# ***Candidate Instructions***

## Role:

You are a General Practitioner. Sam Taylor is a 32 year old female who has come to discuss their hallucinations and disconnected thought patterns.

## Candidate Instructions:

1. **0-15 minutes:** Take an appropriate history and mental state examination. You are NOT required to physically examine the patient.
2. **15-20 minutes:** Answer the examiner's questions.

# Simulator Instructions 1/3- History

## Patient Demographics:

- You are Sam Taylor, 32.
- Come to the GP to discuss your hallucinations and disconnected thoughts.

## History of Presenting Complaint:

- Onset & Duration: 6 months
- Severity: Regular auditory hallucinations, disconnected from reality.
- Triggers: High stress at work.
- Functional Impairment: Unable to work, disturbed sleep.
- Associated Symptoms: Paranoia, disorganized speech.
- Overdose: None
- ICE: I - feeling scared and confused C- Worried about losing her mind E- Wants to understand what's happening.

## Past Psychological History:

- No previous mental health issues.

## Past Medical History:

- Diagnoses & Treatments: Asthma – managed with inhaler.
- Allergies: Penicillin – causes breathing difficulty

## Family History:

- History of Mental illness: Uncle had schizophrenia.

## Social:

- Alcohol: Drinks socially, no dependency.
- Accommodation: Lives with a roommate.
- Finances: On leave from work, savings running low.
- Support network: Has a supportive sister, but feels embarrassed to discuss her condition.

## Personal History:

- No significant events.

# Simulator Instructions 2/3- Mental State Examination

## Appearance:

- Distinguishing features: Looks distressed
- Weight/ Physique & Hygiene: Normal weight, disheveled

## Behaviour:

- Engagement + Rapport: Sam is agitated and restless.
- Eye contact: Poor
- Body language: Anxious
- Psychomotor activity: Increased
- Abnormal movement/ posture: None

## Speech:

- Rate: Fast
- Quantity: Gives disjointed answers
- Tone: Tense
- Volume: Normal
- Fluency + Rhythm: Disorganized

## Mood + Affect:

- Mood: Anxious, feels scared.
- Affect: Incongruent with mood, flat.

## Thought:

- Form: Disorganized
- Content: Paranoid delusions, auditory hallucinations.
- Ideation: No suicidal ideation.
- Possession: None

## Perception: Reports hearing voices when alone.

## Cognition:

- Orientation to Place, Person, Time: Disoriented at times
- Short-term memory, Attention span: Poor attention span

## Insight & Judgment: Poor insight into illness, impaired judgment.

## Risk:

- To Self: Neglects self-care, paranoid.
- To Health: Neglects physical health.

- To/ From Others: None
- Driving: Stopped driving due to hallucinations.

# ***Examiner Marksheet 1/2***

## Opening

- Introduces themselves
- Confirms Patient demographics
- Explains and gains consent from patient about consultation
- Demonstrates Professionalism & Empathy throughout consultation
- Demonstrates strong Communication skills, allowing clear conversation throughout

## History

- Establish clear chronology of events
- Fully explores:
    - History of Presenting Complaint
        - Onset, Duration, Severity, Function impairment, Associated Symptoms
        - Overdose (How, Events before/ during/ after, Feelings about event)
        - ICE
    - Past Psychiatric History
        - Mental health issues (Treatments in Community/ Hospital?)
        - Mental health admissions (Voluntary? Lengths, Diagnoses)
        - Self-harm/ Suicidal thoughts or behaviour
    - Past Medical History
    - Family History
    - Social History (Drugs, Alcohol, Accommodation, Finances, Support
    - Eating Disorder assessment, if appropriate
        - History (Time, Weight changes, Restrictions, Ideal weight)
        - Current diet (Quantity, Frequency, Rules, Avoidances, Hunger)
        - Weight Control (Fasting, Binges, Purging)
        - Attitude (Feelings, Weight/ measure selves, Do others know?)
        - Associated Symptoms (Fatigue, Pale, Hair, Periods, Chest)
    - Personal History, if appropriate
        - Infancy- Birth, Development, Milestones
        - Adolescence/ Education- Relationships, Qualifications, Authority
        - Forensic

## Mental State Examination

- Appearance (Distinguishing features, Physique, Clothing, Hygiene)
- Behaviour (Eye contact, Facial Expression, Body language, Psychomotor activity)
- Speech (Rate, Quantity, Volume, Fluency, Rhythm)
- Mood & Affect (Asks mood)
- Thought (Form, Content, Ideation, Possession)
- Perception (Hallucinations)

- Cognition (Orientation, Concentration)
- Insight & Judgment (Illness, Medication)
- Risk (Self-harm, Suicide, Neglect, To others, Driving)

## Ending Consultation

- Summarises and clarifies any points
- Thanks patient
- Signposting

### Examiner Question:

- Most likely diagnosis & differentials
    - Schizophrenia
    - Psychotic Depression
    - Bipolar Disorder
    - Schizoaffective Disorder
    - Drug or Alcohol-induced Psychosis
- Management plan, including knowledge of psychiatric medications
    - Conservative - Psychological interventions
    - Medical – Antipsychotics (Risperidone or Olanzapine).