Psych. 427 Dr. R.L. Weiss
Abnormal Psychology Winter 1985

COURSE OBJECTIVES & REQUIREMENTS

Readings:

Main Text: Davison & Neale, ABNORMAL PSYCHOLOGY (3rd ed.) 1983
Leon, CASE HISTORIES OF DEVIANT BEHAVIOR (3rd ed.) Allyn & Bacon,1984

1. Course Description

This survey course in Abnormal Psychology will explore: (a) theories and conceptions of madness, (b) methods used for assessment and diagnosis of the recognized disorders in this field, (c) theories and practices of those who provide mental health services.

There are three lines of inquiry: I. How do we learn to label behavior and people as deviant, disordered, abnormal or mad? What are the cultural, political and scientific foundations of this learning? II. What are the clinical appearances of abnormal behavior? How are the people thus labelled problems to themselves and others? What is the subjective experience of abnormality? III. How does modern behavioral science approach abnormal behavior? What are the empirical bases for understanding abnormal behavior? How do psychologists formulate research questions and conduct research in this area?

Successful performance in this course (espcially for students new to psychology) requires each person to (1) develop a working vocabulary of the concepts used in this field, (2) become familiar with the behavioral science approach used to understand abnormality, (3) keep current in the assigned readings. The course assumes some prior work in psychology; it is NOT intended as a first course. Please note: This is not a field course for psychology majors.

Films and video tape demonstrations will be used in conjunction with lectures and readings to illustrate various aspects of abnormal behaviors, thought disorders, and treatments. Some films may be offensive to viewers because of sexually explicit material, scenes showing electroconvulsive shock therapy, or unfavorable portrayals of homosexuals. One objective of the course is to provide students an opportunity to examine their own values about a wide range of behavioral differences, and to be confronted by value judgments that may be opposed to their own.

There are two texts for this course: The main text is ABNORMAL BEHAVIOR It is comprehensive, and represents a considerable amount of reading for one term. It follows the DSM-III classification system used for describing abnormal behavior. The second text is much lighter reading, consisting of case histories that provide a more clinical description of disorders and how these fit the various theories. The course will follow the organization of the main text covering some seven sections:

(Organization, cont'd)

I. Models of madness--history and current theories of abnormal behavior.
II. Anxiety, neuroses and stress-related disorders --consideration of the less severe forms of abnormal behavior.
III. Affective Disorders--survey of current views of depression and research on depression.
IV. Social Problems--personality or "character" problems that are often more problematic for society than the individual.
V. Psychoses and major thought disorders-- emphasis on schizophrenia and research topics in this area.
VI. Developmental disorders-- a brief survey of some typical childhood and age related disorders.
VII. Behavior Change--survey of major forms of behavior change (therapies) with legal and ethical considerations.

2. Course Objectives

From your work in Abnormal Psychology this term you should be able to:
--Distinguish between and among biological, psychological, and sociological theories of behavior deviance;
--Distinguish between and among the methods involved in psychodiagnosis, assessment, and classification of behavior disorders and identify basic assumptions of DSM-III;
--Describe the major concepts used in theories of anxiety, neuroses and psychoses;
--Distinguish between forms of organic factors in psychopathology;
--Differentiate between the different forms of therapy in terms of goals and applicability;
--Know about rights of persons judged to be mentally ill.

3. Exams and Grading

There will be four exams given in this course, two midterm length and two of shorter length. The longer exams (scheduled for 80 minutes each) will be objective (multiple-choice questions) covering eight and nine chapters respectively. The first (mid-term) is scheduled for February 7, 1985. The second major exam is scheduled during finals week on March 20, 1985 at 10:15 AM. Two 30 min. tests are scheduled for January 24th and February 28th, 1985. The short exams will be given during the last 30 minutes of class on those dates, after the lectures. These will be a combination of multiple-choice and short-answers, and will cover a much smaller set of the readings and lecture material. Note that the longer exams will sometimes include topics covered in the shorter exams, but not the same questions. A passing grade will be determined by performance on these four exams. The two short tests will be treated as a single long exam, so that your grade will be based on the rough equivalent of three long exams.

The short tests are scheduled so that students get feedback early on in the course well in advance of the major exams; the short tests can serve as a diagnostic of one's progress, allowing for correctives if necessary. Although performance on the short tests figures into one's final (course) grade they can also serve as diagnostics for how well a student is progressing. Tests will cover material from lectures, readings, films, video presentations, and guest lectures.

4. Extra Credit Options

Students frequently feel they do better on written material rather than on multiple choice exams. Extra credit may be earned for Journal Article Reviews (JARs). Not more than three reviews may be submitted. The maximum credit from doing JARs can be sufficient to raise one's final grade one level, e.g., from C to B. However, this is not guaranteed. Only if the JARs papers earn sufficient quality points will a full letter grade increase be possible. Three inadequate JARs do not increase one's letter grade. Detailed information on JARs is contained in a separate handout.

JARs may be turned in anytime before March 18,1985, 5:00PM. Students are advised not to turn in all three JARs papers at once. One need not turn in three JARs.

5. Policy on Make Up Exams

Make-up exams are possible ONLY for the first three tests. The policy is the same for any exam missed: a 10 to 15 page paper summarizing and critically evaluating the material covered by the scheduled exam will be due not later than one week after the exam date. Any submission after the one week deadline will not be accepted.

6.Graduate credit

Students taking this course for graduate credit are required to write a paper on a topic mutually acceptable to the student and instructor. The due date for these papers is March 15, 1985, 5:00PM. Papers must have prior approval of topic and must conform to APA style. A wide variety of topics will be acceptable, but the paper must be based on some literature in the field (not popular books).

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Abnormal Psychology
Winter 1985

Dr. R. L. Weiss
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COURSE SYLLABUS & READINGS

TEXTS: Davison & Neale: ABNORMAL PSYCHOLOGY,(3rd ed.), 1982 (Text)
Leon: CASE HISTORIES OF DEVIANT BEHAVIOR, (3rd ed.) 1984 (Cases)

WEEK	DATE	DAY	TOPIC	READINGS: Text	Cases
			SECTION I: CONCEPTIONS OF MADNESS		
1	1/10	H	Introduction and Course Organization		
2	1/15	U	Madness: Cultural and Professional Views	1,2	2
	1/17	H	Classification of Abnormality	3,4	
			Film: ABNORMAL BEHAVIOR: A MENTAL HOSPITAL		
			SECTION II: ANXIETY & STRESS RELATED DISORDERS		
3	1/22	U	Nature of Anxiety Disorders	5,6	5,7,9
	1/24	H	Psychophysiological Disorders	7	8,13
			****EXAM I: SHORT TEST****	Chapters 1-6	
			SECTION III: AFFECTIVE DISORDERS		
4	1/29	U	Depression: Clinical views: VIDEO DEMONSTRATION	8	6
	1/31	H	Theories and Research Issues in Depression	8	20
5	2/5	U	Psychotic Depressions:VIDEO DEMONSTRATION		
	2/7	H	***** EXAM II: "Mid-term" *****	Chapters 1-8	
			SECTION IV: SOCIAL PROBLEMS		
6	2/12	U	Personality Disorders	9,10	16,17
	2/14	H	Sexual Variations/Dysfunctions	11,12	
7	2/19	U	FILM: RADICAL SEX STYLES	11,12	14,15
			SECTION V: PSYCHOSES		
7	2/21	H	Schizophrenia I: Clinical Description VIDEO DEMONSTRATION	13	18,19
8	2/26	U	Schizophrenia II: Research Approaches	14	
			SECTION VI: DEVELOPMENTAL DISORDERS		
8	2/28	H	Childhood Disorders	15	10,11
			**** EXAM III: SHORT TEST ****	Chapters 9-14	
9	3/5	U	FILM: TEACHING LANGUAGE TO PSYCHOTIC CHILDREN		1,3
	3/7	H	Aging and Organic Changes	17	
			SECTION VII: BEHAVIOR CHANGE		
10	3/12	U	Forms of Psychotherapy	18,19	12
	3/14	H	Marital/Family Therapies	20-21	
	3/20	W	10:15AM **** EXAM IV: "Mid-term" ****	Chapters 13-21	

ABNORMAL PSYCHOLOGY R.L. WEISS

SUGGESTIONS FOR JARS PAPERS

1. JAR papers should be not more than five pages in length, double spaced typewritten. Please edit your paper for English style (spelling, complete sentences, and connections between paragraphs).

They are to be a critical review of an empirical article in a journal directly related to abnormal psychology or psychiatry. Review articles, essays, or strictly theoretical papers are not acceptable for JARs. Students are encouraged to pick JARs topics from the different areas of the course, i.e., not three from the same section (e.g., three form schizophrenia would not work). Book reviews are not acceptable.

Each JARs paper should present a clear statement about the research aims, a brief indication why the problem is important for study, what was done, measured how, on whom, and what was found. The student should then be prepared to comment on the study, evaluating the method and conclusions and relating it to other information from the course, text, etc. It is not intended for the JARs to just be a summary of an article.

2. Here is the general plan of a JAR paper:

A. Title of Article and citation (correct APA style citation)
B. Your name
C. Summary of article

(1) What is the purpose of the study? What does it set out to show? You should rewrite in your own language what the author(s) state as the purpose. Paraphrase hypotheses and condense these if necessary.

(2) What is the background of the study; briefly indicate where the idea came from. (E.g., Studies of depression have not answered the question of why women are more depressed than men. Anxiety has not been shown to be directly related to childhood experiences.) The author(s) will tell you why they are doing the study, i.e., why it is important to do.

(3) What is the design of the study? What conditions and groups are needed to provide the necessary data. (E.g., three groups of subjects were used, depressives, psychiatric controls, and normal controls. Children referred for gender problems were compared with those not seen for nongender related problems.)
What measures were used to establish what findings? What manipulations were used to establish a cause-effect relationship between variables? If it is a correlational study, then mention this.
The reader of the JAR should be able to know what the study was designed to test.

(4) What were the findings that pertain to the hypothesis or purpose? Do not put tables of results in your paper. (If you must show the results as tables, then do so as an appendix in addition to the five pages.)

(5) Evaluation of the Study: This is where you become creative. The more you can show your understanding of the study (adequacy of method, how the conclusions relate to the data, whether the important variables were controlled) the better your score. A simple commentary that "I liked this study and I think it was OK" is not going to be impressive.

3. Please be sure your JAR is from a journal that clearly pertains to Abnormal Psychology. I will OK journals and or articles in advance if you wish to be sure.

4. Beware! If you strike out into an area that has not yet been covered in the text or is not in the syllabus your commentary may be limited by insufficient familiarity with the topic. The point of the JAR is to provide depth in an area that you know something about or that you can relate to the text. Your commentary will be much better if it is based upon some knowledge base.

5. Your task is to find something of interest to talk about, either substantively or based on method. If the study, for example deals with psychotic depression, and only college students are used as subjects we would have an important limitation as to the generality of the results.

6. Merely writing a JAR is not sufficient to get extra credit for the course. Any JAR that does not meet our criteria will be returned; this will give you another chance to improve it. However, the second time you submit the same JAR it counts regardless of quality! You get one chance to improve an unacceptable JAR; the grade will reflect its quality the second time around.if it is not very good the second time around. Should your second submission of a JAR be unacceptable, you will not be given points and you will have used up one of your three JAR opportunities. In other words, you cannot keep submitting JARs until you get credit on three of them; there has to be a limit on our charity (and your efforts)!

7. JARs are meant to be a form of high level communication and an sample of how you think about psychology. Admittedly the criteria for excellence are somewhat subjective. Clear writing, well organized paragraphs, good summaries, and a clear statement of your reasoning are all important. If you have doubts about your selection of an article please speak with either me or the TA before you embark on your task. If you find that an article is too complicated to summarize then go to another one. If an article does not make sense to you then either (a) it is badly presented and don't waste time on it, or (b) it is too far removed from your current knowledge base; better stay with something that you can follow more easily.

8. Each JAR will be given a numerical score such that we will be able to scale them as to units of additional course credit. The plan is to use your exams to determine your letter grade for the course and then to add in the effect of the JAR scores. If you have points for a B- the JARs score will be added onto that to increase your final grade by some increment, the maximimum being a full grade, e.g., from B- to A-. We will not use JAR scores to lower your grade.

ABNORMAL PSYCHOLOGY LECTURE # 2 DR. R.L. WEISS

MADNESS: CULTURAL AND PROFESSIONAL VIEWS

I. Outline of Lecture:
- A. Three Foundations of Abnormal Psychology
- B. Illustrations of the Foundations
- C. How do values enter into considerations of abnormality?
- D. Models and Concepts Commonly used in Defining Abnormality
- E. Assessment Diagnosis and Classification

II. Foundations of Abnormal Psychology: CULTURAL, TECHNOLOGICAL, SCIENTIFIC

A. Cultural
- --nonscience belief systems
- --humanities, artistic forms, e.g., novels, movies, etc.
- --political/economic/legal foundations of society

B. Technological
- --Medical practices, drugs
- --psychiatric lore and fads
- --engineering capabilities

C. Scientific
- --Biological sciences
- --physical sciences
- --experimental psychology, basic functions
- --acceptance of science assumptions, i.e., as a way of knowing

D. These three foundations converge in actions we take:
- o **Definition of "Problem"**. What IS the problem?
- o **Action**. What CAN be done about it?
- o **Humanity** What MUST be done about it?

III. Illustrations from the Cultural Basis of Abnormal Psychology:

A. Some examples of opinions about mental illness: Five Factors from the Opinion about Mental Illness Scale (OMI):
1. Authoritarianism --the mentally ill are an inferior class requiring coercive handling
2. Benevolence -- a kindly, paternalistic view toward patients; origins are religion and humanism rather than science
3. Mental Hygiene Ideology -- mental illness is an illness like any other; medical model adapted to psychiatric problems; emphasis on maladaptation
4. Social Restrictiveness -- mental patient is a threat to society,and must be restricted in his/her functioning both during and after hospitalization.
5. Interpersonal Etiology --mental illness arises from interpersonal experiences, espcially deprivation of parental love during childhood

ABNORMAL PSYCHOLOGY

Dr. R.L. Weiss

LECTURE #4 NATURE OF ANXIETY DISORDERS

1. PLAN OF LECTURE

A. CLASSIFICATION OF ANXIETY DISORDERS -- ACCORDING TO DSM-III

B. COMPARISONS BETWEEN DYNAMIC AND 'LEARNING' VIEWS

C. STUDIES ON ILLUSION-OF-CONTROL AND TOLERANCE OF PAIN

D. COMMON ELEMENTS IN THERAPEUTIC APPROACHES TO ANXIETY DISORDERS

2. "Where have all the neuroses gone?"

A. DSM-III middle-of-the-road position regarding concept of Neurosis

B. Descriptive terminology; unlike DSM-II no longer etiological assumptions
Neurosis now equates roughly to psychoanalytic concept of symptom neuroses: distinguishable from "character neuroses"

C. DSM-III includes 5 categories of "Neurotic Disorders"

(1) Affective (Depressions)	(Chapter 8 text)
(2) Anxiety (Phobias, Compulsions)	(Chapter 5 text)
(3) Somataform (Briquet's)	(Chapter 6 text)
(4) Dissociative (Multiple Personality)	(Chapter 6 text)
(5) Psychosexual Disorders	(Chapters 11-12 text)

D. Note: Psychophysiological Disorders (Chapt. 7 in text), the older "Psychosomatic" category, no longer included in DSM-III per se, although physiologically relevelant information is recorded on Axis III.

E. How do people acquire symptomatic behaviors?
Depends upon one's theoretical point of view; cannot be answered simply; will find answers throughout course

F. Contrast between psychodynamic and behavioral positions for differences in meaning of symptoms and issues on symptom substitution

See BOX #1 ~~~~~~~~~~~~~~~~

3. Listing of Anxiety related Disorders (DSM-III)

A. Phobias --agoraphobia, and many others!

B. Anxiety States:
(1) Panic disorder (acute)
(2) Generalized Anxiety disorder (chronic)
(3) Obessive-compulsive disorder
(4) Post traumatic stress disorder (controversial)

C. Somataform Disorders:
(Formerly Hysterical conversion and Hypochondriacal Neuroses)

(1) Conversion Disorder (Note: Malingering/Factitious disorders)
(2) Somatization Disorder (Briquet's Syndrome)
(3) Psychogenic Pain Disorder
(4) Hypochondriasis

D. Dissociative Disorders

(1) Psychogenic fugue
(2) Multiple personality
(3) Depersonalization disorder

4. Role of cognitive factors in anxiety

(1) Attribution and perceived control: Analogue studies
(2) Anxiety arousal and self regulation

See BOX 2 ~~~~~~~~~~~~~~~~~

5. Common elements in therapeutic approaches to anxiety disorders

A. Psychodynamic -- stresses insight and self awareness
B. Behavioral approaches --emphasis on mastery and learning new coping behaviors; relaxation approaches; flooding procedures
C. Cognitive (R.E.T.) -- restructure belief systems

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WEISS's BOX #1: COMPARISON OF Dynamic and "Learning" Models

DYNAMIC	LEARNING
1. THEORY OF PERSONALITY	1. NO UNIFYING THEORY OF PERSONALITY
2. ORGANIZED STRUCTURES	2. NO ORGANIZED STRUCTURES
Traits Needs Dispositional terms	States Capacities Skills
3. VIEW OF 'SELF' AS OBJECT	3. 'SELF' AS PROCESS (e.g.REGULATION)
4. HISTORICAL (DEVELOPMENTAL)	4. CONTEMPORANEOUS (PRESENT EMPHASIS)
5. DEFENSE MECHANISMS	5. LEARNED AVOIDANT BEHAVIORS
6. MOTIVATIONAL FORCES	6. CONSEQUENCES OF REINFORCEMENT
7. ASSESSMENT OF STRUCTURES	7. ASSESSMENT OF FUNCTIONS
8. SYMPTOM SUBSTITUTION	8. SYMPTOMS ARE PROBLEM

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WEISS's BOX #2: ANALOGUE STUDIES: Attribution and Perceived Control

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There have been a number of attempts in the literature designed to explain how people learn to control their fear or anxiety associated with stimuli presented as part of some experimental setting. Some of the illustrative techniques have involved: (a) cognitive appraisals (Lazarus, 1966), (b) self-observation under conditions of threat, when "choice or no-choice" may be influence the making of an avoidance response, and (c) attributions about the cause of some "self-control" behavior.

(a) Cognitive Appraisals

Lazarus maintains that our response to stress or threat is moderated by the cognitive assessment of our resources for dealing with the threat. Similar to Freud's defense mechanisms a person may develop a style of dealing with threat by changing the "meaning" of the situation. (Freud saw defense mechanisms as operating at an unconscious level.) Lazarus was interested in showing whether different cognitive appraisals could effectively reduce threat as measured by self report and by physiological measures of arousal, e.g. skin conductance.

Subjects (undergraduates) viewed either industrial accidents (safety training film) or a film of a so-called primitive initiation ritual that depicted crude surgery on the genitals of young boys. Since the experimenter could control the precise location of these stressful scenes it was possible to obtain continuous physiological measures of stress changes as viewers watched the film. The point was to show that different cognitive appraisals reduced the threat value of the critical scenes.

By using different narratives for the sound track the experimenter could provide "cognitive appraisals" that were similar in function to defense mechanisms. For example, "denial" and "intellectualization" both tended to play down any emotion of the stressful scenes.

Lazarus et al. reported significantly lower arousal (threat?) values, compared to control instructions, when such appraisals as "denial" or "intellectualization" were used prior to critical scenes. These results were taken to show the effectiveness of cognitive appraisals.

(b) Perceived Control, Self-observation, Choice and No-Choice Responding

1. Bowers 1968: (J.C.C.P.)

Anxiety stems from pain that has been experienced; however pain can be amplified by fear of the pain, i.e., the greater our fear that something will hurt the more likely we will perceived the actual pain as more painful. This is called REACTIVE pain in contrast to sensory (actual?) pain.

Bowers reasoned that if persons felt they had control over an impending pain, they would experience it as less painful than if they had no such control. Subjects initially rated the painfulness of mild electric shock; the quantity of electrical current rated as "permissible" was used to index the degree of experienced pain. The question was: Would

increased perceived control allow subjects to take more shock?

Instructions were either did or did not enhance "perceived control" over anticipated pain (shock). One group of subjects was instructed to AVOID SHOCK on a learning task that they would be given later, while another was told that shock would occur at RANDOM during the learning task, i.e., they would not be able to avoid it. Timing was an important variable: half of each group was told about avoidance (SHOULD or RANDOM) either BEFORE or AFTER they were asked to rate shock for painfulness. The pain ratings could be influenced by this timing variable.

The dependent measures were the initial ratings of pain tolerence and self reported anxiety about and painfulness of the shock made after the learning task. (Random shocks were given during the "learning" task.)

The main findings were: (a) Subjects who were told that they should avoid shock during the learning task AND who were given these instructions BEFORE determining acceptable shock levels, rated a significantly higher level of shock as acceptable than any others, (b) subjects who were given should avoid instructions AFTER judging acceptable shock levels, rated much lower levels of shock intensity as acceptable, (c) "after" instruction subjects did not differ in their self report ratings of shock painfulness experienced during the "learning" task. (d) Should Avoid, before, subjects rated their anxiety about shock significantly lower than random, before, subjects.

Believing that one has the ability to perform in ways to avoid shock (when in fact this is NOT the case) does increase one's tolerance for pain, and lessens anxiety as measured by self report.

2. Bandler & Bem, 1968; Corah & Boffa 1970; (J. Pers. & Soc. Psych.):

Bem's theory holds that people use their own behavior as a basis for drawing conclusions about their feeling states, much as outsiders use our behavior to draw conclusions about our feeling states. In a set of ingenious experiements subjects were instructed to either escape (avoid) or not-to-escape (not avoid) an electrical shock depending upon the condition defined by colored lights. For example, under the "red" light condition one should escape the shock by pressing a button; under the "green" light condition one should not press the button, and under the "yellow " light condition, shock would be random and pressing the button would have no effect.

Basically it was found that in the escape condition (where a button press resulted in terminating the shock) subjects rated the shock as MORE painful than in the other conditions. Thus seeing oneself escape from danger enhances the rating of danger!

Corah & Boffa replicated this study, but added an important variable: CHOICE or NO CHOICE in the escape conditions. Bandler et al. had included an instruction about choice, e.g., "If the shock is unbearable you can turn it off, or if the shock is NOT unbearable you could elect to leave it on." This choice element was manipulated in the Corah-Boffa study. The point was to see whether Escape/No-Escape

instructions acted differently when crossed with Choice/No-Choice instructions.

Instead of shock Corah & Boffa used "white noise" (hissing sounds) at high Db levels. Button press would (would not) terminate the white noise. Also took conductance measures during trials.

(a) The main findings were: Bem's hypothesis was correct only under choice conditions, but not under no choice conditions. "Under the no-choice conditions, subjects rated the discomfort of the no-escape trials greater than for the escape trials." However, under the choice condition, subjects rated the discomfort of the escape trials greater than for the no-escape trials. (b) Choice reduced "anxiety" in no escape conditions.

(c)Attribution approaches

Davison, et al., 1973: (Journal of Abnormal Psych.)

Davison reasons that the cause(s) we attribute to some personal action is important and may help explain anxiety control. This is a weak area, but the idea is interesting. Subjects with insomnia were given effective doses of chloral hydrate each night for one week after baseline, together with self-produced relaxation instructions. Half of the subjects were told after being on the drug for a week that their drug dosage was too small to have been effective (the self attribution condition) and the other half were told that the drug was indeed effective for them.

All subjects continued with self-relaxation instructions and sleep measures were continued as before. Subjects told the drug was not the cause of their sleep continued to do better than the "drug caused" group. The theraputic gain was attributed to the self attribution.

LECTURE #5: ANXIETY & PSYCHOPHYSIOLOGICAL DISORDERS

1. PLAN OF LECTURE

   A. Psychophysiological Disorders and Stress
   B. Difficulties with treatments

2. Psychophysiological Disorders and Stress

   A. Mind-Body Dualism revisited: examples from hypnosis and suggestion, e.g. blushing. Personality types.
   B. Distinction between conversion and psychophysiological disorders: tissue damage, organ systems vs voluntary muscles
   C. How we define "stress?"
   D. Theories of psychophysiological disorders
      (1) Biologically based
         a. Somatic weakness--weak organ
         b. Specific reaction--genetically based reaction pattern
         c. Evolution theory--autonomic NS reaction is adaptive

(2) Psychological Theories

a. Psychoanalytic theory (Alexander) chronic emotional states, repression, symbolic connections

(2) b. Specific Attitudes Theory (Graham) Specific attitude rather than chronic emotional state

c. Conditioning theory

e. Diathesis--biological predisposition requiring stress

3. Difficulties with treatements

A. Overcoming the personality bias

B. The example of biofeedback: "Biofeedback as Placebo" (Box #3)

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WEISS's Box #3: BIOFEEDBACK AND THE MYSTERIES OF THE MIND (A Quack-o-Release)
(Plotkin and Rice: Biofeedback as placebo... JCCP 1981)

It has been assumed that people can be trained to increase their alpha rhythms and that by so doing they can achieve a state of relaxation and tranquility. However, Plotkin has found from his own studies and a review of the literature that expectancy effects may be operating, such that the experience of anxiety reduction may have little to do with alpha enhancement, but rather with success in meeting expectations created by the experimental situation itself. Thus, it should be possible to show that alpha suppression --which should be the opposite of relaxation-- produces anxiety reduction under the proper instructions.

10 high trait-anxious subjects were trained to either increase or decrease their alpha rhythms (5 subjects per condition). Both groups were led to believe that they were succeeding at their assigned task. Both groups showed significant decreases on all self report anxiety measures. EXPECTATIONS of success and not ALPHA changes seem to control anxiety.

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ABNORMAL PSYCHOLOGY R.L.WEISS

LECTURE #6: DEPRESSION: DESCRIPTION & DIAGNOSTIC CONSIDERATIONS

1. DESCRIPTIVE ASPECTS OF DEPRESSION

A. The many faces of depression
   1. Psychotic vs Neurotic Depression
   2. Bipolar vs Unipolar Depression (Current Usage)
   3. Endogenous vs Reactive Depression
   4. DSM-III: "Affective Disorders"
      (a) Episodic Affective Disorders
      (b) Chronic Affective Disorders (2 years +)
      (c) Atypical Affective Disorders

B. How do depressed people behave?
   1. Quotation from Pultarch, 2nd century A.D.
   2. Nonverbal behaviors of depressed patients
   3. Study on sex differences in the expression of depression
      (a) 600 college students asked to indicate what behaviors and cognitions they would display if they were depressed
      (b) "Men and women showed distinct differences in the nature of their interpersonal behaviors as well as in cognitive styles for coping with depression." JOURNAL OF ABNORMAL PSYCHOLOGY, 1980, 89,194-202.
   4. Clinical behaviors:
      Behaviors of depressed women rated as "more severely ill" include: Psychomotor Retardation; depressive delusions ("I'am dead," "I killed my children," "I am decaying inside."); Agitation; Guilt; Inital insomnia; Hopelessness; Suicidal tendencies.
   5. Different approaches to diagnosis of depression:
      (a) Psychiatric Diagnosis (Research Diagnostic Criteria (RDC)
      (b) Symptom Ratings and Self Report
          MMPI-D scale; Beck Depression Inventory (BDI), etc.
      (c) Assessment of Overt Behavior

   6. Depression is a heterogenous disorder, no one set of symptoms describes all cases, nor do single symptoms persist

2. EPIDEMIOLOGICAL CONSIDERATIONS

A. The prevalence (diagnosable cases at any given time) 3% to 4%
B. In any given year 15% of all adults will experience a clinically significant depressive episode
C. Evidence for a female preponderance: 2:1
D. Longititudinal study by Amenson & Lewinsohn found:
   (1)Similar incidence for men and women (6.9% vs 7.1%)
   NOTE: Incidence = first-time depression during course of study; no previous history of depressive episodes.
E. Women did not have longer lasting episodes, nor were there differences in age of onset
F. History of depression made a difference: the likelihood of becoming depressed again: women 21.8%, men 12.9%
Women more likely to become depressed IF they have been before!

B. Historically Noted Consistencies in Abnormal Behaviors

1. Survey of Descriptions of Abnormal Behaviors known centuries ago
   --Anxiety: viewed as a major symptom of mental illness since 16th century
   --Melancholia (Depression): first emotional disturbance, associated with Black Bile
   --Mania: clinical form of delirium in which ideas run wildly together, judgment impaired, incoherence and great excitement; blood letting used through the 1700's
   --Dementia: loss of intellectual skills, ability to reason
   --Amentia: feeble-mindedmess, idiocy; person never had adequate intellectual skills
   --Moral insanity: "Monomania", not insane in classical sense, but clearly seemed to lack in moral control. Today's psychopath.
   --Hysteria and Conversion Disorders: Greeks noted this, thought it had to do with wandering uterus! Fits of crying, illness, actual physical symptoms, e.g., blindness and paralysis. Late 1700's notion of conver sion,emotional content converted to bodily symptoms.
   --Masturbation: Condemnation of masturbation as causing mental illness began in 1700. Throughout the years following masturbation has been implicated in mental illness. Most recent --Jan. 13,1980, NY Times _____ Magazine article on sex in China: Prof. from Peking Medical College says that masturbation is not a sickness but an impulsive act that can cause nervous breakdown.

C. From the daily newspapers:
   --Court puts 'bum' under its protection
   --Insanity plea wins acquittal for skyjacker
   --Harlem boy killed by mother; exorcism

D. From the literature
   --Multiplely married patients (Overall study)
   --Psychiatric history and physicians' response (Farina et al)

IV. Illustrations from the Technological Basis of Abnormal Behavior:

A. Dorthea Dix: Angel of Mercy or Bungling fool?
B. Rosenhan report on being sane in insane places;
C. Textbook/lecture bias study
D. Studies of Interest:
   (1) Role Perspective (Snyder)
   (2) Social class and professional status (DiNardo)

V. Illustrations from the Scientific Basis of Abnormal Psychology

A. The MAS study: Consistency in behavior or thought?
B. Issues in "reification"

VI. Models and Concepts Commonly used in Defining Abnormality

A. Overhead of 7 models: strengths and weaknesses of each
B. Influences of psychodynamic theory on current thinking about madness
   (1) Constructs direct our observations--
      ** What are the problems of looking for and "finding evidence of "constructs?"
   (2) Emphasis on theoretical connections rather than acts

D. Continuity-Discontinuity issue (quantitative vs qualitative)
E. Regression vs contemporaneous approaches

VII. Assessment, Diagnosis, and Classification: Issues and Approaches

A. Utility of Diagnostic Efforts
1. Universal language for description
2. Treatment decisions
3. Better understanding of process
4. Facilitate research

B. Turning observations into a language of action: What do we assess?
1. Personality traits vs situationally determined behaviors
2. Stability and other consistencies issues
3. What determines that which we choose to assess?
Techniques, theories, values, again.
Are we instrument dependent?
4. The "sign and sample" distinction
** Have examples in your notes; see tests below
5. The "symptom - syndrome" distinction
6. Standards or norms in assessment
7. Diagnosis as disease based assessment; the search for patterns of symptoms that have explanatory power (Etiology, Treatment, Outcome)
8. Have these goals been met in psychiatry and psychology?

C. DSM-III and its Predecessors

1. Psychiatric ratings scales (Handout)
2. Work of Lorr, Klett, et al. (Symptom Circle overhead)
3. Increases in descriptive categories: More disorders or more work
(a) DSM-I = 60 (b) DSM-II = 145 (c) DSM-III = 230 ***
4. Changes in the concept of Neurosis; behavioral emphasis
5. Multiaxial system more complete description of person
6. Improved reliability; Validity still an issue

D. Assessment and Diagnosis: Assumptions and Differences

1. Concept of multileveled assessment: A three dimensional model
(a) Cognitions, Affect, and Behavior
(b) Situations: limitations of interviews
(c) Methods: self reports, ratings by others, tests, etc.

2. Psychological tests used in assessment
(a) Structured/unstructured: Projective and otherwise
** List better known tests by name in your notes
** What assumptions are they based upon?

(b) Reliability and validity issues
Types of validity
** Know the different types of validity
** How do concepts of reliability and validity differ?
(c) Signs and samples again

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Lecture #9 PERSONALITY DISORDERS AND SUBSTANCE ABUSE

I. PLAN OF LECTURE

A. Concepts of Personality Disorders
B. Psychopathic (Sociopathic) Personality & Criminality
C. Research Considerations in study of Psychopathy
D. Alcoholism: Myths and Bigger Myths
E. Selected Studies on Social Bases of Drinking

II. CONCEPTS OF PERSONALITY DISORDER

A. Concept of Personality and Character Disorders
(1) Problems with "personality types"
(2) Socially annoying behaviors and annoying people
(3) Borderline personality: BORDERLINE between what and what?

B. Some characteristics of "Borderline Personalities"
(Gunderson & Kolb, AMERICAN JOURNAL OF PSYCHIATRY, 1978)

(1) Low achievement in school/work in relation to ability
(2) Impulsivity, drug/alcohol, sexual promiscuity (?)
(3) Manipulative suicide attempts
(4) Heightened affectivity of all sorts (especially anger)
(5) Mild Psychotic experiences (e.g. drug-free paranoid
(6) High socialization in that do not tolerate being alone
(7) Disturbed close relationships, dependency, masochism, and manipulativeness

III. PSYCHOPATHIC (Sociopathic) PERSONALITY & CRIMINALITY

A. "Moral Insanity" & Cleckley' "Mask of Sanity"

(1) Cleckley's criteria (cf. p. 278 text)
(2) Distinguishing between sociopathy and criminality

(a) Widom's approach: using newspaper ads to solicit high PD subjects (p.280 text)
(b) Prison inmates and "mental illness": no more prevalent in prison populations than in general population
Note: drug use & sociopathy are more common in prison groups
(c) How prevalent is criminal behavior among the mentally ill?
Arrest records of ex-mental (hospital) patients:
--prior to 1960's: less likely to be found than than community controls
--after 1960's: during '60's and '70's more likely to be found than community controls
The best predictor of criminal behavior is past criminal behavior; the most prevalent patient groups were sociopaths and drug users; tighter criteria inflates figures for mental patients in other groups
(d) Robins's 1966 longitudinal study (details in text p.281-2; 467)
(e) Quay's four factors: (1) Inadequate-immature; (2) Neurotic-conflictual; (3) Unsocialized-aggressive (Psychopath); (4) Socialized (subcultural) delinquency

B. The Search for the Psychopathic Personality: Research Trail

1. Anxious vs nonanxious psychopath distinction
2. Failure of moral anxiety/guilt as central concept
3. Find evidence that psychopath is not motivated by anxiety
4. Illustrative experimental paradigms (e.g., Hare's experiments on generalization gradients; "shock now or later", etc.)
5. Lyyken's studies; Schachter studies on shock avoidance
   --Conclusion: that Psychopath is UNDERAROUSED
   --What if we increase arousal? (Chesno & Kilmann, JOURNAL OF ABNORMAL PSYCH,1975)
6. Generalized case of electrodermal hyporesponsivity: shown that low GSR reactivity is associated with poor avoidance learning. Not always psychopathic personality. (Excess meaning?)

IV. ALCOHOLISM: MYTHS AND BIGGER MYTHS

A. Addiction as physiological dependence: The case for Alcohol
B. "Abstinence violation effect" (Marlatt & Gordon):
   --Noted similarity in relapse rates across different drugs;
   --Focus on single failure as cognitive precipitant to further drug use
   --"I failed (once), therefore I am an addict" leads to further use
C. Total abstinence vs controlled drinking: controversy!
D. Recent expose' of controlled drinking studies: Sobell and Sobell data
E. "The Etiology of Alcoholism: A Prospective Viewpoint" Vaillant & Miolofsky (AMERICAN PSYCHOLOGIST, 1982)

(1) Separating cause and effect-as-artifact!
(2) Do unhappy childhoods cause alcoholism, or do alcoholics have lousy relationships which are "justified" in terms of unhappy childhoods?
(3) Because alcoholism distorts (a) personality, (b) social stability, (c) recollection of relevant childhood variables, therefore retrospective impressions are suspect (p.494)
(4) HYPOTHESIS: Could alcoholism be the CAUSE not the result of unhappy childhood, broken families, and personality disorder?
(5) Authors investigated the influence of 5 major variables on the development of alcoholism:
   --ethnic background
   --alcoholic heredity
   --antisocial behavior prior to development of alcoholism
   --boyhood emotional adjustment
   --presence or absence of familial instability (p.495)
(6) Used for controls the non-delinquents subjects (boys) from Glueck and Glueck longitudinal study of delinquency
(7) Current sample interviewed at four points over 33 year period

(8) RESULTS:
   --differences usually attributed to etiological significance, e.g., social class, unemployment, mental illness, etc., appear AFTER alcoholism onset rather than before,
   --control for ethnicity etc. strong case for EFFECT rather than cause

V. SELECTED STUDIES ON SOCIAL BASIS OF ALCOHOLISM

A. General findings from lab studies on expectancies

Balanced-Placebo-Design --experimental paradigm for controlling expectancy and alcohol ingestion. (Marlatt studies.)

Subjects are told that they WILL (or will NOT) be given alcohol AND they ARE or ARE NOT given alcohol:

Expectation:	Given Alcohol: YES	Given Alcohol: NO
YES	1	2
NO	3	4

Columns compare alcohol effects;
Rows compare expectancy effect.
Note: Cells 2 & 3 are important

B. Newer studies on expectancies in adolescent groups (Christiansen et al. JCCP, 1982, 50, 336-344;JCCP, 1983, 51, 249-257)

1.Purpose: Do expectancies about effects of drinking develop from pharmacological experience with alcohol or from social-learning factors?

Method: 1,580 adolescents in transition from nondrinking to adult drinking patterns; ages 12 to 19 years. Expectancy questionnaire; factor analysis of responses:

Results: Six expectancy factors repeated across all age groups;
5 were present in adolescents with little or no drinking experience:
Physical tension reduction, diversion from worry,increased interpersonal power, magical transformation of experiences, enhanced pleasure, modification of social-emotional behavior (e.g. people are more caring, do stupid things, etc.)

Conclusions: (1) Expectancies exist prior to drinking and (2) they become more focused with drinking experience. The preconditions for positive reinforcement of alcohol use exist in adolescents the very first time they drink (p.343).
This makes placebo effects more likely.
Pharmacologicl mechnanisms are not necessary for effects.

2. Point of second study was to determine whether by knowing expectancy factors we could improve on ability to predict adolescent drinking, over and above background-factor predictors. Answer: yes. (Background factors included: age, religiosity, parental drinking.)

C. Study of drinking in natural settings (Reid)

Drinking behavior can be influenced by models in naturalistic settings. People "push" drinking and we respond by drinking more. Stimulus control of drinking is largely external, e.g. contextual.

Lecture #11 SCHIZOPHRENIAS: CLINCIAL DESCRIPTION

I. Plan of Lecture

A. Views on Psychotic Behavior

B. Descriptions of Psychotic Behaviors (Emphasis on Schizophrenias)

C. Schizotypy: The case for "magical thinking"

II. Views on Psychotic Behavior

A. Quantitative or qualitative differences: more or different?
B. Psychoses and regression: Normal children are not like psychotic adults, e.g., schizophrenics
C. Is a person psychotic all the time?
D. Are psychotic conditions homogeneous in nature?
   1. Distinction between "organic" and "functional" psychoses
   2. Psychoses as adaptive to overwhelming stress

E. Diagnosis then and now: Kraepelin's cases 75 years later (James and May, Amer. J. of Psychiatry, 1981, 138, 501-504)
   1. Rediagnosed patients in 32 case histories presented by Kraepelin
   2. All references to diagnoses were removed
   3. DSM-III criteria were used
   4. Of 15 cases originally diagnosed "Dementia Praecox" by Kraepelin, 14 were diagnosed schizophrenia by modern criteria
   5. Of 13 cases diagnoses as mania, depression, or manic-depression by Kraepelin, 11 were similarly diagnosed by DSM-III;
   6. Two cases of paranoia and 1 of hysteria (somatization disorder) were identically diagnosed in the two systems;
   7. One case K. diagnosed as senile dementia was classified "atypical psychosis" in DSM-III.
   8. Kraepelin would be at home with DSM-III; DSM-III has moved us back (75 years) to Kraepelin's clinical view of psychosis.

II. Description of Psychotic Behaviors (Emphasis on Schizophrenias)

A. Loss of Contact with Reality: time, place, person
B. Verbal Behaviors:
   1. Slow or fast speech
   2. Grandiosity --dieties, famous people, unusual feats of power
   3. Exaggerations beyond social norms
   4. Bizzareness -- neologisms (newly coined words, e.g. "neurostators")
   5. Clang Associations --"Mr. Smith is a glith"
   6. Echolalia (repeating last message over & over & over & over)

C. Sensory and Motor Behaviors
   1. Hallucinations, visual, auditory, paraesthesias
   2. Light flashes and colors (not like detached retina!)
   3. Unusual gestures, tics, postures, rigidities (catatonics)
   4. Movement rate too fast or slow

D. Cognitive and Affective Processes
   1. Depersonalization
   2. Dellusional thinking
      (a) Persecution
      (b) Grandeur
      (c) Changes in body (organs)
      (d) Personalized meanings; Ideas of Reference
   3. Attention or set dysfunctions
      (a) Distraction
      (b) Overinclusiveness
      (c) Failure to maintain a guiding mental set (e.g. tapping task)
   4. Associative dysfunctions (meaning changes)
   5. Flat or inappropriate affect

E. Descriptions of "schizophrenia" in popular literature (North & Cadoret, Archives of General Psychiatry, 1981, 38,133-137)
   1.Reviewed five personal accounts of "schizophrenia" as portrayed in popular books, e.g.,The Eden Express, I Never Promised You a Rose Garden, Life Time, etc.

   2. In all cases there was insufficient evidence to merit a DSM-III diagnosis of schizophrenia. Most often there was support for a diagnosis of (a) affective disorder, (b) somatization disorder, and (c) biploar disorder.

   3. Popular accounts of "schizophrenia" are misleading.

III. Schizoptypy: The Case for "Magical Thinking"
(Eckblad & Chapman, JCCP, 1983, 51, 215-225)

A. DSM-III defines 'schizotypical personality disorder' in terms of one of its criteria, "magical thinking, e.g., superstitiousness, clairvoyance, telepathy, 6th sense, others can feel my feelings."
B. Authors seeking measures of psychotic proness in college students;Magical thinking is viewed as an important sign of schizophrenia that can be detected before it is full blown. Authors devised a scale to measure tendency toward magical thinking:
   Sample items:(T= True; F = False; count keyed answer):
   "I have had the momentary feeling that I might not be human (T)
   "Numbers like 13 and 7 have no special powers (F)
   "I have noticed sounds on my records that are not there at other times (T)
   "At times I have felt that a professor's lecture was meant especially for me (T)
C. 4.4% males and 3.2% females (N=1,512) scored 2 sigma above the mean; distribution skewed.
D. Samples of 28 experimental and 27 control subjects were interviewed using the SADS-L schedule, and material was rated according to authors' criteria for psychoticlike symptoms.
E. Subjects scoring high on Magical Thinking test also showed more evidence of psychopathology on numerous dimensions; probably not just a measure of schizotypy, but rather psychosis proness.
F. NOTE: This study did not establish that the high magical thinkers become schizophrenic; highly inferential approach suggesting that such would be the case.

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LECTURE #13 CHILDHOOD DISORDERS

PLAN OF LECTURE

I. Defining childhood psychopathology

II. Psychopathology vs Performances: Major Ideological Differences

III. Role of Marital and Family factors in Childhood Disorders

I. Defining Childhood Psychopathology

A. Areas in which children can display atypical behavior (See Box 5)
1. Developmental progression
2. Feeding and elimination
3. Educational adaptability and intellectual capability
4. Conduct and impulse control
5. Affective regulation
6. Interpersonal compliance

B. Distinguishing between "obnoxious" and abnormal behaviors
1. Creating psychiatric disorders where none have existed: the labeling enterprise
2. Are childhood disorders outgrown?
(a) Robins follow-up of children (longitudinal study)
(b) Isolated symptoms do dissipate with age
(c) Symptom groups and those appearing after age 6yrs are more likely to be lasting than those appearing before age 6 yrs.

(d) Children with problem of overcontrol (shy, withdrawn) do not do any worse than base rates as adults.
(e) Children with undercontrol problems (antisocial) have a poor prognosis for adulthood. (Also true for "psychotic" child problems.)

2. What determines how a child is labeled?
Christensen, Phillips, Glasgow & Johnson. JOURNAL OF ABNORMAL CHILD PSYCHOLOGY, 1983

(a) Point of study was to determine correlation between parental variables and child behaviors, e.g., marital satisfaction, parental psychopthology, etc.

(b) Home observations were made using a "bug box," random time audio recording of family interactions;

(c) Significant correlations between parental perception of child behavior problems ("I think my kid is sick") and parental negative behavior directed toward child.

(d) BUT no relationship between the child's negative behaviors and parental rating of the child; parents are not using what the child does as much as what they think the child is doing.

3. Kid power: "My two year old is terrorizing the neighborhood!"
   Teachers live in fear of students.
4. Classification schemes less complex than DSM-III
   (a) Box 5: Listing of what is considered child disorders
   (b) Box 6: Sample structures of rating scales

II. Psychopathology vs Performances: Major Ideological Differences

A. Viewing the symptom as the problem, or the symptom as a flag of underlying psychopathology
B. Childhood Depression: Since it exists in adults it must exist in kids; finding what we think is out there.
C. The influences of behavioral psychology

III. Role of Marital and Family factors in Childhood Disorders

A. Emery, R.E., "Interparental conflict and the children of discord and divorce", PSYCHOLOGICAL BULLETIN, 1982, 92, 310-330.
A major review of the literature on parental conflict on childhood disorders.

B. Study by Emery and O'Leary (J. Abnorm. Child Psychology, 1982)

1. Others have found a strong association between marital discord and conduct problems (not anxiety related problems) in boys and not in girls.

2.Two possible etiological mechanisms:
   (a) "Loss of love" --conflicted parents fail to provide love to kids; the loss of love makes them problem kids;
   (b) Modeling hypothesis -- conflicted parents display aggressive and hostile behaviors; kids imitate this behavior.
3.Children between 8-17 yrs (25 boys and 25 girls) exclusive of learning disabilities, being seen at University clinic.

4. Measures of: Parent marital adjustment/conflict and child perception of relationship
5. Correlations between sets of measures

6. Both boys and girls agreed moderately with their mother's perception of her marriage (r's = .45)

7. No relationship between mother's marital adjustment and children's ratings of their own acceptance.

***8. For both M and F there was a significant relationship between their own rated marital discord and their ratings of their child's conduct problems; true only for boy children.

9. Possible that children model same sexed parent more, and that fathers act out hostility more than mothers.

10. Child's self ratings of acceptance did not correlate with either self-rating or parental rating of martial discord. It would seem that loss of love is not here important.

BOX 5: SAMPLE CLASSIFICATION OF CHILDHOOD DISORDERS

(Adapted from Mash and Terdal, BEHAVIORAL ASSESSMENT OF CHILDHOOD DISORDERS, 1981)

This is a sample of a behaviorally oriented approach to the broad area of assessing childhood disorders; note particularly the choice of terms.

I. Externalizing Disorders

- A. Self-Management Problems in Children
- B. Hyperactivity
- C. Conduct Disorders
- D. Child Abuse

II. Internalizing Disorders

- A. Fears and Anxieties in Children
- B. Childhood Depression
- C. Childhood Psychoses
- D. Social Skills Deficits

III. Developmental Disorders

- A. Autism
- B. Learning Disabilities
- C. Psychosexual and Gender Problems

IV. Health Related Disorders

- A. Chronic Illness: Asthma and Juvenile Diabetes
- B. Childhood Obesity
- C. Seizure Disorders
- D. Sleep Disturbance in Children and Adolescents
- E. Elimination Problems: Enuresis and Encorpresis

BOX 6: TWO POPULAR RATING SCALES: THE BECKER AND THE QUAY

Rating scales are important means for describing child behaviors; they define specific behaviors for the rater (usually a parent or teacher) to rate on some Likert type scale, e.g., 1 = very much, very often, very typical; 7 = never occurs, not at all like child, etc.

The success of the scales depends upon rater agreement and validity; can raters make reliable judgments about the same child and do the ratings correlate with significant criteria? The typical approach is to factor analyze the responses obtained, thereby reducing a large set of items to a few coherent factors. If the factors are independent of one another the scores on the factors provide a rating profile of the child. The factors are named by the investigator usually by taking the item that "correlates" (loads) most highly with the factor dimension. Then the remaining items are used to refine the name of the factor.

BOX 6: Cont'd

Quay's Factors

Conduct Disorder	Lack of interest
Assaultive	Clumsy, poorly coordinated
Temper tantrums	
Disobedience	*Anxiety-Withdrawal*
Destructiveness	Anxious, fearful
Uncooperativeness	Shy
Irritability	Seclusive
Dominates others	Depressed
Dishonest	Hypersensitive
Abusive language	Lacks self-confidence
Steals	Cries frequently
	Easily upset
Immaturity	
Short attention span	*Socialized Aggression*
Daydreams	Has bad companions
Preoccupied	Belongs to a gang
Lacks perseverance	Truant from school
Passive	Truant from home
Inattentive	Stays out late at night

Source: Adapted from Quay (1979).

Becker's early factors:

DESCRIPTION OF THE VARIMAX FACTORS IN PARENTAL RATINGS OF SELF AND EACH OTHER

Loading	Description
	Factor 1—Hostile-Withdrawal
77	Loving.....unloving
68	Responsive.....aloof
68	Warm.....cold
67	Emotionally close.....detached
63	Devoted.....rejecting
63	Forgiving.....begrudging
61	Sociable.....unsociable
53	Approving.....disapproving
51	Kind.....cruel
50	Cooperative.....hostile
49	Meaningful.....meaningless
48	Vigorous.....inert
46	Outgoing.....self-centered
44	Soft hearted.....hard hearted
	Factor 2—Dominance-Strictness
71	Permissive.....strict
64	Mild.....severe
63	Submissive.....dominant
63	Democratic.....authoritarian
60	Nondemanding.....demanding
57	Pliable.....rigid
56	Nonrestrictive.....restrictive
53	Uncritical.....critical
50	Sensitive.....tough
50	Easy going.....irritable
49	Soft.....hard
46	Weak willed.....strong willed
	Factor 3—Nervousness
71	Confident.....unsure
67	Clear.....confused
64	Relaxed.....tense
64	Happy.....depressed
60	Fearless.....fearful
53	Energetic.....fatigued
48	Free from guilt.....guilt ridden
43	Calm.....excitable
38	Optimistic.....pessimistic
	Factor 4—Immature, Aggressive Emotionality
54	Level.....fluctuating
54	Patient.....impatient
51	Consistent.....inconsistent
46	Understanding.....not understanding

Loading	Description
45	Not-prone-to-anger.....prone to anger
41	Rational.....arbitrary
38	Conscientious.....conscienceless
	Factor 5—Commonness (low IQ?)
66	Formed.....formless
62	Individualistic.....ordinary
54	Curious.....uninquiring
51	Deep.....shallow
48	Flexible.....inflexible
45	Adventurous.....timid
45	Quick.....slow
39	Real.....unreal
34	Effective.....ineffective
	Factor 6—Solicitousness
59	Nonchalant.....anxious
43	Not jealous.....jealous
40	Underhelping.....overhelping
40	Inactive.....active
39	Lax.....vigilant
37	Objective.....emotional
37	Nonsuggesting.....suggesting
32	Trusting.....suspicious
	Factor 7—Nonprotectiveness
63	Sheltering.....exposing
53	Protective.....nonprotective
	Factor 8—Harmony
46	Contentious.....concordant
42	Punitive.....nonpunitive
39	Conflicted.....nonconflicted
38	Taking.....giving
36	Threatening.....reassuring
	Factor 9—Social Effectiveness
48	Disorganized.....organized
48	Colorless.....colorful
47	Unsuccessful.....successful
37	Boring.....interesting
	Factor 10—Playfulness
55	Serious.....playful
48	Humorless.....humorous
38	Thwarts curiosity.....satisfies curiosity

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DISORDERS AMONG THE ELDERLY

I. Overview of issues relevant to a discussion of disorders among the elderly.
   A. The lack of a sound data base
   B. The definition of disorder
      1. DSM-III syndromes (e.g., OBS, P)
      2. Psychopathological symptoms (e.g., depression, anxiety)
      3. Stressful situations (e.g., relocation trauma, retirement, bereavement
   C. The definition of elderly
      1. Arbitrary chronological age

II. Knowledge of aging
   A. Before discussing what is abnormal, we need some idea of what is normal
      1. Memory changes as a function of age
      2. Intelligence curves
      3. Personality changes as a function of age/cohort
      4. Sensory deficits

III. Disorders particular to the elderly: description of the condition, discussion of etiological theories, overview of treatment
   A. Organic Brain Disorders
      1. Delirium
   B. Organic Mental Disorders
      1. Dementia
         a. Senile dementia of the Alzheimer's type
         b. Multi-infarct dementia

IV. Disorders evident in all ages: description of the condition, discussion of etiological theories, overview of treatment as applied to the aged
   A. Clarify definition of the disorder among the elderly
      1. Late onset vs. chronic condition

   B. Common syndromes
      1. Depression
      2. Paranoia
      3. Aphasias

Diagnostic criteria for major depressive episode

A. Dysphoric mood or loss of interest or pleasure in all or almost all usual activities and pastimes. The dysphoric mood is characterized by syndromes such as the following: depressed, sad, blue, hopeless, low, down in the dumps, irritable. The mood disturbance must be prominent and relatively persistent, but not necessarily the most dominant sypmtom, and does not include momentary shifts from one dysphoric mood to another dysphoric mood, e.g., anxiety to depression to anger, such as are seen in states of acute psychotic turmoil. (For children under six, dysphoric mood may have to be inferred from a persistently sad facial expression.)

B. At least four of the following symptoms have each been present nearly every day for a period of at least two weeks (in children under six, at least three of the first four).

1. Poor appetite or significant weight loss (when not dieting) or increased appetite or significant weight gain (in children under six, consider failure to make expected weight gains).
2. Insomnia or hypersomia

3. Psychomotor agitation or retardation (but not merely subjective feelings of restlessness or being slowed down)(in children under six, hypoactivity)

4. Loss of interest or pleasure in usual activities, or decrease in sexual drive not limited to a period when delusional or hallucinating (in children under six, signs of apathy)

5. Loss of energy; fatigue

6. Feelings of worthlessness, self-reproach, or excessive or inappropriate guilt (either may be delusional)

7. Comoplaints or evidence of diminished ability to think or concentrate, such as slowed thinking, or indecisiveness, not associated with marked loosening of associations or incoherence

8. Recurrent thoughts of death, suicidal ideation, wishes to be dead, or suicide attemt

Diagnostic criteria for dementia

A. A loss of intellectual abilities of sufficient severity to interfere with social or occupational functioning.

B. Memory impairment

C. At least one of the following:

1. Impairment of abstract thinking, as manifested in concrete interpretation of proverbs, inability to find similarities and differences between related words, difficulty in defining words and concepts and other similar tasks.

2. Impaired judgment

3. Other disturbances of higher cortical function, such as asphasia (disorder of language due to brain dysfunction), apraxia (inability to carry out motor activities despite intact comprehension and motor function); agnosia (failure to recognize or identify objects despite intact sensory function), constructional difficulty (e.g., inability to copy three-dimensional figures, assemble blocks, or arrange sticks in specific designs)

4. Personality change, i.e., alteration or accentuation of premorbid traits

D. State of consciousness not clouded (i.e., does not meet the criteria for Delirium or intoxication, although these may be superimposed)

E. Either (1) or (2)

1. Evidence from the history, physical examination or laboratory tests of a specific organic factor that is judged to be etiologically related to the disturbance

2. In the absence of such evidence, an organic factor necessary for the development of the syndrome can be presumed if conditions other than organic-mental disorders have been reasonably excluded and if the behavioral change represents cognitive impairment in a variety of areas.

DSM-III (Diagnostic & Statisical Manual of the American Psychiatric Association, 1982)

Diagnostic Criteria for Delirium

A. Clouding of consciousness (reduced clarity of awareness of the environment), with reduced capacity to shift, focus, and sustain attention to environmental stimuli

B. At least two of the following:
1. Perceptual disturbance: misinterpretations, illusions, or hallucinations

2. Speech that is at times incoherent

3. Disturbance of sleep-wakefulness cycle, with insomnia or daytime drowsiness

C. Disorientation and memory impairment (if testable)

D. Clinical features that develop over a short period of time (usually hours to days) and tend to fluctuate over the course of a day

E. Evidence, from the history, physical examination, or laboratory tests, of a specific organic factor judged to be etiologically related to the disturbance

COMMON DRUGS WHICH MAY MIMIC/INDUCE/AGGRAVATE DEPRESSION

Drug	Possible depression side effects	Disorder
Diuretics	Lethargy, weakness	Cardiovascular problems
Digitalis	Depression, nausea/vomiting mental confusion, headache, sleeplessness, apathy, weight loss	Cardiac problems
Reserpine Methyldopa Diuretics & others	Depression, fatigue/decreased or loss of energy, crying spells, loss of interest, hopelessness, impaired concentration, sleep disturbances (drowsiness, sleepiness, insomnia), anhedonia suicidal tendencies	Hypertension
L-dopa	Depression, suicidal pre-occupation, tearfulness, hopelessness, negativism, sleep disturbance	Parkinson's Disease
Extrogens	Depression	Menopause*
Iproniazid	Depression, confusion, memory impairment, sleep difficulties	Tuberculosis
Cyclosexine		
Cytostatic Immunosuppressive Drugs	Depression, apathy, legarthy, weakness	Cancer
Psychotropic Drugs	Drowsiness, depression, apathy, withdrawal	Epilepsy
Neuroleptics Haloperidol Chlorpromazine Phenothiazines		Agitation Various mental disorders
Tricyclic anti-depressants Amitriplyline Doxepin	Confusion, lethargy, sleepiness/ drowsiness	Depression
Anti-anxiety Drugs Barbiturates Benzodiazepines Meprobamate	Depression, suicidal thoughts, drowsiness	Anxiety
Hypnotics & sedatives	Depression	Sleep disturbance

*Certainly not a disorder, as such, but mentioned here as esrogens are frequently prescribed which may induce depression

HOW LONG WILL YOU LIVE?

This is a rough guide for calculating your parsonal longevity. The basic life expectancy for males is age 67 and for females it is age 75. Write down your basic life expectancy. If you are in your 50s or 60s, you should add ten years to the basic figure because you have already proven yourself to be quite durable. If you are over age 60 and active, add another two years.

Basic Life Expectancy

Decide how each item below applies to you and add or subtract the appropriate number of years from your basic life expectancy.

1. Family history
   Add 5 years if 2 or more of your grandparents live to be 80 or beyond
   Subtract 4 years if any parent, grandparent, sister, or brother died of heart attack or stroke before 50. Subtract 2 years if anyone died from these diseases before 60.
   Subtract 3 years for each case of diabetes, thyroid disorders, breast cancer, cancer of the digestive system, asthma, or chronic bronchitis among parents or grand-parents

2. Marital status
   If you are married, add 4 years
   If you are over 25 and not married, subtract 1 year for every unwedded decade

3. Economic status
   Subtract 2 years if your family income is over $40,000 per year
   Subtract 3 years if you have been poor for greater part of your life

4. Physique
   Subtract one yer for every 10 pounds you are overweight
   For each inch your girth measurement exceeds your chest measurement deduct two years
   Add 3 years if you are over 40 and not overweight

5. Exercise
   Regular and moderate (jogging 3 times a week) add 3 years
   Regular and vigorous (long distance running 3 times a week) add 5 years
   Subtract 3 years if your job is sedentary
   Add 3 years if it is active

6. Alcohol
   Add 2 years if you are a light drinker (1-3 drinks a day)
   Subtract 5 to 10 years if you are a heavy drinker (more than 4 drinks per day)
   Subtract 1 year if you are a teetotaler

7. Smoking
   Two or more packs of cigarettes per day, subtract 8 years
   One to two packs per day, subtract 4 years
   Less than one pack, subtract 2 years
   Subtract 2 years if you regularly smoke a pipe or cigars

8. Disposition
   Add 2 years if you are a reasoned, practical person
   Subtract 2 years if you are aggressive, intense, and competitive
   Add 1-5 years if you are basically happy and content with life
   Subtract 1-5 years if you are often unhappy, worried, and often feel guilty

9. Education
   Less than high school, subtract 2 years
   Four years of school beyond high school, add 1 year
   Five or more years beyond high school, add 3 years

10. Environment
    If you have lived most of your life in a rural environment, add 4 years
    Subtract 2 years if you have lived most of your life in an urban environment

11. Sleep
    More than 9 hours a day, subtract 5 years

12. Temperature
    Add 2 years if your home's thermostat is set at no more than 65 degrees F.

13. Health care
    Regular medical checkups and regular dental care, add 3 years
    Frequently ill, subtract 2 years

SOME COMMON TERMS USED WITH ORGANIC DISORDERS

APHASIA: Lack of understanding of spoken words

APRAXIA: Disturbance of expressive functions, e.g., inability to pick up a pencil on command even though musculature is intact

Alexia: No reading
Agraphia: No writing

AGNOSIA: No knowledge, e.g., inability to recognize a familiar face
May apply to any sense modality

Brain Disorders Classified by Etiology (Davison and Neale, 2nd ed.)

1.INFECTIONS

Encephalitis
Meninities
Neurosyphlisis

2. TRAUMAS

Concussion
Contusion
Laceration
Skull Fracture

3. NUTRITIONAL DEFICIENCIES

Wernicke and Korsakoff syndromes
Beriberi
Pellagra

4. CEREBROVASCULAR DISEASES

Atherosclerosis
Cerebral thrombosis
Cerebral hemorrhage

5. DEGENERATIVE DISEASES

Alzheimer's disease
Pick's disease
Huntington's chorea
Parkinson's disease
Senile dementia

6. TOXINS

Lead, Mercury, Arsenic, Carbon monoxide, etc.

7. ENDOCRINE DYSFUNCTIONS

Grave's disease
Myxedema
Addison's disease
Chusing's syndrome

8. TUMORS

Benign
Malignant

LECTURE #15: SURVEY OF THEORIES AND METHODS OF THERAPIES

I. Plan of Lecture
- A. The Broader Contexts of Behavior Change: Targets and Philosophies
- B. Toward a Classification of Therapies
- C. The Technological Basis of Change
- D. Meta-Analsyes of Outcome Studies

II. The Broader Contexts of Behavior Change: Targets and Philosophies

A. Agents of Behavior Change

(1) Family, Peers
(2) School
(3) Institutions, e.g. prisons, hospitals
(4) Legal (Courts) and political entities
(5) Church
(6) Economic-Business (Advertising)
(7) Healers of all sorts, e.g., faith healers, doctors, hairdressers, voodoo, bartenders

B. Some targets of behavior change: What is changed?

(1) Body --somatic therapies, medicine, magic
(2) Cognitions and feelings--thoughts, beliefs, values, feelings
(3) Behaviors --actions, choices of movement
(4) Small groups --families
(5) Institutions --schools, work place
(6) Community --political entity (e.g., a union)

C. The Rhetoric of Change: The Basis of our "beliefs" in Change

(1) Appeals to higher wisdom or authority (e.g., God's will, SCIENCE, patriotism, special powers, police, etc.)
(2) "Hocus Pocus": Promises of health and wealth, freedom from suffering
(3) Personal healing: restitution, guilt reduction
(4) Protection from dangers: society, group, individual

D. Philosophical and Value Basis of Therapies

1. Cynicism: The Case for Nonspecifics in Psychological Behavior Change: Placebo Effects

Jerome Franks' arguments from PERSAUSION AND HEALING
- a. People come to therapy feeling demoralized and as failures
- b. Therapist offer acceptance and attention not found elsewhere
- c. All therapies display symbols of healing: hocus pocus, magical sayings, jargon (Latin perscriptions?), masks, diplomas, white coats.
- d. Therapists are given special status, clothes, and only are seen in special places designated for ministering to the needy
- e. Therapists belong to "secret societies" and do not tell their secrets of healing to just anyone!
- f. Therapists are enthusiastic about their powers, believing that they alone have the correct method of healing.

2. Frank 1979: Views on why psychotherapy works:

   a. All forms of PsychoRx are somewhat more effective than informal or unplanned help
   b. One form of PsychRx rarely has been shown to be significantly more effective than any other
   c. Most clients who show initial improvement maintain it
   d. Rx success lies more in the qualities of the client and therapist and their interaction than in the Rx method
   e. All thearpies have a theory, special procedures, and symbols of healing; all offer hope to the demoralized.

3. Pessimism: The Psychoanalytic Point of View

   a. Individuals cannot escape their early (psychosexual) developmental fixations; you will always be the "personality" you have been!
   b. As adults we express the "character structure" developed from the past;
   c. One never "becomes totally normal," therapy never ends; one must settle for less than the ideal;
   d. Strive to gain awareness (insight) into one's motives; that is the only hope. (If all else fails, use Mary Kay cosmetics!)

4. Optimism: Behavioral (B) [and perhaps Existential (E)] Point of View

   a. Psychopathology is a matter of inadequate learning; better living through better learning! (B)
   b. Man/Woman chooses to assign meanings to life; choose to fulfill yourself! Your past is nonexistant. You can only become. (E)
   c. Symptoms are not indications of past failures; better living through better technology! Learn new adaptive behaviors. The symptom is the problem. (B)
   d. Behavior can be changed; we can learn effective strategies of self-control (in the sense of self management) (B)
   e. "Every day, in every way I am getting better and better" (Saying on Mary Kay promotional manual.) (B & E)

II. TOWARD A CLASSIFICATION OF THERAPIES

A. How long is the average term of psychotherapy? (Koss: JCCP, 1979)
Median of 8 sessions over 2.5 months; 1/2 terminated by the 10th sessions; only 20% remained in treatment >25 sessions.

Myth: psychotherapy practiced by experienced therapists consists of hundreds of hours.
Garfield in 1978 reported a median of 6 sessions, with 2/3rds leaving treatment before the 10th session.

B. By Conceptual Model

1. Insight vs action oriented
2. Dynamic vs behavioral
3. Individual vs systems focused (e.g., dyad, family, collective)
4. Emphasis on historical factors vs current capabilities

C. Insight Approaches Emphasize:

1. Symbolic meaning
2. Unconscious processes and special role of affect
3. Some form of "transference" necessary to therapy
4. Integration of thought and feeling (especially Gestalt)

D. Behavioral Approaches Emphasize:

1. Person environment interactions
2. Functional consequences of behaviors
3. View that Symptom IS problem; alter problematic behaviors
4. Role of various cognitive functions

E. System Approaches Emphsize:

1. Structural analysis of interactions (patterning)
2. Homeostatic mechanisms
3. Circular causality, (choice of how we punctuate experiences)

F. Classification By Modes of Therapy

1. Individual
2. Marital
3. Family
4. Small Group
5. Collective
6. Community

III. TECHNOLOGIES OF CHANGE

A. Assessment in Behavioral Therapies

1. Differences between traditional and behavioral assessment
2. Assessment as continuous feedback correctives
3. Observational assessment vs self report: tracking as Rx?
4. Targeting success

B. Respondent and Operant Models

1. Desensitization as counterconditioning: practice without theory
2. Flooding and implosion techniques in anxiety management
3. Aversion therapies
4. Distinguishing between acquisition and performance: Skinner and everday life
5. Behavior Control, contingency management, and the natural reinforcing consequences of everyday life

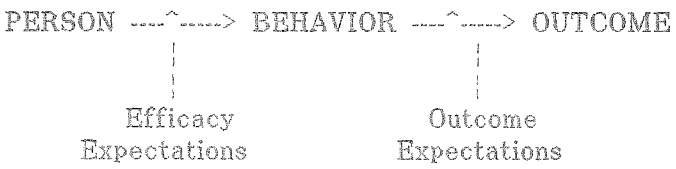
(a) How do I shape thee? Let me count the ways.
(b) Token Economies in hospitals
(c) Coercive control in families
(d) Child management, family therapy, and delinquency

C. New-Wave Cognitive Behavioral Approaches

1. Radical Behaviorism vs Cognitive Behavioral Approaches
   (a) Ellis and RET: The ABC's of the Mind
   (b) Social learning models: Bandura's "reciprocal determinism"

P = cognitive & internal events
B = behaviors
E = environment

(c) Bandura's Self-Efficacy Model:



IV. META-ANALYSIS OF OUTCOME STUDIES

A. What to do If Therapy Actually Works!

1. The case of early Behavior Modification: The sky is falling!
   Mind control; brain washing; people aren't rats (not always);
2. Ethics and behavior change: Whose ethics are correct?

B. Psychotherapy Outcome (Landman & Dawes,1982, AMERICAN PSYCHOLOGIST, 37, 504-516.)
Concept of Meta-Analysis

Determining therapy outcome effects using the "Box Score" approach
Question: how does the effect size (ES) of active therapy compare to a no-treatment control group?

$$ES = (M_t - M_c) / SD_c$$

where ES = effect size, M = mean, SD = Standard Deviation, t = treatment, c = control

ES is a Standard Score; a positive ES means that the treatment better than control; negative ES means that Control did better than Treatment.

An effect size = 1 indicates that the mean of the treatment group is at the 84th percentile of the control group after treatment.

C. Smith & Glass 1977) study:

Analysed 375 psychotherapy and counseling studies, using 833 ES's; the overall ES magnitude was .68 "which is considered to be a moderately large effect for a clinical analysis," (Landman & Dawes, 505).

The average client receiving therapy was better off than 75% of the untreated controls (quoted from Smith and Glass).

D. Problems with other meta-analyses, e.g., Smith & Glass 1977,

1. Most therapy outcome studies use multiple measures; if each outcome measure is treated as a separate score we have ignored the mutual dependence of scores, violating statistical assumptions of independence;

2. "Different" studies by the same author(s) often use same subjects for each; the analyses in these cases therefore are not independent;

3. Assessments are made on the same clients at successive times (not independent) but are then reported as separate (independent) outcomes;

4. Suggested Solution: figure ES on each measure within each study, average these ES's within each study and report the average score per study.

D. Landman & Dawes Study: Method and Results

1. Drew a random sample of 65 studies from all those available to S&G and 93 additional ones (since 1977);

2. Determined whether these studies had adequate NT or placebo control groups; 42 did;

3. Found that that the methodologically sound studies yielded ES = .78;

4. The potency of the placebo effect was considerably less than the ES for treatment; ALSO--placebo ES was not different from that for NT ES; This means that placebo offers little "therapy" effect. (Franks take note! RLW)

5. The re-analysis (L&D) supports the original S&G study.

6. When looked at in terms of severity of problem:

(a) snake/rat phobia, test anxiety, speech anxiety ES=1.11 (sd=.76)
(b) schizophrenia, depression, alcoholism, delinquency ES= .68 (sd=.43)

7. All is well; RX is effective relative to NT. Also: a review of the studies included in the L&D re-analysis indicate a high proportion of behavioral studies. The effectiveness results were based relatively more on studies utilizing behavioral techniques.

Psych. 427 R.L. Weiss
Abnormal

TWELVE REPRLICATED PSYCHIATRTIC SYNDROMES

The following illstrates the results of some 18 studies reported in the literature through the years which provided information in the form of symptom ratings, usually based upon interview interactions with hospitalized psychitric patients. Factor analysis, or some variant thereof, generally was used to treat the data. The twelve replicated factors are listed below, with the number of studies (out of 18 total) which supported the factor in each case. This table helps demonstrate commonalities in describing behaviors and interview information observed in the context of a psychiatric hospital.

I. Paranoid Delusions (14)
- feels systematically persecuted
- believes others influence him
- belives people talk about him.

II. Thinking Disorganization (12)
- irrelevant speech
- disoriented
- emotional disharmony

III. Anxiety-Depression (14)
- doubts he can be helped
- feelings of impending doom
- unrealistic self-blame

IV. Excitement-Hostility (13)
- initiated physical assualts
- destructive
- obscene

V. Excitement-Depression (9)
- shouts, sings, talks loudy
- irritable
- temper tantrums

VI. Withdrawal-Retardation (9)
- speech is slow or deliberate
- shut-in personality
- lacks motivation

VII. Perceptual Distortions (6)
- visual hallucinations
- auditory hallucinations
- tactual hallucinations

VIII. Phobic Complusive Reaction
- behavior disrupted by phobias
- compulsive acts occur daily
- obessional thinking

IX. Paranoid-Grandiose (7)
- grandiose convictions
- dramtically attention-demanding
- voices praise or extol him

X. Motor Disturbances (6)
- manneristic movements
- giggling
- assumes bizzare postures

XI. Deterioration (7)
- incontinent because of own negligance
- foreign objects in mouth
- unaware of feelings of others

XII. Conversion Hysteria (5)
- no organic basis for complaint
- organic pathology with emotional basis
- use made of physical disease symptoms

Psychology 427 Derek Evan

SEXUAL DYSFUNCTION:
Selected Topics in Description, Assessment and Therapy

I. Sex Problems in Perspective
- A. Importance of Sex Life (Shaver and Freedman, 1976)
- B. Labeling Sexual Problems
  1. Frigidity and Impotence
  2. Medical Terminology
  3. Current Nosology
- C. Prevalence of Sexual Problems

II. Origins of Sex Problems
- A. Erectile Failure (Kinsey Data): Biogenic or Psychogenic?
- B. Organic Factors
  1. Neurological, Vascular, Hormonal, Genital disorders
  2. Side effects of medication, alcohol
- C. Psychological Factors
  1. Depression, Low Self-Esteem
  2. Unrealistic expectations
  3. Anxiety
- D. Interpersonal Factors
  1. Anger and hostility
  2. Fear of Intimacy
  3. Boredom
  4. Poor communication
  5. Incompatibility
- E. Cultural Factors
  1. Negative Attitudes, Myths
  2. Social Stereotypes and Double Standards
  3. Sexually restrictive family or religious background
- F. Blazer study of Married Virgins
- G. Sexual Myths

III. Models for Assessment and Organization
- A. The DAOE model of the Sexual Response Cycle (Montgomery)
  1. Desire - Arousal - Orgasm - Evaluation
  2. DAOE model for dysfunctional males
  3. DAOE model for dysfunctional females
- B. Kaplan's Taxonomy
  1. Biphasic Nature of Sexual Response
     a) vasocongestive genital response
     b) reflexive clonic contractions
  2. Matrix comparing males and females
- C. Barlow's 3 x 3 x 2 Assessment Model
  1. Arousal, Social Skill, Gender Role
  2. Self Report, Physiological, Behavioral
  3. Contrived, Natural situations

IV. Principles of Sex Therapy
- A. Master's and Johnson
- B. LoPiccolo
- C. Annon's PLISSIT model
  1. Permission
  2. Limited Information
  3. Specific Suggestions
  4. Intensive Treatment
- D. Other Treatment Approaches
- E. Treatment of Specific Disorders
  1. Erectile Dysfunction
     a) Master's and Johnson
     b) Systematic Desensitization
     c) Inflatable Penile Prosthesis
  2. Orgasmic Dysfunction
- F. Sex Therapy Success Rates

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