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### 1.0 Descriptive summary of station:

In this station the candidate is working in an outpatient clinic. The patient is a mother recovering from a Major Depressive episode who now has concerns about her 6-year-old son. The candidate is to take a history from the mother regarding these concerns to determine what factors may be playing a role in his difficulties, and discuss potential ways to help her assist him. The station focusses on the theory of attachment in which the candidate is expected to consider specific disorders like oppositional defiant disorder (ODD), but to also assess the impact of parental mental illness on children.

### 1.1 The main assessment aims are to:

- Assess the possible effect of maternal psychiatric illness on the children.
- Formulate and communicate the possibilities to the mother.
- Make suggestions on how to assist the son with sleep, preferably based on attachment theory, recognising the importance of the child's recent maternal separation during illness.

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

- Establish that Joseph's problems emerged in the context of Annie's illness and hospitalisation, and did not precede it.
- Formulate the presentation in the context of attachment theory.
- Articulate the difference between Joseph's emotional distress and ODD.
- Suggest the mother help Joseph sleep by giving him opportunities to feel a secure connection with her.

### 1.3 Station covers the:

- **RANZCP OSCE Curriculum Blueprint Primary Descriptor Category:** Child & Adolescent Disorders
- **Area of Practice:** Adult Psychiatry
- **CanMEDS Domains:** Medical Expert
- **RANZCP 2012 Fellowship Program Learning Outcomes:** Medical Expert (Assessment – Data Gathering Content, Formulation, Diagnosis, Management – Initial Plan)

#### References:

- Bowlby, J. (1988). *A secure base: clinical applications of attachment theory*. London: Routledge.
- Cowling, V (1999) *Children of the Mentally Ill*. Camberwell: Acer press.
- Powell, B., Cooper, G. et al (2014) *The Circle of Security intervention*. Guildford.
- Schore, A. N. *Effects of a Secure Attachment Relationship on Right Brain Development, affect Regulation, and Infant Mental Health*. *Infant Mental Health Journal*, Vol. 22(1-2), 7-66(2001).
- Siegel, D. *No Drama Discipline*. Norton 2014.
- Winnicott, D. W. (1987; 1st ed.: 1964). *The child, the family and the outside world*. Pp. 239. Penguin Books.

### 1.4 Station requirements:

- Standard consulting room.
- Four chairs (examiners x 1, role player x 1, candidate x 1, observer x 1).
- Laminated copy of 'Instructions to Candidate'.
- Role player: woman in her early 30's, tidy appearance.
- 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 a community outpatient clinic.

Your patient, Annie, is a 32-year-old married mother of two school age children (8-year-old Sofia, and 6-year-old Joseph). Annie has come to the psychiatric clinic for a routine follow up after discharge from hospital where she had been successfully treated for a Major Depressive episode. She is recovering well (you do not need to focus on Annie's mental state).

Today she raises concerns about Joseph being difficult to manage; obstinate, and argumentative. He has been unwilling to go to bed, and is having trouble getting to sleep. Annie wants advice on how to help him sleep.

His teacher says he has become uncooperative in class, and has refused to follow instructions and requests from school staff. The teacher raised the possibility of Oppositional Defiant Disorder after a playground incident when he pushed another boy.

Your tasks are to:

- Assess Annie's concerns about her son.
- Formulate causes of Joseph's difficulties, and communicate these to Annie.
- As part of the discussion with Annie, make at least one suggestion of how she can help Joseph with sleep, based on your understanding of his difficulty.

**You will not be given any time prompts.**

## Station 6 - 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'.
  - Pens.
  - Water and tissues (available for candidate use).
- Do a final rehearsal with your simulated patient.

### During examination:

- Please ensure mark sheets and other station information, are out of candidate's view.
- At the **first bell**, take your places.
- At the **second bell**, start your timer, check candidate ID number on entry.
- TAKE NOTE that there is no cue / time for any scripted prompt for you to give.
- DO NOT redirect or prompt the candidate unless scripted – the simulated patient has prompts to use to keep to the aims.
- If the candidate asks you for information or clarification say:  
***'Your information is in front of you – you are to do the best you can'.***
- At **eight (8) minutes**, as indicated by the timer, the final bell will ring. Finish the examination immediately.

### At conclusion of examination:

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

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

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

### 3.0 Instructions to Examiner

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

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

When the candidate enters the room, briefly check ID number.

You have no opening statement or scripted prompt.

The role player opens with the following statement:

*'I'm good, but my son is stressing me out because I can't get him to sleep.'*

#### 3.2 Background information for examiners

In this station the candidate is expected to assist a patient, Annie, about concerns related to the behaviour of her 6-year-old son, Joseph.

The candidate should enquire about the child's relationship with the mother prior to her illness. This may include exploration of how Joseph has responded to previous stresses, and apparent resilience in the setting of his father's absence, as well as how the mother responded to him, from an attachment perspective. The candidate should ask questions which reflect exploration of the child's experience of the mother's illness. They may ask about his capacity to use the mother as a secure base, and the child's capacity to ask for connection in a direct way, rather than miscues. Another additional factor could include Sofia's adjustment.

As the teacher has suggested Oppositional Defiant Disorder (ODD), the candidate should exclude this as diagnostic possibility. The candidate is expected to formulate the problem, demonstrating their understanding that maternal mental illness and absence can cause emotional distress in children, and that the child's behaviour at home can be understood through him seeking connection. A psychiatric diagnosis is not required.

The candidate should communicate the formulation to the mother in a way that helps her understand her child's experience. The candidate must recommend at least one strategy to help the child at bed time. Bedtime has been chosen because bedtime and sleep are a separation of the child from the mother, and so highlights the meaning of the child's behaviour. The candidate must suggest a strategy which reflects an understanding of the meaning of the child's behaviour i.e. that the child is having difficulty separating and needs support from the mother in order to feel secure, so that he is able to separate, and therefore sleep.

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

- Establish that Joseph's problems emerged in the context of Annie's illness and hospitalisation, and did not precede it.
- Formulate the presentation in the context of attachment theory.
- Articulate the difference between Joseph's emotional distress and ODD.
- Suggest the mother help Joseph sleep by giving him opportunities to feel a secure connection with her.

A surpassing candidate may use a model such as Circle of Security to explain the child's need for connection to feel secure. They may enquire about the wellbeing of the 8-year-old daughter, and help the mother think about how her children have each responded differently to her illness and her absence.

If the candidate diagnoses the child as having ODD this is a clear fail.

## Theory of Attachment

This station focusses on the theory of attachment, its importance for child and parent relationships, and in maintaining good child mental health. Attachment theory was first described by Bowlby in *Attachment and Loss*, and later in further attachment research by Bowlby and his team. This strong initial relationship provides children with a secure connection with their primary carer, to develop and function optimally. It is within the primary attachment relationship that the infant learns to self-regulate, internal working models of relationships develop, and identity formation begins. This relationship is described with a range of attachment types including secure, insecure ambivalent, insecure avoidant (Ainsworth 1978) and insecure disorganised (Main and Solomon 1986). Those with a secure attachment relationship have a secure base for exploration and a safe haven to return to at times when the need for connection is triggered. Within this relationship the parent is able to help their child manage distress, trauma and negative events as well as engage in positive events and allow exploration. A secure attachment also protects children from the detrimental effects of stresses such as of low socioeconomic status, violence and some trauma, including war. The need for attachment is a primary need for human beings, for example demonstrated by studies on the Romanian orphans who failed to develop in environments where their physical needs were (barely) met, but their need for love and connection were not met. (Nelson, C.A, Fox, N.A., Zeanah, C. H., (2014)) *Romania's abandoned Children: Deprivation, Brain Development and the struggle for recovery*. Harvard University Press).

Attachment relationships are mutually regulating (Schore, A. N., 2001). An infant or child being exposed to their parents' emotional regulation gives the child the opportunity to form their own understanding of the world and ways in which to evaluate the outside environment, and learn to make responses. A distressed child may be able to become regulated through the connection with the parent.

A child may need this safe haven experience when anxious or uncertain about an unfamiliar situation or person, or if the child has strong feelings which they need help to organise. Even in good relationships there will also be a process of rupture and repair when the parent may be miss-attuned to the child, and then repairs the rupture, for example by noticing the rupture, naming the feeling or describing the problem, accepting responsibility without blame, and providing what the child needs.

There can be a difficulty in the relationship precipitated by a situation or stress which does not meet the threshold for the diagnosis for an attachment disorder, as in this case. A child with secure attachment to their care-giver may express their distress with behaviour within the relationship which expresses their distress.

Parenting places demands on the adult and this can be especially significant at times of illness. Children are affected by psychiatric illness in a parent (Cowling, V. (1999) *Children of the Mentally Ill*, Camberwell: Acer Press (1975)) and this can be expressed in the attachment relationship. A general psychiatrist should be able to address the needs of the whole family at times of illness. Assisting a parent to understand their child's behaviour and meet the child's needs will also assist the parent's recovery. The overwhelming majority of parents wish to do the best job they can, and this can motivate and aid an unwell parent in recovery. Furthermore, being a parent can be a protective factor for an adult with mental illness, for example giving motivation to not act on suicidal thinking.

An understanding of attachment theory has broad applicability in psychiatric practise, not only in child psychiatry. Attachment relationships in childhood inform relationships throughout life. The relationship with a caring professional such as a psychiatrist, especially a psychotherapist, will be informed by attachment status. A number of psychiatric conditions in adulthood can be understood through the lens of attachment, particularly the personality disorders including Borderline Personality (Kernberg (1975), Fonagy and Bateman (2004)). Evidence supported treatment modalities such as Mentalisation Based Therapy, Transference Focussed Therapy and other psychotherapies, are grounded in an understanding of attachment. Attachment theory informs much of contemporary psychoanalytic and psychodynamic psychotherapeutic formulation (Slade, A. 1999; Holmes, J. 2014).

As part of the formulation to the mother, the candidate is to offer a suggestion as to how to help Joseph with his difficulty going to bed. This should be informed by attachment theory, and based in an understanding that the child is expressing his feelings and his needs through the behaviour. Going to sleep requires separation from the parent. Therefore, separation difficulties often will present with problems at bedtime. Joseph experienced a significant and problematic separation from his mother through her illness and hospitalisation. The difficulties at bed time reflect his struggle to separate from her as a result.

Appropriate suggestions will help Joseph sleep by helping him feel a secure connection with her so as to help him feel safe to separate into sleep. The candidate may suggest that the mother try to stop and reflect what is going on for the child at the time i.e. what is the child's feeling? Why is he feeling this at this time?

What is his need and how can she meet his need? How can she help him express his need in a more direct way, for example, in words?

The parent could develop a bedtime routine in which the child is able to feel connected to the mother. Letting him know in advance that bedtime is coming up, spending quiet 'time in' with him, talking about the day, reading a book, for example. He may need reassurance that she will be there for him if he needs her. The mother may help the child to identify his feelings by asking are you sad or mad, or scared? She may name the feelings for him if he is unable to, e.g. I wonder if you felt mad when I asked you to go to bed and you didn't feel like it. She may help him express his feelings in words and understand why he feels that way at this time. Avoiding explanations which are blaming of either person, but rather develop explanations in which both people can take responsibility. The mother can model this in her reaction, by neither blaming him, nor herself, but explaining how the difficulty came about. For example, explaining that she was tired at the end of the day, and she forgot to warn him 1/2 hour before that bedtime was coming up, and she hoped that he wouldn't need a story tonight.

Better candidates will highlight the daughter's different way of expressing her distress and achieving connection with her mother, for example acting in, or being a somewhat parentified child, engaging in 'being an angel', which could perhaps express a denial of Sofia's own needs at the expense of her mother's needs. It is generally more gender typical for girls to 'act in' and boys to 'act out'.

### **Oppositional Defiant Disorder (ODD)**

It can sometimes be difficult to recognise the difference between an emotional or strong-willed child, and a child with an oppositional defiant disorder. While it is normal to exhibit oppositional behaviour at certain stages of a child's development, signs of ODD usually begin during preschool years. Sometimes ODD may develop at a later age, but almost always before the early teen years.

Oppositional Defiant Disorder is not a sudden onset disorder. Distressed and angry children can present with similar behaviours to children with ODD. However, when the behaviour occurs in a context where it is acute, and clearly in response to a recent environmental of attachment stress, and where the symptoms are of recent duration then the symptoms are better understood as the child expressing their feelings and trying to engage with a care giver. It is important to identify and intervene as some children can go on to develop Conduct Disorder, especially those with more defiant, argumentative and vindictive symptoms. Depression and anxiety may also develop in children who have presented with angry, irritable mood symptoms.

A child may not see their behaviour as a problem, and may believe that unreasonable demands are being placed on them. However, if a child has features commonly found in ODD more frequently than is typical in their peers, then a professional assessment should be sought. These behaviours cause significant impairment with family, social activities, school and later with work.

ODD is described in both the DSM-5 and ICD 10.

In the **ICD 10: F91.3, Oppositional defiant disorder** is described under the group heading of Conduct Disorders (F91) and described as:

usually occurring in younger children, primarily characterised by markedly defiant, disobedient, disruptive behaviour that does not include delinquent acts or the more extreme forms of aggressive or dissocial behaviour. The disorder requires that the overall criteria for F91- be met; even severely mischievous or naughty behaviour is not in itself sufficient for diagnosis. Caution should be employed before using this category, especially with older children, because clinically significant conduct disorder will usually be accompanied by dissocial or aggressive behaviour that goes beyond mere defiance, disobedience, or disruptiveness.

### **DSM-5: Oppositional Defiant Disorder 313.81**

A. A pattern of angry / irritable mood, argumentative / defiant behaviour, or vindictiveness lasting at least 6 months as evidenced by at least four symptoms from any of the following categories, and exhibited during interaction with at least one individual who is not a sibling.

#### Angry / Irritable Mood

- Often loses temper.
- Is often touchy or easily annoyed.
- Is often angry and resentful.

#### Argumentative / Defiant Behaviour

- Often argues with authority figures or, for children and adolescents, with adults.
- Often actively defies or refuses to comply with requests from authority figures or with rules.
- Often deliberately annoys others.
- Often blames others for his or her mistakes or misbehaviour.

#### Vindictiveness

- Has been spiteful or vindictive at least twice within the past 6 months.

Note: The persistence and frequency of these behaviours should be used to distinguish a behaviour that is within normal limits from a behaviour that is symptomatic. For children younger than 5 years, the behaviour should occur on most days for a period of at least 6 months unless otherwise noted (Criterion A8). For individuals 5 years or older, the behaviour should occur at least once per week for at least 6 months, unless otherwise noted (Criterion A8). While these frequency criteria provide guidance on a minimal level of frequency to define symptoms, other factors should also be considered, such as whether the frequency and intensity of the behaviours are outside a range that is normative for the individual's developmental level, gender, and culture.

B. The disturbance in behaviour is associated with distress in the individual or others in his or her immediate social context (e.g., family, peer group, work colleagues), or it impacts negatively on social, educational, occupational, or other important areas of functioning.

C. The behaviours do not occur exclusively during the course of a psychotic, substance use, depressive, or bipolar disorder. Also, the criteria are not met for disruptive mood dysregulation disorder.

#### *Specify current severity:*

Mild: Symptoms are connected to only one setting (e.g., at home, at school, at work, with peers).

Moderate: Some symptoms are present in at least two settings.

Severe: Some symptoms are present in three or more settings.



### 3.3 The Standard Required

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

**Achieves the Standard** – the candidate demonstrates competence expected of a junior consultant psychiatrist. That is the candidate is able to demonstrate, *taking their performance in the examination overall*, that

- i. they have competence as a **medical expert** who can apply psychiatric knowledge including medicolegal expertise, clinical skills and professional attitudes in the care of patients (such attitudes may include an ability to tolerate uncertainty, balance, open-mindedness, curiosity, 'common sense' and a scientific approach).
- ii. they can act as a **communicator** who effectively facilitates the doctor patient relationship.
- iii. they can **collaborate** effectively within a healthcare team to optimise patient care.
- iv. they can act as **managers** in healthcare organisations who contribute to the effectiveness of the healthcare system, organise sustainable practices and make decisions about allocating resources.
- v. they can act as **health advocates** to advance the health and wellbeing of individual patients, communities and populations.
- vi. they can act as **scholars** who demonstrate a life-long commitment to learning as well as the creation, dissemination, application and translation of medical knowledge.
- vii. they can act as **professionals** who are committed to ethical practice and high personal standards of behaviour.

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

**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 Annie, a 35-year-old married mother of two children. Joseph is 6 and in grade one at school. Sofia is 8 years old and is grade three. Today you would like to talk with your psychiatrist about your son.

#### About Joseph:

He has been difficult to manage for 2 months. He has been stubborn / obstinate and uncooperative, as well as being whingy. He doesn't want to go to bed in his own room. He wants to sleep in bed with you. He is making any excuse to delay bedtime. He gets out of bed and asks for a drink or a snack. He calls you back to his room after you finally get him to bed. You are getting exasperated and exhausted by this. He also doesn't want to go to school. He won't cooperate with getting dressed in the morning. He wants you to do up his shoes, which he was doing quite well a couple of months ago.

At times Joseph gets angry when you insist he does things like get dressed for school. Sometimes he hits you when he is angry. At times he gets tearful and upset about small frustrations. For example, the other day he couldn't find his favourite toy car and became really upset. Another example was last week when you had had a tiring day, you had been busy cleaning up after dinner and time had got away from you. You had forgotten to give him the usual reminder that it was bedtime, and had asked him to go to bed immediately. Because it was late, and you were tired, you said that you wouldn't read him a story and he just had to go straight to bed. Probably you sounded a bit more cranky and short with him than you intended. *'He just lost it'*, he got really upset, was crying and having a tantrum. You just didn't really know what to do. You thought you should be tougher with him but in the end, you tried to bribe him with more TV and ice-cream. It took a long time before he calmed down. You worry that he just exhausted himself with his tantrum, and went to sleep in the end because he was so spent. This is not like him.

The other day Joseph's teacher asked to meet with you after a playground incident when he pushed another boy, resulting in a complaint from the other child's parents. The teacher said he has been angry and uncooperative, and raised the possibility of something called Oppositional Defiant Disorder (or ODD). Joseph's behaviour has been worse over the last 6 weeks or so. It is now past the first few months of the year, and he had been quite settled last term and had seemed to enjoy school.

Before this behaviour change Joseph seemed to like school. He had settled into the new classroom at the beginning of the year. He liked school and had seemed to get on well enough with the other kids including a buddy who would come for play dates. He was achieving appropriately at school. He liked reading and maybe needed more help with maths, but he was going okay. He was pleased to be a big boy who could dress himself and tie his own shoes up.

You did see him struggle for a while when your husband Dave first went away. He was a bit of a baby at first. He wanted help tying his shoe laces for a while. You have been using Skype to stay in touch with Dave, but the 4-hour time difference made it tricky at times for the kids to have daily contact. But regular Skyping seemed to help, and Joseph appeared to get to cope okay with Dave away - until you got sick. But as you struggled more while getting unwell, Joseph had become increasingly needy.

Joseph has had no illnesses, nor operations, nor allergies.

#### About your personal life:

Your husband Dave, an engineer, has been working overseas for 8 months, having been posted to Indonesia for a year by the mining company he works for. You had talked a lot about the job offer before he went, and although you knew it would be tough, you thought that you could cope. Your marriage is stable and loving.

The kids get on pretty well with each other generally. Sofia takes her role of big sister quite seriously. She is a good helper and has really stepped up since Dave has been away. Sofia is a lot like you. She like things to be orderly and doesn't like to be late. She enjoys gymnastics. She enjoys school. She never gives you a moment's worry.

You are a police officer, working 4 shifts per week part time. Before you got depressed a few months ago (see notes on the following page), you liked work and are known as a bit of a perfectionist. You enjoy going to the gym and would go every day if you could. You like the house to be clean and tidy. You normally take care with your appearance, and like the kids to be smartly dressed. You are an independent person who doesn't like to ask for help. Before the depression that you are recovering from, you would have said that you were a strong person. People come to you for help, not the other way around.

You had felt embarrassed that you had got into this situation, with not being able to cope and getting depressed. Before the admission you had not told your parents or friends how much you are struggling with Dave away. Now you realise that you need to let people in to get support. You have a couple of friends, but you tend not to want to burden them with your difficulties because everyone is busy these days.

You love the kids to bits and it is important to you to be a good mum. Before you got ill the kids seemed to be doing okay.

Your mental wellbeing: *you do not have to provide this detail of information unless the candidate specifically asks about your mental health.*

You are recovering from a serious episode of depression, for which you were admitted to hospital for two weeks because you were so unwell. You were discharged four weeks ago. You are taking the medications prescribed. You are doing 'pretty well', and at the moment you are concerned about Joseph.

You started to become depressed 4 months or so ago, after Dave went to Indonesia. You were struggling to cope with work and family commitments. You were waking up at 3am and worrying about things. You lost your appetite and lost 10kg. You lost interest in things, you weren't looking after yourself. You stopped going to the gym, stopped paying the bills because it all seemed too hard. Even though you felt so lonely without Dave around, you were isolating yourself and stopped enjoying time with the kids.

You tried to keep everything normal for the kids, but it became such an effort. There were times you were irritable with them. You have never hit them or abused them, but you felt really bad when you yelled at Joseph one day and made him cry. Sometimes when it all seemed too hard you did tend to just let the kids do what they wanted. One day they had ice-cream for breakfast because you just couldn't argue about it. The kids had also started going to bed late.

For a short period of time you felt so awful that you believed that your family would be better off without you. The GP had given you some sleeping tablets because you had told him the problem was just difficulty sleeping. You had felt too ashamed to tell him you really weren't coping. One morning when your parents-in-law had the kids (so you could sleep), you drank a bottle of wine to help you feel better, but you felt worse. You wrote a letter to your children and one to your parents. You had connected the car exhaust to a hose and diverted it to the cabin of the car, closed the garage up, taken a few sleeping tablets and sat in the car. A colleague at work had become concerned when you had not shown up at work. She had arranged a welfare check. Subsequently the ambulance was called. After you were medically stable you had been admitted to the psychiatric ward, where you stayed for 2 weeks.

Dave came back for a couple of weeks but has gone back overseas as things seemed to be okay. When you were in hospital your family thought it best not to bring the kids in to see you, because the ward seemed to be a noisy somewhat scary place, and when they had come in Joseph got pretty upset when they went to leave.

In hospital, you were prescribed two medications - Desvenlafaxine (Des-ven-la-fax-een) (also known as venlafaxine in New Zealand) and Quetiapine (Kwet-i-apeen). You found the admission to be very helpful. The doctor had met with your family and helped arrange supports in the transition back home.

While you were in hospital your family rallied around, and the kids were cared for by both sets of grandparents and your sister. Your parents had come from the country for a week. The kids don't know your parents well and your dad is pretty strict, but you appreciated their help. Dave came home for a couple of weeks. Dave's parents had them for a couple of sleepovers, and the kids had a good time as Dave's Mum always spoils them.

Sofia has been an angel through this time. You have been pleased to see how mature she has been. You think she is strong, like you were before you got sick. Before you went to hospital she seemed to know you were struggling and would try to help. She would also help to get Joseph to cooperate.

Looking back, you think you probably had suffered from post-natal depression after Joseph was born. Joseph was difficult to settle as a baby, but by the time he was 15 months old it had seemed to work out. You didn't get any treatment; as at the time you put your low feelings down to being tired. You remember lying awake at night even when Joseph did sleep. You lost quite a bit of weight and didn't enjoy anything much.

#### 4.2 How to play the role:

You are smartly dressed and are well groomed. You present with a generally fairly tough, no nonsense persona. You are well at the moment (not depressed). You are worried about Joseph but not too worried about Sofia.

#### 4.3 Opening statement:

*'I'm good, but my son is stressing me out because I can't get him to sleep.'*

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

Firstly, the candidate should ask about your son and the problems he is having. They should ask how he was before your illness and may ask you about what happened to Joseph while you were in hospital.

Secondly the candidate should explain to you what they think is causing the problems.

The third task for the candidate is to suggest some things that you could do that would help your son.

#### 4.5 Responses you MUST make:

*'He just seems to be so angry with me.'*

*'The teacher thinks it's Oppositional Defiant Disorder, what do you think?' (After about 3-4 minutes)*

*'How can I get him to sleep better?'*

#### 4.6 Responses you MIGHT make:

If the candidate asks what things were like before you became unwell:

Scripted Response: *'Joseph had really settled down after we moved to the new house. I think we all felt safe.'*

If the candidate asks whether you have been violent towards your children:

Scripted Response: *'I have never deliberately harmed the children.'*

If the candidate asks about Sofia:

Scripted Response: *'She has been an angel, she tried to help.'*

If the candidate asks about Joseph:

Scripted Response: *'He seemed to enjoy school.'*

*'What can I do to help him, doctor?'*

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

Devenlafaxine (des-ven-la-fax-een) 150 milligrams in the morning.

Quetiapine (Kwet-I-apeen) XR 50milligrams at night.

## STATION 6 – MARKING DOMAINS

The main assessment aims are to:

- Assess the possible effect of maternal psychiatric illness on the children.
- Formulate and communicate the possibilities to the mother.
- Make suggestions on how to assist the son with sleep, preferably based on attachment theory, recognising the importance of the child's recent maternal separation during illness.

Level of Observed Competence:

### 1.0 MEDICAL EXPERT

#### 1.2 Did the candidate take an appropriately detailed and focussed history from Annie? (Proportionate value – 40%)

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

clearly achieves the overall standard with a superior performance in a range of areas; demonstrates prioritisation and sophistication.

**Achieves the Standard by:**

demonstrating use of 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; taking hypothesis-driven history; integrating key social issues relevant to the assessment; demonstrating ability to prioritise; eliciting the key issues; completing a risk assessment relevant to the individual case; demonstrating phenomenology; clarifying important positive and negative features; enquiring about her relationship with the children over time.

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

- Establish that Joseph's problems emerged in the context of Annie's illness and hospitalisation, and did not precede it.

**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:**

does not establish that the child's problems are related to the mother's illness. Omissions adversely impact on the obtained content; significant deficiencies such as substantial omissions in history.

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"/>	

#### 1.11 Did the candidate generate an adequate formulation to make sense of the presentation? (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.

**Achieves the Standard by:**

identifying and succinctly summarising important aspects of the history; integrating medical, developmental, psychological and sociological information; developing hypotheses to make sense of the patient and child's predicament; accurately linking formulated elements to any diagnostic statement; including a sociocultural formulation; analysing vulnerability and resilience factors; explaining the child's behaviour as an expression of his emotional struggle in experiencing disruption of mother-child relationship.

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

- Formulate the presentation in the context of attachment theory.

**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) 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; provides an inadequate formulation or diagnostic statement.

1.11. Category: FORMULATION	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 relevant diagnostic explanation? (Proportionate value – 20%)**

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

highlights the different expressions of distress between the children; uses concepts like Circle of Security; appropriately identifies the limitations of diagnostic classification systems to guide interventions.

**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; adequate prioritising of conditions relevant to the obtained history and findings, utilising a biopsychosocial approach, identifying relevant predisposing, precipitating perpetuating and protective factors; including communication in appropriate language and detail, and according to good judgment.

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

a. Articulate the difference between Joseph’s emotional distress and ODD.

**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:**

inaccurate or inadequate diagnostic formulation; does not exclude oppositional defiant disorder; does not consider Joseph’s behaviour as an expression of his feelings to engage his mother; errors or omissions are significant and do materially adversely affect conclusions.

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"/>	

**1.13 Did the candidate formulate and describe a relevant initial management plan? (Proportionate value - 10%)**

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

provides a sophisticated link between the plan and key issues identified; clearly addresses difficulties in the application of the plan.

**Achieves the Standard by:**

demonstrating the ability to prioritise and implement evidence-based care; recommending specific interventions; considering safe, skilful engagement of appropriate resources / supports; identifying realistic time frames for review; recognising their role in effective treatment; identifying potential barriers; recognising the need for consultation / referral.

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

a. Suggest the mother help Joseph sleep by giving him opportunities to feel a secure connection with her.

**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:**

plans are only based on learning theory; plan lacks structure; not tailored to the immediate needs or circumstances.

1.13. Category: MANAGEMENT - Initial Plan	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"/>	

## 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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