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Introduction

Welcome to Psych 270, Introduction to Abnormal Psychology. We will be exploring the world of abnormal psychology over the next several months and along the way will encounter a large amount of

content starting with baseline information in the first three lessons and eventually touching upon various families of mental disorders such as depression, anxiety, and schizophrenia. We will also learn about mental health-related topics such as suicide and a few more obscure yet very interesting topics such as dissociative disorders.

One advantage that we have on our journey is that the subject matter is inherently interesting to most people. Mental illness is a fascinating and engaging topic that can promote a great deal of thought and discussion.

This course was created by Dr. David J. Wimer during the summer of 2016, but an on-line course such as this one is like a relay race with many scholars cultivating it over time. Your instructor may not be the original creator of the course and if not then they will provide their own unique perspective by putting their own spin on the subject matter.

I am choosing to write in first person because the narrative will be less clunky and more engaging that way; also, I am a published fiction author and parts of my novels and many of my short stories are in first person so it is a format that I'm comfortable with. Thus, when I say "I", I am referring to Dr. David J. Wimer.

Our exposure to the subject matter in this course will be a combination of the textbook, the DSM, certain media clips, and the online commentary. In the online commentary I see my role as that of a "tour guide" in that I will add context above and beyond the textbook while also pointing out important subject matter that may receive more emphasis on exams.

So what is "abnormal"? As we will learn in this first lesson, "abnormal" is a highly subjective term and there are many factors that need to be considered when determining abnormality.

Why do people behave in abnormal ways? For example, why would a celebrity like Ariana Grande do something like lick a donut and put it back on the shelf?

Deciphering the cause (or "etiology") of abnormal behavior is an important aspect of abnormal psychology.

Lesson Objectives

After completing this lesson you should be able to:
Define key terms and concepts.

1. Understand the concept of abnormality.
2. Differentiate among the various standards and criteria for determining abnormality.
3. Understand the basics of psychotherapy.
4. Think critically about the current and future trends in abnormal psychology.

Lesson Readings and Activities

By the end of this lesson, make sure you have completed the readings and activities found in the Lesson 1 Course Schedule.

Note that there is a very high probability that your instructor is a "mandated reporter" of child abuse, elder abuse, and life threatening behavior. Thus, know up front that if any of you disclose any of those things in any of your work for this class then your instructor is legally and ethically mandated to report it.

Abnormal Psychology Terms
Let's start with the definition of this course.

Abnormal Psychology:

The scientific study whose objectives are to describe, explain, predict, and control (or treat) behaviors that are considered strange or unusual.

Let's break down this definition. Who determines what is or is not abnormal? There is some degree of subjectivity to this. There are certain entities with the power to determine standards of abnormality, such as the American Psychiatric Association or the World Health Organization. A major part of this chapter is learning some of the criteria for judging abnormality, but for now let's go over a few more important terms.

Psychopathology
The study of the symptoms, causes, and treatments of mental disorders.

Etiology
The possible causes of a mental disorder. The etiology of a disorder is usually a combination of nature (i.e. biological or genetic) and nurture (i.e. learned or environmental) factors.

Psychodiagnosis
An attempt to describe, assess, and systematically draw inferences about an individual's psychological disorder. We will learn about diagnosis in more detail in Lesson 3.

Psychotherapy
A program of systematic intervention designed to improve a person's affective (emotional), behavioral, or cognitive state.

We will examine psychotherapy in more depth on the subsequent pages, starting with our first "Fact or Myth" game of the semester:

Psychotherapy is more effective than medication for most mental disorders
Many people think that medication is more effective than talk therapy, but that is actually a myth as therapy is more effective in most cases and medication by itself without concurrent psychotherapy has a high relapse rate (Berenbaum, 2013).

The mental health world is very diverse and convoluted and can thus be a little confusing, and there are over 400 different kinds of psychotherapy (Prochaska & Norcross, 2007). Psychotherapy is performed by many different people with various educational and training backgrounds. The pie chart in figure 1.1 is from a study conducted in May of 2014, and as you can see Ph.D.-level psychologists only make up about 16% of all mental health professionals. Master's-level clinical social workers and mental health

counselors make up a large majority of those who conduct psychotherapy and other forms of mental health treatment (Centers for Medicare and Medicaid Services, 2014).

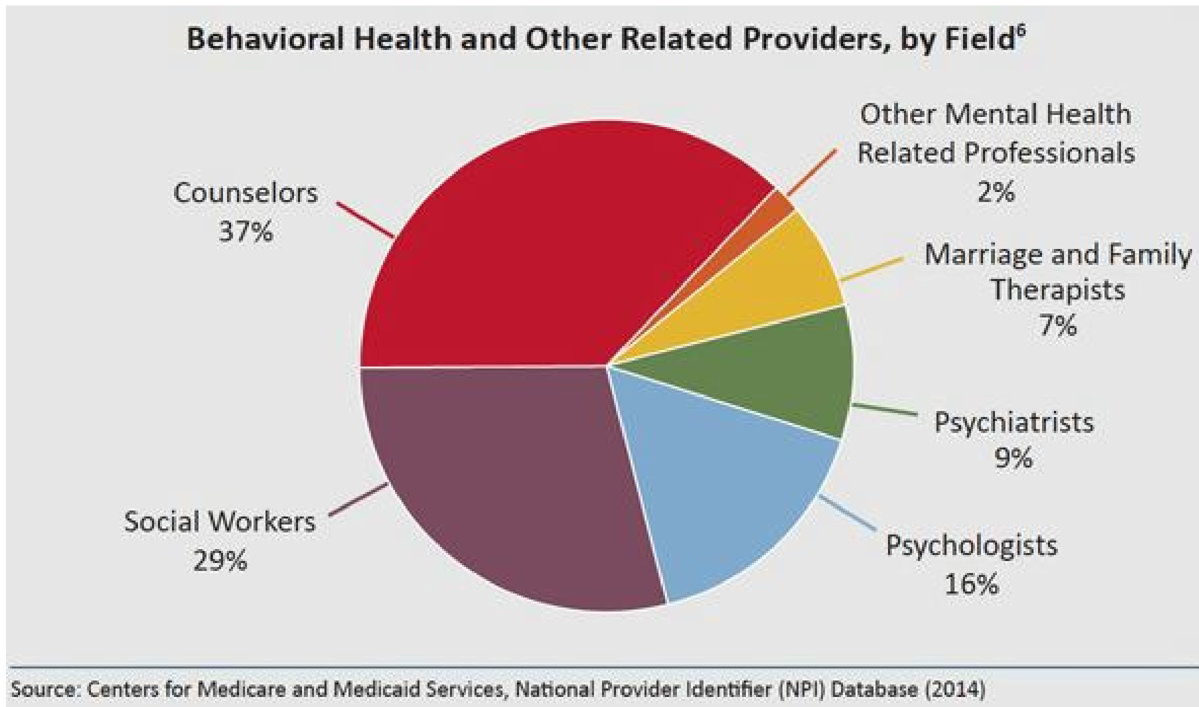

Figure 1.1. Behavioral Health Providers

Behavioral Health and Other Related Providers, by Field	
Field	**Percentage**
Counselors	37%
Social Workers	29%
Psychologists	16%
Psychiatrists	9%
Marriage and Family Therapists	7%
Other Mental Health Related Professionals	2%

Note: **There is a major difference between Counselors and Counseling *Psychologists***. Counselors typically have a master's degree in counseling whereas Counseling Psychologists have a Ph.D. in psychology. Many people are confused about the difference between counseling psychology and clinical psychology; the two sub-disciplines within psychology do similar things but through different philosophical lenses, which we don't have the time and space to go into here. On a concrete level, however, counseling psychology is different in that it has a greater focus on multicultural issues and career issues.

Explanations and treatments of abnormal behavior vary based on the mental health professional's philosophical and theoretical lens, and those 400+ types of therapy become less confusing and less intimidating when you realize that most of them can be boiled down to the four main theories of psychotherapy: Psychodynamic, Behavioral, Cognitive, and Humanistic. Each of these four main theories enacts change through a different route or focus:

Psychodynamic

The unconscious/subconscious

A key for psychodynamic therapy is "consciousness raising", or raising awareness of one's maladaptive patterns that may stem from problematic childhood experiences. For example, let's say that a man was overprotected by his mother as a child so now he is very clingy and dependent in romantic relationships; a psychodynamic therapist would help the client to develop insight by becoming more aware of this relationship pattern and would then use that insight to improve his relationships.

Behavioral

Behavioral = Actions

The major key for behaviorists is, not surprisingly, to simply change a client's behavior in a concrete way. For example, if a client is addicted to pornography then a behaviorist would focus on reducing the number of times per week that the client watches pornography.

Cognitive

Cognitive = Thoughts

Cognitive therapists tend to focus on the "inner dialogue" that we all have within our minds, and they typically try to change irrational or negative/self-defeating thoughts. For example, let's say that a client with depression keeps having thoughts like "I'm a failure" or "I'm worthless"; a cognitive therapist would scientifically examine those thoughts with the client to point out how they're not necessarily true while also coming up with more positive thoughts such as "I have value".

Humanistic

Humanistic = Emotions

Humanistic therapists use empathy, support, and a nonjudgmental stance toward clients to validate them and make them feel safe to be themselves. They also use techniques such as reflection of feeling to help a client engage in emotions that they need to get in touch with. For example, imagine that a psychotherapy client had a loved one die a few years ago but never really dealt with the emotions surrounding the loss; a humanistic therapist would have the client experience those emotions and would then validate them to ultimately help the client come to terms with the loss.

Note: You could teach an entire course on these four theories so the descriptions above are gross oversimplifications for the sake of time.

Many psychotherapists nowadays are ***eclectic***, meaning that they utilize multiple theories instead of just one. Cognitive-Behavioral Therapy (CBT) is obviously a combination of the two, which brings us to our next Fact or Myth.

Cognitive-Behavioral Therapy is the most effective form of psychotherapy.

Answer: MYTH!

A few early studies found that Cognitive-Behavioral Therapy (CBT) was more effective than other forms of psychotherapy, but then Berman, Miller, and Massman (1985) found that this initial superiority went away when they controlled for researcher biases or "allegiance effects". Those early studies were biased

and methodologically flawed in that the researchers wanted CBT to look superior so they "stacked the deck" in favor of CBT when designing the studies.

Imagine a little league referee who has a child on one of the teams so they call more penalties on the opposing team (possibly without even being aware of it) – that's another example of an allegiance effect.

Thus, the belief that CBT is the most effective form of psychotherapy is a myth. All four theories of psychotherapy mentioned above have a great deal of empirical support (Lambert, 2004; Wampold, 1997). What matters is *how well* and *how appropriately* you utilize a theory, rather than which theory you use – which leads to our next topic…

Common Factors Model

The *Common Factors Model* (Frank & Frank, 1991) conveys that any psychotherapy theory can work as long as the therapy incorporates some universal, effective factors. Imagine a stew that will taste good as long as it includes four key ingredients. The four common factors are as follows:

1. **Therapeutic Relationship**

The therapeutic relationship is considered by many psychotherapy researchers to be the most important determinant of positive change (Lambert, 2004), and it is the most important of the four common factors. A strong therapeutic relationship is a foundation of trust that allows psychotherapy to be more fruitful (regardless of theory). For example, clients are less resistant or defensive and interventions work better when a strong therapeutic relationship is in place. Doing certain interventions or techniques without a strong therapeutic relationship in place is like taking food out of an oven before it's cooked or walking a tightrope without a safety net.

2. **Healing Setting**

This refers to a comforting, healing place in which a client can get into the "mode" of working on oneself. It's an atmosphere that creates a relaxed and open feeling within the client, which subsequently facilitates dialogue and disclosure. An ethical, empathetic therapist can create this by making the client feel welcome and safe. An example from my own career when there was ***not*** a good healing setting was when I was attempting to use relaxation techniques on a client with panic disorder but the clinic was under construction and workers in the next room were using loud drills and other construction tools, which exacerbated my client's nervousness. That was definitely not a healing setting!

3. **Accepted Rationale**

This basically means a shared belief between client and therapist; both the client and therapist must be optimistic about the prognosis to a reasonable degree and must believe in the style of therapy being used and/or the content of each session. This does not mean that the client and therapist have to have the exact same worldview or life philosophy, but it does mean that they need to be "on the same page" regarding the therapy taking place. For example, if a therapist uses guided meditation for a client's anxiety both the therapist and client must believe that the technique will be helpful.

4. **Rituals or Procedures Requiring Active Participation**

This refers to the events and/or techniques that take place in a therapy session; ideally, the client must *actively* participate in the techniques and activities rather than being passive or disconnected. For example, if a therapist challenges a client's negative, irrational beliefs the client must actively work with the therapist in coming up with ways to refute those negative beliefs. The term "ritual" refers to repeated

things performed in session. An example of a ritual in therapy is the "check in" and "check out" procedure during a typical group therapy session, which is when each client in the group talks about how their week was and so forth (check in) and then when everyone at the end processes how the session went (check out).

Now that we have established ways in which psychotherapy works, let's discuss an important goal of mental health treatment: moving a client to a higher stage of change.

Stages of Change

Mental health practitioners obviously want their clients to improve, and a major goal of psychotherapy is for the client to progress to a higher stage of change in the model engendered by Prochaska and DiClemente (1983), with the ultimate goal being the client not needing treatment anymore. Clients progress and regress (as relapse is part of the process and change is rarely linear) through the following six stages:

1. **Precontemplation**

In precontemplation, the client is in denial or uninterested in changing. This stage is very common among court-mandated clients and others who do not want to be in therapy, and clients in this stage can be resistant and difficult to work with. However, there are ways to help clients progress through this stage, such as the empirically supported technique known as **motivational interviewing** (Miller & Rollnick, 1991).

This "stages of change" model can be used for many things and not just psychotherapy, so I'm going to use the example of losing weight and getting in better shape as we go through the stages. If someone is in precontemplation then they think they're fine and they are not interested in changing.

"I'm fine – I don't need to lose weight"

Contemplation

In this stage, the person is aware of the problem (or they move past denial to admit that they have a problem) and they have thoughts about changing. Essentially, they're starting to think about change but they don't have a concrete plan yet.

"Maybe I need to start exercising and losing weight"

Preparation

In the preparation stage the individual has an actual, concrete plan to change – but they haven't implemented it yet.

"Next week I'm going to get a gym membership and I'm going to start a diet program."

Action

This is where you want clients to be; the individual is implementing the plan(s) from the previous stage and is doing what they need to do to change.

"I'm going to the gym several times per week and I'm actively engaged in a diet program."

Maintenance
As the name implies, this stage is about sustaining the change and progress from the action stage; essentially, the maintenance stage is about preventing relapse.

"I renewed my gym membership, I still go several times per week, and I'm sticking with my diet."

Termination
This is when the client no longer needs treatment. In psychotherapy, termination typically involves wrapping up treatment and coming up with strategies for maintaining progress after treatment is over. A caveat to this last stage regards drug and alcohol treatment: when it comes to addiction, nobody is ever considered to be "fully recovered". People prefer to use the term "in recovery" because someone can be clean for 20 years but still relapse. Thus, if you're treating someone for addiction then there is no termination stage per se and the client just stays in maintenance long term.

Criteria for Determining Abnormality
According to the textbook, mental disorders involve behavior that departs from some norm and harms the affected individual or others (Sue et al., 2016). In this section we will go over what are called the "4D Criteria", or the four major factors involved in judging psychopathology:

1. **Distress**
    a. This involves experiencing unpleasant mental or physical health symptoms. The textbook does not mention physical symptoms but I'm adding it here because physical discomfort or distress can worsen psychological distress and vice versa; e.g., chronic pain is a huge issue in the mental health world right now.
    b. *Many of the diagnostic criteria in the DSM-5 involve distressing symptoms such as irritability or sadness.*

Deviance
    a. Abnormal behaviors differ from the typical experiences of most people, and can sometimes deviate from the shared, agreed-upon reality most of us encounter.

Hallucinations and *delusions* are considered psychologically deviant experiences because they are not something that one typically encounters in normal human experience. Thus, hearing the voice of Satan or believing that you are a famous Hollywood actor when you are not are considered deviant and abnormal.

a. **Hallucinations** = False sensory impressions, such as hearing or seeing things that are not actually occurring.
b. **Delusions** = False beliefs held despite contradictory, objective evidence.

A clinical delusion is one that someone believes even when it is clearly wrong. For example, suppose that a man has a delusion of jealousy and he believes that his partner is cheating on him. He is 100% convinced that his partner is cheating on him and he even hires a private investigator to follow them. The man will still be convinced of the infidelity even if the private investigator shows him definitive proof that his partner is not cheating.

We will learn more about hallucinations and delusions (which are known as "positive symptoms") when we discuss psychotic disorders in Lesson 12.

Another form of deviance is *statistical deviation*, or being discrepant based solely on raw numbers. Let's consider I.Q. scores as an example of this. The average I.Q. score is 100, and a standard deviation is 15. That means that someone's I.Q. score is statistically deviant if it is below 85 or above 115. You can probably think of some issues with using statistical deviation as a criterion for abnormality: judging someone based solely on a number does not consider context, and it may lead to pathologizing people who are actually high functioning. Can you think of other problems with this approach? Can you think of potential benefits of statistical deviation?

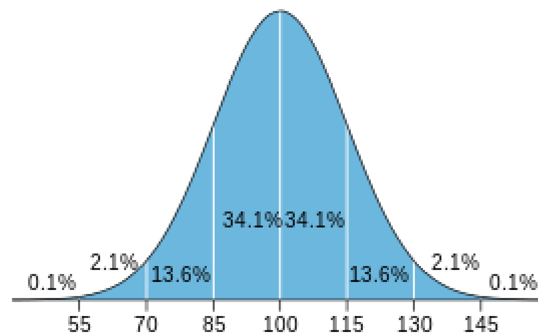

Figure 1.2 Normalized distribution of IQ with mean of 100 and standard deviation 15 by Dmcq - Own work. Licensed under CC BY-SA via Wikimedia Commons.

Dysfunction

This domain refers to how well one can function in life. Life functioning is a very important factor that clinicians need to take into account when assessing a client. For example, I work at a college counseling center and I always ask my student-clients if their grades dropped off recently because of their symptoms – that's one way of judging the impact that their mental health problems may be having on their life.

The DSM-IV-Text Revision (American Psychiatric Association, 2000) featured something known as the "Global Assessment of Functioning" or GAF scale. A client's GAF score was determined by his or her level of distress or symptomology (which is obviously related to the Distress domain from earlier) combined with his or her level of life functioning, which is this Dysfunction domain.

There are various areas of life functioning that one can consider: school or academic functioning, occupational functioning, social relationships, and day to day tasks such as grooming or driving a car are common examples.

Dangerousness

This domain is fairly self-explanatory: can the person be considered a danger to self or others? It is rare for mentally ill individuals to commit violent crimes (Sue et al., 2016), but it's still important for clinicians to assess for dangerousness. We will discuss this issue in more detail in Lesson 2. For now, however, just know that if someone is dangerous then they can certainly be considered abnormal.

Frequency & Burden of Mental Disorders

Epidemiology
The academic study of the occurrence of various health issues in society.
Epidemiological data reveals how common or rare certain health conditions are.
The following epidemiological terms are very important to know, and you will need to know them throughout the entire course:
Incidence

Incidence
The onset or new occurrence of a given disorder over some period of time; the proportion of people who "get" a condition for the first time within a given year. This is always the smallest of the three numbers.
For example, in the United States, approximately 29,218 new cases of Hepatitis C occurred in 2013, which is approximately 1 out of every 10,918 people or .009% of the population (Centers for Disease Control & Prevention, CDC, 2016).
Prevalence
The % of people in a population who suffer from a disorder at a given point in time; the proportion of people who "have" the disorder right now, including both new and persisting cases.
For example, according to the CDC (2016), approximately 3.5 million Americans are believed to be currently infected with Hepatitis C; this is approximately 1% of the population.

Lifetime Prevalence
The total proportion of people in a population who have *ever* had a certain condition at any point in their life, even if they've been cured and no longer have the condition. This is always the highest of the three numbers.
Hepatitis C is usually a chronic condition, so let's switch to clinical mood disorders as an example.
According to the Harvard Medical School (2007) the lifetime prevalence for a clinical mood disorder is approximately 21.4% of the American population, meaning that more than 1 out of every 5 Americans meets the criteria for a clinical mood disorder such as depression or bipolar.

A Brief History of Mental Illness
Considerations of abnormal behavior and mental illness are rooted in the system of beliefs that operate in a given society at a given time (Sue et al., 2016). Thus, we must consider historical context in our discussion of abnormality. One could easily teach an entire course on the history of mental illness (and the author of this course has), but for the sake of time we will focus on a few things: demonological explanations of mental illness in the middle ages, the rise of naturalism and moral treatment, and the mental asylum movement.

Demonology
The belief that mental illness was the result of supernatural forces, such as being possessed by a demon.

The Western World reverted to demonology as the dominant explanation for mental illness following the collapse of the Roman Empire.

In order to counteract threats to the church's power, Pope Innocent VIII called for the identification and extermination of witches in 1486; this led to the publication of *The Malleus Maleficarum* ("Witch's Hammer") two years later. Clergy wrote this tome to suppress revolutionary individuals and groups who the church saw as a threat, including the mentally ill in many cases. The "treatment" for mental illness was usually death or torture.

Historians estimate that *at least* 100,000 people were executed as witches from the late 1400s through the late 1600s, and approximately 85% of them were women (Viney & King, 2003).

Johann Weyer (1515-1588) was an important figure who challenged the prevailing beliefs about witchcraft, and he argued that many individuals who were persecuted as witches were actually mentally ill. This was an early, *naturalistic* explanation of mental illness.

Naturalism

The doctrine that scientific procedures and laws are applicable to all phenomena; there are natural, scientific explanations for all events in the world, including mental illness (Viney & King, 2003).

Copernicus showing that the earth revolves around the sun is an example of Naturalism. Naturalism met a great deal of resistance early on (such as Copernicus being jailed for his findings), and naturalistic explanations of mental illness met even more resistance.

Phillipe Pinel worked within the naturalistic framework and instituted the *moral treatment movement* around the year 1800 in France. Pinel freed the mentally ill from chains and dungeons and promoted healthy behaviors. He noted how the patients responded positively to such humane treatment, which seems obvious today but was revolutionary then. Moral therapy involved the following practices (Viney & King, 2003):

- Individualized care
- Occupational therapy
- Exercise
- Recreation
- Religious lessons
- Arts & crafts

Note: However, moral therapy did *not* involve talk psychotherapy.

Be sure to pay attention in the textbook to the contributions of William Tuke, Benjamin Rush, Dorothea Dix, and Clifford Beers.

Mental Asylums in America

The growth of cities in America led to the need for mental asylums, which were an example of good intentions that went bad (Benjamin & Baker, 2004). Families had difficulty caring for the mentally ill and so they transferred care of the mentally ill to public institutions.

The first American mental asylum opened in Philadelphia in the 1750s (Benjamin & Baker, 2004).

Asylums got larger and larger as demand grew and the moral therapy of Pinel eventually became too difficult to apply because of *overcrowding* in asylums. By the late 1800s mental asylums became like warehouses for mentally disturbed people, and in 1869 Willard State Hospital in New York was the first hospital specifically designated for chronic cases. Asylum admissions went up approximately 830% across the 19th century (Benjamin & Baker, 2004). Hospitals were eventually forced to release patients who were not cured simply due to lack of room.

Image 1.3 Willard Asylum, Ovid, N.Y. Main building and general entrance for visitors, by W. L. HallWillard Asylum. Licensed under Public Domain via Wikimedia Commons.

The deplorable conditions in mental asylums combined with revolutionary new drug treatments led to John F. Kennedy signing the *1963 Community Mental Health Centers Act* into law (Benjamin & Baker, 2004).

Once again, this was good intentions gone awry. The 1963 Community Mental Health Centers Act was ultimately a failed attempt to improve care for the mentally ill by allowing their families to take care of them while they received services at an outpatient community mental health center. The problem with this is that many of the patients were abandoned or forgotten by their families and thus had nobody to turn to, so the act ended up swelling the ranks of America's homeless and the effects of this are seen to this very day as a large proportion of homeless individuals are mentally ill (Benjamin & Baker, 2004).

Additional Concepts

Be sure to carefully read about the following concepts in the textbook:

- Biological viewpoint
- Psychological viewpoint
- Cathartic method
- Intrapsychic
- Multicultural psychology
- Positive psychology

Present and Future Trends in Abnormal Psychology

Carefully read the section in the textbook entitled “Changes in the Therapeutic Landscape”, which covers the topics of the drug revolution, managed health care, an increased appreciation for research, and technology-assisted therapy.

In this section we will consider a major contemporary issue that is not in the textbook: prescription privileges for psychologists. This is the trend that certain states and U.S. territories (New Mexico, Louisiana, and Guam were the first three) allow psychologists to prescribe psychotropic mediations such as Prozac if they go through the appropriate schooling and certification process. Table 1.1 contains some of the arguments for and against psychologist prescription privileges (from Gutierrez & Silk, 1998)

Table 1.1. Psychologist Prescription Privileges

Pro's	Con's
Studies have shown that psychologists and psychiatrists are equally competent at diagnosing and prescribing.	In the distant future psychologists may focus too much on prescribing and thus lose sight of talk therapy.
Psychologists spend more time with clients and get to know them better, which can allow them to monitor meds more effectively.	Medication may be less empowering than psychotherapy and patients may attribute change to an outside source rather than from something within themselves.
Psychologists can more effectively treat clients with more severe mental illnesses such as schizophrenia and bipolar.	Getting prescription privileges may place an added burden on an already overly long grad school curriculum.
Clients in rural areas may have more access to providers who can prescribe medication (this is a reason why more remote places were the first to grant prescription privileges for psychologists).	There are many people within the field of psychology who oppose prescription privileges so there is a lack of consensus among psychologists; thus, pursuing prescription privileges may create a divide within the field.

Note that psychologists have to go through a great deal of additional training in order to be able to prescribe psychotropic medication. See the following American Psychological Association for more information.Training may include everything from receiving an additional Master's degree or close to 1000 hours of additional coursework and practica. Nobody just fills out a form and gets a prescription pad in the mail! At the time of this writing there are only a few hundred prescribing psychologists in the United States and U.S. territories like Guam. There are some psychologists who get their Nurse Practitioner or Physician's Assistant degree just so they can be able to prescribe medication.

Lesson Summary

One take away message from this lesson is that the concept of “abnormality” is highly diverse. You need to consider many different criteria and many different contextual factors when determining whether a behavior is “abnormal” or not. Also, there are many different ways of treating abnormal behavior of a clinical nature.

We’ll end this discussion of abnormality with one final distinction that you’ll need to know throughout the semester: the difference between “clinical” and “sub-clinical”. *Sub-clinical* or “normal” means that a person does not meet the formal criteria for a DSM-5 or ICD diagnosis; it’s possible for someone to be considered abnormal using various criteria from this chapter yet their issues can be sub-clinical in nature. *Clinical* means that an issue does meet a formal mental health diagnosis and is thus in need of treatment in some way. In Lesson 3 we will discuss certain assessment tools that are for a clinical population (such as mental health tests) and others that are for a sub-clinical population (such as personality and career tests). However, the next lesson involves key ethical and legal issues that all mental health professionals (and students) need to know.

Finally… beware of the “Medical Student Syndrome”! This is when you read through something like the DSM-5 and say, “Oh no that’s me! I have that!” Diagnosing yourself while taking this class can be very dangerous so please try to avoid doing so.

However, feel free to diagnose people in your life like roommates, friends, or even pets. I like to bring the DSM-5 to family gatherings and then go through and check off the disorders that people have (just kidding, of course :p).

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Assignment(s):

Psychotherapy is more effective than medication for most mental disorders. The mental health world is very diverse and convoluted and can thus be a little confusing, and there are over 400 different kinds of psychotherapy (Prochaska & Norcross, 2007). Psychotherapy is performed by many different people with various educational and training backgrounds.

Make a substantive post or reply:

- What are some possible reasons why therapy is more effective than medication in most instances?
- What are some reasons why many people think or hold onto the belief that medication is more effective?
- What are some explanations as to why medication by itself has a high relapse rate?

Hello everyone:

Psychotherapy is more effective than medication for most mental disorders because it mediates the patient's internal motivation and presents a tool to increase the desire to act. Deci and Ryan's (1980) Self-Determination Theory (SDT) can explain one possible reason for this. SDT can be defined as an "empirically based theory of human motivation, development, and wellness" (Deci & Ryan, 1980).

According to Deci and Ryan (2008), SDT surrounds the types of motivations that one experiences when contemplating change, highlighting unique "differential relations of intrinsic versus extrinsic life goals" and their relatedness to psychological operation and performance. SDT posits that change is sustained or fixed more reliably by individuals with internal motivation than those who face change due to extrinsic motivation.

Accordingly, one who selects therapy as a central feature of their psychological health plan would be more likely to encounter success in effecting the desired change than one who relies on a pharmaceutical as the cornerstone change agent.

One may believe medication is more effective; we should consider more modern approaches to the internally motivated desire to reduce one's weight. In this example, one may believe they are overweight simply because of societal norms; therefore, they make minimal efforts through medication to effect a

change that would reduce the anxiety experienced around their weight. Following SDT, this could be seen an extrinsically motivated change as the patient didn't really take personal responsibility for their condition, only relied on the supposition that they had one. Mediating this discomfort the patient selected medication as a primary intervention without the significance of personal investment and responsibility.

This reveals why, in this case, medication by itself has a high relapse: when personal habits remain fixed, and they are detrimental to the patient's goal, the medication itself is not enough to overcome the imbalance of expectation versus actual progress in achieving their goal. In this regard, the patient relapses, finding that the personal investment in effecting change is overly tricky compared to the extrinsic pressure to do so. In other words, the patient may not find internal motivation to make a meaningful and sustained change because the rewards or punishments one receives due to being overweight may not be enough to continue mediating motivation.

SDT offers a lens to explain why change becomes more reliably fixed through psychotherapy than medication.

My best,

Christopher

PS. GLP1s make this example hard.

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Assignment 1: Tarasoff Ruling

The Duty to Warn has many critics, and critics such as Bersoff (2014) argue that the *Tarasoff* ruling is bad law, bad social science, and bad social policy for the following reasons:

- Informing patients of the duty to warn may inhibit clients from expressing violent urges.
- If a client does disclose violent intent then he or she may never return to therapy due to having their confidentiality breached.
- The client may feel that their trust was violated by the therapist.
- The *Tarasoff* ruling leads to too many false positives (unnecessary breaches of confidentiality) and may actually do more harm than good.

The *Tarasoff* ruling in California (or the "Duty to Warn") has been adopted by over 40 other states in the USA. As mentioned before each state has its own mental health-related rules and regulations, but the Duty to Warn typically requires therapists to breach confidentiality if three criteria are met:

1. The client has expressed intent to harm another person (there is homicidal intent).
2. The client has the ability or the means to carry out the harm (usually this means that the client has access to a firearm).
3. The client has identified a potential victim.

Make a substantive post or reply:

- What are your thoughts about the Tarasoff case and the Duty to Warn?
- Do you agree with Bersoff's criticisms? Why or why not?

Confidentially, it is paramount in the therapeutic relationship.

Tatiana Tarasoff was a University of California Berkeley student in 1968 when she met a graduate student from Bengal, India named Prosenjit Poddar. The two kissed during a New Year's Eve party which Poddar inferred meaning to which did not exist. Feeling rejected he entered a therapeutic relationship with a campus psychologist. Later, he confided that he intended to kill Tarasoff once she returned from a vacation to Brazil (CITE Center for Practical Bioethics).

Poddar performed on his threat, killing Tarasoff. The family sued.

What resulted was the determination of a standard of care known as duty to warn. A standard of care is the "benchmark that determines whether professional obligations *to* patients have been met (Vanderpool, 2021, p. 50). When one breaches a standard of care, they have performed negligently (p. 51). Correspondingly, the duty to warn is a legal doctrine that surrounds the *obligation* held by therapists and other mental health professionals, to breach confidentiality in the case of a patient threatening harm to someone and inform the target of the potentiality of harm (*Duty to Warn, Duty to Protect - SocialWorker.Com*, n.d.).

This doctrine emerged in 1974 as the result of the California Supreme Court's holding that psychologists intervening with Poddar did not effectively discharge their duties and acted negligently. The holding survived another challenge in 1976, which established or potentially clarified a similar doctrine known as

the duty to protect. Mental health professionals are obligated by duty to both (see Kopels & Kagel, 1993 as cited in Duty to Warn, Duty to Protect - SocialWorker.Com, n.d.).

An entire thesis could be written on the topic of the damage to the therapeutic relationship that emerges from this standard of care. Bersoff's (2014) criticisms discuss in detail, the varying degrees that the ruling inhibits the therapeutic relationship. The topics surround trust and confidentiality.

To that end, it is so difficult to detail my thoughts coherently surrounding two opposed dyads: the therapeutic relationship, designed to facilitate change through openness, vulnerability, and trust versus the danger one presents to themselves or others while doing so. To that end, it would be my opinion that the actions of patients outside the therapeutic relationship are simply those: actions independent of any patient client relationship, undertaken by the client, at the client's sole discretion, and with consequences either way, positive or negative, as an outcome of that relationship. Confidentiality is paramount. It is one of the cornerstones of the therapeutic relationship. How can one facilitate change within oneself if around every corner they fear disclosure of their most intimate thoughts and potential plans.

Now, on the other hand, I do not want the responsibility for conducting what seems to be high risk engagements with clients that could potentially harm another person. I infer that responsibility internally, which means that I see it as an absolute must to inform for the purpose of public safety, whenever there is a credible threat to another person.

I'll stay with research.

Nevertheless, the standard of care is there. One must wade through the weeds to apply it, and subject themselves to great risk by not, while at the same time, risking whatever progress is made in the context of the therapeutic relationship that has resulted in one's client being so comfortable processing difficult cognitions that they confide in their source of though transformation: their therapeutic team.

There is no greater breach of trust. There is no greater need to do so. Its dammed if you do and dammed if you don't.

My best,

CJD

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Assignment 2: Predicting Dangerousness

Recall from the lesson:

The FBI made the following conclusions about serial killers in a 2008 report (FBI, 2008 as cited in Sue et al., 2016)

- Most serial killers are not social misfits or noticeably strange.
- The racial distribution of serial killers corresponds with that found in the overall U.S. population.
- Motivations are wide-ranging and may include sexual fantasies, anger, thrill, financial gain, or attention.
- Serial killers are rarely insane, although they typically have personality disorders (including antisocial personality disorder). Their intelligence ranges from below to above average.
- There is no single factor that causes someone to become a serial killer: it appears to be a combination of biological, social, and psychological factors.
- Common risk factors include neglect and abuse in childhood, substance use disorders, eroticizing violence, and personality disorders. However, it's important to keep in mind that an overwhelming majority of the individuals with these risk factors do not become killers.

Make a substantive post or reply:

- How do these conclusions differ from what people typically think about serial killers?
- How has popular media given people false impressions about serial killers?

The phenomenon of serial murder has perplexed me since entering school for the second time. I have quite a few acquaintances employed in judicial or quasi-so careers. As a former litigation consultant, I followed the evolution of Dr. Burgess and Douglas' careers as they evolved the Behavioral Science Unit of the FBI. My family, whether by virtue of a small state or our careers, is friendly with several former Attorney Generals.

Serial murder, which can best be understood by the distinction between spree murder and mass murder, surrounds multiple homicides separated by time and place. Bartool (2021) does a fantastic job describing the nuances and distinctions of each type of murder. Spree murder is homicide committed at

multiple locations, with no time or little time differential. For example, one murders on the subway then murders again at the airport. Mass murder, therefore, is multiple homicides that occur in the same location and at the same time. This could be seen as the Aurora Theatre Shooting or the Sandy Hook tragedy (Bartol & Bartol, 2021).

Bartool continues to elaborate surrounding the notion that serial killers are unique and distinct but quite similar to you and I. The similarities are what make serial killers functional and successful: their unique ability to blend in. To this end, society shapes serial killers as the opposite of our lesson: social misfits that look more like Ted Kaczynski and less like Ted Bundy. Remember, Kaczynski was a college professor. This notion is supported by the FBI's 2008 report, as cited in Sue et. al (2016) that characterizes serial killers as rarely insane with ranging distributions of intelligence.

When taken together, the media does an outstanding job (see generally Hannibal) in showcasing the psychopathy of serial killers, without their innate charm and character, which serves their purpose of avoiding detection.

My supervised research project this semester surrounds serial killer typologies and the concept of serial killer summers, or the phenomena that serial killers are most active during more temperate times of the year. My lens examines the artic serial killer and their unique distinctions: Alaska has 17 since 2019 which share the common thread of higher winter killing than summer, a unique distinction from their southern counterparts. Media may further reinforce the environment in which serial killers thrive: passive and inconspicuous reinforcement for countless murders. They kill for reasons, they utilize their intelligence and social ability to thrive and avoid detection, and for these reasons, society incorrectly generalizes serial killers. This could impede their detection.

Finally, I would encourage anyone interested to consider the work of Hervy Cleckley. In his writing *Mask of Sanity* he forwards this very notion: that psychopaths are not necessarily those misfits of society that we so endear, but can look like you or I, separated arguably only by our regard for the human condition.

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Lesson 3: Assessment and Diagnosis

Introduction

This is likely the most important lesson in the course. Why? Because understanding assessment and diagnosis is crucial to understanding and being adept with the disorder-based lessons throughout the

rest of the class; also, much of the material in this chapter is "cumulative" in that you will be expected to know it throughout the entire course, and an understanding of DSM diagnosis is crucial for doing well on the exams in this course.

This lesson will be broken up into a few different sections: we will begin with a discussion of assessment and then we will focus on diagnosis (recall that we defined and briefly touched upon diagnosis in chapter one).

I **highly recommend** reading the assigned sections in the online DSM. I know it's not exactly a swashbuckling adventure story, but students who struggle on the exams in this course tend to be the **students who don't closely read and familiarize themselves with the sections of the DSM (Z Codes in particular). For the exams in this class you will not be expected to know any T codes (which concern victims of abuse) but all Z codes are "fair game" for the exams.**

Lesson Objectives

After completing this lesson, you should be able to:

1. Be familiar with assessment-related concepts and definitions such as reliability and validity.
2. Understand common assessment tools used in psychology such as the MMPI-2.
3. Understand the basics of DSM-5 diagnosis.
4. Identify the major differences between the DSM-5 and the International Classification of Diseases (ICD).
5. Be familiar with diagnostic terms such as principal and provisional diagnosis.

Lesson Readings and Activities

By the end of this lesson, make sure you have completed the readings and activities found in the Lesson 3 Course Schedule.

The Basics of Assessment

Assessment = The process of gathering information and drawing conclusions about the traits, skills, abilities, emotional functioning, and psychological problems of an individual (Sue et al., 2010). The information gathered from an assessment is used to formulate a diagnosis.

Assessment is something that sets the field of Psychology apart from other mental health-related disciplines such as Psychiatry and Social Work; the creation of assessment tools such as the MMPI-2 was a major contribution of Psychology in the twentieth century (Benjamin & Baker, 2004).

Rule #1 with assessment is that it's best to use multiple methods rather than just one method. Data gathered from a variety of sources allow a more thorough understanding of a client (Sue et al., 2016), and it also provides redundancy in case one method is flawed. So how can you tell how good or bad an assessment method is? A major way is by evaluating reliability and validity. Reliability is consistency whereas validity is accuracy.

Psychometrics is the systematic evaluation of reliability and validity (among other aspects of a measure); a test with high validity and reliability values has strong psychometric qualities, and vice versa.

Reliability = The degree to which a procedure, test, or classification system yields the same results repeatedly under the same circumstances. There are several types of reliability:

Test-retest Reliability = If you give a test twice to the same person, are the results similar? Let's use intelligence tests as an example. Imagine that someone takes an IQ test and receives a score of 105, and then a week later they take the test again and all of a sudden their score is 130. That's a sign of poor test-retest reliability. However, if their scores are 105 and 107 then that's a sign of strong test-retest reliability. There's almost always some degree of error in assessment so no measure is perfect.

Internal Consistency ("Cronbach alpha") = When various parts of a measure yield similar or consistent results. This is a bit of a tricky concept so I'll go into more detail than the textbook.
In the assessment world, most measures have "subscales". For example, I created a measure called the Health Behavior Inventory (Levant, Wimer, & Williams, 2011), which is a measure of health behaviors with five subscales: diet, proper use of health care resources, anger and stress, preventive self-care, and substance use. To have internal consistency reliability each of those five subscales needs to "hold together" as a unit, such that all of the diet questions pertain to diet and all of the substance use questions pertain to substance use and so forth. Each of the subscales should also be consistent with the overall theme of health.

Interrater Reliability = When two or more people observe or measure the same thing in a similar way. For example, I once took a developmental psychology class in which the students all watched a video of a delinquent child on a playground and we all had to count the number of times the child hit other kids. The students in the class had wildly different numbers, so there was poor interrater reliability in that instance.

Validity = When a test or measure does its job by measuring what it was intended to measure. The Beck Depression Inventory 2 (BDI-2) was designed to measure depression so it should be an accurate measure of depression. There are many types of validity, but in this class we will be most concerned with this one:

Predictive Validity = How well a test or measure predicts how a person will behave, respond, or perform. For example, the Scholastic Aptitude Test (SAT) is supposed to predict how well a student will perform in college, so if a student gets a high score on the SAT and they get a high college GPA then the test has strong predictive validity.

Observations, Interviews, and the Mental Status Exam

Be sure to read about observations, interviews, and the mental status exam in the textbook.
Here we will go into more detail about one aspect of observations: naturalistic ("field") vs. controlled ("lab") studies. An example of a naturalistic study would be researchers examining the behavior of children on a playground with no experimental manipulation; an example of a controlled study would be researchers in a lab examining how children react to various stimuli that the researchers control and/or manipulate based on the conditions of the experiment. Understanding this difference requires an understanding of two more terms, however:

External Validity = When the results of a study can be generalized to other situations.
Internal Validity = When a study is tightly controlled and has strong psychometric qualities.

Naturalistic studies tend to have higher external validity but lower internal validity whereas controlled studies tend to be the opposite (lower external validity but higher internal validity).
Let's move on to a discussion of psychological tests, beginning with projective tests.

Projective Test = A subjective assessment tool involving responses to ambiguous stimuli.

Projective tests are **derived from Freud's psychoanalytic theory**, and as such their main purpose was to tap into a client's unconscious or subconscious mind in order to achieve insight. There are many projective tests, but in this class we will discuss three of them: the **Rorschach**, the **Thematic Apperception Test (TAT)**, and the **sentence completion test**.

I have never used the Rorschach, but in my clinical experience I received extensive training on the TAT and have used it many times. I found it useful as a way to generate insight for clients and as a way to take therapy to a deeper level. The textbook mentions criticisms of projective tests and cites studies indicating their questionable psychometric qualities, but projective tests were not really intended as a way to formulate an accurate diagnosis so many of the criticisms leveled at them miss the point.

Rorschach

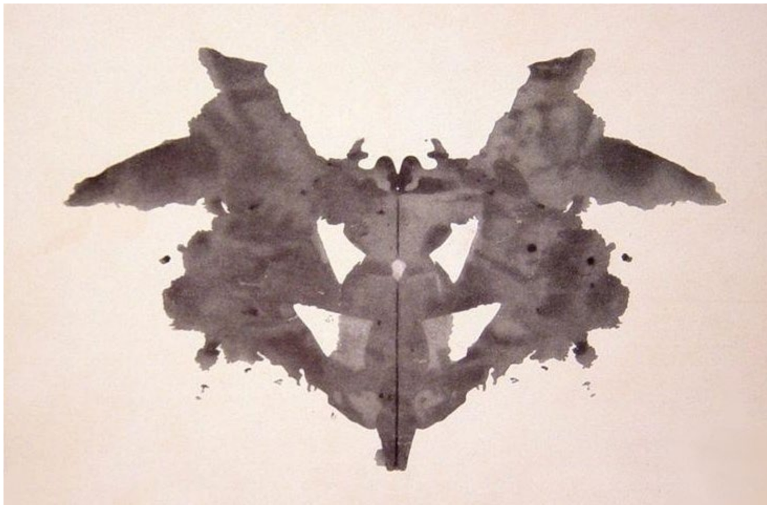
Let's begin by going over the **Rorschach**, which was created in 1921 by Swiss psychiatrist Hermann Rorschach (Sue et al., 2016). This was a popular test until the 1960s or so, when the aforementioned criticisms led to a drop-off in its use and popularity. However, Exner (2002) created a new scoring and interpretation system that somewhat improved the test's psychometric properties and has led to a slight resurgence in its use, although the Rorschach is still much less popular than it was in the early-to-mid 20th century.

Administration of the Rorschach involves showing the **same ten standard cards in the same order every time**. The test taker is prompted to give responses to each card, and the assessor analyzes things such as motivations, response tendencies, emotions, and recurring themes that emerge across the test administration.

Certain cards tend to elicit certain responses from test-takers, such as "The Father Card":

The father card tends to elicit negative, foreboding responses.

As a class, let's examine the first Rorschach card and have a class discussion about it:



Brainstorm Ideas

Think about these questions as you generate thoughts and ideas in preparation for the Lesson 3 Discussion Forum questions found at the end of the lesson.

- What do you see in this inkblot?
- What are your general thoughts about projective tests?
- Do you think they can be useful, or do you agree with the critics who say that they're questionable and outdated? How come?

Thematic Apperception Test (TAT)

Let's move on to a discussion of the **Thematic Apperception Test (TAT)**.

The TAT involves showing a series of 10-15 picture cards to a client (the textbook says 20 but that's incorrect) one at a time and asking the client to describe the following:

- The events leading up to the picture.
- What's happening in the picture.

- What the characters are feeling.
- The outcome of the story.

The outcome is the most important thing, and if the client does not relate an outcome then the **assessor must prompt for it**. The TAT differs from the Rorschach in that the **assessor chooses which cards to administer** (although there are certain core cards in every administration, like “the family card”).

The last card is always the same, however: a blank card. The assessor shows a blank card to the client and asks them to make up a story, and how a client reacts to the blank card can be very interesting. Scoring partially involves looking for recurring themes across the test administration that may be meaningful to the client’s situation. For example, I once gave the TAT to a client who had a really overprotective mother, and many of her stories involved the main character being defiant and standing up to authority.

Sentence Completion Test
Finally, a fairly simple projective assessment is the **sentence completion test**, which involves simply filling in the end of a sentence. Feel free to try out the sample and look for themes across your responses.

Objective Tests
Objective Test = A questionnaire-style measure that is typically scored with numbers. There are two categories of objective tests:
- *Sub-clinical tests* are appropriate for anyone and are for gathering information about non-clinical subject matter such as career interests. The **NEO-PI-R** personality test (which we’ll discuss soon) is an example of a sub-clinical **objective** test.
- *Clinical tests* are **designed to detect pathology in a clinical population**. The MMPI is the most famous and most widely used clinical objective test (Sue et al., 2016).

In this section of the lesson it’s important for you to understand what stands out about each of the tests we will discuss, and when a certain test would be preferred over another.

THE MMPI
The **Minnesota Multiphasic Personality Inventory** (MMPI) is the gold standard for detecting and outlining serious mental health pathology in a client. The name is misleading because it is actually not a “personality” test per se. The third edition of the MMPI (the MMPI-3) was released in 2020.

Another major advantage of the MMPI is that it is excellent at detecting whether or not someone is “faking” the test (Groth-Marnat, 2009, as cited in Sue et al., 2016) because it has very strong *validity scales*, which are subscales built into a test to detect faking or unusual response patterns that could render a person’s profile invalid and thus unusable.

There are two kinds of faking:
- **Faking Good** (or “socially desirable responding”) is when someone responds in a dishonest way to look better than they really are.
- **Faking Bad** (or “malingering”) is when a person responds in a dishonest way to intentionally look mentally ill or worse than they really are.

So why would someone fake a mental health or personality test? I would like you to think about that for the following discussion questions.

Brainstorm Ideas
Think about these questions as you generate thoughts and ideas in preparation for the Lesson 3 Discussion Forum questions found at the end of the lesson.

- What's a possible reason why someone would "fake good" on a mental health or personality test?
- Why would someone would "fake bad" on a test?
- Explain in a little more detail why these individuals would be motivated to fake a test.

Let's get back to the MMPI. **The test consists of 567 true/false statements** and when you take the test your **pattern of responses is mathematically compared with the responses of individuals in various clinical categories (this is a psychometric process known as "empirical keying").** The results of a MMPI administration are rather lengthy and complex, but the main part of the results involves the test taker getting scores on the ten main scales (8 clinical scales and 2 sub-clinical scales, masculinity-femininity and social isolation). The ten main MMPI scales are as follows (Greene, 1991):

Ten Main MMPI Scales

1. **Hypochondriasis**.
    - A high score on this scale indicates that the client may experience vague and nonspecific complaints about their health, or they may have excessive health-related anxiety.
2. **Depression**.
3. **Hysteria**.

Psychopathic Deviate.

- A high score on this scale indicates anger, impulsiveness, and proneness to criminal behavior.

Masculinity-Femininity.

- This scale was designed as a way to detect homosexuality, but it has poor psychometric support and is not accurate (Greene, 1991); this scale should be dropped from the test if there is ever a MMPI-3.

4. **Paranoia**.

Psychasthenia (Anxiety).

- The MMPI was created in the 1940s so some of the language is outdated; "psychasthenia" simply refers to anxiety.

5. **Schizophrenia**.
6. **Hypomania**.
    - **A high score on this scale is indicative of bipolar disorder.**

Social Isolation.

Let's discuss a few interesting combinations. The result that is perhaps most strongly indicative of severe mental illness is the 6-8 combo, when a person has a high score on both paranoia and schizophrenia (Greene, 1991).

<u>HIGH ON SCALE 4 + LOW ON SCALE 7</u> = Antisocial Tendencies (scale 4 is psychopathic deviate and scale seven is psychasthenia.

If a person has a high score on scale 4 (psychopathic deviate) while also being abnormally low in anxiety (scale 7) they may exhibit antisocial tendencies (Greene, 1991).

<u>Million Clinical Multiaxial Inventory MCMI</u>

Let's discuss another objective clinical test that is not in the textbook: the **Millon Clinical Multiaxial Inventory** or MCMI. The thing you need to remember about the MCMI is that it is especially useful for detecting personality disorders in a client. Among a few other things such as depression the test assesses problematic personality patterns such as schizoid, avoidant, dependent, histrionic, narcissistic, antisocial, borderline, and several others (and a score over 75 indicates that the client's score is in the "clinical" range).

<u>NEO-PI-R (Costa & McCrae, 1992)</u>
Finally, the **NEO-PI-R** (Costa & McCrae, 1992) is perhaps **the most famous example of a sub-clinical personality test**.

NEO-PI-R stands for Neuroticism, Extraversion, Openness Personality Inventory Revised and it has strong psychometric qualities. The measure assesses a person in terms of how they score on the "Big 5" personality factors:

1. Neuroticism
2. Extraversion
3. Openness
4. Agreeableness
5. Conscientiousness

Conscientiousness (or how reliable someone is) is a personality factor that is particularly valued by employers (Feist & Feist, 2009).

<u>Intelligence Tests</u>
Intelligence tests typically result in a score known as the *intelligence quotient* or IQ; 100 is an average IQ score and a standard deviation is 15, meaning that anything below 85 is low whereas anything above 115 is high.

<u>Intelligence "G"</u>

The core of what constitutes intelligence is known as "g" (Sattler, 2001), **and the ultimate goal of an IQ test is to assess "g" in a person as closely as possible.**

There are two main IQ tests: the **Wechsler Adult Intelligence Scale** (or WAIS) and the **Stanford-Binet Intelligence Scale**. The **Wechsler Intelligence Scale for Children** (WISC) is the child version of the WAIS and is typically given to children age 15 and younger.

Wechsler Adult Intelligence Scale (WAIS)
The WAIS assesses four areas: Verbal Comprehension, Perceptual Organization, Working Memory, and Processing Speed (Sue et al., 2010). Below is a list of the core subtests within each of these four areas.

Verbal Comprehension

- Similarities
- Vocabulary
  - (CLOSEST TO G) Vocabulary subset
  - and also has the best psychometric values of any subtest
- Information

Perceptual Organization

- Block Design
- Matrix Reasoning
- Digital Puzzles

Working Memory

- Digit Span
- Arithmetic

Processing Speed

- Symbol Search
- Coding

Stanford-Binet When Assessing Giftedness

Finally, the Stanford-Binet has an advantage of having a higher maximum score, making it the preferred IQ test for assessing giftedness (Sattler, 2001).

The DSM & the ICD
The Diagnostic and Statistical Manual of Mental Disorders (DSM) = A widely used classification system for psychiatric disorders that lists all officially designated mental disorders and the characteristics or symptoms needed to confirm a diagnosis. The DSM is created by the American Psychiatric Association, who make over five million dollars per year on sales of the DSM (Gordon, 2013).

The DSM-5 was released in May of 2013, and many people in the mental health field found it scary and threatening.

Why was it scary and threatening? Partially because there were some pretty radical (and controversial) changes. However, before we discuss some of these changes let's mention some basic info about the DSM and its international counterpart from the medical field, the *International Classification of Disease (ICD)*.

The International Classification of Disease (ICD)

A classification system covering all health conditions, including mental disorders. The ICD is created by the World Health Organization (WHO).
Let's compare the two (Gordon, 2013):

Table 3.1. Comparison of DSM versus ICD

DSM	ICD
American Psychiatric Association	World Health Organization
Originally cost $199 when it was first released; apps are expensive	Free electronic copies and apps
Originally only available in English, but there are plans to translate it into 18 different languages	Available in 42 different languages

In the DSM-5, ICD-10 codes are listed in parentheses after the DSM code. For example: 297.1 (F22), Delusional Disorder.

*Note, however, that the online DSM we have been using only lists the ICD codes (e.g., F22). You are not responsible for memorizing specific codes, so that will not be an issue for the purposes of this class, but I wanted to make you aware.

One other important piece of information: as part of the enforcement of the Health Insurance Portability and Accountability Act (HIPAA) all mental health practitioners must use ICD codes for billing as of October 1st, 2015. Thus, DSM codes are no longer used for insurance billing.

So why are we still using the DSM for this class? Because the ICD is very “bare bones” and does not make a very good teaching tool. The DSM has much more context and detail so it is much better to use in an educational setting like this.

DSM-IV (APA, 2000) to the DSM-5 (APA, 2013):

Now we will discuss a few of the major changes that occurred when the American Psychiatric Association switched from the DSM-IV (APA, 2000) to the DSM-5 (APA, 2013):

- The DSM suddenly developed a disdain for Roman numerals.
- Many disorders shifted from one category to another.
    - E.g., body dysmorphic disorder was moved from Somatic Symptom Disorders to Obsessive-Compulsive & Related Disorders; selective mutism moved from Childhood Disorders to Anxiety Disorders.
- New official diagnoses.
    - E.g., binge eating disorder, premenstrual dysphoric disorder, hoarding disorder.
- New categories & category names.
    - E.g., “Schizophrenia Spectrum” instead of Schizophrenia & Other Psychotic Disorders; Mood Disorders were split into two categories, Depressive Disorders and Bipolar & Related Disorders.
- Terminology changes.
    - E.g., “Mental retardation” is now known as “intellectual disability”.
- The removal of certain diagnoses.

- Perhaps the most controversial thing about the DSM-5 is how Asperger's disorder was removed and lumped in with the catch all autism spectrum disorder diagnosis, which leads to another block of discussion questions:

Diagnostic Terminology

Diagnosis = Describing and drawing inferences about an individual's psychological state; a classification of pathology based on an observed pattern of symptoms. The word "pattern' here is important because one instance is not very telling – an issue needs to recur over time to be diagnosable.

Diagnosis serves three main purposes (Sue et al., 2010):

1. Helps organize data about a client.
2. Helps a therapist to select an appropriate treatment.
3. Helps therapists communicate with one another through a common professional language.

This section involves important terminology that we will be using throughout the course. We will start with two terms that are not in the textbook, but are crucial to know for an understanding of mental health pathology.

Ego-syntonic = When a person does not realize they have a problem. Clients with ego-syntonic pathology typically have a distorted perception of reality and lack self-awareness regarding their pathology. Anorexia Nervosa is a good example of an ego-syntonic condition because the disorder is marked by a distorted perception of weight and body image.

Ego-dystonic = When a person does realize they have a problem, but has difficulty controlling it. Obsessive-Compulsive Disorder is an ego-dystonic condition because afflicted individuals are aware that the symptoms are problematic (in most cases).

Which of these two is worse?

Ego-syntonic, because clients tend to be more resistant if they do not think they have a problem, and possessing a sense of awareness is an important part of change.

Certain conditions that we will learn about in this class are ego-dystonic, others are ego-syntonic, and others have aspects of both or are one or the other depending on level of severity. For example, milder cases of schizophrenia are more ego-dystonic because the person realizes their delusions and hallucinations are not real, whereas more serious cases are ego-syntonic because the person believes their symptoms are real.

Etiology

The cause or origin of a disorder.

Comorbidity

When someone has more than one disorder at the same time. Comorbidity is extremely common in mental health – anxiety and depression are very commonly comorbid, for instance (Sue et al., 2010). Sometimes disorders can feed off of each other and make each other worse, such as depression and substance use.

Course

The usual pattern that a disorder follows. In this class it's important to pay attention to how long a person has experienced their symptoms.

Remission

When someone met the full diagnostic criteria for a diagnosis in the past but now their symptoms only meet some of the criteria (this is known as *partial remission*) or don't meet the criteria at all anymore (*full remission)*.

Prognosis

The probable outcome of a disorder, including the chances of recovery.
The next six terms are a little tricky as students tend to ask questions about them. I would recommend reading about these in the DSM in addition to reading the definitions below.

Subtype

Distinctly different subgroups within a diagnostic category. You cannot assign multiple subtypes for the same diagnosis; it has to be one or the other. For example, for illness anxiety there are two subtypes: care-seeking and care-avoiding.

Someone cannot be both of those. A subtype is denoted with "specify whether…" in the DSM.

Specifier

Specific features associated with a diagnostic category. People can have multiple specifiers associated with a diagnosis. For example, for major depressive disorder someone can have both melancholic features and with seasonal pattern. A specifier is denoted with "specify…" or "specify if…" in the DSM.

Principal Diagnosis

The condition considered to be chiefly responsible for occasioning admission of the individual; the major focus of treatment or the client's "presenting concern". In the real world, the principal diagnosis is the disorder associated with funding that's submitted to an insurance company. Note that clients can have an unlimited number of diagnoses, but they can only have one *principal* diagnosis – and the principal diagnosis is always listed first.

Provisional Diagnosis

When there is a strong presumption that the full criteria will be met for a disorder but there is not enough information to make a full diagnosis yet (or not enough time has passed).
Basically, clinicians give a provisional diagnosis when clinicians are pretty sure that a client meets the diagnosis (or will meet it eventually) but they're not completely sure because there is a piece of the diagnostic criteria that is not met or cannot be met yet. For the exams in this class, the correct answer tends to be "provisional" if not enough time has passed to meet the full diagnostic criteria for a disorder. Let's consider Generalized Anxiety Disorder (GAD) as an example. Someone must exhibit the symptoms for at least 6 months in order to be diagnosed with GAD. Imagine that someone meets the criteria for GAD… but it's only been five months. In that case the correct diagnosis would be "Generalized Anxiety Disorder, Provisional."

Unspecified/Other Specified

When a client meets the criteria for a general disorder or a family of disorders but does not necessarily meet the criteria for a specific category within that family of disorders. A clinician may use this if having difficulty deciding between a few different disorders within a general family of disorders such as depression or anxiety.

- **Unspecified** is used when there is no specific reason why the client does not meet the criteria for a more specific diagnosis; this is a little more vague than other specified.
- **Other Specified** is used when a clinician does have a good clinical reason why a client does not meet the criteria for a more specific diagnosis. For example, a client may meet some criteria for several personality disorders but does not specifically meet the criteria for one particular personality disorder, so in this case the clinician has a reason for giving a diagnosis of Other Specified Personality Disorder.

One of the most common questions I get is: "What is the difference between provisional and unspecified/other specified? When would you use one over the other?" This is an excellent question and I realize that the distinction can be a little tricky, but a fundamental difference is that provisional is the appropriate choice if the full diagnostic criteria for *one specific diagnosis that the clinician is pretty sure about* have almost been met but not quite. With unspecified/other specified, the client meets the characteristics of a general family of disorders, but the clinician is just not sure which specific subcategory of the disorder that the person falls into. So with provisional the clinician knows the one specific diagnosis but cannot formally make the diagnosis at the time, but with unspecified/other specified the pieces should be there for a general diagnostic category (such as depression or anxiety) but the clinician is not sure which specific type of depression or anxiety the client has or there is one little piece missing that prevents the clinician from making a specific diagnosis within the more general category.

Z Codes

In my classroom version of abnormal psychology, Z codes are probably the one thing that students ask the most questions about. Thus, I'll try to explain them as best I can here. However, make sure you read through the various Z codes in the "Other Conditions That May Be a Focus of Clinical Attention" section of the DSM (except for the victim/perpetrator ones as mentioned at the beginning of this lesson) and study them for all three exams.

Z Codes

Diagnoses of relationship problems, abuse/neglect, or other sub-clinical problems in a person's life. Z codes add context to the principal diagnosis and can certainly be related to a person's pathology even if they are not actual mental disorders (APA, 2013).

In my clinical experience, it is rare for someone to use a Z code as a principal diagnosis and most insurance companies would not accept one as a principal diagnosis, so Z codes are typically listed as "secondary diagnoses" after the principal diagnosis.

Let's go over some of the more common Z codes. Many of them are fairly self-explanatory given the name, but others can be a little tricky (which is why it's important to read the full descriptions in the DSM):

- **Z63.0, Relationship Distress With Spouse or Intimate Partner**

  - I typically list this as a secondary diagnosis when I do couples therapy.
- **Z55, Academic or Educational Problem**
- **Z56.9, Other Problem Related to Employment**
  - The name of this one can be a tad misleading or confusing. It's basically a catch all term for "a problem with work". Being unemployed or being unable to work could fall under this Z code.
- **Z72.811, Adult Antisocial Behavior**
  - People commonly misunderstand and misuse the term "antisocial". Antisocial does NOT mean shy or someone who does not like to go out to bars, antisocial means engaging in criminal behavior. Thus, this Z code is assigned when a client is engaged in criminal activity.

Lesson 3 Summary (11 of 11)

2. Lesson Summary

In this very important lesson we learned about assessment and then diagnosis. Take away messages from the assessment section include the importance of using multiple assessment tools rather than one method and the importance of selecting the most appropriate measure for a particular situation.

Self-Check

Which assessment tool is very good at detecting someone who is trying to fake the test?

Answer

The MMPI

The diagnosis section in the second half of this lesson is crucial because you will be expected to know that information throughout the rest of the semester (and your entire career if you go into the mental health field).

Next we will finally start learning about the disorders themselves, starting with anxiety.

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<u>Assignment:</u>

- What's a possible reason why someone would "fake good" on a mental health or personality test?
- Why would someone would "fake bad" on a test?
- Explain in a little more detail why these individuals would be motivated to fake a test.

A variety of contexts could explain the phenomenon of faking mental health symptomologies. Faking, while not implicitly defined by our text, surrounds the feigning of symptomology that may fit within the subject's construct of illness. This may serve to make one appear more socially desirable or more detrimentally affected by their mental health illness. One method serves to obstruct the discovery of an undesirable pathology, while the other may serve to evidence pathology, albeit indirectly.

One is said to be malingering when they feign a greater degree of illness than what may be present. Our text illustrates the features of selective amnesia to avoid mens rea or evidence of the guilty mind, an underlying statutory requirement for finding of guilt during criminal prosecutions. Twenty to thirty percent of those accused of violent crime report features of selective amnesia to avoid the consequences of criminal behavior (Sue, 2021, p. 228). The forensic community responded. More and more, criminal investigators utilize specific interrogatories and procedures to detect feigned amnesia (see Zago et al., 2019; as cited in Sue, 2021 p. 228).

Attempting to fake a test serves the client well: Malingering clients in legal matters feign symptomology to enhance punitive and compensatory damage awards in civil lawsuits, alongside their more overtly criminal counterparts, who feign tests to avoid consequences for criminal conduct. Each, however, is noteworthy as it offers evidence of underlying pathology.

I am enamored by using the MMPI as a utility of purpose for the selection of law enforcement personnel. Within this clinical population, a prospective candidate has every reason to respond in socially desirable ways, presenting themselves most favorably to obscure the detection of personality features that could be detrimental to their performance on the job. This also applies to candidates for security clearance and sensitive government positions or those positions in the private sector requiring ultimate trust. In these cases, one rightfully expects the subject to present themselves in the most favorable light. Thankfully, there are objective measures like the MMPI, which has a specific version for police (Laguna, 2020).

Assignment 2: Projective Tests

Note that many people misunderstand projective tests - they are NOT meant to be used as a diagnostic tool. They are meant to spark insight and take therapy to a deeper level. Keep this in mind when you respond to this discussion question.

- What do you see in this inkblot?
- Also, what are your general thoughts about projective tests?
- Do you think they can be useful, or do you agree with the critics who say that they're questionable and outdated? How come?

Our scholarship surrounds this topic when issuing our task: projective tests are derived from Freud's psychoanalytic theory (85). Our text furthers the analysis to reveal the presumption that projective tests access the agencies of the mind to discover latent needs and motivations (85). Most notably, one can notice the differentiation in the naming of the measures, in particular, the Rorschach Technique. The Rorschach Technique is the tool of utility in the progression of the therapeutic relationship, but not analogous to the scientific method: they do not meet reliability and validity standards and limited cultural relevance (86). They should be used in conjunction with other assessment measures and should only be considered a tool of purpose to enrich the therapeutic environment.
Projective tests, to me, are not a utility of purpose for the design of what I imagine my future work to hold. They not scientifically reliable, so they would be difficult to administer and form hypotheses around as interpretation varies significantly. Now, having said that, if I were to put my therapeutic lens on (if only for a moment) projective tests offer a rich library of information concerning one's patient. They are rich talking points, which could serve to deepen the efficacy of any therapeutic model. From a diagnostic point of view, then, they would be especially useful as they would offer latent information drawn from the patients interpretation of conflict in their lives. This could be useful.

In the inkblot referenced, to me, reflects a fruit bat which feels a bit trivial but it seems just that easy.

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Another major advantage of the MMPI is that it is excellent at detecting whether or not someone is "faking" the test (Groth-Marnat, 2009, as cited in Sue et al., 2016) because it has very strong *validity scales*, which are subscales built into a test to detect faking or unusual response patterns that could render a person's profile invalid and thus unusable.

There are two kinds of faking:

- **Faking Good** (or "socially desirable responding") is when someone responds in a dishonest way to look better than they really are.
- **Faking Bad** (or "malingering") is when a person responds in a dishonest way to intentionally look mentally ill or worse than they really are.

Lesson 4: Anxiety Disorders (Part 1)

Introduction

We have completed going over the baseline information, and we are now in the disorders part of the course until the end of the semester (with the exception of the Suicide and Traumatic Brain Injury lessons, as they don't necessarily involve DSM-5 diagnoses). A major goal for a disorder-based lesson is to recognize what constitutes a clinical case of a given disorder and recognizing the differences between the various disorders in a given category.
Anxiety Disorders are the most common mental health disorders in the United States (Sue et al., 2016). Anxiety is such a broad topic that it is split into two lessons: this lesson will involve Generalized Anxiety Disorder (GAD), Social Anxiety, Specific Phobias, Agoraphobia, Panic Disorder, and Selective Mutism (which is not covered in the textbook) whereas the next lesson involves Obsessive-Compulsive Disorder (OCD), Hoarding Disorder, and Body Dysmorphic Disorder.

Lesson Objectives

After completing this lesson you should be able to:

1. Understand the difference between normal and pathological anxiety.
2. Differentiate among the various symptom categories of anxiety.
3. Explain diagnostic criteria for understanding the differences between the various anxiety disorders.
4. Remember the etiology, course, and treatment of anxiety disorders.

Lesson Readings and Activities

By the end of this lesson, make sure you have completed the readings and activities found in the Lesson 4 Course Schedule.

Anxiety Defined

Anxiety = A fundamental human emotion that produces bodily reactions that prepare us for "fight or flight"; anxiety is anticipatory because the dreaded event or situation has not yet occurred.

The term "fundamental" in this definition means that anxiety is something normal that everyone experiences. It's normal to feel some anxiety before a job interview or before giving a speech, and mild anxiety might even be beneficial in some ways as it may motivate you to prepare for that job interview or that speech.

However, anxiety crosses the line and becomes an **anxiety disorder** when it creates clinically significant distress or life functioning problems. For example, Person A has mild anxiety that motivates them to study for their exam and they end up doing well, while Person B has *clinical* anxiety that causes them to worry excessively about the exam, have insomnia the night before so that they're exhausted when they get to the exam, and then their mind goes blank when they start taking the test so they end up doing poorly.

Anxiety, like most of the disorders we will learn about in this course, manifests in various ways. In treating anxiety it can be helpful to determine the ways in which a person's anxiety manifests. Anxiety symptoms typically fall into one of the following four categories (Sue et al., 2010):

Affective (Emotions)

1. Examples of symptoms in this category include fear, apprehension, dread, and irritability.

Behavioral (Actions)

2. Smoking marijuana, avoiding an intersection where you had a car accident, and compulsively washing your hands are all physical, observable behaviors that clients may do in response to anxiety, or as a way to cope with anxiety.

Cognitive (Thoughts)

3. Examples of symptoms on this domain include worrying, having "racing thoughts" (thinking about a million things at once to the point in which you stress yourself out), having perfectionistic thoughts and unrealistic goals (such as "I *must* never make a mistake"), and catastrophizing (thinking about a minor setback or negative detail and blowing it out of proportion in your mind until you're really upset).

Somatic (Physiological)

4. Muscle tension, headaches, and sleep problems are examples of anxiety symptoms that manifest in your body.

So where does anxiety come from? Let's discuss etiological factors on the next page.

Etiological Factors

The following are some factors that are associated with anxiety (Sue et al., 2010):

Negative appraisal

- When you interpret events (including neutral or ambiguous ones) as threatening when in fact that likely are not. Anxiety tends to negatively skew a person's perception of reality; people with anxiety disorders typically see the world as a threatening place.

Anxiety sensitivity

- A personality variable in which a person is fearful of physiological changes in his or her body, and they tend to interpret physiological changes in their body (such as an increased heart rate) as a sign of danger. Anxiety sensitivity can sometimes trigger a panic attack, such as a client of mine who would have panic attacks after climbing up a tall flight of

stairs because she would be winded and would think she was passing out or having a heart attack.

Being female

- Women are significantly more likely to be diagnosed with mental disorders in general, including anxiety disorders. The explanation for this is a complex interplay of psychological, social/cultural, and biological factors.

Stressful or abusive childhood

- Being bullied, growing up in a conflict-filled household, and many other difficult childhood experiences are related to anxiety. Childhood trauma is an etiological factor for most if not all of the disorders we will learn about in this class.

External locus of control

- Someone with an *external* locus of control tends to believe that his or her life is determined by external forces in their environment, whereas someone with an *internal* locus of control feels more in control of their life as they see a strong causal relationship between what they do and the consequences of their actions (Rotter, 1990). An external locus of control is associated with anxiety because the person may feel that their life is random, which can be associated with worrying and other anxiety symptoms. Having a sense of self-control (or an internal locus of control) can be a protective factor against anxiety (Gallagher, Naragon-Gainey, & Brown, 2014). It's important for clients to feel in control of their anxiety, rather than feeling like their anxiety is in control of them; this is the case for most of the disorders we will learn about this semester.

Daily environmental stressors

- Examples would be having to deal with heavy traffic on your commute to work every day or having a noisy, inconsiderate neighbor or roommate.

Poverty

- Having a low socioeconomic status (SES) is a risk factor for many different mental health problems for many different reasons, including higher stress levels.

Note: This list of risk factors is not exhaustive; these are just some of the more common ones.
Next we will examine a common anxiety symptom that is a feature of all anxiety disorders: panic attacks.

Panic Attacks

An episode of intense fear accompanied by symptoms such as a pounding heart, trembling, shortness of breath, and fear of losing control or dying.

Panic attacks are quite common, as approximately 40% of the American population experiences panic attack symptoms at some point in their lifetime (Sue et al., 2016) and approximately 30% of American college students report that they have experienced a panic attack (Sue et al., 2010). One important thing to keep in mind about panic attacks is that a panic attack is *not* a codable mental disorder, it is a *symptom*. However, it is unique in that it is a symptom with criteria.

DSM-5 Criteria (American Psychiatric Association, 2013)

A discrete period of intense fear or discomfort in which **four** (or more) of the following symptoms developed abruptly and reached a peak within 10 minutes:

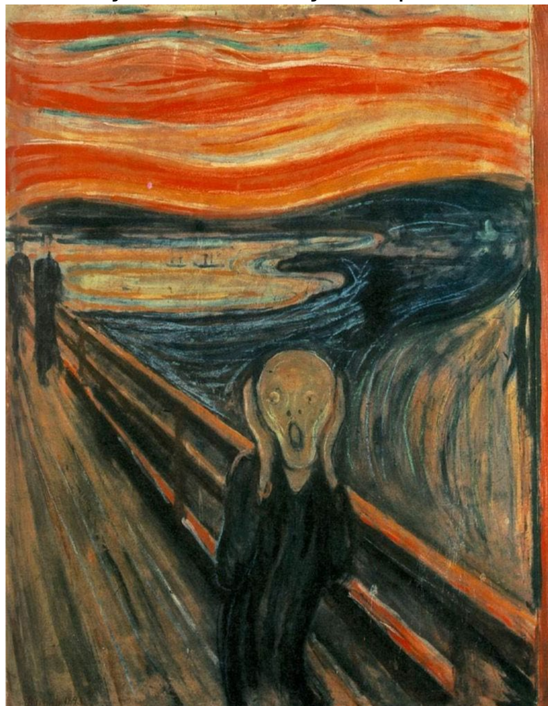
1. Palpitations, pounding heart, or accelerated heart beat
2. Sweating
3. Trembling or shaking
4. Shortness of breath/smothering
5. Feeling of choking
6. Chest pain or discomfort
7. Nausea or abdominal distress
8. Feeling dizzy, lightheaded, faint
9. Derealization/depersonalization
10. Losing control/feeling of going crazy
11. Fear of dying
12. Paresthesias
13. Chills or hot flashes

Most of these symptoms are self-explanatory, except for a few.

Derealization/depersonalization = A feeling of being disconnected from one's self or environment or experiencing life as if it's a dream-like state.

Paresthesias = A sensation of numbness or "pins and needles".

We'll talk more about these symptoms when we learn about dissociative disorders in Lesson 8.
One more thing to consider: just because someone has a panic attack it doesn't automatically mean that someone has an anxiety disorder (or any disorder, for that matter), and just because somebody has an anxiety disorder it doesn't automatically mean that they have panic attacks.



Edvard Munch's famous painting *The Scream* captures the visceral fear and distress associated with a panic attack.

Categories of Panic Attacks

Not all panic attacks are created equal; panic attacks fall into one of the three following categories (Sue et al., 2010) and it's very important to understand the difference between them.

- **Situationally-bound** panic attacks *always* happen before or during exposure to a feared stimulus.
- **Situationally-predisposed** panic attacks *usually or sometimes* occur when encountering a feared stimulus.
- **Unexpected or uncued** panic attacks occur spontaneously and without warning; they seem random.

Example: Suppose that a young woman has an extreme fear of crowded spaces, and she especially has problems with riding on a crowded subway or bus. If she has **situationally-bound** panic attacks then she has a panic attack *every single time* that she gets on a crowded subway or bus (I use a mnemonic device to remember this: a panic attack is "bound" to happen in the situation). However, if she has **situationally-predisposed** panic attacks then she *tends* to have a panic attack on a crowded subway or bus, but sometimes she is okay. If she has **unexpected or uncued** panic attacks then the subway example wouldn't necessarily apply because there is no "trigger" for her anxiety – it just seems random.

Self-Check

Which of the these three panic attacks (listed above) has the worst prognosis?

Unexpected or uncued, because in mental health treatment it's usually better when a clinician can trace a client's pathology to some kind of trigger. A trigger provides clues that you can use when treating someone. What is it about crowds that causes the person anxiety? Did they have a traumatic experience on a subway when they were a child? And so on. Also, if there is a trigger then the client can avoid the trigger or you can role play how to deal with the situation in therapy. On the other hand, randomness tends to be more distressing.

Generalized Anxiety Disorder

Generalized Anxiety Disorder, or GAD, is the most common anxiety disorder in the world (Sue et al., 2010). The term "generalized" is meaningful because the afflicted individual worries about many different things, rather than one specific thing like with a phobia. A clinically significant case of GAD reduces life functioning partially because the person spends so much energy worrying that it takes energy away from other things, which tends to impede performance and efficiency. Basically, GAD makes life much harder than it needs to be. Many of the worries associated with GAD are irrational or excessive in nature, such as worrying too much about trivial things such as getting the laundry done or what to get at the supermarket.

DSM-5 Criteria

A. Excessive anxiety and worry (apprehensive expectation), occurring more days than not for at least **6 months**, about a number of events or activities (such as work or school performance).

- In this class it is very important to pay attention to the length of time in which symptoms have occurred. As you can see, a person must experience the symptoms for at least 6 months in order to have a *clinical* case of GAD. You should remember from Lesson 3 that if a person has the symptoms for less than 6 months then the appropriate diagnosis would be “Generalized Anxiety Disorder, Provisional.” Also, note that worrying about a *variety* of different things is an important aspect of this disorder.

B. The person finds it difficult to control the worry.

- GAD is typically an ego-dystonic condition in that people know that their worrying is excessive, they just don’t know how to curtail it.

C. The anxiety & worry are associated with **three** (or more) of the following six symptoms (with at least some symptoms present for more days than not for the past 6 months). Note that only one item is required for children.

1. Restlessness or feeling keyed up or on edge
2. Being easily fatigued
3. Difficulty concentrating or mind going blank
4. Irritability
5. Muscle tension
6. Sleep disturbance (difficulty falling or staying asleep, or restless, unsatisfying sleep)

A few things to point out from criterion C. First, throughout this course you’ll note that criteria can be somewhat different for children. Only one of the six items on the list above would be clinically disruptive to a child so it’s easier for children to meet the criteria. Regarding #3, stress and anxiety have a negative influence on memory (Sue et al., 2010). Finally, sleep problems and anxiety problems are commonly comorbid. Many times people with anxiety have racing thoughts when trying to sleep, which makes it hard for them to sleep, and then they worry about not getting enough sleep… and you can see how this can create a negative spiral.

Social Anxiety Disorder

Individuals with Social Anxiety Disorder tend to be “thin skinned” and overly concerned about what others think of them; they typically have a fear of criticism and do not like being the center of attention (Sue et al., 2010).

The two most common fears held by people with social anxiety are…
public speaking and meeting new people (APA, 2013).

DSM-5 Criteria

A. Marked fear or anxiety about one or more social situations in which the individual is exposed to possible scrutiny by others. Examples include social interactions, being observed, and performing in front of others.

- The term “marked” means that the fear or anxiety is palpable to the point of being almost debilitating. It’s beyond normal fear.
- In children, anxiety must occur in peer settings.
  - For kids, it’s normal and even adaptive for them to be wary around strange adults, which is why the criteria specify that they must be anxious with peers.

B. The individual fears that he or she will act in a way or show anxiety symptoms that will be negatively evaluated.

- Many times the person is afraid of doing something humiliating or embarrassing, which goes back to the thin skinned issue mentioned above.

C. Exposure to the feared social situation almost invariably provokes anxiety, which may take the form of a panic attack.

- This means that the feared social situation is a problem for the person every time or almost every time, and it may be the trigger for a panic attack (which would be situationally bound or predisposed depending on frequency of occurrence).
- In children, fear or anxiety may be expressed by crying, tantrums, freezing, clinging, shrinking from unfamiliar people, or failing to speak in social situations

D. The feared social or performance situations are avoided or endured with intense fear & anxiety.

- The individual may avoid a situation altogether, which can reduce functioning, or the person may just experience an enormous amount of distress. I once had a client who was terrified of job interviews so he just didn't schedule them or he didn't go to them, which obviously impacted his ability to find a job. Making him comfortable with job interviews was the focus of treatment, and we role played mock job interviews in session in order to quell his anxiety.

E. The fear or anxiety is out of proportion to the actual threat.

- This refers to how the anxiety is irrational.

Types of Social Anxiety (Sue et al., 2010)

1. Performance
   - Public speaking, eating, playing a musical instrument, etc.
   - Essentially, the person is nervous about doing things in front of others.
2. Limited interactional
   - Asking somebody out on a date, going to a party, having a job interview, etc.
   - The person only has problems in specific social situations, but is okay in others.
3. Generalized
   - The person experiences extreme anxiety in most social situations.
   - This is obviously the worst kind and has the worst prognosis.

Social anxiety used to be called "social phobia" but the name was changed for the DSM-5 (APA, 2013).

Specific Phobias

As the name implies, a specific phobia is an extreme, clinical fear of a specific object or situation. Overall, phobias are the most common mental disorder in the United States (Sue et al., 2016). As you'll see on the list below, phobias are quite diverse – and it's common for people to have multiple phobias. Read over the formal diagnostic criteria in the mini DSM as we won't go over them here, but we will go over the following list of specific phobia categories. Be sure to know the differences between each category as this will likely be emphasized on the first exam.

Animal

- Examples:
  - Spiders
  - Birds
  - Dogs
- Generally has a childhood onset.
- Typically stems from having a bad experience with the animal in question, such as being bitten by a dog.

Natural Environmental

- Examples:
    - Heights
    - Storms
    - Water
- Fear of heights falls under this category, as some people get confused and think that it's in the situational category.

Blood Injection Injury

- Examples:
    - Blood
    - Needles
    - Invasive medical procedures
- This category is fundamentally different from the others as this phobia is associated with a unique physiological response (fainting). A treatment for the fainting aspect of this phobia is known as *applied tension*, and I would recommend reading about that in the textbook. This phobia is also more hereditary than the other categories (Sue et al., 2010).

Situational

- Examples:
    - Airplanes
    - Elevators
    - Tunnels
- Claustrophobia (fear of enclosed spaces) falls into this category.

Other

- Miscellaneous fears that don't fit into the other categories.
    - Examples
        - Choking
        - Vomiting
- In children, a fear of loud sounds or costumed characters.
    - Have you ever seen a child at Disney World freaking out when they meet Mickey Mouse? The child may have an "other" phobia. To a five year old that huge Mickey Mouse costume is like the size of a forklift!

Treating Phobias

Closely read about **cognitive restructuring, modeling therapy**, and **systematic desensitization** in the textbook.

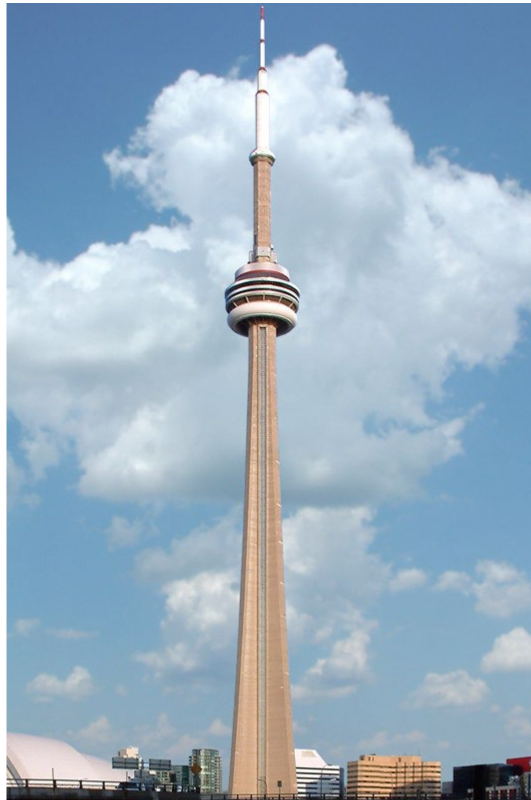
One difference between systematic desensitization and exposure therapy is that systematic desensitization involves using **mental imagery** in a therapist's office to reduce the client's anxious response to the stimuli (exposure involves exposing the client to the stimulus in real life, although systematic desensitization may progress to real life exposure eventually). A typical course of treatment involves having the client imagine imagery in a gradual order from least threatening to most threatening, kind of like gradually getting used to a chilly swimming pool.

Let's define exposure therapy and then we'll go through an example of it as a class, using my own vacation photos from the CN Tower in Toronto, Ontario, Canada.

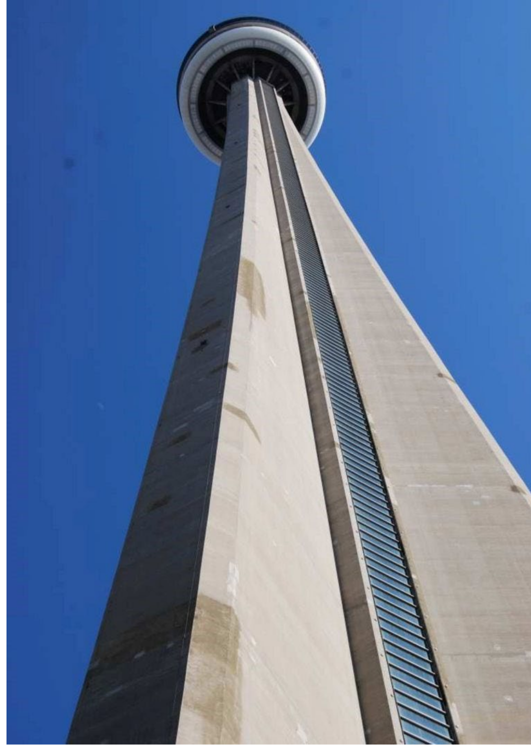
Exposure Therapy

Treatment that involves introducing the client to increasingly difficult (real life) encounters with a feared situation.

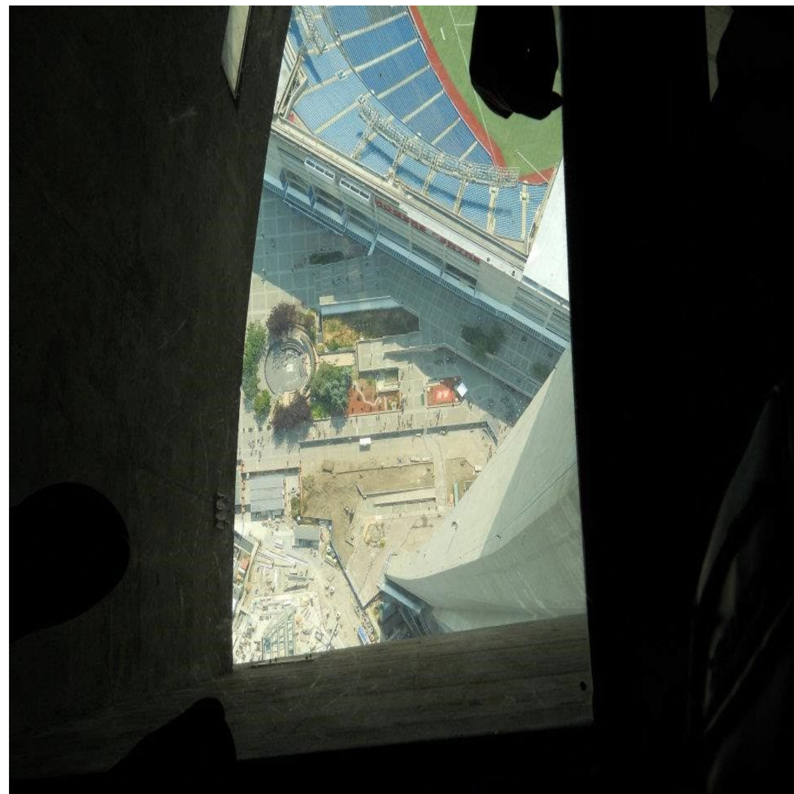
Imagine that you and I are working together to treat a client who has a severe case of acrophobia, or fear of heights. An ideal place to take them would be the CN Tower in Toronto, which at the time of this writing is the 2nd tallest man-made structure in the world (approximately 550 meters tall, or 1,800 feet). First, I would have the client (in as relaxed a state as possible, while being empathetic and supportive) just look at the CN Tower.



I would have the client do this a few times until he or she feels relatively okay about it.



The next step would be to actually get in the elevator and go up to the top, when the client is ready of course.



At the top of the CN Tower is a glass bottom floor. I would first have the client approach the glass bottom floor. Finally, while being as supportive and empathetic as possible, the last step would be for the client

to stand in the middle of the glass bottom floor and look 1,800 feet straight down into the stadium where the Toronto Blue Jays play.

By this point the client should be able to cope with his or her acrophobia.

Agoraphobia
An intense fear of being in public places where escape or help may not be readily available.
DSM-5 Criteria

Let's begin by breaking down the DSM-5 criteria, which contain the definition of the condition:
A. Marked fear or anxiety about **two** (or more) of the following situations:

1. Using public transportation
2. Being in open spaces (e.g., parking lots, marketplaces, bridges)
3. Being in enclosed places (e.g., shops, theaters, cinemas)
4. Standing in line or being in a crowd
5. Being outside of the home alone

Note: It can only be a *clinical* case of agoraphobia if the person has at least two of these five problems.
B. The individual fears or avoids these situations because of thoughts that escape might be difficult or help might not be available in the event of developing panic-like symptoms or other incapacitating or embarrassing symptoms (e.g. fear of falling in the elderly; fear of incontinence).
C. The agoraphobic situations almost always provoke fear or anxiety.

- This fear or anxiety can manifest as a panic attack.

D. The agoraphobic situations are actively avoided, require the presence of a companion, or are endured with intense fear or anxiety.

E. The fear or anxiety is out of proportion to the actual danger posed by the agoraphobic situations and to the sociocultural context.

- Like with most (or all) anxiety disorders, the person's fears are irrational and/or excessive

F. The fear, anxiety, or avoidance is persistent, typically lasting for **6 months** or more

Note: Agoraphobia is diagnosed irrespective of the presence of panic disorder. If an individual's presentation meets criteria for panic disorder and agoraphobia, both diagnoses should be assigned.

This last point refers to how agoraphobia and panic disorder were diagnostically linked in the DSM-IV. The diagnosis used to be called "Agoraphobia without history of panic disorder" (American Psychiatric Association, 2000), but now the two disorders have been separated. However, they are commonly comorbid (APA, 2013).

Agoraphobia can be a debilitating anxiety disorder that greatly reduces functioning because of the afflicted person's reluctance to leave the home; it can prevent them from working, shopping, or even going to a therapist's office to have their agoraphobia treated. With the agoraphobic clients I have treated in my career, simply making it to therapy in and of itself was part of the treatment. I had one client whose husband brought her and waited in the waiting room because she was too nervous to leave the home alone.

Panic Disorder

A condition in which a person experiences recurrent, unexpected panic attacks (that can be worse than a panic attack associated with other disorders) followed by apprehension or dread about future panic attacks and/or changes in behavior to avoid future attacks.

Panic disorder was formerly known as "Panic Disorder Without Agoraphobia" in the DSM-IV. The essence of the condition is a deep, profound sense of dread. The clients I have worked with who have a true case of panic disorder have such a deep sense of dread that it almost becomes the driving factor in their life.

For example, I should mention one diagnostic pitfall with this condition: sometimes a therapist will learn that a client has panic attacks and will automatically diagnose them with panic disorder. This is a mistake because a client doesn't have panic *disorder* just because they have panic attacks. Panic disorder is a specific, unique condition with more involved than just panic attacks.

DSM-5 Criteria

An abridged version of the DSM-5 criteria, with my commentary, appears below:

A. Recurrent, unexpected panic attacks

- By the "letter of the law", someone with panic disorder typically has unexpected or uncued panic attacks, which as you learned earlier tend to be the worst kind.

B. At least one panic attack has been followed by 1 month (or more) of one or both of the following:

1. A persistent concern or worry about having additional panic attacks or their consequences (e.g., losing control, having a heart attack, "going crazy").
2. A significant maladaptive change in behavior related to the attacks (e.g., behaviors designed to avoid having panic attacks, such as avoidance or exercise or unfamiliar situations).

C. The disturbance is not attributable to the physiological effects of a substance or medical condition

  - There are certain drugs (especially MDPV or "bath salts") that can trigger severe panic attacks and this should be ruled out.

As an example, I once had a college student client with panic disorder and she experienced a profound sense of dread about getting bad grades; she once said that her GPA "defines her existence". This was fueled by perfectionism and an intense fear of failure partially due to unrealistically high expectations and demands placed on her by her overprotective parents and competitive siblings. The client reported having panic attacks at unexpected intervals and at unexpected times, but they typically involved something related to school such as studying or thinking about grades; she would frequently have panic attacks during exams and that obviously hurt her performance quite a bit. I used insight-oriented psychodynamic techniques to illuminate the link between her upbringing and her current pathology combined with cognitive techniques to point out how dangerous it was for her sense of self to be derived from her grades (which creates a great deal of pressure for her) and a series of relaxation techniques such as guided visualization. Thankfully, by the end of the semester her panic attacks greatly reduced in frequency and intensity and she was able to study and take exams without such a sense of fear.
And now for something completely different: the Guess the Disorder game. You'll see a picture of a famous person and you have to guess which disorder they have (don't worry, this isn't graded – it's just a way of applying the material from this lesson).

Guess the Disorder
Click on the image to see the disorder

Uma Thurman: Claustrophobia

Amanda Seyfried: Social Anxiety Disorder

Johnny Deep: **Coulrophobia (fear of clowns)**

I have a funny story about this, from my high school reunion (which is certainly an event that's related to abnormal psychology). Some schools have a kid who is the "class clown", or a kid who tries to goof around and be funny. Did you have a class clown at your school when you were growing up? Heck, maybe you *were* the class clown! Anyway, when I went to my high school reunion I found out that the class clown… became a clown! I'm completely serious; the class clown got a job as a clown for Ringling Brothers circus.

<u>Selective Mutism</u>
For some reason Selective Mutism is not covered in the anxiety disorders chapter of the textbook, yet it is an underrated condition that is more common than people realize so it is important to cover. Selective mutism used to be in the "Childhood Disorders" section of the DSM, but in the DSM-5 it was moved to the anxiety section (American Psychiatric Association, 2013). This move makes sense because anxiety is the major culprit with this condition, not speech.
DSM-5 Criteria (APA, 2013)

A. Consistent failure to speak in specific social situations in which there is an expectation for speaking (e.g., school) despite speaking in other situations.

B. Interferes with educational/occupational achievement or with social communication.

- So the condition, which is essentially a problematic way of coping with anxiety, causes functioning deficits for the afflicted individual (such as lower grades or a lack of friends).

C. Duration of the disturbance is at least 1 month, and is not limited to the beginning of school.

- This caveat was placed in the diagnostic criteria because it's normal for children to be really shy at the beginning of school, and the 1 month criterion is in place to make sure that the aversive lack of speech is not simply due to a short term stressor.

D. Failure to speak is not attributable to a lack of knowledge of, or comfort with, the spoken language required in the social situation.

- In other words, the afflicted individual can speak perfectly fine (although they may have a slight delay in some cases due to lack of use or practice) but they choose not to out of fear/anxiety.

E. Rule out communication disorders, autism spectrum disorders, and psychotic disorders.

The clip below conveys the story about a little girl with selective mutism named Morgan:
Length: 00:06:09

SPEAKER 1: In this morning's American family, a childhood condition that has confused doctors and confounded parents for many years. It's known as selective mutism, and it affects hundreds of thousands of kids who can speak perfectly well when they're at home but can't talk at all when playing with friends or attending school. Good Morning America's Ann Pleshette Murphy has more about one family's struggle with this disorder.
[MUSIC PLAYING]
ANN MURPHY: Imagine a world where anyone and any place outside the comforts of home elicits fear and anxiety so paralyzing you shut down and physically cannot speak. That's the reality for seven-year-old Morgan Gaile.
VINCENT GALIE: She describes it as the words get stuck in her toes, so it must be just nerve-wracking to not be able to talk when you want to.
ANN MURPHY: But with her family, Morgan is a totally different child.
MORGAN GAILE: And I'm seven years old and my tooth is loose.
VINCENT GALIE: She's the loudest kid in the house, running around, you know. A normal kid, but very loud.
MORGAN GAILE: Pizza!
COLLEEN GALIE: She's a chatterbox. She loves to talk. She loves to tell me about her day at school, all her friends.
MORGAN GAILE: This girl [INAUDIBLE] she got stung by these bees, and the one girl got sick.
ANN MURPHY: Morgan suffers from selective mutism which, according to a recent study, is almost twice as common as autism. Unaware of this disorder, her parents initially saw it as defiance.
COLLEEN GALIE: It's very frustrating because how she is at home, and to hear that she's not talking in school. I thought she was doing it on purpose.
VINCENT GALIE: You feel really bad for yelling at her for not talking, to find out that she can't talk.
ELISA SHIPON-BLUM: They feel afraid. Many of them say the words won't come out, their voice box feels like it's closing up, their stomach hurts, their head hurts, their body won't let them speak.
ANN MURPHY: Dr. Elisa Shipon-Blum runs a treatment center in Jenkintown, Pennsylvania where she's treated Morgan for the last three months. The doctor stresses that selective mutism is the result of

extreme anxiety, usually in group settings or around strangers. But it is very different from everyday shyness.
ELISA SHIPON-BLUM: The difference between shyness and selective mutism is ability to function. Shy children function. Children with selected mutism have a difficulty socially, emotionally, academically.
ANN MURPHY: Morgan's mutism makes every class a challenge. In reading, she uses occasional gestures to communicate.
ANN DIETER: What do you think, Morgan? Point to it. Which one?
ANN MURPHY: In art class, she may respond but can't ask a question or make her needs known.
ANN DIETER: How many eyes am I going to see? Rachel?
RACHEL: Two.
ANN DIETER: Two.
If I want more than one bird, do I want to make a gigantic face up here?
ALL: No.
ANN DIETER: No, because then I couldn't fit the other birds in.
The primary thing that you're working on in first grade and second grade is reading. And it's difficult to assess where she is in reading if she's not reading for me.
ANN MURPHY: This widely misdiagnosed disorder is often ignored or dismissed as just a phase, leaving kids to suffer in silence.
ELISA SHIPON-BLUM: Because if I ask you a question and you don't reply, Morgan, and you just sit there, I don't know what you're thinking.
ANN MURPHY: The first goal of treatment is not to get her to talk but to help Morgan combat her anxiety and begin to engage socially in nonverbal ways.
COLLEEN GALIE: He's cute. Whichever one you want.
ANN MURPHY: In a local store, we see improvement. Morgan hands money to the cashier, something she could not possibly have accomplished a few months ago. But when mom pressures her to wave goodbye, Morgan shuts down.
COLLEEN GALIE: There you go.
SPEAKER 2: Thanks very much.
COLLEEN GALIE: Thank you. Can you give him a hand twist, Morgan? Can you just wave to him?
ANN MURPHY: Morgan still has a long way to go. Seen here on home video shot by her parents, she has no problem asserting herself with her siblings.
MORGAN GAILE: Don't take it apart if you don't know how to put it back together.
ANN MURPHY: But on our visit with our cameras rolling, Morgan clammed up while playing with her siblings. And though she agreed to draw pictures with me, even simple questions elicited blank stares.
So do you want me to draw another kitty cat?
VINCENT GALIE: It is slow. It's small steps, a lot of small steps to equal one big step.
ANN MURPHY: Morgan's progress has been painstaking, but it hasn't dimmed her parents' hopes.
COLLEEN GALIE: I say, maybe by the end of this year, you'll be talking, and she just smiles. So I can see a difference in her like that. I feel like she wants to start talking.
ANN DIETER: You're going to read real hard words today.
SPEAKER 1: And Ann is joining us now. When you look at this little girl, you can understand there's a paralysis of fear because you told me that. But she doesn't look scared.
ANN MURPHY: This is a coping mechanism. In fact, the anxiety is dealt with by not speaking, so it reduces the anxiety. So you aren't going to see a child who looks terrified of being in the classroom.
SPEAKER 1: Do they grow out of it?

ANN MURPHY: Some of them will, but they will do that by developing other coping mechanisms, and frankly, being miserable. So why have them go through that? Some of them will, but others will develop anxieties as adults that, again, really can be paralyzing and terrible.
SPEAKER 1: But the way you treat it is to try to deal with the underlying anxiety, not with the speech itself which is just a manifestation of that anxiety?
ANN MURPHY: Exactly. You want to reduce the anxiety, you want to boost their self-esteem and confidence, and then you want to teach them some non-verbal ways of making their needs known and communicating. And last, hopefully the words will follow. But it takes a long time, so parents have to be really patient.
SPEAKER 1: Do we know what causes it?
ANN MURPHY: They don't really know except that, first of all, there's a genetic factor. A lot of them have a family history, and they know that it usually happens when they are first introduced into a social situation, which is usually preschool or school.
SPEAKER 1: All right. Ann Pleshette Murphy, thanks.
ANN MURPHY: Thanks.

Lesson Summary

Anxiety is very common (about a third of all Americans will meet the criteria for an Anxiety Disorder at some point in their lifetime; Sue et al., 2016) and it manifests in myriad ways. Yet, it is also a very treatable condition so there is hope for afflicted individuals.
By this point you should be familiar with the anxiety disorders from this lesson; the subsequent lesson will feature more anxiety disorders, which fall under the category of "Obsessive-Compulsive and Related Disorders".

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Assignment: Part 1

Make a substantive post or reply:
- What are your thoughts about celebrities coming forward about having mental illness?

- What are some potential benefits of that?
- Can you think of any potential downsides?

The celebrity, as a status symbol, encompasses a style or type of idol to many of those in the consuming public, it seems. Celebrities endorse brands, compel us to change the way we talk, think, or even dress, and seem to generally be influential in society when they carry messages through their celebrity to the mass public.

Our assignment contemplates a substantive post that considers these features alongside our individual thoughts about celebrities coming forward about their own encounters with mental illness. I can think of one case that I encountered in my former business that seemed to encompass this style of self-disclosure, albeit with an enormous amount of stigmatization.

Lee Thompson Young (1984-2013), commonly known as Jett Jackson, was African American and male. He was close with Angela Harmon, a co-star on *Rizzoli & Isles*, and his agent, John. I knew his sister, Tamu Lewis, and mother, Velma Love, quite well. Lee, however, I never had the opportunity to get to know: he committed suicide in Los Angeles in August of 2013, and I met his family in response to that event.

Lee struggled. Significantly. He felt restrained from coming forward and talking publicly about his struggles. He was diagnosed and treated for bipolar I disorder. I shouldn't discuss features of his illness even posthumously, but it was commonly known that he had a continuing obsession with bees and the thought that they were constantly buzzing in his ear. This didn't feel like bipolar disorder to me, but I am not and was not trained to make those determinations.

Nevertheless, he feared that his disclosure would lead to the end of his career on *Rizzoli & Isles*. To this end, more celebrities should come forward and discuss their encounters and feelings surrounding mental illness. It's important. As I referenced above, society seems to place a high value on the messaging received from celebrity sources, so accordingly, one might rightfully believe that if that group is outspoken in support of proactively addressing mental health concerns, the potential benefits, I believe, outweigh the potential downsides.

Society benefits from conversations with narratives from this group because of the high value the messages carry and the heavy influence they accordingly have. When properly sourced and accurately represented, this could serve as a massive conduit of information to destigmatize the mental health landscape and potentially lead others who "suffer in silence" to hope.

There are risks, however. Celebrities, while they have enormous messaging moxie, also tend to be caught up in scandalous affairs (see, generally, Kanye West) and behavior that clearly includes afflictions of the mental health variety. Celebrities who relay information inaccurately could lead followers astray and actually pollute the highly positive message carried forward by NAMI and others.

However, I believe that celebrities should be talking about this. So did the Love/Young families, who we helped launch the Lee Thompson Young Foundation in 2014 to carry this message forward.

<u>What are some possible explanations for why women are more likely to be diagnosed with an anxiety disorder?</u>

Anxiety disorders are the most prevalent mental health condition, impacting nearly 20% of adults in the United States annually (Sue, 2021, p. 134). Disorders of this variety, as you would imagine, feature anxiety defined as a condition that produces tension, worry, and physiological reactivity (pp. 134-135). Anxiety can surround fear and stress, but its etiological models encompass multimodal dimensions: biological, sociocultural, social, and psychological (p. 135). Each seems to interact with the person differently. When these interactions produce an effect upon the person that interrupts their daily life, they are said to have an anxiety disorder. (Trethewey, 1999)

While this entirely simplistic defining view doesn't encompass the litany of anxiety spectrum disorders—or disorders that feature anxiety as a core characteristic, it does capture the essence of the prevalence of anxiety in society.

Naturally, one may attempt to explain why anxiety seems to be discriminatory: women are more likely to be diagnosed with an anxiety disorder than their male counterparts (p. 134). My lens tends to view this phenomenon through the social and biological dimensions. Let's discuss each.

Socially, women work alongside men every day, yet they are also highly disciplined in society (see Tretheway, 1999). I encountered this view of women in their employment environments, and I closely examined the relationship Tretheway discusses between features of their unique femininity and the features of their more masculine male counterparts, which seem to serve to discipline them. Discipline, in this context, doesn't mean sending women to the corner. It means telling women what is socially acceptable to wear, how to act in social situations, and the normative responses expected from women.

Women also serve to replicate this style of discipline—they agree to it. I often write: consider a convenience store with a sign that reads, *"No Shirt, No Shoes, No Service."* Imagine a man walks into the store without a shirt on. I would suppose that man, under this thinking, would be disciplined to follow the norms. Yet, in this context, would a woman? I would rather doubt it, regardless of whether the clerk is female or male.

While this may seem like a rant, it's not. When women are told by society how to act (behavioral), how to think (cognitive), and, to certain degrees, how to feel (affective), they fall right into the center of a situation primed for psychological discomfort. If they don't act, think, or feel properly and in context with their environment, they are seen as emotionally unstable and volatile, or worse.

One must also take a reasonable biological view of gender from this perspective. From an evolutionary standpoint, women have traditionally had a specific role. Through this role, women also have a built-in, significant degree of security concerns. When men are traditionally responsible for hunting and gathering, so to speak, women are then dependent upon their male counterparts for survival. This must be an evolutionary feature of anxiety disorders' gendered etiologies—although it seems I could write an entire thesis on the subject.

Women are also more likely to engage in emotional labor and emotional work then their male counterparts (Lamb, 2024). When taken together, women are clearly primed for feelings of inferiority and

no doubt the corresponding and varying degrees of anxiety that accompanies that status. They are disciplined and accordingly controlled, and through these two minimal examples of the gendered view of anxiety disorders, they are uniquely predisposed to them—especially when society sets the normative expectation, through a minority of women, that this should change.

My hope is that we correct this from a gendered point of view so that our societies are not breeding grounds for female-targeted anxiety by virtue of how we, as men, talk, act, and relate to our feminine human companions and counterparts.

Lesson 5: Anxiety Disorders (Part 2)

Introduction

This lesson is a continuation of the Anxiety chapter, with a focus on a family of anxiety-related disorders known as "obsessive-compulsive and related disorders."

One thing that these disorders have in common is that they are essentially unhealthy or problematic coping mechanisms (Sue et al., 2010). There are many etiological factors associated with these disorders, and I would recommend paying attention to the psychological and social/sociocultural etiology dimensions in the textbook, but one particularly potent factor is neurotically overcompensating for a lack of safety or security, sometimes by attempting to control something that is inherently uncontrollable or difficult to control.

For example, a person who had an abusive and chaotic childhood may crave a sense of control as they get older and they may develop a washing or checking ritual as a way to address that neurotic need. We will now examine each of these disorders in turn, starting with OCD.

Lesson Objectives

After completing this lesson you should be able to:

1. Explain diagnostic criteria for understanding the differences between the various obsessive-compulsive and related disorders.
2. Understand the difference between sub-clinical and clinical obsessions and compulsions.
3. Remember the etiology, course, and treatment of these disorders.
4. Apply knowledge to real world examples.

Lesson Readings and Activities

By the end of this lesson, make sure you have completed the readings and activities found in the Lesson 5 Course Schedule

Obsessive-Compulsive Disorder (OCD)

Obsessive-Compulsive Disorder = A condition characterized by intrusive, repetitive anxiety-producing thoughts or a strong need to perform acts or dwell on thoughts to reduce anxiety.

OCD is a good example of an ego-dystonic condition in that the person typically realizes that their obsessions and/or compulsions are a problem – they simply don't know how to stop them. However, there are some rare cases in which OCD is ego-syntonic, and in these more serious cases the

obsessions and/or compulsions can be psychotic in nature (e.g., a person actually believes that they might bring their dead mother back to life if they obsessively clean the house); in these cases then the “with poor insight” or “with absent insight” specifier is appropriate (APA, 2013).

DSM-5 Criteria (Paraphrased)
The presence of either obsessions or compulsions that cause marked distress, take more than 1 hour per day, or significantly interfere with functioning.

To meet the criteria the client can only have just obsessions or compulsions, but most clients have both. The 1 hour criterion is there because if someone is spending more than an hour per day on their pathology then that certainly reduces their life functioning (and energy). It’s very important to understand what constitutes a *clinical* obsession or compulsion:

Clinical Obsessions
The client must have ***both*** of the following:

1. Recurrent & persistent thoughts, urges, or images that are experienced, at some time during the disturbance, as intrusive & unwanted and that in most individuals cause marked anxiety or distress.
    - A clinical obsession is not just a thought; as you can see by this definition it can be an urge or an image as well. For example, a new mother can have obsessive thoughts about harming her baby, an urge to harm the baby, or can have intrusive images in her mind of her baby dead or injured. Finally, a clinical obsession is usually very unpleasant but the client does not know how to stop it.
2. The individual attempts to ignore or suppress such thoughts, urges, or images, or to neutralize them with some other thought or action (i.e., by performing a compulsion)
    - The person tries to stop the problem and cannot (almost like an addict who can’t stop their addictive behavior), and/or they do something irrational in a neurotic attempt to quell the anxiety.

Clinical Compulsions
Once again, the client must have ***both*** of these to be in the clinical range:

1. Repetitive behaviors (e.g., hand washing) or mental acts (e.g., counting) that the person feels driven to perform in response to an obsession, or according to rules that must be applied rigidly.
    - The person can be engaging in the behavior as a way to reduce the anxiety from the second criterion above, and/or they may be very rigid about the compulsion. For example, someone may have a counting ritual and if someone else disturbs them they may get irritated with the person and feel compelled to start over from the beginning.
2. The behaviors or mental acts are aimed at preventing or reducing distress, or preventing some dreaded event or situation; however, these behaviors or mental acts either are not connected in a realistic way with what they are designed to neutralize or prevent, or are clearly excessive.
    - The ritual is something that reduces their anxiety, so deviating from the rigid performance of the ritual is very threatening to them. This criterion also addresses the irrational nature of the compulsion. For example, someone might perform a hand washing compulsion in order to prevent their father from dying of cancer. The two are obviously not logically connected, but the behavior makes the client feel better in a neurotic way. This example stems from a clinical case I had in which a young woman washed her hands over 50 times

per day because her father developed cancer and the hand washing was a way to quell her anxiety about her father's health. However, the client's hands were cracked, raw, and bloody and she spent so much time and energy on her compulsion that she was doing poorly in her classes.

In an extreme form (i.e. if someone has lengthy, very time consuming compulsions or obsessions to an extreme, psychotic degree) OCD can be the most debilitating of all anxiety-related disorders (Sue et al., 2010).

Next we will examine a disorder that was not in the DSM-IV (APA, 2000) but was added as an official disorder in the DSM-5.

Hoarding Disorder

Most of you are probably familiar with what hoarding is, but let's look at the definition so that we're all on the same page:

Hoarding Disorder = A condition involving congested living conditions due to accumulation of items and distress over the thought (or threat) of discarding them.

With hoarding, the person uses the stuff they hoard as a sort of psychological security blanket, almost like a teddy bear for a child. This is why it's so difficult for them to get rid of the stuff – because the stuff usually represents their sense of security. Let's now think critically about the diagnostic criteria.

A. Persistent difficulty discarding or parting with possessions, regardless of their actual value.
   - Many times the "stuff" is just useless junk, but it has neurotic psychological value to the afflicted individual.

B. The difficulty is due to a perceived need to save the items and to distress associated with discarding them.

C. The difficulty discarding possessions results in the accumulation of possessions that congest and clutter active living areas and substantially compromises their intended use. If living areas are uncluttered, it is only because of the interventions of third parties (e.g., family members, cleaners, authorities).
   - Criterion C refers to the life functioning deficit associated with hoarding. Sometimes the accumulation of items can lead to safety or sanitary concerns as well.

Specifiers for Hoarding Disorder

With excessive acquisition: If difficulty discarding possessions is accompanied by excessive acquisition of items that are not needed or for which there is no available space.

- In other words, the person keeps accumulating stuff even though there is no more room. This kind of hoarding is worse than a kind without this specifier.

With good or fair insight

- This is an ego-dystonic case of hoarding with a better prognosis.

With poor insight

- In this case the person is *mostly* convinced that beliefs and behaviors are not problematic despite evidence to the contrary. So the case has both ego-syntonic and ego-dystonic aspects and the person still has a glimmer of rationality.

With absent insight/delusional beliefs

- In this case the person is c*ompletely* convinced that their hoarding is not a problem. These are the worst cases of hoarding with the worst prognosis, and cases with this specifier may be psychotic in nature.

Brainstorm Ideas

Think about these questions as you generate thoughts and ideas in preparation for the Lesson 5 Discussion Forum questions found at the end of the lesson.
Hoarding is a popular mental disorder in the media.

- What are some reasons why hoarding gets so much media attention?
- On a related note, what are some potential, specific reasons why somebody would engage in hoarding?

Body Dysmorphic Disorder

Body Dysmorphic Disorder = Preoccupation with an imagined defect in appearance in a normal-appearing person or an excessive concern over a slight physical defect.

Given this description, the person may have nothing wrong with them or they may have a slight physical defect such as a birth mark but then think it's much worse than it really is.

Body dysmorphic is a sad condition in which a person tends to have low self-esteem or even self-hatred because of a body part or feature that they are obsessed with. It's kind of like OCD but focused on a part of your body. The disorder may be underdiagnosed because clients may be unwilling to bring attention to the "problem" (Sue et al., 2010).

The afflicted individual may also experience or engage in the following:

- Frequent mirror checking
- Embarrassment and self-loathing
- Over-concern about what others think
- Frequent requests for cosmetic surgery and/or repeated cosmetic surgeries
  - Sadly, cosmetic surgery does not make the person feel better because it does not address the real issue – which is the underlying anxiety

In terms of treatment, body dysmorphic disorder tends to be chronic and it may have the lowest success rate of any mental disorder. Phillips, Pagano, Menard, and Stout (2006) found that only 9% of body dysmorphic patients had full remission while 21% had partial remission. A large majority of the patients did not improve.

Trivia Question:

Can you name the pop star who many psychologists believe had body dysmorphic disorder?

Brainstorm Ideas
Think about these questions as you generate thoughts and ideas in preparation for the Lesson 5 Discussion Forum questions found at the end of the lesson.

- Do you agree that Michael Jackson may have had body dysmorphic disorder?
  - If so, what are some of the signs?
- What are some potential reasons why treatment for this disorder has such a low success rate?

Assignment 1:

Body dysmorphic disorder, BDD, surrounds a condition of preoccupation with a perceived physical defect or excessive concern over a minimal defect surrounding physical appearance (Sue, 2021, p. 162)The Diagnostic and Statistical Manual of Mental Disorders Fifth Version, or DSM-5, delineates three criteria that surround the disorder and relate to preoccupation with the physical defect, repetitive behaviors such as checking one's appearance or applying measures to conceal the flaw, and the perceived defect or flaw causing significant distress or impairment in life activities as a result (p. 162).

Our text discusses commonalities of concern that surround individuals who present with clinically supportive symptomology of the diagnosis. They surround *obsessive* thoughts surrounding the shape of the nose, face, or eyes (p. 162, see generally Figure 5.10) yet commonly include perceived defects surrounding the skin, eyes, face, stomach, teeth, breasts, buttocks, and penis.

Patients suffering from BDD maintain strong delusions or false beliefs about their bodies and regard their defect with embarrassment, loathing, and an obsession with the notion that others may be making generalizations about them as a result of their observations of the false belief. Regarding prevalence, 0.7 to 2.4 percent of samples possess features within the criterion in their daily functioning, yet prevalence has been found as high as 13 percent under those hospitalized for treatment. An astonishing 60% of patients experience a comorbid anxiety spectrum condition and 38 percent experience a more specific form of social anxiety (see Mufaddel, Osman, Almugaddam & Jafferany, 2013 as cited in (Sue, 2021, p.

162). The disorder is chronic and difficult to treat due to its cooccurrence with depression and substance abuse (p. 162-63). Treatment prognosis is grim and highly challenging and most effective in those with an internal locus of control and internally motivated desire to change.

Considering Michael Jackson, one must assume information that is only within the context of media messages and his own disclosures about his struggles. Jackson was overly concerned with his image, in particular his skin, yet his obsession could be argued to surround his skin condition, which was defined as vitiligo, the rendering of a non-contagious condition that causes white patches on the skin.

BDD surrounds conditions of the imagined variety. I would argue that Jacksons disposition surrounding bleaching of his skin, is not representative of the *imagined* context or *false belief* and *delusional* variety that the DSM-IV categorizes as akin to the condition. Indeed, he was obsessed with his skin condition, but does BDD work to explain his obsession. I argue no, in that his condition was not based on an imagined or perceived flaw; he may have rightfully seen his condition as socially debilitating and taken measures to correct it on his own.

The guiding definition surrounding BDD is twofold: preoccupation with a *perceived* physical defect OR an excessive concern over a *slight* physical defect. Objectively, one must measure whether his skin condition was more than slight as it was not perceived: he actually had an autoimmune disease.

Considering the imagery of vitiligo, which one can easily source through a Google search, reveals how a patient could rightfully see their condition as more than slight. Accordingly, Jackson is not a candidate for BDD in my opinion, rather a candidate for other disorders in the anxiety spectrum including obsessive compulsive disorder and social anxiety disorder.

Patients properly classified as BDD experience low success rates in therapy and low remission rates because of the cooccurrence of anxiety, substance use, (p. 162) and without a doubt, depression. While trying to stretch my mind a bit, patients who are open to treatment and have the internally motivated desire to change their thoughts surrounding their concern, may have better outcomes than others. I would argue that Jackson, through his rhetoric and prose, attempted unsuccessfully to mask his autoimmune disorder which in itself could be revealing of other psychologically related turmoil.

Class, if I'm wrong on any of this, give me a hand. I've never applied the logic of the DSM-IV to a case, accordingly, I only have the lens of the guiding criterion, my observations, and the research in support of each, to draw from.

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A Treatment for OCD & Related Disorders: Response Prevention

Response Prevention = A treatment in which a person with OCD is prevented from performing a compulsive behavior.

For example, imagine that a person has a compulsive cleaning ritual. After building up to it in therapy the therapist may prevent the person from engaging in their cleaning ritual while being supportive and processing their emotions as the client resists engaging in the behavior.

Lesson Summary

In this lesson we have explored the etiology, diagnosis, and treatment of mental disorders that fall into the obsessive-compulsive and related category. These disorders can be very serious and difficult to treat, but there have been advancements in treatment so there is hope for the future (Sue et al., 2016). And now on to Exam #1…

The first exam will cover Lessons 1 through 5 and includes the following topics: Abnormality, Legal & Ethical Issues, Assessment & Diagnosis, Anxiety Part 1, and Anxiety Part 2.

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