Committee for Examinations
Objective Structured Clinical Examination

Station 4
Melbourne April 2016

The Royal Australian & New Zealand College of Psychiatrists

1.0 Descriptive summary of station:

In this station candidate is expected to make a diagnosis of agoraphobia and panic disorder, and discuss an initial non-pharmacological management plan with Patricia, a 36-year-old mother who is mainly concerned about the significant chronic agoraphobia symptoms. This initial assessment is undertaken in a community setting at the request of her GP.

1.1 The main assessment aims are:

- To evaluate candidate's ability to:
  - Accurately confirm the diagnoses of agoraphobia and panic disorder including the severity and impact of the presentation.
  - Demonstrate their knowledge of the major non-pharmacological management of agoraphobia when talking with a patient.

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

- Elicit core symptoms of agoraphobia to make a diagnosis; specifically including situational avoidance due to fear of panic.
- Confirm recurrent unexpected panic attacks.
- Mention the diagnoses of both panic disorder and agoraphobia.
- Outline the level of disability associated with agoraphobia.
- Accurately explain the components of in-vivo exposure programme.

1.3 Station covers the:

- **RANZCP OSCE Curriculum Blueprint Primary Descriptor Category of:**
  Anxiety Disorders
- **Area of Practice:**
  Adult Psychiatry
- **CanMEDS Domains of:**
  Medical Expert and Communicator
- **RANZCP 2012 Fellowship Program Learning Outcomes of:**
  Medical Expert (Assessment, Formulation, Management), Communicator (Patient Communication)

References:

- Malbos, E., Rapee, R. M., & Kavakli, M. A controlled study of agoraphobia and the independent effect of virtual reality exposure therapy. *Australian and New Zealand Journal of Psychiatry, 2013; 47(2), 160-168*.
- Martin A Katzman, Pierre Bleau, Pierre Blier, Pratap Chokka, Kevin Kjernisted, Michael Van Ameringen,: Canadian clinical practice guidelines for management of anxiety, posttraumatic stress and obsessive compulsive disorder: *BMC Psychiatry* 2014 : 14(Suppl 1): S1
- Price, M., Mehta, N., Tone, E. B., & Anderson, P. L. Does engagement with exposure yield better outcomes? Components of presence as a predictor of treatment response for virtual reality exposure therapy for social phobia. *Journal of anxiety disorders, 2011; 25(6), 763-770.*
- Van Apeldoorn, F. J., Van Hout, W. J., Timmerman, M. E., Mersch, P. P. A., & den Boer, J. A. Rate of improvement during and across three treatments for panic disorder with or without agoraphobia: Cognitive behavioural therapy, selective serotonin reuptake inhibitor or both combined. *Journal of affective disorders, 2013;150(2), 313-319.*
- Wittchen, H-U., Gloster, A.T., Beesdo-Baum, K, Fava, G.A.,Craske, M.G. Agoraphobia: A review of the diagnostic classificatory position and criteria. *Depression and Anxiety; 2010: 27:113–133.*
- Sanchez-Meca J, Rose-Alcazar Al, Marin-MartinezF, Gomez-Conesa A: Psychological treatment of panic
- Disorder with or without agoraphobia: a meta-analysis. Clin Psychol Rev 2010 30:37-50.

1.4 Station requirements:

- Standard consulting room; no physical examination facilities required.
- Four chairs (examiner x 1, role player x 1, candidate x 1, observer x 1).
- Laminated copy of 'Instructions to Candidate'.
- Role player – woman around the age of 35, casually but neatly dressed.
- Pen for candidate.
- Timer and batteries for examiner.

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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 a community mental health clinic that specialises in mood and anxiety disorders. You are about to see Patricia, 36-year-old mother of two children for an initial review. She has been referred to your clinic by her GP for your opinion. One of her daughters has driven Patricia to the clinic for this review and will come back and fetch her later**.**

Your tasks are to:

- Take a focussed history of her presenting complaints to be able to diagnose Patricia's concerns.
- Explain your findings and rationale for your diagnostic assessment to Patricia.
- Discuss an initial non-pharmacological management plan with Patricia.

You will not receive any time prompts.

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Station 4 - 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:
  - Duplicate copy of 'Instructions to Candidate'.
  - 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:

- You are to state the following:
  "Are you satisfied you have completed the task(s)?
  If so, you <u>must</u> remain in the room and <u>NOT</u> 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).

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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.

When the candidate enters the room briefly check ID number.

You have no opening statement or prompts.

The role player opens with the following statement:

"It took a lot for me to be here, as I don't usually go out of my house".

3.2 Background information for examiners

The first part of this station is where the candidate is expected to make a diagnosis of agoraphobia. The presentation is in the context of panic disorder which the candidate should also identify. Secondly, the candidate should explain, using appropriate language, the diagnoses and is expected to justify their assessment of severity of the presentation to Patricia. In the final part of the station the candidate must discuss an initial non-pharmacological management plan with Patricia, focussing mainly on the symptoms of chronic agoraphobia. The candidate should not discuss pharmacological interventions in this station.

The assessment is undertaken in a community setting at the request of her GP and it is not expected that the candidate will recommend compulsory treatment or inpatient admission.

In order to **Achieve** in this station the candidate **MUST**:

- Elicit core symptoms of agoraphobia to make a diagnosis; specifically including situational avoidance due to fear of panic.
- Confirm recurrent unexpected panic attacks.
- Mention the diagnoses of both panic disorder and agoraphobia.
- Outline the level of disability associated with agoraphobia.

For agoraphobia, the symptoms elicited should include most of the following: significant avoidance of situations / environments, cognitions of not being able to escape to safety, anticipatory anxiety and significant anxiety if she had to be in such situations. When taking the history the candidate is expected to focus on the associated disability in some detail. When explaining the diagnosis to Patricia the candidate should include the duration as part of their standard nosological criteria.

For panic disorder the candidates should elicit symptoms which include the majority of the following: establishing panic attacks as per any standard criteria. The candidate should establish bodily / physical symptoms and the cognitive sense of impending doom. The candidate should also elicit the de-novo nature of the same along with strong anticipatory anxiety.

A better candidate may:

- Demonstrate their knowledge of almost all the symptoms for both disorders within the allotted timeframe of the station.
- Effectively screen for other comorbidity especially anxiety disorders, depression, and substance misuse.

The candidate must give feedback to Patricia about diagnoses of panic disorder and agoraphobia, explaining that these are anxiety disorders. Candidates are expected to recognise and acknowledge that the agoraphobia is very disabling and justify the same by giving reasons. These reasons may include severe social drift, significant impact on her ability to carry out activities of daily living and higher level occupational functioning, being house bound, impact of her behaviour on her children, etc.

The treatment focus that candidates present must include in-vivo exposure as a preferred modality of treatment. Candidates should be able to explain the principle in-vivo exposure, most importantly, habituation / extinction. Their explanation should reflect a brief outline of the programme which should include the construction of hierarchy based on the subjective distress in these situations; how long a typical exposure session should last; when to progress down the hierarchy of activities; how each session of exposure continues until the anxiety peaks and comes down significantly from the maximum distress; movement to the

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next task on the hierarchy when the previous exposure situation is no longer distressing or significant reduction in baseline anxiety. Candidates are also expected to explain about safety behaviours and their significance in maintaining the anxiety symptoms.

A better candidate may:

- Talk about advantages and disadvantages of different frequency and intensity of exposure approaches. These candidates may also elaborate on issues related to self / therapist directed exposure.
- Provide an accurate account of other non-pharmacological interventions for agoraphobia.
- Identify the need to treat panic disorder if complete recovery is to be aimed for.
- Discuss psychological interventions for panic disorder (e.g. Panic Control Treatment (PCT)) and how they can enhance the treatment programme.

Diagnostic considerations

According to Wittchen et al (2010), the community prevalence of agoraphobia without a history of panic disorder and even the prevalence of agoraphobia without the presence of panic attacks or panic-like symptoms has been found to be at least as high as the combined rates of panic disorder with and without agoraphobia across all epidemiological studies. In clinical settings however, a diagnosis of agoraphobia without the history of panic disorder is rarely assigned in clinical practice. However it is worth noting that DSM-5 has separated agoraphobia into a separate diagnostic category.

Similar age of onset curves for panic disorder and panic attacks (with or without agoraphobia) indicate that the mean age of onset is 21–23 years. As a function of different sample composition, some studies report slightly higher ages but the studies consistently show that two thirds of all panic disorder patients develop symptoms before age 35. Findings for agoraphobia are less clear, and among those specifically addressing agoraphobia without panic attacks, a slightly later mean onset was shown, ranging from 25–29 years. Overall, however the age of onset does not necessarily assist in diagnostic clarification.

In the majority of cases, agoraphobia seems to be associated with preceding panic attack or panic-like symptoms and / or are subsequently mediated by the expectation of panicking in particular situations. However a significant group of agoraphobia patients develop symptoms for reasons other than or in addition to panic. So, the most plausible interpretation is the existence of multiple pathogenic pathways involved in the development of agoraphobia.

With regard to levels of impairment, studies consistently find the greatest impairment for those with both panic disorder and agoraphobia, with the lowest impairment for those with panic attacks without meeting criteria for either disorder.

While few studies have allowed for direct comparisons of comorbidity patterns in community samples, there is agreement that panic disorder and agoraphobia both are rarely seen in pure forms and both are significantly associated with many other diagnoses, including other anxiety, mood, substance, and somatoform disorder.

There is no evidence that agoraphobia and panic disorder or any other anxiety disorder demonstrate differences in the structure and frequency of life events over the life span; however, all conditions were increased when past significant life events were reported. Other risk factors apart from stressful life events can include poor health, and lower education and income.

The clinical course of agoraphobia and panic disorder in clinical and epidemiological samples have been reported as being chronically persistent and chronically recurrent respectively. The presence of severe agoraphobic avoidance has been the most consistent of the predictors of poorer long-term outcome of panic disorder.

Classificatory models

ICD-10 defines agoraphobia as a separate diagnosis to panic disorder and does not necessarily assume that it arises from panic attacks: in fact agoraphobia takes precedence over panic attacks. There is however, historical evidence that that panic attacks and panic-like features may play a core role in the development of some but not all agoraphobia patients.

In the DSM-5 the biggest change (from DSM-IV-TR) with these two disorders is that panic disorder and agoraphobia are no longer linked together, but recognised as two separate disorders. The APA justifies this unlinking because they found that a significant number of people with agoraphobia do not experience panic symptoms.

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The agoraphobia symptom criteria remain unchanged from DSM-IV, apart from the fact that endorsement of fears from two or more agoraphobia situations is now required, because this is a robust means for distinguishing agoraphobia from specific phobias. Additionally, the criteria for agoraphobia are extended to be consistent with criteria sets for other anxiety disorders (e.g., clinician judgment of the fears as being out of proportion to the actual danger in the situation, with a typical duration that must be of 6 months or more).

DSM-5 criteria for agoraphobia include:

- Marked fear or anxiety about • 2 of the following 5 groups of situations:
  (1) Public transportation (e.g. traveling in automobiles, buses, trains, ships, or planes).
  (2) Open spaces (e.g. parking lots, market places, or bridges).
  (3) Being in shops, theatres, or cinemas.
  (4) Standing in line or being in a crowd.
  (5) Being outside of the home alone in other situations.
- The individual fears or avoids these situations due to thoughts that escape might be difficult or help might not be available in the event of panic-like symptoms.
- The agoraphobic situations almost always provoke fear or anxiety.
- The situations are actively avoided, require presence of a companion, or endured with marked fear or anxiety.
- The fear or anxiety is out of proportion to actual danger posed by agoraphobic situation.
- The fear, anxiety, or avoidance is persistent, typically lasting • 6 months.
- The fear, anxiety, and avoidance cause clinically significant distress or functional impairment.

DSM-5 Panic Disorder (includes previous DSM-IV diagnoses of panic disorder with agoraphobia and panic disorder without agoraphobia)

A. Recurrent unexpected panic attacks.
B. At least one of the attacks has been followed by 1 month (or more) of one or both of the following:
   - Persistent concern or worry about additional panic attacks or their consequences (e.g. losing control, having a heart attack, going crazy).
   - Significant maladaptive change in behaviour related to the attacks (e.g. behaviours designed to avoid having panic attacks, such as avoidance of exercise or unfamiliar situations).
   - The panic attacks are not restricted to the direct physiological effects of a substance (e.g. a drug of abuse, a medication) or a general medical condition (e.g. hyperthyroidism, cardiopulmonary disorders).
   - The panic attacks are not restricted to the symptoms of another mental disorder.

<u>Non-pharmacological interventions</u>

Evidence suggests that Cognitive Behavioural Therapy (CBT) is a very effective form of treatment for both panic disorder and agoraphobia. CBT is not a single approach to treatment, but a process that manages the factors that cause and maintain the symptoms of anxiety in patients. Some of the core components of CBT include exposure, arousal management (e.g. relaxation training, diaphragmatic breathing), cognitive restructuring and management of safety behaviours. There is strong evidence to suggest, it is an effective form of treatment when the above components are used in varied combination. Further evidence also supports the exposure as being the most useful of the components in the treatment of the above disorders.

There is an impressive body of evidence on the efficacy of exposure in treating agoraphobia. The details are described above. There are options for intense exposure versus starting the programme with the least distressing situation, as well as more frequent sessions versus regular spaced out sessions. There are also options of therapist assisted vs self-driven approaches.

In-vivo exposure draws from the concepts of classic and operant conditioning. The two most important principles that are in play are habituation and extinction. In habituation, when a response is elicited repeatedly, the strength of the response reduces. In the context of exposure, the intensity of anxiety is reduced with prolonged and repeated exposure.

In extinction (as per classic conditioning), when a conditioned stimulus is presented repeatedly without the unconditioned stimulus, the conditioned response will decrease. In the context of exposure treatment, when

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a person is exposed to the avoided situation (conditioned stimulus) and does not experience feared arousal in the form of severe anxiety (unconditioned stimulus) then the avoidance behaviour reduces significantly.

Many other forms of therapy can be applied with CBT, including possible positive effects of conventional psychotherapy.

Today, technology such as virtual reality and the internet are providing opportunities for people with agoraphobia to begin therapy in the 'safe' environment of their home. Virtual Reality Exposure Therapy (VRET) is a popular form of exposure therapy and has produced positive effects on reducing the symptoms of agoraphobia in an Australian study (Malbos, Rapee, Kavakli, 2012). Similar to the findings on VRET in other anxiety disorders, the argument in agoraphobia studies is that merely creating a fear rating through realness and presence does not correlate with a positive treatment outcome. The level of involvement of the participant plays an important role in predicting the treatment outcome (Price, Mehta, Tone, & Anderson, 2011).

Panic Control Treatment (PCT) is a widely used, empirically validated cognitive behavioural treatment for panic disorder. Initially it was developed for the treatment of panic disorder with limited agoraphobic avoidance, but more recently has been applied in more broad applications. The general goal of PCT is to enable patients to develop the ability to identify and correct maladaptive thoughts and behaviours that initiate, sustain, or exacerbate anxiety and panic attacks. It combines education, cognitive interventions, relaxation and controlled breathing procedures and interoceptive exposure (form of in vivo exposure) to the bodily cues that initiate and maintain panic symptoms. It is usually delivered in 11 or 12 weekly sessions, either individually to patients or in a small group format.

The two disorders continue to be treated together, as well as separately. Increasingly, medication (usually SSRIs) and cognitive behavioural therapy are used together. This combined treatment has proven to be more effective in the treatment of anxiety disorders. With moderate-to-severe agoraphobia, the combined treatment was more effective in reducing panic attacks. Long-term follow-up studies of CBT therapy in the treatment of panic disorder with agoraphobia revealed that the positive behaviour and reduced symptoms were maintained.

3.3 The Standard Required

In order to:

Surpass the Standard – a better 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 well-being 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.

Does Not Achieve the Standard – 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.

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4.0 Instructions to the Role Player

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

You are Patricia, 36-year-old single mother of two teenage daughters who live with you. Your daughters are Chloe aged 16 and Amy who is almost 18. You separated from your husband 6 years ago.

You have been referred by your GP to see a psychiatrist in a specialist community service. Your GP, Dr Andrews, suggested that it would be a good idea to get opinion from a psychiatrist about your anxiety problems, which you have had for years. You have been driven to the appointment by your older daughter, as you have not driven in 6 years and are too scared to drive. Your daughter has gone to do some shopping and will come back and pick you up.

You have been suffering from anxiety for the last 6 years. This started becoming an issue following separation from your husband Mark. Over time your anxiety has become worse and in the last 3 years it has become disabling. This means you are house bound and you have hardly left your house in the last 3 years. You are overwhelmed by thoughts of "*not being able to get to safety*" when you are out. This includes activities like driving, being in shopping centres, visiting relatives / friends, or going to your hairdresser.

The above problems followed on from when you had a sudden-onset attack of anxiety 6 years ago while at a shopping centre with your daughters. During this time you felt that your knees were going to buckle. For no reason you suddenly got overwhelmed with your heart racing, you felt sweaty, nervous, dizzy, shaky, and thought you were going crazy. The incident lasted for a few minutes during which time it felt as though you were having a heart attack and needed urgent help, but you could not ask for the same. This experience was very difficult to cope with.

You have subsequently learned that this was a 'panic attack'. Since then you have felt very anxious to be in these kinds of situations and have even started having panic attacks at the thought of being in such places. You always have thoughts of "*not being able to get to safety*" and so over time you have actively avoided going out of your house and you feel very comfortable within your home. Over the last 3 years, even the thought of having to go out alone makes you very anxious. You have been increasingly distressed by this anxiety but have managed to cope with life by doing most of your shopping online or sending your daughters, and organising things like having the hairdresser come to your house.

In the last two years your bedroom has become your safe space and with difficulty you come out of your room. You spend most of your day there. On the odd occasion of you having to go out of your room, you do it swiftly so that you are back to your safe space. During this time you have not been cooking and find it difficult to look after your house. You get a lot of support from your teenage daughters to manage day-to-day things who are almost acting as the adults of the house, which you are quite distressed about.

If you are to imagine going out of your room and even spending time in other parts of your house, you at times have a panic attack thinking about it. Further you think that that the anxiety will be as high as 90/100 (100 being the worst anxiety you have ever experienced) if you were to have to do those activities for a significant period of time. The same is true in your mind for activities like going to the garden, sitting in the backyard, walking to the next block, catching public transport.

Along with the above complaints you also suffer from panic attacks that come out of the blue once in every few weeks. Though you feel overwhelmed by the thought of going out of your safe zone, these panic attacks are distinct and they come for no reason and they make you feel that you are going crazy. You experience a strange sense of anxiety, feel that things around you are changing shapes; your heart pounds and you experience severe sweating and you get a terrible feeling of impending doom that you cannot really explain. At times you worry that you might have an attack and when your heart starts pounding it makes you think that you might have a panic attack.

Though you have these spontaneous panic attacks, you are relieved they are not as frequent these days. You are more distressed by the fact that you are house bound. Although you are worried about both problems you are keen to address your fears of leaving the house first. This is mainly because, even though you feel like your house is your safe zone, it is overwhelming for you to think of doing anything outside this zone.

Up until now you have been hesitant to see your GP, but you saw him recently at the insistence of your teenage daughters. Even though you are afraid, you are open to understanding about your problems and explore treatment options, as you have been informed by your GP that there are potential treatments available. You feel it is very important to get help to improve your home and social circumstances. Your knowledge about your problem is limited, the only thing you know is that you are feel so terribly anxious.

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With regard to your past personal life, if you are asked - when you were growing up you lived with your younger sister, father and mother. You were close to your sister and mother. However your father was a violent alcoholic. You were quite scared of him. He was very angry when drunk and at times was physically aggressive toward you and your sister. Your mother found it difficult to manage life with him. After a long period of struggle, your mother separated from your father when you were 15. You and your sister went on to finish high school while mother was working full time to support the family financially.

You remember that you were nervous as a child and were not very bold. Your schooling was largely uneventful except for some minor troubles with bullying on occasions. Despite these issues you went on to finish high school and worked in retail for a year. Consequently you met your husband Mark when you were 18 and got married to him the next year.

Initially you had a good relationship with your husband. However, in the years leading up to separation, Mark felt that the relationship had become distant and "*called it quits*". After the separation you felt very distressed, unsupported and emotionally out of control. You remember that the current problems date back to this time.

In the initial years of the onset of your anxiety, you used to meet up with your mother and sister intermittently. In the last 3 years you have almost become estranged, as you cannot go out and they rarely come over to see you. Both your children are teenagers and almost independent. The older daughter is in the process of enrolling into University to do optometry.

You do not have any physical health problems (except when you think you are having a heart attack during a panic attack) and you are not on any medication. You have no allergies.

With regard to other mental health symptoms, if you are asked - you have not felt depressed over the last few years. You feel you have a lot to live for as your daughters are doing well in studies and you think they have a bright future. You sleep okay and your appetite is good. Though on occasion you do question the need for such an existence you have not ever wished you were dead or felt suicidal.

You have not had obsessive thoughts that come into your mind over and over again or symptoms to suggest fear of specific things such as animals, lifts or heights. You are not worried about being judged by people while in groups nor are you worried about performance anxiety - what other people might think of you. You also don't have problems related to your weight or body image.

You do not hear any voices or have any other unusual experiences such as thinking that you are being followed or troubled by other people.

You do not consume drugs (including coffee or cigarettes) or alcohol and have never really done so.

4.2 How to play the role:

People with agoraphobia most commonly have a fear of public places. Agoraphobia is an anxiety disorder involving a persistent fear of certain environments, often either due to their crowdedness or openness. This fear is disproportional to the threat or danger posed by the environment. The person who has agoraphobia will go to great lengths to avoid the environment, and the presence or anticipated presence of the environment will create a high level of distress. These irrational fears and reactions result in interferences with social and work life.

You should play the role as an anxious lady with some level of agitation in the interview. You present this anxiety by repeatedly linking the troubles that you are having with not being able to go out. However you are also very polite and cooperative and should give information freely when the candidate questions you.

You are keen to know about your condition and the initial suggestions for treatment. If the candidate explains about exposure treatment in a manner that you understand please show a keen interest and accept the advice.

Please come dressed in casual but neat attire.

4.3 Opening statement:

"It took a lot for me to be here, as I don't usually go out of my house."

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4.4 What to expect from the candidate:

Expect the candidate to ask you about your complaint of "Not being able to go out of your house". Candidates may ask about your 'safe space' within the house. Further they may also ask about anxiety and distress levels if you are asked to spend time out of your room. Then answer as per the script.

Candidates should also ask for the details of your panic attacks, and other problems such as fear of being in groups, animals, etc.

Candidates should aim to be reassuring and polite with you despite your repeated talk about distress.

4.5 Responses you MUST make:

"I am literally house bound because of these problems and keen to address this first."

"What is wrong with me doctor?"

"How bad are my symptoms doctor?"

If the candidate talks about 'exposure treatment' you must ask for details of the treatment.

If the candidate does not mention 'exposure treatment' you must say:
"My daughter read about something called exposure."

If the candidate uses terms like 'habituation or hierarchy' please ask for an explanation of the term.

4.6 Responses you MIGHT make:

These responses are dependent on whether the candidate raises the issue:

"I am keen to reconnect with my family."

"If you advised medication treatment I am happy to accept it."

Any questions that are asked respond as per the script. If it is not scripted respond by saying,
"*I am unsure*" or "*I don't think so.*"

4.7 Medications:

Nil

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STATION 4 – MARKING DOMAINS

The main assessment aims are:

- To evaluate candidate's ability to:
  - o Accurately confirm the diagnoses of agoraphobia and panic disorder including the severity and impact of the presentation.
  - o Demonstrate their knowledge of the major non-pharmacological management of agoraphobia when talking with a patient.

Level of Observed Competence:

1.0 MEDICAL EXPERT

1.2 Did the candidate take appropriately detailed and focussed history? (Proportionate value - 30%)

Surpasses the Standard (scores 5) if:
achieves a score of at least 4 *and* clearly achieves the overall standard with a superior performance in a range of areas; demonstrates prioritisation and sophistication; also explores in detail other anxiety spectrum disorders such as Simple Phobia, GAD, OCD, PTSD, Body Dysmorphic disorder with accurate phenomenology.

Achieves the Standard by:
conducting a targeted assessment to elicit almost all of the key symptoms of both agoraphobia and panic disorder; screening for depression, substance use, psychotic features, suicidality; integrating symptoms with exploration of social drift because of her anxiety issues along with difficulties in relationships; exploring in detail about the problems in day- to-day living in the context of the above.

To score 3 or above the candidate **MUST**:
a. elicit core symptoms of agoraphobia to make a diagnosis; specifically including situational avoidance due to fear of panic.
b. confirm recurrent unexpected panic attacks.

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) if:
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:
significant deficiencies such as substantial omissions in history; omissions adversely impact on the obtained content.

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** ☐

1.11 Did the candidate generate an adequate formulation to make sense of the presentation? (Proportionate value - 30%)

Surpasses the Standard (scores 5) if:
achieves a score of at least 4 *and* demonstrates prioritisation; communicates findings in a sophisticated manner.

Achieves the Standard by:
correctly communicating both as being anxiety disorders; justifying their assessment of the level of disability by giving reasons; explaining about anxiety disorders and their impact on function; reassuring about the absence of other comorbid disorders.

To score 3 or above the candidate **MUST**:
a. mention the diagnosis of both panic disorder and agoraphobia.
b. outline the level of disability associated with agoraphobia.

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) if:
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:
incorrectly interprets symptoms of anxiety disorders; significant deficiencies including inability to synthesise information obtained; inadequate diagnostic statement.

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

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1.15 Did the candidate adequately engage, inform and discuss the treatment plan with the patient including suitably incorporating patient goals / preferences? (Proportionate value - 30%)

Surpasses the Standard (scores 5) if:
achieves a score of at least 4 *and* clearly achieves the overall standard with presentation of a specific and sophisticated plan; weighs up advantages and disadvantages of options related to intensity, frequency; accurately identifies alternative options; includes the need to treat panic disorder and offers options like Panic Control Treatment (PCT).

Achieves the Standard by:
accurately defining habituation / extinction; talking further about the principles of operant conditioning / classic conditioning; providing practical examples of a session taking a real life scenario; highlighting that additional cognitive techniques can improve outcomes; taking into account patient's goals; reasonably establishing that the patient understands and is in agreement with the plan.

To score 3 or above the candidate **MUST**:
a. recommend in vivo exposure as a preferred modality of treatment.
b. accurately explain the process of an in vivo exposure programme.

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) if:
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:
description of the management plan lacks structure; inaccuracies or errors about specific therapies impact adversely on patient care; difficulty tailoring treatment to the patient's specific circumstances.

1.15. Category: MANAGEMENT - Treatment Contract	**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

2.1 Did the candidate demonstrate an appropriate professional approach to gathering information from patient / family / carer? (Proportionate value - 10%)

Surpasses the Standard (scores 5) if:
able to generate a complete and sophisticated understanding of complexity; effectively tailors interactions to maintain rapport within the therapeutic environment.

Achieves the Standard if (scores 4 or 3) if:
adopts a polite and reassuring style of interview while the patient presents as being very anxious; makes an effort to avoid jargon and asks questions to facilitate better understanding; attempts to normalise the disorders; explains the team's role and what can be offered.

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) if:
the candidate does not effectively put the patient at ease; uses technical language that impairs the therapeutic alliance / acceptability of plans.

Does Not Achieve the Standard (scores 0) if:
errors or omissions adversely impact on alliance; inadequately reflects on relevance of information obtained; unable to maintain rapport.

2.1. Category: PATIENT COMMUNICATION - to patient	**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**

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