# Tutorial Letter 202/1/2018

## Abnormal Behaviour and Mental Health

# PYC3702

## Semester 1

## Department of Psychology

- Feedback – Assignment 02
- The Examination
- Assignment 03 – Module Evaluation Survey

BARCODE

**PYC3702**

**ABNORMAL BEHAVIOUR AND MENTAL HEALTH**

**TUTORIAL LETTER 202/2018**

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Dear Student

This is the last tutorial letter you will receive from your PYC3702 lecturers. We trust that you have found this module interesting and that by now you not only have a thorough knowledge and understanding of abnormal behaviour, but will also play a proactive role in your community and will cooperate to prevent abnormal behaviour.

The examination is almost upon us and we trust that this tutorial letter will help you with your final preparations for the examination. We wish you all the best for the examination and hope that your hard work will be rewarded with good marks. If you are still experiencing any problems, or if there is anything about the content of the course that is not clear, we appeal to you to contact one of your lecturers without delay.

## 1. Feedback on Assignment 02

As stated in Tutorial Letter 101/3/2018, Assignment 02 is a second compulsory assignment that assisted you in mastering the curriculum. This assignment contained questions related to the following chapters in the prescribed book 7, 8, 9, 11, 12 and 13 and Learning Units 8, 10, 12, 13, 14 and 15 in Tutorial Letters 502 and 503.

By now those of you who have submitted Assignment 02, will have received a printout in which the correct answers, your answers and your marks are recorded. If you have submitted Assignment 02 and have not yet received a printout, please contact the assignment section without delay at assignments@unisa.ac.za and if you still don't received your printout contact Mrs C Nel, either by telephone 012 - 4298233 or e-mail, nelc1@unisa.ac.za.

Compare your answers carefully with the following correct answers. The aim of the answers is to give you the correct information concerning each question and to explain the correct answers to you in case you have problems with 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 resolved.

| 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 Their 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

The correct answer is alternative **3**.

**Explanation**: Emma most likely suffers from *Major Depressive Disorder*, severe, with melancholic features as she shows various symptoms of a serious Depressive Disorder for a period of three months. Her functioning is also seriously impaired. She displays the following symptoms: *severely* depressed mood, loss of pleasure and interest in life, weight loss, terminal insomnia, guilt feelings, suicidal ideation, and psychomotor retardation (speech has decreased in amount), decrease in self-care and an inability to maintain personal hygiene. Emma meets the criteria for *melancholia* due to the following considerations: she finds no pleasure in life-; nothing makes her feel better-; she wakes up very early in the morning-; she feels worse in the morning-; she shows symptoms of psychomotor retardation-; she has lost a lot of weight and the quality of her depression is serious.

Alternative 1, *Bereavement,* is eliminated because Emma's symptoms are in excess of the symptoms of a normal grief response. Emma clearly meets the criteria for Major Depressive Disorder for severity (i.e. eight out of nine symptoms), duration (most of the day, every day for three months) and clinically significant distress and impairment. Refer to Tutorial letter 502/3/2018, Activity 12.7, page 83 should you be unsure about the distinction between Major Depressive Disorder and uncomplicated grief (Bereavement).

Alternative 2, *Adjustment Disorder with Depressed Mood,* is eliminated because a diagnosis of Adjustment Disorder cannot be made when the criteria for another mental disorder (Major Depressive Disorder in this case) are met.

Alternative 4, *Persistent Depressive Disorder (Dysthymia) with catatonic features,* is eliminated in Emma's case as she is manifesting the symptom criteria of a severe Depressive Disorder for a period of

three months while a diagnosis of Persistent Depressive Disorder (Dysthymia) is only made if the depressive episode has persisted for at least a two-year duration. Persistent Depressive Disorder (Dysthymia) and Major Depressive Disorder are differentiated based on chronicity and persistence.

**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

The correct answer is alternative **3**.

**Explanation**: According to Seligman and his colleagues' Cognitive-learning approach, Emma's disorder can mainly be attributed to *thinking patterns associated with learned helplessness.* Individuals who have developed an attribution style of learned helplessness often make inaccurate assumptions about their experiences and these beliefs can result in depression when they experience negative events such as the death of loved ones. Although we do not know much about Emma's attribution style, the fact that she feels guilty about the death of her daughter and grandchildren indicates that she tends to make inaccurate assumptions and attributes negative experiences to personal faults (e.g. she could have prevented the accident). The Behavioural perspective on the other hand, focuses on *the loss of social reinforcement* as the main contributing factor to the development of Emma's disorder. According to the Behavioural perspective, depression develops when an individual receives insufficient social reinforcement from his/her environment. Losses such as the death of an only child and grandchildren reduce available reinforcement and contribute to the development of depression. Although we do not know much about Emma's relationship with her daughter and grandchildren, we can assume that Emma has lost a positive source of reinforcement when her daughter and grandchildren died. When Emma became depressed, she became withdrawn and thus also lost other possible social sources of reinforcement.

Alternative 1, *arbitrary inference; the lack of proper role models during childhood years,* is eliminated for the following reasons: according to Beck, a Cognitive psychologist, *arbitrary inference* (drawing conclusions about oneself and the world without sufficient and relevant information) is one of the types of faulty thinking which contributes to the development of depression. The Behavioural perspective does not attribute *depression to the lack of proper role models during childhood years.*

Alternative 2, *her current negative life situation; exposure to stress during her early development*, is incorrect as the Cognitive-learning perspective focuses on attribution style and learned helplessness in the explanation of depression, not on *negative life situations.* The Behavioural perspective's explanation of depression focuses on insufficient social reinforcement, not on *childhood stressors.*

Alternative 4, *an absence of positive reinforces in the event of severe stress; magnification and exaggeration*, is eliminated for the following reasons: the Cognitive-learning perspective focuses on individuals' attribution style and learned helplessness in the explanation of depression, not on *insufficient social reinforcement*. The Behavioural perspective focuses on social reinforcement in the explanation of depression not on *magnification and exaggeration* (overestimating the significance of negative events), a type of faulty thinking, which according to Beck who adheres to the Cognitive perspective, contributes to the development of depression.

Should you be uncertain about the Cognitive-learning and Behavioural perspectives' explanation of depression, please refer to pages 241 to 244 of your prescribed book and Activities 12.15 and 12.6, pages 87 to 89 in Tutorial letter 502/2/2018 for more information.

**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.

The correct answer is alternative **4**.

**Explanation**: *All six* of the descriptions (a, b, c, d, e and f) in this question contain the correct information about the relationship between depression and stress. Please refer to page 245 of your prescribed book, *Social Dimension,* and make sure that you know what role stress plays in the development of depression.

**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.

The correct answer is alternative **4**.

**Explanation**: In assessing the seriousness of Emma's threat of suicide, it is clear that there is a strong probability that she might try to end her life. The following high risk factors are present: Suicide ideation and plan (taking and hiding her husband's revolver), giving away prized possessions, a recent severe loss (death of only child and grandchildren), severe depression and hopelessness and easy access to lethal method (gun). She is in serious danger of hurting herself. Immediate appropriate actions should be implemented to prevent suicide. *She should be hospitalised immediately, voluntary or involuntary, intensive medical and psychological treatment as well as comprehensive supervision should be provided*.

Alternatives 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*, and 3, *Provide preventative counselling and weekly monitoring*, are eliminated for the following reasons: the preventative measures mentioned in alternatives 1 (*recommended bed rest and*

*potential counselling)* and 2 (*provide Emma with the telephone number of a telephone crisis intervention centre and give her husband specific guidelines about how to support her)*, apply to low risk suicide cases and the preventative measures contained in alternative 3 (*provide preventative counselling and weekly monitoring)* apply to moderate risk suicide cases. Emma is clearly a high-risk suicide case.

**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 - - - - - according to the DSM-5 classification system.

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

The correct answer is Alternative **3**.

**Explanation**: **Patricia** has an enduring pattern (for 25 years) of inner experiences and behaviour that deviate from the expectations of her culture. She shows the characteristic symptoms of *Borderline Personality Disorder* (fluctuation and instability in self-image, relationships and mood). **Michelle** on the other hand, suffers from a chronic (at least two years), mood disturbance, *Cyclothymic Disorder*. The essential features of Cyclothymic Disorder are the presence of numerous episodes of hypomanic symptoms that do not meet the criteria for a hypomanic episode and numerous periods with depressive symptoms that do not meet criteria for a major depressive episode for at least two years.

Alternative 1, *Dysthymic Disorder; Bipolar II Disorder*, is ruled out as **Patricia's** mood fluctuations are not characteristic of a *Persistent Depressive Disorder (Dysthymia)*. The mood in Persistent Depressive Disorder (Dysthymia) is persistently depressed for at least two years. **Michelle** does not manifest the essential features of Bipolar II disorder as she does not meet the criteria for either a major depressive episode or a hypomanic episode. Refer to page 256 of the prescribed book, *Table 8.7 Bipolar Disorders* for more information on the DSM-5 criteria for Bipolar II Disorder.

Alternative 2, *Histrionic Personality Disorder; Major Depressive Disorder*, is also eliminated. **Patricia** does not manifest a pattern of excessive emotionality and attention seeking behaviour that is characteristic of *Histrionic Personality Disorder*. *Major Depressive Disorder* is ruled out in **Michelle's** case as she is clearly not only depressed – she also experiences mood swings which eliminates Major Depressive Disorder.

Alternative 4, *Dissociative Identity Disorder; Bipolar I Disorder chronic*, is ruled out as **Patricia** meets the criteria for a long-term, stable personality disorder which is in contrast to the inconsistencies among *identities* which is characteristic of *Dissociative Identity Disorder*. **Michelle** experiences only mild mood swings whereas *Bipolar I Disorder* is characterised by at least one or more manic episodes and one or more major depressive episodes.

**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

The correct answer is alternative **1**.

**Explanation**: This is a straightforward question that can be easily answered from a reading of the prescribed textbook on pages 273-279. Musicians are not listed as a profession with a higher than average rate for suicide. Certain occupations practiced by physicians, lawyers, law enforcement and dentists have a higher average suicide rate (Sue et al., 2016, p. 270). According to Sue et al. (2016), "It is unknown whether the speciality influences susceptibility or whether people who are prone to suicide are more likely to be attracted to certain specialities" (p. 270).

**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.

The correct answer is alternative **4**.

**Explanation**: This is a straightforward question that can be easily answered from a reading of the prescribed textbook from pages 273-279. Alternative one is the incorrect alternative since the elderly have a higher suicide rate when compared to the general population (p. 277). Alternative two is the incorrect alternative since victims of bullying are 2 to 9 times more likely to commit suicide when compared to those that are not (Sue et al., 2016, p.274). Alternative three is the incorrect alternative since women have a higher rate of suicide thoughts and attempted suicide but men have a higher rate of completed suicide (Sue et al., 2016, p. 285). Alternative four is the correct alternative since certain occupations practiced by physicians, lawyers, law enforcement and dentists have a higher average suicide (Sue et al., 2016, p. 270). According to Sue et al. (2016), "It is unknown whether the speciality influences susceptibility or whether people who are prone to suicide are more likely to be attracted to certain specialities" (p. 270).

**Question 8**

Which of the following statements is **most** accurate in describing all **four** dimensions according to the Multipath Model 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

The correct answer is alternative **2**.

**Explanation**: The Multipath Model consists of four dimensions i.e. the *biological, psychological, sociocultural* and *social* dimension. These dimensions, when combined, present the cumulative risk factors that interact with a situation, an event, or a series of events that become the final catalyst for suicide according to Sue et al. (2016, p. 281). Alternative two is the correct answer because it contains risk factors from all four dimensions of the Multipath Model. Alternative one is incorrect because it does not consider the *sociocultural* dimension of the Multipath Model as stated in figure 9.2 on page 281 of Sue et al. (2016). Alternative three is incorrect because it does not consider the *sociocultural* and *social* dimension of the Multipath Model as stated in figure 9.2 on page 281 of Sue et al. (2016). Alternative three is incorrect because it does not consider the *psychological* and *social* dimension of the Multipath Model as stated in figure 9.2 on page 281 of Sue et al. (2016).

**Read the following case study and answer 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

The correct answer is alternative **3**.

**Explanation**: In order to answer this question, you would need to demonstrate an understanding of the diagnostic criteria for Major Depressive Disorder. For a diagnosis of Major Depressive Disorder, a person would have to exhibit five (or more) of the listed symptoms (on page of Tutorial and Sue et al., 2016. pp. 230-234) have been present during the same 2-week period and represent a change from previous level of functioning: at least one of the symptoms **must be either** (1) depressed mood or (2) loss of interest or pleasure.

From the case study, Ayanda has clearly demonstrated a loss of interest and pleasure and depressed mood together with other symptoms to indicate that he had Major Depressive Disorder.

Other symptoms are identified in the table below and should assist you in the thought process behind answering a question like this in the exam:

| Symptoms from Case Study | Symptoms of Major Depression |
|---|---|
| "refused to socialise with his team members during their Friday night drinks ritual as he enthusiastically used to" | Behavioural symptom- social withdrawal |
| "Ayanda rapidly lost a substantial amount of weight within a month or two" | Physiological symptom- appetite and weight changes |
| "he described his marked sense of despair and hopelessness to his psychologist" | Emotional Symptom- depressed mood which involves feeling of sadness, emptiness, hopelessness, worthlessness or low self-esteem. |
| "He has been unable to concentrate and this affected his inability to construct meaningful case arguments" | Cognitive Symptoms- depression can cause distractibility and interfere with our ability to concentrate, remember things or make decisions. |
| "His colleagues and management team noticed a steady decline in his work with Ayanda frequently missing deadlines" | Evidence in change from previous levels of functioning |
| "He often felt like he had no energy but still could not fall asleep at night" | Physiological Symptoms- sleep disturbance |

**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

The correct answer is alternative **4**.

**Explanation**: Ayanda's diagnosis changed to Schizoaffective Disorder because he demonstrated psychotic symptoms that met the diagnostic criteria for Schizophrenia in addition to his major depressive symptoms. His psychotic symptoms also persisted for a period longer than two weeks after his depressive symptoms subsided. It is important to note that Major Depressive Disorder can co-exist with psychotic features present. However, in Schizoaffective Disorder, there is a period of at least two weeks in which the psychotic features do not exist together with a major depressive or manic episode.

| Symptoms from Case Study | Symptoms of Schizoaffective Disorder |
|---|---|
| "He was convinced that she was having an affair despite the fact that his beliefs were proven untrue repeatedly" | Delusions |
| "he heard numerous voices speaking to him regularly giving him direction as to how to pursue his next plot to catch her out." | Hallucinations |
| "He was incoherent for the most part" | Disorganised speech |

**Question 11**

For the diagnosis above (Q) 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

The correct answer is alternative **2**.

**Explanation**: Alternative 2 is correct because for a diagnosis of Schizoaffective Disorder to be made a person would need to demonstrate psychotic symptoms that met the diagnostic criteria for Schizophrenia combined with the symptoms of a major depressive or manic episode that continue for the majority of the time that the schizophrenic symptoms are present (Sue et al., 2016, pp. 396-397). It is important to note that Major Depressive Disorder can co-exist with psychotic features present. However, in Schizoaffective Disorder, there is a period of at least two weeks in which the psychotic features do not exist together with a major depressive or manic episode as evidenced in Ayanda's case. The other alternatives can therefore be eliminated because there is no disorder in the DSM classification system that combines the disorders listed as options in alternatives one, three and four. Whilst, these disorders can potentially co-exist with each other, there is no official category in the DSM-5 classification system for these combinations.

**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

The correct answer is alternative **1**.

**Explanation**: Alternative 1 is the correct answer since people with Delusional Disorder generally behave normally when they are not discussing or reacting to their delusional ideas. Ayanda was already experiencing impairment in his overall functioning before experiencing delusions (Sue et al., 2016, pp. 392-395). His impairment in overall functioning goes beyond his delusions, therefore, ruling out a diagnosis of Delusional Disorder. Alternative two, three and four could not be considered as the correct answer since Schizophrenia, and Major Depressive Disorder are characterised by marked impairment in normal functioning.

**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.

The correct answer is alternative **2**.

**Explanation**: Alternative two is correct since, according to the sociocultural dimension of the Multipath Model of Schizophrenia (figure 12.4, Sue et al., 2016, p. 376), low socioeconomic status and poverty may be a contributing factor to the aetiology of Schizophrenia. Alternative one and three can therefore be easily eliminated. Alternative four is incorrect because there is no evidence to suggest a differential severity risk for Schizophrenia based on socioeconomic status according to Sue et al. (2016).

**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 being 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.

The correct answer is alternative **3**.

**Explanation**: The main symptoms associated with a diagnosis of Delirium is difficulties associated with attention and focus with possible associated memory problems. As Mary manifests forgetfulness and a decreased ability to attend to multiple tasks at the same time, as well as experiencing problems regarding her ability to complete her crossword puzzles, which implies sustained attention difficulties, the psychiatrist was correct to consider Delirium as a possible diagnosis.

Alternative 1, *Possible Major Vascular Neurocognitive Disorder – Mary reports using paracetamol*, is incorrect as the case study clearly states that the clinical tests found that Mary did not suffer from a

vascular condition and therefore considering a Major Vascular Neurocognitive Disorder would be irrelevant.

Alternative 2, *Substance/Medication-Induced Neurocognitive Disorder – Mary reports disturbance in attention and awareness*, is incorrect as the case study also states that besides the occasional use of paracetamol for joint pain, Mary does not report any substance or medication use. As Mary consulted the clinic of her own free will and since the case study describes an extensive and thorough clinical assessment, we can assume that Mary would not lie about her substance use behaviour, and if she did, that the assessment would have picked up the presence of substance use or abuse. Furthermore, the occasional use of paracetamol could not account for the type and intensity of symptoms with which Mary presents.

Alternative 4, *Major Depressive Disorder – Her worrying regarding the increased need for assistance*, is incorrect although Mary has cognitive symptoms namely forgetfulness, her problems relating to completing her puzzles in the usual time frame, her decreased ability to attend to multiple tasks at the same time and her needing assistance to do her budget and paying her bills, as well as her emotional symptoms of feeling agitated, could all be described as the cognitive and emotional symptoms associated with a Major Depressive Disorder, the reasoning of the psychiatrist for considering this disorder is incorrect. The mere fact that Mary is bothered by her need for assistance alone is not sufficient to consider Major Depressive Disorder, since Mary does not show any other symptoms of a Major Depressive Disorder such as a depressed mood or inability to enjoy previous pleasurable activities (in fact she still enjoys playing bingo with her friends at the community centre). Mary also still does her own shopping and cleaning, which might also not necessarily be the case for a person who is suffering from a Major Depressive Disorder, as these individuals experience, amongst others, psychomotor retardation or agitation, fatigue or loss of energy and feelings of worthlessness, which is not the case for Mary.

**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

The correct answer is alternative **1**.

**Explanation**: Mary's symptoms have an insidious onset and gradual progression. Also her symptoms relate to mild impairment in multiple cognitive domains (for extensive information pertaining to the different cognitive domains refer to table 15.1 in tutorial letter 503 on pages 24 to 25). Mary is concerned about her symptoms and has therefore consulted with the clinic.

| Mary's symptoms | Relevant cognitive domain | Psychological domain |
|---|---|---|
| Feeling agitated | | Mood symptoms |
| Forgetfulness | Learning and memory | |
| Decreased ability to complete her crossword puzzles in the same timeframe as she used to | Complex attention | |
| Decreased ability to attend to multiple tasks at the same time | Executive function | |
| Need for assistance in doing her monthly budget and paying her bills | Executive attention | |

However, Mary is still able to do her own shopping and cleaning and her symptoms therefore do not interfere with her capacity for independence in everyday activities. She does need assistance in doing her budget and paying her bills but this is at the level of a compensatory action, she needs assistance yet is then still able to complete the activity and is therefore not at the level of not being able to do it at

all.

As Mary's clinical assessment shows no evidence of an underlying medical condition or a substance use aetiology for her symptoms the diagnosis of a Mild Neurocognitive Disorder due to Alzheimer's Disease is made.

This diagnosis is further defined by stating a *Possible* Mild Neurocognitive Disorder due to Alzheimer's Disease, as it is clear from Mary's familial history that there is no evidence of a genetic mutation that could account for Alzheimer's Disease. Yet at the same time Mary does show clear evidence of a decline in memory and learning, her symptoms show a steady progressive and gradual decline in cognition without extended plateaus, and no evidence for a mixed aetiology (another neurodegenerative or cerebrovascular, neurological, or systematic disease or condition as causation) is present.

Alternative 2, *Illness Anxiety Disorder*, is incorrect, as Mary's reported symptoms have been supported by a clinical assessment. Also, Mary is concerned regarding symptoms such as her forgetfulness and increased difficulty in completing cognitive tasks and do not represent a preoccupation in having or acquiring a serious illness. Mary also does not exhibit with high anxiety about her health status and does not show maladaptive avoidance behaviour or the performance of excessive health-related behaviours, as would be expected in an Illness Anxiety Disorder.

Alternative 3 and 4, *Substance/Medication Induced Mild Neurocognitive Disorder* and *Medication-Induced Delirium*, respectively, are incorrect as the case study states that besides the occasional use of paracetamol for joint pain, Mary does not report any substance or medication use. As Mary consulted the clinic of her own free will and since the case study describes an extensive and thorough clinical assessment, we can assume that Mary would not lie about her substance use behaviour, and if she did, that the assessment would have picked up the presence of substance use or abuse. Furthermore, the occasional use of paracetamol could not account for the type and intensity of symptoms with which Mary presents. Furthermore, Mary shows symptoms that are characteristic of Mild Neurocognitive Disorder, i.e. additional cognitive symptoms that are in excess of symptoms of delirium alone, and therefore Alternative 4 which entails a diagnosis of a Delirium is incorrect.

**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), and (g)
2. (a), (e), (f), and (h)
3. (b), (c), (e) and (f)
4. (c), (d), (g), and (h)

The correct answer is alternative **3**.

**Explanation**: The insidious onset and gradual progression of impairment of Mary's symptoms is characteristic of a Neurocognitive Disorder that is due to an underlying aetiology that entails a condition/disease that produces cognitive symptoms in a gradual and insidious manner. When cognitive symptoms' onset is fast and fluctuates through the day one should first consider a Delirium as a possible NCD – given the nature of the symptoms i.e. disturbance in attention and awareness. Often these types

of symptoms with such an onset and duration is due to Substances. If these symptoms entail additional cognitive symptoms, one would then rather consider a Mild or Major NCD depending on the severity and number of cognitive domains impacted. Diseases/conditions that account for fast onset of NCD symptoms are usually e.g. vascular incidents (Stroke). Mary furthermore has no family history of Alzheimer's disease and therefore the diagnosis should entail a specified "Possible" as there is no way to test for a definite presence of Alzheimer's Disease and given the lack of evidence in her family history it remains only a possibility and not a probable aetiological consideration. The diagnostic criterion of exclusion is met for Mary's case as the cognitive symptoms are not better explained by another mental disorder and therefore the diagnosis of a NCD is made possible. Mary shows concern about her symptoms that indicates that she is aware of her decline in functioning and experiences insight and distress regarding this. Therefore, one could start to consider eliminating other disorders that might have some of Mary's symptoms as features such as Major Depressive Disorder, Psychotic Disorders, and Factitious Disorder etc.

Alternatives with option (a) *Mary shows a mixed aetiology*, is incorrect as Mary does not manifest a mixed aetiology. According to the DSM-5, a mixed aetiology for a NCD is the presence of another neurodegenerative or cerebrovascular, neurological, or systematic disease or condition as causation, which is not the case for Mary.

Alternatives with option (d) *Mary has a history of frequent medication use*, is incorrect as besides Mary's occasional use of paracetamol for joint pain, Mary does not report any substance or medication use. As Mary consulted the clinic of her own free will and since the case study describes an extensive and thorough clinical assessment, we can assume that Mary would not lie about her substance use behaviour, and if she did, that the assessment would have picked up the presence of medication or substance use or abuse.

Alternatives with option (g) *Mary's symptoms represent a substantial impairment in cognitive functioning which causes a significant cognitive decline from her previous level of functioning*, is incorrect as the symptoms Mary is manifesting represents a modest decline in cognitive functioning and she is still able to function independently in her activities of daily living. Option (g) refers to substantial impairment in cognitive functioning which causes a significant cognitive decline from her previous level of functioning that is not yet relevant to Mary's case.

Alternatives with option (h) *Mary no longer enjoys activities she used to enjoy before the symptoms started*, is incorrect as it is stated in the case study that Mary is still able to do her own cleaning and monthly shopping and still enjoys playing bingo at the local community centre.

**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

The correct answer is alternative **3**.

**Explanation**: For a thorough discussion of the six cognitive domains in reference to Neurocognitive Disorders, refer to table 15.1 in tutorial letter 503 on pages 24 to 25. Also for specific reference to Mary's symptoms according to these cognitive domains refer to the discussion of the correct answer to question 15 above.

**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

The correct answer is alternative **3**.

**Explanation**: For a thorough discussion of the six cognitive domains in reference to NCD refer to table 15.1 in tutorial letter 503 on pages 24 to 25. Also for specific reference to Mary's symptoms according to these cognitive domains refer to the discussion of the correct answer to question 15 above.

**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

The correct answer is alternative **2**.

**Explanation**: The main feature of Delirium is a disturbance in attention or awareness which develops over a short period of time (usually hours to a few days); represents a change from baseline attention and awareness and tends to fluctuate in severity during the course of a day (APA, 2013).

Alternative 1, *learning and memory, perceptual-motor functioning*, is incorrect as *learning and memory* as described as the cognitive domain in table 15.1 in tutorial letter 503 on pages 24 to 25, is not a key feature in Delirium. The individual with Delirium would most likely show deficits in learning and memory which is related to deficits in awareness and attention. However, *perceptual-motor functioning* as described in the same table, include symptoms of motor function that are not included in the diagnostic features of Delirium.

Alternative 3, *perceptual-motor functioning, baseline cognition*, is incorrect as the main features of Delirium is disturbance in attention or awareness and not *perceptual-motor functioning*.

Alternative 4, *the psychological domain, perceptual-motor functioning*, is incorrect as 'psychological domain' is not one of the six cognitive domains that could be affected in relation to NCDs. The six domains are complex attention, executive function, learning and memory, language, perceptual-motor and social cognition. These cognitive domains are umbrella terms defining sets of specific symptoms, therefore you need to and understand the specific symptoms under each domain.

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

Mr Thobela, 41 years old, was admitted to the orthopaedic 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

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

**Explanation**: Alternative 2, *Alcohol Use Disorder* is correct for the following reasons:

- Mr Thobela's pattern of alcohol consumption clearly meets the duration requirement of a 12-month period (he has been abusing alcohol for the past four years).
- He shows more than two symptoms of Alcohol Use Disorder.
- Mr Thobela's maladaptive pattern of alcohol use leads to failure to fulfil his obligations at home (strained relationship with wife and children).
- He shows definite signs of withdrawal (shakiness, anxiety, insomnia, sweaty palms and nausea).
- The Alcohol Withdrawal is a co-morbid disorder.
- He was subsequently retrenched from his job due to his alcohol abuse (impairment in functioning).

Alternative 1 is incorrect because DSM-5 does not list Alcohol Abuse as a diagnosis. Alternative 3 Alcohol Withdrawal is incorrect because although Mr Thobela is currently manifesting withdrawal symptoms it is regarded as a co-morbid diagnosis not his principal diagnosis. Alternative 4 is also incorrect because he is not presenting with symptoms of Alcohol intoxication such as slurred speech, unsteady gait, nystagmus,

**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

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

**Explanation**: Alternative 1, *Withdrawal; Use Disorder* is the correct answer because Mr Thobela's symptoms of shakiness, insomnia, nausea and sweaty palms, illustrate the symptoms of Withdrawal which is Characteristic of Alcohol Use Disorder.

Alternative 2, *Intoxication; Withdrawal* is incorrect since Alcohol Intoxication "is the presence of clinically significant problematic behavioural or psychological changes that develop during, or shortly after, alcohol ingestion" (APA, 2013, p. 497). It is indicative of an episode of intoxication shortly after alcohol is ingested. The case study above does not simply describe a single episode but rather provides a synopsis of prolonged alcohol use.

Alternatives 3, *tolerance; Use Disorder,* and 4, *tolerance; Intoxication,* are eliminated, because alcohol tolerance is when there is a need for markedly increased amounts of alcohol to achieve intoxication or desired effect.

Learn these criteria very well. Refer to the above answer which clearly explains the different criteria for Tolerance, Withdrawal and Intoxication of Alcohol, and also to refer to Tutorial Letter 502, pages 45-46.

**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

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

**Explanation**: Alternative 4, *other Problems Related to Primary Support Group; Economic Problems* is the correct answer since Mr Thobela was retrenched from work and is currently unemployed, it is possible that his family could be experiencing economic problems and his relationship with his wife became very difficult after he began drinking.

Relationship Distress with Spouse (a sub category used when the quality of that relationship is affecting the course, prognosis, or treatment of a mental or other medical disorder, the conflict between Mr and Mrs Thobela may have an impact on his mental problem and prognosis) which is actually a subcategory of Other Problems Related to Primary Support Group and Economic Problems.

Alternative 2, *Spouse or Partner Neglect; Economic Problems* is incorrect because the category Spouse or Partner Neglect is any egregious act or omission in the past year by one partner that deprives a dependent partner of basic needs. In Mr Thobela's case there is no evidence in the case study which indicates that he is extremely dependent on his wife for his basic needs.

Alternative 3, *Adjustment Disorder with mixed emotions* is incorrect since Adjustment Disorder with mixed emotions is a mental disorder which does not fall under the category of Other Conditions That May Be a Focus of Clinical Attention according to the DSM-5 classification system.

Alternative 1, *Disruption of Family by Separation or Divorce; Economic Problems* is incorrect because the category Disruption of Family by Separation or Divorce should only be used when partners in an intimate adult couple relationship are living apart due to relationship problems or are in the process of divorce. In Mr and Mrs Thobela's case the couple is not in the process of divorce yet but it is only Mrs Thobela who is contemplating divorce.

**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.

**Feedback**: Alternative **4** is the correct answer.

**Explanation**: Alternative 4 *The potential for dependency is low in all age groups* is correct, because potential for dependency in Marijuana use and abuse may be low for physical dependence however psychological dependence is higher. Several studies demonstrate that abuse rates for cannabis are lower than rates for other common drugs.

Alternative 1 *mild hallucinations may occur is* incorrect because it reflects effects of cannabis use for more detailed information refer to page 54 of tutorial letter 502/3/2018.

Alternative 3, *cannabis is used successfully to ward off the nausea associated with chemotherapy* is incorrect because it is based on the common belief that cannabis is useful in warding off nausea amongst cancer patients.

Alternatives 2, *Prolonged use increases the risk for heart attack and chronic bronchitis,* is incorrect because it reflects effects of cannabis use for more detailed information refer to page 54 of tutorial letter 502/3/2018.

**Question 24**

Which one of the following are associated with 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 and d

**Feedback**: This question was deleted.

**Explanation**: This question was deleted because of the error in the question statement. The question statement should have been: Which one of the following are associated with long- term use of Mandrax? Toxic psychosis and epilepsy are included in long- term effects of Mandrax use.

Alternative 1, *Kidney damage and delirium Tremens* is incorrect because it includes the long-term effect of alcohol abuse (Delirium Tremens). Alternative 2 and 4 include long term effects of "Nyaope" and "Ecstasy" which is Kidney Damage.

**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 model that specialises in the modelling of swimwear. 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

The correct answer is alternative **4**.

**Explanation**: Alternative 4, Conversion Disorder is the correct alternative since Charlize's symptom presentation matches the criteria for Conversion Disorder according to the DSM-5 classification system. Charlize presents with symptoms of altered voluntary motor function (difficulties swallowing) and sensory function (sensation of a lump in her throat). Her symptom presentation is not better explained by a neurological or medical condition or another mental disorder. The sensation of a lump in her throat has caused her significant impairment in terms of losing an excessive amount of weight placing her at risk of losing her modelling contract. Charlize can therefore be diagnosed with Conversion Disorder with the symptom type of *with swallowing symptoms* which is a viable diagnosis according to the DSM-5 classification system (refer to learning unit 8 of Tutorial Letter 502).

Alternative 1, *Adjustment Disorder*, is incorrect, since Charlize's symptoms in response to the stressor of her boyfriend leaving her, has manifested as somatic symptoms that are better explained by the diagnosis of Conversion Disorder. The diagnosis of an Adjustment Disorder is not made when the symptoms meet criteria of another mental disorder (refer to p. 36 of Tutorial Letter 502) .

Alternative 2, *Factitious Disorder*, is incorrect since Charlize has not falsified her symptom presentation. The essential feature of Factious Disorders is the intentional falsification of medical or psychological signs and symptoms in oneself that are associated with the identified deception, in the absence of obvious external rewards. Charlize's symptom presentation causes her severe distress and she is at risk of losing her modelling contract. There is no evidence to suggest that Charlize is falsifying her symptoms for external rewards when she is in fact at risk of losing her job as a result of her symptom presentation (refer to learning unit 9 in Tutorial Letter 502).

Alternative 3, *Illness Anxiety Disorder*, is incorrect, as Charlize does not present with preoccupation with having or acquiring a serious illness. In addition, she experiences somatic symptoms that are severe in

intensity, whereas Illness Anxiety Disorder is not characterised by the presence of severe somatic symptoms that cause impairment in functioning.

**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.

The correct answer is alternative **1**.

**Explanation**: In psychodynamic theory, somatic symptoms are seen as a defense against the awareness of unconscious emotional issues. Two mechanisms produce and then sustain somatic symptoms i.e. primary gain and secondary gain. Primary gain keeps the focus on the body, drawing the person's awareness away from underlying conflict thereby protecting the person from the anxiety associated with the unacceptable desire or conflict. Secondary gain accrues when the person's dependency needs are fulfilled through attention and sympathy (refer to p. 207 Sue et al. (2016)). In Charlize's case, both primary and secondary gain play a role in the development of her disorder.

**Question 27**

The **Multipath Model** 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.

The correct answer is alternative **1**.

**Explanation**: Alternative 1 is correct as these factors are clearly outlined on page 206 in Sue et al. (2016), figure 7.2 as factors that fall under the sociocultural dimension of the Multipath Model of Somatic Symptom and Related Disorders.

**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. Post-traumatic Stress Disorder
4. Mild Neurocognitive Disorder due to Traumatic brain injury

**Explanation**: Alternative **1** is correct as David is suffering from the sudden inability to recall autobiographical information that is not due to ordinary forgetting or other physical conditions.

Alternative 2, *Acute Stress Disorder*, is incorrect as David only presents with memory loss, and despite having experienced a life-threatening incident, does not meet criteria for an Acute Stress Disorder that requires that a person experiences nine or more symptoms from the following symptom categories: intrusion symptoms, negative mood, avoidance symptoms, dissociative symptoms and/or arousal symptoms.

Alternative 3, *Post-traumatic Stress Disorder*, is incorrect as David also does not meet criteria for a Post Traumatic Stress Disorder, that requires that a person experiences a combination of intrusion symptoms, avoidance symptoms, negative alterations in cognitions and mood as well as marked alterations in arousal and reactivity for more than one month following a traumatic incident.

Alternative 4, *Mild Neurocognitive Disorder due to Traumatic brain injury*, is incorrect as David's doctor had found that his memory loss was not due to the effects of a traumatic brain injury, and a Mild Neurocognitive Disorder due to Traumatic brain injury is by definition caused by a 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

**Explanation**: Alternative **2** is correct, as Localised Amnesia is characterised by a lack of memory for a specific event or events, as is the case with David.

Alternative 1, *Derealisation*, is incorrect, as Derealisation is characterised by feelings of unreality concerning the environment and does not refer to memory loss.

Alternative 3, *Selective Amnesia*, is incorrect, as Selective Amnesia is characterised by an inability to remember certain details of an event, whereas David could not recall details for the entire event.

Alternative 4, *Dissociative Fugue*, is incorrect, as Dissociative Fugue is characterised by sudden confusion about one's identity and life history coupled with bewildered wandering or purposeless travel. David's memory loss, however, is for a specific event and not his identity or life history. Also he did not present with purposeless travel.

**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

**Explanation**: Alternative **4** is correct as the factors that are necessary for the development of DID according to the post-traumatic model of DID are clearly outlined on page 220 of Sue et al. (2016).

## 2. The examination

The following general information and guidelines should help you with your final preparations for the examination.

2.1 If you have any questions concerning administrative aspects about the examination, please contact the Examination Section. Make sure that you know when and where you write the PYC3702 examination.

2.2 The examination paper consists of 70 multiple choice questions and the paper is marked out of 70. These marks are converted to a mark of 80. The other 20 marks come from your year mark. Both Assignments 01 and 02 count towards your year mark. You have two hours to complete the paper.

2.3 You have to indicate your answers on a mark reading sheet. Use an HB pencil to mark your answers on the mark reading sheet. Instructions for using the mark reading sheet are included with the paper. Please read these instructions carefully.

2.4 The examination paper covers the whole syllabus. The examination questions will be asked from the sections which you have to **study** in both your prescribed book and your Tutorial Letters 501, 502 and 503. Please refer to the Tutorial Letters 501, 502, and 503. The term **study** in the Tutorial Letters 501, 502 and 503 are used to indicate the sections in the prescribed book and Tutorial Letters 501, 502 and 503 which you have to study for the examination. You will need to have more than a theoretical knowledge of these sections as we will expect you to be able to apply your knowledge to short case studies.

2.5 **DO NOT LEARN PREVIOUS EXAM PAPERS**. We write new MCQ items for every exam paper. We also DO NOT PROVIDE THE MEMORANDUMS for the previous exam papers on MyUnisa. Use the previous exam papers on MyUnisa to test yourself once you have studied the curriculum to identify which sections of the curriculum you have not yet fully mastered. The new questions we write for the exam will follow the same format as in the previous exam papers.

2.6 The volume of the work is large and examinations are hugely stressful. However, if you use the remaining time fruitfully and apply yourself in a systematic way to your study time-table, you will be well prepared for the examination.

2.7 **NOTE re FI-concessions:** After the examination period and once the marks have been released, the Examination Department releases an official FI concessions list which we at the department then use to put the FI concession process into motion. If you have any queries regarding your FI concession eligibility you need to contact the Examinations Department and NOT THE PSYCHOLOGY DEPARTMENT, as we at the department DO NOT have any decision making ability regarding your FI status and can therefore not answer your FI queries.

Best of luck with the examination!

## 3. Assignment 03 – evaluation of the module

Assignment 03 is not compulsory and carries no examination credits. However, we kindly request that you submit this assignment. Your evaluation of the module will assist us to improve the module.

Best wishes with your studies: **Your lecturers in Abnormal Behaviour and Mental Health (PYC3702)**