Committee for Examinations
Objective Structured Clinical Examination

Station 6
Brisbane September 2016

The Royal Australian & New Zealand College of Psychiatrists

1.0 Descriptive summary of station:

In this station the candidate is expected to elicit the normal versus abnormal mood states of bipolar disorder from Jane, a 34-year-old female who has had a history of severe manic episodes. Her husband is convinced she is relapsing and there is high expressed emotion at home. The assessment is undertaken in an outpatient clinic.

1.1 The main assessment aims are:

- To evaluate the ability to distinguish normal range of mood versus abnormal mood states in bipolar disorder.
- To assess the ability to explore the presence of a high expressed emotion environment.
- To assess the capacity to manage an individual's concern regarding possible relapse.

1.2 The candidate MUST demonstrate the following to achieve the required standard:

- Assess for both elevation and depressive symptoms of bipolar disorder.
- Consider that Jane is unlikely to be presenting with a bipolar relapse.
- Explain features of high expressed emotion (EE) to the patient without using jargon.
- Convey the importance of obtaining collateral information from the husband to confirm the findings.

1.3 Station covers the:

- **RANZCP OSCE Curriculum Blueprint Primary Descriptor Category:** Mood disorders
- **Area of Practice:** Adult Psychiatry
- **CanMEDS domains:** Medical Expert, Communicator
- **RANZCP 2012 Fellowship Program Learning Outcomes:** Medical Expert (Assessment - Data Gathering Content; Management – Initial Plan), Communicator (Synthesis)

References:

- David J. Miklowitz, Michael J. Goldstein**,** Keith H. Nuechterlein**,** Karen S. Snyder, Jim Mintz; Family Factors and the Course of Bipolar Affective Disorder, *Arch Gen Psychiatry.* 1988;45(3):225-231.
- Gin S Malhi, Darryl Bassett, Philip Boyce,Richard Bryant, Paul B Fitzgerald, Kristina Fritz, Malcolm Hopwood, Bill Lyndon, Roger Mulder,Greg Murray, Richard Porter and Ajeet B Singh; Royal Australian and New Zealand College of Psychiatrists clinical practice guidelines for mood disorders, *Australian and New Zealand Journal of Psychiatry* 2015, Vol. 49(12) 1087–1206
- Ronald L. Butzlaff, Jill M. Hooley, Expressed Emotion and Psychiatric Relapse A Meta-analysis *Arch Gen Psychiatry.* 1998;55(6):547-552.Hooley, JM. Expressed Emotion and Relapse of Psychopathology. Annual Review of Clinical Psychology. Vol. 3: 329-352 (Volume publication date April 2007) DOI: 10.1146/annurev.clinpsy.2.022305.095236

1.4 Station requirements:

- Standard consulting room; no physical examination facilities required.
- Four chairs (examiner x 1, roleplayer x 1, candidate x 1, observer x 1).
- Laminated copy of 'Instructions to Candidate'.
- Role player – woman in her early to mid-30s, casually but neatly dressed.
- Pen for candidate.
- Timer and batteries for examiner.

2.0 Instructions to Candidate

You have **eight (8) minutes** to complete this station after **two (2) minutes** of reading time.

You are working as a junior consultant psychiatrist in an outpatient service. You are about to see Jane, a 34-year-old mother of two who has bipolar disorder. She has a history dating back to her late teens, with the last two severe manic episodes occurring post-partum in the last 6 years.

Her husband Paul made the appointment for her because he believes she is relapsing and your administrative officer noted he said 'she needs sorting'.

Your tasks are to:

- Take a history from Jane to elicit her current symptom status.
- Discuss your findings with Jane.
- Outline a plan to address her husband's concerns to Jane.

You will not receive any time prompt.

Station 6 - Operation Summary

Prior to examination:

- Check the arrangement of the room, including seating and other specifics to your scenario.
- On the desk, in clear view of the candidate, place:
  - A copy of 'Instructions to Candidate' and any other candidate material specific to the station e.g. investigation results.
  - Pens.
  - Water and tissues are available for candidate use.
- Do a final rehearsal with your simulated patient.

During examination:

- Please ensure mark sheets and other station information, are out of candidate's view.
- At the **first bell**, take your places.
- At the **second bell**, start your timer, check candidate ID number on entry.
- TAKE NOTE – there are no cues or time prompts for you to give.
- DO NOT redirect or prompt the candidate – the simulated patient has prompts to use to keep to the aims.
- If the candidate asks you for information or clarification say:

  'Your information is in front of you – you are to do the best you can.'
- At **eight (8) minutes**, as indicated by the timer, the final bell will ring. Finish the examination immediately

At conclusion of examination:

- Retrieve all station material from the candidate.
- Complete marking and place your mark sheet in an envelope by/under the door for collection (**do not seal envelope**).
- Ensure room is set up again for next candidate. (See 'Prior to examination' above.)

If a candidate elects to finish early after the <u>final task</u>:

- You are to state the following:

  'Are you satisfied you have completed the tasks?

  If so, you must remain in the room and NOT proceed to the next station until the bell rings.'
- If the candidate asks if you think they should finish or have done enough etc. refer them back to their instructions and ask them to decide whether they believe they have completed the task(s).

3.0 Instructions to Examiner

3.1 In this station, your role is to:

Observe the activity undertaken in the station and judge it according to the station assessment aims and defined tasks as outlined in 1.1 and 1.2.

You have no opening statement or prompts.

When the candidate enters the room briefly check ID number.

The roleplayer opens with:

'Hello Doctor. Paul thinks I am getting unwell again.'

3.2 Background information for examiners

The aim of this station is for the candidate to elicit the difference between normal variations in emotion versus abnormal mood states in a woman with bipolar disorder. The candidates are expected to identify that Jane's husband is convinced she is relapsing but that there is high expressed emotion at home which impacts on their relationship. The candidates are expected to come to the conclusion that Jane is not experiencing a relapse but is repsonding to stressors within the home.

In order to 'Achieve' this station the candidate **must**:

- assess for both elevation and depressive symptoms of bipolar disorder.
- consider that Jane is unlikely to be presenting with a bipolar relapse.
- explain features of high expressed emotion (EE) to a patient without using jargon.
- convey the importance of obtaining collateral information from the husband to confirm the findings.

A surpassing candidate may:

- investigate in what way the high EE has developed and how these background factors can be addressed
- consider the psychodynamic features of high EE in Jane's parents and what psychotherapeutic options may address this
- clearly address barriers to the application of the plan such as difficulty engaging husband and how to focus on this or whether to involve other family members.

Expressed Emotion (EE) has been described since the 1970s as a qualitative measure of the 'amount' of emotion displayed, mainly in the family setting, and usually by a family member or carer. EE measures hostility, warmth, and positive remarks and was developed as a measure for the assessment of expressed emotion in relatives of adult patients with mental disorders like schizophrenia, bipolar disorder, depression, and eating disorders. It has been found to be a useful tool to predict relapse in these patients (Vaughn and Leff, 1976; Eisenberg, Thompson, Fabes, Shepard, Cumberland, Losoya et al., 2001; Hooley and Parker, 2006). Research supports that families that express emotion in an inadequate and excessive way toward the patient produce increased levels of stress that in turn do not favour readjustment and the recovery.

Critical comments, hostility and emotional over-involvement were found to be the most predictive areas on the semi-structured Camberwell Family Interview (CFI; Leff and Vaughn, 1985). 'Criticism' was defined as unfavourable comments about a family member; 'hostility' was defined as generalisation of criticism or hostility; and 'emotional over-involvement' consists of over-protective behaviour, devoted behaviour and exaggerated emotional response. Following the CFI, came the Five-Minute Speech Sample (FMSS; Magana, Goldstein, Karno, and Miklowitz, 1986). The FMSS is a brief method that is designed to assess the respondent's expressed emotional (EE) status toward a family member and is derived from statements made by a patient's relative during a 5-minute monologue. Low EE is demonstrated by a low level of expressed emotion, characterised by a well-modulated and balanced level of communicated emotion as opposed to High EE which is more often characterised by an excessive presence or intensity of the emotions, often beyond the control of the family member who has difficulty modulating their responses. Within each major sub-scale there can be high or low ratings; for instance, High Criticism can be scored when a) the first statement is negative, b) the family member/carer describes a negative relationship with the patient, or c) they criticise the patient.

The concept is used as a measure of the family environment that predicts poorer clinical outcomes for patients with a range of disorders. There is evidence that links high EE to clinical relapse in patients.

Evidence suggests that EE may play a causal role in the relapse process, and the possibility that high levels of EE may stress patients by disturbing activity in neural circuits that underlie psychopathology.

Management

Apart from general interventions like undertaking a more thorough history and mental state examination, and obtaining collateral there are specific interventions that can be considered:

Lithium is effective for the treatment of mania and for the longer term maintenance of bipolar disorder. Lithium levels are important in the longer term maintenance of bipolar disorder and with optimum levels for this being 0.6 – 0.75mmol/L (Severus et al 2008, Malhi et al 2015). It prevents the recurrence of mania and is associated with an increased risk of relapse if stopped suddenly (Young and Newham, 2006), hence the need for adherence to a medication regime.

There is a known relationship between the sleep-wake cycle and bipolar disorder (Levenson, Nusslock, Frank, 2013). Sleep disturbance can be one of the first 'symptoms' to occur in manic relapse and predicts the onset of mood symptoms (Bauer, 2008). Increasing wakefulness and decreased need for sleep are the key characteristics of such sleep disturbance during these episodes of elevation but should be distinguished from other causes of, and reasons for insomnia. However prolonged periods of sleep disruption from other causes such as social disruptions after life events (Frank, 2005), or transmeridien travel (Inder, Crowe, Porter, 2015) can themselves lead to mood dysregulation. Attention to regulating sleep is therefore an important component of the management of bipolar disorder (Frank, 2005).

Involvement of the partner is critical to resolving whether the patient has relapsed, and to address the problems within the relationship and any specific intervention that the partner may benefit from. Getting collateral without undermining the patient is an important part of the intervention plan.

3.3 The Standard Required

In order to:

Surpass the Standard – the candidate demonstrates competence above the level of a junior consultant psychiatrist in several of the domains described below.

Achieve the Standard – the candidate demonstrates competence expected of a junior consultant psychiatrist. That is the candidate is able to demonstrate, *taking their performance in the examination overall*, that

i. they have competence as a ***medical expert*** who can apply psychiatric knowledge including medico-legal expertise, clinical skills and professional attitudes in the care of patients (such attitudes may include an ability to tolerate uncertainty, balance, open-mindedness, curiosity, 'common sense' and a scientific approach)

ii. they can act as a ***communicator*** who effectively facilitates the doctor patient relationship

iii. they can ***collaborate*** effectively within a healthcare team to optimise patient care

iv. they can act as ***managers*** in healthcare organisations who contribute to the effectiveness of the healthcare system, organise sustainable practices and make decisions about allocating resources

v. they can act as ***health advocates*** to advance the health and wellbeing of individual patients, communities and populations

vi. they can act as ***scholars*** who demonstrate a life-long commitment to learning as well as the creation, dissemination, application and translation of medical knowledge

vii. they can act as ***professionals*** who are committed to ethical practice and high personal standards of behaviour.

Below the Standard – the candidate demonstrates significant defects in several of the domains listed above.

Standard Not Achieved – the candidate demonstrates significant defects in most of the domains listed above or the candidate demonstrates significant defects in the first domain of being a medical expert.

4.0 Instructions to the Role Player

4.1 This is the information you need to memorise for your role:

You are Jane, aged 34 years. You live with your husband, Paul, and your two children, Robbie (6) and Angus (18 months). You have not worked since you had Robbie and you were a bank teller for 8 years before this, a job which you thoroughly enjoyed.

You have known Paul for 10 years and have been married for 7 years. He is a persuasive, rather charismatic and confident person. He is usually a nice man but he has become more '*difficult and hostile''* over the past 4 or 5 years since you had children, and there is more conflict in the relationship. The impact of the manic episodes you had in the past took him by surprise even though you had been honest with him about your bipolar disorder when you decided to marry.

He has always told you he was traumatised and embarrassed by your manic episodes, and does not want you to relapse. He is concerned about any signs of possible relapse and constantly watches you in a controlling and critical fashion. He is very quick to be critical and comment negatively on things you do around the house if they are not up to 'standard' and makes you feel that you are ineffective. He appears to be becoming overinvolved with your daily activities and checks your phone, Facebook page, internet use and banking, and wants justification for your spending. You are not happy in the relationship but you still love him and '*forgive him'* as '*he must be stressed being a busy IT consultant and the only wage earner'*.

Lately you have been thinking about your role as a mother and a woman, and would like to return to work so you have been looking at banking related jobs on the internet. Your husband has twice come home late in the last week and criticised you for what he describes as '*internet overuse and unrealistic plans about work because the children are still young*'. When you repeatedly try to engage him in animated discussions about how you feel about going to work, you only get so far and then he tells you he thinks your mood is overly high, so you back down and tend to withdraw for a bit to let things settle.

Despite the increasing tension at home you have good support from close friends who have told you they think Paul is a critical controlling man, and that he is not helpful for you. They think your plans to work part-time are perfectly reasonable and have had no concerns about you. You also have a very good relationship with your boys and they are developing normally; Robbie is at school and Angus has just started attending a toddler playgroup two mornings per week. They are sociable and happy though lately Robbie has become '*a bit feisty and stubborn*', and last week your husband came home to you raising your voice at him. You then had an argument with your husband as he criticised you for this, and were upset enough that you could not get to sleep that night so got up out of bed (as per your sleep hygiene rules) and played a game of cards.

Without even trying to discuss it with you, this week Paul phoned your parents to tell them he thinks you may be relapsing, which caused further conflict with him. This action has just again reminded you of your upbringing with a critical controlling father, and a very un-nurturing angry mother who probably had her own '*issues'*. Your parents live 50km away in the country and told him to '*sort you out'*.

You have come to the appointment reluctantly '*to keep the peace'* even though you (and your friends) do not believe you are relapsing. You have been in conflict with your husband but you feel it is him who has been the difficult one.

Since your last manic episode about 18 months ago you have been stable on your medication, which is 1000 milligrams of lithium (500 mg twice a day) to stabilise your mood. You don't have any concerns about taking lithium and know that this medication needs regular blood tests to check the levels of medication. The levels were last measured at '0.6' about 10 days ago. This level is very similar to others taken over the years when you are well.

<u>Past Psychiatric History:</u>

You have had two clear depressive episodes in your late teens/early twenties, the first in the context of conflict with your parents and the second in the context of conflict with your then boyfriend. You did not require inpatient treatment for either. You then had one manic episode overseas while travelling and were admitted to a mental health unit in the UK for about a week. More recently, after the birth of both your sons you had severe manic episodes requiring involuntary admission and treatment for three months each. After your last episode you were discharged from hospital to the outpatient services, and have been under their care for the past year and are in a discharge planning phase to the GP.

When you were depressed, you were sad and teary on most days for a few weeks, slept poorly, did not want to do anything and stayed in bed a lot. You were never suicidal, and did not try to hurt yourself or anyone else.

During the last manic episode your mood was high and you felt you were invincible, making plans to open several online businesses and spending lots of money on clothes for your children and yourself. You also posted multiple rambling messages on Facebook which your husband was embarrassed about. You did not sleep and lost weight, and you had more conflict with your husband when he intervened, which led to you telling him you were leaving him. You were admitted because you were not feeding your baby enough as you were so distracted and busy, and he lost weight. You were not sexually disinhibited and did not show dangerous behaviours like driving fast or recklessly.

Your doctor has also prescribed an 'as required' medication called lorazepam (which is like Valium and is to help calm you down when you are upset). But have only needed to take this twice earlier this year when you still hadn't fallen asleep by 11.30pm. You accept that you have bipolar disorder and always try to take your medication, and have learned to pay particular attention to your sleep-wake cycle. You have had antidepressants in the past (citalopram and Prozac) and an antipsychotic that made you put on weight after you were admitted with mania in the UK - you cannot recall the name.

You keep regular appointments with the mental health team and have really benefited from the support the mental health clinicians have provided you. Unfortunately, your husband Paul has not been in too many appointments and the community team has not provided any input to him; he therefore does not fully understand bipolar disorder or how it presents for you.

You have never had psychotic symptoms like hearing voices or seeing things that others do not, believing that people were out to harm you or believing that the TV and radio refer to you.

You do not drink alcohol or use drugs – you have never done so. You are a non-smoker.

You have never had any problems or charges by the police.

4.2 How to play the role:

You present within a normal range of mood. You have no mood symptoms at the moment, though you are upset and worried about your relationship and this is the primary focus of the station. In light of this you are happy to consider couple counselling if offered.

You have not been elevated in mood and have not had significantly increased anxiety levels. Your ability to concentrate, your energy levels and libido are all normal. You had that one night last week when you could not sleep after an argument with Paul, and it was too late to take your lorazepam so you got up and played patience (cards) and had a hot milk.

You have no unusual ideas or grand plans and haven't been overspending. You have been on the internet a lot recently looking for jobs (but at times when the boys are in bed or at school) and are excited about the possibility of obtaining a part-time position in a bank as you feel this would give you some better sense of identity and a source of social contact.

4.3 Opening statement:

'Hello Doctor, Paul thinks I am getting unwell again.'

4.4 What to expect from the candidate:

The candidate may ask how the last 2-4 weeks have been going, and will ask about your past history and about the home environment. They should also ask why Paul is concerned about you.

The candidate may suggest obtaining information from Paul or your parents or friends about how you have been and you are ok with this. The candidate may also suggest Paul comes in for an appointment, you are happy with this.

The candidate may suggest that Paul could be depressed or anxious – you hadn't thought of this but accept suggestions the candidate may make.

4.5 Responses you MUST make:

'Why is Paul so critical of me?'

'Do you think I might get unwell?'

4.6 Responses you MIGHT make:

'I am happy to accept any suggestions you make.'

'I am worried about my relationship.'

4.7 Medications:

Lithium 1000 milligram (you take two 250 milligram tablets twice a day) – you haven't missed any doses and do not get any side effects.

Lorazepam (half a tablet) as required to help with sleep/anxiety – you have taken it twice in the past year – not sure how many milligrams it is.

STATION 6 – MARKING DOMAINS

The Main Assessment Aims are:

- To evaluate the ability to distinguish normal range of mood versus abnormal mood states in bipolar disorder.
- To assess the ability to explore the presence of a high expressed emotion (EE) environment.
- To assess the capacity to manage an individual's concern regarding possible relapse.

Level of Observed Competence:

1.0 MEDICAL EXPERT

1.2 Did the candidate take appropriately detailed and focussed history? (Proportionate value – 35%)

Surpasses the Standard (scores 5) if:
clearly achieves the overall standard with a superior performance in a range of areas; elicits the intergenerational component of high expressed emotion; elicits why the husband may be overly concerned about relapse; explores her understanding of Paul's experience and his knowledge of her disorder.

Achieves the Standard by:
demonstrating use of a tailored biopsychosocial approach; conducting a targeted assessment for any current symptoms of bipolar; obtaining a history of how is Jane functioning and whether this is validated by others; eliciting evidence in keeping with high levels of EE in the home; history taking is hypothesis-driven considering what are the concerns of the husband/what factors are influencing this; integrating key sociocultural issues in particular the high EE at home; eliciting the key issues of a normal relationship with children, and realistic ideas regarding work; completing a risk assessment relevant to the individual case.

To achieve the standard ***(scores 3)*** the candidate **MUST:**
a. Assess for both elevation and depressive symptoms of bipolar disorder.

A score of 4 may be awarded depending on the depth and breadth of additional factors covered such as other factors that could affect relapse – adherence to meds, knowledge of lithium levels, understanding and acceptance of diagnosis.

Below the Standard (scores 2 or 1) if:
scores 2 if the candidate does not meet (a) above, or has omissions that would detract from the overall quality response; significant omissions affecting quality scores 1.

Does Not Achieve the Standard (scores 0) if:
omissions adversely impact on the obtained content such that the candidate ignores the possibility that Jane may be well; significant deficiencies such as substantial omissions in history.

1.2. Category: ASSESSMENT – Data Gathering Content	Surpasses Standard	Achieves Standard		Below the Standard		Standard Not Achieved
ENTER GRADE (X) IN ONE BOX ONLY	5 ☐	4 ☐	3 ☐	2 ☐	1 ☐	0 ☐

2.0 COMMUNICATOR

2.5 Did the candidate demonstrate effective communication skills appropriate to the context? (Proportionate value – 30%)

Surpasses the Standard (scores 5) if:
integrates information in a sophisticated manner that can effectively be utilised by Jane; provides succinct and professional information about EE in bipolar disorder and/or psychiatric illness in general; describes in detail the research in high EE; does not appear to blame Jane's husband for his responses.

Achieves the Standard by:
providing an accurate and structured description of how the family environment is impacting on presentation; mentioning the research component in relation to EE; acknowledging Jane's opinion of her illness status; recognising that the presence of high EE may lead to relapse in the future; adapting communication style to Jane's responses and to the setting; demonstrating discernment in selection and delivery of content particularly in relation to Jane's husband's behaviour.

To achieve the standard ***(scores 3)*** the candidate **MUST:**
a. Consider that Jane is unlikely to be presenting with a bipolar relapse.
b. Explain features of high EE to a patient without using jargon.

A score of 4 may be awarded depending on the depth and breadth of additional factors covered; if the candidate includes most or all correct elements.

Below the Standard (scores 2 or 1):
scores 2 if the candidate does not meet (a) or (b) above, or has omissions that would detract from the overall quality response; significant omissions affecting quality scores 1.

Does Not Achieve the Standard (scores 0) if:
talks over Jane or utilises a dictatorial style; does not take into account concerns about home situation; places blame for the situation on the husband; focusses on this being a relapse; does not accept her view that she is well.

2.5. Category: SYNTHESIS	Surpasses Standard	Achieves Standard		Below the Standard		Standard Not Achieved
ENTER GRADE (X) IN ONE BOX ONLY	5 ☐	4 ☐	3 ☐	2 ☐	1 ☐	0 ☐

1.0 MEDICAL EXPERT

1.13 Did the candidate formulate and describe a relevant initial plan on how to address the husband's concerns? (Proportionate value – 35 %)

Surpasses the Standard (scores 5) if:
provides a sophisticated link between the plan and key issues identified; explores potential barriers to engaging the husband; respectfully considers the role Jane plays in the conflict at home e.g. dependency, lack of confidence, own poor communication.

Achieves the Standard by:
obtaining collateral information from a range of sources; demonstrating the ability to prioritise and implement evidence based care which includes targeting the stressors (home environment and relationship); planning for risk management with Jane in case her condition deteriorates; confirming recent/current lithium levels; strengthening Jane's coping skills and communication with Paul; suggesting psychological interventions like couples counselling; recommending specific interventions of value e.g. Interpersonal and Social Rhythm Therapy that may assist; setting realistic timeframes and recognition of the need for review.

To achieve the standard ***(scores 3)*** the candidate **MUST:**
a. Convey the importance of obtaining collateral information from the husband to confirm the findings.

A score of 4 may be awarded depending on the depth and breadth of additional factors covered; if the candidate includes most or all correct elements.

Below the Standard (scores 2 or 1):
scores 2 if the candidate does not meet (a) above, or has omissions that would detract from the overall quality response e.g. no plan for review or follow up; significant omissions affecting quality scores 1.

Does Not Achieve the Standard (scores 0) if:
plan includes changes to medication because candidate considers the patient is unwell; plan lacks structure or is inaccurate; plan not tailored to patient's immediate needs or circumstances.

1.13. Category: MANAGEMENT - Initial Plan	**Surpasses Standard**	**Achieves Standard**		**Below the Standard**		**Standard Not Achieved**
ENTER GRADE (X) IN ONE BOX ONLY	**5** ☐	**4** ☐	**3** ☐	**2** ☐	**1** ☐	**0** ☐

GLOBAL PROFICIENCY RATING

Did the candidate demonstrate adequate overall knowledge and performance at the defined tasks?

Circle One Grade to Score	**Definite Pass**	**Marginal Performance**	**Definite Fail**