



AQA Psychology A-level

Clinical Psychology and Mental Health

Summary Notes

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Part 1: Definitions in the Field of Mental Health

1. Deviation from Ideal Mental Health

Deviation from Ideal Mental Health was proposed by **Jahoda (1958)**, who focused on what represents ideal psychological wellbeing rather than abnormality. She suggested that individuals are considered abnormal if they do not meet certain criteria for good mental health. Jahoda identified six criteria for ideal mental health:

- **Positive attitude towards the self** – having high self-esteem and a strong sense of identity.
- **Self-actualisation** – achieving one's full potential.
- **Accurate perception of reality** – being able to see yourself and the world realistically.
- **Resistance to stress** – being able to cope effectively with life's challenges.
- **Autonomy** – being independent and able to make your own decisions.
- **Mastery of the environment** – being able to successfully manage everyday demands, such as work and relationships.

AO3 - EVALUATION

A limitation of deviation from ideal mental health is that it sets **unrealistic standards for psychological wellbeing**. Jahoda's criteria are very **demanding**, and it is unlikely that **most individuals** would meet all of them at all times. For example, many people may struggle with coping with stress or maintaining high self-esteem, yet would not be considered **clinically abnormal**. This suggests that a **large proportion of the population** could be classified as "abnormal" under this definition, even when they are functioning adequately in everyday life. Therefore, deviation from ideal mental health may **over-pathologise normal behaviour**, reducing its **validity** as a definition of abnormality.

A further limitation of deviation from ideal mental health is that it is **culturally relative**. Jahoda's criteria are based on **Western values**, such as self-actualisation, which emphasises personal growth and putting the individual first. However, in **collectivist cultures** such as China, prioritising the self may be viewed as **selfish**, as greater importance is placed on the needs of the group. In contrast, **individualist** cultures such as the UK are more likely to value personal achievement and **independence**. This suggests that what is considered "ideal" mental health **varies** across cultures, meaning this definition cannot be applied universally. Therefore, deviation from ideal mental health lacks cultural validity as a definition of abnormality.



2. Deviation from Social and Cultural Norms

Deviation from **social and cultural norms** suggests that behaviour is considered abnormal when it **deviates from the accepted rules and expectations** of a particular **society or culture**.

These norms are **socially constructed** and vary depending on the **culture and context** in which a person lives. A behaviour may be considered **normal in one culture** but **unusual or unacceptable in another**.

→ **For example**, walking around in public without shoes on may be viewed as **abnormal in the UK** because it goes against expectations of **appropriate dress and behaviour**. However, in **Australia**, going barefoot in public is more **socially accepted** and may not be considered abnormal.

AO3 - EVALUATION

A strength of deviation from social and cultural norms is that it can be **useful for identifying behaviours that may be harmful to the individual or others**. Social norms often exist because they help maintain safety and order within society. For example, **extreme violence** or dangerous behaviour would be considered **abnormal** in most cultures because it threatens the wellbeing of others. This means the definition has **practical value** because it allows psychologists to identify behaviours that may require **intervention and support**. Therefore, deviation from social and cultural norms can be a useful way of recognising some forms of abnormal behaviour.

A limitation of deviation from social and cultural norms is that it may lead to **cultural bias in the diagnosis of mental health disorders**. Behaviours that are considered abnormal in one culture may be viewed as normal or even valued in another. Hearing voices may be considered a symptom of schizophrenia in many Western cultures, whereas some African and Asian cultures may interpret this experience as a spiritual connection with ancestors. This suggests that definitions based on social norms may **not apply universally across cultures**. In a culturally diverse society such as the UK, this could contribute to some groups being **over-represented or under-represented in mental health diagnoses** if clinicians judge behaviour using the values of the dominant culture. Therefore, deviation from social and cultural norms may lack **cultural validity** as a universal definition of abnormality.





3. Failure to Function Adequately

Failure to function adequately suggests that abnormality occurs when an individual is **unable to cope with everyday life**.

Rosenhan and Seligman (1989) suggested that abnormal behaviour can be identified through several signs, including:

- **Distress** – experiencing significant emotional suffering.
- **Maladaptive behaviour** – behaviour that prevents an individual from functioning effectively.
- **Socially inappropriate behaviour** – behaviour that breaks expected social rules.
- **Dangerous behaviour** – behaviour that may cause harm to themselves or others.

This definition considers both the **individual's perspective** (such as personal distress) and the views of others, such as **family members or professionals**, when deciding whether behaviour is abnormal.

AO3 - EVALUATION

A strength of failure to function adequately is that it provides **clear criteria for identifying when an individual may need support**. By outlining **signs** such as **distress**, inability to cope with everyday life and behaviour that may be harmful to themselves or others, it gives professionals and others a **framework** for recognising potential mental health difficulties. Therefore, failure to function adequately has **practical value** because it can help identify individuals who may benefit from **mental health support**.

A limitation of failure to function adequately is that it assumes there is a **universal standard for what is considered 'normal' functioning**. What is considered normal behaviour can vary depending on an individual's **age, circumstances and lifestyle**. For example, a university student may have an irregular routine, sleep pattern or social behaviour that would appear unusual compared with a 35-year-old parent with children, but this does not mean the student is experiencing a mental health disorder. This suggests that failure to function adequately may **incorrectly label individuals as abnormal** simply because their lifestyle differs from social expectations. Therefore, this definition may lack **validity** because it does not fully consider **individual differences** in what constitutes normal functioning.



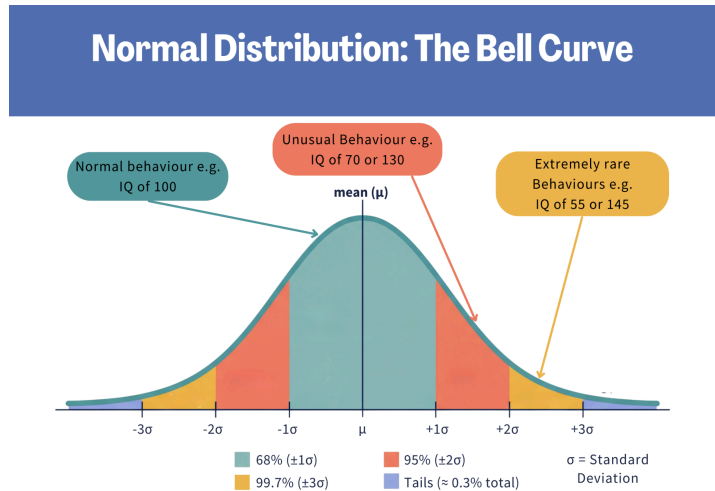


4. Statistical Infrequency

Statistical infrequency suggests that behaviour is considered abnormal if it is **rare or unusual** compared to the **majority of the population**.

This definition is based on the idea that characteristics which occur **less frequently** are more likely to be considered abnormal. A behaviour is considered statistically abnormal if it falls more than **two standard deviations away from the mean** on a **normally distributed bell curve**.

- For example, having an IQ below **70** is considered **statistically unusual** and may be used as part of the diagnosis of **intellectual disability**.



AO3 - EVALUATION

A strength of statistical infrequency is that it is useful in the **diagnosis of some mental health disorders**. Psychologists often compare an individual's characteristics against **population averages** to identify how far they deviate from what is considered typical. For example, schizophrenia affects around **1% of the population**, meaning that experiencing symptoms associated with schizophrenia is statistically unusual. Therefore, statistical infrequency can be useful as part of the **diagnostic process** because it provides an **objective measure** for assessing how rare and severe a behaviour may be.

A limitation of statistical infrequency is that it assumes that **anything unusual is automatically abnormal or undesirable**. However, some rare characteristics are considered **positive rather than problematic**. For example, an IQ score above 130 is statistically unusual, but it is associated with **high intelligence** rather than a mental disorder. Similarly, unusually high levels of empathy may be considered a **positive trait** rather than something requiring treatment. Therefore, statistical infrequency lacks **validity as a complete definition of abnormality** because **rarity alone does not determine whether a behaviour is harmful or requires treatment**.





Part 2: Characteristics of Phobias

Behavioural characteristics – what the individual **does** or how they **act**.

Cognitive characteristics – how the individual **thinks** and **processes information**.

Emotional characteristics – how the individual **feels** emotionally

Two common **behavioural** characteristics to phobias are panic and avoidance.

1. **Panic** - the individual experiences **heightened physiological arousal** when exposed to the phobic stimulus. This occurs because the hypothalamus activates the sympathetic branch of the autonomic nervous system (ANS) causing symptoms of **anxiety**.
2. **Avoidance** - the individual attempts to **avoid the phobic stimulus**. This is **negatively reinforced** because avoiding the stimulus removes the unpleasant anxiety response, making avoidance more likely in the future. This can interfere with everyday life.

The main **emotional** characteristic of phobias is anxiety, which is the emotional consequence of the physiological response of panic.

1. **Anxiety** – the individual experiences intense **fear and distress** when faced with the phobic stimulus. This emotional response is often **disproportionate** to the actual threat posed. For example, **xanthophobia** is a fear of the colour yellow, despite it posing little or no danger.

The **cognitive** characteristics of phobias are selective attention to the phobic stimulus, irrational beliefs and cognitive distortions:

1. **Selective attention**- the individual focuses excessively on the **phobic stimulus**, even when it causes significant anxiety. This may maintain the fear by making the stimulus appear more threatening.
2. **Irrational beliefs** - the individual has **unrealistic thoughts** about the danger posed by the phobic stimulus, leading to an exaggerated fear response.
3. **Cognitive distortions** - the individual's perception of the phobic stimulus is **inaccurate or exaggerated**, causing it to appear more threatening than it actually is. For example, someone with **mycophobia** (fear of mushrooms) may perceive mushrooms as extremely dangerous despite them posing little threat.





Part 3: Characteristics of Depression

Behavioural characteristics – what the individual **does** or how they **act**.

Cognitive characteristics – how the individual **thinks** and **processes information**.

Emotional characteristics – how the individual **feels** emotionally

The **behavioural** characteristics of depression include changes in activity levels, aggression, and changes in sleeping and eating patterns.

1. **Changes in activity levels** – individuals may experience **psychomotor agitation**, where they become restless and unable to stay still, or the opposite, where they experience **low energy and reduced activity levels**, making everyday tasks difficult.
2. **Aggression** – individuals may show **aggression towards themselves or others**, which can be verbal or physical.
3. **Changes in sleeping and eating patterns** – individuals may experience insomnia/hypersomnia, weight gain or reduced appetite.

The **emotional** characteristics of depression include low self-esteem, persistent low mood and anger.

1. **Low self-esteem** – individuals experience negative feelings about themselves, including **worthlessness** and guilt.
2. **Persistent low mood** – individuals experience a **long-lasting and severe depressed mood**, rather than simply feeling temporarily unhappy.
3. **Anger** – individuals may experience increased **anger towards themselves or others**, which may be expressed verbally or physically.

The **cognitive** characteristics of depression include absolutist thinking, selective attention and poor concentration.

1. **Absolutist thinking** – individuals may use **black-and-white thinking**, leading to irrational conclusions. “I failed my exam, so I am a failure and will never achieve anything.
2. **Selective attention** – individuals focus on **negative information** while ignoring positive events or experiences.
3. **Poor concentration** – individuals may struggle to **focus and process information**, which can affect school, work and everyday functioning.





Part 4: Obsessive-Compulsive Disorder (OCD)

Behavioural characteristics – what the individual **does** or how they **act**.

Cognitive characteristics – how the individual **thinks** and **processes information**.

Emotional characteristics – how the individual **feels** emotionally

The **behavioural** characteristics of OCD include compulsions and avoidance behaviour.

1. **Compulsions** – these are **repetitive behaviours** carried out to reduce the anxiety caused by obsessive thoughts. For example, excessive hand washing may be used to reduce fears about contamination.
2. **Avoidance behaviour** – individuals may avoid situations linked to their obsessions because this reduces anxiety. This is **negatively reinforced** because avoiding the stimulus removes the unpleasant feelings associated with the obsession, making avoidance more likely in the future.

The **emotional** characteristics of OCD include anxiety, guilt and disgust, and depression.

1. **Anxiety** – individuals experience high levels of **anxiety** caused by obsessive thoughts and the need to carry out compulsive behaviours, despite recognising that these thoughts may be irrational.
2. **Guilt and disgust** – individuals may experience **negative emotions** linked to their obsessive thoughts, particularly if they involve fears of causing harm or contamination.
3. **Depression** – individuals may experience **low mood** due to the distress caused by obsessions and compulsions, which can interfere with everyday life and relationships.

The **cognitive** characteristics of OCD include obsessive thoughts, recognition that thoughts are irrational and cognitive strategies.

1. **Obsessive thoughts** – these are **intrusive and repetitive thoughts** that focus on a particular fear or concern and create high levels of anxiety.
2. **Recognition of irrational thoughts** – individuals with OCD often understand that their thoughts and behaviours are **excessive or unreasonable**, but feel unable to control them.
3. **Cognitive strategies** – individuals may develop strategies to manage their anxiety, such as carrying hand sanitiser at all times to reduce fears about contamination.





Part 5: The Behavioural Approach to Explaining Phobias

Mowrer (1947) proposed the **two-process model**, suggesting that phobias are *acquired* through **classical conditioning** and *maintained* through **operant conditioning**.

Classical conditioning (acquisition)

A phobia can be **acquired through association**:

- A **neutral stimulus (NS)** is initially not associated with fear.
- The NS is paired with something **frightening**.
- Through **repeated pairings**, the NS becomes associated with fear.
- The stimulus becomes a **conditioned stimulus (CS)** that produces a **conditioned fear response (CR)**.
- The person therefore learns that the stimulus is **threatening**, even when the frightening event is no longer present.

Example: Watson and Rayner (1920) demonstrated this in the **Little Albert study**. The white rat was initially a **neutral stimulus (NS)**. It was paired with a loud bang (**UCS**), which naturally produced fear (**UCR**). After repeated pairings, the rat became a **conditioned stimulus (CS)** that produced a learned fear response (**CR**). Albert's fear also **generalised** to similar stimuli, such as white fluffy objects.

Operant conditioning (maintenance)

Once a phobia has developed, it can be **maintained through negative reinforcement**:

- The person encounters the **phobic stimulus** and experiences **fear or anxiety**.
- They **avoid or escape** from the phobic stimulus.
- Avoidance causes the **fear or anxiety to decrease**.
- This reduction in fear makes **avoidance more likely to happen again**.
- Repeated avoidance means the person does not learn that the stimulus is **actually safe**, so the **phobia is maintained**.

Example: A person with a fear of dogs may cross the road when they see a dog. Their anxiety decreases when they move away, reinforcing the avoidance behaviour and preventing them from learning that most dogs are not dangerous.



AO3 - EVALUATION

A strength of the behaviourist explanation of phobias is that it has **led to effective treatments**.

Mowrer's two-process model (1947) has been used to develop treatments such as **systematic desensitisation and flooding**, which are based on **exposure therapy and counterconditioning**. These treatments aim to reduce phobic responses by changing the **learned association** between the phobic stimulus and fear. Therefore, the effectiveness of these treatments supports the **validity** of the behaviourist explanation, as it shows that understanding how phobias are acquired and maintained can lead to successful interventions.

A weakness of the behaviourist approach to explaining phobias is that it may **not fully explain avoidance behaviour**. **Deacon and Maack (2008)** suggested that avoidance may be driven by the presence of **safety signals**, rather than simply reducing anxiety through **negative reinforcement** as proposed by **Mowrer's two-process model**. For example, individuals with **social anxiety** may be able to go out in public if they are accompanied by a **trusted friend**, despite still being exposed to large numbers of strangers that would usually trigger anxiety. This suggests that avoidance is not always about escaping the **phobic stimulus** itself, but about feeling safe in the situation. Therefore, the behaviourist explanation may be **too simplistic**, as it does not fully account for the role of **safety signals** in maintaining phobias, reducing its **overall validity**.

A weakness of the behaviourist approach to explaining phobias is that it **may not provide a complete explanation for the acquisition of all phobias**. **Seligman (1971)** proposed that humans are **biologically prepared** to develop phobias towards certain '**prepared**' stimuli that would have posed a threat to our evolutionary ancestors, such as **fire or deep water**. Avoiding these stimuli would have increased the chances of **survival and reproduction**, meaning this behaviour could have been passed on through **natural selection**. Therefore, **evolutionary explanations** provide an alternative account for why some phobias are more common than others, suggesting that the behaviourist approach may overlook the role of **evolution** in phobia development.





Part 6: The Behavioural Approach to Treating Phobias

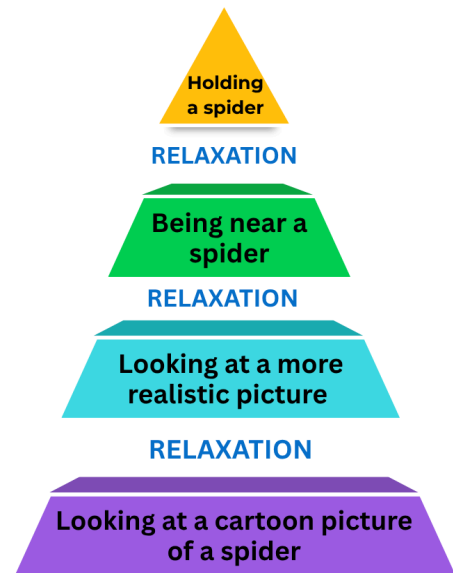
Systematic Desensitisation

Systematic desensitisation is a **behavioural therapy** used to treat phobias through **gradual exposure** to the phobic stimulus. It is based on **counterconditioning**, where the individual learns a new response of relaxation instead of fear. This occurs through **reciprocal inhibition**, which suggests that it is impossible to experience anxiety and relaxation at the same time.

Systematic desensitisation involves three main stages that gradually reduce the individual's fear response towards the phobic stimulus:

1. **Fear hierarchy** – the individual and therapist create a hierarchy of situations involving the phobic stimulus, ranked from **least to most anxiety-provoking**.
2. **Relaxation techniques** – the individual is taught techniques such as **breathing exercises and meditation** to help them remain calm when exposed to the phobic stimulus.
3. **Gradual exposure** – the individual works through the anxiety hierarchy, starting with the least anxiety-provoking situation. They only move to the next stage once they can remain relaxed. The phobia is considered overcome when the individual can face the most anxiety-provoking situation without experiencing fear.

FEAR HIERARCHY



AO3 - EVALUATION

A strength of systematic desensitisation is that it is **supported by research evidence**. **Gilroy et al. (2003)** followed up **42 patients with a spider phobia** who received three sessions of systematic desensitisation. Their progress was compared to a **control group of 50 patients** who only received relaxation techniques, with the severity of their phobia measured using the Spider Questionnaire and behavioural observations. The researchers found that the systematic desensitisation group showed **greater reductions in phobic symptoms** than the control group at both **3 and 33 months**. This suggests that systematic desensitisation is effective in reducing phobic responses and producing **long-lasting improvements**, supporting its **practical effectiveness** as a treatment for phobias.





A further strength of systematic desensitisation is that it is **suitable for a wide range of patients**. This is because, unlike **flooding**, which involves immediate and intense exposure to the phobic stimulus, systematic desensitisation uses **gradual exposure alongside relaxation techniques**, making the treatment **less distressing** for patients. Therefore, it may be more appropriate for **vulnerable individuals**, such as children, older adults and those with learning difficulties, who may find more intense treatments difficult to tolerate. This greater acceptability is reflected in **lower refusal and attrition (drop-out) rates**, meaning patients are more likely to complete the therapy and achieve **long-term improvements**.

A limitation of systematic desensitisation is that it may have **limited practical usefulness due to the time and resources required**. Systematic desensitisation is based on a **gradual build-up of repeated exposure sessions** with a trained therapist. This can place pressure on **mental health services**, contributing to **long waiting lists**, meaning that some individuals may not receive treatment when they need it. Therefore, although systematic desensitisation can be an effective treatment for phobias, its reliance on **therapist time and multiple sessions** may reduce its **accessibility in real-world settings**.



Flooding

Flooding, first used by **Thomas Stampfl (1967)**, is another **behavioural therapy** designed to reduce phobic anxiety through **immediate exposure** to the phobic stimulus, often within a single session. The individual is placed in a **safe environment** and prevented from escaping or using **avoidance behaviours**. As avoidance is prevented, it is no longer **negatively reinforced**, meaning the phobia is not maintained.

Habituation occurs because the body cannot maintain a state of **high physiological arousal** indefinitely. Therefore, anxiety naturally decreases over time, allowing the individual to learn that the phobic stimulus is not dangerous and weakening the association between the stimulus and fear.

AO3 - EVALUATION

A strength of flooding is that it is a **cost-effective treatment for phobias**. **Ougrin et al. (2011)** compared flooding with cognitive therapies and found that flooding was **cheaper** because the treatment can often be completed in **fewer sessions**. This means patients can overcome their phobia **more quickly**, allowing them to return to normal activities sooner and reducing the **time and resources** required from therapists. Therefore, flooding has **practical value** because it can provide an effective treatment for phobias while reducing the **financial and time costs** associated with therapy.

A further strength of flooding is that it can be **adapted through the use of virtual reality (VR)**, **making exposure therapy more practical and accessible**. VR allows individuals to be exposed to a **realistic representation** of their **phobic stimulus** in a **controlled environment**, without needing to encounter the stimulus in real life. This can be particularly useful for phobias where **real-life exposure is difficult**, such as flying or swimming in the sea. Therefore, the use of **VR** increases the **practical value** of flooding because it allows exposure to take place in a **safer and more manageable way**, improving the **accessibility of treatment**.

A limitation of flooding is that it may be **less effective for more complex phobias, particularly those involving cognitive factors**. **Social phobias**, for example, are not only associated with **anxiety responses** but also involve **negative thoughts and beliefs** about social situations, such as fears of **embarrassment or judgement**. In these cases, **cognitive therapies** may be more appropriate because they target the **underlying thoughts** maintaining the phobia, whereas flooding mainly focuses on reducing the **fear response through exposure**. Therefore, flooding may provide only a **limited treatment** for some phobias, reducing its **overall effectiveness**.





Part 7: The Cognitive Approach to Explaining Depression

Beck's Cognitive Theory (1967)

Beck's (1967) cognitive theory suggests that individuals have a **cognitive vulnerability** towards developing depression. This occurs through three main processes:

1. Faulty information processing

- Individuals with depression process information in a **negative and biased way**.
- They may **focus on negative events**, exaggerate problems and use **black-and-white thinking**.
- This means small problems may appear much worse than they actually are.

2. Negative self-schemas

- Individuals develop **negative beliefs about themselves** based on past experiences.
- This causes them to interpret new information in a negative way, lowering **self-esteem** and reinforcing feelings of worthlessness.

3. Cognitive triad

- Individuals experience **negative automatic thoughts** about three areas:
 - **The self** – “I am worthless.”
 - **The world** – “The world is unfair.”
 - **The future** – “Things will never improve.”

AO3 - EVALUATION

A strength of the cognitive approach to explaining depression is that it is **supported by research evidence**. **Grazioli and Terry (2000)** assessed **65 pregnant women** for **cognitive vulnerability** and levels of depression both before and after giving birth. They found a **positive correlation** between higher levels of cognitive vulnerability and a greater likelihood of developing **postnatal depression**. This supports **Beck's cognitive theory**, as it suggests that **negative thought patterns and dysfunctional beliefs** can increase an individual's vulnerability to depression, increasing the **validity of the cognitive explanation**.

A strength of the cognitive approach to explaining depression is that it has **practical applications in the treatment of depression**. Beck's cognitive theory identifies **negative thoughts within the cognitive triad**, which can be challenged by therapists as irrational and replaced with more realistic ways of thinking. This forms the basis of **cognitive behavioural therapy (CBT)**, where patients are encouraged to identify and challenge **negative thought patterns**. Therefore, the **success of CBT** provides support for Beck's theory, as it suggests that targeting **faulty cognition** can be an effective way of reducing depressive symptoms.



Ellis' ABC model (1962)

Ellis (1962) proposed the **ABC model**, suggesting that depression is caused by an individual's **irrational beliefs** about events, rather than the events themselves.

A – Activating event

- This is the situation or event that happens to the individual.
- The event itself does not directly cause depression.

B – Irrational Belief

- The individual develops a **negative or irrational interpretation** of the activating event.
- This interpretation determines whether the person experiences depression.

C – Emotional Consequence

- The irrational belief leads to negative emotional consequences, such as **depression**.

For example, failing an exam (**activating event**) does not automatically cause depression. However, believing “**I am a failure and I will never achieve anything**” (**irrational belief**) may lead to feelings of worthlessness and depression (**emotional consequence**).

AO3 - Evaluation

A strength of Ellis' ABC model is that it has **practical applications in the treatment of depression**. The model led to the development of **Rational Emotive Behaviour Therapy (REBT)**, where therapists help individuals identify and challenge **irrational beliefs** that contribute to negative emotional consequences. The effectiveness of **REBT** suggests that changing **faulty interpretations of activating events** can reduce depressive symptoms, supporting Ellis' explanation that depression is influenced by **irrational thinking patterns**. Therefore, the **success of REBT** provides support for the **ABC model**, increasing its **validity as an explanation of depression**.

A limitation of Ellis' ABC model is that it may provide a limited explanation of depression because it **focuses too heavily on the role of irrational beliefs**. Some individuals develop depression without a clear **activating event**, suggesting that other factors may be involved. For example, **Sullivan et al. (2000)** found evidence for a **genetic vulnerability to depression**, suggesting that **biological factors** may contribute to the development of depression. Therefore, Ellis' ABC model may be **too reductionist**, as it does not fully explain the range of **biological and environmental factors** involved in depression, reducing its **explanatory validity**.





A limitation of cognitive explanations of depression is that they **cannot explain all aspects of the disorder**. Both **Beck's cognitive theory** and **Ellis' ABC model** focus on the role of **faulty cognitions**, such as **negative thoughts and irrational beliefs**, in the development of depression. However, some symptoms of depression, such as **hallucinations, extreme anger and Cotard's syndrome**, are difficult to explain through cognitive processes alone. This suggests that cognitive explanations may provide an **incomplete account of depression**, as they overlook other factors, such as **biological influences**, that may contribute to the disorder.



Part 8: The Cognitive Approach to Treating Depression

Cognitive Behavioural Therapy (CBT)

CBT is a psychological treatment that aims to reduce depression by **challenging negative thoughts** and **replacing** them with more realistic ways of thinking. This is achieved through several techniques:

1. Identifying negative thoughts

- Therapists help individuals recognise negative automatic thoughts linked to **Beck's cognitive triad**, **faulty information processing** and **negative self-schemas**.
- These thoughts are then challenged and replaced with more realistic alternatives.

2. Testing reality ("patient as scientist")

- Individuals are encouraged to **collect evidence** to test whether their negative beliefs are accurate.
- For example, a patient who believes "everyone dislikes me" may record times when others are kind or supportive. This evidence can then be used to challenge their belief.

3. Behavioural activation

- Individuals are encouraged to engage in enjoyable and rewarding activities.
- This provides **counter-evidence** against negative beliefs and helps improve mood.

Rational Emotive Behaviour Therapy (REBT)

Ellis' REBT aims to reduce depression by challenging **irrational beliefs** that develop following negative life events. Ellis argued that it is these irrational beliefs, rather than the event itself, that lead to negative emotional consequences such as depression. Therefore, treatment focuses on changing the individual's interpretation of events.

Disputing irrational beliefs – therapists challenge irrational beliefs through a process of **vigorous argument**, with the aim of replacing them with more realistic beliefs.

- **Logical argument** – the therapist challenges whether the belief follows logically from the facts. *Example: "Does failing one exam logically mean you are a failure?"*
- **Empirical argument** – the therapist challenges whether there is evidence to support the belief. *Example: "What evidence shows that you will never succeed?"*



AO3 - EVALUATION

A strength of CBT as a treatment for depression is that it is **supported by research evidence**.

March et al. (2007) compared the effectiveness of **CBT, antidepressants and a combination of both treatments** in **327 adolescents with depression**. After **36 weeks**, improvement rates were **81% for CBT**, showing that CBT can be an **effective treatment** for reducing depressive symptoms. This supports the **practical value of CBT** because it suggests that challenging **negative thoughts and irrational beliefs** can help individuals manage depression. However, the fact that the **combined treatment produced the highest improvement rate** suggests that depression may not be explained by **cognitive factors alone** and that **biological factors** may also play an important role. Therefore, the cognitive approach has some **validity**, but it may provide an **incomplete explanation of depression**.

A strength of REBT as a treatment for depression is that it is **supported by research evidence**.

David et al. (2008) compared the effectiveness of **REBT, medication and a placebo treatment** for individuals with depression. They found that **REBT was effective in reducing depressive symptoms**, suggesting that challenging **irrational beliefs** can be a useful treatment approach. Therefore, this supports the **effectiveness of REBT** and increases its **practical validity** as a treatment for depression.

A limitation of CBT as a treatment for depression is that it may **not be suitable for individuals with severe depression**. CBT requires individuals to **actively engage with therapy** by identifying and challenging negative thoughts. However, people experiencing severe depression may have symptoms such as **low motivation, hopelessness and poor concentration**, which may make it difficult to participate effectively in treatment. This suggests that CBT relies on individuals having the **ability and motivation to engage** with the process, which may not apply to everyone with depression. Therefore, CBT may not be an **effective standalone treatment for more severe cases of depression**, reducing its **usefulness as a treatment for all individuals**.

A limitation of the cognitive approach to treating depression is that CBT may place **too much focus on current thoughts and experiences while ignoring the influence of past events**.

CBT aims to identify and challenge **negative thinking patterns** in the present, but some individuals may believe their depression is linked to significant past experiences, such as **trauma or bereavement**. If therapists focus mainly on changing current thoughts rather than exploring the causes of these experiences, patients may feel that important factors contributing to their depression are being ignored. This suggests that CBT may not fully consider the **complex causes of depression**, reducing its effectiveness for individuals whose symptoms are linked to past events. Therefore, the cognitive approach may provide an **incomplete treatment** for depression by focusing more on present thinking patterns than the **wider life experiences** that may contribute to depressive symptoms.



Part 9: The Biological Approach to Explaining OCD

The **biological approach** suggests that OCD develops due to **genetic vulnerability** and **neural abnormalities**, including differences in neurotransmitters and brain functioning.

Genetic explanation

The genetic explanation suggests that OCD is inherited, with individuals passing on genes that increase their **vulnerability** towards developing the disorder.

- OCD is **polygenic**, meaning that multiple genes are involved in its development. **Taylor (2013)** suggested that up to **230 genes** may contribute to OCD.
- Two important candidate genes are the **COMT gene** and the **SERT gene**.

COMT gene

- The **COMT gene** is involved in regulating **dopamine** levels.
- A variation of this gene linked to **increased dopamine activity** is more common in individuals with OCD.
- This may contribute to difficulties with **shifting attention** and adapting to change, which may explain the rigid thinking patterns seen in OCD.

SERT gene (5-HTT gene)

- The **SERT gene** affects the transport of **serotonin** between neurons.
- A variation of this gene may **reduce serotonin functioning**, which has been associated with OCD.
- This may also explain why OCD commonly occurs alongside other disorders, such as **depression and anxiety disorders**.

Neural explanation

The neural explanation focuses on abnormalities in the **worry circuit**, which is involved in how individuals respond to **new, unfamiliar or threatening situations**. This circuit involves the **orbitofrontal cortex (OFC)**, **caudate nucleus** and **thalamus**, which work together to identify and regulate potential threats.

Orbitofrontal cortex (OFC)

- The OFC is responsible for detecting potential threats, such as contamination or danger, and sends signals that something may be wrong.



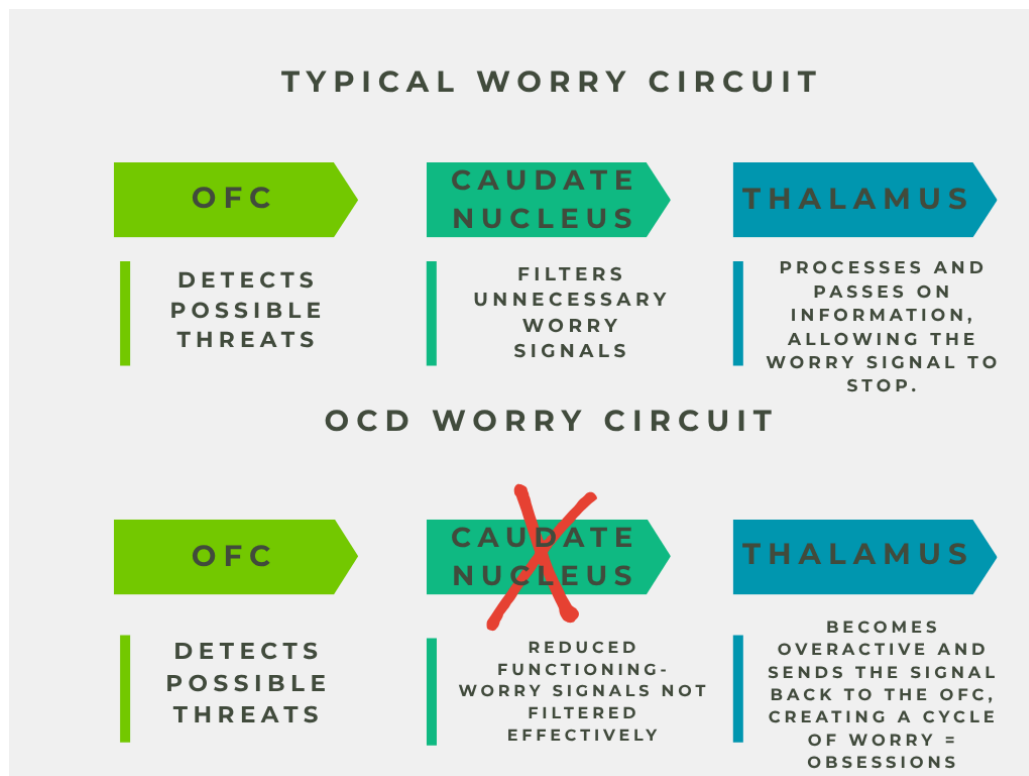


Caudate nucleus

- Normally, the **caudate nucleus** acts as a filter, stopping unnecessary worry signals from continuing through the circuit.
- In individuals with OCD, the caudate nucleus may not function effectively, meaning these signals are not filtered out.

Thalamus

- The worry signals continue to the **thalamus**, which becomes overactive and sends these signals back around the circuit.
- This creates a **cycle** of persistent obsessive thoughts and compulsive behaviours, explaining why individuals with OCD struggle to stop worrying.



AO3 - EVALUATION

A strength of the biological explanation of OCD is that it is **supported by evidence from twin studies**. **Nestadt et al. (2000)** reviewed previous twin studies of OCD and found that **68% of identical twins** shared OCD compared to **31% of non-identical twins**. This supports a **genetic explanation** because identical twins share **100% of their genes**, whereas non-identical twins only share around **50%**, suggesting that genes contribute to vulnerability to developing OCD. However, this does not mean that OCD is **completely determined by genetics**, as having certain candidate genes does not guarantee that an individual will develop the disorder. Instead, **genetic vulnerability may interact with environmental stressors**, as explained by the **diathesis-stress model**. Therefore, the biological explanation has some **validity** as it recognises the role of genetic factors, but it may be **too simplistic** if it ignores the influence of environmental factors.

A further strength of the neural explanation of OCD is that **understanding the role of neurotransmitters has led to effective treatments**. This means the explanation has **practical value**, as understanding the role of neurotransmitters has allowed psychologists to develop treatments that reduce OCD symptoms. **Soomro et al. (2009)** conducted a meta-analysis and found that **SSRIs were significantly more effective than a placebo** in reducing OCD symptoms. As SSRIs increase the availability of **serotonin** in the brain, this supports the idea that abnormal serotonin functioning is involved in OCD. **Therefore, the neural explanation has practical value because it has contributed to successful treatments for OCD, increasing its usefulness.**

A limitation of the biological explanation of OCD is that it is **difficult to identify which genes are most responsible for the disorder**. Research has identified **over 230 candidate genes** that may each contribute to an increased risk of developing OCD. This creates a **practical problem** because it is unclear which genes have the greatest influence, making it difficult to develop **targeted drug treatments** or accurately predict who is most likely to develop OCD. Therefore, although genetics may play a role in OCD, the **large number of possible genes involved** reduces the **predictive value and practical usefulness** of the biological explanation.

Another limitation of the biological explanation of OCD is that it may ignore the **influence of environmental factors**. **Cromer et al. (2007)** found that **over half of OCD patients** in their study had experienced a **traumatic event**, and there was a **positive correlation** between the number of traumas experienced and the severity of OCD symptoms. This suggests that **environmental experiences**, such as trauma, may contribute to the development and severity of OCD rather than OCD being caused by biological factors alone. Therefore, the biological explanation may be **incomplete** because it overlooks the role of **life experiences**, reducing its **validity as a complete explanation of OCD**.





Part 10: The Biological Approach to Treating OCD

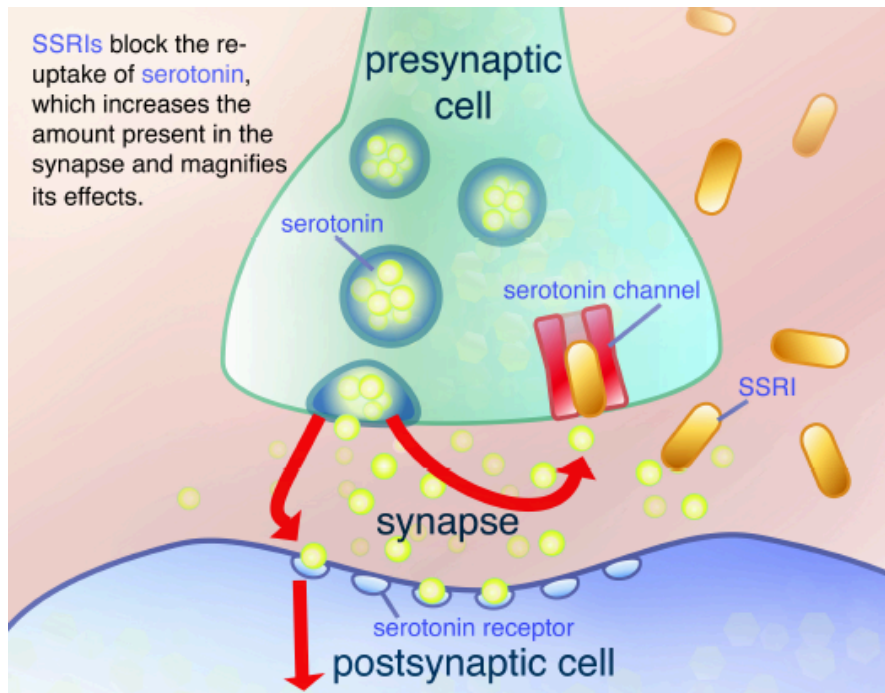
Drug therapy aims to reduce OCD symptoms by correcting **neurotransmitter imbalances**, particularly abnormalities involving **serotonin**. The main drugs used to treat OCD are **SSRIs**, with **SNRIs** and **tricyclic antidepressants** used as alternatives when SSRIs are ineffective.

1. Selective Serotonin Reuptake Inhibitors (SSRIs)

SSRIs are the first-line drug treatment for OCD and work by increasing levels of **serotonin** in the brain.

- Normally, serotonin is released into the synapse and then reabsorbed by the presynaptic neuron.
- SSRIs block the **reuptake** of serotonin, meaning more serotonin remains in the synapse.
- This increases stimulation of the **postsynaptic neuron**, improving communication between neurons.
- Increased serotonin activity may help reduce anxiety and intrusive thoughts associated with OCD.

Example: Fluoxetine (Prozac)



2. Serotonin-Noradrenaline Reuptake Inhibitors (SNRIs)

SNRIs are a second-line treatment for OCD, usually considered when SSRIs have not been effective.

- They work by preventing the reuptake of both **serotonin** and **noradrenaline**.
- This increases the concentration of these neurotransmitters in the synapse, improving communication between neurons.
- Increased serotonin and noradrenaline functioning may help reduce OCD symptoms.

Example: Venlafaxine (Effexor)

3. Tricyclic antidepressants

Tricyclic antidepressants may be prescribed when SSRIs have not been effective.

- They increase levels of **serotonin and noradrenaline** by blocking their reuptake.
- However, they are used less frequently because they produce more side effects than SSRIs and can be addictive.
- They are usually prescribed cautiously due to their toxicity and risk if taken in overdose.

Example: Clomipramine



AO3 - EVALUATION

A strength of drug therapy for OCD is that it is **supported by research evidence**. **Soomro et al. (2009)** conducted a **meta-analysis** investigating the effectiveness of **selective serotonin reuptake inhibitors (SSRIs)** for treating OCD. They found that SSRIs were **significantly more effective than a placebo** in reducing OCD symptoms. This supports the **neural explanation of OCD** because SSRIs increase the availability of serotonin in the brain, suggesting that **abnormal serotonin functioning** may contribute to OCD symptoms. Therefore, the effectiveness of SSRIs provides support for the role of neurotransmitters in OCD and shows that drug therapy has **practical value as an effective treatment**.

A further strength of drug therapy for OCD is that it is **cost-effective and has wider practical benefits for society**. Drug treatments such as **SSRIs** can be prescribed **relatively cheaply** and allow individuals to manage their symptoms without needing frequent therapy sessions. This may reduce the amount of time individuals take off work due to OCD symptoms, increasing **productivity** and reducing costs for healthcare services such as the **NHS**. Therefore, drug therapy has **practical value** because it provides an **accessible treatment option** that can benefit both individuals and society.

A limitation of drug therapy for OCD is that it can cause **unpleasant and sometimes serious side effects**. For example, individuals taking **Clomipramine** may experience side effects such as **weight gain, tremors and sexual problems**, with some people also experiencing **increased heart rate and aggression**. These side effects may negatively affect an individual's **quality of life** and could reduce their willingness to continue with treatment. Therefore, although drug therapy can be effective in reducing OCD symptoms, the **potential risks of side effects** reduce its overall usefulness as a treatment.

Another limitation of drug therapy for OCD is that it may only **treat the symptoms rather than addressing the underlying causes of the disorder**. SSRIs increase the availability of **serotonin** in the brain, which can reduce OCD symptoms, but they do not address the **intrusive thoughts and compulsive behaviours** that maintain the disorder. This suggests that drug therapy may manage the symptoms of OCD without providing individuals with strategies to overcome the **cognitive processes** involved in the condition. Therefore, drug therapy may be **less effective as a long-term treatment** compared to psychological approaches that aim to change **maladaptive thoughts and behaviours**.

