



## Psychopathology

A-level Revision Notes AQA(A)

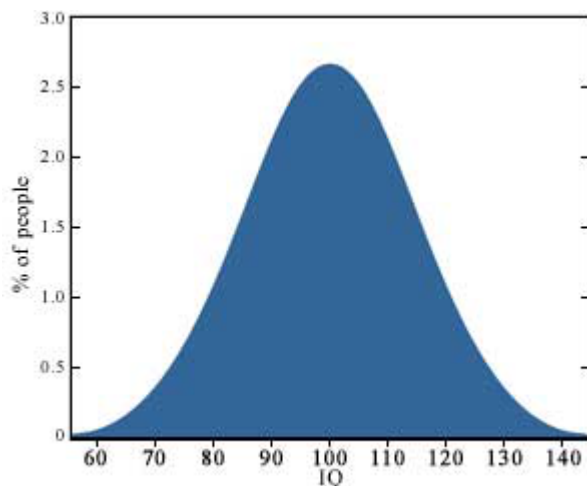
By [Saul Mcleod](#), updated 2020

## Definitions of Abnormality

### Statistical Infrequency

#### AO1

Under this definition of abnormality, a person's trait, thinking or behavior is classified as abnormal if it is rare or statistically unusual. With this definition it is necessary to be clear about how rare a trait or behavior needs to be before we class it as abnormal



For instance one may say that an individual who has an IQ below or above the average level of IQ in society is abnormal.

However this definition obviously has limitations, it fails to recognize the desirability of the particular behavior.

Going back to the example, someone who has an IQ level above the normal average wouldn't necessarily be seen as abnormal, rather on the contrary they would be highly regarded for their intelligence.

This definition also implies that the presence of abnormal behavior in people should be rare or statistically unusual, which is not the case. Instead, any specific abnormal behavior may

be unusual, but it is not unusual for people to exhibit some form of prolonged abnormal behavior at some point in their lives.

## AO3

### **Strengths**

This definition can provide an objective way, based on data, to define abnormality if an agreed cut-off point can be identified.

No value judgements are made –Homosexuality was defined as a mental disorder under early versions of the diagnostic criteria used by psychiatrists, would not be seen as ‘wrong’ but merely as less frequent than heterosexuality.

### **Limitations**

However, this definition fails to distinguish between desirable and undesirable behavior. Statistically speaking, many very gifted individuals could be classified as ‘abnormal’ using this definition. The use of the term ‘abnormal’ in this context would not be appropriate.

Many rare behaviors or characteristics (e.g. left handedness) have no bearing on normality or abnormality. Some characteristics are regarded as abnormal even though they are quite frequent. Depression may affect 27% of elderly people (NIMH, 2001). This would make it common but that does not mean it isn't a problem

## Deviation from Social Norms

## AO1

Deviation from ideal mental health suggests that we define mental illness by looking at the absence of signs of physical health (Jahoda).

A person's thinking or behavior is classified as abnormal if it violates the (unwritten) rules about what is expected or acceptable behavior in a particular social group. Their behavior may be incomprehensible to others or make others feel threatened or uncomfortable. Social behavior varies markedly when different cultures are compared.

For example, it is common in Southern Europe to stand much closer to strangers than in the

UK. Voice pitch and volume, touching, direction of gaze and acceptable subjects for discussion have all been found to vary between cultures.

With this definition, it is necessary to consider: (i) The degree to which a norm is violated, the importance of that norm and the value attached by the social group to different sorts of violation. (ii) E.g. is the violation rude, eccentric, abnormal or criminal?

## AO3

### **Strength**

Comprehensive – Covers a broad range of criteria, most for which why someone would seek help from mental health services or be referred for help – Makes it a good tool for thinking about mental health.

This definition gives a social dimension to the idea of abnormality, which offers an alternative to the 'sick in the head' individual.

### **Limitations**

Social norms can vary from culture to culture. This means that what is considered normal in one culture may be considered abnormal in another. This definition of abnormality is an example of cultural relativism.

Unrealistic – Most people do not meet all the ideals because few people experience personal growth all the time – The criteria may be ideals rather than actualities.

One limitation of the deviation of social norms definition is that norms can vary over time. This means that behavior that would have been defined as abnormal in one era is no longer defined as abnormal in another. For example drink driving was once considered acceptable but is now seen as socially unacceptable whereas homosexuality has gone the other way. Until 1980 homosexuality was considered a psychological disorder by the World Health Organization (WHO) but today is considered acceptable.

## Failure to Function Adequately

## AO1

Failure to function adequately (FFA) refers to abnormality that prevent the person from carrying out the range of behaviors that society would expect from them, such as getting out of bed each day, holding down a job, and conducting successful relationships etc.

Rosenhan & Seligman suggested seven criteria that are typical of FFA. These include personal distress (e.g. anxiety or depression), unpredictably (displaying unexpected behaviors and loss of control) and irrationality among others. The more features of personal dysfunction a person has the more they are considered abnormal.

To assess how well individuals cope with everyday life, clinician use the Global Assessment of Functioning Scale (GAF), which rates their level of social, occupational and psychological functioning.

## AO3

### **Strengths**

The definition provides a practical checklist of seven criteria individuals can use to check their level of abnormality.

It matches the sufferers' perceptions. As most people seeking clinical help believe that they are suffering from psychological problems that interfere with the ability to function properly, it supports the definition.

### **Limitations**

FFA might not be linked to abnormality but to other factors. Failure to keep a job may be due to the economic situation not to psychopathology.

Cultural relativism is one limitation; what may be seen as functioning adequately in one culture may not be adequate in another. This is likely to result in different diagnoses in different cultures.

FFA is context dependent; not eating can be seen as failing to function adequately but prisoners on hunger strikes making a protest can be seen in a different light.

## Deviation from Ideal Mental Health

## AO1

Jahoda suggested six criteria necessary for ideal mental health. An absence of any of these characteristics indicate individuals as being abnormal, in other words displaying deviation from ideal mental health.

- Resistance to stress: Having effective coping strategies and being able to cope with everyday anxiety provoking situations.
- Growth, development or self-actualisation: Experiencing personal growth and becoming everything one is capable of becoming.
- High self-esteem and a strong sense of identity: Having self-respect and a positive self-concept.
- Autonomy: Being independent, self-reliant and being able to make personal decisions.
- Accurate perception of reality: Having an objective and realistic view of the world.

## AO3

### **Limitations**

Difficulty of meeting all criteria, very few people would be able to do so and this suggests that very few people are psychologically healthy.

Cultural relativism: these ideas are culture-bound, based on a Western idea of ideal mental health, and should not be used to judge other cultures.

## AO2 Scenario Question

Diane is a 30-year-old businesswoman and if she does not get her own way she sometimes has a temper tantrum. Recently, she attended her grandmother's funeral and laughed during the prayers. When she talks to people she often stands very close to them, making them feel uncomfortable.

Identify one definition of abnormality that could describe Diane's behavior. Explain your choice.

(4 marks)

## Answer

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“Diana’s behavior could be defined as deviating from social norms.

Although she is 30 she still has childish temper tantrums, she acted in a socially abnormal way at her grandmother’s funeral and she disobeys social norms about how close it is appropriate to stand to people.

She is deviating from what is regarded as socially normal, thus according to this definition she would be defined as psychologically abnormal.”

## AO2 Scenario Question

'The following article appeared in a magazine: Hoarding disorder – A ‘new’ mental illness Most of us are able to throw away the things we don’t need on a daily basis. Approximately 1 in 1000 people, however, suffer from hoarding disorder, defined as ‘a difficulty parting with items and possessions, which leads to severe anxiety and extreme clutter that affects living or work spaces’.

Apart from ‘deviation from ideal mental health’, outline three definitions of abnormality. Refer to the article above in your answer. (6 marks)

# The Biological Approach to OCD

## Characteristics of OCD

### AO1

Obsessive Compulsive Disorder (OCD) is an anxiety disorder characterised by intrusive and uncontrollable thoughts (i.e. obsessions), coupled with a need to perform specific acts repeatedly (i.e. compulsions).

Common clinical obsessions are fear of contamination (esp. being infected by germs), repetitive thoughts of violence (killing or harming someone), sexual obsessions and obsessive doubt. Compulsions are the behavioral responses intended to neutralize these obsessions.

The most common compulsions are cleaning, washing, checking, counting and touching. To the compulsive these behaviors often seem to have magical qualities. If they are not performed exactly “something bad” will happen.

Some O.C.D. sufferers will meticulously perform their rituals hundreds of times and experience extreme anxiety if prevented from carrying them out. Cleaning/washing rituals are more common in women; checking rituals are more common in men.

**Cognitive** (What do you THINK?): Obsessions dominate ones thinking and are persistent and recurrent thoughts images or beliefs entering the mind uninvited and which cannot be removed. At some point during the course of the disorder the person has recognized that the obsessions or compulsions are excessive or unreasonable.

**Emotional** (How do you FEEL?): Obsessive thoughts often lead to anxiety, worry and distress.

**Behavioral** (How do you BEHAVE?): Compulsions are the repetitive behavioral responses intended to neutralize these obsessions, often involving rigidly applied rules. Most OCD sufferers recognise their compulsions as unreasonable, but believe something bad will happen if they don't perform that behavior.

## A02 Exam Style Question

Steven describes how he feels when he is in a public place. I always have to look out for people who might be ill. If I come into contact with people who look ill, I think I might catch it and die. If someone starts to cough or sneeze then I have to get away and clean myself quickly.

Outline one cognitive characteristic of OCD and one behavioral characteristic of OCD that can be identified from the description provided by Steven. (2 marks)

## AO3

The approach can also be criticised for ignoring environmental influences. For example, people are not born with OCD they might learn it from their environment through the process of classical and operant conditioning.

Strengths of this approach include its testability via neuroscience research, evidence for genetic and neurotransmitter involvement in conditions such as schizophrenia. For example, the dopamine hypothesis argues that elevated levels of dopamine are related to symptoms of schizophrenia.

Biological explanations are reductionist as they focus on only one factor and at present our understanding of biochemistry is oversimplified. This means other psychological factors, such as cognitions are ignored.

The biological explanations are also deterministic because they ignore the individual's ability to control their own behavior, which in turn may affect their biochemistry levels.

## Genetic Explanations

### AO1

Genetics is the study of genes and inheritance. OCD seems to be a polygenic condition, where a number of genes are involved in its development. Family and twin studies suggest the involvement of genetic factors. The prevalence of OCD in the random population (about 2–3%) is the baseline against which the concordance rates can be compared.

The SERT gene (Serotonin Transporter) appears to be mutated in individuals with OCD. The mutation causes an increase in transporter proteins at a neuron's membrane. This leads to an increase in the reuptake of serotonin into the neuron which decreases the level of serotonin in the synapse.

The COMT gene is a gene that regulates the function of dopamine. It appears that this gene is also mutated in individuals with OCD. However this mutation causes the opposite effect as the SERT mutation discussed above. The mutated variation of the COMT gene found in OCD individuals causes a decrease in the COMT activity and therefore a higher level of dopamine.



## AO3

Carey and Gottesman (1981) found that identical twins showed a concordance rate of 87% for obsessive symptoms and features compared to 47% in fraternal twins. This difference suggests that genetic factors are moderately important.

The higher concordance rate found for identical twins may be due to nurture as identical twins are likely to experience a more similar environment than fraternal twins since they tend to be treated the same.

Genes alone do not determine who will develop OCD—they only create vulnerability. Thus, they are not a direct cause as other factors must trigger the disorder. Evidence for this is that the concordance rates are not 100%, which shows that OCD is due to an interaction of genetic and other factors.

The OCD may be culturally rather than genetically transmitted as the family members may observe and imitate each other's behavior, as predicted by social learning theory. Alternatively, family members might be more vulnerable to OCD because of the stressful environment rather than because of genetic factors.

## Neural Explanations

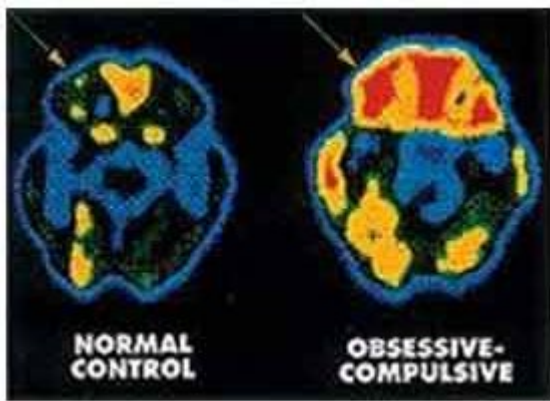
### AO1

Neural mechanisms refer to regions of the brain, structures such as neurons and the neurotransmitters involved in sending messages through the nervous system.

One region of the brain; the prefrontal cortex (PFC), is involved in decision making and the regulation of primitive aspects of our behavior. An over active PFC, causing an exaggerated control of primal impulses

For example, after a visit to the bathroom, your primal instinct to survive by avoiding germs is brought to your attention. You may make the decision to wash your hands to remove any harmful germs you may have encountered.

Once you have performed the appropriate behavior, the



PFC reduces in activation and you stop washing your hands and go about your day. It has been suggested that if you have OCD, your PFC is over activated. This means the obsessions and compulsions continue, leading you to wash your hands again and again.

Abnormalities, or an imbalance in the neurotransmitter serotonin, could also be related to OCD. Reduced serotonin and excessive dopamine may cause OCD.

Serotonin is the chemical thought to be involved in regulating mood. OCD patients have low levels of serotonin.

Additionally Dopamine is abnormally high in individuals with OCD. High levels of dopamine have been thought to influence concentration. This may explain why OCD individuals experience an inability to stop focussing on obsessive thoughts and repetitive behaviors.

### AO3

The brains of OCD patients are structured and function differently from those of other people. Brain scans of OCD patients reliably show increased activity in the PFC (Salloway & Duffy, 2002).

Whether low serotonin causes OCD is unknown. All that's known is that low serotonin and OCD are related. It is difficult to establish whether the low levels of neurotransmitters cause OCD, are an effect of having the disorder, or are merely associated. Causation cannot be inferred as only associations(i.e. correlations) have been identified.

We do not know whether high levels of dopamine cause OCD or whether OCD is caused by something else and the effect is high levels of dopamine.

The biochemistry hypothesis does not account for individual differences because the research does not explain why one individual develops OCD and another develops a different mental disorder, because low serotonin levels are also found in other mental disorders.

Thus, these biochemical abnormalities are not specific to OCD, and may be true of any form of mental distress.

Psychological therapy (CBT) can be very successful treatment and this is difficult to account for in the serotonin hypothesis.

## Biological Treatment - Drugs

Two classes of drug have proved effective in the treatment of obsessive compulsive disorder: serotonin reuptake inhibitors (SRIs) and selective serotonin reuptake inhibitors (SSRIs). Both classes of drug increase serotonin levels, and so support the neural explanation / biochemical hypothesis.

Drugs that mainly affect neurotransmitters other than serotonin are of little or no value in treating obsessive compulsive disorder.

### AO3

Studies using drugs have shown a reduction in dopamine levels is positively correlated with a reduction in OCD symptoms.

Experiments which inject animals with drugs that increased levels of dopamine have caused the animals to demonstrate OCD type behaviors.

Drugs that increase serotonin (anti depressants such as SSRIs) have been shown to reduce OCD symptoms. Soomro et al found that SSRIs were significantly better than placebos in reducing symptoms in 17 different clinical trials

But research results relating to serotonin are varied – sometimes symptoms have been made worse. There is a great deal of contradictory research. - Drugs seem to show only partial alleviation of the symptoms so the process is not fully understood. The exact function of neurotransmitters in the development of OCD is far from understood.

Most SSRIs have side effects which can be unpleasant, e.g. dry mouth, a slight tremor, fast heartbeat, constipation, sleepiness, and weight gain.

The success of antidepressant drugs as a treatment does not necessarily mean the biochemicals are the cause of OCD in the first place. This is known as the treatment

aetiology fallacy and, using headaches as an example, aspirin works well as a treatment but this doesn't mean the headache was due to an absence of aspirin.

# Cognitive Approach to Depression

## Characteristics of Depression

### AO1

Depression is a mood, or affective disorder. This mental illness is a collection of physical, emotional, mental and behavioral experiences that are severe, prolonged and damaging to everyday functioning.

The criteria for depression to be diagnosed using the DSM-IV-TR is that at least 5 or more symptoms of depression should be apparent. The possible symptoms include:

**Behavioral** (How do you BEHAVE when you're depressed?): Neglect of personal appearance, loss of appetite, disturbed sleep patterns (insomnia), loss of energy (tiredness), withdrawal from others.

**Emotional** (How do you FEEL when you're depressed?): Intense sadness, irritability, apathy (loss of interest of enjoyment), feelings of worthlessness, anger.

**Cognitive** (How do you THINK when you're depressed?): Negative thoughts, lack of concentration, low self-esteem, poor memory, recurrent thoughts of death, low confidence.

The cognitive approach believes that depression stems from faulty cognitions about others, our world and us. This faulty thinking may be through cognitive deficiencies (lack of planning) or cognitive distortions (processing information inaccurately). These cognitions cause distortions in the way we see things and caused behavior such as depression.

Ellis suggested depression occurs through irrational thinking, while Beck proposed the cognitive triad.

## AO2 Scenario Question

Ben recently moved away from home to go to university. He was loving his new life of going out, meeting new friends, his new university course. However, after a while he struggled getting out of bed and started to become very tired.

His eating patterns changed and he lost a lot of weight. He noticed that he got angry at little things and snapped at his friends. When he was sat in lectures, he found it hard to concentrate for long periods of time.

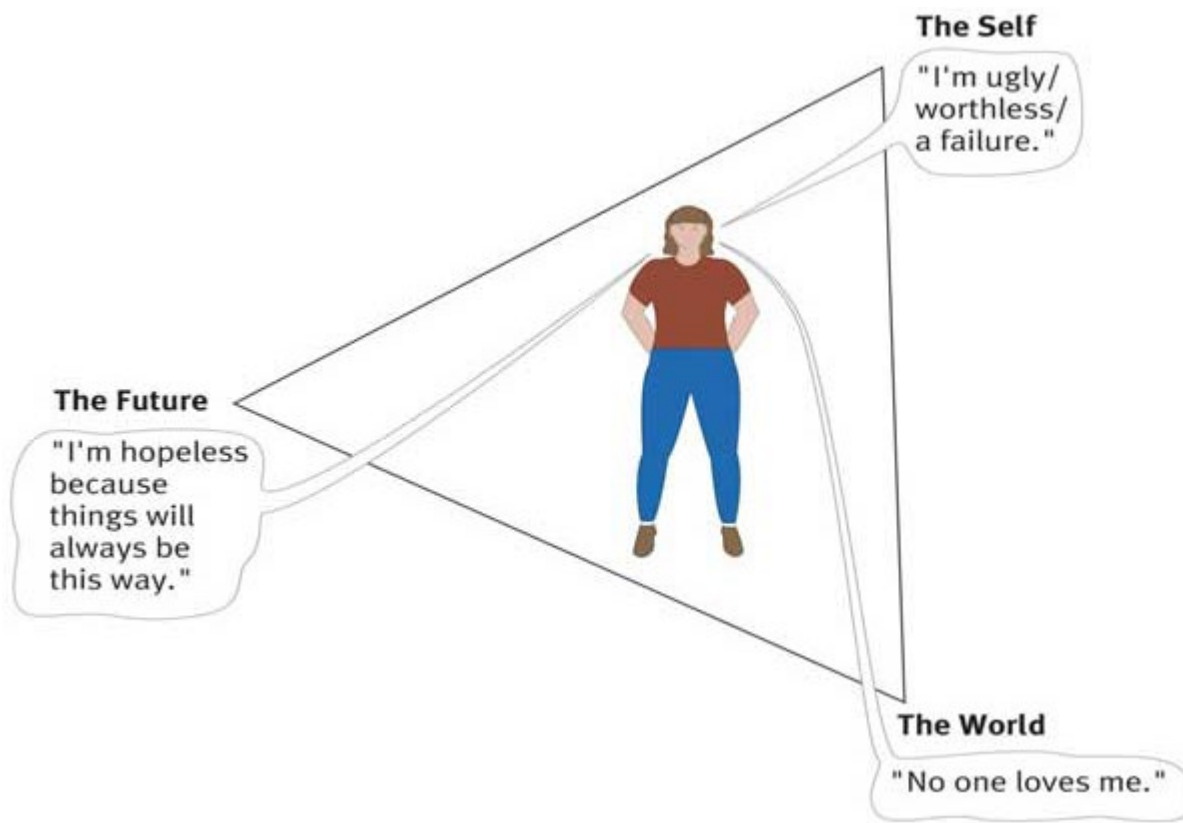
Identify the behavioral, emotional and cognitive aspects of Ben's state. (3 marks)

## Beck's Negative Triad

### AO1

The cognitive triad are three forms of negative (i.e. helpless and critical) thinking that are typical of individuals with depression: namely negative thoughts about the self, the world and the future. These thoughts tended to be automatic in depressed people as they occurred spontaneously.

For example, depressed individuals tend to view themselves as helpless, worthless, and inadequate. They interpret events in the world in a unrealistically negative and defeatist way, and they see the world as posing obstacles that can't be handled. Finally, they see the future as totally hopeless because their worthlessness will prevent their situation improving.



The negative triad interacts with negative schemas and cognitive biases to produce depressive thinking.

Cognitive biases are distortions of thought processes. Individuals with depression are prone to making logical errors in their thinking and they tend to focus selectively on certain negative aspects of a situation while ignoring equally relevant positive information.

In addition to cognitive biases, the negative triad is also influenced by schemas. In essence, schemas can be seen as deeply held beliefs that have their origins primarily in childhood. Beck believed that depression prone individuals develop a negative self-schema. They possess a set of beliefs and expectations about themselves that are essentially negative and pessimistic.

Beck claimed that negative schemas may be acquired in childhood as a result of a traumatic event (e.g. parental or peer rejection). Schemas influence how a person interprets events and experiences in their life. Beck predicted that in depression 'latent' (i.e. dormant) negative schemas that have been formed in childhood become activated by a life events or ongoing stressors.

Negative schemas and cognitive biases maintain the negative triad, a pessimistic view of the self, the world (not being able to cope with the demands of the environment) and the future.

## AO3

It may be that negative thinking generally is also an effect rather than a cause of depression. Perhaps individuals only start experiencing negative thoughts after having developed depression. However, evidence that negative thinking can be involved in the development of depression was obtained by Lewinsohn et al. (2001).

They measured negative thinking in non-depressed adolescents. One year later, the life events of participants over the previous 12 months were assessed, and also whether they were suffering from depression.

The results showed those who had experienced many negative life events had an increased likelihood of developing depression only if they were initially high in negative attitudes. This study supports the theory that negative beliefs are a risk factor for developing depression when exposed to stressful life events.

The cognitive approach to depression is limited in that genetic factors are ignored.

Little attention is paid to the role of social factors relating to life events and gender in the cognitive explanation of depression.

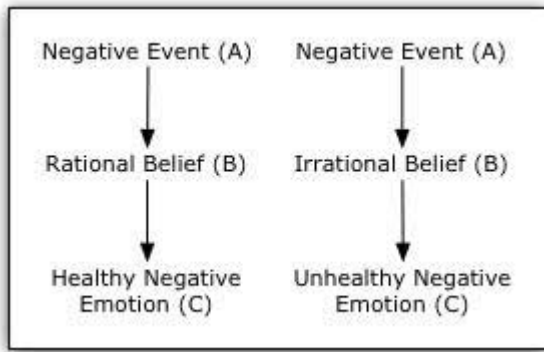
## Ellis's ABC Model

### AO1

Albert Ellis (1957, 1962) proposes that each of us hold a unique set of assumptions / beliefs about ourselves and our world that serve to guide us through life and determine our reactions to the various situations we encounter.

Unfortunately, some people's assumptions are largely irrational, guiding them to act and react in ways that are inappropriate and that prejudice their chances of happiness and success. Albert Ellis calls these basic irrational assumptions.

According to Ellis, depression does not occur as a direct result of a negative event but rather is produced by the irrational thoughts (i.e. beliefs) triggered by negative events.



Ellis believes that it is not the activating event (A) that causes depression (C), but rather that a person interpret these events unrealistically and therefore has an irrational belief system (B) that helps cause the consequences (C) of depressive behavior.

For example, some people irrationally assume that they are failures if they are not loved by everyone they know (B) - they constantly seek approval and repeatedly feel rejected (C). All their social interactions (A) are affected by this assumption, so that a great party can leave them dissatisfied because they don't get enough compliments.

### AO3

The precise role of cognitive processes is yet to be determined. It is not clear whether faulty cognitions are a cause of the psychopathology or a consequence of it.

Sometimes these negative cognitions are in fact a more accurate view of the world: depressive realism.

Cognitive theories lend themselves to testing. When experimental subjects are manipulated into adopting unpleasant assumptions or thought they became more anxious and depressed (Rimm & Litvak, 1969).

## Treatment - CBT

### How would you use the therapy

**Cognitive behavioral therapy** aims to change the way a client thinks, by challenging irrational and maladaptive thought processes and this will lead to a change in behavior as a responses to new thinking patterns. Specifically, our thoughts determine our feelings and our behavior.



Therefore, negative - and unrealistic - thoughts can cause us distress and result in problems. When a person suffers with psychological distress, the way in which they interpret situations becomes skewed, which in turn has a negative impact on the actions they take.

Cognitive therapists help clients to recognize the negative thoughts and errors in logic that cause them to be depressed. The therapist also guide clients to question and challenge their dysfunctional thoughts, try out new interpretations, and ultimately apply alternative ways of thinking in their daily lives.

The clients learn to discriminate between their own thoughts and reality. They learn the influence that cognition has on their feelings, and they are taught to recognize observe and monitor their own thoughts.

The behavior part of the therapy involves setting homework for the client to do (e.g. keeping a diary of thoughts). The therapist gives the client tasks that will help them challenge their own irrational beliefs.

The idea is that the client identifies their own unhelpful beliefs and then proves them wrong. As a result, their beliefs begin to change. For example, someone who is anxious in social situations may be set a homework assignment to meet a friend at the pub for a drink.

CBT would be used when a person's faulty thinking was effecting their life in a negative way.

### AO3

A strength of this therapy is that it has shown to be very effective in treating depression, in fact, it has shown to produce longer lasting recovery than antidepressants.

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Sometimes these negative cognitions are in fact a more accurate view of the world: depressive realism.

Cognitive theories lend themselves to testing. When experimental subjects are manipulated into adopting unpleasant assumptions or thought they became more anxious and depressed (Rimm & Litvak, 1969).

An important advantage of CBT is that it tends to be short (compared to psychoanalysis), taking three to six months for most emotional problems. Patients attend a session a week,

each session lasting either 50 minutes or an hour.

Another strength is that it can reduce ethical issues – the way this therapy works is that the client is actively involved and in control. They feel empowered as they are helping themselves.

## AO2 Scenario Question

Jack suffers from depression. His symptoms include loss of concentration, lack of sleep and struggles to sleep at night. He finds himself having absolutist thinking thinking that everything is negative and bad all the time.

How might a cognitive behavior therapist tackle Jack's depression? (4 marks)

# Behavioral Approach to Phobias

## Characteristics of Phobias

### AO1

Phobias are a type of anxiety disorder. Phobias are characterized by a marked and persistent fear that is excessive or unreasonable, cued by the presence or anticipation of a specific object or situation (e.g. flying, heights, seeing blood).

The symptoms of phobias can be place into one of three categories

**Behavioral** (How do you BEHAVE when you see your feared object?): The phobic stimulus is either avoided or responded to with great anxiety. For example, someone with a phobia of dogs may cross the road every time they see a dog, therefore receiving negative reinforcement which will maintain the phobia. This avoidance could interfere with the individual's normal daily routine.

**Emotional** (How do you FEEL when you see your feared object?): Exposure to the phobic stimulus nearly always produces a rapid anxiety response.

**Cognitive** (What do you THINK about your feared object?): A person would recognise that the fear is excessive or unreasonable. The person is consciously aware that the anxiety levels they experience in relation to their feared object or situation are overstated.

The DSM defines three categories of phobias: agoraphobia, social phobia and specific phobias. Agoraphobia is fear of open spaces, but is better characterized as a fear of being away from home.

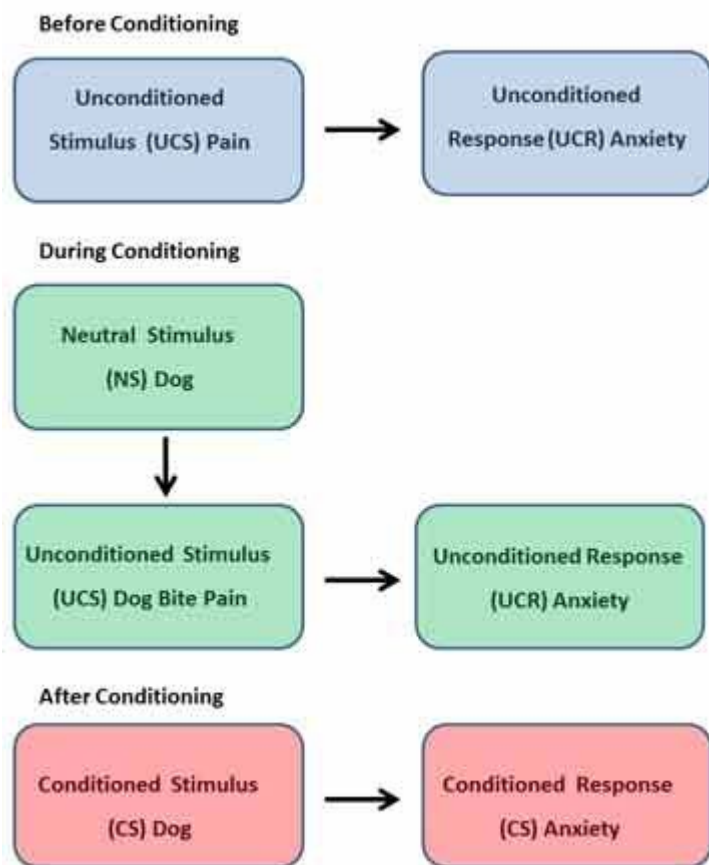
Social phobias involve an intense fear of social situation or having to interact with other people. Specific phobias relate to a fear of a specific object, such as a spider, or a situation, such as an enclosed space (claustrophobia).

## The Two-Process Model

### AO1

The **behavioral approach** explains the development and maintenance of phobia mainly using the theories of classical conditioning and operant conditioning. These were first combined as a single explanation for phobia by Mowrer, in the two-process model of phobia.

According to the behaviorists, phobias are the result of a **classically conditioned** association between an anxiety provoking unconditioned stimulus (UCS) and a previously neutral stimulus. For example, a child with no previous fear of dogs gets bitten by a dog and from this moment onwards associates the dog with fear and pain. Due to the process of generalisation the child is not just afraid of the dog who bit them, but shows a fear of all dogs.



**Operant conditioning** can help to explain how the phobia is maintained. The conditioned (i.e. learned) stimulus evokes fears, and avoidance of the feared object or situation lessens this feeling, which is rewarding. The reward (negative reinforcement) strengthens the avoidance behavior, and the phobia is maintained.

## A02 Questions

Kirsty is in her twenties and has had a phobia of balloons since one burst near her face when she was a little girl. Loud noises such as ‘banging’ and ‘popping’ cause Kirsty extreme anxiety, and she avoids situations such as birthday parties and weddings, where there might be balloons.

Suggest how the behavioral approach might be used to explain Kirsty’s phobia of balloons. (4 marks)

## A03

There is empirical support to show how classical conditioning leads to the development of phobias. Watson and Rayner (1920) used classical conditioning to create a phobia in an

infant called [Little Albert](#). Albert developed a phobia of a white rat when he learned to associate the rat with a loud noise.

The behaviorist approach adopts a limited view of the origins of a phobia, as it overlooks the role of cognition. Ignoring the role of cognition is problematic, as irrational thinking appears to be a key feature of phobias. Tomarken et al. (1989) presented a series of slides of snake and neutral images (e.g. trees) to phobic and non-phobic participants. The phobics tended to overestimate the number of snake images presented.

In theory anyone could develop a phobia to a potentially harmful object, although this does not always happen. Despite the fact the most adults have either experienced, witnessed or heard about car accidents where another person is injured, phobia of cars is virtually non-existent.

Seligman (1970) suggests that humans have a biological preparedness to develop certain phobias rather than others, because they were adaptive (i.e. helpful) in our evolutionary past. For example, individuals that avoided snakes and high places would be more likely to survive long enough and pass on their genes than those who did not.

The idea of biological preparedness is further supported by Ost and Hugdahl (1981) who claim that nearly half of all people with phobias have never had an anxious experience with the object of their fear, and some have had no experience at all. For example, some snake phobics have never encountered a snake.

The cognitive approach criticises the behavioral model as it does not take mental processes into account. They argue that the thinking processes that occur between a stimulus and a response are responsible for the feeling component of the response.

## Treatment - Systematic Desensitisation

### AO1

[Systematic desensitization](#) is a type of behavioral therapy based on the principle of classical conditioning. This therapy aims to remove the fear response of a phobia, and substitute a relaxation response to the conditional stimulus gradually using counter conditioning. This will lead to extinction of the fear response. There are three phases to the treatment:

**First**, the patient is taught a deep muscle relaxation technique and breathing exercises. E.g. control over breathing, muscle detensing or meditation. This step is very important because of reciprocal inhibition, where once response is inhibited because it is incompatible with another. In the case of phobias, fears involves tension and tension is incompatible with relaxation.

**Second**, the patient creates a fear hierarchy starting at stimuli that create the least anxiety (fear) and building up in stages to the most fear provoking images. The list is crucial as it provides a structure for the therapy.

Behavior	Fear rating
Think about a spider.	10
Look at a photo of a spider.	25
Look at a real spider in a closed box.	50
Hold the box with the spider.	60
Let a spider crawl on your desk.	70
Let a spider crawl on your shoe.	80
Let a spider crawl on your pants leg.	90
Let a spider crawl on your sleeve.	95
Let a spider crawl on your bare arm.	100

**Third**, the patient works their way up the fear hierarchy, starting at the least unpleasant stimuli and practising their relaxation technique as they go. When they feel comfortable with this (they are no longer afraid) they move on to the next stage in the hierarchy. If the client becomes upset they can return to an earlier stage and regain their relaxed state.

The number of sessions required depends on the severity of the phobia. Usually 4-6 sessions, up to 12 for a severe phobia. The therapy is complete once the agreed therapeutic goals are met (not necessarily when the person's fears have been completely removed).

Exposure can be done in two ways:

- In vitro – the client imagines exposure to the phobic stimulus.
- In vivo – the client is actually exposed to the phobic stimulus.

Research has found that in vivo techniques are more successful than in vitro (Menzies and Clarke 1993). However, there may be practical reasons why in vitro may be used.

## **Practical Issues**

One weakness of in vitro systematic desensitization is that it relies on the client's ability to be able to imagine the fearful situation. Some people cannot create a vivid image and thus systematic desensitization is not always effective (there are individual differences).

Systematic desensitization is a slow process, taking on average 6-8 sessions. Although, research suggests that the longer the technique takes the more effective it is.

## **Theoretical Issues**

Systematic desensitization is highly effective where the problem is a learned anxiety of specific objects/situations (e.g. phobias). However, SD is not effective in treating serious mental disorders like depression and schizophrenia.

Studies have shown that neither relaxation nor hierarchies are necessary, and that the important factor is just exposure to the feared object or situation. Therefore, therapies like flooding may be more effective.

Social phobias and agoraphobia do not seem to show as much improvement. Could it be that there are other causes for phobias than classical conditioning? For example, if a fear of public speaking originates with poor social skills then phobic reduction is more likely to occur in a treatment which includes learning effective social skills than systematic desensitization alone.

## **Empirical Evidence**

Rothbaum used SD with participants who were afraid of flying. Following treatment 93% agreed to take a trial flight. It was found that anxiety levels were lower than those of a control group who had not received SD and this improvement was maintained when they were followed up 6 months later.

## **Ethical Issues**

SD creates high levels of anxiety when patients are initially exposed, which raises ethical issues and so questions appropriateness. It should be noted that the virtual reality therapy does help resolve these issues.

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# Treatment - Flooding

## AO1

**Flooding** (also known as implosion therapy) works by exposing the patient directly to their worst fears. (S)he is thrown in at the deep end. For example a claustrophobic will be locked in a closet for 4 hours or an individual with a fear of flying will be sent up in a light aircraft.

What flooding aims to do is expose the sufferer to the phobic object or situation for an extended period of time in a safe and controlled environment. Unlike systematic desensitisation which might use in vitro or virtual exposure, flooding generally involves vivo exposure.

Fear is a time limited response. At first the person is in a state of extreme anxiety, perhaps even panic, but eventually exhaustion sets in and the anxiety level begins to go down. Of course normally the person would do everything they can to avoid such a situation. Now they have no choice but confront their fears and when the panic subsides and they find they have come to no harm. The fear (which to a large degree was anticipatory) is extinguished.

Prolonged intense exposure eventually creates a new association between the feared object and something positive (e.g. a sense of calm and lack of anxiety). It also prevents reinforcement of phobia through escape or avoidance behaviors.

## AO3

Flooding is rarely used and if you are not careful it can be dangerous. It is not an appropriate treatment for every phobia. It should be used with caution as some people can actually increase their fear after therapy, and it is not possible to predict when this will occur. Wolpe (1969) reported the case of a client whose anxiety intensified to such a degree that flooding therapy resulted in her being hospitalized.

Also, some people will not be able to tolerate the high levels of anxiety induced by the therapy, and are therefore at risk of exiting the therapy before they are calm and relaxed. This is a problem, as existing treatment before completion is likely to strengthen rather than weaken the phobia.

However one application is with people who have a fear of water (they are forced to swim out



of their depth). It is also sometimes used with agoraphobia. In general flooding produces results as effective (sometimes even more so) as systematic desensitisation. The success of the method confirms the hypothesis that phobias are so persistent because the object is avoided in real life and is therefore not extinguished by the discovery that it is harmless.

For example, Wolpe (1960) forced an adolescent girl with a fear of cars into the back of a car and drove her around continuously for four hours: her fear reached hysterical heights but then receded and, by the end of the journey, had completely disappeared.

## Exam Question Guides

### Revision Resources

[How To Write AQA Psychology Essays for 16 Marker Questions](#)

[How To Answer AQA Psychology Short Context Questions](#)

[How to Answer 'Design a Study' Research Methods Questions](#)

[Research Methods Exam Questions and Answers](#)

[Research Methods Exam Questions and Answers \(48 marks\)](#)

[Research Methods Exam Questions and Answers \(24 marks\)](#)

[How to Revise for Psychology A-level](#)

## Revision Notes

### Paper 1: Introductory Topics

[Social Influence](#)

[Memory](#)

[Attachment](#)

Psychopathology

## Paper 2: Psychology in Context

Biopsychology

Research Methods

## Paper 3: Issues and Options

Issues & Debates

Schizophrenia

Aggression

Forensic Psychology

Relationships

Gender

# Past Papers

## AS Paper 1

2017 Exam Paper

2017 Mark Scheme

2017 Examiner Report

2016 Exam Paper

2016 Mark Scheme

2016 Examiner Report

## A-Level Paper 1

2017 Exam Paper

2017 Mark Scheme

2017 Examiner Report

# Assessment Objectives

## AO1

### Demonstrate knowledge

(a) demonstrate knowledge and understanding of scientific ideas, processes, techniques and procedures.

(b) show a knowledge and understanding of psychological theories, terminology, concepts, studies and methods.

## AO2

### Application of knowledge

(a) apply knowledge and understanding of scientific ideas, processes, techniques and procedures:

in a theoretical context

in a practical context

when handling qualitative data

when handling quantitative data

This skill area tests knowledge of research design and data analysis, and applying theoretical understanding of psychology to everyday/real-life examples.

## Analyse, interpret and evaluate

(a) analyse, interpret and evaluate scientific information, ideas and evidence, including in relation to issues, to:

make judgements and reach conclusions

develop and refine practical design and procedures.

## Examples of how you can score AO3 marks

Whether or not theories are supported or refuted by valid research evidence.

After describing a theory go on to describe a piece of research evidence saying, 'X's study supports/refutes this theory...' and then describe the research study.

Contextualising how the topic in question relates to broader debates and approaches in Psychology.

For example, would they agree or disagree with a theory or the findings of the study?

Animal Research - This raises the issue of whether it's morally and/or scientifically right to use animals.

The main criterion is that benefits must outweigh costs.

Animal research also raises the issue of extrapolation. Can we generalize from studies on animals to humans as their anatomy & physiology is different from humans?

General criticisms and/or strengths of theories and studies.

E.g. 'Bandura's Bobo Doll studies are laboratory experiments and therefore criticisable on the grounds of lacking ecological validity'.

To gain marks for criticising study's methodologies the criticism must be contextualised: i.e. say why this is a problem in this particular study.

‘Therefore, the violence the children witnessed was on television and was against a doll not a human’.