2021 PsySOM OSCE Night Station 4

*You have been provided with the following candidate instructions. You have **4 minutes** to read and prepare for your station. Please read the instructions carefully.*

CANDIDATE INSTRUCTIONS

You are the psychiatry registrar on call in the emergency department.

Lily Jones is a 25-year-old woman who has presented to ED after taking a paracetamol overdose. She has been physically stabilised and moved to the short-stay unit. Your handover from the emergency physician is terse and they seem extremely disgruntled - the emergency physician calls Lily a "frequent flyer" and complains that this is her third presentation in two weeks.

Upon entering Lily's room in the short-stay unit, you note that she is a young woman of normal body habitus. She appears pale and dishevelled and is dressed in a hospital gown and sitting in the hospital bed with her knees drawn tightly to her chest. A cannula in Lily's left hand is attached to an IV line, and her outstretched arm is covered by a criss-cross of scars. You also notice some tar-staining on her fingers. Lily's affect appears to be hostile and suspicious of her surroundings.

Lily's EMR documents the following:

<u>Past Medical History</u>

- Motor vehicle accident, minor trauma

<u>Family History</u>

- Bipolar disorder type II (mother)

<u>Social History</u>

- Lives with boyfriend
- Alcohol use: 5 standard drinks most days in a week
- Tobacco use: 7 pack years
- Recreational drugs: occasional cannabis, MDMA use

This patient does not identify as being Aboriginial or Torres Strait Islander.

In 8 minutes, your tasks are as follows:

1. Take a relevant history from Lily including a suicide risk assessment. (6 minutes)
2. Report your comprehensive suicide risk assessment to the examiner. (2 minutes)

ROLE PLAYER INSTRUCTIONS

You are Lily Jones, a 25-year-old female who has presented to the ED after a paracetamol overdose. Your attitude is somewhat mistrustful and hostile at first. Your affect shifts from distraught and angry at the start to more flat disposition as the conversation progresses. If the candidate asks anything for which there is no scripted answer, please answer with, "I don't wish to go into that."

Unless stated, assume Lily does not know the answer to the question.	
Opening Statement	"You're just going to discharge me right? No one cares about me. You doctors and nurses don't care about me either, I've heard what you say about me behind my back."
History of Presenting Complaint / Suicide Attempt	
General	● History of attempt - **You do not remember too well** what happened this time. You felt very "**numb and disconnected**" from your body, and felt like you were watching your **"own body from the outside walk to the cabinet with the pills.**" The next thing you knew, you were waking up in the hospital. Unsure who brought you into the hospital. ● Trigger - You had a fight with your boyfriend yesterday and kicked him out of your shared apartment. **"I thought he had been cheating on me so I broke up with him before he could leave me… Everyone leaves me… I hate him so much but I know I can't live without him."** ● Recent mood - "I just feel **so angry and it's so, so intense and overwhelming,** but then some days I just feel so **depressed and empty**."
Suicide Risk Assessment	
● Suicidal thoughts: Frequent and involuntary; wish you were dead nearly every day. ● Previous attempts: (1) Attempted overdose on drugs at 17 after another breakup (2) Deliberately crashed your boyfriend's car while on MDMA after an argument last weekend (3) Increased self-harming activities lately. ● Triggers, recent stressors or loss: Conflict with your boyfriend. ● Intent: "Get back" at your boyfriend, didn't want to die initially but you can't see hope of a better future right now; suicide seems the best way out. ● Length and degree of planning: No wills/suicide notes. Stockpiled a few packets of paracetamol and benzodiazepines. You were alone, did not let anyone know, but knew your boyfriend still had keys to their apartment and that he was likely to come back to collect his belongings. ● Current method: Took a few packets of paracetamol alongside large quantities of alcohol. ● Protective factors: You have two cats that you need to look after. ● Risk factors: Family history of suicide (mother).	

Psychosis	Sometimes you hear voices that tell you terrible things like **"You're worthless", "You're ugly", "No one loves you."** They don't sound like voices in your head, but external voices of people that you think you know. *Nil to all else*
Mania	You took MDMA last weekend and crashed my boyfriend's car. Sometimes you do "reckless" things but this is a way to escape from intense emotions. *Nil to all else*
Depression	**Energy -** You feel some loss of energy as if you are constantly "hungover" **Concentration** - Sometimes you just feel "out of it" *Nil to all else*
Anxiety	You have recurrent "fear or anxiety over other people's motives, or worries that my friends all hate me, or that people are going to abandon me" *Nil to all else*
Borderline Personality Disorder - Specific Questions	● Mood: "**Up and down**" often experience raw and overwhelming anger and at other times "**empty**" like you are falling into a **"black hole"**. These emotions tend to precede you doing **"crazy things in the spur of the moment".** ● Self-identity: You feel like you're **"moulding"** to fit other people and you "give them everything'' and often feel you're **"losing a part of myself"** with each relationship. ● Abandonment: Always fears that people might leave, so you **"lash out"** or do impulsive or self-destructive things to keep them around

Past Psychiatric and Medical History

- Have been brought to ED 2-3x over last 6 years for "overdoses" or "self-harm"
- Nil past medical conditions, surgeries. Nil allergies or medications.

Social History

- Lived with boyfriend until recently
- Used to work in "hospo" but now just "bumming off Centrelink" during lockdown
- Alcohol use: increased recently to **at least 10 standard drinks most days** in a week
- Tobacco use: smokes at least **a pack a day**
- Recreational drugs: taking **MDMA every weekend** now

Developmental History

- Doesn't remember much of her childhood, "bounced around a lot" with different relatives
- Mother had bipolar disorder, "mum killed herself when I was 15 or 16, dad wasn't around"

MARKING GUIDE († denotes pertinent points)

	Needs Improvement	Proficient	Excellent
Task 1: History Taking and Suicide Risk Assessment			
Introduces self and confirms patient details. Sets context for the interview including consent. Uses open and closed questions appropriately. Establishes good rapport.			
† Explores HOPC including duration and onset, evolution of Sx and events leading up to the presentation			
† Obtains info on suicidal thought, plan, intent, length/degree of planning, method, previous attempts, protective/risk factors in order to formulate a suicide Rx			
Conducts a comprehensive BPD screen by eliciting ≥ 5 traits: affective instability, chronic emptiness, intense anger, impulsivity, recurrent suicidal or self-harming behaviour, dissociative Sx, poor self-esteem, unstable interpersonal r/s, avoidance of abandonment			
† Excludes at least 4 of the following causes: organic Sx, manic Sx, psychotic Sx, anxiety Sx.			
† Explores at least 2-3 of domains of patient's personal Hx: developmental Hx, current living situation/finances, social supports, exercise/diet, substance use			

† Task 2: Reporting a Comprehensive Suicide Risk Assessment			
Reports risk of suicide: high/intermediate/low, states frequency of thoughts and if patient is capable of controlling their thoughts			
Reports previous attempts: frequency and age of attempts, states most serious attempt, states if patient has a pattern of escalating attempts, any triggers/recent stressors/loss			
Reports intent: discusses that patient had no intent to kill herself but wished to elicit a reaction from her boyfriend			
Reports length and degree of planning: discusses presence of (1) any efforts to arrange personal affairs (2) any efforts to not be discovered			
Method: discusses lethality of method use, describes what was used, states presence of ongoing level of distress and hopelessness and plans after failed attempt			
Reports protective/risk factors: presence of social/family supports (protective) and presence of FHx of suicide (risk)			
General feedback:			

KEY LEARNING POINTS FROM OSCE NIGHT

- Look for hints in the stem which may clue you into what you might ask in your history and a relevant diagnosis e.g. evidence of previous NSSI (self-harm scars), history of frequent presentations to the emergency department and potentially risky/impulsive behaviour.
- Begin reporting your suicide risk assessment with a statement quantifying overall risk as low, intermediate or high. Justify your risk with the information you have gathered from your history including prior attempts, presence of impulsivity, intent, length and degree of planning, lethality of method chosen, presence of risk and protective factors.
- Do not forget to ask about substance use (determine frequency, quantity and substances of use), especially in the context of suicide risk as substance use, in particular polysubstance use independently increases the risk of suicidal behaviour given the disinhibiting effects of intoxication.
- Patients with BPD can present with psychotic symptoms, in particular auditory verbal hallucinations as well as delusional ideation. It may be pertinent to screen for further symptoms relevant to psychotic syndromes and mania in order to rule these out as differentials.