Tutorial Letter 201/1/2016

Abnormal Behaviour and Mental Health

PYC3702

Semester 1

Department of Psychology

Feedback – Assignment 01

Bar code

Dear Student

After the completion of your first assignment we trust that you are well on your way to mastering the content of the Abnormal Behaviour and Mental Health course. We would like to encourage you to follow the recommended study programme (please refer to Tutorial Letter 101/3/2016, p. 9) and work through the syllabus systematically. Abnormal Behaviour and Mental Health is not a subject you can master in one week. Over and above the facts that you have to know, you are also expected to display insight into the nature and causes of the various mental disorders, to be able to classify and explain them according to different theoretical perspectives, and to be able to make suggestions about how to prevent the various disorders. Superficial knowledge of the subject will only confuse you and result in poor examination performance.

Do not hesitate to contact one of your lecturers if you encounter any problems with your studies. If you cannot reach a particular lecturer, please phone the secretary in charge of Abnormal Behaviour and Mental Health, Mrs Cornia Nel at (012) 4298233. She will put you in contact with the lecturer who is available. The lecturers' e-mail addresses are:

Ms Christine Laidlaw	laidlc@unisa.ac.za (Module leader)
Mrs Elmarié Visser	vissee@unisa.ac.za
Mrs Banti Mokgatlhe	mokgapb@unisa.ac.za
Mrs Janice Moodley	moodlj@unisa.ac.za
Mr Ruane Bester	bester@unisa.ac.za
Dr Nico van Zyl	vzylfn@unisa.ac.za

1 FEEDBACK ON ASSIGNMENT 01

Assignment 01 is based on chapters 1, 2A, 2B, 3, 5, 6A, and 8 of the Unisa Study Guide and the corresponding chapters in the prescribed book. These chapters are no more important than the other chapters in the syllabus, but it is important that you master them, especially chapters 1, 2A, 2B and 3 before you continue with the rest of the learning material.

By now those of you who have submitted Assignment 01, will have received a printout in which the correct answers, your answers and your marks are recorded. If you submitted Assignment 01 and have not yet received a printout, please contact Mrs C. Nel immediately, either by telephone (012) 4298233, e-mail nelc1@unisa.ac.za or by letter.

Compare your answers with the following correct answers. The aim of the feedback is to give you the correct information concerning each question and to explain the correct answers to you in case you have problems understanding them. Should you still experience problems and feel unsure about the learning material, we encourage you to contact one of the lecturers so that these problems can be solved.

We wish you success and hope you enjoy your studies!

This assignment is based on the Learning Units **1, 2, 3, 4, 5, 6, and 7** of the Tutorial Letter 501 and the chapters **1, 2, 3, 16, and 5** in the prescribed book.

Question 1

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

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

Feedback: The correct answer is alternative **4**.

Explanation: The DSM-5's definition of mental disorders is built on the following criteria of abnormality namely: dangerousness, dysfunction, personal distress and deviance (Refer to pp. 8-10 of the prescribed textbook).

Alternative 4 is correct as dangerousness refers to the level of risk the person displaying abnormal behaviour poses in terms of harming themselves or others, for example suicide attempts and physical assaulting others. Deviance refers to bizarre or unusual behaviour as an abnormal deviation from an accepted standard of behaviour. For example deviance can include antisocial acts against the law or a false perception of reality, or any other unusual or bizarre behaviours taking into account cultural expectations.

Alternative 1 and Alternative 3 are incorrect as dysfunction refers to the ability of an individual to fulfil daily life roles at home, at work/school or in relationships. Psychological problems can interfere with the functionality of the person to perform these roles productively.

Alternative 2 is incorrect as discomfort or distress refers to the level of intensity of the psychological suffering/ emotional reaction that the individual is experiencing.

Question 2

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

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

Due to the ambiguous nature of the question it was not marked and deleted.

Question 3

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

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

Feedback: The correct answer is alternative **4**.

Explanation: Alternative 4 is the correct answer because the statement "a person is a person because of other people" expresses the core of African traditional values which explains what it means to be "human". According to African worldview, personhood is understood as a process and a product of interconnectedness experienced and or achieved in the context of the community. It is also an affirmation of one's humanity through the recognition of an "other" in his or her uniqueness and difference. Furthermore, consistent with African worldview is a sense of connection and appreciation that extends beyond own family to the extended family. There is also a sense of "I am because we are" and a tendency to be part of and an obligation to the community. The African worldview places emphasis on humanity or "Ubuntu", which means that people are people in relation to other people. "Ubuntu" is also consistent with the concept of collective identity which encourages the importance of belonging to a cultural group; in a way reinforcing the sense and importance of community. Africans are therefore collectivistic in their orientation, with emphasis on collective identity, in-group solidarity, and a strong distinction between in-group and out-group.

Alternatives 1, 2 and 3 can therefore be eliminated.

Question 4

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

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

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

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

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

Feedback: The correct answer is alternative **3**.

Explanation: Alternative 3 is the correct answer because the concept of psychopathology within the traditional African worldview has evolved through the years to incorporate both traditional African and Western biomedical views. Most South Africans are located in the continuum between Western and more traditional orientation as evidenced during moments of crisis in their lives. The traditional African and Western systems of explaining and treating psychopathology or mental ill-health are widely utilised and impact on a large number of people in Africa. There is also sufficient evidence in contemporary society that Africans tend to incorporate both views therefore knowledge of both orientations would enable healthcare professionals in becoming culturally sensitive, client centred and effective with their interventions.

Alternative 1 is incorrect because western perspectives are based on traditional/mainstream psychology which is not generalizable to people of diverse contexts.

Alternative 2 is incorrect because most South Africans are located on the continuum between western and Traditional African orientation.

Alternative 4 is incorrect because South Africans do not need to lose their individual and collective diversity in thought, feeling and behaviour in order to collaborate with people in the First World.

Question 5

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

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

Feedback: The correct answer is alternative **1**.

Explanation: Alternative 1 is the correct answer because within the traditional African perspective, the disorders are grouped into two categories in line with their perceived causal factors. A distinction is made between Umkhuhlane which refers to disorders caused by natural factors) and Ukufa kwabantu which refers to disorders caused by supernatural factors or the ancestors). Ubuthakathi on the other hand refers to disorders caused by malicious people like witches and sorcerers.

Alternatives 2, 3 and 4 are thus eliminated.

Question 6

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

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

Feedback: The correct answer is alternative **4**.

Explanation: The correct answer is alternative 4, because mastery of the universe is characteristic of the Western worldview, which places emphasis on experimentation and objectivity unlike within the African worldview, which encourages harmony and balance in the universe and nature. According to the African worldview man is not the master of the universe, he is only the center. Although man is the center of the universe, he does not consider himself the master. He acknowledges forces outside of himself, which are powerful. Forces outside of man, in the spirit world, control the order of the universe. Consequently, in terms of the African worldview man's primary task is to live in consonance with the forces that govern the universe through obeying the Laws of the natural order, the moral order, the religious order and the mystical order. Furthermore, within the African worldview there is also a belief in the supernatural and holistic view of well-being. There is a strong belief in the unity of the spirit, mind and matter. This connection is evident in people's relationships with those who are part of the extended family, the clan and the community. The individual cannot, therefore, be viewed in isolation but must be viewed holistically as part of a collective. Spirituality, traditional norms and rituals are the most important aspects of healing within the African worldview. The African worldview places a strong emphasis on humanity or Ubuntu, which means that people are people in relation to other people. In the African worldview, there is a sense of “I am because we are" and a tendency to feel part of and an obligation to the community.

Alternatives 1, 2, and 3 are thus eliminated.

Question 7

Which **one** of the following statements applies to "Ukuthwasa"?

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

Feedback: The correct answer is alternative **3**.

Explanation: Alternative 3 is the correct answer, because "Ukuthwasa" according to the Traditional African perspective refers to a "creative illness" following a calling by the ancestors to become a diviner. "Ukuthwasa" is also regarded as a healthy or positive calling by ancestors to become a traditional healer and it happens through a ritual process of "thwasa".

Alternatives 1, 2 and 4 are incorrect as they denote a negative relationship with ancestors which is more of a characteristic of "Amafufunyana" which is an illness associated with bewitchment or breaking of customs and often resulting in symptoms of mental illness.

Question 8

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

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

Feedback: The correct answer is alternative **2**.

Explanation: Alternative 2 is the correct answer as individuals with disorders that are within the category of Impulse-control Disorders fail to resist an impulse, drive, or temptation to perform acts that are harmful to themselves or others as the essence of the disorder. Some disorders have impulse control as a primary characteristic (refer to Table 15.2, p. 511 of the prescribed book). While other disorders within the DSM-5 classification system may also involve problems in emotional and/or behavioural regulation, the disorders in the category of Disruptive, Impulse-control and Conduct Disorders are unique in that these problems are manifested in behaviours that violate the rights of others, for example, aggression or destruction of property, and/or bring the individual into significant conflict with societal norms or authority figures. For example, Intermittent-Explosive Disorder involves poorly controlled anger and outbursts of anger that are not in line with societal norms.

The clinical manifestations of Obsessive-Compulsive Disorder is characterised by intrusive thoughts, images or urges or by repetitive behaviours that are performed in response to these intrusions and it falls under the category of Obsessive-Compulsive and Related Disorders and therefore is not under the category of Impulse-control Disorders. Pathological gambling is an addictive behaviour and therefore forms part of the category of Substance-Related and Addictive Disorders and therefore is not under the category of Impulse-control Disorders.

Alternative 3 is incorrect as Obsessive-Compulsive Personality Disorder is characterised by enduring and pervasive maladaptive pattern of excessive perfectionism and rigid control and falls within the category of Personality Disorders and therefore is not under the category of Impulse-control Disorders. Road rage is not a recognised disorder according to the DSM-5 classification system.

Alternative 4 is incorrect as Bipolar I Disorder is mainly characterised by a *persistent* mood disturbance that lasts for at least a week and not the failure to resist the impulse, drive or temptation to perform harmful

acts; impulsive behaviours do occur in disorders listed in the category of Bipolar and Related Disorders, however, impulsivity is not the key characteristic. Suicide is not a recognised disorder according to the DSM-5 classification system. Furthermore, the act of suicide is not necessarily always an impulsive action.

Question 9

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

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

Feedback: The correct answer is alternative **4**.

Explanation: Alternative 4 is the correct answer as the psychodynamic approach argues that a person's abnormal behaviour is a result of early unresolved trauma that through therapy can be addressed by focusing on bringing the repressed pain that is now in the unconscious to the conscious awareness of the person. The psychodynamic therapist looks into an individual's internal conflicts and personal history to locate the development of their abnormal behaviour (Refer to p. 51 of the prescribed textbook).

Alternative 1 is incorrect as the family systems approach argues that a person's abnormal behaviour is a result of the ways that their family members interact or communicate with one another. The individual who displays the abnormal behaviour is seen as the symptom-bearer (identified patient), but the actual site of the abnormal behaviour (psychopathology) is located or embedded in the family system itself and therefore the therapist needs to see the family as a whole in order for the symptom that the individual is manifesting to no longer be 'necessary' in the family. Family systems theorists and therapists prioritise perturbing (disturbing with the intention to alter) observable interactional patterns of a family to bring about adaptive change within the interactional system.

Alternative 3 is incorrect as the humanistic approach that believes that people experience problems due to a sense of incongruence and therefore the therapist needs to facilitate the distressed individual in developing a greater sense of self-congruence which will bring about symptom relief and healthy adjustment (Refer to pp. 61-62 of the prescribed textbook).

Alternative 2 is incorrect as the cognitive approach believes a person's abnormal behaviour is a result of irrational beliefs about self that need to be disputed in therapy, in order for the person to have improved self-esteem. By changing their thoughts, people can change how they feel and what they do or how they behave (Refer to pp. 57-58 of the prescribed textbook).

Question 10

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

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

Feedback: The correct answer is alternative **1**.

Explanation: Alternative 1 is correct as *classical conditioning* is defined as learning a new behaviour via

the process of association. In simple terms, two stimuli are linked together to produce a new learned response in a person. If two stimuli are repeatedly paired: a response which is at first elicited by the second stimulus is eventually elicited by the first stimulus alone. As shown by Pavlov, classical conditioning can be used to make a dog salivate to the sound of a bell. For example if a bell is rung when the dog is presented with his bowl of food the dog will begin to reflexively assume that food is on its way when the dog hears bells ring. The link between food and bells ringing is now learnt.

Alternative 2 is incorrect as *operant conditioning* is defined as a voluntary modification of one's behaviour. This learning process requires reinforcement. For example a parent can change the undesirable behaviour of their child by the use of reinforcement which is given when the child demonstrates a more desired behaviour. The mother may say to her disruptive child: "If you complete your work quietly, you can go watch an additional TV programme".

Alternative 3 is incorrect as *vicarious conditioning* refers to the learning of various attitudes, feelings, beliefs and emotions, not through direct exposure to a stimulus, but through observing how others react to it, as such the individual is not directly involved.

Alternative 4 is incorrect as *reinforcemen*t is the reward element in operant conditioning.

Please also refer to pp. 53-56 of the prescribed textbook for further explanation.

Question 11

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

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

Feedback: The correct answer is alternative **2**.

Explanation: Alternative 2 is correct as a person who has engaged in self-harming behaviour, yet does not meet the criteria for Borderline Personality Disorder (Refer to p. 76 of Tutorial Letter 501/3/2016) can have the diagnosis or co-morbid diagnosis of Personal History of Self-Harm from the category of Other Conditions That May Be a Focus of Clinical Attention. Noting Personal History of Self-Harm helps the treating clinicians to be aware of the risk of harm in the patient's history or current mental health status (Refer to page 50 of the Tutorial Letter 501/3/2016).

Alternative 4 is incorrect. Self-harming is a possible criterion of Borderline Personality Disorder (self-mutilation is a possible criterion of BPD, refer to p. 76 of Tutorial Letter 501/3/2016), however individuals with other disorders can engage in self-harming behaviours and yet not meet the necessary criteria (at least five criteria need to be met) to diagnose Borderline Personality Disorder.

Alternatives 1 and 3 are incorrect. Eventhough there has been research Non-suicidal Self-Injury Disorder (NSSI) and Unspecified Self-Injury Disorder are not yet part of the DSM-5 classification system. Non-suicidal self-injury (NSSI) is defined as the deliberate, self-inflicted destruction of body tissue without suicidal intent and for purposes not socially sanctioned. NSSI includes behaviours such as cutting, burning, biting and scratching skin.

Question 12

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

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

Feedback: The correct answer is alternative **4**.

Explanation: Alternative 4 is the correct answer because for an individual to meet the DSM-5 diagnostic criteria for Alcohol Use Disorder he/she might have as one of his/her presenting symptoms: "Tolerance" which is described as markedly diminished effect with the continued use of the same amount of the alcohol.

Alternatives, 1, 2 and 3 describes other symptoms of Alcohol Use Disorder (refer to Tutorial Letter 502/3/2016; p. 45).

Question 13

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

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

Feedback: The correct answer is alternative **1**.

Explanation: Alternative 1 is the correct answer because the psychodynamic perspective views the use of alcohol as (a) releasing the inhibitions and allowing repressed conflicts to be expressed or (b) enabling people to obtain oral gratification and to satisfy oral dependency needs. Please refer to (Tutorial Letter 502/3/2016, p. 52).

Alternatives 2, 3 and 4 are incorrect because they all based on the cognitive- behavioural perspective's explanation of the cause of Alcohol Abuse Disorder which assumes the following:- (a) alcohol temporarily reduces anxiety and tension, (b) drinking behaviour is learned, and (c) cognitive explanations, which emphasises the expectancy effect which indicates that those who expect to gain pleasure from drinking alcohol are likely to drink it. This cognitive expectation might play a significant role both in initiating and maintaining drinking behaviour (Please refer to Tutorial Letter 502/3/2016, pp. 52-53).

Question 14

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

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

Feedback: The correct answer is alternative **1**.

Explanation: Alternative 1 is therefore correct as individuals who suffer from Paranoid Personality Disorder are reluctant to confide in others and therefore maintain interpersonal aloofness from others because of unwarranted suspicion that the information shared will be used maliciously against them. People with Paranoid Personality Disorder exhibit excessive suspicion of others and come across as hostile towards others. Their hostility is fuelled by mistrusting others and being hypervigilant of potential threats from others.

Alternative 2 is incorrect as eventhough a reluctance to confide in others is a shared characteristic of Paranoid Personality Disorder and Avoidant Personality Disorder, individuals who suffer from Avoidant Personality Disorder are reluctant to confide in others due to their fear of being embarrassed or being found inadequate not due to being suspicious of others' malicious intentions.

Alternative 3 is incorrect. Like Avoidant Personality Disorder, Schizoid Personality Disorder is also characterised by social isolation and therefore do not confide in others. This lack of engagement with others is not due to unwarranted suspicion of others or suspecting others of malicious intentions, but rather people with Schizoid Personality Disorder like to be by themselves and have a limited desire for intimacy with others. People with Schizoid Personality Disorder also do not exhibit paranoid ideation which is characteristic of people with Paranoid Personality Disorder.

Alternative 4 is incorrect as people with Antisocial Personality Disorder do actively engage with others, even if it is in an exploitative manner and are not suspicious of others' motives to the extent that they exhibit paranoid ideation.

Question 15

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

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

Feedback: The correct answer is alternative **1**.

Explanation: Panic Disorder, the disorder Phiri has been diagnosed with, is characterised by recurrent, unexpected attacks of intense panic, fear and acute distress. Several (at least four) somatic and cognitive symptoms accompany these panic attacks. The periods between panic attacks are characterised by anticipatory anxiety about having another attack. The intensity of this anticipatory anxiety is of a far lower intensity than the anxiety experienced during panic attacks.

Alternative 2, *Phiri is constantly worried about a range of life situations*, is eliminated as the anticipatory anxiety between panic attacks is focused on having another attack. Worry about a *range* of life situations and events are not characteristic of Panic Disorder.

Alternative 3, *Mpho experiences no somatic aspects of anxiety*, is eliminated as the characteristic free-floating anxiety and worry of Generalised Anxiety Disorder are associated with several (at least three) somatic symptoms such as restlessness, fatigue, muscle tension and sleep disturbance.

Alternative 4, *Mpho is persistently concerned about having an anxiety attack*, is ruled out as the sustained and excessive anxiety characteristic of Generalised Anxiety Disorder is about several events and activities and not focused on the fear of having a panic attack. Although Mpho might experience a panic attack in addition to his excessive free-floating anxiety, the panic attack would be superimposed on the worry and anxiety which are not linked to specific causes.

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

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

Question 16

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

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

Feedback: The correct answer is alternative **3**.

Explanation: Alternative 3, *Obsessive-Compulsive Disorder; Specific Phobia,* is correct. Herbert's symptoms meet the DSM-5 diagnostic criteria for Obsessive–Compulsive Disorder. The primary characteristics of Obsessive-Compulsive Disorder are recurrent obsessions and compulsions. Herbert also experiences obsessions as he has repetitive distressing thoughts about dirt and germs. His recurrent and persistent thoughts about dirt and germs are time-consuming, distressing and clearly beyond his ability to control. Herbert also engages in repetitive hand-washing rituals which is indicative of a compulsion which is a repetitive behaviour or mental act the person feels compelled or driven to perform. **Richard** on the other hand meets the diagnostic criteria of a Specific Phobia i.e. Acrophobia. He has a marked, longstanding and out of proportion fear of a specific situation (heights) which he actively tries to avoid. Please refer to page 134 of the prescribed book, *Table 5 Anxiety Disorders* for a detailed description of Specific Phobia.

Alternative 1 is incorrect. The diagnosis of *Specific Phobia* is ruled out in **Herbert's** case as his anxiety is a result of an obsession (intrusive thoughts about dirt and germs) and he shows other diagnostic criteria for Obsessive-Compulsive Disorder as described above (alternative 3). **Richard** also does not manifest symptoms of an *Avoidant Personality Disorder* which is characterised by a pervasive pattern of social inhibition, feelings of inadequacy and hypersensitivity to negative evaluation.

Alternative 2 can also be eliminated because **Herbert** does not manifest symptoms of *Obsessive-Compulsive Personality Disorder* which is characterised by a pervasive pattern of preoccupation with orderliness, perfectionism as well as mental and interpersonal control at the expenses of flexibility, openness and efficiency. **Richard** does not meet the criteria for *Agoraphobia* which is characterised by intense fear or anxiety triggered by the real or anticipated exposure to a wide range of situations (at least two situations) such as being in open spaces, standing in line or being in a crowd or being outside of his home alone.

Alternative 4 can also be eliminated. As described above, *Specific Phobia* (alternative 1) is ruled out in **Herbert's** case. **Richard** is also not manifesting the characteristic symptoms of a *Panic Disorder* such as unexpected panic attacks and persistent concern about additional attacks. Richard *only* experiences anxiety when confronted with the feared situation (heights).

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

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

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

Question 17

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

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

Feedback: The correct answer is alternative **3**.

Explanation: *Somatic Symptom Disorder* is eliminated because Tracey's excessive worries are not restricted to her health. Tracey worries about a number of events and situations; worry about her health is only one of her worries. Individuals with Somatic Symptom Disorder typically have multiple, current, somatic symptoms that are distressing and/or result in significant disruption of daily life. Refer to pages 198 to 200 in the prescribed book for more information on Somatic Symptom Disorder.

Obsessive-Compulsive Disorder, alternative 1, should have been eliminated because Tracey does not manifest the typical obsessive thoughts and compulsive behaviour of Obsessive-Compulsive Disorder. Obsessive thoughts are not simply excessive worries about every day or real life problems such as worries about health, family members or career. Obsessions are ego-dystonic intrusions that often take the form of urges, impulses and images in addition to thoughts. Tracey also does not suffer from any compulsions (repetitive behaviours or mental acts) that reduce her anxiety.

Alternative 2, *Posttraumatic Stress Disorder*, should have been eliminated because Tracey's symptom response pattern does not meet the criteria for Posttraumatic Stress Disorder. Refer to pages 28 and 29 of Tutorial letter 502/3/2016 for the DSM-5 diagnostic criteria for Posttraumatic Stress Disorder.

Alternative 4, *Factitious Disorder*, should have been eliminated because Tracey's symptoms are not produced intentionally or feigned in order to assume the sick role. She tries to hide her symptoms and does not use them to gain sympathy or support. Malingering, not Factitious Disorder, is characterised by symptoms which are motivated by external motives such as financial compensation.

Question 18

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

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

Feedback: The correct answer is alternative **4**.

Explanation: Tracey's symptoms meet the criteria for *Generalised Anxiety Disorder*. Tracey experiences excessive free-floating anxiety and worry that lasted for more than six months (nine months in Tracey's case). She is unable to control her worries and anxiety. Her anxiety and worry are associated with feeling on edge, difficulty concentrating, irritability and muscle tension. The anxiety, worry and physical symptoms cause clinically significant distress and impairment in her functioning.

Alternative 1, *Bereavement*, is eliminated since Tracey's behaviour is not typical of bereavement/grief (her predominant affect is characterised by persistent excessive anxiety and worry about a variety of issues/situations and persons and not by feelings of emptiness and loss associated with the loss of a loved one). Tracey is clearly displaying the symptoms of an Anxiety Disorder.

Alternative 2, *Adjustment Disorder with Anxiety*, is eliminated since Tracey's symptoms meet the criteria for Generalised Anxiety Disorder. The diagnosis of Adjustment Disorder should not be made if the disturbance meets the criteria for another specific mental disorder (Generalised Anxiety Disorder in this case).

Alternative 3, *Panic Disorder* is eliminated since Tracey's excessive worry is not restricted to having a Panic Attack. Tracey also does not experience recurrent, unexpected, spontaneous, uncued or "out of the blue" panic attacks. She experiences chronic free-floating anxiety and worry which she cannot control.

Question 19

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

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

Feedback: The correct answer is alternative **2**.

Explanation: Tracey's thoughts of worry illustrate the **cognitive** manifestation of her GAD (Generalised Anxiety Disorder), the symptom of uncontrolled anxiety illustrates the **affective** domain and the symptoms

of heart palpitations, sweaty palms and muscle tension illustrate the **somatic** manifestation of her GAD. Refer to page 97 of Tutorial Letter 501/3/2016 (7.1 Study Unit: Types of Anxiety Disorders) for a detailed explanation of the behavioural, cognitive, somatic and affective domains of anxiety.

Question 20

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

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

Feedback: The correct answer is alternative **2**.

Explanation: Tracey manifests some features of Dependant Personality Disorder. Not only was Tracey's husband her main source of support and care since they got married at an early age, he also assumed responsibility for some important areas of her life. Tracey seldom opposed his decisions and after his death she sought another relationship (her colleague) as a source of care and support. Although Tracey is dependant of other people, her personality traits do not meet the threshold (at least five symptoms to make the criteria) for Dependent Personality Disorder.

Alternative 1, Schizoid Personality Disorder, is eliminated because Tracey does not lack a desire for intimacy, nor does she avoid opportunities to develop close relationships and she clearly derives satisfaction from interpersonal relationships. She cannot be described as a "loner" as she has a close friend. Tracey has a pattern of seeking and making close connections to important others. The social relations of those individuals with traits of dependency tend to be limited to those few people on whom they are dependent.

Alternative 3, Borderline Personality Disorder, is eliminated because Tracey does not have a pattern of unstable interpersonal relationships, self-image and affects. She also does not display impulsive behaviour which is an essential feature of Borderline Personality Disorder.

Alternative 4, None, is eliminated because Tracey has a pervasive and enduring pattern of dependency traits which causes her distress and impairment in functioning.

Question 21

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

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

Feedback: The correct answer is alternative **1**.

Explanation: Please refer to page 150 in the prescribed book, where it states **Psychological Dimension**-second paragraph. According to Wells, a person with Generalised Anxiety Disorder worries about his/her worries which leads to increased anxiety and reinforces the person's view that worry has negative effects. Make sure that you are able to explain Generalised Anxiety Disorder according to the cognitive theories.

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

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

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

Question 22

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

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

Feedback: The correct answer is alternative **2**.

Explanation: Alternative 2 is the correct answer as Jasper's abnormal behaviour is consistent with the DSM-5 classification system criteria of Avoidant Personality Disorder. Jasper's symptoms fall under Cluster C Personality Disorders which are characterised by anxious or fearful behaviours and in Jasper's case these include his hypersensitivity to negative evaluation, pervasive pattern of social inhibition and feelings of inadequacy.

Although Obsessive Compulsive Personality Disorder in Alternative 1 is also a personalitydisorder from Cluster, C we can see from Jasper's behaviours that he does not display a pervasive pattern of preoccupation with orderliness, perfectionism, and mental and interpersonal control (Sue et al., 2016, p. 485). Alternative 1 is therefore incorrect.

Alternatives 3 and 4 are also eliminated as the behaviours that Jasper is displaying are in contrast with these personality disorders. These disorders are categorised under Cluster A of Personality Disorders in the DSM-5 classification system and are characterised by odd or eccentric behaviours. As explained in Tutorial Letter 501/3/2016, similarities between Schizoid Personality Disorder and Avoidant Personality Disorder do include social isolation. As can be seen by Jasper's yearning for close interpersonal relationships, individuals with Avoidant Personality Disorder do want to have relationships with others and feel their loneliness deeply, whereas those with Schizoid Personality Disorder may be content with and even prefer their social isolation. Jasper might be reluctant to confide in others, which is also a key characteristic of Paranoid Personality Disorder. Jasper's behaviour is however characteristic of individuals with Avoidant Personality Disorder who are reluctant to confide in others due to their fear of being embarrassed or being found inadequate. The reason for their avoidance of others is in contrast with Paranoid Personality Disorder where the individual avoids confiding in others because of the fear of others' malicious intent.

Question 23

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

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

Feedback: The correct answer is alternative **1**.

Explanation: Alternative 1 is the correct answer as the prognosis for Jasper's diagnosis of Avoidant Personality Disorder is poor as individuals are reluctant to commit to the process of psychotherapy. As Sue et al. (2016) highlight, these individuals are reluctant to disclose personal thoughts and feelings due to their fear of scrutiny and rejection (p. 484).

Alternatives 2 and 3 are eliminated because the prognosis for Avoidant Personality Disorder is not good, as explained in alternative 1 above.

Alternative 4 is incorrect as keep in mind that *all personality disorders are ego-syntonic to the individual* as to the individual with a Personality Disorder their behaviours, values and feelings which are seen by themselves to be in harmony or acceptable to their needs and goals of their ego and consistent with their ideal self-image. Generally all other disorders in the DSM-5 classification are ego-dystonic to the individual in that the individual is distressed on some level by their disorder and want the distress to disappear.

Question 24

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

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

Feedback: The correct answer is alternative **3**.

Explanation: Alternative 3 is correct as due to the longstanding and unchanging patterns of interrelationships it is easier for the clinician over a number of consultations to identify whether the dysfunctional pattern of relating behaviours is maintained and therefore constitutes a Personality Disorder. Clinicians track the presenting patterns over time in order to accurately diagnose a Personality Disorder (Refer to Tutorial Letter 501/3/2016, p. 59).

Alternative 1 is incorrect as illustrated with the short questionnaire in Activity 6.1 in Tutorial Letter 501/3/2016 to highlight how all individuals at some point in their lives exhibit traits that characterise Personality Disorders to varying degrees (p. 60). The feedback from this activity is to remember to always consider the combination and pervasiveness of these behaviours and whether it cause significant clinical distress.

Alternative 2 is also incorrect because of the overlap of Personality Disorders with each other (as mentioned by Sue et al., 2016, p. 494). An example of this is where attention-seeking behaviour is characteristic of both Borderline Personality Disorder and Histrionic Personality Disorder. Borderline Personality Disorder is, however, distinguished by self-destructiveness, angry disruptions in close relationships, and chronic feelings of deep emptiness and identity disturbance.

Alternative 4 is also eliminated as Sue et al. (2016) further caution that Personality Disorders are not easily diagnosed due to the high co-morbidity rates with other disorders listed in the DSM-5 classification system. For example, Major Depressive Disorder or Bipolar Disorder may be diagnosed due to the immediate presenting distress of the individual with mood disturbance, without also checking whether a pervasive pattern of emotional reactivity is present in the individual and self-image problems which are characteristic of Borderline Personality Disorder.

Question 25

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

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

Feedback: The correct answer is alternative **2**.

Explanation: Both of these disorders come from Cluster A which is characterised by odd or eccentric behaviour.

Alternative 2 is the correct option as it is the only alternative that gives the correct clue about an individual's thoughts. Schizoid Personality Disorder can be distinguished from Schizotypal Personality Disorder by the lack of cognitive and perceptual distortions. This alternative is in line with criteria as stipulated in the DSM-5 classification system and provided in Tutorial Letter 501/3/2016. Individuals who are diagnosed with Schizotypal Disorder are more likely to display peculiar thoughts and behaviours.

Alternative 1 is incorrect as individuals who are diagnosed with Schizoid Personality Disorder based on the DSM-5 classification system are socially isolated, emotionally cold and indifferent to others. Refer to Table 15.1 in Sue et al. (2016) for a detailed discussion of these symptoms (p. 472).

Obsession with perfectionism and detail are in contrast with the behaviour displayed by individuals who are diagnosed with Schizotypal Personality Disorder as highlighted in Table 15.1 (Sue et al., 2016). Individuals who are obsessed with perfectionism and detail is characteristic of Obsessive Compulsive Personality Disorder and therefore makes alternative 3 incorrect.

Alternative 4 incorrect as the question is asking for the differences between Schizoid Personality Disorder can be and Schizotypal Personality Disorder, not Paranoid Personality Disorder. Sue et al. (2016) highlight that Paranoid Personality Disorder is characterised by paranoid thoughts and behaviours, including believing others have malicious intentions toward them (p. 474).

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

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

Question 26

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

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

Feedback: The correct answer is alternative **3**.

Explanation: Alternative 3 is correct as Darius displays self-dramatisation as he likes to draw attention to himself as the centre of attention and he uses impressionistic speech and his physical appearance to garner the attention of others and to impress other people. He displays exaggerated emotional reactions and behaves in a seductive and provocative way with the girls. Darius also engages in a shallow expression of emotions that he meets which are key criteria in Histrionic Personality Disorder. Darius also shows a lag in enthusiasm for his job as evident by his absenteeism and people with Histrionic Personality Disorder are often intolerant of situations that lack immediate gratification or are too routine-orientated.

Alternative 1 is incorrect because individuals who are diagnosed with Narcissistic Personality Disorder (NPD) display an exaggerated sense of self-importance and a lack of empathy and are not consistent with the behaviours that Darius is displaying. Individuals with Narcissistic Personality Disorder seek attention from others to be seen as superior whereas people with Histrionic Personality Disorder (HPD) do not mind other people seeing them as fragile in order to secure attention from others. Individuals with NPD can also exaggerate their closeness to others but the focus is on the "VIP" status or wealth of their friends and not necessarily merely to convey the idea of being intimate or close to others. Excessive pride in their achievements, a relative lack of emotional display and a relative disdain for others' feelings in the case of NPD distinguishes the disorder from HPD. It is clear that Darius uses emotionality to secure the attention of others.

Although Darius displays impulsive, superficial, excitement-seeking, reckless, seductive and manipulative behaviour which is similar to the behavioural symptoms of Antisocial Personality Disorder, Darius displays more exaggerated emotions and does not engage in antisocial behaviours (breaking the law). Alternative 2 is therefore also incorrect. Individuals with Histrionic Personality Disorder can be manipulative to gain nurturance whereas individuals with Antisocial Personality Disorder can be manipulative to gain profit or power.

Alternative 4 is incorrect because Darius does not display symptoms of odd or eccentric behaviours (Cluster A characteristics) or symptoms of peculiar thoughts and behaviours, which are specific to Schizotypal Personality Disorder.

Question 27

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

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

Feedback: The correct answer is alternative **2**.

Explanation: Alternative 2 is correct as Secondary Prevention refers to an attempt to shorten the duration and impact of mental disorders by detecting their presence in the early stages (Refer to p. 15 of Tutorial Letter 501/3/2016).

Alternative 1 is incorrect as Primary Prevention interventions are efforts to lower the incidence of *new* cases of mental disorders by strengthening or introducing information, resources or skills that promote mental health and by curbing community characteristics that threaten mental health. In Darius' case, he already presents with a long-term mental disorder (Refer to p. 14 of the Tutorial Letter 501/3/2016).

Alternative 3 is incorrect as Crisis Prevention is not a recognised term in this particular Prevention model.

Alternative 4 is incorrect as Tertiary Prevention is aimed at facilitating the readjustment of an individual to the community after treatment for a mental disorder that they already have (Refer to p. 15 of the Tutorial Letter 501/3/2016).

Question 28

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

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

Feedback: The correct answer is alternative **3**.

Explanation: Alternative 3 is the correct answer as Tutorial 501 highlights the DSM-5 classification criteria for General Personality Disorder as the behaviour that deviates from cultural expectations and manifests in two or more of the areas of cognition, affectivity, interpersonal functioning, and impulse control (p. 64). Refer also to page 63 for a more detailed discussion.

Alternative 1 is ruled out because it gives the option of two areas where the deviated behaviour could manifest.

Alternatives 2 and 3 are also eliminated as these alternatives incorrectly refer to three areas where the deviated behaviour could manifest in.

Question 29

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

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

Feedback: The correct answer is alternative **2**.

Explanation: Alternative 2 is correct as the aim of Primary Prevention intervention is to lower the incidence of *new* cases of mental disorders by strengthening or introducing information, resources or skills that promote mental health and by curbing community characteristics that threaten mental health (Refer to p. 14 of the Tutorial Letter 501/3/2016).

Alternative 1 is incorrect as social support is not a term recognised in this particular Prevention model.

Alternative 3 is incorrect as the aim of Tertiary Prevention is to facilitate the readjustment of an individual to the community after treatment for a mental disorder that they already have (Refer to p. 15 of the Tutorial Letter 501/3/2016).

Alternative 4 is incorrect as training paraprofessionals is not a recognised term in this particular Prevention model.

Question 30

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

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

Feedback: The correct answer is alternative **1**.

Explanation: Alternative 1 is correct as the aim of Primary Prevention is to lower the incidence of possible *new* cases of mental disorders by strengthening or introducing information, resources or skills that promote mental health and by curbing community characteristics that threaten mental health (Refer to p. 14 of the Tutorial Letter 501/3/2016).

Alternative 2 is incorrect as the aim of Secondary Prevention is to shorten the duration and to reduce their impact of mental disorders by detecting their presence in the early stages (Refer to p. 15 of the Tutorial Letter 501/3/2016).

Alternative 3 is incorrect as Secondary Corrective is not a recognised term in this particular Prevention model.

Alternative 4 is incorrect as Tertiary Prevention is aimed at facilitating the readjustment of an individual to the community after treatment for a mental disorder (Refer to p. 15 of the Tutorial Letter 501/3/2016).

All the best with your studies!

Your Abnormal Behaviour and Mental Health Lecturers