Clinical Psychology

SSC 2004

‘Melancholy’ by Lotte®

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Clinical Psychology

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Problems

Course coordinator

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Introduction

Clinical psychology is the study of mental disorders; it is a combination of scientific theory and research, and applied clinical knowledge. It is aimed at understanding, preventing, and relieving mental and behavioural distress and/ or dysfunction and thereby promoting subjective well-being and personal adaptation. The study of mental disorders is also (e.g. in Anglo-Saxon textbooks) sometimes referred to as 'Abnormal Psychology', however as at least 1 out of 4 adults worldwide will at some point in their life be diagnosed with a mental disorder, they can hardly still be seen as 'abnormal' anymore. Furthermore, if we take 1947 definition of health by the World Health Organisation (WHO) as "health is the absence of disease and complete wellbeing", none of us are truly ever healthy. This is why we see new definitions arise such as for example Doctor Machteld Huber's reformulation of the rather outdated WHO definition, who sees health as "…the ability to adapt and self-manage, when faced with physical, emotional and social challenges." This definition encourages people to focus on the abilities of individuals instead of their 'dysfunctions' and 'abnormalities'. However, even though in nature the ostensive boundary between 'normal' and 'abnormal' may not be evident or may even be absent, for clinical purposes such as diagnosing and treating a patient, there is need for such a boundary between 'normal' and 'abnormal' or mentally 'ill' and 'healthy'. Therefore, clinicians use "need for care" to demarcate the line between subclinical and clinical experiences and thereby between healthy and ill. Need for care arises when the symptoms become so frequent or intense that they lead to subjective suffering and may prevent a person from doing things they could or want to be doing. Consider, for example, 42 year-old nurse John who fears that working with cancer patients will give him cancer. When asked directly, he reports that he knows that cancer is not contagious. Nevertheless, this knowledge does not prevent him from taking as many steps as possible to reduce the probability of infection. When he gets home after work, he undresses in front of his apartment door, takes more than an hour to thoroughly wash himself from head to toe, gathers his work clothes using plastic gloves, and carefully deposits the clothes in the washing machine. Any object that may have come into contact with his work clothes is subjected to intensive cleaning. He will not touch anything that has possibly been in contact with the severely ill residents of the nursing home. The bike shed is, for example, a "contaminated area." In addition, he considers regularly washing his hands to be of the utmost importance: he does so more than 50 times a day. He wants his family to also wash their hands at least three times after each visit to the bathroom. He only touches doorknobs with his elbows. And if his children played in the lobby, he won't touch them until they have thoroughly washed themselves. After all, the lobby may contain contaminated objects too… Undoubtedly, he but also his family suffers from his fears. In cases like this, clinical psychologists usually have three questions: i) what is the nature of the problem? ii) what causes it? and iii) what can be done about it? The

assumption is that knowledge about the causes of mental illness will give clues as to what can be done to make people like John more able to cope with their symptoms and somewhat alleviate the suffering they and the people who are close to them might go through.

Clinical psychology: learning outcomes

The current course has three learning outcomes; learning what type of (most common) disorders there are, what causes them, and how they are treated. The first learning outcome is to become acquainted with the clinical picture (e.g. symptoms) of a number of relatively common psychiatric disorders. For example, the lifetime prevalence (i.e. the odds for an individual to develop the disorder in their lifetime) of social phobia is 3% to 13%. The lifetime prevalence of depression varies from 10% to 20%. Thus, in the worst case 1 out of 5 people will become depressed at some point in their lives; this means two students in your tutorial group. Note that this *clinical* anxiety and *clinical* depression and not just relatively common non-clinical feelings of nervousness or melancholia. This may make you wonder what the differences between clinical and non-clinical symptoms are. Who does not get nervous when they have to lead a discussion for the very first time? Who does not get anxious when they have to give a presentation for the very first time? The question is whether such nervousness indicates the presence of (predisposition towards) social phobia. Stated more generally: When can someone no longer cope by themselves and should we speak of a psychiatric disorder or psychological disturbance? In order to help researchers and clinicians decide, a number of useful rules were put together in the Diagnostic and Statistical Manual of Mental Disorders (DSM). In this course, the fifth and most recent edition (DSM-V, 2013) is used. The DSM-V is an inventory of psychopathology: All known psychological disturbances are described and grouped into dimensions and categories. By carefully examining whether someone meets the criteria for a particular disorder, a diagnosis is established. This has a clear advantage: for example, everybody knows what John's problem is. Diagnostic criteria provide uniformity and thus enhance communication among clinicians, researchers etc. in a given area. Yet, although useful, a diagnosis is nothing more than a summary. It tells us that John fears contamination despite knowing that he should not; it does not give us a clue about why this is the case. Thus during this course, the DSM-V should not be regarded as some sort of 'holy book' but simply as a useful description of different psychological disorders. The same goes for the World Health Organisation' ICD-10 (The International Classification of Diseases) which is similar to the DSM-V. The second learning outcome of this course is familiarizing you with theoretical perspectives on the disorders you will learn about. Put differently: you will search for explanations of disturbed thoughts, feelings, and behaviours. Why does Peter wash his hands exactly 17 times after touching a given doorknob? Why does the amount of food eaten by Ann between nine o' clock and ten o' clock on Sunday night equal the amount of three normal weekdays? Why is Julia so afraid to leave her house, let alone walk down the street? Why is your friend regularly depressed, and why does his brother hear voices when no one is speaking? We see something that we do not understand and, in order to make sense of it, we assume that it must be caused by something. We reason as

follows: if A (cause), then B (effect). And if we can attribute something unfamiliar (for example, hearing voices while no one talks) to a cause, then we have tentatively explained it. Scientific research on the aetiology of psychiatric disorders varies widely; studies differ with regard to design as well as the causal theory they examine. Your difficult task, then, is to separate the wheat from the chaff. Is the research well designed? Does the theory have empirical credibility? You are encouraged to employ (and further develop) a critical attitude studying the literature. Keep in mind that any theory on the aetiology of psychological disorders should be tested (and should be testable). The third learning outcome of this course is to learn about different forms of psychotherapy and pharmacotherapy. Just what do the different therapies entail? And how effective are they? The latter question is of great importance because the answer regarding which intervention is most effective allows one to indicate which of the available therapy is most suited for the treatment of a given psychological disorder. Next to reading literature on psychopathology, you will also be introduced to one of the clinician's assessment tool for psychopathology: the clinical interview. Since diagnosing clients mostly depends on clinical interviews and/ or clinical questionnaires filled out by the clients, this course includes a basic introduction to clinical assessment by means of a simulation clinical interview (see page 5 of this manual for more detailed information on the simulation interview).

Objectives

At the end of this course, you will:

- Be familiar with relatively common psychiatric disorders.
- Be able to differentiate various appearances of symptoms of psychiatric disorders.
- Have knowledge of theories concerning the aetiology of different disorders and the empirical evidence for and against the theories.
- Have knowledge of different forms of treatment and their effects.
- Have theoretical knowledge of clinical assessment via the clinical interview and lecture.
- Have acquired (basic) practical knowledge of conducting a clinical interview, writing a patient role, a letter of patient referral, and an interview report.

Setup of the course

The course consists of two parts: 1. you will study different aspects of psychopathology taking a traditional Problem Based Learning (PBL) approach and 2. you will write a role[1] for a given type of disorder, you will play the role during a (simulation) clinical interview, you will be a clinical interviewer yourself, and you will write a short report on your findings during the interview (of where you were the interviewer).

[1] Instructions for the practical (Role-writing, etc.) can be found in the Practical manual on Eleum

1. Psychopathology

- Problems and tutorials

Psychopathology is a broad terrain. Therefore, you do not have the time to study all facets of a given disorder. Thus, the PBL problems differ in the emphasis they put on certain themes (e.g., biological theories, cognitive models, treatment). Your tutor will intervene if your learning goals do not cover the area intended by the problem in question. Note that this precludes a tempting solution for formulating learning goals like: 1) what diagnosis applies to this case? 2) what is the theory on disorder X? and 3) what treatment options are there for X?

It should be clear that using these questions as learning goals is simply too general. It does not help you focus on those parts of the literature that are most relevant for a certain type of disorder. General learning goals will turn out to be a problem when selecting the appropriate literature for self-study. Of course (one of) those three questions might serve as problem statement for the brainstorm in your group. But remember; if you want to ask these questions, use them as a starting point but not as the conclusion of the first discussion of a task.

- Literature study

As is common practice in PBL, the learning goals emerging from the group discussion should give rise to literature study. The next question is where to find relevant sources of information. Searching for relevant journal articles would consume considerable amount of your time. Therefore, the last part of this course manual consists of a list of journal articles and chapters that contain useful clues for answering your learning goals. These articles/ chapters can be accessed in electronic form through Eleum. Do not attempt to read every article that is listed for a certain case (especially when the list contains relatively many articles). Scan through the papers (or their abstracts) to see if they contain useful information for your learning goals, and only read the (parts of) those papers that do. Note that the literature list also sometimes refers to textbooks relevant for a particular case. Again, this is intended as nothing more than a useful clue. It does not indicate that such a text is absolutely required.

2. Psychopathology: the clinical interview

Next to conventional group meetings to discuss the problems, an important part of this course is becoming acquainted with the basics of clinical interviews. Since psychological disorders cannot be diagnosed by using standard medical diagnostic tools such as blood tests, brain scans, etc., a clinical interview or assessment is a necessary tool for clinicians to diagnose clients. In order to pass this part of the course, there are three things that you need to do. First, after being assigned (the course coordinator will randomly assign disorder types to students during the third week of the course) a topic (e.g. obsessive compulsive disorder), you will need to learn as much as you can on the behavioural (how does a client behave?), cognitive (what thoughts do clients report?), and emotional (how do clients feel?) characteristics of that given disorder. You will then write a short (fictional) client-role

based on your findings which you have to hand in during the fourth week of the course. Second, you will play that client (so keep age, gender, family history etc. the same as yours, or as similar to yours as possible) during a clinical interview with a fellow student in the sixth or seventh week of the course. You will also have to write a short letter of patient referral in the fifth week and hand it in. The course coordinator will give the letter to the student interviewing you. The interviewer-student will have to write a report on the findings during the interview, specifically diagnose you based on DSM-V criteria. Third, you are going to be a clinical interviewer yourself and interview a fellow student who also wrote his or her own role. Again, you will have to write a report of your own on your findings during the clinical interview, which you need to hand in before 17:00 hours June 2nd. How to conduct clinical interviews and write clinical reports is explained during a mandatory lecture in week 6 of the course.

To summarise you have to:

- Write a client-role for the disorder assigned to you.
- Write a letter of patient referral and play the role.
- Conduct a clinical interview and write a report on your findings during this interview.

The interview/ roleplay sessions are held in the sixth (and possibly seventh) week of the course. During what would normally be 2-hour group meetings, 3 interview/ roleplay sessions will be held (approximately 20-25 minutes per interview), where you will either play the client or interview a client. This means that you and 5 of your fellow students will meet and observe each other during the interviews. It would be nice if you gave feedback after the interviews to the students whom you observed. During the third week of the course, the course coordinator will put a sign-up list on her room door (1.020) at UCM, where you can sign up for your role-play session and your interviewer session (so remember to sign up for 2 timeslots). Dates on when the interview meetings are can be found on Eleum at the beginning of the course so you can check your schedule to see what date would fit you best. If you have a (valid!) reason for not being able to attend a certain date, you can let the course coordinator know (preferably before she hangs up the list so your name can already be filled in) and you can choose a date for both the interview and role playing session. Otherwise the rule simply is that whoever signs up first gets the day and time he or she prefers. During the interview and roleplay sessions, it is absolutely necessary that you are present on the time you signed up for. If absent, you do not only jeopardise your own passing of the course, but also that of the fellow student giving or receiving the interview. More detailed information on the practical is the Practical Manual on Eleum.

Attendance and grading

The current course is taught in a PBL format, so an 85% tutorial attendance is required. This means that you can miss 2 of the 11 tutorial meetings without it having any negative consequences for your attendance requirement. Keep in mind that you are advised to attend all meetings. If you miss 3 meetings you can ask for an additional assignment for failed attendance via the Office of Student

Affairs. If you miss more than 3 meetings you fail the current course with no chance of making up for failed attendance.

There are two grades to be earned during this course; the final grade is a weighted average of the exam grade and the clinical interview grade. The exam makes up 70% of the final grade and the clinical interview part 30% of the final grade (10% role, 5% letter, 15% report). If your final grade is 5.4 or below, you may be eligible for a resit. You are eligible to resit if the following requirements are met:

- Your final grade is 5.4 or below.
- Your exam is considered a valid attempt[2].
- You passed attendance.

Course overview per week[3]

Week	Monday/ Tuesday	Thursday/ Friday
1 9/04 - 13/04	**Opening lecture** by M. Heins Pre-discussion problem 1 & 2	Post-discussion problem 1 & 2 Pre-discussion problem 3
2 16/04 - 20/04	Post-discussion problem 3 Pre-discussion problem 4	Post-discussion problem 4 Pre-discussion problem 5
3 23/04 - 27/04	**Lecture** 'Addiction, stress and psychopathology' by M. Heins Post-discussion problem 5 Pre-discussion problem 6	FREE
4 30/05 - 04/05	**Lecture** 'Stigmatization of mental illness' by C. van Zelst Post-discussion problem 6 Pre-discussion problem 7	Post-discussion problem 7 Pre-discussion problem 8
5 07/05 - 11/05	**Lecture** 'Recovery in mental illness' by M. Heins Post-discussion problem 8 Pre-discussion problem 9	FREE
6 14/05 - 18/05	**Lecture** ''Clinical assessment' by M. Heins (Note: mandatory attendance) Post-discussion problem 9	Interviews
7 21/03 - 25/05	FREE (on Monday) Interviews (Tuesday-Friday)	
8 28/05 - 01/06	Date/ time exam t.b.a.	

[2] The person who grades the exam decides on what is considered a valid attempt.

[3] Note that this is a preliminary schedule and the final schedule might still change –please view the final timetable via your student portal after publication.

Problem 1: No one to blame but yourself

Mr. Oliver, 44 years old, runs a drugstore. He does so with pleasure and considerable devotion. The store is perfectly clean and the goods are carefully arranged. And Mr. Oliver certainly is good at organizing. He has a sophisticated system for inventory management. Costs and benefits are all written out with great precision. As for sending bills, his sense of responsibility is enormous: every outgoing bill is re-read twice. To avoid undetected errors, Mr. Oliver also regularly undertakes random checks. Already checked bills are taken out of their envelopes and checked yet again. With the exception of minor spelling errors, Mr. Oliver has never caught a miscalculation. Fortunately!

When she was young, Ms. Peterson wanted to do missionary work; she still prays 12 times in a row before leaving for work and if she feels anxious at work she repeats this procedure. Now, at age 53, she works as a librarian. There is not much left of her religious drive (besides the prayers), but she is still concerned with the fate of people around her. She does not have the illusion that she can change the world for the better, but she is determined not to make the world worse. And that determination causes problems. Whenever she drives to work, she spots branches, pieces of wood, broken glass, and so on lying on the bicycle path. She stops to pick up every piece of junk. You never know, it may cause some kind of accident. What if she had seen a branch, not picked it up, and a biker fell over it and got seriously injured? She would be responsible, in a very direct way.

Six years ago a car hit a biker. The driver denied guilt but was nevertheless convicted. Reading this in the newspaper started Ms. Peterson thinking. Is it possible to hit a child with your car and not notice it? The probability would not be very high, but still, it would be possible, wouldn't it? Better safe than sorry. Thus, Ms. Peterson does not drive her car at times at which children may be under way to school. And even when she drives to work as late as 9:30 am, she is — upon arrival — not completely sure of what happened. She drives back home again in search of any traces of an accident.

Ms. Peterson also seriously doubts her memory. Sometimes at work she forgets the names of important authors. Of course, forgetting names is not such a big deal, but forgetting other things may lead to a major disaster. If she should absentmindedly leave the gas stove on, her elderly neighbour would be immediately exposed to explosion danger. Therefore, she thoroughly checks the stove and lights: 12 times before going to bed and 12 times prior to leaving the house. She spends an average of about 6 hours per day checking things. She also finds it increasingly difficult to throw away letters and newspapers. After all, they could contain important information. Therefore, two rooms in her house are stacked to the ceiling with old newspapers, magazines, and other items. Her hoarding behaviour is seriously interfering with her life. At the library, Ms. Peterson has also started saving everything that may possibly be of interest. This increasingly annoys the other library employees. It irritates them that Ms. Peterson makes a mess and never gets her work done. Tomorrow her boss wants to see her for an evaluation. He is planning to send her to a psychotherapist because he feels her problems are getting out of hand.

Problem 2: The Elephant Man

Peter is a somewhat shy 28-year old carpenter. He appears nervous. Recently he was hospitalised at a psychiatry ward after a (assumed) suicide attempt during which he covered his head in a plastic bag. He asks the psychologist whether it is possible to have their meeting in a darkened room.

Peter wears a cap that partly covers his eyes and he continuously stares at the floor. He lives with his parents, has no friends and has recently lost his job. The psychologist asks him why. Peter says “I don’t know if I can tell you about that. It is so embarrassing. But then again, that is why I am here of course”

After 5 minutes of deathly silence, Peter whispers: “it is my nose...” “Your nose?” asks the psychologist. “Yes, my nose is enormous, I look like a monster. My nose is so ugly you wouldn’t believe it. The past 10 years, I have not been able to do anything but think about my nose.”.

The psychologist looks and looks again but there is nothing that abnormal about Peter’s nose, not even when they enter a very bright room later on. On the contrary, Peter is a rather attractive man with a handsome face. Perhaps his nose is a tad big, but nothing out of the ordinary.

The psychologist says, “I don’t see anything wrong with your nose at all”. “Oh, you are just like everybody else”, says Peter. “My mom and dad also pity me and pretend not to see anything. But when I look in the mirror, which I often do, I can see how ugly it is very clearly. It is huge, horrible and disgusting, I hate my face. ”

“How often do you look in the mirror?” “For hours. I cannot stop it. That is why I used to be absent at work and why I was fired. But then again, I don’t think getting fired is that bad; at least now my colleagues cannot look at me anymore. I used to be really nervous if somebody looked at me. It all started in secondary school. I never minded my big nose until that one guy started calling me ‘Pinocchio’ and they all laughed about it… for a long time that’s what they called me.”

When the psychologist asks Peter how he can help him Peter answers: “I need plastic surgery but the surgeon said I need to see a psychologist first. I don’t agree, I just want her to make my nose smaller.”

Problem 3: Panic in the lab

Why is it that some people suffer from panic attacks? This question gives rise to a number of different answers. These answers point to causes, with panic attacks as a consequence. Simply put, the reasoning is as follows: whenever cause A is present, result B (panic attack) also occurs. But how do we know if and when such an explanation is tenable? The most straightforward method of testing an "if A, then B" explanation is conducting an experiment.

During the past 35 years or so, a number of manipulations (A) successfully elicited anxiety attacks (B) in hundreds of experiments. More specifically, pharmacological manipulations produce severe panic in anxiety patients, whereas panic does not occur when a placebo is administered. Healthy control subjects are not made anxious by either the placebo (why should they?) or the substance that causes anxiety patients to vehemently react. The interventions in question are the intravenous administration of sodiumlactate, the inhalation of a high concentration of CO2, the consumption of mega-doses of caffeine, or swallowing isoproterenol. Administer the relevant substances to healthy subjects (hundreds of students can talk about it), and they experience all kinds of things (dizziness, heart palpitations, tremors, etc.) but they do not experience anxiety or panic. What is the implication of these findings?

The following line of reasoning is very influential. Interventions in the biochemical and physiological systems of anxiety patients lead to the complaint (B). Apparently, the manipulations tap the underlying causal mechanism (A). The manipulation is pharmacological. Therefore, the cause of the panic attacks is pathophysiological. "Results of lactate studies suggest that panic disorder is a biological disease," state the Americans Carr and Sheehan (1984). This is a bold statement. Anxiety patients presumably suffer from a, further to describe, *biological disorder* that is activated by lactose, CO2, caffeine, and isoproterenol. In order to deactivate this pathogenic mechanism, anxiety patients should be treated with psychopharmaca. We should assume that by now, with their ideas being over 30 years ago, it has been well established that panic disorder is a biological disorder.

In the following, you will see the design of a few studies intended to examine the causal process (A) involving CO2, lactose, caffeine, and isoproterenol. The particular problem and specific results are not reported. Your task is to predict the results and explain them. Your tutor has the outcomes.

Study 1

Anxiety patients inhaled a 35% concentration of CO2 and reported, shortly after inhalation, severe anxiety. In all previous studies, the patients inhaled only once; in the present study, the patients were asked to inhale 35% CO2 ten times per hour during 6 sessions (a total of 60 inhalations). After every inhalation, the subjective anxiety was indicated on a scale running from 0 (no anxiety whatsoever) to 100 (extremely anxious). Following a single inhalation of CO2, anxiety patients produce a score of about 75 on average. Question: What do you think were the average scores for the anxiety patients in sessions 1, 2, 3, 4, 5, and 6? Why?

Study 2

Twenty panic patients receive a lactose infusion. Half of the patients are told that it is a physiological test that can elicit symptoms of anxiety and that the test is not dangerous. The other ten patients are given an extensive explanation of how lactose works, the symptoms of lactose are discussed, and a comparison is drawn to the physical feelings that occur during physical exertion. The verbal and non-verbal reactions of the patients are recorded on video, and an experienced clinician interviews the patients after completion of the session. The clinician was unaware of the condition to which the patient belonged. On the basis of the videos and interviews, the clinician determined the percentage of patients suffering a real anxiety attack for the two groups. For the first group, 8 of the 10 patients were reported to have had an anxiety attack. Question: How many of the 10 patients in the second group had a real attack? Why?

Study 3

A total of 20 anxiety patients are asked to inhale 5.5% CO2 for a period of 15 minutes. All patients were told that turning a knob could decrease the concentration of CO2, but that the knob was only operative when a green light was lit. When the light was out, the concentration could not be altered. During inhalation, the green light was lit for 10 of the patients. For the remaining 10 patients, the light was off. In fact, the patients were being fooled: Even when the light was lit, it was simply impossible to alter the supply of CO2 by turning the knob. Question: How many of the patients in the two conditions had an anxiety attack? Why?

Study 4

A total of 25 anxiety patients and 25 similarly aged, healthy control subjects received auditory feedback on their heart rate: boom-boom.....boom-boom....., etc. After some time, this factual feedback was replaced by fake feedback. The patients were led to believe that a sudden increase in their heart rate had occurred: boom-boom, boom-boom, boom-boom, etc. Throughout the experiment, the patient's blood pressure, degree of transpiration, and actual heart rate were measured. The subjective anxiety of the subjects was measured shortly before the provision of the fake feedback. Along a 10-point anxiety scale (0 = no anxiety whatsoever, 10 = a very large amount of anxiety), the anxiety patients produced an average score of 1.5 and the control subject produced an average score of 0.3. Questions: 1) What were the scores for the anxiety patients and control subjects during the provision of fake feedback? 2) What happened to the heart rates, blood pressures, and degrees of perspiration for the patients and controls during the provision of fake feedback?

Problem 4: Haunting memories

From the intake report concerning Linda M. Williams, birth date 23/05/1997

Client is a Law student who recently stopped attending classes at the University. The primary reason for dropping out (although she hopes to return and make up for lost time when she gets better) was a severe lack of concentration. Has disturbing thoughts that keep her from studying: in the end these thoughts were so uncontrollable that she couldn't follow a lecture or read a book anymore. Hardly sleeps at night: is afraid to go to sleep and lies awake for hours. When she finally sleeps she is likely to wake up at least once every night due to horrible nightmares. Client is reluctant to talk about the content of these thoughts and nightmares. After a considerable amount of probing, she reveals that they refer to something that happened to her about two years before.

She still lived at her parents' home at the time. They were away on a trip and client looked after the house and the cat. At the request of her parents, their friend L. came by regularly to check how she was doing. One evening, he dropped in while she already was in her nightgown. She invited him in for a drink. They talked for a while and then he left. In the middle of the night (about 2:00 am) she woke up, almost being smothered by a hand covering her nose and mouth. She noticed a penetrating smell of alcohol. A voice hissed that she shouldn't move and do what she was told. She recognized L's voice. It was only then that she realized that he held a knife to her throat. She was too scared to scream or do anything. Then "it" happened (client does not want to give details). It ended at dawn. L. said that she'd better not tell her parents. After all, she was the one that had dressed seductively. Besides, they wouldn't believe that L. would do such a thing; they were friends for many years.

Client never talked about her experience, nor did she go to the police. She felt guilty for letting L. in the house while she was half-dressed. Soon after this happened, she left home to go to university. She never saw L. again. The intrusions and nightmares were very bad at first, but became bearable after some time. But now her parents' 25th wedding anniversary is approaching. She fears that she will not be able to avoid meeting L. anymore.

Conclusion and plan of action

Clear case of... No co-morbidity. Refer to psychotherapy unit for cognitive-behaviour therapy or other psychosocial interventions. Already talked in general terms about what CBT encompasses. Client became very anxious when I mentioned the exposure component. Perhaps EMDR as an alternative? Next time I also need to talk to her about pre-trauma factors that might have increased her odds of developing…

Problem 5: A bad case of the blues

Miss Ann Jones, 26 years old, single, Ph.D. student, is seeing her general practitioner. She complains about feeling constantly tired, as if she never gets enough sleep, and she feels really down. Never before did she go through something this bad. She cannot think of a reason for being this way. She says she has always been sort of melancholic, but not like this. Every day is a struggle, she does not look forward to anything anymore, she loses too much weight (food doesn't taste good anymore) and she is unable to concentrate on reading a book, watching television or anything at all. Concentration is worst regarding her job; it is even so bad that she keeps forgetting things no matter how hard she tries.

Every morning Ann wakes up at 4.30 am and from then on she cannot sleep anymore. These are the worst moments. She lies in her bed, fearing the rest of the day and despite of waking up that early she cannot get herself to get up. Most of the days she does not get out of bed before noon. She cancels all her appointments with the few friends she has. Some don't even consider her an actual 'friend' since the times they do stuff together per year can be counted on the fingers of one hand. If she cannot avoid visiting her parents, they start out with complaining about her laziness. "You've become a lazy student", they snap at her. Ann feels that her parents are right, she does absolutely nothing lately. But then again, she is just so tired. And it's not even the first time that she feels like this. Three years ago, she almost quit her studies because she was having the same difficulties. She feels worthless and guilty because of taking advantage of her parents. Her family doctor refers Ann to the RIAGG (Regional Institute for Mental Welfare).

Ann never got there. Her parents found her lying unconscious in bed on Sunday morning. She overdosed on sleeping pills. The attempted suicide failed and the next day at the outpatient clinic of the academic hospital, she's given medication (Duloxetine) and a first session of cognitive therapy. Especially the latter is supposed to prevent (another?) relapse.

Problem 6: Suzanne Q.

The Department of Child and Adolescent Psychiatry in an academic hospital has an outpatient consultation hour. The couple Q. appears with their 18-year old daughter, Suzanne. Mother Q. says that she is worried about her only child. Suzanne has been sleeping less and less well over the past few months and she is hardly eating. She has had more 'active' periods in the past, but this time no one can reach her. She talks incessantly, mixes everything up, and cannot sit still for even a second. She draws strange diagrams and mumbles things as: "Everything is a mistake, this is not true...".

Suddenly, Suzanne interrupts her mother and says that indeed it is all a mistake. She does not need help. She wrote everything down. She is sure that the letters that she tucked in the coat pocket of her boyfriend during class break — containing phrases as "do you know for sure who you are meant for" — will make everything work out. In a loud tone, she says that she understands how the world really works. She takes a pile of crumpled papers out of her purse and puts them on the psychiatrist's desk. "Look, I have written it all down, the story of my parents, myself, the whole world!" The pages are full of text and diagrams. She does not give the psychiatrist time to look through the papers but rummages through them, continuously talking. At a certain point, she takes a book from the bookcase and says: "Look, it's all here, my story. I could have written it, no, I wrote it!" In response to the question of whether she really believes what she says, she looks at the psychiatrist with sparkling, restless eyes and laughs loudly. "You don't even understand, you are just as stupid as my mother and the rest of the world. Everyone knows it; I was walking in the city, the people talked out loud about me and my boyfriend. They signalled that everything would work out....all the red cars in the city transmit my thoughts!"

Suzanne is given oral medication (Olanzapine) and she quickly improves.

More than a year later, we see Suzanne again. She has been admitted to the local psychiatric hospital. Her very concerned parents found Suzanne, in a total mess in the student dorm where she lived. Her room was full of appliances and junk tied together with a rope. When her parents found her, she was sitting in the middle of the room on a wooden stool, agitatedly plucking at her arms. She warned them with large, fearful eyes about impending danger. She mentioned voices that gave her commands. She was admitted under court order.

From the psychiatry resident's intake report:

Clear consciousness but disoriented with respect to place and person (seems to take me for someone from outer space). Very scared and agitated. Cannot sit still for a second. Acoustic hallucinations — Suzanne talks back. Sometimes she covers her ears with her hands and repeatedly yells, "No, no, no, I won't do it" (imperative hallucinations?). A normal conversation is very difficult, but from what she says she appears to think that she is controlled by cosmic radiation of some sort. Everyone on earth is steered in this manner. Suzanne is put on medication, but this time in combination with her attending peer support groups. Her condition quickly changes, and she is discharged from the clinic one month later. She's attending college again.

Problem 7: Go for it!

It all began when Mike B., an active and agreeable young man, had just celebrated his 25th birthday. That was in the winter of 2016. For weeks on end, the weather had been dull and overcast. Otherwise, there was nothing special going on. Or it must have been that Mike's girlfriend, Eileen, had just given birth to a healthy baby boy the month before. Mike was a father and very proud as well.

On the day before Christmas, it was as if lightning had struck Mike's brain. He came home. He had bought engravings for 10,000 Euro at an antique shop. Eileen loved engravings so much, didn't she? And now they could start their own antique shop! Mike had visited the Chamber of Commerce that morning to make arrangements. And the day after Christmas (darn holidays!) they were going to see a real estate agent. And, oh yeah, he had ordered a large Volvo station wagon (with car phone and a navigation board computer). That way they could move everything. And he had already quit his job as a teacher. Sometimes you just have to take risks in life. Right?

In the following days, Mike barely slept. He was completely occupied by his business plans. It was more than Eileen could take. She took the baby and moved in with her parents.

Mike's uncle had also been a strange man. But he was rather passive and quiet. Until he took his own life two years earlier.

In April 2017, Mike was involuntarily admitted to a psychiatric hospital. He was not doing well. He was sombre, unresponsive, and lethargic.

A psychiatrist gave him Lithium. "That helps in such cases," said the psychiatrist. But not for Mike. He just kept going: periods in which he ordered Jaguars and wanted to buy Picassos alternated with periods in which he was deeply distressed and tried to hurt himself. Right now, he has attempted to commit suicide more than 10 times. All in all, Mike's condition is only getting worse.

"Perhaps we should try ECT?" uttered the psychiatrist.

Problem 8: I spy, I spy with my little eye...

Complaint inventory

Client (Martha S.) indicates that things have been going really bad lately. She is depressed and has the idea that she'll never get out of it. According to the client, her problems started when she was about 16. She went on a very strict diet. She ate about three apples a day and, if possible, less. She lost more than 15 kilos, got more and more depressed, and then started bingeing. As she did not want to get fatter, she deliberately threw up after every binge. Still, she gained weight. She is now back on her old weight.

Sometimes things go better, and the client has fewer eating binges. All in all, however, she says that the eating problem has really only gotten worse over the past two years. She has at least one binge per day. She then eats chocolate (usually two large bars), two packages of cookies (sometimes more), at least half a loaf of bread thickly spread with butter and jam, and usually thereafter an entire bag of potato chips, liquorice, or some other candy. She makes a special trip to the store to purchase the things for an eating binge.

The client says that she is very unsure of herself. She considers her current weight unacceptable (62 kilos for a height of 1.70 meters). She says to herself: "I can't live with this body. My stomach is way too big and my hips are much too wide and fat. My legs and especially my thighs are terrible to look at. If things stay this way, I will never be happy." She is also afraid of losing control over the rest of her eating behaviour and gaining more and more weight as a result. This would be a disaster; as "everyone could then see how little will power I have, and who wants to be associated with such a weakling? I can already forget a relationship at this point because I'm so ugly, but I'll be even uglier if I get fatter — a weak big cow."

To prevent getting fatter, the client not only vomits but also consumes 9 laxative pills (Nourilax) after every binge. She continues to try to eat as little as possible. She eats nothing in the morning and tries to keep to a maximum of 800 calories for the rest of the day.

Observations during intake:

Client is a 20-year old, slender, well-groomed, attractive woman. She does not talk easily about her eating problem and appears to be very ashamed of it. At the beginning of the interview, she spoke very softly and avoided eye contact. Contact was nevertheless rather easy to establish. With visible contempt, she speaks of her outward appearance. She also comes across as very insecure in further contact. Help request: "I have to get rid of the eating binges and the rolls of fat". Describes herself rather anxious and perfectionistic, which for her is not at all a good combination of personality traits.

Problem 9: Don’t take it personal

Helen is 32 years old, married, housewife and mother of one child. She was hospitalized at the Psychiatry Ward because of a crisis. The situation at home became untenable: she threatened her husband with a knife, regularly engaged in reckless driving when furious or in a bad mood, hurt herself and took a large dose of Valium. Helen admitted that she was not able to control herself anymore; amongst other things she said that her uncontrollable rage frightened her. Moreover, her husband can no longer cope with the situation. The reason for the present crisis is not clear, but appears to be related to the recent death of Helen’s father, as well as to the increasing alienation between her and her husband. She did not see her father anymore, but his death induces many complicated emotions. Her psychiatrist suspects that Helen may have had traumatic experiences during childhood; she seems to be very unable to regulate her emotions. Helen has not known her husband for long and is convinced that he will leave her. He is not the father of her child; the child's father was someone with whom she had a brief relationship. Before her marriage, Helen used to have many brief relationships, which she used to end herself abruptly for fear of being abandoned. At that time she used various kinds of drugs and drank heavily. Helen tried to commit suicide several times, but mostly in a half-hearted way: by taking pills in large but insufficient doses, crossing the road recklessly, et cetera. After secondary school Helen enrolled in various colleges, but she never finished one. Being pregnant she became convinced that leading her life as a mother and housewife would be her destiny. Currently, however, she feels that her child restricts her freedom.

Helen’s psychiatrist decided to contact her colleague’s abroad; she met some inspiring colleagues at a conference on personality disorders in the U.S. These consultations, however, did not bring any clear answers regarding aetiology and treatment.

Sources of information

There is no mandatory basic textbook for the current course. In case you do want to have one, below two books are recommended. However, you can also use the many general and specific books on clinical psychology in the library at Randwyck. Furthermore, the latest version of the DSM is also an acceptable basic book (or the online WHO ICD-10). Important, however, the basic books are not the only or best books to read. The (research) articles are of greater importance as the books are just meant to give you the basic background knowledge you need to help you understand some of the articles. The articles are in the electronic reader (e-reader) accessible through the link on Eleum. However, keep in mind that this list is by no means complete or to be read completely: it should be seen as an indication of what titles may contain interesting clues to answering your learning goals.

Recommended (though non-mandatory) for all problems:

Barlow, D.H., & Durand, V. M. (2014). *Abnormal Psychology: An Integrative Approach*. Cengage Learning, Stamford.

OR

Nolen-Hoeksema, S. (2013). *Abnormal Psychology*. McGraw-Hill, New York.

Problem 1: No one to blame but yourself

Bokor, G., & Andersen, P. D. (2014). Obsessive–Compulsive Disorder. Journal of Pharmacy Practice, 1-15. DOI: 10.1177/0897190014521996

Calkins, A. W., Berman, N. C., & Wilhelm, S. (2013). Recent Advances in Research on Cognition and Emotion in OCD: A Review. *Curr Psychiatry Rep*, 15:357. DOI: 10.1007/s11920-013-0357-4

Grant, J. E . (2014). Obsessive–Compulsive Disorder. *The New England Journal of Medicine*, 371:646-653. DOI: 10.1056/NEJMcp1402176

Mauzay, D., Spradlin, A., & Cutler, C. (2016). Devils, witches, and psychics: The role of thought-action fusion in the relationships between obsessive-compulsive features, religiosity, and paranormal beliefs. *Journal of Obsessive-Compulsive and Related Disorders*, 11:113–120. http://dx.doi.org/10.1016/j.jocrd.2016.10.003

Veale, D., & Roberts, A. (2014). Obsessive-compulsive disorder. BMJ, 1-6. DOI: 10.1136/bmj.g2183

Wootton, B. M., Diefenbach, G. J., Bragdon, L. B., Steketee, G., Frost, R. O., & Tolin, D. F. (2015). A Contemporary Psychometric Evaluation of the Obsessive Compulsive Inventory—Revised (OCI-R). *Psychological Assessment*, 27 (3):1-9.

Problem 2: The elephant man

Bowyer, L., Krebsa, G., Mataix-Cols, D., Veale, D., & Monzanie, B. (2016). A critical review of

cosmetic treatment outcomes in body dysmorphic disorder. *Body Image*, 19:1-8. http://dx.doi.org/10.1016/j.bodyim.2016.07.001

Dey, J., K., Ishii, M., Phillis, M., Byrne, P. J., Boahene, K. D. O., & Ishii, L. E. (2015). Body Dysmorphic Disorder in a Facial Plastic and Reconstructive Surgery Clinic Measuring Prevalence, Assessing Comorbidities, and Validating a Feasible Screening Instrument. *JAMA Facial Plast Surg,* 17(2):137-143. DOI:10.1001/jamafacial.2014.1492

Gupta, R., Huynh, M., & Ginsburg, I. H. (2013). Body Dysmorphic Disorder. *Semin Cutan Med Surg*, 32:78-82.

Lavell, C. H., Zimmer-Gembeck, M. J., Farrell, L., & Webb, H. (2014). Victimization, social anxiety, and body dysmorphic concerns: Appearance-based rejection sensitivity as a mediator. *Body Image*, 11:391-395. http://dx.doi.org/10.1016/j.bodyim.2014.06.008

Weingarden, H., & Renshaw, K, D. (2016). Body Dysmorphic Symptoms, Functional Impairment, and Depression: The Role of Appearance-Based Teasing. *The Journal of Psychology*, 150(1):119-131. DOI: 10.1080/00223980.2015.1012144

A nice online chapter on BDD can be found via google scholar, just use “body dysmorphic disorder McKay, Gosling, and Gupta” as search words, it’s chapter 11 by McKay, Gosling, and Gupta (2011).

Problem 3: Panic in the lab

Clark, D. (1993). Cognitive mediation of panic attacks induced by biological challenge tests. *Advances in Behaviour Research and Therapy*, 15:75-84.

Fentz, H. N., Arendt, M., O’Toole, M. S., & Hoffart, A. (2014). The mediational role of panic self-efficacy in cognitive behavioral therapy for panic disorder: A systematic review and meta-analysis. *Behaviour Research and Therapy*, 60:23-33.

Sandin, B., Sánchez-Arribas, C., Chorot, P., & Valiente, R. M. (2015). Anxiety sensitivity, catastrophic misinterpretations and panic self-efficacy in the prediction of panic disorder severity: Towards a tripartite cognitive model of panic disorder. *Behaviour Research and Therapy*, 67:30-40.

Vickers, K., Jafarpour, S., Mofidi, A., Bijan Rafat, B., & Woznica, A. (2012). The 35% carbon dioxide test in stress and panic research: Overview of effects and integration of findings. *Clinical Psychology Review*, 32:153-164.

Note: even though the emphasis here is on Panic Disorder, you also need to know the general clinical pictures of some of the other common anxiety disorders as listed in the DSM-V or the basic books.

Problem 4: Haunting memories

DiGangi, J., A., Gomez, D., Mendoza, L., Jason, L. A., Keys, B. C., & Koenen, K. C. (2013). Pretrauma risk factors for posttraumatic stress disorder: A systematic review of the literature. *Clinical Psychology Review*, 33:728–744

Jeffreys, F., W. & Davis, P. (2013). What is the Role of Eye Movements in Eye Movement

Desensitization and Reprocessing (EMDR) for Post-Traumatic Stress Disorder (PTSD)? A Review. *Behavioural and Cognitive Psychotherapy*, 41:290–300. DOI:10.1017/S1352465812000793

Perrin, M., Vandeleur, C. L., Castelao, E., Rothen, S. Glaus, J., Vollenweider, P., & Preisig, M. (2014). Determinants of the development of post-traumatic stress disorder, in the general population. *Soc Psychiatry Psychiatr Epidemiol*, 49:447–457. DOI 10.1007/s00127-013-0762-3

Qi, W., Gevonden, M., & Shalev, A. (2016). Prevention of Post-Traumatic Stress Disorder After Trauma: Current Evidence and Future Directions. *Curr Psychiatry Rep*, 18:20. DOI 10.1007/s11920-015-0655-0

Sareen, J. (2014). Posttraumatic Stress Disorder in Adults: Impact, Comorbidity, Risk Factors, and *Treatment. Can J Psychiatry*, 59(9):460–467

Sayed, S., Iacoviello, B. M., & Charney, D. S. (2014). Risk Factors for the Development of Psychopathology Following Trauma. *Curr Psychiatry Rep*, 17:70. DOI 10.1007/s11920-015-0612-y

Xue, C, Ge, Y., Tang, B., Liu, Y., Kang, P., Wang, M., & Zhang, L. (2015). A Meta-Analysis of Risk Factors for Combat-Related PTSD among Military Personnel and Veterans. PLOS ONE, 10(3):1–21. DOI:10.1371/journal.pone.0120270

Problem 5: A bad case of the blues

Beck, A. T., & Bredemeier, K. (2016). A Unified Model of Depression: Integrating Clinical, Cognitive, Biological, and Evolutionary Perspectives. *Clinical Psychological Science*, 4(4):596–619. DOI: 10.1177/2167702616628523

Biesheuvel-Leliefeld, K. E. M., Kok, G. D., Bockting, C. L. H., Cuijpers, P., Hollon, S. D., van Marwijk, H. W. J., & Smit, F. (2015). Effectiveness of psychological interventions in preventing recurrence of depressive disorder: Meta-analysis and meta-regression. *Journal of Affective Disorders*, 174:400–410. http://dx.doi.org/10.1016/j.jad.2014.12.016

Bockting, C. L., Hollon, S. D., Jarrett, R. B., Kuykene, W., & Dobson, K. (2015). A lifetime approach to major depressive disorder: The contributions of psychological interventions in preventing relapse and recurrence. *Clinical Psychology Review*, 41:16–26. http://dx.doi.org/10.1016/j.cpr.2015.02.003

Cameron, C., Habert, J., Ananda, L., & Furtado, M. (2014). Optimizing the management of depression: primary care experience. *Psychiatry Research*, 220(S1):S45–S57

Heim, C., & Binder, E. B. (2012). Current research trends in early life stress and depression: Review of human studies on sensitive periods, gene–environment interactions, and epigenetics. Experimental Neurology, 233:102–111.

Jager-Hyman, S., Cunningham, A., Wenzel, A., Mattei, S., Brown, G. K., & Beck, A. T. (2014). Cognitive Distortions and Suicide Attempts. *Cogn Ther Res*, 38:369–374. DOI 10.1007/s10608-014-9613-0

Videos:

A very nice (a bit long, the part on ECT and its effectiveness starts around 18 minutes) video on emerging anti-depressive treatments (non-pharmacological):

https://www.youtube.com/watch?v=ZJp2qpoqR_E

Problem 6: Suzanne Q.

Castelein, S., Bruggeman, R., Davidson, L., & Van der Gaag, M. (2015). Creating a Supportive Environment: Peer Support Groups for Psychotic Disorders. *Schizophrenia Bulletin*, 41(6):1211–1213. DOI:10.1093/schbul/sbv113

Fleischhacker, W. W., & Uchida, H. (2014). Critical review of antipsychotic polypharmacy in the treatment of schizophrenia. *International Journal of Neuropsychopharmacology*, 17:1083–1093. DOI:10.1017/S1461145712000399

Harrow, M., & Jobe, T. H. (2013). Does Long-Term Treatment of Schizophrenia With Antipsychotic Medications Facilitate Recovery? Schizophrenia Bulletin, 39(5):962–965. DOI:10.1093/schbul/sbt034

Harrow, M., Jobe, T. H. & Faull, R. N. (2014). Does treatment of schizophrenia with antipsychotic medications eliminate or reduce psychosis? A 20-year multi-follow-up study. *Psychological Medicine*, 44:3007–3016. DOI:10.1017/S0033291714000610

Van Os, J., Kenis, G., & Rutten, B. P. F. (2010). The environment and schizophrenia. Nature, 468: 203–212. DOI:10.1038/nature09563

Van Os, J., & Reininghaus, U. (2016). Psychosis as a transdiagnostic and extended phenotype in the general population. *World Psychiatry*, 15:118–124

Problem 7: Go for it!

Alda, M. (2015). (EXPERT REVIEW) Lithium in the treatment of bipolar disorder: pharmacology and pharmacogenetics. *Molecular Psychiatry*, 20:661–670. DOI:10.1038/mp.2015.4 (Note: do not focus on the biological details, the clinical aspects are of main interest here)

Dukart, J., Regen, F., Kherif, F., Colla, M., Bajbouj, M., Heuser, I., Frackowiak, R. S., & Draganski, B. (2014). Electroconvulsive therapy-induced brain plasticity determines therapeutic outcome in mood disorders. *PNAS*, 111(3):1156-1161. www.pnas.org/cgi/doi/10.1073/pnas.1321399111

Geddes, J. R., & Miklowitz, D. J. (2013). Treatment of bipolar disorder. *Lancet*, 381:1672–82.

Lopez-Castroman, J., Courtet, P., Baca-Garcia, E., & Oquendo, M. A. (2015). Identification of suicide risk in bipolar disorder (Commentary). *Bipolar Disord*, 17:22–23.

Malhi, G. S., Tanious, M., Das, P., Coulston, C. M., & Berk, M. (2013). Potential Mechanisms of Action of Lithium in Bipolar Disorder: Current Understanding. *CNS Drugs*, 27:135–153. DOI 10.1007/s40263-013-0039-0

Perugi, G., Mariani, M. G., Toni, C., & Medda, P. (2015). ECT in bipolar disorder: it can be considered a mood-stabilizing treatment? *Abstracts / Brain Stimulation*, 8:417.

Phillips, M. L., & Kupfer, D., J. (2013). Bipolar disorder diagnosis: challenges and future directions. *Lancet*, 381:1663–71.

Singh, N., Halliday, A. C., Thomas, J. M., Kuznetsova, O., Baldwin, R., Woon, E. C. Y., Aley, P. K., Antoniadou, I., Sharp, T., & Vasudevan, S. R., & Churchill, G. C. (2013). A safe lithium mimetic for bipolar disorder. *Nat Commun*, 4:1332. DOI:10.1038/ncomms2320

Problem 8: I spy, I spy with my little eye

Cena, H., Stanford, F. C., Ochner, L., Fonte, M. L., Biino, G., De Giuseppe, R., Taveras. E., & Misra, M. (2017). Association of a history of childhood-onset obesity and dieting with eating disorders. *Eating Disorders*. DOI:10.1080/10640266.2017.1279905

Egan, S. J., Watson, H. J., Kane, R. T., McEvoy, P., Fursland, A., & Nathan, P. R. (2013). Anxiety as a Mediator Between Perfectionism and Eating Disorders. *Cogn Ther Res*, 37:905–913. DOI 10.1007/s10608-012-9516-x

Kaye, W. H., Wierenga, C, E., Bailer, U. F., Simmons, A. N., & Bischoff-Grethe, A. (2013). Nothing tastes as good as skinny feels: the neurobiology of anorexia nervosa. *Trends in Neurosciences*, 36(2):110–120.

Meyer, C., Taranis, L., Goodwin, H., & Haycraft, E. (2011). Compulsive Exercise and Eating Disorders. Eur. Eat. Disorders Rev. 19:174–189.

Smink, F. R. E., Van Hoeken, D., Oldehinkel, A. J., & Hoek, H. W. (2014). *Int J Eat Disord*, 47:610–619.

Treasure, J., Corfield, F., & Cardi, V. (2012). A Three-phase Model of the Social Emotional Functioning in Eating Disorders. Eur. Eat. Disorders Rev. 20:431–438.

Problem 9: Don't take it personal

Beeney, J. E., Hallquist, M. N., Clifton, A. D., Lazarus, S. A., & Pilkonis, P. A. (2016). Social Disadvantage and Borderline Personality Disorder: A Study of Social Networks. *Personality Disorders: Theory, Research, and Treatment*. Advance online publication. http://dx.doi.org/10.1037/per0000234

Crowell, S. E., Beauchaine, T. P., & Linehan, M. M. (2009). A Biosocial Developmental Model of Borderline Personality: Elaborating and Extending Linehan's Theory. *Psychological Bulletin*, 135(3):495–510.

Dixon-Gordon, K. L., Peters, J. R., Fertuck, E. A., & Yen, S. (2016). Emotional Processes in Borderline Personality Disorder: An Update for Clinical Practice. *Journal of Psychotherapy Integration*. Advance online publication. http://dx.doi.org/10.1037/int0000044

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Gunderson, J. G. (2009). Borderline Personality Disorder: Ontogeny of a Diagnosis. *Am J Psychiatry*,

166:530–539.

Leichsenring, F., Leibing, E., Kruse, J., New, A. S., & Leweke, F. (2011). Borderline personality disorder. *Lancet*, 377:74–84.

Stepp, S. D., Lazarus, S. A., & Byrd, A. L. (2016). A Systematic Review of Risk Factors Prospectively Associated With Borderline Personality Disorder: Taking Stock and Moving Forward. *Personality Disorders: Theory, Research, and Treatment*, 7(4):316–323. http://dx.doi.org/10.1037/per0000186