Introduction to Clinical Psychology

GCE 206

University of Ibadan Distance Learning Centre
Open and Distance Learning Course Series Development

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Vice-Chancellor's Message

The Distance Learning Centre is building on a solid tradition of over two decades of service in the provision of External Studies Programme and now Distance Learning Education in Nigeria and beyond. The Distance Learning mode to which we are committed is providing access to many deserving Nigerians in having access to higher education especially those who by the nature of their engagement do not have the luxury of full time education. Recently, it is contributing in no small measure to providing places for teeming Nigerian youths who for one reason or the other could not get admission into the conventional universities.

These course materials have been written by writers specially trained in ODL course delivery. The writers have made great efforts to provide up to date information, knowledge and skills in the different disciplines and ensure that the materials are user-friendly.

In addition to provision of course materials in print and e-format, a lot of Information Technology input has also gone into the deployment of course materials. Most of them can be downloaded from the DLC website and are available in audio format which you can also download into your mobile phones, IPod, MP3 among other devices to allow you listen to the audio study sessions. Some of the study session materials have been scripted and are being broadcast on the university's Diamond Radio FM 101.1, while others have been delivered and captured in audio-visual format in a classroom environment for use by our students. Detailed information on availability and access is available on the website. We will continue in our efforts to provide and review course materials for our courses.

However, for you to take advantage of these formats, you will need to improve on your I.T. skills and develop requisite distance learning Culture. It is well known that, for efficient and effective provision of Distance learning education, availability of appropriate and relevant course materials is a *sine qua non*. So also, is the availability of multiple plat form for the convenience of our students. It is in fulfilment of this, that series of course materials are being written to enable our students study at their own pace and convenience.

It is our hope that you will put these course materials to the best use.

Prof. Abel Idowu Olayinka

Vice-Chancellor

Foreword

As part of its vision of providing education for "Liberty and Development" for Nigerians and the International Community, the University of Ibadan, Distance Learning Centre has recently embarked on a vigorous repositioning agenda which aimed at embracing a holistic and all encompassing approach to the delivery of its Open Distance Learning (ODL) programmes. Thus we are committed to global best practices in distance learning provision. Apart from providing an efficient administrative and academic support for our students, we are committed to providing educational resource materials for the use of our students. We are convinced that, without an up-to-date, learner-friendly and distance learning compliant course materials, there cannot be any basis to lay claim to being a provider of distance learning education. Indeed, availability of appropriate course materials in multiple formats is the hub of any distance learning provision worldwide.

In view of the above, we are vigorously pursuing as a matter of priority, the provision of credible, learner-friendly and interactive course materials for all our courses. We commissioned the authoring of, and review of course materials to teams of experts and their outputs were subjected to rigorous peer review to ensure standard. The approach not only emphasizes cognitive knowledge, but also skills and humane values which are at the core of education, even in an ICT age.

The development of the materials which is on-going also had input from experienced editors and illustrators who have ensured that they are accurate, current and learner-friendly. They are specially written with distance learners in mind. This is very important because, distance learning involves non-residential students who can often feel isolated from the community of learners.

It is important to note that, for a distance learner to excel there is the need to source and read relevant materials apart from this course material. Therefore, adequate supplementary reading materials as well as other information sources are suggested in the course materials.

Apart from the responsibility for you to read this course material with others, you are also advised to seek assistance from your course facilitators especially academic advisors during your study even before the interactive session which is by design for revision. Your academic advisors will assist you using convenient technology including Google Hang Out, You Tube, Talk Fusion, etc. but you have to take advantage of these. It is also going to be of immense advantage if you complete assignments as at when due so as to have necessary feedbacks as a guide.

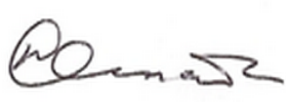
The implication of the above is that, a distance learner has a responsibility to develop requisite distance learning culture which includes diligent and disciplined self-study, seeking available administrative and academic support and acquisition of basic information technology skills. This is why you are encouraged to develop your computer

skills by availing yourself the opportunity of training that the Centre's provide and put these into use.

In conclusion, it is envisaged that the course materials would also be useful for the regular students of tertiary institutions in Nigeria who are faced with a dearth of high quality textbooks. We are therefore, delighted to present these titles to both our distance learning students and the university's regular students. We are confident that the materials will be an invaluable resource to all.

We would like to thank all our authors, reviewers and production staff for the high quality of work.

Best wishes.



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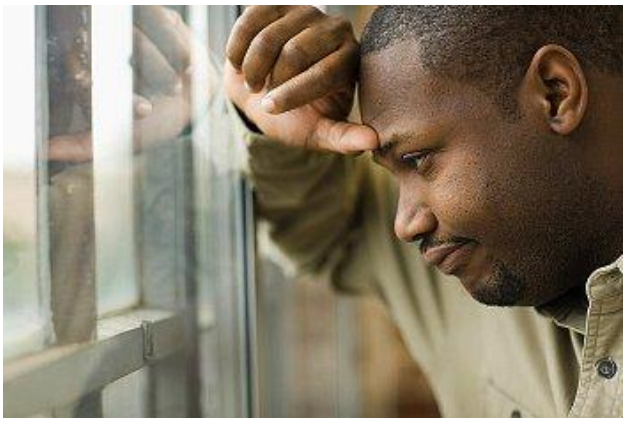
Study Session 1: Definitions and Scope of Clinical Psychology

Expected duration: 1 week or 2 contact hours

Introduction

Everyone has his/her off days when they just don't feel like themselves. For most people, these feelings are usual, and they don't last long at all. For some individuals, however, these feelings are more serious, and they could suggest a mental or emotional problem.

Clinical psychology is a wide branch of psychology that focuses on diagnosing and treating mental, emotional, and behavioral disorders. Some common disorders that might be treated include learning disabilities, substance abuse, depression, anxiety, and eating disorders.



In this study, you will learn about psychology, clinical psychology and scope of clinical psychology

Learning Outcomes for Study Session 1

At the end of this study, you should be able to:

1.1 Explain the meaning of Psychology
1.2 Define Clinical Psychology
1.3 Identify the scope of clinical Psychology

1.1 The Meaning of Psychology

The **World Health Organization** (2007) has defined mental health as a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, and is able to make a contribution to his or her community.

Clinical psychology is concerned with the assessment and treatment of emotional and adjustment problems in order to improve the mental health.

Psychology's first major theoretical position came from the writings of **Wilhelm Wundt** (1832-1920), a professor of philosophy who founded the first formal laboratory of psychology at the University of Leipzig in Germany, in 1879.

Figure 1.1: *Wilhelm Wundt*
Source: *https://upload.wikimedia.org/wikipedia/commons/5/56/Wilhelm_Wundt.jpg*

According to **Wundt**, psychology is the immediate conscious experience, one's experience or awareness of the content of one's own conscious mind. Psychology thus should seek to understand the structure of the mind. Hence, before the 1920s, psychology was defined as the 'science of mental life.'

Later, **John B. Watson** (1878-1950), the father of a psychology school of thought known as behaviourism, became very dissatisfied with how psychology was studied and thus de-emphasized and played down on the implicit, covert, and subjective phenomena then prevalent in psychology and replaced them with explicit, overt, objective and observable phenomena, that is, things that could be objectively measured.

Figure 1.2: *John B. Watson*
Source:*http://image2.findagrave.com/photos250/photos/2015/240/52554663_1440901712.jpg*

From the 1920s to the 1960s, psychology thus became the scientific and objective study of observable behaviour. Psychologists began to assert that psychology need never use the terms "consciousness", "mental state", "mind", "content", and "introspection" since

experiences such as sensation, emotion or reflection that occur within the body cannot be observed.
Psychologists rather emphasized the study of human behaviours that can be observed as they respond to different situations in their environment. From the 1960s however, psychology regained its earlier interest in the study of how the human mind processes and retains information. Hence the definition of psychology expanded to include the study of the phenomenon of observable behaviour as well as inner thoughts and feelings.
Psychology has thus become the scientific study of behaviour and mental process. Behaviour is any observable action of an individual that we can see, describe and even record. Mental processes however are subjective internal experiences triggered by the biological activities occurring within the brain and can be inferred from behaviour.
For instance you can infer how a person is feeling by his facial expression or the tone of his voice. Finally, as a scientific study, psychology endeavours to examine phenomenon, make observations, and formulate theories, test the theories and either accept, reject or refine the theories in line with whether or not you are able to predict specific behaviours in the pursuit of your understanding of the nature of man.
Psychology is a collection of diverse subfields broadly categorized into:

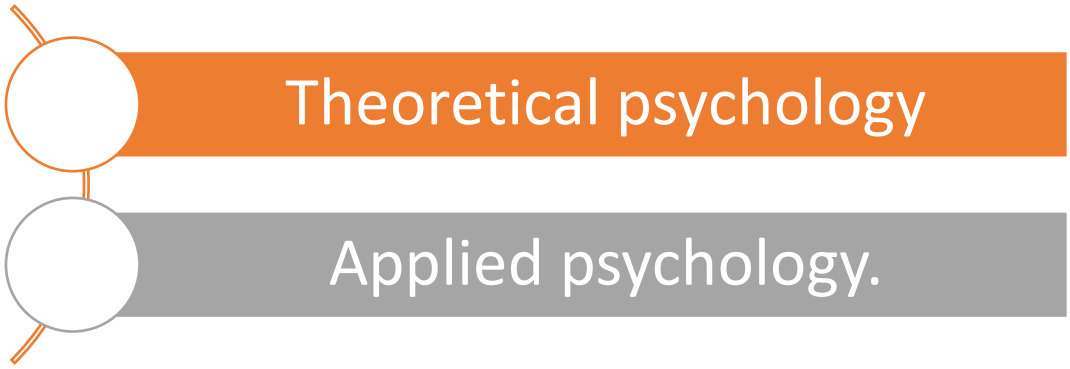


Figure 1.3: *Psychology subfields*

Theoretical psychology involves basic research aimed at increasing the scientific knowledge base that aids in the development of theories. Subfields in theoretical psychology include but are not limited to biological, developmental, cognitive, personality and social psychology.

Applied psychology on the other hand involves the use of psychology's concepts and methods to find solutions to pressing challenges in the respective fields where psychologists find themselves. It includes the works of industrial/organizational, sports, school/educational and clinical psychologists to mention a few.
For instance an industrial psychologist uses knowledge acquired in psychology to assist companies in the effective selection and training of employees, in designing marketable products, in enhancing the morale and productivity of workers and in implementing systems.

The clinical psychologist also uses the knowledge gained during training to study, assess and treat people experiencing emotional/psychological problems. Though there are several subspecialties in psychology, in this study however you will learn about the applied field of clinical psychology.

In-Text Question

_____involves basic research aimed at increasing the scientific knowledge base

A. Clinical Applied Psychology
B. Applied Psychology
C. Theoretical Psychology
D. None of the above

In-Text Answer

C. Theoretical Psychology

1.2 The Definition of Clinical Psychology

The nature and definition of clinical psychology has continued to evolve over the years. From its initial prime focus on assessment, evaluation, and diagnosis, clinical psychology has grown to now comprise a variety of approaches to rendering treatment and prevention services to individuals, groups and families.

Given the evolving nature of clinical psychology, any definition of the field ought to be taken as transitory and to be altered and restructured regularly to precisely mirror new advancements and emerging directions within the field.

The term "clinical psychology" was first used by **Lightner Witmer** in 1896 to refer to assessment procedures which were carried out with retarded and physically handicapped children. The establishment of the Vineland Institute for the investigation of mental retardation in 1906 and the Chicago Child Guidance Clinic in 1909 reflects the preoccupation of the pioneering psychologists in the clinical field with handicapped children.

Figure1.4:*Lightner Witmer*
Source: *https://s-media-cache-ak0.pinimg.com/736x/11/4d/89/114d8967bad33237bb300741c4fee94e.jpg*

Several definitions of clinical psychology have been given by different psychological associations from different countries of the world. Some of such definitions will be considered here.The definition of the **Society of Clinical Psychology of the American Psychological Association** states that: ‘‘the field of clinical psychology integrates science, theory, and practice to understand, predict, and alleviate maladjustment, disability, and discomfort as well as to promote human adaptation, adjustment, and personal development.
Clinical Psychology focuses on the intellectual, emotional, biological, psychological, social, and behavioural aspects of human functioning across the life span, in varying cultures, and at all socioeconomic levels.’’

Figure1.5: *Emotional behaviour (one of the focus on clinical psychology)*
Source:*http://www.alternet.org/files/styles/story_image/public/story_images/black_depression.png*

To the **British Psychological Society, Division of Clinical Psychology**: ‘‘Clinical psychology aims to reduce psychological distress and to enhance and promote psychological well-being by the systematic application of knowledge derived from psychological theory and data.’’
The **Canadian Psychological Association** states that ‘‘Clinical psychology is a broad field of practice and research within the discipline of psychology, which applies psychological principles to the assessment, prevention, amelioration, and rehabilitation of psychological distress, disability, dysfunctional behaviour, and health-risk behaviour, and to the enhancement of psychological and physical well-being.’’

Box 1.1: Clinical Psychology Definition

Clinical Psychology focuses on the intellectual, emotional, biological, psychological, social, and behavioural aspects of human functioning across the life span, in varying cultures, and at all socioeconomic levels.’’

In the view of the New Zealand College of Clinical Psychologists ‘‘Clinical Psychology seeks to apply psychological understandings with individuals and families who may wish

to change or develop, often for the alleviation of suffering and the achievement of their personal goals.''

The specialty of clinical psychology may also be defined as the branch of psychology which deals with the search for and the application of psychological principles aimed at understanding the uniqueness of the individual client or patient, reducing his personal distress, and helping him to function more meaningfully and effectively.

Clinical psychology uses scientific methods that are reliable and valid to assess both normal and abnormal human behaviour and it involves developing and using evidence based strategies for delivering mental health care services.

Box 1.2:The Specialty of clinical Psychology

The specialty of clinical psychology may also be defined as the branch of psychology which deals with the search for and the application of psychological principles aimed at understanding the uniqueness of the individual client or patient, reducing his personal distress, and helping him to function more meaningfully and effectively

Resnick (1991) defined clinical psychology as involving "research, teaching, and services relevant to the applications of principles, methods and procedures for understanding, predicting and alleviating intellectual, emotional, biological, psychological, social and behavioural maladjustment, disability and discomfort, applied to a wide range of client population".

Rodnick (1985) also defined clinical psychology as "the aspect of psychological science and practice concerned with the analysis, treatment, and prevention of human psychological disabilities and with the enhancing of personal adjustment and effectiveness".

Clinical psychology is one of the newest professions concerned with the health care of people. Clinical psychology contributes something special in the way it looks at man as a unique whole person in social context, and with less emphasis on the damaged tissue or the malfunction of parts that can pre-occupy the medical doctor.

Clinical psychology thus justifies its place alongside other health care professions by providing a balance to the medical model, and emphasizing the need to be included in the explanation and treatment of mental dysfunctions.

In-Text Question

The field of clinical psychology integrates science, theory, and practice to understand, predict, and alleviate maladjustment. True or False

In-Text Answer

True.

1.3 Scope of Clinical Psychology

Clinical psychology has some scope and these include:

- The applied area
- The scientific area
- The professional area.

You may thus want to know what these various areas stand for and what clinical psychologists do as applied psychologists, as scientists and as professionals. This therefore is the subject of this lecture.

1.3.1 Clinical Psychology as an Applied Discipline

Clinical psychology is an applied area of psychology because of the fact that it has derived most of its techniques, that is, scientific techniques from its parent's area, general psychology. Clinical psychology thus uses such scientific methods as research, naturalistic observations, clinical case methods, diagnosis and instrumentation in the diagnosis, treatment, management and rehabilitation of maladaptive individuals.

Thus, clinical psychology is said to be an applied field because it uses theories developed in general psychology to solve human problems. Some of such problems are: asthma, tension headaches and migraine, colitis, irritable bowel movement, chronic pain of psychogenic origin,

Others include ulcers, obesity, psoriasis, tics, stuttering, autism, developmental disabilities, learning disorders, smoking, drug abuse, phobias and anxiety states, impotence and premature ejaculation in males, frigidity, vaginismus and anorgasmia in females.

Figure 1.6:*Obesity (can be solved by clinical psychology)*

Source*:http://static.guim.co.uk/sysimages/Guardian/Pix/pictures/2014/9/17/1410960483374/Obesity-in-Kenya-009.jpg*

All of which are subsumed under psychosomatic cardiovascular, respiratory, sexual dysfunctions and endocrinological disorders. These psychological problems have been successfully treated and managed by the use of theories of learning, perception, motivation, personality and psychopathology in accounting for both normal and abnormal behaviours.

In-Text Question

Some of the problems that are addressed by clinical psychology include the following except

A. Obesity
B. Stuttering
C. Drug abuse
D. Dumbness

In-Text Answer

D. Dumbness

1.3.2 Clinical Psychology as a Scientific Area

The goal of any scientific enterprise is to explain some aspects of the natural or social world in a logical and understandable manner. Science is often defined as the development of knowledge in an empirical, validated and replicable manner. The three defining features of science are:

- The development of a general theory
- The testing and empirical validation of the theory
- The replication of tests of the theory.

Because of the foregoing, scientific inquiry is thus the keystone of every psychologist's formal education. The clinical psychologist is taught to assume a detached and an objective attitude in his investigative research and to take nothing for granted without experimental verification.

He learns to design rigorous experiments with careful controls and to analyse his results with the appropriate precise quantitative measures. The ultimate aim is to contribute theoretically by producing hypotheses which themselves will continue to undergo further scientific scrutiny.

The clinical psychologist who is better equipped (in terms of vast knowledge in research methodology and advanced statistics) to carry out clinical research than any of his mental health colleagues - including psychoanalysts, psychiatrists, psychiatric social workers, or psychiatric nurses and occupational therapists - carries out clinical research in at least six areas, viz:

(1) Personality
(2) Psychopathology
(3) Relationship of social factors and psychopathology
(4) The biochemistry and genetics of psychopathology
(5) Clinical assessment of individuals
(6) Psychotherapy.

1.3.3 Clinical Psychology as a Profession

Every profession has certain rules, regulations, ethics and norms guiding the entry, qualification and professional practice of the professionals. Therefore, the clinical psychologist as a "fully functioning professional person" has certain characteristic attributes which include:

- ❖ He renders services
- ❖ He adheres to a code of ethics
- ❖ He possesses at least minimum standards of competence based upon specific attainments in the areas of knowledge, skills, and values
- ❖ He has a firm sense of identity as a member of his profession
- ❖ He is an emerging, growing person in the pursuit of his professional functions
- ❖ He is committed to the advancement of the basic scientific substrate of his profession

- ❖ He is concerned with training - with the professional preparation of the younger members of the calling who will succeed him
- ❖ He is concerned with, and participates in the organizations which order the existence of his profession

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Activity 1.1: Scope of Clinical Psychology
Time Allowed:1 hour

Discuss with a clinical psychologist to give you more insight on clinical psychology as a course.

Summary for Study Session 1

In study session 1, you have learnt that

1. Psychology's first major theoretical position came from the writings of Wilhelm Wundt.
2. Clinical Psychology focuses on the intellectual, emotional, biological, psychological, social, and behavioural aspects of human functioning across the life span, in varying cultures, and at all socioeconomic levels.''
3. The definition of the Society of Clinical Psychology of the American Psychological Association states that: ''the field of clinical psychology integrates science, theory, and practice to understand, predict, and alleviate maladjustment, disability, and discomfort as well as to promote human adaptation, adjustment, and personal development.
4. Clinical psychology has some scope and this includes - the applied area, the scientific area, and the professional area.
5. The goal of any scientific enterprise is to explain some aspects of the natural or social world in a logical and understandable manner.

Self-Assessment Questions (SAQs) for Study Session 1

Now that you have completed this study, you can assess how well you have achieved its Learning outcomes by answering the following questions. You can check your answers with the Notes on the Self-Assessment questions at the end of this study.

SAQ 1.1 (Testing Learning outcomes 1.1)

Define theoretical psychology

SAQ 1.2 (Testing Learning outcomes 1.2)

Define Clinical Psychology

SAQ 1.3 (Testing Learning outcomes 1.3)

Outline the scope of clinical psychology

Notes on Self-Assessment Questions

SAQ 1.1

Theoretical psychology involves basic research aimed at increasing the scientific knowledge base that aids in the development of theories.

SAQ 1.2

Clinical psychology is a broad field of practice and research within the discipline of psychology, which applies psychological principles to the assessment, prevention, amelioration, and rehabilitation of psychological distress, disability, dysfunctional behaviour, and health-risk behaviour, and to the enhancement of psychological and physical well-being.

SAQ 1.3

- The applied area
- The scientific area
- The professional area.

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Study Session 2: History and Development of Clinical Psychology

Expected duration: 1 week or 2 contact hours

Introduction

Having discussed the definitions and scope of Clinical Psychology, this study session will therefore discuss how Clinical Psychology emerged to play an important role in the area of human adjustment.

While part of this emergence is due to the society's increased interest in mental health and adjustment in recent years, a substantial part rests also on the contributions made by psychologists and on the potential services they are seen as capable of providing.

Thus the growth and history of clinical psychology has followed several traditions, namely; experimental research tradition, measurement of individual differences, the development of the related profession of psychiatry, and the influence of the humanitarian movement which you will study. You will also learn about the development of contemporary clinical psychology.

Learning Outcomes for Study Session 2

At the end of this study, you should be able to

2.1 Discuss the history of clinical psychology

2.2 Discuss the development of contemporary clinical psychology

2.1 History of Clinical Psychology

Clinical Psychology can be traced to several traditions which include experimental research, measurement of individual differences, the impact of psychiatry and the humanitarian movement.

2.1.1 The Legacy of Experimental Research

The academic and laboratory beginnings of psychology are themselves not much older than the professional beginnings of clinical psychology. Over 130 years ago, **Wilhelm Wundt** (1832-1920) founded the first psychological laboratory in 1879 at Leipzig, helping psychology gain recognition as an independent science.

Figure2.1: *Wilhelm Wundt*
Source: *https://upload.wikimedia.org/wikipedia/commons/5/56/Wilhelm_Wundt.jpg*

Observations and experimentation, still among the major sources of data in psychology, stem from **Wundt's** early work. **Wundt**, rigidly and systematically, can be considered the first modern psychologist founder of the first psychology laboratory, editor of the first psychology journal, synthesizer of research findings, classifier of seemingly diverse data, quantifier and pursuer of laws pertaining to the human mind.
Wundt's definitions of psychology's content and methods continue to influence modern psychologists, for even today, clinical psychologists, like all other psychologists, are taught to emulate the experimenter who with a detached and an objective attitude carried out carefully controlled, rigorous experiments while searching for verifiable laws of human behaviour.

In-Text Question

Wilhelm Wundt (1832-1920) founded the first psychological laboratory in _____

A. 1879
B. 1890
C. 1880
D. 1770

In-Text Answer

A. 1879

Ivan Pavlov (1849-1936), the Russian physiologist, has also enormously influenced clinical psychology. Pavlov studied the connection between behaviour and environmental stimuli. He began investigating conditioned reflexes in dogs in 1899, demonstrating how learning by conditioning could take place if a bell or a tuning fork rang when food was presented.
By repeating this procedure, the dog ultimately learned to respond (by salivating) to the bell or the tuning fork alone.

Figure 2.2:*Ivan Pavlov (Russian Physiologist*
Source:*https://upload.wikimedia.org/wikipedia/commons/c/c2/Ivan_Pavlov_NLM2.jpg*

Pavlov's greatest contribution was to demonstrate with a simple, objective, experimental technique that complex behaviour could be analysed and controlled in the laboratory. Pavlov was also interested in abnormal behaviour; in the animal's behaviour: and during the last decade of his life, he designed a series of experiments in which he produced an experimental neurosis in an animal.

Thus, his work along with American psychologist **Edward Lee Thorndike's** studies inspired many later psychologists to pursue the objective description and analysis of behaviour. The recent revival of interest in developing behaviour modification programmes for changing or eliminating undesirable or maladaptive behaviour stems from **Pavlov's** and **Thorndike's** early work.

Figure2.3:*Edward Lee Thorndike's*
Source:*https://upload.wikimedia.org/wikipedia/commons/6/66/PSM_V80_D211_Edward_Lee_Thorndike.png*

2.1.2 The Measurement of Individual Differences

Charles Darwin (1809-1882), naturalist and biologist, created a scientific revolution with his theory of evolution by natural selection. Among his major contributions especially relevant to future scientists was the careful, painstaking way he collected and organized the large-scale, detailed record of evidence to support his hypotheses.

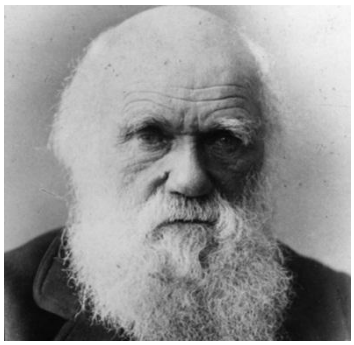

Figure 2.4: *Charles Darwin*
Source:*http://a4.files.biography.com/image/upload/c_fit,cs_srgb,dpr_1.0,h_1200,q_80,w_1200/MTE5NDg0MDU0OTM4NjE3MzU5.jpg*

Darwin's work particularly influenced the emerging field of psychology, which it seemed was striving to become an exact quantitative science. **Darwin** helped shape psychology in the direction of biology generally; more specifically he influenced psychologists to understand mental processes in terms of their function in an organism's adaptation to the world.

Darwin began studies in child psychology - for example, infant development and language development - as well as studies of group behaviour. **Beck and Molish** (1959) even suggested that **Darwin's** work be credited as representing the beginning of scientific clinical psychology.

Darwin's emphasis on individual variation stimulated his cousin, **Sir Francis Galton** (1822-1911), to study individual variations in men, particularly differences in hereditary make up. **Galton** set out to prove that eminence runs in families with a frequency that could not be explained on an environmental basis. He first collected data on the family trees of eminent scientists, jurists, authors and others in order to show that genius was inherited.

Noting an enormous variation in physical and mental characteristics among individuals, which he attributed to heredity, **Galton** found it necessary to develop a set of psychological measurement to study quantitatively, the individual differences he was obtaining.

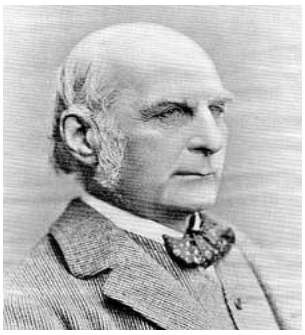

Figure 2.5:*Sir Francis Galton*
Source:*http://www.moilliet.ws/Pics/Francis_Galton.jpg*

Galton's 'inventiveness contributed a great deal to modern clinical psychology, and among those contributions were:

- The focus on the individual
- The development of quantitative mental measurements
- The statistical analysis of psychological data
- The invention of the mental tests such as the word-association test, the first experimental attempt to study and measure an individual's associated thoughts
- The development of the questionnaire method
- The use of the free-association method to demonstrate the significance of childhoodmemories on adult life.

In-Text Question

Darwin's emphasis on individual variation stimulated his cousin, Sir Francis Galton, though Galton eventually performed woefully. True or False

In-Texr Answer

False

2. 1.3 The Impact of Psychiatry

Aberrant, bizarre and disordered behaviour has characterized certain individuals since the beginning of recorded history. Until the 16th century, insanity continued to be explained as the work of demons and witches, and behaviourally disordered individuals were kept in monasteries and prisons.

Slowly, a more enlightened attitude emerged and hospitals (or asylums), were established. However; these early asylums were little more than penal institutions into which the insane were herded and treated in a most inhumane manner, for instance, Overbrook Insane Asylum, New Jersey is one of the asylum where patients are been treated in an inhumane manner.

Towards the end of the 18th century, **Phillipe Pinel** (1745-1826), the French physician and reformer who has been called the father of scientific psychiatry, and **Benjamin Rush** (1745-1813), the first American psychiatrist began to make an impact on the medical

thinking and psychiatric thought of their time.

Figure 2.6:*Phillipe Pinel & Benjamin Rush*
Source*:http://www.ohwy.com/history%20pictures/benjrush.gif*

Thus **Pinel** became in charge of the large Parisian asylum and tried to make psychiatry more scientific by keeping more accurate hospital records, taking case histories on inmates, and attempting some classification system of mental illness (Reisman, 1966).
Like **Pinel**, **Rush** took a humane view of the mentally ill. His efforts at scientific systematization of psychiatry-resulted in his 1812 treatise, Medical Inquiries and Diseases of the Mind, the first and only American textbook on mental illness for the next 70 years (Lewis, 1959).
Apart from **Pinel and Rush, Emil Kraepelin** (1855-1926), a German psychiatrist, spent years gathering thousands of case histories from which he developed his classification of mental illnesses by symptomatology as well as the cause.

Figure 2.7*: Emil Kraepelin*
Source:*https://pbs.twimg.com/profile_images/460879292742660096/ADBF5HDe_400x400.jpeg*

Certain mental diseases like dementia praecox (now known as schizophrenia) were believed by **Kraepelin** to be incurable. **Kraepelin's** classification systems and work on attitudes of clinical psychologists and psychiatrists for many years to come regarding treatment of

individuals was classified as schizophrenic.
Another authority in psychiatry whose influence helped shape the history of clinical psychology was **Sigmund Freud** (1856-1939), who trained in neurology. He used hypnosis on hysterical patients but found out that the technique did not produce the permanent relief of symptoms he was seeking.

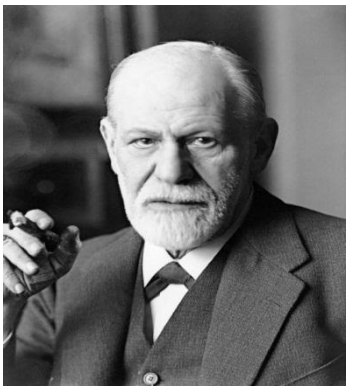

Figure 2.8: *Sigmund Freud*
Source: *http://content.ngv.vic.gov.au/col-images/api/EXHI015320/large*

Freud, the father of psychoanalysis, is also identified with the importance of unconscious, instinctual forces in human behaviour, transformed psychiatry from a relatively static and descriptive branch of medicine to a vital force concerned with uncovering the causes of human suffering. His psycho-analytic treatment provided the first comprehensive, psychological set of therapeutic procedures for relieving such suffering.

2. 1.4. The Humanitarian Movement

You will be acquainted with three key persons as regards the humanitarian movement, viz: **William Tuke** (1732-1822), **Dorothea Dix** (1802-1887), and **Clifford Beers** (1876-1943). **William Tuke** was an English Tea Merchant, who became so horrified at the conditions in the asylums he visited, that he induced the Society of Friends - of which he was a member - to establish a retreat under his guidance at York, in the English countryside.

Figure 2.9: William*Tuke, Dorothea Dix and Clifford Beers*
Source: *http://www.naswfoundation.org/pioneers/images/beersphoto.jpg*

Rather than operating as a prison, the York Retreat provided a simple, tranquil Quaker atmosphere where patients were given good food, exercise, and recreation and were treated with respect and dignity. Thus **Tuke** and his small group of Quakers also influenced the public to develop a more enlightened attitude towards mental illness, including the belief that such illness was ultimately curable.

The most celebrated and certainly the most effective reformer in the United States was **Dorothea Dix**, a New England school teacher. While she was teaching Sunday school to female prisoners, she became aware that mentally ill patients were often housed with criminals, and both were treated brutally.

Because of her constant visits to every jail and alms house in Massachusetts, she mounted campaign for the release of these persons, and thus creating greater public awareness of the need for humane and adequate treatment and facilities for criminals.

One more recent influence has been the development of the mental hygiene movement. The term mental hygiene refers to the promotion of mental health and the prevention of mental illness. This movement was founded by **Clifford Beers** and came about as a result of Beer's book, A Mind that Found Itself (1908), an account of his experiences as a patient in various mental hospitals.

Beers experienced several breakdowns after graduating from Yale and was hospitalized in private sanatoriums and state hospitals in Connecticut, receiving the then prevailing treatment of restraints and isolation. Upon his eventual release after several years of hospitalisation, Beers was determined to inform the ' public how it felt to be mentally ill and to arouse a movement to reform existing evils in the hospital treatment programmes.

Beer's books, as **Bromberg** (1950) notes, proved to be "the shot heard round the world," the catalyst that finally forced an indifferent public to become aware of some of the problems of mental illness and to demand changes in patient care.

In-Text Question

Charles Darwin's major contribution to the development of clinical psychology is in the area of_____

A. Group variation
B. Evolution
C. Child psychology
D. Individual variations.

In-Text Answer

Child psychology

2.2 The Development of Contemporary Clinical Psychology

The contemporary clinical psychologists were mainly working in settings where their services were highly needed. They worked in places such as hospitals, schools, geriatric homes, schools for the handicapped, etc. and they were also engaged in teaching, research, assessment, therapy and administration. To have a better understanding, you will have to

visit a contemporary psychological clinical and see how it took its root from various generations.

2.2.1 The First Generation

The history of clinical psychology began in the early 1900's when the first generation of clinical psychologists developed (Watson, 1953). In the 1890's, the following events paved the way for this development:

1. William James published his Principles of Psychology (1890), considered a major source of ideas reaching into all realms of pure and applied psychology;
2. Sigmund Freud published an early paper on hysteria (1893), thus introducing the psychodynamic approach to understanding and treating abnormal behaviour;
3. LightnerWitner, a student of Wundt's, founded the first psychological clinic in the United States at the University of Pennsylvania in 1896.
4. A small group of about 30 psychologists, at the invitation of G. Stanley Hall, met at Clark University to found the American Psychological Association in 1892.

The early psychologists functioned primarily in academic settings; it is no coincidence that Witner's early efforts to develop what he called a clinical method in psychology emerged from the psychological laboratory of a university. Witmer, in short was more interested in clinically applying the developing methods of psychological laboratories to individual problems.

According **Thomas** 2009, Lighter even though he was known as the father of clinical psychology his name may have been historically forgotten evidence by lack of posting of his obituary in the American Psychological Association's (APA) website among the great psychologists of his time.

Some other psychologists were also becoming interested in the study of the individual. They tried to develop tests to measure individual differences in ability, such as intelligence. **Cattell** (1860-1944), an American, combining experimental psychology and individual differences, introduced the first battery of psychological tests in the United States in 1894, when he attempted to appraise the mental abilities of incoming, freshmen at Columbia University (Cattell and Ferrand, 1896).

A more successful attempt to develop psychological tests of intelligence, soon to become an important impetus to the growth of clinical psychology came from the work of Alfred Binet (1857-1911). Binet and Theodore Simon, a physician, sought a more objective, practical, diagnostic method for measuring the degree of intellectual deficiency.

Figure2.10:*Alfred Binet*
Source:*https://sites.google.com/site/alfredbinet18571911/_/rsrc/1320070739466/home/BINE%20PORTRAIT.jpg*

The result was the 1905 Binet-Simon sale, including 30 tasks of increasing degrees of complexity that would provide a crude means of differentiating normal and mentally deficient children.
Psychological testing was just the impetus clinical psychology needed to grow and to gain public acceptance. Psychologists began to use the Stanford-Binet and similar tests of intelligence and other functions in a variety of clinical situations, and so did schools, children's homes, juvenile courts, reformatories and prisons.
The first child-guidance clinic was founded in Chicago, in 1909. It was meant for delinquent children. The clinic was originally named the Juvenile Psychopathic Institute (now as the Institute for Juvenile Research). At first, it had a psychiatrist, William Healy as the director, and later, a social worker, **Grace Fernald**.

In-Text Question

_____founded the first psychological clinic in the United States

A. LightnerWitner
B. Charles Darwin
C. Binet Simon
D. Sigmund Freud

In-Text Answer

A. LightnerWitner

2.2.2 The Second Generation

During the second generation, the emergence of clinical psychology expanded when internship training was instituted in mental hospitals and training schools were established for the mentally retarded, in an effort to supplement the academic course work of psychology students.
During the World War I when United States entered the war, the sudden influx of army

recruits necessitated development of some methods to group and classifies them according to their abilities. Thus came the boom period for clinical psychologists, since various tests of intelligence, achievement, and vocational aptitudes were developed and used in schools, industries, prisons, mental hospitals, and the new child-guidance clinics.

During the 1930's, clinical psychology started leaving the areas of measuring intellectual ability and school achievement in children. Thus psychologists expanded into diagnostic work with adults, usually in mental hospitals. In addition, psychological testing itself was expanding, augmented by the introduction of personality tests. The Rorschach Inkblot Test, named after originator - a Swiss psychiatrist, Herman Rorschach - was introduced after World War I (Rorschach, 1921).

2.2.3 The Third Generation

World War II and its aftermath were the years of perhaps the greatest growth to date for clinical psychology. During the war itself, 1500 psychologists served in the Armed Forces (Andres and Dreese, 1948), making significant contribution to such applied problems as selection, evaluation and job placement of draftees, morale maintenance and studying human factors in equipment design. These Psychologists also involved themselves in the treatment of a large number of mental patients in army Hospitals.

The Third generation clinical psychologists differed from their predecessors in many ways. They were better trained as practitioners - in diagnosis, psychotherapy, and research - than any previous group of psychologists because of the enormous government undertaking in establishing training programmes.

2.2.4 The Present Generation

The present generation i.e. (the fourth generation) of clinical psychologists engaged in four sets of activities. These activities are diagnosis and assessment, clinical research, psychotherapy, and community consultation. The diagnosis of psychopathology has given way for many clinicians, to the assessment of an individual's psychological strengths as well as his weaknesses.

From the foregoing, you will have seen that the history of clinical psychology started from the United States of America, but you will now be acquainted with the development of clinical psychology in Nigeria.

The birth of clinical psychology in Nigeria started under the auspices of **Professors Alfred Awaritefe** of the department of mental health, University of Benin, **Z, A. F. Uzoka**, of the department of psychology, University of Lagos**, I.O. Dada**, of the Psychiatric Hospital, Yaba, Lagos, and **H. I. Amatu**, of the Psychiatric Hospital, Bauchi.

They pioneered the emergence and birth of the **Nigerian Association of Clinical Psychologists**, in 1979. The Journal published by this association is known as **Nigerian Journal of Clinical Psychology.**

Though, the development of clinical psychology in Nigeria is still in its infancy, it has gained a little more recognition in hospital settings as was previously the case. It is not uncommon therefore to find a department or unit of clinical psychology in teaching hospitals and some federal medical centers in Nigeria though some of these units are grossly

understaffed.
The future prospects are however bright for clinical psychology as a discipline in Nigeria. Psycho-Oncology practice which is a subspecialty of clinical psycho-oncology has been evolved in the University College Hospital, Ibadan. A unit of Psycho-Oncology has been created in the department of Radiotherapy, Faculty of Clinical Sciences, College of Medicine, University of Ibadan, Ibadan.

Summary for Study Session 2

In study session 2, you have learnt that:

1. Observations and experimentation, still among the major sources of data in psychology, stem from Wundt's early work.
2. Charles Darwin (1809-1882), naturalist and biologist, created a scientific revolution with his theory of evolution by natural selection
3. The history of clinical psychology began in the early 1900's when the first generation of clinical psychologists developed (Watson, 1953).
4. During the 1930's, clinical psychology started leaving the areas of measuring intellectual ability and school achievement in children.

Self-Assessment Questions (SAQs) for Study Session 2

Now that you have completed this study, you can assess how well you have achieved its Learning outcomes by answering the following questions. You can check your answers with the Notes on the Self-Assessment questions at the end of this study.

SAQ 2.1 (Testing Learning outcomes 2.1)

Explain the impact of psychiatric in history

SAQ 2.2 (Testing Learning outcomes 2.1)

Discuss the third generation development of clinical psychology

Notes on Self-Assessment Questions

SAQ 2.1

Towards the end of the 18th century, Phillipe Pinel (1745-1826), the French physician and reformer who has been called the father of scientific psychiatry, and Benjamin Rush (1745--1813), the first American psychiatrist began to make an impact on the medical thinking and psychiatric thought of their time.
Apart from Pinel and Rush, Emil Kraepelin (1855-1926), a German psychiatrist, spent years gathering thousands of case histories from which he developed his classification of mental illnesses by symptomatology as well as the cause

SAQ 2.2

World War II and its aftermath were the years of perhaps the greatest growth to date for clinical psychology. During the war itself, 1500 psychologists served in the Armed Forces (Andres and Dreese, 1948), making significant contribution to such applied problems as selection, evaluation and job placement of draftees, morale maintenance and studying human factors in equipment design. These Psychologists also involved themselves in the

treatment of a large number of mental patients in army Hospitals.
The Third generation clinical psychologists differed from their predecessors in many ways. They were better trained as practitioners - in diagnosis, psychotherapy, and research - than any previous group of psychologists because of the enormous government undertaking in
establishing training programmes.

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Study Session 3:Clinical Psychology and other Allied Mental Health Professions

Expected duration: 1 week or 2 contact hours

Introduction

Clinical psychology is the branch of psychology that is concerned with the assessment and treatment of mental illness and disability. It has several closely related health fields which include Paediatrics psychology, Neurosciences and neurology.

In this study therefore you will learn about other closely related fields of clinical psychology which counselling psychology, school psychology, psychiatry, psychiatry nursing and rehabilitation psychology.

Learning Outcomes for Study Session 3

At the end of this study, you should be able to

3.1 Explain counselling psychology
3.2 Discuss school psychology
3.3 Explain Psychiatry
3.4 Discuss psychiatric nursing
3.5 Explain rehabilitation psychology

3.1 Counselling Psychology

It is important to distinguish between counselling psychology and counselling. Counselling is a genericterm used to describe a range of mental health professions with various training and licensurerequirements (Robiner, 2006). Counselling psychology has a great deal in common with clinical psychology.

Figure 3.1: *Counselling Psychology*
Source: *http://www.sacap.edu.za/content/uploads/2015/04/what-is-counselling.jpg*

The roots of counselling psychology can be traced to the vocational guidance movement, in which knowledge of personality traits, aptitudes, and interests that affect job performance and satisfaction were applied to help match employees to the most suitable jobs.

After World WarII the Veterans Administration contracted with universities and colleges for services advising on vocational and educational matters. Historically, the distinction between clinical and counselling psychology was in terms of the severity of problems treated.

Traditionally, the focus of clinical psychology was on the assessment and treatment of psychopathology: that is, manifestations of anxiety, depression, and other symptoms that were of sufficient severity to warrant a clinical diagnosis.

On the other hand, counselling psychologists provided services to individuals who were dealing with normal challenges in life—those predictable developmental transitions such as leaving home to work or to attend college, changes in work or interpersonal roles, and handling the stress associated with academic or work demands.

Simply put, counselling psychologists dealt with people who were, by and large, well-adjusted, whereas clinical psychologists dealt with people who were experiencing significant problems in their lives and who were unable to manage the resulting emotional and behavioural symptoms.

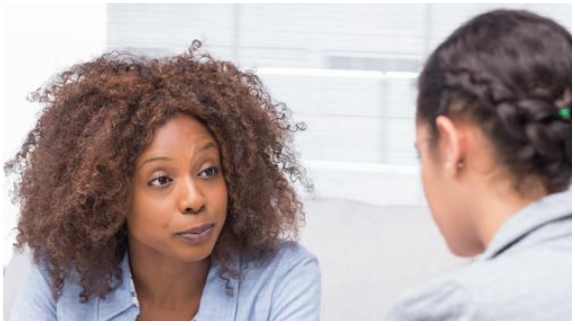

Figure 3.2:*counselling psychologists*
Source: *http://www.citylit.ac.uk/media/catalog/category/Counselling_thumbnail_1.jpg*

Another distinction between the two professions was the type of setting in which the practitioners worked. Counselling psychologists were most commonly employed in educational settings (such as university counselling clinics) or general community clinics in which various social and psychological services are available.

Figure 3.3: *Counselling psychologists*
Source:*http://epsy.tamu.edu/sites/epsy.tamu.edu/files/styles/main_page_photo/public/14418210638_c7860d0285_h.jpg?itok=ob0aUUEi*

Clinical psychologists, in contrast, were most likely to be employed in hospital settings—both in general hospitals and in psychiatric facilities. These traditional distinctions between clinical and counselling psychologists are fading due to changes within both professions.

Nowadays, counselling psychologists provide services to individuals who are having difficulty functioning: for example, treatments for university students suffering from disorders such as major depressive disorder, panic disorder, social phobia, or eating disorders (Benton, Robertson, Tseng, Newton, & Benton, 2003; Kettman et al., 2007).

Both clinical and counselling psychologists are now employed in a wide range of work settings, including both public institutions and private practices.

In-Text Question

Traditionally, the focus of clinical psychology may not always be on the assessment and treatment of psychopathology. True or False

In-Text Answer

False

3.2 School Psychology

School psychologists have specialized training in both psychology and education. Educational psychologists are concerned with psychology as it pertains to education. Their activities include the design, development, and evaluation of materials and procedures for education and training.

They are usually employed in an applied setting such as a public school system, the military, or a large industrial concern. They also are concerned with the development, administration, scoring and interpretation of psychological tests. For instance, there is always a psychologist or counsellor in the secondary school who attends to students.

Figure 3.4: *School Psychologist*
Source: *http://www.smith.edu/ssw/images/MillerAfricanDelegationApril2015c.jpg*

These tests are used mostly for screening the mentally retarded people with brain damage, those with learning disability, educationally backward pupils and children who are emotionally maladjusted. Given the focus on children's functioning, there is a natural overlap between school psychology and child clinical psychology. Historically, school psychology emphasized services related specifically to the learning of children and adolescents, including the assessment of intellectual functioning, the evaluation of learning difficulties, and consultation to teachers, students, and parents about strategies for optimizing students' learning potential.

Clinical child psychology focused on the treatment of diagnosable mental disorder. Currently, the role of school psychologists has expanded to include attention to social, emotional, and medical factors in a context of learning and development.

These changes, combined with legal obligations that schools provide the most appropriate education for all children, have resulted in school psychologists diagnosing a range of disorders of childhood and adolescence as well as developing school and/or family-based programs to assist students in learning to the best of their abilities.

School psychologists have also taken a leadership role in the development of school-based prevention programs designed to promote social skills, to reduce bullying, to facilitate conflict resolution, and to prevent violence (Kratochwill, 2007).

In-Text Question

Clinical child psychology is focused on _____

A. The treatment of diagnosable mental disorder
B. Attitudinal change
C. Mental assent
D. Clinical Leadership

In-Text Answer

A. The treatment of diagnosable mental disorder

3.3 Psychiatry

Although we have focused on psychology-based professions thus far, it is important to note that primary care physicians provide more mental health services than any other health care profession (Robiner, 2006).

As medical generalists, these physicians are usually the first health care professionals consulted for any health condition, be it physical or mental. Psychiatrists are physicians who specialize in the diagnosis, treatment, and prevention of mental illnesses. As with other medical specialties, training as a psychiatrist requires at least three years of residency training after the successful completion of basic medical training.

Figure 3.5:*Mental illness*
Source: *https://i.ytimg.com/vi/GoVdrAIUu8k/hqdefault.jpg*

Once they have completed specialization in psychiatry, psychiatrists rarely examine or treat the basic health problems that were covered in their medical training. Psychiatric training differs in important ways from applied psychology training. First, psychiatric training deals extensively with physiological and biochemical systems and emphasizes biological functioning and abnormalities. Psychiatrists are well qualified to determine whether mental disorders are the result of medical problems and to unravel the possible interactions between physical illnesses and emotional disturbances.

Psychiatric training provides the skills to evaluate the extent to which psychological symptoms result from or are exacerbated by medications used to treat physical ailments and chronic illnesses.

Figure 3.6: *Psychiatry issues*
Source:*http://www.bellanaija.com/wp-content/uploads/2014/11/dreamstime_xl_30062782.jpg*

Many psychiatrists have become active researchers and have contributed in important ways to the knowledge base of the neurosciences and human sciences. Nevertheless, the average psychiatry resident receives far less training in research than does the average graduate student in clinical psychology.
Another fundamental difference between training in clinical psychology and psychiatry is that psychiatric training generally emphasizes psychopharmacological treatment over psychological treatment.
Accordingly, compared with psychologists, psychiatrists tend to receive less training in the use of scientifically based psychological assessment and psychotherapy. Historically, psychiatrists were trained in forms of psychoanalytic and psychodynamic treatments such as those developed by Sigmund Freud, Carl Jung, and Alfred Adler.

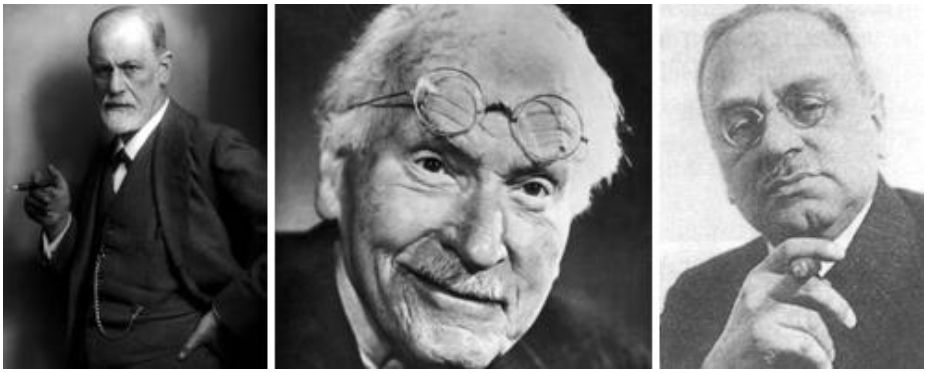

Figure3.7: *Sigmund Freud, Carl Jung and Alfred Adler*
Source: *http://www.nndb.com/people/256/000097962/alfred-adler-1-sized.jpg*

Due in part to the proliferation of effective psychopharmacological treatments in recent decades and the growing emphasis on evidence-based practice in psychiatry, there has been a waning of emphasis on training in psychoanalytic and long-term psychodynamic psychotherapy.
Despite the tendency for many psychiatrists to favour psychopharmacological approaches to treatment, psychiatrists were among the pioneers in the development of evidence-based

psychological treatments.
Aaron Beck was the primary developer of cognitive therapy for depression (and subsequently other disorders), Gerald Weissman was the primary developer of the interpersonal treatment of depression, and Isaac Marks has played a prominent role in the development of cognitive-behavioural treatments for anxiety disorders.
Thus, although the relative emphasis of psychotherapy within the profession differs from that in clinical psychology, the provision of psychotherapeutic services remains, for many psychiatrists, a central aspect of psychiatric services.

In-Text Question
Psychiatrists receive relatively little training in human psychological development. True or False

In-Text Answer
True

3.4Psychiatric Nursing
Psychiatric nurses receive their basic training in nursing as part of three-year program to be a registered nurse in addition to specialized training in the management and treatment of persons with mental disorders necessitating admittance into a healthcare facility. Psychiatric nurses spend several hours in close contact with patients in the process of providing care.

Figure3.8: *Psychiatric nurse*
Source*: http://www.nursingscholarships.org/wp-content/uploads/international-nurse-200x300.jpg*

As a result of this proximity they are in the best position to give relevant information in relation to patients' hospital adjustment and play a vital part in fostering a suitable healing environment for the patient. They work in close collaboration with the psychiatrists or clinical psychologists and they carry out treatment recommendations.
They, cannot conduct psychotherapeutic sessions by themselves, but provide help to

professionals. They are however responsible for managing administrative matters in inpatient settings and supervising ancillary services provided by others (such as nurses' aides and volunteers).

In-Text Question

Psychiatric nurses cannot conduct psychotherapeutic sessions by themselves. True or False

In-Text Answer

True.

3.5Psychiatric Social Works

Social workers help you to be a better person, they tend to help disturbed individuals, families and/or groups to restore or improve their emotional and social functioning by attempting to deal with the social forces contributing to the individuals, families and/or groups' psychological and social challenges.

Figure 3.9: *Social Worker*
Source*: http://www.shell.com.ng/environment-society/shell-in-the-society/_jcr_content/par/html5hero/heroimage/mainimage.496323006.jpeg*

Social workers emphasize the importance of removing or reducing the impact of social circumstances that impede development. Many social workers function as part of a mental health team in the role of taking case history, interviewing employers and relatives in order to understand the possible social causes of the emotional problems, and they are sometimes involved in making arrangements for vocational placement of patients as they get better.

Compared to the training of clinical psychologist, a psychiatric social worker's training is rather brief. The responsibilities of a psychiatric social worker are also not as vast as those of clinical psychologists.

In contrast to clinical psychologists, who provide services at clinic or hospital, psychiatric social workers are more likely to visit the home, work place or the patient's neighbourhood and other places where the patient spends much time in order to better understand the peculiarities of the patient's social life that may be contributing his or her problems.

In-Text Question
The responsibilities of a psychiatric social worker are vast as those of clinical psychologists. True or False

In-Text Answer
False

3.6Rehabilitation Psychology
The main focus of the rehabilitation psychologists is on persons with physical or cognitive disability. The disability may have been due to birth defects or as a result of certain illnesses or accidents later in life.

The rehabilitation psychologist helps the people with disabilities adjust to their disabilities as well as learn to deal with the psychosocial, physical and environmental barriers that often go along with their disabilities. For instance, government and NGOs create centers for learning and empowerment for the disables. They are mostly found employed in rehabilitation centres.

Other Mental Health Professions

The other areas closely related to clinical psychology include:

- Health psychology
- Paediatrics psychology
- Neurology
- Neurosciences.

Summary for Study Session 3
In study session 3, you have learnt that:

1. Counselling is a generic term used to describe a range of mental health professions with various training and licensure requirements.
2. Educational psychologists are concerned with psychology as it pertains to education.
3. Psychiatrists are physicians who specialize in the diagnosis, treatment, and prevention of mental illnesses
4. Psychiatric nurses spend several hours in close contact with patients in the process of providing care.
5. Social workers tend to help disturbed individuals, families and/or groups to restore or improve their emotional and social functioning by attempting to deal with the social forces contributing to the individuals, families and/or groups' psychological and social challenges.
6. The main focus of the rehabilitation psychologists is on persons with physical or cognitive disability.

Self-Assessment Questions (SAQs) for Study Session 3

Now that you have completed this study, you can assess how well you have achieved its Learning outcomes by answering the following questions. You can check your answers with the Notes on the Self-Assessment questions at the end of this study.

SAQ 3.1 (Testing Learning outcomes 3.1)

Define counselling psychology

SAQ 3.2 (Testing Learning outcomes 3.2)

Explain the role of school psychologists

SAQ 3.3 (Testing Learning outcomes 3.3)

Explain the role of a psychiatrist in psychology

SAQ 3.4 (Testing Learning outcomes 3.4)

Outline the role of a psychiatry nurse

SAQ 3.5 (Testing Learning outcomes 3.5)

State the functions of The Psychiatry social worker

SAQ 3.6 (Testing Learning outcomes 3.6)

Identify the role of rehabilitation psychologist.

Notes on Self-Assessment Questions

SAQ 3.1

Counselling psychology can be traced to the vocational guidance movement, in which knowledge of personality traits, aptitudes, and interests that affect job performance and satisfaction were applied to help match employees to the most suitable jobs.

SAQ 3.2

Educational psychologists are concerned with psychology as it pertains to education.Their activities include the design, development, and evaluation of materials and procedures for education and training.

SAQ 3.3

Psychiatrists are physicians who specialize in the diagnosis, treatment, and prevention of mental illnesses.Psychiatrist training deals extensively with physiological and biochemical systems and emphasizes biological functioning and abnormalities.

Psychiatrists are well qualified to determine whether mental disorders are the result of medical problems and to unravel the possible interactions between physical illnesses and emotional disturbances.

SAQ 3.4

Nurses give relevant information in relation to patients' hospital adjustment and play a vital part in fostering a suitable healing environment for the patient. They work in close collaboration with the psychiatrists or clinical psychologists and they carry out treatment recommendations.

SAQ 3.5

Many social workers function as part of a mental health team in the role of taking case history, interviewing employers and relatives in order to understand the possible social

causes of the emotional problems, and they are sometimes involved in making arrangements for vocational placement of patients as they get better

SAQ 3.6

The rehabilitation psychologist helps the people with disabilities adjust to their disabilities as well as learn to deal with the psychosocial, physical and environmental barriers that often go along with their disabilities.

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Study Session 4: The Duties of the Clinical Psychologist

Expected duration: 1 week or 2 contact hours

Introduction

Having discussed about the branches of clinical psychology in the previous study session, you will therefore in this study session learn about the lack of agreement between clinical psychologists as to the sort of services they should be providing can be both a drawback and a blessing in disguise.

The disadvantage of this state of affairs is that the newly-appointed psychologist might find himself expected to contribute in particular ways which are discrepant from his own role expectations.

On the other hand, the clinician can be seen to be in all almost unique position in the hospital setting, for because of the ambiguous nature of the discipline, he can very often stipulate his own job description. Thus the lack of a clear-cut list of functions can work both for and against clinical psychologists.

Learning Outcomes for Study Session 4

At the end of this study, you should be able to:

4.1Explain clinical psychologists work setting

4.2 Discuss the daily execution of clinical psychologist

4.3 Outline the duties of clinical psychologist

4.1 Clinical Psychologists' Work Settings

The activities of today's clinical psychologists are considerably broader than those of their predecessors. Some years past, most clinical psychologists worked primarily with children's problems in university or community clinics or in institutions such as those for the physically handicapped or the mentally retarded.

Figure4.1: *A community clinic*
Source:*http://www.kdf.org.ng/images/health.jpg*

Clinical psychologists nowadays work in a variety of settings including the following places:

- University psychology or counselling departments (as teachers and researchers);
- Psychiatric hospitals or outpatient clinics (performing research and providing clinical services);
- Community mental health centres
- University student health centres
- Child guidance clinics
- Public and private school
- State youth authority agencies
- Prisons (as prison psychologists)
- Medical schools
- Industries (as industrial management consultants).

Figure4.2: *Public School*
Source*: http://scannewsnigeria.com/wp-content/uploads/2015/03/PIC.16.-GOV.-FASHOLA-INAUGURATES-A-BLOCK-OF-18-CLASSROOMS-IN-KETU.jpg*

The problems the clinical psychologists might deal with include:

- Social and interpersonal problems;
- Sexual problems;
- Marital problems;

- Vocational problems;
- School adjustment problems;
- Speech pathology;
- Problems arising from delinquency and addictive behaviours, which cover taking of hard drugs, dependency on tranquilizers and other prescribed medication, smoking of cigarette, excessive consumption of alcohol, overeating, compulsive gambling, and even excessive sexuality;
- Problem arising from organic brain dysfunctions; and many others.
- Emotional distress of adults and children with chronic illnesses such as cancer, hypertension, diabetes etc.

In-Text Question

Clinical psychologists nowadays work in the following settings except_____

A. Psychiatric hospitals
B. Public and private schools
C. Community mental health centre
D. None of the above

In-Text Answer

D. None of the above

Clinical psychologists work with individuals of all ages. For example they work with

- Infants: Perhaps evaluating them for signs of mental retardation, with or without accompanying brain damage;
- Preschool children: Identifying the gifted, the emotionally disturbed, or consulting in schools for the handicapped;
- School-age chi1dren- helping them with learning and behavioural problems or perhaps working with a high school drug-abuse programme;
- Young adults - vocational guidance; premarital counselling and sex education;
- Parents - child rearing problems marital problems;
- The elderly - geriatric or retirement problems.
- Individuals of all ages with chronic illnesses such as mental illness, cancer, hypertension, diabetes

Figure 4.3: *A medical psychologist working with a baby*
Source: *http://www.our-africa.org/images/doctor-checking-the-health-of-a-baby-in-uganda/@@images/f84f2372-1bb8-47fe-9469-99adcd7c8a04.jpeg*

4.2 What Clinical Psychologist Do

What clinical psychologists do in the daily execution of their duties broadly involve:

Figure 4.4: *Clinicalpsychologists' daily execution*

1. Description of human behaviour

For a perfect understanding of a person's mental health predicament to be achieved, an accurate description of the individual and the contexts in which he or she lives has to be made. Such description should comprise the client's present behaviour without leaving out how he/she behaved before the psychological problem began.

The clinical psychologist tries to identify a specific pattern of behaviours, thoughts, or feelings that characterize the difficulties his/her client is experiencing so as to determine if these problems are unique or have similarities to challenges experienced by other people. After some initial information has been obtained about a person, clinical psychologists must formulate a series of questions to systematically gain more information.

Figure4.5:*Mental health predicament*
Source: *http://www.ifred.org/wp-content/uploads/2014/04/Ahmed-Adan-Ahmed.jpg*

These questions should be guided by a sound theory of human behaviour and by research findings regarding the problems of the individual client. The questions may address the strengths and weaknesses of the client, identifying what other aspect of life the client may have experienced success or satisfaction as well as the future plans regarding the current problem(s).
This will enable the clinical psychologist develop a careful and detailed description of the scope and nature of client's problem(s). The most important observations and descriptions are those that focus on consistent patterns of problematic behaviours across individuals and within the same individual over time.
For example, the clinical psychologist would need to determine if the problem is representative of a larger group of individuals who display a similar pattern of behaviours due to their developmental stage in life (childhood, adolescence, adulthood, old age) or their having gone through some traumatic experiences such as war, divorce of parents, rape, loss of a job and so on.

Figure 4.6:*Mental trauma*
Source:*https://bossip.files.wordpress.com/2014/04/black-woman-frustred-with-man.jpg?w=700*

To achieve a concise description of behaviour that other mental health professionals can relate to, a clinical psychologist uses standardized systems for classification (taxonomies) of mental problems such as the diagnostic and statistical manual of mental disorders (DSM). They also describe how they arrive at the classification by describing the tool(s) used for the measurement of the problem(s), and documenting the frequency of occurrence of the problem(s).

2. Explanation of human behaviour
Human behavior refers to the array of every physical action and observable emotion associated with individuals, as well as the human race as a whole. While specific traits of one's personality and temperament may be more consistent, other behaviors will change as one moves from birth through adulthood.
In addition to being dictated by age and genetics, behavior, driven in part by thoughts and feelings, is an insight into individual psyche, revealing among other things attitudes and values.
This task includes the development and testing of models of etiology or cause, including but

not limited to the use of experimental methods to test causality. The explanation enterprise of psychological science and of psychological practice involves the generation of hypotheses about an individual or a problem, hypotheses that can then be carefully and rigorously tested.
The clinical psychologists develop explanations of problematic behaviour using questions as guidelines for research. They may explain psychological problems emphasizing the role of biological factors, cognitive schemas and networking, conditioning and learning processes, interpersonal relationships, and an integration of one or more of these factors.

3. Prediction of human behaviour

The most stringent and necessary test of any explanation is to see if it leads to predictions that are supported by empirical research. The importance of prediction, like description and explanation, is evident in the work of psychologists helping individuals as well as in the work of clinical researchers trying to understand a problem in the general population.
Prediction is possible only through repeated observations in which conditions are either controlled or well understood. In research, prediction is tested in two ways: (a) longitudinal studies of the course of problems as they occur in real life; and (b) experimental studies testing specific predictions or hypotheses under controlled circumstances. In both methods, the goal of clinical psychologist is to try to identify cause and effect relationships regarding important clinical problems.

4. Change of human behaviour

Naturally, there are basically two typess of change: evolutionary and disruptive. Evolutionary change is gentler, less destructiv but it takes a very long time. Disruptive change on the other hand is fast, and sometimes necessary – but extremely destructive. Human beings are clever, though. They have figured out how to speed up evolutionary change (selective breeding programs) and how to contain disruptive change (managed forest fires)
Clinical psychology involves the application of psychological knowledge to alleviate human problems, it is not enough for clinical psychologists to describe, explain, or predict human functioning.
Clinical psychologists must also be concerned with producing change in people's lives. Specifically, clinical psychologists develop and carry out planned and controlled interventions for the treatment and prevention of psychopathology, for coping with and prevention of some forms of physical illness, and for the promotion of psychological and physiological health. Facilitating change is a goal of researchers and practicing clinicians alike.
Efforts to change people's lives must be based on research evidence that allows the clinician to make reasonable predictions about the effects of specific interventions. Clinical psychologists are concerned with developing much more than a set of techniques for helping people change. They are committed to developing a broad set of principles to understand how and why people change.
Clinical psychologists are more than technicians who can follow a set of procedures

designed to help a person deal with a problem or change some aspect of his or her behaviour. Clinical psychologists need to understand whether certain techniques work with some people or some problems and not others, and they need to understand the reasons that these techniques work.

Without this type of comprehensive understanding of the mechanisms of how people change, psychologists cannot continue to systematically improve the ways that they can help people, and they may be unaware of ways to generalize their current methods to different people or problems.

In-Text Question

What clinical psychologists do in the daily execution include the following except_____?

A. A description of human behaviour
B. An explanation of human behaviour
C. A mind of human behaviour
D. The changing of human behaviour

In-Text Answer

C. A Mind of human behaviour

4.3 The Duties of Clinical Psychologists

Basically a clinical psychologist expected to carry out assessment, treatment, teaching and research in relation to mental health and adjustment problems.

(1)Assessment and Diagnosis - Assessment involves the use of psychological methods and principles to gain better understanding of psychological attributes and problems. It consists of collecting information related to behavioural repertories, cognitive functioning and emotional states of people.

Figure 4.7: *Emotional imbalance*
Source:*http://cdn.physorg.com/newman/gfx/news/2011/blackmenatbo.jpg*

The information can be collected to diagnose psychological problems, choose techniques of

intervention and treatment, do vocational guidance, select candidates for a vacancy, obtain complementary data from a previous assessment, select possible participants in a certain psychological research, establish a base-line of a particular behaviour which may be matched with post-treatment changes and some other purposes.

The question of whether a patient is clinically depressed and/or intellectually deteriorating is a difficult one to answer merely by interviewing him or watching his behaviour on the ward. In such a case, the psychologist may be asked to administer tests which have been devised specifically to distinguish between the two types of disorder.

In general, the most used instruments are some kind of tests, questionnaires, interviews, observation techniques and psycho-physiological devices. The clinical psychologist may thus use personality, intelligence, cognitive, perceptual, learning and memory tests for diagnostic purposes and psychotherapeutic evaluation.

Frequently a combination of these procedures are often used together to gather information to aide in diagnosis. Diagnosis should be understood as the output of a psychological assessment process. It involves identifying and labelling behavioural, cognitive, emotional or social problems of a person, group or community.

Based on diagnosis best line of intervention is decided and sometimes the client may be referred to psychiatrists or general practitioners for medical evaluation if it is suspected that client may have an underlying medical condition or chemical imbalance that may require prescription medication.

(2) Treatment - Treatment involves clinical interventions on people with the purpose of understanding, relieving and solving psychological, emotional, cognitive and behavioural disorders.

Clinical psychologists use different types of evidence-based treatment techniques such as behaviour therapy, cognitive therapy, cognitive behavioural therapy (CBT), logo therapy, interpersonal therapy, or any other depending on the psychologist's theoretical orientation, preference, training and/or needs of the client to help patients overcome their presenting problems.

These techniques are typically applied in a one-on-one session with the client or sometimes in group sessions and can be carried out by one or more psychologists as a team. The duration of treatment usually takes between five to forty sessions (once or twice a week) but it also may be so short as a session and so long as it takes several years.

Figure 4.8: *One on One session (treatment) with a client*
Source:*http://psychassociatesgroup.com/images/beta/Rotating/AboutUs/PsychAssociatesGroup4.jpg*

Normally the average session duration takes between half an hour and one hour, but it also may change according to type of therapy and circumstances.

(3) Teaching and Supervision - Teaching involves the sharing of skills and knowledge with other members of the mental health team in order to enhance a greater understanding of the psychological dimension of a patients problems.
The training courses associated with each of these professions recognize the importance of grounding in psychology and attempt to provide some coverage of the main topics. In addition, the psychologist often finds himself carrying out more specialized forms of teaching in higher institutions of learning.

Figure 4.9: *Sharing skills*
Source:*http://eeas.europa.eu/delegations/ghana/images/content/press_corner/2015/20150528_en_01_conference.jpg*

Psychologists can be dedicated to teaching accredited psychology courses leading to a partial or full degree in areas of personality, psychopathology, abnormal psychology, clinical assessment, psycho diagnosis, behaviour therapy or modification, psychotherapy,

intervention and treatment techniques, community interventions, research design and others. Supervision of a practicum is a special kind of teaching where clinical psychologists provide their professional expertise to students training. In a general sense, the model consist of students attending sessions considered suitable for them, and also carrying out some task with a client, always controlled by the supervisor. In any case, clients always know that they are dealing with training students and the person in charge is the supervisor. This supervision may be individual or in small groups. In the same way, other tasks showing professional practice to the students are usual such as tests application, correction and valuation, the use of certain methods and techniques and the attendance to clinical meetings.

Obviously, the student is also obliged to keep professional secret as clinical psychologists. The aid given to students requesting it with the purpose of planning or doing a certain research is another way of training and supervision.

The supervisor task has to be in such a manner that he/she acts as a facilitator who gives direction in terms of research design and framing of research topic and/or hypothesis without becoming the main supplier of ideas to the student. Teaching may also be directed to clients as part of a therapeutic context whenever clinical rapport implies helping people in order to make them learn new ways of behaviour to be applied in daily life situations.

(4) Research - Clinical psychologists are far better trained to conduct research projects than any of their professional colleagues. Both as undergraduates and as postgraduates, they have been schooled in the intricacies of experimental design and statistical procedures, and have been involved in a wide range of psychological experiments.

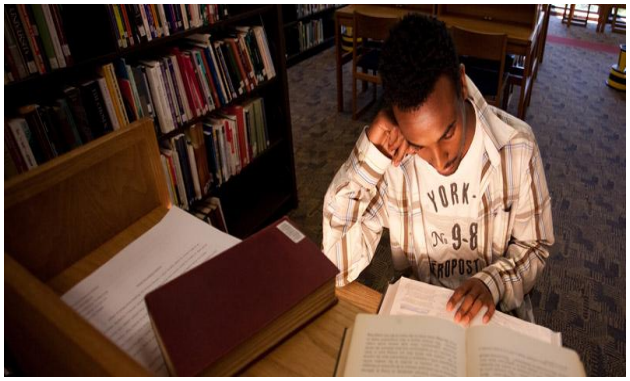

Figure 4.10: Clinical Psychologist doing research
Source:https://www.hamline.edu/ploadedImages/Hamline_WWW/_Images/Program_page_banner_images/study.jpg

It is not surprising therefore, that one of the functions of the clinical psychologist, in the psychiatric setting is not only to carry out his own research projects, but to encourage and assist others to carry out projects themselves. Some of the main types of research projects in the field of abnormal psychology are as follows:

- ❖ Carrying out animal experiments in order to set up hypotheses of psychiatric

disorders.

- ❖ Testing hypotheses regarding the precise nature of psychological disturbance in the various psychiatric groups.
- ❖ Investigating the causes of psychological disturbances.
- ❖ Comparing the effectiveness of different forms of treatment.
- ❖ Looking for signs which might enable one to predict the likelihood of a particularpatient recovering.
- ❖ Apart from these four cardinal duties of the clinical psychologist, they may also be involved in leadership, administrative and managerial roles as well as health prevention and promotion activities.

Summary for Study Session 4

In study session 4, you have learnt that

1. The activities of today's clinical psychologists are considerably broader than those of their predecessors.
2. For a perfect understanding of a person's mental health predicament to be achieved, an accurate description of the individual and the contexts in which he or she lives has to be made.
3. It is imperative that clinical psychologists develop careful models to explain how or why the problem developed, either in an individual or in people in general.
4. Clinical psychology involves the application of psychological knowledge to alleviate human problems, it is not enough for clinical psychologists to describe, explain, or predict human functioning.
5. Clinical psychologists use different types of evidence-based treatment techniques such as behaviour therapy, cognitive therapy, cognitive behavioural therapy (CBT), logo therapy, interpersonal therapy, or any other depending on the psychologist's theoretical orientation, preference, training and/or needs of the client to help patients overcome their presenting problems

Self-Assessment Questions (SAQs) for Study Session 4

Now that you have completed this study, you can assess how well you have achieved its Learning outcomes by answering the following questions. You can check your answers with the Notes on the Self-Assessment questions at the end of this study.

SAQ 4.1 (Testing Learning outcomes 4.1)

Outline the various new worksettings for clinical psychologists

SAQ 4.2 (Testing Learning outcomes 4.2)

Identify the roles of clinical psychologist in the execution of their duties

SAQ 4.3 (Testing Learning outcomes 4.3)

Explain the duties of clinical psychologist

Notes on Self-Assessment Questions

SAQ 4.1

1. University psychology or counselling departments (as teachers and researchers);
2. Psychiatric hospitals or outpatient clinics (performing research and providing clinical services);
3. Community mental health centres
4. University student health centres
5. Child guidance clinics
6. Public and private school
7. State youth authority agencies
8. Prisons (as prison psychologists)
9. Medical schools
10. Industries (as industrial management consultants

SAQ 4.2

They do the following:

a) A description of human behaviour
b) An explanation of human behaviour
c) A prediction of human behaviour
d) The changing of human behaviour

SAQ 4.3

Assessment and Diagnosis
Treatment
Teaching and Supervision
Research

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Study Session 5: Professional Training in Clinical Psychology

Expected duration: 1 week or 2 contact hours

Introduction

The issue of professional training in clinical psychology has generated a lot of debate, heated arguments, controversy, and professional rivalries among various persons in this country, the United Kingdom as well as the United States of America. However, you will be acquainted with only the training as it is in the U.S.A. and currently in Nigeria. In this study, you will also learn about clinical psychology licensure.

Learning Outcomes for Study Session 5

At the end of this study, you should be able to:

5.1 Discuss clinical psychology training in the United State of America
5.2 Discuss clinical psychology training in Nigeria
5.3 Explain clinical psychology licensure

5.1 Training in the United States

The question of the importance of meaningful norms for clinical training for clinical and other psychologists has pre-occupied the attention of clinical psychologists elsewhere. This has led to several conferences, and such conferences include the Boulder, North-western. Thayer, Stanford, and Estes Park conferences, all in the U.S.A.
Three models guide the training of clinical psychologists: They are:

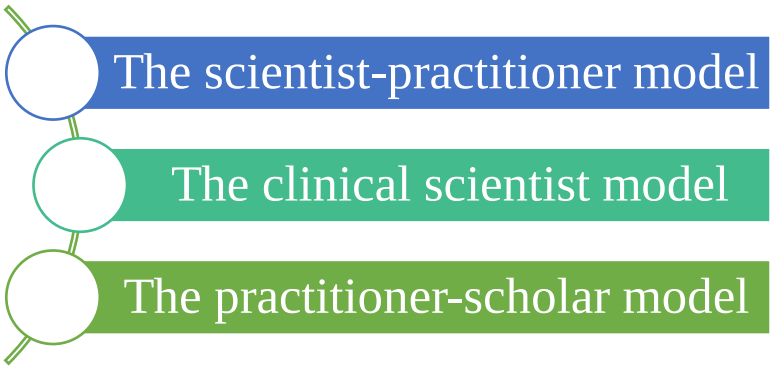

Figure 5.1: *Three models guide the training of clinical psychologists*

The scientist-practitioner model was an important upshot of a National Institute of Mental Health (NIMH) sponsored conference in Boulder, Colorado, in 1949 to develop consensual standards for education and training in clinical psychology.

Most doctoral programs awarding Ph.D. in the field maintain the scientist-practitioner model demanding academic requirements in general areas of psychology such as cognitive, developmental, physiological and social psychology as well as psychopathology and methods of assessment and intervention including supervised practical experience and a one-year pre-doctoral internship.

This was to ensure that clinical psychologist would be continually reminded of the complexity of human needs and problems and the need for continued training in assessment and treatment (Raimy, 1950). In the scientist-practitioner model, graduate students must develop and demonstrate competencies in research and psychological service provision.

The guiding philosophy underlying the scientist-practitioner model is that clinical psychologists should be capable of producing research and utilizing empirical evidence to guide their clinical services. Most programmes require a research project at the master's level and an original research dissertation for the doctoral degree.

The clinical scientist model strongly promotes the development of research skills, with the primary goal of equipping graduates to contribute to the knowledge base of psychology and related disciplines. In the 1950s and 1960s, most graduates from Boulder model programs were employed in practice settings with primary responsibility for clinical service.

These psychologists very rarely conducted any research after completing the doctoral dissertation. At a training conference in Vail, Colorado, participants expressed their dissatisfaction with the manner in which the scientist-practitioner model was applied in many training programs and developed a new model, the practitioner-scholar model, which was refined at subsequent conferences (Peterson et al., 1991).

Figure 5.2: *Clinical Psychologist training in the US*
Source: *http://www.gc.cuny.edu/CUNY_GC/media/CUNY-Graduate-Center/PDF/Psychology/Staff/4.jpg?width=3648&height=2736&ext=.jpg*

The practitioner-scholar model was designed to emphasize training in the clinical skills that most clinical psychologists would need in a service setting and to place less emphasis on research skills taught in Ph.D. programs. Programs training students in the practitioner-scholar model offered a different degree, the Psy.D. Many Psy.D.

Programs have developed research requirements that include considerable research training and the completion of a research project. Compared with Ph.D. programs, Psy.D. Programs place less emphasis on experimental designs and large sample analyses and greater emphasis on naturalistic designs and the evaluation of individual cases or service-oriented programs.

Psy.D. programs are designed to train research consumers who are informed by science in their service activities but who do not need the skills to conduct research. Ph.D. programs in professional psychology are offered by universities; Psy.D. Programs are found both at universities and in free-standing professional schools.

Many in the profession have expressed concerns about the proliferation of the free-standing schools. Critics note factors that negatively affect the quality of students' training, including larger class sizes, lower financial support, and an overreliance on part-time instructors with little experience in research or teaching (McFall, 2006).

The main distinction between Ph.D. and Psy.D. models of training is the weight given to science and practice. The American Psychological Association (APA) was the first to develop an accreditation process designed to ensure that training programs maintain standards that meet the profession's expectations for the education of clinical psychologists. The APA Committee on Accreditation evaluates the quality of clinical psychology training in both clinical training models.

A program that receives accreditation from APA has met, therefore, the high standards of training set by the profession, and graduates from the program are likely to receive some of the best training available in clinical psychology. Students are strongly advised, therefore, to seek training in an accredited clinical psychology program.

In-Text Question

In the U.S.A., the issue of clinical training in psychology has led to the following except-

___

A. New York Conference
B. Thayer Conference
C. Boulder Conference
D. North-western Conference

In-Text Answer

A. New York Conference

5.2 Clinical Training in Nigeria

There is an urgent need to create broad based goals for clinical psychology training in Nigeria. Therefore, an effort should be geared towards the development, demonstration, and popularization of our expertise in other areas of medicine such as paediatrics, neurology, ophthalmology, cardiology, public health, nursing, therapeutics (e.g. cancer treatment), and to involve our trainees in the whole spectrum of health-related problems in which a clinical psychologist has clearly substantial competence.

Figure5.3: *Clinical training in Nigeria*

Source*:http://newsexpressngr.com/images/news/Apollo.%20Dr%20Muhammed%20Sehar.jpg*

In pursuance of the goal of evolving a broad based orientation in clinical psychology, training programmes should maintain not only relations with university based, and medicine based units, but also more importantly with community based organizations-including even such privately organized groups like the Cancer Foundation, Leprosy Foundations, etc. (Uzoka, 1982, p. 14).

Uzoka further observed that the various areas of human and social welfare where the skills of a clinical psychologist can make positive contributions should be included in our training. The emphasis in our programmes seems to be too heavily on mental illness. This is

certainly part and should remain part of clinical psychology. Uzoka in his paper gave the following suggestions:

a) That all candidates for admission to clinical psychology be holders of good first degrees in psychology
b) That until we develop good screening devices only candidates with first class and second class upper honours degrees be admitted to the M.Sc. /Ph.D. degree programme.
c) That other qualified candidates be admitted to the Masters level degree and pursue programmes that have been clearly specified (Uzoka, 1982, pp. 16-17).

In-Text Question

. …….. provided the training patterns of clinical psychologists in Nigeria

A. Ebigbo
B. Bakare
C. Uzoka
D. Amantee

In-Text Answer

C. Uzoka

5.3 Licensure in Clinical Psychology Health care professionals are usually licensed by a licensing body to provide their services as they deal with issues related to human life. Like medical doctors and other health practitioners, clinical psychologists, must meet minimal requirements for their academic and clinical training and are required by law to provide ethical and competent services.

They are also regulated by a professional organization (e.g., state licensing boards) that holds them accountable for their professional activities. State licensing boards help citizens to identify qualified practitioners and have the power to suspend or remove the license of a person whose professional practice has been incompetent or unethical.

Without some form of licensing there is no regulatory body to ensure that the public is protected when receiving health care services. To be licensed as a psychologist, the person must meet requirements including education, examination, and supervised experience. Licensure requirements in clinical psychology vary from country to country.

In the United States, doctoral training is required to become a clinical psychologist. In most European countries, a master's degree is required, whereas in other countries, such as Canada, Australia, New Zealand, and Britain, doctoral-level training is preferred, although it may be possible for someone with master's-level training to become licensed as a clinical psychologist.

In some countries, such as New Zealand, registration is compulsory for psychologists working in the public sector but is optional (although strongly recommended) for psychologists in private practice. In Nigeria, there is yet to be a licensing body to grant licenses for professional practice to clinical psychologists. It is however hoped that in the

nearest future a licensing and regulatory body will be available.

Activity 5.1: Licensure in Clinical Psychology
Time Allowed: 24 hours

Speak with the clinical psychologist board in your city and find out the requirement for accreditation for professional study

Summary for Study Session 5

In Study Session 5, you have learnt that:

1. There are three models guiding the training of clinical psychologists
2. The clinical scientist model strongly promotes the development of research skills
3. The practitioner-scholar model was designed to emphasize training in the clinical skills that most clinical psychologists would need in a service setting and to place less emphasis on research skills taught in Ph.D. programs.
4. Health care professionals are usually licensed by a licensing body to provide their services as they deal with issues related to human life.
5. In some countries, such as New Zealand, registration is compulsory for psychologists working in the public sector but is optional (although strongly recommended) for psychologists in private practice.

Self-Assessment Questions (SAQs) for Study Session 5

Now that you have completed this study, you can assess how well you have achieved its Learning outcomes by answering the following questions. You can check your answers with the Notes on the Self-Assessment questions at the end of this study.

SAQ 5.1 (Testing Learning outcomes 5.1)

State the three model guide for clinical psychology training in the United State

SAQ 5.2 (Testing Learning outcomes 5.2)

Outline the suggestions Uzoka made in his paper

SAQ 5.3 (Testing Learning outcomes 5.3)

Discuss licensure in clinical psychology training

Notes on Self-Assessment Questions

SAQ 5.1

- The scientist-practitioner model
- The clinical scientist model
- The practitioner-scholar model

SAQ 5.2

a) That all candidates for admission to clinical psychology be holders of good first degrees in psychology
b) That until we develop good screening devices only candidates with first class and second class upper honours degrees be admitted to the M.Sc. /Ph.D. degree programme.

c) That other qualified candidates be admitted to the Masters level degree and pursue programmes that have been clearly specified

SAQ 5.3

To be licensed as a psychologist, the person must meet requirements including education, examination, and supervised experience. Licensure requirements in clinical psychology vary from country to country.

In the United States, doctoral training is required to become a clinical psychologist. In most European countries, a master's degree is required, whereas in other countries, such as Canada, Australia, New Zealand, and Britain, doctoral-level training is preferred, although it may be possible for someone with master's-level training to become licensed as a clinical psychologist

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Study Session 6: Research in Clinical Psychology

Expected duration: 1 week or 2 contact hours

Introduction

Clinical psychology as an applied area of scientific psychology is based on sound scientific tenets and philosophy. Therefore if one is to advance in the field and if we are to aspire to sound and orderly progress in the decades to come, comprehensive and sophisticated research is a necessity of the highest priority. In this study, you will learn the descriptive, correlational and experimental research approach.

Learning Outcomes for Study Session 6

At the end of study, you should be able to

6.1 Discuss the descriptive research method used by clinical psychologists.

6.2 Discuss the Correlational research method used by clinical psychologists

6.3 Explain the Experimental research approach is the process

6.1 Descriptive Research

Generally, in research, there are three important considerations and these are

- consensual validation - others must be able to see what the researcher is seeing
- Reliability/replicability - the research must be able to be repeated with similar results
- Validity - the research must measure what it intends to measure.

The outstanding characteristic of the descriptive research is its focus on phenomena as they are. Descriptive studies usually do not manipulate or control events. Rather, they attempt to define and identify important factors.

This type of investigation covers a wide spectrum, from broad surveys of public opinion to behavioural studies of specific hospital, school, or other population. Interviews, questionnaires, and natural-environmental observation are commonly used in these studies. Data obtained with these instruments are then translated into the descriptive statistics of frequency counts, averages, and standard deviations.

Figure 6.1: *Descriptive Research involving survey*
Source: *http://webapp2.wright.edu/web1/newsroom/files/2015/07/nigerian-educatiors-16040_004.jpg*

Observational studies make up one class of descriptive research. For example, frequency of conversational interchanges between residents of a hospital ward, an average sleep time of depressed subjects, comparison of years in therapy of depressed versus schizophrenic patients are all subject of representative of observational research.

In-Text Question

Descriptive research is not concerned with ……..

A. Manipulation
B. Investigation
C. Observation
D. Collecting data

In-Text Answer

A. Manipulation

6.2 Correlational Research

Correlational research like descriptive research, does not manipulate the variables that it examines. Rather, this approach takes the description of events or individuals one step further, to evaluate relationships between existing variables.
Correlation is the analysis of how variables interrelate, associate and influence each other. What is the relationship between parental divorce and children's aggressive behaviour? Is there a correlation between overcrowded living conditions and the incidence of neurotic behaviour?

Box 6.1: Definition of Correlational Research

Correlation is the analysis of how variables interrelate, associate and influence each other.

These questions typify the correlation approach. It is important to note that correlation indicates nothing about cause and effect. A correlation between parental divorce and children aggression does not mean the divorce caused the aggression - only that they tend to

occur together.

In-Text Question

Correlational research is concerned with how variables are ……..

A. Interrelated
B. Associated
C. Influenced each other
D. Rectified

In-Text Answer

D. Rectified

6.3 Experimental Research

Experimental research is the process of hypothesis testing in which investigators manipulate variables and make objective observations of the effects of the variables on specified behaviours.

A variable is any factor, event, or phenomenon that may assume different values, i.e., that may have variable magnitudes. Variables can be environmental factors (heat, light, sound), physiological factors (fatigue, body injury), or psychological factors (attitudes, learned behaviours).

Figure6.2: *Experimental Research*
Source*: http://leadership.ng/wp-content/uploads/2015/10/LIBRT-300x225.gif*

In experimental research, variables are usually divided into those variables that experimenters manipulate (the independent variables) and those they measure or observe (dependent variables). Although many factors may be present in research studies, it is important to recognize that not all of them are experimental variables.

The researcher will usually speak of controlling for confounding or extraneous variables. Thus strict control of experimental variables increases the probability that predictions based on the research findings will prove correct.

Activity 6.1: Descriptive Research

Time Allowed: 2hours

Perform a descriptive research on a topic of interest.

Summary for Study Session 6

In study session 6, you have learnt that

1. Descriptive studies usually do not manipulate or control events. Rather, they attempt to define and identify important factors.
2. Correlational research like descriptive research, does not manipulate the variables that it examines.
3. Correlation is the analysis of how variables interrelate, associate and influence each other.
4. Experimental research is the process of hypothesis testing in which investigators manipulate variables and make objective observations of the effects of the variables on specified behaviours

Self-Assessment Questions (SAQs) for Study Session 6

Now that you have completed this study, you can assess how well you have achieved its Learning outcomes by answering the following questions. You can check your answers with the Notes on the Self-Assessment questions at the end of this study.

SAQ 6.1 (Testing Learning outcomes 6.1)

Define the focus of descriptive research

SAQ 6.2 (Testing Learning outcomes 6.2)

Explain correlational research

SAQ 6.3 (Testing Learning outcomes 6.3)

Discuss experimental research

Notes on Self-Assessment Questions

SAQ 6.1

Descriptive studies usually do not manipulate or control events. Rather, they attempt to define and identify important factors.

This type of investigation covers a wide spectrum, from broad surveys of public opinion to behavioural studies of specific hospital, school, or other population. Interviews, questionnaires, and natural-environmental observation are commonly used in these studies.

SAQ 6.2

Correlational research like descriptive research, does not manipulate the variables that it examines. Rather, this approach takes the description of events or individuals one step further, to evaluate relationships between existing variables. Correlation is the analysis of how variables interrelate, associate and influence each other.

SAQ 6.3

Experimental research is the process of hypothesis testing in which investigators manipulate

variables and make objective observations of the effects of the variables on specified behaviours.

In experimental research, variables are usually divided into those variables that experimenters manipulate (the independent variables) and those they measure or observe (dependent variables).

Reference

Edwards, A.L. (1972). Experimental Designs in Psychological Research.

Study Session 7: Clinical Psychology and the Community

Expected duration: 1 week or 2 contact hours

Introduction

The most recent revolutionary development in psychology and the mental health fields in general involve a variety of approaches to behavioural and social problems that implicate the community both as a causative factor and as a potentially therapeutic agent.
Clinical psychology as an applied field of general psychology and as a profession has over the years revolutionized its practices and services to reflect the contemporary needs of the people it is meant to serve. This has evolved what is today known as community psychology.

The most recent revolutionary development in psychology and the mental health fields in general involves a variety of approaches to behavioural and social problems that implicate the community both as a causative factor and as a potentially therapeutic agent.
Clinical psychology as an applied field of general psychology and as a profession has over the years revolutionized its practices and services to reflect the contemporary needs of the people is meant to serve. This has evolved what is today known as community psychology. In this study, you will learn about community psychology, goals of community psychology and community psychology and crisis intervention.

Learning Outcomes for Study Session 7

At the end of this study, you should be able to:

7.1 Define the terms of community psychology
7.2 Identify the goals of community psychology
7.3 Discuss community psychology and crisis intervention

7.1 Definitions of Terms

There are several terms of community psychology. They are:

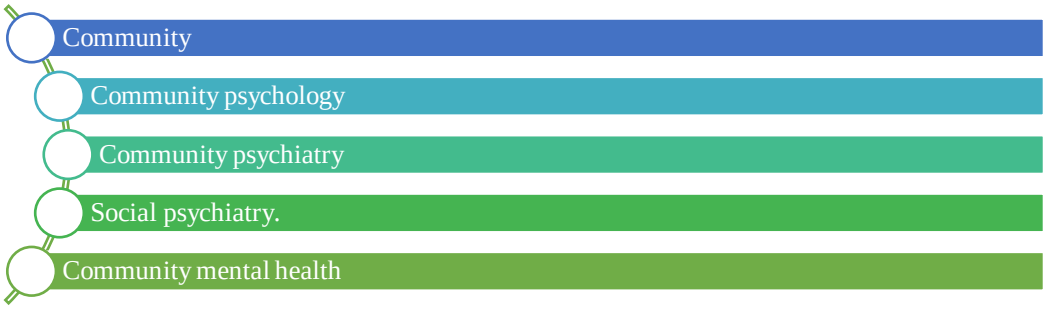

Figure 7.1: *Terms of community psychology*

(a) Community: There are over a hundred definitions of this term. It can mean such divers things as a group of scholars ('the scientific community'), ethnic groups ('the Hausa community') and neighbourhoods ('the community of farmers').

(b) Community psychology: This is regarded as an approach to human behavioural problems that emphasizes contributions made to their development by environmental forces as well as the potential contributions to be made toward their alleviation by the use of these forces.

(c) Community psychiatry: "Community psychiatry is the use of community resources in addition to interpersonal and intrapersonal resources to help mentally ill and emotionally disturbed people achieve greater personal and social adequacy"
(Loab, 1969, p. 235). Caplan (1965) asserts that community psychiatry deals with entire populations, all age, cultural, and socio economic groups whether agency cases or not. He goes even further in specifying that part of the preventive function of the community psychiatrist is to collaborate actively with a variety of civic leaders and government administrators in an effort to reshape the structure of the community to make it a psychologically healthier place in which to live.

(d) Social psychiatry: The term social psychiatry usually brings to mind preventive community programmes, industrial and forensic psychiatry, group therapy, the participation of psychiatry in administrative medicine, the utilization of the social milieu in treatment, and the study of social factors in the aetiology and dynamics of mental illness (Leighton in Goldston, 1965, p. 198).
This definition places the major emphasis on the application of social psychiatry to a number of psychiatric problems. In summary, however, when social psychiatry is viewed as having a basic applied component, it overlaps considerably with most definitions of community psychiatry.
When it is regarded as primarily an area of study and research, social psychiatry maintains a separate existence as a potentially useful contributor to community psychiatry because it is devoted to understanding the effects on individual behaviour of the social forces that the community psychiatrist seeks to manipulate.

(e) Community mental health: "Community mental health encompasses all activities which are involved in the discovery, development, and organization of every facility in a community which effects all attempts which the community makes to promote mental health and to prevent and control mental illness" (Howell and Goldston, 1965, p. 197).

Community psychologists are seen as "change agents, social systems analysts, consultants in community affairs and students generally of the whole man in relation to all his environments," (Bennett, 1965, p. 833).
Since community psychology and other current community approaches are, at least, in part, outgrowths of clinical psychology and psychiatry, the historical roots of these disciplines are to be found in the same-soil. Essentially, community psychology may be viewed as a theoretical outlook and a method of practice that has evolved out of clinical psychology.

In-Text Question
The idea that Community psychiatry is the use of community resources in addition to interpersonal and intrapersonal resources to help mentally ill and emotionally disturbed people achieve greater personal and social adequacy is not entirely true. True or False

In-Text Answer
False

7.2 Goals of community psychology
Community psychology has been variously defined since it was founded in Swampscott, Massachusetts, in 1965. Community psychology focuses on social issues, social institutions and other settings that influence groups and organizations as well as individuals in them, with the primary goal being to optimize the well-being of communities and their citizens with innovative and alternative interventions (Duff & Wong, 1996)
This definition deserves a closer appraisal. The social issue crucial to this course is mental disorder. Like clinical psychologists, community psychologists are extremely interested in this issue. Community psychology also have a strong interest in other disaffected groups like the homeless, school drop outs, juvenile delinquents and the elderly because they too are community members.

Box 7.1: Focus of Community Psychology

Community psychology focuses on social issues, social institutions and other settings that influence groups and organizations as well as individuals in them, with the primary goal being to optimize the well-being of communities and their citizens with innovative and alternative interventions

As mentioned in the definition, the primary goal of community psychology is to enhance the well-being of individuals, groups, organizations and communities. Enhancing well-being is another goal of clinical psychology. Beyond this link however, clinical and community psychology part ways.
Other goals of community psychology include prevention rather than treatment of social problems; examination of extra-personal (i.e. environmental and social) causes of disordered behaviour; an emphasis on empowerment; choices among available interventions and treatments; and the development of a sense of community.

The Prevention Goal: Community psychologists rely on community level interventions such as education and alteration of the environment to reduce the likelihood of mental disorders. One method of achieving this is through mental health education. In this type of education, people acquire knowledge skills and attitudes that directly contribute to their mental health and to their effect on the mental health of others.

The purpose of mental health education is to teach people how to think instead of just instructing them on what to think (Cowen, 1980). In this way people learn to make responsible choices and decisions and to feel a sense of responsibility for their own well-being.

In other words, mental health education ensures the ability to think well, which paves the way for emotional relief, which in turn prevents dysfunction (Shure & Spivack, 1988).

Caplan 1964, distinguished between three types of preventive efforts:

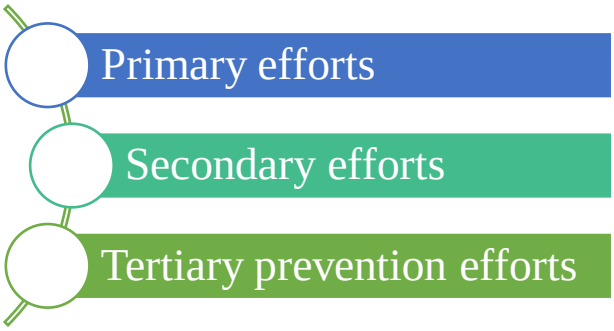

Figure7.2: *Types of preventive efforts*

P

rimary prevention efforts are geared towards reducing the incidence of mental disorders of all types in the community. This prevention programs could be targeted at high risk groups who are particularly vulnerable to emotional and behavioural disorders before the problem even starts such as adolescents, children from broken homes, divorced or bereaved, retirees etc.

For instance, education about healthy and safe habits (e.g. eating well, exercising regularly, not smoking)

Secondary prevention is an effort geared towards reducing the prevalence of mental disorders by shortening the duration, reducing the symptoms, limiting the consequences, and minimizing their effects on others.

In this way, partial prevention is achieved through early diagnosis and effective treatment of individuals who exhibit signs of emotional disturbance. For instance, regular exams and screening tests to detect disease in its earliest stages (e.g. mammograms to detect breast cancer)

Tertiary prevention is aimed at limiting the disability and promoting the rehabilitation of individuals with mental disorders. By returning such individuals to their productive capacity as quickly as possible, the social and occupational life of the community is improved. For instance, cardiac or stroke rehabilitation programs, chronic disease management programs (e.g. for diabetes, arthritis, depression, etc.)

The Goal of Ecological perspective: community psychologists are highly interested in the

person-environment fit- the suitability of the person to the setting and the setting to the person. To assure such fit, an ecological perspective is extremely important. This perspective recognizes that there exists a transaction between people and setting.

Individuals influence the settings in which they find themselves; settings influence the individuals in them (Seidman, 1990). Establishing an optimal match between the individual and the environment is a goal of community psychology. In this way, they eschew labelling people who do not fit well into a particular setting as 'misfits'. Similarly, they avoid controlling the environment simply to control the individual in it.

Empowerment: This is the process of enhancing the possibility that people can more actively control their own lives (Rappaport, 1987). In other words, community psychologists try to keep people from feeling powerless. However the service to individuals is indirect. Rather, they provide the tools, environments and information that engender collaboration so that affected individuals can do things for themselves

Choices among alternative interventions: As part of the recognition of uniqueness and diversity, community psychologists recognize that one intervention or one community service probably will not help all individuals equally well. So, they seek to establish a number of alternative services in various communities in recognition of the diversity in our communities. As part of this diversity of population and services, community psychologists also concur that accessibility is of utmost importance. A service that is not readily available has no client base.

A sense of community: Research has demonstrated that subjective sense of wellbeing is often positively related to the sense of community or the sense of belonging in the community (Davidson & Cotter, 1989). Sense of community is the feeling of the relationship an individual holds for his or her community (Heller, Price, Reinharz, Riger & Wandersman, 1984).

Specifically, sense of community includes a perception of similarity to others in the community, a willingness to maintain and acknowledge interdependence with others and the feeling that one is part of a larger, dependable and stable structure (Sarason, 1974). Community and sense of community relate to mental health in a number of ways.

Firstly, alternative care for the mentally disordered typically involves settings in which a smaller number of clients are served compared to the large number served by a psychiatric hospital. One might conclude that such smaller settings result in a greater sense of community and/or a greater sense of self-efficacy.

Secondly, some communities do not want alternative facilities in their neighbourhoods (Miller, 1982). Community residents give many reasons for rejecting alternative services such as psychosocial clubs and group homes.

Because residents usually have very little information about mental illness and therefore stereotype and stigmatize the mentally ill as dangerous, the residents fear that patients will commit crimes or will be inadequately supervised by the staff. Other residents may feel if they accept one such service, other such services will follow and thus property values may decrease (Arce, 1978, Johnson and Beditz, 1981).

In-Text Question
The primary goal of community psychology is to enhance the well-being of individuals, groups, organizations and communities. True or False

In-Text Answer
True

7.3 Community Psychology and Crisis Intervention
Have you ever seen someone in crisis before? A crisis is provoked when a person faces an obstacle to important life goals that is for a time insurmountable through the utilization of the customary methods of problem solving (Cplan, 1961). Typically, the crisis situation is followed by a period of disorganization and emotional upset, during which the individual makes various abortive attempts at a solution.

Crises are produced by two sources of stress. One source of stress can consist of external events such as death in the family, natural disaster, sudden loss of job etc. The second source of stress is related to internal conditions such as desire to commit suicide, acute alcoholism, depression etc. The most common type of crisis is associated with loss, or impending loss of a loved one, a prized job, health, or physical strength.

Figure 7.3: *Crisis-loss of a loved one*
Source: *http://www.sierraherald.com/ebola-grief.jpg*

Crises associated with situations such as death are of short duration, especially if the normal grief process has ensued. Developmental or existential types of crises, such as going off to school, entering the army, or facing a conflict choice, are usually more prolonged. Kubler-Ross (1975) has described the five stages persons facing death go through; denial and isolation, anger, bargaining, depression, and acceptance.

The task of the clinical and community psychologists is to help patients or clients work through these stages and the same time helping them to regain their pre-crisis psychological well-being through crisis intervention.

As psychologists have begun to think in community mental health terms, it has become evident that changes must be made both in how clinical services are traditionally delivered and what populations are customarily served.

If the focus is to be on prevention, early detection, and rapid intervention to help

individuals maintain themselves in their communities, local programmes must be established to provide inexpensive, easily accessible, short-term treatment aimed directly at resolving immediate problems. Therefore community psychologists must be concerned with crisis detention, intervention and resolution.

Activity 7.1: Crises Intervention and Community Psychology
Time Allowed: 2hours

Watch a video clip on crises Intervention in relation to community psychology

Summary for Study Session 7

In Study Session 7, you have learnt that:

1. Community psychiatry is the use of community resources in addition to interpersonal and intrapersonal resources to help mentally ill and emotionally disturbed people achieve greater personal and social adequacy.
2. Community mental health encompasses all activities which are involved in the discovery, development, and organization of every facility in a community which effects all attempts which the community makes to promote mental health and to prevent and control mental illness
3. Community psychology focuses on social issues, social institutions and other settings that influence groups and organizations as well as individuals in them, with the primary goal being to optimize the well-being of communities and their citizens with innovative and alternative interventions
4. A crisis is provoked when a person faces an obstacle to important life goals that is for a time insurmountable through the utilization of the customary methods of problem solving

Self-Assessment Questions (SAQs) for Study Session 7

Now that you have completed this study, you can assess how well you have achieved its Learning outcomes by answering the following questions. You can check your answers with the Notes on the Self-Assessment questions at the end of this study.

SAQ 7.1 (Testing Learning outcomes 7.1)

Define Community Psychology

SAQ 7.2 (Testing Learning outcomes 7.2)

Identify the three types of preventive measures

SAQ 7.3 (Testing Learning outcomes 7.3)

Explain crises intervention in community psychology

Notes on Self-Assessment Questions

SAQ 7.1

This is regarded as an approach to human behavioural problems that emphasizes contributions made to their development by environmental forces as well as the potential contributions to be made toward their alleviation by the use of these forces

SAQ 7.2

Primary efforts
Secondary efforts
Tertiary prevention efforts

SAQ 7.3

A crisis is provoked when a person faces an obstacle to important life goals that is for a time insurmountable through the utilization of the customary methods of problem solving.

Crises are produced by two sources of stress. One source of stress can consist of external events such as death in the family, natural disaster, sudden loss of job etc. The second source of stress is related to internal conditions such as desire to commit suicide, acute alcoholism, depression etc.

The task of the clinical and community psychologists is to help patients or clients work through these stages and the same time helping them to regain their pre-crisis psychological well-being through crisis intervention.

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Study Session 8: Classification & Diagnosis in Clinical Psychology

Expected duration: 1 week or 2 contact hours

Introduction

Classification system helps psychologists arrive at a diagnosis for psychological disorders. In this study, you will learn about the various approaches to classification and diagnosis of mental disorders, diagnostic and statistical manual of mental disorders and the uses of a diagnostic system.

Learning Outcomes for Study Session 8

At the end of this study, you should be able to:

8.1 Highlight the various approaches to classification and diagnosis of mental disorders
8.2 Discuss the diagnostic and statistical manual of mental disorders
8.3 State the uses of a diagnostic system.

8.1 Approaches to Classification and Diagnosis of mental disorders

Classification is at the core of any science. It is necessary for the ordering and labeling of objects or experiences to enhance communication amongst scientist without which there would be no advancement in knowledge.

The term itself is very broad but basically refers to any effort to construct groups or categories and to assign objects, people or experiences to the groups based on their shared characteristics. This grouping based on shared attributes is referred to as nomothetic strategy.

If the classification is in a scientific context in the classification of entities for scientific purposes such as insects or rocks or if the subject is psychology, it is often referred to as taxonomy. If the taxonomic system is applied to psychological or medical phenomena or other clinical areas, it is called nosology. Nomenclature describes the names or labels of the disorders that make up the nosology such as anxiety, or mood disorders.

For a classification system to be useful, it has to be both reliable and valid. For it to be reliable, it has to describe specific subgroups of symptoms that are clearly evident and can be readily identified by experienced clinicians such that if two clinicians interviewed the same patient on the same day (all things being constant), they both should be able to make similar diagnosis. If otherwise then the classification system would appear unreliable and hence subject to bias.

A system of nosology is valid if it consistently measures what it is designed to measure. The classification system has construct validity if the signs and symptoms chosen as criteria for the presence of the diagnostic category consistently discriminate the disorder from other categories of disorders.

In addition, a valid diagnosis predicts the course of the disorder and the likely effect of one treatment or another. This is called predictive validity and sometimes criterion validity if the outcome is the criterion by which we judge the usefulness of the category. There is also the content validity which means that the criteria for a diagnosis should reflect how most experts in the field view the diagnosis as opposed to other forms of diagnosis.
Different approaches have been used in the classification of medical conditions mental disorders over the years. They include:

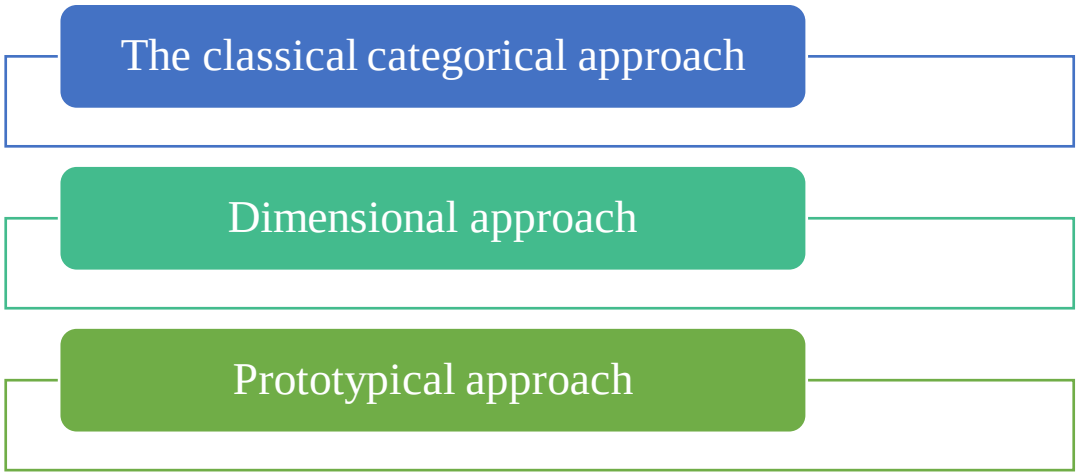

Figure 8.1: *Different approaches in the classifications of medical conditions mental disorders*

8.1.1 Classical Categorical Approach

Classification can be based on this approach if an object is determined to either be a member of a category or not. The underlying assumption is that there is an important qualitative difference between objects that are members of a category and those that are not. An extreme example of a categorical approach is to classify objects as either living or non-living.
This approach emanated from the work of Emil Kraeplin (1856-1926) and the biological tradition in the study of psychopathology. Here it is assumed that every diagnosis has a clear underlying cause such as viral or bacterial infection, a malfunctioning endocrine system, or any other physiological, psychological or cultural factor and that each disorder is unique having unique features that do not overlap with other disorders
.

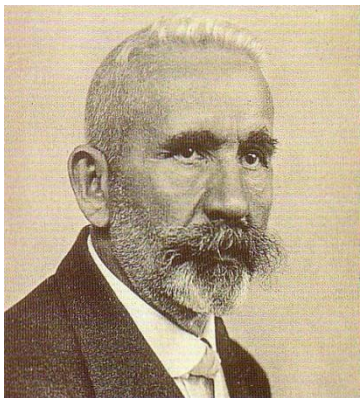

Figure 8.2:*Emil Kraeplin (1856-1926)*
Source: *https://c2.staticflickr.com/4/3007/3051358028_d823b8e3e4.jpg*

This implies that if there are a set of criteria for a particular diagnosis to be made then all criteria most be present for that diagnosis to be made and given this condition, the clinician will be able to tell the cause of the disorder. This approach though quite useful in medicine is not so effective in the mental health field in determining the causes of psychological disorders.

While a trained physician may be able to tell if a patient complaining of a fever accompanied by stomach ache is having an infected appendix or just a stomach upset based on a close examination of signs and symptoms and hence determine what treatment will be effective, a clinical psychologist may not be able to so easily determine the cause of depression in a patient.

This is because most psychological disorders are caused by an interaction of emotional, social and biological factors.

In-Text Question

Classical categorical approach to classification originated from the work of _____

A. Emil Kraeplin
B. Kendell Kablensky
C. Emil Kablensky
D. Emil Kendell

In-Text Answer

A. Emil Kraeplin

8.1.2 Dimensional Approach

In contrast to the classical categorical approach, a dimensional approach to classification is based on the assumption that objects differ in the extent to which they possess certain characteristics or properties.

This approach focuses on quantitative differences among objects and reflects the assumption that all objects can be arranged on a continuum to indicate the degree of

membership in a category. In this approach, the variety of cognitions, moods and behaviours presented by the patient are noted and quantified on a scale of say 1 to 10.
An increasing number on the rating scale indicates the severity of presenting signs and symptoms for the specific condition. Though dimensional approaches have been applied to psychological disorders, most theorists have not been able to come to a consensus on how many dimensions are required.

8.1.3 Prototypical Approach

This third strategy for organizing and classifying behavioural disorders is a categorical approach that combines some of the features of the classical (pure) categorical and dimensional approaches. The prototypical approach identifies certain essential characteristics of an entity so it can be classified while also making allowance for certain nonessential variations that do not necessarily change the classification.
In describing a dog for instance, you can use a general description (the essential categorical characteristics) that distinguishes a dog from other four legged animals like cats, cows and goats without delving into the specifics of colours, sizes or species (the nonessential dimensional variations). Thus this approach to classification of a psychological disorder requires that a certain number of the different possible features of the disorder are met out of all the possible features for a diagnosis to be made.
Applying the prototype model to psychiatric diagnosis implies that not all people receiving the same diagnosis have exactly the same set of symptoms. Though this system is not perfect as some symptoms may apply to more than one disorder, it has the advantage of fitting best into our current state of knowledge of psychopathology and it is relatively user friendly.

Box 8.1: Defining the prototypical approach

The prototypical approach identifies certain essential characteristics of an entity so it can be classified while also making allowance for certain nonessential variations that do not necessarily change the classification.

8.2 Diagnostic and Statistical Manual of Mental Disorders

Clinical psychologists utilize the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association to determine whether a set of symptoms or behaviors meets the criteria for diagnosis as a psychological disorder. The DSM uses a categorical classification system.

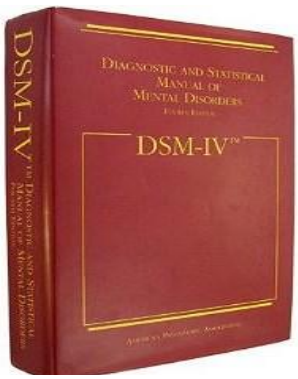

Figure8.3:*Diagnostic and Statistical Manual of Mental Disorders (DSM)*
Source: *http://psychcentral.com/blog/wp-content/uploads/2011/06/dsmiv.jpg*

The categories are prototypes, and a patient with a close approximation to the prototype is said to have that disorder. The 5th edition of the diagnostic and statistical manual of mental disorders (DSM-5) was released on the 18th of May 2013.
There are some changes in the current edition of the DSM when compared to the fourth and earlier editions. While the DSM-IV organized each psychiatric diagnosis into a multiaxial system made up of five dimensions relating to different aspects of disorder or disability, DSM-5 has moved to a no axial documentation of diagnosis. Below is the DSM-IV multiaxial system of diagnosis.

Axis I: Clinical Disorders and Related Conditions
Axis II: Personality Disorder and Mental Retardation
Axis III: General Medical Conditions (Related to Mental Disorders
Axis IV: Psychosocial and Environmental Problems
Axis V: Global Assessment of Functioning (GAF)

DSM-5 uses a single axis system that combines the former Axes I-III, with separate notations for important psychosocial and contextual factors (formerly Axis IV) and disability (formerly Axis V).
Also, certain terminologies used in DSM-IV such as Not Otherwise Specified (NOS) used as a "catch-all" for patients who didn't fit into the more specific categories has been eliminated in DSM-5 and replaced with Not Elsewhere Classified (NEC) which will typically include a list of specifiers as to why the patient's clinical condition doesn't meet a more specific disorder.

The phrase "general medical condition" is replaced in DSM-5 with "another medical condition" where relevant across all disorders.

The new DSM-5 has three sections and an appendix. Section I is titled DSM-5 Basics and covers: Introduction and Use of Manual. Section II is titled Diagnostic Criteria and Codes and covers DSM-5 Organization.docx. Section III is titled Emerging Measures and Models covering assessment measures and cultural interviews.

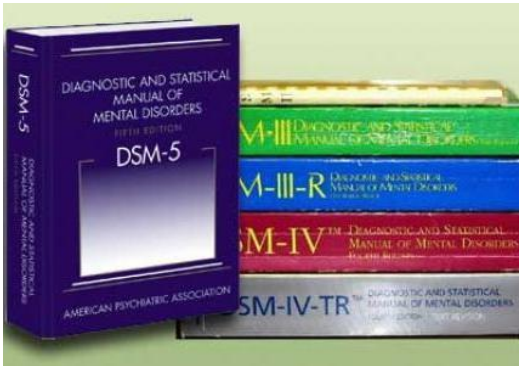

Figure 8.4:*DSM -5*
Source:*http://www.brainphysics.com/sites/default/files/images/dsm-books.preview.jpg*

The diagnostic criteria for some disorders were changed, the names for some disorders were adjusted (e.g., pedophilia disorder was renamed pedophilic disorder), and some disorders were removed while new disorders (such as excoriation (skin-picking) disorder and hoarding disorder)were also introduced.
The disorders listed in Section II of the DSM-5 are: neurodevelopmental disorders, schizophrenia spectrum and other psychotic disorders, bipolar and related disorders, depressive disorders, anxiety disorders, obsessive-compulsive and related disorders, trauma-Others include: stressor-related disorders, dissociative disorders, ssomaticsymptom and related disorders, feeding and eating disorders, sleep–wake disorders, ssexual dysfunctions, gender dysphoria; ddisruptive, impulse-control, and conduct disorders; substance-related and addictive disorders, neurocognitive disorders, paraphilic disorders and personality disorders (18 groups of disorders in all).

In-Text Question

Section I is titled DSM-5 Basics and covers _____

A. Introduction and Use of Manual.
B. DSM-5 Organization.docx
C. Assessment measures and cultural interviews.
D. DSM-4

In-Text Answer

A. Introduction and Use of Manual.

8.3 The Uses of a Diagnostic System

The classification and diagnostic system is useful in the following ways:
1. Provide a concise description of essential aspects of the patient's condition
2. Reflect best current scientific knowledge of psychopathology
3. Provide a common language for clinicians and researchers to use in discussing mental health conditions.

4. Indicate possible causes of the current condition (i.e., etiology)
5. Indicate possible future developments in the condition (i.e., prognosis)
6. Provide guidance on possible co-existing problems or conditions that should be evaluated
7. Provide guidance on treatment options to be considered
8. Provide a key term that can be used by clinicians to search the scientific literature for most current information on the condition
9. Provide a framework for determining reimbursement of health services and eligibility for special programs or services.

Despite the advantages of diagnosis, there are also possible drawbacks, such as stigmatization of the person receiving the diagnosis and the potential for an inaccurate diagnosis to result in harmful or inappropriate treatment.

A reality faced by most health care providers (whether practicing in an institutional setting such as a hospital or in a private practice setting), is that it is necessary to diagnose a patient to determine whether the patient is eligible for certain services (e.g., extra academic support for students with learning disabilities).

Furthermore, many managed health care companies require a diagnosis before they will agree to reimburse the clinician for services.

Activity 8.1: Diagnostic and Statistical Manual of Mental Disorders
Time Allowed: 2 hours

Read through the Diagnostic and Statistical Manual of Mental Disorders

Summary for Study Session 8

In study session 8, you have learnt that

1. Classification is at the core of any science and it is necessary for the ordering and labeling of objects or experiences to enhance communication amongst scientist without which there would be no advancement in knowledge.
2. An extreme example of a categorical approach is to classify objects as either living or non-living.
3. Though dimensional approaches have been applied to psychological disorders, most theorists have not been able to come to a consensus on how many dimensions are required.
4. Applying the prototype model to psychiatric diagnosis implies that not all people receiving the same diagnosis have exactly the same set of symptoms.
5. Clinical psychologists utilize the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association to determine whether a set of symptoms or behaviors meets the criteria for diagnosis as a psychological disorder
6. Diagnostic system Provide guidance on possible co-existing problems or conditions that should be evaluated

Self-Assessment Questions (SAQs) for Study Session 8

Now that you have completed this study, you can assess how well you have achieved its Learning outcomes by answering the following questions. You can check your answers with the Notes on the Self-Assessment questions at the end of this study.

SAQ 8.1 (Testing Learning outcomes 8.1)

Highlight the various approaches to the classification and diagnosis of mentaldisorders.

SAQ 8.2 (Testing Learning outcomes 8.2)

Outline the disorders listed in Section II of the DSM-5 are

SAQ 8.3 (Testing Learning outcomes 8.3)

State the uses of a diagnostic system

Notes on Self-Assessment Questions

SAQ 8.1

- The classical categorical approach
- Dimensional approach
- Prototypical approach

SAQ 8.2

Neurodevelopmental disorders, schizophrenia spectrum and other psychotic disorders,bipolar and related disorders, depressive disorders, anxiety disorders, obsessive-compulsive and related disorders, trauma-

SAQ 8.3

1. Provide a concise description of essential aspects of the patient's condition
2. Reflect best current scientific knowledge of psychopathology
3. Provide a common language for clinicians and researchers to use in discussing mental health conditions.
4. Indicate possible causes of the current condition (i.e., etiology)
5. Indicate possible future developments in the condition (i.e., prognosis)

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Study Session 9: Assessment in Clinical Psychology

Expected duration: 1 week or 2 contact hours

Introduction

Having discussed classification and diagnosis in clinical psychology in the previous study session, you will therefore in this study session be introduced to clinical assessment, steps involved in clinical assessment, the clinical interview, explain the different types of clinical interview, the factors affecting effective interviewing.

Learning Outcomes for Study Session 9

At the end of this lecture, you should be able to:

9.1 Define clinical assessment
9.2 Explain the clinical interview and state how it differs from regular conversations.
9.3 Discuss the different types of clinical interview
9.4 Enumerate the uses and factors affecting effective interviewing

9.1 Clinical Assessment

Assessment involves the appraisal of individuals as a basis for decision making. Clinical assessment is the systematic evaluation and measurement of psychological, biological and social factors in a person presenting with a possible psychological disorder.

Psychological assessment entails the gathering and integration of various types of data from multiple sources and perspectives; at a minimum, this involves information provided by the client and information based on the psychologist's observation of the client during a clinical interview.

The term assessment incorporates a wide variety of activities, ranging from descriptive assessment which describes the symptoms of a client as an aid to diagnosis, to functional assessment which determines the situational and behavioural features that serve to maintain maladaptive behaviour, to prescriptive assessment that prescribes types of interventions that are most likely to be beneficial.

The assessment process is systematic and as such goes through some orderly steps.

Table 9.1: The steps involve in the assessment process

First step	This step requires the psychologist to formulate some questions addressin the purpose for referral or request for assistance made by either a individual or by significant others such as parents, physician, religiou leader or teacher, on behalf of an individual.

Second step	In this step, a psychologist determines what he/she hopes to accomplis during the assessment process in order to decide on the type c information that would be relevant.
Third step	The third step entails identifying the standards by which the collecte information will be interpreted.
Fourth Step	The actual collection of the relevant information is the fourth step in th assessment process which involves the collection of information regardin the individual, his/her environment and a detailed description of th individual's behaviour and appearance. Clinical interview is almos always one component of data collection and may include specialise form of interview known as the mental status examination.
Step five	Decision making and judgment based on the collected data is the fifth ste in the assessment process. When decision making is based on researcl based formula to diagnose, classify or predict behaviour then th psychologist is using actuarial judgment

Structured interview schedules, observation, behavioural assessment and psychological testing also provide information relevant to assessment. It should be noted however, that sometimes, clinicians base their judgement on intuition in which case the psychologist may intuitively sense that a patient is suicidal and make decision based on this though the patient does not exhibit any of the research-based characteristics suggestive of his/her intuition.

In this case he/she is using clinical judgment. Although actuarial judgment is usually superior, clinical psychologists still rely heavily on clinical judgment. Finally, the psychologist must communicate his/her opinion, judgments and decisions to significant others either verbally or in the form of a psychological assessment report.

In-Text Question

_____ involves the appraisal of individuals as a basis for decision making
(A).Assessment. (B)Assessment process (C).Assessment structure (D). Assessment analysis

In-Text Answer

(A).Assessment
Reports have to be well written as they function as a permanent and positive guide for the referral source and for others who may work with the client/patient later. The clinical assessment process is often guided by psychological theory and research making it a more systematic and scientific method of creating opinions about people than how it is ordinarily done among people in our daily experience.

9.2 How clinical interview differs from regular conversations.

Interview has been defined as a form of conversation wherein two people or more people engage in verbal and non-verbal interaction for the purpose of accomplishing a previously

defined goal Maccoby (1954) are more specific about the kind of interaction, when they define the interview as "a face-to-face verbal interchange, in which one person, the interviewer attempts to elicit information or expressions of opinion or belief from another person.

Figure 9.1: *Maccoby*
Source:*http://www.fabbs.org/files/6312/7929/1399/Maccoby.jpg*

In the interview, the verbal expression of the respondent must be directed towards the interviewer in response to the interviewer's questions or comments." Khan and Cannell (1958) see the interview as necessarily' being restricted in scope and 'focused on some specific content area, with consequent elimination of extraneous material.'

They see the important feature of the interview as 'a pattern of interaction in which the role relationship of interviewer and respondent is highly specialized.' A clinical interview is a dialogue between psychologist and patient that is designed to help the psychologist diagnose and plan treatment for the patient. It is often called 'a conversation with a purpose.

The various definitions considered together cover the main features of the clinical interview which are:

(a) That it must be a face-to-face meeting between two or more people who must be able to see, hear and understand one another.
(b) That it must be conducted for some specific purpose which is known by the interviewer, and usually by the client as well.
(c) That the range of topics for discussion is deliberately restricted and controlled by the interviewer who attempts to elicit information or expressions of opinion from the client.
(d) That specific roles are adopted by both interviewer and client.

It is however vital to note that an interview for the clinical psychologist is not a cross-examination but rather an opportunity for the clinical psychologist to be attentive to the client's body language such as facial expression, making of eye contact, body postures and gestures as well as how the client says what he or she says in response to questions such as the pitch of voice, rate of speech, and stuttering.

Also, interview is not often exclusively used as a method of assessment but rather it is employed in conjunction with a number of other methods of assessments such as projective and non-projective tests which will be discussed in study session10. It however provides the

necessary background upon which the decision to have further psychological assessments is based.

Table 9.2: There are several key differences between a conversation with a friend and a clinical interview:

Clinical interview	Conversation with a friend
A clinical interview is purposeful - to make a diagnosis	A conversation with a friend is not often focused on a single issue but rather the discussion could drift from one topic to another.
There are clearly defined roles between the clinical psychologist and the client in a clinical interview	Unlike in a conversation with a friend
The clinical psychologist does most of the Questioning and the interview is basically about client/patient	In contrast, in everyday conversation between friends, any of the friends could ask question as necessary
Also, a clinical interview takes place within a pre-determined time frame	Unlike a normal conversation that can start and end at any time.

In-Text Question

The various definitions considered together cover the main features of the clinical interview, state any one

In-Text Answer

It states that, it must be a face-to-face meeting between two or more people who must be able to see, hear and understand one another.

9.3 Types of Interview

The clinical psychologist conducts various types of interviews. The purpose of the interview determines the type to be adopted. Some of the available types of interviews are:

1. The intake interview
2. The case history interview

3. Structured interview
4. Mental status examination interview
5. The crisis interview
6. Diagnostic interview

1. The Intake Interview

The intake interview otherwise called the admission or point of entry interview is conducted at the first contact with the client. It aims to have a better insight into the client/patient's presenting problems by attempting an appraisal of the patient's circumstances as efficiently as possible so as to decide on the most suitable mode of intervention.

Primarily, the interviewer is interested in identifying the exact reason for the client/patient seeking help, the type of help that is desired and if the help had been sorted from elsewhere before coming. Though the intake interview is often short, it is particularly vital in offering the right kind of help to the potential client/patient.

Some patient may desire or be in need of interventions which the particular clinic they have visited may not be equipped to give. The intake interview thus enables the interviewer to quickly determine and give appropriate referral as soon as it is discovered that the client/patient cannot be helped where he/she has sorted help thus saving everyone's time including that of the client/patient.

It should be noted that every patient will not be able to state coherently what the nature of his trouble may be. Moreover, there may be other non-verbal details which the interviewer might observe and record that could be helpful later during intervention. No gain saying that a poorly conducted intake interview would be expensive in terms of time spent on treatment while a well conducted intake interview could save time.

2. Case History Interview

Immediately after the intake interview, the interviewer takes the socio-personal history of the client/patient. A typical case history interview seeks information on client/patient's name, address, date of birth, early life, nature of family relationships, and physical environment of upbringing, his/her educational and vocational history, medical history, drug taking history, as well as other details.

Information is obtained not just from the client/patient but also from members of client/patient's social network. Information from significant others such as family members, friends, neighbours and others is necessary because in most cases, the client/patient is unable to concisely and accurately communicate the necessary social and personal information.

This may be needed to get a full understanding of the origin of the client's problems as well as the factors maintaining the problem. Moreover, it also serves as a check and balance in case the client/patient is a less than truthful information. The primary aim of conducting the case history interview is to get ample information that will aid in making accurate diagnosis and in the design of an appropriate intervention to help client/patient.

3. Structured Interview Schedules

In an effort to increase the reliability and validity of clinical interviews, a number of structured interviews have been developed. These interviews include very specific questions asked in a detailed flow chart format such that if a patient answers yes to particular question (for example, about OCD obsessive compulsive disorder), a list of additional questions might be asked to obtain details and clarification.

One of the most popular structured clinical interviews is the Structured Clinical Interview for DSM Disordersor SCID**.** Structured clinical interviews contain standardized questions to ensure that each patient is interviewed in the same way. These questions usually ask about the nature, severity and duration of symptoms.

The goal is to obtain necessary information, to make an appropriate diagnosis, to determine whether a patient is appropriate for a specific treatment or research program, and to secure critical data that are needed for patient care. The advantage of this approach is that variations between interviewers are minimized, which tends to improve the reliability of the interview.

The most significant weakness however, is that the approach lacks efficiency as the process takes substantially longer time than the traditional diagnostic interview and patients often end up responding to questions for which the answers are almost foregone conclusions. Also the lack of flexibility may cause the interviewer to overlook promising avenues of enquiry not covered in the schedule.

4. Mental Status Examination Interview

A mental status examination (MSE) interview is a semi-structured interview often conducted to assess the client's level of emotional and mental functioning. The typical MSE interview comprise a brief observation and evaluation of the patient's appearance and behaviour in the interview, speech characteristics, mood, thought processes, insight, judgment, attention, concentration, memory, and orientation.

Outcome of the client's mental status examination often provides the initial data on the probable psychiatric diagnosis as well as offering some suggestions for additional appraisal and possible intervention. For instance, mental status interviews typically include question and tasks to verify client's orientations in time (e.g., "what is today's date?

What day of the week is today?), place (e.g., Where are you? What is the name of the hospital are you in?"), and person ("Who am I? Who are you?"). Also, the MSE assesses long, intermediate and short term memory (e.g. "Where did you attend primary school?", "What did you have for dinner", "I am going to name three places and I'd like you to repeat them in the same order:

Lagos, Calabar, and Belgium") and concentration (e.g., "count backwards in 5s from 100"). During the examination the interviewer notes any unusual behaviour or answers to questions that might be indicative of a psychiatric disturbance. While the MSE is often a useful assessment tool, it can be subject to bias as it is based on the interviewer's clinical judgment during evaluation.

5. The Crisis Interview

A crisis interview occur when the patient is in the middle of a significant and often traumatic or life threatening crisis. The psychologists or the mental health professionals (e.g., a trained volunteer) might encounter such a situation while working at a suicide or poison control hotline, an emergency room, a community mental health clinic, a student health service on campus, or in many other settings.

The nature of the emergency dictates a rapid, "get to the point" style of interview as well as quick decision making in the context of a calming style. For example, it may be critical to determine whether the person is at significant risk of hurting him or herself or others.

Or it may be important to determine whether the alcohol, drugs, or any other substances are used, so as to make sure that the clinician interviews the person in a calming and clear headed manner while asking critical questions in order to deal with the situation effectively.

The interviewer may need to be more directive (e.g., encouraging the person to phone the police, unload a gun, provide instructions to induce vomiting, or step away from a tall building or bridge); break confidentiality if the person (or someone else, such as a child) is in serious and immediate danger; or enlist the help of others (e.g., police department, ambulance).

6. The Diagnostic Interview

The purpose of the screening or diagnostic interview is to assist the clinician in his attempt tounderstand the patient.If the level of diagnostic understanding required is merely a separation of the fit from the unfit, as in military neuro-psychiatric examinations, the interview task is one of screening.

That is, after a brief interview the interviewee could be adjudged fit for specific duties, such as a regular military assignment, or he may be referred for prolonged observation and extended psychological testing. Occasionally, limit or trial duty may be recommended as an alternative to regular duty of psychological observation.

Upon other occasions the diagnostic task is highly specific, and a detailed level of understanding is required. This may involve a diagnostic label as categorized as "paranoid schizophrenia" and a description of personality dynamics. In this later case primary dependence is not placed upon the interview alone, for psychological tests play a most important role in such detailed diagnostic procedures.

In the diagnostic interview, while the examination progresses; the interviewer observes the interviewee's behaviour as well as noticing the content of his answers. An observation of a client's thighs pressed together, a mincing walk, and fluttery feminine gestures in a male should lead the interviewer to suspect and investigate the possibility of homosexuality.

The bubbling, enthusiastic replies and exaggerated gestures in another interviewee should lead the interviewer to hypothesize tentatively a manic condition and seek further evidence. Thus this kind of interview is used to ascertain whether an individual needs help or not.

9.4 Uses and factors affecting effective interviewing

Interviews are the most common and inexpensive strategy for gathering information that cannot be easily assessed in psychometric tests but which are undoubtedly important in case formulation, problem definition, goal setting and making of diagnosis.

Apart from being a source of invaluable information to the psychologist, the clinical interview also serves as a tool for developing rapport and a sense of collaboration between the client and the psychologist in the process of resolving the challenge that has brought the client to the psychologist.

The uses of the clinical interview may be classified under three headings which are:

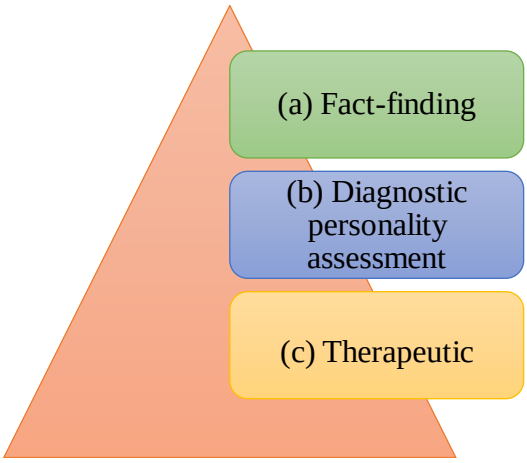

Figure 9.2: *Uses of clinical interview*

Any such classification is bound to be artificial since each category overlaps the other two. Any interview tends to be therapeutic in the sense that the client may benefit in some way from his encounter with the interviewer. Diagnostic and personality assessment interviews involve a great deal of fact-finding, and fact-finding interviews yield pointers to diagnosis and personality.

In-Text Question

Following are the uses of clinical interview except _____

A.Fact-finding

B.Diagnostic and personality assessment

C.Therapeutic

D. Structured interview

In-Text Answer

D. Structured interview

However, the classification is probably useful as it defines the goal of the interview in question. The fact-finding interview is designed to elicit matters of fact rather than of opinion. This information is something the client possesses and which need not be about

him or concern him directly. The diagnostic or personality assessment interview is usually directed to eliciting data from, and about the client himself.
The therapeutic interview seeks to change the client in some way, to modify his attitudes, opinions and behaviour, rather than just to learn about them. In practice, the clinical interview may be partly fact-finding, will certainly be diagnostic and may prove to be therapeutic as well.

9.4.1 Factors Affecting Interviews

Whether the outcome of an interview will be useful or otherwise is often determined by various factors. These factors could range from the physical setting of the interview to the lack of the adequate skills on the part of the interviewer or the lack of willingness to cooperate on the part of the client. Some of the factors that could affect the outcome of an interview are discussed below.

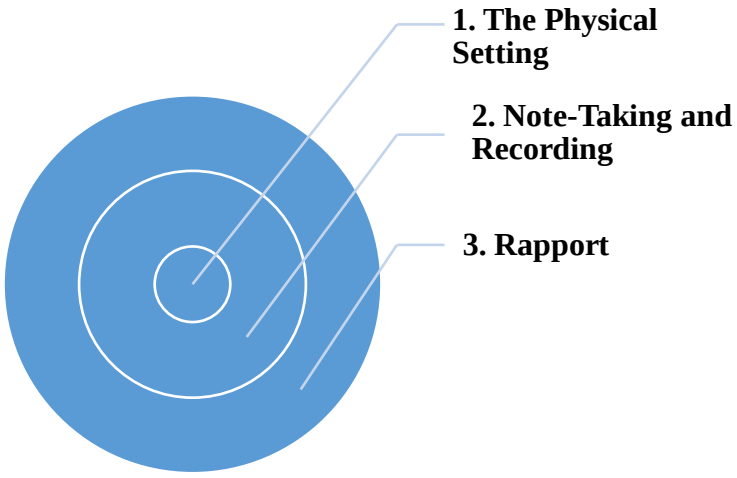

Figure 9.3: *Factors Affecting Interviews*

1. The Physical Setting

An interview should be conducted in a neat, comfortable and well ventilated environment. The physical setting should be such that absolute privacy is ensured without the fear of an uninvited third party listening in on the conversation. There should also be freedom from interruption due to unnecessary noise or people moving in and out of the office that could interfere with the flow of thought and communication.

2. Note-Taking and Recording

While a detailed documentation of all contacts with the client is part of the job of the clinical psychologist, care must be taken in ensuring that note taking during sessions does not adversely affect the interview process. A clinical psychologist may take a few notes to aid memory when writing the detailed report but should avoid the temptation to act as a

secretary by attempting to capture verbatim all that the client is saying.
Such an attempt is likely to distract the clinical psychologist from fully grasping the meaning behind what is being said as well as how it is being said as he/she will miss the opportunity of observing and noting the patient's body language. To overcome some of these shortcomings the clinical psychologist may opt for the option of audio or video tapping the interview after obtaining the prior permission of client/patient to do. Issues related to how interview should be documented should be discussed even before commencing the interview.

3. Rapport

Rapport describes the quality of patient-clinician relationship. Good rapport is inevitable if the purpose of the interview is to be achieved. No worthwhile result can be expected in a situation of mistrust and unclear understanding of the rationale for the interview.
The interviewer's professional skills will have an excellent opportunity to be effectively harnessed in helping the client only if the interviewer is able to establish a relationship with the client based on mutual respect, trust and a clear understanding of the purpose of the interview.

1. Tact

The client should not be rushed into giving answers to questions neither should the clinical psychologist be too eager to supply or suggest answers for a client. There is the need to be tactful in determining how long a pause should be allowed for a client to reflect on his/her responses to questions.

This is to avoid a situation where the pause becomes so extended as to make both parties (especially the client) ill at ease.Also the clinical psychologist should watch out for the possibility of excessive emotional expression and tactfully put this under check before it to gets out of hand

2. Reliability and Validity of Interview Method

Reliability and validity may also be threatened. For example, if two or more interviewers conduct independent interviews with a patient, they may or may not end up with the same diagnosis, hypothesis, and treatment plans.
Furthermore, patients may not report the same information when questioned may be several different interviews. Interviewer gender, race, age, and skill level are some of the factors that may affect patient response during an interview (Grantham, 1973).

Figure 9.4: Grantham
Source:http://image1.findagrave.com/photos/2010/339/62635748_129168650519.jpg

Emotional level may also have an impact on reporting of information. For example, personal questions regarding sexual behaviour, alcohol use, child abuse, or other sensitive issues may elicit varying responses from patients under different circumstances. Reliability and validity may be enhanced by using structured interviews, asking similar questions in different ways, using multiple interviewers, and supplementing interview information from other sources (e.g., medical records, observers, questionnaires).

Summary of Study Session 9

In this study session, you have learnt that:

1. Clinical assessment is the systematic evaluation and measurement of psychological, biological and social factors in a person presenting with a possible psychological disorder.

2. Clinical interview is a highly purposeful exercise that takes place within a predetermined time frame with specific roles being adopted by both interviewer and client.

3. Different types of interviews such as the intake, crisis, structured, case history, diagnostic and mental status examination interviews

4.Factors that could affect the outcome of a clinical interview include physical setting, note taking/recording, rapport, tact, interviewer's bias as well as the reliability and validity of the interview method.

Self-Assessment Questions (SAQs) for Study Session 3

Now, that you have completed this study session, you can assess how well you have achieved its learning outcomes by answering the following questions. Write your answers in your study diary and discuss them with your Tutor at the next Study Support Meeting. You can check your answers with the Notes on the Self-Assessment Questions at the end of this study session.

SAQ 9.1 (Testing Learning Outcome 9.1)
What is the Psychological assessment?
SAQ 9.2 (Testing Learning Outcome 9.2)
Explain the main features of the clinical interview
SAQ 9.3 (Test Learning Outcome 9.3)
Mention any three types of interview, then explain any one
SAQ 9.4 (Test Learning Outcome 9.4)
Interviews are the most common and inexpensive strategy for gathering information that cannot be easily assessed in psychometric tests but which are undoubtedly important in case formulation, problem definition, goal setting and making of diagnosis. True/False
SAQ 9.5 (Test Learning Outcome 9.4)
Highlight factors affecting Interviews

Notes on SAQS

SAQ 9.1

Psychological assessment entails the gathering and integration of various types of data from multiple sources and perspectives; at a minimum, this involves information provided by the client and information based on the psychologist's observation of the client during a clinical interview.

SAQ 9.2

1. That it must be a face-to-face meeting between two or more people who must be able to see, hear and understand one another.
2. That it must be conducted for some specific purpose which is known by the interviewer, and usually by the client as well.
3. That the range of topics for discussion is deliberately restricted and controlled by the interviewer who attempts to elicit information or expressions of opinion from the client.
4. That specific roles are adopted by both interviewer and client.

SAQ 9.3

1. The intake interview
2. The case history interview
3. Structured interview

The Intake Interview: The intake interview otherwise called the admission or point of entry interview is conducted at the first contact with the client. It aims to have a better insight into the client/patient's presenting problems by attempting an appraisal of the patient's circumstances as efficiently as possible so as to decide on the most suitable mode of intervention.

The case history interview: Immediately after the intake interview, the interviewer takes the socio-personal history of the client/patient. A typical case history interview seeks information on client/patient's name, address, date of birth, early life, nature of family relationships, and physical environment of upbringing, his/her educational and vocational

history, medical history, drug taking history, as well as other details.

SAQ 9.4

True

SAQ 9.5

1. The physical setting
2. Note-taking and recording
3. Rapport

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Study Session 10: Testing in Clinical Psychology

Expected duration: 1 week or 2 contact hours

Introduction

Psychological testing was primarily and basically the function of the clinical psychologist. More recently, because the clinical psychologist is seen to do or conduct psychotherapy and research, behaviour therapists have frowned at the use of psychological tests within the field of clinical psychology. Despite this, the clinical psychologist cannot function at all without making use of some psychological tests.

In this study session, you will be introduced to Psychological tests, different objective and projective tests and the uses of psychological tests

Learning Outcomes for study session 10

At the end of this study session, you should be able to:

10.1 Define psychological tests

10.2 Explain Different Types of psychological tests

10.3 State the uses of psychological tests.

10.1 The Definition of Psychological Tests

Kleinmuntt (1974) defines psychological test as 'a standardized instrument or systematic procedure designed to obtain an objective measure of a sample of behaviour' (p. 69). By 'standardized' it is meant that the test should be of such a nature that it is presented in an identical fashion to all subjects.

Figure 10.1: *Kleinmuntt*

Source: *https://media.licdn.com/mpr/mpr/shrinknp_200_200/p/6/005/071/0e4/2279e97.jpg*

An 'objective measure' is a score which is arrived at by adding up certain clearly specified response characteristics in a manner which precludes any bias from the assessor. The 'sample of behaviour' implies the notion of representativeness. Clearly it is impossible to

record everything a person says, thinks and feels in his many different life situations.

In-Text Question

What is psychological test?

In-Text Answer

Psychological test is defined as 'a standardized instrument or systematic procedure designed to obtain an objective measure of a sample of behaviour'

Thus samples must be taken and some generalizations made from the hopefully representative data which are collected. Psychological tests include specific tests to determine cognitive, emotional or behavioural responses that might be associated with a specific disorder and more general tests that assess long standing personality features.

Box 10.1 Definition of psychological test

A psychological test is essentially an objective and standardized measure of the same behaviour. The key concepts in the definition are: Standardized objective, and Sample of behavior.

10.2 Types of Psychological Test

Psychological tests can be broadly classified into two which are listed in the diagram below objective test and projective test

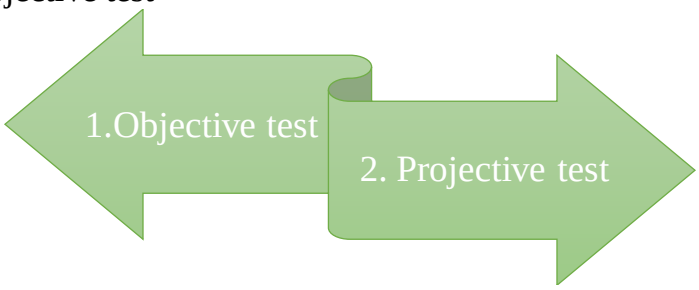

Figure 10.2: *Types of Psychological Tests*

1. **Objective Psychological Tests**

Objective tests are very structured questionnaires involving multiple choice and/or true or false questions. They are self-report questionnaires in which a person is required to respond to items that are indicative of habitual tendencies that may or may not apply to the respondent.

When these tests are developed, they are typically administered to many people to analyze how certain kinds of people tend to respond so as to establish statistical norms for the test that can serve as the basis for comparison of scores on the test. This process is called standardization.

Objective tests limit the range of response available to respondents making it possible to only respond based on the provided format. Because scoring is very straight-forward and each answer receives a certain amount of points based on a point scale, objective tests are a lot more valid and reliable than projective tests.

However, a major downfall to objective tests is that people can lie and fake their answers.

An individual could easily check off all of the desirable answers containing traits that they wish they had to make them look like a better person.

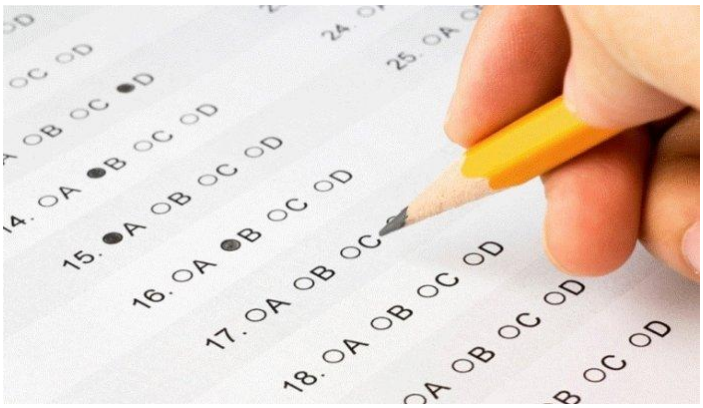

Figure 10.3: *Objective Psychological Tests*

Good examples of objective psychological test are:

- ✓ Self-report personality inventories such as the Minnesota Multiphasic Personality Inventory-2 (MMPI-2),
- ✓ The Millon Clinical Multiaxial Inventory-III (MCMI-III),
- ✓ The Sixteen Personality Factor Questionnaire (16PF) and intelligence tests such as Wechsler Adult Intelligence Scale (WAIS-IV),

Minnesota Multiphasic Personality Inventory-2 (MMPI-2) made up of 567 true/false test is a good measure of dysfunction within personality. It is less useful as a measure of healthy or positive personality traits, because its design was based on helping a professional to find a psychiatric diagnostic label that best suited an individual.

Originally developed in the 1940s, it was significantly revised in 1989 (and had another minor revision in 2001). The MMPI-2 measures personality traits such as paranoia, hypomania, social introversion, masculinity/femininity, and psychopathology, among others.

It does this by connecting an individual's responses to dozens of questions scattered throughout the test that are positively or negatively correlated with a particular personality trait. Because the questions are not always obviously related to the trait to which they are correlated, it is difficult to "fake" this test.

In-Text Question

Many psychological tests are of the objective type while others are of the _____ type.

(a) Subjective

(b) Essay

(c) Multiple choices

(d) Projective

In-Text Answer

(a) Subjective

The MMPI-2 is most often self-administered on a computer in a clinician's office in technologically advanced societies but it is also available in the paper-and-pencil format. The Millon Clinical Multiaxial Inventory-III (MCMI-III) is specifically used to arrive at a DSM-IV personality disorder diagnosis. Because it takes only about a third of the time to take as the MMPI-2, it is often preferred when a simple assessment of an individual's personality disorder is needed.

There would be a need to revise this test to align with the current DSM-5 specifications for the diagnosis of different disorders. Because the MMPI-2 is not an ideal measure for people with healthy personalities, other measures, such as the 16PF may be more appropriate. The 16PF measures 16 basic personality traits and can help a person better understand where their personality falls amongst those traits:

1. Warmth (Reserved vs. Warm; Factor A)
2. Reasoning (Concrete vs. Abstract; Factor B)
3. Emotional Stability (Reactive vs. Emotionally Stable; Factor C)
4. Dominance (Deferential vs. Dominant; Factor E)
5. Liveliness (Serious vs. Lively; Factor F)
6. Rule-Consciousness (Expedient vs. Rule-Conscious; Factor G)
7. Social Boldness (Shy vs. Socially Bold; Factor H)
8. Sensitivity (Utilitarian vs. Sensitive; Factor I)
9. Vigilance (Trusting vs. Vigilant; Factor L)
10. Abstractedness (Grounded vs. Abstracted; Factor M)
11. Privateness (Forthright vs. Private; Factor N)
12. Apprehension (Self-Assured vs. Apprehensive; Factor O)
13. Openness to Change (Traditional vs. Open to Change; Factor Q1)
14. Self-Reliance (Group-Oriented vs. Self-Reliant; Factor Q2)
15. Perfectionism (Tolerates Disorder vs. Perfectionistic; Factor Q3)
16. Tension (Relaxed vs. Tense; Factor Q4)

1. Projective Psychological Tests

Projective tests involve questions that are open-ended and relatively unstructured which allows the person being tested to have more freedom to respond as desired. The use of projective tests assumes that the respondent would be either unable or unwilling to express his or her true feelings if asked directly.

Figure 10.4: Projective *Psychological* Tests
Source:*http://www.minddisorders.com/images/gemd_02_img0100.jpg*

Freud's work on the presence and influence of unconscious processes in psychological disorders no doubt contributed to the development of projective tests. These tests include a variety of methods in which ambiguous stimuli such as pictures of people or things are presented to a person who is asked to describe what he or she sees.

The tasks presented thus, often permit an almost unlimited variety of possible responses. The basic assumption here is that people project their own personality and unconscious fears onto other people and/or objects (in this case the ambiguous stimuli) and without realizing it, reveal their unconscious thought to the therapist.

Projective tests include the Rorschach Inkblot Test, the Thematic Apperception Test (TAT), complete a story (or sentence) test and the Draw-a-Person test.Inkblot tests are a major example of projective tests. These tests are highly unstructured and the responses and outcomes can be determined and interpreted in various ways.
Responses are scored based on what shape is seen on the inkblot as well as what pattern or theme is noticeable in the individual's choices. The Rorschach Inkblot testis perhaps the best-known projective technique. In the test, a person is shown 10 inkblots one at a time, and asked to tell what the blots look like. Half the inkblots are in black, white, and shades of gray; two also have red splotches; and three are in pastel colours.

In-Text Question

Good examples of the projective techniques are the Rorschach Inkblot and the
(a) Sentence completion test
(b) Draw a person test
(c) Thematic Apperception Test
(d) Both (a) and (c).

In-Text Answer

(c) Thematic Apperception Test

Exner (1978) designed the most commonly used system for scoring the Rorschach test. The Exner scoring system concentrates on the perceptual and cognitive patterns in a person's responses derived from the location described in the inkblot, and the things in the blot that prompted the person's response.

Rorschach suggested this approach to scoring in his original manual, Psychodiagnostics: A Diagnostic Test Based on Perception (1921), but he died at the age of 38 only 8 months after publishing his 10 inkblots, and his immediate followers devised other methods of interpreting the test.

The Exner scoring system has norms, although the sample on which they are based was rather small and did not represent different ethnicities and cultures well. The Thematic Apperception Test(TAT) is comprised of 31 cards that depict people in a variety of situations. A few contain only objects and one card is completely blank. Often only a small subset of the cards is given (such as 10 or 20).

The person viewing the card is asked to make up a story about what he/she sees. The TAT is not often formally scored because it is designed to tease out recurring themes in a person's life. The stories that are created are analysed based on the themes that occur which help to identify an individual's personality as well as the pressures that they face and what each person needs internally.

The pictures themselves have no inherent or "correct" story; therefore anything a person says about the picture may be an unconscious reflection into the person's life or inner turmoil. Interpreting the stories told by the client/patient is often subjective and depends on the therapist's frame of reference as well as what the patient may say.

This has led to little reliability across raters using the TAT and doubts remain about its use in psychopathology. The construct validity of the TAT is also limited (Lilienfeld, Wood, & Garb, 2000). There are several different other ways of classifying the projective techniques and schemes have been proposed by Lindzey (1959) and based on the type of response elicited which are listed below.

Table 10.1: Characteristics of Projective Test

1. **Association techniques:** The subject responds to a stimulus with a word, an image, or precept. Example: the World Association tests and the Rorschach.
2. **Construction Techniques:** The response is a product of a complex cognitive c constructive activity. For instance, the subject may make up a story about a picture Example: the Thematic Apperception Test (TAT).
3. **Completion Techniques:** The subject is asked to complete some incomplete stimulus such as a sentence root or the beginning of a story. Example: Rotter Incomplete Sentenc Blanks.
4. **Choice or Ordering Techniques:** A number of alternative stimuli are presented. Th subject is asked to choose one or more of these alternatives on the basis of preference c arrange them in some defined sequential order. Example: Picture Arrangement Test.
5. **Expressive Techniques:** Examples: drawing and painting techniques and psychodrama.

10.1.1 Intelligence Test

The intelligence quotient (IQ) is a theoretical construct of a measure of general intelligence. It's important to note that IQ tests do not measure actual intelligence but rather they measure what is believe to be probable important components of intelligence.

IQ tests are based on the assumption that a detailed sample of a person's current intellectual functioning can predict how well he or she will perform in school, and most are individually administered.

Alfred Binet, a French psychologist, originally constructed tests to help the Parisian school board predict which children were in need of special schooling. The two primary measures used to test a person's intellectual functioning are intelligence tests and neuropsychological assessment.

Neuropsychological assessment which can take up to 2 days to administer is a very extensive form of assessment. It is focused not just on testing for intelligence, but also on determining all of the cognitive strengths and deficits of the person.

Figure 10.5:*Intelligence Test*
Source:*https://s-media-cache-ak0.pinimg.com/736x/65/fb/27/65fb27547d8449f171398b163e32be2a.jpg*

Neuropsychological assessment is most usually done with people who have suffered some sort of brain damage, dysfunction or some kind of organic brain problem, just as having a brain haemorrhage. Intelligence tests are the more common type administered. Intelligence testing has since developed into one of the largest psychological industries.

The most commonly administered tests include the Wechsler Adult Intelligence Scale, 4th edition (WAIS-IV, 2008); the Wechsler Intelligence Scale for Children, 4th edition (WISC-IV, 2003); the Wechsler Preschool and Primary Scale of Intelligence, 3rd edition (WPPSI-III, 2002); and the Stanford–Binet, 5th edition (SB5, 2003). IQ tests are regularly updated, and, like personality inventories, they are standardized.

The most commonly administered of these tests is the WAIS-IV which generally takes anywhere from an hour to an hour and a half to administer, and is appropriate for any individual aged 16 or older to take The WAIS-IV is divided into four major scales to arrive at what's called a "full scale IQ." Each scale is further divided into a number of mandatory

and optional (also called supplemental) subtests.

The mandatory subtests are necessary to arrive at a person's full scale IQ. The supplemental subtests provide additional, valuable information about a person's cognitive abilities.

Table 10.2: The four major scales and subtests of intelligence test

1 **Verbal Comprehension Scale (**Similarities, Vocabulary, Information an Supplemental Subtest: Comprehension);
2. **Perceptual Reasoning Scale (**Block Design, Matrix Reasoning, Visual Puzzles an Supplemental Subtests: Picture Completion; Figure Weights (16-69) only);
3. Working Memory Scale **(**Digit Span, Arithmetic, Supplemental Subtest: Letter-Numbe Sequencing (16-69 only);
4. **Processing Speed Scale (**Symbol Search, Coding, Supplemental Subtest: Cancellatio (16-69 only).

Beyond predicting school performance, intelligence tests are also used in conjunction with achievement tests, to diagnose learning disorders and to identify areas of strengths and weaknesses for academic planning. They also help in determining whether a person has intellectual developmental disorder (formerly known as mental retardation) and to identify intellectually gifted children so that appropriate instruction can be provided them in school.

In-Text Question

Good examples of intelligence tests are the Wechsler Adult Intelligence Scale and the ---
(a) Student Problem Inventory
(b)The Wechsler Preschool and Primary Scale of Intelligence
(c) Ravens Progressive Matrices
(d) The Rorschach

In-Text Answer

(b)The Wechsler Preschool and Primary Scale of Intelligence

10.3 Uses of Psychological Testing

Psychological testing can be found useful in the following area listed below;
1. Screening
2. Predicting Success of Therapy
3. Detecting Individual Differences
4. Diagnostic Formulations
5. Classification and Placement
6. Enhancing Self-Understanding
7. Program Evaluation
8. Performing Scientific Inquiry or Research

1. Screening: One of the principal functions of tests for the clinical or counseling psychologist is as a rough' 'screen'' for pathology. By giving a brief test battery at an

appropriate spot early in the process, the clinical psychologist can get a clearer picture of the likely issues to be faced later.
Severe pathology often does not show up until later interviews. By giving a projective technique or the MMPI, the psychologist often can obtain a clearer understanding of current or more obscure pathology.
Similarly, on intellectual variables, the psychologist often desires a quick estimate of the client's intellectual capacity and functioning in advance of more definitive data. Therefore, a short vocabulary test such as the Wechsler Adult Scale vocabulary subtest can give these data.
2. Predicting Success of Therapy: Psychological tests can provide information regarding readiness for counselling. Research studies support the statement that the rapidity of achieving successful counselling outcomes hinges on ego-strength factors such as response adaptability, capacity to test demands of reality, and undistorted perception. Therefore, the clinical psychologist can decide early in the process whether continued counselling with the client would be feasible or desirable.
3. Detecting Individual Differences :A psychological test is used to measure the individual differences, which are different between abilities of different persons and the performance of the same person at different time.

In-Text Question

_____is the Psychological tests can provide information regarding readiness for counseling.

(a) Predicting success of therapy
(b) Detecting Individual Differences
(c) Screening
(d) Diagnostic Formulations

In-Text Answer

(a) Predicting success of therapy

4. Diagnostic Formulations: The psychological tests are usually used in clinical psychology to diagnose mental disorders. Pinpointing pathological types has been and continues to be a major forte of the clinical psychologist. Projective techniques such as the Rorschach and Thematic Apperception Tests have been used along with tests such as the Wechsler Adult Intelligence Scale to give a rounded picture of the perceptual, conceptual, and affective functioning of the client.
5. Classification and Placement: A psychological test helps in classifying a number of people into different categories so that they can be appropriately placed into training programs or positions of service that best suits their ability, potential, interest or personality.
Psychological tests are helpful in selection and classifying personnel for placement in jobs that range from the simpler semiskilled to the highly skilled, from the selection of filling clerks and sales-person to top management for any of these position, however test results are only one source of information , though an important one. People could be classified

into normal and abnormal, criminal and innocent, intelligent and mentally retarded, able and disabled, fit and unfit etc

6. Enhancing Self Understanding: A psychological test provide standardized information about the abilities, capabilities, aptitudes, potentials, competencies, interest, trait and states of a person which helps in understanding one's personality and planning future prospects.

7. Program Evaluation: The effectiveness of a particular program or intervention is usually assessed by applying of some kind of achievement test to ascertain if the goal of the program has been attained.

8. Performing Scientific Inquiry or Research: Some clinical psychologists use tests for research purpose to make available information about the mental, emotional and/or personality traits of a particular person or a group of people.

In-Text Question

Program Evaluation is theeffectiveness of a particular program or intervention is usually assessed by applying of some kind of achievement test to ascertain if the goal of the program has been attained. True/False

In-Text Answer

True

Summary of Study Session 10

In this study session, you have learnt that:

1. Kleinmuntt (1974) defines psychological test as 'a standardized instrument or systematic procedure designed to obtain an objective measure of a sample of behaviour' (p. 69)
2. An 'objective measure' is a score which is arrived at by adding up certain clearly specified response characteristics in a manner which precludes any bias from the assessor.
3. Objective tests are very structured questionnaires involving multiple choice and/or true or false questions.
4. Screening is the One of the principal functions of tests for the clinical or counseling psychologist is as a rough' 'screen'' for pathology.

Self-Assessment Questions (SAQs) for Study Session 10

Now, that you have completed this study session, you can assess how well you have achieved its learning outcomes by answering the following questions. Write your answers in your study diary and discuss them with your Tutor at the next Study Support Meeting. You can check your answers with the Notes on the Self-Assessment Questions at the end of this study session.

SAQ 10.1 (Testing Learning Outcome 10.1)

1. What is an 'objective measure'?
2. The _____ implies the notion of representativeness.

(a) Sample of behaviour
(b) Sample of data
(c) Sample of observations
(d) Sample of population.

SAQ 10.2 (Testing Learning Outcome 10.2)

Mention two types of Psychological tests and explain any one

SAQ 10.3 (Test Learning Outcome 10.3)

Enumerate any five uses of psychological testing

SAQ 10.4 (Test Learning Outcome 10.4)

Briefly explain any two uses of psychological testing enumerated above

Notes on SAQS

SAQ 10.1

1. An **objective measure** is a score which is arrived at by adding up certain clearly specified response characteristics in a manner which precludes any bias from the assessor.

2. (a) The Sample of behaviour

SAQ 10.2

1. Objective Testing
2. Projective Testing

Objective tests: These are very structured questionnaires involving multiple choice and/or true or false questions. They are self-report questionnaires in which a person is required to respond to items that are indicative of habitual tendencies that may or may not apply to the respondent.

SAQ 10.3

1. Screening
2. Predicting Success of Therapy
3. Detecting Individual Differences
4. Diagnostic Formulations
5. Classification and Placement

SAQ 10.4

Screening: This is the one of the principal functions of tests for the clinical or counseling psychologist is as a rough' 'screen" for pathology.

Diagnostic Formulations: This is the psychological tests that are usually used in clinical psychology to diagnose mental disorders.

Reference:

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Lindzey, G. (1959). "On the classification of Projective Techniques." Psycho1ogical bulletin. 56,158-168.

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Study Session 11:Common Psychological Disorders

Expected duration: 1 week or 2 contact hours

Introduction

The DSM-5 defined mental disorder as "A mental disorder is a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress in social, occupational, or other important activities.

In this study session, you will be introduced to neurodevelopmental disorders, depressive disorders, anxiety disorders, obsessive-compulsive and related disorders, feeding and eating disorders and paraphilic disorders

Learning Outcomes for study session 11

At the end of this study session, you should be able to:

1. Define Neurodevelopmental Disorders
2. Discuss Depressive Disorders
3. Describe Anxiety Disorders
4. Explain Obsessive-Compulsive And Related Disorders
5. Define Feeding And Eating Disorders
6. Explain Paraphilic Disorders

11.1 Neurodevelopmental disorders

Neurodevelopmental disorders are deficiencies of the growth and development of the brain or central nervous system. They are disorders associated with widely varying degrees of difficulty which may have significant mental, emotional, physical, and economic consequences for individuals, and in turn their families and society in general that unfolds as the individual grows.

Figure 11.1 *Neurodevelopmental disorders*

Source:*http://www.howardlawpc.com/articles/ssd/files/brains.jpg*

Disorders categorized within neurodevelopmental disorders include:

(a) Intellectual developmental disorders,
(b) Communication disorders,
(c) Autism spectrum disorder,
(d) Attention-Deficit/Hyperactivity Disorder,
(e) Motor disorders and

(A) Intellectual Developmental Disorders

Intellectual Developmental Disorders has the following properties which are listed below

1. Intellectual disability
2. Global developmental delay

1. **Intellectual disability** is the term used by the DSM-5 as a more contemporary and commonly acceptable replacement for the term mental retardation which was used in DSM-IV. According to the DSM-5, intellectual disability (intellectual developmental disorder) is a disorder with onset during the developmental period that includes both intellectual and adaptive functioning deficits in conceptual, social and practical domains. For intellectual disability to be diagnosed, the following three criteria must be met:

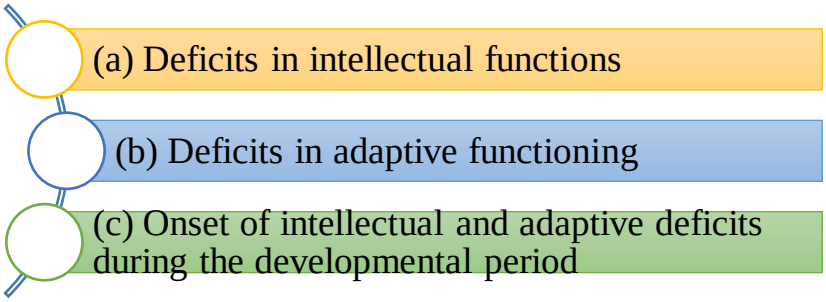

Figure 11.2: *Criteria for Intellectual Disability to be diagnosed*

(a) Deficits in intellectual functions, such as reasoning, problem solving, planning, abstract thinking, judgment, academic learning, and learning from experience, confirmed by both clinical assessment and individualized, standardized intelligence testing. Deficits in intellectual functions are determined by using standardized and culturally appropriate IQ tests.

A score of approximately two standard deviations below average represents a significant cognitive deficit. These scores would occur about 2.5% of the population. Or stated differently, 97.5% of people of the same age and culture would score higher. This is typically an IQ score of 70 or below.

(b) Deficits in adaptive functioning: This result in failure to meet developmental and socio-cultural standards for personal independence and social responsibility. Without on-going support, the adaptive deficits limit functioning in one or more activities of daily

life, such as communication, social skills, personal independence, school/work functioning.
Communication refers to the ability to convey information from one person to another. Communication is conveyed through words and actions. It involves the ability to understand others, and to express one's self through words or actions. Social skills refer to the ability to interact effectively with others.
You usually take social skills for granted. However, these skills are critical for success in life. These skills include the ability to understand and comply with social rules, customs, and standards of public behaviour. This intricate function requires the ability to process figurative language and detect unspoken cues such as body language.

(c) Onset of intellectual and adaptive deficits during the developmental period: These limitations occur during the developmental period. This means problems with intellectual or adaptive functioning were evident during childhood or adolescence. If these problems began after this developmental period, the correct diagnosis would be neurocognitive disorder. For instance, a traumatic brain injury from a car accident could cause similar symptoms.
The various levels of severity (mild, moderate, severe and profound) in intellectual disability are defined on the basis of adaptive functioning in the three domains of social, conceptual, and practical skills and not IQ scores because it is adaptive functioning that determines the level of supports required.

2.Global developmental delay: This is a term used to describe a generalized intellectual disability that is usually characterized by lower than average intellectual functioning along with significant limitations in at least two other areas of development.

Table 11.1:Common signs of global developmental delay

1. Delayed acquisition of milestones (e.g., sitting up, crawling, walking)
2. Limited reasoning or conceptual abilities
3. Poor social skills and judgement
4. Aggressive behaviour as a coping skill Communication difficulties
5. Communication difficulties.

All these aforementioned in the table above pertain to those under the age of 5years whose intellectual functioning cannot be systematically assessed.Global developmental delay has many causes which, as an end result, affect the functioning of the central nervous system. Causes can be any of the listed below

i. Genetic (e.g., Fragile X syndrome),
ii. Metabolic (e.g., PKU),
iii. Prenatal (e.g., rubella or birth trauma),
iv. Perinatal (e.g., prematurity or the result of a childhood injury or infection). Sometimes the cause for the condition is undetermined.

In-Text Question

Attention-Deficit/Hyperactivity Disorder, is a type of _____

(a) Neurodevelopmental disorder
(b) Depressive disorder
(c) Communication disorder
(d) Anxiety disorder

In-Text Answer

(a) Neurodevelopmental disorder

(B) Communication Disorders

A communication disorder is any disorder that affects somebody's ability to communicate. The delays and disorders can range from simple sound substitution to the inability to understand or use one's native language.

Communication disorder has the following types

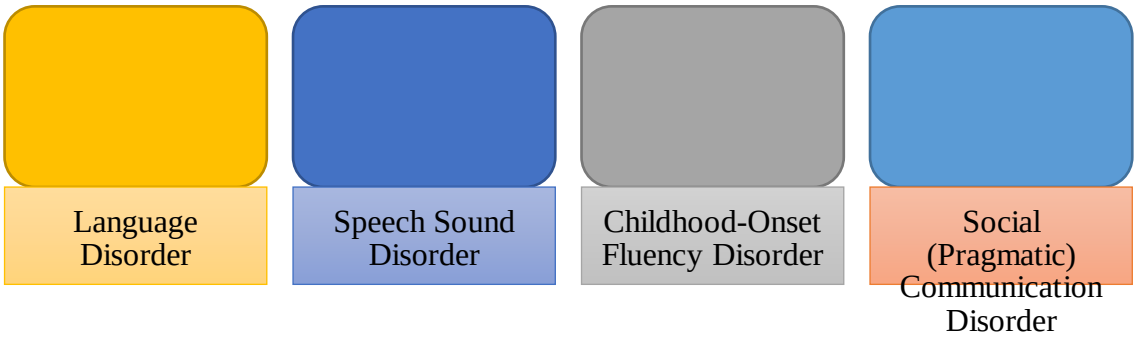

Figure 11.3: *Types of communication disorders*

i. Language Disorder: The diagnostic criteria for language disorder include "persistent difficulties in the acquisition and use of language across modalities (i.e., spoken, written, sign language, or other) due to deficits in comprehension or production" and language abilities that are "substantially and quantifiably" below age expectations.

Figure 11.4:*Language Disorder*
Source: *https://mdmedicine.files.wordpress.com/2011/05/slp.gif*

ii. Speech Sound Disorder (previously Phonological Disorder): The key diagnostic criterion for speech sound disorder includes "persistent difficulty with speech sound production that interferes with speech intelligibility or prevents verbal communication of messages."

Figure 11.5:*Speech Sound Disorder*
Source:*http://cdn.entwellbeing.com.au/wpcontent/uploads/2014/05/Effective_therapy_for_speech_disorders.jpg*

iii. Childhood-onset fluency disorder (Stuttering): The diagnostic criteria for childhood-onset fluency disorder (stuttering) are "disturbances in the normal fluency and time patterning of speech …" and the disturbance causes "anxiety about speaking.

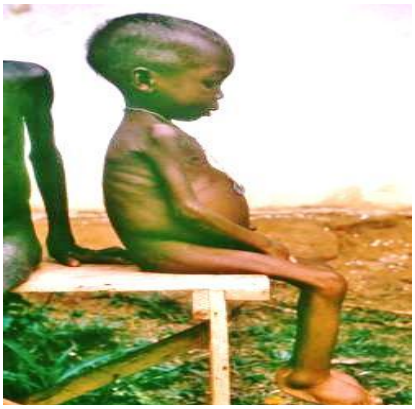

Figure 11.6:*Childhood-Onset Fluency Disorder*
Source:*https://pharmaceuticalintelligence.files.wordpress.com/2015/10/listless-child-who-was-among-many-kwashiorkor-cases.jpg*

iv. Social (Pragmatic) Communication Disorder: Social (pragmatic) communication disorder (SCD) is a new diagnosis for DSM characterized by a persistent difficulty with verbal and nonverbal communication that cannot be explained by low cognitive ability.

Symptoms include difficulty in the acquisition and use of spoken and written language as well as problems with inappropriate responses in conversation.

It includes deficits in "using communication for social purposes, impairment in the ability to change communication to match context or the needs of the listener, difficulties following rules for conversation and storytelling, and difficulties understanding what is not explicitly stated and ambiguous meaning of language.

Figure 11.7: *Social Communication Disorder*
Source:https://s-media-cacheak0.pinimg.com/236x/50/69/3d/50693ddf04538200b2287688fa98d121.jpg

(C) Autism Spectrum Disorder (ASD)
Autism is a neurodevelopmental disorder which according to the DSM-5 is characterized by persistent deficits in social communication and social interaction across multiple contexts, as manifested by deficits in social-emotional reciprocity, deficits in nonverbal communicative behaviours used for social interaction, and deficits in developing, maintaining, and understand relationships.

Severity is based on the following listed below:
1. Social communication impairments and restricted
2. Repetitive patterns of behaviour.
3. Restricted, repetitive patterns of behaviour
4. Interests, or activities, as manifested by at least two of:
   i. Stereotyped or repetitive motor movements,
   ii. Use of objects, or speech (e.g., simple motor stereotypes, lining up toys or flipping objects, echolalia, idiosyncratic phrases)
   iii. Insistence on sameness

5. Inflexible adherence to routines, or ritualized patterns of verbal or nonverbal behavior (e.g., extreme distress at small changes, difficulties with transitions, rigid thinking patterns, greeting rituals, need to take same route or eat same food every day)
6. Highly restricted, fixated interests that are abnormal in intensity or focus (e.g., strong attachment to or preoccupation with unusual objects, excessively circumscribed or perseverative interests) and
7. Hyper- or hypo reactivity to sensory input or unusual interest in sensory aspects of the environment (e.g. apparent indifference to pain/temperature, adverse response to specific sounds or textures, excessive smelling or touching of objects, visual fascination with lights or movement).

(D) Attention-Deficit/Hyperactivity Disorder (ADHD)

ADHD is a neurodevelopmental disorder that begins in childhood and can continue through adulthood for some people. ADHD is characterized by a pattern of behaviour present in multiple settings (e.g., school and home), that can result in performance issues in social, educational, or work settings.

Box 11.1: Symptoms of Attention-Deficit/Hyperactivity Disorder

Symptoms are divided into two categories of inattention and hyperactivity and impulsivity that include behaviours like failure to pay close attention to details, difficulty organizing tasks and activities, excessive talking, fidgeting, or an inability to remain seated in appropriate situations.

Children must have at least six symptoms from either (or both) the inattention group of criteria and the hyperactivity and impulsivity criteria, while older adolescents and adults (over age 17 years) must present with five.

Using DSM-5, several of the individual's ADHD symptoms must be present prior to age 12 years, compared to 7 years as the age of onset in DSM-IV. To be diagnosed of ADHD DSM-5 requires that people with ADHD show a persistent pattern of inattention and/or hyperactivity-impulsivity that interferes with functioning or development.

Symptoms of inattention can be observed in an individual who often: fails to give close attention to details or making careless mistakes in schoolwork, at work, or with other activities; has trouble holding attention on tasks or play activities; seems not to be listening when spoken to directly; fails to follow through on instructions and fails to finish schoolwork.

To be diagnosed of inattention, children up to age 16 must have six or more symptoms of inattention, adolescents 17 and older and adults must have at least five symptoms. Also, these symptoms of inattention must have been present for at least 6 months, and are deemed inappropriate for individual's developmental level.

Symptoms of hyperactivity and Impulsivity can be seen in an individual who often: fidgets with or taps hands or feet, or squirms in seat; leaves seat in situations when remaining seated is expected; runs about or climbs in situations where it is not appropriate (adolescents or adults may be limited to feeling restless).
To be diagnosed of hyperactivity and impulsivity six or more symptoms of hyperactivity-impulsivity must be present in children up to age 16, or five or more for adolescents 17 older and adults. Also, these symptoms of hyperactivity-impulsivity must have been present for at least 6 months to an extent that is disruptive and inappropriate for the person's developmental level.

(E) Motor Disorders

Motor disorders are disorders of the nervous system that cause abnormal and involuntary movements. They can result from damage to the motor system (Knierim, 2013). DSM-5 defines it as a new sub-category of neurodevelopmental disorders.
Types of Motor Disorders
Motor Disorders has three types which are:

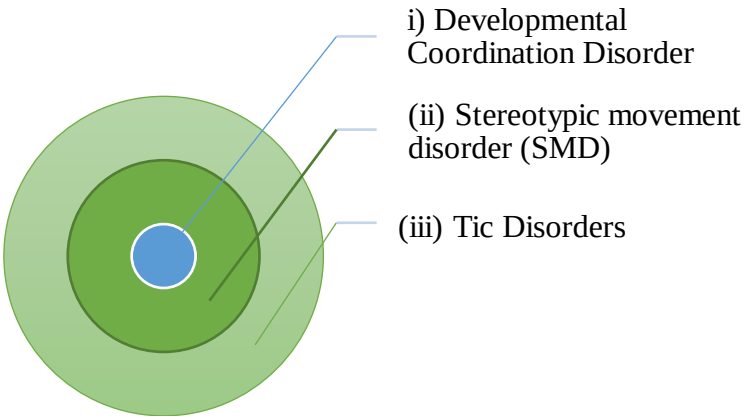

Figure 11.8: *Types of Motor Disorders*

***(i)* Developmental Coordination Disorder:**The acquisition and execution of coordinated motor skills is substantially below that expected for the patient's age and opportunities for learning. Clumsiness (dropping or bumping into objects) and slow inaccurate performance of motor skills (catching objects, handwriting, using utensils, bicycle-riding or participation in sports).
The diagnosis is made by synthesis of the developmental and medical history, physical and neurological examination, report from school or workplace and appropriate psychometric assessment.
NDSM-5, Criterion A (impaired coordination) is manifested differently at different ages: delayed motor milestones in some very young children, delay in acquiring or slowness and inaccuracy in performing skills such as stair-climbing or buttoning in older children, and slowness or inaccuracy in typing or handwriting or athletic pursuits in adolescence and adulthood.

Criterion B (impairment of motor skills interferes with daily activities) is necessary for the diagnosis. The disorder is not better accounted for by intellectual disabilities, visual problems, or a neurological condition such as cerebral palsy, or a degenerative disorder.

(ii) Stereotypic movement disorder (SMD): This is a motor disorder with onset in childhood involving repetitive, non-functional motor behaviour that markedly interferes with normal activities or results in bodily injury. The behaviour must not be due to the direct effects of a substance or another medical condition.

Common repetitive movements of SMD include head banging, arm waving, hand shaking, rocking and rhythmic movements, self-biting, self-hitting, skin-picking; other stereotypies are thumb-sucking, nail biting, trichotillomania, bruxism and abnormal running or skipping.
(iii) Tic Disorders: Tics are sudden twitches, movements, or sounds that people do repeatedly. People who have tics cannot stop their body from doing these things. A person can exhibit a motor tic (such as, blinking or shrugging the shoulders) or a vocal tic (such as humming, grunting, clearing the throat, or yelling out a word or phrase unwillingly).

Three tic disorders are included in the *DSM-5* which are:

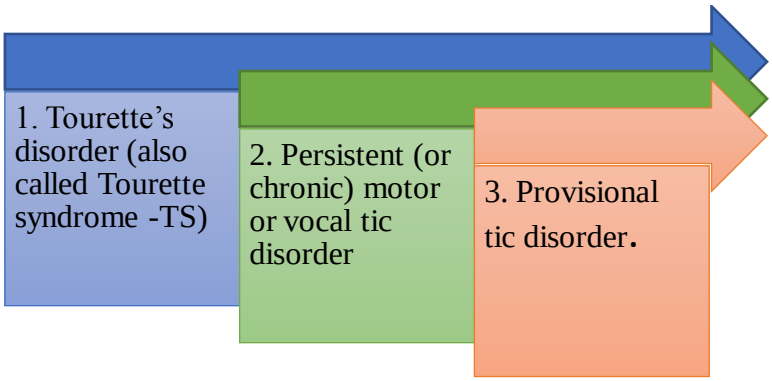

Figure 11.9: *Three Tic disorders included in the* DSM-5

The tic disorders differ from each other in terms of the type of tic present (motor or vocal, or a combination of both), and how long the symptoms have lasted.

According to the DSM-5, people with Tourette syndrome have at least two motor *and* at least one vocal tics together which may not always happen at the same time, and have had tic symptoms for at least 1 year which can occur many times a day (usually in bouts) nearly every day, or off and on.

In-Text Question

A recurrent pulling out of one's hair with repeated attempts to decrease or stop the behavior is a disorder known as _____

(a) trichotillomania

(b) kleptomania
(c) excoriation
(d) pyromania

In-Text Answer
(a) Trichotillomania

People with persistent motor or vocal tic disorders (have not been diagnosed with TS) have either motor *or* vocal tics, and have had tic symptoms for at least 1 year which can occur many times a day, nearly every day, or off and on. People with provisional tic disorders (formerly called 'transient' tic disorder in DSM-IV) can have motor or vocal tics, or both, but have had their symptoms less than 1 year.

11.2 Depressive Disorders
A depressive disorder is an illness that involves the body, mood, and thoughts. It interferes with daily life, normal functioning, and causes pain for both the person with the disorder and those who care about him or her.

A depressive disorder is not the same as a passing blue mood. It is not a sign of personal weakness or a condition that can be willed or wished away. People with a depressive illness cannot merely "pull themselves together" and get better.

Without treatment, symptoms can last for weeks, months, or years. Depression is a common but serious illness, and most people who experience it need treatment to get better. Appropriate treatment, however, can help most people who suffer from depression. Depressive disorders come in different forms, just as is the case with other illnesses such as heart disease.

Figure 11.11:*A depressive disorder*
Source:*http://woman.ng/wp-content/uploads/2015/11/depression.jpg*

Disorders grouped among the depressive disorders in the DSM-5 are listed and discussed below:

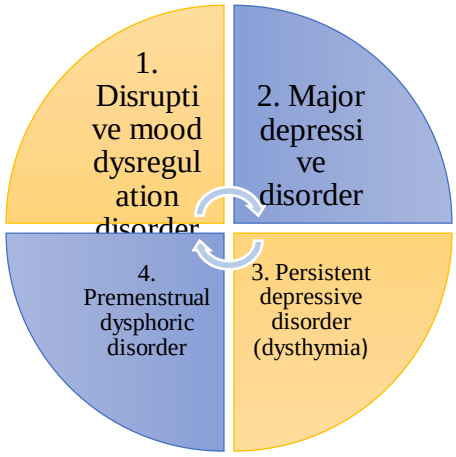

Figure 11.12:*Disorders grouped among the depressive disorders in the DSM-5*

(1)Disruptive Mood Dysregulation Disorder: This is a new DSM disorder characterized by severe recurrent temper outbursts and persistent negative mood for at least one year beginning before age 10

(2) Major Depressive Disorder: The cardinal symptoms of major depressive disorder include profound sad mood and/or lose of pleasure. In addition to these, the DSM-5 requires the person to be diagnosed as depressed must also experience at least three of sleeping too much or too little, psychomotor retardation or agitation, weight loss or change in appetite, loss of energy, feelings of worthlessness or excessive guilt.

Difficulty concentrating, thinking or making decisions, and recurrent thoughts of death or suicide. The symptoms are present nearly every day, most of the day for at least two weeks. The new inclusion of bereavement related symptoms in the diagnosis of major depressive disorder which was excluded in DSM-IV has been the focus of several debates.

In-Text Question

_____ is an illness that involves the body, mood, and thoughts.
(a) Major Depressive Disorder
(b)Depressive disorder
(c) Disruptive Mood Dysregulation Disorder
(d) All of the above

In-Text Answer

(b) Depressive disorder

(3) **Persistent Depressive Disorder (Dysthymia)**: Depressed mood and at least two other symptoms of depression (poor appetite or overeating, insomnia or hypersomnia, low energy or fatigue, low self-esteem, poor concentration or difficulty making decisions, feelings of hopelessness) for most of the day more than half of the time for two years (at least 1 year for children and adolescents)

(4)**Premenstrual Dysphoric Disorder:** This is a new DSM disorder characterized by significant distress or functional impairment in the week before menses in most menstrual cycle during the past year involving at least five of:

i. Affective liability
ii. Irritability,
iii. Depressed mood/hopelessness/or self-deprecating thoughts,
iv. Anxiety, diminished interest in usual activities,
v. Lack of energy,
vi. Changes in appetite/overeating or food craving,
vii. Sleeping too much/too little,
viii. Subjective sense of being overwhelmed or out of control,
ix. Physical symptoms such as breast tenderness or swelling/joint or muscle pain/ or bloating, and Improves within a few days of menses onset.

11.3 Anxiety Disorders

The experience of anxiety and fear is common among many. Though these terms are often used as synonymous, they are not exactly the same. While anxiety is basically an apprehension over an anticipated future problem, fear is a reaction to immediate danger.

Thus a person who sees a snake and is frightened is experiencing fear while a student who is concerned about the possibility of getting a good job after graduation is experiencing anxiety. Both anxiety and fear involve sympathetic nervous system arousal though at different levels.

Anxiety involves moderate arousal of restless energy and physiological tension while fear involves higher arousal of profuse sweating, rapid breathing and an overpowering urge to run.
Though anxiety and fear may appear bad, they are actually necessary for our survival.
Fear enables us to respond promptly and appropriately in times of exposure to danger while anxiety helps us to prepare for future eventualities by thinking through potential problems before they happen and guiding against their happening.

Figure 11.13:*Anxiety Disorders*
Source:*http://informationng.com/wp-content/uploads/2013/09/Anxiety54637383930.jpg*

There are various types of anxiety disorders and the symptoms of each must meet the DSM-5 criteria of interfering with important areas of functioning or cause marked distress, not being due to a drug or a medical condition and the fears and anxieties are distinct from the symptoms of another anxiety disorder.

In-Text Question
Anxiety involves moderate arousal of restless energy and physiological tension while fear involves higher arousal of profuse sweating, rapid breathing and an overpowering urge to run. True/False

In-Text Answer
True

Types of Anxiety Disorders
a. Separation anxiety disorder
b. Selective mutism
c. Specific phobia
d. Social anxiety disorder (Social Phobia)
e. Panic disorder

(a)Separation Anxiety Disorder: An individual with separation anxiety disorder (SAD) experiences clinically significant distress or impairment in social, academic, occupational, or other important areas of functioning from a developmentally abnormal level of persistent anxiety in response to separation or impending separation from an attachment figure.

Under DSM-5 SAD is defined as separation anxiety disorder that persists in individuals under 18 for at least four weeks and adults for six months or more as evidenced by three

of the following symptoms: recurrent excessive distress when anticipating or experiencing separation from home or major attachment figures.

(b)Selective Mutism:Children and adults with selective mutism are fully capable of speech and understanding language but fail to speak in certain situations, though speech is expected of them. The behaviour may be perceived as shyness or rudeness by others. A child with selective mutism may be completely silent at school for years but speak quite freely or even excessively at home.

Selective mutism is by definition characterized by consistent failure to speak in specific social situations (in which there is an expectation for speaking, e.g., at school) despite speaking in other situations. The disturbance interferes with educational or occupational achievement or with social communication.

The duration of the disturbance is at least 1 month (not limited to the first month of school). The failure to speak is not due to a lack of knowledge of, or comfort with, the spoken language required in the social situation. The disturbance is not better accounted for by a communication disorder (e.g., stuttering) and does not occur exclusively during the course of a pervasive developmental disorder, schizophrenia, or other psychotic disorder.

(c) Specific Phobia: The DSM-5 criteria for specific phobia include avoidance of specific objects (snakes, spiders, and blood) or situations (climbing heights, crowd) that consistently trigger marked and disproportionate fear for at least six months. The names of these fears consist of a Greek word for the feared object or situation followed by the suffix – phobia (derived from the name of a Greek god Phobos, who frightened his enemies). Examples of some specific phobias are claustrophobia (fear of closed spaces), musophobia (fear of mice), acrophobia (fear of height), xenophobia (fear of spiders) etc.

(d) Social Anxiety Disorder (Social Phobia): This term was formerly called social anxiety disorder in the DSM-IV. It is a persistent, unrealistically intense fear of social situations that might involve being negatively evaluated resulting in such situations being avoided or else endured with intense anxiety.
The symptom must persist for at least six months. The most common fears include public speaking, meeting new people, speaking at meetings or classes etc.

(e) Panic Disorder: Panic disorder is characterized by frequent panic attacks that are unrelated to specific situations and by worry about having more panic attacks. A panic attack is a sudden attack of intense apprehension, terror, and feelings of impending doom, accompanied by at least four other symptoms. Physical symptoms can include laboured breathing, heart palpitations, nausea, and upset stomach.

Chest pain, feelings of choking and smothering, dizziness, light headedness, sweating, chills, heat sensations, and trembling. Other symptoms that may occur during a panic attack include depersonalization – a feeling of being outside one's body, derealisation – a feeling of the world not being real, and fears of losing control, of going crazy or even dying.

Panic attacks that occur unexpectedly are called uncued attacks while those triggered by specific situations are referred to as cued panic attacks. People who only have cued attacks are most likely to suffer from a phobia.

The DSM criteria require that a person must experience recurrent uncured panic attacks for a diagnosis of panic attack to be made. They also must worry about the attack or change their behaviour because of the attacks for at least 1 month hence the response to the attack is as important as the attacks themselves in making this diagnosis

In-Text Question

The DSM-5 criteria for specific _____include avoidance of specific objects (snakes, spiders, and blood).
a. Panic attacks b. Specific phobia c.Panic disorder d.Social anxiety disorder

In-Text Answer

b. Specific phobia

11.4 Obsessive Compulsive and Related Disorders

Obsessive Compulsive Disorder

Obsessive compulsive disorder (OCD) is characterised by obsessions (recurrent, intrusive, and disturbing ideas, thoughts, impulses, or images) as well as compulsions (repetitive behaviours, or mental acts performed according to certain rules or in a stereotyped fashion, designed to reduce discomfort), and may be severe enough to be time-consuming or cause-marked distress or significant functional impairment.

Key features of Obsessive Compulsive Disorder in the DSM-5 include

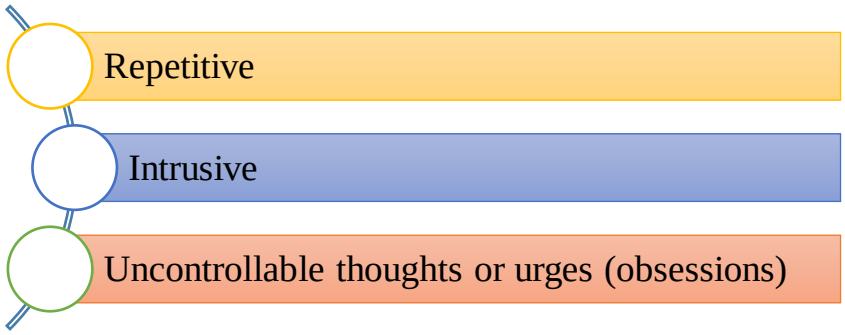

Figure 11.14:*Key features of Obsessive Compulsive Disorder in the DSM-5*

Repetitive behaviours or mental acts that the person feels compelled to perform (compulsions). The most frequent foci of obsessions include fear of contamination, sexual or aggressive impulses, body problems, religion etc. Compulsions involve carrying out ritualistic behaviour for fear that something bad will happen if the act is not performed.

Form of Obsessive Compulsive Disorder

- ✓ Body dysmorphic disorder
- ✓ Hoarding disorder
- ✓ Trichotillomania (hair-pulling disorder)
- ✓ Excoriation (skin-picking) disorder

In-Text Question

All of the following are key features of obsessive compulsive disorder in the DSM-5 include

a. Repetitive b.Intrusive c. Body dysmorphic disorder d. Uncontrollable thoughts or urges (obsessions

In-Text Answer

c. Body dysmorphic disorder

(a) Body Dysmorphic Disorder: This is characterized by a preoccupation with an imagined flaw in one's appearance and excessive repetitive behaviours or acts regarding appearance such as checking appearance or seeking reassurance.

(b) Hoarding Disorder: This new DSM-5 diagnosis is marked by the acquiring of excessive number of objects with the inability to part with the objects. The symptoms result in the accumulation of a large number of possessions that clutter key areas in the home or workplace to the extent that their intended use is no longer possible unless others intervene.

(c) Trichotillomania (Hair-Pulling Disorder):*DSM-5*, places trichotillomania in the category of obsessive-compulsive and related disorders that it is characterized by recurrent body-focused repetitive behavior (hair pulling) and repeated attempts to decrease or stop the behavior.

The behavior can occur during both relaxed and stressful times, but there is often a mounting sense of tension before hair pulling occurs or when attempts are made to resist the behavior. The specific *DSM-5* criteria for trichotillomania (hair-pulling disorder) include:

- ➢ Recurrent pulling out of one's hair, resulting in hair loss
- ➢ Repeated attempts to decrease or stop the hair-pulling behavior

- The hair pulling causes clinically significant distress or impairment in social, occupational, or other important areas of functioning
- The hair pulling or hair loss cannot be attributed to another medical condition (e.g. a dermatologic condition) and
- The hair pulling cannot be better explained by the symptoms of another mental disorder (e.g, attempts to improve a perceived defect or flaw in appearance, such as may be observed in body dysmorphic disorder).

(d) Excoriation (Skin-Picking) Disorder: Excoriation (skin-picking) disorder is characterized by recurrent skin picking resulting in skin lesions. Individuals with excoriation disorder must have made repeated attempts to decrease or stop the skin picking, which must cause clinically significant distress or impairment in social, occupational or other important areas of functioning.

The skin picking cannot be attributed to the physiologic effects of a substance or another medical condition. The skin picking cannot be better explained by the symptoms of another mental disorder.

In-Text Question

DSM-5, places _____ in the category of obsessive-compulsive and related disorders that it is characterized by recurrent body-focused repetitive behavior

a. Trichotillomania
b. Excoriation
c. Hoarding disorder
d. Body dysmorphic disorder

In-Text Answer

Trichotillomania

11.5 Feeding and Eating Disorders

The subject of food and eating is one that preoccupies many in our world. People are also concerned about gaining too much weight leading to obesity while others seek to diet in order to lose weight.

There are different types of feeding and eating disorders which are listed below:

a. Pica
b. Rumination disorder
c. Avoidant/restrictive food intake disorder
d. Anorexia nervosa
e. Binge-eating disorder

(a) Pica: Eating non-food substances for a period of at least one month. The eating behavior is not culturally sanctioned. Individuals with pica may consume a variety of non-nutritive substances, including mud, pottery, clay, and laundry starch. Pica eating of numerous other substances, such as paper, tissues, wood, plastic straws, soap, cloth,

carpet, hair, string, wool, paint, gum, metal, pebbles, chalk, charcoal, coal, and ash, has also been reported.

(b) Rumination Disorder: Rumination disorder is an eating disorder in which a person (usually an infant or young child) brings back up partially digested food and then swallows it again or spits it out. To be considered a disorder, this behavior must occur in children who had previously been eating normally, and it must occur on a regular basis usually daily for at least one month. The child may exhibit the behavior during feeding or right after eating.

Symptoms of rumination disorder in babies and young kids include: repeated regurgitation of food, with/without re-chewing of food, weight loss, bad breath and tooth decay, repeated stomach aches and indigestion, raw and chapped lips.

(c) Avoidant/Restrictive Food Intake Disorder: Previously defined as a disorder exclusive to children and adolescents, the DSM-5 broadened the disorder to include adults who limit their eating but not as a result of unavailability of food, neither is it due to observation of cultural norms.

The disorder includes disturbance in eating or feeding, as evidenced by one or more of: substantial weight loss (or, in children, absence of expected weight gain), nutritional deficiency, dependence on a feeding tube or dietary supplements and significant psychosocial interference.

(d) Anorexia Nervosa: The term anorexia refers to loss of appetite, and nervosa indicates that the loss is due to emotional reasons. The term is however a misnomer as most people with anorexia nervosa actually do not lose their appetite of interest in food but rather most people with the disorder become preoccupied with food and may even read cookery books constantly and prepare nice meals for their families.

The disorder is often marked by restriction of food to promote healthy weight even though body weight is significantly below normal accompanied with intense fear of weight gain and body image disturbance.

In-Text Question

_____ is often marked by restriction of food to promote healthy weight

In-Text Answer

The disorder

(e) Binge-Eating Disorder: This has been moved from condition in need of further study in DSM-IV to a recognized diagnosis in DSM-5. Binge eating includes recurrent binges at least once per week for at least 3months involving at least three of eating more quickly

than usual, eating until over full, eating large amounts even if not hungry, eating alone due to embarrassment about large food quantity, feeling bad (e.g., disgusted, guilty, or depressed) after the binge.
There is no compensatory behaviour present. It is distinguished from anorexia nervosa by the absence of weight loss and from bulimia nervosa by absence of compensatory behaviour. Most people with binge eating disorder are obese (having a BMI greater than 30) but not all obese people meet the criteria for binge eating disorder.

Box 11.2: Examples of eating and feeding disorders

Examples of eating and feeding disorders include: pica, rumination disorder, avoidant/restrictive food intake disorder, anorexia nervosa, bulimia nervosa and binge eating.

11.6 Paraphilic Disorders

Humans are sexual beings with divergent private sexual preferences and fantasies some of which may be shocking. These sexual fantasies and preferences are ordinarily no problems until they cause marked distress or impairment to the individual or when the individual engages in sexual activities with non-consenting persons.

In DSM-5, Paraphilic disorders are defined by persistent and troubling sexual attractions to unusual objects or sexual activities lasting at least 6months which often cause significant distress and impairment in functioning.

There are different types of paraphilic disorders distinguished on the basis of the source of sexual arousal. This disorder is more common among men than women.

(a) Voyeuristic Disorder
(b) Exhibitionistic Disorder
(c) Frotteuristic Disorder
(d) Sexual Masochism Disorder
(e) Sexual Sadism Disorder
(f) Pedophilic Disorder
(g) Fetishistic Disorder
(h) Transvestic Disorder

(a) Voyeuristic Disorder: This disorder involves an intense and recurrent desire to obtain sexual gratification by watching unsuspecting others who are naked, undressing or having sex and the individual must have acted on this desire with at least three unsuspecting persons on separate occasions or the urges and fantasies cause marked distress or interpersonal problems.

(b) Exhibitionistic Disorder: This disorder involves a compulsive and distressing desire to expose one's genitals to an unwilling stranger and the individual must have acted on

this desire with at least three strangers on separate occasions or the urges and fantasies cause marked distress or interpersonal problems. Frotteuristic and voyeuristic disorders are very common in exhibitionists.

(c) Frotteuristic Disorder: This involves an individual's sexually oriented towards touching of or rubbing against an unsuspecting person and the individual must have acted on this desire with at least three nonconsenting persons on separate occasions or the urges and fantasies cause marked distress or problems.

The frotteur may rub his genital against a woman's thighs or buttocks or fondle her breasts or genitals. These acts usually occur in places such as a crowded bus or crowded areas that provide an opportunity to rub against unsuspecting persons.

(d) Sexual Masochism Disorder: This disorder is defined by an intense and recurrent desire to obtain or increase sexual gratification by receiving pain or humiliation. The manifestation of this disorder include physical bondage, blindfolding, spanking, whipping etc. Most sadists establish relationships with masochists to derive mutual sexual gratification although many people can change roles.

In-Text Question

Mention any two types of paraphilic disorders distinguished on the basis of the source of sexual arousal.

In-Text Answer

1. Voyeuristic disorder
2. Exhibitionistic disorder

(e) Sexual Sadism Disorder: This disorder is defined by an intense and recurrent desire to obtain sexual gratification by inflicting pain or psychological suffering on another and the individual has acted on these urges with at least two noncondensing others on separate occasions.

(f) Pedophilic Disorder: This disorder is diagnosed when adults derive sexual gratification through sexual contact with children, or when the sexual arousal is as strong or stronger for children than for adults, or when they experience recurrent, intense and distressing desires for sexual contact with children, or have repeatedly gained more arousal from child pornography than from pornography depicting mature persons for at least 6months. DSM-5 requires that the offender be at least 18years old and at least 5years older than the child.

Box 11.3: Definition of Paraphilic disorders
Paraphilic disorders are defined by persistent and troubling sexual attractions to unusual objects or sexual activities lasting at least 6months which often cause significant distress and impairment in functioning.

Summary of Study Session 11

In this study session, you have learnt that:

1. Neurodevelopmental disorders are deficiencies of the growth and development of the brain or central nervous system.

2.A depressive disorder is an illness that involves the body, mood, and thoughts.

3.Anxiety involves moderate arousal of restless energy and physiological tension while fear involves higher arousal of profuse sweating, rapid breathing and an overpowering urge to run.

Though anxiety and fear may appear bad, they are actually necessary for our survival.

4. Obsessive compulsive disorder (OCD) is characterised by obsessions (recurrent, intrusive, and disturbing ideas, thoughts, impulses, or images)

5.The subject of food and eating is one that preoccupies many in our world. People are also concerned about gaining too much weight leading to obesity while others seek to diet in order to lose weight.

6. In DSM-5, Paraphilic disorders are defined by persistent and troubling sexual attractions to unusual objects or sexual activities lasting at least 6months which often cause significant distress and impairment in functioning.

Self-Assessment Questions (SAQs) for Study Session 2

Now, that you have completed this study session, you can assess how well you have achieved its learning outcomes by answering the following questions. Write your answers in your study diary and discuss them with your Tutor at the next Study Support Meeting. You can check your answers with the Notes on the Self-Assessment Questions at the end of this study session.

SAQ.11.1 (Testing Learning Outcome 11.1)

Defined Neurodevelopmental disorders?

SAQ 11.2 (Testing Learning Outcome 11.2)

_____ is an illness that involves the body, mood, and thoughts. It interferes with daily life, normal functioning, and causes pain for both the person with the disorder and those who care about him or her.

SAQ 11.3 (Test Learning Outcome 11.3)

Anxiety involves moderate arousal of restless energy and physiological tension while fear involves higher arousal of profuse sweating, rapid breathing and an overpowering urge to run. True/False

SAQ 11.4 (Test Learning Outcome 11.4)

Highlight key features of obsessive compulsive disorder in the DSM-5

SAQ 11.5 (Test Learning Outcome 11.5)

What is Rumination Disorder**?**

SAQ 11.6 (Test Learning Outcome 11.6)

Briefly explain Sexual Masochism Disorder

Notes on SAQS

SAQ 11.1

Neurodevelopmental disorders are deficiencies of the growth and development of the brain or central nervous system.

SAQ 11.2

A depressive disorder

SAQ 11.3

True

SAQ 11.4

i. Repetitive
ii. Intrusive
iii. Uncontrollable thoughts or urges (obsessions)

SAQ 11.5

Rumination disorder is an eating disorder in which a person (usually an infant or young child) brings back up partially digested food and then swallows it again or spits it out.

SAQ 11.6

Sexual Masochism Disorder: This disorder is an intense and recurrent desire to obtain or increase sexual gratification by receiving pain or humiliation.

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Study Session 12: Psychotherapeutic Approaches in Clinical Psychology

Expected duration: 1 week or 2 contact hours

Introduction

The duty of the clinical psychologist is to change maladaptive patterns of thought and/or behaviour of people to more adaptive patterns. There are however different approaches that can be adopted for this change to be accomplished depending on each clinical psychologist's theoretical perspective or expertise.

Psychological therapies are usually built on personality theories which fall mainly into four categories of psychoanalytic, humanistic, behavioural and cognitive.

In this study session, you will learn psychotherapy, counseling and guidance, common psychotherapeutic approaches in clinical psychology and skills needed to use psychoanalytic, humanistic, behavioural and cognitive psychotherapeutic approaches

Learning Outcomes for Study session 12

At the end of this study session, you should be able to:

12.1 Explain psychotherapy, counselling and guidance
12.2 Discuss Common psychotherapeutic approaches in clinical psychology
12.3 Highlight skills needed to use psychoanalytic, humanistic, behavioural and cognitive psychotherapeutic approaches

12.1 Clarification of the terms Psychotherapy, Counselling and Guidance

12.1.1 Psychotherapy

Psychotherapy is a method of treatment which aims to help the impaired individual by influencing his emotional processes, his evaluation of himself and of others, his evaluation of and his manner of coping with the problems of life.

It may also include, if need be, influencing and changing his environment and thus altering the problems he has to deal with and simultaneously increasing his potentialities of mastery and integration. In its classic sense, psychotherapy is defined as the restructuring of the malfunctioning personality.

It can also be defined as a psychological process occurring between two (or more) individuals in which one (the therapist), by virtue of his position and training, seeks systematically to apply psychological knowledge and interventions in an attempt to understand, influence and ultimately modify the psychic experience, mental function and behaviour of the other (the patient or client).

Figure 12.1:*Psychotherapy*
Source:*http://www.jaynelifetherapy.co.uk/blog/wp-content/uploads/2013/09/counselling.jpg*

This form of interaction is distinguished from other relationships between two people by the formality of a therapeutic agreement (whether explicit or implicit), the specific training, skill and experience of the therapist, and the fact that the patient or client (either voluntarily or by coercion) has come to the therapist seeking professional therapeutic help.

From the above definitions of psychotherapy, you will notice that the professional who is professionally competent, skilled and knowledgeable to do psychotherapy is the clinical psychologist who has the knowledge of and theories of psychopathology or behavioural disorders. However, the psychiatrist may sometimes do psychotherapy but specifically the psychiatrist uses or administers physical treatments such as chemotherapy and ECT - electroconvulsive therapy.

Figure 12.2: *Clinical Psychologist*
Source: *http://www.thecelebworth.com/wp-content/uploads/2013/07/Psychologist-Salary.jpg*

In-Text Question
Simply defined Psychotherapy

In-Text Answer

Psychotherapy is defined as a method of treatment which aims to help the impaired individual by influencing his emotional processes.

12.1.2 Counselling and Guidance

Counselling

Counselling has been defined byBoy and Pine (1968) as ‘A face-to-face, person-to-person relationship in which a person (the client) seeks the help of, or seeks to effectively communicate with another person (the counsellor)’.

Figure 12.3:*Counselling*
Source:*http://scannewsnigeria.com/wp-content/uploads/2015/10/PIC.-5.-THE-AART-OF-LIFE-FOUNDATION-HOLDS-SYMPOSIUM-IN-ABUJA.jpg*

A relationship characterized by mutual respect, effective communication, genuine and complete acceptance of the client by the counsellor and concentration on the needs, problems and feelings of the client. A relationship which facilitates growth and change in the client to become more freely and fully functioning.

A professional service based upon a substantive rationale that reflects philosophy emanating from theoretical and empirical considerations of men, human behaviour, and society. Vaughan (1976), after completing an analysis of how the word counsel1ing' is used, distills three themes which generally recur:
Counselling is a person-to-person form of communication marked by the development of a subtle emotional understanding, often called 'empathy.' It is centered upon one or more problems of the client and It is free from authoritarian judgments and coercive pressures by the counselor.

Table 12.1:Two broadly process considered in counselling by individual to stimulate

"Evaluate yourself and the opportunities, make a feasible choice in the light of hi

1. unique characteristics and opportunities; accept responsibility for his choice and initiat a course of action consonant with his choice."
2 "Counselling is a learning-oriented process, carried on in a simple, one-to-one socia environment, in which a counselor, professionally competent in relevant psychologica skills and knowledge, seeks to assist the client by method appropriate to the latter needs, to learn more about himself, to learn how to put such understanding into effect i relation to more clearly perceived, realistically defined goals to the end that the clie may become a happier and more productive member of his society." (Gustad, 1957, p 17).

Counselling, therefore, stresses more rational planning, problem solving decision making, intentionality, prevention of severe adjustment problems, and support for situational pressures arising in the everyday lives of normal people. Psychotherapy, in contrast, is defined as more inclusive re-education of the individual.
The basic aims of psychotherapy are to gain perceptual clarity and change, to integrate insights into everyday behaviour, and to cope with intense feelings originating in past hurtful experiences. Those professionals who can counsel include the clinical and counselling psychologists, the educational and school psychologists, etc.

In-Text Question

A relationship characterized by mutual respect, effective communication, genuine and complete acceptance of the client by the _____ and concentration on the needs, problems and feelings of the client
A. Guidance
B. Psychotherapy
C. Counsellor
D. All of the above

In-Text Answer

C. Counsellor

Guidance

Guidance is a process of information giving to an individual; thus providing him with a diversity of choice. The Guidance worker does not help the client with choice processes. The image below showing how guidance work.

Figure 12.4: *Guidance*
Source:*http://www.aamu.edu/Academics/EHBS/SWPC/Psychology_and_Counseling/Documents/counselor.jpg*

The various types of guidance include:
(i) Career guidance
(ii) Marriage guidance,
(iii) Vocational guidance, and
(iv) Occupational guidance which involves total systems of living involving entire life of self and family.
Broadly, however, Guidance can be defined as a process, developmental in nature, by which an individual is assisted to understand, accept and utilize his abilities, aptitudes, and interests and attitudinal patterns in relation to his aspirations (Zeran and Riccio, 1962). It is important to note that counselling and guidance are two different things.
For example, counselling is a more personalized process than guidance. Counselling is equally more private and confidential than guidance. Counselling aids growth, independent thinking and self-reliance. Those who can offer guidance services include guidance counsellors, educational psychologists, etc.

In-Text Question
All the following are types of guidance except
A.Marriage guidance
B. Life guidance
C.Career guidance
D.Occupational guidance

In-Text Answer
B. Life guidance

12.2 Psychoanalytical and Psychodynamic therapies
The focus of psychoanalytical and psychodynamic therapies is an insight and is based on discovering an individual's unconscious thoughts and perceptions that have developed throughout their childhood, and how these affect their current behaviour and thoughts.

Sigmund Freud who first developed this method of therapy believed that mental disorders were caused by early traumatic experiences. During early forms of psychoanalysis, patients typically lay on a couch with the therapist sitting out of view, in order to reduce patients' inhibitions and allow freer access and expression of unconscious thought processes.

Treatment was based on uncovering unconscious feelings and drives that give rise to maladaptive thoughts and behaviour using a techniques such as free association in which the patient says whatever comes to mind and dream analysis in which the therapist interprets the hidden meaning of dreams.

In-Text Question

Who was the first person to developed method of therapy?
A. Sigmund Freud
B.Zeran
C. Riccio
D. Fritz Perls

In-Text Answer

A. Sigmund Freud

Freud calls whatever interrupts the progress of analytic work "resistance". Indicators of resistance are behaviour such as being late, missing a session, refusing to speak about thoughts or avoiding a particular issue. In its most simple and practical sense, resistance results from fear of having to face and relinquish one's anger victim.

The general goal of psychoanalysis is to help the patient gain insight or develop a better understanding of their own psychological processes so that they can be freed of disturbing symptoms emanating from these unconscious influences. Some of Freud's original ideas have since been reformulated to various adaptations which are collectively known as psychodynamic approaches.

Box 12.1: The basic aim of psychoanalytic and psychodynamic therapies

The basic aim of psychoanalytic and psychodynamic therapies is to help the client develop insight by discovering the individual's unconscious thoughts and perceptions that have developed throughout their childhood, and how these affect their current behaviour and thoughts.

12.3 Skills Needed To Use Psychoanalytic, Humanistic, Behavioural and Cognitive Psychotherapeutic Approaches

Humanistic therapy emphasizes personal experience and belief systems and the phenomenology of individuals. The goal of the therapy is to boost self-fulfillment by

helping people grow in self-awareness and self-acceptance.

The clinician focuses on the present and future instead of the past, conscious rather than unconscious thoughts and on helping the client take responsibility for his/her feelings and actions instead of uncovering the hidden determinants of feelings and actions.

Box 12.2: Major difference between humanistic counselors and other therapists

One major difference between humanistic counsellors and other therapists is that they refer to those in therapy as 'clients', not 'patients'. This is because they see the therapist and client as equal partners rather than as an expert treating a patient. Unlike other therapies the client is responsible for improving his or her life, not the therapist.

This is a deliberate change from both psychoanalysis and behavioral therapies where the patient is diagnosed and treated by a doctor. Instead, the client consciously and rationally decides for themselves what is wrong and what should be done about it. The therapist is more of a friend or counselor who listens and encourages on an equal level.

Therapies that adopt the humanistic/experiential orientation include:

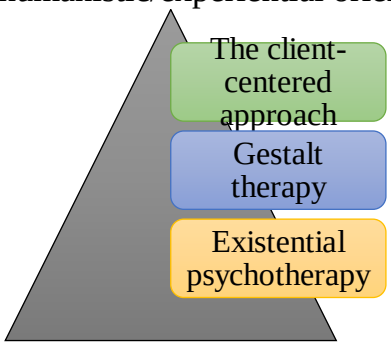

Figure 12.4: *Therapies that adopt the humanistic/experiential orientation*

The client-centered approach, also known as person-centered therapy: This is a non-directive form of talk therapy that was developed by humanist psychologist Carl Rogers during the 1940s and 1950s. Self-direction plays a vital part of client-centred therapy.

Mental health professionals who utilize this approach strive to create a therapeutic environment that is deeply understanding (empathic), accepting (having unconditional positive regard) and genuine (congruent). Empathetic understanding refers to the therapist's ability to understand sensitively and accurately [but not sympathetically] the client's experience and feelings in the here-and-now.

Unconditional positive regard demands a complete acceptance and support for the clients irrespective of whatever feeling is being exhibited - confusion, resentment, fear, anger, courage, love, or pride. Congruence indicates that the therapist is authentic and does not

have a façade (like psychoanalysis), that is, the therapist's internal and external experiences are one and the same.

The goal of this is to allow the client to gain a clearer understanding of their own inner thought, perceptions and emotions and change their behavior through self-direction. At one level, Rogers' theory and work is very simple to describe.

However, using the approach can be very difficult in practice because the approach does not use techniques but relies on the personal qualities of the therapist to listen, accept and build a non-judgmental and empathic relationship.

In-Text Question

The client-centred approach, also known as person-centered therapy was developed by humanist psychologist called Fritz Perlsduring the 1950s and 19600s. True/ False

In-Text Answer

False
Reason: The client-centered approach was not developed by Fritz Perlsduring the 1950s and 19600s, rather it was developed by Carl Rogers during the 1940s and 1950s.

Gestalt therapy: This was developed by Fritz Perls, Laura Perls, and Paul Goodman in the 1940s. At the core of gestalt therapy is the holistic view that people are intricately linked to and influenced by their environments and that all people strive toward growth and balance.

Gestalt therapy is similar to person-centered therapy in this way, as well as in its emphasis on the therapist's use of empathy, understanding, and unconditional acceptance of the client to enhance therapeutic outcomes. According to gestalt therapy, context affects experience, and a person cannot be fully understood without understanding his or her context.
With this in mind, gestalt psychotherapy recognizes that no one can be purely objective including therapists whose experiences and perspectives are also influenced by their own contexts—and practitioners accept the validity and truth of their clients' experiences.

Gestalt therapy also recognizes that forcing a person to change paradoxically results in further distress and fragmentation. Rather, change results from acceptance of what is. Thus, therapy sessions focus on helping clients learn to become more self-aware and to accept and trust in their feelings and experiences to alleviate distress.

Gestalt therapy sessions do not follow specific guidelines; in fact, therapists are encouraged to use creativity in their approach with clients, depending on context and the personality of the current client. What is consistent is the emphasis on process (what is happening) than content (what is being discussed).

In-Text Question

_____was developed by Fritz Perls, Laura Perls, and Paul Goodman in the 1940s.

A.The client-centered approach B.Gestalt therapy C.Existential psychotherapy D.All are correct

In-Text Answer

B.Gestalt therapy

The emphasis is on what is being done, thought and felt at the moment rather than on what was, might be, could be or should be. Distinction between direct experience and indirect or secondary interpretation is developed in the process of therapy.

The objective of Gestalt Therapy, in addition to helping the client to overcome symptoms, is to enable him or her to become more fully and creatively alive and to be free from the blocks and unfinished issues that may diminish optimum satisfaction, fulfillment and growth. Existential psychotherapy is a therapy that emphasises the whole human condition.

It appreciates and acknowledges human capacities to build meaningful experiences of relationship, love, commitment, courage, creativity, power, will, self-actualization, transcendence etc without naively denying the inherent limitations and challenges of being human such as the experience of death, finitude, fate, freedom, responsibility, loneliness, loss, suffering, meaninglessness and malevolence.

Existential psychotherapy: This is concerned with more deeply comprehending and alleviating as much as possible all of our negative emotional experiences that result in maladaptive behaviour in order to promote positive change (where this is possible) or the acceptance of oneself and situation (where we can do nothing to change the situation) to enhance the living of life to the full moment by moment.

It emphasizes coming to terms with reality and one's own inner fears without denying, avoiding, distorting or sugar-coating it is key to existential therapy. Existential psychotherapy teaches people to face and accept their fears and equip them with the skills necessary to overcome them through action and the assuming of responsibility for ones feelings and actions/inactions.

Box12.3: Key Point
Therapists who practice existential psychotherapy do not focus on the client's past, rather they work with the client to discover and explore the choices that lie before him or her. Through retrospection, the client and therapist work to understand the implications of the past choices and the beliefs that led those to take place, only as a means to shift to the goal of creating a keener insight into oneself.

The emphasis never dwells on the past, but uses the past experience as a tool to promote freedom and newfound assertiveness. Key existential psychotherapists are: Friedrich Nietzsche, Soren Kierkegaard, Jean-Paul Sartre, Rollo May, James Bugental, Viktor Frankl, Irvin Yalom, Kirk Schneider, Stephen Diamond, and Myrtle Heery.

12.3.1 Cognitive behavior therapy (CBT)

Cognitive Behavior Therapy (CBT) incorporates theory and research on cognitive and behavioural processes. Cognitive therapists believe that irrational thinking or faulty perceptions cause dysfunctions. Aaron Beck's a foremost cognitive therapist, focus on changing certain thought patterns. The image below showing the Aaron Beck's a foremost cognitive therapist

Figure 12.6:*Aaron Beck'sa foremost cognitive therapist*
Source:*http://fenichel.com/beck90.jpg*

The premise, in Beck's words, is that "the way you perceive situations influences how you feel emotionally," and so by changing thoughts, then behaviour will also change. For example, a person with depression may focus exclusively on negative happenings and ignore positive ones. Imagine that a woman's romantic partner both praises and criticizes her. If the woman attends to the praise and remembers it the next day, she is likely to feel happy.

But if she focuses on the criticism and continues to dwell on it the next day, she is likely to feel unhappy. Beck's therapy addresses thought biases by trying to persuade patients to change their opinions of themselves and the way in which they interpret life events.

When a depressed person expresses feelings that nothing ever goes right, for example, the therapist offers counterexamples, pointing out how the client has overlooked favorable happenings. The general goal of Beck's therapy is to provide people with experiences, both inside and outside the therapy room that will alter their negative schemas, enabling them to

have hope rather than despair. This type of therapy is often effective for clients suffering from depression or anxiety.

Behavioral therapists focus on changing observable problematic behaviors that have been ingrained through years of reinforcement. A good example of behavioral therapy would be a therapist working with a client to overcome a fear of heights.

The therapist would encourage the client to gradually face their fear of heights through experience. The client might first imagine standing on the roof of a tall building or riding an escalator. Next, the client would slowly expose themselves to greater and greater levels of their fear until the phobia diminishes or disappears entirely in a process called systematic desensitization.

In-Text Question
What is the believe of cognitive therapists?

In-Text Answer
Cognitive therapists believe that irrational thinking or faulty perceptions cause dysfunctions.

12.3.3 Other forms of therapy
Group Therapy
Group therapy is a form of psychotherapy where two or more clients work with one or more therapists or counselors. This method is a popular format for support groups, where group members can learn from the experiences of others and offer advice. This method is also more cost effective than individual psychotherapy and is oftentimes more effective.

It is common for those suffering from a mental illness or problem behavior to feel alone, isolated or different. Group therapy can help clients by providing a peer group of individuals that are currently experiencing the same symptoms or who have recovered from a similar problem. Group members can also provide emotional support and a safe forum to practice new behaviors. Group therapies vary greatly in types of patients enrolled in the group, duration of treatment, size and structure.

Arts therapies
Arts therapies involve the use of creative arts such as music, art, drama and dance - in a therapeutic environment. A clinician can sometimes get a much deeper sense of how a client is feeling and thinking, when the client expresses their feelings through drawings, music or even dance.

Family/Systemic therapy
Family/systemic therapy emphasis the role played by a client/patients family or social network in recovering from mental disorders. The therapy views the individual as part of a

larger context and any change in the individual's behavior will affect the whole system and a change in the system will affect the individual.

This is often most clear at the family level where each person plays a particular role and interacts with the other members in specific ways. In the course of therapy the way the individual thinks, behaves and interacts with others may change and this change could have profound effects on family dynamics.

In-Text Question

Briefly defined Group therapy is a form of psychotherapy where two or more clients work with one or more therapists or counselors.

In-Text Answer

Group therapy is defined as a form of psychotherapy where two or more clients work with one or more therapists or counsellors.

Summary of study session 12

In this study session, you have learnt that:

1. Psychotherapy is a method of treatment which aims to help the impaired individual by influencing his emotional processes.
2. Counselling has been defined by Boy and Pine (1968) as 'A face-to-face, person-to-person relationship in which a person (the client) seeks the help of, or seeks to effectively communicate with another person (the counsellor)'.
3.Guidance is a process of information giving to an individual; thus providing him with a diversity of choice.
4. Sigmund Freud who first developed this method of therapy believed that mental disorders were caused by early traumatic experiences.
5. Humanistic therapy emphasizes personal experience and belief systems and the phenomenology of individuals.
6. Cognitive Behavior Therapy (CBT) incorporates theory and research on cognitive and behavioural processes.

Self-Assessment Questions (SAQs) for Study Session 12

Now, that you have completed this study session, you can assess how well you have achieved its learning outcomes by answering the following questions. Write your answers in your study diary and discuss them with your Tutor at the next Study Support Meeting. You can check your answers with the Notes on the Self-Assessment Questions at the end of this study session.

SAQ 12.1 (Testing Learning Outcome 12.1)

1. What is Psychotherapy?
2. Differentiate between counselling and guidance Counseling has been defined byBoy and Pine (1968) as 'A face-to-face, person-to-person relationship in which a person (the client) seeks the help of, or seeks to effectively communicate with another person (the

counselor)'while Guidance is a process of information giving to an individual; thus providing him with a diversity of choice.

SAQ 12.2 (Testing Learning Outcome 12.2)

The focus of psychoanalytical and psychodynamic therapies is on insight and is based on discovering an individual's unconscious thoughts and perceptions that have developed throughout their childhood, and how these affect their current behaviour and thoughts. Yes/No

SAQ 12.3 (Test Learning Outcome 12.3)

Highlight the key major difference between humanistic counselors and other therapists

SAQ 12.4 (Test Learning Outcome 12.4)

_____ focus on changing observable problematic behaviors that have been ingrained through years of reinforcement.

Notes on SAQS

SAQ 2.1

1. Psychotherapy is a psychological process occurring between two (or more) individuals in which one (the therapist), by virtue of his position and training, seeks systematically to apply psychological knowledge and interventions in an attempt to understand, influence and ultimately modify the psychic experience, mental function and behaviour of the other (the patient or client).
2. Counseling is a face-to-face, person-to-person relationship in which a person (the client) seeks the help of, or seeks to effectively communicate with another person (the counselor)'while Guidance is a process of information giving to an individual; thus providing him with a diversity of choice.

SAQ 2.2

The answer is YES

SAQ 2.3

The different is that, humanistic counselors and other therapists both are refer to those in therapy as 'clients', not 'patients'. This is because they see the therapist and client as equal partners rather than as an expert treating a patient. Unlike other therapies the client is responsible for improving his or her life, not the therapist.

SAQ 2.4

Behavioral therapists

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Study session 13: Personality Theory (Psychoanalytic)

Expected duration: 1 week or 2 contact hours

Introduction

When psychology emerged as an independent scientific discipline in Germany during the middle of the 19th century, it defined its task as the analysis of consciousness in the normal, adult human being. It conceived of consciousness as a being made up of structural dements that were closely correlated with processes in the sense organs.Freud's attack upon the traditional psychology of consciousness came from quite a different direction.

In this study session you will be introduced to psycho-analytic theory of personality as propounded by Sigmund Freud, the principles of psychoanalysis, the assumptions of psychoanalysis, psychosexual development and the intrapsychic structures.

Learning Outcomes for study session 13

At the end of this lecture, you should be able to:

13.1 Explain psycho-analytic theory of personality as propounded by Sigmund Freud

13.2 Discuss the principles of psychoanalysis, the assumptions, psychosexual development and the intrapsychic structures.

13.1 The Life History of Sigmund Freud

Sigmund Freud was bum in Moravia, May 6, 1856, and died in London, September 23, 1939. He entered the medical school the University of Vienna in 1873 and graduated from there eight year later. In his medical career, Freud specialized in microanatomy and neurophysiology.

His scientific training and many years of work in physiological laboratory taught him the value of the empirical approach. The Darwinian views of evolution emphasized the defensive and adaptive nature of an organism, a theme later repeated in Freud's theories.

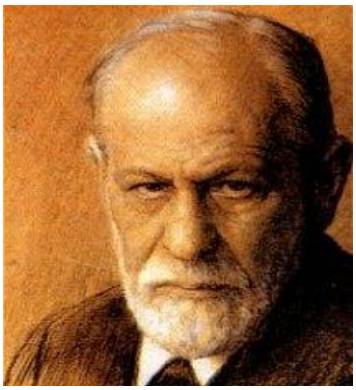

Figure: 13.1:*Sigmund Freud*
Source: *http://psychcentral.com/blog/wp-content/uploads/2011/08/3-facts-about-freud.jpg*

Trace of the new thermodynamic concepts in physics, such as the conservation of energy, are also found in Freud's conceptualization of psychic energy. Freud later studied with Jean Chatcot, who was using hypnosis in the treatment of hysteria. He later collaborated with Josef Breuer on several cases, thus resulting in a publication entitled Studies on Hysteria (Breuer and Freud, 1895/1962).

Box 13.1: Sigmund Freud
Sigmund Freud was born in Austria, Moravia, May 6, 1856, and died in London, September 23, 1939. Freud specialized in neuroanatomical and neurophysiology. Freud later studied with Jean Charcot and collaborated with Josef Breuer to publish their Studies on Hysteria.

In-Text Question

Sigmund Freud was born in Australia in _____
(a) 1886
(b) 1865
(c) 1857.
(d) 1856

In-Text Answer

(d) 1856

13.1.1 Basic Concepts of psychoanalytic Theory

The theory of psychoanalytic are explain below
(a) The psychoanalytic view maintains that all behaviour is caused, or determined by internal factors. Therefore, all behaviour is meaningful, even if the meaning is not apparent to the conscious mind. Freud believed that our actions, our dreams, our errors, even our slips of the tongue, all have meaning and are determined largely by conscious processes. Therefore, the first general feature of psychoanalytic theory is that it is based on the principle of psychic determinism.
(b) Closely related to this is a second characteristic, the emphasis given to unconscious

processes. Unconscious thoughts and motives cannot be observed directly. They can be inferred, however, from the patient's dreams and free associations, which are less subject to conscious control. Freud believed that most of our actions and mental functioning are determined by unconscious forces, particularly those portions of behaviour regarded as "abnormal" or irrational.

(c) A third characteristic of the psychoanalytic theory is the central role played by drives or instincts. The theory proposes that we are all born with instinctual needs that provide energy for the operation of the psychic system. This energy is called libido, and the instincts contributing to it are

Three instinct contribution of Libido to the psychoanalytic theory are listed in the diagram below

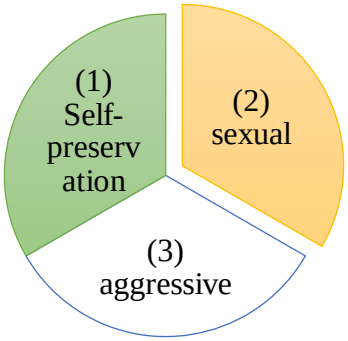

Figure13.2:*Three instinct contribution of Libido to the psychoanalytic theory*

Freud perceived the instincts as genetically determined biological needs. Unsatisfied instincts were said to create tensions within the individual. Reduction of these tensions (by satisfying the instinctual demands) was experienced as pleasurable.

Libido: In Freudian theory the repository of psychic energy and the mechanism that directs the energy toward desired objects and goals.

(d) A fourth characteristic of psychoanalysis is its dynamic nature. The individual expends energy in the pursuit of his or her goals. This psychic energy is channeled by conscious and unconscious forces that operate in a purposeful fashion to achieve their aims.

In-Text Question

One of the characteristics of psychoanalysis is _____

(A).Dynamic nature (B) Static in nature (C). Both static and dynamic in nature (D). All of the above

In-Text Answer

A.Dynamic nature

13.1.2 Personality Structure of psycho-analytic theory

In Freud's theory, the structure of the mind can conceivably be seen "as comprising three main parts, differentiated by their functions. These are

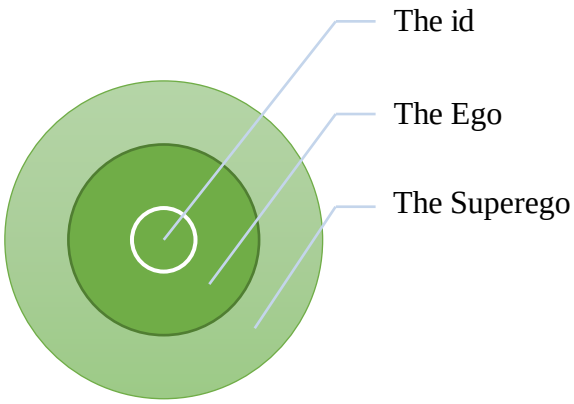

Figure 13.3: *Personality Structure of psycho-analytic theory*

(a) The id: The new born infant is all id, a reservoir of instinctual, primitive, drive-related biological energy. The basic, instinctual drives, of which the most important is the libidinal or sex drive, are simultaneously the source of all thinking, feeling, and behaviour. A primary function of the id is to maintain a balance in the forces which pull people in various ways.

Tensions build up in the id and demand release. When there is a need to reduce tension the id conjures up an internal fantasy of the object of the instinctual drive (e.g. the mother) an achieves vicarious satisfaction by releasing the tension in relation to the fantasy rather than to the real life object.

(c) The ego: This is the executive aspect of the personality and mediates between the instinctual demands of the id and the requirements of reality. The ego functions to bring the discharge of energy under control; it encompasses the conscious aspects of personality including the individual's skills and abilities, his fears and hopes.

(c) The superego: The superego develops in turn from the ego, and is the structure that represents the standards and ethical values learned through contact with society in general, and with parents in particular. It is closely connected to the ego, but retains considerable independence.

The superego acts to perfect and civilize our behavior. It works to suppress all unacceptable urges of the id and struggles to make the ego act upon idealistic standards rather that upon realistic principles. The superego is present in the conscious, preconscious, and unconscious.

Freud has divided the personality into three structures, namely, the id - wholly unconscious and primitive, the ego, conscious and very rational, and the superego, or the conscience - the moral aspects of the personality.

In-Text Question

The term _____ is the executive aspect of the personality and mediates between the instinctual demands of the id and the requirements of reality.

A. The superego B.The ego C.The id D. The Cash

In-Text Answer

B. The ego

13.2. Psychosexual development

As the person grows from infancy to adulthood, the energy of the libido progressively centers on different parts of the body. The stages of development are indicated by these various areas, called *erotogenic (erogenous*) zones by Freud.

Conflicts at each psychosexual stage must be resolved before the individual passes on to the next stage. Therefore, when a substantial part of the libido is left behind, or fixated, the individual's personality may become dominated by less mature modes of obtaining gratification or tension reduction.

The stages in psychosexual development are:

(a) The Oral stage
(b) Libidinal drives stage
(c) The phallic stage
(d) Tile latency period
(e) The genital stage

*(***a) The Oral stage:** The first stage is the oral stage, the time when the infant is completely dependent upon others for its survival, and the libido expresses itself through sucking and chewing. Adult behaviours such as excessive gum-chewing and smoking, verbal aggression and other oral activities are related to the person's experiences with early oral pleasures.

(b**) During the second year of life, the aim becomes the focus on anal stage:** during this anal stage, toilet training is normally begun and how this is done has profound effects on later development. The child learns that its bowel movements are ideal ways of controlling the parents' behaviour. Fixation at this stage can take several forms depending on the nature of the conflicts.

(c) The phallic stage: The fourth and fifth years represent the time when the psychic energy is centered in the genital region. Masturbation, experimentation with peers, and questioning of adults are indicative behaviours. This stage is labeled "phallic" because the penis is presumed to be the object of main interest to children of either sex.

The little girl is envious, according to Freud, while the little boy constantly fearing castration for his unconscious desire to experience sexual gratification with his mother. This represents the major conflict of the phallic stage, and has been termed the *oedipal complex* (named after Oedipus Rex, a figure from classic Greek drama, who murdered his father and

married his mother). Resolution hinges on the child's identification with the parent of the same sex.

The girl assumes a female role, and the boy relinquishes the desire to possess his mother and begins to emulate the traits of his father. In Freud's view, failure to resolve the oedipal complex is "one of the most important sources of the sense of guilt which so- often torments neurotic people" (Freud, 1935, p. 291).

In-Text Question

What is the first stage in psychosexual development
A. The genital stage B. Tile latency period stage C. The Oral stage D. Libidinal drives stage

In-Text Answer

C. the Oral stage

(d) Tile latency period stage: Freud felt that after about the sixth year, the child's sexual urges were dormant until their reawakening at puberty. During this period, the libido is channeled into school activities, relationships with peers, hobbies, etc.

(e) The genital stage: At puberty, the adolescent becomes sexually mature and the libido is centered again on the genital area. The person learns to direct sexual impulses towards appropriate objects and to enter into satisfying adult relationships.

Box 13.3:	**Libido work**
The libido is focused on different parts of the body at different stages of development. Most of these stages occur during the first five years of life, and if at any of these stages major conflicts are not resolved, the person, may become fixated at that stage, producing a lasting effect on the person's adult life	

Summary of Study Session 13

In this study session, you have learnt that:
1.Sigmund Freud was bum in Moravia, May 6, 1856, and died in London, September 23, 1939. He entered the medical school the University of Vienna in 1873 and graduated from there eight year later. In his medical career, Freud specialized in microanatomy and neurophysiology.
2. The psychoanalytic view maintains that all behaviour is caused, or determined by internal factors. Therefore, all behaviour is meaningful, even if the meaning is not apparent to the conscious mind.
3. In Freud's theory, the structure of the mind can conceivably be seen "as comprising three main parts, differentiated by their functions
4. As the person grows from infancy to adulthood, the energy of the libido progressively centers on different parts of the body. The stages of development are indicated by these various areas, called *erotogenic (erogenous*) zones by Freud.

Self-Assessment Questions (SAQs) for Study Session 13

Now, that you have completed this study session, you can assess how well you have achieved its learning outcomes by answering the following questions. Write your answers in your study diary and discuss them with your Tutor at the next Study Support Meeting. You can check your answers with the Notes on the Self-Assessment Questions at the end of this study session.

SAQ.13.1 (Testing Learning Outcome 13.1)

1. _____ was bum in Moravia, May 6, 1856, and died in London, September 23, 1939.SAQ 2.2 (Testing Learning Outcome 2.2)
2. Briefly explain any one characteristics of psychoanalytic theory.
3. Mention three Personality Structure of psycho-analytic theory

SAQ 13.2 (Test Learning Outcome 13.3)

Conflicts at each psychosexual stage must be resolved before the individual passes on to the next stage. True/False

SAQ 13.3 (Test Learning Outcome 13.2)

Explain any one stage in psychosexual development

Notes on SAQS

SAQ 2.1

1. Sigmund Freud
2. Closely related to this is a second characteristic, the emphasis given to unconscious processes. Unconscious thoughts and motives cannot be observed directly. They can be inferred, however, from the patient's dreams and free associations, which are less subject to conscious control.
3. Three Personality Structure of psycho-analytic theory are
   i. The id
   ii. The Ego
   iii. The Superego

SAQ 2.2

True

SAQ 2.3

The Oral stage: The first stage is the oral stage, the time when the infant is completely dependent upon others for its survival, and the libido expresses itself through sucking and chewing. Adult behaviours such as excessive gum-chewing and smoking, verbal aggression and other oral activities are related to the person's experiences with early oral pleasures.

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Study Session 14: Personality Theory (Jung and Adler)

Expected duration: 1 week or 2 contact hours

Introduction

Carl Jung was a young psychiatrist in Zurich when he read Freud's Interpretation of dreams soon after it was published in 1900. Since then Jung and Freud became friends and Jung bought all the ideas of Freud.

However, in August 1914, Jung withdrew from being a member of the International Psychoanalytic Association, broke away from Freud and propounded his own theory of personality the Analytic theory. On the other hand, Alfred Adler began to develop ideas that were at variance with those of Freud. He then formed his own ideas, which came to be known as Individual Psychology.

In this study session, you will be introduced to the differences that can be seen in theories of Freud, Jung and Adler and those theorists that have emphasized different concepts

Learning Outcomes for study session 14

At the end of this study session, you should also be able to:

1. Explain the differences that can be seen in theories of Freud, Jung and Adler
2. Discuss those theorists that have emphasized different concepts, 14.1 Carl Gustuv Jung (1875-1961)

It is ironical that Jung had to split with Freud because Freud himself had said that Jung was going to be his own successor. Jung's points of disagreement with Freud form the cornerstone of his (Jung's) own theory.

The Car Gustuv Jung Theories

1 There is a basic or general libido which is a form of psychic energy. Sexual libido is only one variant of this libidinal energy. This energy comes into being during the pre-pubertal period.

2 The roots of neurosis are to be found in the child's early interactions with the parents especially the mother. Although Freud later acknowledged this early child parent interaction, he emphasized instincts as the cause of neurosis and their derivatives.

3 According to Jung, the unconscious mind has several layers. The uppermost layer or level is closest to the human mind. The deepest level is called the collective unconscious. This layer contains or is the storehouse of latent memory traces inherited from one's ancestral past.

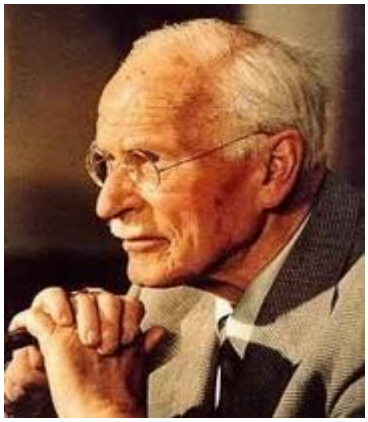

Figure 14.1:*Car Gustuv Jung*
Source: *http://www.astro.com/imwiki/adb/with/thumb002835-1333517546.jpg*

A past that includes not only the racial history of humans as a separate species but their pre-human or animal ancestry as well. The collective unconscious is the psychic residue of human evolutionary development, a residue that accumulates as a consequence of repeated experiences over many questions.

In-Text Question

_____ is only one variant of this libidinal energy. This energy comes into being during the pre-pubertal period
(A)Asexual libido (B).Sexual libido (C). Both sexual and asexual (D) No Answer

In-Text Answer

(B).Sexual libido
The structural, components of the collective unconscious are called by various names; archetypes, dominants, primordial images, imagoes, mythological images and behaviour patterns. An archetype is a universal thought form (idea) that contains a large element of emotion.

This thought form creates images or visions that correspond in normal waking life to some aspect of the conscious situation. For example, the archetype of the mother produces an image of a mother figure that is then identified with the actual mother. The collective unconscious is manifested through dreams and symbols.

The dream is an expression of unconscious or primordial images from the archetype. Thus, one could say that Jung's view of the unconscious is *phylogenetic* while Freud's view is *ontogenetic*. For Freud, the unconscious consist of infantile experiences and repressions.

Box 14.1: Jung Theory

Jung formulated his personality around (a) general libido - a form of psychic energy, (b) the idea that neurosis takes root from the child-parent interactions, and (c) the theory of collective unconscious - made of many layers or levels.

14.2 Alfred Adler (1870-1937)

Alfred Adler was born in Vienna in 1870 and died in Aberdeen, Scotland, in 1937 while on a lecture tour. Adler broke away from Freud in 1911. He disagreed with Freud over the role of sexuality in the causation of neurosis. He was also opposed to Freud's intrapsychic and biological orientations. Therefore he proposed his own theory of personality.

According to Adler, the prime mover of human action is a feeling of inferiority. *Inferiority* is a universal human field of experience. Although Adler restricted this inferiority to organ inferiority, he later generalized it to any form of human inferiority.

Adler says that inferiority originates in childhood because the child is small and helpless. The result of the feeling of inferiority is that the individual feels the need to strive for superiority of power. This is the expression of what Adler called the *Will to power*. The will to power then is the guiding force of human behaviour.

Figure 14.3:*Alfred Adler*
Source:*http://www.nndb.com/people/256/000097962/alfred-adler-1-sized.jp*

The struggle for power has been referred to as masculine protest because Adler believes that males are' characterized by the striving for superiority whereas females are characterized by passivity and inferiority. The Oedipal complex then is an expression of power relationships.

In-Text Question

4. Adler was born in _____
(a) Austria
(b) Scotland

(c) Germany
(d) Vienna

In-Text Answer

(d) Vienna

It expresses the boy's need to subjugate his mother and be a successful competitor with his father. The will to power is guided and restrained by social interest. One way to elaborate and achieve social interest is by education.

Box 14.2: Adler Theory

Adler opined that the prime mover of human action is a feeling of inferiority. This inferiority, according to Adler, originates in childhood. The result of the feeling of inferiority is that the individual feels the need to strive for superiority of power. This expression has been called the will to power by Adler.

Summary of Study Session 14

In this study session, you have learnt that:

1. Jung's theory of personality centered on the collective unconscious, made of so many layers. Adler's theory on the other hand, centered around the will to power which is the guiding force of human behaviour.
2.It is ironical that Jung had to split with Freud because Freud himself had said that Jung was going to be his own successor. Jung's points of disagreement with Freud form the cornerstone of his (Jung's) own theory.
3. There is a basic or general libido which is a form of psychic energy. Sexual libido is only one variant of this libidinal energy. This energy comes into being during the pre-pubertal period.
4. According to Jung, the unconscious mind has several layers. The uppermost layer or level is closest to the human mind. The deepest level is called the collective unconscious. This layer contains or is the storehouse of latent memory traces inherited from one's ancestral past.
5. A past that includes not only the racial history of humans as a separate species but their pre-human or animal ancestry as well.
6.Alfred Adler was born in Vienna in 1870 and died in Aberdeen, Scotland, in 1937 while on a lecture tour. Adler broke away from Freud in 1911.
7. According to Adler, the prime mover of human action is a feeling of inferiority. *Inferiority* is a universal human field of experience.

Self-Assessment Questions (SAQs) for Study Session 14

Now, that you have completed this study session, you can assess how well you have achieved its learning outcomes by answering the following questions. Write your answers in your study diary and discuss them with your Tutor at the next Study Support Meeting.

You can check your answers with the Notes on the Self-Assessment Questions at the end of this study session.

SAQ.14.1 (Testing Learning Outcome 14.1)

1. Give any one of theCar Gustuv Jung Theories
2. Adler died in the year _____.

(a) 1837
(b) 1957
(c) 1937
(d) 1637
(e) 1987.

SAQ 14.2 (Testing Learning Outcome 14.2)

1. What did Adler says about **inferiority**?
2. State the Jung's theory of personality

Notes on SAQS

SAQ 2.1

1. According to Jung, the unconscious mind has several layers. The uppermost layer or level is closest to the human mind. The deepest level is called the collective unconscious. This layer contains or is the storehouse of latent memory traces inherited from one's ancestral past.
2. The Alfred Adler die in (c) 1937

SAQ 2.2

1. Adler says that inferiority originates in childhood because the child is small and helpless. The result of the feeling of inferiority is that the individual feels the need to strive for superiority of power. This is the expression of what Adler called the *Will to power*. The will to power then is the guiding force of human behaviour.
2. The Jung's theory of personality centered on the collective unconscious made of so many layers. Adler's theory on the other hand, centered around the will to power which is the guiding force of human behaviour.

References

Adler, A. (1948). *Studies in Analytical Psychology*. Norton. New York.

Hall, S.C. and Lindzey, G. (1978). *Theories of Personality* (3rd Edition). John Wiley and Sons. New York. Jung, C.G. (1961). Memories, Dreams, Reflections. Random House, New York.

Study Session 15: Ethics in Clinical Psychology

Expected duration: 1 week or 2 contact hours

Introduction

Ethics are standards of correct professional behaviour. The standards exist so that clients, students, research participants and others are well served. The American Psychological Association developed a code of ethics for psychologists shortly after the Second World War in 1953. Since then, nine revised editions of the ethical code have been published, including the most recent edition published in 2002 and amended in 2010.

In this study session, you will be introduced to five general principles identified in the APA Ethics Code as a guide to professional practice, categories of the ethical standards as stated in the APA Ethical Code and the individual standards that are most relevant to the clinical psychologists.

Learning Outcomes for study session 15

At the end of this study session you should be able to:

15.1 Discuss Five General Principles Identified In The APA Ethics Code As A Guide To Professional Practice.

15.2 Explain Ten the Categories of the Ethical Standards As Stated in the APA Ethical Code

15.3 State Some Of The Individual Standards That Are Most Relevant To The Clinical Psychologists.

15.1 The Five General Principles of the APA Ethics Code

There are five general principles associated with APA Ethics Code which are listed below:

Principle A: Beneficence and No maleficence

Principle B: Fidelity and Responsibility

Principle C: Integrity

Principle D: Justice

Principle E: Respect for People's Rights and Dignity

Principle A: Beneficence and Nonmaleficence: Psychologists are expected to attempt to benefit those with whom they work and avoid doing harm.

Principle B: Fidelity and Responsibility: Psychologists are expected to develop relationships of trust with those with whom they work; they are expected to demonstrate awareness of their professional and scientific responsibilities to society and to the specific communities in which they work.

Principle C: Integrity: Psychologists are expected to promote accuracy, honesty and truthfulness in the science, teaching, and practice of psychology.

Principle D: Justice: Psychologists are expected to recognize that all people should have access to benefit from the contribution of psychology; psychologists are expected to avoid bias and to not condone unjust practices.

Principle E: Respect for People's Rights and Dignity: Psychologists are expected to respect people's right to privacy, confidentiality, and self-determination.

Box 15.1: The five general principles of the APA Ethics Code

The five general principles that act as ideals guiding the clinical psychologist's professional conduct are beneficence and no maleficence, fidelity and responsibility, integrity, justice and respect for people's rights and dignity.

15.2 Ten the Categories of the Ethical Standards as Stated in the APA Ethical Code

The Ethical Standards set forth enforceable rules for conduct as psychologists. Most of the Ethical Standards are written broadly, in order to apply to psychologists in varied roles, although the application of an Ethical Standard may vary depending on the context. The Ethical Standards are not exhaustive. The fact that a given conduct is not specifically addressed by an Ethical Standard does not mean that it is necessarily either ethical or unethical.

The 10 broad categories of the ethical standards made up of enforceable rules of conduct for psychologists are:

(1) Resolving ethical issues
(2) Competence
(3) Human relations
(4) Privacy and confidentiality
(5) Advertising and other public statements
(6) Record keeping and fees
(7) Education and training
(8) Research and publications
(9) Assessment and
(10) Therapy

1. Resolving Ethical Issues

If psychologists' ethical responsibilities conflict with law, regulations, or other governing legal authority, psychologists clarify the nature of the conflict, make known their commitment to the Ethics Code, and take reasonable steps to resolve the conflict consistent with the General Principles and Ethical Standards of the Ethics Code. Under no circumstances may this standard be used to justify or defend violating human rights.

Likewise, if the demands of an organization with which psychologists are affiliated or for whom they are working are in conflict with this Ethics Code, psychologists clarify the nature of the conflict, make known their commitment to the Ethics Code, and take reasonable steps to resolve the conflict consistent with the General Principles and Ethical Standards of the Ethics Code. Under no circumstances may this standard be used to justify or defend violating human rights.

2. Competence

Psychologists provide services, teach, and conduct research with populations and in areas only within the boundaries of their competence, based on their education, training, supervised experience, consultation, study, or professional experience. Psychologists planning to provide services, teach, or conduct research involving populations, areas, techniques, or technologies new to them undertake relevant education, training, supervised experience, consultation, or study.

In emergencies, when psychologists provide services to individuals for whom other mental health services are not available and for which psychologists have not obtained the necessary training, psychologists may provide such services in order to ensure that services are not denied. The services are discontinued as soon as the emergency has ended or appropriate services are available.

Psychologists' work is based upon established scientific and professional knowledge of the discipline. Psychologists who delegate work to employees, supervisees, or research or teaching assistants or who use the services of others, such as interpreters, take reasonable steps

Table 15.1: Reasonable steps a Psychologists take before delegate work to any professional

1. Avoid delegating such work to persons who have a multiple relationship with those being served that would likely lead to exploitation or loss of objectivity
2. Authorize only those responsibilities that such persons can be expected to perform competently on the basis of their education, training, or experience, either independently or with the level of supervision being provided
3. See that such persons perform these services competently

3. Human Relations

Psychologists do not engage in unfair discrimination or behavior that is harassing or demeaning to persons with whom they interact in their work based on age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, socioeconomic status, or any basis proscribed by law.

Psychologists take reasonable steps to avoid harming their clients/patients, students, supervisees, research participants, organizational clients, and others with whom they work, and to minimize harm where it is foreseeable and unavoidable.

Psychologists do not engage in sexual harassment. Sexual harassment is sexual solicitation, physical advances, or verbal or nonverbal conduct that is sexual in nature, that occurs in connection with the psychologist's activities or roles as a psychologist, and that either

(1) Is unwelcome, is offensive, or creates a hostile workplace or educational environment, and the psychologist knows or is told this or
(2) Is sufficiently severe or intense to be abusive to a reasonable person in the context. Sexual harassment can consist of a single intense or severe act or of multiple persistent or pervasive acts.

4. Privacy and Confidentiality

Psychologists have a primary obligation and take reasonable precautions to protect confidential information obtained through or stored in any medium, recognizing that the extent and limits of confidentiality may be regulated by law or established by institutional rules or professional or scientific relationship.

Psychologists discuss with persons (including, to the extent feasible, persons who are legally incapable of giving informed consent and their legal representatives) and organizations with which they establish a scientific or professional relationship

(1) The relevant limits of confidentiality and
(2) The foreseeable uses of the information generated through their psychological activities. Unless it is not feasible or is contraindicated, the discussion of confidentiality occurs at the outset of the relationship and thereafter as new circumstances may warrant.

Psychologists who offer services, products, or information via electronic transmission inform clients/patients of the risks to privacy and limits of confidentiality. Before recording the voices or images of individuals to whom they provide services, psychologists obtain permission from all such persons or their legal representatives.

Psychologists may disclose confidential information with the appropriate consent of the organizational client, the individual client/patient, or another legally authorized person on behalf of the client/patient unless prohibited by law.

Psychologists disclose confidential information without the consent of the individual only as mandated by law, or where permitted by law for a valid purpose such as to

(1) Provide needed professional services
(2) Obtain appropriate professional consultations
(3) Protect the client/patient, psychologist, or others from harm; or
(4) Obtain payment for services from a client/patient, in which instance disclosure is limited to the minimum that is necessary to achieve the purpose. When consulting with colleagues,

(1) Psychologists do not disclose confidential information that reasonably could lead to the identification of a client/patient, research participant, or other person or organization with whom they have a confidential relationship unless they have obtained the prior consent of the person or organization or the disclosure cannot be avoided, and

(2) They disclose information only to the extent necessary to achieve the purposes of the consultation. Psychologists do not disclose in their writings, lectures, or other public media, confidential, personally identifiable information concerning their clients/patients, students, research participants, organizational clients, or other recipients of their services that they obtained during the course of their work, unless
(1) They take reasonable steps to disguise the person or organization,
(2) The person or organization has consented in writing, or
(3) There is legal authorization for doing so.

5. Advertising and Other Public Statements
Psychologists do not knowingly make public statements that are false, deceptive, or fraudulent concerning their research, practice, or other work activities or those of persons or organizations with which they are affiliated.

Psychologists do not make false, deceptive, or fraudulent statements concerning
(1) Their training, experience, or competence
(2) Their academic degrees;
(3) Their credentials;
(4) Their institutional or association affiliations;
(5) Their services; (6) the scientific or clinical basis for, or results or degree of success of, their services;
(7) Their fees; or
(8) Their publications or research findings.

Psychologists claim degrees as credentials for their health services only if those degrees

(1) Were earned from a regionally accredited educational institution or

(2) Were the bases for psychology licensure by the state in which they practice.

When psychologists provide public advice or comment via print, Internet, or other electronic transmission, they take precautions to ensure that statements
(1) are based on their professional knowledge, training, or experience in accord with appropriate psychological literature and practice;
(2) are otherwise consistent with this Ethics Code; and
(3) do not indicate that a professional relationship has been established with the recipient.

6. Record Keeping and Fees

Psychologists create, and to the extent the records are under their control, maintain, disseminate, store, retain, and dispose of records and data relating to their professional and scientific work in order to
(1) Facilitate provision of services later by them or by other professionals,
(2) Allow for replication of research design and analyses,
(3) Meet institutional requirements,
(4) Ensure accuracy of billing and payments, and
(5) Ensure compliance with law.

In-Text Question

In Privacy and Confidentiality,Psychologists have a primary obligation and take reasonable precautions to protect confidential information obtained through or stored in any medium, recognizing that the extent and limits of confidentiality may be regulated by law or established by institutional rules or professional or scientific relationship. True/ False

In-Text Answer

True

Psychologists may not withhold records under their control that are requested and needed for a client's/patients emergency treatment solely because payment has not been received.As early as is feasible in a professional or scientific relationship, psychologists and recipients of psychological services reach an agreement specifying compensation and billing arrangements. Psychologists' fee practices are consistent with law.

7. Education and Training

Psychologists responsible for education and trainingprograms take reasonable steps to ensure that the programs are designed to provide the appropriate knowledge and proper experiences, and to meet the requirements for licensure, certification, or other goals for which claims are made by the program.

They also take reasonable steps to ensure that there is a current and accurate description of the program content (including participation in required course- or program-related counselling, psychotherapy, experiential groups, consulting projects, or community service), training goals and objectives, stipends and benefits, and requirements that must be met for satisfactory completion of the program.

This information must be made readily available to all interested parties. Psychologists do not engage in sexual relationships with students or supervisees who are in their department, agency, or training centre or over whom psychologists have or are likely to have evaluative authority.

8. Research and Publication

Among other obligation for research and publication, psychologists are expected to provide accurate information about their research proposals and obtain approval prior to conducting the research when institutional approval is required. They conduct the research in accordance with the approved research protocol.

When obtaining informed consent psychologists should inform participants about

(1) The purpose of the research, expected duration, and procedures;
(2) Their right to decline to participate and to withdraw from the research once participation has begun;
(3) The foreseeable consequences of declining or withdrawing;
(4) Reasonably foreseeable factors that may be expected to influence their willingness to participate such as potential risks, discomfort, or adverse effects;
(5) Any prospective research benefits;
(6) Limits of confidentiality;
(7) Incentives for participation; and
(8) Whom to contact for questions about the research and research participants' rights. They provide opportunity for the prospective participants to ask questions and receive answers.

Psychologists conducting intervention research involving the use of experimental treatments clarify to participants at the outset of the research

(1) The experimental nature of the treatment;
(2) The services that will or will not be available to the control group(s) if appropriate;
(3) The means by which assignment to treatment and control groups will be made;
(4) Available treatment alternatives if an individual does not wish to participate in the research or wishes to withdraw once a study has begun; and
(5) Compensation for or monetary costs of participating including, if appropriate, whether reimbursement from the participant or a third-party payor will be sought.

In-Text Question

When obtaining informed consent, psychologists should inform participants about _____

A.Any prospective research benefits
B. Limits of confidentiality
C. Incentives for participation
D. All of the above

In-Text Answer

D. All of the above

9. ASSESSMENT

Psychologists base the opinions contained in their recommendations, reports, and diagnostic or evaluative statements, including forensic testimony, on information and techniques sufficient to substantiate their findings. Except in exceptional cases, psychologists provide opinions of the psychological characteristics of individuals only after they have conducted an examination of the individuals adequate to support their statements or conclusions.

When, despite reasonable efforts, such an examination is not practical, psychologists document the efforts they made and the result of those efforts, clarify the probable impact of their limited information on the reliability and validity of their opinions, and appropriately limit the nature and extent of their conclusions or recommendations.

When psychologists conduct a record review or provide consultation or supervision and an individual examination is not warranted or necessary for the opinion, psychologists explain this and the sources of information on which they based their conclusions and recommendations.

With regards to use of assessments, psychologists administer, adapt, score, interpret, or use valid and reliable assessment techniques, interviews, tests, or instruments in a manner and for purposes that are appropriate in light of the research on or evidence of the usefulness and proper application of the techniques.

Psychologists use assessment methods that are appropriate to an individual's language preference and competence, unless the use of an alternative language is relevant to the assessment issues

.Psychologists obtain informed consent for assessments, evaluations, or diagnostic service except when

(1) Testing is mandated by law or governmental regulations;

(2) Informed consent is implied because testing is conducted as a routine educational, institutional, or organizational activity (e.g., when participants voluntarily agree to assessment when applying for a job); or
(3) One purpose of the testing is to evaluate decisional capacity. Informed consent includes an explanation of the nature and purpose of the assessment, fees, involvement of third parties, and limits of confidentiality and sufficient opportunity for the client/patient to ask questions and receive answers.

When interpreting assessment results, psychologists take into account the purpose of the assessment as well as the various test factors, test-taking abilities, and other characteristics of the person being assessed, such as situational, personal, linguistic, and cultural differences that might affect psychologists' judgments or reduce the accuracy of their interpretations.

10. THERAPY

When obtaining informed consent to therapy, psychologists inform clients/patients as early as is feasible in the therapeutic relationship about the nature and anticipated course of therapy, fees, involvement of third parties, and limits of confidentiality and provide sufficient opportunity for the client/patient to ask questions and receive answers.

When obtaining informed consent for treatment for which generally recognized techniques and procedures have not been established, psychologists inform their clients/patients of the developing nature of the treatment, the potential risks involved, alternative treatments that may be available, and the voluntary nature of their participation.

When the therapist is a trainee and the legal responsibility for the treatment provided resides with the supervisor, the client/patient, as part of the informed consent procedure, is informed that the therapist is in training and is being supervised and is given the name of the supervisor.

Psychologists do not engage in sexual intimacies with current therapy clients/patients nor with individuals they know to be close relatives, guardians, or significant others of current clients/patients. Psychologists do not terminate therapy to circumvent this standard.

Psychologists do not accept as therapy clients/patients persons with whom they have engaged in sexual intimacies. Psychologists do not engage in sexual intimacies with former clients/patients for at least two years after cessation or termination of therapy.

Psychologists terminate therapy when it becomes reasonably clear that the client/patient no longer needs the service, is not likely to benefit, or is being harmed by continued

service. Psychologists may terminate therapy when threatened or otherwise endangered by the client/patient or another person with whom the client/patient has a relationship.
Except where precluded by the actions of clients/patients or third-party payors, prior to termination psychologists provide pre-termination counseling and suggest alternative service providers as appropriate.
Source: Adapted from www.apa.org/ethics/code/principles.pdf (Accessed 13/07/14)

In-Text Question

Psychologists obtain informed consent for assessments, evaluations, or diagnostic service except when _____

A. Regards to use of assessments B.Testing is mandated by law or governmental regulations C.precluded by the actions of clients/patients D. Psychologists do not accept as therapy clients/patients

In-Text Answer

B.Testing is mandated by law or governmental regulations

Summary for study session 15

In this study session, you have learnt that:

1. The five general principles that act as ideals guiding the clinical psychologist's professional conduct are beneficence and nonmaleficence, fidelity and responsibility, integrity, justice and respect for people's rights and dignity.
2. The Ethics Code is intended to provide guidance for psychologists and standards of professional conduct that can be applied by the APA and by other bodies that choose to adopt them.
3. Beneficence and Nonmaleficence Psychologists are expected to attempt to benefit those with whom they work and avoid doing harm.
4. The Ethical Standards set forth enforceable rules for conduct as psychologists. Most of the Ethical Standards are written broadly, in order to apply to psychologists in varied roles, although the application of an Ethical Standard may vary depending on the context.
5.Resolving Ethical IssuesIf psychologists' ethical responsibilities conflict with law, regulations, or other governing legal authority, psychologists clarify the nature of the conflict.

Self-Assessment Questions (SAQs) for Study Session 15

Now, that you have completed this study session, you can assess how well you have achieved its learning outcomes by answering the following questions. Write your answers in your study diary and discuss them with your Tutor at the next Study Support Meeting. You can check your answers with the Notes on the Self-Assessment Questions at the end of this study session.

SAQ.15.1 (Testing Learning Outcome 15.1)

1. Mention five Principles associated with APA Ethics Code

2. Explain any two principles mentioned above

SAQ 15.2 (Testing Learning Outcome 15.2)

1. Explain Resolving ethical issues
2. Highlight three reasonable steps psychologists take before delegate work to any professional

Notes on SAQS

SAQ 15.1

1) Beneficence and Nonmaleficence
2) Fidelity and Responsibility
3) Integrity
4) Justice
5) Respect for People's Rights and Dignity

2.

A Fidelity and Responsibility: Psychologists are expected to develop relationships of trust with those with whom they work; they are expected to demonstrate awareness of their professional and scientific responsibilities to society and to the specific communities in which they work.

B Psychologists are expected to recognize that all people should have access to benefit from the contribution of psychology; psychologists are expected to avoid bias and to not condone unjust practices.

SAQ 15.2

1. Explain Resolving ethical issues If psychologists' ethical responsibilities conflict with law, regulations, or other governing legal authority, psychologists clarify the nature of the conflict, make known their commitment to the Ethics Code, and take reasonable steps to resolve the conflict consistent with the General Principles and Ethical Standards of the Ethics Code. Under no circumstances may this standard be used to justify or defend violating human rights.

2.

1. Avoid delegating such work to persons who have a multiple relationship with those being served that would likely lead to exploitation or loss of objectivity
2. Authorize only those responsibilities that such persons can be expected to perform competently on the basis of their education, training, or experience, either independently or with the level of supervision being provided
3. See that such persons perform these services competently

References

American Psychological Association. (2010). *American Psychological Association ethicalprinciples of psychologists and code of conduct*. Retrieved July 13, 2014, from http://www.apa.org/ethics/code/principles.pdf

Source: Adapted from www.apa.org/ethics/code/principles.pdf (Accessed 13/07/14