

CONTENT	PAGE
<p>Overview</p> <ul style="list-style-type: none"> - Descriptive summary of station - Main assessment aims - 'MUSTs' to achieve the required standard - Station coverage - Station requirements 	2-3
Instructions to Candidate	4
Station Operation Summary	5
<p>Instructions to Examiner</p> <ul style="list-style-type: none"> - Your role - Background information for examiners - The Standard Required 	<p>6</p> <p>6-11</p> <p>12</p>
Instructions to Role Player	13-15
Marking Domains	16-17

1.0 Descriptive summary of station:

Prior to seeing Mavis Davies, a 72-year-old woman, her community mental health nurse (called Rita) asks to speak with the candidate. Since discharge, Mrs. Davies has been frequently ringing the ward and the reception, wanting whomever answers to listen to her and to help her. This has been happening both day and night, with the staff becoming frustrated by her behaviour. This station explores how bereavement in an older person with a dependent personality affects her interaction with others. The candidate's tasks are to explore the concerns of the community mental health nurse, to make sense of the history obtained, and describe diagnoses of grief and dependent personality with relevant differential diagnoses.

1.1 The main assessment aims are to:

- Take a focussed history from the community mental health nurse in order to understand their concerns.
- Provide a psychological framework that explains the presentation.
- Describe relevant diagnoses and differential diagnoses to the examiner.

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

- Explore the possibility of major depression.
- Identify three (3) psychological factors influencing the presentation.
- Propose both diagnoses of grief / loss and Dependent Personality Structure / Disorder.

1.3 Station covers the:

- **RANZCP OSCE Curriculum Blueprint Primary Descriptor Category:** Personality Disorders
- **Area of Practice:** Old Age Psychiatry
- **CanMEDS Domains:** Medical Expert
- **RANZCP 2012 Fellowship Program Learning Outcomes:** Medical Expert (Assessment – Data Gathering Content; Formulation; Diagnosis)

References:

- International Statistical Classification of Diseases and Related Health Problems. 10th Revision (ICD-10)-WHO Version for;2016 – <http://apps.who.int/classifications/icd10/browse/2016/en> - Chapter V Mental and behavioural disorders (F00-F99): specifically, F30-39; F40-F48; F60-F69
- International Statistical Classification of Diseases and Related Health Problems. 10th Revision (ICD-10)-WHO Version for;2016 – <http://apps.who.int/classifications/icd10/browse/2016/en> - Chapter XXI Factors influencing health status and contact with health services (Z00-Z99): Z55-Z65 - Persons with potential health hazards related to socioeconomic and psychosocial circumstances – specifically, Z63 Other problems related to primary support group, including family circumstances
- Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition – copy of DSM-5 – American Psychiatric Publishing, Washington, DC, 2013 - specifically, Depressive Disorders p160; Personality Disorders p675; Other Conditions That May Be a Focus of Clinical Attention p716
https://www.sciencetheearth.com/uploads/2/4/6/5/24658156/dsm-v-manual_pg490.pdf
- Gabbard, GO. Psychodynamic Psychiatry in Clinical Practice. Fourth Edition. American Psychiatric Publishing, Washington, DC, 2005 – Chapter 3 Psychodynamic Assessment of the Patient p63 & Chapter Cluster C Personality Disorders p565
- Iglewicz, A., Seay, K., Zetumer, S.D., Zisook, S. The removal of the bereavement exclusion in the DSM-5: Exploring the evidence. *Current Psychiatry* 2013 Nov;15(11):413
- Kaplan & Sadock's Comprehensive Textbook of Psychiatry 9th Edition – Lippincott Williams & Wilkins, Philadelphia, USA, 2009 – Chapter 6 Theories of Personality and Psychopathology p788; Chapter 13 Mood Disorders p1629; p1689; p1693. Chapter 23 Personality Disorders p2197; Chapter 25 Relational Problems p2469
- Pies, R. The Bereavement Exclusion and *DSM-5*: An Update and Commentary. *Innovations in Clinical Neuroscience* 2014 Jul-Aug; 11(7-8): 19–22
- Shear, M.K. et al. Complicated Grief and Related Bereavement Issues for DSM-5. *Depress Anxiety*. 2011 February; 28(2): 103–117. <https://www.ncbi.nlm.nih.gov/pubmed/21284063>

Committee for Examinations
Objective Structured Clinical Examination
Station 7
Auckland September 2018



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: Female 40-45 years of age, well dressed and relaxed.
- Pen for candidate.
- Timer and batteries for examiner.

2.0 Instructions to Candidate

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

You are working as a junior consultant psychiatrist in the community mental health service. Rita Matthews, the community mental health nurse for Mrs. Mavis Davies, has asked to meet with you prior to your appointment with Mrs. Davies at the clinic today.

Mrs. Davies, a 72-year-old widow, had her first admission to the inpatient psychiatric unit five weeks ago. She was admitted in a tearful and distressed state, finding it difficult to cope without her husband, who had died after a long illness. Since discharge, she has been frequently ringing the ward and the clinic reception at all hours wanting help to make decisions.

Rita would like to understand why this is happening.

Your tasks are to:

- Explore the concerns of the community mental health nurse.
- Explain Mrs Davies' presentation from psychological perspectives to Rita.
- Justify your preferred diagnoses and relevant differential diagnoses **to the examiner**.

You will not receive any time prompts.

Station 7 - 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 simulated patient.

During examination:

- Please ensure mark sheets and other station information, are out of candidate's view.
- At the **first bell**, take your places.
- At the **second bell**, start your timer, check candidate ID number on entry.
- TAKE NOTE that there is no cue / time for any scripted prompt 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 **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.

The role player opens with the following statement:

'Hello Doctor, I want to talk to you about Mrs. Davies before you see her.'

3.2 Background information for examiners

In this station the candidate is to meet with a community mental health nurse to obtain an update about an elderly widow who has recently been admitted to an inpatient unit following the death of her husband. The candidate is to listen to the community mental health nurse, and take a focussed history from which they can generate a formulation, and describe relevant diagnoses and differential diagnoses.

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

- Explore the possibility of major depression.
- Identify three (3) psychological factors influencing the presentation.
- Propose both diagnoses of grief / loss and Dependent Personality Structure / Disorder.

The following information is provided to inform an understanding of this case.

BEREAVEMENT

(Bereavement and Grief - From Kaplan & Sadock's Comprehensive Textbook of Psychiatry)

Definitions:

The terms **bereavement** and grief refer to either the state of having lost someone to death or the response to such a loss. Researchers have suggested that the term bereavement be used to refer to the fact of the loss. The term **grief** is then used to describe emotional, cognitive, functional, and behavioural responses to the death. Manifestations of grief vary from person to person, from moment to moment, and involve all aspects of the bereaved individual's being.

Mourning usually refers more specifically to the behavioural manifestations of grief, which are influenced by social and cultural rituals such as funerals, visitations, or other rituals.

Complicated grief sometimes referred to as unresolved or traumatic grief is the current designation for a syndrome of prolonged and intense grief that is associated with substantial impairment in work, health, and social functioning.

An Attachment Theory Perspective

Grief can be understood using attachment theory. Attachment theory posits a basic human instinct to form strong, persistent affectionate relationships. Loss of such a relationship is always difficult. Thomas Bowlby and others have described attachment figures as people that we most want to be with and to whom we turn when under stress. Most adult relationships attachment is reciprocal so that those people who provide us with secure base and safe haven functions are also the ones for whom we provide this support. When a relationship with an attachment figure / caregiving recipient is disrupted, there is a loss of sense of well-being, increase in distress, and difficulty solving problems and fully engaging in other aspects of life.

Phenomenology of Grief

Grief includes intense feeling states, entails a variety of coping strategies, and leads to alterations in interpersonal relationships, biopsychosocial functioning, self-esteem, and world view that may last indefinitely. Manifestations of grief reflect the individual's personality, previous life experiences, and past psychological history; the significance of the loss; the nature of the bereaved individual's relationship with the deceased; the existing social network; intercurrent life events; health; and other resources. There is little evidence for systematic progression of grief. Instead, progress is typically erratic and recursive, occurring in explosive bursts plentifully interspersed with moratoria as information regarding the reality and meaning of the death is periodically engaged, evaluated, and set aside. Different aspects of the loss and their associated feelings may be repeatedly revisited, leading to an impression that the process is going nowhere, yet this is usually not true, and normal grief can have this recursive quality.

Duration of Grief

Most societies mandate modes of bereavement and time for grieving. Grief researchers have suggested that re-engagement in restoration-related activities is an important part of the early period of normal grief. While ample evidence indicates that the bereavement process does not end within a prescribed interval, the lasting form of grief (i.e., integrated grief) is much more private, less intense, and less preoccupying than the acute form. Aspects of grief often persist indefinitely for many otherwise high-functioning, normal individuals. Perhaps the most lasting manifestation of grief, especially after spousal bereavement, is loneliness.

Multidimensional Assessment of Bereavement and Grief

Because people we love invade our minds and every aspect of our lives, the loss of such a person results in a range of difficulties. A multidimensional approach to the assessment of bereaved people includes: (1) emotional and cognitive responses, (2) coping strategies, (3) continuing relationship with the deceased, (4) alterations in existing relationships and forming new ones, (5) changes in functioning and health, and (6) changes in identity. Assessing these features lends itself to rational management and treatment strategies.

Complicated Grief (CG)

Although the personality of the bereaved person may play a role, the same person may successfully grieve the loss of one person and not another, so the development of CG appears to be more specific to a given relationship than to a given personality type. It has been reported that, if recently bereaved individuals meet criteria for complicated grief by 6 months, they are at increased risk for changes in smoking, eating, depression, and high blood pressure by 13 months. By 25 months, these bereaved individuals may be at an increased risk to develop heart trouble, new cases of cancer, and more often expressed suicidal ideation.

Bereavement and Depression

Many clinicians are confused by the relationship between grief and depression. Bereavement is a major stressor that is one of the most likely to precipitate an episode of major depression. Studies show that approximately one-third of all widows or widowers manifest a full major depressive episode 1 month after the death of a spouse, approximately one-fourth at 7 months, and approximately 15 percent at 1 and 2 years. Up to 10 percent may meet criteria for major depressive episode for the entire year. In addition, bereaved persons are not only at a high risk for a major depressive episode, but they also are at risk for lingering subsyndromal depressive symptoms. Such symptoms, even in the absence of full depressive disorders, may be associated with prolonged personal suffering, role dysfunction, and disability.

Dependent personality and grief

Research has shown that people with certain personality traits are more likely to have long-lasting depression after a loss. People with dependent personality disorder who are dependent on their spouse are more likely to develop depression and have difficulty coping with the loss of their loved one.

Dependent personality and depression

Often those with dependent personality have low self-esteem and / or a sense that life cannot be controlled. Consequently, they are more likely to have a complicated grief response such as depression and physical problems.

Social Support

A lack of social support increases the chance of having problems coping with loss. Social supports include the person's family, friends, neighbours, and community members who give psychological, physical and financial help. After the death of a close family member, there are many related losses. The death of a spouse may cause a loss of income and changes in lifestyle and day-to-day living.

Psychological perspectives that the candidate may discuss in their presentation

The biopsychosocial theory perspective proposes that most disorders may be a direct or indirect result of biological, psychological, and social factors / dynamics. Mrs. Davies displays difficulty making decisions or meeting ordinary demands of life, feelings of devastation or helplessness when relationships end (death of husband, departure of daughter, and discharge from ward), being preoccupied with fears of being abandoned, and consistent attempts to avoid responsibility. She is thus more susceptible to a range of problems and illnesses, such as depression and anxiety.

From classical psychoanalytic theory perspective, dependency issues may stem from the oral stage of infant development. Infants who were either frustrated or overindulged in this stage may later develop dependency behaviours. The child becomes dependent on the interactions between themselves and their caregivers, which later becomes the self-concept of the individual. It is possible that past traumas may have been experienced and are now being repressed, to ensure maintenance of the caregiver relationship, and the meeting of their dependency needs. Insecure attachment to the parental figure through being overindulgent, unresponsive, inconsistent, or abusive may cause anger, anxiety, fear and dependency reactions in the child.

In respect of defence mechanisms employed by Mrs. Davies, she reacts to abandonment with increasing submissiveness and clinging behaviour as evidenced by her excessive contact with mental health services. The death of her husband, the departure of her daughter, and the discharge from the hospital are all perceived as varying degrees of abandonment. Given that the mental health services remain present, she has projected her need onto the service.

Another possibility psychodynamic is that she is defending against unconscious hostility, originally directed against possible overbearing parents, by submitting to others to unconsciously avoid anger. From the perspective of object relations theory, Mrs. Davies may have internalised images of persons who matter to her, especially her parents.

It is possible that Mrs. Davies had overprotective, authoritarian parenting, and that her husband could have been similar to her parents. She likely developed sensitivity to interpersonal cues especially regarding the need to maintain a dependency on others rather than develop independence and autonomy. In her presentation she clearly has a strong desire to obtain and maintain nurturing, supportive relationships.

In terms of attachment theory, there is biological need for comfort and support in the relationship between parents and young children. In secure attachment the child has comforting psychological images of reliable caretakers who provide a solid base from which to explore the world, and achieve a balance between independence and closeness to others. It is possible that her parents may have been unresponsive, inconsistent, or abusive. She may have consequently developed a fearful or insecure attachment to her parents. Thus, this internalised model is taken into future relationships. This might have led to Mrs. Davies' excessive demands for care and may explain her difficulty self-soothing and calming herself when sad, anxious, frustrated or angry.

From a behavioural and social learning theory, children learn through conditioning (automatic associations) and reinforcement (reward and punishment). Mrs. Davies may have been rewarded for making excessive demands for care. This can reinforce expectations for care and development of dependence. It is possible she has never been rewarded for independence. In insecure attachment parents are inconsistent, so children may learn that they cannot control their lives. In regard to Mrs. Davies she went from the care of her parents into the care of her husband, so has never had the opportunity to develop independence.

From the perspective of cognitive psychology Mrs. Davies' dependency developed as a result of how she and others thought about her. Somehow in growing up she received the idea that she is powerless, and others are powerful and effective. Possibly her parents may have conveyed to her that she would be abandoned and alone unless she submits.

Temperamentally, Mrs. Davies seemed to be a gentle, shy and easily frightened child and as such she may have evoked protective feelings in others. Her parents may have been overanxious and discouraged independence. A sibling may have bullied her, reinforcing her temperament and protective tendencies in others. As a result, Mavis became more sheltered, reinforcing her behaviour and that of others to protect her, intensifying her dependency on powerful others.

An example of a possible psychological explanation of Mrs. Davies

Mrs. Davies' presentation occurs most notably in the context of the death of her husband, to whom she had been married for over fifty years. It seems that her husband had managed most practical aspects of their daily life, and that his strong presence had acted to complement Mavis' dependant personality style. As a result, when he died she was unable to cope with many of the tasks which he had normally taken care of. It is also likely that Mavis' own intense grief at losing her husband created an anxiety which made it even more difficult for her to manage such tasks. From a systems perspective, Mrs. Davies' own anxiety seems to have caused discord between her and her children, who themselves are likely grieving for their father. Her behaviour is thereby isolating her from her children, which is likely to strengthen her feelings of emptiness and isolation.

Mrs. Davies' presentation can also be understood from a developmental perspective. There is a sense that she has depended upon attachment figures for excessive care and reassurance from a young age, a pattern that may have its origin in her insecure attachment style with her parents. This forms a basis for an entrenched dependency which has occurred throughout her life and is now contributing to difficulties managing grief, and finding a sense of autonomy following her husband's death.

DIAGNOSIS

Bereavement or Grief Reaction
Dependent Personality Traits (or disorder)

Differential Diagnosis

Mild / Moderate Depressive Episode
Adjustment Disorder due to Grief Reaction

Less likely Differential Diagnoses

Major Depressive Disorder
Complicated Grief

Discussion of Diagnoses:

The information below is provided as background material when considering the diagnosis and differential diagnoses. The candidate will **achieve a 'surpass'** if they discuss the complexity of the diagnostic systems addressing grief.

Bereavement-related grief and major depression share some features, but are distinct and distinguishable conditions. Recognising major depression in the context of recent bereavement takes careful clinical judgment. The removal of the bereavement exclusion in the DSM-5 now permits the diagnosis of major depressive disorder after and during bereavement, and includes a note and a comprehensive footnote in the major depressive episode criteria set to guide clinicians in making the diagnosis in this context. The decision to make this change was widely and publically debated and remains controversial.

ICD 10 Relational Problems: V62.82 (Z63.4) Uncomplicated Bereavement

This category can be used when the focus of clinical attention is a normal reaction to the death of a loved one. As part of their reaction to such a loss, some grieving individuals present with symptoms characteristic of a major depressive episode—for example, feelings of sadness and associated symptoms such as insomnia, poor appetite, and weight loss. The bereaved individual typically regards the depressed mood as 'normal', although the individual may seek professional help for relief of associated symptoms such as insomnia or anorexia. The duration and expression of 'normal' bereavement vary considerably among different cultural groups.

ICD 10 F43 Reaction to severe stress, and adjustment disorders: F43.2 Adjustment disorders

Adjustment disorders are states of subjective distress and emotional disturbance, usually interfering with social functioning and performance, arising in the period of adaptation to a significant life change or a stressful life event. The stressor may have affected the integrity of an individual's social network (bereavement, separation experiences) or the wider system of social supports and values (migration, refugee status), or represented a major developmental transition or crisis (going to school, becoming a parent, failure to attain a cherished personal goal, retirement). Individual predisposition or vulnerability plays an important role in the risk of occurrence and the shaping of the manifestations of adjustment disorders, but it is nevertheless assumed that the condition would not have arisen without the stressor. The manifestations vary and include depressed mood, anxiety or worry (or mixture of these), a feeling of inability to cope, plan ahead, or continue in the present situation, as well as some degree of disability in the performance of daily routine.

DSM-5 Dependent Personality Disorder - 301.6 (F60.7)

A pervasive and excessive need to be taken care of that leads to submissive and clinging behaviour and fears of separation, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

- Has difficulty making everyday decisions without an excessive amount of advice and reassurance from others.
- Needs others to assume responsibility for most major areas of his or her life.
- Has difficulty expressing disagreement with others because of fear of loss of support or approval. (Note: Do not include realistic fears of retribution.)
- Has difficulty initiating projects or doing things on his or her own (because of a lack of self-confidence in judgment or abilities rather than a lack of motivation or energy).
- Goes to excessive lengths to obtain nurturance and support from others, to the point of volunteering to do things that are unpleasant.
- Feels uncomfortable or helpless when alone because of exaggerated fears of being unable to care for himself or herself.
- Urgently seeks another relationship as a source of care and support when a close relationship ends.
- Is unrealistically preoccupied with fears of being left to take care of himself or herself.

Diagnostic Features

The essential feature of dependent personality disorder is a pervasive and excessive need to be taken care of that leads to submissive and clinging behaviour, and fears of separation. This pattern begins by early adulthood and is present in a variety of contexts. The dependent and submissive behaviours are designed to elicit caregiving, and arise from a self-perception of being unable to function adequately without the help of others. Dependent behaviour should be considered characteristic of the disorder only when it is clearly in excess of the individual's cultural norms or reflects unrealistic concerns. Only when these traits are inflexible, maladaptive, and persisting and cause significant functional impairment or subjective distress do they constitute dependent personality disorder.

Differential Diagnosis

- dependent personality disorder can be distinguished by its predominantly submissive, reactive, and clinging behaviour.
- reacts to abandonment with increasing appeasement and submissiveness and urgently seeks a replacement relationship to provide caregiving and support.
- strong need for reassurance and approval and may appear childlike and clinging by self-effacing and docile behaviour.
- feelings of inadequacy, hypersensitivity to criticism, and a need for reassurance have a pattern of seeking and maintaining connections to important others, rather than avoiding and withdrawing from relationships.
- dependent personality disorder must be distinguished from dependency arising as a consequence of other mental disorders (e.g., depressive disorders, panic disorder, agoraphobia) and as a result of other medical conditions.

ICD10 F60.7 Dependent Personality Disorder

Personality disorder characterised by pervasive passive reliance on other people to make one's major and minor life decisions, great fear of abandonment, feelings of helplessness and incompetence, passive compliance with the wishes of elders and others, and a weak response to the demands of daily life. Lack of vigour may show itself in the intellectual or emotional spheres; there is often a tendency to transfer responsibility to others.

Personality (disorder): Asthenic; Inadequate; Passive; Self-defeating

DSM-5 Major Depressive Disorder

Diagnostic Criteria

A. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.

Note: Do not include symptoms that are clearly attributable to another medical condition.

1. Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad, empty, and hopeless) or observation made by others (e.g., appears tearful). (Note: In children and adolescents, can be irritable mood.)
2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation).
3. Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. (Note: In children, consider failure to make expected weight gain.)
4. Insomnia or hypersomnia nearly every day.
5. Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down).
6. Fatigue or loss of energy nearly every day.
7. Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick).
8. Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others).
9. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

B. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

C. The episode is not attributable to the physiological effects of a substance or another medical condition.

Note: Responses to a significant loss (e.g., bereavement, financial ruin, losses from a natural disaster, a serious medical illness or disability) may include the feelings of intense sadness, rumination about the loss, insomnia, poor appetite, and weight loss noted in Criterion A, which may resemble a depressive episode. Although such symptoms may be understandable or considered appropriate to the loss, the presence of a major depressive episode in addition to the normal response to a significant loss should also be carefully considered. This decision inevitably requires the exercise of clinical judgment based on the individual's history and the cultural norms for the expression of distress in the context of loss.

In distinguishing grief from a major depressive episode (MDE), it is useful to consider that in grief the predominant affect is feelings of emptiness and loss, while in an MDE it is persistent depressed mood and the inability to anticipate happiness or pleasure. The dysphoria in grief is likely to decrease in intensity over days to weeks and occurs in waves, the so-called pangs of grief. These waves tend to be associated with thoughts or reminders of the deceased. The depressed mood of an MDE is more persistent and not tied to specific thoughts or preoccupations. The pain of grief may be accompanied by positive emotions and humour that are uncharacteristic of the pervasive unhappiness and misery characteristic of an MDE. The thought content associated with grief generally features a preoccupation with thoughts and memories of the deceased, rather than the self-critical or pessimistic ruminations seen in an MDE. In grief, self-esteem is generally preserved, whereas in an MDE feelings of worthlessness and self-loathing are common. If self-derogatory ideation is present in grief, it typically involves perceived failings vis-à-vis the deceased (e.g., not visiting frequently enough, not telling the deceased how much he or she was loved). If a bereaved individual thinks about death and dying, such thoughts are generally focussed on the deceased and possibly about 'joining' the deceased, whereas in an MDE such thoughts are focussed on ending one's own life because of feeling worthless, undeserving of life, or unable to cope with the pain of depression.

ICD10 F32 Depressive episode

In typical mild, moderate, or severe depressive episodes, the patient suffers from lowering of mood, reduction of energy, and decrease in activity. Capacity for enjoyment, interest, and concentration is reduced, and marked tiredness after even minimum effort is common. Sleep is usually disturbed and appetite diminished. Self-esteem and self-confidence are almost always reduced and, even in the mild form, some ideas of guilt or worthlessness are often present. The lowered mood varies little from day to day, is unresponsive to circumstances and may be accompanied by so-called 'somatic' symptoms, such as loss of interest and pleasurable feelings, waking in the morning several hours before the usual time, depression worst in the morning, marked psychomotor retardation, agitation, loss of appetite, weight loss, and loss of libido. Depending upon the number and severity of the symptoms, a depressive episode may be specified as mild, moderate or severe.

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 Rita Matthews, the community mental health nurse for Mrs. Mavis Davies, a 72-year-old Anglo-New Zealander who presented for the first time to the mental health service 5 weeks ago with distress, tearfulness, feelings of grief and being unable to cope at home. Her husband George had died three months ago from cancer.

Mrs. Davies was admitted to the inpatient psychiatric unit and quickly settled enough to return home after a week, but she did not want to be discharged. She had enjoyed the company of staff and other patients; she loved all the activities and wanted to remain on the ward. Mrs. Davies explained that she could not cope at home alone. She wanted to live on the ward, saying she needs help and felt unable to care for herself. She said that her husband had taken very good care of her, and now she needed someone else to take care of her. She felt incapable of being on her own. How was she going to know 'what clothes to wear or what to do every day?'

Mrs. Davies had very reluctantly left the ward five weeks ago but has since been frequently ringing both the inpatient and outpatient mental health services. Her behaviour is frustrating / distressing to staff due to her frequent calls and neediness. Staff are saying she seems unable to make decisions for herself, ringing staff to ask what she should wear for the day to suit the weather, to tell her how to pay her bills, and what to do about a myriad of things and decisions she needs to make in everyday life.

During admission, there was no evidence of disturbed sleep, concentration, appetite, energy levels or fatigue. Her mood was mildly low, with no history of elevated (high) mood. Her main worry was how she would care for herself and the difficulty she was having making everyday decisions, without her husband. She had times when she would focus on remembering her husband and feel sadness, emptiness and loss. There were other times when she felt that the intensity of her grief was getting less.

Last week you spoke with Mrs. Davies' daughter, June, who explained that the family is also getting frustrated and worried about her behaviour. June's brothers (Gregory and James) have returned to their homes because they can't tolerate their mother's intense and intrusive 'demands for attention', and inability to make decisions.

June commented that their father had 'managed' their mother for many years. He had always been a kind and tolerant man, and would only rarely get frustrated by her needy behaviour. She explained that their father always made the decisions even when he was very sick. June believes that her mother is sad about her husband's death and missing him terribly, but she also thinks there is something more going on with her mother. Now that their father is gone, June explained that they don't know what to do about their mother's behaviour, exclaiming: 'She's just so helpless'. During the admission they were told that the 'doctors were sure that she was not depressed – she is happy when she is with other people'.

You have spoken with the nurse-in-charge of the inpatient unit and the outpatient reception staff, who have all received multiple calls during the day and night from Mrs. Davies with a great need to have all her questions answered, and help with decision making. She will ring and ring until someone answers. Now staff are hesitant to answer the phone for fear it is Mrs. Davies. It is difficult to terminate the calls, especially as she is such a nice lady and they feel sorry for her. Mrs. Davies' calls are interfering with daily work and beginning to cause conflict on the ward. Some staff just want to hang up on her whilst other staff will talk with Mrs. Davies for long periods.

During all your contacts with Mrs. Davies over the past five weeks, there has been no evidence of deterioration in mood or escalation of grief. You have seen her twice weekly since discharge and taken multiple calls from her, and at no time have you thought she was becoming unwell with depression. Furthermore, there was no evidence of psychosis (odd behaviour, hearing voices, fear of being persecuted or controlled). She seems to have accepted her husband's passing after a long period of illness. Her daughter has taken over managing her father's estate and finances because this seems to escalate Mrs. Davies anxiety and help seeking behaviour. To the best of your knowledge there is no conflict between Mrs. Davies and her children over the will or the estate.

As Mrs. Davies' community mental health nurse you have organised this appointment with the psychiatrist. You are not entirely sure what is going on with Mrs. Davies, and you want to let the doctor know what has been happening. You wonder what is causing the problems the community mental health service is having with Mrs. Davies and what the diagnosis might be.

Background

Mrs. Davies' husband, George, died three months ago at age 74 after a long battle with lung cancer. During her husband's illness they received support and regular contact with the children and community / clinical support. It was a very difficult time for Mrs. Davies because she was not used to managing finances or making decisions. When her husband died her children stayed with her for a few weeks. She became increasingly distressed and refused to allow her daughter to leave her.

Mrs. Davies met George when she was 16 years old, and married when she was 18 years old. She describes herself as always being shy and cautious, even as a child. George was an engineer, and they lived a good life raising three children. When George retired they spent all their time together, and she became completely reliant on him for everything. Their children maintain contact by phone and infrequent visits, and do not want this burden on themselves.

Admission

Her daughter, June, felt Mrs. Davies' indecisiveness was worse than usual so took her to see the general practitioner. The GP was worried by her degree of distress and indecision, and wondered if she had depression. She was referred for admission six weeks ago. She settled well on the ward and did not require medication. On the ward the Occupational Therapist assessed her as having the ability to function independently in the home and socially. However, she sought out constant reassurance and validation, both from other patients and staff, which reduced her distress.

Mrs. Davies started to refer to particular staff as friends even when explained that the nursing staff function in their professional capacity, and not as friends. Attempts were made to manage some of the boundary issues with Mrs. Davies. Being on the ward and being expected to make so many of her own decisions was very distressing for her. She was supported by the Social Worker on the ward to begin to address the Will and bills. On discharge she was encouraged to consider attending groups and activities to meet others; she thought this was a good idea.

She continues to ring the ward in the morning when she gets out of bed, during the day and even during the night to check in with the staff regarding how she was coping, trying to get staff to help her make decisions about all kinds of things at home and in her life. She misses the ward wishing she could return. She was also ringing the community mental health nurse daily as well as the front reception in the community mental health service. This is causing problems in the community team as anyone who gets her on the phone has a very difficult time ending the call.

Medical and Psychiatric History

While in the hospital her memory was checked and there is no evidence of forgetfulness or problems like dementia. There were no changes to suggest an acute medical problem, or other disorders like high blood pressure or diabetes. She does not take any medicines.

You are not aware of any past psychiatric history or admissions to mental health units. There is no evidence of a significant depression, specific anxiety disorder, or psychotic disorder and there is no evidence of an acute mental illness. Mrs. Davies does not have any significant alcohol use, and she does not use drugs.

4.2 How to play the role:

As a community mental health nurse, you can dress in comfortable work attire and are well groomed. You present as relaxed but concerned about what is happening with Mrs. Davies, and the impact on the staff and yourself from the frequent contacts and requests of Mrs. Davies.

To give information as per the role, any questions asked that you do not have answers for, please say that you do not know or are uncertain, or will check and get back to the doctor.

4.3 Opening statement:

'Hello Doctor, I want to talk to you about Mrs. Davies before you see her.'

4.4 What to expect from the candidate:

The candidate will listen to your concerns as the community mental health nurse for Mrs. Davies.

They will ask questions and seek clarification about her history, admission to hospital and what is happening now. They will try to make sense of what you tell them and will try to explain to you what they think is causing Mrs. Davies to call so frequently, and what may explain her behaviour recently. If you do not have a scripted answer, explain that you do not know or are uncertain or will check and get back to the doctor.

The third task involves the candidate turning to the Examiner. At that time sit quietly and relax.

4.5 Responses you MUST make:

'She doesn't think she can take care of herself.'

'It seems she is trying to get anyone she can to make decisions for her.'

'She misses her husband, he made all the decisions for her.'

'What are we going to do, I don't understand why this is still going on?'

4.6 Responses you MIGHT make:

If asked if Mrs. Davies is suicidal

Scripted Response: ***'No suicidal thoughts, intent or plan.'***

If asked if Mrs. Davies is depressed

Scripted Response: ***'I think she is sad about George's death, but doesn't seem depressed.'***

If asked if Mrs. Davies is anxious

Scripted Response: ***'I haven't seen any evidence of significant anxiety or panic attacks.'***

4.7 Medication and dosage that you need to remember:

Nil

STATION 7 – MARKING DOMAINS

The main assessment aims are:

- Take a focussed history from the community mental health nurse in order to understand their concerns.
- Provide a psychological framework that explains the presentation.
- Describe relevant diagnoses and differential diagnoses to the examiner.

Level of Observed Competence:

1.0 MEDICAL EXPERT

1.2 Did the candidate take appropriately detailed and focussed collateral history? (Proportionate value – 40%)

Surpasses the Standard (scores 5) if:

clearly achieves the overall standard with a superior performance in a range of areas; demonstrates prioritisation; elicits a complete and sophisticated understanding of complexity.

Achieves the Standard by:

demonstrating use of a tailored biopsychosocial approach; conducting a detailed but targeted assessment; obtaining a history with appropriate depth and breadth (history taking is hypothesis-driven); integrating key sociocultural issues relevant to the assessment; demonstrating ability to prioritise; clarifying important positive and negative features; assessing for typical and atypical features.

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

- Explore the possibility of major depression.

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

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

1.2. Category: ASSESSMENT – Data Gathering Content	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"/>	

1.11 Did the candidate generate an adequate psychological explanation to make sense of the presentation? (Proportionate value – 30%)

Surpasses the Standard (scores 5) if:

presents a sophisticated psychological explanation to accurately describe and explain the presentation.

Achieves the Standard by:

identifying and succinctly summarising important aspects of the history; synthesising information using a biopsychosocial framework; integrating medical, developmental, psychological and sociological information; developing hypotheses to make sense of the patient's predicament; incorporating relevant predisposing, precipitating, perpetuating and protective factors; commenting on missing or unexpected data; including a sociocultural formulation; analysing vulnerability and resilience factors.

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

- Identify three (3) psychological factors influencing the presentation.

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 including inability to synthesise information obtained; provides an inaccurate formulation.

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

1.11. Category: FORMULATION	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 candidate describe the relevant diagnosis and differential diagnoses?
(Proportionate value – 30%)**

Surpasses the Standard (scores 5) if:

demonstrates a superior performance; appropriately identifies the limitations of diagnostic classification systems to guide treatment; accurately justifies a range of differential diagnoses.

Achieves the Standard by:

demonstrating capacity to integrate available information in order to provide a diagnosis and differential diagnoses; accurately linking formulated elements to any diagnostic statement; demonstrating detailed understanding of diagnostic systems to provide justification for diagnosis and differential diagnosis; considering adjustment disorders; excluding substance misuse as a contributing factor.

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

- a. Propose both diagnoses of grief / loss and Dependent Personality Structure / Disorder.

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 diagnoses; errors or omissions are significant; does not offer any diagnosis.

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"/>	

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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