Instructor: Elizabeth A. Maynard, Ph.D.

Co-Instructor: Justyn D. Smith, M.S. (morning section)

Office: School of Education & Human Services Annex (1202 Colquitt)

Work Phone: 713-942-5938

Office Hours: M, T, & TH 4-5pm, W 3:45-4:30 & by appointment (in-person, phone, and Skype) other days and times

E-mail: maynare@stthom.edu (Justyn: jds131@shsu.edu)

Course Home Page: On Blackboard

Class Meeting: Mondays 9-11:45 & 1-3:45pm

Prerequisites: CMHC 5300

Course Description: This course introduces students to fundamental principles in understanding distress, impairment, and dysfunction in human behavior and social systems. Students are also introduced to the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) and other systems of conceptualizing psychopathology. An overview of classification, diagnosis, and etiology of mental disorders most likely encountered in professional counseling is offered. Excellent practice is evidence-based practice. To that end, this course offers the student the opportunity to gather and interpret evidence, both through direct client contact and through exploration of empirical research in this area. Both of these approaches to coursework support students’ understanding and application of diagnostic procedures, differential diagnosis, and social justice issues related to diagnosis.

Learning Outcomes: This course is designed to support the student in mastery of the following 2016 CACREP competencies:

SECTION 2: PROFESSIONAL COUNSELING IDENTITY
COUNSELING CURRICULUM (F)

2. SOCIAL AND CULTURAL DIVERSITY
f. help-seeking behaviors of diverse clients

3. HUMAN GROWTH AND DEVELOPMENT
c. theories of normal and abnormal personality development
d. theories and etiology of addictions and addictive behaviors
e. biological, neurological, and physiological factors that affect human development, functioning, and behavior
f. systemic and environmental factors that affect human development, functioning, and behavior
g. effects of crisis, disasters, and trauma on diverse individuals across the lifespan
h. a general framework for understanding differing abilities and strategies for differentiated interventions
i. ethical and culturally relevant strategies for promoting resilience and optimum development and wellness across the lifespan

5. COUNSELING AND HELPING RELATIONSHIPS
l. suicide prevention models and strategies
m. crisis intervention, trauma-informed, and community-based strategies, such as Psychological First Aid

7. ASSESSMENT AND TESTING
k. use of symptom checklists, and personality and psychological testing
l. use of assessment results to diagnose developmental, behavioral, and mental disorders

SECTION 5: ENTRY-LEVEL SPECIALTY AREAS
C. CLINICAL MENTAL HEALTH COUNSELING
1. FOUNDATIONS
d. neurobiological and medical foundation and etiology of addiction and co-occurring disorders
e. psychological tests and assessments specific to clinical mental health counseling

2. CONTEXTUAL DIMENSIONS
b. etiology, nomenclature, treatment, referral, and prevention of mental and emotional disorders
c. mental health service delivery modalities within the continuum of care, such as inpatient, outpatient, partial treatment and aftercare, and the mental health counseling services networks
d. diagnostic process, including differential diagnosis and the use of current diagnostic classification systems, including the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* and the International Classification of Diseases (ICD)
e. potential for substance use disorders to mimic and/or co-occur with a variety of neurological, medical, and psychological disorders
f. impact of crisis and trauma on individuals with mental health diagnoses
g. impact of biological and neurological mechanisms on mental health
h. classifications, indications, and contraindications of commonly prescribed psychopharmacological medications for appropriate medical referral and consultation
j. cultural factors relevant to clinical mental health counseling

3. PRACTICE
a. intake interview, mental status evaluation, biopsychosocial history, mental health history, and psychological assessment for treatment planning and caseload management

In addition to addressing the CACREP standards described above, this course is also designed to assist the student in her or his preparation for the National Counselor Examination (NCE) and licensure requirements for Licensed Professional Counselors (LPCs) in Texas (*Abnormal Behavior*).
This course addresses the following Catholic social justice dimensions:

**The Principle of Human Dignity:** Every human being is invaluable and worthy of respect as a member of the human family.

**The Principle of Association:** The person is not only sacred but also social. By association with others, human persons achieve their fulfillment.

**The Principle of Preferential Protection for the Poor and Vulnerable:** The good of society as a whole requires us to put the needs of the poor and vulnerable first.

**Required Texts:**


**Recommended Text:**


**Methods of Instructions and Conduct of the Course:**

This course will use lecture, class discussion, and case study to support student learning.

**Final Grade Distribution:**

The course grade will be determined by summing points from each of the assignments. The total number of points earned for the course will then be divided by the total possible points to yield a percentage. That percentage will then be used to assign the letter grade:

<table>
<thead>
<tr>
<th>Grade</th>
<th>Points Range</th>
<th>Assignments</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>94-100%</td>
<td>Case Studies (5 x 10 points)</td>
<td>50 points</td>
</tr>
<tr>
<td>A-</td>
<td>90-93</td>
<td>Exam #1</td>
<td>100 points</td>
</tr>
<tr>
<td>B+</td>
<td>87-89</td>
<td>Exam #2</td>
<td>100 points</td>
</tr>
<tr>
<td>B</td>
<td>84-86</td>
<td>Exam #3 (Final)</td>
<td>100 points</td>
</tr>
<tr>
<td>B-</td>
<td>80-83</td>
<td>Total</td>
<td>350 points</td>
</tr>
<tr>
<td>C</td>
<td>70-79</td>
<td></td>
<td></td>
</tr>
<tr>
<td>F</td>
<td>Below 70%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Grading:**

**Case Studies (50 points)**

Each student will complete 5 take-home case studies, each of which is due on the date specified in the course schedule. Each case study is worth 10 points. The case studies are designed to assess the student’s application of course material, including lectures and reading, into a response to a clinical vignette. Each case study should be 2-3 pages, typed and double-spaced. Case studies are designed to address CACREP standards 2.F.3.c-g.
<table>
<thead>
<tr>
<th>Case Study Content</th>
<th>Rating Criteria</th>
<th>Points Assigned</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paper format &amp; grammatical and stylistic accuracy</td>
<td>Appropriate use of APA 2010 style. Writing is clear, concise, and organized.</td>
<td>2 points</td>
</tr>
<tr>
<td>Mental Status Exam</td>
<td>Provides a brief mental status exam, including identifying information.</td>
<td>2 points</td>
</tr>
<tr>
<td>Symptomatology</td>
<td>Able to coherently identify three or more of the most significant symptoms reported by the client and describe the rationale for their importance.</td>
<td>2 points</td>
</tr>
<tr>
<td>Diagnosis</td>
<td>Provides a diagnosis to describe the client’s current symptoms and functioning, including rule-outs.</td>
<td>2 points</td>
</tr>
<tr>
<td>Diagnostic Rationale</td>
<td>Offers a narrative explanation of the diagnosis suggested.</td>
<td>2 points</td>
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</tbody>
</table>

**Examinations (300 points)**

Each student will complete three examinations worth 100 points each. The examinations will test mastery of assessment, diagnosis and research as discussed in class and in the course readings. Each examination will consist of multiple choice, short-answer, and essay items. The examinations will be cumulative, including information from throughout the course. The student will be permitted to use his or her copy of the DSM for the essay portions of each exam. The multiple choice and short answer portions of each exam are closed-book/closed-note. The exams are offered as take-home exams through Blackboard. Examinations are designed to address CACREP competencies 2.F.2.f, 2.F.3.c-l, and 2.F.7.k-l.

<table>
<thead>
<tr>
<th>Examination Content</th>
<th>Rating Criteria</th>
<th>Points Assigned</th>
</tr>
</thead>
<tbody>
<tr>
<td>Multiple Choice Items</td>
<td>25 questions</td>
<td>2 points each: 50 points total Points awarded for correct answers</td>
</tr>
<tr>
<td>Short Answer Questions</td>
<td>5 short-answer questions focusing on the application of theory and research. Completed questions should be 3-4 sentences each</td>
<td>6 points each: 30 points Half of the points for each question awarded for description of theory/research, half for application</td>
</tr>
<tr>
<td>Short Essay</td>
<td>1 short essay question asks the student to respond to a short client vignette, describe the key features of the vignette from a diagnostic perspective and apply theory and/or research to the case</td>
<td>20 points, of which 5 will be awarded for clarity of writing, 10 points for the identification of the key elements of the vignette, and 5 points for the application of theory/research</td>
</tr>
</tbody>
</table>
Late Assignment Policy: Late submission of case studies incurs a point deduction of two points for each late calendar day. Late submission of an exam incurs a point deduction of 5 points for each late calendar day. Students may submit late assignments to the instructor by email. The last day to submit the final exam is the day following the final exam date established by the registrar, as the instructor is accountable to grading windows established by the registrar’s office.

Academic Integrity and Standards of Conduct:

**Academic Integrity**

As a Catholic, Basilian university, integrity and honesty are integral components of UST’s core values. We support open, civil discourse and careful, respectful listening where freedom of thought and expression are valued and protected. The University also supports honesty and integrity by striving in various ways to foster respect for oneself and one’s own work, as well as respect for others, their work, and their basic human rights.

Students are expected to conduct themselves honestly on all academic assignments. University-wide information about academic integrity as well as procedures for addressing alleged violations can be found in the Graduate Catalog. Violations of academic integrity include, but are not limited to cheating, stealing, lying, forgery, and plagiarism. Ignorance of any of these offenses is not a valid reason for committing an act of academic dishonesty.

**Blackboard**

Course materials are placed on UST’s content management system, Blackboard.

**Recording Class Lectures**

With the instructor’s permission, students may record class lectures for their private use only. No clinical case presentations or case studies offered in class may be recorded. The materials may not be given, loaned, or sold to others without the consent of the instructor. In addition, class lectures must be appropriately cited when used (see APA Manual).

**Weather-Related Cancellations or Changes to Schedule**

When UST closes due to a weather event, the University will place this information on local television and radio channels, and the university’s website. Missed classes will be made up, either through the rescheduling of the class time, or through a supplemental academic activity.

**Learning Disabilities or Differences**

To request academic accommodations due to a disability or difference, contact Counseling and Disability Services (713-525-2169). If you have a letter from Counseling and Disability Services indicating that you are eligible for academic accommodations, please present the letter to the instructor to arrange for the use of your accommodations. To ensure fairness to all students and maintain appropriate professional boundaries, instructors follow the guidance of the Counseling and Disability Services office in the provision of accommodations.

**Writing Center**

To request assistance with writing papers, contact UST’s Tutorial Services office, located on the second floor of Crooker Center.
**Communication Devices**
To avoid distracting the instructor and other students from their class work, please turn off all cell phones or other communication devices during class time. Please refrain from text messaging, e-mailing, or surfing the web in class.

**Incomplete Grades**
Incomplete grades will only be given for extreme emergencies, at the discretion of the instructor. A death in your family, extreme illness (not colds and flu), military activation, or other significant events outside of your control may be grounds for an Incomplete grade.

**Withdrawal from Course**
To withdraw from the course with a grade of ‘W’, the student must withdraw by the date reflected in the University's academic calendar. Please consult the graduate catalog for more information.

**Course Evaluation at the End of the Semester**
Students are asked to evaluate the course and instructor at the end of each semester. This evaluation is extremely helpful in the improvement of our courses. Please participate in this important process.

IDEA Course Evaluation Dimensions (Discipline Code 5115 Mental Health Services)
CMHC 5325 Psychopathology & Atypical Behavior

<table>
<thead>
<tr>
<th>Item</th>
<th>Minor</th>
<th>Important</th>
<th>Essential</th>
<th>Dimension</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td>X</td>
<td></td>
<td>Gaining a basic understanding of the subject (factual knowledge, methods, principles, generalizations, theories)</td>
</tr>
<tr>
<td>2</td>
<td>X</td>
<td></td>
<td></td>
<td>Developing knowledge and understanding of diverse perspectives, global awareness, or other cultures</td>
</tr>
<tr>
<td>3</td>
<td></td>
<td>X</td>
<td></td>
<td>Learning to apply course material (to improve thinking, problem solving, and decisions)</td>
</tr>
<tr>
<td>4</td>
<td></td>
<td>X</td>
<td></td>
<td>Developing specific skills, competencies, and points of view needed by professionals in the field</td>
</tr>
<tr>
<td>5</td>
<td>X</td>
<td></td>
<td></td>
<td>Acquiring skills in working with others as a member of a team</td>
</tr>
<tr>
<td>6</td>
<td>X</td>
<td></td>
<td></td>
<td>Developing creative capacities</td>
</tr>
<tr>
<td>7</td>
<td>X</td>
<td></td>
<td></td>
<td>Gaining a broader understanding and appreciation of intellectual/cultural activity</td>
</tr>
<tr>
<td>8</td>
<td>X</td>
<td></td>
<td></td>
<td>Developing skill in expressing oneself orally or in writing</td>
</tr>
<tr>
<td>9</td>
<td>X</td>
<td></td>
<td></td>
<td>Learning how to find and use resources to explore a topic in depth</td>
</tr>
<tr>
<td>10</td>
<td>X</td>
<td></td>
<td></td>
<td>Developing ethical reasoning and/or ethical decision making</td>
</tr>
<tr>
<td>11</td>
<td></td>
<td>X</td>
<td></td>
<td>Learning to analyze and critically evaluate ideas, arguments, and points of view</td>
</tr>
<tr>
<td>12</td>
<td></td>
<td>X</td>
<td></td>
<td>Learning to apply knowledge and skills to benefit others or serve the public good</td>
</tr>
<tr>
<td>13</td>
<td>X</td>
<td></td>
<td></td>
<td>Learning appropriate methods for collecting, analyzing, and interpreting numerical information</td>
</tr>
</tbody>
</table>
### Schedule of Class Sessions:

<table>
<thead>
<tr>
<th>Week</th>
<th>Class</th>
<th>Session Topic</th>
<th>Required Reading</th>
<th>Assignment</th>
<th>Competencies</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1/23</td>
<td>Introduction to the Course History &amp; Culture</td>
<td>B &amp; D 1 &amp; 4</td>
<td></td>
<td>2.F.2.f 2.F.3.c,e,f,i</td>
</tr>
<tr>
<td>2</td>
<td>1/30</td>
<td>Bio-Psycho-Social-Spiritual Model Symptomatology Diagnosis</td>
<td>B &amp; D 2 DSM 5-25</td>
<td></td>
<td>2.F.2.f 2.F.3.c,e,f,i 2.F.7.k-l</td>
</tr>
<tr>
<td>3</td>
<td>2/6</td>
<td>Assessment &amp; Differential Diagnosis Diagnostic Customs V and Z codes</td>
<td>B &amp; D 3 DSM 707-732</td>
<td></td>
<td>2.F.2.f 2.F.3.c,e,f 2.F.7.k-l</td>
</tr>
<tr>
<td>4</td>
<td>2/13</td>
<td>Anxiety, OCD, and Trauma-Related Disorders</td>
<td>B &amp; D 5 DSM 189-290</td>
<td></td>
<td>2.F.3.c,e,g,i</td>
</tr>
<tr>
<td>5</td>
<td>2/20</td>
<td>Somatic &amp; Dissociative Disorders</td>
<td>B &amp; D 6 &amp; 9 DSM 291-328</td>
<td>Case Study #1 Due</td>
<td>2.F.3.c,e</td>
</tr>
<tr>
<td>6</td>
<td>2/27</td>
<td>Mood Disorders Review for Exam #1</td>
<td>B &amp; D 7 DSM 123-188</td>
<td>Take Home Exam #1 Distributed</td>
<td>2.F.3.c,e,i</td>
</tr>
<tr>
<td>7</td>
<td>3/6</td>
<td>Eating, Elimination &amp; Sleep-Related Disorders</td>
<td>B &amp; D 8 DSM 329-422</td>
<td>Exam #1 Due</td>
<td>2.F.3.c,e</td>
</tr>
<tr>
<td>8</td>
<td>3/13</td>
<td>Spring Break: No Class</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>3/20</td>
<td>Sex &amp; Gender-Related Disorders</td>
<td>B &amp; D 10 DSM 423-460 &amp; 685-706</td>
<td>Case Study #2 Due</td>
<td>2.F.3.c,e</td>
</tr>
<tr>
<td>10</td>
<td>3/27</td>
<td>Substance-Related Disorders Disruptive &amp; Impulse-Related Disorders</td>
<td>B &amp; D 11 DSM 461-590</td>
<td></td>
<td>2.F.3.c,d,e</td>
</tr>
<tr>
<td>11</td>
<td>4/3</td>
<td>Personality Disorders Review for Exam #2</td>
<td>B &amp; D 12 DSM 645-684 &amp; 761-782</td>
<td>Case Study #3 Due Take Home Exam #2 Distributed</td>
<td>2.F.3.c,e</td>
</tr>
<tr>
<td>12</td>
<td>4/10</td>
<td>Schizophrenia Spectrum &amp; Other Psychotic Disorders</td>
<td>B &amp; D 13 DSM 87-122</td>
<td>Exam #2 Due</td>
<td>2.F.3.c,e</td>
</tr>
<tr>
<td>13</td>
<td>4/17</td>
<td>Neurodevelopmental Disorders</td>
<td>B &amp; D 14 DSM 31-86</td>
<td>Case Study #4 Due</td>
<td>2.F.3.c,e,h</td>
</tr>
<tr>
<td>14</td>
<td>4/24</td>
<td>Neurocognitive Disorders</td>
<td>B &amp; D 15 DSM 591-644</td>
<td></td>
<td>2.F.3.c,e,h</td>
</tr>
<tr>
<td>15</td>
<td>5/1</td>
<td>Legal &amp; Ethical Issues Course Summary Final Exam Review</td>
<td>B &amp; D 16</td>
<td>Case Study #5 Due</td>
<td>2.F.2.f 2.F.3.c,e,f 2.F.7.k-l</td>
</tr>
<tr>
<td>Exam Period</td>
<td>5/15</td>
<td>Final Exam Due by 5pm on Date Scheduled by the Registrar</td>
<td>Final Exam Due</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
This is the instructor’s best estimate of how the course will proceed. Revisions may be made to the schedule, as needed, throughout the semester. In the schedule, B & D refers to chapters in the Barlow & Durand text, and DSM numbers refer to page numbers in the DSM-5.
Case Study #1: Brandon

**Identifying Information/Referral Source**
Brandon is a 25 year-old African-American man enrolled in medical school. He is partnered, gay-identified, and a member of an AME church. He was self-referred for counseling due to problems completing some course requirements.

**Presenting Problem (in the client’s own words)**
“I’m failing one of my lab classes. I’m fine with blood and stuff like that, but I just can’t handle dissecting the cadaver in my anatomy lab. My head starts to spin and I feel like throwing up. My mind races and I feel a weight pressing down on my chest. I feel like I’m going to die. If I don’t pass this class I’m going to fail out of school.”

**History of Presenting Problem**
Brandon was raised in a working class neighborhood of New Orleans. He felt inspired to pursue medicine due to a love of science and his observation that many of the families in his neighborhood could not afford medical care: “most of the families in my neighborhood made too much money to qualify for free care, and too little to pay for it on our own. Most of our parents’ jobs didn’t come with health insurance when I was a kid. Some of that changed with the Affordable Care Act, but not a lot.” Brandon was a successful student at a competitive math and science magnet high school.

During Brandon’s childhood, New Orleans was struck by Hurricane Katrina, and experienced significant flooding. Much of Brandon’s neighborhood was destroyed by this flooding. Because Brandon’s father was considered “essential personnel” in a local hotel, his family did not evacuate prior to the hurricane, and Brandon experienced many fearful hours at home during the storm, and some emotional trauma when he saw the bodies of two people who had drowned. Brandon and his family relocated to Houston after the hurricane so that his parents could secure work and housing. Brandon was able to complete school there and was admitted as a pre-med student at a competitive college. He maintained good grades throughout college and was able to gain admission to medical school during his first round of applications.

**Current functioning**

**Academic/Vocational:** Brandon has been successful in each of his lecture-based courses in medical school, and has been successful in labs that do not require human or animal dissection.

**Financial:** As a medical student, Brandon is on a limited budget, supported primarily by grants and loans. His partner, Ryan, is also a graduate student on a limited budget.

**Social Support:** Brandon experienced disruption in his relationships with his school friends and teachers following Hurricane Katrina. However, he was able to develop positive relationships with peers in college, and he has made several good friends in medical school. He reports that his parents are very proud of him and supportive of his career path. He is not “out” to his parents because he fears their reaction; he is “out” to his sister, who has remained supportive. He is not sure if his parents would be more upset that he is gay or that his partner is a white man, though he suspects that they would be more upset that he is gay. He attends a local AME church weekly without his partner.

**Sexual:** Brandon dated girls in high school and early college, but has dated men exclusively for the last five years. He reports that he and Ryan are in a closed (monogamous) sexual relationship, and that they are sexually active three or four times per week (“depends on how much studying we have to do”). He reports no current or past concerns with sexual dysfunction.

**Eating:** Brandon reports that he eats 3 full meals and 2 snacks most days. He reports disruption in his appetite on lab days: “I wake up just feeling sick to my stomach and I can’t eat on lab days.” He appears to be height-weight proportional.
Sleeping: Brandon reports that he sleeps 5-6 hours each night. He would like to sleep more, but sometimes has so much studying to do that he compromises sleep. He also reports that on lab days he often has difficulty falling asleep, even when very tired: “I can’t stop thinking about those bodies...I see them in my mind’s eye...it feels so bad to touch them.”

Exercise: Brandon exercises 3-4 days/week.

Spiritual: Brandon attends church weekly and finds it to provide good social support. He notes some pressure at church to date women and he feels that he can’t be “out” at church: “Sometimes I see the women looking at me, and the guys joke with me that I could have my pick.” He also reports that “I don’t know if God and I are cool about the gay thing.”

Family History
Brandon is the elder of two children. His parents are married and live in Texas. His younger sister, age 21, is a college student. He reports that he has good relationships with his parents and sister overall, though he keeps information from them “so they don’t worry too much.” Brandon and his partner, Ryan, met in college and have been together for 3 years. He tells you that it was “love at first sight” for him, though he suspects that it was “lust at first site” for Ryan. They have talked about getting married in the future, though they want to see where their relationship goes before they make that commitment. Brandon would like to be a father in the future “but not until I’m finished with my residency.”

Abuse History (Physical, Sexual, Emotional)
Brandon denies any significant abuse history. He reported that his parents used spanking as a form of discipline when he was a child.

Previous Treatment
Brandon participated in brief counseling in college during the coming out process. He reports that the counseling was helpful overall, though “my counselor didn’t understand Black people very well.”

Medical History
Brandon denies any history of major illnesses or accidents. He is currently in good health, with some seasonal allergy symptoms.

Substance Use/Abuse
Brandon reports that he drank alcohol frequently in college (“about as much as the other guys”), but limits his current consumption to 1-2 beers on the weekends. He also reports that he used marijuana on several occasions during college, but has given it up in medical school. He denies any other drug use.

Mental Status
Client was alert and oriented x 4. His mood and affect appeared to be anxious, and his voice trembled when he mentioned the lab courses. He tapped one of his feet rhythmically throughout the session, and sometimes appeared to be humming under his breath. He sighed heavily several times during the session, often after discussing the pressures of medical school.

Suicidality/Dangerousness
To Self: Brandon denies suicidal ideation, intent, or plan.
To Others: Brandon denies ideation, intent, or plan to harm others.

Legal/Ethical Issues
None
Case Study #2: Maria

Identifying Information/Referral Source
Maria is a 27 year-old Mexican-American woman in the third trimester of her second pregnancy. She is married, heterosexual, and identifies as Roman Catholic. She was referred for counseling by her OB/GYN due to her report of persistent symptoms of depression.

Presenting Problem (in the client’s own words)
“I’m feeling so down every day. I don’t have any energy. It wasn’t this way with my first pregnancy.” “I’m scared because I’ve had thoughts of hurting myself and I’m afraid that I won’t be able to take care of my baby.”

History of Presenting Problem
Maria reports that she had an uncomplicated first pregnancy at age 24. Although she experienced “baby blues” for a week following the vaginal delivery of her son, her mood lifted and she was able to return to many of the activities that she enjoyed within a month of her son’s birth. She reports that she has enjoyed being a parent, and finds her husband to be loving and supportive.

She reports that her current pregnancy was planned. She began to experience feelings of depression during the first trimester. This surprised her, as she had not experienced any depressive symptoms during her first pregnancy. She tried to ignore the depressed feelings, and attributed her loss of energy, sadness, and sleep disruptions to morning sickness and other physical symptoms related to pregnancy. However, she has become increasingly tearful and hopeless in the last two months, and her anxiety about being a good parent to her children has escalated. She reports that she has had thoughts of committing suicide that frighten her. She is also frightened that she will neglect or harm her new baby.

She reports that she is scheduled to have a C-section to delivery her second baby, as the baby is positioned in such a way that a vaginal delivery is not recommended. She has refused medication for her depressive symptoms up to this time, and reports that her husband is strongly opposed to her taking medication for her symptoms, due to a fear that the medications will harm the fetus.

Maria reports that she had one episode of depression in her junior year of high school that lasted three months. During that time, she experienced sleep disruption, hopelessness, and tearfulness on most days. Her parents were going through a contentious divorce at that time. She met with the school counselor for three sessions, but did not find that experience helpful. She did not take any medications.

Current functioning
Academic/Vocational: Maria completed her B.A. in Elementary Education and teaching credential at a local university. She has worked as a second grade teacher in a Catholic school since her graduation. She took a 3-month maternity leave after the birth of her first child and plans to do the same with her second child.

Financial: Maria reports some anxiety about money because both she and her husband work as school teachers. They have medical insurance through their jobs, but she is worried about the expenses from the upcoming birth that will not be covered by insurance, and the lost income from taking FMLA during maternity leave.

Social Support: Maria reports that her relationship with her husband is good. She also reports good relationships with her mother, older sister, and two other female friends/coworkers. She attends mass at her church regularly, and has some acquaintances at church. She feels supported by the priest of her parish, but confused because he encouraged her to talk to a psychiatrist about medication for her depression.

Sexual: Maria reports that she was raped by a classmate during her first year of college. She reports that she has
flaskbacks to that experience several times per year, and has noticed that the flashbacks have increased during her pregnancy. She reports that her sexual relationship with her husband has been “fine,” though she has lost interest in sex due to her depression and physical discomfort in the last trimester of pregnancy.

*Eating:* Maria reports diminished appetite in the second and third trimesters, and her doctor is concerned that she is not gaining the appropriate amount of weight for the pregnancy.

*Sleeping:* Maria reports sleep disruptions that began at the same time that her depressive symptoms began. She often has difficulty falling and staying asleep, and she wakes early in the morning and is unable to return to sleep. These sleep disruptions appear to be separate from those caused by her baby kicking.

*Exercise:* At her doctor’s suggestion, Maria walks 6 blocks each day.

*Spiritual:* Maria attends mass at her local parish weekly. She states that she is confused why God would allow her to feel depressed like this.

**Family History**

Maria is the middle of three children. Her parents divorced when she was in high school. Both parents are living. She has good relationships with both siblings, though she talks to her younger brother less often than her older sister. She also has regular contact with her grandparents and several cousins.

Maria and her husband have been married for five years. They have one child, age 3.

**Abuse History (Physical, Sexual, Emotional)**

Maria reports that she was raped by a classmate during her freshman year of college. She denies any other abuse history.

**Previous Treatment**

Maria participated in brief counseling with a school counselor when her parents divorced. She reports that she did not find the experience to be helpful.

**Medical History**

Maria has not history of major illnesses or accidents. She is currently pregnant. Her previous pregnancy was uncomplicated.

**Substance Use/Abuse**

Maria denies any current substance use or abuse.

**Mental Status**

The client was alert and oriented x 4. She was visibly pregnant. *Add the other dimensions to this mental status exam based on what would be plausible for a person in her situation.*

**Suicidality/Dangerousness**

*To Self:* Maria reports passive suicidal ideation, without intent or plan.

*To Others:* Maria reports concern that she may accidentally hurt her new baby, without intent or plan.

**Legal/Ethical Issues**

None
Case Study #3: Guy

Identifying Information/Referral Source
Guy is a 54 year-old European-American man. He is married, heterosexual, and “spiritual but not religious.” He was self-referred for counseling.

Presenting Problem (in the client’s own words)
“I feel pretty bad. I lost my job about 18 months ago and things have been going downhill since then. I have a hard time sleeping. My eating is all messed up. And to add insult to injury, my sex life is a wreck.”

History of Presenting Problem
Guy reports that he lost his job as a marketing manager 18 months ago when his company experienced financial crisis. He feels upset about the job loss, due both to the financial problem it has caused in his own life (“we are living on my wife’s salary and our savings”) and the loss of meaningful daily activity. He has applied for several similar positions, but has not been invited to any interviews. He tells you that he is “very discouraged” about his job prospects, and feels like he is leaving the burden of supporting the family on his wife.

Worries about money and his future have led to sleeping problems. He reports that he is up for several hours past the time that his wife goes to sleep. He is usually up until 2 or 3 am, unable to sleep. He tells you, “If I try to lay there in bed and sleep, I just stare at the ceiling for hours. I toss and turn. I’m miserable.” He would like to fall asleep between 10 and 11 pm each night. He has begun to spend most of his nighttime waking hours on the internet, checking updates on the upcoming election and watching pornography.

He feels guilty about the pornography use: “my wife would be really pissed at me if she knew what I was doing.” He would like to stop using the pornography or spend much less time on the computer. He reports that he has become increasingly disinterested in sex with his wife. For the last five months, she has initiated sex with him and he has either found himself disinterested or unable to sustain an erection. He reports that he does not have any difficulty sustaining an erection when he masturbates.

Guy reports that he has gained about 40 pounds since he lost his job. He reports that “I was always a heavier person, but I’ve really packed on the pounds these last few months.” He tells you that he eats 3-4 large meals per day, but denies any binges or purges. He says that “some days I just sit in front of the computer or TV and just snack on junk food.”

Current Functioning
Academic/Vocational: Guy is currently unemployed and looking for work in marketing.
Financial: Guy is “extremely stressed” about the family finances since he lost his job.
Social Support: Guy reports that his wife is “a really great person – really supportive.” He feels that he is letting her and their 14 year-old daughter down because he is not earning money for the family. He talks to his older brother on the phone a few times each month. His mother is deceased and his father is “not a very social person” and not a source of support.
Sexual: See above history.
Eating: See above history.
Sleeping: See above history.
Exercise: “None. I need to get off my butt.”
Spiritual: Guy describes himself as “spiritual but not religious.” He was raised in a Seventh Day Adventist home, but reports that he has not practiced that tradition since he left home to go to college. “I think that there’s something bigger than me, but I don’t know that I would call that God, or consciousness, or just something else.”

Family History
Guy is the middle of three children. He has one older brother who lives in a neighboring state. His younger sister died of leukemia as an adolescent. His mother died of breast cancer 5 years ago. Guy met his wife in college and they married in their late-20s. They have one daughter, age 14.

Abuse History (Physical, Sexual, Emotional) The client denies any history of abuse. He reports “my dad spanked us when we acted up as kids, but it was no big deal.”

Previous Treatment
Guy reports that he and his wife participated in pre-marital counseling before their marriage 15 years ago. “It was OK.”

Medical History
Guy reports that during a recent physical with his doctor he was diagnosed with hypertension. He now takes 20mg of Lisinopril (a blood pressure medication) each day. He also reports that his doctor encouraged him to lose 30 or more pounds to reduce his blood pressure and reduce the likelihood of developing Type II diabetes.

Substance Use/Abuse
Guy reports that he drinks “socially,” usually 1-2 alcoholic drinks with his wife when they go out to dinner. He denies any previous history of substance abuse or dependence. He denies tobacco use.

Mental Status
This section is up to you this time. Write an MSE that would be possible for a man who reports the symptoms listed above. In other words, you can be creative. Be sure to cover each of the important dimensions of an MSE. The MSE must be consistent with the diagnosis that you choose.

Suicidality/Dangerousness
Guy denies any current suicidal ideation, intent, or plan. He denies any intent to harm others.

Legal/Ethical Issues
None
Case Study #4: Felicia

Identifying Information/Referral Source
Felicia is a 19 year-old single, biracial (African-American and Anglo) woman. She is heterosexual and “spiritual.” She incorporates elements of Roman Catholicism, Wicca, Native American and indigenous African religious practices into her daily life. She was referred for counseling by her physician.

Presenting Problem (in the client’s own words)
Felicia’s physician referred her to you for counseling after treating her for several superficial cuts to both of her forearms. She tells you “I was drunk and stoned when I did that, so it doesn’t really mean anything.” Her physician also noted evidence of past cigarette burns on her arms and shoulders.

History of Presenting Problem
Felicia reports that she has cut herself before, and burns herself with cigarettes from time to time when she feels upset. She has used marijuana 2 or more times per day, every day, for more than 7 months, but feels frustrated because “it just isn’t doing for me what it used to. I might have to find something stronger.”

She tells you that she took an introductory psychology course at the local community college last semester and thinks that she might have bipolar disorder: “I get really down sometimes, but other times I’m on top of the world.” Upon further questioning, she reveals that she feels “high” when she is in a new relationship and “suicidal” when a boyfriend leaves her, no matter how long they have been together. She wonders if her sexual interests cause men to leave her: “I like a lot of sex, and I like the rough stuff…the rougher the better. It’s hard for me to get off if it is gentle.” Her last boyfriend did not enjoy the slapping that she wanted, and he broke off the relationship ten days ago.

Current Functioning
Academic/Vocational: Felicia is employed half-time at a local pet store. She takes 1-2 classes at the local community college per semester. She is pursuing her associate’s degree.

Financial: Felicia reports that she has some stress about money, but living with her parents or boyfriend (when she has one) helps her save money.

Social Support: Felicia reports intense attachments to dating partners, both during and after each relationship. She has dated 3 men in the last 18 months. She feels supported by her parents, with whom she lives, and by her maternal grandmother. She reports conflicted relationships with other women: “They are jealous of me. It’s easy for me to get a guy to notice me, and that makes some of them mad.”

Sexual: Felicia has been sexually active with male peers since age 13. She reports that she had a pregnancy scare in her last relationship, and felt happy that her boyfriend was willing to stay. However, after she had an early-term miscarriage, her boyfriend ended the relationship.

Eating: Felicia is slender and physically fit. She appears to be within healthy limits and height-weight proportional. She denies any disordered eating. “I’m usually not that hungry, but I’ll eat anyway.”

Sleeping: No problems reported.

Exercise: “I walk my parents’ dog every day. That’s pretty good exercise.”

Spiritual: Felicia incorporates elements of Roman Catholicism, Wicca, and Native American and indigenous African religions into her daily life. “I do all of it. It’s all good.” She reports that she feels connected to Catholicism and Wicca through her European ancestry, and to Native American and African practices through her African-American ancestry.
Family History
Felicia is an only child. Her mother (Anglo) and father (African-American) met during high school and dated on and off before marrying in their mid-20s.

Abuse History (Physical, Sexual, Emotional)
The client reports that some of her early experimentation with sex “wasn’t exactly consensual, but we were all kids – I don’t think that they knew they were hurting me”. She denies any history of physical abuse within her family or intimate relationships.

Previous Treatment
None.

Medical History
Felicia was referred by her physician for multiple cuts to her forearms and past burns. She denies any significant childhood injuries or illnesses. In addition to the unplanned pregnancy that ended in a miscarriage earlier this year, she also reports that she has been diagnosed with genital herpes and HPV. She has had some flare-ups of the herpes, particularly when she is under significant stress.

Substance Use/Abuse
See previous report of marijuana use. She denies the use of alcohol other than at big parties, tobacco, and other drugs.

Mental Status
This section is up to you this time. Write an MSE that would be possible for a woman who reports the symptoms listed above. In other words, you can be creative. Be sure to cover each of the important dimensions of an MSE. The MSE must be consistent with the diagnosis that you choose.

Suicidality/Dangerousness
Felicia denies any current suicidal or homicidal ideation, intent, or plan at the time of the meeting with the counselor.

Legal/Ethical Issues
None
Case Study #5: Hoyda

Identifying Information/Referral Source

Hoyda is a 10 year-old Egyptian-American elementary student enrolled in the 3rd grade. She was born in the U.S. to immigrant parents. She was referred for treatment by her teacher.

Presenting Problem (in the client’s own words)

“My teacher says I don’t pay attention, but I do. I try to pay attention, but then she tells me that I’m not trying hard enough.”

History of Presenting Problem

English is Hoyda’s second language. Both of her parents speak English fluently, but do not use it at home. When Hoyda first began having academic problems, her teachers assumed it might be a language problem. However, Hoyda’s verbal language skills seem comparable to those of her peers. During a parent-teacher conference, Hoyda’s parents reported that they, too, have noticed that Hoyda is distractible and often daydreams when she has been assigned a task. They have used discipline and rewards to attempt to change her behavior, to no avail. When the teacher suggested that Hoyda may have an attentional problem and recommended a referral to a child psychiatrist, her father stated “We don’t believe in that. Too many American children are being medicated for this Attention Deficit problem. It is a problem of discipline. She needs to learn how to pay attention and do her work if she is to become successful. She can’t rely on medication.” Concerned that the problem has persisted since first grade and seems to be impacting her social relationships with her peers, the teacher asked the parents’ permission to refer her to a professional counselor in the school district. They agreed, so long as medication was not involved.

Current functioning

Academic/Vocational: Hoyda’s grades have slipped consistently over the last three years as class material has become more complex and requires sustained attention.

Financial: Not assessed.

Social Support: Hoyda reports that she enjoys some friends at school, mostly students from other countries.

Sexual: Hoyda has not gone through menarche yet. She says that she had a “boyfriend” earlier in the year when they worked on a class project together.


Sleeping: No disturbances.

Exercise: She participates in a school physical education class and walks to and from school.

Spiritual: She and her family practice Islam.

Family History

Hoyda is the youngest of three children. Her father, an engineer, and her mother, a homemaker, are married. Her older brothers, ages 14 and 17, are performing well in high school and have plans to enroll in college. Hoyda’s paternal grandmother lives with the family. Other members of the extended family live in Egypt.

Abuse History (Physical, Sexual, Emotional)

Hoyda’s parents use spanking to discipline her. They deny any emotional or sexual abuse.
Previous Treatment
None.

Medical History
Normal gestation and birth. Met normal developmental milestones the first 5 years. Experienced mild concussion when family vehicle was struck in a car accident when Hoyda was 6 years old. No current medical conditions or medications.

Substance Use/Abuse
None.

Mental Status
Hoyda was alert and oriented x 4. Complete this MSE.

Suicidality/Dangerousness
To Self: None.
To Others: None.

Legal/Ethical Issues
Client is a minor (age 10). Parents have given consent for assessment, but will not give consent for psychiatric evaluation.