Candidate Instructions

Role:
Presenting Complaint:

Alex Johnson is a 23 year old male who has come to the GP to discuss their feelings of worry .

You are expected to:
0-15 minutes:

- Take an appropriate history and mental state examination
- You are NOT required to physically examine the patient

15-20 minutes:

- Answer the examiner’s questions

Simulator Instructions 1/3- History

Patient Demographics
You are Alex Johnson, 23

Presenting Complaint: come to the GP discuss your worry

History of Presenting Complaint

- Onset & Duration 8 months
- Severity- cannot go to work anymore or see friends/family – haven't been to work for a month.
- Triggers work – emails also trigger or when people want to meet up.
- Functional Impairment (Job, Family, ADLs) - sleep disturbed – 4-5 hours and disrupted.
- Associated Symptoms (Physical, Cognitive) anxiety attacks where you hyperventilate and start to feel dizzy.
- Overdose - have been buying paracetamol but keep backing out because you know your family would miss you and that stops you.
    - Planned/ Unplanned, Method, Final Actions
    - Before/ During/ After
    - How came to medical attention
    - Current feelings about event
- ICE I - work stress C- getting to the point where he goes through with the overdose E- any help to make the worry go away.

Past Psychological History

- Mental health issues- Treated? Under GP or Secondary care? n/a
- MH admissions- Voluntary/ Sectioned, Dates, Diagnoses n/a
- History of Self-harm or Suicidal behaviour/ thoughts
    - What was done? n/a
    - When? How often? n/a
    - How significant were the attempts? n/a

Past Medical History

- Diagnoses & Treatments- Efficacies coeliac disease – diet managed.
- Allergies – penicillin – felt like throat was closing up

Family History

- History of Mental illness esp. ASD/ ADHD/ Anxiety (if relevant) n/a
- Physical illness n/a

Social

- Drugs- Injections, Sharing needles, Withdrawal Symptoms n/a
- Alcohol- Quantity, Frequency, Withdrawal Symptoms – has beer to help him fall asleep (wakes up to see about 5-6 bottles)
- Accommodation- Residential Type + State of repair, Who living with lives alone but has girlfriend who comes to visit occasionally as they are long-distance but recently don't talk as much as she says that his personality has hanged (on further questioning – he has become more irritable)
- Finances- Employed, Debts, Benefits, Gambling thankful that he hasn't got into gambling but his co-workers do try to encourage him to

- Support network parents are older so don't get out as much. He calls them almost every week

(If relevant) Personal History

- Infancy- Birth, Development, Milestones n/a
- Adolescence/ Education- Relationships, Qualifications, Authority issues didn't suffer with anything like this before, but in school until now has always kept himself in check so he doesn't "fail in life" and does well in terms of occupation (Alex is a trainee lawyer)
- Forensic n/a

Simulator Instructions 2/3- Mental State Examination

Appearance

- Distinguishing features tired looking young man
- Weight/ Physique & Hygiene – slim, well kempt
- Stigmata of disease fidgeting
- Clothing & Objects wearing smart clothes

Behaviour

- Engagement + Rapport (Difficulty establishing) Alex is good at maintaining conversation
- Eye contact (Sustained, Intense, Reduced) sustained, but when he starts speaking about work, starts to break eye contact and look down
- Facial expression neutral
- Body language closed at first but opens with rapport being built
- Psychomotor activity (Agitation, Retardation) n/a
- Abnormal movement/ posture n/a

Speech

- Rate (Speed, Delay in starting, Ease of interruption normal
- Quantity) short answers at first but expands as consultation occurs
- Tone monotone
- Volume quiet at first, goes normal when he becomes comfortable
- Fluency + Rhythm (Stammering, Slurr, Dysarthria, Dysphasia) n/a

Mood + Affect

- Describe Mood, if asked he is aware that its not normal, he feels "flatter" than before
- Affect
    - Range & Mobility (Fixed, Restricted, Labile) fixed
    - Intensity (Heightened, Blunted/ Flat) n/a
    - Congruency (Affect in keeping with thought contents) congruent

Thought

- Form (Speed, Flow, Coherence) slow at first then becomes normal

- Content (What thinking about? Worries? Delusions? Obsessions? -ve thought of self?)worried about work stress
- Ideation (Suicide/ Self-harm/ Harm to others)no threat to others, considered overdosing but hasn't due to family and friends
- Possession (Insertion/ Withdrawal/ Broadcasting)

Perception: Hallucinations (Auditory, Visual, Olfactory, Gustatory, Somatic) n/a

Cognition
- Orientation to Place, Person, Time oriented
- Short-term memory, Attention span n/a

Insight & Judgment: Insight (Illness, Medication), Judgment

Risk
- To Self (Self-Harm, Suicide, Neglect) ideation – overdose on paracetamol
- To Health (Worsening MH illness, Deteriorating physical health) poor sleep
- To/ From Others (Paranoid delusions, Command hallucinations) n/a
- Driving doesn't drive and just walks to corner shop if he needs anything

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 Marksheet 2/2

Examiner Question examples

- Most likely diagnosis & differentials
    - Generalised Anxiety Disorder
    - Depression
    - Adjustment reaction
    - Hyperthyroidism
    - Alcohol withdrawal

- Mental Health Act
- Management plan, including knowledge of psychiatric medications
    - **Conservative -** CBT
    - **Medical –** SSRI (trial for 12w)