

**WURZWEILER SCHOOL OF SOCIAL WORK
YESHIVA UNIVERSITY**

PSYCHOSOCIAL PATHOLOGY

SWK 6111

SUMMER- 2016

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COURSE DESCRIPTION

Psychosocial pathology, is a required course for second year advance clinical practice with individual and families majors, it introduces students to content on the assessment and classification of human behavior that often requires social work intervention. This course expands the knowledge learned in Foundations of Social Work Practice and Human Behavior in the Social Environment.

It is a continuation of the human behavior sequence which includes HBSE I&II with a focus on “normative” development and this course, with a focus on the distinctions between what is commonly thought to be abnormal and that which is clinically understood as abnormal. This course examines signs, symptoms and complexity of mental health diagnostic categories. Students learn to examine mental health concerns of diverse social, racial, ethnic and social class groups with special emphasis on those who have historically been devalued and oppressed.

The initial identification of individuals, whose symptoms and level of functioning indicate that they have a psychologically and/or sociologically based disorder, is often a social work function. Therefore, social workers need to understand how to use the DSM V and the ICD 10. The under-pinning of use of these manuals is accurately assessing the behavior and competency functioning of clients to expedite referrals, provide concurrent treatment and provide information to other involved mental health disciplines.

I. COURSE COMPETENCY OUTCOMES

This course will help students achieve the following competencies:

COMPETENCY 2-ENGAGE DIVERSITY AND DIFFERENCE IN PRACTICE

Social workers understand diversity and difference characterize and shape the human experience as the intersectionality of multiple factors including but not

limited to age, class, color, culture, disability and ability, ethnicity, gender, gender identity and expression, immigration status, marital status, political ideology, race, religion/spirituality, sex, sexual orientation, and tribal sovereign status. Social workers understand that, as a consequence of difference, a person's life experiences may include oppression, poverty, marginalization and alienation as well as privilege, power acclaim. Social workers also understand the forms and mechanisms of oppression and discrimination and recognize the extent to which a culture's structures and values., including social, economic, political, and cultural exclusions, may oppress, marginalize, alienate, or create privilege and power.

Social workers apply and communicate understanding of the importance of diversity and difference in shaping life experiences in practice at the micro, mezzo, and macro levels. social workers present themselves as learners and engage clients and constituencies as experts of their own experiences; and social workers apply self-awareness and self-regulation to manage the influence of personal biases and values in working with diverse clients and constituencies.

MEASURE 2A- Gain sufficient self-awareness to eliminate the influence of personal biases and values in working with diverse groups.

MEASURE 2B- View themselves as learners and engage those with whom they work as informants.

Ethical conduct of research, and additional codes of ethics as appropriate to context.

MEASURE 2C- Demonstrates particular knowledge and sensitivity to forces impacting clients who represent stigmatized or at-risk populations.

Competency 1- Demonstrate Ethical and Professional Behavior

Social workers understand the value base of the profession and its ethical standards, as well as relevant laws and regulations that may impact practice at the micro, mezzo, and macro levels.

Social workers understand frameworks of ethical decision-making and how to apply principles of critical thinking to those frameworks in practice, research, and policy arenas. Social workers recognize personal values and the distinction between personal and professional values. They also understand how their personal experiences and affective reactions influence their professional judgment and behavior. Social workers understand the professional history, its mission, and the roles and responsibilities of the profession. Social workers also understand the role of other professions when engaged in inter-professional teams. Social workers recognize the importance of life-long learning and are committed to continually updating their skills to ensure

they are relevant and effective. Social workers also understand emerging forms of technology and the ethical use of technology in social work practice. Social workers make ethical decisions by applying the standards of the NASW Code of Ethics, relevant laws and regulations, models for ethical decision-making, ethical conduct of research, and additional codes of ethics as appropriate to context.

Social workers use reflection and self-regulation to manage personal values and maintain professionalism in practice situations. Social workers demonstrate professional demeanor in behavior, appearance, and oral, written, and electronic communication. Social workers use technology ethically and appropriately to facilitate practice outcomes; and. Social workers use supervision and consultation to guide professional judgment and behavior.

MEASURE 1A-Practice personal reflection and self-correction to assure continual professional development.

Competency 7- Assess Individuals, Families, Groups, Organizations and Communities

Social workers understand that assessment is an ongoing component of the dynamic and interactive process of social work practice with, and on behalf of diverse individuals, families, groups, organizations and communities. Social workers understand theories of human and the social environment, and critically evaluate and apply this knowledge in the assessment of diverse clients and constituencies, including individuals, families, groups, organizations, and communities. Social workers understand methods of assessment with diverse clients and constituencies to advance practice effectiveness. Social workers recognize the implications of the larger practice context in the assessment process and value the importance of inter-professional collaboration in this process. Social workers understand how their personal experiences and affective reactions may affect their assessment and decision-making.

Social workers collect and organize data, and apply critical thinking to interpret information from clients and constituencies. Social workers apply knowledge of human behavior and the social environment, person-in-environment, and other multidisciplinary theoretical frameworks in the analysis of assessment data from clients and constituencies. Social workers develop mutually agreed-on intervention goals and objectives based on the critical assessment of strengths, needs, and challenges within clients and constituencies; and social workers select appropriate intervention.

MEASURE 7A- collect, organize and interpret data.

MEASURE 7B- Formulates and writes a biopsychosocial assessment utilizing a range of psychological, biological, cultural, family, social, economic and other environmental factors. Shows the ability to develop this document to meet professional standards.

MEASURE 7C-Develops a treatment or action plan for individual and family systems, utilizing a range of theories about families and individuals, life cycle and biopsychosocial factors.

II. INSTRUCTIONAL METHODS

Psychosocial pathology is designed as a lecture/discussion course. Students will have ample opportunity to ask questions, discuss relevant issues and present relevant material. There will be announced quizzes, a midterm assignment and a final examination.

III. COURSE EXPECTATIONS AND GRADING

Students are expected to attend all classes and to be on time. Class participation is important and there is an expectation that students will do the required reading and be prepared for class discussion. Class discussions are meant to enhance the student understanding of content; reading assignments will not be summarized or reviewed in class.

Grades will be weighted as follows:

- 15% Assigned readings in preparation for class discussions and quizzes.
- 15% Mental Status Evaluation
- 30% Mid-term assignment (Assessment and treatment plan)
- 40% Final examination (Multiple choice)

Required Texts

Barlow, David H. & Durand, V. Mark (2015). *Abnormal Psychology: An Integrative Approach* (7th edition). Stamford, Conn.: Cengage Learning. ISBN: 13:978-1-285-75561-8. \$199.00.

American Psychiatric Association. (2013) *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.). (Pocket Edition) Washington, DC: Author. ISBN: 978-0-89042-555-8

Additional articles will be available on e-res; for the online course the articles will be available online in the reading folders for each module.

IV. COURSE REQUIREMENTS

Assignment I- CLASS PARTICIPATION

Class participation is an important part of the learning process and all students are expected to participate in all assigned exercises and discussions.

Traditional In class: students are expected to be prepared for class discussions on assigned readings, related questions raised by the professor and/or in class exercises. You will be graded on the depth of your contributions and preparedness for class discussions and exercises.

On-line class participation: Due to the nature of the on-line course, your participation is imperative. *You will be responsible for being on-line each week and responding to the on-line questions found in the lessons and for responding to classmates posts. This is an interactive class where you will need to both post and respond to your classmates' posts.* You are expected to complete assignments on time and take responsibility for your learning. Responses to posts must be informed by your readings and identification of same in the posts and responses. Respect for the variety of views and values will foster an atmosphere of free exchange and growth through group process. Your time on-line will be logged and the depth of your participation will be graded by responses to assigned questions and responses to posts.

Assignment II- MENTAL STATUS EVALUATION

This is a written assignment to measure the assessment skills of the student. The context will be created or chosen by the individual professor. You will be expected to write a Mental Status Assessment.

Students will write an assessment based upon either (1) the student choice of a client from his/her current caseload or (2) a case presented by the professor, or (3) a role play in class or (4) a film clip provided by the individual professor. Regardless of which context is used, this is a first contact with a client. This first contact (ONLY) is the basis of the Mental Status Evaluation. You will be required to use the current evaluation system in the DSM 5 and ICD 10 to hypothesize a possible diagnosis and to discuss possible recommendations.. You may use any resources that are available on the syllabus or on-line lesson section.

You should use 2-3 outside readings from **professional journals or texts** in addition to any assigned readings. **Do not use online computer sites such as Wikipedia or sites that provide psycho-educational information.** Use APA 6th edition style for writing, citations and references. Total number of pages should be 7-10 pages (NO MORE), double spaced, 12 pt. font.

Use the following outline to write the Mental Status Evaluation:

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MENTAL STATUS EVALUATION

- I. **DEMOGRAPHIC DESCRIPTION:** Identify and place client in his current reality situation including age, sex, race, ethnicity, religion, nationality, marital status, social class, sexual orientation etc.
- II. **PRESENTING PROBLEM:** Include problem for which client seeks help. What is the source and reason for referral; whether problem is of recent origin or a long standing issue? What is client's perception of problem? What precipitated the referral at this time? Is this client mandated and if so, what is the client's response to this?
- III. **APPEARANCE:** Describe physical appearance and any comments client makes about his appearance. Indicate if client description seems accurate.
- IV. **LEVEL OF CONSCIOUSNESS:** Describe level of alertness of the client; level of distraction; ability of client to stay connected to the worker. Did client seem sleepy, lethargic, drugged?
- V. **BEHAVIOR:** Include quality, tone, and rate of speech. Include statement of any unusual movement and when occurred.
- VI. **MOOD AND AFFECT:** Describe mood and affect of client. Were mood and affect consonant? Were they consonant with content? What is the evidence of mood and affect?
- VII. **THOUGHT CONTENT AND PERCEPTION:** Describe the content of the client's thoughts and perceptions. Indicate accuracy and appropriateness of them. Indicate whether there are any indications of hallucinations, delusions, suicidal or homicidal thinking. Are there any indications of thought disturbances such as thought broadcasting, thought withdrawal, thought insertion, ideas of reference, illusions or projections?
- VIII. **THOUGHT PROCESS:** Describe the thinking process. Indicate whether the thinking includes magical thinking, blocking, self critical thinking, tangential thinking, echolalia, clanging, circumstantial thinking, loosening of associations, nonproductive thinking or flight of ideas.

- IX. **INTELLECTUAL FUNCTIONING:** Describe level of abstract thing or lack of this; describe ability to calculate numbers, how distractible is the person? Indicate if there is agnosia, apraxia, dementia or concrete thinking. How much schooling has the person had?
- X. **MEMORY SPHERES:** Describe short and long term memory. Indicate if there is confabulation, word finding difficulties.
- XI. **ORIENTATION:** Awareness of self in person, place and time.
- XII. **INSIGHT:** Refers to level of awareness and understanding of the illness.
- XIII. **JUDGMENT:** Ability to make good judgments, and pragmatic choices appropriate to protecting self and others.
- XIV. **IMPRESSIONS AND DIAGNOSTIC STATEMENT:** Include the following
- a. significant personal history of client
 - b. assessment of client's current social functioning in immediate social situations (family relationships, work, recreation, school etc.)
 - c. assessment of personality structure of the client with particular reference to intellectual endowment, capacity for and quality of object relationships, tolerance for frustration and capacity to delay; capacity for reality testing; discuss interplay between client's current reality situation and his/her ability (ego strengths and weaknesses) to deal with the situation. Discuss the nature and appropriateness of his/her defense mechanism in relation to the social factors and influences of current external pressures.
 - d. Assessment of the nature of the client's problem in light of his/her history. Tie together the significant history and factors in cause-effect relationship as understood from the history. If the history does not contain sufficient information about a specific aspect, it is important to state that this is unclear, thus pointing out areas for further exploration and assessment.
- XV. **HYPOTHESIZED DIAGNOSIS, PROGNOSIS AND RECOMMENDATIONS**

There may be other specific instructions given to you by the individual professor. Due date will be given by the individual professor. Late papers are not accepted.

Assignment III- QUIZZES

This assignment is a combination of demonstration of mastery of content as well as application of content in an assessment and quizzes. Either weekly or bi-weekly practice quizzes will be given in class. The quizzes are multiple choice and will include

content questions and practice developing a diagnosis based upon a given vignette. Although there are several quizzes, the scores will be summed so that there is one grade for the quizzes.

Assignment IV-FINAL EXAMINATION

There will be a final examination evaluating students on the mastery of content covered during the semester. The details and a review will be discussed during the semester. The questions are multiple choice objective questions and short essay. The examination will be administered during the last class session.

All students must complete ALL class assignments, pass quizzes, mid-terms and final exams to receive a passing grade for the course. DO NOT make last minute requests for special accommodations for completion of work; if accommodations are necessary this must be thoroughly discussed with the professor with sufficient time to explore options and for the professor to plan. LATE ASSIGNMENTS ARE NOT ACCEPTED!

V. STUDENTS WITH DISABILITIES

Students with disabilities who are enrolled in this course and who will be requesting documented disability-related accommodations are asked to make an appointment with the Office of Disability Services, Abby Kelsen, Wilf Campus, 646-685-0118, akelsen@yu.edu, during the first week of class. Please submit your accommodations letter to the Disability Services Office immediately. **After approval for accommodations is granted, documentation should be submitted to the professor; this should be done by the end of the third class. Any accommodations must be discussed and negotiated with the individual professor; specific accommodations are not automatic.**

VI. E-RES (Electronic Reserve)

Most of the articles mentioned in the syllabus are available on electronic reserve [E-RES]. You can access the full text articles from your home or from a university computer at no charge. You may have to locate specific journal articles independently; the absence of an article on **ERES** is not a reason to be unprepared for class. You are expected to learn to search for the scholarly material needed.

How do I Use E-RES?

1. Go to the library's online resources page:
http://www.yu.edu/libraries/online_resources.asp
2. Click on E-RES. If you are off-campus, at this point you will be prompted for your Off Campus Access Service login and password.

3. Click on "Search E-RES" or on "Course Index," and search by instructor's name, department, course name, course number, document title, or document author.
4. Click on the link to your course.
5. Enter the password given to you by your instructor.
6. Locate and click on the item you wish to view. Titles beginning with "A", "An", or "The" are alphabetized under "A" and "T" respectively.
7. When the article text or book record appears on the screen, you can print, email, or save it to disk.

To view documents that are in pdf format, the computer you are using must have Adobe Acrobat Reader software. You can download it FREE at www.adobe.com/products/acrobat/readstep2.html

VII. PLAGIARISM

Students should remember that the School will not condone plagiarism in any form and will sanction acts of plagiarism. A student who presents someone else's work as his or her own work is stealing from the authors or persons who did the original thinking and writing. Plagiarism occurs when a student directly copies another's work without citation; when a student paraphrases major aspects of another's work without citation; and when a student combines the work of different authors into a new statement without reference to those authors. It is also plagiarism to use the ideas and/or work of another student and present them as your own. It is not plagiarism to formulate your own presentation of an idea or concept as a reaction to someone else's work; however, the work to which you are reacting should be discussed and appropriately cited. Any student who can be shown to have plagiarized any part of any assignment in this course will automatically **FAIL** the course and will be referred to the Associate Dean for disciplinary action that may include expulsion.

VIII. HIPAA ALERT

In line with the new HIPAA regulations concerning protected health information, it is important that you understand that any case information you present from your work, will need to be de-identified. What this means is that any information that would allow another to identify the person needs to be changed or eliminated. This includes obvious things like names and birth dates but may also contain other information that is so unique to the person that it will allow for identification, including diagnosis, race/ethnicity, or gender. If diagnosis, race/ethnicity, or gender is directly related to the

case presentation it can be included if it will not allow for identification.

IX, CONFIDENTIALITY

Given the nature of classroom discussion and the presentation of case materials and at times personal revelation in class, students are reminded that the same commitment to confidentiality with clients extends to classmates. What is shared in class stays in class.

X.COURSE OUTLINE

UNIT I: INTRODUCTION

This unit examines

- Definition and content of course; review of course objectives
- Historical and theoretical concept of illness and disease, normality and abnormality and use of diagnostic manuals
- Adaptiveness in illness and health
- Bio-psychosocial emphasis of assessment for social workers
- The social worker's roles: diagnostician, advocate, collaborator, mediator, educator, evidenced-based practitioner
- Use of DSM V and ICD 10 as paradigms for diagnosing mental illness and use of psycho-pharmacology

Required Reading:

*Aneshensel, C. (2009). Toward explaining mental health disparities. *Journal of Health and Social Behavior*, 50, (4), Dec. 377-394.

*Barnes, H. (2011). Does mental illness have a place alongside social and recovery models of mental health in service users' lived experience? Issues and implications for mental health education. *Journal of Mental Health training Education and Practice*, 6, (2), 65-71.

*Davidson, L. et al. (2006). Play, pleasure and other positive life events: Non-specific factors in recovery from mental illness? *Psychiatry*, 69 (2), Summer, 151-161.

*Gove, W. (2004). The career of the mentally ill: An integration of psychiatric

labeling/ social construction and lay perspectives. *Journal of Health and Social Behavior*, 45, (4), Dec. 357-375.

- *Hudson, C. (2012). Disparities in the geography of mental health: Implications for social work. *Social Work*, 57, (2), April, 107-119.

UNIT II. Abnormal Behavior in Society: Historical Perspectives, Diagnosis and Dimensional Approach to understanding Psychopathology

This unit will explore the historical antecedents to our understanding of mental illness, diagnosis, and treatment.

Required Reading:

Barlow, David H. & Durand, V. Mark (2015) *Abnormal Psychology: An Integrative Approach*. Stamford, Conn: Cengage Learning.

Chapter 1: Abnormal Behavior in Historical Context
Chapter 2: An Integrative Approach to Psychopathology

- * Overton, SL., Medina, SL., (2008) The Stigma of Mental Illness. *Journal of Counselin and Development*, 86, (2), Spring, 1-11.
- * Roberts, R. (2006). Laing and Szasz: Anti-psychiatry, Capitalism and Therapy . *Psychoanalytic Review*, 93, (5) October, 781-801.
- *Scheyett, A. M. (2005). The mark of madness: Stigma, serious mental illnesses, and social work. *Social Work in Mental Health: The Journal of Behavioral and Psychiatric Social Work*, 3 (4), 79-97.
- * Szasz, T. (1998). Parity for mental illness, disparity for the mental patient, *The Lancet*, 352, (9135) October, 1213-1215.(CLASSIC)

UNIT III. Assessment: Continual Process and a Product

Required Reading

Barlow, David & Durand, V. Mark, (2015) *Abnormal Psychology: An Integrative Approach*. Stamford, Conn: Cengage Learning.

Chapter 3: Clinical Assessment and Diagnosis

*Applegate, J.S. "The Good Enough Social Worker: Winnicott Applied" in Edward, J. & Sanville, J.Eds. (1996) *Fostering Healing*. Northvale, N.J.: Jason Aronson.

*McWilliams, N. (1994). *Psychoanalytic Diagnosis*. New York: Guilford Press.
Chapter 1 "Why Diagnose?"(CLASSIC)

Recommended Reading:

Hudson, C. (2005) Socioeconomic status and mental illness: Test of the social causation and selection hypothesis. *American Journal of Orthopsychiatry*, 75, 3-18.

Lopez, S.R. & Guarnaccia, P.J. (2000) Cultural psychopathology: Uncovering the social world of mental illness. *Annual Review of Psychology*, 51, 571-598.

Millard, D. W.(2000). A transdisciplinary view of mental disorder. Turner(Ed). *Adult Psychopathology, a social work perspective (2nd ed)*. New York: Free Press.

Taylor, R.J, Ellison, C.G.,Chatters, L.M.,Levin, J.S., & Lincoln, K.D. (2000). Mental health Services in faith communities: The role of clergy in black churches. *Social Work*, 45, 73-87.

UNIT IV. Building Blocks of Diagnosis

This unit will explore man as a whole person; we teach the breakdown of mental functions as an artifice for the purpose of teaching the theoretical content. The professional defines the illness. The professional functions in the following roles in the process: collaborator, mediator, advocate, educator, diagnostician and evidence based practitioner. The following issues must be considered in causality.

- Understanding the whole patient
- How physical and mental disorders are related
- Mental Status Evaluation and Diagnostic Statement as Baseline Assessment: Dimensional Approach, Developmental and Lifespan Considerations
- Culture, Genetics and Social Construction

Required reading:

Barlow, David & Durand, V. Mark (2015). *Abnormal Psychology: An Integrative Approach*. Stamford, Conn: Cengage Learning.

Chapter 4: Research Methods

*Walker, I. & Read, J. (2002). The differential effectiveness of psychosocial and biogenetic causal explanations in reducing negative attitudes toward mental illness. *Psychiatry*, 65, (4), Winter.

UNIT V: Basics of Diagnosis

- A. The roadmap- Developing the clinical history includes the history of present illness with symptoms, signs and syndromes; previous mental health history; personal and social background; family history; physical symptoms; mental status evaluation.
- B. The diagnostic method- This includes systematic assessment of date; hierarchy of diagnoses; differential diagnosis; the decision tree.
- C. Tips for Integration of data- (1) History may beat current appearance in developing the diagnosis. (2) Recent history may be more important than ancient history. (3) Collateral history may be more accurate than client's version of history. (4) Signs, meaning what you observe may be more important than symptoms. (5) Objective findings may be more important than subjective judgment. (6) Consider family history. (7) Prefer first the diagnosis that gives the simplest explanation that is more common. (8) Evaluate for differential diagnosis.
- D. Red Flags and Uncertainty-Accept diagnostic uncertainty. The condition may be undiagnosed. Typical red flags are (1) a story that keeps changing (2) repeated unsuccessful suicide attempts (3) unusual symptoms (4) spotty amnesia (5) memory loss in absence of cognitive disorder (6) in-congruous affect (7) hospitalizations in many locations (8) history that conflicts with the usual course of mental illness as we know it.
- E. Multiple Diagnoses- Identify co-morbidity and impose an order for this.
- F.

UNIT VI: Diagnostic Categories, DSM V and ICD 10

These manuals are classifications of mental disorders with specifically defined criteria. They are not sacred texts; they are guides to categorize illness and provide a language of communication for professionals. The diagnoses overlap with each other and with normality.

All diagnoses in the manuals will not be discussed but specific diagnostic categories from each section will be explored as representative.

Class Lecture

Use of the manuals, coding and reporting

VII: Study of Specific Diagnostic Categories (The individual professor will choose the specific disorders to study that are representative of this category.)

A. Neurodevelopmental Disorders and Neurocognitive Disorders

Required Readings :

American Psychiatric Association (2013). *Diagnostic and Statistical Manual of Mental Disorders (5th ed.)* Washington, D.C. Author
 Neurodevelopmental Disorders, 31-87
 . Neurocognitive Disorders, 591-644

Barlow, David & Durand, V. Mark (2015). *Abnormal Psychology: An Integrative Approach*. Stamford, Conn: Cengage Learners
 Chapter 14: Neurodevelopmental Disorders
 Chapter 15 Neurocognitive Disorders

B. Schizophrenia Spectrum and Other Psychotic Disorders

Required Reading

American Psychiatric Association (2013). *Diagnostic and Statistical Manual of Mental Disorders (5th ed.)* Washington, DC: Author. 87-102

Barlow, David & Durand, V. Mark (2015). *Abnormal Psychology: An Integrated*

Approach. Stamford, Conn.: Cengage Learners

Chapter 13 Schizophrenia Spectrum 476-509

C. Mood Disorders

Required Reading

American Psychiatric Association (2013). *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.) Washington, D,C: Author

Bipolar and Related Disorders 123- 154

Depressive Disorders 155-188

Barlow, David & Durand, V. Mark (2015). *Abnormal Psychology: An Integrated*

Approach. Stamford, Conn: Cengage Learners

Chapter 7 Mood Disorders and Suicide 212-267

D. Anxiety Disorders, Trauma and Stress; Obsessive Compulsive Disorders

Required Reading

American Psychiatric Association (2013). *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.) Washington, DC: Author 189-233; 235-264; 265-291

Barlow, David & Durand, V. Mark (2015). *Abnormal Psychology: An Integrated Approach*. Stamford, Conn: Cengage Learners

Chapter 5 Anxiety, Trauma & Stress 122-179

E. Eating Disorders

Required Reading

American Psychiatric Association, (2013). *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.). Washington, DC: Author 329-354.

Barlow, David & Durand, V. Mark (2015). *Abnormal Psychology: An Integrated Approach*, Stamford, Conn: Cengage Learners

Chapter 8 268-294

Beumont, P., Touyz, S. (2003) What kind of illness is anorexia nervosa? *European Child and Adolescent Psychiatry, (Suppl. 1)* 12: 20-24.

Hope, Tony, Tan, Jancinta, Stewart, Anne; Fitzpatrick, Ray (2011) *Anorexia Nervosa*

and the language of authenticity. *The Hastings Center Report*. 41.6
(Nov/Dec) 19-29.

F. Substance Related Addictive and Impulse Control Disorders

Required Reading

American Psychiatric Association (2013). *Diagnostic and Statistical Manual of Mental Disorders*. (5th ed.) Washington, DC: Author 461-490.

Barlow, David and Durand, V. Mark (2015). *Abnormal Psychology: An Integrative Approach*. Stamford, Conn: Cengage Learners

Chapter 11 Substance Abuse, Addictive and Impulse Control disorders
396-439

VIII. Final Exam

REFERENCES

Berger, C.S. & Ai, A. (2000) Managed care and its implications for social work curricula reform:

Policy and research initiatives. *Social Work in Health Care*, 31, 59-82.

Dulmus, C. N. & Rapp-Paglicci, L.A. (2000) The prevention of mental disorders in children and

adolescents: Future research and public policy recommendations. *Families in Society*, 81,

94-303.

Dulmus, C.N. & Smyth, N.L. (2000) Early onset schizophrenia: A literature review of

empirically-based interventions. *Child and Adolescent Social Work Journal*, 17, 55-69.

Gantt, A.B., Cohen, N.L. & Sainz, A. (1999) Impediments to the discharge planning effort for

psychiatric inpatients. *Social Work in Health Care*, 29, 1-14.

Glass, C.R.& Arnkoff, D.B. (2000) Consumers' perspectives on helpful and hindering factors in

mental health treatment. *Journal of Clinical Psychology*, 56, 1467-1480.

Lesser, J.G.(2000) Clinical social work and family medicine. *Health and Social Work*, 25, 119-126.

Lewinsohn, P.M., Solomon, A., Seely, J.R. & Zeiss, A. (2000) Clinical implications of "subthreshold" depression symptoms. *Journal of Abnormal Psychology*, 109, 345-351.

Loveland Cook, C.A., Becvar, D.S., & Pontious, S.L. (2000). Complimentary alternative medicine in health and mental health: Implications for social work practice. *Social Work in Health Care*, 31, 39-57.

McFall, M., Malte, C., Fontana, A. & Rosenheck, R.A. (2000) Effects of an outreach intervention on use of mental health services by veterans with posttraumatic stress disorder. *Psychiatric Services*, 51, 369-374.

Melchert, T.P. (1999). Relations among childhood memory: A history of abuse, dissociation and repression. *Journal of Interpersonal Violence*, 14, 1172-1192.

Miller, B.V., Fox, B.R. & Garcia-Beckwirth, L. (1999). Intervening in severe physical abuse cases: Mental health, legal and social services. *Child Abuse and Neglect*, 23,

905-914.

Murray, M.G. & Steffen, J. J.(1999). Attitudes of case-managers toward people with serious

mental illness. *Community Mental Health Journal*, 35, 505-514.

Nobles, A.Y., & Sciarra, D.T.(2000). Cultural determinants in the treatment of Arab Americans:

A primer for mainstream therapists. *American Journal of Orthopsychiatry*, 70, 182-191.

Olfson, M., Guardino, M., Streuning, E., Schneier, F.R., Klein, D.F.(2000). Barriers to the

treatment of social anxiety. *American Journal of Psychiatry*, 157, 521-527.

Olsen, D.P. (1998). Toward an ethical standard for coerced mental health treatment: Least

restrictive or most therapeutic? *Journal of Clinical Ethics*, 9, 235-246.

Ohayon, M.M. & Schatzberg, A.F. (2002).Prevalence of depressive episodes with psychotic

features in the general population. *The American Journal of psychiatry*,159, 1855-1861.

Okuji, Y., Matura, M., Kawasaki,N., Kometani, S. & Abe, K. (2002). Prevalence of insomnia

in various psychiatric diagnostic categories. *Psychiatry and Clinical Neurosciences*, 56,

239-240

.Olfson, M., Shaffer, D., Marcus, S.C. & Greenberg, T.(2003). Relationship

between antidepressant medication treatment and suicide in adolescents. *Archives of*

General Psychiatry, 60,978-982.

Primm, A.B., Gomez, M.B., Tzoloz-Iontchev, I., Perry, W., Vu, H.T., & Crum, R.M. (2000).

Mental health versus substance abuse treatment programs for dually diagnosed patients

. *Journal of Substance Abuse Treatment*, 19, 285-290.

Rahkonen, T., Makela, H., Paanila, S., Halonen, P., Sulkava, R. (2000). Delirium in elderly

people without severe predisposing disorders: Etiology and 1-year prognosis after discharge. *International Psychogeriatrics*, 12,(4), 473-481.

Rapport, M.D. (2001). Bridging theory and practice: Conceptual understanding of treatments for

children with attention deficit hyperactivity disorder (ADHD), obsessive compulsive

disorder (OCD), autism and depression. *Journal of Clinical Child Psychology*, 30, (1), 3-

7.

Ritter, B. & Dozier, C.D. (2000). Effects of court ordered substance abuse treatment in child

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