

**Faculty of Health
Department of Psychology
GS/PSYC 6422 3.00, Section A:
Foundations of Clinical Psychology: Psychopathology and Personality
Tuesdays 11:30 AM - 2:20 PM (in-person, BSB 207, Keele Campus)
Fall 2026**

Instructor Information

Instructor: Andrew Brankley, Ph.D., C.Psych. (he/him/his)

Office Hours: By request ([15-minute booking](#) | [30-minute booking](#)).

Email: brankley@yorku.ca

Questions, Inquiries, and Course Communication

For quick responses, begin email subject lines with "PSYC6422 F26." Messages are typically answered within 48 hours on weekdays and 72 hours on weekends or holidays.

- Speak to Dr. Brankley. I prefer in-person/video communication to email.
 - Shorter questions, such as straightforward assignment questions. I am available during the break.
 - Longer questions. Request an in-person or virtual office-hours meeting.

Course website: [eClass](#). All course materials will be available on the course eClass site unless otherwise indicated by Dr. Brankley. The site will be the central access point for course materials and confirmed deadlines.

Land Acknowledgment

First Nations peoples have lived on this part of Turtle Island for millennia, stewarding the land, the water and all that contributes to life in this region. Today, the culture and presence of First Nations, Inuit and Métis peoples enrich the lands and people of this territory. More than two centuries ago, the Mississauga people welcomed settlers to this territory, providing sustenance and engaging in trade and commerce. Between 1781 and 1820, eight treaties were signed between the Crown and the Mississaugas of the Credit First Nation, who opened their territory to settlement. Today, York University's Keele Campus is located on Toronto Purchase Treaty, No. 13 lands and is situated on the traditional territory of the Huron-Wendat and Haudenosaunee. Treaty history is foundational, and it is our collective responsibility to honour the land, as we honour and respect those who have gone before us, those who are here and those who have yet to come. We are grateful for the opportunity to be learning, working and thriving on this land, and we commit to learn the truth and be active in the process of reconciliation.

Course Description

In this course, students examine clinical psychology theory and practice through diagnostic and descriptive psychopathology and evidence-based cognitive-affective, social-learning, and developmental models. Topics include depressive, anxiety, obsessive-compulsive, substance, trauma- and stressor-related, eating, and personality disorders. Race/ethnicity, gender, sexuality, ability, and class are considered throughout. Students develop practical skills in DSM-based diagnostic decision-making through lectures, scribe packages, guided case formulations, and discussion.

Course Learning Outcomes

Upon completion of this course, students should be able to:

1. Describe and differentiate major adult psychopathology presentations using DSM-5-TR criteria, phenomenology, course, impairment, distress, and common patterns of comorbidity.
2. Apply DSM-5-TR reasoning to case material by identifying criteria, generating and evaluating differential diagnoses, assigning provisional diagnoses, identifying missing information, and communicating uncertainty.
3. Link diagnoses to evidence-based etiological and maintenance models while distinguishing the explanatory scope of a diagnosis from issues requiring broader clinical formulation.
4. Critically evaluate psychiatric classification and diagnosis, including DSM history, reliability and validity, diagnostic inflation, stigma, boundary problems, and categorical versus dimensional models.
5. Integrate cultural, contextual, Indigenous, social-location, and bias-aware reasoning into diagnosis, including symptom expression, impairment, help-seeking, bias, and risks of overpathologizing.
6. Recognize professional limits in diagnostic work, including medical, substance, and medication-related rule-outs; risk and safety implications; consultation or referral needs; and appropriate restraint when communicating diagnostic conclusions.

Required Text and Course Readings

American Psychiatric Association. (2022). *Diagnostic and statistical manual of mental disorders* (5th ed., text rev.). <https://doi.org/10.1176/appi.books.9780890425787>

All other student readings are open access, available through York, or posted on eClass.

Optional readings listed in the weekly sections are not assigned and are not included in the weekly reading estimates.

Assessment of Course Learning Outcomes

Assessment	Component	Weight	Due date / timing
Student Scribe Notes Package	Scribe Package 1	15%	Assigned regular lecture week; email by Sunday 11:59 p.m. (five days after class)
Student Scribe Notes Package	Scribe Package 2	15%	Assigned regular lecture week; email by Sunday 11:59 p.m. (five days after class)
Differential Diagnosis Test Package 1	In-class diagnostic report	20%	October 27, 2026, in class
Differential Diagnosis Test Package 1	Self-marking and reflection	5%	November 3, 2026
Differential Diagnosis Test Package 1	Case Formulation Materials	10%	November 3, 2026
Differential Diagnosis Test Package 2	In-class diagnostic report	20%	December 8, 2026, in class
Differential Diagnosis Test Package 2	Self-marking and reflection	5%	December 15, 2026
Differential Diagnosis Test Package 2	Case Formulation Materials	10%	December 15, 2026
Total		100%	

Student Scribe Notes Package - 30%

Pairs complete two scribe packages, each worth 15% (30% total), during assigned lecture weeks, including Week 1. None are assigned during Reading Week or diagnostic test weeks. For each package, email one Weekly Scribe Protocol per pair to Dr. Brankley by Sunday at 11:59 p.m., five days after Tuesday's class. Both members receive the same grade. Follow the exemplar's formatting and connected paragraphs without internal headings; aim for two pages and do not exceed two. Cover the first two hours, retaining DSM tags for symptoms or criteria reviewed and explaining what discussion, readings, and models added to their interpretation. Show how examples and context affect diagnostic reasoning, distinguish evidence from inference, and identify unresolved questions. It is not a transcript, exhaustive minutes, or a recording-based task; Dr. Brankley leads the final-hour case formulation, which is not part of the protocol. For full instructions and criteria, see the Weekly Scribe Protocol handout, rubric, and exemplar on [eClass](#).

Differential Diagnosis Test Packages - 70%

Each 35% Differential Diagnosis Test Package has the components and due dates above. Students use the Case Formulation Materials in class and on both tests. Dr. Brankley portrays the client and answers interview questions; students observe and write but do not interview. In Sections 2.1.1–2.1.3 (15 marks), students connect DSM-5-TR criteria and case evidence for justified hypotheses, explain Yes, No, or Unclear judgments, and distinguish evidence against from missing or ambiguous information. In Section 2.2 (5 marks), students prioritize primary, provisional, and ruled-out diagnoses and explain their decisions and what could change them. Relevant client

information from unmarked Section 1.0 should support their reasoning. After reviewing the answer guide, students explain corrections and identify a reasoning step to retain or change (Sections 3.1–3.2). For Section 3.3, students apply a course model or theory to corrected diagnostic information, evaluate cultural/contextual and evidence-base fit, identify professional limits and next questions, and write concisely. Aim for 1,000–1,250 words across Section 3.3. See the Case Formulation Materials and Differential Diagnosis Test Package Rubric on [eClass](#).

Test 2 is cumulative: it assesses all Test 1 disorders and the additional disorders introduced after Test 1.

Test 1 disorders (also assessed on Test 2)	Additional disorders assessed on Test 2
Major Depressive Disorder	Attention-Deficit/Hyperactivity Disorder
Persistent Depressive Disorder	Obsessive-Compulsive Disorder
Prolonged Grief Disorder	Hoarding Disorder
Bipolar I Disorder	Alcohol Use Disorder
Bipolar II Disorder	Premenstrual Dysphoric Disorder
Panic Disorder	Posttraumatic Stress Disorder
Agoraphobia	Binge-Eating Disorder
Specific Phobia	Insomnia Disorder
Social Anxiety Disorder	Antisocial Personality Disorder
Generalized Anxiety Disorder	Borderline Personality Disorder

Class Format and Attendance

This course includes lectures, guided case-formulation exercises, group discussion, student scribe packages, and actor-presented differential-diagnosis exercises. Readings, slides, assignment instructions, and course updates will be posted on eClass.

There is no separate participation grade. Attendance is expected because discussions, case exercises, and actor-based assessments take place in class. If an absence affects graded work, follow the applicable York process and contact Dr. Brankley promptly.

Course and University Policies

Academic Consideration for Missed Course Work

Students who miss course work because of circumstances beyond their control should review York's current Absences and Missed Course Work information and contact Dr. Brankley promptly. Academic relief is not automatic; the appropriate remedy depends on the missed component, the course learning outcomes, and the University and graduate-program rules that apply to graduate students.

[York Absences and Missed Course Work](#)

Religious Accommodation

York will accommodate recognized religious observances. For term work, students should make a formal request no later than 14 days before the date for which

accommodation is sought, or at the earliest opportunity when the observance falls within 14 days of the start of term. For examinations in a formal examination period, use the Religious Accommodation Agreement no later than 21 days before the start of the examination period.

York religious-observance policy and procedures

Grading as per Faculty of Graduate Studies

The letter-grade system is the fundamental system for assessing course performance in York graduate programs. Where percentages are used for individual work, the conversion below applies unless alternative written provisions are announced within the first two weeks. Criterion bands or point allocations may be used in assessment rubrics to determine a percentage; the Faculty of Graduate Studies letter-grade conversion remains applicable. Percentage ranges are guidelines and are not part of the official grading scheme.

Grade	Descriptor	Percentage guideline
A+	Exceptional	90-100%
A	Excellent	85-89%
A-	High	80-84%
B+	Highly Satisfactory	75-79%
B	Satisfactory	70-74%
C	Conditional	60-69%
F	Failure	0-59%
I	Incomplete	N/A

Faculty of Graduate Studies grading system

Grade Reappraisal

Students with sufficient academic grounds should first contact the course director to discuss the grade and request review of tangible work. A reappraisal may raise, lower, or confirm the original grade. If the matter is not resolved, the student may submit a formal written request through the graduate program. For a fall-term grade, the Senate deadline is February 15 or at least 21 days after the grade is released, whichever is later. Grade reappraisals are subject to the current Faculty of Graduate Studies procedures.

Information on Plagiarism Detection

Except for Weekly Scribe Protocols, which are emailed directly to Dr. Brankley as described above, assignments will be submitted online using eClass.

Electronic Device Policy

Electronic devices such as tablets and laptops are permitted during class for course-related purposes.

Academic Conduct and Test Banks

York University takes academic integrity seriously. Students are responsible for becoming familiar with the Academic Conduct Policy and Procedures and for completing course work honestly. The offering for sale of, buying of, or attempting to sell or buy test banks or course-specific test questions/answers is not permitted and may constitute a breach of academic conduct.

Academic Conduct Policy and Procedures

Artificial Intelligence (AI) Use in PSYC 6422

You may use AI tools only to help locate sources (for example, to identify potentially relevant peer-reviewed articles or credible information). You must read and verify every AI-identified source. All reading, note-taking, analysis, writing, and submitted content must be your own work. Submitting AI-generated text or media is prohibited and may constitute a breach of academic conduct. If broader AI use is permitted for a specific task, the permission will be stated in writing on the assignment page. You remain responsible for accuracy and complete citation of the sources you use.

Academic Accommodation for Students with Disabilities

York University encourages students with disabilities to register with Student Accessibility Services as early as possible to discuss accommodation needs. All students are expected to satisfy the essential learning outcomes of the course; access should be supported through accommodations without compromising the academic integrity or standards of the curriculum. Please let Dr. Brankley know as early as possible if you anticipate barriers so that course-specific arrangements can be discussed in the context of your Letter of Accommodation.

Student Accessibility Services

Privacy, Recordings, and Intellectual Property

Course materials and any recordings are for enrolled students only and may not be shared outside the class. Students retain copyright in their own work. Reuse of a student's image or voice beyond the course requires explicit consent. York's privacy and computing policies apply.

These course materials are designed for use as part of PSYC 6422 at York University and are the property of the instructor unless otherwise stated. Third-party copyrighted materials have been licensed or are used under an applicable exception or limitation in Canadian copyright law. Copying or distributing these materials outside the course, including upload to a commercial third-party website, may violate copyright.

Course Schedule

Date	Week	Topic	Client
<u>Sep. 15</u>	<u>1</u>	<u>Introduction and theories/approaches to classification</u>	Mx. Maren Cardinal
<u>Sep. 22</u>	<u>2</u>	<u>Depressive Disorders, Part 1</u>	Mr. Amir Habib
<u>Sep. 29</u>	<u>3</u>	<u>Depressive Disorders, Part 2; Bipolar Disorders</u>	Ms. Sofia Muñoz
<u>Oct. 6</u>	<u>4</u>	<u>Panic Disorder, Agoraphobia, and Specific Phobia</u>	Mr. Ethan Kuiper
Oct. 13	5	Reading Week - no class	
<u>Oct. 20</u>	<u>6</u>	<u>Social Anxiety Disorder and Generalized Anxiety Disorder</u>	Ms. Maya Chan
Oct. 27	7	Differential Diagnosis Test 1	
<u>Nov. 3</u>	<u>8</u>	<u>Obsessive-Compulsive Disorder and Related Disorders</u>	Mx. Noah Perlman
<u>Nov. 10</u>	<u>9</u>	<u>Substance Use Disorders</u>	Ms. Aisha Lawal
<u>Nov. 17</u>	<u>10</u>	<u>Posttraumatic Stress Disorder and Trauma- and Stressor-Related Disorders</u>	Mx. Jordan Tolentino
<u>Nov. 24</u>	<u>11</u>	<u>Insomnia, Introduction to Personality Disorders, and Antisocial Personality Disorder</u>	Mx. Theo Hatzis
<u>Dec. 1</u>	<u>12</u>	<u>Borderline Personality Disorder</u>	Mx. Riley Jean-Baptiste
Dec. 8	13	Differential Diagnosis Test 2	

Week 1 - What Counts as a Mental Disorder? DSM Classification, Cultural Formulation, and Diagnostic Humility

Learning Objectives

1. **Describe** major conceptual problems in defining mental disorder, including distress, impairment, dysfunction, social value, and the disorder/non-disorder boundary. (*Remember–Understand*)
2. **Differentiate** DSM-5-TR descriptive classification from harmful-dysfunction, cross-cultural/constructivist, and CFI-informed approaches, explaining why diagnostic categories are useful clinical tools rather than culturally neutral facts or complete formulations. (*Understand–Analyze*)
3. **Analyze** how cultural definition of the problem, explanatory models, stressors/supports, coping/help-seeking, and the clinician-client relationship can shape symptom meaning, impairment judgments, help-seeking, and diagnostic thresholds. (*Analyze–Evaluate*)
4. **Evaluate** benefits and risks of psychiatric classification, including reliability/validity limits, diagnostic inflation, false positives, stigma, cultural/contextual overpathologizing, and categorical-versus-dimensional alternatives such as RDoC/HiTOP. (*Analyze–Evaluate*)
5. **Apply** introductory DSM-5-TR diagnostic reasoning to brief case material by identifying threshold questions, possible rule-ins/rule-outs, provisional conclusions, missing information, and culturally/contextually informed uncertainty. (*Apply–Analyze*)
6. **Articulate** and apply Indigenous diagnostic humility and bias-aware reasoning, including recognition of DSM limits, colonial/contextual humility, no identity-based inference, consultation when needed, and checks for anchoring, confirmation bias, stereotype risk, base-rate neglect, overpathologizing, and diagnostic uncertainty. (*Apply–Evaluate*)

Required Readings (48 pages, approximately 3 hours 45 minutes at 150 words per minute)

- American Psychiatric Association. (2022). *Diagnostic and statistical manual of mental disorders* (5th ed., text rev.). <https://doi.org/10.1176/appi.books.9780890425787>
 - Read pp. 14–17.
 - Read pp. 21–25.
- Persons, J. B. (2008). *The case formulation approach to cognitive-behavior therapy*. Guilford Press.
 - Read pp. 4–8.

- Wakefield, J. C. (1992). The concept of mental disorder: On the boundary between biological facts and social values. *American Psychologist*, 47(3), 373–388.
<https://doi.org/10.1037/0003-066X.47.3.373>
 - Read pp. 373–381.
 - Read pp. 384–385.
- Frances, A. J., & Widiger, T. A. (2012). Psychiatric diagnosis: Lessons from the DSM-IV past and cautions for the DSM-5 future. *Annual Review of Clinical Psychology*, 8, 109–130.
<https://doi.org/10.1146/annurev-clinpsy-032511-143102>
 - Read pp. 109–115.
 - Read pp. 121–125.
- Langa, M. E., & Gone, J. P. (2020). Cultural context in DSM diagnosis: An American Indian case illustration of contradictory trends. *Transcultural Psychiatry*, 57(4), 567–580.
<https://doi.org/10.1177/1363461519832473>
 - Read pp. 567–577.

Required-Reading-to-Weekly-LO Alignment

Required Reading	Learning Objectives Addressed
DSM-5-TR, pp. 14–17 and 21–25	LO1, LO2, LO4, LO5, LO6: Coverage of the DSM-5-TR definition of mental disorder and responsible use of the manual, including clinical judgment, cultural context, boundaries, and limitations of classification.
Persons (2008), pp. 4–8	LO2, LO3, LO5: The distinction between classification and formulation, together with the hypothesis-testing structure used later.
Wakefield (1992), pp. 373–381 and 384–385	LO1, LO2, LO4, LO5: Definition of harmful dysfunction and support for disorder/non-disorder, harm, dysfunction, social-value, and threshold judgments.
Frances and Widiger (2012), pp. 109–115 and 121–125	LO2, LO4, LO5, LO6: Support for diagnostic conservatism, risk-benefit reasoning, false-positive caution, and restrained conclusions.
Langa and Gone (2020), pp. 567–577	LO2, LO3, LO4, LO5, LO6: Application of cultural and Indigenous-context reasoning to DSM use, diagnostic contradiction, uncertainty, and humility.

Optional Readings

Reference	Relevance to the Week's Learning Objectives
Thakker, J., Ward, T., & Strongman, K. T. (1999). Mental disorder and cross-cultural psychology: A constructivist perspective. <i>Clinical Psychology Review</i> , 19(7), 843–874. https://doi.org/10.1016/S0272-7358(98)00077-4	LO2, LO3, LO4, LO5: Further discussion of the applicability of disorder concepts across cultural settings.
Wakefield, J. C. (2016). Diagnostic issues and controversies in DSM-5: Return of the false positives problem. <i>Annual Review of Clinical Psychology</i> , 12, 105–132. https://doi.org/10.1146/annurev-clinpsy-032814-112800	LO4, LO5, LO6: An updated account of the false-positive and overdiagnosis problems introduced this week.
Kirmayer, L. J., Gone, J. P., & Moses, J. (2014). Rethinking historical trauma. <i>Transcultural Psychiatry</i> , 51(3), 299–319. https://doi.org/10.1177/1363461514536358	LO3, LO6: Additional context for discussing historical trauma without treating Indigenous identity as diagnostic evidence.
Kotov, R., Krueger, R. F., Watson, D., Achenbach, T. M., Althoff, R. R., Bagby, R. M., Brown, T. A., Carpenter, W. T., Caspi, A., Clark, L. A., Eaton, N. R., Forbes, M. K., Forbush, K. T., Goldberg, D., Hasin, D., Hyman, S. E., Ivanova, M. Y., Lynam, D. R., Markon, K., ... Zimmerman, M. (2017). The Hierarchical Taxonomy of Psychopathology (HiTOP): A dimensional alternative to traditional nosologies. <i>Journal of Abnormal Psychology</i> , 126(4), 454–477. https://doi.org/10.1037/abn0000258	LO4: Introduction to a dimensional alternative to categorical diagnosis.
Insel, T., Cuthbert, B. N., Garvey, M. A., Heinssen, R. K., Pine, D. S., Quinn, K. J., Sanislow, C. A., & Wang, P. S. (2010). Research Domain Criteria (RDoC): Toward a new classification framework for research on mental disorders. <i>American Journal of Psychiatry</i> , 167(7), 748–751. https://doi.org/10.1176/appi.ajp.2010.09091379	LO4: Introduction to RDoC as a research framework rather than a clinical diagnostic system.
Mendel, R., Traut-Mattausch, E., Jonas, E., Leucht, S., Kane, J. M., Maino, K., Kissling, W., & Hamann, J. (2011). Confirmation bias: Why psychiatrists stick to wrong preliminary diagnoses. <i>Psychological Medicine</i> , 41(12), 2651–2659. https://doi.org/10.1017/S0033291711000808	LO5, LO6: Empirical evidence on the effects of preliminary diagnoses on later information gathering.
Phillips, J., Frances, A., Cerullo, M. A., Chardavoyne, J., Decker, H. S., First, M. B., Ghaemi, N., Greenberg, G., Hinderliter, A. C., Kinghorn, W. A., LoBello, S. G., Martin, E. B., Mishara, A. L., Paris, J., Pierre, J. M., Pies, R. W., Pincus, H. A., Porter, D., Pouncey, C., ... Zachar, P. (2012a). The six most essential questions in psychiatric diagnosis: A pluralogue. <i>Part 1: Conceptual and definitional issues. Philosophy, Ethics, and Humanities in Medicine</i> , 7, Article 3. https://doi.org/10.1186/1747-5341-7-3	LO1, LO2, LO4: Further development of the conceptual and definitional debates surrounding psychiatric diagnosis.

Reference	Relevance to the Week's Learning Objectives
Phillips, J., Frances, A., Cerullo, M. A., Chardavoyne, J., Decker, H. S., First, M. B., Ghaemi, N., Greenberg, G., Hinderliter, A. C., Kinghorn, W. A., LoBello, S. G., Martin, E. B., Mishara, A. L., Paris, J., Pierre, J. M., Pies, R. W., Pincus, H. A., Porter, D., Pouncey, C., ... Zachar, P. (2012b). The six most essential questions in psychiatric diagnosis: A pluralogue. <i>Part 2: Issues of conservatism and pragmatism in psychiatric diagnosis. Philosophy, Ethics, and Humanities in Medicine</i>, 7, Article 8. https://doi.org/10.1186/1747-5341-7-8	LO4, LO5, LO6: Further discussion of diagnostic conservatism, pragmatism, and clinical restraint.
Phillips, J., Frances, A., Cerullo, M. A., Chardavoyne, J., Decker, H. S., First, M. B., Ghaemi, N., Greenberg, G., Hinderliter, A. C., Kinghorn, W. A., LoBello, S. G., Martin, E. B., Mishara, A. L., Paris, J., Pierre, J. M., Pies, R. W., Pincus, H. A., Porter, D., Pouncey, C., ... Zachar, P. (2012c). The six most essential questions in psychiatric diagnosis: A pluralogue. <i>Part 3: Issues of utility and alternative approaches in psychiatric diagnosis. Philosophy, Ethics, and Humanities in Medicine</i>, 7, Article 9. https://doi.org/10.1186/1747-5341-7-9	LO2, LO4: Examination of the utility of diagnosis and alternatives to traditional nosology.
Phillips, J., Frances, A., Cerullo, M. A., Chardavoyne, J., Decker, H. S., First, M. B., Ghaemi, N., Greenberg, G., Hinderliter, A. C., Kinghorn, W. A., LoBello, S. G., Martin, E. B., Mishara, A. L., Paris, J., Pierre, J. M., Pies, R. W., Pincus, H. A., Porter, D., Pouncey, C., ... Zachar, P. (2012d). The six most essential questions in psychiatric diagnosis: A pluralogue. <i>Part 4: General conclusion. Philosophy, Ethics, and Humanities in Medicine</i>, 7, Article 14. https://doi.org/10.1186/1747-5341-7-14	LO2, LO4, LO6: A synthesis of the series' implications for diagnostic uncertainty and future classification.

Week 2 - Depressive Disorders Part 1: Major Depressive Disorder, Threshold Judgment, Grief, Models, and Differential Diagnosis

Learning Objectives

1. **Apply** DSM-5-TR criteria to identify Major Depressive Disorder and related depressive disorders, including symptom count, two-week duration, impairment, exclusions, and specifiers. (*Apply*)
2. **Differentiate** MDD from prolonged grief disorder/normative grief, persistent depressive disorder, bipolar disorder, anxiety/trauma presentations, psychosis, eating/starvation effects, and medical/substance/sleep contributors. (*Analyze*)
3. **Explain** how to extend diagnosis into case formulation using cognitive, behavioural, relapse/recurrence, and treatment-response models. (*Understand–Analyze*)
4. **Evaluate** sadness, grief, fatigue, demoralization, withdrawal, and contextual adversity as threshold problems requiring attention to duration, impairment, cultural norms, and expected response. (*Evaluate*)
5. **Apply** cultural/contextual and bias-aware reasoning to depressive presentations, including idioms of distress, somatic expression, stigma, help-seeking, support, poverty, discrimination, disability, caregiving, gendered expectations, and isolation. (*Apply–Analyze*)
6. **Identify** when diagnostic restraint, risk/safety assessment, consultation, or referral is warranted for suicidality, bipolar history, psychosis, trauma, medical/substance/sleep contributors, or ambiguous grief. (*Apply–Evaluate*)

Required Readings (46 pages, approximately 3 hours 55 minutes at 150 words per minute)

- American Psychiatric Association. (2022). *Diagnostic and statistical manual of mental disorders* (5th ed., text rev.). <https://doi.org/10.1176/appi.books.9780890425787>
 - Read Major Depressive Disorder (pp. 183–192).
 - Read Persistent Depressive Disorder criteria (pp. 193–194).
 - Read Prolonged Grief Disorder (pp. 322–326).
- Beck, A. T. (2008). The evolution of the cognitive model of depression and its neurobiological correlates. *American Journal of Psychiatry*, 165(8), 969–977. <https://doi.org/10.1176/appi.ajp.2008.08050721>
 - Read pp. 969–976.
- Brouwer, M. E., Williams, A. D., Kennis, M., Fu, Z., Klein, N. S., Cuijpers, P., & Bockting, C. L. H. (2019). Psychological theories of depressive relapse and recurrence: A systematic review and meta-analysis of prospective studies. *Clinical Psychology Review*, 74, Article 101773. <https://doi.org/10.1016/j.cpr.2019.101773>
 - Read PDF pp. 1–14.

- Hilberdink, C. E., Ghainder, K., Dubanchet, A., Hinton, D., Djelantik, A. A. A. M. J., Hall, B. J., & Bui, E. (2023). Bereavement issues and prolonged grief disorder: A global perspective. *Cambridge Prisms: Global Mental Health*, 10, Article e32. <https://doi.org/10.1017/gmh.2023.28>
 - Read PDF pp. 1–7.

Required-Reading-to-Weekly-LO Alignment

Required Reading	Learning Objectives Addressed
DSM-5-TR: MDD, pp. 183–192; PDD criteria, pp. 193–194; PGD, pp. 322–326	L01, L02, L04, L06: Coverage of thresholds, criteria, impairment, exclusions, specifiers, grief distinctions, and rule-outs.
Beck (2008), pp. 969–976	L03: Coverage of cognitive vulnerability, appraisal, schema, rumination, and maintenance mechanisms.
Brouwer et al. (2019), PDF pp. 1–14	L03, L06: Evaluation of prospective support and limitations for relapse/recurrence models and uncertainty.
Hilberdink et al. (2023), PDF pp. 1–7	L02, L04, L05, L06: Support for culturally situated PGD/normative-grief distinctions, mourning practices, impairment, and diagnostic restraint.

Optional Readings

Reference	Relevance to the Week's Learning Objectives
Hollon, S. D. (2020). Is cognitive therapy enduring or antidepressant medications iatrogenic? Depression as an evolved adaptation. <i>American Psychologist</i> , 75(9), 1207–1218. https://doi.org/10.1037/amp0000728	L03, L04: A contested account of depression, relapse, and treatment effects.
Horwitz, A. V. (2015). The DSM-5 and the continuing transformation of normal sadness into depressive disorder. <i>Emotion Review</i> , 7(3), 209–215. https://doi.org/10.1177/1754073915575401	L04, L06: A sharper distinction between depressive disorder and expectable sadness.
Ferster, C. B. (1973). A functional analysis of depression. <i>American Psychologist</i> , 28(10), 857–870. https://doi.org/10.1037/h0035605	L03: A classic behavioural account of depressive withdrawal and reduced reinforcement.
Porter, R., Mulder, R., & Lacey, C. (2013). DSM-5 and the elimination of the major depression bereavement exclusion. <i>Australian & New Zealand Journal of Psychiatry</i> , 47(4), 391–393. https://doi.org/10.1177/0004867413481504	L02, L04, L06: A concise argument about the removal of the bereavement exclusion.
Scher, C. D., Ingram, R. E., & Segal, Z. V. (2005). Cognitive reactivity and vulnerability: Empirical evaluation of construct activation and cognitive diatheses in unipolar depression. <i>Clinical Psychology Review</i> , 25(4), 487–510. https://doi.org/10.1016/j.cpr.2005.01.005	L03: Further development of the cognitive-vulnerability account of depressive relapse.

Reference	Relevance to the Week's Learning Objectives
Gonschor, J., Eisma, M. C., Barke, A., & Doering, B. K. (2020). Public stigma towards prolonged grief disorder: Does diagnostic labeling matter? <i>PLOS ONE</i> , 15(9), Article e0237021. https://doi.org/10.1371/journal.pone.0237021	LO4, LO5: Evidence on how a prolonged-grief label may affect public attitudes.
Nierenberg, A. A., Agustini, B., Köhler-Forsberg, O., Cusin, C., Katz, D., Sylvia, L. G., Peters, A., & Berk, M. (2023). Diagnosis and treatment of bipolar disorder: A review. <i>JAMA</i> , 330(14), 1370–1380. https://doi.org/10.1001/jama.2023.18588	LO2, LO6: A broad clinical review useful for bipolar rule-out questions.
Eisma, M. C. (2023). Prolonged grief disorder in ICD-11 and DSM-5-TR: Challenges and controversies. <i>Australian & New Zealand Journal of Psychiatry</i> , 57(7), 944–951. https://doi.org/10.1177/00048674231154206	LO2, LO4, LO6: A comparison of current DSM-5-TR and ICD-11 prolonged-grief definitions.
Gureje, O., Lewis-Fernández, R., Hall, B. J., & Reed, G. M. (2020). Cultural considerations in the classification of mental disorders: Why and how in ICD-11. <i>BMC Medicine</i> , 18, Article 25. https://doi.org/10.1186/s12916-020-1493-4	LO4, LO5: Discussion of cultural information in ICD-11 classification.

Week 3 - Depressive Disorders Part 2 and Bipolar Disorders: Bipolar I/II, and Differential Diagnosis

Learning Objectives

1. **Differentiate** persistent depressive disorder, major depressive disorder/chronic MDD, bipolar I disorder, and bipolar II disorder using DSM-5-TR criteria, duration, episodicity, impairment, specifiers, and exclusion logic. (*Analyze*)
2. **Evaluate** evidence for mania and hypomania by checking duration, clear change from baseline, observable change, reduced need for sleep, impairment/hospitalization/psychosis status, and substance/medical/medication exclusions. (*Analyze–Evaluate*)
3. **Explain** how PDD chronicity and impairment can be shaped by rumination, insomnia, trauma exposure, medical burden, social isolation, poverty/precarity, racism/discrimination, disability, and reduced support without replacing DSM reasoning. (*Understand–Analyze*)
4. **Compare** etiological and maintenance models for chronic depression and bipolar disorder, including sleep/circadian instability, reward sensitivity, biomarkers/neurobiology, interpersonal/social rhythm disruption, and developmental vulnerabilities. (*Analyze*)
5. **Apply** bias-aware diagnostic reasoning to mood presentations, including culturally and contextually shaped energy, ambition/productivity, spirituality/religiosity, irritability, substance use, help-seeking, family concern, emotional expression, and impairment. (*Apply–Evaluate*)
6. **Distinguish** DSM diagnosis from case formulation by linking mood categories to maintaining mechanisms, missing information, diagnostic uncertainty, risk/safety, treatment implications, consultation/referral needs, and diagnostic humility. (*Analyze–Evaluate*)

Required Readings (51 pages, approximately 3 hours 45 minutes at 150 words per minute)

- American Psychiatric Association. (2022). *Diagnostic and statistical manual of mental disorders* (5th ed., text rev.). <https://doi.org/10.1176/appi.books.9780890425787>
 - Read Bipolar and Related Disorders (pp. 139–158).
 - Read Persistent Depressive Disorder (pp. 193–196).
- Schramm, E., Klein, D. N., Elsaesser, M., Furukawa, T. A., & Domschke, K. (2020). Review of dysthymia and persistent depressive disorder: History, correlates, and clinical implications. *The Lancet Psychiatry*, 7(9), 801–812. [https://doi.org/10.1016/S2215-0366\(20\)30099-7](https://doi.org/10.1016/S2215-0366(20)30099-7)
 - Read pp. 801–809.

- Harvey, A. G. (2008). Sleep and circadian rhythms in bipolar disorder: Seeking synchrony, harmony, and regulation. *American Journal of Psychiatry*, 165(7), 820–829. <https://doi.org/10.1176/appi.ajp.2008.08010098>
 - Read pp. 820–828.
- Wu, Z., Wang, J., Zhang, C., Peng, D., Mellor, D., Luo, Y., & Fang, Y. (2024). Clinical distinctions in symptomatology and psychiatric comorbidities between misdiagnosed bipolar I and bipolar II disorder versus major depressive disorder. *BMC Psychiatry*, 24, Article 352. <https://doi.org/10.1186/s12888-024-05810-3>
 - Read PDF pp. 1–9.

Required-Reading-to-Weekly-LO Alignment

Required Reading	Learning Objectives Addressed
DSM-5-TR: bipolar disorders, pp. 139–158; PDD, pp. 193–196	LO1, LO2, LO6: Coverage of episode criteria, longitudinal distinctions, impairment thresholds, specifiers, and exclusion logic.
Schramm et al. (2020), pp. 801–809	LO1, LO3, LO4: Coverage of PDD history, chronicity, impairment, comorbidity, correlates, and clinical implications.
Harvey (2008), pp. 820–828	LO2, LO4, LO6: A distinction between reduced need for sleep and insomnia, with sleep/circadian disruption considered as a symptom, trigger, prodrome, and maintenance factor.
Wu et al. (2024), PDF pp. 1–9	LO1, LO2, LO5, LO6: Support for applied differentiation of bipolar I/II from MDD, including longitudinal and comorbidity information relevant to diagnostic confidence.

Optional Readings

Reference	Relevance to the Week's Learning Objectives
Frey, B. N., Andreazza, A. C., Houenou, J., Jamain, S., Goldstein, B. I., Frye, M. A., Leboyer, M., Berk, M., Malhi, G. S., Lopez-Jaramillo, C., Taylor, V. H., Dodd, S., Frangou, S., Hall, G. B., Fernandes, B. S., Kauer-Sant'Anna, M., Yatham, L. N., Kapczinski, F., & Young, L. T. (2013). Biomarkers in bipolar disorder: A positional paper from the International Society for Bipolar Disorders Biomarkers Task Force. <i>Australian & New Zealand Journal of Psychiatry</i> , 47(4), 321–332. https://doi.org/10.1177/0004867413478217	LO4, LO6: A review of proposed bipolar biomarkers and the limits of using them diagnostically.
Rhebergen, D., & Graham, R. (2014). The re-labelling of dysthymic disorder to persistent depressive disorder in DSM-5: Old wine in new bottles? <i>Current Opinion in Psychiatry</i> , 27(1), 27–31. https://doi.org/10.1097/YCO.0000000000000022	LO1, LO3, LO6: Examination of the relabelling and boundary problems surrounding persistent depressive disorder.

Reference	Relevance to the Week's Learning Objectives
Gotlib, I. H., & LeMoult, J. (2014). The 'ins' and 'outs' of the depressive disorders section of DSM-5. <i>Clinical Psychology: Science and Practice</i>, 21(3), 193–207. https://doi.org/10.1111/cpsp.12072	LO1, LO3, LO4: A review of changes to the DSM-5 depressive-disorders section.
Brancati, G. E., Nunes, A., Scott, K., O'Donovan, C., Cervantes, P., Grof, P., & Alda, M. (2023). Differential characteristics of bipolar I and II disorders: A retrospective, cross-sectional evaluation of clinical features, illness course, and response to treatment. <i>International Journal of Bipolar Disorders</i>, 11, Article 25. https://doi.org/10.1186/s40345-023-00304-9	LO1, LO2, LO6: Evidence on clinical differences between bipolar I and bipolar II disorders.
Li, K., Richards, E., & Goes, F. S. (2023). Racial differences in the major clinical symptom domains of bipolar disorder. <i>International Journal of Bipolar Disorders</i>, 11, Article 17. https://doi.org/10.1186/s40345-023-00299-3	LO2, LO5: Examination of racialized differences in bipolar symptom presentation and care.
Martini, J., Leopold, K., Pfeiffer, S., Berndt, C., Boehme, A., Roessner, V., Fusar-Poli, P., Young, A. H., Correll, C. U., Bauer, M., & Pfennig, A. (2021). Early detection of bipolar disorders and treatment recommendations for help-seeking adolescents and young adults. <i>International Journal of Bipolar Disorders</i>, 9, Article 23. https://doi.org/10.1186/s40345-021-00227-3	LO2, LO4, LO6: A staged approach to early bipolar assessment and diagnostic uncertainty.
Miola, A., Tondo, L., Pinna, M., Contu, M., & Baldessarini, R. J. (2023). Characteristics of rapid cycling in 1261 bipolar disorder patients. <i>International Journal of Bipolar Disorders</i>, 11, Article 21. https://doi.org/10.1186/s40345-023-00300-z	LO2, LO6: Longitudinal evidence on rapid cycling, recurrence, and risk.

Week 4 - Panic Disorder, Agoraphobia, and Specific Phobia

Learning Objectives

1. **Differentiate** panic attacks, the panic attack specifier, panic disorder, agoraphobia, and specific phobia using DSM-5-TR criteria, exclusions, and 'not better explained by' reasoning. (*Understand–Apply*)
2. **Apply** differential diagnosis to panic-like symptoms by considering panic disorder, expected panic attacks in other disorders, medical/substance/medication/sleep contributors, trauma-related avoidance, and adaptive caution. (*Apply–Analyze*)
3. **Use** cultural formulation to examine bodily symptom meanings, catastrophic interpretations, idioms of distress, health beliefs, help-seeking pathways, family/community interpretations, and stigma. (*Analyze–Evaluate*)
4. **Distinguish** DSM diagnosis from case formulation by linking triggers, threat appraisal, anxiety sensitivity, learning history, avoidance, safety behaviours, and social context to maintenance hypotheses. (*Analyze*)
5. **Evaluate** agoraphobic and phobic avoidance in context, distinguishing pathological avoidance from adaptive caution, disability-related safety planning, trauma-related avoidance, cultural/religious norms, environmental barriers, and realistic danger. (*Evaluate*)
6. **Demonstrate** bias-aware diagnostic restraint by avoiding dismissal of somatic symptoms as 'just anxiety,' avoiding overpathologizing realistic fear, and identifying when further assessment, consultation, or referral is needed. (*Evaluate*)

Required Readings (52 pages, approximately 3 hours 45 minutes at 150 words per minute)

- American Psychiatric Association. (2022). *Diagnostic and statistical manual of mental disorders* (5th ed., text rev.). <https://doi.org/10.1176/appi.books.9780890425787>
 - Read Specific Phobia (pp. 224–229).
 - Read Panic Disorder and Agoraphobia (pp. 235–249).
- Zinbarg, R. E., Williams, A. L., & Mineka, S. (2022). A current learning theory approach to the etiology and course of anxiety and related disorders. *Annual Review of Clinical Psychology*, 18, 233–258. <https://doi.org/10.1146/annurev-clinpsy-072220-021010>
 - Read pp. 234–242.
 - Read pp. 247–250.
- Tunnell, N. C., Corner, S. E., Roque, A. D., Kroll, J. L., Ritz, T., & Meuret, A. E. (2024). Biobehavioral approach to distinguishing panic symptoms from medical illness. *Frontiers in Psychiatry*, 15, Article 1296569. <https://doi.org/10.3389/fpsy.2024.1296569>
 - Read PDF pp. 1–3.
 - Read PDF pp. 10–14.

- Lewis-Fernández, R., Hinton, D. E., Laria, A. J., Patterson, E. H., Hofmann, S. G., Craske, M. G., Stein, D. J., Asnaani, A., & Liao, B. (2010). Culture and the anxiety disorders: Recommendations for DSM-V. *Depression and Anxiety*, 27(2), 212–229.
<https://doi.org/10.1002/da.20647>
 - Read pp. 212–219.
 - Read pp. 225–226.

Required-Reading-to-Weekly-LO Alignment

Required Reading	Learning Objectives Addressed
DSM-5-TR: specific phobia, pp. 224–229	L01, L02, L05, L06: Support for subtype, persistence, proportionality, impairment, and rule-out judgments.
DSM-5-TR: panic disorder and agoraphobia, pp. 235–249	L01, L02, L05, L06: Coverage of panic-attack, panic-disorder, agoraphobia, exclusion, and clinical-significance rules.
Zinbarg et al. (2022), pp. 234–242 and 247–250	L04, L05: Connections among learning history, threat appraisal, avoidance, safety behaviours, context, and maintenance.
Tunnell et al. (2024), PDF pp. 1–3 and 10–14	L02, L03, L06: Additional guidance on medical and somatic differential diagnosis and on avoiding premature 'just anxiety' conclusions.
Lewis-Fernández et al. (2010), pp. 212–219 and 225–226	L03, L05, L06: Support for attention to cultural symptom meaning, idioms of distress, impairment, help-seeking, and diagnostic restraint.

Optional Readings

Reference	Relevance to the Week's Learning Objectives
Craske, M. G., Rauch, S. L., Ursano, R., Prenoveau, J., Pine, D. S., & Zinbarg, R. E. (2009). What is an anxiety disorder? <i>Depression and Anxiety</i> , 26(12), 1066–1085. https://doi.org/10.1002/da.20633	L01, L04: A broader account of fear, anxiety, and anxiety-disorder boundaries.
Craske, M. G., Kircanski, K., Epstein, A., Wittchen, H.-U., Pine, D. S., Lewis-Fernández, R., & Hinton, D. E. (2010). Panic disorder: A review of DSM-IV panic disorder and proposals for DSM-V. <i>Depression and Anxiety</i> , 27(2), 93–112. https://doi.org/10.1002/da.20654	L01, L02: A historical account of the classification and differential-diagnosis issues surrounding panic disorder.

Reference	Relevance to the Week's Learning Objectives
Canadian Psychological Association, & Psychology Foundation of Canada. (2018). <i>Psychology's response to the Truth and Reconciliation Commission of Canada's report</i> . https://cpa.ca/docs/File/Task_Forges/TRC%20Task%20Force%20Report_FINAL.pdf	LO5, LO6: Canadian professional context for cultural safety and diagnostic humility.
Lewis-Fernández, R., Aggarwal, N. K., Bäärnhielm, S., Rohlof, H., Kirmayer, L. J., Weiss, M. G., Jadhav, S., Hinton, L., Alarcón, R. D., Bhugra, D., Groen, S., van Dijk, R., Qureshi, A., Collazos, F., Rousseau, C., Caballero, L., Ramos, M., & Lu, F. (2014). Culture and psychiatric evaluation: Operationalizing cultural formulation for DSM-5. <i>Psychiatry</i> , 77(2), 130–154. https://doi.org/10.1521/psyc.2014.77.2.130	LO3, LO5, LO6: Practical guidance for using cultural formulation during assessment.
LeBeau, R. T., Glenn, D., Liao, B., Wittchen, H.-U., Beesdo-Baum, K., Ollendick, T., & Craske, M. G. (2010). Specific phobia: A review of DSM-IV specific phobia and preliminary recommendations for DSM-V. <i>Depression and Anxiety</i> , 27(2), 148–167. https://doi.org/10.1002/da.20655	LO1, LO2, LO5: A review of specific-phobia classification, proportionality, and differential diagnosis.
Wittchen, H.-U., Gloster, A. T., Beesdo-Baum, K., Fava, G. A., & Craske, M. G. (2010). Agoraphobia: A review of the diagnostic classificatory position and criteria. <i>Depression and Anxiety</i> , 27(2), 113–133. https://doi.org/10.1002/da.20646	LO1, LO2, LO5: A review of agoraphobia's boundaries with panic disorder and other avoidance presentations.
Hinton, D. E., & Lewis-Fernández, R. (2010). Idioms of distress among trauma survivors: Subtypes and clinical utility. <i>Culture, Medicine, and Psychiatry</i> , 34(2), 209–218. https://doi.org/10.1007/s11013-010-9175-x	LO3, LO5: Examples of culturally patterned expressions of distress after trauma.

Week 6 - Social Anxiety Disorder and Generalized Anxiety Disorder

Learning Objectives

1. **Differentiate** Social Anxiety Disorder and Generalized Anxiety Disorder using DSM-5-TR criteria, duration, impairment, exclusions, course, and common comorbidity. (*Apply–Analyze*)
2. **Distinguish** fear of scrutiny or negative evaluation from diffuse, difficult-to-control worry across multiple domains, and differentiate both presentations from panic disorder, depressive disorders, OCD, trauma-related conditions, adjustment-related worry, and medical/substance/sleep contributors. (*Analyze–Evaluate*)
3. **Explain** evidence-based maintenance models for SAD and GAD, including self-focused attention, negative self-imagery, anticipatory and post-event processing, safety behaviours, intolerance of uncertainty, cognitive avoidance, metacognitive processes, and emotion-regulation difficulties. (*Understand–Analyze*)
4. **Evaluate** how cultural expectations, language, migration, racism, gender, sexuality, disability, family/community roles, realistic stressors, and norms regarding reserve or emotional expression may shape symptom meaning, impairment, and help-seeking without determining diagnosis. (*Analyze–Evaluate*)
5. **Distinguish** what SAD or GAD diagnoses describe from what requires broader formulation, including learning history, interpersonal context, avoidance, reinforcement, role demands, supports, and maintaining cycles. (*Analyze*)
6. **Identify** missing information, medical/substance/sleep rule-outs, risk-relevant concerns, diagnostic uncertainty, and circumstances requiring consultation, referral, or restrained provisional conclusions. (*Apply–Evaluate*)

Required Readings (34 pages, approximately 2 hours 45 minutes at 150 words per minute)

- American Psychiatric Association. (2022). *Diagnostic and statistical manual of mental disorders* (5th ed., text rev.). <https://doi.org/10.1176/appi.books.9780890425787>
 - Read Social Anxiety Disorder (pp. 229–234).
 - Read Generalized Anxiety Disorder (pp. 250–254).
- Behar, E., DiMarco, I. D., Hekler, E. B., Mohlman, J., & Staples, A. M. (2009). Current theoretical models of generalized anxiety disorder: Conceptual review and treatment implications. *Journal of Anxiety Disorders*, 23(8), 1011–1023. <https://doi.org/10.1016/j.janxdis.2009.07.006>
 - Read pp. 1011–1021.

- Hofmann, S. G. (2007). Cognitive factors that maintain social anxiety disorder: A comprehensive model and its treatment implications. *Cognitive Behaviour Therapy*, 36(4), 193–209. <https://doi.org/10.1080/16506070701421313>
 - Read pp. 193–204.

Required-Reading-to-Weekly-LO Alignment

Required Reading	Learning Objectives Addressed
DSM-5-TR: SAD, pp. 229–234; GAD, pp. 250–254	LO1, LO2, LO4, LO6: Coverage of diagnostic thresholds, duration, impairment, exclusions, and differential boundaries.
Behar et al. (2009), pp. 1011–1021	LO2, LO3, LO5: A comparison of major GAD models and support for mechanism-focused formulation rather than criterion repetition.
Hofmann (2007), pp. 193–204	LO2, LO3, LO4, LO5: An explanation of self-focused attention, negative imagery, safety behaviour, and post-event processing in SAD.

Optional Readings

Reference	Relevance to the Week's Learning Objectives
Andrews, G., Hobbs, M. J., Borkovec, T. D., Beesdo, K., Craske, M. G., Heimberg, R. G., Rapee, R. M., Ruscio, A. M., & Stanley, M. A. (2010). Generalized worry disorder: A review of DSM-IV generalized anxiety disorder and options for DSM-V. <i>Depression and Anxiety</i> , 27(2), 134–147. https://doi.org/10.1002/da.20658	LO1, LO2, LO3: A review of diagnostic options and boundary questions for GAD.
Bögels, S. M., Alden, L., Beidel, D. C., Clark, L. A., Pine, D. S., Stein, M. B., & Voncken, M. (2010). Social anxiety disorder: Questions and answers for the DSM-V. <i>Depression and Anxiety</i> , 27(2), 168–189. https://doi.org/10.1002/da.20670	LO1, LO2, LO4: A review of unresolved classification questions for social anxiety disorder.
Dugas, M. J., Marchand, A., & Ladouceur, R. (2005). Further validation of a cognitive-behavioral model of generalized anxiety disorder: Diagnostic and symptom specificity. <i>Journal of Anxiety Disorders</i> , 19(3), 329–343. https://doi.org/10.1016/j.janxdis.2004.02.002	LO3, LO5: Examination of empirical support for a cognitive-behavioural model of GAD.
Hyett, M. P., & McEvoy, P. M. (2018). Social anxiety disorder: Looking back and moving forward. <i>Psychological Medicine</i> , 48(12), 1937–1944. https://doi.org/10.1017/S0033291717003816	LO2, LO3: A concise review of the social-anxiety literature and remaining questions.

Week 8 - Obsessive-Compulsive Disorder and Related Disorders

Learning Objectives

1. **Apply** DSM-5-TR criteria to identify OCD and hoarding disorder, including obsessions, compulsions, time burden, distress/impairment, insight, exclusions, and relevant specifiers. (*Apply–Analyze*)
2. **Differentiate** OCD and related presentations from GAD, psychosis, illness anxiety, depressive rumination, autism-related repetitive behaviour, tic-related phenomena, trauma-related intrusions, and medical, neurological, medication, or substance explanations. (*Analyze–Evaluate*)
3. **Explain** maintenance mechanisms involving intrusive experiences, threat or responsibility appraisals, intolerance of uncertainty, ritualized behaviour, avoidance, reassurance seeking, family accommodation, and short-term negative reinforcement. (*Understand–Analyze*)
4. **Critically** evaluate the OCD-and-related-disorders grouping and the clinical advantages and limits of categorical versus dimensional descriptions. (*Analyze–Evaluate*)
5. **Apply** targeted ADHD differential reasoning by examining developmental onset, cross-setting persistence, impairment, collateral information, and whether apparent inattention is better explained by rituals, intrusive thoughts, anxiety, depression, sleep loss, or another condition. (*Apply–Evaluate*)
6. **Integrate** cultural, religious, developmental, medical, neurological, and contextual information without treating identity or belief content as diagnostic evidence; identify missing information, consultation/referral needs, and limits of diagnostic confidence. (*Apply–Evaluate*)

Required Readings (54 pages, approximately 3 hours 25 minutes at 150 words per minute)

- American Psychiatric Association. (2022). *Diagnostic and statistical manual of mental disorders* (5th ed., text rev.). <https://doi.org/10.1176/appi.books.9780890425787>
 - Read Attention-Deficit/Hyperactivity Disorder (pp. 68–76).
 - Read Obsessive-Compulsive Disorder (pp. 265–270).
 - Read Hoarding Disorder (pp. 277–280).
- Stein, D. J., Costa, D. L. C., Lochner, C., Miguel, E. C., Reddy, Y. C. J., Shavitt, R. G., van den Heuvel, O. A., & Simpson, H. B. (2019). Obsessive-compulsive disorder. *Nature Reviews Disease Primers*, 5, Article 52. <https://doi.org/10.1038/s41572-019-0102-3>
 - Read the substantive Lexis export (PDF pp. 2–25).
- Stein, D. J., Costa, D. L. C., Lochner, C., Miguel, E. C., Reddy, Y. C. J., Shavitt, R. G., van den Heuvel, O. A., & Simpson, H. B. (2024). Author correction: Obsessive-compulsive disorder. *Nature Reviews Disease Primers*, 10, Article 79. <https://doi.org/10.1038/s41572-024-00569-z>
 - Read the full correction.

- Posner, J., Polanczyk, G. V., & Sonuga-Barke, E. (2020). Attention-deficit hyperactivity disorder. *The Lancet*, 395(10222), 450–462. [https://doi.org/10.1016/S0140-6736\(19\)33004-1](https://doi.org/10.1016/S0140-6736(19)33004-1)
 - Read pp. 450–459.

Required-Reading-to-Weekly-LO Alignment

Required Reading	Learning Objectives Addressed
DSM-5-TR: ADHD, pp. 68–76; OCD, pp. 265–270; hoarding disorder, pp. 277–280	LO1, LO2, LO4, LO5, LO6: Coverage of criteria, insight, impairment, exclusions, developmental onset, cross-setting evidence, and differential logic.
Stein et al. (2019), Lexis substantive PDF pp. 2–25, plus the 2024 correction	LO1, LO2, LO3, LO6: Current information on phenomenology, comorbidity, assessment, mechanisms, and professional limitations, with a correction included for factual accuracy.
Posner et al. (2020), pp. 450–459	LO5, LO6: Support for attention to developmental history, impairment, comorbidity, collateral evidence, and limits of adult ADHD inference.

Optional Readings

Reference	Relevance to the Week's Learning Objectives
Abramowitz, J. S., & Jacoby, R. J. (2015). Obsessive-compulsive and related disorders: A critical review of the new diagnostic class. <i>Annual Review of Clinical Psychology</i> , 11, 165–186. https://doi.org/10.1146/annurev-clinpsy-032813-153713	LO4: A critique of the OCD-and-related-disorders grouping.
Mataix-Cols, D., & Pertusa, A. (2012). Annual research review: Hoarding disorder: Potential benefits and pitfalls of a new mental disorder. <i>Journal of Child Psychology and Psychiatry</i> , 53(6), 608–618. https://doi.org/10.1111/j.1469-7610.2011.02464.x	LO1, LO4: A review of the benefits and risks of recognizing hoarding as a separate disorder.
Moffitt, T. E., Houts, R., Asherson, P., Belsky, D. W., Corcoran, D. L., Hammerle, M., Harrington, H., Hogan, S., Meier, M. H., Polanczyk, G. V., Poulton, R., Ramrakha, S., Sugden, K., Williams, B., Rohde, L. A., & Caspi, A. (2015). Is adult ADHD a childhood-onset neurodevelopmental disorder? Evidence from a four-decade longitudinal cohort study. <i>American Journal of Psychiatry</i> , 172(10), 967–977. https://doi.org/10.1176/appi.ajp.2015.14101266	LO5, LO6: Examination of whether adult ADHD always reflects a childhood-onset disorder.

Week 9 - Substance Use Disorders

Learning Objectives

1. **Apply** DSM-5-TR criteria to identify Alcohol Use Disorder, including impaired control, social impairment, risky use, pharmacological criteria, severity, remission, and withdrawal-related considerations. (*Apply–Analyze*)
2. **Differentiate** primary mood or anxiety disorders from alcohol intoxication, withdrawal, substance/medication-induced presentations, and medical complications, using chronology, dose/pattern, periods of abstinence, and functional change. (*Analyze–Evaluate*)
3. **Compare** developmental-learning, reinforcement, neurobiological, and disease-model accounts of addiction, distinguishing empirical guidance from contested explanatory positions. (*Analyze–Evaluate*)
4. **Integrate** culture, social determinants, stigma, harm-reduction context, identity, family/community effects, access to care, and person-defined goals without moralizing substance use or assuming causation from social identity. (*Apply–Evaluate*)
5. **Apply** targeted PMDD reasoning using prospective menstrual-cycle timing, recurrence across cycles, symptom-free intervals, impairment, and differential diagnosis from MDD, bipolar disorder, anxiety disorders, substance effects, and other medical or reproductive-health explanations. (*Apply–Analyze*)
6. **Identify** withdrawal and safety concerns, suicide or other risk implications, medical assessment needs, medication/substance interactions, consultation/referral thresholds, and appropriate limits on psychological diagnostic conclusions. (*Apply–Evaluate*)

Required Readings (42 pages, approximately 3 hours 10 minutes at 150 words per minute)

- American Psychiatric Association. (2022). *Diagnostic and statistical manual of mental disorders* (5th ed., text rev.). <https://doi.org/10.1176/appi.books.9780890425787>
 - Read Premenstrual Dysphoric Disorder (pp. 197–200).
 - Read Alcohol Use Disorder (pp. 553–561).
- Wood, E., Bright, J., Hsu, K., Goel, N., Ross, J. W. G., Hanson, A., Teed, R., Poulin, G., Denning, B., Corace, K., Chase, C., Halpape, K., Lim, R., Kealey, T., Rehm, J., & Canadian Alcohol Use Disorder Guideline Committee. (2023). Canadian guideline for the clinical management of high-risk drinking and alcohol use disorder. *CMAJ*, 195(40), E1364–E1379. <https://doi.org/10.1503/cmaj.230715>
 - Read pp. E1364–E1377.
- Lewis, M. (2017). Addiction and the brain: Development, not disease. *Neuroethics*, 10, 7–18. <https://doi.org/10.1007/s12152-016-9293-4>
 - Read pp. 7–16.

- Carlini, S. V., Lanza di Scalea, T., Trentacoste McNally, S., Lester, J., & Deligiannidis, K. M. (2022). Management of premenstrual dysphoric disorder: A scoping review. *International Journal of Women's Health*, 14, 1783–1801. <https://doi.org/10.2147/IJWH.S297062>
 - Read pp. 1783–1786.
 - Read p. 1794.

Required-Reading-to-Weekly-LO Alignment

Required Reading	Learning Objectives Addressed
DSM-5-TR: PMDD, pp. 197–200; AUD, pp. 553–561	LO1, LO2, LO5, LO6: Coverage of AUD severity/withdrawal logic and PMDD prospective-cycle requirements and exclusions.
Wood et al. (2023), pp. E1364–E1377	LO1, LO2, LO4, LO6: A current Canadian clinical reference for screening, diagnosis, withdrawal/risk, medical considerations, and referral.
Lewis (2017), pp. 7–16	LO3, LO4: Support for critical comparison of developmental-learning and disease-model assumptions.
Carlini et al. (2022), pp. 1783–1786 and 1794	LO5, LO6: Support for prospective timing, differential diagnosis, pathophysiology, and limits of PMDD evidence.

Optional Readings

Reference	Relevance to the Week's Learning Objectives
Browne, T. K. (2015). Is premenstrual dysphoric disorder really a disorder? <i>Journal of Bioethical Inquiry</i> , 12(2), 313–330. https://doi.org/10.1007/s11673-014-9567-7	LO5, LO6: A focused critique of PMDD as a diagnostic category.

Week 10 - Posttraumatic Stress Disorder and Trauma- and Stressor-Related Disorders

Learning Objectives

1. **Apply** DSM-5-TR criteria to identify PTSD, including qualifying exposure, symptom clusters, duration, impairment, exclusions, and specifiers, and distinguish PTSD from acute stress disorder, adjustment disorder, depressive and anxiety disorders, traumatic brain injury, substance effects, and other trauma-related presentations. (*Apply–Analyze*)
2. **Explain** evidence-based mechanisms of adaptation and non-adaptation following trauma, including threat processing, memory and contextualization, avoidance, negative beliefs, arousal/reactivity, sleep disruption, and social/interpersonal processes. (*Understand–Analyze*)
3. **Evaluate** how culture, occupation, current safety, systemic context, discrimination, social support, meaning, disclosure, and help-seeking shape trauma presentation and diagnostic confidence without treating trauma exposure as automatically producing PTSD. (*Analyze–Evaluate*)
4. **Identify** suicide/self-harm, violence, vulnerability, dissociation, substance use, current danger, medical/TBI, and functional concerns that require further assessment, consultation, referral, or urgent action while respecting the course's diagnostic—not full risk-assessment—scope. (*Apply–Evaluate*)
5. **Apply** targeted Binge-Eating Disorder reasoning by assessing episode features, loss of control, frequency, duration, distress, compensatory behaviour, and differential diagnosis from bulimia nervosa, normative overeating, emotional eating, substance-related eating, and medical conditions. (*Apply–Analyze*)
6. **Distinguish** diagnosis from formulation, compare PTSD and BED maintenance hypotheses with the person's actual context, evaluate evidence-base fit, and communicate uncertainty and professional limits. (*Analyze–Evaluate*)

Required Readings (44 pages, approximately 3 hours 45 minutes at 150 words per minute)

- American Psychiatric Association. (2022). *Diagnostic and statistical manual of mental disorders* (5th ed., text rev.). <https://doi.org/10.1176/appi.books.9780890425787>
 - Read Posttraumatic Stress Disorder (pp. 301–313).
 - Read Binge-Eating Disorder (pp. 393–396).
- Bryant, R. A. (2021). A critical review of mechanisms of adaptation to trauma: Implications for early interventions for posttraumatic stress disorder. *Clinical Psychology Review*, 85, Article 101981. <https://doi.org/10.1016/j.cpr.2021.101981>
 - Read PDF pp. 1–10.

- Department of Veterans Affairs, & Department of Defense. (2023). *VA/DoD clinical practice guideline for management of posttraumatic stress disorder and acute stress disorder: Provider summary* (Version 4.0).
<https://www.healthquality.va.gov/HEALTHQUALITY/guidelines/MH/ptsd/VA-DOD-CPG-PTSD-Provider-Summary.pdf>
 - Read pp. 1–3.
 - Read pp. 13–18.
- Schulte, E. M., Grilo, C. M., & Gearhardt, A. N. (2016). Shared and unique mechanisms underlying binge eating disorder and addictive disorders. *Clinical Psychology Review*, 44, 125–139. <https://doi.org/10.1016/j.cpr.2016.02.001>
 - Read pp. 125–130.
 - Read pp. 133–134.

Required-Reading-to-Weekly-LO Alignment

Required Reading	Learning Objectives Addressed
DSM-5-TR: PTSD, pp. 301–313; BED, pp. 393–396	LO1, LO4, LO5, LO6: Coverage of trauma, cluster, duration, impairment, exclusion, BED frequency/distress, and compensatory-behaviour rules.
Bryant (2021), PDF pp. 1–10	LO2, LO3, LO6: Support for understanding adaptation and maintenance mechanisms, together with attention to uncertainty and heterogeneity.
VA/DoD provider summary (2023), pp. 1–3 and 13–18	LO1, LO4, LO6: A current clinical framework for assessment, differentials, safety implications, and professional referral limits.
Schulte et al. (2016), pp. 125–130 and 133–134	LO5, LO6: A comparison of shared and unique BED/addiction mechanisms without conflation of the diagnoses.

Optional Readings

Reference	Relevance to the Week's Learning Objectives
Friedman, M. J. (2013). Finalizing PTSD in DSM-5: Getting here from there and where to go next. <i>Journal of Traumatic Stress</i> , 26(5), 548–556. https://doi.org/10.1002/jts.21840	LO1, LO6: A historical account of changes to PTSD in DSM-5 and remaining classification questions.
Rauch, S. A. M., & Foa, E. B. (2006). Emotional processing theory and exposure therapy for PTSD. <i>Journal of Contemporary Psychotherapy</i> , 36(2), 61–65. https://doi.org/10.1007/s10879-006-9008-y	LO2, LO6: A concise account of emotional processing theory and exposure therapy for PTSD.

Week 11 - Insomnia, Introduction to Personality Disorders, and Antisocial Personality Disorder

Learning Objectives

1. **Apply** DSM-5-TR general personality-disorder criteria by evaluating enduring patterns, inflexibility, pervasiveness, stability, onset, distress/impairment, cultural expectations, and exclusions for substances, medical conditions, developmental stages, and episodic mental states. (*Apply–Analyze*)
2. **Compare** the DSM-5-TR Section II categorical personality-disorder model with the Alternative DSM-5 Model for Personality Disorders, including level of personality functioning, maladaptive traits, dimensionality, reliability, validity, and clinical utility. (*Analyze–Evaluate*)
3. **Differentiate** enduring personality pathology from mood episodes, trauma-related adaptations, substance effects, neurodevelopmental conditions, situational reactions, and culturally/contextually understandable interpersonal patterns. (*Analyze–Evaluate*)
4. **Apply** targeted insomnia reasoning by examining sleep complaint, frequency, duration, daytime impairment, opportunity for sleep, and medical, substance, medication, circadian, mood, anxiety, trauma, pain, and sleep-disorder differentials. (*Apply–Analyze*)
5. **Apply** targeted ASPD reasoning by requiring an adult pervasive pattern and evidence of conduct disorder before age 15, using longitudinal and collateral information, and distinguishing ASPD from isolated illegal behaviour, psychopathy as a separate construct, substance-related behaviour, intermittent aggression, and other personality pathology. (*Apply–Evaluate*)
6. **Evaluate** stigma, gender/racialized/forensic assumptions, cultural context, collateral-source limitations, safety concerns, evidence-base fit, consultation needs, and restraint when communicating personality, sleep, or ASPD-related conclusions. (*Analyze–Evaluate*)

Required Readings (55 pages, approximately 3 hours 50 minutes at 150 words per minute)

- American Psychiatric Association. (2022). *Diagnostic and statistical manual of mental disorders* (5th ed., text rev.). <https://doi.org/10.1176/appi.books.9780890425787>
 - Read Insomnia Disorder (pp. 410–417).
 - Read General Personality Disorder criteria (pp. 733–737).
 - Read Antisocial Personality Disorder (pp. 748–752).
 - Read the Alternative DSM-5 Model for Personality Disorders (pp. 881–895).

- Sharp, C., Clark, L. A., Balzen, K. M., Widiger, T. A., Stepp, S. D., Zimmerman, M., & Krueger, R. F. (2025). The validity, reliability and clinical utility of the Alternative DSM-5 Model for Personality Disorders (AMPD) according to DSM-5 revision criteria. *World Psychiatry*, 24(3), 319–340. <https://doi.org/10.1002/wps.21339>
 - Read pp. 319–320.
 - Read pp. 329–333.
- Riemann, D., Espie, C. A., Altena, E., Arnardottir, E. S., Baglioni, C., Bassetti, C. L. A., Bastien, C., Berzina, N., Bjorvatn, B., Dikeos, D., Dolenc Groselj, L., Ellis, J. G., Garcia-Borreguero, D., Geoffroy, P. A., Gjerstad, M., Gonçalves, M., Hertenstein, E., Hoedlmoser, K., Hion, T., ... Spiegelhalder, K. (2023). The European Insomnia Guideline: An update on the diagnosis and treatment of insomnia 2023. *Journal of Sleep Research*, 32(6), Article e14035. <https://doi.org/10.1111/jsr.14035>
 - Read PDF pp. 1–7.
- Burke, J. D., Butler, E. J., Shaughnessy, S., Karlovich, A. R., & Evans, S. C. (2024). Evidence-based assessment of DSM-5 disruptive, impulse control, and conduct disorders. *Assessment*, 31(1), 75–93. <https://doi.org/10.1177/10731911231188739>
 - Read pp. 75–79.
 - Read pp. 84–86.

Required-Reading-to-Weekly-LO Alignment

Required Reading	Learning Objectives Addressed
DSM-5-TR: insomnia, pp. 410–417; general PD, pp. 733–737; ASPD, pp. 748–752; AMPD, pp. 881–895	L01, L02, L03, L04, L05, L06: Coverage of categorical and dimensional criteria, pervasiveness, sleep diagnostic rules, ASPD developmental requirements, and exclusions.
Sharp et al. (2025), pp. 319–320 and 329–333	L02, L03, L06: A current evidence review of AMPD validity, reliability, clinical utility, limitations, and proposed revision.
Riemann et al. (2023), PDF pp. 1–7	L04, L06: Support for current insomnia diagnosis, differential assessment, medical/sleep referral, and evidence limits.
Burke et al. (2024), pp. 75–79 and 84–86	L05, L06: Support for developmental conduct-history assessment, informant use, competing explanations, and restraint before ASPD diagnosis.

Optional Readings

Reference	Relevance to the Week's Learning Objectives
Zimmerman, M. (2011). A critique of the proposed prototype rating system for personality disorders in DSM-5. <i>Journal of Personality Disorders</i> , 25(2), 206–221. https://doi.org/10.1521/pedi.2011.25.2.206	LO2: A critique of an earlier dimensional prototype proposal for personality disorders.
Lichstein, K. L. (2017). Insomnia identity. <i>Behaviour Research and Therapy</i> , 97, 230–241. https://doi.org/10.1016/j.brat.2017.08.005	LO4, LO6: Examination of how identifying as an insomniac may affect symptoms and treatment.
Alegria, A. A., Blanco, C., Petry, N. M., Skodol, A. E., Liu, S.-M., Grant, B. F., & Hasin, D. (2013). Sex differences in antisocial personality disorder: Results from the National Epidemiological Survey on Alcohol and Related Conditions. <i>Personality Disorders: Theory, Research, and Treatment</i> , 4(3), 214–222. https://doi.org/10.1037/a0031681	LO5, LO6: Epidemiological evidence on sex differences in antisocial personality disorder.
Krueger, R. F. (2013). Personality disorders are the vanguard of the post-DSM-5 era. <i>Personality Disorders: Theory, Research, and Treatment</i> , 4(4), 355–362. https://doi.org/10.1037/per0000028	LO2, LO3: Discussion of personality-disorder dimensionality within broader post-DSM-5 classification debates.

Week 12 - Borderline Personality Disorder

Learning Objectives

1. **Apply** DSM-5-TR criteria to identify Borderline Personality Disorder, including pervasive pattern, onset, impairment, identity disturbance, interpersonal instability, affective instability, impulsivity, anger, emptiness, abandonment sensitivity, dissociation/paranoia, and self-harm or suicidality. (*Apply–Analyze*)
2. **Differentiate** BPD from Bipolar II Disorder, PTSD and other trauma-related presentations, Major Depressive Disorder, substance-related affective instability, ADHD-related impulsivity, and other personality pathology using chronology, interpersonal triggers, episode structure, trait pervasiveness, and collateral information. (*Analyze–Evaluate*)
3. **Explain** the biosocial developmental model of BPD, including emotional vulnerability, invalidating environments, transactional processes, learning history, and developmental pathways without treating trauma or identity as a deterministic cause. (*Understand–Analyze*)
4. **Explain** the Borderline Interpersonal-Affective Systems model by linking interpersonal context, expectations, perception, affective responses, behaviour, feedback loops, and relationship consequences to case-specific maintenance hypotheses. (*Understand–Analyze*)
5. **Integrate** culture, race/ethnicity, gender identity, sexuality, disability, attachment and trauma context, housing or economic adversity, stigma, support systems, and evidence-base fit without reproducing gendered, racialized, queer/trans, or trauma-based diagnostic shortcuts. (*Apply–Evaluate*)
6. **Identify** self-harm, suicide, aggression, substance use, dissociation, current safety, medical concerns, consultation/referral needs, and limits of competence; communicate BPD conclusions with uncertainty, restraint, and person-centred language. (*Apply–Evaluate*)

Required Readings (29 pages, approximately 2 hours 50 minutes at 150 words per minute)

- American Psychiatric Association. (2022). *Diagnostic and statistical manual of mental disorders* (5th ed., text rev.). <https://doi.org/10.1176/appi.books.9780890425787>
 - Read Borderline Personality Disorder (pp. 753–757).
- Crowell, S. E., Beauchaine, T. P., & Linehan, M. M. (2009). A biosocial developmental model of borderline personality: Elaborating and extending Linehan's theory. *Psychological Bulletin*, 135(3), 495–510. <https://doi.org/10.1037/a0015616>
 - Read pp. 495–506.
- Fitzpatrick, S., Liebman, R. E., & Monson, C. M. (2021). The borderline interpersonal-affective systems model: Extending understanding of the interpersonal context of borderline personality disorder. *Clinical Psychology Review*, 84, Article 101983. <https://doi.org/10.1016/j.cpr.2021.101983>
 - Read PDF pp. 1–9.

- American Psychiatric Association. (2024). Practice guideline for the treatment of patients with borderline personality disorder: Executive summary. *American Journal of Psychiatry*, 181(11), 1024–1028. <https://doi.org/10.1176/appi.ajp.24181010>
 - Read pp. 1024–1026.

Required-Reading-to-Weekly-LO Alignment

Required Reading	Learning Objectives Addressed
DSM-5-TR: BPD, pp. 753–757	LO1, LO2, LO6: Coverage of criteria, pervasiveness, impairment, differential diagnosis, and risk-relevant features.
Crowell et al. (2009), pp. 495–506	LO3, LO5: Support for biosocial-developmental and transactional formulation, with emphasis on non-deterministic application.
Fitzpatrick et al. (2021), PDF pp. 1–9	LO4, LO5: Support for interpersonal-affective feedback loops and case-specific maintenance formulation.
APA BPD guideline executive summary (2024), pp. 1024–1026	LO1, LO2, LO5, LO6: A current person-centred clinical framework for assessment, context, comorbidity, safety, and professional limits.

Optional Readings

Reference	Relevance to the Week's Learning Objectives
Selby, E. A., & Joiner, T. E., Jr. (2009). Cascades of emotion: The emergence of borderline personality disorder from emotional and behavioral dysregulation. <i>Review of General Psychology</i> , 13(3), 219–229. https://doi.org/10.1037/a0015687	LO3, LO4: An additional model of interacting emotional and behavioural dysregulation in BPD.