

Four Example Outlines for the Written Comprehensive Exam

College of St. Joseph in Vermont

Rutland, Vermont

Compiled to Assist Students in Preparation for the

Written Comprehensive Exam

August, 2011

This guide is meant only to help stimulate ideas. The answers given for the written comp questions are those done by a selection of students. These are examples of what students put in their outlines as preparation for written comp exam.

The format for the guide is as follows:

1. The question is given with its number, and sub-number (like 2a, 2b).
2. Each question is then followed by each student's response, shown by a red student header.
3. The order of the student responses remains the same for all seven questions, that means that student 1 is the same student for all seven questions.

At this point the guide is not complete, but it contains enough information to be useful.

More student responses may be added in the future. The aim here was to select student responses that show a diversity of style and content in their approach to constructing an outline for the written comp exam.

Again, it needs to be restated that this document is not meant to provide the "right" answer. It is a document that is to be used to help stimulate ideas that can be used to improve your own personal outline.

Question 1:**Individual Differences/Ethical Practice**

- a) *Discuss the major variables (e.g. personal attributes, interpersonal skills, legal, cultural, organizational, etc.) that must be taken into consideration in order to engage in ethical, professional counseling services, with due regard for individual differences and maintaining the dignity of the client as well as the integrity of the counseling process.***

Student One:**Essential Information for 1.a.**

- APA code of ethics- general principles A,B,C,D,E. Page 2-3. Do no harm, practice only with competence, do not exploit, treat people with respect for their dignity as human beings, protect confidentiality, acting only with informed consent, promoting equality and justice.
- Personal Attributes-Theoretical framework from which we are working, humanist, Rogerian, client-centered therapy, and why we are doing it, awareness of our biases, prejudices, scope of knowledge, and commitment to best practice, adherence to standards of ethical codes. Above all to do right by the client. promote accuracy, honesty, and truthfulness, self-awareness, understand and awareness of biases, beliefs, goals, morals, values, proper self-care (awareness of the possible effects of own physical and mental health on the ability to help those that I work with and refrain from counseling if I know that my personal problems will prevent me from performing work-related activities in a competent manner. Take adequate steps when aware of problems such as professional consultation or assistance and determine if need to limit, suspend, or terminate work-related duties). We can be affected by past trauma/unresolved issues, disabilities, stereotypes, past experiences either personal or professional, professional knowledge, honesty in documentation, reporting, and all aspects of service, ability to document properly, ability to know when to consult with a supervisor or colleague, proper supervision while learning, ethical principles, commitment to code of ethics, compassion for clients, belief to do no harm, trust worthy, willingness to take responsibility for mistakes, actions, and take steps to correct them.
- Interpersonal Skills- Humanistic skills for me, Good listening skills, genuineness, assessment, reflection skills, conflict resolution skills, ability to manage conflicts of interest that could lead to exploitation and harm,
- Legal- informed consent, confidentiality, discuss the limits of confidentiality, safety of client and others, duty to warn, parental consent for minors, knowledge of the state and federal laws and agency policies and procedures, mandated reporting, the law is the minimum to do, but it doesn't always agree with ethics, can be legal and not ethical, and can be ethical but not legal, above all do right by the client, always meet ethical and legal code if you can.

- Cultural- religion, race, poverty, sexuality, biases, prejudices, stereotypes, cultural knowledge, responsibility to ask client to educate about beliefs, values, culture etc., research clients culture, and refer if unable to serve the client's best interests, e.g., counselor feels client is being resistant due to no eye contact, not following through, not talking, or being late or missing appointments, but in some cultures Asian, Native American, may adhere to different standards. Asian respectful to family, no eye contact, etc.. Native American time not important, not talking to those outside of the family, collectivism versus individualism.
- Organizational- Know and understand company policies, proper documentation, psychological assessment of client problems, ability to clarify professional roles and obligations, professional responsibilities to society and the community, work within consult with, refer to, or cooperate with other professionals and institutions to the extent needed to serve the best interests of those with whom we work, ethical compliance of colleagues and professional conduct (standard 1: Resolving Ethical Issues- 1.04-resolve issue by first bring to attention of that professional committing violation, then if not resolved and reported by them 1.05 report the violation, p. 3), work within boundaries of competence and maintain competence.

Additional Information for 1.b.

- Client wants to give a gift- organizational rules and policies, consult with supervisor or colleagues, depends on gift, organization and client. If a child in a school draws a picture for you, gives a cookie, etc..., may be acceptable, but in agency setting gifts are not usually accepted.

Client dependent for advice, asks personal info, self-disclosure humanist may disclose some info or stories pertinent to situation perhaps based on others' lives, e.g.- friends. Restate boundaries, consult with others, empower the client, beneficence, my job to empower client to trust their own decisions, document all, am I helping the client by sharing

Student Two:

Q1. Part A.

A. Introduction

1. Guidelines/assumptions assisting decision making between right/wrong.
 - a. Do no harm
2. Social responsibility to profession, clientele, community, and society at large.
3. Balance between law and ethics
 - a. State dilemma; make known commitment to code.
 - b. Follow law, but take all reasonable steps to ethically resolve conflict.
 - c. Safeguard welfare and rights of clients

4. Ethics is a higher standard than law
5. Transitional sentence: Variables

Student Three:

Q1. Part A

Theoretical Framework: Disabilities, biases, trauma/unresolved issues, cultural knowledge, past experiences, and professional knowledge. This goes for your clients as well.

Aspirational: autonomy, non-maleficence, beneficence, justice, fidelity, veracity

Personal Attributes: self awareness, beliefs "religious" , goals, morals, values, respect for other professionals.

Personal Attributes (part 2): Dress professionally, carry one's self professionally- clothes in place, hair clean and neat, no pig tails, long earrings etc. appropriate shoes stocking etc.

Interpersonal skills: good listening skills, doing what is right for the client and self, do no harm, show appropriate honesty.

Interpersonal Skills intrapersonal skills: Communication, listening, boundaries, cultural knowledge, conflict.

Legal: Confidentiality, Payment: bartering

Cultural: views on counseling, eye contact, rituals, 0 integration- slight integration.

Maintain dignity and integrity.

Agency Restrictions/Rules: Honesty in all aspects "code of ethics", Documentation, Ethical Principles, Stake holders, Fed and State laws > duty to protect mandated reporting.

Ethical and Professional: Things to consider in all practices: law, knowledge, conflict resolution skills, mandated reporting, respect for other professionals (interpersonal

skills), theoretical framework, commitment to best practice, solid knowledge and commitment to ethical code.

*Be concise: state conflicts between code and law, but follow law, protect client welfare.

1. Theoretical approach
2. Variables
3. Ethical applied approach

Canadian *model*- Ethical Code -*Model of decision making* ID whether or not you have an ethical issue. Reasons in the study. Cite ethical code as applied

(apa.org/ethic/code/index.aspx) Code retrieval

Student Four:

Q1. Part A

Question 1: Ethics

Q1. Part A.

B. Introduction

6. Guidelines/assumptions assisting decision making between right/wrong.
 - b. Do no harm
7. Social responsibility to profession, clientele, community, and society at large.
8. Balance between law and ethics
 - a. State dilemma; make known commitment to code.
 - b. Follow law when possible, taking all reasonable steps to ethically resolve conflict, but there are a small percentage of times where law may be “wrong” so following ethical standards is the best choice as it’s a higher standard.
 - c. Law is open to interpretation
 - d. Documentation is important as evidence of decision making process.
 - e. Psychology is not a black and white field.
 - f. Safeguard welfare and rights of clients
9. Ethics is a higher standard than law
10. Transitional sentence: Variables: Personal Attributes, Interpersonal Skills, Legal/Ethical Variables, Cultural Variables, Organizational, and Professional Competence.

C. Major Variables

1. Personal attributes

- a. Trust worthy
- b. Fairness
- c. Responsible
- d. Dependable
- e. Reliable
- f. Accurate/detail oriented
- g. Confidence
- h. Self-determination
- i. Honesty
- j. Truthful
- k. Non-judgmental/non-biased
- l. Respectful
- m. Self-awareness of biases/attitudes
- n. Adequate cultural and professional knowledge base
- o. Professional experiences
- p. Law awareness and adherence
- q. Cautious
- r. Positive regard
- s. Commitment to best practice
- t. Healthy sense of humor
- u. Tolerance for ambiguity
- v. Persistence
- w. Patience

2. Interpersonal Skills

- a. Consultation
- b. Collaboration
- c. Appreciation and respect of others' opinions/beliefs within the profession
- d. Objectivity
- e. Responding vs. Reactivity
- f. Clear and concise communication
- g. Non-judgmental expression-facial and verbal
- h. Problem-solving skills/conflict resolution skills
- i. Reframing/rephrase/paraphrase
- j. Supervision
- k. Listening

3. Legal/Ethical Variables

- a. Confidentiality
- b. HIPAA
- c. Boundary Maintenance
- d. Harm avoidance
- e. Conflicts of interest/multiple relationships
- f. Informed Consent
- g. Tarasoff
- h. Mandated Reporting
- i. Referrals and Fees appropriately
- j. Appropriate therapy termination
- k. Minimize privacy intrusions
- l. Knowledge and commitment to state and federal law
- m. Legal precedence; court cases
- n. Knowledge of and adherence to all ethical codes that may apply, depending upon the nature of work
- o. Court testimony issues

4. Cultural Variables

- a. Respect values and beliefs
- b. Professional understanding, education, and competence of components
- c. Diversity issues and challenges commonly faced
- d. Cultural norms
- e. Understand relevance in regard to assessment and therapy
- f. How social stigmatization pose risks
- g. How prejudicial and cultural values, and views affect client presentation
- h. Awareness of both client and professional cultural variables

5. Organizational

- a. Knowledge of and adherence to organizational policies and procedures
- b. Clarify nature of conflicts if occur
- c. Cooperation with ethical committees
- d. Reporting violations
- e. Law adherence
- f. Documentation
- g. Maintain good professional relationships and respect for other colleagues

6. Professional competence
 1. Diagnostic procedures
 2. Continuing education
 3. Membership to state and local organizations within profession

Question 1b:

Given a hypothetical case scenario, describe in detail the decision making process that you would utilize and the conclusions that you would reach in order to arrive at ethical, appropriate solutions to issues raised in the case. Support your position through reference to appropriate decision making models, ethical and legal codes of conduct, and other sources as appropriate.

Student One:

Essential Information for 1.b.

Utilize and refer to APA code of ethics.

Canadian Code of Ethics for Psychologists (Canadian Psychological Association, 2000)

1. Identification of the individuals and groups potentially affected by the decision.
2. Identification of ethically relevant issues and practices, including the interests, rights, and any relevant characteristics of the individuals and groups involved and of the system or circumstances in which the ethical problem arose.
3. Consideration of how personal biases, values, stresses or self-interest might influence the development of or choice between courses of action. (Can consult with colleague or supervisor at any point in the process- communication and problem solving with colleagues; changes in procedures and practices.)
4. Development of alternative courses of action.
5. Analysis of likely short-term, ongoing, and long-term risks and benefits of each course of action on the individual(s)/group(s) involved or likely to be affected (e.g., client, client's family or employees, employee institution, students, research participants, colleagues, the discipline, society, self).
6. Choice of course of action after conscientious application of existing principles, values, and standards.
7. Action, with a commitment to assume responsibility for the consequences of the action.
8. Evaluation of the results of the course of action.
9. Assumption of responsibility for consequences of action, including correction of negative consequences, if any, or re-engaging in decision-making process if the ethical issue is not resolved.

10. Appropriate action, as warranted and feasible, to prevent future occurrences of the dilemma (e.g., communication and problem solving with colleagues; changes in procedures and practices.

Additional Information for 1.b.

- Client wants to give a gift- organizational rules and policies, consult with supervisor or colleagues, depends on gift, organization and client. If a child in a school draws a picture for you, gives a cookie, etc..., may be acceptable, but in agency setting gifts are not usually accepted.
- Client dependent for advice, asks personal info, self-disclosure humanist may disclose some info or stories pertinent to situation perhaps based on others' lives, e.g.- friends. Restate boundaries, consult with others, empower the client, beneficence, my job to empower client to trust their own decisions, document all, am I helping the client by sharing.

Student Two:

Q1. Part B

Canadian Code (Decision Making Process) (Bersoff (2008))

1. Identification of the individuals and groups affected by the decision
2. Identification of the relevant issues and practices, including practices, interests, rights, and characteristics of the individuals/groups
3. Consideration of how personal biases, stresses or self interest may influence the choice of action.
4. Development of alternative courses of action
5. Analysis of likely short-term, ongoing, and long-term risks and benefits of each course of action likely to be affected
6. Choice course of action
7. Action with a commitment to assume responsibility for any consequences
8. Evaluation of results
9. Assumption of responsibility for consequences, including correction of negative consequences or rearranging in the decision making process
10. Appropriate action, as warranted and feasible, to prevent future occurrences of the dilemma.

Student Three:

Q1. Part B

Psychological Assessment: Assumptions: it can be measured-schema, can be tested, help send us in the right direction/Dx Tx plan, possibility of error, faking good or bad, validity, reliability, proper training, purpose or goal. Certain behaviors =/specific personalities. Never make diagnosis off of one assessment. Labels.

Functions: Behavioral issues, IQ, past history, personality(MMPI), background, medical history and issues, current issues, goal or purpose of assessment, diagnosis, achievement, aptitude, projective (TAT, Rawshak), treatment planning, investigate neurological implications, effects of test anxiety, visual and hearing imparity

Practical: refrain from administering tests that cause trauma for test takers, resist from giving a number; give a range.

Theoretical issues: Validity, Are questions relevant,

Clinical issues: Misuse of a test,

Testing: environment- seating, distraction, accessible, air conditioning/ heat, hearing, roomy, test complete/ ready, test early in the day, take child's needs into consideration, give breaks, As a tester be well rested, fed, prepared with everything laid out, show confidence.

Test subject: culture/ bias, male/ female, (Theoretical, clinical, ethical issues) rapport,

In session: Non-judgmental, bias on your part?

Legal: You report the test subject is faking- possibility of lawsuit.

Ethical: respect privacy, right to refuse, stop at any time, confidentiality,

Interpretation: just facts, background/ history, observations, quoting,

MMPI for adults:

Student Four:

Q1. Part B

ETHICAL PRACTICE –B

1. Decision Making

a. Types

- i. Canadian Code (Canadian Psychological Association, 1991)
- ii. Ethics in Psych (Thomas, Koocher, and Keith-Spiegel, 1998)

b. Steps for Canadian Code (steps re-arranged)

- i. Identify issue
 - 1. Review relevant APA code
 - 2. Consult with colleague
- ii. Develop actions
- iii. Analyze
 - 1. Short-term consequences
 - 2. Long-term consequences
 - 3. Benefits on those involved
- iv. Make choice
- v. Take action
- vi. Evaluate results
- vii. Assume responsibility

Question 2:**Assessment**

- a) *Discuss the assumptions and functions of psychological assessment. Include in your discussion the theoretical, clinical, and practical issues involved in the interpretation of psychological evaluative procedures as well as social, ethical, and legal consequences of testing.*

Student One:**Essential Information for 2.a.**

- We must be knowledgeable, qualified, trained, and competent.
- **Assumptions of psychological assessment-** what you are assessing can be measured or tested. (e.g.- IQ tests can test intelligence.)
- A diagnosis can be made to formulate a treatment plan.
- Every test score will always reflect some degree of measurement error.
- Faking good or bad.
- Tests have reliability. In psych testing reliability refers to the attribute of consistency of measurement. Behavioral measurements are perfectly reliable. Some degree of inconsistency is almost always present from one measurement to the next.
- Tests have validity. Validity of a test is the degree to which it measures what it claims to measure. A test is valid to the extent that inferences made from it are appropriate, meaningful, and useful. Reliability is a necessary but a sufficient precursor to validity. Content validity-degree to which questions, tasks, items on test are representative of the universe of behavior the test was designed to sample. (e.g.- spelling ability easy, but specifying traits for anxiety harder.) Tests has face validity if looks valid to test users, examiners, and examinees. Important for social acceptability but irrelevant for psychometric purposes. Criterion-Related Validity-demonstrated when a test is effective in predicting performance on appropriate outcome measures. Construct Validity- a construct is a theoretical, intangible quality or trait in which individuals differ. Construct validity pertains to psych tests that claim to measure complex, multifaceted, and theory-bound psych attributes like leadership ability, overcontrolled hostility, and intelligence.
- For tests that require examiner judgment interscorer reliability is needed.
- Most tests have norms or standards by which results can be used to predict other more important behaviors.

- Tests are not ends in themselves. Ultimate purpose of test is to predict additional behaviors, other than those directly sampled by the test.
- Empiricism vs rationalism
- Rooted in logical positivism
- An external reality exists and behavior can be observed and can be used to categorize people.
- **Functions of psychological assessment-** need to consider past history, personality, behavioral issues, IQ, medical history and issues, current issues.
- The most common use is to make decisions about persons. (e.g.-educational institutions use tests to determine placement levels for students, universities use to ascertain who should be admitted, in part on basis of test scores. State, federal, and local civil service systems also rely heavily on tests for purposes of personnel selection.)
- Five uses of tests to include: (can overlap and on occasion are difficult to distinguish, e.g.-test to help determine psychiatric diagnosis might also provide a form of self-knowledge.)
- 1. Classification- variety of procedures that share a common purpose: assigning a person to one category rather than another. (e.g.- grant or restrict access to a specific college, hired for a particular job.) Many variant forms of classification such as Placement-sorting of people into different programs appropriate to their needs or skills. (e.g.-college use math placement test to determine which math class to take. Screening-quick and simple tests or procedures to identify persons who might have special characteristics or needs. (e.g.- 10 minute paper and pencil test to school kids to determine those who might take more comprehensive tests. Can result in misclassification so follow up tests with other instruments are required.) Certification-and selection have a pass/fail quality. (e.g.- right to drive a car or practice psychology.) Person has a minimum proficiency in some discipline or activity.
- 2. Diagnosis and Treatment Planning- with diagnosis to determine the source and nature of one's behavior and classify behavior in a diagnostic system. Diagnosis usually precursor to remediation or treatment of personal distress or impaired performance. (e.g.- intelligence tests essential to diagnose mental retardation. Personality tests helpful to diagnose nature and extent of emotional disturbance. MMPI designed for the purpose of increasing the efficiency of psychiatric diagnosis.) Proper diagnosis conveys info about strengths, weaknesses, etiology, and best choices for remediation/treatment. (e.g.-child diagnosis or Id is useful, but also knowing below average in reading comp, very distractible, and needs help with basic phonics can provide basis for treatment.)
- 3. Self-Knowledge- Feedback from psych tests can change a career path or later a person's life course.
- 4. Program Evaluation- evaluation of educational and social programs. (e.g.- head start is a social program designed to provide services that improve social conditions and community life. Provides educational enrichment and health services to at-risk

preschool children. Congress wanted to know if program was helping, worth the money, and if it improved scholastic performance and reduced school failure among enrollees. Centers vary so much so hard to ascertain. Psych tests provide an objective basis for answer these questions. Head Start kids show immediate gains in IQ, school readiness, and academic achievement, but the gains dissipate in ensuing years.)

- 5. Research- applied and theoretical branches of behavioral research. (e.g.- applied research- neuropsychologist to investigate hypothesis that low-level lead absorption causes behavioral deficits in kids. Tests normal and lead-burdened kids with psych tests.) (Theoretical research- e.g.- analyze perceptual field dependence. May have no immediate or obvious practical applications.)
- Used to help form a diagnosis.
- Devise a treatment plan and point in the right direction.
- To help formulate goals and for placement purposes.
- IEP, referral, court system, achievement, aptitude, job evaluations, projective tests like TAT and Rorschach. Personality-MMPI-2.
- To assess for diagnostic purposes, neuropsych function, Bender-Gestalt, Myers-Briggs, employment, state licensure, forensics, research, academic
- **Theoretical Issues-** on interpretation there can be test bias, test can be skewed, computerized results, construct validity-does the test, test what it was designed to test and does it have validity, validity and reliability of instrument being used.
- **Clinical Issues-** Misuse of a test (wrong test or using it for the wrong purpose), report-understanding the outcome. Can test what's normal and abnormal-cultural issues. Using standardized conditions and procedures for administration and scoring that are outlined in the publisher's test manual. Specifications regarding instructions to test taker, time limits, form of item presentation or response, and test materials or equipment should be strictly observes. Exceptions made only on the basis of carefully considered professional judgment, primarily in clinical applications. Clinical experience, responsible report writing, communication of test results,
- **Practical Issues-** Different races (cultural groups can vary in cultural values, language and nuances in language style or lingo, view of life and death, roles of family members, problem-solving strategies, attitudes towards education, mental health and mental illness, stage of acculturation-group may follow traditional values accept dominant group values, or be at a point between the two. Must understand how particular behaviors make sense in each culture., validity, test environment to include proper lighting, free from noise disturbances and distraction or interruptions, comfort, hot or cold, accommodations for disabilities, medications they are taking, Tester- departing from test instructions, consistency in testing, interpreting results, knowledge and training on how to give the test and interpret the test, establish rapport, self-care, breaks, not fumbling, relaxed, confident, not influencing responses (are you sure, negative expressions). Autism-sensory to light issues, hearing or visual problems- have glasses with them, or hearing aids. Also must recognize speech or motor control disabilities. Can be branded as intellectually

- or emotionally impaired. Testing is time consuming, expensive, effects of test anxiety, equipment, accommodations, considering individual differences- know when a test is not applicable because of factors such as age, gender, race, ethnicity, national origin, religion, sexual orientation, disability, language, socioeconomic status.
- **Social Consequences of testing-** stigma, labels, job determination, child placements in custody disputes, learning disability to get proper accommodations, disability status for SSI, need to balance the risk of the label versus the benefit of getting the needed help or accommodations, college admissions, driver's license, security clearance, personality function, brain dysfunction, marital compatibility, competency to manage financial affairs.
 - **Ethical Consequences of testing-** tests designed for white students, validity training, report the facts without imparting judgment, tests could harm clients or test results, results only for intended use, use correct test, respect rights and dignity-in APA code, informed consent, privacy, right to refuse test or stop at any time, parental consent, no disclosure of results to outside parties unless written and signed consent to release or mandated by law. Provided within the context of a professional relationship. What is in the best interest of the client? Allowing client to attach a surplus meaning to test results would not be in the best interest of client and are unethical testing practices such as with worry-prone or self-doubting clients.
 - **Legal Consequences of testing-** funding, jail, disability insurance, custody court, competent to stand trial, duty to warn, communicate serious threats to victim, law enforcement, or both. Legal informed consent-disclosure, competency, voluntariness. Parental consent. School services, employment testing must know the legal guidelines. Go to page 578-579.

Q2. Student two:

Part A

A. Introduction

- a. **Definition:** Whole process of gathering information about a person, and using it to make inferences of behavior prediction and referral or further testing needs.
- b. **Environment Conducive ie. Seating, distractions, accessibility, comfortable air temperature, and consider client needs.**
- c. **Good practice to use multiple methods of assessment for diagnosis determination**
- d. **Transition: Assessment includes important variables such as assumptions, functions, theoretical issues, clinical issues, social consequences, ethical/practical consequences, and legal consequences which are important to understand and have a basic knowledge of for all professional whom may be working with assessments in any manner.**

B. Assumptions

- a. Standardization ie. Uniform procedures despite examiner or setting; examiner demeanor unless indicated.
- b. Behavior prediction; inferences about domain of relevant behaviors
- c. Norms -population sample representation
- d. Reliability
- e. Validity
- f. Theoretical basis; follows theoretical assumptions
- g. Practical considerations
- h. Diversified
- i. Ability to be altered due to disabilities or needs
- j. Measurement of error to degree
- k. Give direction to proceed further
- l. Construct can be tested
- m. Test is used how designed.
- n. Used within parameters
- o. IQ can be measured

C. Functions

- a. Aid in decision making and problem solving about clients
- b. Answer relevant questions about client
- c. Obtain data or information
- d. Evaluate and identify problematic areas of personal functioning and behavior.
- e. Generate a hypothesis/ making predictions; diagnosis
- f. Provide data that is accurate and dependable
- g. Classification

D. Theoretical Issues

1. Construct validity

- a. Constructs are independent variables, but are behavioral influences which can be predicted.
- b. Data measuring what's it's intended to
- c. Test item correspondence
- d. Construct description
- e. Internal consistency/Test Homogeneity

2. **Convergent validity-** Correlation between different test measuring same constructs.
 3. **Three categories:** 1)Psychological, 2)Intellectual, and 3)Vocational
- E. Clinical Issues**
- a. **Competence to administer and interpret; qualified**
 - b. **Consultation**
 - c. **Understanding of research and norms**
 - d. **Extraneous variable minimization**
 - e. **Testing strengths and limitations**
 - f. **Test familiarity**
 - g. **Disability sensitivity and adaptation**
 - h. **Client interest and welfare consideration**
 - i. **Safeguard confidentiality**
 - j. **Effective rapport**
 - k. **Test History**
 - l. **Data interpretation**
 - m. **Understand how to use information**
- F. Social Consequences**
- a. **Risk of useless information provision**
 - b. **Needless testing**
 - c. **Discovery of unwarranted test evaluation**
 - d. **Hidden agendas**
 - e. **Counter-transference**
 - f. **Inaccurate diagnosis and referral**
 - g. **Out dated results, or test relevance**
- G. Ethical/Practical Consequences**
- a. **Test use in inappropriate contexts**
 - b. **Privacy invasion**
 - c. **Cultural biases**
 - d. **Test use despite inadequate validity**
 - e. **Examiner influence on subject performance**
 - f. **Inappropriate evaluation of client motivation and anxiety**
 - g. **Informed Consent**
 - h. **Data accuracy**
 - i. **Right test for right problem(s)**
- H. Legal Consequences**

- a. Court ordered evaluations and testing
- b. Influences on legal decisions
- c. Broken confidentiality
- d. Results may sway outcome of restrictions
- e. Inmate classification
- f. Tarasoff
- g. Mandated Reporting

Q2. Student three:

Part A and B (mixed)

Psychological Assessment: Assumptions: it can be measured-schema, can be tested, help send us in the right direction/Dx Tx plan, possibility of error, faking good or bad, validity, reliability, proper training, purpose or goal. Certain behaviors =/specific personalities. Never make diagnosis off of one assessment. Labels.

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Testing: environment- seating, distraction, accessible, air conditioning/ heat, hearing, roomy, test complete/ ready, test early in the day, take child's needs into consideration, give breaks, As a tester be well rested, fed, prepared with everything laid out, show confidence.

Test subject: culture/ bias, male/ female, (Theoretical, clinical, ethical issues) rapport,

In session: Non-judgmental, bias on your part?

Legal: You report the test subject is faking- possibility of lawsuit.

Ethical: respect privacy, right to refuse, stop at any time, confidentiality,

Interpretation: just facts, background/ history, observations, quoting,

MMPI for adults:

Q2a. **Student four:**

No Answer.

Question 2:

- b) Choose an assessment instrument and justify its use by discussing the underlying assumptions about the nature of human beings which entered into the development of the instrument, and by discussing the strengths and limitations which are implied by those assumptions.*

Student One:

Essential Information for 2.b.

- Minnesota Multiphasic Personality Inventory-Adolescent (MMPI-A)

- A self-report inventory that was primarily designed to aid in the clinical diagnosis of general psychopathology in adolescents.
- Construct being measured is psychopathology. Test trying to determine whether or not psychopathology exists and if it can be measured for the person taking the test.
- Two major functions: 1) provides the ability to objectively evaluate and describe the person's level of functioning in relation to selected standardized dimensions of psychopathology. 2) the repeated administration of the MMPI-A can provide the clinician with a way of assessing changes in psychopathology across time.
- The authors of the MMPI-A have many books that discuss the test. Included are different adolescent developmental theories.
- They include physiological/sexual maturation as described by Kimmel and Weiner.
- They discuss cognitive maturation as described by Piaget.
- Psychological development is discussed in terms of Erickson's theory.
- The Storm and Stress model was discussed as well as Anna Freud's theories on adolescents.
- The authors of the MMPI-A are basically making the **assumption** that psychopathology looks the same for all adolescents and that it can be measured by their test.
- Also believe that the MMPI-A can be utilized in the treatment process as the individual can be re-tested to determine the severity of symptoms and the effectiveness of treatment.
- **The strengths which are implied by those assumptions** are it can assess a number of the major patterns of personality and emotional disorders.
- Appropriate for evaluating adolescents who are experiencing or suspected of experiencing some form or type of psychopathology.
- Provides the ability to objectively evaluate and describe the person's level of functioning in relation to selected standardized dimensions of psychopathology. The repeated administration of the MMPI-A can provide the clinician with a way of assessing changes in psychopathology across time.
- Used most extensively among psychiatric inpatients and outpatients as screening instrument for a wide range of mental disorders.
- Used as a measure of clinical prediction and prognosis and to provide guidelines for treatment planning.
- Medical or neurological, forensic, and vocational applications are well established for this instrument.
- Test very suitable to use when an assessment of the accuracy or honesty of the adolescent's self-report is questionable and is an important part of the evaluation due to the built in basic and supplementary validity scales within the tests have been empirically shown to be successful in identifying a variety of willful or self-deceptive distortions and manipulations.

- **Limitations which are implied by those assumptions** are that the norm sample for this test which included a majority of white adolescent's with highly educated parents is sufficient. This might not be representative of many ethnic populations. The test could be utilized improperly for some cultures and ethnicities.
- Test must be carefully administered by highly trained professionals. Altering how a standardized test is administered can affect the results significantly.
- When reporting results clinicians must address testing circumstances that can affect the reliability and validity of the results.
- Clinical scales have retained the labels given in original MMPI such as Hysteria and Psychopathic Deviate.
- Some interpretive problems among the clinical scales especially with the Masculinity-Femininity scale. The interpretation of this scale can be widely misused and has no purpose for diagnosing psychopathology.
- It can very difficult to interpret the MMPI-A findings. Tests should not be used in isolation especially in regards to suicide.
- MMPI-A often used to assess global and symptomatic outcomes of treatment and the amount of time it takes to administer the test can be a disadvantage.
- Tests may lack the sensitivity to change that would be necessary to closely track the response to specific treatments and interventions.
- This test requires a licensed professional to administer the test and to accurately look at other sources of info before making a determination.
- Psychopathology may look different for differing cultures and if utilized alone this test may label an adolescent with a disorder that can follow them for the rest of their life. It may affect school placements, future jobs, etc. This test is being used in many different countries and cultural differences could make the data from the norm group ineffective or biased.
- Best used in conjunction with data from other psychometric tests, psychosocial assessment results, and a clinical evaluation to interpret the findings.
- Adolescent psychopathology looks very different than adult issues due to growth and development. Due to the complexities of adolescent development it's important for professionals that use MMPI-A to be well versed in adolescent development. This is stressed by Robert P. Archer who is one of developers of the test manual. Must understand adolescent stages and development.
- Interpreting the test requires a high level of psychometric, developmental, clinical, and personological sophistication.
- Administrator must have strong commitment to ethical principles of test usage.
- Strong background in test theory. Knowledge of the role of norms and their evaluation, selection, and application.

- Know how test responses can be summarized using various standard scores, and transformations, corrections, and configurations.
- Know about limits of the accuracy of scores, standard errors of measurement, effects of base rates on the accuracy of decisions and classifications in regard to applying test results to certain assessment questions.
- Must understand adolescent development, psychopathology, and personality structure.
- Hypothesis must be integrated with detailed knowledge of the adolescent's background and characteristics.

Q2. Student two:

Part B

A. Thematic Apprehension Test (TAT)

1. Assumptions of Human beings

- a. Unconscious expression of needs
- b. Individuals will project onto their images, expressing unconscious needs that he or she is ordinarily unable or unwilling to report
- c. Provide insight to person's personality
- d. Internal representations
- e. Individuals' thoughts, attitudes, observational capacity, and emotional responses can all be evaluated effectively.
- f. It's possible to make accurate predictions of future behavior.
- g. People can project expectations, world views, motives, beliefs, attitudes, and personality attributes through story construction.
- h. Internal object representations aid in the construction of story characters.
- i. Denial, projection, and identification can be indicated through language and written expression to indicate possible issues a person may be struggling with.

2. STRENGTHS of TAT

1. NO right or wrong answers, but is merely a projection of the person's inner self.
2. Valid results shown if used appropriately; TAT has high predictive, construct, and criterion validity.
3. Average reliability coefficients were .85 or higher (Marnat, 2003).

4. Widely used test in the field of psychology worldwide.
5. Clinician is able to have the freedom to select which cards to use, according to theme.
6. Standard Error of Measurement equaled 1.00 for the TAT, indicating no significant measurements of error produced.
7. Validity Coefficients ranged from .66-.78 from previous research from Marnat (2003).

3. **LIMITATIONS OF TAT**

1. It is difficult to establish test-retest reliability and internal consistency reliability.
2. Standardization due to test's projective nature, subjects asked to be creative with expression, and subject free to move around at will.
3. Subject mood at administration may confound results.
4. Relying on TAT results either alone or heavily...critics.
5. Extent of examiner training to avoid misdiagnosis.

Q2. **Student four:**

No answer

Question 3a:

Human Development and Learning

Describe your theory of normal human development. Explain what is meant by a "developmental model of counseling." Integrate into your answer specific developmental theories, and explain how culture affects theoretical formulations.

Student One:

Essential Info for 3.A.

Ontology

- More than objective material or what can be seen and touched.
- Level of reality that exists beyond the senses called subjective spiritual.

- People have a body, mind, and soul.
- These 3 parts of our being are interconnected.
- Our being composed of material and immaterial.
- Psychosocial interactionism-strong mind-body relationships and the 2 interact. At times the mind affects the body and sometimes the body affects the mind. Mind-body relationship has a cyclical effect, 2 separate things but do interact.
- Mind is immaterial and exists separately from the body, which is material. Mind is a medium between the physical body (including brain) and the soul. Mind is immaterial and can't be measured. Can't see my feelings, only I know when I feel hurt.
- Our realities will vary based on different life experiences. Reality can be shared, but perceptions of that reality may differ because of the feelings attached to the reality.
- Relationship goes further to include the soul, which would be a pluralistic view.
- We have a conscious and subconscious mind.
- Conscious mind is what we are thinking, doing, feeling in the present.
- Access to the subconscious through counseling or a process of soul searching (coming to an awareness of how one thinks, feels, and why we think that way).
- Subconscious is valuable to protect the conscious mind from info or experiences that are too traumatic or painful to recall at the present time.
- To be human means we were created by one creator God.
- Born with certain a priori knowledge. God created humans with certain genetics needed to ensure continued survival of species.
- Other factors influence the life humans will lead and characteristics of the personality.

Cosmology

- Belief in the biblical origin of creation.
- One creator God, yet because of differing beliefs humans have different descriptions of reality.
- People interpret those beliefs differently which is why we have so many religions.
-
- Objective reality-“the external world of physical objects, events, and forces that can be observed, measured, and tested” (2007, APA Dictionary of Psychology). Many can agree about certain aspects of objective reality, e.g.- water fall from sky, it is raining.
- Subjective reality- e.g.-two people argue, blame each other for something that happened. Perceptions differ based on learned values, thoughts, ideas, and behaviors, and past experiences.
- Objective and subjective reality both exist and coexist.

Epistemology

- Come to know, gain knowledge, and understand and believe through 1) contextual knowing-from our family and/or caregivers, society, school, churches, media, friends, etc...
- Learn also through experience- e.g.-family violence and anger, but can be changed through a process of deep understanding of past and self-awareness of self.
- When born have a priori knowledge in regards to basic human necessities. E.g.-babies born with reflexes, express discomfort, react to pain and loud noises, and turn face towards mom. These are genetic or survival skills, but need parent to meet these needs. Innate needs in place before birth.
- As child grows, learns, and is influenced by family, school, society, culture, etc.. Then a posteriori knowledge comes into play due to experiences.
- Learned behaviors first from family or caregiver.
- Different due to different styles of parenting- e.g.-cycle of abuse.
- Rationalism-people use reasoning or a process of self-discovery to understand certain aspects of the past and uncover why need to change some aspects of their behavior.
- Variety of ways that we come to know.
- As we grow and evolve we often change our perspectives.
- Must understand the past to understand ourselves and to be able to move forward.

Theory of Normal Human Development

- Majority of people born neutral or blank slate.
- Nature/Nurture, biological basis and environment/ can have a genetic predisposition to alcoholism but if have caring, loving environment where nobody drinks and not huge amounts of stress, may never become an alcoholic.
- Love, acceptance, reassurance, encouragement, self-esteem.
- Trauma and early life experiences can affect normal development, but up through high school experiences, learned behavior, modeling of behavior. Drug/alcohol abuse, accidents, etc.. can affect normal human development.
- Factors that help a person develop “normally” so they can function in the world- meeting basic needs, (Maslow)having trusting and meaningful relationships, ability to cope appropriately with stress, multiple roles (spouse, parent, worker, community member, etc.), striving for self-improvement or self-awareness.
- Development as a biopsychosocial task to include; biological system, psychological system, and societal system.
- Erickson’s psychosocial theory
- Biological system-processes necessary for physical functioning of the organism and for mental activity. (genetics, skeletal, sensory, motor, respiratory, endocrine, circulatory, waste elimination, sexual-reproductive, digestive ad

CNS) Systems change over time. Biological changes due to genetically guided maturation processes, and result of interaction with physical and social environment. Cultures differ in their support of physical health and growth. (availability of nutrition, treatment of illness, exposure to toxins, hazardous conditions)

- Biological system change factors to include genetically guided maturation, environmental toxins, environmental resources (nutrition, sunlight), accidents and diseases, and lifestyle(eat, sleep, exercise, drugs)
- Psychological system-those mental processes central to ability to make meaning of experiences and take action, emotion, memory, perception, problem solving, language, learning, critical thinking, reasoning, self-awareness, symbolic abilities.
- Psychological system change factors-life experiences including education, genetically guided maturation, self-direction and insight.
- Societal system-processes that foster or disrupt a person's sense of social integration and social identity. Social roles, culture-rituals, myths, and social expectations, media, leadership styles, communication patterns, family organization, ethic and subcultural influences, political and religious ideologies, patterns of economic prosperity or poverty, war or peace, exposure to racism, sexism, other forms of discrimination, intolerance, or intergroup hostility. Resulting from interpersonal relationships often with significant others.
- Societal system change factors-move from one culture to another, entry into new roles, age-graded expectations, historical events, technological change.
- Psychosocial approach seeks to understand the internal experiences that are product of interactions among biological, psychological, and societal processes.
- Changes in 1 of systems usually brings change in the others.
- Development results from the continuous interaction of person and social environment.
- At each period of life people try to master new psychological tasks.
- Each life stage brings a normative crisis- tension between competencies and new demands of society.
- Reduce tension by using known coping strategies and learn new ones.
- Positive resolution- new abilities and new understanding of self and others and allows to adapt in future stages with success.
- Negative resolution-may result in defensiveness, rigidity, withdrawal, and decrease ability to adapt to future stages successfully.
- Growth occurs at every period of life, conception to old age.
- People's lives show continuity and change over time.
- Need to understand the whole person.
- Each person's behavior must be analyzed in context of relevant settings and personal relationships.

- People contribute actively to own development.
- Freud's psychosexual theory-importance of childhood experiences, but I consider even into adolescence very important. Unconscious- some is accessible and unconscious used to protect us from traumatic experiences, accidents, abuse, death. Defense mechanisms may be used to protect us such as repression of memories, denial.
- Piaget-Cognitive development theory-strive to achieve equilibrium.
- Achieve this through adaptation
- Vgotsky-cognitive development theory-development understood within a social-historical framework.
- Boundaries between person and environment are less clear than other theories.
- Role of social interaction and culture to shape cognitions.
- Mental structures and functions of people raised in different cultures will be different.
- Reasoning and problem solving varies per cultures.
- Role of language and cultural tools as new generations to ancestors.
- Guidance of peers and adults to discover cultural knowledge base.
- Can promote own cognitive development by seeking interactions with others who can help draw them to higher levels of functioning with their zone of proximal development. (How learning and development converge. Distance between developmental level as determined through problem solving and level of potential development as determined through problem solving under guidance of adults or with more capable peers.)
- Cultural theory-individualism and collectivism
- Morality and empathy from proper modeling and from being shown love, compassion, empathy. Not as Kohlberg lists the stages because this view is too narrow for me. Different children based on personality, sensitivity level should be taught differently.
- Bowlby theory of attachment-system emerges as parents and caregivers provide protection from danger and stress and let infant learn skills needed to function independently.
- **Developmental Model of Counseling**
- Need to meet people where they are developmentally, not just based on age. Also based on emotionally. May be delayed due to trauma, substance abuse, or other mitigating factors.
- What level are at and where should be based on age.
- My theory to allow the client to take the therapy in their direction, they guide where to start and where need to go.
-

How Culture Affects Theoretical Formulations

- Physical culture-objects, technologies, structures, tools, and other artifacts of a culture. (computers, cell phones, I-phones, social media sites).
- Social culture- norms, roles, beliefs, values, rites, and customs.
- Culture is a worldview or way of making meaning of relationships, situations, and objects in daily life.
- Systems Theory
- Religion, ethnicity, grandparents.
- E.g.-Native American kid, quiet, no eye contact, time not important, developing normally for their culture, but some in ours may say abnormal.
- Gender role expectations or standards are cultural expectations about appropriate behavior for boys and girls and men and woman.

Q3a. Student two:

A. Personal Theory of Human Development

- 1. Factors necessary for normal development**
 - a. Positive and meaningful relationships with others throughout entire lifespan.**
 - b. Cope effectively and appropriately with life stressors with having a foundation of mechanisms to use as needed.**
 - c. Motivation for achievement and improving one's self**
 - d. Basic needs are met and person is satisfied with means.**
 - e. Ability to fulfill multiple roles in society and within systems.**
 - f. Ability to contribute to society in a meaningful way.**
 - g. Participation, belief, and/or associating a sense of belonging to positive sectors and groups within systems such as church/higher power, volunteering, sports, and/or affiliation groups.**
 - h. Positive and strong attachments early in life, leading to this ability later on.**
 - i. Effective communication skills learned and observed in varying contexts and situations throughout lifespan modeled.**
 - j. A multitude of available resources available to use in need.**
 - k. Discipline learned through positive role modeling and effective communication.**
 - l. Milestones and stages mastered successfully and ability to build upon accomplishments.**

- 2. Development as a bio-psychosocial task.**
 - a. Biological- genes, injury, abnormality formation, substance interaction, environmental toxins, lifestyle, disease.**

- b. Psychological- temperament, personality formation, identity, abuse/trauma factors, modeling, life experiences, insight.
- c. Social-environmental factors, interactions with others, experiences, technology, education, culture.

3. **Theory inclusion**

- a. Havighurst- Life stage- developmental task theory
 - 1. teachable moments-critical as learning may be harder later on.
 - 2. Mastered tasks, then new competencies can be enhanced.
 - 3. Development is a process, learning tasks which society requires and adapting as needed with expectations by age.

- b. Erikson- Theory of Psychosocial Development
 - 1. Psychosocial crisis-adaptation to demands within life stages
 - 2. Developmental stages
 - a. Oral sensory-trust vs. mistrust
 - b. Muscularanal-autonomy vs. shame
 - c. Locomotor-genital- initiative vs. guilt
 - d. Latency- industry vs. inferiority
 - e. Puberty and adolescents- identity vs. role confusion
 - f. Young adult hood- Intimacy vs. isolation
 - g. Adulthood- Generativity vs. stagnation
 - h. Maturity- Ego integrity vs. despair

- a. Radius of significant relationships: age associated demands from society and culture are communicated through these relationships
 - a. Loved one
 - b. Parents, caregivers, children
 - c. Siblings, close relatives
 - d. Close friends
 - e. Peer groups
 - f. Leaders
 - f. co-workers
 - h. Subculture
 - i. Mankind

- c. Freud- Psychosexual Theory ****EXTRA****
 - 1. ID, EGO, & Superego
 - a. ID- instincts and impulses
 - b. EGO- self and mental functioning/awareness

- c. Superego- rewards and punishment
2. Motivation behind behavior- consciousness and drives; nothing happens without purpose.

d. Piaget- Cognitive Theory

1. Equilibrium through schema(thought) development to overcome disequilibrium through adaptation by assimilation (interpretation of new experiences) and accommodation (modification of schemes).
2. Cognitive development stages:
 - a. Sensorimotor intelligence- birth to 18 mo.; sensory and motor
 - b. Preoperational thought- 2-6 yrs.; language, imitation, imagery, symbolic play and drawing.
 - c. Concrete operational thought- 6-12 yrs.; casual relationship understanding, problem solving, classification systems
 - d. Formal Operational Thought- 13-adulthood; intelligence quality

B. Developmental Model of Counseling

1. Meeting the client where they are at in counseling
 - a. Developmentally what to expect; varies by accomplishment of stages
 - b. Personally, emotionally, physically and intellectually.
 - c. Family challenges, systemic changes, stress involvement in relation to client
 - d. Look at client progression throughout stages and maturity levels
 - e. Coping mechanisms and ability to handle expectations.
 - f. Ability to fulfill expected roles and tasks
 - g. Relationship building and interactions; supports

C. Cultural Effects on Theoretical Formulations

- a. Beliefs
- b. Traditions
- c. Expectations
- d. Values
- e. Theory applications- arranged marriages; strong family base and excluding members from outsiders; cultural relationships; control vs. independence; symbolic practices; role expectations

D. Keeping theory in mind with cultural sensitivity

- a. Alter counseling techniques to allow better understanding and enhance the building of knowledge.

- b. Allow clients to gain a sense of accomplishment while building insight and task mastery.
- c. Be conscientious that goals/tasks will allow successful completion with their ability level; attainable
- d. Use body language and verbal language within their developmental level/culture to allow clients to feel more comfortable.
- e. Elicit client wants and needs to enhance motivation and gain personal investment in change.
- f. Education around concepts
- g. Reinforcement and redirection as needed with client comprehension.
- h. May need to use resources such as the aid of an interpreter, visual/symbolic cues or devices, reframe or explain things in easier terms for understanding, or research cultural components or issues further.
- i. Understand cultural variables, issues, and ability levels to learn how best to respond to challenges.
- j. If unable to meet client needs, refer them to other professionals to help, working within scope of competence.

Q3a. **Student three:**

No answer

Q3a. **Student four:**

No answer.

3b) In preparation for the exam, develop a fictitious case scenario, depicting a specific disorder. During the exam be prepared to describe the case scenario and to explain the relevance of both developmental and learning theory in the counseling intervention process.

Student One:

Essential Info for 3.B.

Case Scenario - no answer

Q3b. **Student two:**

a. Client Scenario-

1. 65 year old Male Caucasian
2. Severe Depression
3. Married with 3 adult children
4. Dog
5. Trailer outside city limits
6. Motorized wheelchair/ Cain
7. Multitude of health issues ie. Heart and breathing
8. Oxygen dependent
9. Worked 6 days a week up till 5 years ago.
10. Estranged relationships with children
11. Wife constantly on the go with child from another relationship
12. Client and wife have limited education, 6th grade.
13. Wife helps to limited extent, expressing “I don’t understand what the doctors are saying” and wants the grandson’s wife to explain in easier terms.
14. Depends on grandson’s wife for transportation to appointments and oversee medications
15. Sleeps most the day and night
16. Isolation in bedroom
17. No interest in activities or outings when opportunities present themselves
18. Verbalized to grandson that he feels like a burden, and expressed guilt over travel limitations per doctor orders and wife continual complaints over not being able to go on vacations.
19. Emotionally deregulated over continual loss of body function ie. Sight and tremor formation.
20. Taking a low dose anti-depressant with other medication for other issues.
21. Disability income as sole financial base for both client and wife.

b. Perception of client-My theory base/relevance of developmental and learning theories.

1. Client vulnerability due to medical and physical restrictions, no longer able to contribute to family and society as valued, fulfill roles as done in the past, and contribute to income. Ie. Strong work ethic
2. Loss of support from children
3. Wife feels unable to be of help husband due to lack of education and understanding, and therefore the client feels he is unable to communicate concerns and obtain feedback.
4. Loss of motivation to improve circumstances
5. Lack of belonging and interaction with others; supportive foundation.

6. Lacks coping mechanisms to deal with arising issues
7. Loss of integrity and rise in despair
8. Loss of equilibrium and adaptation to circumstances.

c. **Therapeutic Interventions**

1. Individual counseling once a week in client's home to start with long-term goal to office.
2. Introduce new activities ie. Journaling
3. Educate husband and wife local senior center and community activities with transportation, Invivo teaching.
4. Counseling with wife participation to enhance how they can work together more effectively ie. Mediation, role-play.
5. Relationship building techniques through role-play, discussion, homework
6. Medical evaluation to control depressive symptoms; interaction with other medications.
7. Shaping interactions and communication.

Q3b. Student three:

Axis I-V

Clinical Disorders/Personality Disorders & Mental Retardation/General Medical Conditions/Psychosocial and Environmental Problems/Global Assessment of functioning (GAF).

Numbers before diagnosis

Differed if dispassion of access but not enough info

Axis IV write moderate-severe

If there's no diagnosis you can write differed or V7109

Abnormal= anything that is keeping you from doing regular adl's or regular activities or if the person is at risk for hurting themselves or others.

Treatment goals 2 short term and 2 long term.

Q3b. Student four:

No answer

Question 4:

Counseling/Therapeutic Interventions

Given a hypothetical case scenario of a client, be prepared to make a complete, multi-axial, differential diagnosis. Is the client's behavior "abnormal"? If so, assign a formal diagnosis or diagnoses using DSM-IV-TR and clinically justify your diagnosis or diagnoses. Then develop proposed treatment goals and describe the process of counseling and techniques that you feel should be utilized. Provide a sound clinical rationale for your treatment goals and interventions.

Student One:

Essential Information for 4.

Treatment Goals and Techniques

- Borderline Personality-Goals-Develop and demonstrate coping skills to deal with mood swings. Develop the ability to control impulsive behavior. Replace dichotomous thinking with ability to tolerate ambiguity and complexity in people and issues. Develop and demonstrate anger management skills. Learn and practice interpersonal relationship skills. Terminate self-damaging behaviors (substance abuse, reckless driving, sexual acting out, binge eating, or suicidal behaviors). Techniques- Build trust, genuineness, compassion, good listening and reflection, unconditional positive regard.
- Anger Management-Decrease overall intensity and frequency of angry feelings, and increase ability to recognize and appropriately express angry feelings as they occur. Develop an awareness of current angry behaviors; clarify origins of alternatives to aggressive anger. Come to an awareness and acceptance of angry feelings while developing more control and serenity. Become capable of handling angry feelings in constructive ways that enhance daily functioning. Demonstrate respect for others and their feelings.
- Antisocial Behavior-Accept responsibility for own behavior and keep behavior within the acceptable limits of the rules of society. Develop and demonstrate a healthy sense of respect for social norms, the rights of others, and the need for honesty. Improve method of relating to the world, especially authority figures: be more realistic, less defiant, and more socially sensitive. Come to an understanding and acceptance of the need for conforming to prevailing social limits and boundaries on behavior. Maintain consistent employment and demonstrate financial and emotional responsibility for children.
- Anxiety-Reduce overall frequency, intensity, and duration of the anxiety so that daily functioning is not impaired. Stabilize anxiety level while increasing ability to function

- on a daily basis. Resolve the core conflict that is the source of the anxiety. Enhance ability to effectively cope with the full variety of life's anxieties.
- Adult ADD- Reduce impulsive actions while increasing concentration and focus on low-interest activities. Minimize ADD behavioral interference in daily life. Accept ADD as a chronic issue and need for continuing meds tx. Sustain attention and concentration for consistently longer periods of time. Achieve a satisfactory level of balance, structure, and intimacy in personal life.
 - Chemical Dependence-Accept the fact of chemical dependence and begin to actively participate in a recovery program. Establish a sustained recovery, free from the use of all mood-altering substances. Establish and maintain total abstinence while increasing knowledge of the disease and the process of recovery. Acquire the necessary skills to maintain long-term sobriety from all mood-altering substances. Improve the quality of personal life by maintaining an ongoing abstinence from all mood-altering chemicals. Withdraw from mood-altering substances, stabilize physically and emotionally, and then establish a supportive recovery plan. For relapse-establish a alcohol/drug free lifestyle. Develop understanding of personal pattern of relapse in order to help sustain long-term recovery. Awareness of relapse triggers and coping strategies needed to deal with them. Achieve a quality of life that is drug free on a continuing basis.
 - Childhood Trauma-Develop an awareness of how childhood issues have affected and continue to affect one's family life. Resolve past childhood/family issues, leading to less anger and depression, greater self-esteem, security, and confidence. Release the emotions associated with past childhood/family issues, resulting in less resentment and more serenity. Let go of blame and begin to forgive others for pain caused in childhood.
 - Chronic Pain-Acquire and use necessary pain management skills. Regulate pain in order to maximize daily functioning and return to productive employment. Find relief from pain and build renewed contentment and joy in performing activities of everyday life. Find escape route from the pain. Accept the chronic pain and move on with life as much as possible. Lessen daily suffering from pain.
 - Cognitive Deficits-Develop understanding and acceptance of the cognitive impairment. Develop alternative coping strategies to compensate for cognitive limitations.
 - Dependency-Develop confidence that he/she is capable of meeting own needs and of tolerating being alone. Achieve a healthy balance between independence and dependence. Decrease dependence on relationships while beginning to meet own needs, build confidence, and practice assertiveness. Establish firm individual self-boundaries and improved self-worth. Break away permanently from any abusive relationship. Emancipate self from emotional and economic dependence on parents.
 - Depression-Alleviate depressed mood and return to previous level of functioning. Recognize, accept, and cope with feelings of depression. Develop healthy cognitive patterns and beliefs about self and the world that lead to alleviation and help prevent the relapse of depression symptoms.

- Develop healthy interpersonal relationships that lead to alleviation and help prevent the relapse of depression symptoms. Appropriately grieve the loss in order to normalize mood and to return to previous adaptive level of functioning.
- Dissociation-Integrate the various personalities. Reduce frequency and duration of dissociative episodes. Resolve the emotional trauma that underlies the dissociative disturbance. Reduce level of daily distress cause by dissociative disturbance. Regain full memory.
- Eating Disorder-Restore normal eating patterns, body weight, balanced fluid and electrolytes, and a realistic perception of body size. Terminate the pattern of binge eating and purging behavior with a return to normal eating of enough nutritious foods to maintain a healthy weight. Develop healthy cognitive patterns and beliefs about self that lead to alleviation and help prevent the relapse of the eating disorder. Develop healthy interpersonal relationships that lead to alleviation and help prevent the relapse of eating disorder. Develop alternate coping strategies (feeling identification, problem-solving, assertiveness) to address emotional issues that could lead to relapse.
- Family conflict-Resolve fears of rejection, low self-esteem, or opposition by resolving conflicts developed in the family of origin and understand their connection to current life. Decrease level of present conflict while start to let go of or resolve past conflicts. Achieve reasonable level of family connectedness and harmony where members support, help, and are concerned for each other. Become a reconstituted/blended family unit that is functional and whose members are bonded to each other.
- Financial Stress- Establish clear income and expense budget that will meet bill demands. Contact creditors to make arrangements. Gain new sense of self-worth where value is not attached to doing or owning things that cost money. Understand personal needs, insecurities, and anxieties that make overspending possible. Achieve inner strength to control impulses, cravings, and desires that directly or indirectly increase debt responsibility.
- Unresolved Grief/loss-Begin healthy grieving process around the loss. Develop awareness of how avoidance of grieving has affected life and begin healing process. Complete process of letting go of significant other. Resolve the loss and begin renewing old relationships and initiating new contact with others.
- Impulse Control Disorder-Reduce frequency of impulsive behavior and increase frequency of carefully thought out behavior. Reduce thoughts that trigger impulsive behavior and increase self talk that controls behavior. Learn to stop, listen, and think before acting.
- Low Self-Esteem-Elevate self-esteem. Develop a consistent, positive self-image. Demonstrate improved self-esteem through more pride in appearance, more assertiveness, greater eye contact, and identification of positive traits in self-talk messages. Establish an inward sense of self-worth, confidence, and competence.
- Mania or Hypomania-Reduce psychic energy and return to normal activity levels, good judgment, stable mood, and goal-directed behavior. Reduce agitation,

- impulsivity, and pressured speech while achieving sensitivity to consequences of behavior and having more realistic expectations. Talk about underlying feelings of low self-esteem or guilt and fears of rejection, dependency, and abandonment. Achieve controlled behavior, moderated mood, and more deliberative speech and thought process through psychotherapy and meds.
- Medical Issues- Medically stabilize physical condition. Work through grief process and face with peace reality of own death. Accept emotional support from those who care and not push away in anger. Live life to fullest extent possible. Cooperate with med tx. Become knowledgeable about condition. Reduce fear, anxiety, and worry about condition. Accept illness and adapt life to limitations.
 - Obsessive-Compulsive Disorder-Reduce frequency, intensity, and duration of obsessions. Reduce time involved with or interference from obsessions and compulsions. Function daily at a consistent level with minimal interference from obsessions and compulsions. Resolve key life conflicts and the emotional stress that fuels obsessive-compulsive behavior pattern. Let go of key thoughts, beliefs, and past life events in order to maximize time free from obsessions and compulsions.
 - Panic/Agoraphobia-Reduce frequency, intensity, and duration of panic attacks. Reduce the fear that panic symptoms will recur without the ability to manage them. Reduce fear of triggering panic and eliminate avoidance of activities and environments thought to trigger panic. Increase comfort in freely leaving home and being in a public environment.
 - Paranoid Ideation- Show more trust in others by speak positive of them and report comfort in socialize with other. Interact with others without defensiveness or anger. Verbalize trust of significant others and eliminate accusations of disloyalty. Report reduced vigilance and suspicion around others as well as more relaxed, trusting, and open interaction. Concentrate on important matters without interference from suspicious obsessions. Function appropriately at work, social activities, in community with only minimal interference from distrustful obsessions.
 - Parenting-Achieve level of competent, effective parenting. Manage challenging behavior of child. Realistic view and approach to parenting given child's developmental level. Terminate ineffective or abusive parenting and implement positive, effective techniques. Strengthen parental team by resolve marital conflicts. Level of greater family connectedness.
 - Psychotic-Control or eliminate active psychotic symptoms so that supervised functioning is positive and meds taken consistently. Eliminate acute, reactive, psychotic symptoms and return to normal functioning in affect, thinking, and relating. Increase goal-directed behaviors. Focus thoughts on reality. Normalize speech patterns, as evidence by coherent statements, attention to social cues, and remain on task.
 - Sex Abuse-Resolve issue of sex abuse with increased capacity for intimacy in relationships. Begin healing process from abuse with resultant enjoy appropriate sex contact. Work through issues relayed to abuse with understanding and control of feelings. Recognize and accept abuse without inappropriate sexualization of

- relationships. Establish whether abuse occurred. Begin process of moving away from being a victim of abuse and toward a survivor.
- Sexual Identity Confusion-Adult- Identify sexual identity and engage in a wide range of relationships that are supportive of that identity. Reduce overall frequency and intensity of the anxiety associated with sexual identity so daily functioning is not impacted. Disclose sexual orientation to significant others. Return to previous level of emotional, psychological, and social functioning. Eliminate all feelings of depression (depressed mood, guilt, worthlessness).
 - Sleep Disturbance-Restore restful sleep pattern, Feel refreshed and energetic during wake hours, terminate anxiety producing dreams that cause awakening. End abrupt awakening in terror and return to peaceful, restful sleep pattern. Restore restful sleep with reduction of sleepwalk incidents.
 - Social Discomfort-Interact socially without undue fear or anxiety. Participate in social performance requirements without undue fear or anxiety. Develop essential social skills that enhance quality of relationship life. Develop ability to form relationships that enhance recovery support system. Reach personal balance between solitary time and interpersonal interaction with others.
 - Suicidal Ideation-Alleviate the suicidal impulses/ideation and return to highest level of previous daily functioning. Stabilize suicidal crisis. Placement in appropriate level of care to safely address the suicidal crisis. Reestablish sense of hope for self and future. Cease the perilous lifestyle and resolve the emotional conflicts that underlie the suicidal pattern.
 - Vocational Stress- Improve satisfaction and comfort surrounding coworker relationships. Increase sense of confidence and competence in deal with work responsibilities. Be cooperative with and accepting of supervision of direction in work setting. Increase sense of self-esteem and elevation of mood in spite of unemployment. Increase job security as result of more positive evaluations of performance by supervisor. Pursue employment consistency with hopeful and positive attitude. Increase job satisfaction and performance due to implementation of assertiveness and stress management strategies.
 - PTSD-Reduce negative impact traumatic event has had on many aspects of life and return to pre-traumatic level of function. Develop and implement effective cope skills to carry out normal responsibilities and participate constructively in relationships. Recall traumatic event without becoming overwhelmed with negative thoughts, feelings, or urges. Terminate destructive behaviors that serve to maintain escape and denial while implement behaviors to promote healing, acceptance of past events, and responsible living.

Q4. Student two:

A. Counseling/Therapeutic interventions

1. **Abnormality- false cognitive beliefs; unacceptable behaviors, distortions, inability to cope with life stressors effectively; Behavior that is different or**

unacceptable from normal standards and attitudes that are valued and implied in culture and society; causing harm to self or others; state of distress.

2. Write 2 short-term and 2 long-term goals

B. AXIS 1-4

1. V71.09 = deferred or no diagnosis
2. Axis 4- write moderate/severe

C. Counseling Process (CBT)

1. Intake
2. Informed Consent/HIPPA
3. Needs assessment
4. Rights
5. Background credentials
6. Treatment Plan
7. Strategies
8. Termination
9. Follow-up

D. Counseling Techniques

1. Role-play
2. Reframing
3. Imagery
4. Education
5. Homework
6. Survival Kit
7. Mediation
8. Journaling/writing
9. DBT
10. Individual counseling/ Talk therapy

Q4. Student three:

Axis I-V

Clinical Disorders/Personality Disorders & Mental Retardation/General Medical Conditions/Psychosocial and Environmental Problems/Global Assessment of functioning (GAF).

Numbers before diagnosis

Differed if dispassion of access but not enough info

Axis IV write moderate-severe

If there's no diagnosis you can write differed or V7109

Abnormal= anything that is keeping you from doing regular adl's or regular activities or if the person is at risk for hurting themselves or others.

Treatment goals 2 short term and 2 long term.

Q4. Student four:

No Answer

Question 5:

Biological Bases of Behavior/Psychopharmacology

a) Discuss what constitutes a biological explanation of human behavior and describe various theoretical perspectives related to this issue. Describe relevant research which supports contrasting views related to this question and clearly articulate your own position by discussing the strengths and limitations of alternative views.

Student One:

Essential Info for 5.a.

Biological Explanation of Human Behavior

- Genetic make-up, abnormal genes are the cause of mental illness.
- Development of brain and systems, environment can shape the brain.
- Neurochemical
- Body trying to maintain a state of homeostasis (the regulation by an organism of all aspects of its internal environment, including body temp, salt-water balance, acid-base balance, and blood sugar level. This involves monitoring changes in the external and internal environments by means of receptors and adjusting bodily processes accordingly. Maintenance of a stable balance, evenness, or symmetry).
- Control system model-help scientists understand and represent basic biological processes such as homeostasis.

- Individuals function as units composed of component structures and processes and self-regulation is a fundamental characteristic of humans' biological, psychological, and behavioral functioning.
- The control system model used by engineers and others could help to understand humans too.
- Human biological characteristics make possible their psychological and behavioral functions and provide a physical boundary between internal and external dynamics. Because the control system didn't encompass key features of humans many rejected this model for trying to understand people.
- The Living Systems Framework: A Transformed Control system Model.
- First there must be a biological life so cannot ignore clients' current biological states.
- Biological and physiological states are related.
- Some people are more genetically vulnerable to disorders such as alcoholism and depression.
- Chronic physiological states such as high level of emotions may alter some steady biological patterns (neurochemical, circulatory, gastrointestinal, or immune system functioning) that compound the problem.
- How person interprets the meaning of biological dysfunction, deficiency, or losses may significantly impact psychological and behavioral functioning.
- The body is composed of biological structures.
- Cells, the basic structural unit are complex organizations of parts such as genes, organelles, and membranes.
- The nuclei of all of a person's cells contain the same genetic material.
- Cell development creates different patterns of active and inactive genes that in turn produce different types of cells that become different types of tissues.
- Tissue subtypes become different types of organs such as bones, heart, brain, skin.
- Groups of organs are organized into organ systems such as skeletal, nervous, and gastrointestinal systems.
- Organ systems interrelated to produce a single structure that can operate as a unit- the human body.
- Every cell of a person has the same genetic material in its nucleus and genes operate in organized patterns, single genes do not independently determine specific human characteristics.
- Now known that genetic influences are not static and fixed at birth as was once thought, but are dynamic and changeable.
- In each cell some genes are turned on and others off.
- Pattern of active and inactive genes produce different kinds of cells, different patterns of cellular activity, and therefore different patterns of genetic influence on the development and functioning of the person.
- Pattern of active and inactive genes in any cell may change across life span, depending on biochemical influences on or within the cell.

- Cells are open systems and must carry out continual selective transactions with their contexts.
- Dynamics of cell metabolism is protected by a membrane that separates cell from its context. Membrane selectively permits some material to enter and leave the cell, so each cell can selectively influence and be influenced by its environment and affect the functioning of the body.
- Thus genes exert influence on person-level development and functioning through influence on cell metabolism and products produced and exported to other cells.
- Any substance can influence any cell only if it can pass through or can influence what can pass through the membrane into the cell.
- Additional functional possibilities emerge at each level of structural organization.
- Regulation of these activities is accomplished through self-organizing processes that use varied, interrelated feedback and feedforward loop-assemblages to produce two results: 1. Self-maintenance through control of subsystem components. This control allows successive adaptation to various resources and demands from the system environment to ensure the variables of the system remain within preferred or permissible limits. 2. Role fulfillment-the parts of the structure perform specialized functions within the suprasystem of which they are a part.
- Because body must function as a unit, disruptions in any physiological subsystem will trigger activity to restore or maintain unitary functioning.
- Biological symptoms are manifestations of such activity and may represent 3 types or processes: 1. Physiological manifestations of the disruption itself, such as pain. 2. Physiological processes operating to overcome the disruption through the body's well-known self-corrective capabilities, as when white blood cells increase and temp rises to fight infection. 3. Physiological processes operating to accommodate the disruption, such as hypertension produced by chronic overarousal.
- Therefore patterns of signs and symptoms, called syndromes, for different kinds of biological disorders include not only indicators of disruption of normal functioning but also indicators of the body's effort to overcome or adapt to dysfunction.
- All physiological subsystems must operate in integrated fashion to produce person-level functional unity.
- Biological health and effective psychological and behavioral function depend on the continuous, interdependent biological functions.
- Dysfunction in any single component will affect operation of other components which are interrelated.
- Because person must function as a unit in context a failure or disruption of any component function may have consequences for the entire system as a whole.
- To coordinate a set of complex physiological subsystems to produce unitary functioning the human body has the circulatory system and the nervous system.
- The linkage of the CNS and ANS make it possible to tune physiological functioning to support the needs of the person's behavior patterns and vice versa.
- Failure in either of these subsystems results in death, the systems are interdependent so failure of one leads to failure of the other.

Q5a. Student two:**A. Biological Explanation of Human Behavior**

1. Behavior is the result of how brain systems function cohesively together.
2. Neurotransmitters with specific functions control behavior through chemical communication within the CNS synapses and neurons through pathways.
3. Neuronal factors to consider: reuptake, neuronal transport (fast vs slow); synapse transmission; receptors; synaptic mimicry (drug interactions).
 - a. Reuptake- transmitter amount and frequency
 - b. Synapse transmission- transmitter amount lingering within synapse to create heightened effect.
 - c. Receptors- presynaptic firing frequency, transmitter concentration at terminal, long-term receptor changes,
 - d. Synaptic mimicry- transmitter action released through stimulation of nerve is mimicked by substances.
4. Genetic make-up vulnerability; degrees of genetic abnormality affects
5. Behavioral responses: a) Elicited (produced with specific and similar stimulus'; under normal conditions), and b) Emitted (produced by any stimulus type that may be identified).
6. Environmental and Internal factors may influence levels of and behavioral patterns.
7. Dopamenergic pathways within the striatum are vital to motivational behavioral expression.
8. Key areas of the brain: 1. Cortex (memory and environmental understanding); 2. Forebrain (reinforcement and motivation); 3. Amygdala (emotions).

B. Related Theoretical Perspectives

1. Classical Theory
 - a. Single abnormal gene may cause mental illness
 - b. Mental Illness as an inherited disease
 - c. No such gene identified
2. Symptom Endophenotype Model
 - a. Genes as the cause of symptoms, temperaments, behaviors, and personality types of mental illnesses; not mental illness itself.
 - b. Coding of abnormal gene as cause of malfunctions of neurons for traits, symptoms and behaviors.
 - c. No genes identified for personality or behaviors.

3. **Stress Diathesis Model**
 - a. **Abnormal gene presence alone not causes mental illness, but environmental stress must occur to manifest risk of illness.**
 - b. **Stress ie. Life events, physical illness, ect.**

C. Contrasting Views (Newman & Newman, 2009)

1. **Tolman- Cognitive behaviorism**
 - a. **Focus around behavior influence and internal mental “activities”**
 - b. **Cognitive Map- “an internal mental representation of the learning environment”; includes reward system expectations, present operating spatial relationships, priority behaviors; behavior mediation through encodings(constructs of self and others), expectancies(ability to perform/consequences/environmental meaning), affects(emotional reactions of situations), goals/values(situational outcomes), cognitive competencies(knowledge/skills/abilities), and self-regulation plans(goal strategies).**
2. **Freud-Psychosexual Theory**
 - a. **Childhood Experiences are vital in molding behavior and thoughts**
 - b. **All behavior is intentional and purposeful; having meaning**
 - c. **The unconscious and conscious mind, and drives motivate behavior.**
 1. **The unconscious mind- primary motives stored; powerful influence; guidance of behavior is its major role**
 2. **The conscious mind- awareness; small component**
 3. **Drives/instincts- connected to psychological processes and metabolic functioning; linked through biological formation; aim to be satisfied to maintain equilibrium and immediately if possible.**
3. **B.F. Skinner- Operant Conditioning**
 - a. **Behaviors are manifested and learned through positive and negative consequences.**
 - b. **Learning is the outcome of responses and stimulus consequences (reinforcement)**
 1. **Reinforcement can be positive(hug) or negative(cry)**
 2. **Shaping reinforces responses**
 - c. **Other factors include: Schedules or reinforcement, continuous reinforcement, extinction, and Punishment.**

d. As environmental changes occur, shaping operant behaviors, individuals change behaviors.

D. Personal Position

1. Strengths

a. Stress is a real and identified factor reflected in many theories such as the stress diathesis model, and could be linked to Tolman, Freud, and Skinner theories; it's shown to cause and aid in maladaptive behaviors, cause dysregulation through disequilibrium of homeostasis threshold; linked to neurotransmitter functioning and activity.

b. Certain mental illness' have shown or exhibited a pattern in family histories indicating an explanation of heredity, some with documented causes due to gene expression and repeats ie. Huntington's disease; Alzheimers

c. Abnormal gene functioning has shown to affect traits, behaviors, and symptoms.

d. Genetic makeup formation is what makes individuals unique, encompassing variations in personality, temperament, symptomology, and behaviors.

e. Childhood experiences have shown to be very influential in behavioral expression and shaping, cognitive understanding, unconscious drive reaction, perceived nature of consequences and reinforcement, and internal map representation.

2. Limitations

a. Specific gene identification still unproven as single cause of mental illnesses; linked projections only expressed in certain illness', more research needed and who knows if such a link can be proven.

b. It's difficult to say that genes are the sole cause of symptomology, behaviors, and personality when brain functioning is made up of many components such as pathway regulation, neuronal functioning/neurotransmitter intensity, abnormality formation, and affected by environmental influences ie. Substances, injury, trauma, nourishment etc.

c. Behavioral, learning, and cognitive theories are behavioral explanations based on specific areas through which can all explain behavior logically and have been proven so in studies, but differently due to their area of expertise, and shouldn't be heavily weighted upon in their entirety.

d. People are unique individuals, functioning through systems including environmental or biological components which appear to interact and affect individuals differently depending upon circumstances and developmental outcomes, so to pinpoint one cause is virtually impossible.

Q5a. Student three:

Psychopharm – name (year) for reference page

A. Human Behavior:

Biological: genes as direct causes for subtle molecular abnormalities that cause the risks for mental illness. Genes act as an agent of “biasing” in causing brain circuit inefficiency in processing.

The hope is: meds are easier to prescribe, determine side effects and manufacture.

Investigations of DNA

CNS-I central nervous system investigators.

Through a strand of DNA an abnormal gene can sit thus causing an inherited disease.

Theoretical Perspectives: Single genetic abnormality to cause a specific psychiatric disorder.

Inherited abnormal gene.

New scientific developments make the above look simplistic.

Genes do not equal mental illness.

Packages of symptoms make syndromes

DSM evolved out of the genome (complete set of genetic material of an organism).

The new paradigm: Genes encode proteins.

Q5a. Student four:

No Answer

Question 5 continued - Theoretical Perspective Related to this Issue

b. Discuss the biological basis of mood and thought disorder as it is currently understood and the use of psychotropic medications and their impact on the nervous system.

Q5b. **Student one:**

Biological Basis of Mood and Thought Disorder as Currently Understood

- **Genes and Psychiatry: The Classic Theory-**At one time researchers were looking for the single genetic abnormality thought to cause a specific psychiatric disorder. This model proved to be successful in defining Huntington's disease and cystic fibrosis. So they thought maybe work for finding an abnormal inherited gene as cause of schizophrenia or depression. This paradigm now is overly simplistic.
- **Genes for mental illness been hard to find** because genes do not encode mental illness. Mental illnesses are mixtures of symptoms packaged in syndromes. These syndromes are used by committees to write the DSM's. These people are working backwards from the syndrome to the gene called a nosology. Since the genome didn't evolve out of the DSM it's no wonder committees of experts have failed to define the symptoms and syndromes that have evolve out of numerous genes. Research is still in the early stages to work in other direction from the genome to the mental illness. Next stage they will try to look for genes for personality, temperament, behaviors or symptoms of a mental illness, but not for a mental illness per se. Not found because genes do not encode personality or behavior either.
- **Genes and Psychiatry: The New Paradigm-**Genes encode proteins, and that in mental illnesses, individual genes code for a subtle molecular abnormality caused by genetically altered protein. Could include proteins that regulate neurodevelopment, such as neuronal selection, migration, differentiation, or synaptogenesis. Could also include proteins ranging from enzymes to transporters to signal transduction molecules, synaptic plasticity machinery, axonal and dendritic protein transport machinery, and many more. No longer thought that illnesses are caused by a huge biological contribution from a single gene. No abnormality is sufficient to cause any known mental illness. So what is the pathway from gene to mental illness? The hypothesis is that mental illnesses are caused not by single gene nor by a single subtle genetic abnormality, but by multiple small contributions from several genes, all interacting with environmental stressors. Sometimes called complex genetics. Not simple

dominant or recessive genetics, but a complex set of risk factors that bias a person toward an illness but do not cause it. In this model a person inherits risk, not illness and there are several possible ways to combine sufficient risk with sufficient opportunity to express that risk in the environment by summing all these factors, reaching the tipping point, and then developing the illness.

- Endophenotypes-Scientists exploring the path from gene to mental illness have discovered a few important intermediaries that assist in unraveling contribution of genes. Lying on this pathway between the subtle molecular abnormality encoded by a gene that contributes risk for a mental illness and the mental illness itself are intermediaries called endophenotypes or intermediate phenotypes. If the illness is the phenotype, lying at the end of the path, then there are 2 classes of intermediate phenotypes, called biological endophenotypes and symptom endophenotypes lying along the path. Both are intermediaries between gene and disease and are measurable, but not by the unaided eye of clinician. Endophenotypes are inherited with and closely linked to disease. They are more precisely and reproducibly measurable than the illness itself since each psychiatric diagnosis can describe many different illnesses or at least different biological routes to same illness. Measuring a biological endophenotype can reduce the variability and let scientists link the gene to the biological endophenotype more clearly than linking gene to the DSM illness also known as the phenotype itself.
- Biological Endophenotypes are measurable biological phenomena and can range from electrophysiological response to startle to the neuroimaging response to info processing, as well as many more. Often measured by functional magnetic resonance imaging (fMRI) as a sign of info processing in specifically localized brain circuits, often in prefrontal cortex.
- Symptom Endophenotypes are single symptoms associated with a mental illness and usually one of the DSM criteria for that illness. Like guilt and insomnia. Behaviors are obviously difficult to define because they have many complex functional interactions and emergent phenomena, but are simpler to define than mental illness itself, which has many different abnormal behaviors and not the same abnormal behavior in every person with same illness, but just several from a number of possibilities off same diagnostic list. This variability makes it too tough to link a subtle gene effect to a complex and multiply defined mental illness.
- Traveling the Hypothetical Path from Gene to Mental Illness-The hypothetical path from gene to mental illness goes from the gene via molecules, circuits, and info processing (biological endophenotype), to symptom endophenotypes (a single symptom of mental illness), to the full syndrome of symptoms of a mental illness. Not everyone with a subtle molecular abnormality that causes abnormal info processing in a specific circuit has a symptom, but everyone with a symptom is presumed to have somewhere abnormal info processing caused by a subtle molecular abnormality. Also, the same inefficient info processing that causes a symptom can be caused by a whole variety of subtle molecular abnormalities

working alone or along with additional subtle molecular abnormalities. At the behavioral level some people with the abnormality have symptoms or abnormal behavior and some do not. This is because genes exert variable effects throughout life, no one has just one gene, and it depends on whether you have healthy compensatory backup systems for your subtle molecular abnormality or if you have additional genetic biases, additional molecular abnormalities, and additional independent causes of inefficient info processing in that same circuit. For example-if someone expresses an abnormal form of gene for neurodevelopment after the brain has developed it might have no clinical consequences. If another family member expresses the same abnormal gene within a critical window of time, it could have a more profound effect. There are also multiple copies of each gene and multiple genes that may have complementary or redundant effects, so it may be possible to have an abnormal gene in the presence of other normal genes that render the abnormality clinically silent, whereas the same genetic abnormality in the presence of certain other critical abnormalities could lead to manifest malfunctioning of brain circuits.

- Stress Diathesis Hypothesis-Adding to complexity of complex genetics is the observation that genes alone are not necessarily enough to cause a mental illness. Something else generally has to occur from the environment to make the inheritance of silent risk become manifest as illness. That something else is often stress. Environmental stressors are often life events, such as childhood abuse, difficult adult experiences such as divorce or financial reversals, or biological stressors such as viruses, toxins, or other illnesses. Mentally healthy people have a genome built to handle stressors and normal or idela response hypothetically would be to activate neuronal circuits to process info associated with stress, to mobilize adaptive behaviors to reduce the stress, but to have no adverse behavioral symptoms and thus a normal phenotype. Those with a risk gene for mental illness will react differently to a life stressor but you might never know it. The same stressor may cause no adverse behavioral symptom and thus there is a normal phenotype.
- If you could measure the effect the stressor had on ifo processing of the circuit in the person with the subtle molecular abnormality you would see there is overactivation of that circuit. This person has a compensatory backup system in place and no other critical genetic flaws so the circuit is behaviorally silent. Then there is a person that has multiple genetic risk factors and with multiple life stressors who is reaching the tipping point so the circuit either underperforms or overactivates. The overactivation is the same biological endophenotype as that person with just one subtle molculat abnormality and no symptoms. An fMRI scan of both circuits would look the same but the person that lacks the successful compensatory mechanisms and has additional molecular flaws in backup systems, thus the abnormal biological endophenotype in this case is not silent but produces a psychiatric symptom, such as anxiety.

- The diathesis is the biological risk, whether one or many or none. The same stress with different diathesis can yield normal biological endophenotype and no symptoms, abnormal biological endophenotype and no symptoms, or abnormal biological endophenotypes plus symptoms. It all depends on reaching the breaking point.
- Personality as Buffer or Amplifier of Stress-Even the combo of genes coding for subtle molecular abnormalities and environmental stressors is not the whole story. To add another level, the net outcome of a stressor is determined to some extent by the personality of the person experiencing the stressor, not just the genes of that person. Development of personality and temperament themselves is determined both genetically and environmentally. Thus, if the same stressor is filtered through the personality of person with good coping skills, adaptive responses to adverse circumstances, and a healthy lifestyle, the stressor is mitigated and the effects on the genome are so subtle that there is no decompensation of info processing in the vulnerable circuit, and no symptoms appear (a normal phenotype). If person with poor coping skills, bad habits, and maladaptive responses to stress, such as arguing, drinking, fighting, etc. In this case the same stressor can be amplified rather than mitigated. A stressor that would be silent in the previous person may cause breakdown into the symptom of mental illness in this person.
- Degrees of Genetic Abnormalities and Environmental Stressors-Some molecular abnormalities are by nature more subtle than others. For example many of us may be carrying the gene for major depression. An illness like this is moderately biologically determined in many people- not enough to manifest without environmental input but vulnerable to breakdown in the presence of major stressors. The molecular lesions in schizophrenia though are highly biologically determined so it may be that little or no stressor is needed for the illness to be expressed. There may also be conditions to which even a normal genome is vulnerable, like when a person experiences overwhelming stress, like combat, rape, or natural disaster. It may take someone better than normal with resilience genes rather than vulnerable genes to resist responding to such a situation with symptoms of mental illness, such as an acute stress reaction or PTSD. Thus both stress load and genetic load interact to determine the final outcome of whether a person has no problems processing info, silent brain circuit inefficiencies, or manifest symptoms.
- Conclusion-Genes encode proteins, not psychiatric symptoms or mental illnesses. The subtle molecular abnormalities encoded by genes do not cause mental illness but can bias brain circuits toward inefficient info processing, which can lead to mental illness under certain circumstances. The hypothetical path from gene (genotype) to mental illness (phenotype) passes through some important intermediaries called endophenotypes, which are inherited with and closely linked to illness. Biological endophenotypes are measurable biological phenomena such as brain imaging, whereas symptom endophenotypes are single symptoms that are components of a mental illness syndrome. The stress

diathesis model integrates all this info by formulating the idea that sufficient genetic bias toward inefficient info processing combined with a stressful load from the environment that exceeds the capacity of brain circuits to process that load can result in breakdown into symptoms of a mental illness. In the future, it may be possible to measure a portfolio of critical genes to assess risk for mental illness in individual patients and their families, and this may someday help guide treatments selection as well.

The Use of Psychotropic Meds and Their Impact on the Nervous System

- Psychotropic drugs have many mechanisms of action, but they all target specific molecular sites having profound effects upon neurotransmission. About one-third of psychotropic drugs target one of the transporters for a neurotransmitter. A third target receptors coupled to g proteins. The rest target ion channels or enzymes.
- The known or suspected neurotransmitters in the brain number several dozen. Considering the amount of genetic material in neurons, there may be several hundred to thousand unique brain chemicals. Psychotropic drugs used in clinical practice act largely on serotonin, norepinephrine, and dopamine as well as acetylcholine, glutamate, and GABA (gamma-aminobutyric acid). These 6 are sometimes called the classic neurotransmitters because discovered first and developed into the major target systems for psychotropic drugs. Some naturally occurring neurotransmitters may be similar to drugs. For example-brain makes its own morphine (beta endorphin) and its own marijuana (anandamide). Brain may even make its own antidepressants, anxiolytics, and hallucinogens. Drugs often mimic the brain's natural neurotransmitters and the discovery of some drugs has preceded that of the natural neurotransmitters. Today we know that many neurons utilize more than one neurotransmitter at a single synapse. Also input to each neuron at various sites involves many different neurotransmitters. Since these networks of neurons send and receive info via a variety of neurotransmitters, it may therefore be not only rational but necessary to use multiple drugs with multiple neurotransmitter actions for patients with psychiatric disorders, especially if single agents with single neurotransmitter mechanisms are not effective in relieving symptoms.
- Impact on Nervous System-

Q5b. Student two:

A. Biological Basis of Mood and Thought Disorder (Stahl, 2008)

- 1. Serotonin(5HT), Dopamine(DA), and Norepinephrine(NE) are key neuronal transmitters which contribute to mood and thought.**
 - a. These three monoamines make up “trimonominergic” system**

- b. Disorder symptoms caused by combinations of deficits/dysfunctions within these systems.
 - c. Examples: 1) NE transport pump issues preventing transmitter action in synapse without neuronal destruction; 2) NE control of 5HT is bidirectional, dependent upon terminal input of axon with negative/positive “feedback inhibition”; negative is brake on 5HT and positive is accelerator 3) 5HT regulates NE through negative feedback, inhibiting its release.
2. Neuronal firing, receptor abnormality, axon channels deficits, and synapse deficits; absence thereof; excessive reuptake; decreased/increased transmitter release.
 3. Deficiency of monoamines
 4. Maladaptive information processing within the amygdala region.
 5. Hyperactive functioning with circuits (mania); hypoactive (depression)
 6. Link between genes>protein balance>molecular structure>mental illness
- B. Use of Psychotropic Medications and Impacts on Nervous System**
1. Allows more or inhibits amount of neurotransmitters to be released and remain in synapse.
 2. May control neuronal firing
 3. Inhibits negative symptoms; symptom control
 4. May slow progression of neuronal degeneration; neuronal death
 5. First generation antipsychotics block D2 receptors in all dopaminergic pathways (Mesolimbic, Nigrostriatal, Tubularindibular, Mesocortical); D2 antagonist
 6. Atypical antipsychotics affect both dopamine and serotonin, blocking one or the other, or partially so; includes- D2 antagonist with rapid dissociation, partial D2 antagonist, serotonin partial agonist.
 7. D2 antagonists reduce hyperactivity, reducing positive symptoms
 8. Side-effect risk; benefits should out-weigh risk association.
 9. Medication examples: Lithium, Depakote, Tegretol (mania); Lamictal (depression); Zyprexa for monotherapy.
 10. Drug types: SSRI, MAOI, Tricyclics, Tetracyclics, First-generation; Atypical
 11. Risks: Neuroleptosis, EPS, pleasure reduction, and Tardative Dyskinesia.

Q5b. Student three:

No answer

Q5b. **Student four:**

No answer

Question 5c. Discuss the criteria for the selection of psychotropic medications and the implications for their use in the treatment of psychological disorders.

Q5c. **Student one:**

Criteria for the Selection of Psychotropic Meds

- Clinical strategy should be to reduce or eliminate as many symptoms as possible and to prioritize among all the evidence-based treatments available those that target neurotransmission in malfunctioning brain circuits. By treating each patient with their unique portfolio of symptoms may be possible to improve information processing and thereby reduce symptoms. This tactic would enable the rational selection and combination of treatments for each individual patient as well as the restructuring of treatment on the basis of the patient's response to prior treatment.
- Using a categorical approach one would list symptoms and construct diagnosis according to DSM-IV-TR. Could then go to a list of evidence-based approved treatments for the disorder. Prior experience, side effect profile, and clinician preference may guide this choice. Can also chose treatment based on patient's symptom profile. In this case approach is to deconstruct a patient's syndrome into the specific symptoms that patient is experiencing. This is the dimensional approach. Listed next in seven steps.
- 1. Construct a diagnosis-listing symptoms and constructing a psychiatric diagnosis according to accepted criteria such as in the DSM-IV-TR. Need to have the correct diagnosis, family and client history.
- 2. Deconstruct the diagnosis into its component symptoms.
- 3. Match each symptom to its hypothetically malfunctioning circuit.
- 4. Consider the portfolio of neurotransmitters that theoretically regulate each circuit.
- 5. Select a treatment that targets the neurotransmitter regulating the hypothetically malfunctioning circuit.
- 6. Add or switch to another treatment if the symptom is not relieved.
- 7. Repeat for each symptom until the patient is asymptomatic or in remission whenever possible.

- Many psychiatric symptoms cut across several psychiatric disorders, and the genetics, functional imaging and localization of circuits involved in these symptoms may be similar across many psychiatric disorders.
- Example- major depression, person has trouble concentrating and anxiety, these dimensions of ongoing symptomatology may share inclusion in numerous other psychiatric disorders. Also, a symptom shared by different psychiatric disorders may actually share same localization in the brain. The brain has a limited number of neuronal highways by which it can express its symptoms, so executive dysfunction or anxiety may share the same circuits in several different psychiatric disorders characterized by either of these symptoms.
- As soon as this strategy provides treatments that lead to remission of all symptoms, the job is done. However, in the frequent situation where treatments either do not work, or only work on some symptoms and leave other residual symptoms, the tactics change now to either adding or switching to another treatment that targets a different neurotransmitter in that pathway. This can be repeated for each symptom in each pathway until patient is asymptomatic or in remission whenever possible. This above 7 step strategy depends on the tactics of selecting and combining specific drugs on the basis of the topographical location of functions, topographical location of neurotransmitters, and mechanisms of action of psychotropic drugs. This approach is already routine practice for many clinicians on the basis of their clinical experience, but now there is emerging science that supports this clinical approach.
- This approach makes sense to many clinicians and scientists because there does not appear to be a single drug mechanism for any psychiatric disorder (such as major depressive) any more than there appears to be a single gene for any psychiatric disorder (such as major depressive). May be a drug that acts on mechanisms that could improve information processing in one part of brain, thus improving depressed mood and another drug that acts on different mechanisms that could improve information processing in another part of brain to improve insomnia, anxiety, or problems concentrating no matter what the psychiatric diagnosis. Many clinicians already use these strategies and tactics intuitively and now major developments in the neurosciences reinforce these actions, inform them, and allow them to anticipate more powerful strategies and tactics for psychopharmacology in the not too distant future.

Implications for Their Use in the Treatment of Psychological Disorders

- Important first to have the correct diagnosis.
- Some side effects are intolerable.
- Compliance can be an issue with strong drugs such as those used for bipolar, schizophrenia, etc...
- Client is best judge of whether the med is working.
- Implications for use may be that drugs are the best route to solve the issue, but may also need to consider whether drugs are the best route, only route, or

whether counseling alone or in combo with meds are a better approach. Using drugs may be necessary in some situations, but need to consider the long term side effects, such as those possible for young kids taking Ritalin or the side effects of psychiatric drugs.

Q5c. Student two:

A. Criteria for Selection of Psychotropic Medications

1. Side effects- benefits out-weigh risk potential
2. Risk factors
3. Age range factors
4. Allergies
5. Addiction/abuse potential
6. Drug/alcohol usage
7. Dietary restrictions with medications
8. Med interaction
9. Compliance and the necessity thereof with medication and conditions such as blood draws, extended release or dissolvable benefit.
10. Correct diagnosis
11. Symptoms and severity thereof
12. Family History; risk factors
13. Medical History
14. Past medication history
15. Functioning Level
16. Client perception/desires
17. Neurological information

B. Implications for medication use in tx for psychological disorders

1. Fatality- earlier fatality rate on average due to organ damage from medications than non-medicated people.
2. Organ damage- Medications, dependent upon type, affect various organs more than others, causing progressed damage over time and irreversible affects.
3. Addiction- Potential for client to become addicted themselves and abusing the medication, and selling potential on the street/within the community.
4. Key factor- no one tx works for everyone; tailored tx or grand experiment
5. May lead into other behaviors such as smoking due to pleasure reduction which may affect or cause physical health symptoms.
6. Could cause other disorders such as TD, Neuroleptosis, and Parkinsonism.

Q5c. **Student three:**

No answer

Q5c. **Student four:**

No answer

Question 6:

The Counselor and Society

- a) *Discuss the professional role of the counselor in today's society. What responsibilities and obligations do counseling professionals have and what contributions should we make to the community and society at large in order to address issues of social relevance? What directions should the fields of psychology and counseling in general take in order to most effectively contribute to our future in the 21st century.*

Q6a. **Student one:**

Professional Role of Counselor in Today's Society

- Advocate-for safety of client or others, environmental, children.
- Consultation- with other providers to continue care, families, guardians, other agencies for community support or resources. Consultation for business or industries.
- Psychological testing- for jobs, schools, crisis eval, etc.
- Services-referrals, know who to contact, agency, psychiatrist, insurance, evaluation, diagnostic, ADL's., interagency support.
- Evaluation-diagnosis, IEP, insurance purposes, therapy, services.
- Case Management-heat, housing, money, health, rights-state house, education. Maslow's hierarchy of needs.
- Liaison- go between, peace maker, parents vs school, compromise, kid is # 1, kids with disabilities, special ed services.
- Court-law, guardians, expert witnesses, custody evals and testimony, rights of the people you serve being not being ignored.
- Administrative-program planning
- Therapy- assessment initially to determine if my skills are appropriate for client's presenting concerns and interaction of personalities and personal values are a good match for counseling success, treatment, evaluations, diagnosis, and crisis

management, empower our clients to be able to make changes in their life, in community, etc..

- Research-for client on religious background, ethnicity, gender identity, socioeconomic status, issues we are not familiar with. Client educate you, research, and who to refer to if unable to benefit the client. Research psychologist to further the studies of mental illness, etc.
- Mandated Reporter-crisis management, abuse, suicide, report of harm to self, others, or property.
- Make improvements or needed changes in agency regulations, policies, procedures. Create or improve existing programs, cooperative working relationships, helping clients have a say over the services they receive.
- Good Record Keeping
- Work in school settings for testing, counseling, teaching for prevention and education about mental health issues, teaching acceptance, diversity, etc.

Responsibilities and Obligations

- Responsibility as mandated reporter.
- To treat clients and if unable to treat know where to refer.
- Know services in the community for referral.
- Responsibility to our clients to always do what's in their best interest. Empower others.
- Obligation to organizations we work for, society, APA, to protect those in community, role as a professional, to the field of psychology, co-workers, act professionally, educate our clients (other kids-those with disabilities, parents on how to teach empathy in kids) empower others, be open-minded, non-judgmental, compassionate, attend workshops and be updated with relevant issues in the field, continuing education requirements.
- Awareness of the complex role culture plays in interpersonal relationships.
- Improve the Service Delivery System- change program regulations, improve program delivery, encourage cooperation between agencies, develop new programs, and empower clients.

Contributions to Community and Society at Large to Address Issues of Social Relevance

- Actively involved in our communities to identify community problems and issues.
- Stay up to date on current issues facing our communities and our societies.
- Get involved on a political level, local, state, or national, to address needed changes. Voting, lobbying for candidates.
- Empowerment-work with others to promote change. People feel more capable through the skills they acquire, but it is through their connection with others that they become more powerful.
- Assist others to develop stronger beliefs in their own personal power and in the power of an organized group.

- Cultural Awareness, and competence.
- Respect for cultural diversity.
- Starting new programs that serve the community, volunteering for existing programs. Promote prevention programs. Outreach for vulnerable populations.

Directions for the Fields of Psychology and Counseling to Most Effectively Contribute to our future in the 21st Century

- Becoming more diverse by having more psychologists, counselors, APA members, etc.. from different races, ethnicities, religions, sexual orientations.
- More integrated services, holistic approach to health and mental health care. Agencies with doctors, counselors, alternative med-yoga, acupuncture, homeopathy, chiropractic, etc...
- Changes in the DSM and how clients are diagnosed.
- Insurance and access or counseling care for those in need and unable to afford care, alcohol/substance abuse care, inpatient tx when needed.
- Positive psychology

Q6a. Student two:

A. Professional Roles of the Counselor

1. Client advocate
2. Safety and Legal enforcer
3. Role-model
4. Ethical boundary monitor and enforcer
5. Health promoter
6. Case manager
7. Therapist/Clinician
8. Treatment Planner
9. Competence Maintainer and organizer
10. Relationship builder and supporter
11. Mediator
12. Assessment administrator and scorer
13. Support worker (emotionally, spiritually, Needs met)
14. Crisis stabilization
15. Researcher
16. Program planner
17. Mandated reporter
18. Treatment termination when appropriate
19. Referral as appropriate

B. Responsibilities and Obligations of Counseling Professionals

1. Objectivity
2. Sensitivity to racial, cultural, and ethnic factors
3. Open-mindedness
4. Self-awareness and understanding
5. Maintain and strive for competence building
6. Trustworthiness
7. Confidentiality
8. Referral as appropriate and necessary
9. Terminate when appropriate; goals met or when referral necessary
10. Monitor communication
11. Effective and appropriate documentation
12. Do no harm; act reasonably
13. Uphold society and client welfare in high regard
14. Empathetic
15. Genuine
16. Positive regard for others
17. Consultation as necessary and able
18. Responsibility to not just society and the community, but the clients, agency if applicable, self, professional organization, law, and profession itself.

C. Contributions to Society and Community that Should be Made

1. Community service
2. Volunteerism
3. Mentoring other professionals
4. Consultation
5. Role-modeling
6. Empowering others to stay mentally and physically healthy
7. Protect clients and the community
8. Educate others about current and “hot” issues
9. Participate in workshops and trainings as available

D. Future Directions Psychology/Counseling should take

1. Raise more awareness of increasing needs and issues within society such as actively participating in programs that are effective for such issues, and advocating for them.
 - a. Issues include Autism, Veteran trauma, Youth and Family, criminal justice, and geriatrics.

2. Increase Technological advances to better secure and uphold professional responsibilities, and meet client interest and needs.
3. Profession should strive to become more diverse.
4. Strive for better communication
5. Integration of services
6. Continue to work towards a holistic approach
7. Advocate for insurance changes to make counseling restrictions/requirements less tedious, and make counseling more accessible to clients of all walks of life.
8. Work on continuum based diagnosis

Q6a. Student three:

No answer

Q6a. Student four:

The Counselor and Society

A. Professional role

a. Advocate

i. Client safety

1. Self
2. Others
3. Environmental

ii. Client Services

1. Evaluations
2. Therapy
3. ADL's
4. Housing
5. Finances
6. Health services (ex. Hearing test, vision test)
7. Client rights

a. Basic needs

8. Educational rights

iii. Providing Referrals

iv. Liaison

1. Go Between
2. Compromise
3. Mediate

- a. Conflict Resolution
- v. Support
 1. Practical
 2. Spirituality/religion
 3. Emotional
- vi. Crisis
 1. De-escalation
 2. Prevention
- vii. Program Planning
- viii. Administrative work

Question 6.

b) What unique characteristics qualify you to practice in a counseling related capacity? What contributions do you currently make and how do you see yourself in the future contributing to address the community and societal obligations which you identified above?

Q6b. Student one:

- Self-awareness and understanding
- Good psychological health
- Sensitivity to and understanding of racial, ethnic, and cultural factors in self and others.
- Open-mindedness
- Objectivity
- Competence
- Trustworthiness
- Empathetic, genuine, and accepting
- Compassionate
- Belief in the personal meaning of another person.
- Empathy
- Respect for different cultures, beliefs, religions.
- Non-judgmental

Q6b. Student two:

A. My Characteristic Qualifications

1. Assertiveness
2. Motivated
3. Positive regard
4. Calming presence
5. Objectivity
6. Honest
7. Trustworthiness
8. Dependability and Reliability
9. Role-modeling
10. Growing legal awareness of issues
11. Detail oriented
12. Self-determination
13. Non-judgmental
14. Respectful
15. Healthy sense of humor
16. Tolerance for ambiguity
17. Patience
18. Professional experiences with CSAC

B. Current Contributions Made

1. Peer/Professional helper and mentoring
2. Client advocate
3. Role-modeling
4. Consultation as needed
5. Strive to build competence through training/workshop participation
6. Peer education on hot/new issues through upcoming awareness

C. Future Contributions

1. Community Service
2. Volunteerism
3. Learn more about integration of services
4. Raise awareness of issues and programs to address new and hot issues in psychology to others
5. Advocate for diversity in the field
6. Strive to enhance communication
7. Work towards a holistic approach to therapy

Q6b. Student three:

No answer

Q6b. Student four:

Responsibilities/Obligations

- a. See above
- B. Contributions to society
 - a. Fighting for justice/rights
 - b. Healthy clients
 - c. Education
 - i. Conferences
 - ii. Workshops
 - iii. Assemblies
- C. Future Direction
 - a. Greater diversity
 - b. Greater Collaboration between agencies
 - c. Bringing programs together-physically (integrating services)
 - d. Focus on positive psychology
 - e. Medication/therapy in conjunction

Question 7:

Addictive Behaviors/Co-Occurring Disorders

- a) Describe biological, psychological, and socio-cultural factors which are commonly associated with the etiology of addictive disorders. Contrast and compare biologically based and psychosocial theories of alcoholism and be prepared to discuss and support your professional perspectives in regard to those theoretical models. Describe the various steps that are generally associated with successful recovery from an addictive disorder (in particular, alcohol or substance abuse), as well as factors that are commonly associated with relapse.***

Q7a. Student one:

Biological Factors

- Genetic Predisposition/Hereditry-children of alcoholics, vulnerabilities, several genes, abnormal neurotransmitter functioning-reinforcing effect, influence of dopamine in dependence. Least concentration of dopamine in brain are those who experience

pleasant effects from drugs. Fewer dopamine receptors most vulnerable to drug abuse.

- Homeostasis Threshold
- Abnormality Formation
- Physiological Factor-metabolic defect for heroin abuse.

Psychological Factors

- Brain Damage-TBI, trauma, PTSD, mental illness-schizophrenia, abuse, neglect, anti-social personality disorder, anxiety, and depression more common among drug users. Increased need for stimulation, excitement, and immediate gratification. Sensation-seeking people are risk-takers and drug use is risk-taking behavior, especially for teens.
- Pathway Deficits
- Environment-family and learned drug abuse behavior, not learned good coping skills, Maslow-needs fulfillment, resiliency-more resiliency, less likely, peer influences, poor self-esteem, community based expectations, dysfunctional family systems, pressure, modeling from parents or peers.
- Drug abusers typically demonstrate poor judgment, difficulty learning from mistakes, emotionally insensitive to others, and unable to form long lasting relationships with others. Risk factor-not want to conform to society, availability, peer group. Protective factors-family , activities.

Socio-Cultural Factors

- Legal age limits
- Acceptance at gatherings
- Religious beliefs
- Environment and peers. Media, acceptance in our culture.
- Most crucial factor is the situations, social relations, or social structures the individual is in or has been.

Biologically Based and Psychosocial Theories of Alcoholism

- E.M Jellinek-medical model of addiction. Much of behavior based on genetic predisposition. Like a disease such as cancer. Addiction goes through 4 stages-prealcoholic-use to relieve social tensions of stress and anxiety. Prodromal stage-memory blackouts, secret use, preoccupation with it, guilt over intoxicated behavior. Crucial stage- dependence physically, loss of self-esteem, loss of control of drinking, social withdrawal, self-pity, neglect of nutrition. Try to stop but return to it. Chronic phase-deterioration of morals, drink with social inferiors, motor tremors, obsession with drinking, substitute like rubbing alcohol if can't get alcohol.
- Jellinek-1960 theoretical model-symptoms of alcoholic included physical, social, emotional, vocational complications.

- Genetic Inheritance Theory-Genetic patterns that predispose some to use. Gene called slo-1 which controls the activity of the protein called BK channel seemed to mediate sensitivity to alcohol's effects. This protein usually controls flow of ions out of neuron during normal cycle of firing. When alcohol binds at this protein complex it holds ion channel open longer than normal, slowing rate at which neuron can prepare to fire for the next firing cycle and slows the level of activity for that neuron.
- Biological Differences Theory-alcohol-dependent person seems to metabolize alcohol differently than nondependent drinkers. Site/mechanism of alcohol biotransformation different for alcohol-dependent person compared to nonalcoholic. Dependent person seems to have a reaction to effect of chemical different from non-addict.
- Personality Predisposition-abuse might trace back to personality structure. Might be result of self-regulating disorder. Engage in harmful or self-destructive behavior because lack ability to meet emotional needs in appropriate ways. Drug of choice allows them to better cope with emotional states that are unpleasant and threaten to overwhelm them. Karen Horney was early proponent of this model.
- Biological Theory-genetic factors, physiological factors, and neurochemical systems in the brain. Alcoholism has a genetic component. Metabolic Defect Theory-Chronic abusers may have a metabolic defect.
- Anomie/Strain Theory-Robert Merton used Emile Durkheim's concept and applied it to drug use. Society has cultural goals and ways to achieve them, in US economic success, when can't reach economic success leads to feeling frustrated and anomie. This anomie or strain highest among disadvantaged groups. Five adaptations or responses to anomie when can't reach cultural goals through acceptable means. Conformity-if alcohol and nicotine acceptable behaviors by society would use them, but not illegal drugs. Innovation-aspiring to be a drug dealer to make money because reject legitimate avenues of goal attainment. Ritualism-reject goal of economic success because feel its unattainable so uses drugs or alcohol to get through job they hate or their life. Retreatism-reject both goal of economic success and hard work. Given up. Not found success through conformity nor through criminal activity.. Undemanding world. Rebellion-reject goal of economic success and hard work, but also seek to overturn the social values and replace with alternate set of values. Break law in attempt to change it. This theory tends to oversimplify a complex problem. Lots of people who attained economic success, such as rock stars and celebrities, are addicted to drugs/alcohol. It doesn't explain also why one person may become a ritualist and one an innovator. It also disregards influence of social factors like peer group association, access to drugs, degree of attachment to one's community and family.
- Social Control/Bonding Theory-Social control theory all human beings are rule breakers. The bonds people have to society and its moral codes are what keeps them from breaking the law and remaining socially controlled. Bonded to family, religious affiliation, school, or community they are less likely to engage in delinquent

behavior. When the bonds become weakened then deviant behavior such as drug use can occur. Four social bonds that promote conformity. Attachment-closeness to significant others. Conform to social norms and refrain from drug use because they seek approval of significant individuals. Commitment-Investment and pursuit of reaching conventional goals like good education and job. Involvement-extent to associations with activities in school, community, or religious affiliation. Belief-how well one has internalized moral values of society, like honesty, perseverance, and respect for authority. Weakness of this theory is empirical test results have been mixed. Some studies show parental attachment and school attachment related to lower drug use, but others show peer relationships to be more important predictor. This theory also underestimates the role of delinquent friends, while overestimating importance of involvement in social activities. No explanatory role for peers in this theory.

- Differential Association Theory-Based on premise that drug-taking behavior is learned in interactions and communications with individuals by Donald Sutherland. Learning takes place in intimate groups like with family and friends. If more friends use drugs more likely to use. Learning to use involves learning techniques and how to enjoy from others. Strong sense of social bonding withing drug subculture motivates to continue use.
- Subcultural Recruitment and Socialization Theory-draws on assumptions of differential reinforcement theory, but focuses more directly on relationship drug abusers have with each other within a cohesive subculture and the changes that occur in this subculture over time.
- My thought- need to have a holistic model or biopsychosocial model-include spiritual, mental, emotional, and physical. Respect chemical effects on brain and body, genetic predisposition, effect mentally on feelings and feelings affecting use, culture and human interaction part, effects on social settings, peer influences and parental standards, social norms, public policy and legislation impact. Must take into account environment, friends, strong ties to parents, religion, involvement, self-esteem, stress, cope skills.

Steps Associated with Successful Recovery from Addictive Disorders

- Professionals recognizing that there are multiple pathways to drug abuse and dependence. Combo of biological, psychological, and sociological factors played a role. Integrated approach to treatment called biopsychosocial model. Integrated approach to treatment.
- Readiness to change-stages of change are pre-contemplative(no problem), contemplative(maybe I do have a problem) honesty with self, preparation(planning, steps to change, figuring out the steps, action(taking the steps to change), and maintenance(maintaining the change).
- The steps can overlap; the person can relapse, and have to start over again.
- Very individualized-some may not have to hit rock bottom, others may once, twice or more.

- Avoid people, places, and things that are triggers.
- Support system-family, friends, AA and sponsor, group counseling, etc.
- Reaction from family-family rules, parent's reaction.
- Education-biologically what can do to the body, legal penalties, available groups, AA.
- Manage triggers-some avoidable and others not.
- Maslow-meeting basic needs-food, water, clothing, housing, love, support, etc.
- Appropriate level of care-inpatient, outpatient, medical-DT's, withdrawal management.
- Structure, spirituality(higher power), Step programs, self-help, motivation to change-what's at stake?
- Education, increase problem solving and decision making skills, enhance coping skills, increase assertiveness skills.
-

Factors Commonly Associated with Relapse

- Avoiding people, places, things associated with addiction and old behaviors.
- Isolation
- Trauma
- Stress-need activities or ways to relieve stress, running, surfing, crafts, resource systems to meet basic needs (Maslow)
- Not having a good support system-family, AA/NA, peer group, therapy (individual and/or group), wrap around services, education.
- Not learning good coping skills.
- Need motivation to change- what's at stake?
- Stopping aftercare, support networks.

Q7a. Student two:

A. Factors associated with the Etiology of Addictive Disorders

1. **Biological**
 - a. **Genetic predisposition**
 1. **Stress**
 - b. **Mental illness**

2. **Psychological**
 - a. **Childhood disturbances**
 1. **Trauma**
 2. **Abuse**

- b. Learning through reinforcement
 - c. Resiliency
 - d. Peer influences
 - e. Personality
 - 1. Sensation seeking
 - 2. Disorders
 - 3. Characteristic problems such as impulsivity, antisocial traits etc.
3. Socio-cultural factors
- a. Alienation
 - b. Frustration
 - c. Bonds between society and morals
 - d. Learned interactions through association
 - e. Labeling
 - f. Modeling
 - g. Environment

Q7a. Student three:

A.) Biological: Genetic disposition, Breaking point, heredity, brain damage (neurological deficits)

Psychological: Pathway deficits, coping, malnourish, homelessness, accident, inner personal dynamics,

Socio-cultural: religious practice, legal age, cultural practices (acceptance for gatherings), climate.

Psycho-social: Modeling, household, coping skills, generational?, availability.

Successful Recovery: Precontemplative, Contemplative, Preparative, Action, Maintenance, Relapse (PPL, places and things), Triggers

Support: Family (rules, dad vs. mom, reaction), Peers/groups (social), access to resources, education (scare tactic< institutions, and death>, prevention, changing the circle of friends, legal penalties).

- Structure
- Readiness for recovery?

- Free will
- “I don’t have a problem”

Maslow’s basic needs

Level of care (inpatient) supervision (problems with insurance, \$\$)

Spirituality

Self help programs STEP.

Q7a. Student four:

No answer

Question 7b: Given a hypothetical case scenario of a client with co-occurring addictive and mental health difficulties, be prepared to describe an appropriate treatment strategy for the client.

Q7b. Student one:

CBT

- Engagement-help cope with psychiatric problems. Not aggress drug use yet because lack understanding.. Express empathy, motivational interviewing to connect and to motivate them to work on drug abuse. Open and honest discussions. Reflective listening without judgment, criticism, or attempting to alter the drug use yet.
- Persuasion-continue to use motivational interviewing. Use CBT to help develop skills to meet social, recreational and coping needs. New skills replace old habits of use substances to meet those needs. Understand cognitive, emotional, and behavioral events that occur before, during, and after substance use. Awareness promotes change. Explore withdrawal symptoms, cravings prior to use, hangovers, insomnia, anxiety, and dejection.
- Active treatment-Use CBT to help learn the skills to reduce use and gain abstinence. Help to set goals, behavior action plan, practice plan through role play. Support incremental changes like stop smoke pot, then later address stop alcohol.

- Relapse Prevention- attain and sustain sobriety. May slip but use awareness of thoughts, feelings, and behavior before and after slip to improve future success. Use CBT to examine and change aspects of lifestyle that can contribute to slips. Process of gently separating from therapy. Encourage to volunteer with peer-support groups, this will help them to help others. Rely less of professionals and more on social networks.
- Other evidence-based practices for Dual disorders-Prevent the most amount of relapse, promote high level of independent living, increase continuity of care, generate high level of consumer and caregiver care, reduce cost of care.
- Other-community living, work a job, understand symptoms of mental illness, recognize signs of relapse, manage stress, manages med use and side effects, access to med care and mental health and addictive services, safe and affordable housing, communication with family and friends who are supportive, communicate with professional providers.
- Getting substance abuse and mental health treatment not separate, but from provider familiar with both. Continuity of care.
- The New Hampshire-Dartmouth Dual Disorder Integrated Treatment (DDIT) model-integrates substance abuse and mental health services. DDIT utilizes biopsychosocial treatments (which combine psychopharmacological, psychological, educational, and social interventions) to address needs of consumer and their caregivers. Promotes family involvement, stable housing, and employment. 4 stages-engagement, persuasion, active treatment, relapse prevention.
- For drugs intervention-gather history of alcohol use, amount, pattern, signs and symptoms, social, family, legal, vocation. Drug test, physical exam, psychotropic meds, med side effects, how substances have negatively impacted life, consequences of use, family how use affects them, client accept an addict, educate about addiction and recovery process, attend AA or group counseling support group, awareness of genetics, family, social factors that led to it, plan for sober relationships, support network, activities with no use, job,, build self-esteem with job or projects, living situation, plan to help recovery, coping skills, self-talk and schema, role play, manage stressors with exercise, yoga, music, art, relapse prevention.
- Beware of suicide risk in this population, very high risk. Medical model most effective with this population. Be nonconfrontational, optimistic, empathetic, and not make moral judgments of behavior. Support system needs to be stable and usually is fragile, psychotropic med acceptance for me and client, denial to work on of either illness or drug abuse, integrated approach or if can't treat both a team approach.
- Stage one-initial/assessment/engagement-also called acute treatment and stabilization-therapeutic relationship and accurate diagnosis. Early stage assess and address psychiatric problems. If in detox problems clear then maybe not dual-diagnosis. Second half relationship based on trust. Stage Two-

Persuasion-Help client to understand relationship with drugs and psychiatric problems. Convince client abstinence a goal worth the effort because use complicates psychiatric condition and use is destructive. Motivational interviewing good in this stage. Engagement/Motivational Enhancement stage-break client from denial system of illness and drug abuse. Work with family or legal representative to get client involuntary admitted if needed. Stage Three-Active Treatment-teach skills and help find resources to manage their illness. Group therapy at this stage. Hard to find support system because like at AA encourage to take no drugs. Stage Four-Relapse Prevention-identify problems that can cause or contribute to relapse. Techniques to minimize these problems. Teach life skills to learn how to function in society without drugs. Tailor to person.

Q7b. Student two:

Biologically Based Theories of Alcoholism (Doweiko, 2009)

A. Medical Model

1. Jellinek (1960)

- a. Argued that alcoholism exhibits specific characteristics with control loss, symptom progression, and the final outcome being death.**
- b. Alcoholism is viewed as a disease similar to other medical issues such as cancer.**
- c. Person may be predisposed or at risk for outcomes dependent upon experiences in life.**
- d. 4 stages of alcoholism progression**
 - 1. Pre-alcoholic phase- social tension relief from stress and anxiety, beginning signs of control loss.**
 - 2. Prodromal stage- closet drinking, blackouts, alcohol preoccupation, guilty feelings over behavior.**
 - 3. Crucial phase- physical dependence, self-esteem loss, social withdrawal, self-pity, nutrition neglect, and abstinence attempts.**
 - 4. Chronic phase- moral's deterioration, motor tremor development, drinking obsession, alcohol substitute in absence.**

2. Cloniger, Gohman & Sigvardsson (1981)

- a. Theorized and studied the inheritability of alcoholism in adopted children from natural alcoholic parents.**
- b. Concluded that such children could be classified into two groups: Type 1 and Type 2.**

1. Type 1- late onset alcoholism; productive and functional young adults only drinking in moderation, developed alcoholism later into adulthood; $\frac{3}{4}$ of all children.

1. Type 2- early onset; male limited, onset of alcoholism; 20% of males and become dependent no matter what environment raised.

B2. Psychologically Based Theories of Alcoholism

1. Moral Model- Schomerus, Matchinger & Angermeyer (2006)

a. Alcoholism viewed as a “self inflicted disorder”; addiction is a reflection of “moral weakness”.

2. Alcoholic Personality theory- Howard, Kivlahan, & Walker (1997)

a. There are 3 assumptions:

1. Dependent individuals are immature developmentally

2. Dysfunctional family hx shapes alcoholic personality

3. “Denial” ego defense is overused by individual

b. Individuals are novelty seekers, reward dependent, and high in harm avoidance

c. Personality type poses risk for abuse and dependence.

B3. Compare Theories

1. The Jellinek theory and the moral model

a. Similar in that they both seem to share opinions about the environment which can contribute to risk increase for substance abuse.

b. Both share a sense of moral weakness in that as stages of Jellinek’s theory progress further, the individual in question develops an increasing amount of loss of control, uncaring attitude about how the substance is affecting themselves and others around them, and therefore whatever moral standards they did have before becoming addicted to the substance decreases over time.

c. Both involve self-infliction, appearing to be intentional to mask other symptoms as stated in Jellinek’s theory of stress and anxiety.

2. Cloninger, Gohman & Sigvardsson, and the Alcoholic Personality Theory by Howard, Kivlahan, & Walker are similar in ways.

a. These theories seem to be somewhat more concrete in nature; appearing that the individual is either born as one type of alcoholic out of two possibilities given as a

result of being conceived from natural alcoholic parents, or born with an alcoholic personality type due to dysfunctions in development, upbringing, and in ego.

b. Alcoholism happens or it doesn't; no in-between options given for either theory; little room for ambiguity.

c. Both result in alcoholism in final outcomes; posing risk for dependence and abuse issues and include factors such as novelty seeking and reward dependence.

3. The theories of Jellinek, Cloniger and associates, and Howard and associates have clear and concise criteria which define the classifications behind their theories. They clearly state in understandable terms things that may be able to be observed or noted about the individual in question.

4. All the theories/models may be able to be linked to the moral model in a way that the eventual outcome is moral deterioration due to alcoholism, and no matter what the reason, depending upon the theory followed, is self-inflicted.

B4. Contrast Theories

1. Although Jellinek's theory and the theory of Cloniger and associates are both medically based, the theory by Jellinek could potentially apply to anyone with or without family history, and the progression of their drinking problem.

a. Cloniger and associates appear to convey that alcoholic's offspring will ultimately result as one of the two types of mentioned, and their theory only pertains to this specific population.

2. Although the moral model and theory by Howard and associates, are psychologically based theories, the moral model appears to be extremely vague and include a lot of ambiguity; generally stated terms

a. The Theory by Howard and associates appears to be more concrete, criteria broken down into definitions, and gives people a general sense of what to look for in those individuals.

3. No one theory or model can be absolute, but have been studied in the past with successfully stated results; discretion is advised.

C. Steps Associated with Successful Recovery From Addictive Disorders

1. Stages of Change

a. Pre-contemplative

b. Contemplative

- c. Preparation
- d. Planning
- e. Action
- f. Maintenance
- 2. Support System ie. Family, positive friends, education
- 3. Readiness; motivation
- 4. Structure
- 5. Step programs (most successful)

D. Factors Associated with Relapse

- 1. People
- 2. Places
- 3. Things
- 4. Triggers
- 5. Coping skills

Q7b. Student three:

Q7b. Student four: