Adult Psychopathology

18:820:565
Fall, 2009

GRADUATE SCHOOL OF APPLIED & PROFESSIONAL PSYCHOLOGY

Co-Instructors: Jim Langenbucher & Jamie Walkup

Course Objectives

Adult Psychopathology introduces the student to the lawful aspects of mental functioning as these express themselves in various forms of mental abnormality, disorder, and distress. The student will acquire: (a) a practically-focused introduction to the use of the DSM-IV diagnostic system in the contemporary health care system; (b) a grasp of central concepts important in the description, classification, and treatment of psychopathology, including relevant aspects of the historical and cultural context of these concepts; (c) an introduction to substantive scientific theories accounting for most important categories of psychopathology; (d) an awareness of the wider human context of diagnosis, including both the individual client’s psychosocial setting and the larger social contextual factors, such as population dynamics, social structure, and the like. While treatment will be surveyed, and while theory will be discussed, the primary focus of Adult Psychopathology is descriptive, with an emphasis on psychopathology rather than intervention.

In the past, many GSAPP students have found this course to be one of the most demanding - often the most demanding - of their graduate career. The subject matter is wide-ranging and diverse. Many facts need to be learned. Your instructors will work very hard, and you are expected to work very hard as well. Nevertheless, student evaluations indicate most people who take the course enjoy it and believe they learn a lot. Certainly we enjoy teaching it, as will be apparent after a few sessions. However, even if adult psychopathology is not an area of particular interest to you, the information contained in this course provides an absolutely essential foundation for any practice of professional psychology. Clinical students will find the central position of psychopathology represented on the comprehensive exams, which are just around the corner, and on the state licensing exam, which, if you work hard, you will take in 5 to 7 years.

We need to adhere to a manageable structure, and to keep a pretty fast pace because there is simply so much material to cover, but we want to consider special interests of yours that were not anticipated in the course outline. When there is a group consensus and we can agree on the educational value of a proposal, we can try to customize the course to some extent.

Seven sources of teaching material are used. These include lectures, interactive group exercises and role-plays, readings, videotapes, web-based resources, field laboratories, and directed student class presentations and papers. The format for each disorder typically includes material on

- Epidemiologic patterns of the psychopathologies being discussed
- The etiology and clinical picture of the disorders
- Examples of the disorders taken from life
• A customized glossary of terms
• DSM-IV diagnostic criteria for the disorders and important additional experimental or historical criteria, where applicable, and
• Valid and reliable interviews, instruments, or clinical techniques used to assess the presence, severity and complications of the disorders.

Readings

Major Texts:


2. Maxman and Ward’s *Essential Psychopathology, 2nd edition* (Norton, 1995). Follows DSM IV pretty closely. It doesn’t add lots of new information that can’t be found in the DSM IV, but it’s very readable. Several students have told us that they were glad they read it along with the DSM.

3. *Oxford Textbook of Psychopathology*, edited by T. Millon, P. Slaney, and R. Davis (Oxford, 1999). This one covers the science base of psychopathology, and may be useful in research, but it’s pretty expensive. If you buy it, you may want to share.

In most cases, the lectures will not be based on readings from major texts. You should, however, try to keep up with the lectures by reading the DSM sections associated with a class session, and the appropriate sections in Maxman and Ward and Millon et al. If you find that any of the material is difficult for you, and you think your undergraduate preparation may have been inadequate, you should do two things. One is to let us know, early in the term. We are confident that everyone accepted to GSAPP is smart and capable of doing the work, but we also know perfectly well that some of you may be unused to the demanding pace of graduate work here, and/or may have undergraduate preparations in other areas. It is to your credit to recognize a problem and speak up. Keeping it to yourself is not wise. Second, you may want to supplement your course reading with a good textbook in abnormal psychology. We suggest: Wilson GT, Nathan PE, O’Leary K, & Clark LA. (1996). *Abnormal Psychology*. Boston: Allyn & Bacon. It may also be necessary to work individually to identify additional undergraduate level readings, though of course this does not relieve you of the responsibility to do all the assigned readings for the course.

Additional required materials will be provided to you:


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<td>JL</td>
<td>Student Presentation / Advanced Topics / Wrap-up</td>
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**Class Readings:**

Some readings will be required of everyone. Others will be required of individuals, but not the class as a whole. For any class taught by Jim Langenbucher, a sheet will be passed out the week before class and you will sign up to take responsibility to read an article (these are called “One-on-one Readings”) and master its content well enough to brief the other class members on it, if requested. Sometimes you will be asked to brief the class; other times you will not, depending on the pace of the material and the flow of the discussion. For a class taught by Jamie Walkup, there are sometimes primary readings assigned to everyone, plus individual readings. Neither of us typically bases our lectures primarily on required readings, but each reading has been carefully selected to provide you with important information on some aspect of the psychiatric categories being discussed that week.
Each class heading lists additional suggested supplementary readings. They are optional. Reading them may increase your enjoyment and mastery of the course. In addition, they represent a quick snapshot of readings one or both of us think may be important. Some are overview or review articles and merit sustained study. Others are important largely because they contain a noteworthy finding. They are provided as a good place to go when it’s time to investigate further one of the areas, and, in the past, students have found them useful when taking the general and clinical comprehensive exams toward the end of their studies at GSAPP. (A word to the wise: at GSAPP, we push you very quickly through the program and the comps will be upon you before you know it. Be smart, do at least some of the optional reading now so you don’t have to cram so much of it into your head the summer before the exams.)

Access to Readings: We know all of you are very busy and we have made an effort to provide easy access to readings, and to help you economize whenever possible. Copies of many required readings will be put on the course’s Sakai website and can be downloaded. In other cases, we have duplicates and will distribute them in class. In still others, readings are easily available on electronic journals held by the library, which can be accessed from your computer. (Although we provide you with optional background references to help you investigate disorders, when and if you have the interest, we do not provide copies of these.) Finally, you should be aware that the Library of Science and Medicine has current and bound periodicals on the 3rd floor, introductory classes to familiarize you with the details of their holdings and resources, and reference librarians who can direct you to specific materials if you are having trouble. (We want to help you get the readings, and we realize that many of you are just learning your way around Rutgers and GSAPP. But you should understand that we do not view it as unduly onerous that graduate students may occasionally have to go to the library and do some searching to find an article.)

We have only recently shifted to reliance on a Sakai website (a course support tool that resembles Blackboard, which you may have encountered as an undergraduate). We’re still learning how best to use it. Be patient.

Internet. The internet has lots of information on it and the syllabus includes a number of links. These include a variety of sites, ranging from videos of traditional grand rounds presentations to sites actively rejecting diagnostic classification. Putting up a link does not of course imply agreement with the content of what you find there. But even extreme opinions can be informative and provide a place to start.

Course content priorities. We deliberately give you far more information than you can reasonably be expected to learn in any depth. We do this so that, when you are getting ready for the comps, or you have a question about psychopathology in the future, you will have some idea where to look and, to the extent possible, have information readily available to help. In the past, some students have experienced frustration because they approached this class as they would an undergraduate course, where a high degree of mastery of the full course content could be considered an appropriate goal. For this course, you will work hard, but no matter how hard you work you can be sure there will be much left to learn when you are done.

We want to be certain that this abundance of information does not cause any confusion. To some extent, the work of sorting out what is and is not important is part of the learning experience and is not time wasted. However, to provide support, we offer some guidelines that may help you set priorities.

• You should keep in mind that the lecture represents our organization of essential material. It is the instructor’s guide to the topic. If confused, you should refer to any handouts
provided by the instructor that accompany a lecture or topic. They provide a good guide to what we believe are the main points made in the lecture.

- Another strategy is to bear in mind that the most important material is the material covered in both the lecture and assigned readings.
- Next most important is material in the lecture, but not covered in an assigned reading.
- Third most important is material from an assigned reading, but not in the lecture.
- Fourth most important is material in background readings, but not in the lecture or an assigned reading.
- Finally, if you’re feeling at sea, just ask one of us for help.

Requirements / Grading

Your final grade in the course is intended to reflect your grasp of the essential subject matter, the quality of your written work, and the level of skill and understanding reflected in your participation. Every effort will be made to provide explicit standards and continuous feedback.

Your final grade will be based on: participation in class (25%); two written assignments to be explained in class (10% each = 20%); exercises (15%); final project (40%).

Class Participation

We have designed the course to rely on interactive group exercises, so your active participation in class affects everyone's learning experience. Conducting diagnostic interviews and structured assessments, sometimes with difficult and even menacing patients, is not for the faint-hearted, and you need to be prepared to dive in to a group exercise at a moment's notice. If it helps, recall the spontaneity, curiosity and focus (though not the anxiety!) you needed to show during the group interviews that were part of your application to GSAPP, and strive to retrieve and emulate a portion of that intensity in the class exercises.

A crucial part of your participation is ongoing feedback on the pace, process and content of the course. We have acquired experience with our joint teaching approach to Adult Psychopathology, but we still consider it a "work-in-progress." Some new ideas work, others don't. Each year, we have learned about some things that didn’t work and we expect to do so again. You will find we are thick skinned, take constructive suggestions, and are concerned to monitor how well you are learning the material we present. Note however that the ultimate responsibility for learning is yours, and you need to let us know about any difficulties early, so that changes or extra help can be arranged.

By making class participation an important part of your grade, we mean to indicate to you the importance we place on it. We want expectations to be clear, however, so here is how we operationalize this admittedly vague concept.

Reading: While most classes are built around a lecture, adequate participation requires preparation prior to class and thoughtful attention during class. Lectures may not be closely tied to a particular reading, but classes drag on when nobody has done the reading; so make every effort to be prepared, particularly when you have responsibility for a reading.

Class Comments: If you present material, make every effort to speak plainly, avoiding technical jargon when it adds nothing, and try to focus on central points and themes. Excellent presentations exhibit an awareness of the difference between minor details and major points.
fine to try to explain points, and to make sure you are understood, but do not ‘filibuster’ or go on and on in a way that detracts from the class goals.

**Attendance:** A class session may involve a live interview, which cannot be adequately captured by class notes; so attendance is very important. While we understand that GSAPP students have busy schedules and many obligations, attending these interviews allows you to observe psychopathology first hand and is part of the work of the course.

**Atmosphere:** Almost by definition, a course in psychopathology touches on subject matter that is not easily discussed. An atmosphere of honesty, mutual support, and civility must be present. All class participation is expected to be consistent with this atmosphere.

**Field Laboratories:** As a member of the class you will participate in several field laboratories. These are often the most interesting and memorable elements of the course. Some guidelines to keep in mind include:

- The individuals who have agreed to be interviewed are opening their lives to us, during a time of suffering, so that we may inspect them and learn. Show respect. Do not talk to one another during the interview, and do not enter or leave an interview while it is in progress. Your conduct at sites must be courteous and businesslike.
- Each laboratory is designed so that the kinds of cases encountered under field conditions will have been the subject of prior readings and class discussion. It is therefore important that you complete the appropriate reading and review any relevant class notes or handouts prior to going into the field.
- The interviews you'll be observing will be conducted either by one of us or by one of the staff clinicians at the field site. You, however, should not feel confined to a passive role, and you should be prepared to yourself make any queries that the situation requires. We will, of course, enter the diagnostic situation with care and discretion - we are guests of the host site, and we are indebted to the patients being interviewed - but in the field setting you will be occupying a professional as well as training role, and you should expect to bear some of the responsibility for the success of the diagnostic workup. On the issue of asking questions of a patient, you will receive guidance from one of us on whether we think it is appropriate in a specific clinical situation.
- The sites hosting the laboratories are typically popular practicum or internship training sites for Rutgers students. Therefore, seize the opportunity that your visit affords to learn more about the site and to get a "feel" for it as a possible site for your future training. You may end up spending a year or two there.
- Finally, because you will be occupying a professional as well as training role when we go into the field, you will be expected to be professionally attired; men should wear jackets and ties, women the equivalent of this professional style.

**Papers**

(1) The first writing assignment is to write 2 reaction papers to first person accounts of major psychopathology. I (JW) prefer for you to write one for mood disorder and one for schizophrenia/psychotic disorders, but if for some reason you prefer to write both reaction papers on books concerned with one or the other category of disorder, they will be accepted. Approved examples appear in the syllabus. Some are better than others. If you’d rather use something else, propose it to JW for approval. Each should be 2-5 pages. You do not have
to follow the format slavishly, but students in the past have said they found helpful a rough
guideline regarding length. In the paper, you should:

- briefly describe the person who is the focus of the book (1-2 paragraphs);
- identify at least two descriptions of symptoms that were prominent. Provide any relevant
  information on context, duration, overlaps between symptoms, etc. (including page
  references for symptom descriptions) (2-4 paragraphs);
- comment either on the significance of the symptom(s) for the disorder or how it affected
  the person’s functioning (3-5 paragraphs); and
- give your reactions to the book (e.g., its interest and usefulness as a teaching tool; any
  thoughts about the author, his/her life, etc.; any elements that surprised you or differed
  from your expectations; any personal reflections on either the life described, or the book
  as a text) (variable length, depending on your choices).

- Provide two discussion questions you think would be engaging for the class. (All write
  ups must contain these two discussion questions.)

The second writing assignment (6-9 pages) is a psychological evaluation of a film character
who will be assigned to you. Good examples include, but are not limited to: Robert DeNiro
in *Taxi Driver*, Jessica Lange in *Blue Sky*, Jennifer Jason Leigh in *Georgia*, Ray Liotta in
*Goodfellas*, Michael Douglas in *Wall Street*, Jack Nicholson in *As Good as it Gets*. You are
responsible for accessing the film and viewing it. Write up the character as if you were in a
treatment setting and you were assigned the evaluation. Sometimes you will need to make up
aspects of his/her background and extra symptoms. You will follow a format supplied in
class, and JL will email you a copy of a successful effort from a prior year.

**Written Exercises**

From time to time, you will be given exercises to be completed, either handed out in class or
posted on the sakai site. Occasionally they provide an opportunity for thinking through major
concepts. Most are intended to give you practice using the *DSM-IV*, plus a few important
concepts. One purpose is to provide you and your instructors with information on any problems
you are having following the material, so remediation strategies can be developed. Because, as
we will discuss, specific DSM criteria are arbitrary in many respects, they cannot be learned
without practice. All that is needed for full credit is to turn the exercises in on time and to make
an honest effort.

**“Knowledge Hunt” and Final Project**

To be explained.

**Electronic Instruction**

As you will learn, psychopathology is an area bubbling with the excitement of new discoveries.
We will selectively utilize instructional technologies available through sakai. It is your
responsibility to check the site to keep up with any new developments. You are required to have
an email and to use the sakai site.

**Diversity Training and Course Content**

A professional psychologist needs to have a firm grasp of important facts related to
human diversity, as well as an appreciation of the language and concepts used when
psychologists discuss race, culture, ethnicity, gender, and sexual differences. While you will later have coursework specifically devoted to diversity issues, you should understand that they are relevant to a wide range of other courses as well, including this one.

We address diversity issues in four ways. First, as we survey a variety of psychiatric disorders in the bulk of the lecture sessions, differences between and among ethnic, racial, gender, sexual-preference and age-specific groups are discussed as they relate to the epidemiology, course, and outcome of disorders, as well as group differences in styles of clinical presentation and help-seeking.

Second, specific and customized lecture material is devoted to the DSM-IV approach to cultural differences, including a 'how-to' discussion of the preparation of a cultural formulation. Research findings and models are presented that focus on distinguishing between psychopathological vs. cultural contributions to material that might otherwise be framed as "symptomatic." An examination is offered of how DSM-IV has tried to tackle issues related to diversity, as well as ways in which participants in this process believe it may have fallen short of what is needed.

Third, we pay attention to instances when human differences based in ethnicity, race, gender, sexual-preference and/or age have been misconstrued as exemplars of psychopathology. (For example, an important role in the development of the modern diagnostic system was played by the debate in the 1970s about the status of homosexuality, and the development of a consensus against the view of it as pathological.)

Fourth, each year we try to arrange field visits to clinical setting which serve diverse populations. Diversity issues are often relevant to the live interview process (e.g., interpersonal interaction dynamics, style of clinical presentation and self-presentation). They may also be relevant to the clinical care being provided to the patient interviewed. These issues are integrated into the discussion as appropriate.

Contacting Us

Jamie Walkup: The best way to contact me is email: Walkup@rci.rutgers.edu. If you need to send a document to me at home, convert to an MSWord document and send to jaywalks@aol.com. If I am not in my GSAPP office (732/445-6120), you can try me at my research office on the College Ave campus (732/932-1171), where I can usually be found every day except Thursday. If you want to be sure to get a message to me, you should call my machine in New York (212/724-8362), which I check every day. (Do not leave a message for me on my machine at GSAPP, as I do not check it frequently enough to ensure that I will receive your message in a timely way.

Jim Langenbacher: My office is Room 309, Center of Alcohol Studies, Brinkley and Adelle Smithers Hall, Busch Campus. Office (732) 445-0908, home and cell (732) 672-9350. Never hesitate to call or just drop by, my office is open pretty much all day every day, from 8:00am to 5:30pm, and I’m rarely too busy to meet or just chat with a student. I can also be emailed at lngnbchr@rci.rutgers.edu.

Lastly .....  

If you’re feeling overwhelmed or intimidated, there is no shame in that, Adult Psychopathology is a demanding course, leading to an outcome (your doctorate in professional psychology) that is
worth a little worry. But you’ll find that we are much more interested in supporting the strengths we see in you than in pointing out the deficiencies that all mortal souls possess. Life’s short, and you should be enjoying all of it. The parts of it that stretch and challenge you, most of all.

So work hard, but never forget that there is a kernel of enjoyment and satisfaction that always attends the acquisition of new knowledge and skills. You’ll do fine. In this class, and in the graduate program that accepted you over a huge raft of other candidates. Really. You’ll do fine.

We just hope you enjoy taking *Adult Psychopathology* half as much as we enjoy teaching it. Welcome! Now … let’s get to work!
Class 1: Meet the Instructors, Course Overview, Introduction to Psychopathology
Tuesday (9/1), Friday (9/4)

Goals:

On Tuesday and on Friday, the first goal is to get acquainted and review housekeeping details of class.

We will consider some rationales for this class, then take a bird’s eye view of diagnosis as a practice that has arisen in response to various cultural and institutional needs. Historical context is provided to show how these needs have shaped our current understanding of diagnosis, to encourage you to think critically about it, and to be aware that, as professions pursue a scientific foundation for treatments, they (i.e., we) are also subject to numerous off-stage influences. And, finally, to the extent time permits, we will look at some basic epidemiological ideas. Most students have found that some knowledge of historical context proves useful in organizing answers to comps questions. Every year, some people find this material exciting and some people find it too theoretical and/or historical. If you’re in the latter camp, be patient. The rest of the class focuses more on the disorders themselves.

Major Readings:

Nesse R. (1991). What good is feeling bad? The evolutionary benefits of psychic pain. The Sciences, Nov/Dec, 30-37. Easy reading. A nice way to get your feet wet in evolutionary psychiatry. We will not discuss much in this session, but it should be read.


DSM IV, Browse Introduction.

Internet Assignment

The controversy over designation of homosexuality as a disorder has an antique quality today but it once played a role in the heated debate surrounding the creation of the 3rd edition of the Diagnostic and Statistical Manual, which is the historical locus on the contemporary approach to diagnosis. In an interesting pair of radio programs, journalist Alix Spiegel provides a fascinating glimpse of this period of transition, making use of her position as the granddaughter of John P. Spiegel, a gay man who was president elect of the American Psychiatric Association in 1973. While criticisms can be made of some of her characterizations of the politics of this controversy, it’s fun to listen to the broadcast. A written transcript is available on the website.

You can download from “This American Life,” but it costs 95 cents.

Supplementary


Hinshaw SP.  (2007).  The mark of shame: stigma of mental illness and an agenda for change.  Oxford.  A top ADHD researcher and clinical psychologist applies a rigorous and impassioned perspective to this important cultural topic.  His interest is based in part on his experiences growing up with a father who had bipolar illness.


Our brothers and sisters downstairs in cognitive science have discovered how much fun we are having. Doubtless green with envy, they have begun to work on some interesting conceptual issues concerned with classification.


Rosenhan, D.L. (1973). On being sane in insane places. Science, 179, 250-258. Must be read as a pair with Spitzer (1976), below. When one reads Rosenhan first, it has an air of plausibility, and an undoubted flare for the dramatic. It is only when one stops to think, and to track Spitzer’s trenchant criticisms, that it becomes clear there is less here than meets the eye.


Supplementary Internet Readings:

It is difficult to recapture the negative response elicited by the DSM III. More radical and psychosocially oriented figures opposed it. Here is a brief video of psychiatrist Ronald Laing criticizing it as an example of psychophobia.

http://video.google.com/videosearch?q=psychiatry+lecture&www_google_domain=www.google.com&hl=en&emb=1&oq=psychiatry+#q=laing&hl=en&emb=1

An alternative approach to classification can be found in the Psychodynamic Diagnostic Manual, which draws on modern psychological and neuroscience work but is rooted in psychoanalytic theoretical constructs. Our own Nancy McWilliams was an important contributor to this effort.


An overview discussion of theoretical issues related to nature of mental illness, focusing on philosophical perspectives and giving generous attention to Wakefield’s views. Stanford Encyclopedia of Philosophy:

http://plato.stanford.edu/entries/mental-illness/


http://www.surgeongeneral.gov/library/mentalhealth/chapter1/sec1.html
Online audio/video

Interview/discussion of the ‘mad pride’ identity-politics movement and its attitude toward diagnosis. “Madness Radio: Mad Science Mad Pride Bradley Lewis”. Interestingly, the interviewee is a psychiatrist himself: http://www.nyu.edu/gallatin/about/bios/bradley_lewis.html

In the interview they refer to the Icarus Project, and interesting website built around various types of self-affirmation and self-help approaches initiated and maintained by people diagnosed by psychiatry: http://theicarusproject.net/
Class 2: Anxiety Disorders
Friday (9/11), Tuesday (9/15)

Format
Lecture by JL

Goals
To introduce students to the broad class of anxiety disorders and to elements of the prodigious literature they've generated in psychological research. Etiologic theories with psychological roots, particularly social learning theory (SLT) approaches to anxiety, will be emphasized, though ethological constructs such as preparedness will also be covered.

Clinical Tools Studied
Social Readjustment Rating Scale (Holmes-Rahe Scale)
Symptom Checklist 90 (SCL-90)
PRISM Anxiety Disorders Modules

Required Reading
DSM-IV, Maxman & Ward, Anxiety Disorders sections

Glossary Reading
Study all entries coded 5

One-on-One Readings
Most of the readings are selected to canvass major theories on the etiology or ramification of anxiety disorders. Though seeking to explain the effects of clinical intervention rather than etiology, Bandura's theory offers important insights, and is one of the most important heuristics to surface in clinical psychology generally in the past quarter-century. Every psychology student should own a well-thumbed copy.


The next reading is a classic paper by a psychologist, Martin Seligman, who has provided several of the most important concepts in adult psychopathology, including the learned helplessness theory of depression. His preparedness theory is intuitive and striking in both its simplicity and its ability to account for phobic object choice.


The paper by Rosen and Schulkin in Psychological Review is very demanding, simply because its range is so great - from the cellular level to gross manifestations of anxiety in human behavior. It's certain to become a classic, though, so the student who selects this reading will come away very well informed.

The next paper is one of many cognitive explanations of the origin and elaboration of anxiety disorders. Now a bit dated, it is nonetheless attractive for its brevity and even-handedness.


To Deffenbacher et al add this more recent paper, by one of the most influential behavioral theorists of anxiety disorders. A very interesting aspect of Barlow’s piece is its tracing of an ostensibly fairly straightforward construct - generalized anxiety - through a number of different incarnations in DSM-III, DSM-III-R, DSM-IV, and new research directions suggested by the authors. The paper is therefore illustrative of how diagnostic constructs evolve through time, in reaction to, and hopefully in conformance to, new knowledge.


Next are a few papers on PTSD. The Keane et al (2006) paper is a nice recent review. The Geuze paper is an interesting examination by fMRI of the phenomenological finding that PTSD patients often display inattentiveness and memory complaints, showing in a small controlled study which brain structures are implicated. Foa’s examination of the core features of posttraumatic stress disorder (PTSD) is one of the most important papers in the literature. Which is most truly pathognomonic? Arousal? Numbing? Or intrusion? Follow that with Resnick’s important experiment examining the etiology PTSD in a community sample of female crime victims. An important innovation was the authors’ look at premorbid Axis I psychopathology and its effect on the later expression of PTSD. See also the Segman paper on PTSD and Parkinsonism. The two illnesses share some of the same phenomenology and may also share similar abnormalities of brain function.


Mannuzza’s study does an excellent job of delineating the boundaries between three disorders - Panic Disorder, Social Phobia, and Agoraphobia - that are sometimes confusing to differentiate. The study is particularly noteworthy for the richness of its data, for the multilevel validation scheme used, and for the sensitive, clinically-informed description of the phenomenology of these disorders. It’s also a good example of the quality of research conducted at New York State Psychiatric Institute. The Low et al paper presents interesting new large-n data on the specificity of etiologic factors, including genetic influences, in the origin of panic and social anxiety syndromes, and Sanders et al discusses the role of the hippocampus in fear
conditioning.


The next is an artfully done study with, among many other advantages, a test of the comparative validity of the safety-signal and cognitive models of panic vs. biological models of anxiety, on which it casts doubt. It is an important study in a field that has been quickly taken over by fairly reductionistic, somatic models that, while generating efficient treatment measures, fail to speak to the human experience of anxiety states, as this study and Mannuzza's does.


Written by one the most productive and talented researchers in this area, Leonard (1994) is an excellent review of nearly 90 studies of the chemical pathogenesis of anxiety with reference to specific mechanisms in the gamma-aminobutyric acid (GABA) system.


Finally, while the focus of the other assigned studies is on the differentiation and description of discrete diagnostic entities within the larger anxiety disorders category, Kitamura et al show some of the unifying pathological factors which underlie them. The study has several weaknesses, but the thesis that three dimensions - anxiety/somatic, depression/OC, and hysteria - describe the majority of cases of anxiety disorder is worth its review.


**Supplementary Sources**


Class 3: Substance Use Disorders

Friday (9/18), Tuesday (9/22)

Goals

To introduce students to one of the broadest and most frequently encountered classes of problems in clinical practice: substance use disorders. The "discovery of addiction" in historical terms will be discussed, and major current concepts including the division of addictive disorders into the categories of dependence and abuse, the Substance Dependence Syndrome, subtyping schemas, illness staging models, psychiatric comorbidities, and other issues will be surveyed. All nine major drug classes will be briefly reviewed, though stress will be laid on the five most frequently encountered: alcohol, cannabis, cocaine, nicotine, and the opiates.

Clinical Tools Studied

Addiction Severity Index
Alcohol Dependence Scale
PRISM, Substance Use Disorders Modules
Time-Line Followback

Required Reading

DSM-IV, Maxman & Ward, Substance Disorders sections and sections on Compulsive Sexuality and Pathological Gambling

Glossary Reading

Study all entries coded 3

One-on-One Readings

We will start with two of the most heuristic pieces to emerge in the large field of addiction studies. One of the true classics of the alcoholism literature, the first paper summarizing and extending Conger's important animal laboratory work on the "Tension Reduction Hypothesis" has stimulated four decades of research, and still forms the conceptual basis for most psychological theories of alcohol and drug abuse. Badly undervalued in terms of its effect on the field, it is also one of the few papers you're likely to encounter in which a dedicated animal experimenter openly defers to Freudian theories of the unconscious in his most important theoretical statements.


The next very brief, clinically-based piece has proven to be the single most influential description of alcoholism to emerge in the last two decades. Now serving as the conceptual core, not just for alcoholism or even other drug use disorders but for appetitive disorders generally, the Edwards and Gross model is found undergirding the substance use disorders sections of DSM-III-R, DSM-IV, ICD-9 and ICD-10. If you read nothing else on addiction in graduate school, read Edwards and Gross (1976).

Next, I’d like you to check out two pieces on the developmental trajectory experienced by substance users. First is a piece by Ferdinand et al (2001). This study is methodologically pretty powerful, recruiting a large sample of Dutch adolescents, measuring a variety of behavioral and personality constructs, and then following the sample for 8 years, correlating observations in adolescence with outcomes in young adulthood. There are very few papers on the transition from adolescence to adulthood that are as good as this one. Second is the Carlson et al paper, an interesting psychophysical study which shows the relationship between specific brain activity, externalizing processes, and an important way of differentiating SUDs as early- vs. late-onset.


In a unique contribution to the field, the cognitive psychologist, Steve Tiffany, applies the concept of the routinized cognitive action schema to addictive behavior, particularly cigarette smoking, showing that large segments of the smoker's behavior can be nicely accounted for by cognitive concepts. This is a powerfully heuristic piece that is certain to generate considerable research and theory building in the future. Then, check out the contribution by Blum et al (2000), on the “reward deficiency” model of appetitive behavior, especially substance use. Very different model from Tiffany, laying a premium on intentionality rather than automaticity. This last piece is, unfortunately, of ghastly length. Don’t knock yourself out, but the two papers do make an interesting contrast.


Next, while there are many subtyping schemes and comorbidity studies to choose from in addictions studies, I have tried to select for you two of the best. Developed by one of the most successful groups of addictions researchers in the country - the group at the University of Connecticut Health Sciences Center - Babor's "Type 1/2 model of alcoholism" is replicable and is fast becoming heavily researched. Kessler et al is an update of Helzer and Pryzbeck (1988), one of the most-cited studies of its kind. Like its predecessor it is robust, superbly conducted and controlled, presenting data from the National Comorbidity Survey, probably the most ambitious epidemiologic study of psychiatric illness in the community ever conducted.


Next, I'd like you to look at a recent study of the familial transmission of addictive disorders. The idea that alcoholism and drug addiction runs in families dates at least to the time of Aristotle, who remarked "Ebrii gignunt ebrios," ("Drunkards beget drunkards"), but it is unusual to see a study this well done, on this rich a database (the COGA study), and with a broad focus on several drugs of abuse. Enjoy.


Next, I'd like you to take a look at a very brief but broad-ranging review of theories of drug addiction, pulled together by one of the most widely respected neuroscientists in the field. George Koob is an intriguing fellow, just as likely to pop up full of questions at a symposium on family therapy as at a meeting in his own research area of molecular biology. This essay, published in the most hard-core of neuroscience journals, is also an interesting find. See what you think.


I'd like you to look at this polemical piece on why physicians – and, by extension, clinicians in general – distrust and dislike working with addicted patients. It’s directed at physicians and medical students, but it speaks to psychologists-in-training as well.


Next, I’d like you take a look at contributions by my own research group. In the first, one of my graduate students and I use a new quantitative technique, survival-hazard analysis, to study patterns of symptom onset in alcohol dependence. Langenbucher and Chung (1995) was the first study to use SHA in this manner, and has been widely copied. In the second, my group and I test a new model of alcohol dependence, the Withdrawal-Gate Model, and test it against the DSM-IV model, arguing, in effect, that alcohol dependence can be best diagnosed by the presence of a single symptom, withdrawal liability. In the third piece, we present another methodological demonstration, this time using a powerful quantitative method for studying symptom behavior – Item Response Theory (IRT) analysis – to study the structure of symptoms for alcohol, cannabis and cocaine use disorders in DSM-IV. This was the first such application of IRT to psychiatric symptoms, though why that would be so is a mystery, since IRT is so powerful and heuristic, as the study shows.


criteria in DSM-IV. *Journal of Abnormal Psychology, 113*(1), 72-80.

The piece by Manchikanti is a real find: An excellent and quite recent overview of one of the most important problems in addiction studies, namely the growing illicit use of prescription drugs, principally opiates and other analgesics. And the Forman piece shows how many of these drugs are acquired: Via the ‘net.


Finally, I’d like you to look at two pieces on a substance use issue that seems to come around at least as often as the Olympic Games, and that has been very much in the public eye since Ken Caminiti claimed that the majority of MLB players use anabolic steroids. The first, a review by a hematologist at the University of Minnesota, is by far the best single discussion of anabolics I have ever encountered. It is a quite complete introduction to a topic that is particularly esoteric. The second is a piece by my own research group. To understand the outlaw drug culture of gymrats and other “gearheads” (perhaps 6.75 million Americans, far more than the number who use opiates), not to mention the (probable) majority of both professional and high-level competitive amateur athletes who use these agents, you have to know what all the excitement is about. This is a good place to find out.


**Supplementary Sources**


Class 4: Mood Disorders I
Friday (9/25), Tuesday (9/29)

Format:
Lecture by JW

Refer to Glossary Items: section 2

Relevant Instruments:

Center for Epidemiological Studies – Depression Scale (You can take it yourself if you like at an industry run ‘screening’ site: http://intelihealth.com/IH/ihtIH/WSIHW000/8271/9025.html

Hamilton Rating Scale for Depression

Mood Chart

Required Major Readings:

DSM IV-TR section on mood disorders (pp. 345-428). Be familiar. At your option, supplement with Maxman and Ward, chapter 10 (pp. 206-243).

Nesse R. (2000). Is depression an adaptation? Archives of General Psychiatry, 57, 14-20. Examines the complexity of claims about the evolutionary function of depression. [Everyone should be sure to read this one.]

Additional Individual Articles


Baumeister R. (1990). Suicide as escape from self. Psychological Review, 97, 90-113. One of the few distinctly psychological approaches to suicide, this article focuses on processes, rather than diagnostic or symptomatic components


Gotlib I. (1992). Interpersonal and cognitive aspects of depression. *Current Directions in Psychological Science*, 1, 149-154. While not the most detailed account by Gotlib, this article is accurate, information, easy to read, and very short.


Smith D, Tracy J, Murray M (1993). Depression and category learning. *Journal of Experimental Psychology: General*. 122, 331-46. This article provides a much needed corrective to the traditional overemphasis on the content of cognition in depression, stressing instead how depression impacts cognitive processes. By doing so it moves the reader much closer to an adequate appreciation of ways the life world, and the person environment fit, are transformed in depression.


**First Person Readings**


Manning, M. (1994) *Undercurrents*. San Francisco: Harper. A psychologist whose severe depression prompted her treatment with electro-convulsive therapy (hence the pun in the title). Compared to other books, descriptions tend to be flat. Worth reading because she is “one of us” (yes, even nice people get depression). Also wins a Kevin Bacon small-world award because, at one point, her psychotherapist was Kay Jamison.

Sheed W. (1995). *In love with daylight*. NY: Simon & Schuster. Particularly interesting because Sheed describes a common comorbidity, the combination of depression with alcoholism and substance abuse. He also narrates how a childhood illness left him with a disability, again interesting because rates of depression are higher among people with a physical impairment. Very winning description of how foolish mental health professionals and 12-step champions can look to a patient. Out of print now, but worth searching the net or getting through the library.

Shields, B. (2005). *Down came the rain*. NY: Hyperion. Discussion of Ms. Shields post-partum depression heated up when actor Tom Cruise, echoing a line advocated by Scientology, loudly took issue with the whole notion of mental illness. Unless you like reading about the stars, this may seem thin.


**Supplementary**


Adler, D.Thomas J., McLaughlin,T., Rogers, WH et al. (2006). Job Performance Deficits Due to Depression *American Journal of Psychiatry* , 163, 1569-1576


Hofer M. Early symbiotic processes: hard evidence from a soft place. In R Glick, S Bone (eds.) Pleasure beyond the pleasure principle, pp. 55-78. New Haven CN: Yale U.P.


Grand Rounds:

Susan Nolen-Hoeksema, Ph.D., Professor, Yale Department of Psychology. *Lost in Thought: The Role of Rumination in Depression*
[http://media.med.yale.edu:8080/ramgen/psych/lectures/cmhc9_30_05.rm](http://media.med.yale.edu:8080/ramgen/psych/lectures/cmhc9_30_05.rm)

Ronald Duman, PhD, Elizabeth Mears & House Jameson Professor of Psychiatry and Pharmacology *"A Neurotrophic Hypothesis of Depression"*
[http://media.med.yale.edu:8080/ramgen/psych/lectures/cmhc9_26_03.rm](http://media.med.yale.edu:8080/ramgen/psych/lectures/cmhc9_26_03.rm)

Robert I. Simon, MD, Professor and Chairman of Psychiatry, director, Program in Psychiatry and Law, Georgetown University School of Medicine *Suicide Risk Assessment: Evidence Based Psychiatry.*
[http://media.med.yale.edu:8080/ramgen/psych/lectures/cmhc4_8_05.rm](http://media.med.yale.edu:8080/ramgen/psych/lectures/cmhc4_8_05.rm)

Jan Fawcett – University of New Mexico. *The prevention of recurrent depression with medication and CT study – interim findings.*

If you have difficulty with this link, go to the main site, at the university of New Mexico, scroll down to find the title of the talk, and click on link: [http://hsc.unm.edu/about/hscmedia/index.cfm?D=3](http://hsc.unm.edu/about/hscmedia/index.cfm?D=3)

Jan Fawcett – University of New Mexico. *“Combined medication and psychotherapy for mood disorder”* [audio]

If you have difficulty with this link, go to the main site, at the university of New Mexico, scroll down to find the title of the talk, and click on link: [http://hsc.unm.edu/about/hscmedia/index.cfm?D=3](http://hsc.unm.edu/about/hscmedia/index.cfm?D=3)

NIMH Talks. David Brent, M.D., University of Pittsburgh School of Medicine. *Suicide in Adolescents: Assessment and Treatment.*

NIMH Talks. Cheryl Boyce, Ph.D., NIMH, for Charlotte Brown, Ph.D., Western Psychiatric Institute/Clinic. Cultural Issues Related to Diagnosis and Treatment of Depression for Women.

Class 5: Mood Disorders (continued) 
Friday (10/2), Tuesday (10/6)

Reaction paper for mood disorder due. (Use sakai drop box.)

We will continue our discussion mood disorder finishing with bipolar disorder.

Format:
Lecture by JW

Major Readings: Sections of DSM and Maxman and Ward on bipolar.

Additional Individual Readings


Ghaemi SN, Rosenquist, KJ. (2004). Is Insight in Mania State-Dependent? A Meta-Analysis. J Nerv Ment Dis, 192, 771–775. As with many findings in psychology, the answer to this question may not seem surprising (once we know it), but scientific study gives us an appropriate grounding for faith in intuitions and prompts consideration of clinical implications.


Lim L, et al. (2004). A qualitative approach to identifying psychosocial issues faced by bipolar patients. Journal of Nervous and Mental Disease, 192, 810-817. This research provides an opportunity to hear from people with this illness about how it affects their lives.


**First Person**


Hinshaw SP (2002). *The years of silence are past: my father’s life with bipolar disorder*. Cambridge. Clinical psychologist Hinshaw describes his philosophy professor father’s struggle with mental illness, and its impact on his upbringing.


Vonnegut, M. (1975) *The Eden Express: A memoir of insanity*. Vonnegut the author viewed his illness as schizophrenia. Listing the book here is a concession to his later, considered judgment that it is bipolar illness. (He is now a trained physician, a pediatrician.) Whether you chose this book or not, you should read his wonderful short talk given to NAMI. [http://www.namimass.org/conv2003/mvspeaks.htm](http://www.namimass.org/conv2003/mvspeaks.htm)

**Supplementary**

American Psychiatric Association. (2002). Practice guideline for the treatment of patients with bipolar disorder,


Internet websites

Author of Electroboy interviews author of Manic.

http://bipolar.about.com/od/electroboy/a/andy_cheney.htm

Web page of Michael David Crawford, an individual who wants to educate the public about his illness: http://geometricvisions.com/Madness/

Internet audio/video

Story on Jane Pauley and her experience of mania.

http://www.msnbc.msn.com/id/5887567/

Short videos of individuals with bipolar illness, from the BBC.

http://www.bbc.co.uk/health/tv_and_radio/secretlife_bipolarstories.shtml

Radio interview, Talk of the Nation, on NPR, with David Lovelace regarding his own bipolar illness, and that of all but one members of his immediate family. His book is: Scattershot: A Memoir of my Bipolar Family. (Listen to his interesting description of how his father could pull himself together in front of others even when acutely ill.) Terri Cheny also discusses her illness, and her book (above).

http://www.npr.org/templates/player/mediaPlayer.html?action=1&t=1&islist=false&id=94282263&m=94282249


Grand Rounds, available online

Michael J. Gitlin, M.D. Director, Mood Disorders Clinic and Division of Adult Psychiatry. Professor, David Geffen School of Medicine at UCLA Semel Institute for Neuroscience and Human Behavior. *The Difficult Lives of Bipolar Patients:*
Contributors to functional outcome and implications for treatment
http://mentalhealth.ucla.edu/cgi-bin/av-npi-rs8?gr080916mg

Gary Sachs, MD. Associate Professor of Psychiatry, Harvard Medical School Director, Bipolar Clinic and Research Program Massachusetts General Hospital, Boston.
Lessons in Bipolar Disorder From STEP-BD.
http://mentalhealth.ucla.edu/cgi-bin/av-npi-rs8?gr070306gs

Maria Oquendo, MD, Clinical Professor of Psychiatry, Columbia University.
Distinguishing Characteristics of Bipolar Patients Who Make Suicide Attempts
http://media.med.yale.edu:8080/ramgen/psych/faceofsuicide/Oquendo.rm

Norman Sussman, MD, Professor Psychiatry, Association Dean for Postgraduate
Psychiatric Comorbidities Associated with Bipolar Disorder
http://video.biocom.arizona.edu/video/videolibrary/psychgr/

Stephen M. Strakowski, MD, Professor of Psychiatry
Assessing Antipsychotic Therapy in Bipolar Disorder
http://accordent.biocom.arizona.edu/2007/02/14/PsychGR2007_02_14/msh.htm

Donald Hilty, MD, UC, Davis
The pathophysiology, diagnosis and treatment of bipolar disorder
http://www.youtube.com/watch?v=3PURi75GaxA
Class 6: Eating disorder, body image disorders, and disorders of appetite dyscontrol
Tuesday (10/7), Friday (10/9),

Format

Lecture by JL

Goals

This meeting will focus on a mixed array of disorders of appetite dyscontrol, including eating disorders, pathological gambling and compulsive sexual behavior. Eating disorders will be emphasized, including the role in them of body image distortion. Obesity, anorexia and bulimia nervosa will all be introduced, but stress will be laid on anorexia. Readings will canvass etiologic models including psychodynamic, family systems and biological mechanisms, but cognitive-behavioral models have proven most robust and will be featured.

Clinical Tools Studied

*Eating Disorder Inventory*
*South Oaks Gambling Screen*

Required Reading

*DSM-IV, Maxman & Ward*, Eating Disorders sections and sections on Body Dysmorphia, Compulsive Sexuality and Pathological Gambling

Glossary Reading

Study all entries coded 7

One-on-one Readings

As usual, I want to start with a basic understanding of epidemiology, first of eating disorders. A number of good studies are available, some sampling many diagnostic categories, and drawing patients from national and even international cohorts. Lucas et al (1991), however, and a new piece by Lewinsohn and colleagues (2000) are the ones I've chosen. Lucas is a very nice example of using a single community as a "natural laboratory," a strategy that is one of the most elegant and persuasive study types in epidemiologic research. It's also pretty brief, and it appears in a journal that is approachable by nonspecialists. Lewinsohn describes ED in a community sample of adolescent girls, looks at subthreshold as well as robust cases, and relates adolescent pathology to adult adjustment. Definitely worth a read.


Next, Bastiani et al have this study into the long-observed relationship between eating disorders and perfectionism. It was carried out at the University of Pittsburgh School of Medicine, one of the strongest research centers in eating disorders. This study has the advantage of studying perfectionism in eating disordered patients both when underweight and after weight restoration. This permits you to observe how abiding is this personality construct. Cororve and Gleaves (2001) is a much more general review of a broader issue than just perfectionism – a multiplicity of constructs that inform our understanding of body dysmorphia – that is worth a peek.


In a two-part study by a group at Sweden's University of Goteborg, the authors contrasted a fairly large sample of anorexics with matched community controls, and checked for the stability of diagnosis, psychiatric comorbidity, and post-treatment course. In their study, Stice et al (1998) use an advanced statistical technique we will look at again in Classroom 10 - survival/hazard analysis - to explore when exactly in the lifecourse patterns of bingeing and purging begin to emerge. Still another nice contribution is the paper by Heatherton et al (1997), which follows a fairly large cohort of young adults across a 10-year time frame, looking for changes in eating and dieting behavior and body satisfaction as their post-college years unfold. The study is quite strong methodologically, showing in essence the "natural history" of eating disorders after subjects have exited from the sturm and drang of adolescence.


The next paper is, like the ones immediately above, a longitudinal analysis, but this time of bulimia, rather than anorexia. The authors follow a fairly large sample of bulimics over a 10 years period, and examine both eating pathology and the associated psychopathology (distress and disinhibition) that may prolong and exacerbate bulimic behaviors. See what you think.


The next study, appearing in the premier journal in clinical psychology, investigated the interesting hypothesis that some eating disorders are caused by a desire to attract and please male sexual partners, who overly emphasize thinness and physical attractiveness in the selection of mates. To address this question, the author was inspired to contrast gay men and heterosexual women, vs. heterosexual men and lesbians, an
interesting and creative twist. You’ll be intrigued by the results. Take a look at the Westen article, which is an interesting study of the perceived characteristics of eating disordered patients, as filtered through the lens of expert practitioners. Reas and Grilo write about the temporal sequence of overweight, dieting and binging behavior, and Kittler et al discuss weight concerns in body Dysmorphic disorder. Scott et al present a meta-analysis of the relationship between obesity and mental health problems, an interesting take on an otherwise purely social/medical phenomenon. And Wood et al (1996) present a small study on body image dissatisfaction in young children.


Finally, after doing all that reading on anorexia, take a look at this piece on morbid obesity. One of its authors, Terry Wilson, is well-known for his synthesizing scholarship, and it is much in evidence here.


Next are three pieces on pathological gambling. The first two are descriptive and theoretical. Sharpe and Tarrier (1993) is brief, critical, and tightly drawn. Walters (1994) is long, but he has to integrate fairly diverse literatures from learning theory, cognitive interactionalism, and existential philosophy in order to develop his model of the "gambling lifestyle." This makes it a good deal richer than most other review papers, including Sharpe and Tarrier (1993), so you may prefer it. The McIntyre piece looks at the relationship between PG and bipolarity, presenting both fresh data and a nice review of prior work.


Next are two contrasting pieces on the structural integrity of compulsive sexual behaviors. Comparing and contrasting four different etiologic models, Travin (1995) is current, fairly critical, and well-balanced. Black et al (1997), however, provide the unvarnished argument that compulsive sexual behavior is in essence a "wastebasket category," describing a collection of patients too diverse for the category itself to have much utility. If you have time, compare the two and see what you think.


**Supplementary Sources**


Class 7: Schizophrenia and psychosis
Friday (10/16), Tuesday (10/20)

Reaction paper for schizophrenia/psychosis due. (Put in sakai drop box.)

Format:
Lecture by J.W.

Refer to Glossary items: section 6

Relevant Instruments:

Scale for the Assessment of Negative Symptoms

Scale for the Assessment of Positive Symptoms

Major Readings:


Dohrenwend, et al. (1992). Socioeconomic status and psychiatric illness: The causation-selection issue. Science, 255: 946-952. This is one of the finest, and most well-known, papers in psychiatric epidemiology. It requires some study, since some people find the logic of its design to be counter-intuitive. Almost all graduate students find it tough going, but hang in there with it. [NOTE: Everyone should read this one for class.]

Additional Individual Readings:


Hoffman RE, et al. (2008). Experiential features used by patients with schizophrenia to differentiate ‘voices’ from ordinary verbal thought. Psychological Medicine, 38, 1167-76.


**First Person Accounts:**

Chadwick P. (1997). Schizophrenia: The positive perspective. London: Routledge. Written by a British psychologist who suffers from schizophrenia. Much of the book presents scientific evidence regarding the disorder and argues that there are some advantages provided by the abnormalities involved. Nevertheless, there are sections on his personal experience that are very interesting. Dr. Chadwick appears as a panelist in session run by Dr Raj Persaud, which can be accessed through Spoken Word Services. (You have register but it’s free. Just search on his name: [http://www.spokenword.ac.uk/](http://www.spokenword.ac.uk/)).


Neugeboren, Jay. (1997). Imagining Robert: My Brother, Madness and Survival: A Memoir. Rutgers University Press. Written by the brother of someone who has struggled for many years with his illness. (There’s also a film but it can’t be accessed online. Here’s the link: [http://www.florentinefilms.org/imagrob/index.htm](http://www.florentinefilms.org/imagrob/index.htm)).

North, C. (19 ). Welcome, Silence. A psychiatrist now on the faculty of Washington University Medical School describes how she began to develop psychotic symptoms in high school, which she never revealed to her psychotherapist because he ‘didn’t ask’. She becomes gravely ill, is diagnosed with schizophrenia, and has to struggle to complete medical school. She attributes her recovery to an unorthodox procedure, not supported by the scientific evidence.
Saks, E. (2007). *The Center Cannot Hold*. Law professor and trained psychoanalyst describes her own history of psychosis and her long struggle to recover. You can learn more about her on her personal webpage. [http://mylaw.usc.edu/blog/index.cfm](http://mylaw.usc.edu/blog/index.cfm)


**Supplementary.**


Sheehan S. 1983. *Is there no place on earth for me?* Vintage.


Susser E. Life course cohort studies of schizophrenia. *Psychiatric Annals, 29*, 161-165.


**Video/audio from the Internet:**

Be aware some videos have commercial sponsorship, and some youtube postings reflect attitudes and beliefs of the posters.

**Illness Education and Recovery:** Ted Thomas discusses learning about, and dealing with, his mental illness, and makes the case for illness self-education in recovery.  
[http://www.youtube.com/watch?v=VpUW0udGkFs&feature=PlayList&p=9EF4DEFE774B4B42&index=8](http://www.youtube.com/watch?v=VpUW0udGkFs&feature=PlayList&p=9EF4DEFE774B4B42&index=8)

*From the AnswersTV series. Each cuts back and forth between TV host, sound bites by experts, and comments by patients.*

**What does schizophrenia do?** Reviews basic information on neurotransmitters, discusses genetic, prenatal and environmental facts.  
[http://www.youtube.com/watch?v=fs1qVBW9HzA](http://www.youtube.com/watch?v=fs1qVBW9HzA)

**Do I have schizophrenia?** Gives good basic information on the illness and how it is diagnosed.  
[http://www.youtube.com/watch?v=-_kl_5xaBfY&feature=channel](http://www.youtube.com/watch?v=-_kl_5xaBfY&feature=channel)

**Schizophrenia Treatment: Drugs.** Gives basic information on how and why medicines are used, describes the major medications, and gives simple descriptions of the mechanisms of action. Informative and generally accurate, but reflects the love affair with atypical antipsychotics of a few years back – one which has now cooled.  
[http://www.youtube.com/watch?v=iG1fcE1HK-c&feature=channel](http://www.youtube.com/watch?v=iG1fcE1HK-c&feature=channel)

**Schizophrenia Treatment: Rehab therapy.** Gives very brief description of multiple psychosocial programs, phrased in plain language. Information is elementary and best suited to those with little familiarity with the topic area.  
[http://www.youtube.com/watch?v=L5LS99OLFkU&feature=related](http://www.youtube.com/watch?v=L5LS99OLFkU&feature=related)
Healthy Minds Video aired on WLIW. Nice discussion by authors of DIVIDED MINDS. 
http://www.narsad.org/?q=node/11143/multimedia#

Adapting to mental illness: After Psychosis. People living with major mental illness briefly describe how they came to terms with their illnesses. While not downplaying the difficulties, they discuss what they have found helpful and emphasize how it is possible to come through the early stormy periods and achieve greater stability and fulfillment. The perspectives articulated seem thoughtful, measured, and reflective of hard won self-knowledge and self-acceptance. Nice guitar music. From the Vancouver Island Health Authority.

After Psychosis – Part 1. 
http://www.youtube.com/watch?v=CtcK_Wx4snc&NR=1


Schizophrenia: Heather. A videotape of what seems to be an interview with a young woman whose speech seems to reflect thought disorder, followed by a comment on her care from her mother, then scenes of mother struggling with her quite disturbed daughter, trying to convince her she needs to go back to the hospital. Focus particularly on the mother’s pained dilemma and how, in the life of this family, the mundane, everyday considerations of returning to the hospital (e.g. getting soap) combine with the emotionally consequential interactions.  http://www.youtube.com/watch?v=kvdw4b7tC-8&feature=related

For Family and Friends – Part 1. Video shows family members discussing psychotic illness of family member, stressing how difficult it can be to distinguish between storms of early adulthood and psychosis. For this section on hospital care, listen particularly to the woman who discusses bringing in son for assessment, leading to hospitalization (2:24-4:07) 
http://www.youtube.com/watch?v=gbjXoiaOgSQ&feature=PlayList&p=9EF4DEFE774B4B42&index=9

For Family and Friends – part 2. Continues presentation of family perspectives. 
http://www.youtube.com/watch?v=SGSr7VXsHKU&feature=channel

Educational video on schizophrenia with William McFarland, M.D. 
http://video.google.com/videoplay?docid=9040899243742534082

Schizophrenia and Recovery. Columbia University psychiatrist Robert Gil discusses economist John Nash, as well as schizophrenia more generally, in this short video.  
http://www.schizophrenia.com/video/videofam.htm

Schizophrenia and Art. Interview with our own Louis Sass.
American Experience show, A Brilliant Madness that discusses life and career of Nobel Prize winner John Nash. Webpage with background information for the TV show. Various clips from show can be seen on youtube (including interview material from Sass commenting on schizophrenia).

Grand Rounds related to Schizophrenia:

The Center Cannot Hold: My Journey Through Madness
Elyn R. Saks, JD
Associate Dean and Orrin B. Evans Professor of Law, Psychology, and Psychiatry and the Behavioral Sciences
USC Gould School of Law University of Southern California, Los Angeles
http://mentalhealth.ucla.edu/cgi-bin/av-npi-rs8?gr080129es

Evidence-Based Practices for Schizophrenia
Anthony F. Lehman, MD MSPH
Professor and Chairman, Department of Psychiatry
University of Maryland Medical Center, Baltimore
http://mentalhealth.ucla.edu/cgi-bin/av-npi-rs8?gr070130al

Cognitive and Vocational Rehabilitation for People with Schizophrenia
Morris Bell, Ph.D.
Yale, Dept of Psychiatry
http://media.med.yale.edu:8080/ramgen/psych/lectures/cmhc4_25_07.rm

“Listening to Voices”: Pathophysiology and treatment
Judith Ford, Ph.D. and Ralph Hoffman, M.D.
Department of Psychiatry
Yale University
http://media.med.yale.edu:8080/ramgen/psych/lectures/cmhc5_26_06.rm

Declarative Memory in Schizophrenia
Carol Tamminga, M.D.
Professor and Chair
Communities Foundation of Texas
Dept Psychiatry
UT Southwestern Medical Center
Dallas Texas
http://media.med.yale.edu:8080/ramgen/psych/lectures/cmhc10_21_05.rm

*Antipsychotics and Cognition: A translational neurophysiological approach.*  
John Sweeney, Ph.D.  
Professor of Psychology  
University of Illinois at Chicago  
http://media.med.yale.edu:8080/ramgen/psych/lectures/cmhc10_14_05.rm

**Internet News/discussions**

Discussion of inclusion of ‘psychosis risk’ in DSM V.  
PSYCHIATRIC NEWS story:  
http://pn.psychiatryonline.org/cgi/content/full/psychnews;44/16/5  
Schizophrenia Research Forum: Discussion of schizophrenia prodrome in DSM V:  

Related studies regarding early detection.  
NPR study on Lancet study of MRI study.  

Discussion of U.S. Supreme Court case regarding legal self-representation by a person with schizophrenia. Should the judgment that a person is competent to stand trial imply she or he is competent to represent him/herself. Includes interview with psychologist with schizophrenia, Frederick Frese, Ph.D.  
Further coverage regarding case outcome.  
Class 8: Inpatient Field Visit
Tuesday (10/21), Friday (10/24)
Class 9: Substance Use Disorders Field Visit
Friday (10/30), Tuesday (11/3)
Class 11: Delirium, dementia and cognitive disorders
Friday (11/13), Tuesday (11/17)

Format
Lecture by JL

Goals
To introduce students to the major categories of organic disorders, particularly dementias and amnestic disorders. A broad array of etiologic models will be considered, including neurotoxicity, vascular disorders, endocrinologic abnormalities and normal aging, but emphasis is on the dementias of the Alzheimer's type. The development of screening, assessment and triaging skills will be emphasized, and we will practice the administration of several of the more widely used measures.

Clinical Tools Studied
Mini-Mental Status Examination
Wechsler Memory Scales
Boston Naming Test

Required Reading
DSM-IV, Maxman & Ward, Cognitive Disorders sections

Glossary Reading
Study all entries coded 8

One-on-One Readings
I would like everyone to start with a very brief but useful study of Folstein's "Mini-Mental." Different versions of this generic screening device are available, but this is one of the best, and more broadly used, ones, and includes empirical studies of the exam's performance characteristics. Of one thing you can be certain: You will use the Mini-Mental a lot in your advanced training, and probably in later professional roles you'll occupy.


Next, there is this fairly brief piece by Selkoe (1992) on the etiology and pathophysiology of the dementias. This is a piece written for nonspecialists, yet it does a very nice job of reviewing a fairly voluminous literature and developing an accurate cross-section of this important class of organic disorders. More detail on the history as well as the etiology, description, and nosology of cognitive disorders is offered in the much longer review by Morris (2000). It’s recommended to those with a real appetite for this area of study.


Next is a series of papers based on “The Nun Study,” a longitudinal study of aging and cognitive disease being carried out among nearly 700 Sisters of Notre Dame religious congregations in the United States by David Snowdon and his colleagues at the University of Kentucky. The study will be discussed in some detail in class. Snowdon, the director of the study, presents a nice overview of study design and methods with a focus on the distinction between healthy aging and dementia. Riley et al (2005) present one of the study’s most robust findings, namely the strong association between linguistic ability, even in early life, and later cognitive decline. Riley et al (2002) and Grossi both look at the prognostic significance of neurofibrillary structures in Alzheimer’s Disease.


Finally, I have assigned three very interesting papers that will make you think about some things you’re not used to thinking about. The first is a paper examining the ethical and clinical issues of disclosing to a demented patient that they are, in fact, demented. Seems that practitioners are pretty unsettled by that prospect, and this very brief paper by Pinner (2000) will help you think this crucial matter through. The second is a paper by Trapper and Backfield (2001) on the survival and evolution of Axis II symptoms into older life. No, personality disorders are not the exclusive province of the young. The last is an interesting study of the kinds of problems faced by caregiving family members burdened with the care of a demented individual. I’d like you to read this piece by the principal student of this issue, Rachel Pruchno. In your practice you will most likely come in contact with family members, as well as organic patients themselves, and it will profit you if you are able to bear in mind the special cares and stresses that they experience.


**Supplementary Sources**


Class 12: Field Visit to Dementia Unit, COPSA
Friday (11/20), Tuesday (11/24)

****Note: NO CLASS 11/27****
Class 13: Personality Disorders I
Tuesday (12/1), or Friday (12/4)
Lecture by JW

Refer to Glossary Items: section 4

Major Reading


Additional Individual Readings


**First Person:**

Compared to a mood disorder, or schizophrenia, a personality disorder is trickier to write about in the autobiographical mode. Even more problematic is the strategy of reading a memoir of someone who writes about someone they know who seems to have an Axis II disorder. That said, I found this recent book very interesting and wonder how you might react.


**Supplementary**


Blair RJR (2005) Applying a cognitive neuroscience perspective to the disorder of psychopathy. Development and Psychopathology, 17, 865-91


Kernberg O. (1984). Severe Personality Disorders. New Haven, CN: Yale UP. Chapters one and two provide the most readable overview ever written by Dr. K. Does a very good job of integrating psychiatric and psychoanalytic perspectives. JW requires it in his interviewing class.


Kramer P. (1993). Listening to Prozac. NY: Viking. Say what you will about its popularity, this now famous book gives an excellent review of the subtleties involved in the relations among temperament, adverse events, personality, and disorder, although some findings and now dated.


**Internet materials:**

Ted Millon’s website on personality and psychopathology. [http://www.millon.net/](http://www.millon.net/)


Emily Yoffe’s column in SLATE from last March, asking why everyone seems to have Narcissistic Personality Disorder. Be wary of efforts to use psychiatric and psychological categories in public discourse, but can be entertaining and this includes a piece of tape from her appearance on Colbert. [http://www.slate.com/id/2213740/](http://www.slate.com/id/2213740/)

Webpage for Kenneth Levy, Ph.D. Active researcher regarding role of emotion regulation in Axis II and controlled trials of psychodynamic psychotherapy. [http://psych.la.psu.edu/directory/faculty-bios/levy.html](http://psych.la.psu.edu/directory/faculty-bios/levy.html)

Webpage for Marsha Linehan, developer of dialectical behavior therapy and prominent researcher on its use. Has jazzy tunes in the background when you go to site; so enable volume if you want to listen. [http://faculty.washington.edu/linehan/](http://faculty.washington.edu/linehan/)


John Clarkin: [http://www.mentalhelp.net/poc/view_index.php?id=119&w=9&e=28704&d=1](http://www.mentalhelp.net/poc/view_index.php?id=119&w=9&e=28704&d=1)

Brief interview with Marsha Linehan. [http://www.mentalhelp.net/poc/view_index.php?id=119&d=1&w=9&e=28746](http://www.mentalhelp.net/poc/view_index.php?id=119&d=1&w=9&e=28746)
Class 14: Personality Disorders II, Culture & Psychopathology
Tuesday Tuesday (12/8) or Friday (12/11)

Be prepared to discuss reading distributed in class last week, if there’s time.

Major Readings regarding cultural and clinical issues. Everyone should read one or the other of these two readings.


Additional Individual Readings


Diala C. et al. (2000). Racial differences in attitudes toward professional mental health care and in the use of services American Journal of Orthopsychiatry, 70, 455-464


Harris K., et al. (2005). Racial and Ethnic Differences in the Mental Health Problems and Use of Mental Health Care. Medical Care, 43, 775-84.


Supplementary


Lowenthal, K., Cinnirella M. (1999). Beliefs about the efficacy of religious, medical, and psychotherapeutic interventions for depression and schizophrenia among women from different cultural-religious groups in Britain. Transcultural Psychiatry, 36, 491-504.

Nickerson K, et al. (1994). Cultural mistrust, opinions about mental illness, and Black students’ attitudes toward
Class 15: Student Presentation, Advanced Topics, Class Wrap Up
Tuesday (12/15) and Friday (12/18)