

**1.0 Descriptive summary of station:**

In this station the candidate must assess Carol, a 28-year-old woman referred by her GP with a history of 'funny turns', anxiety and difficulty sleeping. Carol has a history of trauma and the candidate is expected to elicit and provide a formulation to the examiner, identifying PTSD and dissociation as the preferred diagnosis.

**1.1 The main assessment aims are:**

- To evaluate the candidates' ability to assess PTSD and associated symptoms of dissociation.
- To provide a sophisticated formulation for PTSD with dissociation incorporating the role of previous trauma.
- To apply relevant theories to the formulation.

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

- Establish a history of specific trauma relevant to PTSD symptoms presented.
- Enquire about depersonalisation symptoms.
- Confirm the diagnosis of PTSD with dissociative symptoms.
- Identify at least two of the most appropriate differential diagnoses.
- Explore the relevance of trauma with sensitivity.
- Apply a relevant theory when providing a formulation for her PTSD.

**1.3 Station covers the:**

- **RANZCP OSCE Curriculum Blueprint Primary Descriptor Category:** Anxiety Disorders, Core Psychiatric Skills
- **Area of Practice:** Adult Psychiatry
- **CanMEDS Domains:** Medical Expert, Communicator
- **RANZCP 2012 Fellowship Program Learning Outcomes:** Medical Expert (Assessment – Data Gathering Content; Diagnosis; Formulation), Communicator (Patient Communication – To Patient / Family / Carer)

**References:**

- Levin, A.P, Kleinman S.B. and Adler J.S. (2014) DSM-5 and Posttraumatic Stress Disorder *Journal of the American Academy of Psychiatry and Law* 42:146–58.
- Mueller-Pfeiffer C et al (2013), Characteristics of Child Maltreatment and Their Relation to Dissociation, Posttraumatic Stress Symptoms, and Depression in Adult Psychiatric Patients *Journal of Nervous and Mental Disease* 201: 471 – 477.
- Simeon, D., Guraknik, O., Schmeidler, J., Sirof, B., & Knutelska, M. (2001). *The role of childhood interpersonal trauma in depersonalisation disorder. American Journal of Psychiatry*, 158(7), 1027-1033.
- Van der Kolk, B. A., David, P., Roth, S., Mandel, F., McFarlane, A. C., & Herman, J. (1996). *Dissociation, somatisation, and affect dysregulation: The complexity of adaptation to trauma. American Journal of Psychiatry*, 153 July 1996 Festschrift supplement(7), 83-93.
- Wolf E. J. et al (2012) A Latent Class Analysis of Dissociation and Posttraumatic Stress Disorder Evidence for a Dissociative Subtype, *Archives of General Psychiatry*, 69(7):698-705.

**1.4 Station requirements:**

- Standard consulting room; no physical examination facilities required.
- Five chairs (examiners x 2, role player x 1, candidate x 1, observer x 1).
- Laminated copy of 'Instructions to Candidate'.
- Role player: female, late 20s.
- Pen for candidate.
- Timer and batteries for examiners.

## 2.0 Instructions to Candidate

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

You are working as a junior consultant psychiatrist in an outpatient setting.

A GP has referred a 28-year-old woman called Carol. His letter reads:

*'Please can you see Carol, a school teacher who is well known to me since 2011, although I don't know too much about her distant past. She presented to me about a month ago with difficulty sleeping and anxiety. When I saw her she described 'funny turns' where she feels she cannot connect with her students. These have interfered with her ability to teach and as a result she had to take sick leave.*

*There is no history of hypertension or a head injury and she has seen both a cardiologist and neurologist and had a normal CT and EEG, and bloods. I therefore do not believe that these 'turns' are cardiac or neurological.*

*From a psychiatric perspective, I could not elicit any psychotic symptoms and she has no history of drug or alcohol use. I am rather at a loss about her diagnosis so I gave her some zopiclone to help with sleep but she is not keen on medication.'*

### Your tasks are to:

- Take a focussed psychiatric history from Carol with sufficient detail to establish a diagnosis and formulation.
- Present a detailed explanatory formulation, diagnosis and differential diagnoses **to the examiner**.

**If you have not commenced the second task by twelve (12) minutes you will receive a prompt.**

### Station 3 - 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 and co-examiner.

#### During examination:

- Please ensure mark sheets and other station information, are out of candidate's view.
- At the **first bell**, take your places.
- At the **second bell**, start your timer, check candidate ID number on entry.
- TAKE NOTE of the cue for the scripted prompt you are to give at ten (10) minutes.
- 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 **twelve (12) minutes**, as indicated by the timer, if the candidate has not already begun, provide the following prompt:  
***'Please proceed to the second task.'***
- At **fifteen (15) minutes**, as indicated by the timer, the final bell will ring. Finish the examination immediately.

#### At conclusion of examination:

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

#### If a candidate elects to finish early after the final task:

- You are to state the following:  
***'Are you satisfied you have completed the task(s)?  
If so, you must remain in the room and NOT proceed to the next station until the bell rings.'***
- If the candidate asks if you think they should finish or have done enough etc., refer them back to their instructions and ask them to decide whether they believe they have completed the task(s).

### 3.0 Instructions to Examiner

#### 3.1 In this station, your role is to:

Observe the activity undertaken in the station and judge it according to the station assessment aims and defined tasks as outlined in 1.1 and 1.2.

When the candidate enters the room briefly check ID number.

You have no opening statement.

The role player opens with the following statement:

***'My GP thought I should come and see you as I feel like I don't know who I am anymore.'***

At **twelve (12) minutes**, as indicated by the timer, if the candidate has not already begun, provide the following prompt:

***'Please proceed to the second task.'***

#### 3.2 Background information for examiners

In this station the candidate is expected to take a focussed history from a young woman who is experiencing 'funny turns' associated with anxiety and insomnia. The candidate is to elicit a history of trauma and conclude that she is suffering from PTSD with associated symptoms of dissociation, incorporating the role of previous trauma in the formulation.

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

- Establish a history of specific trauma relevant to PTSD symptoms presented.
- Enquire about depersonalisation symptoms.
- Confirm the diagnosis of PTSD with dissociative symptoms.
- Identify at least two of the most appropriate differential diagnoses.
- Explore the relevance of trauma with sensitivity.
- Apply a relevant theory when providing a formulation for her PTSD.

A surpassing candidate may synthesis the following material and also distinguish the difference between dissociative SYMPTOMS and dissociative DISORDERS.

There has long been a recognised link between trauma and mental and emotional disturbance, specifically that severe trauma can seriously affect people on an ongoing basis. In her classic book 'Trauma and Recovery' Judith Herman (1992) describes trauma as events that overwhelm the ordinary adaptations to life and are characterised by terror and helplessness (pp. 33-35). This can have long-term self-perpetuating effects where the overwhelming events remain unintegrated in the psyche, damaging both one's sense of self and relational capacities. She notes that for those whose trauma included a physiological freeze response (frozen with terror) are particularly prone to later problems. Where the trauma is from childhood, she identifies three major forms of adaptation: dissociative symptoms, a fragmented identity, and difficulty regulating emotional states (p. 110).

#### **Dissociative Symptoms**

Dissociation is a word that is used to describe the disconnection or lack of connection between things usually associated with each other. Dissociative symptoms include depersonalisation (feeling unreal), derealisation (feeling as if the world is unreal) or blanking out.

Dissociated experiences are not integrated into the usual sense of self, resulting in discontinuities in conscious awareness (Anderson & Alexander, 1996; Frey, 2001; International Society for the Study of Dissociation, 2002; Maldonado, Butler, & Spiegel, 2002; Pascuzzi & Weber, 1997; Rauschenberger & Lynn, 1995; Simeon et al., 2001; Spiegel & Cardena, 1991; Steinberg et al., 1990, 1993). In severe forms of dissociation, disconnection occurs in the usually integrated functions of consciousness, memory, identity, or perception. For example, someone may think about an event that was tremendously upsetting yet have no feelings about it. Clinically, this is termed emotional numbing, one of the hallmarks of post-traumatic stress disorder.

Fragmented identity is associated with an unstable changeable personality or an internal sense of fragmentation. Difficulty regulating emotional states refers to symptoms of emotional instability and reactivity.

The psychological process of dissociation is commonly found in people seeking mental health treatment (*Maldonado et al., 2002*). Dissociation may affect a person subjectively in the form of 'made' thoughts, feelings, and actions. These are thoughts or emotions seemingly coming out of nowhere, or finding oneself carrying out an action as if it were controlled by a force other than oneself (*Dell, 2001*). Typically, a person feels 'taken over' by an emotion that does not seem to make sense at the time. Feeling suddenly, unbearably sad, without an apparent reason, and then having the sadness leave in much the same manner as it came, is an example. Or someone may find himself or herself doing something that they would not normally do but unable to stop themselves, almost as if they are being compelled to do it. This is sometimes described as the experience of being a 'passenger' in one's body, rather than the driver.

There are five main ways in which the dissociation of psychological processes can change the way a person experiences living: depersonalisation, derealisation, amnesia, identity confusion, and identity alteration. There are several types of dissociative disorders, all of which cause a change in consciousness, memory, identity, or how one views his or her surroundings. The change can come on abruptly or slowly, and it may not happen all the time.

There are four types of dissociative disorders:

- **Depersonalisation / Derealisation Disorder:** a person feels 'detached from' their thoughts or body. For example, they may feel as though they are floating outside their body, looking at people through a window, or in a dream. Despite these experiences, the person still stays in touch with reality.
- **Dissociative Amnesia:** where a person has one or more experience of being unable to remember or recall important information about themselves. This difficulty in remembering information goes beyond simple forgetfulness. The information that the person cannot recall is usually about some kind of traumatic or stressful event.
- **Dissociative Identity Disorder:** used to be called, 'Multiple Personality Disorder' where a person will have two or more separate identities that each have their own way of thinking and relating to the world. To have this disorder, a minimum of two of these identities must also take control over the person's behaviour again and again. The person with dissociative identity disorder may also have difficulty remembering personal information that, like dissociative amnesia, goes beyond simple forgetfulness.
- **Dissociative Disorder Not Otherwise Specified:** this term is used to describe a dissociative disorder where the main feature is still some kind of dissociative experience, but criteria for other dissociative disorders are not present.

Dissociative disorders are common among people with other disorders. For example, some studies have found that over 10 percent of people with psychiatric disorders in treatment have had some kind of dissociative disorder.

In addition, people who have experienced abuse and / or neglect in childhood may be particularly at risk for developing a dissociative disorder. For example, one study found that 71 percent of people with a dissociative disorder experienced physical abuse in childhood, and 74 percent indicated that they had been sexually abused as a child (*Foote, B. 2006*).

### **PTSD and Dissociation**

Individuals with PTSD also may be more likely to have a dissociative disorder. For example, a study of 628 women from the general community found that, of those with a dissociative disorder (the most common of which was dissociative disorder not otherwise specified, followed by dissociative amnesia), 7 percent also had a PTSD diagnosis (*Sar V, Akyuz G. Dogan O. (2007)*).

### **The Link Between Trauma and Dissociation**

The relationship between traumatic experiences and dissociative symptoms is well-established in the literature and can be found in studies from many cultures and countries worldwide (e.g. *Baita, 2006; Gingrich, 2006; Sar et al., 2014*).

## Depersonalisation

Depersonalisation is the sense of being detached from, or 'not in' one's body. This is what is often referred to as an 'out-of-body' experience. However, some people report rather profound alienation from their bodies, a sense that they do not recognise themselves in the mirror, recognise their face, or simply feel not 'connected' to their bodies in ways which are challenging to articulate (Frey, 2001; Guralnik, Schmeidler, & Simeon, 2000; Maldonado et al., 2002; Simeon et al., 2001; Spiegel & Cardeña; Steinberg, 1995). Depersonalisation is often associated with trauma. It can sometimes present like atypical depression and is often co-morbid with it (Baker et al., 2003, p. 428). The symptoms include feeling emotionless and detached from various aspects of self (Depersonalisation Research Unit DRU, 2001, p. 128) and 'feelings of having the mind empty of thoughts, memories or images, and an inability to focus and sustain attention' (Sierra & Berrios, 2000, p. 154). Clients may report such things as 'I don't feel like a person' or 'Most of the time I'm feeling empty' or 'It's very rarely that I can conjure up memory or emotions about the past or anything like that, because normally I can't'.

Physiologically depersonalisation is understood as a 'heightened arousal combined with a dampening of emotional response, [and] is widely viewed as a defence mechanism in the face of severe stress, life-threatening situations or trauma' (DRU, 2001, p. 129). This view is shared by Sierra & Berrios who contend that depersonalisation 'results from two simultaneous mechanisms: an inhibition of emotional processing, and a heightened state of alertness' (2000, p. 154).

## Derealisation

Derealisation is the sense of the world not being real. Some people say the world looks phony, foggy, far away, or as if seen through a veil. Some people describe seeing the world as if they are detached, or as if they were watching a movie (Steinberg, 1995).

## Post-Traumatic Stress Disorder (PTSD)

In 2013, the American Psychiatric Association revised the PTSD diagnostic criteria in the fifth edition of its Diagnostic and Statistical Manual of Mental Disorders (DSM-5). The diagnostic criteria are specified below.

Diagnostic criteria for PTSD include a history of exposure to a traumatic event that meets specific stipulations and symptoms from each of four symptom clusters: intrusion, avoidance, negative alterations in cognitions and mood, and alterations in arousal and reactivity. The sixth criterion concerns duration of symptoms; the seventh assesses functioning; and, the eighth criterion clarifies symptoms as not attributable to a substance or co-occurring medical condition.

Two specifications are noted including delayed expression and a dissociative subtype of PTSD, the latter of which is new to DSM-5. In both specifications, the full diagnostic criteria for PTSD must be met for application to be warranted.

**Criterion A: stressor** - The person was exposed to: death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence, as follows: (one required)

1. Direct exposure.
2. Witnessing, in person.
3. Indirectly, by learning that a close relative or close friend was exposed to trauma. If the event involved actual or threatened death, it must have been violent or accidental.
4. Repeated or extreme indirect exposure to aversive details of the event(s), usually in the course of professional duties (e.g., first responders, collecting body parts; professionals repeatedly exposed to details of child abuse). This does not include indirect non-professional exposure through electronic media, television, movies, or pictures.

**Criterion B: intrusion symptoms** - The traumatic event is persistently re-experienced in the following way(s): (one required)

1. Recurrent, involuntary, and intrusive memories. Note: Children older than six may express this symptom in repetitive play.
2. Traumatic nightmares. Note: Children may have frightening dreams without content related to the trauma(s).
3. Dissociative reactions (e.g., flashbacks) which may occur on a continuum from brief episodes to complete loss of consciousness. Note: Children may re-enact the event in play.
4. Intense or prolonged distress after exposure to traumatic reminders.
5. Marked physiologic reactivity after exposure to trauma-related stimuli.

**Criterion C: avoidance** - Persistent effortful avoidance of distressing trauma-related stimuli after the event: (one required)

1. Trauma-related thoughts or feelings.
2. Trauma-related external reminders (e.g., people, places, conversations, activities, objects, or situations).

**Criterion D: negative alterations in cognitions and mood** - Negative alterations in cognitions and mood that began or worsened after the traumatic event: (two required)

1. Inability to recall key features of the traumatic event (usually dissociative amnesia; not due to head injury, alcohol, or drugs).
2. Persistent (and often distorted) negative beliefs and expectations about oneself or the world (e.g., 'I am bad', 'The world is completely dangerous').
3. Persistent distorted blame of self or others for causing the traumatic event or for resulting consequences.
4. Persistent negative trauma-related emotions (e.g., fear, horror, anger, guilt, or shame).
5. Markedly diminished interest in (pre-traumatic) significant activities.
6. Feeling alienated from others (e.g., detachment or estrangement).
7. Constricted affect: persistent inability to experience positive emotions.

**Criterion E: alterations in arousal and reactivity** - Trauma-related alterations in arousal and reactivity that began or worsened after the traumatic event: (two required)

1. Irritable or aggressive behaviour
2. Self-destructive or reckless behaviour
3. Hypervigilance
4. Exaggerated startle response
5. Problems in concentration
6. Sleep disturbance

**Criterion F: duration** - Persistence of symptoms (in Criteria B, C, D, and E) for more than one month.

**Criterion G: functional significance** - Significant symptom-related distress or functional impairment (e.g., social, occupational).

**Criterion H: exclusion** - Disturbance is not due to medication, substance use, or other illness.

**Specify if: With dissociative symptoms.**

In addition to meeting criteria for diagnosis, an individual experiences high levels of either of the following in reaction to trauma-related stimuli:

1. Depersonalisation: experience of being an outside observer of or detached from oneself (e.g., feeling as if 'this is not happening to me' or one were in a dream).
2. Derealisation: experience of unreality, distance, or distortion (e.g., 'things are not real').

**Specify if: With delayed expression.**

Full diagnosis is not met until at least six months after the trauma(s), although onset of symptoms may occur immediately.

The addition of a dissociative subtype of PTSD in DSM-5 was based on three lines of evidence:

1. Several studies using latent class, taxometric, epidemiological, and confirmatory factor analyses conducted on PTSD symptom endorsements collected from Veteran and civilian PTSD samples indicated that a subgroup of individuals (roughly 15 - 30%) suffering from PTSD reported symptoms of depersonalisation and derealisation (1-3).
2. Neurobiological evidence suggests depersonalisation and derealisation responses in PTSD are distinct from re-experiencing / hyperarousal reactivity.
3. Early evidence suggests that symptoms of depersonalisation and derealisation in PTSD are relevant to treatment decisions in PTSD (*reviewed in Lanius et al., 2012;5*); e.g. respond better to treatments that included cognitive restructuring and skills training in affective and interpersonal regulation in addition to exposure-based therapies (7,8).

**ICD-10 describes PTSD as:**

- A.** Exposure to a stressful event or situation (either short or long lasting) of exceptionally threatening or catastrophic nature, which is likely to cause pervasive distress in almost anyone.
- B.** Persistent remembering or 'reliving' the stressor by intrusive flash backs, vivid memories, recurring dreams, or by experiencing distress when exposed to circumstances resembling or associated with the stressor.
- C.** Actual or preferred avoidance of circumstances resembling or associated with the stressor (not present before exposure to the stressor).
- D. Either (1) or (2):**
  - 1)** Inability to recall, either partially or completely, some important aspects of the period of exposure to the stressor
  - 2)** Persistent symptoms of increased psychological sensitivity and arousal (not present before exposure to the stressor) shown by any two of the following:
    - difficulty in falling or staying asleep;
    - irritability or outbursts of anger;
    - difficulty in concentrating;
    - hyper-vigilance;
    - exaggerated startle response.
- E.** Criteria B, C (For some purposes, onset delayed more than six months may be included but this should be clearly specified separately).

ICD-10 does not specifically identify dissociative symptoms as a specifier for PTSD like DSM-5 does.

**ICD-10 Dissociative [conversion] Disorders** are made up of a separate grouping made up of Dissociative amnesia; Dissociative fugue; Dissociative stupor; Trance and possession disorders; Dissociate motor disorders; Dissociative convulsion; Dissociate anaesthesia and sensory loss; Mixed dissociative [conversion] disorders. Other dissociative [conversion] disorders include Ganser's syndrome, Multiple personality disorder, Transient dissociative [conversion] disorders occurring in childhood and adolescence, Other specified dissociative [conversion] disorders, and Dissociative [conversion] disorder, unspecified.

**Formulation:**

Various theories have been proposed to explain the development and maintenance of post-traumatic stress disorder (PTSD).

The most prominent current theories of emotional processing, dual representation, and the cognitive model of PTSD draw on earlier work, in particular conditioning, information processing, and classical cognitive theory.

Psychodynamic and attachment theory have also influenced thinking in this area. The latest theories combine stimulus and response elements with meaning, interpretation, and appraisal; they argue that successful processing depends on being able to access and assimilate new information within pre-existing schemas. From a biological perspective, the classic fight-or-flight response to perceived threat is a reflexive nervous phenomenon that has obvious survival advantages in evolutionary terms. However, the systems that organise the constellation of reflexive survival behaviours following exposure to perceived threat can under some circumstances become dysregulated in the process. Chronic dysregulation of these systems can lead to functional impairment in certain individuals who become 'psychologically traumatised' and suffer from post-traumatic stress disorder (PTSD).

A body of data accumulated over several decades has demonstrated neurobiological abnormalities in PTSD patients. Some of these findings offer insight into the pathophysiology of PTSD as well as the biological vulnerability of certain populations to develop PTSD. Several pathological features found in PTSD patients overlap with features found in patients with traumatic brain injury, paralleling the shared signs and symptoms of these clinical syndromes. Social factors are also recognised as playing a significant role in the development and maintenance of PTSD. Social factors that moderate the response to traumatic events include:



- Community function and support
- Family function and support
- Displacement
- Disconnection
- Living conditions
- Material loss
- Loss of role
- Food
- Finance
- Disorganised services
- Employment
- Leisure activities

The preferred diagnosis is PTSD with dissociative symptoms.

The candidate should consider important differential diagnoses, the most appropriate being:

- PTSD
- Major Depressive Disorder
- Dissociative Disorder NOS
- Panic Disorder
- Anxiety Disorder NOS
- Borderline Personality Disorder

### 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

- 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).
- they can act as a **communicator** who effectively facilitates the doctor patient relationship.
- they can **collaborate** effectively within a healthcare team to optimise patient care.
- 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.
- they can act as **health advocates** to advance the health and well-being of individual patients, communities and populations.
- 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.
- they can act as **professionals** who are committed to ethical practice and high personal standards of behaviour.

**Below the Standard** – the candidate demonstrates significant defects in several of the domains listed above.

**Does Not Achieve the Standard** – the candidate demonstrates significant defects in most of the domains listed above or the candidate demonstrates significant defects in the first domain of being a medical expert.

## 4.0 Instructions to the Role Player

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

Your name is Carol and you are 28 years old. You are a teacher and are married to Nick who is a 29-year-old builder. You have been referred to an outpatient mental health service by your GP, Dr Maddison.

You are coming to this appointment today as you are worried because you are finding it very difficult to concentrate in the classroom. You have had several strange episodes when students have asked you questions and you find that even though you can hear them it seems as if they are far away. At these times, you feel detached / disconnected and as if you are outside your body looking on.

On two occasions, you have left the classroom and found yourself in the staff toilet without consciously being aware you had meant to go there. You have no idea what you did or said before leaving the class which is very embarrassing. You have even wondered if you are blacking out or having a fit.

You have had some tests organised by your GP and 2 medical specialists, and they have found nothing wrong. Despite this you are now on sick leave.

You have started to feel desperate as this has been going on for 4 weeks now and you have been off work for 2 weeks. You are worried you will lose your job and this worry is stopping you from falling asleep. You have even started to feel like it would be easier if you were just dead. If you are asked if you would commit suicide, you are sure that you could never harm yourself. The reason you are so sure is because of the distress it would cause your parents whom you saw in great pain when your brother was murdered (see details under personal background and family circumstances below).

If asked about your opinion of your future or future plans: you feel as if you have no future especially if you can't work (which you usually take great pride in), and you are worried about your relationship with your husband as you now feel distant from him (as well as everyone else). The idea of having children seems impossible which makes you worry more about your relationship.

If you are asked by the candidate: you do not have strange experiences like seeing things or hearing voices; you are not paranoid (you don't feel threatened by anyone) or hold any other beliefs that others don't think are real. You do not drink alcohol and have never used drugs. You have never been referred to a psychiatrist before and have never been admitted to a psychiatric hospital.

#### About your personal trauma background and family circumstances:

You have a difficult relationship with your parents whom you find intrusive and critical. You try to keep them at arm's length, and purposefully work and live on the other side of Perth from them. You have never confronted them about how you feel about their behaviour as you think this will make matters worse. Your mother, Annette, suffers from bouts of depression and your father Martin drinks too much. Both these issues have worsened since your brother's murder. You have a sister, Debbie, who is 2 years older than you and lives in England and with whom you have little contact.

You were sexually abused between ages of 11 and 14 by a male extended family member (your paternal aunt's husband - your father's sister's husband George). You have never disclosed this to your parents or had any specific sexual abuse counselling. You try not to think about this and block it out so don't really feel anything (well you say you don't).

When you were 16 your older brother Simon was shot in somewhat unclear circumstances which may have involved a drug deal. You were very traumatised by this and particularly by what was written in the papers, and the intrusive nature of the press on you and your family. The perpetrator was convicted for murder but the motive was never established. You had some brief counselling through victim support at the time of your brother's death and at that time disclosed the sexual abuse to that counsellor but you did not want to take things any further. You feel that your brother's death, and the events around that 'took over' and blocked out the previous experiences with your uncle.

You have never sought counselling since then, preferring to throw yourself into work and sport and 'get on with your life' with Nick, and have tried not to think about things from the past too much. Living on the other side of the city away from childhood haunts also helps you not to be reminded of him and you generally don't accept invitations to meet up with childhood associates or attend functions in that area of the city. You also tend to avoid family gatherings - of which there are few anyway. You have not been aware of being distressed over the last few years and would describe yourself as calm. You and Nick don't discuss much

about how either of you feel about things in general and don't argue about things. You are aware that people see you as unemotional and also that you don't seem to get as excited or enjoy things as much as other people. You have had flashbacks over the years more often to do with your brother e.g. of the press crowding around the house when you were trying to get to the car and have been surprised when you have also had flashbacks of the sexual abuse as you thought you had 'dealt with this'. You try to never watch the news on TV as you feel very upset and angry when you see the press asking family members questions after a traumatic event.

The perpetrator of your brother's murder is now due for release from prison and you suddenly find yourself unable to function. You have great difficulty in getting to sleep and staying asleep (which has been a long term issue but is currently even worse than ever) and have experienced a panic attack for the first time recently, waking you from sleep (woke up terrified, sweating, heart racing, hyperventilating, feeling like you are having a heart attack) with nightmares, low mood, tearfulness. You find that you no longer can get interested in or care about your students and are struggling with your own study and assignments.

#### About your medical care:

You have had the same GP, Dr Maddison, for the past 6 years since you moved to where you now live and work. You have seen her regularly for contraception and minor illnesses or sports injuries. You have some trust in her and have told her a little about what happened with your brother and a little about your plans / concerns about having children e.g. how it will impact on your career / study.

In response to your recent symptoms, your GP has examined you and referred you to see a cardiologist (heart specialist) and a neurologist (nerve / brain specialist) who have also examined you and run some tests. One test was a scan of your brain and another was called an EEG - that was like a heart tracing test.

They have not found any explanation for your symptoms and the GP thinks you might be depressed. The GP has given you some sleeping tablets but they are not helping and now wants you to take medication for depression but you are hesitant and frightened it will make you feel worse. You took an antidepressant for a short period after your brother died but you didn't think it helped you, and it didn't agree with you (headaches and nausea). You can't remember what the antidepressant was called and are reluctant to try one again so your GP has referred you to mental health for further advice.

#### About your social life and marriage:

You met your husband Nick through Touch Rugby-Football when you were 20. You live in your own home which Nick renovated. You are very focussed on your job and are also studying further papers in education and are hoping to gain a Master's degree in education. While you and Nick socialise a little with some members of his family and colleagues of yours from work, the two of you have been busy with the house renovation and you with your study. You gave up Touch a couple of years ago, as you were studying but Nick still plays. You have no children but have talked about it and Nick is keen for this to happen soon. You are quite ambivalent about having children but have not disclosed this to Nick as you are worried that this will affect your relationship.

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

Plain slightly formal casual clothing: conservative skirt and top, flat shoes, tidy grooming but no make-up. Sit in upright posture, knees together, feet flat on floor, hands folded in lap.

You are ill at ease but sitting still, looking down or ahead, with very little eye contact with the candidate. Your speech is soft and monotonous in tone and you do not really talk unless it is in response to questions with little spontaneity.

You can give the candidate one or two shy smiles but not much emotional expression / reaction overall. Not angry or hostile.

## **4.3 Opening statement:**

***'My GP thought I should come and see you as I feel like I don't know who I am anymore.'***

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

Candidate should ask you about your mood (low and sad and numb), concentration (bad), memory(okay), sleep (terrible-can't get to sleep, can't stay asleep), appetite (never been great and currently not much different), enjoyment of things and interest (non-existent), anxiety (you are not aware of worrying about anything in particular), panic attacks (yes), repeated, unwanted thoughts – obsessions - about things like excessive cleanliness or compulsive checking or cleaning (no), fear of being in social situations (no, but you don't socialise much and feel like you don't like people).

#### 4.5 Responses you MUST make:

*'It's like I am watching from outside my body.'*

*'I feel like I'm fake, it's as if I'm not real.'*

*'At the time my brother's death took over my life.'*

#### 4.6 Responses you MIGHT make:

Anticipated Question: Do you feel like you are numb or you have lost your identity?

Scripted Response:

*'Yes — although I'm not sure I have ever really felt like I was truly part of things.'*

*'I don't think I have ever known who I am.'*

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

Zopiclone 7.5 milligrams one tablet at night to help with sleep.

## STATION 3 – MARKING DOMAINS

### The main assessment aims are:

- To evaluate the candidates' ability to assess PTSD and associated symptoms of dissociation.
- To provide a sophisticated formulation for PTSD with dissociation incorporating the role of previous trauma.
- To apply relevant theories to the formulation.

### Level of Observed Competence:

#### 1.0 MEDICAL EXPERT

#### 1.2 Did the candidate take appropriately detailed and focussed history? (Proportionate value - 25%)

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

Clearly achieves the overall standard with a superior performance in a range of areas; demonstrates prioritisation and sophistication incorporating questions which clearly differentiate between the Dissociative Disorders and PTSD with dissociative symptoms.

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

demonstrating use of a tailored biopsychosocial approach; conducting a detailed but targeted assessment; history taking is hypothesis-driven; eliciting key issues relevant to the patient's problems and circumstances including: relevant PTSD symptoms e.g. re-experiencing event, negative emotion, autonomic hyperarousal; integrating key psychosocial issues relating to the trauma; exploring dissociative symptoms; completing a risk assessment relevant to mood and trauma related symptoms.

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

- Establish a history of specific trauma relevant to PTSD symptoms presented
- Enquire about depersonalisation symptoms.

**A score of 4** may be awarded depending on the depth and breadth of additional factors covered; if the candidate includes most or all correct elements.

##### **Below the Standard (scores 2 or 1):**

scores 2 if the candidate does not meet (a) or (b) above, or has omissions that would detract from the overall quality response; significant omissions affecting quality scores 1.

##### **Does Not Achieve the Standard (scores 0) if:**

does not ask if there is a history of trauma; does not ask about symptoms of PTSD or dissociation.

1.2. Category: ASSESSMENT – Data Gathering Content	Surpasses Standard	Achieves Standard			Below the Standard		Standard Not Achieved
ENTER GRADE (X) IN ONE BOX ONLY	5 <input type="checkbox"/>	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	0 <input type="checkbox"/>	

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

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

concludes and justifies PTSD with dissociative symptoms and rules out other forms of PTSD and other dissociative disorders. Demonstrates a superior performance; appropriately identifies the limitations of diagnostic classification systems to guide treatment.

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

demonstrating capacity to integrate available information in order to formulate a diagnosis / differential diagnosis; demonstrating detailed understanding of diagnostic systems to provide justification for diagnosis and differential diagnosis; adequately prioritising the conditions relevant to the obtained history and findings, utilising a biopsychosocial approach, and / or identifying relevant predisposing, precipitating perpetuating and protective factors.

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

- Confirm the diagnosis of PTSD with dissociative symptoms
- Identify at least two of the most appropriate differential diagnoses.

**A score of 4** may be awarded depending on the depth and breadth of additional factors covered; if the candidate includes most or all correct elements.

##### **Below the Standard (scores 2 or 1):**

scores 2 if the candidate does not meet (a) or (b) above, or has omissions that would detract from the overall quality response; significant omissions affecting the quality scores 1.

##### **Does Not Achieve the Standard (scores 0) if:**

inaccurate or inadequate diagnostic formulation; errors or omissions are significant and do materially adversely affect conclusion. Does not include PTSD or Dissociation in differential diagnosis.

1.9 Category: DIAGNOSIS	Surpasses Standard	Achieves Standard			Below the Standard		Standard Not Achieved
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"/>	

**2.0 COMMUNICATOR**

**2.1 Did the candidate demonstrate an appropriate professional approach to gathering information from a patient who has PTSD? (Proportionate value - 20%)**

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

able to generate a complete and sophisticated understanding of the complexity of issues for this person; effectively tailors interactions to maintain rapport within the therapeutic environment tailoring the approach to be able to sensitively gather enough information.

**Achieves the Standard by:**

demonstrating empathy and the ability to establish rapport with an anxious and traumatised female; forming a partnership using language and explanations tailored to an individual who has a history of trauma and recent poor functioning; effectively managing challenging communication.

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

- a. Explore the relevance of trauma with sensitivity.

**A score of 4** may be awarded depending on the depth and breadth of additional factors covered; if the candidate includes most or all correct elements.

**Below the Standard (scores 2 or 1):**

scores 2 if the candidate does not meet (a) above, or has omissions that would detract from the overall quality response; significant omissions affecting quality scores 1.

**Does Not Achieve the Standard (scores 0) if:**

would adversely impact on alliance by being overly pushes for information with an intrusive manner or is avoidant approach to gathering information; demonstrates lack of understanding of the patient; inadequately reflects on relevance of information obtained; unable to maintain rapport.

<b>2.1. Category: PATIENT COMMUNICATION - To Patient / Family / Carer</b>	<b>Surpasses Standard</b>	<b>Achieves Standard</b>		<b>Below the Standard</b>		<b>Standard Not Achieved</b>
<b>ENTER GRADE (X) IN ONE BOX ONLY</b>	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**

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

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

provides a superior performance in a number of areas; demonstrates prioritisation and sophistication; applies a sophisticated sociocultural formulation. Includes several explanatory models which are relevant for this particular patient.

**Achieves the Standard by:**

identifying and succinctly summarising important aspects of repeat past trauma and vicarious trauma; incorporating accurate observation of the mental state phenomenology of dissociation; synthesising the information using a biopsychosocial framework; integrating enough of the medical, developmental, psychological and sociological information to plausibly explain symptoms in this person; accurately describing evidence of theories such as emotional processing, cognitive, biological, stimulus and response, psychodynamic; analyses vulnerability and resilience factors; commenting on missing or unexpected data, particularly with a traumatic past; accurately linking formulated elements to any diagnostic statement (**NB: diagnosis is marked separately**)

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

- a. Apply a relevant theory when providing a formulation for her PTSD.

**A score of 4** may be awarded depending on the depth and breadth of additional factors covered; if the candidate includes most or all correct elements.

**Below the Standard (scores 2 or 1):**

scores 2 if the candidate does not meet (a) above, or has omissions that would detract from the overall quality response; significant omissions affecting quality scores 1.

**Does Not Achieve the Standard (scores 0) if:**

significant deficiencies including inability to synthesise information obtained; failure to question veracity where this is important; does not formulate PTSD.

<b>1.11. Category: FORMULATION</b>	<b>Surpasses Standard</b>	<b>Achieves Standard</b>		<b>Below the Standard</b>		<b>Standard Not Achieved</b>
<b>ENTER GRADE (X) IN ONE BOX ONLY</b>	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 defined tasks?

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