Learning Objectives

Issues to Consider
Kraepelin (1856–1926) and Bleuler (1857–1939) shaped the direction of the modern approach to mental illness, where different types of mental illness are diagnosed and classified according to specific symptoms. This is where we will begin the study of obsessive compulsive disorder (OCD); we will look at the clinical characteristics or symptoms of the disorder. Diagnosis and classification raise issues such as is the diagnosis of OCD consistent (reliable) and accurate (valid)? You will be familiar with the models of abnormality from this topic at AS level, so try to recall what factors are likely to be implicated by the different models. We will also look at how the models of abnormality explain the causes of OCD. Finally, we will consider the methods of treatment of OCD.

On completion of this topic you should be familiar with the following.

Use this list of learning objectives as a revision checklist. Cross-reference the objectives with the Specification.

Clinical characteristics and diagnosis of obsessive compulsive disorder
- Outline the clinical characteristics of OCD.
- Discuss issues surrounding the classification and diagnosis of OCD, including reliability and validity.

Biological explanations of obsessive compulsive disorder
- Critically consider biological explanations of OCD.

Psychological explanations of obsessive compulsive disorder
- Outline and evaluate psychological explanations of phobias.

Biological therapies of obsessive compulsive disorder
- Discuss biological therapies of phobias.

Psychological therapies of obsessive compulsive disorder
- Outline and assess psychological therapies of OCD.

NOTE: All exam questions will refer to one anxiety disorder rather than OCD because the Specification allows for choice as to which anxiety disorder is studied. So if you prefer to study phobias then turn to the previous chapter. You do NOT need to know both disorders.
Clinical Characteristics and Diagnosis of Obsessive Compulsive Disorder

For details, see Eysenck’s A2 Level Psychology (pages 514–521).

Clinical Characteristics of Obsessive Compulsive Disorder (OCD)

---

**Fill in the blanks.**

Obsessive compulsive disorder is characterised by ob___________e thi___________g and co___________e be___________r in the form of rituals. It is classified as an anxiety disorder because the great majority of patients with obsessive compulsive disorder typically experience high levels of an___________y. Patients' obsessional thoughts create anxiety, and their compulsive behaviour occurs to try to re___________e anxiety.

**Cognitive symptoms**

- The obsessions are co___________e because they consist of persistent thoughts, impulses, or images that keep intruding into an individual's consciousness. For example, aggressive thoughts about loved ones or concerns about cl___________s or security.
- These obsessions can involve wi___________s (e.g. that an enemy would die), im___________s (e.g. of disturbing sexual activities), impulses (e.g. desire to attack one's boss), ideas (e.g. that one's illegal actions will be discovered), or d___________ts (e.g. that a crucial decision was wrong). Obsessions tend to fall into one of the following five categories that are in order of frequency: dirt and contamination; ag___________n; orderliness of inanimate objects; sex; and religion (Akhtar et al., 1975; see A2 Level Psychology page 515).

**Behavioural symptoms**

- The compulsions are behavioural symptoms because they are rigid, repetitive ac___________s that individuals feel compelled to perform to reduce their anxiety level.
- For example, repetitive hand-cleaning, checking doors are locked, or walking along the cracks in the pavement. Cl___________g and checking rit___________ls are the two most common compulsions.

---

**Classification of OCD**

DSM-IV (*Di__ic and St__al, Volume 4*) and the revised edition (DMS-IV-TR) published in 2000, which is the American classification system, and ICD (*In__al Cla__n of Di__s*, the tenth edition of which (ICD-10) was published by the World Health Organization in 1992, are the two most common classification systems. According to DSM-IV-TR, the diagnosis of obsessive compulsive disorder requires the following symptoms to be present:
• Recurrent ob____________s or co________________ns.
• Past or present recognition that the obsessions or compulsions are ex________________e or unr________________le.
• Obsessions or compulsions cause marked distress, take up more than 1 hour a day, or interfere significantly with the individual's normal fu________________ng.

Within DSM-IV-TR, obsessions are defined on the basis of four criteria, all of which must be present:
1) 
2) 
3) 
4) 

Within DSM-IV-TR, compulsions are defined on the basis of two criteria, both of which are required:
1) 
2) 

ICD-10 uses similar but less detailed criteria. Obsessions and compulsions have to share all of the following four criteria: they originate in the m_____d of the patient; they are re____________e and unpleasant, and at least one obsession or compulsion is recognised as ex________________e or unreasonable; the patient tries to re___________t their obsessions and compulsions; the patient must experience their obsessive thoughts or compulsive acts as “not pl________________e”.

Issues Surrounding Classification and Diagnosis

Fill in the blanks.

For any diagnostic system to work effectively, it must possess re___________ty and va________________y. Reliability means that there is good co______________y over time and between different people’s diagnosis of the same patient; known as i____r-j_______e (or inter-rater) reliability. If diagnosis of OCD is valid then patients who are diagnosed as suffering from it must have the disorder. If a diagnostic system is to be valid, it must also have high rel______________y. Clearly if a disorder cannot be agreed upon (so there is low reliability) then all of the different views cannot be correct (so there is low va__________y). On the other hand, a diagnostic system can be reliable but not valid—it can produce con________________y wrong diagnoses.

In terms of classification, DSM-IV and ICD-10 take a categorical approach, which assumes that all mental disorders are distinct from each other, and that patients can be categorised with a disorder based on them having particular sy________________s. However, diagnosing abnormality is not as straightforward as this approach suggests.

The categorical approach

• The great majority of diagnostic systems (including DSM-IV and ICD-10) are based on ca________________es. This is basically an a____-or-n____e approach—either you have a given disorder, such as obsessive compulsive disorder, or you haven’t.
• Unfortunately, reality is not as neat and tidy as suggested by these categorical approaches. For example, what if the individual does not recognise that their obsessions are unreasonable? This clearly doesn’t mean that they are reasonable.
Comorbidity

- Comorbidity occurs when someone suffers from two or more different mental disorders at the same time.
- Steketee (1990) found that many patients having obsessive compulsive disorder also suffered from one or more personality disorders (e.g. histrionic, avoidant, schizotypal, dependent, obsessive compulsive). Patients with OCD often have other anxiety disorders.
- This suggests there is overlap between the symptoms of obsessive compulsive disorder and those of several other disorders. This means the diagnostic categories in DSM-IV and ICD-10 are not distinct from each other, yet the classification systems assume that they are.
- This means that there are problems of diagnosis among disorders, so diagnosis may lack reliability and validity. Furthermore, this means OCD is not the same disorder for all patients, making it harder to recognise and harder to treat.

Subjectivity of diagnosis

- Judging whether patients have any given symptom is subjective because symptoms cannot be measured. For example, one of the criteria is that the disorder interferes significantly with the individual's normal functioning; clearly there is room for subjectivity in how much the disorder has to interfere with normal functioning for a diagnosis of OCD to be made.
- This is known as the “threshold issue” in that does the patient cross the threshold of significantly impaired functioning? This reduces reliability of diagnosis because therapists sometimes disagree as to whether the symptoms exceed the threshold.

Diagnosis: semi-structured interviews

- Patients are generally diagnosed mainly on the basis of one or more interviews with a therapist. There are various kinds of interviews. Some are unstructured and informal, which can help to establish good rapport between patients and therapists but reliability and validity of diagnosis tend to be low (Hopko et al., 2004).
- Semi-structured interviews, in which patients are asked a largely predetermined series of questions, do have good reliability and validity. Two of the most used semi-structured interviews for OCD are the Structured Clinical Interview for DSM-IV-Patient Version (SCID-I/P) and the Anxiety Disorder Interview Schedule for DSM-IV (ADIS-IV). Both interviews involve systematic questioning about a range of symptoms common to OCD.
- The evidence suggests that it is a reasonably reliable and valid assessment procedure (Comer, 2001). Brown et al. (2001) found the inter-rater agreement for OCD was excellent, indicating that this disorder can be diagnosed with high reliability. Indeed, the reliability of diagnosis for obsessive compulsive disorder was as high as, or higher than, almost any other anxiety disorder or type of depression. The high reliability of diagnosis is because the compulsions of OCD are clear and symptoms that make it relatively easy for therapists to diagnose them.
- The unreliability was mainly due to patients reporting different symptoms during the two interviews. The “threshold issue” also reduced reliability because therapists sometimes disagreed as to whether the symptoms exceeded the threshold. There was also inter-rater error, in which the interviewer simply made a mistake in categorising the patient’s responses.
Steinberger and Schuch (2002) found large differences between DSM-IV and ICD-10 in their diagnoses of children and adolescents having symptoms of OCD. Using DSM-IV criteria, 95% of the patients were diagnosed as obsessive compulsive, compared to only 46% using ICD-10 criteria. This suggests reliability of diagnosis is an issue. They concluded that the ICD-10 criteria are less developed and clear than those of DSM-IV, and so the DSM-IV system is preferable.

Culture bias and gender bias
Culture and gender bias exist when members of one ethnic group or gender are more likely to be diagnosed than others. These biases are not evident in diagnoses of OCD as the incidence across cultures in males and females is fairly equal.

Content validity
- Any form of assessment (e.g. interview, checklist, medical records) possesses content validity if it obtains detailed information from individual patients regarding all of the symptoms of OCD.
- Assessment procedures such as SCID-I/P and ADIS-IV have high content validity, because they exhaustively address all the DSM-IV symptoms for obsessive compulsive disorder.

Criterion validity
- The assessment of obsessive compulsive disorder possesses good criterion validity if those diagnosed with obsessive compulsive disorder differ in predictable ways from those not receiving that diagnosis.
- Karno et al. (1988) found that patients with OCD disorder were more likely than healthy controls to be diagnosed or separated and unemployed. Thus, there is some evidence for criterion validity for OCD, but note that poor social and work functioning are found in those suffering from most mental disorders and so this doesn’t distinguish patients with OCD from patients with other mental disorders.

Construct validity
- This is a type of validity that involves testing hypotheses based on the diagnosis of OCD. For example, the reason patients engage in elaborate rituals is to reduce the level of anxiety caused by their obsessional thoughts. Patients do report this to be the case so this indicates high construct validity.
- However, a problem arises when the hypotheses is not supported. For example, if we found that for some obsessive compulsive patients performing rituals did not reduce their anxiety level it would be hard to know whether this failure occurred because the diagnosis was wrong or because the original hypothesis was wrong.

Predictive validity
- Predictive validity concerns our ability to predict the eventual outcome for patients receiving a diagnosis of OCD.
- It is generally regarded as a severe mental disorder that is hard to treat effectively so it should take some time for most obsessive compulsive patients to respond to treatment. This is the case and therefore supports predictive validity. However, some patients with obsessive compulsive disorder are harder to treat than others and so this reduces predictive validity.
FIND OUT FOR YOURSELF: Research the DSM-IV and ICD-10 classifications for yourself. Identify similarities and differences in the two classifications systems.

CONCLUSIONS—SO WHAT DOES THIS MEAN?

Answer the following questions in your conclusions:

• Which types of validity are reasonably well-supported?

• Which issues question the reliability and validity of diagnosis of OCD?

Using this in the exam

Outline the clinical characteristics of one anxiety disorder.  
(5 marks)

Discuss the issues associated with the classification and diagnosis of one anxiety disorder.  
(20 marks)
Biological Explanations of Obsessive Compulsive Disorder

For details, see Eysenck’s A2 Level Psychology (pages 521–529).

Three biological explanations of OCD are genetic, evolutionary, and biological factors. These three factors are likely to be related, for example evolutionary pressures have shaped the genes that we have inherited and our biochemical systems.

Genetic Explanation

Fill in the blanks.
Family and twin studies suggest the involvement of genetic factors. The prevalence of OCD in the random population (about 2–3%) is the baseline against which concordance rates can be compared.

RESEARCH EVIDENCE FOR GENETIC FACTORS

Summarise the research evidence below.

Ψ Twins studies. What concordances have been found in twin studies?

Ψ Family studies. What concordances have been found in family studies?

RESEARCH EVIDENCE AGAINST GENETIC FACTORS

Summarise the research evidence below.

Ψ Nurture not nature. Why might concordances be due to nature?
**Cultural transmission.** What is this and how does it explain inheritance in families?

The research evidence for psychological factors can be used as evidence against genetics (see later).

---

**EVALUATION OF RESEARCH INTO GENETIC FACTORS**

<table>
<thead>
<tr>
<th>Sample size</th>
<th>Diathesis–stress model</th>
<th>Strong empirical support</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reductionism</td>
<td>Generalisability of twin research</td>
<td>Not 100% concordance</td>
</tr>
<tr>
<td>Nature vs. nurture</td>
<td>Biologically deterministic</td>
<td></td>
</tr>
</tbody>
</table>

**Methodological weaknesses of concordance studies**

*Match the above points to their evaluations below:*

- Twin and family studies have consistently found evidence for genetic factors. The twin studies have good reliability because concordances are relatively consistent across studies.

- The concordance rates are not 100%, which suggests that genetic factors may predispose but not cause OCD, and that environmental factors must be involved.

- Do concordance rates reflect nature or are they really due to nurture? The OCD could be culturally rather than genetically transmitted because close family members and twins may learn the same behaviour; one may imitate the other.

- The samples in such studies are very small so generalisability and population validity may be limited, which means the findings may not be representative of other populations.

- Twins share a special relationship, particularly identical twins. This means that identical twins experience a more similar environment than fraternal twins, and so this supports nurture over nature in explaining OCD. A second issue is that research on twins lacks generalisability because twins are not representative of the general population.

- The suggestion that genes determine OCD is deterministic because this ignores the individual’s ability to control their own behaviour. For example, the individual could choose to challenge their faulty cognitions and so not suffer from the disorder.

- Family and twin studies must be considered cautiously because they are retrospective and diagnosis may be biased by knowledge that another family member has been diagnosed.
Evolutionary Explanations

Fill in the blanks.
The compulsive and ritualised behaviours often involve cl__________g and ch__________g behaviours. This supports an evolutionary basis as such cleaning is adaptive because it protects against contamination and dis__________e, and checking behaviours can be linked to defence of re__________s and te__________. Thus, according to evolutionary explanations, OCD is a distortion of adaptive gro__________g and territorial behaviours.

The biological approach only focuses on one level of explanation and therefore is too simplistic.

Genes alone do not determine who will develop OCD—they only create vulnerability. Thus, they are not a direct cause as other factors must trigger the disorder. Evidence for this is that the concordance rates are not 100%, which shows that OCD is due to an interaction of genetic and other factors.

RESEARCH EVIDENCE FOR EVOLUTIONARY EXPLANATIONS

Summarise the research evidence below.

Abed and de Pauw (1998) proposed the “Involuntary Risk Scenario Generating System”. What was the purpose of this system?

Szechtman and Woody (2004) suggested a security motivation system. What do they suggest this system did?

Rachman and de Silva (1978) support the universality of OCD symptoms. Why does universality support an evolutionary basis?
### EVALUATION OF EVOLUTIONARY EXPLANATIONS

*Summarise the evaluation points below.*

- **Face validity.** Why do the evolutionary accounts have face validity?

- **Universality of mental disorders.** What evidence is there for universality?

- **Individual differences.** Why are these a weakness of the evolutionary explanations?

- **Conjecture—evolutionary stories?** Why are the explanations no more than stories?

- **Reductionist and deterministic.** Why are evolutionary theories reductionist and deterministic?

- **Psychological explanations.** How do these challenge the evolutionary explanations?
Social learning theory has great explanatory power. Why does it have explanatory power?

Nature/nurture. Which aspect is ignored by the evolutionary explanations?

Maladaptive rather than adaptive. Why can an adaptive function be questioned?

Alternative explanations. What are the alternative explanations?

FIND OUT FOR YOURSELF: Design a survey to test the OCD-like symptoms experienced within the general population. Do the types of symptoms support evolutionary explanations?

Biochemical and Anatomical Explanations

Fill in the blanks.
Bi____________________l abnormalities and brain str_________________l abnormalities have been identified as explanations of OCD.

Biochemical explanations

Fill in the blanks.
According to the s_________________in hypothesis, individuals with OCD have reduced levels of the neurotransmitter serotonin or have deficient serotonin metabolism.
**RESEARCH EVIDENCE FOR BIOCHEMICAL FACTORS**

*Summarise the research evidence below.*

Ψ **Two classes of drug have proved effective in the treatment of OCD.** What are these?

Ψ **Drugs that affect other biochemicals.** What effect do these have?

**RESEARCH EVIDENCE AGAINST BIOCHEMICAL FACTORS**

*Summarise the research evidence below.*

Ψ **Serotonin levels in OCD patients compared to healthy controls.** What do these comparisons show?

Ψ **Serotonin levels and drug therapy.** Why does this research challenge the serotonin hypothesis?

Ψ **Antidepressant drugs do not work for all patients.** Why does this challenge the serotonin hypothesis?
<table>
<thead>
<tr>
<th>Evaluation Point</th>
<th>Evaluation Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cause, effect, or correlate.</td>
<td>Why can cause and effect not be established?</td>
</tr>
<tr>
<td>Serotonin level.</td>
<td>How do Dougherty et al. (2002) challenge the serotonin hypothesis?</td>
</tr>
<tr>
<td>Descriptive not explanatory.</td>
<td>Why does the biochemical hypothesis lack explanatory power?</td>
</tr>
<tr>
<td>Treatment aetiology fallacy.</td>
<td>Why is the cause not necessarily the cure?</td>
</tr>
<tr>
<td>Reductionist and deterministic.</td>
<td>Why are the explanations reductionist and deterministic?</td>
</tr>
<tr>
<td>Individual differences.</td>
<td>Why does the biochemistry hypothesis not account for individual differences?</td>
</tr>
</tbody>
</table>
ANATOMICAL EXPLANATIONS

Fill in the blanks.

According to this explanation, certain areas of the brain do not function the same in OCD patients as in healthy controls. Baxter et al. (1992) suggest that there is overactivity in the orbital frontal cortex and the caudate nucleus and, as this area is responsible for our primitive urges concerning sex, aggression, danger, and hygiene, this explains many common obsessions of OCD. There is also dysfunction of neural circuits, including the corpus striatum, which leads to inappropriate repetitive behaviour. Areas such as the orbital frontal cortex and the caudate nucleus are sometimes larger in OCD patients than in controls, and obsessive compulsive symptoms often seem to increase or decrease when the orbital region and/or the caudate nucleus are damaged through either illness or accident. A review of brain-imaging research shows elevated activity in the orbital region and the caudate nucleus. This has been found consistently in OCD patients compared to healthy controls, and after treatment, activity in these brain areas reduces to a level comparable to that of controls (Saxena & Rauch, 2000).

The consistency of these findings supports reliability and therefore validity of an anatomical explanation. However, findings are not completely reliable: there are studies in which no differences in brain anatomy were found between OCD patients and controls. A key limitation is the fact that the research is correlational so only associations are identified between elevated brain activity and OCD. As it is only an association, we cannot be sure of the direction of effect because it’s not clear whether the brain areas cause OCD or whether these brain abnormalities are effects of having OCD. The explanation is also restricted because it only focuses on biological factors not psychological ones (such as life events) and it is unclear how such psychological factors might influence brain activity.

CONCLUSIONS—SO WHAT DOES THIS MEAN?

Answer the following questions in your conclusions:

• How strongly is the genetic hypothesis supported?

• How does the diathesis–stress model best account for individual differences?

• Why do the evolutionary explanations lack scientific validity?

Using this in the exam

Outline and evaluate one or more biological explanation(s) of one anxiety disorder. (25 marks)
Psychological Explanations of Obsessive Compulsive Disorder

For details, see Eysenck’s A2 Level Psychology (pages 529–536).

Psychodynamic Explanation

Fill in the blanks.

Psychodynamic explanations of OCD originate with Fr___________d, but have since been developed by other psychodynamic theorists. The ego (the conscious, rational mind) of patients with OCD is disturbed by their obsessions and compulsions, and this leads them to use ego de____________e me____________s including isolation, undoing, and reaction formation.

- **Isolation**: patients regard their unwanted thoughts as being alien and not be________g to them.
- **Undoing**: an undesirable im________e can be cancelled out by performing certain acts, e.g. patients who have undesirable sexual impulses may clean themselves to undo this impulse.
- **Reaction formation**: the patient adopts a lifestyle that is completely op________e from that suggested by their undesirable impulses. For example, practising celibacy to repress obsessive sexual desires.

Freud argued that OCD is linked to the a______l stage of development, which occurs at about 2 years of age, because during this stage children are t________t trained. A major conflict within the child between wanting to soil his or her clothes and wanting to retain faeces can occur if parents are too harsh and make the child feel dirty and ash________ed. The child may deliberately soil his or her clothes as an act of rebellion. This conflict over cleanliness can lead to OCD. Freud (1949) also argued that anxiety was linked to sexual re____________n.

EVALUATION OF THE PSYCHODYNAMIC EXPLANATION

Summarise the evaluation points below.

Ψ **No scientific evidence.** Why is there no scientific evidence?

Ψ **Generalisability.** Which obsessions and compulsions do the explanations relate to?
**Cause and effect.** Why can causation not be established?

---

**Behavioural Explanation**

*Fill in the blanks.*

According to the behavioural explanation, fear in individuals with obsessions and compulsions is triggered by fear as associated with stimuli (e.g. unwashed hands, obsessional thoughts) that are very unlikely to cause real harm. The compulsive rituals (e.g. hand washing) reduce fear and so this behaviour is reinforced or rewarded by fear reduction.

---

**RESEARCH EVIDENCE FOR BEHAVIOURAL EXPLANATIONS**

*Summarise the research evidence below.*

Ψ **Mowrer (1947) developed a two-process theory.** Which two processes does Mowrer use to explain OCD?

Ψ **Rachman and Hodgson (1980).** How do they provide support for Mowrer’s theory?

---

**EVALUATION OF BEHAVIOURAL EXPLANATIONS**

*Summarise the evaluation points below.*

Ψ **Face and scientific validity.** Why do the behavioural explanations have face validity?
<table>
<thead>
<tr>
<th><strong>Psychopathology: Anxiety Disorders</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Exposure and response prevention therapy.</strong> Why do these therapies support the behavioural explanations?</td>
<td></td>
</tr>
<tr>
<td><strong>Reductionist.</strong> Why are the behavioural explanations reductionist?</td>
<td></td>
</tr>
<tr>
<td><strong>Doesn’t explain obsessions.</strong> Why not?</td>
<td></td>
</tr>
<tr>
<td><strong>Environmental determinism.</strong> How are the explanations deterministic?</td>
<td></td>
</tr>
<tr>
<td><strong>Explain maintenance better than cause.</strong> Why do the explanations explain maintenance better than cause?</td>
<td></td>
</tr>
<tr>
<td><strong>Nature vs. nurture.</strong> Which aspect do the behavioural explanations account for?</td>
<td></td>
</tr>
</tbody>
</table>
Lack explanatory power. What do the explanations not explain?

Multi-dimensional approach. Why is this approach needed?

Cognitive Explanations

Fill in the blanks.

According to the cognitive perspective, OCD patients have an inflated sense of personal responsibility and so feel they must carry out their compulsive rituals to avoid adverse consequences, and this is their key cognitive error. Salkovskis (1996) explains the compulsions are based on cognitive errors. He draws from the behavioural approach, in saying that compulsions are redefined or reinforced by immediate reduction of distress or anxiety. The carrying out of the compulsive rituals mean that they never get to test out their faulty thinking and realise there is not a dire consequence if they make a mistake. This resembles the behavioural explanation but more emphasis is given to the cognitive processes involved.

RESEARCH EVIDENCE FOR COGNITIVE EXPLANATIONS

Summarise the research evidence below.

OCD and pregnancy. How does research show a link between the two?

Exaggerated sense of personal responsibility. How does Abramowitz’s (2006) review support this explanation?
RESEARCH EVIDENCE AGAINST COGNITIVE EXPLANATIONS

Summarise the research evidence below.
Ψ Tallis (1995). What challenge does Tallis provide?

EVALUATION OF COGNITIVE EXPLANATIONS

Summarise the evaluation points below.
Ψ Face and scientific validity. Why does the personal responsibility explanation make sense?

Ψ Self-report criticisms. How do these criticisms weaken the evidence for cognitive factors?

Ψ Lack explanatory power. Why does the cognitive account lack explanatory power?

Ψ Cause or effect?
Descriptive not explanatory. Why do cognitive explanations lack explanatory power?

Reductionism and multi-dimensional approach. Why is a multi-dimensional approach needed?

Social Explanation: Life Events

Fill in the blanks.

There is some evidence that life events play a role in the development of OCD. Khanna, Rajendra, and Channabasavanna (1988) discovered that patients with OCD had experienced significantly more life events than healthy controls in the 6 months prior to the onset of the disorder. McKeon, Roa, and Mann (1984) took account of whether the patient had had an anxious or non-anxious personality before the onset of OCD. Patients with an anxious personality did not experience any more life events than healthy controls whereas those with a non-anxious personality experienced three times as many life events as healthy controls in the 12 months before the onset of the disorder. These findings suggest that life events or an anxious personality are possible causes of OCD. The life event may not immediately precede the disorder, as shown by Saunders et al. (1992), who found that those who had experienced childhood sexual abuse were about five times more likely than non-abused individuals to develop OCD.

Research on life events is correlational so cause and effect cannot be inferred. We do not know if the life event(s) triggered the OCD or if the OCD led to the life event. For example, individuals who are very anxious and stressed a few months before developing OCD may help to create life events such as losing their job or marital separation. A further weakness of the research is that it is based on retrospective self-report so internal validity may be reduced due to bias and distorted recall. A final concern is that the life event research fails to contextualise: for some people a life event may not be stressful, e.g. a marital separation that was desired may even reduce stress, so the wider context of individual patients needs to be considered.
CONCLUSIONS—SO WHAT DOES THIS MEAN?

Answer the following questions in your conclusions:

• Why do the psychological factors provide only a partial explanation?

• Why is a multi-dimensional approach needed?

Using this in the exam

Outline and evaluate one or more psychological explanation(s) of one anxiety disorder. (5 marks)
Biological Therapies for Obsessive Compulsive Disorder

For details, see Eysenck’s A2 Level Psychology (pages 536–539).

Drug Therapy

Fill in the blanks.

The ser____________n reuptake inhibitors (SRIs) were initially the most effective for OCD, in particular clomipramine, which has greater effects on the ne____________r serotonin than do the other SRIs. The selective serotonin reuptake inhibitors (SSRIs), which include fluvoxamine, fluoxetine (Prozac), sertraline, and paroxetine, have also been found to be effective. It is now known that patients with OCD do not have, as previously thought, low se__________n levels (Rachman, 2004). It is possible that various br______n structures in obsessive compulsives show increased sensitivity to serotonin. However, we do not really know why SRIs and the SSRIs are both effective in treating OCD.

EVALUATION OF DRUG THERAPY

Summarise the evaluation points below.

Effectiveness

Ψ Drugs work but not immediately. What does Dougherty et al.’s (2002) research show about serotonin levels?

Ψ SRIs and SSRIs are most effective. Which drugs are these more effective than?

Ψ A combination of drugs. Which drugs should be combined?
<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Drop-out rate.</strong> Why is this high?</td>
<td></td>
</tr>
<tr>
<td><strong>Treats symptoms not causes.</strong> Why is this an issue?</td>
<td></td>
</tr>
<tr>
<td><strong>Relapse rates.</strong> Why are these high?</td>
<td></td>
</tr>
<tr>
<td><strong>Placebo effect.</strong> What is this?</td>
<td></td>
</tr>
<tr>
<td><strong>A multi-dimensional approach to treatment.</strong> Why is this optimal?</td>
<td></td>
</tr>
<tr>
<td><strong>Appropriateness</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Effectiveness.</strong> Why does this affect appropriateness?</td>
<td></td>
</tr>
<tr>
<td><strong>Valid basis for therapy.</strong> Why is there a valid basis to therapy?</td>
<td></td>
</tr>
<tr>
<td>---</td>
<td></td>
</tr>
<tr>
<td><strong>Individual differences.</strong> Why is clomipramine not appropriate for all patients?</td>
<td></td>
</tr>
<tr>
<td><strong>Slow acting.</strong> How long does drug therapy take to work?</td>
<td></td>
</tr>
<tr>
<td><strong>Side effects.</strong> What are the side effects?</td>
<td></td>
</tr>
<tr>
<td><strong>Drop-out rate.</strong> Is this high or low?</td>
<td></td>
</tr>
<tr>
<td><strong>Lack understanding of their effect.</strong> How does this affect appropriateness?</td>
<td></td>
</tr>
</tbody>
</table>
Using this in the exam

(a) Outline one or more biological therapy(ies) for one anxiety disorder.  
(b) Evaluate the therapy(ies) described in (a).  

---

CONCLUSIONS—SO WHAT DOES THIS MEAN?

Answer the following questions in your conclusions:

- Which type of drug seems to be more effective?

- Why does drug therapy raise issues of appropriateness?
Psychological Therapies for Obsessive Compulsive Disorder

For details, see Eysenck’s A2 Level Psychology (pages 539–548).

Psychodynamic Therapy

Fill in the blanks.

The key goal of psychodynamic therapy is to enable patients to recover their re____________d memories and provide the patient with insight into his or her disorder. Freud used free ass____________n to gain access to the un____________s. This involves the client saying whatever comes into his or her mind. The client might be reluctant to say what he or she is really thinking. However, according to Fr____d, long pauses in what the client says indicate that he or she is moving close to an important repressed idea. Skilled therapists regard the presence of long pauses as an indication that additional questioning and discussion are required.

A second method Freud used to access the unconscious was dr________m an____________s. He claimed we are much more likely to gain access to repressed material while dreaming than when we are awake because the censor in our minds that keeps the repressed material in the unc____________s does not work as well during sleep. The repressed material is included in our dreams in a disguised or sy____________c form because of its unacceptable nature. Freud called the dream as we remember it the manifest content and the true or underlying meaning the latent content. Dream analysis involves interpretation of the symbols in the ma____________t content and questioning clients about their dreams to work out the l____________t content.

Progress in therapy depends partly on transference. This involves the client transferring onto the therapist the powerful em____________l reactions previously directed at his/her own parents or highly significant others. These intense feelings can be negative or positive and the client is usually unaware of what is happening. Tr____________e often provides a direct link back to the client’s childhood by providing a re-creation of dramatic conflicts that were experienced at that time. As a result, transference can facilitate the uncovering of repressed me____________s.

The psychodynamic approach to therapy is difficult to use with patients suffering from OCD because patients often tend to be suspicious of therapists, whom they suspect of invading their private th____________s and threatening their security by questioning them.

EVALUATION OF PSYCHODYNAMIC THERAPY

Summarise the evaluation points below.

Effectiveness

Ψ Modest effectiveness. How effective is psychodynamic therapy?
<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Not a valid basis for therapy.</strong> Why is validity of the therapy questioned?</td>
<td></td>
</tr>
<tr>
<td><strong>Ineffective with severe mental disorders.</strong> Why?</td>
<td></td>
</tr>
<tr>
<td><strong>Encourages obsessive thinking.</strong> Why might this happen?</td>
<td></td>
</tr>
<tr>
<td><strong>Appropriateness</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Focus on undoing.</strong> Why is this technique appropriate?</td>
<td></td>
</tr>
<tr>
<td><strong>Overemphasis on childhood factors.</strong> How does this affect appropriateness?</td>
<td></td>
</tr>
<tr>
<td><strong>Ignores behaviour and cognition.</strong> How does this affect appropriateness?</td>
<td></td>
</tr>
</tbody>
</table>
**Behavioural Therapy**

**Fill in the blanks.**

Exposure and response prevention therapy is a be__________________al therapy. Ex______________________________e involves exposing patients to situations that trigger their obsessions and compulsions. Response pr______________________________n involves not allowing the patients to perform the ri______________________________ls they would typically use to reduce an__________________________y. The combination of these two strategies leads to ex______________________________n of the fear response. Behavioural therapy begins with an assessment of the patient’s obsessional thoughts and impulses and the stimuli that trigger these. The patient is also asked to consider the negative consequences he or she imagines will happen if they confront the fe______________________________d stimuli and do not perform their co______________________________e actions. Exposure starts with only moderately distressing stimuli and only when the patient seems to be coping successfully is he or she exposed to more distressing situations. The patient is expected to practise ex______________________________e for several hours alone before the next treatment session.

**EVALUATION OF BEHAVIOURAL THERAPY**

*Summarise the evaluation points below.*

**Effectiveness**

Ψ **Strong evidence for effectiveness.** What evidence is there for effectiveness?

Ψ **Individual differences.** How many patients does the treatment not work for?

Ψ **A multi-dimensional approach.** Why is this optimal?

Ψ **Artificiality.** How much does this limit effectiveness?
<table>
<thead>
<tr>
<th>Well controlled and scientific.</th>
<th>How does this contribute to effectiveness?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cognitive factors are ignored.</td>
<td>How much does this limit effectiveness?</td>
</tr>
<tr>
<td>Appropriateness</td>
<td></td>
</tr>
<tr>
<td>Valid basis for therapy.</td>
<td>Why is the basis valid?</td>
</tr>
<tr>
<td>Ethical issues.</td>
<td>Why are these raised?</td>
</tr>
<tr>
<td>Individual differences.</td>
<td>Why is the therapy not suitable for all patients?</td>
</tr>
<tr>
<td>Doesn’t treat the obsessions.</td>
<td>Why not?</td>
</tr>
</tbody>
</table>
Cognitive Therapy

Fill in the blanks.

Attempts have been made to combine cognitive therapy with exposure and response prevention to produce cognitive behavioural therapy. However, this has not been found to be very effective (Hill & Beamish, 2007). The main goal of cognitive therapy is to change patients’ faulty cognitions and thereby challenge their obsessional thinking. One approach within cognitive therapy is the pie technique. With this technique, patients indicate their degree of responsibility for a negative outcome linked to their obsessional thinking. The percentage of responsibility is very high and so the therapist supports the patient in exploring other sources of responsibility until their own percentage is lowered to a more realistic amount.

Another technique is called the “double standard” technique. This also seeks to lower the patient’s perceived sense of responsibility by asking them first to imagine their own level of responsibility for a negative outcome. They are then asked whether they would find someone else responsible and guilty if the same threatening event happened to this person. There is usually a high discrepancy between their own level of responsibility and that which they attribute to others and can therefore result in the patient feeling less responsible than before for unfortunate outcomes. Freeston, Rheaume, and Ladouceur (1996) developed several ways of changing the dysfunctional beliefs of obsessive compulsive patients. Patients often overestimate the importance of their obsessional thoughts, based on the illogical belief: “It must be important because I think about it, and I think about it because it is important” (Freeston et al., 1996). This belief can be challenged by asking patients to record their thoughts to show that many unimportant thoughts occur every day. Another method is to ask patients to attend closely to something obviously unimportant (e.g. the tip of their nose). This shows that it is entirely possible to spend much time thinking about matters that have very little importance.

Freeston et al. (1996) have developed a number of ways of challenging patients’ belief that thoughts can increase the probability of an event. For example, they challenge the importance the patient attaches to their obsessions by asking them to think about something meaningless to show that thinking about something a lot does not make it important. They also challenge their faulty belief that their thoughts can influence their environment by asking them to test this out, e.g. they could think a household appliance will break down within the next week. Hopefully it will not! Thus, the faulty cognition would be challenged.

EVALUATION OF COGNITIVE THERAPY

Summarise the evaluation points below.

Effectiveness

Ψ Effectiveness. How effective is cognitive therapy?
### Less effective than behavioural in the long term.
How do Cottraux et al. (2001) demonstrate this?

### Drop-out rate.
Is this higher or lower than for behavioural therapy?

### A multi-dimensional approach.
Why is a combined approach more effective?

### Appropriateness

<table>
<thead>
<tr>
<th>Valid basis for therapy.</th>
<th>Why is the basis for therapy valid?</th>
</tr>
</thead>
</table>

| Low drop-out rate. | Why is this low? |

| Does not treat behavioural symptoms. | How does this affect appropriateness? |
**CONCLUSIONS—SO WHAT DOES THIS MEAN?**

*Answer the following questions in your conclusions:*

- Why is it difficult to compare the effectiveness of treatments?
- Why is informed consent an issue?
- Why is the optimal approach to treatment multi-dimensional?

**FIND OUT FOR YOURSELF:** Try explaining the different therapies to a friend and then ask them to decide which treatment they think would be best for phobias. Teaching somebody else is an excellent way to learn the information. Make sure you present a balanced account of the treatments otherwise your friend's answer might be extremely biased!

**Using this in the exam**

(a) Outline one or more psychological therapy(ies) for one anxiety disorder. (9 marks)

(b) Evaluate the therapy(ies) described in (a). (16 marks)
Example Essay Plan

(a) Outline one or more biological therapies for one anxiety disorder. (9 marks)

(b) Evaluate the therapy(ies) described in (a). (16 marks)

The marking is broken down into three sets of criteria, AO1, AO2 and AO3, but this is not how you should write your essay. The essay should include all these criteria in a holistic way—e.g. as you write about drug therapy you will then write about the research studies supporting or challenging the effectiveness of drug therapy, and then discuss the effectiveness and appropriateness of the therapy, which could include methodological (e.g. participant sample size), ethical, and reductionist issues, etc.

AO1 (9 marks)
A general but accurate description of the drug therapy is needed. Describe the different forms of drug therapy to achieve breadth but be selective as you do also want to achieve depth.

AO2 (12 marks)
Commentary and evaluation of the drug therapy is needed. This can include research studies on the effectiveness of the therapies. A good focus is to base your commentary around the effectiveness and appropriateness of the therapy.

AO3 (4 marks)
Evaluation and/or interpretation of the research could include the weaknesses of the research evidence that supports the therapy, and use issues such as reductionism to add to your evaluation.

So the essay could be structured in the following way.

Note the question is divided into AO1 in part (a) and AO2 in part (b).

(a) Outline one or more biological therapy(ies) for one anxiety disorder. (9 marks)

Introduce drug therapy as the main biological approach in the treatment of OCD. Describe the use of SRIs and SSRIs.

Outline research evidence such as Dougherty et al. (2002) who explain why SSRIs take 6 weeks to work and Eddy et al.’s (2004) comparison of different types of drugs.

(b) Evaluate the therapy(ies) described in (a). (16 marks)

Conclude what the above research suggests about the effectiveness of drug therapy. Discuss why a combined approach of SRIs/SSRIs and anti-psychotics may be optimal.

Consider issues that limit effectiveness such as: drop-out rate; the unpleasant side effects (dry mouth, drowsiness, sedation, and sweating); treats symptoms not causes; relapse rates; and the placebo effect.

Consider in what ways the treatment is appropriate, for example: effectiveness; there is a valid basis for therapy. Consider the ways in which drug therapy is not appropriate, for example: individual differences; slow-acting; side effects; drop-out rate; and we lack understanding of the drugs’ effect.
Discuss why drug therapy should be combined with other treatments and consider why the psychological therapies provide strong alternatives.

Consider the strongest arguments for drug therapy—their effectiveness in reducing anxiety. Patients may find the psychological treatments too demanding in terms of effort and motivation so drugs compare well in terms of ease of use. Furthermore, some patients may need drug therapy to calm them down to a state in which they can benefit from psychological therapy.

Consider the limitations of drug therapy—drugs are only reasonably effective. The length of any improvement is a key issue because research suggests the improvement lasts only as long as patients stay on the drugs and of course being on drugs is not a permanent solution!

Discuss how comparisons of the effectiveness of different treatments should be treated with caution due to issues such as individual differences of the patient or therapist. Consider the ethical issues of therapy, such as informed consent and confidentiality.

Conclude by explaining why a multi-dimensional approach is optimal.