**Argosy University**

**COURSE SYLLABUS**

*PC6712*

*Diagnosis and Treatment of Behavioral and Emotional Disorders*

**Faculty Information**

**Professor:                               Juergen E. Korbanka, Ph.D.**

**Phone Number:                        (801) 367-7964**

**E-mail:**[**Jkorbanka@argosy.edu**](mailto:Jkorbanka@argosy.edu)**or korbanka@yahoo.com**

**Office hours:**By appointment (during the week, call me on my cell, reach me via text or e-mail. On the weekends, text or e-mail is the best way to reach me). Please no calls after 8:00 pm.

**Brief Bio:**Dr. Korbanka serves as the Executive Director of Wasatch Mental Health, a community mental health center in Provo, Utah since 2007. His research interests include evidence-based and outcome oriented time-limited treatment programs, program effectiveness, and treatment efficiency. He has presented numerous times at local, statewide, and national conferences, including the American Counseling Association Conference (2002 & 2003), the Utah State Mental Health Conference, the National Conference for Behavioral Health (2009) and the Utah Domestic Violence Conference. He has authored work appearing in Psychological Reports (1997 & 2003) and the Journal for Interpersonal Violence (2000). Together we Andrew Barber, Ph.D., he wrote the introductory statistics text “Research and Statistics for the Social Sciences” (2004). A workbook geared towards treatment of individuals with Borderline Personality Disorder and Substance abuse issues appeared in Spring 2004 (authored with Randy Huntington, LCSW). In his clinical practice, Dr. Korbanka worked extensively with perpetrators of domestic violence and individuals with Borderline Personality Disorder. In addition to administrative and clinical responsibilities, Dr. Korbanka teaches for the College of Social Sciences at the Utah Campus of the University of Phoenix and Argosy University. From 2007 – 2010, he served as the Chair of the Utah Behavioral Healthcare Committee. Dr. Korbanka has been recognized with an Who is Who in America listing, an Outstanding Practitioner Award (Chi Sigma Iota – 2003), a Lifetime Achievement Award (UMHCA-2008), a Distinguished Teaching Award (University of Phoenix – 2002), an Employee of the Year Award (Wasatch Mental Health – 2000), an Excellence of Teaching Award (University of Phoenix, Utah – 1999), and an Outstanding Service Award (Utah County Domestic Violence Coalition – 1998).

**Course Scope:**

PC6712 is a course that should be taken during the second year in the Master’s in Clinical Mental Health Counseling program. This core course presents students with the fundamentals of diagnosis, comorbidity, assessment and treatment to be a competent counselor. Additionally, students will learn how to evaluate multicultural, lifespan, and ethical constructs as related to diagnosis and treatment.

**Course Description:**

The course provides a framework for exploring the established diagnostic criteria for mental and emotional disorders, including the principles of the diagnostic process and differential diagnoses across the lifespan.  The course also focuses on the knowledge of co-occurring substance use disorders with medical and psychological conditions and addresses the potential biases of commonly used diagnostic tools with multicultural populations. The models and theories that guide intervention and ethical treatment planning are discussed, including the use of diagnoses in times of crisis, disaster, or trauma.

**Class Meeting Schedule**

**We will meet the Following Saturdays**

**Saturday, October 1st from:                   8:00 am – 1:00 pm (this is correct !)**

**Saturday, October 8th from:                  8:00 am – 12:30 pm**

**Saturday, October 22nd from:               8:00 am – 12:30 pm**

**Saturday, November 12th from:           8:00 am – 12:30 pm**

**Saturday, December 3rd from:              8:00 am – 12:30 pm**

**Saturday, December 17th from:                        8:00 am – 12:30 pm**

**Please note:            The Argosy shell lists the class as a 7.5 week class. However, we will be meeting over a 15 week period. Therefore, the due dates in the shell are incorrect. Please follow the outline for the assignments and due dates below. The listed due dates in following table supersede the dates listed in the class shell.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Assignment** | **Module** | **Points** | **Week** | **Due Date** |
| Discussion Question – Module 1 Assignment 1 | 1 | n/a | 1 | 09/09 |
| Discussion Question – Module 1 Assignment 2 | 1 | 40 | 2 | 09/16 |
| Portfolio work - Module 1 – Assignment 3 | 1 | n/a | 3 | 09/23 |
| Working Ahead – Module 1 – Assignment 4 | 1 | n/a | 4 | 09/30 |
| Discussion Question – Module 2 Assignment 1 | 2 | 40 | 5 | 10/05 |
| **Journal Article Critique** – Module 2 Assignment 2  **Option 1:** Complete paper as described  **Option 2**: Write a brief (3-4 pages) partial assessment (Identifying information, Presenting Issues, Mental Status Exam, and Social History on one of the vignettes provided in class.  **Please note: You do ONLY need to complete Option 1 OR 2, not both.** | 2 | 60 | 6 | 10/12 |
| Discussion Question – Module 3 Assignment 1 | 3 | 40 | 6 | 10/14 |
| **Cultural Immersion Experience** – Module 3 Assignment 2  **Option 1:** Complete paper as described on the Cultural Immersion Experience  **Option 2**: Write an assessment of an individual who is culturally diverse from you.  **Please note: You do ONLY need to complete Option 1 OR 2, not both.** | 3 | 60 | 7 | 10/21 |
| Discussion Question – Module 4 – Assignment 1 | 4 | 40 | 8 | 10/26 |
| Diagnosis Research Paper – Module 4 – Assignment 2 | 4 | 200 | 9 | 10/28 |
| Discussion Questions – Module 5 – Assignment 1 | 5 | 40 | 10 | 11/02 |
| Differential Diagnosis – Module 5 – Assignment 2 | 5 | 40 | 10 | 11/09 |
| Discussion Question – Module 6 – Assignment 1 | 6 | 40 | 11 | 11/16 |
| **The Role of Culture**– Module 6 – Assignment 2  **Option 1:** Complete paper as described on the case of John  **Option 2**: Write an assessment following the outline provided in class on John including a diagnosis  **Please note: You do ONLY need to complete Option 1 OR 2, not both.** | 6 | 60 | 12 | 11/23 |
| Discussion Question – Module 7 – Assignment 1 | 7 | 40 | 13 | 11/30 |
| **LASA Due (no late papers accepted!)**  **Module 7 – Assignment 2** | 7 | 300 | 14 | 12/07 |
| Discussion Question – Module 8 – Assignment 1 | 8 | 40 | 15 | 12/10 |

**Course Pre-requisites:  N/A**

**Program Requirement:**

**IMPORTANT: The Master’s in Clinical Mental Health Counseling Program requires all students to purchase two texts used across several courses in the program and for general reference:**

*Publication manual of the American   Psychological Association:*University Approved Edition.

American Psychiatric Association (2013). *Diagnostic and statistics manual of mental          disorders* (5th). Arlington, VA: American Psychiatric Publishing.

**Required Readings:**

**Required Text:**

**IMPORTANT: You are not required to purchase the textbook for this course.  Your textbook will be available as an electronic book within your fully online or blended course on the eCollege platform.**

Nolen-Hoeksema, S. (2014). *(ab)normal Psychology* (6th ed.). McGraw Hill Education.

**Required Articles**

Ellor, J.W. (2013). Religion and spirituality among older adults in light of DSM-5.             Social Work and Christianity, 40(4), 372-383.

Halter, M. J., PhD., A.P.R.N., Rolin-Kenny, D., & Grund, Faye, MS, A.P.R.N.,

P.M.H.N.P.-B.C. (2013). DSM-5: Historical perspectives. Journal of Psychosocial Nursing & Mental Health Services, 51(4), 22-29.

Jones, K. (2012). Dimensional and Cross-Cutting Assessment in the "DSM-5". *Journal Of Counseling & Development*, *90*(4), 481-487.

Kendler, K. S. (2013). A history of the DSM-5 scientific review committee.           Psychological Medicine, 43(9), 1793-800.

Kupfer, D. (2013). The DSM-5 - an interview with david kupfer. BMC Medicine, 11,       203.

Miller, R., & Prosek, E. A. (2013). Trends and implications of proposed changes to the      DSM-5 for vulnerable populations. Journal of Counseling and Development:          JCD, 91(3), 359-366.

Reed, G. M., Roberts, M. C., Keeley, J., Hooppell, C., Matsumoto, C., Sharan, P., & ... Medina-Mora, M. (2013). Mental Health Professionals' Natural Taxonomies of Mental Disorders: Implications for the Clinical Utility of the ICD-11 and the DSM-5. *Journal Of Clinical Psychology*, *69*(12), 1191-1212.

Spitzer, R. L., M.D., Williams, J. B. W., PhD., & Endicott, J., PhD. (2012). Standards for             DSM-5 reliability. The American Journal of Psychiatry, 169(5), 537-8.

Wakefield, J. C. (2013). DSM-5: An overview of changes and controversies. Clinical        Social Work Journal, 41(2), 139-154.

**Required Digital Assets:**

**Please note that the FACES videos listed below are not available through the Argosy library collection. They can be accessed only through the eCollege course and are linked directly to the McGraw-Hill website:**

Faces of Abnormal Psychology Videos.

         Faces of Abnormal Psychology Video: Attention Deficit Hyperactivity Disorder

         Faces of Abnormal Psychology Video: Bipolar Disorder

         Faces of Abnormal Psychology Video: Borderline Personality Disorder

         Faces of Abnormal Psychology Video: Bulimia Disorder

         Faces of Abnormal Psychology Video: Major Depression

         Faces of Abnormal Psychology Video: Obsessive Compulsive Disorder

         Faces of Abnormal Psychology Video: Panic Disorder with Agoraphobia

         Faces of Abnormal Psychology Video: Paranoid Schizophrenia

         Faces of Abnormal Psychology Video: Posttraumatic Stress Disorder

         Faces of Abnormal Psychology Video: Substance Abuse

         Faces of Abnormal Psychology Video: Tourette’s Syndrome

Website: American Psychiatric Association: Online Assessment Measures

<http://www.dsm5.org/Pages/Default.aspx>

**Recommended Readings:**

NOTE: The recommended readings listed below are not required readings, but supplemental resources should you want to gain additional information on the module topics. You will need to access them from the Argosy online library, or from external sites through URLs provided below. These readings will not be available in the online classroom.

Agüera, Z., Riesco, N., Jiménez-Murcia, S., Islam, M. A., Granero, R., Vicente, E., . . .      Fernández-Aranda, F. (2013). Cognitive behaviour therapy response and dropout   rate across purging and nonpurging bulimia nervosa and binge eating disorder:             DSM-5 implications.*BMC Psychiatry, 13*, 285.

American Psychiatric Association (2000).  *Practice guidelines for the treatment of psychiatric disorders. Compendium 2000*.  Washington, D.C.: Author.

American Psychological Association (2009). Publication Manual of the American

 Psychological Association (6th). American Psychological Association

Barlow, D. H. (Ed.) (2007).  *Clinical handbook of psychological disorders, 4th Ed*.  New York: The Guilford Press.

Barlow, D. H., & Durand, V. M. (2015). Abnormal Psychology: An Integrative Approach            (7th ed.).  Cengage.

Brown, R. J., & Lewis-Fernández, R. (2011). Culture and conversion disorder: I    mplications for DSM-5. Psychiatry, 74(3), 187-206.

Casey, P., & Doherty, A. (2012). Adjustment disorder: Diagnostic and treatment   issues.*Psychiatric Times, 29*(1), 43-46.

Castillo, Richard J. (1997). *Culture and Mental Illness: A Client-Centered Approach.* Pacific Grove, CA: Brooks/Cole Publishing Co.

Copeland, W. E., Angold, A., Costello, E. J., & Egger, H. (2013). Prevalence, c     comorbidity, and correlates of DSM-5 proposed disruptive mood dysregulation      disorder. The American Journal of Psychiatry, 170(2), 173-9.

Cosgrove, V. E., & Suppes, T. (2013). Informing DSM-5: Biological boundaries between bipolar I disorder, schizoaffective disorder, and schizophrenia. BMC Medicine,           11, 127.

Cox, K. S., Resnick, H. S., & Kilpatrick, D. G. (2014). Prevalence and correlates of           posttrauma distorted beliefs: Evaluating DSM-5 PTSD expanded cognitive          symptoms in a national sample.*Journal of Traumatic Stress, 27*(3), 299-306.

Dziegielewski, S. F. (2014). *DSM-IV-TR in Action* (2nd ed). Hoboken, NJ: John Wiley & Sons.

Epperson, C. N., Steiner, M., Hartlage, S. A., Eriksson, E., Schmidt, P. J., Jones, I., &       Yonkers, K. A. (2012). Premenstrual dysphoric disorder: Evidence for a new           category for DSM-5. The American Journal of Psychiatry, 169(5), 465-75.

Frances, A., & Ross, R. (2001). *DSM-IV-TR case studies:  A clinical guide to differential diagnosis.*Washington, D. C.: American Psychiatric Publishing.

Huerta, M., Bishop, S. L., Duncan, A., Hus, V., & Lord, C. (2012). Application of DSM- 5 criteria for autism spectrum disorder to three samples of children with DSM-IV          diagnoses of pervasive developmental disorders.*The American Journal of    Psychiatry, 169*(10), 1056-64.

Gore, W. L., & Widiger, T. A. (2013). The DSM-5 dimensional trait model and five-         factor models of general personality.*Journal of Abnormal Psychology,122*(3),            816.

Kuthchins, H. & Kirk, S. A. (1997).  *Making us crazy.  DSM: The psychiatric bible and the creation of mental disorders*.  New York: The Free Press.

Lilienfeld, S. O. (1995).  *Seeing both sides: Classic controversies in abnormal psychology*.  New York: Brooks/Cole.

Mijares, S. G., & Khalsa, G. S. (2005). *The psychospiritual clinician’s handbook:  Alternative methods for understanding and treating mental disorders.*New York: The Hawthorne Press.

Othmer, E. & Othmer, S.C. (1994). *The Clinical Interview using DSM-IV:  Volume 1:       Fundamentals.* Washington, DC: American Psychiatric Press

Sadock, BJ, & Sadock, VA.  (Eds.) (2007). *Kaplan & Sadock’s Synopsis of Psychiatry (10th Edition).* Baltimore, MD: Lippincott Williams and Wilkins

Schroeder, C. S. and Gordon, B.N. (2002). Assessment and Treatment of Childhood P     Problems: A Clinicians Guide (2nd Ed.) New York: NY, The Guilford          Press.

Skodol, A. E., M.D., Shea, M. T., Yen, S., PhD., White, C. N., PhD., & Gunderson, J. G.,

M.D. (2010). Personality disorders and mood disorders: Perspectives on diagnosis and classification from studies of longitudinal course and familial associations. *Journal of Personality Disorders, 24*(1), 83-108.

Szasz, T. S. (1974).  *The myth of mental illness.  Foundations of a theory of personal conduct*. New York: Harper & Row.

Tandon, R. (2013). Schizophrenia and other Psychotic Disorders in DSM-5. *Clinical Schizophrenia & Related Psychoses*, *7*(1), 16-19.

von Gontard, A. (2013). The impact of DSM-5 and guidelines for assessment and             treatment of elimination disorders. European Child & Adolescent Psychiatry, 22,      61-7.

Walsh, B.W. (2005). *Treating self-injury: A practical guide*. New York, NY: The   Guilford Press.

Wolfe, F., Brian, T. W., Robert, S. K., & Winfried Häuser. (2014). Symptoms, the nature of fibromyalgia, and diagnostic and statistical manual 5 (DSM-5) defined mental            illness in patients with rheumatoid arthritis and fibromyalgia. PLoS One, 9(2)

Woo, S. M., & Keatinge, C. (2008). *Diagnosis and Treatment of Mental Disorders*

*Across The Lifespan*. Hoboken, NJ: John Wiley & Sons.

World Health Organization (WHO). (1992). *The ICD-10 Classification of Mental and Behavioural Disorders: Clinical Descriptions and Diagnostic Guidelines.*Author.

Zero to Three/National Center for Clinical Infant Programs. (1994).

*Diagnostic classification of mental and developmental disorders of infancy and early childhood* (DC: 0-3). Washington, DC: Author.

**Technology Requirements:**<http://intcampus.ecollege.com/TechReq.learn>

**Course length:  15** Weeks

**Credit Value:**3.0

**Instructional Contact and Credit Hours:**

Students can expect 15 hours of instructional engagement for every 1 semester credit hour of a course. Instructional engagement activities include lectures, presentations, discussions, group-work, and other activities that would normally occur during class time. Instructional engagement activities may occur in a face-to-face meeting, or in the eclassroom.

In addition to instructional engagement, students can expect to complete 30 hours of outside work for every 1 semester credit hour of a course. Outside work includes preparing for and completing readings and assignments.  Such outside work includes, but is not limited to, all research associated with completing assignments, work with others to complete a group project, participation in tutorials, labs, simulations and other electronic activities that are not a part of the instructional engagement, as well as any activities related to preparation for instructional engagement.

At least an equivalent amount of work as required in paragraph above shall be applied for other academic activities as established by the institution, including laboratory work, internships, practica, studio work, and other academic work leading to the award of credit hours.

**Institutional Learning Outcomes:**

**1.**      **Analytical Reasoning**

Analyze issues objectively, interpret and synthesize data and ideas, and develop feasible, flexible, and creative solutions to real world problems.

**2.**      **Effective Communication**

Identify audiences, assess information provided, interpret needs, and present relevant information using appropriate written, oral, and listening skills and media to meet the needs of the situation.

**3.**      **Information Competency**

Gather, evaluate, and ethically use information from a variety of relevant technological and library resources to make decisions and take action.

**4.**      **Interpersonal Effectiveness**

Develop individual and group interpersonal skills to improve and foster participation and interaction critical for achieving individual and group goals.

**5.**      **Personal and Professional Integrity and Ethical Behavior**

Demonstrate a multi-dimensional awareness of individual and social responsibility to act ethically and with integrity in a diverse, global society.

**6.**      **Professional Competence**

Apply skills appropriate to program objectives and employ critical reasoning to

contribute to one's field and profession.

**Program Outcomes:**

1.      **Professional Orientation and Ethical Practice:**Value all aspects of professional functioning, including history, roles, organizational structures, ethical standards, legalities, advocacy, and credentialing.

2.      **Social and Cultural Diversity:**Apply core theory and research of the cultural context of relationships, issues, and trends in a multicultural and diverse society to the counseling profession.

3.      **Human Growth and Development:**Interpret and apply core theory and research of the nature and needs of individuals at all developmental levels and in multicultural contexts.

4.      **Career Development:**Apply core theory and research of career development, the psychology of work, and related factors in career planning and decision making.

5.      **Helping Relationships:**Deliver ethical and effective counseling and consultation services consistent with professional research and practice across a range of settings in a multicultural society.

6.      **Group Work:**Apply methods, skills, and other group approaches in a multicultural society using theories of group counseling, principles of group dynamics, facilitation styles, and direct experiences.

7.      **Assessment:**Analyze principles of testing and measurement, and incorporate social, ethical, and cultural factors in both individual and group methods of assessment and evaluation.

8.      **Research and Program Evaluation:**Apply research methods, statistical analysis, needs assessment, and program evaluation to inform ethical and culturally relevant evidence-based practice and to advance the counseling profession.

**CACREP Core and CMHC Standards:**

<http://syllabi.courseassets.com/v1-cacrep.pdf>

**Course Objectives:**

After completion of this course, students will be able to:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Course Objectives | Program Outcomes | Institutional Learning Outcomes | CACREP Core Standards | CACREP CMHC Standards |
| 1.       Describe and explain etiology, the diagnostic process and nomenclature, treatment, referral, and prevention of mental and emotional disorders, including co-occurring disorders based upon the current DSM. | 2, 3,7 | 5, 6 | 3b, 3e, 3f,   3g | C2, C4,   K1, K2 |
| 2.       Identify and apply diagnoses, including differential diagnoses, from a brief case history utilizing the current DSM. | 2, 3,7 | 5, 6 | 3b, 3c, 3e,   3f, 3g | D2, G3, K1, K2, K4, L1, L2 |
| 3.       Differentiate between developmental crisis, disability, psychopathology, addiction, trauma reaction and situational and environmental factors that affect both normal and abnormal behavior. | 2, 3,7 | 5, 6 | 3b, 3c, 3d,   3f, 3g | K5, L3 |
| 4.       Compare and contrast the advantages and disadvantages to psychiatric diagnosing and mental illness labels. | 2, 3,7 | 5, 6 | 2a, 3b, 3d,   3f, | C4, K2, L1 |
| 5.       Analyze and explain ethical issues pertaining to involuntary hospitalization, informed consent, confidentiality, suicide risk and mandated treatment. | 1, 2, 3,7 | 1, 5, 6 | 2a, 3b, 3c,   3f, 3g | A2, C9, K2 |
| 6.       Examine and describe the range of mental health service delivery—such as inpatient, outpatient, partial treatment and aftercare—and the clinical mental health counseling services network. | 2, 3, 5,7 | 5, 6 | 2a, 3e, 3f,   3g | C5, K2 |
| 7.       Identify and describe potential cross-cultural issues affecting diagnosis, including culture-bound syndromes, and recommend strategies to improve cross-cultural interactions within the initial clinical interview. | 2, 3, 5,7 | 1, 2, 3, 4, 6 | 2a, 3f | D2, K4 |

**Assignment Table:**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Topics** | **Academic Resources** | **Learning Activities and Assessments** |
| **1** | History of the DSM and Psychopathology           Introduction to the DSM           DSM History           Defining a Psychological Disorder           Origins of Abnormal Behavior           Effects of Stigma  Classification of Psychological Disorders           Categorical Classification           Prototypical Classification           Dimensional Classification  Psychopathology and an Integrative Approach           Multidimensional Models           Genetic and Neuroscience Influences           Behavioral Influences           Developmental Influences           Multicultural Influences           Social and Interpersonal Influences           Environmental Influences           Role of Emotions           Role of Stress | **Required Readings**  **Textbook**  Nolen-Hoeksema, S. (2014).           Chapter 1: Looking at Abnormality           Chapter 2: Theories and Treatment of Abnormality           Chapter 15: Health Psychology    American Psychiatric Association (2013).           Preface           Introduction           Use of the Manual           Cautionary Statement for Forensic Use of the DSM-5    **Articles:** (for a complete citation, see reading list above)           Halter et al. (2013).           Kendler. (2013).           Kupfer. (2013).           Wakefield, J. C. (2013). | Looking Ahead: RA Overview Placeholder. |
| **2** | Clinical Assessment and Diagnosis           Assessment of Psychological Disorders           Research Methods           Diagnosing using the DSM           Differential Diagnosis           DSM Assessment Measures           DSM and Culture           Mental Status Exam | **Required Readings**  **Textbook**  Nolen-Hoeksema, S. (2014).  Chapter 3: Assessing and Diagnosing Abnormality  Chapter 4: The Research Endeavor    American Psychiatric Association (2013).           Assessment Measures           Cultural Formulation           Glossary of Technical Terms           Glossary of Cultural Concepts of Distress    **Articles:**           Ellor. (2013).           Jones. (2012).           Miller & Elizabeth. (2013).           Reed et al. (2013).           Spitzer et al. (2012).    **Digital Assets**           Website: American Psychiatric Association: Online Assessment Measures  <http://www.dsm5.org/Pages/Default.aspx> | Weekly Assignment 1 (60 pts) |
| **3** | Neurodevelopmental Disorders, Disruption, Impulse Control, and Conduct, and Elimination Disorders           Overview           Clinical Symptoms           Cultural and Developmental Considerations           Treatment    Schizophrenia Spectrum and Other Psychotic Disorders           Overview           Clinical Symptoms           Cultural and Developmental Considerations           Treatment | **Required Readings**  **Textbook**  Nolen-Hoeksema, S. (2014).           Chapter 8: Schizophrenia Spectrum and Other Psychotic Disorders           Chapter 10: Neurodevelopmental Disorders and Neurocognitive Disorders           Chapter 11: Disruptive, Impulse Control, and Neurocognitive Disorders    American Psychiatric Association (2013).           Neurodevelopmental Disorders           Disruption, Impulse Control, and Conduct Disorders           Elimination Disorders           Schizophrenia Spectrum and Other Psychotic Disorders    **Digital Assets**           Faces of Abnormal Psychology Video: Attention Deficit Hyperactivity Disorder           Faces of Abnormal Psychology Video: Tourette’s Syndrome           Faces of Abnormal Psychology Video: Paranoid Schizophrenia | Weekly Assignment 2 (60 pts) |
| **4** | Depressive Disorders, Bipolar and Related Disorders, and Suicide           Overview           Clinical Symptoms           Cultural and Developmental Considerations           Treatment    Anxiety Disorders, Trauma-and Stressor, and Obsessive-Compulsive and Related Disorders           Overview           Clinical Symptoms           Cultural and Developmental Considerations           Treatment | **Required Readings**  **Textbook**  Nolen-Hoeksema, S. (2014).           Chapter 5: Trauma, Anxiety, Obsessive-Compulsive, and Related Disorders           Chapter 7: Mood Disorders and Suicide    American Psychiatric Association (2013).           Bipolar and Related Disorders           Depressive Disorders           Anxiety Disorders           Obsessive-Compulsive and Related Disorders           Trauma- and Stressor-Related Disorders    **Digital Assets**           Faces of Abnormal Psychology Video: Major Depression           Faces of Abnormal Psychology Video: Obsessive Compulsive Disorder           Faces of Abnormal Psychology Video: Panic Disorder with Agoraphobia           Faces of Abnormal Psychology Video: Posttraumatic Stress Disorder | **RA (200 pts)** |
| **5** | Dissociative Disorders, and Somatic Symptom and Related Disorders           Overview           Clinical Symptoms           Treatment    Sleep-Wake, and Feeding and Eating Disorders           Overview           Clinical Symptoms           Cultural and Developmental Considerations           Treatment | **Required Readings**  **Textbook**  Nolen-Hoeksema, S. (2014).           Chapter 6: Somatic Symptom and Dissociative Disorders           Chapter 12:  Eating Disorders    American Psychiatric Association (2013).           Dissociative Disorders           Somatic Symptom and Related Disorders           Feeding and Eating Disorders           Sleep-Wake Disorders    **Digital Assets**           Faces of Abnormal Psychology Video: Bulimia Disorder | Assignment (40 points) |
| **6** | Sexual Dysfunctions, Paraphilic Disorders and Gender Dysphoria           Overview           Clinical Symptoms           Cultural and Developmental Considerations           Treatment    Substance-Related, Addictive and Impulse-Control Disorders           Overview           Clinical Symptoms           Cultural and Developmental Considerations           Treatment | **Required Readings**  **Textbook**  Nolen-Hoeksema, S. (2014).           Chapter 13: Sexual Disorders           Chapter 11: Substance Use and Gambling Disorders    American Psychiatric Association (2013).           Sexual Dysfunctions           Gender Dysphoria           Paraphilic Disorders           Substance-Related and Addictive Disorders    **Digital Assets**           Faces of Abnormal Psychology Video:               Substance Abuse | Weekly Assignment 3  (60 pts) |
| **7** | Neurocognitive Disorders           Overview           Clinical Symptoms           Cultural and Developmental Considerations           Treatment    Personality Disorders           Overview           Clinical Symptoms           Cultural and Developmental Considerations           Treatment    Other Mental Disorders, and Medication Induced Movement Disorders           Overview           Clinical Symptoms           Adverse Effects of Medication | **Required Readings**  **Textbook**  Nolen-Hoeksema, S. (2014).           Chapter 10: Neurodevelopmental and Neurocognitive Disorders (Continued)           Chapter 9: Personality Disorders  American Psychiatric Association (2013).           Neurocognitive Disorders           Personality Disorders           Alternative DSM-5 Model for Personality Disorders           Other Mental Disorders           Medication-Induced Movement Disorders and Other Adverse Effects of Medication    **Digital Assets**           Faces of Abnormal Psychology Video: Borderline Personality Disorder | **LASA**  **(300 pts)** |
| **8** | Other Conditions that                                        May be the Focus of Clinical Attention   * Key Issues in Clinical Practice     Legal and Ethical Issues and Psychopathology   * Involuntary Hospitalization * Informed Consent * Mandated Treatment * Service Delivery Options | **Required Readings**  **Textbook**  Nolen-Hoeksema, S. (2014).           Chapter 16: Mental Health Services and the Law    American Psychiatric Association (2013).           Other Conditions That May Be a Focus of Clinical Attention           Conditions for Further Study |  |

**Required Assignments (RA):**

Required Assignments (RAs) are substantive assignments intended to measure student performance against selected course objectives and/or program outcomes within a course.  RAs are completed by all students across all Argosy University campuses and delivery formats without exception. Each RA contributes to a significant portion of the overall course grade and is assessed by faculty using the grading criteria designed for that assignment.  These are individual assignments and students earn individual grades.

**RA Alignment Table:**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Assignment** | **Course Objectives** | **Program Outcomes** | **ILOs** | **CACREP**  **Core** | **CACREP CMHC Stds.** | **Assessment Type** | **Scoring Tool** |
| RA: Diagnosis Research Paper | 1, 3, 4, 7 | 1, 2, 3, 5, 7 | 1, 2, 3, 4, 5, 6 | 2.a, 3.b, 3.c, 3.d, 3.e, 3.f, 3.g | A2, C2, C4, C9, D2, K1, K2, K4, K5, L1, L3 | Written Report | Grading Table |

**Learning Assessment System Assignments (LASA):**

A LASA is a signature assessment intended to measure student performance against selected course objectives and/or program outcomes within a course.  These signature assessments are completed by all students across all Argosy University campuses and delivery formats without exception.  Each assignment contributes to a significant portion of the overall course grade and is assessed by faculty using the rubric designed for that assessment.  These are individual assignments, and students earn individual grades.  Both the signature assignments and related rubrics become part of the Learning Outcome Manager database and are used in the aggregate to evaluate levels of student learning, as well as the effectiveness of the curriculum, course content, and faculty.  The combined results of the signature assessments across an entire academic program provide a comprehensive picture of the students' academic programs.  These data drive the continuous improvement cycle as part of comprehensive program reviews conducted by the colleges.

**LASA Alignment Table:**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Assignment** | **Course Objectives** | **Program Outcomes** | **ILO** | **CACREP**  **Core** | **CACREP CMHC Stds.** | **Assessment Type** | **Scoring Tool** |
| LASA: Applied Differential Diagnosis Paper | 1, 2, 4, 5,  6, 7 | 2, 3, 5 ,7 | 1, 2, 3, 4, 5, 6 | 2.a, 3.b, 3.c, 3.e, 3.f, 3.g | C2, C4, C5, D2, G3, K1, K2, K4, L1, L2 | Written Report | Rubric |

**Week 6:**

**Weekly Assignment: 60 pts**

**Effects of Stigma on Diagnosis**

In this assignment, you will choose one recent news article that addresses an incident involving a mental health issue (i.e., suicide attempt, arrest for peeping, etc.).

Directions:

Provide a summary of the article, highlighting the mental health concerns found within the article. Explain why the person’s behavior is considered abnormal, and describe how stigma affects a person’s willingness to seek help. In addition, describe the risk factors and benefits, and ethical considerations associated with diagnostic labeling.

Your final product should be a 3-4 page paper, written in a clear, concise, and organized manner.  Demonstrate ethical scholarship in accurate representation and attribution of sources, and display accurate spelling, grammar, punctuation, and references page.

WA Grading Criteria:

CO: 1, 3, 4

|  |  |  |
| --- | --- | --- |
| **Assignment Components** | **Proficient** | **Max Points** |
|  |  |  |
| Provide a summary of the article, highlighting the mental health concerns found within the article. | Summary of article is succinct. Summary includes clear identification of the mental health concerns found within the article. | /12 pts. |
| Explain why the person’s behavior is considered abnormal. | Explanation is clear. Explanation accurately justifies why the behavior is considered abnormal. | /8 pts. |
| Describe how stigma affects a person’s willingness to seek help. | Description is clear and accurate. The affect of stigma to a person’s willingness to seek help is completely described. | /12 pts. |
| Describe the risks associated with diagnosing. | Description of risks associated with diagnosis as they pertain to the client and counselor is appropriate. | /12 pts. |
| Describe ethical considerations associated with diagnostic labeling. | All ethical considerations described are feasible and likely for the client exhibiting similar symptoms as the subject within the article. | /8 pts. |
| Academic Writing |  |  |
| Write in a clear, concise, and organized manner; demonstrate ethical scholarship in accurate representation and attribution of sources (i.e. APA); and display accurate spelling, grammar, and punctuation. | Written in a clear, concise, and organized manner; demonstrated ethical scholarship in appropriate and accurate representation and attribution of sources; and displayed accurate spelling, grammar, and punctuation. Use of scholarly sources aligns with specified assignment requirements. | /8 pts. |
| **Total** |  | **/60pts** |

**Week 7:**

**Weekly Assignment: 60 pts**

**Diagnosing the Whole Person**

In this assignment, you will provide a discussion of cultural, developmental, neurobiological, social, and environmental considerations given the following vignette.  Develop an appropriate diagnostic profile and recommendations for treatment. Be sure to address any ethical considerations pertaining to diagnosis and treatment.

Scenario:

Jane is a 56-year-old self-identified, African American female. She is self-referred to your private practice. During the initial telephone contact with Jane, she states she is depressed and also suffers from chronic pain due to a back injury she received at work two years ago. She is seeking counseling services to help her improve her daily functioning.

Jane initially misses the scheduled intake appointment with you. She calls you two days later and explains she “forgot” about the appointment. You reschedule the appointment. Three days before the rescheduled appointment, she calls you saying, in a very weary voice, that she was trying to locate your office and got lost. You provide the correct date and time for her appointment and give her directions to your office. On the day of her rescheduled appointment, Jane arrives 15 minutes late, and she completes her initial paperwork (i.e., informed consent, medical history, etc.) in 20 minutes.

History of the Problem:

Jane reports she injured her back while at work two years ago. She was working as a licensed vocational nurse and was helping to lift an obese patient onto a bed. Jane describes the patient as being of a minority race and said, “You know, those people just sit around all day eating and getting fat off of their welfare checks. If it weren’t for them, I would be alright today.” She states she underwent surgery on her back followed by three months of “excruciating” physical therapy and has gone through a “long, arduous recovery” from the injury. She has problems sleeping because of the continued pain, which is “terrible when it comes”. She has not worked since her injury, and indicates she is in the process of seeking Social Security disability benefits for her physical problems.

Jane has “dealt with anxiety and depression all (of her) life, especially when (she) felt unstable”. When queried, she states her feelings of instability are related to the quality of her relationships with significant others. She reports feeling sad much of the time and has difficulty initiating tasks. She believes she does not “think” as well as she used to. She denies current suicidal ideation and intent. She engages in few activities due to her back pain and limited finances, and states there are times when she can not get her breath and feels “chills or an internal vibration and chest pressure”.

She uses yoga, deep breathing, and soft music to reduce these symptoms. She also carries a balloon with her and goes to a restroom, if she is in a public setting and she feels symptoms, she inflates the balloon. If the symptoms persist, she goes to the emergency room; she has been to the emergency room six times in the past 12 months. She stated that sometimes “PTSD kicks in”. For example, she explained she was recently driving when an ambulance passed her with its lights and siren on. She had to pull over and started crying.

Relevant Psychosocial History:

During the intake session, Jane reports her parents are in a biracial marriage. Her mother is African American, and her father is White. Jane states her parents lived together “off and on” during her childhood. She indicates there were many verbal arguments between them and she describes herself as the “family peacemaker”. She believes she experienced stress and anxiety as a teenager because of this parental strife and her role as mediator. She denies any history of abuse from either parent. Though, she alleges both parents drank to excess at times, which resulted in arguments at times. She further notes her father was fired from a job he held for many years and told her it was due to the company hiring more minority workers “to keep the government happy”. Her mother is deceased; her father lives two thousand miles away, and she has limited contact with him. Three of her five siblings are dead. One of her brothers died in a car accident as a young adult, another brother died from cancer when he was 44 years old, and her oldest sister, the first born, died from a heart attack 3 years ago at age 64. She reports having a close relationship with her twin sister who resides locally, but describes her relationship with her youngest brother as disconnected. Jane stated she was the youngest twin and the third child born.

Jane married when she was 20 years old. She and her husband have two children, and she has three grandchildren. She sees her daughter and her grand children frequently. However, she is “very disappointed” her son married a woman who is Hispanic and described her relationship with her son and daughter-in-law as “strained”. She states her husband drank, was physically violent, which included aggression directed at her, and he “cheated” on her. She reports he was never abusive to their children and “was always an exceptional father.”  Jane states her husband died 20 years ago as the result of a car accident. She was driving her family home from a family reunion late at night on a rural road. Her husband leaned against the car door, which was not shut tightly and fell out of the car. Jane immediately sent their two children to find a house where they could call an ambulance. It was approximately 30 minutes before the ambulance arrived; by that time, her husband had died. Jane became tearful while relaying this information. After his death, Jane took an antidepressant, Prozac, for one year. Jane reports following the loss of her husband, she was sad, cried every day, had no energy, lost weight, had difficulty falling asleep at night, and felt responsible for his death. She also continues to re-experience the accident, was “jumpy,” tries not to think about the accident, has difficulty paying attention, and feels “numb”.

Several years after her husband’s death, she starts dating a man who was an alcoholic, abusive, and did not let her “mourn” her late husband. During this relationship, she checks into a motel one evening, takes sleeping pills and Xanax, and wakes up to a maid knocking at the door. She is hospitalized as an inpatient at a psychiatric hospital for three weeks. She denies this is a suicidal act and states she was simply trying to get some rest away from the chaos of her boyfriend and children. She indicates she has not participated in counseling since her brief hospitalization. Jane denies history of alcohol or drug abuse.

During the intake session, Jane compliments you on several aspects of your office décor. As previously stated, she cries several times when recalling her husband’s death and her marriage to him. She states she had never discussed some of these topics with others before now. She believes you are especially understanding of her situation and that, because of this; she is able to confide in you. The day after the intake session, Jane calls and leaves you a voice message saying she has been thinking about your session and there is more information she wants to share with you because you were such a “good listener”. She goes on to say, “there have been periods when I couldn’t do anything but go back to bed,” that she has missed many appointments over the past year, and that she often misplaces things around her home. Four days after the intake session, Jane calls and leaves a second voicemail for you. She says she “didn’t want anybody to think less of (her)”, and she has difficulty socializing and she can’t be away from her home for very long without feeling anxious. She ends her voicemail message by apologizing for “causing you more work, if I’ve caused any”.

Directions:

Describe how the contextual factors described within the vignette might influence the diagnoses that are given, and how or if they are addressed in the client’s diagnostic list. Create an appropriately written diagnostic profile of the client.

Your final product should be a 3-4 page paper, utilizing a minimum of 3 scholarly sources. Your paper should be written in a clear, concise, and organized manner.  Demonstrate ethical scholarship in accurate representation and attribution of sources, and display accurate spelling, grammar, punctuation, and references page.

WA Grading Criteria:

CO: 1, 2, 3, 5, 6, 7

|  |  |  |
| --- | --- | --- |
| **Assignment Components** | **Proficient** | **Max Points** |
|  |  |  |
| Describe how the factors described within the vignette influence diagnosis, and how or if they are addressed in the client’s diagnostic list. | A description of how each cultural, developmental, neurobiological, social, and environmental factor described influences diagnosis is accurate and clear. A description of whether each factor is addressed in a diagnostic list is included. | /20 pts. |
| Create an appropriately written diagnostic profile of the client. | Diagnostic profile of the client is complete. Profile appropriately reflects all factors described within the vignette. | /32 pts. |
| Academic Writing |  |  |
| Write in a clear, concise, and organized manner; demonstrate ethical scholarship in accurate representation and attribution of sources (i.e. APA); and display accurate spelling, grammar, and punctuation. | Written in a clear, concise, and organized manner; demonstrated ethical scholarship in appropriate and accurate representation and attribution of sources; and displayed accurate spelling, grammar, and punctuation. Use of scholarly sources aligns with specified assignment requirements. | /8 pts. |
| **Total** |  | **/60 pts** |

**Week 9:**

**RA 1: 200 pts**

**Diagnosis Research Paper**

**Description of RA:**

In this assignment, you will choose one specific disorder (e.g., generalized anxiety disorder, binge-eating disorder, conduct disorder, etc.), and research evidence-based treatment that has been shown to be effective (e.g., solution-focused, psychodynamic, CBT, experiential, etc.) for the chosen disorder. Post your choice to the appropriate discussion thread for approval.

You will write a research paper that addresses the following content areas:

•     **Introduction**: Introduce the disorder and your reasons for choosing this particular disorder.

•   **Overview of the Disorder**: Provide a discussion of the diagnostic criteria, prevalence, incidence, and etiology of the disorder. Include information about the genetic, biological, environmental, trauma, and/or psychological factors that cause or contribute to the development of the disorder in individuals. Discuss disadvantages associated with persons diagnosed with this condition.

•   **Effective Treatment Approaches**: Based upon current research, discuss the best treatment options or interventions for treating this disorder. Outcome literature must be reviewed for this component.

•   **Social and Cultural Implications**: Describe relevant social/cultural implications as related to the disorder including: age, gender, race, socioeconomic status, sexual orientation.

•   **Assessment of Treatment Approach**: Discuss or compare/contrast your overall assessment of the treatment approach or approaches (e.g. the value, limitations and significance, etc.). You must discuss the effect of culture on treatment.

•   **Conclusion**: Provide a summary of your findings.

Your final product should be an 8-10 page paper, utilizing a minimum of 8 scholarly sources. Your paper should be written in a clear, concise, and organized manner.  Demonstrate ethical scholarship in accurate representation and attribution of sources, and display accurate spelling, grammar, punctuation, and references page.

         Only minimal direct quotes are allowed for this assignment, and only primary citations are accepted. This means you must directly read the article instead of referencing it with “as cited in” another article, and you are not to simply copy the *DSM* diagnostic criteria.

         The DSM and a minimum of five peer reviewed journal articles must be cited in the paper, with the total number of references not less than 8.  Only scholarly references will be accepted.

         The research paper must follow APA 6th edition format (e.g., margins, page numbers and headers, abstract, text and final references, 12 point font, double spacing, unbiased language, etc.).

RA 1 Grading Criteria

CO: 1, 3, 4, 7

PO: 2, 3, 5, 7

ILO: 1, 2, 3, 4, 5, 6

CACREP Core: 2.a, 3.b, 3.c, 3.d, 3.e, 3.f, 3.g

CMHC Standards: C2, C4, D2, K1, K2, K4, K5, L1, L3

|  |  |  |
| --- | --- | --- |
| **Assignment Components** | **Proficient** | **Max Points** |
| Introduce the disorder and your reasons for choosing this particular disorder. | Introduction provides basic information regarding the disorder. Introduction provides appropriate justification for choosing the disorder. | /12 pts. |
| Provide a discussion of the diagnostic criteria, prevalence, incidence, and etiology of disorder. | Diagnostic criteria, prevalence of disorder, incidence, and etiology of disorder are all accurately described. Common genetic, biological, environmental, trauma, and/or psychological factors that cause or contribute to the development of the disorder are included. | /32 pts. |
| Discuss disadvantages associated with persons diagnosed with this condition. | All applicable disadvantages for persons diagnosed are appropriate and accurate. | /28 pts. |
| Discuss the best treatment options or interventions for treating the disorder. | Treatment options discussed follow current best practices. Outcome literature is cited in support. | /32 pts. |
| Describe relevant social/cultural implications as related to the disorder. | Typical social/cultural implications including such factors as: age, gender, race, socioeconomic status, and sexual orientation are accurately described. | /28 pts. |
| Discuss or compare/contrast your overall assessment of the treatment approach or approaches. | Judgment of the treatment approach or approaches is supported using scholarly support and current best practices. Strengths and weaknesses of each approach are accurately described. | /32 pts. |
| Provide a summary of your findings. | Summary succinctly wraps up the research. | /12 pts. |
| Academic Writing |  |  |
| Write in a clear, concise, and organized manner; demonstrate ethical scholarship in accurate representation and attribution of sources (i.e. APA); and display accurate spelling, grammar, and punctuation. | Written in a clear, concise, and organized manner; demonstrated ethical scholarship in appropriate and accurate representation and attribution of sources; and displayed accurate spelling, grammar, and punctuation. Use of scholarly sources aligns with specified assignment requirements. | /24 pts. |
| **Total** |  | **/ 200 pts.** |

**Week 12:**

**Weekly Assignment: 60 pts**

**The Role of Culture in Diagnosis**

The DSM supports the consideration of the effects of cultural variables on the diagnostic process. In this assignment, you will identify and describe potential cross-cultural issues affecting diagnosis, and provide culturally sensitive treatment recommendations and risk assessment. In addition, in your response you will provide an accurate diagnostic profile, which includes your diagnostic rationale.

**Scenario:**

John is a 42-year-old, Hispanic male who has been referred to you by his psychiatrist for counseling. During the initial session, John reports he experiences overwhelming anxiety. He currently takes the following psychotropic medications: Tegretol, Wellbutrin, Vistaril, and Elavil. According to John, he was diagnosed with Type I diabetes two years ago for which he takes medication. John says gender identity is an important topic for him because he feels he is a female, although he is a biological male. He reports becoming aware his feelings approximately 15 years ago, but states he has not began hormone replacement therapy due to his family’s negative response to him feeling he is female. There is no discussion of this topic in the family, or with others in the community leaving John feeling like an “outcast.”

John also reports feeling uncomfortable around others, particularly in one-to-one situations. He describes himself as feeling “pretty good” with small groups of people. When he feels anxious he feels his heart pounding, believes others are watching him because they can tell he is anxious, sweats, his mind races, he can not organize his thoughts, and he perceives events as occurring “in a dream”.  He is afraid he may have one of these “attacks”; therefore, he tries to avoid going places without a family member or a very close friend. He tends to spend much of his time at home because of his symptoms, the family’s limited financial resources and lack of transportation. He relies on public transportation or church members to go to appointments and complete necessary shopping. However, he often becomes very anxious when using public transportation. The only way he has found to alleviate his anxiety in these types of situations is to listen to music he has downloaded on his cell phone.

In addition, John spends 6-10 hours a day on the computer. Most of this time is spent in science fiction role play with others. John became very verbal and enthusiastic when he discussed this aspect of his life. He explains he is a “captain” on one of the spaceships and enjoys creating various scenarios and challenges for him and other “crews” to resolve. He communicates with a number of people in the U.S. and other countries who have similar interests, and this is the way he met his fiancée.

John denies current suicidal intent, but reports experiencing intermittent suicidal ideation. He does not believe he could harm himself because of his parents and his religious beliefs, but states sometimes he wishes he would die, so he does not have to “live a lie”.

Relevant Psychosocial History:

John has always lived in the same town where he was born, where his father is a minister. Due to financial difficulties, John had to move in with his parents two years ago.  John and his parents are very active in their small church. John reports he is in charge of the technical aspects of the services, where he spends Sunday morning, Sunday evening, and Wednesday evening each week.

John reports he got married when he was 20 years old, when he was in the military. His wife was unable to accompany him overseas, and he reports becoming “severely depressed” because of this and experiencing suicidal ideation. He received an honorable discharge from the military due to his depression. After two years of marriage, he and his wife divorced. John is currently engaged to a woman who lives in Germany. They met face-to-face one time when he visited her, but they talk every day by phone. She is aware and reportedly accepting of his gender identity. She plans on visiting the United States next year, when they will marry. After the marriage, John plans to move overseas and live with her. John is concerned his parents will not approve of his marriage; therefore, he has not shared his plans with his parents. John reports he does not have any children or plan on having children in the future.

After his discharge from the military, John was employed in a number of different jobs including long-distance truck driving. At the time of his intake, John reports he has unemployed for three years. His last job was in telephone customer service for a large electronics company where he had worked for nine years. He believes he was fired from this job because he sometimes wore women’s clothing to work. He also reports he became increasingly anxious at work, to the point where he would “freeze” when talking to customers even though he had the knowledge to assist them. He reports this anxiety was not new stating this “freezing” behavior first began at the age of 13, when he had to speak in front of the class, and then later when he was in the military during performance based evaluations.

He further denies a history or current use of alcohol or other substances. He would like to find a job where he can work out of his home on his computer. He believes he has the technical ability to do this and that he will be able to continue this type of work after he marries his fiancée and moves oversees. However, he is fearful he may be unable to complete any type of job where he has to interact with the public or be monitored for quality control.

Directions:

Provide a summary of the relevant diagnostic information that could be included in the Cultural Formulation Interview. Within your summary:

         Explain why you should, as a counselor, consider cultural variables as part of the intake process.

         Describe how culture can influence diagnosis and treatment.

         Explain how you would address the issue of not understanding aspects of a client’s culture during the intake assessment.

Finally, create a comprehensive diagnostic profile with treatment recommendations. Be sure to also address any ethical considerations pertaining to risk assessment.

You can find a copy of the CFI interview questions in Section III of your DSM.

Your final product should be a 3-4 page paper, utilizing a minimum of 3 scholarly sources. Your paper should be written in a clear, concise, and organized manner.  Demonstrate ethical scholarship in accurate representation and attribution of sources, and display accurate spelling, grammar, punctuation, and references page.

WA Grading Criteria:

CO: 1, 2, 5, 6, 7

|  |  |  |
| --- | --- | --- |
| **Assignment Components** | **Proficient** | **Max Points** |
|  |  |  |
| Provide a summary of the relevant diagnostic information that could be included in the Cultural Formulation Interview. | Summary describes all relevant diagnostic information to include within the Cultural Formulation Interview (CFI). | /8 pts. |
| Explain why you should, as a counselor, consider cultural variables as part of the intake process. | The effect of considering cultural variables in the intake process is explained. Benefits of considering cultural variables are described. | /8 pts. |
| Describe how culture can influence diagnosis and treatment. | The effect of culture to diagnosis and treatment is clear. Description is supported by examples of how culture has affected a client’s diagnosis and/or treatment. | /12 pts. |
| Explain how you would address the issue of not understanding aspects of a client’s culture during the intake assessment. | Explanation of how to further understand specific aspects of a client’s culture during the intake assessment is clear. Specific steps to take are described. | /12 pts. |
| Create a comprehensive diagnostic profile with treatment recommendations. | Diagnostic profile is complete. Profile accounts for cultural considerations. Appropriate treatment recommendations are included. | /12 pts. |
| Academic Writing |  |  |
| Write in a clear, concise, and organized manner; demonstrate ethical scholarship in accurate representation and attribution of sources (i.e. APA); and display accurate spelling, grammar, and punctuation. | Written in a clear, concise, and organized manner; demonstrated ethical scholarship in appropriate and accurate representation and attribution of sources; and displayed accurate spelling, grammar, and punctuation. Use of scholarly sources aligns with specified assignment requirements. | /8 pts. |
| **Total** |  | **/60 pts** |

**Week 14:**

**LASA: 300 pts**

**Applied Differential Diagnosis Paper**

**Description of LASA:**

In this assignment, you will read the assigned case study from which you use the current DSM to provide an accurate diagnostic profile, which includes your diagnostic rationale.

**Scenario:**

You have been hired as the counseling intern for Maeve.  An initial psychosocial assessment was completed, which provided you with the following information.

**Presenting Issue/History of the Problem:**

Maeve is a 36-year-old, second generation Irish, divorced female who presents for individual counseling.  Maeve reports having some difficulty dealing with her 18 year old daughter, Niamh, who is currently a senior in high school.  Maeve describes fighting with Niamh daily and being unable to “manage” her.  Maeve states her daughter was recently arrested on marijuana possession charges and was expelled from high school. Maeve describes feeling distraught over her lack of ability to “control” her daughter’s behavior, and described feeling guilty and responsible for her daughter not being a “good kid.” She said she has a conflictual relationship with Niamh’s father, her ex-husband. Maeve says she feels sad most of the time, irritable, and like she was “out-of-control”.  In addition, Maeve always feels hopeless about her future and is not able to see how she could ever improve her life condition.  She reports having enjoyed “little in her life” and indicates her choice of husbands and boyfriends has been in part a resignation to what was available rather than a real attraction.  Her mood is frequently blue and she only experiences brief periods of time when her mood is positive and she attempts to mask her underlying negative affect.

Maeve exhibits high levels of anxiety, expressing ongoing worries regarding her relationship with her daughter, her finances, her dissatisfaction with her career, her problems in relationships with men and her perceived personal deficits. She describes herself as being anxious and ruminative since the age of 8. She is also quite apprehensive regarding the intentions of men with whom she has interpersonal contact, reflecting not only her general level of anxiety but also her self-consciousness and antagonistic suspiciousness.  In addition, she also experiences frequent episodes of anger and bitterness, mainly provoked by sexually aggressive men.

Compensating for these feelings, Maeve demonstrates high levels of escapism. When Maeve’s high levels of anxiety and depression are exacerbated by situational factors, she reportedly attempts to reduce these feelings through overuse of alcohol.  This, along with her reported low tolerance for frustration and her inability to resist cravings, leads to alcoholic binges.  She states she binges on weekends using alcohol and food as a means of trying to regulate her mood.

**Behavioral Observations:**

At the time of assessment, Maeve presents as a well groomed and neatly dressed woman.  She speaks in a grammatically precise manner with clearly enunciated speech. She often speaks rapidly and intensely, clearly exhibiting her predominate affect. Her body language is theatrical, and she uses elaborate facial expressions and arm gestures. When highly anxious or angry she wrings her hands, paces, or rocks her foot back and forth. Her affect is intense and variable, ranging from sobbing and screaming, to manic excitement, and back to sobbing and screaming.  Her rapidly changing emotions appear unable to modulate her affect. Based on her response style, she appears to be of average intelligence, with no reported difficulties in concentration or memory.  She denies a history of auditory/visual hallucinations, but confirmed a history of self-harm dating back to the age of 12. She states she had not cut in the past six months, but often thinks about doing it.  She describes having one suicide attempt after she found out she was pregnant, but states after she took her mother’s medication, she called 911.  She reported that her parents refused to see her when she was in the hospital.

**Family History:**

Maeve was born in Lawrence, Kansas, and was the youngest of four children.  She has two older brothers, who are twins, and an older sister.  Her siblings and parents, who are devout Catholics, continue to live in Kansas. Maeve describes her relationship with her family as disengaged. Maeve describes the relationship with her mother as “not supportive” and she has felt that everyone else is more important to her mother than she is. Despite this, Maeve has always respected her mother and longed for her approval, but describes her as “domineering and cold” during her childhood.  Maeve’s father is described as passive and weak; even though she reports feeling her relationship with her father was a positive one overall. She attempts to contact her father every couple of months, but he reportedly does not return her calls.  She describes feeling “abandoned all over again” every time this occurs.

**Trauma History:**

Maeve indicates she stopped talking to her family, after she told her parents the oldest of her twin brothers molested her from the age of 4 until the age of 9, when he moved out of the home.  Maeve states that upon her disclosure of the abuse, her mother said, “That is not possible, you are a liar as always”, and ignored her. Maeve states her mother would not let her father speak to her after her disclosure and she still resents this. Maeve revealed specifics of her abuse history and reports she has several specific memories of the abuse that she could “not get out of my head.” She described having some difficulty falling asleep at night because she was worried she would have dreams about her brother coming into her room late at night. She described feeling “scared and alone” when she was a child, and reports that she always loves her brother and does not always “trust my memories.” She recalls one incident when she was 8 years old of being forced to perform oral sex, and states if she engages in this sexual behavior as an adult, she experiences intense nausea.

**Relationship History:**

Maeve describes a problematic relationship history.  She dated throughout high school, but denies having any serious relationships until she was 17 years of age.  Her first sexual experience reportedly occurred when she was 17 ½ years old, which resulted in pregnancy.  She describes her first sexual experience as “disgusting” and indicates, at first she became angry to learn she was pregnant, but over time she discovered she was happy to have someone there who would always love her.  Maeve describes being raised in a strict Catholic family, and the relationship between Maeve and her daughter’s father did not last through the pregnancy, because her mother forbade her from seeing him.  Maeve recalls her mother telling her she “brought shame upon the family”, but her mother allegedly did not allow her to have an abortion due to her family’s religious beliefs. Maeve denies any religious affiliation.

At the time of treatment, Maeve had been divorced for five years.  This was her third marriage, with each marriage characterized by intense emotionality and high levels of conflict. Maeve’s first marriage occurred at the age of 21, with a man of Hispanic decent who was willing to help care for her daughter.  She states this marriage ended when her husband died as a result of a fatal car crash two years into their marriage. Maeve’s second marriage, at the age of 26, was to a very conservative man, who believed in traditional family roles. Maeve describes her attempts to adopt a traditional role by allowing her husband to hold all of the power in the relationship, but states she had difficulty not asserting herself.  She remembers feeling unhappy and began having extramarital trysts one year into their marriage.  She divorced him two years later, when she was 28 years old. In addition, she reports having a problematic communication style, where she tries to manipulate interpersonal situations rather than discussing her concerns directly. Her manipulations become more oppositional with her husbands, with whom she initially acts as if she wants them to control everything but, when they attempted to take responsibility for making decisions, she covertly resists by taking actions to undercut them.  This leads to chronic but covert power struggles with her husbands.  Maeve reports that her third marriage ended after she gave her husband herpes, which she contracted after she participated in a one-night stand.  She reports she found out her husband was having an affair and acted out, sleeping with several men in a 6 month time frame, during which time she contracted herpes.  She denies currently dating, but states she would “hook up with guys” off of a herpes dating website, when she does not want to feel alone.

Maeve reportedly has few close friends and describes friendships as difficult, emotionally intense, but transient and superficial.  She states most of her friendships are with men, but the relationships typically end abruptly due to interpersonal conflict. Maeve states she really does not have any support system except for the friends that she has made on social media sites. Although, when in public she makes an effort to smile and act warmly towards others, her interpersonal warmth is quite shallow.  She is very involved in her own difficulties, so much so that extending herself to make deeper contact with others is too stressful.

**Educational/Work History:**

Maeve reports completing three years of college between the ages of 19 and 22, but withdrew from school due to experiencing severe depressive symptoms and motivational problems.  Maeve states she never returned to college and feels guilty about this. Maeve has worked for the past seven years, as a waitress at a local restaurant and bar. She describes working at a variety of jobs, including retail jobs, waitressing, bartending, and for a 6-month period of time, stripping. Maeve denies any military history.

**Substance Use History:**

Maeve reports some substance use history dating back to the age of 13.  She reports she had her first drink at that time, and described intermittent drinking binges since.  She reports receiving a DUI charge at the age of 24, but denies having alcohol related problems.  Maeve states she experimented with marijuana, mushrooms, and cocaine when she was in her mid 20s as well, but denies long-term or current use.

**Family Mental Health History:**

Maeve states she is unsure of any family mental illness.  She thinks her mother is “unhappy and depressed”, but knows her mother has never had any treatment. She says there is also something “obviously wrong with my brother who traumatized me.”

**Medical/Medication History:**

In addition, Maeve was initially diagnosed with Type I diabetes 10 years ago, but denies feeling her diabetes is under control.  She states she does not like using insulin, but does so “I won’t die”, and reports she missed her last endocrinologist appointment “on purpose.” Maeve reports a known allergy to penicillin.  Maeve reports a recent weight gain of 50 pounds resulting in a BMI of 32, placing her in the obese range.  She states she is unwilling to take any psychotropic medications and indicates she tried taking Prozac when she was 23, but did not like how it made her feel. She denies taking any other medication other than one for her chronic high blood pressure.

**Strengths/Interests:**

Maeve appears to have difficulty identifying her character strengths, and was only able to say she is a “good worker.”  She reports she likes to shop and spends time reading mystery novels. She says she does not spend time on enjoyable activities at this time, and that she prefers to sleep.  Often times she sleeps over 12 hours a day.

Directions:

Your differential diagnosis paper will address the following content areas:

•    **Introduction**: Introduction must include a brief description of the client and overview of the client’s presenting issues.

•   **Differential Diagnosis**: Based on the information presented in this vignette, develop an appropriate diagnostic profile. Be sure to include all appropriate specifiers. In addition, you will need to provide your rationale to support your choice of diagnoses and use of specifiers, as well as documented support as to why other diagnoses were ruled out or are still under consideration. Discussion of differential and co-occurring diagnoses should also be provided.

•   **Cultural Considerations**: Describe cross-cultural factors that may influence the diagnoses that you are recommending and identify cultural issues that may require additional exploration in treatment.

•   **Health Conditions**: Describe potential health conditions and consider potential impact on the client’s primary and sub-diagnoses and treatment.

•   **Other Mental Health Conditions**: Describe any psychosocial and environment problems and consider the potential impact on the client, primary and sub-diagnoses, and treatment.

•   **Diagnostic Profile**: Provide a complete diagnostic profile for this client.

•   **Treatment Considerations & Recommendations**: Provide a summary of counseling problem statement, long-term goals, therapist interventions, medications and side effects, modalities, and placement (i.e., outpatient, inpatient, etc and /adjunctive treatment recommendations) based on diagnostic profile. Be sure you clearly outline how you will manage client risk factors in treatment. Provide an explanation of how you considered the risks and benefits of the diagnostic labels you assigned.

•   **Conclusion**: Provide a comprehensive summary of your case findings. Be sure to include a review of diagnosis and any specific factors that influenced your diagnostic determination, treatment recommendations, etc.

Your final product should be a 12-15 page paper, utilizing a minimum of 12 scholarly sources. Your paper should be written in a clear, concise, and organized manner.  Demonstrate ethical scholarship in accurate representation and attribution of sources, and display accurate spelling, grammar, punctuation, and references page.

         Only minimal direct quotes are allowed for this assignment, and only primary citations are accepted. This means you must directly read the article instead of referencing it with “as cited in” another article, and you are not to simply copy the *DSM* diagnostic criteria.

         The DSM and a minimum of 4-5 peer reviewed journal articles must be cited in the paper, with the total number of references not less than 12.  Only scholarly references will be accepted.

         The research paper must follow APA 6th edition format (e.g., margins, page numbers and headers, abstract, text and final references, 12 point font, double spacing, unbiased language, etc.).

LASA Grading Criteria

|  |  |  |
| --- | --- | --- |
| **Assignment Components** | **Proficient** | **Max Points** |
|  |  |  |
| **Client Presenting Issues:**  Include a brief description of the client and overview of the client’s presenting issues  CO: 1  PO: 2, 3, 7  ILO: 5, 6  CACREP: 3.b, 3.e, 3.f,   3.g, C2, C4, K1, K2 | Introduction provides a brief yet clear description of the client, along with issues which the client currently faces. | /16 pts. |
| **Diagnostic Profile Dvt:**  Develop an appropriate diagnostic profile.  CO: 2  PO: 2, 3, 7  ILO:5, 6  CACREP: 3.b, 3.c, 3.e, 3.f, 3.g, D2, G3, K1, K2, K4, L1, L2 | Determines an appropriate diagnosis based on the information provided, with some evidence supporting diagnostic rationale. | /40 pts. |
| **Cultural Considerations:**  Describe cross-cultural factors that may influence diagnoses and identify cultural issues that may require additional exploration in treatment.  CO: 7  PO: 2, 3, 5, 7  ILO: 1, 2, 3, 4, 6  CACREP: 2.a, 3.f, D2, K4 | Describes all key cultural factors that may influence diagnoses, and identifies issues that may require additional exploration in treatment. | /40 pts. |
| **Health Contributors**  **Description:**  Describe potential health conditions and consider potential impact on the client’s primary and sub-diagnoses and treatment.  CO: 6  PO: 2, 3, 5, 7  ILO: 5, 6  CACREP: 2.a, 3.e, 3.f,   3.g, C5, K2 | Describes all key health conditions that may have an impact on the client’s diagnoses and treatment. | /40 pts. |
| **Psychosocial/Environmental Contributors’ Description** Describe any psychosocial and environment problems and consider the potential impact on the client, primary and sub-diagnoses, and treatment.  CO: 6  PO: 2, 3, 5, 7  ILO: 5, 6  CACREP: 2.a, 3.e, 3.f,   3.g, C5, K2 | Describes all key psychosocial and environmental problems that may impact the client, the diagnoses, or the treatment. | /40 pts. |
| **Diagnostic Profile:**  Provide a complete diagnostic profile for this client.  CO: 2  PO: 2, 3, 7  ILO:5, 6  CACREP: 3.b, 3.c, 3.e, 3.f, 3.g, D2, G3, K1, K2, K4, L1, L2 | Provides an appropriate diagnostic profile based on the information provided. Diagnostic profile is accurately formatted to ensure the profile has clinical utility. | /40 pts. |
| **Counseling Summary:**  Provide a summary of counseling problem statement, long-term goals, therapist interventions, medications and side effects, modalities, and placement based on diagnostic profile.  CO: 4, 5  PO: 1, 2, 3, 7  ILO: 1, 5, 6  CACREP: 2.a, 3.b, 3.c, 3.d, 3f, 3g, A2, C4, C9, K2, L1 | All recommended treatment options are clearly summarized. All treatment options focus on the diagnostic profile. Any risk factors pertaining to treatment and the client are summarized. | /40 pts. |
| **Case Finding Summary**: Provide a summary of your case findings.  CO: 1  PO: 2, 3, 7  ILO: 5, 6  CACREP: 3.b, 3.e, 3.f,   3.g, C2, C4, K1, K2 | Summarizes all relevant information from the case. | /16 pts. |
| **Academic Writing** |  |  |
| Write in a clear, concise, and organized manner; demonstrate ethical scholarship in accurate representation and attribution of sources (i.e. APA); and display accurate spelling, grammar, and punctuation. | Written in a clear, concise, and organized manner; demonstrated ethical scholarship in appropriate and accurate representation and attribution of sources; and displayed accurate spelling, grammar, and punctuation. Use of scholarly sources aligns with specified assignment requirements. | /28 pts. |
| **Total** |  | **/300 pts** |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Unsatisfactory** | **Emerging** | **Proficient** | **Exemplary** | **Max Points** |
| **Assignment Components** |  |  |  |  |  |
| **Client Presenting Issues:**  Include a brief description of the client and overview of the client’s presenting issues.  CO: 1  PO: 2, 3, 7  ILO: 5, 6  CACREP: 3.b, 3.e, 3.f,   3.g, C2, C4, K1, K2 | Introduction does not describe the client or the overview of the client’s issues. | Introduction provides a vague description of the client, along with issues which the client faces. | Introduction provides a brief yet clear description of the client, along with issues which the client currently faces. | Introduction provides a brief yet clear description of the client. The introduction provides a thorough overview of each issue the client faces as described in the vignette. | Unsatisfactory: <8  Emerging: 11 – 12  Proficient: 13 – 14  Exemplary: 15 – 16    \_\_\_\_\_\_\_\_/16 pts. |
| **Diagnostic Profile Dvt:**  Develop an appropriate diagnostic profile.  CO: 2  PO: 2, 3, 7  ILO:5, 6  CACREP: 3.b, 3.c, 3.e, 3.f, 3.g, D2, G3, K1, K2, K4, L1, L2 | Does not provide a diagnosis of the client. | States a diagnosis without support of the information provided. | Determines an appropriate diagnosis based on the information provided, with some evidence supporting diagnostic rationale. | Explains a likely diagnosis based on the information provided, and includes comprehensive evidence supporting diagnostic rationale. | Unsatisfactory: <30  Emerging: 31-34  Proficient: 35-38  Exemplary: 39-40    \_\_\_\_\_\_\_\_\_\_/40 pts. |
| **Cultural Considerations:**  Describe cross-cultural factors that may influence diagnoses and identify cultural issues that may require additional exploration in treatment.  CO: 7  PO: 2, 3, 5, 7  ILO: 1, 2, 3, 4, 6  CACREP: 2.a, 3.f, D2, K4 | Does not describe key cultural factors that may influence diagnoses. | Mentions some of the key cultural factors that may influence diagnoses. | Describes all key cultural factors that may influence diagnoses, and identifies issues that may require additional exploration in treatment. | Examines all key cultural factors that may influence diagnoses, and identifies issues that may require additional exploration in treatment. | Unsatisfactory: <30  Emerging: 31-34  Proficient: 35-38  Exemplary: 39-40    \_\_\_\_\_\_\_\_\_\_/40 pts. |
| **Health Contributors’ Description:**  Describe potential health conditions and consider potential impact on the client’s primary and sub-diagnoses and treatment.  CO: 6  PO: 2, 3, 5, 7  ILO: 5, 6  CACREP: 2.a, 3.e, 3.f,   3.g, C5, K2 | Does not describe key health conditions that may have an impact on the client’s diagnoses and treatment. | Mentions some of the key health conditions that may have an impact on the client’s diagnoses and treatment. | Describes all key health conditions that may have an impact on the client’s diagnoses and treatment. | Examines all key health conditions that may have an impact on the client’s diagnoses and treatment. | Unsatisfactory: <30  Emerging: 31-34  Proficient: 35-38  Exemplary: 39-40    \_\_\_\_\_\_\_\_\_\_/40 pts. |
| **Psychosocial/Environmental Contributors’ Description:**  Describe any psychosocial and environment problems and consider the potential impact on the client, primary and sub-diagnoses, and treatment.  CO: 6  PO: 2, 3, 5, 7  ILO: 5, 6  CACREP: 2.a, 3.e, 3.f,   3.g, C5, K2 | Does not describe key psychosocial and environmental problems that may impact the client, the diagnoses, or the treatment. | Mentions some key psychosocial and environmental problems that may impact the client, the diagnoses, or the treatment. | Describes all key psychosocial and environmental problems that may impact the client, the diagnoses, or the treatment. | Examines all key psychosocial and environmental problems that may impact the client, the diagnoses, or the treatment. | Unsatisfactory: <30  Emerging: 31-34  Proficient: 35-38  Exemplary: 39-40    \_\_\_\_\_\_\_\_\_\_/40 pts. |
| **Diagnostic Profile:**  Provide a complete diagnostic profile for this client.  CO: 2  PO: 2, 3, 7  ILO:5, 6  CACREP: 3.b, 3.c, 3.e, 3.f, 3.g, D2, G3, K1, K2, K4, L1, L2 | Does not provide a diagnostic profile of the client. | States a diagnostic profile that is not supported by the information provided in the vignette. Diagnostic profile is vague or not accurately formatted. | Provides an appropriate diagnostic profile based on the information provided. Diagnostic profile is accurately formatted to ensure the profile has clinical utility. | Justifies the diagnostic profile using the information provided. Diagnostic profile is accurately formatted and provides appropriate rationale to ensure the profile has clinical utility. | Unsatisfactory: <30  Emerging: 31-34  Proficient: 35-38  Exemplary: 39-40    \_\_\_\_\_\_\_\_\_\_/40 pts. |
| **Counseling Summary:**  Provide a summary of counseling problem statement, long-term goals, therapist interventions, medications and side effects, modalities, and placement based on diagnostic profile.  CO: 4, 5  PO: 1, 2, 3, 7  ILO: 1, 5, 6  CACREP: 2.a, 3.b, 3.c, 3.d, 3f, 3g, A2, C4, C9, K2, L1 | Some possible treatment options are identified. | All recommended treatment options are identified. | All recommended treatment options are clearly summarized. All treatment options focus on the diagnostic profile. Any risk factors pertaining to treatment and the client are summarized. | All recommended treatment options are critiqued. All treatment options focus on the diagnostic profile. All risk factors pertaining to treatment and the client are synthesized. | Unsatisfactory: <30  Emerging: 31-34  Proficient: 35-38  Exemplary: 39-40    \_\_\_\_\_\_\_\_\_\_/40 pts. |
| **Case Finding Summary**:  Provide a summary of your case findings.  CO: 1  PO: 2, 3, 7  ILO: 5, 6  CACREP: 3.b, 3.e, 3.f,   3.g, C2, C4, K1, K2 | Restates the findings of the case. | Organizes the information from the case. | Summarizes all relevant information from the case. | Abstracts each of the main points from the case. | Unsatisfactory: <8  Emerging: 11 – 12  Proficient: 13 – 14  Exemplary: 15 – 16    \_\_\_\_\_\_\_\_/16 pts. |
| **Academic Writing** |  |  |  |  |  |
| Write in a clear, concise, and organized manner; demonstrate ethical scholarship in accurate representation and attribution of sources (i.e. APA); and display accurate spelling, grammar, and punctuation. | Writing is unclear and disorganized and rereading to solidify understanding is frequently necessary. Although an attempt at ethical scholarship is attempted, it is sloppy or incomplete throughout.  Spelling, grammar, or punctuation errors severely interfere with readers’ comprehension.  Citations in text and at the end of the document are not in the correct APA format. | Writing is somewhat clear and is somewhat organized, although rereading to solidify understanding is occasionally necessary.  It demonstrates an attempt at ethical scholarship in accurate representation and attribution of sources, but errors are occasional or minor. Writing has good spelling, grammar, and punctuation, but errors somewhat interfere with readers’ comprehension.  Citations in text and at the end of the document are mostly in the correct APA format. | Writing is generally clear and in an organized manner. It demonstrates ethical scholarship in accurate representation and attribution of sources; and generally displays accurate spelling, grammar, punctuation. Errors are few, isolated, and do not interfere with reader’s comprehension.  Citations in text and at the end of the document are in correct. Many useful ideas are present.  APA format. | Writing is clear, concise, and in an organized manner; demonstrates ethical scholarship in accurate representation and attribution of sources; and displays accurate spelling, grammar, and punctuation.  Citations in text and at the end of the document are in correct APA format. | /28 |
| **Total** |  |  |  |  | **/300 pts** |

**Comments**

Areas for improvement:

General Comments

**Grading Criteria**

*Grading Scale                                                        Grading requirements*

|  |  |
| --- | --- |
| *Discussion and Participation* | *32%* |
| *Weekly Assignments* | *18%* |
| *RA* | *20%* |
| *LASA* | *30%* |
|  | *100%* |

|  |  |
| --- | --- |
| **A** | 100 – 93 |
| **A-** | 92 – 90 |
| **B+** | 89 – 88 |
| **B** | 87 – 83 |
| **B-** | 82 – 80 |
| **C+** | 79 – 78 |
| **C** | 77 - 73 |
| **C-** | 72 – 70 |
| **D+** | 69 – 68 |
| **D** | 67 – 63 |
| **D-** | 62 – 60 |
| **F** | 59 and below |

**Attendance, Academic Policies, and Library**

<http://syllabi.courseassets.com/gradargpolicies.pdf>