

Biological explanation of OCD:

Genetic explanations:

**Genes** are involved in in individual’s vulnerability to OCD. Lewis = 37% of OCD patients has parents with OCD

**Candidate genes** – genes identified which create a vulnerability to developing OCD e.g. SERT gene

**Polygenic** – OCD not caused by one single gene, could be up to 230 involved in development

**Different types** – different combinations of genes could cause different types of OCD e.g. hoarding

Neural explanations:

**The role of serotonin** – low levels of serotonin = normal transmission of mood-relevant information can’t happen

**Decision-making systems** – some types of OCD associated with impaired decision making and abnormal functioning in frontal lobes. Worry circuit = overwhelming worries

Biological treatment of OCD:

**Drug therapy** – aims to increase serotonin in OCD sufferers

**SSRI’s** – selective serotonin reuptake inhibitors work on the serotonin system in the brain. They block the reuptake of serotonin meaning the synapse is flooded with serotonin meaning it’s more likely to stimulate the post-synaptic receptors. Fluoxetine – 20mg taken daily, to be increased if unsuccessful. 3-4 months of daily use to have much impact on symptoms of OCD

**Combining SSRI’s with other treatments** – often used alongside CBT, drugs reduce symptoms which helps engagement. Sometimes used with other drugs

**Alternatives** – When SSRI’s are unsuccessful other drugs may be tried.

**Tricyclics** – have the same effect on serotonin system e.g. Clomipramine – have more severe side-effects

**SNRI’s** – serotonin noradrenaline reuptake inhibitors, increase levels of serotonin and noradrenaline

Cognitive treatment of depression:

**Cognitive behaviour therapy (CBT)** - most commonly used psychological treatment for depression. Begins with an assessment of the patient, the therapist and patient work together to clarify problems, identify goals and work towards them. Irrational thoughts are identified and challenged, most draw on techniques from both Beck and Ellis.

**Beck’s cognitive therapy** – Aims to identify and challenge negative thoughts to do with the **negative triad** (self, world, future). Patients tested about the reality of their negative beliefs. Homework may be given to help

**Ellis’s rational emotive behaviour therapy (REBT)** – extends the ABC model to ABCDE. D = disputing (dispute irrational thoughts and E = effect. **Logical disputing** = do irrational thoughts follow from fact? **Empirical disputing** = is there evidence to support the irrational thought?

**Behavioural activation** – aim for patient to be more active and engage in enjoyable activities

Behavioural explanation of phobias:

Mowrer called it the **2-process model** – acquisition by classical conditioning, maintaining by operant conditioning

Acquisition by classical conditioning – an association is made between something which causes no fear (NS) and something which does (UCS). Little Albert – Watson and Rayner present Albert with a mouse (NS) he liked it. When they banged a metal rod (UCS) he cried (UCR). When they showed him the mouse (NS) they banged the rod (UCS) at the same time. Albert learned to fear the mouse so it has now become the CS and produces fear as the CR.

Maintenance by operant conditioning – by avoiding the phobia we get rid of any anxiety it brings – **negatively reinforced**, so avoidance continues and phobia remains

Psychopathology

Behavioural, emotional, and cognitive symptoms of OCD, phobias and depression:

**Emotional** – how we feel. **Behavioural** – how we act. **Cognitive** – how we think/ process information

OCD – **emotional** = anxiety, accompanying depression, guilt & disgust. **Behavioural** = Compulsions (repetitive behaviours done to reduce anxiety) and avoidance. **Cognitive** = obsessions, cognitive strategies to deal with obsessions, aware obsessions & compulsions aren’t rational

Phobias – **emotional** = anxiety, irrational fear responses. **Behavioural** = panic, avoidance or endurance when this is not possible. **Cognitive** = irrational beliefs about phobic stimulus, cognitive distortions and selective attention paid to phobia

Depression – **emotional** = lowered mood, anger, lowered self-esteem. **Behavioural** = aggression and self-harm, lack of activity, disruption to sleeping and eating patterns. **Cognitive** = poor concentration, attending to the negative, think of things as all bad not a mix of good and bad

Definitions of abnormality:

Statistical infrequency – occurs when an individual has less common characteristics e.g. being more or less intelligent than average. Applies when we have characteristics that can be easily measured e.g. IQ score

Deviation from social norms – concerns behaviour that is different from the accepted standards of behaviour in a community or society. Norms are specific to the culture we live in. An example is antisocial personality disorder

Failure to function adequately – occurs when someone is unable to cope with the demands of everyday life e.g. can’t maintain basic hygiene or hold down a job. They may stare or not give any eye contact or get to close to people and they may be a danger to themselves or others

Deviation from ideal mental health – occurs when someone does not meet the criteria for good mental health. We form a criteria for good mental health and look at who deviates from this. Examples of criteria to meet: no symptoms or distress, good self-esteem, realistic view of the world, can cope with stress, we self-actualise

Behavioural explanation of phobias:

Systematic desensitisation – patient gradually exposed to their phobia. An **anxiety hierarchy** is created from things which cause the least anxiety to the most e.g. a photo of the phobia – being in the room with the phobia. The hierarchy is then worked through and the patient is taught **relaxation** techniques e.g. breathing exercises or patient may be given medication e.g. Valium to lower anxiety before moving onto the next step in the hierarchy. The final step is **exposure,** the patient should now be in a relaxed state and able to be in the presence of the phobia and stay calm. The patient cannot be relaxed and scared at the same time so relaxation overtakes the fear

Flooding – immediate expose to an extreme for of the phobia e.g. locked in a room full of spiders. Sessions are longer, but less are needed. Patient has no option to avoid so learns the phobia isn’t as bad as they thought. CS is encountered without the UCS so phobia is extinguished **(extinction**). Ethics must be considered carefully

Cognitive explanation of depression:

Beck’s cognitive theory – we have **faulty information processing** and only attend to the negative. We might also blow things out of proportion. We view ourselves negatively; the package of information we hold about ourselves is negative **(negative self-schemas)** and we have negative thoughts about the world (life is so hard and there’s no hope), the future(things won’t get better) and ourselves (thinking you’re a failure and having low self-esteem) **(negative triad).**

Ellis’s ABC model – irrational thoughts affect our behaviour and emotional state. A = activating event, depression is triggered by a negative event. B = beliefs, believing we must always succeed, or believing things are a major disaster if they go wrong. C = consequences, activating event triggers irrational beliefs there are emotional and behavioural consequences.