AQA Psychology A-level

Topic 4: Clinical Psychology and Mental Health

Notes

Part 1 — Definitions of Abnormality

- Statistical infrequency = Implies that a disorder is abnormal if its frequency is more than two standard deviations away from the mean incidence rates represented on a normally-distributed bell curve.

+ Statistical infrequency is almost always used in the clinical diagnoses of mental health disorders as a comparison with a baseline or 'normal' value. This is used to assess the severity of the disorder e.g. the idea that Schizophrenia only affects 1% of the general population, but subtypes are even less frequent (such as hebephrenic or paranoid Schizophrenia).

— Statistical infrequency makes the assumption that any abnormal characteristics are automatically negative, whereas this is not always the case. For example, displaying abnormal levels of empathy (and thus qualifying as a Highly Sensitive Person) or having an IQ score above 130 (and thus being a genius) would rarely be looked down upon as negative characteristics which require treatment.

- The failure to function adequately definition of abnormality was proposed by Rosenhan and Seligman (1989) and suggests that if a person's current mental state is preventing them from leading a 'normal' life, alongside the associated normal levels of motivation and obedience to social norms, then such individuals may be considered as abnormal. This occurs when the patient does not obey social and interpersonal rules (e.g. standing precariously close to others), are in distress or are distressing, and their behaviour has become dangerous (not limited to themselves, but may also pose a danger to others).

+ A major strength of this definition of abnormality is that it takes into account the patient's perspective, and so the final diagnosis will be comprised of the patient's (subjective) self-reported symptoms and the psychiatrist's objective opinion. This may lead to more accurate diagnoses of mental health disorders because such diagnoses are not constrained by statistical limits, as is the case with statistical infrequency.

— A major weakness of using this definition of abnormality is the idea that it may lead to the labelling of some patients as 'strange' or 'crazy', which does little to challenge traditional negative stereotypes about mental health disorders. Not everyone with a mental health disorder requires a diagnosis, especially if they have a high quality of life and their illness has little impact upon themselves or others. Instead, such labelling could lead to discrimination or prejudice faced against them by employers and acquaintances.

- The deviation from social norms definition of abnormality suggests that 'abnormal' behaviour is based upon straying away from the social norms specific to a certain culture. There are general norms, applicable to the vast majority of cultures, as well as culture-specific norms. For example, an individual would be diagnosed with antisocial personality disorder (APD) if they behave aggressively towards strangers (breaching a general social norm) and if they experience certain hallucinations (which breaches the social norms of multiple cultures also, whereas other cultures may encourage this as a sign of spirituality).

— The fact that mental health diagnoses based on this definition vary so significantly between different cultures has historically led to discrimination, as a mechanism for social control. For example, in the nineteenth century within Great Britain, 'nymphomania' described the mental health disorder suffered by women who demonstrated sexual attractions towards working-class men. In reality, this diagnosis was simply made to prevent infidelity, cement the differences between social classes and further discriminate against women, thus being a reflection of a patriarchal society.

— Due to its reliance on subjective social norms, this explanation also suffers from cultural relativism. One such example would be the hearing of voices which have no basis in reality, or 'hallucinations'. Some African and Asian cultures in particular would look upon this symptom positively, viewing it as a sign of spirituality and a strong connection with ancestors, as opposed to a symptom of Schizophrenia. This therefore suggests that the use of this definition of abnormality may lead to some discrepancies in the diagnoses of mental health disorders, between cultures.

- Deviation from ideal mental health is the fourth definition of abnormality, and was proposed by Jahoda (1958). Instead of focusing on abnormality, Jahoda looked at what would comprise the ideal mental state of an individual. The criteria include being able to self-actualise (fulfill one's potential, in line with humanism!), having an accurate perception of ourselves, not being distressed, being able to maintain normal levels of motivation to carry out day-to-day tasks and displaying high self-esteem.

— The main issue with this definition of abnormality is that Jahoda may have had an unrealistic expectation of ideal mental health, with the vast majority of people being unable to acquire, let

alone maintain, all of the criteria listed. This means that the majority of the population would be considered abnormal, even if they have missed a single criteria e.g. being able to rationally cope with stress (which most people would agree does not merit a diagnosis). Therefore, deviation from ideal mental health may be considered a very limited method of diagnosing mental health disorders.

— This definition, just like deviation from social norms, suffers from cultural relativism. For example, the concept of self-actualisation, which suggests that we must each put ourselves first in order to achieve our full potential, may be viewed as selfish in collectivist cultures (e.g. China) where the needs of the group are valued more than the needs of the individual. On the other hand, self-actualisation may be a more popular concept in individualist cultures (e.g. the UK), where personal achievement is celebrated and the needs of the individual are greater than the needs of the group. This suggests that deviation from ideal mental health would only be accepted as a definition for abnormality in some (individualist) cultures.

Part 2 — Characteristics of Phobias

- The behavioural characteristics of phobias are panic, avoidance and endurance.
- Panic — the patient suffers from heightened physiological arousal upon exposure to the phobic stimulus, caused by the hypothalamus triggering increased levels of activity in the sympathetic branch of the autonomic nervous system.
- Avoidance — avoidance behaviour is negatively reinforced (in classical conditioning terms) because it is carried out to avoid the unpleasant consequence of exposure to the phobic stimulus. Therefore, avoidance severely impacts the patient's ability to continue with their day to day lives.
- Endurance — this occurs when the patient remains exposed to the phobic stimulus for an extended period of time, but also experiences heightened levels of anxiety during this time.

- The main emotional characteristics of phobias are anxiety (the emotional consequence of the physiological response of panic) and an unawareness that the anxiety experienced towards the phobic stimulus is irrational (from an evolutionary perspective, the phobic anxiety is not proportionate to the threat posed by the stimulus).
- The cognitive characteristics of phobias are selective attention to the phobic stimulus, irrational beliefs and cognitive distortions.
- Selective attention — this means that the patient remains focused on the phobic stimulus, even when it is causing them severe anxiety. This may be the result of irrational beliefs or cognitive distortions.
- Irrational beliefs — this may be the cause of unreasonable responses of anxiety towards the phobic stimulus, due to the patient's incorrect perception as to what the danger posed actually is.
- Cognitive distortions — the patient does not perceive the phobic stimulus accurately. Therefore, it may often appear grossly distorted or irrational e.g. mycophobia (a phobia of mushrooms) and rectaphobia (a phobia of bottoms).

Part 3 — Characteristics of Depression

- The behavioural characteristics of depression include changed activity levels (may result in psychomotor agitation or, on the other end of the spectrum, an inability to wake up and get out of bed in the morning), aggression (towards oneself and towards others, which may be verbal or physical) and changed in patterns of sleeping and eating (insomnia and obesity on one end of the spectrum, whilst constant lethargia and anorexia may appear on the other).
- The emotional characteristics of depression include lowered self-esteem, constant poor mood (lasting for months at a time and high in severity, therefore not simply 'feeling down') and high levels of anger (towards oneself and towards others).

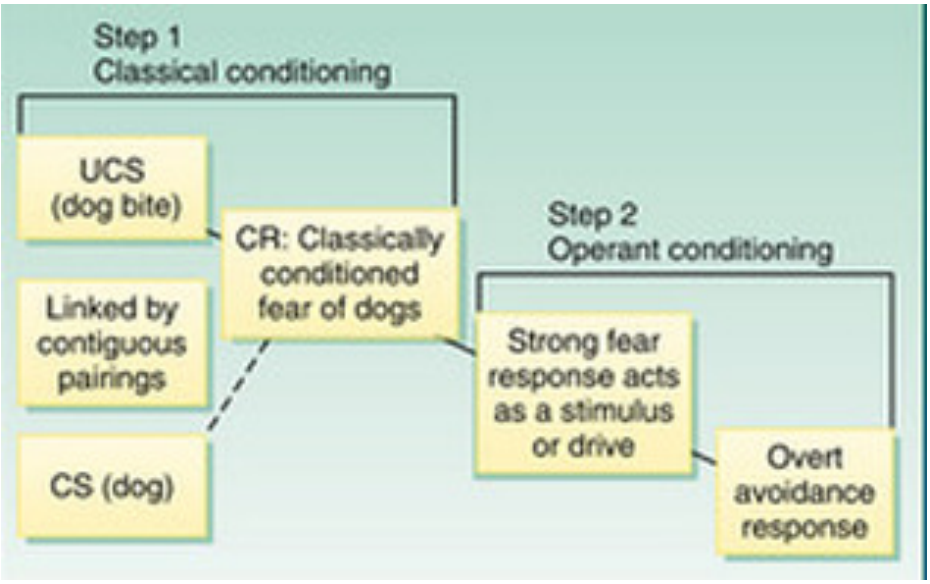
- The cognitive characteristics of depression include absolutist thinking (jumping to irrational conclusions e.g. "I am unable to visit my mother today and so I am a failure of a son"), selective attention towards negative events (patients with depression often recall only negative events in their lives, as opposed to positive) and poor concentration (the consequent disruptions to school and work add to the feelings of worthlessness and anger).

Part 4 — Obsessive-Compulsive Disorder (OCD)

- The main behavioural characteristics of OCD are compulsions (repetitive and intrusive thoughts focused around the stimulus which reduce anxiety through being a method of acting upon obsessive thoughts) and avoidance behaviour. This avoidance behaviour is once again negatively reinforced (in terms of classical conditioning) because an individual who avoids the specific stimulus will avoid the anxiety associated with having to carry out compulsive behaviours and suffer from obsessive thoughts.
- The emotional characteristics of OCD are guilt and disgust, depression (due to the constant compulsion to carry out compulsive/repetitive behaviours, which often interfere with day to day functioning and relationships) and anxiety (associated with the acknowledgement that the obsessive thoughts are irrational, but despair at the fact that they will always lead to compulsive behaviours).
- The cognitive characteristics of OCD include the patient's acknowledgement that their anxiety is excessive and irrational (a hallmark of OCD), the development of cognitive strategies to deal with obsessions (such as always carrying multiple bottles of hand sanitiser) and obsessive thoughts (these are repetitive, focus on the stimulus, are intrusive, cause excessive amounts of anxiety and lead to compulsive behaviours).

Part 5 — The Behavioural Approach to Explaining Phobias

Mowrer suggested that phobias are acquired through classical conditioning and then maintained through operant conditioning. Watson and Rayner demonstrated how Little Albert associated the fear caused by a loud bang with a white rat. He was exposed to a white rat (NS), producing no response. When paired with the loud bang (UCS), this produced the UCR of fear. Through several repetitions, Albert made the association between the rat (CS) and fear (CR). This conditioning then generalised to other objects e.g. white fluffy Santa Claus hats. Operant conditioning takes place when a behaviour is rewarded or punished. For example, phobics practice avoidance behaviours, meaning that they avoid the phobic stimulus. By avoiding this phobic stimulus, they avoid the associated fear. By avoiding such an unpleasant consequence, the avoidance behaviour is negatively reinforced and likely to be repeated again, hence maintaining the phobia.



+ - Good explanatory power - The main advantage of this theory is that it can explain the mechanism behind the acquisition and maintenance of phobias, which classical or operant conditioning alone cannot do. This translates to practical benefits in systematic desensitisation and flooding. Mowrer emphasises the importance of exposing the patient to the phobic stimulus because this prevents the negative reinforcement of avoidance behaviour. The patient realises that the phobic stimulus is harmless and that their responses are irrational/disproportionate, thus translating into a successful therapy.

— = Alternative explanation for avoidance behaviour (Buck) - Buck suggested that safety is a greater motivator for avoidance behaviour, rather than simply avoiding the anxiety associated with the phobic stimulus. For example, he uses the example of social anxiety phobias - such sufferers can venture out into public but only with a trusted friend, despite still being exposed to hundreds of strangers which would usually trigger their anxiety. This means that Mowrer's explanation of phobias may be incomplete and only suited for some.

— = Alternative explanation for the acquisition of phobias - Seligman suggested that we are more likely to develop phobias towards 'prepared' stimuli. These are stimuli which would have posed a threat to our evolutionary ancestors, such as fire or deep water, and so running away from such a stimulus increases the likelihood of survival and reproduction, and so this behaviour has a selective evolutionary advantage. This means that alternative theories can explain why some phobias (i.e. towards prepared stimuli) are much more frequent than other phobias (i.e. towards unprepared stimuli).

Part 6: The Behavioural Approach to Treating Phobias

Systematic desensitisation is a behavioural therapy designed to reduce phobic anxiety through gradual exposure to the phobic stimulus. It relies upon the principle of counterconditioning i.e. learning a new response to the phobic stimulus i.e. one of relaxation rather than panic. This works due to reciprocal inhibition i.e. it's impossible to be both relaxed and anxious at the same time. Firstly, the patient and therapist draw up an anxiety hierarchy together, made up of situations involving the phobic stimulus, ordered from least to most nerve-wrecking. The therapist then teaches the patient relaxation techniques e.g. breathing techniques and meditation, to be used at each of these anxiety levels. The patient works their way up through the hierarchy, only progressing to the next level when they have remained calm in the present level. The phobia is cured when the patient can remain calm at the highest anxiety level.

+ Supporting evidence = Gilroy et al. followed up 42 patients treated in three sessions of systematic desensitisation for a spider phobia. Their progress was compared to a control group of 50 patients who learnt only relaxation techniques. The extent of such phobias was measured using the Spider Questionnaire and through observation. At both 3 and 33 months, the systematic desensitisation group showed a reduction in their symptoms as compared to the control group, and so has been used as evidence supporting the effectiveness of flooding.

+ Systematic desensitisation is suitable for many patients, including those with learning difficulties = Anxiety disorders are often accompanied with learning disabilities meaning that such patients may not be able to make the full cognitive commitment associated with cognitive behavioural therapy, or have the ability to evaluate their own thoughts. Therefore, systematic desensitisation would be a particularly suitable alternative for them.

+ More acceptable to patients, as shown by low refusal and attrition rates. = This idea also has economical implications because it increases the likelihood that the patient will agree to start and continue with the therapy, as opposed to getting 'cold feet' and wasting the time and effort of the therapist!

Flooding is a behavioural therapy designed to reduce phobic anxiety in one session, through immediate exposure to the phobic stimulus. This occurs in a secure environment from which the patient cannot escape - without the option of practising avoidance behaviour, such behaviour is not reinforced and so the phobia is not maintained. Thus, in the case of a spider phobia, the patient will instantly be exposed to a room full of large spiders, which can crawl over them. This relies on the principle that it is physically impossible to maintain a state of heightened anxiety for a prolonged period, meaning tat eventually, the patient will learn that the phobic stimulus is harmless.

+ = Cost-effective - Ougrin compared flooding to cognitive therapies and found it to be cheaper. This is because the patient's phobia will typically be cured in one session, thus freeing them of their symptoms and allowing them to continue living a normal life.

— = Less effective for complex phobias. Social phobias involve both anxiety and a cognitive aspect i.e. thinking unpleasant thoughts about a situation. Thus, in such cases, cognitive therapy may be more appropriate because this therapy can target the distal causes of the phobia, as opposed to the mere proximal (indirect) causes. This suggests that alternatives may be more effective.

Part 7: The Cognitive Approach to Explaining Depression

Becks proposed that one has a cognitive vulnerability towards developing depression, through faulty information processing, negative self-schemas and the cognitive triad of automatic negative thoughts. Through faulty information processing, the patient blows small problems out of proportion, attending to and dwelling on the negative, whilst thinking in 'black and white' terms. Through negative self-schemas, the patient interprets all information about themselves from the world in a negative light, further lowering their self-confidence. Through the cognitive triad, the patient suffers from negative automatic thoughts about the self, the future and the world.

+ = Supporting research evidence - Grazioli and Terry's evaluation of 65 pregnant women for cognitive vulnerability and depression before and after birth. The researchers found a positive correlation between an increased cognitive vulnerability and an increased likelihood of acquiring depression after birth. This supports the link between faulty cognition and depression, which is in line with the predictions made by Beck's cognitive theory, thus increasing the validity of this theory.
+ = An increased understanding of the cognitive basis of depression translates to more effective treatments i.e. elements of the cognitive triad can be easily identified by a therapist and challenged as irrational thoughts on the patient's part. Thus, it translates well into a successful therapy and the consequent effectiveness of CBT (as discussed later on) is merit to the accuracy of Beck's cognitive theory as an explanation for depression.

Ellis proposed that an activating event (A), leads to an irrational belief (B), which results in an emotional consequence (C) in the form of depression. The key here is the specific interpretation of the irrational belief, which is why some people have depression, whilst others don't, according to the ABC model.

— = Ellis' ABC model cannot explain all types of depression, apart from those which clearly have an activating event i.e. reactive depression. However, many suffer from depression without an apparent cause, and may feel frustrated that their concerns/experiences are not reflected in this theory. Therefore, this suggests that the ABC model is limited at best.

+ = The ABC model shares the same advantage as Beck's cognitive theory in that it provides a practical application in CBT. The effectiveness of CBT suggests that identifying and challenging irrational beliefs are at the core of 'curing' depression, which in turn supports the theoretical basis of the ABC model, through a specific focus on the role of faulty cognitions in the development of depression and specifically, in the interpretation of an activating event.

— = Both the ABC model and Beck's cognitive theory of depression share the same disadvantage in that they cannot explain all aspects of depression e.g. hallucinations, anger, Cotard Syndrome. This poses a particularly difficult practical issue in that patients may become frustrated that their symptoms cannot be explained according to this theory and therefore cannot be addressed in therapy.

Part 8: The Cognitive Approach to Treating Depression

CBT aims to identify and challenge irrational thoughts, replacing them with more productive behaviours, and thus treating depression. Beck's CBT aims on identifying the patient's thoughts

and challenging them as irrational. This can be guided by the cognitive triad of automatic negative thoughts (negative thoughts about the self, the future and the world), faulty information processing and negative self-schemas. Cognitive therapy also aims for patients to test the reality of their beliefs. For example, a patient may record each time someone was nice to them for the past week. Next time they say that everyone hates them, the therapist can point towards the journal as counter-evidence, thus proving the patient's beliefs as irrational. This demonstrates the idea of 'patient as scientist'. Ellis's rational emotive behaviour therapy aims to identify the patient's thoughts and challenge them as irrational, leading to a vigorous argument. This may be a logical argument (i.e. the belief doesn't follow on logically from the facts) or an empirical argument (there is no evidence to support the irrational belief). Thus, this aims to change the irrational belief and to break the link between negative life events and depression. Through behavioural activation, patients are encouraged to engage in enjoyable activities, to provide further counter-evidence for their irrational beliefs.

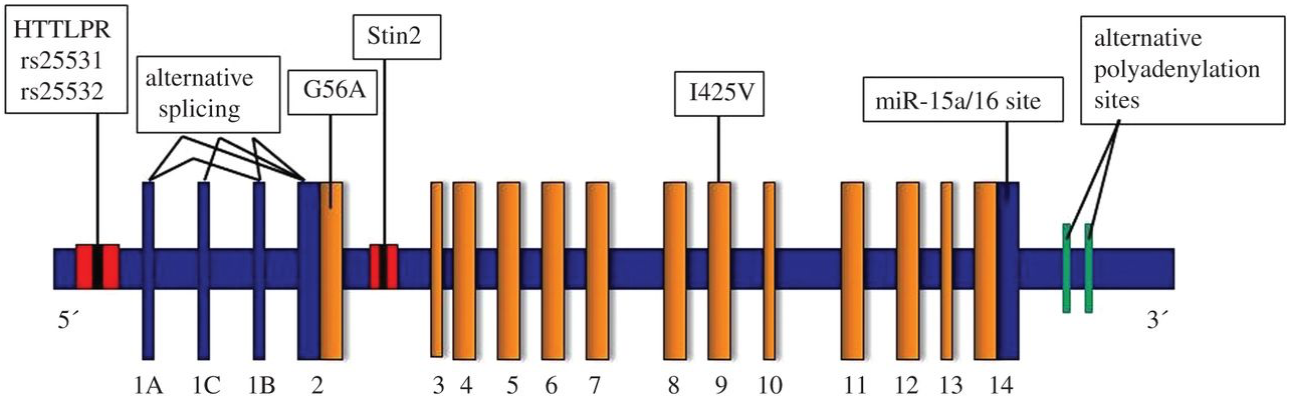
+ = Supporting research evidence - March followed a group of 327 adolescents with a main diagnosis of depression. After 36 weeks - 81%, 81% and 86% were the respective improvement rates for each of the three experimental conditions (CBT, antidepressants, CBT+ antidepressants). Therefore, this is compelling evidence for the idea that antidepressants are effective in treating depression and are based on accurate biological explanations of depression i.e. linked to the role of serotonin and noradrenaline in the development of depression.

— = CBT may not be an appropriate treatment for all cases of depression, and particularly the most severe cases. This idea could also have been reflected in the evidence provided by March et al, where a combination of CBT and antidepressants is the most effective combination. This is because those with severe depression may not be able to attend the regular CBT sessions, due to a lack of motivation/ an inability to get out of bed in the morning, and also may feel completely hopeless i.e. that they are beyond help. This means that CBT cannot be used to address all cases of depression, and arguably is not suitable for cases which need help the most!

— = The focus of the cognitive approach is on present life and the present challenges which life presents. It is then assumed that the patient's current circumstances are responsible for their depression. However, a considerable number of patients may be aware of specific past events which may be responsible for their depression, such as a traumatic life event or the death of a loved one. Therefore, since CBT therapists are unwilling to 'dwell on the past', patients may become frustrated that they have such little input or say into how their therapy is brought about.

Part 9: The Biological Approach to Explaining OCD

The genetic explanation, through the diathesis-stress model, suggests that some have a genetic vulnerability towards developing depression. For example, Lewis et al. found that of his OCD patients, 37% had parents with OCD and 21% had siblings with OCD. OCD is polygenic, meaning that up to 230 different genes are involved in its development (Taylor). These are often associated with the functioning of neurotransmitters, such as dopamine and serotonin, both associated with regulating mood. Researchers have identified candidate genes which increase a person's



vulnerability towards developing OCD. One of these is 5HT1-D beta, which is implicated in the efficiency of serotonin transport across synapses. OCD is also aetiologically heterogenous, meaning that its origin has many different causes. For example, it has been suggested that hoarding disorder is caused by a particular genetic variation.

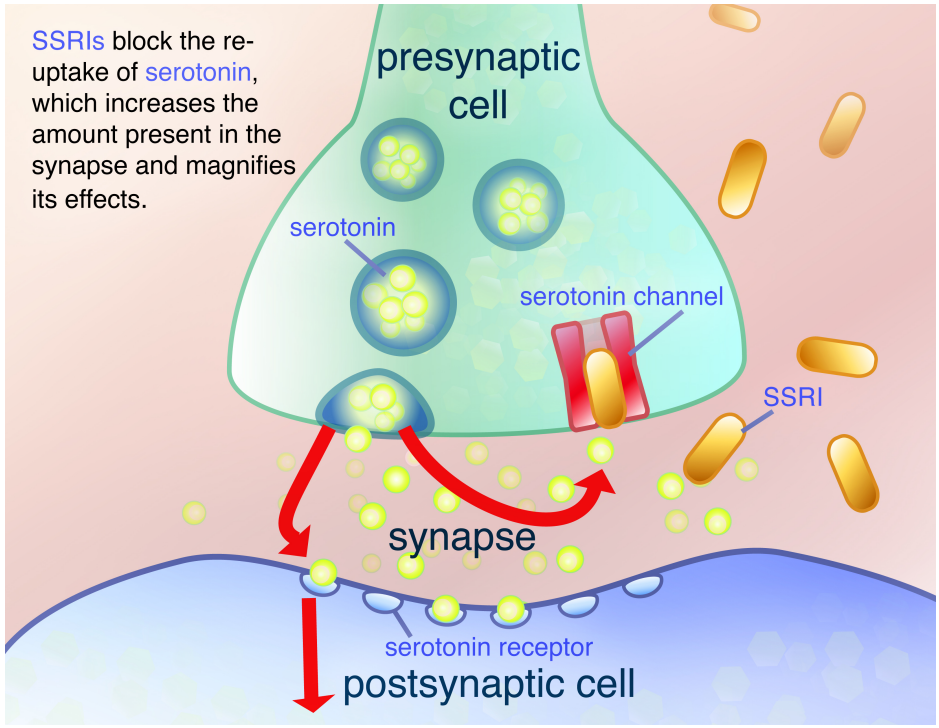
+ = Supporting evidence - Nestadt et al. reviewed previous twin studies of OCD and found that 68% of identical twins, compared to 31% of non-identical twins, share OCD. This strongly suggests that there is a genetic basis for this disease because identical twins share 100% of their genes with each other, whilst dizygotic twins only share 50% of genes with each other. However, it is important not to be deterministic - just because an individual has a particular combination of candidate genes does not mean that the individual is 'doomed' to develop OCD, but rather that this genetic vulnerability must be paired with an environmental stressor to result in OCD, as dictated through the diathesis-stress model.

— = Too many candidate genes = With over 230 candidate genes each individually coding for an increased risk of OCD, then this poses a practical issue in that it is difficult to assess which candidate genes have the greatest influence and so which genes drug treatments should target. Thus, such an explanation is likely to have little predictive value in the future.

— = Ignores environmental factors = Cromer et al. found that of his OCD patients, over half had experienced a trauma in their lives, and that there was a positive correlation between an increasing number of traumas and the increasing severity of the OCD which patients suffered from.

Part 10: The Biological Approach to Treating OCD

- Selective serotonin reuptake inhibitors (SSRIs) act on the serotonin system by preventing the reuptake and breaking down of serotonin by the presynaptic neuron. Thus, the concentration of serotonin within the synapse increases, causing the post-synaptic neuron to be continually stimulated.
- Tricyclics have a similar effect, but are reserved for those who do not respond well to SSRIs. Selective noradrenaline-reputake inhibitors (SNRIs) increase the concentration of the noradrenaline neurotransmitter in the brain.



— A limitation of drug therapy are the serious side effects. For example, for those taking Clomipramine, more than one in 10 suffer from erection problems, weight gain and tremors. More than 1 in 100 suffer from increased heart rate and aggressiveness. These side effects can have serious implications on how the patient can go about their everyday lives.

+ Increased knowledge about the effectiveness of certain drug treatments for OCD and cognitive treatments can reduce the time people take off work through sick days, thus increasing the productivity of the workforce and ensuring that more people are working. This means that more

people will be paying taxes. Research into the cost-effectiveness of treatments for OCD (and other psychiatric disorders) can be the basis of public health services choosing which treatments they use, which can help organisations like the NHS save money.

— A strength of such drug use is that it's cost-effective and non-disruptive. They are cheap compared to psychological treatments, and so prove to be good value for public health organizations like the NHS. They are also non-disruptive. Patients can discretely take the drugs to manage their symptoms and lead a relatively normal life, as compared to life in hospital.