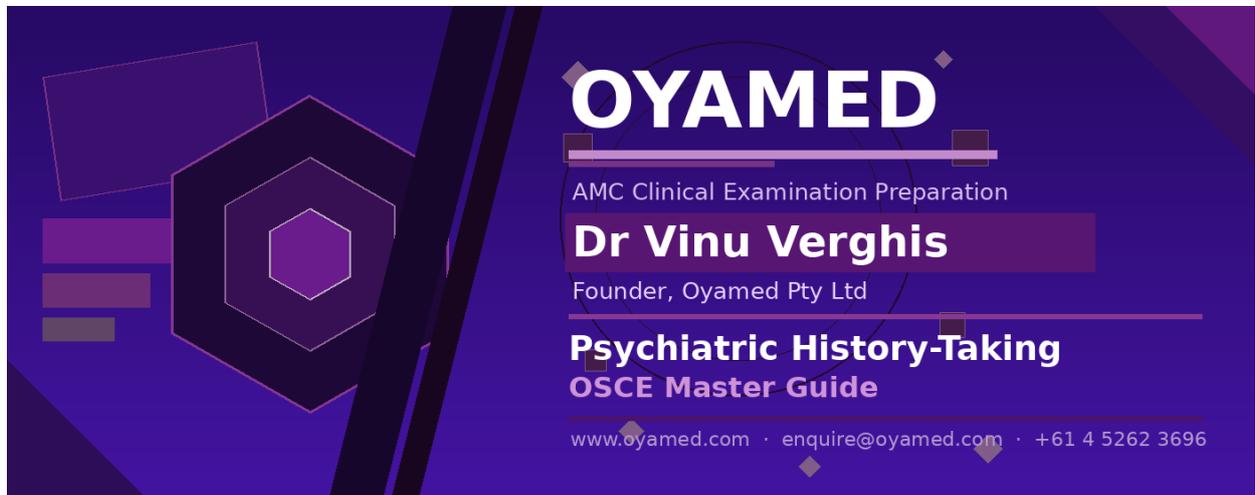


OYAMED

AMC Clinical Examination Preparation
Dr Vinu Verghis | Ipswich QLD

PSYCHIATRIC HISTORY-TAKING IN THE OSCE

8-Minute Station Master Guide



OYAMED
AMC Clinical Examination Preparation
Dr Vinu Verghis
Founder, Oyamed Pty Ltd
**Psychiatric History-Taking
OSCE Master Guide**
www.oyamed.com · enquire@oyamed.com · +61 4 5262 3696

TABLE OF CONTENTS

1. The 8-Minute Psych Station — What Examiners Want
2. Universal Psychiatric History Framework
3. Depression — Targeted Screening + SIG E CAPS
4. Anxiety Disorders — Targeted Screening + Mnemonics
5. Psychosis & Schizophrenia — Targeted Screening + HALT / TAAAV
6. Bipolar Disorder — Targeted Screening + DIG FAST
7. PTSD — Targeted Screening + TRAUMA
8. Eating Disorders — Targeted Screening + ANDS / BIG PC
9. Alcohol & Substance Use — Targeted Screening + CACTUS
10. Closing & Summary Template
11. Quick Reference — Condition Symptom Checklist
12. Psychiatric Diagnosis Timeline
13. Mental State Examination (MSE)
14. Mini-Mental State Examination (MMSE)
15. Worked OSCE Scenario — Depression Station
16. Top Examiner Pitfalls — What Loses Marks
17. Exam-Day Cheat Sheet — Key Mnemonics & Rapid Review



8-Minute Framework

Section 1 & 10

1. THE 8-MINUTE PSYCH STATION — WHAT EXAMINERS WANT

The psychiatric history station tests your ability to rapidly establish rapport, systematically explore symptoms, and arrive at a working diagnosis — all within a strict 8-minute window. Most IMGs fail not from lack of knowledge, but from poor structure or spending too long on one area.

🕒 TIME MANAGEMENT FRAMEWORK

- 0:00–0:45 — Introduction, consent, open opener
- 0:45–3:00 — Presenting complaint & HPC (let patient talk, then funnel)
- 3:00–5:30 — Targeted psychiatric screening (condition-specific)
- 5:30–6:30 — Past psychiatric Hx, medications, social Hx
- 6:30–7:30 — Risk assessment (ALWAYS — non-negotiable)
- 7:30–8:00 — Summarise, check, thank patient

Golden Rules for Every Psych Station

- **Open with an open question:** "What brings you in today?" or "Tell me what's been happening for you."
- **Do NOT jump straight to closed questions** — let the patient speak for at least 30 seconds.
- **Use ICE:** Ideas, Concerns, Expectations — especially when patient seems distressed.
- **Risk is MANDATORY:** You WILL lose marks if you omit suicidal ideation / self-harm / risk to others.
- **Signpost transitions:** "I'd now like to ask about your mood..." — shows structure to the examiner.
- **Avoid jargon:** Say "feeling low" not "dysphoric". Your language should be plain.

2. UNIVERSAL PSYCHIATRIC HISTORY FRAMEWORK

Use this skeleton for EVERY psychiatric station, then overlay condition-specific questions from Section 3 onwards.

A — Presenting Complaint & History of Presenting Complaint

- **Open:** "Can you tell me in your own words what's been bothering you?"
- **Onset:** When did this start? Sudden or gradual?
- **Duration:** How long has this been going on?
- **Severity:** "On a scale of 0–10, how bad is it at its worst?"
- **Pattern:** Constant or comes and goes? Any triggers?
- **Previous episodes:** Has this ever happened before?
- **Impact:** "How is this affecting your day-to-day life? Work? Relationships?"

B — Psychiatric Screening (Condition-Specific — See Sections 3–8)

This is where you layer in the specific symptom clusters for the suspected condition. See the relevant section below.

C — Past Psychiatric History

- Any previous psychiatric diagnoses?
- Previous admissions — voluntary or involuntary?
- Previous self-harm or suicide attempts?
- Response to past treatments?

D — Medications & Substances

- **Current medications:** psychiatric and non-psychiatric
- **Adherence:** "Are you taking them as prescribed?"
- **Substances:** Alcohol (CAGE), cannabis, stimulants, opioids — quantity and frequency
- **Caffeine:** relevant in anxiety, insomnia, mania

E — Personal & Social History

- Current living situation — alone, with family, supported?
- Employment / study status
- Relationships — partner, children, support network
- Recent stressors — bereavement, financial, legal, relationship
- Forensic history if relevant

F — Family History

- Any family history of mental illness?
- Family history of suicide?

G — Premorbid Personality

- "Before all this started, how would you describe yourself as a person?"
- Introverted/extroverted, stable relationships, work history

H — Risk Assessment (EVERY STATION — MANDATORY)

RISK ASSESSMENT — NON-NEGOTIABLE IN EVERY STATION

- Suicidal ideation: 'Have you had any thoughts of ending your life or not wanting to be here?'
- Intent & plan: 'Have you thought about how you might do it?'
- Access to means: 'Do you have access to medications, weapons, or other means?'
- Previous attempts: 'Have you ever tried to hurt yourself in the past?'
- Self-harm: 'Have you been hurting yourself in any other way, such as cutting?'
- Risk to others: 'Have you had any thoughts of hurting anyone else?'
- Protective factors: 'What has stopped you from acting on these thoughts?' (children, faith, hope)

3. DEPRESSION — TARGETED SCREENING

Suspect depression when the patient presents with low mood, tearfulness, loss of enjoyment, fatigue, or somatic complaints (especially in older patients).

DSM-5 Core Symptoms — Screen ALL of These

Symptom Domain	Sample Question
Depressed mood	"How has your mood been? Most of the day, most days?"
Anhedonia (loss of interest)	"Is there anything you used to enjoy that you no longer feel interested in?"
Sleep disturbance	"How have you been sleeping? Trouble getting off, staying asleep, or waking early?"
Energy & fatigue	"How are your energy levels? Do you feel tired even after rest?"
Concentration	"Have you noticed any difficulty concentrating or making decisions?"
Appetite / weight	"Has your appetite changed? Any change in weight recently?"
Psychomotor changes	"Has anyone said you seem slower, or do you feel agitated or restless?"
Guilt / worthlessness	"Do you find yourself blaming yourself or feeling like a burden to others?"
Suicidal ideation	"Have you had any thoughts of ending your life or not wanting to be here?"

Severity Indicators to Elicit

- Duration ≥ 2 weeks?
- Number of symptoms present (mild: 2–3 core; moderate: 4–5; severe: 6+)
- Functional impairment — can they work, care for family, maintain hygiene?
- Psychotic features — delusions of guilt/nihilism, hallucinations?
- Biological features — marked early morning waking, diurnal mood variation, marked weight loss, loss of libido

DSM-5 Mnemonic — SIG E CAPS (5+ symptoms for ≥ 2 weeks; must include S or I)

 **SIG E CAPS — Major Depressive Episode** Need $\geq 5/9$ for ≥ 2 weeks; must include depressed mood or anhedonia

#	Stands For	DSM-5 Criterion / What to Elicit
S	Sleep	Insomnia (esp. early morning waking) OR hypersomnia — nearly every day
I	Interest	Markedly diminished interest or pleasure in all/almost all activities (Anhedonia)
G	Guilt	Feelings of worthlessness OR excessive/inappropriate guilt (not just self-reproach)
E	Energy	Fatigue or loss of energy nearly every day
C	Concentration	Diminished ability to think, concentrate, or make decisions
A	Appetite	Decreased or increased appetite; significant weight loss or gain (>5% body weight/month)
P	Psychomotor	Psychomotor agitation OR retardation observable by others (not just subjective)
S	Suicidality	Recurrent thoughts of death, suicidal ideation, plan, or attempt
+ Mood	Depressed mood	Subjectively reported or observed — sad, empty, tearful, hopeless (core criterion)

EXAMINER TIP — DEPRESSION

- Distinguish unipolar vs bipolar — always ask about manic episodes ('Have you ever had a period of feeling unusually high, needing less sleep, or spending a lot of money?')
- Ask about suicidality even if the patient seems 'not that bad' — you will be marked on this
- In postnatal context, always screen for thoughts of harming the baby
- Don't forget thyroid, anaemia as differentials — mention in your summary

4. ANXIETY DISORDERS — TARGETED SCREENING

The anxiety family includes GAD, panic disorder, social anxiety, specific phobia, and health anxiety. The presentation will guide which subtype you explore — but all share core anxiety symptoms.

Core Anxiety Symptoms

- Excessive worry — difficult to control, multiple domains
- Physical symptoms: palpitations, chest tightness, dyspnoea, tremor, sweating, GI symptoms
- Psychological: restlessness, feeling on edge, irritability, poor concentration
- Sleep: difficulty getting to sleep due to racing thoughts
- Avoidance behaviour — what situations does the patient avoid?

Panic Disorder — Ask When Episodic Panic Attacks Present

- **Onset:** "Do these feelings come on suddenly, like waves?"
- **Peak intensity:** "How quickly does it build? Does it peak within 10 minutes?"
- **Physical symptoms:** palpitations, chest pain, dizziness, paraesthesia, derealization, fear of dying
- **Agoraphobia:** "Do you avoid going out or being in places because you're worried about having an attack?"
- **Between attacks:** "Are you worried between attacks that you'll have another one?"

GAD — Ask When Pervasive, Multi-Topic Worry

- **Duration:** "How long have you been feeling this way? More days than not for 6 months?"
- **Control:** "Can you switch these worries off, or do they keep coming back?"
- **Topics:** health, finances, relationships, work — does worry spread across multiple areas?
- **GAD-2 screen:** "Feeling nervous/anxious/on edge? Not able to stop worrying?"

Social Anxiety

- **Trigger situations:** "Are there specific situations where your anxiety is worst — like meeting new people or speaking in public?"
- **Fear of scrutiny:** "Are you worried about being judged or embarrassed by others?"
- **Anticipatory anxiety:** "Do you worry beforehand about these situations?"
- **Avoidance:** "Do you avoid these situations, or endure them with a lot of distress?"

DSM-5 Mnemonic — GAD: 3 WARM (6+ months, more days than not)

 GAD — Worry + 3 of WARM (≥3 symptoms required) Excessive worry about multiple domains, difficult to control, for ≥6 months		
#	Stands For	DSM-5 Criterion / What to Elicit
W	Worry (core)	Excessive anxiety and worry about multiple events/activities — difficult to control
W	Wound up	Feeling restless, keyed up, or on edge
A	Aches & fatigue	Easily fatigued
R	Racing mind / poor concentration	Difficulty concentrating or mind going blank
M	Muscle tension	Muscle tension
+	Moody / irritable	Irritability
+	wAke	Sleep disturbance — difficulty falling/staying asleep, restless unsatisfying sleep

DSM-5 Mnemonic — Panic Disorder: STUDENTS FEAR the 13

 STUDENTS FEAR — Panic Attack (4+ of 13 symptoms, peaking within 10 min) Recurrent unexpected attacks + ≥1 month anticipatory anxiety or avoidance		
#	Stands For	DSM-5 Criterion / What to Elicit
S	Sweating	Diaphoresis
T	Trembling	Trembling or shaking
U	Unsteady	Dizziness, unsteady, light-headed, or faint
D	Depersonalisation	Derealisation or depersonalisation
E	Extra heartbeats	Palpitations, pounding heart, or accelerated heart rate
N	Numbness	Paraesthesia (numbness or tingling)
T	Terror of dying	Fear of dying
S	Shortness of breath	Shortness of breath or smothering sensation
F	Fear of losing control	Fear of going crazy or losing control
E	Extra warm/chills	Chills or hot flushes
A	Abdominal distress	Nausea or abdominal distress
R	Restricted airway	Choking sensation

EXAMINER TIP — ANXIETY

- Always exclude medical causes — hyperthyroidism, arrhythmia, phaeochromocytoma, asthma
- Substance withdrawal (alcohol, benzodiazepines) can mimic severe anxiety
- Ask about caffeine and stimulant use
- Assess functional impairment — work attendance, social withdrawal, relationship strain

5. PSYCHOSIS & SCHIZOPHRENIA — TARGETED SCREENING

Psychosis may present as first episode, relapse, or under a different label (e.g. 'strange behaviour', 'not himself'). Your job is to elicit positive and negative symptoms, explore insight, and assess safety.

Positive Symptoms

Symptom	Sample Question
Hallucinations — auditory	"Do you ever hear voices or sounds when no one is around?"
Hallucinations — visual	"Do you ever see things that others can't see?"
Delusions — persecutory	"Do you ever feel that people are out to get you or watching you?"
Delusions — reference	"Have you noticed things in the environment — like TV or radio — sending you messages?"
Delusions — grandiose	"Do you feel you have special powers or a special mission?"
Thought insertion/withdrawal	"Do you ever feel thoughts are being put into your mind, or taken out?"
Thought broadcasting	"Do you ever feel others can hear your thoughts?"
Passivity experiences	"Do you ever feel your actions or feelings are controlled by an outside force?"

Negative Symptoms

- Flat/blunted affect — observe during history, but also ask: 'Have people commented that you seem less emotional than usual?'
- Alogia — poverty of speech
- Avolition: 'How has your motivation been? Are you managing daily tasks like cooking, washing?'
- Anhedonia
- Social withdrawal: 'Are you spending more time alone than usual?'

Insight

- "Do you think there might be a mental health component to what you're experiencing?"
- "Have you seen a doctor or psychiatrist before for anything like this?"
- "Are you willing to take medications if that's what's recommended?"

First Episode Considerations

- Duration of untreated psychosis (DUP) — when did symptoms start?
- Prodromal symptoms — social withdrawal, decline in function, odd beliefs before florid psychosis
- Substance use — cannabis is a major trigger in vulnerable individuals
- Family history of psychosis or schizophrenia

DSM-5 Mnemonic — Schizophrenia: HALT + TAAAV

 HALT — Positive Symptoms (≥2 required, ≥1 must be from first 3, for ≥1 month) Schizophrenia = ≥2 of HALT for ≥1 month + 6 months total duration incl. prodrome		
#	Stands For	DSM-5 Criterion / What to Elicit
H	Hallucinations	Auditory (most common), visual, olfactory, tactile, gustatory
A	And delusions	Fixed false beliefs — persecutory, grandiose, referential, nihilistic, somatic
L	Loose/disorganised speech	Tangentiality, loosening of associations, incoherence, word salad
T	Target behaviour (disorganised)	Disorganised or catatonic behaviour — agitation, waxy flexibility, stupor

 TAAAV — Negative Symptoms (can diagnose with 2+ positives OR 1 positive + prominent negatives) Negative symptoms cause significant functional impairment		
#	Stands For	DSM-5 Criterion / What to Elicit
T	Thought poverty (alogia)	Reduced speech output, brief empty replies, thought blocking
A	Affect (flat/blunted)	Reduced emotional expression — flat face, reduced eye contact, monotone voice
A	Avolition	Inability to initiate/persist in goal-directed activities — poor hygiene, work, social function
A	Anhedonia	Diminished ability to experience pleasure from positive stimuli
V	Volition (asociality)	Lack of interest in social interactions — not due to avolition alone

EXAMINER TIP — PSYCHOSIS

- Do NOT use the word 'voices' first — ask 'Do you hear sounds or people talking when no one is there?' to avoid leading
- Assess insight explicitly — it affects management and risk
- Always ask about substance use — cannabis, amphetamines, cocaine can cause/exacerbate psychosis
- Risk includes violence to self and others — enquire about command hallucinations telling the patient to hurt themselves or someone else
- Mention organic causes in your summary: temporal lobe epilepsy, delirium, brain tumour, steroid-induced

6. BIPOLAR DISORDER — TARGETED SCREENING

Bipolar often presents when a patient is depressed. You may not recognise it as bipolar unless you specifically ask about past hypomanic or manic episodes. Always ask.

Manic / Hypomanic Episode Screening

Symptom	Sample Question
Elevated/irritable mood	"Have you ever had a period of feeling extremely high, elated, or unusually irritable?"
Decreased need for sleep	"During that time, did you need much less sleep but still feel full of energy?"
Grandiosity	"Did you feel you had special abilities or were better than others in some way?"
Racing thoughts / flight of ideas	"Were your thoughts racing — jumping from one thing to another?"
Increased goal-directed activity	"Were you much more active than usual — starting lots of projects?"
Distractibility	"Were you easily distracted — jumping between things?"
Impulsivity / risky behaviour	"Did you do things you later regretted — spending sprees, risky sexual behaviour, unusual business decisions?"

Distinguishing Hypomania from Mania

Feature	Hypomania vs Mania
Duration	≥4 days (hypomania) vs ≥7 days (mania)
Hospitalisation	Not required (hypomania) vs may be required (mania)
Psychosis	Absent (hypomania) vs may be present (mania)
Functional impairment	Mild/none (hypomania) vs marked impairment (mania)
Insight	Usually present (hypomania) vs often impaired (mania)

Mixed Features & Cycling

- Ask about rapid cycling: 'Have you had 4 or more episodes in a single year?'
- Mixed state: simultaneous depressive and manic symptoms — especially suicidal risk is HIGH
- Precipitants: sleep deprivation, substance use, antidepressants (may trigger mania)

DSM-5 Mnemonic — DIG FAST (Manic Episode: 3+ if elevated mood; 4+ if irritable only)

💡 DIG FAST — Manic Episode (≥7 days or any duration if hospitalised) Must cause marked impairment OR include psychosis OR require hospitalisation for Mania (Hypomania = ≥4 days, no hospitalisation, no psychosis)		
#	Stands For	DSM-5 Criterion / What to Elicit
D	Distractibility	Attention easily drawn to irrelevant external stimuli or unimportant details
I	Indiscretion / Impulsivity	Excessive involvement in risky activities — spending sprees, sexual indiscretions, unwise investments
G	Grandiosity	Inflated self-esteem or grandiosity — may reach delusional intensity
F	Flight of ideas	Racing thoughts or subjective experience that thoughts are racing
A	Activity increase	Increased goal-directed activity (social, work, school, sexual) OR psychomotor agitation
S	Sleep decreased	Decreased need for sleep — feels rested after only 3 hours (not insomnia)
T	Talkativeness	More talkative than usual OR pressure to keep talking (pressured speech)

💡 EXAMINER TIP — BIPOLAR

- Never diagnose bipolar on depressive symptoms alone — you MUST find a manic or hypomanic episode
- Bipolar II: hypomania + depression (no full mania, no psychosis)
- Suicide risk in bipolar is highest during mixed states — ask specifically
- Ask about lithium — compliance, levels, side effects (polyuria, tremor, hypothyroidism)
- Differentiate from ADHD, personality disorder, substance misuse — these all look similar

7. PTSD — TARGETED SCREENING

PTSD follows exposure to actual or threatened death, serious injury, or sexual violence. The patient may not volunteer the traumatic event — sensitively enquire about its nature without pressing for graphic detail.

Trauma Exposure

- "Sometimes difficult or distressing experiences from the past can have a lasting impact. Have you ever experienced something very frightening, dangerous, or traumatic?"
- "You don't need to tell me all the details, but I'd like to understand what kind of experience it was."

PTSD Symptom Clusters

Cluster 1 — Re-experiencing

- Flashbacks: 'Do you ever feel like you are reliving the event, as if it is happening right now?'
- Nightmares: 'Do you have distressing dreams about what happened?'
- Intrusive memories: 'Do unwanted memories of the event come into your mind even when you don't want them to?'
- Psychological / physiological reactivity to reminders

Cluster 2 — Avoidance

- 'Are there thoughts or feelings about the event you try to push away?'
- 'Are there places, people, or situations you avoid because they remind you of what happened?'

Cluster 3 — Negative Cognitions & Mood

- 'Do you feel differently about yourself since this happened? Perhaps blaming yourself?'
- 'Do you feel detached from the people around you?'
- 'Are there things you used to enjoy that you no longer feel anything about?'

Cluster 4 — Hyperarousal

- Sleep disturbance — mainly initial insomnia, nightmares
- 'Do you find yourself easily startled — for example by sudden noises?'
- 'Do you feel constantly on guard, as if something bad might happen?'
- Irritability, anger outbursts, concentration difficulties

Important Additional Areas

- **Duration:** symptoms must be present for >1 month
- **Dissociation:** "Do you ever feel detached from your surroundings, or like things aren't quite real?"
- **Comorbidities:** depression, alcohol/substance misuse, chronic pain are very common

DSM-5 Mnemonic — PTSD: TRAUMA (symptoms from ≥1 month post-event)

 TRAUMA — PTSD Clusters (DSM-5 requires criteria from ALL 4 clusters) Exposure to actual/threatened death, serious injury, or sexual violence (direct, witnessed, or indirect)		
#	Stands For	DSM-5 Criterion / What to Elicit
T	Traumatic re-experiencing (Cluster B)	≥1 of: flashbacks, nightmares, intrusive memories, psychological/physiological reactivity to cues
R	Re-experiencing	The event feels like it is happening again — dissociative flashback episodes
A	Avoidance (Cluster C)	≥1 of: avoiding distressing thoughts/feelings OR avoiding external reminders (people, places, conversations)
U	Unwanted negative changes in cognition & mood (Cluster D)	≥2 of: amnesia, negative beliefs, self-blame, negative emotion, diminished interest, detachment, restricted affect
M	Marked alterations in arousal (Cluster E)	≥2 of: irritability/anger, recklessness, hypervigilance, exaggerated startle, concentration difficulty, sleep disturbance
A	At least 1 month duration	Symptoms must persist for >1 month (if <1 month = Acute Stress Disorder)

EXAMINER TIP — PTSD

- Approach the traumatic event sensitively — you do not need graphic details to make the diagnosis
- Acute Stress Reaction: same symptoms but duration <4 weeks following trauma
- Complex PTSD (ICD-11): prolonged/repeated trauma — add 'disturbances in self-organisation' (emotional dysregulation, negative self-concept, relational difficulties)
- Substance use is frequently a comorbidity — patients self-medicate with alcohol
- Assess risk carefully — PTSD carries significant suicide risk, especially with comorbid depression

8. EATING DISORDERS — TARGETED SCREENING

Eating disorder stations often involve a young woman presenting with weight loss, amenorrhoea, fatigue, or GI complaints. Your ability to sensitively but directly address eating and body image is key.

Opening the Topic Sensitively

- "I'd like to ask some questions about your eating and your thoughts about your weight and body. Is that okay?"

Anorexia Nervosa — Screen for

Domain	Sample Question
Restriction	"Can you walk me through what you would typically eat in a day?"
Weight fear	"How would you feel if you put on some weight?"
Body image distortion	"When you look in the mirror, what do you see? Do you feel you look overweight?"
BMI / weight loss	"What is the lowest weight you have been? What is your current weight and height?"
Amenorrhoea	"Have your periods been regular? Have they stopped?"
Excessive exercise	"Do you exercise? How often and for how long? Do you feel you have to exercise?"
Denial of seriousness	"Are you worried at all about your current weight?"

Bulimia Nervosa — Additional Questions

- **Bingeing:** "Do you ever eat a large amount of food in a short time, feeling out of control while doing so?"
- **Purging (vomiting):** "After eating, do you ever make yourself sick?"
- **Laxative misuse:** "Do you use laxatives, diuretics, or diet pills?"
- **Guilt cycle:** "How do you feel after a binge? Do you feel ashamed or disgusted?"

SCOFF Screening Tool (Quick 5-Question Screen)

SCOFF Questions (2+ = likely eating disorder)

- S — Do you make yourself Sick because you feel uncomfortably full?
- C — Do you worry you have lost Control over how much you eat?

- O — Have you recently lost more than One stone (6 kg) in a 3-month period?
- F — Do you believe yourself to be Fat when others say you are thin?
- F — Would you say that Food dominates your life?

Medical Complications to Ask About

- Cardiovascular: palpitations, syncope (hypokalaemia, arrhythmia)
- Dental: tooth erosion (acid from purging)
- Peripheral oedema
- Fatigue, weakness (electrolyte disturbance)
- Lanugo hair, hair loss

DSM-5 Mnemonic — Anorexia: ANDS | Bulimia: BIG PC

 ANDS — Anorexia Nervosa (DSM-5 requires ALL 3 criteria) Severity based on BMI: Mild ≥ 17 Moderate 16–16.99 Severe 15–15.99 Extreme < 15		
#	Stands For	DSM-5 Criterion / What to Elicit
A	Avoidance of adequate nutrition	Restriction of energy intake leading to significantly low body weight for age/sex/developmental trajectory
N	Negative body image	Disturbance in the way body weight or shape is experienced; undue influence on self-evaluation
D	Dread of weight gain	Intense fear of gaining weight or becoming fat, even when underweight
S	Subtypes	Restricting Type vs Binge-Purge Type (distinguish from Bulimia by the low body weight)

 BIG PC — Bulimia Nervosa (DSM-5 requires ALL criteria, weekly for ≥ 3 months) Distinguish from Anorexia Binge-Purge type by NORMAL or HIGH body weight		
#	Stands For	DSM-5 Criterion / What to Elicit
B	Binge eating episodes	Recurrent episodes of eating a large amount in a discrete period with sense of lack of control
I	Inappropriate compensatory behaviour	Self-induced vomiting, laxatives, diuretics, fasting, or excessive exercise
G	Goes on for ≥ 3 months	Bingeing and compensatory behaviours occur at least once a week for 3 months
P	Perception of body distorted	Self-evaluation unduly influenced by body shape and weight
C	Criteria excludes Anorexia	Disturbance does NOT occur exclusively during episodes of Anorexia Nervosa

EXAMINER TIP — EATING DISORDERS

- Don't avoid the question — examiners expect you to ask directly about purging and restriction
- Assess motivation to change — vital for management planning

- Anorexia has the highest mortality of any psychiatric disorder — suicide and medical complications
- Always ask about comorbid depression, anxiety, OCD traits, trauma
- In males: eating disorders are underdiagnosed — ask the same questions without gender assumptions

9. ALCOHOL & SUBSTANCE USE — TARGETED SCREENING

Substance use may be the primary presentation or a comorbidity with any other psychiatric diagnosis. Approach this non-judgementally — patients are more forthcoming when they do not feel judged.

CAGE Screen for Alcohol (2+ = Likely Problem)

CAGE Questions

- C — Have you ever felt you should Cut down on your drinking?
- A — Have people Annoyed you by criticising your drinking?
- G — Have you ever felt bad or Guilty about your drinking?
- E — Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover (Eye-opener)?

Full Alcohol History

- **Quantity:** "How much do you drink in a typical week? What type of drinks?"
- **Frequency:** "Is it every day, or does it vary?"
- **Pattern:** Binge vs daily maintenance drinking
- **Dependence features:** "Do you need a drink in the morning to feel normal? Do you shake if you don't drink?"
- **Tolerance:** "Has it taken more and more alcohol to get the same effect?"
- **Withdrawal:** "When you've stopped drinking suddenly, have you had shaking, sweating, fits, or seeing things?"
- **Blackouts:** "Have you had memory blackouts from drinking?"

Other Substances

Substance	Key Questions
Cannabis	Frequency, strength (skunk?), age of onset, psychotic symptoms
Cocaine / stimulants	Route (snorted/smoked/IV), bingeing, cardiac symptoms, paranoia
Opioids	Route (IV = high risk), tolerance, withdrawal symptoms, use of services
Benzodiazepines	Prescribed or illicit? Dose, withdrawal risk
MDMA / other	Frequency, psychiatric sequelae, poly-substance use

Dependence vs Harmful Use

- Dependence: compulsion to use, tolerance, withdrawal, use despite harm, salience, rapid reinstatement
- Harmful use: causes physical or psychological harm, no dependence features

DSM-5 Mnemonic — Substance Use Disorder: CACTUS (2+ criteria in 12 months)

 CACTUS — Substance Use Disorder (DSM-5: 11 criteria; Mild=2-3, Moderate=4-5, Severe=6+) Note: DSM-5 combines abuse + dependence into one spectrum disorder — no separate categories		
#	Stands For	DSM-5 Criterion / What to Elicit
C	Control impaired	Often taken in larger amounts or over a longer period than intended
A	Attempts to cut down fail	Persistent desire or unsuccessful efforts to cut down or control use
C	Craving	Strong desire or urge to use the substance
T	Time consumed	Great deal of time spent obtaining, using, or recovering from effects
U	Unmet role obligations	Recurrent use resulting in failure to fulfil major role obligations at work, school, or home
S	Social/interpersonal problems	Continued use despite persistent social or interpersonal problems caused by the substance
+	Tolerance	Need markedly increased amounts to achieve effect OR markedly diminished effect with same amount
+	Withdrawal	Characteristic withdrawal syndrome OR substance taken to relieve/avoid withdrawal symptoms
+	Hazardous use	Recurrent use in physically hazardous situations (e.g. driving)
+	Health problems ignored	Continued use despite knowledge of persistent physical or psychological problem caused by the substance
+	Hobbies given up	Important social, occupational, or recreational activities reduced/abandoned

EXAMINER TIP — SUBSTANCES

- Alcohol withdrawal seizures can be fatal — always assess withdrawal risk if presenting with alcohol cessation
- Wernicke's encephalopathy: ophthalmoplegia, ataxia, confusion — requires IV thiamine urgently
- Cannabis can trigger and maintain psychosis — this changes management
- Naltrexone, acamprosate, disulfiram — know these for the management plan
- Non-judgemental tone scores you rapport marks — never appear shocked

10. CLOSING & SUMMARY TEMPLATE

Closing well adds marks. Use the final 30–60 seconds to demonstrate insight, synthesis, and patient-centredness.

Closing Script

- **Summarise:** "Let me briefly summarise what you've told me to make sure I've understood correctly..."
- **Check:** "Is there anything important I've missed, or anything you'd like to add?"
- **ICE close:** "What were you hoping we might be able to do to help you today?"
- **Safety net:** "If things get worse or you feel unsafe before I see you next, please go to your nearest ED or call 000."
- **Thank:** "Thank you for being so open with me today. I know this wasn't easy."

🎯 PRESENTATION TO EXAMINER — STRUCTURE

- This is [Name], a [age]-year-old [occupation] who presents with [main complaint] for [duration].
- Key features consistent with [condition]: [list 3–4 positive findings].
- Importantly, [risk finding — even if absent: 'There was no suicidal ideation'].
- Relevant background: [PMH / medications / substance use / social factors].
- My working diagnosis is [X], with differentials including [Y] and [Z].
- I would like to [next steps: collateral history, investigations, referral, safety planning].

11. QUICK REFERENCE — CONDITION SYMPTOM CHECKLIST

Use this as a rapid revision checklist before the exam.

Condition	Must-Ask Domains
Depression	Low mood, anhedonia, sleep, energy, concentration, appetite, guilt, psychomotor, SI
Mania/Bipolar	Elevated/irritable mood, decreased sleep, grandiosity, racing thoughts, impulsivity, risky behaviour
Anxiety/GAD	Worry (uncontrollable, multi-topic), physical symptoms, avoidance, duration ≥ 6 months
Panic Disorder	Episodic, sudden onset, peaks < 10 min, physical symptoms, anticipatory anxiety, agoraphobia
Psychosis	Hallucinations (auditory/visual), delusions, thought insertion/broadcasting, negative symptoms, insight
PTSD	Trauma, re-experiencing (flashbacks/nightmares), avoidance, hyperarousal, negative mood, duration > 1 month
Anorexia	Restriction, weight fear, body image distortion, BMI, amenorrhoea, exercise compulsion
Bulimia	Bingeing, purging, laxative use, SCOFF, dental/electrolyte complications
Alcohol	CAGE, quantity, dependence features, withdrawal (fits, DTs), blackouts
All stations	Risk: SI, plan, means, previous attempts, self-harm, risk to others, protective factors

12. PSYCHIATRIC DIAGNOSIS TIMELINE — QUICK REFERENCE

Duration criteria are frequently tested in the AMC Clinical Exam. Use this table to quickly distinguish between diagnoses that share similar symptom clusters.

Category	Diagnosis	Minimum Duration
Mood Disorders	Bipolar I	7 days or more
	MDD	2 weeks or more
	Dysthymia	2 years or more
	Cyclothymia	2 years or more
Psychotic Disorder	Delusional Disorder	1 month or more
	Brief Psychotic Disorder	< 1 month
	Schizophreniform	1–6 months
	Schizophrenia	> 6 months
Anxiety Disorder	Panic Disorder	1 month or more
	Phobias	> 6 months
	Acute Stress Disorder	< 1 month
	PTSD	> 1 month
	Adjustment Disorder	< 6 months (must occur within 3 months of stressor)
	GAD	> 6 months

💡 EXAM TIP — DURATION CRITERIA

- Schizophrenia vs Schizophreniform: only difference is duration (>6 months vs 1–6 months)
- Dysthymia vs MDD: both are depressive disorders — dysthymia is milder but chronic (2 years)
- Acute Stress Disorder vs PTSD: same symptom clusters — ASD resolves within a month, PTSD persists beyond

- Adjustment Disorder: must start within 3 months of stressor and resolve within 6 months of stressor ending
- Cyclothymia: sub-threshold hypomania + sub-threshold depression cycling for 2 years



13. MENTAL STATE EXAMINATION (MSE)

The MSE is a structured, systematic observation and description of a patient's mental functioning at the time of the interview. It is distinct from the psychiatric history — the history is what the patient TELLS you; the MSE is what you OBSERVE and ELICIT during the consultation.

⚡ MSE IN THE OSCE — KEY POINTS

- Present your MSE findings to the examiner at the end of the station
- Many domains can be assessed passively while taking the history — you do not need to stop and formally test everything
- Always comment on ALL domains, even if findings are normal (e.g. 'No perceptual disturbances elicited')
- Abnormal findings should be described precisely — avoid vague terms like 'seemed a bit off'

A — Appearance

- **Build & age:** Does the patient look their stated age? Over/under weight?
- **Dress & grooming:** Well-kempt or dishevelled? Appropriate for weather/context?
- **Hygiene:** Evidence of self-neglect (body odour, soiled clothing, poor dental hygiene)?
- **Distinguishing features:** Tattoos, piercings, scars (including on wrists/arms — note self-harm)
- **Eye contact:** Good, poor, avoidant, intense/staring?

B — Behaviour & Psychomotor Activity

- **Attitude to interviewer:** Cooperative, guarded, suspicious, hostile, seductive, withdrawn?
- **Psychomotor:** Retardation (slow movements, long response latency) or agitation (restlessness, hand-wringing, pacing)?
- **Abnormal movements:** Tremor, tardive dyskinesia, tics, stereotypies, mannerisms, waxy flexibility, catatonia
- **Rapport:** Easily established, difficult, none?

C — Speech

Speech Parameter	Descriptors
Rate	Normal / pressured (rapid, difficult to interrupt) / poverty (slow, long pauses)
Volume	Normal / loud / whispered
Tone & prosody	Normal / monotonous / dysarthric / accented
Quantity	Normal / logorrhoea (excessive) / poverty of speech
Fluency	Fluent / hesitant / word-finding difficulties / stammering
Spontaneity	Spontaneous / only in response to direct questions

D — Mood & Affect

Mood = subjective (what the patient reports). Affect = objective (what you observe). Both must be documented.

- **Subjective mood:** Ask 'How would you describe your mood right now?' — record in patient's own words
- **Objective affect:** What emotion do you observe?
 - Euthymic, depressed, elevated/elated, anxious, irritable, angry, labile, dysphoric
- **Range:** Full range / restricted / blunted / flat
- **Reactivity:** Does affect change appropriately in response to topic? (reactive vs non-reactive)
- **Congruence:** Is affect congruent with mood and thought content? (e.g. laughing while describing a tragedy = incongruent)

E — Thought

Thought Form (How the patient thinks)

Abnormality	Description
Circumstantiality	Gets to the point eventually but takes an indirect, overly detailed route
Tangentiality	Goes off on tangents, never returns to the original point
Flight of ideas	Rapid switching between loosely connected topics — goal-directed but hard to follow
Loosening of associations	Connections between ideas are unclear or lost — 'knight's move' thinking
Word salad	Completely incoherent speech — no logical connection between words
Perseveration	Repetitive return to the same topic or phrase
Clang associations	Words chosen based on sound rather than meaning (rhyming)
Thought blocking	Sudden, unexplained halt mid-sentence — patient loses train of thought

Poverty of thought

Very little spontaneous thought content — brief, empty responses

Thought Content (What the patient thinks)

- **Delusions:** Fixed, false, unshakeable beliefs not in keeping with cultural norms
 - Persecutory, grandiose, referential, nihilistic, somatic, jealous, erotomanic
 - Assess: degree of conviction, pervasiveness, acting on the belief
- **Overvalued ideas:** Strongly held beliefs that dominate thinking but not completely fixed
- **Obsessions:** Recurrent, intrusive, unwanted thoughts recognised as one's own — ego-dystonic
- **Phobias:** Irrational fear of specific object or situation with avoidance
- **Suicidal ideation:** Passive ('I wish I wasn't here') vs active ('I want to kill myself') — document plan, intent, access to means
- **Homicidal ideation:** Thoughts of harming others — document target, plan, intent

F — Perceptions

- **Hallucinations:** Perception without an external stimulus — patient believes it is real
 - Auditory: elementary (noises) vs verbal (voices) — 2nd person ('you are bad') vs 3rd person ('he is bad') vs running commentary
 - Visual, olfactory, gustatory, tactile — always document modality
 - Command hallucinations: 'Are the voices telling you to do anything?'
- **Illusions:** Misperception of a real external stimulus (e.g. seeing a face in curtains)
- **Pseudo-hallucinations:** Perceived in inner subjective space, patient knows not real
- **Depersonalisation:** Feeling detached from oneself — 'like a robot' or 'watching myself from outside'
- **Derealisation:** Feeling the world is unreal, dreamlike, or distant

G — Cognition

Brief cognitive screen during MSE — full formal testing covered in MMSE (Section 14).

- **Orientation:** Time (day, date, month, year), Place, Person
- **Attention & concentration:** Serial 7s, days of week backwards, WORLD backwards
- **Memory:** Registration, short-term recall (3 objects at 5 min), long-term (historical facts)
- **Language:** Naming, repetition, comprehension, reading, writing
- **Visuospatial:** Clock drawing, copying intersecting pentagons
- **Executive function:** Abstraction (proverb interpretation), similarities, differences

H — Insight & Judgement

Level	Description
Full insight	Patient acknowledges they have a mental illness, understands its nature, and accepts need for treatment
Partial insight	Patient acknowledges something is wrong but may not accept a psychiatric explanation or need for treatment

Intellectual insight	Patient can describe their illness intellectually but does not apply this understanding to their situation
No insight	Patient completely denies any mental illness or need for treatment

- **Judgement:** Ability to make sound decisions — assess through history (e.g. risky behaviour, impulsivity) or hypothetical scenarios
- **Test:** "If you found a sealed, stamped envelope on the street, what would you do?"

MSE PRESENTATION TEMPLATE — USE THIS STRUCTURE

- Appearance: [Age-appropriate/dishevelled/well-kempt] [gender] appearing [stated age/older/younger]
- Behaviour: [Cooperative/guarded/agitated], [good/poor] eye contact, [no] psychomotor abnormality
- Speech: [Rate], [volume], [tone], [quantity] — e.g. 'pressured, loud, with flight of ideas'
- Mood: Subjectively '[patient's words]'; objectively [depressed/elevated/euthymic/anxious]
- Affect: [Full/restricted/blunted/flat], [reactive/non-reactive], [congruent/incongruent] with mood
- Thought form: [Normal/circumstantial/tangential/loosened associations/flight of ideas]
- Thought content: [No delusions elicited] / [Persecutory delusions present — describe]
- Perceptions: [No hallucinations elicited] / [Auditory hallucinations — 3rd person, non-command]
- Cognition: [Alert and oriented x3] / [Disoriented to time] — [MMSE score if performed]
- Insight: [Full/partial/none] — patient [does/does not] acknowledge illness and need for treatment
- Suicidal ideation: [Absent] / [Present — passive/active, with/without plan or intent]

14. MINI-MENTAL STATE EXAMINATION (MMSE)

The MMSE is a 30-point standardised cognitive screening tool developed by Folstein et al. (1975). In the OSCE, you may be asked to perform it, interpret a score, or explain it to a patient or carer. It takes approximately 10 minutes to administer in full.

⚡ MMSE IN THE OSCE

- If asked to 'perform a cognitive assessment', default to the MMSE unless told otherwise
- Always introduce it sensitively: 'I'd like to ask you some questions to test your memory and concentration — some may seem simple'
- Score as you go — document each domain's sub-score, not just the total
- Interpret the score in context: education level, language, anxiety, and sensory impairment all affect performance
- The MoCA is now preferred in many clinical settings for MCI — be ready to discuss both

MMSE Domains & Scoring

Domain / Item	Instruction to Patient	Score
1. ORIENTATION TO TIME		/5
Year	"What year is it?"	1
Season	"What season are we in?"	1
Month	"What month is it?"	1
Date	"What is today's date?"	1
Day	"What day of the week is it?"	1
2. ORIENTATION TO PLACE		/5
Country	"What country are we in?"	1
State	"What state are we in?"	1
City/Town	"What city or town are we in?"	1
Building	"What building are we in?"	1
Floor/Ward	"What floor or ward are we on?"	1
3. REGISTRATION		/3
3 objects	"I am going to name 3 objects. Please repeat them after me: APPLE, TABLE, PENNY. Remember them — I will ask again shortly."	3
4. ATTENTION & CALCULATION		/5
Serial 7s	"Starting at 100, subtract 7 and keep going: 93, 86, 79, 72, 65"	5

Alternative	"If serial 7s not possible: Spell WORLD backwards (D-L-R-O-W)"	(5)
5. RECALL		/3
3 objects recall	"Can you tell me those 3 objects I asked you to remember?"	3
6. LANGUAGE		/8
Naming ×2	"What is this?" [show watch] "And this?" [show pen]	2
Repetition	"Repeat after me: No ifs, ands, or buts"	1
3-stage command	"Take this paper in your right hand, fold it in half, and put it on the floor"	3
Reading	"Please read this and do what it says" [show card: CLOSE YOUR EYES]	1
Writing	"Write a sentence — anything you like" (must have subject + verb, make sense)	1
7. VISUOSPATIAL / COPYING		/1
Intersecting pentagons	"Please copy this design exactly" [show intersecting pentagons — must have 10 corners and intersect]	1
TOTAL SCORE		/ 30

MMSE Score Interpretation

Score Range	Interpretation
27–30	Normal cognition (note: some cognitively intact people score <27)
24–26	Borderline / possible MCI — warrants further assessment
18–23	Mild cognitive impairment / mild dementia
10–17	Moderate dementia
< 10	Severe dementia

Factors That Affect MMSE Score — Always Contextualise

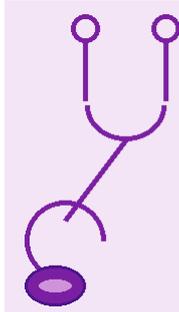
- **Education:** Low education = lower baseline scores — adjust interpretation accordingly
- **Language:** Non-English speakers disadvantaged — consider interpreter, use culturally adapted tools
- **Anxiety:** Acute anxiety impairs attention and recall — can falsely depress score
- **Sensory impairment:** Hearing/visual loss affects performance — ensure glasses/hearing aids in place
- **Delirium:** Fluctuating cognition — MMSE is a snapshot; serial testing more informative
- **Depression:** Pseudodementia — depressed patients may score low but improve with treatment

MMSE vs MoCA — Key Differences

Feature	MMSE vs MoCA
Year developed	MMSE: 1975 MoCA: 1996
Total score	MMSE: 30 points MoCA: 30 points
Time to administer	MMSE: ~10 min MoCA: ~10–15 min
Sensitivity for MCI	MMSE: Low (misses up to 60% of MCI) MoCA: High (~90% sensitivity for MCI)
Executive function	MMSE: Minimal MoCA: Extensive (Trail B, abstraction, verbal fluency)
Clock drawing	MMSE: No MoCA: Yes (3 points)
Visuospatial	MMSE: Intersecting pentagons MoCA: Cube copy + clock
Language	MMSE: Naming 2 objects MoCA: Naming 3 animals (lion, camel, rhinoceros)
Cutoff (normal)	MMSE: ≥ 27 MoCA: ≥ 26 (add 1 point if ≤ 12 years education)
Copyright	MMSE: Copyrighted — requires licence MoCA: Free for clinical use

💡 EXAMINER TIP — MSE & MMSE

- In the OSCE, present your MSE findings systematically — examiners follow the same structure
- If asked to screen cognition in 8 minutes, prioritise: orientation, registration, recall, and one attention task
- Always mention education and language as confounders when interpreting an MMSE score
- MoCA is preferred for detecting Mild Cognitive Impairment — know the key differences
- Pseudodementia (depression presenting as dementia): history of depression, rapid onset, patient complains of memory loss (in true dementia they often deny it), responds to antidepressants
- Delirium vs Dementia: Delirium = acute onset, fluctuating, impaired consciousness; Dementia = gradual, progressive, clear consciousness until late stages



Worked OSCE Scenario

Section 15

15. WORKED OSCE SCENARIO — DEPRESSION STATION

Read through this worked example before your exam. Notice how the candidate structures each minute, transitions between domains, and closes with a clear examiner presentation. Practise saying the lines aloud.

STATION STEM (as given to candidate)

- You are a GP. Sarah, a 34-year-old primary school teacher, has come in today saying she has been 'not feeling herself' for the past 6 weeks.
- Take a focused psychiatric history. You will be asked to present your findings and give a working diagnosis to the examiner.
- Time allowed: 8 minutes.

Minute-by-Minute Model Consultation

Time	Candidate Says	Examiner Note / Why It Works
0:00–0:45	"Hi Sarah, I'm Dr [Name]. Thanks for coming in today. Before we start, I just want you to know that what we discuss stays confidential, unless I have concerns about your safety. Is it okay if I ask you some questions?" [pause] "Can you tell me in your own words what's been going on for you lately?"	Introduction + consent + open question. Gives patient space to tell their story. Do NOT jump to closed questions yet.
0:45–2:30	"I'm really sorry to hear that. It sounds like things have been quite difficult. You mentioned not feeling yourself — can you tell me more about how your mood has been? [pause] How long has this been going on?" ... "Most of the day, or does it come and go?" ... "Is there anything you used to enjoy that you no longer feel interested in?"	Core depressive symptoms: low mood + anhedonia. Open questions first, then funnel. Reflects back patient's language — builds rapport.
2:30–3:30	"Thank you. I'd like to ask about a few other areas — sometimes these things affect other parts of life too. How has your sleep	Biological symptoms of depression: sleep, energy, appetite, concentration. Signposting the transition shows structure to examiner.

	been? [pause] Are you getting off to sleep okay, or waking early? [pause] And your energy levels and appetite — any changes there? Have you been able to concentrate at work?"	
3:30–4:30	"Has there been any sense of blaming yourself, or feeling like a burden to others? [pause] Sometimes when people feel this way, they can have thoughts that life isn't worth living — have you had any thoughts like that?"	Guilt/worthlessness + RISK ASSESSMENT introduced naturally and sensitively. Not abrupt. This is the most common place candidates lose marks — doing it well here is critical.
4:30–5:15	[If SI present] "Thank you for telling me that — it takes courage. Can I ask, have you had any thoughts about how you might do it? [pause] Do you have access to any medications or other means? [pause] What has stopped you from acting on these thoughts?"	Full risk assessment: ideation, plan, means, protective factors. Even if patient says no SI — you MUST have asked. Document it either way.
5:15–6:15	"I'd like to ask a couple of other important questions. Have you ever had a period in the past where you felt the opposite — unusually high, needing very little sleep, or doing things you later regretted? [pause] Have you had anything like this before? Any previous treatment or hospital admissions for your mental health?"	Ruling out bipolar — mandatory in any depression presentation. Past psychiatric history. One question = enormous diagnostic value.
6:15–7:00	"Can I ask about alcohol and any other substances — just to get a full picture? [pause] And how are things at home — are you getting support from family or friends? Any major stressors recently — work, finances, relationships?"	Substances + social history + stressors. Brief but covers essential ground. Shows holistic approach.
7:00–7:45	"Sarah, before I finish — is there anything you were hoping we might be able to do to help you today? [pause] Is there anything important I've missed?" [to examiner] "I've finished my history — would you like me to present now?"	ICE close + invitation to present. Handing back to examiner professionally. Never just stop mid-station — signal completion.
7:45–8:00	"This is Sarah, a 34-year-old teacher presenting with a 6-week history of low mood, anhedonia, early morning waking, fatigue, poor concentration, and feelings of worthlessness. She has [no/passive] suicidal ideation with no plan or intent. There is no history of manic episodes. My working diagnosis is a Major Depressive Episode, moderate severity. I would like to arrange a safety plan, commence an SSRI, and refer for CBT."	Perfect examiner presentation: demographics, symptom summary, risk, differential exclusion, working diagnosis, management plan. Concise and structured.

COMMON MISTAKES IN THIS SCENARIO — AVOID THESE

- Starting with 'Are you depressed?' — never lead with a diagnostic question
- Spending 4 minutes on HPC and running out of time for risk — use the time framework
- Forgetting to ask about manic episodes — this could be Bipolar II
- Asking about suicide in a clunky, abrupt way — practise the transition phrase until it sounds natural

- Not presenting to the examiner — always signal when you are done and offer to present
- Saying 'no abnormalities' in MSE without commenting on each domain individually



Examiner Pitfall Alert

Section 16

16. TOP EXAMINER PITFALLS — WHAT LOSES MARKS

These are the most common reasons IMG candidates lose marks in the psychiatric history station, based on recurring examiner feedback. Read each one carefully — most are about process, not knowledge.

Category 1 — Structure & Time Management

Pitfall	How to Avoid It
Spending too long on HPC — running out of time for risk	Set a mental 3-minute alarm for HPC. Risk takes 60–90 seconds minimum — protect that time.
Not signposting domain transitions	Say: 'I'd now like to ask about...' — it shows the examiner you have a structure and are not just free-associating.
Not finishing the station — trailing off or going silent	Always close deliberately: summarise, check, offer to present. Never just stop.
Trying to cover everything and covering nothing well	Depth over breadth. Nail the presenting complaint, risk, and 2–3 key screening areas rather than a shallow run through all conditions.

Category 2 — Risk Assessment

Pitfall	How to Avoid It
Omitting risk assessment entirely	Risk is ALWAYS asked — even if the patient seems stable. You WILL lose marks for omitting it. No exceptions.
Asking about suicide awkwardly or apologetically	Practise the transition until it is natural. 'Sometimes when people feel this way, they have thoughts of not wanting to be here...' — calm, matter-of-fact tone.
Only asking 'Do you feel suicidal?' and moving on	Ask the full sequence: ideation → plan → means → previous attempts → protective factors. A single closed question is insufficient.
Not asking about risk to others	In psychosis and mania especially — always ask about harm to others, particularly command hallucinations.

Treating absent SI as 'no need to mention'

Say it explicitly in your presentation: 'There was no suicidal ideation elicited.' Silence ≠ asked.

Category 3 — Diagnostic Reasoning

Pitfall	How to Avoid It
Diagnosing depression without ruling out bipolar	ALWAYS ask about manic/hypomanic episodes in every depression presentation. One question, massive diagnostic impact.
Not excluding organic causes	Mention thyroid, anaemia, neurological causes in your summary — especially in new-onset psychiatric symptoms in older patients.
Anchoring on the first diagnosis and not considering differentials	State your working diagnosis AND two differentials in your presentation. Examiners want to see differential reasoning.
Labelling without evidence	If you say 'psychotic depression' — you must have elicited psychotic symptoms. If you haven't asked, don't label.
Ignoring substance use as a cause or comorbidity	Cannabis and stimulants can cause and maintain psychosis. Alcohol withdrawal mimics anxiety. Always ask.

Category 4 — Communication & Rapport

Pitfall	How to Avoid It
Jumping straight to closed questions	Open questions first for the first 60–90 seconds. Let the patient speak before you start funnelling.
Using psychiatric jargon with the patient	Say 'feeling low' not 'dysphoric'. Say 'voices' not 'auditory hallucinations'. Plain language always.
Not acknowledging emotion — ploughing through questions	Brief empathic statements go a long way: 'That sounds really difficult.' Then continue. You don't need to stop for 2 minutes.
Appearing shocked or judgemental at disclosures	Maintain a calm, neutral expression at all times — especially when patients disclose self-harm, abuse, or suicidal thoughts.
Asking multiple questions at once	'How has your sleep been, and your appetite, and your energy?' — the patient will only answer one. Ask one question at a time.

Category 5 — MSE & Presentation

Pitfall	How to Avoid It
Not commenting on MSE domains	Even if all normal — say so. 'Appearance was appropriate, behaviour cooperative, speech normal rate and volume...'
Vague MSE language — 'seemed a bit off'	Be precise: 'Speech was pressured with mild flight of ideas. Affect was labile and incongruent with thought content.'

Presenting findings in a disorganised way	Use the MSE structure: Appearance → Behaviour → Speech → Mood/Affect → Thought → Perception → Cognition → Insight.
Forgetting to give a management plan	Your presentation should always end with: safety plan, treatment (medication + therapy), referral, and follow-up.

17. EXAM-DAY CHEAT SHEET — KEY MNEMONICS & RAPID REVIEW

Revise this page the morning of your exam. All the essential mnemonics, frameworks, and rapid-recall tables in one place.

8-Minute Time Framework

Time	What to Cover
0:00–0:45	Intro, consent, open opener — let patient speak
0:45–3:00	Presenting complaint & HPC — open then funnel
3:00–5:30	Condition-specific symptom screening
5:30–6:30	Past psych Hx, meds, substances, social Hx
6:30–7:30	RISK — SI, plan, means, attempts, harm to others, protective factors
7:30–8:00	Summarise, ICE close, present to examiner

MSE Domains — In Order

#	Domain	Key Points
A	Appearance	Age, build, dress, grooming, hygiene, eye contact
B	Behaviour	Attitude, psychomotor (retarded/agitated), abnormal movements
C	Speech	Rate, volume, tone, quantity, fluency
D	Mood & Affect	Subjective mood (patient's words) Objective affect (range, reactivity, congruence)
E	Thought	Form (how) + Content (what) — delusions, obsessions, SI, HI
F	Perceptions	Hallucinations (modality), illusions, depersonalisation/derealisation
G	Cognition	Orientation, attention, memory, language, visuospatial, executive
H	Insight	Full / Partial / Intellectual / None

Key Mnemonics at a Glance

Mnemonic	Used For	Stands For
----------	----------	------------

CAGE	Alcohol screen	Cut down Annoyed Guilty Eye-opener
SCOFF	Eating disorder screen	Sick Control One stone Fat Food dominates
SIG E CAPS	Depression symptoms	Sleep Interest Guilt Energy Concentration Appetite Psychomotor Suicidality
DIG FAST	Mania symptoms	Distractibility Indiscretion Grandiosity Flight of ideas Activity Sleep reduced Talkativeness
4 Cs	Dependence criteria	Compulsion Can't stop Consequences ignored Craving
PTSD clusters	4 domains	Re-experiencing Avoidance Negative cognitions Hyperarousal
ICE	Patient-centred	Ideas Concerns Expectations
MMSE domains	Cognitive screen	Orientation (10) Registration (3) Attention (5) Recall (3) Language (8) Visuospatial (1)

⚡ Rapid Diagnosis Differentiators

'Is it A or B?' Question	Key Differentiating Feature
Schizophrenia vs Schizophreniform	Duration: >6 months = Schizophrenia 1–6 months = Schizophreniform
MDD vs Bipolar II	Has there EVER been a hypomanic episode? Yes = Bipolar II
GAD vs Panic Disorder	GAD = persistent multi-topic worry Panic = discrete episodic attacks with physical symptoms
PTSD vs Acute Stress Disorder	Duration: >1 month = PTSD <1 month = Acute Stress Disorder
Delirium vs Dementia	Delirium = acute, fluctuating, impaired consciousness Dementia = gradual, clear consciousness until late
Depression vs Pseudodementia	Pseudodementia: complains of memory loss, rapid onset, Hx of depression, responds to antidepressants
Anorexia vs Bulimia	Anorexia = restriction + low BMI Bulimia = normal/high BMI + binge-purge cycles
Dependence vs Harmful Use	Dependence = tolerance + withdrawal + compulsion Harmful Use = damage without dependence features

🚨 NEVER FORGET IN ANY STATION

- RISK — Always ask about suicidal ideation, plan, means, past attempts, harm to others
- BIPOLAR CHECK — Always ask about manic episodes in any depression presentation
- ORGANIC CAUSES — Always mention in your differential (thyroid, neuro, substances)
- MSE COMMENT — Present all 8 domains, even if findings are normal
- CLOSE DELIBERATELY — Summarise, ICE, signal to examiner. Never just trail off

OYAMED PTY LTD

AMC Clinical Examination Preparation



Address

16 East Street, Ipswich QLD 4305, Australia



Website

www.oyamed.com



Email

enquire@oyamed.com



Phone / WhatsApp

+61 4 5262 3696



Telegram

<https://t.me/+Bv9ncIDrtpc2ZmU1>



Facebook

<https://www.facebook.com/Oyamedclinical>



Instagram

https://www.instagram.com/oyamed_clinical/



YouTube

<https://www.youtube.com/@Oyamed>

Dr Vinu Verghis | Founder, Oyamed Pty Ltd

Prepared for IMG candidates preparing for the AMC Clinical Examination

Not for clinical use · © Oyamed Pty Ltd