Committee for Examinations
Objective Structured Clinical Examination
Station 10
Adelaide September 2017

The Royal Australian & New Zealand College of Psychiatrists

1.0 Descriptive summary of station:

The candidate is treating James, a 34-year-old married accountant, who suffers from obsessive compulsive disorder, with exposure and response prevention therapy (ERP). The candidate has been working with him for two (2) months in an outpatient clinic. Mary, James' wife, has come to an arranged appointment to discuss her husband's progress.

1.1 The main assessment aims are:

- To demonstrate an ability to communicate the principles of psychological therapy for treatment of OCD.
- To demonstrate knowledge of how to monitor symptoms of OCD using rating scales.
- To outline the importance of family when intervening in anxiety disorders.

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

- Explain the core concept of Exposure Response Prevention and / or Cognitive Behaviour Therapy.
- Provide at least one example of a rating scale for OCD.
- Explain that recovery/remission is possible.
- Explain how accommodating OCD related behaviours is unhelpful.

1.3 Station covers the:

- **RANZCP OSCE Curriculum Blueprint Primary Descriptor Category**: Anxiety Disorder
- **Area of Practice**: Psychotherapies
- **CanMEDS Domains**: Medical Expert, Communicator.
- **RANZCP 2012 Fellowship Program Learning Outcomes**: Medical Expert (Management **–** Therapy); Communicator (Patient Communication **–** To Family / Carer, Patient Communication **–** Disclosure)

References:

- http://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/ocd-guide.pdf
- https://www.ranzcp.org/Files/Publications/Guides/Obsessive-compulsive-disorder-(OCD).aspx
- Soomro GM, Altman DG, Rajagopal S, Oakley Browne MSoomro GM, Altman DG, Rajagopal S, Oakley Browne M.Selective serotonin re-uptake inhibitors (SSRIs) versus placebo for obsessive compulsive disorder (OCD).Cochrane Database of Systematic Reviews 2008, Issue 1. Art. No.: CD001765.DOI: 10.1002/14651858.CD001765.pub3.
- Himle MB, Franklin.FE The more you see it, the easier it gets: Exposure and response prevention for OCD,Cognitive and Behavioral Practice 16 (2009) 29–39.
- Maina G, Saracco P, Albert U Family-Focused Treatments For Obsessive-Compulsive Disorder, Clinical Neuropsychiatry (2006) 3, 6, 382-390.
- Williams TI , Shafran R, Obsessive–compulsive disorder in young people, BJPsych Advances May 2015, 21 (3) 196-205; **DOI:** 10.1192/apt.bp.113.011759

1.4 Station requirements:

- Standard consulting room; no physical examination facilities required.
- Four chairs (examiner x 1, role player x 1, candidate x 1, observer x 1).
- Laminated copy of 'Instructions to Candidate'.
- Role player: female aged 35 – 45.
- 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 an outpatient clinic.

You have been treating James, a 34-year-old accountant for two (2) months. He suffers from Obsessive Compulsive Disorder (OCD) characterised by fear of contamination, and infection for himself and his family. He has developed rituals that he wants his family to follow as well, and when they refuse he gets very distressed. James is not on any medication – he has refused this when it has been suggested.

You have an arranged appointment with his wife Mary, with James' consent. You met Mary previously at the time of your initial assessment of James.

Mary is happily married to James, and they have two children. She is a lawyer.

There is no history of family trauma or intra-familial problems.

Your tasks are to:

- Explain which type of psychological therapy you are using to help James with his OCD, and how it works.
- Explain how you will monitor James' response to treatment, and the likelihood of success.
- Educate Mary on how she can help James.

You will not receive any time prompts.

Station 10 - Operation Summary

Prior to examination:

- Check the arrangement of the room, including seating and other specifics to your scenario.
- On the desk, in clear view of the candidate, place:
  - A copy of 'Instructions to Candidate' 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 are no cues / scripted prompts for you to give.
- DO NOT redirect or prompt the candidate unless scripted – the simulated patient has prompts to use to keep to the aims.
- If the candidate asks you for information or clarification say:

  'Your information is in front of you – you are to do the best you can.'
- At **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 <u>final task</u>:

- You are to state the following:

  'Are you satisfied you have completed the task(s)?

  If so, you <u>must</u> remain in the room and <u>NOT</u> proceed to the next station until the bell rings.'

- If the candidate asks if you think they should finish or have done enough etc., refer them back to their instructions and ask them to decide whether they believe they have completed the task(s).

3.0 Instructions to Examiner

3.1 In this station, your role is to:

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

When the candidate enters the room briefly check ID number.

There are no prompts.

The role player opens with the following statement:

'Hello Doctor thanks for meeting me. Can you tell me about the treatment that James is receiving from you?'

3.2 Background information for examiners

In this station, Mary, the wife of a man with OCD has come to see the psychiatrist providing therapeutic intervnetions for him. He is showing some improiement and Mary is keen to get a better understanding of what the therapy entails and how it is monitored. She also wants to know how she can help, as the are ongoing difficulties at home in relation to James symptoms.

The aims of this station are:

- To demonstrate an ability to communicate the principles of psychological therapy for treatment of OCD.
- To demonstrate knowledge of how to monitor symptoms of OCD using rating scales.
- To outline the importance of family when intervening in anxiety disorder.

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

- Explain the core concept of Exposure Response Prevention and / or Cognitive Behaviour Therapy.
- Provide at least one example of a rating scale for OCD.
- Explain that recovery/remission is possible.
- Explain how accommodating OCD related behaviours is unhelpful.

A surpassing candidate may:

- Choose to use diagrams and examples to explain the concept of ERP.
- Describe the role of metacognitions (e.g. though action fusion).
- Demonstrate greater knowledge of cognitive aspects of OCD, e.g. central role of intolerance of uncertainty.
- Have an in depth knowledge of rating scales.

As one of the most life interfering of the anxiety disorders, Obsessive Compulsive Disorder (OCD) is characterised by frequent thoughts, images or impulses that cause anxiety or distress (obsessions) about the possibility of usually intensely adverse outcomes (e.g. illness, injury, death). A key feature is that the obsessions are experienced as ego dystonic, usually persistent, irrational and recurrent. They are also usually experienced as intrusive. The anxiety or distress triggers the urge to undertake behaviours that are designed to prevent or reduce the severity of the feared outcome (compulsions). Compulsive behaviours may be overt (e.g. handwashing, checking) or covert (e.g. mentally repeating a phrase or saying a prayer). Generally, compulsions are performed in response to obsessions and are often experienced as senseless or repugnant. An individual generally recognises the compulsions as senseless and from which they do not derive pleasure although they may provide a release from tension. A person with an OCD diagnosis has significant daily impairment from these thoughts and behaviours, which has a daily impact on quality of life in several domains and serves as a significant source of distress.

By relieving anxiety, the compulsive behaviours act both to reinforce the obsessional fears and the continued use of compulsions as a response, hence resulting in maintenance cycles.

OCD tends to run in families. The symptoms often begin in children or teens. Treatments that combine medicines and therapy are often effective.

The candidates are expected explain that the core concept to be addressed in therapy is the link in the brain between the obsessional thoughts – the intense feelings of anxiety – the overwhelming urge to perform a compulsive behaviour – the subsequent immediate relief – then the anxiety starts to build again, completing the cycle.

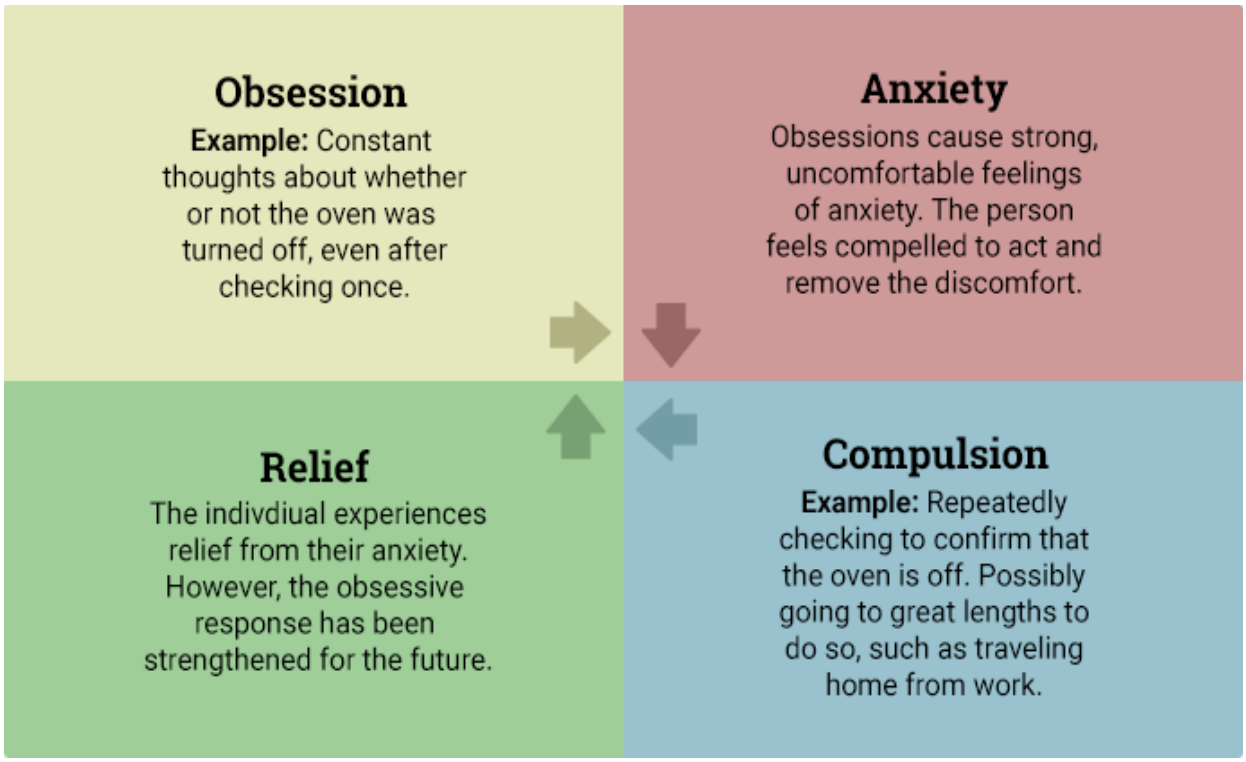

Image from - https://twitter.com/javedalloo/status/839193421264928769

Use of drawings to explain the cycle often will distinguish the better candidates, as it illustrates a collaborative approach and shows that they understand that: Thoughts → Feelings / Mood → Behaviours → Physical Reactions In this scenario an example would be to explain James' thinking around contamination.

Choice of effective therapeutic psychological interventions:

The gold standard for treatment of OCD is thought to be a treatment first described by Meyer (1966) "exposure and response prevention" or ERP. The treatment is to repeatedly expose the person to their obsessive thoughts while preventing them from carrying out the compulsions (or rituals).

The goal is to break the conditioning that maintains the disorder i.e. compulsions relieve anxiety (= negative reinforcement) and hence are more likely to continue to be used in response to obsessions, rather that the person having the chance to learn that the feared outcomes would not in fact occur. ERP has been extensively studied in the intervening 50 years, and continues to provide an average of 70% full remission of symptoms.

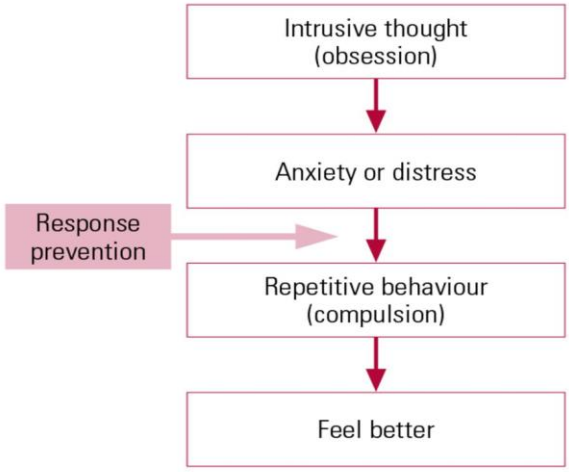

FIG 2 Behavioural treatment of obsessive–compulsive disorder: response prevention aims to break the link between the emotional changes and the compulsions.

*Image from - Williams TI , Shafran R, Obsessive–compulsive disorder in young people, BJPsych Advances May 2015, 21 (3) 196-205; **DOI:** 10.1192/apt.bp.113.011759*

The key elements of ERP are:

- Identification of stimuli that trigger obsessions.
- Deliberate exposure to relevant stimuli.
- Resisting the urge to engage in compulsions to relieve the resulting anxiety / distress.
- Remain in the situation (or confronting the trigger) until anxiety / distress has reduced by at least 50%.

The goal of ERP is to break the reinforcement cycles that are maintaining the disorder. The repeated exposure to the obsessive thoughts, situations, events or other triggers of the obsessive thoughts without engaging in the compulsive behaviour will result in:

1. Reduced anxiety in response to the trigger(s).
2. Insight that the thoughts can be tolerated without the need for the compulsive behaviour.
3. Insight that the thoughts are not dangerous.
4. Learning that it is possible to have anxious thoughts but remain safe.

A graded approach to tolerating the anxiety associated with relevant stimuli and obsessional thoughts is generally best tolerated by patients. This is achieved by creating a “hierarchy” in terms of fear level (usually measured subjectively by the Subjective Units of Distress Scale (SUDS) and given a score out of 10 or 100). In general, patients should confront triggers that cause SUDS of about 40-60/100 as these are most tolerable but still result in treatment gains.

For example, an approach to reducing handwashing in response to fears about germs.

The patient identifies that after touching a doorknob at their work their anxiety level would be 50/100 if they resisted the urge to wash their hands; after catching the bus to work their anxiety would be 70/100; after shaking hands with someone they didn’t know their anxiety would be 60/100. They would therefore start with the doorknob. The therapist would ask them to resist washing their hands after touching doorknobs at their work. However, they may wash their hands normally before eating or after toileting.

Variations of ERP are also seen where the number of repetitions or duration of a behaviour may be negotiated, e.g. reducing showers from 15 minutes to 12 minutes to 10 minutes etc.

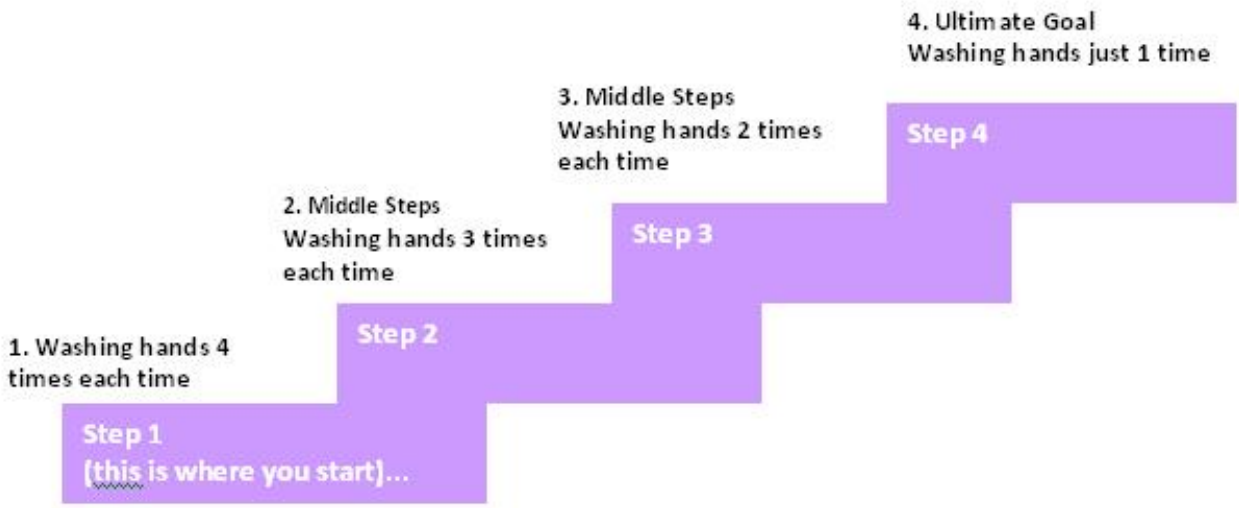

Image from - http://www.cheo.on.ca/en/obsessive-compulsive-disorder

Cognitive Behaviour Therapy (CBT) for OCD is also used but is less effective than ERP. It has proven effective for OCD based on fears of contamination, and would be an acceptable explanation if the candidate used similar explanatory model of the condition, and how increased tolerance of uncertainty and elimination of maladaptive responses that reinforce anxiety are the goal of treatment by any number of techniques including thought challenging, delaying behaviour until anxiety is reduced, alternative behaviours or thoughts. This Danger Ideation Reduction therapy has only been shown to be effective for contamination fears. The risks of thought challenging in OCD is that it can end up acting as reassurance, and reinforce obsessions.

Generally, CBT targets the negative automatic thought behind the OCD (could be pictorially illustrated). For example, a person with OCD related to contamination might have a thought:

"this object is dirty" – then "if I don't wash my hands I'll contaminate the whole family" – "my children will die from a disease I gave them".

These thoughts are associated with rapidly increasing anxiety, fear and an overwhelming sense of responsibility. The following is often used to help explain how thoughts, feeling behaviours can interact and thus any part can be the primary target of psychological treatment.

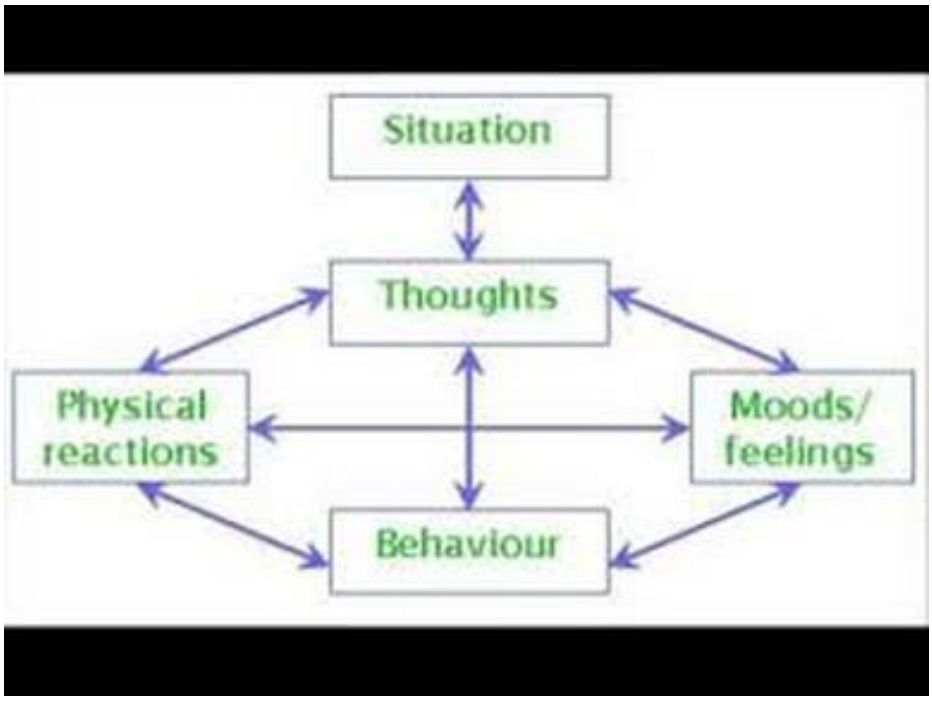

Image from - https://noelbellblog.wordpress.com/2011/04/27/cognitive-behavioural-therapy-cbt

To monitor response to structured psychotherapies like CBT, ERP or behavioural therapy, use of scales are the standard. These scales can be developed between the patient and the therapist, for example a Likert scale of 0 to 10 where 10 is most anxious ever, and 0 is almost asleep. The same type of scale may be used for all the symptoms troubling the patient, in this case it may be the level of worry about germs, where 10/10 is being so worried that the person cannot think about anything else. However, it is also important to monitor the level of functional recovery, and resistance to compulsions.

Alternately or in conjunction with a Likert scale, a Yale-Brown Obsessive Compulsive Scale can be used (Y-BOCS). This is considered the gold standard measure of OCD symptom severity. This is a semi-structured interview with the scale that covers many common symptoms of OCD. It should be done at the beginning, middle, and end of treatment or as often as desired in collaboration with the patient. Measurement of treatment response is an integral aspect of CBT (including ERP).

*Goodman, W.K; Price, L.H; Rasmussen, S.A; et al. (1989). "The Yale–Brown Obsessive–Compulsive Scale. I. Development, use, and reliability". Arch Gen Psychiatry. **46** (11): 1006–1011. doi:10.1001/archpsyc.1989.01810110048007. PMID 2684084.*

Storch, E. A.; Larson, M. J.; Goodman, W. K.; Rasmussen, S. A.; Price, L. H.; Murphy, T. K. (2010). "Development and Psychometric Evaluation of the Yale-Brown Obsessive-Compulsive Scale—Second Edition". *Psychological Assessment*. **22** (2): 223–232. doi:10.1037/a0018492. PMID 20528050.

*Esfahani, S.; Motaghipour, Y.; Kamkari, K.; Zahiredin, A.; Janbozorgi, M. (2012). "Reliability and Validity of the Persian Version of the Yale-Brown Obsessive-Compulsive Scale (Y-BOCS). (English)". Iranian Journal Of Psychiatry & Clinical Psychology. **17** (4): 297–303.*

DSM-5 Diagnostic Criteria for OCD

A. Presence of obsessions, compulsions, or both:
   (a) Obsessions are defined by (1) and (2):
      (1) Recurrent and persistent thoughts, urges, or images that are experienced, at some time during the disturbance, as intrusive and unwanted, and that in most individuals cause marked anxiety or distress.
      (2) The individual attempts to ignore or suppress such thoughts, urges, or images, or to neutralise them with some other thought or action (i.e., by performing a compulsion).

   (b) Compulsions are defined by (1) and (2):
      (1) Repetitive behaviours (e.g., hand washing, ordering, checking) or mental acts (e.g., praying, counting, repeating words silently) that the individual feels driven to perform in response to an obsession or according to rules that must be applied rigidly.
      (2) The behaviours or mental acts are aimed at preventing or reducing anxiety or distress, or preventing some dreaded event or situation; however, these behaviours or mental acts are not connected in a realistic way with what they are designed to neutralise or prevent, or are clearly excessive.

   Note: Young children may not be able to articulate the aims of these behaviours or mental acts.

B. The obsessions or compulsions are time-consuming (e.g., take more than 1 hour per day) or cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

C. The obsessive-compulsive symptoms are not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition.

D. The disturbance is not better explained by the symptoms of another mental disorder (e.g., excessive worries, as in generalised anxiety disorder; preoccupation with appearance, as in body dysmorphic disorder; difficulty discarding or parting with possessions, as in hoarding disorder; hair pulling, as in trichotillomania [hair-pulling disorder]; skin picking, as in excoriation [skin-picking] disorder; stereotypies, as in stereotypic movement disorder; ritualised eating behaviour, as in eating disorders; preoccupation with substances or gambling, as in substance-related and addictive disorders; preoccupation with having an illness, as in illness anxiety disorder; sexual urges or fantasies, as in paraphilic disorders; impulses, as in disruptive, impulse-control, and conduct disorders; guilty ruminations, as in major depressive disorder; thought insertion or delusional preoccupations, as in schizophrenia spectrum, and other psychotic disorders; or repetitive patterns of behaviour, as in autism spectrum disorder).

Specify if:

- **With good or fair insight:** The individual recognises that obsessive-compulsive disorder beliefs are definitely or probably not true or that they may or may not be true.
- **With poor insight:** The individual thinks obsessive-compulsive disorder beliefs are probably true.
- **With absent insight / delusional beliefs:** The individual is completely convinced that obsessive-compulsive disorder beliefs are true.

Specify if:

- **Tic-related:** The individual has a current or past history of a tic disorder.

Diagnostic Criteria for OCD

A. Either obsessions or compulsions (or both), present on most days for a period of at least two weeks.

B. Obsessions (thoughts, ideas or images) and compulsions (acts) share the following features, all of which must be present:

(1) They are acknowledged as originating in the mind of the patient, and are not imposed by outside persons or influences.

(2) They are repetitive and unpleasant, and at least one obsession or compulsion must be present that is acknowledged as excessive or unreasonable.

(3) The subject tries to resist them (but if very long-standing, resistance to some obsessions or compulsions may be minimal). At least one obsession or compulsion must be present which is unsuccessfully resisted. (

(4) Carrying out the obsessive thought or compulsive act is not in itself pleasurable. (This should be distinguished from the temporary relief of tension or anxiety).

C. The obsessions or compulsions cause distress or interfere with the subject's social or individual functioning, usually by wasting time.

D. Most commonly used exclusion criteria: not due to other mental disorders, such as schizophrenia and related disorders (F2), or mood [affective] disorders (F3). The diagnosis may be specified by the following four character codes:

F42.0 Predominantly obsessional thoughts and ruminations

F42.1 Predominantly compulsive acts

F42.2 Mixed obsessional thoughts and acts

F42.8 Other obsessive-compulsive disorders

F42.9 Obsessive-compulsive disorder, unspecified

Role of the family in treatment of OCD

Research investigating obsessive-compulsive disorder (OCD) in the context of the family has consistently found a bidirectional influence, insofar as families affect and are affected by the disorder.
OCD has an adverse effect on the quality of family life and family interaction because of relatives' involvement in the sufferer's avoidance behaviours and compulsions, in an effort to relieve the fear and anxiety that the patient is feeling; the engagement in illness-related behaviours can dominate family life, and provoke intense disagreements among family members about how to respond to the patient's symptoms. On the other hand, several studies have also highlighted the negative effects of marital discord, and the climate of the familial environment in maintaining or worsening OCD symptoms.

Recognition that the family may play an important role in the maintenance of OCD has directed attention to strategies involving family members in therapy. Benefits have been described in case studies of family involvement in behavioural treatment of children and adolescents or adults with OCD, where the parent, spouse or other family member acted as a coach or supervisor during exposure homework. However, family participation in behavioural treatments (family-assisted behavioural treatments or the 'Multifamily Behavioural Treatment') has produced somewhat mixed results in larger controlled trials, with greater benefits reported in some studies but not in others.

Several researchers have also reported on the benefits of combined patient and family or family only time-limited psychoeducational and support groups, which included sessions on diagnosis, assessment, theories of OCD, behavioural and medication treatment, and relapse prevention. Psychoeducational interventions were aimed at reducing the direct involvement of families in the rituals, and of improving the perceived burden due to the disorder.

Relatives fall on a continuum of behavioural interaction patterns; the family may respond in various ways depending on the symptoms severity and functional impairment of the patient, as well as its own level of anger and frustration. This spectrum of responses can be visualised as having two polar opposites: on one hand are families that directly participate and / or assist in the rituals (enmeshed or accommodating families - in this case accommodation is used restrictively to indicate all kinds of participation in rituals); reasons for supporting the rituals (accommodating behaviours) were different, ranging from the wish to save the patient from conflicts to worry that burdens resulting from the obsessions could lead the patient into a state of crisis.

On the other pole of the continuum, according to this model, are families who completely resist and oppose OCD behaviours - these antagonistic behaviours included ignoring the rituals, attempting to stop the patient from performing compulsions, rejecting the patient's wishes for reassurance and, finally, forced, traumatic exposure to the feared stimuli. A third type of familial response lies in the middle of the continuum, and involves a divided stance of two or more family members (split family) that give equivocal responses; in this situation one family member is accommodating the symptoms while another is antagonistic, so that a certain amount of family disharmony can be expected.

Both type of responses can be counterproductive; relatives who take over roles and participate in or assist with compulsions tend to become emotionally over-involved, neglecting their own needs and at the same time perpetuating the cycle of obsessions and compulsions. Despite the fact that family accommodation is often well-intentioned, this form of involvement typically provides short-term relief from anxiety for the patient and for the family, thereby possibly reinforcing the continuation of these behaviours and the patient's symptoms over the long-term. Likewise, family members who are involved in the patient's symptomatology in a hostile or critical way may also inadvertently be increasing the frequency and the severity of the rituals, by augmenting the degree of anxiety experienced by patients, who tend to react performing rituals.

Consequently, some clinicians consider family members' responses to OCD during and after treatment to be critical to recovery, although relatively few investigations have studied this issue; preliminary data suggest that patients with relatives who express attitudes consistent with either an accommodating response or an antagonistic one appear to benefit less from otherwise successful treatments, and to be more likely to relapse after such treatments. Therefore, both type of responses, as family variables, may be viewed as negative predictors of outcome.

This would suggest that the approach to family members would be likely to be most helpful if it:

- Demonstrates an empathic understanding of the mixed emotions attendant on having a close relative or partner with OCD (frustration, distress, anxiety etc.)
- Demonstrates an understanding of the drivers of accommodation (e.g. relieve distress, avoid conflict, save time).
- Includes effective psychoeducation.
- Takes a collaborative approach that includes all involved family members in decision-making.
- Results in clear guidelines for action for all parties e.g., most usually that the patient agrees to resist the urge to ask for accommodation, and all parties have agreed on what the response will be if asked.
- Schedules follow up sessions.

The candidate is therefore expected to explain more than just the fact that family accommodating responses are unhlepful. They need to demonstrate an understanding of how the responses of the family to accommodate James' behaviour is impacting on maintenenace of the symptoms.

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 well-being 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.

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:

You are a 36-year-old married lawyer called Mrs Mary Goodwin.

You have come to see the psychiatrist treating your husband James, aged 34, for OCD (obsessive compulsive disorder) which is related to his fear of contamination by germs. James worries that the germs might kill him or his family. This problem emerged about three (3) years ago after his mother died from an infectious illness – if asked, you think the doctors said she had septicaemia.

Your main goal for this meeting is better understand the details of treatment the psychiatrist is providing and how they check that it is working.

To do this, you want to know more about the treatment, how it may be expected to lead to recovery, what you can do to help your family at home.

He has never exhibited any other odd behaviours, never been aggressive or suicidal, and has never appeared to hear voices that other people do not. He does not appear depressed to you.

Background
Over the last three years James has developed multiple behaviours to try to reduce the risk of infectious illnesses to himself and your family. These behaviours have impacted on his ability to function effectively as an accountant, father and husband. The negative effect on the family was what finally lead him to seek treatment.

James had always been a clean, neat man but in the past three years he has become more and more driven to perform cleaning and to decontaminate the house, his work space and himself. He has also been putting pressure on you and your children to use antiseptic hand cleaner multiple times a day.

You think he has been responding to current treatment, and can now fulfil the requirements of his work without being distracted by rituals of decontamination however there is still a significant impact at home which is causing a lot of friction between James and the children. This has led to you being caught in the middle trying to keep the peace but you are worried that you may be contributing to the problem.

James seems to worry excessively about dirt, he nags the kids to wash frequently, and goes to their rooms to use cleaning products on their furniture almost daily. In order to ease the situation, you often find yourself encouraging them to listen to his requests, and clean their rooms as per his specific instructions. You just want to keep the peace.

About your family:
You met your husband James at university, while you were studying law, where he trained as an economist. You married while completing your study for the bar exam, and have specialised in business law. You have two children, Penny (11) and Robert (14), who are happy at a local private school. There are no problems within the marriage or the family apart from the reactions and effects of James' OCD.

James is the first person you have known personally who has a mental health problem. You have never experienced a mental illness before.

4.2 How to play the role:

You are a professional well-dressed woman who has left work today to attend this arranged appointment. James knows you are coming and is supportive. As a lawyer, you consider yourself to be well educated but have no understanding about biology, details of mental illness and how psychological therapies work.

You want to understand the treatment that James is receiving, and how the psychiatrist can know that it is working. You have not been exposed to someone with an anxiety disorder before, and don't know if they can recover.

You have tried to educate yourself by the Internet but keep being more scared by the sites that pop-up.

4.3 Opening statement:

'Hello Doctor thanks for meeting me. Can you tell me about the treatment that James is receiving from you?'

4.4 What to expect from the candidate:

Candidate should ask you about what you wanted to know and talk about, and should proceed to answer your questions.

That they should explain in layman's language what OCD is, how the main therapies, called ERP (exposure and response prevention) and / or CBT (cognitive behaviour therapy) or even just behaviour therapy, are thought to work and they can measure treatment response with James. Candidates are expected to instil hope for you that James can and should get better with treatment.

The candidate should also explain to you how your response to James' symptoms and the treatment is impacting on his recovery. A better candidate may explain details of how responses by family are so very important.

4.5 Responses you MUST make:

With the initial description of the therapy / or when asked if you understand ERP / CBT:

'If you could explain that to me in more detail?'

'What can we do to help him?'

'I find it really confusing.'

'I just don't know how I will talk to the kids about when it is best to listen to him and when it is best to ignore him. Which do you think is better?'

'How do you know this is working?'

'So do you think he will get better?'

4.6 Responses you MIGHT make:

If asked what you understand the problem to be:

Scripted Response: ***'He is troubled by thoughts of dying from germs he might catch in public, and of killing the family by germs he brings into the home.***

'It has settled at work.'

If asked if you are worried whether James will recover:

Scripted Response: ***'Yes.'***

If asked if James is on any medicines:

Scripted Response: ***'No, you know he refused to take any tablets when you offered them previously.'***

If the candidate explains that James has a right to confidentiality:

Scripted Response: ***'Oh yes, I am not asking for private details I want to understand his problem so I can help him.'***

If given advice you need to assist James:

Scripted Response: ***'How will we do that?'***

STATION 10 – MARKING DOMAINS

The main assessment aims are:

- To demonstrate an ability to communicate the principles of psychological therapy for treatment of OCD.
- To demonstrate knowledge of how to monitor symptoms of OCD using rating scales.
- To outline the importance of family when intervening in anxiety disorders.

Level of Observed Competence:

1.0 MEDICAL EXPERT

1.14 Did the candidate demonstrate an adequate knowledge and application of relevant CBT / ERP for treatment of OCD? (Proportionate value – 40%)

Surpasses the Standard (scores 5) if:
demonstrates a sophisticated understanding of CBT / ERP including a clear understanding of levels of evidence to support this treatment; uses a reinforcement cycle diagram (obsession-anxiety-compulsion-relief) to demonstrate the process.

Achieves the Standard by:
demonstrating a general understanding of CBT / ERP; using psychoeducation to help the wife understand expected treatment responses; explaining application of therapy; using symptoms and behaviour illustrations in the explanation; sensitively considering barriers to implementation; instilling hope in relation to outcomes.

To achieve the standard ***(scores 3)*** the candidate **MUST:**
a. Explain the core concept of Exposure Response Prevention and / or Cognitive Behaviour Therapy.

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 explain link between thoughts-feelings-behaviours).

Does Not Achieve the Standard (scores 0) if:
Errors in information would lead to poor care; there is no structure and / or answer is inaccurate; does not answer that specific question; not tailored to the patient in the scenario.

1.14. Category: MANAGEMENT – Therapy	**Surpasses Standard**	**Achieves Standard**		**Below the Standard**		**Standard Not Achieved**
ENTER GRADE (X) IN ONE BOX ONLY	**5** ☐	**4** ☐	**3** ☐	**2** ☐	**1** ☐	**0** ☐

2.0 COMMUNICATOR

2.1 Did the candidate explain the process of monitoring response to treatment and the likelihood of the treatment being successful? (Proportionate value – 30%)

Surpasses the Standard (scores 5) if:
able to explain the role of review of symptoms and functioning in monitoring response to treatment, the role of medication in treatment if psychological treatment is unsuccessful; possesses an in-depth knowledge of rating scales; able to demonstrate awareness of various targets for monitoring including triggers and potency in triggering anxiety / distress, avoidance behaviours, and / or compulsive behaviours.

Achieves the Standard by:
demonstrating empathy and ability to establish rapport; explaining that improvement is gradual and setbacks are not uncommon; using non-technical language to instil better understanding; showing optimism with caution; recognising confidentiality; mentioning any means of monitoring improvement.

To achieve the standard ***(scores 3)*** the candidate **MUST:**
a. Provide at least one example of a rating scale for OCD.
b. Explain that recovery / remission is possible.

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:
Unable to maintain rapport; does not answer the question or is unaware that treatment outcomes are usually good.

2.1. Category: PATIENT COMMUNICATION – To Family / Carer	**Surpasses Standard**	**Achieves Standard**		**Below the Standard**		**Standard Not Achieved**
ENTER GRADE (X) IN ONE BOX ONLY	**5** ☐	**4** ☐	**3** ☐	**2** ☐	**1** ☐	**0** ☐

2.2 Did the candidate appropriately and adequately explain the role of the family in the management of the patient's illness? (Proportionate value – 30%)

Surpasses the Standard (scores 5) if:
comprehensively explains the principles of working closely with families / carers; demonstrates the importance of ensuring respectful and open communication; is aware of the range of responses of the family to the individual's compulsions; recognises the consequences these may have on the family and the illness.

Achieves the Standard by:
providing a clear and appropriate explanation; recognising the importance of explanations outside the usual doctor-patient / treatment relationship with a concerned and involved family member; addressing the concerns of the wife and the possible impact on the children, elaborating on how accommodation can act to maintain OCD but is not the sole responsibility of the family, i.e. the individual needs to work with the family to resist the urge to ask for it; empathic demonstration of awareness of the drivers to accommodate OCD suggesting the involvement of the entire family in the treatment + / - a support group.

To achieve the standard ***(scores 3)*** the candidate **MUST:**
a. Explain how accommodating OCD related behaviours is unhelpful.

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:
approach is disrespectful; does not offer any strategies to help the family cope with the illness and the behaviours.

2.2. Category: PATIENT COMMUNICATION – Disclosure	**Surpasses Standard**	**Achieves Standard**		**Below the Standard**		**Standard Not Achieved**
ENTER GRADE (X) IN ONE BOX ONLY	**5** ☐	**4** ☐	**3** ☐	**2** ☐	**1** ☐	**0** ☐

GLOBAL PROFICIENCY RATING

Did the candidate demonstrate adequate overall knowledge and performance at the defined tasks?

Circle One Grade to Score	**Definite Pass**	**Marginal Performance**	**Definite Fail**