Psychology 210: Adult Psychopathology

Spring 2004

Instructor:	Kenneth Carter, PhD Associate Professor of Psychology	Office:	Seney Hall 214A
Phone:	770-784-8439	Office Hours	10:15-11:15 Monday, Wednesday, Friday 1:15-2:15 Tuesday and Thursday you can always make an appointment with me--check my calendar first at http://calendar.yahoo.com/drkencarter this link can be found at the end of each of my e-mail messages.
E-mail	kcarter@learnlink.emory.edu		

TEXT:

REQUIRED

Barlow & Durand *Abnormal Psychology: An integrated approach*

Client's Autobiography (described later)

COURSE DESCRIPTION

COURSE OBJECTIVES AND LEARNING OUTCOMES

In accordance with the National Guidelines and Suggested Learning Outcomes for the Undergraduate Psychology Major (APA 2001) this course is designed to help develop and improve your critical thinking skills. You should leave this course with cognitive tools that can provide you with specific strategies for inquiry and well reasoned thought.

COURSE OBJECTIVES *(What you will learn if you successfully complete this course)*

1. To become more knowledgeable about criteria used to classify behavior as abnormal as well as diagnostic criteria for various psychological disorders.
2. To understand how multiple factors interact to influence the development of psychological disorders.
3. To develop a basic understanding of the methods used and the kinds of information gathered in clinical assessments.
4. To increase awareness of cultural and personal biases toward individuals diagnosed with psychological disorders and how these biases can influence diagnoses, treatments, and outcomes.
5. To acquire basic knowledge related to prevention strategies and current treatment options for various psychological disorders.
6. To develop an understanding of some of the legal and ethical issues involved in providing mental health services.

REQUIREMENTS:

There are three regularly scheduled exams, six quizzes, one intake report and case consultations in this class. The assignments are discussed below in greater detail.

TESTS There will be three exams (all cumulative). The test items will be taken primarily from class material, but you can expect some test questions on reading material, films, or any class activity. If you feel that the answer you chose for a test question is better than the correct answer, submit you case in WRITING to me (after a 24 hour "cool down" period). Make up exams (all essay) will be allowed ONLY for officially excused absences when notice has been provided to me in advance of the exam.

Exam 1 30 points September 22nd	Exam II 60 points October 27th	Test III (Final) 100 points During Finals
Psychopathology History and Systems Dynamic Theories Cognitive/Behavioral Theories Biological Theories Psychopharmacology The DSM Anxiety Disorders Ethics and the Law	Previous Topics and Mood Disorders Suicide Somatoform Disorders Factitious Disorders Dissociative Disorders	Previous Topics and Personality Disorders Thought Disorders Sexual Disorders Treatments
Chapters 1,2,3,5,16	Chapters 1,2,3,5,16 6,7	Chapters 1,2,3,5,16 6,7,13, 8,10,12

INTAKE REPORT (40 points)
The paper is due in class on Thursday November 15th. Your assignment is to examine the way an autobiography portrays psychopathology. You will write up an intake report by using the sample one provided in this syllabus. Your report should be more than 3 single spaced typed pages. There is a penalty for late papers. Later in the semester you will receive a folder with your assigned "client. You are to analyze the specific symptoms and diagnose the individual. Specific requirement are described in a separate part of the syllabus.

GRAND ROUNDS PRESENTATION AND CASE CONSULTATION (10 points for presentation 12 points for consultation)
Starting on November 15th I will call on individuals to do a 10 minute presentation of their intake report. When called on, you will come to the front of the class, present your case and answer questions about your "client". Afterwards, each member of the class will give their idea of what the diagnosis and appropriate treatment for the client might be (the consultation). Each person will get .5 points for the diagnosis and the presenter will get up to 10 points for their presentation. Your points will be based on your ability to answer questions as well as elocution.

DIAGNOSTIC QUIZ: (25 points)
Diagnostic quizzes (5 points each) will test you ability to diagnose a case example in class. Some will be online, others in class They come without warning, but I will only count your best 5 quizzes. Please be diligent about your attendance as you cannot "make-up" a diagnostic quiz.

EVALUATION: (277 points)
The final grade will be based on EXAM 1 (30 points), EXAM II (60 points), EXAM III (100 points), and the Intake Report (40 points) as well as your consultation points (12) and your Grand Rounds Presentation (10) and diagnostic quizzes (25) for a total of 282 points. A letter grade will be assigned to the TOTAL points accumulated during the semester. I will NOT use plus/minus in this class.

COURSE POLICIES

SUBJECT TO CHANGE
The class outline on the following page should be considered very fluid. Any and all of the dates, topics, values, and assignments listed are subject to change by the instructor. In fact, some changes are very typical for my courses as circumstances warrant. Some topics may take longer to cover than anticipated while others may require less time; each class is different. Every effort will be made to follow the outline and policies on this syllabus. However, if the class is particularly interested in a given topic, I may decide to spend more time on it, or if the class is interested in a topic not assigned, I may decide to include it. You will be notified of any changes that become necessary due to unforeseen circumstances.

EMAIL *(I reserve the right not to answer emails that do not follow this policy.)*
For most of us, sending and receiving email is simple and fun. We use it to communicate with friends and family in an informal manner. But while we may be unguarded in our tone when we email friends, a professional tone should be maintained when communicating with your professors. Many professors receive up to 100 emails a day and email has become the primary and preferred way of contacting professors. If you follow these simple guidelines you will communicate and you will shine. Use it improperly, however, and you might accidentally communicate immaturity. Apply the following guidelines to your emails:

1. Use a meaningful subject header for your email—one that is appropriate to the topic. Emails with these headers get attention first
2. Always be professional and business-like in your correspondence
3. Be sure to proofread and spell-check your email before sending it.
4. Don't ask questions you can easily find yourself like "When is the next test" or "When is the paper due?" You might consider the 'crossing the quad' rule. If you wouldn't cross the quad to ask me this question why email it to me?

STATEMENT OF ACADEMIC INTEGRITY

Academic integrity includes a commitment to not engage in or tolerate acts of falsification, misrepresentation or deception. Violation of academic integrity in this course includes plagiarizing (submitting the work of another person as your own) and tampering with the work of another student. All students are expected to act with civility, personal integrity; respect other students' dignity, rights and property; and help create and maintain an environment in which all can succeed through the fruits of their own efforts. An environment of academic integrity is requisite to respect for self and others and a civil community.

All work done in this class is subject to the Oxford College Honor Code. Work produced through academic misconduct (e.g., cheating on exams, plagiarism) will be dealt with according to the policies of the Honor Code and will result *in a failing grade for the entire course.* Unless I tell you otherwise, all work in the course should be done on your own. Please note that exams may not be removed from the exam room or copied at any time. Cheating is a very serious matter and will not be taken lightly. The College imposes serious penalties for

breaches of academic honesty and all cases of suspected breaches of honesty will be reported. Please http://www.emory.edu/OXFORD/CampusLife/honor.html for more details on the honor code.

Intake Report

This paper should be done with an autobiography of a person with one or more identifiable Axis I or Axis II disorders. Your paper will be no more than 3 pages in length. You should also include a "diagnostic memo" to your intake report.

Be careful about accepting the diagnosis of the character that is included in your book. Some books on your lists were written during DSM-II, a very different typology. Others are simply poorly diagnosed.

Your paper will consist of 4 sections. These are:

- ***Presenting problem (including signs and symptoms and history of present illness).***.
- ***Biopsychosocial Assessment***
- ***Mental Status Exam.***
- ***diagnosis.*** A DSM-IV diagnosis or diagnoses (all five axes) should be provided and defended. Why did you reject other possible diagnoses?

The Psychological Report

A psychological report also known as a integrated summary, a psychological evaluation, a consultative examination, or a clinical assessment, provides a technically accurate yet concise overview of the client's psychological functioning. The report integrates all aspects of the information gathered in a pre-interview screening and initial intake. Although several different report format exists, it is important that reports be easily understood by both mental health professionals and non-professionals. Using technical jargon is unnecessary, especially because the report is meant to be summative.

Different readers focus on different aspects of the report depending on their level of understanding and reason for reading the report. Some readers focus on raw data and observations, whereas others prefer reading the diagnosis and recommendations. Overall, the report should be written so that the client can easily understand if;

The Biopsychosocial Assessment

The biopsychosocial assessment provides background information for several areas of the client's life. Much of the information is obtained through the initial interview and additions and revisions are made throughout therapy. Information covered includes biological (or physical), psychological, and social. Biological information includes information about the client's family, development, education, employment, legal, and other medical history. Psychological information focuses on previous and current psychological status and treatment. Social information includes the client's social relationships and supports. Each area of biopsychosocial information collected should include both strengths and weaknesses.

<u>The Presenting Problem</u>

The presenting problem is the client's description of the problem rather than the clinician's diagnostic statement of it.

<u>History of Present Illness</u>

The client's personal history provides valuable information to help predict future performance, identify precipitating factors such as strengths and stressors that tend to alleviate or increase problem areas, consider previous mental and physical health diagnoses, and recognize behavior patterns.

Mental Status Exam
(described in the textbook)

Final Diagnosis on all 5 axis should then be given

Diagnostic Memo
You normally would not do this, but you should attach a "memo" to your intake report that shows the connections between the diagnosis and the symptoms you described in your intake report. For example, for Major Depressive Disorder, you need to have 5 symptoms and you would indicate which symptoms you described in the narrative which correlate with the diagnosis.

SAMPLE INTAKE REPORT

PRESENTING PROBLEM

Signs and Symptoms

Judy Doe, age 23, is self-referred for counseling services due to excessive worrying and nervousness. She states that she feels anxious and usually panics whenever she is in public places where she may not be able to get away immediately. During the interview she appeared to be quite anxious. She often fidgeted, breathed rapidly, stuttered a few times, and showed poor eye contact. She reported having a panic attack in the waiting room prior to the interview.
She began experiencing panic attacks three months ago. Approximately one month after losing her job as a videographer, which she held for three years. She currently experiences up to 5 panic attacks per day, each lasting 20-30 minutes. When she has panic attacks she reports shortness of breath, choking sensations, palpitations, dizziness, chills, and feeling of doom. Since her first panic attack in public two months ago, she refuses to go to public places, such as malls or grocery stores. Stating that it is too anxiety-provoking. At home she experiences fewer panic attacks except when the doorbell or phone rings. She will not go out with her friends or relatives and states that she is afraid to apply for another job, noting that she is a "mess-up" and "no one wants to hire a has been."

History of Present Illness

Judy Doe reports no known family history of mental health treatment. She has never attended a counseling session, nor has she been previously diagnosed with a mental health condition. Most of her life she has been somewhat withdrawn and anxious in public, viewing herself as "shy". She reports that she began feeling increasingly more anxious at work when a "college graduate" was hired in a position similar to hers. The college graduate was eventually promoted in the company due to exceptional work quality. Judy Doe became fairly upset and admits that her work quality suffered from her increased amount of worrying about her job. She began making a greater number of errors and missing work due to headaches and upset stomach. After another "college graduate" was hired, she states her work quality became "poor." She was eventually fired.

Since leaving her job, her anxiety level has increased. She feels incapacitated in her ability to work competitively with people who more highly trained than her. She worries excessively that if she were able to go back to work that she would just get fired again. One month ago she filled out three job applications and received a phone call for an interview. On the day of the interview she arrived at the building of the meeting, panicked, and drove home. When she arrived home she claims to have felt relieved of much of the anxiety.

BIOPSYCHOSOCIAL ASSESSMENT

Judy Doe if the youngest of five children and describes her family as close knit. Her parents have been married for 40 years. She reports that she is from a functional family who treated her "too well" as a child. She describes herself as a "daddy's girl" and "the baby of the family." Until she began working full time, her parents took care of all her expenses. She lived at home, expense-free, until two years ago.

She currently lives alone in an apartment. Her parents and most of her siblings live within five miles of her. She talks with them on the phone regularly. Two of her sisters visit her at least once per week. About once per month she will visit their homes or her parents in the evening, but may experience panic symptoms in transit. She describes her family as "supportive." Her best friend, whom she has known for over 10 years, recently moved to California due to a job transfer. She has no other close friends.

Her primary schooling was noneventful. She was in mainstream classes and earned average grades. She had few friends in high school and graduated five years ago with average grades. She subsequently attended Tech Institute for one year of a two year program and majored in videography. She left the school after being offered a position at her most recent job where she worked until three months ago. Technical school was very difficult for her academically.

As a child she had few friends and was not involved in any school or outside activities. Others often teased her due to her small size and occasional stuttering. Her older siblings often protected her from teasing and ridicule, but she often worried about what would happen if they were not present. She dated a few times as a teenager and early adult but was involved in no serious relationships. She states that she is too "reserved" and "afraid" to phone any of her acquaintances or former work associates to enhance her social life, but she wishes she were able to learn how to make friends.

She has not made any new friends since graduating from technical school. She usually talks with one of her neighbors on weekends. They have a planned trip to Colorado this coming summer. She attends religious services approximately twice per month, which she finds comforting. Her spiritual beliefs and thoughts are very important to her, and she views them as a definite strength. She describes the people at her place of worship as friendly. She has been asked to join a singles group there but hasn't yet made up her mind about joining.

Prior to developing panic symptoms she enjoyed weekly visits to the zoo by herself. At times she would take her two nieces with her. She played on a neighborhood softball team two years ago, but her friend, who urged her to join the team with her, moved away. She did not continue with the team. She still attends family social functions, such as birthday parties, but is not willing to go to events not involving her family. Prior to impairment, she was willing to attend public events if invited by others. She enjoys camping with her two sisters and their families.

Her last physical evaluation was conducted six months ago by Dr. Anderson, of Main Health Clinic. She states that exam indicated no health concerns. No medications are prescribed. She is allergic to penicillin. Her weight is within normal limits for her height. She was hospitalized once in her life for a tonsillectomy at age nine. She visits the dentist once per year for routine check-ups. She reports no significant physical traumas occurring in her life.

She rarely drinks alcoholic beverages and had never tried in her life, three years ago, when she was camping with her sisters. There is no family history of chemical dependence. She has no history of history of arrests or incarcerations for any reason.

Although she has never been in counseling, she believes it will be helpful because her friend successfully went through counseling following her divorce. She is looking for a female therapist "who understands what it is like being the youngest in a family."

MENTAL STATUS EXAM

Clinical Observations

She appeared at the interview neatly dressed and groomed. Posture and health seemed to be in normal range. Nails were very short, as if bitten. She appeared to be her chronological age. There were no unusual mannerisms or gestures. She was alert. Gait was normal. She sat somewhat rigidly and did not appear relaxed. Eye contact increased as the interview progressed.

Speech was clear and easily understood. She provided a normal range of vocabulary, details, and reaction time. Volume was soft. She did not mumble, slur, or stutter. There was nothing unusual about her speech.

She was cooperative, answering every question. She seemed somewhat inhibited socially, as evidenced by not initiating interactions, but rather responding when spoken to. She did not appear to be defensive, guarded, defiant, manipulative, or hostile. She seemed to be interested in the interview process.

Stream of Consciousness

There was no evidence of a thought disorder. No concerns were noticed regarding issues with thought processes, content of thought, thought disturbances, hallucinations, illusions, or depersonalization. She denies any history of suicidal thoughts, preoccupations, delusions, or detachment.

Affect/Mood

Affective observations included a restricted range of affect concordant with her speech and ideas. Mobility and intensity of affect were within her normal limits. Predominant mood was neutral. No psychomotor concerns were observed. She appeared to be anxious, as evidenced by fidgeting with her fingers often. She asked to go to the restroom two times during the interview. She did not appear to be irritable or angry.

She states that she is able to show a normal range or affection toward her family, but not "outsiders." She denies having any anger management issues. When upset she usually holds it in rather than expressing it to others. She denies currently feeling depressed, but claims to be frustrated with herself due to being unemployed. She does not endorse symptoms suggesting a depressive disorder, mania, nor PTSD.

She currently endorses symptoms and impairments concordant with Panic Disorder with Agoraphobia. Symptoms include abrupt development of heart palpitations, sweating, shortness of breath, chest pain, a feeling of choking, dizziness, and chills. She reports that she has had four panic attacks, each taking place when she had to be in public. She has not been able to feel comfortable in social settings, noting major impairments in which she is beginning to feel isolated and not be able to apply for a new job.

She further states that for most of her life she only gets involved in activities if she is sure that she will be accepted and liked. In social situations she is often preoccupied with thoughts that people will criticize or reject her. On two occasions she stated that she is "not as good as other people" academically, socially, and on the job. She has taking relatively few risks in her life. She meets the criteria for Avoidant Personality Disorder.

Sensorium/Cognition

She was in touch with reality, able to hold a normal conversation, and was oriented x3. Attention and concentration were within normal limits as evidenced by counting to 40 by threes beginning with one and counting backwards by sevens from 100.She repeated six digits forward and four digits backward, which is within the normal range. She correctly spelled words backward. She recalled three out of three words after five minutes and two out of three words after 30 minutes. Short-term, long-term, and immediate memory were intact.

She appeared to have average intelligence. Level of judgment and abstract thinking suggest age-appropriate behavior. She seems to have appropriate insight into the nature of her concerns, stating that she wants to return to work and learn how to cope with current anxiety. She does not meet criteria for a particular personality disorder but has dependent and avoidant features. There was no evidence of a somatoform disorder.

(EXAMPLE DIAGNOSTIC MEMO)
To: Dr. Ken Carter
From: Stewart Dent
Re: Diagnostic Memo on Derrick Java

Axis I: 305.90 Caffeine Intoxication
Patients with this disorder have recently consumed caffeine in excess of 250mg (e.g., more than 2-3 cups of brewed coffee and have 5 symptoms developing during or shortly after use.

Recently consumed caffeine in excess of 250mg	"He had a couple of cups of coffee..during the next 7 hours he took 7 more pills"
Restlessness	Joe said "I can't sit still"
Nervousness	Felt increasingly nervous and restless
Excitement	
Insomnia	
Flushed face	
Diuresis	He went to the bathroom to urinate every half hour
Gastrointestinal disturbance	
Muscle Twitching	
Rambling Flow of thought or speech	
Tachycardia or cardiac arrhythmia	He could feel his heart racing
Periods of inexhaustibility	
Psychomotor agitation	

Axis II None

Axis II	No evidence of personality disorder

Axis III None

Axis III	No reported general medical condition

Axis IV

Psychosocial Stressors	Work stressors. Next time he has a busy work schedule there is a possibility he may abuse caffeine again.

Axis V
GAF=75

If symptoms are present they are transient and expectable reactions to psychosocial stressors. No more than slight impairment in social, occupational, or school functioning.	No evidence of social impairment, he is stressed by his deadline at work and I expect that his use of the caffeine pills will not continue to occur after the deadline has passed.