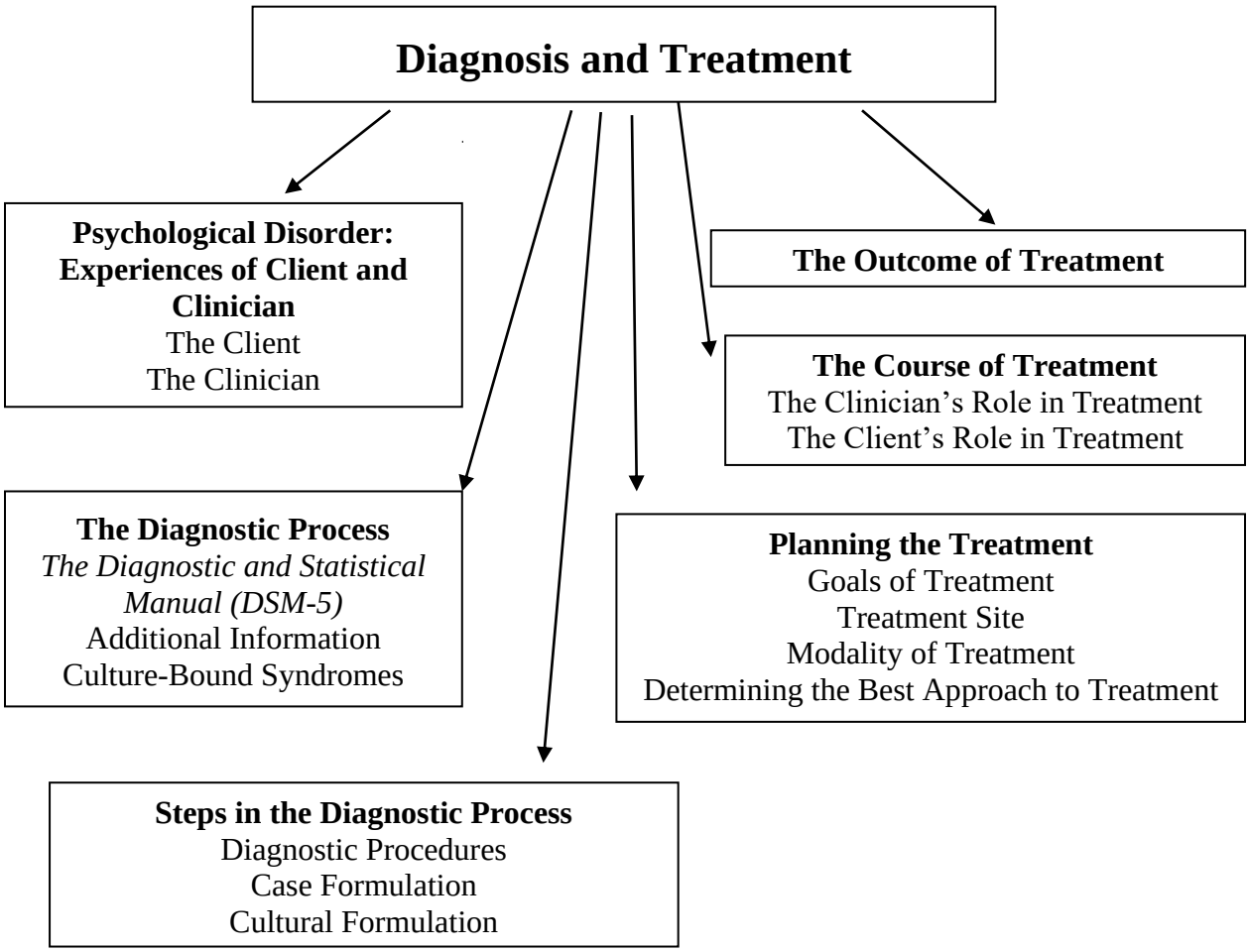
SOLUTIONS

to accompany

abnormal psychology 9th edition by whitbourne

CHAPTER 2
DIAGNOSIS AND TREATMENT

CHAPTER AT A GLANCE



Learning Objectives

2.1 Describe the experiences of the client and the clinician.
2.2 Assess the strengths and weaknesses of the *DSM* approach to psychological disorders.
2.3 Identify the *International Classification of Diseases (ICD).*
2.4 Explain the steps of the diagnostic process.
2.5 Describe treatment planning and goals.
2.6 Explain the course and outcome of treatment.

Activities Available in Connect

Connect is a teaching and learning platform designed to boost performance.

Connect offers:

- one destination for all course content
- assignment and quiz banks
- deep insights into student performance
- recommendations for students to improve
- adaptive learning features that customize the student experience

The following are a selection of the resources available for in Connect for this course:

Chapter	Activity	Activity Type
2	NewsFlash: Mindfulness in the Military	NewsFlash
2	Thinking Critically: Diagnosis and Treatment	Thinking Critically

Lecture Discussion Topics and Controversies

1. In the case of Pedro Padilla, what are the sources of his anxiety? What areas of his life have been most affected by anxiety? What is the rationale for prescribing medication and a course of cognitive-behavioral therapy?

2. Have students distinguish the difference between mental health providers. Why would we choose one discipline over the other? Explore the different theoretical perspectives as it influences the nature of treatment. Discuss the need for an eclectic approach. Introduce the concept of common factors among different approaches to psychotherapy.

3. Have students consider the reasons why treatment is not always successful. Preview the client's insight and judgment, motivation and ability to change. Be sure students also consider the clinicians role: choosing the appropriate level and modality of treatment, and therapist competence.

4. The field of mental health is plagued by disparities. Many of these disparities are in the access and availability of services and affect those of a particular culture and race. Gender and age are also among the inequities of care. Does culture influence whether we seek treatment? Or what type of treatment we seek? Is culture taken into significant consideration in the treatment process?

   (2001). Culture counts in MH Treatment. *Mental Health Weekly*, *11*, 1–3

5. Have students consider how they would go about testing a therapy to see if it is effective. Who would serve as subjects? Who would serve as controls? What would be the "placebo"? How would one determine if the therapy was effective? What kinds of problems would prevent generalization of the results to the population?

6. It is now well recognized that culture impacts the way certain psychological disorders manifest in individuals. Yet, culture itself is a very broad construct that encompasses a wide range of factors. Researchers have recently turned their interest to specific cultural factors that may lead to differences in disorders that are observed between different ethnic and racial groups. Okazaki (1997) hypothesized that one potential factor that might lead to some well-documented differences in social anxiety and depression between Asian Americans and White Americans is the ethnic difference in self-construal. Okazaki notes that Asian Americans typically have more *interdependent* self-construals; that is, their self-definition is based more on their relationships with significant others. White Americans typically have *independent* self-construals—their self-definition is based more on individual and personal factors. By using multivariate techniques, Okazaki correlated Asian-American and White-American students' scores on measures of self-construal, depression, and fear of negative evaluation. Although no differences were found on measures of depression, ethnic differences were found on measures of social anxiety. The author suggests that ethnic differences in self-construal might predispose Asian Americans to certain types of disorders characterized by social anxiety (e.g., social phobia). Okazaki also points out that the current findings shed light on a culture-bound syndrome observed in Japan called *Taijin Kyofusho*, characterized by avoidance of social situations due to a fear of offending or embarrassing others. More researchers will need to focus on the specific cultural factors that may lead to ethnic differences in psychopathology.

   Okazaki, S. (1997). Sources of ethnic differences between Asian-American and White-American college students on measures of depression and social anxiety. *Journal of Abnormal Psychology, 106,* 52–60.

7. The movement of evidence-based practice in psychology has become an important feature in health care systems. The APA 2005 Presidential Task Force on Evidence Based Practice defines and discusses evidence-based practice in psychology (EBPP). According to the APA EBPP Task Force's report (2006), the integration of science and practice, describes psychology's fundamental commitment and takes into account the full range of evidence psychologists and policymakers must consider. Research, clinical expertise, and patient characteristics are all supported as relevant to good outcomes. EBPP promotes effective psychological practice and enhances public health by applying empirically supported principles of psychological assessment, case formulation, therapeutic relationship, and intervention. The report provides a rationale for and expanded discussion of the EBPP policy statement that was developed by the Task Force and adopted as association policy by the APA Council of Representatives in August 2005.

8. Raise the question with students about what a successful treatment might look like. Discuss the difficulties in making lasting change. Relate the question of successful treatment to the prognosis associated with different disorders. Show the difference between the remediation of specific symptoms on the one hand and more global changes on the other. Identify various obstacles to treatment (external ones, such as limited insurance coverage, and more internal or personal ones such as resistances to treatment from a psychodynamic perspective). Perhaps compare psychological with medical models of assessment, treatment, and outcomes. Discuss remission and relapse.

Demonstrations and Classroom Exercises

1. Have students close their eyes. Tell them to share whatever comes to mind when you say the word

PATIENT, now have them do the same for the word *CLIENT*. Elaborate on the sickness, passivity, and lack of control that we find when we think of a patient as opposed to a client. Be sure respect any different responses that may come up.

2. Create a client! Have students give you a name of a client. Then have them yell out information and symptoms pertaining to the hypothetical client. They can get really creative. Now have them refer to the DSM 5 and identify which pertinent information best describes their functioning.

3. Divide students into groups and give each group a brief case description, highlighting a hypothetical client's symptoms. Then have students prepare a group report on how they might arrive at a diagnosis, and how they might plan a treatment for the client. The steps highlighted in the text can serve as guidelines for the students.

4. This *DSM* related exercise allows students to estimate the prevalence of mental disorders. Very briefly describe the symptoms of substance abuse disorders, anxiety disorders, mood disorders, schizophrenia, antisocial personality disorders, and cognitive disorders. Ask students to estimate the percentage of people over 18 years of age who could be diagnosed with any of the disorders above. Ask them which disorder they think is the most common and the least common, and which have higher rates among men than women. Put their responses on the board and see if there is a consensus. Below are the figures according to the National Comorbidity Study:

Table 1. Lifetime prevalence of DSM-IV/WMH-CIDI disorders by sex and cohort[1] (n=9282)

Lifetime	Total		Sex				Cohort							
			Female		Male		18-29		30-44		45-59		60+	
	%	SE	%	SE	%	SE	%	SE	%	SE	%	SE	%	SE
I. Anxiety Disorders														
Panic disorder	4.7	(0.2)	6.2	(0.3)	3.1	(0.3)	4.2	(0.5)	5.9	(0.6)	5.9	(0.4)	2.1	(0.4)
Agoraphobia without panic	1.3	(0.1)	1.6	(0.2)	1.1	(0.2)	1.2	(0.3)	1.4	(0.2)	1.8	(0.3)	0.9	(0.2)
Specific phobia	12.5	(0.4)	15.8	(0.6)	8.9	(0.6)	13.0	(0.9)	13.9	(0.7)	14.4	(1.0)	7.7	(0.6)
Social phobia	12.1	(0.4)	13.0	(0.6)	11.1	(0.6)	13.3	(0.7)	14.5	(0.9)	12.6	(0.9)	6.8	(0.5)
Generalized anxiety disorder	5.7	(0.3)	7.1	(0.3)	4.2	(0.4)	4.3	(0.4)	6.5	(0.5)	7.6	(0.7)	4.0	(0.4)
Post-traumatic stress disorder[2]	6.8	(0.4)	9.7	(0.7)	3.6	(0.3)	6.3	(0.6)	8.1	(0.9)	9.2	(0.8)	2.8	(0.5)
Obsessive-compulsive disorder[3]	2.3	(0.3)	3.1	(0.5)	1.6	(0.3)	3.1	(0.7)	3.0	(0.9)	2.4	(0.8)	0.6	(0.3)
Adult/Child separation anxiety disorder[2]	9.2	(0.4)	10.8	(0.6)	7.4	(0.5)	12.4	(0.9)	11.1	(0.7)	9.2	(0.8)	3.1	(0.5)
Any anxiety disorder[5]	31.2	(1.0)	36.4	(1.1)	25.4	(1.2)	32.9	(1.3)	37.0	(1.5)	34.2	(1.7)	17.8	(1.4)
II. Mood Disorders														
Major depressive disorder	16.9	(0.5)	20.2	(0.5)	13.2	(0.8)	16.0	(0.8)	19.3	(0.9)	20.1	(1.2)	10.7	(0.7)
Dysthymia	2.5	(0.2)	3.1	(0.3)	1.8	(0.2)	1.8	(0.3)	2.8	(0.4)	3.8	(0.6)	1.3	(0.2)
Bipolar I-II-sub disorders	4.4	(0.3)	4.5	(0.3)	4.3	(0.4)	7.0	(0.8)	5.3	(0.4)	3.7	(0.4)	1.3	(0.3)
Any mood disorder	21.4	(0.6)	24.9	(0.6)	17.5	(0.9)	22.6	(1.0)	24.5	(1.0)	24.2	(1.2)	12.2	(0.9)
III. Impulse-control Disorders														
Oppositional-defiant disorder[4]	8.5	(0.7)	7.7	(0.9)	9.3	(0.8)	9.9	(1.0)	7.3	(0.8)	--	--	--	--
Conduct disorder[4]	9.5	(0.8)	7.1	(0.9)	12.0	(1.0)	10.8	(1.1)	8.4	(0.7)	--	--	--	--
Attention-deficit/hyperactivity disorder[4]	8.1	(0.6)	6.4	(0.7)	9.8	(1.0)	7.8	(0.8)	8.3	(0.8)	--	--	--	--
Intermittent explosive disorder	7.4	(0.4)	5.7	(0.4)	9.2	(0.6)	12.6	(1.1)	8.8	(0.7)	5.3	(0.5)	2.4	(0.5)
Any impulse control disorder[4]	25.0	(1.1)	21.6	(1.4)	28.6	(1.5)	27.0	(1.6)	23.4	(1.1)	--	--	--	--
IV. Substance Disorders														
Alcohol abuse with/without dependence[2]	13.2	(0.6)	7.5	(0.5)	19.6	(0.9)	14.5	(1.0)	16.4	(1.1)	14.1	(1.0)	6.3	(0.7)
Drug abuse with/without dependence[2]	8.0	(0.4)	4.8	(0.4)	11.6	(0.7)	11.1	(0.9)	12.1	(1.0)	6.8	(0.7)	0.3	(0.1)
Nicotine dependence[2]	29.6	(0.8)	26.5	(1.3)	33.0	(1.0)	26.5	(1.8)	29.4	(1.5)	34.3	(1.6)	27.3	(1.7)
Any substance disorder[2]	35.3	(0.9)	29.6	(1.3)	41.8	(1.1)	33.2	(1.9)	37.1	(1.8)	39.8	(1.5)	29.6	(1.7)
V. Any Disorder														
Any[5]	57.4	(1.1)	56.5	(1.5)	58.4	(1.4)	58.7	(2.2)	63.7	(1.9)	60.0	(1.6)	44.0	(2.3)

[1]This table includes updated data as of July 19, 2007. Updates reflect the latest diagnostic, demographic and raw variable information.
[2]Assessed in the Part II sample (n = 5692).
[3]Assessed in a random one-third of the Part II sample (n = 2073).
[4]Assessed in the Part II sample among respondents in the age range 18-44 (n = 3197).
[5]Estimated in the Part II sample. No adjustment is made for the fact that one or more disorders in the category were not assessed for all Part II respondents.

http://www.hcp.med.harvard.edu/ncs/

5. Divide the class into groups. Using the disorders of your choice (substance abuse, anxiety disorders,

and depression lend themselves well to this activity) have the students determine what information they would need to form a treatment plan and then create a hypothetical treatment plan for each of these disorders.

7. Divide the class into groups. Picking as many *DSM 5* disorders as is practical for the number of students, assign different groups to enact in class different treatment modalities of psychodynamic, cognitive, behavioral, cognitive-behavioral, and humanistic therapy for whatever disorder you have chosen. This works best if each group has only one disorder and one treatment modality. Encourage them to present the treatment in as lively a manner as possible. Students can decide among themselves which roles to play. Again, you can have the class vote for best dramatization, and include in your criteria the substance of their presentation, as well as the presentation format.

8. Visit the *DSM-5* website at http://www.dsm5.org/Pages/Default.aspx and discuss the research, process, complexities, and involvement necessary to complete this process.

9. To give students practice in informal assessment and stereotypes have them think of a time when they saw a person on the street and they thought, "That person is abnormal." Write a few sentences describing the scene. Discuss in small groups of four. Each person should rank their scenario across the following dimensions:
    - The person's behavior was:
        - Predictable/Unpredictable
        - Safe/Dangerous
        - Internal/External

    Collect class data and open up the floor for discussion on stereotypes.

10. *DSM 5* continues to be controversial. Discuss the continuum view of mental disorders versus the categorical approach of the *DSM*. See: http://www.personalityresearch.org/acton/dimcat.html

    De Boeck, P., Wison, M., & Acton, G. S. (2005) A conceptual and psychometric framework for distinguishing categories and dimensions. *Psychological Review, 112*, 129–158.

Videos and Films

Abnormal Behavior: A Mental Hospital provides students with a glimpse inside the walls of a mental hospital. The film shows several therapy sessions as well as an ECT treatment. This film provides a good overview of the medical model. (CRM; 28 min., color).

Interrupted Lives demonstrates the plight of clients with long-term mental illnesses and how they struggle to reestablish themselves in the community. (Boston University Center for Rehabilitation Research and Training in Mental Health, 1019 Commonwealth Ave., Boston, MA 02215; 60 min., color).

Larry is the dramatization of an actual case of a man mistakenly institutionalized who struggles to conquer the effects of years of harsh treatment. (Learning Corporation of America; 78 min., color).

Madness and Medicine is a two-part film, which shows a mental institution and deals with the issues of drug therapy, ECT, and psychosurgery from both the patients' and the doctors' perspectives. (CRM; 49 min., color).

TED Talks on Mental Health presents a series of 68 TED Talks cover a wide range of mental health

issues of relevance to discussions about abnormal psychology. People with disorders talk about their experiences in some instances and mental health professionals discuss key topics in others. The series can be found at: https://www.ted.com/talks?topics%5B%5D=mental+health

Titticut Follies is a documentary filmed at a state hospital in Massachusetts. It illustrates many of the difficult conditions that characterized mental hospitals in the sixties. (Zipporah; 90 min., b/w).

MentalHealthChannel.tv presents a wide range of videos covering a numerous topics in mental health issues relevant to discussions about abnormal psychology. People with disorders talk about their experiences in some instances and mental health professionals discuss key topics in others. The series can be found at: http://mentalhealthchannel.tv/series

Literature Guide and Suggested Readings

American Psychiatric Association (2013). *DSM 5 Clinical Cases*, J. W. Barnhill, (Ed.). Washington, DC: Author.

American Psychiatric Association (2013). *DSM-5 Diagnostic and statistical manual of mental disorders*. Washington, DC: Author.

Berlin, R. M. (2008). *Poets on prozac: Mental illness, treatment, and the creative process*. The Johns Hopkins University Press.

Damasio, A. (2018). *The strange order of things: Life, feeling, and the making of cultures.* New York: Pantheon Books.

Evans, R. B., & Koelsch, W. A. (1985). Psychoanalysis arrives in America: The 1901 psychology conference at Clark University. *American Psychologist, 40,* 942-948.

Kirk, S. A., & Kutchins, H. (1992). *The selling of the DSM: The rhetoric of science in psychiatry*. Hawthorne, NY: Aldine De Gruyter.

Kirk, S. A., & Kutchins, H. (1997). *Making us crazy: DSM: The psychiatric bible and the creation of mental disorders.* New York: The Free Press.

Mayes, S. D., Calhoun, S. L., & Crites, D. L. (2001). Does *DSM-IV* Asperger's disorder exist? *Journal of Abnormal Child Psychology, 29,* 263–271.

McCabe, I. O. (2004). Crossing the quality chasm in behavioral health care: The role of evidenced-based practice. *Professional Psychology: Research and Practice, 35,* 571–579.

Munetz, M. R., Grande, T. P., & Chambers. M. R. (2001). The incarceration of individuals with severe mental disorders. *Community Mental Health Journal, 37,* 361–372.

Ratey, J., & Johnson, C. (1997, May/June). Out of the shadows. *Psychology Today,* 47–48, 50, 78, 80.

Seligman, M. E. P. (2018). *The hope circuit: A psychologists journey from helplessness to optimism.* New

York: PublicAffairs.

Singh, N. N., McKay, J. D. (1999). The need for cultural brokers in mental health services. *Journal of Child & Family Studies, 8,* 1–10.

Wampold, B. E. (2001). *The great psychotherapy debate: Models, methods, and findings.* Mahwah, NJ: Eribaum.

Widiger, T. A. (2004). Looking ahead to DSM-V. *The Clinical Psychologist, 57* (1&2), 8–15.

Paper Topics

1. The National Institute of Mental Health Collaborative Psychiatric Epidemiology Surveys (CPES) provides data on the distributions, correlates, and risk factors of mental disorders among the general population, with special emphasis on minority groups. Have students research and respond to this information.

2. Students may want to creatively create a hypothetical client. Have them arrive at a diagnosis and then discuss alternative treatment plans, as well as treatment modalities.

3. Ask students to compare and contrast the roles of the client and the therapist. In addition to identifying the how the therapist helps the client in treatment, ask them to consider how the client might help the therapist in her or his life, even if they remain unware of their influence.

4. It may be interesting for students to look at the previous *DSM*s, compare and contrast them with the current *DSM* and report their findings.

5. Have students research the current status of hospitalization for mental disorders. For what kinds of disorders are most people hospitalized and for how long? Students will find a wealth of resources online.

6. The Fifth Edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) was released at the American Psychiatric Association's Annual Meeting in May 2013. Students can check out the *DSM-5* website at www.dsm5.org.

7. Students may want to further research the cultural and ethnic disparities that one particular group may be experiencing.

8. Students can view the movies *One Flew Over the Cuckoo's Nest*, *Girl Interrupted*, and *Awakenings* and compare and contrast the type of treatment patients received in mental institutions. Though the patients in *Awakenings* were suffering from an organic disorder, they were hospitalized in a mental institution. You can also ask the students to discuss the disorders depicted in these movies.

9. Students can use the *DSM 5* Clinical Cases to critique criteria in real life cases.

10. Have students write about what distinguishes abnormality as a mental disorder and the kind of idiosyncracies one might see in a creative artist. Have them consider the benefits of being "different" or "abnormal" to creativity and consider how these statuses are different from diagnosed mental illness.