AS PSYCHOLOGY REVISION

PSYCHOPATHOLOGY
3.2.2 Psychopathology Specification

- Definitions of abnormality, including deviation from social norms, failure to function adequately, statistical infrequency and deviation from ideal mental health.
- The behavioural, emotional and cognitive characteristics of phobias, depression and obsessive compulsive disorder (OCD).
- The behavioural approach to explaining and treating phobias: the two-process model, including classical and operant conditioning; systematic desensitisation, including relaxation and use of hierarchy; flooding.
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DEFINITIONS OF ABNORMALITY

STATISTICAL INFREQUENCY

- Abnormality is defined as those behaviours that are extremely rare.
- If we can define what is most common or normal, then we have an idea of what is not common (i.e., it is abnormal).

EVALUATION OF SI

- Some abnormal behaviour is desirable
  - E.g. having an extremely high IQ is not undesirable
  - So using SI to define abnormality means we can’t distinguish between desirable and undesirable behaviours
  - So to distinguish behaviours that need treatment we need to identify behaviours that are infrequent and undesirable
- The cut-off point is subjectively determined
  - If using SI to define abnormality we need to decide where to separate normality from abnormality
- SI is sometimes appropriate
  - Using standard deviation to show normal distribution (more than 2 SD below the mean = mental disorder)
DEFINITIONS OF ABNORMALITY

DEVIATION FROM SOCIAL NORMS
• Abnormal behaviour is seen as a deviation from unstated rules about how one “ought” to behave
  – Anything that violates these rules is considered abnormal
  – These rules are set by society
  – E.g. politeness

EVALUATION OF DfSN
• Susceptible to abuse
  – This varies in time (e.g. 50 years ago it was socially unacceptable to be homosexual; now it is acceptable)
  – Szasz (1974) claimed that the concept of mental illness was simply a way to exclude nonconformists from society
• Deviance is related to context and degree
  – Making judgement on deviance is related to the context of behaviour
  – There is a fine line between abnormal deviant and harmless eccentricity
• There are some strengths
  – DfSN does distinguish between desirable and undesirable behaviour
  – DfSN also takes into account the effect that behaviour has on others
  – DfSN says that abnormal behaviour is one that damages others
DEFINITIONS OF ABNORMALITY

FAILURE TO FUNCTION ADEQUATELY

• People are judged on their ability to go about daily life
  – E.g. eating regularly, washing clothes, being able to communicate with others, etc
• If they cannot do this and are also experiencing distress (or others distressed by their behaviour) then it is considered a sign of abnormality

EVALUATION OF FtFA

• Who judges?
  – A patient may recognise that their behaviour is undesirable and become distressed
  – Or they may be content in their situation but others are uncomfortable and judge them to be abnormal
  – The weakness of FtFA is that it depends on who is making the judgement on abnormality
• The behaviour may be quite functional
  – Some dysfunctional behaviour may actually be functional (e.g. cross-dressing is regarded as abnormal but people make money out of it)
• Strengths of this definition
  – FtFA does recognise the subjective experience of the patient (allowing us to see the point of view of the person experiencing it)
  – Failure to Function is quite easy to judge objectively as we can list behaviours
DEFINITIONS OF ABNORMALITY

DEVIAISON FROM IDEAL MENTAL HEALTH

• Abnormality is defined in terms of mental health, behaviours that are associated with competence and happiness
• IMH would include a positive attitude towards the self, resistance to stress and an accurate perception of reality
• I.e. looking at the absence of signs of mental health (Jahoda, 1958)
• Jahoda identified 6 categories commonly referred to self-attitudes (having high self-esteem), personal growth, integration (coping with stress), autonomy (being independent), having accurate perception of reality, mastery of the environment

EVALUATION OF DfIMH

• Unrealistic Criteria
  – According to these criteria, most of us are abnormal
  – We need to ask how many need to be lacking to be judged as abnormal
  – Criteria are difficult to measure
• Suggests that mental health is the same as physical health
  – It is possible that some mental disorders also have physical causes (e.g. brain injury) but many do not
  – It is unlikely that we could diagnose mental abnormality in the same way that we can diagnose physical abnormality
• It is a positive approach
  – DfIMH offers an alternative perspective on mental disorders by focusing on the positives rather than negatives and what is desirable rather than undesirable
EVALUATION FOR DEFINITIONS OF ABNORMALITY – CULTURAL RELATIVISM

- **Cultural relativism** (the view that all beliefs, customs, and ethics are relative to the individual within his own social context. *I.e. behaviour cannot be judged properly unless it is viewed in the context of the culture in which it originates*)

- **SI** = Behaviours that are statistically infrequent in one culture may be statistically frequent in another

- **DfSN** = What is socially normal in one culture is not normal in another culture. The classification system was based on the social norms of the dominant culture in the West (white and middle class), yet the same criteria are applied to subcultures in the West

- **FtFA** = FtFA criteria is likely to result in different diagnoses when applied to people from different cultures (as the standard of one culture is being used to measure another)
  - This could be why lower-class and non-white patients are more often diagnosed with a mental disorder (due to their lifestyles being different from the dominant culture)

- **DfIMH** = The criteria here are also culture-bound. If we apply the criteria to non-Western or non-middle-class then there may be more incidence of abnormality
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PHOBIAS

• These are anxiety disorders
  – Primary symptom is extreme anxiety
• They are instances of irrational fears that produce a conscious avoidance of the feared object or situation

Emotional Characteristics
• Fear that is marked and persistent, likely to be excessive and unreasonable
• Also anxiety and panic cued by presence or anticipation if a specific object or situation

Behavioural Characteristics
• Avoidance (which interferes with person’s normal routine, occupation, social activities or relationships)
• Freeze (adaptive response as predator may think prey is dead) or faint

Cognitive Characteristics
• These relate to thought processes
• Here the irrational nature of the person’s thinking and resistance to rational arguments
• The person recognises that their fear is excessive or unreasonable
DEPRESSION

• Is classified as a mood disorder

**Emotional Characteristics**
• At least 5 symptoms must be present to diagnose
  – Including sadness (most common description given such as feeling worthless or empty) or loss of interest and pleasure in normal activities (activities associated with feelings of despair and lack of control)
  – Also anger is associated with depression (towards self or others)

**Behavioural Characteristics**
• Reduced energy (being tired or wanting to sleep all the time)
• Being agitated and restless (pace around the room, tear at skin)
• Some sleep more, others may experience insomnia
• Some may lose appetite and other may eat considerably more

**Cognitive Characteristics**
• Negative thoughts like negative self-belief, guilt, sense of worthlessness
• Negative view on the world (expect things to turn out badly)
• Negative expectations about their lives, relationships and the world
  – These can be self-fulfilling (if you believe you will fail you may reduce effort or increase your anxiety and so will fail)
OCD

• Is classified as an anxiety disorder broken into:
  – Obsessions (persistent thoughts)
  – Compulsions (repetitive behaviour)

Emotional Characteristics
• Obsessions and compulsions are a source of considerable anxiety and distress
• Sufferers are aware that their behaviour is excessive and this causes feelings of embarrassment and shame
• A common obsession concerns germ which leads to feelings of disgust

Behavioural Characteristics
• Compulsive behaviours are performed to reduce the anxiety created by the obsessions
• They are repetitive and unconcealed (e.g. hand washing)
• Patients feel compelled to carry out these actions or something bad will happen
  – This creates anxiety
• Some patients only experience compulsive behaviours with no particular obsession

Cognitive Characteristics
• Obsessions are recurrent, intrusive thoughts or impulses that are perceived as inappropriate or forbidden
• These thoughts, impulses or images are not simply excessive worries about everyday problems; but are seen as uncontrollable, which creates anxiety
• They recognise that the obsessional thoughts or impulses are a product of their own mind
• They also, at some point, recognise that the obsessions or compulsions are excessive or unreasonable
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BEHAVIOURAL APPROACH TO EXPLAINING PHOBIAS

TWO-PROCESS MODEL

• Classical Conditioning: **Initiation**
  – A phobia is caused through association (see diagram)

• Operant Conditioning: **Maintenance**
  – Likelihood of a behaviour being repeated is increased if the outcome is rewarding
    • Here avoidance of the phobic stimulus reduces fear and so is reinforcing (i.e. **negative reinforcement**)

• Social Learning (not part of the two-process model)
  – Phobias may also be acquired through modelling the behaviour of others (e.g. seeing a parent respond to a spider with fear)
BEHAVIOURAL APPROACH TO EXPLAINING PHOBIAS

TWO-PROCESS MODEL EVALUATION

IMPORTANCE OF CLASSICAL CONDITIONING

• People with phobias often recall a specific event when their phobia appeared (e.g. being bitten by a dog)
  – However, not everyone who has a phobia can recall an incident (although it may have been forgotten)

• Sue et al suggest that different phobias may be the result of different processes
  – E.g. Agoraphobics were more likely to cite a specific incident but arachnophobics cite modelling as the cause

DIATHESIS-STRESS MODEL

• We inherit a genetic vulnerability for developing mental disorders but this disorder will only manifest itself if triggered by a life event (e.g. being bitten by a dog)

SUPPORT FOR SOCIAL LEARNING

• An experiment by Bandura and Rosenthal (1966) supported the social learning explanation

• A model acted as if he was in pain every time a buzzer sounded and later on the participants who had observed this showed an emotional reaction to the buzzer, demonstrating an acquired “fear” response
BEHAVIOURAL APPROACH TO EXPLAINING PHOBIAS

TWO-PROCESS MODEL EVALUATION

BIOLOGICAL PREPAREDNESS

- Humans are genetically programmed to rapidly learn an association between potentially life-threatening stimuli and fear (Seligman, 1970)
- These stimuli are called ancient fears (things that would have been dangerous in our evolutionary past, e.g. snakes, heights, strangers)
  - It would have been adaptive to rapidly learn to avoid these
- Biological preparedness can explain why people are less likely to develop fears of modern objects (e.g. toasters) as they were not a threat in our evolutionary past
- Behavioural explanations alone cannot be used to explain the development of phobias

TWO-PROCESS MODEL IGNORES COGNITIVE FACTORS

- There are cognitive aspects to phobias that behaviourist frameworks cannot explain
- Cognitive approach suggests phobias may develop as a consequence of irrational thinking
  - E.g. thinking “I could be trapped in this lift and suffocate” (an irrational thought) which creates extreme anxiety and may trigger a phobia
- This leads to cognitive therapies like CBT which may be a more successful treatment (as social phobias respond better to CBT – Engles et al, 1993)
BEHAVIOURAL APPROACH TO TREATING PHOBIAS

SYSTEMATIC DESENSITISATION (SD)

- Patient is taught to associate the phobic stimulus with a new response (relaxation) so their anxiety is reduced and they are desensitised
  - The response of relaxation inhibits the response of anxiety
- Therapist teaches the patient relaxation techniques (focus on breathing, visualising on a peaceful scene, progressive muscle relaxation)
- Desensitisation Hierarchy used

FLOODING

- This is applied in one session in the presence of the patient’s most feared situation (lasting around 2-3 hours)
- When adrenaline levels naturally decrease, a new stimulus-response link can be learned between feared stimulus and relaxation
BEHAVIOURAL APPROACH TO TREATING PHOBIAS

SYSTEMATIC DESENSITISATION (SD) EVALUATION

EFFECTIVENESS
• SD is successful for a range of phobic disorders (McGrath et al, 1990, found that 75% of patients with phobias responded to SD)
• The key to success is having contact with the feared stimulus (in vivo techniques being more successful then in vitro – imaging)

NOT APPROPRIATE FOR ALL PHOBIAS
• Ohman et al (1975) suggest that SD is not as effective in treating phobias that have an evolutionary survival link (e.g. dark, heights, dangerous animals), than those as a result from personal experience

STRENGTHS OF BEHAVIOURAL THERAPIES
• Behavioural therapies are generally fast and require less effort from the patients than other psychotherapies (e.g. CBT)
• This lack of “thinking” means the technique is useful for people who lack insight to their emotions (e.g. children, people with learning difficulties)
• SD can also be self-administered, making it also cheaper
BEHAVIOURAL APPROACH TO TREATING PHOBIAS

FLOODING EVALUATION

EFFECTIVENESS

• For patients that choose this, they stick to it and it appears to be effective and is relatively quick (compared to CBT)
• Choy et al reported that both SD and flooding are effective but flooding was more effective of the two in treating phobias
• Although Craske et al (2008) found that SD and flooding were equally effective in treating phobias

INDIVIDUAL DIFFERENCES

• Flooding is not for every patient (or some therapists)
• It can be highly traumatic
• Patients are made aware of this beforehand but still may quit during the treatment (reducing the effectiveness)
BEHAVIOURAL APPROACH TO TREATING PHOBIAS

OTHER EVALUATION

RELAXATION MAY NOT BE NECESSARY

- Success of SD and flooding may be due to exposure of the feared stimulus more than relaxation.
- It might also be due to the expectation of being able to cope with the feared stimulus being most important.
- Klein et al. (1983) compared SD with supportive therapy with patients with social or specific phobias.
  - They found no difference in effectiveness, suggesting that the “active” ingredient in SD or flooding may be the generation of hopeful expectancies that the phobia can be overcome.

SYMPTOM SUBSTITUTION

- Behavioural therapies may not work with certain phobias as symptoms are only the tip of the iceberg.
- If the symptoms are removed the cause still remains, and symptoms will resurface, possibly in another form (symptom substitution).
  - E.g. the psychodynamic approach, phobias develop due to projection (Little Hans’ fear of his dad was projected onto horses. If he had been treated for his phobia of horses the underlying issue would have remained and resurfaced elsewhere.)
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COGNITIVE APPROACH TO EXPLAINING DEPRESSION

ELLIS’ ABC MODEL (1962)

- Negative Event (A) → Rational Belief (B) → Healthy Negative Emotion (C)
- Negative Event (A) → Irrational Belief (B) → Unhealthy Negative Emotion (C)
COGNITIVE APPROACH TO EXPLAINING DEPRESSION

ELLIS’ ABC MODEL (1962)
• A = an activating event (e.g. getting fired at work)
• B = the belief; which could be rational or irrational (e.g. “the company was overstaffed” or “I was sacked because they’ve always had it in for me”)
• C = the consequence – rational beliefs lead to healthy emotions (e.g. acceptance) but irrational beliefs lead to unhealthy emotions (e.g. depression)

MUSTABATORY THINKING
• The source of irrational beliefs lie in mustabatory thinking (thinking that certain ideas/assumptions must be true in order for an individual to be happy)
• Ellis identified the three most important irrational beliefs:
  – I must be approved of or accepted by people I find important
  – I must do well or very well, or I am worthless
  – The world must give me happiness, or I will die
• An individual who holds such assumptions is bound to be, at the very least disappointed, at worst, depressed
• Someone who fails an exam becomes depressed due to an irrational belief about that failure (e.g. “I must always do well, so failing the exam means I am stupid”), not because they have failed the exam
• Such “musts” need to be challenged in order for mental healthiness to prevail
COGNITIVE APPROACH TO EXPLAINING DEPRESSION

BECK’S NEGATIVE TRIAD (1967)

• Negative Schema
  – These are developed during childhood (from rejection from peers/parents, criticism from teachers)
  – These are activated whenever a person encounters a new situation that resembles original conditions schemas were learned

• Negative Triad
  – This is a pessimistic and irrational view of 3 key elements in a person’s belief system:
COGNITIVE APPROACH TO EXPLAINING DEPRESSION

EVALUATION

SUPPORT FOR THE ROLE OF IRRATIONAL THINKING

- Hammen and Krantz (1976) found that depressed participants made more errors in logic than non-depressed participants.
- Bates et al (1999) found that depressed participants who were given negative automatic-thought statements became more and more depressed.
- However, as these suggest there is a link between irrational thinking and depression, it does not mean they cause depression.
  - Negative thinking could be caused by depression, not the other way around.

BLAMES THE CLIENT RATHER THAN SITUATIONAL FACTORS

- The cognitive approach suggest the client is responsible for their disorder (it is in their mind).
  - This may be good as it gives the client the power to change, but this is negative and could mean the client or therapist may overlook situational factors (e.g. not considering life events, etc).
COGNITIVE APPROACH TO EXPLAINING DEPRESSION

EVALUATION

PRACTICAL APPLICATIONS IN THERAPY

• Cognitive explanations led to the development of CBT (which is consistently the best treatment for depression)
• Cognitive explanations have specific implications for the success of the therapy and the therapy supports the explanation
  – E.g. If depression is alleviated by challenging irrational thinking then this suggests these thoughts had a role in depression in the first place

IRRATIONAL BELIEFS MAY BE REALISTIC

• Not all irrational beliefs are “irrational”
  – Alloy and Abrahmson (1979) suggest that depressive realists tend to see things for what they are and they found that depressed individuals gave more accurate estimates of the likelihood of a disaster than “normal” controls (they called this the sadder but wiser effect)

ALTERNATIVE EXPLANATIONS

• The biological approach suggests genes and neurotransmitters may cause depression
• The success of drug therapies for treating depression suggest that neurotransmitters do play an important role
• At the very least a diathesis-stress approach might be advisabe
COGNITIVE APPROACH TO TREATING DEPRESSION

COGNITIVE BEHAVIOUR THERAPY (CBT)

- Developed by Ellis; CBT challenges irrational thoughts and changes them into rational ones
- Ellis renamed it **Rational Emotional Behaviour Therapy (REBT)**
- Ellis extended his ABC model to ABCDEF:

```
A  (activating event)  B  (belief)  C  (consequence - emotional and behavioral)
     |                |              |
     |                v              |
     D  (disputing intervention)  E  (effect - an effective philosophy is developed)  F  (new feeling)
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COGNITIVE APPROACH TO TREATING DEPRESSION

COGNITIVE BEHAVIOUR THERAPY (CBT)

CHALLENGING IRRATIONAL THOUGHTS

- Ellis extended the ABC model to ABCDEF where:
  - **D** = disputing irrational thoughts/beliefs
  - **E** = effects of disputing and effective attitude to life
  - **F** = the new feelings (emotions) that are produced

- It is not the activating event that cause unproductive consequences (it is the beliefs)

- REBT focuses on challenging/disputing the irrational thoughts/beliefs and replacing them with effective ones
  - Logical disputing (does it make sense?)
  - Empirical disputing (where is the proof/evidence?)
  - Pragmatic disputing (how is this helping?)

- Effective disputing changes self-defeating beliefs into more rational beliefs

- This makes the client feel better and become more self-accepting
COGNITIVE APPROACH TO TREATING DEPRESSION

COGNITIVE BEHAVIOUR THERAPY (CBT)

HOMEWORK
• Clients are often asked to complete assignments between therapy session (e.g. asking someone out on a date)
• Such homework is vital in testing irrational beliefs against reality and putting new rational ones into practice

BEHAVIOURAL ACTIVATION
• CBT often involves a specific focus on encouraging depressed clients to become more active and engage in pleasurable activities (as being active leads to rewards which combat depression i.e. feeling good after exercising)

UNCONDITIONAL POSITIVE REGARD
• Ellis (1994) realised that convincing the client of their value as a human being was an important ingredient in successful therapy
• As if they feel worthless, they will be less willing to change their beliefs and behaviour
COGNITIVE APPROACH TO TREATING DEPRESSION

CBT EVALUATION

RESEARCH SUPPORT
• Ellis (1957) claimed a 90% success rate for REBT (taking an average of 27 sessions to complete the treatment)
  – Although the therapy was not always effective
• REBT and CBT have done well in outcome studies of depression
  – Cuijpers et al (2013) review of 75 studies found that CBT was more effective than having no treatment
• Kuyken and Tsivrikos (2009) found that 15% of the variance in CBT outcomes may be due to therapist competence

INDIVIDUAL DIFFERENCES
• CBT appears to be less suitable for people who have high levels of irrational beliefs that are rigid and resistant to change (Elkin et al, 1985)
• CBT also appears to be less suitable in situations where high levels of stress are in a person’s life that the therapy cannot resolve (Simons et al, 1995)
• Ellis suggested that some people do not want the direct advise given by CBT (they prefer to share their worries without getting involved in cognitive effort)
COGNITIVE APPROACH TO TREATING DEPRESSION

CBT EVALUATION

SUPPORT FOR BEHAVIOURAL ACTIVATION
• The belief that changing behaviour can go some way to alleviating depression is supported by a study on the beneficial effects of exercise (Babyak et al, 2000)
  – Where all clients who exercised exhibited significant improvements at the end of 4 months of exercise and also had lower relapse rates than clients in the medication group

ALTERNATIVE TREATMENTS
• The most popular treatment for depression is the use of antidepressants like SSRI’s
• Drug therapy requires less effort from the client and can be used in conjunction with CBT
  – This may be useful as the drugs treat the symptoms and so the client can focus/cope better on the CBT (which treats the cause of depression)
  – Cuijpers et al found that CBT was more effective when used with drugs

THE DODO BIRD EFFECT
• Rosenzweig (1936) argued that all methods of treatment for mental disorders were equally effective (called the Dodo Bird Effect – everyone wins)
• Research does find fairly small differences in success rates (e.g. Luborsky et al, 1975 and 2002)
• Rosenzweig argued that the lack of difference was due to so many common factors in the various psychotherapies (like being able to talk to a sympathetic person)
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BIOLOGICAL APPROACH TO EXPLAINING OCD

GENETICS EXPLANATIONS

• COMT Gene
  – OCD patients have found to have a variation of this gene that produces a lower activity of COMT and higher levels of dopamine = linked to OCD

• SERT Gene
  – This affects the transportation of serotonin (creating lower levels of this neurotransmitter)
  – Higher levels of SERT (and so lower levels of Serotonin) have been linked to OCD

• Diathesis-Stress
  – Each individual gene creates a vulnerability for OCD as well as other conditions, but this does not mean that they will develop

NEURAL EXPLANATIONS

• Abnormal levels of neurotransmitters
  – Abnormally high levels of dopamine are linked to OCD
  – Lower levels of serotonin are associated with OCD

• Abnormal brain circuits
  – The caudate nucleus suppresses signals from the orbitofrontal cortex (OFC)
  – OFC sends signals of worry to the thalamus
  – If caudate nucleus is damaged it fails to suppress minor worry signals and the thalamus is alerted (which sends signals back to the OFC acting as a worry circuit)
BIOLOGICAL APPROACH TO EXPLAINING OCD

EVALUATION

FAMILY AND TWIN STUDIES

• Nestadt et al (2000) found that people with first-degree relatives with OCD had a 5 times greater risk of having OCD as well at some point in their lives

• Billett et al (1998) found that MZ twins were more than twice as likely to develop OCD if their co-twin had the disorder (concordance rate) than DZ twins

• The concordance rate is never 100% and so environmental factors must play a role too (the diathesis-stress model)

TOURETTE’S SYNDROME AND OTHER DISORDERS

• Pauls and Leckman (1986) concluded that OCD is one form of expression of the same gene that determines Tourette’s

• The obsessional behaviour of OCD and Tourette’s is also found in children with Autism

• Obsessive behaviour is also typical of anorexia nervosa

• Two out of every three patients with OCD also experience one episode of depression (Rasmussen and Eisen, 1992)

• This supports that there is not one specific gene for OCD
BIOLOGICAL APPROACH TO EXPLAINING OCD

EVALUATION

RESEARCH SUPPORT FOR GENES AND OFC
• Menzies et al (2007) found that OCD patients and their close relatives had reduced grey matter in key regions of the brain, including the OFC (which sends worry signals to the thalamus)
  – This supports the view that anatomical differences are inherited and may lead to OCD in certain individuals

REAL-WORD APPLICATION
• Mapping the human genome has led to hope that specific genes could be linked to particular mental and physical disorders
  – E.g. if a fertilised egg is screened and the COMT gene is found, the parents could choose to abort the egg with the gene
• Gene therapy could lead to being able to turn genes “off” so the disorder is not expressed
• Both of the above raise ethical concerns
BIOLOGICAL APPROACH TO EXPLAINING OCD

EVALUATION

ALTERNATIVE EXPLANATIONS

• The two-process model can be applied to OCD
  – Initial learning occurs when a neutral stimulus (like dirt) is associated with anxiety
  – The association is maintained as the anxiety-provoking stimulus is avoided
  – Thus an obsession is formed and a link is learned with compulsive behaviours (e.g. washing hands) which appears to reduce the anxiety

• These explanations are supported by the success of a treatment for OCD called “exposure response preventions” (ERP) which is similar to SD
  – Patients have to experience their feared stimulus and at the same time are prevented from performing their compulsive behaviour
  – Albucher et al (1998) reported a high success rate (60-90% of adults with OCD improved considerably by using ERP)
BIOLOGICAL APPROACH TO TREATING OCD

ANTIDEPRESSANTS: SSRI’s
• SSRI’s are the preferred drug for treating anxiety disorders
• SSRI’s increase the levels of serotonin in the synapse by inhibiting the re-uptake process

ANTIDEPRESSANTS: TRICYCLICS
• Tricyclics block the re-absorption of serotonin and noradrenaline into the pre-synaptic neuron after it fires
• This prolongs their activity in the synapse (same as SSRI’s)
• There are greater side effects associated with tricyclics than SSRI’s

ANTI-ANXIETY DRUGS
• BZ’z reduce anxiety by slowing down the activity of the central nervous system by enhancing the activity of the neurotransmitter GABA
• GABA opens up channels on the receiving neuron and increase the flow of chloride ions into this neuron
• Chloride ions make it harder for the neuron to be stimulated by other neurotransmitters (therefore slowing down its activity and making them feel relaxed)

OTHER DRUGS
• D-Cycloserine reduces anxiety
• It is an antibiotic used to treat tuberculosis and enhances the transmission of GABA and so reduces anxiety
EVALUATION

EFFECTIVENESS

• Soomro et al’s (2008) review of 17 studies found that using SSRI’s with OCD patients was more effective than using a placebo in reducing the symptoms of OCD up to 3 months after treatment (i.e. in the short term)

• One issue regarding the evaluation of treatment is that most studies are only 3-4 months in duration (so little long-term data exists)

DRUG THERAPIES ARE PREFERRED TO OTHER TREATMENTS

• It is preferred as it requires little effort and little time (much less than CBT)

• This is also cost-effective for the health service as they require little monitoring and cheaper than psychological treatments

• They may still benefit from simply talking with a doctor during consultations (“Dodo Bird Effect”)

BIOLOGICAL APPROACH TO TREATING OCD

EVALUATION

SIDE EFFECTS
• All drugs have side effects, some more severe than others (e.g. nausea, headache and insomnia are common side effects of SSRI’s)
  – These may not seem terrible but can be enough to make a patient prefer not to take the drug
• Tricyclic antidepressants tend to have more side effects (hallucinations and irregular heartbeat) than SSRI’s
• Side effects of BZ’z include increased aggressiveness and long-term impairment of memory; as well as problems with addiction

NOT A LASTING CURE
• Koran et al (2007) suggested that, although drug therapy may be more commonly used, psychotherapies like CBT should be tried first
• Drug therapy may require little effort and may be relatively effective in the short-term, but it does not provide a lasting cure
  – Patients relapse within a few weeks if medication is stopped (Maina et al (2001))
BIOLOGICAL APPROACH TO TREATING OCD

EVALUATION

PUBLICATION BIAS

- Turner et al (2008) claim that there is evidence of a publication bias towards studies that show a positive outcome of antidepressant treatment (which will exaggerate the benefits of antidepressant drugs)
  - Not only were positive results more likely to be published; but studies that were not positive were often published in a way that conveyed a positive outcome
  - Drug companies have a strong interest in the continuing success of psychotherapeutic drugs and much of the research is funded by these companies

- Turner et al consider that such selective publication can lead doctors to make inappropriate treatment decisions that may not be in the best interest of their patients