Committee for Examinations
Objective Structured Clinical Examination
Station 10
Auckland September 2018

The Royal Australian & New Zealand College of Psychiatrists

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1.0 Descriptive summary of station:

In this station, a 45-year-old veteran who has Post Traumatic Stress Disorder (PTSD) and some current psychosocial stressors presents with questions regarding non-pharmacological management of PTSD. The candidate is to address his concerns, outline various psychological interventions for PTSD, specifically including Trauma-focussed Cognitive Behavioural Therapy and Eye Movement Desensitisation and Reprocessing, and provide ideas of psychosocial rehabilitation interventions.

1.1 The main assessment aims are to:

- Demonstrate competence in engaging the patient and addressing his concerns, and identify factors contributing to his presentation.
- Discuss the components, procedure and effectiveness of Trauma-focussed Cognitive Behavioural Therapy (TF-CBT) and Eye Movement Desensitisation and Reprocessing (EMDR).
- Outline other psychotherapeutic interventions for PTSD that have some evidence base and recommend appropriate interventions.

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

- Explain exposure as a part of TF-CBT.
- Accurately outline the process of EMDR.
- Outline at least two (2) other psychological interventions for PTSD that have an evidence base.
- Identify at least three (3) psychosocial factors and recommend appropriate interventions.

1.3 Station covers the:

- **RANZCP OSCE Curriculum Blueprint Primary Descriptor Category**: Anxiety Disorders
- **Area of Practice**: Adult Psychiatry
- **CanMEDS Domains**: Medical Expert, Communicator
- **RANZCP 2012 Fellowship Program Learning Outcomes**: Medical Expert (Management – Therapy; Formulation - Communication), Communicator (Patient Communication – Disclosure)

References:

- Australian Centre for Posttraumatic Mental Health (ACPMH) (2013*) Australian guidelines for the treatment of adults with acute stress disorder and posttraumatic stress disorder.*
- Clinical Practice Guideline for the Treatment of Post Traumatic Stress Disorder (PTSD) in Adults, American Psychological Association, APA Policy, February 2017
- Department of Veterans Affairs and Department of Defence (2010) *VA/DoD clinical practice guideline for management of post-traumatic stress,* https://www.healthquality.va.gov/PTSD-FULL-2010c.pdf
- EMDR International Association. https://emdria.site-ym.com
- National Institute for Clinical Excellence (NICE) (2005) *The management of PTSD in adults and children in primary and secondary care*
- Seidler GH[1], Wagner FE. *Comparing the efficacy of EMDR and trauma-focussed cognitive-behavioral therapy in the treatment of PTSD: a meta-analytic study*. Psychol Med. 2006 Nov;36(11):1515-22. Epub 2006 Jun 2.
- Swinson RP, Anthony MM, Bleau P, et al, for the Canadian Psychiatric Association (2006) Chapter 8: *Posttraumatic stress disorder: Clinical practice guidelines: Management of anxiety disorders*. Canadian Journal of Psychiatry 51 (Suppl 2) 57S-63S

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: 40 to 45-year-old man, casually attired.
- 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 mental health team.

You are about to see Mr Daniel Thomas, a 45-year-old army veteran with a history of Post Traumatic Stress Disorder (PTSD). He was diagnosed 9 months ago. He was medically retired and he receives full army pension. He lives in Auckland with his ex-partner Margaret and their 11 year-old-son, Nathan. His parents live in Christchurch. He is unemployed.

He is on the following medication regime (Paroxetine 60mg mane, Quetiapine 100mg nocte, Prazosin 2mg nocte, Pregabalin 300mg BD), and his condition is partially controlled. He does not use alcohol or drugs. He is not at risk to himself or others.

He wants to explore non-pharmacological options for better control of his symptoms, particularly specific psychological interventions for PTSD.

Your task is to:

- Address Mr Thomas's concerns and interest in treatment options.
- Explore other factors contributing to his presentation and recommend appropriate interventions.

You are not expected to do a mental state examination or risk assessment.

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' and any other candidate material specific to the station.
  - Pens.
  - Water and tissues are available for candidate use.
- Do a final rehearsal with your simulated patient.

During examination:

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

The role player opens with the following statement:

'***Doctor, does cognitive therapy work for my condition?'***

3.2 Background information for examiners

In this station the candidate is expected to provide Mr Thomas with information about psychological interventions for PTSD, and respond to his questions about TF-CBT and EMDR. The candidate is also expected to identify that Mr Thomas has a number of psychosocial stressors for which they can provide recommendations on appropriate psychosocial rehabilitation interventions.

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

- Explain exposure as a part of TF-CBT.
- Accurately outline the process of EMDR.
- Outline at least two (2) other psychological interventions for PTSD that have an evidence base.
- Identify at least three (3) psychosocial factors and recommend appropriate interventions.

Better candidates will be able to provide clear details of the key therapies in a manner that indicates familiarity with the techniques. Their use of language and terminology will be adapted to the needs of the patient. They will also demonstrate the ability to sensitively engage the patient without causing distress or anxiety.

<u>Approaches to psychological management of PTSD</u>

According to the RANZCP PTSD practice guidelines:

- Guidelines are often situation-specific.
- All of the guidelines are considered useful.
- All guidelines emphasise careful diagnosis and treatment planning.
- All guidelines emphasise the role of psychotherapeutic treatment and the limitations of the role of pharmacotherapy.
- All guidelines emphasise the desirability of early interventions, although clear data on prevention is still lacking.

All the widely used protocols include education about PTSD and its treatment, which includes exposure related to the traumatic event. The amount and quality of evidence varies for different interventions.

The approaches differ in terms of intensity of exposure, varying from gradually increasing exposure using written accounts of traumatic events to extensive exposure using vivid imagery and exposure to situations that resemble the trauma site

Treatments like TF-CBT and EMDR generally include two key factors: they assist patients to confront the memory of their traumatic experience(s) in a controlled and safe environment; and identify, challenge and modify any biased or distorted thoughts, and memories of their traumatic experience as well as any subsequent beliefs about themselves, and the world that are getting in the way of their recovery.

Some interventions that may involve elements of trauma-focussed work are not included in the guidelines, either because they have not yet been properly tested (e.g. brief psychodynamic therapy), or because they have been tested and found to be less effective than recommended interventions (e.g. hypnotherapy and supportive counselling).

Psychological interventions for PTSD

According to the *Australian guidelines for the treatment of adults with acute stress disorder and post traumatic stress disorder,* Grade A recommendations indicate that the body of evidence can be trusted to guide practice.

1. Trauma-focussed Cognitive Behavioural Therapy (TF-CBT) – Grade A:

   The term TF-CBT is a subset of trauma-focussed psychological treatment. It was originally developed for use in traumatised children and adolescents. The two core interventions of TF-CBT for PTSD are exposure, and cognitive restructuring. TF-CBT is a short-term intervention that generally lasts anywhere from eight to 25 sessions, and these structured psychological interventions aim to address the emotional, cognitive and behavioural sequelae of exposure to traumatic events. It has been shown to be superior to therapies which do not involve talking about the trauma – creating the trauma narrative - and it is as e-ffective as other evidence-based therapies for PTSD such as Eye Movement Desensitisation and Reprocessing (EMDR). A common approach, for example, would be to use exposure alongside psychoeducation, anxiety management, cognitive restructuring and relapse prevention to treat PTSD.

   Desensitisation / graded exposure is a core component of TF-CBT. Controlled and planned exposure to the trauma narrative, and reminders of the trauma or emotions associated with the trauma, are used to help the patient reduce avoidance and maladaptive associations with the trauma. Discussing the trauma or going through exposure exercises may trigger intense emotions or bring up memories of the trauma that are particularly difficult. It is crucial to undertake TF-CBT in the context of a safe, stable, and supportive environment.

2. Eye Movement Desensitisation and Reprocessing (EMDR) – Grade A:

   EMDR, a treatment for PTSD was developed by Shapiro in the late 1980's. EMDR is based on the assumption that, during a traumatic event, overwhelming emotions or dissociative processes may interfere with information processing. This leads to the experience being stored in an unprocessed way, disconnected from existing memory networks.

   Although the exact mechanism of action of EMDR is not well understood, in EMDR the person is asked to focus on trauma-related imagery, negative thoughts, emotions, and body sensations while simultaneously moving their eyes back and forth following the movement of the therapist fingers across their field of vision for 20-30seconds or more. This process may be repeated many times. It is proposed that this dual attention facilitates the processing of the traumatic memory into existing knowledge networks, although the precise mechanism involved is not known. The unique feature of EMDR is the use of eye movements as a core and fundamental component throughout treatment.

   Therapy commences with history taking of the specific problem and associated symptoms and behaviours, from which specific treatment targets for EMDR are developed. These targets include the event(s) from the past that created the problem, the present situations that cause distress, and the key skills or behaviours the patient needs to learn to move forward. Detailed in-depth discussion of disturbing memories is not required at this stage. In the next phase of therapy, the patient is taught specific techniques to rapidly deal with emotional disturbances that may arise. At the same time the therapist outlines the theory of EMDR.

   The therapist then identifies the aspects of the target to be processed, and the patient selects a specific picture or scene from the target event that best represents the memory. A statement is chosen that expresses a negative self-belief associated with the event, and another more appropriate positive self-statement is identified that represents what the patient would rather believe. Ratings of distress are used as a measure of improvement as the targeted event changes and its disturbing elements are resolved. During desensitisation, the therapist will lead the person in sets of eye movement (or other forms of stimulation) with appropriate shifts and changes of focus until the level of distress is zero. During treatment more positive cognitions are strengthened and installed. The goal is to concentrate on and increase the strength of these positive beliefs that the person has identified to replace the original negative beliefs.

   Based on evidence that indicate a physical response to unresolved thoughts (often referred to as motoric memory) successful therapy should also enable a patient to bring up the original target without feeling bodily tension. Each session should end with the person feeling in control. If the processing of the traumatic target event is not complete at the end of the session, the therapist must assist the person to apply a variety of self-calming techniques in order to regain a sense of balance. As with any form of good therapy, it is important to determine the success of the treatment over time.

3. Exposure therapy:

   The key objective of exposure therapy is to help the person confront the object of their anxieties. The notion that if people can be kept in contact with the anxiety provoking stimulus for long enough, they're anxiety will inevitably reduce. Exposure therapy for PTSD involves confronting the memory of traumatic experiences in a controlled and safe environment (imaginal exposure), as well as confronting trauma - related avoided situations and activities through in viable exposure. The importance of grading the exposure, often using a hierarchy, prolonging the exposure until the anxiety has reduced and repeating the exposure item until it evokes minimal, anxiety are central to traditional exposure approaches.

   Prolonged exposure works on the idea is that facing up to the memory in a planned way will lead to reduction of the negative emotions connected to the memory - so that remembering or being reminded is not associated with distress. When the memory or reminders are less distressing, the person does not have to avoid them and can have a more normal life.

4. Cognitive therapy:

   In the treatment of PTSD, cognitive therapy helps the individual to identify, challenge and modify any biased or distorted thoughts and memories of the traumatic experience, as well as any subsequent maladaptive or unhelpful beliefs about themselves, and the world that they may have developed.

5. Cognitive processing therapy:

   This is a particular form of cognitive therapy, refined specifically for the treatment of PTSD. Treatment focusses mainly on identifying unrealistic and unhelpful thoughts a person has about the trauma. It helps the person challenge the unhelpful thoughts and beliefs, and replace them with a rational alternative in an adaptation of standard cognitive therapy approaches. It is a 12-session cognitive behavioural manual lies treatment for PTSD that systematically addresses key post-traumatic teams, including safety, trust, power and control, self-esteem and intimacy.

6. Group therapy:

   This is not an intervention per se, but a vehicle for delivering an intervention. They have included supportive, psychodynamic, cognitive behavioural approaches (including exposure, cognitive processing therapy, problem solving). The presence of other individuals with similar experiences may help overcome a belief that the therapist cannot be helpful because he or she has not experienced the specific trauma. The group may also be used to promote a non-judgemental approach towards behaviour required for survival during the traumatic event.

7. Brief psychodynamic psychotherapy:

   Psychodynamic therapy encourages the individual to use the supportive relationship with a therapist, and the transference that occurs within that relationship, to verbalise and reflect upon their experiences. This process allows unconsciously held thoughts, urges and emotions to be brought into conscious awareness, which in turn allows the cognitive, emotional and social aspects of experience to be integrated into a meaningful structure that helps the person to accept and adapt to their experiences.

   Brief psychodynamic therapy focusses on the emotional conflicts caused by a specific traumatic event. The patient is encouraged to put their experience into words, and examine the meaning that the event and surrounding circumstances holds for them. Through this retelling, the therapist assists the individual to integrate the event and re-establish a sense of purpose and meaning in life.

8. Hypnosis:

   This is not an intervention in itself. It is the induction of a state of relaxation and receptivity that makes intervention easier to implement. Hypnosis in PTSD may be used as a precursor to several interventions including imagery, stress management techniques, ego strengthening self-talk, and exposure.

9. Internet – mediated therapy:

   This approach is likely to be particularly useful for people living in remote areas, for those who are physically disabled and have restored mobility, or who are unwilling to seek face-to-face therapy due to anxiety or fear of stigmatisation. Web-based treatment for PTSD usually includes psychoeducation, symptoms management, exposure, and cognitive reappraisal, all of which involve structured writing assignments that can be submitted to the therapist for feedback.

10. Interpersonal therapy (IPT):

    It is a time-limited therapy that was originally designed for the treatment of Depression. IPT considers that interpersonal relationships are important to the formation, and maintenance of psychological problems due to a strong relationship between symptoms and social environment, that is, interactions with other people affect psychological wellbeing and vice versa. IPT focusses on identifying specific problems and patterns in personal relationships, and on building skills to improve interpersonal functioning and increase social support. It may include addressing grief over lost relationships, different expectations in relationships, changing roles in relationships, and improving social skills.

11. Mindfulness-based therapies:

    This includes acceptance and commitment therapy (ACT), mindfulness-based cognitive behavioural therapy (MCBT) and mindful meditation. Mindfulness can be defined as 'paying attention in a particular way, on purpose, in the present moment and non-judgementally'.

12. Narrative exposure therapy (NET):

    It was originally developed both to treat survivors and to document human rights violations, in NET, the person is asked to construct a narrative of their life from early childhood to present, focussing in detail on the traumatic events and elaborating on the associated thoughts and emotions. It is proposed that NET works in two ways: promoting habituation to traumatic memories thorough expose and reconstructing the individual's autobiographic memory.

Psychosocial rehabilitation interventions for PTSD

Psychosocial rehabilitation interventions are used to facilitate independent living, socialisation and effective life management in people who have chronic mental health conditions. Components of psychosocial rehabilitation include social skills training, housing support, vocational rehabilitation, case management and family support. Psychosocial rehabilitation often occurs alongside other treatments. It is important to consider early psychoeducation of the individual and family members, maximising existing social supports or creating new ones, and providing vocational support to enable the individual to maintain their optimal work / study performance.

Social emotional rehabilitation

Social emotional rehabilitation (SER) has three components:

- social skills training, which focusses on practising basic conversational skills, particularly those important for creating and maintaining social networks.
- anger management and problem-solving skills training, which was designed to reduce temper outbursts by introducing alternate ways of expressing anger, teaching problem-solving and emotional regulation skills as well as teaching veterans how to communicate assertively in and nonthreatening way.
- veterans issues management where veterans are taught how to talk to civilian support, combat trauma and other military issues in a way that fosters understanding of these issues by the veteran's other support network.

Vocational rehabilitation

This is to help the person with PTSD return to an optimal level of functioning. It could be paid employment or voluntary work, study, and other key roles in society, such as parenting. Depending on the current level of functioning, interventions may involve supporting the veteran to stay in his or her current role of employment or to return to that role in a supported and graduated fashion.

Psychosocial rehabilitation helps the person to regain the best possible level of social functioning, and occupational functioning, which is fundamental to quality of life.

3.3 The Standard Required

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

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

i. they have competence as a ***medical expert*** who can apply psychiatric knowledge including medicolegal expertise, clinical skills and professional attitudes in the care of patients (such attitudes may include an ability to tolerate uncertainty, balance, open-mindedness, curiosity, 'common sense' and a scientific approach).

ii. they can act as a ***communicator*** who effectively facilitates the doctor patient relationship.

iii. they can ***collaborate*** effectively within a healthcare team to optimise patient care.

iv. they can act as ***managers*** in healthcare organisations who contribute to the effectiveness of the healthcare system, organise sustainable practices and make decisions about allocating resources.

v. they can act as ***health advocates*** to advance the health and wellbeing of individual patients, communities and populations.

vi. they can act as ***scholars*** who demonstrate a life-long commitment to learning as well as the creation, dissemination, application and translation of medical knowledge.

vii. they can act as ***professionals*** who are committed to ethical practice and high personal standards of behaviour.

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

Domain Not Addressed – the candidate demonstrates significant defects in all of the domains listed above or the candidate demonstrates significant defects in the first domain of being a medical expert.

4.0 Instructions to the Role Player

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

You are Daniel Thomas, a 45-year-old army veteran. You are divorced but currently living with your ex-partner Margaret and your 11-year-old son, Nathan. You were diagnosed with Post Traumatic Stress Disorder (which is usually shortened to PTSD) 9 months ago.

The reason you have come to see the doctor today is that while your PTSD symptoms have reduced on medication, the nightmares and flashbacks (see below) are still very distressing, and you are keen to get some help with this. However, you do not wish to take more tablets or change the ones you are on.

The background to your symptoms is based on your experience in the army which you joined from the age of 19. You were a Crew Commander for few years before medical retirement. You were deployed to Afghanistan between 2010 and 2013. You witnessed and were a part of violent encounters, but you do not wish to talk about these in any detail today. You were medically retired as you sustained a knee and hand injury in combat when your LAV crashed after being shot at in early 2013; but these physical injuries are no longer a significant problem for you.

You developed PTSD on deployment in Afghanistan, and with regards to PTSD, you experience:

- Nightmares of being in active conflict and of gun firing.
- You wake up sweating and anxious, and this affects your sleep.
- You have real difficulty getting to and staying asleep, and you have previously tried a few medications.
- You have flashbacks, but it is less severe compared to how it was few months ago. These occur every few days and without specific triggers. In the flashback it feels like you are reliving the terrible experiences you underwent.
- You get easily irritated and become angry.
- You avoid going out as you are always on the look-out for any kind of threats, but this is better with medications.
- You do not have panic attacks (sudden onset of intense anxiety), but often feel on edge.

You do feel down at times, but don't think you are depressed. Your appetite, energy levels, concentration are '*not bad*'. You don't feel suicidal or you don't have thoughts of harming yourself or others. You have never felt that people are out to get you and you do not hear or see things that others do not.

Your current medications are:

Paroxetine 60 milligrams in the morning, quetiapine 100 milligrams at night, prazosin 2 milligrams at night for nightmares, and pregabalin 300 milligrams twice a day for pain. You have tried few other antidepressants, but you don't remember the names, and few pain killers. You don't want any more tablets.

Talking therapies:

With regards to therapy, you initially saw a psychologist through the New Zealand Veterans Affairs, but you didn't like her and so stopped going after 3 sessions. Now, you are keen to try some talking treatment again.

You have had no admissions to psychiatric hospitals. You had few surgeries over the years to both knees (ligament damage and repair), and right hand (for a fracture) following the incident in Afghanistan in 2013.

You don't have any other medical problems. You are not allergic to any treatment.

Social history:

You were living with your parents in Christchurch for few years but moved to Auckland six months ago to live close to your 11-year-old son. As you don't have any accommodation yet, you are staying with an ex-partner. Your marriage began to break up three years ago because you had started getting irritable, and having angry verbal outbursts. You have been separated from her for two years as she was annoyed with your PTSD symptoms and anger outbursts. You have never been violent towards any of your family.

You are a carpenter by trade. You were working casual hours in a warehouse in Wellington. You have been unemployed since you moved 6 months ago. You are keen to go back to work as you have always tried to work.

Your sleep is affected by nightmares and this is affecting your day. You are snappy and angry. This has started to annoy Margaret, and she has been asking you to '*get out*'. She says that you are lazy, and that you should be better by now as you are on so many tablets. You spend few hours at night playing on the computer and watch TV. You sleep at 12 or 1 am.

You are worried you will be homeless.

The veterans affairs services should play a significant part in your wellbeing, and are probably an important support for you. Your RSL / RSA advocate / support person had suggested you discuss with your doctor about 'rehab' for PTSD. You don't know what that is all about.

You have no other supports here. You have few mates who suffer from similar problems, but not many of them talk about their problems. You feel isolated at times.

You don't drink alcohol or use any recreational drugs. You smoke 10 cigarettes / day. You were never on addictive pain killers or sleeping tablets.

You are worried about taking more tablets as few of your mates who committed suicide were on tablets. You are keen to try therapy.

Background information to assist you to understand your role - the candidate is not expected to ask you about this information:

As an armoured combat specialist you were trained to operate the New Zealand Light Armoured Vehicle (NZLAV), providing the army with a light armoured vehicle capability (the NZLAV is a highly mobile eight wheeled armoured vehicle used by day and night with early warning systems that enhance survivability, and communication equipment to receive and share information). As part of a tight-knit crew of three, you operated the NZLAV in a combat role in Afghanistan. You and your crew manoeuvred the vehicle to directly engage with an enemy, gather information and provide protected mobility to soldiers from other trades across the army. You had to be able to operate in the confined space of the vehicle, for extended periods, at all times and in all environmental conditions. You also had to be able to quickly process and react to all that you saw and heard, under challenging operational conditions. You initially trained as a Gunner and completed further training to become a Crew Commander.

The NZ Defence Force was in Afghanistan from 2003, and the last staff left in April 2013; you were evacuated in February 2013. Since 2015 military personnel have been deployed alongside the Australian Defence Force to train Iraqi Security Forces personnel. You have not been deployed to Iraq as you were medically retired from the army in late 2013.

New Zealand Veteran Affairs: • providing support to those with Qualifying Service, their family and whānau, so they can be well at home, at work, and in their communities. • working with other organisation that also support and advocate for veterans. • helping coordinate commemorative activities • maintaining over 180 Service Cemeteries throughout NZ.	Australian Veteran Affairs (very similar supports): • providing support for access to benefits and payments, including compensation and income support. • helping access to health and wellbeing services, including health cards and addressing homelessness. • Access to consultation and grants. • maintaining commemoration and war graves, providing education and supporting anniversaries.
Royal New Zealand Returned and Services Association (RSA): RSA offers financial assistance, advocating for service benefits, and connections and comradeship.	Returned & Services League of Australia (RSL): RSL offers very similar services to veterans and their families by offering care, financial assistance and advocacy, along with commemorative services that help all Australians remember the Fallen.

What is Post Traumatic Stress Disorder (PTSD):

PTSD can develop after a person has been exposed to actual or threatened death, serious injury, or sexual violation in one (or more) of the following ways:

1. Directly experiencing the traumatic event(s).
2. Witnessing, in person, the traumatic event(s) as they occurred to others.
3. Learning that the traumatic event(s) occurred to a close family member or close friend (the event causing threatened of actual death of a family member or friend must have been violent or accidental).
4. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains, police officers repeatedly exposed to details of child abuse; this does not apply to exposure through electronic media, television, movies, or pictures, unless this exposure is work-related.)

The person then develops specific types of problems:

- Intrusion symptoms; re-experiencing intrusive distressing recollections of the traumatic event; flashbacks; nightmares; intense psychological distress or physical reactions, such as sweating, heart palpitations or panic when faced with reminders of the event.
- Negative mood: persistent loss of ability to experience positive emotions; loss of interest in normal activities and restricted emotions.
- Dissociative symptoms: altered sense of reality of one's surroundings or oneself; feeling detached from others; inability to remember certain aspects of the trauma.
- Avoidance and emotional numbing—avoidance of activities, places, thoughts, feelings, or conversations related to the event.
- Hyperarousal—difficulty sleeping; irritability; difficulty concentrating; hypervigilance; exaggerated startle response.

4.2 How to play the role:

You start with the opening statement and then let the candidate provide you with information.
You appear keen, attentive and interested in what the candidate has to say, and how they respond to your questions.

The candidate should use language that you are able to understand, and if not, you can ask them to explain further. They should be sensitive to you social situation, and provide advice and options for you to consider.

4.3 Opening statement:

'*Doctor, does cognitive therapy work for my condition?'*

4.4 What to expect from the candidate:

The candidate is to briefly outline various psychological (talking therapy) treatments for PTSD as you don't want to change any tablets. The candidate is expected to discuss a range of options but to also explain two specific therapies called Trauma-focussed Cognitive Behavioural Therapy (TF-CBT) and Eye Movement Desensitisation and Reprocessing (EMDR).

When you tell the candidate that you are worried about being kicked out by your ex-partner (becoming homeless), that you are keen to work (vocation), and that your family including your ex-partner does not understand your condition, the candidate should talk about psychosocial rehabilitation interventions like providing explanations (psychoeducation) for you, and your family about your condition and treatment, referring / recommending you for vocation training or retraining, social skills training, and discussing about the possible role of engaging with a rehabilitation coordinator to help you find accommodation, and implement the interventions mentioned.

Australian candidates may talk about **'Mates4Mates' which provide national and regional integrated support programs** across five key areas:

- Physical rehab and welling services
- Psychological services
- Employment and educational services
- Evidence based individual and group therapies
- Rehabilitation adventure challenges
- Social connection services

Australian candidates will also use the term RSL and not RSA: please use the term '*Returned Services*' as opposed to the RSA - if asked you can confirm that you are linked in with RSA / RSL, and if you are aware of what they offer.

4.5 Responses you MUST make:

'There is something called 'eye movement treatment', what do they do?'

'Are there any other treatments that work well?'

'No one understands what I am going through, Margaret will kick me out!'

4.6 Responses you MIGHT make:

If asked if you are attending any group therapies – you are not.

If asked about any reliable supports –
Scripted Response: ***'My sister lives in Hamilton and my parents in Christchurch.'***

4.7 Medication and dosage that you need to remember:

You do not have to remember these as the candidate is given them –

- Paroxetine 60millingrams in the morning
- Quetiapine 100milligrams at night
- Prazosin 2milligrams at night
- Pregabalin 300milligrams twice a day

STATION 10 – MARKING DOMAINS

The main assessment aims are:

- Demonstrate competence in engaging the patient and addressing his concerns, and identify factors contributing to his presentation.
- Discuss the components, procedure and effectiveness of Trauma-focussed Cognitive Behavioural Therapy (TF-CBT) and Eye Movement Desensitisation and Reprocessing (EMDR).
- Outline other psychotherapeutic interventions for PTSD that have some evidence base, and recommend appropriate interventions.

Level of Observed Competence:

1.0 MEDICAL EXPERT

1.14 Did the candidate demonstrate an adequate knowledge about TF-CBT? (Proportionate value - 25%)

Surpasses the Standard (scores 5) if:
a clear understanding of levels of evidence for TF-CBT; incorporates theory smoothly into description; choice and rationale for TF-CBT is clearly outlined; systematically discusses components and procedure of the intervention.

Achieves the Standard by:
demonstrating the understanding of the evidence based psychological treatment of TF-CBT for PTSD; demonstrating understanding and knowledge of what TF-CBT is; outlining the key components of TF-CBT; providing information about the procedure and its effectiveness; accurately outlining the components of TF-CBT; explaining how TF-CBT varies to other forms of CBT.

To achieve the standard ***(scores 3)*** the candidate **MUST:**
a. Explain exposure as a part of TF-CBT.

A score of 4 may be awarded depending on the depth and breadth of additional factors covered.

Below the Standard (scores 2):
scores 2 if the candidate does not meet (a) above or has omissions that would detract from the overall quality response.

Below the Standard (scores 1):
scores 1 if there are significant omissions affecting quality; does not identify TF-CBT as a recommended intervention; provides significantly inaccurate information about TF-CBT.

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

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

1.14 Did the candidate demonstrate an adequate knowledge about EMDR? (Proportionate value - 15%)

Surpasses the Standard (scores 5) if:
provides a clear understanding of levels of evidence for EMDR including its rating in international guidelines; choice and rationale for EMDR is clearly outlined; systematically discusses components and procedure of the intervention.

Achieves the Standard by:
demonstrating understanding of the evidence based psychological treatment of EMDR for PTSD; demonstrating understanding and knowledge of what EMDR is, the procedure and its effectiveness; accurately outlining the specific details of EMDR; outlining the phases of preparation for EMDR; explaining that the mechanism of action is not well understood; describing how to mitigate risks for the patient.

To achieve the standard ***(scores 3)*** the candidate **MUST**
a. Accurately outline the process of EMDR.

A score of 4 may be awarded depending on the depth and breadth of additional factors covered.

Below the Standard (scores 2):
scores 2 if the candidate does not meet (a) above or has omissions that would detract from the overall quality response.

Below the Standard (scores 1):
scores 1 if there are significant omissions affecting quality; does not identify EMDR as a recommended intervention; provides significantly inaccurate information about EMDR.

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

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

1.12 Did the candidate outline other psychological treatments for PTSD? (Proportionate value - 30%)

Surpasses the Standard (scores 5) if:
a clear understanding of levels of evidence to support treatment options; accurate explanation of a range of options.

Achieves the Standard by:
demonstrating the understanding of other psychological treatments for PTSD; outlining choice and rationale for specific psychotherapies; presenting options in language that the patient can understand; sensitively responding to patient verbal and non-verbal communication; providing information that is accurate and suitable to the specific needs and circumstances of the patient; including options like - mindfulness based therapies, internet-based therapies, group therapy, brief psychodynamic psychotherapy, hypnosis, interpersonal therapy (IPT), narrative exposure therapy.

To achieve the standard ***(scores 3)*** the candidate **MUST:**
a. Outline at least two (2) other psychological interventions for PTSD that have an evidence base.

A score of 4 may be awarded depending on the depth and breadth of additional factors covered; if the candidate is able to identify that some are non-specific treatments for PTSD.

Below the Standard (scores 2):
scores 2 if the candidate does not meet (a) above or has omissions that would detract from the overall quality response.

Below the Standard (scores 1):
scores 1 if there are significant omissions affecting quality; information is inaccurate; unsuitable for patient's needs or circumstances.

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

1.12. Category: MANAGEMENT - Communication	**Surpasses Standard**	**Achieves Standard**		**Below the Standard**		**Domain Not Addressed**
ENTER GRADE (X) IN ONE BOX ONLY	**5** ☐	**4** ☐	**3** ☐	**2** ☐	**1** ☐	**0** ☐

2.0 COMMUNICATOR

2.2 Did the candidate demonstrate capacity to identify current psychosocial stress and discuss appropriate interventions with the patient? (Proportionate value - 30%)

Surpasses the Standard (scores 5) if:
comprehensively applies the principles of working closely with patient / families / carers; systematically identifies all the current stressors and addressed them. Obtains consent from patient to discuss with rehabilitation coordinator.

Achieves the Standard by:
identifying the stress of the following - that the patient will be homeless, unemployment status, inadequate knowledge of the family about his condition and treatment, anger potentially affecting filial relationships - particularly with son, social isolation, financial difficulties; discussing interventions like psychoeducation of patient, family including son, anger management strategies, vocational training and re-training, social skills training; considering voluntary work; offering group sessions / therapy; recommending sleep hygiene techniques.

To achieve the standard ***(scores 3)*** the candidate **MUST:**
a. Identify at least three (3) psychosocial factors and recommend appropriate interventions.

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. Identifies 4 or more stress and manages them appropriately. Discusses the importance of continuing medications.

Below the Standard (scores 2):
scores 2 if the candidate does not meet (a) above, or has omissions that would detract from the overall quality response.

Below the Standard (scores 1):
scores 1 if there are significant omissions affecting quality, does not identify any psychosocial stress factor and fails to manage.

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

2.2. Category: PATIENT COMMUNICATION - Disclosure	**Surpasses Standard**	**Achieves Standard**		**Below the Standard**		**Domain Not Addressed**
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 level of a junior consultant psychiatrist?

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