



# **Tutorial Letter 201/1/2018**

## **Abnormal Behaviour and Mental Health PYC3702**

**Semester 1**

**Department of Psychology**

Feedback – Assignment 01

BARCODE

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 101/3/2018, pp. 9-10) 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.

It is very important that you work consistently and that you remain active and engaged on the discussion forums on myUnisa. This online community of students mastering the curriculum for PYC3702 is a rich source of support and mutual learning. Do not hesitate to contact one of your lecturers if you encounter any problems with your studies that are not addressed on these forums.

If you cannot reach a particular lecturer, please phone the secretary in charge of Abnormal Behaviour and Mental Health, Mrs Cornia Nel at (012) 429-8233. She will put you in contact with the lecturer who is available.

Each of these lecturers are responsible for a specific section of your curriculum and we therefore strongly advise you to direct your queries regarding the specific sections directly to the responsible lecturer. Only when you do not get a response to your query from the specific lecturer – please allow for at least 48 hours response time – should you redirect your query to one of the other lecturers in the module.

Please see the table below for the responsible lecturers.

LECTURER	E-MAIL/Tel	SECTION OF CURRICULUM		
		Title	Sue et al.	TUT-LU
Mrs Louise Henderson (Module leader)	hendeh@unisa.ac.za	(Externalising Disorders of Childhood and Adolescence) Disruptive – Intermittent Explosive Disorder, Conduct Disorder, Oppositional-Deviant Disorder	16	501-6
	Tel. 012 429 8214	Impulse Control Disorders	15	501-6
		Neurocognitive Disorders	13	503-15
		Suicide	9	502-13
Mrs Elmarié Visser	vissee@unisa.ac.za	Anxiety and OCD and related disorders	5	501-7
		(Childhood and Adolescence Mood and Anxiety Disorders) Depressive Disorder	8, 16	502-12
	Tel. 012 429 8270	Bipolar and Related Disorders	8	502-12
Mrs Banti Mokgatlhe	mokgapb@unisa.ac.za	Psychopathology from an African Perspective	-	501-4
	Tel. 012 429 8238	Substance Use Disorders	11	502-10
		Sexual Dysfunctions/Paraphilias/Gender	14	502-11

		Dysphoria		
Dr Janice Moodley	moodlj@unisa.ac.za	Somatic Symptom Disorders	7	502-8
		Schizophrenia and other Psychotic	12	503-14
Dr Nico van Zyl	vzylfn@unisa.ac.za	Dissociative Disorders	7	502-8
	Tel. 012 429 8239	Personality Disorders	15	501-6
Ms Christine Laidlaw	laidlc@unisa.ac.za	Abnormal behaviour and mental health	1	501-1
		Perspectives/Models	2	501-3
		Assessment and classification:DSM-5	3	501-5
	Tel. 012 429 88294	Trauma and Stress	9	502-9
		Childhood and Adolescence (Neurodevelopmental and Internalising Disorders)	16	503-16

## 1 FEEDBACK ON ASSIGNMENT 01

Assignment 01 was based on learning units 1 to 7 and 9 in Tutorial Letter 501 and 502, and the corresponding chapters 1, 2, 3, 5, 6, 15 and 16 (“Externalising Disorders among the Youth”) 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 learning units 1, 2, 3, 4 and 5 and their associated chapters in the prescribed book, 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 the Assignments Section immediately at [assignments@unisa.ac.za](mailto:assignments@unisa.ac.za) and if you still do not receive the information, contact Mrs C. Nel, either by telephone (012) 4298233, e-mail [nelc1@unisa.ac.za](mailto:nelc1@unisa.ac.za) or by letter.

Compare your answers with the correct answers contained in this feedback letter. 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, see table above for specific sections assigned to specific lecturers, so that these problems can be solved.

We wish you success and hope you enjoy your studies!

<b>Assignment 01</b>		
<b>Semester 1</b>	<b>Closing date: 6 March 2018</b>	<b>Unique number: 703459</b>

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

**Question 1**

An assumption of the Multipath Model regarding abnormal behaviour is that - - - - .

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

The correct answer is alternative **3**.

**Explanation:** The correct alternative for this question is 3, as the Multipath Model is integrative and interactive and acknowledges that aetiological factors combine in complex and reciprocal ways. This means that some people can be exposed to the same influences, but not develop the same disorder, and also that different individuals exposed to different aetiological factors may develop similar mental disorders (Sue et al., 2016, pg. 36). Alternative 1 is incorrect as the Multipath Model is based on the assumption that most psychological disorders result from four interacting factors: the biological, psychological, social, and sociocultural. This would then explain why alternative 2 is also incorrect: according to the Multipath Model no single factor or perspective can best explain the complexities of human behaviour. Finally, alternative 4 is incorrect as the Multipath Model does not assume that biological, psychological, social, and sociocultural factors contribute equally to most psychological disorders; rather the model states that not all factors/dimensions contribute equally to a disorder.

More can be read on the Multipath Model of mental disorders on pages 35 to 39 in the prescribed textbook (Sue et al., 2016).

**Question 2**

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

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

The correct answer is alternative **4**.

**Explanation:** For this question, alternative 4 is the right answer as the biological model postulates that thoughts, emotions and behaviours involve physiological activity occurring in the brain, and that changes in the way we think, feel or behave affect these biological process. Furthermore, over time, this can change the structures of the brain (Sue et al., 2016, pg. 40). Alternative 1 is incorrect as the diathesis-stress theory does not only endorse the notion of genetic inherited abnormalities, but rather relates to the predisposition to develop an illness through multiple factors. Neither alternative 2 nor 3 are correct as the biological model no longer only supports the linear explanation of genetic determinism, and considers environmental factors through the study of epigenetics. Although structural brain abnormalities can account for certain mental disorders, this is not always the case.

For further information regarding biological factors, and how mental disorders can be explained through our biological makeup, read pages 40 to 50 in your prescribed textbook (Sue et al., 2016).

### Question 3

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

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

The correct answer is alternative **2**.

**Explanation:** Alternative 2 is the correct answer for this question. The Multicultural Model is a contemporary view that emphasises the importance of considering various cultural backgrounds and experiences in psychological assessment. Cultural diversity (for example family experiences) is also considered of great importance as our population diversifies (Sue et al., 2016, pg. 66). Neither alternative 1 nor 3 are correct as the western culture values individualism and autonomy over collectivity (Sue et al., 2016, pg. 67). The same explanation is therefore valid for the incorrectness of alternative 4, traditional models of psychopathology operate from the European American worldview already discussed, which primarily focuses on the individual and so places much value on individual pathology in understanding abnormal behaviour, and do not engage primarily with the cultural group.

Read pages 65 to 68 of your prescribed textbook (Sue et al., 2016) for more information on sociocultural factors and the importance of considering mental disorders from a multipath perspective.

### Question 4

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

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

The correct answer is alternative **3**.

**Explanation:** Comorbidity, alternative 3, is the correct answer for this question. It denotes the presence of two or more disorders being present at the same time. Alternative 1, subtypes, is incorrect as these are distinctly different subgroups within a diagnostic category. Specificity, alternative 2, is also incorrect as this term is used to describe specific features associated with a diagnostic category. Finally, alternative 4, differential diagnosis, refers to the process of differentiating between two or more conditions which share similar signs or symptoms, and so is the incorrect answer.

More can be read on diagnosing mental disorders on pages 93 to 95 of your prescribed textbook (Sue et.al, 2016) and pages 44 to 57 in Tutorial Letter 501/3/2018.

## Question 5

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

1. Cultural factors
2. Substance aetiology
3. General medical condition
4. All of the above

The correct answer is alternative 4.

**Explanation:** Alternative 4, all of the above is the correct answer. The process of DSM-5 differential diagnosis involves the elimination of many other possible factors which may be contributing to the client's symptomology. These include alternative 1 cultural factors, alternative 2 substance aetiology, and alternative 3 general medical condition. One of the first of these steps is establishing whether or not a client's psychopathology is due to substance use, for example abuse of amphetamines may produce persecutory delusions usually attributed to schizophrenia. Next, the therapist needs to consider whether any general medical condition is causing or contributing to their client having a mental disorder, for example the experience of a cerebrovascular accident causing depressive disorder. Lastly, cultural factors are also important in considering all possible contributors of abnormal behaviour. The DSM-5 affirms that cultural factors can influence a person's symptoms and so encourages cultural considerations when making a diagnosis.

You can read further on assessment and classification of abnormal behaviour on pages 44 to 57 in Tutorial letter 501/3/2018. Pages 95 and 96 in the prescribed textbook (Sue et. al, 2016) offer more information on cultural factors in assessment.

## Question 6

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

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

The correct answer is alternative 1.

**Explanation:** Alternative 1, "Yes, it is necessary because existing western perspectives are one sided and sometimes limited for understanding people from diverse cultures" is the correct answer because traditional psychology is presented from a limited perspective and this does injustice to one of the greatest attributes of people: the individual and collective diversity in thought, feeling and behaviour. Traditional psychology is therefore not generalisable to people of diverse cultural contexts. Also the fact that western conceptions of normality and abnormality have been exported to Africa to explain the African client has resulted in a lack of development of a theory of abnormal behaviour from a purely African perspective.

Therapists who have little experience of indigenous methods of treatment often have great difficulty in working effectively with indigenous clients. It is, therefore, important that therapists and scholars of psychology should be open to alternative worldviews and as such, become culturally sensitive to clients' diverse contexts, develop an understanding of the latter and, as a result, avoid equating differences with deviance. Mental health specialists accordingly have to be sensitive to the cultural context in which they operate. Ignoring the patient's cultural background can only result in misunderstanding and ineffective therapeutic interventions. Alternatives, 2, 3 and 4 are therefore eliminated.

### Question 7

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

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

The correct answer is alternative 4.

**Explanation:** Alternative 4, *a person is a person because of other people* is correct based on the fact that within the African worldview 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. The African worldview also 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 which eliminate alternative 1.

Alternative 2 is incorrect because collective identity is much broader than one's association with her family. Alternative 3 is also incorrect as from a traditional African perspective although ancestors are viewed as intermediators between God and the people a person is only a person because of his relationship with other people.

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

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

### Question 8

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

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

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

**Explanation:** Alternative 1, *Amafunfunyane* is the correct answer because Zama can be said to be presenting with Amafunfunyane which can be described from an African perspective as a form of spirit possession primarily due to witchcraft or sorcery. The individual concerned strongly believes that they

have been bewitched. Amafufunyane is also due to bewitchment or the breaking of customs, which is seen as being related to a negative relationship with the ancestors often resulting in symptoms of mental illness. The symptoms of Amafufunyane may include somatoform reactions (abdominal swelling), hysteria, suicidal tendencies, violent outbursts, listlessness, delusions (such as a belief that one has been bewitched), auditory hallucinations (hearing threatening voices of a foreign culture coming from the person's stomach), fearfulness, disorientation, aggressive and destructive behaviour, tactile hallucinations (strange moving sensations in the stomach) and physical pressure on the head.

Alternative 2 is incorrect because *Ukuthwasa* according to the Traditional African perspective refers to a "creative illness" following a calling by the ancestral spirits 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 process of "thwasa". There is no indication in the case study that Zama received a calling to become a healer.

Alternative 3 is incorrect because *Malombo* is a form of spirit possession found among the Venda and the Kgaga and Lobedu (Pedi groups). The illness manifests in the patient complaining of being physically unwell, which is usually ignored by others because the patient is not incapacitated. The illness progresses until the patient falls down and lies flat in a state of trance. It is at this stage that the diviner tells the family to prepare for the malombo music service, which serves a therapeutic purpose resulting in the curing of the symptoms. Zama's symptoms are not indicative of Malombo spirit possession because she is not in a trance state.

Alternative 4 is incorrect because there is no indication in the case study that Zama experienced the effect of "Sejeso" which is characterised by the belief that an enemy (malicious people) has poisoned one's food or liquid. It is usually experienced as a growth or pain in the stomach, which is said to be due to sorcery or witchcraft.

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

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

### Question 9

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

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

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

**Explanation:** Alternative 4, "*go lahla maseko*" is the correct answer because according to the traditional African perspective refers to failure to perform the traditional practices which is evident in Motlalepule's

case. Her aunt did not see the need to perform any traditional African rituals for her during different phases of her development in line with traditional customs.

Alternative 1, *Schizoaffective Disorder* is incorrect because it denotes a specific mental disorder according to the DSM-5 classification system. Should her disorder be viewed from a western perspective, she does not meet the diagnostic criteria of Schizoaffective disorder since it is only diagnosed when someone demonstrates psychotic symptoms that meet the criteria for Schizophrenia combined with symptoms of a major depressive or manic episode that continue for the majority of the time the schizophrenic symptoms are present.” (Sue et al., p. 397, 2016).

Alternative 2 is incorrect because there is no indication in the case study that Motlalepule could have been a victim of witchcraft or sorcerers. Alternative 3 is incorrect because “*Ukuthwasa*” is regarded as a healthy or positive calling by ancestors to become a traditional healer and in Motlalepule’s case there is no mention of her receiving a calling to become a healer.

### Question 10

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

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

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

**Explanation:** Alternative 1, *Relative, as abnormal behaviour should be viewed from its cultural context* is the correct answer because in order to get a clear understanding of abnormal behaviour within an African perspective, it is paramount to realise that no individual can be understood independently of his or her beliefs, values, traditions, myths, symbols, religion and language. Individuals are carriers of culture, and their behaviour and interaction with others and is influenced by the beliefs, customs, thought patterns and symbolism of their community. Alternatives 2, 3 and 4 are all characteristics of western worldview’s understanding of how abnormal behaviour should be viewed.

### Question 11

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

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

The correct answer is alternative 3.

**Explanation:** In your prescribed textbook, Sue et al. (2016) defines stressors as external events or situations that place physical or psychological demands on a person (pg. 166), whereas stress is defined an internal psychological or physiological response to a stressor (pg. 166). For example, an exam would be a stressor (as external event that places physical or psychological demands on you), whilst your experiences of anxiety or trembling hands would be examples of the stress (internal psychological or physiological response to a stressor) that you experience because of the exam/stressor. This means that the correct answer to this question is alternative 3. Alternative 2 refers to a traumatic event or situation that is beyond a person's ability to cope, however a stressor need not always be a traumatic event. Sue et al. (2016) states on page 165 of your textbook that stressors range from daily, irritating or frustrating events to traumatic, life altering events. This alternative also does not specify a physiological or

psychological demand on a person, and so is not the right answer. Alternative 1 is incorrect as it relates to stress; an internal psychological or physical response to a traumatic event, and not a stressor. Finally, alternative 4 relates to emotional distress and behavioural symptoms that are excessive relative to the severity of a situation, and so describes the emotional intensity in a reaction to a stressor, rather than a stressor itself.

Read more on the role that stress plays in psychophysiological health on page 165 and 166 of the prescribed textbook (Sue et. al, 2016).

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

Liyana is an only child aged 7 years old. Her parents both died before her second birthday and she has since been raised by her grandmother. Liyana has been referred for assessment by her school principal, who is concerned with Liyana's increasingly disruptive and impulsive behaviour in the classroom. Liyana's Grade 2 teacher reports that the child often wanders into other classrooms, seeking attention from other teachers, or tries to go home with classmates' parents after school. This behaviour has increased over the past two years, as have Liyana's frequent bouts of crying.

The school psychologist asks to meet with Liyana and her grandmother. The grandmother states that her daughter and son-in-law were not good parents to Liyana before they died. It was only after their deaths that she was made aware Liyana's living conditions. From the age of 6 months, Liyana had been placed in various foster homes as her parents were not able to take care of her. Liyana's grandmother then applied for, and was awarded, physical custody of the child. She also admits that she knows very little of Liyana's experiences in the foster homes. Her grandmother relates how they now both live with extended family members and explains that she works long hours to assist with the family income. As a result, Liyana is often left in the care of older cousins or neighbours, but her grandmother says that this is not a problem as Liyana easily adjusts to the company of various caregivers.

During the interview, Liyana sits on her grandmother's lap. Later, she climbs onto the psychologist's lap and when the psychologist rises to leave the room, Liyana attempts to follow. Liyana is easily distracted and noticeably uncooperative during the interview. She also often ignores instructions issued by her grandmother.

#### Question 12

Taking into consideration the symptoms discussed in the case study above, with which disorder would you, as the school psychologist, diagnose Liyana?

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

The correct answer is alternative 4.

**Explanation:** The correct diagnosis from this case study would be alternative 4, Disinhibited Social Engagement Disorder. Liyana's behaviour fulfils the primary criteria of the disorder where a child's pattern of behaviour involves culturally inappropriate, overly familiar behaviour with relative strangers. She also displays reduced or absent reticence (hesitation) in approaching and interacting with unfamiliar adults, including overly familiar verbal or physical behaviour and a willingness to go off with an unfamiliar adult with minimal or no hesitation. She is over nine months old and has experienced social neglect and repeated change in primary caregivers. Alternative 1, Conduct Disorder is incorrect as this externalizing disorder of childhood is characterised by a persistent pattern of antisocial behaviour with deliberate aggression and destruction to others property (Sue et al. 2016, pg. 514). Adjustment Disorder, alternative 2, is incorrect as it not a disorder of childhood and requires the development of emotional or behavioural symptoms in response to an identifiable stressor, occurring within 3 months of the onset of the stressor, and lasting no longer than 6 months after termination of the stressor. Lastly. Reactive

Attachment Disorder, alternative 3, is also incorrect as this childhood attachment disorder’s primary characteristic is a consistent pattern of inhibited, withdrawn behaviour towards adult caregivers. This behaviour would be directly opposite to Liyana’s reduced or absent reticence (hesitation) in approaching and interacting with unfamiliar adults, and a willingness to go off with an unfamiliar adult with minimal or no hesitation.

More can be read on Disinhibited Social Engagement Disorder on pages 506 to 507 of your prescribed textbook (Sue et. al, 2016), and pages 40 to 41 of Tutorial Letter 502/3/2018.

When trying to answer a case study question it is beneficial to work through the case study systematically and list the various symptoms experienced by the individual presented in the case study. This method will make it easier to identify possible disorders and answer diagnostic application questions.

The table below is intended to help you with the process of identifying the disorder presented in the case study above. You can read further on identifying disorders from pages 44 to 57 in Tutorial letter 501/3/2018.

Criteria in Case Study	Disorder Criteria
“Liyana is a little girl aged 7 years old.”	The child has a developmental age of at least 9 months.
“Later, she climbs onto the psychologists lap and when the psychologist rises to leave the room, Liyana attempts to follow”; “Tries to go home with classmates’ parents after school”; “often wanders into other classrooms, seeking attention from other teachers”	- Reduced or absent reticence in approaching and interacting with unfamiliar adults.  - Willingness to go off with an unfamiliar adult with minimal or no hesitation.
“The grandmother states that her daughter and son-in-law were not good parents to Liyana before they died”; “From the age of 6 months Liyana was placed in various foster homes as her parents were not able to take care of her”; “She also admits that she knows very little of Liyana’s experiences in the foster homes.”	- Social neglect or deprivation in the form of persistent lack of having basic emotional needs for comfort, stimulation, and affection met by caregiver adults.  - Rearing in unusual settings that severely limit opportunities to form selective attachments
“From the age of 6 months, Liyana had been placed in various foster homes as her parents were not able to take care of her”; “Liyana is often left in the care of older cousins or neighbours, but her grandmother says that this is not a problem as Liyana easily adjusts to the company of various caregivers.”	Repeated changes of primary caregivers that limit opportunities to form stable attachments (e.g., frequent changes in foster care).
“Liyana’s increasingly disruptive behaviour in the classroom over the past two years”	Persistent: The disorder has been present for more than 12 months.

**Question 13**

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

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

The correct answer is alternative **2**.

**Explanation:** Alternative 2, Persistent, is the correct answer as Liyana's disorder is reported by her teacher to have been present for more than 12 months. Acute, alternative 1, is incorrect as according to the DSM-5, acute implies that the disorder has lasted a few hours or days but no more than a month. Both specifiers in alternatives 3 and 4 are incorrect as neither delayed expression of symptoms, nor an accompanying language impairment, are specifiers associated with the DSM-5 criteria of Liyana's identified disorder.

More can be read on Disinhibited Social Engagement Disorder on pages 506 to 507 of your prescribed textbook (Sue et. al, 2016), and pages 40 to 41 of Tutorial Letter 502/3/2018.

#### Question 14

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

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

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 501/3/2018).

Alternative 1 is incorrect as Primary Prevention interventions are efforts to lower 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 tutorial letter 501/3/2018).

Alternative 3 is incorrect as crisis prevention is not a recognised term in this 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.14 of tutorial letter 501/3/2018).

#### Question 15

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

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

The correct answer is alternative 1.

**Explanation:** Alternative 1 is correct as Primary Prevention interventions are efforts to lower 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 tutorial letter 501/3/2018).

Alternative 2 is incorrect 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 501/3/2018).

Alternative 3 is incorrect as secondary corrective is not a recognised term in this 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.14 of tutorial letter 501/3/2018).

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

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

### Question 16

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

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

The correct answer is alternative **2**.

**Explanation:** Alternative 2 is correct as Schizotypal Personality Disorder is characterised by social and interpersonal deficits resulting in acute discomfort with, and reduced capacity for close relationships as well as by cognitive or perceptual distortions and eccentricities as exhibited by Sibongile (Refer to learning unit 6 of Tutorial Letter 501/2018).

Alternative 1 is incorrect since Sibongile's peculiar beliefs are not of a delusional quality (i.e. a false fixed belief) and her behavioural pattern has affected her overall level of functioning. In Delusional Disorder, apart from the impact of the delusion (s) or its ramifications, functioning is not markedly impaired, and behaviour is not obviously bizarre or odd as in Sibongile's case (refer to learning unit 14 of Tutorial Letter 503/2018).

Alternative 3 is incorrect since even though individuals with Schizoid Personality Disorder are also excessively introverted and show interpersonal deficits similar to individuals with Schizotypal Personality Disorder, they do not manifest peculiarities and oddities in speech and behaviour like individuals with Schizotypal Personality Disorder as in the case of Sibongile. Therefore, whilst Sibongile does display the hallmark of Schizoid Personality Disorder which is a pervasive pattern of detachment from social relationships, her peculiar behaviours and beliefs eliminates Schizoid Personality Disorder as a correct answer (refer to learning unit 6 of Tutorial Letter 501/2018).

Alternative 4 is incorrect since Sibongile does not present prominently with two or more Criterion A symptoms (delusions, hallucinations, disorganised speech, disorganised or catatonic behaviour) needed to make a diagnosis for Schizophrenia (refer to learning unit 14 of Tutorial Letter 503/2018).

### Question 17

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

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

The correct answer is alternative **1**.

**Explanation:** Alternative 1 is correct as individuals with Schizotypal Personality Disorder experience ideas of reference, which refers to ideas that they are the centre of attention or that all happenings revolve around them (refer to learning unit 6 of Tutorial Letter 501/2018).

Alternative 2 is incorrect since thought insertion is a form of delusion characteristic in Schizophrenia where a person may believe that someone or something is removing thoughts from their mind (refer to p. 367 of Sue et al., 2016).

Alternative 3 is incorrect since suicide is not a typical feature of Schizotypal Personality Disorder.

Alternative 4 is incorrect since nihilism is not a characteristic feature of Schizotypal Personality Disorder. Nihilism is the belief that a major catastrophe will occur.

### Question 18

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

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

The correct answer is alternative **2**.

**Explanation:** Alternative 2 is correct, as Sibongile's sensing that someone is in the room with her, when she is in fact alone, is an example of an unusual perceptual experience characteristic in a diagnosis of Schizotypal Personality Disorder (refer to learning unit 6 of Tutorial Letter 501/2018).

Alternative 1 is incorrect since delusions of reference are a positive symptom of Schizophrenia and therefore does not describe Sibongile's symptoms (refer to p. 367 of Sue et al., 2016).

Alternative 3 is incorrect since paranoid ideation is defined as suspiciousness about the action or motives of others and therefore does not describe Sibongile's symptoms (refer to p. 367 of Sue et al., 2016).

Alternative 4 is incorrect since delirium, which is classified as a Neurocognitive Disorder, is characterised by a disturbance in awareness and inability to direct, focus, sustain and shift attention and therefore does not describe Sibongile's symptoms (refer to p. 405 of Sue et al., 2016).

### Question 19

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

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

The correct answer is alternative **4**.

**Explanation:** Alternative 4 is correct because Schizoid Personality Disorder is defined in the DSM-5 as a disorder characterised by "a pervasive pattern of detachment from social relationships and a restricted range of expression of emotions in interpersonal settings".

Alternative 1 is incorrect as Social Anxiety Disorder is an anxiety disorder characterised by the intense fear of being scrutinised or of doing something embarrassing or humiliating in the presence of others. Therefore, individuals with Social Anxiety Disorder do not manifest with a pervasive pattern of detachment or restricted emotions as do individuals who are diagnosed with Schizoid Personality Disorder.

Alternative 2 is incorrect as Schizoaffective Disorder is a psychotic disorder that is characterised by psychosis with concurrent mood episodes. Although Schizoaffective Disorder symptoms such as social withdrawal and other negative symptoms may mimic the social detachment and restricted range of expression of emotions as seen in Schizoid Personality Disorder, the latter is more pervasive and longstanding, whereas in Schizoaffective Disorder, these symptoms are episodic.

Alternative 4 is incorrect, as Autism Spectrum Disorder is characterised by persistent deficits in social communication and social interaction that may include deficits in social-emotional reciprocity, deficits in nonverbal communication, stereotypical behaviours and interests, as well as deficits in developing, maintaining and understanding relationships. Individuals with Schizoid Personality Disorder on the other hand is characterised by a detachment and/or disinterest in social relationships and do not necessarily manifest with communication deficits as found in Autism Spectrum Disorder.

### Question 20

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

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

The correct answer is alternative **3**.

**Explanation:** Alternative 3 is correct as Cindy-Lee's pervasive pattern of social inhibition, feelings of inadequacy and hypersensitivity to negative evaluation is the hallmark of an Avoidant Personality Disorder. This diagnosis is further supported by the fact that Cindy-Lee's symptoms are pervasive, longstanding and inflexible.

Alternative 1 is incorrect as Social Anxiety Disorder is characterised by an intense fear of being scrutinised or of doing something embarrassing or humiliating in the presence of others. Although Cindy-Lee's symptoms may include fear of being embarrassed, her symptoms also include feelings of inadequacy and social inhibition which is pervasive and longstanding and therefore better accounted for by an Avoidant Personality Disorder.

Alternative 2 is incorrect as Major Depressive Disorder is characterised by either depressed mood and/or loss of interest in pleasurable activities as well as a range of other symptoms which may include excessive feelings of worthlessness. Therefore, although Cindy-Lee may experience feelings of inadequacy or worthlessness, she does not show any signs of depressed mood or loss of interest in pleasurable activities and therefore do not meet criteria for a Major Depressive Disorder.

Alternative 4 is incorrect as a Borderline Personality Disorder is characterised by a pervasive pattern of instability in interpersonal relationships, self-image and affects. Although Cindy-Lee has fears of rejection as is often seen in individuals with Borderline Personality Disorder, her symptoms emanate from a feeling of inadequacy, as is characteristic of Avoidant Personality Disorder. Also she does not show symptoms of affective instability or identity disturbance/unstable self-image as is characterised by Borderline Personality Disorder.

## Question 21

The Multipath Model for explaining the development of Antisocial Personality Disorder refers to different dimensions of aetiological factors. The *social dimension* emphasises - - - - as factors that exert its influence on the development of Antisocial Personality Disorder in the following manner: - - - - .

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

The correct answer is alternative 1.

**Explanation:** Alternative 1 is correct, as this alternative accurately describes the social dimension of ASPD, as the family is the primary agent of socialisation. Poor parental involvement and lack of supervision of children and adolescents are seen as good predictors of antisocial behaviours as well as children exposed to a family environment of neglect, maltreatment, abuse, hostility and indifference are at risk for developing ASPD, amongst other disorders. Children learn in these environments that the world is cold, unforgiving and punitive (Refer to Sue et al. 2016, p. 490)

Alternatives 2 and 3 are factors included in the psychological dimension of the Multipath Model for explaining the development of Antisocial Personality Disorder and therefore makes these options incorrect (Refer to pp. 503, 505-507 of Sue et al., 2013).

Cultural values and gender are the two variables discussed under the sociocultural dimension of the Multipath Model, which therefore makes Alternative 4 incorrect (Refer to pp. 489 - 490 Sue et al., 2016).

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

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

## Question 22

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

1. Bipolar I Disorder
2. Conduct Disorder
3. Intermittent Explosive Disorder
4. Adjustment Disorder, with disorder of conduct

The correct answer is alternative 3.

**Explanation:** James presents with the full symptom picture to make a diagnosis of Intermittent Explosive Disorder. He shows impulsive behavioural outbursts that occur frequently, which he finds impossible to control and that are grossly out of proportion to what would be expected, given the stressor

that elicits these outbursts. He experiences distress regarding his behaviour and is even worried that he might lose his job. For the full DSM-5 diagnostic criteria for Intermittent Explosive Disorder refer to page 87 of Tutorial letter 501.

Alternative 1, Bipolar I Disorder, is incorrect as James' symptoms do not relate to any of the Depressive or Bipolar Disorders as he does not show symptoms related to discrete mood episodes such as a manic, hypomanic, mixed or depressive episodes. Refer to the prescribed book on 230 to 233 regarding patterns and criteria for the different mood episodes.

Alternative 2, Conduct Disorder, is incorrect as although both Intermittent Explosive Disorder and Conduct Disorder involve high rates of aggression, Alternative 2 is incorrect as the aggression in Intermittent Explosive Disorder is limited to impulsive aggression, is not premeditated, and is not committed to achieve some tangible goal, as would be the case in Conduct Disorder. Furthermore, Conduct Disorder is primarily a disorder of childhood and the diagnosis as is, is seldom carried over into adulthood – Conduct Disorder as diagnosis is only retained into adulthood if the individual still manifests the symptoms that warrant the diagnosis of a Conduct Disorder whilst not fulfilling the diagnostic criteria for Antisocial Personality Disorder. Additionally, James' symptoms also do not fulfil the other symptoms of Conduct Disorder that are present outside of the impulsive aggressive outbursts as found in Intermittent Explosive Disorder.

Alternative 4, Adjustment Disorder, with disorder of conduct, is incorrect as the intensity of James' impulsive aggressive outbursts are much more severe than the emotional or behavioural symptoms manifested in Adjustment Disorder. In Adjustment Disorder, the symptoms are more constant and pervasive over the duration of the disorder although less intense, not as aggressive and harmful, and not usually as impulsive and episodic as in Intermittent Explosive Disorder. Both these disorders present an exaggerated reaction to an identifiable stressor but the nature and intensity of the reactions are vastly different. In Adjustment Disorder the symptoms are described as "marked distress" and "significant impairment in social, occupational, or other important area of functioning" whereas the symptoms in Intermittent Explosive Disorder are described as "recurrent behavioural outbursts representing a failure to control aggressive impulses and manifested by verbal or physical aggression" (APA, 2013).

### Question 23

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

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

The correct answer is alternative **2**.

**Explanation:** According to the Multipath Model of the aetiology of externalising disorders, biological factors appear to exert the greatest influence on the development of Conduct Disorder and antisocial behaviours have been linked to brain abnormalities. However, both family and social contexts also play a role, especially certain parenting styles. Given the information regarding James' father's impulsive aggressive behaviour we can consider a strong genetic link (biological dimension) to James' impulsive aggressive behaviour.

However, you should also consider that his father's behaviour could also have set a bad example for James as a child (psychological dimension) and approached from a more behaviourist approach it might be possible that James could have learned this behaviour through modelling.

Alternative 1, James has a history of Oppositional Defiant Disorder, is incorrect as no research confirms Oppositional Defiant Disorder as an aetiological factor in the development of

Intermittent Explosive Disorder as one psychological disorder is not considered an aetiological factor for another psychological disorder according to the Multipath Model. A history of Oppositional Defiant Disorder merely reinforces the consideration of a biological link to James' behaviour.

Alternative 3, James' girlfriend threatened to leave him if he does not receive professional help, is incorrect as James' girlfriends' threatening to leave him, is a consequence of his impulsive aggressive behaviour and not a precursor that could be viewed as an aetiological factor.

Alternative 4, James' fear of being unable to control himself, is incorrect as James' fear of not being able to control himself refers to a symptom of the disorder and not an aetiological factor. Furthermore, the case study doesn't state that James has a fear of not being able to control himself but merely states that James is unable to control himself which is part of the reason for his distress regarding his symptoms.

#### Question 24

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

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

The correct answer is alternative 1.

**Explanation:** The essential feature of *Agoraphobia* is intense fear or anxiety triggered by the real or anticipated exposure to a wide range of situations (at least two situations) such as being stuck in a crowd or being alone in enclosed public places such as in shops or cinemas or when using public transportation. This fear, anxiety and avoidance are persistent and last for *six months* or more and cause clinically significant distress. Individuals suffering from Agoraphobia typically experience thoughts that something terrible might happen should they be in these feared situations and fear that escape from these situations might be difficult or that help might not be available when panic like or other embarrassing symptoms occur. As in Lerato's case, individuals with Agoraphobia actively avoid these feared situations. The avoidance can become so severe that the person becomes completely housebound.

Alternative 2, *Panic Disorder*, is eliminated as Lerato does not experience any recurrent, unexpected panic attacks nor does she fear another unexpected panic attack. Please refer to Tutorial letter 501/3/2018, Activity 7.9, page 100, for the criteria of panic attack and Panic Disorder. Lerato only experiences intense anxiety and distress at the thought of the feared situations (expected anxiety) and her symptoms therefore do not meet the criteria for Panic Disorder.

Alternative 3, *Generalised Anxiety Disorder*, is also eliminated. Individuals with Agoraphobia, as in Lerato's case, have real or anticipatory anxiety that is focused on specific situations from which they believe escape might be difficult or in which help might be unavailable when they experience panic-like symptoms, whereas individuals with Generalised Anxiety Disorder worry, for at least six months, excessively about a number of everyday situations or activities.

Alternative 4, *Specific Phobia Situational type*, is eliminated because Lerato does not only fear one agoraphobic situation, she fears two situations namely being alone in public places and being stuck in a crowd. Should she be afraid of only one situation, a diagnosis of Specific Phobia Situational type would have been considered.

**Question 25**

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

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

The correct answer is alternative 1.

**Explanation:** Panic Disorder, the disorder Glenn 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, *Glenn 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, *Michael experiences no somatic symptoms 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, *Michael is persistently concerned about having an anxiety attack*, is ruled out as the sustained and excessive anxiety characteristic of Generalised Anxiety Disorder is fear of several events and activities and is not necessarily focused on the fear of having a panic attack. Although Michael 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 questions **26, 27 and 28**.

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

The Principal of the school where Bonita teaches requested Bonita to seek professional help after a group of parents complained about her frequent absence from class. Bonita is seriously distressed about the parents’ complaint. She fears that she might lose her job despite the Principal’s reassurance to the contrary. Although Bonita is an experienced and respected Maths teacher, she has refused several opportunities for promotion due to a lack of self-confidence. She also never had the confidence to teach Grade 12 learners. Ten months ago, after the unexpected death of the Grade 12 Maths teacher, Bonita was asked by the Principal to take over the Grade 12 Maths class. To avoid conflict, Bonita agreed to the Principal’s request despite serious doubts about her ability to cope with the challenges of Grade 12 learners. Bonita experienced the death of her colleague, who was also her

continue

only close friend, as a great loss. Bonita relied on her colleague and friend for guidance regarding teaching and personal matters since the death of her husband six years ago. Bonita's husband was her main source of support and care since they got married at an early age. He assumed responsibility for some important areas of her life. Bonita seldom opposed her husband's decisions. After the loss of her husband, Bonita became very attached to her colleague that had died.

### Question 26

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

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

The correct answer is alternative 4.

**Explanation:** Bonita's symptoms meet the criteria for *Generalised Anxiety Disorder*. Bonita experiences excessive free-floating anxiety and worry that lasted for more than six months (nine months in Bonita'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 Bonita'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). Bonita is clearly displaying the symptoms of an Anxiety Disorder.

Alternative 2, *Adjustment Disorder with Anxiety*, is eliminated since Bonita'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 Bonita's excessive worry is not restricted to having a Panic Attack. Bonita also does not experience recurrent, unexpected panic attacks. She experiences chronic free-floating anxiety and worry which she cannot control.

### Question 27

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

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

The correct answer is alternative 2.

**Explanation:** Bonita manifests **some** features of *Dependant Personality Disorder*. Not only was Bonita'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. Bonita seldom opposed his decisions and after his death she sought another relationship (her colleague) as a source of care and support. Although Bonita 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. For more information on Personality Disorders, refer to Tutorial letter 501/3/2018, Learning Unit 6, pages 58 to 82.

Alternative 1, *Schizoid Personality Disorder*, is eliminated because Bonita 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. Bonita has a pattern of seeking and making close connections to significant 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 Bonita 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 Bonita has a pervasive and enduring pattern of dependency traits which causes her distress and impairment in functioning.

### Question 28

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

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

The correct answer is alternative 1.

**Explanation:** Please refer to page 150 in the prescribed book: *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 short case study and then answer question 29.

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

### Question 29

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

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

The correct answer is alternative 3.

**Explanation:** Alternative 3, *Obsessive-Compulsive Disorder; Specific Phobia* is correct for the following reasons: Dale's symptoms meet the DSM-5 diagnostic criteria for Obsessive-Compulsive Disorder. The essential characteristics of Obsessive-Compulsive Disorder are recurrent obsessions (recurrent, persistent and intrusive thoughts, images or urges) and compulsions (repetitive behaviour that the individual feels driven to perform in response to an obsession or according to rules that must be applied rigidly). Dale experiences obsessions as he has repetitive, intrusive 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. Dale also engages in repetitive hand-washing rituals which is indicative of a compulsion which is performed in response to his obsessions. **Steven** 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 5.1, Anxiety Disorders* for a detailed description of Specific Phobia.

Alternative 1, *Specific Phobia; Avoidant Personality Disorder*, is incorrect. The diagnosis of *Specific Phobia* is ruled out in **Dale'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 such as compulsions (rituals) which are time consuming. Rituals are not characteristic of Specific Phobia. **Steven** 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. The only avoidance behaviour he manifests, is the avoidance of heights.

Alternative 2, *Obsessive-Compulsive Personality Disorder; Agoraphobia*, is also eliminated because **Dale** 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 expense of flexibility, openness and efficiency. **Steven** 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. Individuals diagnosed with Agoraphobia also believe escape from these feared situations might be difficult or that help might not be available.

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

### Question 30

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

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

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

The correct answer is alternative 4.

**Explanation:** Family variables such as a *controlling and critical parenting style, discouragement of autonomy, minimal parental warmth and hostile relatives* are associated with the development of OCD

symptoms. In addition, OCD symptoms also seem to increase when loved ones provide *assistance* or reassurance regarding behavioural rituals (*assisting the child to perform his/her compulsive rituals*). Refer to your prescribed book, page 159 for a detailed description of the social factors that are associated with the development and maintenance of Obsessive-Compulsive and related Disorders.

**-oOo-**

*We hope that this feedback helps you in mastering the curriculum. If you still experience challenges with this section of the curriculum please do not delay in making contact with your module lecturers, so that we can assist you in clarifying what you don't understand, before you move on to further sections of the curriculum.*

*All the best with your studies!*

**Your Abnormal Behaviour and Mental Health Lecturers**