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1.0 Descriptive summary of station:

This is a short core skills station that examines the ability of the candidate to perform and present a focussed mental state examination (MSE) and clarify the findings of a MSE recorded by a junior doctor on a patient who presents with ideas of persecution, and non-psychotic hallucinations / pseudo-hallucinations, which have been incorrectly recorded as persecutory delusions, auditory and visual hallucinations respectively.

1.1 The main assessment aims are to:

- Demonstrate the ability to conduct a focussed mental state examination (MSE).
- Present and justify the discrepancies with previous MSE findings provided by a trainee.

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

- Explore thought content to clearly establish that the patient does not experience a pathological sense of persecution.
- Correctly present at least 3 of the following mental state findings: dysphoric mood / affect consisting of depression, distress or instability; absence of formal thought disorder; absence of delusions; possible non-psychotic hallucinations / pseudo-hallucinations.
- Justify their findings for disorder of thought content and perception.

1.3 Station covers the:

- **RANZCP OSCE Curriculum Blueprint Primary Descriptor Category:** Psychotic Disorders, Core Psychiatric Disorders
- **Area of Practice:** Adult Psychiatry
- **CanMEDS Marking Domains Covered:** Medical Expert, Scholar
- **RANZCP 2012 Fellowship Program Learning Outcomes:** Medical Expert (Assessment - Mental State Examination), Scholar (Application of Knowledge)

References:

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1.4 Station requirements:

- Standard consulting room.
- Four chairs (examiners x 1 role player x 1, candidate x 1, observer x 1).
- Laminated copy of 'Instructions to Candidate'.
- Role player: young woman in her early 20s, dressed in casual clothes.
- 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 are working as a junior consultant psychiatrist in a busy Emergency Department (ED) of a large general hospital, and are about to assess 22-year-old Ilana Jenkins. Ilana has recently been assessed in the ED by new first year psychiatry trainee, Dr Jason Drummond. He called and informed you that Ilana presented to ED early this morning following an argument with her boyfriend.

Dr Drummond tells you that he has diagnosed Ilana with schizophrenia, and on mental state examination she is flat in her affect, she is thought disordered, has delusions of persecution and reference, as well as auditory and visual hallucinations.

You are now going to assess Ilana in the ED.

Your tasks are to:

- Conduct a focussed assessment to clarify the phenomenology findings reported by the registrar **from Ilana**.
- Present your mental state findings in light of those reported by the trainee and justify them **to the examiner**.

You are not required to do a cognitive assessment.

Station 10 - 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 are 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 that 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:

'Doctor, I think I am ready to go home.'

3.2 Background information for examiners

In this station the candidate is expected to perform a mental state examination on the patient specifically focussing on the findings presented by the trainee. They are expected to establish the psychopathology by asking appropriate set of questions to the patient, and then present and justify their mental state examination (MSE) findings which may differ from those reported by the trainee.

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

- Explore thought content to clearly establish that the patient does not experience a pathological sense of persecution.
- Correctly present at least 3 of the following mental state findings: dysphoric mood / affect consisting of depression, distress or instability; absence of formal thought disorder; absence of delusions; possible non-psychotic hallucinations / pseudo-hallucinations.
- Justify their findings for disorder of thought content and perception.

A surpassing candidate should be able to do a focussed MSE, and demonstrate their interview skills of establishing various phenomena such as delusions, hallucinations. The candidate would be able to demonstrate their depth of understanding of phenomenology by asking appropriate questions to the patient, including carefully and sensitively challenging the persecutory beliefs. A better candidate will be able to confidently challenge the findings presented by the trainee, and give justification for their opinion.

Background:

The mental status examination (MSE) is a structured assessment of the patient's behavioural and cognitive functioning. It includes descriptions of the patient's appearance and general behaviour, level of consciousness and attentiveness, motor and speech activity, mood and affect, thought and perception, attitude and insight, the reaction evoked in the examiner, and, finally, higher cognitive abilities.

The MSE can be regarded as a psychological equivalent of physical examination. It includes both objective observations by the clinician (signs), as well the subjective descriptions provided by the patients (symptoms). However, an MSE must not be regarded as a replacement for good physical exam.

The skill in examining patient depends on a sound knowledge of how symptoms and signs are defined, and elicited. Without such knowledge, the psychiatrist is liable to misclassify phenomena, and thereby make inaccurate diagnoses (Oxford shorter textbook chapter 1).

A standard mental state examination should include the following:

1. Level of consciousness
2. Appearance and behaviour
3. Speech
4. Mood and affect
5. Thought form and content
6. Perception
7. Insight and judgement
8. Detailed cognitive examination

The level of consciousness refers to the state of wakefulness of the patient, and depends both on brainstem and cortical components. Alteration in sensorium is highly suggestive of an organic pathology.

Appearance and behaviour: It generally includes observations regarding the patient's build, posture, dress, grooming, prominent physical abnormalities, and their attitude toward the examiner (cooperative / uncooperative). It may also include comments regarding rapport and eye contact with the examiner. Patient's psychomotor activity is often described here.

Speech: Physical characteristics of speech is described here. It can be described in terms of its quantity, rate of production and quality. Speech can be rapid or slow, pressured, hesitant, emotional, dramatic, monotonous, loud, whispered, slurred, staccato or mumbled. Speech impairments such as stuttering are also included in this section. Any unusual rhythms (dysprosody) or accent should also be described here.

Mood and affect: Mood is defined as a pervasive and sustained emotion that colours the person's perception of the world. Statements about the patient's mood should include depth, intensity, duration and fluctuations. Common adjectives that can describe mood include depressed, despairing, irritable, anxious, angry, expansive, euphoric, empty, guilty, hopeless, futile or frightened.

Affect is defined as the patient's present emotional responsiveness, inferred from the patient's facial expression. It can be described under various subheadings:

- Type / quality: euthymic (normal mood), dysphoric (depressed, irritable, angry), euphoric (elevated, elated) anxious etc.
- Range: full (normal), restricted, blunted or flat. The range is often commented upon after a reasonable conversation that includes topics that would normally evoke a range of emotional responses. Lability of affect can also be commented upon in this section to describe.
- Appropriateness / Congruence: The appropriateness is assessed in the context of the subject the patient is discussing. The term inappropriate affect can be used for a quality of response in which the patient's affect is incongruent with what the patient is saying. For example, laughing while talking of a loved one's death.

Thought form: Formal thought disorder is abnormality in the mechanism of thinking described by the patient introspecting into his own process of thought; that is, the patient describes in his own words a process of thinking that is clearly abnormal to the outside observer. Types include:

- Circumstantiality: over-inclusion of trivial or irrelevant details that impede the sense of getting to the point.
- Clang Associations: thoughts are associated by the sound of words rather than by their meaning.
- Derailment / loosening of association: A breakdown in both the logical connection between ideas and the overall sense of goal-directedness. The words make sentences, but sentences do not make sense.
- Flight of ideas: A succession of multiple associations so that thoughts seem to move abruptly from idea to idea; often expressed through rapid, pressured speech.
- Neologism: the invention of new words or phrases or the use of conventional words in idiosyncratic ways.
- Perseveration: repetition of words, phrases or ideas, out of context.
- Tangentiality: replies to questions are off-point or totally irrelevant.
- Thought blocking: a sudden disruption of thought or a break in the flow of ideas.

Thought content: Disturbances in content of thought include delusions, overvalued ideas, preoccupations, obsessions, compulsions, phobias, plans, intentions, recurrent ideas about suicide or homicide, hypochondriacal symptoms, and specific antisocial urges.

Delusion is a belief that is firmly held on inadequate grounds, is not affected by rational argument or evidence to the contrary and is not a conventional belief that the person might be expected to hold given his educational and cultural background. The definition of delusion remains controversial and debatable.

Rather than suggesting a unitary definition for delusion, Kendler et al (1983) proposed several dimensions of delusional severity:

- Conviction: the degree to which the patient is convinced of the reality of the delusional beliefs.
- Extension: the degree to which the delusional beliefs involves the area of patient's life.
- Bizarreness: the degree to which the delusional beliefs depart from the culturally determined consensual reality.
- Disorganization: the degree to which the delusional beliefs are internally consistent, logical and systematized.
- Pressure: the degree to which the patient is preoccupied and concerned with the expressed delusional beliefs.
- Affective response: the degree to which the patient's emotions are involved with such beliefs.
- Deviant behaviour resulting from delusion: Patients sometimes act on their delusions.

Types of delusions:

According to Onset:

Primary: also called autochthonous delusion, is the one that appears suddenly and with full conviction, but without any mental events leading up to it.

Secondary: these are apparently derived from preceding morbid experiences like a hallucination, change of mood or an existing delusion.

According to Theme:

Persecution: delusion that persons or organizations are trying to inflict harm on the patient, damage their reputation or make them insane.

Reference: delusion that objects, events or people unconnected with the patient have a personal significance for them.

Grandiosity: delusion of exaggerated self-importance.

Guilt and worthlessness: most often found in depressive illness. Typical themes are that of minor infringement of laws in the past will be discovered and bring shame.

Nihilism: delusion that some person or thing has ceased or is about to cease to exist. When occurs in a severe depressive disorder, the condition is known as **Cotard's Syndrome**.

Hypochondriacal: the patient believes wrongly despite all the evidence to contrary that they are suffering from a disease.

Religious: a firmly held abnormal religious belief.

Delusion of jealousy: related to spouse's infidelity. They are particularly important because they may lead to dangerously aggressive behaviours

- a) Delusion of love: usually occur in women. The person believes that she is loved by a man who is usually inaccessible to her, and often of higher social status.

Delusion of Control: Delusion that one's actions, impulses or thoughts are controlled by an outside agency.

Misidentification: they are of four types

- a) Capgras' delusion: person believes that a closely related person has been replaced by an exact double / imposter.
- b) Fregoli's delusion: the person misidentifies an unfamiliar person as a familiar one, despite no physical resemblance.
- c) Intermetamorphosis: belief that others undergo radical changes in physical and psychological identity, resulting in a different person altogether.
- d) Doppelganger: Delusion of subjective doubles

Delusion concerning the possession of thought / thought alienation: They are of three types:

- a) Thought insertion: beliefs that certain thoughts are not the patient's own and implanted by an outside agency.
- b) Thought withdrawal: beliefs that thoughts have been taken out of patient's mind.
- c) Thought broadcasting: beliefs that unspoken thoughts are known to other people through radio, telepathy or in some other way.

Overvalued ideas: It is an isolated preoccupying belief which is neither delusional nor obsessional in nature and comes to dominate a person's life and sometimes affect their actions. The belief itself may be understandable when the person's background is known.

Obsessions: these are recurrent and persistent unwanted thoughts, impulses or images. They are recognised as one's own and are regarded as senseless distinguishing them from delusions.

Compulsions: these are repetitive and seemingly purposeful behaviours performed in a stereotyped way. They are accompanied by a subjective sense that the behaviour must be carried out and by an urge to resist. They may be associated with an obsession where they serve the purpose of relieving the anxiety generated by the obsession (for example, compulsion of washing hands repeatedly accompanied with obsession of contamination).

Perception: the abnormalities mainly include illusions and hallucinations and pseudo-hallucinations.

- a) *Illusions* are misperceptions of external stimuli. They occur when the general level of sensory stimulation is reduced and when attention is not focussed on the relevant sensory modality.
- b) *Hallucinations* are, phenomenological, the most significant type of false perceptions. Here are five definitions of hallucination:
 - A perception without an object (Esquirol, 1817).
 - Hallucinations proper are false perceptions that are not in any way distortions of real perceptions but spring up on their own as something quite new and occur simultaneously with and alongside real perception (Jaspers, 1962).
 - A hallucination is an exteroceptive or interoceptive percept that does not correspond to an actual object (Smythies, 1956).
 - According to Slade (1976a), three criteria are essential for an operational definition: (a) percept-like experience in the absence of an external stimulus; (b) percept-like experience that has the full force and impact of a real perception; and (c) percept-like experience that is unwilling, occurs spontaneously and cannot be readily controlled by the percipient. This definition is derived from Jasper's formal characteristics of a normal perception.
 - A hallucination is a perception without an object (within a realistic philosophical framework) or the appearance of an individual thing in the world without any corresponding material event.

Hallucinations can be classified according to:

Complexity:

- a) Elementary: refers to experiences such as whistles, bangs, flashes.
- b) Complex: refers to voices, music, seeing faces and scenes.

Sensory Modality involved:

- a) Auditory
- b) Visual
- c) Olfactory
- d) Gustatory
- e) Somatic

Special features:

- a) Auditory
 - Second person: voices talking to the patient
 - Third person: voices talking about patient in third person
 - Audible thoughts: hearing once own thoughts aloud
 - Thought echo: hearing once own thoughts immediately after thinking them
 - Extracampine: voices coming from long distance which are impossible to be heard otherwise due to geographical separation.
- b) Visual

Extracampine: hallucinations located outside the field of vision, usually behind the head or in a different place altogether

Autoscopic hallucinations: experience of seeing one's own body projected into external space, usually in front of oneself, for short periods.

Reflex hallucinations: stimulus in one sensory modality results in hallucination in another modality.

Functional hallucinations: in this type, an external stimulus is necessary to provoke hallucinations.

'Pseudo-hallucinations': Pseudohallucination is one of the least understood phenomena in psychopathology.

Part of the confusion over the meaning of the term pseudohallucination has arisen because it is often used in two different and mutually contradictory ways, according to Kräupl Taylor (1981). On the one hand, it refers to hallucinations with insight (Hare, 1973), and on the other hand to vivid internal images.

Hallucinations with insight would be those hallucinatory experiences in which the subject is aware that the hallucinatory percepts do not correspond to external reality despite the perceptions being veridical, and in external objective space. Vivid internal images are those phenomena that have all the clarity and vividness of a normal percept except that they occur in inner subjective space.

Jaspers identified pseudohallucination as similar to normal perception except that it occurs in inner subjective space. It shares this characteristic with imagery. However, it has all the vividness and clarity of a normal perception.

A recent work by Wearne and Genetti recommends that 'pseudohallucinations' or hallucinations described in non-psychotic illness like PTSD and complex trauma are often difficult to differentiate from hallucinations in Schizophrenia phenomenologically. However, hallucinations in Schizophrenia are more likely accompanied by complex delusional system. The voices were also more likely to be critical and negative towards the individual, consistent with the experience of abuse in people with PTSD.

Insight

In psychopathology, the term insight refers to awareness of morbid change in oneself, and a correct attitude to this change including a realisation there is a mental illness. Insight is best understood as a continuum rather than simply absent or present. The degree of insight can be best determined by asking following question:

1. Is the patient aware that there is a problem? (insight into symptom)
2. If so, do they understand the problem is attributable to the mental illness? (insight into illness)
3. If so, do they think it needs treatment?

Based on above, six levels of insight have been described:

- i. Complete denial of illness
- ii. Slight awareness of being sick and needing help, but denying at the same time
- iii. Aware of being sick but blaming it on others, or external factors like physical illness
- iv. Awareness that illness is caused by something unknown
- v. Intellectual insight: awareness that there is mental illness without applying this knowledge to future experiences
- vi. Emotional insight: emotional awareness into the feelings and illness and ability to modify behaviour accordingly.

Determining the degree of insight helps in predicting likelihood of compliance with treatment.

Judgment. It is the ability to anticipate the consequences of one's behaviour and make decisions to safeguard their well-being and that of others.

Importance of correct elicitation and interpretation of psychopathology

While it is extremely important to have a clear understanding of the psychopathology, correct elicitation is equally important. Jumping to conclusions regarding a presence of a phenomenon without proper elicitation poses a risk of over-diagnosis. For example, a poorly conducted mental state examination may incorrectly reveal presence of delusions and hallucinations when in reality, the person might only have these beliefs at an idea level, and the hallucinatory experiences are non-psychotic in nature (commonly related to past trauma).

A recent study by Coulter et al concluded that potential overdiagnosis of schizophrenia is of considerable concern, given the treatment and prognostic implications of schizophrenia compared with alternative diagnoses. An important reason for overdiagnosis was identified as literal interpretation of patients' self-reported symptoms, especially 'hearing voices'. There is evidence that the experience of hallucinations, which may be common in the general population, is categorically different for individuals with schizophrenia. In addition, the term 'hearing voices' may be used imprecisely by patients to emphasize extreme emotional distress. This may be particularly common in individuals with cognitive, communication, language, or cultural limitations in their capacity for self-description.

An abnormal belief should therefore be carefully explored to establish it as a false, firm unshakeable belief which is held with extraordinary conviction before it is labelled as a delusion.

Similarly, reported 'hearing voices' should be sufficiently and carefully explored to establish presence of a hallucination. Despite increasingly blurred definition of pseudo-hallucination, a skilled candidate should be able to differentiate between psychotic and non-psychotic types of hallucinations.

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 all 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 Ilana Jenkins, a 22-year-old woman. You do not have a regular job, but you sometimes do casual work as a cleaner. You live locally with your stepfather and mother in a rented 2-bedroom unit. You are on unemployment benefits for the last 2 years.

Current Presentation to the Emergency Department (ED):

You have been in a relationship with Mark, a 34-year-old man. Mark lives in his unit with a flatmate. You have known Mark for the last 6 months after you met on a social website. You began chatting with him on Facebook and started dating two months ago. Mark is unemployed and on government benefits as well.

For the last 2 weeks Mark has been avoiding you and not answering your calls. You have recently seen a few of his Facebook posts and you are concerned that he might be seeing another girl. You fear that he is going to leave you for her.

You met him today in his unit and had a verbal argument. He asked you to leave and you returned home. Your parents were not home, and you were feeling terrible. When your parents got home you were very upset and were crying. They could not get you to stop so they called the ambulance. The nice lady in the ambulance thought it may be better for you to see a doctor and so they brought you to ED.

You have been seen by the ED staff and told that you would be seeing a doctor from mental health for further assessment. You saw the junior doctor who then asked the psychiatrist to see you. You know that you are going to see a psychiatrist now.

Background information:

The candidates have the specific task of asking you about your mood and experiences in the last few weeks.

If they ask how you are feeling now or how your mood is now: say, ***'I feel like crying'*** and then start getting teary.

When asked if people laugh or talk about you, you sometimes feel people on the street are laughing at you. For example, when you were driving home back from Mark's home yesterday, it felt as if everyone was laughing at you. If asked further, you wonder why a stranger would laugh at you, so you are not sure they actually do so. You do feel similarly when you are stressed. You have never been 100 percent sure of this.

When asked if someone wants to harm or kill you, you mention that when you are alone at home or on the street at night, you feel that someone will come to sexually assault you or kill you. You remain very anxious and vigilant. If asked if this is a fear or if you are sure someone will assault you, you say you are not sure.

When asked about hearing voices, you say that sometimes, you feel that there is a devil that lives around you. When stressed, you can hear him saying bad things to you. He calls you names and tells you to go kill yourself. When probed more, you say you can hear him clearly, but his voice comes from inside your head. When asked, you say that it sounds like a human voice and maybe sound similar to your biological father's voice. The voice does not last long and comes and goes specially around stressful times. It also happens when you are lying in bed just before you go to sleep. You have no control over the voice. If asked why you hear them, you say ***'Maybe I have schizophrenia'***. You don't hear any voices continuously coming from outside. You don't hear voices arguing about you or commenting on your actions. You don't hear your own thoughts out loud.

When asked if you see things others cannot, you say that sometimes, you can see the devil and you get frightened. Only if asked, you say that it happens when you are half asleep at night and you suddenly hear your name. You open your eyes and you think you can see a black shadow looking at you. You are very vague in your description of the shadow. It fades away quickly, and this has happened maybe 5 times in the last 6 months.

You don't think anybody can read your mind or people know your thoughts. Nobody can put thoughts into your head or take them out of your head. No one can control your body or feelings from outside. You don't think radio / TV or newspapers play your personal information / news. If asked these questions, you can say ***'I am not crazy, doctor.'***

You do feel anxious when you are meeting strangers or new people. You avoid meeting them because you feel they will judge you.

You don't have any fear of any specific things or situations. You don't wash your hands or check things repeatedly.

Your sleep has never been good. You often get nightmares that you don't clearly remember later. You don't get any flashbacks of your childhood trauma (see below).

Regarding your mood, it has always been ***'up and down'*** as far as you can remember. However, you do enjoy life sometimes and go out with your mates. Your ups and downs don't last for more than few hours and your mood changes very quickly depending on your surroundings.

You are not suicidal. You don't want to harm yourself. You feel bad about what happened last night. You now want to go home and rest.

You don't use any drugs. You drink alcohol only occasionally and socially.

You have never been in trouble with the police.

If asked about your childhood, you say **'don't remember much'**. However, you remember that your childhood was very traumatic. Your own father sexually abused you between 6-10 years of age. When you told your mother, she initially did not believe you. However later, she did find the truth and that led to their separation. Your father is now uncontactable. You blame yourself for your parents' separation. You started believing that you were worthless. You started thinking of suicide and harming self frequently each time you would be in some kind of emotional pain. You started cutting yourself in your thighs very often. You found it difficult to make close friends and most of your relationships have been short lived and superficial due to you having difficulty trusting them.

If asked, you say you don't think you are impulsive, but look annoyed and say **'I don't know'** if probed further.

If asked whether you have any mental illness, say you think you have depression, anxiety and schizophrenia, because you have read about these on the internet, and the description matches your symptoms.

You have never seen a psychiatrist in the past and never been on any medication.

4.2 How to play the role:

You are dressed in casual clothes (jeans and a T-shirt / appropriate to the weather) and you look distraught.

Your hair is not groomed given you have spent night in the ED. You don't have any make up on.

You are cooperative but not very forthcoming until you are asked specific questions.

You get upset and annoyed if the candidate asks a lot about your childhood.

You can get teary on a few occasions but that should not interrupt the conversation.

You are fairly organised in your thoughts and talk at normal pace. You are neither loud nor too soft in your voice.

4.3 Opening statement:

'Doctor, I think I am ready to go home.'

4.4 What to expect from the candidate:

Candidates are expected to ask you about your mood and recent experiences. They should particularly explore experiences like hearing voices, seeing things that others don't see, feelings of being watched or talked about. They are not expected to ask details of your childhood and other personal information.

4.5 Responses you MUST make:

'The devil sometimes calls me names and I hate that.'

'I feel like crying.'

'Sometimes at night I worry that someone is going to hurt me.'

4.6 Responses you MIGHT make:

If asked about your mood recently:

Standard response: **'Up and down.'**

If asked why you think you hear voices:

Standard response: **'Maybe I have schizophrenia.'**

If asked about unusual experiences like associations with the TV / radio, etc:

Standard response: **'I am not crazy, doctor.'**

4.7 Medication and dosage that you need to remember

None

STATION 10 – MARKING DOMAINS

The main assessment aims are:

- Demonstrate the ability to conduct a focussed mental state examination (MSE).
- Present and justify the discrepancies with previous MSE findings provided by a trainee.

Level of Observed Competence:

1.0 MEDICAL EXPERT

1.3 Did the candidate demonstrate adequate proficiency in undertaking a mental state examination? (Proportionate value - 40%)

Surpasses the Standard (scores 5) if:

the mental state examination is relevant to the patient's problems and circumstances; it is conducted at a sophisticated level to demonstrate establishment of psychopathology.

Achieves the Standard by:

demonstrating capacity to: conduct a organised and accurate focussed mental state examination; assess key aspects of observation of mood and affect, thought (stream, form, content, control) and perception; specifically focus on the findings provided by the junior doctor and probe them in greater depth in order to establish the psychopathology.

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

- Explore thought content to clearly establish that the patient does not experience a pathological sense of persecution.

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. Or if explores the psychopathology only superficially without demonstrating that patients beliefs are shakeable.

Below the Standard (scores 1):

scores 1 if there are significant omissions affecting quality; significant deficiencies in technique, organisation, accuracy and / or presentation; did not explore the psychopathology at all.

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

1.3 Category: ASSESSMENT – Mental State Examination	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"/>

1.3 Did the candidate demonstrate adequate proficiency in presenting the discrepancy in the findings reported by the trainee? (Proportionate value - 30%)

Surpasses the Standard (scores 5) if:

the mental state examination is relevant to the patient's problems and circumstances; it is presented at a sophisticated level in detail.

Achieves the Standard by:

demonstrating capacity to: present a focused and accurate findings of psychopathology; assess and present key aspects of mood and affect, thought (stream, form, content, control) and perception; specifically mentioning the psychopathology reported by the junior doctor.

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

- Correctly present at least 3 of the following mental state findings: dysphoric mood / affect consisting of depression, distress or instability; absence of formal thought disorder; absence of delusions; possible non-psychotic hallucinations / pseudo-hallucinations.

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; significant deficiencies in technique, organisation, accuracy and / or presentation.

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

1.3 Category: ASSESSMENT – Mental State Examination	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"/>

6.0 SCHOLAR

6.4 Did the candidate prioritise and apply appropriate and accurate knowledge based on clinical experience for justification of their findings? (Proportionate value - 30%)

Surpasses the Standard (scores 5) if:

candidate acknowledges that concept of pseudo-hallucinations and hallucinations is in a state of debate; acknowledges that growing literature is supportive of describing pseudo-hallucinations and hallucinations on a continuum; recognises the impact of environment, people and new knowledge on current understanding; acknowledges their own gaps in knowledge.

Achieves the Standard by:

discussing differences in the available evidence provided by the patient; providing appropriate justification for their opinion of psychopathology based on the standard definitions of various psychopathologies;

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

- a. Justify their findings for disorder of thought content and perception.

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; if they infer that patient has delusions, clear hallucinations or a formal thought disorder.

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

6.4 Category: APPLICATION OF KNOWLEDGE	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?

Circle One Grade to Score	Definite Pass	Marginal Performance	Definite Fail
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