Oxford Brookes University
Department of Psychology

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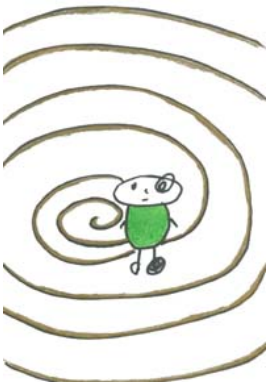
Module U24170 – Abnormal Psychology

COURSEWORK



Module Leader - Luci Wiggs

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COURSE QUERIES

While the university encourages the use of email as a means of communication within the university, it is important to recognise that sending individual emails is not always appropriate. Staff-student ratios inevitably mean that staff are on the receiving end of many more demands for information and clarification than they can easily deal with. Many staff receive over a hundred emails a day. Staff time is split between responsibilities for teaching at undergraduate and postgraduate level, research and administration. Undergraduate teaching and activities supporting it take up only around one third of staff time. Staff are often away at conferences, carrying out research or working away from the department preparing teaching. As a result they cannot check or deal with email every day, though they will attempt to respond as soon as possible. For this reason it is departmental policy to urge students to access the information about modules made available in module handbooks/resources page before they send individual emails to staff. Occasionally there are matters of module business requiring clarification. If you have a query about a module follow these Departmental guidelines:

1. Check the resources page, starting with the announcements.
2. Check the module handbook, then the supporting information.
3. Check your email for messages from the module leader or relevant lecturers. Queries and clarifications are often sent by block email, and the clarification added to the resources page.
4. If your query is not answered by the above, or by a lecturer in a class, use email. If you do not receive a response then make an appointment to see the module leader or lecturer using the electronic booking system (see below).
5. Email communication is not the same as text messaging, so please make your email is as clear as possible and avoid the sort of abbreviations used in text messages. Unclear or text-language emails are likely to be returned to you for clarification.

Electronic booking system: If you have any queries which are not answered by the above steps then please make an appointment, **during my office hours** via the on-line appointments system http://www.2000ad.org/psych/officehours.php

WHAT YOU HAVE TO DO

In this book you will find five brief case descriptions which include the individual's history, symptoms and other relevant information necessary for drawing at least provisional diagnostic conclusions and management suggestions. You are asked to select one of these cases and produce a case report (maximum 2500 words) which will be worth 50% of your total marks for this module. BASE YOUR CASE REPORT ON BOTH THE INFORMATION GIVEN IN THE CASE VIGNETTE AND THE PUBLISHED LITERATURE. Do not provide anecdotal information!
Your report should be structured, by using sub-headings, to include the following sections (marks will be awarded for EACH of these sections):

Diagnosis
As far as you can, provide a complete (5 axis) DSM-IV diagnosis, and explain the signs and symptoms that led you to this diagnosis. If further assessments/information would help you make a firm diagnosis explain what information you require and justify this.

Consider and state the nature of:

- Axis 1 - All clinical disorders except personality disorders & intellectual disabilities. Explain the Axis 1 condition(s) from a clinical perspective (ie. what are the symptoms, how is it defined?). Indicate how this person fulfils the criteria. Are there any atypical features? How might they be explained (if at all)?
- Axis 2 - Personality disorders and mental retardation
- Axis 3 - General medical conditions
- Axis 4 - Psychosocial and environmental problems (see Appendix 1)
- Axis 5 - Global Axis of Functioning Scale (GAF) (see Appendix 2 and consider in which broad category you would place this person eg. '31-40')

Justify your conclusions about the above by referring to what you know about this case. Consider the inter-relationships between the five axes. Also consider differential (alternative) diagnoses if appropriate – justify why you consider/reject these (eg. could abnormal behaviour be caused by a substance such as toxin exposure, medication (prescribed or drug misuse) etc; could it be caused by a general medical condition? Are their other psychiatric disorders which could present in a similar way? Does the person actually fulfil the criteria for the presence of a disorder? Could the client be malingering or feigning symptoms? Is it not possible to reach any firm conclusions? If not, what further information would you need to help you reach a decision?

Case Formulation
Present, explain, and justify your hypotheses about the causes of this person's mental disorder. Explain theories about the causes of the relevant disorder and apply them to the specifics of the individual you are writing about. What are the theories about the aetiology of this disorder? Present and critically evaluate the theories you have discussed in the light of available research and what you know about this case (eg. how well does the research literature support Theory X as an explanation? From what you know, how applicable is Theory X to this particular case?). Please cite the literature on which you base your discussion about causes.

Treatment Plan
Outline, explain, and justify a plan of treatment(s) that you think will help this client. Do not simply list your recommended treatments; describe them (in outline, perhaps with some specific examples where appropriate) and explain why you think they are the best approach to this particular case.

Which treatments could you consider for this client's disorder(s)? What are the treatments (in outline)? What do they involve? How might they work? What is the evidence that they work? Critically examine that evidence. Are there any reasons why they might be particularly suitable/unsuitable for this person? On the basis of the information you have about this individual case which treatment approach(es) is/are most likely to help, in your opinion?, … justify this decision using both what you know about the client and available published research. Again, provide sources from the published literature to support your treatment recommendations.

Prognosis

What is the likely course of this person's disorder? Do you expect him/her to recover completely? If so, how long will recovery take; If not, to what extent will s/he return to previous (pre-disorder) functioning? How likely is relapse? What things might affect outcome? How might they apply to this particular case? Support your prognosis by citing relevant literature and applying it to the case at hand or justify why you can't provide conclusions about prognosis.

Reference list

Provide a full and complete reference list (see the Field handbook for details of required referencing style) of all material cited in the report.

HOW TO SUBMIT YOUR REPORT

Your completed report should be submitted to the coursework deposit box in the Psychology Department by the end of week 8 (ie. 5pm on Friday 19th November 2010). Penalties for work which is submitted late or which exceeds the stated word limit are explained in the Field Handbook. Please complete a coursework coversheet and attach securely to the front of your work (available on the Abnormal Psychology Resources Page (http://ssl.brookes.ac.uk/psychology/resources/res.asp?CategoryID=345).

You should also submit your coursework electronically by the deadline. We are using plagiarism detection software from 'TurnitinUK' (http://submit.ac.uk/).
If you have any problems with registering/using Turnitin please go and see Wakefield Carter in the Psychology Department (room C227).

HOW YOUR REPORT WILL BE ASSESSED

You will receive marks for each section but also your report will be marked as a whole, taking into account the overall presentation and quality of the work, Please see Appendix 3 for a copy of the comment sheet that staff will complete when they mark your work. This should help you to see the sort of things we are looking for in your report.

THE CASES

CASE 1

SV, a 4 year old boy, was brought for evaluation by his parents as they were concerned by his behaviour. Their decision to seek an assessment was prompted by the fact that he had recently started nursery and his teachers were also concerned that he was not coping well and that his behaviour was disruptive to the rest of the children. He would frequently resist joining in with group activities and become quite aggressive when the teacher tried to encourage him to leave the carpeted area of the classroom, where he would spend much of the day sat spinning the wheels of a toy car to which he had taken a particular fancy or lining up his collection of bits of string (which he insisted on taking with him to nursery).

He was born following a normal pregnancy and birth and was described by his mother as a very 'good' baby who slept and fed well and was very placid. He developed normally in most respects, sitting up and walking at about the expected times but his language appeared to be somewhat delayed. When he was 18 months old his health visitor recommended that he have a hearing test to check that his lack of speech and apparent non-responsiveness at times was not due to a hearing impairment. The tests suggested that he had normal hearing and his parents were reassured that he was just a late talker. By the time he was three he was speaking a little although his communication was limited to single word requests (eg. for a biscuit or for the TV to be switched on) rather than for social exchange.

As he got older he would speak in longer sentences but usually these were phrases from favourite television programmes that he was repeating verbatim. His parents were impressed by his ability to memorise these phrases although not altogether surprised since he would watch his favourite video (a cartoon of a little car) repeatedly, sometimes up to 15 times in a row. His mother allowed him to do this as it appeared to give him obvious pleasure and she felt that few things did. Whilst he watched the cartoon he often made some strange twitching movements with his fingers, which his parents reported that he did at times when he was very excited.. and also when he was upset too.

He had no friends either at home or at nursery and although she sometimes invited the boy next door to come around to play with him she noticed that they didn't really play together; SV typically continued to watch the TV or play with his collection of string bits whilst his friend would play with other toys and activities.

He continued to be unresponsive a lot of the time, not looking much at his parents, seeming to ignore them when they spoke to him, however other noises such as the vacuum cleaner or cars passing nosily would appear to panic and terrify him. His mother could only vacuum when he was taken out of the house

because to do otherwise resulted in him being severely distressed and screaming. SV was described by his parents as ‘an anxious and difficult child’. He became very distressed in any unfamiliar situation, such that his mother found it almost impossible to go to the shops or to visit friends with him. She was increasingly upset by the limitations that this placed upon her life.

On evaluation was otherwise healthy although he had frequent bouts of constipation and diarrhoea which his parents attributed to his restricted diet; for the last year he would only eat food which was yellow in colour.

SV’s parents said that their concerns about SV had increased over time as they had watched the development of SV’s younger brother (now aged 30 months) and identified large contrasts between the two. They said that as SV was their first child they had had nothing to compare him with until his younger brother came along. SV’s mother joked that initially she had viewed SV’s lack of social skills and behavioural oddities as a manifestation of her father-in-law’s ‘quirkiness’ (she described her father-in-law as eccentric and her husband agreed with this description!). However, they both acknowledged that whilst SV’s grandfather was somewhat ‘odd’ and rigid, SV’s behaviour was more extreme. They gave as an example an account of how every time SV enters the living room at home he straight away goes to touch a particular spot on the wall, before he can do anything else. He had touched this particular spot so often that a large dirty patch had been created on the wall and a hole had been formed in the wall paper.

CASE 2

JN was a 33 year old single woman who worked as an office administrator. She had a longstanding, intermittent complaint of difficulty sleeping (she described always being a “light sleeper” and having difficulty getting off to sleep at times of stress). The problem had however escalated in the last year and a half, since the death of her mother and she was seeking help now because she felt that her sleeplessness was seriously impacting on both her work and personal life; she was feeling exhausted at work and believed that she wasn’t very productive or able to concentrate because she was so tired. She reported feeling very tearful and irritable during the day, snapping at colleagues with just the slightest provocation. She had also curtailed her evening social life because she was desperate not to miss out on opportunities for sleeping. She believed that if she could just get adequate sleep she would be able to function perfectly during the day and so always tried to get to bed quite early.

Typically she went to bed about 9.30pm, read for half an hour or so and then turned off the light but she described rarely falling asleep until about 1.30am at the earliest. During this time she lay in bed, tossing and turning. Whilst lying there, she said that she sometimes thought about worrisome things that had happened during the day but mainly she was concerned about how she was

going to be feeling the next day, if she didn't get to sleep soon. She described how she was aware of her heart racing fast and some tingling sensations on the side of her body on which she was lying. JN said "I feel so tired but I'm not able to fall asleep no matter how hard I try".

Having fallen asleep, she would usually remain asleep (although she said that she slept lightly) until woken by her alarm at 7.30am in the morning. Upon waking she described feeling "terrible and half asleep, until I've had at least 3 coffees".

At the time of her mother's death her GP had prescribed sleeping tablets and she continued to take these most nights, even though she wasn't keen on the idea of using them. Although she was aware that the problem was persisting despite the medication she reported that on nights when she hadn't taken a sleeping tablet her sleep was even worse and she usually woke up during the night too and had trouble getting back to sleep, again lying in bed for an hour or so before she got back to sleep.

At the weekend, when she usually turned off her alarm clock and allowed herself to sleep-in she would usually remain asleep until about 9am. Although she reported feeling a little better during the day she was still careful not to do anything too strenuous because she knew her energy levels were low. As a result, she had stopped going to the gym where she used to go every Saturday morning. Despite feeling tired she did not typically nap during the daytime, although at the weekend she sometimes 'rested' for an hour or so during the afternoon.

At her consultation, JN was in tears as she described her current problems. She was upset by the fact that no-one appeared to understand quite how serious her problem was; friends dismissed it and her GP had only offered her a different type of sleeping medicine but nothing to address how low she was feeling during the day.

There was nothing else remarkable about her sleep and apart from a childhood history of eczema and asthma she was otherwise apparently healthy. She had a couple of glasses of wine once or twice a week. She was unable to provide much detail about her early sleep patterns or her family's sleep; her father had died when she was quite young and she had not had a specially close relationship with her mother so they had not discussed such matters. She was an only child.

CASE 3

WG was a handsome, athletic-looking youth of 19, who was admitted to the psychiatric service on referral of his family GP. On his admission, the boy's parents said that their son's behaviour during the previous few months had changed drastically. He had been an adequate student at school, but he had to leave college recently because he was failing all his subjects. He had excelled in

a variety of non-team sports such as swimming, weight-lifting and athletics, winning several awards, but now he did not exercise at all. Although he had always been careful about his health and he had hardly ever mentioned any physical problems, within the past few weeks he had repeatedly expressed vague complaints about his head and chest which, he said, indicated that he was 'in very bad shape'. During the past few days, the patient had spent most of his time staring vacantly out of his window. He had become (quite uncharacteristically) careless about his personal appearance and habits.

Although there was no doubt that the patient had exhibited serious recent changes in his behaviour, further conversation with the parents indicated that the patient's childhood and adolescent adjustment had not always been healthy. He had always been painfully shy, except in highly structured situations, and had spent much of his free time alone, often working out with weights. He had no close friends.

The staff at the psychiatric service found it hard to converse with the patient; an ordinary diagnostic interview was impossible. For the most part, the boy volunteered no information. He would usually answer direct questions, but often in a flat, toneless way devoid of any emotional content. Frequently, his answers were not logically connected to the questions. Observers often found it taxing to record their conversations with the patient. After speaking to him for a while, they would find themselves wondering just what the conversation had been about.

At times, the disharmony between the content of the patient's words and his emotional expression was striking. For example, while speaking sympathetically of an acute illness that had rendered his mother bedridden during a portion of the previous winter, the boy giggled constantly.

At times, WG became agitated and spoke with a curious intensity. On one occasion he spoke of 'electrical sensations' and 'an electrical current' on his brain. On another, he revealed that when lying awake at night, he often heard a voice repeating the command 'You'll have to do it'. The patient felt that he was somehow being influenced by a force outside himself to commit an act of violence – as yet undefined – directed at his parents.

CASE 4

RB, fifty-six years old, was a dentist who for most of his 25 years of dental practice provided rather well for his wife and three daughters. His wife reported that there had been times when RB displayed behaviour similar to that which preceded his hospitalisation, but that this was the worst she had ever seen.

About two weeks prior to hospitalisation, the patient awoke one morning with the idea that he was the most gifted surgeon in his county; his mission then was to provide services for as many people as possible so that they could benefit from

his talents. Consequently, he decided to enlarge his two-chair practice to a twenty-chair one, and his plan was to reconstruct his two dental offices into twenty booths so that he could simultaneously tend to as many patients. That very day he drew up the plans for this arrangement and telephoned a number of builders and invited them to submit bids for this work. He also ordered the additional necessary dental equipment.

Towards the end of the day he became irritated with the ‘interminable delays’ and, after he had attended to his last patient, rolled up his sleeves and began to knock down the walls of his dental offices. When he discovered that he could not manage this chore with the sledge hammer he had purchased for this purpose earlier, he became frustrated and proceeded to smash his more destructible tools, washbasins and x-ray equipment. He justified this behaviour in his own mind by saying ‘This junk is not suitable for the likes of me; it’ll have to be replaced anyway’.

He did not tell any of his family about these goings-ons for about a week, and his wife started to get frantic telephone calls from his patients whom he had turned away from his office. During this time, also, his wife realised that something was ‘upsetting him’ because he looked ‘haggard, wild-eyed, and run-down’. He was in perpetual motion, and his speech was ‘over-excited’. That evening, RB’s wife mentioned the telephone calls and his condition and she was subjected to a fifteen-minute tirade of ‘ranting and raving’. She said later that the only reason he stopped shouting was because he became hoarse and barely audible.

After several more days of ‘mad goings-ons’, according to RB’s wife, she telephoned two of her married daughters for help and told them that their father was completely unreasonable and that he was beyond her ability to reach him. Her daughters, who lived within several minutes’ drive, then visited their parents one evening and brought along their husbands. It turned out that bringing their spouses was a fortunate occurrence because the father, after bragging about his sexual prowess, made aggressive advances towards his daughters. When his sons-in-law attempted to curtail this behaviour, RB assaulted them with a chair and had to be physically subdued. The police were then called and he was admitted to the hospital several hours later.

During the interview with RB, it was apparent that he was hyperactive and overwrought. He could not sit still in his chair; instead he paced the office floor like a caged animal. Throughout his pacing he talked constantly about how his wife and two daughters had double-crossed him. It was also learned both from him and subsequently from his wife, that this was not the first episode of this sort and that he had a history of three prior hospitalisations.

CASE 5

Dr B is a 32 year old junior doctor who is in training in a large teaching hospital. He has a history of several years of extreme discomfort at the thought of doing a therapeutic removal of a toenail or a fingernail for a patient. He first heard descriptions of this procedure while he was doing his undergraduate work in preparation for medical school. He recalls feeling sick, faint and disgusted at the thought of doing this although he had no similar squeamishness about the thought of doing other procedures. He states that he would rather "take a cockroach out of a kid's ear than take a fingernail off".

Dr B was an active child who frequently had minor accidents requiring visits to the family doctor. He had a series of sprains and broken bones and recalls getting a finger smashed in a door when he was about 6 years old. He remembers the finger becoming swollen and bruised and the fingernail eventually coming off as the finger healed. Although he does not ever remember feeling particularly upset during visits to the doctor, he does recall seeing his mother turn pale and look sick whenever he had to get an injection or stitches. He was always willing to try things with his friends and describes a self-induced fainting spell when he was 13 years old. He purposely hyperventilated then stood up quickly. He passed out for about 10 seconds and remembers being very scared as he regained consciousness. He as aware that they voices of his friends seemed abnormal and their faces were distorted and he had a sense of unreality and a brief feeling of terror.

During medical school, Dr B successfully avoided doing a nail removal procedure but as a forth year student was forced to observe the procedure. He stood as far back as possible in the examination room and as he watched he began to feel sick, sweaty, noticed his heart begin to race and then began to feel faint and weak. He had to sit down to avoid fainting. He explained that "nails are supposed to be there" and how he can't stop thinking of the excruciating pain that might be experienced if the patient were not totally anesthetised.

During the first two years of his hospital training Dr B became known for his willingness to do surgical procedures. He often volunteered to help fellow doctors and seemed to enjoy tasks such as setting bones and even incision and drainage of cysts and boils and stitching acute lacerations. None of his colleagues were aware that he had never removed a nail – a procedure that was commonly done in that hospital. During an evening clinic, when he was the only doctor available, a young girl was brought in and needed a nail removed. Unable to perform the procedure himself, he called a fellow doctor at home and persuaded her to come in a help him. She agreed on the condition that he see a therapist to deal with the problem.

Appendix 1

Axis IV: Psychosocial and Environmental Problems

Problems with primary support group
Problems related to the social environment
Educational problems
Occupational problems
Housing problems
Economic problems
Problems with access to health care services
Problems related to interaction with the legal system/crime
Other psychosocial and environmental problems

Appendix 2
Axis V: Global Assessment of Functioning Scale (GAF Scale)

Consider psychological, social, and occupational functioning on a hypothetical continuum of mental health-illness. Do not include impairment in functioning due to physical (or environmental) limitations.

Code (*Note*: Use intermediate codes when appropriate, *e.g.*, 45, 68, 72.)

100 | 91	**Superior functioning in a wide range of activities, life's problems never seem to get out of hand, is sought out by others because of his or her many positive qualities. No symptoms.**
90 | | 81	**Absent or minimal symptoms** (*e.g.*, mild anxiety before an exam), **good functioning in all areas, interested and involved in a wide range of activities, socially effective, generally satisfied with life, no more than everyday problems or concerns** (*e.g.*, an occasional argument with family members).
80 | | 71	**If symptoms are present, they are transient and expectable reactions to psychosocial stressors** (*e.g.*, difficulty concentrating after family argument); **no more than slight impairment in social, occupational, or school functioning** (*e.g.*, temporarily falling behind in schoolwork).
70 | | 61	**Some mild symptoms** (*e.g.*, depressed mood and mild insomnia) **OR some difficulty in social, occupational, or school functioning** (*e.g.*, occasional truancy, or theft within the household), **but generally functioning pretty well, has some meaningful interpersonal relationships.**
60 | | 51	**Moderate symptoms** (*e.g.*, flat affect and circumstantial speech, occasional panic attacks) **OR moderate difficulty in social, occupational, or school functioning** (*e.g.*, few friends, conflicts with peers or co-workers).
50 | | 41	**Serious symptoms** (*e.g.*, suicidal ideation, severe obsessional rituals, frequent shoplifting) **OR any serious impairment in social, occupational, or school functioning** (*e.g.*, no friends, unable to keep a job).
40 | | | 31	**Some impairment in reality testing or communication** (*e.g.*, speech is at times illogical, obscure, or irrelevant) **OR major impairment in several areas, such as work or school, family relations, judgment, thinking, or mood** (*e.g.*, depressed man avoids friends, neglects family, and is unable to work; child frequently beats up younger children, is defiant at home, and is failing at school).
30 | | 21	**Behaviour is considerably influenced by delusions or hallucinations OR serious impairment, in communication or judgment** (*e.g.*, sometimes incoherent, acts grossly inappropriately, suicidal preoccupation) **OR inability to function in almost all areas** (*e.g.*, stays in bed all day, no job, home, or friends)
20 | | 11	**Some danger of hurting self or others** (*e.g.*, suicide attempts without clear expectation of death; frequently violent; manic excitement) **OR occasionally fails to maintain minimal personal hygiene** (*e.g.*, smears faeces) **OR gross impairment in communication** (*e.g.*, largely incoherent or mute).
10 | 1	**Persistent danger of severely hurting self or others** (*e.g.*, recurrent violence) **OR persistent inability to maintain minimal personal hygiene OR serious suicidal act with clear expectation of death.**
0	Inadequate information.

Appendix 3

U24121 ABNORMAL PSYCHOLOGY COURSEWORK: COMMENT SHEET

Diagnosis

Understanding	Clear insight and understanding	Competent use of written sources	Overly derivative with too much reliance on undigested sources
Relevance	All material relevant	Some irrelevant material some repetitive material	Too much irrelevant material

Case Formulation

Theoretical discussion	Appropriate discussion of a range of theories	Discussion of some theories. Could be broader or more detailed	Lacking adequate theoretical discussion
Understanding	Clear insight and understanding	Competent use of written sources	Overly derivative with too much reliance on undigested sources
Relevance	All material relevant	Some irrelevant material some repetitive material	Too much irrelevant material
Use of evidence	Good use of examples and experimental evidence when appropriate.	Some use of evidence and experimental examples	Essay lacks much evidence to back up statements

Treatment Plan

Content	Appropriate discussion of approaches to management	Discussion of some approaches to management. Could be broader or more detailed	Lacking adequate discussion of approaches to management
Understanding	Clear insight and understanding	Competent use of written sources	Overly derivative with too much reliance on undigested sources
Relevance	All material relevant	Some irrelevant material some repetitive material	Too much irrelevant material
Use of evidence	Good use of examples and experimental evidence when appropriate.	Some use of evidence and experimental examples	Essay lacks much evidence to back up statements

Prognosis

Understanding	Clear insight and understanding	Competent use of written sources	Overly derivative with too much reliance on undigested sources
Relevance	All material relevant	Some irrelevant material some repetitive material	Too much irrelevant material
Use of evidence	Good use of examples and experimental evidence when appropriate.	Some use of evidence and experimental examples	Essay lacks much evidence to back up statements

Other

References	References complete and correctly cited	References incomplete not fully cited	Hardly any or no references given
Legibility	Very clear and easy to read	Acceptable, but could be improved	Difficult to read Unacceptable
Grammar spelling	Good grammar spelling	Acceptable, but could be improved	Poor grammar Poor spelling
Style	Correct and effective use of English	Style generally acceptable	Style too colloquial
Overall quality	Well organized Well presented	Generally satisfactory	Untidy or messy Too careless

Comment

Grade