<table>
<thead>
<tr>
<th>Question Number</th>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
</table>
| 1.              | Evaluate either the DSM IVR or DSM V approach to the diagnosis and classification of mental disorders. | **DSM IVR**  
A01  
- DSM IVR uses a ‘multiaxial’ system for assessment. This means that clinicians must assess patients on five different axes or scales in order to make a full evaluation of their condition.  
- The use of axes 1–3 are compulsory, yet the use of axes 4 and 5 are non-compulsory. The DSM-IV organises each psychiatric diagnosis into five levels (axes) relating to different aspects of disorder or disability.  
- This assessment model is designed to provide a comprehensive diagnosis that includes a complete picture of not just acute symptoms, but of the entire scope of factors that comprise mental health.  
- A ‘text revision’ of the DSM-IV, known as the DSM-IV-TR, was published in 2000. The diagnostic categories and the vast majority of the specific criteria for diagnosis were unchanged.  
A03  
- It is in such wide use and is commonly agreed upon, which allows for a common and universal diagnosis. Through its many revisions, the DSM has stood the test of time. Having a diagnostic companion such as the DSM or ICD allows, theoretically, for two doctors to make the same diagnosis on the same patient – if the symptoms are the same, a more agreeable diagnosis is likely using the DSM.  
- However, the DSM serves as confirmation that sufferers of these conditions are ‘sufferers’ who need ‘treatment’, although some suggest mental illness is often just another way of living. |

(6, AO1, 6, AO3)
Who is to say the patient is actually suffering a mental disorder? Laing (1960) suggested that schizophrenia is just another way of living and not a condition.

- The DSM has been criticised for its lack of reliability and validity in its diagnoses; basing its diagnoses on superficial symptoms rather than underlying causes, its distinct cultural bias and a conflict of interest related to its relationship with pharmaceutical companies.
- Beck *et al.* (1961) found that the agreement among diagnosticians was at about the level of chance. They gave two psychiatrists 153 patients to diagnose, but the two only agreed 54% of the time suggesting that diagnosis can be highly unreliable. Similarly, Zeigler and Phillips (1961) found between 54 and 84% agreements among diagnosticians.

**DSM V**

- DSM V has eliminated the multiaxial system of its last two predecessors and instead is focused around just three sections.
- Section I looks at the rationale of changes from the previous version and focuses the reader on how the three sections are organised and instructions for using DSM V.
- Section II contains all the main mental disorders and lists diagnostic criteria and codes.
- Section III is a sort of ‘work in progress’ continually evolving around other assessment measures to aid diagnosis. Any categories that need more research before they can be permanently included in Section II will be found in Section III.

- DSM V went through various pre-trials before being published which included test–retest reliability which demonstrates thorough procedural checks.
- However, a lack of transparency has been cited as an issue as agreements were put in place that no-one was able to talk about the review process of DSM V during its development, this ‘gagging order’ has reduced its credibility.
- Critics of the DSM V suggest that lowering the threshold for
certain conditions or expanding the symptom criteria may lead to over-diagnosis, that is, identification of conditions that do not necessarily need treatment.

- Others lament the expansion of diagnostic criteria in DSM V and argue that this may increase the number of ‘mentally ill’ individuals and/or pathologies of ‘normal’ behaviour, and lead to the possibility that thousands, if not millions, of new patients will be exposed to medications which may cause more harm than good.
<table>
<thead>
<tr>
<th>Question Number</th>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.</td>
<td>Evaluate the role of non-biological factors as possible causes of one mental disorder you have studied other than schizophrenia.</td>
<td><strong>Anorexia</strong>&lt;br&gt;A01&lt;br&gt;- Disturbed interactions within the family: Minuchin, Roseman and Baker (1978) suggested that the family system in which the individual with anorexia lives can be marked by enmeshment or over-closeness.&lt;br&gt;- Refusing to eat is a kind of rebellion by the child which enables her to assert a kind of independence. So anorexia might be an act of rebellion in order to gain independence from an enmeshed family.&lt;br&gt;- Minuchin (1978) even suggests that the development of anorexia serves the function of preventing conflict within the family.&lt;br&gt;- Learning theorists suggest that slimming becomes a ‘habit’, just like any other habit through stimulus response mechanisms. Therefore, individuals are being rewarded for not eating and hence the abnormal behaviour is reinforced.&lt;br&gt;- Individuals may form an association between fear of gaining weight and eating so a classically conditioned anxiety response develops.&lt;br&gt;- Social learning theory can also provide explanations, in terms of the way that thin models give expectations and to help to shape an adolescent’s body image.&lt;br&gt;- Gregory <em>et al.</em> (2000) found that 16% of 15–18-year-old girls in the UK are currently on a diet and that this western ideal of beauty is further promoted through social media.&lt;br&gt;- Irrational cognitive thought processes put much more emphasis on their perception and over-concern of weight, body shape and what they eat.&lt;br&gt;A03&lt;br&gt;- Fairburn (1989) found that most patients with eating disorders</td>
</tr>
</tbody>
</table>
admit they are unlikely ever to be completely satisfied with their shape and weight.

- Gregory et al. (2000) found that 16% of 15–18-year-old girls in the UK are currently on a diet and that this western ideal of beauty is further promoted through social media.

- Alberge (1999) found a high incidence of anorexia in ballet dancers and models, supporting the influence of the media and SLT in the development of anorexia nervosa (the pressure to be slim).

- Fearn (1999) reported an increase in eating disorders in Fiji following the introduction of American television programmes which emphasised a westernised, idealised body shape provides support for role of media and SLT in the development of anorexia.

- The cognitive explanations can only explain eating disorders so far, as they do not explain what caused the breakdown in information processing in the first place. Moreover, they may be an effect rather than a cause of the disorder, in which case they are a characteristic, rather than a causal factor.

- Cultural factors do not account for variations in vulnerability to eating disorder. The great majority of young women are exposed to cultural pressures towards slimness yet do not develop eating disorders, and so these factors lack explanatory power as they do not explain why some people are more influenced by these factors than others.

- The behavioural explanations can be criticised as environmentally deterministic because they imply that the environment shapes behaviour such as anorexia, which ignores the free will of the individual to reject the influence of the environment.

- The behavioural explanations are also reductionist because they only consider nurture. They are too simplistic as they do not consider other explanations for eating disorders, such as biological and cognitive factors.

**Depression**

A01
Dysfunctional behaviour is the result of irrational or faulty thinking according to cognitive explanations. The approach believes that we actively process information and use cognitive processes, such as attention and memory, to guide our behaviour.

For example, attending to particular thoughts (e.g. destructive ones) rather than others (e.g. more positive ones) might lead to the dysfunctional behaviour of depression.

Beck (1976) argues that patients with unipolar depression have lower self-esteem, and are high in self-blame, paranoia and other inappropriate and illogical cognitive distortions.

Beck’s cognitive model of depression is the cognitive triad which puts forward three areas where there are negative automatic thoughts. These are negative views of the self (feeling inadequate), negative views of the world (feeling defeated) and negative views of the future (believing that your suffering will continue).

A sufferer of depression tends to think life will always be that way for them and that nothing can improve. This comes from the ‘future’ aspect.

The second part of the model looks at cognitive errors where an individual gives selective attention to the negative side of a situation, always ignoring the positive aspects.

Schemata make up the final part of the model and are built up through experiences of the world. A generalised negative belief outlook makes someone susceptible to depression.

The diathesis stress model suggests that having an inclination towards developing depression alone is not enough to trigger the illness. Instead, an individual’s diathesis must interact with stressful life events in order to prompt the onset of the illness.

Lewinsohn et al. (2001) assessed teenagers with no existing history of depression and measured their level of negative thinking. A year later, those scoring highest for negative thinking were the ones most likely to be diagnosed with major depression.
• Evans et al. (2005) found that women in the 18th week of pregnancy and scoring highest for negative beliefs were the ones most likely to develop depression later.

• The most powerful support for the validity of the theory must be that it has led to the most successful treatments for depression. These include Ellis' Rational Emotive Therapy (RET) which encourages patients to recognise their negative thoughts and replace them with more realistic outlooks.

• Cognitive explanations are associated with successful therapies for depression:
  o Butler and Beck (2000) reviewed 14 meta-analyses investigating the effectiveness of Beck’s cognitive therapy and concluded that about 80% of adults benefited from the therapy.
  o Bates et al. (1999) found that depressed participants who were given negative automatic thought-like statements became more and more depressed, suggesting that depression does indeed have a cognitive basis.
  o Hammen and Krantz (1976) found that depressed participants made more errors in logic when interpreting written material than non-depressed participants. This suggests that the concepts of irrational thinking and cognitive biases in both Ellis and Beck’s models are correct and valid.
  o There is the issue of what causes what and, in particular, does the negative thinking exist before the depression. This would have to be the case to establish a causal relationship.
  o McIntosh and Fischer (2000) believe it to be unnecessarily complex. Rather than the triad of self, world and future, they suggest that only self is necessary. All other negative thoughts then arise from this.
Individuals with OCD have faulty beliefs, and that it is their misinterpretation of intrusive thoughts that leads to OCD. According to the cognitive model of OCD, everyone experiences intrusive thoughts from time-to-time.

However, people with OCD often have an inflated sense of responsibility and misinterpret these thoughts as being very important and significant which could lead to catastrophic consequences.

The repeated misinterpretation of intrusive thoughts leads to the development of the obsessions and because the thoughts are so distressing, the individual engages in compulsive behaviour to try to resist, block or neutralise the obsessive thoughts.

Similar to the behaviourist view, compulsions are rewarded or reinforced by immediate reduction of distress or anxiety.

Once a connection between an object and the feeling of fear becomes established, people with OCD avoid the things they fear, rather than confront or tolerate the fear. Because these actions temporarily reduce the level of fear, the fear is never challenged and dealt with and the behaviour is reinforced.

An OCD patient will use strategies to reduce the negative thought, but the effort they put in to trying to inhibit the thoughts ends up inducing a preoccupation with it.

OCD is also more likely to develop in individuals who have a psychological vulnerability to developing such a disorder. One such vulnerability is the lack of ‘perceived control’ over stressful life circumstances.

Those who have perceived control tend to be resilient individuals who believe they can control, or at least influence, what happens to them.

Buttolph and Holland (1990) found that 69% of female patients with obsessive compulsive disorder had the onset or worsening of symptoms during pregnancy or childbirth, which is consistent with the inflated sense of personality theory.

Neziroglu et al. found that 39% of female patients with obsessive compulsive disorder with children reported an onset
- Tallis (1995) challenges the inflated sense of personal responsibility explanation because, if this was the only factor involved in obsessive compulsive disorder, many more people would suffer from it.
- Khanna et al. (1988) discovered that patients with OCD had experienced significantly more negative life events than healthy controls in the six months prior to the onset of the disorder.
- Stekett et al. (1998) found those with OCD scored higher on cognitive measures than those with anxiety disorders.
- Novara et al. (2011) found a correlation between severity of OCD symptoms and the level of dysfunctional thinking.
- CBT has proved a successful therapy for OCD which validates the explanation, as the therapy works on the idea that thoughts guide feelings, leading to behaviour, which reinforces the thoughts.
- Cognitive explanations are more descriptive than explanatory as if symptoms of OCD are cognitive in nature then using a cognitive model to explain them is just repeating these symptoms.
Evaluate one contemporary study other than Carlsson (1999) from clinical psychology.

**Mark**

**Kroenke et al. (2008)**

- Researchers wanted to assess if PHQ-8 was a valid measure of depression.
- A sample of 198,678 Americans took part in a mental health survey gathering data that measure current health issues and any correlates associated with poor health, and questions were asked about depression using the PHQ-8.
- The researchers obtained the data from the BRFSS survey and analysed responses to questions about their behaviour over the previous two weeks. These questions had various themes which included poor sleep, appetite and concentration, and slow movement.
- Respondents were diagnosed based on their answers using two methods: the depressive disorder based on PHQ algorithm or PHQ-8. Respondents were also asked three health-related, quality-of-life questions about their physical and mental health and thirdly whether their health limited their activities.
- 9.1% of respondents were judged to have a depressive disorder based on the PHQ algorithm, whereas 8.6% respondents scored ≥10 on PHQ-8.
- The PHQ-8 seems to be a good tool for measuring large population-based studies and links to depression.

**Mark**

- Due to the nature of phone surveys, a very large sample was used which makes it representative of the US population and so can be said to have generalisability to the target population.
- The findings have reliability and support from other research regarding the validity of the PHQ-8, such as Martin et al. (2006) who found similar results.
- The sample excluded those without phones or those in an...
institution and, as these were likely to be in the depression category. It limits the generalisability of the results.

- The measure only focused on symptoms from the previous two weeks, so it may have just been looking at the effect of recent life events rather than measuring actual depression.

Williams et al. (2013)

- The aim of the research was to see if a combined programme of CBM and iCBT would be effective in depression.
- Participants were recruited via a clinical research unit in Sydney and were randomised to either the intervention or wait-list control (WLC) group. The WLC group completed iCBT after the intervention group had completed all study components.
- The Beck Depression Inventory, 2nd edn (BDI-II) was used to measure the severity of depression and distress was measured using the Kessler Psychological Distress Scale.
- The CBM component consisted of seven 20-minute sessions of imagery-focused CBM completed daily over the course of one week. The iCBT component consisted of the Sadness Program, which has been evaluated in three previous trials and an effectiveness study conducted in primary care. All patients completed the primary measures after the seven-day intervention phase, followed by either the ten-week iCBT component or the wait-list. All patients completed the baseline battery of questionnaires after ten weeks. The WLC group then commenced deferred treatment (iCBT).
- Baseline measures were seen to be similar between the intervention and waiting-list group based on mean scores for each measure.
- The treatment group showed a reduction in both depression and distress scores after the first week of CBM training.
- The results suggest that Internet-delivered CBM for depression can effect rapid symptom reduction over just one week, via seven 20-minute sessions and this was at least partially mediated by the trained change in imagery-based interpretive bias.
• The waiting-list group is technically not an active control group as they are simply waiting for an active comparison. It may have been better where the control group had some kind of different intervention rather than just waiting.

• The change in symptoms of depression was measured using a self-report, whereas an interview may have been better served to double check the validity of the self-report.

• It is unclear whether the CBM or the iCBT had the most impact or even how far one programme impacted on the other in that one may have improved patients’ motivation on the other.

• However, researchers did use a number of different measures to look at depression before and after the intervention and reliability was shown as the different measures highlighted similar findings.

Scott-Van Zeeland et al. (2013)

• Researchers aimed to look at a number of genes which they thought might play a role in anorexia using a candidate gene approach, as the genes are candidates for contributing to disease risk.

• The researchers studied DNA from 1,205 people with anorexia (the cases) and 1,948 people without the condition (the controls).

• The researchers initially started with 262 white European women with early-onset severe anorexia and 80 matched controls who were not underweight. The cases had been clinically diagnosed with a history of restricting-type anorexia (where a person limits their calorie intake) with or without purging (vomiting) and were an average age of 14 years when they first experienced these symptoms, had a body mass index (BMI) of 15 or less during their lifetime, and had an assessment age of 19 years or older.

• After initially looking at the candidate genes in these women, they went on to an additional phase to test their findings in 500 anorexia cases and 500 controls, and also data on a further 444
cases of anorexia or eating disturbances and 1,146 controls from previous studies.

- The two variants which showed the strongest association with anorexia were in the Estrogen Receptor Beta gene (ESR2). Previous studies have suggested that oestrogen and oestrogen receptors might play a role in anorexia.
- The researchers concluded that they had identified a novel association of gene variants within EPHX2 to susceptibility to anorexia and provide a foundation for future study of this important yet poorly understood condition.

A03

- Due to nature of studying genetic functioning, a large sample was used which makes it representative and so can be said to have generalisability to the target population.
- The results have opened the door to a more scientific approach to understanding anorexia using a biological basis and challenges the older assumptions that it is a purely sociocultural disorder.
- There is still little known about the actions of many genes and even though there seems to be a relationship here, it is not transparent how these gene variants are implicated in anorexia, so causation cannot be inferred.
- There is reliability as data from other studies were used, including scores on depression and anxiety scales, to see how these fit with the gene variants, and similar conclusion can be drawn using these data giving reliability.

Guardia et al. (2012)

A01

- The researchers wanted to establish whether patients with anorexia nervosa usually report feeling larger than they really are, in particular this flawed judgement is specifically observed when it concerns their own body or whether it is indicative of a general problem in their perceptual discrimination.
- 25 anorexic participants and 25 control participants (students) made up the sample and were matched on age and education. The BMI and shoulder width of each group was measured to
give an indication of their actual body size.

- 51 different openings ranging from 30 to 80 cm were projected onto a wall with a door-like aperture. They had to judge whether or not the aperture was wide enough for them to pass through (first-person perspective) and for another person present in the testing room to pass through (third-person perspective). Each participant had to imagine themselves walking through the opening and to say whether they could walk through at normal speed without turning sideways. They then had to estimate whether the experimenter who was also in the room could pass through the opening.

- There was a higher passability ratio (whether they thought their body could pass through the opening) in anorexic patients for the first person perspective, but not for the third-person perspective.

- The results suggest that body overestimation can affect judgements about the capacity for action, but only when they concern the patient’s own body. Overestimation of the body schema might occur because the anorexic has not updated their internal body image in relation to their current emaciated body.

A03

- The sample is restricted in terms of size, gender, age and all from the one clinic, which makes generalisations regarding anorexia affecting one’s own body size perceptions and not that of others difficult.

- The task itself may lack validity as it involved personal judgements about passing through a door frame which is not the same as actually walking through one. A more realistic setting may have been better served to match actual behaviour.

- Having a control group matched on variables means cause and effect conclusions can be drawn as a comparison group is there to see the effect of the independent variable.

- There is reliability as data from other studies were used including previous research from the same researchers who highlighted problems in perception of those with anorexia and
similar conclusions can be drawn using these data giving reliability.

Masellis et al. (2003)

- Researchers wanted to examine the degree of difference between obsessions, compulsions and depression comorbidity on the quality of life of individuals with OCD.
- Forty-three individuals between the ages of 18 and 65 diagnosed with OCD according to DSM-IV made up the sample. To be eligible for inclusion, participants had to be experiencing clinically significant obsessive and compulsive symptoms.
- All participants completed the Yale Brown Obsessive Compulsive Scale, which comprises ten items relating to obsessions and compulsions, rated on a five-point Likert scale ranging from 0 (no symptoms) to 4 (severe symptoms).
- Second, participants completed the Illness Intrusiveness Rating Scale which is designed to measure objective and perceived interference of symptoms across 13 life domains considered important to quality of life. These domains include health, diet and work, and ratings are according to a seven-point Likert scale ranging from 1 (not very much) to 7 (very much).
- The final scale was the Beck Depression Inventory which is a 21-item (four-point scale), self-report instrument designed to assess depressive symptom severity.
- Obsession severity was found to significantly predict patient QOL, whereas the severity of compulsive rituals did not impact on QOL ratings.
- Given the importance of these symptoms, the results indicate treatments that directly target obsessions and secondary depression symptoms in OCD are necessary.

Standardised scales were used for measuring depression as well as quality of life. They have been used in previous research and so can be tested for both reliability and validity.
- Statistical testing was used such as correlational analysis which gives strengths to the claims. Strong levels of significance were
established in some cases demonstrating how compulsions seem to relate less to OCD than obsessions.

- Self-report data were used from a moment in time but OCD is an illness that can vary over time, so a longitudinal design may have been better served than the cross-sectional one which was employed.
- The researchers themselves state that their conclusions were based upon limited data as the sample was small and self-report data were used, using data from others and increasing the sample size would have helped them generalise.

_POTS team including March et al. (2004)_

To evaluate the effectiveness of CBT alone and medical management with the selective serotonin reuptake inhibitor sertraline alone, or CBT and sertraline combined, as initial treatment for children and adolescents with OCD.

- A volunteer outpatient sample of 112 patients aged 7–17 years with a diagnosis of OCD using DSM-IV was recruited. The severity of their symptoms was measured using the Children’s Yale-Brown Obsessive-Compulsive Scale (CY-BOCS) with a score of 16 or higher.
- Participants were randomly assigned by computer to receive CBT alone, sertraline alone, combined CBT and sertraline, or pill placebo for 12 weeks.
- Ninety-seven of 112 patients (87%) completed the full 12 weeks of treatment. Results indicated a statistically significant advantage for CBT alone, sertraline alone and combined treatment compared with placebo.
- Patients treated with CBT either alone or in combination with medication showed a substantially higher probability of improvement, with the edge going to combination treatment over CBT alone in one site, but not in the other. Children and adolescents with OCD should begin treatment with the combination of CBT plus a selective serotonin reuptake inhibitor or CBT alone.
- The team used randomisation when sampling, which means cause and effect conclusions can be made and reduces any bias from other sampling techniques.
- There was consistency in treatment across the three centres used as all of them used the CBT manual which provides standardisation in the methodology and so increase chances of replicability and thus reliability.
- Ethical guidelines were adhered to throughout, as informed consent was gained from participants, and parents and psychiatrists were provided to monitor and support. Drugs were regularly checked and dosage was also monitored.
- A large sample was used which makes it representative and so can be said to have generalisability to the target population. The dropout rate was also quite low as 87% completed the study.
<table>
<thead>
<tr>
<th>Question Number</th>
<th>Question</th>
<th>Answer</th>
<th>Mark</th>
</tr>
</thead>
</table>
| 4.              | Evaluate the use of case studies as they are used in clinical psychology. | A01  
• Case studies are often used in clinical psychology in order to help the patient or client in difficulty. They are in-depth investigations of a single person or group and are often used in clinical situations when laboratory research is not possible or practical.  
• Typically, data are gathered from a variety of sources using several different methods, such as observations and interviews. The client also reports detail of events from his or her point of view.  
• The researcher then writes up the information from both sources above as the case study, and interprets the information. Today, case histories are one of the main methods of investigation in clinical psychology and psychiatry.  
• They can give a real insight into what those who suffer with mental disorders, such as schizophrenia, often have to endure. The case study should only be used by someone with a professional qualification, such as a therapist or psychiatrist.  

A03  
• Case studies of patients with mental disorders are useful as it would be unethical to test using other methods, i.e. we cannot deliberately damage the brains of people just to see the effect it may have on their behaviour.  
• They can therefore be used for studying unusual behaviours or circumstances which may be hard to find outside clinical settings.  
• Case studies provide a greater amount of detail than other research methods. As they are conducted over a long period of time using a variety of methods and a large amount of data can be gathered about a particular disorder, such as anorexia.  
• Case studies have given us a more sophisticated | (4, AO1, 4, AO3) |
understanding of the nature of mental disorders and have been used alongside neuroscience to give us an understanding of the modular nature of brain processes and the different parts of the brain involved in these.
<table>
<thead>
<tr>
<th>Question Number</th>
<th>Question</th>
<th>Answer</th>
<th>Mark</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.</td>
<td>Evaluate the classic study by Rosenhan (1973).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A01</td>
<td>Rosenhan wanted to address the issue as to whether sanity and insanity exist, how can we tell the difference between the two?</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Eight sane people attempted to gain admission to 12 different hospitals in the United States complaining that they had been hearing voices.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Not one of the pseudopatients was detected and all but one was admitted with a diagnosis of schizophrenia. This diagnosis was made without one clear symptom of this disorder. They remained in hospital for 7–52 days (average 19 days) and were eventually discharged with a diagnosis of schizophrenia ‘in remission’.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>The overwhelming experience of hospitalisation for the pseudopatients was one of depersonalisation and powerlessness.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Rosenhan claims that ‘it is clear we cannot distinguish the sane from the insane in psychiatric hospitals’.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A03</td>
<td>The participant observation meant that the pseudopatients could experience the ward from the patients’ perspective, while also maintaining some degree of objectivity.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Results are able to be generalised as Rosenhan used 12 hospitals across five states so could be said to be fairly representative a range of hospitals. These were on both coasts, old/shabby and new, research-orientated and not, well-staffed and poorly staffed, one private, federal or university funded.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Although high in ecological validity, there is a lack of control which could make the results less valid. For example, differences in staff could have affected the results.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>The hospital staff was unaware of the pseudopatients so were deceived. The pseudopatients were told to stay in</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
hospital until they were released, so could be said to have been unable to withdraw from the study. They could also have suffered harm.
<table>
<thead>
<tr>
<th>Question Number</th>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.</td>
<td>Outline how cultural bias can lead to different diagnosis of mental</td>
<td></td>
</tr>
<tr>
<td></td>
<td>disorders.</td>
<td>(6)</td>
</tr>
</tbody>
</table>

AO1

- The cultural group you belong to influences your likelihood of being diagnosed with a particular disorder and the treatment you receive (1).
- It is therefore important to know what cultural group is most important to the individual because their understanding of their problems will reflect their particular culture (1).
- The cultural group to which a person belongs may influence how they view and express that illness to others (1).
- In turn, mental health professionals may misinterpret reported symptoms which could lead to inappropriate diagnosis and treatment (1).
- First is the argument that psychiatrists in different countries will use the same classification system but in different ways – that is, give different diagnoses for the same symptoms (1).
- Second is the point that mental illnesses included in the classification systems are not universal, and there are, what is called ‘culture bound syndromes’ (CBS) (1).
<table>
<thead>
<tr>
<th>Question Number</th>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.</td>
<td>Evaluate a biological treatment of one mental disorder other than schizophrenia.</td>
<td>Anorexia</td>
</tr>
<tr>
<td></td>
<td></td>
<td>A01</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Anorexia is associated with altered levels of neurotransmitter in the brain. This is particularly true of serotonin levels.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Several different categories of psychiatric medications have been shown to be beneficial, but the most widely studied are the SSRIs (selective serotonin reuptake inhibitors).</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Antipsychotic drugs focus on the interaction of dopamine and serotonin systems, and often they increase appetite and weight gain in patients with major psychiatric disorders, for example, schizophrenia or bipolar disorder.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Paradoxically with anorexia, antipsychotic drugs are not particularly useful in weight recovery, but they are used to reduce other symptoms present in anorexia, such as body image alteration and fear of gaining weight.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Olanzapine and other medications may finally offer a drug that can help some low-weight anorexia nervosa patients. Olanzapine lessens anxiety and obsessional thinking, and some anorexic patients find they feel less paralysed due to rigid thinking and behaviour on this medication.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• One of the major reasons for looking at olanzapine in anorexia was its observed long-term adverse effect of weight gain in patients with schizophrenia.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Further, the drug produces a mood-modulating effect observed in bipolar patients and has also been used as adjunctive therapy to antidepressant treatment in patients with obsessive disorders.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Olanzapine significantly increases appetite, slows metabolism and alters all kinds of homeostatic physiological functions.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>A03</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Mice treated with small doses of the drug olanzapine were more</td>
</tr>
</tbody>
</table>
likely to maintain their weight when given an exercise wheel and restricted food access, conditions that normally produce activity-based anorexia in animals.

- Brambilla et al. (2007) using 30 anorexia nervosa patients treated with cognitive-behavioural therapy wanted to see whether olanzapine improves the disorder. The group treated with olanzapine reported a greater increase in weight and a significant reduction in depressive symptoms and aggression.

- Bissada et al. (2008) compared the olanzapine with placebo over a period of ten weeks in a group of 34 patients with anorexia. The group treated with olanzapine presented a higher recovery rate of weight gain and improvement in obsessive-compulsive symptoms.

- Hansen (1999) reports a case of a 50-year-old woman with anorexia nervosa since she was 17 years old given treatment of anorexia nervosa with olanzapine. After two months, she stopped talking about being overweight weighs 53 kg and feels herself completely healthy. She still receives 5 mg olanzapine daily.

- Babarich (2004) suggests drug therapy can help with weight gain alongside the anxiety and depression that may accompany anorexia.

- Zhu and Walsh (2002) and Casper (2003) have found that drug therapy has a limited use and is not recommended as a first calling point for treatment, perhaps because the medication is hidden by patients rather than taken by them.

- Mitchell et al. (2013) found antidepressants were more effective with bulimia patients than anorexics.

- Anorexic patients may be prone to further risk from drug therapy, such as cardiac arrest, as they tend to have poor physical health due to malnutrition in the first place.

- Actually putting on weight may be difficult for some, even though it is a desired outcome, simply due to the nature of the illness, this may make it more difficult for them to continue using the medication.

- Much of the support for drug treatment comes from a limited
number of small-scale research which do not separate the effects of the drug from other possible factors, such as extra attention and psychological therapy, given alongside the medication.

### Depression

<table>
<thead>
<tr>
<th>A01</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Antidepressants</strong> are used to treat depression and these drugs usually work by increasing the levels of serotonin in the brain, since some of the symptoms of depression come about due to low levels of serotonin (leading to low levels of noradrenaline).</td>
</tr>
<tr>
<td><strong>MAOIs</strong> (monoamine oxidase inhibitors) prevent the action of monoamine oxidase so results in higher levels of serotonin and noradrenaline in the synapse.</td>
</tr>
<tr>
<td>The increased noradrenaline activity leads to a reduction in depressive symptoms.</td>
</tr>
<tr>
<td>Tricyclics block the reuptake of serotonin and noradrenaline. On the pre-synaptic side there are reuptake sites that reabsorb the chemicals very quickly.</td>
</tr>
<tr>
<td>Tricyclics act by blocking these sites (or channels) so again result in more of the chemical being available in the synapse for a longer period of time.</td>
</tr>
<tr>
<td>Tricyclics are so called because of their three carbon ring structure. Tricyclics slow down the re-absorption of serotonin and noradrenaline by the presynaptic vesicles.</td>
</tr>
<tr>
<td>Consequently, more of the neurotransmitters are left in the synapse and so serotonin and noradrenaline activity increase at the postsynaptic receptors. This is linked to arousal and improved mood.</td>
</tr>
<tr>
<td><strong>SSRIs</strong> (selective serotonin re-uptake inhibitors) work in a similar way to tricyclics by inhibiting reuptake, but only impact on serotonin pathways, so leaving the serotonin to have an enhanced effect on the postsynaptic neuron without influencing other neurotransmitters, such as noradrenaline.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>A03</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Karp and Frank (1995)</strong> showed that adding cognitive therapy to drug therapy was no more effective than merely prescribing</td>
</tr>
</tbody>
</table>
anti-depressants. This suggests that drug therapy for depression is sufficient treatment for depression without other components.

- The MAOIs are reasonably effective in reducing depression, but they do produce various side-effects, such as blocking the production of monoamine oxidase in the liver, leading to the accumulation of tyramine.
- This is dangerous, because high levels of tyramine cause high blood pressure. Accordingly, depressed patients taking MAOIs have to follow a careful diet, making sure to avoid foods containing tyramine (e.g. cheese, bananas).
- The tricyclics are less dangerous than the MAOIs, but they can impair driving to a dangerous extent, and other side effects include dry mouth and constipation.
- Depressed patients taking SSRIs are less likely to suffer from dry mouth and constipation than those taking tricyclics, and it is harder to overdose on SSRIs.
- However, SSRIs conflict with some other forms of medication and Prozac is reported to have severe effects in some people, including suicidal thoughts where none were experienced previously.
- There is empirical support for the effectiveness of these treatments. The MAOIs, the tricyclics and the SSRIs have proved consistently effective in the treatment of major depressive disorder, but the tricyclics are generally more effective than the MAOIs, and produce fewer side-effects.
- However, there are problems of non-compliance (i.e. discontinuing medication, disregarding instructions on dosage and timing) due to the side-effects. This is not such an issue with SSRIs because there are fewer side-effects, although it should be noted SSRIs have severe side-effects in rare cases.
- Leykin et al. (2007) found the recovery rate in patients treated with selective serotonin reuptake inhibitor was nearly 60% among those who had never received drug therapy before, but was under 20% among those who had received drug therapy for depression twice or more in the past.
The 2005 World Health Organization report pointed to a large number of studies showing that anti-depressants are effective for depression in adults.

- Anti-depressants are often used as a starting point in therapy to help boost mood so that other therapies like CBT can then be used later if necessary.

**OCD**

- The biological explanation suggests that OCD (and depression) is the result of low levels of the serotonin in the brain.
- SSRIs (selective serotonin re-uptake inhibitors) are one type of anti-depressant drug, which include drugs like Prozac. When serotonin is released from the pre-synaptic cell into the synapse, it travels to the receptor sites on the post-synaptic neuron. Serotonin which is not absorbed into the post-synaptic neuron is reabsorbed into the sending cell (the pre-synaptic neuron).
- SSRIs increase the level of serotonin available in the synapse by preventing it from being reabsorbed into the sending cell. This increases the level of serotonin in the synapse and results in more serotonin being received by the receiving cell (post-synaptic neuron).
- So SSRIs and tricyclic drugs reduce the uptake and slow the transmission, reducing the excitation and lowering the electric impulse bringing the observable behaviour to a more normal level.
- Anti-depressants (like anti-anxiety drugs) improve mood and reduce anxiety which is experienced by patients with OCD.
- Benzodiazepines (BZs) are a range of anti-anxiety drugs, which include trade names like Valium and Diazepam.
- BZs work by enhancing the action of the neurotransmitter GABA which in turn tells neurons in the brain to 'slow down' and 'stop firing' and around 40% of the neurons in the brain respond to GABA.
- This means that BZs have a general quieting influence on the brain and consequently reduce anxiety, which is experienced as
a result of the obsessive thoughts.

As with depression, drug treatment alone does not prove successful with OCD patients. The POTS team found through various conditions that drug therapy was effective in treating OCD, but interestingly a combination of CBT and drugs may work best of all.

Stanford School of Medicine found that 40–60% of OCD patients responded well to SSRIs (selective serotonin re-uptake inhibitors) and that symptoms returned if the drug was stopped.

Koran et al. (2002) found patients who were given sertraline and then continued on it had a much lower relapse rate of 21% as compared to those who were given sertraline originally but then moved onto a placebo.

Dougherty et al. (2011) cites a number of studies carried out over time which show high rates of OCD symptoms returning despite drug therapy.

Abramowitz (1997) found that exposure response prevention therapy (ERP) was effective in reducing OCD symptoms and suggested that medication that focused on serotonin levels was effective too.

Side-effects, such as nausea and headache, of drug therapy may lead to an increase in anxiety which may in turn cause an increase in obsessive thoughts.

Brody (1988) found that differences in brain chemistry may mean an individual may respond better to drugs or CBT and that it would be extremely difficult to establish which is best due to the need for advanced scanning techniques so these individual differences may prove problematic in treatment.

Soomro et al. (2008) conducted a review of the research examining the effectiveness of SSRIs and found that SSRIs were more effective than placebos in the treatment of OCD, in 17 different trials. This supports the use of biological treatments, especially SSRIs, for OCD.

Anti-anxiety drugs are relatively cost-effective in comparison with psychological treatments, like cognitive behavioural
therapy (CBT).

- Drugs are non-disruptive and can simply be taken until the symptoms subside. As a result, drugs are likely to be more successful for OCD patients who lack motivation to complete intense psychological treatments.

- Drug treatments are criticised for treating the symptoms of the disorder and not the cause. Although SSRIs work by increasing the levels of serotonin in the brain, which reduces anxiety and alleviates the symptoms of OCD, it does not treat the underlying cause of OCD.
8. Evaluate the use of primary and secondary data as it is used in clinical psychology.

<table>
<thead>
<tr>
<th>Question Number</th>
<th>Question</th>
<th>Answer</th>
<th>Mark</th>
</tr>
</thead>
<tbody>
<tr>
<td>8.</td>
<td>Evaluate the use of primary and secondary data as it is used in clinical psychology.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>A01</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Primary data means original data that have been collected by those who saw an event first hand or collected data themselves for a specific purpose. They present original thinking or new information.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- A questionnaire or experiment can yield qualitative or quantitative primary data, respectively</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Secondary data are second-hand analyses of pre-existing (primary) data in a different way or to answer a different question than originally intended.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Secondary data analysis uses data that were collected by someone else in order to further a study that you are interested in completing.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>A03</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Primary data are a reliable way to collect data because the researcher can do it again as they know the procedures, how the data were collected and analysed.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- However, the data have to be gathered from scratch which involves finding a large enough population, this usually makes it more costly and time consuming.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Secondary data saves time and expense that would otherwise be spent collecting data.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- However, secondary data has limitations and should be carefully evaluated to determine the appropriateness for the problem at hand.</td>
<td></td>
</tr>
<tr>
<td>Question Number</td>
<td>Question</td>
<td>Answer</td>
<td>Mark</td>
</tr>
<tr>
<td>-----------------</td>
<td>----------</td>
<td>--------</td>
<td>------</td>
</tr>
</tbody>
</table>
| 9.              | Evaluate the use of longitudinal and cross-sectional methods as used in clinical psychology. | **A01**

- Mental disorders can be studied effectively by using longitudinal designs for many reasons, as there is usually some kind of progression with a disorder.
- A longitudinal study is an observational research method which takes place over a long period of time and involves tracking the same participants with usually the same disorder through a period of development.
- Individuals with Parkinson’s or unipolar depression do not just stop living once diagnosed, they have to adapt to life but continue as best they can.
- Similarly, longitudinal studies are useful when applied to mental disorders because the disorder means the patient often requires return trips to the hospital.
- A cross-sectional study takes place at one specific moment in time, and compares different groups of people with the same or different disorders at that time.
- In the cross-sectional study, to examine if there are different percentages of females diagnosed with anorexia at different ages, you may find out that the percentages are higher as the age group increases.
- This information does not tell you why anorexia diagnosis increases with age only that it does.
- If you combine this information with other research, you could use it to develop a hypothesis about why anorexia diagnosis increases with age. You would then need to use other research methods to test your idea.

**A03**

Cross-sectional studies are usually relatively inexpensive and allow researchers to collect a great deal of information regarding a particular illness quite quickly. Data are often obtained using self-report surveys (6, AO1, 10, AO3). |
and researchers are often able to amass large amounts of information from a large pool of participants who may suffer from, say, depression. Researchers can collect data on some different variables to see how differences in sex, age, educational status and income might correlate with the critical variable of schizophrenia.

While cross-sectional studies cannot be used to determine causal relationships that can provide a useful springboard to further research, when looking at whether a particular behaviour might be linked to schizophrenia, researchers might utilize a cross-sectional study to look for clues that will serve as a useful tool to guide further experimental studies.

Finding participants who are very similar, except in one specific variable, can be difficult. Cross-sectional studies generally require a large number of participants, so it is more likely that there will be small differences among participants. While such differences might seem minor, they can influence findings into a particular mental disorder. Also, groups can be affected by cohort differences that arise from the particular experiences of a unique group of people. Individuals born in a given geographic region may share experiences limited solely to their physical location, which has implications for social explanations of schizophrenia or cross-cultural differences in diagnosis.

Longitudinal studies can be helpful in determining patterns. It is possible to learn more about cause-and-effect relationships between behaviour and a mental illness through these types of research studies and connections can be made more clearly, say, between unemployment and depression.

More data over longer periods of time allow for better and more concise results. These studies are high in validity and are ideal for picking up long-term changes in a specific mental disorder.

Time is a real weakness to any longitudinal study, because it takes so much time to collect all the data needed. It takes a long period of time to gather results before the patterns, for example, between lifestyle and schizophrenia can even begin to be made. Longitudinal studies can make observation of changes more accurate. For example, longitudinal studies are used to discover predictors or indicators of certain diseases.
<p>| High dropout rates are a problem for longitudinal studies, if researchers are only relying upon the same group of participants for research that takes place at certain points in time in years, and then there is the possibility that some would no longer be able to participate. This is especially the case regarding those with a mental disorder who due to incapacity, for example, cuts down the usable data to be drawn to formulate the conclusion. |</p>
<table>
<thead>
<tr>
<th>Question Number</th>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>10.</td>
<td>Outline what is meant by clinical psychology.</td>
<td></td>
</tr>
</tbody>
</table>

| AO1             | Clinical psychology uses scientific theory for the purpose of understanding and preventing psychologically based distress or dysfunction and to promote well-being and personal development (1). |
|                 | It aims to provide continuing and comprehensive mental and behavioural health care for individuals and families right through to education and training (1). |
|                 | It focuses on how nature and nurture shape individuals, in terms of abnormal behaviour, and both are considered throughout clinical psychology, although biology is viewed as far more important than the influence of the environment (1). |
|                 | The scope of clinical psychology encompasses all ages, multiple diversities and varied systems (1). |
|                 | Clinical psychologists disagree about the causes of abnormal behaviour and will have a different view about the cause and possible treatment for each individual (1). |
|                 | However, they all aim to reduce the distress and improve the psychological wellbeing of their clients. They use psychological methods and research to make positive changes to their clients’ lives and offer various forms of treatment (1). |

Mark (6)
### Question

11. Assess the diagnosis of mental health issues in terms of reliability and validity.

<table>
<thead>
<tr>
<th>Question Number</th>
<th>Question</th>
<th>Answer</th>
<th>Mark</th>
</tr>
</thead>
<tbody>
<tr>
<td>11.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**A01**

- For a classification system to be of any use at all, it must be reliable. In other words, clinician’s diagnosis of disorders must be consistent with each other, i.e. a diagnosis is considered to be reliable if more than one psychologist gives the same diagnosis to the same individual.

- In order for a classification system to be useful, it must be valid. This refers to the extent to which it reflects an actual disorder (and possible cause) and enable a suitable treatment to be identified.

- For example, if individuals with the same diagnosis show different symptoms, then the diagnosis has low validity. Similarly, if individuals with the same diagnosis do not respond to the same treatment, then the diagnosis has low validity.

- For a diagnosis to be valid, it should also be predictive. That is, it should predict a patient’s prognosis and treatment.

**A03**

- Beck *et al.* (1961) found that the agreement among diagnosticians was at about the level of chance. They gave two psychiatrists 153 patients to diagnose, but the two only agreed 54% of the time suggesting that diagnosis can be highly unreliable.

- Similarly, Zeigler and Phillips (1961) found between 54 and 84% agreement amongst diagnosticians.

- Cooper *et al.* (1972) showed American and British psychiatrists the same videotaped interview and asked them to make a diagnosis. New York psychiatrists said it was schizophrenia twice as often, whereas the London psychiatrists said it was depression twice as often.

- Banister *et al.* (1964) found there was no clear-cut relationship between diagnosis and treatment. This means that the
predictive validity of the diagnoses in the sample was low.
• Moreover, research suggests that there is only a 50% chance of correctly predicting the treatment a patient will receive on the basis of diagnosis (Heather, 1976).
<table>
<thead>
<tr>
<th>Question Number</th>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>12.</td>
<td>Compare one biological and one non-biological explanation of schizophrenia.</td>
<td>A02</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- One mark each for any appropriate similarity and or difference between the two explanations of schizophrenia.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- One mark for each comparison point identified and one mark for each application of that point to the explanations.</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Similarities</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Both approaches may be deemed deterministic (1) as they provide complete reasons for the psychosis, and fail to consider free-will, as many would argue that there is a considerable amount of choice regarding schizophrenia (1).</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Both explanations take into account the role of the family (1), the influence of genes within the biological explanation and the role of expressed emotion within the family as regards the social explanation (1).</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Differences</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- The biological approach is reductionist, yet the psychological explanation is holistic (1), as the former focuses fully on the bodily and natural causes, ignoring any environmental aspects they may contribute to the development of schizophrenia. The latter provides arguments for environmental and natural causes as it mentions family influence and deficits in bodily functions (1).</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- The biological explanation is highly scientific, whereas the psychological approach has few scientific elements (1), as the former uses objective methods with control of variables to study causes, whereas the latter uses interviews and correlational data to establish findings (1).</td>
</tr>
</tbody>
</table>

(6)