Psychiatry: three favourite OSCE stations

OSCE stations in psychiatry tend to fill medical students with dread. Psychiatric patients aren’t as forthcoming when it comes to providing the interviewer with information as general medical patients are. Unsurprisingly, examiners don’t usually use real psychiatric patients in medical student OSCE exams, but you shouldn’t underestimate how convincingly the actors employed can act psychotic or depressed as required!

There are several OSCE scenarios in psychiatry that you need to be familiar with:

- performing a mini mental state examination on an elderly patient with likely dementia
- assessment of a depressed patient in A and E
- assessment of a psychotic patient being held in the police cells
- counselling a patient with bipolar affective disorder on commencing lithium therapy
- assessment of a patient with suspected alcohol dependence syndrome

Below are some helpful hints on how to handle three of these scenarios – eliciting psychopathology from an acutely psychotic patient, the risk assessment of a suicidal patient and counselling a patient on commencing lithium.

**Eliciting psychopathology from an acutely psychotic patient**

An OSCE station in which you are asked to assess a patient for evidence of psychotic phenomena can be particularly taxing. The key to succeeding in this scenario is to try to establish good rapport with the patient from an early stage. You will get marks for introducing yourself to the patient, checking the patient’s name, explaining what the interview is about and putting the patient at ease. Use appropriate body language- for example sit at 45 degrees to the patient (not facing him/her which might be perceived as confrontational) and use open rather than closed questions and clarify any obscure terms used.

The examiner will be looking for you to establish:

- the content of the patient’s delusion
- the fact that it is a false belief (i.e. there is no evidence for its existence)
- the patient is unshakeable in explaining their delusion and
- that you have confirmed that the delusion is outside of the patient’s culture (i.e. no-one agrees with their delusion).

The other psychopathology the examiner will want you to tease out of the patient include:

- any evidence of hallucinations (auditory and visual being the two commonest forms)
- any evidence of formal thought disorder – i.e. thought insertion, thought withdrawal, thought broadcast, thought echo; and
- any evidence of somatic passivity.

Marks will be awarded for showing empathy towards the patient and establishing a good rapport as these demonstrate that you have good interpersonal skills, which are particularly important in psychiatry.
You should never forget to round off the interview in an appropriate way. Always reflect back to the patient what he/she has told you and invite the patient to ask you any questions they may have or provide any information they require if you are able to do so. Finally, thank the patient for agreeing to talk to you.

The key to successfully passing an OSCE station in which you are required to interview a psychotic patient hinges on your ability to establish a good rapport with the patient (the patient may well have paranoid delusions!) and use open-ended questions to try to tease as much information as possible out of the patient so that you are able to comment to the examiner on which psychopathology he/she exhibits.

**Risk assessment of a suicidal patient**

A common scenario faced by all psychiatric trainee doctors is the risk assessment of a patient who has presented to A and E after an unsuccessful suicide attempt. This is therefore a common psychiatry OSCE station used in medical student exams. The examiner will expect you to introduce yourself to the patient and check the patient’s full name. You will be expected to explain to the patient what the interview is about and will be rewarded for putting the patient at ease.

You should begin by determining the seriousness of their suicide attempt.
- What was the patient’s intention?
- Does the patient have a previous history of self harm?
- Does the patient have any co-existing mental illness?
- Have they had any previous involvement with psychiatric services?

It is important to establish the patient’s current and previous use of alcohol and of any illicit drugs. The examiner will expect you to identify whether the patient has any support person.

Next, you need to assess the patient’s current thinking.
- Has anything changed since the suicide attempt?
- Does the patient have any regrets about attempting to take their own life?

You should ascertain what the patient’s current intent is; for instance, if he/she is discharged home following your psychiatric assessment is he/she wishing to attempt suicide again?

Suicide intent is suggested by various factors. Was the attempt planned in advance? A lethal suicide attempt usually involves days or weeks of planning the method and location of suicide. It is rarely an impulsive, spur-of-the-moment idea (except in the case of the psychotic patient who responds to command auditory hallucinations).

Were there any final acts, such as the making of a will or leaving a suicide note? You should establish whether the patient took precautions to avoid discovery or rescue, e.g. ensuring they were alone in the house at the time. What method was used? Violent methods, such as hanging or electrocution, are more suggestive of lethal intent than an overdose. Did the patient seek help after committing the act? Those who immediately regret what they have just done and seek help from family or friends are probably less at risk than those who don’t.
The examiner will expect you to be able to identify reasons why the patient will not attempt suicide again – e.g. the patient was drunk at the time and not thinking rationally.

**You need to ask the patient how he/she sees the future.** Does the patient feel positive or does he/she have a negative outlook on the future?

**One useful structure is to think- past, present and future:**
- Past- how serious was the attempt?
- Present- what does the person feel now (regret, disappointment, sadness, anger etc)?
- Future- how does this individual see the future?

As with any OSCE station, it is important to reflect back to the patient. To round off the risk assessment, you should invite questions from the patient and thank him/her for agreeing to talk to you. A competent demonstration of your interpersonal skills will always score you marks with the examiner – empathy and establishing a rapport with the patient being two key skills in this clinical scenario.

To finish the station, the examiner will probably ask you to summarise your risk assessment of the patient (low, medium or high) and to suggest what your subsequent management would be – i.e. would you be happy to allow the patient to be discharged home, or would you like the patient to be kept in hospital for further psychiatric assessment?

**Counselling a patient on commencing lithium**

Lithium has been a first-line treatment for bipolar affective disorder for over 50 years and is regarded as the gold standard long-term agent. A common psychiatric OSCE station involves the counselling of a patient on commencing lithium treatment.

You will be rewarded for formally introducing yourself to the patient and checking the patient’s name and date of birth. You should commence the interview by explaining to the patient that you have been asked to talk to them today because he/she needs to be commenced on lithium treatment and you wish to explain what its side effects are and to educate him/her on the signs of lithium toxicity and the need for regular blood monitoring (i.e. serum lithium level, U and Es and TFTs). The examiner will award you marks for being able to put the patient at ease prior to proceeding any further.

You should inform the patient that lithium is a “mood stabiliser” and as such will help to maintain the patient’s mood at a stable level (i.e. prevent their mood going too high – resulting in mania, or too low – resulting in depression).

The exact mechanism of action of lithium is unknown, though it appears to modulate the neurotransmitter-induced modulation of second messengers.

You should explain that the patient will most likely need to remain on lithium long-term, to stabilise their mood, but that he/she will be regularly reviewed by a psychiatrist to determine whether the dose and/or formulation that he/she is on is adequate. This review process will occur more frequently upon commencing lithium treatment, but will gradually become less frequent (e.g. once or twice a year) when the patient’s mood has stabilised following lithium initiation.
You should explain to the patient that because lithium is a potentially toxic substance, safe and effective therapy requires regular monitoring of its levels in the blood (i.e. serum lithium level). You should point out to the patient that up to 75% of patients who are on lithium will experience some side effects.¹

The major dose-related side effects of lithium that you should mention to the patient are as follows:
- Polyuria
- Polydipsia
- Weight gain
- Cognitive problems (e.g. dulling, impaired memory, poor concentration, confusion)
- Fine tremor
- Sedation or lethargy
- Impaired co-ordination
- Gastrointestinal disturbance (e.g. nausea, vomiting, dyspepsia, diarrhoea)
- Hair loss
- Acne
- Peripheral oedema

You should explain that the management of these side effects usually involves lowering the dose of lithium that they are taking, or altering the formulation or dose schedule. Additional medications may be necessary if side effects persist – e.g. the use of a beta-blocker for the fine tremor, the use of a loop or thiazide diuretic for peripheral oedema, or the use of topical or oral antibiotics for acne caused by lithium use. Gastrointestinal disturbances can be managed by taking lithium with meals, the use of an anti-emetic or a proton pump inhibitor (omeprazole or lansoprazole), or by switching lithium preparations, e.g. to lithium citrate rather than lithium carbonate.

With regards to the long-term effects of taking lithium, you should inform the patient that lithium may affect the kidneys and the thyroid gland in the long-term. Approximately 10-20% of patients on lithium long-term demonstrate morphological kidney changes, with > 1% developing irreversible kidney failure after 10 years or more of lithium treatment. Between 5 and 35% of patients on lithium develop subclinical or clinical hypothyroidism. This is more frequently found in women than men, and tends to occur 6-18 months after commencing lithium treatment.

If the patient you are interviewing is female, you should warn her of the adverse risks of becoming pregnant whilst taking lithium. Lithium has been shown to cause up to an 8-fold increase in the risk of the foetus developing “Ebstein’s anomaly” (a congenital malformation of the tricuspid valve in the heart) during the first trimester of pregnancy.² Other reported second and third trimester problems include: polyhydramnios, premature delivery, thyroid abnormalities, nephrogenic diabetes insipidus and floppy baby syndrome.

With regards to whether or not lithium therapy needs to be discontinued should the patient wish to become pregnant, the following guidance should be offered:
- Mild, stable forms of bipolar disorder – dose may be tapered down and stopped pre-pregnancy.
- Moderate risk of relapse – lithium should be tapered and discontinued during the first trimester.
Severe forms of bipolar disorder, with high risk of relapse – lithium should be maintained during the pregnancy (with informed consent from the patient, appropriate counselling of the risks to the foetus, prenatal diagnosis and detailed ultrasound and echocardiography at 16-18 weeks gestation).

As well as educating the patient on the immediate and long-term side effects of lithium, you need to also explain that lithium is a drug with a narrow therapeutic index – i.e. patients can easily become toxic. The usual upper limit for a therapeutic serum lithium level is 1.2 mmol/L. If the lithium level exceeds 1.5 mmol/L, most patients will experience some symptoms of toxicity. In levels > 2.0 mmol/L, life-threatening toxic effects occur. You should explain to the patient that the early signs and symptoms of lithium toxicity include: marked coarse tremor, poor appetite, nausea, vomiting, diarrhoea and associated lethargy and dehydration.

As the lithium level rises, severe neurological complications occur, such as restlessness, muscle fasciculation, myoclonic jerks and an increase in muscle tone. This may progress to ataxia (unsteadiness on feet), dysarthria (disturbed speech articulation), drowsiness and confusion. Hypotension and cardiac arrhythmias precede circulatory collapse, followed by seizures and eventual coma.

It is important to educate patients on how to recognise the clinical features of lithium toxicity so that they may seek urgent medical help if they are concerned that they may be toxic. You should stress the importance to the patient of ensuring adequate hydration and salt intake – as the lithium level rises when the patient is dehydrated.

You will also be awarded marks for explaining that before the patient is commenced on lithium, he/she will require a series of tests – i.e. full blood count (FBC), renal function and electrolytes (U and Es), thyroid function (TFTs), a pregnancy test (if the patient is female) and an ECG.

The patient should have their lithium level checked 5 days after the initial dose. Their dose of lithium may then be titrated up as required until a suitable maintenance dose is acquired (where good symptom control is achieved).

You should explain to the patient that he/she will require weekly measurement of their serum lithium level after commencing lithium, until a therapeutic level has been stable for 4 weeks. The lithium level should then be checked every 3 months. The patient will then need to have their kidney function (U and Es) and thyroid function (TFTs) checked every 6 months, due to the recognised potential side effects of lithium on these 2 organs. (The above blood monitoring is as recommended by the NICE Guidelines on the management of bipolar affective disorder.)

Finally, you should tell the patient that he/she needs to inform any doctor that he/she sees that he/she is taking lithium, as it interacts with many different drugs. Some of the drugs that are known to interact with lithium are: anti-epileptics, diuretics and calcium-channel blockers.

As with any OSCE station, you will be awarded marks for using appropriate open body language, using lay terms for the patient and avoiding the use of medical jargon. You should regularly check the patient’s understanding of everything that you have told them and explain in simple terms anything that they he/she does not understand.
You should stress the importance of the patient taking their lithium as prescribed by the psychiatrist and that non-compliance will become apparent when the patient has their lithium level checked. The candidate’s interpersonal skills will be assessed by the examiner throughout the course of the interview; with marks being awarded for a suitable level of rapport being established with the patient.

References

Important Note
These notes were written by Dr Declan Hyland in 2010. They are presented in good faith and every effort has been taken to ensure their accuracy. Nevertheless, medical practice changes over time and it is always important to check the information with your clinical teachers and with other reliable sources. Disclaimer: no responsibility can be taken by either the author or publisher for any loss, damage or injury occasioned to any person acting or refraining from action as a result of this information.

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