



Psychopathology: Understanding Mental Disorders

Welcome to this comprehensive exploration of psychopathology, a core component of the AQA A-level Psychology specification. Throughout this presentation, we shall examine the definitions of abnormality, delve into specific disorders including phobias, depression and obsessive-compulsive disorder (OCD), and analyse the various approaches to explaining and treating these conditions. We will consider behavioural, cognitive and biological perspectives, providing you with a thorough understanding of this fascinating area of psychology.



by Stephen Renwick

Defining Abnormality: What Makes Behaviour 'Abnormal'?

Deviation from Social Norms

Behaviour that contravenes unwritten rules and expectations within a society may be considered abnormal. These norms vary across cultures and time periods, making this definition somewhat subjective. For example, hearing voices may be considered a sign of mental illness in Western cultures but might be interpreted as spiritual communication in others.

Statistical Infrequency

Behaviour that occurs rarely within a population may be considered abnormal. This approach uses statistical measures to determine what falls outside the 'normal' range. However, statistically unusual traits aren't necessarily problematic (e.g., exceptional intelligence), highlighting a limitation of this definition.

Failure to Function Adequately

This definition focuses on whether an individual can maintain daily activities and responsibilities. When psychological distress prevents someone from working, maintaining relationships or caring for themselves, their behaviour may be classified as abnormal. This approach considers the impact on the individual rather than societal standards.

Deviation from Ideal Mental Health

This perspective defines abnormality as deviation from characteristics of ideal psychological wellbeing. Jahoda proposed six criteria for positive mental health, including accurate perception of reality, self-acceptance, and capacity for growth. Absence of these qualities might indicate abnormality, though critics argue this sets an unrealistically high standard.

Limitations of Defining Abnormality

Cultural Relativism

What is considered 'normal' varies dramatically across cultures. Behaviours accepted in one society may be viewed as abnormal in another. For instance, certain religious practices involving trance states might be pathologised in Western contexts but considered spiritually significant elsewhere.

This cultural variation makes universal definitions of abnormality problematic and raises concerns about imposing one culture's standards on another.

Historical Context

Definitions of abnormality change over time. Homosexuality was classified as a mental disorder in the DSM until 1973, reflecting how societal attitudes influence psychological classifications rather than objective scientific criteria.

Individual Differences

Statistical approaches fail to account for the value of diversity and individual differences. What's unusual isn't necessarily problematic or dysfunctional.

Additionally, the boundary between 'normal' distress (e.g., grief) and 'abnormal' conditions (e.g., clinical depression) can be difficult to determine, leading to concerns about over-diagnosis.

Power and Control

Critics argue that definitions of abnormality can be used as mechanisms of social control. Labelling theory suggests that diagnostic labels can create stigma and self-fulfilling prophecies, potentially worsening outcomes for individuals.

The anti-psychiatry movement contends that psychiatric diagnosis often pathologises legitimate responses to difficult circumstances rather than identifying genuine disorders.

Characteristics of Phobias

Behavioural Characteristics

Phobias are characterised by persistent avoidance behaviours. Individuals go to great lengths to avoid the feared stimulus, often disrupting their daily functioning. When confronted with the phobic stimulus, they may display escape behaviours such as fleeing or freezing. Safety behaviours (carrying medication, having an escape route planned) are common coping mechanisms.

Emotional Characteristics

The primary emotional response in phobias is intense, irrational fear disproportionate to the actual danger posed. This fear is immediate and automatic upon exposure to the stimulus. Individuals with phobias typically experience significant anxiety even when anticipating potential contact with the feared object or situation. Many recognise their fear is excessive but feel powerless to control it.

Cognitive Characteristics

Cognitive features include catastrophic thinking patterns where individuals overestimate the danger and underestimate their ability to cope. Attentional biases cause heightened vigilance for the feared stimulus. Irrational beliefs about the phobic stimulus persist despite contradictory evidence. Intrusive thoughts about potential encounters with the feared object or situation are common.

According to the AQA specification, phobias are classified as anxiety disorders characterised by marked and persistent fear that is excessive or unreasonable, cued by the presence or anticipation of a specific object or situation. The DSM-5 criteria specify that exposure to the phobic stimulus almost invariably provokes an immediate anxiety response, which may take the form of a situationally bound panic attack.

Characteristics of Depression

Behavioural Characteristics

- Psychomotor retardation: slowed movements, speech and thought processes
- Reduced activity levels and social withdrawal
- Neglect of personal appearance and hygiene
- Sleep disturbances: insomnia or hypersomnia
- Changes in appetite leading to significant weight loss or gain
- Reduced engagement in previously enjoyed activities (anhedonia)

Emotional Characteristics

- Persistent low mood or sadness
- Feelings of worthlessness and excessive guilt
- Emotional numbness or emptiness
- Irritability and reduced frustration tolerance
- Anxiety often co-occurs with depression
- Suicidal ideation in severe cases

Cognitive Characteristics

- Negative thinking patterns about self, world and future (Beck's negative triad)
- Rumination: persistent dwelling on negative thoughts
- Poor concentration and difficulty making decisions
- Memory impairments, particularly for positive events
- Cognitive distortions such as catastrophising and all-or-nothing thinking
- Hopelessness about the future

The AQA specification emphasises that depression involves persistent sadness or low mood and/or loss of interest or pleasure, fatigue or low energy. At least one of these symptoms must be present to make a diagnosis, along with associated symptoms such as disturbed sleep, poor concentration, and suicidal thoughts. The severity is determined by the number and intensity of symptoms and their impact on functioning.

Characteristics of Obsessive-Compulsive Disorder (OCD)

Behavioural Characteristics

Compulsions are repetitive behaviours or mental acts that the person feels driven to perform in response to an obsession. These behaviours aim to prevent or reduce distress or prevent a dreaded event, though they are not realistically connected to what they are designed to neutralise. Common compulsions include:

- Excessive hand washing or cleaning
- Checking behaviours (doors, appliances, etc.)
- Ordering and arranging objects in a precise way
- Mental rituals such as counting or repeating words silently
- Seeking reassurance repeatedly

Emotional Characteristics

Individuals with OCD experience significant anxiety and distress when obsessions occur and when prevented from performing compulsions. There is often a temporary relief after completing rituals, reinforcing the behaviour. Many feel shame about their symptoms, recognising them as irrational but feeling unable to control them.

Cognitive Characteristics

Obsessions are persistent, intrusive thoughts, images or urges that cause anxiety or distress. They are unwanted and often recognised as products of one's own mind. Common obsessive themes include:

- Contamination fears
- Doubting and need for certainty
- Need for symmetry or exactness
- Aggressive or horrific thoughts
- Sexual or religious obsessions

Cognitive distortions include thought-action fusion (believing thoughts can influence events) and inflated responsibility (feeling responsible for preventing harm).

The Behavioural Approach to Explaining Phobias

The Two-Process Model

Mowrer's two-process model combines classical and operant conditioning to explain how phobias develop and persist:

Classical Conditioning (Acquisition)

Phobias initially develop when a neutral stimulus is paired with an aversive unconditioned stimulus (UCS) that naturally produces fear (unconditioned response, UCR). Through association, the previously neutral stimulus becomes a conditioned stimulus (CS) capable of eliciting fear (conditioned response, CR) on its own.

For example, in Watson and Raynor's (1920) Little Albert experiment, a previously neutral white rat (NS) was paired with a loud noise (UCS) that naturally caused fear (UCR). Eventually, Albert feared the rat (now a CS) alone, demonstrating a conditioned fear response (CR).

Operant Conditioning (Maintenance)

Once the fear is established, avoidance behaviours are negatively reinforced, maintaining the phobia:

- When an individual avoids the feared stimulus, they experience relief from anxiety
- This relief acts as negative reinforcement, strengthening the avoidance behaviour
- Avoidance prevents extinction of the conditioned fear response
- The phobia is maintained in a self-perpetuating cycle

Supporting Evidence

Case studies like Little Albert demonstrate how phobias can be acquired through conditioning. DiNardo et al. (1988) found that 56% of participants with dog phobias could recall a specific conditioning event. However, many people experience traumatic events without developing phobias, suggesting additional factors are involved.

Behavioural Treatments for Phobias

Systematic Desensitisation

Developed by Joseph Wolpe, systematic desensitisation is based on the principle of reciprocal inhibition—the idea that it's impossible to be relaxed and anxious simultaneously. The treatment involves three key components:

1. Relaxation training: Patients learn progressive muscle relaxation techniques to induce a state incompatible with anxiety
2. Construction of anxiety hierarchy: Patient and therapist create a ranked list of feared situations from least to most anxiety-provoking
3. Gradual exposure: Patient imagines or encounters each situation while maintaining relaxation, only progressing when comfortable at each level

Flooding

Flooding involves intense exposure to the feared stimulus without escape. The theoretical basis is that:

- Prolonged exposure without negative consequences leads to extinction of the conditioned fear response
- The anxiety response naturally diminishes over time due to habituation
- The patient learns that the feared consequences do not occur, challenging catastrophic beliefs

Unlike systematic desensitisation, flooding does not use relaxation techniques or a gradual approach. The patient experiences maximum anxiety initially, which then subsides.

Evaluation of Behavioural Treatments

Research supports the effectiveness of these approaches. Systematic desensitisation has success rates of 75-80% for specific phobias (Wolpe, 1958). McGrath et al. (1990) found that both systematic desensitisation and flooding were effective in treating animal phobias, though systematic desensitisation had lower dropout rates.

Limitations include the time-intensive nature of systematic desensitisation and the potential distress caused by flooding. Additionally, behavioural approaches may not address cognitive aspects of phobias or underlying issues that might contribute to their development.

The Cognitive Approach to Explaining Depression

Beck's Negative Triad

Aaron Beck proposed that depression results from negative cognitive schemas—mental frameworks that shape how individuals perceive and interpret experiences. These schemas develop from early life experiences and become activated by stressful events. The negative triad consists of negative views about:

1. **The self:** "I am worthless, inadequate, unlovable"
2. **The world:** "The world is unfair and disappointing"
3. **The future:** "My suffering will continue indefinitely"

These negative schemas lead to cognitive distortions (systematic errors in thinking) such as:

- Catastrophising: Expecting the worst possible outcome
- Overgeneralisation: Viewing a single negative event as a never-ending pattern
- Selective abstraction: Focusing on negative details while ignoring positives
- Personalisation: Assuming responsibility for external events

Ellis's ABC Model

Albert Ellis's Rational Emotive Behaviour Therapy (REBT) explains depression through the ABC model:

- **A - Activating event:** An objective situation or trigger
- **B - Beliefs:** Interpretation of the event, which can be rational or irrational
- **C - Consequences:** Emotional and behavioural outcomes resulting from beliefs

Ellis identified common irrational beliefs that contribute to depression:

- "I must be thoroughly competent, adequate, and achieving"
- "It's awful and catastrophic when things aren't the way I want them to be"
- "I have no control over my happiness; my emotions are caused solely by external events"

According to Ellis, it's not events themselves that cause depression, but rather how individuals interpret those events through their belief systems.

Cognitive Behaviour Therapy (CBT) for Depression



Identifying Negative Thoughts

Patients learn to recognise automatic negative thoughts and the situations that trigger them. Techniques include:

- Thought records: Documenting situations, emotions, and associated thoughts
- Mood monitoring: Tracking emotional states throughout the day
- Identifying cognitive distortions in thinking patterns



Challenging Irrational Thoughts

Patients learn to evaluate and question the validity of negative thoughts through:

- Examining evidence for and against the thought
- Considering alternative interpretations of events
- Assessing the utility of holding the belief
- Identifying cognitive distortions (e.g., all-or-nothing thinking)



Replacing with Rational Alternatives

Patients develop more balanced, realistic thoughts to replace negative ones:

- Formulating rational responses to negative thoughts
- Practising positive self-statements
- Developing more flexible thinking patterns



Behavioural Activation

CBT also incorporates behavioural techniques to break the cycle of inactivity:

- Activity scheduling to increase engagement in pleasurable activities
- Graded task assignments to build a sense of accomplishment
- Social skills training to improve interpersonal relationships

Research supports CBT's effectiveness for depression. A meta-analysis by Butler et al. (2006) found CBT more effective than no treatment and as effective as medication for depression, with lower relapse rates. The NICE guidelines recommend CBT as a first-line treatment for mild to moderate depression in the UK.

Evaluating the Cognitive Approach to Depression

Strengths of the Cognitive Approach

The cognitive approach to depression has substantial empirical support:

- Research consistently finds negative thinking patterns in depressed individuals. Hammen and Krantz (1976) found that depressed participants were more likely to attribute failure to internal, stable factors.
- CBT has strong evidence for effectiveness. The UK's NICE guidelines recommend it as a first-line treatment based on numerous randomised controlled trials.
- The approach acknowledges individual differences in vulnerability to depression based on cognitive schemas developed from unique experiences.
- It provides a clear treatment pathway that can be tailored to individual needs and has been adapted for different populations.

Limitations of the Cognitive Approach

Despite its strengths, the cognitive approach has several limitations:

- Direction of causality issues: Negative thinking may be a symptom rather than a cause of depression. Mood-dependent memory suggests that emotional states influence cognition, not just vice versa.
- Biological factors are not adequately addressed. Twin studies suggest a heritability of 40-50% for depression, indicating significant biological influences.
- Social and environmental factors like poverty, discrimination, and trauma may contribute to depression independently of cognitive processes.
- CBT may not be effective for everyone. Response rates vary, and some individuals with severe depression may require medication or combined approaches.

The cognitive approach provides valuable insights into depression and effective treatments, but a comprehensive understanding requires integration with biological and social perspectives. The diathesis-stress model suggests that cognitive vulnerabilities interact with life stressors to produce depression, acknowledging multiple causal pathways.

The Biological Approach to Explaining OCD: Genetic Factors

Twin Studies

Evidence for genetic contributions to OCD comes primarily from family and twin studies:

- Monozygotic (identical) twins show higher concordance rates (80-87%) for OCD compared to dizygotic (fraternal) twins (47-50%), suggesting significant genetic influence (van Grootheest et al., 2005)
- Heritability estimates range from 45-65%, indicating that genetic factors explain a substantial portion of the variance in OCD symptoms
- First-degree relatives of OCD patients have a 3-5 times higher risk of developing the disorder compared to the general population

These findings support a genetic component in OCD vulnerability, though environmental factors clearly play a role as well.

Candidate Genes

Research has identified several genes potentially involved in OCD:

- Serotonin transporter gene (SLC6A4): Variations may affect serotonin reuptake, influencing OCD symptoms and treatment response
- COMT gene: Encodes an enzyme that breaks down dopamine; the Val158Met polymorphism has been linked to OCD in some studies
- Glutamate-related genes: GRIN2B, SLC1A1, and DLGAP3 have been implicated in OCD, suggesting glutamate system involvement

However, OCD likely involves multiple genes with small individual effects rather than a single "OCD gene." Genome-wide association studies (GWAS) continue to search for relevant genetic markers.

The genetic basis of OCD appears to overlap with other disorders like Tourette's syndrome and body dysmorphic disorder, suggesting shared genetic vulnerability for a spectrum of related conditions.

The Biological Approach to Explaining OCD: Neural Explanations

Cortico-Striatal-Thalamic Circuit

Neuroimaging studies consistently implicate the cortico-striatal-thalamic circuit in OCD.

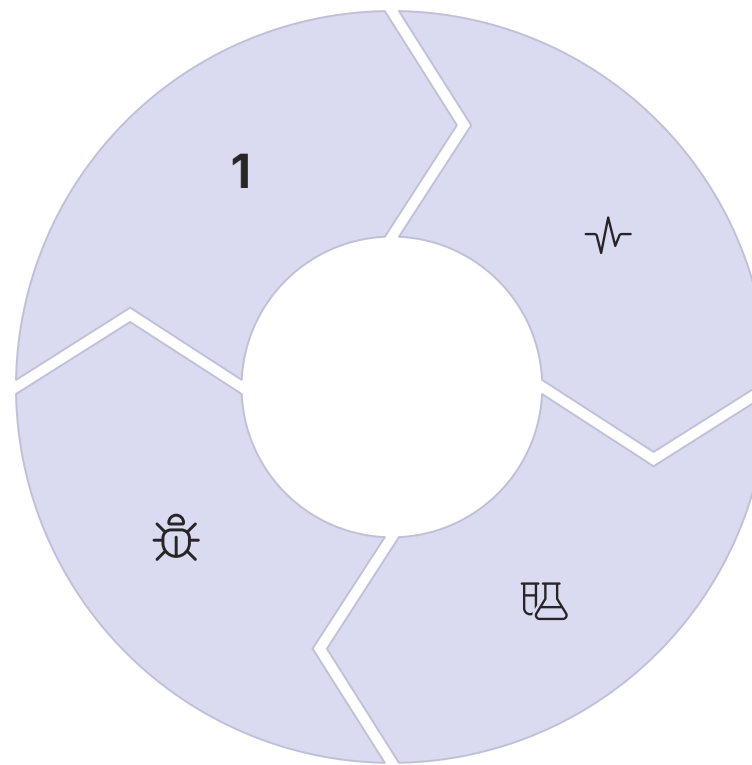
This neural loop includes:

- Orbitofrontal cortex (OFC): Involved in decision-making and response inhibition
- Anterior cingulate cortex (ACC): Plays a role in error detection and conflict monitoring
- Caudate nucleus: Part of the striatum involved in habit formation and goal-directed actions
- Thalamus: Relays information between brain regions

Error Monitoring Theory

Pitman's theory suggests OCD involves dysfunction in the brain's error detection system:

- Hyperactivity in the ACC creates persistent "error signals"
- These signals generate a feeling that something is "not right" (incompleteness)
- Compulsions are performed to reduce this uncomfortable feeling
- The cycle repeats because the error signal persists or quickly returns



Hyperactivity in the Circuit

Functional neuroimaging studies show hyperactivity in this circuit in OCD patients:

- PET and fMRI studies reveal increased metabolic activity in the OFC, ACC, and caudate nucleus
- Activity in these regions correlates with symptom severity and decreases with successful treatment
- Saxena et al. (1998) found that OCD patients showed higher glucose metabolism in the OFC compared to controls

Neurotransmitter Imbalances

Dysregulation of several neurotransmitter systems may contribute to OCD:

- Serotonin: Reduced serotonin function may contribute to inability to suppress thoughts and behaviours
- Dopamine: May play a role in the reinforcing nature of compulsive behaviours
- Glutamate: Excessive glutamate transmission may contribute to hyperactivity in the cortico-striatal circuit

Biological Treatment for OCD: Drug Therapy

Selective Serotonin Reuptake Inhibitors (SSRIs)

SSRIs are the first-line pharmacological treatment for OCD:

- Medications include fluoxetine (Prozac), fluvoxamine, sertraline (Zoloft), and paroxetine (Paxil)
- Mechanism: Block the reuptake of serotonin, increasing its availability in synapses
- Efficacy: 40-60% of patients show significant improvement
- Higher doses are typically needed for OCD than for depression
- Longer treatment duration (10-12 weeks) may be required before benefits appear

Side effects may include nausea, headache, sleep disturbances, sexual dysfunction, and initial anxiety. Most side effects diminish over time.

Clomipramine

A tricyclic antidepressant that was the first medication proven effective for OCD:

- Mechanism: Inhibits reuptake of serotonin and norepinephrine
- Often considered if SSRIs are ineffective
- May have stronger effects but more side effects than SSRIs

Augmentation Strategies

For patients with partial response to SSRIs, additional medications may be added:

- Antipsychotics (e.g., risperidone): May help with treatment-resistant OCD
- Glutamate modulators (e.g., memantine): Based on the glutamate hypothesis of OCD
- N-acetylcysteine: May regulate glutamate and reduce symptoms

Evaluation of Drug Therapy

Strengths:

- Empirical support: Multiple randomised controlled trials demonstrate efficacy
- Accessibility: More readily available than specialised psychological treatments
- May be particularly helpful for severe cases where psychological therapy is initially difficult

Limitations:

- Not effective for all patients; approximately 40% show minimal response
- Relapse rates of 80% when medication is discontinued
- Side effects can affect quality of life and treatment adherence
- Does not address psychological factors or teach coping skills

Psychopathology: Exam Practice Questions

Test Your Understanding

1. Outline two definitions of abnormality. (4 marks)
2. Describe the behavioural characteristics of phobias. (3 marks)
3. Explain how the two-process model accounts for the acquisition and maintenance of phobias. (6 marks)
4. Outline systematic desensitisation as a treatment for phobias. (4 marks)
5. Describe Beck's negative triad and explain how it contributes to depression. (6 marks)
6. Outline the process of cognitive behaviour therapy (CBT) for depression. (6 marks)
7. Discuss the evidence for genetic factors in OCD. (8 marks)
8. Explain the role of the cortico-striatal-thalamic circuit in OCD. (4 marks)
9. Evaluate the effectiveness of drug therapy for treating OCD. (8 marks)
10. Compare and contrast the behavioural and cognitive approaches to explaining psychological disorders. (12 marks)

Remember to use the AO1 (knowledge and understanding) and AO3 (evaluation) assessment objectives in your answers. For evaluation questions, consider strengths and limitations of theories and treatments, supporting your points with relevant research evidence.