

Psychiatry Finals

OSCEs

Structure

- 5 minutes at each station
- Read the instructions
- The clues are in the scenario
- Stations may be history, examining or procedure – history is hardest
- Who's at the station?
- Introduce yourself
- Explain to the patient what you've been asked to do
- Marked by structured sheet, 1 point per item attempted
- Extra marks for overall excellence
- How you are graded – there is a degree of peer referencing for borderline scores

Why an OSCE?

- See www.kcl.ac.uk/depsta/medicine/gppc/osce.htm
- Validity vs reliability – OSCEs are reliable
- Tests breadth rather than depth
- Test competence rather than excellence
- Any 1 station is less important than all stations put together – don't be put off if one goes badly
- Legal considerations – candidates who fail can sue if process not equitable and transparent

Tips

- You're there to score POINTS, not take a perfect history/do a perfect exam
- It's more important that everything is DONE than done well
- Try to appear confident but not arrogant
- It's fairer than long cases and short cases!

Psychiatric assessment

In general, remember that psychiatric assessment is no different than general medical/surgical assessment.

Management = assessment + intervention

Assessment = history, examination + investigations

1. Personal details
2. Reason for referral
3. History of presenting problem
4. Past psychiatric history
5. Past medical history
6. Drug history
7. Family history
8. Personal history
9. Social history
10. Forensic history
11. Premorbid personality
12. Mental state examination
13. Physical examination
14. Investigations

Psychiatric assessment

Personal details

Reason for referral

Presenting problem

- Patient's own words
- Symptom clusters
- Psychosis
- Mood
- Anxiety
- OCD
- Substance misuse, risk

Past psychiatric

- Diagnoses, admissions, detentions, self-harm, who's involved

Past medical

- Head injuries
- Seizures

Drug

- Prescribed
- OTC + homeopathic
- Smoking
- Illicit
- Alcohol

Family

Personal

Social

Forensic

- Charges past and pending

Premorbid personality

- From others where possible

Mental state

- Use psychiatric terminology

Physical

Investigations

Mental state examination

Appearance

- Build, distinguishing features, clothing, hygiene

Behaviour

- Agitated/retarded/overactive, eye contact, rapport, appropriateness

Mood/affect

- Subjective
- Objective – euthymic/depressed/anxious/flattened/blunted/elated/labile, reactivity

Speech

- Rate, rhythm, volume, tone/prosody, coherence

Thought form

- Disorder – loosening of associations, derailment, tangentiality, fusion, overinclusion, concrete thinking, neologism, metonyms, drivelling, verbigeration/word salad
- May occur in psychosis, autism, learning disability

Thought stream

- Disorder – flight of ideas, circumstantiality, perseveration, echolalia, retardation/inhibition of thought, thought blocking

Thought content

- Delusion* – primary or secondary
- Self, world, future
- Risk

Perception

- Illusions, hallucinations[^], pseudohallucinations

Cognition

- Orientation, attention, registration/recall, language skills, capacity

Insight

- Are you ill? Mentally ill? Will you accept treatment? Will you accept admission?

* Delusion – belief which is abnormal within cultural context (may be true and vary in intensity therefore not fixed false – check level of conviction, preoccupation and distress

[^] Hallucination – percept in the absence of corresponding stimulation

Glasgow Master List

The rest of this handout is in the following format:

No. Title

Information from Glasgow Master List

1. My top questions to remember to answer during the station – headings to structure your history

Specific areas to cover

- Individual points
-

You'll find more background info including ICD-10 summaries at www.julyan.co.uk/finals/finals_extended.doc

There are also loads of psychiatry OSCEs with marking schedules at www.trickylists.col.uk/osces.htm

Enjoy!

Dr T Everett Julyan
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9. Anxiety/panic disorder

Personality disorder Physical cause, e.g. hyperthyroidism Situation-specific, e.g. phobia

1. **Is it anxiety?**
2. **What type?**
3. **Any other problems?**

Psychological symptoms

- Fear of losing control/going crazy/dying, derealisation/depersonalisation

Physical symptoms

- Palpitations, sweating, trembling/shaking, dry mouth, breathing, choking, chest pain, nausea, dizzy, flushes/chills, numbness/tingling

Situation

- Generalised – everywhere/all the time
- Agoraphobia – crowds, public places, travelling alone/away from home
- Social phobia – fear of scrutiny by others, e.g. focus of attention, small groups: blushing, shaking, urinary urgency
- Panic disorder – anxiety attacks, recurrent, unpredictable

Panic disorder

- Symptoms
- Frequency

Other symptoms

- Avoidance
- Anticipation

Impact on life

- Restriction
- General functioning

Mood

- Primary or secondary

Coping strategies

- Alcohol

17. Distorted body image

Delusional disorder Eating disorders

1. Is it body dysmorphic disorder (dysmorphophobia, a form of hypochondriasis)?
2. Is it anorexia?
3. Is it psychotic?

Part of the body affected

Reason for concern

- Size
- Shape
- Other

Conviction

- Overvalued idea
- Delusion

Coping

- Covering up
- Avoidance
- Checking
- Reassurance

Plans

- Surgery
- Other

Associated problems

- Mood
- Anxiety
- OCD
- Psychosis
- Suicide

27. Acute confusion (history from relative/witness)

Any acute illness, e.g. chest infection or heart failure Brain metastases Hypercalcaemia Toxins/drugs
--

1. Is it delirium or dementia (acute or chronic)?
2. What is the cause?

Fluctuating consciousness

Illusions, hallucinations

Check cognitive function

- Orientation (time, place)
- Registration
- Attention/concentration
- Naming
- Repeating
- Reading
- Writing
- Obeying
- Drawing
- Recall

Think of causes

- Infection
- Neoplasia
- Organ failure
- Drugs
- Endocrine/metabolic
- Trauma

Collateral history

57. Hearing voices/odd ideas

Alcoholic hallucinosis Dementia Depression Hallucinations Psychosis Schizophrenia Puerperal psychosis

1. Is it perceptual (illusion, hallucination or pseudohallucination)?
2. Is it secondary to mood?
3. Is it secondary to drugs/alcohol?
4. Is it a primary psychosis?

Hallucinations

- What
- Where
- Who
- To whom
- How often
- How long
- Reality
- Distress
- Coping

Content

Other perceptual disturbance

- First rank symptoms

Delusions

- Primary
- Secondary

Mood

- Depressed
- Elated

Drugs/alcohol

61. Hyperactivity

Behavioural Drug and food reactions
--

1. Is it hyperkinetic disorder (ADHD – attention-deficit hyperactivity disorder)

Criteria for HKD

Abnormal levels of

- inattention
- hyperactivity
- impulsivity

In 2 or more situations

Onset before age 7

Significant distress or impaired social functioning

Not due to

- Pervasive developmental disorder (autism)
- Mania
- Depression
- Anxiety

62. Addiction

Alcohol misuse/dependence Other psychiatric diagnoses, e.g. personality disorder or depression Drug misuse/dependence

1. **Is it misuse?**
2. **Is it dependence?**
3. **What is the risk to self and others, e.g. suicide, forensic?**

Pattern

- What
- When
- Where
- Frequency
- Duration

Misuse

- Harm to physical or mental health
- At least 1 year

Dependence

- Compulsion
- Loss of control
- Withdrawal
- Tolerance
- Preoccupation/primacy
- Persistence despite harm
- Reinstatement

Other substances

Effects

- Physical
- Mental – mood, suicide
- Social – job, relationships, forensic

63. Obsessions and compulsions

Obsessive-compulsive disorder Psychosis, e.g. schizophrenia
--

1. Are there obsessions or compulsions?
2. Underlying depression, anxiety or psychosis?

Obsessions

- Thoughts, ideas, images, ruminations, doubts
- Own thoughts
- Intrusive
- Recurrent
- Not pleasurable
- Resisted

Compulsions

- Subjective sense of pressure to act, e.g. checking, counting, touching, washing, rituals
- Purposeful
- Rules
- Aim is avoidance
- Magical

Depression

Psychosis

Risk

- Self
- Others

74. Suicidality

Association with physical illness and disability Depression Personality disorder
--

1. **Is it self-harm or suicide?**
2. **Is there a mood disorder, psychosis or personality disorder?**
3. **What is the risk?**

Preparation

- Intention
- Planning
- Note

Circumstances

- Alone
- Precautions

After the act

- Sought help
- Remorse
- Accepted help/treatment
- Current thoughts/feelings/plans

Previous self-harm

Mood

Psychosis

Risk

- Ideation, intent and plans
- Medication
- Social

79. Depression

Adjustment reaction Depression Personality disorder

1. **Is this a depressive disorder?**
2. **Is this dysthymia?**
3. **Is this secondary to substance misuse?**
4. **Is this personality disorder?**

Mood

- Diurnal
- Reactivity
- Anhedonia
- Elation

Duration >2 weeks (dysthymia >2 years)

Biological

- Sleep (EMW = >2 hours earlier than usual)
- Appetite
- Weight loss
- Energy
- Fatigue
- Motivation
- Concentration
- Libido

Psychological

- Negative thinking – self, world, future
- Hopelessness
- Guilt
- Delusions
- Hallucinations

Suicidality

Substance misuse

Personality

81. Dementia

Alzheimer's disease Lewy body dementia Vascular dementia
--

1. **Is this dementia or delirium (chronic vs acute)?**
2. **What type?**
3. **Is it reversible?**

Problems

- Memory
- Verbal
- Wandering
- Social – shopping, cooking, bathing, toileting

Cognitive assessment

Collateral history

Alzheimer's disease

- Amnesia, aphasia, agnosia, apraxia
- Insidious onset
- Gradual progression
- Depressed mood, personality change

Lewy body dementia

- Fluctuating course with variation in attention/alertness
- Visual hallucinations
- Parkinsonism (rigidity, bradykinesia, festination, mask-like facies > tremor)
- Falls, hallucinations, systematised delusions, recurrent LOC
- Usually no stroke or other physical illness

Vascular dementia

- Uneven impairment – memory loss, focal neuro signs but intact insight, judgment, personality
- Abrupt onset
- Stepwise progression, fluctuating course
- History of strokes
- Depression
- Emotional lability, incontinence

92. Medically unexplained symptoms

Dissociative disorders Factitious disorders Malingering (not a psychiatric diagnosis) Somatoform disorders

1. **Is there an organic cause?**
2. **Have appropriate investigations been done?**
3. **What are the patient's concerns?**

Somatization

- Multiple recurrent symptoms for years, changing, emphasis on symptoms

Hypochondriasis

- Preoccupation with 1 or more serious/progressive physical disorders

Dissociative (conversion) disorders

- Unconscious production of symptoms for unconscious reasons – loss of integration between memories, identity, motor control and sensation
- Amnesia, fugue, motor/sensation, Ganser, multiple personality, trance, possession

Factitious disorders

- Conscious production of symptoms for gain (entry into sick role)
- Munchausen's syndrome (also by proxy)

Malingering

- Conscious production of symptoms for conscious gain

101. Visual hallucinations

Acute and chronic organic brain syndrome

See **57. Hearing voices/odd ideas** – visual similar to auditory

Usually “organic” (although 30% of those with schizophrenia also experience visual hallucinations)

- 1. Is it perceptual (illusion, hallucination or pseudohallucination)?**
- 2. Is it secondary to mood?**
- 3. Is it secondary to drugs/alcohol?**
- 4. Is it a primary psychosis?**

Hallucinations

- What
- Where
- Who
- How often
- How long
- Reality
- Distress
- Coping

Other perceptual disturbance

- First rank symptoms

Delusions

- Primary
- Secondary

Mood

- Depressed
- Elated

Drugs/alcohol

127. Weight loss (gain = ?bulimia or atypical depression)

Hyperthyroidism Infection Malabsorption Neoplasm Psychogenic
--

1. Is it anorexia/bulimia?
2. Is it life-threatening?

Weight loss

- 15% < expected
- Self—induced
- Avoid fattening foods

Self-perception

- Too fat
- Dread of fatness
- Self-imposed low weight threshold

Endocrine disorder

- HPA axis
- Amenorrhoea in women
- Loss of sexual interest and low potency in men

Not bulimia

- Overeating or preoccupation with eating or compulsion to eat

Other factors

- Vomiting
- Purging
- Exercise
- Appetite suppressants and/or diuretics