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**1.0 Descriptive summary of station:**

The candidate is expected to empathetically assess a refugee woman presenting with Medically Unexplained Symptoms (MUS) in the form of a Conversion Disorder with unconscious collapses, and inability to weight-bear. This was precipitated in context of acute chronic back pain following a relatively minor real injury, against a background of some depressive symptoms, and multiple psychosocial stressors. The case also illustrates some of the difficulties encountered by the refugee population. The candidate is expected to provide a diagnosis, and an explanatory model for her symptoms, before suggesting possible treatment options.

**1.1 The main assessment aims are to:**

- Empathetically undertake a focussed assessment of Medically Unexplained Symptoms, in order to demonstrate an understanding of potential predisposing, precipitating and perpetuating concerns, whilst taking other psychiatric co-morbidities into account.
- Provide a diagnosis and coherent explanatory model for the patient in order to provide a link between psychosocial factors and physical symptoms.
- Demonstrate an awareness of treatment modalities including a MDT (multi-disciplinary team) patient-centred approach, as well as specific options including psychological treatment (like CBT or ACT) and antidepressants.

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

- Validate the patient's distress through direct assertion that the symptoms are real in order to facilitate engagement.
- Accurately make a diagnosis of Conversion Disorder / Functional Neurological Symptom Disorder as the primary diagnosis.
- Use a model to link the somatic symptoms to the relevant psychosocial stressors.

**1.3 Station covers the:**

- **RANZCP OSCE Curriculum Blueprint Primary Descriptor Category:** Other Disorders (DSM-5: Somatic Symptom and Related Disorders)
- **Area of Practice:** Consultation Liaison
- **CanMEDS Marking Domains Covered:** Medical Expert, Communicator
- **RANZCP 2012 Fellowship Program Learning Outcomes:** Medical Expert (Diagnosis; Management – Therapy), Communicator (Patient Communication – To Patient)

**References:**

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Committee for Examinations  
Objective Structured Clinical Examination  
Station 6  
Perth September 2019



**1.4 Station requirements:**

- Standard consulting room.
- Four chairs (examiner x 1, role player x 1, candidate x 1, observer x 1).
- Laminated copy of 'Instructions to Candidate'.
- Role player: female aged 23 to 35.
- Pen for candidate.
- Timer and batteries for examiners.

## 2.0 Instructions to Candidate

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

You work as a junior consultant psychiatrist in a suburban mental health service, and are providing cover for your colleague doing Consultation-Liaison psychiatry. You are about to see the following patient who has been referred from one of the medical teams:

*Dear colleague,*

*Thank you for seeing Zara, a 32-year-old woman, to consider for transfer to the psych ward.*

*Admitted 2 weeks ago to the medical ward with acute lower back pain, and now claims she cannot walk. She also started to have unresponsive episodes.*

*No cause has been found and all investigations including routine bloods, MSU, MRI Brain and EEG have been normal. MRI of the Back did show L4 / L5 disc bulging with possible impingement of the right L4 root.*

*Neurology and Neurosurgery suggested conservative management only, and pathology on scan, and clinical findings are not able to explain current symptoms.*

*We feel it is behavioural, and she is not participating in rehab; she cries when the physiotherapist tries to work with her.*

*? Personality disorder ? Depressed and needs treatment.*

*With thanks*

Your tasks are to:

- Take an adequate history to enable you to formulate her presentation in order to make a diagnosis.
- Explain your diagnostic opinion **to the patient** by providing an explanatory model to help her understand her situation.
- Suggest possible treatment options.

**You are not required to examine the patient.**

## Station 6 - Operation Summary

### Prior to examination:

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

### 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 role player has prompts to use to keep to the aims.
- If the candidate asks you for information or clarification say:  
***'Your information is in front of you – you are to do the best you can.'***
- At **eight (8) minutes**, as indicated by the timer, the final bell will ring. Finish the examination immediately.

### At conclusion of examination:

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

### If a candidate elects to finish early after the 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.

There are no prompts.

The role player opens with the following statement:

***'I am so frustrated. Nobody seems to believe me.'***

#### 3.2 Background information for examiners

In this station, the candidate is expected to demonstrate the ability to empathetically do a focussed and patient-centred assessment of Medically Unexplained Symptoms (MUS) in a female refugee. The patient presents in context of a two-week hospital stay, with an inability to walk and recurrent unresponsive episodes not accounted for by underlying pathology after extensive investigation.

The onset of symptoms followed an actual injury (spinal disc herniation, annular tear, nerve root compression) obtained whilst bending to pick up her baby. This is a very common mechanism of injury for mothers with infants given the laxity of ligaments post-partum, and also the repetitive lifting required with infants.

The injury occurred in context of some background depressive and numerous psychological stressors including difficulty passing the citizenship test (denying her a sense of permanency, security and belonging), as well as ongoing distress about her loved ones scattered around the world with little prospect of reuniting. It is clear that she is struggling with the demands of parenting five children on her own with no other supports, and being fairly isolated in the community. There are financial stressors, and also heightened anxiety about the implications of her injury resulting in her being incapacitated, with her husband being unable to get to work, and being at risk of losing their source of income; she also has an underlying fear that if she is unable to perform her duties at home, he will divorce her. A sense of being dismissed, not believed and not listened to by medical professionals are further acting to perpetuate the situation.

It is expected that a successful candidate will elicit sufficient information to be able to formulate this problem and to establish a diagnosis of Conversion Disorder, in the context of understanding the predisposing, precipitating and perpetuating factors leading to the current presentation. The process of engagement of the patient is important so as to not contribute to the patient's sense of not being listened to or not being believed by medical professionals with a dismissal of her symptoms. The candidate will be expected to explain the diagnosis in easy to understand language to the patient, and should include validating the reality of the symptoms and distress experienced by the patient, and reassuring the patient that it is not uncommon to be unable to find an exact cause for symptoms. The candidate is asked to provide an explanatory model linking behavioural, psychological, and emotional factors to the onset and / or exacerbation of somatic symptoms. A patient-centred approach with the aim of strengthening the patient-doctor relationship by listening carefully to the patient's presentation and concerns, validating concerns through direct assertion that the symptoms are 'real', exploring psychological cues and responding to emotions should be followed.

A positive stance with regards to recovery and the expectation of a full return to function is important, and the candidate is expected to have some knowledge of specific treatment modalities including the use of SSRI's in MUS, especially where there are underlying depressive symptoms, as well as Reattribution strategies, CBT, short term dynamic psychotherapy, mindfulness based interventions, and the importance of practical supports (for example around child care, finances), and rehabilitation.

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

- Validate the patient's distress through direct assertion that the symptoms are real in order to facilitate engagement.
- Accurately make a diagnosis of Conversion Disorder / Functional Neurological Symptom Disorder as the primary diagnosis.
- Use a model to link the somatic symptoms to the relevant psychosocial stressors.

A surpassing candidate may also identify underlying depressive symptoms, and will show a sophisticated understanding of more than one explanatory models for MUS enabling linkage between MUS and psychological stressors. The candidate will also establish sophisticated connections between a family history of vague somatic symptoms (her sister with recurrent abdominal pain), as well as her own history of chronic headaches with a psychosomatic component, and her current situation when helping the patient to make sense of her presentation. The process of empathetic engagement and validating the patient's distress will be exemplary and may include exploration of the meaning of the symptoms from the patient's perspective.

## **Background:**

### **Context**

At the dawn of the psychoanalytic era, Breuer and Freud developed the concept of 'conversion', a process whereby intra-psychic activity putatively brings about somatic symptoms. Their work introduced the idea of early emotional trauma or intra-psychic conflict as the cause of physical symptoms, and an unconscious form of communication. Medically unexplained symptoms, including Conversion Disorder, remains one of the most puzzling phenomena encountered by health care providers.

Medically Unexplained Symptoms (MUS) are considered an important problem in primary care (between 25% and 50% of primary care patients present with MUS), as well as in specialist clinics where prevalence rates of 53%, 42% and 32% in gastroenterology, neurology and cardiology respectively have been shown. They account for a high consumption of healthcare resources, and often result in frustration for both physicians (feeling disempowered, inadequate and irritated), and patients (feeling disbelieved and not taken seriously). About half of all patients with MUS also suffer from depressive and anxiety disorders.

In general, the literature suggests that MUS are more common in women, young subjects, patients from low socio-economic status, and possibly in patients with poor educational achievement. A background of family dysfunction, trauma or abuse is often associated with MUS. The role of ethnicity is unclear and prevalence vary across countries in an inconsistent pattern.

MUS have been linked with disorders of affect regulation, specifically alexithymia where difficulty in identifying feelings, and distinguishing between feelings and bodily sensations, difficulty describing feelings and an externally focussed cognitive style is present. Somatic symptoms are traditionally thought of as 'idioms of distress', and often seen as the bodily expression of depression and / or anxiety, although this view tends to be simplistic and inadequate.

Prognostically, a significant proportion of patients have a poor outcome with between 50% and 75% of patients improving over time regardless of intervention, but up to 30% of patients deteriorating. The amount of MUS at baseline predicts the outcome with especially more than five symptoms associated with significantly increased morbidity, and physical disability over time. Studies evaluating expectations of patients with MUS suggest that rather than looking for medical treatment, these patients seek support, a convincing explanation (rather than just reassurance and normalisation based on negative test results), emotional support and reassurance. Interestingly inappropriate medical interventions contributing to the risk for iatrogenic harm is more often than not physician driven, rather than by the patients.

### **Management**

At the centre of addressing the notion of MUS (and in this case the Conversion Disorder as an example thereof), stands the doctor-patient relationship with the 'Assessment' being already part of any intervention, exploring predisposing, precipitating and perpetuating factors, with this following a patient-centred approach characterised by listening carefully to the patient, exploring the patient's belief systems around the symptoms and – very importantly – validating the patient's concerns through direct assertion that the symptoms are real, and exploring emotional cues around that. Doctors should reiterate familiarity with the symptoms / condition and practical advice regarding interventions around any disability or addressing stressors (e.g. physiotherapy, social interventions etc.), creating an expectation of recovery, and encouraging an eventual return to normal activity, and coping with symptoms that may wax and wane, are all helpful.

Following from that, reattribution (providing clear explanations that link physical to psychological issues) with a goal of broadening the agenda beyond physical symptoms and negotiating further treatment, is important. In this regard, various explanatory models for MUS have been described, including:

<b><i>Somatosensory Amplification theory</i></b>	Initially developed for hypochondriasis and later adjusted for MUS, suggests that when a physical sensation arises, patients focus attention on this and as a consequence develop certain cognitions and attributions which further amplify the perception of physical signals, becoming a vicious circle in a way that the symptoms are reinforced by the patient's thoughts and concerns.
<b><i>Sensitisation theory</i></b>	Repeated pain experiences and symptoms lead to memory traces at a neuronal level increasing sensitivity for future stimulation. This results in benign stimuli being perceived as pain. For MUS wider memory complexes may play a role activated by single symptoms and resulting in various physical symptoms.
<b><i>Sensitivity theory</i></b>	Certain individuals are more vulnerable due to personality traits, such as neuroticism and negative affect. Early childhood traumatic experiences and insecure attachment play a role in these vulnerabilities.
<b><i>Immune System Sensitisation theory</i></b>	Early life stressors lead to sensitisation of the immune system resulting in MUS. Normally, the brain cytokine system is activated by the immune system which mediated the subjective, behavioural and physiological components of illness (leading to the sick role). However, if the immune system is sensitised, it reacts to non-immune stimuli too, reacts faster and is less likely to shut down again once the initial stimuli has been eliminated. This results in chronic immune activation with cytokine production and feeling sick.
<b><i>Endocrine Dysregulation theory</i></b>	Based on the stress model, according to which stress in early life leads to dysregulation of the hypothalamo-pituitary-adrenal axis and hypercortisolemia, frequently present in patients with MUS.
<b><i>Signal Filter theory</i></b>	The sensory noise from various parts of the body is not filtered by the brain, and results in overstimulation from physiological processes and external processes, and as a result a large number of physical sensations are experienced and increased, manifesting as MUS.
<b><i>Illness Behaviour theory</i></b>	Patients' behaviour is influenced by their beliefs and affects physiology and symptoms, resulting in a vicious circle and maintaining symptoms. Avoidance of activity results in more symptoms.
<b><i>Autonomic Nervous System Dysfunction theory</i></b>	Proposes a dysfunctional autonomic system, where after a mentally distressing task the heart rate activity does not decrease as normally would happen, resulting in longer term increased heart rate and stress burden.
<b><i>Abnormal Proprioception theory</i></b>	Increased or abnormal proprioception in patients with MUS leading to even small benign physiological sensations being interpreted as signs of physical disease.
<b><i>Cognitive Behavioural Therapy model</i></b>	This is a meta-model incorporating aspects of sensitivity, sensitisation, somatosensory amplification, endocrine dysregulation and illness behaviour models. It proposes a self-perpetuating vicious circle taking into account genetics, early life experiences, the HPA axis dysregulation, attention bias and response to illness.

Collaborative care between health care professionals and a multi-disciplinary team approach is helpful, in particular with regards to a rehabilitation focus, and the use of physiotherapy and occupational therapy input and an expectation of recovery. Iatrogenic harm through excessive medical investigations and interventions should be guarded against, and communication between medical professionals is essential. Co-morbid depression / anxiety should be identified and addressed.

Psychological interventions with some evidence include CBT, which result in modest improvements although outcomes are limited by patient and symptom heterogeneity. Common aspects of CBT include systematic relaxation training, psycho-education, and exploring of dysfunctional beliefs regarding the symptoms, followed by problem solving / coping skills training.

Integration of mindfulness approaches and ACT (acceptance and commitment therapy) are increasingly shown to be helpful.

The use of SSRIs has been shown to be helpful regardless of underlying symptoms of depression or not, and should be considered as part of any intervention. The evidence base for other antidepressants is less robust, although also thought to be helpful regardless of class; a mild side effect profile is desirable though to avoid further somatic symptoms arising.

The candidate is expected to demonstrate sensitive consideration of barriers to implementation of any interventions - especially practicalities around childcare, poor mobility; identification of role of other health professionals in regard to ongoing rehabilitation and the social / financial stressors.

**DSM-5 diagnostic criteria for Functional Neurological Symptom Disorder (300.11):**

- A) The patient has at least one symptom of altered voluntary motor or sensory function.
- B) Clinical findings provide evidence of incompatibility between the symptoms and recognised neurological or medical conditions.
- C) The symptom or deficit is not better explained by another medical or mental disorder.
- D) The symptom or deficit causes clinically significant distress or impairment in social, occupational, or other important areas of functioning or warrants medical evaluation.

Specify type of symptom or deficit as:

- With weakness or paralysis
- With abnormal movement (e.g. tremor, dystonic movement, myoclonus, gait disorder)
- With swallowing symptoms
- With attacks or seizures
- With amnesia or memory loss
- With special sensory loss symptoms (e.g. visual blindness, olfactory loss, or hearing disturbance)
- With mixed symptoms.

Specify if:

- Acute episode: Symptoms present for less than six months
- Persistent: Symptoms present for six months or more.

Specify if:

- Psychological stressor (conversion disorder)
- No psychological stressors (functional neurological symptom disorder).

**ICD-10 diagnostic criteria for dissociative (conversion) disorders (F44):**

The common themes that are shared by dissociative or conversion disorders are a partial or complete loss of the normal integration between memories of the past, awareness of identity and immediate sensations, and control of bodily movements.

All types of dissociative disorders tend to remit after a few weeks or months, particularly if their onset is associated with a traumatic life event. More chronic disorders, particularly paralysis and anaesthesias, may develop if the onset is associated with insoluble problems or interpersonal difficulties. These disorders have previously been classified as various types of 'conversion hysteria'. They are presumed to be psychogenic in origin, being closely associated in time with traumatic life events, insoluble and intolerable problems, or disturbed relationships. The symptoms often represent the patient's concept of how a physical illness would manifest. Medical examination and investigation do not reveal the presence of any known physical or neurological disorder. In addition there is evidence that the loss of function is an expression of emotional conflicts or needs. The symptoms may develop in close relationship to psychological stress, and often appear suddenly.

**F44.2 Dissociative stupor**

Dissociative stupor is diagnosed on the basis of a profound diminution or absence of voluntary movement and normal responsiveness to external stimuli such as light, noise, and touch, but examination and investigation reveal no evidence of a physical cause. In addition, there is positive evidence of a psychogenic causation in the form of recent stressful events or problems.

**F44.4 Dissociative motor disorders**

In the commonest varieties there is loss of ability to move the whole or part of a limb or limbs. There may be close resemblance to almost any variety of ataxia, apraxia, akinesia, dysarthria, aphonia, dyskinesia, seizures, or paralysis.

### 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 Zara, a 32-year-old married woman, originally from a war-torn country. You live with your husband, Mohammed, and five children (two boys and three girls) aged between five months and 10 years. You arrived as a refugee in Australia about two years ago after living in a refugee camp for 10 years.

You are currently in hospital, and the medical team have referred you to a psychiatrist because they do not believe you have a physical illness.

#### **Current situation:**

Two weeks ago (one day after you again failed the citizenship test), you bent over to pick up your 5-month-old baby daughter, and suddenly felt a sharp pain in your back going down your legs. After this, you felt a lot of pain and unable to walk or move properly. You did not want to go to the hospital initially, but then had an episode the next day where you collapsed to the ground unable to walk, and apparently did not respond to your husband – you can't remember this. He brought you to hospital where you have been since.

You have continued to be unable to walk, and despite standing up sometimes, you end up with your legs collapsing. On three occasions, you collapsed unresponsive and remember waking up after some minutes with an 'emergency team' around you on the floor. The pain has been coming and going, but with medication it has made it a bit better. The main issues now are that you still can't seem to walk, and that you 'black out'.

You had an MRI scan of your back which apparently showed that you had 'a slipped disc' in your lower back that is 'pressing on the nerves'. Lots of blood tests and a urine test have been done which you were told were 'all normal'; you also had a brain scan which was 'normal'. You have seen 'many doctors', all said 'there is nothing wrong with me', and you remember a neurosurgeon told you 'it is not that bad, just get on with it', and that they do not need to operate your back. You feel nobody believes you when you say you can't walk, and they get impatient when you don't feel you could do physiotherapy because of pain. You overheard a member of the staff make a comment that 'she's faking it' which made you cry. And now, you are upset because having to see a psychiatrist means they think you are crazy too.

You worry about your husband who had to take time off work to care for the children whilst you are in hospital. You worry he might lose his job as a result if you don't recover soon. You are still breastfeeding, and feel helpless because you can't even pick up your baby at the moment. If only you could have your sister to help you, it might have been easier - you even wondered if the doctors couldn't write to the Immigration department to ask whether she could get a visa to come and help you.

#### **Medical history:**

In terms of your back, you have had some intermittent back pain over 'a few years', but never this bad and never going down your legs or causing you not to walk. It never was bad enough for you to see a doctor. You have never had these 'black outs' or seizures (epilepsy) in the past.

You also have regular headaches – at times this can happen daily, at other times weeks can go without one. If you are asked, they are 'dull all over' and you have noticed that they seem to start when you feel stressed, or if things are not going well at home. They are worse when you feel stressed. When you are relaxed, you don't get these headaches. Your headaches have been much worse in the last few months, and have also been a bother in hospital.

You have generally otherwise been in good health, and don't normally take medication. You don't smoke and do not drink alcohol or take drugs.

#### **Psychiatric history and symptoms:**

If you are asked about any of the following: you were never diagnosed with, or treated for a mental illness, and have never seen a psychiatrist or psychologist.

In the last six months, you often lay awake worrying about the family at night. You feel a bit sad most days and often cry when you feel overwhelmed. You mostly enjoy playing with your baby and the rest of your children, and feel that you have a good bond with them, but occasionally feel you just can't be bothered. Your appetite and concentration are normal. You have never wished that you could die or thought of suicide. You don't feel worthless or guilty about anything. You just feel overwhelmed by everything. You worry about the family and the finances, but you are not normally anxious about anything else; you never have panic attacks and you are normally not shy around other people. You never have nightmares, and never think about the war or get flashbacks about your time in the camps. You never hear voices or see things that others can't; you never felt threatened or persecuted or held beliefs that other people thought were not true. You normally get along well with people, and never got into trouble with the police.

### **Your personal background:**

You left your country with your parents and family, because the village came back under the control of rebels during an insurgency. You know of many family members and friends that got killed in the war, but your life was never in direct danger. You remember the bombs falling far away, and the sound of gunshots during the war, but it was all over fairly soon when your family decided to flee the country. You met your husband in the refugee camp in a neighbouring country and got married. It was an arranged marriage but it has been a good partnership and he has been a kind, supportive and hardworking husband that has taken good care of his family through all the difficult times.

Things have been difficult for you as a family in the last two years, and re-settling in Australia was harder than expected. Your husband is doing long hours as a tiler apprentice, which is what he did previously back home, but had to retrain in Australia. You barely make ends meet on his salary, and are under financial stress. The mosque and some kind people from the local community are helping out here and there with groceries, clothes, and other support, but it is not the same as having family or close friends around. You fell pregnant again soon after you arrived in Australia, and have been mainly looking after the household and the children for the last two years. As a result, you have not had much opportunity to meet people or make new friends.

None of the rest of either of your extended families are in Australia – most of them are back in your home country, but some are still in refugee camps or in Canada and Europe. You are very happy and grateful that you could come to Australia, and have enjoyed the freedom of life here, but you miss your family, and especially your mother and older sister, and wish they could also come to Australia. Unfortunately they previously had their visa applications rejected. You worry a lot about them because you know they are struggling. You also worry about other family members left behind in your country. You are the middle of five siblings, two of whom remain in your country of birth, one who is in Canada and your oldest brother died in the war. Your father never recovered from that loss, and now has to be cared for by your mother and sister. You Whatsapp and Skype with them regularly, but it is not the same.

You have been attending English language classes, but this has been difficult because you are breastfeeding and have to take the baby with you which is distracting. You were not allowed to go to school during the war, and had to learn how to read and write as an adult which makes learning harder. You feel this is why you are finding the citizenship test so difficult. You have sat the exam five times already, and failed each time – you just seem to ‘shut down...can’t think’ when you have to do the test. You feel guilty about that and feel ‘stupid’; you worry that unless you are a citizen, the government could ‘kick me out again sometime’; you also hope that being a citizen might help you to bring your sister to Australia, and now you feel this might never happen.

### **Family history:**

You are not aware of any history of formally diagnosed mental illness in your family, but you think your father might be depressed since your brother died. You don’t know of specific medical problems in your family, but your older sister has struggled with lots of abdominal pain and seen a few doctors for it, you don’t know whether she has been diagnosed with anything.

## **4.2 How to play the role:**

Casually but modestly dressed. Initially more reserved and clearly stressed, then more spontaneous and forthcoming if you feel comfortable, reassured and being listened too. Present as cooperative but somewhat anxious, worried, and a bit depressed.

It is clear that you feel overwhelmed and isolated with no relatives in the country to support you, and you have not been here long enough to make close friends. You miss your friends and relatives from back home very much. You wish you could get your sister to come to Australia to help you with the children. You are scared that your husband might leave you if you can’t do your housework or be a good wife to him. You feel guilty because he is currently unable to work because he needs to look after the children whilst you are in hospital, and you know it will add financial strain, and worry he might lose his job. You are very worried about the citizenship exam, and worry that you will never pass it, and as such will not be able to become Australian.

## **4.3 Opening statement:**

*‘I am so frustrated. Nobody seems to believe me.’*

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

The candidate will need to explore your current symptoms and problems leading to the presentation, including the background history and psychological factors leading to your presentation. The candidate should be able to make you feel listened to and understood. The candidate is expected to provide you with a diagnosis, as well as a brief and easy to understand explanation of why this has occurred, and importantly be able to draw links between psychological distress and the symptoms occurring. They should be able to mention what treatments could be offered to help.

#### 4.5 Responses you MUST make:

*'I can't seem to walk and I black out.'*

*'Do you believe me when I say I can't walk, doctor?'*

*'Will I ever be able to walk again?'*

*'Why has this happened to me?'*

#### 4.6 Responses you MIGHT make:

If the candidate asks where you are from:

*Scripted Response: 'I don't want to talk about home.'*

If the candidate asks to, or attempts to examine you physically:

*Scripted Response: 'All those other doctors told me it won't be necessary for you to examine me again.'*

If the candidate asks what you think you need to help you get better:

*Scripted Response: 'Can't you write to immigration asking that my sister come over here; I need her here. The pain is not so bad, it's just I can't walk.'*

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

You are taking 'pain killers' since being admitted to hospital, but you can't remember which ones. They have been helpful although you still have some discomfort.

You are otherwise healthy and do not take any regular medication.

## STATION 6 – MARKING DOMAINS

### The main assessment aims are to:

- Empathetically undertake a focussed assessment of Medically Unexplained Symptoms, in order to demonstrate an understanding of potential predisposing, precipitating and perpetuating concerns, whilst taking other psychiatric co-morbidities into account.
- Provide a diagnosis and coherent explanatory model for the patient in order to provide a link between psychosocial factors and physical symptoms.
- Demonstrate an awareness of treatment modalities including a MDT patient-centred approach, as well as specific options including psychological treatment (like CBT or ACT) and antidepressants.

### Level of Observed Competence:

#### 2.0 COMMUNICATOR

##### 2.1 Did the candidate demonstrate an appropriate professional approach to gathering information from the patient? (Proportionate value - 30%)

###### **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 by:**

demonstrating a patient-centred approach by showing empathy, active and attuned listening, and the ability to establish rapport; forming a partnership using language and explanations tailored to the functional capacity of the patient taking regard of culture, gender, ethnicity etc.; sensitively managing the patient's address; communicating plans and discussing acceptability; negotiating alternatives; accommodating minor inappropriateness; recognising confidentiality and managing cognitive / cultural bias.

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

- Validate the patient's distress through direct assertion that the symptoms are real in order to facilitate engagement.

**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 materially adversely impact on alliance; inadequately reflects on relevance of information obtained; unable to maintain rapport.

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

2.1. Category: PATIENT COMMUNICATION - To Patient	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"/>	

#### 1.0 MEDICAL EXPERT

##### 1.9 Did the candidate formulate and describe the relevant diagnosis / differential diagnosis? (Proportionate value - 40%)

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

demonstrates a superior performance; appropriately identifies the limitations of diagnostic classification systems to guide treatment.

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

integrating available information in order to formulate a diagnosis / differential diagnosis; demonstrating understanding of diagnostic systems to provide justification for diagnosis and differential diagnosis; adequate prioritising of conditions relevant to the obtained history and findings; identifying co-morbid depressive symptoms; utilising a biopsychosocial approach placing the diagnosis in the context of psychosocial circumstances; identifying relevant predisposing, precipitating perpetuating and protective factors; including communication in appropriate language and detail and according to good judgment.

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

- Accurately make a diagnosis of Conversion Disorder / Functional Neurological Symptom Disorder as the primary diagnosis.

**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; the candidate is unable to explain the diagnosis / formulation to the patient in easy to understand language and / or only uses complex terminology and language.

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

scores 1 if there are significant omissions affecting quality; inaccurate or inadequate diagnostic formulation; 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"/>

**1.14 Did the candidate demonstrate an adequate knowledge and application of relevant biological / psychological / social therapies? (Proportionate value – 30%)**

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

includes a clear understanding of levels of evidence to support treatment options; demonstrates an in-depth awareness of treatment modalities; takes breastfeeding into consideration if suggesting pharmacotherapy.

**Achieves the Standard by:**

demonstrating the understanding of the importance of both psychological and pharmacological treatments especially given the depressive component; using at least one explanatory model to provide a coherent explanation of the symptoms to the patient as a therapeutic intervention; choice and rationale for specific psychotherapies as a priority; describing medication choices (SSRI), dosing and monitoring; demonstrating application of psychoeducation; considering sensitively barriers to implementation; identifying the roles of other health professionals in regards to ongoing rehabilitation and the social / financial stressors; identifying specific treatment outcomes and prognosis.

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

- a. Use a model to link the somatic symptoms to the relevant psychosocial stressors.

**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; the candidate is aware of a range of psychotherapeutic modalities.

**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 impact adversely on patient care; plan lacks structure and / or is inaccurate; plan not tailored to patient's needs or circumstances.

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

1.14. Category: MANAGEMENT - Therapy	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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