PSYCHOPATHOLOGY

SEMINAR ACTIVITIES AND LEARNING EXERCISES

A MENTAL HEALTH AWARENESS QUIZ

TYPE OF ACTIVITY:	***QUIZ***
SUITABLE CLASS SIZE:	***INDIVIDUAL STUDENT, SMALL GROUP OR LARGE GROUP***
SKILLS DEVELOPMENT:	***-***
LEARNING OBJECTIVE:	***HEIGHTENED AWARENESS OF MENTAL HEALTH ISSUES***
TIME REQUIRED:	***APPROX. 30 MINS***
SUPPORTING CHAPTER:	***CHAPTER 1 – PSYCHOPATHOLOGY: CONCEPTS AND CLASSIFICATION***

See how many of the following questions you can answer correctly to test your own awareness of mental health issues.

1. Are mental health problems inherited?

2. Violence towards others is a symptom of which mental illness?

3. 35-50 year-olds show the highest incidence of suicide –True or False?

4. People who talk about suicide are not likely to go on to do it – True or False?

5. Men are more likely than women to attempt suicide – True or False?

6. What proportion of people are known to experience mental health problems? Is it a) 1 in 8, b 1 in 4 or c) 1 in 6?

7. What percentage of GP consultations are for mental health problems? Is it a) 30%, b) 50% or c) 25%?

8. Drugs such as cannabis and ecstasy can increase the risk of panic attacks, anxiety disorders and psychotic episodes – True or False?

9. At what age are mental health problems most likely to occur?

10. In a MIND survey of people who currently have or have previously experienced a mental health problem:

    (a) What percentage of these people said that they had been abused or harassed in public?
    (b) What percentage of these people claim to have been harassed, intimidated or teased at work because of a psychiatric history?

11. Mental Health Media (a campaigning organisation) has identified 3 major stereotypes of how people with a mental illness are portrayed by the media. One of these is sad and pitiable. What are the other two?

Answers:

1. They can be, but not always.
2. None. Violence towards others is not on any diagnostic criteria. For every person killed by someone with a mental illness there are roughly 70 deaths on the road and 10 alcohol-related deaths. We are far more likely to be assaulted by someone we know, in our own homes, than by a random stranger with a mental illness. People with mental health problems are more likely to be victims than perpetrators of violence.

   Interestingly, approximately 70% of media coverage links mental distress to violence.

3. Highest risk group is 18-25 years
4. False – most people who commit suicide usually tell someone of their intentions within the prior 2 months
5. False
6. c) 1 in 4. However, this is only the number of people who we know about, who have sought help. The associated stigma means that many will be too embarrassed to seek help.
7. 25% (source – National Service Framework for Mental Health, Department of Health)
8. True
9. 16-25 years and over 65 years
10. (a) 47%
    (b) 38%
11. (a) Comical, and (b) violent to themselves and others. These stereotypes are found in fictional accounts and 'factual' reporting. This means that the key messages from the media are that if someone has a mental illness we should:
    - Feel sorry for them
    - Be afraid of them
    - Laugh at them

50% of people surveyed by Mind said that media coverage had a negative effect on their mental health. Effects included feeling more anxious or depressed and experiencing hostility from neighbours. A third of respondents said family or friends reacted to them differently because of recent media coverage.

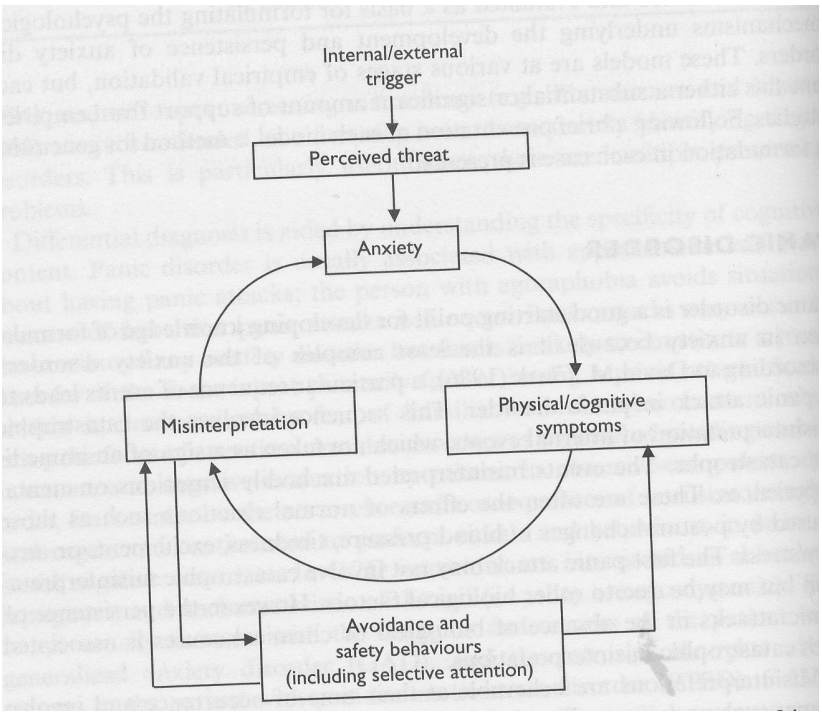
Adapted from Student Psychological Health Project, Educational Development & Support Centre, University of Leicester (www.le.ac.uk/edsc/sphp) and 'Looniversity Challenge', a mental health awareness quiz provided by mental health awareness group 'Fifteen Training & Development', Brighton, UK.

A COGNITIVE BEHAVIOURAL FORMULATION FOR PANIC DISORDER

TYPE OF ACTIVITY:	***INSTRUCTOR-LED EXERCISE***
SUITABLE CLASS SIZE:	***INDIVIDUAL STUDENT, SMALL GROUP OR LARGE GROUP***
SKILLS DEVELOPMENT:	***TRANSFER OF LEARNING TO NEW MATERIAL***
LEARNING OBJECTIVE:	***DEVELOPMENT OF CASE FORMULATION SKILLS***
TIME REQUIRED:	***1-2 HOURS***
SUPPORTING CHAPTER	***CHAPTER 2 – CLINICAL ASSESSMENT***

This activity should be attempted with the help and advice of your instructor or teacher. It consists of four stages: (1) a description of the cognitive theoretical model of panic disorder in which the formulation is to be attempted (see Chapter X, pxx), (2) a template for the formulation interview that a clinician would undertake to gain the information required, (3) a template formulation diagram to be completed following the interview, and (4) an illustrative interview that you can use to gather the information required to complete the formulation diagram. All these examples are taken from Wells (2006)

Part 1: The cognitive model of panic disorder



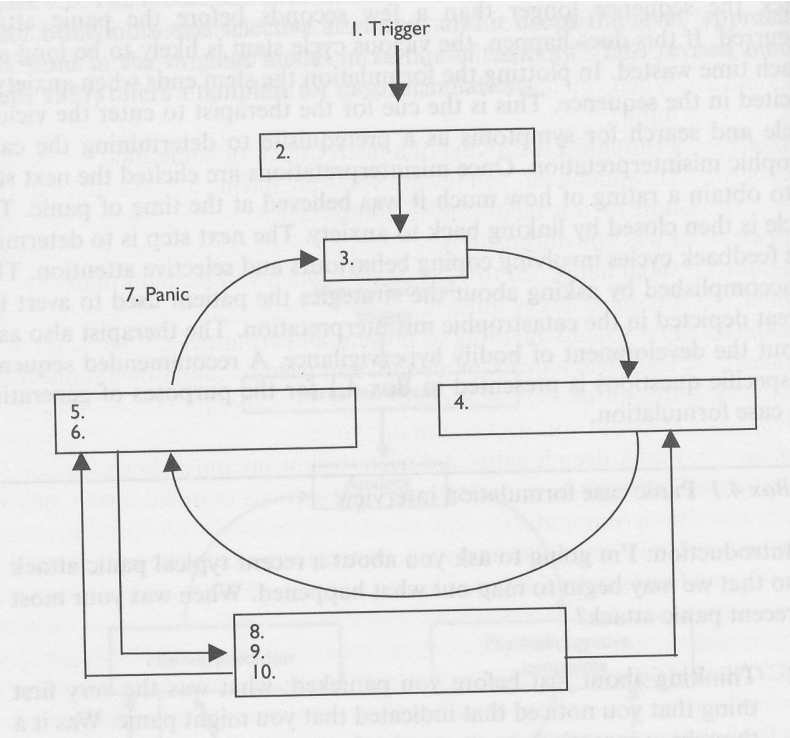
Part 2: The template panic disorder formulation interview

Introduction: I'm going to ask you about a recent typical panic attack so that we may begin to map out what happened. When was your most recent panic attack?

1. Thinking about just before you panicked: what was the very first thing that you noticed that indicated that you might panic. Was it a thought, a sensation, or an emotion?
   (Answer=thought, go to Q3; Answer= sensation, go to Q2; Answer= emotion, if anxiety go to Q4 and if other emotion ask: "When you had that emotion what sensations did you have? Then proceed with Q2)

2. When you noticed that sensation what thought went through your mind?
3. When you noticed that thought how did that make you feel emotionally?
4. When you noticed that emotion what sensations did you have?
5. When you had those sensations what thought went through your mind?
6. How much did you believe [insert catastrophic thought] at that time?
7. What happened to your anxiety when you thought that?
8. Did you do anything to prevent [insert catastrophic thought]? What was that?
9. Did you do anything to lower anxiety? What was that?
10. Since you have developed panic do you focus attention on your body/thoughts? In what way?

Part 3: The template formulation diagram. Try to fill this in with the appropriate details once you have read the illustrative interview in Part 4



Part 4: An illustrative interview

Clinician: Thinking about just before you panicked. What was the very first thing that you noticed that indicated that you might panic? Was it a thought, a sensation or an emotion?
Client: It was an emotion, frustration.
Clinician: When you had that emotion what sensations did you have?
Client: I felt dizzy, vertigo I suppose you'd call it.
Clinician: When you noticed that sensation what thought went through your mind?
Client: I thought it's going to bring it on.
Clinician: When you had that thought how did that make you feel emotionally?
Client: I felt scared and anxious.
Clinician: When you noticed that emotion what sensations did you have?
Client: I got the lot, dizziness, choking, chest tight, sweating, nausea.
Clinician: When you had those sensations what thought went through your mind?
Client: I thought I was dying of a heart attack or something.
Clinician: How much did you believe you were having a heart attack on a scale of zero to 100%?
Client: I was convinced, 70%.
Clinician: What happened to your anxiety when you thought that?
Client: I panicked very quickly.
Clinician: Did you do anything to prevent a heart attack?

Client:	Yes, I had a drink of alcohol and tried to calm down. I also took an aspirin.
Clinician:	How did you try to calm down?
Client:	I took deep breaths and tried to slow my pulse down.
Clinician:	Since you developed panic do you focus more attention on your body/thoughts?
Client:	I take my pulse and try to listen to my heart beating when I'm falling asleep.

HOW *NOT* TO REPORT RESEARCH FINDINGS: THE EXAMPLE OF WATSON & RAYNER (1920)

TYPE OF ACTIVITY:	***RESEARCH CRITIQUE – PREFERABLY INSTRUCTOR-GUIDED***
SUITABLE CLASS SIZE:	***INDIVIDUAL STUDENT, SMALL GROUP OR LARGE GROUPS***
SKILLS DEVELOPMENT:	***CRITICAL THINKING***
LEARNING OBJECTIVE:	***EVALUATING RESEARCH REPORTS IN CLINICAL PSYCHOLOGY***
TIME REQUIRED:	***APPROXIMATELY 1 HOUR***
SUPPORTING CHAPTER:	***CHAPTER 3 – RESEARCH METHODS IN CLINICAL PSYCHOLOGY***

In 1920 J.B. Watson and Rosalie Rayner reported the findings of a study that has come to be known as the ***"Little Albert" study***, and is often cited as one of the founding pieces of scientific research in psychopathology. However, despite being quoted in almost every clinical psychology textbook since that time, the original report of this research is not as clearly written as we might wish, and many subsequent studies were unable to replicate it.

After reading the Watson & Rayner (1920) article:

1. Can you accurately describe what they did?
2. Can you describe exactly what they found?
3. Can you describe the procedures you would use in a study designed to try and replicate their findings?

Two other articles that are instructive here are:

Harris B. (1979). Whatever happened to Little Albert? *American Psychologist, 34*, 151-160.

Delprato DJ (1980). Hereditary determinants of fears and phobias: A critical review. *Behavior Therapy, 11,* 79-103.

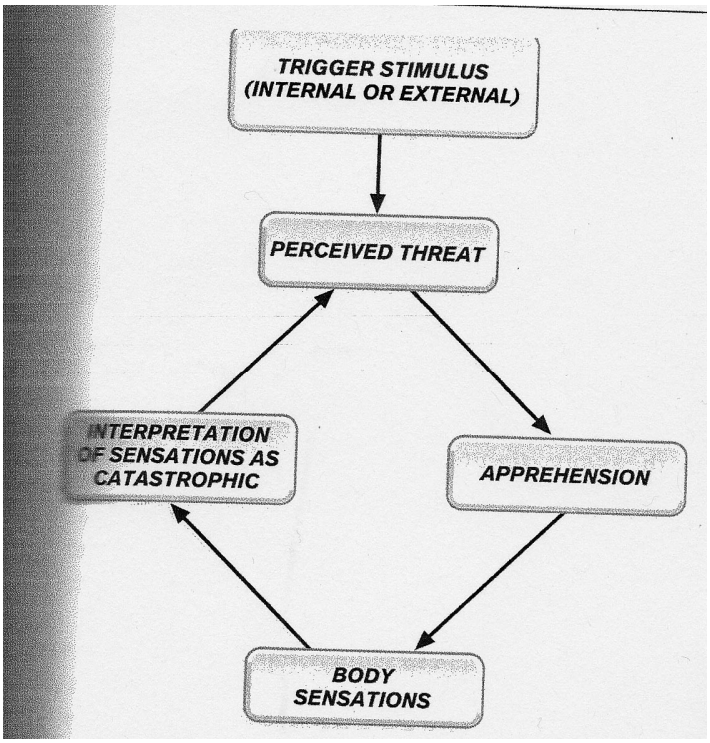
Harris (1979) describes how the Watson & Rayner study has become a well-known piece of psychological 'folklore' with many textbooks misquoting the details of the research because their authors have relied on secondary sources rather than reading the original article. Even Watson himself misrepresented and distorted this research in later writings.

Delprato (1980) describes a number of studies conducted in the 10-15 years after 1920 that attempted to replicate the 'Little Albert' findings. Many of these failed in their attempts, and as a consequence are rarely mentioned in clinical psychology textbooks.

Conclusion: Accurate descriptions of research and accurate reporting of research are essential for proper understanding. If research reports lack necessary detail or are confusing, they are not only difficult to replicate, they may also give rise to misreporting of findings.

TESTING A THEORY OF PANIC DISORDER

TYPE OF ACTIVITY:	***RESEARCH CRITIQUE – PREFERABLY INSTRUCTOR-GUIDED***
SUITABLE CLASS SIZE:	***INDIVIDUAL STUDENT, SMALL GROUP OR LARGE GROUP***
SKILLS DEVELOPMENT:	***ANALYTICAL THINKING***
LEARNING OBJECTIVE:	***PRACTICING HYPOTHESIS TESTING***
TIME REQUIRED:	***MINIMUM 30 MINS***
SUPPORTING CHAPTER	***CHAPTER 3 – RESEARCH METHODS IN CLINICAL PSYCHOLOGY***



This is a schematic (diagrammatic) representation of Clark's (1986) theory (or model) of panic disorder. In this theory, perception of a threat triggers apprehension followed by a focussing on bodily sensations caused by that apprehension. Finally, these bodily sensations are catastrophically misinterpreted as threatening. This then creates a vicious cycle of cause-effect events that precipitates a panic attack.

If this theory meets Popper's criteria as a scientific theory, then we should be able to generate testable hypotheses from it which will either confirm the theory or falsify it. Below are a few examples of testable hypotheses from this theory. See if you can think up any more.

Testable hypotheses:

In individuals diagnosed with panic disorder:

1. Perceiving a threat should lead to increased apprehension (as measured by increased levels of anxiety).

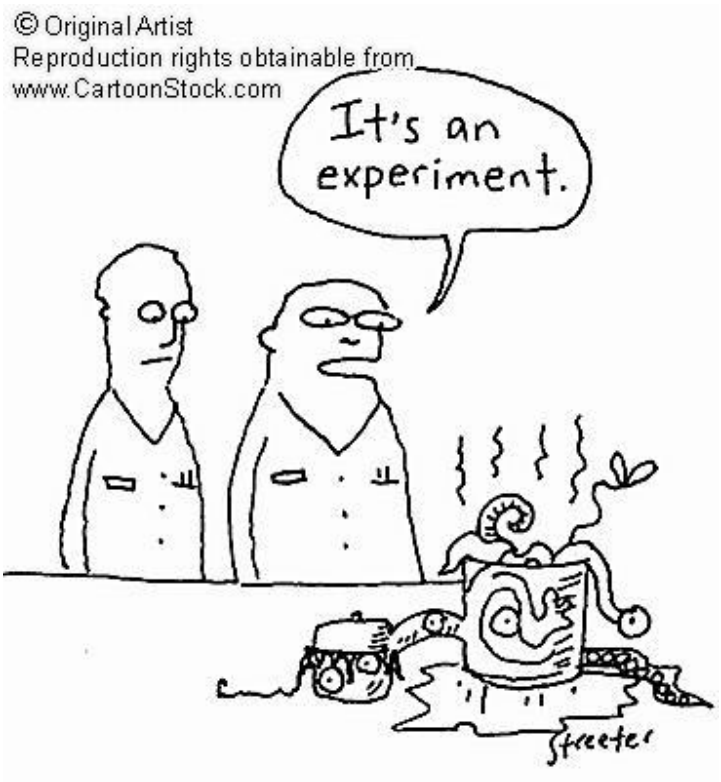
2. Perceiving a threat should eventually lead to enhanced discrimination of body sensations.

3. Increasing discrimination of body sensations should trigger catastrophising.

4. Inducing catastrophic interpretations of bodily sensations should lead to increased perception of threat.

QUESTIONS TO ASK WHEN DESIGNING AN EXPERIMENT

TYPE OF ACTIVITY:	***INSTRUCTOR-LED ACTIVITY***
SUITABLE CLASS SIZE:	***INDIVIDUAL STUDENT, SMALL GROUP OR LARGE GROUP***
SKILLS DEVELOPMENT:	***ANALYTICAL AND CREATIVE THINKING***
LEARNING OUTCOME:	***CONSTRUCTING A WELL-DESIGNED EXPERIMENT***
TIME REQUIRED:	***1-2 HOURS***
SUPPORTING CHAPTER	***CHAPTER 3 – RESEARCH METHODS IN CLINICAL PSYCHOLOGY***



Below are a series of questions that you can ask yourself as you go through the process of designing an experiment. The example answers to these questions are based on a researcher who wants to find out whether negative mood significantly increases worrying (see Johnston & Davey, 1997, for one example of how this question has been tackled experimentally)..

1. What is my ***experimental hypothesis*** and what prediction can I derive from it?

   Hypothesis: That negative mood makes people worry more. Prediction: That inducing a negative mood in participants will make them worry more

2. What existing evidence am I using to justify my experimental hypothesis?

   That there is a significant positive correlation between worry and anxious and depressed moo (e.g. Meyer, Miller, Metzger & Borkovec, 1990)

3. What is my ***experimental manipulation***, and what materials and procedures will I need to practically implement it in the experiment?

   The manipulation is to induce negative mood in the experimental group. I could do this by playing them sad music or getting them to watch stressful videos

4. Am I sure that my experiment is manipulating only one ***independent variable***? (N.B. never try to manipulate more than one variable in a single experiment because you will not know which one caused any effects you observe – manipulate the second variable in a different experiment).

   Yes

5. What possible ***confounding variables*** do I need to control for?

   A change of mood in any direction could increase worrying, as could just listening to music or watching a video regardless of its content

6. What ***control groups*** do I need to control for these confounding variables?

   I need to have control groups that experience a change in mood other than an increase in negative mood – perhaps a group that listen to music or watch a video that increases positive mood; and I need a group that listens to music or watches videos that do not cause any change in mood

7. Does my ***experimental group*** differ from my control groups only on the one single factor that I am trying to manipulate?

   Yes – my experimental group listen to music or watch videos, they differ only to the extent that they are the only group to experience an increase in negative mood

8. Am I sure that there is a ***random assignment*** of participants to the various groups in my experiment?

   Yes – I will allocate each participant to a group by drawing lots

9. Prior to undertaking the experimental manipulation, can I be sure that my groups do not differ on important characteristics that may spuriously affect the outcome of the study?

   Prior to the experimental manipulation I need to be sure that each group does not differ on levels of positive or negative mood or on the frequency with which they normally worry. I will give them validated questionnaires that measure these attributes prior to the experiment to check that participants in each group do not differ significantly on the scores on these questionnaires

10. How can I check that my experimental manipulation is effective enough?

    I need to be sure that the music/video causes an increase in negative mood in my experimental group, an increase in positive mood in my first control group and no change in mood in my second control group. I will take a measure of their mood before and after they experience the manipulation and see if their moods change as predicted.

11. How can I objectively measure my ***dependent variable***?

    My dependent variable has to be a measure of the frequency of worry. I could ask them to think about something that is worrying them at present and time how long they do this for. Alternatively, I could get them to write down what they are worrying about and count how many sentences this amounts to (see Davey, 2006, for an example).

12. Is my ***experimental design*** one that lends itself easily to statistical analysis so that I can ascertain whether my findings are ***statistically significant***?

    Yes – it represents a simple one-way ANOVA comparing worry scores across the three groups in the study. See Field (2006, pXX).

13. Are there any ***ethical issues*** that I need to consider about subjecting my participants to this kind of procedure?

    With any experiment that manipulates mood or asks the participant to think about stressful material, such as their current worries, there are likely to be ethical issues. You should consider how you can minimise these issues and send the participant out of the experiment in a physical and mental state that is similar to the ones they were in when the started the experiment. See Section 3.XX for more about ethical issues.

14. Do I have the means to obtain the ***informed consent*** of my participants?

    see Focus Point 3.X.

15. Is there any way that I might introduce some ***experimenter bias*** that will affect the way in which participants may respond in each of the groups in my experiment?

I must be sure to give the participants their experimental instructions in exactly the same way. I could also conduct the experiment ***blind****, by asking someone else to conduct the mood induction so that I am unaware what condition the participant is in when I ask them to worry.*

16. Is there any way that I, as the experimenter, might bias the way that the dependent variable is measured?

Worrying is a fairly subjective phenomenon. I must be very sure that the method of measuring this is objective and fair and involves no subjective judgements on my part.

Now you have looked through these examples, can you attempt to answer these same questions when designing an experiment to tackle one or more of the following research issues:

(1) Do uncontrollable stressful experiences make people feel sad and depressed?

(2) Does actively suppressing an unpleasant thought cause the thought to occur more frequently once the person has stopped suppressing it?

(3) When people are anxious, do they have a tendency to interpret ambiguous stimuli as threats (see Activity Box 4.2)?

(4) Does reading poetry make people feel less anxious?

(5) Does feeling sad or depressed increase a person's body dissatisfaction?

(6) Do people remember threatening words better when they are in an anxious mood?

(7) Does an increase in feelings of anxiety also cause an increase in feelings of sadness and depression?

DEVELOPING YOUR OWN BEHAVIOURAL-SELF CONTROL PROGRAMME – PROMOTING STUDYING BEHAVIOUR

TYPE OF ACTIVITY:	***INSTRUCTOR-LED EXERCISE***
SUITABLE CLASS SIZE:	***INDIVIDUAL STUDENT, SMALL GROUP OR LARGE GROUP***
SKILLS DEVELOPMENT:	***CREATIVE THINKING***
LEARNING OBJECTIVE:	***DEVELOPING A PERSONAL BEHAVIOUR-CHANGE PROGRAMME***
TIME REQUIRED:	***1 HOUR OR LONGER***
SUPPORTING CHAPTER:	***CHAPTER 4 – TREATING PSYCHOPATHOLOGY***

How often do you sit down to write an essay or a lab report or do some reading for a seminar, only for your attention to begin to wander almost immediately? After just a few minutes, you are up making a cup of coffee to distract yourself from the difficulty of concentrating on the task in hand.

Below are some examples of how you might apply behavioural self-control principles to help you concentrate more easily when you are studying. All of these principles are based on operant or classical conditioning. When you have read these principles, sit down and write a behavioural self-control programme for your own studying behaviour that takes into account your own learning environment and your personal circumstances.

Reinforcement / punishment: Always try and find some way of rewarding yourself whenever you have achieved a study goal, and make sure that you take this reward immediately on completion of the task. It may be something as simple as a refreshing cup of coffee, a chat with friends, trip to the cinema, or just listening to your favourite music CD.

Response-reinforcer contiguity / contingency: While many people claim to be aware of the principle of operant reinforcement, most rarely apply it consistently. For instance, you may decide to spend two hours in the library writing an essay and then reward yourself for this effort by going and having a coffee and a chat with friends. However, you may find that you are working so well that you continue writing until your concentration and motivation begins to wane - then you go off for coffee. With all the good intentions in the world, what has happened is that you have inadvertently reinforced behaviours consistent with falling levels of concentration and motivation rather than the two hours focused work that preceded this. Always ensure that the things you like doing (i.e. rewards) occur *immediately after* the behaviour you want to foster (i.e. concentrating).

Stimulus Control (Environmental Planning): If you study in an environment that also controls other behaviours, then you will inevitably find it difficult to concentrate solely on studying. For example, if you try and write an essay in your kitchen, that could be very difficult, because a kitchen will also have come to elicit other competing behaviours such as eating, putting on the kettle, etc. To study effectively, you need to do this in an environment that does not control alternatives to studying (e.g a Library is a good example).

Response shaping and the setting of attainable targets: All behavioural programs set attainment targets of some kind, and it is extremely important that any sub-goals in the program are attainable. For example, if studying you must set yourself a goal that you are certain you can achieve (e.g. reading a text book for 15 minutes rather than 6 hours!). It is critical that goals are attainable: if they are not met because they are over-ambitious, then this is tantamount to punishing the effort that was expended in attempting to meet the goal.

Response discrimination / feedback: Can you recall accurately how many hours you have spent studying in the last week? Probably not, and this is because most people have poor recall of the frequency of behaviours they are trying to develop or reinforce. This being the

case, it is perhaps not surprising that you may have difficulty controlling your studying – because you are unable to accurately discriminate it or to remember it. One way in which this can be overcome is by including in the program a period of self-observation, where the you record or chart information relevant to studying behaviour (e.g. how many hours you studied each day, what you achieved, and where you studied). This will give you an idea of the baseline frequency with which you study and will allow you to set some future goals that can increase this baseline level.

(From Davey, 2004)

ASSESSING EVOLUTIONARY EXPLANATIONS OF SPECIFIC PHOBIAS

TYPE OF ACTIVITY:	***INSTRUCTOR-LED EXERCISE***
SUITABLE CLASS SIZE:	***INDIVIDUAL STUDENT, SMALL GROUP OR LARGE GROUP***
SKILLS DEVELOPMENT:	***CRITICAL THINKING***
LEARNING OBJECTIVE:	***CRITICAL ANALYSIS OF EVOLUTIONARY EXPLANATIONS OF FEARS AND PHOBIAS***
TIME REQUIRED:	***30-60 MINS***
SUPPORTING CHAPTER:	***CHAPTER 5 – ANXIETY-BASED PROBLEMS***

Some explanations of specific phobias argue that the rather limited set of fears that become the focus for clinical phobias (e.g. spiders, snakes, heights, water, blood and injury, confined spaces, etc.) are the result of evolutionary selection pressures. They argue that those of our ancestors that feared and avoided these stimuli survived and so passed their fear and avoidance tendencies on to their offspring. Evolutionary-based accounts such as these assume that those things that are the focus of phobias today did pose a real threat to the survival of our ancestors.

Have a look at what is displayed in the following pictures and take a few minutes to write down as many reasons as you can think of why each one might be a threat to the survival of a human being. Then read on.

You were probably able to think of a number of reasons why each of these might be a threat to the survival of a human being. Of these six stimuli, 1 & 2 are typical phobic stimuli, 3 & 4 are potentially life threatening but are rarely the focus for phobias, and we would not normally consider 5 & 6 to be any threat to survival at all. Yet it is still not difficult to think of reasons why 5 & 6 *might* be dangerous if we are pressed to do so. This is known as the ***adaptive fallacy*** (McNally, 1995) – that is, you can usually think up reasons why any stimulus or event might be dangerous. Given that you were able to do this with all 6 of these stimuli (1) why is it that only 2 of them are the focus for phobias, and (2) why are 2 of them clearly dangerous, yet not the focus for phobias? These are questions that evolutionary accounts of phobias need to address.

INTERPRETATION BIASES AND ANXIETY – THE HOMOPHONE SPELLING TASK

TYPE OF ACTIVITY:	***PRACTICAL EXERCISE***
SUITABLE CLASS SIZE:	***STUDENTS IN PAIRS***
SKILLS DEVELOPMENT:	***-***
LEARNING OBJECTIVE:	***EXPERIENCE OF MOOD-INDUCED INTERPRETATION BIAS***
TIME REQUIRED:	***30 MINS***
SUPPORTING CHAPTER:	***CHAPTER 5 – ANXIETY-BASED PROBLEMS***

Homophones are words that sound the same but have different meanings. These types of words have been used to detect interpretation biases for threat in anxious individuals. For example, the word Die/Dye has two meanings, one of which is a potentially negative or

threatening meaning. If an anxious individual is given auditory presentations of threat/neutral homophones and asked to spell the words they hear, they are more likely to write down the threatening rather than the neutral interpretation (Blanchette & Richards, 2003). This is evidence of a bias towards interpreting ambiguous information as threatening that is related to anxiety, and this bias can be found in most of the anxiety disorders.

Read out the following list of homophones to a fellow student (at the rate of about one every 2 seconds), and get them to spell the words as they hear them. How many do they spell in the threatening way? If your participant is anxious – perhaps because of an imminent exam – they are likely to respond with even more threatening spellings.

Die/Dye
Pain/Payne
Patients/Patience
Mourn/Morn
Weak/Week
Bury/Berry
Groan/Grown
Flu/Flew
Slay/Sleigh
Tense/Tents
Tied/Tide
Ail/Ale
Wail/Whale
War/Wore
Flee/Flea

WHY ARE WOMEN TWICE AS LIKELY AS MEN TO BE DIAGNOSED WITH MAJOR DEPRESSION?

TYPE OF ACTIVITY:	***GROUP DISCUSSION***
SUITABLE CLASS SIZE:	***SMALL GROUP***
SKILLS DEVELOPMENT:	***CRITICAL THINKING; PRESENTATION SKILLS***
LEARNING OUTCOME:	***UNDERSTANDING OF THE CAUSES OF SEX DIFFERENCE IN DEPRESSION***
TIME REQUIRED:	***APPROX. 1 HOUR***
SUPPORTING CHAPTER:	***CHAPTER 6 – DEPRESSION & MOOD DISORDERS***

The prevalence rate for Major Depression is between 10-25% for women and only 5-12% for men, so what accounts for this major sex difference? You might like to begin a group discussion by asking males and females in your group to say how their experiences as a male or female might influence their susceptibility to developing episodes of depression.

Prior to your group discussion, you might find it useful to read Volume 74, Issue 1, of the *Journal of Affective Disorders* (2003) that is a dedicated special issue on Women and Depression.

Your discussion may want to take into account the following facts:

- There is no sex difference in the rate of experienced depression prior to age 14-15 years (Nolen-Hoeksema, 2001)
- Women are more likely to ruminate about their depressive symptoms, whereas men tend to try and distract themselves or express their depression as anger (Mirowsky & Ross, 1995; Just & Alloy, 1997)
- After puberty, females tend to be less at ease with the physical changes occurring with their body than do males (Harter, 1999)
- After puberty, women experience more life stressors than men (Hankin & Abramson, 2001)
- Being married and having children increases the risk of Major Depression in women, but not in men (Lucht, Schaub, Meyer, Hapke et al., 2003)

Think about the following possibilities:

- Do women get more depressed than men because they feel they have less control over their lives?
- Are women more likely to blame themselves for failures than men?
- Do Western societies set higher cultural standards for women than men (e.g. body shape standards are more defined for women than men), and do women get depressed when they fail to meet these relatively high standards?
- Are men simply less likely to admit that they are depressed than women?

Researchers are far from agreed as to the reasons why twice as many women as men suffer from depression, so there are no right or wrong answers and your group discussion will add to this ongoing debate.

IDENTIFYING EXAMPLES OF EXPRESSED EMOTION

TYPE OF ACTIVITY:	***INSTRUCTOR-LED EXERCISE***
SUITABLE CLASS SIZE:	***INDIVIDUAL STUDENT, SMALL GROUP OR LARGE GROUPS***
SKILLS DEVELOPMENT:	***TRANSFER OF LEARNING TO NEW MATERIAL***
LEARNING OBJECTIVE:	***TO IDENTIFY EXAMPLES OF EXPRESSED EMOTION***
TIME REQUIRED:	***30-60 MINS***
SUPPORTING CHAPTER:	***CHAPTER 7 – EXPERIENCING PSYCHOSIS: SCHIZOPHRENIA AND ITS SYMPTOMS***

Families with high levels of Expressed Emotion (EE) exhibit: (1) high levels of criticism, (2) hostility towards the individual diagnosed with schizophrenia, (3) intolerance of the sufferer's problems, (4) inflexible strategies for dealing with the symptoms of schizophrenia, (5) blaming the sufferer themselves for their symptoms and behaviour, and (6) a tendency to attribute the sufferer's behaviour to global, stable causes, making it difficult to conceive of change and improvement.

Can you identify these characteristics in the fragments of conversation below? These are statements made by members of families with high EE talking about the individual who has been diagnosed with schizophrenia.

"Four days ago he told my wife that he was going to kill the police… now whether that's just bravado, that's just childish, the sort of thing a child would do."

"He has this thing that he is the most important person and they'd have to wait for him, so he'd have to miss appointments."

"He knows I don't like swearing, so he would continue to swear…. I think he did it just to be difficult".

"When he came back with his funny ideas about blacks' persecution and natural health I just thought it was typical Nicholas picking things up en route, he's not to strong a character and tends to absorb other people's views."

"The other day she threatened to top herself. Now that is not her, that is not an expression that she would use. It's completely out of character with her …. It's a bit of emotional blackmail; she wants me to take her home."

"She's a bit on the lazy side, and she's not very logical. If you are cleaning a place out, she'll help, but she won't finish things."

"He was smoking very heavily, which he hadn't been doing before … he really wasn't the smoking type, you know, he got with some friends who smoked and he kept on smoking".

CONTROVERSIES IN THE DIAGNOSIS AND TREATMENT OF SCHIZOPHRENIA

TYPE OF ACTIVITY:	***GROUP DISCUSSION***
SUITABLE CLASS SIZE:	***SMALL GROUPS***
SKILLS DEVELOPMENT:	***CRITICAL THINKING AND PRESENTATION SKILLS***
LEARNING OBJECTIVE:	***UNDERSTANDING & EVALUATING CONTROVERSIES IN THE DIAGNOSIS & TREATMENT OF SCHIZOPHRENIA***
TIME REQUIRED:	***APPROXIMATELY 1 HOUR***
SUPPORTING CHAPTER:	***CHAPTER 7 – EXPERIENCING PSYCHOSIS: SCHIZOPHRENIA & ITS SYMPTOMS***

Below is an extract from an article by British psychologist Oliver James that was published in The Guardian newspaper in October 2005. You may like to read this with your fellow students and then discuss the issues he raises in relation to the material you have read in sections 6.5 and 6.6 of this chapter.

"New research on schizophrenia suggests that the drugs won't always work"

Oliver James
The Guardian, Saturday 22 October, 2005-11-01

"…..Rates of schizophrenia vary as much as 16-fold around the world, as does its course. It is less common in developing nations and tends to last much longer and be more severe in rich, industrialised nations compared with poor, developing ones (even so, about 20% of schizophrenics in developed nations recover

completely without taking anti-psychotic drugs). In fact, if you become ill in a developing nation where hardly anyone is treated with drugs, you are 10 times less likely to have any recurrence of the illness - a huge difference, also nothing to do with genes.

What it may have a lot to do with is the administration of drugs (see British psychologist Richard Bentall's book, Madness Explained). They have been shown to impede traumatised people from understanding their voices or visions and recovering from them. There is a close relationship between the drug companies and the psychiatric establishment. While it may not be the intention, the establishment explanation of the causes of and solutions to schizophrenia are crucial components in the process of selling drugs. If patients can be persuaded their illness is an unchangeable genetic destiny and that it is a physical problem requiring a physical solution, drug companies' profits will grow. An analysis in Acta Psychiatrica Scandinavica by New Zealand psychologist John Read shows those who buy this genetic fairytale are less likely to recover, and that parents who do so are less supportive of their offspring.

The huge importance to drug company profits of the bio-genetic refrain becomes apparent when you learn that most people do not hum along with it. Surveys find that the majority of people mention such environmental factors as trauma, stress and economic hardship as the commonest causes of schizophrenia. It may be seen that the drug companies have an uphill struggle to persuade them otherwise, for which they badly need the help of the psychiatric establishment's towrope. In Read's analysis, letting go of that rope will prevent it strangling the many schizophrenics whose illness has been caused by abuse. Genes may still emerge as a major cause of vulnerability to schizophrenia, as may problems during pregnancy. There is already no question that illicit hallucinogenic drugs are a major reason some vulnerable people become ill. But even if this is true, following Read's important work, it will be hard to ignore its implications…."

Bentall R.P. (2005) *Madness Explained: Psychosis & Human Nature*. Penguin paperback.

Read J, van Os J, Morrison AP & Ross CA (2005) Childhood trauma, psychosis and schizophrenia: A literature review with theoretical and clinical implications. *Acta Psychiatrica Scandinavica*, 112, 330-350.

- Given the evidence provided in Sections 6.5 and 6.6 how would you evaluate Oliver James' views?
- Is the role of genetic inheritance over-emphasised in the explanation and treatment of psychotic symptoms?
- Does the policy of long-term treatment with antipsychotic drugs prevent individuals "coming to terms" with their delusions and hallucinations as suggested by James?
- Are the symptoms that constitute schizophrenia an "unchangeable genetic destiny that requires a physical solution" such as drugs?

Remember to make your arguments objective and evidence-based. Support your arguments with facts from empirical studies that are described in Sections 7.5 and 7.6 or are taken from the additional reading material highlighted in those sections.

HOW MANY UNITS OF ALCOHOL DO YOU CONSUME IN A WEEK?

TYPE OF ACTIVITY:	***SELF-ADMINISTERED TEST (POSSIBLY INSTRUCTOR GUIDED)***
SUITABLE CLASS SIZE:	***INDIVIDUAL STUDENT, SMALL GROUP OR LARGE GROUPS***
SKILLS DEVELOPMENT:	***-***
LEARNING OBJECTIVE:	***HEIGHTENED AWARENESS OF ALCOHOL CONSUMPTION***
TIME REQUIRED:	***30 MINS***
SUPPORTING CHAPTER:	***CHAPTER 8 – SUBSTANCE ABUSE AND DEPENDENCE***

What is a unit of alcohol?

One unit of alcohol is 10 ml (1 cl) by volume, or 8 g by weight, of pure alcohol. For example:

- One unit of alcohol is about equal to:
  - Half a pint of ordinary strength beer, lager, or cider (3–4% alcohol by volume), or
  - A small pub measure (25 ml) of spirits (40% alcohol by volume), or
  - A standard pub measure (50 ml) of fortified wine such as sherry or port (20% alcohol by volume).
- There are one and a half units of alcohol in:
  - A small glass (125 ml) of ordinary strength wine (12% alcohol by volume), or
  - A standard pub measure (35 ml) of spirits (40% alcohol by volume).

A more accurate way of calculating units is as follows. The percentage alcohol by volume (%abv) of any drink equals the number of units in one litre of that drink. For example:

- Strong beer at 6% abv has six units in one litre. If you drink half a litre (500 ml) - just under a pint - then you have had three units.
- Wine at 12% abv has 12 units in one litre. If you drink a quarter of a litre (250 ml) - two small glasses, then you have had three units.

Check your weekly alcohol levels

Unless you're teetotal, you probably drink more than you think. The medically recommended units of alcohol per week are 14 for women and 21 for men. How do you compare? Take a minute to try this test. Enter the number of units you consume each day for a week. The chart will then tell you whether the number of units you have consumed in a week is above or below the recommended level.

	Beer	Wine	Spirits	Cocktails	Others
					
Monday					
Tuesday					
Wednesday					
Thursday					
Friday					
Saturday					
Sunday					
TOTAL					

WHAT'S YOUR BODY MASS INDEX (BMI)?

TYPE OF ACTIVITY:	***SELF-ADMINISTERED TEST (POSSIBLY INSTRUCTOR-GUIDED)***
SUITABLE CLASS SIZE:	***INIDIVIDUAL STUDENT, SMALL GROUP OR LARGE GROUP***
SKILLS DEVELOPMENT:	-
LEARNING OBJECTIVE:	***HEIGHTENED AWARENESS OF BODY MASS INDEX (BMI) IN RELATION TO DIAGNOSTIC NORMS***
TIME REQUIRED:	***30 MINS***
SUPPORTING CHAPTER:	***CHAPTER 9 – EATING DISORDERS***

A healthy weight range is based on a measurement known as the Body Mass Index (BMI), and you can calculate this if you know your weight and your height.

To calculate your BMI divide your weight (in kilograms) by the square of your height (in metres).

i.e., weight (in kilograms) / height (in metres)^2

- A BMI of 25 to 29.9 is considered overweight, and one of 30 or above is considered obese.

- People with BMIs between 19-22 live longest. Death rates are significantly higher for people with indices 25 and above.

- If your BMI is below 18.5, then you would normally be considered to be underweight.

- A BMI of less than 15, with rapid weight loss and medical complications is sometimes used as criteria for hospitalization in the case of anorexia nervosa.
- However, two people can have the same BMI, but a different percent body fat. A bodybuilder with a large muscle mass and a low percent body fat may have the same BMI as a person who has more body fat because BMI is calculated using weight and height only.
- Remember, BMI alone is not diagnostic. It is one of many risk factors for disease and death. As a person's BMI increases the risk for many diseases increases as well. It is important to talk with your doctor about other measures and risk factors. (e.g., waist circumference, smoking, physical activity level, and diet.)

When you have calculated your BMI, think about how this makes you feel. Are you dissatisfied with your weight even though your BMI may be within an acceptably normal range? What kinds of action do you think might be necessary if your BMI is in the overweight range?

CULTURAL DIFFERENCES IN SEXUAL EXPRESSION

TYPE OF ACTIVITY:	***GROUP DISCUSSION***
SUITABLE CLASS SIZE:	***SMALL GROUPS***
SKILLS DEVELOPMENT:	***CRITICAL THINKING AND PRESENTATION SKILLS***
LEARNING OBJECTIVE:	***UNDERSTANDING AND EVALUATING CULTURAL ISSUES IN THE DIAGNOSIS OF SEXUAL AND GENDER IDENTITY PROBLEMS***
TIME REQUIRED:	***APPROXIMATELY 1 HOUR***
SUPPORTING CHAPTER:	***CHAPTER 10 – SEXUAL AND GENDER IDENTITY PROBLEMS***

On March 15th 2006, CBS News wrote:

Dutch Immigrants Must Watch Racy Film

(AP)

"The camera focuses on two gay men kissing in a park. Later, a topless woman emerges from the sea and walks onto a crowded beach. For would-be immigrants to the Netherlands, this film is a test of their readiness to participate in the liberal Dutch culture.

If they can't stomach it, no need to apply.

Despite whether they find the film offensive, applicants must buy a copy and watch it if they hope to pass the Netherlands' new entrance examination.

The test, the first of its kind in the world, became compulsory Wednesday, and was made available at 138 Dutch embassies.

"As of today, immigrants wishing to settle in the Netherlands for, in particular, the purposes of marrying or forming a relationship will be required to take the civic integration examination abroad," the Immigration Ministry said in a statement.

Not everyone is happy with the new test.

Dutch theologian Karel Steenbrink criticized the 105-minute movie, saying it would be offensive to some Muslims.

"It is not a prudent way of welcoming people to the Netherlands," said Steenbrink, a professor at the University of Utrecht. "Minister Verdonk has radical ideas."

But Mohammed Sini, the chairman of Islam and Citizenship, a national Muslim organization, defended the film, saying that homosexuality is "a reality."

Sini urged all immigrants "to embrace modernity."

A censored version with no homosexual and nude material had been prepared because it is illegal to show such images in Iran and some other countries, filmmaker Walter Goverde said.

———

This news item provides a good example of the differences in sexual expression found in different societies, and the tensions that these differing views may generate. Whether a sexual behaviour is acceptable or not is certainly not just a matter of psychology - it is a determined by cultural or religious norms and the legal restrictions imposed in a particular society. You and your fellow students may wish to discuss some of the issues raised in this news story that relate to how sexual disorders might be defined and categorised. In particular:

- Could a universal set of diagnostic criteria for sexual and gender identity disorders be applied across different cultures?
- Will cultural norms affect how diagnostic criteria for sexual and gender identity disorders are defined?
- If a sexual activity is illegal in a country (e.g. homosexuality in Iran) does this also imply that individuals in that country who indulge in that activity require psychological treatment?
- Do cultural norms about sexual expression influence the kinds of sexual behaviours that are considered pathological?

APPLYING SEXUAL DYSFUNCTION DIAGNOSTIC CRITERIA

TYPE OF ACTIVITY:	***CLASS TEST (PREFERABLY INSTRUCTOR GUIDED)***
SUITABLE CLASS SIZE:	***SMALL GROUPS OR LARGE GROUP***
SKILLS DEVELOPMENT:	***DIAGNOSTIC SKILLS***
LEARNING OBJECTIVE:	***APPLYING SEXUAL DYSFUNCTION DIAGNOSTIC CRITERIA***
TIME REQUIRED:	***APPROXIMATELY 1 HOUR***
SUPPORTING CHAPTER:	***CHAPTER 10 – SEXUAL & GENDER IDENTITY PROBLEMS***

Below are listed a number of very brief case histories. After having read Section 10.2 of Chapter 10 read these brief descriptions and try to answer the following questions in each case:

(a) Would this case be diagnosable as a sexual dysfunction?
(b) If so, what is the precise disorder?
(c) What factors might have contributed to the disorder?

1. A frustrated and distressed man confides that every time he and his new wife attempt lovemaking she becomes hysterical and writhes in pain when he attempts vaginal penetration. They have successfully satisfied each other through other means, such as mutual masturbation, but he believes something is wrong or that he is doing something wrong.

2. A 36-year-old man seeks advice because over the last 6 months he has been experiencing the occasional inability to become erect. His relationship is satisfying, and he usually enjoys the sexual aspects of his life. However, the man is concerned that the situation may worsen.

3. A 26-year-old woman in a sexually exclusive relationship that has lasted for 1 year wants to know if she is normal because she does not always have orgasm but enjoys sex with her partner. Her friend told her that something may be wrong if she does not experience orgasm every time she has sex.

4. A 58-year-old woman wants to know why her partner, who is 10-years older than her, has lost his desire for sex. He is not always aroused like he used to be. Her partner enjoys sex but states that it just takes him longer to “get going”.

5. A 49-year-old woman is concerned that her partner of the same age no longer initiates sexual activity. Her partner has been experiencing irregular menses and low energy for the past year. Nothing seems to stimulate her partner as it used to. When the woman extends foreplay to give her partner more time to respond, she does not respond as before, and it is beginning to affect their relationship in that they do not communicate like they used to.

6. An 18-year-old man has sought advice on two occasions complaining of penile discharge. Both times the findings were negative for any infection, and he seems evasive about the nature of the discharge. It emerges that he has only recently had sex for the first time, and during that encounter he ejaculated almost immediately after vaginal penetration. His girlfriend asked him if "that was it?" He believes there is something wrong with him.

---

1 (a) Yes
(b) Sexual pain disorder such as dyspareunia or vaginismus
(c) physical causes such as allergic reactions; gynaecological diseases or infections of the vagina, bladder or uterus; conditioned fear responses to prior traumatic experiences, such as sexual assault.

2 (a) No, because the person's inability to become erect is not persistent and does not diminish sexual satisfaction
(b) -
(c) -

3 (a) No, because the woman experiences sexual satisfaction and orgasm at a frequency that is acceptable to her.
(b) -
(c) -

4 (a) No, because the partner is probably experiencing changes in sexual function that is a normal part of the ageing process
(b) -
(c) -

5 (a) Yes
(b) This could be diagnosable as hypoactive sexual desire disorder because the partner's lack of desire is beginning to significantly affect the relationship that the two have.
(c) Poor communication between the couple could be a cause of the problem rather than simply an outcome; changes in hormone levels in the partner as part of the ageing process could also contribute to increased lack of desire.

6 (a) Yes
(b) Premature ejaculation
(c) This could be caused by lack of sexual experience, over-responsiveness to tactile or other stimulation, and anxiety caused by sexual inexperience or lack of technique.

(adapted from http://www.engenderhealth.org)

PARAPHILIAS AND THE LAW

TYPE OF ACTIVITY:	***GROUP DISCUSSION***
SUITABLE CLASS SIZE:	***SMALL GROUPS***
SKILLS DEVELOPMENT:	***CRITICAL THINKING AND PRESENTATION SKILLS***
LEARNING OBJECTIVE:	***HEIGHTENED AWARENESS OF THE RELATIONSHIP BETWEEN PSYCHOLOGICAL DIAGNOSIS AND CRIMINAL ACTIVITY IN RELATION TO PARAPHILIAS***
TIME REQUIRED:	***APPROXIMATELY 1 HOUR***
SUPPORTING CHAPTER:	***CHAPTER 10 – SEXUAL AND GENDER IDENTITY PROBLEMS***

Some paraphilias become sexual offences when the individual acts on their sexual urges against nonconsenting people, and this is true of Exhibitionism, Voyeurism, Frotteurism, Pedophilia, and, under circumstances where a partner is not consenting, it also includes Sexual Sadism. In 2006, the UK Government sought consultation with a view to making it a criminal offence to download sexually violent pornography. This prompted a letter published in The Psychologist in May 2006, an extract of which is provided below:

> ”The government is considering making it a crime to download sexually violent pornography. This will extend the legislation on child pornography to adult material that is defined as the realistic depicting or acting of a scene that would, if acted out, cause grievous bodily harm. This would include a variety of bondage and masochistic scenes acted out by consenting enthusiasts ….. Simply viewing the material will now constitute a serious criminal offence. And anyone looking at bondage scenes where somebody is wearing a mask and might suffocate (if this scene were acted out ‘in reality’) must be prepared to defend themselves in court. The ‘evidence’ focuses on the effects of pornography on either children or disturbed offenders. We do not dispute that psychopaths may be kick-started into action by all manner of things, including pornography. But there is no evidence at all that those not already predisposed to such action will be similarly affected. The

> reason the government is concerned about sexually violent pornography is that atrocious crimes may be committed in the making of the material. But of course, this is already a crime, and rightly so. The government's aim here is to punish consumers, not perpetrators."

You might like to consider the issues raised by this debate. In particular:

- Are there grounds for considering downloading sexually violent pornography either a sexual offence or a psychopathology?
- If a behaviour is a sexual offence in law, should it also be considered a psychopathology?

Could being a "consumer" of internet pornography contribute to paraphilic behaviour?

THE PATHOLOGICAL CONSEQUENCES OF PERSONALITY DISORDERS

TYPE OF ACTIVITY:	***INSTRUCTOR-LED EXERCISE***
SUITABLE CLASS SIZE:	***INDIVIDUAL STUDENT, SMALL GROUP OR LARGE GROUP***
SKILLS DEVELOPMENT:	***TRANSFER OF LEARNING TO NEW MATERIAL***
LEARNING OBJECTIVE:	***UNDERSTANDING HOW PERSONALITY DISORDERS CAN AFFECT DAILY LIVING***
TIME REQUIRED:	***APPROXIMATELY 1 HOUR***
SUPPORTING CHAPTER:	***CHAPTER 11 – PERSONALITY DISORDERS***

First, read Focus Box 11.2 which describes one particular view of how patterns of behaviour relevant to personality disorders can have specific psychopathological outcomes. These outcomes may give rise to specific Axis I symptoms, such as anxiety and depression, or to life stressors (such as failed relationships, poor educational or occupational achievements) that prompt the individual with a personality disorder to seek treatment. After having read the various diagnostic characteristics of the main personality disorders in Section 11.1 of Chapter 11, see if you can fill in the specific personality disorders that may have the problematic behavioural styles and pathological outcomes listed below.

PERSONALITY DISORDERS	EXAMPLES OF PROBLEMATIC BEHAVIOURAL STYLE	PATHOLOGICAL CONSEQUENCE OF THE BEHAVIOURAL STYLE

Schizoid, avoidant, paranoid, antisocial, borderline, narcissistic, histrionic, dependent	Behaviour that avoids potential relationships (e.g. withdrawal) or that disrupts relationships (e.g. confrontational, self-oriented behaviour) ⇨	Relationship problems: Inability to form lasting relationships or turbulent or problematic relationships
Schizotypal, borderline, avoidant, dependent	Behaviours associated with fear of rejection, criticism and abandonment ⇨	Development of Axis I anxiety disorders
Borderline, dependent, avoidant	Behaviours associated with fear of rejection, criticism and abandonment ⇨	Development of comorbid Major Depression, self-harm, suicidal ideation
Antisocial, borderline	Impulsive behaviour; aggressive, angry reactions; behaviours aimed at remorseless short-term self-gain ⇨	Behaviour incurs risk of harm to self or others
Most personality disorders, particularly antisocial, borderline, avoidant	Avoidance of interaction with others; emotional lability; consistent failure to honour obligations (irresponsibility) ⇨	Behaviour causes impairment in occupational functioning and educational underachievement

*To be omitted in the table and provided as answers on a different page

THE PAIN ANXIETY SYMPTOMS SCALE

TYPE OF ACTIVITY:	***SELF-ADMINISTERED TEST***
SUITABLE CLASS SIZE:	***INDIVIDUAL STUDENT, SMALL GROUP OR LARGE GROUP***
SKILLS DEVELOPMENT:	***-***
LEARNING OBJECTIVE:	***HEIGHTENED AWARENESS OF THE ROLE OF PERCEIVING PAIN AS THREATENING IN THE EXPERIENCE OF PAIN***
TIME REQUIRED:	***30 MINS***
SUPPORTING CHAPTER:	***CHAPTER 12 – SOMATOFORM DISORDERS***

One theory of pain disorder is that some individuals learn to interpret pain in a threatening way, and this leads to avoiding situations that might cause pain (e.g. indulging in heavy, physical work) and hypervigilance to bodily sensations and pain which heighten the personal experience of pain. In order to measure the degree to which people 'fear' pain symptoms, Roefels, McCracken, Peters, Crombez et al. (2004) developed the Pain Anxiety Symptoms Scale (PASS). You might like to complete this questionnaire so that you can get some experience of the questions that relate to fear of pain. The higher your score on an individual sub-scale the more you are likely to view pain as threatening.

PASS

Individuals who experience pain develop different ways to respond to that pain. We would like to know what you do and what you think about when in pain. Please use the rating scale below to indicate how often you engage in each of the following thoughts or activities. Circle any number from 0 (NEVER) to 5 (ALWAYS) for each item.

		NEVER					ALWAYS
1.	**I think that if my pain gets too severe, it will never decrease**	**0**	**1**	**2**	**3**	**4**	**5**
2.	**When I feel pain I am afraid that something terrible will happen**	**0**	**1**	**2**	**3**	**4**	**5**
3.	**I go immediately to bed when I feel severe pain**	**0**	**1**	**2**	**3**	**4**	**5**
4.	**I begin trembling when engaged in activity that increases pain**	**0**	**1**	**2**	**3**	**4**	**5**

5.	**I can't think straight when I am in pain**	**0**	**1**	**2**	**3**	**4**	**5**
6.	**I will stop any activity as soon as I sense pain coming on**	**0**	**1**	**2**	**3**	**4**	**5**
7.	**Pain seems to cause my heart to pound or race**	**0**	**1**	**2**	**3**	**4**	**5**
8.	**As soon as pain comes on I take medication to reduce it**	**0**	**1**	**2**	**3**	**4**	**5**
9.	**When I feel pain I think that I may be seriously ill**	**0**	**1**	**2**	**3**	**4**	**5**
10.	**During painful episodes it is difficult for me to think of anything else besides the pain**	**0**	**1**	**2**	**3**	**4**	**5**
11.	**I avoid important activities when I hurt**	**0**	**1**	**2**	**3**	**4**	**5**
12.	**When I sense pain I feel dizzy or faint**	**0**	**1**	**2**	**3**	**4**	**5**
13.	**Pain sensations are terrifying**	**0**	**1**	**2**	**3**	**4**	**5**
14.	**When I hurt I think about the pain constantly**	**0**	**1**	**2**	**3**	**4**	**5**
15.	**Pain makes me nauseous (feel sick)**	**0**	**1**	**2**	**3**	**4**	**5**
16.	**When pain comes on strong I think I might become paralyzed or more disabled**	**0**	**1**	**2**	**3**	**4**	**5**
17.	**I find it hard to concentrate when I hurt**	**0**	**1**	**2**	**3**	**4**	**5**
18.	**I find it difficult to calm my body down after periods of pain**	**0**	**1**	**2**	**3**	**4**	**5**
19.	**I worry when I am in pain**	**0**	**1**	**2**	**3**	**4**	**5**
20.	**I try to avoid activities that cause pain**	**0**	**1**	**2**	**3**	**4**	**5**

There are 4 sub scales that measure (1) Avoidance of pain (by adding the scores for items 3+6+8+11+20), Fearful appraisal of pain (by adding the scores for items 1+2+9+13+16), (3) Cognitive Anxiety (by adding the scores for items 5+!0+14+17+19), and Physiological Anxiety (by adding the scores for items 4+7+12+15+18).

THE SYMPTOM VALIDITY TEST

TYPE OF ACTIVITY: ***PRACTICAL EXERCISE***
SUITABLE CLASS SIZE: ***STUDENTS IN PAIRS***
SKILLS DEVELOPMENT: ***-***
LEARNING OBJECTIVE: ***UNDERSTANDING HOW TO DETECT THE FAKING OF AMNESIA***
TIME REQUIRED: ***APPROXIMATELY 1 HOUR***
SUPPORTING CHAPTER: ***CHAPTER 13 – DISSOCIATIVE EXPERIENCES***

The Symptom Validity Test (SVT) is an instrument that can be used to determine whether an individual who claims they have no memory of a crime is faking these symptoms. The SVT consists of forced-choice questions about the crime that the defendant is asked to complete. Individuals who are faking amnesia perform on the SVT at *levels significantly below chance* (i.e. get significantly less than 50% correct). This is because individuals who attempt to feign no knowledge of a crime they have been involved in overcompensate by tending to choose the *wrong* answer.

Try this test with a friend. Ask them to read the paragraphs below written in bold italic *very carefully* – say you may ask them some questions about them later on (do not let them see the questions). Then ask them the following 20 questions about the crime, allowing them to chose between the two possible answers to each. If they are actively feigning ignorance they will probably score well below 50% correct! (see also Focus Point 13.1 in Chapter 13)

From this moment on you are involved in a petty crime. You will steal some money from an envelope. You are on the university campus and you go to the School of Life Sciences. You go into the café in corridor 1C2. There is no one else in the café. You close the door shut behind you, and notice that the walls have just been freshly painted in a bright yellow colour. You see the white cash till behind the bar. It is closed. You push the 'sale' key and the till opens. There are only coins in the till, but you see a large sealed brown envelope. You take the envelope out of the till and open it. Inside is £200 in ten pound notes. You take the money and put the envelope into the bin beside the water dispenser. At that moment the man working behind the café bar comes into the room. You ask for a cappuccino coffee, drink it very quickly but to avoid looking suspicious you sit down at a table and stay there reading a newspaper for 15 minutes before leaving.

You are suspected of stealing the money from the till. There are some other suspects and the police are aiming to find the real perpetrator. Under no circumstances do you want to confess to the crime!! Try to convince the police in an intelligent way that you have nothing to do with the crime, so that you will be considered innocent. Act as if you have never been in the café and that you have no knowledge of the theft. The police ask you a series of questions.

1. Was there a water dispenser in the café?:
   1) yes 2) no

2. What was the colour of the café walls?:
   1) bright blue 2) bright yellow

3. The café was in:
   1) The School of Life Sciences 2) The Business School

4. When the thief entered the café the cash till was:
   1) open 2) closed

5. The thief pressed which key to open the till?
   1) the 'Cash' key 2) the 'Sale' key

6. The cash that was stolen was in a:
   1) Brown envelope 2) White envelope

7. The cash till was:
   1) Brown 2) White

8. The till only contained:
   1) notes 2) coins

9. The thief took how much from the envelope?
   1) £50 2) £200

10. The stolen money was made up of:
    1) £20 notes 2) £10 notes

11. The suspected thief had what drink before they left?
    1) a cappuccino coffee 2) an espresso coffee

12. The person who worked behind the café bar was:
    1) a man 2) a woman

13. What did the thief do with the envelope that contained the money?
    1) put it back into the till after removing the money2) put it in the bin in the café

14. How long did the suspected thief remain in the café after stealing the money?
    1) 15 mins 2) 10 mins

15. On which corridor was the café?
    1) 2B4 2) 1C2

16. What was striking about the walls of the café
    1) they were covered in posters 2) they had just been freshly painted

17. The bin in the café was next to?
    1) a soft drinks dispenser 2) a water dispenser

18. The envelope in the cash till was
1) sealed 2) unsealed

19. The suspected thief drank their coffee
1) standing at the bar 2) sitting at a table

20. While drinking their coffee, the suspected thief;
1) read a magazine 2) read a newspaper

(After Jelicic, Merckelbach & van Bergen, 2004)

PROVIDING ADVICE AND HELP FOR CAREGIVERS

TYPE OF ACTIVITY:	***OUT-OF-CLASS EXERCISE***
SUITABLE CLASS SIZE:	***INDIVIDUAL STUDENT***
SKILLS DEVELOPMENT:	***-***
LEARNING OBJECTIVE:	***HEIGHTENED AWARENESS OF THE PROBLEMS FACED BY CARERS OF INDIVIDUALS WITH PHYSICAL OR MENTAL DISABILITIES***
TIME REQUIRED:	***UNLIMITED***
SUPPORTING CHAPTER:	***CHAPTER 14 – NEUROLOGICAL DISORDERS***

If you have a friend or relative who cares for someone with a physical or mental disability, you may like to ask them about their experiences as a caregiver. In particular ask them what practical and emotional problems they encounter caring on a day-by-day basis for a handicapped individual. For example:

- Do they have practical problems around the house (e.g. will the sufferer wander off if doors are left open)?
- Do they understand what support and relief they can get from local services?
- Are they able to look after their own physical and mental health (i.e. do they become depressed and disillusioned)?
- Do they get support and help from friends and family?

Once you have identified some issues that are important for this particular caregiver, you could try and find out (1) what advice national support groups give in the case of these particular issues, e.g. support groups such as the UK Alzheimer's Society (www.alzheimers.org.uk), the Parkinson's Disease Society (www.parkinsons.org.uk), or the brain injury association 'Headway' (www.headway.org.uk), and (2) see how carer intervention programmes have been designed to provide caregivers with a range of skills (e.g. how to modify the home environment to support the sufferer or training in skills to develop self-care behaviours by the sufferer) (see Gitlin, Hauck, Dennis & Winter, 2005; Pinkston, Linsk & Young, 1988).

ADHD AND FAMILY DYSFUNCTION

TYPE OF ACTIVITY:	***INSTRUCTOR-LED EXERCISE***
SUITABLE CLASS SIZE:	***INDIVIDUAL STUDENT, SMALL GROUPS OR LARGE GROUPS***
SKILLS DEVELOPMENT:	***CRITICAL THINKING***
LEARNING OBJECTIVE:	***UNDERSTANDING THE RELATIONSHIP BETWEEN ADHD AND FAMILY DYSFUNCTION***
TIME REQUIRED:	***APPROXIMATELY 1 HOUR***
SUPPORTING CHAPTER:	***CHAPTER 15 – CHILDHOOD PSYCHOLOGICAL PROBLEMS***

Having a child with ADHD is certain to be a challenging experience for parents and other family members. Parents may well suffer burnout in their attempts to control a hyperactive child, deal with the disruption that this can cause in peer and family relationships, and in dealing with the inevitable problems that will arise at school.

In an interesting study published in the *Journal of Attention Disorders*[1], Kaplan, Crawford, Fisher & Dewey (1998) began their study with the premise that having any child who is struggling at school (such as one with ADHD) is likely to create stress for the parents and detrimentally affect family functioning. However, in their study they wanted to find out whether having a child with ADHD posed additional problems above and beyond the stresses and problems encountered as a result of having a child who was struggling at school.

In their study they obtained information on family functioning from parents whose children were having difficulty at school for different reasons – specifically parents who had children with (1) ADHD, (2) a reading disorder, or (3) both ADHD and a reading disorder. They compared these with parents of children who had no disability.

Their survey asked parents to say how much they would endorse statements of the following kind (on a 4-point scale):

- There are lots of bad feelings in the family
- We don't get along well together
- We are not able to make decisions on how to solve problems

Parents endorsing these kinds of statements would be acknowledging high levels of dissatisfaction with how things are going in their family.

The results found that parents of children with ADHD reported significantly higher levels of dissatisfaction with family life than did parents of children with a primary reading disability. This suggests that problems in families with ADHD children are significantly greater than if the child simply has a basic schooling difficulty. Why do you think this might be? Use some of the evidence you've read about in this section to come to some view on this. For example are families with children diagnosed with ADHD more dysfunctional because:

- ADHD disrupts more aspects of family life than those related to learning and education?
- ADHD runs in families, so parents of such children may also be suffering from dysfunctions caused by ADHD?
- Having an individual with ADHD in the family disrupts effective communication between members, resulting in disagreements about how to solve problems?
- Parents of children with ADHD are less likely than parents of children with a learning disorder to accept that their children have a disorder at all (and thus seek effective help for the problem)?
- ADHD causes frustrations in the family because it is less easy to treat than, say, a reading disability?

Adapted from http://www.focusas.com/ADHD-FamilyLife.html

[1] Journal of Attention Disorders (1998), Vol 2(4), 209-216

AUTISM AND THE MMR VACCINE

TYPE OF ACTIVITY:	***GROUP DISCUSSION***
SUITABLE CLASS SIZE:	***SMALL GROUPS***
SKILLS DEVELOPMENT:	***CRITICAL THINKING AND PRESENTATION SKILLS***
LEARNING OBJECTIVE:	***UNDERSTANDING THE EVIDENCE FOR AND AGAINST A RELATIONSHIP BETWEEN THE MMR VACCINE AND AUTISM***
TIME REQUIRED:	***APPROXIMATELY 1 HOUR***
SUPPORTING CHAPTER:	***CHAPTER 16 – LEARNING, INTELLECTUAL AND DEVELOPMENTAL DISABILITIES***

"I have three children. The eldest, who is 15, did not have the MMR injection and is not autistic. The second two, who did have MMR are both autistic and showed no signs of the condition prior to immunisation"

This was a comment sent to a BBC web-site by a mother following a TV programme discussing claims that pervasive developmental disorders were associated with the measles, mumps and rubella (MMR) vaccine given to children during infancy. The claim that the MMR vaccine might be a cause of some forms of autism was first made by Wakefield, Murch & Anthony (1998). They proposed that the vaccine was linked to a new syndrome consisting of certain gastrointestinal conditions associated with marked regression in multiple areas of functioning after 2 years of age (e.g. Childhood Disintegrative Disorder, CDD). This claim caused a significant fall in the number of parents in the UK willing to have their children vaccinated with MMR, and resulted in an increase in incidence of mumps, measles and rubella infections.

Evidence *for* the link between MMR and autism: Wakefield et al. (1998) based their claim of an association between the MMR vaccine and autism on a study of 12 children with inflammatory bowel conditions and regressive developmental symptoms typical of autism. In 8 of the 12 cases, the children's parents suggested that the MMR vaccine might have contributed to the onset of the behavioural problems. We have already noted (pxx) that epidemiological studies suggest that the prevalence rate of autism has been increasing significantly over the last 10-15 years (Chakrabarti & Frombonne, 2005), and supporters of the link between MMR and autism suggest that the introduction of new "environmental risk factors", such as new vaccines, may be partly responsible for this increase.

Evidence *against* the link between MMR and autism: Wakefield et al. (1998) themselves admit that their study did not prove an association between MMR and the development of autistic symptoms, and the following factors are important in providing a balanced view of this issue:

- The sample that Wakefield et al. (1998) used to make the claim is very small and very selective (Payne & Mason, 1998), meaning that their findings are neither statistically significant nor generalisable to the population as a whole.

- It is not obvious what the mechanism might be that would link the MMR vaccine with the development of autistic symptoms. Wakefield et al. (1998) do attempt to relate their findings to the effect of the vaccine on intestinal disorders, and that some forms of intestinal disorders can lead to the incomplete breakdown of of peptides in the gut which have been shown to cause autistic-like symptoms (Panksepp, 1979).

- If there is a causal link between MMR and autism, then we would expect to find that more children who have been given the MMR vaccine would exhibit autistic symptoms than those who have not received the vaccine. However, numerous studies have indicated that children given MMR are no more likely to develop autistic symptoms than those who have not received the vaccine (DeStefano, Bhasin, Thompson, Yeargin-Allsopp et al., 2004; Farrington, Miller & Taylor, 2001).

- Finally, an interesting experiment to test the hypothesised link between MMR and autism would involve finding out what happens when we stop giving MMR injections – does the rate of autism go down, as we might predict if the MMR vaccine is the cause of recent rises in the prevalence of autism? Unfortunately, this is not an easy experiment to do! However, Honda, Shimizu & Rutter (2005) do report the results of what turns out to be a type of 'natural experiment' in Japan. Japan introduced the MMR vaccine for children in 1977 but then terminated the programme in April 1993. Honda et al. found that between 1988 and 1993 (during the time that the vaccine was being administered) the incidence of autistic spectrum disorder (ASD) increased. However, the statistics also show that the incidence of ASD continued to increase in children born even after the vaccine had been withdrawn. They conclude that MMR is unlikely to be the main cause of the increase in incidence of ASD in many counties, and that the withdrawal of MMR is unlikely to lead to a reduction in the incidence of ASD.

This issue is still far from resolved, although the weight of evidence is now more consistent with the fact that there is no causal link between the MMR vaccine and autism. ***You may want to discuss this evidence with your fellow students, and perhaps try to think up some further studies that might contribute to resolving this debate***.