

Psy 3313 Syllabus
(Course Number 45404)

Psychopathology

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General Course Policies in Psy 3313

Welcome to Psy 3313.

Psy 3313 is a serious course for students serious about learning the subject matter of psychopathology. On the basis of past experience, it is safe to say that **if you don't do most of the work you won't do well in this course**. On the other hand, students who do the work typically do well. The great majority finish with grades in the range of A to B-.

Class Format

The topics listed in this syllabus may be covered in class by lecture, discussion, exercises, videos, or any other medium that proves useful. In general, **the lectures complement but do not duplicate the readings** and only occasionally involve detailed comment on the readings. In this course, lectures and readings are two different sources of information in the area of psychopathology, and each should be able to stand on its own. If you have a problem with either one, please raise questions in class, since in that case other students probably have the same problem. Please also feel free to talk to the teaching assistants or to me outside of class.

In Psy 3313, most class meetings will include opportunities to discuss current readings. Depending on class members' preferences, we will also schedule special class meetings as review sessions, especially just before the examinations.

There will be at least two discussions of recently published articles. Each will last approximately a half class session and will start with a brief quiz on basic features of the article, continue with a discussion of the article, and end with a quiz aimed at more subtle points that the discussion was aimed at clarifying.

Teaching Assistants

The course is staffed with two undergraduate teaching assistants (TAs). The TAs will have office hours, will be available for individual consultation or tutoring, will conduct occasional discussion sections, and will meet with study groups at their request. The TAs will also assist in administering and grading quizzes and examinations.

Other Course Activities

You will receive occasional assignments in Psy 3313 designed to sharpen your understanding of psychopathology and the research methods of the field. These activities will consist of brief papers and discussions of research articles drawn from the current literature.

Study Groups

You are encouraged to participate in a small study group. The purpose of study groups is mutual support in achieving the objectives of the course. By sharing information, and by probing and tutoring one another, all members help themselves and other group members to master the material. Using and teaching are the very best ways to learn. Because none of the quizzes or tests in this course is graded on the curve, helping others can in no way hurt your own chances.

Study groups should include between four and eight committed members. If you already know people in the course with whom you would like to form a group, you are welcome to do that. We will ask you to let us know the membership of your group. If, like a majority of students, you do not already have the makings of a study group, we will assign you to one during the first week of the course.

Study groups normally meet independently of the teaching staff, but, if you like, the teaching assistants and I will be happy to meet with your study group at a mutually convenient time.

Grading standards and Workload Expectations

University policy now requires all course syllabi to contain the following statements. A moment's reflection by a critical thinker will make it apparent that the grading standards below are too ambiguous to place any serious constraints on an instructor's judgments but, for what they are worth, here they are. Note that the workload expectations are quite *unambiguous* and are the basis for deciding on workload in this course.

University Grading Standards.

- A achievement that is outstanding relative to the level necessary to meet course requirements.
- B achievement that is significantly above the level necessary to meet course requirements.
- C achievement that meets the course requirements in every respect.
- D achievement that is worthy of credit even though it fails to meet fully the course requirements.
- S achievement that is satisfactory, which is equivalent to a C- or better.
- F (or N) Represents failure (or no credit) and signifies that the work was either (1) completed but at a level of achievement that is not worthy of credit or (2) was not completed and there was no agreement between the instructor and the student that the student would be awarded an I.
- I (Incomplete) Assigned at the discretion of the instructor when, due to extraordinary circumstances, e.g., hospitalization, a student is prevented from completing the work of the course on time. Requires a written agreement between instructor and student.

Credits and Workload Expectations. For undergraduate courses, one credit is defined as equivalent to an average of three hours of learning effort per week (over a full semester) necessary for an average student to achieve an average grade in the course. For example, a student taking a three credit course that meets for three hours a week should expect to spend an additional six hours a week on coursework outside the classroom.

(End of mandated section)

Equal Opportunity Statement. The University of Minnesota is committed to the policy that all persons shall have equal access to its programs, facilities, and employment without regard to race, color, creed, religion, national origin, sex, age, marital status, disability, public assistance status, veteran status, or sexual orientation.

Students with Special Needs

It is University policy to provide, on a flexible and individualized basis, reasonable accommodations to students who have disabilities that may affect their ability to participate in course activities or to meet course requirements. Because we cannot anticipate every student's special needs, we urge students with disabilities or other special needs to contact the instructors early in the semester to discuss their individual needs for accommodations. UMM's Academic Assistance Center (362 Briggs Library; www.mrs.umn.edu/services/dsoaac/aac/) is also available for help beyond the help available from the instructor and teaching assistants of the course. If you have a disability and need accommodations, please contact Colleen Frey at the UMM Disability Services office, 362 Briggs Library, extension 6163.

This syllabus is available in alternative formats upon request.

(Portions of the above several sections were adapted verbatim from official University policy statements.)

Academic Misconduct

In the University of Minnesota Policy on Scholastic Misconduct, scholastic misconduct is broadly defined as "any act that violates the rights of another student in academic work or that involves misrepresentation of your own work." Scholastic dishonesty includes (but is not necessarily limited to): cheating on assignments or examinations; plagiarizing, which means misrepresenting as you own work any part of work done by another; submitting the same paper, or substantially similar papers, to meet the requirements of more than one course without the approval and consent of all instructors concerned; depriving another student of necessary course materials; or interfering with another student's work.

Note that appropriating without quotation marks and attribution any string of words written or spoken by another individual is one form of plagiarism.

For the protection of students and the integrity of Psy 3313, I take academic misconduct quite seriously. Academic misconduct in any portion of the academic work for this course shall be grounds for awarding a grade of F or N for the entire course.

On a personal note, when I post a grade I am delivering my best judgment of the student's level of accomplishment. I cannot be an accomplice to undermining the honesty of the grades I report and still preserve an honest relationship to my faculty and student colleagues in the UMM community. The grades I report must therefore represent my honest best judgment of each

student's accomplishment. A student who cheats is exploitatively manipulating my honest judgment and thereby falsifying it.

In light of this, I regard cheating, including plagiarism, as a form of personal betrayal, and I react to it self-protectively as I would respond to any other form of betrayal, by avoiding having anything more to do with the person involved. I therefore regard evidence of deliberate plagiarism or other cheating as an immediate involuntary withdrawal from this course. The only exceptions would depend upon the re-establishment of my trust in the person, which would be at best difficult and for which there is no pat formula.

I believe that most UMM students are basically honest and decent people, but even basically honest and decent people are subject to temptation and error. Be sure you understand the rules, including the definition of plagiarism (see above), and be scrupulous in abiding by them.

Adverse Emotional Reactions to the Readings

Many people react to descriptions of psychopathology with varying degrees of distress. Because most psychopathology consists of exaggerated or out-of-control forms of normal experience, it is natural to perceive similarities between yourself and the various cases of psychopathology that you will encounter in this course. That is as it should be. The people suffering from some diagnosable form of psychopathology—about 30% of us in any given year, about half of us over our lifetimes—are ourselves or people very much like us. Their/our psychopathology is at most an extension of the human experience. Therefore, if you perceive similarities to yourself, there is no necessary cause for alarm.

If anything in the course makes you emotionally uncomfortable, or if you wish to talk about the course for any reason, don't hesitate to see me about it. If you feel distressed for any reason and wish more than a faculty conference, the UMM Counseling Service (235 Behmler Hall, second floor rear; 589-6060) is available to help you. After hours, you can reach emergency services through the Stevens Community Medical Center at 589-1313.

Examinations, Grading, and Deadlines

Kinds of tests. There are four in-class, closed-book tests in Psy 3313. There will also be occasional quizzes during regular class sessions. The examinations consist of short-essay identify-define-describe questions, longer essay questions, and possibly multiple-choice, matching, listing, or fill-in-the-blank items. Quizzes will contain only the non-essay kinds of items. There is a specimen examination along with comments on how it is graded in the full version of this syllabus, which will be posted on electronic reserve (ERes).

In addition to the quizzes and examinations, there will be a series of short paper assignments.

Point distributions. Final grades will be based on 1000 points. These are distributed as follows: 150 points for each of four in-class examinations, totaling 600 points; 200 points for the quizzes; and 200 points total for the occasional brief paper assignments.

Alternate exams. If you are disappointed with your performance on an examination and wish to study some more to improve your mastery of the material, you may take an alternate examination on the same material with similar questions. If your performance on the alternate examination is better than that on the original examination, the new grade will replace the old one on your grade record. If it is worse, the old grade will stand. You may take as many alternate examinations on a given part of the course as you wish, but after the first alternate they will take the form of oral examinations.

There are no alternate forms for the quizzes. If you have an acceptable excuse (see below), I will waive the quiz and prorate the average of your other quiz grades to fill the gap.

The right to take an alternate examination is contingent on a good faith effort on the original examination. Except for Test 4, I reserve the right not to admit you to an alternate examination if it looks as if you blew off the original. You are free to take either Test 4 or its alternate or both.

Writing style. I do not grade directly on general writing style. However, if your writing makes it hard to understand what you are saying, you will *not* receive the benefit of the doubt; and I will refuse to grade examinations that fall below university standards of acceptable writing style. I also reserve the right to dock you points for misspellings and other such violations that are covered in the spelling section of the full syllabus. Therefore, please read that section carefully and retain it.

PLEASE USE A PEN, NOT A PENCIL, IN WRITING YOUR TEST ANSWERS, AND WRITE VERY LEGIBLY.

Absences and excuses. All tests and quizzes must be taken when scheduled except in the case of *certifiable* illness, mental incapacitation, or *dire* family emergencies. Students who fail to take a quiz or examination for other reasons lose the points associated with it.

Disagreements about Grades

Being human, instructors and teaching assistants sometimes make mistakes. Therefore, if you believe that a grade reflects grader errors or is unfair, please be sure to see me or a teaching assistant. We can't guarantee that we will agree with you, but we will never hold this against any student, and we welcome the opportunity for interchange.

Specimen Examination Questions

(Unlike an actual unit examination, the questions for this specimen are drawn from several units and illustrate all of the major kinds of questions that might be used. Difficulty levels may be a bit easier in these examples than on actual tests. Any given test will contain only one kind of essay question.)

Total points: 150

I. A matching question: please write to the left of each word in the left-hand column the letter of the entry in the right-hand column that best corresponds to it. (30 points)

- | | |
|--------------------------|--|
| _ schizophrenia | a. fear of dying from a heart attack |
| _ panic disorder | b. social unresponsiveness from infancy on |
| _ bipolar disorder | c. guiltless betrayal |
| _ autism | d. trouble paying attention |
| _ antisocial personality | e. severe mood swings |
| | f. claiming multiple physical symptoms |

II. Please write your essay answers in a blue book. You *must* write with a pen rather than a pencil. If you don't have a pen, borrow one. Identify, define, and describe precisely any 6 of the following (120 points):

- | | |
|----------------------------|-------------------------------|
| 1. Diathesis-stress theory | 5. Autogenic training |
| 2. Psychopathy | 6. Systematic desensitization |
| 3. Taxometrics | 7. Moral treatment |
| 4. Paranoid schizophrenia | 8. Sociopsychological model |

OR

II. Essay

[Brief case description]. Your task is to perform a psychological evaluation leading to a DSM IV diagnosis.

1. Drawing just on the disorders we have covered in the course up to this point, (a) list the possible disorders of which the behavior described above could be a symptom and (b) list any disorders that could reasonably be ruled out from the start. (c) For those disorders you rule out, state your reasoning in ruling them out.

2. Taking your differential-diagnostic list of possibilities, what pieces of information would you need to narrow down the list to a single likely diagnosis? That is, what pieces of information would rule it in and what other pieces of information would rule it out? *In each case, describe your reasoning, preferably with reference to the research evidence that applies to each form of psychopathology.*
3. For the diagnoses that seem most likely to you, what kind of treatment would you recommend?

Comments on Specimen Examination

Part I. This is a standard kind of "objective" question. In this example, each correctly placed letter gets the examinee 6 points. Note that many Part I questions will be multiple choice, and some may be questions in which you are asked to list things.

Part II identify-define-describe question. The answer should be relatively short—usually a blue-book page or two. However, your answer should be *precise*. That is, it should include the main distinguishing features of the concept (i.e., should identify it); it should distinguish it from other concepts with which it can be confused ("define" comes from the Latin root "fin" meaning "end" and means "set limits or boundaries on"); and it should indicate the relevance of the term to psychopathology if that is not already obvious. Brief examples and empirical evidence help.

Suppose you are asked to "identify, define, and describe precisely" the concept *drive* for a maximum of 20 points. Here are four illustrative answers and the number of points each would get:

- A. Any of several gear ratios in an automobile. (0)
- B. A process that motivates someone toward a goal. (10)
- C. According to Hull, drive is a physiological imbalance that motivates behavior, such as hunger and anxiety. It is characterized by elevated arousal levels, restlessness, sensitivity to cues related to reducing drive levels, and temporarily increased value of incentives related to drive reduction. Reducing drive reinforces the behavior that led to drive reduction. (17)
- D. (Same as above, *plus*:) Some investigators define it operationally through deprivation (such as number of hours since last feeding) and others define it by assessing arousal levels. Hull multiplied drive times habit strength times incentive value times some other variables to predict whether the organism will emit a given response. (20)
- E. (Same as D. *plus*:) . In the Yerkes-Dodson Law, drive relates to performance with an inverted-U function, such that intermediate levels of drive lead to optimal performance. Other examples are thirst and sexual arousal. [Etc.] (20)

Note that Answer B received only half credit (a C- in my point system; see below) because there are several kinds of motivational processes. It doesn't zero in on the distinguishing features of drive. Answer C takes care of that problem and gets an A, but not quite full credit. Answer D is longer (total of five sentences), shows a lot of knowledge about the concept, and receives full credit. Answer E is longer still and adds important points about the concept, but it gets no more points than Answer D because Answer D already met our highest expectations and we cannot give more than full credit. Even though the student writing Answer E makes excellent points, s/he has actually suffered by losing time that should have been spent on other questions.

Part II, long essay. The purpose of the course is to provide an *understanding* of the field. Understanding is best measured by assessing a student's ability to use the material in thinking about people. The essay questions therefore usually ask students to think with the material--to compare, argue, conclude, and so on, going beyond what is already spelled out for them in readings and lectures. In this way, also, the essay questions perform an important teaching function in their own right.

Since psychology is a science, the questions ask students to think scientifically. Therefore, statements of opinion are worth little--whether or not they agree with mine--unless they are supported by valid arguments based where possible on rigorous evidence. This may sound formidable, but most students learn to do this well enough to do well on these examinations. As you study, you will be well off to keep in the back of your mind questions such as "How does the author know this is true?" "On the basis of what evidence does she disagree with So-and-so?" and so on.

Point System

The points assigned to each essay answer are actually a rating system in which points reflect my judgment of the letter grade that an answer merits. For instance, I assign from 53% to 56% of the maximum points for a "C," from 67% to 71% for a "B," and from 83% to 100% for an "A." Note that this is not a linear scale. The full equivalencies are as follows:

(A+ 90-100	C+ 57-61	(F+ 30-39)
A 83-89)	C 53-56	F 20-29
A- 77-82	C- 50-53	(F- 00-19)
B+ 72-76	D+ 47-49	() = not
B 67-71	D 43-46	differentiated
B- 62-66	(D- 40-42)	in final grade

The advantages of using points rather than just letter grades are that I can add them up across questions (and later across tests), they can reflect the relative importance of a question, and they permit finer judgments within a grade level. The advantage of nonlinearity is that I can give disproportionately high rewards for brilliant work and disproportionately low rewards for abysmal work. In other words, some brilliance on

some questions can more than outweigh mediocre work on others, and blowing off parts of the material can more than outweigh mediocre work on other parts. Also, these points correspond well to the way I cut distributions of scores on multiple choice examinations, thereby making it easy to combine points from those kinds of questions with essays.

Reference Tools

In this course you will encounter many new terms. If you are not sure you know what they mean, look them up. *Don't assume* (a) that they mean about the same as some simple, familiar word you already know, (b) that a confusing passage is either unimportant or will be explained later, or (c) that if the author lists two or more similar-sounding terms, they are probably different ways of saying the same thing.

One thing you can do to clear up confusion, of course, is to ask a TA or me. There are, however, some first-aid remedies readily available.

First of all, most textbooks (including the textbook by Butcher et al. used for this course) have glossaries that can be helpful. However, many times a good dictionary of the English language can clear up the confusion over a word you think is technical. Always react to a feeling of vagueness about a word, or to a feeling that the author has used two words to mean the same thing, by checking first in a dictionary. If you don't own a dictionary, buy one. It is an inexpensive and very worthwhile investment—if you use it. However, dictionary entries are also available on the web using, for example, Google.

If the dictionary doesn't list the word or still leaves you confused, consult one of the following, which are in the reference section of the library:

English, H. B., & English, A. C. (1958). *A Comprehensive Dictionary of Psychological and Psychoanalytical Terms*. N.Y.: Longmans, Green.

Chaplin, J.P. (1968). *Dictionary of Psychology*. NY: Dell. (Paperback)

Kazdin, A. E. (Ed.) (2000). *Encyclopedia of Psychology*. New York: Oxford U. Press/Washington, D.C.: American Psychological Association. (8-volume set!)

Longman Dictionary of Psychology and Psychiatry. (1984). New York: Longman.

Although a confusing passage may sometimes be cleared up by later material, more commonly it causes further confusion about the later material, and the confusion then accumulates to the point where you may have serious difficulties. Try to clear up all confusion when it first occurs.

If you wish to pursue a question into the psychological literature, there are many reference tools. The original, comprehensive, paper tool is *Psychological Abstracts*, a monthly periodical that abstracts or lists nearly every article or dissertation in psychology within about a year of its appearance. However, most people now consult *Psychological Abstracts* electronically on the *PsycINFO* database. You can access this now back to 1872 through the UMM web site: Library—Article and Reference Databases—PsycINFO. (I click on R and scroll up to PsycINFO.) That brings you to the search screen. (From off-campus, you will be asked to provide your username and UMM [“X.500”] password.) Now just fill in your search terms, and off you go. PsycINFO abstracts articles, dissertations, books, and chapters in books. Books and chapters are relatively recent additions, so older books and chapters are not listed. PsycINFO now also provides links to full-text html and pdf files of many journal articles.

Another useful reference tool is the *Annual Review of Psychology*, in which 15 to 20 prominent psychologists spend a chapter each reviewing developments in their specialty during a recent period. It is far less comprehensive than *PsycINFO* but provides an integration of the material. Other important sources are the *Review of Personality and Social Psychology* (appearing since 1980) and *Professional Psychology*.

There is also, of course, the broader Web. You can find useful material through the sites for the American Psychological Association (www.apa.org) and the American Psychological Society (www.psychologicalscience.org). APA has created PsychCrawler (www.PsychCrawler.com) as a search engine for psychologically related material. Google (www.google.com) is an amazingly efficient search engine when you enter a series of search terms, but the information it finds is usually unvetted and hence not necessarily reliable.

Vocabulary

Whatever vocabulary you came into the course with, it can stand improvement. The only way you can increase your vocabulary is to be exposed to new words. Therefore, when you come across unfamiliar words in readings and lectures, they provide you with a learning opportunity. Seize it! If you hear the word in class, jot down what it sounded like and look it up or ask one of us about it. If it happens in class, I would appreciate your raising your hand and asking then and there.

You may not realize it, but you are the victim of a strategic decision made around 1970 by American publishers to "dumb down" their textbooks. They did this by editing out of textbooks all words that seemed uncommon, that dropped below some fairly common frequency in American English. They also simplified the structure of their prose, so that students acquire less ability to comprehend complex sentences. These publishers were responding to a gradual drop in students' reading abilities and were motivated by their desire for market share, but their policy doomed generations of students to impoverished vocabularies--at least those students who did little reading outside of their textbooks and came from less well educated family backgrounds.

A rich vocabulary helps you to communicate. Less common words are typically not just showy versions of more common ones. Their special connotations let you convey finer gradations of meaning and hence let you be more precise about what you mean to say. If you are planning on graduate school, there is one more, very concrete advantage to a rich vocabulary: It is a crucial factor in Graduate Record Examination scores. Students with restricted vocabularies are likely to do substantially less well and therefore lose out in the competition for the best graduate opportunities.

Therefore, students who wish that instructors would talk exclusively "on my level" are wishing for something educationally unwise. I don't plan to cooperate with it. (But I *do* want to be clear!)

Writing Style and Spelling

It might seem strange to find a section on style in a psychology syllabus, but because this is a liberal arts college, writing competency should be an issue in all work you do. One of the goals of a liberal education is the ability to write effectively. At the very least, your everyday writing style ought to be good enough not to be an embarrassment to you or to UMM.

Writing style is not something you can put on at will, like company manners. It has to be ingrained through practice. That is why you are expected to write competently in this course. If you feel that this is too much of a challenge, I urge you to visit the English faculty's Writing Room (327 Briggs Library) for help in upgrading your skills. They will actually coach you through your papers and exams.

Bad writing is not only ineffective communication; it is also hard on your readers. For a fluent reader, trying to wade through material that is badly spelled, badly punctuated, and poorly organized is like trying to slide down a wooden chute that hasn't been properly sanded. It cuts your speed, increases your effort, and becomes a pain in the backside.

This syllabus is not the place to provide you with the fundamentals of good writing, but there are certain kinds of spelling errors that occur with special frequency in psychology courses because the words are heavily used in psychological writing. This section of the syllabus points out some of the most common of these. Please memorize the correct spelling of these words and use it in your examinations and papers.

The old nemesis: "ie" versus "ei." The following traditional rhyme might help you:

"I" before "e" (achieve, believe)
Except after "c" (receive, perceive)
Or when sounded like "ay"
As in "neighbor" or "weigh"

— with certain exceptions, including weird, foreigner, either, neither, counterfeit, seize, and probably some others!

Adjective versus noun endings and the letter "l." In English, the adjectival ending that uses "l" is spelled "-al." The ending "-le" is a noun ending. That is why we write about principal factors but about scientific principles. In the first instance, "principal" modifies "factors" as an adjective, but in the second instance "principles" is a noun. (If you are confused by the differences between nouns and adjectives, visit the Writing Room today! Use the emergency entrance!) That is also why we have "virtual," "rational," and "theoretical" spelled "-al" but "pinnacle," "monocle," and "pickle" spelled "-le." As with all things in English, there are exceptions. Principals of schools are spelled "-al," but that is probably because of historic accident—here, "principal" is probably short for "principal teacher." Also "withdrawal" is spelled with an "-al" even though "withdrawal" is a noun; but it is a noun formed from the verb "withdraw" (not from "drawl"). In English, nouns formed from verbs often have an "-al" ending (committal, revival, referral).

Doubling consonants on stressed syllables. Sometimes a rule in a language creates undesired outcomes. Then the language must come up with a second rule to get around the problem created by the first rule. For instance, in Italian a "g" followed by an "e" is soft (as in "gelatin"), so to get a hard "g" when the next sound is "e" Italians interpose a silent "h." That is why there is an "h" in "spaghetti" and "ghetto." In English, the sounds of certain vowels change when they are followed by a single consonant and then by an "e." Compare "quit" with "quite." Therefore, if you don't want the vowel sound to change when you put a verb in the past tense, for example, the second rule is to double the consonant. That is why we write "commit" and "commitment" but "committed," or "occur" but "occurrence." However, for some reason this is done only if the vowel is in a stressed syllable. Therefore, we write "reFER" and "reFERred" but "REference."

"Effect" versus "affect." I won't try to reason this one out. Both can serve as either nouns or verbs, but they mean different things according to the spelling. The noun "effect" means the impact of one thing on another, as in "the effect of the action." The *verb* "effect" carries this meaning out in one way, as in "He effected the plan." (I.e., "He put the plan into effect.") But if you wish to carry out another meaning of the noun "effect" in a verb form, meaning one thing had an effect on another, the spelling changes: "Thirst affected her perception of the desert." The best way to remember this last spelling is to recall that in English we occasionally prefix the letter "a" (often along with a consonant) to indicate impact, as in "the aggrieved party," "aggravated assault," "acknowledged letter." The prefix is a form of the Latin "ad-" meaning "to" or "toward." Finally, there is the noun "affect," as in "Happiness is positive affect." Used as a noun, "affect" is a synonym for "emotion" or, as in this course, for certain components of emotion. Now you should be able to understand the following sentence: "Effecting the plan with such poor effects affected his affect." (!) Please get it right.

The endings "ence" versus "ance." Here again there is no way to reason out this distinction. However, try to be sensitive to the spelling differences in your writing, even

if it takes rote memorization. Thus, we write "occurrence," "tendency," "dependency" (and, of course, "dependent") but "maintenance," "resistance," and "deviance."

Singular and plural forms of Latin and Greek words. Until about the middle of the 20th century, liberally educated people were expected to know Latin and Greek, because these languages, and especially Latin, formed such an important basis for the English language, and because Latin long served as the international language of Western scholarship. People with that kind of background had no problems with English words imported directly from the Latin or Greek. Today, few students ever learn these languages and most are therefore at a loss when trying to use their imports into English. However, here are some simple rules for people without that background.

Latin nouns can be masculine, feminine, or neuter. All genders appear commonly in various words used in English. Most nominative singular and plural endings are as follows:

	Singular	Plural	Examples
Masculine	-us	-i	stimulus, stimuli; alumnus, alumni
Feminine	-a	-ae	alumna, alumnae; fovea, foveae
Neuter	-um	-a	datum, data; memorandum, memoranda

Note that we speak of one stimulus but of two stimuli and that "data" is plural. We speak of a single *datum*. "The data is..." is incorrect usage. Always, data *are* (or *were*). You should be able to generalize from these examples to new instances. For example, you might look at several aquaria before buying the aquarium of your choice, and you might compare the UMM PE Center with other gymnasia.

Watch out for the Greek endings, too. There are only two sets in common use in English. One set ends "-on" in the singular and becomes "-a" in the plural: for instance, "phenomenon" (singular) but "phenomena" (plural). Likewise, "criterion" and "criteria." Many people treat "phenomena" and "criteria" as if they were Latin singular nouns, but they are Greek plurals. We speak correctly of one criterion for success or of several criteria, of one phenomenon but several phenomena. The second Greek set ends in "-a" in the singular but in "-ata" in the plural, as in "schema" and "schemata," or "stigma" and "stigmata."

Etc. This is *not* spelled "ect." even though in English one might think that "c" after "t" must be a typo. "Etc." is an abbreviation for the two Latin words "et cetera," which mean "and other things." That is why the "c" follows the "t."

NOTE: Although this is a course in psychology, and therefore nearly your entire grade is based on your working knowledge of the material in the area of this course, I reserve

the right to reduce your grade for repeated language errors, especially if they are among those covered in this syllabus.

Main General Psychopathology Learning Goals

1. Be able to describe various meanings of the terms *psychopathology* and *abnormal* and the extent of their relativity to their sociocultural context.
2. Be able to articulate the differences among the medical model, sociopsychological model, and biopsychosocial model of psychopathology and their implications for clinical practice.
3. Given any major recognized class of abnormal behavior, be able to describe the major conceptual systems for thinking about it, its diagnostic characteristics, its prognosis, its probable causes, and the best ways to treat it, insofar as all these appear to be known; or be able to describe the nature of the confusion in the field about them. In all of this, *be able to describe the evidential basis* for each assertion. The operational definition of "major recognized class" is its appearance as more than a mere mention in any of the class materials.
4. Here's an application goal for Psy 3313: Given any instance of behavior, be able to suggest alternative classifications of psychopathology (i.e., diagnostic categories) into which it might fit and be able to formulate questions about it the answers to which would enable you to render a specific diagnosis. That is, be capable of *differential diagnosis*. (This will form an important part of Tests 2 and 4 and your papers.)
5. Be able to describe the chief psychological approaches historically and currently in use for treating behavioral problems. Be able to describe what is known in general about the effectiveness of each approach and be able to describe in general terms *the scientific evidence on which you base your judgment*.
6. Become sufficiently familiar with the terminology of psychopathology that you can understand *precisely* what is meant by the many standard terms used in the field and be able to use them *precisely*.

References

- Butcher, J. N., Mineka, S., & Hooley, J. M. (2004). *Abnormal psychology and modern life* (12th Edition). New York: Pearson Education/Allyn and Bacon. PURCHASE REQUIRED. (Referred to as BMH in the schedule of class topics.)
- Cox, W. M., & Klinger, E. (2004). A motivational model of alcohol use: Determinants of use and change. In W. M. Cox & E. Klinger (Eds.), *Handbook of motivational counseling: Concepts, Approaches, and Assessment* (pp. 121-138). Chichester, UK: Wiley.
- Docherty, N. M., Gordinier, S. W., Hall, M. J., & Dombrowski, M. E. (2004). Referential communication disturbances in the speech of nonschizophrenic siblings of schizophrenia patients. *Journal of Abnormal Psychology, 113*, 399–405.
- Miller, M. W., Kaloupek, D. G., Dillon, A. L., & Keane, T. M. (2004). Externalizing and internalizing subtypes of combat-related PTSD: A replication and extension using the PSY-5 scales. *Journal of Abnormal Psychology, 113*, 636–645.
- Schwartzberg, S. S. (2000). *Casebook of Psychological Disorders*. Boston: Allyn and Bacon. PURCHASE REQUIRED. (Referred to as S in the schedule of class topics.)

Psy 3313 Schedule of Class Topics and Readings

(Note: This schedule of topics constitutes a statement of aspiration. We may not get to everything on this list or in the lecture outlines. This material constitutes a selection out of a vast field of information. We will cover as much of it as time permits. The discussion opportunity dates indicate the dates by which the respective readings should have been completed. All dates except test dates should be considered approximate.)

January 17-19 Introduction to the course and to psychopathology and its models
Discussion opportunities: BMH Chs. 1-3

24-Feb. 7 Anxiety-based, somatoform, and dissociative disorders (Videos: Panic Disorder; Obsessive-Compulsive Disorder)
Discussion opportunities: BMH Chs. 4, 5, 6, and 8; S Chs. 1, 2, 5, 6

February 9-14a Personality disorders, antisocial behavior, and psychopathy (video: Antisocial Personality Disorder)
Discussion opportunity: BMH Ch. 11; S Chs. 8 and 9

14b Article discussion, Miller et al., 2004

16 Test 1

21-23 Substance abuse (videos: Substance Abuse/Alcohol; Anorexia Nervosa)
Discussion opportunity: BMH Chs. 9, 10, and 12; Cox & Klinger, 2004; S Chs. 7 and 10

21 Evening: video (R-rated; attendance completely optional) on the drugs scene: *Union Square*)

28 Sexual violence and abuse; Video: Male Sexual Dysfunction
Discussion opportunity: BMH Ch. 13; S Chs. 11 and 12

March 2 Test 2

(6-10 Spring break—enjoy!)

14 Videotapes: Major affective disorders; Classification of major affective disorders

16 Affective disorders: Recent findings and conclusions;
Discussion opportunity: BMH Ch. 7; S 3-4

21a Response integration and organization: An approach to schizophrenic disorganization

21b Symptoms of schizophrenia: Videotapes

March 23-28 Core symptoms and degeneration of response integration in schizophrenia
Discussion opportunity: BMH Ch. 14; S 13

March 28 Evening: Video on schizophrenia: the film *Promise* (James Garner, James Woods)

30a Video: Behavioral Treatment of Autistic Children

30b Article discussion TBA

30 Evening: video on autism: the film *Rainman* (Dustin Hoffman, Tom Cruise)

April 4 Video: Amnesic Disorder
Discussion opportunity: BMH Chs. 15-16, S 14-15

6 Test 3

11 Basic operations in psychological treatment

13 Video: Depression: A Cognitive Therapy Approach

18 Video: The Abused Woman: A Survivor Therapy Approach

20 Imagery and relaxation methods and therapies

25-May 2 Outcomes of psychological treatment
Discussion opportunity: BMH Chs. 17-18 and course to date

4 Test 4

May 10 Alternate Test 4 (4-6 pm)

Lecture Outlines

Introduction to Psychopathology and its Models

- I. By “psychopathology” we tend to mean problem behavior that gets in the way of somebody's goals--for the patient or relatives, the neighborhood, government, educational or economic institutions, etc.--and constitutes behavior not explainable in terms of normal cognition, emotion, and motivation.
 - A. The bases of diagnostic judgments: statistical concepts of normality, political judgments, and professional consensus: DSM IV; ICD-10 (Follette & Houts, 1996)
 - B. Cultural relativity and cultural universality
- II. Prevalence, incidence, and cost of mental disorder
- III. Task of the field of psychopathology: Explain abnormal behavior in accordance with general principles of psychological science: description, taxonomy, diagnosis (telling apart), etiology, prognosis (telling ahead of time), treatment
- IV. Metatheories of psychopathology
 - A. Spirit possession
 - B. Medical model
 1. Internal (underlying, probably neurohumoral) cause for external symptoms
 2. Predictable etiology, course, outcome
 - C. Sociopsychological model (Ullmann & Krasner)
 - D. Biopsychosocial model (Engel, 1977)
- V. Violence and mental disorder (and personality disorders: Berman et al., 1998)
- VI. Heritability (DiLalla et al., 1996)
- VII. Social support and mental disorder (expressed negative emotion versus support--effects on
 - depression (e.g., Moos et al., 1998),
 - schizophrenia,
 - alcohol (O’Farrell et al., 1998) and drug abuse (Farrell & White, 1998), and
 - post-traumatic stress disorder
- VIII. Some terminology:
 - symptom, syndrome, and disorder;
 - differential diagnosis;
 - etiology; prognosis (to tell ahead);
 - acute, chronic, and severe;
 - psychopathology versus psychopathy

Anxiety-Based Disorders

- I. Changing approaches to taxonomy of emotional disorders
 - A. The classical categorizations
 - B. Proposals for reorganization (Watson, 2005): “The existing structural evidence establishes that the mood and anxiety disorders should be collapsed together into an overarching class of emotional disorders, which can be decomposed into 3 subclasses: the bipolar disorders (bipolar I, bipolar II, cyclothymia), the distress disorders (major depression, dysthymic disorder, generalized anxiety disorder, posttraumatic stress disorder), and the fear disorders (panic disorder, agoraphobia, social phobia, specific phobia). The optimal placement of other syndromes (e.g., obsessive-compulsive disorder) needs to be clarified in future research” (p. 522).

- II. Anxiety-Based Disorders: Descriptions
 - A. Anxiety: “an apprehensive anticipation of future danger, often accompanied by somatic symptoms of tension or feelings of dysphoria” (Bouton, Mineka, & Barlow, 2001, p. 7)
 - B. Anxiety disorders
 1. Cued (phobia) versus *seemingly* uncued (panic, generalized anxiety) (Barlow, 2002; Forsyth & Eifert, 1998)
 2. Physical hyperarousal versus worry (subjective anxiety) (Joiner et al., 1999)
 3. Obsessions, compulsions, neurotic ambition
 4. Posttraumatic Stress Disorder (PTSD)
 - a. dimensions (Anthony et al., 1999; McWilliams et al., 2005)
 - b. getting “stuck in the past” (Holman et al., 1998)
 - c. nontaxonic (Ruscio et al., 2002)
 - d. May be preventable with propranolol (Vaiva et al., 2003; Pitman et al., 2002)
 - C. Somatoform disorders:
 1. Conversion dysfunctions and pains (“hysteria”)
 2. Related to animal defensive reactions to imminent predation (Nijenhuis et al, 1998)?
 - D. Dissociative disorders: amnesia, fugues, and Dissociative Identity Disorder (“multiple personality”) (Gleaves, 1996; Lilienfeld et al., 1999; Scropo et al, 1998)
 - E. Anxiety sensitivity (Taylor et al., 1996); and panic (Clark et al., 1997; Schmidt et al., 1997)

- III. Nature of fear/anxiety and its relation to anxiety-based disorders
 - A. 3 basic systems (Jeffrey Gray and others):
 1. Behavioral Activation (BAS); too much: mania; too little: depression
 2. Behavioral Inhibition (BIS): anxiety
 3. Fight-Flight: fear, panic/terror
 - B. The all-clear signal—its failure as a source of pathological anxiety (Lebrón, Milad, & Quirk, 2004; Millad & Quirk, 2002; Milad, Vidal-Gonzalez, & Quirk, 2004)
 - C. Applications to anxiety disorders
 1. Phobias: specific cued fears out of proportion to cue, prepared by evolution (Gray, 1982; Öhman & Mineka, 2001)
 2. Panic disorder: Anxiety-potentiated, conditioned attacks (Bouton, Mineka, & Barlow, 2001)

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Anxiety-Based Disorders (continued)

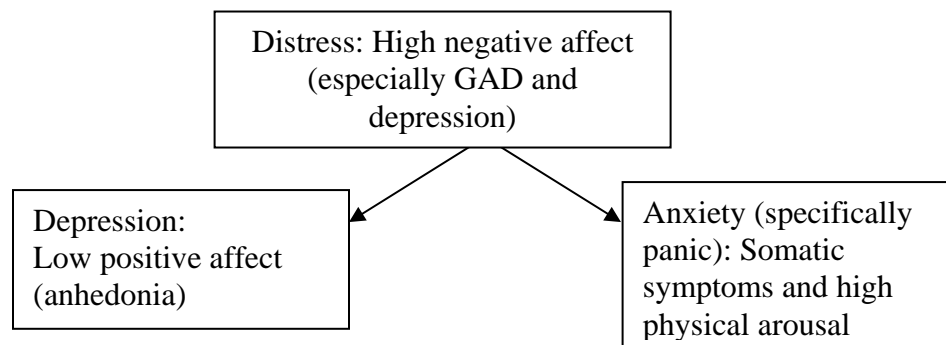
(III. continued)

- D. Other connections in the area of anxiety and behavioral inhibition
 1. anxiety, active versus passive avoidance, and basic brain systems (Gray, 1982)
 2. clinical anxiety as oversensitization to fear cues (Rosen & Schulkin, 1998)
 3. self-reinforcing nature of anxiety avoidance (Solomon & Wynne, 1954)
- E. Cognitive processing biases in anxiety disorders
 1. Attentional biases (Broadbent & Broadbent, 1988, 1990; Ehlers et al., 1990; Kindt & Brosschot, 1997); Newman et al., 1993); specific to goal/fear-related cues (Amir et al., 2005; Hadwin et al., 1997; Lecci et al., 1996; Mogg et al., 1992; Pauli et al., 1997; Pineles & Mineka, 2005; Riemann et al., 1995).
 2. Memory biases (Ingram et al., 1987)
 3. Expectancies (in social phobia: Foa et al., 1996; Wallace & Alden, 1997) and history of lost control (Chorpita & Barlow, 1998)
 4. Dual Representation Theory of PTSD (Brewin et al., 1996)

IV. Comorbidity involving anxiety and relation to broad personality dimensions

- A. Comorbidity among anxiety disorders and between anxiety and depression (Barlow, 2002; Clark, 1989; Newman et al. 1998)
- B. Distinctions between anxiety and depression (Beck et al., 1987; Clark, Watson, & Mineka, 1994; Jolly et al., 1994; Trull & Sher, 1994)
- C. The Tripartite Model (Clark & Watson; Brown et al., 1998; Brown et al., 1998; Chorpita et al., 1998; Joiner, Catanzaro, & Laurent, 1996)

Watson & Clark Tripartite Model of Anxiety and Depression



- D. A personality-diathesis dimensional viewpoint (Clark, 2005)
- E. Organization of disorders into internalizing (anxiety, depression) and externalizing (aggressive, overassertive) (Krueger, Caspi, & Moffit, 1998)
- F. An individual differences approach to anxiety disorders: susceptibility to fear responding, other negative affects, and fear conditioning (e.g., Krueger et al., 1996; Lilienfeld, 1997)
- G. Suicide hazard in anxiety disorders (Sareen et al., 2005) after controlling for other factors: Odds ratio (any anxiety disorder vs. none) of attempts: 2.48.

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Anxiety-Based Disorders (continued)

- V. Treatments for Anxiety Disorders
 - A. Integrated psychological treatments for panic and agoraphobia (Barlow, 2002; Barlow et al., 1989; Craske et al., 1991; Beck & Emery, 1985)
 - 1. Relaxation
 - 2. Desensitization: exposure, response prevention, and other behavioral methods
 - 3. Cognitive therapy
 - B. Obsessions and compulsions
 - 1. Compulsions: As above, plus expectancy X value cognitive approaches
 - 2. Obsessions: Satiation and clarification of what they are (Freeston et al., 1997)
 - C. Somatoform disorders: behavioral methods (changing reinforcement contingencies) and social support
 - D. Pharmacotherapies: short-term effectiveness, side effects, high relapse rates, and dependency (Lydiard et al., 1996)

Personality Disorders, Antisocial Behavior, and Psychopathy

- I. The Nature of Personality Disorders
 - A. Dimensional nature
 - B. Spectrum disorders
 - C. Difficulty maintaining categories

- II. Antisocial PD
 - A. A heterogeneous category in DSM IV (Widiger et al., 1996)
 - B. Adolescent-limited vs. life-course-persistent antisocial behavior (Moffitt)

- III. Antisocial behavior: Pathology of rational choice?
 - A. E x V approaches: abnormal V and E terms?
 - B. Cognitive processing biases during development (Dodge et al., 1995)
 - C. Possible roles of intelligence and impulsivity (Block, 1995; Lynam et al., 1993; Lynam & Moffitt, 1995; Séguin et al., 1995)
 - D. Inflated and vulnerable self-esteem, narcissism (Baumeister, 1996; Bushman & Baumeister, 1998) [Note cultural relativity of need for self-esteem: Heine et al., 1999]

- IV. Research problems: Selectivity of accessible criterion populations: successive filters (Widom, 1978)

- V. Demographics and distribution of crime (Brody et al., 2003; Rivers, 1989)

- VI. History and definition of psychopathy: Cleckley

- VII. Dimensionality of psychopathy
 - A. An oblique two-factor conception (Harpur, Hare, & Hakstian, 1989)
 - 1. Exploitative use of others
 - 2. Unstable antisocial lifestyle
 - B. Relation to age (Harpur & Hare, 1994)
 - C. A two-cluster solution (Hicks et al., 2004)
 - 1. Emotionally stable psychopaths (low Stress Reaction, high Agency)
 - 2. Aggressive psychopaths (high Negative Emotionality, low Constraint, low Communion)
 - D. Evidence on taxonicity
 - 1. For: Ayers, 2000 (substance-abusing sample; ASPD); Grant et al., 1994; Harris et al., 1994 (psychiatric sample); Skilling et al., 2001 (sample of boys)
 - 2. Against: Marcus et al., 2004 (prison inmates; pure psychopathy measure)
 - 3. Upshot: Some evidence for taxonicity of antisocial/aggressive component, not for Psychopathy Factor 1
 - E. "Syndromes of disinhibition" (Patterson & Newman, 1993)
 - F. A continuous "externalizing spectrum" for alcohol and drug abuse and antisocial personality (Krueger et al., 2005)

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- VIII. Studies of avoidance conditioning, fear, and emotion in psychopathy
- A. Difficulty with passive avoidance learning and fear conditioning (Lykken, 1957; Newman & Schmitt, 1998; Birbaumer et al., 2005 [fMRI of limbic activity in fear conditioning])
 - B. Chlorpromazine effects on cheating (Schachter & Latané, 1964)
 - C. Adrenaline and placebo effects on passive avoidance learning in psychopathic and nonpsychopathic convicts (Schachter & Latané, 1964)
 - D. Temporal gradient of fear arousal in psychopaths (Hare, 1965, 1966)
 - E. Emotional differences in processing of words (Day & Wong, 1996); Williamson, Harpur, & Hare, 1991), startle reflex (Patrick et al., 1993), and processing of fear-arousing imagery (Patrick, Cuthbert, & Lang, 1994)
 - F. The problem may be only one of relative insensitivity to own emotions (failure of “response modulation” [Newman et al., 1997]; cf. also Bechara et al.; Damasio’s somatic marker hypothesis)
 - G. **But** not all psychopaths are low-anxious (Schmitt & Newman, 1999)
- IX. Strong genetic component, little shared-environmental effect in conduct disorder (Rhee & Waldman, 2002; Slutske et al., 1997; Wootton et al., 1997); genetically determined co-occurrence with depression in adolescence (O’Connor et al., 1998); onset in childhood (Lynam, 1997, 1998)
- X. Relation to personality dimensions (Krueger et al., 1994, 1996; Sher & Trull, 1994) and gender (Huselid & Cooper, 1994)

Substance Abuse

- I. Scope of the Problem
- II. Chemicals and the Brain
 - A. Neural communication
 - B. Neural impulse generation: traveling membrane depolarization
 - C. Synaptic transmission and transmitter substances
 - D. Emotions and transmitter substances
 - E. Neuropeptides and neuromodulation; Endorphins
 - F. Upshot: All psychoactive substances are built like and mimic either transmitter substances and neuropeptides that change how you feel, or substances in the chain leading up to transmitter substances.
- III. The argument in outline:

Brains are made up of about 100 billion neurons.
Neurons run on chemicals.
Alcohol and other psychoactive drugs act like or change natural brain substances.
Therefore, alcohol and other drugs change the way the brain works.

Some neurons determine how we feel.
Alcohol and other drugs change the way those neurons work.
Therefore, alcohol and other drugs change the way we feel.
Therefore, we take alcohol and other drugs when we expect that doing so will lead to a net positive gain in feeling good or feeling less bad.
- IV. Some evidence on alcohol, response to stress, and emotion:
 - A. Depression and substance use in the Viet Nam war (Robins, 1974)
 - B. Response to stress (Armeli et al., 2000; Sillaber et al.; 2002; Cooper et al., 1995)
 - C. Effects on mood (Carney et al., 2000)
 - D. Steele on changed self-evaluations; etc.)
- V. Withdrawal symptoms are not the primary factor in maintaining dependence (Mello & Mendelson, 1972; other considerations)
- VI. Individual differences in disposition toward chemical dependency
 - A. Genetics and brain function (Cloninger; Kendler & Prescott; Sillaber et al., 2002)
 - B. Family X gene interactions and related data (Widom et al., 1999; LeGrand et al., 2005)
 - C. Personality correlates (Caspi et al., 1997; Cox, 1978 to 1988; Krueger et al., 1996; Mohr et al., 2001; Sher et al., 2000; Trull & Sher, 1994; Wills et al., 1998; Dugman et al., 2004), especially Antisocial Personality (lower serotonin transporter density in anterior cingulate affect area: Manterre et al., 2002), and comorbidity (with PTSD: Stewart, 1996; conduct disorder and alcohol abuse: Slutske et al., 1998)
 - D. Taxonomies

(Outline continues on next page)

Substance Abuse (continued)

- VII. Approaches to treatment of chemical dependency
- A. Traditional disease-model-based, AA-type, “12-step” (McKellar et al., 2003)
 - B. Antabuse/Disulfiram
 - C. Cognitive-behavioral approaches: Relapse prevention (Marlatt & Gordon, 1985; Jaffe et al., 1996); Skills-Based Substance Abuse Counseling (Langley & Ridgely, 1994); Cue-exposure (Sitharthan, 1997); other reinforcement (Iguchi et al., 1997; Wong et al., 2004); CBT for crack (Maude-Griffin, 1998); disattention training using Alcohol Stroop (Fadardi, 2003 [based on attentional biases of alcoholics, many studies, e.g., Pothos & Cox, 2002])
 - D. Motivational restructuring (Cox & Klinger, 1988, 2004) and interviewing (Marlatt et al., 1998); susceptibility to rational decision-making even when inebriated (MacDonald et al., 2000)
 - E. Pharmacotherapy, naltrexone (opioid antagonist, blocks opioid receptors ; Jaffe et al., 1996; O'Brien, 1996; Schuckit, 1996) and buprenorphine (opioid with reduced euphoria, beginning to replace methadone) with or without naloxone (opioid antagonist) (Clark, 2003); topiramate reduces alcohol drinking and craving during treatment (Johnson, 2003)
 - F. Vocational rehabilitation (Platt, 1995)
 - G. Relative effectiveness (Babor et al., 1997; Morgenstern et al., 1997; Ouimette et al., 1997)
 - H. Antidepressant medication as treatment for smokers (Hitsman et al., 1999)
 - I. Project DARE (Lynam et al., 1999)

Sexual Violence And Abuse

- I. Definitions; date versus predatory rape (Ellis, 1989); adolescent-limited vs. life-course-persistent rape (Lalumière et al., 2005) as part of antisociality
- II. Prevalence
- III. Consequences, coping styles, and treatment (Boney-McCoy & Finkelhor, 1996; Golding, 1999; Resick & Schnicke, 1993; Rodriguez et al., 1997; Valentiner et al.; 1996)
- IV. Three theories of rape (Ellis, 1989): (A) "feminist" (Brownmiller, 1975), (B) biosocial evolutionary, (C) social learning
- V. Ellis' (1989, 1991) synthesized biosocial theory
- VI. Models and Data on Causation of Rape
 - A. Path analysis by Malamuth et al. (1991, 1995): hostile masculinity and impersonal sex
 - B. Insensitivity to women's communications (Malamuth & Brown, 1994)
 - C. Arousal uninhibited by suffering (Lohr et al., 1997)
 - D. Reactance + narcissism (Baumeister et al., 2002)
 - E. Three-course model (Lalumière et al., 2005); antisociality + high mating effort (which are also correlated)
 - F. Other factors:
 1. Authoritarianism (Lalumière et al., 2005 ; Walker et al., 1993)
 2. Birth order (Lalumière et al., 2005)
- VII. Types of rape and rapists in a convicted offender sample (Groth, 1979): anger, power, sadistic (see also Prentky & Knight, 1991)
- VIII. Victimization of children
 - A. Prevalence of sexual assault of children in Los Angeles (Siegel et al., 1987)
 - B. Vicious cycle: sexual abuse of children begets sexual abuse of children (Worling, 1995)
 - C. Incest
 1. Clinical outpatients (Meiselman, 1978)
 - a. Types of incest, predominance of father-daughter incest
 - b. Seduction methods
 2. Sequelae (Meiselman; Yapple, O'Donnell, & Cunningham, 1988; but not necessarily pervasive as recalled by nonclinical college students: Rind et al., 1998)
 3. The question of veracity: Can "restored memories" be believed?
- IX. "Is homophobia associated with homosexual arousal?" (Adams et al., 1996)
- X. The role of pornography (Donnerstein, 1980-87)

Affective Disorders: Recent Findings and Conclusions

- I. Traditional classification of affective disorders
 - A. The traditional scheme (see figure)
 - B. Taxonic or dimensional? Dimensional! (Hankin et al., 2005)

 - II. Neurochemical and -anatomical features of affective disorders: Unipolar vs. bipolar
 - A. Manic states and dopamine (Depue & Iacono, 1988)
 - B. Depression and serotonin (Jacobs, 1994)
 - C. Manic episodes contain elements of depression (a “manic defense”? Lyon et al., 1999)
 - D. Reduced glial cell counts in dorsolateral prefrontal cortex and left amygdala in MDD and untreated bipolar disorder (Bowley et al., 2002)

 - III. Precipitating Events in Affective Disorders
 - A. Lack of clear distinctions among types of depression re onset: Losses and life events affect all depression, even bipolar (Johnson & Miller, 1997; Johnson & Roberts, 1995)
 1. Cumulative impact of stressors in series (Overmier, in rats: ulcers)
 2. Point of no return? Kuhl’s (2000) argument that HPA-cortisol production overwhelms hippocampus and weakens its feedback function of inhibiting HPA.
 - B. First episodes (clear effects of life stressors) versus recurrences (reduced role of life events) (Lewinsohn et al., 1999; Monroe et al., 1999); but marital dissatisfaction plays a continuing role (Whisman & Bruce, 1999); parents’ divorce disposes toward depression over and above genetics (D’Onofrio et al., 2005).

 - IV. Reduced positive affect and response to rewards (Bäckman et al., 1996; Dunn et al., 2004 (in response to pos & neg pictures); Henriques, Glowacki, & Davidson, 1994; Jolly et al., 1994; Trull & Sher, 1994); weak BAS, active BIS (Kasch et al., 2002)

 - V. Cognition and Depression
 - A. Cognitive properties of depression
 1. Past vs. future orientation (Kroll-Mensing, 1993; MacLeod & Byrne, 1996)
 2. Attention to cues for negative affect (e.g., Gotlib et al., 2004; Tucker et al., 2003)
 3. Memory for negative cues (Lewinsohn & Rosenbaum, 1987; Lyubomirsky et al., 1998; Tobias, Kihlstrom, & Schacter, 1992) and memory specificity (Goddard et al., 1996; Gotlib et al., 2004)
 4. Attributional/interpretive differences versus incidence of unhappy events (Iardi et al., 1997; Seidlitz & Diener, 1993; Sweeney, Anderson, & Bailey, 1986; Terry et al., 1996); irrational beliefs (Solomon et al., 1998); change in treatment as predictors of relapse (Beevers et al., 2003); worse in chronic depression (Riso et al., 2003)
 5. Reassurance-seeking style (Potthoff, Holahan, & Joiner, 1995)
 7. Rumination (Just & Alloy, 1997; Lyubomirsky & Nolen-Hoeksema, 1995; Lyubomirsky et al., 1999; Nolen-Hoeksema, 2000; Joormann & Siemer, 2004) and automatic thoughts (Schniering et al., 2004)
 8. Self-standards versus self-efficacy (Cervone et al., 1994) and perfectionism (Hewitt, Flett, & Ediger, 1996)
- (Outline continued on next page)

Affective Disorders (continued)

V. (continued)

- B. Causality: which direction?
 1. Depression causes cognitive changes (Cole et al., 1998; Hamilton & Abramson, 1983; Simons, Garfield, & Murphy, 1984)
 2. But cognitive traits dispose to depression (Alloy et al., 2006); Metalsky, Joiner, Hardin, & Abramson, 1993; Hilsman & Garber, 1995; Stewart et al., 2004; but Ralph & Mineka, 1998, have discrepant findings)
 3. Effectiveness and nonspecificity of cognitive therapy
 4. Maybe recovery from depression is a matter of metacognitive monitoring of own thoughts (Sheppard & Teasdale, 2004)

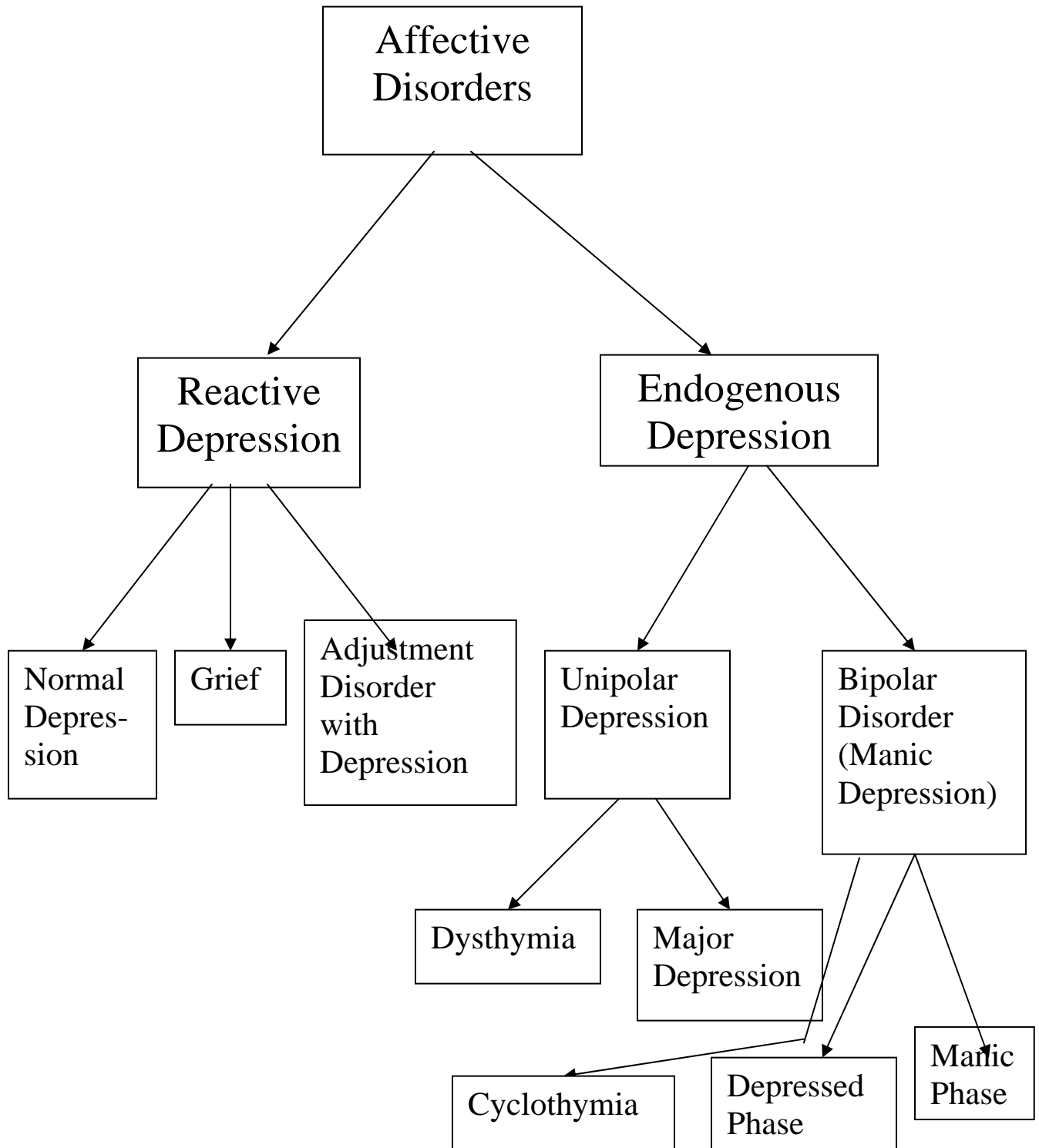
- VI. Depressed individuals also generate stress for themselves (Daley et al., 1997; especially if they also have a personality disorder: Daley et al., 1998) and alienate others (e.g., Alloy et al., 1998), especially peers (Stice et al., 2004); shyness and low social support lead to loneliness and depression (Joiner, 1997); but social support helps stave off depression (Lara et al., 1997), especially parental support (Stice et al., 2004)

- VII. Variability in global self-esteem (Roberts & Gotlib, 1997) and well-being (Gable & Nezlek, 1998)

- VIII. Body image, eating disturbance, and depression (Stice et al., 2000)

- IX. Heritability of depression in old age (McGue & Christenson, 1997)

Traditional Classification of Affective Disorders



Characteristics of Types of Endogenous/Psychotic Affective Disorders

(based on: Depue, R.A., & Monroe, S.M. (1978). The unipolar-bipolar distinction in the depressive disorders. *Psychological Bulletin*, 85, 1001-1029.)

Diagnostic Criteria	Bipolar				"Unipolar" Manic	Unipolar Depressed	
	I	II	III ^a	Other		I	Other
Depression episode	x	x	x	x	0	x	x
Manic episode	x	x	0	x	x	0	0
Hospitalization for Depression	x	x	x	0	0	x	0
Hospitalization for Manic State	x	0	0	0	x	0	0
Manic family history	0	x	x	0	0	0	0

CHARACTERISTICS

	Attribute	
Retarded depression (dopaminergic deficit in extrapyramidal nigro-striatal pathway?)	x	less
Agitated depression (dopaminergic hyperactivity in extrapyramidal nigro-striatal pathway?)	0	x
Depressed sleep	hypersomniac	hyposomniac
Somatic complaints in depression (headaches, impaired vision, nausea, appearance)	low	high, f(severity)
Affect in depression	less angry, anxious	angrier, more anxious
Median age at onset	20's, 30's	40's
Limit on no. of episodes (generally over first 20 years of disorder)	7-9	4-6
Divorce rate	high (generally after manic attack)	low
Alcohol use	high in manic episodeslower
Suicide rate	higherlower
Inheritance	dominant X-linked	polygenic
Response to Lithium Carbonate	high in depressed and manic	lower but still positive

^a Also called "Unipolar II." However, response to Lithium carbonate and probable X-linked genetic transmission (i.e., transmitted via X-chromosomes and hence not from father to son) suggests it is a variant of bipolar disorder.

Response Integration And Organization: An Approach to Understanding Schizophrenia

- I. Perception and imagery as efferent processes (Tomkins, Leuba, Ellson, Perky)
- II. Important Facts about Response Organization (using language as paradigm)
 - A. Order cannot usually be predicted from associative frequencies (Deese)
 - B. Infinite variety of an individual's response sequences (e.g., sentences, athletic motions)
 - C. Language and other behavior follows grammatical rules ("I putted it down.")
 - D. Language and other behavior is "chunked" or unitized
 - 1. Fodor & Bever's clicks
 - 2. Johnson's recall of consonant groups
 - E. Response units are organized hierarchically (vs. by Markov process)
 - 1. Johnson: Sentence latencies as a function of grammatical "depth"
- III. The Concept of Meaning Complex
 - A. Meaning supercedes verbal thought; thought precedes speech
 - 1. Sentence recall: Bransford & Frank
 - 2. Subfluency
 - B. Organizational response
 - C. Controls unfolding of response
 - D. Commands integrated responses
 - E. Carries meaning, intention
- IV. Response Integration
 - A. Characteristics: segmentation, smooth flow, hierarchic organization, automaticity
 - B. Overlearning
 - C. Integration of perceptual feedback, imaginal, cognitive, and motor elements in the response sequence
 - D. Flexibility in response to feedback, within limits
- V. Response Degeneration
 - A. Disintegration of integrated sequences at vulnerable poin
 - B. Effects of fatigue, sleep deprivation, sleepiness, drugs
 - C. Mechanism for fusion in fantasy and dream symbolism
 - D. Mechanism for positive symptoms in schizophrenia?:

"[S]chizophrenia is `a disease of neuronal connectivity'. Perhaps the search must refocus on those mechanisms that influence and continually shape and reshape neural connectivity at the level of dendrites, spines, synapses, neurotransmitters, and signal transducers." (Andreasen, 2000)

Core Symptoms and Degeneration of Response Integration: An Approach to Schizophrenia

- I. Distractibility and Interference
 - A. McGhie-Chapman interviews; Freedman and Chapman, 1973
 - B. McGhie-Chapman-Lawson experiments on distracting stimuli
 - C. Fragmentation of thought, self-interruption; slow (Fuller et al., 2005) or nonconsolidation of memory (Gold et al., 2000)
 - D. Effects of movement and perception on each other (McGhie-Chapman interviews)
 - E. Disruptive effect of affective stimuli (plurisignificance; concern-relatedness)
 - F. Studies of children at risk (Garmezy program; Marcus, 1972; Rutschmann, Cornblatt, & Erlenmeyer-Kimling, 1977) and adults (Finkelstein et al., 1997); Nuechterlein et al.; reduced differential activation (target vs. other stimuli) in frontostriatal regions (fMRI) in prodromal high-risk individuals (Morey et al., 2005)
 - G. Corrective effects of reducing stimulation (Lang & Buss, 1965, p. 94), immobilization (McGhie-Chapman interviews), and amplification of feedback re success or failure
 - H. Impaired control of attention when tasks require switching attention (Smith et al., 1998)
 - I. Similar distractibility in schizotypal personality disorder (Braunstein-Bercovitz & Lubow, 1998)

- II. Reduced Use of Contextual Cues
 - A. Speech perception (McGhie-Chapman interviews)
 - B. Recall of word groups and contextual constraint (Lawson, McGhie, Chapman)
 - C. Stronger-meaning effects (Chapman & Chapman)
 - D. Sundry cognitive tasks (Cohen et al., 1999); also in Schizotypal Personality Disorder (Barch, 2004)
 - E. Deficit in prepulse inhibition of the startle reflex (Perry et al., 2002)
 - F. Deficit on AX task correlated with deficient activation of dorsolateral prefrontal cortex (MacDonald & Carter, 2003; MacDonald et al., 2005)

- III. Motor Impairment
 - A. Deautomatization (McGhie-Chapman interviews; Elaine Walker et al., 2004; Walker & Lewine, 1990; Neumann et al., 1995)
 - B. Difficulty in getting behavior started; blocking; disattention problems
 - C. Motor impairment is correlated (inversely) with age of first diagnosis (Manschreck, Maher, et al., 2004) and with impairment in use of context (Manschreck, Maher, et al., 2000)
 - D. Developmental precursors (Elaine Walker; Neumann et al., 1995)
 - E. Ameliorative effect of practice (Shakow)
 - F. Ameliorative effect of mental rehearsal
(Outline continues on next page)

Schizophrenia (Continued)

- IV. Perceptual Changes
 - A. Brightness, flatness, looming, shape distortion, and size constancy
 - B. Hallucinations
 - 1. Not simply vivid images
 - 2. Belief in reality of imagined stimuli
 - C. Deficits in early-stage visual processing, potentially reflecting dysfunction of the magnocellular visual pathway (Butler et al., 2005)

- V. Cognitive Changes
 - A. Delusions
 - 1. Best explanation for disturbed sensorium (Maher, 1988; Nielsen, 1963)
 - 2. Dimensions (conviction, preoccupation, distress, and disruption to behavior) and relation to reasoning traits (jumping to conclusions, belief inflexibility, extreme responding [“black-white thinking”]; Garety et al., 2005)
 - 3. Attenuated error monitoring (error negativity in event-related-potential recordings; Kopp & Rist, 1999)
 - B. Schizophrenia and fantasy/daydreaming
 - 1. Contrast to delusions
 - 2. Lack of relationship (Starker, 1982)
 - C. Idiosyncratic word associations
 - D. Associational intrusions from recent prior events (Cromwell and Dokecki)
 - E. Sense of unreality of things and of self (derealization, depersonalization)
 - F. Predictability of schizophrenia 10 years later from earlier thought peculiarities (perceptual aberrations, magical thinking, cognitive slippage) (Chapman et al., 1994)
 - G. Reduction of self-guiding statements (i.e., self-evaluative, operant elements) while performing tasks (Lang, Losen)
 - 1. Corrective effect of external evaluative feedback

- VI. Affective changes and nonchanges
 - A. Flat affect in schizophrenia is true of expression, not of inner experience (Kring, Kerr, Smith, & Neale, 1993)
 - B. Perception of others' emotions is no more inferior than performance in general (Kring & Neale, 1996; Salem, Kring, & Kerr, 1996)
 - C. Anhedonia predicts development of schizophrenia-spectrum disorders (Kwapil, 1998)
 - D. Lack of amygdala activation to unpleasant images and of prefrontal cortex to pleasant images (Paradiso, Andreasen, et al., 2003)

- VII. Both response integration and psychoticism fluctuate in an individual

(Outline continues on next page)

Schizophrenia (Continued)

VIII. Genetics and Environment

- A. Inheritance of disposition to become schizophrenic (Albee; Faraone et al., 1995, 1999; Gottesman & Shields); taxonicity of schizotypy (Lenzenweger, 1999)
- B. Family influences (Goldstein, 1988; Hultman et al., 1996; Rosenfarb et al., 1995).
- C. Intrauterine and obstetric events: influenza and cold temperatures (Brown et al., 2004; Mednick; Öhman & Hultman, 1998; Venables, 1996), extreme temperatures (Kinney et al., 1999)
- D. Positive symptoms associated with winter birth, negative with summer birth (Messias et al., 2004)
- E. Referential communication deficiencies in schizophrenia and healthy relatives (Docherty et al., 2004)

IX. Neuropsychology of schizophrenia

- A. Loss of cortical gray matter (Thompson, Rapoport, et al., 2001), especially temporal lobe volumes, especially hippocampus, but also orbitofrontal and dorsolateral prefrontal cortex, cingulate, cerebellum (Davatzikos et al., 2005; Walker et al., 2004)
- B. Thalamic abnormalities in schizophrenia (Andreasen et al., 1994)
- C. Will discovery of (so far) 5 different dopamine receptor types save the dopamine theory of schizophrenia (D2 receptor especially implicated; Hirvonen et al., 2005 re “Increased Caudate Dopamine D-sub-2 Receptor Availability”; Taubes, Science, 1994, 265, 1034-1035)?
 - 1. Glutamate activity may be deficient, and it has reciprocal relation to DA (Walker et al., 2004). Glutamate-receptor-related gene different in schizophrenic patients (Egan & Weinberger, 2004). Glutamate-mediated visual pathways may be impaired (Butler et al., 2005)
 - 2. “Prefrontal activity deficit predicts exaggerated striatal dopaminergic function in schizophrenia” (Meyer-Lindenberg et al., 2002); PFC inhibits DA in striatum, may be necessary for detecting nonreward and making distinctions
- D. Role of hypothalamic-pituitary-adrenal axis (Walker & Diforio, 1997).
- E. ERP differences (Bruder et al., 1998; Kopp & Rist, 1999)
- F. Laterality differences associated with anhedonia (Luh & Gooding, 1999)
- G. A disorder of neural connectivity (Andreasen, 2000)

- X. Dimensions of schizophrenic symptoms: Lorr, Klett, & McNair (1964); Raskin & Clyde (1963) (See table.)

Symptom Factors in Schizophrenia

Points of Comparison	Raskin & Clyde (1963)	Lorr, Klett, & McNair, 1964
No. of first order factors	11	11
First order factors	10. Paranoid projections 4. Irritability 1. Self-care 5. Anxiety; 6. Guilt feelings; 7. Depression 2. Social participation; 3. Extraversion 9. Slowed speech & movements 11. Excitement 8. Feelings of unreality	1. Paranoid projection 2. Hostile belligerence 3. Resistiveness 4. Dominance 5. Anxious Depression 6. Seclusiveness 7. Retardation (motor) 8. Apathy 9. Conceptual disorganization 10. Perceptual distortion 11. Motor disturbance
Second order factors		1. Perceptual distortion 2. Withdrawal (apathy-seclusion- retardation) 3. Hostility (paranoid-hostile- resistive)
Instruments	Inpatient Multidimensional Scale Ward Behavior Rating Scale	Psychotic Reaction Profile
N, sex of patient	417, male and female	1185 males
Method of analysis	Principal Components and Varimax	Multiple Group Factor Analysis

Basic Operations in Psychological Treatment

- I. Delineating the area
 - A. Definition: Any treatment procedure that does not employ *direct physiological* manipulation (except as mediated by behavioral or sensory processes).
 - 1. Includes certain physical manipulations: electric shock, rocking, etc.
 - 2. Excludes pharmacological treatments, *but* psychologists are now authorized to use these in New Mexico and Louisiana.
 - 3. Huge variety of approaches
 - B. Two different facets of treatment: Content skills and relationship skills
 - 1. Skills analysis of helping relationships (Truax, Carkhuff, Ivey)
 - 2. Content: Throwing everything we know about psychology into psychotherapy

- II. Treatment most effective when
 - A. Therapist tackles manifest problems directly
 - B. Therapist uses whatever methods client is most amenable to (e.g., Rational-Emotive therapy with introverts and Client-Centered therapy with extroverts [DiLoreto, 1971]).
 - C. Therapist employs "core conditions" in relationship with client
 - D. It is based on sound empirical evidence of effectiveness
 - 1. Controversy about stifling creativity and spontaneity
 - 2. Third-party reimbursers and professional organizations increasingly demanding evidence-based treatments

- III. Therapist skills, behaviors, method
 - A. From general medicine:
 - 1. Listening
 - 2. Questions
 - 3. Information/Education
 - 4. Direction
 - 5. Reassurance, support
 - B. Contributed by Sigmund Freud
 - 1. Free-association plus relaxation
 - 2. Interpretation
 - C. "Core conditions" formalized by Carl Rogers:
 - 1. Empathy (taking the client's frame of reference)
 - a. Stable individual trait (Marangoni, 1995)
 - b. Trainable (Marangoni, 1995)
 - 2. Warmth ("unconditional positive regard")
 - 3. Genuineness ("congruence")

(Outline continued on next page)

Basic Operations (Continued)

III. (cont.)

- D. Various behavioral and cognitive therapy procedures
 1. Relaxation
 2. Desensitization
 3. Sensitization
 4. Operant reward
 5. Monitoring
 6. Modeling
 7. Contracts
 8. Rational-emotive therapy (Ellis) and cognitive restructuring (Goldstein, Beck); hypothesis-testing
 9. Self-talk and other "cognitive-behavioral" techniques (Meichenbaum)
 10. Virtual reality techniques

- E. Guided imagery methods

- F. Hypnosis--an imagery-based technique

- G. Miscellaneous
 1. Paradoxical methods (Frankl)
 2. Story-telling (Milton Erickson)
 3. Acceptance and commitment therapy (Steven Hayes)

IV. Ivey's analysis of relationship skills (in single-skill microcounseling process)

- A. Attending Skills
 1. Listening (eye contact, attentive body language, verbal following)
 2. Questioning (open--what, how, could you, why--vs closed)
 3. Minimal encouragers (head nods, um hms)
 4. Paraphrase
 5. Reflection of feeling
 6. Summarization
- B. Self-Expressing (Influencing) Skills
 1. Directions
 2. Expression of content (giving information)
 3. Expression of feeling
 4. Summarization
 5. Interpretation

Imagery and Relaxation Methods and Therapies

- I. Experiencing fantasy
 - A. Universality of imagery
 1. Counting windows (or rows of seats on CTA buses, time on a clock face turned upside down)
 2. Shorr Movie warm-up exercises
 3. Barber Creative Imagination Scale and the nature of hypnosis
 - a. The *only* common denominator of all hypnotic procedures: Guided imagery
 - b. "Inductions": 1 (arm heavy) & 4 (water) from Barber Creative Imagination Scale (CIS)
 - c. Hypnosis and imagery-on-demand
 - i. CIS correlates .60 with Barber Hypnotic Suggestibility Scale (Barber, 1978)
 - ii. Hilgard & Hilgard: Hypnotizability correlates best with ability to imagine and ability to live in the present.
 - B. Experiencing the flow
 1. Shorr's (Movie) "dual imagery"
 2. Leuner's "meadow": "Imagine yourself on any kind of meadow and let your imagination flow from there."
- II. Variety of imagery methods in psychological treatment
 - A. Range from static and brief (e.g., systematic desensitization) to dynamic and long (e.g., Hanscarl Leuner's Guided Affective Imagery)
 - B. Range from diagnostic use (e.g., Joseph Shorr's dual imagery) to extinction effects (e.g., Wolpe's systematic desensitization) to psychotherapeutic process (e.g., Hanscarl Leuner's Guided Affective Imagery)
- III. Types of relaxation methods and therapies
 - A. Hypnotic induction methods
 - B. Progressive relaxation: Edmund Jacobson
 - C. Autogenic Training: Johannes H. Schultz after Oskar Vogt (cf. W. Luthe & Schultz, *Autogenic Training*)
 - D. Meditation
 - E. Guided Imagery
- IV. Progressive relaxation
 - A. Strategy, principles
 1. Relaxation as a voluntary act
 2. Downward ratchet effect of repeated cumulative relaxation steps
 3. Effect of skeletal-muscle relaxation on autonomic activity (tension, anxiety, etc.); possible opioid mediation (McCubbin et al., 1996)
 4. Relaxation as a portable self-control method
 - B. Techniques: Rotation of focus on muscle groups
 - C. Experiential episode

- V. Autogenic (meaning "self-generated") training
 - A. Positions: reclining, sitting back, sitting forward; eyes closed; reduction of afferent and efferent stimulation
 - B. Passive concentration and self-verbalization
 - C. Induction steps: Standard exercises (4 weeks to 8 months)
 - 1. Heaviness in extremities ("My right arm feels heavy")(average of 3-4 weeks to master)
 - 2. Warmth in extremities
 - 3. Regulation of cardiac activity ("Heartbeat calm and regular")
 - 4. Regulation of respiration ("Breathing calm and regular"; "It breathes me")
 - 5. Abdominal warmth ("My solar plexis is warm")
 - 6. Cooling of forehead ("My forehead is cool")
 - D. Meditative exercises (imagining specific colors, concrete objects (box), abstract objects (justice), feeling states ("positive feelings in general"), persons, "answers from the unconscious" ("What do I want?"; "What do I do wrong?"))

- VI. Individual differences in response to relaxation procedures

Outcomes of Psychological Treatment

I. Does it work?

- A. Absolute percentage improvement rates versus effect size.
- B. Is any figure meaningful? What do we need to know to evaluate it?
 - 1. Source of outcome measures
 - a. Therapist judgment (but hello-goodbye effect)
 - b. Patient judgment (satisfaction versus improvement: Lambert et al., 1998)
 - c. Observer's ratings
 - d. Test scores
 - 2. Control groups
 - a. Own-control
 - b. No-treatment control
 - c. Attention/placebo control
 - d. Component analysis ("dismantling")
 - 3. Type of patients (backgrounds, diagnoses)
 - 4. Therapeutic methods
 - 5. Properties of therapist
- C. Estimates of spontaneous remission
 - 1. Bergin (1971) survey (P. 241): Mdn ca 30%
 - 2. What is "spontaneous"? (Role of clergy, MD, social workers, family, friends, teachers, etc.)

II. Broad Surveys of Outcome Studies

- A. The birth of meta-analysis: Outcome survey by Smith & Glass (1977), Landman & Dawes (1982)
- B. The entire treatment realm: Lipsey & Wilson, 1993; Shadish et al., 1997
- C. Pitting "bona fide psychotherapies" against one another (Wampold et al., 1997)

III. How well do controlled trials hold up in normal community practice?

- A. Psychotherapy with children and adolescents: Weiss et al. (1999, 2000); Weisz et al. (1995)
- B. Cognitive therapy for depression: Merrill et al. (2003)
- C. In general (Shadish et al., 1997, 2000)

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Outcomes Of Psychological Treatment (continued)

IV. Cognitive (-Behavioral), Interpersonal, and Pharmacological Therapy of Depression

- A. Cognitive therapy of depression
 - 1. NIMH cooperative study on interpersonal, cognitive, and tricyclic antidepressant therapy (Elkin et al., 1989; Shea et al., 1992)
 - a. Treatment effectiveness
 - b. Relapse rates
 - 2. The subsequent debate (Blatt et al., 1996; Elkin et al., 1996; Jacobson & Hollon, 1996a,b; Klein, 1996), including who is best off treated by what (Barber & Muenz, 1996)
 - 3. Cognitive and tricyclic antidepressant therapy (Evans et al., 1992; Hollon et al., 1992; Jacobson et al., 1996)
 - 4. Cognitive therapy vs. medication for moderately and severely depressed clients: New evidence on immediate and follow-up outcomes (Hollon et al., 2005)
 - 5. Importance of therapist training (DeRubeis et al., 2005)
- B. Component analyses of cognitive therapy (Catonguay et al., 1996; Gortner et al., 1998; Hayes et al., 1996; Jacobson et al., 1996) and corresponding content analyses of process (DeRubeis & Feeley, 1990; Feeley et al., 1999; Hayes & Strauss, 1998); brief form (Barkham et al., 1999); specific cognitive effect (Williams et al., 2000)
- C. Value of booster sessions after completing main treatment phase (Jarrett et al., 1998)
- D. Medication for unipolar depression (Greenberg et al., 1992; Segal et al., 1999; Thase & Kupfer, 1996); relation to brain laterality (Stewart et al., 1999); comparison with interpersonal therapy (Schulberg et al., 1998)
- E. Depression in alcoholism (Brown et al., 1997)
- F. Pathological gambling (Sylvain et al., 1997)
- G. Bulimia (Wilson et al., 1999)
- H. Role of psychosocial treatment in bipolar disorder (special section in Nov., 1999, *Journal of Abnormal Psychology*)

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Outcomes Of Psychological Treatment (continued)

V. Cognitive-Behavioral Treatment of Anxiety Disorders

- A. Integrated psychological treatments for panic and agoraphobia (Barlow, 1988; Barlow et al., 1989; Beck & Emery, 1985; Bruce et al., 1999; Craske et al., 1991); effective brief form (Clark et al., 1999); CBT versus medication (Bruce et al., 1999); augmentation of exposure therapy with D-Cycloserine for Social Anxiety Disorder (Hofmann et al., 2006)
 - 1. Relaxation
 - 2. Desensitization: exposure, response prevention, and other behavioral methods
 - 3. Cognitive therapy
- B. Youth (Dadds et al., 1997; Kendall et al., 1997; Kendall & Southam-Gerow, 1996) and childhood social phobia (Weibel, 2000)
- C. Cognitive-behavioral and adjunctive family therapy for anxious children (Barrett et al., 1996; Cobham et al., 1998); CBT for Generalized Anxiety Disorder (Ladouceur et al., 2000; Stanley et al., 2003)
- D. Obsessive-Compulsive Disorder (Abramowitz, 1997)
- E. Applicability of experimental outcomes with panic disorder to field settings (Wade et al., 1998)
- F. PTSD treatment (Tarrier et al., 1999; Taylor et al., 2003) and prevention (Bryant et al., 1998)
- G. Eye Movement Desensitization and Reprocessing (Feske & Goldstein, 1997; Goldstein, 2000; Muris, 1998; Taylor et al., 2003; Wilson et al., 1997)
- H. Virtual reality exposure therapy for fear of flying (Olasov et al., 2000)

VI. Outcomes with victims of sexual abuse (Foa et al., 1999; Resick & Schnicke, 1993)

VII. Outcomes with schizophrenia

- A. Psychotherapy vs. medication (Karon & Vandenbos; Tarrier et al., 2000)
- B. Cognitive therapy of schizophrenia (Kingdon & Turkington, 2005)

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Outcomes of Psychological Treatment (continued)

- VIII. Behavioral medicine and health psychology
- A. Headaches
 - B. Chronic Pain (Kole-Snijders et al., 1999)
 - C. Substance abuse (Babor et al., 1997; Bickel et al., 1997; Comer et al., 2006 [naltrexone and opioid dependency] ; Fals-Stewart et al., 1997; Hester & Delaney, 1997 ; Peirce et al., 2006 [contingent incentives and stimulant use])
 - D. Prevention (HIV-AIDS: Belcher et al., 1998; Sanchez-Craig et al., 1996; Weinhardt et al., 1998)
- IX. Psychotherapy reduces utilization of medical resources: Cummings & Follette (1968); Follette & Cummings (1967); Jones & Visch (1980); effects on general distress (Bovasso, 1999)
- X. The dose-effect relationship (Barkham et al., 1996; Howard et al., 1986) but not necessarily (Salzer et al., 1999)
- XI. Therapist variables
- A. Truax studies (Truax & Mitchell, 1971) (But, Sloane et al (1976 JCCP, 44, 340-350) failure to replicate. Maybe better therapists 10 yrs later?)
 - B. Therapist-client similarity in personality and social class; gender doesn't much matter (Zlotnick et al, 1998)
 - C. Therapeutic alliance: little therapist, much client contribution (Krupnick et al., 1996)
 - D. Training (Bright et al., 1999) and competence (Shaw et al., 1999)
- XII. Cultural factors (Miranda, 1996 Oct. *Journal of Consulting and Clinical Psychology* Special Section)