Tutorial letter 101/3/2016

Abnormal Behaviour and Mental Health

PYC3702

Semesters 1 and 2

Department of Psychology

IMPORTANT INFORMATION:

This tutorial letter contains important information about your module.

BAR CODE

CONTENTS

Page

Important note:
Formal tuition in this module will be conducted in English only. Where capacity exists, and upon request, individual discussions will be conducted in any preferred South African language.

1 INTRODUCTION AND WELCOME

Dear Student

Welcome to *Abnormal Behaviour and Mental Health*! May you find the experience of studying this semester module stimulating and rewarding. We trust this module will prove to be interesting, informative and useful and that it will contribute positively toward the achievement of your study goals.

You will receive a number of tutorial letters during the semester. A tutorial letter is our way of communicating with you about teaching, learning and assessment. Read all tutorial letters immediately and carefully as they contain important, and sometimes, urgent information. You further need to actively participate on myUnisa by utilising the discussion forum for this module. In addition also regularly check for announcements on myUnisa for important notices. All study material is downloadable from the myUnisa page for this module, so do not wait for hardcopies to arrive to start working on this module.

This tutorial letter (Tutorial Letter 101/3/2016) contains important information regarding the scheme of work, resources and assignments for this module. We urge you to read it carefully and to keep it at hand when working through the study material, preparing the assignments, preparing for the examination and addressing questions to your lecturers.

Please read Tutorial Letter 301 in combination with Tutorial Letter 101 as it gives you an idea of important general information when studying at a distance and within a particular College.

In Tutorial Letter 101/3/2016 you will find the assignments and assessment criteria as well as instructions on the preparation and submission of the assignments. This tutorial letter also provides all the information you need regarding the prescribed study material and other resources and how to obtain them. Please study this information carefully and make sure that you obtain the prescribed material as soon as possible.

We have also included certain general and administrative information about this module. Please read this section of the tutorial letter carefully.

We wish you a pleasant and rewarding semester. Do not hesitate to contact one of your Lecturers if you encounter any problems with your studies.

1.1 Tutorial matter

Some of the tutorial matter may not be available when you register. Tutorial matter that is not available when you register will be couriered to you as soon as possible, but is also available on myUnisa. Please consult **my Studies @ Unisa** with regard to which department you should contact for assistance to obtain missing study material.

At the time of registration, you will receive an **inventory letter** that will tell you what you have received in your study package and also show items that are still outstanding. Also see the brochure entitled **my Studies @ Unisa**.

Check the study material that you have received against the inventory letter. You should have received all the items listed in the inventory, unless there is a statement like “out of stock” or “not available”. If any item is missing, follow the instructions on the back of the inventory letter without delay.

PLEASE NOTE: Your lecturers cannot help you with missing study material.

The Department of Despatch should supply you with the following **study material** for this module:

- **myStudies @ Unisa** (General administrative information about Unisa.)

- **Tutorial Letters 501, 502, and 503** (They replace the Study Guide for 2016 and contain extensive content to be studied and used in conjunction with your prescribed textbook (the purple edition)

- **Tutorial Letter 101/3/2016** (The tutorial letter you are reading now.)

1.2 *my*Unisa

m*y*Unisa is an Internet facility offered free of charge to all registered Unisa students. With the aid of *my*Unisa students will ultimately be able to perform all study-related functions on the Internet which are now normally done by telephone, by letter or personal visits to the campus.

To make use of *my*Unisa, you will need a **computer** with a **modem** and an **Internet connection**, as well as a **browser** such as Netscape or Internet Explorer. See **my Studies @ Unisa** for further information.

The following functions have already been implemented on *my*Unisa:

- you can contact your lecturers via e-mail;
- you can join a discussion forum (e.g. to discuss your module with other students who are doing the same module);
- you can order books from the library, and search for books on the library database;
- you can download study material placed on *my*Unisa;
- you can check whether your assignments have been received and marked;
- you can submit written as well as multiple-choice assignments via *myUnisa;*
- you can look up your assignment or exam marks as soon as they are released.

To register on *my*Unisa, you should go to the Unisa web page, which is located at the Internet address http://www.unisa.ac.za.

On this web page, select the option "*my*Unisa". If you are a first time user, you must click on the option "Register as *my*Unisa user" which will enable you to register online (this does not cost anything). Type in your name, student number and a password (the password must be at least 6 characters long). You will then be supplied with a PIN code (personal identity number) which you will use in all future transactions with *my*Unisa.

Once you have registered, select the option "Enter *my*Unisa", which will take you into *my*Unisa. In *my*Unisa, select the option "My Courses", (in this case PYC3702). From here, you will be able to submit assignments and do related activities (consult the publication **my Studies @ Unisa**).

2 PURPOSE OF AND OUTCOMES FOR THE MODULE

2.1 Purpose

The purpose of this module is to empower you with the knowledge, skills and attitudes to:

- identify abnormal behaviour that is associated with distress and/or impairment in functioning.

- classify certain abnormal behaviour patterns according to the DSM-5 classification system.

- describe abnormal behaviour according to the African perspective and various other theoretical models/perspectives.

- gain insight into the nature of abnormal behaviour and the suffering it causes.

- consider cultural descriptions and explanations of abnormal behaviour.

- become sensitive to factors which both threaten and promote mental health in your community.

- become actively involved in the promotion of mental health in your community.

2.2 Outcomes

When you have completed this module you should:

- understand the complexities of abnormal behaviour and mental health.
- be able to distinguish between normal and abnormal behaviour.
- be able to identify abnormal behaviour in various multicultural contexts.
- be able to classify abnormal behaviour according to the DSM-5 classification system.
- be able to explain abnormal behaviour according to different perspectives.
- have a sound knowledge of professional and other support services in your community to which you can refer people with abnormal behaviour.
- be able to promote mental health on primary and tertiary levels in your community.

3 LECTURERS AND CONTACT DETAILS

3.1 Lecturers

The lecturers and secretary responsible for this module are provided in the table below. All queries about the **content of this module** should be directed to the **lecturers** and all queries about **administrative matters** should be directed to the **module administrator co-ordinator**. Please, have your student number and study material with you when you contact us.

Module Administrator Coordinator	**Building and office number**	**Telephone number**	**e-mail address**
Mrs Cornia Nel	Theo van Wijk, 5-86	012 4298233	nelc1@unisa.ac.za
Lecturing team	**Building and office number**	**Telephone number**	**e-mail address**
Ms Christine Laidlaw (Module leader)	Theo van Wijk, 5-81	012 4298294	laidlc@unisa.ac.za
Mrs Banti Mokgatlhe	Theo van Wijk, 5-84	012 4298238	mokgapb@unisa.ac.za
Mrs Elmarié Visser	Theo van Wijk, 5-93	012 4298270	vissee@unisa.ac.za
Mr Ruane Bester (from Jan-June 2016)	Theo van Wijk, 5-91	012 4298214	bester@unisa.ac.za
Mrs Louise Henderson (from July 2016 onwards)	Theo van Wijk, 5-91	012 4298214	hendeh@unisa.ac.za
Mrs Janice Moodley	Theo van Wijk 5-80	012 429 8069	moodljk@unisa.ac.za
Mrs Vhuhwavho Nekhavhambe	Theo van Wyk 5-51	012 429 8513	nekhavm@unisa.ac.za

If you want to contact a lecturer via *my*Unisa proceed as follows:

Register as a *my*Unisa user (follow the procedure in Section 1.2 in this tutorial letter). Select “My Courses” and then the option “Contact Lecturer”. This will enable you to send e-mail correspondence to the lecturers involved in this module (also consult the brochure **my Studies @ Unisa**).

3.2 Department

3.2.1 Communication with the Department (by letter)

Address all correspondence concerning
- problems experienced in studying a specific module or
- arrangements for an appointment with a lecturer to:

The Department of Psychology
(Name of lecturer and module concerned)
P.O. Box 392
Unisa
0003

NOTE: You may enclose more than one letter to the *Psychology Department* in an envelope, but do not address enquiries to different departments (e.g. Despatch and Library Services) in the same letter. This will cause a delay in the replies to your enquiries. Write a separate letter to each department and mark each letter clearly for the attention of that department. *Always write your student number and the study-unit code at the top of your letter.*

Letters to lecturers may not be enclosed together with assignments.

3.2.2 Communication with the Department (by telephone, e-mail or fax)

Refer to page 5, section 3.1 for the telephone numbers and e-mail addresses of the lecturers and module administrator co-ordinator involved in PYC3702.

Lecturers frequently have to attend meetings, and conferences. They may therefore not be in their offices at all times. **If you cannot get hold of any particular lecturer in her office, phone the administrator co-ordinator Mrs C Nel on [012] 429-8233**. **Her e-mail address is nelc1@unisa.ac.za**.

Note that study material cannot be faxed to students.

3.2.3 Personal visit to the Department

Always make an appointment *before* coming to Unisa to see a lecturer. Lecturers often have other commitments which prevent them from seeing students without formal appointments.

3.3 University

Please consult **my Studies @ Unisa** for general contact details.

4 MODULE RELATED RESOURCES

4.1 Prescribed book

The prescribed book ("purple textbook") for this course is: **Sue, D., Sue, D.W., & Sue, S. (2016). *Understanding Abnormal Behavior* (11th ed.) International Version. Stamford, CT: Wadsworth Cengage Learning**.

Please place an order at your bookseller early. This will save you delay and frustration experienced by those who wait too long. Please ensure you use only the latest "purple textbook" as it is accurately aligned with the DSM-5. Unfortunately, no previous edition is suitable to study from.

4.2 Recommended books

The following are publications that you may consult to broaden your knowledge of abnormal behaviour.

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

Sadock, B.J., Sadock, V.A & Ruiz, P. (2014). Kaplan & Sadock's *Synopsis of psychiatry: Behavioral sciences/clinical psychiatry* (11th revised ed.). Baltimore, MD: Williams & Wilkins.

4.3 Additional books

While studying psychopathology you will frequently come across terminology which is new to you. The **Glossary** in the prescribed book is very helpful in such cases and you should consult it often. It is also advisable to have a good psychology dictionary. For those of you who are considering buying one, we recommend the following:

Colman, A.M. (2009). *Oxford dictionary of psychology*. Oxford, England: University Press.

Corsini, R.J. (1999). *The dictionary of psychology*. Philadelphia, MA: Bruner/Mazel.

Grieves, J. (1998).*Oxford psychology study dictionary*. Oxford, England: Oxford University Press.

Plug, C., Louw, D.A., Gouws, L.A., & Meyer, W.F. (1997). *Verklarende en vertalende sielkunde woordeboek*. (3rd ed.). Johannesburg, South Africa: Heinemann.

Reber, A.S. & Reber, E.S. (2001).*The Penguin dictionary of psychology*. (3rd ed.). London, Engkand: Penguin Books.

Sutherland, S. (1995). *MacMillan dictionary of psychology* (2nd ed.). Basingstoke, England: MacMillan Press.

4.4 Tutorial Letters 501, 502, and 503 (Study Guide)

Due to the new edition of the DSM classification system (DSM-5) the Study Guide that was based on the DSM-IV-TR had to be revised. Due to this the Study Guide for PYC3702 for 2016 is replaced by Tutorial Letters 501, 502, and 503. The purpose of the Tutorial Letters 501, 502, and 503 are to systematically guide you to study the contents of the prescribed book.

The content of Tutorial Letters 501, 502, and 503 is comprised of the following:

Tutorial Letter 501	Introduction Abnormal Behaviour Prevention of abnormal behaviour Models of abnormal behaviour Psychopathology from an African perspective Assessment and classification of abnormal behaviour Personality Psychopathology and Impulse Control Disorders Anxiety and Obsessive-Compulsive and Related Disorders
Tutorial Letter 502	Somatic Symptom and Dissociative Disorders Trauma and Stress-Related Disorders Substance-Related Disorders Sexual Dysfunction and Gender Dysphoria Depressive and Bipolar Disorders Suicide
Tutorial Letter 503	Schizophrenia and Other Psychotic Disorders Neurocognitive Disorders Disorders of Childhood and Adolescence

Tutorial Letters 501, 502, and 503 contain information concerning **the sections in the prescribed book you have to study, the sections you have to read for background information, and the sections of the prescribed book you can leave out**. They also contain **additional information** to the prescribed book which you must know and which will help you to understand and master the contents of the syllabus more easily. Read the Orientation in Tutorial Letter 501 carefully and follow the guidelines as set out in the **Introduction** in Tutorial Letter 501.

Aspects of the syllabus that students frequently find difficult are explained fully. There are also many questions, case studies and exercises in Tutorial Letters 501 to 503 (study guide) that you can do. Complete **all** the activities in each learning unit before proceeding to the next unit. Should you still have problems and feel unsure about some of the questions and activities contact one of your lecturers so that your problems can be resolved. You are strongly advised to cover each Learning Unit according to the recommended schedule. Previous students have found it impossible to cover the material adequately by "cramming" the information a few days prior to the examination

4.5 Videos

A number of videos have been selected which serve to illustrate some of the disorders that are included in the syllabus. The videos are meant to make the written content of the module come alive on screen. The videos are available in the audio-visual section of the Unisa library in Pretoria and can be requested from the library.

The following videos are available:

- A Beautiful Mind.
- Iris.
- One Flew Over The Cuckoo's Nest.
- Three Faces of Eve.
- The Hours.

4.6 Electronic Reserves (e-Reserves)

There are no e-Reserves for this course.

5 STUDENT SUPPORT SERVICES FOR THE MODULE

For information on the various student support systems and services available at Unisa (e.g. student counselling, tutorial classes, language support), please consult the brochure **my Studies @ Unisa** that you received with your study material.

PLEASE NOTE: Unfortunately, there will be **no** group discussion classes for this module during 2016.

6 MODULE SPECIFIC STUDY PLAN

NOTE: Use the brochure **my Studies @ Unisa** for general time management and planning skills.

This semester module runs over ± 15 weeks. On average students need about 150 hours to learn the material for this module. We advise that you draw up a study time-table as soon as possible. It should make provision for all your subjects, and also for unforeseen circumstances such as illness and work pressure, to enable you to work through the entire syllabus in good time and submit your assignments on time. The Abnormal Behaviour and Mental Health module is very labour-intensive and the volume of work is large. It is therefore very important to study regularly.

The following is an example of a study time-table, which you should, of course, adapt to suit your own circumstances: (Tutorial Letters 501 to 503 **(SG)** and prescribed book **(PB)**).

STUDY TIME		**WORK COVERED**
First Semester	**Second Semester**	
Week 1 (first week in February 2016)	**Week 1 (first week in July 2016)**	Read Tutorial Letter 101 as well as the Introduction to Tutorial Letter 501, Abnormal Behaviour **(Tut 501 & prescribed book (PB)).** Study: Prevention of Abnormal Behaviour **(Tut 501)**, Models of Abnormal Behaviour **(Tut 501 & PB)**.
Week 2	**Week 2**	Study: Psychopathology from an African Perspective **(Tut 501)** Assessment and Classification of Abnormal Behaviour **(Tut 501 & PB)** Personality Psychopathology and Impulse Control Disorders (**Tut 501 & PB)**
Week 3	**Week 3**	Anxiety and Obsessive-Compulsive and Related Disorders **(Tut 501 & PB)**
Week 4	**Week 4**	**Complete and submit Assignment 01**. **First semester** closing date **3 March 2016** **Second semester** closing date **3 August 2016**
Week 5	**Week 5**	Somatic Symptom and Dissociative Disorders **(Tut 502 & PB)**
Week 6	**Week 6**	Trauma and Stress-Related Disorders **(Tut 502 & PB)**.
Week 7	**Week 7**	Substance-Use Disorders **(Tut 502 & PB)**
Week 8	**Week 8**	Sexual Dysfunction and Gender Dysphoria **(Tut 502 & PB)**
Week 9	**Week 9**	Depressive and Bipolar Disorders **(Tut 502 & PB)** Suicide **(Tut 502 & PB)**
Week 10	**Week 10**	**Complete and submit Assignment 02**. **First semester** closing date **1 April 2016** **Second semester** closing date **7 September 2016**
Week 11	**Week 11**	Schizophrenia and Other Psychotic Disorders. **(Tut 503 & PB)** Neurocognitive Disorders (Tut 503 & PB)
Week 12	**Week 12**	Disorders of Childhood and Adolescence **(Tut 503 & PB)**
Week 13	**Week 13**	**Submit Assignment 91** **First semester** closing date **4 May 2016** **Second semester** closing date **2 October 2016** **Revision and examination preparation**
Week 14	**Week 14**	**Revision and examination preparation**
Week 15	**Week 15**	**Revision and examination preparation**

7 MODULE PRACTICAL WORK AND WORK INTEGRATED LEARNING

There is no practical work for this module.

8 ASSESSMENT

8.1 Assessment plan

Assignments are seen as part of the learning material for this module. As you do your own answers for the assignments, study the reading texts, consult other resources, discuss the content with fellow students or tutors or do research, you are actively engaged in learning.

Three assignments have been set for this module. Only **two** of these assignments, assignments 01 and 02, **are compulsory**.

Assignment 01 consists of 30 multiple choice questions and Assignment 02 consists of 30 multiple choice questions. Both these assignments are compulsory. By submitting **both** Assignments 01 and 02 on time, you gain examination admission. Note that you do not have to pass the assignments to gain examination admission – you merely have to submit them on time. Assignments 01 and 02 also count 20% towards your year mark and it is in your best interest to try your best to gain good marks in both assignments. Your assignments must reach us by the closing date. Because feedback is given shortly after the closing dates, **no extensions** can be given. Please note that there are no further opportunities to gain examination admission.

The third assignment, Assignment 91, is not compulsory. In Assignment 91 we request you to evaluate the Abnormal Behaviour and Mental Health course in the form of a multiple choice assignment.

8.2 Due dates of assignments, assignment numbers and unique assignment numbers

Please consult the following table for the closing dates, unique numbers and other relevant information regarding assignments:

Assignment 01 (Compulsory)	**Semester**	**Closing date**	**Unique number**
You will find the assignment on pages 13 to 20 (for semester 1) and on pages 34 to 42 (for semester 2) in this tutorial letter.			
Pages 13 to 20	1	3 March 2016	600435
Pages 34 to 42	2	3 August 2016	613593
Assignment 02 (Compulsory)	**Semester**	**Closing date**	**Unique number**
You will find the assignment on pages 20 to 29 (for semester 1) and on pages 42 to 50 (for semester 2) in this tutorial letter.			
Pages 20 to 29	1	1 April 2016	600497
Pages 42 to 50	2	7 September 2016	613632
Assignment 91 (Module Evaluation)	**Semester**	**Closing date**	**Unique number**
You will find the assignment on pages 29 to page 33 (for semester 1) and on pages 51 to 55 (for semester 2) in this tutorial letter.			
Pages 29 to 33	1	4 May 2016	600585
Pages 51 to 55	2	2 October 2016	613689

You will see that each multiple choice assignment has a **unique assignment number**. Please indicate this unique number on your mark reading sheet before submitting your assignments. The computer identifies all assignments by the unique number. For detailed information and requirements for assignments, as well as instructions for the use of mark reading sheets, consult **my Studies @ Unisa** which you received with your study material.

8.3 Submission of Assignments

You may submit your assignments electronically via *my*Unisaor submit in Unisa assignment boxes at stores such as Pepcor. If submitting by post (on mark reading sheets), take into account that you will

need to submit at least three weeks prior to the due date. For detailed information and requirements as far as submissions of assignments are concerned, refer to **my Studies @ Unisa** which you received with your study material.

8.3.1 Submission via myUnisa

One of the great advantages that *my*Unisa offers is that your assignment is immediately delivered to the Assignment Section at Unisa so that you do not have to agonise as to whether your assignment has arrived safely, and you also no longer have to worry about postal delays.

To submit an assignment via ***my*Unisa:**

- Go to *my*Unisa.
- Log in with your student number and password.
- Select the module.
- Click on assignments in the left-hand menu.
- Click on the assignment number you want to submit.
- Follow the instructions on the screen.

8.3.2 Submission via post

If you do not have access to the Internet, you must complete your assignments on the mark reading sheets provided with your study material. Please read the sections "Assignments" and "Submitting Assignments" in **my Studies @ Unisa** before you submit your assignments. Always keep a copy of your assignment answers in case your assignment does not reach the University. Submit the original copy. Remember to use your correct student number and unique number of the relevant assignment.

Assignments submitted by post should be addressed to:
The Registrar
PO Box 392
UNISA
0003

8.4 Feedback on assignments

You will receive two kinds of feedback on Assignments 01 and 02.

- A computer printout showing your answers, the correct answers and the mark you obtained.

- A tutorial letter with feedback about each assignment. As soon as you have received the commentaries, please check your answers. The assignments and the feedback on these assignments constitute an important part of your learning and should help you to be better prepared for the next assignment and the examination.

Note that you will **not** receive feedback on Assignment 91 (evaluation of the course).

8.5 Assignments applicable to each Semester

8.5.1 Assignments for Semester 1

Assignment 01		
Semester 1	*Closing date: 3 March 2016*	*Unique number: 600435*

This assignment is based on **learning units 1 to 7 in Tutorial Letter 501** and the corresponding chapters **1, 2, 3, 5 and 16** in the prescribed book.

Question 1

Tom, 25-years-old, was taken to the psychiatric hospital in Durban, after allegedly, shooting three people in a local shopping mall. While doing a diagnostic assessment of Tom's mental health status, the clinical psychologist assesses for any previous suicide attempts and physical assaults as risk factors when assessing Tom for his level of - - - - -, whereas taking into account any unusual or bizarre behaviours that are outside of the norms of behaviour in South Africa would be considered as assessing Tom's level of - - - - -.

1. deviance; dysfunction
2. dangerousness; distress
3. deviance; dysfunction
4. dangerousness; deviance

Question 2

Sue et al. (2016), outline a number of shortcomings of the biopsychosocial model. Which statement below is a criticism of the biopsychosocial model.

1. the biopsychosocial model does not explain comprehensively how factors interact to produce mental illness.
2. the biopsychosocial model does not explain comprehensively how to treat mental illness
3. the biopsychosocial model does not explain how cultural factors contribute to mental illness
4. the biopsychosocial model does not explain how medical problems contribute to mental illness.

Question 3

Collective identity is important in the African worldview, which is epitomised in the following statement, "I am because, we are" which means - - - - -:

1. a person is not a person because of other people.
2. a person is a person because of his/her family.
3. a person is a person because of God.
4. a person is a person because of other people.

Question 4

Tebogo, Pieter and Susan are critically debating whether it is relevant for South Africans to study abnormal behaviour from an African perspective. Which statement is contextually accurate?

1. It is not really relevant as well-researched Western perspectives have already been developed to explain and describe abnormal behaviour.

2. It is relevant in South Africa to study the African perspective only, as First World ideas do not really apply to Africa.

3. It is relevant as most South Africans are located on a continuum between Western and a Traditional African orientation, and knowledge of both perspectives would therefore be important.

4. It is not relevant because if South Africans want to be part of the First World, they should incorporate Western perspective into their thinking.

Question 5

According to the traditional African perspective - - - - - refers to disorders caused by natural causes while - - - - - refers to disorders caused by supernatural factors or the ancestors.

1. Umkhuhlane; Ukufa kwabantu
2. Ukufa kwabantu; Ubuthakathi
3. Umkhuhlane; Ubuthakhathi
4. Ukufa kwabantu; Umkhuhlane

Question 6

Which **one** of the following attributes does **not** relate to the African worldview on healing?

1. Holism
2. Humanity
3. Spirituality
4. Mastery of the universe

Question 7

Which **one** of the following statements applies to “Ukuthwasa”?

1. An unhealthy “calling” by the ancestors to become a traditional healer.
2. An illness caused by bewitchment and breaking of customs.
3. A “creative” illness following the calling by ancestors to become a diviner.
4. A psychotic disorder whereby an individual manifests with hallucinations, delusions, and reclusiveness.

Question 8

Individuals with a/an - - - - - Disorder fail to resist an impulse, drive, or temptation to perform acts that are harmful to themselves or others. - - - - - is an example of such a disorder.

1. Obsessive-compulsive; Pathological Gambling
2. Impulse-control; Intermittent-Explosive Disorder
3. Obsessive-compulsive Personality; Road rage
4. Bipolar I; Suicide

Question 9

Tsidi believes that abnormal behaviour stems from unmet childhood emotional needs. She thinks that the more severe the problem, the earlier the trauma in childhood. She believes that these traumas are so deep and disturbing that most people are unaware of them. Tsidi probably adheres to the - - - - - approach.

1. family systems
2. cognitive
3. humanistic
4. psychodynamic

Question 10

From the behaviourist perspective learning can occur without personal reward, punishment or praise when the individual experiences - - - - -.

1. classical conditioning.
2. operant conditioning.
3 vicarious conditioning.
4. direct reinforcement.

Question 11

According to the DSM-5 classification, a clinical psychologist can list a client's self-injury as the following diagnosis - - - - - in the category of Other Conditions That May Be a Focus of Clinical Attention?

1. Non-suicidal Self-Injury Disorder
2. Personal History of Self-Harm
3. Unspecified Self-Injury Disorder
4. Cannot be listed in this category, as Borderline Personality Disorder (a mental disorder) would be diagnosed.

Question 12

Which one of the following statements is **not** a criterion of Alcohol Use Disorder?

1. An inability to control the use of alcohol, despite its harmful physical, psychological, or interpersonal effects.
2. Craving for and preoccupation with obtaining and using alcohol.
3. Reduction or cessation of alcohol intake results in withdrawal.
4. A markedly elevated effect with continued use of the same amount of the alcohol.

Question 13

According to the psychodynamic explanation of Alcohol Use Disorder, the use of alcohol is seen as - - - - -?

1. releasing inhibitions allowing the repressed conflicts to surface.
2. reducing anxiety and tension.
3. socially learnt behaviour.
4. driven by the expectancy of its effect.

Question 14

According to the DSM-5 classification system long-term unwarranted suspiciousness, hypersensitivity with regard to the reactions of others, and reluctance to confide in others characterise an individual who suffers from - - - - - Personality Disorder.

1. Paranoid
2. Avoidant
3. Schizoid
4. Antisocial

Question 15

Mpho has been diagnosed with Generalised Anxiety Disorder, while **Phiri** suffers from Panic Disorder according to the DSM-5 classification system. Which **one** of the following statements is **true**?

1. Phiri shows relatively low anxiety levels between episodes of panic.
2. Phiri is constantly worried about a range of life situations.
3. Mpho experiences no somatic aspects of anxiety.
4. Mpho is persistently concerned about having an anxiety attack.

Read the following case study carefully and then answer question 16.

Herbert complains of persistent and distressing thoughts about dirt and germs. He cannot eat without washing his hands six times before every meal with a specific strong detergent. Although his hands are raw from his hand-washing rituals, he becomes overwhelmed with anxiety if he does not wash his hands repeatedly before every meal. **Richard** complains of an excessive, unrealistic longstanding fear of heights. He avoids heights wherever possible. He not only experiences overwhelming fear in the face of heights, he also experiences several distressing physical symptoms such as breathlessness, nausea and heart palpitations.

Question 16

According to the DSM-5 classification system, **Herbert's** abnormal behaviour could be classified as - - - - - and **Richard's** abnormal behaviour as - - - - -

1. Specific Phobia; Avoidant Personality Disorder.
2. Obsessive-Compulsive Personality Disorder; Agoraphobia.
3. Obsessive-Compulsive Disorder; Specific Phobia.
4. Specific Phobia; Panic Disorder.

Read the following case study carefully and then answer questions 17, 18, 19, 20 and 21.

Tracey, a 56-year-old Maths teacher at a prestigious private school, complains of the following symptoms: heart palpitations, ringing in the ears, dizziness, sweaty palms, dry mouth, severe muscle tension, irritability and a constant "edgy" and watchful feeling that interferes with her ability to concentrate. According to Tracey, she has been suffering from these symptoms for the past nine months. Tracey attributes these symptoms to constant, uncontrollable anxiety and worries. She finds herself constantly worrying about her health despite the fact that a general practitioner as well as a specialist declared her medically fit and healthy. Tracey also constantly worries about her children, her friends, her finances, her religious faith and her career. In addition to the vast range of life circumstances which Tracey worries about, she also worries about her worries and her inability to control her anxiety and worries which she realises are unfounded. Tracey tries to hide her symptoms, especially from her colleagues and learners but she often has to leave her classroom when her symptoms become intolerable.

The Principal of the school where Tracey teaches requested Tracey to seek professional help after a group of parents complained about Tracey's frequent absence from class. Tracey is seriously distressed about the parents' complaint. She fears that she might lose her work despite the Principal's reassurance to the contrary. Although Tracey is an experienced and respected Maths teacher, she has refused several promotion opportunities due to a lack of self-confidence. She also never had the confidence to teach Grade 12 learners. Ten months ago, after the unexpected death of the Grade 12 Maths teacher, Tracey was asked by the Principal to take over the Grade 12 Maths class. To avoid conflict, Tracey agreed to the Principal's request despite serious doubts about her ability to cope with the challenges of Grade 12 learners. Tracey experienced the death of her colleague, who was also her only close friend, as a great loss. Tracey relied on her colleague and friend for guidance regarding teaching and personal matters since the death of her husband six years

ago. Tracey's husband was her main source of support and care since they got married at an early age. He assumed responsibility for some important areas of her life. Tracey seldom opposed her husband's decisions. After the loss of her husband, Tracey became very attached to her colleague that had died.

Question 17

In diagnosing Tracey's abnormal behaviour, several disorders were considered and some of them were eliminated. Unfortunately **three** of the following differential diagnoses were eliminated for the **wrong** reason. Identify the disorder that was eliminated for the **correct** reason:

1. Obsessive-Compulsive Disorder: Tracey recognises that her anxiety and worries are unfounded and unreasonable.
2. Posttraumatic Stress Disorder: Tracey does not experience sleep disturbances.
3. Somatic Symptom Disorder: Tracey's excessive worries are not restricted to her health.
4. Factitious Disorder: Tracey's symptoms are not motivated by external motives such as financial compensation.

Question 18

A psychologist will probably make the principal diagnosis of - - - - - according to the DSM-5 classification system in Tracey's case.

1. Bereavement
2. Adjustment Disorder with Anxiety
3. Panic Disorder
4. Generalised Anxiety Disorder

Question 19

Tracey's symptom of worry illustrates the - - - - - manifestation of her principal disorder, the symptom of uncontrolled anxiety illustrates the - - - - - domain and the symptoms of heart palpitations, sweaty palms and muscle tension illustrate the - - - - - manifestation of her principal disorder.

1. behavioural; cognitive; somatic
2. cognitive; affective; somatic
3. affective; behavioural; cognitive
4. somatic; behavioural; affective

Question 20

According to the DSM-5 classification system, the co-morbid diagnosis of - - - - - should be considered in Tracey's case because - - - - -

1. Schizoid Personality Disorder; she only had one close friend.
2. Other Specified Personality Disorder; Tracey manifests some features of Dependent Personality Disorder.
3. Borderline Personality Disorder; Tracey experiences interpersonal problems and a lack of self-confidence.
4. None; in general Tracey is a well-functioning adult and a respected Maths teacher.

Question 21

According to Wells' cognitive model (Sue et al., 2016), the roots of **Tracey's** type of mental disorder lie in - - - - -

1. beliefs regarding worry that are responsible for increased and persistent worry.
2. beliefs that worry can provide a way to cope with stressful situations.
3. beliefs that worry can provide solutions to challenges that might occur.
4. ineffective methods for dealing with difficult and stressful situations.

Read the following case study carefully and then answer questions 22 and 23.

Jasper (30 years old) grew up in the city. Since childhood he seemed to be extremely sensitive to people's reactions toward him. He usually expected them to criticise and reject him. He was therefore very lonely as he would avoid situations where he needed to interact with people he didn't know very well. This caused him endless difficulties at school as he could never relax and interact like the other school learners did. Oral presentations were a nightmare since he felt that his classmates thought he was stupid and would laugh at him. These thoughts resulted in him forgetting his speech and failing orals repeatedly.

As he grew older Jasper yearned for a close interpersonal relationship hoping he would someday get married and have children but could simply not get himself so far to start talking to the girls he admired from afar. Recently, a girl that Jasper found extremely attractive was placed to work alongside him as an intern. Jasper started developing a lot of anxiety as he wasn't able to interact with the girl as he believed she might think he was incompetent and a loser. This anxiety and uneasiness started to affect his work negatively and he received a formal warning from his supervisor.

Question 22

According to the DSM-5 classification system, **Jasper's** abnormal behaviour could be classified as - - - - -.

1. Obsessive-Compulsive Personality Disorder
2. Avoidant Personality Disorder
3. Schizoid Personality Disorder
4. Paranoid Personality Disorder

Question 23

The prognosis for **Jasper's** diagnosis is - - - - - because - - - - -.

1. poor; onset is gradual and pervasive and resistant to change
2. good; onset is acute and therefore shows a successful response to treatment
3. good; his disorder is ego-syntonic
4. poor; his disorder is ego-dystonic

Question 24

Which **one** of the following is **not** a reason why it is difficult to diagnose a Personality Disorder?

1. At different times all individuals exhibit some traits that characterise traits of a Personality Disorder.
2. The symptoms of the specific Personality Disorders may overlap and therefore diffierent clinicians might diagnose the same individual with different Personality Disorders.
3. Due to the longstanding nature of Personality Disorder they are difficult to identify.
4. The comorbidity rate of Personality Disorders with other disorders are high and therefore such individuals more often receive a diagnosis of the comorbid disorder as this disorders' symptoms are more obvious or easily identified.

Question 25

One way to differentiate Schizoid Personality Disorder from the Schizotypal Personality Disorder is on the basis of thoughts, because the person suffering from a - - - - -

1. Schizoid Personality Disorder is more likely to have delusions and hallucinations.
2. Schizotypal Personality Disorder is more likely to have odd thoughts.
3. Schizotypal Personality Disorder is more likely to be obsessed with perfectionism and details.
4. Schizoid Personality Disorder is more likely to think that others are out to get him or her.

Read the following case study carefully and then answer questions 26 and 27.

Darius is 31-years-old and works as a fast food cook in his company's cafeteria. He hangs out with gangs in his neighbourhood, often abuses various substances and is often absent from work. He likes to draw attention to himself (he has various body piercings and many tattoos). He exaggerates his expression of emotions yet on closer inspection his emotions seem very shallow. He behaves very dramatically, almost exclusively uses gang-related lingo and makes sexual advances toward nearly all the girls he meets.

Question 26

What is the most appropriate DSM-5 Personality Disorder diagnosis for Darius' abnormal behaviour, given the above information?

1. Narcissistic Personality Disorder
2. Antisocial Personality Disorder
3. Histrionic Personality Disorder
4. Schizotypal Personality Disorder

Question 27

The clinical psychologist recommends individual psychotherapy for Darius; this recommendation is an example of a - - - - - intervention.

1. Primary Prevention
2. Secondary Prevention
3. Crisis Prevention
4. Tertiary Prevention

Question 28

Criterion A of the DSM-5 diagnostic criteria for Personality Disorder includes an enduring pattern of inner experience and behaviour that deviates markedly from the expectations of the individual's culture which is manifested in - - - - - (or more) of the following areas: - - - - -, - - - - -, - - - - -, - - - - -.

1. two; long-term memory, affectivity, reality testing, impulse control.
2. three; cognition, adaptability, interpersonal functioning, impulse control.
3. two; cognition, affectivity, interpersonal functioning, impulse control.
4. three; long-term memory, adaptability, reality testing, interpersonal functioning.

Question 29

A community psychologist teaches police officers who often deal with marital violence to reduce aggression and increase interpersonal communication in their clients. This programme is an example of - - - - -.

1. social support
2. primary prevention
3. tertiary prevention
4. training paraprofessionals

Question 30

A clinical psychologist develops a talk for high school learners about, "Nayope: A lethal drug-cocktail". Alerting adolescents to the links between substances and psychosis is an example of - - - - - intervention.

1. primary prevention
2. secondary prevention
3. secondary corrective
4. tertiary prevention

Assignment 02		
Semester 1	*Closing date: 1 April 2016*	*Unique number: 600497*

This assignment is based on **learning units 8 to 13 of the tutorial letter 502** and the corresponding **chapters 6, 7, 8, 9, 10, and 15 in the prescribed book.**

Read the following case study carefully and answer questions 1 and 2.

Arthur is the CEO of a multinational corporation in the mining industry in Johannesburg. His wife is called by her husband's doctor to say that he has just had a heart attack at work and is now in surgery. Tearfully, his wife describes to the doctor how she has been very worried about her Arthur as he has been very stressed and short-tempered both at home and at work. She describes her husband as driven to succeed and always impatient to get things done properly and effectively! So much so that even though Arthur has reached the top as CEO he finds it hard to let the financial manager do the financial statements as he doesn't trust that the accounts will balance properly, so he takes this extra work home to do late into the night and weekends. She finds that it is difficult to know how he is feeling and spend recreational time with him as he seems constantly preoccupied with being the best mining company and beating the competition.

Question 1

According to the psychological dimension of the Multipath Model in relation to the diagnosis of Psychological Factors Affecting Medical Conditions, the aspects of Arthur's personality that his wife is describing are characteristic of a - - - - -.

1. Type-A personality
2. Type-B personality
3. Type-C personality
4. Type-D personality

Question 2

Arthur's doctor investigates the hardiness of Arthur's personality. A hardy personality refers to - - - - -.

1. traits of stubbornness and drive to achieve
2. levels of high conscientiousness and low agreeableness
3. an approach of commitment, control and challenge
4. a tough-minded character

Question 3

- - - - - is defined as recurrent, intense sexually arousing fantasies, sexual urges, or behaviours involving acts in which the psychological or physical suffering of a victim is sexually exciting to a person. Whereas, recurrent, intense sexually arousing fantasies, sexual urges, or behaviours involving acts of being humiliated, beaten, bound, or otherwise made to suffer is characteristic of - - - - -.

1. Sadistic Rape; Sexual Sadism Disorder
2. Sexual Sadism Disorder; Sexual Masochism Disorder
3. Sexual Masochism Disorder; Sadistic Rape
4. Sadistic Rape; Sexual Masochism Disorder

Read the following case study carefully and answer question 4.

Talitha, a 16-year-old young woman, was continually sexually abused by her father and her paternal uncle. She was threatened with perpetration of sexual abuse on her younger 10-year-old sister if she disclosed the abuse to anyone. Talitha had thoughts of wanting to die but felt that she had to stay alive to protect her sister. Three weeks ago, she ran away from home after being gang-raped by her father and a group of his friends one night. She travelled to another province, where she had lived before the age of five, with the hope that she would find her maternal grandmother with whom she had spent much of her time with as a young child. Talitha travelled by bus and when her money ran out she walked the streets, apparently, without attracting attention at first. However, when she was sitting on a street corner oblivious to the pouring rain and lightning staring at passer byers, she was taken to the police station by a shopkeeper.

When questioned, Talitha could not recall recent events or give her current address, insisting that she lived with her maternal grandmother. When the psychiatrist at the hospital evaluated her she was aware that her name was Talitha, but she believed that it was 2013, giving her age as three years younger and insisting that none of the events of recent years had occurred.

According to the DSM-5 classification system, Talitha's abnormal behaviour could be classified as - - - - -

1. Post-traumatic Stress Disorder
2. Bipolar Disorder, Manic Episode
3. Dissociative Amnesia with dissociative fugue
4. Dissociative Identity Disorder

Question 5

Gender Dysphoria is primarily characterised by - - - - - .

1. conflict between one's anatomical sex and one's psychological feeling of being male or female.
2. sexual urges which are not part of the usual pattern leading to reciprocal and affectionate sexual activity.
3. sexual attraction towards people of the same sex.
4. sexual arousal by wearing clothing appropriate for the opposite sex.

Question 6

Tolerance for a substance can be seen when - - - - -.

1. repeated consumption of the same amount of the substance produces diminishing effects.
2. significant others are more and more accepting of a substance user's problem.
3. the substance user experiences shaking and irritability after he or she stops using the substance.
4. increased amounts of the substance leads to stronger psychological effects.

Question 7

Jan, a 23-year-old, university student who had never used dagga before was given two "joints" by his roommate. Jan smoked the first of the two joints in the same manner that he normally smoked a cigarette (in about three to five minutes). Noting no major impact, Jan immediately smoked the second joint in five minutes. Within a half an hour, he began to experiencing his heart beating fast, dryness in his mouth and increased anxiety, and the belief that his throat was closing up and that he was going to die. He became more panicked which led to him presenting at the casualty ward of the hospital. Reassurance that he would not die had no effect.

Which **one** of the following diagnoses would be considered by the psychiatrist in Jan's case - - - - - according to the DSM-5 classification system?

1. Nonproblematic use of cannabis
2. Cannabis Intoxication
3. Cannabis Use Disorder, Moderate
4. Addiction to Stimulants

Question 8

Which **one** of the following statements is **inaccurate** about the regular use of cannabis (dagga)?

1. Mild hallucinations may occur.
2. Prolonged use increases the risk for heart attack and chronic bronchitis.
3. Cannabis is used successfully to ward off the nausea associated with chemotherapy.
4. The potential for dependency is low in all age groups.

Question 9

The condition called delirium *tremens* involves hallucinations and body tremors during withdrawal from - - - - -.

1. heroin
2. cocaine
3. alcohol
4. cannabis (dagga)

Question 10

Bandile suddenly notices that the world looks weird to him. Some objects look bigger than normal and others look smaller. Cars and people passing by seem oddly shaped. Even the reflection he sees in the mirror does not seem to be his. Bandile is petrified by these symptoms. Two days ago, Bandile was hijacked and suffered severe distress.

Which **one** of the following DSM-5 diagnoses is most appropriate in John's case?

1. Depersonalisation/Derealisation Disorder.
2. Delusional Disorder.
3. Post-Traumatic Stress Disorder.
4. Dissociative Identity Disorder.

Question 11

Ntombi, a six-year-old, has been repeatedly brought into the casualty ward at the hospital, by her recently divorced mother, for a persistent ear infection. Whilst the hospital staff had always been sympathetic and supportive to Ntombi and her mother, they have begun to suspect that Ntombi's reoccuring ear infection is a result of Ntombi's mother failing to give Ntombi her prescribed medication. Ntombi's mother, following her divorce, moved to a new town to resume working as a teacher. Following all the recent life changes, Ntombi's mother reports feeling overwhelmed and unsupported in her life,

According to the DSM-5 classification system, Ntombi's mother is most likely to be diagnosed with - - - - -, and Notmbi is likely to be diagnosed with - - - - -.

1. Malingering; Child Physical Abuse
2. Factitious Disorder Imposed on Self; Illness Anxiety Disorder
3. Factitious Disooder Imposed on Another; Child Neglect
4. Antisocial Personality Disorder; Maladaptive Health Behaviours affecting Ear Infection

Question 12

Sienna is a 16-year-old who experienced the traumatic event of a gunman opening fire at the local supermarket. Whilst Sienna was not injured she has since developed a progressive weakness in her muscles that now prevents her from leaving the house to attend school or other activities that she was previously involved in. Sienna is very distressed by her impairment. Doctors have been unable to find a medical reason for her deteriorating muscle weakness despite running a battery of neurological tests. According to the DSM-5 classification system, which **one** of the following diagnoses is likely to be diagnosed by the clinical psychologist?

1. Somatic Symptom Disorder
2. Malingering
3. Factitious Disorder Imposed on Self
4. Conversion Disorder (Functional Neurological Symptom Disorder)

Read the following case study carefully and then answer question 13, 14, 15 and 16.

Diane, a 40-year-old successful business woman, has been unable to function on almost all levels since the death of her beloved husband four months ago. He was a victim of a hijacking incident while Diane was attending an international conference for business women. Diane is deeply depressed; she suffers severe guilt feelings and has a general sense of worthlessness and hopelessness. She has lost interest in her business and has suffered serious financial losses the past few weeks. She suffers from severe terminal insomnia and her sad and depressed mood is worse in the morning. She has lost a lot of weight and experiences no joy in life. For the past three days she has been lying immobile in bed without paying any attention to her personal hygiene. When her arms and legs are moved by someone to different positions, they just stay there. Diane has stopped speaking and does not appear to hear what is being said to her.

Except for a few business associates, Diane has no support systems to support her in times of stress. Her mother and sister were killed in a car accident when she was five years old and her father, who suffered from episodes of severe depression, committed suicide several years ago.

Question 13

In diagnosing Diane's abnormal behaviour several disorders were considered and some of them were eliminated. Unfortunately **three** of the following differential diagnoses were eliminated for the **wrong** reason. Identify the disorder that was eliminated for the **correct** reason.

1. Bipolar I Disorder: Diane does not manifest any manic symptoms and she has no history of any manic episodes.
2. Mild Neurocognitive Disorder: Diane is too young to suffer from a Neurocognitive Disorder.
3. Schizophrenia: Mood disturbance is uncommon during the prodromal, active and residual phases of Schizophrenia.
4. Persistent Depressive Disorder (Dysthymia): This disorder always has a slow, progressive onset in the absence of clearly identifiable triggers.

Question 14

According to the DSM-5 classification system, Diane's abnormal behaviour can be classified as - - - - -, as principal diagnosis.

1. Bereavement
2. Posttraumatic Stress Disorder
3. Adjustment Disorder with Depressed Mood
4. Major Depressive Disorder

Question 15

Diane's symptoms of loss of appetite and insomnia illustrate the - - - - - symptoms of her principal diagnosis, the symptoms of apathy and depressed mood illustrate the - - - - - domain and the psychomotor retardation illustrates the - - - - - domain of her principal diagnosis.

1. behavioural; physiological; cognitive.
2. physiological; affective; behavioural.
3. somatic; cognitive; behavioural.
4. affective; behavioural; physiological.

Question 16

According to Behavioural explanations of abnormal behaviour, the development of Diane's principal diagnosis can mainly be attributed to - - - - -.

1. arbitrary inference
2. the loss of a positive reinforcer
3. her current negative life situation
4. thinking patterns associated with learned helplessness

Question 17

Amy has been diagnosed with Factitious Disorder Imposed on Self which involves - - - - - while **Marius** has been diagnosed with Malingering which involves - - - - -

1. a display of physical or psychological symptoms with the purpose of pretending to be ill; deliberate displays of false or exaggerated physical or psychological symptoms that are induced by a clear external motive.
2. unawareness of fabricating psychological or physical symptoms; fabricating physical or psychological symptoms simply to pretend to be ill.
3. experiences of actual physical or psychological symptoms but expressed in an exaggerated manner; deliberate steps to make his child ill and attempts to convince a doctor that the child is really ill.
4. motivation to fabricate physical or psychological symptoms by the possibility of financial reward; fabricating physical and psychological symptoms as a result of inner conflict.

Read the following short case study carefully and then answer question 18 and 19.

A distraught wife brings her husband, Mr. Jansen, 46-years-old, to the clinical psychologist at the psychiatric hospital after she finds him writing a suicide note and planning to shoot himself in the veld with a rifle. Mr. Jansen is subdued, shows minimal emotional expression, and his breath smells of alcohol. When asked about his suicidal thoughts, Mr. Jansen states that he feels worthless and that his wife and family would be better off if he were dead.

Mr Jansen is a construction contractor who went overseas to do construction during the Iraq War. He lost half his construction team from a roadside bombing, narrowly escaping with his life. He walks with a permanent limp due to the attack. Upon returning to South Africa he refused to attend psychotherapy stating, "I was in a war, I can handle stress."

But six months after his return, Mrs. Jansen noticed that her husband had trouble sleeping, his mood was at times irritable or withdrawn, he avoided the news reports on television, and he started drinking daily. He complained of nightmares but would not talk about his fears to anyone, including his wife. Tearfully, Mrs Jansen expressed how their relationship was non-existent as she felt she was living with a "man she did not recognise". Mr Jansen only agreed to go to his General Practitioner, to request sleeping medication.

Now at the hospital, the clinical psychologist notes that Mr Jansen is quiet and passive as he is oriented but that he looks around vigilantly and is easily startled by sounds on the ward.

Question 18

According to the DSM-5 classification system Mr Jansen's abnormal behaviour could be classified as - - - - -.

1. Posttraumatic Stress Disorder with delayed expression; Alcohol Use Disorder
2. Posttraumatic Stress Disorder; Alcohol Use Disorder
3. Acute Stress Disorder; Alcohol Use Disorder
4. Adjustment Disorder with Mixed Emotions

Question 19

In addition to the principal diagnosis(es) Mr Jansen's clinical psychologist would consider the following diagnosis/es from the category of Other Conditions That May Be a Focus of Clinical Attention according to the DSM-5 classification system - - - - -.

1. None
2. Relationship Distress with Spouse
3. Spouse or Partner Neglect
4. Insomnia

Question 20

Norman wakes up in Cape Town, some hundred kilometers from his home in Colesberg. He cannot remember how he got there and he has no memory of his former life. He establishes a new identity in Cape Town. **Joe** has an intense and terrifying feeling that he is no longer real and that he is looking at himself and the world from a distance. Although he has not lost contact with reality, these feelings have caused major impairment in his work and personal life.

According to the DSM-5 classification system, **Norman's** abnormal behaviour could be classified as - - - - - and **Joe's** abnormal behaviour as - - - - -.

1. Dissociative Identity Disorder; Dissociative Amnesia with dissociative fugue
2. Dissociative Amnesia with dissociative fugue; Dissociative Identity Disorder
3. Depersonalisation/Derealisation Disorder; Conversion Disorder (Functional Neurological Symptom Disorder
4. Dissociative with dissociative fugue; Depersonalisation/Derealisation Disorder

Read the following case study carefully and answer question 21 and 22.

Mercia's mother severely abused her from the time she was four years old. At the age of 26, Mercia manifests eight different personalities, each with its own distinct identity, name and self-image. The shifts from one personality to another are triggered by psychosocial stress and occurs abruptly. Some of the personalities are aware of the existence of the other personalities. Mercia experiences frequent gaps in memory for personal history, both remote and recent.

Question 21

Which **one** of the following DSM-5 diagnoses is the most appropriate diagnosis in Mercia's case?

1. Dissociative Amnesia
2. Depersonalisation Disorder
3. Dissociative Identity Disorder
4. Bipolar I Disorder With Rapid Cycling

Question 22

According to the psychodynamic therapist who treats Mercia, the development of separate personalities served the purpose of - - - - -

1. eliciting attention and nurturance from other family members.
2. taking the pain of the abuse in order for the core personality to survive.
3. strengthening the weak superego.
4. protecting Mercia from becoming an abusive mother herself.

Question 23

Which **one** of the following statements is **most accurate** in relation to individuals with a DSM-5 diagnosis Paraphilic Disorder?

1. They have weaker than normal sexual desires.
2. They are only aroused by bizarre imagery or actions.
3. They are able to become sexually aroused under normal conditions.
4. They are not distressed by their sexual fantasies and urges.

Question 24

Lebo, a 32-year-old woman, has been married for five years. Since the birth of her last child one year ago she has lost interest in either fantasising or engaging in any sexual activity. In fact, she does whatever she can to avoid situations where sexual intercourse is a possibility. This state of events has put significant strain on her marital relationship to an extent that her husband is threatening to leave her.

Based on the information above, Lebo will most likely receive a DSM-5 diagnosis of - - - - -.

1. Sexual Arousal Disorder.
2. Secondary Frigidity.
3. Female Sexual Interest/Arousal Disorder
4. Secondary Orgasmic Dysfunction

Question 25

Bongani, a 30-year-old man always experienced inner conflict about being male. He enjoys dressing in female clothing, has often fantasised about being a woman and has rejected male stereotypical games and activities since childhood. He expresses intense stress due to the fact that he is being stigmatised by people in his community who are unable to accept his preference with regard to his sexual orientation. Two months ago he attempted suicide as he could no longer cope.

According to the DSM-5 classification system, the psychiatrist would consider the diagnosis of - - - - - in Bongani's case.

1. Paraphilic Disorder
2. Gender Dysphoria in Adolescents and Adults
3. Transvestic Disorder
4. Homosexuality

Question 26

Herby has been pessimistic, depressed and fatigued with little interest in food and social activities for the past three years. In fact, his colleagues would not recognise him if he was not down and disinterested in work. His boss noticed that though Herby still did most of his work it was not at the level tthat the job required.

The most appropriate DSM-5 diagnosis in Herby's case is a - - - - -.

1. Persistent Depressive Disorder (Dysthymia)
2. Personality Disorder
3. Cyclothymic Disorder
4. Major Depressive Disorder

Question 27

William is diagnosed with Bipolar I Disorder, recent episode Manic. His symptoms are elevated mood, grandiosity, disjointed speech, excessive sleep and irritability. His occupational and social functioning is severely impaired. Which aspect of William's case is **unusual**? The fact that - - - - -

1. he manifests with disjointed speech.
2. his functioning is severely impaired.
3. he is irritable and grandiose.
4. he sleeps excessively.

Question 28

Emma's style of functioning in the past 25 years is characterised by fluctuations and instability in self-image, relationships and mood. **Michelle** has had many mild mood swings over the past 26 months. Her functioning is moderately impaired. She has never experienced a manic episode. According to the DSM-5 classification system **Emma's** abnormal behaviour could be classified as - - - - -, and **Michelle's** abnormal behaviour as - - - - - .

1. Dysthymic Disorder; Bipolar II Disorder
2. Histrionic Personality Disorder; Major Depressive Disorder
3. Borderline Personality Disorder; Cyclothymic Disorder
4. Dissociative Identity Disorder; Bipolar I Disorder chronic

Question 29

According to the DSM-5 classification system, a diagnosis of Fetishistic Disorder refers to which of the following?

1. Intense sexually arousing fantasies that occur while observing an unsuspecting person is naked, in the process of undressing, or engaging in a sexual activity.
2. Sexual arousal and satisfaction from the psychological or physical suffering of others.
3. Intense recurrent sexual urges to touch and rub up against non-consenting people.
4. Intense sexually arousing fantasies and urges involving non-animate objects, and which leads to the individual's personal distress or affects social and occupational functioning.

Question 30

Chris can only be sexually aroused when he fantasises about inflicting pain on others. He is manifesting signs of - - - - -.

1. Sexual Masochism Disorder
2. Sexual Sadism Disorder
3. Frotteuristic Disorder
4. Sado-Masochism

Assignment 91		
Semester 1	*Closing date: 4 May 2016*	*Unique number: 600585*

Note: This assignment is **not compulsory**, and carries **no examination credits**. The assignment consists of 24 questions to evaluate the Abnormal Behaviour and Mental Health module. Will you please assist us to improve our module by evaluating it? It will only take a few minutes of your time to answer the questions on a mark reading sheet. Please note that this is not an assignment in the real sense of the word and you will not get any marks or credits for completing it. We only use the assignment format to utilise the computer to analyse the data for us.

SECTION A: MODULE EVALUATION

1 My **overall opinion** of the Abnormal Behaviour and Mental Health module is that the module is - - - - -.

1. poor
2. average
3. good
4. excellent

2 Have your **expectations** of this module been met?

1. No, not at all
2. Yes, but only to some extent
3. Yes, to a great extent
4. Absolutely, yes!

3 Has this module enabled you to **identify abnormal behaviour**?

1. No, not at all
2. Yes, but only to some extent
3. Yes, to a great extent
4. Absolutely, yes!

4 Has this module enabled you to have a **greater understanding** of people suffering from abnormal behaviour?

1. No, not at all
2. Yes, but only to some extent
3. Yes, to a great extent
4. Absolutely, yes!

5 Has this module led you to greater **insight** into issues concerning abnormal behaviour?

1. No, not at all
2. Yes, but only to some extent
3. Yes, to a great extent
4. Absolutely, yes!

6 Has this module enabled you to **refer individuals** with identified problems to appropriate health practitioners?

1. No, not at all
2. Yes, but only to some extent
3. Yes, to a great extent
4. Absolutely, yes!

7 Has this module made you more involved with **promoting mental health**?

1. No, not at all
2. Yes, but only to some extent
3. Yes, to a great extent
4. Absolutely, yes!

8 How would you describe the **level of difficulty** of **Tutorial Letters 501, 502, and 503** for this module?

1. Very difficult
2. Difficult
3. Acceptable
4. Easy

9 To what degree have **Tutorial Letters 501, 502, and 503 supported** you in mastering the course material?

1. Not at all.
2. To some extent.
3. To a great extent.
4. The study guide is crucial.

10 How would you describe the **level of difficulty** of the **prescribed book** for this module?

1. Very easy
2. Acceptable
3. Difficult
4. Very difficult

11 How easy or difficult was it for you to **get hold** of the **prescribed book**?

1. Very easy
2. Fairly easy
3. Difficult
4. Very difficult

12 How would you describe the **level of difficulty** of the **recommended material** for this module?

1. Acceptable
2. Difficult
3. Very difficult
4. Not applicable (e.g. you did not consult the recommended material)

13 To what degree has the **recommended material** supported you in mastering the course material?

1. Not applicable (e.g. you did not consult the recommended material)
2. Not at all
3. To some extent
4. To a great extent

14 How would you describe the **level of difficulty** of the **tutorial letters** for this module?

1. Very difficult
2. Difficult
3. Acceptable
4. Easy

15 To what degree have the **tutorial letters supported** you in mastering the course material?

1. Not at all.
2. To some extent.
3. To a great extent.
4. The tutorial letters are crucial.

16 How would you describe the **level of difficulty** of the **assignments** for this module?

1. Very difficult
2. Difficult
3. Acceptable
4. Easy

17 If you studied this module through the **medium of English**, and if English is **not your first language**, would you attribute difficulties you might have experienced to the use of English as the medium of instruction?

1. Not applicable (e.g. English is my first language).
2. It caused serious difficulties.
3. It sometimes contributed to the level of difficulty.
4. It was not a source of difficulty.

18 What is your opinion on the **total workload** of this module?

1. Too demanding
2. Unsure
3. Manageable
4. Easy to manage

19 On average, how many **hours per week** did you spend studying this module?

1. Less than 4 hours per week.
2. 4 to 6 hours per week.
3. 7 to 10 hours per week.
4. More than 10 hours per week.

20 Did you **enjoy** studying this module?

1. Absolutely yes!
2. Yes, to some extent.
3. No, not really.
4. No, I did not enjoy it at all.

21 Would you **recommend** this module to your colleagues or friends?

1. No, not at all.
2. Yes, but only to some extent.
3. Yes, to a great extent.
4. Absolutely, yes!

SECTION B: CONTACT WITH YOUR LECTURER/S

22 How **often** during 2016 have you made contact with an Abnormal Behaviour and Mental Health lecturer?

1. Weekly
2. Monthly
3. Quarterly
4. Not at all

23 How do you prefer to **communicate** with your lecturer(s)?

1. Telephone calls
2. E-mails
3. Personal visits
4. Letters/faxes

24 How would you describe the **helpfulness of your lecturer(s)**?

1. Not applicable
2. Very helpful
3. Helpful
4. Not at all helpful

THANK YOU FOR YOUR PARTICIPATION.

8.5.2 Assignments for Semester 2

Assignment 01		
Semester 2	*Closing date: 3 August 2016*	*Unique number: 613593*

This assignment is based on **learning units 1 to 7 in Tutorial Letter 501** and the corresponding chapters **1, 2, 3, 5 and 16** in the prescribed book.

Question 1

Sarie, a first year university student far from home, feels lonely, sad and dejected. Her academic performance is good and she gets along with the other women in her residence, but she experiences severe feelings of hopelessness and despair. Identify the criteria of abnormal behaviour that are **most evidently** met with regard to Sarie's case?

1. Deviance; Dysfunction
2. Dangerousness To Self Or Others; Distress
3. Distress; Dysfunction
4. Dangerousness To Self Or Others; Deviance

Question 2

Sbu believes he is Shaka Zulu, reborn. He believes that he is destined to lead the South African Defence Force to take over Botswana, Mozambique and Zimbabwe, and to form a new nation which he will lead and then pass on to his sons. He has accumulated spears and carries them around when walking down the street. Identify the criteria of abnormal behaviour that are **most evidently** met with regard to Sbu's case?

1. Deviance; Dysfunction
2. Dangerousness To Self Or Others; Distress
3. Dangerousness To Self Or Others Distress; Dysfunction
4. Dangerousness To Self Or Others; Deviance; Dysfunction

Question 3

All the following are characteristics of the Western perspective regarding abnormal behaviour, **except** - - - - -.

1. harmony with nature
2. mastery of the universe
3. emphasis on experimentation
4. analytical and objective

Question 4

Zama, 19 years old, has said to her mother that she hears voices telling her that there is an electrical current coming up from the floor and into her feet and legs. This current she adds is trying to pull her into the floor. She thus has resorted to not getting out of bed. Thirteen months ago, Zama abandoned her radiography studies, yet she spends her days and nights tirelessly working on coming up with a new machine to produce 3-D X-rays, isolated in her bedroom. She no longer goes out to see her friends and her self-care has deteriorated.

According to the African perspective, Zama's abnormal behaviour would be regarded as - - - - -.

1. Amafunfunyane
2. Ukuthwasa
3. Malombo
4. Sejeso

Question 5

With reference the African worldview, which one of the following statements best describes the concept of "Ubuntu"?

1. I think therefore I am.
2. I am because we are.
3. I feel therefore we are.
4. I do therefore I am.

Question 6

Boitumelo subscribes to the African worldview. Which **one** of the following characteristics most accurately explains his understanding of healing?

1. Empirically logical.
2. Emphasis on experimentation.
3. Supernatural and holistic.
4. Oriented to the future.

Question 7

Which **one** of the following statements **does not** apply to the causes of mental disorders according to the traditional African perspective regarding abnormal behaviour?

1. They are sent by the ancestors.
2. They are caused by exposure to a polluted environment.
3. They are caused by malicious people like sorcerers.
4. They are due to the breaking of customs and bewitchment.

Question 8

All of the following are characteristics common to a diagnosis of Specific Phobia **except** - - - - -.

1. persistent, unrealistic fears of specific objects or situations.
2. significant attempts by the anxious individual to avoid the phobic situation or object.
3. exposure to a feared stimulus produces intense fear or panic attacks.
4. intense fear of being in public places where escape or help may not be available when confronted with the feared object.

Read the following short case study and answer questions 9, 10 and 11.

For the past six weeks Mandy, a Grade 2 learner whose parents went through a high-conflict divorce recently, has been experiencing excessive and persistent worries that something will happen to her mother and that she will be separated from her. She also experiences persistent nightmares with themes of being lost and separated from her mother and refuses to go to sleep without her mother being with her. Mandy refuses to leave the house without her mother.

Although she adjusted well to school in Grade 1, she currently refuses to go to school without her mother being with her all the time. An attempt by Mandy's mother to leave her in the care of her teacher, led to an episode of intense fear during which Mandy experienced feelings of choking, dizziness, accelerated heart rate, sweating and uncontrollable trembling and shaking of her body.

Question 9

According to the DSM-5 classification system, Mandy's principal diagnosis will be - - - - -?

1. Agoraphobia
2. Panic Disorder
3. Specific Phobia, Situational
4. Separation Anxiety Disorder

Question 10

In addition to the principal diagnosis, Mandy would also be diagnosed with - - - - - according to the DSM-5 classification system.

1. Educational Problems
2. Social Anxiety Disorder
3. Adjustment Disorder with anxiety
4. Child Affected by Parental Relationship Distress

Question 11

Mandy's symptom of unrealistic worry illustrates the - - - - - manifestation of her principal diagnosis, the symptoms of avoidance and clinging behaviour illustrate the - - - - - domain of this diagnosis and the symptom of fearfulness illustrates the - - - - - manifestation of her principal diagnosis.

1. affective; cognitive; somatic
2. cognitive; behavioural; affective
3. behavioural; affective; emotional
4. emotional; somatic; behavioural

Question 12

Since Beth was bitten by a dog eight months ago, she experiences recurrent terrifying episodes that last approximately 15 minutes. Beth's heart beats so fast, she believes she is having a heart attack, she sweats profusely and she feels a sense of doom. Since the first episode, Beth has feared having another episode. According to the DSM-5 classification system, Beth's abnormal behaviour can be classified as - - - - -.

1. Specific Phobia
2. Panic Disorder
3. Illness Anxiety Disorder
4. Somatic Symptom Disorder

Question 13

Helené is so afraid of being alone in public places or being caught in a crowd that she cannot bring herself to leave her house. The mere thought of being in these feared situations produces overwhelming anxiety and distress. According to the DSM-5 classification system, should these symptoms be present for - - - - - months, Helené is probably suffering from - - - - -.

1. six; Agoraphobia
2. twelve; Panic Disorder
3. six; Generalised Anxiety Disorder
4. twelve; Specific Phobia Situational

Question 14

According to the General Adaptation Syndrome, an increase in lymphocyte production means that the body's - - - - - and - - - - - reaction to - - - - - indicates that the body is fighting a developing disease.

1. immune system; the invading organism's; stress
2. physicality; psychological; biological stressors
3. defences; its resistance to having a; biological stressors
4. suppression; repressive; psychological defences

Question 15

Which **one** of the following statements is most accurate in describing the aetiology of Obsessive-Compulsive Disorder according to all four dimensions of the Mutlipath Model?

1. Reduced availability of serotonin; cognitive distortions; controlling or critical parenting; demographically equally common in males and females.
2. Cognitive distortions; social vulnerabilities; anxiety reduction; poor impulse control.
3. Increased activity in the orbitofrontal cortex; lack of trust in one's performance; anxiety reduction; controlling or critical parenting.
4. Cultural differences in obsessions/compulsions; social vulnerabilities; subgroups differ regarding genetics; lower activation in the caudate nuclei.

Read the short case study and answer questions 16, 17 and 18

Junaid, a Grade 7 learner is regarded as the school bully. He is aggressive and intimidates his co-learners at every opportune moment. Over the past three years he has been expelled from two schools and the principal of his current school has summoned Junaid's parents to a meeting to discuss Junaid's behaviour. The principal tells Junaid's parents that he has been caught threatening a classmate with a knife when this classmate caught Junaid stealing his new Nike sneakers from his sports bag. Junaid's parents acknowledged to the principal that they are extremely concerned regarding Junaid's behaviour as they have increasingly been trying to control Junaid who has been acting violently and extremely disrespectful of their rules. They said they considered Junaid a danger to their family as he had cut a piece out of the family's dog's ear when they tried to ground him for sneaking out of the house one night. The police contacted his parents to notify them of Junaid's arrest when the police found him smoking marijuana (dagga) with boys much older than him in the parking lot of the local mall.

Question 16

If the principal refers Junaid to a clinical psychologist, the most likely principal DSM-5 diagnosis to be made is - - - - -.

1. Antisocial Personality Disorder
2. Intermittent Explosive Disorder
3. Conduct Disorder
4. Bipolar I Disorder

Question 17

Which of the following additional diagnoses should the psychologist also make for Junaid's case according to the DSM-5 classification system?

a) Problems related to Family Upbringing
b) Educational Problem
c) Social Exclusion or Rejection e.g. bullying
d) Problems Related to Other Legal Circumstances
e) Child Physical Abuse

1. a, b and c
2. a, b, and d
3. b, c, and e
4. c, d and e

Question 18

Sue et al. (2016) describes Junaid's most probable principal diagnoses (refer to question 16), as a(n) - - - - - disorder among youth. Furthermore, the development of Junaid's specific disorder is described as - - - - - when explained according to the Multipath Model.

1. externalising; a disorder most strongly influenced by biological factors
2. internalising; a disorder influenced by a combination of the "low-activity MAOA" genotype and childhood maltreatment
3. Personality; a disorder which is caused due to fluctuating cortisol levels
4. Disruptive and Impulse Control; a disorder which is due to parental over involvement with an only child

Question 19

Emma's style of functioning in the past 25 years is characterised by fluctuations and instability in self-image, relationships and mood. **Michelle** has had many mild mood swings over the past 26 months. Her functioning is moderately impaired. She has never experienced a manic or mixed episode. According to the DSM-5 classification system **Emma's** abnormal behaviour could be classified as - - - - - and **Michelle's** abnormal behaviour as - - - - -

1. Persistent Depressive Disorder (Dysthymic Disorder); Bipolar II Disorder.
2. Histrionic Personality Disorder; Major Depressive Disorder.
3. Borderline Personality Disorder; Cyclothymic Disorder.
4. Dissociative Identity Disorder; Bipolar I Disorder, chronic.

Read the following short case study and then answer question 20.

Herbert complains of persistent and distressing thoughts about dirt and germs. He cannot eat without washing his hands six times before every meal with a specific strong detergent. Although his hands are raw from his hand-washing rituals, he becomes overwhelmed with anxiety if he does not wash his hands repeatedly before every meal. **Richard** complains of an excessive, unrealistic longstanding fear of heights. He avoids heights wherever possible. He not only experiences overwhelming fear in the face of heights, he also experiences several distressing physical symptoms such as breathlessness, nausea and heart palpitations.

Question 20

According to the DSM-5 classification system, **Herbert's** abnormal behaviour could be classified as - - - - - and **Richard's** abnormal behaviour as - - - - -

1. Specific Phobia; Avoidant Personality Disorder.
2. Obsessive-Compulsive Personality Disorder; Agoraphobia.
3. Obsessive-Compulsive Disorder; Specific Phobia.
4. Specific Phobia; Panic Disorder.

Question 21

According to the DSM-5 classification system which of the following criteria are required to make a diagnosis of Hoarding Disorder?

a) There is an inability to discard items regardless of their value.
b) A perceived need for items and distress over the thought of giving or throwing them away.
c) An accumulation of items that produces congestion and clutter in living areas.
d) Social pressure to discard is distressing because of emotional attachment to items.

1. a and b
2. a, b and c
3. a, c, and d
4. all of the above

Question 22

Which of the following statements is correct about Obsessive-Compulsive Disorder?

a) The primary symptoms in OCD are obsessions, which are persistent, anxiety-producing thoughts or images, and compulsions involving the overwhelming need to engage in activities to counteract the anxiety or prevent the occurrence of the dreaded event.
b) The primary symptoms in OCD are obsessions involving an overwhelming need to engage in activities add to the anxiety or prevent the occurrence of the dreaded event, and compulsions which are persistent, anxiety-producing thoughts or images.
c) Obsessions and compulsions do not occur separately from each other.
d) Compulsions are frequently performed to neutralise or counteract a specific obsession.

1. a and c
2. a and d
3. b and c
4. b and d

Question 23

Mrs Van Rooyen is suffering from an Anxiety Disorder in which she has occasional panic attacks when shopping at the mall. This type of panic attack is referred to as - - - - -.

1. cued.
2. uncued.
3. situationally bound.
4. situationally predisposed.

Question 24

Dr Ndlovu says this about a pathological gambler: “Betting is like masturbation in that there is a build-up of inner tension and a need to release it, followed by both excitement and guilt.” Dr Ndlovu’s explanation suggests that he holds a - - - - - view of impulse-control disorders.

1. behavioural
2. genetic
3. psychodynamic
4. cognitive

Question 25

The **key** feature of the Borderline Personality Disorder is - - - - -.

1. a tendency to experience paranoid delusions that are similar to those experienced in Schizophrenia.
2. the occurrence of severe fluctuations in mood and self-image.
3. the occurrence of shifts from normal to psychotic functioning.
4. the demand for unconditional acceptance by authorities but a need for feedback from family members.

Question 26

Regarding the gender distribution of Personality Disorders, men are more likely to be diagnosed with - - - - - and - - - - - Personality Disorders, while women are more likely to be diagnosed with - - - - - and - - - - - Personality Disorders.

1. Antisocial; Obsessive-compulsive; Borderline, Dependent
2. Paranoid; Antisocial; Borderline, Histrionic
3. Paranoid; Histrionic; Narcissistic; Obsessive-compulsive
4. Obsessive-compulsive; Borderline; Paranoid, Histrionic

Question 27

Rihanna, 10 years old, is taken to a clinical psychologist by her concerned parents as she, over the last year has repeatedly pulls strands of her hair out despite ongoing efforts by her parents and even herself to stop the behaviour. Rihanna's behaviour has resulted in significant hair loss and distress as she is constantly teased at school for the patches of baldness that have emerged as a result of pulling out her hair. According to the clinical psychologist, Rihanna 's - - - - - to pull her hair out is in line with the DSM-5 diagnosis of - - - - -?

1. compulsion; Excoriation Disorder
2. obsession; Trichotillomania
3. obsession; Excoriation Disorder
4. compulsion; Trichotillomania

Question 28

A psychologist is asked by Teddy Bear Clinic for Abused Children to do a presentation to parents at local schools show how child abuse and neglect is a risk factor for individuals developing a mental disorder such as a Depressive or Anxiety Disorder. These presentations to parents are an example of - - - - -?

1. Primary Prevention
2. Risk Prevention
3. Secondary Prevention
4. Tertiary Prevention

Question 29

In Community Psychology, the - - - - - model aims to prevent mental disorders in society, whereas, the - - - - - model aims to assist the poor and equalise opportunities in society.

1. social action; mental health
2. mental health; ecological
3. ecological; social action
4. mental health; social action

Question 30

Minimising the effects of psychiatric institutionalisation by facilitating individuals with mental disorders returning to their community refers to:

1. Primary prevention
2. Secondary-level treatment
3. First-level treatment
4. Tertiary prevention

Assignment 02		
Semester 2	*Closing date: 7 September 2016*	*Unique number: 613632*

This assignment is based on **learning units 8 to 13 of Tutorial Letter 502** and the corresponding **chapters 6, 7, 8, 9, 10, and 15 in the prescribed book.**

Question 1

Which **one** of the following statements regarding suicide is **accurate**?

1. Severe depression is the primary precipitating cause in most cases of suicide.
2. Feelings of hopelessness or negative expectations about the future are even more strongly related to suicidal behaviour than depression.
3. Suicide is most likely when people are in the depths of a Major Depressive Episode.
4. Only a very small percentage of suicides are preceded by either verbal or non-verbal behavioural cues indicating the intention to commit suicide.

Read the following short case study carefully and then answer questions 2 and 3.

Mavis attended an appointment with a clinical psychologist as she had developed symptoms in the wake of an assault that occurred about seven weeks ago. While leaving work late one evening, Mavis was attacked in the parking lot. She was raped and badly beaten. After the rapists fled, she was able to retrieve her cellphone from a nearby dustbin and call for help.

In the interview with the psychologist, Mavis reported frequent intrusive thoughts about the assault and recurrent intrusive images of her assailant, feeling as if the assault was reoccurring. She also relayed that she now took the Gautrain to work to avoid the scene of the attack and that she had to change her work hours so that she did not have to leave the building after dark. She also always ensured that she was accompanied by colleagues when leaving the building. Furthermore, Mavis reported that she had difficulty interacting with men, particularly those that resembled her attacker, and that she constantly avoided such interactions. However, her boss and colleagues kept on asking her why she was avoiding attending a number of critical meetings.

Tearfully, Mavis also stated that since the incident her husband found her to be irritable, and continually asked her why she was constantly waking up in the middle of the night and he noted that she seemed jumpy and on edge in the evenings, constantly, checking if the gate and doors were locked. Moreover, Mavis stated that she and her husband have not had sexual relations since the incident, and when he has attempted to be affectionate she finds herself snapping at him that she has work to do. She has not told her husband yet about the assault. Mavis relays to the psychologist that this is the first time she has disclosed to anyone about the assault.

Question 2

According to the DSM-5 classification system, Mavis' abnormal behaviour could be classified as - - - - -.

1. Posttraumatic Stress Disorder with delayed expression.
2. Posttraumatic Stress Disorder.
3. Adult Sexual Abuse Disorder by non-partner.
4. Depersonalisation/Derealisation Disorder.

Question 3

According to the DSM-5 classification system, what would have been Mavis' diagnosis if she had visited the clinical psychologist four days after she was raped?

1. Posttraumatic Stress Disorder.
2. Acute Stress Disorder.
3. Adult Sexual Abuse Disorder by non-partner.
4. Adjustment Disorder with anxiety.

Question 4

According to the DSM-5 classification system, a psychiatrist would consider the diagnosis of - - - - - where sexual arousal of a 19-year-old patient occurs in the context of inappropriate objects and non-consenting people.

1. Paraphilic Disorder
2. Gender Dysphoria in Adolescents and Adults
3. Transvestic Disorder
4. Genito-Pelvic Pain/Penetration Disorder.

Read the following case study carefully and then answer questions 5, 6, 7, 8 and 9

Caroline, a middle-aged woman, was dressed in wrinkled and slightly soiled clothes and there was a faint body odour about her. She sat motionless with an expressionless face, staring at the floor. She said nothing unless asked a simple question. Even then her answers were delayed and of a monotonous quality. Caroline was unresponsive to all pleasurable stimuli and clearly had no interest in life anymore. According to her husband, Caroline had lost 8 kg in the past three weeks, she suffered from severe terminal insomnia and her depressed and sad mood was worse in the morning. According to Caroline's husband, Caroline became preoccupied with guilt feelings and suicidal ideation after the unexpected death of their only child and two grandchildren three months ago Their daughter and her children lost their lives in a horrific car accident. Caroline's husband sought professional help for Caroline when he realised that she was giving away her valuable jewellery and refused to hand over her revolver to him.

Question 5

If Caroline's abnormal behaviour would be classified according to the DSM-5 classification system, the most likely diagnosis would be - - - - -

1. Bereavement.
2. Adjustment Disorder with Depressed Mood.
3. Major Depressive Disorder, severe, with melancholic features.
4. Persistent Depressive Disorder (Dysthymia) with catatonic features.

Question 6

Caroline's apathy and depressed mood illustrate the - - - - - domain of her principal disorder, the symptoms of insomnia and weight loss illustrate the - - - - - domain and the neglect of personal appearance and psychomotor retardation illustrates the - - - - - domain of her principal disorder.

1. affective; physiological; behavioural
2. cognitive; affective; physiological
3. physiological; cognitive; affective
4. behavioural; somatic; cognitive

Question 7

According to Seligman and his colleagues' cognitive-learning approach, Caroline's disorder can mainly be attributed to - - - - -, while the Behavioural explanations of mental disorders will focus on - - - - - as the main contributor to the development of Caroline's current disorder.

1. arbitrary inference; the lack of proper role models during childhood years.
2. her current negative life situation; exposure to stress during her early development
3. thinking patterns associated with learned helplessness; the loss of social reinforcers
4. an absence of positive reinforcers in the event of severe stress; magnification and exaggeration

Question 8

Which of the following alternatives contain the **correct** information regarding the influence of stress on the development of the kind of disorder Caroline is suffering from?

a) The loss of her daughter and grandchildren three months ago is more likely to have led to the development of the disorder Caroline is suffering from than several smaller stressors during the past few years would have.
b) Should Caroline experience less severe stressors in future, she probably will develop similar episodes she is currently suffering from.
c) Not all people who experience the tragic loss of a loved one will develop the kind of disorder Caroline is suffering from.
d) A failure to develop secure attachments and trusting relationships during childhood years might have contributed to a vulnerability to develop the disorder Caroline is currently suffering from.
e) Not only does stress increase the risk of the disorder Caroline is suffering from, but this specific disorder can also increase social stress.
f) Distressing social interactions increase the risk of the kind of disorder Caroline is suffering from.

1. a) and b)
2. b), c) and d)
3. a), d), e) and f)
4. all of the above.

Question 9

Which of the following actions would you regard as the most appropriate suicide preventative measures in Caroline's case?

1. Recommended bed rest and potential counselling.
2. Provide Caroline with the telephone number of a telephone crisis intervention centre and give her husband specific guidelines about how to support her.
3. Provide preventative counselling and weekly monitoring.
4. Hospitalise Caroline immediately voluntary or involuntary, provide intensive medical and psychological treatment as well as comprehensive supervision.

Question 10

Elaine is diagnosed with Bipolar I Disorder, most recent episode mania. Her symptoms are elevated mood, distractibility, disjointed speech, excessive sleep and irritability with others. She has been suffering from these symptoms for the past ten days. Her occupational functioning is impaired. Before this current manic episode she suffered from a major depressive episode during which she became obsessed with her personal appearance. She spent hours on choosing the right outfit and doing her hair. The depressive episode lasted for eight weeks. Which aspects of Elaine's case are **unusual** for Bipolar I Disorder?

1. The duration of the manic episode and the presence of disjointed speech during a manic episode.
2. An increased need for sleep during a manic episode and an obsession with appearance during a major depressive episode.
3. The impairment in occupational functioning and the irritable mood during a manic episode.
4. The history of a major depressive episode and the duration of this episode.

Read the following case study and then answer questions 11, 12, and 13.

Mr Thobela, 41 years old, was admitted to the orthopedic ward after falling down stairs at home and breaking his leg. On the third day of his hospital stay, Mr Thobela became increasingly nervous and started to tremble. He was unable to sleep at night, talked incoherently, and was obviously very anxious. Mr Thobela, when asked by his doctor, denied misusing alcohol other than the occasional beer with friends.

When interviewed with his wife, Mrs Thobela disclosed that her husband drank large quantities of alcohol for the past four years. Last year when he was retrenched from his job, his drinking would begin every evening and would not end until he fell asleep. On the evening when he was admitted to the hospital, his fall occurred before he was able to consume any alcohol.

During the few weeks prior to his admission to hospital Mr Thobela had eaten very little. On several occasions, his wife noticed that Mr Thobela was unable to recall even important events from the previous day. Mr Thobela had a car accident coming home from watching a soccer match two years ago without major injury. He has no other major health problems.

Reportedly, his relationship with his wife became very difficult after he began drinking and Mrs Thobela stated in the interview that she was seriously contemplating divorce. Mr Thobela had a tense relationship with his two children and often argued with them. Recently, the children tried to avoid their father as much as possible.

Mr Thobela's speech was rambling and incoherent. He believed that he was still at work and that he had tasks to finish. At times he thought that the hospital staff was his work colleagues. He also was observed to be picking at bugs that he could see on his bed linen. He was disorientated in time and was startled easily by sounds from outside the interview room and his hospital room. He perspired profusely and could not hold a cup without spilling some of the water.

Question 11

Which **one** of the following DSM-5 diagnoses would be the most appropriate diagnosis in Mr Thobela's case?

1. Alcohol Abuse
2. Alcohol Use Disorder
3. Alcohol Withdrawal
4. Alcohol Intoxication

Question 12

Mr Thobela's symptoms of shakiness, insomnia, nausea and sweaty palms, illustrate the symptoms of - - - - - that is present in Alcohol - - - - -.

1. Withdrawal; Use Disorder
2. Intoxication; Withdrawal
3. Tolerance; Use Disorder
4. Tolerance; Intoxication

Question 13

In addition to the principal diagnosis Mr Thobela's clinical psychologist would consider the following diagnosis/es from the category of Other Conditions That May Be a Focus of Clinical Attention according to the DSM-5 classification system.

1. Disruption of Family by Separation or Divorce; Economic Problems
2. Spouse or Partner Neglect; Economic Problems
3. Adjustment Disorder with mixed emotions
4. Other Problems Related to Primary Support Group; Economic Problems

Question 14

For over three years, **Tom**, 24 years old, experiences a recurrent preoccupation with sexual fantasies and acts of observing his unsuspecting neighbour undressing in her bedroom. Whereas, for seven months, **Peter**, 33 years old, finds himself attending clubs that are packed with partygoers so that he is in a position to rub his penis against fully clothed young women jam-packed in the crowd. The clinical psychologist would consider the DSM-5 diagnosis of - - - - - in **Tom's** case and the DSM-5 diagnosis of - - - - - in **Peter's** case.

1. Gender Dysphoria in Adolescents and Adults; Partialism
2. Voyeuristic Disorder; Frotteuristic Disorder
3. Transvestic Disorder; Pedophilic Disorder
4. Voyeuristic Disorder; Exhibitionistic Disorder.

Question 15

Based on research, which **one** of the following adolescents has the **greatest risk** of committing suicide?

1. Thabo, whose parents are both employed and perceived as financially secure.
2. Dee, who fluctuates between anger and depression.
3. Fred, who is regarded as a gifted child and is head boy of his school.
4. Maria, whose parents demand that they go on regular family outings.

Question 16

According to Sue et al. (2016), which **one** of the following common characteristics of suicide is **incorrect**?

1. There is a strong underlying desire to die by the individual who attempts/commits suicide.
2. Suicidal intent is communicated directly or indirectly through behavioural cues.
3. Triggering events include intense interpersonal conflicts.
4. There is a perceived inability to make progress towards goals or to solve problems.

Question 17

Duncan is a 24-year-old engineer. He was diagnosed with Leukaemia when he was seven years old. After thirteen rounds of chemotherapy, the cancer was certified to be in remission. All his susequent medical check-ups have shown no signs of the disease returning. Despite Duncan's physician reassut¨ring him of his cancer-free status, Duncan's preoccupation with thoughts that his cancer has returned has progressively worsened over the years. Duncan routinely checks himself into hospital for a full medical examination before his scheduled bi-annual check-ups. He spends hours every week examining himself for any bruising or lesions that might confirm his suspicions of the cancer having returned. According to the DSM-5 classification system, Duncan would most likely be diagnosed with - - - - -.

1. Somatic Symptom Disorder
2. Conversion Disorder (Functional Neurological Symptom Disorder)
3. Illness Anxiety Disorder
4. Factitious Disorder Imposed on Self

Question 18

According to Sue et al. (2016) the aetiology of Somatic-Related Disorders from a Cognitive Behavioural Therapy perspective refers to - - - - -.

1. Reinforcement, modelling and congnitions, or a combination of these factors.
2. Defending against the awareness of unconscious conflicts.
3. Genetic factors that have been shown to be modestly influential.
4. The need for protection from overwhelming anxiety which gives rise to the physical symptoms experienced.

Question 19

Dr. Holmes, a plastic surgeon, referred Jade, 22 years old, to a clinical psychologist for an evaluation. This followed after Jade consulted him regarding what she calls "her disproportionate facial strcuture". Startled, by the Jade's concerns, Dr Holmes attempted to reassure Jade that the proportions of her face fell well within the normal range for the general population. However, brushing aside his professional opinion Jade insisted that she required surgery to correct the gross disproprtions in her facial structure that have been causing her immeasurable distress for a number of years. According to Jade, if her "imperfections" were fixed, she would be able to return to university and go out of the house, since everyone would no longer stare at her as if she was a "freak of nature". Which **one** of the following DSM-5 disorders would Jade most likely be diagnosed with?

1. Illness Anxiety Disorder
2. Agoraphobia
3. Delusional Disorder
4. Body Dysmorphic Disorder

Question 20

Ingrid injured her back on a hiking holiday three years ago. Although, she was successfully treated by her doctor and considered to have recovered completely, Ingrid still complains of severe and debilitating back pain. Other than some minor scar tissue, her doctor cannot find anything that could cause more pain than some minor stiffness. According to the DSM-5 classification system, Ingrid is most likely suffering from - - - - -.

1. Conversion Disorder (Functional Neurological Symptom Disorder)
2. Illness Anxiety Disorder
3. Factitious Disorder Imposed on Self
4. Somatic Symptom Disorder

Question 21

Which parts of the following statement regarding the role of stress in depression are **incorrect**?

a) Interpersonal stress is frequently linked with depression.
b) Several minor stressors are more likely to cause depression than one severe stressor.
c) Chronic stress is more highly related to depression than acute stress.
d) Stressors, associated with loss and humiliation are more likely to cause depression than stressors associated with dangerous events.
e) Social support may alleviate the impact of stress and prevent the development of depression.

1. a and e
2. b and c
3. b and d
4. d and e

Question 22

Ben was diagnosed with Post-traumatic Stress Disorder (PTSD) when he came back from the war in Sudan. His symptoms include daily flashbacks of bombing raids, emotional numbness, withdrawal from family and friends and extended periods of sleep. Which **one** of Ben symptoms is unusual in cases of PTSD?

1. Daily flashbacks
2. Emotional numbness
3. Withdrawal from family and friends
4. Extended periods of sleep

Read the following case study carefully and answer questions 23 and 24.

Thembi, a 26-year-old college student, has been referred for psychotherapy. It is alleged that she has been abusing cocaine for the past year and is also involved in a sexual relationship with a married man who agreed to pay for her studies and living expenses. In her conversation with the therapist this is what she said: "I know that what I'm doing is wrong, and I don't like it because it has affected my academic performance and has strained my relationship with significant people in my life. I tried to stop but I cannot cope without a fix. I feel terrible that I have to sell my body to avoid feeling shaky, restless and nauseous whenever I cannot get hold of a fix. A week ago I attempted suicide after being diagnosed HIV positive and this has made me feel hopeless about the future."

Question 23

Given the information above, Thembi will most likely receive a DSM-5 diagnosis of - - - - -.

1. Cocaine Use Disorder, Mild
2. Cocaine Intoxication
3. Cocaine Use Disorder, Severe
4. Cocaine Withdrawal

Question 24

In addition to the principal diagnosis and noting her medical condition of HIV, Thembi's clinical psychologist would consider the following diagnosis/es from the category of Other Conditions That May Be a Focus of Clinical Attention according to the DSM-5 classification system.

1. Other Problems Related to Primary Support Group; Educational Problems; Problems Related to Lifestyle: high-risk sexual behaviour
2. Adjustment Disorder with anxiety
3. Adult Maltreatment and Neglect Problems; Educational Problems
4. Other Problems Related to Primary Support Group; Problems Related to Crime

Question 25

From an early age onwards, Albert, 15 years old, avoided all traditionally male activities and felt that he was a girl trapped in the body of a boy. As an adult, he had a sex change operation and is now called Alberta. Which one of the following DSM-5 diagnoses is most appropriate in Albert's case?

1. Gender Dysphoria in Adolescents and Adults
2. Gender Dysphoria in Children
3. Paedophilic Disorder
4. Transvestic Disorder

Read the following case study carefully and answer questions 26 and 27.

Theolise, married for seven years, has no interest in either fantasising or engaging in any sexual activity. In fact, she does whatever she can to avoid situations where sexual intercourse is a possibility. This state of events has put significant strain on her marital relationship to the extent that her husband is threatening to leave her.

Question 26

Based on the information above, Theolise will most likely receive a DSM-5 diagnosis of - - - - -.

1. Sexual Arousal Disorder.
2. Secondary Frigidity.
3. Female Sexual Interest/Arousal Disorder
4. Secondary Orgasmic Dysfunction

Question 27

In addition to the principal diagnosis Theolise's clinical psychologist would consider the following diagnosis/es from the category of Other Conditions That May Be a Focus of Clinical Attention according to the DSM-5 classification system - - - - -.

1. Disruption of Family by Separation or Divorce
2. Relationship Distress with Spouse
3. Spouse or Partner Neglect
4 Adjustment Disorder with mixed emotions

Read the following case study and then answer questions 28, and 29.

Jeff, 35 years old, is always working on six projects at the same time. He is easily angered and constantly competitive. Jeff's father died of a heart attack recently and this has caused Jeff to consider going for a medical check-up.

Question 28

If you were Jeff's doctor, you would have at least two good reasons to consider the possibility that he might develop - - - - -. The first reason being Jeff's personality which matches - - - - - personality characteristics and the second reason would involve a - - - - - that Jeff has most likely inherited from his father.

1. coronary heart disease; Type A; genetic vulnerability
2. cancer; Type B; hardy personality
3. coronary heart disease; Type B; genetic vulnerability
4. cancer; Type A; hardy personality.

Question 29

If Jeff's doctor's concerns are realised and Jeff does develop the medical condition, his abnormal behaviour will most likely qualify to receive a diagnosis of - - - - - according to the DSM-5 classification system?

1. Type A personality
2. Somatic Symptom Disorder
3. Obsessive-compulsive Personality Disorder
4. Psychological Factors Affecting a Medical Condition

Question 30

Which **one** of the following alternatives seems to be the **key** element in the relationship between Type A personality and heart disease?

1. The type A person's tendency to do everything quickly.
2. The type A person's tendency to relax too little.
3. The type A person's tendency to be hostile.
4. The type A person's tendency to constantly strive for achievement.

Assignment 91		
Semester 2	*Closing date: 2 October 2016*	*Unique number: 613689*

Note: This assignment is **not compulsory**, and carries **no exam credits**. The assignment consists of 24 questions to evaluate the Abnormal Behaviour and Mental Health module. Will you please assist us to improve our moduleby evaluating it? It will only take a few minutes of your time to answer the questions on a mark reading sheet. Please note that this is not an assignment in the real sense of the word and you will not get any marks or credits for completing it. We only use the assignment format to utilise the computer to analyse the data for us.

SECTION A: MODULE EVALUATION

1 My **overall opinion** of the Abnormal Behaviour and Mental Health module is that the module is - - - - -.

1. poor
2. average
3. good
4. excellent

2 Have your **expectations** of this module been met?

1. No, not at all
2. Yes, but only to some extent
3. Yes, to a great extent
4. Absolutely, yes!

3 Has this module enabled you to **identify abnormal behaviour**?

1. No, not at all
2. Yes, but only to some extent
3. Yes, to a great extent
4. Absolutely, yes!

4 Has this module enabled you to have a **greater understanding** of people suffering from abnormal behaviour?

1. No, not at all
2. Yes, but only to some extent
3. Yes, to a great extent
4. Absolutely, yes!

5 Has this module led you to greater **insight** into issues concerning abnormal behaviour?

1. No, not at all
2. Yes, but only to some extent
3. Yes, to a great extent
4. Absolutely, yes!

6 Has this module enabled you to **refer individuals** with identified problems to appropriate health practitioners?

1. No, not at all
2. Yes, but only to some extent
3. Yes, to a great extent
4. Absolutely, yes!

7 Has this module made you more involved with **promoting mental health**?

1. No, not at all
2. Yes, but only to some extent
3. Yes, to a great extent
4. Absolutely, yes!

8 How would you describe the **level of difficulty** of the **study guide** for this module?

1. Very difficult
2. Difficult
3. Acceptable
4. Easy

9 To what degree has the **study guide supported** you in mastering the course material?

1. Not at all.
2. To some extent.
3. To a great extent.
4. The study guide is crucial.

10 How would you describe the **level of difficulty** of the **prescribed book** for this module?

1. Very easy
2. Acceptable
3. Difficult
4. Very difficult

11 How easy or difficult was it for you to **get hold** of the **prescribed book**?

1. Very easy
2. Fairly easy
3. Difficult
4. Very difficult

12 How would you describe the **level of difficulty** of the **recommended material** for this module?

1. Acceptable
2. Difficult
3. Very difficult
4. Not applicable (e.g. you did not consult the recommended material)

13 To what degree has the **recommended material** supported you in mastering the course material?

1. Not applicable (eg you did not consult the recommended material)
2. Not at all
3. To some extent
4. To a great extent

14 How would you describe the **level of difficulty** of the **tutorial letters** for this module?

1. Very difficult
2. Difficult
3. Acceptable
4. Easy

15 To what degree have the **tutorial letters supported** you in mastering the course material?

1. Not at all.
2. To some extent.
3. To a great extent.
4. The tutorial letters are crucial.

16 How would you describe the **level of difficulty** of the **assignments** for this module?

1. Very difficult
2. Difficult
3. Acceptable
4. Easy

17 If you studied this module through the **medium of English**, and if English is **not your first language**, would you attribute difficulties you might have experienced to the use of English as the medium of instruction?

1. Not applicable (e.g. English is my first language).
2. It caused serious difficulties.
3. It sometimes contributed to the level of difficulty.
4. It was not a source of difficulty.

18 What is your opinion on the **total workload** of this module?

1. Too demanding
2. Unsure
3. Manageable
4. Easy to manage

19 On average, how many **hours per week** did you spend studying this module?

1. Less than 4 hours per week.
2. 4 to 6 hours per week.
3. 7 to 10 hours per week.
4. More than 10 hours per week.

20 Did you **enjoy** studying this module?

1. Absolutely yes!
2. Yes, to some extent.
3. No, not really.
4. No, I did not enjoy it at all.

21 Would you **recommend** this module to your colleagues or friends?

1. No, not at all.
2. Yes, but only to some extent.
3. Yes, to a great extent.
4. Absolutely, yes!

SECTION B: CONTACT WITH YOUR LECTURER/S

22 How **often** during 2016 have you made contact with an Abnormal Behaviour and Mental Health lecturer?

1. Weekly
2. Monthly
3. Quarterly
4. Not at all

23 How do you prefer to **communicate** with your lecturer(s)?

1. Telephone calls
2. E-mails
3. Personal visits
4. Letters/faxes

24 How would you describe the **helpfulness of your lecturer(s)**?

1. Not applicable
2. Very helpful
3. Helpful
4. Not at all helpful

THANK YOU FOR YOUR PARTICIPATION.

9 EXAMINATIONS

9.1 Examination admission

You gain admission to the examination by submitting **both** Assignment 01 and 02 **on time**. Note that you do not have to pass the assignments to gain admission. You only have to submit them.

9.2 Examination period

There are only two examination sessions per year in the semester system, in May/June 2016 or October/November 2016. If you fail the module, but achieve a mark of 40% or higher, you are entitled to one supplementary examination. This will take place during the next examination session at the end of the next semester. You will be expected to inform the Examination Department of your intention to write the supplementary examination. You will also be expected to pay the examination fees. Note that there will be **no** further supplementary exams. If you fail the supplementary examination, you will be required to re-register for the module. The Examination Section will provide you with information regarding the examination in general, examination venues, examination dates, examination times, supplementary and special examinations (due to illness or accident). Please make sure that you have these details. If you do not know your examination date or venue, please consult **my Studies** @ **Unisa** with regard to finding contact details for who you should contact for assistance.

9.3 Basic information about the paper

The examination paper in Abnormal Behaviour and Mental Health is a two-hour paper. The paper consists of 70 multiple choice questions and the paper is marked out of 70. These marks are converted to a mark out of 80. The other 20 marks come from your year mark which is obtained by averaging the marks you received for Assignments 01 and 02 and converting it to a mark out of 20.

The examination paper covers the **whole** syllabus. Examination questions will be asked from the sections which you have to **study** in both your prescribed book and Tutorial Letters 501, 502 and 503. You may, however expect that the examination questions will be similar to the questions asked in the assignments. The examination paper will be in English only.

Please note: It is not advisable to base your examination preparation solely on past/old examination papers (papers prior to 2013), since those questions are based on the outdated DSM-IV-TR.

9.4 Marking Policy

Our marking policy for multiple choice questions for the exam paper is as follows: We adjust the marks to accommodate the effect of blind guessing or random guessing by subtracting a fraction of the marks for each incorrect answer. For questions with four alternatives the **maximum** that we can deduct is 1 mark for three incorrect answers (ie 0,33 marks for each wrong answer). If we find, however, that a specific exam paper was difficult, we will deduct less than 0,33 marks for a wrong answer (e.g. only 0,12). We may also decide not to subtract any marks at all. But it is only fair to inform you in case we have to use it in future.

We would advise you to attempt to answer all questions, and to leave only those out that you really do not know. Intelligent guessing, where you use your knowledge to eliminate some of the alternatives before guessing the answer from the remaining alternatives, is acceptable and even advisable. The chance of selecting the correct alternative with intelligent guessing is much greater than with blind guessing.

If you prefer not to respond to some questions rather than guessing the answer to these questions, you may do so. No marks will be subtracted for omitted items. Bear in mind however that it can be shown mathematically that intelligent guessing is always a good strategy when you do not know the correct answer and is preferable to simply omitting an item.

10 OTHER ASSESSMENT METHODS

There are no other assessment methods for this module.

11 FREQUENTLY ASKED QUESTIONS

The brochure **my Studies @ Unisa** contains an A-Z guide of the most relevant study information.

12 A FINAL WORD

By now, you are no doubt eager to get started. We trust that you will find this module meaningful and enriching for your personal use as well as your career.

If you can find the time, please submit Assignment 91 to let us know what your thoughts are about this module.

We hope that you will enjoy this module and wish you success with your studies.

Kind regards

The Abnormal Behaviour and Mental Health Team