Completion assessment

A diagnosis in the record doesn't match what's in the room now

Supervisee training · Orchard Human Services, Inc.

Supervisee	Date completed

How this works

Twelve scenario-based items covering all six stages. Answer every item before turning to the answer key, then read every rationale — including for the items you answered correctly. The rationales carry as much of the teaching as the questions do, and several explain why a plausible-sounding option is wrong.

This is not a timed or proctored test. Ten or more correct indicates the material has landed. Fewer than ten means revisiting the relevant stages before moving on — record which ones below and discuss them in individual supervision.

Item coverage

Items	Stage	Focus
1–3	Stage 1	Syndrome and cause; the exclusion criterion; both error directions
4–8	Stage 2	Sleep direction, delirium, bacteriuria, withdrawal, antidepressant-emergent mania
9	Stage 3	Mechanisms of persistence
10	Stage 4	Scope
11	Stage 5	Testing rather than confirming a formulation
12	Stage 6	Consultation outcomes

> Log your time per your supervision agreement. Module reading and worksheets are recorded as indirect hours; group facilitation is recorded separately.

Assessment items

Circle or mark one answer per item.

1. A discharge summary reads: "Patient presented with pressured speech, minimal sleep and grandiosity. Bipolar I disorder, manic episode." Which statement best describes what this documentation has established?

A. It has established a manic syndrome and its cause.

B. It has established a manic syndrome; the cause is asserted rather than established.

C. It has established neither, because a single episode cannot support any conclusion.

D. It has established the cause, since those three features are specific to bipolar disorder.

2. DSM-5-TR states that a manic episode must not be attributable to the physiological effects of a substance or another medical condition. What is the status of this statement?

A. A recommendation to consider alternatives where time permits.

B. A criterion that must be satisfied for the diagnosis to be met.

C. A note applying only to older adults and medically complex patients.

D. A guideline that applies to research settings rather than clinical practice.

3. A supervisee completes this module and concludes that bipolar diagnoses encountered in the record should generally be treated as unreliable. What is wrong with this conclusion?

A. Nothing — it is the intended takeaway.

B. It is too cautious; the module argues these diagnoses are usually accurate.

C. It guards against one error while making the opposite error more likely, and the opposite error carries its own serious harms.

D. It is correct clinically but outside the supervisee's scope to act on.

4. A client reports having slept roughly two hours a night for five nights. Which additional piece of information most changes the differential?

A. Whether the client found the sleeplessness distressing or felt energised by it.

B. The exact number of hours slept each night.

C. Whether the client has a family history of insomnia.

D. Whether the client has tried sleep hygiene strategies.

5. Which cluster of features should most strongly raise suspicion for delirium rather than a primary mood episode?

A. Grandiosity, increased goal-directed activity, and elevated mood sustained for a week.

B. Irritability, rapid speech, and a history of childhood trauma.

C. Onset over 48 hours, cognition that clears in the morning and worsens by evening, and visual hallucinations.

D. Impulsive spending, reduced sleep, and recent relationship conflict.

6. An older adult is admitted with confusion. A urine culture is positive. There is no documented fever, no urinary symptoms, and no other systemic signs. What is the appropriate conclusion?

A. The urinary tract infection explains the confusion.

B. The urinary tract infection can be excluded as a factor.

C. A positive culture without urinary or systemic symptoms may represent asymptomatic bacteriuria, which is common in older adults and does not by itself explain confusion; other precipitants still require assessment.

D. Confusion in an older adult is presumptively dementia until imaging is obtained.

7. Which circumstance most often causes a withdrawal-related presentation to be missed?

A. The client conceals substance use.

B. The medication list records what was prescribed rather than what was actually taken.

C. Withdrawal states are clinically indistinguishable from mania.

D. Withdrawal only occurs with illicit substances, so it is not considered.

8. A client developed a full manic syndrome six weeks after starting an antidepressant. The antidepressant was stopped, and the syndrome continued at full severity for a further three weeks. What does the persistence indicate?

A. Nothing — any activation during antidepressant treatment is medication-induced by definition.

B. That the client is treatment-resistant.

C. That a syndrome persisting at fully syndromal level beyond the physiological effect of the treatment is sufficient evidence for a manic episode.

D. That the antidepressant was ineffective and should be restarted.

9. A primary care note reads: "PMH significant for bipolar I disorder. Reports fatigue and 24 lb weight gain. Likely related to psychiatric illness and medication. Continue current management." Which mechanism is most clearly at work?

A. Anchoring only.

B. Diagnostic overshadowing — physical complaints are attributed to the psychiatric diagnosis without independent evaluation.

C. Copy-forward only.

D. Circular documentation only.

10. Your longitudinal picture of a client diverges substantially from the bipolar diagnosis in their record. Which action is within your scope?

A. Tell the client the diagnosis appears unsupported so they can make informed decisions.

B. Document your current formulation, and bring the divergence to supervision.

C. Record a corrected diagnosis in your notes alongside the historical one.

D. Advise the client to discuss stopping the medication with their prescriber.

11. Your formulation attributes a client's activation to trauma-related hyperarousal. Over eight weeks of trauma-focused work, the client improves substantially. What does this establish?

A. That the formulation was correct.

B. That the prior bipolar diagnosis was wrong.

C. That the improvement is consistent with the formulation, which several other explanations would also predict.

D. Nothing — clinical improvement carries no diagnostic information.

12. You send a well-constructed consultation summary. The prescriber replies that the diagnosis stands, citing prior records and a medication trial history you did not have. What is the appropriate response?

A. Treat the consultation as unsuccessful and document the disagreement.

B. Treat it as a successful consultation, revise your formulation on the new information, and continue treating what presents.

C. Request a second opinion from another prescriber.

D. Explain to the client that you disagree with the prescriber.

Answer key and rationales

Read every rationale, including for items you answered correctly.

1. Correct answer: B · Stage 1

The observable features are documented, which establishes the syndrome. Nothing in the summary addresses why the syndrome occurred — no medication timeline, no medical evaluation, no sleep directionality, no collateral. The diagnosis is therefore an assertion sitting on top of an accurate description.

Why the others are wrong:

A — the summary contains no information bearing on cause.

C — a single episode can support a manic episode diagnosis, and a first severe episode may legitimately establish bipolar I. The problem is the missing workup, not the episode count.

D — none of those three features is specific to bipolar disorder; each occurs in delirium, withdrawal, sleep deprivation and stimulant intoxication.

2. Correct answer: B · Stage 1

It is a criterion. If the episode is attributable to a substance or medical condition, the diagnosis is not met, and DSM-5-TR provides separate categories for those presentations: substance/medication-induced bipolar and related disorder, and bipolar and related disorder due to another medical condition.

Why the others are wrong:

A — treating a criterion as optional under time pressure is the mechanism this module exists to address.

C — it applies to every patient.

D — it is a diagnostic criterion in clinical use.

3. Correct answer: C · Stage 1

Bipolar disorder is also frequently missed, commonly misread as unipolar depression, sometimes for years. That error delays appropriate treatment, can lead to antidepressant monotherapy that destabilises the person, and leaves untreated a condition carrying one of the highest suicide rates in psychiatry. A clinician who has decided in advance which error to guard against will reliably commit the other.

Why the others are wrong:

A — the module states explicitly that this is the wrong takeaway.

B — the module makes no claim about which way the base rate runs.

D — the problem is that the reasoning is unsound, not merely that acting on it exceeds scope.

4. Correct answer: A · Stage 2

This establishes the direction of the sleep arrow. Decreased need for sleep — sleeping little and feeling energised, capable, not distressed — points toward mania. Wanting sleep and being unable to obtain it points toward insomnia from some other cause, with the deterioration that follows several nights of sleep loss. The two look alike from outside by night four.

Why the others are wrong:

B — the quantity is already known and does not separate the possibilities.

C — relevant to a sleep history but does not resolve the direction.

D — a treatment question, not a differential one.

5. Correct answer: C · Stage 2

Acute onset, fluctuating attention and awareness, and visual hallucinations are cardinal delirium features. Fluctuation across a single day is particularly informative, because a manic episode is sustained most of the day nearly every day rather than clearing and returning.

Why the others are wrong:

A — this is the pattern of a manic episode.

B and D — consistent with several explanations, and neither cluster contains the attention and fluctuation features that distinguish delirium.

6. Correct answer: C · Stage 2

Symptomatic urinary infection can precipitate delirium in a vulnerable person. Bacteria in the urine without urinary or systemic evidence of infection is a common incidental finding in older adults. The questions that matter are whether infection symptoms were present, whether delirium criteria were met, whether other precipitants were assessed, and whether the neuropsychiatric picture resolved as the medical condition resolved.

Why the others are wrong:

A — declaring the cause on a positive culture alone is the specific error the stage warns against.

B — overcorrection; it cannot be excluded either, only left unestablished.

D — presumes a different conclusion on equally thin grounds.

7. Correct answer: B · Stage 2

A prescription that was never filled, was interrupted by vomiting or hospitalization, ran out during a pharmacy problem, or was missed through caregiver error will still appear on the medication list as current. Reconstructing what was actually taken, and when it stopped, is a different task from reading the list.

Why the others are wrong:

A — it happens, but it is not the most common route to a missed withdrawal picture.

C — they overlap but are distinguishable through chronology and physical signs.

D — false; withdrawal from prescribed benzodiazepines, antidepressants, anticonvulsants and opioids is well recognised.

8. Correct answer: C · Stage 2

DSM-5-TR addresses this directly: a full manic episode emerging during antidepressant treatment but persisting at fully syndromal level beyond that treatment's physiological effect is sufficient evidence for a manic episode. Activation during treatment does not settle the question on its own; what happens after the drug's effect should have ended does much of the work.

Why the others are wrong:

A — this is the error in one direction, and it is why some genuine bipolar presentations are dismissed.

B and D — neither addresses the diagnostic question.

9. Correct answer: B · Stage 3

Fatigue and substantial weight gain are attributed to psychiatric illness and closed out, without thyroid studies, metabolic screening or any independent workup. That is diagnostic overshadowing. Copy-forward and anchoring are also present in the surrounding record, but the specific act in this note is attributing a physical complaint to the psychiatric label.

Why the others are wrong:

A, C, D — each names a real mechanism operating elsewhere in the chart, but none describes what this note does with the physical symptoms.

10. Correct answer: B · Stage 4

Independent history, formulation, treatment planning and longitudinal documentation are yours. The diagnostic conclusion is made in supervision. Bringing a well-documented divergence is the highest-value contribution you make in these cases, because you hold information the original assessment never had.

Why the others are wrong:

A — conveying diagnostic doubt to a client can reach medication decisions without you ever advising one. Abrupt discontinuation of a mood stabiliser carries real recurrence and suicide risk.

C — recording a diagnosis is a diagnostic act.

D — raising medication cessation with the client, however indirectly framed, is outside scope.

11. Correct answer: C · Stage 5

Improvement is consistent with the formulation but does not confirm it, because competing explanations predict it too: the precipitant resolved on its own, concurrent medication is working, regression to the mean after a crisis peak, natural remission between episodes, or alliance and expectancy effects. A test that every formulation passes is not a test. Confidence comes from predictions that could have failed and did not.

Why the others are wrong:

A — adopting this rule confirms wrong formulations as enthusiastically as right ones.

B — improvement under one treatment says nothing definite about a different diagnosis.

D — overcorrection; course over time is real evidence, it is simply not confirmatory on its own.

12. Correct answer: B · Stage 6

The prescriber holds information you do not — prior records, response patterns, and what the client discloses to them and not to you. Receiving information that revises your formulation is the process working. The consultation succeeded: it moved information in both directions.

Why the others are wrong:

A — the purpose was to exchange information, and it did.

C — shopping for a preferred answer, and outside your role.

D — places the client between two clinicians and risks the medication consequences named in Stage 6.

Score and follow-up

Items correct	Items missed (numbers)	Stages to revisit

Reflection

Which rationale changed your thinking most, and what will you do differently as a result?

Which item did you answer correctly but for the wrong reason?

Supervisor sign-off

Supervisor	Date	Hours logged

> This assessment measures comprehension of the training material. It does not confer diagnostic authority, and completing it does not change the scope boundaries described in Stage 4.
>
> DSM-5-TR references in this assessment are summarised for training purposes. Verify all criteria against the DSM-5-TR text.