Revising Case Study Assignment in Abnormal Psychology Undergraduate Course to Enhance Critical Thinking

By Dr. Samantha Strife

A psychology instructor modifies a case study assignment for an Abnormal Psychology undergraduate course to enhance use of data and identification of multiple sides of an issue.

Background

Abnormal Psychology (PYSC 3303) is divided into three major content sections: 1) symptom presentations of mental health disorders 2) models of development/assessment/treatment of disorders 3) pros and cons of our current diagnostic system and ethical issues. To increase critical thinking (e.g., use of data and identification of multiple sides of an issue), I modified a case study assignment, which required students to read a vignette about a pretend individual struggling with various mental health symptoms and respond to questions ranging from diagnosis to treatment options.

Implementation

When I first taught Abnormal Psychology, I had students turn in three case studies as homework assignments. Student responses seemed incomplete and I was unable to provide extensive feedback given the short time between when assignments were due. In the Fall of 2015 I reduced the number to two case studies and added questions about differential diagnosis, assessment techniques, perspectives of etiology, and treatment options to better reflect the course learning objectives. I gave these revised case study assignments in 2015 toward the end of the semester without much opportunity for in-class practice and found that many of the student responses still included inaccurate information or emotional reasoning. Consequently, for Fall 2016 I assigned just one case study and attempted to scaffold the case study by creating several in-class group activities emphasizing each component of the assignment. This scaffolding approach was intended to provide more intentional structure for practice and feedback. After these in-class activities, students then completed a full practice/low-stakes case study assignment. They peer-edited their responses in class after collaboratively revising the rubric to increase student agency and transparency for the final assignment.

Student Work

Selected student work was compared between the second case study assigned in Fall 2015 and the case study in Fall 2016. This comparison was made because the questions were very similar for both assignments, while also highlighting the potential impact of the revised 2016 scaffolding in-class practice, peer-editing the mock assignment, and collaborating to redesign the rubric.

Despite limitations in this comparison, there are some indications that the revisions made in 2016 improved students' use of data and identification of multiple sides of an issue for the case study assignment (e.g., use of appropriate research articles, application of data to case study, and more complexity/depth in demonstrating understanding of differential diagnosis).

Reflections

I am pleased that the selected responses shown in the student work section of this portfolio exemplify more consistent use of data and identification of multiple sides of an issue. However, there are several ways I would like to further refine this assignment and my approach to assessment of student learning. In the future, I hope to use Learning Assistants in this class, in part with the intention of providing students more opportunity for feedback during in-class assignments and additional help outside of class. I also think that more formal ways of assessing student engagement throughout the semester and the inclusion of a baseline assessment could provide meaningful data. Clearly this case study assignment will continue to evolve and I look forward to making the improvements more effective and generalizable to all my students.

Background

Abnormal Psychology (PYSC 3303) emphasizes diagnostic and etiological perspectives of major mental health disorders (e.g., Generalized Anxiety Disorder, Major Depressive Disorder, etc.). The class size fluctuates from about 40 to 150 students, all of whom have taken Introduction to Psychology (PSYC 1001). Many of these students have specific clinical interests and go on to take classes like Clinical Interventions (PSYC 4541) and Field Internship Placement (PSYC 4931). The course content is connected to the general learning goals of the Psychology undergraduate major (e.g., demonstrating disciplinary knowledge, evaluating scientific evidence, identifying relevant assumptions, expressing ideas with clear organization, identifying ethical issues, and developing intercultural competency). Below are the specific learning objectives for Abnormal Psychology.

Objectives:

Upon completion of this course, the successful student will be able to:

- describe the main symptoms associated with selected mental health diagnoses
- compare and contrast presenting symptoms to understand differential diagnoses
- identify and apply selected theoretical orientations regarding the development of abnormal behavior
- describe the various ways in which social, gender, cultural, biochemical, and psychological factors influence the behavior of individuals and predispose persons towards mental disorders

- demonstrate a basic understanding of treatments that have research support for selected disorders
- evaluate ethical implications, potential biases, and gaps of diagnostic system
- develop and show compassion for individuals with mental illnesses

This course is, therefore, divided into three major content sections:

1. symptom presentations of disorders (including anxiety disorders, mood disorders, eating disorders, substance use disorders, schizophrenia, and developmental disorders)
2. models of development/assessment/treatment of disorders
3. pros and cons of our current diagnostic system and ethical issues.

My Aim

My aim is to have students retain a basic understanding of the way we categorize mental health disorders AND think critically about the gaps in our current diagnostic system. I have taught this course many times since 2012 and continue to work/struggle to have students:

- use data (and not emotional reasoning) to determine diagnostic criteria and treatment considerations, and
- identify multiple sides of an issue (e.g., using a multidimensional approach to explain possible etiological factors of a disorder).

To address the above concerns, I further developed and modified a case study assignment, which required students to read a vignette about a pretend individual struggling with various mental health symptoms and respond to questions ranging from diagnostic considerations to treatment options. In previous semesters, I have given the case study toward the end of the semester without much opportunity for in-class practice. I received feedback from students that they were confused and overwhelmed by the assignment, which, I believe, was reflected in the quality of their written responses. I also fielded several questions about the rubric, which was not given until after the assignment was completed. Consequently, I attempted to scaffold the case study by offering several in-class group activities emphasizing each of the following revised components of the assignment:

- difference between symptoms (e.g., sleep disturbance and limited energy) and full clinical criteria (e.g., Major Depressive Disorder),
- differential diagnoses to compare/contrast diagnostic categories (e.g., concentration problems can be consistent with both depression and anxiety),
- multidimensional approach to etiology (e.g., understanding that biology, cognition, and social/systemic factors all contribute to the development of a mental health disorder) ,
- research to identify appropriate treatment options (e.g., learning to find an article that is evidenced based for a particular presenting mental health problem), and
- reflection about possible limitations/gaps in the diagnostic approach.

Students then peer edited a full practice/low-stakes case study assignment (combining all of the above components covered in class activities into one complete assignment-similar to what

would be asked in the final case study assessment) (see example here). Emphasis was placed on collaboratively revising the rubric to increase student agency and transparency for the final assignment (see rubric here). Selected student responses from a previous semester are compared to this semester to explore potential impact of the revised approach with scaffolding.

Implementation

When I first taught Abnormal Psychology in 2012 I had students turn in three case studies as homework assignments. These assignments were primarily focused on identifying clinical symptoms to correctly diagnose a pretend client from a given vignette. Student responses seemed incomplete and I was unable to provide extensive feedback given the short time between when assignments were due. I also felt that these first iterations of the case study assignment over-emphasized forming a definitive diagnosis at the expense of recognizing the context behind these labels. In the Fall of 2015 I reduced the number to two case studies and added the following components to better reflect the course learning objectives:

- Provide two possible differential diagnoses. Explain why each is a possible diagnosis and why the client does not meet full criteria at this point.
- List two assessment techniques you would use to gather more clinically relevant information. Explain your rationale for why you selected these specific assessments, and what information you would gain from each technique.
- Pick two perspectives of etiology and describe how the diagnosed disorder may have developed according to these perspectives.
- Review an empirical article for a treatment that has research support for the disorder and describe how this approach would specifically be beneficial to the client.

I gave these revised case study assignments in 2015 toward the end of the semester without much opportunity for in-class practice and found that many of the student responses still included inaccurate information (e.g., diagnoses listed based on incomplete criteria) or emotional reasoning (e.g., focusing on treatment recommendations based on assumptions without research support). Consequently, for Fall 2016 I assigned just one case study (in part because my class size increased to over 100 students) and attempted to scaffold the case study by breaking the assignment into manageable “chunks.” Specifically, I created several in-class group activities emphasizing each component of the assignment. For example, early in the semester I introduced the difference between isolated clinical symptoms compared to full diagnostic criteria for a mental health disorder. Students responded to clicker questions about short vignettes to practice identifying when pretend clients met full clinical criteria for particular disorders. Emphasis was placed on alignment between the clinical criteria outlined in the diagnostic manual and “client” report in the vignettes to highlight importance of using “data” (not emotional reasoning) when considering diagnosis. They were asked to respond to the clicker question individually, share their rationale with their “neighbor,” and then click in again if they had changed their answer based on the conversation with their peers. Students received immediate feedback about the correct answer, but only participation points were given for the clicker questions.

A similar approach was used to address the following areas:

- Differential Diagnoses. Group in-class activity emphasized indicating all present symptoms for each possible diagnosis (how client meets partial diagnostic criteria) while also identifying all missing symptoms for said diagnosis (how the client does not meet full diagnostic criteria at this point). Subsequent class discussion focused on the imperfections of the current mental health diagnostic system.
- Assessment. Group in-class activity emphasized practicing articulation of the rationale for why the assessment technique would be relevant and useful for the pretend client. Subsequent class discussion focused on collecting reliable data.
- Multidimensional approach to etiology. Group in-class activity emphasized identifying cognitive, behavioral, biological, and cultural/systemic causal factors. Subsequent class discussion focused on identifying multiple sides of an issue.
- Empirical treatment article. Group in-class activity emphasized identifying and summarizing rigorous studies using library database. Subsequent class discussion focused on clinical implications of disseminating treatment without research support.

This scaffolding approach was intended to provide more intentional structure for practice and feedback. After these in-class activities, students then completed a full practice/low-stakes case study assignment (combining all of the above components covered in class activities into one complete assignment-similar to what would be asked in the final case study assessment). They peer-edited their responses in class after collaboratively revising the rubric to increase student agency and transparency for the final assignment. I also hoped that reviewing a peer's work would help them identify strengths and possible gaps in their own papers. Students were graded on participation and their meta-cognitive reflections about their individual areas of strength and why they missed points. Students were encouraged to meet with me (or the graduate teaching assistant) to further discuss responses and increase engagement in designing the rubric. Taken together, the overall intent of this case study assignment was to provide a window into how clinical psychologists make informed decisions about diagnosis.

Student Work

Student work was compared between the second case study assigned in Fall 2015 and the final case study in Fall 2016. This comparison was made because the questions were very similar for both assignments, while also highlighting the potential impact of the revised 2016 scaffolding in-class practice, mock assignment, and collaboration with rubric design. Comparison of overall case study grades was not particularly relevant, because rubric was revised for 2016 (see 2016 Rubric at the end of this document). Consequently, I compared selected student responses based on case study grade across years. Specifically, I compared the four highest case study grades from 2015 to the four highest case study grades from 2016. I also compared students who earned in the lowest range across years. I re-graded these selected responses with emphasis on the following factors (see Revised Rubric for this portfolio at the end of this document):

- use of data (and not emotional reasoning) to determine diagnostic considerations and treatment options, and
- identification of multiple sides of an issue (e.g., using a multidimensional approach to explain possible etiological factors of a disorder).

Although clearly not a rigorous comparison, there are some indications that the revisions made in 2016 (i.e., scaffolding in-class practice, peer-editing a mock assignment, and collaborating to redesign rubric) improved students' responses to the case study assignment. The most notable improvement across years was for the students with the highest case study grades. For example, although the high achieving students from both years made correct diagnoses (understanding complete criteria vs. isolated symptoms), the student responses from 2016 were anchored with more detailed examples from the case study (see Case Study Example 1, at end of document). This highlights the importance of using "data" when tasked with the challenge of diagnosing a pretend client. Alignment between the clinical criteria outlined in the diagnostic manual and client report was emphasized during the in-class practice assignments, which might account for some of these improvements. The highest performing students from 2016 also referenced research more thoroughly when discussing treatment options for the pretend client in the case study (see Case Study Example 2, at end). Importantly, 102 students out of 104 in 2016 (98%) submitted appropriate articles that had empirical support for the given diagnosis. This is compared to 40 out of 46 students in 2015 (87%). The revisions made in 2016 may have also helped these students interpret the data with more emphasis placed on applying the article information directly to the case study.

Identification of multiple sides of an issue was the second value emphasized in this retrospective comparison. The group of students who earned the highest grades on the case study from 2016 (compared to the highest earning students from 2015) seemed to benefit from the additional practice and transparency about rubric, as indicated by the depth of responses about differential diagnosis (see Example 3, at end of document). For example, students from 2016 identified multiple sides of an issue by showing competing explanations of symptom presentation with emphasis on plausibility (indicating which symptoms are present and missing as indicated in the case study). Interestingly, the selected responses from students who scored in the lowest range on the case study did not seem to differ significantly across years.

Reflections

Now, more than ever, I am certain that teaching is an iterative process and I'm humbled and excited that I am left with more questions compared to when I initiated this portfolio. I think there is some initial evidence to show that my revisions to the case study in 2016 (scaffolding with in-class assignments, peer-editing the mock assignment, and revising the rubric collaboratively) improved the work of high performing students. Specifically, I think the selected responses shown in the student work section of this portfolio exemplify more consistent use of data and identification of multiple sides of an issue. However, there are several ways I would like to further refine this assignment and my approach to assessment of student learning.

I am particularly concerned that students who earned in the lowest range across years may not have benefitted from in-class practice and collaboration with rubric development compared to higher achieving students. One possible explanation is that these students were not as engaged/invested during in-class learning activities. In an effort to address this, I will be using Learning Assistants in this class next fall, in part with the intention of providing students more opportunity for feedback during in-class assignments and additional help outside of class. I also hope to include a more formal ways of assessing student engagement throughout the semester (e.g., using pre and post questionnaires or perhaps clicker questions addressing student perception of relevance and alignment of course objectives and assignments). In addition, assessing students in the middle range and including a baseline assessment early in the semester (to use as a in-group comparison of growth) could provide meaningful data. It would still provide an imperfect comparison, but it will eliminate some of the confounding variables of comparing across semesters.

I think students would also benefit from additional help in the treatment section of the case study assignment. Specifically, I think it would be interesting to shift from identification of an empirically supported treatment and brief review of said treatment to critically thinking about the possible benefit and limitations of a treatment article provided. This shift might better emphasize and echo department goals of evaluating scientific evidence and identifying relevant assumptions. Finally, I would like to further explore how to measure the course objective of students demonstrating compassion towards individuals with mental health disorders. Clearly this case study assignment will continue to evolve and I look forward to collaborating with my teaching team and students to make the improvements more effective and generalizable.

Abnormal Psychology –PSYC 3303-001
Fall 2016
MWF 9:00-9:50am

Instructor: Samantha Strife, Ph.D.
Email: samantha.strife@colorado.edu

Text: Comer, Ronald. (2015). Abnormal Psychology-9th edition.

Objectives: Upon completion of this course, the successful student will be able to:

- describe the main symptoms associated with selected mental health diagnoses
- compare and contrast presenting symptoms to understand differential diagnoses
- identify and apply selected theoretical orientations regarding the development of abnormal behavior
- describe the various ways in which social, gender, cultural, biochemical, and psychological factors influence the behavior of individuals and predispose persons towards mental disorders
- demonstrate a basic understanding of treatments that have research support for selected disorders
- evaluate ethical implications, potential biases, and gaps of diagnostic system
- develop and show compassion for individuals with mental illnesses

Learning opportunities: The following assessments will be used throughout the semester.

Tests: There will be three non-cumulative tests for this course.

Case Study: The case study is a written assignment emphasizing differential diagnosis, assessment, causal factors, and treatment considerations for a pretend clinical case.

Participation: Part of your grade will include participation points evaluated on the degree of your active involvement in the class. Participation grades will include responses to case study preparation questions, clicker questions, and reflection assignments. It is your responsibility to make sure that your clicker is working correctly.

Your grade will be determined out of a total of 450 points.

3 exams	300 points
Case study	100 points
Participation / Clicker questions/ HW	50 points
Total	**450 points**

Letter grades will be assigned as follows:

	A = 100-94%	A- = 93-90%

B+ = 89-87%	B = 86-84%	B- = 83-80%
C+ = 79-77%	C = 76-74%	C- = 73-70%
D+ = 69-67%	D = 66-64%	D- = 63-60%

All documents and grades will be available on the course website, Desire to Learn, https://learn.colorado.edu/.

MISSED CLASS AND LATE WORK

If you miss a class, please get notes from a classmate. **You are responsible for all information communicated in class, whether or not you are in attendance. You must check the course website and your email to stay on top of any changes to the course plan or assignments.**

It is **not** in your interest to explain to me reasons for missed class or late work without clear, written, verifiable documentation. Except for unavoidable, well-documented circumstances such as illness or family emergencies, when an assignment is turned in late, your grade for that assignment will be reduced by 10% for each day late.

An incomplete is only given if you, for reasons beyond your control, have been unable to complete course requirements. You must have documentation that verifies reasons that were beyond your control that interfered with your ability to complete the class. Moreover, a substantial amount of work must have been satisfactorily completed before approval for such a grade is given.

CONTROVERSIAL AND SENSITIVE TOPICS

Class lectures, discussions, and activities may include topics that are controversial and that may be upsetting in nature (e.g., traumatic events, suicide). The goal of this course is to think critically about such topics, and it is my aim to create an atmosphere that is conducive to dialogue and inquiry by nurturing a classroom based on respect and consideration for oneself and one's peers. If you have concerns about topics that are listed on the syllabus or that are addressed in class discussions, I encourage you to talk individually with me at any point.

DISABILITY ACCOMMODATIONS

If you qualify for accommodations because of a disability, please submit to me a letter from Disability Services in a timely manner (for exam accommodations provide your letter at least one week prior to the exam) so that your needs can be addressed. Disability Services determines accommodations based on documented disabilities. Contact Disability Services at 303-492-8671 or by e-mail at dsinfo@colorado.edu. If you have a temporary medical condition or injury, see Temporary Medical Conditions: Injuries, Surgeries, and Illnesses guidelines under Quick Links at Disability Services website and discuss your needs with me.

RELIGIOUS OBSERVANCE

Campus policy regarding religious observances requires that faculty make every effort to deal reasonably and fairly with all students who, because of religious obligations, have conflicts with scheduled exams, assignments or required attendance. In this class, I expect you to notify me in advance if religious observances will conflict with class requirements so that we can arrange a suitable accommodation. See full details at http://www.colorado.edu/policies/fac_relig.html

CLASSROOM BEHAVIOR

Students and faculty each have responsibility for maintaining an appropriate learning environment. Those

who fail to adhere to such behavioral standards may be subject to discipline. Professional courtesy and sensitivity are especially important with respect to individuals and topics dealing with differences of race, color, culture, religion, creed, politics, veteran's status, sexual orientation, gender, gender identity and gender expression, age, disability, and nationalities. Class rosters are provided to the instructor with the student's legal name. I will gladly honor your request to address you by an alternate name or gender pronoun. Please advise me of this preference early in the semester so that I may make appropriate changes to my records. See policies at http://www.colorado.edu/policies/classbehavior.html and at http://www.colorado.edu/studentaffairs/judicialaffairs/code.html#student_code

DISCRIMINATION AND HARASSMENT

The University of Colorado Boulder (CU-Boulder) is committed to maintaining a positive learning, working, and living environment. The University of Colorado does not discriminate on the basis of race, color, national origin, sex, age, disability, creed, religion, sexual orientation, or veteran status in admission and access to, and treatment and employment in, its educational programs and activities. (Regent Law, Article 10, amended 11/8/2001). CU-Boulder will not tolerate acts of discrimination or harassment based upon Protected Classes or related retaliation against or by any employee or student. For purposes of this CU-Boulder policy, "Protected Classes" refers to race, color, national origin, sex, pregnancy, age, disability, creed, religion, sexual orientation, gender identity, gender expression, or veteran status. Individuals who believe they have been discriminated against should contact the Office of Discrimination and Harassment (ODH) at 303-492-2127 or the Office of Student Conduct (OSC) at 303-492-5550. Information about the ODH, the above referenced policies, and the campus resources available to assist individuals regarding discrimination or harassment can be obtained at http://hr.colorado.edu/dh/

HONOR CODE

All students of the CU-Boulder are responsible for knowing and adhering to the academic integrity policy of this institution. Violations of this policy may include: cheating, plagiarism, aid of academic dishonesty, fabrication, lying, bribery, and threatening behavior. All incidents of academic misconduct shall be reported to the Honor Code Council (honor@colorado.edu; 303-735-2273). Students who are found to be in violation of the academic integrity policy will be subject to both academic sanctions from the faculty member and non-academic sanctions (including but not limited to university probation, suspension, or expulsion). Other information on the Honor Code can be found at http://www.colorado.edu/policies/honor.html and at http://honorcode.colorado.edu

Course Outline and Schedule

Week 1		**Readings:**
Mon, 8/22	Course introduction	Chapter 1
Wed, 8/24	Diagnostic Issues	Chapter 4 (pp. 113-119)
		Article
Fri, 8/26	Models of abnormality	Chapter 3
Week 2		**Readings:**
Mon, 8/29	Anxiety disorders	Chapter 5
Wed, 8/31	Anxiety disorders	Chapter 5
Fri, 9/2	Anxiety disorders	Article
Week 3		**Readings:**
Mon, 9/5	**NO CLASS**	

Wed, 9/7	Assessment	Chapter 4 (97-112) Culture article
Fri, 9/9	Case study practice	

Week 4		**Readings:**
Mon, 9/12	OCD related disorders	Jenike (2004)
Wed, 9/14	PTSD	Chapter 6
Fri, 9/16	PTSD	Chapter 6

Week 5		**Readings:**
Mon, 9/19	Guest Lecture	
	Empirically supported treatments	Chapter 4
Wed, 9/21	Common Factors/ Review	
Fri, 9/23	**TEST 1**	

Week 6		**Readings:**
Mon, 9/26	Mood disorders	Chapter 8,9
Wed, 9/28	Guest lecture	Chapter 8,9
Fri, 9/30	Mood disorders	Chapter 9,10

Week 7		**Readings:**
Mon, 10/3	Somatic and Dissociative disorders	Chapter 10
Wed, 10/5	Somatic and Dissociative disorders	Chapter 10
Fri, 10/7	Somatic and Dissociative disorders	Article

Week 8		**Readings:**
Mon, 10/10	Eating disorders	Chapter 11
Wed, 10/12	Eating disorders	Chapter 11
	Case study practice	
Fri, 10/14	Eating disorders	Article

Week 9		**Readings:**
Mon, 10/17	Guest lecture	Chapter 12
Wed, 10/19	Substance disorders	Chapter 12
	How to find/read an empirical article	
Fri, 10/21	Substance disorders	Article

Week 10		**Readings:**
Mon, 10/24	Catch up/review	
Wed, 10/26	**TEST 2**	
Fri, 10/28	Schizophrenia	Chapter 14,15

Week 11		**Readings:**
Mon, 10/31	Schizophrenia	Chapter 14,15
Wed, 11/2	Schizophrenia	Article
Fri, 11/4	**Case Study practice**	

Week 12		**Readings:**
Mon, 11/7	Personality disorders	Chapter 16
Wed, 11/9	Personality disorders	Chapter 16
Fri, 11/11	Guest lecture	Chapter 17

Week 13		**Readings:**
Mon, 11/14	Developmental disorders	Chapter 17
Wed, 11/16	Developmental disorders	Chapter 17
Fri, 11/18	Mental health law and ethics	Chapter 19
	CASE STUDY DUE (9AM)	

Week 14		**Readings:**
11/23-11/27	**NO CLASS…THANKSGIVING!**	

Week 15		**Readings:**
Mon, 11/28	Mental health law and ethics	Chapter 19
Wed, 12/30	Mental health law and ethics	Chapter 19
Fri, 12/2	Positive psychology	Articles

Week 16		**Readings:**
Mon, 12/5	Positive psychology	
Wed, 12/7	Special topic	TBD
Fri, 12/9	Review	

The 3rd exam for this class is during finals week: Thurs. Dec. 15 7:30 p.m. – 10:00 p.m.

Case Study Rubric Fall 2016

Question						Total Points
What is the diagnosis/diagnoses?	**0 points** Incorrect diagnosis and/or no diagnosis is given	**3 points** Incorrect but related diagnosis; or correct but incomplete list given (if multiple present)	**6 points** Correct diagnose(s) given with correct DSM 5 label			_____/6 pts
Relevant symptoms for the diagnosis	**0 points** No relevant symptoms listed from DSM 5, symptoms are not present in case study	**3-6 points** Less than half of relevant symptoms listed, or additional symptoms added that are not present in case study	**9 points** About half of relevant symptoms listed correctly using DSM 5 and relevant information from case study.	**12-15 points** More than half of relevant symptoms listed correctly using DSM 5 and relevant information from case study	**18 points** All relevant symptoms listed based on DSM 5 criteria and anchored with examples from case study	____/18 pts
Impact of the disorder	**0 points** No impacts are listed	**3 points** Some impact listed, but missing important areas	**6 points** Impact is thoroughly described			_____/6 pts
Differential Diagnosis #1	**0 points** Differential diagnosis invalid (not based on any symptoms present)	**3 points** Correct possible differential diagnosis is given				_____/3 pts

	and/or missing					
Differential Diagnosis #1 – Present Symptoms	**0 points** Incorrect symptoms and/or section missing	**3 points** Partial list of present symptoms correctly using DSM 5 and relevant information from case study.	**6 points** Complete list of present symptoms correctly using DSM 5 and relevant information from case study.			_____/6 pts
Differential Diagnosis #1 – Symptoms the client does NOT have and rationale	**0 points** Incorrect symptoms and/or section missing	**3 points** Partial list of missing symptoms (correctly using DSM 5 and relevant information from case study), and/or no rationale given	**6 points** Complete list of missing symptoms (correctly using DSM 5 and relevant information from case study) and rationale clearly articulated			_____/6 pts
Differential Diagnosis #2	**0 points** Differential diagnosis invalid (not based on any symptoms present)	**3 points** Correct possible differential diagnosis is given				_____/3 pts
Differential Diagnosis #2 – Present Symptoms	**0 points** Incorrect symptoms and/or section	**3 points** Partial list of present symptoms correctly using	**6 points** Complete list of present symptoms correctly using			_____/6 pts

	missing	DSM 5 and relevant information from case study.	DSM 5 and relevant information from case study.			
Differential Diagnosis #2 – Symptoms the client does NOT have and rationale	**0 points** Incorrect symptoms and/or section missing	**3 points** Partial list of missing symptoms (correctly using DSM 5 and relevant information from case study), and/or no rationale given	**6 points** Complete list of missing symptoms (correctly using DSM 5 and relevant information from case study) and rationale clearly articulated			_____/6 pts
Assessment Strategy	**0 points** Assessment strategy missing or incorrect	**3 points** Assessment strategy only	**6 points** Assessment strategy and thorough rationale explaining why it is relevant for client			_____/6 pts
Etiological Perspective	**0 points** Perspective is not given	**3 points** 1 perspective is given with little rationale	**6 points** multiple perspective are given with partial rationale or rationale is missing component(s)	**9 points** Thorough perspectives provided with examples from case study, but rationale has some missing supporting evidence	**12 points** Thorough perspectives provided with examples from case study, and rationale has clear supporting evidence	____/12 pts
Empirical Treatment Article	**0 points** Article is not	**3 points** Article is	**6 points** Article is			_____/6 pts

	empirical, treatment is irrelevant, or article is missing	empirical, but treatment is not completely relevant to client	empirical, and treatment is relevant to client			
Article Citation/Abstract	**0 points** No citation or abstract provided	**2 points** Citation incorrect/ missing or abstract missing	**4 points** Correct citation & abstract provided			_____/4 pts
Empirical Article Review and Rationale	**0 points** Article review and/or rationale for choice is missing.	**3 points** Review of article or description of treatment benefits missing	**6 points** Review of article and/or description of treatment benefits incomplete	**9 points** Brief review of article and description of benefits of treatment; could be more comprehensive (e.g. missing limitations of study)	**12 points** Review of key points and thorough description of benefits of approach to client	____/12 pts
NPR & Other Questions	**0 points** Missing or markedly poor description provided	**3 points** Two questions missing or incomplete description	**6 points** One question missing or rationale is still lacking; or answers not sufficiently linked to client	**9 points** All questions answered with thorough rationale & sufficiently tied back to client		____/9 pts
TOTAL POINTS EARNED						_____/109

Additional Feedback:

Revised rubric for Strife Portfolio

Modeled after the Critical Thinking Value Rubric (https://www.aacu.org/sites/default/files/files/VALUE/CriticalThinking.pdf)

	4 capstone	3 milestones	2 milestones	1 benchmark
Use of data	Correct diagnosis with examples anchored in case study. Includes thorough explanation of impact. Clear understanding that a few symptoms do not represent a disorder. Treatment considerations are based on relevant research, interpreted clearly, and linked to examples of case study.	Missing some relevant symptoms needed for diagnosis. Impact not clearly explained. Treatment considerations are used with some interpretation and with some reference made to case study.	Missing many relevant symptoms needed for diagnosis. Impact not clearly stated. Treatment considerations are used with limited interpretation and with limited reference made to case study.	Incorrect diagnosis. Emotional reasoning used to diagnose (e.g., using isolated symptoms to diagnose), resulting in overpathologizing. Impact not noted. Research not used to inform treatment considerations or information is taken from source(s) without any interpretation. Treatment is not linked back to case study.
Identification of multiple sides of an issue	Multiple etiological perspectives grounded in research and case study. Differential diagnoses	Multiple perspectives of etiology provided, with some reference to research or case study. Differential	Multiple perspectives of etiology provided, but with limited reference to research or case study.	Singular perspective of etiology. No research or examples from case study given in explanation. No differential diagnosis made. Conclusions are

	provided, clearly referencing case study with examples. Complexity of an issue is clearly articulated through comparison of symptoms.	diagnoses are listed with some supporting evidence.	Differential diagnoses are listed without supporting evidence.	oversimplified.

EXAMPLE1: Using "data" for diagnostic criteria

2016 sample of high earning grade (with scaffolding in-class practice, mock assignment, and collaboration with rubric design)

Bipolar 1,

Major Depressive Episode:

- The presence of five or more of the following symptoms during the same two-week period, including at least one of the first two symptoms:
  - Two-week duration
    - Lila was found in a motel where she had spent the past three weeks in a state of depression.
  - Daily depressed mood for the most the day
    - Lila had spent three weeks in bed, crying, sleeping, and feeling worthless.
  - Daily diminished interest or pleasure in almost all activities for most of the day
    - Lila ignored her passion for music and her pursuits of becoming a famous recording artist and instead spent three weeks crying, sleeping, and watching TV.
    - She reported not having the energy to care about her career, which she was once passionate and excited about.
  - Significant weight gain, increase in appetite
    - Lila was found surrounded fast food wrappers and soda cans.
    - Lila had gained weight during her 3-week stint in the motel room due to her consumption of fast food.
  - Daily hypersomnia
    - Lila disappeared because she felt the need to get away from everyone and just sleep.
    - Lila spent all day in bed, often sleeping yet still felt like she had no energy.
  - Daily fatigue and loss of energy
    - Lila felt fatigued despite her hypersomnia.
    - Lila did not the have energy to care about her future career in music.
    - Lila did not have the energy to reach out to loved ones, especially her girlfriend.
  - Daily feelings of worthlessness and guilt
    - When she was found, Lila said she felt, "so empty and worthless."

Samantha Strife 6/7/2017 11:44 AM
Comment [1]: The clinical criteria is accurately and clearly outlined.

Samantha Strife 6/7/2017 11:54 AM
Comment [2]: Examples are anchored with "data" from the mock case study.

        - Lila also reported feeling like she was a useless and horrible person.
    - Daily reduced ability to think or concentrate, or indecisiveness
        - When asked what she wanted to do next, Lila said, "I dunno…. I can't even decide what kind of food to order next or whether to call my girlfriend, let along what to do with my life."

2015 sample of high earning grade response to same question:

Symptoms for Bipolar Disorder 1

1) Major depressive episode
    a) 3 weeks of a depressed mood
    b) Weight gain
    c) Sleep disturbance – increased sleeping patterns
    d) Feelings of worthlessness and guilt
    e) Fatigue
    f) Concentration problems

Samantha Strife 6/7/2017 6:33 PM

Comment [3]: The student accurately identifies the clinical criteria, but does not use examples from the case study. This can lead to assumptions and emotional reasoning, which can contribute to misdiagnosis if not careful.

EXAMPLE 2: Using data to identify treatment options.

2016 sample of high earning grade (with scaffolding in-class practice, mock assignment, and collaboration with rubric design)

Treatment: Interpersonal Psychotherapy (IPT) coupled with Family-Focused Therapy (FFT) for the treatment of Bipolar Disorder.

Article: Hollon, S. D., & Ponniah, K. (2010). A review of empirically supported psychological therapies for mood disorders in adults. *Depression and Anxiety,27*(10), 891-932. doi:http://dx.doi.org.colorado.idm.oclc.org/10.1002/da.20741

Brief Article Summary (who participated in the study, what they did in the study, and what the outcomes were/how they compared across groups/conditions.

- A systematic review of 125 randomized controlled looking at the effectiveness of various empirically supported therapies for various mood disorders.
- Pulled past studies from PsycINFO, PubMed, and the reference sections of scientific journals.
- They concluded that IPT and FFT were the most effective for the management of Bipolar Disorder, especially when coupled with medication.
- These therapies also help to reduce relapse in the future.

Samantha Strife 6/7/2017 6:42 PM

Comment [1]: Clearly a brief review with limitation of article not clearly outlined; however, this student demonstrates that she can find an empirical article relevant to a particular presenting issue.

Rationale (why you would recommend this specific treatment and *how* it might help the client):

- While Lila was hospitalized she could be prescribed a mood stabilizer such as lithium in order to stabilize her intense mood swings.
- But it is shown that although medication is effective, it does not significantly improve the patients' risk of future relapse of depressive and/or manic episodes.
- It would be most effective if Lila coupled medication with both IPT and FFT.
- Benefits of Interpersonal Psychotherapy
    - Lila would benefit from seeing a clinical psychologist who could help her structure her days because it has been shown that planned social activity, order, and regularized sleep patterns are crucial in helping with mood stability.
- Benefits of Family-Focused Therapy
    - Lila would be able to step back, out of the spotlight, and seek support with the help of her family. Her parents could help her regularized her daily routine. FFT could also help Lila and her mom with finding effective communication techniques therefore reducing conflict and ultimately stress.

Samantha Strife 6/7/2017 12:18 PM

Comment [2]: This response shows application in interpretation and is clearly linked back to case study.

2015 sample of high earning grade response to same question:

Machado-Vieira, R., Manji, HK., Zarate Jr CA. (2009). The role of lithium in the treatment of bipolar disorder: convergent evidence for neurotrophic effects as a unifying hypothesis. Bipolar Disorder, 11 (Suppl. 2): 92 – 109.

Brief Review of article:

This article focuses the positive effects of lithium and what is further known regarding its neurotrophic effects. The effectiveness of lithium along with other mood stabilizers opens doors for future research on the neurotrophic effects and pathways that are directly affected by this potent metal. One positive aspect of lithium is its ability to increase neuroprotection of neurons by slowing their degeneracy during the onset of the disorder. Future work regarding lithium's course of action is crucial to the development and understanding of other neurotrophic enhancers that could be helpful in treating other disorders.

Rationale (why you would recommend this specific treatment and how it would help the client):

- € Lithium is a mood stabilizer that can help prevent future symptoms from developing.
- € Continued doses could help relieve client of potential future suicide attempts.
- € Although researchers do not quite fully understand the course of action of mood stabilizers and how they operate, it is thought that they could be affecting the synaptic activity of neurons and communication of synapses. It could be positively affecting the impaired transport mechanism individuals with bipolar disorders are thought to have.

Samantha Strife 6/7/2017 12:22 PM
Comment [3]: Article is relevant to presenting issue outlined in case study.

Samantha Strife 6/7/2017 12:20 PM
Comment [4]: Although clearly referencing key parts of the study, this response ignores important factors that the reader needs to know (e.g., methodology).

Samantha Strife 6/7/2017 6:41 PM
Comment [5]: This response is a good start, but is limited in interpretation. Also, the student does not show how the data is specifically applied to the case study.

Samantha Strife 6/7/2017 6:44 PM
Comment [6]: More clarity is needed.

Samantha Strife 6/7/2017 6:43 PM
Comment [7]: The client in the case study did not attempt suicide.

Samantha Strife 6/7/2017 6:44 PM
Comment [8]: Interesting comment, but more clarity is needed here.

EXAMPLE 3: Multiple sides of an issue

2016 sample of high earning grade (with scaffolding in-class practice, mock assignment, and collaboration with rubric design)

Differential Diagnosis #1: Bulimia Nervosa

Samantha Strife 6/7/2017 7:00 PM

Comment [1]: Differential diagnoses accurately use case study as examples. Multiple sides of an issue demonstrated by showing competing explanations of symptom presentation with emphasis on plausibity.

Symptoms client has:

1) Recurrent compensatory behavior in order to prevent weight gain.
    - Following an occasion when she replaced regular meals with ice cream, Lila would only eat whole grains, lean meat and veggies, to avoid gaining weight.
2) Undue influence of weight or shape on self-evaluation.
    - Lila would call herself fat and pinch the excess skin/fat on her stomach.

Symptoms client does <u>not</u> have (missing criteria/reasons this diagnosis can be ruled out):

1) Recurrent episodes of binge eating.
    - Although Lila may consider eating an ice cream cone a binge because that is out of the norm for her, a clinical binge is characterized by eating a large quantity of food over a limited period of time, which is often two hours. One ice cream cone in one sitting would not fit the criteria for a binge.
2) Symptoms continuing, on average, at least once a week for three months.
    - The potential binges Lila's experienced while staying at the motel were only over the course of three weeks, and there was no sign of compensatory behavior during that time.
    - There is no definitive pattern to Lila's ice cream cone consumption other than the description of "often." So it is difficult to discern if that would fit the once a week criteria.

2015 student response to same question:

Differential Diagnosis #1:

Persistent Depressive Disorder Symptoms client has:

Client shows low energy and self –esteem, but does not meet full

criteria because of length of symptoms.

Samantha Strife 6/7/2017 7:07 PM

Comment [2]: This is a plausible differential diagnosis; however, more examples are needed from case study to show application. Also, more information is needed to show specifically why the client does not meet criteria. This would help demonstrate the complexity of seeing multiple sides of an issue.