Scenario
Jane Cunningham is a 31-year-old woman. Her GP is worried that she is anorexic because she is vomiting after her meals.

Instructions
Take a history of her eating behaviours.

PLEASE REMEMBER TO HAND YOUR IDENTITY LABEL TO THE EXAMINER
Instructions for Patients

Answer questions based on the following scenario.

Do not volunteer information unless asked.

This station tests the candidate’s ability to take a history from a patient.

You are Jane Cunningham, a 31-year-old woman.

Key Attributes
You are a little unsure of why you are there, but there is no hostility. You get a bit tearful when talking about your relationship problems. You seek some reassurance that things will improve.

History of problem, and eating patterns
• Your main complaint is that for 3-4 months, you have been having some relationship problems
• You find yourself eating excessively and then making yourself sick afterwards, feeling self-reproach
• You are preoccupied with food, thinking about it most of the day, but trying to restrict your dietary intake at work. When you get home, you feel lonely, and start eating cakes, biscuits, and sweets. You do this 3-4 times a week
• Typically you will eat a packet of biscuits, 2-3 chocolate bars, and occasionally crisps (3-4 packets)
• You feel guilty afterwards, and make yourself sick. Sometimes, you don’t have to put your fingers down your throat to be sick – it just happens almost automatically

Body image
• You feel fat most of the time, and very self-conscious
• You think that you look fat, although you are a size 10, and your clothes fit the same as before.

Mood, and associated symptoms
• You are often tearful, experience anxiety, and sleep poorly
• Your appetite is up and down
• Your concentration is a little below-par, but you have had no problems at work
• Motivation is slightly reduced, but you have been able to go to the gym, out with friends, and enjoy yourself at least 1-2 times a week
• You feel pessimistic, and hopeless, but you have had no thoughts of suicide. Your self-esteem is low
• Your periods haven’t really changed, and you have not lost significant weight. There are no bodily changes that you have noticed.

Past psychiatric history
• You remember similar phases like this at various difficult times during your life, but they have usually improved by themselves, and haven’t required treatment
• You were once treated for depression six years ago, but didn’t finish the course of antidepressants

Personal History
• You live with your partner of 8 months, Richard
• You have a 4-year-old child from a previous marriage who lives with you and Richard
• You work as a secretary in a paper company. You have worked there for 6 years.
• You have also noticed that you are drinking more alcohol than usual – 20-30 units per week, going out with friends after work.
History Taking: Bulimia nervosa

Instructions for Examiners

REMEMBER TO ASK THE STUDENT FOR THEIR IDENTITY LABEL AND AFFIX IT TO THE TOP OF THE MARK SHEET.

This is a clinical case where the candidate must:

a) Demonstrate their ability to set the patient at ease.

b) Be able to ask difficult questions in a potentially defensive patient.

c) Gain the patient’s trust and demonstrate empathy, as well as take a good history of symptoms to differentiate between anorexia and bulimia.
History Taking: Bulimia nervosa

**Marking Sheet**

*Please circle the appropriate mark for each criterion. The standard expected is that of a psychiatric Senior House Officer.*

<table>
<thead>
<tr>
<th>Criterion</th>
<th>Performed competently</th>
<th>Performed, but not fully competent</th>
<th>Not performed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Approach to the patient – Rapport, empathy, and style</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td><strong>Eating Patterns (one point for each, up to a maximum of 2):</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Start of symptoms/ changes over time</td>
<td>1</td>
<td>½</td>
<td>0</td>
</tr>
<tr>
<td>2. Premorbid obesity</td>
<td>1</td>
<td>½</td>
<td>0</td>
</tr>
<tr>
<td>3. Assessment of quantities/ frequency of eating</td>
<td>1</td>
<td>½</td>
<td>0</td>
</tr>
<tr>
<td>4. Reasons for avoiding food</td>
<td>1</td>
<td>½</td>
<td>0</td>
</tr>
<tr>
<td><strong>Other behaviours (one point for each, up to a maximum of 3):</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>1. Bingeing (amount, when, feelings associated with)</td>
<td>1</td>
<td>½</td>
<td>0</td>
</tr>
<tr>
<td>2. Purging</td>
<td>1</td>
<td>½</td>
<td>0</td>
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<tr>
<td>3. Excessive exercise</td>
<td>1</td>
<td>½</td>
<td>0</td>
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<tr>
<td>4. Use of laxatives/ diuretics</td>
<td>1</td>
<td>½</td>
<td>0</td>
</tr>
<tr>
<td><strong>Physical symptoms (one point for each, up to a maximum of 5):</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Current weight &amp; Current height</td>
<td>1</td>
<td>½</td>
<td>0</td>
</tr>
<tr>
<td>2. Menstrual changes</td>
<td>1</td>
<td>½</td>
<td>0</td>
</tr>
<tr>
<td>3. Changes in libido</td>
<td>1</td>
<td>½</td>
<td>0</td>
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<tr>
<td>4. Symptoms of anaemia, etc.</td>
<td>1</td>
<td>½</td>
<td>0</td>
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<tr>
<td>5. Constipation, Muscle cramps</td>
<td>1</td>
<td>½</td>
<td>0</td>
</tr>
<tr>
<td><strong>Assessment of body image disturbance</strong></td>
<td>1</td>
<td>½</td>
<td>0</td>
</tr>
<tr>
<td><strong>Overall Approach to Task</strong></td>
<td>4</td>
<td>3</td>
<td>2</td>
</tr>
</tbody>
</table>

**Score (Max 20)**

**Overall Grading of station**

- **Clear Pass**
- **Borderline**
- **Clear Fail**