CAP Part 2 Exam Candidates Tell All

A Special Report for Child & Adolescent Psychiatry Part 2 Exam Candidates

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Dear Colleague, Thanks so much for downloading my Special Report for the CAP Part 2 Exam. I believe you will find the following information invaluable. You will get the real lowdown on the exam from colleagues who've taken the exam. These psychiatrists were kind enough to submit their exam experiences with the express purpose of helping you, a future candidate for this exam.

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CAP Part 2 Exam Structure

The Child & Adolescent Psychiatry Part 2 Exam has two parts, a live adolescent patient interview exam and a vignette exam.

- Adolescent Interview Exam: This section is identical to that of the adult psychiatry Part 2 Exam. You have approximately 30 minutes to interview a patient between the ages of 13 and 19. You then have an approximately 30 minute examination period in which you present the case and respond to examiner questions.
- Vignette Exam: In contradistinction to the current adult psychiatry vignette format, in the CAP Part 2 exam you have one video vignette and one written vignette only. If the video vignette is of a school-age child, then the written vignette will be of a preschool child and vice versa. This has the consequence that on the exam you will have an adolescent case, a school-age child case and a preschool child case. Also, note that the vignette exam period lasts 75 minutes, which is 15 minutes longer that the adult vignette format.
    - Video Vignette: The vignette exam begins with the video vignette presentation. You will be seated in a room with other candidates and be shown a video clip of approximately 10 minutes duration of either a preschool or school age child. You then will be called out and join your examiner in an individual exam room. You will present the case and respond to your examiner's questions based on that case. The challenge in the video vignette is to pay close attention both to any history that is presented as well as observe any physical and behavioral abnormalities.
    - Written Vignette: The written vignette is presented by the same examiner who examined you on the video case. At a point approximately halfway through the vignette exam, the examiner will present you with a written vignette and the focus will change to that written vignette. The written vignette is between half and a full single-spaced typed page. Occasionally, the case is long enough to end on a second page. In contradistinction to the adult exam, on the CAP Part 2 Exam, you read the vignette yourself – the examiner does not read it aloud to you. (Note that this has been the format up to 2007 and there is a possibility that this detail or another may be changed by the ABPN.) After you read the case, you respond to questions related to the case. Then, at some point in the examination period the examiner will ask you either one or two separate "consultation questions." These consultation questions often begin with a sentence similar to this, "The school nurse is concerned about the child's <name a problem> and calls you to consult on the case. What is the first thing you would do?"

Now let me shift and present to you actual candidates' experiences at this exam. Note that the cases below were submitted by various doctors and are thus not from a single exam. I begin with vignette cases and then shift to adolescent interview cases.

Recent Exam Video-Vignette Cases

Vignette Case 1: Video Vignette

"On the Video-Vignette Exam, I only had one examiner in the room with me the whole time. The senior examiner floated between two rooms. The head of the team came in once while the senior examiner was also in the room. The examiner that was in the room with me the whole time was the only one that asked me questions.

"The Video showed a 3.5 year old female. Her parents described the patient's development compared to that of her older sister. The patient was seen playing with toys on a table in the corner of the room. She was putting some of the toys in her mouth and rubbing them against her face. She placed play coins into a play cash register when the evaluator handed them to the her. I observed her to be scribbling with a marker held in her left hand. At other times she used her right hand. There was no real eye contact. She hid behind a curtain at one point. There was a brief period of jumping up & down. She did not speak any words. She squealed a little while jumping up and down. Even with her curly hair obscuring the outlines of her head, she looked to have a little head on a bigger body. Also, maybe the dress was older sister's which threw off my perception of her body size. (So we would need the head circumference measured to confirm). The patient's mother apparently mentioned that patient had hyperactivity, although I missed that comment."

<u>Examination Session of Video Case</u>

"During the examination session, I was asked about self-injurious behaviors (SIB). When I mentioned treatment with naltrexone, the examiner asked me the dose I would use. I did not know and said so. I was asked about testing. I mentioned tests I would use, but see my suggestion below - Autism vs. Retts - ABA mentioned - resources in community - medical covered - MR / seizures discussed."

Vignette Case 2: Written Vignette

"My vignette case was about a page long. The case was of a 10 year old boy who was adopted a few weeks after birth. He has a history of rocking and head banging from early on. Now he has been tested with a verbal IQ of 102 and a performance IQ of 116. The adoptive couple has two younger biological girls. In the case it was presented that the patient inappropriately grabs peers in the crotch area. He is rigid in his play. For instance, he places military figures in a line. He corrected the evaluator in the vignette on how to use military figures. The adoptive father has a family history of mood disorder and alcohol use disorders. The adoptive mother has some issue with identifying the patient as contributing to difficulties in her life. It was presented in the vignette that the patient hugged the mother when she arrived and "commented on her smell.

"Other information provided in the vignette includes that he was withdrawn and may have been experiencing sleep problems. Also, he said that others would be better off if he were 'not here.'"

Examination Session of Written Vignette Exam

"In my presentation I included the following diagnoses in my differential:

- ✓ Asperger's Disorder
- ✓ Anxiety disorders
  - o I considered the possibility of sexual abuse given his behavior of grabbing his peers in the crotch. I mentioned the possibility of him being or becoming a perpetrator versus engaging in horseplay. Given my consideration of sexual abuse, I included PTSD in my differential.
  - o I also considered OCD given his rigid play behavior.
- ✓ Depressive disorders"

"Regarding stressors I spoke about:

- ✓ The father being away in the military
- ✓ Adoption issues: It appeared from the vignette that the mother may have wanted to adopt while the father did not want to. Later, they end up having two of their own biological children).
- ✓ Possible sexual abuse issues as I've mentioned above."

"The consultative questions I was asked were these. "The school calls you, the consultant, about this patient's difficulties in school."

- ✓ "Who does the consultant serve?"
- ✓ "How would the consultant assist with this student's issues?"
- ✓ "Would it be through the teacher or through the parents?"
- ✓ "Would it involve mobilizing an appropriate peer group for at risk students?"
- ✓ "Would it include intervening directly with the patient?"
- ✓ "Would it involve an IEP?"
- ✓ "Would you involve Child Protective Services and under what circumstances?"

"This is the supplementary information I spoke about getting.

- ✓ That I would review any pertinent testing results (i.e., Wechsler, Vineland, Leiter, Peabody). I was asked, Why?
- ✓ My examiner then asked me which Wechsler exam I would order (for the video patient). I blanked and could only say that the one appropriate for her age (3.5 years). At this time both the senior examiner well as the team leader were in the room observing. Also, I sort of felt like a fraud just mentioning the tests by name and not really knowing the ins and outs of how the results look and how they could help me. I was afraid to mention the Vineland because I thought he would then ask me if you could use a Vineland in a 3.5 year old child. I didn't know the answer to that."

"My examiner was very kind. He seemed too senior to be a junior examiner though. We covered a lot of things. When I got to the point where I could not provide an answer, I just admitted so and said that I would use a reference to get the answer, such as, when I was asked about the naltrexone dose and which Wechsler to use in a 3.5 year old."

Vignette Case 3: Written Vignette

"A 4 year old girl Alicia is currently living with her birth father and her step mother, along with her 6-year-old brother and 7 and 10 year-old step brother and sister, respectively. Her father brings her into your clinic in July because she is violent; having multiple temper outbursts daily, to the point where her father reports that she threw a rock and broke the car window yesterday. She also has punched her step brother and has bitten her step sister. Her father is worried that if something isn't done soon, the family will be evicted. The preschool is closed for the summer. At its worst, the temper tantrums go on for a few hours, with yelling, crying, screaming and slamming doors.

"In gathering the history you find out that these behaviors have being going on for about the past 6 months. Alicia sleeps poorly and is up and down all night. Getting her to bed at night is particularly difficult. Amanda also reportedly has bad dreams at night. Amanda refuses to do what he or his wife tells her to do and this has caused a lot of strain in their relationship. Alicia is reported to be very irritable and angry. Part of the strain is that both father and step mother need to work to support the family.

"The parents have been married for 2 years, the children of both parents a product of prior relationships. About 3 years ago a male friend of the step mother's family was convicted of molesting the now 10 year step sister. This caused a great deal of added stress at the time. The perpetrator is currently serving time in jail and will not get out for another 5 years. Socially, Alicia does have some friends at daycare. Her father reports that she has been physically healthy and has no allergies.

"Alicia is brought into your office and appears fairly shy but fidgety. Surprisingly, when she is alone she shows none of the violent behaviors reported by her father. She seems curious about the doll house in the office. She makes good eye contact and helps clean up at the end of the interview. After the interview her father wants you to do something to help as quickly as possible."

Vignette Case 4: Written Vignette

"Before our video was played, they told us the name of the patient (Katie). It was a female name which was the only reason I knew the pt was a girl. The girl in the video looked very masculine (short hair, prepubescent, uni-sex clothing, dysmorphic features). I think it threw off some people because they assumed it was a boy. When talking with other examinees after the exam, at least 2 people in our group thought the patient was a boy.

My examiner announced that I would get two consultation questions at the end. They were written down and she read me the consultative scenario.

Consultative Question #1: "Mother asks you to write a note excusing child from school due to medical reasons b/c principal has initiated truancy charges. What would you do? (In the vignette, the child had separation anxiety and had missed many days of school)

Consultative Question #2: A pediatrician contacts you because the child has bruises and suspects abuse. What would you do?

Vignette Case 5: Video Vignette

My video was of a girl with looked like she had fetal alcohol syndrome with hyperactive symptoms. I just chose ADHD (even though I had already discussed the possibility of symptoms due to etoh exposure while talking about the differential), but I felt that my examiner wanted me to say both ADHD and FASD.

Vignette Case 6: Video Vignette

"My video was of a school-age girl, clearly mentally retarded, somewhat bizarre looking (wearing big eye glasses and a PJ bottom). There was some time on the clip in which the girl's foster mother spoke to the interviewer about her: "She recently came to my house. Her real mom used to hit her. I do not know how long she will stay with me, before she will go to another home. She has problems with sleep and does not go to sleep easily, but once she falls asleep, she sleeps through the night."

"Then the camera showed the patient with the doctor. The patient did not have any boundaries whatsoever. The poor doctor was elderly and got somewhat bothered I guess. She was touching him (not sexually) on his shoulders and on his back repeatedly. He asked her some questions and her answers were way below her age. Her speech was somewhat hard to understand and she had an articulation defect. Her motor activity was hyperactive and she was on the go the entire time. She did not have any eye contact with the examiner even when she was talking to him.

"The PDD, MR and possible PTSD diagnoses were at the top of the list. I am not sure whether I mentioned any ADHD??? Also, I considered possible Adjustment Disorder because of the recent change in her environment. I was questioned how to make the MR diagnosis, how to handle her sleep (I preferred not to jump on medicines, get more information and consider sleep hygiene), and what other things I would recommend for her treatment (e.g.,. stable environment, school issues, therapy including speech).

Recent Exam Adolescent Interview Cases

Adolescent Case 1

"My adolescent interview was at a Residential Treatment Facility and went very well. The patient was a 15 year old adolescent male whose chief complaint was that he had problems with anger management. His symptoms included running away from home, using alcohol and 'dip' (snuff), and cutting down trees when angry. He gave very information during the interview. He minimized his problems and gave a picture of a chaotic home situation. I put together the information I had obtained and was able to come up with a fairly decent formulation. The discussion also went well."

Jack's Comment

The instructive lesson here is that this candidate was not thrown off by the fact that the patient provided minimal information. I want you to remember that you are not responsible for the nature or degree of the patient's psychopathology. You are assessed by how well you handle the situation you have been given. This candidate kept her cool, organized the little she had and presented it well. She passed.

Adolescent Case 2

"My patient was a 16 year old Caucasian male who presented with a reported hospitalization lasting for 8 months. He was taking 3 different psychotropic medications at the time of the interview. They were Depakote, Seroquel, and Paxil.

History of Present Illness: He endorsed a depressed mood, a high anxiety level, positive auditory hallucinations with voices commanding him to kill himself, positive suicidal ideation with plans to overdose on medications. He had been physically assaultive to staff and other patients. He had a history of non-compliance with medication treatment and other therapeutic interventions.

Past History: He had been disruptive and inattentive in 1st grade. He had learning problems and a long history of being in special educational classes. He had a history of stealing and fighting which began in 3rd grade and using substances by 5th grade. He had received multiple therapies and medication treatments without improvement. He reportedly had been kidnapped, kept in captivity, and sexually assaulted about one year ago. He attempted to kill the abuser with a knife. He was arrested, sent to Juvenile Hall and then transferred to the hospital for psychiatric care.

Medical History: A minor head injury during a fight about 2 yrs ago.

Family History: Mother has depression; Father abuses alcohol.

Social History: in 10th grade his grades were all Fs. He has no best friends. He has acquaintances with substance abuse problems. He used marijuana, cocaine, and alcohol. He does not get along with his father, but likes his mother.

MSE: blunt affect, depressed mood; short term and recent memory deficits with trouble recalling dates of important life events; positive suicidal ideation with plans; positive auditory hallucinations.

<u>Examiner Questions</u>

1. What is your impression on the history of kidnapping and sexual assault? Is there a possibility of the event being a part of his delusions?
2. Please formulate a comprehensive treatment plan in a Bio-Psycho-Social format.
3. Why do you think about medication treatment first?
4. What are the psychosocial interventions to consider for this patient? What therapy will you use? Why? Do you think CBT is appropriate for the patient given his cognitive ability and current psychotic features?

5. How do you manage the patient's safety and the assaultive behavior on the unit? What are your instructions to staff? What exactly will you tell staff?
6. Are there any other treatments and interventions you are recommending?
7. What is his prognosis?

Adolescent Case 3

"My live patient was a 13 year old boy who appeared more like 8 year old both in appearance and behaviors. He was either an inpatient or in residential. He was very confused with timelines telling me he had been in the hospital for 5 years since was 12 years old.

"He was very small in size...and on Pedialyte. He told me he has had 100 foster families (which didn't seem possible). I did a full mini-mental exam. When I showed him a piece of paper saying "Close your eyes," he started rubbing his ears. I asked him what he read and he said "Clean your ears."

"He also had behavioral and aggression problems. I diagnosed him with Mood Disorder NOS, and put a psychotic disorder at the bottom of my differential. I thought I answered all questions as best as I could given the limited information I was able to obtain."

Candidates' Personal Exam Experiences

In this section I present the more personal side of the exam experience that candidates have shared with me.

Candidate 1

"Dear Dr. Krasuski, I must say that I felt 100% much more comfortable going [to take the exam] this time than last year. I believe that the most significant strengths that I developed at your course were the anticipation of autism and MR, but most important, the organizational scheme to present the information.

"It is quite remarkable how, despite being side-tracked by the examiner, when you have that scheme in your head, it's easy to go back to it and continue with the right sequence (impression, additional info, differential diagnosis, treatment - based on the presenting symptoms and syndromes - and prognosis).

Another helpful thing was that I could make the adjustments necessary to the presentation of the video and of the vignette. The previous year I had tried to do both presentations in the same way and it turned out to be a disaster. The "AMBLe CAT" mnemonic was VERY helpful for the video.

The video I had was loaded with information from one thing to the next, so it made it much easier to organize the information and to get the diagnostic criteria from it. I must also say that this year, as you may have heard, there was only one examiner in the room for the video-vignette exam, but unlike last year, my examiner was particularly kind and able to direct me when I missed something. Last year, both examiners were particularly brutal (or simply tired), which added to my frustration. This brings me to the last (but not

least) helpful thing about the course, which was the opportunity to practice. The videos and the vignettes were very close to the actual Board experience, so there was no added anxiety due to a surprise element, and made me feel a little bit more comfortable during the exam itself.

“Thanks again for the e-mails, and I highly recommend the course, at least for the video-vignette part of the exam - I didn't have a chance to meet with people who took also the adolescent interview part of the exam (Everyone was particularly nervous, running to and from the shuttle buses), but I'm sure you'll get positive feedback from them as well. If I flunk...well, then I guess I felt too comfortable. I'll let you know.

Sincerely, Anonymous

(Name withheld by editor to maintain the writer’s confidentiality. Editor’s Note: Candidate did pass her exam.)

Candidate 2

“Good day Dr Krasuski, the video went well I thought. I had a middle school female with a mood disorder - Bipolar most likely. The quality of the video was poor. I sat in the front and still missed some of what was said. The examiner was fair and reasonable. The vignette was about a hyperactive 3 year old who responded poorly to a stimulant. I think that the exam generally went well. There was a floater who asked a lot of questions. By the end my brain was mush. I could not remember the term "Child Study Team" until I was walking to the bus, literally, a few minutes later!!

“The oral exam was just ok. I had a teenager at a Residential Drug Rehab facility. He was forthcoming yet superficial about his symptoms and tended to downplay his symptoms. I felt that I did not get meat - just the skeleton of his condition. I took "broad strokes" but I pointed out that collateral information was crucial. I did not feel very confident about the oral. I know that I could have done better- even in an exam situation. So....I am just hoping for a positive outcome. It would be an excuse for me to blame it on my cold and not sleeping well the night before the oral. As usual - after the fact I thought about all the other things I should have said during the actual interview and presentation. I forgot to mention about the patient’s Developmental History - even though I reminded myself over and over that Dr. Martinez stressed that we have to mention it.

“When I asked about trauma the patient spoke about physical trauma. I had to press him for emotional trauma - again he downplayed it. A nicer approach would have been to point out exactly that "You have mentioned the physical trauma. What about the emotional trauma that you have experienced in your life."

“Hind sight is 20/20! Bye for now, Anonymous”

(Name withheld by the editor to maintain the writer’s anonymity. Editor’s Note: The candidate passed her exam.)

Faculty Member's Feedback about Participants' Performances

Dr. Shiraz Butt, one of our faculty members, sent me this feedback about course participants' performances. I include his comments here.

Problematic Performance Patterns on Child Mock Exams: Tips from Dr. Shiraz Butt

Jack, over the three days I noted some consistent patterns among the course participants:

1. During the video presentations, most of the candidates were showing good observational skills. However, some candidates were too focused on presenting the MSE in a robotic, packaged form. Many failed to pick up on the interaction between the child and the caregiver. They did not comment on the nature of the dyadic relationship, especially the mother's response to the child, including the parenting skills, warmth, and ability of the mother to respond to the child's behavior. This is very relevant to the formulation and has both diagnostic and treatment implications.

2. A number of candidates were focused too early on the PDD spectrum and hence narrowed their differential diagnosis, potentially missing other diagnostic entities.

3. Note that whenever you have a 4-6 yr old child with communication and social problems, you have to raise the possibility of abuse and neglect and comment on the possibility of attachment disorders. Most candidates didn't bring up that possibility.

4. During the vignette presentation, some candidates were just repeating the information provided in the vignette. This is not a test of memory. Candidates should be able to pick up on the major issues requiring clinical assessment or intervention, and then present them in the form of a synthesis of available and missing information. Such a focus should then lead towards a broad range of diagnostic possibilities.

5. Most candidates were did not pick up on the "KEY" issues in the vignette, that is, what is the most immediate concern here? And is there anything I need to do NOW? For instance, does this case suggest that I call DCFS or that I admit the patient or order a physical exam to rule out sex or physical abuse?. Candidates should always think, What is the MOST URGENT issue here.

6. During the adolescent interview exam, candidates were relying too much on the youth's self report. When do we ever see these kids alone? NEVER! They are always brought in by parents. So when the candidate presents the case to the examiners they should mention the need for collateral information right away. Also, they should make it clear that the patient's self-report is only one part of the information-gathering.

Your Turn

That's it for now. Let me know your thoughts and after your exam I would appreciate it if you send me your contributions too. I will incorporate them into this report for the benefit of future candidates.

If you are interested in joining us for the CAP Part 2 Beat The Boards! Course, then please read more about it the www.BeatTheBoards.com website and call us with any remaining questions at 877-225-8384. There is a certain time urgency since most of our courses sell out weeks ahead of time.

I can give you my personal assurance that the CAP Part 2 Beat The Boards! Course is a very solidly developed course that will sky-rocket your confidence and skill. Please note that the course comes with an "All The Way To Pass" Guarantee, which means that you may return to the course until you pass. I hope you don't need such a guarantee, but it is my way of telling you that once you're in, we work with you until you succeed. You're not investing simply in a course but in exam success. That's what you get from us.

Thank you for reading this Special Report. I hope you found it of benefit. And, if you choose to join us, I can't wait to meet and work with you. In either case, I wish you the very best on your exam.

Take care,

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