same thing (validity).

c) Components:

- **WHO disability Assessment schedule (WHODAS 2.0)**: self-administered; measures disability along cognition, interpersonal relations, work, and social impairments; Can be taken at intervals along the course of a person's illness; reliable in tracking changes that indicate a positive or negative response to therapeutic interventions or course of illness; recommended for general use.

- **Structured clinical interview for DSM (SCID):** starts with a section on demographic information and clinical background; 7 diagnostic groups: mood, psychotic, substance abuse, anxiety, somatic, eating, and adjustment disorders; available information (hospital records, informants, and patient observation) should be used to rate the SCID; administered by experienced clinicians; formal training in the SCID is required; Reliability data suggests that SCID performs better on more severe disorders (ex. bipolar disorder, alcohol dependence) than on milder ones (ex. dysthymia); validity is limited; used as the gold standard ; considered standard interview to verify the diagnosis in clinical trials; useful to ensure a systematic evaluation in psychiatric patients (ex. on admission to an inpatient unit or at intake into an outpatient clinic); also used in forensic practice to ensure a formal or reproducible examination.

- **Brief Psychiatric Rating scale (BPRS):** short scale measuring the severity of psychiatric symptomatology; assess change in psychotic inpatients and covers thought disturbance, emotional withdrawal and retardation, anxiety and depression, and hostility and suspiciousness; Reliability is good to excellent when raters are experienced but is difficult to achieve without substantial training; Validity is also good; been used extensively for decades as an outcome measure in treatment studies of schizophrenia; given its focus on psychosis and associated symptoms, it is only suitable for patients with fairly significant impairment.

- **Positive and Negative Syndrome Scale (PANSS):** used to remedy perceived deficits in the BPRS in the assessment of positive and negative symptoms of schizophrenia and other psych disorders; requires a clinician because it requires considerable probing and clinical judgment; a semi structured interview guide is available; reliability for each scale is reasonably high with excellent internal consistency and interrater reliability; Validity is good; standard tool for assessing clinical outcome in treatment studies of schizophrenia and other psychotic disorders; east to administer and sensitive to change with treatment; useful for tracking severity in clinical practice

- **Scale for the assessment of positive symptoms (SAPS) and scale for the assessment of negative symptoms (SANS)**: designed to provide a detailed assessment of positive and negative symptoms of schizophrenia and may be used separately or in tandem; SAPS assesses hallucinations, delusions, bizarre behavior, and thought disorder; SANS assesses affective flattening, poverty of speech, apathy (lack of interest), anhedonia (inability to experience pleasure from activities usually found enjoyable), and inattentiveness; both are used to monitor treatment effects in clinical research

- **Hamilton Rating scale for depression (HAM-D):** monitors severity of major depression with a focus on somatic symptomatology; commonly used version consists

of 17 items; 17 item version does not include some symptoms for depression in DSM-II and its successors most noticeably the reverse neurovegetative sighs (increased sleep, increased appetite, and psychomotor retardation); designed for clinician; can be completed in 15 to 20 minutes; reliability is good to excellent when sturtured interview version is used; validity appears good based on correlation with other depression symptom measures; used HAM-D has been used extensively to evaluate change in response to pharmacologic and other interventions and this offers the advantage of comparability across a broad range of treatment trials; problematic in elderly and medically ill

- **Beck Depression Inventory (BDI):** used to rate depression severity with a focus on behavioral and cognitive dimensions of depression; Current version (Beck-II) has added more coverage of somatic symptoms and covers the most recent two weeks; Earlier versions are focused on the past week or even shorter intervals which may be preferable for monitoring treatment response; can be completed in 5-10 minutes; consistency is high; test-retest reliability is no consistently high; validity is supported by correlation with other depression measures; the principle use of the BDI is as an outcome measure in clinical trials of interventions for major depression including psychotherapeutic interventions; a self-report instrument for major depression

- **Hamilton Anxiety Rating Scale (HAM-A):** assesses anxiety symptoms, both somatic and cognitive; score of 14 has suggested as the threshold for clinically significant anxiety but score of 5 or less are typical in individuals in the community; designed to be administered by a clinician, and formal training or the use of a structured interview guide is required to achieve high reliability; a computer-administered version is available; reliability is fairly good; validity is good; used extensively to monitor treatment response in clinical trials of generalized anxiety disorder and may be useful for this purpose in clinical settings.

- **Panic Disorder Severity Scale (PDSS):** brief rating scare for the severity of panic disorder; has 7 items each of which is rated on an item-specific 5 point Likert scale; 7 items address frequency of attacks, distress associated with attacks, anticipatory anxiety, phobic avoidance, and impairment; reliability is excellent; validity is supported by correlations with other anxiety measures

- **Clinician Administered PTSD Scale (CAPS):** includes 17 items required to make a diagnosis covering the event itself, reexperiencing the event, avoidance, and increased arousal; the diagnosis requires evidence of a traumatic event, one symptom of reexperiencing, three of avoidance, and two of arousal; the items can be used to generate a total PTSD severity score obtained by summing the frequency and intensity scales for each item; must be administered by trained clinician; requires 45 to 60 minutes to complete with follow-up examinations somewhat briefer; demonstrates reliability and validity in multiple settings and languages; has more limited testing in the setting of sexual and criminal assault; too long for use in clinical practice; commonly used in research setting for diagnosis and severity assessment

- **Yale-Brown Obsessive-Compulsive Scale (YBOCS):** used to measure the severity of OCD. It has 10 items rated based on a semi structured interview; the first 5 items concern obsessions and the amount of time they consume, the degree ot wich they interfere with normal functioning, the distress they cause, the patients attempts to resist them, and the patient's ability to control them; the remaining 5 items ask parallel questions about compulsions; Can be completed in 15 minutes or less; a self-administered version has recently been developed and can be completed in 10 to 15 minutes; reliability is good; validity appears good; standard instrument for assessing OCD severity and is used in virtually every drug trial; also used clinically to monitor