

NOTE THE FOLLOWING SCHEDULE:

9:00 am --12:00 noon, Thursday, Aug. 17, Question 1 -- Clinical Case  
1:00 pm -- 4:00 pm, Thursday, Aug. 17, Question 2 -- DSM-IV  
8:45 am -- 10:45 am, Friday, Aug. 18, Question 3 -- Psychopathology  
11:00am -- 1:00 pm, Friday, Aug. 18, Question 4 -- Psychotherapy, Part I  
2:00 pm-- 4:00 pm, Friday, Aug. 18, Question 5 -- Psychotherapy, Part II

**GRADUATE SCHOOL OF APPLIED AND PROFESSIONAL PSYCHOLOGY**

**ADVANCED COMPREHENSIVE EXAMINATION**

**August 17 and 18, 2005**

**CLINICAL COMPREHENSIVE EXAM**

ON EACH BLUE BOOK OR ON THE TOP OF EACH PRINTED SHEET FOR EACH QUESTION  
WRITE:

- (1) THE FOUR DIGITS OF YOUR STUDENT NUMBER AS LISTED ON THE BROWN ENVELOPE,
- (2) THE QUESTION NUMBER,
- (3) THE DATE, AND
- (4) "CLINICAL EXAM."

Do **not** write your name on the blue book or printed sheet.

**GOOD LUCK!**

## 2006 Clinical Psychology Comprehensive Exam

### Question 1: Clinical Case

**Required of each student. Write no more than twenty-four single-sided pages on this question. Computer generated -- no more than seven sheets (10-point), double-spaced, single-sided of paper.**

**Read the accompanying case report carefully, and then answer the following questions in appropriate detail. Be specific; avoid vague generalizations. Any additional points you wish to make that fall outside the questions as outlined are most welcome. On the front cover of your blue book indicate clearly whether you are taking essentially a cognitive behavioral, psychoanalytic, or systems approach to the case so that an appropriate grader can be assigned.**

1. On the basis of the information given, provide the best tentative diagnosis available among the categories in DSM-IV (with numbers if you know them), and give the evidence for the suitability of your diagnostic formulation. If you question the applicability of a DSM-IV diagnosis for this case, please explain your reasons, and present the alternative you would prefer. (you should first, however, state what you think is the most appropriate DSM-IV diagnosis.)
2. Give the "differential diagnosis"; that is, mention any other possible diagnosis or assessment formulations that might, with additional assessment, interviewing or third party information, prove to be more accurate than your current best information. What specifically would constitute evidence for revising your preferred diagnosis in the direction of possible alternatives?
3. What other information would you require if you were assigned to work with this client, and why? If this necessitates psychological testing, please explain your choice of tests, what you hope to learn and how this information would be used.
4. Provide a case formulation within your chosen theoretical approach. **Spend more of your time on this part than on the others.**
5. What would constitute reasonable goals for treatment with this client? Give your rationale for the goals you mention, including limiting factors and other relevant considerations.
6. How would you work with the person? Be as specific as possible with respect to types of interventions, frequency of sessions, expected parameters of treatment, etc.
7. What issues of age, gender, race, ethnicity, religious orientation, sexual orientation, educational disparity, or socioeconomic differences (if any) would you need to be sensitive to if you were to work with this person?
8. Given optimal treatment, what prognosis would you expect, and why?  
The patient is a 26-year-old woman of mixed ethnic background (Jewish father and Japanese mother), trained as a nurse but currently staying home to care for her two children, a daughter 3 years old and an infant son of three months. She was referred by her family physician.

### Presenting problems

The major symptoms began in the last month of her first pregnancy and consist of acute attacks of free-floating anxiety accompanied by palpitations, sweating, a sense of dread and terror, and at times a fear of dying. For two weeks after the delivery of the child, she had people helping her and was free of the symptoms, but as soon as she was alone again, there was a recurrence of the intermittent acute anxiety and panic attacks which have persisted to the present time. She also has a variety of specific fears, particularly involving being alone; she frequently has the fear that someone will break into the apartment. These symptoms are particularly acute when her husband, a physician now in his residency in internal medicine, is working at night. She fears various illnesses and becomes panicky at seeing or reading about any type of illness. She has fears of imminent death, although she has come to recognize that these are irrational. At times she has fears that she will not be able to breathe, and on one or two occasions insisted that her husband come home to reassure her on this score. She has had difficulty in falling asleep at night, and her sleep is broken at times by nightmares which are quite disturbing to her. She volunteered the most recent one:

A crazy man was loose and I was afraid he was going to break into the house. I was worried he would do something to my child. I went down into the basement and there I saw a toilet and I thought I saw my husband's arm in the toilet. I thought my husband was dead and was very upset. I ran back upstairs and told someone about it. They said to me that it was not my husband but it was "just worms," and I woke up.

The patient also complained of difficulties getting along with her daughter, and of feelings of anger and rejection toward the child. She also has episodes of moderately severe depression in which she feels that everything looks bleak and unhappy and she fears she will not be able to continue functioning. Nonetheless, she finds that she is always able to do so even though not feeling like it. She sometimes has the impulse just to go to bed but never does so, and she has reportedly taken good care of her children in spite of her symptoms.

She and her husband moved to this area one year ago when he began his residency. Shortly after getting settled here, she found herself increasingly reluctant to participate in sexual relations with her husband. Previously their sexual adjustment had been satisfying, and even currently she finds that once involved in sex, she is excited and eventually orgasmic. However, she finds that she is irritable and unhappy at her husband's initial approaches and would prefer not to participate, but she feels a tremendous sense of pressure to do so and a fear that her husband will no longer love her if she refuses.

### Personal history

The patient is the second of three daughters, her older sister being one year older and her younger sister four years younger. The father is a lawyer whom she describes as having been stern, rigid, strict, at times harsh and punitive, and emotionally somewhat unstable. As a young man he had begun a promising career in government and politics, but because of his emotional difficulties he had to resign and has since been in private law practice. The father had repeated extramarital affairs throughout the patient's life, which resulted in much marital unhappiness and discord, with many accusations by the mother, who brought all the children up "to hate my father as a bad and wicked person."

The mother is described as a more stable person but a cold and somewhat bitter woman, and the patient states that she and her mother always had considerable difficulty and tension between them until after her marriage, since which time their relationship has been more friendly. The patient says

that her mother had told her years ago that she was born at about the time the mother had made up her mind to leave the father, and that the patient's birth had prevented this and caused the mother to change her mind. There were many threats of divorce throughout the patient's childhood, and when she was sixteen, the family left their community and moved across the state because of one of the father's extramarital affairs. Since that time there has been another move, for the same reason, but the parents are staying together.

The patient describes herself as having been an anxious child with fears of being left alone, of death, and of suffocation. She remembers one occasion of having severe nightmares in which soldiers, tanks, guns, and trucks were all coming toward her in her room. After repeated crying and screaming, she was able to get her mother to come and lie down next to her, thereby relieving for the moment some of her anxiety. She had occasional enuresis until the sixth grade. She describes herself as "a tense child with many feelings of inferiority and uncertainty."

The patient had an average academic and extracurricular record in high school. Socially, she developed a pattern of intense relations with one boy at a time, followed by intense searching for a replacement when a relationship broke up. Beginning in her sophomore year of high school, she had intermittent episodes of driven overeating, to the point that she would quickly gain weight. She would gorge on junk food, at times eating to the point of physical discomfort. She denies vomiting. The binges gradually disappeared by the end of her sophomore year in college. After graduating with a nursing degree, she began working in a hospital where she met her husband, who was in his first year of medical school. They were married about a year later, though they actually saw each other fairly infrequently over this courtship year because of the demands of his training. In the few weeks prior to her marriage, she found herself increasingly anxious to the point that her physician prescribed mild tranquilizers, but she states that she had no hesitations or doubts about her husband as the proper person to marry. Her eating disturbance recurred in the few weeks prior to her marriage, resulting in a gain of 15 lbs.

She describes her marriage as having been a satisfying and satisfactory one, and states that sexually she was extremely responsive and involved, at times being concerned that she might be "more sexually active and interested than my husband." At the same time, during the first year or so of her marriage, she was extremely preoccupied with fears that her husband might be having extramarital affairs. He would often come home to find her in tears about this. In the last two or three years of marriage, these doubts and suspicions have subsided considerably. She feels that her marriage is stable and solid. She describes her husband as a supporting, kind, considerate, and reasonably warm person, and points out that they share a number of interests.

### Mental status

The patient is a tall, attractive young woman who talked freely and easily with considerable spontaneity and awareness, and who overall made a very favorable, appealing impression. She is intelligent and articulate, and seemed psychologically minded and highly motivated to work on reducing her suffering. She related warmly in the interview and seemed to make an alliance readily. There was no evidence of hallucination, delusion, ideas of reference, or thought disorder.

Because of the clinic waiting list, she was told that she would be contacted by a therapist within the next six weeks. While waiting, she became particularly depressed, reporting recurrent fantasies of slashing her wrists. Her anxieties and specific fears also intensified. She called on the phone several times, saying she felt alone and helpless in the face of her symptoms and asking that something be done to help her while waiting for treatment.