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## **DO NOT REMOVE FROM ROOM**

### **ACTIVE BYE STATION 1 NOTES**

*The following information is provided for you. These same 'Instructions to Candidate' will be available in Station 1.*

*You may make notations on your notepad, which you will take with you into Station 1.*

- You have **twenty (20) minutes** in this Active Bye Station to watch a DVD of the 'Strange Situation' procedure, and work on the responses to the tasks based on the DVD. The video has been shortened to 15 minutes but provides you with all the information you need to complete your tasks.
- After you leave the bye station, you have a further **five (5) minutes outside the examination room** to continue working on the responses.

You are a junior consultant psychiatrist working in a country town. You are providing a secondary consultation to the regional child protection team. You will be meeting with a social worker, Gemma Brown. She has graduated recently from university, and this is her first job. She is the long-term case worker for the family you will see in the video. She wants advice on how to interpret the interactions between Rhianna and Charlie Armstrong who have been identified as at risk.

During her pregnancy, the mother Rhianna Armstrong (whom you will see in the video) suffered a relapse of schizophrenia after her medication was ceased by the GP because of the risk to the foetus during the pregnancy.

Rhianna is a 22-year-old single woman who moved in with her parents after the birth of her son, Charlie, 14 months ago. She has a history of substance abuse prior to the pregnancy, but none since she became pregnant. Rhianna now wants to move into her own home, and live independently with Charlie. The child protection team wants to ensure that there is no risk to Charlie's welfare if this were to occur.

Your tasks are to:

- Describe the interaction between the child and his mother in this 'Strange Situation' scenario.
- Determine the likely attachment style of the dyad.
- Explain different attachment styles and their significance.
- Prioritise specific interventions to support Rhianna and Charlie.

### 1.0 Description summary of station:

In this long station, the candidate is a junior consultant in a country town who is providing secondary consultation to a child protection team. There is an active bye in which the candidate watches a modified (shortened) video of the 'Strange Situation' procedure, edited to fit into the time allowed. The mother and her infant have been identified as at risk due to the mother's past history of substance abuse and schizophrenia. She is a single mother who has moved in with her own parents for support after the baby was born. She is now wanting to move out of her parent's home. The candidate is expected to evaluate the interaction between the mother and her child, looking for strengths and difficulties. In the examination, the candidate also has to address the concerns of the child protection worker, who is new to this work and suggest further interventions to support them in the future.

### 1.1 The main assessment aims are to:

- Observe and describe the behaviour of a mother-infant dyad in the 'Strange Situation' procedure, and identify the attachment style of the dyad.
- Demonstrate an understanding of categories of attachment and behaviours that could be observed, supporting each diagnosis.
- Listen to the concerns of a junior child protection worker, and educate her about attachment theory; addressing the perceived stigma against this mother who has schizophrenia.
- Suggest interventions that can be put in place to support the mother and her child.

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

- Focus on attachment in the description of the observed behaviour of the dyad.
- Identify a generally secure attachment with some avoidant features.
- Explain all four categories of attachment.
- Advocate for the mother who is providing good enough care for her child.
- Ensure clarification of the level of involvement of the father.

### 1.3 Station covers the:

- **RANZCP OSCE Curriculum Blueprint Primary Descriptor Category:** Child & Adolescent Disorders, Other Skills (e.g. ethics, consent, capacity, collaboration, advocacy, indigenous, rural, etc.)
- **Area of Practice:** Child & Adolescent
- **CanMEDS Marking Domains Covered:** Medical Expert, Health Advocate, Scholar
- **RANZCP 2012 Fellowship Program Learning Outcomes:** Medical Expert (Formulation – Communication; Diagnosis; Management – Initial Plan), Health Advocate (Addressing Stigma), Scholar (Medical Terminology)

#### References:

- Ainsworth M and Bowlby J (1965) *Childcare and the Growth of Love*. London: Penguin Books
- Bowlby J. (1969) *Attachment and Loss*. London: Hogarth
- Healy S et al. Affect recognition and the quality of mother-infant interaction: understanding parenting difficulties in mothers with schizophrenia
- Mares S Newman L and Warren B (2005) *Clinical Skills in Infant Mental Health*. Camberwell: Acer
- Seeman M (2011) *Intervention to Prevent Child Custody Loss in mothers with Schizophrenia*. Schizophrenia Research and Treatment vol 2012 pp
- Zeanah C (2019) *Handbook of Infant Mental Health*. New York: Guildford

### 1.4 Station requirements:

- Standard consulting room.
- Five chairs (examiners x 2, role player x 1, candidate x 1, observer x 1).
- Laminated copy of 'Instructions to Candidate'.
- Role player: female aged early 20's.
- Pen for candidate.
- Timer and batteries for examiners.

## 2.0 Instructions to Candidate

You have **fifteen (15) minutes** to complete this station after **five (5) minutes** of reading time.

In the active bye station, you have watched a video of Rhianna Armstrong and her 14-month-old son, Charlie.

You are a junior consultant psychiatrist working in a country town. You are providing a secondary consultation to the regional child protection team.

You will be meeting with a social worker, Gemma Brown. She has graduated recently from university, and this is her first job. She is the long-term case worker for the family you have seen in the video. She wants advice on how to interpret the interactions between Rhianna and Charlie Armstrong who have been identified as at risk.

During her pregnancy, the mother Rhianna Armstrong (whom you have seen in the video) suffered a relapse of schizophrenia after her medication was ceased by the GP because of perceived risk to the foetus during the pregnancy.

Rhianna is a 22-year-old single woman who moved in with her parents after the birth of her son, Charlie, 14 months ago. She has a history of substance abuse prior to the pregnancy, but none since she became pregnant. Rhianna now wants to move into her own home, and live independently with Charlie. The child protection team wants to ensure that there is no risk to Charlie's welfare if this were to occur.

Your tasks are to:

- Describe the interaction between the child and his mother in this 'Strange Situation' scenario.
- Determine the likely attachment style of the dyad.
- Explain different attachment styles and their significance.
- Prioritise specific interventions to support Rhianna and Charlie.

## Station 1 - 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.
  - Pens.
  - Water and tissues (available for candidate use).
- Do a final rehearsal with your simulated patient and co-examiner.

### 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 / time prompts for you to give.
- DO NOT redirect or prompt the candidate unless scripted – 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 **fifteen (15) 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 co-examiner's and your mark sheet in **one** 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 final task:

- You are to state the following:  
***'Are you satisfied you have completed the task(s)?  
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.

When the candidate enters the room, briefly check ID number.

The role player opens with the following statement:

*'Hello Doctor, I don't really understand what this video is about. Can you tell me a bit more?'*

#### 3.2 Background information for examiners

In this station, the candidate is providing secondary consultation to a child protection team in a rural setting. The candidate will watch a modified (shortened) video of the 'Strange Situation' procedure. The single mother and her infant have been identified as at risk due to the mother's past history of substance abuse and schizophrenia. She moved in with her own parents for support, and now wants to move out of her parents' home.

The candidate is expected to observe, evaluate the interaction between the mother and her child, and describe the behaviour of a mother-infant dyad, looking for strengths and difficulties. The candidate needs to be able to recognise the attachment style, and demonstrate an understanding of categories of attachment, and behaviours that could be observed supporting each diagnosis.

The candidate is to discuss the presentation with the child protection worker, who is new to this work and educate her about attachment theory, and address perceived stigma regarding a mother with schizophrenia. They then have to suggest further interventions to support the dyad in the future.

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

- Focus on attachment in the description of the observed behaviour of the dyad.
- Identify a generally secure attachment with some avoidant features.
- Explain all four categories of attachment.
- Advocate for the mother who is providing good enough care for her child.
- Ensure clarification of the level of involvement of the father.

A surpassing candidate will give a superior description of the interaction observed, and may refer to the Adult Attachment Interview as another method to assess and understand the attachment style of the dyad.

Candidates are expected to describe observed behaviour with a focus on proximity maintenance or avoidance of proximity and contact, gaze, vocalisation. The candidate may comment on sensitivity, contingency, marked communication (baby talk where the mother uses a higher pitched voice to describe the infants experience or give voice to the baby's experience).

Candidates are expected to identify that the infant does show signs of appropriate attachment to the mother. He does seek proximity and come to her for comfort, and he shows distress at separation. He is able to make use of the stranger for comfort. There is a somewhat avoidant tone in the interaction which may be commented on by candidates.

Attachment Theory was initially developed by John Bowlby who described that 'the young child will seek proximity to or contact with a specific figure and more so in certain situations, notably when frightened, tired, or ill'. If the child feels threatened in any way, the attachment system is activated and the child seeks proximity with the caregiver for comfort.

Attachment is a relational construct. The attachment relationship is mutually regulating for the infant and the care giver. The attachment relationship provides, warmth, nurturance and comfort at times of distress. It is through the empathic attunement of the mother that the infant comes to recognise himself, and other. It is through the attachment relationship that the infant develops capacity for emotional self-regulation through the experience of being soothed at times of distress. The child can use the attachment relationship as a secure base for exploration. The care giver provides encouragement and support for the infant to explore their world.

The attributes of an attachment relationship are:

1. The relationship provides a secure base for exploration.
2. The relationship provides a safe haven to return to at times of stress and when emotion needs to be regulated.
3. Proximity maintenance.
4. Separation distress.

Attachment is a biologically determined survival imperative which is hard-wired in all mammals, and other animals with possible phylogenetic age of over 200 million years. An understanding of attachment theory can inform psychiatric practice in perinatal psychiatry and in psychotherapy, and in understanding relationships and transference and countertransference. It is also helpful in understanding the experience of patients with borderline and other personality disorders. People with insecure attachment styles are more vulnerable to some psychiatric disorders including Post Traumatic Stress disorder. Each dyad will work out ways of being connected that feel safe.

Secure attachment is present when the child is comfortable to seek comfort and comfortable to explore. He can cue his needs directly. The inevitable ruptures in the relationship and missed cues that occur are easily repaired. Internal working models of self and other will generally be positive. Children with secure attachment will usually be able to make use of alternative care givers to provide support and regulation. In the 'Strange Situation', the child will be seen to use the parent as a secure base to explore. They will be distressed by the separation; however they are likely to be able to accept comfort from the stranger. They will seek proximity on the mother's return and settle to play quite quickly.

Insecure avoidant dyads feel more comfortable with some distance in the relationship. Mary Main describes that avoidant behaviour in the 'Strange Situation' is 'a conditional strategy, which paradoxically permits whatever proximity is possible ...by de-emphasising attachment needs'. The avoidant dyad may disregard each other on reunion or connect with just a glance or a smile. The infant may show little or no contact maintaining behaviour.

Insecure preoccupied (insecure ambivalent) infants are likely to feel most comfortable with a great deal of closeness, and uncomfortable with distance. The child may struggle to make use of the parent as a secure base and may not explore very much. They may be very wary of the stranger and not find comfort in the stranger. The preoccupied child will be very distressed by the departure of the parent.

### **The 'Strange Situation' Procedure (SSP)**

The 'Strange Situation' is a structured observation of a carer / infant dyad that was developed by Mary Ainsworth as a research tool to investigate the qualities of attachment relationships between young children and their primary carers. Over recent years, the 'Strange Situation' has been used as a clinical assessment tool. In particular, the behaviour of the child when the caregiver leaves, the response to the stranger and especially the behaviour of the dyad when the mother returns to the room can evaluate the child's ability to use the mother as a secure base for exploration, and a safe haven at times of stress.

The procedure takes place in a room set up as a playroom, with a one-way screen that professionals can observe. It takes 21 minutes in eight stages and is videotaped. The stages are:

1. mother and child are oriented to the room.
2. the infant explores the room and toys.
3. a stranger enters.
4. first separation, the mother leaves the room, leaving the infant and the stranger together.
5. first reunion, the mother returns and the stranger leaves the room.
6. second separation, the mother leaves the infant alone in the room.
7. the stranger enters the room.
8. second reunion, the mother returns to the infant and the stranger leaves.

Trained observers are interested in whether the child uses the mother as a secure base for exploration in the initial phase of play in a new environment. Does the child feel confident to explore?

Observers look for how the dyad manage proximity and contact seeking. Can the child cue directly their need for proximity and comfort, and how does the mother respond to the cues.

How does the dyad maintain proximity and contact?

Is there resistance to contact and comforting from either or both partners?

The video used in this examination has been shortened to 15 minutes but contains all the necessary information.

The initial play session is marked by a low affective tone, relatively independent play by the infant. The mother comments on his exploration. He makes some attempt to engage his mother in the play. She comments on the green spoon which he shows to her. He holds on to this fork for much of the SSP, possibly giving him a sense of connection with his mother when she is not there. There is very little vocalisation on his part. She continues to talk to him about what he is doing.

The stranger enters and the infant welcomes her with his spoon. The infant is not disturbed by the arrival of the stranger. He continues to explore the toys without needing to approach his mother. The mother makes a general disparaging comment 'you are spoiled'. The infant does make some vocalisation. He moves a little closer to the mother and shows her the spoon. The moving closer to her probably does express his need to be connected to her while meeting the stranger. He looks from mother to the stranger, and back again and engages with the stranger by showing her the spoon.

He watches mother leave and turns himself around to face the door. He shows some uneasiness at the initial separation from his mother but is not distressed. He has a tight-lipped expression on his face. He looks to the stranger and seems to be reassured. He looks at the door where his mother left. He plays in a listless way for a few moments and goes over to the chair. He does not interact much with the stranger. He continues to hold a green spoon that he had been playing with when his mother was in the room. Later he crawls towards the door but comes back. There is more vocalisation than previously.

In the first reunion he initially does not make contact with the mother with gaze or voice, neither does she initially. He watches the stranger leave and then gazes at his mother. He lets out a sigh and she does the same (reciprocal and contingent). This is repeated in a playful way and there is some (modest) delight reciprocally in this interaction. He remains on the floor, but his play becomes a bit more structured. He approaches the mother with a toy truck, still clutching the green spoon. There is some vocalisation with more intonation than previously. He seeks some proximity to his mother with the truck. She welcomes him gently with 'Hi'. She takes the truck he offers her, and he climbs up closer to her, seeking proximity. She does not pick him up, but he does not clearly request this. She redirects him to the toys with the truck. He returns to the toys but not the truck she offers. She touches him on the back as he leaves her. He goes to stand at the chair and looks to the door. He returns to the toys. He is not very demonstrative, and neither is the mother.

In the second separation, he watches mother leave, crawls to the door and regards the room for a few seconds. He stands at the door. He quickly becomes very distressed, crying loudly and plaintively. His distress at separation is appropriate, and clearly distinguishes this dyad from an insecure-avoidant dyad. An insecure-avoidant infant would not demonstrate their distress. Markers of distress, such as heart rate variability, would indicate stress but the behaviour would not demonstrate distress in avoidantly attached infants.

When the stranger enters the room, he immediately is silent and accepts her picking him up. He has his arm around her shoulder, still clutching the green spoon. He accepts sitting on the floor with the stranger for a few moments but is not really interested in the toys. He goes to the chair near the door. He returns to the playmate and shows her the spoon. He shows her the phone that he had played with when his mother was in the room. He crawls back to the door and again to the mat. He pushes the truck that he had earlier shown to his mother but in a listless disorganised way. He looks at the door repeatedly.



In the second reunion once again there is initially little recognition. He does look up at her and smile for a moment. This is reciprocated by the mother. There is no vocalising. He turns away. He goes to a chair and she mimics his sigh again, synchronously. He goes over to a chair to stand up. His mother reaches out towards him as an invitation to proximity. He offers her the spoon and comes over to her. He is vocalising pleasure as he approaches. He stands on his toes, and she contingently and warmly picks him up. He sits on her lap and indicates the door; she reciprocally comments on. She quite quickly puts him back on the floor, but he coos with apparent pleasure. He continues to hold a spoon. Mother joins him on the floor. There is an attempt at reciprocal play with the truck. There is obvious pleasure in the interaction but not real delight. There does not appear to be reverie, the state described by British Psychoanalyst Bion where the mother and infant are fully and mutually involved with one another.

He has been able to use his mother as a secure base to explore, and has been able to indicate his need for comfort. However, the affective tone is generally restricted and vocalisations similarly restricted. He has been able to use the stranger as an alternative when only she was available, and his need for connection was extreme due to the absence of his mother. He seemed to use the green spoon as a transitional object and a vector to communicate his experience of loss and reunion. The attachment appears to be secure, however there is a generally avoidant style to this with restricted responses to reunion.

### **Attachment Styles**

In Ainsworth's original sample, 70% of dyads showed secure attachment. Children who are securely attached show an ability to leave their mother and to play independently. They will be distressed when she leaves but are likely to be able to make use of the stranger for some comfort, although they should show some reservation. The secure child will be uninhibited in the reunion with the mother and settle quickly to play.

Children with preoccupied (resistant / ambivalent) attachment comprised 15% of Ainsworth's sample. The behaviour seen may include struggling to separate and play independently, particularly after the reunion. The child will show obvious distress on separation, may show fear of the stranger and struggle to find any comfort with the stranger, and will approach the mother on reunion but reject the contact with her.

Children with avoidant attachment may appear to be overly independent. They may appear as if they are not troubled by the separation, and may lack an obvious reaction to the reunion. However, we know from the research that these infants are physiologically stressed by the separation, but they do not indicate this in their behaviour.

All three of these attachment styles (secure, ambivalent and avoidant) are organised to facilitate maximum proximity, given the carer's own attachment style and, strengths and vulnerabilities.

The fourth style of attachment is so called Disorganised Attachment, which is understood as indicating a pattern of attachment that stems from the infant / caregiver relationship having been prone to disruption and unpredictable emotional experiences. This has been associated with Borderline Personality. It could be argued that this is where the child is very highly organised around the mother's behaviour, which may be unpredictable, and can be frightening to the child. Alternatively, the mother can be frightened of the relationship with the child. Conflicting behaviour of 'approach and avoid' will be seen. On reunion, a child with disorganised attachment may initially seek proximity, but then may run away or seem frightened or even attack the parent.

Attachment relationships are reciprocal, and the mother's behaviour will be complementary to the child's. In fact, it is the mother's attachment style, her comfort with separation and her comfort with closeness which will be mirrored in the child's behaviour and expectations of the relationship. Attachment relationships are mutually regulating. Attachment style of the infant can be predicted with 85% accuracy by the attachment style of the parent.

## Evaluating the Relationship

In evaluating the relationship between a small child and the mother the observer notices the following:

### Behaviour:

In relation to one another, such as body position in relation to own body parts and in relation to the 'other', muscle tone and any changes in this, activity including in particular if this is towards or away from each other and at what times movement occurs, contact, and the quality of this, the infant's state (e.g. tiredness).

- Is the behaviour **RESPONSIVE**, high responsiveness might be shown in the baby's response to encouragement by the mother?
- Is the behaviour **CONTINGENT**, the reaction being in keeping with the other's action?
- Is the behaviour **RECIPROCAL**, with appropriate turn taking and responsiveness to the interest shown?
- Is the behaviour **SYNCHRONISED**, appears to be coordinated, occurring at the same rate?
- Do they **MIRROR** each other's behaviour?
- Do they **SEEK PROXIMITY** and how do they communicate this to each other. If the baby is held, does his body mould comfortably to the mother or not?
- Are they responding in a **SENSITIVE** way to each other, or does it appear that communications are missed?

### Visual Interaction:

- Do infant and parent look at each other, **GAZE**, how often, in what situations / prompts?
- What is the other persons response, do they have a 'light in their eyes', does this change when they are looking at the other?
- How long do they sustain eye contact? When do they look away?

### Vocal Interactions:

- Amount, tone, prosody, developmental level, reciprocity, relationship to affective state and position to other.
- Does the mother '**MARK**' her baby's experience by putting his experience into words using a higher pitched voice e.g. 'baby talk'?

### Affect Tone:

- What is the affective tone of the interaction, how is this evidenced in facial expression, movements, proximity?
- Is there **WARMTH** in the interaction? Is affect experienced **MUTUALLY**?
- Is there **REVERIE**, the condition described by Bion when the mother and baby are mutually and fully engaged in being together?
- Does the mother mirror the affect of the baby with her facial expression or gesture, and does she mark this with a slight exaggeration, in contrast to the more natural display of her own affect? It is through this marked mirroring that the baby comes to recognise his own affective experience, and can come to understand the causes and effects of affective experience, and how to communicate this with others.

### Depth of Interaction:

- Are the behaviour, vocalisation and gaze attuned?
- Does the caregiver perceive, make sense of and respond in a timely manner to the actual moment to moment signals sent by the child?
- What is the intensity of the affect, including joy, in the interaction?
- What is the intensity of the interaction?

### Parental Reflective Capacity:

- To what extent does the parent have this capacity? Is it consistent or do current factors appear to influence this?

### Infant Reactivity:

- How does the infant respond to their parent?
- How does this compare to their responses to other significant people in their life, and how does it compare to their reaction to you and to other professionals?
- Does he seem to respond in an uncomplicated way, cuing directly what he wants or needs?

### Risk:

- Is anything that you observe raise concerns for the safety of the baby, e.g. dangerous environment, significant parental lack of awareness of infant, misinterpretation of cues or anger in parent directed toward child?

There is a great deal of stigma towards mothers with schizophrenia. It has been reported that approximately 50% of mothers with schizophrenia lose custody of their children (Seeman 2012). A study in London identified that 63% of women with psychosis were parents. A study in Canada showed that 83% of parents with schizophrenia were not living with their children, although this figure included fathers and mothers, so is probably higher than it would be for mothers alone. Mothers with serious mental illness often fear that schizophrenia is equated with parental incompetence, neglect or violence. Ackerson has commented that parents with a diagnosis of psychosis are victimised twice, first by illness and then by protective removal of their children.

This perception can lead a mother to fear seeking help at times that they may need it. Removal of a child from a parent that they are attached to is a traumatic event for any child, as well as traumatic for the parent. Women who are parents are usually very often motivated to make changes in their lives on behalf of their children, and to ensure that they are able to be the best parents that they can be. Issues such as compliance with medication, self-monitoring and recognition of early signs of relapse, abstaining from drugs and alcohol, engagement with services and capacity to keep the child's real needs in mind, developing a crisis plan, making use of parenting resources.

At times it may be necessary to provide assistance with other domestic stresses, such as financial matters and housing in order to support the mental health of a parent. The presence of an engaged supportive family is very protective. The child's father and grandparents can provide supplementary attachment relationships, can provide respite and assist to ensure the mother gets adequate sleep, and can be engaged with services to help monitor the mother's mental health.

There have been deficits in parenting documented in mothers who suffer from psychiatric illness, and the quality of the interaction can be impaired particularly if the mother has difficulty in recognising the infant's cues. Of course active illness can impair sensitivity to cues. However in a well mother with schizophrenia, there may still be deficits in recognising, assessing and experiencing emotions. This could be related to negative symptoms of schizophrenia, and is consistent with the neuropsychological profile of someone with schizophrenia. Sedating medication could also contribute to the mother being less sensitive to emotional cues of an infant. Of course people diagnosed with schizophrenia are a very heterogeneous group with regard to negative symptoms.

People earlier in the course of illness and with a less severe illness, and with good premorbid personality functioning are likely to do better with regard to emotional functioning. Parents who do have difficulties in recognising babies cues may do well with programmes that address these problem which are available in the community, such as Circle of Security parenting courses or similar, or in home support or other one-on-one parenting coaching.

### 3.3 The Standard Required

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

**Achieves 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 medicolegal 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.

**Domain Not Addressed** – 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 Gemma Brown, a social worker who has recently joined a child protection team in a country town (population approximately 2500) called York, which is about 100 km away from Perth. This is your first job after graduating from university with a degree in Social Work.

You are meeting a consultant psychiatrist for a secondary consultation (a process where the psychiatrist discusses a case with you but does not meet with the client personally). Your team has undertaken and filmed an assessment of a child Charlie (aged 14 months) with his mother (Rhianna Armstrong) in a process called the 'Strange Situation'.

The 'Strange Situation' process is a structured, observed and videoed process (usually over 20 minutes) where the mother and child enter a playroom, and are asked to play together. After a few minutes, they are joined by a stranger. After a few minutes, the mother leaves the room. The child is left with the stranger. A few minutes pass, the mother then returns and later the stranger leaves. The quality of the interaction is observed by a team of health professionals, looking for the child's capacity to use the mother as a secure base for exploration, and the mother's ability to provide security for her child.

The consultant psychiatrist that you are meeting has watched the video. You want to understand the significance of the behaviour observed in the video. You would like to know how they would describe what is seen in the video. You would like to know how to use this knowledge in planning for managing this case.

You have not worked with psychiatric patients previously, and you come with a strongly biased view that anyone with schizophrenia is not likely to be a safe and suitable parent. You are not convinced that she will manage, and are concerned that Rhianna should not be supported to live independently with her son. The community knows that people with mental illness and substance use cannot really be trusted to look after themselves without lots of support.

#### Regarding Rhianna and Charlie:

Rhianna is a 22-year-old single mother of Charlie, a 14-month-old boy. You have not met Charlie's dad, and have been told that he is not involved in the child's care. He was someone she met and dated briefly while he was on a backpacking holiday in WA, and was living in the area for a few weeks. He has now returned to Germany.

Rhianna grew up in the town of York, and is the only child of Robert and Mary Armstrong. She and Charlie currently live in their home. They are a nice, solid couple who care deeply for their daughter and grandson, and the Child Protection Service have had no concerns while they have been living together. However, Rhianna now wants to move to her own home with Charlie, and so the concerns about his welfare have been raised.

Rhianna was diagnosed with schizophrenia when she was 18 years old. At the time, she used marijuana and alcohol quite regularly, and was not very good about taking her medicines. She has had two admissions to hospital in the two year of her illness. She then did well for a period of time, and took her medicines regularly (you are unsure what the name of the tablets are).

Once she discovered she was pregnant, she went to her family doctor (GP) who advised her to stop her medicines as he was unsure what effect it would have on her child. Within a few weeks, she became unwell again and was readmitted to hospital, and restarted on medicines. After that she has remained well. She also stopped smoking and using marijuana since that time.

It is because of her mental health and drug use that Child Protection was involved since before Charlie's birth. Given that Rhianna has continued to live with her parents, that she is well and seems to be coping and that Charlie has appeared to be a happy baby, no action has been taken so far. However, you know that people with mental illnesses, especially schizophrenia, can be unpredictable and dangerous. You want to make sure that Rhianna is capable of caring for her child, and this assessment is one of the precautions you are taking.

Rhianna does not have a regular psychiatrist, and you do not know the name of the medicines she is on. She sees her GP regularly, and he monitors her health and prescribes her medicines.

At present, she appears well and healthy. She is not presently smoking, drinking alcohol or using drugs. She does not have a boyfriend.

She gets some benefits from the government, and her parents are financially comfortable and are happy to help her out with the rent, and buying things for the child.

She completed school till Year 12, and did ok but did not go to university as she became unwell.

#### 4.2 How to play the role:

Casual working clothes. You are earnest and curious about how to understand the client and his mother.

#### 4.3 Opening statement:

*'Hello Doctor, I don't really understand what this video is about. Can you tell me a bit more?'*

#### 4.4 What to expect from the candidate:

The candidate should describe the behaviour seen in the video with reference to how the baby uses the mother as a secure base to explore the world, and a safe haven to come back to when he needs a 'top up' of a sense of connection to her. The candidate should be looking for times that the baby seeks proximity and comes closer to her, and times he moves away. The candidate should comment on how and when they look at each other. The candidate should comment on whether they seem to be sensitive to each other, whether they take turns in the interaction, whether the mother uses 'baby talk' to give a voice to the baby's experience. The candidate should describe moments in the video when there was delight in the interaction, and should pay particular attention to the child's behaviour when the mother leaves and the reunion.

The candidate should also address your beliefs that a person with mental illness cannot look after a child independently.

#### 4.5 Responses you MUST make:

*'What do you see that is most worrying?'*

*'Can you elaborate on the different types of attachment?'*

*'Is it really okay for Charlie to be brought up by someone who is mad?'*

*'Will he be able to be normal and make friends?'*

#### 4.6 Responses you MIGHT make:

*'What do you see that is good?'*

*'What should I look out for to identify secure or insecure attachment?'*

*'What shall we do to help them?'*

#### 4.7 Medication and dosage that you need to remember:

None.

## STATION 1 – MARKING DOMAIN

### The main assessment aims are:

- Observe and describe the behaviour of a mother-infant dyad in the 'Strange Situation' procedure, and identify the attachment style of the dyad.
- Demonstrate an understanding of categories of attachment and behaviours that could be observed, supporting each diagnosis.
- Listen to the concerns of a junior child protection worker, and educate her about attachment theory; addressing the perceived stigma against this mother who has schizophrenia.
- Suggest interventions that can be put in place to support the mother and her child.

### Level of Observed Competence:

#### 1.0 MEDICAL EXPERT

#### 1.12 Did the candidate communicate the interactions observed in the 'Strange Situation' video appropriately and accurately? (Proportionate value – 30%)

##### **Surpasses the Standard (scores 5) if:**

communicates findings in a sophisticated manner; is able to interpret the individual interactions and put them in the context of the wider clinical situation.

##### **Achieves the Standard by:**

correctly communicating results in suitable language, with appropriate detail and sensitivity; reflecting any limitations and value of the examination; succinctly conducting presentation with accurate use of descriptive terms; commenting on behaviour, vocalisation, gaze, proximity seeking or avoidance of proximity and contact between the dyad; including appropriate positive and negative findings.

To achieve the standard (**scores 3**) the candidate **MUST:**

a. Focus on attachment in the description of the observed behaviour of the dyad.

**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):**

scores 2 if the candidate does not meet (a) above, or has omissions that would detract from the overall quality response.

##### **Below the Standard (scores 1):**

scores 1 if there are significant omissions affecting quality; inability to synthesize information in a coherent manner, incorrectly interprets observed behaviour.

##### **Does Not Address the Task of This Domain (scores 0).**

1.12. Category: FORMULATION - Communication	Surpasses Standard	Achieves Standard			Below the Standard		Domain Not Addressed
ENTER GRADE (X) IN ONE BOX ONLY	5 <input type="checkbox"/>	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	0 <input type="checkbox"/>	

#### 1.9 Did the candidate formulate and describe relevant diagnosis / differential diagnosis? (Proportionate value – 25%)

##### **Surpasses the Standard (scores 5) if:**

demonstrates a superior performance; appropriately identifies the limitations of a single observation in making an accurate assessment; discusses deficits in emotional processing in women with schizophrenia, and how this may impact on parenting.

##### **Achieves the Standard by:**

demonstrating capacity to integrate available information in order to formulate a diagnosis / differential diagnosis; adequate prioritising of conditions relevant to the obtained history and findings; including communication in appropriate language and detail in communicating with the health worker; recognising that the child does look to the mother for support and is distressed at separation, he does seek proximity with the mother and she welcomes this, even though she quickly encourages him to go and explore rather than waiting for him to cue this.

To achieve the standard (**scores 3**) the candidate **MUST:**

a. Identify a generally secure attachment with some avoidant features.

**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):**

scores 2 if the candidate does not meet (a) above, or has omissions that would detract from the overall quality response.

##### **Below the Standard (scores 1):**

scores 1 if there are significant omissions affecting quality; inaccurate or inadequate conclusions; errors or omissions are significant and do materially adversely affect conclusions.

##### **Does Not Address the Task of This Domain (scores 0).**

1.9 Category: DIAGNOSIS	Surpasses Standard	Achieves Standard			Below the Standard		Domain Not Addressed
ENTER GRADE (X) IN ONE BOX ONLY	5 <input type="checkbox"/>	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	0 <input type="checkbox"/>	

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**6.0 SCHOLAR**

**6.6 Did the candidate explain the relevant terminology correctly according to current critical understanding? (Proportionate value – 15%)**

**Surpasses the Standard (scores 5) if:**

provides a well-structured approach and systematically works through the process; recognises the opportunity that teaching and learning present; refers to the Adult Attachment Interview.

**Achieves the Standard by:**

communicating at a level and in a manner appropriate to the training of the social worker; allowing the social worker time to respond to the information provided; highlighting differences between various attachment styles; elaborating on how to recognise the different categories of attachment; providing examples or referring back to the behaviour observed in the video; referring to relevant resources.

To achieve the standard (scores 3) the candidate **MUST:**

- a. Explain all four categories of attachment.

**A score of 4** may be awarded depending on the depth of information provided; if the candidate includes most or all correct elements.

**Below the Standard (scores 2):**

scores 2 if the candidate does not meet (a) above, or has omissions that would detract from the overall quality response.

**Below the Standard (scores 1):**

scores 1 if there are significant omissions affecting quality; does not apply any structure to their approach; does not see provision of learning opportunities as part of their role.

**Does Not Address the Task of This Domain (scores 0).**

6.6. Category: MEDICAL TERMINOLOGY	Surpasses Standard	Achieves Standard		Below the Standard		Domain Not Addressed
ENTER GRADE (X) IN ONE BOX ONLY	5 <input type="checkbox"/>	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	0 <input type="checkbox"/>

**5.0 HEALTH ADVOCATE**

**5.2 Did the candidate appropriately seek to address stigma? (Proportionate value - 15%)**

**Surpasses the Standard (scores 5) if:**

recognises the important role of psychiatrists in addressing stigma; reflects on personal behaviours that increase stigma.

**Achieves the Standard by:**

demonstrating the capacity to: identify the impact of cultural beliefs and stigma of mental illness on patients, families and carers; apply principles of prevention, promotion, early intervention and recovery to clinical practice; recognise the role of staff in the generation and maintenance of stigma; constructively address competing attitudes towards mental health; explain other protective factors available for the mother and baby, such as engagement with psychiatric and parenting services; engage with family supports; be compliant with medication; gain insight as to the need for treatment and early signs of possible relapse; recognise the importance of abstaining from drugs and alcohol.

To achieve the standard (scores 3) the candidate **MUST:**

- a. Advocate for the mother who is providing good enough care for her child.

**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):**

scores 2 if the candidate does not meet (a) above, or has omissions that would detract from the overall quality response.

**Below the Standard (scores 1):**

scores 1 if there are significant omissions affecting quality; limited capacity to identify impact of stigma on wellbeing of people with mental illness; does not actively seek to address stigma.

**Does Not Address the Task of This Domain (scores 0).**

5.2. Category: ADDRESSING STIGMA	Surpasses Standard	Achieves Standard		Below the Standard		Domain Not Addressed
ENTER GRADE (X) IN ONE BOX ONLY	5 <input type="checkbox"/>	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	0 <input type="checkbox"/>

**1.13 Did the candidate formulate and describe a relevant initial management plan? (Proportionate value - 15%)**

**Surpasses the Standard (scores 5) if:**

provides a sophisticated link between proposed interventions and key issues identified; recommends referral of the mother to specific programmes to assist her parenting capacity, such as Circle of Security therapy programme or Circle of Security parenting course; clearly addresses difficulties in the application of any interventions.

**Achieves the Standard by:**

demonstrating the ability to prioritise and implement evidence-based interventions; recommending psychiatric services monitor maternal mental state and treatment compliance; integrating child and family focussed services to promote maternal parenting capacity and child wellbeing monitoring; recognising the significant supportive role of family / close supports, recognising of their role in effective interventions; identifying potential barriers; recognising the need for consultation / referral / supervision.

To achieve the standard (**scores 3**) the candidate **MUST:**

- a. Ensure clarification of the level of involvement of the father.

**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):**

scores 2 if the candidate does not meet (a) above, or has omissions that would detract from the overall quality response.

**Below the Standard (scores 1):**

scores 1 if there are significant omissions affecting quality; errors or omissions will impact adversely on support for the dyad; recommended interventions lack structure or are inaccurate; plans not tailored to dyad's immediate needs or circumstances.

**Does Not Address the Task of This Domain (scores 0).**

1.13. Category: MANAGEMENT - Initial Plan	Surpasses Standard	Achieves Standard		Below the Standard		Domain Not Addressed
ENTER GRADE (X) IN ONE BOX ONLY	5 <input type="checkbox"/>	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	0 <input type="checkbox"/>

## GLOBAL PROFICIENCY RATING

Did the candidate demonstrate adequate overall knowledge and performance at the level of a junior consultant psychiatrist?

<b>Circle One Grade to Score</b>	<b>Definite Pass</b>	<b>Marginal Performance</b>	<b>Definite Fail</b>
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