Tutorial Letter 101/3/2018

Abnormal Behaviour and Mental Health

PYC3702

Semesters 1 and 2

Department of Psychology

This tutorial letter contains important information about your module.

BARCODE

Define tomorrow.

UNISA university of south africa

CONTENTS

Page

1 INTRODUCTION AND WELCOME ... 3
1.1 Tutorial matter ... 3
1.2 *my*Unisa ... 4
2 PURPOSE OF AND OUTCOMES FOR THE MODULE ... 4
2.1 Purpose ... 4
2.2 Outcomes ... 5
3 LECTURERS AND CONTACT DETAILS ... 5
3.1 Lecturers ... 5
3.2 Department ... 6
3.3 University ... 6
4 MODULE-RELATED RESOURCES ... 7
4.1 Prescribed books ... 7
4.2 Recommended books ... 7
4.3 Additional books ... 7
4.4 Electronic Reserves (e-Reserves) ... 8
4.5 Library services and resources information ... 8
4.6 Videos ... 8
5 STUDENT SUPPORT SERVICES FOR THE MODULE ... 9
6 MODULE-SPECIFIC STUDY PLAN ... 9
7 MODULE PRACTICAL WORK AND WORK-INTEGRATED LEARNING ... 10
8 ASSESSMENT ... 11
8.1 Assessment plan ... 11
8.2 Due dates of assignment, assignment numbers and unique assignment numbers ... 11
8.3 Submission of assignments ... 12
8.4 Feedback on assignments ... 12
8.5 Assignments applicable to each Semester ... 13
8.5.1 Assignments for Semester 1 ... 13
8.5.2 Assignments for Semester 2 ... 36
9 EXAMINATIONS ... 58
10 OTHER ASSESSMENT METHODS ... 59
11 FREQUENTLY ASKED QUESTIONS ... 59
12 FINAL WORD ... 59

Please note:

Formal tuition in this module will be conducted in English only.

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. To enhance your experiences in mastering the knowledge contained in this module you need to participate actively on *my*Unisa by utilising the discussion forum for this module. You should also interact with your assigned etutor on a regular basis and do not leave curriculum challenges unresolved for too long, as you will find that once you start falling behind your challenges will escalate. Regularly check for announcements on *my*Unisa for important notices. All study material is downloadable from the *my*Unisa page for this module, so do not wait for hardcopies to arrive to start working on this module.

This tutorial letter (Tutorial Letter 101/3/2018) 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 101/3/2018 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 for downlaod. 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 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 2018 and contain extensive content to be studied and used in conjunction with your prescribed textbook (the purple edition).

- **Tutorial Letter 101/3/2018** (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 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 Internet Explorer. See **my Studies @ Unisa** for further information.

You can use *my*Unisa to perform the following functions:

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

To register on *my*Unisa, you should go to the Unisa web page at 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 is a free registration). 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 on *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 perform 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 that 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 individuals who show abnormal behaviour.
- be able to promote mental health on primary and tertiary levels in your community.

3 LECTURER(S) 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 and 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			
Mrs Louise Henderson (Module Leader)	Theo van Wijk, 5-124	012 4298214	hendeh@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
Dr Janice Moodley	Theo van Wijk 5-80	012 429 8069	moodljk@unisa.ac.za
Mrs Vhuhwavho Nekhavhambe	Theo van Wijk 5-51	012 429 8513	nekhavm@unisa.ac.za
Dr Nico van Zyl	Theo van Wijk 5-48	012 4298239	vzylfn@unisa.ac.za
Ms Christine Laidlaw	Theo van Wijk 5-81	012 4298294	laidlc@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 or e-mail)

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 and conduct research. They may therefore not be in their offices at all times. **If you cannot get hold of any particular lecturer in their 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.

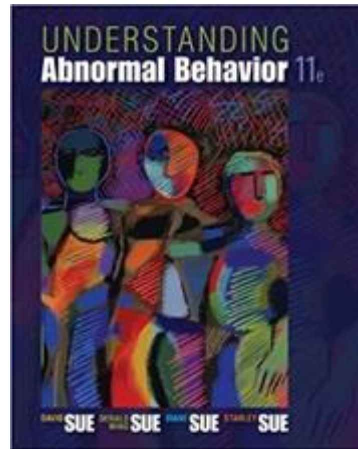
3.3 University

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

4 MODULE RELATED RESOURCES

4.1 Prescribed book

The prescribed book ("purple textbook") for this module is:



Sue, D., Sue, D.W., Sue, D. & Sue, S. (2016). ***Understanding Abnormal Behavior*** **(11th ed.) International Version. Stamford, CT: Wadsworth Cengage Learning**.
(ISBN-13: 978-1-305-08806-1)

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. You can also purchase your prescribed book online on book selling sites such as:

http://www.wizebooks.co.za/understanding-abnormal-behavior

4.2 Recommended books

Diagnostic and statistical manual of mental disorders: DSM-5 Arlington, Va: American Psychiatric Association, 2013, 5th ed.

Diagnostic and statistical manual of mental disorders: DSM-5 Arlington, Va: American Psychiatric Association, 2013, 5th ed.
E-Book

A dictionary of psychology / Andrew M. Colman. [Oxford]: Oxford University Press, 2009, 3rd ed.
E-Book

A dictionary of psychology / Andrew M. Colman. [Oxford]: Oxford University Press, 2009, 3rd ed.

A dictionary of psychology / Andrew M. Colman. [Oxford]: Oxford University Press, 2015, 4th ed.

Kaplan & Sadock's synopsis of psychiatry: behavioral sciences/clinical psychiatry. Philadelphia: Wolters Kluwer, 2015, Eleventh edition / Benjamin James Sadock, Virginia Alcott Sadock, Pedro Ruiz

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, England: Penguin Books.

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

4.4 Electronic reserves (e-reserves)

There are no e-Reserves for this course.

4.5 Library services and resources information

For brief information, go to www.unisa.ac.za/brochures/studies

For detailed information, go to http://www.unisa.ac.za/library. For research support and services of personal librarians, click on "Research support".

The library has compiled a number of library guides:

- finding recommended reading in the print collection and e-reserves – http://libguides.unisa.ac.za/request/undergrad
- requesting material – http://libguides.unisa.ac.za/request/request
- postgraduate information services – http://libguides.unisa.ac.za/request/postgrad
- finding, obtaining and using library resources and tools to assist in doing research – http://libguides.unisa.ac.za/Research_Skills
- how to contact the library/finding us on social media/frequently asked questions – http://libguides.unisa.ac.za/ask

4.6 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.

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

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.

FREE COMPUTER AND INTERNET ACCESS:

Unisa has entered into partnerships with establishments (referred to as Telecentres) in various locations across South Africa to enable you (as a Unisa student) free access to computers and the Internet. This access enables you to conduct the following academic related activities: registration; online submission of assignments; engaging in e-tutoring activities and signature courses; etc. Please note that any other activities outside of these are for your own costing e.g. printing, photocopying, etc. For more information on the Telecentre nearest to you, please visit www.unisa.ac.za/telecentres.

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.

STUDY SCHEDULE

STUDY TIME		WORK COVERED	ASSIGNMENTS
First Semester	**Second Semester**		
Week 1 (last week of January 2018)	**Week 1 (last week of June 2018)**	**Read**: Tutorial Letter 101 Read 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)**. Assessment and Classification of Abnormal Behaviour **(Tut 501 & PB)**	**COMPLETE ASSIGNMENT 1**
Week 2	**Week 2**	**Study:** Psychopathology from an African Perspective **(Tut 501)**	
Week 3	**Week 3**	**Study:** Personality Psychopathology and Impulse Control Disorders (**Tut 501 & PB)**	

Week 4	Week 4	**Study:** Anxiety and Obsessive-Compulsive and Related Disorders **(Tut 501 & PB)**		
Week 5	Week 5	**Study:** Trauma and Stress-Related Disorders **(Tut 502 & PB)**.		
SUBMIT ASSIGNMENT 1			**First semester** closing date **6 March 2018**	**Second semester** closing date **10 August 2018**
Week 6	Week 6	**Study:** Depressive and Bipolar Disorders **(Tut 502 & PB)** Suicide **(Tut 502 & PB)**	**COMPLETE ASSIGNMENT 2**	
Week 7	Week 7	**Study:** Schizophrenia and Other Psychotic Disorders. **(Tut 503 & PB)**		
Week 8	Week 8	**Study:** Neurocognitive Disorders **(Tut 503 & PB)**		
Week 9	Week 9	**Study:** Substance-Use Disorders **(Tut 502 & PB)**		
Week 10	Week 10	**Study:** Somatic Symptom and Dissociative Disorders **(Tut 502 & PB)**		
SUBMIT ASSIGNMENT 2			**First semester** closing date **10 April 2018**	**Second semester** closing date **10 September 2018**
Week 12	Week 12	**Study:** Sexual Dysfunction and Gender Dysphoria **(Tut 502 & PB)**	**COMPLETE ASSIGNMENT 91**	
Week 13	Week 13	**Study:** Disorders of Childhood and Adolescence **(Tut 503 & PB)**		
SUBMIT ASSIGNMENT 91			**First semester** closing date **2 May 2018**	**Second semester** closing date **9 October 2018**
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 21 (for Semester 1) and on pages 36 to 44 (for Semester 2) in this tutorial letter.			
Pages 13 to 21	1	6 March 2018	703459
Pages 36 to 44	2	10 August 2018	623140
Assignment 02 (Compulsory)	**Semester**	**Closing date**	**Unique number**
You will find the assignment on pages 22 to 31 (for Semester 1) and on pages 45 to 54 (for Semester 2) in this tutorial letter.			
Pages 22 to 31	1	10 April 2018	615175
Pages 45 to 54	2	10 September 2018	777760
Assignment 91 (Module Evaluation)	**Semester**	**Closing date**	**Unique number**
You will find the assignment on pages 32 to 35 (for Semester 1) and on pages 55 to 58 (for Semester 2) in this tutorial letter.			
Pages 32 to 35	1	2 May 2018	hendeh@unisa.ac.za
Pages 55 to 58	2	9 October 2018	hendeh@unisa.ac.za

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*Unisa or 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: 6 March 2018**	**Unique number: 703459**

This assignment is based on **Learning Units 1, 2, 3, 4, 5, 6, 7 and 9 in Tutorial Letters 501 and 502** and the **corresponding chapters 1, 2, 3, 5, 6 15 and 16 ("Externalising Disorders among the Youth")** in the prescribed book.

Question 1

An assumption of the Multipath Model (Sue et al., 2016) regarding abnormal behaviour is that - - - - -.

1. most psychological disorders are due to one or two primary factors
2. the biological perspective best explains the complexities of human behaviour
3. different individuals exposed to different aetiological factors may develop similar mental disorders
4. biological, psychological, social, and sociocultural factors contribute equally to most psychological disorders

Question 2

Which one of the following statements regarding the Biological model is the **most** accurate?

1. It constitutes the core assumption of the diathesis-stress theory.
2. It has proven that genetic inheritance is the direct cause of most mental disorders.
3. It has shown that mental disorders are mainly caused by structural brain abnormalities.
4. It supports the assumption that the interaction between physical activity in the brain and mental processes are of a circular nature.

Question 3

A psychologist who supports the Multicultural Model would **most** likely say that - - - - -.

1. Western cultures value "belongingness" over individualism
2. some cultures value family identity more than individuality
3. almost all non-Western cultures value individuality over collectivity
4. European American therapists emphasise the importance of collectivism over individualism

Question 4

- - - - - is the term used by the DSM-5 classification system when an individual is diagnosed with more than one mental disorder.

1. Subtypes
2. Specificity
3. Comorbidity
4. Differential diagnosis

Question 5

Aneni has recently immigrated to South Africa from Zimbabwe and is experiencing physical and mental fatigue, dizziness, headaches, and problems with her memory, concentrating and sleeping. She is also irritable and highly excitable. Her psychologist believes that her symptoms support the diagnosis for Bipolar Disorder. However, before making this diagnosis, the therapist should rule out the possibility that Aneni's symptoms are caused by the following factors:

1. Cultural factors
2. Substance aetiology
3. General Medical Condition
4. All of the above

Question 6

A friend asks you the following question: "Is it really necessary to study Psychopathology from an African perspective
Which one of the following can be regarded as the most logical answer to the posed question?

1. "Yes, it is necessary because the existing Western perspectives are one sided and sometimes limited for understanding people from diverse cultures".
2. "No, it is not necessary, if people of Africa want to be part of the first world, they should incorporate Western psychology into their thinking".
3. "No, it is not necessary, because there is basically no difference between African and Western views on psychopathology.
4. "Yes, it is not necessary because African people can only be understood from an African perspective.

Question 7

Collective identity, which is important in the African culture, is best illustrated by which one of the following statements?

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

Read the following short case study and then answer question 8.

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.

Question 8

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

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

Read the following brief case study and answer questions 9 and 10.

For most of Motlalepule's life, she has preferred to keep to herself and actively avoid social interactions. Even as an adolescent she was described by her mother as indifferent and emotionally cold towards others. She has always been a loner and has not had the desire to pursue, and prefers to interact with animals as opposed to interacting with people. Her aunt, who is a nurse, took her in when she was 15 years old as she thought that she understood Motlalepule much better than her parents. Her aunt follows a Western way of life and as a result did not see the necessity of performing any traditional rituals for Motlalepule during different phases of her development in line with African traditional customs. Motlalepule has been working as an accountant for a major firm for the past eight years and for most of her working life she never had to meet with clients. Now, with the appointment of a new manager, she has been instructed to start having face to face consultations with clients which creates stress for her. The stress is increasingly affecting the quality of her work. Her parents think that her difficulties might be due to the fact that the necessary traditional rituals were not performed for her whilst her aunt thinks that her niece Motlalepule needs to consult with a psychologist.

Question 9

From an African perspective, Motlalepule's parents' explanation of the cause of her illness can be viewed as - - - - -.

1. Schizoaffective Disorder.
2. Bad spell from sorcerers who are against her family.
3. Ukuthwasa.
4. "Go lahla maseko"/ ukulahla amasiko.

Question 10

Motlalepule's parents subscribe to the African worldview, which one of the following would reflect their understanding of how her abnormal behaviour should be viewed?

1. Relative, as abnormal behaviour should be viewed from its cultural context.
2. Universal, as abnormal behaviour it is the same across contexts.
3. Individualistic, as the abnormal behaviour of each person is unique and different.
4. Hereditary, as abnormal behaviour runs in the family.

Question 11

The term stressor is confusing to a fellow student. How would you explain the concept?

1. An internal psychological or physical response to a traumatic event.
2. A traumatic event or situation that is beyond a person's ability to cope.
3. An external event or situation that places a physical or psychological demand on a person.
4. Emotional distress and behavioural symptoms that are a disproportionate reaction to the intensity of a given situation.

Read the following short case study and answer questions 12 and 13.

Liyana, seven years old, is an only child. Her parents both died before her second birthday and she has since been raised by her grandmother. Liyana has been referred for assessment by her school principal who is concerned with Liyana's increasingly disruptive and impulsive behaviour in the classroom. Liyana's Grade 2 teacher reports that Liyana often wanders into other classrooms, seeking attention from other teachers, or tries to go home with classmates' parents after school. This behaviour has increased over the past two years, as have Liyana's frequent bouts of crying. The school psychologist asks to meet with Liyana and her grandmother. The grandmother states that her daughter and son-in-law were not good parents to Liyana before they died. It was only after their deaths that she was made aware of Liyana's living conditions. From the age of six months, Liyana had been placed in various foster homes as her parents were not able to take care of her. Liyana's grandmother then applied for, and was awarded, primary care and residency of the child. She also admits that she knows very little of Liyana's experiences in the foster homes. Her grandmother relates how they now both live with extended family members and explains that she works long hours to assist with the family income. As a result, Liyana is often left in the care of older cousins or neighbors, but her grandmother says that this is not a problem as Liyana easily adjusts to the company of various caregivers. During the interview, Liyana sits on her grandmother's lap. Later, she climbs onto the psychologist's lap and when the psychologist rises to leave the room, Liyana attempts to follow. Liyana is easily distracted and noticeably uncooperative during the interview. She also often ignores instructions issued by her grandmother.

Question 12

Taking into consideration the symptoms discussed in the case study above, with which disorder, according to the DSM-5 classification system, would you, as the school psychologist, diagnose Liyana?

1. Conduct Disorder
2. Adjustment Disorder
3. Reactive Attachment Disorder
4. Disinhibited Social Engagement Disorder

Question 13

Which one of the following Specifiers would you apply in the principal diagnosis of this case study?

1. Acute
2. Persistent
3. With delayed expression
4. With accompanying language impairment

Question 14

When a clinical psychologist recommends individual psychotherapy for an individual, this recommendation is an example of a - - - - - intervention.

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

Question 15

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

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

Sibongile’s behaviour is marked by social isolation combined with peculiar behaviours and beliefs about the world. Sometimes Sibongile senses that someone is in the room with her when she is actually alone. This behavioural pattern is pervasive, longstanding and affects her overall level of functioning.

Question 16

According to the DSM-5 classification system, Sibongile most likely suffers from - - - - -.

1. Delusional Disorder
2. Schizotypal Personality Disorder
3. Schizoid Personality Disorder
4. Schizophrenia

Question 17

It would be typical of the disorder that Sibongile is suffering from, to also manifest ideas of - - - - -.

1. reference
2. thought withdrawal
3. suicide
4. nihilism

Question 18

Sibongile’s sense that someone is in the room with her when she is actually alone, is characteristic of her DSM-5 disorder. This is an example of - - - - -.

1. a delusion of reference
2. unusual perceptual experiences
3. paranoid ideation
4. delirium

Question 19

A pervasive pattern of egosyntonic detachment from social relationships and a restricted range of expression of emotions in interpersonal settings are the most prominent characteristics of which DSM-5 Disorder?

1. Social Anxiety Disorder
2. Schizoaffective Disorder
3. Autism Spectrum Disorder
4. Schizoid Personality Disorder

Question 20

Cindy-Lee shows a longstanding, inflexible and pervasive pattern of restraint in intimate relationships for fear of being shamed. She is preoccupied with being rejected, views herself as inferior to others and is socially inhibited due to feelings of inadequacy. Cindy-Lee is likely to meet the criteria for which one the following DSM-5 disorders:

1. Social Anxiety Disorder
2. Major Depressive Disorder
3. Avoidant Personality Disorder
4. Borderline Personality Disorder

Question 21

The Multipath Model (Sue et al., 2016) for explaining the development of Antisocial Personality Disorder refers to different dimensions of aetiological factors. The *Social dimension* emphasises - - - - - as factors that exert its influence on the development of Antisocial Personality Disorder in the following manner: - - - - -.

1. poor parental supervision and involvement; children are exposed to family environments of neglect, hostility, indifference and physical abuse through which they learn the world is a cold, unforgiving and punitive place.
2. cognitive distortions; unconscious core beliefs such as that the world is hostile and other people are weak, influence the individual's behaviour through the mechanism of the so-called 'predatory strategy'.
3. learning processes; delay or impeding of learning by lack of positive role models or the presence of poor role models, in developing pro-social behaviours.
4. cultural values; since society considers individualism and independence and the rise above the achievements of others as healthy, these individuals' aggression and violent behaviour is fuelled accordingly and in this way encourages the development of the disorder.

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

James, a 25-year-old male, with a history of Oppositional Defiant Disorder, presents with frequent impulsive behavioural outbursts that are grossly out of proportion to the stressor. He reports to the psychologist that he is unable to control himself and is worried that he might lose his job if this behaviour continues. He also reports that his mother told him that his father also had a history of behavioural outbursts that cost him his job. His father was dismissed from his job after he had a physical fight with one of his colleagues. James came to therapy as his girlfriend threatened to leave him if he does not receive professional help as soon as possible.

Question 22

Which one of the following DSM-5 diagnoses would be an appropriate diagnosis in James' case?

1. Bipolar Disorder
2. Conduct Disorder
3. Intermittent Explosive Disorder
4. Adjustment Disorder

Question 23

Which one of the following alternatives relates to the Biological dimension in the development of James' mental disorder according to the Multipath Model (Sue et al., 2016)?

1. James has a history of Oppositional Defiant Disorder.
2. James' father also had a history of behavioural outbursts that cost him his job.
3. James' girlfriend threatened to leave him if he does not receive professional help.
4. James' fear of being unable to control himself.

Question 24

Lerato is so afraid of being alone in public places and being stuck 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 at least - - - - - months, Lerato is probably suffering from - - - - -.

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

Question 25

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

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

Read the following case study carefully and then answer questions 26, 27 and 28.

Bonita, 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 Bonita, she has been suffering from these symptoms for the past nine months. Bonita 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. Bonita also constantly worries about her children, her friends, her finances, her faith and her career. In addition to the vast range of life circumstances which Bonita worries about, she also worries about her worries and her inability to control her anxiety which she realises are unfounded. Bonita 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 Bonita teaches requested Bonita to seek professional help after a group of parents complained about her frequent absence from class. Bonita is seriously distressed about the parents' complaint. She fears that she might lose her job despite the Principal's reassurance to the contrary. Although Bonita is an experienced and respected Maths teacher, she has refused several opportunities for promotion 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, Bonita was asked by the Principal to take over the Grade 12 Maths class. To avoid conflict, Bonita agreed to the Principal's request despite serious doubts about her ability to cope with the challenges of Grade 12 learners. Bonita experienced the death of her colleague, who was also her only close friend, as a great loss. Bonita relied on her colleague and friend for guidance regarding teaching and personal matters since the death of her husband six years ago. Bonita'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. Bonita seldom opposed her husband's decisions. After the loss of her husband, Bonita became very attached to her colleague that had died.

Question 26

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

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

Question 27

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

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

Question 28

According to Wells' Cognitive model (Sue et al., 2016), the origin of Bonita's principal diagnosis stems from - - - - -

1. worry about worry which leads to increased and persistent anxiety and 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 short case study and then answer question 29.

Dale 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. **Steven** 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 29

According to the DSM-5 classification system, **Dale's** abnormal behaviour could be classified as - - - - - and **Steven'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 30

Which of the following family factors, according to Sue et al. (2016), are regarded as possible aetiological factors in the development and maintenance of Obsessive-Compulsive and Related Disorders?

a) Controlling and critical parenting style
b) Discouragement of children's autonomy
c) Minimal parental warmth
d) Hostile relatives
e) Assisting the child to perform his/her compulsive rituals.

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

END OF ASSIGNMENT 1

Assignment 02		
Semester 1	**Closing date: 10 April 2018**	**Unique number: 615175**

This assignment is based on **Learning Units 8, 10, 12, 13, 14 and 15 of Tutorial Letters 502 and 503** and the **corresponding chapters 7, 8, 9, 11, 12 and 13 in the prescribed book.**

Read the following case study carefully and then answer questions 1, 2, 3 and 4.

Emma, 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 question. Even then her answers were delayed and of a monotonous quality. Emma was unresponsive to all pleasurable stimuli and clearly had no interest in life anymore. According to her husband, Emma 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. Emma's husband also reports that Emma became preoccupied with guilt feelings and suicidal ideation after the unexpected death of their only child and two grandchildren three months ago. Emma's daughter and her children lost their lives in a horrific car accident. Emma's husband sought professional help for Emma when he realised that she was giving away her valuable jewellery and was hiding his revolver, which she took from the safe without his consent.

Question 1

Emma's abnormal behaviour can be classified as - - - - - according to the DSM-5 classification system.

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 2

According to Seligman and his colleagues' Cognitive-learning approach, Emma's mental disorder can mainly be attributed to - - - - -, while the Behavioural explanations of mental disorders will focus on - - - - - as the main contributor to the development of Emma'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 reinforces
4. an absence of positive reinforces in the event of severe stress; magnification and exaggeration

Question 3

Which of the following alternatives contain the **correct** information regarding the influence of stress in the development of the kind of disorder Emma 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 Emma is suffering from than several smaller stressors during the past few years would have.
b) Should Emma 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 Emma 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 Emma is currently suffering from.
e) Not only does stress increase the risk of the disorder Emma is suffering from, but this specific disorder can also increase social stress.
f) Distressing social interactions increase the risk of the kind of disorder Emma is suffering from.

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

Question 4

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

1. Recommended bed rest and potential counselling.
2. Provide Emma 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 Emma immediately voluntary or involuntary, provide intensive medical and psychological treatment as well as comprehensive supervision.

Question 5

Patricia'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 episodes of 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, **Patricia'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 6

According to Sue et al. (2016), which one of the following occupations **do not** have a higher than average rate of suicide?

1. Musicians
2. Lawyers
3. Dentists
4. Physicians

Question 7

According to Sue et al. (2016), which one of the following statements is **false**?

1. The elderly are classified as a high risk group for suicide.
2. Victims of bullying are at a higher risk for suicide.
3. Females are at lower risk for completed suicide than men.
4. Physicians, lawyers, and dentists have the lowest average rates of suicide.

Question 8

Which of the following statements is **most** accurate in describing all **four** dimensions according to the Multipath Model (Sue et al., 2016) of suicide?

1. Childhood abuse, alcohol affects, bullying, prior attempts
2. Psychache, sleep difficulties, isolation, financial decline
3. Impulsivity, mental illness, physical disability, prior attempts of suicide
4. Access to firearms, male gender, cultural alienation, genetic and epigenetic effects.

Read the following case study and answer questions 9, 10, 11 and 12.

Ayanda is a 25-year-old law graduate. He is currently serving his articles at a prestigious law firm in Johannesburg. He has been referred to a psychologist since his colleagues and management team noticed a marked difference in his work ethic and overall behaviour over the past nine months. Before the decline, Ayanda was noted for his attention to detail and his ability to work effectively and efficiently under extreme pressure. He was able to balance the demands of work with that of his moderate social life.

His colleagues however noticed a gradual yet progressive change in his behaviour. Ayanda rapidly lost a substantial amount of weight within a month or two. He has refused to socialise with his team members during their Friday night drinks ritual as he enthusiastically used to. His colleagues and management team noticed a steady decline in his work with Ayanda frequently missing deadlines. He has been unable to concentrate and this affected his ability to construct meaningful case arguments.

During his first consultation with the psychologist, Ayanda would frequently launch into monologues that the psychologist had trouble comprehending. During the moments that Ayanda spoke with some clarity, he described his marked sense of despair and hopelessness to his psychologist. He described how he simply did not feel the same zeal for life as he once did. He often felt like he had no energy but still could not fall asleep at night. When probed further Ayanda revealed that his feelings of despair and hopelessness were not continuous. He did have periods when he would “regain perspective” as he put it but for the most part he felt overwhelming periods of emptiness.

During the second consultation with the psychologist, Ayanda described how his girlfriend had left him because of his jealousy. He was incoherent for the most part but the psychologist pieced together that he (Ayanda) was convinced that his (Ayanda’s) girlfriend was having an affair despite the fact that his beliefs were proven untrue repeatedly. He narrated how he would check her cell phone daily and would follow her regularly to work and to the gym without her knowledge to see who she was cheating on him

with. He said that despite his lack of evidence he knew beyond a shadow of a doubt that she was cheating on him because he heard numerous voices speaking to him regularly giving him direction as to how to pursue his next plot to catch her out. He described how it was during these periods (approximately two weeks) that he would forget his sense of hopelessness since he became pre-occupied with what he called his “higher calling” to prove his girlfriend’s infidelity.

Blood tests confirmed that Ayanda’s symptoms were not attributable to the physiological effects of a substance or an underlying medical condition.

Question 9

After the first consultation, Ayanda’s psychologist was most likely to diagnose Ayanda with which of the following DSM-5 disorders?

1. Delusional Disorder
2. Schizophrenia
3. Major Depressive Disorder
4. Schizoaffective Disorder

Question 10

During Ayanda’s second consultation with his psychologist, the psychologist reassessed his initial diagnosis after being presented with additional symptoms to which of the following DSM-5 disorders?

1. Delusional Disorder
2. Schizophrenia
3. Major Depressive Disorder
4. Schizoaffective Disorder

Question 11

For the diagnosis above (Question 10) to be made, diagnostic criteria from which of the following DSM-5 classification system disorders need to occur concurrently?

1. Delusional and Schizophrenia
2. Schizophrenia and Major Depressive
3. Major Depressive and Brief Psychotic Disorder
4. Delusional and Schizoaffective

Question 12

In considering another disorder, - - - - -, was ruled out because Ayanda’s overall functioning was markedly impaired.

1. Delusional Disorder
2. Schizophrenia
3. Major Depressive Disorder
4. Schizoaffective Disorder

Question 13

Which statement **best** describes the relationship between Schizophrenia and socioeconomic level?

1. Schizophrenia is most common at the upper socioeconomic level.
2. Schizophrenia is most common at the lower socioeconomic levels.
3. There is no consistent relationship between Schizophrenia and socioeconomic level.
4. Severe forms of Schizophrenia are most common at the upper socioeconomic level and milder forms are more common at the lower socioeconomic levels.

Read the following case study and then answer questions 14, 15, 16, 17 and 18.

Mary, 70 years old, is referred to a local outpatient memory clinic by her general practitioner. She reports feeling agitated and forgetful. She states that she has noticed the gradual worsening of her symptoms over the past few months, especially regarding her ability to complete her crossword puzzles in the same timeframe as she used to, and her decreased ability to attend to multiple tasks at the same time. She is worried about her need for assistance in doing her monthly budget and paying her bills although she is still able to do her own cleaning and monthly shopping and enjoys playing bingo at the local community centre. Mary is concerned about her symptoms as both her parents and all her grandparents had a history of actively working and living independently without problems until their late eighties/early nineties. On completion of the screening assessments at the clinic, the psychiatrist states that Mary does not suffer from a vascular condition and has tested negative on all the tests he ran to diagnose any neurological or systemic disease or condition, and does not report any substance or medication use outside of the infrequent use of paracetamol for joint pain.

Question 14

In assessing Mary's case, the psychiatrist at the memory clinic considers a number of DSM-5 diagnoses to account for Mary's abnormal behaviour. Which one of the following alternatives contains the **correct** combination of the disorder that the psychiatrist considered in the diagnostic process and the correct reason for considering this disorder?

1. Possible Major Vascular Neurocognitive Disorder – Mary reports using paracetamol.
2. Substance/Medication-Induced Neurocognitive Disorder – Mary reports disturbance in attention and awareness.
3. Delirium – Mary reports experiencing memory problems.
4. Major Depressive Disorder – Her worrying regarding the increased need for assistance.

Question 15

The psychiatrist will most likely diagnose Mary with - - - - - according to the DSM-5 classification system.

1. Possible Mild Neurocognitive Disorder due to Alzheimer's Disease
2. Illness Anxiety Disorder
3. Substance/Medication Induced Mild Neurocognitive Disorder
4. Medication-Induced Delirium

Question 16

Which of the following are valid reasons for making the DSM-5 diagnostic decision in question 15?

(a) Mary shows a mixed aetiology.
(b) The insidious onset and gradual progression of impairment of the symptoms.
(c) There is no family history or proof of a genetic disease mutation.
(d) Mary has a history of frequent medication use.
(e) The cognitive symptoms are not better explained by another mental disorder.
(f) Mary shows concern about her symptoms.
(g) Mary's symptoms represent a substantial impairment in cognitive functioning which causes a significant cognitive decline from her previous level of functioning.
(h) Mary no longer enjoys activities she used to enjoy before the symptoms started.

1. a, b, d, g
2. a, e, f, h
3. b, c, e, f
4. c, d, g, h

Question 17

Mary's cognitive slowing indicated by her inability to complete her crossword puzzles in the same timeframe as she was always used to, indicates difficulties in the - - - - - domain.

1. executive function
2. perceptual motor
3. complex attention
4. learning and memory

Question 18

Mary's decreased ability to attend to multiple tasks at the same time, is an indication of difficulties in the - - - - - domain.

1. language
2. complex attention
3. executive function
4. social cognition

Question 19

A disturbance in - - - - - and which is accompanied by a change in - - - - - is the main feature of **Delirium.**

1. learning and memory, perceptual-motor functioning
2. attention or awareness, baseline cognition
3. perceptual-motor functioning, baseline cognition
4. the psychological domain, perceptual-motor functioning

Read the following case study and then answer questions 20, 21 and 22.

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, his 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 were his work colleagues. He became disorientated in time and place, and was startled easily by sounds from outside his hospital room. He perspired profusely and could not hold a cup without spilling some of the contents. He was unable to sleep at night, talked incoherently, and was obviously very anxious. Mr Thobela, when asked by his doctor, denied misusing alcohol or any other substances apart from an occasional beer with friends.

Mrs Thobela disclosed that her husband drank large quantities of alcohol for the past four years. Last year he lost his job due to his heavy drinking. After losing his job, his drinking would begin late in the afternoon and would not end until he fell asleep. On the evening when he was admitted to the hospital, he fell from the stairs after consuming a large amount of 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 two years ago, coming home from a pub where he had been drinking with friends but did not sustain any major injury. He has no other major health problems.

Reportedly, his relationship with his wife became very strained after he began drinking. Mrs Thobela stated in the interview with the doctor 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.

Question 20

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

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

Question 21

According to the DSM-5 Classification system, Mr Thobela's symptoms of increased hand tremors, insomnia, anxiety and visual hallucinations, illustrate the symptoms of his co-morbid diagnosis of - - - - - that is present in Alcohol - - - - -.

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

Question 22

In addition to his principal and co-morbid diagnoses, 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 23

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 24

Which of the following are associated with the long-term use of Cocaine?

(a) Kidney damage
(b) Delirium Tremens
(c) Toxic Psychosis
(d) Epilepsy

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

Read the following case study carefully and then answer questions 25, 26 and 27.

Charlize is a 25-year-old successful model for an international clothing company that specialises in fashion for the fuller female figure. She sought a second medical opinion for the persistent, irritating sensation of a lump in her throat and having difficulty swallowing after she was warned by her concerned agent that she might lose her modelling contract should she lose more weight. Due to the sensation in her throat and her difficulty swallowing, Charlize has lost her appetite and has lost 14 kg in the past three months. The sensation in her throat developed shortly after her boyfriend of the past eight years had left her for a young, skinny swimwear model. Not only does the persistent sensation of a lump in her throat cause Charlize severe distress, she is also terrified that she might lose her modelling contract. Charlize's friends and family are very concerned about her and shower her with sympathy and attention.

The medical evaluations could not find any physical reason for the sensation in her throat and her difficulty swallowing.

Question 25

According to the DSM-5 classification system, Charlize's abnormal behaviour can be diagnosed as a/an - - - - -.

1. Adjustment Disorder
2. Factitious Disorder
3. Illness Anxiety Disorder
4. Conversion Disorder

Question 26

The development of Charlize’s principal diagnosis is conceptualised by the Psychodynamic perspective as due to the - - - - -.

1. conversion of unconscious emotional conflict into physical symptoms. These symptoms are produced and then sustained by two mechanisms namely primary and secondary gain.
2. experiencing of physical symptoms as a result of an over-developed super-ego. The only gain involved is primary gain which entails the fulfilment of dependency needs.
3. conversion of conscious conflicts into physical symptoms in order to gain attention and sympathy (secondary gain) and to reduce humiliation (primary gain).
4. manifestation of psychological symptoms caused by underlying physical vulnerabilities. Primary and secondary gains do not play any significant role in the onset and maintenance of the symptoms.

Question 27

The Multipath Model (Sue et al., 2016) emphasises the following *Sociocultural factors* as important in the development of the kind of disorder Charlize is suffering from:

1. Economic stressors; degree of knowledge about medical concepts; cultural acceptance of physical symptoms.
2. Uninvolvement in social activities; gender roles; cultural focus on certain medical conditions.
3. Family history of illnesses, social status; social and cultural uninvolvement.
4. Media reinforcement of certain culturally bound illnesses; social and cultural isolation; cultural vulnerability to develop the disorder.

Question 28

David was the victim of a robbery at his home where he was repeatedly beaten and violated by the perpetrators. Following the traumatic incident, David experiences an inability to recall any details of the event, including the fact that his wife was raped in front of him. David’s doctor is satisfied that his memory problems are not the result of a medical condition or the physiological effects of a substance. According to the DSM-5 classification system, David can be diagnosed with - - - - -.

1. Dissociative Amnesia
2. Acute Stress Disorder
3. Posttraumatic Stress Disorder
4. Mild Neurocognitive Disorder due to Traumatic Brain Injury

Question 29

David’s inability to recall any details of the event is an example of - - - - - .

1. Derealisation
2. Localised Amnesia
3. Selective Amnesia
4. Dissociative Fugue

Question 30

According to the post-traumatic model of Dissociative Identity Disorder (DID), the following factors are necessary for the development of DID:

a) Substance use.
b) Being exposed to overwhelming childhood stress.
c) Genetic or biological predispositions, psychiatric vulnerabilities, life stressors.
d) Negative role models and susceptibility to peer pressure.
e) Having the capacity to dissociate.
f) Walling off the experience.
g) Developing different memory systems.

1. a, d, g
2. a, b, c, d
3. a, d, e, f
4. b, c, e, f, g

END OF ASSIGNMENT 2

Assignment 91		
Semester 1	**Closing date: 2 May 2018**	**Unique number: hendeh@unisa.ac.za**

Note: This assignment is **not compulsory**, and carries **no examination credits**. The assignment consists of 22 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 **tutorial letters** for this module?

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

13 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.

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

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

15 You have studied this module through the **medium of English**. 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.

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

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

17 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.

18 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.

19 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

20 How **often** during 2018 have you made contact with an Abnormal Behaviour and Mental Health lecturer?

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

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

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

22 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 <u>SEMESTER 2</u>

Assignment 01		
Semester 2	**Closing date: 10 August 2018**	**Unique number: 623140**

This assignment is based on **Learning Units 1, 2, 3, 4, 5, 6, 7 and 9 in Tutorial Letters 501 and 502** and the corresponding chapters **1, 2, 3, 5, 6 15 and 16 ('Externalising Disorders among the Youth')** in the prescribed book.

Question 1

Rose has an exaggerated fear of flying. She refuses to board an airplane and avoids airports altogether. If her psychologist attributed this fear to Rose's observation of her mother's fear of flying when Rose was a child, the therapist would be explaining the aetiology of Rose's behaviour from the - - - - - in psychology.

1. Behavioural model
2. Psychodynamic model
3. Social-relational model
4. Cognitive-behavioural model

Question 2

A psychologist who sees a client's psychological problems as caused by a lack of the requisite socially acceptable behaviours, as well as insufficient feedback regarding their actions, would most likely support which model of psychopathology?

1. Existential model
2. Humanistic model
3. Behavioural model
4. Psychodynamic model

Question 3

An assessment method that asks Kabelo to respond "agree" or "disagree" to a list of personality descriptive statements would be an example of a - - - - -.

1. clinical interview
2. self-report inventory test
3. cognitive impairment test
4. projective personality test

Question 4

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.

Read the following information that was extracted from an interview with Sihle three weeks after her parents' death in a remote area of Mpumalanga, then answer questions 5, 6, 7, 8, 9 and 10.

Sihle's family is known to live a traditional lifestyle in the rural area of Mpumalanga, a place her family has called home for the past five generations. Sihle's parents expected her to marry a local boy and continue the family tradition of running the household and bringing up children. She often watched the glamorous secretaries on TV at a friend's house and dreamt of one day working in an office. Sihle left school at the age of 16 and followed her boyfriend to Gauteng to learn everything she needed to know about becoming a secretary.

It was difficult for Sihle to make a living while learning to become a secretary but she succeeded through sheer hard work and determination. Sihle was hired by a big firm in Gauteng as a secretary shortly after completing her studies. While still on probation, Sihle now 22 years old, was working under stressful circumstances for long hours for months on end, without visiting at home, because she wanted to have a permanent position at the big firm. Her small salary only allowed her to travel to Mpumalanga once a year.

She failed to attend a number of birth and marriage rituals in her village and the villagers began to speak openly about the ancestors withdrawing their protection from the family because Sihle was breaking their traditional customs. It was said that the ancestors were also angry about Sihle's neglect of her parents by visiting them too seldom and neglecting the custom of caring for her tribe.

During a heavy thunderstorm, her parents' hut was struck by lightning, killing both parents. On the day her parents died, all the taxi companies began a weeklong strike. Sihle was unable to find alternative transport in time, and the funeral rites of her parents had to begin without her. Very stressed, she only arrived after the burial, where she collapsed on her parents' grave. When someone tried to assist her in getting up, she suddenly felt faint and dizzy, felt as if she was choking, and as if her heart was beating irregularly, and she perspired profusely. Sihle felt as if she was dying.

Because Sihle's community considered her as breaking with tradition and having disgraced her parents, they considered her as an outcast and Sihle was isolated in the community without support or friends. Three weeks later, she could still not stop thinking about the horrible way her parents had died. She was unable to sleep and unable to concentrate on tasks, felt dissociated from everybody and everything, was highly aroused, irritated and felt as if she was in a daze all the time. She further got a choking feeling every time she saw her parents' burnt hut. Although Sihle tried to avoid the hut, she continued to experience intense anxiety whenever she passed the burnt hut. These state of events had an adverse impact on her mood and concentration.

Question 5

Which one of the following statements directly relates to Sihle's recent illness according to the African perspective?

1. Sihle's parents expected her to marry a local boy and continue the family tradition of running the household and bringing up children. Instead, she left school at the age of 16 and followed her boyfriend to Gauteng to learn everything she needed to know to become a secretary.
2. Sihle failed to attend a number of rituals in her village and the villagers began to speak openly about the ancestors withdrawing their protection from Sihle's family.
3. Sihle was working under stressful circumstances for long hours for months on end.
4. Sihle could not stop thinking about the horrible way her parents had died.

Question 6

According to the African perspective Sihle's illness can be defined as - - - - -.

1. Ukufa kwabantu
2. Amafufunyana
3. Umkhuhlane
4. Ukuthwasa

Question 7

According to the DSM-5 classification system, Sihle's abnormal behaviour can be diagnosed as - - - - -.

1. Bereavement
2. Adjustment Disorder with anxiety
3. Panic Disorder
4. Acute Stress Disorder

Question 8

According to the DSM-5 classification system, the symptoms of Sihle being very stressed, collapsing on her parents' grave, suddenly feeling faint and dizzy, as if she was choking, irregular heartbeat and perspiring profusely could indicate the presence of a - - - - -.

1. Panic attack
2. Panic Disorder
3. Factitious Disorder
4. Conversion Disorder

Question 9

According to the Multipath Model (Sue et al., 2016), which one of the following refers to factors related to the Psychological dimension in the development of Sihle's mental disorder?

1. Sihle experienced low income.
2. Sihle's family had very strict traditional expectations of her.
3. Sihle's perception that her parents died in a horrible way.
4. Sihle being separated from her family.

Question 10

Which one of the following alternatives indicates the Social dimension in the development of Sihle's mental disorder according to the Multipath Model (Sue et al. 2016)?

1. Sihle lived in the city far away from her village.
2. The fact that she is a female, which makes her more vulnerable to developing this mental disorder.
3. Sihle worked within a stressful environment earning a low income.
4. Sihle was isolated and did not receive social support from the community and friends.

Question 11

Which one of the following statements concerning stressors and stress is the **most** accurate?

1. Stressors are only temporary, while stress is a chronic condition.
2. Stressors and stress are two different words that have the same meaning.
3. Stressors are external events; stress is an internal reaction to such events.
4. Stressors are internal reactions such as increased heartbeat; stress is an external condition.

Read the following case study and answer questions 12 and 13.

Thanda is a 23-year-old graphic designer who recently left her job. This position at a reputable corporate design firm was her first employment appointment since graduating *cum laude*. During the first three months after she joined the company, Thanda began struggling with intense feelings of sadness, worry and nervousness. Despite her participation in a work mentorship programme and the efforts of Thanda's colleagues to include her in activities, she remained unhappy, anxious and isolated. These feelings continued for the next six months until she resigned.

During this period, Thanda experienced burnout and was hospitalised eight times for exhaustion, but doctors could not find anything medically wrong with her. These admissions to hospital caused her severe anxiety as it further impacted her performance at work. When questioned by a counsellor, Thanda said that she did not feel that she was coping well. She stated that she was not adapting well to the corporate culture she experienced in her new workplace after the academic environment she had experienced at university. The despair and anxiety that Thanda felt as a result of her belief that she was not doing a good job, persisted throughout the six months of her employment. She confessed that she felt hopeless as an employee and would often cry alone in the bathrooms at work. Thanda is currently unemployed and she no longer experiences any of these symptoms.

Question 12

Taking into consideration Thanda's symptoms, what, according to the DSM-5 classification system, would be the principal diagnosis made by a clinical psychologist?

1. Panic Disorder
2. Adjustment Disorder
3. Acute Stress Disorder
4. Generalised Anxiety Disorder

Question 13

Which one of the following Specifiers are applicable in accordance with the principal diagnosis?

1. Depressed mood
2. Disturbance of conduct
3. Mixed anxiety and depressed mood
4. Mixed disturbance of emotions and conduct

Question 14

A stressful environment during childhood that lacks predictable parenting and nurturing are aetiological factors that result in inhibited, emotionally withdrawn behaviour towards the caregiver by the child, which is a core characteristic of - - - - -.

1. Social Anxiety Disorder
2. Autism Spectrum Disorder
3. Reactive Attachment Disorder
4. Disruptive Mood Dysregulation Disorder

Question 15

A clinical psychologist develops a play for high school learners about ways to promote positive feelings and activities that reduce the risk of Depressive Disorders. This is an example of - - - - -.

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

Question 16

A support group for recovered substance abusers assists its members to adjust to their new drug-free lifestyle and how to implement the coping skills they learnt at rehab in their day-to-day lives at home. This support group is an example of - - - - -.

1. Tertiary Support
2. Secondary Support
3. Tertiary Prevention
4. Secondary Prevention

Read the following short case study and then answer questions 17 and 18.

Gerald, a 34-year-old comedian, goes to the psychologist at the psychiatric hospital in Cape Town. He tells the psychiatrist that he struggles to sleep properly and that he feels so down that his manager had to cancel his comedy shows for the past four weeks. Gerald feels that he has nothing to live for as his long-time girlfriend left him six months ago after having been physically assaulted by Gerald once too often. Gerald justifies his abusive behaviour by insisting that his girlfriend always provokes him and he feels he has done nothing wrong. Recently, he threatened to shoot his girlfriend and then himself. His manager felt that he could not trust Gerald to be by himself and drove him to the hospital.

After the consultation, the social worker informs the psychologist that according to community members and extended family members, Gerald's girlfriend left him allegedly, due to the stress surrounding his arrest, his excessive use of cocaine as well as his infidelity at the time. Furthermore, a newspaper reporter from the *Sunday Times* who has been documenting Gerald's violent criminal record, including multiple arrests for selling drugs since his early teens, has been trying to contact the hospital for the last three hours to find out about Gerald's condition. Gerald has been in the newspapers for the past 12 months regarding his tumultuous break-up with his girlfriend, his pending sentencing for tax fraud and being involved in an infamous hijacking ring which has targeted stealing 4x4's and selling them across the Lesotho border.

Question 17

In assessing Gerald's abnormal behaviour according to the DSM-5 classification system, the psychologist should consider the following possible principal diagnosis:

1. Narcissistic Personality Disorder
2. Antisocial Personality Disorder
3. Borderline Personality Disorder
4. Conduct Disorder

Question 18

During his psychotherapy sessions, Gerald's psychologist finds out that, as a child, he had frequently been neglected and physically abused by his stepfather who was arrested for a variety of criminal offences. This history of abuse and neglect points to the role of - - - - - as an aetiological factor for Gerald's disorder according to the Multipath Model (Sue et al., 2016).

1. cultural values
2. genetic influences
3. the social dimension
4. the socio-cultural dimension

Question 19

Which one of the following statements about Personality Disorders is **true**?

1. Individuals with Personality Disorders possess rigid patterns of responding that are inflexible, episodic and transitory.
2. Personality Disorder symptoms are mostly evident in a prime context of a person's life.
3. The maladaptive personality patterns are subtle and rarely cause problems for the person or for others.
4. Personality Disorders should only be diagnosed in late adolescence or adulthood when personality development is more complete.

Question 20

Longstanding, inflexible and pervasive distrust and suspiciousness of others, such as perceiving their motives as malevolent, is a core characteristic of which one of the following DSM-5 disorders?

1. Schizophrenia
2. Delusional Disorder
3. Schizoid Personality Disorder
4. Paranoid Personality Disorder

Question 21

According to the Psychodynamic perspective, the - - - - - shown by individuals with Narcissistic Personality Disorder is due to - - - - -

1. impulsivity; parental neglect and abuse.
2. consistent irresponsibility and deceitfulness; faulty superego development.
3. extreme self-focus and lack of empathy; a lack of parental modelling of empathy during childhood.
4. grandiose sense of self-importance; distorted cognitive schemas that developed since early childhood.

Question 22

All of the following are distinguishing features of Impulse-Control disorders **except**:

1. Individuals with this disorder feel out of control with regard to their actions.
2. They engage in the impulsive activity not knowing that it will produce consequences, such as harm to self or others.
3. Before the act, they feel tense and/or aroused.
4. After the act, they are filled with guilt and/or shame.

Question 23

All of the following are characteristics of Pyromania **except**:

1. It is a deliberate act of setting of fires more than once.
2. The individual will exhibit a fascination and attraction to fire and any objects associated with it.
3. Before the fire is set, there is tension, with a resolving relief once the fire is set.
4. Acts of pyromania are done to express anger.

Read the following short case study and then answer questions 24, 25 and 26.

For the past six weeks Megan, 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. Megan refuses to leave the house without her mother.

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

Question 24

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

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

Question 25

In addition to the principal diagnosis, a diagnosis of - - - - -, according to the DSM-5 classification system, would also be made in Megan's case.

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

Question 26

Being exposed to a high conflict divorce and the associated losses and changes at a young age, pose high levels of stress to most young children. Should Megan's parents have taken her for counselling at the onset of their divorce, their action would have been an example of - - - - -. Taking her to a psychologist for psychotherapy after the onset of her symptoms is an illustration of - - - - -.

1. Primary Prevention; Secondary Prevention
2. Secondary Prevention; Tertiary Prevention
3. Child neglect; Factitious Disorder Imposed on Another
4. Paranoid Ideation; Illness Anxiety Disorder

Question 27

Since Kate was bitten by a dog eight months ago, she experiences recurrent, unexpected episodes of terror that last approximately 10 minutes. Kate's heart beats so fast, she believes she is having a heart attack, her whole body trembles uncontrollably, she sweats profusely, experiences numbness in her legs and she feels a sense of doom. Since the first terrifying episode, Kate has feared having another episode. According to the DSM-5 classification system, Kate's abnormal behaviour can be classified as - - - - -.

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

Question 28

Which of the following factors would be considered by a Cognitive-Behaviourist in explaining Kate's abnormal behaviour?

a) Kate's family history pertaining to mental disorders
b) Low levels of serotonin
c) Uncomfortable bodily experiences
d) Her gender
e) Stress experienced during her childhood years
f) Catastrophic thoughts.
g) A classical conditioning process.

1. a, d, f
2. b, c, g
3. c, f, g
4. d, e, f

Question 29

Which of the following statements are 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 which 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, c
2. a, d
3. b, c
4. b, d

Question 30

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 possessions is distressing because of a strong emotional attachment to saved items.
e) The hoarding causes clinical significant distress or impairment in functioning.

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

END OF ASSIGNMENT 1

Assignment 02		
Semester 2	**Closing date: 10 September 2018**	**Unique number: 777760**

This assignment is based on **Learning Units 8, 10, 12, 13, 14 and 15 of Tutorial Letters 502 and 503** and the corresponding **chapters 7, 8, 9, 11, 12 and 13 in the prescribed book.**

Read the following case study carefully and then answer question 1, 2, 3 and 4.

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 in 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 1

In diagnosing Diane's abnormal behaviour, several disorders were considered and some of them were eliminated. T**hree** 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 2

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

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

Question 3

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 4

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 5

Conrad, 39 years old, has been pessimistic, depressed and fatigued with a decreased appetite and little interest in 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 although Conrad still did most of his work, it was not at the level that the job required.

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

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

Question 6

Zanelli is diagnosed with Bipolar I Disorder, most recent episode mania. Her symptoms are elevated mood, distractibility, disjointed speech, excessive sleep and irritability with others. Her occupational functioning is also impaired. She has been suffering from these symptoms for the past ten days. 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 Zanelli’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.

Question 7

As stated in your study guide, suicide is a complex act with no obvious aetiology. However, the Multipath Model’s perspective considers - - - - - as a risk factor of the - - - - - dimension that may influence a person’s decision to commit suicide.

1. childhood abuse; Psychological
2. physical disability; Social
3. male gender; Biological
4. isolation; Sociocultural

Question 8

Which of the following characteristics of suicide is **incorrect** according to Sue et al. (2016)?

1. There is a strong underlying desire to die by the person who attempts/ commits suicide.
2. Suicidal intent is communicated directly or indirectly through verbal or 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 9

As a therapist, you would be one of the first lines of defence against a person committing a suicidal act. Sue et al. (2016) states that in most cases there are clues or risk factors that may be key indicators of the planned act of suicide. In the process of assessing the risk for suicide, which would be an immediate action to take when the determined lethality is high?

1. Monitoring
2. Providing a crisis number
3. Preventive Counselling
4. Hospitalisation

Read the following case study and answer questions 10, 11, 12, 13 and 14.

Mia was 24 years old when she was first admitted to hospital. She was one year away from completing her medical degree, the duration over which she obtained an A average throughout. Mia has been described by her close friend as always being a disciplined, conscientious student who was respectful, likeable and caring towards others. Her close friends first began to notice subtle changes in Mia's behaviour approximately eight months ago. She began missing classes and grew increasingly distant from and nonchalant towards, her closest friends. She stopped calling her parents for their weekly chats citing that her phone-line had been tapped. Mia stopped using all forms of communication devices such as her iPad, cell-phone and laptop for the same reason. Her last post on Facebook was confusing but related to her being watched.

After approximately seven weeks of progressively disturbing behaviour, she would eventually only emerge from her room looking disheveled and unkempt to go to the library. When asked about her absence from classes and failure to submit assignments by her concerned professors, she empathically rambled on almost unintelligibly about her ground breaking research that had resulted in her finding a cure for cancer. When asked to present her research for analysis, she launched into a 10-minute soliloquy that progressed to ranting about tiny alien microchips that were being implanted in people's heads without their knowledge. Growing concerned about the obvious degeneration in her social relationships and rapid grade decline at school, Mia's family in collaboration with her professors, decided to seek professional help.

During the intake interview at the hospital, Mia showed no emotion as she stared blankly at her psychologist. She displayed no emotion when the psychologist probed her about the passing of her beloved grandmother a year ago. Her answers were abruptly short requiring extensive amount of additional questions to be asked by the psychologist before even the most basic amount of useful information was gathered from her. Mia was tested for possible drug abuse and underlying medical conditions during the mandatory drug testing at the hospital and was found to be drug-free and physically healthy.

Question 10

Which one of the following diagnoses best describes Mia's abnormal behaviour according to the DSM- 5 classification system?

1. Schizophreniform Disorder
2. Schizoaffective Disorder
3. Delusional Disorder
4. Schizophrenia

Question 11

Which one of the following DSM-5 diagnoses could have been made if Mia's abnormal behaviour presented for at least one month but less than six months?

1. Schizophreniform Disorder
2. Schizoaffective Disorder
3. Delusional Disorder
4. Schizophrenia

Question 12

The delusions experienced by Mia can best be described as - - - - -.

1. Delusions of reference and thought withdrawal
2. Delusions of persecution and delusions of control
3. Delusions of reference and delusions of persecution
4. Delusions of grandeur and paranoid ideation

Question 13

Mia's inability to display any emotional response and her succinct answers to questions is an example of - - - - -.

1. anhedonia and avolition
2. alogia and anhedonia
3. avolition and restricted affect
4. restricted affect and alogia

Question: 14

Examples of the Negative Symptoms of Schizophrenia include:

a) delusions
b) diminished emotional expression
c) hallucinations
d) avolition
e) disorganised thinking

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

Question 15

According to the Dopamine Hypothesis, - - - - - may result from excess dopamine activity at certain synaptic sites in the brain.

1. Schizophrenia
2. Bipolar Disorder
3. Major Cognitive Disorder
4. Disruptive Mood Dysregulation Disorder

Read the following case study and then answer questions 16, 17 and 18.

Mohammed, a 65-year-old boxing champion and current trainer, has progressively been manifesting worrying symptoms over the past few years. It all started with a tingling and stiffness in his arms and legs, causing him increasing difficulty in all his fitness-training activities. He is unable to jump rope or jog and even has difficulty walking without often stumbling. Furthermore, he has been finding it difficult to hold full cups of coffee and other liquids without spilling. He finds that he can no longer get around as quickly as he used to and sometimes it seems as if his arms and legs have a will of their own. More recently, people around him have started noticing that Mohammed is increasingly finding it difficult to talk, slurring his words and using the wrong names for everyday objects. Mohammed has difficulty remembering significant information regarding his former career and family life and is no longer able to figure out opponents' weak points and accordingly plan a match strategy for the boxers he trains. His reaction speed is slowed and he can no longer act as his trainees' sparring partner as he finds he cannot anticipate their next move, and even if he could he is not able to counteract the moves quickly enough. This has now become so bad that he was forced to hire a trainer to take over the training of the boxers in his gym.

Mohammed consulted a neurologist specialising in sport medicine who sent him for a neurological evaluation. The doctor suspects Parkinson's Disease as MRI scans showed atrophy of the brain in the motor regions of the brainstem.

Question 16

Given the symptoms in the case study, Mohammed will most likely be diagnosed as - - - - - because he exhibits - - - - -.

1. Mild Neurocognitive Disorder due to Parkinson's disease; modest decline in at least one area of cognitive functioning and the ability to meet the demands of daily living.
2. Major Neurocognitive Disorder due to Parkinson's disease; significant decline in one or more areas of cognitive functioning and the ability to meet the demands of daily living.
3. Major Neurocognitive Disorder due to Parkinson's disease; modest decline in at least one area of cognitive functioning.
4. Major Neurocognitive Disorder due to Parkinson's disease; significant decline in perceptual-motor functioning and the ability to meet the demands of daily living.

Question 17

The symptoms Mohammed is experiencing regarding tingling and stiffness in his arms and legs, inability to jog and jump rope, to move around quickly and to hold liquids without spilling, all refer to the - - - - - symptoms of his - - - - - domain being affected.

1. psychological; social cognition
2. physical; perceptual-motor
3. physical; executive ability
4. psychological; perceptual-motor

Question 18

Mohammed's increasing difficulty communicating effectively for example using the wrong names for everyday objects, is termed - - - - -.

1. agnosia
2. apraxia
3. aphasia
4. anhedonia

Question 19

According to the DSM-5 classification system, a Neurocognitive Disorder caused by a toxin which has a rapid onset and involves a disturbance in consciousness and changes in cognition such as memory impairment, disorientation and language and perceptual disturbances, as well as reduced ability to focus, sustain or shift attention together with disorganised patterns of thinking is diagnosed as - - - - -.

1. Delirium
2. Major Neurocognitive Disorder due to substance/medication use
3. Intellectual Disability, severe
4. Dementia

Question 20

Strokes damaging the left hemisphere of the brain typically affect - - - - -, as well as physical movement on the right half of the body; whereas strokes occurring within the right hemisphere can - - - - - in addition to impairing motor movement on the left side of the body.

1. speech and language proficiency ; impair judgment and short-term memory
2. judgment and short-term memory ; impair speech and language proficiency
3. ability to feel empathy ; increase impulsivity
4. impulse control ; decrease empathy

Read the following case study and then answer questions 21, 22 and 23.

Kgosi, a 21-year-old university third year student spends most of his afternoons drinking beer (alcohol) in a bar with his friends. After eight to ten glasses, he becomes argumentative, challenging one of his bigger companions to step outside with him and fight. Normally Kgosi is a quiet, unaggressive person, but at times like these, he speaks in a loud voice challenging the bigger guy to fight him, apparently with no good reason. When the fight does not develop, he becomes distressed and tearful, spends long periods of time staring into his beer glass. After more beers, he begins to tell long and indiscreet stories about his ex-girlfriends. His attention drifts when others talk and he finds the most trivial things like tripping over a beer glass so humorous that he laughs so loudly until the bartender gives him a warning look, which usually calms him down. However, this time he starts to get up and say something to the bartender, but trips, falls to the floor, and injures his arm. His friends help him to the car to take him to hospital. At the hospital, the doctors attend to his injured arm. He falls into a deep sleep, from which he wakes up with a headache and a bad taste in his mouth, he once again the quiet and shy person his friends know him to be.

According to his Uncle, Kgosi has always been a bit of a loner since childhood. He heard from his sister (Kgosi's mom) that Kgosi always had a few friends, but lost many of his friends because of his tendency to become excessively reliant on them. It was as if he could not cope without a friend. Ever since his parents' divorce, he became very close to his mother. He could rarely leave home without his mother for most of his school career. When he left for varsity, he made a few friends and now he does not go out unless they take him along. He has a low self-esteem and has always allowed his friends to make decisions for him. A year ago Kgosi became emotionally traumatised when his mother passed away in a car accident. It would appear that he battled to cope with her death since he tried to commit suicide but was found by his uncle with a hand full of sleeping pills. His uncle who subsequently became his guardian has never known him to use alcohol or drink any other substance.

Question 21

According to the DSM-5 classification system, the principal diagnosis for Kgosi's abnormal behaviour would be - - - - -.

1. Alcohol Abuse
2. Alcohol Dependence
3. Alcohol Intoxication
4. Alcohol Tolerance

Question 22

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

1. Avoidant Personality Disorder
2. Schizoid Personality Disorder
3. Dependent Personality Disorder
4. Antisocial Personality Disorder

Question 23

Given the information in the case study, the effect of Kgosi's alcohol with regard to his sociability and behaviour could be the following:

1. Alcohol increases inhibition of aggressive impulses
2. Alcohol increases the central nervous system functioning, thus making it easier for individuals to be more sociable.
3. Alcohol increases disinhibition of aggressive impulses.
4. Alcohol makes one more socially inhibited.

Read the following case study carefully and answer question 24

Des, a 23-year-old, university student who had never used dagga before, was given two "joints" by his roommate. Des smoked the first of the two joints in the same manner that he usually smoked a cigarette (in about three to five minutes). Noting no major impact, Des immediately smoked the second joint in five minutes. Within a half an hour he felt on top of the world, however shortly thereafter, he began to experience increased heartbeat, anxiety, dryness in his mouth and the belief that his throat was closing up and that he was going to die. Des became more panicked which led him to rush to hospital. Reassurance that he would not die from the casualty team, had no effect on him.

Question 24

Which one of the following DSM-5 diagnoses would be considered by the psychiatrist in Des' case?

1. Non problematic use of cannabis
2. Cannabis Intoxication
3. Cannabis Use Disorder, Moderate
4. Addiction to a Stimulant

Read the following case study carefully and then answer questions 25 and 26.

Joshua is a 29-year-old medical doctor who works for Doctors Without Borders. His most recent trip abroad was to help with an Ebola outbreak in a neighbouring country. Since his return more than 12 months ago, Joshua has been plagued with insistent concern that he may have contracted the Ebola virus during the course of his work abroad. Despite Joshua's own knowledge of the disease and numerous medical check-ups that cleared him as 100% healthy, he still cannot shake his fear that he may be infected. In fact, he is so anxious about his health, that he immediately leaves his work at the slightest sign of physical pain or discomfort in order to have himself examined for any signs of the illness. Joshua's anxiety about his health has become excessive to the extent that his colleagues are avoiding him at all costs because of his insistent requests for reassurance and check-ups. Some of his colleagues have even lodged complaints against him for neglecting his patients.

Question 25

According to the DSM-5 classification system, Joshua's abnormal behaviour can be diagnosed as - - - - -

1. Factitious Disorder.
2. Illness Anxiety Disorder.
3. Somatic Symptom Disorder.
4. Obsessive Compulsive Disorder.

Question 26

The Multipath Model (Sue et al., 2016) emphasises the following psychological factor in the development of Joshua's condition:

1. History of illness or injury
2. Preoccupation with bodily sensations
3. Parental modelling of injury and illness
4. Degree of knowledge about medical concepts

Question 27

Thandi, a 21-year-old student, suddenly lost the use of her arms three months ago. After numerous medical tests, the doctors have ruled out a medical cause for her sudden paralysis. Her complete paralysis has slowly improved to the point that she can raise her arms slightly. However, Thandi's symptom is causing her severe distress as she cannot write her University exams or perform most chores at home.

According to the DSM-5 classification system, Thandi's abnormal behaviour can be diagnosed as:

1. Body Dysmorphic Disorder
2. Factitious Disorder Imposed On Self
3. Somatic Symptom Disorder
4. Conversion Disorder (Functional Neurological Symptom Disorder)

Question 28

Which one of the following statements about Dissociative Disorders is not true?

1. Dissociative Amnesia with Dissociative Fugue is characterised by an inability to recall autobiographical information, identity confusion and a sudden departure to a new area.
2. Depersonalisation Disorder is characterised by an impairment in reality testing that results in experiences of unreality, detachment or being an outside observer with respect to one's thoughts, feelings, sensations or actions.
3. Derealisation Disorder is characterised by experiences of unreality or detachment with respect to one's surroundings.
4. Dissociative Identity Disorder is characterised by a disruption in identity that involves a marked discontinuity in an individual's sense of self and sense of agency.

Question 29

According to the Multipath Model of Dissociative Identity Disorder (DID), which one of the following is not a psychological factor that may contribute to its development?

1. Media portrayals of DID may unconsciously encourage reports of DID from clients.
2. Hypnotisability or suggestibility may increase the likelihood of someone developing DID.
3. Exposure to severe stress and trauma during childhood may lead to the development of separate identity states
4. Individuals who develop DID must have the ability to separate certain memories or mental processes in response to traumatic events.

Question 30

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 Bandile's case?

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

END OF ASSIGNMENT 2

Assignment 91		
Semester 2	**Closing date: 9 October 2018**	**Unique number: hendeh@unisa.ac.za**

Note: This assignment is **not compulsory**, and carries **no exam credits.** The assignment consists of 22 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 **tutorial letters** for this module?

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

13 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.

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

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

15 You have studied this module through the **medium of English**. 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.

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

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

17 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.

18 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.

19 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

20 How **often** during 2018 have you made contact with an Abnormal Behaviour and Mental Health lecturer?

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

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

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

22 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 2018 or October/November 2018. 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.

Please note: It is not advisable to base your examination preparation solely on past/old examination papers (papers prior to 2014), 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 (i.e. 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