AQA A LEVEL PSYCHOLOGY

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TOPIC ESSAYS

Psychopathology

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PSYCHOPATHOLOGY ESSAYS

1. Outline and evaluate two or more definitions of abnormality. (16 marks)

2. Raymond is a college student who has recently started hearing voices. Raymond is worried and frightened when he hears the voices, which are usually threatening in nature. Consequently, these voices are interrupting Raymond's life and he is struggling to complete his homework and concentrate in the classroom, and he is growing increasingly worried that he might not get into university because of his condition. While Raymond hasn't explicitly told anyone, his teachers and parents are becoming increasingly worried because he looks stressed and anxious.

Discuss deviation from ideal mental health and failure to function adequately as two definitions of abnormality. Refer to Raymond in your answer. (16 marks)

3. Outline and evaluate the behavioural approach to explaining phobias. (16 marks)

4. Outline and evaluate the behavioural approach to treating phobias. (16 marks)

5. Jack and Jill are discussing their eight-year-old daughter, Jemimah, who is refusing to go swimming for her friend's ninth birthday party. Jack says: 'Jemimah has a real fear of the water which she gets from you. Maybe I should go with her and wait outside the pool until she becomes more relaxed. After that, we could try sitting on the edge of the pool and watching the others. Hopefully, she might be encouraged and go in the swimming pool to join her friends'. Jill says: 'No way, we don't have time for that; I need to go to the supermarket! Let's just drop her off and throw her in the pool; that will sort her out!'

Outline and evaluate two behavioural treatments for phobias. Refer to Jack and Jill's conversation in your answer. (16 marks)

6. Outline and evaluate the cognitive approach to explaining depression. (16 marks)

7. Outline and evaluate the cognitive approach to treating depression. (16 marks)

8. Discuss the biological approach to explaining OCD. (16 marks)

9. Outline and evaluate the biological approach to treating OCD. (16 marks)

10. Two teachers were talking about their student, Benedict, who has recently been diagnosed with OCD. Cordelia said: 'I wasn't surprised really. I met Benedict's mother Delilah at parents evening and she told me that Benedict's father, Archibald, has OCD.' 'Oh my', said Alasdair. 'I had no idea. I thought OCD was a neural condition.'

Discuss neural and genetic explanations for OCD and refer to Cordelia and Alasdair's conversation in your answer. (16 marks)

INTRODUCTION

Thank you for downloading the AQA Psychology Topic Essays - Psychopathology. Many people have heard me use the phrase 'Essays matter. Full stop.' This is because I firmly believe that good essay writing is a skill and that essays can make all the difference in A Level Psychology.

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Outline and evaluate two or more definitions of abnormality. (16 marks)

One definition of abnormality is known as the deviation from social norm definition. A social norm is an unwritten rule about what is acceptable within a particular society. Therefore, according to this definition, a person is seen as abnormal if their thinking or behaviour violates these social norms of what is acceptable. For example, if someone was walking around the streets of London naked, you might think they were abnormal. However, this same behaviour in a remote African tribe would be considered perfectly normal as part of their culture.

The first definition is presented clearly and accurately, using an example to demonstrate understanding.

One issue with this definition of abnormality is that social norms change over time, an issue referred to as hindsight bias. For example, homosexuality was regarded as a mental illness in the UK until 1973, often resulting in institutionalisation, but is now simply considered a variation of normal behaviour. This means that, historically, a reliance upon deviation from social norms as a definition of abnormality may have resulted in violations of human rights where people, by today's standards, were deemed 'abnormal'. It could be argued that diagnoses upon these grounds may have been used as a form of social control over minority groups as a means to exclude those who do not conform.

An interesting discussion point about hindsight bias and how it relates to social norms changing over time.

How far an individual deviates from a particular social norm is mediated by the severity of their 'behaviour' and the context. For example, when someone breaks a social norm once this may not be deviant behaviour, but persistent repetition of such behaviour could be evidence of psychological disturbance. Likewise, someone walking topless on a beach would be considered normal but adopting the same attire for the office would be viewed as abnormal and possibly an indication of an underlying psychological problem. As a consequence, this definition fails to offer a complete explanation in its own right, since different conclusions are reached in different situations and contexts.

The evaluative commentary is enhanced by the discussion of context as a mediating factor in determining whether behaviour deviates from social norms.

According to the Failure to Function Adequately (FFA) definition, a person is considered abnormal if they are unable to cope with the demands of everyday life and live independently in society. Furthermore, to be classified as abnormal, a person's behaviour should cause personal suffering and distress because of their failure to cope. However, they may also cause distress or discomfort to other people who observe their behaviour. For example, someone who is suffering from depression may struggle to get out of

bed in the morning or they may find it difficult to communicate with their family and friends. Consequently, they would be considered abnormal as their depression is causing an inability to cope with the demands of everyday life (going to work), whilst their behaviour is also causing distress and discomfort to relatives.

A second definition is presented in equal depth to the first and is explained well.

One weakness of the FFA definition stems from individual differences. For example, one person with Obsessive Compulsive Disorder (OCD) may exhibit excessive rituals that prevent them from functioning adequately, as they constantly miss work; whereas another person may suffer from the same excessive rituals, but find time to complete their rituals and always attend work on time. Therefore, despite the same psychological and behavioural symptoms, each person would be diagnosed differently according to this definition, thus questioning the validity of this definition. This issue exemplifies the problem of taking a nomothetic approach in psychology. Definitions of abnormality typically take a nomothetic approach and try to identify a list of factors, or symptoms, that can be used to diagnose abnormal behaviour. However, some psychologists, in particular Humanistic psychologists, would argue that this approach ignores the essence of being human (e.g. individual differences) and therefore an idiographic approach to defining abnormality might be more appropriate.

An excellent argument centred around individual differences is presented.

The essay developed this point further and demonstrates excellent knowledge of the idiographic and nomothetic approach applied to the definitions of abnormality topic.

[~600 Words]

Examiner Style Comments: *Mark Band 4*

This essay demonstrates clear knowledge and understanding of two definitions of abnormality – deviation from social norms and failure to function adequately. Likewise, statistical infrequency or deviation from ideal mental health would have been creditworthy. The description is excellent and supported with viable examples tied to psychopathology. The evaluative commentary is thorough, effective, interesting and focused on the demands of the question. Furthermore, the inclusion of an appropriate issue and debate further demonstrates excellent psychological knowledge. It is worth noting that this essay is lengthy and there is no requirement for a 16-mark essay to be this length. The essay would still achieve mark band 4 without one of the evaluation paragraphs and therefore it is important that students consider how they could use their time effectively in exam conditions to maximise their overall marks.

Raymond is a college student who has recently started hearing voices. Raymond is worried and frightened when he hears the voices, which are usually threatening in nature. Consequently, these voices are interrupting Raymond's life and he is struggling to complete his homework and concentrate in the classroom, and he is growing increasingly worried that he might not get into university because of his condition. While Raymond hasn't explicitly told anyone, his teachers and parents are becoming increasingly worried because he looks stressed and anxious.

Discuss deviation from ideal mental health and failure to function adequately as two definitions of abnormality. Refer to Raymond in your answer. (16 marks)

According to the Failure to Function Adequately (FFA) definition, a person is considered abnormal if they are unable to cope with the demands of everyday life (e.g. social or work life) and live independently in society. Furthermore, to be classified as abnormal, a person's behaviour should cause personal suffering and distress because of their failure to cope. However, they may also cause distress or discomfort to other people who observe their behaviour. Therefore, according to this definition, Raymond could be considered abnormal because his symptoms are causing an inability to cope with everyday life as he is finding it difficult to 'complete his homework'. Furthermore, Raymond's symptoms are also causing distress or discomforted, as 'his teachers and parents' have noticed his stress and anxiety.

Explanation of the FFA definition is clear and coherent.

Application of this definition to the case of Raymond is explicit, using material from the scenario to support the point being made.

One strength of the FFA definition is that is takes into account the subjective personal experiences of people like Raymond. This definition considers the thoughts and feelings of Raymond and the issues he is facing and does not simply make a judgement based on a pre-defined list of symptoms. This suggests that the FFA definition is a useful tool for assessing psychopathological behaviour as it takes into account the effect of a person's symptoms of their everyday life.

Evaluation of the FFA definition is simple yet effective.

However, one weakness of the FFA definition is the issue of individual differences. For example, one person who hears voices may be unable to function adequately, whereas another person may suffer from the same symptoms, but function perfectly well. Therefore, despite the same psychological and behavioural symptoms, each person would be diagnosed differently according to this definition, thus questioning the validity of this definition.

Evaluative commentary for this definition is balanced with a weakness.

Jahoda (1958) took a different approach to defining abnormality, suggesting that abnormal behaviour should be defined by the absence of particular, ideal characteristics. In

other words, behaviours which move away, or deviate, from ideal mental health. Jahoda outlined a series of principles, including: having an accurate view of reality; being able to integrate and resist stress; and being able to master your environment including love, friendships, work and leisure time. Therefore, if an individual does not demonstrate one of these criteria, they would be classified as abnormal according to this definition. It could be argued that Raymond does not have an accurate view of reality as he is hearing voices which are not present. Furthermore, he seems to be unable to resist stress as his parents and teachers have noted that he is anxious, and he is unable to master the environment, in particular his school work, as his symptoms are preventing him from completing his homework. Consequently, Raymond would be seen as abnormal, according to this definition.

The second definition described demonstrates clear knowledge and understanding.

Reference to the scenario is consistent throughout the answer.

One strength of Jahoda's definition is that it takes a positive and holistic view. Firstly, the definition focuses on positive and desirable behaviours, rather than considering just negative and undesirable behaviour. Secondly, the definition considers the whole person, considering a multitude of factors that can affect their health and well-being. Therefore, a strength of the deviation from ideal mental health definition of abnormality is that it is comprehensive, covering a broad range of criteria.

An interesting discussion point to consider.

However, one weakness of the deviation from ideal mental health definition is the unrealistic criteria proposed by Jahoda. There are times when everyone will experience stress and negativity, for example, when grieving following the death of a loved one. However, according to this definition, these people would be classified as abnormal, irrespective of the circumstances which are outside their control. With the high standards set by these criteria, how many need to be absent for diagnosis to occur needs to be questioned.

The essay is concluded with a valid weakness of the deviation from ideal mental health definition.

[~600 Words]

Examiner Style Comments: *Mark Band 4*

This essay demonstrates an exceptionally clear understanding of two definitions of abnormality intertwined with the skill of applying these to a novel scenario. The outline knowledge is accurate and detailed, striking a balance between the two definitions in equal depth. The evaluation commentary is thorough, effective and focused on the demands of the question. The application draws upon suitable material from the scenario to provide an interesting discussion.

Outline and evaluate the behavioural approach to explaining phobias. (16 marks)

The two-process model suggests that phobias are acquired through classical conditioning: learning by association, and are maintained through operant conditioning: negative reinforcement. According to the theory of classical conditioning, humans can learn to fear an object or stimulus, such as a dog, by forming an association between the object and something which triggers a fear response, for example being bitten. In this example, the dog, which was originally a neutral stimulus, becomes associated with being bitten, which is an unconditioned stimulus. This pairing leads to the dog becoming a conditioned stimulus, which when encountered will elicit fear, a condition response.

Specialist terminology is used from the outset and defined succinctly.

A good explanation of classical conditioning is applied correctly to the acquisition of phobias, with the use of an example.

According to operant conditioning, phobias are negatively reinforced where a behaviour is strengthened, because an unpleasant consequence is removed. For example, if a person with a dog phobia sees one whilst out walking, they might avoid it by crossing the road. This reduces the person's anxiety and so negatively reinforces their behaviour, making the person more likely to continue avoiding dogs, thus maintaining their phobia.

The second element of the two-process model is well explained to create a comprehensive description of the behaviourist approach.

The behaviourist explanation of phobias is supported by research evidence. Watson & Raynor (1920) demonstrated the process of classical conditioning in the formation of a phobia in Little Albert, who was conditioned to fear white rats. This supports the idea that classical conditioning is involved in acquiring phobias in humans and that generalisation can occur to other phobic stimuli. However, since this was a case study, it is difficult to generalise the findings to other children or even adults due to the unique nature of the investigation.

Research evidence is used effectively to support the behaviourist account of phobias.

A strength of the behaviourist explanation is its application to therapy. These ideas have been used to develop treatments, including systematic desensitisation and flooding. Systematic desensitisation helps people to unlearn their fears, using the principles of classical conditioning, while flooding prevents people from avoiding their phobias and stops the negative reinforcement from taking place. These therapies have been successfully used to treat people with phobias, supporting the effectiveness of the behaviourist explanation in helping people to overcome their phobias.

The evaluative commentary commences with a strength of this approach linked to the treatment of phobias. Both treatments are identified and well explained.

The behaviourist explanation for phobias ignores the role of

cognition: phobias may develop because of irrational thinking, not just learning. For example, sufferers of claustrophobia may think: 'I am going to be trapped in this lift and suffocate', which is an irrational thought that is not taken into consideration. Consequently, the behaviourist explanation for the development of phobias has been criticised for being environmentally reductionist, by reducing human behaviour to a simple stimulus–response association. Many psychologists, for example cognitive psychologists, would disagree with this explanation, as they argue that other cognitive factors (e.g. irrational thinking) also play an important role. Furthermore, the cognitive approach has also led to the development of cognitive behavioural therapy (CBT), which is said to be more successful than behaviourist treatments.

The AO3 element of the essay is balanced by the development of a counter-argument highlighting the limitations of this approach to explaining phobias. The use of environmental reductionism is effective and demonstrates further evaluative commentary.

There is a claim that the behavioural approach may not provide a complete explanation of phobias. For example, Bounton (2007) highlights the fact that evolutionary factors could play a role in phobias, especially if the avoidance of a stimulus (e.g. snakes) could have caused pain or even death to our ancestors. Consequently, evolutionary psychologists suggest that some phobias are not learned but are in fact innate, as they acted as a survival mechanism for our ancestors. This is called biological preparedness (Seligman, 1971) and casts doubt on the two-process model since it suggests that there is more involved than learning and that some phobias (e.g. snakes) are not learned, but are in fact innate.

An interesting discussion point about biological preparedness.

[~550 Words]

Examiner Style Comments: *Mark Band 4*

This essay demonstrates a remarkably clear understanding of the two-process model proposed by behaviourists to explain the development and maintenance of phobias. The outline knowledge is accurate and detailed, striking a balance between classical conditioning and operant conditioning well. The evaluation commentary is thorough, effective and focused on the demands of the question, concluding with reference to suitable issues and debates to provide an interesting discussion.

Outline and evaluate the behavioural approach to treating phobias. (16 marks)

There are two behavioural therapies used to treat phobias: systematic desensitisation and flooding. Systematic desensitisation uses counter-conditioning to help patients 'unlearn' their phobias, by eliciting another response: relaxation instead of fear. A patient works with their therapist to create a fear hierarchy, ranking the phobic situation from least to most anxiety-inducing. The patient is also taught relaxation strategies, such as breathing techniques, to help them remain calm when exposed to their fear. Finally, the patient works through their fear hierarchy, starting at the bottom, while trying to remain relaxed at each stage. Systematic desensitisation works on the assumption that two emotional states cannot exist at the same time, a theory known as reciprocal inhibition, and eventually relaxation will replace the fear.

A concise introduction to this essay.

An accurate and detailed description of systematic desensitisation as a treatment for phobias is presented.

One strength of systematic desensitisation comes from research evidence that demonstrates its effectiveness. McGrath *et al*. (1990) found that 75% of patients with phobias were successfully treated using systematic desensitisation. This was particularly true when using *in vivo* techniques in which the patient came into direct contact with the feared stimulus, rather than simply imagining (*in vitro*). This shows that systematic desensitisation is effective when treating specific phobias, especially when using *in vivo* techniques.

The evaluative commentary begins with a suitable strength being identified and well explained, drawing on research to support the point.

However, systematic desensitisation is not effective in treating all phobias. Patients with phobias which have not developed through a personal experience (classical conditioning), such as a fear of snakes, are not effectively treated using systematic desensitisation. Some psychologists believe that certain phobias have an evolutionary survival benefit and are not the result of learning. This highlights a limitation of systematic desensitisation, which is ineffective in treating evolutionary-based phobias which have an innate basis.

The discussion is balanced with a counter-argument.

Flooding is a behavioural therapy which, rather than exposing a person to their phobic stimulus gradually, exposes the individual to the most anxiety-inducing stimulus immediately. With flooding, a person is unable to avoid (negatively reinforce) their phobia and through continuous exposure, anxiety levels eventually decrease. Since the option of employing avoidant behaviour is removed, extinction will soon happen because anxiety is time limited, and as a result,

A second behavioural therapy is outlined in sufficient detail to strike a good breadth and

the fear will eventually subside.

depth trade-off.

One issue with flooding is that it can be highly traumatic for patients since it purposefully elicits a high level of anxiety. Wolpe (1969) recalled a case with a patient becoming so intensely anxious that she required hospitalisation. Although flooding is not unethical as patients provide fully informed consent, many patients do not complete their treatment because the experience is too stressful. Therefore, flooding is sometimes a waste of time and money as not all patients engage in the treatment, which will result in the unsuccessful treatment of their phobias.

An interesting evaluation point is argued here about the ethics of flooding.

An issue for behavioural therapies such as flooding and systematic desensitisation is symptom substitution. This means that although one phobia may be successfully removed through counter-conditioning, another may appear in its place. If symptoms are treated and removed, the underlying cause may remain and simply resurface under a new guise. Research in this area is mixed; however, such criticisms are heavily disputed by behaviourists who claim that behavioural treatments provide an ideal treatment for phobias.

The final evaluation paragraph applies to both behavioural treatments, drawing the essay to a neat conclusion.

[~500 Words]

Examiner Style Comments: *Mark Band 4*

This is a well-structured and coherent essay which provides an accurate and well-detailed account of the two behavioural therapies for treating phobias that are named on the specification: systematic desensitisation and flooding. A range of effective evaluation points to both support and critique these therapies are elaborated well, supported by relevant research studies. The essay is focused and specialist terminology is used effectively throughout.

Jack and Jill are discussing their eight-year-old daughter, Jemimah, who is refusing to go swimming for her friend's ninth birthday party.

Jack says: 'Jemimah has a real fear of the water which she gets from you. Maybe I should go with her and wait outside the pool until she becomes more relaxed. After that, we could try sitting on the edge of the pool and watching the others. Hopefully, she might be encouraged and go in the swimming pool to join her friends'.

Jill says: 'No way, we don't have time for that; I need to go to the supermarket! Let's just drop her off and throw her in the pool; that will sort her out!'

Outline and evaluate two behavioural treatments for phobias. Refer to Jack and Jill's conversation in your answer. (16 marks)

There are two behavioural therapies used to treat phobias: systematic desensitisation and flooding. Systematic desensitisation uses counter-conditioning to help patients 'unlearn' their phobias, by eliciting another response: relaxation instead of fear. Here, Jemimah would work with her therapist to create a fear hierarchy, ranking her phobia of water from the least to most anxiety-inducing situations. For example, her least feared situation might be looking at a picture of a swimming pool and her most feared might be falling into the deep end of a swimming pool. Jemimah would also be taught relaxation strategies, such as breathing techniques, to help her remain calm when exposed to her fear. Finally, Jemimah would work through her fear hierarchy, starting at the bottom, while trying to remain relaxed at each stage. Systematic desensitisation works on the assumption that two emotional states cannot exist at the same time, a theory known as reciprocal inhibition, and eventually relaxation will replace her fear.

A swift start to the essay setting the scene for the rest of the discussion to follow logically and coherently.

A well-detailed description of what is involved in systematic desensitisation with clear application to Jemimah.

One strength of systematic desensitisation comes from research evidence that demonstrates its effectiveness. McGrath *et al*. (1990) found that 75% of patients with phobias were successfully treated using systematic desensitisation. This was particularly true when using *in vivo* techniques in which the patient came into direct contact with the feared stimulus, rather than simply imagining (*in vitro*). This shows that systematic desensitisation is effective when treating specific phobias, especially when using *in vivo* techniques and therefore could be an ideal treatment for Jemimah.

Evaluative commentary effectively elaborated with research support from McGrath et al.

Jack, Jemimah's father, is suggesting an *in vivo* form of systematic desensitisation, as he is putting forward a gradual, step-by-step approach to treat his daughter. For example, the father has created a fear hierarchy starting with sitting in the

car at the pool, until the girl calms down, followed by sitting in the viewing area, etc. Jack has also acknowledged that it is important for his daughter to remain relaxed at each stage as she will only progress onto the next stage if she calms down. Based on research evidence (McGrath *et al*.) this is likely to be an effective treatment for Jemimah to help her overcome her phobia of water.

Excellent application of knowledge and understanding to the context.

Flooding is a behavioural therapy which, rather than exposing a person to their phobic stimulus gradually, exposes the individual to the most anxiety-inducing stimulus immediately (e.g. throwing her in the swimming pool). With flooding, Jemimah will be unable to avoid (negatively reinforce) her phobia and through continuous exposure to water, her anxiety levels will eventually decrease. Since the option of employing avoidant behaviour is removed, extinction will soon happen because anxiety is time limited, and as a result, her fear of water will eventually subside.

The second treatment for phobias – flooding – is outlined in sufficient detail to create a good breadth/depth trade-off with systematic desensitisation.

One issue with flooding is that it can be highly traumatic for patients since it purposefully elicits a high level of anxiety. Wolpe (1969) recalled a case with a patient becoming so intensely anxious that she required hospitalisation. Although it is not unethical as patients provide fully informed consent, many do not complete their treatment because the experience is too stressful. Therefore, initiating flooding is sometimes a waste of time and money if patients do not engage in the treatment, which will ultimately fail to treat patients in such cases.

An interesting limitation of flooding is effectively elaborated with reference to the psychologist who devised the treatment.

The mother is suggesting the use of flooding for her daughter as she wants to expose Jemimah to her phobia by placing her in an anxiety-inducing situation to cure her fear. However, while flooding is not seen as unethical when patients provide informed consent, it would not be deemed as appropriate for an eight-year-old, who is unable to provide fully informed consent for herself.

The essay is concluded with excellent application skills demonstrating real engagement with the scenario.

[~575 Words]

Examiner Style Comments: *Mark Band 4*

This is a well-detailed and accurate account of two behavioural treatments for phobias, applied seamlessly to the scenario with Jemimah and her fear of swimming. The use of specialist terminology is excellent and adds clarity and focus to the essay. The evaluation is well-elaborated, thorough and effective, drawing on a range of points to support or show limitations of the treatment in question.

Outline and evaluate the cognitive approach to explaining depression. (16 marks)

Cognitive theories for explaining depression include Beck's Cognitive Triad and Ellis's ABC Model. Beck claimed depression is caused by negative self-schemas and cognitive biases that maintain a cognitive (negative) triad: a negative view of ourselves, the future and the world around us. According to Beck, depressed people possess negative self-schemas, caused by negative experiences in childhood, for example, criticism from parents. Furthermore, Beck found that depressed people are more likely to focus on the negative aspects of a situation, while ignoring the positives. This distorts information, a process known as cognitive bias, and includes overgeneralising. For example, '*I've failed one test so I will fail ALL of my exams!*'

A clear statement to set the scene for the rest of the essay.

A concise, yet accurate, overview of Beck's Cognitive Triad explanation for depression.

Ellis proposed the ABC three stage model, to explain how irrational thoughts can lead to depression. An activating event (A) occurs, for example, you pass a friend in the corridor at school and they ignore you, when you say 'hello'. Your belief (B) is your interpretation, which could either be rational or irrational. According to Ellis, an irrational belief (e.g. 'my friend must hate me') can lead to unhealthy emotional consequences (C), including depression.

The second explanation of depression is slightly shorter in length, but achieves the breadth/depth trade-off when attempting to describe two cognitive explanations of depression.

One strength of the cognitive explanation for depression is its application to therapy. Cognitive explanations have been used to develop effective treatments for depression, including Cognitive Behavioural Therapy (CBT) and Rational Emotive Behaviour Therapy (REBT), which was developed from Ellis's ABC model. These therapies attempt to identify and challenge negative, irrational thoughts and have been successfully used to treat people with depression, providing further support to the cognitive explanation of depression.

A simple yet effective evaluation point highlights the real-world application of the cognitive approach to treating depression.

However, one weakness of the cognitive approach is that it does not explain the origins of irrational thoughts. Since most of the research in this area is correlational, psychologists are unable to determine if negative, irrational thoughts cause depression, or whether a person's depression leads to a negative mindset. Consequently, it is possible that other factors, for example genes and neurotransmitters, are the cause of depression and the negative, irrational thoughts are the symptom of depression.

An interesting discussion point outlining a major issue in the support for cognitive explanations of depression.

In addition, there are alternative explanations which suggest that depression is a biological condition, caused by genes and

neurotransmitters. Research focused on the role of serotonin has found lower levels in patients with depression. In addition, drug therapies, including SSRIs (Selective Serotonin Reuptake Inhibitors) which increase the level of serotonin, are found to be effective in the treatment of depression, which provide further support for the role of neurotransmitters in the development of depression. This therefore casts doubt on the cognitive explanation as a sole cause of the disorder.

The previous evaluation point is further developed with the discussion of alternate explanations.

There is research evidence which supports the cognitive explanation of depression. Boury *et al.* (2001) found that patients with depression were more likely to misinterpret information negatively (cognitive bias) and feel hopeless about their future (cognitive triad). Further to this, Bates *et al.* (1999) gave depressed patients negative automatic thought statements to read and found that their symptoms became worse. These findings support different components of Beck's theory and the idea that negative thinking is involved in depression.

A final effective evaluation point drawing on research support.

[~500 Words]

Examiner Style Comments: *Mark Band 4*

This is a well-detailed an accurate account of the cognitive approach to explaining depression and its contribution to psychology and society. The evaluation is well-detailed, thorough and effective, drawing on a range of strengths and limitations. The use of key terminology is excellent and adds clarity and focus to the essay.

Outline and evaluate the cognitive approach to treating depression. (16 marks)

Cognitive Behavioural Therapy (CBT) involves both cognitive and behavioural elements and typically starts with an initial assessment, in which the patient and therapist identify the patient's problems. Thereafter, the patient and therapist agree on a set of goals, and a plan of action to achieve these goals. While there are different forms of CBT (e.g. based on Beck's and Ellis's theories) the aim to identify the negative and irrational thoughts remains the same, despite the fact their approaches differ. Ellis developed his ABC model to include D (dispute) and E (effective). The idea here is that the therapist will dispute the patient's irrational beliefs, to replace their irrational beliefs with more effective beliefs and attitudes. There are different types of dispute which can be used, including: empirical dispute – where the therapist seeks evidence for a person's thoughts: '*Where is the evidence that your beliefs are true*?' Following a session, the therapist may set their patient homework. The idea is that the patient identifies their own irrational beliefs and then proves them wrong. As a result, their beliefs begin to change.

The process involved for a patient undergoing CBT is described effectively, with reference to Ellis's ABC-DE theory.

One strength of cognitive behaviour therapy comes from research evidence which demonstrates its effectiveness in treating depression. Research by March *et al.* (2007) found that CBT was as effective as antidepressants in treating depression. The researchers examined 327 adolescents with a diagnosis of depression and looked at the effectiveness of CBT, antidepressants, and treatment with a combination of CBT and antidepressants. After 36 weeks, 81% of the antidepressant group and 81% of the CBT group had significantly improved, demonstrating the effectiveness of CBT in treating depression. However, 86% of the CBT with antidepressant group had significantly improved. This suggests that a combination of both treatments may be more effective. While March *et al.* provide some support for cognitive treatments of depression, their research demonstrates that a combination of cognitive and biological treatments is more effective. This suggests that cognitive treatments and explanations do not provide a complete explanation of depression and other factors (namely biological ones) should also be considered.

A very well-elaborated evaluation point with supporting research is discussed in an effective and highly academic manner.

One issue with CBT is that it requires motivation. Patients with severe depression may not engage with CBT, or even attend the sessions and therefore this treatment will be ineffective in treating these patients. Alternative treatments,

such as antidepressants, do not require the same level of motivation and may be more effective in these cases. This poses a problem for CBT, as CBT cannot always be used as the sole treatment for severely depressed patients, who often lack the motivation to attend therapy and to speak about their depression.

An interesting critique of CBT as a treatment for depression.

CBT has been criticised for its overemphasis on the role of cognitions as the primary cause of depression. Some psychologists have criticised CBT for not considering other factors such as social circumstances which might contribute to a person's depression. For example, a patient who is suffering from domestic violence or abuse does not need to change their negative/irrational beliefs, but in fact needs to change their circumstances. Therefore, CBT would be ineffective in treating these patients until their circumstances have changed.

The evaluative commentary is concluded with a simple, yet effective, argument about the questionable role of other factors in explaining depression.

[~450 Words]

Examiner Style Comments: *Mark Band 4*

This is a succinct yet sufficiently detailed essay which explains the components of cognitive behavioural therapy (CBT) accurately. The evaluation is generally effective with the first evaluation point embedding a successful reference to a relevant debate in psychology which is pertinent to the demands of the question. The use of specialist terminology related to CBT is consistent throughout the response. A good attempt.

Discuss the biological approach to explaining OCD. (16 marks)

The biological approach to explaining obsessive compulsive disorder (OCD) considers genetic and neural explanations. Genetic explanations suggest that OCD is inherited. Neural explanations for OCD suggest that abnormal levels of neurotransmitters are implicated. OCD is a polygenic condition, which means that several genes are implicated. Taylor (2003) suggests that as many as 230 genes may be involved and different genetic variations contribute to the different types of OCD, e.g. hoarding or obsessions with religion. A gene that has been linked to OCD is the COMT gene which produces *catechol-O-methyltransferase.* This variation regulates dopamine and is more common in patients with OCD, compared to people without OCD.

A breakdown of what the biological approach to OCD entails provides a platform for the rest of the essay.

Specialist terminology is used from the outset and is explained well.

Lower levels of serotonin are also associated OCD. Evidence for this comes from research examining antidepressants (SSRIs). Piggott *et al.* (1990) found that drugs which increase the level of serotonin in the synaptic gap are effective in treating patients with OCD, suggesting that serotonin is a contributory factor.

Effective use of research evidence is used to support the description.

A strength of the biological explanation of OCD comes from research support seen in family studies. Lewis (1936) examined patients with OCD and found that 37% of the patients with OCD had parents with the disorder and 21% had siblings who suffered. Nestadt *et al.* (2000) take this point further and proposes that individuals who have a first-degree relative with OCD are up to five times more likely to develop the disorder in their lifetime compared to members of the general population without this genetic link. Research from family studies like this provides support for a genetic explanation for OCD, although it does not rule out other (environmental) factors playing a role. This explanation for OCD reduces a complex human behaviour to a single gene or brain chemical and so is considered biologically reductionist. For example, the biological explanation does not consider the role cognitions (thinking) or learning in the development or maintenance of OCD and is therefore criticised by behavioural and cognitive psychologists for its overly simplistic view.

The evaluative commentary is well-elaborated, drawing upon family studies in this field of psychology.

Reference to the key issue of reductionism is effortlessly integrated into the response.

Further support for the biological explanation of OCD comes from twin studies which provide strong evidence for a genetic link. Billett *et al.* (1998) conducted a meta-analysis of 14 twin studies investigating the genetic inheritance rate of OCD. It was concluded that monozygotic (MZ) twins had *double* the risk of developing OCD compared to dizygotic twins (DZ) if

one of the pair had the disorder. Since concordance rates in twin studies are never 100%, it suggests that the diathesis-stress model may be a better explanation whereby a genetic vulnerability is inherited and triggered by a stressor in the environment.

Another sound evaluation point which extends the discussion.

There are credible alternative explanations for the development of OCD. For example, the two-process model proposed by behaviourists suggests that learning could play a crucial role in the disorder. Initial learning of the anxiety-inducing stimulus could occur through classical conditioning, for example if dirt/germs are paired with anxiety (e.g. becoming ill). Compulsive behaviour (e.g. continual hand washing) is then maintained through operant conditioning and negative reinforcement, as the compulsive behaviour reduces the anxiety associated with the anxiety-inducing stimulus which serves to reinforce the condition. Support for this alternative explanation is found in the success of behavioural treatments for OCD where symptoms of patients are improved for 60–90% of adults (Albucher *et al.,* 1998).

An interesting alternative explanation from the behaviourist approach is offered to conclude the evaluative commentary.

[~550 Words]

Examiner Style Comments: *Mark Band 4*

This is a highly detailed and accurate essay examining the biological explanations of obsessive compulsive disorder (OCD), including reference to genetic and neural explanations. The use of specialist terminology is impressive throughout the response. The evaluation is focused, thorough and effective, drawing upon relevant research studies to support the arguments made. Overall, a remarkable account of the biological explanations for OCD.

Outline and evaluate the biological approach to treating OCD. (16 marks)

Biological treatments work on the assumption that OCD is cause by neurochemical imbalances in the brain, and therefore work to readdress these imbalances. Antidepressant drugs and anti-anxiety drugs are commonly used in the treatment of OCD.

A good introduction linking the treatment rationale to the biological approach.

Selective serotonin reuptake inhibitors (SSRIs) are the preferred biological treatment for OCD. SSRIs increase the level of serotonin available in the synapse by preventing it from being reabsorbed into the sending cell. This increases the level of serotonin in the synapse which, in turn, improves the concentration of the brain chemical at the receptor sites on the post-synaptic neuron, intensifying the stimulation on the receiving nerve. Consequently, SSRIs work to improve mood and reduce the anxiety experienced by patients with OCD.

Excellent use of specialist terminology with reference to antidepressants.

Well-detailed and accurate outline of the mode of action for SSRIs.

Benzodiazepines (BZs) work by enhancing the action of the neurotransmitter GABA (gamma-aminobutyric acid). GABA tells neurons in the brain to 'slow down' and 'stop firing'. Some neurons have GABA receptor sites at the synapse and when GABA locks onto one of these, the flow of chloride ions into the neuron is increased. The chloride ions make it more difficult for the receiving neuron to be stimulated further, thus slowing down the nervous system. This means that BZs produce a relaxing effect and consequently reduce anxiety, which is experienced as a result of the obsessive thoughts common in OCD.

An accurate and detailed outline of BZs is also provided.

One strength of biological treatments for OCD comes from research support for their effectiveness. Randomised drug trials compare the effectiveness of SSRIs with a placebo. Soomro *et al*. (2008) conducted a review of research examining the effectiveness of SSRIs and found that they were significantly more effective than placebos in the treatment of OCD, across 17 different trials. This supports the use of biological treatments, especially SSRIs, for OCD. However, studies such as this are criticised for only concluding the short-term effectiveness of drug treatments with long-term effects still to be investigated empirically. The biological explanation follows a nomothetic approach which suggests the same treatment for all people suffering from OCD, without considering individual differences. Some psychologists suggest that other treatments are better at providing long-term relief for sufferers of OCD and therefore cognitive therapies should be used instead of biological ones.

Research is used well to support the strength of biological treatments being discussed here.

A reference to issues and debates is integrated into the AO3 content.

An advantage to biological treatments for OCD is their cost effectiveness. Drug therapies, such as SSRIs and BZs, are relatively cost effective in comparison with psychological treatments, like CBT. Consequently, many doctors prefer the use of drugs to psychological treatments, as they are a more cost effective solution for treating OCD, which is beneficial for health service providers. In addition, psychological treatments like CBT require a patient to be motivated to engage whereas drugs are non-disruptive to everyday life, and can simply be taken until the symptoms subside. As a result, this means that drug treatments are likely to be more successful for patients who lack motivation to complete intense psychological treatments.

The evaluative commentary is further enhanced with another well-elaborated strength of drug treatments.

A limitation of prescribing drug treatments for OCD is the possible side effects of drugs. Although evidence suggests that SSRIs are effective in treating OCD, some patients experience mild side effects like indigestion, while other might experience more serious side effects like hallucinations, erection problems and raised blood pressure. BZs are renowned for being highly addictive and can also cause increased aggression and long-term memory impairments. As a result, BZs are recommended for short-term treatment only of up to four weeks according to Ashton (1997). Consequently, side effects diminish the effectiveness of drug treatments, as patients will often stop taking medication if they experience negative side effects.

The evaluative commentary is balanced with a limitation of drug effects in reference to the negative side effects which can result from the treatment.

[~575 Words]

Examiner Style Comments: *Mark Band 4*

This response demonstrates sound knowledge and understanding of drug therapies which are advocated by the biological approach to treating obsessive compulsive disorder (OCD). The description is excellent, with an appropriate balance achieved between the outline of SSRIs and BZs. The evaluative commentary is interesting, thorough and effectively elaborated with suitable critiques offered.

Two teachers were talking about their student, Benedict, who has recently been diagnosed with OCD.

Cordelia said: 'I wasn't surprised really. I met Benedict's mother Delilah at parents evening and she told me that Benedict's father, Archibald, has OCD.'

'Oh my', said Alasdair. 'I had no idea. I thought OCD was a neural condition.'

Discuss neural and genetic explanations for OCD and refer to Cordelia and Alasdair's conversation in your answer. (16 marks)

Genetic explanations for OCD suggest that it is inherited because individuals receive specific genes from their parents which influence the onset of the disorder. OCD is a polygenic condition, which means that several genes are involved. Taylor (2003) suggests that as many as 230 genes may be involved and different genetic variations contribute to the different types of OCD, e.g. hoarding or obsession with religion. A gene that has been linked to OCD is the COMT gene which produces *catechol-O-methyltransferase.* This variation regulates dopamine and is more common in patients with OCD, compared to people without OCD. This is what Cordelia is alluding to when she says that Benedict's father, Archibald, also has the condition in that he may have passed it down to his son at birth, giving him the predisposition to develop the condition later in life.

The genetic explanation for OCD is well explained, drawing upon relevant research to support the description.

Effective reference to the scenario drawing on appropriate material.

Neural explanations for OCD suggest that abnormal levels of neurotransmitters are implicated. Lower levels of serotonin are associated OCD. Evidence for this comes from research examining antidepressants (SSRIs). Piggott *et al.* (1990) found that drugs which increase the level of serotonin in the synaptic gap are effective in treating patients with OCD. This explanation is what Alasdair considers to be the cause of the disorder, as he believed that OCD was a neural condition.

The second element of the question is addressed well, although in less detail to remain within the number of marks allocated for AO1.

Application to the scenario is good.

A strength of the biological explanation of OCD comes from research support seen in family studies. Lewis (1936) examined patients with OCD and found that 37% of the patients with OCD had parents with the disorder and 21% had siblings who suffered. This research also support Cordelia's view and suggests that her claim that Archibald has OCD as a result of inheriting the condition from his father is support by psychological research.

The evaluative commentary is well-elaborated and makes excellent use of research studies for support.

While research from family studies provides support for a genetic explanation for OCD, it does not rule out other (environmental) factors playing a role. This explanation for OCD reduces a complex human behaviour to a single gene or

brain chemical and so is considered biologically reductionist. For example, the biological explanation does not consider the role cognitions (thinking) or learning in the development of OCD. While Cordelia and Archibald both outline biological explanations, they both fail to acknowledge the possibility of other explanations that could also explain Benedict's behaviour. For example, the two-process model proposed by behaviourists suggests that learning could play a crucial role in the disorder. Initial learning of the anxiety-inducing stimulus could occur through classical conditioning, for example if dirt/germs are paired with anxiety (e.g. becoming ill). Compulsive behaviour (e.g. continual hand washing) is then maintained through operant conditioning and negative reinforcement, as the compulsive behaviour reduces the anxiety associated with the anxiety-inducing stimulus which serves to reinforce the condition.

An interesting alternative explanation from the behaviourist approach is offered with some application to the scenario.

Further support for the biological explanation of OCD comes from twin studies which have provided strong evidence for a genetic link. Billett *et al.* (1998) conducted a meta-analysis of 14 twin studies investigating the genetic inheritance rate of OCD. It was concluded that monozygotic (MZ) twins had *double* the risk of developing OCD compared to dizygotic twins (DZ) if one of the pair had the disorder. Since concordance rates in twin studies are never 100%, it suggests that the diathesis-stress model may be a better explanation whereby a genetic vulnerability is inherited and triggered by a stressor in the environment.

The evaluation is continued with interesting discussion about the genetic link to the disorder coming to a thought-provoking conclusion.

[~550 Words]

Examiner Style Comments: *Mark Band 4*

This is a good response to this application question relating to the case of Benedict and his father, Archibald. The answer provides detailed knowledge of the biological approach to explaining obsessive compulsive disorder (OCD) including both genetic and neural explanations, as demanded by the question, which are highly accurate and detailed. The use of specialist terminology is consistent throughout the response and explained well. Furthermore, the discussion is centred on two strengths of these explanations and provides an in-depth commentary that is thorough and effective.

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