Introduction

These Teacher Notes accompany and complement the OCR A2 Unit G543: Health & Clinical Psychology Workbook. At A2, students should have a deeper understanding of psychology than at AS, and they will be required to write essay-style answers in the exam. Throughout these notes, any answers given are suggestions and examples, and credit should be given for reasonable alternatives. Use your discretion when marking unexpected responses by assessing whether the student has recognised the requirements of the question.

The Unit G543 exam lasts 1½ hours, and students are required to answer two questions for each applied option. Students should therefore aim to write for about 45 minutes in each applied option, and spend about 20 minutes on each question.

Answering the questions in the workbook should help students develop the skills they need to perform well in the exam. Ideally, they should practise answering questions under timed exam conditions, when they will need to write rapidly but accurately.

In questions asking the candidate to evaluate, assess or discuss etc., students frequently lose marks because they only describe psychological content and/or they have not learned how to make their points in an effective manner. Effective evaluation and analysis requires practice, and students need to be taught how to separate points on research methods, sampling, data collection methods, ethics of research, approaches and potential implication(s) and application(s) of research into different strands of argument.
Skills of analysis and argument can be developed. For example, you might teach students to use the ‘three-point rule’:

1. State the point (for example X lacks ecological validity).
2. Justify the point (say where and why X lacks ecological validity).
3. Explain why this point is a weakness/strength.

Students could also practice using analytical sentence starters, for example:

- However, there are limitations to X because...
- On the other hand...
- This implies that...
- This is useful because...
- Not all psychologists agree, for instance...
- There are advantages to X because...
- This breached the ethical guidelines because...

The purpose of these Teacher Notes is not to provide a model answer for each question, but to provide guidance on the content and characteristics of an effective answer.

The workbook is organised into four topics:

- **Topic 1** focuses on psychological research into aspects of healthy living.
- **Topic 2** looks at the psychology of stress.
- **Topic 3** examines the psychology of dysfunctional behaviour.
- **Topic 4** focuses on the characteristics of, explanations for, and treatments for specific disorders (for example anxieties and phobias).

There are several ways in which you and your students could use the workbook: as an integral part of the learning experience to be used in conjunction with class notes, handouts and textbooks; as a revision tool; or as a combination of both.

**Topic 1 Healthy living**

At the end of this topic, students should be able to describe and evaluate psychological research into factors that influence health lifestyles, beliefs about health and how healthy behaviour can be promoted (for example by adherence to medical advice).

**Question 1**

- **a** Students should write a synopsis of one health belief model.
- **b** Students could mention factors such as:
  - whether the person thinks he or she needs to take action; if patients do not believe that an illness is severe, they are not likely to take action to change their health behaviour
  - whether the person estimates that the cost of changing his or her behaviour will bring a benefit; if the cost of adopting a healthy behaviour is seen as greater than the reward for the behaviour, people are unlikely to change the way they behave
• whether the person has a cue to take action, such as internal symptoms of pain or discomfort, or external stimuli, such as health campaigns or screening programmes
• whether the person has a high level of self-efficacy — people who are confident that they can change their behaviour (for example diet) are more likely to make changes

The Becker and Rosenstock cognitive model is useful because it can be applied to design health promotion programmes that give people information about health problems and cues to action, for example raising awareness of how obesity may cause type-2 diabetes.

The Weinstein theory that people are unrealistically optimistic about risks to their health is useful because it can be applied to design health promotion programmes for young people, who tend to believe that their unhealthy behaviour does not put them at risk.

However, theoretical models are not useful because they are ‘generalistic’ and do not take account of individual differences in health behaviour. Understanding how people differ in their health decision-making is useful, because differences in health locus of control may affect how people make decisions about their health behaviours, and people with high self-efficacy are more likely to make lifestyle changes and invest more time and effort than those with low self-efficacy.

**Question 2**

**a** Students should describe one study from Item 2, in less than 10 minutes. It would be a useful approach to set students a challenge to write a synopsis of the Anderson et al. ‘Healthy Heart’ study in less than 150 words.

**b** Answers will depend on which study the students describe.

Suggestions:

• Janis and Feshbach (fear): low ecological validity and low generalisability because of the biased sample. However, useful in the design of health promotion programmes.
• Cowpe (using the media): high ecological validity, but can only really be applied to problems where ‘clear recommendations’ (‘don’t overfill your chip pan’) can be made. Difficult to assess the effectiveness of media campaigns (explain why); also, do they reach the people who most need to change their behaviour?
• Healthy Heart campaign (action research, longitudinal): high ecological validity (explain why), high generalisability because this approach could be applied to many health promotion programmes. Limitation — longitudinal health promotion programmes need large samples, are expensive to set up and run, and it may be difficult to gain a valid measure of effectiveness.

**c** Answers will depend on which study the students describe.

Suggestions:

• Janis and Feshbach (fear): useful in the design of health promotion programmes because the study showed that using fear to promote healthy behaviour is not effective. Methodology problems — laboratory experiment has low ecological validity and sample bias.
• Cowpe: using the media can be useful to give cues to action but can only be applied to problems where ‘clear recommendations’ (for example wearing seat belts and cycle helmets) can be made. Difficult to assess the effectiveness of the media campaign and whether the campaign persuades the people who most need to change health behaviours.

• Healthy Heart campaign: useful because this community approach could be applied to many health promotion programmes, but longitudinal health promotion programmes need large samples, are expensive to set up and run, and it may be difficult gain a valid measure of effectiveness.

**d** Students should write about 200 words. They should make a plan before they start writing, deciding which problems they are going to explain and what evidence they will use to support their arguments.

Suggestions:
• deciding which sample of the population the health promotion programme will target and whether a volunteer sample should be used
• deciding how to give the information, for example should a ‘fear message’ be used, and, if so, is this a breach of the ethical guidelines?
• deciding how to gain a valid measure of the effectiveness of the promotion — whether to use a snapshot study or a longitudinal study
• deciding whether to collect quantitative or qualitative data and whether findings should be based on self-report or on some objective measure of health behaviour changes
• designing the programme so that it can be replicated, to ensure reliability

**Question 3**

**a** Students will probably outline the Stanton model. Stanton developed a model to predict compliance in hypertension, which can also be generalised to other conditions. This model says that adherence can be predicted from several factors:
• knowledge of the medical regime
• satisfaction with the provider
• patient/provider communication
• internal locus of control
• perceived social support
• the extent to which adherence will disrupt one’s lifestyle

This model suggests that adherence may depend on both situational factors and individual characteristics.

**b** The Stanton model is useful because:
• it is not reductionist, as it suggests that adherence may depend on situational and social factors as well as individual characteristics such as locus of control
• it suggests that if health professionals communicate effectively with the patient, adherence will increase
it helps to identify the samples of patients (for example those having no social support) who may not follow advice

However, the model does not identify the factor most likely to reduce adherence to medical advice.

c Students will probably describe either the Funhaler study or the Lustman study, which is given here, as an example. An effective answer will clearly identify the aims, participants, procedures, findings and conclusions.

d Strengths of the Lustman study include:
- Objective measures of adherence (blood sugar levels) give a valid measure of adherence.
- The double-blind technique also adds to the validity of the measurement.
- There was high ecological validity for this sample — real patients were treated.

Limitations of the study are:
- There is low generalisability to samples of patients who suffer depression as well as another health problem.
- It can only be generalised to volunteer samples, who may already be more likely to adhere to their treatment regime.

e Students should plan to write three paragraphs (about 150 words in total), and each paragraph should clearly identify the problem being assessed.

Possible problems should be explained in full and include:
- gaining a valid measure of adherence if self-report methods or if biological samples (for example blood) are used
- deciding how long to measure adherence for, and the advantages and disadvantages of a longitudinal study
- gaining a representative sample: should volunteer samples be used or not?
- controlling for individual differences in patients; patients are all different — some patients may have high levels of self-efficacy and thus be more likely to adhere to advice, but others may decide that the cost of adherence is greater than the benefits; these individual differences mean it is difficult to know, with any certainty, which patients will adhere to advice and why, and which ones will not
- avoiding drawing reductionist conclusions, because many environmental factors may affect patient adherence, such as seeing a ‘cue to action’ in the media

**Question 4**

Students should plan their answers and write them up in full under timed conditions (allow 30 minutes). Then they should mark their work against the marking criteria and make suggestions as to how their answers could be improved.
**Topic 2 Stress**

At the end of this topic, students should be able to describe and evaluate psychological research into factors that cause stress, how to measure stress and how to improve health by helping people to manage stress. They should also be able to discuss and apply psychological research methods, perspectives and issues when answering questions related to these aspects of research into stress.

**Question 1**

a  Factors that may cause stress include:

- the workplace: work can be stressful. For some people, the kind of work they do, where they work and with whom they work can be a source of stress. Some of the more stressful occupations are nursing, teaching, and roles in the emergency services. Someone who is stressed at work may become ill and need to take time off.

- life events: throughout our lives we experience many changes, such as leaving home, marriage, changing employment, the birth of children and moving house. Holmes and Rahe found that these events cause us to change the way we live and that adjusting to change causes stress.

- daily hassles: DeLongis et al. theorised that it was everyday hassles that caused stress. They created a hassles scale to assess the effect of the routine problems of life. The frequency and intensity of hassles significantly correlated to ill health.

b  **Note:** the OCR specification does not require students to learn the physiology of stress, but understanding how stress may be a cause of physical ill health will be useful.

Selye (1956) proposed a biological model of how stress causes physical illness. He called the response to stress the ‘general adaptation syndrome’ (GAS) and identified three stages in the model:

- alarm stage: when we perceive a stressor, the autonomic nervous system (ANS) responds — adrenaline, noradrenaline and corticosteroids (hormones) are released into the bloodstream. The bodily reaction is increased arousal levels, i.e. the heart rate increases and blood pressure rises.

- resistance stage: if the stressor continues, the bodily reaction ceases and we appear to be coping, but output from the adrenal cortex continues and the adrenal glands may become enlarged.

- exhaustion stage: if the stressor continues for a long time, the body’s resources are reduced, but alarm signs, such as increased blood pressure, may return. The person may become depressed and the immune system may be damaged. Stress-related diseases, such as stomach ulcers or high blood pressure, may occur.

c  There is a wide range of evidence for students to select from:

- the role of control and social support: Johnson and Hall, research into control and interpersonal relationships at work
- causes of stress, life events: Holmes and Rahe, Social Readjustment Rating Scale (SRRS)
- daily hassles and stress: DeLongis et al.
- causes of stress, individual differences in response to stressors: Friedman and Rosenman
  Type-A personality

**d** There is a wide range of answers to this question. An effective answer will provide a balanced argument and will justify and explain each strength/weakness by quoting evidence from the study. In class, students could be encouraged to score their answer against the mark scheme and then suggest how the answer could be improved.

**e** Johnson and Hall investigated the relationship between social support, perceived control and how demanding jobs are, and the incidence of cardiovascular disease. Data from 14,000 male and female workers were analysed to explore the relationship between cardiovascular disease and job stress associated with control, demand and social support. The data included four scales of measurement:
- work control, based on questions about the level of influence over the planning of work
- work-related social support, based on questions about how and when workers could interact with co-workers
- psychological demands of work, based on questions about how demanding the work was
- cardiovascular health

Jobs that were perceived to be demanding but that involved low levels of control were related to increased incidence of heart disease. Where workers had few opportunities for social interaction (low social support), there was an increase in cardiovascular disease in the high-demand, high-control combination. Low social support combined with low control increased cardiovascular disease.

It was concluded that both social support and control are important factors in work-related stress.

**f** Students could suggest the following strengths:
- Not reductionist — takes a biological/psychological/social approach rather than assuming that one single factor causes stress in the workplace.
- A large sample reduces the impact of individual differences such as Type-A personality — thus should be generalisable to workplaces having similar characteristics.
- High ecological validity — this was a real workplace and workplace procedures were not changed.

A weakness would be that because the study looks at the interaction between three factors — job stress associated with control, demand and social support — it cannot tell us which of these factors is most likely to cause stress in the workplace and therefore what employers should change to reduce stress in the workplace.
Question 2

a Students are likely to choose either of the following studies:

- Johansson et al. investigated whether work stressors such as repetitiveness, machine-regulated pace of work and high levels of responsibility increase stress-related physiological arousal and stress-related illness. Levels of stress-related hormones (adrenaline and noradrenaline) in the urine were measured on work days and rest days. Records were kept of stress-related illness and absenteeism. A combination of work stressors, especially repetitiveness, machine-pacing of work and high levels of responsibility, lead to chronic (long-term) physiological arousal, which in turn leads to stress-related illness and absenteeism.

- Beek et al. evaluated 32 lorry drivers’ work stress by measurement of adrenaline and noradrenaline excreted in the urine, to find out which factors in their working situation are related to the excretion rates of these catecholamines. The urinary excretion was studied for one working day and one rest day. Each driver was asked to provide six urine samples on both days. The excretion rates of adrenaline and noradrenaline on the working day were higher than those found in earlier studies among professional drivers, and insufficient recovery took place after the work was ended.

b Students may make the following points:

- Biological measurement provides objective and quantitative data, which can be used to make comparisons and carry out statistical analysis. However, although biological measures provide objective evidence, the person may not feel that he or she is stressed. If the person does not feel stressed, is he or she really suffering from stress? Perhaps self-reported feelings of stress should be correlated with the biological stress measures to decide how valid biological measurements are.

- Ecological validity: if biological samples are taken as part of the normal working day, as in the Beek sample where lorry drivers only had to save urine samples, then the procedures will be unlikely to alter the stress levels of the participants.

- In a small sample, biological measurements may not be a valid measure of stress because individual differences in participant characteristics may have a large effect. For example, Type-A personalities may have increased levels of adrenaline because of their competitive and time-pressured lifestyles.

c Students will probably describe the Holmes and Rahe Social Readjustment Rating Scale or the DeLongis et al. daily hassles measure of stress.

d Students should write three paragraphs of about 150 words in total and should make sure they use evidence to justify their arguments:

- One strength of using self-report methods is that they are not intrusive. For example, stress questionnaires can be circulated to a large sample, whereas biological samples require consent and specialist staff and equipment to take measures.

- However, self-reports that take quantitative measures of stress, such as the Holmes and Rahe SRRS, may not be valid. This is because every person’s view of how stressful an event
is subjective, and even if two people agree that Christmas is stressful, they may not find it equally stressful.

- Self-reports can be biased by social desirability, where participants answer questions in the way they believe is socially acceptable. In this case, self-report will not be a valid measure of stress.
- People are often asked to self-report on questionnaires how stressed they are, but the questionnaire may only be useful with a limited sample. For example, the Holmes and Rahe SRRS has questions about mortgages and employment, and thus may not be a reliable measure of stress in any other sample but employed adults.
- Self-reports that ask people about how stressful they find some situations, such as daily hassles scales, may underestimate the effect of individual differences. For example, Type-A personalities might find being held up by a traffic jam more stressful than non-Type-A personalities.

Students should write two paragraphs and make sure they focus on reductionism. They should start by giving a clear explanation of what is meant by reductionism.

**Example**

Research is reductionist if it explains complex human behaviour in terms of one single factor, ignoring other factors that have an effect on what is being measured. The experience of stress is an example of complex human behaviour, and whether a person feels stressed can be affected by individual, social and situational factors, and the result of stress can be cognitive (feeling anxious), behavioural (sleeping badly or absence from work) and biological (raised levels of adrenaline and increased blood pressure).

This means that one problem faced by psychologists who want to measure stress is deciding what to measure:

- Should they measure individual differences in personality (as per Friedman and Rosenman)?
- Should they measure locus of control (as per Rotter)?
- Should they measure biological factors (as per Beek, who tested the urine samples of lorry drivers for adrenaline)?

Arguably, if only one of these factors is measured, this can be described as a reductionist measure, because the resulting findings will ignore other factors that have been found to be associated with stress.

However, an advantage of taking a reductionist measurement is that findings are more useful because when psychologists identify a factor that is associated with stress, such as having little control or social support in the workplace, the findings can be applied to make recommendations as to how stress can be reduced.

**Question 3**

a Students are likely to describe stress management by using behavioural techniques such as biofeedback or stress inoculation by Meichenbaum (cognitive behavioural therapy, CBT).
If students choose stress inoculation, remind them to describe the aims and procedures of this treatment.

**Example**
The aim of this cognitive behavioural therapy is to prepare people to cope with stress in a similar way to which an injection prevents a disease. Training people to deal with stress before it becomes a problem involves three stages:

- First, in the conceptualisation stage, patients are encouraged to imagine stressful situations and to analyse what is stressful about them and how they might deal with them.
- Second, in the skill acquisition and rehearsal stage, patients are taught to practise how to relax and how to express their emotions. Specific skills may be taught, such as positive thinking, communication skills and time management.
- Finally, in the application and follow-through stage, patients are supported through progressively more threatening real-life situations while they apply their newly learned skills.

**b** Advantages of biofeedback (behavioural) include:

- There are no side effects.
- It reduces symptoms and gives people a sense of control.
- The learned techniques can be generalised to other stressful situations.
- It is more effective if combined with psychological therapies that encourage people to think about the causes of their stress and how their behaviour may contribute to it.

Advantages of stress inoculation (cognitive) include:

- It focuses on the cause of stress and ways of coping with it.
- It is effective for both short-term and long-term stressors and can be combined with other treatment methods.
- The increased feelings of ‘being in control’ and improved communication and time-management skills lead to increased self-confidence and self-efficacy.
- There are no physiological side effects.

Disadvantages of stress inoculation include:

- It may only be successful with patients who are already determined to make the time and effort to help themselves.
- The research findings are based on a narrow sample (mainly white, middle-class, well-educated people), thus they may not generalise to other populations.

**c** A range of points can be made. For example, research is useful if it:

- leads to an application, for example reducing stress in the workplace
- helps people to cope with stress in their lives, for example stress inoculation has a long-term effect
- can be used to reduce the probability that people will become ill as a result of stress, for example biofeedback reduces the physiological effects of stress
- helps us to understand why some people are more likely to suffer stress-related ill health than others, for example research into Type-A personality and locus of control.
However, research may be less useful if it takes a reductionist approach. For example, even if people do change the way they think (CBT), they may still suffer from stress, and may blame themselves for feeling stressed.

d Students could discuss several problems and should make a plan as to which problems they are going to explain and what evidence they will use to support their arguments. Examples of such problems include:

- deciding what to measure in order to gain a valid measure of the effectiveness of the stress management technique, whether to collect quantitative or qualitative data, and whether data should be gathered by self-report or by some biological measure of stress levels
- deciding how long the measurement programme should last (should it measure short-term effects or long-term effects? What are the advantages and disadvantages of using a longitudinal design?)
- how to control variables that may interact with the stress management programme, such as whether the participant experiences a stressful life event
- how to select a representative sample of the people being treated in order to generalise the findings as widely as possible

Question 4

Students should plan their answers and write them up in full under timed conditions (allow 30 minutes). Then they should mark their work against the marking criteria and make suggestions as to how their answers could be improved.

Topic 3 Dysfunctional behaviour

At the end of this topic, students should be able to describe and evaluate psychological research into the diagnosis of, explanations for and treatments for dysfunctional behaviour. They are also required to discuss and apply psychological research methods, perspectives and issues when answering questions related to research into dysfunctional behaviour.

Question 1

a Rosenhan and Seligman (1989) propose seven major features that appear in abnormal behaviour. The more of these features that are possessed by the individual, the more likely he or she is to be considered dysfunctional:

- Suffering: most abnormal individuals (such as those with anxiety disorders) report that they are suffering.
- Maladaptiveness: maladaptive behaviour prevents an individual from achieving major life goals or from having fulfilling relationships with others.
- Vividness and unconventionality: behaviour is unusual or differs substantially from the way in which we would expect people to behave in similar situations.
• Unpredictability and loss of control: dysfunctional behaviour is often highly unpredictable and uncontrolled, and inappropriate for the situation.
• Irrationality and incomprehensibility: there appears to be no good reason why the person should choose to behave in that way.
• Observer discomfort: when others break unspoken social rules, we experience discomfort.
• Violation of moral and ideal standards: when moral standards are violated, this behaviour may be judged as dysfunctional.

b One of the problems with using Rosenhan’s seven categories is that they rely on subjective opinion, and it can be difficult to decide which of the features are actually present in a person’s behaviour. Another problem is that social norms vary from one culture to another — thus behaviour that causes observer discomfort in one culture may not do so in another culture.

There may also be problems with the reliability and validity of the diagnosis. Reliability refers to the extent to which different psychiatrists agree on patients’ diagnoses (inter-observer reliability). In his study on being sane in insane places, Rosenhan found that psychiatrists diagnosed normal people as having schizophrenia.

c Two types of bias can be considered here:
• Culture bias: we cannot judge normality or abnormality without reference to the norms of the culture where the behaviour arose. Behaviour that appears abnormal in one cultural setting, because it deviates from the norms of that culture, may not be abnormal in its native cultural setting. Because cultures differ in their attitudes and customs, it is not possible to formulate absolute definitions of abnormality, so psychiatrists from one culture may diagnose normal behaviour from another culture as dysfunctional.
• Gender bias: much research suggests that women are more likely to be diagnosed as depressed than men. This may be because men are less likely to visit their GP, and/or men are less likely to express their feelings. Research has found that separated, divorced or widowed women are almost five times as likely to be diagnosed as depressed as those who were never married, suggesting some evidence of possible gender bias in the diagnosis of depression.

**Question 2**

a The biological approach assumes that psychological abnormalities are symptoms of underlying physical causes. Thus, psychological disorders may be referred to as ‘mental illnesses’. These are seen as arising from specific factors:
• Genetics: there is evidence that some mental disorders, such as schizophrenia, run in families, suggesting an underlying genetic abnormality.
• Neurotransmitters: too much or too little neurotransmitter may result in psychological disorders. In this case, there is the assumption that there is a direct relationship between the function of the brain and behaviour.
b Strengths of the biological explanation for dysfunctional behaviour include:
- The approach does not blame people for their abnormal behaviour. It has led to a more humane treatment of the mentally ill.
- The scientific status and association with the medical profession means that this approach enjoys credibility.
- Objective evidence shows that biological causes can be linked to psychological symptoms, for example genetic differences in schizophrenia.

Limitations include:
- Psychiatrists such as Szasz and Laing object to the medical approach. They see the use of labels, such as ‘mentally ill’, as a way of pathologising people whose behaviour we do not like or cannot explain.
- There may be problems of validity and reliability of the diagnosis. There is frequently a degree of overlap between symptoms of different disorders, meaning the diagnosis may be unreliable.
- Biological explanations take a reductionist approach to psychological abnormality and ignore the relationship between the mind and body.

**Question 3**

a The behavioural explanation makes three assumptions:
- All behaviour is learned.
- What has been learned can be unlearned.
- Abnormal behaviour is learned in the same way as normal behaviour.

This model sees the abnormal behaviour as the problem and not a symptom of an underlying cause.

b Behaviourists propose that classical conditioning can explain phobias. In classical conditioning, an unconditioned stimulus, such as an unexpected loud noise, triggers a natural reflex, for example the startle response and fear. If another stimulus, for example seeing a spider, occurs at the same time, this may in future elicit the fear response.

Behaviourists also propose that phobias such as fear of heights can be learned by the process of operant conditioning, in which behaviour is learned through the consequences of our actions. If our actions result in rewarding consequences (positive reinforcement), or in something unpleasant ceasing (negative reinforcement), we will repeat the behaviour.

c You could ask students to select their strength/limitation and then write two sentences linking them with the word ‘however’.

Strengths of the behavioural explanation include:
- The behavioural approach proposes a simple testable explanation that is supported by experimental evidence.
- The approach is hopeful, as it predicts that people can change (re-learn) their behaviour.
Limitations of the behavioural explanation include:

- The approach is criticised as being dehumanising and mechanistic (Heather, 1976). People are reduced to programmed stimulus–response units.
- The approach cannot explain all psychological disorders. Conditioning cannot cure all disorders, for example schizophrenia.
- The approach takes a reductionist approach to psychological abnormality and ignores biological factors.

Example
One strength of the behavioural approach is that it is hopeful, as it predicts that people can change (re-learn) their behaviour. However, the approach cannot explain all psychological disorders. Conditioning cannot cure all disorders, for example schizophrenia.

Question 4

a Cognitive explanations are based on the assumption that the mind controls behaviour, and that people can control how they select, store and think about information.

The cognitive approach proposes that dysfunctional behaviour is caused by faulty or irrational thoughts — psychological problems are caused when people make incorrect inferences about themselves or others, and have negative thoughts about themselves and the future.

b The cognitive explanation for the friend’s depression is that he or she may have irrational and self-defeating thought patterns. According to Beck, depressed individuals have acquired negative schema during childhood and these negative schema are activated when they encounter any new experience which in turn causes them to ‘expect to fail’. Beck and Clark found that irrational beliefs were common in patients suffering anxiety and depression, and that depressive people often believe that they are unloved, that they are failures as parents, and that nothing good will ever happen in the future.

c Example
One advantage of the cognitive approach is that it focuses on how the individual experiences the world and his or her feelings and beliefs, rather than relying on interpretations by other people. However, a limitation of the cognitive approach is that it may encourage the idea that people are responsible for their own psychological problems, i.e. that they could be ‘normal’ if they did not think irrationally. This could lead to people being ‘blamed’ for psychological abnormalities.
Question 5

a Assumptions of the biological approach

The biological approach assumes that psychological abnormalities are symptoms of underlying physical causes, such as abnormal biochemistry in the brain (neurotransmitters). The biological approach assumes that too much or too little neurotransmitter may result in psychological disorders. Thus the cause of Jojo’s anxiety and panic attacks may be an imbalance in the biochemistry of his brain.

b Assumptions of the psychological approach

Cognitive explanations are based on the assumption that the mind controls behaviour, and that people can control how they select, store and think about information. The cognitive approach proposes that dysfunctional behaviour is caused by faulty or irrational thoughts — psychological problems are caused when people make incorrect inferences about themselves or others, and have negative thoughts about themselves and the future. Horace may have irrational and self-defeating thought patterns. According to Beck, depressed individuals have acquired negative schema during childhood and these negative schema are activated when they encounter any new experience, which in turn causes them to expect to fail. In Horace’s case, losing his job may have triggered his negative schema.

c Assumptions of the psychological approach

The behavioural explanation makes three assumptions. First, it assumes that all behaviour is learned; second, that what has been learned can be unlearned; third, that abnormal behaviour is learned in the same way as normal behaviour. This model sees the abnormal behaviour as the problem and not a symptom of an underlying cause. One way that the snake phobia may have been learned is by classical conditioning. In classical conditioning, an unconditioned stimulus, such as an unexpected loud noise, triggers a natural reflex, for example the startle response and fear. If another stimulus, for example seeing a snake, occurs at the same time, this may in future elicit the fear response.

Question 6

Students should plan their answers and write them up in full under timed conditions (allow 30 minutes). Then they should mark their work against the marking criteria and make suggestions as to how their answers could be improved.

Question 7

a Treatments based on the biological approach assume that dysfunctional behaviours are symptoms of underlying physical causes and drug treatments are often used to change or rebalance the biology of the brain. Anti-anxiety drugs, such as benzodiazepines, slow the activity of the central nervous system (CNS), reducing serotonin activity (and thus anxiety) and increasing relaxation. Beta-blockers act on the autonomic nervous system (ANS) to reduce activity in the ANS associated with anxiety.
Obsessive-compulsive disorder (OCD) is an anxiety disorder characterised by recurrent, unwanted thoughts (obsessions) and/or repetitive behaviours (compulsions). Jenike et al. (1997) conducted a 10-week placebo-controlled trial of fluoxetine drugs for OCD. Of the 64 patients, the fluoxetine-treated patients improved significantly more than those in the placebo condition, suggesting the drug treatment was effective.

Advantages for the use of drugs in the treatment of psychological abnormalities include:
- It is claimed that biological therapies (drugs) reduce the symptoms of conditions such as schizophrenia, which could formerly not be treated.
- Drug therapy can be used alongside therapies based on psychological approaches.
- Drug treatments are easy to administer and do not involve the patient changing his or her lifestyle or behaviour.
- Drug therapies act rapidly to relieve symptoms.

Limitations of this approach include:
- Biological therapies may cause ethical concerns. Some drug therapies can have unpleasant side effects. Patients with some conditions may be unable to understand the implications of their treatment and thus be unable to give their informed consent.
- Taking drugs may lead to addiction and dependency.
- Drugs may simply suppress the symptoms, not cure the disorder. The use of drugs may divert attention away from the real causes of the problem.
- Drug treatments take a reductionist approach to the treatment of abnormality because they ignore psychosocial factors.

The treatments proposed by the behaviourist model are based on the assumption that dysfunctional behaviour is learned in the same way as normal behaviour and that it can be unlearned. Dysfunctional behaviour is seen as ‘a problem to be cured’.

Behaviourists try to identify the reinforcers of abnormal behaviour and change the consequences of behaviour. Behavioural therapies may use:
- classical conditioning, in which an undesirable behaviour can be paired with an unpleasant response (aversion therapy)
- systematic desensitisation, in which phobics can be gradually reintroduced to a feared object or situation

Systematic desensitisation is a type of behaviour therapy where the undesired behaviour, for instance a person's phobia, is broken down into the small stimulus–response units that comprise it. The therapy involves:
- the construction of a hierarchy of fears
- training in relaxation — the relaxed state is incompatible with anxiety
- graded exposure (in imagination) and relaxation
- homework — practice in real life
For instance, in a phobia of snakes, the least stressful situation might be to look at a picture of a snake and the most stressful might be to have to touch a snake. The therapist works through each stimulus–response unit in the ascending hierarchy, helping the person to replace each dysfunctional response of being afraid with the response of feeling relaxed.

**d  Example**

One advantage of behavioural therapies is that they are effective for treating phobias, obsessive-compulsive disorder and eating disorders, and are appropriate for those whose symptoms are behavioural. *On the other hand*, behavioural therapies are only effective for a limited number of disorders — conditioning cannot cure all disorders, for example schizophrenia.

**e** Cognitive treatments focus on helping the patient to change irrational or negative thoughts to ones that are rational and positive. The objective of treatment is to correct unrealistic ideas, so that thinking becomes an effective means of controlling behaviour. The therapist supports the patient through a process of cognitive behavioural therapy (CBT) until thought processes become more rational. As an example of treatment, Ellis developed rational emotive behaviour therapy (REBT) based on the idea that some people have persistent self-defeating thoughts that are irrational. According to Ellis, irrational beliefs cause distress and can be identified when we catch ourselves thinking ‘should’ or ‘must’ in ways that are subjective and judgemental. In REBT, clients are taught to recognise and replace their ‘irrational’ thoughts with more constructive and realistic ones.

**f** One advantage of cognitive-based therapies is that they may increase self-efficacy and self-belief and thus improve people’s lives in the future, and evidence suggests that CBT is more effective than drugs for treating depression and anxiety. *On the other hand*, cognitive treatments may only be effective for anxiety disorders and depressive illnesses, and may not be generalisable to many psychological abnormalities.

**g  Example**

Systematic desensitisation is a type of behaviour therapy where the undesired behaviour, for instance Shabnam’s phobia, is broken down into the small stimulus–response units that comprise the phobia. The treatment follows stages:

- the construction of a hierarchy of fears
- training in relaxation — the relaxed state is incompatible with anxiety
- graded exposure (in imagination) to the object of the phobia and relaxation
- homework — practice in real life

For instance, with a phobia of spiders, the least stressful situation might be to look at a picture of a spider and the most stressful might be to have to touch a spider. The therapist works through each stimulus–response unit in the ascending hierarchy, helping the person to replace each dysfunctional response of being afraid with the response of feeling relaxed. If Shabnam completes this programme, she should learn to overcome her fear of spiders.
**Question 8**

Raisa could be offered rational emotive behaviour therapy (REBT). In REBT, clients are taught to recognise and replace their ‘irrational’ thoughts with more constructive and realistic ones and are encouraged to realise that it is not the events in themselves that lead to negative consequences but the self-defeating beliefs that we develop about the events. Clients are encouraged to change the way they think about events in their lives by asking themselves whether the way they think ‘makes sense’, whether there is proof that their belief is accurate, and whether the way they think is helpful to them. This internal disputation changes self-defeating beliefs into more rational beliefs that should help Raisa feel less depressed.

**Question 9**

*Example*

It can be argued that if the cause of mental illness is known to be biological, then drug treatment is effective because it quickly relieves symptoms, enabling people to manage their lives more easily, especially as drug treatment only requires the patient to remember to take the drugs, and does not involve changes of lifestyle. The antipsychotic drug clozapine is an effective treatment for both the positive symptoms (delusions and hallucinations) and negative symptoms (social withdrawal) of schizophrenia, and one benefit of drugs such as chlorpromazine is that they allow psychotic patients to live outside psychiatric hospitals.

However, if, as has been suggested, schizophrenia has a genetic cause, drugs are unlikely to provide a long-term cure because they will not ‘cure’ the cause of the problem. Also, a possible problem with chemotherapy is that drugs may only provide temporary relief from symptoms, and when the patient stops taking the drugs the symptoms are likely to recur.

A further limitation is that it may be difficult to separate the effect of the drug from any placebo effect. Khan et al. (2000) reviewed the data from 45 clinical trials where patients were assigned either to treatment by antidepressant drugs or to placebo comparison conditions. They found that for suicide/attempted suicide, there was no significant difference between the treatment and placebo groups.

Also, it is suggested that patients overstate their symptoms at the start of treatment in order to ensure care and then understate their symptoms at the end of treatment to show gratitude. This ‘hello–goodbye’ effect tends to make drug treatment (or any treatment) appear more effective than it really is. That said, an advantage of chemotherapy is that drugs can be used together with other therapy; however, individuals may respond differently to the same drug treatments and drug-induced side effects can be problematic. Also, ethical issues may arise, because if we do not know what effects the same drug will have on different people, how can valid informed consent to drug treatment be obtained?
**Topic 4  Disorders**

This topic focuses on the characteristics of different types of disorder (anxiety, affective and psychotic disorders) and the explanations and treatments for one of these disorders.

**Question 1**

Schizophrenia is a complex psychotic disorder affecting a person's thoughts, perceptions, behaviour and ability to communicate, and is a severe and disabling condition. The symptoms of schizophrenia are said to be either positive or negative. Positive symptoms are a distortion or excess of normal functions, and negative symptoms are a reduction or loss of normal functions. The main positive symptoms are hallucinations, delusions and disordered thinking. Hallucinations are perceptual disturbances, such as hearing internal voices giving the person orders. Delusions are disturbances of thought involving false beliefs, and there may be a disorder of thinking and speech where communication is difficult because the sufferer may believe that other people can hear his or her thoughts.

Negative symptoms are usually a reduction in the range and intensity of emotional expression and a reduction in speech fluency and willingness to talk to others. The sufferer may spend whole days doing nothing and may appear to lose interest in life.

**Question 2**

Clinical depression is a serious condition that affects the lives of millions of people every year. Depression is a mood or 'affective' disorder, in which a negative emotional state colours a person's perceptions, thoughts and behaviour. Clinical depression occurs when depression lasts a long time and affects a person's ability to function normally. Diagnosis of clinical depression requires five or more of the following symptoms, including either 1 or 2, for at least 2 weeks:

1. Extreme sadness, tearfulness and depressed mood
2. Loss of interest and pleasure in usual activities and social withdrawal
3. Disturbed sleep — either loss of sleep (insomnia) or more sleep than normal
4. Changed activity level — often agitated, or may be slowed down and lethargic
5. Disturbed appetite and weight change (which may be significant gain or loss)
6. Loss of energy and tiredness
7. Negative self-concept, including feelings of guilt, low self-esteem and anxiety
8. Difficulty making decisions and diminished concentration span
9. Recurrent thoughts of death or suicide attempts

**Question 3**

Obsessive-compulsive disorder (OCD) is an anxiety disorder characterised by recurrent, unwanted thoughts (obsessions) and repetitive behaviours (compulsions). People with OCD may experience persistent, unwelcome thoughts or images, or the urgent need to engage in certain rituals. Repetitive behaviours, such as hand washing, counting or cleaning are to prevent (block...
out) obsessive thoughts or to make them go away. Performing these behaviour rituals provides temporary relief from anxiety, while not performing these behaviours increases anxiety.

**Question 4**
Three factors support a biological explanation of depression:

1. The symptoms of depression include physical changes.
2. Depression appears to run in families.
3. Drug treatment is effective.

Research suggests that depression may have a genetic cause. Depression seems to run in families. Close relatives of someone with depression, especially identical twins, have a higher than average risk of developing it themselves. McGuffin et al. studied 177 people with depression and their same-sex twins. The concordance rate for depression was 46% in identical (MZ) twins and 20% for non-identical (DZ) twins, which suggests that genes are a factor in depression.

**Question 5**
Cognitive explanations of depression are based on the theory that how we feel is based on how we ‘think’ (cognition) and that ‘faulty’ or ‘irrational’ thinking is the main cause of depression. According to Beck (1967), depressed individuals have acquired negative schema during childhood and these negative schema are activated when they encounter any new experience, which in turn causes them to ‘expect to fail’. Beck proposes that negative schema generate cognitive biases in thought processes, for example drawing negative conclusions from small pieces of evidence, and that negative schema and cognitive biases maintain the depressed person's pessimistic view of the self, the world and the future.

**Question 6**

*Example*

The evidence suggests that genetic relatedness does increase the risk of depression, but even for identical twins the concordance rate is less than 50%, which suggests that other factors must be involved. The research by Zubenko et al. is strong evidence for a genetic explanation of recurrent major depressive disorder, but less strong for mild depression, which suggests that genes may only explain major depressive disorders. However, even when genetically related people do not live together, they tend to share characteristics such as culture and lifestyle that may provide an alternative explanation for depression.

However, cognitive explanations for depression are also supported because there is substantial evidence to suggest that if depressed people change the way they think, they become less depressed. Smith and Glass (1977) conducted a meta-analysis of therapies and cited rational emotive behaviour therapy as the second most effective therapy of ten types of psychotherapy. However, just because negative thinking is associated with depression, this does not mean that cognitive processes cause depression.
Looking at behavioural explanations, although Seligman’s theory was based on experiments with dogs, which may not respond in the same way as humans, learned helplessness has been demonstrated in human participants. The ‘real world’ realism of the Fisher experiment, in which depressed people were asked to judge their performance in a trivial typing task, appears to be low. However, Seligman noted that the physiology of depression (in humans) and the physiology of helplessness (in rats) was similar, which does suggest a link between learned helplessness and biochemical explanations of depression.

Each of the three approaches is supported by evidence, which suggests that there is more than one cause for depression, and that both biological and psychological explanations should be considered.

**Question 7**

If a depression is thought to have a biological cause, drug treatment may be offered. Two types of anti-depressant drug are tricyclic drugs and SSRIs (selective serotonin re-uptake inhibitors, for example Prozac). Depression is thought to be the result of having too little of the neurotransmitters serotonin and norepinephrine. Tricyclics work by blocking the mechanism that reabsorbs the neurotransmitters serotonin and norepinephrine, leaving more of these neurotransmitter substances in the synapse. SSRIs work in a similar way but block the re-uptake of the neurotransmitter serotonin so it remains in the synapses for longer.

**Question 8**

The World Health Organization (WHO 2001) concluded that SSRIs are effective as a treatment for severe depression and have fewer unwanted side effects than tricyclic drugs. Fisher and Greenberg (1995) looked at 15 literature reviews and conducted two large-scale meta-analyses of the use of antidepressants and reported a more than 60% relapse rate among those who responded positively to the drugs and who later ceased to take them, which suggests that the drug was effective.

However, antidepressants may also work by enhancing the placebo effect, in which case almost anything that causes a physiological reaction might turn out to have antidepressant properties.

A disadvantage of drug treatment is that it may cause unpleasant side effects and Prozac is known to cause, in some people, an agitated state of mind and an urge to commit suicide.

However, Khan et al. (2000) reviewed the data from 45 clinical trials where patients were assigned either to treatment by antidepressant drugs or to placebo comparison, and observed no significant difference between the treatment and placebo groups, which tends to suggest that antidepressant drugs do not increase suicidal thoughts. One reason why it is difficult to assess the effectiveness of drug treatment is the ‘hello–goodbye effect’, where patients overstate their symptoms at the start of treatment in order to ensure care and understate their symptoms at the end of treatment to show gratitude. This effect would tend to make drug treatment (or any treatment) appear more effective.
Another problem with using drugs to treat depression is that the depression may return when the patient stops taking the drugs, because the drugs may not treat the underlying cause of depression. If the cause of the depression is cognitive, for instance irrational thinking, then drug treatment will not be an effective long-term cure.

**Question 9**

*Example*

One problem psychologists have when explaining dysfunctional behaviour is deciding which approach provides the best explanation, because each of the approaches — cognitive, biological and behavioural — offers a different explanation, often for the same disorder. Cognitive explanations of depression are based on the theory that how we feel is based on how we ‘think’, and that negative thinking or distorted attribution of failure leads people to blame themselves when things go wrong. Evidence supports this explanation, because helping people to change the way they think appears to be an effective treatment for depression. Butler and Beck (2000) reviewed meta-analyses of Beck’s cognitive therapy and concluded that 80% of adults benefited and that cognitive therapy was more effective than drug treatment.

Behavioural explanations for the same disorder, the learned helplessness theory, proposes that depression is caused because in the past, the person experienced an inability to control unpleasant experiences and as a result learns that there is no point trying to control future situations, so new trauma is met with inaction and depression. Evidence does support this explanation, because Hiroto and Seligman (1974) found that college students who were exposed to unpleasant events were more likely to fail at cognitive tasks.

On the other hand, biological explanations of depression suggest that abnormal biochemistry in the brain increases the risk of depression and this explanation is supported because SSRI drug treatment, which raises levels of serotonin, appears to be an effective treatment for depression.

This is a problem because if each of the three approaches offers a different explanation, and recommends a different treatment, it may be reductionist to assume that any one approach can provide an effective explanation. Another problem psychologists have is obtaining a representative sample of patients having a valid diagnosis to study. Each patient is different and may be experiencing a different type of dysfunctional behaviour, or even the same problem to a different extent. For example, phobias and anxiety disorders may have been learned, but it is unlikely that schizophrenia results from learned behaviour. Where unusual disorders are studied, research is likely to involve small samples, or even case studies, with the resulting problems of low generalisability.