

1.0 Descriptive summary of station:

This station tests the ability of the candidate to conduct a psychiatric assessment of a young man with a preoccupation with hair loss and his appearance, which is having a significant impact on his personal and professional life. This station assesses capacity to take an empathic psychological history in order reach a diagnosis of Body Dysmorphic Disorder (BDD).

1.1 The main assessment aims are to:

- Take an appropriately focussed history, consider the diagnostic possibilities and establish a diagnosis of Body Dysmorphic Disorder.
- Communicate the diagnosis and reasoning to the patient including potential differential diagnosis in a non-judgemental, non-stigmatising empathic manner.

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

- Specifically ascertain that the patient's concern is far in excess of the physical evidence.
- Establish how Body Dysmorphic Disorder symptoms are affecting function across a range of areas.
- Sensitively explain the working diagnosis of Body Dysmorphic Disorder.
- Not diagnose Delusional Disorder or Psychosis as a primary diagnosis.
- Effectively manage resistance from the patient in a non-judgemental, empathic manner.
- Not collude with patient e.g. by agreeing to send them to see another specialist or test the hair.

1.3 Station covers the:

- **RANZCP OSCE Curriculum Blueprint Primary Descriptor Category of:**
Other Disorders: Obsessive Compulsive and Related Disorders
- **Area of Practice:**
Adult Psychiatry
- **CanMEDS Domains of:**
Medical Expert, Communicator
- **RANZCP 2012 Fellowship Program Learning Outcomes of:**
Medical Expert (Assessment), Communicator (Synthesis), Collaborator (Patient Relationships)

References:

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- Phillips KA, Wilhelm S, Stein DJ. Body dysmorphic disorder: some key issues for DSM-V. *Depress Anxiety* 2010; June 27(6): 573-591.
- Conrado LA, Hounie AG, Diniz JB, et al. Body dysmorphic disorder among dermatologic patients: prevalence and clinical features. *J Am Acad Dermatol* 2010; 63: 2354-243.
- Castle DJ, Rossell S, Kyrios M. Body Dysmorphic Disorder. *Psychiatr Clin N Am* 2006; 29:521-538.
- Phillips KA, Diaz SF. Gender differences in body dysmorphic disorder. *J Nerv Ment Dis* 1997; 185:570-7.
- Phillips KA. Psychosis in body dysmorphic disorder. *J Psychiatr Res* 2004; 38:63-72 Phillips KA: *Understanding Body Dysmorphic Disorder: An Essential Guide*. New York, Oxford University Press, 2009.
- Wilhelm S, Phillips KA, Steketee G: *Cognitive-Behavioural Therapy for Body Dysmorphic Disorder: A Modular Treatment Manual*. New York, Guilford, 2013.
- Buhlmann U, Glaesmer H, Mewes R, et al: Updates on the prevalence of body dysmorphic disorder: a population-based survey. *Psychiatry Res* 178(1):171-175, 2010.
- Conroy M, Menard W, Fleming-Ives K, et al: Prevalence and clinical characteristics of body dysmorphic disorder in an adult inpatient setting. *Gen Hosp Psychiatry* 30(1):67-72, 2008.
- American Psychiatric Association: *Diagnostic and statistical manual of mental disorders*. Washington, DC: Author, 2013.

1.4 Station requirements:

- Standard consulting room; no physical examination facilities required.
- Four chairs (examiners x 1, role player x 1, candidate x 1, observer x 1).
- Table fan, room spray / air freshener.
- Laminated copy of 'Instructions to Candidate'.
- Role player – young man wearing a cap or hat. Must have a full head of hair.
- 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 in a GP Liaison setting and one of the local GPs has requested assessment of a patient to assist with his diagnostic clarification.

John is a 29-year-old single man, who has been sent to you for assessment because the GP is quite concerned about his recent abnormal behaviour that includes bringing in samples of hair for testing to enable him to get treated for baldness.

John is worried that he is rapidly going bald. He has also been seeking repeated referrals to various specialists for this complaint. He has now started reporting suicidal thoughts related to the distress and worries.

Your tasks are to:

- Take a focussed history from John.
- Discuss your diagnosis and differential diagnoses with John.

You will not receive any time prompts.

Station 6 - Operation Summary

Prior to examination:

- Check the arrangement of the room, including seating and other specifics to your scenario.
- Ensure table fan is turned on.
- Ensure 3-4 cups of water are placed on the desk for easy access to the candidates. Replace when used.
- On the desk, in clear view of the candidate, place:
 - Duplicate copy of 'Instructions to Candidate'.
 - Any other candidate material specific to the station e.g. investigation results.
 - Pens.
 - Tissues 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 – there is no scripted prompt for you to give.
- DO NOT redirect or prompt the candidate – 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:

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

3.0 Instructions to Examiner

3.1 In this station, your role is to:

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

When the candidate enters the room briefly check ID number.

There is no scripted introduction or any time prompt from the examiner.

The role player opens with the following statement:

“Hello doctor. I don’t know how you can help me from losing my hair!”

3.2 Background information for examiners

In this station the candidate is expected to conduct a psychiatric assessment with a focus on the psychological history, specifically to elicit core symptoms to arrive at a preferred diagnosis of Body Dysmorphic Disorder (BDD), and identify the significant impact it is having on the patient’s personal and professional life.

BDD is a severe disorder characterised by distressing or impairing preoccupations with nonexistent or slight defects in one’s physical appearance. BDD is also characterized by repetitive behaviours in response to the appearance concerns (e.g., mirror checking, excessive grooming; American Psychiatric Association, 2013). BDD is common, with a prevalence of 1.7–2.4% in nationwide population-based surveys (Rief et al., 2006; Koran et al., 2008; Buhlmann et al., 2010).

This station revolves around John, a 29-year-old single man who has been sent by his GP for review in the context of his repeatedly seeking referrals to specialists for problems like hair loss or paleness of skin. More recently, his GP is finding it quite difficult to deal with John’s complaints and reports that John has started showing increasingly abnormal behaviour like bringing samples of hair for testing to enable him to get treated for baldness.

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

- Specifically ascertain that the patient’s concern is far in excess of the physical evidence.
- Establish how BDD symptoms are affecting function across a range of areas.
- Sensitively explain the working diagnosis of BDD.
- Not diagnose Delusional Disorder or Psychosis as a primary diagnosis.
- Effectively manage resistance from the patient in a non-judgemental, empathic manner.
- Not collude with patient e.g. by agreeing to send him to see another specialist or test his hair.

The candidate should ask questions about the breadth of perceived, imagined or slight flaws. There seems to be gender differences in body parts of concern with men more likely to obsess about their genitals, body build and hair thinning / balding, whereas women are more likely to obsess about their skin, stomach, weight, breasts, buttocks, thighs, legs, hips, toes, and excessive body hair. The candidate’s line of questioning should elicit that the patient has a preoccupation with imagined defects in appearance with disproportionate concern regarding the anomaly.

The candidate’s questions should reflect this, although more general screening is also expected: including evidence that they are aware that the focus is most commonly on the face or head such as hair thinning, acne, wrinkles, scars, vascular markings, paleness or redness of the complexion, swelling, facial asymmetry or disproportion (e.g. > 80% focus on some part of face). Other common preoccupations include the shape, size, or some other aspect of a body part (the nose, eyes, eyelids, eyebrows, ears, mouth, lips, teeth, jaw, chin, cheeks, or head).

A better candidate would focus on specific questioning to show that the candidate is aware that any part of the body can be a focus or the focus could even be the overall body size. The better candidate may enquire about whether John’s preoccupation focusses on a number of body parts simultaneously. They may clarify whether his complaint is specific (which is more common) or more vague. A better candidate will also ask if his symptoms run a continuous course (body part focus can remain the same or change over time, with a mean number of 5-7 parts, with skin, nose or hair being the most common in both genders).

The history of BDD should include that it is a chronic disorder which started in adolescence, and that the diagnosis may not have been made earlier because of the patient's secrecy / reluctance to openly discuss bodily preoccupations (BDD usually starts in early adolescence, but can begin as early as five; onset may be gradual or abrupt, prevalence is similar in men and women).

The candidate must elicit that even though there is minimal or no physical anomaly present, John's concern is markedly excessive, and is causing high levels of distress and impairment in his social, occupational and / or other important areas of functioning. Through their questioning the candidate should show evidence that they are aware that the core belief in BDD is that the person is somehow defective or unattractive and this is accompanied by low self-esteem, embarrassment, shame and fear of rejection.

The candidate needs to try to elicit how John's social impairment correlates with symptom severity and any co-morbidity, especially co-morbid depression, particularly as John does not have strong primary interpersonal relationships because of his BDD.

Approximately 80% of individuals with BDD have experienced suicidal ideation, about a quarter have attempted suicide (Veale et al., 1996; Phillips and Diaz, 1997; Phillips, 2007). BDD is usually associated with substantial impairment across work and social domains (Didie et al., 2008; Phillips, 2009). BDD is characterized by poor psychosocial functioning and high rates of suicidality (Buhlmann et al. 2010; Phillips et al. 2005b, 2008; Veale et al. 1996a), yet BDD usually goes undiagnosed in clinical settings (Conroy et al. 2008; Grant et al. 2001).

The candidate should ask about suicidal ideation (in psychiatric treatment settings up to 70% report a history of suicidal ideation and 24% have attempted suicide: even those in the population not seeking treatment have high rates - 25% ideation and 7% attempts. People with BDD have many of the risk factors associated with suicide; namely, being single or divorced, high co-morbidity, poor social supports, poor self-esteem, high anxiety levels, depression and hostility, high rates of psychiatric admissions).

The predominant view today is that BDD is an obsessive-compulsive spectrum disorder due to strong evidence of the overlap between BDD and obsessive-compulsive disorder (OCD) in terms of phenomenology, comorbidity, and treatment response. Given the recent research attention on the strong relationship between BDD and OCD, DSM-5 now includes BDD under a new section for OCD and related disorders.

As all BDD patients engage in a range of associated time-consuming features, the candidate needs to establish what common behaviours John undertakes; including any mirror checking, excessive grooming, camouflaging (including wearing a hat / cap), seeking reassurance or questioning others regarding their looks, touching and comparing the 'defect' to other people directly or through pictures, seeking dermatological or cosmetic surgical treatments.

Findings from family studies indicate that the prevalence of BDD is significantly higher among first-degree relatives of probands with OCD compared with other obsessive-compulsive spectrum disorders, such as hypochondriasis, eating disorders, and impulse control disorders, which supports the conceptualization of BDD as an obsessive-compulsive spectrum disorder. The candidate should ask about a family history of any mental illness and specifically of BDD and OCD.

BDD is relatively common in various outpatient mental health settings, including among patients with OCD, social anxiety disorder, and atypical major depressive disorder (Kelly and Phillips, 2011). Among psychiatric inpatients, 13–16% have BDD (Grant et al., 2001; Conroy et al., 2008), which is more common than many other disorders, including schizophrenia and bipolar disorder (Grant et al., 2001).

Comorbidity rates with other disorders are very high, with men and women having similar rates of depression, OCD, social phobia, agoraphobia, and anorexia nervosa. The longitudinal association is strongest with major depression (found in at least 36-50% people with BDD). Substance use is common with over one third of men with BDD having a substance use disorder, and 25% of women. Even though John does not currently have active symptoms of comorbidity, he has experienced a prior depressive episode and suicidal ideation.

The candidate should try to assess for more common differential diagnoses which include:

- **Normal appearance concerns and clearly noticeable physical defects**

BDD differs from normal appearance concerns in being characterised by excessive appearance-related preoccupations and repetitive behaviours that are time-consuming, are usually difficult to resist or control, and cause clinically significant distress or impairment in functioning. Physical defects that are clearly noticeable (i.e. not slight) are not diagnosed as BDD. However, skin picking as a symptom of body dysmorphic disorder can cause noticeable skin lesions and scarring (Didie et al. 2010); in such cases, BDD should be diagnosed.

- **Eating disorders**

In an individual with an eating disorder, concerns about being fat are considered a symptom of the eating disorder rather than BDD. However, weight concerns may occur in BDD. Eating disorders and BDD can be comorbid, in which case both should be diagnosed.

- **Other obsessive-compulsive and related disorders**

The preoccupations and repetitive behaviours of BDD differ from obsessions and compulsions in OCD in that the former focus only on appearance. These disorders have other differences, such as poorer insight in BDD (Phillips et al. 2010a). When skin picking is intended to improve the appearance of perceived skin defects, BDD, rather than excoriation (skin-picking) disorder, is diagnosed. When hair removal (plucking, pulling, or other types of removal) is intended to improve perceived defects in the appearance of facial or body hair, body dysmorphic disorder is diagnosed rather than trichotillomania (hair-pulling disorder).

- **Illness anxiety disorder**

Individuals with BDD are not preoccupied with having or acquiring a serious illness and do not have particularly elevated levels of somatization (Phillips et al. 2010b).

- **Major depressive disorder**

The prominent preoccupation with appearance and excessive repetitive behaviours in BDD differentiate it from major depressive disorder. However, major depressive disorder and depressive symptoms are common in individuals with BDD (Phillips et al. 2010b), often appearing to be secondary to the distress and impairment that BDD causes. BDD should be diagnosed in depressed individuals if diagnostic criteria of BDD are met.

- **Anxiety disorders**

Social anxiety and avoidance are common in BDD (Phillips et al. 2010a). However, unlike social anxiety disorder (social phobia), agoraphobia, and avoidant personality disorder, BDD includes prominent appearance-related preoccupation, which may be delusional, and repetitive behaviours, and the social anxiety and avoidance are due to concerns about perceived appearance defects and the belief or fear that other people will consider these individuals ugly, ridicule them, or reject them because of their physical features. Unlike generalised anxiety disorder, anxiety and worry in BDD focus on perceived appearance flaws.

- **Psychotic disorders**

Many individuals with BDD have delusional appearance beliefs (i.e., complete conviction that their view of their perceived defects is accurate) (Phillips et al. 2010b), which are diagnosed as BDD, with absent insight / delusional beliefs, not as delusional disorder. Appearance-related ideas or delusions of reference are common in BDD (Phillips et al. 2008); however, unlike schizophrenia or schizoaffective disorder, BDD involves prominent appearance preoccupations and related repetitive behaviours, and disorganised behaviour and other psychotic symptoms are absent (except for appearance beliefs, which may be delusional).

- **Other disorders and symptoms**

BDD should not be diagnosed if the preoccupation is limited to discomfort with or a desire to be rid of one's primary and / or secondary sex characteristics in an individual with gender dysphoria or if the preoccupation focusses on the belief that one emits a foul or offensive body odour as in olfactory reference syndrome (which is not a DSM-5 disorder). Body identity integrity disorder (apotemnophilia, which is not a DSM-5 disorder) involves a desire to have a limb amputated to correct an experience of mismatch between a person's sense of body identity and his or her actual anatomy. However, the concern does not focus on the limb's appearance, as it would in BDD (Phillips et al. 2010b). Koro, a culturally related disorder that usually occurs in epidemics in South-eastern Asia, consists of a fear that

the penis (labia, nipples, or breasts in females) is shrinking or retracting and will disappear into the abdomen, often accompanied by a belief that death will result. Koro differs from body dysmorphic disorder in several ways, including a focus on death rather than preoccupation with perceived ugliness (Phillips et al. 2010b). Dysmorphic concern (which is not a DSM-5 disorder) is a much broader construct than, and is not equivalent to, BDD. It involves symptoms reflecting an over concern with slight or imagined flaws in appearance.

Insight is usually partial and patients may display non-bizarre, monothematic beliefs that may become delusional. The delusional variant of BDD in people who are completely convinced that their perceived defects or flaws are truly abnormal appearing is no longer coded as both delusional disorder, somatic type and BDD. It is now designated as only BDD with the absent insight / delusional beliefs specifier.

A better candidate will sensitively seek to clarify whether John has sought medical cosmetic and surgical interventions ($\pm 75\%$ seek non-psychiatric cosmetic medical care, with approximately $\pm 23\%$ receiving surgical procedures. Over 75% of non-psychiatric treatments for BDD defects lead to no change or worsening of the overall disorder, with patients being dissatisfied or very dissatisfied with the outcome. Only 7% lead to a decrease in concern and overall improvement. The poor outcomes may include vexatious litigation or risk of violence to others which is possibly more common in men).

A surpassing candidate will try to elicit:

- Whether John has ever attempted to change his appearance himself (a small number of people with BDD are so dissatisfied with approved interventions that they perform 'do-it-yourself' cosmetic procedures, especially after consulting internet websites. People can also harm themselves in order to get the surgery if it has been turned down. DIY has been found to often be associated with a person spending many hours of mirror gazing and experiencing intense disgust about their perceived defect).
- Whether the presence of poor insight indicates the likelihood of John meeting the absent insight / delusional beliefs specifier according to DSM-5.

Feedback to the patient:

The candidate should provide feedback about the diagnosis and reasoning to John in an empathic and sensitive manner. They should explain the features of BDD that are consistent with their findings. They should be able to generate a few key differential diagnoses and try to distinguish as to how they have ruled them out from being the primary diagnosis.

The candidate should not provide too much technical or less relevant information that will negatively impact on initial engagement.

The candidate should not try to convince John that his entrenched ideas and beliefs are irrational or that he looks normal, as this is unlikely to persuade them to accept psychiatric treatment or referral.

A surpassing candidate would be able to specifically demonstrate some of the following:

- Not collude with the patient.
- Not reassure them that they look fine or that surgical / dermatological treatment is necessary.
- Not display anger or irritation if the patient does not seem to be convinced about the diagnosis.
- Not suggest referral to cosmetic surgeon / dermatologist.
- Not offer investigations of patient's hair.

Rating Scales:

Current severity can be measured using the rater administered Yale-Brown Obsessive Compulsive Scale Modified for Body Dysmorphic Disorder (BDD-YBOCS) (Phillips et al., 1997). The Brown Assessment of Beliefs Scale (BABS) assesses the degree to which body-image beliefs are delusional (Eisen et al., 1998).

3.3 The Standard Required

In order to:

Surpass the Standard – the candidate demonstrates competence above the level of a junior consultant psychiatrist in several of the domains described below.

Achieve 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 Role Player

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

You are John a 29-year-old single man who works as a financial analyst in a merchant bank in the city. It is a competitive environment. You have been with the company for 6 years since graduating from university, but your career has stalled. It is 3 years since your last promotion and your explanation for this is that you are losing your scalp hair and this is costing you a promotion.

Since your adolescence (about 16 years) you have been quite concerned about your appearance and grooming. It began with a strong belief that in some way your face was asymmetrical which you believed was obvious to other people. This led to you checking your facial features in a mirror several times a day; and this confirmed your 'repulsiveness'. Then you began to notice facial flaws and different shades of pigmentation and worried that these made you look ugly. You started using creams and lotions to camouflage the area of paleness of skin leading to excessive spending on skin beauty products and spending a lot of time on browsing through websites to find a solution.

If asked by the candidate, it is your core belief that somehow you are defective or unattractive and this is accompanied by low self-esteem, embarrassment, shame and fear of rejection. You admit to experiencing significant distress and can describe this as 'intensely painful', 'tormenting', or 'devastating'.

Regularly checking your facial appearance during the day has now become part of your daily life. Each mirror-checking episode lasts several minutes with you having to reassure yourself that there are no new blemishes and that the existing blemishes are not getting worse. It is difficult to do this as regularly as you would like to at work, you can probably get to the bathroom once every two hours for a few minutes. At home it is easier where you can inspect your entire head and face several times per day. If asked, you have to agree that the total amount of time you spend checking your appearance in front of the mirror, touching, examining, picking at almost every skin pore and hair follicle, could be about four hours per day on the weekends.

You still live at home with your parents, who are both school teachers approaching retirement. Your mother worries a lot about having a clean and tidy home and does spend a lot of time cleaning in the kitchen. If asked by the candidate, this behaviour has never been so out of control that your mother needed to see anyone. Your parents have become accustomed to you asking "*How do I look?*" or, "*Is there something wrong with my face / skin / mouth / eyes / ears? Are there any spots of pale skin on my face?*". Their unfailing reassurance that there is nothing wrong with your appearance does not reduce any of your concerns as you are sure they are only saying that because they love and care about you.

In the past decade you have spent a fortune on male beauty products, facial treatments, massages, hair styling and allergy free soaps, shaving creams and cosmetics in an attempt to treat or camouflage your skin defects. You have also consulted a dermatologist on at least two occasions because you were concerned that blemishes and pimples were not healing, but were dissatisfied with the outcome of the consultation.

Because of your concerns for your skin you do not like to socialise where people are smoking and would never consider smoking yourself. For similar reasons you do not drink and avoid direct sun exposure as much as you can. Your self-consciousness can lead to avoidance of wider family and social activities. You also avoid crowds and public transport in order to avoid the embarrassment of strangers looking too closely at your facial and head features — all leading to significant social impairment as you don't have any close friends.

Over the last few months you have been monitoring the number of scalp hairs you have found on the floor in your shower cubicle after a shower. Although it may only be 2-3 hairs you have come to believe two things. The first is that the cumulative hair loss means that you are going bald and secondly that the resultant change in your hair density and thickness is obvious to others. You are quite convinced that you are going bald and worry about not getting married and losing out on life and its opportunities with occasional suicidal ideations. You have never attempted self-harm or suicide though suicidal thoughts have crossed your mind.

You have brought in some hair because you have found on the internet that certain laboratories can do tests on hair that can diagnose problems. You hope that the doctor will be able to send your hair sample to a lab that does these tests.

You often find your preoccupations difficult to control, and sometimes you make little or no attempt to resist them. So, you can spend hours / day thinking about your defects, so much that this seems to dominate your life. Sometimes you do feel as if there might be a link between how bad the defects are and whether you avoid people more at these times.

Although you believe you are conscientious and reliable at work, your progress has stalled. Lately you have been taking a few more days of sick leave and are preoccupied about the hair loss and appearance. Fellow candidates from your intake cohort seem to have left you behind. You are certain that this obvious hair loss has influenced your employers not to promote you because thinning hair / baldness and poor / unhealthy looks are not in keeping with the image that the company wants to portray to its customers. More recently you have been tempted to attend one of those private hair clinics they advertise for men on the TV, and have been saving up so you can pay for a course of treatment.

You have just had a performance appraisal interview and have once again been passed over for promotion. In response to this you have decided to seek medical advice about the diagnosis and treatment of your hair loss. You do not trust your family GP because he previously dismissed your concerns and said there was nothing wrong with you, so you are seeking an unbiased opinion from the doctor. You brought a sample of your hair with you so that it could be analysed to find a cause of the excessive loss. You have passed the sample to the nurse on your way into the room.

You have never heard voices or seen things that others do not and never have suspected that people are after you or that your life may be at risk. You have never had any manic or hypomanic symptoms such as an unduly elevated mood, excess energy, increased spending and increased sexual drive. You feel distressed and occasionally depressed about the state of affairs that you are in. However, you still enjoy things as much, do not have reduced energy levels and do not experience hopelessness, helplessness or decreased concentration.

You do not repeatedly check locks, lights and have doubts about cleanliness or symmetry or other repetitive thoughts or actions other than specified above.

If the candidate asks you to show the hair that you have brought, say that you have left the hair with the nurse.

4.2 How to play the role:

You are a young male, must be slightly scruffily dressed and wearing a hat or cap (which you must not take off unless asked to by the candidate). Once removed insist on showing the doctor your 'receding hair line' (if there is a mirror in the consulting room you can show the candidate in the mirror) as well as areas of paleness of skin on your face.

You will look anxious and be somewhat irritable. You will try to be co-operative during the interview and with any examination of your head and face the candidate attempts. Questions regarding your physical and psychological health should be answered as scripted. If there is no scripted response then you should inform the candidate that you have not experienced that symptom.

After your opening statement (see 4.3) your subsequent behaviour and emotional reactions will be in response to the way the interview unfolds. If the doctor rushes to a judgement and dismisses your concerns without tact, empathy or appropriate discussion, then your irritability and exasperation can increase.

If the doctor suggests that the problem is psychological, but also realises the sensitive nature of your underlying psychiatric problem, including the extent of your difficulties and concerns, and they can effectively engage you then be defensive and sceptical, but be prepared to listen and interact appropriately.

Do not willingly volunteer history of your rituals or checking behaviour unless asked. These have been behaviours you have kept secret for years, but may be relieved when at last someone is able to encourage you to talk about them.

4.3 Opening Statement:

"Hello doctor. I don't know how you can help me from losing my hair!"

4.4 What to expect from the candidate:

The candidate is to do an initial assessment of your symptoms and the reasons for wanting your hair assessed. To do this they will ask questions about your recent history including your concerns related to various parts of your body, other medical and psychiatric history and your personal history – answer as per the information provided.

They are likely to assess your mood, as well as current and usual coping styles in order to assess the breadth of your symptoms. Do not volunteer specific information unless asked, be cooperative but anxious, with a sense of irritation if the candidate states that you have a mental disorder.

Expect the candidate to work hard to form an alliance with you and treat your symptoms and distress sensitively.

4.5 Responses you MUST make:

“I want the hair I brought to be analysed by a specialist!”

“You’ve got to tell me what is going on!”

“Can you please refer me to a skin specialist or cosmetic surgeon who will do a hair transplant for me?”

4.6 Responses you MIGHT make:

“Let me show you where I’m going bald”, then proceed to show the doctor various parts of your hairline.

If asked about any other physical health problems, you have not noticed anything.

If asked about any mood symptoms, you have recently felt frustrated and down because of your current situation. Sometimes you do have difficulty getting to sleep but this has not happened recently. You have also had a period of time when your mood was very low and you wished you were dead. This was about 5 years ago and the symptoms passed without any intervention within a few months.

If asked about suicidal ideation or attempts, you had thought of gassing yourself when you were about 22 years old when you had a particularly bad period of acne around exam time, but you have not felt this bad since, although you do feel desperate sometimes and think that it may be better to die than to carry on this way. You have never attempted suicide and strongly reassure the doctor that it would only be the last resort if matters were not sorted. You love your parents too much to hurt them this way.

If asked about appetite and weight, you have no problems with your appetite but obviously take care of what you eat because you don’t want to add to your worries by being overweight as well.

If asked about vague or generalised symptoms of anxiety, you deny this.

If asked about other specific anxiety symptoms, like fear of leaving the house, or performing in some way in front of others, these do not really concern you except when it relates to what you look like.

If asked about other obsessions (intrusive thoughts) or compulsions (repetitive behaviours or mental actions), you do not have any that do not link directly with your looks and your hair loss.

If asked about the course of your symptoms, it has been continuous since your teens with few symptom-free intervals, although the symptom intensity waxes and wanes, but does seem to be worsening over time.

If asked about family history of psychiatric or medical illnesses, there is none.

STATION 6 – MARKING DOMAINS

The main assessment aims are to:

- Take an appropriately focussed history, consider the diagnostic possibilities and establish a diagnosis of Body Dysmorphic Disorder (BDD).
- Communicate the diagnosis and reasoning to the patient including potential differential diagnosis in a non-judgemental, non-stigmatising empathic manner.

Level of Observed Competence:

1.0 MEDICAL EXPERT

1.2 Did the candidate take appropriately detailed and focussed history? (Proportionate value - 35%)

Surpasses the Standard (scores 5) if:

achieves a score of at least 4 *and* completes sophisticated assessment of the pattern of symptom presentation; identifies the relevant family history and past personal history of depressive symptoms; links exacerbations to stressors and comorbidities.

Achieves the Standard by:

demonstrating a tailored biopsychosocial approach; conducting a detailed but targeted assessment; obtaining a history relevant to the patient's problems and circumstances with appropriate depth and breadth; history taking is hypothesis-driven; demonstrating ability to prioritise; completing a risk assessment relevant to the individual case; demonstrating phenomenology; clarifying important positive and negative features including possible delusional disorder and ruling out depressive and anxiety disorder symptoms.

To score 3 or above the candidate **MUST**:

- specifically ascertain that the patient's concern is far in excess of the physical evidence.
- establish how Body Dysmorphic Disorder symptoms are affecting function across a range of areas.

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) if:

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:

significant omissions in history and not prioritising symptoms of Body Dysmorphic Disorder.

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 formulate and describe the relevant working diagnoses / differential diagnoses to the patient? (Proportionate value - 30%)

Surpasses the Standard (scores 5) if:

achieves a score of at least 4 *and* integrates information in a manner that can effectively be utilised by the patient; provides succinct and professional information.

Achieves the Standard by:

providing accurate and structured feedback about the diagnosis; prioritising and synthesising information; adapting communication style to the setting; the use of language so as to enhance patient understanding; demonstrating discernment in selection of content; discussing need to speak with other specialists and GP, recognising the importance of explanations to the patient.

To score 3 or above the candidate **MUST**:

- sensitively explain the working diagnosis of Body Dysmorphic Disorder.
- not diagnose Delusional disorder or Psychosis as a primary diagnosis.

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

Below the Standard (scores 2 or 1) if:

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:

any errors or omissions impact on the accuracy of information provided.

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 effective communication skills and an appropriate professional approach to gathering information from the patient? (Proportionate value - 35%)

Surpasses the Standard (scores 5) if:

achieves a score of at least 4 *and* professionally and sensitively accommodates the patient's distress and respond to it empathically and address the concerns raised effectively.

Achieves the Standard by:

demonstrating ability to develop a therapeutic relationship; addressing to concerns raised; helping the patient feel at ease; sensitively but appropriately responding to the request for hair to be examined; forming a partnership with the patient demonstrating empathy and ability to establish rapport.

To score 3 or above the candidate **MUST**:

- a. effectively manage resistance from the patient in a non-judgemental, empathic manner.
- b. not collude with patient e.g. by agreeing to send them to see another specialist or test the hair.

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) if:

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:

lacking consideration of individual capabilities or preference; using aggressive, patronising or interrogative style; gives in to the patient's demands for further investigations; any errors or omissions adversely impact on alliance.

2.1. Category: PATIENT COMMUNICATION – To Patient	Surpasses Standard	Achieves Standard			Below the Standard		Standard Not Achieved
		5 <input type="checkbox"/>	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	
ENTER GRADE (X) IN ONE BOX ONLY							0 <input type="checkbox"/>

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
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